NHS LEICESTER CITY CLINICAL COMMISSIONING GROUP

PRIMARY CARE STRATEGY 2014-2019

INTRODUCTION

1. This is Leicester City Clinical Commissioning Group's (LC CCG's) Primary Care Strategy. It sets out the vision for primary care over the next five years, describing a service delivery model that addresses the issues and challenges of today whilst transforming primary care services so that they are fit for the future.

2. The strategy is primarily focused upon primary medical care, ensuring it is fit to play its part in the delivery of two key priorities; firstly, improving health and reducing health inequalities for the patients of Leicester City and secondly, the movement from hospital-centred care to care delivered wherever possible in a community setting.

3. The strategy is underpinned by a high level implementation plan which will be refined and implemented to turn the vision into reality.

4. Having a primary care service with sufficient capacity (workforce and premises), capability and resources is the first step in transforming care in Leicester City. Without this in place, key local programmes of change will fail. The strategy should therefore be considered as an enabler for, and read in conjunction with, the LC CCG Better Care Fund (BCF) plan and the Leicester, Leicestershire and Rutland (LLR)-wide five-year transformational programme, Better Care Together (BCT), which is designed to change significantly the settings of care for patients whilst also delivering financial balance to the local health and social care system.

LEICESTER CITY POPULATION

5. Leicester is the largest city in the East Midlands, with a population of around 330,000 people and covering an area of approximately 73 km^2. Much of the area is urban, with a population density of 4,500 people/ km^2 making the city the most densely populated area in the East Midlands.

<u>The population profile</u>

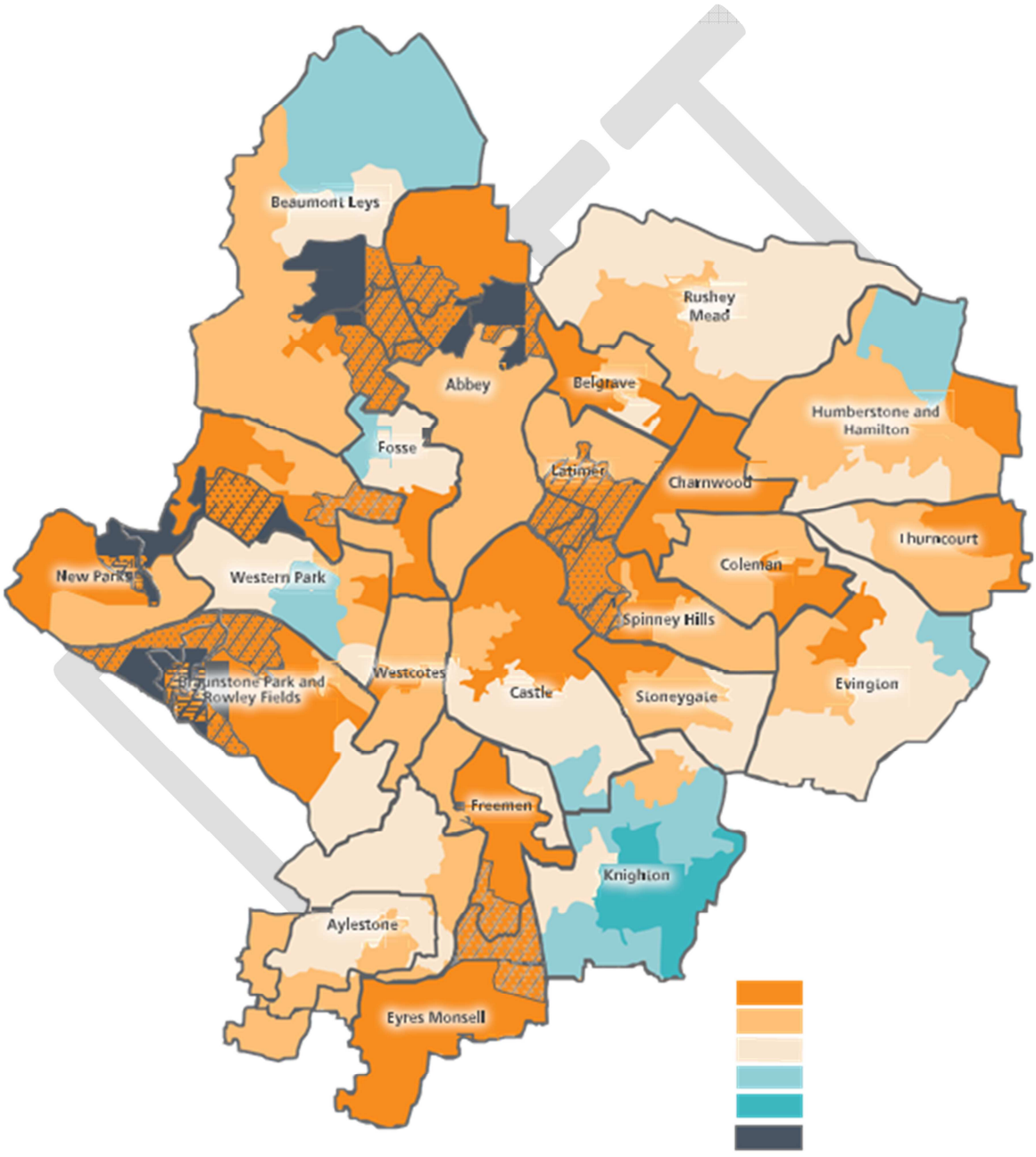
6. The makeup of the population is extremely complex. Appendix A is an extract from the Director of Public Health's report for 2013/14, but some of the key highlights of the population profile are given in Table 1 below:-

