Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 29 AUGUST 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
(1 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

Elaine Baker

For Monitoring Officer

Officer contacts:
Kalvaran Sandhu (Scrutiny Policy Officer):
Tel: 0116 454 6344, e-mail: Kalvaran.Sandhul@leicester.gov.uk)
Elaine Baker (Democratic Support Officer):
Tel: 0116 454 6355, e-mail: elaine.baker@leicester.gov.uk
Leicester City Council, 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

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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 on the agenda.

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

The Minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 4 July 2019 are attached and Members are asked to confirm them as a correct record.

4. CHAIR'S ANNOUNCEMENTS

5. PETITIONS

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

6. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The following representation has been received from Ms Lucy Chaplin:

> "Are health providers aware that by offering mental health support through mainly telephone-based services that phone companies - particularly mobile phone companies - do not inform users that they may have used up contracted minutes and accumulated large phone bills in accessing the support they need?
>
> While it is very helpful to be able to call the crisis team, and other services, it is very difficult to keep track of time. Indeed why should

someone who is already so unwell that they need these services have the additional burden of thinking about their phone bill?

Has any part of the NHS looked into this, or discussed the issue with mobile phone companies, as many patients with severe mental health problems are already on reduced income, indeed many are classed as homeless, and cannot afford huge phone bills. When people can't pay the bill their phones are barred by companies, which actually cuts patients off from ALL the support networks they have.

This is like an additional tax, and additional stress, on those who are ill with poor mental health, as is discriminatory.

Responses from the CCG and LPT would be welcome.

I would also ask that the Leicester City Council Health and Wellbeing scrutiny commission agrees to take this up with NHS England and asks that there are agreements with phone companies about making those telephone services COMPLETELY freephone - in order that already vulnerable people are not faced with huge bills just for accessing the services they need.

Is Leicestershire the only place where this happens?

I've also copied in Keith Vaz as my local MP and Jon Ashworth MP as the shadow Health secretary as they could also take this up nationally.

It is a scandal that while society tries to breakdown the stigma of poor mental health, the telephone companies are making a lot of money from people accessing help, especially when that help is mostly available only via telephone."

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

7. LEICESTERSHIRE PARTNERSHIP NHS TRUST: UPDATE ON STEPS TAKEN IN RESPONSE TO REGULATORY INSPECTIONS

Angela Hillery, Chief Executive Officer, and Anne-Maria Newham, Director of Nursing (AHPs & Quality), from the Leicestershire Partnership NHS Trust (LPT) will give a presentation providing the Commission with details on the current Care Quality Commission position for LPT, assurance around actions that have been taken following recent inspections and the Trust's approach to monitoring and embedding these actions. The Commission is recommended to consider the presentation and comment as appropriate.

8. LEICESTER, LEICESTERSHIRE AND RUTLAND 2019/20-2023/24 PRIMARY CARE STRATEGY **Appendix B (Pages 17 - 34)**

The Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary Care Strategy is submitted by the Leicester City, West Leicestershire and East Leicestershire & Rutland Clinical Commissioning Groups. The Commission is recommended to scrutinise the Strategy and comment as appropriate.

9. COMMUNITY SERVICES REDESIGN - FUTURE MODEL OF CARE, IMPLEMENTATION AND NEXT STEPS **Appendix C (Pages 35 - 44)**

The Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) submit a report describing the Community Services Redesign project to date, setting out the future model that the CCGs will commission, describing what impact that will have on the care people receive and what that will mean to other parts of the health and care system in Leicester, Leicestershire and Rutland, as well as the next steps in the CCGs' work on community health services. The Commission is recommended to consider the report and comment as appropriate.

10. WORK PROGRAMME **Appendix D (Pages 45 - 46)**

The current work programme for the Commission is attached. Members are asked to consider this and to make comments and/or amendments as considered necessary.

11. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 4 JULY 2019 at 5:30 pm

P R E S E N T :

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

Councillor Chamund
Councillor March
Councillor Dr Sangster
Councillor Westley

In Attendance:

Councillor Dempster, Assistant City Mayor - Health
Councillor Joshi
Councillor Khote
Councillor Solanki

Also Present:

Councillor Clair, Deputy City Mayor -
Culture, Leisure, Sport and Regulatory Services
Councillor Nangreave
Councillor Valand
Councillor Whittle

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1. APOLOGIES FOR ABSENCE

No apologies for absence were received

2. DECLARATIONS OF INTEREST

No declarations of interest were made.

3. CHAIR'S ANNOUNCEMENTS

The Chair noted that local media recently had covered proposals for future

services at Leicester hospitals and explained that these would be considered under agenda item 11, “Introduction to the NHS Long Term Plan”.

4. MINUTES OF PREVIOUS MEETING

AGREED:

that the minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 12 March 2019 be confirmed as a correct record.

5. TERMS OF REFERENCE FOR SCRUTINY COMMISSIONS

AGREED:

That the Terms of Reference for scrutiny commissions be noted

6. MEMBERSHIP OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

AGREED:

That the membership of the Health and Wellbeing Scrutiny Commission for 2019/20 be noted.

7. DATES OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION MEETINGS

AGREED:

That the dates of meetings of the Health and Wellbeing Scrutiny Commission for 2019/20 be noted.

8. PETITIONS

The Monitoring Officer reported that no petitions had been received.

9. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations, or statements of case had been received.

10. PRIMARY CARE HUB ACCESS AT THE MERLYN VAZ HEALTH AND SOCIAL CARE CENTRE

The Leicester City Clinical Commissioning Group submitted a briefing paper looking at the rationale and impact of moving from a walk-in appointment system to a combined pre-bookable and walk-in appointment system at the Merlyn Vaz Heath and Social Care Centre.

Richard Morris, Director of Corporate Affairs, Leicester City Clinical Commissioning Group, introduced the briefing paper, drawing attention to the following points:

- The Merlyn Vaz Centre received 24,000 – 26,000 patients per year.

Approximately two-thirds of these were from the city, the remainder being from the county and Rutland;

- When it was set up, it had been anticipated that operating a walk-in appointment system at the Centre would reduce demand on the hospital emergency department, but the number of people attending that department continued to increase;

- Three GP hubs had been established to improve routine access to pre-booked primary care appointments by providing an additional 1,500 additional GP and nurse appointments across the city. These were well used;

- At the time that the walk-in centre contract was due to end in 2017, government guidance indicated a move towards providing pre-booked appointments, rather than a walk-in service;

- Engagement with patients showed a desire to keep the service in the community, but also a desire for pre-bookable appointments in addition to a walk-in service. The new service therefore was commissioned as a hybrid model, with approximately 20% walk-in activity. This equated to approximately 400 bookable appointments and 100 walk-in appointments per week;

- A decreasing number of patients had been deflected from the "front door" over the last 6 – 12 months;

- Most patients regarded the service received in the hub as "good", although there was some frustration that the walk-in facility had been reduced; and

- The new hybrid system appeared to have resulted in a better dispersal of patients across the city.

At the invitation of the Chair, the Right Honourable Keith Vaz MP addressed the Commission. For clarity, he explained that the Merlyn Vaz Centre had been named after his mother and that Professor Farooqi, Co-Chair of the Leicester City Clinical Commissioning Group, was his GP.

Mr Vaz noted that, when people were unable to see their own GPs in a timely manner, the walk-in centre provided an alternative means of accessing health care. It was recognised that funding for services had been reduced, but as the walk-in centre was intended to provide an alternative means of accessing a GP to introduce an appointments system was against the purpose of the Centre. Lack of walk-in facilities also meant that patients were diverted to hospital Accident and Emergency services, so moving the problem of access to services to a different part of the system. This showed that the current balance of appointments and walk-in services at the Centre was wrong.

Mr Vaz asked the Commission to consider undertaking its own survey, to identify what people were looking for from GPs and GP hubs, and offered to

help run a local referendum, with the Ward Councillors, to identify if there was a desire for the Merlyn Vaz Centre to return to being a walk-in centre.

In response, Mr Morris explained that the survey undertaken to assess the impact of the change in services at the Merlyn Vaz Centre had largely been face-to-face with people in the building and patient participation groups. There had been 258 respondents, which was considered a normal rate of response for this type of engagement work.

Mr Vaz queried why the results had been given in percentages, rather than actual numbers and sought reassurance that the questions used in the face-to-face discussions had not been designed to provide a particular result.

Professor Farooqi, Co-Chair of the Leicester City Clinical Commissioning Group, expressed the view that both walk-in and appointment services were needed at the Centre, as the hubs provided services for GP practices, due to the city not having enough GPs. Bookable appointments resulted in a better flow of patients, with less waiting time and a levelling out of peaks and troughs in demand.

Professor Farooqi also noted that booked appointments catered for city residents, while a lot of the people using the walk-in facilities lived in the county. Ideally, both facilities would be provided, but it was recognised that resources were limited.

Mr Morris advised Members that no evidence had been found of an increase in the number of people attending hospital Accident and Emergency services as a result of reducing the walk-in service, but an audit of people attending these services was being undertaken and could provide more information. Professor Farooqi noted that some correlation was possible to people who had recently arrived in the country, as some countries had limited GP services, so people were used to using hospital services. Also, it was known that homeless people would attend hospital as they often were not registered with a GP. It also was know that people in the 0 – 30 age group used hospital services the most.

Mr Morris advised that currently no follow-up was done on people deflected from the services at the Merlyn Vaz Centre. However, the service provider had been asked to examine the data and undertake a retrospective audit over the next few months, to see if any links could be found between the number deflected and use of other services. As part of this, the advice given to those deflected needed to be noted, so that an accurate audit trail could be established.

Sarah Prema, Healthwatch, advised that Healthwatch had visited two hubs to date, to examine patient experiences of services. These experiences had been mixed, with good clinical care, but some confusion caused by a lack of awareness of the change to a hybrid access model. Healthwatch hoped to visit the other two hubs shortly, so offered to assist in assessing the impact of the change to a hybrid system.

Mr Vaz suggested that it would be helpful for the Commission to undertake an in-depth review, through which local people were asked whether or not they liked the walk-in facility at the Merlyn Vaz Centre. He also requested that community languages be used for this. Professor Farooqi suggested to the Commission that, although he did not oppose the suggested survey, some work also could be done to develop services at Leicester General Hospital, so that both systems could be used.

Members stressed that any such review needed to reflect the demography of the city and expressed some concern that the number of responses on which the decision to move to a hybrid system had been based was a very small proportion of the city's population.

Mr Vaz also expressed concern about the future use of Leicester General Hospital. He explained that he considered that the city needed three hospitals, although they did not all need to offer the same services. Reports already were being received that people had to queue to be admitted to some wards at Leicester Royal Infirmary, so Mr Vaz asked that the site of Leicester General Hospital be retained and not sold to developers.

With the permission of the Chair, Councillor Khote addressed the Commission, echoing concerns raised by the Commission that the shortage of GPs across the city was at crisis level. For example, no GP appointments were available at some practices by 9.30 am, so people were being told to attend the walk-in centre. However, at the walk-in centre they were being told to telephone the 111 service, but that service often referred people to services located in parts of the city that people could not get to. Many of these people were limited in the amount of English they could speak. They therefore often chose to use the walk-in facilities at the Merlyn Vaz Centre, as the Centre could be accessed by public transport.

She further noted that it took a along time to train doctors, but in the meantime the number of doctors coming in to the country from abroad had been affected by immigration restrictions. In addition, locum doctors were too expensive for some practices to use. The walk-in centre therefore was a very important resource, serving people from a wide area, so it either should be kept, or a better appointment system used at GP surgeries.

With the permission of the Chair, Councillor Solanki addressed the Commission. She concurred with the views expressed by Councillor Khote and suggested that GP appointments needed to be available at times more suited to people's needs, such as at night.

With the permission of the Chair, Councillor Joshi addressed the Commission, noting that the flow of patients using the walk-in service resulted in peaks and troughs of demand. Better resources therefore were needed at GP surgeries, to ensure that people could access GPs when needed. The Councillors representing the Evington Ward would welcome the suggested consultation with members of the public and were happy to assist with this as needed.

Members expressed concern at the potential exclusion of people with lower digital and/or technical skills, due to the increased use in health services of digital access. Professor Farooqi acknowledged that this was an issue, explaining that work on this was ongoing, along with ensuring that people were not excluded due to language skills.

AGREED:

1) That the Director of Corporate Affairs, Leicester City Clinical Commissioning Group be asked to provide numerical and demographic data on where people using hospital Accident and Emergency services in the city are from, if possible this information to be broken down to show attendances at times when GP practices are both open and closed;

2) That representatives of the Leicester City Clinical Commissioning Group and Healthwatch, plus the Right Honourable Keith Vaz MP, be invited to join discussions about how an analysis of patient experiences following the introduction of a hybrid system for accessing services at the Merlyn Vaz Centre can be undertaken;

3) That as much as possible of the work outlined under 1) and 2) above be undertaken in time for the outcomes to be included in the report scheduled to be considered at the next meeting of this Commission on the Primary Care Strategy; and

4) That, further to 3) above, the report scheduled to be considered at the next meeting of this Commission on the Primary Care Strategy include if possible:

   a) Consideration of the implications of the shortage of GPs in the city;

   b) Information on how the survey undertaken following the introduction of a hybrid system for accessing services at the Merlyn Vaz Centre was undertaken, including examining equality monitoring information, details of who was surveyed and how the questions were worded;

   c) How issues for people with limited digital and English language skills can be addressed;

   d) What happened to the people deflected from using the walk-in facilities at the Merlyn Vaz Centre, (for example, whether they used services located elsewhere in the city); and

   e) Consideration of how any further evidence required to enable proper consideration to be given to the issues recorded above can be obtained.

11. INTRODUCTION TO THE NHS LONG TERM PLAN

As agenda items 11, ("Introduction to the NHS Long Term Plan") and 12, ("The Development of Primary Care Networks"), were considered together, please see minute 12 for the discussion on this item.

12. THE DEVELOPMENT OF PRIMARY CARE NETWORKS

As agenda items 11, ("Introduction to the NHS Long Term Plan") and 12, ("The Development of Primary Care Networks"), were considered together, the discussion on both items is recorded in this minute.

Sarah Prema, Director of Strategy and Implementation with Leicester City Clinical Commissioning Group presented a briefing paper setting out the key requirements of the NHS Long Term Plan (LTP).

Ms Prema reminded the Commission that the LTP contained a vision for how the NHS would develop over the next 5 – 10 years and what it would deliver. Previously, a commissioner and provider model had been used, creating contractual relationships, but the new model moved towards a partnership relationship. The key to this would be to consider services from a Neighbourhood, Place and Systems perspective. For example, Place would help in the consideration of services that could not be delivered economically at a Neighbourhood level and Systems would relate to sets of outcomes based on the health needs of the population under consideration.

MS Prema then drew attention to the following points:

- As part of the LTP, it was anticipated that Integrated Care Systems would be designed and in place nationally by 2021. These would be developed from Sustainability and Transformation Partnerships;

- The first thing that needed to be done under the LTP was to establish Primary Care Networks;

- The draft People Plan had already been published, giving some direction for national initiatives on how recruitment was to be undertaken; and

- In creased use of technology, (digitally enabled care), would be embraced in all aspects of care. For example, it was anticipated that patient follow-up appointments could be reduced by one-third through the use of technology. This would release resources for use in other areas.

Richard Morris, Director of Corporate Affairs, Leicester City Clinical Commissioning Group, then discussed the development of Primary Care Networks (PCNs), showing the presentation attached at the end of these minutes and making the following points:

- PCNs were an element of the Neighbourhood part of the LTP;

- PCNs required groups of GPs to work together, so were not a new idea;

- GPs had been asked to come together in groups of registered populations of between 30,000 and 50,000. The former was a minimum number that would be acceptable, but there was a small degree of flexibility regarding the upper number;

- PCNs were formal arrangements, which they had not been previously, having contracts from Clinical Commissioning Groups to provide primary care;

- All PCNs were required to appoint a Clinical Director and would receive funding for this and other specified roles. It was understood that the Clinical Directors all would be current GPs;

- A number of service specifications would be issued at a national level in April 2020; and

- Ten PCNs had been created across the city. All GP practices were participating.

Members expressed concern that GPs already were unable to cope with the demands being made on them and queried how these changes would improve that situation. In reply, Professor Farooqi, Co-Chair of the Leicester City Clinical Commissioning Group, explained that the aim was to reduce outpatient numbers by 30%. However, these people needed to be seen somewhere else, so PCNs were being designed to have organisational structures that would enable work now being done in hospitals to be done in the community instead. Some services, such as lifestyle services, (for example, smoking cessation), could be tailored to particular areas, as they could be delivered within distinct boundaries.

It was noted that patients would no longer be able to reorder prescriptions from pharmacies, but would have to go through a GP instead, raising concern that this would in crease the burden of work on GPs. In response, Professor Farooqi explained that ordering of repeat prescriptions from pharmacies had led to great wastage of drugs, as many pharmacies reissued every drug on the prescription, irrespective of whether it was needed or not, so this change should reduce costs. When someone's medication was stable and there was no reason to change it, doctors also could consider prescribing six months' medication.

Members also suggested that it would be beneficial to have more nurses in GP surgeries, but Professor Farooqi explained that very few nurses were being trained to go in to general practice, as most remained working in hospitals. Mark Whightman, Director of Marketing and Communications at University Hospitals of Leicester NHS Trust, confirmed this, noting that there currently were 600 vacancies for nurses at the Trust. This was a safe level to work at, but there was no capacity to share nurses outside of the hospitals.

Concern also was raised that there could be a risk of creating a market between PCNs if there was not equity between them in the services provided. However, Professor Farooqi advised Members that funding for specific roles wold not be given if there was no-one in the post(s) to which that funding related. The main problem was likely to be whether there were sufficient people available to fill those roles.

The Commission enquired how much it was estimated the requirements of the LTP would cost and where this funding would come from. It also was questioned who would safeguard community resources when health services were being separated in to distinct parts.

Professor Farooqi advised Members that the NHS had set out plans for a ten-year investment programme in PCNs. As PCNs developed and services moved out of hospital settings, it was anticipated that resources would follow, so that services in the community could develop. Patient Participation Groups would be very important in holding PCNs to account.

The whole system would change, as CCGs and PCNs would work more collaboratively through Care Alliances. These would not be a way to let the private sector take over NHS work, as the emphasis would be on collaboration, rather than testing the market. As funding would be directed to achieving health outcomes, greater levels of funding could be directed to where the greatest health inequalities existed. Many of the targets being set were for 5 – 10 years, which was felt to be helpful, but it also meant that the national expectation that the targets would be met was greater.

Under the LTP, CCGs would have a more statutory role than at present, overseeing the management of the system. As a result of this, discussions were being held to determine whether it was appropriate to continue to have three CCGs for Leicester, Leicestershire and Rutland. Engagement would be undertaken to determine the most appropriate future structure for these CCGs.

Some of the funding for the LTP would be from central government, towards running services locally. It had not yet been decided what proportions of this would be passed to the PCNs and Care Alliances, but care would be taken to ensure that health inequalities were addressed.

