JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

PRIMARY MEDICAL CARE IN LEICESTERSHIRE, LEICESTER & RUTLAND

REPORT OF THE CHIEF OPERATING OFFICER – INTEGRATION AND TRANSFORMATION, LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARDS (ICB)

Purpose of the Report

1. In June 2022, a report was presented to the Health Overview and Scrutiny Committee highlighting the current priorities and opportunities in Primary Medical Care across Leicester and Leicestershire. The purpose of this report is to provide an update on these key priority areas, outlining the current position, next steps, including any challenges and opportunities.

2. In addition, this report provides a summary on the Primary Care Network (PCN) Enhanced Access services delivered by Primary Care Networks across Leicester and Leicestershire from October 2022 and the types of services offered.

3. The report also provides a brief outline the work undertaken by the Integration and Transformation Team in the implementation of the Fuller Stock Take report and timescales for implementation of Integrated Neighbourhood Teams.

4. The report is presented for information and update.

Policy Framework and Previous Decisions

5. This is a Health report on Primary Medical Care in line with NHS five year forward view and the NHS Operational Plan. The report does not relate to the budget and policy framework.

LLR Primary Care Plan Update

6. In the Primary Medical Care report presented in June 2022, it was noted that over the last two years, there has been an unprecedented demand for health and social care services. During this period, considerable work had been undertaken in Primary Care to adapt in response to increasing demand, which included collaborative working with system partners. However, it was noted that Primary Care faced a number of challenges, of which the following four areas were considered as key priorities to address:

    - **Access**: Tackling the variation in appointments, this includes how people can access an appointment and options available
    - **Workforce**: Challenges with recruitment and retention therefore promote use of a wider skill mix (clinical and non-clinical staff) to support the delivery of the right care
    - **Delivery on key Long-Term Conditions** (LTC) and reducing prevalence gap by optimization in primary care.
    - **Quality**: Reducing variation in quality and experience for our patients and aiming for overall improvement of patient experience. Improving resilience and sustainability of LLR practices.

7. Outlined within this report is a summary on each of the four priority areas and the current position following the previous report.

Access in General Practice

8. The GP Appointment Dashboard (GPAD) website was developed for general practice in March 2021 and provides useful information on appointments offered by General Practice. The GPAD data is based on the GP appointment category used which is then extracted via the practice system and presented on the GPAD website.

9. The GPAD website provides practices with an overall view of the appointment types and clinical staff activity during the month. Practices are encouraged to review the data and design their clinics based on demand and capacity from information on the website.

10. Though the ICB do not have access to the GPAD website, NHS England provide a summary report which supports triangulation of information on access and recovery pre-pandemic. Example of the information provided includes:
    - Appointment type
    - Healthcare professional
    - Recovery from pre-pandemic

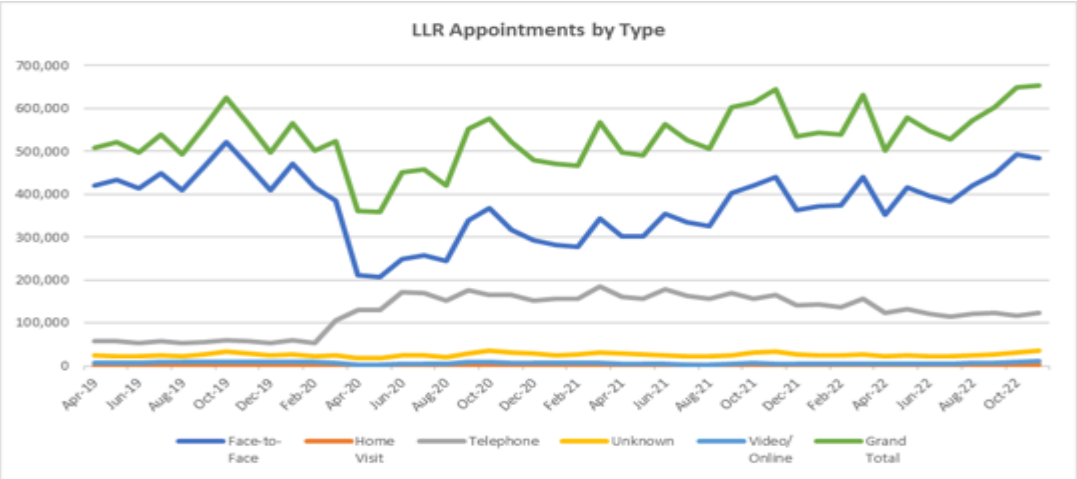
11. Unfortunately, the national monthly data reports from NHS England were discontinued from 20-Oct-2022 and data will now be available through NHS Digital. This has created a time lag in the data reporting.

Monthly data

12. Graph 1 shows the monthly number & type of general practice appointments from April 2019 to November 2022.

13. There was 0.6% increase in the total appointments provided in the latest month (from Oct to Nov 22), which follows a 7.8% increase the previous month.

Graph 1 – Total appointments across LLR



14. GPAD data also provides a summary of the proportion of GP face to face appointments from January 2022 to October 2022; with an average increase of 8.09%.

Table 1; GP Face to Face Appts: Jan – Oct 22

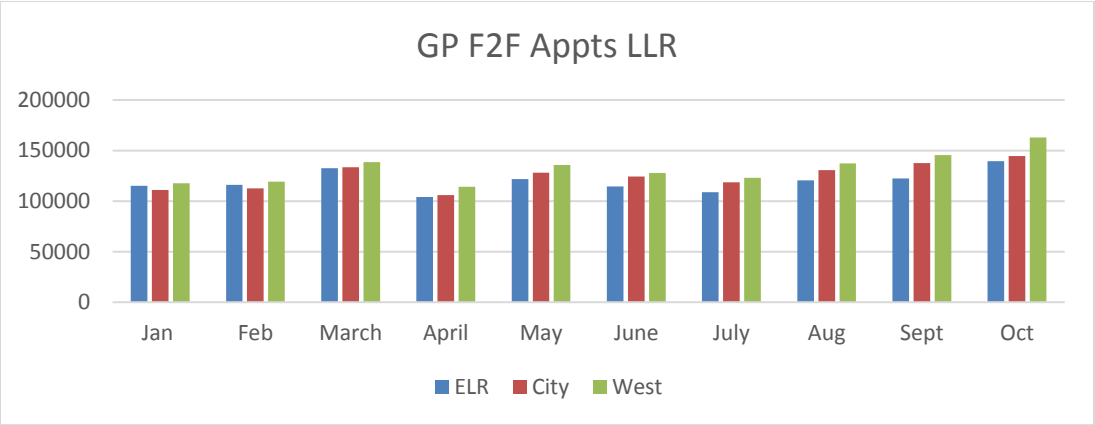
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct
ELR	115005	116000	132586	104073	121659	114495	108794	120420	122381	139607
City	110840	112435	133589	105812	127927	124162	118637	130497	137498	144567
West	117629	119197	138421	114078	135598	127798	123027	137360	145463	163026

