



**Better care together**

Leicester, Leicestershire & Rutland health and social care

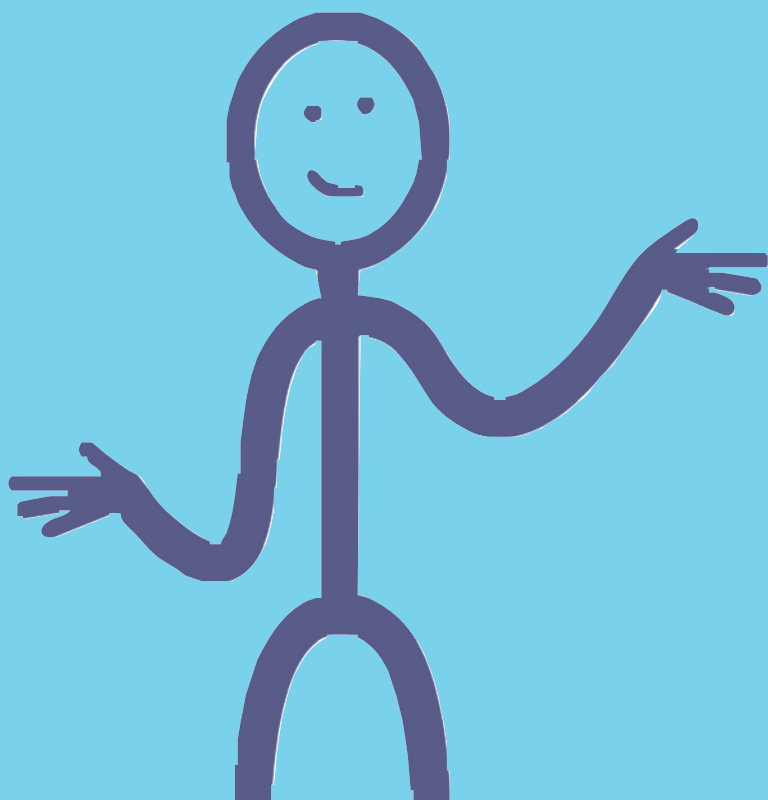
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# Blueprint for General Practice

## Delivering the General Practice Five Year Forward View

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



Final Draft

Final Draft

# Contents

1. Introduction . . . . .	1
2. Our Model for General Practice . . . . .	8
Vision	
Model	
Next steps	
3. Extended Access Across LLR . . . . .	17
LLR Extended Access Service Model	
Next Steps	
4. Workforce . . . . .	24
Education, Training and Recruitment	
Next Steps for General Practice Workforce	
5. Workload . . . . .	30
Next Steps	
6. Infrastructure . . . . .	35
IM&T	
Estate	
Next Steps	
7. Investment . . . . .	45
Five Year Investment Plan for Primary Care	
8. Engaging on Primary Care in Leicester, Leicestershire and Rutland . . . . .	52
Next Steps	
9. Leadership, Governance and Programme Arrangements . . . . .	55
Next steps	
Risks	
10. Conclusion . . . . .	58

# 1. Introduction

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

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

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

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

## **What Primary Medical Care will look like in five years**

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

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

### Challenges:

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

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

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

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

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

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

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

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

### Impact on the 9 “Must Do”s

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

### The Local Landscape—Population

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

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

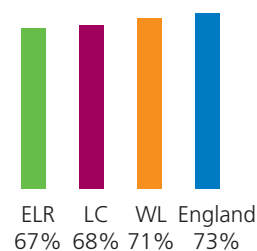
life expectancy is complex and is impacted on by deprivation, lifestyle and the wider determinants of health.

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

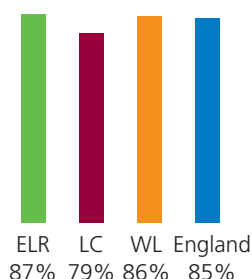
The table below shows the NHS Outcome Indicators and the relative position of each CCG demonstrating variation in performance and outcomes.

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

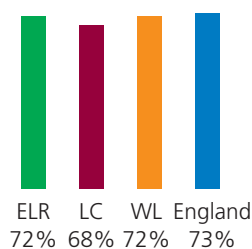
## Patient satisfaction



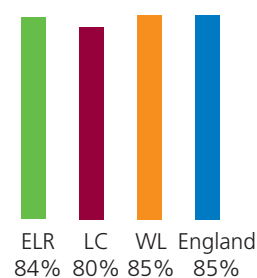
% of patients who find it easy to get through to their surgery by phone.



