Health Devolution Commission On-Line Meeting

Future Integrated Care Systems: Getting Primary and Community Care Reform Right

On-line, 14:00 to 16:00, Thursday 28th March 2024

LINK TO MEETING HERE

The Health Devolution Commission's annual report was launched in Parliament earlier this year and ten high level conclusions were subsequently agreed – see **here**. The aim of this meeting is to explore in detail one of these – the need to get the reform of primary and community care right. In particular, the meeting will look at the what the scope, leadership and development of integrated primary and community care should look like in light of their key and developing roles within Integrated Care Systems.

Devolution of NHS power, resources and accountability to local levels is the central mission of the Commission. Devolution is a model of change rooted in the belief and the evidence that improving the health of the population, and improving the quality and outcomes of health and care services for those in need, will best be achieved when power, resources and accountability are located as close to the frontline as practicable.

Is a triple devolution required - from central government to Integrated Care Systems, from ICSs to place-based partnerships, and from those to localities and neighbourhoods? If so, what should be the extent of devolution to primary and community care systems? What should primary care look like in future? Key questions the Commission will address at its meeting on the 28th March include:

1. **Scope:** What health and social care services and what other public and voluntary sector services should be within the scope of primary and community care?
2. **Population**: Which population groups and needs should be covered and be a priority for primary and community care?
3. **Aims**: What objectives and shared outcomes should primary and community care seek to achieve?
4. **Functions:** What functions should be undertaken by primary and community care to achieve those objectives and outcomes?
5. **Funding:** What direct funding should primary and community care have and what budgets should be within its scope to influence?
6. **GPs and PCNs:** What should be the future model for General Practice and how should this relate to Primary Care Networks to make primary and community care work effectively?
7. **Leadership:** Who should provide the leadership within primary and community care generally, and of Primary Care Networks in particular?
8. **Voice:** How should the local community and those who draw on services be involved and have a voice in primary and community care decisions?
9. **ICSs:** What role should the ICS and local place-based partnerships play in supporting and developing the primary and community care system, and vice-versa?
10. **Resource shift**: What needs to be done at a strategic level to shift resources away from institutional-based care to community-based care and population/public health improvement activities?

The Commission's deliberations will be informed by an ***expert policy panel***:

- **Baroness Pitkeathley, Chair of the Lords' Integration of Primary and Community Care Committee**
- **Ruth Rankine, Director of Primary Care, Primary Care Network, NHS Confederation**
- **Beccy Baird, Lead author, Making care closer to home a reality, King's Fund**

It will also be informed by an ***expert practitioners' panel***:

- **Dr Jane Harvey, Clinical Director, Healthy Hyde, Greater Manchester**
- **Dr Ashish Dwivedi, Director, Health Integration Partners**
- **Laura Churchill, Director of Strategy, Partnerships and Integration, Central London Community Healthcare NHS Trust and former Director, London ICS Network**

This background briefing paper includes:

The partners of the Health Devolution Commission are NHS Confederation, Local Government Association, London Councils, West Yorrkshire Helth and Care Partnership, Mencap and Barnardo's.

1 RECENT RELEVANT POLICY REPORTS

'Prevention in health and social care: healthy places', DHSC Select Committee, January 2024
This first report in a series to be published by the select committee concludes that **'**A determined focus on developing "healthy places" that can prevent ill-health amongst those most at risk is now vital in easing pressures on the NHS, and building a sustainable service for generations to come.'

'Five key elements for discharge – supporting people with a learning disability and autistic people to leave hospital', NHSE, January 2024
This report by NHSE found that 41% of those people in hospital had care and support needs that meant they did not need to be in hospital, a**nd** that this is harmful to people's physical, mental and emotional wellbeing.

'Arrangements for delegation and joint exercise of statutory functions', NHSE, February 2024
This guidance for Integrated Care Boards provides an overview of the new collaborative working arrangements that are possible between NHS organisations and local government. However, NHSE says that 'Considering the additional potential complexity of integrated care board (ICB) to provider delegation, associated risks, and the significant operational and financial pressures facing systems in 2024/25, ***NHS England continues to expect that ICBs not seek to use these powers in financial year 2024/25.'*** [Our bold and italics]

'Making care closer to home a reality', King's Fund, February 2024
This report says that despite successive governments repeating a vision of health and care services focused on communities rather than hospitals, that vision is very far from being achieved. It found that to achieve the vision, political and other national leaders will need to completely shift their focus away from hospitals towards primary and community health and care – and all policies and strategies must align to that focus.

'Illustrating the relationship between poverty and NHS services', King's Fund, February 2024
This report describes the evidence that people living in poverty find it harder to live healthy lives, harder to access NHS services, live with greater illness and die earlier than the rest of the population. The recent rise in deep poverty, cost-of-living increases and high pressure on NHS services are all worsening the problem and adding to the financial cost to the NHS. It says that the NHS has a role to play in addressing poverty, both as an employer and as a provider of public services and that there are examples of good work under way, such as poverty-proofing services. But the NHS can only treat the symptoms of poverty; broader government, economic and civic society action is needed to treat the causes.

