Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: THURSDAY, 4 JULY 2019
TIME: 5:30 pm
PLACE: Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Members of the Commission

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

Councillors Aldred, Chamund, March, Dr Sangster and Westley

I unallocated Non-Group place.

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

JHarget

For Monitoring Officer

Officer contacts:
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

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Further information

If you have any queries about any of the above or the business to be discussed, please contact Julie Harget**, Democratic Support on (0116) 454 6357 or email julie.harget@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
BCF	Better Care Fund
BCT	Better Care Together
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG	Clinical Commissioning Group
LCCCG	Leicester City Clinical Commissioning Group
ELCCG	East Leicestershire Clinical Commissioning Group
WLCCG	West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DAFNE	Diabetes Adjusted Food and Nutrition Education
DES	Directly Enhanced Service
DMIRS	Digital Minor Illness Referral Service
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GPAU	General Practitioner Assessment Unit
GPFV	General Practice Forward View

HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWLL	Healthwatch Leicester and Leicestershire
ICS	Integrated Care System
IDT	Improved discharge pathways
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LTP	Long Term Plan
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
NDPP	National Diabetes Prevention Pathway
NICE	National Institute for Health and Care Excellence
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
OPEL	Operational Pressures Escalation Levels
PCN	Primary Care Network
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
TasP	Treatment as Prevention
TASL	Thames Ambulance Services Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to the area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. CHAIR'S ANNOUNCEMENTS

4. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 12 March 2019 have been circulated and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk:8071/ieListDocuments.aspx?CId=737&MId=8653&Ver=4

5. TERMS OF REFERENCE FOR SCRUTINY COMMISSIONS **Appendix A (Pages 1 - 2)**

Members are asked to note the Terms of Reference for Scrutiny Commissions.

6. MEMBERSHIP OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

Members are asked to note the membership of the Health and Wellbeing Scrutiny Commission:

Chair: Councillor Kitterick
Vice Chair: Councillor Fonseca

Councillors Aldred, Chamund, March, Sangster and Westley.

7. DATES OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION MEETINGS

Members are asked to note the dates of future meetings of the Health and Wellbeing Scrutiny Commission for 2019/20.

Thursday 29 August 2019
Thursday 10 October 2019
Thursday 5 December 2019
Thursday 30 January 2020
Thursday 2 April 2020

All to commence at 5.30pm and to be held in City Hall, Room G.01.

8. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

9. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

10. PRIMARY CARE HUB ACCESS AT THE MERLYN VAZ HEALTH AND SOCIAL CARE CENTRE — Appendix B (Pages 3 - 6)

The Leicester City Clinical Commissioning Group submits a briefing paper relating to the Primary Care Hub Access at the Merlyn Vaz Heath and Social Care Centre. Members are asked to consider the briefing paper which looks at the rationale and impact of moving from a walk in appointment system to a combined pre-bookable and walk-in appointment system. In addition to the briefing paper, there may be contributions from stakeholders who have indicated their intention to speak.

11. INTRODUCTION TO THE NHS LONG TERM PLAN — Appendix C (Pages 7 - 18)

Members are asked to receive a briefing paper from the Leicester City Clinical Commissioning Group which sets out the key requirements of the NHS Long Term Plan. The Long Term Plan was published in January 2019 and sets out how the NHS needs to adapt and change over the coming years to ensure it can provide sustainable health care across England.

12. THE DEVELOPMENT OF PRIMARY CARE NETWORKS **Appendix D (Pages 19 - 26)**

The Leicester City Clinical Commissioning Group submits a report on the Development of Primary Care Networks. Members are asked to consider and comment on the report as they see fit.

13. PUBLIC HEALTH OVERVIEW AND FORTHCOMING WORK PLANS **Appendix E (Pages 27 - 38)**

The Assistant City Mayor for Health and the Director of Public Health will deliver a presentation that provides an overview of Leicester City Council's Public Health and its priorities for 2019/20. Members will be asked to consider and comment on the presentation as they see fit.

14. WORK PROGRAMME

(Pages 39 - 40)

The Scrutiny Policy Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2019/20. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

15. ANY OTHER URGENT BUSINESS

Appendix A

SCRUTINY COMMITTEES: TERMS OF REFERENCE

INTRODUCTION

Scrutiny Committees hold the executive and partners to account by reviewing and scrutinising policy and practices. Scrutiny Committees will have regard to the Political Conventions and the Scrutiny Operating Protocols and Handbook in fulfilling their work.

The Overview Select Committee and each Scrutiny Commission will perform the role as set out in Article 8 of the Constitution in relation to the functions set out in its Terms of Reference.

Scrutiny Committees may:-

i. review and scrutinise the decisions made by and performance of the City Mayor, Executive, Committees and Council officers both in relation to individual decisions and over time.

ii. develop policy, generate ideas, review and scrutinise the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas.

iii. question the City Mayor, members of the Executive, committees and Directors about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects.

iv. make recommendations to the City Mayor, Executive, committees and the Council arising from the outcome of the scrutiny process.

v. review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the Scrutiny Committee and local people about their activities and performance; and

vi. question and gather evidence from any person (with their consent).

- **Annual report:** The Overview Select Committee will report annually to Full Council on its work and make recommendations for future work programmes and amended working methods if appropriate. Scrutiny Commissions / committees will report from time to time as appropriate to Council.

The Scrutiny Committees which have currently been established by the Council in accordance with Article 8 of the Constitution are:

- Overview Select Committee (OSC)
- Adult Social Care Scrutiny Commission
- Children, Young People and Schools Scrutiny Commission

- Economic Development, Transport and Tourism Scrutiny Commission
- Health and Wellbeing Scrutiny Commission
- Heritage, Culture, Leisure and Sport Scrutiny Commission
- Housing Scrutiny Commission
- Neighbourhood Services Scrutiny Commission

SCRUTINY COMMITTEE: OVERVIEW SELECT COMMITTEE

The Overview Select Committee **will**:

- Specifically scrutinise the work of the City Mayor and Deputy City Mayor and areas of the Council's work overseen by them.
- Consider cross cutting issues such as monitoring of petitions
- Consider cross-cutting issues which span across Executive portfolios.
- Manage the work of Scrutiny Commissions where the proposed work is considered to have impact on more than one portfolio.
- Consider work which would normally be considered by a Scrutiny Commission but cannot be considered in time due to scheduling issues.
- Report annually to Council.
- Be responsible for organising and agreeing the work of scrutiny and the Commissions including agreeing annual work programmes and approving reports produced by the Commissions
- Consider the training requirements of Members who undertake Scrutiny and seek to secure such training as appropriate.

SCRUTINY COMMISSIONS

Scrutiny Commissions **will**:

- Be aligned with the appropriate Executive portfolio.
- Normally undertake overview of Executive work, reviewing items for Executive decision where it chooses.
- Engage in policy development within its remit.
- Normally be attended by the relevant Executive Member, who will be a standing invitee.
- Have their own work programme and will make recommendations to the Executive where appropriate.
- Consider requests by the Executive to carry forward items of work and report to the Executive as appropriate.
- Report on their work to Council from time to time as required.
- Be classed as specific Scrutiny Committees in terms of legislation but will refer cross cutting work to the OSC.

Consider the training requirements of Members who undertake Scrutiny and seek to secure such training as appropriate.

NHS
Leicester City
Clinical Commissioning Group

Primary Care Hub Access at the Merlyn Vaz Health and Social Care Centre - briefing Paper for Leicester City Health Overview and Scrutiny Commission

Summary

1. Leicester City Health Overview and Scrutiny Commission requested Leicester City Clinical Commissioning Group provide a briefing as to:

   (a) The rationale and impact of moving from a walk-in appointment system to a combined pre-bookable and walk-in appointment system for the Primary Care Hub service operating from the Merlyn Vaz Health and Social Care Centre.
   (b) As a result of the change in appointment system whether there has been an increased demand on acute ED services.

2. It is the intention of this paper to inform the Committee as to:

   (i) The rationale behind the appointment change; and
   (ii) Any evidenced impact on acute ED services.

3. A pre-bookable appointment system allows the provider to maximise the use of health professionals' time, minimises waiting times for patients and ensures an appointment is the right solution for them.

4. To date there is no evidence to suggest the appointment system change has had a negative impact on ED service delivery.

Background

5. The Merlyn Vaz Health and Social Care Centre officially opened its doors in 2009, hosting a number of local GP practices and an open access walk-in centre. As the name suggests, patients were entitled to walk-in between the hours of 8am and 8pm and sit and wait for an appointment to become available. Patients from outside of Leicester City could also use the service.

6. While a walk-in service could have advantages for patients, it often led to excessive peaks and troughs in demand (times when it is either very busy or very quiet) which made it difficult to make best possible use of health professionals' time. Feedback from patients told us that they often got frustrated with the length of time they needed to wait to be seen. At very busy times, the wait could be several hours.

7. The aim of the walk in centre was to provide improved access to GPs for patients who were finding it difficult to get an appointment at their own practice. It was hoped that this would help lead to a reduction in A&E attendances but, after the service opened, the number of people attending A&E continued to rise.

8. Rather than using the walk-in centre when they could not get an appointment at their practices, we learned that patients were using the walk-in centre as their first port of call, instead of their regular GP practice. This meant they were not receiving any holistic oversight or coordination of all aspects of their care.

9. Patients were also found to be using the walk-in centre for largely minor self-limiting conditions that could have been managed better through self-care and advice from a pharmacy or NHS 111.

Transition from walk-in service to healthcare hub

10. In 2015, Leicester City CCG began a pilot of the extended access primary care healthcare hubs in the city, funded by the Prime Minister's Access Fund. The purpose of the scheme was to make it easier for patients to get an appointment with a GP or nurse in the evenings and weekends and at times when their own practice could not see them.