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



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



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

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

## healthwatch

### Summer Survey 2016



**GP**

**114 Comments**

- Helpful, polite and friendly staff
- Same day appointments
- GP attentive to needs
- Empathetic doctors and nurses



**GP**

**97 Comments**

- Access to a timely appointment
- Waiting times for an appointment
- GPs to listen to patients better
- Seeing the same GP
- Introduce GP hubs in the county
- Holistic support to deal with a range of issues

## What Patients Have Said

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

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

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

## The Local Landscape—General Practice

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

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

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

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

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

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

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

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

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

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

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

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

## Improving Quality in General Practice—Supporting Improvement and Sustainability

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

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

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



## Care Quality Commission (CQC)

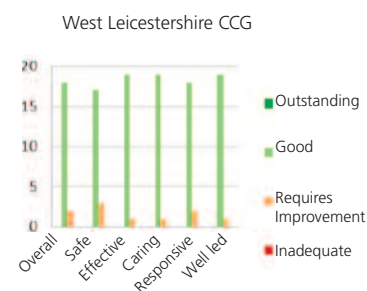
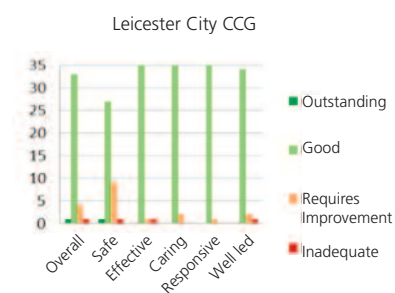
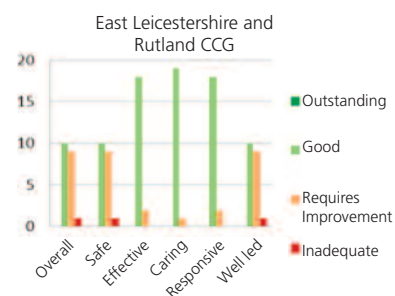
Since the advent of co-commissioning the 3 CCGs (April 2015) have adopted a comprehensive risk share and management process involving the CCG/CQC/NHSE. This allows for formal discussion on a monthly basis to assess and score risk in our primary care providers. Risk factors include, CQC reporting, contract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

## In Conclusion

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

Our priorities for action are to:

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



## 2. Our Model for General Practice

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

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

See the following sections:

4. Workforce
5. Workload
6. Infrastructure
7. Investment

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

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

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

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

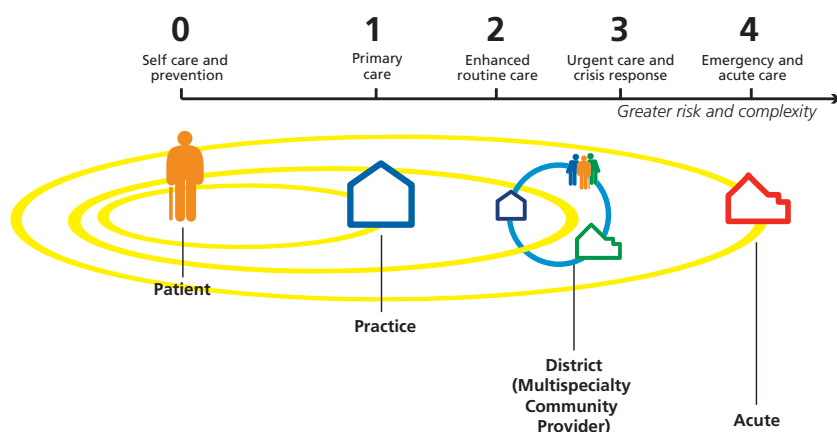
### Vision

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

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

## Model

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



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

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

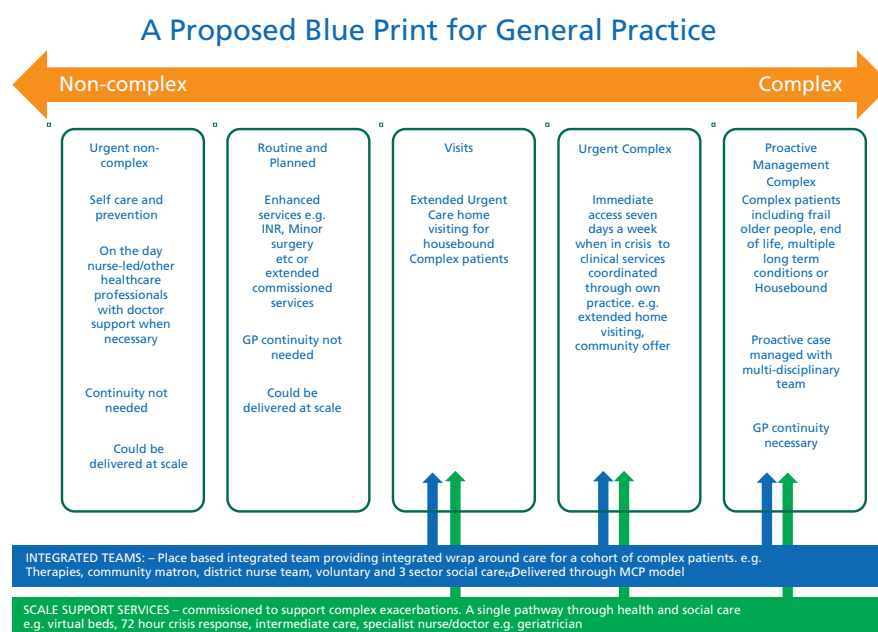
The evidence of demand, patient disease-profile, and expectation, shows that the reasonable needs of patients have changed since the contract was issued in 2004. All practices will need to provide a level of urgent primary care access as well as planned services and should support patients in self-care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

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

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

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

(See Section 4: Workforce)



## Our Baseline

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

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

### *In LC CCG*

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

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

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

### *Federations*

#### **ELR CCG**

- ELR GP Federation

#### **WL CCG**

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

#### **LC CCG**

- Across Leicester
- Millennium
- City Central

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

### *In ELR CCG*

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

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

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

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

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

### *In WL CCG*

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

### *Localities and Federations*

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

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

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

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

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

## Conclusion

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

## Our localities

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

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

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

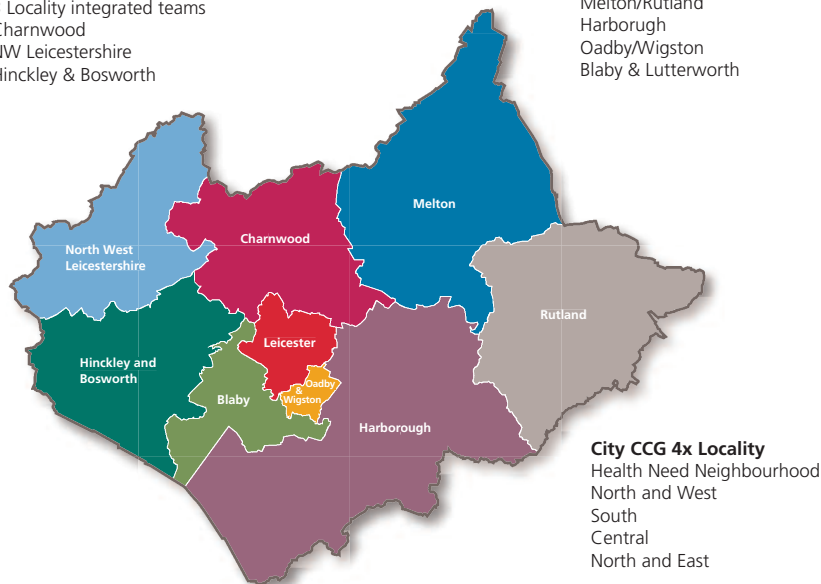
## LLR Integrated Teams

### WLCCG

3 Locality integrated teams  
Charnwood  
NW Leicestershire  
Hinckley & Bosworth

### ELRCCG

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



### City CCG 4x Locality

Health Need Neighbourhood  
North and West  
South  
Central  
North and East

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

## Working together to achieve our model

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

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

These are:

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

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

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



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

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

### Interdependencies with other transformational programmes in LLR

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

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

These are:

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



## Our commitment to our patients

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

### Consistently High Quality

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

### Responsive and Accessible

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

### Integrated

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

### Sustainable

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

### Preventative

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

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

## Next steps

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

### *1 Individual patient level*

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

We will:

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

### *2 Individual practice level*

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

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

### *3 Collective level*

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

- Providing ongoing support to the development of federations.

### *4 Collaborative level*

We will build on our locality structure to:

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

### *5 Specialist level*

We will work with our secondary care providers to:

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

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

## 3. Extended Access Across LLR

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

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

### Our Model

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

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

### LLR Extended Access Service Model



Self-Care

**111, Advice, Pharmacy, NHS Choices**

Monday–Friday, 8am–6.30pm Practices offering core primary care

#### Ambulatory Urgent Access

Monday to Friday evenings and all day at weekends. Multi-disciplinary team including ANPs and GPs. Located across LLR, within community hospitals, and large health centres for a population hub. Access Via GP surgeries, 111 and clinical navigation.