'Social Care 360', King's Fund, March 2024
This is the 2024 report in a series of annual reports since 2019 describing key trends in different aspects of the social care system. This report includes trends in people's access to social care, expenditure and care providers, workforce and unpaid carers, and quality.

'Who Cares Wins', Community Integrated Care, March 2024
This report is the third in a series published by CIC that explores the damaging impact of the large gap in pay between frontline care and support workers and their counterparts in the NHS based on an independent job evaluation. It describes the opportunity of a 'social care triple win' from government investment in fair pay - better lives for those who draw on and provide social care, greater efficiency and productivity in both social care services and the NHS; and economic growth in some of the most deprived areas of the country. It also includes polling data showing widespread support for parity pay from the public and MPs from all parties.

Reforming adult social care in England, Public Accounts Committee (PAC), March 2024
Government is falling short on its promise to "fix the crisis in social care" as chronic understaffing, rising waiting lists and patchwork funding place sustained pressure on local authorities. PAC calls for stronger leadership, long-term financial support, and a clear workforce strategy to address shortfalls in the adult social care sector.

2 OVERVIEW OF PRIMARY AND COMMUNITY CARE SERVICES

In parallel with the development of Integrated Care Systems, primary and community care in England has been a focal point for NHS reform through the GP contract and creation of Primary Care Networks, aiming to address the evolving healthcare needs of local populations. There are 6,500 GP surgeries in England organised in 1,250 Primary Care Networks. The primary care workforce includes 35,000 FTE GPs plus a wide range of other clinical staff, physician associates, social prescribers, and administrative staff providing around 300 million GP consultations every year. However, primary and community care services embrace both the primary care workforce and a very wide range of other health professionals including community nurses, district nurses, allied health professionals (such as physiotherapists), health visitors, dentists, optometrists, GPs, and care workers and social workers (see ***Appendix 1*** for basic facts about the system).

Reform initiatives have sought to enhance accessibility, quality, and efficiency of services, recognising the pivotal role primary and community care play in preventive healthcare and managing chronic conditions. They include a focus upon:

Integration*:* One significant aspect of the reform is the emphasis on integrated care that involves breaking down traditional silos between primary care, community services, and social care to provide a seamless experience for patients; and between primary/community care services and secondary, hospital-based services. Integrated care models aim to create a collaborative approach among healthcare professionals, ensuring that patients receive comprehensive and coordinated support. This not only improves patient outcomes but also reduces the burden of demand and cost on acute care services[1].

Technology: Investment in technology has been a cornerstone of the reform efforts. Digital platforms, electronic health records, and telemedicine have been integrated to streamline processes, enhance communication among healthcare providers, and provide patients with convenient access to services. This shift towards digital healthcare not only improves efficiency but also empowers patients to actively participate in their care. The Spring 2024 Budget[2] included an NHS IT productivity deal of £3.4bn over 5 years to improve digital ways of working such as universal electronic patient records that it estimates will generate a total of £34bn in productivity savings.

Workforce and training*:* Workforce development has been another crucial focus area. Initiatives to recruit and retain healthcare professionals in primary and community care have been implemented to address staffing shortages. The Additional Roles Reimbursement Scheme[3] (ARRS) was introduced in 2019 to improve access to general practice. Through the scheme PCNs can claim reimbursement for the salaries (and some on-costs) of 17 new roles within multidisciplinary teams, selected to meet the needs of the local population. In expanding general practice capacity, the scheme improves access for patients, supports the delivery of new services and widens the range of offers available in primary care. New flexibilities on the ARRS scheme were introduced in the Spring 2024 budget. There has also been an emphasis on training healthcare providers in new and emerging models of care, promoting a patient-centred approach and equipping them with the skills needed for the evolving healthcare landscape.

Patient engagement: Patient engagement and empowerment are intended to be at the forefront of the reform agenda. Efforts to involve patients in decision-making processes (e.g. Patient Participation Groups[4]), care planning, and self-management are prioritised. These include initiatives to improve health literacy, provide accessible information, and encourage shared decision-making between healthcare providers and patients.

[1] https://www.nhsconfed.org/publications/unlocking-power-health-beyond-hospital
[2] https://www.gov.uk/government/publications/spring-budget-2024/spring-budget-2024-html
[3] https://www.england.nhs.uk/gp/expanding-our-workforce/
[4] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/09/ppg-guidance.pdf

Health inequalities: The reform has recognised the importance of addressing health inequalities. Initiatives aimed at reducing inequalities in healthcare access and outcomes among different socio-economic groups are a key aspect of the approach. This involves tailoring services to the specific needs of local communities and implementing strategies to address the social determinants of health.