11. The walk-in centre contract was due to end on 30th September 2017. Therefore during February and March 2017 the CCG carried out some engagement with patients to ask for their views on changing the walk-in centre model from exclusively walk-in to a hybrid model offering a combination of both pre-bookable and walk-in appointments. This was to bring the service more in line with those of the three primary care hubs in the city, although those offer an exclusively pre-bookable appointment system.

12. As part of the engagement, patients were also asked for their views on the potential future location of the service. The options presented were at Merlyn Vaz Health and Social Care Centre and Leicester General Hospital.

13. In total 56% of respondents said they would prefer the service to be located at Leicester General Hospital, compared to 31% who said they would prefer it to be at the Merlyn Vaz Health and Social care Centre. The remainder said that they did not know or had no preference.

14. Despite this, a number of respondents told the CCG that they had reservations about any move to the General Hospital taking place before consultation on the future of the site was undertaken as part of the planned STP consultation on proposals for the future reconfiguration of Leicester's hospitals. As a result, a decision was made to retain the service at Merlyn Vaz Health and Social Care Centre pending the outcome of this process.

15. The engagement also asked patients for their views about whether appointments should continue to be offered on an exclusive walk-in basis, be wholly pre-bookable or a combination of the two. In total 54% of respondents to the engagement either strongly agreed or agreed that most appointments at the hub should be booked in advance, with a smaller proportion ring-fenced as walk-in appointments. 22% disagreed or strongly disagreed, with the remainder neither agreeing nor disagreeing.

16. As a result, the contract was specified as requiring the provider to offer a mixture of both pre-bookable and walk-in appointments, with a transition to achieving an 80/20 split in favour of pre-bookable over the first three years of the contract.

17. Timed slots help to keep waiting times for patients to a minimum and it means that the use of the GPs' and nurses' time who are working in the service can be maximised.

18. Pre-booking also allows for a decision to be made about which service the patients should be appropriately signposted to, ensuring their needs are addressed by the right person, in the right place and at the right time. This could help reduce the number of walk-in patients who wait several hours for an appointment only to be referred onto another part of the service, such as A&E, following consultation with a doctor.

19. The CCG recognised that not every patient has the ability to book an appointment in advance, however. It was for this reason that it was agreed the service could continue to offer some appointments on a walk-in basis.

The current service

20. The extended access primary care service at Merlyn Vaz Health and Social Care Centre continues to be open from 8.00am to 8.00pm 365 days a year.

21. The service provision includes:

- In line with patient feedback, carry out predominantly booked assessment and treatment for patients presenting with urgent care needs and patients looking for routine access 7 days a week, but also provide for walk-in patients.
  Provide medical expertise and as a minimum has on-site doctor presence throughout hours of operation
- Be staffed by a mix of clinicians qualified to manage primary care presentations.
- Provide the capability to prescribe medication throughout the hours of operation.
- Arrange for testing and referrals for urgent conditions.

22. The current split of appointments between pre-bookable and walk-in at the Merlyn Vaz site is approximately 80% pre-bookable and 20% walk-In. However, it should be noted that this is variable, with the number of walk-in patients rising as high as 30% in some months.

23. Overall the service continues to see approximately 500 patients per week, which is consistent with the number of patients seen when the service was exclusively walk-in.

24. The CCG has investigated the impact the appointment system change has on acute ED service delivery and, to date, there is no evidence to suggest the change has had a negative impact on ED attendances or performance. However, the CCG has committed to keeping this under regular review.

Conclusion

25. Both the walk-in model and the healthcare hub model are designed to improve access to primary care appointments. The benefits of a healthcare hub model over a walk-in have been described in this paper. Waiting time for patients is kept to a minimum. Health professionals' time can be better used by managing patient flow across the day. Having a timed appointment also means the needs of the patient can be assessed in advance to ensure the service is right for them.

26. There is no evidence to suggest that there has been a negative impact on ED service delivery by moving to the current service model. A predominantly pre-bookable appointment model was supported by patients through engagement, while a proportion of walk-in appointments are still maintained for use by patients, including those from outside the city.

NHS
Leicester City
Clinical Commissioning Group

An introduction to the NHS Long Term Plan

Purpose of report

1. The purpose of this report is to set out the key requirements of the NHS Long Term Plan.

Background

2. In January 2019 NHS England published The NHS Long Term Plan (LTP) which can be found at www.longtermplan.nhs.uk.

3. The LTP sets out how the NHS needs to adapt and change over the coming years to ensure that we can provide sustainable health care across England. The main areas of focus are:

    - How the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.
    - Strengthening of actions on prevention and health inequalities.
    - Improving care quality and outcomes for patients over the next 10 years.
    - Tackling workforce pressures.
    - Ramping up the use of technology and digital enabled care across the NHS.
    - Increase funding to support these changes.

4. This paper concentrates on some of the key areas of the NHS Long Term Plan, however a summary of the plan can be found in Appendix One.

5. It is important to note that as a system we are not starting from scratch, many of the requirements of the Long Term Plan have already been identified locally as priorities through our Better Care Together (BCT) programme. Collectively we have been working together over the last four years to redesign and improve care and support for our local populations in many of these areas and this will continue and be incorporated into a new local five year plan.

New service model

6. As part of the Long Term Plan there is an expectation that local organisations, through Integrated Care Systems (ICS), will redesign care and improve population health, creating shared leadership and action.

7. By April 2021 there is a requirement that ICSs will cover the whole country, growing out of the Sustainability and Transformation Partnerships. ICSs will have a key role in working with Local Authorities at "place" level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health.

8. Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions to take place at a system level. Locally the first step on this journey has been agreed with the appointment of a single Chief Executive Officer and senior management team across the three local Clinical Commissioning Groups.

9. The NHS Long Term Plan sees that each ICS will typically involve a single CCG and these becoming leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation. Work is currently underway by the three local CCGs to consider the options for future form and engage on these during the summer 2019. Should this result in the need to undertake consultation this will be done during the autumn 2019.

10. Every ICSs will have:

    - A partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate – local authorities, the voluntary and community sector and other partners.
    - A non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards and governing bodies.
    - Sufficient clinical and managerial capacity drawn from across their constituent organisations to enable them to implement agreed system wide changes.
    - Full engagement with primary care, including through a named accountable Clinical Director for each primary care network.
    - A greater emphasis by the Care Quality Commission on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area.

- All providers within an ICS will be required to contribute to ICS goals and performance.
- Clinical leadership aligned around ICSs to create clear accountability to the ICS. ICSs and Health and Wellbeing boards will also work more closely together, although at this stage there is no further guidance on what this means.

11. Work is ongoing to consider the establishment of a Partnership Board, its potential remit and membership. Decisions are likely to be made before the end of the summer 2019.

12. ICSs will have the opportunity to earn greater authority as they develop and perform.

13. The development of our local ICS is part of our Better Care Together Partnership. In our Better Care Together Next Steps to better care in Leicester, Leicestershire and Rutland document we set out what our plans are for delivering care at the different levels of an ICS system, see diagram below.

Level	Population Size	Purpose
Neighborhood (Primary Care Networks)	30,000 to 50,000	• Deliver high quality primary care • Proactive care via integrated locality teams for defined populations and cohorts • Asset based community development to support health, wellbeing and prevention
Place Leicester City Leicestershire County Rutland	37,000 to 610,00	• Based on upper tier authority boundaries • Delivery of specialised based integrated community services, including social care • Delivery of reablement, rehabilitation and recovery services • Prevention services at scale
Systems (Leicester, Leicestershire and Rutland)	1,000,000+	• System strategy, planning and implementation • Work across the system on specialist areas such as cancer, mental health and urgent care • Make best use of all our combined assets including staff and buildings • Manage performance and system finances • Establish a system framework for prevention

14. We have been working together through both place and system to develop integrated models of care over the last few years. This has included our Better Care Fund (BCF), developing health and social care integrated locality teams

and prevention work. It is worth noting that the Long Term Plan states that the BCF will be reviewed to ensure it is meeting its goals and this will conclude in the first quarter of 2019; in 2019/20 there will still be a clear requirement to continue to reduce Delayed Transfers of Care and improve the availability of care packages for patients ready to leave hospital.

15. The Long Term Plans asks us to ensure that we have an ICS in place by April 2021 and this work is being undertaken, by the System Leadership Team, putting in place the necessary actions and building blocks for the creation of an ICS within Leicester, Leicestershire and Rutland. This includes actions to support partners to work collaboratively together; ensuring financial sustainability; developing integrated care; and ensuring we have the resources and infrastructure to deliver.

16. This work is in its early stages but there is an expectation that LLR will be in a shadow ICS by April 2020 in order to prepare for the April 2021 requirement in the Long Term Plan.

17. A key building block of the integrated care system is the neighbourhood level and again in LLR and Leicester City we have done considerable work across health and social care in the last two to three years to develop integrated care teams at a locality level.

18. The Long Term Plan requires all areas to establish Primary Care Networks (PCNs), made up of groups of practices and working with other health and social care providers to provide proactive, personalised, co-ordinated and more integrated primary and community services to improve health outcomes and reduce health inequalities for their populations.

19. To respond to this Leicester City CCG has been working with primary care to establish PCNs by the required start date of 1st July 2019. he finaTl number of PCNs and members will not be known until after the 1st July 2019. At the time of writing this report it is anticipated that there will be 10 PCNs in Leicester City. Final configuration will be shared at the Health Overview and Scrutiny Committee. The PCNs will be underpinned by both a Network Agreement which all member practices will need to sign up to and a new Directed Enhanced Service (DES) contract which will be the vehicle for the CCG to commission network based services from the PCN. In addition each PCN will need to appoint a Clinical Director.

20. Work is ongoing to redesign community services including nursing, reablement and therapy to support the PCNs and to provide the wider community services required to deliver integrated care. Our work with Leicester City Council in

relation to integrated team working and Better Care Fund services continues and will be an integral part of any well-functioning PCN.

