A VISION FOR PRIMARY CARE TRANSFORMATION IN LLR

‘ONE LLR’ OUR PRIMARY CARE STRATEGY 2022-2025

PROFESSIONAL & CLINICIAN VERSION

APPROVED APRIL 23

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Acknowledgments

The ‘One LLR: Primary Care Strategy is presented by the LLR ICB. It has been developed by the LLR ICB Integration & Transformation directorate with the involvement of key stakeholders.

Our key contributors as well at the associated governance boards are listed in section 7 (acknowledgments). We thank everyone who has contributed to drafting, testing, and refining our strategy; as without these generous contributions the development of our strategy would not have been possible.

Foreword

Welcome to our ‘One LLR Primary Care Strategy’, written in collaboration with our patients, staff, partners and wider communities. It sets the broad remit for our primary care ambitions across LLR as a whole- recognising that only with the joining up of our efforts will we truly be able to shape the future of our primary care services; ultimately improving the health and wellbeing of our people and creating a sustainable, resilient health and social care system that is fit for future generations to come.

Exec Summary

The Leicester, Leicestershire and Rutland (LLR) primary care strategy forms an integral part of the core work of the LLR Integrated Care System (ICS). The LLR ICS will enable the further integration of primary care teams (General Practice, Urgent Care, Pharmacy, Dentistry, and Optometry) with the wider health and care system at scale, and in a way previously unachieved, resulting in improved access to care for our patients.

Healthcare services are becoming more complex as they attempt to navigate the changing primary care landscape, increased demand for services, in an environment that is stretched and under pressure.

Whilst there are continued and new challenges in every part of the health and care system, the pandemic has resulted in a healthcare system under even greater pressure across the nation. Many feel they are at 'breaking point' and struggle to cope with the current levels of demand, with staff and patients being pushed to the brink. These challenges alone are significant but set against the backdrop of significant increases in the cost of living, a widening health inequalities gap and a pressing need to improve health outcomes, there is a "perfect storm".

These challenges will require time to address, but they are certainly ones which are best tackled collectively, with integration at the heart of our efforts. The task for our primary care leaders is to learn from the recent lessons and make lasting changes to policy and practice to create an environment that can allow primary care to continue to flourish; enabling the very 'bedrock' of care to continue to deliver a personalised, high quality, sustainable, cost-effective health offer.

We already have place-based partnerships up and running in different forms. This early mobilisation has proved invaluable, allowing us to move at pace and enabling early adopters to trial new ways of working. Our clinical leadership's experience, innovation and commitment to making tangible differences for patient care is exemplary. Our staff remain motivated and enthusiastic to deliver change despite sometimes working in ambiguity. Our new relationships across all organisations are going from strength to strength and we are on the road to successfully improve the health and wellbeing of our population. However, we believe that this is just the beginning of this exciting evolution of primary care.

To truly evolve we need to release the potential of our primary care and wider health and social care workforce, who we consider are our greatest strength and most important asset. Good health and wellbeing starts with people, our connections with family, friends and colleagues, the behaviour, care and compassion we show one another and the environment we create to live together and the unity and spirit we share to rise to the challenges in our communities.

The pandemic has tested our community, but; much was learnt through the experiences of working more collaboratively across organisations and working with our primary care stakeholders in new ways helped us to rise to the challenge that was presented to us. We will continue to build on this learning to meet the new challenges ahead.

Understanding how to make this change happen well is vital. Our strategy sets out a vision for a primary care, building on our existing local health and wellbeing strategies and place

led plans across LLR, solidifying our commitment and shared aspirations.

We share our view of our primary care priorities, and these are used as a starting point for collaborative delivery of our vision. Alongside these priorities there are recommendations for next steps for collaborative work aimed at all the organisations representing primary care in LLR as well as our partners in the Integrated Care System.

We describe why it matters and what it might mean for our patients, colleagues, and partners. We conclude by emphasising our commitment to giving everyone within LLR both a voice and stake in being able to create a community which provides the very best health outcomes.

Delivery of this vision is not going to be easy. We will need to push our boundaries, challenge our abilities, and support each other with the needed cultural shift. There are two essential components that we must harness collectively, regardless of the position that each of us hold – that of leadership (in its widest context) and that of bravery, with the will to succeed.

This strategy is only the start. The implementation requires the continued input and effort of our ICS colleagues, the ICB and LLR Health and Wellbeing Partnership chairs and primary care leaders, as well as the support of our system partners.

We hope you find this strategy useful and invite everyone to play an active part in helping us achieve our ambitions, embarking on this bold journey with us as 'One LLR Primary Care' team.

Rachna Vyas (Chief Operating Officer) LLR ICB

Dr Nilesh Sanganee (Chief Medical Officer) LLR ICB

This strategy will guide and inform the response of our primary care transformation and should be read in conjunction with documents as per Appendix 1A.

1. Introduction

1. 1 Developing Primary Care In LLR

Our population's health and care needs are changing, and primary care must evolve to meet them. Patients seek better care continuity, easy access to local services, and support to maintain independence. However, there is a significant gap between these expectations and what we can currently provide. To bridge this gap, we must transform how we view and approach primary care, recognising that it includes urgent care, pharmacy, dentistry, and optometry services, not just general practice. We aim to integrate a range of primary and community services and collaborate with various stakeholders to create patient-centred care. This strategy translates our vision into action and assures national requirements' delivery while allowing for more localised adaptation through our place-based and PCN plans.

We will focus on achieving both nationally mandated deliverables and local primary care delivery priorities for LLR. This approach ensures our priorities align with the strategy and remain responsive to emerging needs at the local level. We believe this balances our forward-looking ambitions with the reality of change in the primary care and wider health and social care environment today.

1. 2 Our Primary Care Ambitions

Our goal is to create effective primary care services by:

- Removing barriers between health and social care.
- Prioritizing patient needs and addressing health inequalities.
- Collaborating with patients, staff, partners, and communities to shape and deliver care.
- Developing an integrated, multi-disciplinary model of care focused on prevention, self-care, and shared health outcomes.
- Providing timely access to anticipatory and urgent care, including safe alternatives to A&E for non-hospital care needs.
- Integrating mental health and wellbeing services into primary care.
- Implementing new care models for vulnerable and long-term conditions patients.
- Building services tailored to local neighbourhoods.
- Improving communication and engagement to encourage people to seek help when needed.
- Empowering people to manage their own health and support prevention and self-care.
- Supporting a diverse and valued primary care workforce.
- Providing care in appropriate locations, at the right time, and in the right way.
- Offering local primary care facilities with integrated teams and a range of services.
- Investing in and resourcing primary care for sustainability and integrated care outside of hospitals.

1. 3 The Leicester, Leicestershire & Rutland Context

The LLR ICB came together as one statutory organisation in July 2022, replacing the Leicester City, East Leicestershire and Rutland and West Leicestershire CCG's. The LLR ICB is one of 42 national ICS's; a new local partnership of organisations that come together to plan and deliver joined up health and care services to improve the lives of their population.

Our primary care strategy covers our full ICS patient footprint made up of our Leicester, Leicestershire & Ruland (LLR) population of 1.2m. The ICS operates at three levels; Neighbourhood, Place and System to provide the right care. Our partnership also brings together three local authorities and seven district councils served by our dedicated and passionate health and social care ICS workforce of 76'000 individuals. Our primary care community is made up of over 132 General Practises across 26 PCNS, 227 Community Pharmacies, 164 Dentists and 176

Opticians. We have one provider for acute care: University Hospitals of Leicester NHS Trust (UHL) and one for community, mental health and learning disability services: Leicestershire Partnership Trust NHS Trust (LPT). Our other partners also include; East Midlands Ambulance Service (EMAS) who provide emergency services, Derbyshire Health United (DHU) who provides a range of urgent care and general practice services across the system, many out of area provides, hundreds of voluntary, community and social enterprise sector organisations and our regulators NHS England and NHSI.

Our health system is extremely busy. During 2021-2022 across LLR we saw 11k births, 193k emergency department attendances, 6.4m GP appointments, 101k emergency admissions, 137k elective planned operations, over 1.1m outpatient appointments,

The combined investment in local health provision for our ICS is in excess £19bn. However, as a local health system we collectively face a recurring annual in-year financial deficit of over £104m. We currently invest £219m in primary medical care which represents 16% of the total ICS budget. We will soon inherit commissioning responsibility for be optometry, dentistry and pharmacy which represents a further investment of £91m, giving us a total primary care budget of around £310m. This is expected to increase by £51m in the next 5 years.

1. 4 Our ICS Wide Vision

Our goal is to create a health and care system in Leicester, Leicestershire and Rutland that addresses health inequalities and improve the health and wellbeing of local people while delivering value for money. To achieve this, we will prioritise investment in primary care, ensuring it is resilient and transformative in line with the ambitions of the NHS Long Term Plan. Our strategy focuses on strategic priorities (Fig 1) aligned with local plans and the health and wellbeing strategies, consolidated under several themes to maximise impact on health outcomes.

Figure 1: ICS strategic priorities

1. 5 Our Population Health Snapshot

Across LLR our population health and wellbeing picture looks very different due to a diverse range of social, economic and environmental factors which impact on people's health such as housing, employment and education. These wider determinants of health vary massively across our three places, presenting our communities with different challenges. Let's have a quick look at some of these differences.

Leicester City

Leicester is the 10th largest city in England and one of the most populous in the East Midlands. It is ethnically diverse, with over 65% of its 400k population belonging to an ethic minority group. Leicester is ranked as the 32nd most deprived local authority area in the country (out of 317). Just over 35% of the population live in an area classified as being in the most deprived 20% nationally. This deprivation presents Leicester with significant health challenges. These include; 1 in 10 children and around 38k adults with mental health problems, 50% of adults who are overweight or obese, over 45k people living with more than one long term condition, over 35% of 65s+ have 2 or more long term conditions, and 1

in 10 have 8 or more. Behaviours such as smoking, excessive drinking, drug use, poor diet and inactivity are greater in many parts of our city than they should be. Leading to a poorer quality of life and a shorter life expectancy (a seven-year difference in life expectancy between men living in the most and least deprived areas of the city).

- Primary care provisions: 11 PCNS, 56 General Practises, 98 Pharmacies, 71 Opticians, 66 Dental Practices. (Source: DHSC: Shape tool)

Leicestershire

Leicestershire is a predominantly rural County and comprises of seven local authority districts, each with its own distinctive character. The total population is approximately 720,000, 10% of which belong to an ethic minority. Leicestershire has an aging population with over 26% aged 60 and over. This is expected to grow by 20% by 2043. Leicestershire is a relatively affluent county; however, some pockets of significant deprived areas fall into the 10% most deprived neighbourhoods in England. There is an eight-year difference in life expectancy at birth between males in the most deprived decile and least deprived decile of the population. The county also underperforms compared to national averages in areas such as immunisations, A&E attendances for children under 18, dementia diagnosis, and fractures in those over 65. Additionally, Leicestershire has a significant population living with chronic and complex conditions, with over 52,000 people having five or more long-term conditions and 16,000 people having eight or more.
Primary care provisions: 14 PCNS, 71 General Practices, 127 Pharmacies, 99 Opticians, 88 Dental Practices. (Source: DHSC: Shape tool)

Rutland

Rutland is England's smallest historic county, with a population of around 40,000 living in a rural area with two market towns - Oakham and Uppingham. The county has an older population, with almost 24% being over 65. Although life expectancy at birth for males and females is generally better than the national average, Rutland faces challenges in accessing care services, limited health infrastructure, and community health services. Some groups, such as low-income families children with special educational needs and disabilities, the Armed Forces community, the prison population, carers, people living with learning disabilities, and certain farming communities, have poorer outcomes than the wider population in Rutland.

- Primary care provisions: 1 PCN, 5 General Practices, 6 Pharmacies, 6 Opticians, 10 Dental Practises. (Source: DHSC: Shape tool)

At a system, place (LLR) and at neighbourhood (locally) we are already transforming our delivery approaches to further ensure the right care is available in the right places, and that people are getting the support they need, when they need it. We and our patients can see improvements from the work we have been doing, although recognise there remains more to do in an ever-changing landscape.

2. Why we need a new strategy?

Recent and still evolving commissioning landscape changes alongside our existing strong track record for responding to change in Primary Care provides an excellent opportunity in taking our next steps together in planning for how we want Primary Care to look in the future in LLR. To really harness the opportunities going forward we must refresh our primary care strategy; starting by resetting our vision for primary care to ensure that our ambitions are reframed and refocused as we join forces and unite as one team. Working with a shared purpose, common goals, and a system-wide commitment to collaborate and act together to address:

- National changes, contract reforms and the changing structures of the health and care system affecting primary care.
- Key system challenges: many of which are also felt in primary care.

- New models of care driven by changing public expectations, patient need and a focus on improving population health. National changes, contract reforms and the changing structures of the health and care system affecting primary care.

2.1 National context and reform

The NHS is undergoing structural and operational changes that are interconnected and aimed at creating a new model of healthcare delivery and transforming primary care. These changes and reforms are happening at a national level and include:

- The **NHS LTP** published by NHSE in January 2019, building on the FV and GPFV.
- **White Paper Integration and innovation** published by DHSC in 2021.
- **Health and Social Care Act 2022** for Integrated care systems (ICSs).
- **The Fuller Stocktake Report** 2022.
- Changes to the **GP network contract** 2023 and **Directed Enhanced Services** 2019.
- Delegated commissioning for **POD's** 2023.

(A summary of the national changes affecting primary care is included in Appendix 1b)

These changes have the potential to allow primary care to work together across the system and to enable true integration of primary care services with the wider health and care system at scale and pace previously unachieved.

2.2 Key System Challenges

Many challenges in primary care are also present in the broader healthcare system, such as increased demand and limited access to care, secondary and community care pressures, delayed hospital discharges, waiting lists, poor communication between care providers, prioritising illness over wellness, unwarranted variation in healthcare, staff shortages leading to burnout, poor patient experience, underinvestment in primary care funding, short-term commissioning with limited value, limited use of digital technology and infrastructure, and inadequate investment in healthcare facilities.

2.3 Changing Models of Care

Primary care has undergone significant changes, including working together at neighbourhood level to improve outcomes for specific patient groups, providing evening and weekend access to care, access to pharmacies through the Community Pharmacy Consultation Scheme and redesigning Urgent care pathways. New services, such as Acute Respiratory Infection hubs, were established to address urgent primary care needs during 22/23. Healthcare professionals are also delivering home-based care through virtual wards. Similar transformations will continue in primary care and the community over the coming years.

3. How we developed the strategy

We have developed our primary care strategy and the priorities by triangulating with our wider LLR ICS/ICB ambitions and priorities, the NHS Long term plan, LLR place led plans, and district level plans. As well as linking back to our ICB 5-year plan and the ICB clinical model as both these strategies represent the 'clinical thinking' and 'priority actions' for health and care across LLR. By doing this cross pollination we were able to develop a well aligned set of primary care themes and priorities introduced in Chapter 4. Accepting that our primary care strategy is one of the many vehicles driving forward primary care and wider health and social care transformation in LLR.

Over the next few years primary care teams will transform the way they currently provide care to their communities. We have a great opportunity to continue to work together across our professions, with our communities and wider health and social care teams in deciding how primary care services are shaped, designed and delivered.

We started developing the strategy by properly understanding the strategic shift affecting

primary care, agreeing on a framework and methodology to approach our development; as summarised in the figures 2-4 below.