However, the evidence[5] in 2022 shows that health inequalities are widening - for most of their lives, people in the poorest areas of England, on average, have more diagnosed illness over 10 years earlier than those in the richest areas; children and young people (the under 20s) in poorer areas are much more likely to be living with conditions such as asthma, epilepsy, and to experience alcohol problems; and People from Pakistani, Bangladeshi and black Caribbean backgrounds are found to have higher levels of long-term illness than the white population.

Appendix 2 describes the role that primary and social care plays in children's health; and ***Appendix 3*** outlines the role it plays in the health of people with learning disabilities or autism. For both groups there are significant areas for improvement needed including low vaccination rates for children, and reductions in essential annual health checks for people with learning disabilities or autism.

Prevention: Primary prevention and health promotion have also gained prominence in the reform agenda. By focusing on preventative measures and promoting healthy lifestyles, primary and community care aims to reduce the prevalence of chronic conditions and alleviate the strain on services. This includes public health campaigns, education programs, and community-based interventions to foster a culture of proactive health management[6].

3 Primary Care Networks

3.1 A platform for change

The development of Primary Care Networks (PCNs) in England[7] represents a significant shift in the delivery of healthcare services, fostering collaboration and integration to improve patient outcomes. Established as part of the NHS Long Term Plan and seen as crucial to the development of integrated care services, PCNs build on the core work of current primary care services to enable greater provision of proactive, personalised, coordinated and more integrated health and social care for local communities.

One key driver behind the creation of PCNs is the recognition of the increasing complexity of healthcare needs and the necessity for a more interconnected approach. By forming networks, healthcare providers within a PCN can share resources, expertise, and information, leading to more effective and efficient patient care. This collaborative model allows for a holistic view of patients' health, emphasizing preventive measures and addressing the social determinants of health.

Networks are supported by a Clinical Director, often a senior GP within the PCN, who plays a pivotal role in coordinating services and fostering collaboration among member practices. This leadership is seen as crucial for aligning the goals of individual practices with the broader objectives of the PCN, ensuring a unified and patient-centric approach to healthcare delivery.

[5] https://www.health.org.uk/news-and-comment/news/major-study-outlines-wide-health-inequalities-in-england
[6] https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe frailty/#:~:text=The%20specific%20aims%20of%20proactive,reducing%20use%20of%20unplanned%20care.
[7] https://www.england.nhs.uk/long-read/primary-care-networks-pcns/#:~:text=Primary%20Care%20Networks%20(PCNs)%20form,closer%20integration%20of%20services%20locally.

The introduction of PCNs also emphasizes the importance of a multi-disciplinary healthcare team. By integrating various healthcare professionals, such as pharmacists, physiotherapists, and social workers, PCNs can offer a more comprehensive range of services. This team-based approach enhances the capacity to manage chronic conditions, provide preventive care, and support patients with complex needs.

PCNs are designed to strengthen the connection between primary care and other parts of the healthcare system. Through collaboration with secondary care, social care, and community services, PCNs can facilitate smoother transitions for patients between different levels of care. This integrated approach is expected to reduce pressure on acute services and improve the overall efficiency of the healthcare system.

Technology plays a crucial role in the development of PCNs. The implementation of shared electronic health records and digital communication platforms enhances information exchange among healthcare providers within the network. This not only improves the coordination of care but also empowers patients to be more actively involved in their health management.

3.2 Funding of Primary Care Networks

PCNs are formed via sign up to the Network Contract Directed Enhanced Service (DES) Contract Specification 2020/21[8], which was first introduced on 1 July 2019 and sets out core requirements and entitlements for a PCN. PCNs are also supported by the PCN Development Programme which is centrally funded and locally delivered.

Between 2020/2021 and 2023/24, the Network Contract DES committed a total investment of £2.4 billion into primary care across the country, or £1.47 million per typical PCN over 4 years. This includes funding for around 26,000 more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers.
Bigger teams of health professionals work across PCNs, as part of community teams, providing tailored care for patients and allow GPs to focus more on patients with complex needs.

The objective is for the Network Contract DES to support PCNs to deliver the ambition for improved standards of care across the country, setting realistic expectations for delivery that benefit patients. The 2020/21 Network Contract DES introduced three services to be delivered by PCNs from October 2020:

- Enhanced Health in Care Homes
- Early Cancer Diagnosis
- Structured medication reviews and medicines optimisation

Additional services being delivered by PCNs from 2021/22 are:

- Cardiovascular disease (CVD) diagnosis and prevention
- Tackling neighbourhood inequalities
- Personalised care
- Anticipatory care

PCNs are also entitled to earn additional funding through a new incentive scheme – the Investment and Impact Fund. The Network Contract Directed Enhanced Service (DES) has been updated annually until 2023/24. New arrangements for the GP contract in 2024/25[9] were issued on 28th February 2024 which included more flexibility in the operation of PCNs.

