HEALTH AND WELLBEING BOARD: 29 MAY 2025

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

NEIGHBOURHOOD HEALTH PROGRAMME

Purpose of report

1. The purpose of this report is to inform the Board of the progress made to date with implementing the Neighbourhood Health Programme in Leicestershire.

2. The report details the current in-year plans and refers to the commitment to work in partnership to develop 5 and 10 year plans to develop the neighbourhood model of care.

Recommendation

3. The Board is recommended to:

   (a) Note the progress made thus far;

   (b) Support the direction of travel outlined in the report.

Policy Framework and Previous Decision

4. NHS England published 'Neighbourhood health guidelines 2025/26' on the 29 January 2025 which set out guidelines to provide integrated care boards (ICBs), local authorities and health and care providers with more specificity to help them progress neighbourhood health in 2025/26 in advance of the publication of the 10 Year Health Plan.

5. These guidelines outline the NHS England belief that the foundations of a neighbourhood health service are already in place in many areas across the country and are made up of 6 core components:

   a. Population Health Management;

   b. Modern General Practice;

   c. Standardising Community Health Services;

   d. Neighbourhood Multi-Disciplinary Teams;

   e. Integrated intermediate care with a 'Home First' approach;

f. Urgent neighbourhood services.

6. The Neighbourhood health guidelines require systems to:

- Standardise the 6 core components of existing practice to achieve greater consistency of approach.
- Bring together the different components into an integrated service offer to improve coordination and quality of care, with a focus on people with the most complex needs.
- Scale up to enable more widespread adoption.
- Rigorously evaluate the impact of these actions, ways of working and enablers, in terms of both outcomes for local people and effective use of public money.

7. ICBs and local authorities were asked to jointly plan a neighbourhood health and care model for their local populations that consistently delivers and connects the initial core components at scale, with an initial focus on people with the most complex health and care needs.

8. This report will provide an update against these requirements, outline next steps for the neighbourhood health programme, and discuss the ongoing risk to robust evaluation.

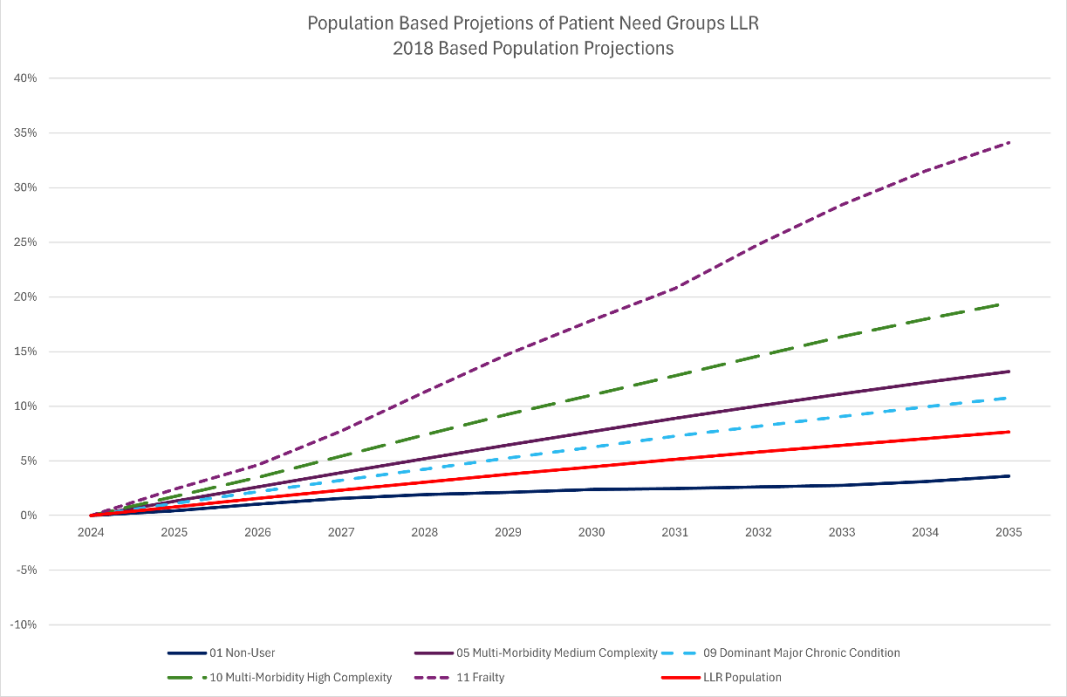
Background

9. The LLR system has been working at place and neighbourhood level since the advent of the Better Care Fund. Based on previous delivery of outcomes, the system remains in a good position to embrace the challenges of neighbourhood health, having embedded a population health management system, a significant Home First programme of care, a nationally lauded Intermediate care programme and neighbourhood health and care plans, covering LLR. Each of these has focussed, over a number of years, across both physical and mental health care.