The Commission suggested that it could be useful for health service organisations to provide officers, or work with voluntary organisations, to liaise with the community. This could be particularly beneficial in ensuring that people recently arrived in the city did not miss out on health services. Professor Farooqi agreed that this could be beneficial, including instances where staff from a PCN had particular language skills. It was hoped that PCNs would liaise with Councillors, either speaking to them direct or through PPGs. This would be facilitated by the majority of PCNs being geographically continuous.

Work had been done with PCNs with a wider geographical spread to ensure that those networks would work and that patients would not have to travel a

long way to access normal GP services during a normal working day. It was considered that if anyone had to travel it should be the GPs, not patients.

It was reported that patients already were asking how these changes would affect them and their care, especially regarding the changes scheduled to take place later. In reply, Mr Morris explained that it had not been possible to openly discuss PCNs while they were forming. The deadline for their formation had been 1 July 2019, so some restrictions had reduced and it now was possible to answer questions and provide other information.

Members noted that the summary of LTP requirements submitted with the reports were the minimum national requirements, so opportunities were available to add to it. Healthwatch had undertaken some engagement in order to inform the LTP and as this developed responses to the engagement would be incorporated in the schedule of requirements.

Some concern was expressed that dementia and older frailty were not mentioned in the summary, but it was explained that partners saw this as a key area for the city. Work on population health management was ongoing though, which included using data to understand the cohorts of patients who were intensive users of services.

In view of this, the Commission asked how it could help shape the LTP to towards local circumstances . Sue Lock, Managing Director of Leicester Clinical Commissioning Group, explained that there was a need for partners to work closely with Public Health officers to identify local health needs. This would then be reported through the Health and Wellbeing Board. However, consideration needed to be given to how wider input could be incorporated, as the draft requirements had to be ready by the end of September 2019, with the final version being completed by mid-November 2019.

AGREED:

That the Leicester City Clinical Commissioning Group be asked to submit a further report to the Commission, on a date to be agreed, on the NHS Long Term Plan, with particular focus on Primary Care Networks and Care Alliances, this report to include information on:

a) How funding for the Long Term Plan is to be calculated;

b) How Primary Care Networks will operate, (for example, how funding will be allocated and managed);

c) How the geographical spread of Primary Care Networks will be addressed to ensure that appropriate services for patients are provided;

d) How individuals and/or groups can contribute to Sustainability and Transformation Partnerships and Primary Care Networks;

e) How health inequalities will be addressed, especially through

funding;

f) How existing plans and protocols, such as the Winter Care Plan, will be embedded in new systems; and

g) If possible, a graphical representation of the structure of health services, showing what it is in place now and what they will be in the future.

13. ADJOURNMENT OF MEETING

The meeting adjourned at 7.47 pm and reconvened at 7.59 pm

14. PUBLIC HEALTH OVERVIEW AND FORTHCOMING WORK PLANS

Councillor Dempster, Assistant City Mayor for Health, reminded Members that currently there was a move towards community-based provision of public health services. As part of this, a holistic approach was being adopted, moving away from a narrow focus on health, which hopefully also would lead to greater parity between physical and mental health services. The presentation circulated with the agenda papers explained how work on this was beginning and observations from this Commission on this work were invited.

The Director of Public Health introduced the presentation that had been circulated with the agenda for this meeting. He noted that the ring fenced grant received from the NHS had been reducing and it was not know when these reductions would stop. At present, 0.9% of this grant was allocated for Public Mental Health in 2019/20 and Councillor Dempster expressed concern at this low level of expenditure. Members noted that 17.8% of this grant was allocated for "Other council services" in 2019/20. These were services such as sports, walking and cycling which added public health value but mostly fell within the remit of other scrutiny commissions.

The Director drew Members' attention to the work done by Mori, on the Council's behalf, to identify how Leicester residents rated their health. This had identified that 75% had rated their health as good in 2018. This was an improvement, but some significant challenges remained to be addressed. There were various determinants of health, some of which were lifestyle factors. However, it needed to be recognised that these factors were not always choices, as people could be driven in to situations. Consideration therefore needed to be given to how this could be addressed.

Members suggested that this provided an opportunity to work alongside primary care networks and asked how this could be achieved. The Director explained that it was hoped that the driver for future strategy would be through the Joint Integrated Commissioning Board. Although much still was unknown about the new structures proposed for primary health care delivery, the new joint health and wellbeing strategy provided an excellent opportunity to work with providers.

The Commission stressed the need for Public Health to work with services such as housing and social care services. The Director explained that this already was underway. For example, Public Health officers were in active conversation with Planning officers regarding standards for internal and external space in relation to housing. This was an example of how the delivery of some public health initiatives would be through other services.

AGREED:

1) That the Director of Public Health be asked to ensure that this Commission continues to monitor how the development of public health initiatives in relation to the development of primary care networks; and

2) That this Commission asks the Assistant City Mayor for Health and the Director of Public Health to consider giving early attention to developing a strategy for how Public Health could impact on housing space standards through the developing Local Plan, it being recognised that this will require evidence to be compiled, including the impact of these standards on mental health.

15. WORK PROGRAMME

The Commission received and considered its outline work programme for 2019/20, noting that this would be developed as the year progressed.

AGREED:

1) That the Chair of this Commission be asked to liaise with the Chair of the Children, Young People and Schools Scrutiny Commission to consider how issues such as education Health Care Plans for children, childhood obesity and children's mental health services can be scrutinised;

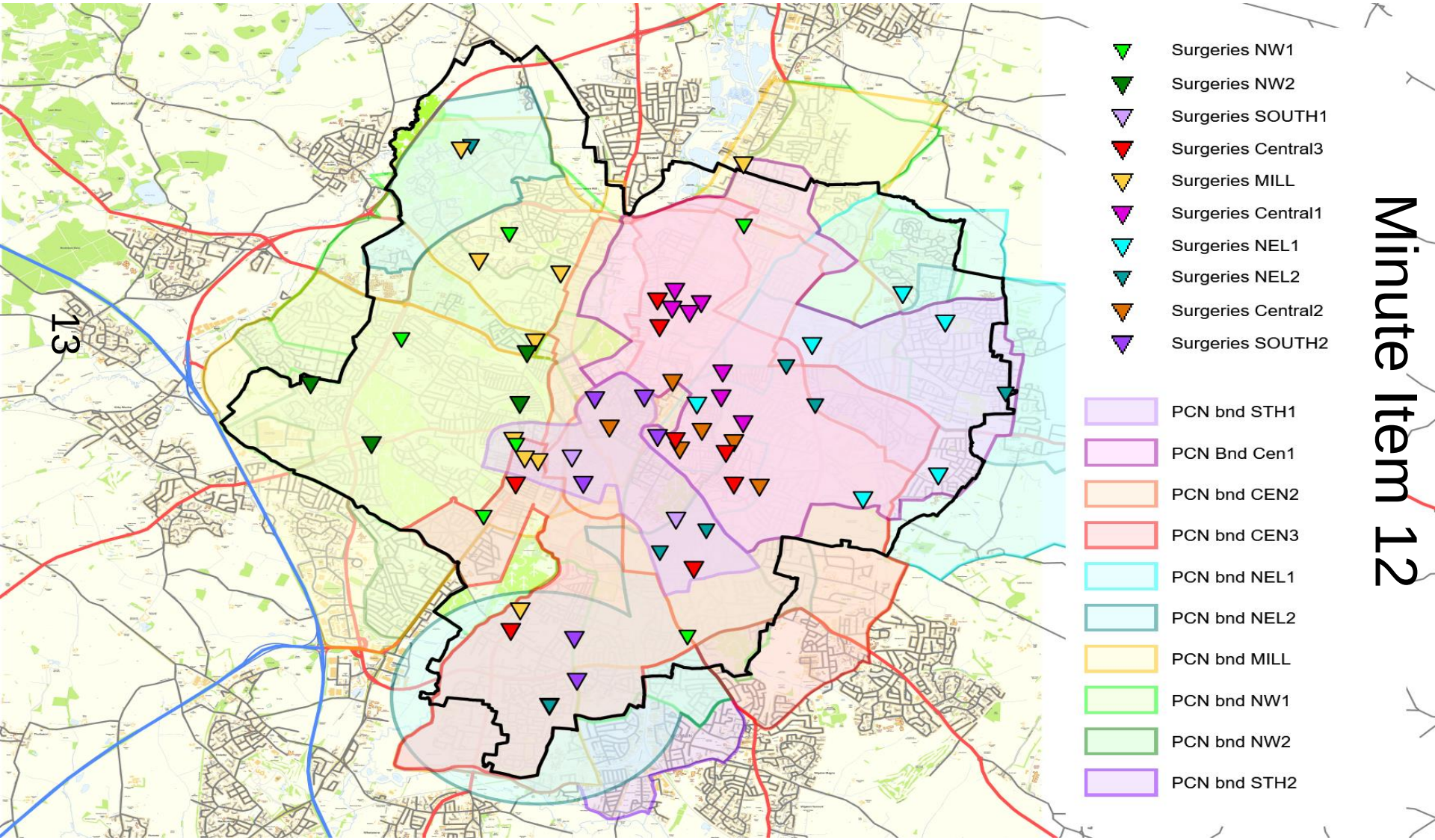
2) That scrutiny of Maternity Services be included in this Commission's work programme; and

3) That all Commission members be invited to advise the Chair, Vice-Chair or Scrutiny Policy Officer of any suggested items for inclusion in the Commission's work programme.

16. CLOSE OF MEETING

The meeting closed at 8.34 pm

Leicester City Primary Care Networks



CENTRAL PCN 1 - Belgrave & Spinney Hill PCN		
Clinical Director - Dr P Pancholi		
Practice Code	**Surgery**	**List Size**
C82037	East Park MC	10,486
C82037	East Park MC -Branch	
C82667	The Charnwood Practice	7,228
C82084	Canon St	3,197
C82024	Spinney Hill MC	20,834
C82024	Spinney Hill MC -Branch	
C82651	Broadhurst Surgery	4,029
Schedule 1	**Registration Form**	**45,774**

CENTRAL PCN 2 - Leicester Central PCN		
Clinical Director - Dr Rajiv Wadhwa		
Practice Code	**Surgery**	**List Size**
C82643	Community Health Centre	12,608
C82116	Highfields Surgery	3,744
C82642	Highfields MC	9,056
C82642	Highfields MC - Branch	
C82080	Shefa Medical Practice	4,769
C82060	Sayeed Med Centre	4,230
Y02686	Heron Practice	9,193
Y02469	Bowling Green Street	4,451
C82105	Ar-Razi	3,007
Schedule 1	**Registration Form**	**51,058**

CENTRAL PCN 3 - The Fox's PCN		
Clinical Director - Dr Vivek Sharma		
Practice Code	**Surgery**	**List Size**
C82659	Dr Kapur - St Peter's	2,684
C82119	Dr Kapur - Narborough Road	2,153
C82671	Dr Kapur - Brandon Street	5,000
C82088	Evington Medical Centre	8,953
C82088	Evington Medical Centre - Branch	
C82099	Al-Waqas	4,239
C82660	Dr D'Souza -St Peters	6,389
C82660	Dr D'Souza -Queens Rd	
C82669	Dr Sahdev - Surgery @ Aylestone	4,080
Schedule 1	**Registration Form**	**33,498**

NEL PCN 1 - SALUTEM PCN		
Clinical Director - Dr Aileen Tincello		
Practice Code	**Surgery**	**List Size**
C82031	Johnson MP	12,721
C82031	Johnson MP - Branch	
C82030	Downing Drive	6,932
C82033	Humberstone MP	10,289
C82676	St Elizabeth's	5,513
Schedule 1	**Registration Form**	**35,455**

NEL PCN 2 - Aegis Healthcare PCN		
Clinical Director - Dr M Roshan		
Practice Code	**Surgery**	**List Size**
C82029	Willowbrook	12,257
C82029	Willowbrook - Branch	
Y00137	The Willows	5,697
C82122	Clarendon Park MC	5,396
C82063	East Leicester MP	12,066
C82623	Heatherbrook Surgery	3,441
C82626	Pasley Road HC (Dr Khong)	2,247
Schedule 1	**Registration Form**	**41,104**

MILLENNIUM PCN		
Clinical Director - Dr Durairaj Jawahar		
Practice Code	**Surgery**	**List Size**
C82018	Manor Park Medical Practice	16,011
C82018	Manor Park Medical Practice - Branch	
C82094	Beaumont Lodge Medical Practice	6,906
C82094	Beaumont Lodge Medical Practice - Branch	
C82620	Briton street surgery	1,855
C82059	Westcotes Surgery 1	1,485
C82653	Westcotes Surgery 2	1,457
Y03587	Westcotes Medical Centre	6,504
C82107	Brandon Street Surgery	7,350
C82639	Westcotes Health Centre 2	5,982
C82092	Aylestone Health Centre	3,421
Schedule 1	**Registration Form**	**50,971**

City Care Alliance PCN (NW PCN 1)		
Clinical Director - Dr Umesh Roy		
Practice Code	**Surgery**	**List Size**
C82073	Merridale MC	14,938
C82610	The Parks	5,723
C82114	Fosse Family Practice	2,428
C82624	Beaumont Leys HC	6,730
C82614	Asquith Surgery	4,095
C82680	Spirit Rushy Mead	4,675
Schedule 1	**Registration Form**	**38,589**

Leicester Health Focus (NW PCN 2)		
Clinical Director - Dr Hafiz Mukadam		
Practice Code	**Surgery**	**List Size**
C82008	Oakmeadow Surgery	8,980
C82005	Groby Road MC	9,437
C82086	Fosse MC	8,931
C82053	Hockley Farm	10,846
Schedule 1	**Registration Form**	**38,194**

SOUTH PCN 1 - Leicester City & University PCN		
Clinical Director - Dr Aruna Garcea		
Practice Code	**Surgery**	**List Size**
C82020	De Montfort University	22,379
C82124	Victoria Park HC	22,855
Schedule 1	**Registration Form**	**45,234**

SOUTH PCN 2 - Leicester City South PCN		
Clinical Director - Dr Amit Rastogi		
Practice code	**Surgery**	**List Size**
C82046	Saffron Health	17,803
C82046	Saffron Health - Branch	
C82100	The Hedges MC	6,013
C82019	Pasley Road (Dr Singh)	4,844
Y00344	Assist	1,230
C82670	Inclusion Healthcare	1,014
C82662	Walnut Street MC	4,513
Schedule 1	**Registration Form**	**35,417**

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

NHS

Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary Care Strategy

A partnership between:

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

Version Control

Version Number	Date	Author	Details of Update
1	24 May 2019	Tim Sacks	
2	28 May 2019	Tim Sacks	Working group input on design and layout
3	31 May 2019	Tim Sacks	Submissions inserted
4	7 June 2019	Tim Sacks/ Paula Vaughan	NEW DRAFT sent for comment.
5	13 June 2019	Tim Sacks/ Paula Vaughan	NEW DRAFT post GBs
6	14 June 2019	Tim Sacks/ Paula Vaughan	Final Draft
7	20 June 2019	Tim Sacks/ Paula Vaughan	Final Draft post PCB

Approval

Date	Name	Position
18 June 2019	Primary Care Board	Chair- Dr Ursula Montgomery
20 June 2019	System Leadership Team	Chair- Dr Peter Miller
20 June 2019	Commissioning Collaborative Board	Chair- Prof Mayur Lakhani

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List of Tables and Figures

List of Abbreviations

BCT	Better Care Together
City CCG	Leicester City Clinical Commissioning Group
DES	Directly Enhanced Service
ELR CCG	Leicester City Clinical Commissioning Group
GP5YFV	General Practice Five Year Forward View
HEE	Health Education England
ICS	Integrated Care System
IM&T	Information Management and Technology
INT	Integrated Neighbourhood Team
IUC	Integrated Urgent Care
LDR	Local Digital Roadmap
LLR	Leicester, Leicestershire and Rutland
LTC	Long Term Condition
NHS	National Health Service
PCCC	Primary Care Commissioning Committee
PCN	Primary Care Network
RSS	Referral Support Service
SCR	Summary Care Record
STP	Sustainability and Transformation Partnership
WL CCG	West Leicestershire Clinical Commissioning Group

1 Executive Summary

In this chapter

- General Practice is the foundation of strong health and social care
- In LLR General Practice is evolving successfully to meet patient needs
- The development of PCNs is a real opportunity for improved sustainability
- Working with GPs, stakeholders and patients we will further develop this plan

1.1 The Evolution of General Practice

The Architecture of the NHS is changing. There is a tangible move away from the transactional necessity of the internal market that creates organisational silos, towards vertical integration that facilitates care alliances to focus on prevention as well as mental and physical wellbeing. Primary Care and the development of Networks designing and delivering services for their population is at the heart of this transformation.

To achieve this aim, General Practice in its current form will need to evolve to meet the challenges of changing health needs and the development of new models of delivering care. A wider reaching strategy is now required to stretch beyond the boundaries of individual practices and better address the current challenges.

"If General Practice fails, the whole NHS fails"...(*Simon Stevens, 2016*)

1.2 Building on success

The drive towards delivering new models of Primary care in Leicester, Leicestershire and Rutland (LLR) began prior to the publication of the General Practice Five Year Forward View (GP5YFV), but the focus and finance this policy introduced galvanised our system to produce our Blueprint for General Practice in 2017. This strategy clearly states that strong General Practice and Primary Care services are essential if we are to have a high quality and responsive NHS, fit for the future.

The resulting acceleration in development and delivery of new models of care, improved access and workforce strategy has meant that the Long Term plan and new GP contract are natural steps in the LLR journey towards Primary Care Networks and neighbourhood working supporting improved patient outcomes and an increasingly resilient General Practice.

1.3 Next Steps in Developing this Primary Care Strategy

A clear programme of incremental changes in General Practice service delivery and organisational form will take time that involves clinicians, stakeholders and patients in the design of new models of primary care. This process is complex to implement, especially in light of the developing Integrated Care System (ICS); and for this reason our Primary Care strategy will give a direction and framework from which to build. In LLR we will engage, involve and work together to ensure that the future direction is both deliverable and sustainable.

2 Vision

In this chapter
- Set out the Vision for the future of General Practice Services in the context of a changing NHS
- How we will build on the success of Primary care in LLR
- The ambitions for service improvement and patient outcomes

2.1 LLR Vision, Goals and Principles

The aim of the LLR wide Better Care Together (BCT) partnership is to improve the provision of health care in Leicester, Leicestershire and Rutland by bringing together NHS organisations and other partners, including local authorities, the voluntary and community sector and patients to deliver a better service, more efficiently. This whole system approach towards integration of service delivery and shared outcomes for the population of LLR has its foundations in resilient and effective General Practice.

Figure 1: *LLR's Vision for Better Health Outcomes*

2.2 The Future of General Practice

In LLR we will work together to develop and co-design a resilient and sustainable model in which general practice can thrive. 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 primary care setting. 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 and provide continuity to those most complex patients and co- ordinate the care for the rest of their patient population.

This Primary Care Strategy is an integral component of the LLR Sustainability and Transformation Partnership (STP). The delivery of this strategy embraces the requirements of the General Practice 5 year Forward View and Long Term Plan.