[8] https://www.england.nhs.uk/publication/des-contract-specification-2020-21-pcn-entitlements-and-requirements/
[9] https://www.england.nhs.uk/long-read/arrangements-for-the-gp-contract-in-2024-25/#:~:text=GP%20contract%20finance&text=There%20will%20be%20an%20overall,GPs%2C%20and%20other%20practice%20staff.

3.3 The Fuller Stocktake

The Fuller Stocktake[10] in May 2022 spelled out a new vision of integrating primary care, and improving the access, experience and outcomes for local communities, which centred around three essential offers:

I. streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it

II. providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions

III. helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

The report identified 4 main changes to help deliver this vision:

a) Building integrated teams in every neighbourhood

The evolution of PCNs into Integrated Neighbourhood Teams with two shifts in mindset towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community; and realignment of the wider health and care system to a population-based approach – for example, aligning secondary care specialists to neighbourhood teams.

b) Improving same-day access for urgent care

Enabling primary care in every neighbourhood to create single urgent care teams and to offer patients the care pathway appropriate to them.

c) Personalised care

Provide continuity of care to those patients who need it most through conversations with patients, clinical judgement and by data analysis. This means managing urgent care differently, and supporting the growth and development of integrated neighbourhood teams, to create the capacity for team-based continuity.

d) *Preventative healthcare*

Three areas where primary care is taking a more active role in creating healthy communities and reducing the incidence of ill health are working with communities; harnessing data effectively; and fostering close working relationships with councils. The wider primary care team should also be much more effectively harnessed, specifically the potential to increase the role of community pharmacy, dentistry, optometry, and audiology in prevention, working together to 'making every contact count'.

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

4 THE KEY CHALLENGES FOR THE PRIMARY AND COMMUNITY CARE SYSTEM

4.1 Matching vision with action

The 2024 report 'Making care closer to home a reality'[11] by the King's Fund assesses the state of the primary and community care system. Evidence shows that financial and workforce growth is not aligned to the vision of shifting NHS care from institutions into the community with larger growth in acute hospital sectors than in primary and community sectors. It says that the failure to grow and invest in primary and community health and care services ranks as one of the most significant and long-running failures of policy and implementation in the NHS and social care for more than 30 years.

The report describes eight main reasons for this failure, and identifies what needs to be done to change the focus of the health and care system towards primary and community health and care across the domains of leadership, culture and implementation:

- More alignment between policy and vision so that funding, regulation, workforce and performance policies match the intention of changing the focus of the health and care system towards primary and community health and care services.
- National leaders need to prioritise primary and community health and care services, including having more national and system leaders with experience in these sectors.
- It is not viable to consider reducing funding for acute hospital services; rather, future growth in funding and staffing needs to be directed proportionately more to primary and community health and care services rather than to acute hospitals.
- National bodies should give integrated care boards (ICBs) more trust and devolved decision-making, with ICBs in turn focusing on greater engagement with staff and wider sector partners, and providers focusing on greater engagement with people and communities.
- A greater focus on operational integration at service level rather than organisational integration, and a greater focus on local-level development and priorities.

Further actions and areas for policy development that the report identifies are workforce development; planning, contracting and delivery; and capital and estates.

4.2 Realising the financial benefits of investing in primary and community care services

The financial benefits of shifting care from institutions in to the community are described in the 2023 report 'Unlocking the power of health beyond the hospital: supporting communities to prosper'[12] by the NHS Confederation. This explores how investing in community care can improve productivity and its analysis found that those areas that spent relatively less on community care in terms of population need have seen higher-than-average levels of hospital and emergency activity, compared to those spending relatively more.

On average, systems that invested more in community care saw 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates, both statistically significant differences, together with lower average activity for elective admissions and A&E attendances. However, despite the increased focus on creating better health value and unlocking system productivity, there is currently no relationship between the amount invested by NHS organisations in community care and their population community care needs. The sheer variation in spend perhaps highlights a wider lack of understanding and prioritisation in community care.

[11] https://www.kingsfund.org.uk/insight-and-analysis/reports/making-care-closer-home-reality
[12] https://www.nhsconfed.org/publications/unlocking-power-health-beyond-hospital

The reduction in acute demand associated with this higher community spend could fund itself through savings on acute activity if a causal relationship were assumed, with an average 31% return on investment and average net saving of £26 million for an average-sized integrated care system (ICS), exemplifying the power and potential of community care at a system level.

A 'Total Place' approach

The 'Who Cares Wins' report highlighted in section 1 above evidenced a potential social care triple win from investing in better pay for frontline care workers: better lives for those who draw on and provide social care, greater efficiency and productivity in both social care services and the NHS; and economic growth in some of the most deprived areas of the country.

Similarly, a funding analysis that embraces primary and community care services but goes much wider would capture the "financial deal flow" from investment in preventative services, capturing the dividend in reduced crisis/failure demand and using that resource to sustain and grow the preventative activity.

