Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP
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Ladies and Gentlemen,

A meeting of the **HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Tuesday, 31st January, 2017** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

Recording of Council Meetings: Any member of the public may film, audio-record, take photographs and use social media to report the proceedings of any meeting that is open to the public. A protocol on this facility is available at www.rutland.gov.uk/haveyoursay

A G E N D A

1) APOLOGIES

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on 29th November 2016 (previously circulated).

3) DECLARATIONS OF INTEREST

In accordance with the Regulations, Members are invited to declare any personal or prejudicial interests they may have and the nature of those interests in respect of items on this Agenda and/or indicate if Section 106 of the Local Government Finance Act 1992 applies to them.

4) PETITIONS, DEPUTATIONS AND QUESTIONS

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 93.

The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received.

Questions may also be submitted at short notice by giving a written copy to the Committee Administrator 15 minutes before the start of the meeting.

The total time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

5) LEICESTER, LEICESTERSHIRE & RUTLAND SUSTAINABILITY AND TRANSFORMATION PLAN

To receive Report No. 31/2017 from Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland Clinical Commissioning Group regarding the submission of the Sustainability and Transformation Plan
(Pages 5 - 84)

6) CAMBRIDGESHIRE & PETERBOROUGH SUSTAINABILITY AND TRANSFORMATION PLAN

To receive Report No. 32/2017 from David Astley, Independent Chair, Sustainability and Transformation Programme System Delivery Unit, Cambridgeshire and Peterborough NHS Trust giving an overview of the priorities of the Sustainability and Transformation Plan for Cambridgeshire and Peterborough
(Pages 85 - 110)

7) LEICESTER CITY, WEST LEICESTERSHIRE AND EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUPS: PERSONAL HEALTH BUDGETS (PHB) LOCAL OFFER

To receive Report No. 33/2017 from Maria Smith, Strategic Lead for Personal Health Budgets on behalf Leicester City, West Leicestershire and East Leicestershire and Rutland Clinical Commissioning Groups detailing the local personal health budget offer from the three Leicestershire CCGs and the plans to expand the personal health budget offer
(Pages 111 - 122)

8) BETTER CARE FUND PROGRAMME UPDATE

To receive Report No. 39/2017 from Sandra Taylor, Health and Social Care Integration Project Manager
(Pages 123 - 132)

9) REGISTER OF MEMBERS' INTERESTS

A new ‘Register of Interest’ form needs to be completed by each member of the Rutland Health and Wellbeing Board
(Pages 133 - 138)

10) CHILDREN, YOUNG PEOPLE AND FAMILIES PLAN 2016-2019: UPDATE

To receive Report No. 34/2017 from Bernadette Caffrey, Head of Families Support – Early Intervention to update the Board on the achievements made against the priority actions detailed in the Children, Young People and Families Plan 2016-2019.

Please note:
THE REPORT IS PURELY FOR INFORMATION AND WILL NOT BE DISCUSSED IN THE MEETING.

Any feedback can be sent to Bernadette Caffrey bcaffrey@rutland.gov.uk
(Pages 139 - 146)

11) ANY URGENT BUSINESS

12) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 28th March 2017 at 2.00 p.m. in the Council Chamber, Catmose.

Proposed Agenda Items:

1. Local Safeguarding Children's Board and Safeguarding Adults' Board: Business Plans
   Report from Paul Burnett, Chair of the Leicestershire and Rutland Safeguarding Children and Adults Boards
   Consultation and input required for the proposed safeguarding business plans

2. Director of Public Health: Annual Report
   Report from Mike Sandys, Director of Public Health for Leicestershire & Rutland

3. Health Protection Board: Annual Report
   Report from Vivienne Robbins, Consultant in Public Health.
   Annual report to provide assurance from the LLR Health Protection Board that it is meeting its statutory functions

4. Congenital Heart Surgery (CHS) Services in Leicester
   Report from Will Huxter, Regional Director of Specialised Commissioning (London), NHS England.
   Discussion regarding the issues relating to the CHS service in Leicester

5. End of Life Care
   Verbal update from Mark Andrews, Deputy Director for People, Rutland County Council
   Discussion regarding the letter from the Department of Health in response to the independent review of choice in end of life care

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DISTRIBUTION
MEMBERS OF THE HEALTH AND WELLBEING BOARD:

Cllr Richard Clifton	Rutland County Council
Cllr Alastair Mann	Rutland County Council
Dr Andy Ker	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
Fiona Taylor	Spire Homes
Gavin Drummond	Leicestershire Constabulary
Helen Briggs	Rutland County Council
Jane Clayton Jones	Community & Voluntary Sector Rep
Jennifer Fenelon	Healthwatch Rutland
Mike Sandys	Rutland County Council - Public Health
Rachel Dewar	Leicestershire Partnership NHS Trust
Dr Tim O'Neill	Rutland County Council
Tim Sacks	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
Trish Thompson	NHS England Local Area Team

OTHER MEMBERS FOR INFORMATION

Emma Jane Perkins	Rutland County Council
Mark Andrews	Rutland County Council
Sandra Taylor	Rutland County Council
Wendy Hoult	NHS England Local Area Team
Yasmin Sidyot	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)

Report No. 31/2017

Report to Rutland Health and Wellbeing Board

Subject:	**Leicester, Leicestershire and Rutland Sustainability and Transformation Plan**
Meeting Date:	**31 January 2017**
Report Author:	**ELR CCG**
Presented by:	**Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland CCG**
Paper for:	**Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:
This is a draft of the LLR STP for discussion
Financial implications:
None
Recommendations:
That the board: 1. NOTES the report
Comments from the board: (delete as necessary)

Strategic Lead:	

Risk assessment:		
Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	
Profile	L/M/H	
Equality & Diversity	L/M/H	

Timeline:

Task	Target Date	Responsibility

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Better care together
Leicester, Leicestershire & Rutland health and social care

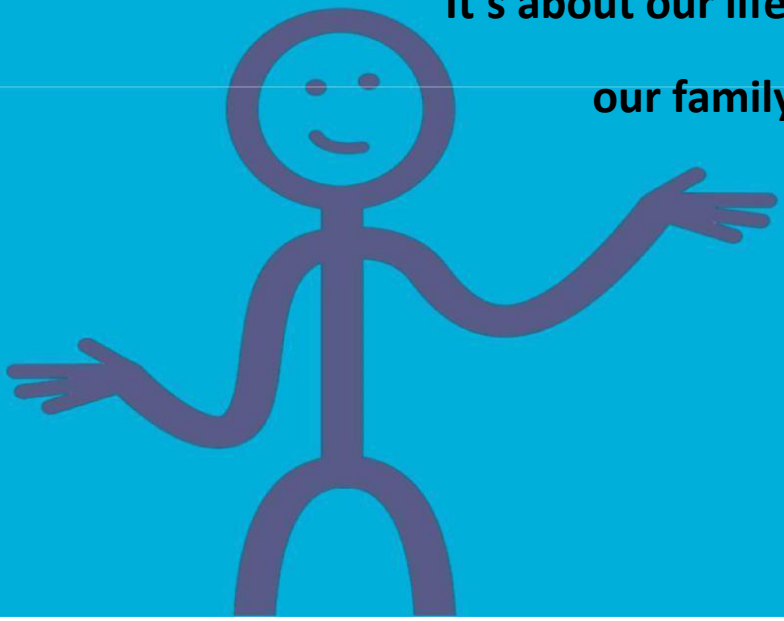
Leicester, Leicestershire and Rutland

(Footprint No.15)

Sustainability and Transformation Plan

Latest Draft at 21st November 2016

"It's about our life, our health, our care, our family and our community"



University Hospitals of Leicester
Leicestershire Partnership Trust
East Midlands Ambulance Service
East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group

NHS

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Foreward

Our organisations commission and provide health and care services for over a million people in Leicester, Leicestershire and Rutland. Every day our services support people to stay healthy and lead independent lives. And when people are ill our services are there for them, their carers and families. Over the next five years, the services we are accountable for will need to adapt and transform in order to ensure that they remain clinically and financially sustainable. This latest version of our Plan sets out the actions that we will need to take in order to balance the various pressures of continued growth in patient demand from an ageing and growing population, a requirement to recover and maintain delivery against national access and quality standards, at a time of historically low levels of financial growth in the NHS and substantial pressures on social care funding.

The financial challenge facing the NHS nationally over the next five years is well recognised, with 2018/19 set to be the most pressurised year where the NHS is set to have negative per person NHS funding growth. Locally, the requirement set against this national backdrop to make more rapid progress in the early years of the Plan to move the provider sector back into financial surplus is going to be incredibly challenging.

Our STP builds on the work of our Better Care Together programme, the plans of which were already well advanced and articulated in many areas, particularly around proposals for reconfiguring acute hospital services to address long standing issues around the condition of our premises and how these are utilised.

It is a Plan that in many areas will take time to deliver. In part because some of the proposed service changes will require formal public consultation before final decisions can be taken. But equally because many of the new models of care set out will require our front line staff to work together in new roles and ways.

Reflecting this, the progression of this Plan over the coming weeks and months will be an iterative one. This latest version will continue to be refined ahead of target publication in November.

Our commitment to the people our organisations serve is to work together to deliver this through shared endeavour and collective accountability.

Toby Sanders
STP Lead for LLR and
Managing Director
West Leicestershire CCG

Sue Lock
Managing Director
Leicester City CCG

Karen English
Managing Director
East Leicestershire and Rutland
CCG

John Adler
Chief Executive
University Hospitals Leicester

Peter Miller
Chief Executive
Leicestershire Partnership
Trust

Local authority officers from the three upper tier local authorities (Leicester City, Leicestershire County and Rutland County) have been part of the discussions responding to the challenges facing health and adult and children social care services across LLR that have shaped the development of this draft STP. This involvement has focused on two particular areas. Firstly, the two way relationship between demand for local authority adults and children's social care services and local
NHS provision, including the proposals to develop more integrated community teams. Secondly, the

contribution to the prevention and inequalities agenda from the local government responsibility for commissioning public health services. In addition, as community representatives the local authorities have a special interest in the configuration and availability of NHS primary and secondary care services.

The local authorities are committed to ensuring an open public discussion on the proposals in the draft STP through their executives, health and wellbeing boards and health overview and scrutiny committees in order to reach their own formal position during the engagement period on the overall plan and specific proposals. The local authorities will wish to apply the same principles of openness and engagement in the implementation of the approved STP.

Plan on a Page - Leicester, Leicestershire and Rutland Sustainability and Transformation Plan

- The Leicester, Leicestershire and Rutland system footprint has a population of 1,061,800. We start our transformation journey from a good point through our Better Care Together Programme which has been developing proposals for transformation and financial sustainability since 2014.
- The system is experiencing increasing pressure and our modelling of the demography and financial challenges clearly shows that we need to respond with much greater transformation if we are to address our do nothing gap
- of £399.3m by 2020/21.
- We have identified five key strands for change which taken together will help us to eliminate our financial gap by 2020/21 and contribute to closing the health and wellbeing and care and quality gaps.
- All of our plans are built on collaborative relationships and consensus amongst our system leaders which we will continue to develop through our new governance arrangements to ensure the success of our STP, and which provide the foundations for an integrated health and social care system. All of our plans will ensure compliance with statutory safeguarding legislation and the Local Safeguarding Boards: Safeguarding Children and Safeguarding Adults procedures.

Our priorities for the next five years

Strand 1: New models of care focused on prevention, moderating demand growth – including place based integrated teams, a new model for primary care, effective and efficient planned care and an integrated urgent care offer.

Strand 2: Service configuration to ensure clinical and financial sustainability – including, subject to consultation, consolidating care onto two acute hospital sites, consolidaiton maternity provision onto one site and moving from eight community hospitals with inpatient beds to six.

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Strand 3: **Redesign pathways to deliver improved outcomes for patients and deliver core access and quality** – including actions to improve long term conditions, improve wellbeing, increase prevention, self-care and harnessing community assets, as wellas our work to improve cancer; mental health and learning disabilites.

Strand 4: Operational efficiencies - to reduce variation and waste, provide more efficienent interventions and support financial sustainability - the Carter recommendations; provider cost improvement plans, medicines optimisation and back office efficiencies.

Strand 5: Getting the enablers right- to creare the conditions of success –including workforce; IM&T; estates; workforce, engagement and health and adult and children social care commissioning integration.

What will be different for the system and patients?

- Patients will have more of their care provided in the community by integrated teams with the GP practice as the foundation of care.
- Patients will only go to acute hospitals when they are acutely ill or for a planned procedure that cannot be done in a community setting.
- Patients will have the skills and confidence to take responsibility for their own health and wellbeing.
- More people will be encouraged to lead healthy lifestyles to prevent the onset of long term conditions.
- Screening and early detection programmes will enable more people to be diagnosed early to enable improved management of disease and to reduce burden.
- Professionals will have access to a shared record to improve the quality and outcome of patient care.
- General Practitioners will increasingly use their skills to support the most complex patients and routine care will be delivered by other professionals.
- General Practice will be increasingly working in networks to improve resilience and capacity.
- The system will be in financial balance, be achieving its performance targets and operate as "one system".
- Delivery of RTT, A&E, Ambulance, Cancer, mental health targets.
- We will also reduce out of area placements.

Services delivered from fit for purposes premises.