21. The PCNs will be able to recruit a new workforce to support them in the delivery of integrated care through a national role reimbursement scheme for which each PCN will be allocated a sum of money based on size. They can then recruit from a list of roles up to the financial resource allocated.

22. From 2020/21 there will be seven national service specifications offered as part of the Network DES contract which is designed to support better care for specific cohorts of patients. In addition local areas can commission local services through the DES.

Improving care quality and outcomes

23. This part of the NHS Long Term Plan focuses on how the NHS could do better on quality and outcomes. It sets out clear improvement priorities for the biggest killers and disablers including cancer; mental health; multi-morbidity; childrens health; cardiovascular and respiratory conditions; learning disabilities and autism. More detail in each area is shown in Appendix 1.

24. Given the time it takes to deliver change, improvements in some areas are expected over a 10 year period for example cancer survival rates; while in other areas improvements are expected earlier, for example halving maternity related deaths.

Tackling workforce pressures

25. Workforce pressures are a key issue within the NHS with growth not keeping up with need over the past decade. There is commitment within the NHS Long Term Plan to:
    - ensure there are enough people, with the right skills and experience, so that staff have the time they need to care for patients well;
    - ensure people have rewarding jobs, work in a positive culture, with opportunities to develop their skills, and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering health care;
    - strengthen and support good, compassionate and diverse leadership at all levels.

26. To support this:
    - A new Workforce Implementation Plan will be published in late 2019.

- Actions will be agreed to improve the supply of nurses, midwives, Allied Health Professionals and other staff.
- Actions will be taken to grow the medical workforce.
- International recruitment will be used.
- Actions to support staff will be introduced.
- Actions will be taken to ensure staff can be productive.
- Leadership and talent management action will be introduced.
- Improve the access to volunteering opportunities, particular amongst young people.

More detail can be found in Appendix 1.

Increase emphasis on prevention and health inequalities

27. As can be demonstrated from the detail in Appendix 1, the Long Term Plan increases the focus on the delivery of prevention and reducing health inequalities. The key areas of focus are smoking, obesity, alcohol, air pollution and antimicrobial resistance.

28. As part of the overall development of LLRs response to the Long Term Plan the LLR Prevention Board will lead the work to further strengthen our prevention offer working with the individual workstreams to ensure the requirements of the Long Term Plan are met. As part of the PCN development there is a requirement to develop a population health management approach and prevention is a key building block to this. To support this, funding is being made available to PCNs from July 2019 for each network to recruit social prescribing link workers.

29. There is an indication in the Long Term Plan that the government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses. To date there is no indication when this work will commence; as and when it does further updates can be provided.

30. The Long Term Plan requires a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care. To support this, a higher share of funding will be targeted to geographies with high health inequalities. Nationally this will be over £1billion by 2023/24. Each area in 2019 will be expected to set out how they will specifically reduce health inequalities by 2023/24 and 2028/29 and this will form part of our new five year plan. This will be supported by a menu of evidence based interventions that if adopted locally could contribute to the goal. Specific actions being taken include:

    - An enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and their babies – by 2024 75%

of women from BAME communities and a similar percentage of woman from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.

- Offer all women who smoke during their pregnancy specialist smoking cessation support to help them quit.
- By 2020/21 the NHS will ensure that at least 280,000 people living with severe mental health problems have their physical health needs met. By 2023/24 the number of people receiving physical health checks will increase by an additional 110,000 people per year.
- Improving care for people with a learning disability, autism or both.
- Investment to meet the needs of rough sleepers.
- Identify and support carers, particularly those from vulnerable communities.
- Expansion of NHS specialist clinics to help more people with serious gambling problems.

Digital

31. The Long Term Plan puts a strong focus on digitally-enabled care across the NHS. Key areas of focus are detailed below and the local response to this is being led by the LLR IM&T Group which has representation from all organisations. In developing the local response consideration will need to be given to existing local plans.

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- Create straightforward digital access to NHS services, and help patient and their carers manage their health.
- Ensure that clinicians can access and interact with patient records and care plans wherever they are.
- Use decision support and artificial intelligence to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition.
- Use predictive techniques to support systems to plan care for populations.
- Protect patients' privacy and give them control over their medical record.
- Link clinical, genomic and other data to support the development of new treatments, clinical research and NHS performance.
- Ensure security of NHS systems.
- Mandate and enforce technology standards to ensure data is interoperable and accessible.
- Encourage a world leading health IT industry.

Investment into the NHS

32. The NHS Long Term Plan is backed by additional investment over the next five years. This extra investment will need to deal with current pressures and unavoidable demographic change and other costs, as well as delivering the new priorities set out in the plan. Headline figures are that funding will grow by an average of 3.4% in real terms a year over the next five years, which compares to an average of 2.2% over recent years.

33. As a result of the additional investment it is expected that:

- The provider sector will return to balance by 2020/21 and year-on-year the number of trusts and CCGs individually in deficit will reduce, so that all NHS organisations are in balance by 2023/24;
- The NHS will achieve cash-releasing productivity of at least 1.1% a year, will all savings reinvested in frontline care;
- The NHS will reduce the growth in demand for care through better integration and prevention;
- The NHS will reduce variation across the health system, improving provider financial and operational performance. This will be a core responsibility of the ICS to bring together clinicians and managers to implement standardised evidence based pathways: and
- The NHS will make better use of capital investment and its existing assets to drive transformation.

34. There will be reforms to the payment system with a move away from funding activity to ensuring the majority of funding is population based, including a blended payment model beginning with urgent and emergency care. System wide control totals will be introduced.

32. There is a commitment within the Long Term Plan financial settlement to ensure that Mental Health Investment Standards are still met and that primary and community service funding should grow faster than CCGs overall revenue growth. How this additional funding is allocated will be discussed between commissioners and providers and will be informed by our work to develop integrated care. There is the flexibility with the changes to consider integrated commissioning models with local authorities.

33. Beyond 2019/20 the NHS Long Term Plan indicates that further financial reforms will be introduced to support ICSs to deliver integrated care through a process of earned financial autonomy. Local health systems will be given greater control over resources on the basis of a strong financial and performance delivery. To date no detail on how this will work has been published.

Conclusion

35. The Long Term Plan sets out how care and outcomes are expected to change over the next five to ten years.

36. Locally we have started this journey through our Better Care Together programme and this will form the basis our Integrated Care System.

37. However like the Long Term Plan sets out there are areas that we need to move faster on including developing an integrated care system, prevention, reducing health inequalities and digital.

Summary of Long Term Plan Requirements

Children and young people with cancer • Development of networked care to improve outcomes for children and young people with cancer. • From 2019 all children with cancer will be offered whole genome sequencing to enable more comprehensive and precise diagnosis. • Increase the number of children and young people taking part in clinical trials to 50% by 2025. • From September 2019 all boys aged 12 and 13 will be offered vaccinations against HPV-related diseases. • Over the next five years NHS England will increase its contribution to the children's hospice grant by match-funding CCGs who commit to increase their investment in local children's palliative and end of life care services.	**Learning Disability** • Improve the uptake of the annual health check in primary care so that at least 75% of those eligible have a health check each year. • Pilot to be introduced for health checks for people with autism. • Expansion of the programmes to stop over medication of people with learning disability and or autism. • NHS staff will receive information and training on supporting people with learning disability and or autism, • National learning disabilities standards will be issued and will apply to all NHS funded services. • By 2023/24 a digital flag in the patient record will ensure staff know a patient has a learning disability and or autism. • Focus on reducing waiting times for autism diagnosis. • By 2023/24 children and young people with a learning disability, autism or both with the most complex needs will have a designated keyworker. • Local providers will be able to take control of budgets to reduce avoidable admissions, enable shorter length of stay and end out of area placements. • By March 2023/24 inpatient provision will have reduced to less than half of 2015 levels. • Every local health system will be expected to use some of its growing community health services investment to have a seven-day specialist multi- disciplinary service and crisis care. • All areas of the county will implement and be monitored against a 12 point discharge plan to ensure discharges are timely and effective.	**Children and young people's mental health** • Funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending. • By 2023/24 at least an additional 345,000 children and young people aged 0-25 will be able to access support. Over the next decade the aim is to ensure that 100% of children and young people who need specialist care can access it. • Additional investment into eating disorder services to ensure waiting time standards are maintained beyond 2020/21. • With a single point of access through NHS 111 all children and young people experiencing crisis will be able to access crisis care 24 hours a day, seven days a week. • Over the next five years the NHS will fund new Mental Health Support Teams working in schools and colleges to be rolled out to between one-fifth and a quarter of the county by the end of 2023. • Extend current service models to create a comprehensive offer for 0-25 year olds. The new model will deliver an integrated approach across health, social care, education and the voluntary sector**.**
Children and young people • Reach base level standards in the NHS public function agreement for childhood immunisations. • In 2019/20 clinical networks will be rolled out to ensure we improve the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes. • Paediatric clinical care and surgical services will evolve to meet the changing needs of patients. • By 2028 the aim is to move towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult service based on age not need.	**Cancer** • From 2019 we will start to rollout new rapid Diagnostic Centres across the country. • In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days. • By 2020 HPV primary screening for cervical cancer will be in place. • By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, care plan and health and wellbeing information and support. • By 2022 the lung health check model will be extended. • By 2023, stratified follow-up pathways for people who are worried their cancer may have recurred will be in place. • By 2028, the NHS will diagnose 75% of cancers at Stage 1 or 2. • Primary care networks will be required to help improve early diagnosis of patients in their own neighbourhoods by 2023/24.	**Cardiovascular disease** • Improving the effectiveness of approaches NHS Health Checks and increase case finding opportunities. • Expanding access to genetic testing to identify risk of early heart attacks so that at least 25% are identified in the next five years. • Improvement to community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest. • By 2028 85% of those eligible will be able to access cardiac rehabilitation care. • Creation of a national CVD prevention audit for primary care to support clinical improvement. • Improve rapid access to heart failure specialist care and advice. • Greater access to echocardiography in primary care.
Stroke care • 90% of stroke patients will receive care on a specialist stroke unit. • All patients who could benefit from thrombolysis should receive it. • Expansion of mechanical thrombectomy to increase the numbers of patients who can be independent following a stroke. • Out of hospital more integrated and higher intensity rehabilitation for people recovering from stroke, delivered in partnership with voluntary organisations to support better outcomes.	**Diabetes** • Patients with Type 1 diabetes to benefit from flash glucose monitors from April 2019 in line with clinical guidelines. • Improve the delivery of recommended diabetes treatment targets and drive down variation between CCGs and practices. • All hospitals to provide multidisciplinary footcare teams and diabetes inpatient specialist nursing teams to improve recovery and to reduce lengths of stays and readmission rates.	**Respiratory disease** • Reduce variation in the quality of spirometry testing. • More staff in primary care to be trained and accredited to provide the specialist input required to interpret spirometry results. • Expansion of pulmonary rehabilitation services over 10 years through a population health management approach in primary care. • New models of providing rehabilitation to those with mild COPD will be offered. • Pharmacists in primary care networks will undertake a range of medicine reviews, including educating patients on the correct use of inhalers. • Patients identified with community acquired pneumonia in emergency departments will be supported to be cared for safely out of hospital by receiving nurse-led supported discharge services. • Increasing the number of people with heart and lung disease to complete a programme of education and exercise based rehabilitation.
Prevention – General • Focus on smoking, poor diet, high blood pressure, obesity and drug use. • Consideration of the role for the NHS in commissioning sexual health services, health visitors and school nurses. **Prevention – Alcohol** Hospitals with the highest rates of alcohol admissions will be supported to fully establish specialist Alcohol Care Teams.	**Prevention - Smoking** • By 2023/24, all people admitted to hospital that smoke will be offered NHS funded tobacco treatment services. This will include all pregnant mothers and their partners. • Universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of mental health, and in learning disability services.	**Prevention – Obesity** • Targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+. • Doubling of the NHS Diabetes Prevention Programme over the next five years. • Test an NHS programme supporting very low calorie diets for obese people with type 2 diabetes. • Revised hospital food standards. • Improving nutrition training as part of professional training.