Ambulatory

**Ambulatory Urgent Access 8–8 7 days per week.** Three Leicester City Hubs and the Oadby Urgent Care Centre—Multi-disciplinary team including ANPs and GPs Access via GP surgeries, 111 and clinical navigation.

#### Out of Hours base service

Available via Clinical Navigation and 111 at Loughborough and the Leicester Royal sites.

**Loughborough Urgent Care 24 hours a day 7 days a week.** Acute diagnostics and Ambulatory care accessed via GPs and booked appointments through the Navigation Hub.



Non-ambulatory

GP (Core) Home Visiting 8am–6.30pm, Monday–Friday.

LLR—Wide Out of Hours Home Visiting 6.30pm–8am, 7 days.

**LLR Urgent Care home visiting service 8am–8pm, 7 days.** Referred by GPs during weekdays and identified at risk (some patients may have a passport for access to the weekend service).



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

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

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

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

## Current Baseline

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

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

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

The current range of services provided by each CCG varies:

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

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

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

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

## Understanding Demand

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

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

## Implementation of the Extended Access Model to achieve 100% coverage

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

### *LC CCG*

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

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

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

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

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

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

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

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

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

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

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

### ELRCCG

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

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

### Definition of Tiers

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

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

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

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

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

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



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

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

### WLCCG

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

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

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

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

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



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

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

- 4. Workforce
- 6. Infrastructure
- 7. Investment.

## Next Steps

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

### ACROSS LLR:

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

### ELRCCG:

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

### WLCCG

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

### LCCCG

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

## 4. Workforce

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### In Five Years

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

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

#### *This will be delivered by:*

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

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

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

### LLR General Practice Workforce Baseline

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

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

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

## LLR Workforce risks

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

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

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

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

## LLR Collaborative Workforce Programme

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

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

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

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

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

## Leadership and Organisational Development

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

### Practice/CCG Level

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

### Collective level

- Federation OD plans and development programme

### Collaborative level

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

maximise the LLR workforce supply pipeline.

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

## Working together to achieve our aim

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

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

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

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

## Education, Training and Recruitment

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

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

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

## New Workforce

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

## Practice Manager Academy

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

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

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

## Investment in Workforce Development

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

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

## Next Steps for General Practice Workforce

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

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

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

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

health professionals, practice managers and administrative staff.

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

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



## 5. Workload

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

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

### *Working with patients to target demand*

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

From The NHS Constitution, 27 July 2015:

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

### In Five Years

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

### Baseline Position

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

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

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



## Working together to achieve our model

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

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

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

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

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

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

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

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

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

### Workshop attendance and feedback

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

On the day feedback included:

"This is just what we need"

"Great opportunity to learn from colleagues in different CCGs"

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

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

### Transferring Care Safely

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

- Medication
- Referrals
- Diagnostics
- Monitoring
- Administration

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

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

## Next Steps

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

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

### Transferring Care Safely

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

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

### Initiatives to reduce demand on General Practice

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

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

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

### **General Practice Development Programme**

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

#### ***Productive General Practice (PGP)***

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

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

#### ***General Practice Improvement Leaders Programme***

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

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

#### ***Ten high impact actions***

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

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

### **General Practice Resilience Programme (GPRP)**

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

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

undertake the following actions:

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

## 6. Infrastructure

### IM&T

#### In Five Years

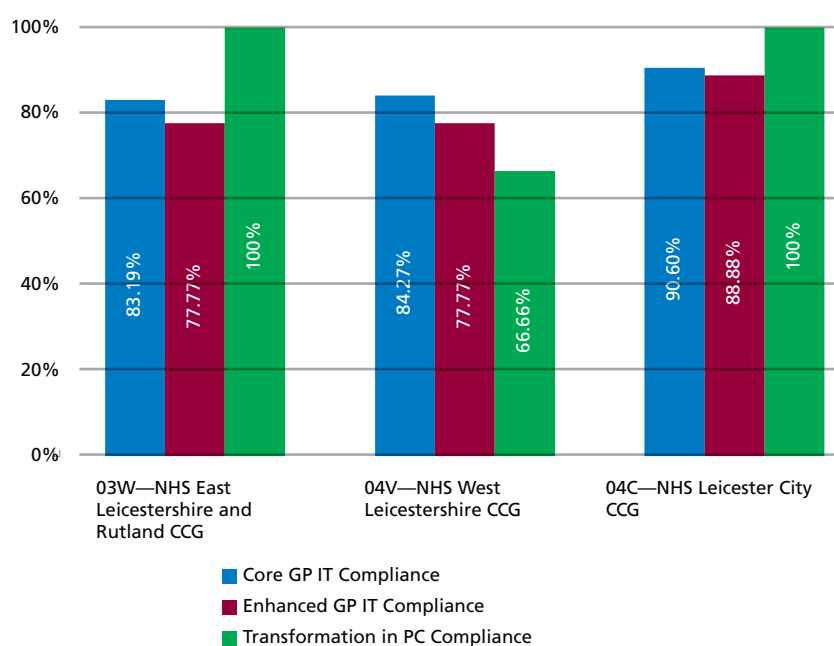
We will ensure robust shared access to paperless patient records across all clinical interfaces to improve patient outcomes and supported integrated care models. We aim to achieve better value from our existing systems through training and systems optimisation so that patients are treated more efficiently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

#### Baseline Position

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

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

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



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

### Case Study

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

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

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

## Collaborative Achievements

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

### Sharing Care Records

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

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

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

**Population Data Analysis**

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

**System Wide Efficiencies**

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

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

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

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

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PRISM—electronic clinical referral pathway system library.

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Supported mobile and agile working through Federated Wi-Fi enabling clinicians and care staff to work without being limited to access organisational native systems.

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Structured secure e-mail with health and social care providers

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Established remote access from OOH/111/Urgent Care for automated booking into City Hubs and GP for certain dispositions for in-hours Links Vanguard Clinical Navigation Hub.

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Implemented our responsibilities for GPSoC, securing ETTf funding to support 12 system migrations.

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

## Next Steps

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

### Interoperability and Record Sharing to Support Care Planning

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

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

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

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

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

### System Integration and Joint Working Hubs

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



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

### *Phase 1—Single clinical system platform*

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

### *Phase 2—Interoperable systems*

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

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

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

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

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

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

### **Technology Enabled Patient Self-Management**

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

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

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

### *Phase 1—Empowering patient self-care*

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

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

### *Phase 2—Connected care*

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

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

### **Systems Optimisation**

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

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

## Estate

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

## Baseline Position

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

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

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

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

## What we are working on together

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

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

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

## Next Steps

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

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

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

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

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

### *East Leicestershire & Rutland CCG*

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

### *Leicester City CCG*

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

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

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

### *West Leicestershire CCG*

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

## 7. Investment

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### In Five Years

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

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

### Financial Baseline for General Practice

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

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

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

### Statutory Budgets

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

### PMS Premium and Funding Differential Review (FDR) reinvestment

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



CCG	Total PMS Premium and FDR funding by 2020/21	Areas or Investment
ELR	£2.27m	<p>Year 1 : £325k recurrently (£1 per patient) invested equally across all practices to provide an enhanced dressing service and to support the new Stoma/Dressing/Catheter formulary</p> <p>Year 2: £650k recurrently (£2 per patient) Invested equally across all practices/ groups of practices to employ pharmacists or pharmacy technicians to increase workforce, support workload and improve cost effective prescribing.</p> <p>Year 3 onwards will be invested in line with CCG/ General Practice priorities</p>
WL	£1.5m	<p>Premises – to support increases in notional rent.</p> <p>Fairer Funding – distribution of funding at a practice level to support the equalising of core funding levels</p> <p>Struggling practices fund – to support practices facing significant and serious issues that have the potential to impact on patient care.</p>
City	£2.25m	<p>This was aligned with practices signing up to Improve Access, Improve clinical outcomes, reduce inequalities and engage and participate in federation development</p> <p>Year 1</p> <ul style="list-style-type: none"> <li>· Funding to raise the baseline GMS capitation to £83.21 for 30 of the city's most lowly funded practices.</li> <li>· £323,618 was invested in a city-wide quality scheme, open to all practices, which aimed to encourage practices to provide a minimum of 90 appointments per 1,000 registered patients, and ensuring that practices are open (and providing appointments) throughout core hours.</li> <li>· £61,347 was reinvested as a PMS premium for a city practice with an atypical (student) population</li> <li>· £100,000 was set aside to provide support any practices experiencing particular difficulties.</li> </ul> <p>Year 2 Onwards</p> <ul style="list-style-type: none"> <li>· In future years, the CCG is committed to maintaining the increased minimum baseline of £83.21 per patient.</li> <li>· CCG is consulting with member practices on plans to allocate the remaining funding in each year using a model that recognises the respective workload based on the burden on practices of high disease prevalence, deprivation and ethnicity/language</li> </ul>