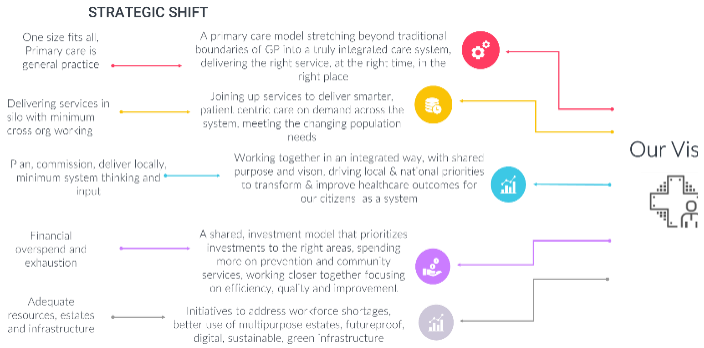


Figure 2: Overview of the strategic shift for primary care

Figure 3: Framework for strategy development

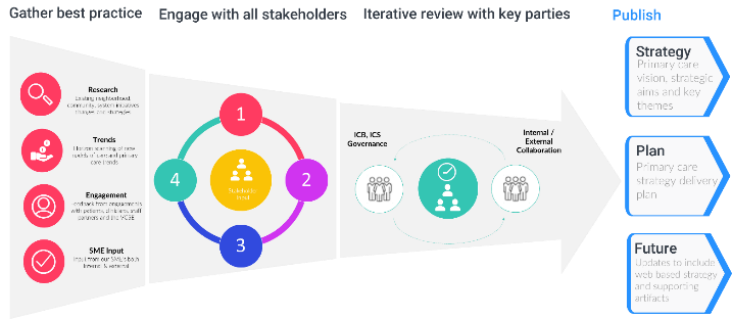


Figure 4: Strategy development methodology

3.1 Engagement with patients, staff, communities and partners

Our patients, staff and partners are at the heart of 'the why, 'the how, 'the when', 'the where' and 'the what', of everything we do. This is reflected in our chosen approach of engagement. Over the course of the last few years, we have gathered intelligence and furthered our insight on the issues and challenges we face. We recognise that we won't be able to solve them all overnight, and we still have a lot to do to get it right. We understand there will need to be differences in approach between neighbourhoods. This will require active listening to guide our learning from those at the "coal face" of primary care. We will need to engage our patients, carers, staff, partners and the wider community in continuing to better shape primary care. We have utilised a range of data and insights from both local and national engagement exercises. These include:

- The National Patient Survey 2022 with over 14'000 responses.
- Local survey with over 5000 responses.
- The Enhanced Access Report with over 44'000 responses.
- The Summary of findings from these surveys can be found within appendix 2.

In addition to using these qualitative and quantitative insights to inform this strategy we have also used secondary data collected including for the Building Better Hospitals Report of Findings (May 2021) and the, Step up to Great Mental Health Report of Findings (October 2021). All this robust data contributes to our Behaviour, Insights and Marketing Hub, which is valuable tool for bringing together insights and data from people which the system should use to enhance services and improve the health and wellbeing of people locally. The hub is a central point for market research and inequality data. Data and insights from patients, carers and staff which helps us to understand needs will support us to develop services to fit these needs. We have also involved our people in decisions about health care via monthly meetings with of the GP practice Patient Participation Group Network and via our online eCitizens' panel comprising of 1,300 local people who actively feedback their experiences and insights of local services. To ensure that we hear from all our socio-demographic groups we also:

- Work with the voluntary, community and social enterprise sector through an LLR VSCE Alliance.
- Work closely with our local Healthwatch organisations and Public Health.

- Engage at practice level to do local work including engaging with their patient population via high profile campaigns for example our 'get in the know campaign'.
- We undertake hyperlocal work within individual communities bringing people together with their practice and the voluntary sector to empower people to increase the control they have of their own lives including their health.

3.2 Guiding Principles

We recognise various principles within primary care, and to maximise our impact, we've developed a set of priorities based on shared principles.

- Equitable Access: Provide equally high-quality care to all, without exception.
- Personalisation: Encourage patients to actively participate in their own health, informed of available services.
- Sustainability: Pool resources to support primary care resilience, provide value for money, and benefit the local economy.
- Joint up: Partner with citizens to integrate and deliver effective services improving local outcomes.
- Multi-disciplinary: Develop population-specific care, focusing on prevention, self-care, shared health outcomes, and suitable facilities.
- Clinical-based design: Apply clinical principles to primary care service and model design.

3.3 Relevance at all levels

Our primary care priorities apply at all levels (Neighbourhood, Place, System) and can be tailored to meet local needs and health inequities. Examples at place include reducing infant mortality in Leicester, implementing targeted interventions for those experiencing poorer outcomes in Leicestershire, and focusing on specific deprived groups in Rutland. Neighbourhood-level priorities may involve building multi-agency teams for personalized care, while system-level priorities may include urgent care hubs and workforce planning.

4.A vision for primary care

In Leicester, Leicestershire & Rutland, we are committed to putting primary care at the centre of our integrated care system. We recognise the benefits of strong primary care, including better population health, improved patient outcomes, increased lifespan, and lower overall care costs. By prioritising primary care, we can accelerate the development of new care models that go beyond traditional general practice and focus on patient needs.

To achieve this, primary care needs to evolve beyond its current form and involve wider primary care services, such as urgent care, pharmacy, dentistry, and optometry. As a primary care collective, we need to collaborate with colleagues from secondary care, community care, social care, government, partners, and the voluntary sector to ensure that care is provided at the right time, by the right person, and in the right place.

Our Primary Care Vision

"We want to build a new primary care system together, for everyone in LLR. Nurturing a safe, healthy, and caring community. Giving all our people the best start in life, supporting them to stay healthy and live longer, happier more fulfilling lives. We will use our collective capabilities and strong partnership working to provide high quality, sustainable, joint up care; ensuring greatest overall impact on health and wellbeing outcomes"

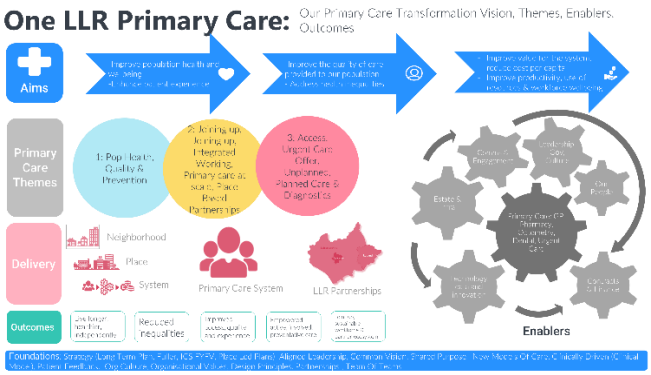


Figure 5: Primary care vision overview

Our Themes

Our vision is based around **three person-centred themes**. To support the needed transformation and to provide a focus for action several **priorities** have been developed for each of these themes. Each priority is fully detailed within the delivery plan appendix 3.

We will interact with these 'transformational' themes individually and at different stages in life; recognising that naturally these will evolve, develop and change in time. Therefore, we commit to continuously reassess these themes- working with our patients and partners across LLR to ensure that they are always appropriate, suitable, realistic and deliverable.

Our transformation will require coordinated and sustained effort across the healthcare system, linking to other workstreams and system enablers both within and outside the NHS. The vision therefore also has **six enabling themes**.

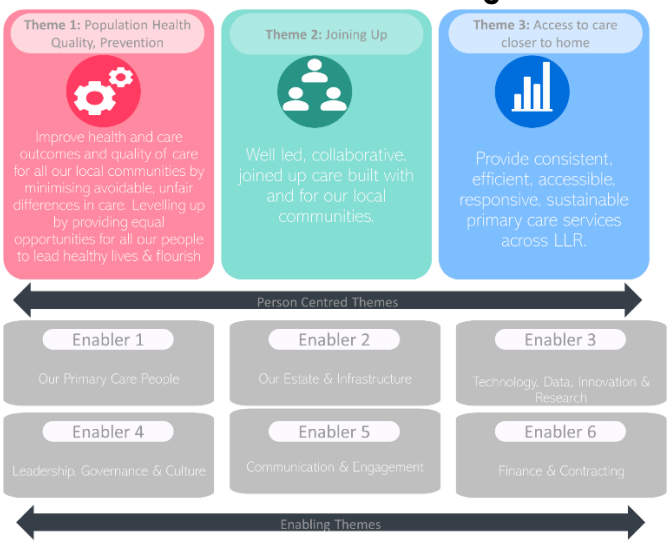


Figure 6: Primary care themes overview

4.1 Theme 1 Population Health Quality, Prevention

Improve health and care outcomes and quality of care for all our local communities by minimising avoidable, unfair differences in care. Levelling up by providing equal opportunities for all our people to lead healthy lives and flourish

Focus Areas: Health inequalities, Quality, Prevention, Self-care, Personalized care, LTC Management, Mental Health, Women's and CYP.

Our aim

Based on factors outside of their direct control, our people experience systematic, unfair and avoidable differences in their health, the care they receive and the opportunities they have to lead healthy lives. Health inequalities have a huge impact on people's lives. In the worst examples, people are dying significantly earlier than the general population because of health inequalities. In LLR, a boy born today in our most deprived area could be expected to die up to nearly nine years earlier than a boy born in the least deprived area. Inequalities can be seen as being present from birth, through someone's early years and into later life. This can be shown in a tale of two babies in figure 7 below.

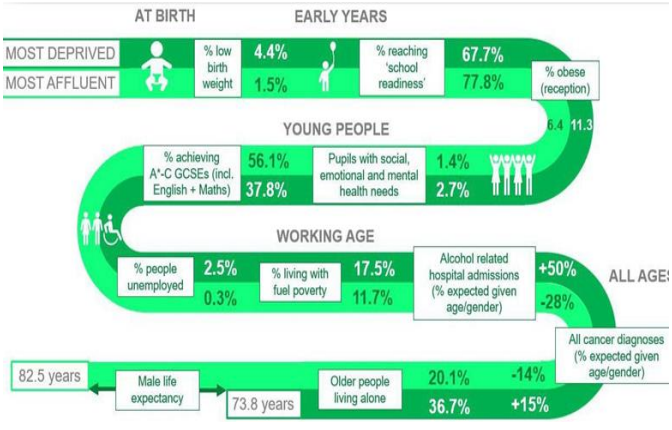


Figure 7: A tale of two babies in LLR, PHE Fingertips

The recent pandemic has served to highlight the impact of health inequalities. Coronavirus has not only replicated existing health inequalities, but in some cases, has increased them, through its disproportionate impact on certain population groups. The cost-of-living crisis will

likely worsen those inequalities that already exist. A 2022 survey commissioned by the Royal College of Physicians found that of those who reported their health getting worse, 84% said it was due to increased heating costs, over three quarters (78%) a result of the rising cost of food and almost half (46%) down to transport costs rising. Health inequalities are not inevitable, and the gaps are not fixed. Evidence shows that a comprehensive, multifaceted approach to tackling them can make a difference. These inequalities cannot be addressed by the health and care system alone. Nationally, integrated care systems will need to work in partnership across the NHS, local government and voluntary sector organisations to slowly start to reverse the current trend.

In LLR we are committed to the 'national mission to tackling inequality'. We aim to advance a business-as-usual PHM approach helping us to improve population health, mental and physical, whilst reducing health inequalities within and across a defined population, through data driven planning and delivery of proactive care to achieve maximum impact. We will embed a standardised universal service across LLR, but with equitable variation between groups helping us to level up.

We will also enhance the quality of care by coming together with our providers and partners; making shared decisions, redesigning services based on population health needs and optimising use of scarce resources to achieve improved health outcomes for our local population. We will become better at predicting and preventing ill health; helping all people to stay well for longer. We also want to ensure that those cohorts with the worst health outcomes or biggest inequalities get the support they need. For example, women, children and young people, our LGBTQ+ community, ethnic minority groups, the elderly, and the armed forces community.

National NHS commitment

- Realising the left shift concept; moving from costly secondary care towards preventative, supported, self-managed, facilitated care.
- Targeting the most deprived populations, suffering from the most significant health issues, core20plus5 (adult and CYP).
- Increasing the focus on population health and population health management. (All three of our place led, joint health and wellbeing strategies include reducing health inequalities as a priority area). ICS commitment to delivering on the LLR health inequalities framework and tackling the wider determinants of health i.e. housing, environment, employment.
- Focusing of specific groups i.e. learning disabilities, the homeless, LGBTQ+.

When we asked our patients and staff what we must do to improve they said

- Patients, service users' and carers' perceptions of the quality of the healthcare they receive is highly dependent on the quality of their interactions with their healthcare professional and team.
- A better understanding of culture and language is needed whether on the telephone, face-to-face, in leaflets or online.
- The use of understandable and consistent terminology, without jargon, and accessible resources including translation and interpreter services.
- People feel that clinicians and health professionals should be encouraged to empower patients and carers to take control of their own health, with information, explanation and an understanding of the range of choices such as social prescribing.
- People feel it is important to have confidence that professionals listen to them and decision making around healthcare is a joint exercise, particularly those with long-term conditions, as they feel this can prevent an appointment to an urgent care.
- Patients would prefer to stay in their own home for as long as possible, but their level of confidence is dependent on support from

health professionals, family and external agencies which they felt can vary.

- A significant proportion of patients do not consider themselves to have any real medical knowledge or confidence to go looking for self-care advice or support. People need an initial consultation to identify their medical issue and to have a treatment pathway and provide advice about their condition, which they see as the gateway to them being able to look after their own health more effectively.
- People want messages from a trusted source and receive information either directly or linked to an up-to-date website.

Our Ambitions

Starting well:

- Best start – Prioritise the first 1,001 critical days, developing a model where every baby and family is able to fulfil their full potential.
- Better births – More personalised care because every woman, pregnancy, baby and family are different.
- Preparing for life – Look beyond just early primary care and plan for the future. Support our partners in education, housing, social care, etc., to create an ecosystem in which we can help our young people transition seamlessly from childhood to adulthood, acquiring the emotional and physical skills to navigate and thrive in society.
- Joining up – Offer a joined-up community service for children and young people, improving their mental and physical health outcomes, with a focus on disadvantaged families, vulnerable individuals, and those with special educational needs and disabilities (SEND).

Staying healthy & well:

- Identify the risk factors affecting the health of our communities, providing the right information and support to prevent illness.
- Actively identify people at risk of becoming ill and support them to stay well.
- Increase early identification of a range of early diagnosis and treatment- vaccines, screening, cancer etc.
- Improve wellbeing in communities and work together to address the wider determinants.
- Encourage better lifestyle choices i.e. reduce smoking, alcohol consumption, better diet.
- Promotion in physical activity.
- Reduce the variation in quality and accessibility of our services. i.e. LGBTQ+
- Reduce cases of and improve health outcomes for major mental and physical health conditions, and those with a LTC.

Living and aging well:

- Provide joined-up care to support older people and reduce social isolation.
- Support people to live independently and avoid unnecessary hospital admissions

Ending well:

- Understand and meet the holistic needs of people in their final phase, supporting them to plan and manage their care and respecting their choice of place of death.
- Provide consistent and continuous care for those with long-term conditions, supporting them to transition to end-of-life care and make informed decisions.
- Support carers and families with end-of-life care plans, respect plans, and bereavement support.

Key priorities to deliver the aim

1. **Tacking Health Inequalities at 3 levels**

Focussing on: System, Place, and Community or Neighbourhood level inequalities.

2. **Implementing CORE20PLUS5 / CORE20PLUS5 CYP**

Focussing on: Prioritizing health inequalities in primary care and focusing on women's health priorities as outlined in DHSC women's health strategy.

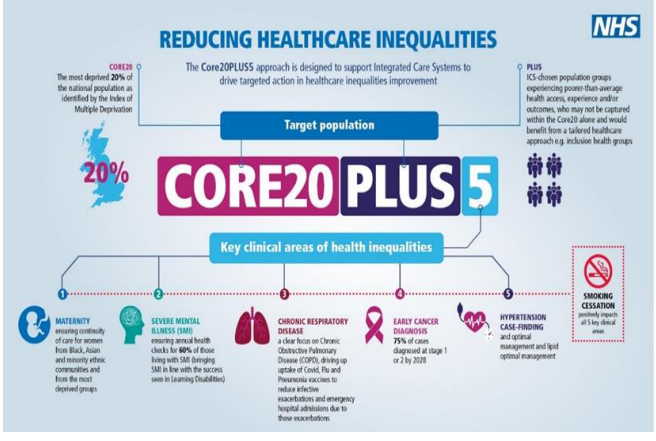


Figure 8: NHS Core20Plus5 Approach (Adults & CYP)

3. **Use of Health Inequalities best practice, frameworks, data and capabilities**

Focussing on: LLR health inequalities framework, tackle "causes of the causes" of local inequalities, leverage our LLR wide data tools, dashboards and intelligence capabilities, resource allocation decisions based on the principle of "proportionate universalism", focussed approach to populations facing greatest inequality in outcomes.