How we will achieve financial sustainability

- The Leicester, Leicestershire and Rutland system will spend £2.121 billion on health and social care in 2016/17.
- If nothing is done the system deficit by 2020/21 will be £399.3m, health £341.6 and social care £57.7m.
- We aim to save across our five priority areas, this will realise savings of £412.9m. To deliver these savings LLR has requested investment of £98.4m from the national Sustainability and Transformation Fund over five years, bringing the system into financial balance by the end of the period.
- To realise our transformation plans the system will require £350m capital, including capital raised from alternative sources such as PF2 and funding some investments from disposal proceeds.

Key Workforce Changes

Primary care up 10% between 2016/17 (2271 WTE) and 2020 (2505 WTE)
Provider workforce down 4% over the same period from 19805 to 18303

Key Bed Changes

Acute Beds 2016/17 beds 1940 2020/21 beds 1697 Community Hospital Beds 2016/17 beds 233 2020/21 beds 195

Purpose and Vision

This plan sets out the actions that we need to take across the health and care system in Leicester, Leicestershire and Rutland (LLR) over the next five years in order to improve health outcomes for patients and ensure our services are safe and high quality, within the financial resources available.

The plan builds on the **vision** of our existing Better Care Together (BCT) programme to:

"Support you through every stage of life: helping children and parents so they have the very best start in life, helping you stay well in mind and body caring for the most vulnerable and frail and when life comes to an end."

The Better Care Together objectives are to:

- Deliver high quality, person-centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff and patients, resulting in a reduction in the time spent avoidably in hospital.
- Reduce inequalities in care (both physical and mental) across and within communities in Leicester, Leicestershire and Rutland (LLR) Local Health and Adult and children social Care Economy.
- Increase the number of those patients with mental, physical health and social care needs reporting a positive experience of care across all health and social settings.
- Optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system.
- All health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate.
- Improve the utilisation of workforce and the development of new capacity and capabilities where appropriate, in the people and the technology used.

Through BCT we have already delivered significant improvements in services and quality of care for patients over recent years. For example, we have commissioned a Mental Health crisis house, expanded the Intensive community Support (ICS), reduced mortality rates, delivered our Better Care Funds, reduced in rates of delayed transfers of care, and begun construction of a new Emergency Department (ED).

At a time when finances of much of the NHS have deteriorated we have held our local position and fulfilled our financial plans. In 2015-16 we achieved savings across partner organisations, and University Hospitals Leicester (UHL)'s deficit shrank by £2m more than was originally planned.

There are areas where we are not doing well enough for our patients against some constitutional standards. Growth in emergency admissions has led to an imbalance in capacity and demand. This is all too evident from safety concerns around ED overcrowding and performance, and ambulance waiting times. We are also facing a changing age profile and growing health needs in our population, while the public sector funding climate is uncertain and the scale of the challenge over coming years increases across NHS, local authority and partners such as the police.

The above leads us to three priorities that our Sustainability and Transformation area will have a relentless focus on over the next two years, they are:

- Drive improvements in health and social care;
- Deliver core access and quality standards; and
- Restore and maintain financial balance.

For our STP process we have convened a set of discussion between April and October 2016 about how we upgrade our work in a number of targeted areas. We have developed this by means of existing formal BCT arrangements (Partnership Board, Delivery Group), individual organisation engagement with Boards and executive teams, alongside a series of joint clinical, managerial and patient conversations including HealthWatch and our Public and Patient Involvement Monitoring and Assurance Group (PPI MAG) representatives.

Reconfiguration decisions will include consultation with Designated Safeguarding Professionals to ensure all services commissioned meet the statutory requirement to safeguard and promote the welfare of children and adults.

The local consensus

This conversation has generated a shared view across the system health and social care leadership community (clinical, lay and managerial) on the scale of the challenge and the actions we need to take to address it. This is across two fronts: operational delivery today while planning for the future.

Locally, we have used the STP process as an opportunity to do five things:

Update our existing BCT plans: we have taken account of learning from experience of schemes over the last two years, particularly actual impact of new services, like Intensive Community Support. This has enabled us to refresh our capacity plan to get a more realistic view on what healthcare in the future needs to look like.

Reflect on latest national policy direction and context:

- Adopt a place-based approach to planning, service delivery and use of NHS resource allocation that focuses on population health and how the "LLR pound" is spent.
- Increase commissioner and provider collaboration. We are co-creating solutions and improving services, with clinicians and other health and social care professionals collaborating across traditional boundaries.
- Increase integration between health, adult and children social care and public health.
- Adopt new models of care and our learning from these, particularly the Urgent and Emergency Care (UEC) Vanguard, our planned care Alliance, and GP Federations.
- Respond to recent national policy and guidance including the financial reset, 2017-19 planning guidance which moves planning and contracting into a two year timeframe and the introduction of STP area control totals.

Identify the key issues, and the resulting decisions that we must make: some things are critical to system sustainability over this period. Given the limited resources – not only financial but also workforce availability and managerial and clinical capacity to manage change – we must focus our efforts on doing these things well over a prolonged period. While the overall BCT programme will continue to make progress across the whole of health and social care services, this plan is intentionally targeted and not a "plan for everything".

Address those areas where our existing BCT plans did not offer an adequate solution: particularly in primary care and some community hospital services, around which there was insufficient consensus to make real progress on plans.

Focus on upgrading delivery and implementation arrangements: notwithstanding the improvements that have been delivered under BCT, the pace of change has been too slow and scale of impact too limited. Our focus to date has been on work-streams and pathway redesign but it has become increasingly evident that the way we have organised ourselves and the misalignment of purpose and incentives now limits the rate of progress. We are learning what does and does not

work in terms of implementation, particularly the need for a more collaborative approach and greater focus on culture, relationships and behaviour.

The result is a plan that demonstrates a set of solutions which taken together enable LLR to reach a sustainable position by 2020/12. This STP represents the continuation of our BCT journey, not a replacement for, nor fundamental change of direction to, it. The STP process has enabled us to look at BCT through a specific lens of system sustainability and this has sharpened the focus on delivering a smaller number of big priorities.

It is a plan that sets out what we would need to do to address the triple aim "gaps". **Health and Wellbeing, Care and Quality,** and **Finance and Efficiency.** Inevitably the early years of the plan are more detailed in terms of solutions to address these. The later years are subject to assumptions about what it would be reasonable for the system to deliver based on current position, scale of opportunity and future demand.

This plan is ambitious. Given the scale of the challenge of balancing finances with demand and new treatments this is inevitable if we are to be viable in five years. We must moderate the current trend of increasing acute hospital activity. Given current operational pressures on the system this is a substantial task. We are confident from current opportunity and experience elsewhere, particularly internationally, that this is possible, but it will only be achieved if we do something significantly different to make it happen.

We will need to refresh elements of our BCT-Pre-Consultation Business Case. Once this tasks is done we are confident that, subject to NHS England support, we will be in a position to move to formal public consultation on the big service reconfiguration decisions regarding new pathways and models of care.

Our challenge against the three gaps

We know what we need to address across the system. This section sets out the local context for Leicester, Leicestershire and Rutland (LLR) using public health data, the STP Data Pack, and analysis of gaps against the three key STP areas of **improving health and wellbeing, care and quality** and **finance and sustainability**. This also reflects what we know from patients, carers and public feedback about their perception of local priorities, which are:

- **For GP services:** access and availability, seeing the same doctor, GP location and compassion
- **For Hospital services:** cleanliness, waiting times, accessibility, facilities, safe discharge
- **For the Community:** activities for the elderly, home services, availability of residential and care homes, care packages for patients discharged from hospital and care for people with learning disabilities.

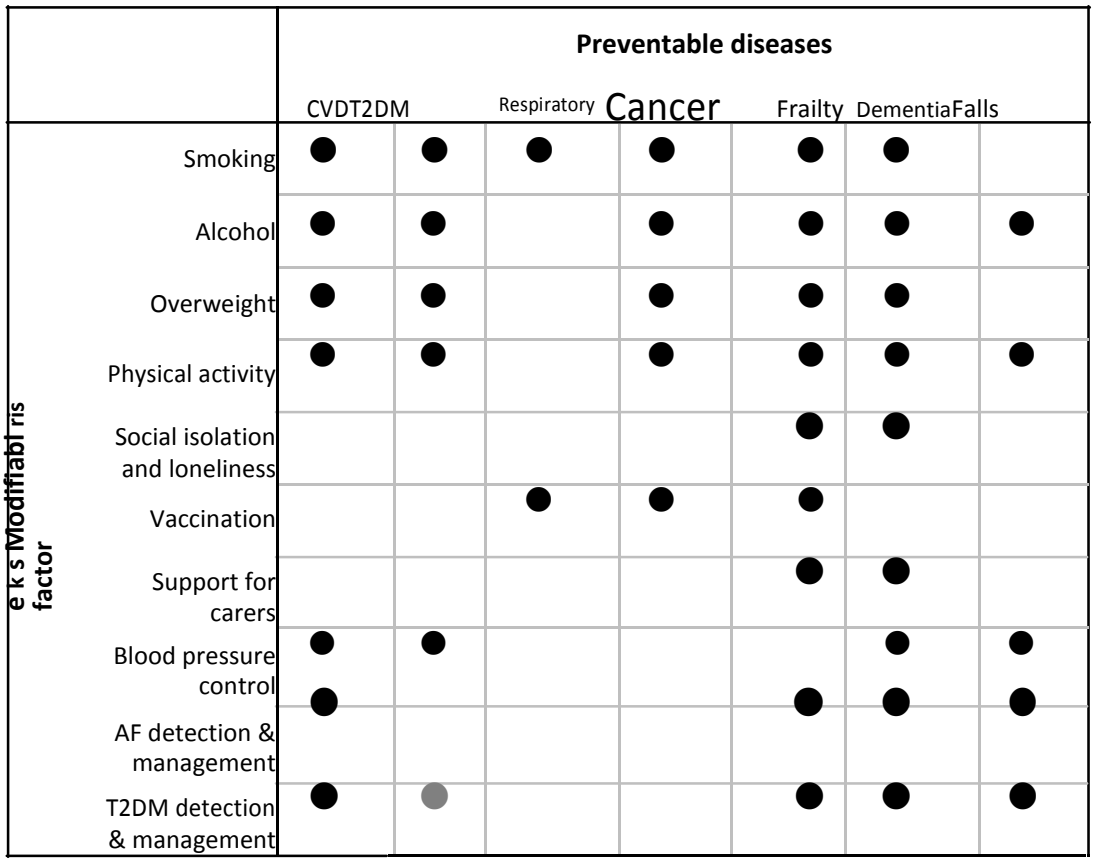
Gap 1: Health and Wellbeing Gap

Across Leicester, Leicestershire and Rutland STP area we have a total population of 1,061,800 with a forecast increase over the next five years of 3.6% for children and young people, 1.7% for adults and 11.1% for older people. The age structure of the area is on par with the national average but there is a variation with Leicester having a higher population of young people and East Leicestershire and Rutland has more people age over 50. Analysing our health data identified the following areas that we need to address.

- **Reducing the variation in life expectancy:** in Leicester the average life expectancy is 77.3 years for males and 81.9 years for females and in Rutland it is 81 years for men and 84.7 for women. More variation can be found across the STP footprint, for example in Leicester city the gap between the best and worst life expectancy is 8 years. The difference in life expectancy is complex and is impacted on by deprivation; lifestyle and the wider determinant of health.
- **Reducing the variation in health outcomes:** there is considerable difference in health outcomes across the STP footprint. For example 43.8% of diabetes patients in Leicester city have all three of the NICE recommended treatments targets compared to 41.9% of patients in East Leicestershire and Rutland. People feeling supported with a long term condition to manage their condition is 66.4% in West Leicestershire and Leicester city at 58.5%.
- **Reduce premature mortality:** premature mortality across the STP footprint is caused by cardiovascular disease, respiratory, diseases, cancer and liver disease, the level of premature mortality varies across LLR. More than 50% of the burden of strokes; 65% of CHD; 70% of COPD and 80% of lung cancer are due to behavioural risk and we will tackle this through early detection programmes and preventative public health strategies and programmes. Infant mortality has improved in Leicester with the city now being comparable to that of England. However the still birth rate at 6.5 days per 1,000 total births in 2012/14 is higher than the national average of 4.7. A strategy is in place which focuses on targeted work on predisposing factors including prematurity and small for date babies.
- **Improve the early detection of cancers and cancer performance:** one year survival rates from all cancers varies across the STP footprint. In Leicester city the rate is 65.9% compared to East Leicestershire and Rutland which is 70.2%. Cancer is also one of the major causes of premature mortality across the STP footprint. Detecting cancers early improves survival rates for example 5 year survival rates for colon cancer is 1 in 10 if detected at stage 4 but if detected at stage 1 survival after 5 years increases to 9 in 10, this is similar for rectal, ovarian and lung cancers. We also need to improve our performance on 63 day cancer rates.
- **Improving mental health outcomes:** across the STP footprint there is a difference in mental health need, East Leicestershire and Rutland and West Leicestershire have high levels of

Dementia, where Leicester City has high levels of psychosis and all have high levels of depression.

- **Move from chronic disease management to prevention:** much of the above health outcomes are caused by lifestyle and are preventable and late detection leads to costly chronic disease management. The table below shows the modifiable risk factors associated with preventable diseases causing the highest health care need and demand in LLR. Focusing on this through primary and secondary prevention will help shift the demand curve and improve outcomes. The main modifiable risk factors with preventable diseases causing the highest care need and demand are demonstrated in the table below.