Key population highlights from Director of Public Health report 2013/14

The current population estimate for Leicester is 331,606 of which 163,911 are males (49%) and 167,695 (51%) are females.
Leicester's population is relatively young compared with England;
A third of all city households include dependent children
20% (65,266) of Leicester's population are aged 20-29 years old (14% in England. The large numbers of younger people in Leicester are partly students attending Leicester's two universities and partly migrants to the city.
12% of the population (38,081) are aged over 65 (16% in England
Whilst Leicester's resident population is estimated at 331,606 the registered population is approximately 378,000 i.e. the City is a "net importer" of patients.
The population is predicted to grow to around 345,000 by 2021, an increase of over 13,000 from 2012. The increases are forecast to be seen in the percentage of the population under 10 and of those aged over 55.
Leicester's population has a very different ethnic make-up to that of England. Black Minority Ethnic (BME) and White ethnic groups each make up some 50% of Leicester's population whereas in England they make up 15% and 85% of the population respectively.
• 37% of Leicester's population are of Asian/Asian British origin, mostly Indian, but also from Pakistani and Bangladeshi backgrounds, • 6% are Black/Black British, • 4% mixed and • 3% from other ethnic origins. • 46% are White British or Irish and 4.6% from other White groups, including Poland and other EU accession countries
Seventeen of the 18 ethnic groups counted in the 2011 Census have 1,000 or more residents.
A third of Leicester's residents (111,000) were born outside of the UK and just under half of those (53,000) arrived between 2001 and 2011, partly as a result of the accession of 10 countries into the EU in 2004 and the arrival of people from non-EU countries as either students or professionals recruited to address labour shortages.
Leicester is also a designated National Asylum Seeker Service dispersal city and home to 638 asylum seekers (as of October 2013). It is estimated that there may be as many as 150 languages and/or dialects spoken in Leicester and almost half of pupils in Leicester primary schools have a home language other than English.

Deprivation

7. Poor health is associated with underlying levels of social and economic disadvantage such as unemployment, low skill levels, low income levels, crime and poor housing. Although Leicester has some areas of relative affluence, the majority of the city is relatively deprived, with some areas of extreme and multiple deprivation. Leicester is ranked as the 25th most deprived local authority area (out of 326) according to the Indices of Multiple Deprivation 2010 (IMD2010), a national study of deprivation across England developed by the Department for Communities and Local Government.



Deprivation map of Leicester City at ward level. (Amber most deprived, blue least deprived. Blue/black, areas of v severe deprivation)

8. Figure 1 shows the pattern of deprivation across Leicester based on 'lower super-output areas' (LSOA), which each contain 1,000 to 1,500 people. These are the smallest neighbourhood-based units of measurement used by Department of Communities and Local Government in the Index of Deprivation. Areas in dark orange are among the most deprived 20% in the country and areas in dark blue are among the most affluent 20% of areas in England, illustrating the extent of relative deprivation in Leicester, compared to the rest of England.

9. The pattern of deprivation across Leicester shows higher levels of deprivation in the west of the city than the east. The majority of the poorest areas of the city are the historically white working class outer-city estates on the periphery of the city, along with a few areas in the inner city, where relatively new communities have settled from various countries of origin in a patchwork of diverse ethnicities. The more affluent areas of the city are in the south, stretching from Victoria Park to the city boundary alongside the A6 road.

10. Forty-one per cent of Leicester's population live in areas classified as the fifth (20%) most deprived in the country and a further 34% live within the two fifths (40%) most deprived nationally. Some 'Lower Super Output Areas' in the city feature within the 5% most deprived of all areas in the country and are home to 12% of Leicester's population. These areas include parts of the New Parks, Braunstone, Beaumont Leys and Spinney Hills wards as well as parts of the St Matthews, St Marks and Saffron Lane Estates. St Matthews contains two LSOAs ranking nationally as some of the most deprived in terms of income deprivation and Braunstone Park and Rowley Fields contains two LSOAs ranking the most deprived in terms of education.

Health Inequalities in Leicester City

11. Life expectancy in Leicester is significantly lower than the England average. Although it has continued to improve over the past decade, life expectancy in Leicester has shown a slower rate of improvement than England overall. Overall, the gap between Leicester and England has been widening since 2000-2002, however there has been a small improvement for both men and women in the last two periods.

12. The principal contributors to the life expectancy gap between Leicester City and England for men and women in the years 2009 – 2011 are circulatory disease (26% men and 32% women) and respiratory disease (13% men and 14% women).

13. In addition to the gap in life expectancy between Leicester and England, there are also gaps in life expectancy within Leicester itself. The impact of deprivation means that poorer health in the UK is generally associated with greater deprivation. People living in areas of higher deprivation have a shorter average life expectancy than those living in areas with lower levels of deprivation. These

differences are seen in Leicester's population. For both men and women, those in the more deprived tenths of the population have a shorter life expectancy. Indeed, from one side of the city to the other, there is an average difference of up to eight years life expectancy.

14. Disease patterns in different ethnic groups are influenced by socio-economic, environmental and cultural factors, as well as by genetic predisposition. Much of the evidence is at England-level and it is not clear how this is reflected in the Leicester population. The central message is that it is important to work at a local level to understand and address health inequalities related to ethnicity and the determinants of health, recognising that these will change over time.

CHALLENGES

15. The CCG's primary care strategy is developed at a time when there are significant challenges, globally, nationally and locally, which impact upon public services.

National Context

16. *"Everyone Counts: Planning for Patients 2014/15 to 2018/19"* sets the overall medium term planning framework for the NHS and describes what the NHS must deliver to patients nationally. The NHS 'Call to Action' asks all NHS providers and commissioners to respond to the significant challenges facing the NHS in delivering health and care policy into the future, including:

    - An ageing society
    - The rise of long-term conditions
    - Rising public and patient expectations
    - Increasing costs of providing care
    - Limited productivity
    - Pressure of constrained public resources that the NHS (and social care) face
    - Variation in quality of care across the health system.

