LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: MONDAY, 3 APRIL 2017

Time: 2:00 pm

Location:
MEETING ROOM G.01, GROUND FLOOR, CITY HALL,
115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey
For Monitoring Officer

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MEMBERS OF THE BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor, Energy and Sustainability

Councillor Piara Singh Clair, Assistant City Mayor, Culture, Leisure and Sport

Councillor Abdul Osman, Assistant City Mayor, Public Health

Councillor Sarah Russell, Assistant City Mayor, Children, Young People and Schools

City Council Officers:

Frances Craven, Strategic Director Children's Services

Steven Forbes, Strategic Director of Adult Social Care

Andy Keeling, Chief Operating Officer

Ruth Tennant, Director Public Health

NHS Representatives:

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Roz Lindridge, Locality Director Central NHS England – Midlands & East (Central England)

Healthwatch / Other Representatives:

Karen Chouhan, Chair, Healthwatch Leicester

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

STANDING INVITEES: (Not Board Members)

Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust

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If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 16)**

The Minutes of the previous meeting of the Board held on 6 February 2017 are attached and the Board is asked to confirm them as a correct record.

4. CCG GP FIVE YEAR FORWARD VIEW **Appendix B (Pages 17 - 80)**

To receive a report from the Leicester City Clinical Commission Group (CCG) on the Blueprint for General Practice – Delivering the General Practice Five Year Forward View, that was jointly published on 24 February 2017 by all 3 CCGs in Leicester, Leicestershire and Rutland.

5. HEALTH, WELLBEING AND PREVENTION STRATEGY **Appendix C (Pages 81 - 96)**

The Director of Public Health to submit a report on the Draft Health, Wellbeing and Prevention Strategy.

6. SPORT ENGLAND BID UPDATE **Appendix D (Pages 97 - 98)**

The Director of Public Health submits an update on the Sport England's new strategy 'Towards and Active Nation'. A presentation will be made to the Board on local proposals being developed by the Council and its partners.

7. IMPACT OF BREXIT ON THE LLR NHS AND CARE WORKFORCE

To discuss the possible impact of Brexit on the LLR NHS and Care workforce.

8. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

9. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be published after the Annual Meeting of the Council on 11 May 2017.

Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

10. ANY OTHER URGENT BUSINESS

Appendix A

Leicester City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: MONDAY, 6 FEBRUARY 2017 at 3:00 pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
John Adler	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Lord Willy Bach	–	Leicestershire and Rutland Police and Crime Commissioner
Andrew Brodie	–	Assistant Chief Fie Officer, Leicestershire Fire and Rescue Service
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Councillor Adam Clarke	–	Assistant City Mayor, Energy and Sustainability, Leicester City Council.
Frances Craven	–	Strategic Director, Children's Services, Leicester City Council.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
David Henson	–	Executive Officer, Healthwatch, Leicester
Wendy Holt	–	Better Care Fund Implementation Manger, Central NHS England, Midlands and East (Central England)
Andy Keeling	–	Chief Operating Officer, Leicester City Council.
Chief Superintendent	–	Head of Local Policing Directorate, Leicestershire

Andy Lee		Police.
Sue Lock	–	Managing Director, Leicester Clinical Commissioning Group
Dr Peter Miller	–	Chief Executive, Leicestershire Partnership NHS Trust.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.
Ruth Tennant	–	Director of Public Health, Leicester City Council.

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

48. MEMBERSHIP OF THE BOARD

The Board noted the following changes to the membership of the Board:-

Leicestershire Fire and Rescue Service have nominated Andrew Brodie, Assistant Chief Fire Officer, to be their representative on the Board.

NHS England – Midlands and East have nominated Roz Lindridge, Interim Locality Director, Central NHS England to be their representative on the Board in place of Trish Thompson.

The Chair welcomed the new members of the Board together with Lord Bach who was attending his first Board meeting.

49. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Karen Chouhan	Healthwatch Leicester
Prof. Azhar Farooqi	Co-Chair Leicester City Clinical Commissioning Group
Roz Lindridge	Roz Lindridge, Locality Director, Central NHS England.
Dr Avi Prasad	Co-Chair Leicester City Clinical Commissioning Group

50. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

51. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of previous meeting of the Board held on 15 December 2016 be confirmed as a correct record.

52. CHILDREN'S JOINT STRATEGIC NEEDS ASSESSMENT

The Director of Public Health submitted a report providing an update on the progress Children's and Young People's Joint Strategic Needs Assessment (JSNA) for 2016.

The Director of Public Health gave an overview presentation in which the following was noted:-

a) The JSNA presented a series of challenges to services for children and young people in the city. Not only were a number of key services provided by the Council and the NHS currently undergoing substantial reconfiguration and restructuring; but the data collected in the JSNA identified the key health outcomes for children. The changing demographics of children and young people in the City also presented challenges to proving services for these emerging needs.

b) The JSNA did not make specific recommendations for service change but provided data and evidence for key health outcomes for children. The JSNA was used by public service, voluntary and community organisations and those bidding for funding to provide children's services, as it provided a digest of children's health issues in city.

c) In addition to the JSNA, a children and young people's survey was currently being undertaken in the city in both primary and secondary schools and with those children who were home schooled The survey aimed to seek young people's views on how they viewed their own health and wellbeing and the services they would like to see provided. The report of the findings of the survey should be available in the next few months and then discussions would be held with young people to see how the survey results could influence future service provision.

d) The data collected in the JSNA could change quickly and it had been decided to move away from large printed documents to a web based document. This would allow it to be updated and refreshed frequently with new information and links to nationally collected data and the data collected routinely in the council. The web page can be found at www.leicester.gov.uk/JSNA and the list of topics on the page are:-

- Demographic profile of Children and Young People in Leicester
- Pre-birth to early life
- Early years (0-4 years)
- School years (5-19 years)
- Young Adulthood (20-24 years)
- Mental Health of Children and Young People
- Looked After Children
- Youth Offenders
- Other Vulnerable groups (including Female Genital Mutilation, Child Sexual Exploitation and Gypsy & Traveller Children)

For each topic there will be

- A summary on a web-page
- A link to a fuller briefing (printable PDF)

Both the summary and the briefing would contain links to further information

e) The Health and Wellbeing Strategy – Closing the Gap would be updated from the JSNA and Board members were encouraged to share the JSNA within their own organisations and with partners. There was useful data on youth offenders and on some of the big issues facing children and young people; such as female genital mutilation, child sexual exploitation and gypsy and travellers children. Although these were small groups they had complicated health needs.

f) The JSNA Programme Board had been working closely with the Children's Trust Board and the Leicester City Children's Safeguarding Board

g) One item of note emerging from the JSNA was the huge change in the demographics within the city; with a big expansion of children and young people within the population. From 2005 to 2015 there had been a 25% increase in number of children aged 0-5 years old, which was double the rate of increase in the rest of country. There had also been a 12.5% increase in the 0 -25 years old age range which was above the national average. This had put huge pressures on services and would continue to do so in future years. There was now some stabilisation of the number of women of child bearing age. Services would need to plan for the future demands for services for older children as they progressed through the system.

h) There was still a large gap in life expectancy from birth for the city compared with the national average and there were variations of life expectancy across different parts of city. Given future pressures on resources, it would be necessary to target those areas with the highest need. Diabetes continued to rise in the city so it would be important to ensure children and young people enjoyed good health for the future.

i) The recommendations of the JSNA had recently been discussed at the Children's Board and they were currently out for consultation. These

recommendations would be circulated to Board members for comment. These included:-

- 0 to 19 Year Olds
- 20 to 24 Year Olds
- Mental Health
- Looked After Children
- Youth Offending
- Female Genital Mutilation
- Child Sexual Exploitation
- Gypsies and Travellers

j) Other emerging issues were:-

- That the city was still below the national average for expectant mothers being seen within the first 12 weeks of pregnancy; so there were some challenges for ante-natal services to improve the situation.

- It was also important to keep a focus on those initiatives which were currently performing well such as immunisation and vaccinations and breastfeeding initiatives to maintain good performance.

- Childhood obesity was still an issue and so was the issue of underweight children. Some elements of these involved ethnicity and work was continuing with schools to try and understand the wider determinants of health which may be involved.

- Good early years and nursery provision so that children were well equipped with social and communication skills before starting school.

- Addressing mental health issues for young children as many experienced anxiety and social behaviour issues. This involved not only having improved access to services such as CAMHS, but also providing initiatives to making young people more resilient to mental health issues.

- Providing services for the health needs for looked after children and young offenders.

Members of Board, in discussing the report and the presentation, made the following comments and observations:-

a) The Council had adopted Sport England's initiatives in early years to work with schools so that children had physical activity as early as 5 years of age. 1 in 7 children had some form of special needs in education and these issues could be addressed through work with early mums and premature births groups providing advice on smoking and

drinking. The Active Leicester scheme had been launched last year and would strengthen the work with schools to increase health and wellbeing and work with community groups to encourage physical and sporting activity.

b) The Assistant City Mayor Children, Young People and Schools stated that the report had been well received at the Children's Trust Board in the previous week; especially by the voluntary and community organisations.

c) The increase in the young population should not be under estimated. Leicester would need a minimum of 5 new secondary schools in the next 3 years which was a significant impact upon providing day to day services in future years.

d) The Chief Executive, Leicester City CCG felt that the regular updates of data and the maps that showed the different needs in different parts of city were extremely useful in identifying needs for future health planning.

e) Healthwatch, Leicester reported that they were embarking on engaging with the Gypsy and Travellers community in relation to their health needs and would be contacting the Director of Public Health so this work was not carried out in isolation to other initiatives in the future.

f) The Chief Executive of LPT stated that he had been involved recently in meetings to engage with the asylum seekers in the city, currently estimated to be in the region of 130 -150. They had multiple health needs as a group and should not be overlooked in the work involving vulnerable groups.

g) The effects of the environment and air quality on health and wellbeing could have a higher profile in the JSNA.

h) The Police and Fire Rescue Services participation in the Braunstone Blues initiative in working with a community need programme had produced a number of beneficial outcomes and there was now an opportunity to use the programme to spread the initiative across city using existing resources in the police and fire services.

The Chair commented that it was important to address intergenerational issues such as lifestyle and mental health etc, as the behaviour of adults in being role models to children had an enormous effect. He welcomed the survey in obtaining the views of young people about health and how they managed their own health needs. He felt the result of the survey should be seen as being of equal importance as that of empirical data.

He also felt that, whilst the change in demographics of the city posed a number of challenges, it also provided a massive opportunity to make changes in the future. If the work with schools and young people could create a community and a generation of healthy conscious youngsters from a public health view, it

could be instrumental in breaking the current generational cycles of poor health. Other initiatives, such as smoking cessation, had shown the impact that children and young people can have in changing the lifestyle habits of their parents and adults around them.

In response to the comments from Board members the Director of Public Health stated that:-

a) She recognised the importance of the opportunities to work with schools. The 'sugar tax' would be a big opportunity as the levy from the tax was being given to schools for physical activity. Part of the challenge would be to get all schools participating up to the current levels of the best schools.

b) Midwifery services were important in working to address issues such as domestic violence, smoking and especially maternal obesity. There were intergenerational issues and the importance of parental support in early years and parenting programmes and the support from health visitors would play a vital role in getting the right messages across changing these issues for future generations.

c) The JSNA contained a lot of data about asthma and the link between air quality and asthma was well known. The work on air quality would be taken on board and incorporated in the JSNA.

d) There was currently no data collected for asylum seekers and this could be looked at in more detail particularly if this group had multiple health issues.

RESOLVED:

That the report be received and that further consideration be given to the recommendations of the JSNA when they are circulated to Board Members.

53. TRANSFORMATION PLAN FOR MENTAL HEALTH AND WELLBEING FOR CHILDREN AND YOUNG PEOPLE - REFRESH 2016/17

The Board received a report on the review and a refresh of the Transformational Plan developed in 2015 as part of the LLR Better Care Together Programme. There was a national requirement to refresh the plan to reflect the progress that had been made in 2015.

Chris West, Director of Nursing and Quality West Leicestershire and East Leicestershire and Rutland CCGs and Tim O'Neill, Director of People, Rutland County Council presented the report and answered Members questions.

The 6 core work schemes in the Plan were:-

- Improve Resilience.

- Enhance Early Help.
- Improve access to specialist Children and Adolescent Mental Health Services (CAMHS).
- Enhance the Community Eating Disorder Service.
- Develop a Children's Crisis and Home Treatment Service.
- Workforce development.

In presenting the report it was noted that:-

a) Phase 1 of improving resilience was underway and 11 out of 24 schools in city were currently involved in the work stream. The procurement process was underway and it was envisaged that the 3 year contract would be up and running in July 2017.

b) CAMHS access had improved and the service was now meeting the 13 weeks' target for assessments to be carried out.

c) The service for eating disorders was now available 24 hours and 7 days a week and was running fully.

d) The crisis and home treatment service had started but was as yet not fully operational. Staff had been recruited and the service was moving into new premises with an on line direct phone line service at the end of February 2017.

e) The workforce development work-stream had concentrated on identifying the training needs of the staff that were already in place and the development of staff moving forward. This was currently at the assessment stage and some non-recurrent funds were being used to fund training resources packages for staff.

f) The steering group overseeing the process had encouraged members to see that the 6 work-streams were connected to each other and good progress had been made. Parts of the procurement process had been both complex and challenging but there had been good engagement and support across the partnership in the city. The challenge moving into next financial year would be to gather the data to assess the impact of the work that had been put in place.

g) The procurement for early health had gone ahead as planned but it had not been possible to secure a provider that met the required needs across the LLR. It was accepted that the plan did not fully reflect the work that had already been done in the city around early health.

h) The next refresh to the Plan would be a more comprehensive explanation of all of the work under each of the work-streams and an assessment of how it was making a difference for children.

Members of the Board commented that:-

a) Prior to the publication of the refresh, it should reflect the terminology used in the city so that all agencies understood that there was a local response as well as an overall response in the county.

b) The efforts being made to strengthen early resilience were particularly welcome. The Children's Trust in the city had undertaken a great deal of work in looking at improving the earliest possible stages to engage with young people to help them develop ways of improving their own mental health and support each other. It had also looked at additional support staff may need in supporting children to ensure that the right services were in place; so that young people and their families had access at the earliest possible point. This was in response to previous evidence that had shown that some young people in the city had previously not been supported until they were in crisis. The impact of this upon the person and their family, in terms of recovery, had been significant. The measures being put in place could have huge benefits in making a difference to young people.

c) Improvement in early health in the city had been fast moving as part of the improvement journey and this could be easily be aligned to the work on early health in the Transformation Plan. The three directors of children's services in the LLR had been working closely to align processes so that it made sense to the whole partnership and not just an individual organisation within the LLR.

The Chair referred to the 11 indicators on the dashboard and stated that 10 of these were precise measures. He felt the 11th indicator for service user feedback and patient satisfaction surveys should be seen as being of equal importance in relation to the other 10 indicators. He felt that what young people said about their experiences of being able to access, or not access, services and their perception of their own health and wellbeing was fundamental to understanding how young people perceived their own health and their ability to seek support at the right point. Although it was laudable to reduce A&E and high level referrals; it was equally important to address other issues which were of concern to young people, such as cyber bullying and on-line harassment.

In response, the Director of People, Rutland County Council stated that a pilot initiative in Rutland supported this view and agreed that feedback and patient experience should be central to the plan.

The Chief Executive of LPT welcomed the investment that had been made to get the crisis team up and running and the investment of resources to improve access. A year ago, 250 children had been waiting more than 13 weeks for an initial assessment but now no one was waiting more than the 13 week target period. However, there was still an unsustainable rise in referrals; averaging a 9% year on year increase and there were still significant numbers of cases waiting between the assessment stage and the subsequent treatment programmes and this needed to be addressed.

The Director of People, Rutland County Council stated that there was a desire to get treatment services in operation as soon as possible and it was not envisaged that the procurement process would be lengthy.

The Chair commented that the Plan only referred to funding for 2015/16 but not for current or future years. As it would take 4-5 years to get resilience within the Plan, it was difficult to plan with any certainty when future funding was unknown. In response the Director of People, Rutland County Council echoed these views and shared concerns that the Department of Health's policy of providing yearly funding was not ideal.

In response to a comment by the Police and Crime Commissioner, the Director of People, Rutland County Council stated that whilst the police service had been engaged during the wider planning aspects of the Plan, there would be more specific involvement by Police Officers in the initiatives that were now in place.

AGREED:

1) That the Board support the publication of the refreshed Plan for 2016/17, subject to the extra information in relation to the early health initiatives and terminology used in the City and the financial information for 2017/18, being included.

2) The Board expressed concerns at the annual funding arrangements by the Department of Health which made long term planning uncertain.

54. STP PRIMARY CARE UPDATE

The Chief Executive Leicester City CCG reported that:-

a) The primary care developments within the STP were guided primarily from NHS England's GP Forward View. More details on the GP Forward View had recently been issued and CCGs were required to submit an improvement plan in response to them by 24 February 2017. The improvement plan was at an STP level of plan but with CCG specific sections added to it.

b) The first STP engagement event in the City was being held at the Peepul Centre, Orchardson Avenue, Leicester on 23rd February 2017 and the primary care work within the STP will be important part of that.

c) The Primary Care Commissioning draft strategy was to be considered at the CCG Board the following day and would be submitted to the Health and Wellbeing Board as part of the engagement process for the strategy.

AGREED:

That the update be noted and that the Primary Care Commissioning

draft strategy be submitted to a future Board meeting.

55. THE PERSONAL HEALTH BUDGETS LOCAL OFFER

The Board received a report from Maria Smith, Strategic Lead for Personal Health Budgets for Leicester City, West Leicestershire and East Leicestershire and Rutland Clinical Commissioning Groups. The report set out the CCG's Local Offer and the plans currently in development to expand the offer in line with national guidance.

It was noted that:-

a) There was requirement for Health and Wellbeing Board to be informed of the local personal health budget (PHB) offer.

b) Individuals eligible for continued health care (CHC) had been given the right to have a personal health budget since 2014.

c) The Integrated Implementation Group comprised representatives of all three local authority's children's, adult social care and education services, LPT, the 3 Healthwatch groups in the LLR and procurement, finance and communications representatives. The group were building the integrated personal budget process and the broad pathway for the future.

d) Services for individuals requiring a mental health package would be the main focus for 2017/18 and the focus in 2018/19 would be those with long term health conditions.

e) One challenge of offering personal budgets was that existing funds were predominately contained within large block contracts and disaggregating these elements to release the resources to offer services in a different way was a complex process. Work was progressing with LPT and contracting and commissioning colleagues to resolve these issues.

f) The proposals for the PHBs Local Offer linked well with the work already being undertaken on the STP. There were close links with the STP's Integrated Locality Teams Programme Board to ensure the models they were creating also had an integrated personal budget offer as part of their delivery offer.

In response to Members' questions the following responses were received:-

a) At present there were 105 PHBs in place within LLR and the early evidence suggested that individuals had yet not chosen to have radically different health care support than they had received in previous packages. Initial feedback from patients, their representative and carers on the group generally indicated that, whilst they were some frustrations with the process as it was being developed, there was, nonetheless, indications that recipients of PHBs were happier with their care

compared to their previous continued health care packages. A cultural change was needed within the NHS to move away from a service led approach, which may not always provide services to meet individual needs. Equally, a corresponding cultural change was also required from individuals who were still generally asking for a specified number of hours for their care rather than opting for other forms of care.

b) There was no evidence to suggest that PHBs for people with physical and mental health issues had been subjected to financial abuse. Those administering the PHBs also had some experience of monitoring budgets for those who couldn't look after themselves within the current CHC packages. Whilst financial abuse could never be guaranteed, there were safeguards and guidelines in place intended to prevent this. Third party organisations were also involved in helping to manage money in these circumstances, and, in some instances, court appointed representatives of the patients were involved. In addition, there was a stringent monitoring programme in place that reviewed the budgets every three months.

c) A recent review of equality and diversity responsibilities had indicated that data was not being collected to allow detailed monitoring of which parts of community had taken up PHBs; either in relation to ethnic diversity or in relation to taking up services which may be more culturally sensitive to their needs. This data would be captured in the future for both PHBs and CHCs and would be integrated into one team. This should make the process more efficient and responsive to patient's needs.

d) It was not possible to confirm the total financial envelope for the 1-2,000 PHBs envisaged in next 3-5 years as this was currently being scoped at present; and there were no details, as yet, of the financial resources that could be released from the large block contracts. This profiling could be shared with the Board members. In essence, there was no new money within the health system for funding PHBs and existing resources would need to be spent in different ways than at present. Staff were working with providers to examine ways in which the process could be taken forward and there was no intention to remove an existing service that worked well. The key to the process would be monitoring the risks and how those risks would be managed, as it would not be possible to provide existing services and provide different care services as part of PHBs at the same time. Resources would gradually need to be transferred from the big block contracts to the PHBs since the CCGs were not allowed to fund both.

f) It was estimated that the likely cost of CHC packages was approximately £3.9m per year per 1,000 people.

g) Staff were working with LPT to see what the potential consequences upon existing services could be and also what future services could look like. There was also a need to break through organisational barriers to

enable different service delivery. For example, PHBs may be able to provide care differently for patients with long term conditions that can't be cured but, nevertheless, could improve a patient's outcomes and prevent them going into crisis. This would benefit the system overall by enabling people to be cared for at home (or in residential setting) for longer instead of being cared for in the acute sector. Services would look very different in 5 and 10 years' time and this transition would need to done in a planned and phased way with all stakeholders involved.

The Chair commented that the Board required a more details of the financial implications for the future service provision of the expanded PHB offer as it needed to understand the potential risks involved and could only endorse the proposals if it had all the relevant information available on which to make an informed decision.

AGREED

1) That the Board support the principle and concept of Personal Health Budgets.

2) That the Board does not have sufficient financial information in relation to future years in order to endorse the planned further expansion of personal health budget/integrated personal budget offer into 2017 and beyond.

3) That the financial information be shared with the Chair to circulate to Board Members and subsequently a response to the planned future expansion.

56. LEICESTER SAFEGUARDING ADULTS BOARD

The Board received the Leicester City Safeguarding Adults Board Annual Report and Executive Summary for 2016. Jane Geraghty, Chair of Leicester Safeguarding Adults Board presented the report and answered Members' questions.

In presenting the report, the following comments were noted:-

a) The was the first report since the Adult Leicester Safeguarding Board became a statutory body following the implementation of the Care Act and the Board was compliant with the statutory requirements Care Act requirements.

b) The Safeguarding Board was responsible for holding all partners to account for their responsibilities and to ensure that each worked with all partners in order that vulnerable adults were safeguarded. Over 350 cases had been considered as part of the Board's work.

c) The Safeguarding Board was working well having committed partners and clear priorities and partners were now engaging in the Board's work

and leading sub-groups. This was considered as a sign that significant progress had be made in partnership working.

d) It was of concern that cases coming into the system didn't reflect the ethnic population of the city and the Safeguarding Board had asked the Stakeholder Engagement Forum (Chaired by Healthwatch) to lead the work on this in order to understand the underlying reasons. Initial thoughts considered it might be that the people were not aware of the processes in place to protect vulnerable people or know how to access them. It could also be that people were being kept safe within their own homes.

e) 86 individuals had come back into the system on more than one occasion and there was currently an audit underway to investigate the reasons for this. It was important to know if this was the result of an inappropriate response being given the first time or whether there were other reasons.

f) The Safeguarding Board had asked to be part of a pilot for a peer review in May 2017 to assess whether the Board was providing good governance and to assess the impact of work being undertaken and whether the Board was able to demonstrate that its work was improving the safety of people within the system.