15. Total GP Face to Face appointments from January to October 2022 was 3,762,581 as outlined in Table 2;

Table 2; Total GP Face to Face appointments in LLR

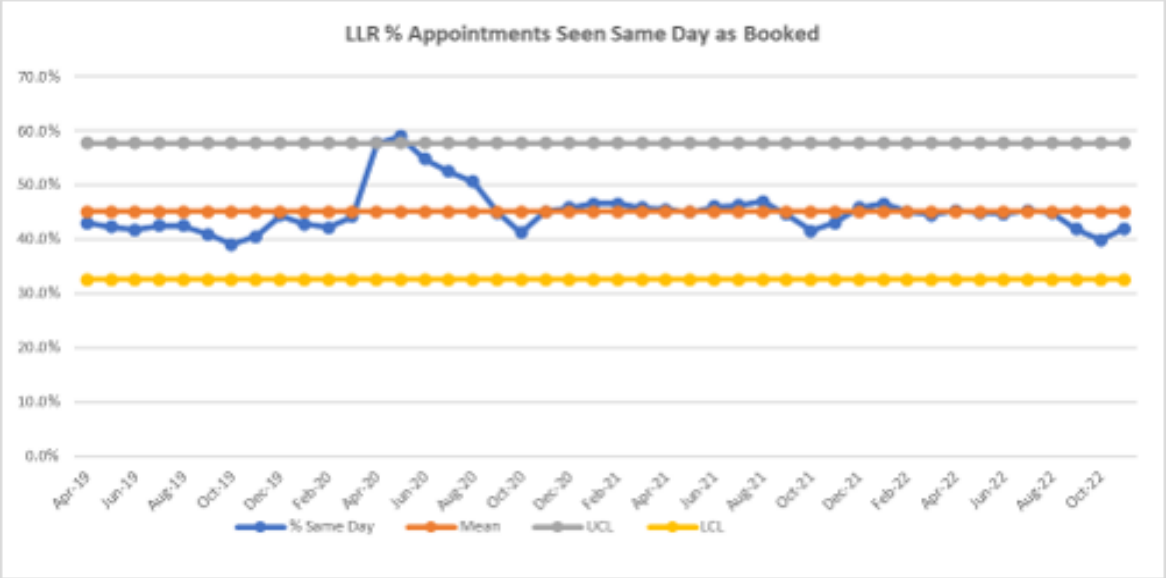
	Total Appts
ELR	1195020
City	1245964
West	1321597
Total	3762581

Graph 2; GP Face to Face Appointments in LLR (Jan – Oct 22)



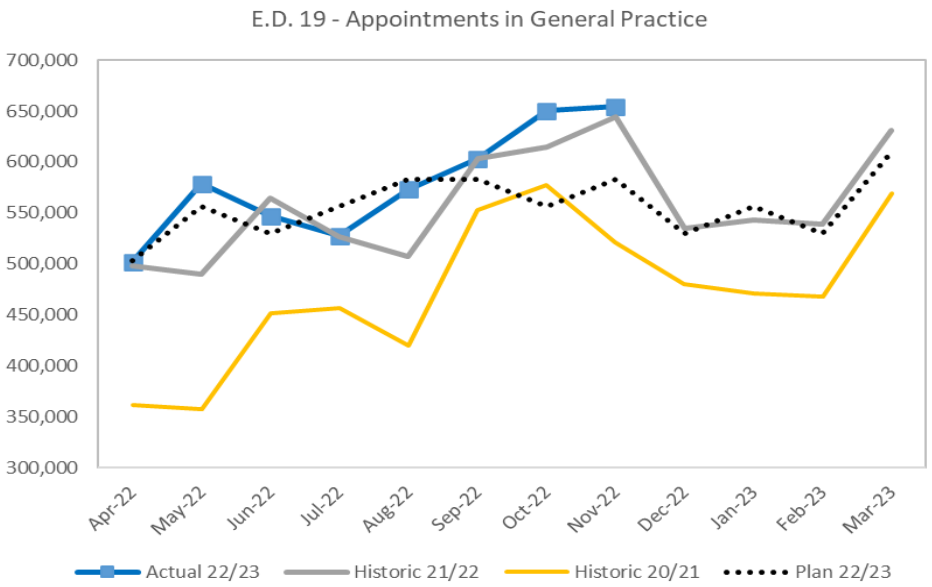
16. The graph below shows the percentage of appointments that took place on the same day they were booked. There has been little variation over the last two years (since Sept 2020), although there has been an increase in Nov 22, to 41.9% from 39.9% in Oct 22.

Graph 3 – LLR % appointments seen same day as booked



17. Graph 4 shows overall there has been an increase in the number of appointments offered in 2022/23 compared to 21/22 and 20/21. In addition, the actual number of appointments on average are above the planned recovery for 22/23.

Graph 4 Appointments in General Practice



18. Table 3 compares the past 4 November's monthly appointments which shows this year's figure is higher than previous year's. In November 2022 an additional 10k appointments were offered comparted to November 2021. This shows a positive trend in access across general practice. The number of appointments is also greater than pre-pandemic (Nov-19).

Table 3 – Total Appointments in November compared to 2019 to 2021

All Appointments	Total
Nov-19	562,391
Nov-20	521,001
Nov-21	643,907
Nov-22	654,370

Enhanced Access

19. As part of the Primary Care Network Contract Directed Enhanced Service, Primary Care Networks (PCNs) across LLR have signed up and delivering Enhanced Access from 1st October 2022 offering appointments as a PCN to the patient population. These appointments are offered from Monday to Friday 18:30-20:00 and Saturdays 09:00-17:00.

20. A mix of services are available within these additional hours with access to the range of health professionals working in the primary care team, these professionals can include GPs, Advanced Nurse, Health Care Assistants, Clinical Pharmacists, Social Prescribers, Paramedics, ANP, etc. Each PCN has designed the services they offered based on their population health needs and therefore use a multi-skilled team to address those key requirements.

21. The Enhanced Access appointments are structured to promote focus on Long Term Conditions and Preventive care management, these also include an offer of same day access.

22. Appointments range from Acute and non-Acute GP appointments, Long Term condition management, Screening, Vaccinations and Immunisation, Cytology, Medication Reviews, Social Prescriber, Health and Wellbeing, NHS Health Checks, Preventive care, Sexual Health Services, COVID Vaccinations, Cervical Screening, Diagnostic review, Joint injection clinics, First contact clinics, wound care, etc.

23. There is a choice of ways to access appointments depending on clinical need, such as telephone, video appointment, online consultation, or face to face. PCNs also offer video consultations for large groups to support health promotion or self-care management sessions and Online Consultations.

24. Details on the service provided are outlined in Appendix 1, however these are variable giving PCNs the flexibility to deliver care based on patient needs. The exact mix of what is provided through the enhanced access offer will be aligned to local health needs, current usage of out of hours services and the views of patients.

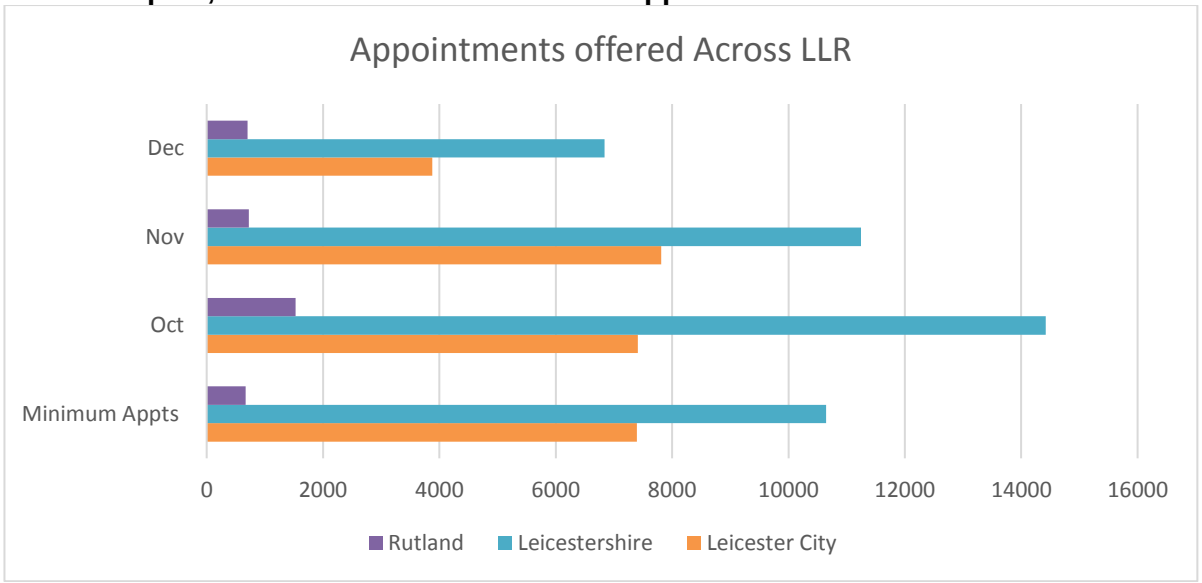
25. Outlined below is the total number of appointments offered across Leicester Leicestershire and Rutland which shows an increase each month.