Health Inequalities

- A higher share of funding targeted towards areas with high health inequalities through CCG allocations.
- Measurable goals will be set for the narrowing of health inequalities.
- All local systems will be expected to set out during 2019 how they will specifically reduce health inequalities by 2023/24 and 2028/29.
- Menu of evidence based interventions will be published.

Primary and Community Care

- Development of primary care networks based on populations of 30-50,000 delivering integrated care
- Roll out of the Enhanced Health in Care Homes model across all areas.
- Proactively managing population health and developing services to support this approach.
- The NHS Personalised Care model to be rolled out by 2023/24 - this will include access to social prescribing link workers.
- Personal Health Budget programme to be accelerated with upto 200,000 people having a PHB by 2034/24.
- Digital first will become an option for every patient improving access to primary care.

Maternity and neonate

- By 2024 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife.
- Reduce stillbirth, maternal mortality, neonatal mortality and serious brain injury by 50% by 2025.
- Roll out of Savings Babies Lives Care Bundle across every maternity unit in 2019.
- Establish Maternal Medicine Networks which will ensure women with acute and chronic medical problems have timely access to specialist advice and care.
- Encourage development of specialist pre-term birth clinics.
- In 2019 20% of women will have access to continuity of care and this will be expanded to most women by March 2021.
- By 2023/24 all women will be able to access their maternity notes and information through their smart phones and other devices.
- Improved access and quality to perinatal mental health services.
- Improvements to postnatal physiotherapy support.
- All maternity services to deliver accredited, evidence based infant feeding programme in 209/20.
- Redesign and expansion of neonatal critical care services to improve safety and effectiveness.

Adult mental health services

- Renewed commitment to grow investment in mental health services faster than the NHS budget overall for the next five years.
- By 2020/21 at least 280,000 people living with severe mental health problems will have their physical health needs met. By 2023/24 this will increase to 390,000.
- Continuation of the IAPT expansion plan, by 2023/24 an additional 380,000 people will have access.
- New community based offer for adults with severe mental illnesses will be introduced to include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use.
- Local areas will be supported to redesign and reorganise core community mental health teams to move towards a new placed-based, multidisciplinary service across health and social care aligned with primary care networks.
- All-age mental health liaison service to be in all A&E departments and inpatient wards by 2020/21 with 70% of these service meeting “core 24” service standards by 2023/24.
- Over the next 10 years anyone experiencing mental health crisis can call NHS 111 and have 24/7 access to the mental health support they need in the community.
- Increase in alternative forms of provision for those in crisis.
- Specific waiting times for emergency mental health services will take effect from 2020.
- Ambulance staff will be trained and equipped to respond effectively to people in crisis.
- Introduction of mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&E.
- Mental health nurses to be part of ambulance control rooms to improve triage and response to mental health calls.
- The ending of acute of out of area in patient placements by 2021.
- Reducing suicides to remain a priority including a new Mental Health Safety Improvement Programme which will have a focus on suicide preventions and reduction for mental health inpatients.
- Suicide bereavement support for families and staff working in mental health crisis services.

Workforce

- Increase in the number of undergraduate nursing degrees, reducing attrition from training and improving retention with the aim of improving nursing vacancy rate to 5% by 2028.
- Establish on line nursing degree linked to guaranteed placement.
- Earn and learn support premiums for students embarking on more flexible undergraduate degrees in mental health or learning disability nursing, who are predominantly mature students.
- NHS organisations should look to take on the lead employer model, setting up the infrastructure to deliver apprenticeships on behalf of several trusts.
- Growing apprenticeships on clinical and non-clinical jobs in the NHS.
- Options to be considered to further expand medical school places.
- Accelerate the shift from a dominance of highly specialised roles to a better balance with more generalists ones.
- Improved medical training to support doctors to manage comorbidities, alongside single conditions.
- Primary Care Networks to receive funding for additional staff to form part of a multidisciplinary team including clinical pharmacists, link workers, first contact physiotherapists and physician associates.
- Newly qualified doctors and nurses will be offered a two-year fellowship.
- New arrangements will be put in place to support NHS organisations in recruiting overseas.
- Improvement of staff retention by at least 2% by 2025.
- Expansion of multi-professional credentialing to enable clinicians to develop new capabilities formally recognised in specific areas of competence.
- Promote flexibility, wellbeing and career development and address discrimination, violence, bullying and harassment.
- Each NHS organisation to set its own target for BAME representation across its leadership team and broader workforce by 2021/22.
- Expanded Practitioners Health Programme to help all doctors’ access specialist mental health support.
- By 2021 NHS trusts will deploy electronic rosters or e-job plans.
- New NHS leadership code will be developed which will set out cultural values and leadership behaviours.
- Systematic identification, development and support to those with the capability and ambition to reach the most senior levels in the NHS.
- Encourage organisations to give greater access for younger volunteers and an increased focus on programmes in deprived areas, and for those with mental health issues, learning disabilities and autism. Double the number of volunteers.

Digital

- NHS App will provide advice, check symptoms and connect people with healthcare professionals.
- Work with the voluntary sector, developers and individuals in creating a range of apps to support particular conditions including IAPT and diabetes.
- By 2020 every patient with a long term conditions will have access to their health record through the Summary Care Records.
- Patient Personal Health Record will hold a care plan that incorporates information added by the patients themselves or their authorised carer.
- Over the next three years all staff working in the community will have access to mobile digital services, including the patient’s care record and plan.
- Ambulance service will have access to digital tools that they need to reduce avoidable conveyance to A&E.
- Informatics leadership representation on the board of every NHS organisations, with chief executives capable of driving the transformation of their organisations and non-executive directors able to support and demand increasing digital maturity over the next five years.
- Over the next five years every patient will be able to access a GP digitally, and where appropriate, opt for a virtual outpatient appointment.
- All providers across acute and community and mental health settings will be expected to advance a core level of digitisation by 2024.
- A new wave of Global Digital Exemplars will enable trusts to use world-class digital technology and information to deliver better care, more efficiently.
- Population health management solutions will be available to ICSs to understand the areas of greatest health need.

Planned Care

- Redesign services so that over the next five years a third of face-to-face follow-up outpatients appointments will no longer take place.
- Expand the number of physiotherapists working in primary care networks.
- Expectation that increased funding will over the next five years cut long waits and reduce waiting lists.
- Anyone who has been waiting for six months will be reviewed and given the option of faster treatment at an alternative provider.

Urgent Care

- In 2019 England will be covered by 24/7 integrated urgent care service, accessible via NHS 111 or online.
- All hospitals with a major A&E will provide Same Day Emergency Care service at least 12 hours a day, 7 days a week by the end of 2019/20.
- Provision of acute frailty service for at least 70 hours a week.
- Further reduce DTOC in partnership with local authorities.
- Clinical Assessment Service to be embedded within NHS 111 from 2019/20.

NHS
Leicester City
Clinical Commissioning Group

The development of Primary Care Networks

Purpose of this document

1. NHS England and the BMA in January 2019 announced a five year framework for GP contract reform to implement *The NHS Long Term Plan*. A major part of the reform is the introduction of Primary Care Networks in every area of England based around GP practice populations of between 30,000 and 50,000 patients. The full framework can be found at https://www.england.nhs.uk/publication/gp-contract-five-year-framework/.