The Strategic Director of Adult Social Services commented that the service was not achieving its obligations on safeguarding as there were currently 548 people who were waiting to be screened or assessed and that this level of outstanding screening and assessments had been experienced for some time. The Cheshire West judgement had confirmed that this was not a new burden for adult social care services and that there were no extra resources to meet the increased demand. The service had changed the risk assessment process behind DoLS (Deprivation of Liberty Safeguards) and the biggest group affected by the changes were those coming forward from acute and hostels settings. Currently they were the least likely to be assessed at the present time. A government review was underway and some provisional arrangements and suggestions for a new approach to DoLS had emerged, but these would not have addressed the large increase in the 13 fold increase in number of cases that had come forward in recent times. The number of outstanding screenings and assessments were of concern, but it was a position that was not uncommon across country as a whole.

The Chair of the Safeguarding Board felt that the issue of repeat referrals was of concern and there was a national issue in determining the impact of initiatives and activity, particularly in relation to preventative measures, to help to determine where best to put limited resources.

AGREED:-

That that The Annual Report be received and that Members of the Board continue to improve the contributions to the safeguarding of adults

through their own areas of responsibility and through the joint work with the Safeguarding Board.

57. QUESTIONS FROM MEMBERS OF THE PUBLIC

In response to a question from a member of the public relating to the scrutiny function of the STP and being made aware of the outcomes so the public can be made aware of what is good or what is a concern, the Chair stated that :-

- The Health and Wellbeing Scrutiny Commission had the responsibility to scrutinise the STP. The Commission met in public and members of the public could make their views known to the Chair through statements of case, representations or questions etc.

- It had originally been intended to have a debate at Council in February, as stated in the minutes of the last meeting, but this may not now be until the March Council meeting, when the STP proposals announced in the engagement process would be debated and the Council would come to a view. This did not mean that the Council would not consider the issue again after the formal consultation process had started on the STP.

- It was not appropriate not for him to comment upon the scrutiny role, as comments and views on this should be discussed with the Chair of the Scrutiny Commission.

- He hoped that when the proposals were fully known and the public saw the future affects upon of specific services, then they would also make their views known and that members would also be engaged in that process.

58. DATES OF FUTURE MEETINGS

The Board noted that the next meeting would be held on Monday 3rd April 2017 at 2.00pm. Note: Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

59. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

60. CLOSE OF MEETING

The Chair declared the meeting closed at 4.48 pm.

Apendix B

LEICESTER CITY HEALTH AND WELLBEING BOARD
3rd April 2017

Subject:	**General Practice 5 year Forward View**
Presented to the Health and Wellbeing Board by:	Richard Morris, Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group
Author:	Richard Morris, Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group

EXECUTIVE SUMMARY:

Primary medical care is the foundation of a high performing health care system and as such is critical to the successful implementation of the LLR Sustainability and Transformation Plan. Ensuring the development and resilience of Primary Care will assist in bringing about the system-wide transformation required to focus on prevention and the moderation of demand growth.

Whilst there are three separate CCGs with distinct geographical, political, social and economic environments, with very differing health needs, we are committed to the development of our response to the GP 5 Year Forward view as a collective. As such, throughout this plan there will be a focus on what brings us together and how we will jointly tackle the challenge, whilst also highlighting locally sensitive solutions.

Board GPs from each CCG have actively engaged in the development of the plan and fully support it. This is not going to be an easy task, there are many challenges facing General Practice, including workforce, funding and rising demand. In the city as well as the county we will work together to develop and co-design a resilient and sustainable model in which general practice can thrive.

We have a clear direction for the future of primary care in which general practice is the foundation of a strong, vibrant, joined up health and social care system. The new system is patient centred, engaging local people who use services as equal partners in planning and commissioning which results in the provision of accessible high quality, safe, needs-based care. This is achieved through expanded but integrated primary and community health care teams, offering a wider range of services in the community with increased access to rapid diagnostic assessment and, crucially, patients taking increased responsibility for their own health.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- **RECEIVE** the narrative plan which has been submitted to NHS England.

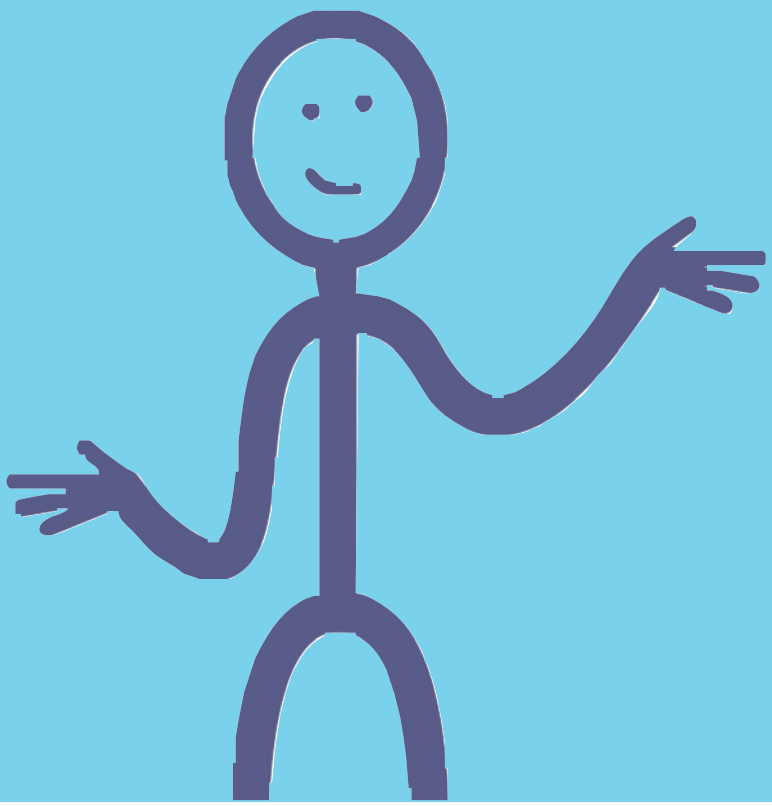
- **COMMENT** on the draft narrative document which may be considered for future iterations.

Better care together
Leicester, Leicestershire & Rutland health and social care

Blueprint for General Practice

Delivering the General Practice Five Year Forward View

Leicester, Leicestershire and Rutland
Sustainability and Transformation Plan
24 February 2017



Final Draft

East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group

NHS

Final Draft

Contents

1. Introduction

Primary medical care is the foundation of a high performing health care system and as such is critical to the successful implementation of the LLR Sustainability and Transformation Plan. Ensuring the development and resilience of Primary Care will assist in bringing about the system-wide transformation required to focus on prevention and the moderation of demand growth.

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This is not going to be an easy task, there are many challenges facing General Practice, including workforce, funding and rising demand. In LLR we will work together to develop and co-design a resilient and sustainable model in which general practice can thrive.

We have a clear direction for the future of primary care in which general practice is the foundation of a strong, vibrant, joined up health and social care system. The new system is patient centred, engaging local people who use services as equal partners in planning and commissioning which results in the provision of accessible high quality, safe, needs-based care. This is achieved through expanded but integrated primary and community health care teams, offering a wider range of services in the community with increased access to rapid diagnostic assessment and, crucially, patients taking increased responsibility for their own health.

What Primary Medical Care will look like in five years

When this plan is fully implemented, General Practice in LLR will be recognisable as follows:

- General Practice with registered lists will remain at the heart of the model, offering a comprehensive service to patients based on differential need according to condition and complexity.
- Patients with complex needs will receive continuity of care and be treated by their own General Practice, close to home on a more proactive basis.
- Practices will come together either formally or informally to provide services on multiple sites, offering planned and unplanned services to meet patient's needs at scale.
- Practices working together will deliver improved efficiency by reducing bureaucracy through the more effective use of existing resources, eg, centralised HR, payroll.
- Groups of practices and federations will provide a significant proportion of non-core services from fit for purpose premises which offer choice to patients, but not necessarily within their own practice premises.
- Practices will actively contribute to place-based care provided around geographically defined local populations. This will support the adaptation of services for patients and act as a catalyst to new models of collaboration.
- Patients will be an active part of the 'practice team', taking greater

Challenges:

General Practice in LLR is full to capacity in its current form with:

- Rising demand
- An increasing population
- A predicted growth of 19% in the 60+ age-group
- Difficulties with recruitment and retention of staff.

These challenges are too great for individual practices to meet alone.

Practice will need to work in an increasingly collective and integrated way, "scaled" to address the challenges they face:

- With patients
- With neighbouring practices
- As part of federations
- With health and social care colleagues.

responsibility for their own health and wellbeing, to reduce demand.

- Patients will be able to access urgent and on the day services seven days per week from the appropriate clinical team member within their locality.
- Practices will work collaboratively, and there will be full integration with community and social care services.
- Practices, federations, localities and patients will play a greater role in shaping how primary care is provided, to improve both quality of care for patients and the sustainability of General Practice.

Priorities	Model	Improve Access	Workforce	Workload	Infrastructure	Investment
Must DO						
STP	✓	✓	✓	✓	✓	✓
Financial Balance	✓	✓				✓
Sustainable General Practice	✓	✓	✓	✓	✓	✓
A and E performance	✓	✓	✓		✓	✓
18 week RTT	✓	✓	✓		✓	✓
Cancer	✓	✓	✓			✓
Mental Health	✓	✓	✓			✓
Learning Disability	✓		✓			✓
Improve Quality	✓	✓	✓	✓	✓	✓

Impact on the 9 "Must Do"s

Once realised, our plan for General Practice will positively and directly impact on the "9 Must Dos" as improving the efficiency, effectiveness and sustainability of general practice will have wider system benefits:

The Local Landscape—Population

It is important to recognise that the starting points and the needs of the population that each CCG serves will require differing approaches which recognises the environment and the local needs and demands. Across the Leicester, Leicestershire and Rutland STP area we have a total population of 1,061,800 with a forecast increase over the next five years of 3.6% for children and young people, 1.7% for adults and 11.1% for older people. The age structure of the area is on par with the national average but there is a variation with Leicester City having a higher population of young people and East Leicestershire and Rutland has more people age over 50. Analysis of our health data identified the following areas that we need to address:

- **Reducing the variation in life expectancy**—in Leicester the average life expectancy is 77.3 years for males and 81.9 years for females and in Rutland it is 81 years for men and 84.7 for women. More variation can be found across the STP footprint, for example in Leicester City the gap between the best and worst life expectancy is 8 years. The difference in

life expectancy is complex and is impacted on by deprivation, lifestyle and the wider determinants of health.

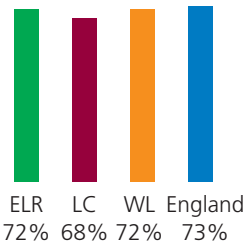
- **Reducing the variation in health outcomes**—there is a considerable difference in health outcomes across the STP footprint. For example 43.8% of diabetes patients in Leicester city meet all three of the NICE recommended treatment targets compared to 41.9% of patients in East Leicestershire and Rutland. 66.4% of people with long term conditions in West Leicestershire and 58.5% in Leicester City feel supported to manage their condition.
- **Reducing premature mortality**—premature mortality across the STP footprint is caused by cardiovascular disease, respiratory diseases, cancer and liver disease, the level of premature mortality varies across LLR. More than 50% of the burden of strokes; 65% of CHD; 70% of COPD and 80% of lung cancer are due to behavioural risk and we will tackle this through early detection programmes and preventative public health strategies and programmes. Infant mortality has improved in Leicester with the city now comparable to England as a whole. However the still-birth rate at 6.5 days per 1,000 total births in 2012/14 is higher than the national average of 4.7. A strategy is in place which focuses on targeted work on predisposing factors including prematurity and small-for-date babies.
- **Improving the early detection of cancers and cancer performance**—one year survival rates from all cancers varies across the STP footprint. In Leicester city the rate is 65.9% compared to East Leicestershire and Rutland which is 70.2%. Cancer is also one of the major causes of premature mortality across the STP footprint. Detecting cancers early improves survival rates for example 5 year survival rates for colon cancer is 1 in 10 if detected at stage 4 but if detected at stage 1 survival after 5 years increases to 9 in 10, this is similar for rectal, ovarian and lung cancers. We also need to improve our performance on 63 day cancer rates.
- **Improving mental health outcomes**—across the STP footprint there is a difference in mental health need. East Leicestershire & Rutland and West Leicestershire CCG areas have high levels of dementia, where Leicester City has high levels of psychosis. All have high levels of depression.
- **Moving from chronic disease management to prevention**—much of the above health outcomes are caused by lifestyle and are preventable; late detection leads to costly chronic disease management.

The table below shows the NHS Outcome Indicators and the relative position of each CCG demonstrating variation in performance and outcomes.

Patient satisfaction

% of patients who find it easy to get through to their surgery by phone.

% of patients who were able to get an appointment to see or speak to someone last time they tried.



%of patients who describe their experience of making an appointments as good.

% of patients who describe their overall experience of this surgery as good.

NHS Outcome Indicators

Domain 1	England	LC	ELR	WL	Data source	Reporting period
Potential years of life lost to treatable disease, persons	2064.5	2642.8	1978.7	1764.2	HSCIC	2014
Percentage of cancers detected at Stage 1 or 2	45.7%	42.9%	48.9%	46.0%	HSCIC	2013
Under 75 mortality rates from cardiovascular disease	63.7	90.1	53.8	57.0	HSCIC	2014
Under 75 mortality rates from respiratory disease	27.6	35.4	19.7	22.4	HSCIC	2014
Under 75 mortality rates from cancer	121.4	129.4	111.1	110.9	HSCIC	2014

Domain 2						
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	805.9	1,131.5	671.7	740.5	Outcome Atlas / HSCIC	2014-15 (July-June) Provisional
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	324.5	246.6	169.1	180	Outcome Atlas / HSCIC	2014-15 (July-June) Provisional
People feeling supported to manage their condition	64.4%	57.3%	65.1%	62.1%	Outcome Atlas / HSCIC	14/15
Domain 3						
Emergency admissions for acute conditions that should not usually require hospital admission	1272.4	1446.1	1047	1066.7	Outcome Atlas	2014-15 (July-June) Provisional
Emergency admissions within 30 days of discharge from hospital	11.9%	11.7%	11.3%	11.3%	Outcome Atlas	11/12
Domain 4						
Percentage of people reporting their GP surgery as very good or fairly good	85.0%	78.3%	84.8%	85.1%	GP Patient Survey	July 2015 publication—data collected from Jul-Sept 2014 and Jan-Mar 2015
Percentage of patients reporting a good experience with out of hour GP services	68.6%	66.1%	69.8%	61.2%	Outcome Atlas	14/15

What Patients Have Said

In total more than 50 events have been held across Leicester, Leicestershire and Rutland with a diverse range of audiences and participants including clinicians and the public. Across those events there have been more than 6,000 attendees—with around 1,500 of those being unique participants.

Overall, almost everyone tells us the high regard in which primary care is held and the vital role it provides for patients and local communities. It is the part of the NHS with which people have most contact, and satisfaction with the services provided by their practice—particularly doctors and other clinical staff—is high. This is evidenced, for example, through work undertaken by Healthwatch in Leicestershire and, in the city, focussed activity with the local PPG network.

However, it is clear that there are also opportunities for improvement. Key themes and feedback emerging from the events and meetings held across the region have influenced our priorities for the future and can clearly be seen within this plan.

The Local Landscape—General Practice

For many people a visit to their GP is the most common form of contact with the NHS, with 90% of all health care episodes in England starting and finishing within a patient's surgery. Nationally each year, there are 340 million appointments and many more contacts via telephone or letter.

Primary medical care is however under significant pressure from patient demand:

- 1993–2013 saw the average GP consultation lengthen by 50% (from 8 to 12 minutes)

- 2005–2015 saw a 40% increase in GP consultation rates
- The average patient now sees their GP eight times a year (100% up on 10 years ago)
- Average annual consultations among the over 75s have increased by over 50% from 7.9 in 2000 to 12.4 in 2015
- In 2010 people with LTCs (29% of the population) accounted for over 50% of all GP appointments.

This is in a climate of years of relative under-investment in primary medical care. There are significant workforce issues with a 15% drop nationally in the numbers coming into GP training, over 50% of GPs under 50 years of age considering leaving the profession in the next five years, and the move away from partnerships to salaried or locum positions. The recruitment and retention issues affecting GPs are mirrored in the practice nursing workforce, 64% of practice nurses are over 50 with only 35% under 40. Between 2001 and 2011 the number of community nurses fell by 38%, whilst the nursing workforce expanded by 4% in the acute sector and there is a growing reliance on agency staff.

This national picture is mirrored locally with recruitment, retention and workload cited as the key issues affecting the local sustainability of General Practice. As such our plan needs both to support our practices in the day to day delivery of core services, and to bring about transformational change.

Across LLR there are over 138 GP practices, ranging from single handed practitioners to registered lists of over 38,000 patients.

Varying delivery methods and premises exist alongside historical funding differences and a range of care models using GPs and other health care professionals. Outcomes for patients differ based on age, sex, deprivation, ethnicity and rurality and there are inequalities across the system.

CCG	Population	Number of Practices	Average List size	Contract Split	GP WTE	Registered Nurses WTE
ELR	325,000	31	10483	GMS 31	206	83
WL	374,000	48	7792	GMS 48	185	67
City	376,000	59	6642	APMS 13 PMS 1 GMS 45	156	68
Total	1,075,000	138	24,917	138	547	218

Within LLR all of the CCGs have taken on responsibility for delegated co-commissioning and have worked hard to ensure additional investment has been channelled into General Practice to improve the outcomes for patients, and focus on ensuring care closer to home. *See Section 7: Investment*.

There is a range of estates, GP systems, and care homes all impacting on the delivery of General Practice.

CCG	Care Homes	Premise —main and branches	GP System
ELRCCG	78 residential homes	GP Owned—25	13 EMIS
	15 combined	GP Lease—21	20 Systm1
		LPT owned—1	
		NHSProp Services—2	
WLCCG	22 nursing homes,	GP Owned -44	18 EMIS
	77 residential homes,	GP Lease—16	30 Systm1
	2 combined and 3 learning disability homes	LPT owned—6	
		NHSProp Services - 0	
LCCCG	20 Nursing homes	GP Owned -38	58 Systm1
	85 Residential homes	GP Lease—10	1 EMIS
	Combined 9	LPT owned—2	
	45/105 homes offer some form of LD provision	NHSProp Services—8	
		CHP—1	

Improving Quality in General Practice—Supporting Improvement and Sustainability

CCGs, since their inception, have had a duty to continually improve the quality of primary medical care services. This has been achieved through active engagement with our member practices and the undertaking of regular quality visits to each practice. Here qualitative and quantitative data at practice level enables practices to understand their performance and the quality of care their patients receive, benchmarked against their peers. Whilst this has led to improvements in many areas there remains significant variation across practices in LLR as a whole. We continue to place a priority on addressing unwarranted variation—though we recognise that external factors also affect the quality of general practice performance.

The programmes led by NHSE provide the opportunity to support the most vulnerable practices. Through the Vulnerable Practice Pilot Programme and the General Practice Resilience Programme, a number of practices across LLR identified themselves as vulnerable. They cited recruitment and retention of GPs and the wider practice team, increasing elderly population, funding, premises and a growing list size as key issues. The table below indicates applications received and those practices that will be supported. The level of applications received demonstrates the anxiety and genuine concern from practices with regard to their sustainability.

	Vulnerable Practice Programme	General Practice Resilience
ELRCCG	2/31 practices applied and supported	7/31applied:
		1 supported
		3 reserve
		3 not supported
WLCCG	9/48 practices applied - 4 supported	12 practices applied:
		5 supported
		5 reserve
		2 not supported
LCCCG	4/58 practices applied and supported	23 practices applied
		4 supported
		8 reserve
		11 not supported

Care Quality Commission (CQC)

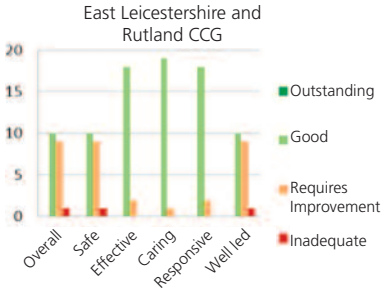
Since the advent of co-commissioning the 3 CCGs (April 2015) have adopted a comprehensive risk share and management process involving the CCG/CQC/NHSE. This allows for formal discussion on a monthly basis to assess and score risk in our primary care providers. Risk factors include, CQC reporting, contract issues, soft intelligence, capacity/workforce and sustainability issues.

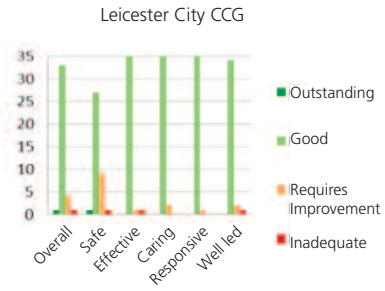
In Conclusion

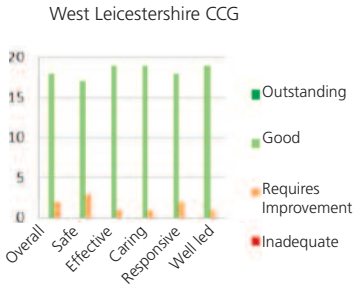
The baseline assessment shows a diverse picture of General Practice within LLR. There are significant variations in quality and outcomes for patients and a system that is in places struggling with the increased demand on workload and the recruitment of highly skilled clinical staff.

Our priorities for action are to:

- Support those practices at greatest risk through local and national schemes
- Work with member practices, federations and the public to co-design and deliver a model of service delivery that will be sustainable and support the STP plan
- Deliver an integrated service that provides both high quality and needs based in hours and out of hours care
- Deliver the workforce plan that will meet the demands of new models of care
- Set a plan and trajectory for improved quality and reduced variation in clinical outcomes and access
- Respond to patients' feedback and concerns.







2. Our Model for General Practice

Sustainable general practice is at the heart of our model and we will:

- Actively work with Public health colleagues on the core prevention agenda
- Expand our workforce, its skill mix and capability
- Decrease unnecessary workload
- Ensure funding follows the patient
- Capitalise on technological advances to enable interoperability of systems and record sharing.

See the following sections:
4. Workforce
5. Workload
6. Infrastructure
7. Investment

The overarching model of care across LLR is the Home First model. This model was originally highlighted by Dr Ian Sturgess in the 2014 Sturgess Report on the Urgent Care Pathway in LLR. However, the principles of Home First are not only applicable to an urgent presentation but define our approach to integrated care across LLR, including general practice.

This approach requires all teams and individuals—whether in secondary, community or primary care—to ask "Why is this patient not at home?" or "How best can we keep them at home?"It requires a move away from organisationally-driven provision to integrated place-based provision.