"General practice will be at the core of a revitalised, well-resourced primary and community care sector, which delivers care closer to home, improves health outcomes and supports patients to self-care and lead healthier, more independent lives".
Fit for the Future- A vision for general practice- RCGP 2019

Our vision for General Practice is that it will continue to be the foundation of the health system, maintaining its position as the bedrock of the NHS, retaining its identity and registered list. It will build on these strengths and past successes by working in larger groups to achieve sustainability, as part of wider primary and community teams and in partnership with local authorities, voluntary and community groups across a range of sites, delivering care with improved quality, outcomes and access.

Recognising the importance of continuity of care and building long term relationships with patients, we will support our practices and PCNs to find the best model for individual neighbourhoods and provider development.

Primary care is an integral part of the current drive to develop a modern integrated out of hospital sector, which goes beyond service integration and develops neighbourhood and place-based models of care that consider the needs of whole populations. General Practice will be at the centre of coordinating this care through proactive management of population health, linking and driving service improvement and Patient outcomes.

This strategy sets out our high level commissioning intentions and approach to delivering change over a 5 year period. We want to build on past successes and provide consistently outstanding GP services for our patients. There is a real opportunity to do this now, as part of our whole system transformation.

What we will do next

- Work with Practices and PCNs to ensure they are robust and sustainable, to deliver new models of care at the heart of an ICS
- Enable PCNs to deliver the care their population needs to improve outcomes
- Work closely with patients and stakeholders to co-design support new models of care

2.3 High Level Strategic Aims for Primary Care

By 2023/24 our vision for General Practice will be:
• **Empowering patients and the public**: We will enable patients and carers to play a more active role in their own health and care, involving local communities at Neighbourhood and PCN footprints, in shaping services, giving people greater involvement in GP services.
• **Empowering clinicians**: We will ensure high quality support for innovation and improvement, developing PCNs to allow more rapid spread of innovation, supporting general practice in developing new models of provision, and releasing time for patient care and service improvement.
• **Defining, measuring and publishing quality**: We will improve information about quality of services both to strengthen accountability to the public, clarity on what the public can expect, and to support clinical teams in continuous quality improvement.
• **Joint commissioning**: we will work as a system to develop a joint, collaborative approach to commissioning general practice and PCN level services, with a stronger focus on local clinical leadership and ownership and allowing more optimal decisions about the balance of investment across primary, community and hospital service
• **Supporting investment and redesigning incentives**: we will support a shift of resources towards general practice and PCNs and 'wraparound' community services, developing the new national GP and PCN contract to support the delivery of the Long Term Plan.
• **Managing the provider landscape**: We will ensure that all general practices and PCNs meet essential requirements, responding effectively to improving the quality of care. We will work closely with Acute and Community service providers, enabling feedback mechanisms to and from Primary Care to further improve services.
• **Workforce, premises and IT**: We will work with national and local partners to develop the new and broader general practice workforce, develop improvements in primary care premises and sustain improvements in information technology services and the digital offer for patients.

3 Introduction

In this chapter:
- An introduction to Joint working in LLR
- The formation of our ICS
- Our Stakeholders, Practices and PCNs

3.1 Introduction to Leicester Leicestershire and Rutland

In LLR we formed our Better Care Together Partnership in 2014 Linking, health, social; care and the voluntary sector with the aim of integrating care.

Local health and social care structures offer ideal opportunities for delivering outstanding integrated care. Across LLR we have two main providers one for acute care and one for community, mental health and learning disability services. In addition we have three local authorities providing children and adult social care services. Together we provide care for over a million people with an NHS workforce of 22,000 and a social care workforce of 32,000.

In LLR we have developed a new model of care that is focused on a stronger system of primary and community care connected with specialist care. This is based on an established culture of GP practices working together.

> *"We are developing the NHS so we have the resources and facilities to deliver better, high quality, community-based services."*
> Professor Azhar Farooqi, Chairman, Leicester City CCG

3.2 Our Better Care Together Partners

- **Leicester City CCG (LCCCG)** responsible for commissioning health services in Leicester City to a population of 415,213 with 58 GP practices.
- **East Leicestershire and Rutland CCG (ELRCCG)** responsible for commissioning health services in East Leicestershire and Rutland to a population of 321,188 with 30 GP practices.
- **West Leicestershire CCG (WLCCG)** responsible for commissioning health services in West Leicestershire for a population of 397,441 with 48 GP practices.
- **University Hospitals of Leicester (UHL)** responsible for delivering the majority of acute services for Leicester, Leicestershire and Rutland patients.
- **Leicestershire Partnership Trust (LPT)** responsible for delivering all-age community services and mental health care and learning disability services in Leicester, Leicestershire and Rutland.
- **East Midlands Ambulance Service NHS Trust (EMAS)** who provide emergency transport.
- **Leicestershire County Council** an upper tier authority responsible for commissioning and providing social and population and public health services to residents of Leicestershire.
- **Leicester City Council** an upper tier Unitary authority responsible for commissioning and providing social and population and public health services to residents of Leicester City.

- **Rutland County Council** an upper tier Unitary Authority responsible for commissioning and providing social and population and public health services to residents of Rutland.
- **Derbyshire Health United (DHU)** provide a range of urgent care and general practice services across the system.

3.3 Our System Geography

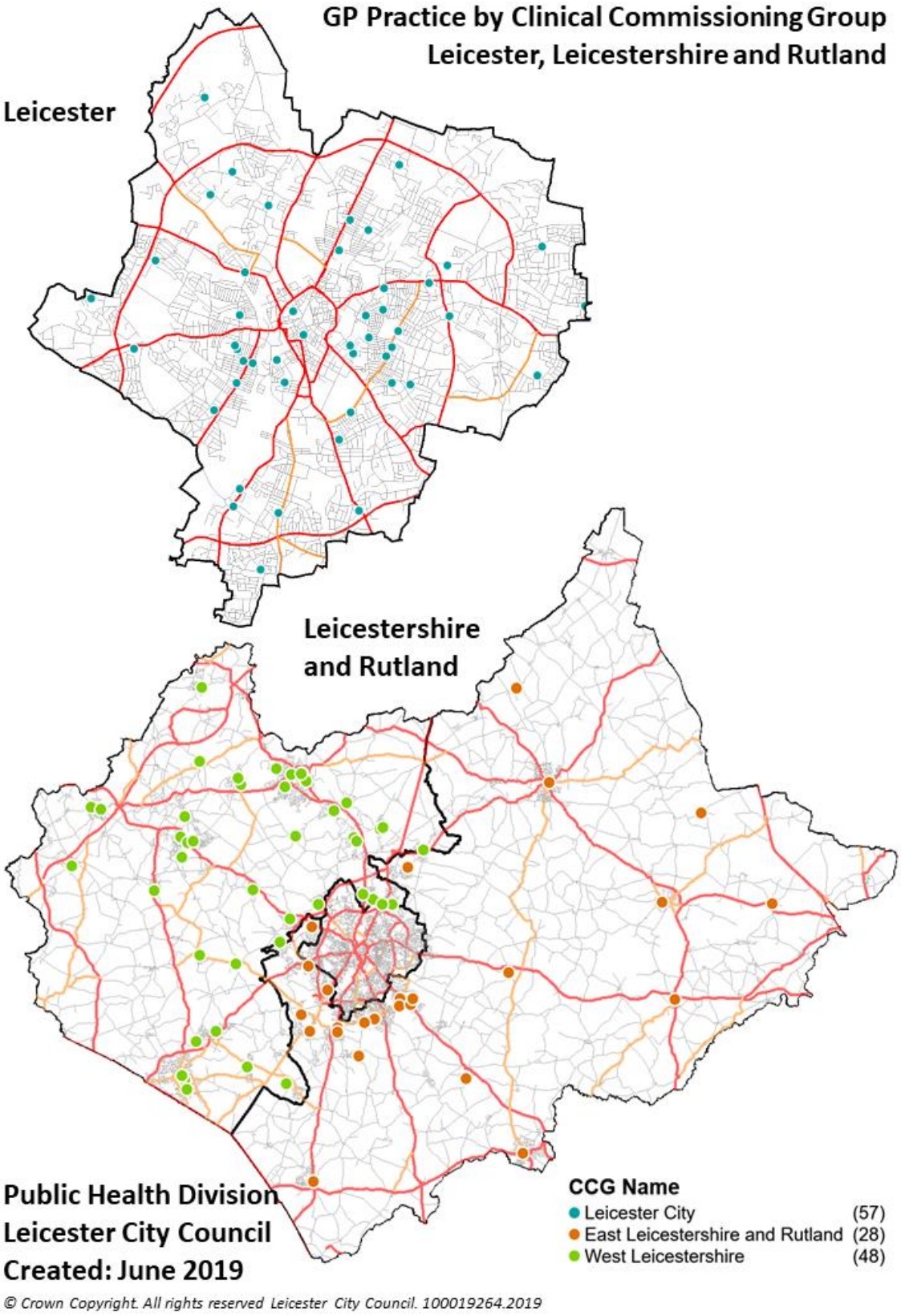
The LLR ICS is designed to operate at 3 levels which enables the right level of delivery for each aspect of service:

- Primary care networks will deliver integrated services to people in 'neighbourhoods', as the foundation of an effective health system
- In 'places' (Local Authority boundaries), primary care will interact with hospitals, community providers and local authorities, working together to meet the population's needs
- As a system, which covers the entire geography of the ICS and all three local authorities

***Figure 2**: Map of LLR including Upper Tier Local Authority and CCG Boundaries*

Within this geography are 136 practices (Figure 3) that have formed into 25 PCNs (Appendix 1) within LLR. These PCNs offer 100% coverage of LLR practices and are situated within local authority boundaries.

***Figure 3**: Map of GP Surgeries in LLR*

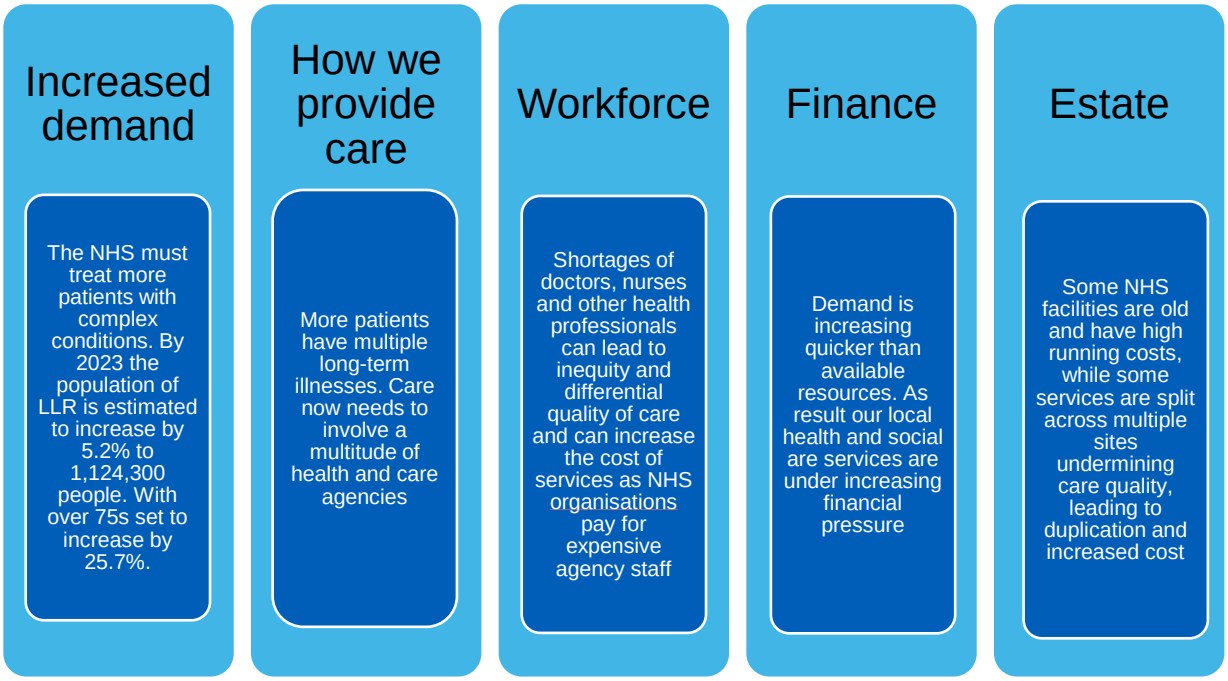


4 The case for change

In this chapter:

- Outline the challenges that face the NHS
- The difference in demographics across LLR and the impact for health service delivery
- Workforce inequity and need for local solutions
- Variation within primary care and the need to support improvement in quality and outcomes

4.1 Key System Challenges



4.2 The Local Landscape—Demographics

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 local needs and demands. Across the Leicester, Leicestershire and Rutland STP area we have a total population of 1,114,316 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.

Leicester City (LCCCG) 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. There are greater inequalities in accessing care and clinical outcomes than many parts of the two counties in LLR.

In both East Leicestershire and Rutland (ELR CCG) and West Leicestershire (WL CCG), the number of patients over the age of 65 is 21% and 19% respectively against a national average of 17% where demand for services significantly increases coupled with the challenge of rurality, creating demand for home visiting.

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.
- **Reducing the variation in health outcomes**—there is a considerable difference in health outcomes across LLR. 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.
- **Reducing premature mortality**—premature mortality across LLR is caused by cardiovascular disease, respiratory diseases, cancer and liver disease. 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.
- **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%.
- **Improving mental health outcomes**—There is a difference in mental health need and prevalence. East Leicestershire & Rutland and West Leicestershire CCG areas have high levels of dementia, where Leicester City have comparatively high levels of psychosis. All have high levels of depression compared with prevalence expectations.

4.3 Population Growth

There are well developed housing development plans across each of the 7 district councils and three Local Authorities up until 2035, set out in Leicester and Leicestershire's Strategic Growth Plan. New housing growth rises to over 112,000 within 30 years. This will have a significant impact on the demand for health and care services, as well as the location and configuration of community based services and facilities.

4.4 Challenges for General Practice

4.41 Demand
Primary medical care is 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 2015 people with LTCs (29% of the population) accounted for over 50% of all GP appointments.

4.4.2 Workforce- National Context
The current national workforce challenges within the NHS and social care are well known. It is anticipated that over two million new workers will need to be recruited and trained into the health and social care sector as the sector grows and current staff retire.

This is the equivalent to over half of the existing workforce and presents some key challenges for training and staff retention. (UKES – Sector insights: skills and performance challenges in the health and social care sector. May 2015)

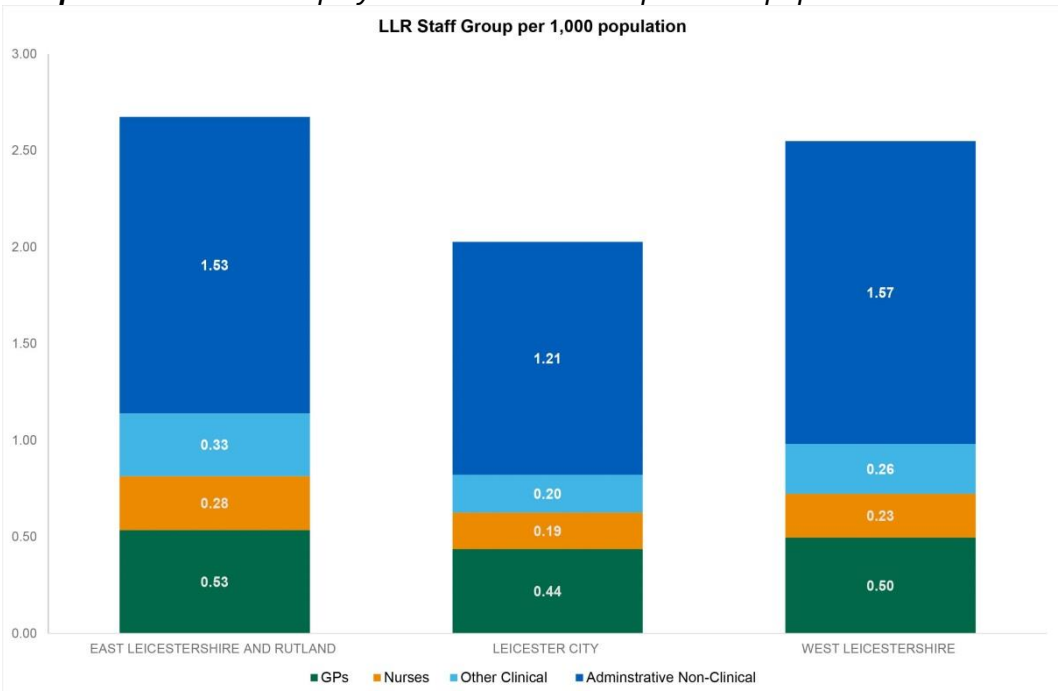
In a climate of years of relative under-investment in primary medical care, there are significant workforce issues with a 15% drop nationally in the numbers coming into GP training, over 50% of GPs under 50 years of age considering leaving the profession in the next five years, and the move away from 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.

> *"The transformation of the NHS must be underpinned by a credible and coherent strategy for improving health and care. Emphasis should be placed on reforming the NHS from within, drawing on the intrinsic motivation of staff delivering care"*
> (Ham, C: 2014- Reforming the NHS from within Beyond hierarchy, inspection and markets-Kings Fund)

4.4.3 Workforce- Local context

The 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 plans need both to support our practices in the day to day delivery of core services, and to bring about transformational change. As a system we acknowledge that each of our three CCGs is at different stages which pose challenges to achieve a broadly consistent approach. There are however real differences in workforce numbers and age profiles, especially between Leicester City and the two Counties.

***Graph 1**: WTE Staff employed within each CCG per 1000 population*



This workforce data is in the context of the national target for WTE GPs set by NHSE in September 2017 of 639, which equates to 0.58wte PER 1000 patients.

In addition, the age profiles of clinical staff in LLR illustrate an ageing workforce. This is no different from the national profile, but of most concern is that the registered nursing workforce have greater than 35% over the age of 55 and for GPs there is a higher proportion of partners in the older age brackets.

4.4.4 Resilience
Our plan needs to support our practices in the day to day delivery of core services, and to bring about transformational change. Across LLR there are 136 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. This leads to a level of vulnerability that needs to be managed early.

4.4.5 Quality and Outcomes in General Practice
It is well known that there are variations in many aspects of healthcare and clinical work. There is a general acknowledgement that good practice is not adopted everywhere. There will always be some variation in General Practice due to the complexity of variables that produce it (for example, characteristics of the individual patient, complexity of disease or unpredictability of symptoms). Such variation is reasonable and, even expected. However, the unwarranted variation in healthcare is the area that requires addressing.

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. With the development of PCNs and new models of care, the CCGs will need to adapt and work collaboratively with providers to ensure the improved outcomes of our patients are met.

4.5 Planning for the Future

In LLR we recognise that there are real differences in the geography, workforce, estate and clinical outcomes that create inequality. Through this planning process and future engagement with patients, practices and stakeholders, we will build on the success of General Practice and deliver improvement to all service users, whilst reducing inequality of access and outcome.

What we will do next

- Through greater understanding of the risks to General Practice and Primary Care services-work to co-design a fit for purpose model of care to support patients, practices and the system
- Address the workforce inequalities with a renewed strategy to create opportunities within the system
- Develop a strategy for the recruitment and retention of the Primary Care MDT, including practice nurses, pharmacist and clinical associates
- Work with patient groups to support a partnership approach to how care is delivered and accessed.