The place-based approach that lies at the heart of health devolution and Integrated Care Systems could provide the opportunity to re-appraise of the value of Total Place or Community Budgets developed over a decade ago.

4.3 Pressures and priorities for action

Pressures

Some key pressures on primary and community care services include:

a) **Workforce Shortages**: Limited healthcare professionals, especially general practitioners and community nurses, pose a significant challenge to the primary and community care system in England.
b) **Aging Population**: With an aging demographic, there is an increased demand for healthcare services, placing strain on the existing system and resources.
c) **Mental Health Support**: Meeting the growing demand for mental health services within primary and community care is now a pressing issue.
d) **Funding Constraints**: Limited financial resources and budget constraints hinder the development and improvement of primary and community care services.
e) **Health Inequalities:** Addressing inequalities in healthcare access and outcomes among different socio-economic groups, different age groups, ethnic groups and people with a learning disability or autism are a persistent challenge.

Priorities for action

To address these pressures and achieve all the aims of primary and community care including reducing health inequalities some key priorities for action include:

a) **Financial framework**: Developing a robust financial framework which incentivises primary care and expands community care, and actively manages the growth in primary and community investment whilst supporting the capacity required in acute services.
b) **Integration of Services**: Improving the co-ordination of care within and between primary, community, and secondary services across NHS, social care and public health; and within the wider public, VCFSE and independent sectors

c) **Digital Transformation**: Implementing and adapting to evolving technologies for healthcare records, telemedicine, assistive technologies and digital communication
d) **Preventive Care and Health Promotion**: Developing the capacity to influence and access the social determinants of health, respond to and reflect the leadership from communities, and encouraging and facilitating preventive measures and health promotion initiatives
e) **Patient Engagement**: Promoting patient involvement in their care and fostering shared decision-making including improving health literacy and communication.
f) **Infrastructure and Facilities**: Ensuring adequate infrastructure and facilities for primary and community care that reflect the new model of care, especially in rural areas.

4.4 A new model of primary care?

There is now an active debate within all political parties about what the future of primary care should look like. The Government have recently announced the creation of a Taskforce on the Future of General Practice[13] during spring/summer of 2024 that they say is a key opportunity for the Department and NHSE to hear from stakeholders about priorities for change through the 2025/26 GP contract.

Labour has also made clear its view that the system needs to move on from the 1948 partnership model of General Practice but is open-minded about any future model. Labour has announced its intention to develop a Neighbourhood Health Service[14] as much as a National Health Service including Neighbourhood Health Centres that bring together family doctors, district nurses, care workers, physiotherapists, and mental health specialists under one roof.

5 KEY QUESTIONS FOR THE COMMISSION

Devolution of NHS power, resources and accountability to local levels is the central mission of the Commission. Devolution is a model of change rooted in the belief and the evidence that improving the health of the population, and improving the quality and outcomes of health and care services for those in need, will best be achieved when power, resources and accountability are located as close to the frontline as practicable.

Is a triple devolution required - from central government to Integrated Care Systems, from ICSs to place-based partnerships, and from those to localities and neighbourhoods? If so, the question arises – what should be the extent of devolution to primary and community care systems? What should primary care look like in future? Key questions include:

Ten key questions	Options
1. What health and social care services and what other sectors should be within scope of primary and community care?	GP practices, district nursing, dentistry, pharmacy, optometry, community mental health, allied health professionals, public health, social care; the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, the wider public sector including education, housing and economic development, private health and social care providers; and local businesses.

[13] https://www.england.nhs.uk/long-read/arrangements-for-the-gp-contract-in-2024-25/#:~:text=GP%20contract%20finance&text=There%20will%20be%20an%20overall,GPs%2C%20and%20other%20practice%20staff.
[14] https://labour.org.uk/missions/nhs/

2. Which population groups and needs should be covered and be a priority for primary and community care?	Children and young people, adults, older people, people in high health risk groups, people with learning disabilities, people who do not routinely access mainstream services
3. What objectives and shared outcomes should primary and community care seek to achieve?	National or locally determined priorities, better access to care including mental health, better experience of care, better health and care outcomes, better population health, reducing inequality
4. What functions should be undertaken by primary and community care to achieve those objectives and outcomes?	Population health improvement activities, planning and re-shaping local services, models of Multi-Disciplinary Teams working, direct patient access to specialist services and pharmacy
5. What direct funding should primary and community care have and what budgets should be within its scope to influence?	DES PCN contract funds, local funding from ICSs and place-based partnerships, budgets of the local partners in health and social care
6. What should be the future model for General Practice and how should this relate to Primary Care Networks to make primary and community care work effectively?	The current GP partnership model, more salaried GPs, a new collaborative model yet to be developed.
7. Who should provide the leadership within primary and community care generally, and of Primary Care Networks in particular?	GPs, other clinicians, local government leaders, VCFSE leaders.
8. How should the local community and those who draw on services be involved and have a voice in primary and community care decisions?	Ward councillors, patient reference groups, unpaid carers forums, people with lived experience of care.
9. What role should the ICS and local place-based partnerships play in supporting and developing the primary and community care system, and vice-versa?	Funding, planning, priorities, decision-making, structures, accountability.
10. What needs to be done at a strategic level to shift resources away from institutional-based care to community-based care and population/public health improvement activities?	Identifying and allocating specific shifts in funding, ensuring active support for change by leaders of acute hospital services, training for staff in the neighbourhood/locality model of care