10. However, since the workstreams were combined with Urgent and Emergency Care (UEC), the work of these programmes has largely been unsighted or understood in detail. There is a danger of work not being fully aligned or being duplicated, learning not being shared and the full benefit of these services not being fully delivered. Equally, the benefits from each of these has not been transacted within or across provider contracts, leaving triangulation of any return on investment unaccounted for. There is significant opportunity to bring these together, therefore, in a single, coordinated programme for this area, with senior executive oversight.

Leicester, Leicestershire & Rutland – local context

11. However developed the local work, it is clear that this will not be enough to meet the demands on services over the next 10 years. The chart below shows the expected growth in each of our 'patient need groups' up until 2025:



12. It is apparent that without a radical change to the models of care across Leicester, Leicestershire and Rutland (LLR), this model will continue to compromise equity of access, equity of outcome and equity of experience. The opportunity of delivering this programme collectively is significant – both for our patients and our colleagues working across health and care services.

13. To this end, a key outcome from the ICB Board Development Session in January 2025 was a commitment across all partners that delivering 'Neighbourhood Health' must be our predominant mindset. We agreed that we would decisively deliver a model of neighbourhood health in 2025/26, building on everything that we have in place already, and that simultaneously we would commit to a jointly designing and delivering a radical model of care, fit for the future.

14. Since this session, a Neighbourhood Health Programme Board has been set up to design and deliver the NHS mandate requirements, chaired by Prof. Aruna Garcea, Associate Medical Director for primary care at University Hospitals of Leicester NHS Trust and Chair of the Primary Care Network at the NHS Confederation. Executive lead for the programme sits with Rachna Vyas, Deputy Chief Exec/Chief Operating officer, NHS LLR ICB. Terms of reference

have been drafted, with a full partnership approach, including a patient reference group, with the Programme Board meeting in April 2025. A clinically led visioning workshop is then planned for June 2025 to begin work on the 10-year model, in line with the three shifts outlined by government.

15. Engagement has been ongoing since January, through a combination of system, place (inc. local government) and organisational-specific sessions, tailored to ensuring alignment between plans. What has been clear through these sessions is that the understanding around each component of the neighbourhood health model is variable across the system and whilst the model has evidenced a tangible reduction in activity, this has not been visible within and across the system.

Headline progress against the NHS England guidelines

16. Given the pressing UEC demands and the ongoing financial challenges, the 2526 plan for neighbourhood health has specifically targeted interventions that will support admission and attendance avoidance, and/or support flow across provider services.

17. The 2025-26 plans include the following specific deliverables:

- 100% of practices will have stratified their population by patient need group in Q1. 75% of practices will have started to use this data to manage their workflow by September 2025.
- 15,984 more care plans for those in patient need groups 5, 9, 10, 11 will be completed by 31st March 2026.
- The same-day access model of care will be implemented, creating an additional 100 appointments per day for patients streamed from the emergency department.
- A single frailty pathway across community and acute care will be in place by Q2 2526 and a 15% increase in the capacity for the falls service from April 1st, 2025.
- An integrated pathway for GP referred multi-morbid patients will be in place by 1st October 2025, jointly across UHL, LPT and general practice.
- An integrated service pathway for chronic kidney disease, cardio-metabolic and respiratory illness (INTERSTELLAR) will be in place by 1st October 2025, jointly across UHL and the community.
- 11 Integrated Neighbourhood Teams, with 100% coverage of LLR, will be functional by June 2025, focussing on the patient need groups with the highest levels of unwarranted variation.
- The Integrated Discharge function will be functionally aligned to the System Coordination Centre, ensuring that no more than 100 patients are awaiting a care plan each day by July 1st, 2025

18. Each of these interventions have been clinically designed / practitioner designed with value for money, patient flow, and patient outcome at the heart of

the service. Again, to really capitalise on the opportunity presented through the neighbourhood health model, there is far more to do, collectively. Headline evidence gathered locally, links to 2025-26 plans and further opportunities are outlined below, for each of the six components of neighbourhood health.

Population health management

19. LLR providers have been utilising the 'ACG risk stratification' system for many years. The system is embedded within General Practice and has been used to identify at-risk groups more effectively and deploy resources where they make the biggest difference.