2. This document summaries the key components of Primary Care Networks (PCNs).

Background to Primary Care Networks

3. Over the last four years Leicester City Clinical Commissioning Group has organised its locality working based on Health Needs Neighbourhoods based on populations of between 65,702 and 124,203 registered patients. To date these have been primarily about how the CCG and practices communicate and engage with each other. Some work has been done to work collectively across practices in areas such as training and development and locality based non recurrent funding. However the national direction of travel is towards these arrangements becoming the providers of integrated care.

4. In addition the Health Needs Neighbourhoods in the city have been the foundation on which the CCG and Leicester City Council have developed integrated working through our Better Care Fund.

5. The idea of primary care networks in one form or another has been around for a while, including GP fund holding, total purchasing pilots and practice based commissioning. The most recent national direction has piloted GP Home and a number of vanguard sites. In 2016 the GP Five Year Forward view was launched which strongly advocated at scale working and new models of care.

6. The next stage of GP networks development has been set out in The NHS Long Term Plan which was released in January 2019. Within this plan there is an expectation that all areas will have in place Primary Care Networks by 30 June 2019.

7. Primary Care Networks will involve groups of practices working with other local health and social care providers in partnership, as one team, to provide proactive, personalised, coordinated and more integrated primary and community services to improve health outcomes and reduce health inequalities of their population.

Core characteristics of a primary care network

8. **Practices working together with other local health and care providers** around geographical communities of between 30,000 and 50,000 registered patients. They will deliver expanded neighbourhood teams comprising of a range of staff including GPs, primary care staff, pharmacists, district nursing, community geriatricians, AHP joined by social care and the voluntary sector. This will be supported by a network contract that will require all practices to enter into as an extension of their existing contract. A designated single fund will be created through which all network resources will flow. A named accountable Clinical Director will be appointed by members for each PCN.

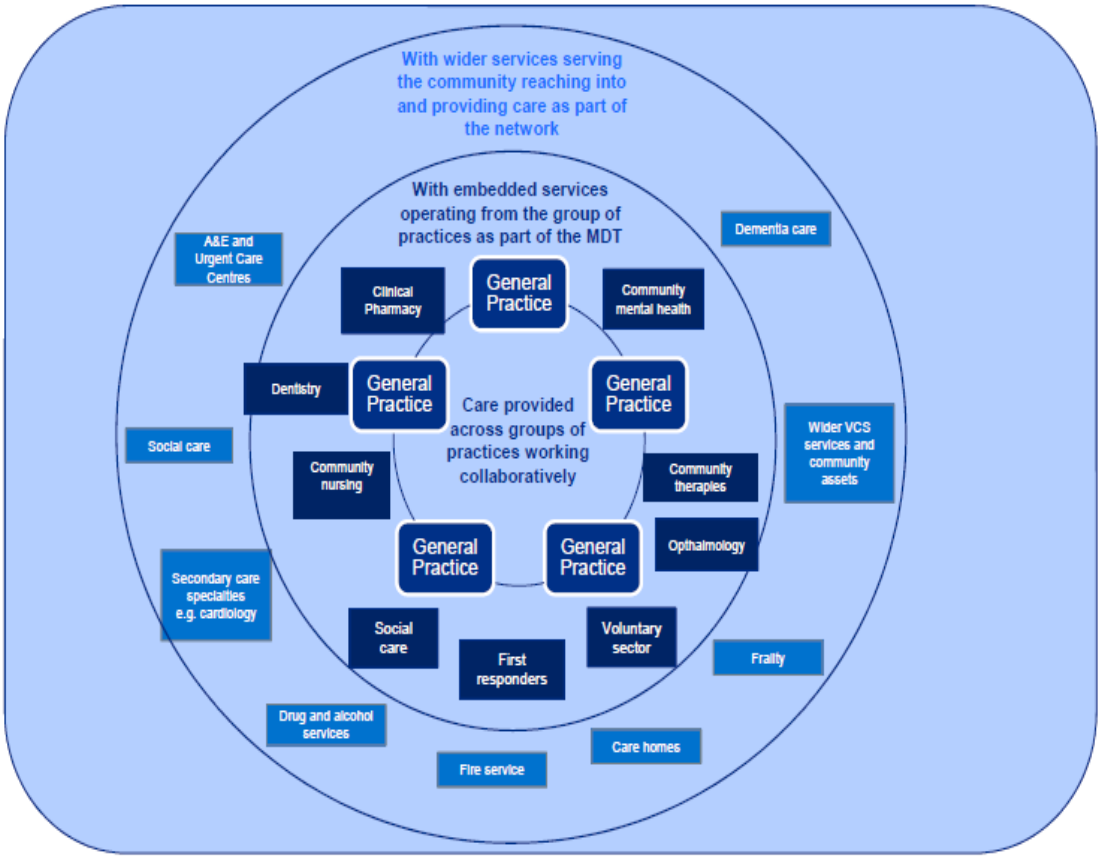
9. **Providing care in different ways to match different people's needs** including flexible access to advice and support for "healthier" sections of the population, and joined up multidisciplinary care for those with more complex conditions. This is effectively how groups of practices in the future will manage routine on the day care requirements and how they will provide continuity of care for those with complex conditions.

10. **Focus on providing proactive, personalised and coordinated care to the local population** PCNs will be required to assess their local population by risk of unwarranted health outcomes and working, with the wider network service providers make support available to people where it is most needed. Using a proactive population health approach, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs.

11. **Focus on prevention** supporting patients to make informed decisions about their care and look after their own health, by connecting them with the full range of statutory and voluntary sector services.

12. **Making best use of collective resources across practices** and other local health and care providers to allow greater resilience, more sustainable workload and access to a larger range of professional groups. The Long Term Plan also sets out a national shared savings plan for PCNs so that they can benefit from actions to reduce avoidable A&E attendances, admission and delayed discharge, streamlining patient pathways to reduce avoidable outpatient visits and over medication through pharmacist review.

The following diagram demonstrates what a Primary Care Network may look like.



What could Primary Care Networks mean for patients, practices and others

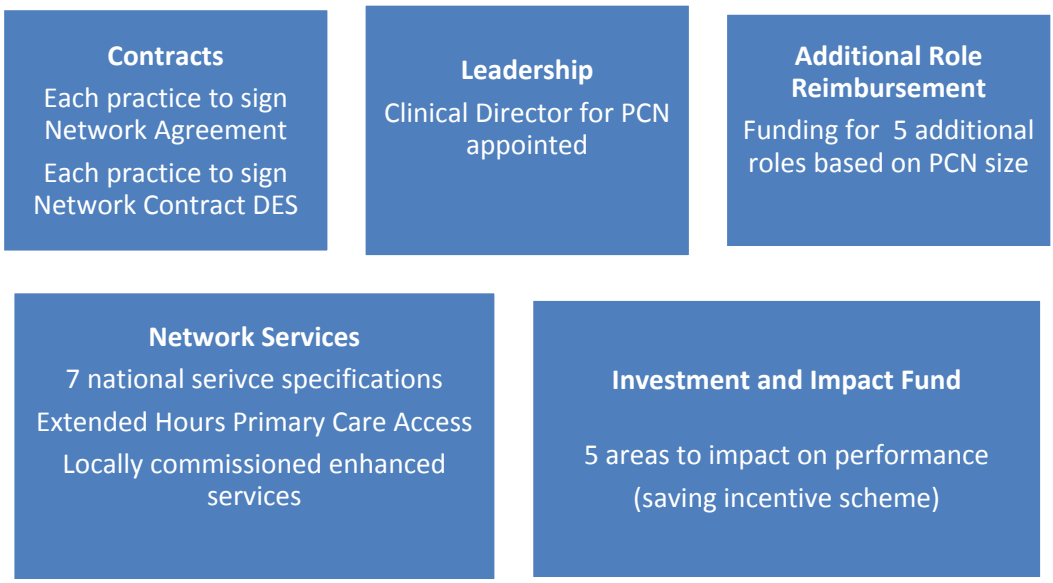
13. The NHS England Primary Care Network Reference Guide sets the following impact of PCNs.

Patients should experience	• Joined up services, **where everyone they engage with knows about previous interactions** • Access to a wider range of professionals and diagnostics **in the community, so they can get access to the people and services they need in a single appointment** • Different ways of getting advice and treatment, **including digital, telephone based and physical services, matched to their individual needs** • Shorter waiting times, **with appointments at a time that work around their lives** • Greater involvement, **when they want it, in decision about their care** • **An increase focus on prevention and personalised care helping people to take charge of their own health, enabling them to stay out of hospital**

Practices should experience	• **Greater resilience** by sharing staff, buildings and other resources, helping to smooth out fluctuations in demand and capacity and make the more efficient use of resources • **A more sustainable work/life balance**, as more tasks are routed directly to appropriate professionals e.g. care navigators, social workers, physios, pharmacists and counsellors • **More satisfying work**, with each professional able to focus on the tasks they do best • **Greater influence** on decisions made elsewhere in the health system • **Ability to provide better treatments to their patients**, through better access to specialists in the community, diagnostics, and partnership with community services, social care, and voluntary organisations
Wider health and care partners should experience	• **Cooperation across organisational boundaries** to allow greater joined up services • **Primary care providers as core partners in system decision making**, helping to drive a more population-focused approach to decision making and resource allocation • **A wider range of services in the community so patients don't have to default to the acute sector** • **More resilient primary care, acting as the foundation of integrated systems**

Key components of the five year framework relating to Primary Care Networks

14. The following diagram show the key components PCNs will be expected to deliver or have in place.



Contracting route and timetable for developing Primary Care Networks

15. As part of the wider GP contract changes practices will be required to sign up to a new Network Directly Enhanced Service (DES) from 1 July 2019. This will be mechanism for both the development of integrated care at a neighbourhood level but also the channel in which much of the additional funding for primary care will flow.