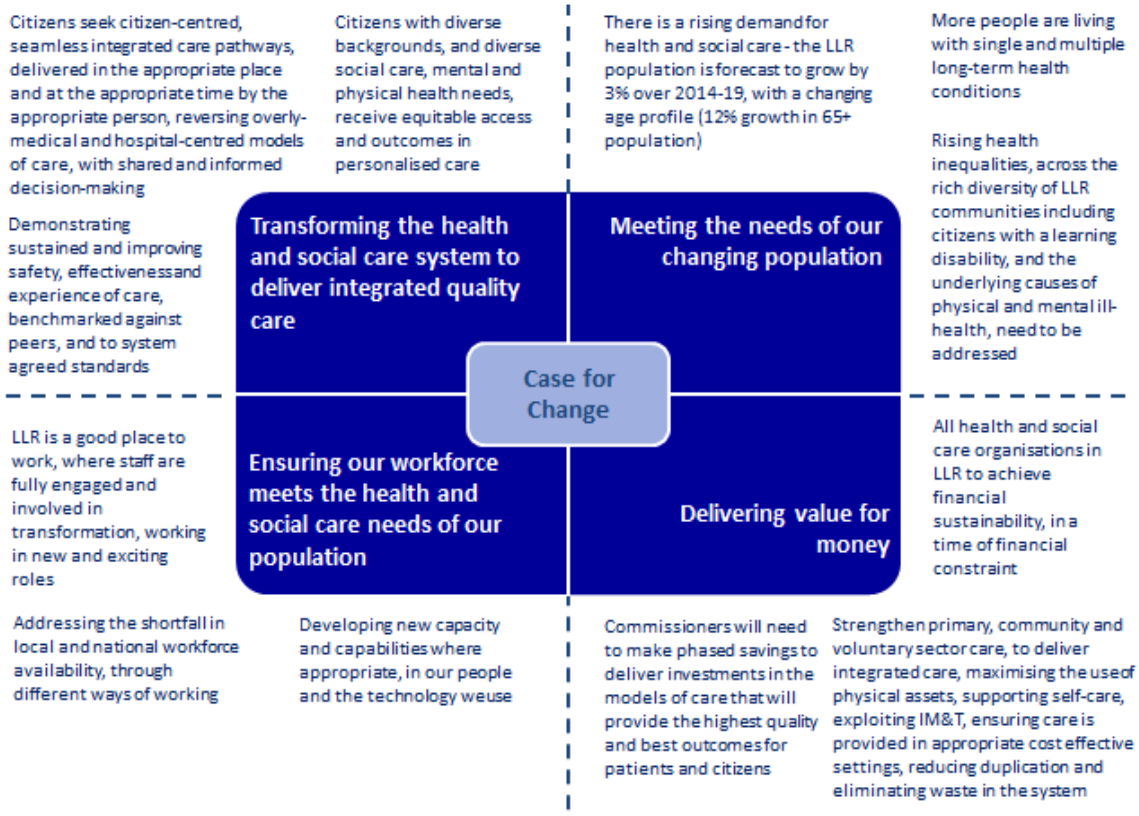
17. Current estimates suggest that only 4% of the NHS budget is spent on preventative interventions but literature suggests that investing wisely and early into prevention could potentially lead to transformative change across Health and Wellbeing Board areas, ("NHS Call to action", November 2013). We know that across the UK, health outcomes are poorer compared to our European neighbours (Law & Wald, 1999) and that we do not do enough to prevent long term disease and subsequent chronic disability. National evidence also suggests that we do not do enough to tackle the underlying risk factors associated with ill health, such as alcohol, smoking and obesity (NICE, 2014).

18. Prevention and effective management of conditions in the community is also likely to be more cost effective than waiting for patients become sick and present at the doors of our GP surgeries or hospitals.

19. This strategy is being developed at a time when there is gathering momentum to deliver actions that prevent or postpone ill health, rather than merely treating illness.

LLR Context

20. The financial picture that is seen nationally is reflected in the local health economy, perhaps with even clearer focus. There is an accepted need to deliver greater local efficiencies and a recognised potential to achieve that by the development of integrated out-of-hospital services, increased in-hospital efficiencies and a stronger focus on disease prevention. The case for change at an LLR level is summarised in the diagram below:-



The LLR Better Care Together strategic case for change

21. Across LLR, an integrated Long Term System Model has been constructed for the Better Care Together Programme which describes and measures how the system challenges will be addressed. This models the impact of actions/ interventions to improve the quality of services provided to patients and/or improve the financial value of services without quality being compromised.

22. The model has been constructed as an integrated tool based on a shared set of planning assumptions, which are mirrored in the individual plans of constituent organisations. It factors in the financial assumptions of all partners across health and social care economy and illustrates the impact of proposed changes on activity and costs across the system including the impact of:

- Implementing new models of care
- Shifting care between settings
- Planned efficiency programmes
- Planned investments across health and social care including those linked to the BCF.

23. The work to develop the Better Care Together five year strategy has involved analysing and prioritising the case for change in eight main service areas, setting out:
    - The main changes that are needed to these service models
    - How care will need to shift across settings in the future.

24. The Leicester City primary care strategy must ensure the provision of sufficient capacity and capability to accommodate agreed city-related activity that will transfer from secondary care settings to primary care, as well as dealing with the growing number and clinical complexity of City patients cared for in primary care.