26. For December 6 PCNs in Leicester City and 4 PCNs in Leicestershire are yet to submit their December Enhanced Access monitoring template due to the winter pressures. Once this data has been received, the projection on total appointments should show a further increase:

Table 4: Number of EA Appointments Oct – Dec 2022

	Minimum Appts	Oct	Nov	Dec
Leicester City	7396	7412	7812	3877
Leicestershire	10647	14423	11245	6836
Rutland	672	1529	726	702
Total appointments offered	18715	23364	19783	11414
% offered above minimum requirement		125%	106%	61%

27. **Graph 5, below shows the increase in appointments each month across LLR**:



28. As part of the Enhanced Access, each PCN has been assigned their contracted hours they are required to provided across their member practices which equates to 4679 hours per month.

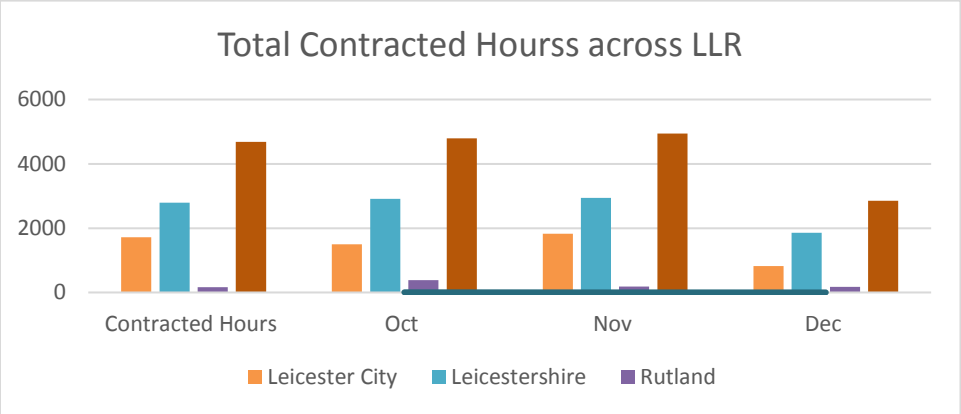
29. Outlined below is a summary of the total contracted hours for PCNs across LLR. As shown a number of PCNs are delivering hours above their contracted hours, based on the service requirements of the patient population and their health needs.

30. December data does not truly reflect the number of the actual total hours offered as 10 PCNs are yet to submit their EA Monthly return and aim to submit these by the end of January due to winter pressures.

Table 5 – number of contracted hours

	Contracted Hours	Oct	Nov	Dec (outstanding returns)	
Leicester City	1718	1501	1823	825	*6 outstanding returns
Leicestershire	2793	2909	2941	1853	*4 outstanding returns
Rutland	168	382	182	176	0 outstanding
Total Hrs	4679	4793	4946	2854	
% of hours provided above the contracted hours		102%	103%	58%	10/ 26 Outstanding returns

31. Graph 6 presents Enhanced Access hours across LLR, noting that December data is not completely reflective and pending 10 returns; on average PCNs across LLR are providing 4700 additional appointments.



Next Steps

32. The ICB will continue to monitor monthly activity reports submitted by PCNs and follow up with those who are delivering sessions under the contracted hours. Often this may be related to DNA or Workforce pressures, however the PCN will be required to adhere to their contract requirement.

33. Encourage PCNs to continue to review their local population health needs and design their appointments to capture these populations.

34. Promote sharing of best practice and successful outcomes across LLR; therefore encouraging other PCNs to adapt their appointments to meet similar health needs.

35. PCNs advised to provide more information in the monthly returns regarding the type of appointments offered, outline any barriers, challenges, benefits, feedback from staff and patients; this will enable the ICB to capture how EA is working across the system.

36. Enhanced Access data will be available via GP Appointment Dashboard from April 2023. The ICB will work collaboratively with PCNs to triangulate this information to ensure population health needs are central in designing appointments and services.

Workforce

37. As part of the Additional Roles Reimbursement Scheme (ARRS), PCNs across LLR continue to recruit to the roles under the scheme. In August and October 2022, PCNs were required to submit their Workforce Plans to NHSE to indicate which roles they had recruited to and those roles they were intending to recruit.

38. Table 6 shows the number of GPs, Nurses, Direct patient Care Roles such as ARRS and other clinical roles were recruited or planned from April to November:

Table 6 – Clinical Staff Plan, Actual and Growth

	Position	Base	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022
Plan	GPs (excluding registrars)	524	527.8	527.8	527.8	531	531	531	534.2	534.2
Actual			524.4	521.6	524.2	521.7	527.0	531.1	532.4	529.7
Variance WTE			-3.4	-6.2	-3.6	-9.3	-4.0	0.1	-1.8	-4.5
Planned Growth %			0.7%	0.7%	0.7%	1.3%	1.3%	1.3%	1.9%	1.9%
Actual Growth %			0.0%	-0.5%	0.0%	-0.5%	0.5%	1.3%	1.5%	1.0%
Plan	Nurses	281	282	282	282	284.9	284.9	284.9	284.5	284.5
Actual			280.6	275.9	279.7	282.1	284.3	279.2	277.7	279.2
Variance WTE			-1.4	-6.1	-2.3	-2.8	-0.6	-5.7	-6.8	-5.3
Planned Growth %			0.4%	0.4%	0.4%	1.5%	1.5%	1.5%	1.3%	1.3%
Actual Growth %			-0.1%	-1.7%	-0.4%	0.5%	1.3%	-0.6%	-1.1%	-0.6%
Plan	Direct Patient Care roles (Claimed ARRS)	277	324	324	324	371	371	371	418	418
Actual			333.4	351.1	354.8	392.4	391.9	403.7	422.9	410.8
Variance WTE			9.4	27.1	30.8	21.4	20.9	32.7	4.9	-7.2
Planned Growth %			15.4%	15.4%	15.4%	32.1%	32.1%	32.1%	48.9%	48.9%
Actual Growth %			20.4%	26.7%	28.1%	41.7%	41.5%	45.7%	52.7%	48.3%
Plan	Direct Patient Care roles (not ARRS funded)	307	313	313	313	320.6	320.6	320.6	330.1	330.1
Actual			310.0	313.7	321.1	319.7	318.1	319.2	320.7	327.7
Variance WTE			-3.0	0.7	8.1	-0.9	-2.5	-1.4	-9.4	-2.4
Planned Growth %			2.0%	2.0%	2.0%	4.4%	4.4%	4.4%	7.5%	7.5%
Actual Growth %			1.0%	2.2%	4.6%	4.1%	3.6%	4.0%	4.5%	6.7%
Plan	Other – admin and non-clinical	1357	1383.7	1383.7	1383.7	1401	1401	1401	1407.8	1407.8
Actual			1363.1	1359.4	1381.3	1382.8	1391.9	1395.4	1383.6	1393.6
Variance WTE			-20.6	-24.3	-2.4	-18.2	-9.1	-5.6	-24.2	-14.2
Planned Growth %			2.0%	2.0%	2.0%	3.2%	3.2%	3.2%	3.7%	3.7%
Actual Growth %			0.4%	0.2%	1.8%	1.9%	2.6%	2.8%	2.0%	2.7%

39. Based on plans submitted to NHSE

- GP workforce numbers is below plan as of November 2022
- Nurse workforce numbers was -6.8 WTE below plan in October and is now -5.3 WTE behind plan in November.
- ARRS role claims are on plan which is set quarterly and need to achieve 418 WTE by December 22 and was reported at 422 in October.
- Direct Patient Care roles (Non ARRS) are only 3 WTE behind plan.

40. This demonstrates the challenges faced by general practice from a workforce perspective across LLR. Particularly in Leicester there are challenges in recruiting to GP Workforce which makes the delivery of services challenging.

41. PCNs continue to be supported with recruitment of the ARRs roles and other clinical support required. Working with the PCNs we have a workforce plan that focuses on how we support PCNs with recruitment, training and very importantly retention.