### Discretionary spend

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

#### *ELR CCG GP Support and Investment Programme (GP SIP)*

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

- Dementia
- End of Life Care
- Care Homes



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

### *West Leicestershire CCG Federation QIPP*

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

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

### *Leicester City CCG*

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

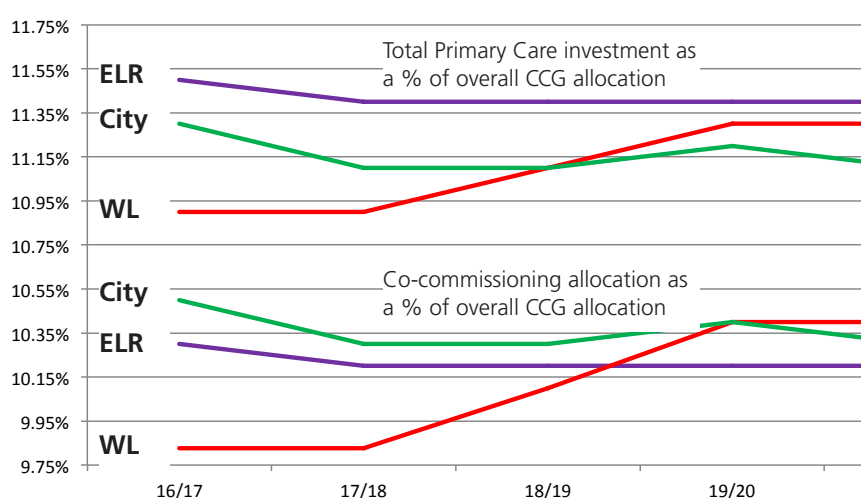
During 2017/18, Leicester City CCG will work with member practices to design and implement a new GP Quality Contract designed to fulfil our ambition as stated above. This will offer services at two levels; practice-level services and services provided by specialist practices at a Health Needs Neighbourhood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

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

## Five Year Investment Plan for Primary Care

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

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



### GPV Expectations

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

\*These figures do not include GPV £6 access fund

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

## Transformational and Devolved Funding

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

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

## Transformation

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

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

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

### On Line GP Consultation Software

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

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

The plans for roll out are as follows:

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

### Training for Reception and Clerical Staff

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

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

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

### Extended Access

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

### Further Investment

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

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

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

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

In summary, this has so far included the following:

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

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

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

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

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

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

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

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

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

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

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

## Engagement in progress

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

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

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

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

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

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

## Next Steps

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

The events will be structured to:

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

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

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

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

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



# 9. Leadership, Governance and Programme Arrangements

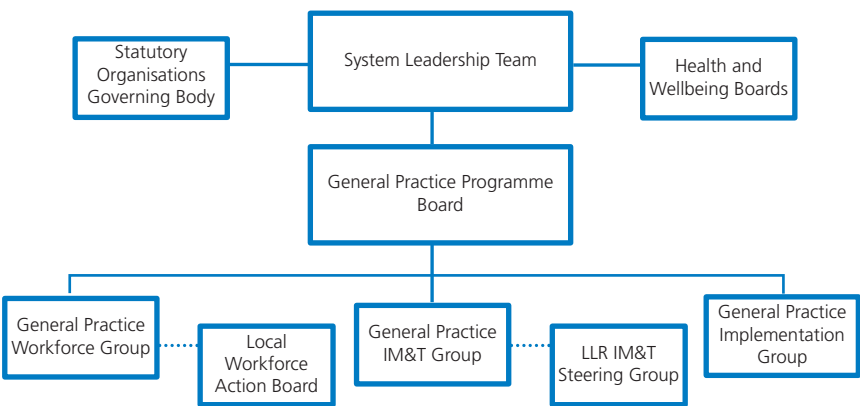
Building on the previous primary care strategies set out by East Leicestershire and Rutland (ELR), West Leicestershire (WL) and Leicester City (LC) Clinical Commissioning Groups, this GP5YFV submission is a collaborative plan that aims to provide a bold vision and clear roadmap for key reforms to our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

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

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

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

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



## Programme Management

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

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

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

## Programme risks

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

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

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

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

## Next steps

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

## Risks

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

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

## 10. Conclusion

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

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

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

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