Leicester City Context

25. The national direction of travel, as outlined in "Everyone Counts" fitted the vision of Leicester City's Health and Wellbeing Board and their strategy "Closing the Gap". The CCG's response to "Everyone Counts" is an ambitious and truly transformational plan to develop comprehensive and fully integrated community-based teams that "wrap around" our patients, helping them to stay in community settings wherever possible rather than being admitted to hospital for care. This ambitious approach forms the basis of our Better Care Fund (BCF) programme which we have launched with our local authority partners. Our core vision for this programme matches that which is set out in Leicester's Health and Wellbeing Strategy, '*Closing the Gap'* :-

"we will work together with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life".

26. Our vision for a healthier population goes much further than just ensuring people get the right care from individual services. We want to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care. We will do this through focussing on 3 priority areas, delivering one integrated model of care:
    i) Prevention, early detection and improvement of health-related quality of life
    ii) Reducing the time spent in hospital avoidably
    iii) Enabling independence following hospital care

27. Whilst the BCF programme is ambitious and stretching, we feel it is achievable and sets the direction of travel for future service models. It will see more and more patients cared for in the community and will therefore result in an increased number of patients that GPs will be actively caring for. Creating time for GPs to

support these patients is crucial to the BCF's success and is a challenge that the strategy must address.

PROFILE OF PRIMARY MEDICAL CARE IN LEICESTER CITY – 2014

28. Whilst Leicester's resident population is estimated at 331,606, the registered population is approximately 378,000 i.e. the City is a "net importer" of patients from the County. Those 378,000 patients are cared for by a total of 62 GP practices (as at September 2014.)
29. At the present time (September 2014), ten GP practices in Leicester are single-handed compared to 52 practices with multiple GP partners or which are alternative providers (for example corporate bodies). In terms of population, 13% of patients are treated by single-handed GPs in Leicester compared to approximately 9% nationally. Analysis shows that as a result, the average practice list size in Leicester is below that seen nationally.

Average list size (Leicester City CCG)	5,920
National average list size	6,487

Health Need N'hood	Ave Pop'n per practice June 14	75+ Pop'n	% 75+ Pop'n	Total GPs (WTE)	Ave List Size per WTE GP
1	5973	4954	5.6%	44.6	2058
2	6056	3130	4.5%	44.3	1888
3	6093	6113	4.5%	74.7	1875
4	6205	5709	8.0%	44.6	1876
TOTAL	**6077**	**19906**	**5.4%**	**208.2**	**1922**

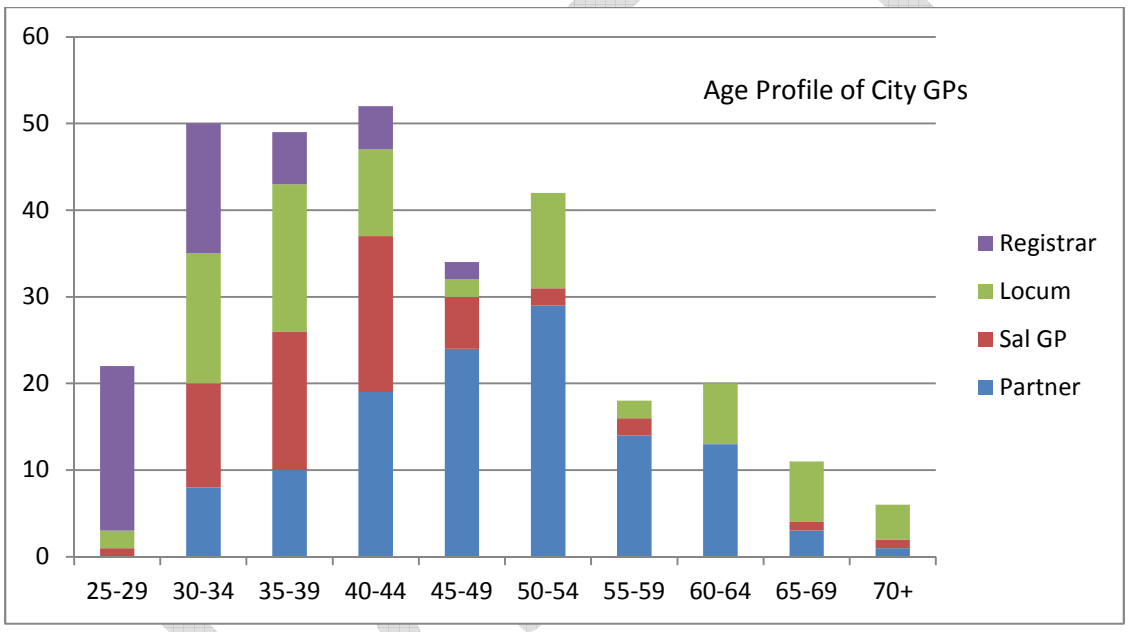
30. The CCG currently has 14 training practices. This is important as training practices can play an important role in supporting new GPs and encouraging them to stay in the area once they are qualified.

31. With regard to contract type, there are:-

- General medical services (GMS) – 35 Practices
- Personal medical services (PMS) – 16 Practices

- Alternative provider medical services (APMS) – 11 Practices.

32. Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The latest information indicates that Leicester now has a GP workforce made up of almost equal thirds of partners, salaried GP and locums. The graph and table below highlights the number of GP partners that are likely to retire in the next 5 to 10 years – 60 out of a total of 121 partners are 50 or over, which is almost 50%. The current structure of practice-based primary care provision is likely to undergo severe instability if new partners cannot be attracted into the system to take their place. Effective recruitment and retention is key to maintaining the City's local primary medical care services.