16. As a DES, it is an extension of the core GP contract and as Leicester City CCG has delegation in relation to primary care the CCG will be the commissioner.

17. It is for each PCN to decide its delivery model for the Network Contract DES. It could be through a lead practice, GP federation, NHS provider or social enterprise partner.

18. In addition to the DES practices will need to sign a Network Agreement which will set out the Primary Care Networks collective rights and obligations and how it will partner with non-GP stakeholders. It is needed for a PCN to claim its financial entitlements (collectively) and deliver national and local services to its whole Network list and area.

19. The Network Agreement strengthens the collaboration between all constituent practices and is the vehicle under which constituent members agree how they work together and share resources and responsibilities.

20. The Network Agreement is also the formal basis for working with other community-based organisations. Collaboration arrangements with other local organisations including community health providers will form a distinct part of every Network Agreement.

21. There is a requirement for 100% geographical coverage of PCNs by 1st July 2019 and in order to achieve this each PCN were required to register by 15th May 2019. CCGs are responsible for agreeing the registrations of the PCNs by no later than 30th June 2019.

22. The CCG has been working with local practices to agree footprints of PCNs in the city. The guidance is clear that the formation needs to be driven from practices but each footprint in the area must cover a boundary that makes sense to:
    - Constituent members;
    - Other community based providers who configure their teams accordingly; and
    - The local community, and would normally cover a geographically contiguous area.

There is also a requirement for the CCG to ensure there is 100% coverage across their area.

23. Final configuration of PCNs will not be known until after the 30th June 2019 and information will be provided at the Health Overview and Scrutiny Committee meeting. However at the time of writing this report it is anticipated that there will be ten PCNs across the city.

Clinical Director

24. Every Primary Care Network must appoint a Clinical Director as its named accountable leader, responsible for delivery. The Clinical Directors will play a critical role in shaping and supporting their Integrated Care System. They will help ensure the full engagement of primary care in developing and implementing local system plans to implement the NHS Long Term Plan.

25. The appointment of the Clinical Director is part of the registration process for the PCN and as such needed to be in place prior to the submission of the PCN registration form in May 2019. There is no prescribed process for the recruitment of the Clinical Director, it was for determination by the member practices in the PCN.

Additional Roles

26. As part of the Network DES funding will be provided for PCNs to recruit to additional roles that will form part of the multi-disciplinary team with a PCN. The roles include Clinical Pharmacists, Social Prescribing Link Workers, First Contact Physiotherapists, Physician Associates and First Contact Community Paramedics. Funding for these roles will be part of the Network Contract DES and will be phased in over the next few years.:

Role	**Maximum reimbursable amount in 2019/20 (with on costs)**
Clinical Pharmacist	From July 2019
Social Prescribing Link Worker	From July 2019
First contact Physio	From 2020/21
Physician Associate	From 2020/21
First Contact Community paramedic	From 2021/22

Network Services

27. As part of the Network Contract DES networks will be asked to deliver seven national service specifications that will support the delivery of the key priorities set out in the NHS Long Term Plan for which funding will be provided.

    The seven service specifications are:

Specification	Commences
Structured Medications Review and Optimisation	2020/21
Enhanced Health in Care Homes	2020/21
Anticipatory Care requirements for complex patients	2020/21
Personalised Care	2020/21
Supporting Early Cancer Diagnosis	2020/21
CVD Prevention and Diagnosis	2021/22
Tackling Neighbourhood Inequalities	2021/22

28. In addition to these seven national specifications the Extended Hours DES will transfer to the Network Contract DES from 1 July 2019. And by 2021 there is an intention that the CCG commissioned access service will transfer to the Network Contract DES to create a single fund to support access.

29. The requirements of the DES transfer will be for 100% of patients to have access to extended hours, on average it is expected that a network with a population of 50,000 would need to provide 25 hours extended access per week, shared between morning, evening and weekends.

Investment and Impact Fund

30. A new network Investment and Impact Fund will start in 2020 and will eventually cover five elements:
    - Avoidable A&E attendances
    - Avoidable emergency admissions
    - Timely hospital discharge
    - Outpatient redesign
    - Prescribing costs

31. It will provide a fund to achieve better performance across those areas listed and national rules will be developed to manage the fund. The funding will be pre-identified and capped, with the exception of prescribing costs and will be available from 2020/21.

32. The scheme will be overseen by Integrated Care Systems. Networks will agree with their Integrated Care System how they spend any monies earned and these will be intended to increase investment for workforce expansion and services.

Health Scrutiny PH Overview and Priorities

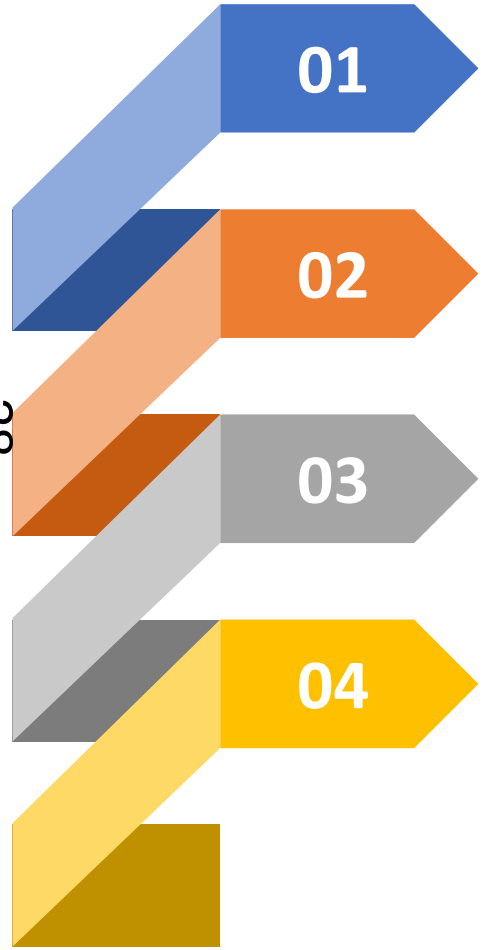
Cllr Dempster

Ivan Browne (DPH)

Appendix E

Public health: who we are & what we do

Your subtitle will go here



The Public Health division

Key functions and funding

Health & well-being services

An overview of the main services we offer

Our big health challenges

What the current picture and what needs to change?

Priorities for 2019/20

Work plans and manifesto commitments

Division of Public Health & Sports Services

What we do

Intelligence, commissioning & evaluation

Commissioning Public Health Services, data & analysis

Sports & Leisure services

City sports development, leisure centres, sport on parks, outdoor facilities

Prevention

Children's public health services (school nursing, health visiting)
Oral health
Lifestyle services

Healthy Places

Health in All Policies
Air Quality
Mental health
Health & Well-being Board
Health &Well-being Strategy
Health Protection

Health & well-being services

We provide a wide range of service to improve population health, funded through a ring-fenced grant

Mandated services:

SEXUAL HEALTH & CONTRACEPTION
16,000 walk-in attendances each year for advice, treatment & contraception

NHS HEALTHCHECKS
Free health MOT every 5 years for 40-74.
45,000 people seen in the last 5 yrs.

HEALTHY TOGETHER
Every child in the city receives support from health visitors and school nursing

Non-Mandated services:

SPORTS & LEISURE SERVICES
7 leisure centres, 1 athletics track, 1 golf course & football & hockey pitches,

LIFESTYLE SERVICES
5000 customers use our health trainers & active lifestyle schemes. 1,830 helped to quit smoking

SUBSTANCE MISUSE
2000 people a year seen for help with drugs & alcohol issues.

Public Health Funding.

01

Leicester PH ring-fenced grant funds

Public Health is funded through the public health ring-fenced grant (£26.8 million) which funds the activities of the division (£20.7 million), drug and alcohol services, and other activities in the council (active travel, parts of regulatory services) that improve health. The major spend areas within the grant are 0-19 Healthy Child Programme, sexual health services, NHS Health-checks, drugs and alcohol services, leisure centres & other lifestyle services

02

Ring fenced grant reduction

The grant has reduced by 2.6% year-on-year since 2016.