20. Our local scheme, devised by local LLR GP's, focusses predominantly on care planning with our multi-morbid population in specific patient need groups, (known as PNG's). Thus far, over 100,00 care plans have been put in place, with 78% of patients in the highest PNG holding care plans. Local analysis shows that patients without care plans in this group have 36% higher Emergency Department attendances and a 54% higher rate of non-elective admissions.

21. In 2024/25, 15,984 plans were planned to be put into place – 11,843 have been delivered year-to-date, with the shortfall attributed to collective action.

22. Our 2025/26 plan includes delivery of an additional 15,984 plans, largely in our higher risk and therefore higher impact PNG's. Resource for General Practice to conduct this activity through the year is in place.

23. The opportunity here is **scale**; further resource will support appropriate levels of patients in each PNG have high quality care plans, thereby reducing the likelihood of acute activity.

Modern General Practice

24. This programme has two components – contact and single workflow. Our local programme also include workforce growth, in recognition of local GP shortages.
    a. Contact – All contact standards for 2425 have already been met, including upgrading of phone systems, implementation of online services and appointment levels.
    b. Single workflow – The 2024-25 plan to pilot 'Rapid Health' is live across 1 Federation, 1 county practice and 1 City practice, with efficacy, scalability, and practice & patient feedback being collected. Current plans for 2025-26 involve scaling the county pilots to cover c90,000 patient population; however, whether this is enacted will depend on assessment of the above.
    c. Workforce growth – In 2023-24, the patient to GP ratio for Leicester City was 3,262 patients per GP, with the regional patient to GP ratio at 2,266. 29 GP's have been recruited into LLR, with a resulting reduction in this ratio. As at Dec 24, patient to GP ratio in Leicester City was 2,829 registered patients to each WTE GP, East

Leicestershire has 2,099 patients to each WTE GP and West Leicestershire had 2,154 patients to each WTE GP.

25. For 2025/26, further workforce recruitment plans are in place, with an expected 8 additional GP's expected to come into the system.

26. The opportunity here is to enact a whole system plan to attract an increased **level of GP workforce** into LLR, through offering combined roles between general and specialty medicine.

Community health services – Home First / Urgent community services

27. This component is perhaps the most complicated but remains the area of significant opportunity to realise the benefits of integration. In 2024-25, the plan was to continue the key areas of focus (admission avoidance services for specific cohorts of patients) and to begin to integrate the offers for all pre-hospital services.

28. In 2024-25, YTD each service line has achieved its trajectory of activity and clinical audits continue to show efficacy. For example, between April 2024 and Dec 2024, our pre-hospital service saw 2,089 patients, with clinical audit showing 1,420 ED attends prevented and over 10,000 bed days saved.

29. The plans for 2025/26 will scale these opportunities and integrate them into one, single service offer, covering all pre-hospital pathways. New pathways include a single frailty pathway across community and acute care in place by Q2 2526 and a 15% increase in the capacity for the falls service from April 1st.

30. The opportunity here is understanding how **acute services can support this integration** across health and care further – particularly with the advent of Same Day Emergency Care services.

Integrated Neighbourhood Teams

31. Integrated Neighbourhood Teams have been in place in various guises for some time across LLR. In 2024-25, these were reformulated to cover physical and mental health across each of the 8 neighbourhoods in Leicestershire County and Rutland. City INT's have been re-cast based on 4 'health needs neighbourhoods' and this will be the proposed footprint for 2025-26 across LLR.

32. In 2024/25, the LUCID pilot has improved care pathways for 1,984 patients. Outcomes include: 232 (12%) high risk people had referral expedited; 179 (9%) secondary care referrals deferred through advice in a virtual clinic; 986 (50%) consultations with a new management plan devised and 1157 (58%) Advice and Guidance requests avoided. Business intelligence modelling indicates in 5 years, we could prevent 317 CVD events; 102 new strokes and 14 premature deaths.

33. For 2025/26, the long terms conditions programme is focussing on the implementation of a cardio renal-metabolic approach to multi-morbidity, an integrated respiratory neighbourhood model of care, and complex care planning, all to support a reduction in short stay admissions for this cohort. This relies on secondary care working with place and neighbourhood teams on management of population health in a much wider, holistic sense.

34. The opportunity here is a **move from reactive care to more preventative and proactive care**, based on the risk stratified population in each neighbourhood. Customising care delivery to the unique needs of a community, from prevention to chronic care management, ensures interventions resonate locally and focus on equity of access and outcome in a meaningful manner.