Age Profile and GP type, by age band

AGE	Partner	Sal GP	Locum	Registrar	No
25-29	0	1	2	19	22
30-34	8	12	15	15	50
35-39	10	16	17	6	49
40-44	19	18	10	5	52
45-49	24	6	2	2	34
50-54	29	2	11	0	42
55-59	14	2	2	0	18
60-64	13		7	0	20
65-69	3	1	7	0	11
70+	1	1	4	0	6
					304

CHALLENGES FACING PRIMARY CARE IN LEICESTER CITY

33. Since the "Call to Action" in November 2013, the CCG has embarked on a series of engagement activities with the public, patients, member practices and wider stakeholders to understand what the challenges and issues are perceived to be and to gather information on what an improved primary care system might look like. With regard to patients, we have worked with representatives from practices' Patient Participation groups, gathered information from listening events with the public, from membership feedback, from Healthwatch, national surveys and from comments and complaints.

34. To gain feedback from member practices, we have held discussions at Locality meetings, at Protected Learning Time (PLT) events, undertaken electronic surveys, taken feedback at professional forums (e.g. Practice Manager and Practice Nurse forums), at practice meetings and at Board Development sessions. Detailed feedback is given at Appendix B and Appendix C, but the main themes that emerged are shown below:-

<u>What patients said</u>:

35. In summary, patients and the public told us:

- **Access** is poor

36. Patients told us that in many practices it is just too hard to make an appointment. They wanted fast access to appointments that are easy to make, particularly for children, those with long terms conditions and older people. Telephone systems should be able to cope with the volume of calls and there should be the choice of on-line booking. Those in most need should be given priority.

37. The national survey shows just how poor our patients rate their experience. In the latest survey, out of 211 CCGs, Leicester City was rated as:
    - Ease of getting through to the surgery by phone – 187th
    - Helpfulness of the receptionist – 204th
    - Frequency of seeing preferred GP – 203rd
    - Confidence and trust in the doctor – 197th
    - Satisfaction in opening hours – 157th
    - Overall experience of GP surgery – 201st
    - Would recommend the practice – 207th

    ➢ The **quality** of general practice should be improved.

38. Patients noted that practices varied in the quality of service that they offered their patients and this variation was justifiably felt to be unacceptable.

    ➢ **Personalised care** is not always available

39. Patients want to be treated by a GP who knows them, where this is appropriate (e.g. where patients have Long Term Conditions (LTCs)). If the complaint is straightforward e.g. a minor illness, many patients who expressed a view were not concerned about seeing their normal GP.

    ➢ There is insufficient appointment **time**

40. Patients said they wanted their GP to have time to listen to them. The length of the appointment should be linked to the nature of the condition e.g. automatically have longer appointments for patients with more complex conditions, particularly mental health issues and those with multi-morbidities. Several mentioned their unhappiness at only being able to discuss a single condition at each appointment.

    ➢ **Communication** and **Information** is sometimes poor

41. Several patients and carers requested clear, easily understood information in an appropriate format and language that helps them to take responsibility for their condition and to use NHS services wisely. This was felt to be particularly important for those who might be new to the City and who came from a country where primary care was not provided. Training in communication skills for the whole primary healthcare team was suggested by several patients. There were several patients who did not understand what they had been told but felt unable to take up any more time in asking questions. They wanted to feel unrushed and be able to discuss their issues properly.

What practices said

42. The detailed responses are shown in Appendix C but the main themes were:-

- The past two years have seen a rapidly growing **workload** with too little time to deal with it, leading to many clinicians feeling stressed and unable to take on any more work. There was an overwhelming message from the majority of practices that "something needs to change" – either less work or more resource, but certainly that the current model is not sustainable and has reached crisis point. With the planned transformation of services to an increased out-of hospital model of care, practices feel that demand needs to be reduced or capacity increased, which requires more resource coming into primary care.

- A lack of **resources**. The extra workload needs to bring resource with it to enable teams to be expanded and provide the extra capacity that is required. The funding of new services needs to recognise the real cost of delivery and offer a sense of financial stability to encourage practices to sign up to them and employ with confidence the extra staff required to support delivery.

- Acute difficulties with **recruitment** and **retention**, particularly relating to the GP workforce. This is an immediate and urgent priority bearing in mind the age profile of the City GPs and the number likely to retire over the coming five to ten years. Younger doctors are showing a growing reluctance to become partners, with more of them enjoying a portfolio of different roles, one of which is as salaried or locum GPs. Numbers going through GP training are falling and for those that do complete training, they are anecdotally reported as not being attracted to working in the City.

- **Premises** issues. Several practices have reported a lack of space to accommodate new services, a lack of funding available from NHSE for refurbishment / expansion and general improvement. Some practices have also encountered issues in LIFT buildings, where they claim that the service costs are very high and there is often a lack of flexibility in discussions relating to extended opening hours or issues with accommodation.

- These challenges come on top of those that have already been highlighted due to the complexities of the city population i.e. population **diversity**; levels of **deprivation**; variation in health **outcomes**, health **inequalities**; **disease** burden and growing public **expectations** of the service.

POSITIVE ASPECTS OF PRIMARY CARE IN LEICESTER CITY

43. It must be acknowledged that there are some positive aspects to primary care in the CCG, which were identified by both patients and practices. As a principle, it was agreed that these should be protected and preserved when thinking about any future model of care. They included:-
    - GPs holding longer term contracts that build real commitment to the local community
    - Registered list that leads to continuity of relationships and care
    - GP acting as the coordinator of care between other health and social care settings
    - Appetite for innovative ways of working
    - Keen to learn new skills through educational programmes designed by local GPs
    - Practices beginning to work together to share good practise and learning
    - Clinical workforce adopting the systematic use of IT to support the management of long term conditions and support population health interventions
    - The delivery of high quality care e.g. anticoagulation, where the increased service quality being delivered is outstanding.
    - Provision of a comprehensive, cost effective and high quality healthcare service, albeit overburdened at the current time.