Our overarching philosophy is that admission to secondary care should only take place when it is clinically unavoidable, and that discharge home from acute care should be achieved as quickly and efficiently as possible. In our model we will increase the proportion of care patients receive close to home through effective, timely interventions. This will require increasing access to seven day—and, where appropriate, 24 hour—care management, developing flexible models that enable care to be provided in both a scheduled and unscheduled manner to meet the clinical needs of patients.

The Home First model is based on transforming services for all patients, but is a particularly urgent priority for the rising number of patients with long term and complex conditions. It requires a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time.

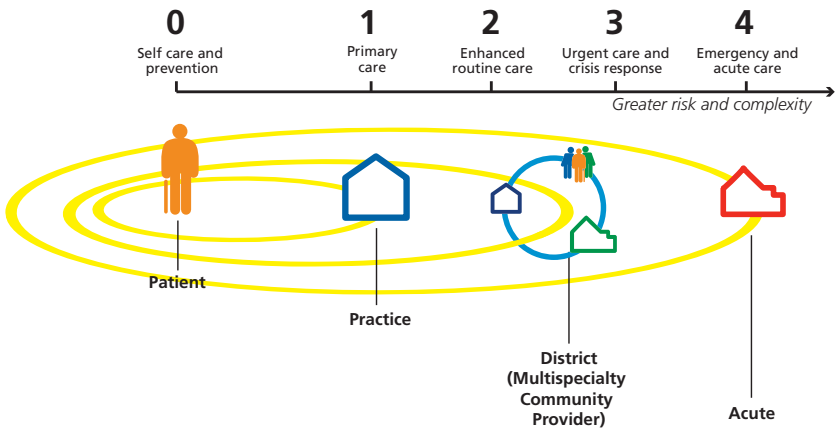
Vision

Over the next five years our new model for general practice which supports the Home First philosophy will be realised. The practice and primary healthcare team will remain as the core unit of care, with the individual practice patient lists retained as the foundation of care. However, while a large proportion of care will remain with a patient's own practice, an increasing proportion will be provided by practices coming together to collaborate in networks or federations using their expertise, sharing premises, staff and resources to deliver care for and on behalf of each other. In this way it will be possible to improve access and provide an extended range of service to our patients, as well as creating an environment that attracts doctors and other health professionals into a career in primary health care.

We believe that the vast majority of health problems— including mental health issues—could be dealt with by primary and community care. We have not yet fully realised the potential of general practice, so too often patients receive care in hospital that could be safely provided in the community, coordinated through their general practice, and supported by the wider health and social care teams.

Model

Our model is based on the GP as expert clinical generalist working in the community, with general practice being the locus of control, ensuring the effective co-ordination of care. The GP has a pivotal role in tackling co-morbidity and health inequalities but increasingly they will work with specialist co-located in primary and community settings, supported by community providers and social care to create integrated out of hospital care.



Our model places the patient and their general practice at the centre of provision, extending the care and support that can be delivered in community settings through multidisciplinary working. The aim is to reduce the amount delivered in acute settings, so that only care that should/must be delivered in the acute setting will take place there in the future.

To achieve this the changes we envision will mean that primary medical care will be more integrated and federated with patients co-designing services and taking increased responsibility for their own health. This new system will be patient-centered, providing accessible high quality needs-based care. This is achieved through expanded but integrated primary and community teams offering a wider range of services in the community with increased access to rapid diagnostics assessment and co-located specialists. This will require a shift of resources from the acute sector, investment in facilities and a greater role for nurses, pharmacists and health care assistants.

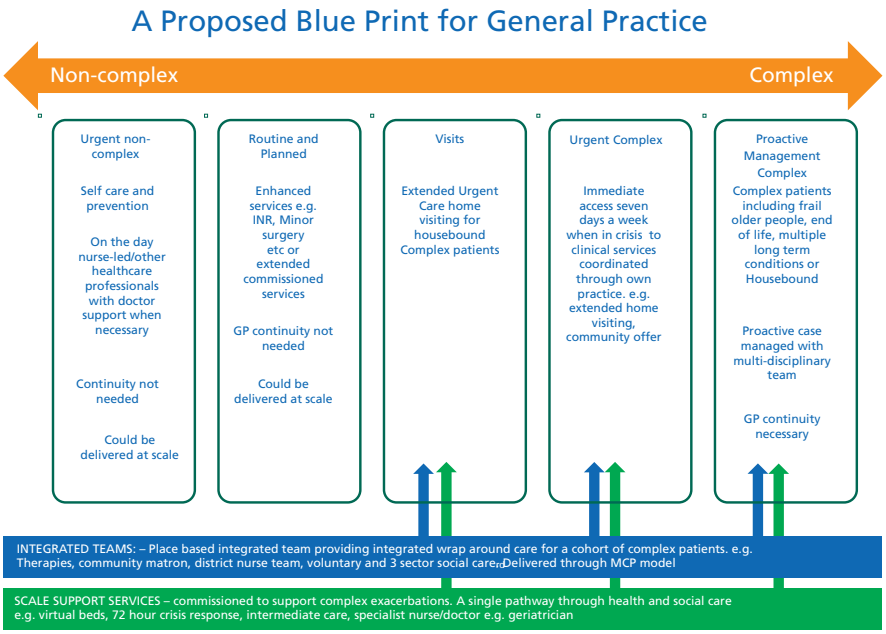
The evidence of demand, patient disease-profile, and expectation, shows that the reasonable needs of patients have changed since the contract was issued in 2004. All practices will need to provide a level of urgent primary care access as well as planned services and should support patients in self-care management as well as accessing other appropriate health services, such as pharmacy or when really necessary, urgent or emergency care.

To meet the reasonable needs of patients, now and in the future, the model of delivery will need to adapt. This adaptation is based around patient need and seeing the right health care professional for their condition.

The evidence shows that patients with complex needs, whether this is LTC, mental health or frailty, require a co-ordinated package of care that will require care planning, regular pro-active interventions and support. This continuous care is best provided by a multi-disciplinary team with the GP acting as the designated accountable care co-ordinator for the most complex or vulnerable patients. This level of service utilises a GP's skills to best effect and patients will be streamed accordingly. All other patients will have access either on the day or pre-booked to another appropriate health professional with GP oversight.

This Blueprint shows a model of how General Practice could manage patients according to need, supported by community services. Care is not necessarily delivered by a GP but by a nurse, pharmacist, nurse practitioner or emergency care practitioner according to need.

(See Section 4: Workforce)



Our Baseline

In reviewing our current position and our journey to achieving our model for general practice we acknowledge that over the past two–three years we have developed a range of new services within both general practice and the community which are as yet are not fully utilised or coordinated.

We also acknowledge that each CCG is at a different stage in achieving the model which poses challenges set against the desire to achieve a broadly consistent approach:

In LC CCG

During 2016/17 the CCG developed a draft primary care strategy that sets out the main challenges faced by primary care in the city as well as the CCG's local approach to addressing those needs. The strategy is currently being engaged upon with key stakeholders. It should be noted that, while the strategy sets the overarching vision for primary care in the city, the detail is underpinned by the requirements of the GP Five Year Forward View operational plan—which forms part of the overall STP.

Within Leicester City, many like-minded GPs have come together and joined one of three federations. Currently around three-quarters of practices are part of a federation, covering around two-thirds of the city's patient population. Each of the three federations is at a different level of development, although two are currently fully legally constituted and CQC registered.

Of these, Millennium Health Federation successfully bid for, and was awarded, £3.2million of funding under wave 2 of the Prime Minister's Access Fund. Under this the federation has, for the last 18 months, delivered a number of healthcare hubs across multiple locations in the city—providing over 100,000 additional face to face appointments during this time. In addition, Across Leicester Health Federation has received funding from NHS England under the Clinical Pharmacists in Practices pilot scheme, with nine clinical pharmacists currently in post to support practices across the city and help to free up clinical time.

Federations

ELR CCG

- ELR GP Federation

WL CCG

- North Charnwood GP Community Network
- Hinckley and Bosworth Medical Alliance
- North West Leicestershire GP LTD
- South Charnwood GP Network LTD

LC CCG

- Across Leicester
- Millennium
- City Central

Members of the respective federations are currently identifying opportunities for collaborative working, supported by the CCG as an 'honest broker'. A task and finish group has been establish that has representation from all three federations, as well as non-federated practices, to examine the possibility of practices coming together as part of one city-wide federation in the future.

In ELR CCG

GP localities have a history of collaborative working. In 2014 the CCG worked with its member practices to develop the Primary Care Strategy this was codesigned and aligns to the overall LLR model. Whilst some progress has been made the CCG acknowledges that further impetus is required to fully realise the ambition.

The practices have recognised the opportunity of the development of the GP landscape and in 2015/16 the ELR GP Federation was formed as a legally constituted organisation covering all 31 member practices. The federation received development funding from the CCG to assist in its establishment. The ELR GP Federation mission is "To champion through GPs and their practices, investment and delivery healthcare services at scale for patients across East Leicestershire and Rutland". A federated general practice will provide leadership for integrated place-based population health which is central to the CCG's strategy and the development of Multispecialty Community Providers. A work plan has been developed to support the vision and objectives outlined in the business plan, including ideas raised by members.

The ELR GP Federation is already beginning to support locality members' practices with regard to changing the way care is delivered and the infrastructure that supports this, through:

- **Integrated Locality Teams**—support practices in the development of the 'leadership teams' in the four ELR localities (B&L, Melton/Syston, Market Harborough, O&W), to work toward developing 'wrap around' community services.
- **Primary Care Home**—the Rutland Locality has been successful in its bid and has a key opportunity for developing new models of working. Learning will be shared across the CCGs as we develop integrated locality teams.
- **GP Programme Board**—the ELR GP Federation is an active part of the Board and is now taking on delivery of GP Five Year Forward View.

The role of the federation at the heart of delivering a new model of sustainable General Practice is in its infancy and although all of our practices have signed up as members, there is still a need for greater engagement and involvement to realise its potential.

In WL CCG

In 2014 the CCG developed its Primary Medical Care Plan, setting out the challenges, case for change, and ambitions to support the resilience of general practice, so that it can thrive. This was followed in 2015 by a Community Services Plan, outlining the system change required to further redesign community services and transform primary care, in order to reduce the proportion of resources assigned to acute care. Implementation is under way for both plans, overseen by the Integrated Primary and Community Services Programme Board. These plans fully align to the General Practice Forward View and place the CCG in a strong position to address the national requirements at a local level.

Localities and Federations

A federation is a legal or formal provider organisation made up of GP practices. The locality is the footprint in which community services are provided. In West Leicestershire the federations are coterminous with the localities. In East Leicestershire and Rutland one federation covers four localities. In Leicester City the federations do not as yet fully match the Health Needs Neighbourhood.

A key aspect of both plans is the delivery model of general practice that will be integrated and federated with patients co-designing services and taking increased responsibility for their health.

Much has already been achieved in realising this ambition. West Leicestershire's four localities have a strong and positive history of collaborative working. The practices recognise the local and national challenges facing them and the impact on the long term sustainability and viability of general practice in its current form. In 2014 each locality formed a legally constituted federation. Each of the four federations are now well established with all 48 practices being active members of the federation in their local area. Initially, each federation received development funding from the CCG to assist in the establishment of the federation leadership team and to undertake organisational development. Federated general practice is providing leadership for integrated place-based population health which is central to the CCG's strategy and the development of the CCG agreed new model of care, the Multispecialty Community Provider.

In testing collaborative arrangements in 2016/17 the four WLCCG federations:

- Led on a number of test beds to develop an integrated approach to care homes, urgent care and inter-practice referrals
- Are active members of the Integrated Locality leadership teams across the CCG area
- Have successfully won contracts to provide services at scale. Most recently, the federations secured the contract to provide integrated urgent care services across WLCCG from April 2017 in collaboration with Derbyshire Health United (DHU) Community Interest Company (CIC), the value of the contract is £3.7m.

Conclusion

Each CCG recognises that the development of federations per se is not sufficient to transform care, but is a part of the answer. In essence our General Practice model, our federations, and the development of integrated locality teams are the start of a journey towards a multispecialty community provider approach.

Our localities

Across our practices in LLR we have a strong sense of locality, promoting with our partners the concept of place-based care.

All our 138 practices are active members of 11 geographical localities (known as Health Needs Neighbourhoods in Leicester City) which have existed for many years. These localities are headed up by GP clinical locality leads who sit on the governing bodies of the three CCGs.

Our localities are the unit at which we actively engage with general practice co-designing pathways and services to improve patient outcomes and the quality of care delivered. They are increasingly the unit at which care is commissioned, coordinated and provided and are forming the basis not only at which our practices collaborate with each other but also with the wider health and social care teams. Each locality is subdivided further into smaller geographical units bringing together practices and teams covering a population of 30-50,00.

LLR Integrated Teams

WLCCG
3 Locality integrated teams
Charnwood
NW Leicestershire
Hinckley & Bosworth

ELRCCG
4 Locality integrated teams
Melton/Rutland
Harborough
Oadby/Wigston
Blaby & Lutterworth

City CCG 4x Locality
Health Need Neighbourhood
North and West
South
Central
North and East

Cementing the localities as the key unit of primary care service provision and delivery has enabled the wider system to, wherever possible, build on this same footprint to deliver wider community services. Both planned and urgent care provision across LLR is now centred around hubs aligned with our GP localities.

Working together to achieve our model

In taking our model forward we have reached consensus from our three CCGs on the direction of travel, and from our partners on the form and function of integrated locality teams. As part of the implementation structure of the Sustainability and Transformation Plan, we have established two key programme boards that will drive implementation of our model.

Our LLR General Practice Programme Board is working to ensure both the core contract requirements and the developments of federations are supported and adequately funded. The board consisting of stakeholders from across Health, Social Care and Patient groups, has established a number of delivery groups to implement our plan.

These are:

- General Practice Workforce Group
- General Practice IM&T Group
- General Practice Implementation Group.

The full programme structure can be seen in the final section on Governance.

Our **LLR Integrated Teams Programme Board** has built on the current locality structures aligning our community and social care teams on the same geographical footprint. We have established 11 locality leadership teams each of which is led by a Board GP and Commissioning Manager, with membership from our federations, adult social care and LPT community services. Their purpose is to:

- Develop a deep understanding of the needs of the initial cohorts identified across organisational boundaries, service users and datasets
- Identify how care and support varies, why it varies and how these differences can be addressed
- Define new ways of working and support staff to change their practise
- Undertake some initial test of new ways to deliver care
- Plan how the new ways of working can be rolled out across all eleven localities in 17/18.

This will enable the full integration of our practices with our community and social care teams to support out of hospital care. Through this we are shaping services with our practices, patients, partners and communities that are coordinated and integrated at a locality level to meet their needs. The locality leadership teams will work 'as one', being jointly accountable for the care of their identified population.

Interdependencies with other transformational programmes in LLR

In order to develop our model, the General Practice Programme Board will be working closely with other leaders and teams in the LLR health and care system who are responsible for related redesign work that builds both the generic and specialist offer in the community to support general practice.

The approach in each of the related programmes is again centred on place-based pathways and systems of care which wrap around the patient and their general practice, delivered through locally based health and care teams.

These are:

- **The LLR Prevention Programme**—supporting patients to manage their own conditions and preventing illness through healthy living
- **The LLR Integrated Teams Programme**—developing and implementing both the generic and specialist offer of integrated placed based teams supporting an identified group of general practices.
- **The Home First Rehabilitation and reablement programme**—seeking to develop a consistent offer at the point of discharge which enables patients to return to the community as quickly and safely as possible
- **The LLR Urgent Care Programme**—leading the development of integrated urgent care across LLR, ensuring that access to 24 hour urgent care aligns with general practice.
- **The LLR Planned Care Programme**—leading the development of planned care in community settings, the diagnostic element of which will increase the number of ambulatory pathways improving direct access by GPs to locally based diagnostic hubs and services some of which will be provided in and by general practitioners working together.

Our commitment to our patients

In delivering our model we have made the following commitments to our patients:

Consistently High Quality

- You can expect to have easy access, on-line or in person, to information, advice and support. This will be through national programmes such as 111, and NHS Choices.
- You will be confident that the advice and care provided by your primary care professional is consistent with best practice.
- Variation in the delivery of primary care will be identified through national data, and the commissioners will work together to support practices to provide core standards of care.
- You will be seen and treated by highly trained healthcare professionals who are committed to delivering the best quality of care.
- You will be treated as an individual by professionals and respected at all times.
- This will link with all other services when you need continued, consistent care to keep you at home.

Responsive and Accessible

- The way you are able to access information and be directed to appropriate services will be transformed through the use of new technology and social media.
- You will be able to access primary care services at weekends. This may not necessarily mean seeing a GP or nurse in the traditional way in your own practice.
- You will be able to have access to a primary care or community professional within a 24 hour period if you feel your primary care need is urgent.
- You will have access to high level quality indicators for General Practice, so that you can make an informed choice of GP practice.

Integrated

- You will find that services are working seamlessly together to co-ordinate your care and deliver the support you need to manage your condition. Holistic care will be delivered that addresses your physical, mental health and social care needs together and not separately. There will be no duplication.
- The voluntary sector, pharmacists, nurses and social care will be more involved in providing your care.
- The way health services and local authorities work will change. Services will align more closely, which will mean that primary care and social care deliver a seamless service.

Sustainable

- You will be confident that Primary Medical Care in LLR is financially well-run, and that the system has been designed to deliver the right care in a way which is affordable to the NHS and the tax-payer for the foreseeable future.
- You can be confident that decisions made about the way care is provided will be made because they benefit patients the most, within available resources.

Preventative

- Primary Care Professionals will act as community leaders who provide your health care.
- You will be actively involved in the management of your own health and care.
- You will receive more information on maintaining your health and we need you to use this information to prevent ill-health that can be avoided.

Underpinning this is the need for services to be innovative and continuously evolve and learn.

Next steps

In developing our model fully we have five main areas of focus:

1 Individual patient level

At the heart of General Practice is the core prevention agenda, whereby people are empowered to make the right lifestyle choices to maintain their health.

We will:

- Use active signposting at a practice level to ensure that when people do require support, they are able to manage their own conditions through appropriate information/tools.
- Develop full roll-out of e-consultation across LLR
- Improve patient access to core general practice 7 days a week.

2 Individual practice level

We will ensure the core offer from general practice meets patient needs by:

- Identifying and tackling unwarranted variation across our practices to drive up the quality of patient care and outcomes
- Supporting recruitment and retention and the development of new roles
- Upskilling the practice team to support extended clinical pathways.

3 Collective level

We will support our practices to work more closely together as collectives or federations by:

- Providing ongoing support to the development of federations.

4 Collaborative level

We will build on our locality structure to:

- Develop integrated locality teams which wrap around the patient and their general practice, extending the care and support that can be delivered in community settings.

5 Specialist level

We will work with our secondary care providers to:

- Bring specialist support nearer to patients in their communities
- Reduce the time taken to access specialist input,
- Reduce the number of separate steps in care pathways.

Fully implementing our model will require a joint focus on the delivery of care that meets the needs of the local population, with teams which share priorities and goals. Federated general practice will provide the leadership for integrated population-level health including the optimal organisation of urgent care services both in and out of hours and long term condition management. This is central to the development of MCPs.

3. Extended Access Across LLR

In 5 years' time the overall vision for extended access across LLR will be realised by the delivery of an integrated, coherent and intelligible care system, with patients supported to access the right service, in the right place, at the right time. Primary and Community services will be available to meet patients' needs 7 days a week with reduced duplication and improved information sharing and signposting between providers.

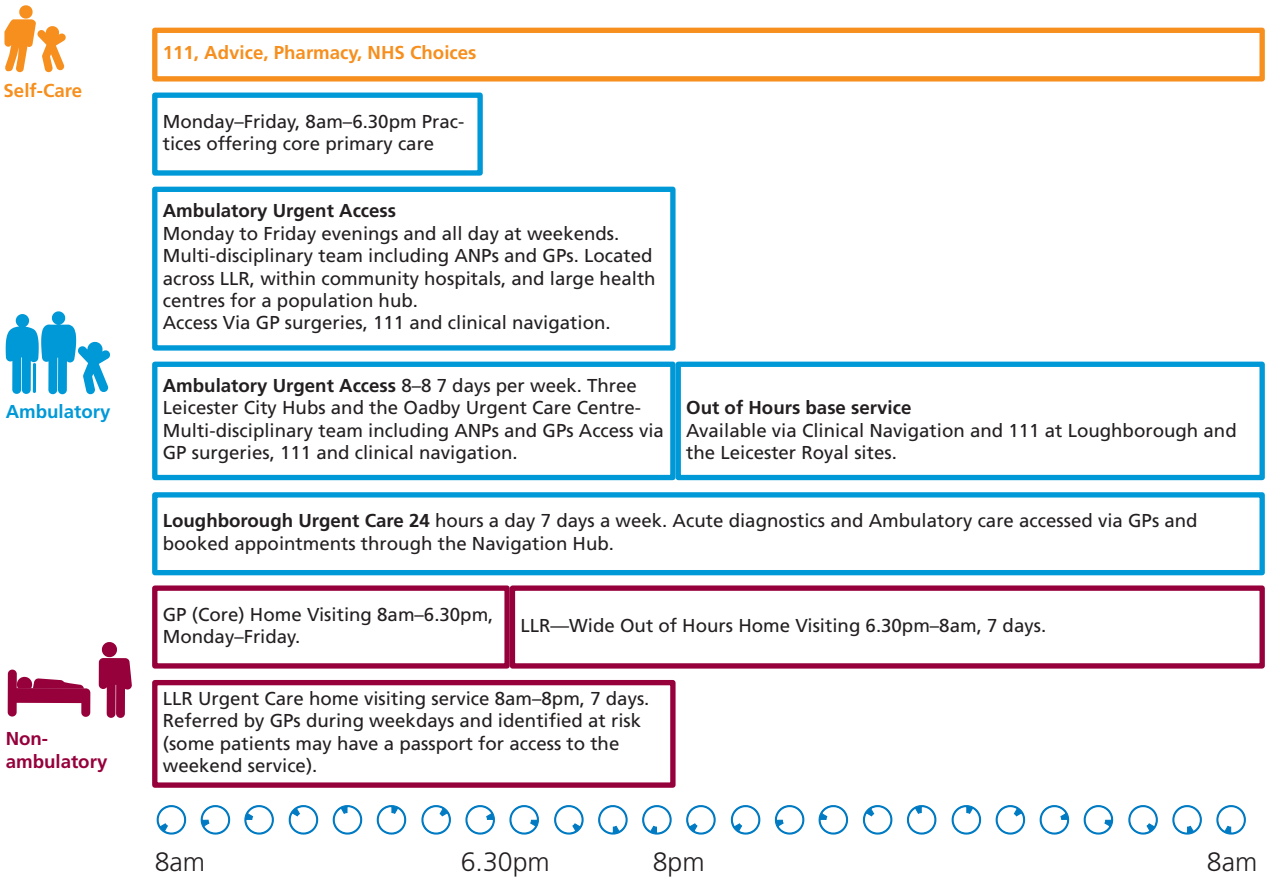
The aim is to slow the rate of growth in use of acute emergency care services and increasingly meet people's needs in lower acuity settings, such as general practice and self-care.