5 General Practice- The Cornerstone of the NHS

In this Chapter
- A focus on the new models of integrated working in Primary Care
- The delivery of the key elements of the GP5YFV, especially workforce planning
- Need for new modern estate for PCNs to thrive
- The drive for constant Quality improvement
- The benefits of PCNs on system delivery and General Practice resilience

5.1 Context

Primary medical care is the foundation of a high performing health care system and as such is critical to the successful implementation of the move towards an ICS. Ensuring the development and resilience of Primary Care will assist in bringing about the system-wide transformation required to focus on prevention and population health management. In LLR we have placed General Practice at the heart of a coordinated model of care, supported by integrated locality teams with the focus on a patients' journey always being "home first" rather than hospital. This approach supports improved patient outcomes and allows a localism, which recognises the fact that there are now 25 new PCNs with distinct communities, with differing geographical, political, social and economic environments, and differing health and care needs.

> *"The NHS is more than 70 years old – we all want it to be around in another 70 years and beyond. That will only happen with a strong, robust and sustainable general practice at its heart, delivering care free at the point of need, to future generations of patients."*
> Professor Helen Stokes-Lampard- Chair RCGP

5.2 A Model for General Practice

Our model is based on the GP as expert clinical generalist working in the community. 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.

To meet the reasonable needs of patients, now and in the future, the model of delivery has started to adapt. The evidence shows that patients with complex needs, whether this is a Long Term Condition (LTC), mental health or frailty, requires a co-ordinated package of care that will require care planning, regular pro-active interventions and support.

This care is best provided by a multi-disciplinary team with the GP acting as the care co-ordinator for the most complex or vulnerable patients. This adaptation of how care is provided has been commissioned through transformation funding and existing incentives. The learning from these schemes has been used across LLR to support commissioning for population health.

5.3 Delivery of the Five Year Forward View

In the two years since LLR published the "Blueprint for General Practice" ,a response to the challenge set by the publication of the GP5YFV (Appendix 1), we have worked together to develop and co-design a resilient and sustainable model in which general practice can thrive. The LLR plan for the continued delivery of the GP5YFV, which complements this strategy is detailed in our local Memorandum of Understanding delivery plan.

The new model of General Practice services now being developed through PCNs, 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. Fundamental in moving towards this new model of care are the developments in the following areas;

5.3.1 Workforce and Training
It is clear that these new models of working and potential workforce shortages will require a change in planning. This involves, not just supporting the existing primary care workforce to improve recruitment and retention but equally important to identify new capabilities, competencies, skills and behaviours required to deliver an enhanced primary care offer.

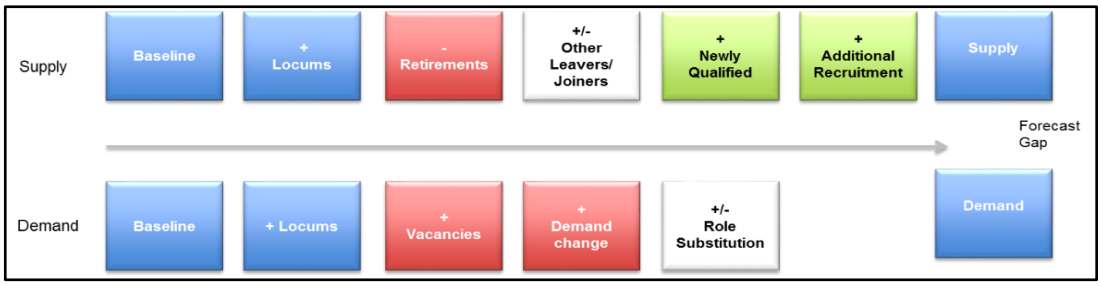
In LLR we have identified and put into place a recruitment and retention plan and recognised the need for new staff groups. The Long Term plan recognises this need and by 2023/24 there will be more than £16m of new funding for additional roles. This funding will support LLR's share of the 20,000 additional staff detailed in the new GP contract and equates to up to 11 new clinical team members per PCN (based on 50,000 patients).

The impact of these new roles has been fed into the LLR workforce modelling tool, the impact of which can see in the following section.

5.3.1.1 Modelling Tool
The LLR GP Workforce group have been working closely with the HEE team from Midlands and East in using local tools to model primary care workforce supply and demand over the coming 5 years. This model (Table 1) assists with forecasting the following:

- The supply of General Practitioners (GPs) and practice nurses
- The gap in supply of GPs and practice nursing staff under chosen demand and supply assumptions;
- Recruitment levels of all clinical staff working in General Practice required to match future demand.
- Developing the capacity and competency of GPN underpinned by the GPN 10 point plan

***Table 1**: HEE Workforce forecasting model*



5.3.1.2 Baseline and Assumptions
Workforce and recruitment is an ongoing process without set timescales, but for the purpose of this plan, the target numbers are set for March 2024 in line with this 5 year strategy.

To cope effectively with the increasing demand in primary care, change will need to take place across the whole General Practice team. Some of the work previously undertaken by GPs will need to be done by others, for example, routine administrative tasks. Key to these assumptions is the impact of the new roles funded through the Primary Care Network DES.

In the following scenario the information used is based on the best evidence available to us.

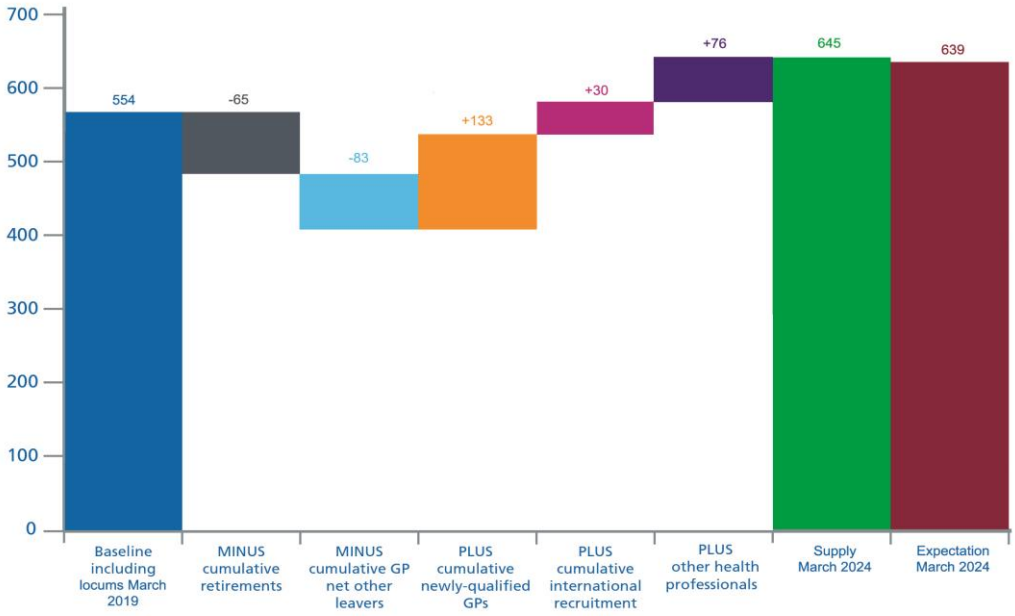
***Table 2**: Workforce Assumptions in LLR*

Leavers and Joiners	Numbers	Total over 5 years	Evidence
Baseline			
Number of WTE GPs in LLR Based at March 2019	554		Based on the workforce returns by practices and 9 sessions being used as a WTE
Leavers			
Current number of WTE GPs over the age of 55 (March 2019)	87	-65	Evidence based on proportion of GPs over the age of 55 who will retire within the next 5 years. Assumption based on 15% over 55 retiring early each year (Figures include the number of GPs currenlty ages 50 or over)
Proportion GP workforce reducing sessions or leaving prior to retirement age	554	-83	GPs reducing clinical sessions or leaving prior to retirement age.Based on 3% reduction per annum
Joiners			
Newly qualified GPs in LLR over the next 5 years	255	133	The number of trainees qualifying over the next 5 years. An assumption has been made that 70% trainees remain in LLR working on average as 0.75WTE
Other recruits due to International Recruitment	30	30	Based on 2019/20 figures of 15 and the same in wave 2 (2020/21)
Other Health Professionals / Role Substitution	230	76	Figure based on the funded clinical posts through the new PCN DES of 10 / 50,000. Using NHSE assumptions these staff would represent a ratio of 3:1 in fulfilling the GP target

This scenario provides a clearer understanding of the demand and supply issues being

faced in LLR, based on the assumptions that can be made. Although this does not answer the problem of where all of the additional staff could come from, it is a very helpful guide in understanding what outcomes the LLR workforce initiatives can achieve if successful and more to the point, the opportunities to meet demands through the opportunities of the PCN DES. It is clear that this is a very difficult challenge and will require a whole system approach to delivery.

***Table 3**: LLR GP Workforce Trajectory*



Key to the development of these staff as well as existing roles is a coordinated approach to training and development, actively utilising the HEEM funded training hubs, support undergraduate medical, nursing and pharmacy training and GP training at a PCN level to promote our practices as positive places to work to aid recruitment and retention.

The delivery of a highly trained workforce to enable the new model of General Practice to be realised is only possible through system collaboration. LLR has a dynamic and responsive programme co-ordinated and held to account through the Local Workforce Action Board.

In LLR we will redevelop our workforce plan (Appendix 2), to address both our commitment to develop and deliver system wide solutions and one which addresses the uniqueness of our general practice workforce. To underpin this we will put in place a Workforce Delivery Team to work with our partners, practices and providers to ensure the appropriate staff are employed to support the new models of care.

Key risks to this programme are the success of the recruitment and retention plan for GPs and nurses, especially with the recognised “perverse” incentives of the new NHS pension scheme, the availability of the new clinicians to fill the roles and the PCNs willingness to fund the 30% of their salaries expected within the DES.

5.3.2 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.

We have implemented a programme of support which will seek wherever possible to reduce the pressure in general practice by addressing bureaucracy (for example, prioritising commissioned interventions with the most benefit to patients) 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.

It is anticipated that the move towards working at PCN level and the increase in clinical staff funded through the DES will have a real impact on workload, there are however national initiatives through the GP5YFV and local systems which have been of tangible benefit to practices, examples of which are;

- Productive General Practice. 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.
- 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 interventions that support practice. This has been funded in part through GP5YFV investment to support care navigation and most practices in LLR have benefited from this programme
- 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 is well 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.

5.3.3 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 2019/20 an NHSE ETTF funded primary care estates strategy is underway at practice level collated into PCN footprint. This will provide a detailed baseline, housing growth forecast and PCN level needs assessment, which will enable a system wide long term estates implementation plan, which supports not just the needs for primary care, but planned care in the community. In order to make any future estate developments a reality this will make the case for continued investment in primary medical care estate.

5.4 Wider Primary Care Landscape

Although CCGs currently do not have responsibility for Pharmacy, Optometry or Dental contracts, the services they provide offer a significant opportunity to draw together a more coordinated approach to the out of hospital offer to patients. In particular there is need to draw the skills, expertise and capacity from within community pharmacy services to support patients within their neighbourhood and PCN. This can deliver a genuine solution to support demand for minor ailments and enable patients to access services locally and for longer.

5.5 Quality and Outcomes

There has been significant national focus over the last twenty years on assuring quality within a General Practice setting. This incrementally built from appraisal to CQC via QOF and the national patient survey.

This created a regime of annual inspection, analysis and scrutiny of General Practice performance, which every primary care clinician aspires to achieve.

> *"General practice is at the heart of the UK healthcare system. The scope, quality and innovation in UK primary care is recognised internationally. The challenge of improving the effectiveness and efficiency of the service we offer to our patients is continuous and ours to take up, to lead on and to achieve."*
> Quality improvement for General Practice RCGP- 2015

5.5.1 Local Quality assurance

In LLR we have worked in parallel with the national regime to support our primary care providers to understand where there is need for improvement and provided capacity and expertise where necessary. This has come in the form of quality visits, advisory groups and at times parachuting into practice to support at times of crisis.

A new LLR wide primary care quality group (focussing on appropriately trained staff, evidenced-based practice, and improved patient outcomes) is currently being formed to support all practices with information, support and clinical involvement to help improve outcomes, reduce variation and improve process. The impact of this new way

of working should deliver;

- Application of standardised interventions
- Reduction in unwarranted variation
- PCNs taking accountability for improving outcomes
- New quality assurance dashboard for PCNs

In the last few years there have been real advances in developing new ways of delivering healthcare in LLR that meets the needs of the twenty first century. The move towards PCNs and formalised joint working will support the delivery of the NHS Long Term Plan and help to improve patient outcomes.

5.6 Our Future Ambitions Summarised

By 2023/24 our ambitions for Primary Care are:
• PCNs are the corner stone for integrated, patient centred care within the LLR ICS, driving the development and delivery of localised care by integrated teams at a neighbourhood and Place level.
• General Practice with registered lists remains at the heart of the primary care model, offering a comprehensive service to patients based on differential need according to condition and complexity.
• Practices, within PCNs will actively contribute to care being provided around geographically defined populations. This will support the adaptation of planned and unplanned services for patients and act as a catalyst to new models of collaboration.
• A system-wide approach to education, training and research bringing together the current training hubs with Academic partners and HEE to deliver an integrated offer for LLR
• Population health management approach, drives local service configuration and resource allocation.
• 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.
• Patients will be an active part of the ‘practice team’, taking greater responsibility for their own health and wellbeing, to reduce demand.

6 Fulfilling the NHS Long Term Plan

In this chapter
- The role and benefits of PCNs within an ICS
- How the CCGs will support PCN establishment and maturity
- How PCNs are a vehicle for system transformation and delivery of the Long Term Plan

6.1 The Formation of PCNs

Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan. They build on current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Clinicians describe this as a change from reactively providing appointments to proactively delivering care for the people and communities they serve. The networks will have expanded neighbourhood teams which will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and Allied Health Professionals such as physiotherapists, joined by social care and the voluntary sector.

The development of PCNs will mean that patients and the public will be able to access:

- Resilient high-quality care from local clinicians and health and care practitioners, with more services provided out of hospital and closer to home
- More comprehensive and integrated set of services, that anticipate rising demand and support higher levels of self-care
- Appropriate referrals and more 'one-stop shop' services where all of their needs can be met at the same time
- Different care models for different population groups (such as frail older persons, adults with complex needs, children) that are person-centred rather than disease centred

In LLR our practices have formed into 25 PCNs (Appendix 1 provides full detail) ranging in size from 30,000 to 107,000 all with Accountable Clinical Directors in place to lead their development. Once the contract commences on the 1st July 2019, the networks will provide the structure for services to be developed locally, in response to the needs of the patients they serve.

6.2 The Role of PCNs

LLR PCNs will form the fundamental building blocks of our ICS, both at a Neighbourhood (PCN) and Place (Local Authority) level. They will be both a vehicle for localised commissioning and service delivery in the community, but also the means to giving General Practice an even stronger voice within the wider ICS.

PCNs provide the structure on which Primary Care and all other key ICS stakeholders can begin to focus on defined patient populations, working together within agreed frameworks to define and achieve local outcome ambitions.

PCNs will be strengthened by the development of the key enablers around them (estates, IM&T and workforce, finance) and the scale of transformation is reliant on the

maturity of the relationships between General Practice working at scale and their local provider partners.

6.3 Delivery of the Primary Care ambitions within the NHS Long Term Plan

PCNs will ultimately be much wider in their membership than primary care. As PCN teams expand, their multi-agency and multi-specialty make-up will be the catalyst behind real integrated working at a Neighbourhood level.

Underpinned by the GP 5 year contract reform (Investment and Evolution: A five year framework for GP contract reform to implement The NHS Long Term Plan), PCNs will be encouraged to deliver workforce modernisation, joined up integrated care and by working together, take accountability for the delivery of better outcomes for their patients.

By transforming primary care at the heart of local care systems, we will set the foundations for the delivery of each element of The Long Term Plan.

The following six chapters (7 to 12) will describe LLR's plan for this journey focussing on the role of both practices and PCNs and describing the positive impact we envisage for patients and the system as a whole.

6.4 The Role of the CCG in supporting PCN Development

The CCG has a key facilitation role in supporting the emerging PCNs. To date, this has been focussed on the formation of the PCNs, their primary care membership and alignment to key stakeholder services.

In the next year the CCGs will support PCNs to mature into strong provider organisations to deliver not just the core elements of the new PCN contract specification, but to co-design in a new architecture of care alliances services and outcomes for the local population groups that support and enable local delivery according to need. Our vision is to provide the right level of support for PCNs enabling them to develop organically and providing the right environment in which local relationships can form and be strengthened by local accountability. Key to this will be the professional development offer for our 25 Accountable Clinical Directors (ACDs) which will encourage leadership building care alliances through a strong provider network.

What we will do next

- Develop a clear timeline and set of actions for the further development of Primary Care and PCNs
- Work proactively with patients, practices and stakeholders in designing the future intentions.
- Ensure governance structures are setup to support focussed delivery of The Long Term Plan
- Provide clarity on the support for our emerging PCNs from our CCGs
- Develop a commissioning framework that recognises the need for locally driven transformation of service delivery

7 Integrated Primary and 'Out-of-Hospital' Care

In this chapter
- A description of how primary and community care have integrated in LLR
- A vision of the role of both primary care and PCNs within integrated community services
- The role of an integrated out of hospital offer in transferring care safely

7.1 Developments in Integrated Care

The LLR Integrated Community Programme is leading on designing an integrated community offer of care that interfaces with the development of PCNs, and the wider prevention programme. Pathway design and delivery has a strong focus on frailty, multi-morbidity and people with long term conditions and we are developing and embedding a consistent approach across the system that will provide improved care to these patients.

We have made some good progress towards developing an integrated out of hospital model, with some important changes planned for 2019/2020, specifically that involve a closer alignment with PCNs.

The LLR model of care is structured around integrated services delivered at the level of 'place' (local authority) or neighbourhood (Primary Care Network). We have already developed an infrastructure of integrated locality teams, with 11 integrated primary, community and social care teams across LLR meeting regularly to review their population health needs and agree co-ordinated approaches to managing the care of the most complex patients, or those at highest risk of admission.

In early 2019 three early implementer sites were identified to test further operational integration of teams through multi-disciplinary team (MDT) working, at the neighbourhood scale. The purpose of these implementer sites is to embed new ways of working across community, primary care, and social services, and to assess how an integrated approach to health and care supports complex case management at neighbourhood/PCN level.