4. **Population Health Management Approach**

Focussing on: Achieving five domains of the NHSE quintuple aims of PHM, developing our PHM capabilities, leverage our LLR wide PHM model to improve segmentation, risk stratify and personalise care.

5. **More PCN involvement: PCN Maturity**

Focussing on: Community and local partnership approach to population health, PCN maturity, use of ARRS, development of action set.

6. **High quality of care**

Focussing on: Making quality and safety everyone business, continued investment in improving quality and driving up standards, intelligence and evidence-based initiatives, quality culture, learning from mistakes, sharing excellence, embed research in all primary care, achieve high quality ratings across all of primary care i.e. CQC, PQS etc, fulfil national & statutory metrics and targets i.e. QOF, IIF, CPCS.

7. **Resilience & Sustainability**

Focussing on: Enhance communication and engagement between ICB/ICS and primary care, at-scale sustainability solutions, rethink spending distribution across primary care to support left shift initiatives, design of a primary care operating model that supports the sustainability of primary care collectively.

8. **Proactive & Preventative Care**

Focussing on: Whole-system approach to self-care, proactive, preventative clinical based model of care, early detection and diagnosis i.e. in pharmacy, primary care liaison service.

9. **Making Every Contact Count (MECC)**

10. **Mental Health, Learning disability & Autism**

Focussing on: Promotion of MH services, improving access to MH, offering MH services closer to home, dementia diagnosis, digital innovation, annual health checks (AHCs) and targeting i.e. LD cancer screening, CYP Keyworker Programme, Primary Care fulfilment of the 3 key requirements of the NHS Confederation's "No Wrong Door: a vision for mental health, autism and learning disability services in 2032"

11. **Personalized care & Empowerment**

Focussing on: Personalised care 'business as usual' in all primary, develop a whole system ,all age approach by default (maternity to EOL).

12. **Chronic Disease Management and Complex Care**

Focussing on: Self-care with support from community MDT model, supporting high risk patients, use of community assets to ensure early intervention i.e. Pharmacy led hypertension case finding, patient education, digital resources, and support networks.

13. **Medicine Optimisation**

Focussing on: A person-centred approach to safe and effective medicine use, reducing medicine-related problems.

14. **Enhancing the involvement of people and communities**

Focussing on: Primary care engagement framework, empower people & communities,

15. **Pharmacy, Optometry and Dentistry Priorities**

Focussing on: New commissioning PODs when these come into effect.

What will success look like

A Higher proportion of people self-reporting good mental and physical wellbeing whilst experiencing less health inequality

- A shared and agreed view and approach to tackling health inequalities.
- Make health inequalities business as usual for primary care and wider care.
- Shift resources towards preventative measures and addressing root causes of inequality.
- Collaboration, investing in relationships.
- Increased healthy life expectancy.
- More people living well independently.
- Provide high-quality care and outcomes
- Integrate mental health and learning disabilities and autism services.

Theme Summary & Delivery Plan

See appendix 3 and 4.

4.2 Theme 2 Joining Up

Well led, collaborative, joined up care built with and for our local communities.

Focus Areas: Joining up, Integrated working, Primary care at scale, Place based partnerships.

Our aim

We want to improve care by connecting health and care teams in our communities, addressing unique challenges and involving local input to tailor care. We aim to lead primary care teams with shared funding and decision-making to innovate and deliver services effectively.

National NHS commitment

- Collaborate better with our primary care colleagues in community pharmacy, optometry, and dentistry to deliver high quality services to our communities.
- Integrated neighbourhood 'team of teams' need to evolve from PCNS, a collaborative, cross-sector, multi-organisational and sector team working in neighbourhoods.
- Enhancing rapid community response teams, to prevent unnecessary emergency hospital admissions, speed up discharges.
- Giving people more control over their own health and the sharing of information between health and social care, delivering more person-centred care.
- Enhanced support in care homes.

When we asked our patients and staff what we must do to improve they said

- IT systems should be joined up and improved between organisations with improved access to records; technology acting as a better tool to support integrated working; and information availability.
- Transfers between services/handovers are stressful times for both GPs and other staff and patients and family carers, in particular older and vulnerable people.
- Family carers want to be recognised as carers and need services which are reliable and appropriate to their situation and allow them to support their loved one.
- Patients and carers need a more efficient and effective link between GP surgeries and hospitals; between professionals working in health and those working in social care and more obvious use of technology using digitised notes and shared computer systems, so they don't have to tell their story a number of times.
- People want primary Care professionals to inform them of local support services and have a better understanding of how to support them and their whole family, particularly on how to live with long term conditions.
- People need more recognised involvement of the voluntary and community sector in a formal capacity, rather than a voluntary one.
- People felt that a more joined up approach to services supporting good physical and mental health would prevent more people from having an emotional breakdown, particularly those people who are coping with a long-term physical condition.

Our Ambitions

Starting well:

- Children and families thriving and supported in our communities.
- Joint up children's and young people's primary care services.
- Embed children and young people's physical and mental health services into our offer.
- Identification and support for vulnerable young people, educating parents on matters such as breastfeeding, immunisations and management of minor ailments.

Staying healthy & well:

- Continuing to improve our joined up and place-based approach to care.
- Prevention is always better than cure. We will actively identify people at risk of becoming ill and support them to stay well.
- Develop primary care mental health services

Living and aging well:

- Joined up, person-centred and seamless services that support people out of hospital in our communities.
- Develop strong networks and partnerships with specialist centres.
- Provide joined up care to be responsive for frail, vulnerable and elderly patients.
- Avoid unnecessary hospital admissions.
- Personalised, multi-agency care at home.

Ending well:

- Fewer organisational barriers for staff, patients and communities to support the people in their own homes.
- When people develop ill health, provide timely and well-coordinated support to ensure it does not dominate their lives and to allow people to stay independent.
- Support and care for our population during their last phase, allowing them to die in a place of their choice.

Key priorities to deliver the aim

1. **Creating the right environment for change**

Focusing on: Fuller stocktake recommendations, back-office support, management support functions, primary care excellence initiatives, clinical leadership/support, clinical culture.

2. **Truly Joining Up Primary Care**

Focussing on: Joint up care models, vertical integration, freedom to innovate, adoption of a 'one place, one budget' 'one population' ethos.

3. **Integration with wider system**

Focussing on: Extending the remit of our PODs, Primary care service offer, ARRS, primary care professional's networks, communities of interest.

4. **Integrated Neighbourhood Teams**

Focusing on: PCN maturity, multi-professional 'team of teams', neighbourhood model of care.

5. **Place Based Partnerships & the VCSE**

Focussing on: Place based partnerships, VCSE, new provider collaboratives, primary care provider support and leadership.

6. **Population Wellbeing, Everyone's Business**

Focussing on: Whole and all system approach, collaboration with Public Health England, development as an 'anchor organisation', Promotion of physical activity (Everyone active).

7. **Devolution**

Focussing on: Pooled budgets, place-based governance, leadership and budgets.

8. **Knowing LLR to give best care**

Focussing on: Operating at Neighbourhood, Place, System level, developing a 'needs based' primary care offer. i.e. Armed forces community.

9. **Maintain continuity of care where possible**

Focussing on: Maintain clinician, holistic person-centred care, across organisational care

10. **Effective Leadership & decision making**

Focussing on: Alignment, right mindset, collaborative decision making, clinical leadership and oversight, leader development.

11. **System Alignment: The bigger picture**

Focussing on: Shared purpose, wider determinants of health, primary care forums and networks.

12. **System wide investment decisions**

Focussing on: Joint investment and decision making, shift of investment (prevention and community), redistributing investment to areas with greater inequality gaps/variations.

13. **Infrastructure First**

Focussing on: Physical space and technology for our 'Team of Teams', PCN clinical and estate strategies, champion a 'One' estate ethos.

14. **Research & Innovation**

Focussing on: Embedding research into all care, build a research and innovation workforce.

15. Focus on patient outcomes, not output.
16. **Change the way we do things to help improve clinical and patient experiences.**

Focussing on: Shared administration from secondary care to primary care, public communication, patient activation and engagement, staff training, patient experience.

17. **Women's Health, Maternity & Children**

What will success look like

Improve health and care outcomes and reduce avoidable illness.

experience and quality of care.

- Increased capacity in primary, secondary and community care to enable more care to be delivered at home and in the community.
- Shared purpose with primary and community care staff, working together to deliver preventative, out of hospital, care for LLR patient population.
- Reduced the pressure on emergency services and hospitals.
- Increase the number of people able to stay at home, freeing up beds for most needed.
- Continue to ensure the sustainability and resilience of our individual GP practices, creating capacity by better managing demand and co-ordinating care.
- The aggregation of our PCNs at 'Place' level – to remove silos of provision, incentivising providers over health outcomes not levels of activity, working together in an integrated delivery model.
- Better patient experience, patients able to access appropriate care in the right place.
- Digital technology such as cloud-based telephony and additional integrated System1 functions will allow us to manage the stack better, predicting, identifying, planning and responding to varying demand.

Theme Summary & Delivery Plan

See appendix 3 and 4.

4.3 Theme 3

Access to care closer to home

Provide consistent, efficient, accessible, responsive, sustainable primary care services across LLR.

Focus Areas: Access, Urgent Care Offer, Unplanned, Planned Care & Diagnostics

Our aim

To meet the changing needs of our communities, we must find innovative ways to develop, access, and deliver quality care more sustainably. Our goal is for everyone in LLR to have easy access to high-quality primary and urgent care services seven days a week. Currently, patients with urgent care needs are unsure which service to contact, adding pressure to general practice. Our urgent care system is under constant pressure, resulting in patients seeking care through inappropriate means. We aim to improve same-day care, urgent care, and diagnostics by testing new approaches and working closely with our partners to provide the right care the first time. Without tackling this together, we won't be able to ease the constant pressures we face.

When we asked our patients and staff what we must do to improve they said:

- People need a better experience of getting through on the telephone easily, being treated respectfully, and accessing GP services, as well as improved confidence and satisfaction with the type of appointment they are offered.
- When asked what makes a good primary care appointment people wanted to be seen in a timely manner, with no long waits, to be listened to by the GP or health professional, to feel they had enough time and not rushed and to leave with a diagnosis/advice/support/referral.
- There is an obvious preference for 'traditional' face-to-face appointments, but

some people say they are happy to have an initial telephone consultation and others are comfortable with an online consultation. Remote consultations are currently viewed as more acceptable for 'non-emergency' medical issues.
- The setting and location of care is important, and people want it to be fair and equitable.
- New services and ways of working need to be shared with/promoted to both staff and patients, but it is important to people that messages are delivered by a known and trusted source.
- Many people are comfortable with digital consultations. However, many are either not digitally enabled or digitally confident, or feel that a digital appointment is not appropriate to their medical problem.
- Many people say they would like to feel more confident in the support they receive in a crisis and to keep mobile and active.

National NHS commitment

- Improve access to primary care services, increasing the number of appointments.
- Boosting out of hospital care, increasing investment in primary and community health services.
- Expand community multidisciplinary teams, with integrated neighbourhood teams becoming the norm.
- An urgent care model made up of primary care, community pharmacists, ambulance and other community-based services who provide a locally accessible and convenient alternative to A&E.
- Commitment to planned care and quicker diagnostics.

Our Ambitions

Access

- We want patients in LLR to continue to have equitable access to high quality primary care services when they need to, getting the right care, in the right place at the right time.
- We need to support patients better and earlier in their pathway, reducing avoidable demand by educating them about services, empowering them to self-care, and better engage with the prevention agenda.

Streamlined and integrated urgent care

- Further develop our out of hospital offer and urgent care offer to reduce acute hospital admissions or assessments.
- Provide a fit for purpose urgent care offer with a single point of access.

Planned Care, Therapy & Diagnostics

- Improved planned care pathways with easy self-access referrals.
- Implements the Proactive care model for better LTC management.
- Access to more diagnostics and testing services closer to home.
- Seamless transfer of care from hospital to home.

Key priorities to deliver the vision

Primary Care Access

1. **Primary care front door 7-day access**

Focusing on: A 7-day primary care offer, same day and pre-bookable availability, standardised front door for access, care navigation, CPCS.

2. **Stabilise Demand in primary care**

Focusing on: Demand and capacity management, stack management, new delivery models, reducing staff burden.

3. **Redesign care pathways**

Focusing on: Inclusive access mechanisms, negate '8am' model, active signposting 'talk before you walk', Urgent Treatment Centre model across LLR, CPCS.

4. **Multichannel primary care access**

Focusing on: Multichannel 24/7 access to primary care, system wide approach to assessment, triage, and streaming. Delivery model focusing of worst outcomes e.g. homeless, people with Learning Disability etc

5. **'Digital First approach'**

Focusing on: Digital by default, patient and staff education, digital inclusion.

6. **Retaining continuity of care as the core strength of primary care**

Focusing on: The separation of cases (urgent same day access and long-term conditions) to offer continuity of care.

Streamlined and integrated urgent care

1. **Single door for all urgent care**

Focusing on: A single place based integrated urgent care offer, single point of access, effective triage and streaming of cases. Delivery model focusing of worst outcomes e.g. homeless, people with LD etc

2. **Responsive Pre-Hospital model**

Focusing on: Extensive range of services locally, UTC, healthcare hubs (increase tier 2/3 activity, reduce tier 4 LRI ED activity).

3. **Direct access and self-referral pathways**

Focusing on: Patient access and self-referrals.

4. **Urgent care response service**

Focusing on: 27/7 365 multidisciplinary urgent response offer across LLR.

5. **Equitable fallers offer across LLR**

Focusing on: Early identification and proactive management, equitable falls crisis response.

6. Making frailty everyone business

Focusing on: Early identification and effective management of frailty in all settings.

7. **Enhanced health in care homes**

Focusing on: Multidisciplinary approach to the management of care in care home.

8. **Home First**

Focusing on: A mature out of hospital community home first model, extension to CYP, virtual wards.

Planned Care, Therapy & Diagnostics:

9. **Pro-active care**

Focusing on: A Proactive care model, to support primary care staff to optimise clinical care and self-management for people with CVD risk factors via structured and holistic care planning.

10. **Community based diagnostics**

Focusing on: Place based models for diagnostics, enhanced diagnostic offer.

11. **Integrated Therapy & Specialist outpatient services**

Focusing on: 7-day therapy and speciality services, utilisation of shared resources.

12. **Seamless discharge and transfer of care**

Focusing on: Timely discharge and seamless transfer of care, integrated neighbourhood teams, LLR Integrated Discharge Hub, DMS.

13. Palliative & EOL care and support

Focusing on: Integrated support offer i.e. community pharmacy support with EOL meds, normalising EOL, supporting patient choice.

What will success look like

Easy and equitable access to primary care services for all patients across LLR.

- Easy access to primary care close to home.
- Right care, right time, right place.
- Moving focus to meeting need and not demand.
- Reduced demand and distribution of cases.
- Increased use of urgent care services, reducing avoidable hospital attendances.
- More patients able to manage their health and illness at home, with appropriate support from a range of services.
- A range of pharmacy services and support.
- Patients with complex needs, LTC's and vulnerabilities better supported in the community.
- Redistribution of finances to support primary care and OOH models of care.
- Increased number of diagnostics conducted in primary care settings.
- Better care for patients with palliative care needs and those in care home.

Theme Summary & Delivery Plan

See appendix 3 and 4.

4.4 Cross Cutting Themes

- Supporting good mental health
- Covid 19 recovery

5. How our primary care vision will be enabled

Alongside our three-person centred themes six enabling themes have been identified as essential in supporting with our primary care transformation. Some enablers are specific to primary care and the organisations that support it both within the NHS and outside. Others require the support of different parts of the healthcare system, and need primary care to be included in wider system strategies and subsequent developments. As with the first three themes, a set of implementation goals have been developed and are included within each theme.