Integrated Intermediate care

35. This is one of the strongest and most collaborative parts of the programme, with national and regional teams regularly seeking to understand the LLR approach and model.

36. For 2024-25, our aspiration was to reduce the number of patients classified as medically optimised for discharge (MOFD) awaiting plans compared to the same point in the previous year, despite over 100 extra acute beds being open in 2425. Looking at Jan 24 vs Jan 25, there were on average 20 less patients awaiting plans daily. For pathway 2, in Jan 24, we saw an average of 108 patients waiting for a pathway 2 discharge – in Jan 25, this had reduced to 67 patients.

37. For 2025-26, plans have been set with our local authority partners which push delivery further, faster. For example, 90% of discharge plans are expected to be in place within 48 hours of referral for pathway 2 and the numbers of plans given daily for each pathway are also expected to increase to meet demand.

38. The opportunity here remains **scaling of triage services at point of ward referral & increasing Pathway 1 capacity**. Currently, 8% of patients are discharged onto pathway 2; this is 4% nationally.

Overall programme for 2025/26

39. The overall programme plan for 2526 is in place, with named leads for each action, a lean governance structure to support delivery, dual reporting into the UEC collaborative and the NH Programme Board and oversight through the LLR Integrated Care Partnership.

40. As place groups will drive the delivery of the vast majority of this work for their respective populations, regular reporting is also scheduled for each Health and Wellbeing Board.

41. All activity assumptions have been clinically validated through the Clinical Responsibility Group, led by Prof Damian Roland and validated by individual clinical leads.

42. Interdependencies with each of the Partnerships and collaboratives are being assessed with each lead and will inform the wider strategy.

43. Risks and escalations will be fed through the exec SRO as required.

Considerations

44. To ensure robust evaluation, transparent data will be required across the major NHS and care provider contracts; whilst some of these issues have been resolved, further work will be required to evidence delivery in a transparent manner. This remains a risk.

45. Given how far ahead LLR have been reported to be in comparison to other ICB areas, Carnell Farrar, the Health Economics Unit and the NHS Confederation are all interested in supporting evaluation; Business Intelligence leads are supporting this offer to understand which best suits the needs of the ICS.

46. Thus far, the work of the programme has been predominantly focussed on adult pathways. A model of care has been released by the NHS England Children and Young People's team; this is being assessed by relevant partners.

47. The scale of opportunity here is significant; whilst the 2025-26 plan has come together with current knowledge and resources, it is hugely important that the LLR sub-region is ambitious, evidence based and visionary in how we use this opportunity to reset local delivery and radically alter the model of care for those we serve over the next 10 years. To this end, a vision workshop is under development so that the right experts can examine our local health and care projections and design a sustainable service for the future.

County Specific plans

48. In County we have just over 8,000 patients who fall into the PNG cohort of 9,10,11.

    Q1 – Develop a robust implementation programme to support the development of a neighbourhood model.

    Q1 – Identify pilot sites to strengthen the INT model and develop robust MDT approach to supporting patients in PNG cohort 9,10,11 with strong MDT developed care plans (contracts) which identify condition management, wider determinants and support structures, actions to be taken in the event of a related health decline, social support decline, and appropriate care pathways to access.

    Q1 – Ensure an agreed approach to implementation via the Place team working group, and update via Integration Executive.

Q1 – Link neighbourhood model to the refresh of the joint health and wellbeing strategy via the working groups.

Proposals/Options

49. We are developing a neighbourhood model of care across LLR, with Place leading the local implementation of the model.

50. The proposals going forward are as follows::
    a. Building on the foundations laid by the Fuller Stocktake, approaches to tackle health inequalities such as Core20PLUS5 and Core20PLUS5 for CYP, outreach work and using data and local insights, we ask systems to work with partner organisations to:
        - Apply a consistent, system-wide population health management approach to segmentation and risk stratification, to coordinate and deliver appropriate care for population cohorts across providers, and to inform commissioning decisions so that funding is used optimally. This approach should include qualitative as well as quantitative insights and data.
        - Continue to embed, standardise and scale the six initial core components of a neighbourhood health service and ensure capacity across providers is best aligned to optimally meet demand. Systems are asked to deliver the six core components of the model.

51. The plans will be further developed in a workshop scheduled for 3 June 2025.

Consultation/Patient and Public Involvement

52. Patient representative groups are involved in the board and workshop

Resource Implications

53. The plans are being progressed within the current financial envelope.

Background papers

https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/

Circulation under the Local Issues Alert Procedure

Not applicable. The plans apply to the County as a whole.

Appendices – N/A

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