Our Model

In developing our model for extended access to general practice we are building on work to date led by the CCGs and the Urgent and Emergency Care Vanguard Programme, to deliver a system which provides responsive, accessible person-centred services as close to home as possible. In our model services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that exploit innovation and promote care in the right setting at the right time.

The LLR Urgent and Emergency Care Vanguard has been supporting the redesign and delivery of a broad and accessible range of extended services to

LLR Extended Access Service Model



patients across LLR. These services in conjunction with the access targets associated with the 5 Year Forward View will deliver an integrated and easily navigable service for all of the patients within LLR by 2018.

The service model described here has been developed in response to national guidance and best practice as well as reflecting the needs of the LLR population and the diversity of population and geography. The principle of a core, consistent offer across LLR, with local flexibility has been followed.

The LLR Extended Access service model delivers the provision of urgent and routine care across a 24 hour period for both ambulatory and non-ambulatory patients. This model recognises the following:

- During the week, day-patients will present to their own registered practice with urgent, planned and routine presentations and GPs will undertake home visits as part of their core service provision.
- The GP acts as the designated accountable care co-ordinator for the most vulnerable and complex patients in community settings and—through the developing geographically based multi-professional integrated sub locality teams—will risk-stratify the population, complete care plans and assign case managers as required.
- The integration of other practitioners into primary care provision is vital—eg, ANPs, ECPs, and clinical pharmacists—to release local GP capacity and more appropriately match the needs of patients with practitioners.
- Some patients will have urgent care clinical presentations during GP core hours but are too unwell to travel or are bed bound and require a home visiting service. This will be provided through the urgent care home visiting service.
- Some patients will have urgent and acute care clinical presentations during GP core hours that require a range of diagnostics, clinical assessment and specialist intervention that can be offered in community settings. This will be provided through the Community Hub, community hospitals and identified GP practices.
- All patients with an urgent care need after their registered practice has closed can be offered assessment and treatment in a community setting or in their own home following appropriate triage through the clinical navigation hub, booking directly into community urgent care services.
- The creation of the clinical navigation service, providing telephone advice, assessment and onward referral for people calling NHS 111 and 999. The clinicians working in the service will have access to the patients' primary care records and care plans, where relevant, and will be able to directly book patients into primary and community urgent care services.
- Extended access to primary care across LLR—so that patients can access primary care services 8am to at least 8pm every day of the week.
- Urgent Care Centres will offer a range of diagnostic tests and medical expertise for people with more complex or urgent needs, and we will strengthen community based ambulatory care pathways which can avoid admission without the need of referral to acute hospital.

Current Baseline

The majority of patients in LLR already have access to a variety of extended daytime, evening and weekend services through Urgent Care centres, Primary care hub services, GP specific extended hours and Out of Hours base services.

However, the current model of access to primary and community services—

whether urgent, planned or routine—does not offer the level of integration or access that local people need and expect. It is also confusing for patients and too variable in terms of service-offer by location and time of day.

The current range of services provided by each CCG varies:

CCG	Contract Type	Service Offer	Location	Access	Hours of Operation
ELR	DES	Extended Access 29/31 practices = additional 165 hours per week	GP Surgery	Prebookable	Morning/Evening/ Weekend
	CBS	Minor Injuries Service 31/31 practices	GP Surgery and Harborough and Rutland hospitals	Walk in/ Prebookable	8.30-5 Mon-Fri
	NHS Contract	Acute Visiting Service	Mobile Visiting	Referral via GP/ Care Home	Weekday 9-4
	NHS Contract	Urgent Care-Minor Injuries and Ailments	St Luke's Hospital at Market Harborough, Rutland Memorial Hospital in Oakham, Melton Mowbray Hospital, Oadby	Walk in and prebookable via NHS111	Harborough/Rutland/Melton service 5-9 pm weekdays and 9-Oadby 8am to 9 pm weekdays and 8am to 8pm weekends and bank holidays
City	DES	Extended Access 6/59 practices =12.75 hours per week	GP Surgery	Prebookable	Morning/Evening/ Weekend
	CBS	Extended Hours 42/ 59 Practices 153 additional hours	GP Surgery	Prebookable	Morning/Evening/ Weekend
	CBS	Quality Contract 29/59 practices offer 90 Clinical appointments per 100 population	GP Surgery	Prebookable	Core GP Hours
	CBS	PMC Fund—3x Primary Care Hubs offering core primary care 1481 additional appointments per week	3 Hubs across the City	Prebookable	1. 8–8 7 days 2. Monday–Friday 6.30pm-10pm Weekend 12-8pm
	CBS	Crisis Response Team	Mobile Visiting	Referral via GP/ Care Home	8am-8pm 7 /7
	NHS Contract	Walk In/ Urgent Care	Merlyn Vaz centre	Walk in	8am-8pm 7 /7
WL	DES	Exteneded Hours 21/48 practices 112 Hours per week	GP Surgery	Prebookable	Morning/Evening/ Weekend
	CBS	Minor Injuries Service 48/48 practices	GP Surgery	Walk In	Core GP Hours
	NHS Contract	Acute Visiting Service	Mobile Visiting	Referral by GP/ care Home and patient "passport" at weekends	Weekdays 9-5 Weekends and bank holidays 8am-7pm
	NHS Contract	Urgent Care Centre	Loughborough Hospital	Walk in and prebookable via NHS111	24 hours 7 days
	NHS Contract	Out Of Hours Base visit	Hinckley and Bosworth District Hospital	Prebookable	Weekdays 7pm-12am

Moving Pathways to Community Settings to improve patient experience and care closer to home

We have identified a range of pathways that could safely be delivered in community settings

Specialty	Pathway
Gynaecology	Early Pregnancy
Urology	Blocked Catheters
	Non complex Urinary Tract
	Abdominal Pain
Cardiology	Atrial Fibrillation
	Heart Failure
Respiratory	Non complex COPD
GP	Hyperkaleamia
Assessment	Non complex diabetics
Unit	Non complex mental
Paediatrics	Non complex asthma
	General paediatric queries

Understanding Demand

In order to understand patient demand in the development of the new model the CCGs have undertaken the following:

- Working with public health colleagues a review of the CCGs population profile was undertaken utilising the 2011 census data to determine health need with regard to age, gender, deprivation and external factors eg, industrial related health needs.
- A baseline assessment of current services was undertaken aligned to settings of care enabling the identification of gaps over the 24 hour period and rapidity of response.
- Detailed data analysis was also undertaken in which we based our assessment of need on the national Ambulatory Care-Sensitive Conditions Directory. SUS data was then analysed against these HRGs. All community based procedures were identified, to determine our activity modelling.
- ELR CCG have commissioned Leicestershire County Public Health to deliver an activity and demand deep dive to understand emergency care access flow across LLR and flows to out of county providers. This piece of work will aim to understand the relationships between actual demand, capacity driven demand and patient flow behaviour.
- GP referrals for hospital diagnosis and treatment, including emergency admissions with a length of stay between 0-6 hours have rapidly increased over the years. Through analysis of this to date we have been able to identify over 12 pathways that could be safely undertaken in a community hub. We believe these will provide more timely local services, increase choice for patients and facilitate more diagnostic support for GPs.

Implementation of the Extended Access Model to achieve 100% coverage

In each CCG area the model of extended urgent and routine access is being developed and implemented as follows:

LC CCG

For LCCCG the continuation of the Hubs model is a key element of its access plan. This builds upon a successful pilot to provide extended access to routine primary and urgent primary care for all city patients outside of core hours via a small number of locality based centres. The pilot was funded from the then Prime Minister's Access Fund (PMAF) following a bid from the city's Millennium GP federation.

During 2016/17 the CCG developed a specification for the service to be commissioned by the CCG from 1st April 2017, making use of national £6 per head funding in each of the next two years. This specification built on learnings from the pilot phase, including the configuration and location of the hubs. Leicester City CCG is considering the most appropriate location for its fourth primary care hub. One option under consideration is utilising vacant space at the Leicester General Hospital site to create a community super hub that could include a wider range of diagnostic services and the potential for observation facilities in the future.

The CCG sought a long-term provider for the service through a comprehensive procurement process but, unfortunately, the process did not yield a provider on the grounds of affordability. As such, the CCG plans to extend

the arrangements with the federation until 30th September 2017 through a Single Tender Action (STA). This is vital to ensure continuity of the service. The CCG will shortly commence a new procurement process and, following a review of the specification and through market testing, fully expects a new provider to commence delivery of the model from 1 October 2017.

The proposed model will see weekday provision of access to pre-bookable and same day appointments to general practice services on a tiered basis. Tier one primary care hubs will be provided at Belgrave Medical Centre and Saffron Health (6.30pm to 10pm Monday to Friday, and 12 noon to 8pm weekends and Bank Holidays). Tier two hubs will be provided at Westcotes Health Centre and either Merlyn Vaz Health and Social Care Centre or Leicester General Hospital (8am to 8 or 10pm seven days a week), subject to consultation. On average the hubs will provide between 1200-1800 extra patient consultations per week.

Tier one Hubs will offer core primary medical care services for ambulatory patients. The tier 2 Community Hubs will core primary medical care services as well as access to some on-site diagnostics. This will include point of care blood tests, urine tests, electrocardiographs (ECG) for monitoring the heart, and ultrasound tests for a restricted range of conditions. Depending on the location of the fourth hub, the range of diagnostic services at this site may be extended to include x-ray in the future, histology, microbiology and patient observations.

This is important because a large proportion of patients receive outpatient appointments at Leicester's Hospitals to have this testing carried out. We believe it would be much more convenient and a better experience for patients to have this carried out in the healthcare hubs instead. We believe this will help to reduce pressure on services provided by Leicester's Hospitals.

Appointments for the same day or up to 48 hours in advance can be booked via the patient's own GP practice, by calling NHS 111 or by calling the designated healthcare hub phone number.

Ambulatory care-sensitive conditions account for one in every six emergency admissions to hospital in England and often reflect poor co-ordination between different elements of the health care system, in particular between primary and secondary care. Community hubs will improve efficiency by speeding patient flow and reducing unnecessary admissions while also delivering faster and more patient centred care for less acute patients.

To meet this need there will be two Community Hubs that will offer extended General Practice and a range of diagnostic / ambulatory care services. Westcotes hub went live in late 2016, and it is planned that a second community hub will open within the City during 2017.

Our vision is to have a fully integrated team, with provider partners from social care working alongside clinical teams in the community hubs, enabling us to build the service around the patient, rather than getting patients to fit in with existing services. By working in partnership we will be able to avoid many more unnecessary hospital admissions, as currently a high number of people are admitted for largely social reasons, rather than on health grounds.

ELRCCG

The current service for extended primary care access was commissioned in April 2015 and provides GP-led service 8-8 7 days per week in Oadby. It supports the nurse-led evening and weekend access on the three spoke sites.

From April 2018 a new service will be procured that will combine the current

Definition of Tiers

Tier 1—Primary Care 'hub' opening 8am to 8pm, seven days a week.

Offers assessment and treatment for patients presenting with urgent care needs, with the ability to prescribe medication and take bloods. Offers access to limited diagnostics and the ability to perform some basic near patient testing

Tier 2—Urgent Care Service opening 8am to 8pm, seven days a week.

Offers assessment and treatment for patients presenting with urgent care needs including minor injuries and minor illness ,with the ability to prescribe medication. Offers on site diagnostics including plain film x-ray and near patient testing, for the majority of opening hours.

Tier 3—Urgent Care Centre. Operates 24/7, seven days a week.

Offers assessment and treatment for patients presenting with urgent care needs. Offers on-site diagnostics including plan film x-ray and near-patient testing, for at least 16 hours a day. Is able to undertake assessment of ambulatory patients, including appropriately staffed observation facilities, to avoid admission.

Extended Access and Out-of-hours base visiting service, enhanced and in line with the expectations of the GP 5 Year Forward View. This will be provided in the existing sites, with an additional evening and weekend service in the Western edge of our Geography to ensure 100% coverage. This extended primary care service will provide:

- An easy to navigate, accessible service for extended primary care access and urgent on the day patient need.
- There will be 4 sites covering our large geographical area open in the evening after GP services are closed and at weekends. One site will be open 7 days from at least 8-8.
- A bookable service utilised by our member practices and the clinical navigation hub, triaging 111 patients to ensure patients access the right centre for their needs. Oadby will offer an element of walk in service with clinical triage.
- This service will integrate with other community based urgent care services, home visiting and clinical navigation to ensure patients are treated locally in the right setting first time.

WLCCG

During 16/17 the CCG working collaboratively with our practices, federations and providers through the development of an urgent care test bed, identified the clinical presentations suitable to be seen both in tier 1 and tier 3 settings. As a result the CCG developed an Integrated Community Urgent Care Service Specification, undertaking an open procurement process to secure a provider to commence from 1st April 2017. The successful bidder has now been announced and is a Community Interest Company jointly provided by DHU and the GP Federations in WLCCG. The service will initially provide patients with access to same day urgent appointments to meet patient need, but will expand by April 2018/19, to offer pre-bookable routine and acute appointments in evenings and at weekends.

Extended Primary Care services will be provided on a tiered basis; tier one Primary Care Hubs at Hinckley Community hospital (19.00-22.00 Monday to Friday and 08.00-20.00 on Saturday, Sunday and Bank Holidays) and Coalville Community Hospital (09.00-12.00 on Saturday), and tier three Community Super Hub at Loughborough Community Hospital (24 hours per day, 7 days a week).

Tier one Extended Primary Care will offer assessment and treatment for ambulatory patients with urgent care needs who have been triaged through 111 and the clinical navigation hub, with access to limited diagnostics.

The tier 3 Community Super-Hub will offer assessment and treatment for patients presenting with urgent care needs including injuries, illness and ambulatory care sensitive conditions for all age ranges and offer a base for patients fit to travel to be seen during the out of hours period. On-site diagnostics, including plain film x-ray, will be available to meet patient need.

From April 18/19 patients with an acute but non-urgent primary care need; or those requiring routine appointments where the patient is unable to attend their own practice during core hours and whose general practitioner is concerned about the patient's needs after the practice has closed, will be pre-booked via their own general practice into the 3 primary care hubs described above. This service will operate from 6.30–8 pm weekdays and Saturdays/Sundays. The CCG will work with our practices, federations and partners to assess demand to ensure the service provided meets patient need. We will take learning from the national Challenge Fund pilots, as it is clear

that some extended hours slots have proved more successful than others, particularly those in the evening and on Saturdays (particularly Saturday mornings), whereas patient demand for routine appointments on Sundays has been low. We will plan to pilot our approach during 17/18.

See the following sections for the impact of our model on workforce, estates, IM&T and finance:

4. Workforce
6. Infrastructure
7. Investment.

Next Steps

These are CCG area specific and dependant on the current service provision and status of planned procurements:

ACROSS LLR:

- Mobilise the LLR wide Home Visiting Service from April 2017.

ELRCCG:

- Procurement commencing June 2017 for an integrated urgent care and extended access service to mobilise from April 18.

WLCCG

- Mobilise the WLCCG Integrated Urgent Care service from April 2017
- WLCCG to develop a test bed for extended primary care access in 17/18 and implement fully in 18/19.

LCCCG

- Current LCCCG Hubs to remain as is until Sept 2017
- Procurement commencing March 2017 of integrated urgent care and extended access service to mobilise October 2017
- Complete pre-consultation engagement on potential location of fourth hub.

4. Workforce

In Five Years

The new model of General Practice services, in conjunction with integrated community and social care teams supports patients to remain cared-for out of a hospital setting for longer than ever before. The utilisation of a broader range of health and social care professionals has enabled patients to be streamed according to need, which means that GPs can manage those most complex patients and co-ordinate the care for the rest of their patient population. The delivery of the majority of care is provided by the multi-disciplinary team that includes pharmacists, nurse practitioners and physicians associates alongside health care assistants.

With practices formally joined through federations, the back office support functions can be redesigned to ensure that practice managers have the time and capacity to deliver and support the cross site services, and the administration staff can flexibly provide the service that both patients and their clinical staff require, due to reduced bureaucratic process.

This will be delivered by:

Supporting the existing primary care workforce to improve recruitment and retention but equally important to identify new capabilities, competencies, skills and behaviours required to make an enhanced primary care offer.

- Identify new roles and capabilities in new staff groups. There is an urgent need to focus on alternative professional roles that support integration, increase capacity and reduce admissions by freeing up GPs time to manage increasing complexity. Such roles include primary care physicians' assistants.
- Identify roles and competencies currently sitting outside of primary care that will be required to support the demand. Such roles include primary care paramedical staff, community pharmacists, emergency care practitioners, and specialist roles such as geriatricians.
- Actively utilising the three training hubs, support undergraduate medical, nursing and pharmacy training and GP training at a federated level to promote our practices as positive places to work to aid recruitment and retention.

It is clear that these new models of working and potential workforce shortages will require a change in workforce planning. These models—including streaming of patients or provision through federations and integrated teams—will bring together groups of existing and new health professionals to meet the future needs of patients covering larger geographical areas. This will mitigate some of the risk of additional workload, ageing and more complex patient needs.

LLR General Practice Workforce Baseline

The local picture mirrors the national evidence of significantly lower growth in GPs compared to hospital consultants in the last decade, creating a shortage of GPs compounded by substantial difficulties with recruitment, both of qualified GPs and GP trainees, with local training places unfilled. In parallel to national research there are fewer GPs working full-time in patient-facing general practice, some working full-time but taking on other responsibilities, including roles in clinical commissioning groups (CCGs); management tasks in their own practice or in a wider federation. The recruitment and retention issues are similar for nursing posts with many close

to retirement. A survey of general practice nurses in 2015 found that a third are due to retire by 2020.

The data analysis is from the most up to date workforce position, extracted from data collected by NHS Digital as at 31st March 2016.

LLR Workforce risks

CCG	WTE GPs Partner/Salaried	GPs Aged 55−59 %	GPs Aged 60+ %
City	156	9.30%	9.90%
ELR	206	13.60%	2.20%
West	185	12.20%	6.80%

Staff Group	Headcount	FTE
GP	697	605
GP (excluding Registrars, Retainers & Locums)	628	547
Nurses	393	276
Direct Patient Care	295	200
Admin/ Non−clinical staff	1426	1031

The local data analysis shows that there are real pressures on workload and demand for services in each of the three CCGs within LLR, but often for very different reasons. Leicester City has significantly greater levels of deprivation, scoring 18/209 most deprived CCG in England and the added pressure of working with diverse populations with high numbers of people from minority ethnic communities who face both language and cultural barriers in accessing care. In both ELR and WL CCGs, the number of patients over the age of 65, (21% and 19% respectively against a national average of 17%), —where demand significantly increases coupled with the challenge of rurality—creates demand for home visiting.

There are also vast differences in numbers of GPs and other health professionals per 1000 registered patients. This is partly down to historical funding, but also the challenge of recruitment in inner city and more deprived areas. This is compounded by the age demographic of both GPs and nurses, where a significant proportion will be retiring in the next 5-10 years, often in areas that are already under doctored.

Practices are finding it increasingly difficult to recruit and retain GPs. Some GPs reaching the end of their careers are choosing to retire early in response to workload pressures. There are also many older GPs who have been affected by changes to the tax treatment of pensions which create disincentives to work when the lifetime allowance for pensions has been reached. Fewer GPs are choosing to undertake full-time clinical work, with more opting for portfolio careers or working part-time. This is true for both male and female GPs. Trainee GPs are often planning to work on a salaried basis. This continues a long term trend in which fewer doctors aspire to become partners in their practices.

There are challenges too with recruitment and retention of other members of the primary care team, particularly practice nurses and practice managers. This makes it difficult for some of the work of GPs to be taken on by other staff and therefore support change of clinical delivery model.

LLR Collaborative Workforce Programme

The delivery of a highly trained workforce to enable the new model of General Practice to be realised is only possible through system collaboration. Through the Better Care Together STP programme, LLR has a dynamic and responsive programme co-ordinated and held to account through the Local Workforce Action Board. Each of the work groups has a defined responsibility to support the whole system.

Examples of projects to make LLR a recruitment hotspot and to retain our valuable workforce have been:

- A programme of marketing and branding LLR as a system that provides a variety of opportunity in both urban and rural settings, with the option to move around the system over time.
- A focus on ensuring that students and trainees have a high quality experience with providers across LLR in order to minimise attrition and

maximise the LLR workforce supply pipeline.

- The recognition of workforce wellbeing as key to our local health economy. As a significant employer supporting our own staff, we have the potential to influence the health and wellbeing of wider family and friends As we share and build on existing workforce wellbeing initiatives, we will explore these opportunities with Public Health colleagues across the system.
- Co-ordinated international recruitment drive for clinical skills across LLR including new staff groups such as Physicians associates.

Leadership and Organisational Development

Leadership and Organisational Development (OD) are central to achieving our plans, targeted at the following levels:

Practice/CCG Level

- GP Board member development
- LMC/HEEM funded GP coaching and mentoring

Collective level

- Federation OD plans and development programme

Collaborative level

- STP Clinical Leadership programme
- Integrated locality teams East Midlands Leadership Academy (EMLA) programme.

Working together to achieve our aim

In January 2015, the LLR General Practice Workforce Delivery Group (LLR GPWDG) was established. The group brings together the commissioners of primary medical services and providers in order to:

- Engage with constituent member practices on the workforce issues facing primary medical care and work together to develop solutions
- Ensure that education and training needs are identified for primary medical care staff and reflected in the LLR-wide workforce development plans provided to Health Education England
- Support the workforce objectives of BCT and now the STP together with the CCGs Primary Medical Care Plans/Strategies, including new models of care.

The Delivery Group reports formally to the LWAB providing monthly updates of progress against the work plan. The group also acts as a conduit for information exchange with the Health Education England (HEE) Regional Primary Medical Services Steering Group.

The LLR STP recognises the vital role of general practice in developing and implementing our local strategy. This will require additional capacity within primary care to accommodate the shift of activity from acute and community settings. Meeting these expectations will mean changes in the skill-mix for primary care as well as appropriate capacity across primary and community settings. To support this workforce development there has been some real success to date.

Education, Training and Recruitment

Each CCG in LLR has a Training Hub, set up from 2015. In combination these are instrumental in helping to train the workforce of the future. Their vision is to provide an educational environment that fosters inter-professional learning between students of different disciplines and deliver enhanced networks of personalised care. These include:

- **Medical Student Placements**—All of the Hubs have Academy Status with the Leicester University Medical School Kings College London and University College London and Nottingham University to teach undergraduate medical students.
- **Pharmacy Student Placements**—The Hubs were instrumental in developing a new pilot with DMU for undergraduate students during 2016. The project phase will take place during 2017, with a view that all undergraduate students will have an educational block in general practice by 2018/19.
- **Student Nurses**—he Hubs have been working closely with DMU to update the mentoring qualifications of general practice nurses. This enables more student nurse placements to be offered LLR.