5.1 Enabler 1 Our People & Workforce

Our Aim

The performance of any health and care system ultimately depends on its people. We must work together to make this a rewarding environment. Delivering our vision requires a confident, capable and motivated workforce. We need to attract and retain skilled people to work here. Workforce is one of the greatest challenges facing general practice, broader primary care services, support services and the NHS. In LLR we are committed to addressing workforce shortages, through retaining our existing workforce whilst supporting and optimising new roles. It is our ambition to make LLR a great place to work, and we will do this by working together to drive our ambitions. We will:

1. Embrace neighbourhood working with an integrated sustainable workforce.
2. Make primary care in LLR a great place to work – ensuring staff are well engaged, supporting wellbeing, promoting diversity and career development.
3. Address workforce shortages, attracting new talent and optimising new roles.
4. Establish a new operating model for primary care workforce ensuring they have the capacity and capability to deliver the right care, at the right time, by the right person.

National Commitment

Through better recruitment and retention, the NHS is nationally committed to ensuring there are enough people working in the NHS to support patients, and that they get the support they need to continue delivering the best possible care. NHSE are also committed to strengthening NHS leadership, while improving the working environment for frontline staff – from support to manage their own health and wellbeing, to investing in the digital technology that can help them do their jobs more easily.

How we see workforce in 5 years

We will work to:

- Ensure we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well.
- Ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment and have support to manage the complex and often stressful nature of delivering healthcare.
- Strengthen, support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan, Long-Term Plan and the 5 Year Joint Forward Plan demands,

Implementation Goals- A focus for activity

We 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.
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.
- Connective recruitment between graduates and local vacancies.
- Data informed, evidence-based decisions
- Attractive and supportive staff packages.
- Sustainable workforce solutions.
- Learning and training to be at the heart of developing our people.
- Partnership working with all.

It is recognised that some of the drivers to achieve the above will be organisational culture, development, and leadership within Primary Care. This is multifaceted and an evolution over time. This will be supported, developed, and enhanced through a range of strategies. Whilst there are workforce gaps and issues there are also areas for workforce transformation such as the Additional Roles Reimbursement Scheme and developing closer working with our Pharmacy, Optometry and Dentistry workforce.

What will success look like

- Closing the gap on national shortages for primary care professionals and open posts.
- Attract more staff, improve recruitment processes and workplace initiatives.
- A happier workforce, working in rewarding jobs and with a more supportive culture.
- New NHS roles and careers will be shaped to reflect the future needs and priorities.
- Improved development opportunities and staff having more control over their working lives.

Finding our more

- Louise Young, People & Workforce, LLR ICB.

5.2 Enabler 2

Estates & Infrastructure

Our Aim

A robust estate of safe, secure, high-quality buildings, capable of supporting current and future service needs across primary, secondary and acute care.
Collaboration is essential, with acute and secondary care estate sitting with our trust partners and, to a great extent, the primary care estate being held privately. Understanding these constraints, whilst openly exploring how the estate can adapt to enable the delivery of clinical models, with the needs of the patient foremost.
To further increase flexibility and create opportunities for health and care integration, we will work closely with our local authority and voluntary sector partners to explore co-location and successfully manage the estate implications of bringing health and care teams together.

Implementation Goals- A focus for activity

Supporting the development plans of the practices identified in the Primary Care Estates Strategy, addressing sufficiency, suitability, and the impacts of housing growth. Development of Primary Care Network strategies which will see PCN's consider how their clinical objectives can be met by their existing estate.

Extending practices where possible, alongside making best use of LiftCo and NHS properties, buildings owned by the health trusts, as well as exploring use of local authority and voluntary sector partner properties will be key to ensuring the primary care estate is sufficient for delivery of services.

In conjunction with our partners, we will develop an **LLR ICS Estates Strategy** by March 2024 that will ensure alignment of trust partner's

strategies, and detail how estates will enable the delivery of ICS objectives.

What will success look like

Close working with our local authority planning partners to understand and put in place plans to mitigate the effects of the location, scale, and timescale of housing growth, predicting impact at neighbourhood level and thereby forecasting health infrastructure need.
Whilst working differently, using new technology and reconfiguring spaces are valid tools for consideration, the identification of areas of estate shortfall through robust analysis will be used to support business cases for future capital investment strategies for NHS England and the ICS.

How it is already happening

Sustainability is a key priority for the NHS and the ICS, both of whom have developed and published their green plans. A Greener General Practice network has been established to promote ideas, share experience and enable GP practices to work to reduce their impact on the environment and climate change.

We work to secure developer contributions which are used to expand health care provision to meet the needs of the increased population.

We actively collaborate with estate partners to share experience, estate opportunities and discuss organisational need through;

- LLR ICS Estates Forum.
- One Public Estate Leicester Partnership.
- ICS/Region green delivery boards.

Finding our more

- Lorna Simpson, Head of Strategic Estates.

5.3 Enabler 3 Technology, Data, Innovation and research

Our Aim

LLR have an agreed Digital Strategy in place which focuses on the direction of travel for the next three years. Within this strategy we have set out the vision for improving data and information sharing. Throughout the Digital Strategy there are initiatives which will support working across primary care.

National Commitment

- Enabling information to flow between care providers within and beyond organisational boundaries, and between care providers.
- GP IT systems sit at the heart of primary care technology, offer patients access to online GP services.
- Supporting practices to develop IT functionality which responds to the evolving needs of patients and underpins integration across care pathways.
- Digital transformation of health and social care is a top priority for NHS England (NHSE). The system's long-term sustainability depends on it.

How we see digital in 5 years

- Person-centred care along care pathways rather than being organisation specific.
- Allow people to remain in their home when it is safe and appropriate to do so.
- Digitally support models of care which provide a seamless patient experience along multi-organisation care pathways.

All of which will improve patient experience, the efficiency of scarce, high-cost inpatient resources and upstream and downstream communication.

Implementation Goals- A focus for activity

Currently;

- There is limited integration between organisational systems.
- Our systems don't easily support multi-organisational pathways.
- Transfers of care can require significant manual effort and communication.

Meaning that;

- Models of care are aligned to individual organisations or locations.
- Conventional referral mechanisms between organisations can be slow, resource intensive, and disjointed.
- Patient discharge from an inpatient stay can be slower than it should be.

Leading to:

- A fragmented patient experience as the retell their story when they are referred between organisations.
- High-cost resources such as ward beds are used when alternative options are available.

How it is already happening

- Roll out of virtual wards and remote monitoring.
- Digital primary care solutions. i.e. video and online consultations, cloud based telephony.
- Digital referral management solution
- LLR Shared Care record within primary, secondary, acute and emergency care
- Patient access: Use of the national NHS App to access a range of NHS services digitally, locally patients have the opportunity to use supplementary apps and portals, integrated with the NHS App, to provide targeted information and healthcare management.

What will success look like

- More patients participating in their health planning and accessing digital services.
- Joined up infrastructure at scale; supporting mobile working and integrated teams.
- Wider information sharing across all settings.
- Improve digital maturity across primary care.

Finding our more

- Sharon Rose. Senior Digital Enablement Manager. LLR ICB.

5.4 Enabler 4

Governance, Measurement & Leadership

Our Overarching Governance Model

To achieve our vision for primary care in LLR, it is crucial to have appropriate governance structures in place. We plan to use the LLR ICS and ICB governance structures to ensure that primary care transformation aligns with other LLR transformation programs. This strategy is just one enabler of the larger vision that the overarching governance structures are responsible for delivering. By utilizing these governance models, we can have a more comprehensive view of other transformation programs. Our approach emphasizes that transformation must be delivered from the bottom up and our engagement with staff, partners, patients, and the public will support us in transforming the planning, shaping, and delivery of primary care services. More information on our governance can be found in appendix 5

The Role Of The (PCTB)

Beneath the ICS/ICB governance structure the Primary Care Strategy's governance will be through the PCTB which was established to oversee and ensure the successful delivery of Primary Care Transformation. Specifically, the PCTB leads on developing the strategy with a focus on design, delivery and quality. A key role of the PCTB is to interpret, disseminate and implement national policy relating to primary care recognising the interdependencies across health and care partners. Specifically, The PCTB will work with reference to key national policies to maximise outcomes for patients. The PCTB reports into the Strategic Commissioning Group which itself reports into System Executive. The PCTB has established five workstreams to ensure efficiency in carrying out its functions. In the first instance these workstreams include:

1. Access 2. Resilience and Sustainability
3. Service delivery 4. Workforce / Leadership

5. PCN Development

Measurement

There are currently many ways by which we will measure the performance of primary care. These include data dashboards, proactive care tools, patient experience and satisfaction, CQC, QOF, IIF etc. However, with the move towards joint working through our ICS and developments within primary care we will need to adapt these methods. Our ICB PMO will help us to track progress and provide us with a view of progress against this strategy with SMART performance measures (Specific, Measurable, Achievable, Realistic, and anchored in a Time frame) and provide regular performance reports and progress updates to the appropriate boards. We will also share our progress with you and celebrate our successes by publishing updates and reports; promoting them through our partnership and community events.

Clinical Leadership

Primary Care has significant clinical leadership across LLR. The Medical Directorate provides direct leadership to the PCTB as well as to the wider ICS. In addition, our 5 Place Based Clinical Primary Care Leaders provide leadership at Place and, through their connections with the Clinical Directors of our 26 Primary Care Networks, at neighbourhood too.

Our ICS Clinical Leadership also has a large number of leaders from a Primary Care background providing enabling clinical leadership (Workforce, Business Intelligence, Population Health and Health Inequality, Digital and Finance and Contracting) as well as transformational clinical leadership, for instance, for Children and Young People, Medicines Management, Elective Care as well as specific Clinical leadership for Primary Care Quality.

On the ICB Board itself, we also have a Primary Care Partner and we work closely with clinical leaders on our Local Medical Committee too.

Finding our more

- Dalijit Bains. Head of Corporate Governance. LLR ICB.

5.5 Enabler 5

Communications & Engagement

Our Aim

Our aim is to work closely with people communities, partner and the VCSE in line with our public involvement legal duties that require us to have arrangements to ensure that people are 'involved'.

National Commitment

Nationally the NHS has committed through the ICS design framework to set the expectation that partners across the ICS should agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

How we see things in 5 years

Through our support of our ICB People and Communities Strategy we would achieve:

- A deep understanding of people and communities.
- Insights and diverse thinking of people and communities helping us to tackle health inequalities and the other challenges faced by primary care.
- Fresh opportunities for strengthening our work, continually expanding relationships, networks and activities.
- Well informed, empowered people and communities, reduced health inequalities, better outcomes, experience and access.

Implementation Goals- A focus for activity

- Effective co-produced communications and engagement strategy.
- Implement the co-designed ICB People and Communities Strategy.
- Effective co-produced voluntary and community strategy.

We will achieve our implementation goals by starting with people:

Figure 9: Our communication and engagement approach

What will success look like

- Improved engagement and patient experience at practice, PCN and system levels.
- Empower communities to provide ongoing and iterative insights and work with system to implement change.
- System is using the insights to design and improve services.
- Focus on what matters to communities and the priorities of those who experience the worst health inequalities.
- Showcase how people's involvement leads to improvement and better outcomes.
- Approaches to better work with specific people and communities.

How it is already happening

- Implementing our People and Communities Strategy, and our Primary Care Engagement Framework.
- Reinvigoration Patient Participation Group.
- Launched the VCSE alliance.

Finding our more

- Sue Venables, Head of Engagement and Insights. LLR ICB.
- Dave Rowson, Head of Communications and Marketing. LLR ICB.

5.6 Enabler 6

Finance & Contracting

Our Aim

We want LLR health and care organisations to work together to ensure that we live within our means. It is vital that we make the right investments in the right areas that will sustain and improve the quality of health and care services within the resources we have. This will involve; innovative ways of working, shifting some of our spending to prevention and community settings, working closer together and a robust focus on efficiency and quality improvement. All of which will support our aim to ensure there is efficient use of our resources and move towards underlying financial balance. Meeting the challenge of increasing demand for services and stretched resources will require a considerable programme of work to; manage demand, invest wisely and make efficiencies to reduce waste whilst maintaining quality.

National Commitment

- Ringfenced funding for primary care.
- Investment in ARRS and enhanced access.
- Financial incentives: i.e. IIF which rewards PCN's for delivering set objectives.
- System development and GPIT funding.
- Use of NHS combined buying power.
- Deliver better value on medicines.
- Make better use of capital investment.

How we see primary care funding in 5 years

The Integrated Care System are experiencing significant financial pressures in 2022/23 with similar pressures being identified for future years. Primary Care investment accounts for just over 16% of the £1.9bn budget for the Leicester, Leicestershire and Rutland Integrate Care System and so will need to be included in any efficiency programme designed to bring the system back to a balanced position in the next few years. There is currently an underlying deficit across the system of £104m and this is set to

increase each year as the allocation for growth and inflation will not be enough to close the gap between income and expenditure. If the system does not take action to address the deficit by becoming more efficient and productive for every pound spent, the underlying deficit is estimated to increase to £272m in 2027/28.

Primary Care Funding Allocations

Table 1 below projects the primary care allocations through to 27/28 based on the latest guidance. It is assumed that the allocations for the Pharmacy, Optometrists and Dental (PODs) increases at the same rate as that for the GP Co Commissioning budget and that the Primary Care budget increases in the same proportion as the ICBs programme allocation.

TABLE 1. Primary Care Allocation Summary					
	23/24	24/25	25/26	26/27	27/28
Primary Care	23,268	23,902	24,746	25,618	26,522
Primary Care Co-Commissioning	195,134	203,138	211,470	220,143	229,172
Delegated Pharmacy, Optometrist and Dental allocations	91,475	93,619	97,459	101,456	105,617
Estimated Primary Allocations	**309,877**	**320,659**	**333,674**	**347,218**	**361,312**
System Programme and Co Comm projected combined allocations	**1,931,205**	**1,986,545**	**2,057,786**	**2,131,588**	**2,208,043**
Proportion allocated to Primary Care	**16%**	**16%**	**16%**	**16%**	**16%**

Figure 10: Projected LLR primary care allocations 23-28

As can been seen in the table above, the budget for 2023/24 for primary care, including the element for delegated budgets for primary medical care and the PODs, is in the region of £310m for the ICB. This is expected to increase by £51m in the next 5 years. The ICBs commitment is to continue to invest in the innovative Primary Care Funding Model where practices are paid for the services that they provide and that there is consistent provision for patients irrespective of where they are registered. Access to Capital Resource – In addition to the access to centrally held capital resource for the funding of practice IT refresh programme, the ICB has earmarked an element of this capital funding to support small practice improvements. Depending on access to central capital resource, it is hoped that this arrangement will continue for the next few years, giving practices some vital support in getting some of the smaller schemes implemented and so improving capacity and the patient experience.

Finding our more

- Andrew Roberts, Finance Partner, LLR ICB.

6. Next Steps

6.1 The role of the Primary Care Transformation Board (PCTB)

We have set out in this strategy, our vision, values and strategic primary care priorities for the next few years. We must now ensure we work collaboratively to deliver our plans. The governance responsibility of which sits with the PCTB, reporting into established ICS and health and wellbeing boards to ensure all key decision makers across LLR, our health and social care teams and system partners support its successful delivery.

During delivery of this strategy the PCTB will:

- Provide appropriate governance and assurance at all levels.
- Through our PMO track progress, outcomes, and financial spend, regularly and transparently sharing progress updates.
- Communicate the strategy across primary care, LLR boards, national, regional and local partners.
- Regularly review the strategy against national and local developments and feedback from our people, communities and partners.

6.2 Delivery Plan

Our delivery plan provides an extensive view of our priorities and our plan for delivery. It is far reaching and comprehensive. We recognise that several key priorities are being delivered by other parts of the system due to similarities in our programmes of work or ongoing collaborations and system wide initiatives. We also recognise that the majority of our primary care priorities will apply at neighbourhood and place level, However, some priorities will be delivered at a system level. (See appendix 3 for the detailed delivery plan).