Gap 2: Care and Quality Gap

The main quality and care gaps that need addressing across Leicester, Leicestershire and Rutland are:

- **Improving performance of the Urgent Care system in LLR**: Our current performance against the A&E four hour target is 79.48% at September 2016 our 999 performance for Red 1 is 67.7% and Red 2 is 56.5%. Our ambulance handover delays are 12.8% for handovers greater than thirty minutes and 6.2% for handovers greater than one hour. The Sustainability and Transformation Funding trajectory set for A&E performance is 92.1% of patients seen under 4 hours by March 2017. This will be achieved through a whole system redesign of the urgent care system through the Vanguard programme and through our Recovery Action Plan. In addition through our solutions set out in this plan we will reduce the numbers attending ED and improve crisis mental health services.
- **Tackling poor patient experience:** there are a number of areas where we know patients have a bad experience of care. LLR is below the average for patient experience of GP services. Across LLR 10% of GP practices inspected were rated as "Requires Improvement"

by the CQC and 3% are rated as “Inadequate”. Both our main providers have been rated as “Requires Improvement”. For the social care sector across LLR the number of care homes rated as “Requires Improvement” is 40% and 1% are rated as inadequate. Domiciliary care is rated well.

- **Supporting Carers:** There are a significant number of carers in the local area. It is estimated there are in excess of 100,000 people in Leicester, Leicestershire and Rutland providing some form of unpaid care. Carers play a critical role in supporting service users and this has a positive impact on reducing the need for formal public service intervention and support. Carers report lower quality of life and satisfaction levels than the national average and appear to spend more hours caring than in other areas of the country. This is a growing area of need that could be further supported through increases community resilience and capacity. Our work on integrated teams will include supporting carers.
- **Supporting people to manage their Mental Health:** we know that the model of mental health services has been secondary care-focused with challenges across a number of areas. These include capacity in the crisis pathway, IAPT recovery and access performance levels which vary across the three CCGs, high level of depression in all CCGs and Leicester City is in the top quartile for Psychosis. Out-of-county placements and specialist placements remain high across LLR.
- **Improving independence and autonomy:** our local system has traditionally been based on services and pathways, rather than individuals, our Personal Health Budgets uptake is low, and, across LLR, we are in the worst quartile for “people with a long term condition feeling supported to manage their conditions”. Promote empowerment and autonomy for adults, including those who lack capacity for a particular decision as embodied in the Mental Capacity Act 2005 (MCA), implementing an approach which appropriately balances this with safeguarding.
- **Improving the sustainability of primary care:** primary care is under increasing pressure from patient demand, recruitment and retention issues and a decrease in the proportion of NHS expenditure spent in primary care over recent years. The result is pressure from avoidable appointments, insufficient staffing and increasing workloads for practice staff.
- **Services in the right place:** LLR has three acute hospital sites and nine community hospital sites this results in workforce being spread too thinly and limited resilience at individual sites. The plans set out in this STP mean more services will be delivered at home or in community settings. Both of these things mean we have to consider the configuration of service across our sites, the number of sites, and reducing duplication, and provide a model that is more sustainable from a workforce perspective and sees patients in the most appropriate setting.
- **Safeguarding:** The complexity of issues relating to substance abuse, mental health and domestic violence has been a continuing theme in child and adult Serious Case Reviews and Domestic Homicide Reviews undertaken by the LLR Safeguarding Children and Adult Boards. Clear coordinated care pathways for families with particular vulnerabilities are needed to ensure parents and children receive timely and accessible help. Local services need clear signposting and clear criteria for referral and acceptance and rejection of cases.
- **Health Care Associated Infection:** a strategic ambition has been developed to improve the quality of patient care by reduction in health care associated infections over the duration of the STP, through appropriate application of evidence and guidance in Leicester, Leicestershire and Rutland. We aim to reduce the burden of sepsis from urinary tract infection and from pneumonia infections.
- **Anti-microbial resistance:** the strategic ambition for this is closely interlinked with the plan for healthcare associated infection. In line with the national CQUIN and Quality Premium, we aim to reduce the use of antibiotics and in particular the use of broad-spectrum antibiotics. This will be achieved through focussing on urinary infections and chest infections,

epidemiologically identified as the most significant. As the plan develops we will add other key infections.

- **Interfaces of care**: we know that often things go wrong for patients at the interface of care, across organisational boundaries. Our recent work on end of life care identified gaps in joint working across primary and secondary care with a lack of consistent structured approaches to joint working which are being addressed through our Learning Lessons to Improve care programme. Other solutions set out in this STP will also support better joint working including plans for integrated teams; integrated urgent and emergency care; and health and social care joint commissioning.

Gap 3: Finance and Efficiency

The analysis of the Finance and Efficiency Gap identifies the following need addressing:

- **Delivering financial balance across the system:** The current system financial gap is £6.7m taking into account Sustainability and Transformation Funding of £25m. We know that if we do nothing by 2020/21 the financial gap across LLR will be £399.3m. The focus for this STP is to ensure that we can bring the system back into balance by 2020/21.
- **Getting our Planned Care pathways right:** our analysis, including the NHS Right Care information, shows that we could make significant improvements in the way we manage elective care across LLR and support continued delivery of waiting time standards. Variation in referral is a key issue. As a system we still have a traditional approach to follow-up appointments and much of our elective work is done in acute settings when it does not need to be.
- **Provider efficiency and productivity:** providers have plans to drive efficiency and productivity, this is a continuous process. Within these plans there is particular emphasis on the Carter Review recommendations, reducing variation, reducing agency spend, and procurement. Longer term efficiencies will come out of the work detailed in our Digital Road Map, the Urgent and Emergency Care Vanguard and integrated place-based teams.
- **Making best use of our estates:** much of the estate across LLR is owned by University Hospital Leicester and Leicestershire Partnership Trust, there are a small number of properties which are owned or managed by NHS Property Services. The service reconfiguration work detailed in this plan has resulted in estate strategies for both provider organisations which will consolidate the estate onto fewer sites. The next phase of our estate work is to improve utilisation rates and to explore what opportunities there are to work with local authorities and wider public sector on estate efficiencies.
- **Efficiencies in prescribing:** across the three CCGs considerable work has been done to improve the effectiveness and efficiency of prescribing. This includes switches, reducing wastage and implementing guidance. While this focus needs to continue there are opportunities to work together with providers to improve the effectiveness and efficiency of prescribing across all organisations.
- **Improving care through the use of effective IT:** we know that we have multiple systems across LLR. This reduces our ability to provide integrated care and wastes time through duplication of effort. We also want to use technology to improve patient's independence and daily lives.
- **Back office efficiencies:** currently STP partners have in the main their own back office functions we are exploring developing more collaborative solutions and early work indicates that integrating Information Services, Procurement and Finance functions can release £2million across the system by reducing duplication and increased efficiencies. Other areas may include Information Systems, IM&T and Human Resources, complaints and legal governance, business planning, quality assurance, health and safety, safeguarding, risk

management and clinical governance. We aim to achieve back office costs of no more than 7% of income by 2018 and 6% by 2020.

- **Over Diagnosis and Treatment:** we have a Low Priority Treatment Policy and a Procedures of Limited Clinical Value Policy while these are in place we have identified variation in activity levels across the CCGs and against procedures in the policies. As a result more focus will be on rigorous application of the policies and identification new procedures of limited clinical value.
- **Continuing Health Spend:** across the three CCGs work has been undertaken to improve our position in relation to the number of packages and the cost of packages including robust application of guidance and scrutiny of package costs. However as a system we are still outliers in terms of cost and number of packages; in the main we benchmark in the two lowest quartiles. While we have done considerable work over the last two years to reduce this position we know more can be done to bring the system into the lower quartiles.
- **Raising Demand:** we are continuing to see above inflation growth in acute activity and we need to reverse this trend if the system is to achieve financial balance. Primary care is also under significant pressure from patient demand where appointments have increased by 11% over the last few years. To manage this demand we need a different model of primary care and a conversation with the public about what their responsibility is, across the whole spectrum of health and social care, and what can be expected of general practice.

Our solutions

As described in the previous chapter we have identified our gaps against the areas of health and wellbeing; Care and Quality and Finance and Efficiency. This has led us to have a focus on five Strands of work for our STP, they are:

Strand 1 New Models of Care focused on prevention and moderating demand growth: the focus of this strand is using new models of care to bring about system wide transformation, moving our efforts upstream to reduce dependency. This will be achieved through a redesigned urgent and emergency care offer, the development of integrated placed based teams, ensuring primary care is resilient and improving the effectiveness of planned care. The impact of this will be about bending the demand curve for acute hospital admissions and bed days as well as reducing high cost placements in health and adult and children social care and impact on other public sector service.

Strand 2 Service Configuration to ensure clinical and financial sustainability: this strand focus on the reconfiguration of acute and community hospitals to ensure that right services are in the right setting of care which optimises the use of public sector estate and ensures clinical adjacencies that deliver safe high quality care and the lowest estate cost possible.

Strand 3 Redesign Pathways to deliver improved outcomes for patients and deliver core access and quality: over the last two years through our Better Care Together Programme we have started the journey to redesign pathways across a number of clinical workstreams. This work will continue under the Sustainability and Transformation Plan. This also includes our work on prevention which cuts across the Better Care Together workstreams; Long Term Conditions; Cancer; Mental Health; Learning Disabilities and Continuing healthcare and personalisation.

Strand 4 Operational Efficiencies: the focus of this strand is about becoming more efficient at the things we currently do for example theatre utilisation and working collaboratively to reduce costs in areas where we have functional duplication. This includes back office functions across providers and commissioners and medicine optimisation. This incorporates the steps we are taking to implement the Carter Review recommendations.

Strand 5 Getting the enablers right to create the conditions for success: in order to support the delivery of the above strands of work there are a number of key enablers these are workforce; IM&T; estates, engagement and health and social care commissioning integration.

Strand 1: New Models of Care focused on prevention and moderation of demand growth

This programme is about a redesigned urgent and emergency care system to support the delivery of the national constitutional target of 95% of patients seen within 4 hours; the development of integrated teams; ensuring a primary care sector that is resilient and can respond to the new models of care; and improving the effectiveness and efficiency of planned care and. It is also a key component of the “right sizing” of the acute sector by making it safe to reduce inpatient beds capacity through the provision of alternative pathways and out of hospital services.

Home First

The overarching model of care across LLR is the “home first “model. This model was originally highlighted by Dr Ian Sturgess in the 2014 Sturgess Report on the Urgent Care Pathway in LLR. However, the principles of home first are not only applicable to an urgent presentation but

define our approach for integrated care across LLR. This approach requires all teams and individuals whether in secondary, community or primary care to ask “Why is this patient not at home?” or “How best can we keep them at home?”

If an emergency admission to hospital does occur, then the ‘home first’ principle applies. Namely, that if someone is admitted to hospital and after necessary interventions and treatment, the system’s primary aim will be to return that person to the home address from which they came.

If there is a need for on-going assessments around decisions for further care, these take place within the persons ‘usual environment’ where they are likely to function at their best. This is to avoid ‘crisis’ decision making about the long term care from a ‘hospital bed’. A recognition that remaining in Hospital when there is no longer any ‘acute’ or ‘sub acute’ need to remain in Hospital, in particular, for people with frailty risks the development of de-conditioning, which can worsen outcomes.

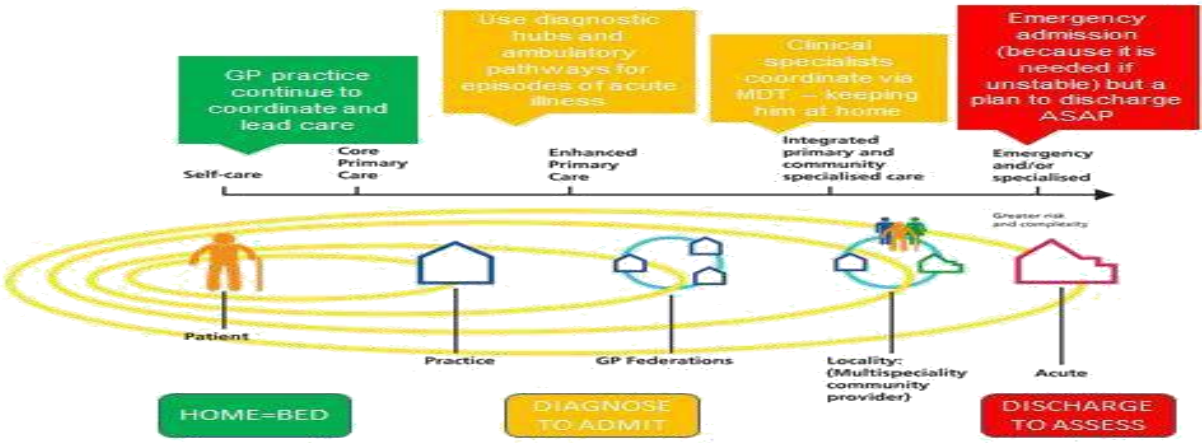
Likewise in the community, teams will be required to place patients and their carers at the centre of the design and delivery of care. This requires a move away from organisationally driven provision to integrated placed based provision.

The principles underpinning this model are:

- Patients, carers and family are at the centre of this model.
- The patient will be known by their registered GP and that a medical management plan and care plan is consistently transferred between settings of care.
- Rehabilitation and reablement should be undertaken at home or in a community care setting.
- Inpatient beds should be utilised for acute and sub –acute care.
- The need to optimise and maintain independence for as long as possible.
- Deliver a Trusted assessment concept which is central to the application of this model.
- The Discharge to assess concept underpins the Home First model.