- **Physician Associate Placements**—This is a new concept and very a recent development for all three Training Hubs. Relationships have been successfully established with Worcester University and the aim is to place 5 PA students within LLR Training Hub Practices from September 2017 and thereafter, for the following academic year commencing September 2018.

New Workforce

- **Clinical Pharmacists**—ELR CCG have funded £2 per patient through PMS funding for employment of pharmacists to improve quality, workload and cost effectiveness, following a successful pilot phase in 2015/16. City and west CCG were successful in bidding for the national programme for pharmacists
- **AVS/CRT Urgent Home Visiting**—Since 2015 the clinical response team has taken referrals directly from GPs and/or care homes for patients that require a same day home visit in order to potentially avoid an emergency admission to hospital. This service is provided 7 days per week and adds clinical workforce capacity and supports workload in General Practice
- **Training Care Navigators and Medical Assistants**—Five year £45m fund has been created to contribute towards the costs for practices of training reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence. This is an enhancement to normal good customer service

Practice Manager Academy

Practice managers play a key role in supporting the day to day delivery of primary medical care services and are crucially important in system wide work to transform how care is delivered. A recent survey of practice managers competed by the Workforce Development Group, received a 72% response. The results of the survey are being used to inform future plans including the proposal to establish a Practice Managers Academy. The survey identified that:

- 48% of practice managers had not worked previously in the NHS
- 48% were promoted to their current role from within the practice
- 70% do not think that they will work at another practice
- 42% were interested in receiving mentoring.

On the basis of the survey results an options appraisal is being completed to inform the development of a LLR wide practice managers academy. The initial focus on the academy will be to establish a practice manager induction programme, appraisal process and mentoring scheme.

Investment in Workforce Development

Since 2015 the group has also secured significant non-recurrent funding through successful bids to HEEto support some of the initiatives outlined above, which include:

Initiative	Funding Secured
The development of a programme to enhance the capability and capacity of medical undergraduate teaching in primary care.	£308k
The implementation of a detailed workforce scoping and audit in general practice to inform a future training needs analysis	£100k
The development and implementation of 3 training hubs	£150k
Workforce scoping projects:	£67k
Qualitative and quantitative Training Needs Analysis to identify and support high quality education and training of the general practice workforce	
Scoping project to develop a Fast Track Transition Programme to practice nursing	
Scoping project to develop Practice Manager Academy – a programme to develop the practice managers of the future	
Coaching/Mentoring project to design and deliver a coaching scheme for all general practice staff(LMC led)	£156k
A project to develop Pharmacy & General Practice Inter-professional Working to build cross-collaborative relationships between pharmacists and GPs.(LMC/LPC led)	£53k
Post Graduate Training in Primary & Community Settings - a project designed to scope the potential approach to fund and support training in community sites (Led by the LLR Alliance)	£26k
Wider workforce funding	£63k
Flexible Learning Beyond registration	£21k
Apprenticeship Education	£9k
Total	£953k

Next Steps for General Practice Workforce

It is clear from the workforce data available that there are current gaps in numbers of GPs required and both the number of and skill mix of other health professionals. To deliver new models of care may require additional recruitment, especially if groups of practices, federations or MCPs undertake extra services to support the left shift of work from secondary to primary care, which may require the transfer of staff across settings.

To deliver the Blueprint for General Practice (see Section 2. Our Model for General Practice) there needs to be detailed modelling of how practices or groups of practices can work to deliver new ways of managing their patient needs, 7 days per week. This will require an analysis of how patients are streamed and the most appropriate clinical skill mix to deliver these services. The whole systems partnership has been working with the 15 GP Vanguard sites nationally to support this modelling and will be working with practices from all three LLR CCGs to support the workforce implications of new models of care. This work will be completed in August 2017. The result will show in detail exactly how the staff mix can change dependent on model of care.

In tandem with this work, which will cover at least 3 pilot sites in LLR, HEEM has funded a nine month work program that has been set up through the GP Workforce Group to deliver the following level of detailed information, which will enable the 5 year forward view to be delivered:

- Produce a comprehensive baseline of current workforce numbers and skills in General Practice to show the gap between current and projected workforce.
- Map the existing programmes of training, education and development for all staff groups within General Practice in LLR and understand gaps and risks.
- Map the future workforce needs in line with the proposed new models of care in General Practice
- Design a strategy for how we meet these needs for GPs, nurses, other

health professionals, practice managers and administrative staff.

- Create an implementation plan that will link this to the General Practice and Integrated Team STP work streams and help deliver sustainable solutions in General Practice and the GP 5 Year Forward View.
- Increase the number and skill set of a new workforce using for example ECPs to deliver urgent home visiting, clinical pharmacists in General Practice through bidding for wave 2 NHSE scheme and upskilling non-clinical staff through the care navigator programme.
- Practice Manager Academy-Practice managers play a key role in supporting the day to day delivery of primary medical care services and are crucially important in system wide work to transform how care is delivered. There has been the development of a LLR wide practice managers academy. The initial focus on the academy will be to establish a practice manager induction programme, appraisal process and mentoring scheme.
- Close working with the NHSE medical director and his team locally to access and integrate the GP Refresher and Retainer Scheme and the International Recruitment Programme.

The LLR workforce groups are not waiting for this analysis and modelling to be completed to drive forward plans for recruitment, retention and training of staff. The success shown already across LLR is enabling new health professionals to enter the workforce and deliver new models of care providing seven day urgent care/primary care access, clinical pharmacists in practice and ECPs providing a seven day urgent care at home service. The next stages will support the longer term systematic design and delivery of scale in General Practice services.

5. Workload

As identified earlier in our plan and well documented at a national level, general practice is under a great deal of pressure driven by a number of factors including increasing demand and growing expectations from the public and policy makers. Workload was identified by the 2015 BMA survey as the single biggest issue of concern to GPs and their staff. National figures estimate the increase in workload in general practice of around 2.5% a year since 2007/8.

This section of the GPFV Plan sets out our approach to reduce pressure on general practice and release time for care. The plan seeks to maximise and implement the initiatives developed to date as part of the GPFV and Operational Planning and Contracting Guidance. The initiatives outlined below should not be seen in isolation from the overall GPFV Plan; they complement "offers" in other sections of the plan which are also designed to support general practice.

In Five Years

We will have implemented a programme of support which will seek wherever possible to reduce the pressure in general practice by addressing bureaucracy and potentially avoidable GP demand. Recognising, though, that demand is likely to continue to increase and the role of General Practice broaden, we will have an equal focus on supporting practices to evolve their operating model to more effectively respond to these demands. This work will be taken forward by a designated subgroup of the GP Programme Board and will report progress on a quarterly basis.

Working with patients to target demand

We will need the support of patients to be open-minded about the changing relationship with their practice, and to play their part in ensuring the appropriate and sustainable use of primary care. We recognise that this will be a major challenge, and so the three CCGs are planning a significant public campaign that seeks to explain the model of primary care to patients, builds a sense of collaboration and shared responsibility, and starts to develop a compact between practice and patient on what they might reasonably expect.

From The NHS Constitution, 27 July 2015:

"Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it."

Baseline Position

As in many parts of the country general practice in LLR is facing a broad range of challenges which until recently have remained hidden. Recent research has identified a number of factors including:

- The number of face to face consultations grew by 13% and telephone consultations by 63% between 2010/11 and 2014/15
- Over a twenty year period the average GP consultation has lengthened by 50% from 8–12 minutes
- Average consultations among the over 75s have increased by over 50% from 7.9 in 2000 to 12.4 in 2015
- Between 2010/11 and 2014/15, GP workforce grew by 4.75% and practice nurse workforce by 2.85%
- Over the same period funding for primary care as a share of NHS overall budget fell every year from 8.3% to just over 7.9%.

The pressures on general practice are compounded by increasing demand and patient expectation, driven in part by our aging population and increasing numbers of people with complex conditions. Medical advances and developments in preventative healthcare have also led to a considerable increase in the number of activities carried out in general practice. There is a strong evidence and feeling amongst general practice that this additional work has not been accompanied by increased resources in terms of staff numbers or funding.

Working together to achieve our model

Building on work undertaken by individual CCGs, we are increasingly working together across the our healthcare system to address the challenges facing general practice.

The prevention agenda is often complex and falls across the boundaries of Health & Social Care and Public Health. Our vision of prevention describes a system in which our patients and family carers have the skills, confidence and knowledge to self-manage and become more 'active' in relation to their physical and mental health promoting independence and rehabilitation.

The General Practice Resilience Programme (GPRP) aims to deliver a menu of support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and secure continuing high quality care for patients.

The approach taken by NHS England Central Midlands is to use this resource in the most flexible, responsive, and meaningful way possible in order to improve the resilience of GP practices and galvanise the transformation of general practice. In recognising that a 'one size fits all' solution isn't available a menu of support has been developed to offer a tailored package for a GP practice, practices, or localities that will improve sustainability and resilience. This includes:

- Diagnostic services to quickly identify areas for improvement support
- Specialist advice and guidance eg, HR, IT
- Coaching/Supervision/Mentorship
- Practice Management Capacity Support
- Rapid intervention and management support for practices at risk of closure
- Co-ordinated support to help practices struggling with workforce issues
- Change management and improvement support to individual practices or group of practices.

The 3 CCGs in LLR have worked closely with the NHS England local teams to identify practices for cohort 1 of the GPRP programme. Initially 52 practices applied for or were put forward by the CCG, of which 10 practices were supported with a further 16 placed on the reserve list. CCGs / NHS England are now working with the practices to identify the support required for each practice based on the above menu. Subject to the support offered, interventions are likely to continue into the 2017/18 year.

General Practice Development Programme—In 2016, working on the STP footprint the 3 CCGs made a successful application to NHS England to roll out elements of the GP Development Programme on an LLR basis. An update on each area is provided below:

Productive General Practice (PGP)—To date 28 practices have signed up to and are participating in wave 1 of this initiative. The programme is designed to provide fast practical support to practices to help reduce pressures and release efficiencies in general practice. The programme consists of 6 half day practice based sessions and 4 group based sessions supported by improvement experts. Practices can choose to participate in a range of initiatives including: 'chasing the tail', workplace organisation, workforce planning and failure demand.

Ten high impact actions—Building on work completed by the Primary Care Foundation and NHS Alliance, the ten high impact actions are a range of

Workshop attendance and feedback

124 GPs, practice managers and members of the primary healthcare team attended the LLR showcase event on 9th Feb 2017.

On the day feedback included:

"This is just what we need"

"Great opportunity to learn from colleagues in different CCGs"

"Practice manager from Gateshead spoke really well and was inspirational"

practical measure to remove unnecessary pressures on general practice and free up time for patient care. In February 2017, the CCGs working in partnership with NHS England Sustainable Improvement Team held a very successful showcase event for LLR practices. The event aimed to further raise the profile of the GP Development Programme particularly focusing on the ten high impact actions. Delegates received an update on the GP Development Programme Offer and detailed information on the ten high impact actions. In the final session delegates were given the opportunity to work in small groups focusing on the high impact actions they were most interested in taking forward.

Transferring Care Safely

The LLR Transferring Care Safely group consisting of primary and secondary care clinicians identified the following of significance:

- Medication
- Referrals
- Diagnostics
- Monitoring
- Administration

Going forward we also need to work with partners to look at Clinical Handovers in the community.

Transferring Care Safely—The un-managed and inappropriate 'left shift' of activity from secondary care to primary care puts significant unnecessary pressure on GP workload. A pan-LLR Transferring Care Safely Interface Group has been established to identify and influence how we can transfer care safely across the whole LLR system in the most effective ways, to improve the patient journey and ensure work is done in the right place at the right time. Initial stages of the work have focused on stakeholder engagement across the primary and secondary care interface and a GP survey has been completed to identify and quantify key themes. The group recognises that the transfer of care is an inevitable part of integrated working and is committed to ensuring this is delivered in a safe way delivering high levels of patient experience.

Next Steps

This project summary sets out our approach to reducing pressure on general practice and releasing time for care. The plan seeks to maximise and implement the initiatives developed to date as part of the GPFV and Operational Planning and Contracting Guidance.

Working with key stakeholders we will take forward a range of initiatives to reduce unnecessary work on general practice.

Transferring Care Safely

Building on the work completed to date there are plans to:

- Finalise and launch a guidebook to clarify issues for GPs and secondary care (and community and social care)
- Agree a communication and engagement plan to support future work, including a public facing campaign to enlist support from patients for the required changes and support appropriate usage of primary care in general practice
- Establish a GP Liaison line (telephone and e-mail) to help resolve issues as they arise
- Work with quality leads to avoid duplication and ensure accurate reporting
- Work with providers to introduce new legal requirements in the NHS Standard Contract for hospitals in relation to hospital/ general practice interface with a view to relieving some of the administrative burden on practices.

Initiatives to reduce demand on General Practice

- Work with NHS England to locally implement initiatives currently being considered to reduce demand on practices includes reductions in inspections from CQC, outcome of the current review of QOF currently

being undertaken by NHS England and GPC, streamlining reporting requirements and payment systems and accelerating paper free at the point of access.

- Take forward our vision of prevention where our patients and family carers have the skills, confidence and knowledge to self-manage and become more 'active' in relation to their physical and mental health promoting independence and rehabilitation.

General Practice Development Programme

Building on the successful collaborative bid we will work together with NHS England to roll out the next stages of the programme:

Productive General Practice (PGP)

Our plan is to build on this positive engagement by 28 practices and support a wider number of practices to participate in future cohorts of the programme. This will involve:

- Working with the external provider to evaluate participation in wave 1 (April 2017)
- Subject to availability of national funding, sharing the outcomes of wave 1 and recruiting practices for phase 2.(May–June 2017).

General Practice Improvement Leaders Programme

Currently there is only one LLR attendee on the programme and we have received feedback from our practices that they are concerned about the time commitment and travel involved in attending the programme. Going forward we think it is crucial to develop local capacity and skills around quality improvement and following our showcase event we are planning to hold local training programmes.

During 2017/18 we will run three Fundamentals of Quality Improvement Training Programmes, for up to 25 participants each. This is a two day programme, each day being 1-2 weeks apart and delivered at different venues across LLR.

Ten high impact actions

The showcase event generated a lot of interest in taking forward elements of the high impacts actions programme. This has been used to inform the next steps outlined below:

- Evaluation of the showcase event (completed February 2017)
- Collation of the expressions of interest in rolling out the ten high impact actions (February 2017)
- Discussion and agreement with the NHS England Sustainable Improvement Team to agree the structure and content of the offer to practices (March 2017)
- A suggested Collaborative Learning in Action Programme, for 15-25 practices, targeting the High Impact Actions 1) Active Signposting and 8) Social Prescribing, which were the top two priorities identified by participants at the Showcase event.

General Practice Resilience Programme (GPRP)

- Deliver a menu of support to help practices become more sustainable and resilient. Encourage and support practices to apply for the GPRP.

Going forward the CCGs will continue to work with NHS England to maximise the support available to practices through the GPRP and will

undertake the following actions:

- Review of implementation and effectiveness of support offered to practices in cohort 1. (March–May 2017)
- Identification of practices for cohort 2—CCGs to identify practices for consideration based on local knowledge and triangulation of data. (April 2016)
- Review/selection of practices—review to be conducted by all NHS England/CCG and practices to be notified of the outcome. (May 2017)
- Roll-out of cohort 2 support (May 2017).

6. Infrastructure

IM&T

In Five Years

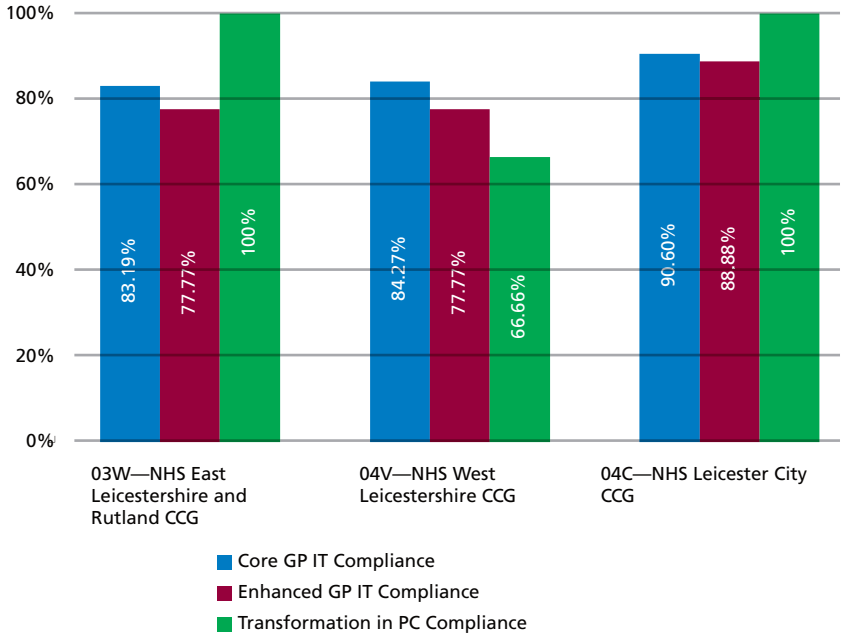
We will ensure robust shared access to paperless patient records across all clinical interfaces to improve patient outcomes and supported integrated care models. We aim to achieve better value from our existing systems through training and systems optimisation so that patients are treated more efficiently and are more empowered in their own management. This work will be taken forward by the LLR IM&T Enablement group and associated subgroups.

Baseline Position

In developing our LDR we undertook a number of audits to assess our performance against key national requirements. A summary of our performance for universal capability is outlined below, along with assessment against the GP IT Operating Framework.

Universal Capability	Completed	Partially Completed	Not Started
Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions		✓	
Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)	✓		
Patients can access their GP record	✓		
GPs can refer electronically to secondary care	✓		
GPs receive timely electronic discharge summaries from secondary care		✓	
Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care		✓	
Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly		✓	
Professionals across care settings made aware of end-of-life preference information		✓	
GPs and community pharmacists can utilise electronic prescriptions	✓		
Patients can book appointments and order repeat prescriptions from their GP practice	✓		

In our assessment against the Securing Excellence in GPIT Services 2016-18 Core and Mandatory Services we have rated ourselves green in 14 of the key service areas and amber in the remaining 5 areas. In the enhanced primary care IT services we have rated ourselves green in 8 of the key services area, amber in 1 area and blue in 4 areas which at this time we are not looking to progress. In the final area of the section on transformational care due to the good progress being made in our system we have rated ourselves amber in each of the 4 service areas. These informed assessments have helped us to determine our priorities over the coming years and will support us to track progress in key service areas.



Whilst our preference is to work collaboratively to tackle the key IM&T priorities, there are times when, due to historical development and local population health need, a more tailored solution is required. The section below identifies some of the key areas where differences in current structures will required the development of a more local solution.

GPSoC—Within LLR all practices are on either SystmOne or EMISWeb. In Leicester City CCG all but one practice is on SystmOne whilst in the county it is more evenly split between the 2 clinical systems with 48 practices on SystmOne and 31 on EMISWeb. The County CCGs are supporting practices to move for SystmOne and further progress will be made over the coming years. Include other providers.

Cross Border Issues—Whilst the majority of patients are within the LLR footprint there are significant numbers of patients in East Leicestershire and Rutland CCG and West Leicestershire CCG that access healthcare outside of the LLR footprint. This has a number of practical issues for patients and practices and will require consideration in the development of local plans.

Case Study

Systems Optimisation for GP Online– Increasing uptake of patients using GP Online services allows patients to use transactional services (such as book appointments and request repeat prescriptions) without contacting the GP practice. It also allows patients to have access to their record and the medication that they are taking. They can view this information on a personal computer, smartphone or tablet. Patients have particularly found this useful whilst using it in connection with EPS2 where they can order repeat medication online and pick it up at a pharmacy of their choice without having to go into a practice.

Collaborative Achievements

Over the last 5 years the LLR Health and Social Care community has invested heavily in IM&T has led to positive changes in the way people interact and work in the system. This collaborative approach, supported by strong leadership enabled the development of a robust Local Digital Road Map which supports the Five Year Forward View, is aligned to our STP and sets out a comprehensive and compelling vision for digital health care. Channelling our energies into key system wide priorities has enabled us to make excellent progress in tackling our key priorities:

Sharing Care Records

All GP practices in LLR currently upload information for the Summary Care Record which can be accessed by any health professional who has a legitimate reason to access the information and also gains the consent of the patient. This direct sharing of records for a limited amount of data from the GP-held electronic patient record allows clinical staff treating patients to have access to appropriate information about the patient.

100% of LLR GP Practices are signed up to a wide data sharing agreement with a range of providers. This extends the ability of clinicians in and out of hours and urgent care settings to view key elements of the patient's record at the point of care in real time using the Medical Interoperability Gateway (MIG), thereby enhancing clinical decision making and support clinical safety.

In developing this work further, we are currently in the implementation phase of a successful LLR-wide bid to the Estates and Technology Fund (ETTF) to further develop our approach to interoperability and record sharing. Phase 1 of the project focuses on a defined minimum dataset for SystmOne and EMISWeb for priority STP workstreams including Children's, Dementia, Frailty, Cancer, LTCs and Planned Care.

Population Data Analysis

The LLR footprint has a strong commitment to using data from a variety of sources to better understand the current health of the local population and also the variation over time in health outcomes and needs within and between various populations. As part of this process we have worked hard to create safe consent models for data extraction, pseudonymisation, analysis and publication back to practices within a secure NHS Environment. Using risk stratification (Adjusted Clinical Groups (AGC) tool), we are able to both identify high risk individuals and aggregate data to look at population health. This has enabled us to identify and provide interventions to patients who are at the highest risk of admission and to help proactively manage healthcare for these patients. This approach is a key element of our work on integrated locality teams and has also informed system wide work on defining our bed base.

System Wide Efficiencies

As a system we have worked hard to identify and tackle initiatives that support more effective working across the system. By definition these projects are prioritised within the STP and our LDR, and are key enablers to help deliver primary care at scale, seven day services, new models of care and transforming care.

The following digital services are 100% enabled and activated across all LLR practices.

GP online—booking, cancelling appointments and ordering repeat medication
Electronic Prescription Service (EPS)
Electronic Repeat Dispensing (ERD)
Electronic Referral Service (ERS) including Advice and Guidance
SCR 1
GP2GP
SMS notifications for patients
IG Toolkit level 2 compliance for all practices

Additionally we have developed and implemented a range of initiatives to support effective system-wide working.

PRISM—electronic clinical referral pathway system library.
Supported mobile and agile working through Federated Wi-Fi enabling clinicians and care staff to work without being limited to access organisational native systems.
Structured secure e-mail with health and social care providers
Established remote access from OOH/111/Urgent Care for automated booking into City Hubs and GP for certain dispositions for in-hours Links Vanguard Clinical Navigation Hub.
Implemented our responsibilities for GPSoC, securing ETTF funding to support 12 system migrations.

Going forward it is important that we maximise use of these initiatives to support the implementation.