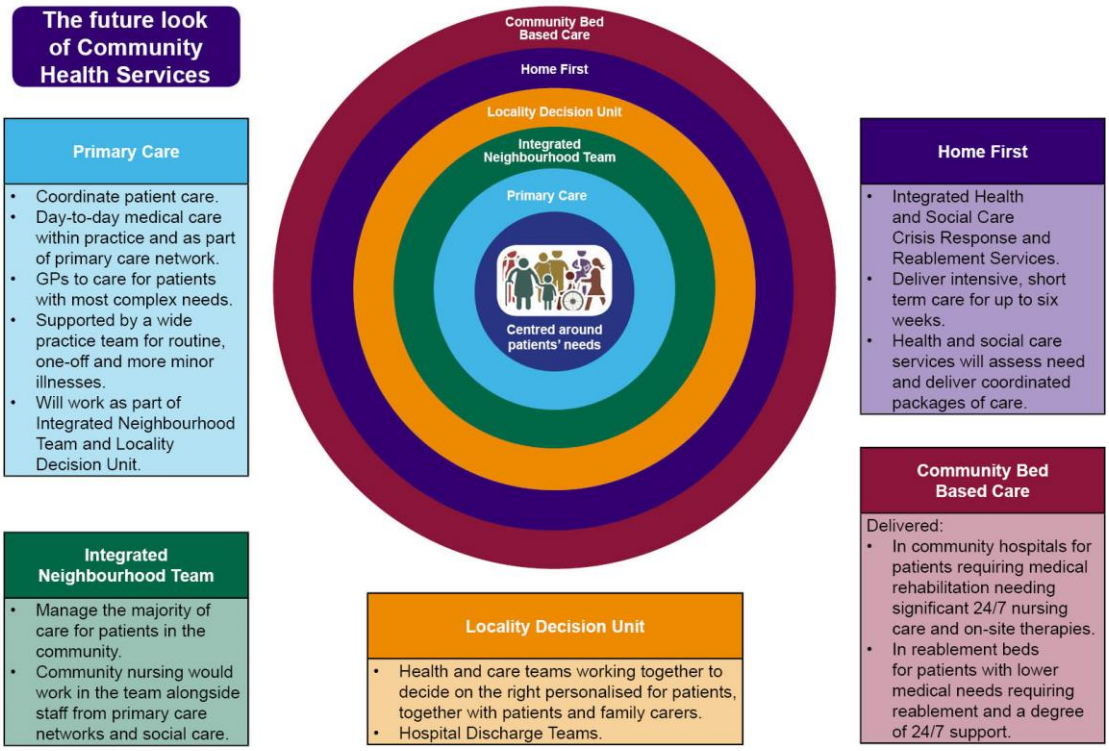
Patients with Long Term Conditions, particularly elderly, comment that good access to a trusted GP or senior nurse whom they know and who knows their condition can make a big difference to their remaining fit and well. Continuity of care with quick access is cited by patients and carers alike as avoiding emergency admissions and helping them to stay independent in their own homes".

healthwatch Rutland

7.2 Immediate Goals (2019/20) and Longer Term Objectives (2023/24)

In 2019/2020 we will put in place a new model of integrated community services. The diagram below (Figure 4) shows how community based integrated services will wrap around primary care across PCN footprints to support patients to stay at home for longer.

***Figure 4**: Primary Care at the Heart of Integrated community services*



The architecture of the mature LLR out of hospital model is based on this wrap-around care concept, with PCNs at its foundations. The aim is to develop integrated neighbourhood teams (INTs) at the same time putting in place integrated crisis response and reablement services providing care for those who need short term intensive or integrated nursing. This 'Home First' objective will be delivered jointly by health and social care teams in each of our local authority areas.

The planned 19/20 changes are only the first step in our 5 year plan to develop out of hospital services. We will invest to increase the capacity of the out of hospital model described, focussing on workforce and organisational development of integrated teams in each PCN.

For example, our strategy is to develop local diagnostic hubs at the PCN/Neighbourhood footprint, which includes capacity in community hospitals, to build on the offer of the PCNs. This will bring together GPs and Secondary Care clinicians alongside social care and the voluntary sector.

7.3 The Role and Impact of Primary Care In Delivery of Integrated Community Care

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
MDTs across community services and social care, supporting patients as individuals	Local prevention and integrated community services offer supporting practices	Support from teams who know them and intensive wrap round offer when crises happen	Community service changes in 19/20 will provide building blocks of integrated care at a neighbourhood level

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
Integrated Neighbourhood Teams will be supported by care co-ordinators and crisis response services	Support for frailty, end of life and long term conditions will lead to better joined up care	Patients with complex physical or mental health needs or multiple conditions will receive co-ordinated care	Commissioning out of hospital care from integrated provider networks
Lead responsibility for population health management, delivering joined up, proactive care for patients	Delivery of more services across PCNs including outpatient and diagnostic	At the end of life better co-ordinated offer through a palliative care triage hub	Devolved delivery and accountability for population health at both neighbourhood and place
Can offer enhanced medical support for patients within a wider MDT		Elective services and diagnostics delivered in community settings	

Our practices and PCNs are at the heart of our integrated community services model. They provide a framework for localised commissioning around a resilient primary care service delivered at scale.

As PCNs develop their structure and capability, the care alliances at a local level will enhance further the level of integration delivered within the community services setting.

7.4 Our Future Ambitions Summarised

By 2023/24 our ambitions for Primary Care within Integrated out of hospital care:
• Better access to timely community based services that support people in their own homes by developing crisis response services.
• Remove the traditional barrier between primary and community services by commissioning community services to deliver integrated team working at neighbourhood level.
• Implementing integrated locality decision units, facilitating access to home based or bed base care, able to respond 24/7.
• Support the development of integrated primary, community and social care teams, with staff members empowered as equals to develop local approaches to meeting the needs of their population.
• Implementation of our enhanced care plan programme across Neighbourhood teams.

8 Planned Care & Diagnostics

In this chapter
- Strong foundations of LLR's community elective programme
- The role that PCNs can play in delivering elective shift into the community
- The plans necessary to deliver planned care in a community setting

8.1 Progress in Developing a Community Planned Care Offer

The relationship between Primary Care and Planned Care is maturing, with PCNs creating a refreshed infrastructure on which significant elective care left-shift into the community can be driven. Local innovations creating improved planned care pathways for patients have paved the way for planed whole system transformation. This work builds on the success of the LLR Alliance, Federations and Primary Care homes.

8.2 Immediate Goals (for 19/20) and Longer Term Objectives (23/24)

The work of the Planned Care team in supporting a move to a greater community offer in 2019/20 is the development of comprehensive Referral Support Services (RSS) to support demand management across key specialties. This is an example of transformational change within primary care, supporting clinicians to access better elective patient pathways.

Future focus will be to model the demand and scale required to ensure increased elective and diagnostic services. The focus will be on what needs to be delivered at a practice level and significantly bolster the offer at PCN level. This will include a minimum offer of diagnostic and planned care services that support a model whereby each PCN can design services with provider partners that will avoid attendance at an acute hospital site.

Aligned to the offer to PCNs is the remodelling of primary care pathways for patient with immediate needs. Examples of plans include the Physio First Contact Practitioner and back pain primary care service, both delivered at PCN/Neighbourhood level and aimed at improving the elective pathway and patient experience. Any drive towards moving activity out of traditional hospital settings will require investment and pathway redesign. This will be facilitated by care alliances across providers with the budgets to support pathway delivery.

8.3 The Role and Impact of PCNs in Delivery of Planned Care

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
Better access to Advice & Guidance to support patient management in the community	PCNs will be the footprint for the left-shift of specialist service pathways	Accessibility to specialist information and support face to face or online	Effective pathways will deliver a robust planned care service with reduced variation
Opportunity to develop practice workforce with more access to specialists	Framework on which a community-based diagnostic offer can be designed and delivered	Accessibility to online advice and support	A system delivering "right place, first time" care

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
Opportunity to enable specialist outpatient and diagnostics services to be PCN based	At scale working enabling sharing of specialist skills to serve a wider Neighbourhood population	A faster response to a specialist referral via the RSS models of elective care	A clinically and financially effective elective care system

The Planned Care offer will support the removal of current organisational boundaries by taking the patient journey from prevention through diagnosis, referral, treatment, discharge or ongoing management in the community.

8.4 Our Future Ambitions Summarised

By 2023/24 our ambitions for Primary Care in delivering Planned care:
• Only patients who need specialist expertise are referred to acute hospital sites , maximising the opportunity to manage elective care in the community and reducing acute activity by a third.
• A uniform PCN planned and diagnostic offer, supporting community pathways.
• All patients will have access to timely therapeutic interventions within their PCN reducing need for specialist or invasive care.

9 Integrated Urgent Care

In this chapter
- A description of the Integrated Urgent Care system in place across LLR
- The role of PCNs in delivering extended access
- The role primary care has within the system to support the urgent care system

9.1 Developments in Integrated Urgent Care

LLR has been an Urgent and Emergency Care Vanguard since 2015, which enabled the development of a sophisticated 24/7 integrated urgent care (IUC) model which aspires to deliver seamless care of patients who enter the urgent care system. Key to the delivery of IUC is a 24/7 telephone based clinical assessment model which supports interoperability with the wider IUC system, electronic record sharing, appointment booking, referrals and prescriptions.

Over the last few years within LLR an enhanced offer by and for primary care offer has been commissioned to support the urgent care system. All 3 CCGs have re-specified and commissioned an extended primary care offer that best fits the needs of the population at a local level. This offers daytime, evening and weekend services that exceed the expectations of the GP5YFV across thirteen separate geographical locations. This will be complimented by full extended hours coverage from within every PCN by July 2019. These services are further enhanced for patients by GP surgeries, Urgent care providers and 111 able to book directly into available appointments, reducing the demand on ED.

> *"Discourses around 'inappropriate' patient demand neglect to recognise that decisions about where to seek urgent care are based on experiential knowledge. Simply speeding up access to primary care or increasing its volume is unlikely to alleviate rising ED use. Systems for accessing care need to be transparent, perceptibly fair and appropriate to the needs of diverse patient groups."*
> (MacKichan et al, BMJ, 2016)

9.2 Immediate Goals (2019/20) and Longer Term Objectives (2023/24)

Our vision is for a highly responsive IUC service that delivers care as close to home as possible and at the point of need, reducing the need for admissions and visits to acute care sites for both physical and mental health crises. PCNs and General Practice has a pivotal role to play in this ambition.

Out of hospital same day emergency care pathways (SDEC) will be used to ensure that patients are only referred or admitted to an acute hospital where this is the best place for their needs. Alternatives pathways that are clinically appropriate in a local setting will be delivered from PCNs where appropriate.

Further integration using the best available IM&T solutions will further enhance the offer for patients. By April 2020 75% (100% by 2021) of all patients will have access to on line consultations through their GP practice or PCN and the ability for 111 and providers to book, where appropriate into available capacity cross the system. This

will further improves access and reduce the demand on ED for primary care related conditions.

Although LLR has already commissioned Extended Primary care access through external providers, meeting the expectations of the GP5YFV, by April 2021 the funding for these services will be transferred to the PCN DES. To ensure full coverage of care for the patients of LLR and a consistent approach, we will work with PCNs to deliver an integrated solution.

9.3 The Role of Primary Care in Delivery of Urgent Care and the Impact

We believe that a fully integrated IUC system with consistency of access, allowing for local variation in the needs of patients across LLR, will make it easier for patients to navigate our system and use alternatives to acute services where appropriate.

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
An integral part of an IUC service with a distinct role for delivering consistent in hours access	Incorporation of the new PCN roles into the MDT team, transforming access to primary care	Ability to in hours access a local primary care system responsive to local patient need	Opportunity to deliver significant capacity at a PCN level
Opportunity to develop an MDT approach to delivering on-the-day access to primary care	The footprint on which key elements of the IUC system, such as some-day emergency services and urgent diagnostics, are commissioned	Access to new online technologies enabling patients to access advice and assessment from home	A strengthened and resilient urgent primary care offer will strengthen the wider IUC system
Integration with the IUC system through online appointments and direct booking to and from providers	Delivery of extended Access services from April 2021	Consistent extended access services from convenient locations	A more accessible consistent IUC offer, reducing pressure on acute services

The strengthening of the local offer of both access to core and extended access services at a PCN or Neighbourhood level will further support the LLR IUC system to offer an even more responsive and personalised service during a crisis.

9.4 Our Future Ambitions Summarised

By 2023/24 our ambitions for Primary Care in delivering Urgent Care:
• We will establish and strengthen SDEC pathways in the community supporting an out of hospital offer that supports primary care.
• By 2023 integration between primary care and our CNH service will be fully developed.
• We will continue to develop the local PCN/Neighbourhood urgent care offer.
• A uniform level of access into primary care and urgent care services in LLR so patients can have available the right care when they need it.

10 The Personalised Care Agenda

In this chapter
- Understanding the need to treat patients as individuals and personalise care
- The role of primary care in helping patients access an entire personalised care offer in the community
- The role of PCNs in understanding their populations' specific needs

10.1 Developments in Personalised Care

The LLR approach to self-care and personalised care is driven by building on the four existing pillars of social prescribing, care coordination, population health management and personal health budgets. This involves a place based (Local Authority) approach to developing this offer and access points. Peronsalised care changes the experience of receiving care for each patient. Their complete needs (mental, physical and well-being) are understood and met by a care system working together.

All three upper tier authorities have developed an offer that harnesses the collective 'assets' of local government and the voluntary sector to provide an interface which all patients can access locally. This social prescribing system recognises that many organisations and individuals have a role in this; some in more generic roles and others more specialist. A comprehensive system is being developed to connect and support cross-agency referrals based on an appropriate redirection principle. There is also been substantial work in train across LLR GP practices with NHS England Active Signposting training. This training has and will support practice staff (including reception) to undertake a social prescribing role within the practice to signpost and refer patients into the existing social prescribing models or specific local interventions.

Although differing models of care coordination are in operation across LLR, the models meet the principles of care coordination and illustrate that within Integrated neighbourhood teams (INTs) care coordinators are currently providing a similar but distinct role to the proposed new social prescribing link workers.

Personal Health Budgets (PHB) and Integrated Personal Budgets are a mainstream funding mechanism across health and social care to give patients greater choice, flexibility and control over how their care and support is provided; and enable them to tailor it to meet their specific outcomes. Personal budgets use existing resource differently, reallocating and devolving commissioning budgets into individual integrated health and social care personal budgets. At present the local priority target groups have been agreed as people flagged for fragility, people at highest risk of emergency admission and people with the greatest health cost.

10.2 Immediate Goals (2019/20) and Longer Term Objectives (2023/24)

Our ambition is to deliver the universal implementation of the comprehensive model of personalised care, which fully embeds the six standard components
- Shared decision making
- Personalised care and support planning
- Enabling choice

- Social prescribing
- Community based support
- Supported self-management

For social prescribing, our strategy is to ensure that primary care networks, have a social prescribing link worker that dovetails effectively with the existing social prescribing 'offer' across LLR. Our longer term our vision is for link workers to be embedded within the social prescribing systems and that the bulk of the 30% of GP appointments where patients attend for non-medical reasons, are directed to appropriate support, ideally before they reach the surgery. We will strive to ensure that there is good coordinating between models of care and social prescribing, avoiding duplication and confusion to patients.

For personal health budgets, work has begun across LLR on a proposed integrated approach between NHS and local authority partners. In 2019-20 the focus is on developing joint principles for consideration within individual organisations' and integrated governance structures. Subsequently a shared strategy will be developed, followed by planning for cultural and technical change, identification of early wins and stakeholder engagement including service users and patients. Subject to the strategy's approval, implementation will take place during the Primary Care Strategy period to 2023/24. The approach will facilitate the achievement of local CCG targets towards the national requirement of 200,000 PHBs by 2023-24, and progression of local authorities' plans for direct payments.

Through the prevention work stream of the STP we will work with primary care to co-design self-management programmes for specific cohorts, including awareness campaigns for healthier living and self-care. Additionally, we will assess and co-design mobile technology to support self-management for specific cohorts.

> *'People want to be treated with dignity and respect. They want their care and support to be coordinated so they only have to tell their story once. They want to be treated as individuals — not as a bag of body parts or problems. They want to talk about their priorities; not necessarily ours. They want to know about their options and what is known of the risks, benefits and consequences of all reasonable courses of action that are open to them. In short, they want to be supported to feel as in control as they would wish"*
> Alf Collins, Clinical Director for Personalised Care, NHS England and Improvement

10.3 The Role of Primary Care in Personalised Care and the Impact this Will Have

Patients will be supported by a full range of personalised services and community assets. In doing so, they will be supported to take control of their own health and care needs to keep them well for longer.

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
Implementation of new non-clinical services within	To understand and work with the local community asset	Supported locally to be accountable for their own health and	A ICS with less reliance on acute services, based on

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
practices to divert workload from clinicians	capacity, providing a link between primary care and community support services	self-care	prevention, self-care and proactive crisis intervention
Enables GPs to spend more time with the most complex patients	Ability to link practices to the wider place-based social prescribing offer	Able to access the support they need to stay well and at home for longer	A stronger prevention offer for all patients, supporting the wider ICS and its sustainability
To support patients to understand which type of primary care service is right for them	To develop PCN specific expertise in the thematic needs of local patients	Will have access to personalised, wrap-around care from an integration local care offer	A more resilient and capable integrated care service

10.4 Our Future Ambitions Summarised

By 2023/24 our ambitions for Primary Care in delivering personalised care:
• Agree joint principles across health and social care for health budgets.
• Developing with PCNs, a process of alignment of link workers within the social prescribing system also contributing to the care navigation offer across the system.
• Production and distribution of locality intelligence packs to support PCNs and patients to have the most appropriate services designed for their needs.
• Deliver universal implementation of the Comprehensive Model of Personalised Care across LLR .

11 Digitally Enabled Primary Care

In this chapter:
- The digital innovations embedded across LLR
- Our immediate and longer term priorities for digital innovation
- How we will support patients to best use these new service offers

11.1 Digital Developments

Within LLR, IM&T (Information Management and Technology) is a key enabler to facilitate the fundamental reshaping of primary care. A number of system-wide initiatives are underway and early implementation has delivered successes for patients through our IM&T work programme as set out in our Local Digital Roadmap (LDR). Examples of recent success in delivery are;

- Summary Care Record V2.1 (SCR 2.1) with an integrated care plan template has been implemented across the whole of LLR primary care. SCR is enabling integrated working between Acute and out-of-hours services through access to clinical information. Further advances are developing in record sharing between adult social care and health services. This multi-agency access to clinical records will lay the foundations for our ICS.

- A single clinical platform (for LLR this is SystmOne) will ensure seamless data flow across all key ICS partner organisations. To date we have 88.6% of our registered population's records accessed using this system, which directly links to community care providers and extends to our Referral Support Service (RSS).