APPENDIX 1 BASIC FACTS ABOUT THE PRIMARY AND COMMUNITY CARE SYSTEM

Primary Care Providers:
There are around 6,500 general practices (GP surgeries) in England[15], serving as the cornerstone of primary care. The majority of primary care services are delivered through these GP practices. The term 'primary care' refers to GPs and the workforce within GP practices. The wider term 'primary and community care' embraces the primary care workforce and the much wider range of local healthcare professionals (see below).

Primary Care Workforce:
The primary care workforce includes over 35,000 FTE general practitioners (GPs)[16] providing medical services. In addition to GPs, primary care teams often include nurses, healthcare assistants, and administrative staff. In addition, there are now additional roles in a GP practice funded by government through the Additional Roles Reimbursement Scheme and a growing number of new roles such as physician associates and social prescribers working in GP practices.

Primary Care Use:
Approximately 90% of patient contact with the National Health Service (NHS) occurs in primary care settings. In a typical year, there are over 300 million GP consultations[17].

Community Care Services:
Community care services[18] aim to improve the health and wellbeing of people of all ages, treat and manage long-term conditions, bring care closer to home, and allow people to live independently in their own homes. They encompass a wide range of healthcare professionals, including community nurses, district nurses, allied health professionals (such as physiotherapists), health visitors, dentists, optometrists, GPs, and social workers. In some cases, community services are co-located with primary care in health hubs or polyclinics.

Primary Care Networks (PCNs):
Primary Care Networks (PCNs) have been established since 2020/21 to promote integrated community care. There are around 1,250 PCNs in England[19] covering all localities and are typically comprised of multiple general practices, covering a patient population of 30,000 to 50,000. This scale enables providers to pool resources and offer a broader range of services, such as extended access to primary care, mental health support, and community-based initiatives.

Digital Health:
Over 90% of GP practices offer online appointment booking and prescription requests.
The majority of GP practices use electronic health records to store and manage patient information.

Patient Engagement:
Patient participation in primary care decision-making is encouraged, with initiatives to enhance health literacy and shared decision-making. Patient satisfaction rates with primary care services are generally high.

Public Health Initiatives:
Primary and community care services actively engage in public health initiatives, including vaccination programs, health promotion, and disease prevention.

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[15] https://www.statista.com/statistics/996600/gp-practices-in-england/
[16] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2022
[17] https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/primary-care/
[18] https://www.nuffieldtrust.org.uk/resource/the-state-of-community-health-services-in-england-0-
[19] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/primary-care-networks-explained

APPENDIX 2 CHILDREN IN PRIMARY AND COMMUNITY CARE

Primary and community care services play a crucial role in enhancing the health and well-being of children and young people in England. As the first point of contact within the healthcare system, primary care serves as a gateway to address a wide range of health concerns and promote preventive measures.

Prevention: One key aspect of primary care's impact on children and young people is the emphasis on preventive healthcare. Regular check-ups and vaccinations are integral components of primary care services. Timely vaccinations protect against infectious diseases, preventing outbreaks and safeguarding the health of the entire community. Routine health screenings help identify potential issues early, enabling prompt intervention and reducing the long-term impact on a child's health. However, in 2022/23 the UK vaccination coverage rates by age five[20] were below the 95% target for all vaccines set by the World Health Organisation. Children's oral health and dentistry services for children play an important role in identifying and preventing ill-health and reducing child health inequalities within primary and community care services.

Childhood illnesses: Primary care providers also play a pivotal role in managing common childhood illnesses. From minor infections to chronic conditions, general practitioners are often the first line of defence. Timely diagnosis and treatment contribute to faster recovery, minimizing the disruption to a child's daily life and educational activities. Additionally, effective management of chronic conditions ensures that children can lead healthier and more fulfilling lives.

Mental health: General practitioners are well-positioned to identify early signs of mental health issues, providing timely interventions and referrals to specialized services. Collaborative efforts with mental health professionals ensure a holistic approach to a child's well-being, recognizing the interconnectedness of physical and mental health.

Family support: Primary care serves as a resource hub for parents and caregivers, offering guidance on nutrition, growth and development, and overall parenting support. Educational initiatives within primary care settings contribute to increased health literacy, empowering families to make informed decisions about their children's health. This proactive approach strengthens the foundation for a healthy lifestyle from an early age.

Continuity of care: The continuity of care provided by primary care practitioners is vital for monitoring the growth and development of children and young people. Through regular visits, healthcare professionals can identify deviations from normal development, enabling early intervention and support.