6.3 Future developments to the strategy

Primary care in LLR is on a journey. This strategy acts as starting point for collaborative primary care action, providing us with a snapshot of some of the priorities and an approach to delivering them, we will add to this strategy in the near future as we look at doing the following;

- A revised primary care strategy towards the end of 2023 which will allow us to review how we are working with our PODs.
- An online interactive primary care strategy, adapted to suit different audiences i.e. public facing.
- A series of supporting documents, such as theme summaries, toolkits and easy reads.

6.4 Closing remarks / conclusion

We acknowledge that we have a lot of work ahead of us to achieve our vision. We have witnessed first-hand the enthusiasm and dedication of our people who have come together to articulate our vision. We appreciate the valuable contributions and inspiring voices that have played an active role in shaping our approach.

Our strategy provides us with a set of shared priorities acting as a starting point for collaborative action. Delivering these will come with further collaboration from all the organisations that lead, support, educate, commission, provide and regulate primary care in LLR. Building on our progress to date by creating a 'learn not blame' culture; supporting each other every step of the way.

This work starts now with us developing a deeper understanding of the 'breadth of primary care'. Ranging from a small surgery to a large multi practice PCN, from the small independent pharmacy on the high street, to a chain of optometrists, to a village dentist inherited from generations of the same family to a multi-million pound urgent care centre.

We will overcome silo working and make deeper more meaningful connections between our organisations, programmes and places. Working together as one system; one shared purpose, one ethos; collectively shaping, influencing and delivering for our people.

We need to embrace our vision at a local and neighbourhood level, with all primary care professionals and their representative organisations, as well as the wider health and social care systems. At a system level, our ICB and ICS, including local authorities, need to apply a 'one system view' to connect primary care teams with each other and with the wider multidisciplinary teams in community and secondary care.

Our success will be measured not just in the traditional dashboards of inputs and outcomes; but also, by looking at reported experiences our people. We know we have succeeded when people who need access to health and care on the same day receive it; those who need care within a hospital setting receive it in an effective and efficient manner; those living with one or more long term conditions or frailty are supported in their place of choice; the integration with community teams working together to form a cocoon of services around our population need; acute and emergency services will be provided to the most in need patient; every service provided will see a measurable impact against inequity and seek to further address this; people who need a diagnosis receive it in a timely manner; and those who deliver care can do so without moral injury.

We are extremely grateful for the passionate contributions toward this work- from our fantastic primary care professionals who care passionately about our patients, from our united and resistant people and communities, from our committed and hardworking partners through to our vibrant VCSE, all of whom will look to us to make good on the delivery of this strategy.

“The secret of change is to focus all your energy not on fighting the old, but on building the new”

Socrates

7. Acknowledgments

We would like to thank the following people, groups or organisations for their input and support in informing, contributing, and developing our Primary Care Strategy:

- Our LLR ICB colleagues from all directorates
- The LLR ICB PCTB (Primary Care Transformation Board)
- Our LLR ICS and ICB Governance, Delivery, Assurance, Design Groups, ISOC, JICB, IDG, Health and wellbeing Boards
- Our LLR ICB Clinical leads, SME's and PCN Clinical Directors
- Public Health, Health Education England, NHS Colleagues, from Leicester City, Leicestershire & Rutland
- Healthwatch Leicester, Leicestershire & Rutland
- LLR Professionals Committee: LMC (Leicester Medical Committee), LOC (LLR Local Optometric Committee), LDC (LLR Dental Committee), LPC (LLR Pharmacy Committee)
- Local Authorities and District Councils
- Our Strategic Partners: UHL, LPT, EMAS, DHU
- All our system partners
- Our LLR Patient Participation Groups
- Public and Patient Involvement Assurance Group
- Voluntary, Community and Social Enterprise Alliance
- The patients and public of Leicester, Leicestershire and Rutland

8. References

- BMA & NHS England (2019). Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan. Retrieved from https://www.england.nhs.uk/publication/gp-contract-five-year-framework/
- Department of Health and Social Care (2019). GP Partnership Review. Retrieved from https://www.gov.uk/government/publications/gp-partnership-review-final-report
- Department of Health and Social Care (2022). Our plan for patients. Retrieved from https://www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients
- Department of Health and Social Care Green Paper (2020). Advancing out Health: Prevention in the 2020's. Retrieved from https://www.gov.uk/government/consultations/shaping-future-support-the-health-and-disability-green-paper/shaping-future-support-the-health-and-disability-green-paper
- House of commons HSCC (2022). The Future of general practice. Retrieved from https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/113/report.html https://www.england.nhs.uk/publication/investment-and-evolution-update-to-the-gp-contract-agreement-20-21-23-24/
- NHS Confederation. Primary care recovery plan and various publications: Retrieved from https://www.nhsconfed.org/publications
- NHS England & Surrey Heartland ICS (2022). Next steps for integrating primary care: Fuller stocktake report. Retrieved from https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/
- NHS England (2015). Primary Care Transformation Fund promises major upgrades to GP premises. Retrieved from https://www.england.nhs.uk/2015/10/primarycaretransfund/
- NHS England (2016). General Practice Forward View. Retrieved from https://www.england.nhs.uk/publication/general-practice-forward-view-gpfv/
- NHS England (2017). General Practice – Developing confidence, capability and capacity: A ten point action plan for General Practice Nursing. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2018/01/general-practice-nursing-ten-point-plan-v17.pdf
- NHS England (2019). The NHS Long Term Plan. Retrieved from https://www.longtermplan.nhs.uk/
- NHS England (2021). Digital-first primary care policy consultation. Retrieved from https://www.engage.england.nhs.uk/consultation/digital-first-primary-care-policy/user_uploads/digital-first-primary-care-consultation.pdf
- NHS England (2021). Update to the GP Contract Agreement 2020/21 – 2023/24. Retrieved from
- NHS England, Future commissioning changes & documentation i.e. PODs. Retrieved from https://www.england.nhs.uk/long-read/direct-commissioning-delegation/
- NHS England, GP contract documentation i.e. DES. Retrieved from https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/
- Nuffield trust (2019). Closing the gap: Key areas for action on the health and care workforce, Retrieved from https://www.nuffieldtrust.org.uk/research/closing-the-gap-key-areas-for-action-on-the-health-and-care-workforce
- RCGP (2020). Future: a new plan for GPs and their patients Vision for General Practice Retrieved from https://www.rcgp.org.uk/representing-you/future-of-general-practice
- The King's Fund (2018). A vision for population health: Towards a healthier future. Retrieved from https://www.kingsfund.org.uk/sites/default/files/2018/11/A%20vision%20for%20population%20health%20online%20version.pdf
- The King's Fund (2019). The NHS after the Health and Social Care Act. Retrieved from https://www.kingsfund.org.uk/projects/new-nhs
- The King's Fund (2019). What does improving population health really mean?. Retrieved from https://www.kingsfund.org.uk/publications/what-does-improving-population-health-mean

9. Supporting Documents (Under Development)

Associated strategies	<Insert from Exec summary>
PCN Profiles	<Insert>
Introduction to the ICS/ICB	<Insert>
Placed based strategies	<Insert>
Population Health Management	<Insert>
Health Inequalities PCN Overview	<Insert>
PCN Maturity Summary	<Insert>
Engagement Findings	<Insert>

10. Appendix

Appendix 1a: Associated Strategies

(Note please check that these strategies are the latest versions as the links will not direct you to any updated documents)

- Leicester health, care and wellbeing strategy 22-27
- Leicestershire joint health and wellbeing strategy 22-32
- Rutland joint health and wellbeing strategy: The Rutland place-based plan 22-27
- LLR primary care strategy 19-22
- LLR Health & Wellbeing Partnership Integrated Care Strategy 22
- LLR ICB quality and improvement strategy
- LLR ICB digital strategy 22-25
- LLR clinical model strategy
- LLR primary care estates strategy
- LLR ICB people plan
- Looking After Our People Priorities
- LLR ICB people and community's strategy 22-24
- LLR operational plan
- LLR ICB health inequalities and inclusion strategy and framework 21-25
- Embedding Research into Practice Strategy
- Green Plan 2022 - 2025
- Better care for all
- Future in Mind Transformation plan
- Better Mental Health For All LPT
- Leicester, Leicestershire and Rutland Living Well with Dementia Strategy 2019-2022
- CYP Future In Mind strategy
- Fuller stocktake report
- NHS Long Term Plan

Appendix 1b: Summary of the national changes affecting primary care

NHS Long Term Plan- Realizing we needed to build on the FV and GPFV in January 2019 NHSe published the LTP, a blueprint for NHS for the next 10 years with focus on prevention, improving services for patients and finally abolishing the divide between primary and community services. A key output of the LTP was the birth of our Integrated Care Systems (ICS), giving us a platform for further partnership working and integration.

GP Contracts- Changes to the GP network contract and Directed Enhanced Services (DES) specifications were published also published in 2019 and translated the commitments in the NHS LTP into a five-year framework for the GP services contract. This solidified the direction of travel for primary care. With joined up commissioning our PCN's are making a real difference to patient health and wellbeing. Example

DHSC White Paper- In 2021 the DHSC published the White Paper Integration and innovation: working together to improve health and social care for all, which set out legislative proposals for a health and care bill. Bringing together proposals that build on the integrating care by collectively looking at the needs of the population at the various partnership levels i.e. System, Place and Neighbourhood.

Health and Social Care Act 2022- Shortly after the proposals in the white paper were passes as cart of the Health and Social Care Act 2022. Integrated care systems (ICS) bring together providers and commissioners of NHS services with local authorities and other local partners in 42 areas across England. A key opportunity offered by ICS is to improve the health of the population at local level through genuine partnership working between the NHS, local government, the voluntary and community and local communities.

Financial initiative schemes- At around the same time other national policies, financial initiatives and changes such as Integrated Urgent Care, Building better hospitals along with investment initiatives such as ARRs, IIF and ETFT have paved the way for 'system level' collaboratives and partnerships; bringing together people from primary, secondary, community, LA, partners and VCSE.

The Fuller Stocktake (Fuller 2022)- Sets out how we do this by introducing a new vision for integrating primary care at place, improving the access, experience and outcomes for our communities, which centred around three essential themes. Streamlining access to care and advice, providing more proactive, personalised care with support from a multidisciplinary team of professionals and helping people stay well for longer.

Delegated commissioning responsibilities for PODs (Pharmacy, Optometry and Dentistry) from April 2023- ICSs will have more ability to deliver services that meet the specific needs of their populations, including local commissioning for dentistry, optometry and community pharmacy from 2023. This additional responsibility gives us the chance to work across the broad set of services to identify how we can reshape improved delivery of care through deeper integrated working.

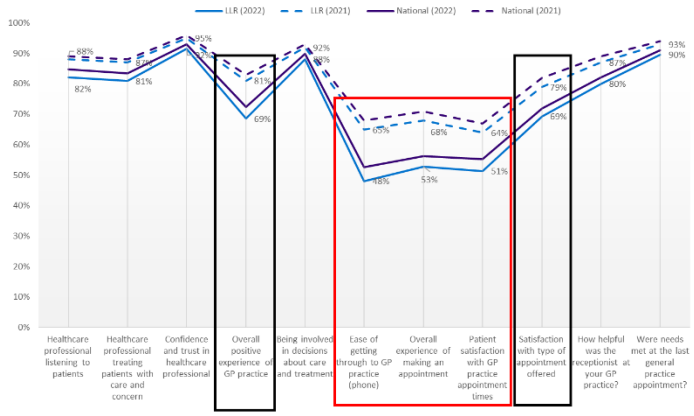
NHS Priorities and operational planning guidance 23/24- The 2023/24 priorities and operational planning guidance reconfirms the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future.

Further Changes to Primary Care Contracts- The changes to the GP contract in 2023/24 set out the requirements of General Practice and PCNs with the goal of improving patient experience and satisfaction, recognising that this will require both time and support to assess, review and implement changes. These changes will be supported in several ways including freeing up workforce capacity through significant changes to the Impact and Investment Fund (IIF) and through the QOF Quality Improvement (QI) modules. One key change was the number of indicators in the IIF which will be reduced from 36 to 5.

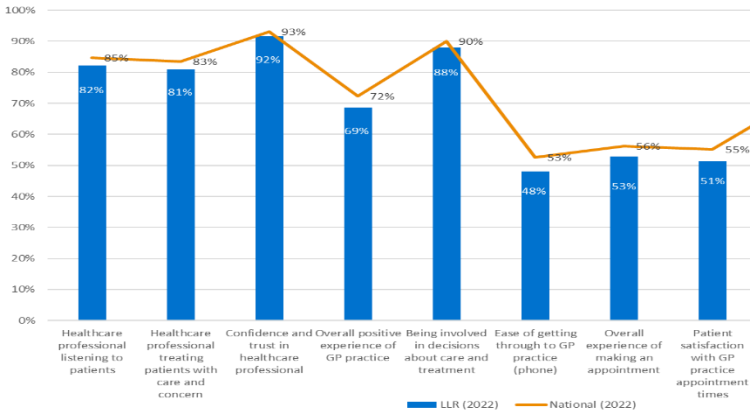
Appendix 2: Summary of findings from engagement with our communities

To help us better understand the patient and carer need we have utilised a range of data and insights from both local and national sources. This intelligence has helped us to shape our vision for the future.

The National GP Patient Survey provides use the trends across 2021 and 2022.



47,789 people were invited to take part in the 2022 survey. 14,426 people returned surveys in Leicester, Leicestershire and Rutland. This represents a 30% response rate. Locally we performed below the national average for 11 questions in both 2021 and 2022. The 2021 data was collected during the third lockdown and 2022 data was collected as the UK was transitioning to 'normal', which may have influenced the data. The data shows that the three worst scoring questions relate to access to GP services. Followed by overall experience of GP practice and satisfaction with the type of appointment on offer.



Although locally we were below the national average, the majority of respondents to the survey had positive perceptions of their care (92%) and felt their needs were met during their last GP appointment. In addition, confidence and trust in healthcare professionals is high among respondents and 90% of respondents felt their needs were met during their last GP appointment.

This survey aligns with a local survey undertaken which 5,483 people contributed to and the consolidated Enhanced Access Report where 44,400 people shared their insights into enhanced access services.

In addition to using these qualitative and quantitative surveys reviewed the information across secondary data collected across 74 reports including from large scale public consultation Report of

Findings including Building Better Hospitals Report of Findings (May 2021) and the, Step up to Great Mental Health Report of Findings (October 2021).

The themes

Outlined below are the key themes emerging from patients, family carers, staff and stakeholders from the consolidated insights. These have informed this strategy:

Health Quality and Prevention

- Patients, service users' and carers' perceptions of the quality of the healthcare they receive is highly dependent on the quality of their interactions with their healthcare professional and team.
- A better understanding of culture and language is needed whether on the telephone, face-to-face, in leaflets or online.
- The use of understandable and consistent terminology, without jargon, and accessible resources are important to the people. Vulnerable groups report the lack of availability of translation / interpreter services. They also report that healthcare staff do not have an awareness of the cultural differences common to these groups.
- People feel that clinicians and health professionals should be encouraged to empower patients and carers to take control of their own health, with information, explanation and an understanding of the range of choices such as social prescribing.
- People feel it is important to have confidence that professionals listen to them and decision making around healthcare is a joint exercise, particularly those with long-term conditions.
- Patients would prefer to stay in their own home for as long as possible, but their level of confidence is dependent on support from health professionals, family and external agencies which they felt can vary.
- A significant proportion of patients do not consider themselves to have any real medical knowledge or confidence to go looking for self-care advice or support. When patients do seek out support from their General Practice or Health Centre, they often find it difficult to even make contact with an appropriate person. Many patients express frustrations about not being able to make appointments in general. Often, they feel they need to have an initial consultation with a GP or other health professional to identify their medical issue and for the GP or health professional to devise a treatment pathway and provide advice about their condition – many patients see this as the gateway to them being able to look after their own health more effectively.
- People would like health professionals to directly support those patients in poor health with advice and support to help them manage their conditions, as they feel this can prevent an appointment to an urgent and emergency care.
- People want messages from a trusted source and receive information directly rather than seek it out.
- Patients feel that their General Practice website is either out-of-date or it is not easy to find things. People want information to include self-care help and advice in order to arm them with as much useful and reliable information as they need in this area.