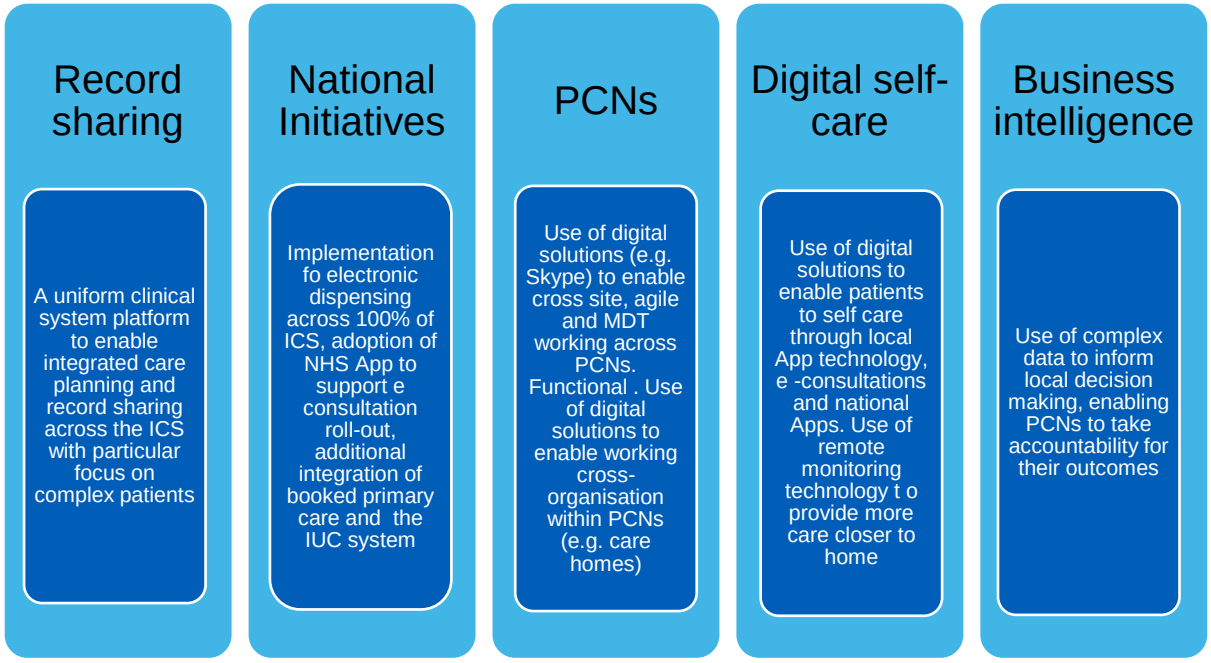
- We are using digital solutions to drive our reduction in clinical variation programme. Over 100 pathways within our local referral system, PRISM, have delivered a reduction in variation of referrals to secondary care. The digital approach has also improved the patient pathway to ensure access to clinically appropriate elective care options.

Despite the strong local history of delivering digital innovations to the advantage of both clinicians and patients, whole system inter-operability has yet to be fully delivered

11.2 Immediate Goals (2019/20) and Longer Term Objectives (2023/24)

We will build on the foundations of our IM&T work programme, which will result in provision of integrated health and care data, providing insight for commissioning and local decision making, enabling PCNs to take accountability for their outcomes

Our Digital Plan will focus on 5 key areas commencing from 2019/20, acknowledging that further plans will evolve over time and aligned to national guidance. In LLR we are fully committed to the roll out of online consultation systems. This will offer patients alternative ways to have a consultation with a GP or other practice-based health professional online. This innovative process will be complimented by the NHS App which will help patients to book online appointments, access their records and order prescriptions when necessary.



"For safe and efficient care of our patients it is crucial that all clinicians and others seeing patients in primary care have access to the full patient record so they can better make the right decision with the patient. Primary Care Networks will see clinical work taking place outside the registered practice and so we continue to work to consolidate primary care IT onto one system as that gives us the safest and best outcome when sharing the clinical record."
Dr Tony Bentley, LLR CCGs' IT Clinical Lead

11.3 The role of Primary Care in Digital innovations and the impact this will have

The changing landscape and emergence of digital solutions will offer our population increasing options for accessing primary care services. Patients will have a greater ability to access to their own health record and digitally enact with their GP provider through e-consultation solutions and mobile apps.

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
Practices will have access to training and support for system optimisation to best benefit from innovations.	Working at scale will be enabled by system interoperability supporting new methods of PCN delivery	Patients and health professionals will have a greater ability to access health records and support digitally interactions between patients and GP provider through e-solutions and mobile apps.	The evolving model of care is bringing local partners closer together to provide integrated patient care

ROLE in Delivery		IMPACT	
Practices	**PCNs**	**Patients**	**System**
Accurate coding delivers data on which local health management decisions and improvement initiatives can be based.	Workload can be shared effectively across the network utilising the skills and expertise within the PCN for the treatment and care management of local patients.	Patients will have ownership of their records, encouraging a greater reliance on self-care management.	Integration of clinical systems and record sharing ensures that patient journey data is captured and shared electronically, enabling partnership working.
With the emergence of e-consultation and digital apps our clinicians will have a greater ability to remotely support patients effectively.	Accurate local clinical data will enable PCNs to understand and proactively plan to support patient need and to manage clinical variation.	Online ability to interact with GP services and to access personal information will support access to a more responsive service.	True integration drives efficiency within the Health and Social Care system, patient experience and patient outcomes.

Integration of clinical systems and record sharing ensures that patient data is captured throughout their clinical journey and shared electronically with relevant professionals and patients promoting proactive care and self-care management.

11.4 Our Future Ambitions Summarised

By 2023/24 our ambitions for Primary Care in digital Delivery:
• Integrated and interoperable clinical systems across primary care and the wider system.
• Digital interfaces will be embedded providing a range of solutions for self-care management, digital interaction with patients, health care professionals and services
• To enable seamless online access to GP services including direct appointments, online booking and access to personal information
• Accurate clinical data enabling population health management tools to correctly identify patient needs for PCN management.

12 Population Health in an Integrated Care System

In this chapter:
- LLR's journey towards integrated care
- Our ambitions for primary care within our ICS
- How we will use information to make the best use of our ICS

12.1 Developments in Population Health

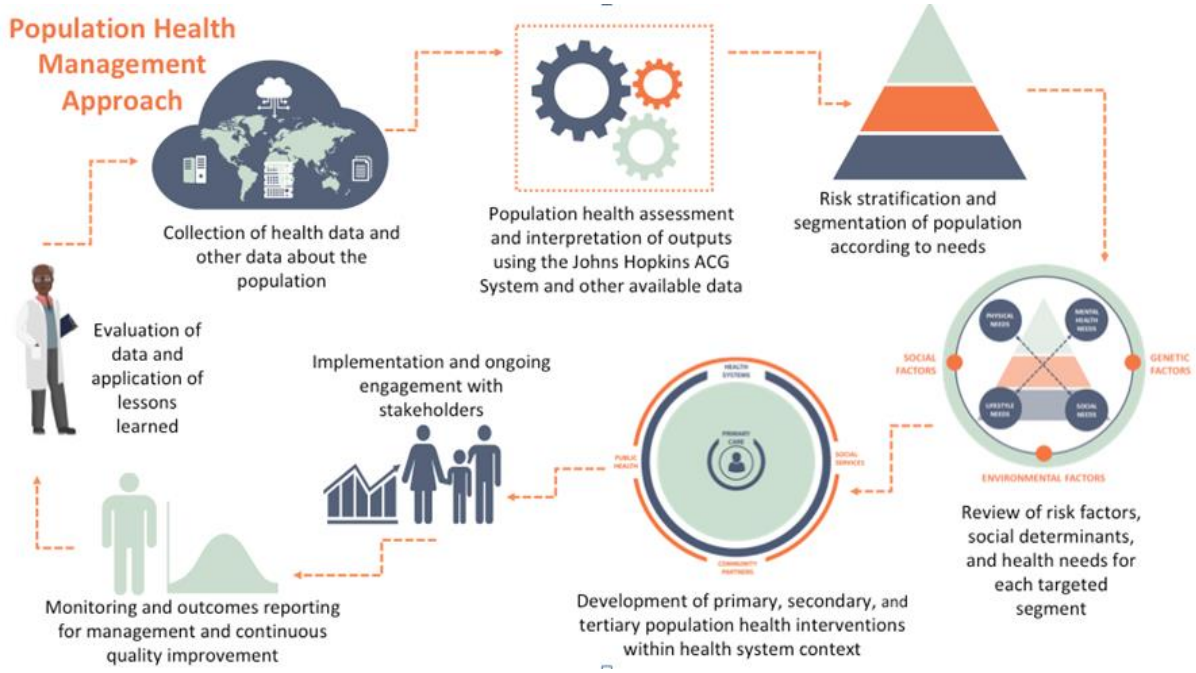
LLR have already taken major steps in moving our care system towards that of a successful Integrated Care System (ICS). For LLR this journey represents a continuation of the Better Care Together programme, bringing together our key social care and health partners to focus jointly on improving health and wellbeing

Locally level there have been real strides in improving access, integrated care coordination for complex patients and delivery of medicines management strategies These locality teams are in their developmental phase, but are acknowledged to have already facilitated better local working relationships, the removal of organisational barriers for clinicians and the increasing ability for patients to be treated holistically and as individuals. These service improvements are supported by a renewed approach to clinical and non-clinical MDT working, underpinned by the use of risk stratification tools, including local clinical intelligence, JSNA and Right care information to support targeted, proactive planning and interventions.

12.2 Immediate Goals (2019/20) and Longer Term Objectives (2023/24)

At a Neighbourhood level population profiles will be developed for each PCN, incorporating risk stratification, social care and information on the wider determinants of health. By 2024 we will have system, place and neighbourhood population health dashboards which will include data outputs created in collaboration with Leicester University. This strategic approach is summarised in the following diagram (Figure 5)

***Figure 5**: Population Health Management Approach in LLR (John Hopkins Model)*



12.3 The role of primary care in delivery and the impact this will have

> *"…a framework for population health centred on four pillars: the wider determinants of health; our health behaviours and lifestyles; the places and communities we live in; an integrated health and care system"*
> (King's Fund 2018).

Our 25 PCNs are the building blocks on which we will further develop our ICS across LLR. With support, the ACDs will lead the development of cross-organisational relationships, breaking down local barriers and enabling health, social and support service professionals to work together to meet the needs of specific patient populations, using population health tools and data analysis

ROLE in Delivery		**IMPACT**	
Practices	**PCNs**	**Patients**	**System**
To become skilled in working at scale and within a wider multi-organisational team	A clearer role in care navigation and coordination within the ICS	Experience individualised and proactive care planning improving everyday health and wellbeing	An ICS with no organisation barriers delivering highest quality care
Access to a wider perspective on population health management, workforce planning and providing proactive care	To establish themselves in the wider ICS, maturing from primary care memberships to become multi-organisational	To experience an individualised, multi-agency response to a crisis	An affordable and sustainable care system meeting the needs of all patients
More support with other aspects of proactive patient management including mental health, social care and community services	Develop systems and processes to enable informed, locally-based decision making and quality improvements	Integrated and coordinated care, closer to home	The ability to deliver system-wide change to the fundamentals of care delivery including workforce, IM&T and estates

12.4 Our future ambitions summarised

By 2023/24 our ambitions for Primary Care in delivering Population health:
• Defining the role of primary care and PCNs within an ICS, setting out clear responsibilities and accountability frameworks
• PCNs with detailed knowledge of the local population will design and deliver the necessary services to improve the outcomes of their patient population
• Developing with PCNs responsive care pathways to deliver prevention and management of complex conditions
• Developing an holistic approach to care for those with multi-morbidity and their carers, including a tailored approach to mental health and wellbeing

13 Patient Voice, Communications & Engagement

In this chapter:
- How we will engage with patients at a local / Neighbourhood level
- How we will keep patients informed of the change we will make and how they can be involved
- How we will adapt our communications strategy as we develop as an ICS of integrated partners

13.1 How we communicate

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, e.g., patient events and meetings with patient groups

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, but they also tell us that they require improved access closer to home.

13.2 The changes we need to make

Key themes and feedback emerging from the events and meetings held across the LLR system have influenced our priorities for the future and can clearly be seen within this plan. It is important to recognise that this is very much a work in progress with more specific engagement on the contents necessary.

13.3 Communicating as an ICS

Implementation of the NHS Long Term Plan offers an opportunity to deliver urgently needed service transformation within primary care. However, we recognise the need to engage and consult where necessary.

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 up of the communications and engagement leads for all of the partner organisations. This aims to ensure that a joined up approach to engagement and consultation is taken across all areas of the STP.

13.4 Our next steps

Over 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 and shape the proposed direction for primary care (both at a CCG level, and as highlighted in the STP).

What we will do next:

- Develop a detailed communication and engagement plan with patients, practices and stakeholders
- Highlight what the CCGs working with PCNs are doing in primary care to make long-term sustainable improvements
- Ask people to consider 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 to feed into developing our future strategy
- Set-up a Citizen's Panel to support our future STP work through Better Care Together

14 Leadership, Governance and Programme Risks

In this chapter:
- How we have set up our primary care governance system and processes
- The roles, functions and ambitions of our Primary Care Board to support PCNs

Building on the GP5YFV submission, this strategy 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 an ICS. 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.

14.1 The Role of the Primary Care Board (within existing governance structures)

The Board has the following roles in directing the future of primary care within LLR, cognisant of the delegated functions of PCCCs;

- Design a Primary Care/ PCN strategy to ensure primary care is a strong and capable ICS partner.
- Support delivery of General Practice, PCN and Place level population health improvement and reduce inequalities, in line with strategic commissioning intentions
- Align and form a joint LLR wide commissioning function for primary care service design and delivery.
- Ensure primary care services contracting, quality and performance is aligned
- Ensure commissioning and contracting sub groups are enabling a joined up approach and continuous improvement through the commissioning cycle process
- Enable the enabling groups of Workforce, IM&T and Estates to drive forward the strategic direction in line with the GP5YFV and NHS Long Term Plan
- Ensure outcome based, patient centred services are commissioned from Primary care

14.2 The Primary Care Board within an Integrated system

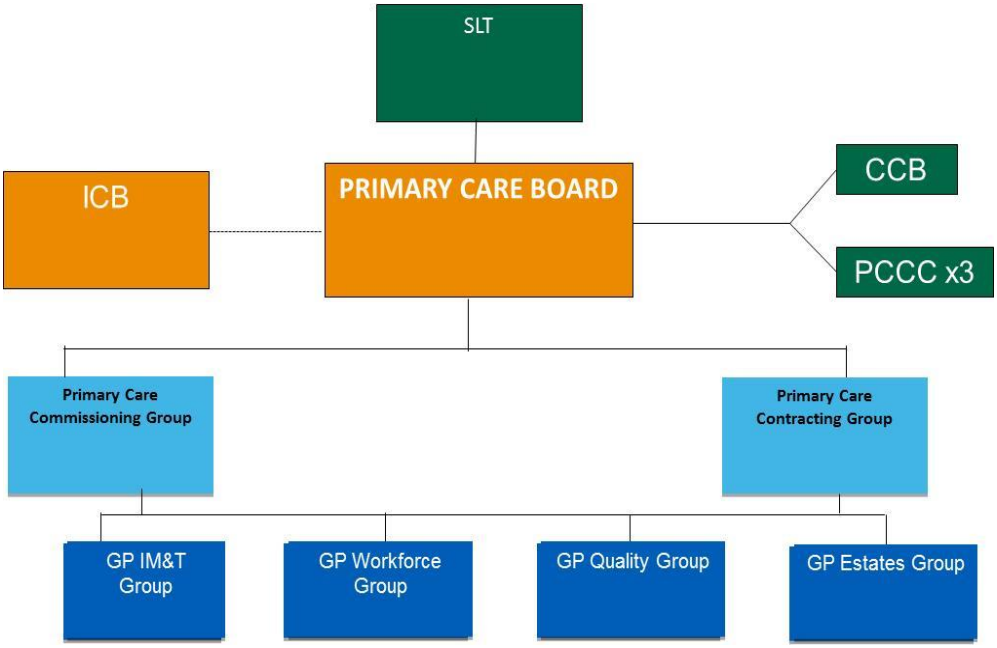
The Board has the following function in delivery of the future of primary care within the LLR ICS.

- Directly link with Prevention/ Planned Care/ Community Services , Local Authority, 3rd Sector and Patient groups to ensure that General Practice services are supported by the system to deliver resilient General Practice and PCN delivery for the LLR population
- Align the 3 CCG teams, process, policies and teams to enable delivery of primary care services at an LLR footprint.
- Develop shared governance process, to drive the joint working and shared purpose for General Practice within the ICS

- Direct link and influence across all STP work streams to ensure primary care has the capacity and skills to deliver new pathways of care that cuts across primary, secondary and social care domains

Figure 6 presents our proposed Primary Care governance structure, relating it directly to the other key work streams underpinning the development of our ICS.

***Figure 6**: Proposed LLR Primary Care Governance Structure*



14.3 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 ICS.

Our Risks to Delivery Are:
• Ability to secure engagement across and mobilise the support of 136 general practices run as independent contractors within 25 PCNs
• 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
• Acceptability of new skill mix models to patients used to a more traditional GP focused model of care

15 Measurement

In this chapter:
- Our current mechanisms for measuring outcomes
- How this needs to adapt to ensure the best outcomes for patients within an ICS
- The role of PCNs in delivering quality and supporting a successful ICS

15.1 Changing how we measure success and outcomes.

There are currently many ways that we are able to measure the performance of General Practice, these in particular include

- Local data dashboards
- Proactive care tools including Right Care and Risk Stratification
- Patient satisfaction surveys
- CQC
- QOF

However, the move towards joint working through an ICS and development of PCNs means that we will need to adapt our methods. There are a number of specific areas that will require a clear methodology, these fall into the following categories;

- Patient experience and patient voice through PPG groups
- Practice and PCN views and maturity
- Quality and outcomes at Practice and PCN footprint
    - Prevalence
    - Variation
    - Population health management risk scores
- Impact of PCN and practice commissioned services on the system through the impact and investment data, including right care metrics
- GP5YFV and PCN DES metrics for NHSE

15.2 Measuring Impact

The data needs to provide real meaning and ability to drive positive change. Key to this will be working through the impact that the developing models in primary care will have on patients, practices, PCNs and the System, as well as from patients. Of particular focus is impact on practice and PCN staff satisfaction and morale. General practice is an anomaly in the NHS, in that there are at present no routine staff surveys in place. We are keen to correct this.

Also new in LLR is determining how effective practices and PCNs are in supporting the overall effectiveness of the wider health and care system and vice versa. There are several measures that could be used here, but we are particularly keen to focus on those that consider rates of hospital utilisation. In general, we would expect that increased investment in, and the improving capacity of, primary care will lead to a narrowing in the present variation.

15.3 Clinical Outcomes

As PCNs develop, we are keen that they obtain the expert advice of their local Director of Public Health to take advice on supporting clinical outcome indicators. We anticipate that by focusing on a small number of clinical outcome indicators, rooted in a thorough

needs assessment, localities will be able to focus their services and interventions on meeting specific local needs.

As we work with existing and emerging PCNs to complete a maturity self-assessment and then subsequently agree a development plan one of the areas for discussion will be outcomes measurement. In any final agreement between a PCN and the CCGs, we would expect to see clear statement on the outcomes that have been selected as local priorities, together with target level of achievement and how they will be reviewed.

What we will do next:

- Train our PCN leaders in qualitative and quantitative data analysis and management
- Deliver PCN level business intelligence systems
- Design robust information offer to support clinical decision making and service design

16 Finance

In this chapter:

- Details of the current funding into General Practice
- New funding into PCNs
- Opportunities and plans to invest in PCNs to support the LLR ICS

16.1 Primary Care Finance

Within LLR there is full delegated commissioning responsibility for General Practice and thus the opportunity to hold a greater share of 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 PCNs to plan services and deliver new models of care. 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.