The home first model is based on transforming services for all patients but is particularly urgent priority for the rising number of patients with long term and complex conditions .It requires a fundamental shift towards care that is co-ordinated around the full range of an individual’s needs

(rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time.



Concrete actions

- **Develop the model and service capacity for the delivery of a home first approach:** undertake a service capacity review to determine the level of service provision required to implement Home First and develop the necessary pathways linking where appropriate to other workstreams including Integrated Teams and Urgent Care (discharge pathways).
- **Community beds:** with a Home First approach the requirment for rehabilitation beds in community hospitalsis likely to reduce – an assummed level of impact has already been factored into our community hopsital reconfiguration plans, however as we progress the model we keep this under review.

Urgent and Emergency Care

This section describes a model for Urgent and Emergency care across LLR together with the actions we are taking to improve the NHS Constitutional target of the percentage of people who spend four hours or less in A&E.

A New Model of Urgent Care

The CCGs will commission, through their Urgent and Emergency Care Vanguard Programme, a system which provides responsive, accessible person-centred services as close to home as possible. Services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that exploit innovation and promote care in the right setting at the right time.

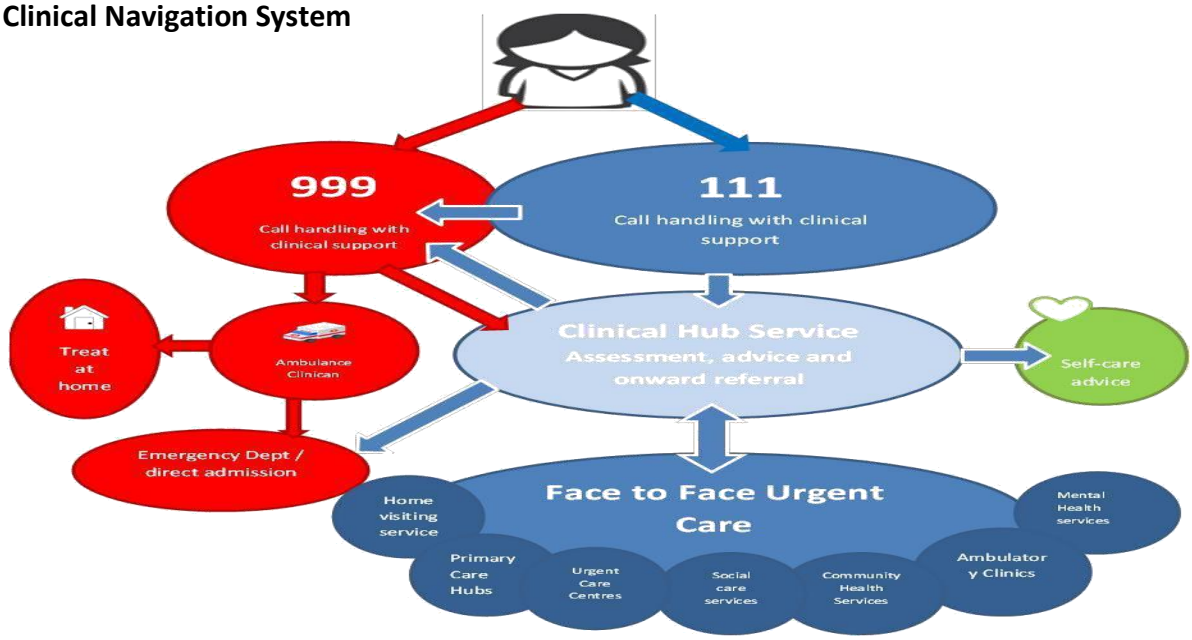
Urgent care services in LLR will be consistently available 24 hours per day, 7 days a week in community and hospital settings. Clinical triage and navigation is a central part of the new integrated urgent care offer, reducing demand on ambulances and acute emergency services. The following diagram identifies the components of our integrated system.

New Urgent Care System in LLR

The main changes which will be delivered by the new service model are:

- The creation of a clinical navigation service, providing telephone advice, assessment and onward referral for people calling NHS 111 and 999. The clinicians working in the service will have access to patients' primary care records and care plans, where relevant, and will be able to directly book patients into primary and community urgent care services. The service will include warm transfer callers to specialist advice for mental health, medication and dental issues. Future plans for the navigation hub include bringing it together with a professional advice line and integration with a single point of access for social care. A diagram setting out this model is provided at the end of this section.
- Extended access to primary care across LLR – so that patients can access primary care services 8am to a minimum of 8pm every day of the week.
- Urgent Care Centres will offer a range of diagnostic tests and medical expertise for people with more complex or urgent needs, and we will strengthen community based ambulatory care pathways which can avoid admission without the need to referral to acute hospital.
- An integrated streaming and urgent care service at the front door of Leicester Royal Infirmary Emergency Department, staffed by senior GPs working within the rebuilt Emergency Department.
- A 24/7 urgent care home visiting service across LLR, including out of hours home visiting and an acute visiting service for people with complex needs or living in care homes.

The Clinical Navigation System



Improving NHS Constitutional Performance

LLR has experienced significant challenges in relation to urgent care system performance, both for A&E waiting times and ambulance response times. We have developed an A&E Recovery Action Plan which responds to national guidance on A&E Improvement and addresses the key interventions that we need to take forward in LLR to improve emergency care system performance. The five intervention areas for LLR are:

- **Developing streaming at the front door of LRI Emergency Department**: this includes increasing the streaming and treating and redirection of patients from the ED front door; maximising the use of ambulatory pathways to avoid ED attendance, review short stay capacity and demand; develop ED internal professional standards and learning from others.

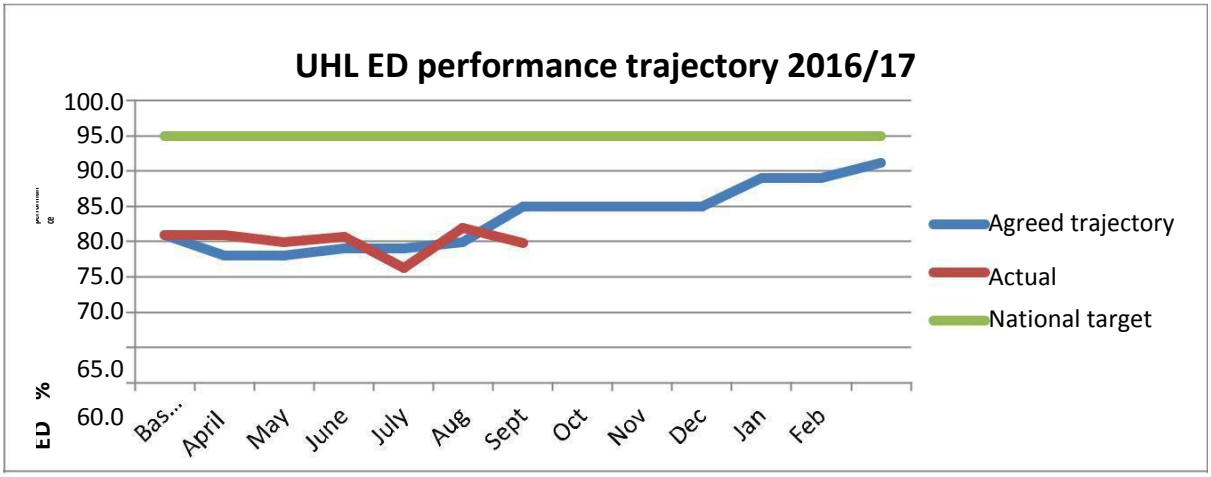
- **Managing demand for urgent care in order to minimise presentations at the Emergency Department:** including introducing clinical navigation, increasing the numbers of people calling NHS 111 who receive clinical triage and advice, ensure GPs have direct access to Consultant support, ensuring alternatives are available in the community such as extended GP hours and targeted visiting services, looking at high user postcodes, ensuring those patients discharged from the Acute Trust with a PARR+ score of +5 are provided with adequate community support and increased utilisation of Intensive Community Service capacity to prevent acute activity.

- **Improving Ambulance response times**: including implementation of A&E Front Door Clinical Navigator and the mobile Directory of Service and sustain the current high levels of hear and treat.

- **Improving flow within hospital**: including the implementation of SAFER patient flow bundle, trail senior acute physicians in ED, reduce time from bed allocation to departure from ED, reduce handover time for medical and nursing teams, reduce delays for diagnostics, reducing overnight breaches, implement direct admissions from ED to specialities and learning from other systems

- **Improving discharge processes**: including reviewing the model of Intensive Community Support (ICS) for opportunities to increase usage and support a home first model, establish pathway of reablement patients and discharge to assess, implement an electronic solution to support a trusted assessment upon transfer of care, improve the pathway to support effective transfer of care for people with dementia and adapt acute SAFER flow bundle to address community hospital service requirements.

Our trajectories for improving A&E performance in 2016/2017 are shown below:



Concrete Actions

- Develop an integrated community urgent care offer including clinical telephony-based clinical navigation services, General Practice extended hours, GP+ services, home based visiting and crisis response services. We will begin to put this in place from October 2016, completing the process in October 2017.
- An integrated clinical navigation hub including triage of ambulance disposition, from October 2016. The hub will extend to include adult and children social care services by 2018, and will act as a single point of access to step up and step down services.
- Enhanced services for ambulatory assessment in community settings, with rapid access to diagnostics to support assessment and admission avoidance.
- Ensure clinical information is shared to support triage, assessment and treatment of urgent care presentations – including Summary Care Record and enabling access to the full electronic primary care record in urgent care services.
- Implement a new pathway at the Leicester Royal Infirmary Front Door enhancing senior clinical presence and effective streaming to ensure patients are seen in the most appropriate setting.
- Improve mental health crisis services, including psychiatric liaison, clinical triage from 111 and crisis cars in the community to prevent admission.
- Continue to improve compliance with the 7-day services priority clinical standards within the acute hospital, within the available financial and manpower resources.
- Develop a real-time demand and activity model to improve management of operational resource and capacity.
- Implement new discharge pathways to provide an integrated, discharge to assess model which is based on the principle of 'home first'.
- Implement SAFER and Red/Green Days in both community and acute inpatient settings.
- Support the development of integrated clinical teams and enable shared approaches to risk.

- Develop an urgent care Alliance, which will bring providers and commissioners into a closer relationship, with a shared set of outcomes. The Urgent Care Alliance will support shared approaches to risk management and clinical governance, workforce planning and capacity planning to meet demand.

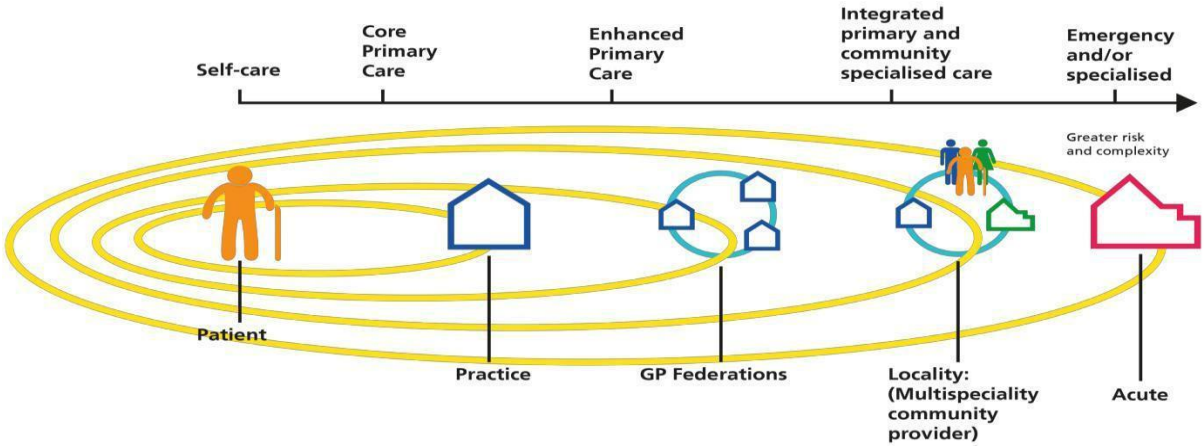
Integrated Teams

Our Better Care Together Programme is in the process of redesigning services to support a model where ill health can be prevented, unnecessary demand on the health and social care system avoided and hospital stays reduced. To date development has been based on individual workstreams improving pathways and patient outcomes through collaboration. While this has been successful in starting to redesign pathways, our workstream leads are telling us that to make a real shift in the demand curve we have to move to integrated placed based teams.

Demand comes from an ageing population; increasing level of need from people with long term conditions; high levels of admissions for ambulatory care sensitive conditions; over reliance on emergency and urgent care; and inconsistent delivery due to the lack of skills and confidence to maintain the target patient cohorts in the community.

So what needs to be different?

Our model of integration wraps around the patient and their GP practice, extending the care and support that can be delivered in community settings through multidisciplinary working, with the aim of reducing the amount of care and support delivered in acute settings, so that only care that should and must be delivered in the acute setting will take place there in the future. It is designed to improve health outcomes and wellbeing, increase our citizens, clinician and staff satisfaction and at the same time moderate the cost of delivering that care. This is demonstrated in the diagram below.