42. The table below outlines the number of clinical staff over the 8 months of 2022/23 financial year:

City

- GP numbers in Leicester were declining from the start of 2022. GP numbers dropped in October and increased by 0.9 WTE in November and the overall number remains below Jan 22.
- Growth YTD is at 0.2%. Growth is falling far behind Leicestershire and Rutland which is showing growth and at a much higher rate.
- Nurse numbers in Leicester have seen a decline since January 2022 but remained static for September, October and November 2022

Table 7 – Leicester City GP Workforce data

City Primary Medical Care (Non ARRS)	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022
GPs excluding registrars	169.0	168.5	167.8	166.1	163.9	162.0	162.2	165.1	166.7	165.0	165.9
GP registrars	53.9	49.6	50.0	45.4	46.1	45.9	46.7	66.9	68.2	67.6	65.5
Nurses	76.6	75.4	75.4	75.3	74.7	74.6	74.6	76.5	73.8	73.8	73.6
Direct Patient Care roles (Non ARRS funded)	88.7	86.3	88.5	91.0	91.2	92.0	92.0	88.6	90.8	92.7	96.0
Other – admin and non-clinical	444.5	446.9	447.6	450.0	451.6	454.1	454.2	453.2	452.7	446.8	445.1
Total excluding registrars	**779**	**777**	**779**	**782**	**781**	**783**	**783**	**783**	**784**	**778**	**781**
Cumulative Growth		-0.2%	0.1%	0.5%	0.3%	0.5%	0.5%	0.6%	0.7%	-0.1%	0.2%

Leicestershire & Rutland

- In November 2022 Leicestershire & Rutland the number of GP's decreased by 2.5 WTE.
- YTD growth has been 5.1% which exceeds Leicester growth.

Table 8 – Leicestershire and Rutland GP Workforce Data

County Primary Medical Care (Non ARRS)	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022
GPs excluding registrars	354.9	356.5	356.5	358.3	357.7	362.2	359.5	361.9	364.4	367.3	363.8
GP registrars	114.5	115.8	112.2	115.8	113.3	111.8	108.1	133.0	133.2	130.6	126.9
Nurses	204.0	206.1	205.4	205.3	201.2	205.1	207.5	207.9	205.4	203.9	205.6
Direct Patient Care roles (Non ARRS funded)	210.3	212.1	218.5	219.0	222.6	229.1	227.6	229.5	228.4	228.0	231.6
Other – admin and non-clinical	895.0	909.3	909.4	913.1	907.9	927.2	928.6	938.8	942.6	936.8	948.5
Total excluding registrars	**1664**	**1684**	**1690**	**1696**	**1689**	**1724**	**1723**	**1738**	**1741**	**1736**	**1750**
Cumulative Growth		1.2%	1.5%	1.9%	1.5%	3.6%	3.5%	4.4%	4.6%	4.3%	5.1%

43. Our workforce risks centre around recruitment and retention of GPs and Nurses and this remains a greater challenge in Leicester compared to Leicestershire and Rutland.

44. Though workforce continues to remain an ongoing challenge across primary care, the Workforce Team continue to develop and promote innovative ways to addressing the workforce shortages by designing training and fellowship schemes in partnership with other organisations.

45. To address these challenges, over the course of 2022/23 the LLR Primary Care Training Hub have delivered the following schemes to support staff retention and development:

- Introduced 33 GP Fellows across LLR across through the Cohort programs
- The Active Mentoring Program has been designed to support GP Fellows and new GP including GPs returning after a period of absence.
- Introduced the 'New to Practice Programme' specifically for newly qualified nurses or those new to primary care through a fully funded access program with De Montfort University General Practice Nursing Fundamentals course. Since commencement, 26 nurses have completed the fundamentals programme and are working in general practice.
- Introduced the Health Care Assistant upskilling programme, which provides staff opportunity to enhance their skills and address workforce gaps.
- Development and expansion of the Student Nursing Associate programme for primary care. This includes the development of a 'fast track' prequalification to enable people new to the NHS to access these roles. These programs address the recruitment shortages in general practice through enabling potential students the opportunity to gain first-hand experience in the field.
- The Training Hub was successful in securing funds from Health Education England to support a GP trailblazer fellow in a large inner-city practice. Once implemented, the learning will be shared.
- Designed, developed and delivering a bespoke primary care induction programme tailored to meet the needs of colleagues entering into the Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS) and other primary care roles for the first time. This induction program is delivered at scale across LLR and promotes integration of these new roles into primary care.
- Physician Associates who are either newly qualified or new to primary care are offered a funded preceptorship program facilitated through the Training Hub as an opportunity to support their induction into primary care.
- Provision of a locally designed and developed 'Continuing Professional Development Calendar of Events' offered by the LLR training hub clinical leads to promote CPDs across primary care.
- Delivery of a non-clinical upskilling programme designed to attract and support people into an administrative role in primary medical care.
- Support for practices and PCNs to recruit to apprenticeship roles (clinical and non-clinical, including pharmacy technicians, student nurse associates and administrative roles)

<u>Primary Care Workforce Strategy</u>

46. The Workforce Team are developing a Primary Care Workforce Strategy which will span across the next 5 years. It will seek to address the challenges and optimise the opportunities to enable workforce growth by examining and confirming the direction of travel for workforce recruitment, retention, attraction, and supply. Whilst striving to balance the day-to-day workforce challenges and possible solutions.

47. The strategy will be underpinned by the outcomes of the:
    - The LLR Primary Care Estates Strategy.
    - The Joint Forward Plan.
    - Fuller Stock Take Report by embedding Primary Care within the wider system workforce planning initiatives and the development of Integrated Neighbourhood Teams.
    - The NHS People Plan
    - The NHS Long Term Plan
    - Triangulation and incorporation of the local population health needs
    - 2023/24 Priorities and Operational Planning Guidance

48. Our Place Led Delivery plans will describe workforce priorities for each of our PCNs and for each Place and how we co-design and co-develop workforce strategies to get to our 5-year projections in terms of the type and quantity of Primary Care Workforce required. The implementation of these strategies will be supported by the following principles:

    - Local jobs for local people to support a local thriving economy.
    - Connective recruitment between graduates and local vacancies.
    - Data informed and evidence-based decision making.
    - Attractive and supportive employment packages.
    - Sustainable workforce solutions linked to our LLR people and communities.
    - Learning, training to be at the heart of developing our people.
    - Partnership working with all educational and training providers.

49. It is recognised that some of the drivers to achieve the above will be organisational culture, development, and leadership within Primary Care. This will require time to transform and change in order to deliver the above.

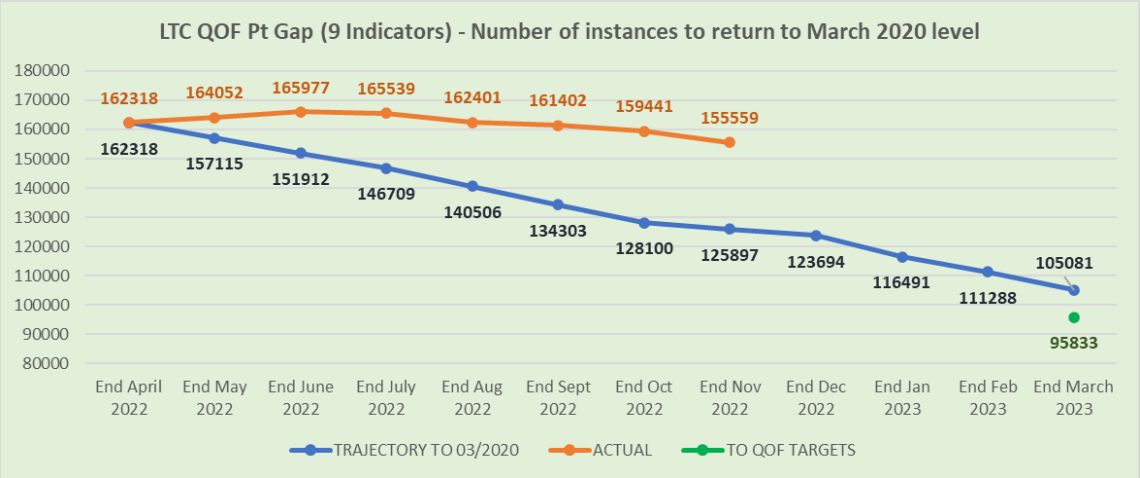
Delivery of key Long-Term Conditions (LTC)

50. The system vision continues to promote the delivery of right care to the right person at the right time, wherever they live, by providing seamless care across our system through;
    - Reducing the prevalence gap through early detection, implementation of Core20Plus5 and improved case findings and coding.
    - Improve Optimisation of LTCs by closing the QOF gap, transform pathways, promote patient self-care
    - Support digital enablement through remote monitoring, facilitate care closer to home, use of virtual wards, progress transformation at scale
    - Reduce Health inequalities by delivering Core20Plus5, making every contact count (MECC), reduce variation of care.