This ongoing relationship between primary care providers and families fosters trust and facilitates open communication, creating a supportive environment for addressing health concerns.

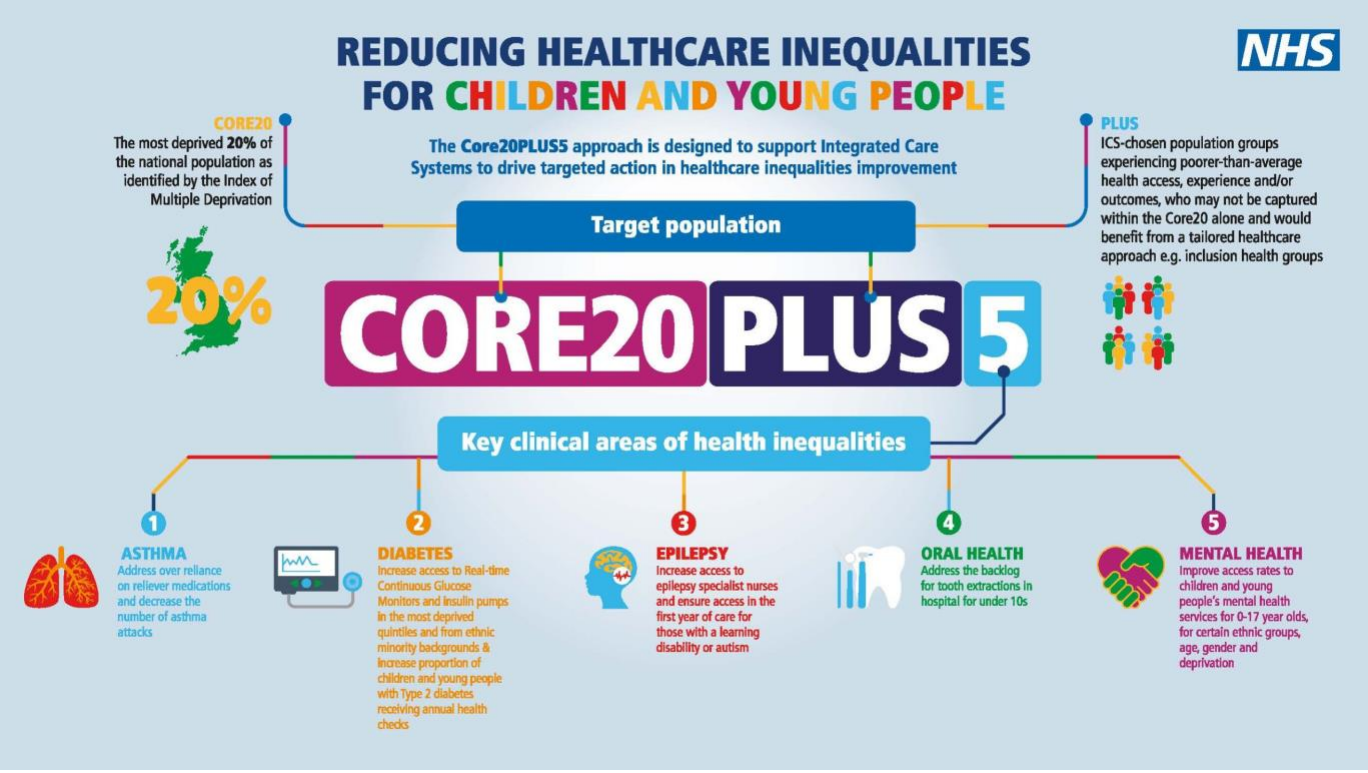
Technology: In recent years, the integration of technology into primary care has further enhanced healthcare delivery. Telehealth services, electronic health records, and digital communication tools enable more accessible and efficient healthcare, reducing barriers to timely medical advice and consultations. This can be particularly beneficial for families in remote or underserved areas, ensuring that children and young people have equitable access to healthcare resources.

Child health inequalities: Core20PLUS5 (children and young people)[21] is an approach to reducing health inequalities for children and young people that both integrated care systems and primary and community care services are expected to adopt by NHSE. It identifies the most deprived 20% of the national population from

[20] https://researchbriefings.files.parliament.uk/documents/CBP-8556/CBP-8556.pdf

[21] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

the Index of Multiple Deprivation plus key population groups including ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others. Specific analysis is needed to include young carers, looked after children/care leavers and those in contact with the justice system.



APPENDIX 3 PRIMARY AND COMMUNITY CARE FOR PEOPLE WITH LEARNING DISABILITIES OR AUTISM

The Commission's March 2022 roundtable discussed in detail the health needs of people with learning disabilities or autism, and the huge inequality that exists in comparison to people without a learning disability or autism. One key conclusion was the need for primary and community services to ensure that this population are on the NHS Learning Disability Register, and that they receive an Annual Health Check.