In our model the general practice and primary health care team will remain the basic unit of care, with the individual practice list retained as the foundation of that care. Our integrated locality teams are the geographical unit at which care is commissioned, coordinated and provided. Whilst a proportion of care will remain within a patient's own practice, an increasingly large proportion will be delivered by locality based integrated teams coming together to deliver care for an identified population. The model places the patient or service user at the centre, with the GP as primary route

for accessing care. The GP is the designated accountable care coordinator for the most complex patients in community settings.

Focus of Integrated Teams

As integrated teams develop they will be responsible and accountable for the care of all patients within their defined geographical "place". However, the focus of the initial phase of our programme will be on those patients most at risk. The following priority cohorts of patients have been identified, via the Adjusted Clinical Groups (ACG) risk stratification system:

- Over 18's with five or more chronic conditions
- All adults with a "frailty" marker, regardless of age but related to impaired function
- Adults whose secondary care costs are predicated to cost three or more times the average cost over the next twelve months.

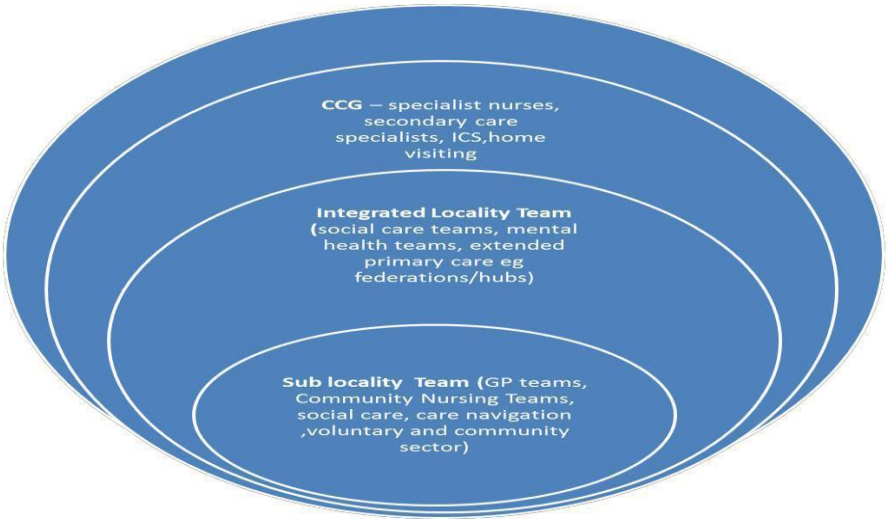
Identifying a targeted patient cohort will enable us to test models and evaluate the impact of integrated teams prior to extending the approach to the wider patient cohort, such as children. During this time patients outside of these cohorts will receive services as normal. However as the model of integrated teams develops we will expand the cohorts.

What services will be included in Integrated Teams?

Through integration general practices, GP Federations, adult and children social care, acute and community care will work with commissioners to introduce a new model of care focussing on four areas:

- Increasing prevention and self-management
- Developing accessible and responsive unscheduled primary and community care
- Developing extended primary and community teams
- Securing specialist support.

The services that will be included within the integrated teams is demonstrated in the following diagram.



The development of integrated locality teams in the initial phase is about bringing existing health and social care teams together to build a new integrated model of provision. Through the effective use of existing resources including the targeting of Better Care Funds, integrated teams will:

- Operate “as one” under a single leadership team.
- Have joint accountability for care coordination and outcomes for their population.
- Provide care in local communities and peoples own homes with less dependency on acute care.
- Create a standardised consistent offer for our citizens and patients through Leicester, Leicestershire and Rutland wide service redesign with interventions delivered at a local level.
- Target resources more effectively based on detailed understanding of population need, demand, service journeys and utilisation and real time data.
- Focus on prevention, the individuals responsibility for their own health and wellbeing, early diagnosis and management of risk factors.
- Through co-redesign create a far more cost efficient and clinically effective person centred model of care.
- Through an allocated placed based budget and integration of health and adult and children social care teams, care will be delivered in the right place, first time.

The critical task initially is to bring the team together and enable them to “get going” on care redesign. All partner organisations are committed to empowering staff to test models and work differently for the benefit of patient care. So in the first phase this is not about changing the employment status of staff or implementing capitated placed based budgets.

However learning from the MCP vanguards demonstrates that to be sustainable and fulfil their potential integrated teams will need to be effectively commissioned so that resources, structures and contracts help rather than hinder staff to do the right thing.

Where will the Integrated Teams be based?

The geographical spread of integrated teams will be based on ten established localities across LLR with a population size of between 63,000 and 121,000. For some services there will sub localities, eighteen in total, which are circa 35,000 in size.

So what will the impact be?

Learning from the national vanguard sites and through local engagements with patients and service users and clinical teams demonstrates that not only is this instinctively the right thing to do but will have an advantage impact on acute activity. Through data analysis we have identified the numbers in each cohort and the levels of need in each cohort to develop an indicative cost and benefit impact:

Cohort Numbers

Leicester City CCG					East Leicestershire & Rutland CCG				West Leicestershire CCG				LLR Cohort Total
Central	North & East	North & West	South	LCCG Total	Blaby & Lutterworth	Melton, Rutland & Harborough	Oadby & Wigston	ELRCCG Total	Hinckley & Bosworth	North & South Charnwood	North West Leicestershire	WLCCG Total	
33,157	16,454	25,842	16,651	**92,104**	23,372	35,795	12,901	**72,068**	24,771	33,541	10,652	**68,964**	**233,136**

Impact on admissions

				Activity		
Category	ED Attends	Unplanned Admissions	absoloute admission proportion	target proportion of admissions per risk group 2021	Level of desired avoided admissions	proportinal allocation of avoided admission per risk group 2021
Very High	17359	18147	32.90%	20.00%	9821	5969
High	16900	15825	28.69%	20.00%	8564	5969
Medium	29804	20183	36.60%	25.00%	10922	7461
Low	1888	870	1.58%	2.05%	471	612
Healthy User	256	125	0.23%	0.20%	68	60
Total	**66207**	**55150**			**29845**	**20071**

The potential cost saving per annum from the risk stratified cohort is £5.9m and a 128 bed reduction. Whilst the impact currently focuses on the acute sector the sense from our social care colleagues is that there will be wider efficiency gain in the reduction in high cost care packages.

Workforce

The development of Integrated Locality teams will require significant change in how the workforce is aligned and led. Currently primary, community and social care staff provide their services under separate structural and contractual arrangements; however the Integrated Locality Teams will operate “as one team” delivering joint outcomes for the populations they serve. Through the

Locality Leadership team, comprised of managerial and clinical leaders from primary, community and adult and children social care, they will hold joint accountability for care coordination and outcomes across organisational teams and boundaries.

The locality leadership teams with the support of Whole Systems Partnership will review current staffing and skill mix, identifying the care functions that will be required to support the cohort of patients identified for the initial phase of roll out.

Intelligence from the ACG risk stratification tool will be used as the cornerstone for this work, together with other intelligence from elsewhere that adds value to the assumptions. For each care functions we will work with the Locality leadership teams to describe the skill mix necessary to deliver these care functions effectively by considering the following:

- What existing care functions might we continue and do more of
- Are there skill mix and activity gains to be made
- What new activity will the teams start to do and how much

- What activity will the teams stop doing and how will staff affected be redeployed and retrained.

Initial, high level data modelling has been focussed on two elements of the patients pathway proactive preventative care, and step up care (step-down care for these cohorts is assumed to be picked up within the existing workforce due to the recent expansion of ICS or 'hospital at home' services). Initial assumptions have been made about how many hours of care would be needed to make a difference in each cohort of patients, over and above existing provision, to reduce admissions to hospital. These are indicative at this stage and will be further validated and modelled by the locality leadership teams.

Concreate Actions

- **Governance:** the Integrated Locality Teams Programme Board has been established and has affirmed the initial patient cohort; undertaken initial modelling of workforce impact; developed a state of readiness methodology to performing a baseline assessment for locality leadership teams in each CCG areas to inform pace and scale of roll out; and incorporated learning from the MCP vanguards into the development planning.
- **Prevention and Self-Management**: support people to manage their own health and well-being with a targeted approach to ensure specific cohorts of people access an approved menu of non-medical interventions including social support systems in the community. Identifying when a non-clinical intervention will produce improved experience and outcomes for patient.
- **Accessible and responsive primary can community car**e: ensure there is a GP led team with a mix of skills and disciplines utilising new technology to manage patients who need a same day appointment or service. Freeing up sufficient GP time to support those patients with more complex needs (more detailed provided in the Resilient Primary Care section).
- **Extended primary and community care teams**: joining up care provided by multiple professionals who support the same caseloads of people in a locality. Pooling the local care resources to manage people at moderate and high risk. Proactive use of shared data and care plans so that more targeted, proactive care can be delivered through multi-disciplinary teams.
- **Securing specialist support**: bringing specialists support nearer to patients in their communities and reducing the time taken to access specialist input, by reducing the number of separate steps in care pathways.

Resilient Primary Care

Across LLR there are over 130 GP practices, ranging from single handed practitioners to registered lists of over 38,000 patients. There are a variety of delivery methods, premises and historical funding differences and a wide range of care models using GPs and other health care professionals. Outcomes for patients differ based on age, sex, deprivation, ethnicity and rurality and there are inequalities across the system. This story will be mirrored across the majority of STP footprints across England.

CCG	Population	Number of Practices	Average List size	Contract Split	GP Headcount (Partners in brackets)	Registered Nurses WTE
ELR	325,000	31	10483	GMS 31	204 (148)	83
WL	374,000	48	7792	GMS 48	184 (130)	67
City	376,000	59	6642	APMS 13 PMS 1 GMS 45	180 (120)	68

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

CCG Primary Care Budgets 2016/17			
	West	**East**	**City**
Delegated co-commissioning budgets	44,070,553	39,545,837	48,441,423
Other: Including Community Based Services, Quality schemes and incentives.	6,274,700	6,386,033	4,380,659
TOTAL	**50,345,253**	**45,931,870**	**52,822,082**

NB: These figures do not include any BCF or PMAF investment or other services commissioned for primary care e.g .AVS/CRT

Although there are significant challenges in the system through demographic change and demand, there are many examples of real innovation within individual practices and across groups of practices working together in legal Federations. The leadership from the GP board members of each of the three CCGs in LLR and the desire to improve patient care has created an environment where our practices are prepared to develop new ways of working to improve outcomes and manage the demand of modern General Practice These developments range from practices merging together into multi-site providers offering an innovative approach to patient needs, to pharmacists being employed to manage workload and patients with Long Term conditions and extended hours hubs to meet the needs of patients This innovation has shown that General Practice even through adversity, with the right support, investment and leadership can adapt to manage the challenges for modern primary care medicine.

Delivering the GP Five Year Forward View

Primary medical care is the foundation of a high performing health care system and as such is critical to the successful implementation of this Sustainability and Transformation Plan. Over the next five years our new model for general practice will be realised. The practice and primary healthcare team will remain as the core unit of care, with the individual practice patient lists retained as the foundation of care. However, while a large proportion of care will remain with a patient's own practice, an increasingly significant proportion will be provided by practices coming together to collaborate in networks or federations using their expertise, sharing premises, staff and resources to deliver care for and on behalf of each other. In this way it will be possible to improve access and provide an extended range of service to our patients, as well as creating an environment that attracts Doctors and other health professionals into a career in primary health care

The LLR promise to the patient is consistently high quality care which is responsive and accessible, integrated, sustainable and preventative. Currently we have not fully realised the potential of general practice and too often patients receive care in hospital that could be safely provided in the community, coordinated through their general practice, supported by the wider health and social care teams.

This is not going to be an easy task, there are many challenges facing General Practice, including workforce, funding and demand, but the vision remains that through focussed investment, improved premises and IT solutions and with additional integrated services supporting General Practice to be able to manage their patients appropriately in a closer to home setting there will be improved outcomes for our patients with the ability to access the right health care professional for their needs.

Our vision for primary care

We have a clear vision for the future of primary care in which is:

> General practice is the foundation of a strong, vibrant, joined up health and social care system. The new system is patient centred, joined up and integrated, engaging local people who use services as partners in planning and commissioning, which results in the provision of accessible high quality, safe needs based care.

This will be achieved through expanded and integrated primary and community health care teams, offering a wider range of services, with increased access to rapid diagnostic assessment and, crucially, patients taking increased responsibility for their own health (see the Integrated Teams section).