PRINCIPLES OF THE STRATEGY

44. Reflecting on feedback from our patients and the wider primary healthcare teams, as well as considering the challenges facing primary care, the following eight key principles have been identified by the Board clinicians to form the main elements of the primary care strategy:

1	Provision of uniform services across the CCG
2	Services as local as possible
3	Equality of service provision
4	Continuity of care where appropriate
5	Patients seen by the most appropriate professional
6	Maximised use of integrated / aligned care pathways
7	High quality and responsive services
8	Resources linked to need

Principle 1 - Provision of uniform services across the CCG

45. All practices are required to deliver services as set out in their medical services core contract. The CCG also commissions a range of community-based services. These are over and above the core contract and are locally designed to address particular priorities that the CCG has identified, such as the cardiology community based service, designed in response to the high number of premature deaths in the City due to heart disease. Practices can decide whether or not to apply to provide these extra services; they are not compulsory.

46. This means that for some patients, there may be a gap in local service provision if their registered practice is not participating in one of these discretionary services. There are varying reasons why a practice many decide not to sign up to a community-based service:-

47. Firstly, the practices vary in size – both in terms of teams and premises – which results in variable capacity to take on extra work over and above their core contract.

48. Secondly, there are different skills in different practices, sometimes because of the size of the teams, but also because of the extra training that some staff have chosen to undertake. In smaller practices, it is hard for a small number of staff to be competent across the full spectrum of community based service areas.

49. Thirdly, some practices feel more willing or confident than others to take on more complex work.

50. Through effective commissioning we will ensure that all patients have access to a uniform range of services, matched to their health need and delivered to a consistent level of quality. We shall do this by designing a framework with varying levels of delivery, as shown below.

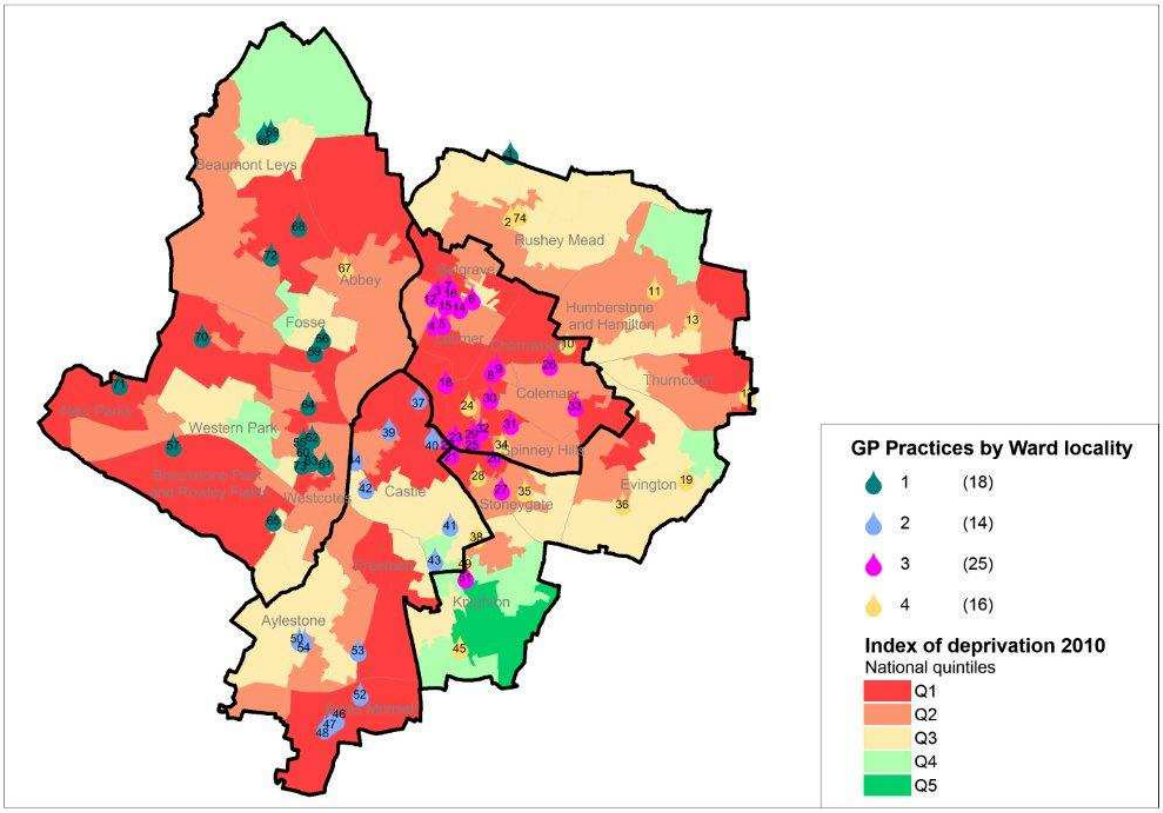
Core set of services	Community based services	More complex services
Delivered by all 62 practices	**All 62 practices eligible to apply. Other local practices provide if required**	**Smaller number of accredited providers deliver the service from local hubs**

51. This framework will also be supported by the delivery of training associated with each of the services so that a general up-skilling of primary care results, with improved outcomes and a more consistent quality of service.

Principle 2 – Services as local as possible

52. The key public health data extracts highlighted in an earlier section demonstrated the complexity and diversity of the population of Leicester City. With large variations in deprivation and pockets of poor health, effective service provision is a complex issue. We know that some communities have relatively poor public transport links, making travel to service centres an issue. Health needs can vary significantly across relatively small geographical areas. For example, in the east of the City there are higher numbers of frail older people and therefore higher rates of dementia. In contrast, smoking rates are highest in the west of the City, resulting in high rates of lung disease in areas such as Braunstone. It is important that the location of services is sensitive to these needs.