16.2 Financial Baseline for General Practice

Funding into General Practice is attached to national formulas and local budgets. A significant proportion is nationally calculated based on historical weightings. This capitated budget has created variation at practice level, although the recent changes in national contracting reduces this to reasonable levels.

Locally investment comes in the form of community based services, clinically driven incentives and Better Care fund aligned priorities. The split of funding into General Practice can be seen in the following table;

***Table 4**: CCG Consolidated 2019/20 Primary Care Budgets*

		Leicester City CCG	East Leicestershire	West Leicestershire	LLR Total
		Annual Budget	Annual Budget	Annual Budget	Annual Budget
		£	£	£	£
SUMMARY					
Core Contract		38,321,247	30,277,996	35,117,570	103,716,813
Dispensing/Prescribing Drs		250,000	1,572,349	1,393,122	3,215,471
Enhanced Services		1,044,512	892,010	871,952	2,808,475
Quality and Outcomes Framework		4,497,279	4,177,294	4,965,981	13,640,554
Premises		6,738,977	4,378,363	4,994,732	16,112,072
PCN		1,887,510	1,535,262	1,842,233	5,265,004
Other GP Services		1,442,075	931,285	1,126,993	3,500,353
Reserve/QIPP		406,400	-359,559	-1,620,583	-1,573,742
Total Co Commissioning		**54,588,000**	**43,405,000**	**48,692,000**	**146,685,000**
					0.0
Community Based Services		2,087,798	2,097,491	2,876,071	7,061,360
Other Primary Care		2,166,083	-72,040	2,139,803	4,233,846
GP Incentives		750,000	1,510,264	1,700,000	3,960,264
GP Forward View		2,703,097	2,063,644	2,303,937	7,070,678
Total Other Primary Care		**7,706,977**	**5,599,359**	**9,019,811**	**22,326,147**
Total Out of Hours		**5,579,792**	**4,168,995**	**4,255,086**	**14,003,873**
Total Prescribing		**51,803,685**	**48,674,058**	**55,696,680**	**156,174,423**
TOTAL		**119,678,454**	**101,847,412**	**117,663,577**	**339,189,443**

16.3 Primary Care Network Investment

The level of funding available to PCNs over the next 5 years is unprecedented in levels of primary care designated investment. With this funding comes a clear expectation on leadership, delivery of 7 new clinical specifications, Extended Access and new clinical roles. If the success of PCNs delivers the subsequent reduction in acute and medicines spend, the reward will come in the form of the investment and impact fund intended for additional staff.

***Table 5**: PCN Budgets 2019-20 to 2023-24*

Primary Care Budgets -2019/20		LLR Total	LLR Total			
	Budget Type	Annual Budget (2019/20)	Annual Budget (2020/21	Annual Budget (2021/22)	Annual Budget (2022/23	Annual Budget (2023/24)
		£	£	£	£	£
PCN						
PCN Participation (£1.761pwp)	CC	1,925,806	1,945,627	1,975,566	2,005,965	2,036,833
PCN Additional Roles (£1.44prp)	CC	1,702,251	4,966,200	8,098,222	12,481,013	17,731,194
ACD leadership (£0.514prp)	CC	587,467	797,390	809,822	822,448	835,271
EOH DES to PCN (£1.099prp)	CC	1,049,481	1,706,694	1,733,304	1,760,328	1,787,773
		5,265,004	**9,415,911**	**12,616,913**	**17,069,754**	**22,391,072**
Core PCN Funding (£1.50 prp)	PC	1,720,015	1,748,662	1,775,926	1,803,615	1,831,735
Improved Access to Primary Care (£6 prp)	PC			7,103,703	7,214,458	7,326,940
Investment and Impact Fund			1,457,218	2,959,876	4,509,036	6,105,783
TOTAL PRIMARY CARE NETWORK FUNDING		**6,985,019**	**12,621,792**	**24,456,418**	**30,596,863**	**37,655,530**

16.4 NHSE Five Year Forward View Investment

The investment into PCNs is new from 2019/20, but it is year 3 of the investment programme from NHSE to support General Practice. There have been significant advances in delivery of initiatives to support practice staff and improve the digital offer. The funding available (additional to the GP5YFV access funding) concludes the investment into these areas.

***Table 6**: GP Forward View Allocations 2019-2021(Not including access payments)*

GP Forward View Allocations		
Leicester, Leicestershire and Rutland		
	19/20 allocation	**20/21 ring-fenced allocation**
Practice Resilience	£146,135	£154,800
GP Retention	£231,960	£232,200
Reception and Clerical	£190,688	£190,971
Online Consultation	£311,080	£303,450
Practice Nursing		£77,400
Total	**£879,863**	**£958,821**

16.5 Five Year Investment Plan for Primary Care

The allocations published by NHSE for Co-commissioning of General Practice services shows a year on year increase until 2023/24. This will support the demographic growth and demand, but is only one element of the budget planning that will need to take place.

***Table 7**: Co-Commissioning Growth 2019-2024*

Co-Commissioning Budget Planning 2019/20 - 2023/24	2019/20	2020/21	2021/22	2022/23	2023/24
	£k	£k	£k	£k	£k
Published Co-commissioning Allocations	146,685	153,219	160,303	168,279	177,194

Key to ensuring improved outcomes and reducing inequalities will be a development of an LLR wide investment plan for additional services commissioned at both practice and PCN level. These will need to recognise the differences in need and demand within and between PCNs according to population.

To focus only on direct primary care planned investment, misses an opportunity to support the shift of activity traditionally delivered in an acute setting into PCN footprints. This “left shift” of work will support the system delivery expectations of for example reducing outpatient attendances by 40%, but with this work will need to follow the investment into staff, buildings and diagnostics to support delivery.

Finally to ensure PCNs deliver their potential, funding will need to follow services and delivery of 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 across PCNs.

What we will do next:

- Develop a plan for aligning primary care investment, where practical and necessary
- Support PCNs to ensure investments support maturity and delivery
- Develop an investment plan for services to be delivered at a PCN level, whether traditional General Practice Services, Community or “left shift”

17 Conclusion

In this chapter:

- A summary of our strategic direction for primary
- The importance of PCNs in a well functioning ICS
- Engagement with patients, practices and stakeholders to further develop this plan

This strategy exists to ensure a resilient and sustainable general practice system working in PCN footprints as the bedrock of a high functioning healthcare system.

In this document, we have outlined the case for change and our intentions to support new models of care through practices and PCNs. This plan recognises the need for greater levels of funding in General Practice and through PCNs, it 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 benefits patients, healthcare professionals and the LLR system.

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 strategy supports the entire STP programme by putting GPs at the centre of patient care, based around population health delivered in Primary Care Networks.

This document provides a high level plan for the development of General Practice and PCNs within an Integrated care system. To ensure that real transformational change takes place, it is necessary to work in partnership with practices, PCNs, patients' and stakeholders to co-design a sustainable solution.

"Never has there been a more important time for GPs and their teams, to change the way they work. GPs can no longer see and manage all aspects of a patient's care. We need nurses, pharmacists, paramedics, and therapists in teams within primary care setting, supported by experienced GPs. We need to work closer with our neighbouring GP and social care colleagues and use the immense potential of voluntary organisations and individuals, alongside the clinical expertise and resources that hospitals can offer."

Dr D.A Ker- GP and Clinical Vice Chair ELR CCG

18 Appendices

18.1 Appendix 1 - Blueprint for General Practice: Delivering the General Practice Five Year Forward View, February 2017

https://www.westleicestershireccg.nhs.uk/publications/corporate-documents/strategies-and-plans/94-gp5yfv-llr/file

18.2 Appendix 2 - General Practice Forward View: LLR – General Practice Workforce Plan, January 2018

https://www.leicestercityccg.nhs.uk/llr-gp-workforce-plan/

18.3 Appendix 3 - LLR Primary Care Networks (20 June 2019)

Appendix 3 - LLR Primary Care Networks (20 June 2019)

CCG	Proposed PCN	Member Practices	Population (List Size)	ACD
ELR	SLAM	Latham House, County, Jubilee, Stackyard(*), Long Clawson	69 519	Dr Fahreen Dhanji
ELR	Oadby & Wigston	Wigston Central, South Wigston, Bushloe, Oadby Central, Severn, Rosemead	49 059	Dr Richard Palin
ELR	North Blaby	Glenfield, Kingsway, Enderby, Forest House, The Limes	60 264	Dr Simon Vincent
ELR	South Blaby & Lutterworth	Northfield, Wycliffe, Masharani, Countesthorpe, Hazelmere	47 248	Dr Rachel Omand
ELR	Harborough	Market Harborough, Husbands Bosworth	28 445	Dr Hamant Mistry
ELR	South Leicestershire, Croft & Billesdon	South Leicestershire, Croft & Billesdon	42 271	Dr Anuj Chahal
ELR	Rutland	Uppingham, Oakham, Empingham, Market Overton	39,920	Dr Hilary Fox
WL	Bosworth	Newbold, Desford, Ratby, Groby, Heath Lane	37,491	Dr James Ogle
WL	Hinckley Central	Station View, Centre, Maples, Castle Mead	38,732	Dr R Dockrell
WL	Fosseway	Orchard, Old School, Burbage, Barwell & Holly Croft	42,742	Dr V Bolarum & Dr A Khalid
WL	North West Leicestershire	Ibstock & Barlestone Surgeries, Castle Medical Group, Measham Medical Unit, The Surgery – Ashby	42,823	Dr Kirk Moore
		Markfield Medical Centre, Long Lane Surgery, Broom Leys Surgery, Hugglescote Surgery	37,319	
		Castle Donnington, Whitwick Road Surgery, Dr Patel & Dr Tailor (Whitwick Health Centre), Manor House Surgery, Dr Virmani (& Dr Bedi) (Whitwick Health Centre)	27,724	
WL	Watermead	Thurmaston, Greengate, Birstall, Silverdale, Mahavir	31,816	Dr Anu Rao
WL	Soar Valley	Quorn, Cottage, Banks, Highgate, Charnwood Surgery, Alpine, Barrow, Anstey	49,863	Dr Nick Simpson
WL	CH3 – Carillon	Bridge Street, Park View, Pinfold, Woodbrook, University	55,445	Dr Leslie Borrill
WL	CH4 – Beacon	Charnwood, Dishley, Field Street, Forest House	33,955	Dr Rebecca Dempsey
City	Belgrave & Spinney	East Park MC, The Charnwood Practice, Canon St, Spinney Hill MC, Broadhurst Surgery	45,774	Dr Prakash Pancholi
City	The Leicester Foxes	Dr Kapur St Peter's, Dr Kapur Narborough Rd, Dr Kapur Brandon ST, Surgery at Aylestone, Evington MC, Al-Waqas, Dr D'Souza St Peter's, Dr D'Souza, Queens Rd	33.498	Dr Vivek Sharma
City	Leicester Central	Community HC, Highfields Surgery, Highfields MC, Shefa MP, Sayeed MC, Heron Practice, Bowling Green St, Ar-Razi	51,058	Dr Rajiv Wadhwa
City	Salutem	Johnson MP, Downing Drive, Humberstone MP, St Elizabeth's	35,455	Dr Aileen Tincello
City	Aegis Healthcare	Willowbrook, The Willows, Clarendon Park MC, East Leicester MP, Heatherbrook Surgery, Pasley Road HC (Dr Khong)	41,104	Dr Mo Roshan
City	Millennium	Manor Park MP, Beaumont Lodge MP, Briton St Surgery, Westcotes Surgeries, Westcotes MC, Brandon St Surgery, Aylestone HC	50,971	Dr Durairaj Jawahar
City	City Care Alliance	Merridale MC, The Parks, Fosse Family Practice, Beaumont Leys HC, Asquith Surgery, Spirit Rushy Mead	38,589	Dr Umesh Roy
City	Leicester City & University	Dr Montfort University, Victoria Park HC	45,234	Dr Aruna Garcea
City	Leicester City South	Saffron health, The Hedges MC, Pasley Road, Assist, Inclusion Healthcare, Walnut St MC	35,417	Dr Amit Rastogi
City	Leicester Health Focus	Oakmeadow Surgery, Groby Ro MC, Fosse MC, Hockley Farm	39,194	Dr Hafiz Mukadam

Leicester, Leicestershire and Rutland CCGs

Community Services Redesign – future model of care, implementation and next steps

1. Introduction and background

Community health services play a vital role in caring for people living at home or in care homes, supporting GP practices in meeting the needs of thousands of people who are living with ongoing health problems or recovering from a crisis but who do not need the level of acute or specialist type of care provided in secondary care. The three CCGs across Leicester, Leicestershire and Rutland have been working on a project to review adult community health services over the last year. The project was initiated to make sure that services were providing a model of care that could meet patients' needs both now and in the future, and in particular, could provide care that joined up with the way that GP practices and social care services will work in future.

The services in scope of the work so far include; the majority of non-specialist adult community health services, including community nursing and therapy teams, district nurses, the Intensive Community Support Service, inpatient beds in community hospitals across LLR. In addition, our work has looked at community stroke rehabilitation and primary care co-ordinators.

This paper describes the Community Services Redesign (CSR) project to date, including how we went about the work, and the engagement with local residents and other stakeholders that has fed into the work. It sets out the future model that the CCGs will commission and describes how we will put that model in place over the coming months and years, describing what impact that will have on the care people receive and what that will mean to other parts of the health and care system in LLR. Finally, this paper sets out the next steps in our work on community health services.

2. Objectives

The key aims of the Community Services Redesign are to:

- Set out a clear model of community services in LLR, which delivers a 'Home First' approach, and supports the integration of services.
- Ensure that community services wrap around local populations and facilitate integrated working at neighbourhood level
- Articulate the bed-based capacity required in LLR now, and in the future, and specify the clinical/care model required in bed based services
- Deliver efficiencies and have a positive impact on acute and emergency services
- Deliver improved outcomes in relation to patient care and patient experience, through a strong evidence base for redesigned services
- Ensure services are affordable and represent value for money, by reducing duplication, preventing admission, enabling rapid discharge and supporting people to live as independently as possible
- Enable a discharge to assess approach across community services – ensuring that people can leave hospital when they are able to do so from a medical perspective
- Embed a re-ablement approach throughout community services
- Support trusted assessment and information sharing between services to deliver seamless patient care
- Support the identification and management of frailty in the community, in line with a consistent, system wide frailty strategy

- Be sustainable in terms of workforce, supports staff retention and increased satisfaction
- Describe the outcomes and key deliverables/targets to be delivered by community health services in future.

In addition to the above, the CSR also enables the CCGs to deliver some of the changes set out in the NHS Long Term Plan published in January 2019, specifically:

- Configuring community health services so that they align with Primary Care Networks (PCNs), and work alongside PCNs as part of extended, integrated teams to meet the needs of the local population
- Removing the barriers between primary care and community services
- Delivering a 2 hour response to people in crisis in the community.

3. Project approach

The Community Services Redesign is a CCG-led project, but has been taken forward very much as a collaborative piece of work with Leicestershire Partnership Trust, social care teams, and other providers and stakeholders. The CSR reports into the Integrated Community Board, one of the workstreams of the LLR Better Care Together Sustainability and Transformation Programme. A Clinical Reference Group has been established, including clinicians from primary, community and secondary care, to secure clinical input into defining the new clinical model.

The work commenced in summer 2018, with a series of workshops with different stakeholders across the system, mapping out what a good model of integrated community care in LLR should look like and ensuring continuity with existing strategic plans within the BCT programme, for example; integrated teams and Home First.

The project was fortunate to have access to consultancy support from Deloitte (funded by NHS England). Deloitte undertook a best practice evidence review of integrated community services looking at examples of successful community services models elsewhere in the UK, which helped shape the design of the future model. In addition, Deloitte undertook some modelling of the impact of introducing a new integrated community services model, looking at what activity could take place within community teams and what would be the likely impact on acute services and community inpatient beds.

We included the findings of previous service reviews, for instance the LLR bed utilisation review and a review of the Intensive Community Support (ICS) service in 2017. In parallel with the Deloitte work we carried out clinical reviews of some existing services to understand how well they were working.

Patients, carers, staff and the public have been involved through one-to-one interviews, focus groups, as well as public events. People have shared their experiences and what matters most, as well as their views. The engagement we have undertaken is described in section 5.

All this enabled the project team to set out a high level proposal for changes to how community health teams support people living in their own homes, or care homes in December 2018, to deliver a different model of care as described in section 4. The CCG Collaborative Commissioning Board CCB supported the high level model and the

direction of travel within the CSR work, and gave approval to further work up the new model of home based support, including a more detailed assessment of the cost implications of implementation.

4. Summary of the proposed new model of Community Health Services

4.1 The future LLR model of community health service delivered in people's homes can be broadly described as being composed of the following three services:

Neighbourhood community nursing and therapy services, aligned to Primary Care Networks, which will offer planned nursing and therapy and same day community nursing, working closely with primary care and social care as part of integrated teams.

Home First services – enhanced 'step up and step down' services offering intensive nursing and therapy as part of an integrated team offer with social care reablement and crisis response. Home First services will typically see people who need a more intensive, short term level of care and intervention to avoid admission or to provide support after a period of hospital stay.

Locality Decision units: access points into multi-disciplinary triage, assessment, care planning and treatment for Home First services in each local authority area. The Locality Decision Units (LDU) will determine whether a person can be safely and well supported at home or whether they need to be admitted to a re-ablement bed or community hospital bed, and if so, will arrange this admission or a package of care to be delivered by Home First. LDUs will work as the interface between hospital staff, GPs or other health professionals referring into Home First. They will work closely with hospital discharge processes on a 'push/pull' basis, proactively arranging the support required on step down from hospital.

The new community health service structure is shown below:

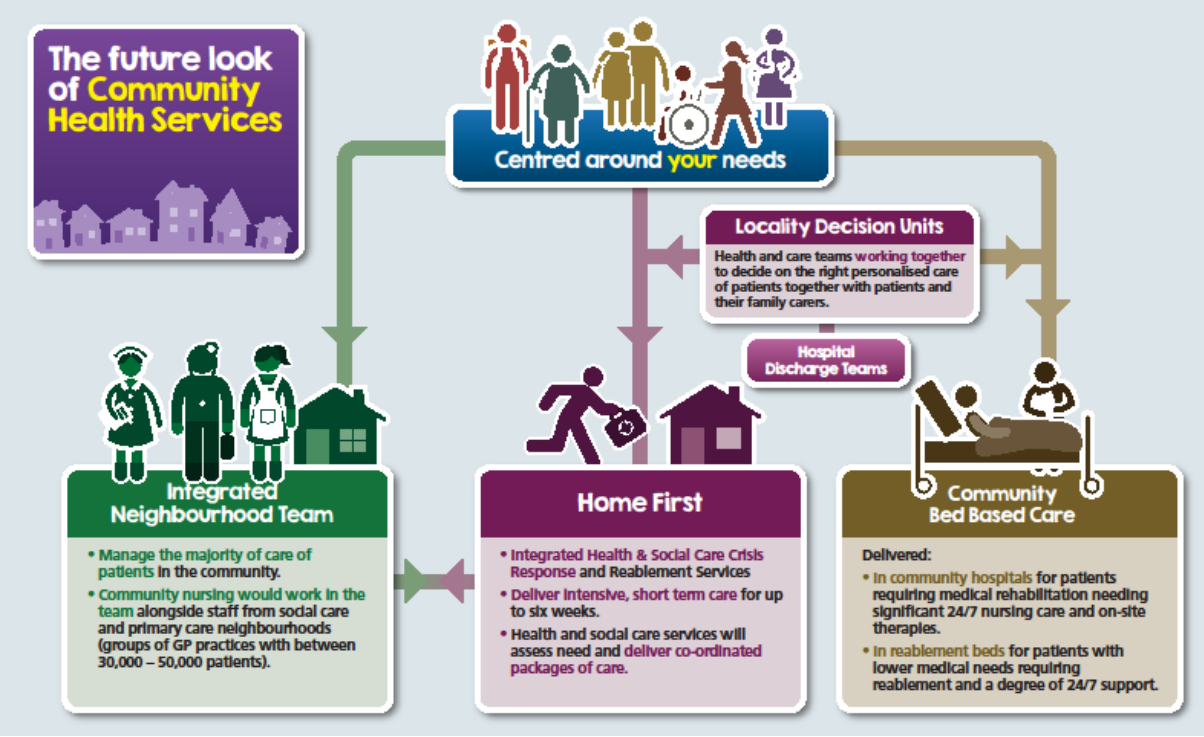


Figure 1: The redesigned Community Health Services Model

These new services will replace the current community and district nursing teams, therapy teams and the Intensive Community Support Service (ICS). The capacity and staff in existing teams will be reorganized into the new team structures and there will be no loss of service offer/function in the new model. ICS will no longer be commissioned in its current form as a stand-alone service. Instead, an urgent same day response will be provided by the core community teams, with Home First providing more intensive care for those who need it.