Next Steps

Building on the progress made to date and our strong commitment to IM&T over the next five years, we deliver our vision by taking forward the following priorities:

Interoperability and Record Sharing to Support Care Planning

Over the last 12months we have reviewed and developed our approach to integration locally and confirmed that rather than looking for an "off the shelf tool" we will pursue the exploitation and optimisation of:

- TPP SystmOne
- Medical Interoperability Gateway (MIG) Solution
- Summary Care Record (SCR)

Following our successful ETTF bid, Phase 1 of this process is under way, and will focus on: Integrating and improving data flows, new ways of working, standardised codes, protocols and flags in as many systems as the integration technology will allow. We will give care professionals and carers access to all the data, information and knowledge they need through real time system integration. To enable this SCR V2.1 will be enabled across LLR with additional datasets to support electronic record sharing and care planning. Special Patient Notes and Electronic Frailty Index will also be added to this method of sharing.

The ETTF bid will also look at implementing additional datasets as part of MIG V2. The datasets will map the SCR V2.1 datasets to maximise sharing in greater care settings such as Social Care. This phase will also look at two-way developments to allow full interoperability to support integrated locality teams.

Phase 2 will look at maximising the use of SCR V2.1 and MIG V2 in providers to ensure that the data that is shared is used for the benefit of patient care. This includes remodelling workflows to ensure that electronic data is utilised in the most appropriate way. It will also explore the use of Open APIs as another mechanism to share data.

System Integration and Joint Working Hubs

In continuation of good work from previous years and in support of CCG strategic direction of travel we will support practices and embark on a three

year programme from 2016/17 to move the local clinical system estate towards a single interoperable platform. We firmly believe this will improve interoperability and information sharing across the healthcare landscape. Currently our community services provider and main acute care provider use the same platform enables sharing of critical information directly at the point of professional / clinical need.

Phase 1—Single clinical system platform

Support collaborative and federated working by matching operational needs to systems that are available. In the absence of true interoperability between clinical systems, there is an emphasis on moving to a single system platform to meet the needs of collaborative working. The Leicester City Healthcare hub (PMAF) has demonstrated that this can dramatically improve the way care is delivered, via a multisite approach. The CCGs understand their GPSoC obligations and will continue to support practices in their choices of clinical systems platform. Where we have a collaborative and federated system established, a common system approach will be in place following best practice, by Q1 2017/18.

Phase 2—Interoperable systems

LLR will look to maximise the interoperability of clinical systems to work in a collaborative and federated way. This will exploit Open API's to improve data sharing and transactional activities. There is a key dependency on the delivery of this from some of the national programmes such as GP Connect. LLR CCGs remain in dialogue with NHS England and NHS Digital on progress with Open API standard developments.

Once the GP Connect programme approves open API's for GP clinical systems, the CCGs will start to explore how this can benefit patient care. We have been advised by NHS Digital that the earliest available time for API connectivity of GP clinical systems is July 2017.

Strategically across LLR this project links with the local digital roadmap and the LLR STP in that it is one of a range of planned enabling projects for digital technology to help LLR deliver:

- Primary care at scale,
- Securing seven day services,
- Enabling new care models
- Transforming care in line with key clinical priorities

The project will operate over a three year period with the introduction of SystmOne hubs in year two.

- **Year One**—18 Proposed clinical system changes
- **Year Two**—20 Proposed clinical system changes and the introduction of 4 clinical system hubs.
- **Year Three**—7 Proposed clinical system changes and the introduction of 3 clinical system hubs.

Technology Enabled Patient Self-Management

Patient self-management is a local priority with local engagement work highlighting the need to use IM&T to support primary care developments. Local GPs and commissioners acknowledge there is a real opportunity to improve patient outcomes through better patient self-management using remote monitoring devices and associated electronic mobile application based solutions with portal access or direct links to clinical systems.

We have experience of electronic self-management technology in relation to blood pressure monitoring due to us undertaking a pilot project in 2014 / 15 using the Flo Telehealth system. We have learnt valuable lessons and want to take the good practice from that project to roll out patient self-management on a wider scale in terms of medical conditions with a more innovative tailored local solution on a larger population scale, across LLR.

We want to improve the outcomes for the local patient population by enhancing the practice offering through the use of a locally tailored and effective technology solution through deployment of electronic health monitoring devices to high risk patient cohorts and associated mobile phone health applications to enable patients to take control of their conditions.

Phase 1—Empowering patient self-care

Our plans over the next three years from 2016/17 involves supporting these developments starting by tackling hypertension during level 1 (first) diagnosis, monitoring and medication compliance stage through GP-led, patient interactive, technology enabled self-management tools. We will offer all General Practice across LLR technology enabled equipment such as SMART monitoring devices that link to mobile applications.

We need to identify the resources for the delivery of this initiative. This may require funding through bids. The initiative will aim to start once funding or resources are available in 2017/18.

Phase 2—Connected care

We will be utilising third party apps and open APIs to allow patients to interact with the health and care service to provide vital statistics about their health. Patients will have greater connectivity to their healthcare records to support improvements in wellbeing. The introduction of third party applications will enable greater innovation for patient self-management.

We need to identify the resources for the delivery of this initiative. This may require funding through bids. The initiative will aim to start once funding or resources are available in 2018/19.

Systems Optimisation

General Practices currently have advanced IT systems as part of the GPSoC framework. Maximising the use of these systems is essential to the delivery of good quality of care. Systems optimisation will help in the following areas:

Initiative	Plan	Timescale
Patient online services for transactional services (booking appointments, requesting prescriptions, accessing the patient record)	Implemented across all GP practices. There is a plan to improve uptake of services with patients. Further targeted communication with the support of medicines management as it will help to reduce wastage.	20% usage by Q2 2017/18
eWorkflow	Smarter working using existing technology.	Ongoing
Development of flags for alerts	Optimisation of flag to be used such as frailty.	Ongoing
Improved data quality	Through the implementation of the single care plan. SNOMED, data coders to improve data quality.	Ongoing
Optimised templates	Process currently in place to review common templates and make them available to all practices.	Ongoing
Pathway tools (PRISM)	Expansion of pathways and mobile connectivity.	Q2 2017/18
E-Consultation	Market engagement taking place.	Q1 2017/18
Electronic messaging for direct patient communication (inc. SMS)	SMS already in place. Currently looking at two way communication.	Q2 2017/18
SNOMED-CT	Preparation in place to move to SNOMED-CT coding.	Q1 2018/19
Optimisation of national systems (ERS, SCR, EPS, EDS)	SCR V2.1 currently being deployed. Updates to other national systems will be implemented once available.	SCR V2.1 - Q4 2016/17
System interoperability (through GP Connect)	Review how systems can interoprated after NHS Digital and NHS England approval of testing through the GP Connect programme.	Q4 2017/18
Greater mobile and agile working capabilities	Greater investment in mobile and agile working including support of practices to have laptops and VPN	Q4 2017/18
Enablement of federation working	Federated Wi-Fi completed. Single clinical system approach to support federated and collabrotive working.	Q2 2017/18
Advanced telephony systems	Investigating what is available. This includes a single telephone number for practices and other automated functions.	Q4 2017/18

Estate

Investment in primary care premises is crucial to the successful implementation of this plan. Investment is needed, both in terms of bringing existing primary medical facilities up to date, addressing the growth in the number of new homes and associated population, and in ensuring there are appropriate facilities to support transformation across the healthcare system. In order to make this a reality, where possible we will explore with our partners options for utilising existing facilities more effectively and make the case for continued investment in primary medical care estate linked to our STP.

Baseline Position

There have been a number of estates reviews in the last few years that have provided the information required to support the overall estates strategy.

- **2009–10**—The two PCTs in LLR undertook a full and detailed review including detailed surveys of every GP premises, including utilisation and valuation. From this a rating was produced that informed the prioritisation of any new builds or developments. Due to very limited revenue funding only a small number of schemes have been completed since 2009.
- **2014–15**—The LLR Better Care Together Estates group produced a strategy that detailed all healthcare estate, including age, condition and backlog maintenance.
- **2015–16**—The three CCGs did a complete refresh of this baseline to ensure there was an up to date analysis to support the decision making for investment using the national Estates and Technology Transformation Fund (ETTF) process.

Each of these reviews supported the development of the STP estates plan and has enabled the work streams to develop plans for use of and development of both primary care and community estate to support service planning

The geographical size and rurality in the county is very different to that of Leicester City CCG and this impacts on the current and future model of care. Across WLCCG and ELRCCG there are nine community hospitals providing a mixture of inpatient beds, community nursing and therapy services and elective care outpatient appointments, diagnostic investigations and treatments. These facilities are very variable in terms of the quality of the estate condition, but many are under-utilised, often have small isolated wards which cause sustainability issues, and are often not fit for 21st century health care delivery. Going forward our proposed new models of care, clinical sustainability and efficiency issues will impact on the scale and location of community hospitals required.

What we are working on together

Many of the changes described in our STP plan have estates implications including providing more planned care in the community; developing place-based teams to deliver services to keep patients at home as long as possible, and moving services around to ensure that the right services are next to one another for reasons of safety, quality and efficiency.

As such the Leicester, Leicestershire and Rutland health and social care system has been reviewing and improving the provision of community health services over the last few years and has also initiated activity to increase the level of day-case procedures and outpatient appointments in community and primary care settings, improving access for patients. The LLR strategy is to provide care for patients closer to home where feasible in facilities fit to deliver sustainable 21st century health care.

The 3 CCGs in LLR have been proactive in utilising their delegated responsibilities for co-commissioning of primary medical care to establish robust primary care estate plans. In 2016, this work informed a successful bid to the ETTF securing funding of up to £7m for 11 projects which will be delivered over the next 4 years. As part of this process the CCGs needed to agree the revenue investment required for each project which has been factored into the financial plans for each CCG.

Next Steps

As outlined above much needed capital funding has been secured through the ETTF and will be utilised for 11 projects. Work is now under way to finalise business cases and complete due diligence, prior to commencing work on the ground. Whist this is significant and welcome investment it will only go so far in meeting local need and leaves many practices facing operational challenges in their current buildings.

Going forward, the detailed prioritisation process undertaken by the CCGs as part of the first wave of ETTF funding will help inform future priorities for investment as other national funding becomes available.

The CCGs will continue to use their delegated commissioning responsibilities to maximise opportunities for tackling the current premises challenges faced by practices in LLR, including working with our partners across health and social care to maximise the use of existing estate.

The County CCGs are also able to work with district/borough local authorities to access secure S106 funding associated with new housing developments and use this as resource to plan for primary health care estate

The schemes supported as part of the ETTF across LLR process are outlined below:

East Leicestershire & Rutland CCG

- **South Wigston Health Centre**—Cohort 2 2017–2019, a significant project in an area identified as having a large deprived population. A new purpose-built primary care facility project will ensure the premises are fit for purpose, sustainable and able to offer increased access and capacity linked to improved service provision in primary care as articulated in the CCG's operational and STP plan. Location viability and initial planning reviewed. Business case supported by CCG and initial approval by NHSE; Funded via ETTF (indicative 40% of overall capital cost)
- **Central Surgery Oadby**—Cohort 2 2017–2019, extension to existing site including two new consulting rooms and one treatment room. A business case is under development and due for consideration by ELRCCG at the Primary Care Co-Commissioning Committee. Initial approval has been obtained from NHS to fund 66% of capital costs
- **Warren Lane Surgery Leicester Forrest East extension**—Cohort 2, 2017/2019 Significant extension to existing build, six new consulting rooms, conference suite for medical education and training, staff room and increase to the waiting rooms. Initial approval from NHSE approved awaiting Primary Care co-commissioning approval will be summer 2017. Funded via ETTF (66% of overall capital cost)

Leicester City CCG

- **Saffron Lane**—Cohort 2, the acquisition of additional land and substantial extension to existing premises to accommodate the merger of two local practices to provide the majority of services in fit for purpose premises and provide further enhanced service to meet the needs of the local population. NHS England will fund 66% of the total approved project cost, which will be a maximum contribution £1.94m. The practice and professional advisors are working on their business case ready for submission to the CCG PCCC in April 2017. Due diligence processes are in place to ensure value for money, including liaison with the DV to ensure ongoing revenue costs are proportionate.
- **Heatherbrook**—Cohort 2, the conversion of a vacant first floor flat to relocate staff room and provide a seminar room/library for teaching purposes and to extend the ground floor to provide two further consulting rooms and a minor operating theatre. NHS England will fund 66% of the total approved project cost, which will be a maximum contribution of £107k. The practice are engaging with an architect to get plans drawn up and will be working on their PID for submission to the CCG PCCC. Due diligence processes in place to ensure value for money, including liaison with the DV to ensure ongoing revenue costs are proportionate.
- **Pasley Road**—Cohort 2, the acquisition of a site has been completed to develop new purpose built health centre which includes the provision of extra clinical rooms in which to perform a wider range of primary care services eg, additional treatment rooms, health promotion, minor ops and recovery suite, ambulatory care day beds, counselling room and optical/audiology screening suite. The scheme requires the change in

Premises Directions and NHS England has allocated a provisional amount of £665k based on an indicative 40% contribution to the cost of the project. The GP practice has met with NHS England and has a proposal for moving forward the development without waiting for the Premises Direction changes and have been advised that they need to work up the proposal and they will discuss it with the CCG. Due diligence processes are in place to ensure value for money, including liaison with the DV to ensure ongoing revenue costs are proportionate.

- **Willowbrook, Springfield Road**—Cohort 3, the acquisition of an existing Health Centre and conversion into the equivalent of new purpose-built accommodation. No announcement has been made on support for practices in Cohort 3 so this scheme is in abeyance at this stage.

West Leicestershire CCG

- **Silverdale Medical Centre**—Cohort 1, a significant extension to existing premises to ensure that they are fit for purpose, sustainable and able to offer increased access and capacity linked to increasing service provision in primary care as articulated in the CCG's operational plan / PMCP / STP. Planning permission has been granted. The business case is supported by the CCG and approved by NHSE and the project has commenced. It is funded via ETTF (66% of overall capital cost) and S106 (S106 contribution deducted from overall cost before applying methodology to determine 66% grant). Due diligence processes are in place to ensure value for money, including liaison with the DV to ensure ongoing revenue costs are proportionate.
- **Burbage**—Cohort 2, extension to an existing site including five new consulting/treatment rooms. The business case is under development and due for consideration by the CCG at the PCCC meeting in April 2017. It will utilise identified S106 funding and ETTF. The total project cost is currently being finalised ahead of the submission of a business case which will clearly articulate the practice vision to expand and increase capacity in primary care in line with strategic objectives. Due diligence processes are in place to ensure value for money, including liaison with the DV to ensure ongoing revenue costs are proportionate.
- **Heath Lane**—Cohort 2, the extension to existing build, four new consulting rooms, surgical suit, admin area, linked to large Sustainable Urban Extension and the practice vision to expand to enable a greater breadth of primary care provision at scale in line with CCG strategic aims and the STP. A business case under development will utilise S106 funding and ETTF for a total cost of £600K. Due diligence processes are in place to ensure value for money, including liaison with the DV to ensure ongoing revenue costs are proportionate.
- **Barwell**—Significant project; new build on a new site in a town centre location, with a strong link to Sustainable Urban Extension in Barwell which will lead to development of 2,500 new homes. The business case is under development utilising existing S106 funding and ETTF to realise the practice vision to provide primary care services from fit-for-purpose premises, sustainable throughout planned housing growth in the local area. The total project cost is in the region of £4m. Plans will be finalised aligned to further guidance linked to the allocation of capital grants to new builds as per updated premises directions from NHSE. Due diligence processes are in place to ensure value for money, including liaison with the DV to ensure ongoing revenue costs are proportionate.

7. Investment

In Five Years

Each CCG within LLR took on full delegated commissioning responsibility for General Practice and thus the opportunity to hold the entire health budget for each population to commission and invest across the whole pathway and spectrum of health and social care.

To ensure sustainable and resilient primary care, certainty on levels of funding for core as well as additional investment is important to enable practices and groups of practices to plan services and future delivery their model. This also supports the aspirations of the LLR STP, where General Practice is key to overall delivery alongside, new models of integrated community services and the seven day primary care access that supports the urgent and emergency care agenda. This transparency and long term planning will support a resilient General Practice.

Financial Baseline for General Practice

The national formula and historical funding by PCTs and now CCGs means that each area has a different baseline position for investment into General Practice. This discrepancy in itself creates variation at practice level with different levels of core global sum; this ranges from £74 to £130 per patient per year. Although the changes in national contracting, move away from the PMS contract and local investment supports reducing this variation, it needs to be recognised as an issue that will need resolving to support the development of new models of delivering General Practice.

The funding into General Practice is split into the following distinct areas:

- Budget for the cost of medicines
- Core contract and additional statutory spend (Including PMS/ FDR reinvestment)
- Discretionary spend
- Over the next five years care pathways will be developed which will see settings of care being transferred to a primary care or community setting. We will ensure that resources follow this activity.

Statutory Budgets

The core budgets were disaggregated to each CCG in April 2015, following the successful award of full delegated co-commissioning responsibility from NHS England. These differ based on historical funding formulas and show in some cases a significant difference in the core global sum paid to practices to care for their patients. An area of funding that has enabled innovation and supported new ways of working is the reinvestment of PMS growth monies.

PMS Premium and Funding Differential Review (FDR) reinvestment

A detailed process was established between NHS England and the three CCGs in 2014 to put in place a transition plan for practices that moved from a PMS contract with premium monies to a GMS contract. The agreement was that the funding would be drawn down over a 5 year period and that all of the funding would be reinvested back into General Practice. The CCGs have invested this in the following ways:

CCG	Total PMS Premium and FDR funding by 2020/21	Areas or Investment
ELR	£2.27m	Year 1 : £325k recurrently (£1 per patient) invested equally across all practices to provide an enhanced dressing service and to support the new Stoma/Dressing/Catheter formulary
		Year 2: £650k recurrently (£2 per patient) Invested equally across all practices/ groups of practices to employ pharmacists or pharmacy technicians to increase workforce, support workload and improve cost effective prescribing.
		Year 3 onwards will be invested in line with CCG/ General Practice priorities
WL	£1.5m	Premises – to support increases in notional rent.
		Fairer Funding – distribution of funding at a practice level to support the equalising of core funding levels
		Struggling practices fund – to support practices facing significant and serious issues that have the potential to impact on patient care.
		This was aligned with practices signing up to Improve Access, Improve clinical outcomes, reduce inequalities and engage and participate in federation development
City	£2.25m	Year 1 · Funding to raise the baseline GMS capitation to £83.21 for 30 of the city's most lowly funded practices. · £323,618 was invested in a city-wide quality scheme, open to all practices, which aimed to encourage practices to provide a minimum of 90 appointments per 1,000 registered patients, and ensuring that practices are open (and providing appointments) throughout core hours. · £61,347 was reinvested as a PMS premium for a city practice with an atypical (student) population · £100,000 was set aside to provide support any practices experiencing particular difficulties.
		Year 2 Onwards · In future years, the CCG is committed to maintaining the increased minimum baseline of £83.21 per patient. · CCG is consulting with member practices on plans to allocate the remaining funding in each year using a model that recognises the respective workload based on the burden on practices of high disease prevalence, deprivation and ethnicity/language

Discretionary spend

This is for local incentives, quality contracts and community based services and has been developed differently by each CCG according to local need and quality outcome measures. This is, however, a significant investment directly into General Practice. Examples across the CCGs of how this funding has been utilised are:

ELR CCG GP Support and Investment Programme (GP SIP)

The ELR CCG GP Support and Investment Plan (GP SIP) has been designed to build on the high quality healthcare provided by General Practice and to fund improvement in quality and outcomes for our patients. The CCG believes that working in collaboration with our providers, partner organisations and members will enable us to exceed the national expectations of high quality outcome focussed health care for our patients. The GP Support and Investment Plan for General Practice is one of ELR CCGs strategies for engaging and involving our member practices in the delivery of the key quality and patient outcomes set out in our constitution and 2 Year Operational Plan of achieving improved outcomes in the following;

- Dementia
- End of Life Care
- Care Homes

- Respiratory/COPD
- Stroke Prevention
- Diabetes
- IAPT Mental Health Access
- Renal/CKD management
- Cancer Screening

West Leicestershire CCG Federation QIPP

2017/18: The CCG has agreed to target investment of up to £2.3 million dependent on delivery to support an outcome based federation level QIPP scheme. The scheme represents a fundamental shift from previous practice level schemes and is closely aligned to our strategic priorities which include the sustainability of general practice, primary care at scale, addressing unwarranted variation, supporting clinical behavioural change, and assisting the CCG achieve financial sustainability. The scheme will be delivered by the 4 federations in WLCCG and will focus on the following areas: efficiency and integrated teams, embedding processes to support delivery and maintaining/ reducing activity levels in prescribing and non elective admissions.

2018/19: Subject to a positive evaluation the 2017/18 Federation QIPP scheme will be updated and funding levels continued for 2018/19.

Leicester City CCG

Leicester City CCG and its member practices recognise that there are opportunities to improve the quality of services patients receive whilst also improving efficiency, lowering costs and providing more care outside of hospitals. The CCG also recognises that general practice and wider primary care services face increasingly unsustainable pressures—and that general practice wants and needs to transform the way it provides services to reflect these growing challenges.

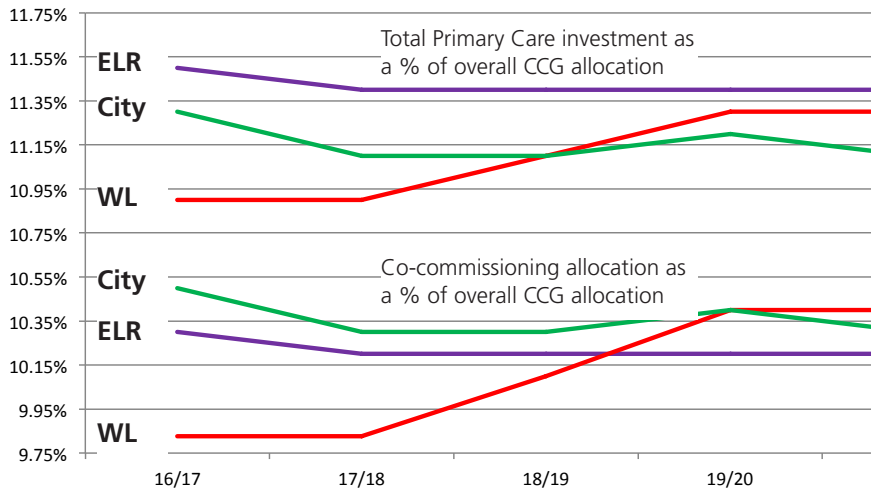
During 2017/18, Leicester City CCG will work with member practices to design and implement a new GP Quality Contract designed to fulfil our ambition as stated above. This will offer services at two levels; practice-level services and services provided by specialist practices at a Health Needs Neighbourhood level. Whilst this co-design process progresses, our practices will continue to provide services at practice level via enhanced services with an investment of £1.5m. Services offered under this portfolio are designed to focus on areas in which we have noted particular unwarranted variation in outcomes such as end-of-life care, cardio-vascular services and respiratory services.

In addition, a further £1m of investment is being made into General Practice to support the implementation of Integrated Care models which will ensure our most at-risk and vulnerable patients are cared for in the community wherever possible by an integrated team of health and social care professionals.