51. Graph 7 indicates General Practice performance, for the whole of LLR, across 9 QOF (Quality Outcomes Framework) indicators.

52. The indicators include performance around Asthma, COPD, Diabetes, Heart Failure and Hypertension.

Graph 7– LTC QOF patients



- The orange line shows our actual monthly performance and counts how many patient optimisation targets haven't been met by our practices.

- The blue line shows a monthly trajectory for us to meet if we were to recover QOF to pre-Covid levels. It shows how many patient optimisation targets weren't met by our practices in March 2020, just before Covid took hold.

- The green number is how many patient optimisation targets we would miss if we met all of the QOF targets, i.e., 70% for asthma patients optimised or 90% for COPD.

53. Although we are currently above our trajectory, our monthly figure shows a downward trend. And, with the traditional QOF activity between now and the end of March 2023, we will continue to improve our position.

54. We have now developed a comprehensive plan for Long-term conditions which is detailed in Appendix 2. Our key focus is based on prevalence data continues to be on the following key areas:

    - Diabetes
    - Cardio-vascular Disease
    - Respiratory
    - Weight management
    - Hypertension

Quality

55. Following on from the report presented in June 2022, an update on each of the following key areas is outlined within this report:

    - Care Quality Commission (CQC) Notifications
    - General Practice Quality and Operations Group/Risk Share Group – Primary Care Quality Dashboard
    - LLR GP Access Variation Group Update
    - Publication of Practice Level Appointment Data

- LLR General Practice OPEL (Operational Pressures Escalation Level) Reporting
- Royal College of General Practitioners Support Offer
- General Practice Patient Survey 2022

Care Quality Commission (CQC) Notifications

56. CQC inspections are currently being carried out for new registrations, scheduled follow ups from special measures or requires improvement ratings and where immediate risk has been identified. The CQC are moving to a new single assessment framework and the frequency and schedule for inspections may change.

57. In Quarter 2 of 2022/23, the CQC inspected 6 GP Practices across LLR; 4 GP Practices were rated as Overall Good, and 2 were rated as Overall Inadequate.

58. Areas of good practice included:
    - Staff had the skills, knowledge, and experience to carry out their roles.
    - There was a system in place to monitor compliance with staff training.
    - Staff were encouraged and supported to develop their skills and knowledge
    - Staff with dealt patients with kindness, respect and patience and involved them in decisions about their care.

59. Notable themes and areas of improvement identified include:
    - Increase uptake and promotion of childhood immunisations and cervical screening - a task and finish group has been set up with our clinical lead for inequalities to identify what the issues are and what actions need to be undertaken to improve uptake
    - Patients prescribed high risk medicines without the appropriate reviews taking place will be addressed through conversations with the Clinical Pharmacy team and Medicines Optimisation Team.
    - Monitoring of patient's long-term conditions and associated treatment plans not being done on a regular basis – we have developed a comprehensive plan to address the issues – particular in areas of low prevalence.
    - Promotion and development of the patient participation group (PPG) – the engagement team have been working with practices to revitalize their PPGs. The team have set up quarterly meetings with PPGs and the ICB to support the engagement work and the team are working with those practices who have not had PPGs set up – detailed further in this report.

60. These themes were shared with GP Practice staff at the most recent CQC grab and go session delivered by the ICB Training and Development team and CQC which included discussion on steps to improve, promote and manage risk.

61. To support GP Practices further in these areas, an improvement plan has been devised. This plan is monitored by the ICB's GP Quality Oversight Group.

General Practice Quality and Operations Group/Risk Share Group – Primary Care Quality Dashboard

62. The Nursing and Quality Team and the Integration and Transformation Primary Care Team continue to work closely to review and update the Primary Care Quality Dashboard. Within this dashboard a range of data is collected for all Leicester Leicestershire and Rutland

Practices and PCNs. The data is collected from a range of national and local sources and used as a tool to support with triangulation with an objective to facilitate early intervention, support and identification of vulnerable practices or PCNs.

63. The Dashboard is developed and updated monthly information from national and local data sources which include information on the following:
    - Workforce - All Admin FTE per 1000 Nov 2022
    - QOF Overall Achievement / Prevalence 21/22
    - Personalised Care Adjustment 21/22
    - Serious Incidents Reported 2020/21
    - Patients' complaints to NHSE 2022/23
    - CQC Inspection and Reporting
    - GP Survey Results
    - Clinical information - Screening, Seasonal Flu, Prescribing, Child Immunisation, LD Health Checks,
    - Urgent Care Activity
    - OPEL Reporting
    - GP Appointment Data (GPAD)

64. The Primary Care Quality Ops Group and The Risk Share Group work collaboratively to review the data and triangulate the information to support vulnerable practices or identify those with resilience or sustainability concerns and offer early intervention.

65. The LLR GP Access Variation Group was established in July 22 with membership that includes Workstream Clinical Lead, Place Leads, LMC representative, Quality, Contracting, and Patient Engagement Team and other Workstream Leads.

66. The purpose of this Group is to review GP Access with particular focus on the data published by NHSE on GP Appointments and triangulating this information with other relevant information, for example in hours ED and Urgent Care/Treatment Centre attendance, with the aim of: -
    - Understanding apparent variation and actual impact on access and patient experience
    - Enabling informed response to System challenges with a focus on primary care
    - Identifying actions for System partners, e.g., patient/public facing communication and information
    - Recommending System initiatives to support access and optimize capacity, e.g., the strategic deployment of specialist nurses
    - Identify those vulnerable practices that would benefit with support which can include:
        a) Help these practices reduce variation - if it is indeed unwarranted or having negative impact
        b) Help practices prepare or respond to the increasing number and scope of CQC inspections and reviews
        c) Help practices prepare for or respond to "Healthwatch" visits

67. Using the GP Appointment Dashboard (GPAD) data provided to ICB from NHSE, (Nov 22) the group have: -
    - Undertaken 7 individual practice interventions (6 in City and 1 Leicestershire and none in Rutland)

- Planned 4 individual practice interventions for January 2023 (2 in Leicestershire and 2 in Leicester City and none in Rutland)

68. Emerging themes from the interventions so far include: -
    - Issues with appointment coding and mapping; how to recognise longer appointments, tasks that become patient contacts – this is to be clarified with regional NHSE team and asked to re-issue practice guidance
    - Support to "kick start" PPGs/Patient engagement – this has already commenced and progressing well.
    - Learning from different "same day"/triage models – sharing of good practice across PCNs has been progressed and promoted.
    - System level deployment of specialist staff (beyond ARRS)

Publication of Practice Level Appointment Data

69. On 24 November 2022, NHS Digital published practice level appointment data which:
    - Supported the Government's commitment in "Our Plan For Patients", making more information available on how many appointments each practice is delivering.
    - Included information on Time between booking and appointment date.

70. Nine (9) LLR practices were identified by NHSE as being in the "bottom 20" in the Midlands region for specific indicators (5 Leicester City, 4 Leicestershire, none in Rutland).

71. A support plan has been developed for these 9 practice which includes;
    - Opportunity to understand each practices access data "in the round" – e.g., low % of same day is not 'bad' if more patients are getting planned appointments
    - Once the above has been clarified, the team are looking at 'soft intelligence/local knowledge' for any practices identified to then look at what specific support is required.
    - Desktop review for remaining practices – triangulating the data with current 3 access metrics, ED usage, quality dashboard, resilience information/reporting.
    - ICB Comms team to continuously engage with practices to support them with queries that might be raised from the public / Health Watch – joint approach or initiatives working with LMC.