The specification for the new services to be provided by Leicestershire Partnership Trust was approved by the three CCGs in their July meetings.

4.2 Medical Support to Home First

In addition to the changes to the LPT service, an intrinsic element of the CSR model is the provision of consistent and responsive medical support to patients on the Home First caseload, who may have additional medical needs which must be appropriately managed in order for them to be supported to remain at home. Reviews of the ICS service showed that without this level of medical support, acute discharge teams were reluctant to discharge people straight to their own home, as they were not confident that medical plans would be always followed through and that any unexpected change in a patient's condition would be promptly and appropriately treated.

The CSR clinical reference group considered a number of different options for enhancing medical cover for patients being managed at home, including consultant and Advanced Nurse Practitioner (ANP) models, as well as dedicated GP with special interest cover for Home First. The preferred model for delivering enhanced medical cover for Home First is for this to be provided by GP practices, as an enhancement to general medical support in primary care. A business case has been agreed by the three LLR CCGs to commission enhanced medical cover, via PCNs, for one year, to test this model of care, and £1.4m will be made available over the first year of implementation to commission the new model of support and fund additional capacity in primary care.

5. Engagement

Extensive engagement activity has been undertaken to hear the views on how a new integrated model of community care changes the experiences of staff, family carers and patients and people who use the service. This engagement has fed into the case for change and the design of the new model.

Prior to the CCGs agreeing to implement the changes above in June 2019, engagement work to support the redesign included:

- Face-to-face qualitative interviews (n. 156)
- Online qualitative survey (n.66)
- Examined 22 existing reports in line with community services from research in LLR representing 4,300 people
- Presented findings at 3 workshops to capture insights regarding travelling communities, Asian family carers of people with learning disabilities and Hinckley PPG locality group – total of 21 people

Through February and March 2019, the insights gathered were presented at six public workshops held across LLR and further insights were gathered from 169 people (patients, family carers and staff). These events were well received by the public as an opportunity to provide feedback on the new community model (figure 1), and were

attended by staff working in acute or community settings, social care staff, domiciliary care workers, GPs, care home staff, patients and family carers receiving or with an interest in community care and people working in voluntary and community organisations. Key messages from public and patients were:

- People want to stay in their own homes, but confidence in support from services in the community to manage this well is sometimes lacking
- Recognition that social care and primary care are fundamental to delivering improved community based care
- Family carers often articulate negative experiences of the support they and their loved one get.
- Family carers, care home staff and domiciliary care staff expressed the need to be more involved in decision making concerning patients.
- People want stronger links between emotional welfare and physical recovery. They place importance on therapy services that support mobility recognising that increased mobility improves their mental wellbeing.
- People want better communication between family carers, staff and internally to include: explanation and advice when required, Appropriate language and use of interpreters when required,
- Improved relationships with other health and social care teams through integrated working across teams to improve a number of concerns, including discharge; managing in a crisis and carers seeking further help when required.
    - There are some concerns over rurality and a desire to see more services delivered in local settings for local populations
    - A view that community hospital beds are a 'safe' option for sicker people
    - Scepticism that we can tackle long standing issues and make a positive change
    - LPT staff were concerned over potential loss of the specialism in ICS through the transfer of capacity into the core neighbourhood CHS model.

The intelligence gathered from the engagement work was fed into the model design, for instance the specialism in ICS will be continued into the Home First model. People's feedback on their experience of care is also being addressed in the implementation plan for the CSR, particularly in respect of ensuring that we pay attention to the way that the new services work. For instance, we are placing great emphasis on therapy and support for mobility as part of the model, and have an organisational development plan to support the new teams to build integrated ways of working to support their relationships with primary care and social care. Integrated teams are supported to build relationships and ways of working, and in the continued specialism of Home First services.

The detailed engagement reports are publicly available to view at the following link: http://www.bettercareleicester.nhs.uk/getinvolved/engagement-and-consultation/ongoing-engagement-and-consultation/community-services-redesign/.

6. Impact – benefits and risks

6.1 The benefits of the new model are:

- Increased resource in neighbourhood teams to offer a same day response to GP referrals, enabling greater continuity of care, where previously this was delivered through ICS as a separate nursing team. For example, end of life patients will benefit from a consistent community nursing team meeting all their non-specialist care

needs, which will improve communications and enhance relationships with patients and their carers.

- Greater alignment of the community health model with PCNs, with increased capacity for assessment, planning and provision of care generated through neighbourhood multi-disciplinary team and risk stratification approaches. This will support a more person-centred approach support better communications and improved relationships between staff, patients and family carers. Complex care nurses and community matrons will have the ability to offer time limited clinical case management to restore clinical stability for patients and/ or offer proactive care in response.
- An integrated access point (locality decisions unit) into an integrated health and social care Home First offer in each local authority area, offering clinical triage and packages of care and support at home as well as referral into non-acute beds. This creates a single process through which the decision about whether a person's needs can be supported at home or not will be taken.
- More rapid, more intensive therapy input as part of a Home First rehabilitation offer. Therapy contacts per patient receiving the Home First offer will increase. This will improve the service's ability to deliver genuine rehabilitation and reablement, moving closer to the national model for rehabilitation (National audit of Intermediate Care Summary report- England, 2017) and reducing risk of admission/ readmission to hospital.
- Increased numbers of patients receiving this more rapid, more intensive Home First rehabilitation offer. 44% of patients currently on the planned therapy caseload meet Home First criteria and will therefore receive a rehabilitation offer within 2 days, with increased patient contacts. Access to therapy for these patients through the Home First offer, will facilitate faster discharge from acute and community hospitals, where currently patients are held onto longer to deliver more therapy pre discharge in acknowledgement of longer community waits.
- Reduced handovers between Home First and planned therapy by fully meeting rehabilitation needs in an intensive Home First offer (compared to ICS with short length of stay in which rehabilitation goals cannot be fully met and patients are then subsequently referred onto planned therapy). This will:
    - reduce potential for patients' function to reduce following initial rehabilitation whilst on a long waiting list for planned therapy
    - reduce risk of admission/ readmission to hospital
    - reduce duplicated effort in re-assessing
    - reduce instances where patients wait for planned therapy following ICS and find at point of care delivery that initial rehabilitation goals are no longer achievable.
- Deliver 7 day therapy provision to support 7 day clinical triage in the Home First locality decisions units and 7 day Home First crisis response to prevent admissions.
- This improved offer will be achieved through increased efficiency in the therapy workforce through roll out of LPTs Community health service transformation programme increasing the average contacts per day that each professional can do
- Care delivered in the most appropriate setting of care and lower levels of ongoing care needs due to the improved home based offer. More patients supported to be discharged straight home from hospital rather than into bed based rehabilitation in community hospitals.

6.2 Disbenefits/limitations

Although the new model brings some real benefits in terms of increasing the number of patients who will get rapid 2 hour/2 day access to therapies for those patients who require a fast, intensive offer to respond to a crisis or prevent deterioration and admission to hospital, the current capacity within therapies means that we are not able

to improve waiting times for patients who have less severe needs. The contractual waiting time for planned therapies (those patients who don't meet the criteria for a Home

First response) will be a maximum of 18 weeks, although patients will be clinically prioritised within this for a more speedy response. End of Life patients will get a maximum two day response. For some patients, therefore there may be a longer wait than currently for non-urgent therapies and this is something that the CSR work will need to look at again for 2020/2021.

6.3 Anticipated impact on settings of care

The community services redesign work has been supported by modelling undertaken by Deloitte and the CCG team which looked at local and national evidence on the activity impact that developing a model of integrated home based care would have on overall demand for both community health and emergency acute care. The modelling indicates that there would be a 10.5% reduction in non-elective admissions for a cohort of frail and medical emergency patients over 5 years, compared to the 'do nothing' position, which takes account of anticipated increases in activity in each year of 2%.

The Home First service is expected to have the impact of increasing services' ability to keep people at home through periods of crisis or deterioration as well as to increase the numbers of patients who can step down from an acute ward direct to their own home. Modelling shows 720 more patients a year being discharged directly home in 2 years' time.

In addition to the above the CSR modelling, supported by previous audits of bed utilisation, shows a shift in the use of community reablement beds, and an additional 661 patients a year being discharged into reablement 'Pathway 3' beds in care home settings rather than the current community hospital inpatient beds. A period of reablement in a residential home can provide an important bridge between hospital and home and is a more homely setting which can help people regain some of their independence before returning home after a period of illness.

If the new home based model is successful in having this impact there will be a reduction in the occupancy of community hospital inpatient beds, potentially of up to 50%. Commissioners will therefore need to review the clinical model and number of beds provided from the current community hospital wards and make proposals for any changes required. This is discussed further in section 9.

7. Implementation

The CSR proposals have the following implications in terms of changes to services:

i) A reorganisation of existing community teams in 2019/2020 to create strengthened community nursing and therapy as part of an Integrated Neighbourhood Team, and an integrated Home First crisis response and reablement service

ii) Additional medical capacity to enable the new community teams to deliver the model of care well, and support people at home. This will be commissioned through Primary Care Networks

iii) Increases in capacity in the new model from year 2 onwards to support a step change in the number of patients being managed at home or in Pathway three, with an expectation that there will be a resultant reduction or changes in use of community hospital beds.

The new model of care will be introduced in 2019/2020 with i and ii becoming operational from December 2019. In 2019/2020, the current LPT community teams will be restructured. In 2020/2021 additional funding will be required to support an expansion of capacity in community services to manage increased activity to improve patient outcomes, deliver the anticipated response times and support increased numbers of patients being cared for at home or in a care home setting. The CCGs have approved this investment in principle, and a more detailed business case for 2020/2021 investment will be prepared for the 2020/2021 planning round, informed by the learning from the implementation of the new model in Q3.

Figure 2: LPT Operational Delivery Model 19/20

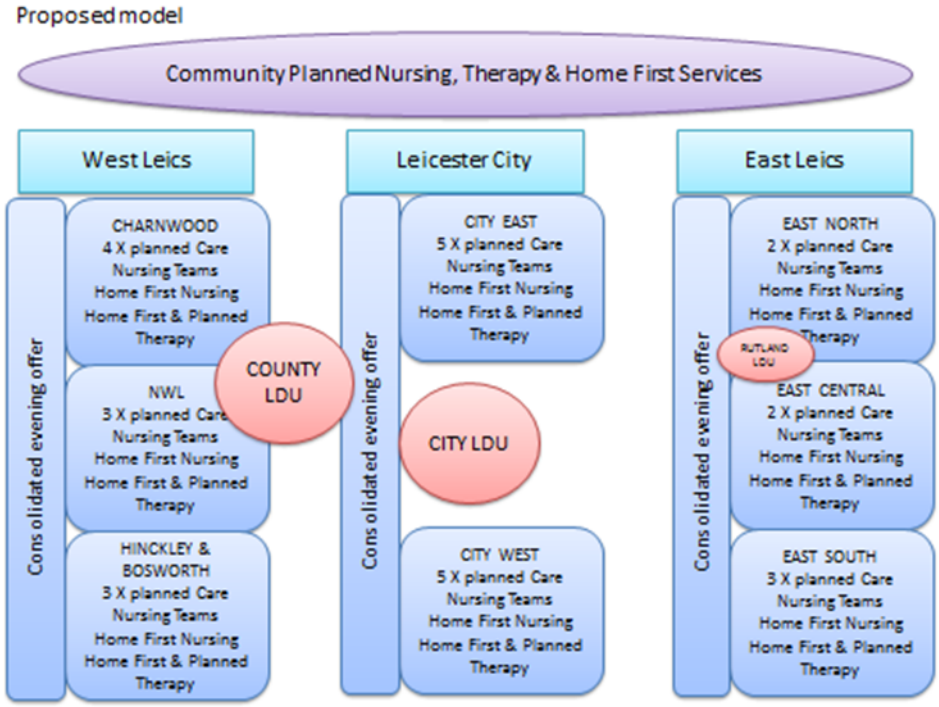


Table 1: Implementation timetable 2019/2020

Action	Timeline
Community nursing, therapy and Home First	
New specification agreed by CCGs and written into LPT contract	July 2019
Testing of new models of care prior to full workforce change • Piloting integrated locality decisions units in county and city for step down referrals (with extension to offer LDU approach with Rutland) • Piloting 'on the ground' integration in Home First offer • Piloting new ways of working in integrated neighbourhood teams	April – Dec 2019
Staff engagement and organisational development, including UHL and primary care networks	March – Dec 2019
LPT workforce change process and staff consultation	July – Oct 2019
Reconfiguration of existing staff to new team structures	Oct – Dec
Staff operational in new teams and CSR model operational	1st Dec 2019
Medical Model	
Commence medical model implementation i.e. recruitment	October 2019

Commencement of medical model	Dec 2019
Interim review of medical model	March 2020

8. Risks

There are a number of key risks to effective delivery of the model in 2019/20;

- The CSR requires significant system change, including primary care, social care and acute staff as well as teams employed by LPT. Managing the transition to a new way of working is a cultural and operational challenge. A Community Transformation Group has been set up with the involvement of all relevant system partners to oversee the change. Support and staff time will be required from partners to ensure effective delivery.
- Workforce - Any organisational change programme creates risks for staff morale and retention. LPT currently have significant challenges with high vacancy rates in parts of Leicester city. These issues are being actively monitored through the Clinical Quality Review Group for the contract. LPT also employ a range of operational approaches (different hubs taking on a caseload, staff physically moving temporarily, clinics picked up by other teams) to manage these issues ensuring no one area is left with less staff than another. The system transformation group is also overseeing a workforce sub group to ensure robust organisational development, staff communication and workforce development plans across LPT and other affected providers.
- There is no additional capacity in LPT to deliver this in 2019/20, either in terms of investment in frontline staffing to support a transitional period or additional change management resource to deliver the change. This may constrain their ability to fully deliver all aspects of the model in the first year. Commissioners will work closely with LPT to understand the demand and capacity requirements to fulfil our vision for community services, and this will support planning for capacity requirements in 2020/2021 and future years.
- Acute discharge processes may not change sufficiently to deliver the anticipated increase in the numbers of patients supported by Home First. Consultant support to GPs in agreeing discharge medical management plans and the ongoing management of cared for in Home First will also be required. This significant cultural change will be underpinned by an organisational development and communication approach, although this requires changes to ways of working for a significant body of staff and will take time to deliver an impact.
- The medical model commissioned from PCNs will need to operate consistently and effectively in every part of LLR if we are to be able to deliver the high quality, responsive care offer that we plan to do. Ensuring that the primary care offer is commissioned and delivered to the expected level will be a challenge. The CSR team is working with CCG primary care commissioning colleagues and PCN Accountable clinical directors to mitigate this risk.
- Integrated therapy is a key part of the new model. Going beyond the changes in this proposal, there is potential for redesign of the whole therapy model including the acute therapy model and more joint funded posts in community settings. The CSR team has recently seconded a lead with a therapy background to accelerate this work and develop proposals for more integrated pathways. Integrated therapy will also be addressed through the functional mapping work and identification of joint roles between health and social care, along with potential shift of acute therapy roles into community settings.
- Equipment services –It is anticipated that increased responsiveness of services and a shift to manage more patients at home could create greater demand on these services. Where the equipment provider is unable to respond to increased demand this risks potential readmissions. The impact for 19/20 is expected to be small due to

small increases in patients managed at home. Plans are in place to monitor the 19/20 impact to inform the future re-procurement of community equipment services across health and social care, which is being led by the Equipment Management Board.

9. Further work and next steps

9.1 **Implementation of the 2019/2020 changes** has already begun, overseen by the Community Transformation Group. Work is underway to pilot Locality Decision Units in City and County. In the first instance Rutland integrated team will link to the County decision unit for reasons of scale. LPT have begun engaging with staff on new ways of working and transition to new team structures. Implementation will feed into the Community Transformation Group.

9.2 **Phase 2 of the CSR** will include looking at the impact of home based community care on the use of community inpatient beds and Pathway 3 beds. As described in section 6 the modelling undertaken so far indicates that there will be shifts in the number and type of beds required for LLR patients as a result of the community model changes. CCGs will begin to develop options for the community bed model, with the expectation that these will support the production of a Pre-Consultation Business Case (PCBC) It is planned to establish a Pre Consultation Business Case, with input from Healthwatch and system partners including UHL, to oversee this work. This group will also use the insights from patients, family carers and staff to help shape future proposals.

9.3 **Engagement** - In developing the next phase of proposals for community health services, the CCGs will continue to engage with local people, and stakeholder groups. We plan further engagement starting in September to discuss the progress on phase 1 of the work, and also explain our next steps towards proposals for the community bed model. We will involve local people in helping to set the criteria for assessing and choosing between different options for the future provision of community care, which will be used to generate a short list of options for CCG consideration and potential future consultation.

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. Primary Care Networks 3. NHS Long Term Plan 4. Public Health Overview		
29th Aug 19	1. Primary Care Strategy 2. Community Health Services Redesign 3. Leicestershire Partnership NHS Trust Update		
10th Oct 19	1. Update on Manifesto Commitments 2. Acute Reconfiguration of UHL 3. Strategic Outline Case for the Rebuild of the Bradgate Unit 4. CCG Merger Plans – Feedback from Stakeholders		
5th Dec 19	1. All-age Mental Health Transformation Programme 2. 0-19 Children's Offer 3. Public Health Contribution to Minimum Space Standards		

Meeting Date	Topic	Actions arising	Progress
30th Jan 20	1. UHL Priorities 2020/21 2. Maternity Services		
2nd Apr 20			

Forward Plan Items

Topic	Detail	Proposed Date
Young People's Council's Mental Health 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.	