Five Year Investment Plan for Primary Care

The target set by NHSE is to spend 10.9%, but with an aspiration of 11.3% of total CCG allocation year-on-year into General Practice services by 2020. The following shows the financial trajectories for each CCG to achieve this goal. This is in line with national allocations and historical differences in funding, but all CCGs meet this goal.

This funding into General Practice services is only one part of the investment required to deliver a sustainable integrated out-of-hospital service, which will see a new commissioned integrated community team model that enables patients to be cared for at home co-ordinated by their GP surgery, which is fundamental to the success of the STP.



GPFV Expectations

	2016/17 £'000			2017/18 £'000			2018/19 £'000			2019/20 £'000			2020/21 £'000		
PRIMARY CARE FUNDING	ELR	City	West	ELR	City	West	ELR	City	West	ELR	City	West	ELR	City	West
CCG Allocation £'000	398,780	477,730	457,845	406,645	487,902	466,838	414,470	497,978	476,518	423,132	508,865	486,906	438,967	528,694	505,832
Primary Care Funding - Co-Commissioning Allocation	40,192	50,246	44,990	41,593	50,335	45,956	42,170	51,420	48,212	43,099	52,819	50,460	44,818	54,453	52,555
Co-Commissioning Allocation as % of Overall CCG Allocation	10.1%	10.5%	9.8%	10.2%	10.3%	9.8%	10.2%	10.3%	10.1%	10.2%	10.4%	10.4%	10.2%	10.3%	10.4%
Primary Care Discretional Spend	5,787	3,900	4,750	5,862	3,950	4,750	5,943	4,005	4,750	6,002	4,045	4,750	6,062	4,085	4,750
Total Primary Care Spend	45,979	54,146	49,740	47,455	54,285	50,706	48,113	55,425	52,962	49,101	56,864	55,210	50,880	58,538	57,305
% of CCG Budget Spent on Primary Care	11.5%	11.3%	10.9%	11.7%	11.1%	10.9%	11.6%	11.1%	11.1%	11.6%	11.2%	11.3%	11.6%	11.1%	11.3%

*These figures do not include GPFV £6 access fund

*ELR Co-commissioning allocation includes £1 million for Oadby UCC

Transformational and Devolved Funding

There are a number of additional funding streams and work programmes that form part of the forward view focus on support and delivery. The details of this level of funding over the next 4 years are detailed in the following table.

Transformational and Devolved Funding												
Area	2016/17			2017/18			2018/19			2019/20		
	ELR	City	West	ELR	City	West	ELR	City	West	ELR	City	West
Transformational Support: £3 per patient split				487	582	575	487	582	575			
OnLine GP Consultation				75	100	98	100	134	131	50	67	65
Training Care Navigators	28	34	33	58	67	65	58	67	65	58	67	65
Extended access							1.09m	1.31m	1.29m	1.95m	2.37m	2.3m

Transformation

Each CCG has allocated an equal split of £1.50 per registered patient in 2017/18 and 2018/19 and has been accounted for through existing resource aligned to each operational financial plan.

Each CCG will use this funding in slightly different ways, but all are already committed to supporting the continued development of GP Federations. In addition to this investment the CCGs will invest the funding as follows:

CCG	Year 1 2017/18	Year 2 2018/19	Outcomes
ELR	Financially support the ELR GP Federation, consisting of all 31 practices, to support the delivery of new care models £175k	Financially support the ELR GP Federation, consisting of all 31 practices, to support the delivery of new care models £175k	A Fully financially sustainable Federation supporting and providing services across ELR
	£312k targeted to support groups of General Practices to come together in line with the proposed new care models	£312k targeted to support groups of General Practices to come together in line with the proposed new care models	Successful transition by groups of practices to a new model of delivery of care for their patient population and a more sustainable long term model
WL	The CCG has agreed to target the investment of £575k to support an outcome based federation level QIPP scheme. The scheme represents a fundamental shift from previous practice level schemes and is closely aligned to our strategic priorities which include the sustainability of general practice, primary care at scale, addressing unwarranted variation; supporting clinical behavioural change and assisting the CCG achieve financial sustainability.	2018/19: Subject to a positive evaluation the 2017/18 Federation QIPP scheme will be updated and funding levels continued	The scheme will be delivered by the 4 federations in WLCCG and focus on the following areas: efficiency and integrated teams, embedding processes to support delivery and maintaining / reducing activity levels in prescribing and non elective admissions
City	Targeted through the four city Health Needs Neighbourhoods (HNNs) which encompass all of the practices in Leicester based on a geographical footprint. The main priority for the CCG is to consider transformational opportunities of practices working together to free-up capacity and enable resources to be redirected to the areas of greatest need.	Targeted through the four city Health Needs Neighbourhoods (HNNs) which encompass all of the practices in Leicester based on a geographical footprint. The main priority for the CCG is to consider transformational opportunities of practices working together to free-up capacity and enable resources to be redirected to the areas of greatest need.	Groups of practices successfully collaborating to provide services at scale, with delivery of appropriate new models of care to patients.
	Support for city federation(s) to bring about the development of 'at scale' solutions within practices across the city through collaborative working initiatives and a focus on delivery of the 10 High Impact Actions.	Support for city federation(s) to bring about the development of 'at scale' solutions within practices across the city through collaborative working initiatives and a focus on delivery of the 10 High Impact Actions.	Increased sustainability of practices in the city.

On Line GP Consultation Software

All three CCGs in collaboration have a clear plan on the delivery of E–Consultations. We wish to make most of the current infrastructure using the EMISWeb and Systm1 GP systems and will explore the functionality, before we then consider what the wider solutions market has on offer. We are mindful that there will be financial implications regardless of the route we decide is the most appropriate for our local health economy. The potential cost implications at this stage are software enhancement, or procurement of additional software, configuration and training as well as marketing implications to inform our populations of this development.

This is a key priority through the LLR Digital Roadmap and a GP IM&T sub-group has been formed to drive forward the piloting and procurement of this as necessary.

The plans for roll out are as follows:

2017/18	2018/19	2019/20
Trial the system using the S1 and EMIS WEB capability	Full Procurement and roll out of system across LLR when fully assessed for capability and reviewed by practices and patients	Evaluate and improve system if underutilised. Work with practices to ensure meeting their needs and expectations.
Assessment day with GPs, IM&T group and patients of all of the available systems to work through which to trial	Engage with patient groups to ensure understanding and useage and how best to promote further	Promote further the uses of and benefits of the system
Review other national procured systems through local STP footprints in the East Midlands to assess merits for procurement		
Pilot across 6 practices		
Work with local PPGs of pilot practices and patient groups prior to roll out and to reviews outcomes		

Training for Reception and Clerical Staff

The training and support will be delivered to practices across the STP footprint through the LLR Primary Care Training department. Over the period of the programme £850,000 will be invested to enable primary care to confidentially and safely signpost patients to the most appropriate service.

This programme will be delivered through the LLR STP workforce group which will enable the programme to be delivered collaboratively across the region.

2016/2017	2017/2018	2018/2019
Identify the Model to deliver the Training	Commence delivery of the first tranche of training	Continuation of training
Identify training providers	Evaluate the first cohort of Training	
Identify Practices to be in first tranche of training	Invite additional Practice to participate	

Extended Access

By 2019/20 all three CCGs in LLR will have been allocated the £6 per patient for extended primary care access. The delivery models can be seen in section 3. Extended Access Across LLR. Each model will be regularly evaluated to understand service usage and impact on the health system. The longer term model, funded from CCG baseline, will be adapted if necessary in line with this evaluation.

Further Investment

There are a number of further investment streams that are aligned to the delivery of the forward view. They are

- **General Practice Resilience Programme**—Detailed in Section 5. Workload
- **Estates and Technology transformation fund (ETTF) and GPIT funding**—Detailed in Section 6. Infrastructure.

8. Engaging on Primary Care in Leicester, Leicestershire and Rutland

The Leicester, Leicestershire and Rutland plan for primary care has been informed by engagement with both clinicians and patients over the course of the last few years. This has included both soft intelligence gathering on the issues and challenges facing primary care locally, as well as more formal engagement to involve people in sharing their views on emerging plans for the future.

In summary, this has so far included the following:

- Specific engagement with practices across Leicester, Leicestershire and Rutland through protected learning time events, locality meetings and listening events
- A range of dedicated stakeholder and public events, including Patient Participation Groups (PPGs)
- Canvassing of practice staff on key issues through online surveys;
- Day-to-day feedback from patients obtained during existing CCG work on their experiences of primary care, eg, patient events and meetings with patient groups
- Sustained engagement on Better Care Together with political and statutory bodies, including health and wellbeing boards, overview and scrutiny committees, councillors, MPs and the community and voluntary sector.

In total more than 50 events have been held across Leicester, Leicestershire and Rutland with a diverse range of audiences and participants including GPs and the public. Across those events there have been more than 6,000 attendees—with around 1,500 of those being unique participants.

Overall, almost everyone tells us about the high regard in which primary care is held and the vital role it provides for patients and local communities. It is the part of the NHS that people have most contact with, and satisfaction with the services provided by their practice—particularly doctors and other clinical staff—is high. This is evidenced, for example, through work undertaken by Healthwatch in Leicestershire and, in the city, focussed activity with the local PPG network.

However, it is clear that there are also opportunities for improvement. Key themes and feedback emerging from the events and meetings held across the region have influenced our priorities for the future and can clearly be seen within this plan. For example, patients have clearly told us that having access to urgent on-the-day appointments which can be booked in advance is extremely important to them—even if that appointment is not at their regular practice. They have also told us that they want to book appointments easily and quickly and at convenient times, including evening clinics and Saturdays.

Patients have also told us that continuity of care is very important to them, particularly if they have a complex or long-term condition. They only want to have to tell their story once, regardless of which health or social care organisation is looking after them. If they do have a long-term condition,

they would like to have more information about it so they can manage day-to-day living better, while they would also like to see a broader range of services within the practice and greater use of technological solutions.

For clinicians, many tell us that they are concerned that the growth in workload means they are not able to provide the range of services of, in some instances, the quality of care that they would want for their patients. Many say that they want to feel empowered and supported to look at innovative ways of collaborating across practices to reduce the burden.

Practices have also told us that there is an urgent need to improve information sharing and the ways in which different providers work together. They want to see seamless care between community nurses and social care services and better care planning and co-ordination to support the increasing number of complex and frail patients.

In the city, in particular, GPs and practice staff have made it clear that we must move towards fairer funding that is based on the prevalence of ill-health to help address health inequalities across Leicester.

All of these themes and many more are addressed within this plan. But, despite this work to date, it is important to recognise that engagement on the contents of this plan is very much a work in progress with more specific engagement on the contents necessary.

At present there are variable levels of knowledge and buy-in across the local health system and among stakeholders. For example, although all three CCGs are subscribed to a model of Multi-speciality Community Providers as a direction of travel this has so far only been officially endorsed by practices within West Leicestershire CCG. Work is currently ongoing within Leicester City and East Leicestershire and Rutland in this regard.

Engagement in progress

Implementation of the GP Five Year Forward View offers an opportunity to deliver urgently needed service transformation and financial efficiencies within primary care. However, legal duties still apply, and public scrutiny of compliance with those duties will be intense.

The overall plan for engagement and communications linked to the STP across the health and social care system is overseen by a dedicated communications and engagement group, made upof the communications and engagement leads for all of the partner organisations. This aims to ensure that a joined up and sustained approach to engagement and consultation is taken across all areas of the STP.

To support this approach a dedicated communications and engagement lead is to be identified for this workstream. This individual will be responsible for co-ordinating ongoing activity, ensuring that it is consistent and joined up with other areas of the STP. He or she will, in partnership with the communications and engagement group and the workstream delivery board, be responsible for forming a view on any elements of the plan that require formal public consultation.

It should be noted that, at this stage, no requirement for formal public consultation has been identified, although this will be kept under review. However, any issues that do require consultation—such as the merger of any practices—will be dealt with as business as usual following existing consultation protocols across the three CCGs.

In the meantime, each CCG will continue to engage with statutory bodies,

elected officials, local authorities, clinicians, the voluntary and community sector, member practices, patients, carers and members of the public in their area on the emerging vision and ambitions going forward—and particularly as the STP develops.

Next Steps

Over the course of the coming months it is proposed that a series of both internal and external LLR-wide engagement events will take place to help people understand the proposed direction for primary care (both at a CCG level, and as highlighted in the STP) and listen to feedback.

The events will be structured to:

- Highlight what the CCGs are doing in primary care to make long-term sustainable improvements
- Ask people to endorse our plans for primary care, building upon the insight and feedback they have shared with us previously
- Engage people in the visions for primary care (as set out in our GP5YFV documents) to feed into developing primary care strategies.

Key messages will be centrally agreed and managed to ensure continuity across the region, but will include the local context tailored by each CCG. Events will be tailored to suit the audience and will involve as wide a range of stakeholders as possible.

Feedback loops and evaluation procedures will also be put in place to ensure that the system is able to capture the feedback from stakeholders on the engagement and incorporate this into planning, as well as recording all engagement taking place in order to evidence stakeholder involvement and input.

An evaluation of all the feedback received via the range of engagement methods will be collated quarterly, key themes identified and an overall report produced to share with System Leadership Team and SRO of the primary care work stream.

We will also develop a significant public campaign that seeks to explain the model of primary care to patients, builds a sense of collaboration and shared responsibility, and starts to develop a compact between practice and patients on what they might reasonably expect.

9. Leadership, Governance and Programme Arrangements

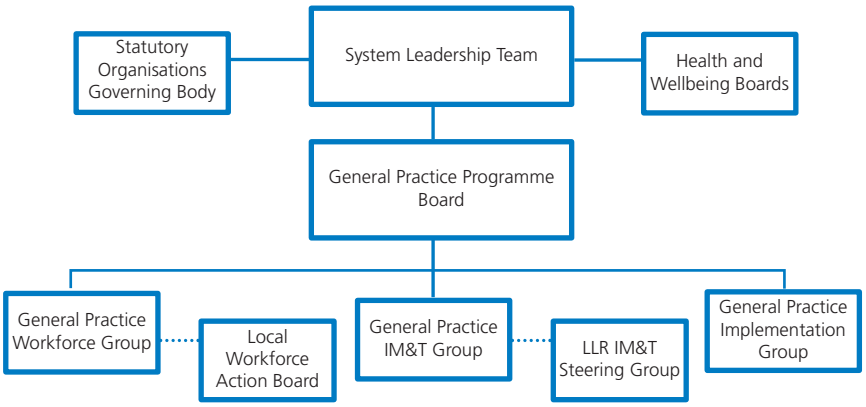
Building on the previous primary care strategies set out by East Leicestershire and Rutland (ELR), West Leicestershire (WL) and Leicester City (LC) Clinical Commissioning Groups, this GP5YFV submission is a collaborative plan that aims to provide a bold vision and clear roadmap for key reforms to our primary care system. We have an opportunity to redefine what we mean by primary care and to locate it in the context of place based systems. It highlights the important principles behind our plans; the benefits we hope the changes will bring to patients, the general public, health and care staff and the local economy as a whole.

The formation of a joint and collaborative structure to support the system-wide development of primary care to deliver sustainable General Practice and therefore enable the STP to be delivered builds on the work each CCG has undertaken over the last few years.

To deliver this programme of work a number of existing groups have been combined or refocussed and a programme board and implementation group is now in place. This governance structure feeds directly into the System Leadership Team (SLT). Each of the groups has clinical and managerial representation from each CCG, as well as Health watch, LMC, NHSE, HEEM, GP member practice managers, federation managers and GPs, UHL and LPT, local authority and public health.

As part of the collaborative arrangements through the System Leadership Team, we have clear and agreed accountability arrangements for the GP resilience strand of our STP. This is led by:

- **Clinical Chair**—Prof Azhar Farooqi Chair of City CCG
- **SLT Executive Lead**—Karen English MD ELR CCG
- **SRO**—Tim Sacks COO ELR CCG



Programme Management

Since summer 2016, the GP programme strand of our STP has been resourced from within existing staff across the three CCG primary care delivery teams, together with some administrative support from the SROs CCG, East Leicestershire and Rutland. An element of additional project management and GP support has been resourced to support delivery of certain workforce schemes through HEEM funding.

Moving forward the ambition and scale of this Plan, combined with our recent experience of the process of drawing this together across the three CCGs, has reinforced the need for a significant upgrade in how this work is locally led and resourced. Implementing the Delivery Plan at the required pace will require a clearer element of dedicated overall managerial and clinical support, together with more specific input to particular elements of the programme.

Based on the schemes set out in the Delivery Plan, a rapid review will be undertaken during March to identify the capacity, capability and accountability arrangements required. Given the financial constraints on the running costs of the three CCGs, this resource will need to be secured through the redeployment of existing staff and clinical leads from within the STP footprint CCGs, supplemented where opportunities emerge by the alignment of capacity from partners, such as the national Arms Length Bodies. The implications of releasing resource in this way will need to be worked through by the three CCGs in order to ensure that core primary care transactional functions continue to be effectively discharged alongside this more transformational work.

Programme risks

Reflecting the multiple pressures and challenges facing general practice, this is an ambitious plan. It needs to be in order to address the underlying pressures around workload, workforce and funding that have built up over recent years, as well as enabling the sector to respond to a broader future role at the heart of the out of hospital care system.

Not surprisingly therefore, a plan with this level of ambition does come with significant risks to delivery, in particular:

- Ability to secure engagement across and mobilise the support of 138 general practices run as independent contractors
- Availability of workforce to support new ways of working and care models
- Ability of commissioners to make the required investment in both core general practice services and wider integrated community teams set against other competing financial pressures
- Impact of changes in other parts of the health and social care system on demand for general practice services
- Acceptability of new skill mix models to patients used to a more traditional GP focused model of care

As part of the Delivery Plan the Programme Board will maintain a full risk register which, importantly, sets out local actions being taken to mitigate the potential impact of these.

Next steps

The Programme Board and the delivery groups are fully constituted and a work plan has been developed to deliver each of the priorities of the five year forward view. All of the CCGs in LLR are fully committed to supporting the delivery of this key work strand of the STP, and additional resource in the form of people and support will enable this to succeed.

Risks

Currently identified risks to the plan are set out below. These risks are being actively managed, and will be monitored through the governance processes above.

Impact / Likelihood	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic					
4 Major		Risk that NHS provider organisations and social care do not evolve at the same pace as primary care.	Lack of resources to support General Practice and out-of-hospital care redesign. Lack of capacity within General Practice to lead or enable change. Lack of ownership by practices of the need to change	Demand for primary care will increase due to an ageing population, demographic change, and use of services.	
3 Moderate			Insufficient capability and capacity of existing General Practice staff to enable new models of care to be delivered.	Insufficient clinical staff to fulfil the current model of General Practice. Federations developing at different rates in each CCG with varying degrees of engagement from their member practices.	
2 Minor				NHSE GP5YFV initiatives delivering minimal change.	
1 Negligible					

10. Conclusion

This plan exists to ensure a resilient and sustainable general practice system as the bedrock of healthcare. It is integral to all other healthcare redesign and redevelopment. We know that there is increased demand and pressure on General Practice. Population is ageing, demand is increasing, and we must ensure that the system meets the health needs of a changing society. The current model is underfunded: pressures on GPs and GP surgeries mean that, unless we do something different, General Practice will not be sustainable.

In this document, we have outlined what the problem is and what we will do about it. This has involved analysing issues of workforce, estates, IT systems and the changing needs of patients, which can only be met by GPs leading in the role of care co-ordinator, working with a team of practice- and federation-based professionals. This plan exists to ensure that we have greater levels of funding in General Practice, and supports a model which not only enables us to deliver current services in a more responsive way, but also enables practices to have the flexibility of designing and delivering a model that introduces new skillsets to the benefit of both patient and healthcare professionals.

Over the past years, a great deal of onus has been put on primary care at scale. This is because there are many benefits of sharing ideas, clinical skills and workforce that will enable patients to live healthier lives, and practices to thrive. This blueprint supports the entire STP programme by putting GPs at the centre of patient care, based around population health of around 100,000 people.

This document has grown from the wisdom, dedication and innovation of a generation of GPs, practice staff, allied health professionals and other health service workers in Leicester, Leicestershire and Rutland, as well our colleagues in social care. This plan is designed to ensure the sustainability and resilience of the health service in which they have invested so much.

Appendix C

LEICESTER CITY HEALTH AND WELLBEING BOARD
3rd April 2017

Subject:	Draft Health, Wellbeing and Prevention Strategy
Presented to the Health and Wellbeing Board by:	Ruth Tennant, Director of Public Health
Author:	Rod Moore and Matt Curtis

EXECUTIVE SUMMARY:

Leicester Health and Wellbeing Board is required to produce a Joint Health and Wellbeing Strategy (JHWS), agreed by all of its partner organisations.

The last JHWS 2013-2016, 'Closing the Gap' finished in October 2016. A draft of the next strategy is presented in this report (Appendix A)
The draft strategy has been developed through informal engagement within the city council and local NHS. The strategy sets out a framework for prevention in the city across 5 key themes and provisionally identifies bodies to take responsibility for moving forward particular elements of the strategy, led by the Health and Wellbeing Board. The key themes, responsible bodies and their responsibilities will need to be confirmed. Implementation of the strategy will be supported through an annual action plan

Public engagement on the Strategy is provisionally planned for May. A one-page public facing version of the Strategy will also be prepared for the final version.

NEXT STEPS

The next step proposed is that comments from the HWB are followed up with partners and a final draft version of the strategy produced for consideration by the HWB meeting in June 2017.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- **Agree** the overall aim and approach of the strategy.
- **Comment** on any aspect of the draft document.
- **Agree** to receive a final draft version of the strategy at its meeting in June 2017.

Appendix A

V3 21 March 2017 DRAFT
TITLE PAGE

Health, Wellbeing and Prevention Strategy

Summary

Theme 1 Healthy Start

Key outcomes

- The proportion of women accessing maternity services early is improved
- Childhood obesity is reduced
- Children's mental resilience and mental well-being is improved
- Proportion of children ready for school is increased
- Children's oral health is improved
- The Infant Mortality rate is reduced

Theme 2 Healthy Lives

Key outcomes

- Improve the proportion of adults living healthier lives
- All organisations promote health through what they do and the advice staff give
- Implement a model of integrated health and social care team which embeds prevention & early detection
- Identify people with higher risk factors for ill-health and help them to manage these risks.

Theme 3 Healthy Minds

Key outcomes

- Reduce mental disorder in children and young people
- Improve recording and increase the number of adults 18+ seeking help with depression
- Improved awareness and response to suicide risk
- Reduce the number of people experiencing isolation in the city.
- Improve the proportion of people reporting poor mental health.

Theme 4 Healthy Ageing

Key outcomes

- Increase the proportion of older people who report their health as good or very good
- Develop schemes to target support to those who are at risk of poorer ageing, including those who are lonely or isolated.
- Improve information so that older people can find appropriate support to maintain or improve their health and wellbeing.
- Ensure that older people who have social care needs are given the right support and protected from harm or abuse

Theme 5 Healthy Places

Key outcomes

- Development of a local Health in All Policies approach, maximising the opportunities for health gain across the council and partner organisations.
- Improvement in air quality through sustainable travel & reducing transport emissions
- Increasing the proportion of people who are physically active

- Maximising the opportunity for people to use the city's parks, outdoor gyms and public outdoor spaces to be physically active.