Joining up care

- IT systems should be joined up and improved between organisations, improved access to records; technology acting as a better tool to support integrated working; and information availability.

- Transfers between services/handovers are stressful times for both GPs and other staff and patients and family carers, in particular, older and vulnerable people.
- Family carers need services which are reliable and appropriate to their situation and allow them to support their loved one. They report difficulties in being recognised as carers by their GP practice and getting the help they need and felt frustrated particularly when trying to get help at times of crisis or prevent a crisis.
- Patients and carers wanted a more efficient and effective link between GP surgeries and hospitals; between professionals working in health and those working in social care and more obvious use of technology using digitised notes and shared computer systems, so they don't have to tell their story a number of times.
- Primary Care professionals could better inform people of local support services and have a better understanding of how to support patient and their whole family, particularly how to live with long term conditions.
- People need more recognised involvement of the voluntary and community sector in a formal capacity, rather than a voluntary one.
- People felt that a more joined up approach to services supporting good physical and mental health would prevent more people from having an emotional breakdown, particularly those people who are coping with a long-term physical condition. People also saw social prescribing as a support service for patients and their family carers.

Access to care closer to home

- When asked what makes a good primary care appointment people wanted to be seen in a timely manner, with no long waits, to be listened to by the GP or health professional, to feel they had enough time and not rushed and to leave with a diagnosis/advice/support/ referral.
- Being able to get an appointment easily is important, as is being treated respectfully by members of staff at the Practice.
- The setting and location of care is important and needs to be fair and equitable. New services and ways of working need to be shared with/promoted to both staff and patients, but it is important that messages are delivered by a known and trusted source.
- Many people are comfortable with digital consultations, however many are either not digitally enabled or digitally confident, or feel that a digital appointment is not appropriate to their medical problem.
- Many people say they would like to feel more confident in the support they receive in a crisis and to keep mobile and active.
- People need a better experience of getting through on the telephone and accessing GP services, as well as improved confidence and satisfaction with the type of appointment they are offered.
- There is an obvious preference for 'traditional' face-to-face appointments but some people say they are happy to have an initial telephone consultation and other are comfortable with an online consultations. Remote consultations are viewed as more acceptable for 'non-emergency' medical issues.

Appendix 3: Delivery plan (Under development)

<Insert>

Appendix 4: One page theme summaries (Under development)

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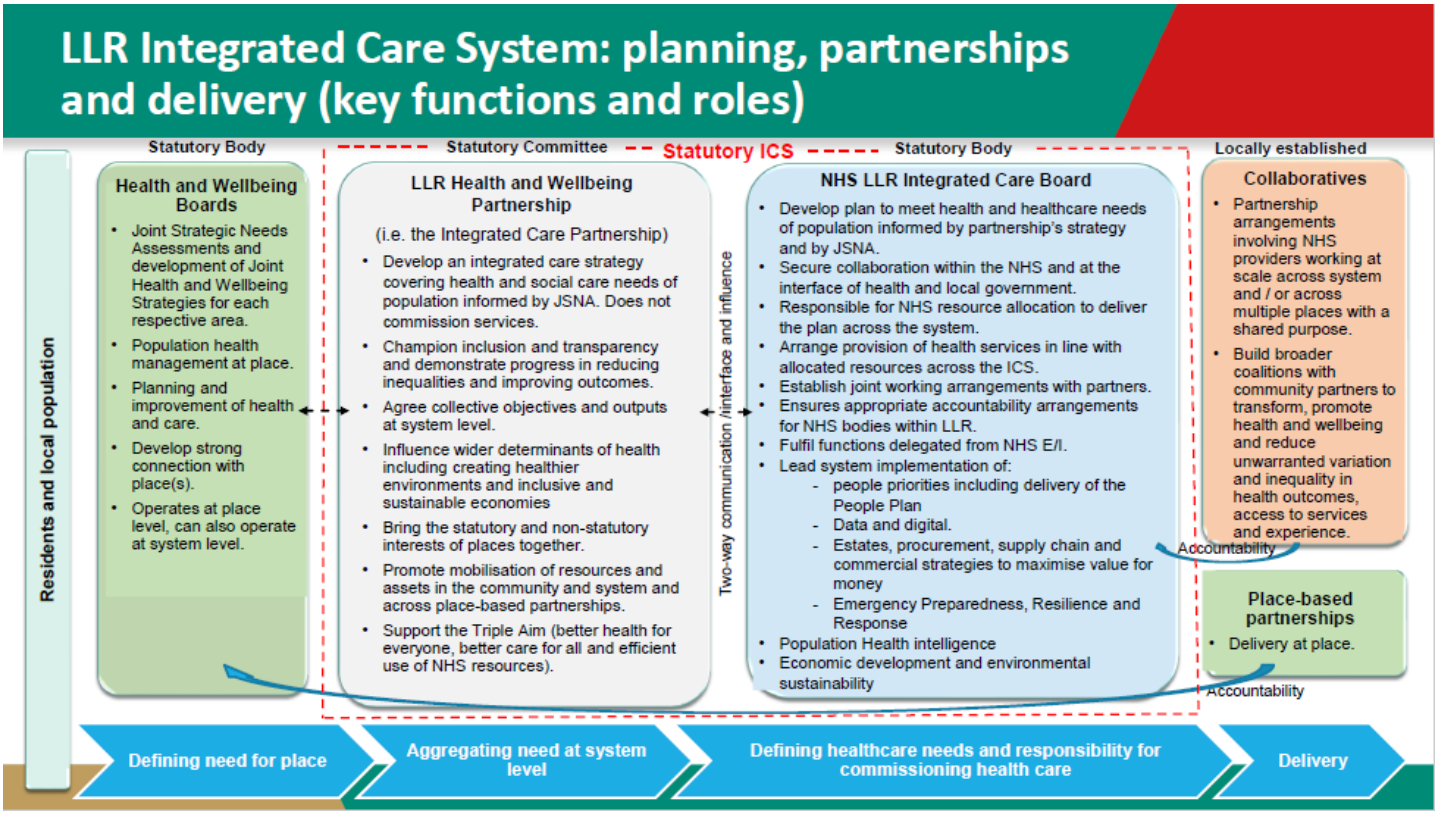
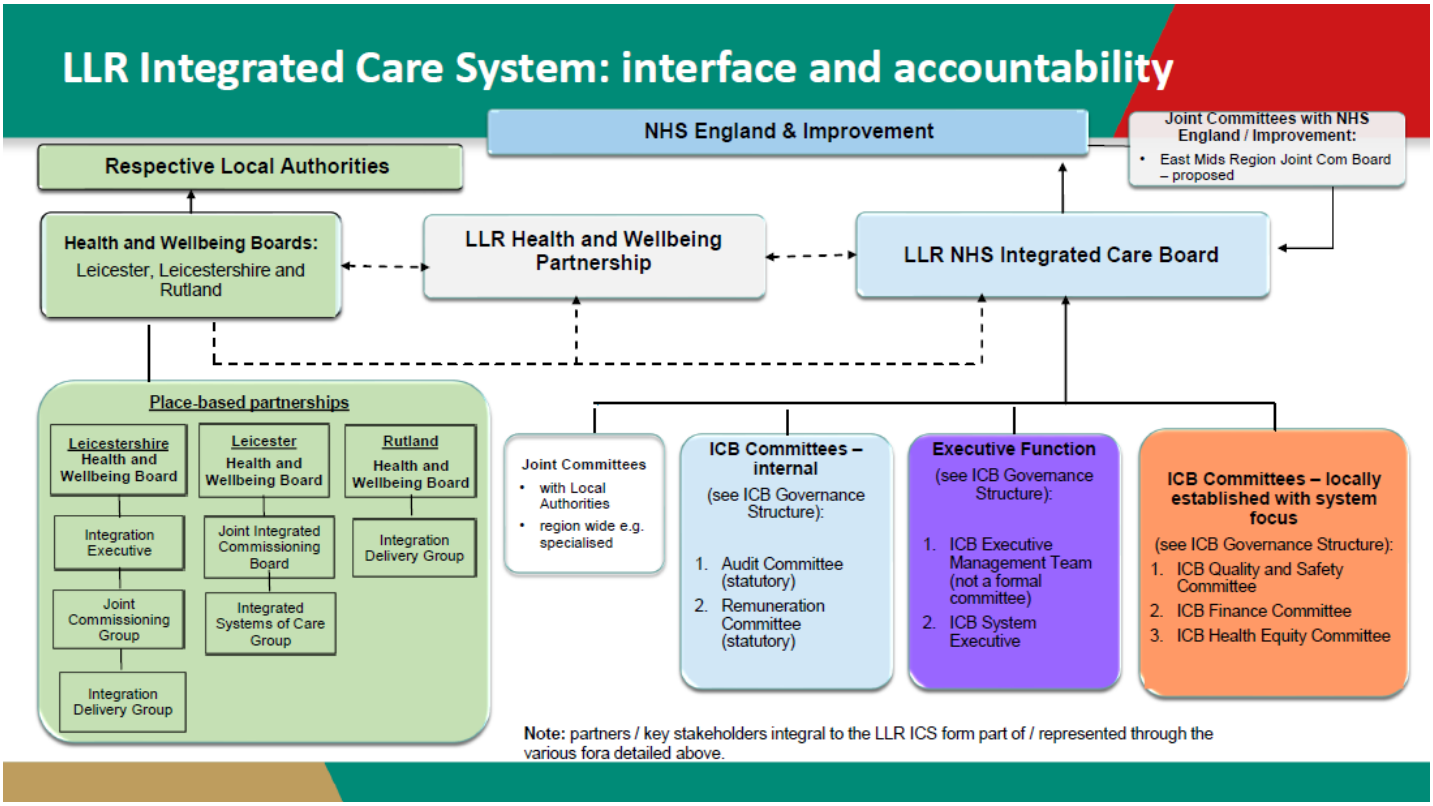
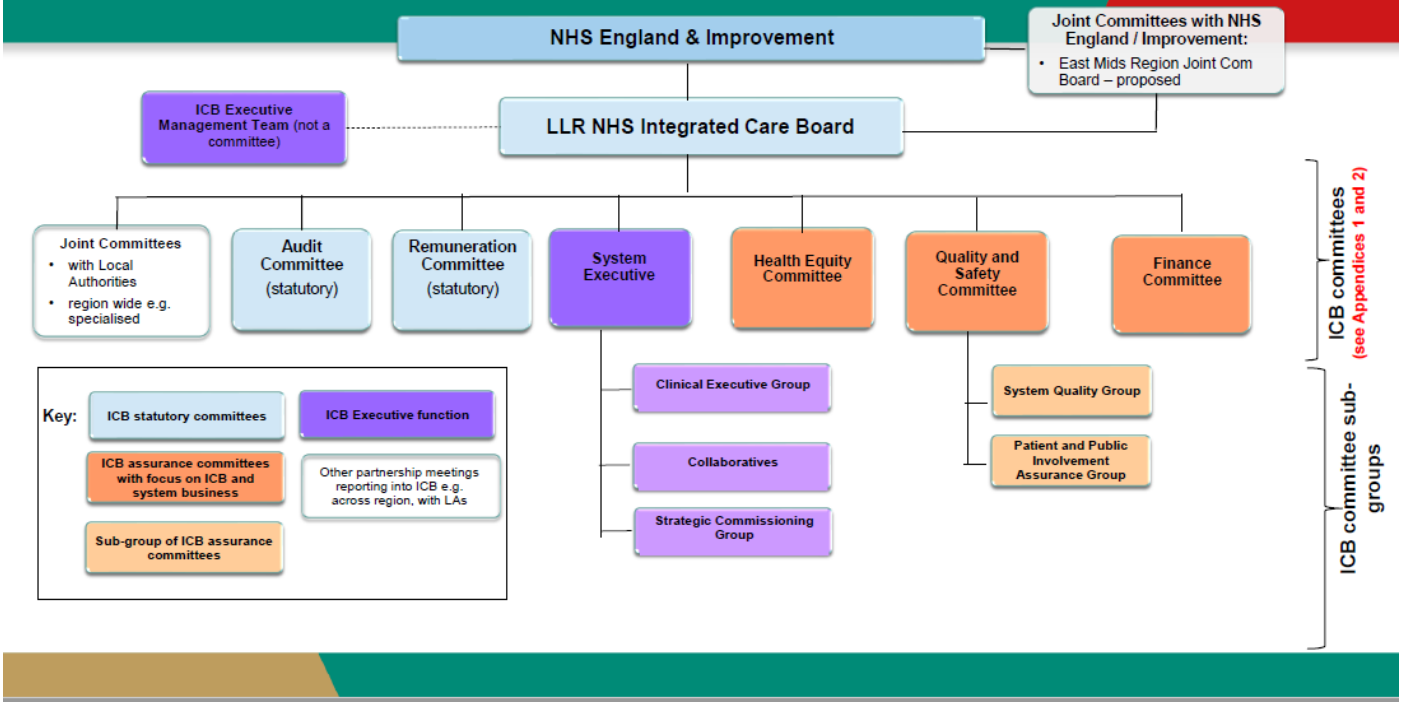
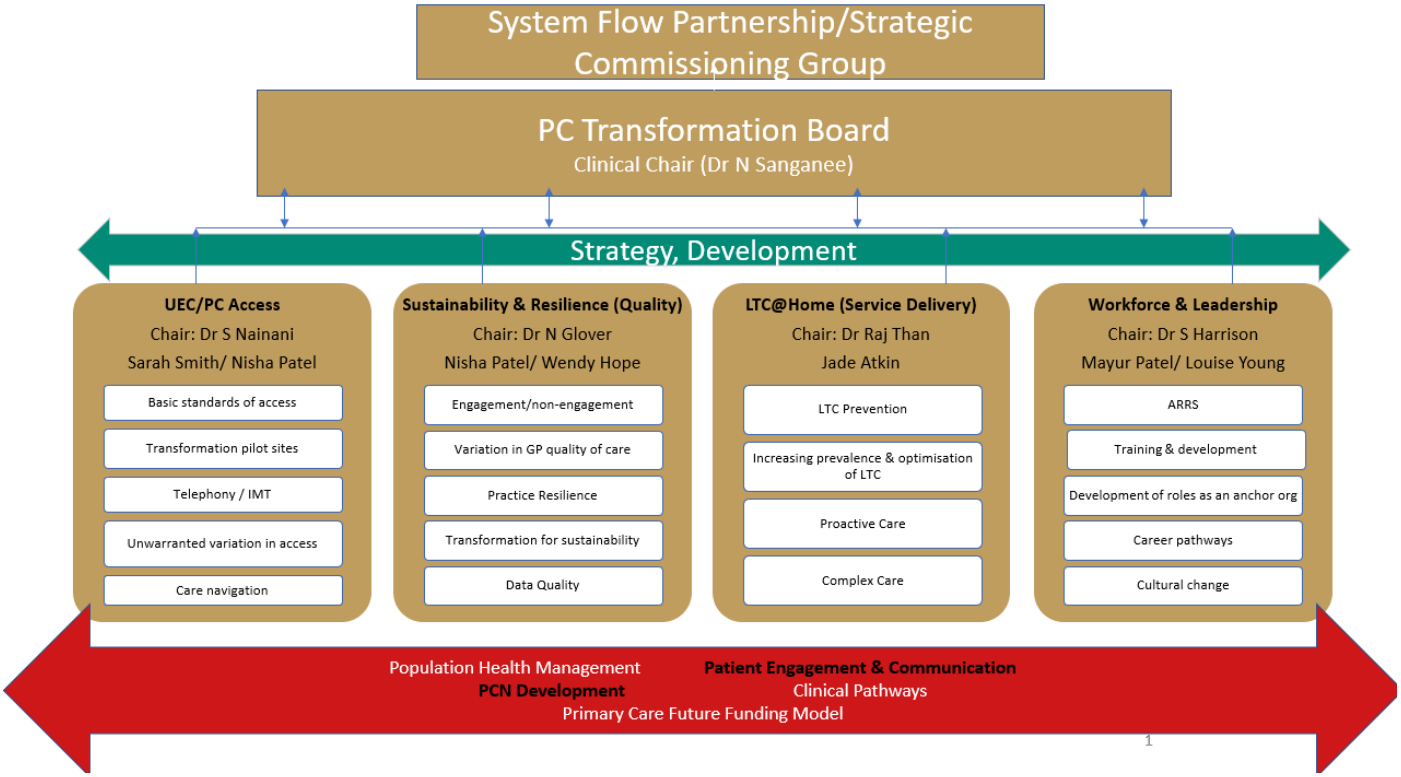
Appendix 5a: ICS/ICB Governance