The model of general practice

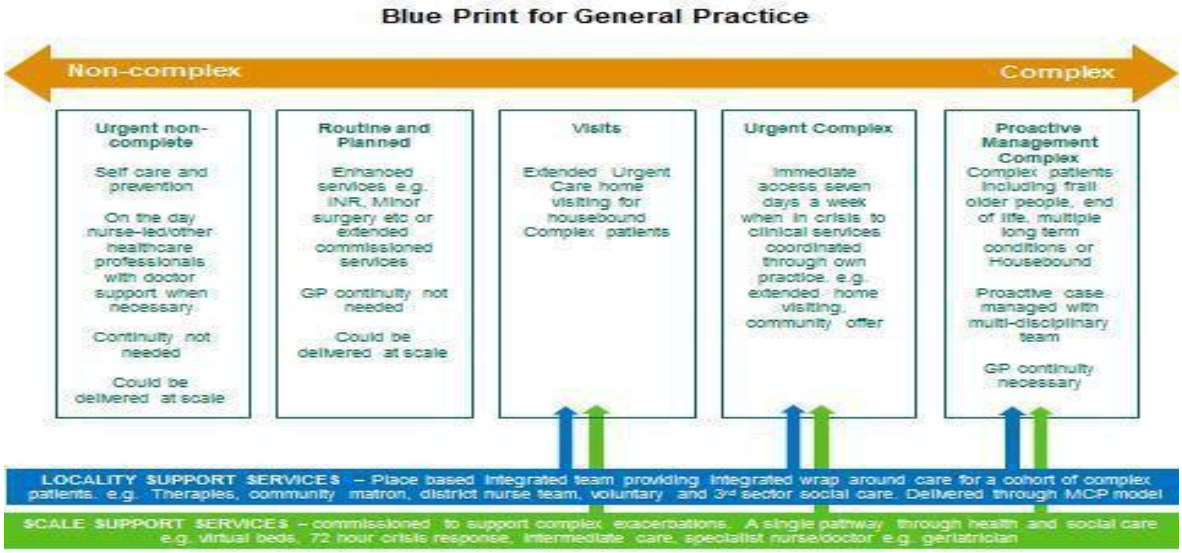
Over the next 5 years our new model of general practice will be realised. The practice and primary healthcare team will remain the basic unit of care, with the individual practice patient list retained as the foundation of care. However, whilst a large proportion of care will remain with a patient's own practice thereby recognising the importance of the therapeutic doctor – patient relationship, an increasingly significant proportion will be provided by practices coming together to collaborate, using their expertise, sharing premises, staff and resources to deliver care for and behalf of each other. In this way, it will be possible to improve access and provide an extended range of services to our patients at scale.

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

Key to supporting patients is the ability to provide a differential service according to need. Not every patient requires contact with a doctor or an appointment on the same day. A cohort of patients, especially those with multiple co-morbidities who are at risk of admission for their complex

condition require a more pro-active offer that could involve a multi-disciplinary team including social care, community nursing and specialist care. Integrated care combines a range of disciplines across health, social services and voluntary organisations to create person-centred care.

Person-centred care recognises that an individual is best placed to make decision about their own health, lifestyle and the level and location of treatment. Successful integrated person-centred care will tend to keep a person in their own home for as long as possible. This model puts the GP at the centre of health care provision working with a range of services to ensure patients access the right services first time. This new model of general practice is demonstrated in the diagram below.



This model of general practice maintains the general practice team at the centre of care with all practices providing a level of urgent primary care access as well as planned services and should support patients in self-care management as well as accessing other appropriate health services. To meet the needs of patients, now and in the future, the model of delivery will need to adapt. This adaptation is based around patient need and seeing the right health care professional for their condition. The evidence shows that patients with complex needs require a coordinated package of care that will require care planning, regular proactive interventions and support. This continuous care is best provided by a multi-disciplinary team with the GP at the heart of that care. This level of service utilises a GPs skills to best effect and patients will be streamed accordingly. All other patients will have access with another appropriate health professional, when needed, supported by a GP

At the heart of General Practice is the core prevention agenda, whereby the population are empowered to make the right lifestyle choices to maintain their health. When people do require support, they are able to manage their own conditions through appropriate information, tools and when necessary the ability to access the right integrated pathway first time, whether that is health, social care or support from the third sector.

Currently too many people use emergency acute services because primary care is perceived as inaccessible where and when they need it. 60 to 70% of emergency admissions are of people with long term conditions or frailty. These patients are known to the system and particularly to general practice. Active planning ought to prevent emergency admissions, and expedite discharge whenever a hospital stay cannot be avoided. Our ambition is to correct this situation and shift the care system so that bulk of work is done through scheduled care, as opposed to the current situation where it is in urgent care.

Going forward we do not believe the status quo will enable GPs to deliver everything patients need in the 21st century. A new model of health and adult and children social care is required that builds on the needs of patients and the strengths and values of general practice.

When intervention is necessary, every patient should be able to access the care they need from the appropriate clinician whether from their own practice, in the community or on a locality or system footprint, in a timely fashion seven days per week.

This access will not necessarily be from a GP, but a nurse, pharmacist, Advanced Nurse Practitioner, Extended Care Practitioner or other health professional according to need. This offer is intrinsically linked with the already developed plans, being piloted and evaluated now through the Leicester, Leicestershire and Rutland Emergency and Urgent Care Vanguard. By April 2017 this will have generated a new model of home visiting, Out-of-Hours provision, clinical navigation, Urgent Care and enhanced primary care access, which in combination will provide a twenty-four hour service across LLR.

Workforce changes

General Practice will not be sustainable or fit for purpose for the next decade without change and crucially without support to grow its workforce. A competent and skilled workforce is a key enabler in implementing the plan to support a sustainable primary care. We cannot address the current GP shortage in isolation: increasing the capacity and capability of practice nurses, practice managers and other health care professionals is vital if we are to address the increased demand on primary care.

Workforce planning and modelling assumptions in primary care need to incorporate new, emerging and more sustainable models of primary care. We need to develop a primary care workforce which is fit for purpose now and in the future rather than merely increasing numbers.

Developing primary care services that span different professional perspectives and work across the traditional primary and secondary care interface is vital. The findings of our engagement programme to date indicate that we must:

- Target the existing primary care workforce to improve recruitment and retention but equally important to identify new capabilities, competencies, skills and behaviours required to make an enhanced primary care offer.
- Identify new roles and capabilities in new staff groups. There is an urgent need to focus on alternative professional roles that support integration, increase capacity and reduce admissions by freeing up GPs time to manage increasing complexity. Such roles include primary care physicians' assistants.

- Identify roles and competencies currently that sit outside of primary care that will be required to support the demand. Such roles include primary care paramedical staff, community pharmacists, emergency care practitioners, and specialist roles such as geriatricians.
- Actively support undergraduate medical, nursing and pharmacy training and GP training at a federated level to promote our practices as positive places to work to aid recruitment and retention.
- To this end we will work with our federated localities, our neighbouring CCGs, local universities and Health Education East Midlands (HEEM) to u to identify current skills and extended skills that could benefit patients and practices.

For over a year this has driven the primary care workforce agenda through an LLR-wide delivery group consisting of stakeholders including HEE, LMC, LPC and clinicians. Baseline assessments have been completed, three multi-disciplinary training hubs have been established and Education networks are working across the footprint. This has resulted in new delivery models and extended roles including Clinical Pharmacists and Emergency Care Practitioners. This forms the basis for a longer term strategy to deliver the solutions for a sustainable service.

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

The workforce metrics show that there are many GPs and nurses working in primary care who intend to retire within the next five years. The plan for a future proof workforce must account not just for replacing these clinicians, but growing the appropriate numbers of staff with the right skills for new models of primary health care. To support this, the plan accounts for a net increase of 1% per year for doctors, but 3% per year for other health professionals to match the skills and capacity necessary and in recognition of workforce pressures.

GP (WTE)		GP Support staff (WTE)	
Current	**2020/21**	**Current**	**2020/21**
593	617	1,678	1,888

What Primary Medical Care will look like five years from now?

If this plan is fully implemented, we envisage General Practice in LLR looking like this:

- General Practice with registered lists will remain at the heart of the model offering a comprehensive service to patients based on differential need according to condition and complexity.
- We will actively encourage practices to work together in networks or merge and provide services on multiple sites offering planned and unplanned services to meet patient's needs. This will reduce bureaucracy and enable economies of scale to enable greater clinical workforce focus.

- CCGs in LLR have already invested significantly into the development of formal legal GP Federations who do and will work as collective providers of services for patients such as enhanced services.
- These federations will be active partners in alliance partnerships or integrated teams supporting place based models of care.
- Place based care provided around geographically defined populations. This will support the adaptation of services for patients, which will act as a catalyst to new models of GP collaboration for core services.
- GPs will increasingly have portfolio careers.

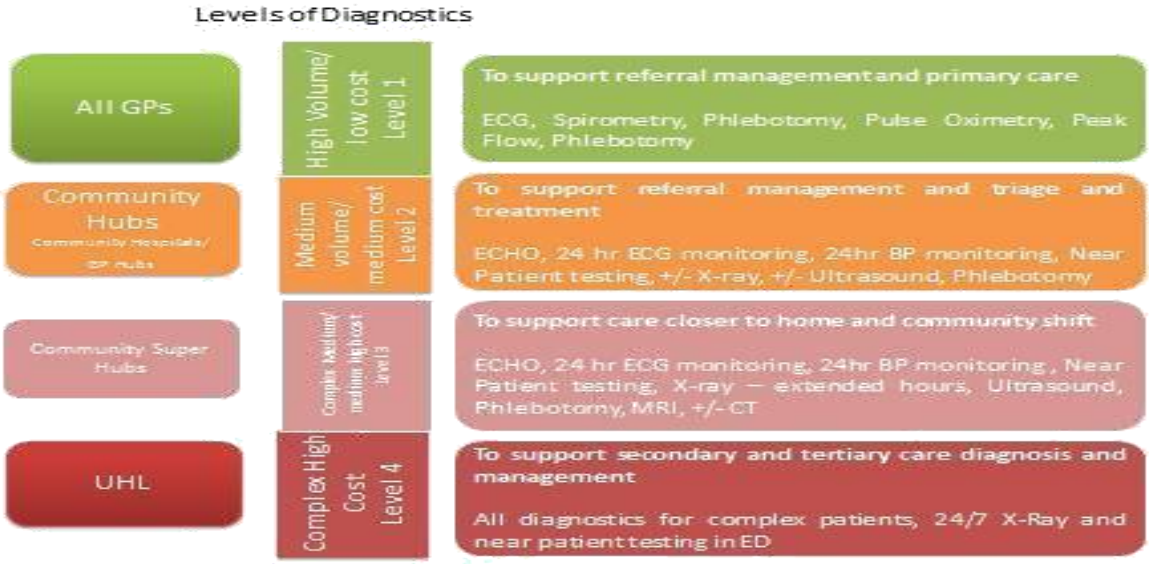
Concrete actions

- Focusing on improvements in primary care, better integration of services through place-based teams. .
- Deliver the Leicester, Leicestershire and Rutland Workforce Plan to improve recruitment and retention of medical staff in primary medical care and develop the required skill mix to deliver the future model of primary care and support integrated placed based teams.
- Use a range of professionals to deliver care particularly to those with less complex health needs.
- Support the development of Federations.
- Work with Federations to enable more collaboration between practices.
- Ensure access to extended primary care services in the evening and weekend outside of core GP opening hours in multiple sites across the geography.
- Develop integrated place-based teams with the general practice at the heart of care.
- Implement the local Digital Roadmap and the requirements set out in the GP IT Operating Model 2016/18.
- Support practices through the Estate and Technology Transformation Fund process based on the LLR Estate Strategy.
- Support practices to take forward the initiatives within the General Practice Five Year Forward View including the 10 High Impact Changes and the General Practice Development Programme.

Planned Care

LLR currently has a traditional model of planned care where the majority of activity takes place in acute settings with face to face follow ups. This model relies on patients travelling to one of the three City based sites and is often hampered by pressure of emergency demand. There are some outpatient services delivered from the community hospitals in the county; however in many cases community hospital capacity is underutilised. Demand is increasing and improving the efficiency of planned care is a key component of our STP financial plan we know there are opportunities to become more efficient and improve patient pathways.

Over the last three years LLR has put in place an Alliance model for elective care that can be delivered in community settings. This model of contracting includes an Alliance Agreement which binds the providers together with commissioners to deliver elective care in community settings including left shift of services from the acute sector. The Alliance model will be used to further move activity from the acute sector to community settings. To support this we will develop a number of diagnostic hubs. The diagram below identifies the different levels of diagnostics to be provided in different settings.



Concrete actions

- Improve theatre utilisation ensure outpatient slots are booked, DNAs (Did Not Attends) reduced, and length of stay shortened. These actions sit within the cost improvement element of our financial plan.
- Redesign thirty-two planned care specialities to shift over 150,000 outpatients and over 20,000 day case procedures from an acute site to community settings, maximising the use of community hospitals and the proposed planned care centre.
- Take out any unnecessary appointments new and follow-up, reducing by an average of 30% across the specialities by using remote options and technology.
- Develop a referral hub to ensure referrals are dealt with by the most appropriate professional whether that is a Consultants, GPs with special interest, specialist nurses or allied professionals.
- Work with public health to identify treatments with no or low clinical evidence of effectiveness to develop evidence bases policies and pathways to be implemented across primary and secondary care.
- Develop an integrated acute and community MSK physiotherapy service.
- Develop a planned ambulatory care hub to manage procedures which require a stay of less than twenty-three hours.
- Use technology to provide alternatives to face-to-face consultations and develop further our electronic referral system with a plan within the next eighteen months to make it the default for most planned care referrals.

Strand 2 Service Configuration to ensure clinical and financial sustainability

Our proposals for service configuration to ensure clinical and financial sustainability are structured on three main areas on which we will go to formal consultation. These are:

- Acute reconfiguration to move all acute clinical services onto two sites, the Leicester Royal Infirmary and the Glenfield.
- Remodel maternity services to consolidate services onto one site at the Royal Infirmary and subject to preferences expressed during consultation provide a midwife lead unit at the General Hospital.
- Reconfiguration of community hospitals to reduce the number of sites with inpatients beds from 8 to 6 sites and redesign services in Lutterworth, Oakham and Hinckley.