    - In preparation for 2023/24 the LLR GP Access Variation Group will be focusing on the following:
    - Undertake the planned practice conversations/interventions as above in January
    - Continue to Track/monitor GPAD and Practice Appointment Data for the practices who have had interventions to assess impact – currently awaiting further data from NHSE dashboards
    - Implement support proposal for the 9 practices identified via published data
    - Subject to receiving/accessing new data, continue to review for all LLR practices as described and continue to offer individual or more generic support/development

LLR General Practice OPEL (Operational Pressures Escalation Level) Reporting

72. The ICB in 2022 implemented a System Level Reporting process designed to understand the demand, pressure in general practice across LLR. It can alert the System of risks, or

forthcoming challenges and helps with planning, promotes partnership/ collaborative working, potentially mitigations can be developed and addressed accordingly.

73. Practices are asked to report reflective OPEL status at least once a week, but can also report any day, any time if an individual practice needs assistance/ support to enable them to provide a safe level of patient and employee care on that day. LLR OPEL reporting levels are outlined in the figure below.

74. Figure 1 – OPEL Reporting Levels

OPEL Level	Description	Support Required
Level 1 Low Pressure (Green)	• Business as usual	None required
Level 2 Moderate Pressure (Yellow)	• Busier than usual but coping • Managing within available resources • Performance deterioration, mitigating actions taken at individual practice level	None required
Level 3 Severe Pressure (Amber)	• Busier than usual and struggling to cope • Increased significant deterioration in performance and quality, majority of mitigating actions taken at individual practice level	PCN Level Support Required and/or Federation/ CCG support
Level 4 Extreme Pressure (Red)	• Unable to cope, only able to meet urgent demand • Risk of service failure, all available mitigating actions taken and potentially exhausted	Whole system support required (CCG Co-ordination required)

75. The OPEL report is monitored and checked every day by 9.00 am, and throughout the day.

76. Table 9 provides an overview of the OPELs reported in November and December 2022 and key themes which have been captured and escalated accordingly.

Table 9- OPLE reporting Nov and Dec

November	159 practice responses (109 County Responses) Level 1 – 76 Level 2 – 70 Level 3 – 12 Level 4 – 1	**Key Themes** IT Issues and Workforce.
December	139 practice responses (93 County Responses) Level 1 – 37 Level 2 – 66 Level 3 – 33 Level 4 – 3	**Key Themes** Workforce and High demand, frequently a combination of both, i.e., increased demand on/of a reduced workforce. In December the Primary Care Team escalated the following to the LLR System: • Overall LLR General Practice OPEL status • Increasing demand - specifically from ARI and Strep A • Longer term recruitment and retention issues • NHSE 111 barriers

77. Collaborative working with LLR Local Medical Council (LMC) to encourage practices in LLR to report “winter pressures”.

78. Continue to work with the LMC, General Practice colleagues and representatives to refresh and re-launch LLR General Practice OPEL reporting process in January 2023.

Royal College of General Practitioners (RCGP) Support Offer

79. Aim of the RCGP Practice Support for LLR practices, includes:
    - Diagnostic Review – our service will place two RCGP advisors in each practice to undertake a diagnostic review; to understand the specific challenges and the areas of focus for sustainable quality improvement
    - Forward Development Action Plan - bespoke for the practice, based on the onsite visit and designed to address practice specific needs
    - Direct Targeted Support – The RCGP advisor team will continue working with the practice to help support the implementation of the Forward Development Action Plan

80. All 26 places commissioned have been taken up by LLR Practices and positive feedback received on the process and impact from practices nearing completion.

81. As the RCGP are not able to work with all 26 practices at the same time, they will undertake a diagnostic review and create a plan, thereby crucially supporting these practices with implementation during the 18 months with an aim to complete all 26 practices.

82. Monthly meetings are held with the RCGP Team for progress updates and to monitor and assess timescales for delivery.
83. Themes of learning are shared across practices; for example, best practice for on-boarding for new non-clinical staff.

84. Summary on RCGP Program across LLR:
    - The RCGP process commenced in May 2022 and 26 practices implemented on the programme.
    - As the 5 Practices approach completion and where practices give permission, RCGP will be able to share the learning.

85. Positive feedback has been received from these practices stating how supported and helpful the RCGP team were in understanding their position and working with them to address it.

General Practice Patient Survey (GPPS) 2022

86. The analysis for the 2022 GPPS results focused on the questions which the CQC use to assess and monitor variance of patient experience. Of those questions, it was evident that the highest variance in results from 2021 related to access; appointment times and experiences of making an appointment. Once patients had an appointment with their GP Practice, the confidence and trust in clinician/health care professional was considerably closer to the national average, with less variance from 2021 results.
87. The largest variance across LLR was ease of getting through via telephone, with a considerable range of satisfaction for this question (3%-97%).

88. Initial work has been to work with those practice that have high levels of satisfaction and share the learning with practices who have considerably lower performance. Furthermore, understanding the limitations for the practices in relation to their telephone systems, digital options and local challenges related to size of practice and estates. Where we are able to we have been supporting practices to move to cloud-based telephony and working with practices to adopt more digital approaches where this works better for their patients.

89. The engagement team have committed to supporting those practices with really poor experience of access with a tailored package of support including:

- Website development and enhancement
- Utilisation of digital technologies – viewing records online, ordering prescriptions online, NSH app etc.
- Engagement with targeted local community groups, i.e., local mosques, community group, and Voluntary sector organisations
- Support with translation services
- Promotion of active signposting, awareness of CPCS, and increasing access options for self-help and support outside of GP practices
- PPG engagement, networks, and benefits
- Review displayed materials within GP practice
- Targeted communication to frequent inappropriate users of A&E high attenders
- Action Google reviews
- Look at targeted text messages for patients on System One / EMIS
- Review phone message and recommend alternative

Engaging and communicating with our people

90. The Leicester Leicestershire and Rutland (LLR) Integrated Care Board (ICB) has an operational plan for 2022-23 focusing on five key priorities for primary care – access, workforce, long-term conditions, Primary Care Network development and quality. Alongside this our LLR People and Communities Strategy 2022-2024, approved in June 2022, outlines how we will work in partnership to put the voices of people and communities at the heart of decision making resulting in the improvement of the health and wellbeing of our local communities.

91. The strategy outlines 17 key priorities for the system, 6 of which directly link to improvements in GP primary care services to respond to negative patient experiences and attitudes. These include:

- Create a primary care engagement framework to work with and involve people and communities to co-deliver the best possible health and wellbeing outcomes.
- Develop a strong and mutually beneficial relationship with the voluntary, community and social enterprises, individual communities, and the volunteering infrastructure to tackle health inequality and empower communities.
- Develop plans for the systematic and effective delivery of engagement activities and public consultation, ensuring that legal requirements are adhered to and the views of our communities, including those with protected characteristics, the vulnerable, those living in areas of deprivation and those living across our borders, but dependent on services, are sought using multiple engagement techniques and methods and that their views influence decision making.
- Enable partners to move away from compartmentalised engagement and involvement

to system co-design, outlining a systematic process to ensure that process of involving people starts at a formative stage on all programmes of work.

- Support the development of a framework for engaging with families, carers and children, young people and families, ensuring that they have a voice and their views influence decision making across health and care.
- Ensure that post-decision making that the impact that insights and business intelligence have made on service design and delivery are clearly fed back to the public without exception – to ensure a 'you said, we did' culture.

Reinvigorate Patient Participation Groups (PPGs)

92. To support the reinvigoration of PPGs and engagement opportunities in general, the ICB has developed a Primary Care Engagement Framework. This Framework would work at practice, PCN, place and system level to ensure that communities are engaged with in a way that fits their needs, and their voices are heard and impact service design and delivery. Joint work with patients, carers, practices and Primary Care Networks is vital to develop the primary care engagement framework. The framework would ensure that PPGs are revitalised and linked into their GP practice, their Primary Care Network and the ICB.