2016/17, Leicester allocation = £28,214k, 2019/20 = £26,103k

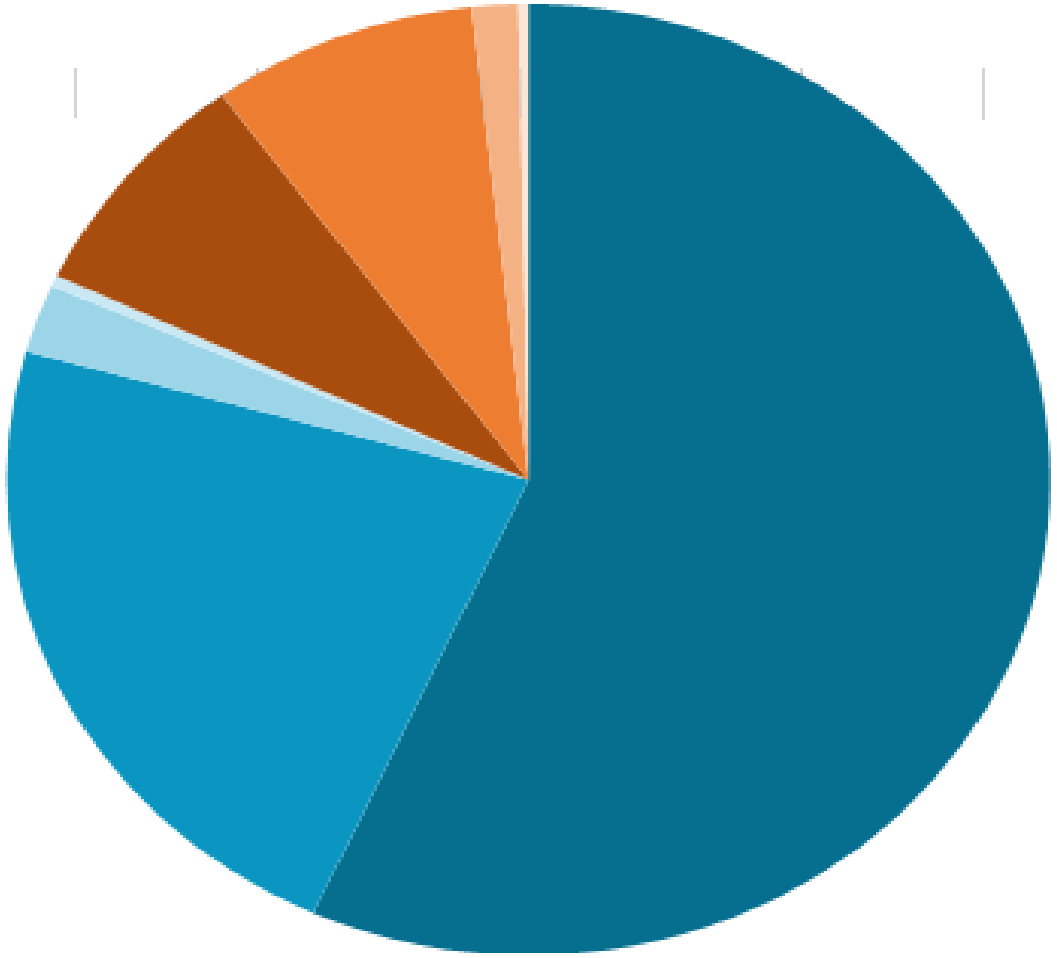
03

Grant income position for 2021

The current funding position suggests that there is not expected to be a further cut to the Grant for 2021

Public health: core budget spend 2019/20

Public Health Grant divisional spend £20.7 mil



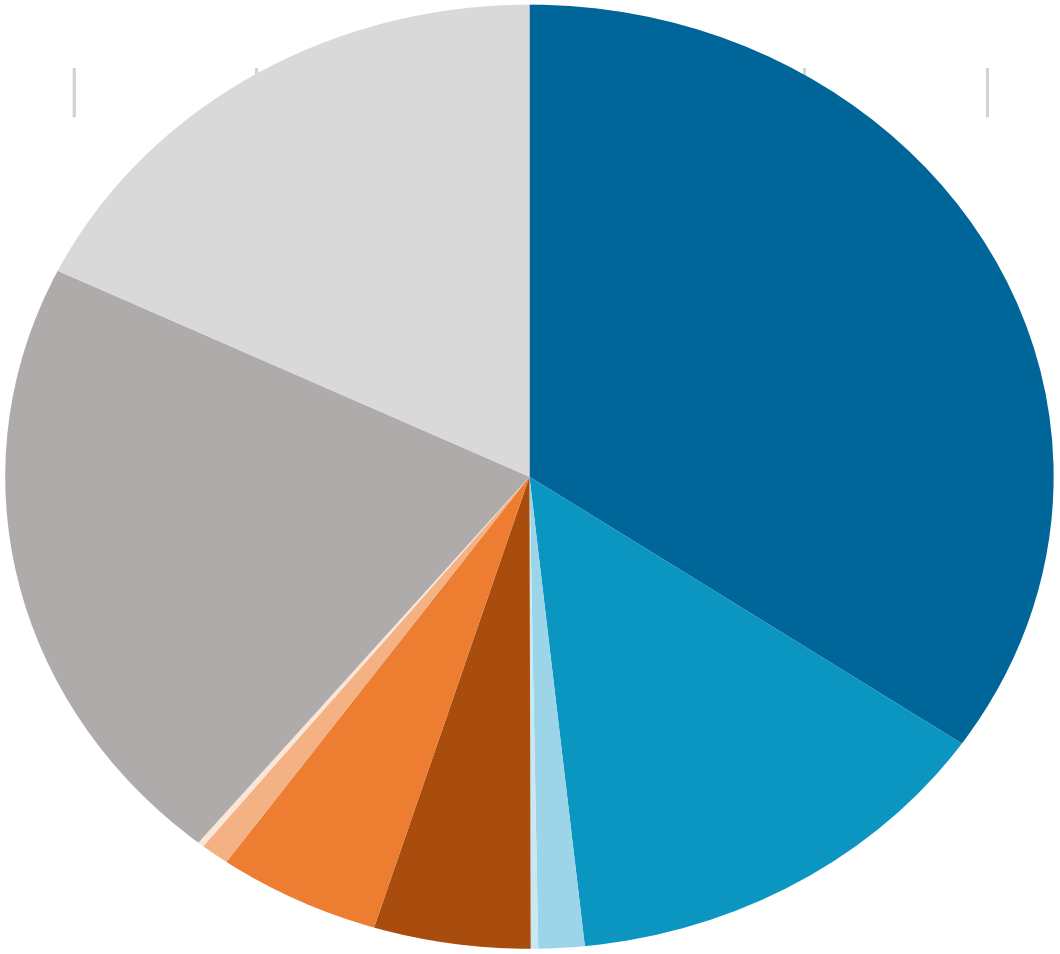
- Childrens 0-19 (56.8% / £9.02m)
- Sexual Health (22.6% / £3.59m)
- NHS Health Checks (2.3% / £0.37m)
- Health protection (0.4% / £0.06m)
- Lifestyle Services (7.9% / £1.26m)
- Staffing & Infrastructure (8.2% / £1.31m)
- Public Mental Health (1.4% / £0.23m)
- Evaluation & Intelligence (0.3% / £0.05m)

% Mandated - 82.1% (£13.04m

% Non-Mandated - 17.9% (£2.85m

Public health: total ring fenced grant spend 2019/20

Public Health Grant £26.8 mil



- Childrens 0-19 (34.6% / 9.02m)
- Sexual Health (13.8% / 3.59m)
- NHS Health Checks (1.4% / 0.37m)
- Health protection (0.2% / 0.06m)
- Lifestyle Services (4.8% / 1.26m)

Mandated - 50%, (£13.04m)

- Staffing & Infrastructure (5% / 1.31m)
- Public Mental Health (0.9% / 0.23m)
- Evaluation & Intelligence (0.2% / 0.05m)

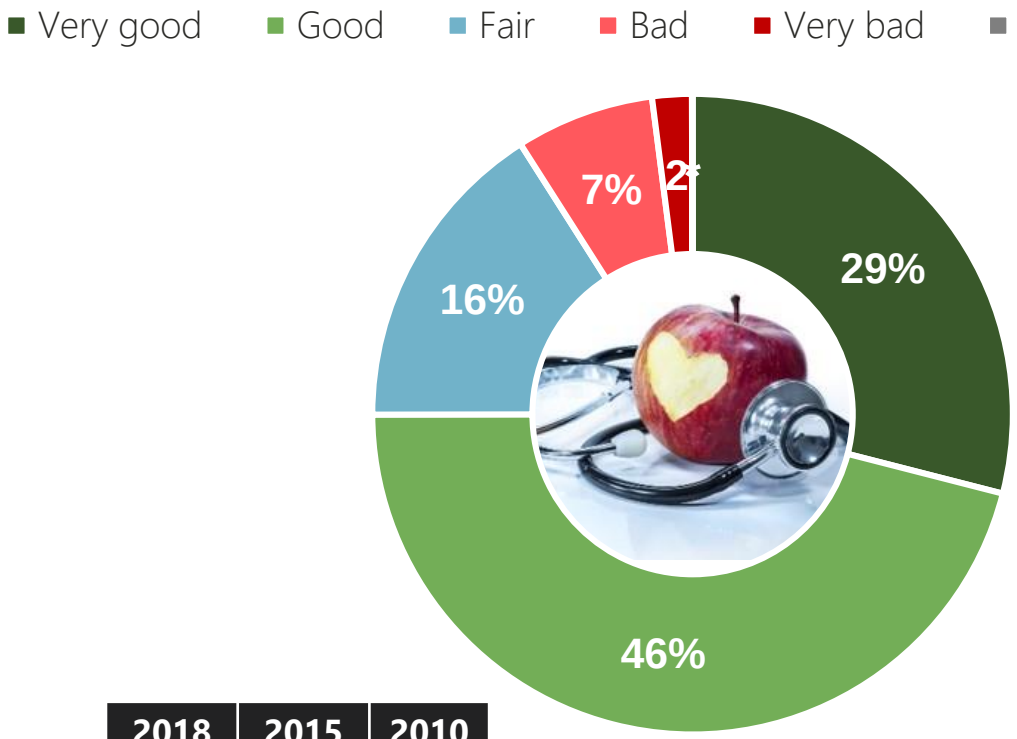
Non-Mandated - 50%, (£13.06m)

- Substance Misuse (21.3% / 5.56m)
- Other council services (17.8% / 4.65m)

Three quarters of Leicester residents rate their health as good

There has been a significant increase in self-reported health compared to the 2015 survey (75% vs. 71% in 2015). The proportion of those who say they are healthy is broadly in line with the national picture*. Three in ten (29%) say they are in very good health, in line with previous years, and less than one in ten (9%) think they are in bad health.

Q1. How is your health in general? Would you say it is…?



	2018	2015	2010
Good	75%	71%	72%
Bad	9%	10%	7%

74%
National rate*
(good health)

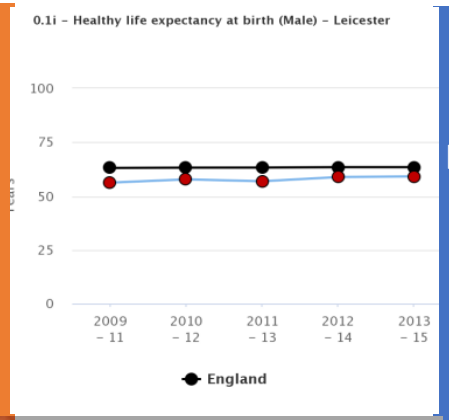
Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018
*Source: National Health Survey for England, 2016. Based on 8008 UK adults aged 16+

Source: Ipsos MORI

OUR HEALTH CHALLENGES

What are the key health issues in the city?