Acute Reconfiguration

We know that Leicester is unusual in having three big acute hospitals for the size of the population we serve and this creates problems. Our specialist staff are spread too thinly; we duplicate and triplicate services across sites and it is expensive to run. And over the last two decades there has been significant and sustained underinvestment in the acute estate relative to most acute hospitals.

Many planned elective and outpatient services run alongside our emergency services and as a result when emergency pressures increase it is elective patients that suffer delays and last minute cancellations. Unfortunately the location of the majority of the acute services have not changed following the formation of the Trust in 2000, so in other words it's an accident of history not best clinical practice that gives us our current configuration.

Evidence indicates that patients, and particularly elderly patients, spend too long recovering in large acute hospitals and potentially deteriorating as a result, when they would be better served by rehabilitation services in their own home or in a community hospital. We want to adopt a "Home First" principle where there is an integrated care offer for people living with frailty and complex needs. Our focus will be to ensure that people can remain in their own homes. When this is not possible and they have to be treated in hospital we will ensure that their discharge is appropriately planned to enable them to get back into their home or community environment as soon as appropriate, with minimal risk of readmission.

As a result UHL will need to consolidate acute services onto a smaller footprint and grow its specialised, teaching and research portfolio, only providing in hospital acute care that cannot be provided in the community.

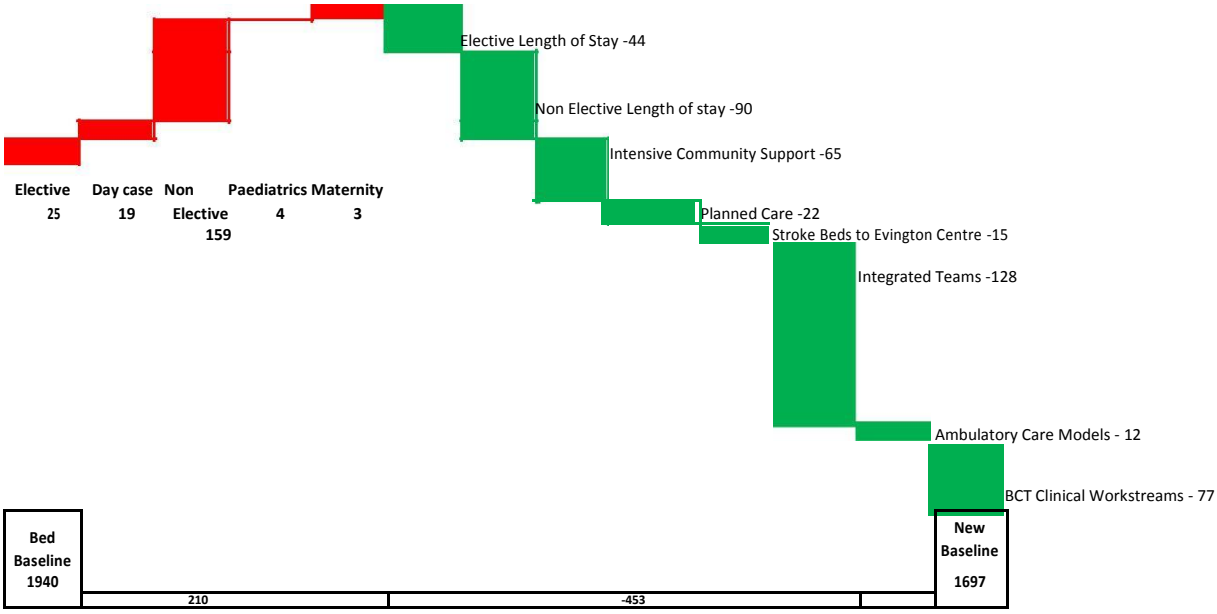
Through our Better Care Together and Better Care Fund programme we already have taken steps on this journey including the development of home based beds and integrated health and social care teams supporting patients in their home and we will take this further through our proposals around integrated placed based teams. The STP process has also led us to question whether we could be more ambitious in terms of how we deliver care in community settings particularly in relation to ambulatory services.

Although shifting the balance of care in the system is one of the important drivers behind our acute reconfiguration plans, they are also driven by three other factors. Firstly, it is not clinically sustainable to maintain three acute sites in a city the size of Leicester. Our medical resources in particular are spread too thinly, making our services operationally unstable. Secondly, by focussing our resources on two acute sites, we can improve our outcomes for patients, for example through increased consultant presence and thus earlier, more regular senior clinical decision-making. Thirdly,

our financial recovery is directly linked to site consolidation. We have calculated this "reconfiguration dividend" at £25.6 million per annum recurrent savings, which is the "structural" element of our current deficit.

In order to consider the impact of the above and the impact of efficiencies planned work has been undertaken to understand the future acute bed capacity requirements. The following bed bridge describes the outcome of this modelling which will take acute beds from the current level of 1940 to 1697 by 2020/21.

The bed bridge below has been updated as further work has been done to assess the impact of the interventions in the bridge. In addition to the changes shown, we are currently considering utilising spare community capacity for sub-acute purposes. This is in order to ensure that we utilise existing estate and minimise investment in new acute estate, whilst ensuring that UHL has access to sufficient beds to operate effectively and can consolidate onto two acute sites. Final decisions will be taken in conjunction with the community beds strategy described in the next section



This has led us to conclude that the fundamental drivers behind the plan to consolidate acute services on to two remains the same. However, we are aware of the constraints on capital availability nationally and we have therefore worked to reduce our capital requirement including the use of alternative sources of finance such as PF2 or continuing utilisation of existing estate.

What does this mean for the General Hospital: Subject to the formal public consultation, the plan remains for acute services to be moved to the Royal Infirmary and Glenfield Hospital. The Leicester Diabetes Centre (as well as potentially some connected services) will remain at the General and will continue to expand to become the pre-eminent diabetes research institute in the UK.

The General will also continue to be home to other health and social care services. The Evington Centre will remain providing community beds for Leicester, incorporating a stroke rehabilitation ward. Joint health and social care teams delivering services in people's homes will continue to have a base at the site. Leicester City CCG are also considering using the General site as a centre for a primary care hub providing extended hours and GP+ services, ambulatory services and diagnostics.

What does this mean for the Royal Infirmary: The Royal Infirmary will continue to be our primary site for emergency care. The Royal will see maternity and gynaecology services consolidation and the completion of the new Emergency Floor. A key component of our overall reconfiguration is the creation of two super ICUs, one at the Royal and Glenfield. The East Midlands Congenital Heart Centre at the Glenfield will move to the Royal as part of the investment to create a properly integrated children's hospital. If congenital heart surgery is ultimately decommissioned then these facilities will be re-purposed for other uses.

What does this mean for the Glenfield: The Glenfield will grow as services move from both the General and the Royal. The first of these moves will be the vascular service so that we can create a complete cardiovascular centre. Renal services, including transplant, will also move to the Glenfield. We also intend to locate our planned ambulatory care hub at the Glenfield.

The following diagram shows the route map to achieving this transformation.

Maternity Services

Following a local review, doctors, midwives, nurses and patient representatives have developed proposals for the future of women's services for Leicestershire, Leicester and Rutland. The proposals for change will ensure greater equality of access to services across the City and counties, reduce waste and offer value for money.

A report in 2012 identified maternity services as unsustainable in the longer term and a review of the services has been taking place since then. UHL currently provide six birth options for women in Leicestershire, Leicester and Rutland. These are home births, community based midwifery care, midwifery led birthing centre at Melton Mowbray, and both midwifery, and doctor led birthing

centres at the Royal Infirmary and Leicester General Hospital. This is a greater number of options than is suggested by NICE guidance; and a recent East Midlands Clinical Senate confirmed that services needed to change to ensure that they are sustainable and equitable for all women across Leicestershire, Leicester and Rutland in the future.

It is proposed that hospital based women's services, including gynaecology and maternity, will be delivered by UHL from one site, the Royal Infirmary. Some outpatient and day case procedures will continue to be delivered from the community hospitals with an increase in services in some cases.

The review identified that some services, such as the standalone midwifery led birthing centre, (no doctor presence), at St Mary's in Melton Mowbray are underutilised. This service is only used by a small proportion of women across the City and counties, and as such it is proposed to close this centre. In order to offer choice, we are considering whether or not to provide a standalone midwifery led unit at the Leicester General. Our proposals are based on the reconfiguration of maternity services to ensure that they are of the highest clinical quality, financially sustainable, equitable (accessible to all) and not introducing unnecessary risk for pregnant women and their babies.

The proposal is that all women in Leicestershire, Leicester and Rutland would be provided with the following equitable maternity options:

1. All obstetric (doctor) led inpatient maternity services will be provided via a shared care (between midwifes and doctors) obstetrics unit at one site, the Royal Infirmary; this means the service would be next to the neonatal and intensive care units in case of emergencies.

2. A midwifery led unit co-located with the obstetric unit at the Royal Infirmary

3. Home birth - Midwife only lead home birth for low risk women, which is as safe as birth in a midwife led unit.

Additionally, subject to women's preferences expressed through the public consultation, a standalone midwifery led unit could be provided at the Leicester General Hospital site.

How will the reconfiguration of acute and maternity impact on quality for patients?

Having three big acute hospitals creates problems, by spreading our specialist staff too thinly across the three sites, resulting in duplication and even triplication of services. Through our Reconfiguration Programme, we will focus our emergency and specialist care at the LRI and the GH, whilst ensuring that appropriate clinical services are provided in the county's community hospitals, to offer care as close to home as possible. The patient is at the heart of reconfiguration, and through consolidation, we will improve patient experience and quality by:

- Reducing unnecessary patient journeys.
- Improving clinical adjacency so that support and diagnostic services are close to where they are needed, promoting closer team working and providing a better patient experience.
- Reducing delays to care by streamlining care pathways.
- Reduce cancellations by protecting our elective beds by separating out emergency and planned care. This will be done by creating a planned ambulatory care hub at the GH as well as re-distributing some of our services into the counties' community hospitals.
- Improving the quality of the patient environment.

Specifically, we will be creating a consolidated women's hospital and an integrated children's hospital on the LRI site, and a planned outpatient and day case centre at the Glenfield. A key

component of our overall reconfiguration is the creation of two 'super Intensive Care Units', one each at the LRI and the GH.

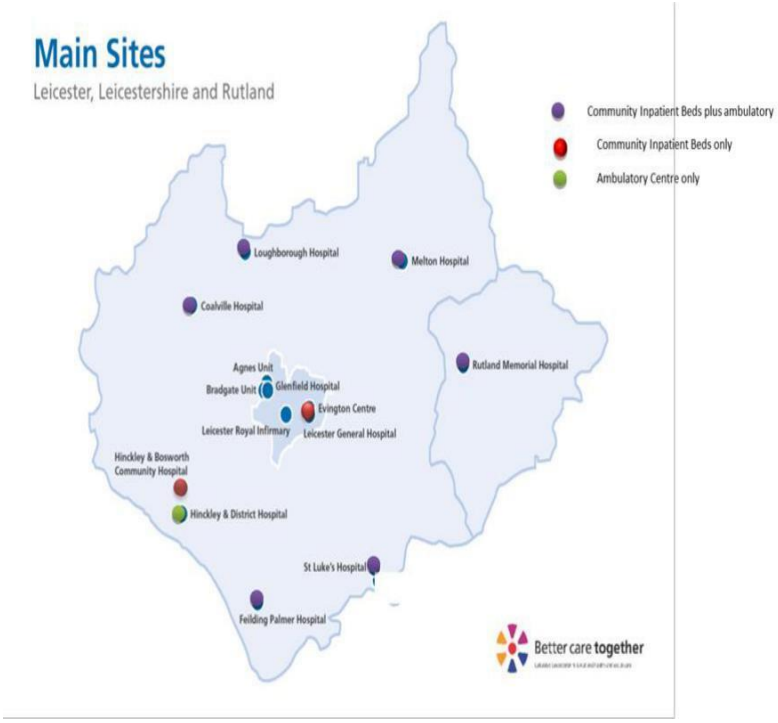
Community Hospitals

Current provision

Across LLR there are nine community hospitals providing a mixture of inpatient beds, community nursing and therapy services and elective care outpatient appointments, diagnostic investigations and treatments. These facilities are very variable in terms of the quality of the estate condition, but many are under-utilised, often have small isolated wards which cause sustainability issues, and are often not fit for 21st century health care delivery.

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

The map and table below show the current provision of inpatient community hospital rehabilitation beds (192) and stroke rehabilitation beds (41) currently provided by LPT:



Place	Current LPT Inpatient Provision
Coalville	Rehab/Sub-Acute (24 beds) Stroke (24 beds)
Loughborough	Rehab/Sub-Acute (24 beds)
Hinckley	Rehab/Sub-Acute (23 beds) Rehab/Sub-Acute (16 beds)
Leicester City	Rehab/Sub-Acute (24 beds) Rehab/Sub-Acute (23 beds) Stroke beds provided by UHL at LGH (15 beds)
Melton	Rehab/Sub-Acute (17 beds)
Oakham	Rehab/Sub-Acute (16 beds)
Market Harborough	Rehab/Sub-Acute (15 beds) Stroke (17 beds)
Lutterworth	Rehab/Sub-Acute (10 beds)
Totals	Rehab/Sub-Acute (192 beds) Stroke (41 beds)

Note: the Stroke total figure above does not include the LGH stroke beds

Changing requirements in response to new models of care

Over recent years the health and care system across LLR has already enacted two significant community hospital reconfigurations following public consultation; the movement of services from Market Harborough and District hospital to the new build St. Lukes hospital in Market Harborough and the closure of Ashby hospital and re-provision of some outpatient services elsewhere in the town. Additionally a new service known as Intensive Community Support (ICS) service was initiated three years ago to provide rehabilitation care to patients out of hospital and avoid unnecessary

hospital stays; the number of ICS 'virtual beds' was increased from 126 to 256 in the latter part of 2015/16.