A second key conclusion was how vital it is for all organisations to listen fully to people with learning disabilities – to their stories, their experiences, their feelings – and to really understand what matters to them and what they want. "We rely on you to make a big difference to our lives, so it is essential that you listen to us and support us to make our contribution". Some areas to be addressed include:

Person-centred care: A key aspect of primary and community care for individuals with a learning disability or autism is the provision of person-centred care. It is important that healthcare professionals in primary care settings strive to tailor their services to each individual, recognising the diverse needs and preferences of this population. This involves understanding the specific requirements, communication styles, and potential accommodations necessary to ensure a positive healthcare experience.

Health assessments: Regular health assessments and screenings are crucial in the primary and community care services for people with learning disabilities or autism. These assessments should go beyond traditional medical examinations, taking into account the specific health needs associated with different kinds of learning disabilities or autism. Monitoring physical health, mental well-being, and addressing any associated conditions are essential components of preventive care, contributing to early intervention and improved health outcomes. However, latest available NHS data[22] shows that 72% of patients with a learning disability had a Learning Disability Health Check in 2021-22, a statistically significant **decrease** from 75% in 2020-21.

Care co-ordination: Primary care providers play a pivotal role in coordinating care for individuals with a learning disability or autism. The complex healthcare landscape can be challenging to navigate, and individuals with these conditions may require additional support and advocacy. Primary care teams collaborate with specialists, social services, and other healthcare professionals to ensure holistic and integrated care, addressing both health and social needs.

Health education: Primary and community care services are essential in promoting health education and empowerment for individuals with a learning disability or autism and their caregivers. Educating this population about healthy lifestyle choices, preventive measures, and self-care empowers them to actively participate in managing their health. Additionally, providing accessible information and resources ensures that individuals and their support networks are well-informed about available healthcare services.

Mental health: Mental health is a significant aspect of overall well-being, and primary care services are increasingly recognizing the importance of addressing mental health concerns in individuals with a learning disability or autism. Integrated mental health services within primary care, including collaboration with specialized mental health professionals, contribute to a comprehensive approach to care. This ensures mental health needs are identified early, reducing the risk of crisis situations and improving overall quality of life.

Technology: The use of technology has become instrumental in enhancing primary and community care services for individuals with a learning disability or autism. Telehealth services, digital communication tools, and electronic health records facilitate more accessible and inclusive healthcare delivery. These help overcome potential barriers to healthcare access, especially for those living in remote or underserved areas.

APPENDIX 4 IMPACT OF PCNS

The main impacts that PCNs seek to achieve include:

Improved Access to Services:
PCNs play a crucial role in enhancing access to primary care services. By pooling resources and collaborating among member practices, PCNs can offer extended access hours and a broader range of services, providing patients with more convenient and timely care.

Holistic and Coordinated Care:
The collaborative nature of PCNs facilitates a holistic and coordinated approach to patient care. With healthcare professionals working together, PCNs can address the complex health needs of patients more comprehensively, promoting preventive care and early intervention.

[22] https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2021-to-2022/health-checks

Enhanced Multi-disciplinary Teams:
PCNs encourage the integration of various healthcare professionals, such as pharmacists, physiotherapists, and social workers, into primary care teams. This can expand the range of services available and improved the overall effectiveness of managing chronic conditions and complex health issues.

Social Determinants of Ill-health:
PCNs may engage in community-based initiatives to address social determinants of health. These initiatives may include health promotion, disease prevention campaigns, and partnerships with local organizations to create a more supportive environment for improved health outcomes.

Digital Transformation:
The adoption of shared electronic health records and digital communication platforms within PCNs can enhance information exchange among healthcare providers. This streamlined communication can contribute to more informed decision-making and continuity of care for patients.

Reduced Pressure on Acute Services:
By promoting proactive and preventive care, PCNs aim to reduce the burden on acute care services. This shift toward managing health at the primary care level can help prevent unnecessary hospital admissions and ensure that patients receive the right level of care in a timely manner.

Empowered Patient Engagement:
PCNs can emphasise patient-centred care, encouraging active patient involvement in decision-making and health management. This empowerment can lead to improved health literacy, better adherence to treatment plans, and overall enhanced patient outcomes.

Addressing Health Inequalities:
PCNs, with their focus on local populations, are well-positioned to address health inequalities. By tailoring services to the specific needs of communities, PCNs can contribute to reducing inequalities in healthcare access and outcomes among different age, socio-economic, or ethnic groups.

Learning and Adaptation:
PCNs can serve as learning laboratories, allowing for experimentation and adaptation of best practice. The experience gained from early implementations can help refine the model and inform ongoing improvements in healthcare delivery.

Prepared by Phil Hope and Steve Barwick, the Health Devolution Commission Secretariat, March 2024

The partners of the Health Devolution Commission are NHS Confederation, Local Government Association, London Councils, West Yorrkshire Helth and Care Partnership, Mencap and Barnardo's.