53. Using public health data, we are able to map disease prevalence at ward level across the whole City. This analysis shows four main geographical areas each with similar levels of deprivation and health need. It is proposed that these areas are termed "Health Need Neighbourhoods" (HNNs). They form logical footprints on which to organise the delivery of services.



Map showing four Leicester City health need neighbourhoods

54. We have analysed the geographical spread of registered patients for each practice against the new HNN footprints (Appx XX) and they show a good alignment.

55. Capacity planning is a key element of the primary care service. When considering the location of services, we shall identify which will be delivered in *each* practice (core services), which shall be delivered in *most* practices (community based services) and the more complex services which will be delivered by a much smaller number of providers and need to be located in "hubs" (intermediate level services). When sizing the hubs, we shall need to understand any BCT activity assumptions or new pathways that result in increased primary care activity and factor that activity into the capacity considerations. Looking at the four HNNs, our initial view is that there are suitable facilities across the City which could act as potential hubs. They are Westcotes Health Centre, Merlyn Vaz, Brandon Street, Victoria Park Health Centre, Inclusion Health, New Parks Health Centre, Leicester Medical Group – Hall Lane/ Dr Sahdev, The Willows Medical Centre, St Matthews Health Centre and Bowling Green Street Surgery. Further capacity planning work is required to test and finalise the hub arrangements, to ensure suitable access for patients in each of the HNNs.

56. We see these four health neighbourhoods as an important planning footprint for the future. Being based on ward boundaries, there will be councillors linked to each area, allowing us to form close working arrangements to discuss and address some of the non-health related determinants of ill health which drive health inequalities. Examples might include issues relating to tobacco control or alcohol sales, or educational issues. The recognition of health neighbourhoods will help to progress the Health and Wellbeing strategy for the City.

57. In their response to the "call to action" the NHSE local Area Team had also described a service provision model based upon hubs, but with doctors, dentists, pharmacists and opticians located together. Such a model would be a suitable arrangement in a more dispersed community. However in Leicester City, such providers exist in sufficient numbers to be in close proximity already, removing the need for co-location within the proposed hubs. The Area Team will however need to ensure that the other primary care contractors are present in sufficient numbers to address the health need of the local population. For instance, children's oral health is particularly bad in the City and the number of children's dental contracts must be tested against each of the four health neighbourhoods.

58. The CCG is not directing what size practices should be, or whether they should be federated. What the strategy sets out is a vision of service provision from the patient's perspective and practices must respond to deliver this in the most efficient and effective way. That is likely to lead to an element of collaboration for many practices, although the level of that collaboration may very significantly in the extent of its formality.

59. With its geographical focus, the strategy encourages local stakeholders to work together to address the determinants of ill-health, many of which fall outside the NHS's scope of influence. This very local focus will not prevent practices from other areas of the City collaborating in a formal or informal way to maximise efficiency and effectiveness.

Principle 3 – Equality of Service Provision

60. The Director of Public Health's report (Appendix A) shows how diverse and complex the population profile is in Leicester City. The CCG attempts to ensure that the services it commissions are accessible by patients from each of the nine protected characteristics. Even so, the patient feedback (Appendix B) gave some clear examples where patients feel overlooked, misunderstood and poorly catered for. Examples include those with mental health issues and the trans-gender population. Unless all of our patients can access services that are sensitive to their needs, we shall not close the inequalities gap.

To improve the equality of service provision, we shall

- **have a programme of actively testing and checking the uptake and impact of our services across the protected characteristics**
- **undertake research to test key inequality hypotheses e.g. testing if there is a lower uptake of dementia services by those from BME groups and the factors that cause this**
- **actively engage with our communities to understand their needs and cultural sensitivities when both designing and evaluating services**

Principle 4 – Continuity of Care where appropriate

61. With an ageing population and the ability to keep people with more complex conditions alive for longer, there is a resultant increase in the size and complexity of primary care workload. This is further increased by the development of the CCG's suite of BCF services which aim to help more people receive an enhanced level of care in a community setting.

62. The use of risk stratification tools allows us to identify with some accuracy those patients who are most at risk of an adverse clinical event and / or an emergency admission. For this more complex cohort, our clinicians know they are often best placed to deliver care, as they know the patients, their clinical history and their care plan.

63. The CCG has already recognised the importance of the GP in supporting the more complex patients by investing in extra GP time to undertake care planning. This is undertaken in partnership with the patient, carer and relatives and gives some reassurance about how the condition might progress and the development of a care plan that reflects the patient's wishes.

64. Evidence shows how important continuity of care is, but an even more important aspect is the continuity of quality of care. The CCG has made huge strides in driving up quality through the use of information technology and shared patients records (with appropriate consent). The CCG will build on this to ensure that the patient's record and care plan can be accessed by those delivering care wherever the patient is – in the GP practice, ED, at home with a district nurse or with a pharmacist who is reviewing medication. Giving clinicians access to the up-to-date care record supports more informed treatment choices and directly contributes to improved clinical outcomes. Those patients with a long term condition are likely to benefit most from this sharing of their clinical record.

Principle 5 – Patient is seen by the most appropriate professional

65. To make the best use of local NHS resources, the system design should direct patients to the correct service and the most appropriate individual within that service. This is particularly important for those patients living in the City who are not familiar with primary care services or how they fit with other health provision.

66. We know that, with better clearer information, more patients could deal with minor ailmens themselves. Experience with local and national pilots hs also demonstrated that it is possible to stream a high percentage of patients to health professionals other than a GP, where the care they receive is effective and provides a good patients experience, without generating more work further down the line.