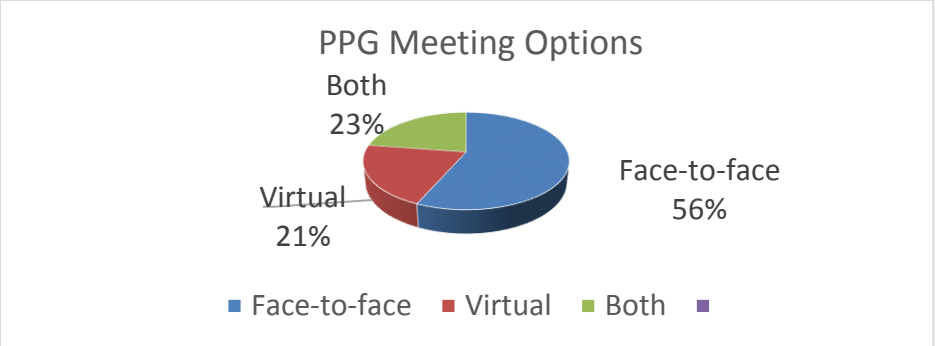
93. During 2022 an audit was undertaken with general practice to support with development of the Primary Engagement Framework and reinvigorating PPGs

94. Outlined below is a summary of the findings from the audit undertaken:
    - As of 6/12/22 there has been 78 responses across LLR and more work will be undertaken to obtain 100% returns.
    - From the 78 responses received, 67% had established PPGs while 32% were in the process and welcomed ICB support to progress these.

Table 10 outlines the number of responses received from practices within LLR who have either established PPGs or not:

ICB	No of Practices - Active PPGs	No of practices – Not Active PPGs
Leicester City	18	10
West Leicestershire	18	11
East Leicestershire	15	4
Rutland	2	0

- Majority of practices welcome support from the ICB to help establish their PPG, expressing concerns as to how difficult it is to recruit and attract people to meetings.
- The 67% that had established PPGs offered a variety of meeting options:



95. The key findings from the audit indicates:

- A significant number of practices do not have an established PPG and those that have a PPGs are not fully active
- The majority of practices have resumed face-to-face meetings, with some practices using both virtual and face-to-face
- A high percentage of GP Practices are involved with their PPG, which is good for relationship building
- A low number of PPGs are involved with other PPGs in the same PCN as them
- A high number of practices would welcome ICB support when engaging with and recruiting their PPG

96. Ongoing progress and utilisation of the following areas:

i. **Routes of access**: practices continue to offer online booking options as an alternative to phoning the practice.

ii. **Awareness of alternatives to a GP – the Multi-disciplinary team**: Practices are promoting self-awareness amongst patients on the options available when booking appointment to see the appropriate health care professional. Examples these skill mix include appointments with:
   - Clinical Pharmacists to carry out medication reviews
   - Physiotherapist for Musculoskeletal conditions
   - Dietician for weight management
   - Social Prescribing and Care Coordinators to support with social care referral links and support in the community

iii. **Promoting the use of self – referral services:** Through the 'Talking Therapies', patients can refer to the Podiatry and Musculoskeletal self-care service using an App.

iv. **Community Pharmacy Consultation Scheme (CPCS):** Practices across LLR are encouraged to promote the utilisation and referral of patients to the Community Pharmacy for aliments that can be reviewed in the pharmacy. If a patient's symptoms can be resolved by a booked consultation with the pharmacist instead of the GP, patients will be given a same-day referral to a pharmacy of their choice. In some circumstances the pharmacist can prescribe. Across LLR a number of practices have promoted this service and working collaboratively with their local community pharmacies to improve access.

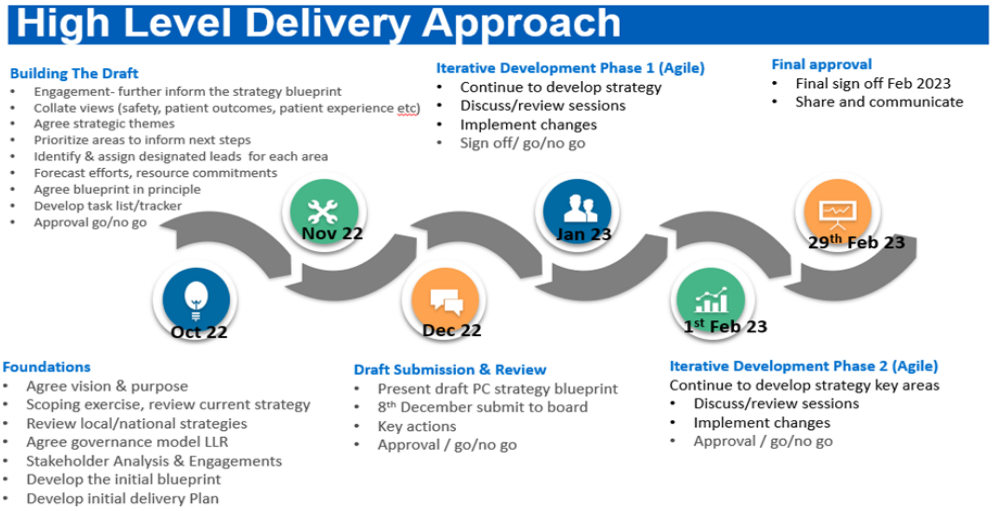
v. **Active signposting/care navigators:** Active signposting continues improve effective collaborative working with system partners to enable patients receive the appropriate care and service from within the community. The ICB Training and Development Hub continues to promote this services within primary care and promotes sharing of best practice.

vi. **Social Prescribing Event** held across LLR promotes integrated development session which includes colleagues from Local Authority to focus on how the needs of the local population can be addressed.

vii. **NHS App:** Ongoing work undertaken to promote the use of NHS App. The App provides access for patients to a range of NHS services including heath advice, ordering a prescription and manage appointments.

viii. **Primary Care Strategy:** Our Primary Care strategy needs a refresh and development in light of the recently published Fuller Stock Take and as we reframe our ambitions as an ICB. We will build on our place led plans, ensuring we direct effort and resource to where it is needed most. Tightening our alignment to better plan and co-ordinate the delivery of not just primary care, but the wider transformation of health and care across LLR. Figure 2 outlines our high-level delivery approach

Figure 2 – High Level Delivery Approach



ix. **Fuller Stocktake Report** – The ICB Fuller Steering Group designed to progress the implementation of the Fuller Stocktake Framework and includes representatives from Primary Care Estates and Workforce, Local Authority, Place Leads, Population Health Leads, LMC, Communication and Engagement, Quality and Integration and Transformation. The purpose of the Steering Group is to progress on delivery of each of the domains within the report and facilitate integrated working across system, place and neighborhood.

97. During the winter period, significant challenges have continued to impact on the level of demand and capacity across primary care. Despite this in LLR our GP Practices have continued to deliver more appointments than the previous 3 years. Access continues to remain challenging, and the work outlined in this report has enabled the ICB to identify where the variation in practice exists.

98. We have undertaken targeted work with practices where we have significant variation to support improvements in those practices where patient experience of access and care has been challenged. We continue to have significant workforce challenges. These are being faced by most regions across the country but in LLR we have specific challenges to nursing and GP workforce particularly in Leicester. Therefore, the focus of our workforce plan is to support retention in Leicestershire and Rutland and work to attract the workforce in Leicester and support training programmes that supports how we 'grow our own'.

99. Finally, the Development of the LLR strategy for Primary Care which will outline a clear vision on how we integrate Primary Care and deliver at Place and Neighbourhood to change the experience of access that tackles the inequality and variation but also supports sustainable and viable primary medical care model in LLR.

Officer to Contact

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Appendix 1 – Enhanced Access Services across Leicester, Leicestershire and Rutland from October 2022

These services may change as they are tailored around the population health needs.