LLR Integrated Care Board governance structure





Appendix 5b: PCTB (PRIMARY CARE TRANSFORMATION BOARD) Group Membership

Organisation	Directorate/Team	Name	Membership Role
Core Membership			
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Integration & Transformation	Yasmin Sidyot	Deputy Chief Operating Officer
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Integration & Transformation	Sabina Esat	I&T Support Officer (PCTB Administrator)
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB) **(CHAIR)**	Medical Directorate	Dr N Sanganee	Chief Medical Officer
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB) **(Deputy Chair)**	Medical Directorate	Dr S Nainani	Deputy Chief Medical Officer
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB) **(Deputy Chair)**	Medical Directorate	Dr Andy Ahyow	Deputy Chief Medical Officer
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Primary Care - Integration & Transformation	Mayur Patel	Head of Integration & Transformation (Programme SRO)
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Primary Care - Integration & Transformation	Nisha Patel	Head of Integration & Transformation (Programme SRO)
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Strategy and Planning	Mark Pierce	Head of Population Health Management
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Nursing and Quality	Wendy Hope	Head of Quality and Safety
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	People and Innovation	Louise Young	Deputy Chief Officer People and Workforce
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	People and Innovation Communications	Dave Rowson	Head of Communications & Marketing
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	People and Innovation Engagement	Susan Venables	Head of Engagement and Insights
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Finance, Contracting and Corporate Governance	Andrew Roberts	Primary Care Finance Business Partner

Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Contracts	Jamie Barrett	Senior Contracts Manager
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	City	Fahad Rizvi	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	City	Dr Avi Prasad	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	County	Dr James Ogle	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	County	Dr Nikhil Mahatma	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Rutland	Lynette Patino	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Long-Term Conditions Care@Home (LTC)	Debra Mitchell	ICB Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Long-Term Conditions Care@Home (LTC)	Dr Raj Tun Than	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	PC/UEC Access	Sarah smith	ICB Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	PC/UEC Access	Dr Girish Purohit	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	PC/UEC Access & Sustainability & Resilience (Quality)	Dr Nick Glover	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Estates and Facilities	Lorna Simpson	Head of Strategic Estates
Leicester, Leicestershire and Rutland LMC	LMC	Dr Fahreen Dhanji	LMC representative
University Hospitals of Leicester (UHL)	UHL - Deputy Director of Organisational Transformation	Lucy Wall	UHL Representative
Leicestershire Partnership Trust (LPT)	LPT	Nikki Beacher	Deputy Director Community Health Services

Healthwatch Leicester and Leicestershire	Leicester and Leicestershire	Kash Bhayani	Healthwatch Leicester and Leicestershire representative
Healthwatch Rutland	Rutland	Tracey Allan-Jones	Healthwatch Rutland representative
Public Health (PH)	Head of Locality East and SRCT Social Care and Education	Sezer Domac	Leicester City Council
Leicestershire County Council	Health and Care Integration Project Manager	Lucy Hulls	Leicestershire County Council
Rutland County Council	Hospital and Clinical Integration Lead	Mat Wise	Rutland Council
In attendance			
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Primary Care Access and Variation	David Muir	ICB Lead – Primary Care Access
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Sustainability & Resilience (Quality)	James Hickman	ICB Lead – Primary Care Access
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Workforce and Leadership	Rajesh Thanki	Senior workforce planning and BI Manager
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Workforce and Leadership	Dr Stacey Harrison	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Home First	Fay Bayliss	ICB Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Home First	Dr Rekash Inamdar	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Long-Term Conditions Care@Home (LTC)	Jade Atkin	ICB Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	LLR ICB Digital Innovation and Transformation Team	Saadia Shafeeq-Uddin	Senior Delivery Manager
University Hospitals of Leicester (UHL)	Chief Operating Officer - UHL	John Melbourne	UHL Representative
Leicestershire Partnership Trust (LPT)		Sam Leak	Executive Director for Community Health Services
Healthwatch Leicester and Leicestershire	Leicester and Leicestershire	Harsha Kotecha	Healthwatch Leicester and Leicestershire representative

Appendix 6: Table of figures (Full Visuals)

Figure 1: ICS strategic priorities

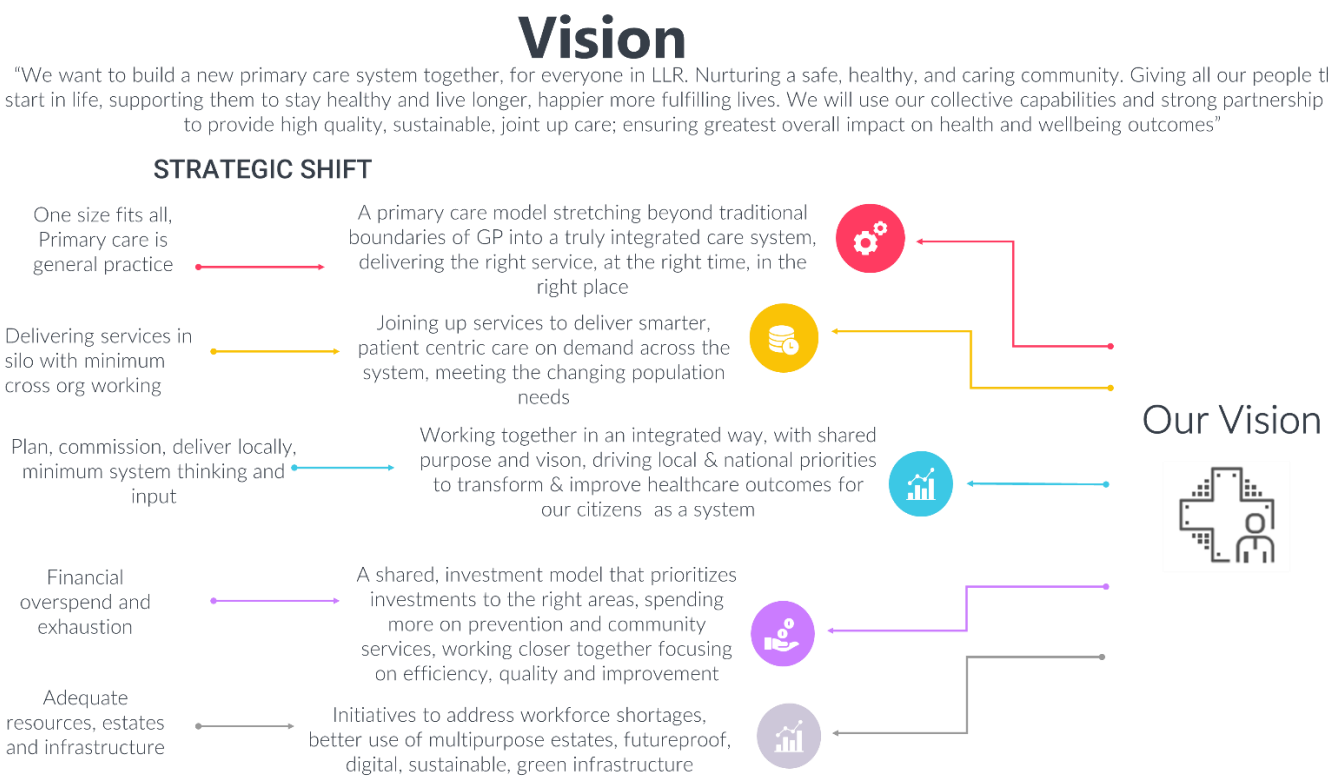


Figure 2: Overview of the strategic shift for primary care

One LLR Primary Care Framework

Our Primary Care Framework is organized using the following core components:

Figure 3: Framework for strategy development

Methodology

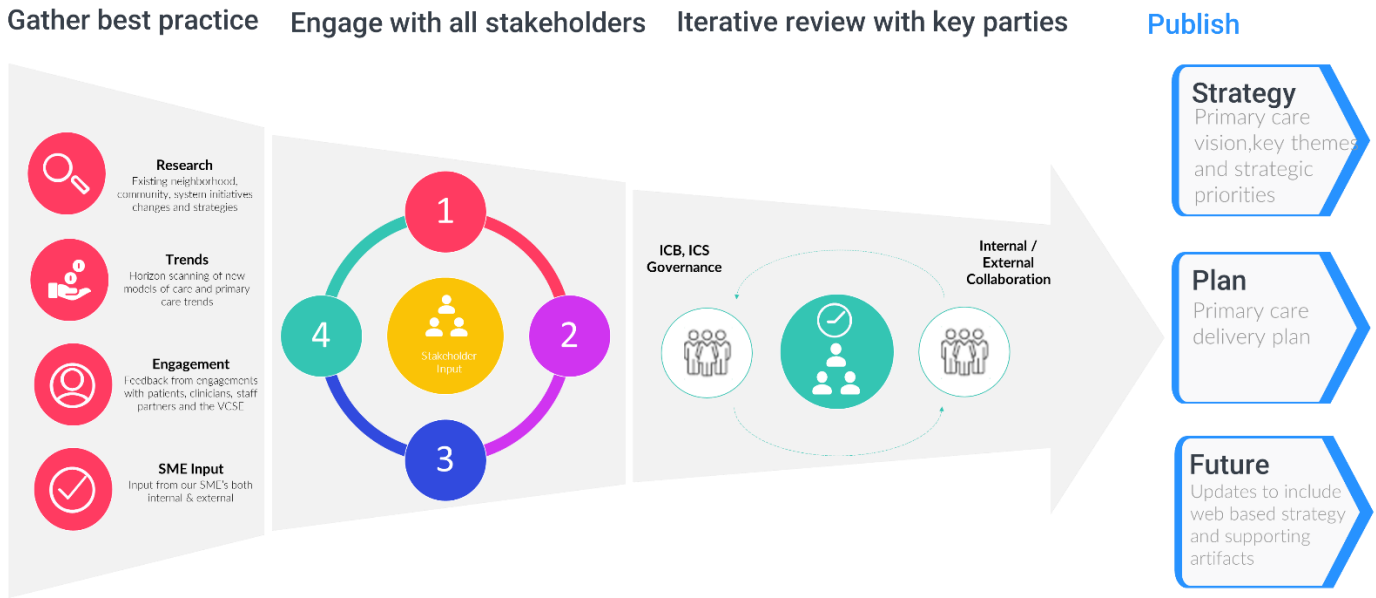


Figure 4: Strategy development methodology

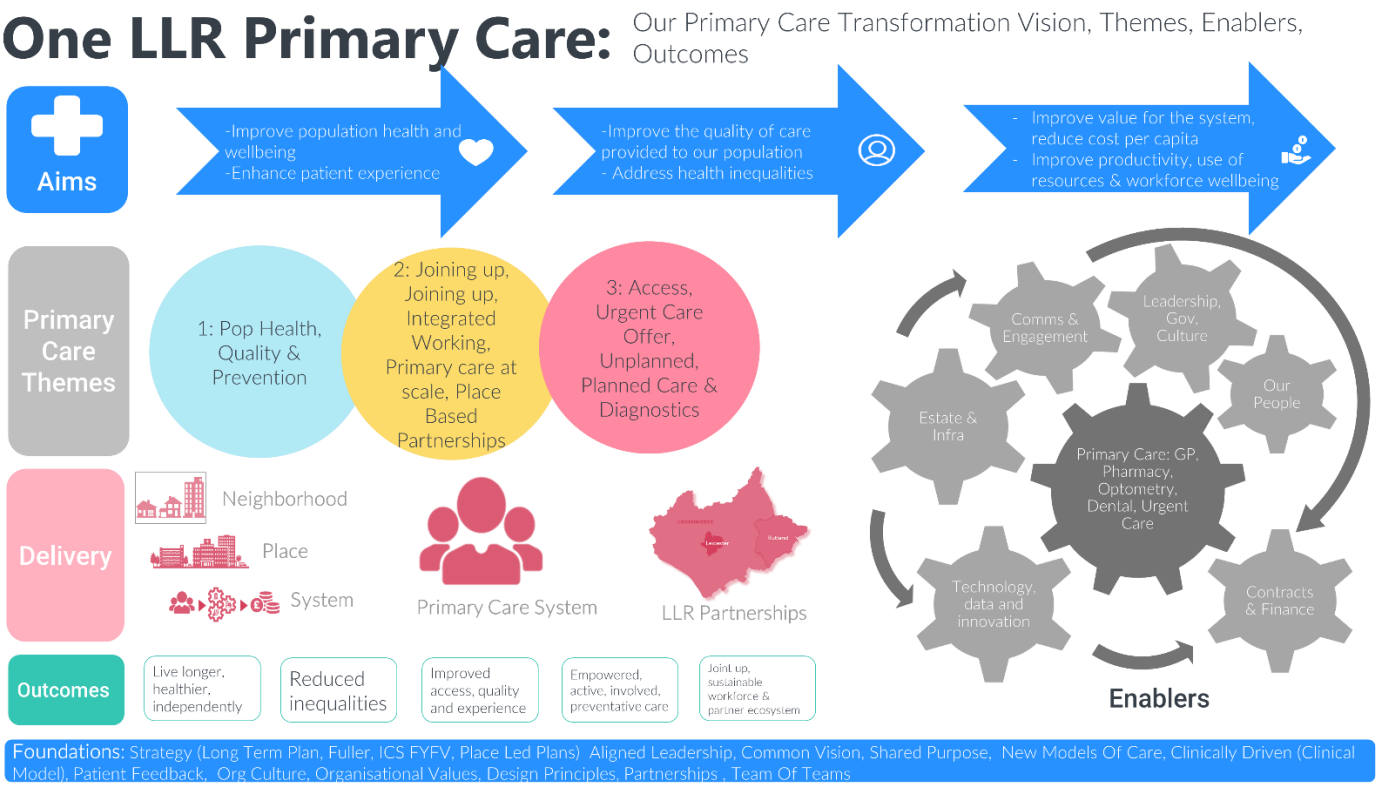


Figure 5: Primary care vision overview

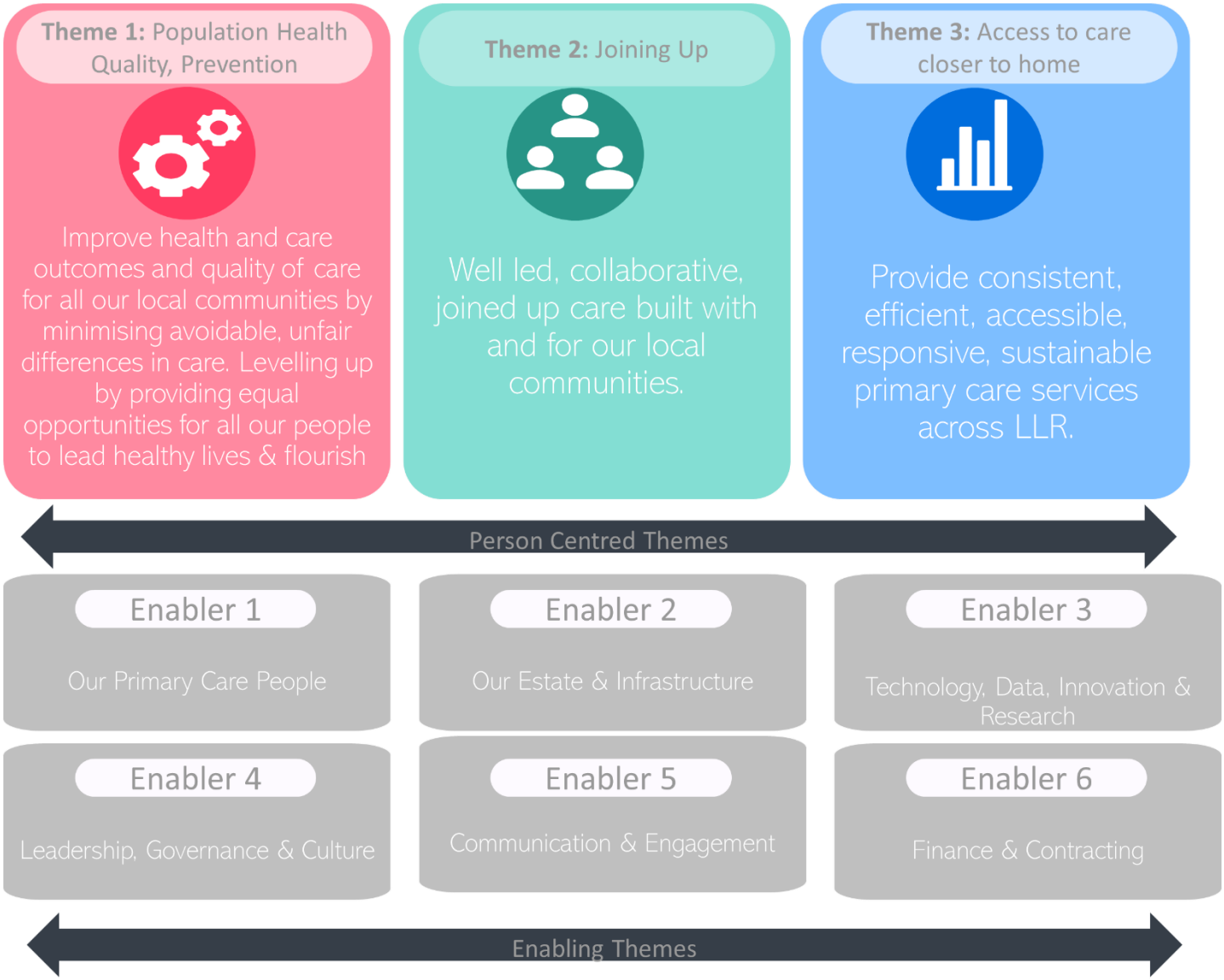


Figure 6: Primary care themes overview

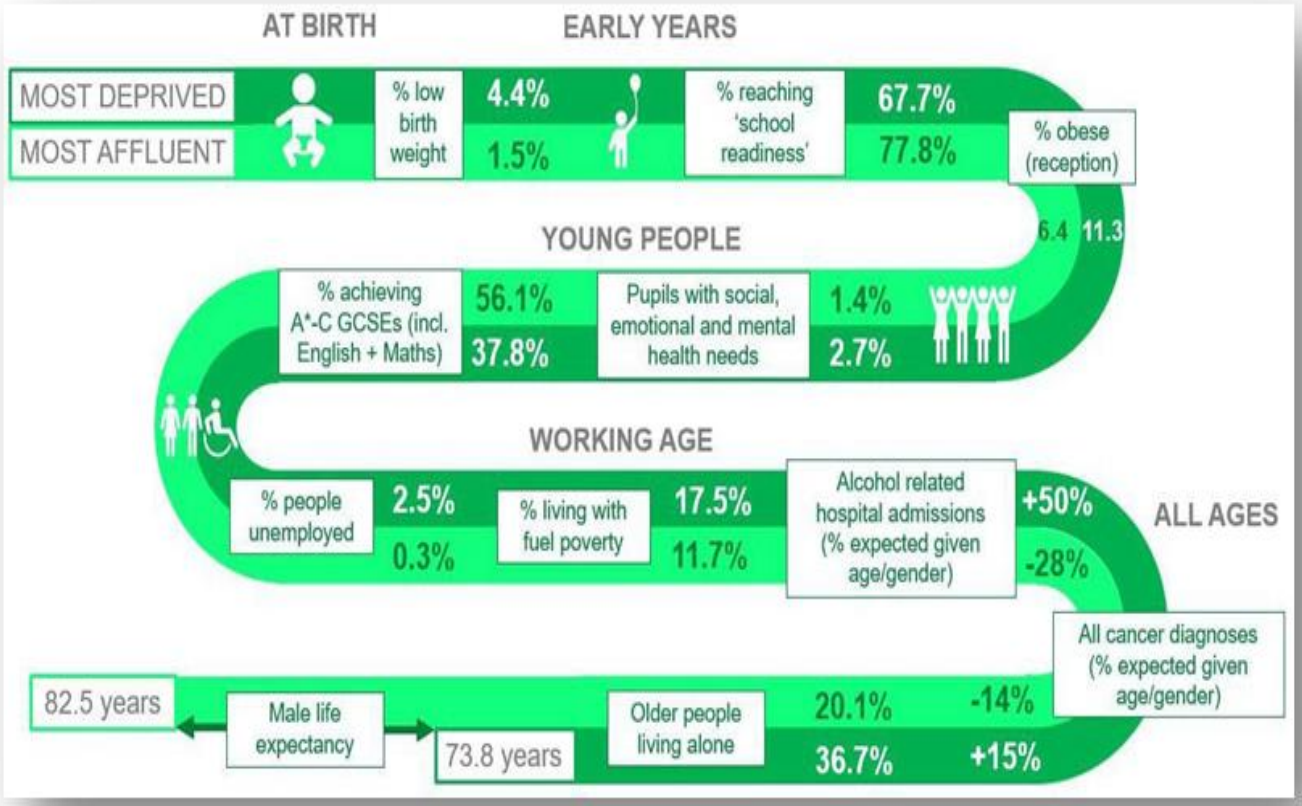
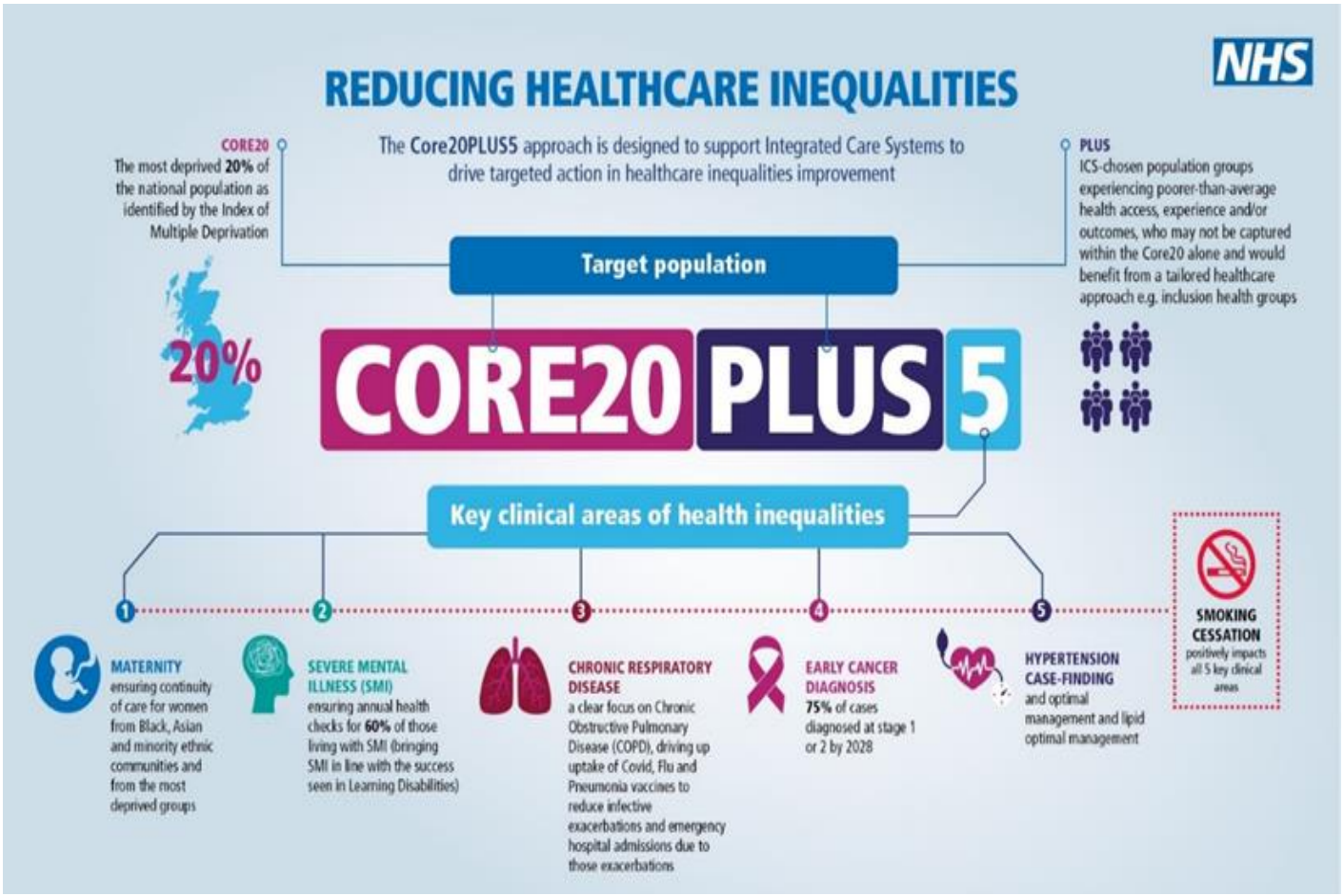


Figure 7: A Tale of Two babies - Difference in health indicators between the most and least deprived local areas of LLR. Source: PHE Fingertips



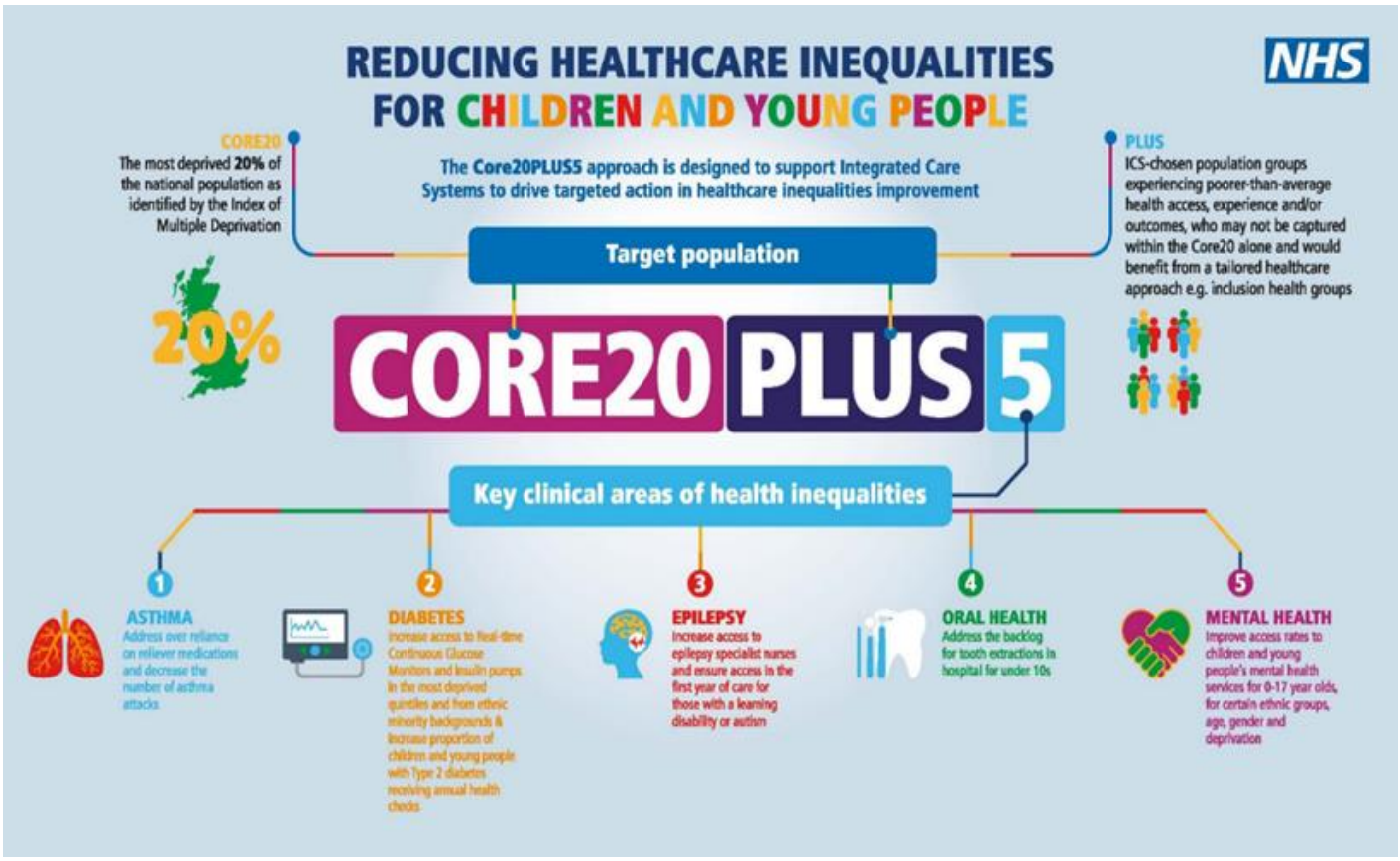


Figure 8: NHSe Core20Plus5 Approach (Adults & CYP)

Figure 9: Our communication and engagement approach

TABLE 1. Primary Care Allocation Summary					
	23/24	**24/25**	**25/26**	**26/27**	**27/28**
Primary Care	23,268	23,902	24,746	25,618	26,522
Primary Care Co-Commissioning	195,134	203,138	211,470	220,143	229,172
Delegated Pharmacy, Optometrist and Dental allocations	91,475	93,619	97,459	101,456	105,617
Estimated Primary Allocations	**309,877**	**320,659**	**333,674**	**347,218**	**361,312**
System Programme and Co Comm projected combined allocations	**1,931,205**	**1,986,545**	**2,057,786**	**2,131,588**	**2,208,043**
Proportion allocated to Primary Care	**16%**	**16%**	**16%**	**16%**	**16%**

Figure 10: Projected LLR primary care allocations 23-28

11. Glossary Of Terms

A&E Accident and Emergency
APMS Alternative Provider Medical Services
ARRS Additional Roles Reimbursement Scheme
BAU Business as Usual
BCF Better Care Fund
CCG Clinical Commissioning Group
Core20PLUS5 NHS England and Improvement approach to reducing health inequalities
CPCS Community Pharmacy Consultation Scheme
DES Direct Enhanced Service
ED Emergency Department
ETTF Estates and Technology Transformation Fund
ETTF Estates Transformation Fund
GMS General Medical Services
GP General Practice
GPFV General Practice Forward View
GPIT General Practice Information Technology
HEE Health Education England
HWB Health and Wellbeing Board
ICB Integrated Care Board
ICP Integrated Care Partnership
ICS Integrated Care System
IIF Impact & Investment Fund
INT Integrated Neighbourhood Teams
ICS Integrated Care System
IT Information Technology
JHWS Joint Health and Wellbeing Strategy
LDC Local Dental Committee
LLR Leicester, Leicestershire, Rutland
LMC Local Medical Committee
LOC Local Optical Committee
LPC Local Pharmaceutical Committee
LTC Long Term Condition
LTP Long Term Plan
MDT Multi-Disciplinary Team
MECC+ Making Every Contact Count
MH Mental Health
NHS E&I National Health Service England and Improvement
NHS National Health Service
PCN Primary Care Network
PHM Population health management
PPG Patient Participation Group
QOF Quality Outcomes Framework
SEND Special Education Needs And Disability
STP Sustainability and Transformation Partnership
UEC Urgent and Emergency Care
UTC Urgent Treatment Centre
VCSE Voluntary Community Social Enterprise