67. Evidence has been gathered on the impact of using physiotherapists, nurse practitioners, community pharmacists and Emergency Care Practitioners.

68. A capacity modelling tool will be explored that helps practices to design a process that works for their particual population and which aims to free GP tiem for those more complex patients where continuity of care is most important.

69. Once the capacity modelling has been concluded, we shall need to formulate a workforce plan that will result in the training and recruitment of sufficient numbers of professionals for the agreed primary care service model. This workforce plan must also accommodate the general population increase for Leicester City in the next five years (estimated to be more than 13,000) as well as the expected impact of the BCF and BCT activity.

70. The transfer out or complete prevention of hospital-based activity through the impact of BCF or BCT initiatives will release capacity within UHL and some of these may be suitable for recruitment into a primary care setting.

71. As we move towards directing patients to the right care professional, the CCG will need to invest time, skills and resources into communicating with patients and the public about their expectations for the service and the fact that they may not always see a GP in the future.

Principle 6 - Maximise use of integrated / aligned care pathways

72. Research has repeatedly shown that the interface between organisations is where care for patients often goes wrong, usually because of poor communication. Increased quality of care and improved outcomes will result from the use of agreed care pathways which pass patients seamlessly across the organisational interface in a managed and predictable way. Agreed integrated pathways can help to get patients rapidly to the right place, having had the agreed level of workup to allow a fast and accurate diagnosis and care. We will ensure we maximise the use and impact of integrated and aligned care pathways through the use of initiatives such as PRISM. Our clinicians will continue to identify opportunities where agreed pathways will result in improved quality and patients experience, such as our 3T cardiology initiative which is now preventing strokes for some residents of Leicester City. These pathways shall then be embedded in our primary care services through the influence that we can bring to bear through our co-commissioning responsibilities.

Principle 7 - High quality and responsive services

73. Feedback from patients shows how important ease of access is to them. It naturally follows that if we want a responsive system that directs patients to the correct healthcare professional, that process must work really well and the patient must find it very easy to make contact and / or secure an appointment with the appropriate person.

74. Practices, patients and the CCG will work to agree what appropriate access means and will work to make sure this is delivered in a way that matches the population need. We shall ensure that services such as walk-in centres and extended opening hours are commissioned to specifications that meet these requirements.

75. The CCG will support practices in the use of new technologies to enable easy patient access. Methodologies range from on-line booking, teleconferencing, telemedicine, effective telephone booking etc.

76. The CCG will continue to work closely with the out of hours service and NHS 111 with a view to commissioning a quality service that delivers seamless care to patients to the same standards out of normal opening hours as in hours. The sharing of patient records will help to facilitate this as will clinically informed service specifications.

Principle 8 – Resources linked to need

77. The health need neighbourhood model aims to build a real local focus on and commitment to the local community and to deliver improved health outcomes and reduced health inequalities. At the same time, the CCG aims to deliver more reassurance to primary care, greater financial stability allowing practices more

opportunity for medium to long-term planning, whilst also aiming to reduce unnecessary bureaucracy within the system. A quality contract could help to achieve these aims.

78. The quality contract would work in the following way:-

- Step 1. Pool the funding that is currently associated with services over and above the core contract e.g. funding associated with any transfer of activity out of secondary care, funding currently in community-based services, BCF support funding, QOF (Quality Outcomes Framework) etc.
- Step 2. Divide the funding across practices using a budget tool methodology that is sensitive to local health profiles (e.g. adjusted Cambridgeshire toolkit) which takes account of health needs / risk stratification / care home patients / older patients).
- Step 3. Identify required health outcomes, linked to the profile of the specific HNN.
- Step 4. Pay the quality contract funding in instalments to practices for achievement of outcomes. Agree what will happen in the event of non-delivery of outcomes.

79. The CCG's clinicians have developed services and initiatives to address the priority health outcomes and we shall continue to refine these and introduce new services. For those services requiring specialised skills and / or staff (e.g. specialist nurses) we shall explore a model that pools the workforce and does not require each practice to source the specialised resource themselves. This of course may include the transfer of appropriate skills from the secondary care sector to a community setting.

STEPS TO MAKE THE VISION REALITY

80. There are a number of key enabling strands of work that underpin the strategy. These tackle the main issues and challenges facing primary care and will allow the CCG to turn the vision into reality. More detailed consideration of them is required in the short term to translate them into an implementation plan. Some of the work lends itself to LLR-wide approach whilst the rest is CCG-specific. The key areas are:-

Enabler	Detail
Demand and capacity modelling	Undertake modelling based upon patient streaming, risk stratification, BCT assumptions and health needs
Health Inequalities	Explore possibility of quantification of health inequalities benefits

Enabler	Detail
Quality Contract	Develop and test quality contract based upon measurable achievement of health outcomes sensitive to local health need
Service development plan	Review services in light of local health need
Develop workforce plan	Develop workforce plan based upon capcity and demand model and local service review. Identify numbers and any skill requirements
Recruitment	Develop recruitment strategy, also linking with other CCGs and Health Education East Midlands (HEEM) to improve Leicester City profile as a place to work
Retention	Develop retention strategy which in particular supports trainee doctors, nurses and allied health professionals, encouraging them to stay in Leicester following qualification.
Premises	Update premises survey to enable accurate capacity planning
Public engagement exercise	Undertake further public engagement exercise, particularly with regard to exploring the definition of appropriate access and the new primary care model
Communications plan	On-going plan, but in particular to focus upon • HNNs and what they mean • Increasing self-care • Improving information availability for the public
IM&T	Maximising the use and efficiencies offered by IM&T e.g. through access to patient records etc.

81. Producing a detailed implementation plan to cover the enabling streams of work is now an immediate priority.