EA PCN Summary_.pptx

EA Summary Excel (1).xlsx

Appendix 2 – Summary of Long Term Condition Plan

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
Diabetes	• **Diabetes Enhanced Service - (Primary Care)** • **Diabetes Virtual Ward (UHL- step up &step down)** • **Improving Diabetes management - Housebound and care homes** • **Technology - Ensuring people with diabetes can access glucose monitoring (NICE Guidelines 2022)**	• Improvements in 9 care process, reduction in variation of diabetic care • Decrease in patients experiencing an inpatient stay. • Improved diabetes and insulin control in care home residents • Increase • Reduction in frail and elderly admissions to hospital, reduce workload of community nursing team • Improved self management, reduce health inequalities	• All practices/PCNs to be enhanced by March 2024 • Expected to have 30 beds a month by March 2023 • Revised Care home hypo pathway in place by Match 2023, training and care home roadshows delivered before March 2023 • Business Case to be finalised and presented by Nov 2022
Cardiology	• **AF, HF and Early discharge post STEMI Virtual Ward** • **Community Cardiology Service** • **National Cardiac Pathway Improvement Programme (CPIP) (Clinical Stewardship for Heart Failure** • **Implement DOAC (DPP) across 17 PCNs (run by Meds Optimisation Team)** • **Through BP Optimisation Programme, improve uptake of HTN Proactive Care @ Home Framework**	• Reduce length of stay, Improved patient pathway, Offering higher quality of outcome and improve patient experience, Early identification of deterioration / support optimisation of rate control, Reduce outpatient waits and unnecessary investigations, Reduce hospital admissions, presentations and transfers • Provide care closer to patients homes • Reallocation of resources to	• AF - expansion of virtual ward to onboard patients direct from ED at LRI to reduce ambulance transfer to CDU at GH. • HF -Review “step up/step down” opportunities by March 2023 • STEMI - • Community cardiology service to be scoped with Business case by end of March 2023 • Completion of clinical stewardship programme by March 2023

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
		where interventions have better impact	
Respiratory	**Respiratory Winter Plan (Top Priority)** **Virtual wards – COPD, Asthma, Bronchiectasis and Pneumonia** **PCN Respiratory Diagnostics (spokes through CDH)** **Pulmonary Rehab Expansion – NHSE 5-year programme** **Referral Support Service (RSS) for COPD** **Spirometry Training and accreditation** **Long COVID Assessment / Treatment / Rehab** **Long COVID – health inequalities - Core20Plus5**	• Improve COPD and Asthma prevalence • Proactively manage high risk patients to reduce need for acute through a MDT approach • Ensure staff are appropriately trained to deliver quality assured spirometry • Patients experiencing long covid, understand the condition, know where to access services, and get the support they need	Achieve 100% estimated prevalence in COPD and close Asthma variation Save bed days through virtual ward programme 5 PCNs delivering spirometry in primary care by March 23 Increase in no. of patients that are seen for spirometry within 6 weeks as per national indicator Clear spirometry backlog in UHL by end March 2023 Achieve better than March 2020 baseline figures for COPD/Asthma QOF Reduced Emergency Admissions with respiratory conditions as 1st/2nd diagnosis
ICKD (integrated Chronic Kidney Disease)	• **CKD education strategy for health care professionals - Ongoing, scheduled CKD education to include new therapies, research, development, guidelines and changes in clinical management.** • **CKD education materials (videos) for patients and the public** • **CKD shared care and joint patient management: patient optimisation in multi-professional primary care clinics with specialist input**	• Raise public awareness and understanding of CKD, promote kidney health, increase heath literacy and support patient activation • Upskilled clinical teams across LLR primary care, better equipped to deliver CKD optimisation • Collaborative working across the LLR system, better healthcare resource utilisation, delivering patient optimisation in the most appropriate setting • Improved health outcomes	• 1st 3 videos by end of November. Next 3 by the end of January • PCN education sessions timetable TBC by end of November • Ongoing through MDT clinics pilot sites. Timeline for additional MDT development TBC by end of November 2022 • Project funded from ERF until March 2023. Outputs will enable the development of business case for 2023/24 submission

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
	• **Introduce the use of novel therapies (SGLT2i, finerenone, roxadustat) for the treatment of CKD and its complications in LLR** • **Improvement of CKD specialist referral process in LLR process through updated PRISM form, launch *NEW* CKD FAQs and secondary care triage of referrals**	through safe, cost-effective use of SGLT2i, finerenone and roxadustat • Optimised LLR CKD pathway, unnecessary outpatient appointments avoided, primary care clinical workforce adequately supported to deliver CKD optimisation	
Hypertension (inc. BP Optimisation)	• **Complete BP Optimisation Programme – target practices and action plans (use LTC Champs)** • **Strengthen the use of the Community Pharmacy Case-finding Service** • **Continue to maximise the use of BP@Home monitors and processes** • **Update and recirculate LLR Hypertension pathway document**	• Reduction in the number of strokes and heart attacks for LLR patients • Improved under-75 mortality rate for cardiovascular diseases and all persons • Improved life expectancy at age 65 • Reduced Emergency Admissions with Hypertension as 1st/2nd diagnosis • Increase patient satisfaction in their care • Reduce inequalities for Hypertension care across LLR	• Achieve 80% of estimated Hypertension prevalence in LLR • Reduction in Hypertension prevalence gaps for practices • Achieve better than March 2020 baseline figures for Hypertension QOF (HYP003 & HYP007) • Improve Hypertension optimisation in the top 20% most deprived areas in LLR • Reduce the number of high-risk Hypertension patients (UCLP searches) • Achieve IIF indicators – CVD-01 and CVD-02 • Increased use of Comm Pharmacy HTN service
Anticipatory Care (multimorbidity / complex care)	• **LLR Anticipatory Care Implementation Plan and Delivery Framework .** • **6-8 Early Adopter sites will support with winter respiratory plan by targeting**	• Vulnerable COPD patients supported to stay healthy at home during winter 22/23. • System supported with resources to embed anticipatory care.	• Plan and delivery framework completed by end December 2022 (subject to national guidance). Early Adopter sites to commence November 2022, with expected decrease in risk of admission and volume of care plans. Evaluation/business case for MDT Facilitators

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
	vulnerable patients with COPD. • **Proof of concept for MDT Facilitators completed.**		by end February 2023.
Weight Mangement	• **Tier 3 weight management service**	• Increase in weight loss and reduction in complications related to severe obesity	• T3 Weight Management approved. Service provision phased over 3 years. • Year 1: establish service and test model of care
Cholesterol Management (pending succesful bid)	• **Use UCLP Size of the Prize for Cholesterol** • **Improve statin use in primary care** • **Familial Hypercholesterolaemia – NICE recommended service** • **STF Bid to support the implementation of the LLR Lipid Pathway**	• Reduction in the number of strokes and heart attacks for LLR patients • Improved under-75 mortality rate for cardiovascular diseases, FH and all persons • Improved life expectancy at age 65 • Reduced Emergency Admissions with Cholesterol as 1st/2nd diagnosis	• Reduce the number of high-risk Cholesterol/FH patients (UCLP searches) • Achieve relevant IIF indicators around statins • Improve QOF optimisation around statins for Diabetic and SMI pts
Primary Care LTC (Proactive Care @ Home)	• **Complete a practice process guide for QOF/LTC Management** • **Recruit and utilise LTC Champions to improve practice processes and reduce variation in LTC management** • **Create practice income packs to show how much more they could receive if their prevalence is increased**	• Reduction in the number of strokes and heart attacks for LLR patients • Improved under-75 mortality rate for cardiovascular diseases, respiratory diseases and all persons • Improved mortality rates from preventable causes • Improved life expectancy at age 65 • Reduced Emergency	• For relevant CVD-R QOF indicators, return to (better than) March 2020 optimisation levels – all QOF targets met • Reduce total LLR QOF gap for the relevant indicators • Achieve 85% of estimated AF prevalence in LLR • Achieve 100% of estimated prevalence in LLR for COPD and HF • For Asthma and Diabetes, bring lower practice prevalence figures to LLR average • Reduce the number of high-risk patients for all

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
	• **Optimise the use of Ardens, including for those practices who haven't yet purchased it** • **Run Webinars for practices staff – disease/role specific**	Admissions with CVD-R conditions as 1st/2nd diagnosis • Increase patient satisfaction in their care • Staff satisfaction in secondary care – seeing appropriate patients • Increase in competencies / knowledge in Primary Care in LTC management	areas (UCLP searches) • Achieve IIF indicators – CVD-03, CVD-04, CVD-05, CVD-06, AC-02, RESP-01 and RESP-02 • Increase in number of practices with Ardens functionality • Increase in number of practice staff trained on the Proactive Care principles