Introduction

Leicester's Health and Wellbeing Board works in partnership to improve the health and wellbeing of people living in the city. The city's Health and Wellbeing Strategy and Joint Strategic Needs Assessments for adults and children are one of the tools to do this. Commissioners of health, health care and social care services have a responsibility to commission services that reflect the main priorities in the city's health and well-being strategy.

This strategy is the successor to the Health and Wellbeing Board's first strategy *Closing the Gap 2013-16.*

Where are we now?

Leicester's Health and Well-being Strategy *Closing the Gap 2013-16* set out a blue print for closing the gap in health inequalities and improving health outcomes in Leicester. Our new strategy builds on this, identifying areas where progress has been made as well as broadening the focus so that it tackles some of the major influences on health.

Closing the Gap made progress in a number of key areas. Particular improvement from the baseline in the strategy included:

- Increasing rates of breast feeding at 6-8 weeks
- Improvements in reducing smoking in pregnancy
- Further reductions in teenage conception rates
- improved management of blood sugar levels in people with diabetes
- An increase in the proportion of carers receiving needs assessments
- An increase in the rate of older people who are still at home 91 days after discharge from hospital into a reablement service
- A reduction in the rate of admission of older people to residential or nursing care on a permanent basis
- An increase in dementia diagnosis rates.

Measures which showed a deterioration over the course of the strategy were:

- Increasing obesity in children in year six
- A decline in smoking cessation - 4 week quit rates
- Further decline in the coverage of cervical screening in women.

We want to build on the achievements of *Closing the Gap* and set the ambition for the next three years.

Our vision

Our vision is that everyone has a chance to live a healthy life, doing what can be done to reduce the barriers to better health, and to make the healthy choice the easier one for everyone in the city.

The best and most favourable physical and mental health comes from being aware and taking care of ourselves at each stage of life. We want to ensure that people whose circumstances have made them vulnerable to poor health are supported to adopt healthier lifestyles and take care of themselves, their families and neighbours.

Everyone needs a chance to live a healthy life. But on average, people in Leicester do not live for as long as their counterparts in England, - women for 1.2 and men 2.2 years less – a gap that is unfair. Men in Leicester live on average for 77 and women 82 years.

Men in Leicester live on average for about 18 and women for over 21, years with poorer health or disability. Again, more so than in England. So these years may not be good quality years and they are also expensive and demanding for the health and social care services we all rely on.

What makes people healthy?

Our health and wellbeing is strongly influenced by the social factors and physical conditions of the environment in which we are born, live, learn, play, work, and age, which impacts on a wide range of health, functioning, and quality-of-life outcomes. Comparing, for example, such factors - including income and poverty, employment, education, skills and training, health deprivation and disability, crime, barriers to housing and services, and the living environment - across all local authorities in England shows that Leicester has one of the highest rates of deprivation in England, and as a consequence many residents face significant barriers to good health.

For this reason improving health requires coordinated action by many organisations and groups, and not just the ones concerned with health, such as the NHS. We want people to take responsibility for their own health, but recognise that, by itself, a focus on this, - enabled by advice and information to inform healthier choices - is insufficient to address the deep seated and persistent inequalities which exist. Promoting good and sustainable health – prevention - requires supporting action both on the part of individuals and to tackle the 'causes of the causes' – the wider factors that are driving poor health in the longer term.

Health in Leicester –summary of our current position

Around 338,000 people live in Leicester. It has a younger and more ethnically diverse population which makes it a distinctive place compared to others in England. The birth rate is above the national average and rising. But older people in the city are more likely to experience poorer health at a younger age. By 2030, Leicester's older population will have increased by 42% compared with 36% in England, from a 2015 baseline.

Three-quarters of Leicester's population live in the most deprived areas in the country, almost double the proportion who do so in England as a whole. How long on average people are expected to live from birth in Leicester is lower than the national rate, for both men and women. This is mostly as a result of premature (under age 75) deaths from cardiovascular diseases – heart attacks and strokes - cancer and respiratory diseases. Premature mortality in Leicester is higher in the more deprived areas of the city.

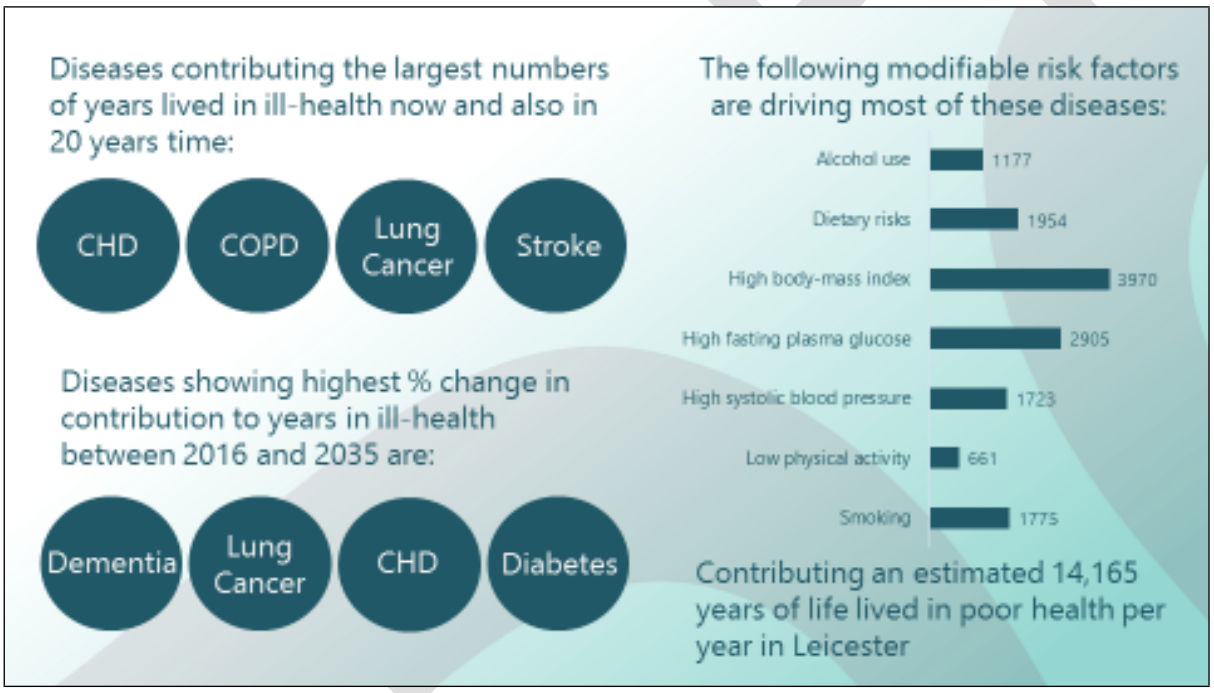
There are significant differences in health, health behaviours and life expectancy across the city. For example, cardiovascular diseases are higher in the more deprived areas. South Asians are more likely to develop diabetes and can develop cardiovascular diseases at a younger age than white population groups.

Lying beneath these causes of death are risk factors which contribute to the years of life lived in poor health each year in the city, and which can be reduced or prevented.

- Poor diet
- Low exercise
- Smoking
- Alcohol consumption

Others are clinical conditions which, if identified can be managed, including:

- High (systolic) blood pressure
- High BMI – being overweight or obese
- High fasting plasma glucose – an indicator for diabetes or potential diabetes



The mid-life years are when disease and disability begin to show themselves as a result, in part, of lifestyle behaviours that were laid down from the early years. Unless we take action together the chronic diseases that are here today will still be here in twenty years' time. Doing no more than we do now will see an increase in years of life lived in poor health or disability increase. It is estimated that by 2035 the contribution to this of dementia will have increase by 53% and each of Lung cancer, CHD and Diabetes by 30%. The estimated cost of NHS and social care in Leicester will increase from £700m in 2016 to £1.11billion in 2035. People are encountering later in life, or surviving, what were previously fatal conditions and are now living longer, but with consequential health issues.

Making the most of all our assets

What has been learned over the years is that no matter how difficult people find it to change their lifestyle or behaviour, we help best by supporting rather than telling, doing things with, rather than to, people, creating opportunities and encouraging an environment for people to do it for themselves. Personal responsibility should not be eroded by the services that are meant to help. Experts of all sorts should be on tap, not on top.

We have a lot to build on. We have a strong commitment to improve health and well-being and we know that many people in Leicester want this also. Smoking prevalence and alcohol related hospital admissions have fallen steadily, and two thirds of current smokers say they would like to give up, motivated largely to improve their general health as well as save money. Residents overwhelmingly regard a healthy diet and regular exercise as the top two aspects of a healthy lifestyle, followed by not smoking. Around three in five Leicester adult residents say they get the recommended 150 or more minutes of moderately intense physical activity per week. Our challenge is to build on the existing knowledge and action of Leicester's people and support them to make the decisions which lead to a healthier life.

We need to continue to maintain momentum and, at a time of austerity and reductions in public sector funding (to add), focus effort where it will make most difference, coordinate what we do as effectively as possible and monitor and evaluate the impact of what we do to understand what difference we are making. This will involve a range of organisations and groups – employers, schools, faith groups, the voluntary sector, as well as the local authority, NHS and other public sector organisations. Crucially, we need to build a coalition for change with local communities. We all need to talk more to local people, to understand what motivates people to lead healthier lives and the skills and capabilities they have to make a difference to their own lives and for their families and communities and use the resources we have to best effect.

How we will work to deliver the strategy

- We will focus on prevention
- We will work differently in close partnership to include prevention in all our work
- We will use data and evidence effectively – focusing the right effort where it is most needed and on key priorities
- We will work in and through communities.

Five key themes have been identified to provide a framework for the delivery and reporting of the strategy. Each theme will be the responsibility of a delivery sub-board, which will develop yearly action plans to achieve the key outcomes associated with their theme. Outcomes are associated with indicators and their progress will be the overall measure of the strategy's success. Oversight of progress and assurance of delivery will be facilitated by reports to the Board from the responsible sub-boards over the course of the strategy.

Measuring Success

Our strategy is intended to deliver our vision of a healthy city whose institutions support people to live well. Our indicators will act as proxies for the wider improvement driven by the strategy and by Health and Wellbeing partners across the city. Our themes and indicators, in the main, focus on areas which we believe to be representative of wider changes to every day health and wellbeing and our indicators are not, therefore, a comprehensive view of all the health activity conducted by the Board's Partners.

Where possible the indicators we have used are collected regularly and will not foreseeably be changed by 2020.

It is important to recognise that the indicators for different themes used in this document are concerned primarily with prevention activity, and not with the needed improvements sought in other plans for health care and social care services. These are to be found in the relevant health and care service improvement plans.

Our Main Challenges

Theme 1 – Healthy Start

Leicester has a young population and this is set grow further over the next twenty years. Children's experiences in the early years (including before they are born) sets the foundation for their future health and well-being. Giving children the best start in life is therefore a key priority for the city and is the single most important area to focus on to reduce health inequalities in the long term.

Access to good quality antenatal and post-natal care is important to sustaining a healthy pregnancy, reducing the risk of low birth weight babies and supporting mothers and babies to establish good patterns of attachment, bonding, breastfeeding in the first days and weeks. Getting it right at this stage has been clearly linked to good emotional, behavioural and health outcomes in the short, medium and long-term. It is cost-effective as well: economic modelling shows that return on investment is higher in early childhood than in later stages of life.

Children's emotional health and well-being is equally important. Supporting children to build resilience so that they are able to deal well with stress and difficult situations is important to success in school and also develops key skills which will help them in later life. Certain children, including children living in more deprived areas and looked after children are more likely to develop behavioural & emotional problems.

Education is also key to future health: children who do better at school are more likely to have higher life expectancy and spend more of their life in good health. They are also more likely to have better self-esteem and good mental health, take up healthy behaviours and in turn support their children to lead healthier lives.

Establishing healthy patterns of behaviour in the early years needs to be a high priority in the city. The city's children have high rates of obesity and poor oral health: turning the tide of this is crucial to reduce the growing burden of preventable illness in the city, which is rising.

The loss of any baby has a devastating effect on family, friends and the community and while infant mortality is reducing, there is much work still to be done. Promoting simple messages about how to keep babies safe, both before they are born and after, particularly to young mums, is key to helping further reduce the level of infant mortality.

	Baseline 2016	Target 2020
Emotional well-being in children is improved	(Children's Survey data) CAHMS waits	TBA
The % of children who are overweight or obese at reception and age 10 is reduced	Reception 20.4% Year 6 37.3% (2015/16)	
The % of children who are physically active is increased	Placeholder – Children and Young People Health and Wellbeing Survey	
Percentage achieving a good level of development	60.7% (at end of reception)	
The % of children with poor oral health is improved	53.2%	10% reduction by 2019 in the proportion children aged 5 with dental decay
Infant mortality rate	4.6 per1,000 live births (2013/15)	

Theme 2 Healthy Lives

Many of the health challenges faced in the city are preventable. We need to focus on reducing some of the new and emerging risks to health: sedentary behaviour, poor diet, particularly sugar consumption, as well as continuing to reduce smoking and excessive alcohol consumption in the city. Pushing prevention up the agenda of all our organisations is central to our vision.

Around 372 deaths a year in the city are as a result of smoking. Over half the Leicester adult population are overweight or obese - associated with a range of health problems including type 2 diabetes, cardiovascular disease and cancer. Only around a fifth of residents say they eat five or more portions of fruit and vegetables per day. Between 15% and 30%, depending on the survey, are inactive, doing less than 30 minutes of physical activity a week. Surveys have shown that lying behind these figures are barriers to change. When asked, younger residents cite being busy, work commitments and/ or laziness. Older residents are more likely to talk about ill health, disability and old age.

There is much that is better and to be built upon. Residents overwhelmingly regard a healthy diet and regular exercise as the top two aspects of a healthy lifestyle, followed by not smoking. Around three in five Leicester adult residents say they get the recommended 150 or more minutes of moderately intense physical activity per week. Smoking prevalence and alcohol related hospital admissions have fallen steadily, and two thirds of current smokers say they would like to give up, motivated largely to improve their general health as well as to save money. We need to build on this foundation to increase the proportion of adults living healthier lives.

There is a key role for health and non-health organisations to stimulate action on health by individuals by providing interest and information. They have a key role in Making Every Contact Count as a stimulus to improved health and also through creating easy access for those who need help with changing their lifestyle.

Starting early in life to ensure people are healthy will reduce the levels of disease and disability in the medium to long term. However where long-term conditions develop (such as diabetes, respiratory diseases, cancer or heart conditions), early detection makes cure or management in the community possible, improving people's quality of life and reducing the need for expensive health and social care.

	Baseline 2016	Target 2020
Improve the proportion of adults living healthy (ier?) lives	Proportion reporting good or very good health 71% (HWB Survey 2015)	Health and Wellbeing Survey
The adoption of principles and a programme to Make Every Contact Count in prevention	Ad hoc coverage	Systematic adoption of MECC by key public serving organisations.
Implement a model of integrated health and social care team which embeds prevention & early detection	Work in progress under Better Care Together	Effective implementation of STP plans in Leicester
Identify people with higher risk factors for ill-health and help them to manage these risks	% take up by eligible population of NHS Health Checks % adopting a programme of health improvement	Take up of NHS Health Checks and adopting a programme

Theme 3 Healthy Minds

Sustaining mental wellbeing is crucial for people to live long healthy lives. Mental illness is linked to physical health problems. Many people with long term conditions experience depression. People with mental illness often make poor lifestyle choices; they are more likely to smoke, drink alcohol, and use drugs and less likely to exercise or eat well.

In Leicester, most indicators used to measure mental health reflect wider health inequalities. Those in poorer, most deprived, communities are most likely to have mental illness. Across Leicester there are high rates of depression and anxiety, psychosis and claims for Employment and Support Allowance because of mental illness. Estimated prevalence for mental health problems in children and young people is higher than the England average and the highest in the East Midlands. This is an important problem because childhood mental illness often has lifelong consequences.

Taken together a picture emerges of the need to prevent mental illness, tackle its impact on physical illness and to take every opportunity to develop a Healthy Minds approach; in our homes, schools and workplaces. In this way, Healthy Minds is a key to all prevention, with links across the life course and greatly impacting on physical wellbeing. There will be a focus on sustaining mental wellbeing in schools, bringing together mindful employer organisations under the Time to Change Pledge and tackling isolation in older age.

	Baseline 2016	Target 2020
Estimated prevalence of mental health disorders in CYP	10.7	9.3
Recorded prevalence of depression on QOF registers for 18+	8.0% (2015/16)	
Suicide: Age standardised rate per 100,000	9.6 per 100,000	8.7 per 100,000
Increase in % reporting that they are not isolated from others (HWB Survey 2015)	54%	Increase %
Reduction in % reporting poor mental health via Warwick Edinburgh Mental Wellbeing Scale (HWB Survey 2015)	14%	Decrease %

Theme 4 Healthy Ageing

Ageing is much more adaptable than we have come to think. “It can be changed, shaped or adjusted by how a person lives their life, the choices they make and they service the access.” The numbers of older people in Leicester will increase in future years, and ageing well is about helping older people to live active, healthy lifestyles, reducing limiting long-term illnesses and enabling them to remain independent for longer. Many older people, with the support of family and health and care services at key times live fulfilled older years, but other struggle. It is estimated, for example, that in Leicester by 2030 some 24,000 over 65 year olds will be unable to manage at least one domestic tasks by themselves, and around 11,000 will be unable to manage on their own at least one activity involving mobility.

Despite generally increasing life expectancy, as people age they experience a gradual decrease in physical and mental capacity and a growing risk of disease. Poorer health and lifestyle earlier in life can accelerate the diseases of older age. There are a number of risk factors for poorer health and wellbeing in older years. This includes mental health problems; loneliness and isolation; dementia; sensory loss; physical disability and the development of long term conditions.

Currently, there are nearly 15,000 people aged 65 and over living alone in Leicester and this is projected to rise to by around 40% to nearly 21,000 by 2030. Not all will experience chronic loneliness, though a significant number will. Most dementia occurs in older age groups and the contribution it makes to the years of life in poor health or disability in the city will increase by 2035 by some 53%, indicating the need to improve the experience of people living with dementia and their families and carers.

	Baseline 2016	Target 2020
Increase the proportion of older people who report their health as good or very good	65+ 51% (Health and Wellbeing Survey)	
Reduce the overall number of older people is residential home or nursing care.	Number of older people (65+) in residential/nursing care per 100,000 population	Reducing rate per 100,000 of population
Develop better information services to support health and wellbeing for older people, based on the Make Every Contact Count approach	Limited adoption of principles and systems to assure quality of information giving and very brief interventions.	Systematic adoption of MECC by key public serving organisations.
Quality assure services for the most vulnerable adults in the city	National regulation of health and social care systems. Local Quality Assurance Frameworks	Further development of approaches to local quality assurance to ensure they are fit for purpose

Theme 5 Healthy Places

A focus on healthy places, encourages collaboration to improve health by considering the range of environments in which people operate and, in each case, maximising the opportunities for health gain across and within the council and partner organisations. The goal is to ensure that all decision-makers are informed about the health, equity, and sustainability consequences of various options for action available during the policy development process. This approach identifies the ways in which decisions in many sectors affect health, and how better health can support the achievement of goals in many sectors.

Health starts, long before illness, in our homes schools, jobs and communities. Improving and sustaining health in this context requires solutions that have a greater emphasis on 'prevention' than 'treatment'. A healthy place can be considered to be one that ensures a person is able to make healthy choices amid a variety of available, accessible, and affordable choices.

Individuals operate within a range of environments that have the potential to either improve or damage the health of potentially large numbers of people. These environments can be addressed through sustained joint policy making. For example:

- The degree of exposure to a polluting environment. In Leicester, national modelling has estimated that in 2010 there were 162 deaths where air pollution was a contributing factor. This is equivalent to 6.6% of all adult deaths in Leicester. The local Air Quality Action Plan offers an opportunity to deliver strategies that improve the health of the population by improvements in local air quality.

- A warm, dry and secure home is associated with better health. In addition to basic housing requirements, other factors in the living environment that help to improve well-being include the neighbourhood, security of tenure and modifications for those with disabilities.

- The so-called 'diseases of comfort' are generated mainly by the sedentary or obesogenic environment in which we live. The creation of active and healthy environments is an important element in addressing this. Solutions can range from establishing cycle routes, or seeking opportunities to incorporate physical activity in to daily life, to ensuring an increased provision of accessible leisure facilities. Restrictions in the number high calorific food outlets, such as fast food takeaways, in a particular location may play a role. The current refresh of the Local Plan provides an opportunity to explore and enact some of these types of initiatives.

- There is growing concerns in relation to isolating environments. A lack of social networks, facilities or difficulty in accessing services or amenities can all contribute to individuals becoming or feeling isolated within their environment

	Baseline 2016	Target 2020
Development of local Health in All Policies approach	Ad hoc arrangements	Systematic strategic approach.
Establish the Health in All Policies Steering Group.		
Make progress in developing a coherent policy approach to a defined number of key health and wellbeing issues, including e.g., air quality, housing and health, reducing the	Currently no coherent approach.	Coherent approach to Health in All policies demonstrated by different organisations pulling together on important determinants of health. Priority policy areas identified with partners.

obesogenic environment – the Food Plan, Transport, Planning		Manifest progress made in identified areas
Ensure that the health implications for the population are taken into account in the Leicester Local Plan	Early discussions with planning team.	Completed plan with clear health outcomes and requirements included

Delivering the strategy

Although overall delivery of the Health and Well-being Strategy will sit with Leicester's Health and Wellbeing Board, responsibility for delivering each theme will lie with the relevant partnership board:

- A Healthy Start: Children's Trust Board
- Healthy Lives: Health and Wellbeing Board
- Healthy Ageing:
- Healthy Minds: Mental Health Partnership Board
- Healthy Places: Health in All Policies Steering Committee

Appendix D

LEICESTER CITY HEALTH AND WELLBEING BOARD
3rd April 2017

Subject:	Sport England Bid Update
Presented to the Health and Wellbeing Board by:	Ruth Tennant, Director of Public Health, Leicester City Council
Author:	Ruth Tennant, Director of Public Health, Leicester City Council

EXECUTIVE SUMMARY:

In May 2016 Sport England launched a new strategy, "Towards an Active Nation": This sets a new direction for Sport England with a much stronger emphasis on getting people active who do not take part in sports or regular physical activity. For the first time, it also includes children and young people.

Sport England's investment decisions over the next 5 years will reflect this. Following the launch of the strategy, Sport England announced that they would be funding 10 places to develop and implement local approaches to address inactivity including working with groups who have particularly low levels of physical activity. The fund is worth £130 million over 4 years. Funds will be awarded on the merit of the application, with no set amount per application.

Sport England are looking for creative and innovative solutions to address inactivity, providing a chance for the city to develop new and exciting ideas, which must ultimately focus on a change towards an active population. The Health and Wellbeing Board will receive a presentation on local proposals being developed by Leicester City Council and its partners.

RECOMMENDATIONS:

- Endorse the plans under development and provide leadership to a local bid.