CHILDREN'S HEALTH
1/3 of children are overweight at the end of primary school – although things are improving in reception year



MENTAL HEALTH
Highest rate of common mental health disorders in children & young people and 2nd highest rate in over 65s in the East Midlands

HEART DISEASE
Rates are rising for men under the age of 75 and are also high for women

DIABETES
Rates of diabetes are higher in South Asian communities. Type 2 diabetes is preventable and is increasing.

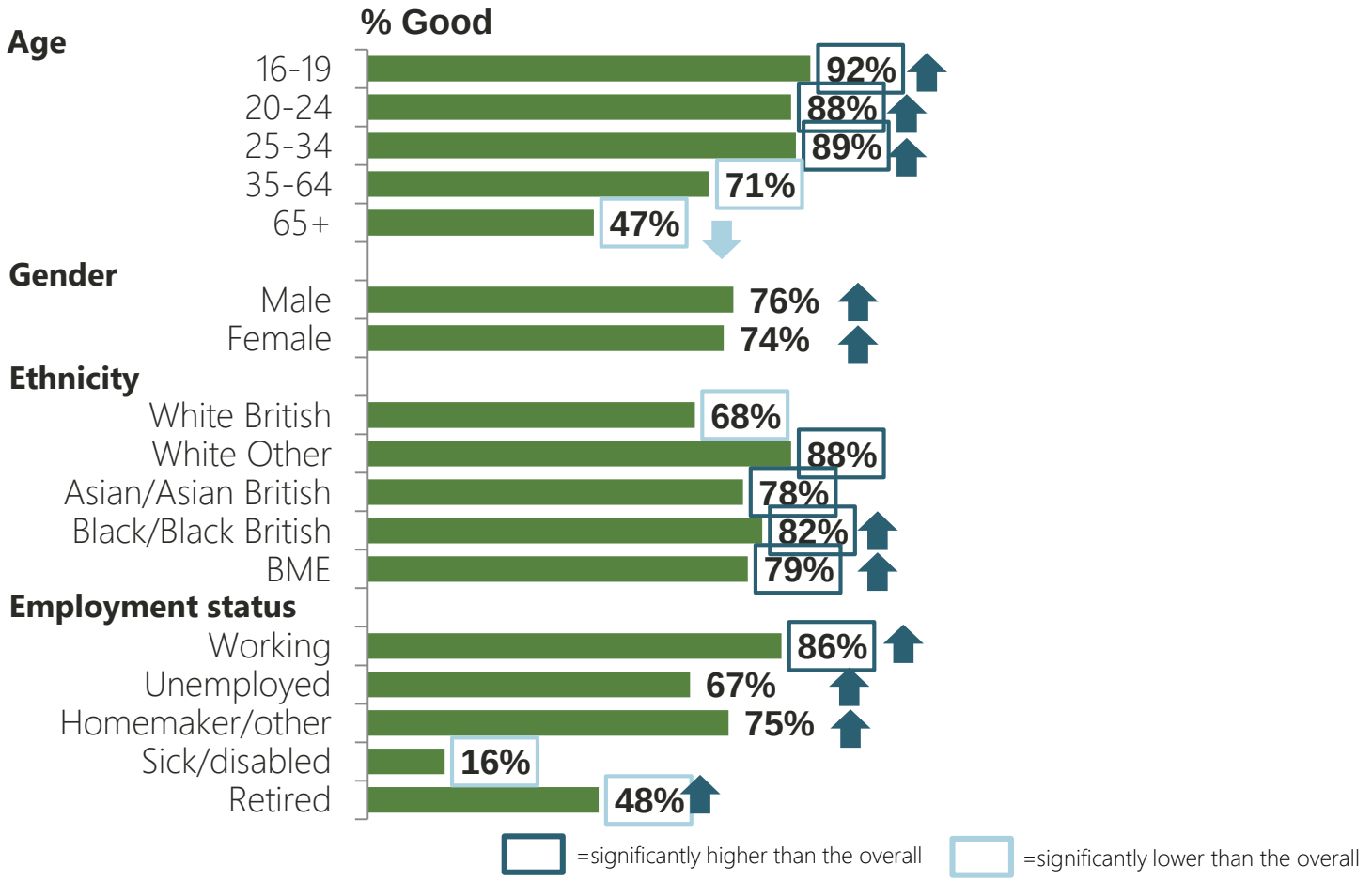
PEOPLE GET SICKER, YOUNGER
Men in Leicester are in good health until the age of 59. For women, it's 60: before they reach retirement age

KEEPING HEALTHY?
Our smoking rates are falling but we are an inactive city. Healthy food choices are also an issue.

Three quarters of Leicester residents rate their health as good

Young people aged between 16-34 are more likely to describe themselves as healthy (89% vs. 47% of those 65+). Those who identify as White British are significantly less likely to rate their health as good (68% vs. 75% overall). It is positive to note that while there are differences between employed residents and those who are workless, this gap has closed – with a significantly higher proportion of those who are workless reporting good health this year (67% vs 61% in 2015).

Q1. How is your health in general? Would you say it is…?



Base: All valid responses (2224) : Fieldwork dates : 5th March – 25th July 2018
Source: National Health Survey for England, 2016. Based on 8008 UK adults aged 16+

Source: Ipsos MORI

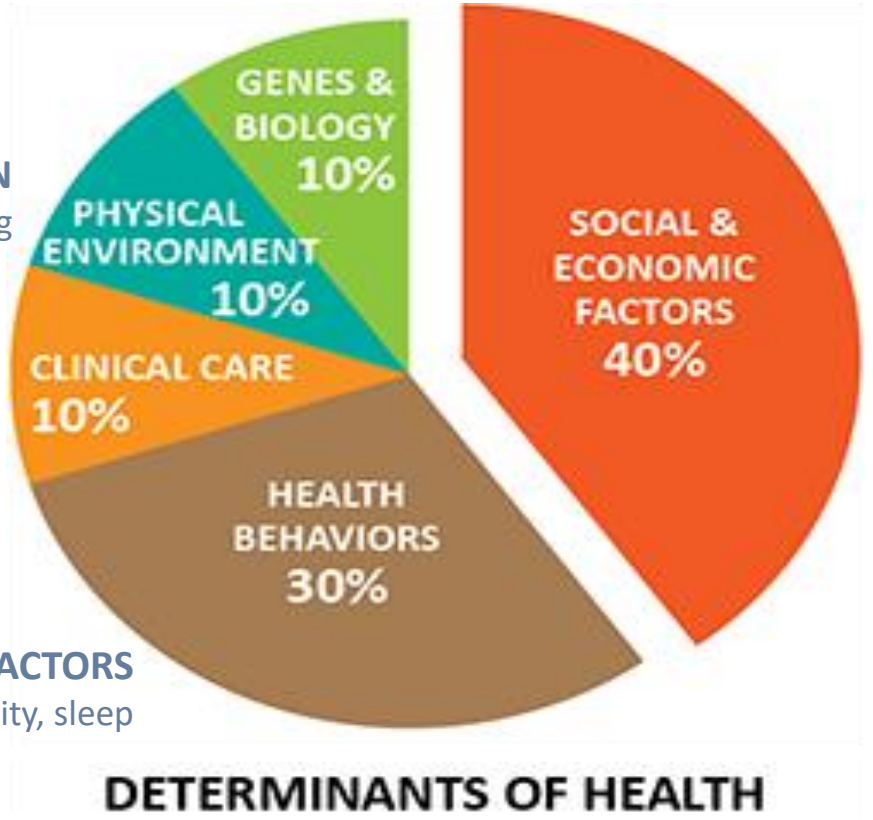
WHAT MAKES US HEALTHY?

WHO WE ARE
Male or female, genetic factors

THE SPACE WE LIVE IN
Air quality, pollution, housing

THE NHS
Seeing the right health professional and getting the right help and treatment

LIFESTYLE FACTORS
Smoking, diet, physical activity, sleep



OUR LIFE CHANCES
Education, employment, income levels, life opportunities

Public health: Priorities 2019/20

Your subtitle will go here

01

Deliver mandated and non mandated public health functions

Supported via departmental business plan and performance management dashboard and quarterly meetings

02

Implement new service delivery arrangements

July 2019 will see the implementation of a new Integrated Lifestyle Service

03

Deliver on Public Health related manifesto commitments.

04

Support delivery of revised health and well being strategy

Focus on coordination of delivery of the associated action plan

Health and Wellbeing Scrutiny Commission

Work Programme 2019 – 2020

Meeting Date	Topic	Actions arising	Progress
4th Jul 19	1. Merlyn Vaz Health and Social Care Centre 2. NHS Long Term Plan 3. Public Health Overview 4. Primary Care Networks		
29th Aug 19	1. Primary Care Strategy 2. CCG Merger Plans – Feedback from Stakeholders 3. Community Health Services Redesign 4. Leicestershire Partnership NHS Trust		
10th Oct 19	1. Update on Manifesto Commitments 2. Acute Reconfiguration of UHL 3. Strategic Outline Case for the Rebuild of the Bradgate Unit		
5th Dec 19	1. All-age Mental Health Transformation Programme		
30th Jan 20	1. UHL Priorities 2020/21		
2nd Apr 20			

Forward Plan Items

Topic	Detail	Proposed Date
Young People's Council's Mental Heath Report	Discussions to be had with the YPC about the best way to bring this to scrutiny.	
Childhood Obesity	To be included on the work programme once Public Health Data has been released.	