The next phase of community service reconfiguration considers how best to respond to the new models of care and pathway redesign set out elsewhere in this STP. In particular the following new model of care, clinical sustainability and efficiency issues will impact on the scale and location of community hospitals required:

- Home First model – will support patients to return home to their normal place of residence, reducing inpatient length of stay and the associated deconditioning impact on rehabilitation and reablement
- Integrated Teams – will help to reduce the need for inpatient community hospital beds by avoiding unplanned admissions and supporting reductions in length of stay
- Planned care settings – will see more elective outpatient, diagnostic and day case treatment activity delivered from non-acute hospital sites in primary and community care
- Workforce - ensure that community hospital inpatient facilities have a resilient and sustainable staffing model
- Estates – ensuring that facilities are well utilised and services are delivered in facilities fit for the 21st century healthcare.

Over the past decade, it has become possible to provide a greater range of rehabilitation services for patients in the community hospital setting and for patients in their own homes. As a consequence, there are now 256 intensive community support beds operating across LLR and the number of beds in community hospitals has been gradually reducing over the period to 192 at present.

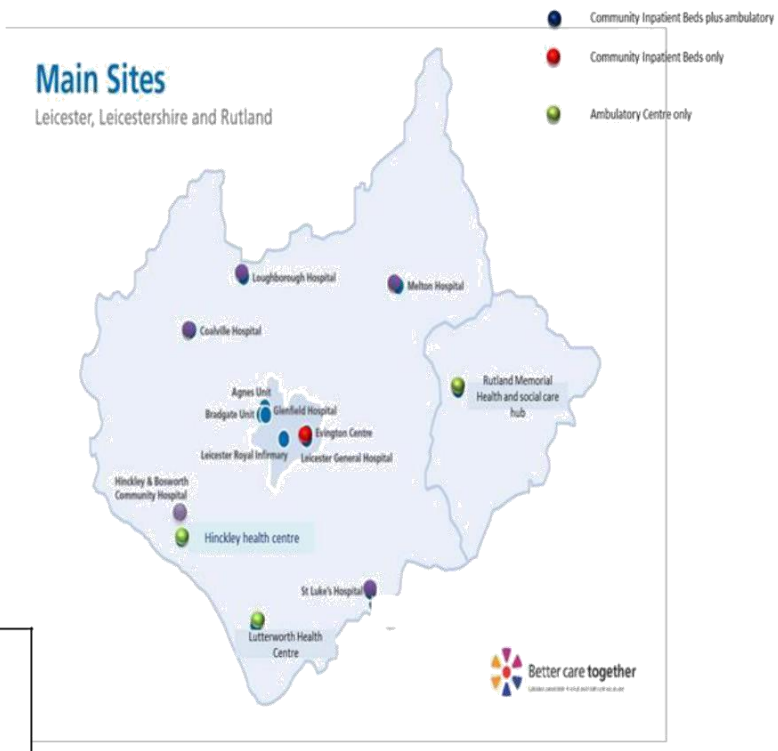
For both stroke and neurology services a lack of specialist community rehabilitation is resulting in increased admissions, dependency on hospital and community based services and longer lengths of stay in both acute and community beds. We plan to address this by providing a new comprehensive, community based stroke specialist services for stroke survivors who need further rehabilitation after their initial period of rehabilitation in hospital. This new community service will provide patient centred, seamless care for both stroke and neurology patients that require rehabilitation in the community, largely in the patient's usual place of residence. The number of stroke and neurology beds will reduce, but continue to be provided on the three existing sites in Coalville, Evington Centre and Market Harborough.

Some community hospitals have small single wards which are too small to be sustainable in the future. Staffing numbers are proportionate to ward size and small single wards have staffing levels that are vulnerable to issues such as short notice sickness, which if not resolved can increase risk and compromise patient safety. Where feasible it is proposed to move towards operating 'paired wards' on a single community hospital site in order to enable flexible and resilient staffing models. Where this is not feasible or desirable in terms of geographic equity of service distribution we are proposing increasing the size of some of the smaller wards to a more optimum scale. In addition, some wards have layouts which do not accord with NICE guidance which identifies ward size and layout as one of the factors in the provision of safe care.

Proposed next phase of changes

In response to the above changes in local models of care, as well as the utilisation and condition of the community hospital estate the following changes are being proposed. Many of these will be subject to formal public consultation in 2017 before any final decisions are made. Several will also require significant NHS capital investment which will need to be secured before any decisions which are ultimately taken could be implemented.

Place	Proposed Inpatient Provision
Coalville	Rehab/Sub-Acute (21 beds) Stroke (15 beds)
Loughborough	Rehab/Sub-Acute (24 beds)
Hinckley	Sub-Acute (21 beds)
Leicester City	Rehab/Sub-Acute (21 beds) Rehab/Sub-Acute (21 beds) Stroke (15 beds)
Melton	Sub-Acute (21 beds)
Oakham	No Beds
Market Harborough	Rehab/Sub-Acute (21 beds) Stroke (15 beds)
Lutterworth	No Beds
Totals	Rehab/Sub-Acute (150 beds) Stroke (45 beds)



Note: the impact of the Home First new care model may see further reductions in the need for inpatient bed based services, particularly in West Leicestershire.

West Leicestershire sites

What does this mean for Hinckley and District Hospital: The condition of this facility is not fit for purpose for providing modern healthcare, has inadequate scope to accommodate the expansion of certain local services and does not lend itself to feasible NHS re-use. As a result the proposal, subject to formal consultation, is to relocate the X-ray and Ultrasound departments into Hinckley Health Centre, which is directly adjacent to and on the same site as Hinckley & District Hospital. To accommodate this, the health centre will be refurbished to increase the number of clinical rooms so that this location can accommodate an extended outpatient provision and new modern X-ray/ultrasound facilities.

What does this mean for Hinckley and Bosworth Community Hospital: This is one of the best condition facilities in LLR with scope for investment to expand the range of local services available. Inpatient community beds will continue to be provided here, but in response to the new Home First and integrated team models of care it is proposed that the number of inpatient beds is reduced from the current two, to a single 21 bed ward. This will create capacity to enable investment in providing a new endoscopy and day case surgery suite within the footprint of the existing building. This will both re-provide existing diagnostic and treatment services provided at Hinckley and District hospital as well as creating additional capacity to enable services to be extended and expanded to meet the needs of a growing and ageing population in Hinckley and the surrounding areas.

What does this mean for Coalville Hospital: This site provides a wide range of general and some specialised services and the NHS is committed to continuing to deliver services from this location. The site will continue to be a key location for providing outpatient services for a range of specialities including Ophthalmology; ENT; Dermatology; Gynaecology; and general surgery. In response to the reduced requirement for inpatient beds as a result of the new models of care set out in the STP it is proposed that the number of inpatient rehab/sub-acute beds will reduce by three and the number of stroke beds by nine. Longer term, once the full impact of the Home First model in particular is more fully evident and understood there may be a requirement for a further reduction in the

rehab/sub-acute provision serving the northern part of West Leicestershire, either at Coalville or nearby Loughborough.

What does this mean for Loughborough Hospital: This site provides a range of urgent care, elective and inpatient services and the NHS is committed to continuing to deliver services from this location. The Planned Care services improvements set out in this STP will see an extended and expanded range of outpatient, diagnostic and day care procedures carried undertaken here. Loughborough will also continue to be the location of the Urgent Care Centre taking advantage of the x-ray and other on-site facilities. A single inpatient ward will continue to operate from here. Longer term, once the full impact of the Home First model in particular is more fully evident and understood there may be a requirement for a further reduction in the rehab/sub-acute provision serving the northern part of West Leicestershire, either at Coalville or Loughborough.

East Leicestershire & Rutland sites

What does this mean for Melton Mowbray Hospital: The proposal is subject to formal consultation, on the Rutland Memorial Hospital proposals, and subject to capital allocation for expansion to increase the inpatient beds from 17 to 21. The hospital will continue to be a base for planned care with greater use of the theatre for day case procedures. An expansion of outpatient specialities linked with outpatient diagnostics will provide access to more one-stop and joined up services at the hospital, as well as nurse lead evening and weekend extended primary care access.

What does this mean for Rutland Memorial Hospital: The proposal is subject to formal consultation and will see the Hospital becoming a hub for health and adult and children social care services. This will include increased planned care outpatient, therapy services, diagnostics and well-being services which will integrate with a GP led evening and weekend urgent care service for the people of Rutland. A feasibility study, designed to ensure the provision of health and social care services for the expanding population of Rutland and exploring options for further health and social care integration, underpins the vision for the hospital. The inpatient beds will close and provision will be available for local patients within a patients' own home using the Home First model, the ICS service or where necessary in other local community hospitals.

What will this mean for St. Luke's Hospital Market Harborough: Initially inpatient beds will remain the same however once the Home First model has been embedded we may see further changes in the configuration of inpatient beds. For ambulatory services, the hospital site will see the opening of the new building in 2017 and the transfer of existing services currently provided at the District Hospital, which will close. This will provide extended planned care and day-case services as well as Endoscopy, therapy services, outpatient diagnostics and well-being services which will integrate with a GP led evening, weekend and home visiting urgent care service for the people of Harborough District.

What does this mean for Feilding Palmer Hospital: The population of Lutterworth is rapidly growing and there is a need for, increased capacity in primary care along with extended outpatient facilities including diagnostic one-stop services. To deliver services to meet local needs, significant investment into community based outpatient and diagnostic capacity is needed. Subject to capital allocation and public consultation, premises will be developed to provide these services on the site, but not necessarily within the existing hospital building. The inpatient beds will close and provision will be available for local patients within a patients' own home using Home First model the ICS service or where necessary in other local community hospitals. Business case options appraisal and public consultation are required to establish the right solution for services in Lutterworth and the viability of the Feilding Palmer hospital site.

Leicester City sites

What does this mean for Leicester Evington Centre: Inpatient beds will reduce by five beds to move towards the 21 bed ward model and the stroke beds currently provided within the Leicester General Hospital will move to the Evington Centre on the General site (owned by LPT). However once the Home First model has been embedded we may see further reductions in inpatient beds.

What will we be formally consulting on?

The following service configuration proposals form the main part of our formal public consultations topics.

Element of services reconfiguration	Would proposed changes if enacted following public consultation close a hospital
The proposal is to move from three acute sites to two (Leicester Royal Infirmary and Glenfield) to ensure that going forward services are clinically sustainable and provided from excellent facilities	Partly. Most acute clinical services will be moved from the General site but part of the site will house the Leicester Diabetes Centre and be home to other community based health and social care services
The proposal is to consolidate maternity services onto the Royal Infirmary site with the option to retain a midwife led birthing unit at the General Hospital	Yes. The midwife led birthing until at St. Marys Hospital Melton Mowbrary will close
The proposed removal of inpatient services from Rutland Memorial Hospital in Oakham.	No. planned care outpatient, therapy services, outpatient diagnostics and well-being services which will integrate with an evening, weekend and home visiting urgent care service for the people of Rutland.
The proposed removal of inpatient services from Feillding Palmer hospital in Lutterworth	Subject to public consultation on service redesign and capital to develop primary care premises to increase capacity for General Practice, incorporate outpatient, services diagnostics and integrated community teams. The hospital building may not be viable and may close
The proposed removal of outpatient services from Feilding Palmer hospital in Lutterworth	Subject to public consultation on service redesign and capital to develop primary care premises to increase capacity for General Practice, incorporate outpatient, services diagnostics and integrated community teams. The hospital building may not be viable and may close
Proposed changes to the provision of services for Hinckley and Bosworth	Yes. Hinckley and District hospital would close

Strand 3 Redesign Pathways to deliver improved outcomes for patients and deliver core access and quality standards

This section describes the intervention we will take to ensure that we deliver improved outcomes, access and quality standards for our patients. Much of this work has already started through our Better Care Together Programme which has been working to improve a range of pathways.

Prevention

Prevention is a key part of Better Care Together. Many factors which drive longer-term demand for social care and secondary care are preventable or could be managed more effectively. Prevention of illness may help people stay working, live independently, or continue caring for loved ones. This will help the health and social care economy to a sustainable position and support the wider economy of LLR. However this is fundamentally about helping people improve their quality of life.

To support the STP prevention work a joint piece of work has been undertaken across the public health teams within LLR to identify the key issues that need to be addressed within the delivery of the various workstreams. These are detailed below:

The prevention agenda is also focused on effective prevention interventions in the short to medium term which impact on lifestyle and behavioural change in risk groups and on reducing the risk of illness and death in people with established disease or risk factors.

Concrete actions

- **Wider determinants of health:** Create an environment that supports community health and builds health into the local area, making healthy behaviour the norm, working with planning, housing, air quality and transport to maximise health benefit and which in the long term will have an impact on mortality.
- **Make better use of risk profiling**: To target communities and places with the poorest health, developing our capability to use real-time data systems to better understand health need and to monitor and evaluate the impact of changes to services on service usage and associated costs.
- **Detecting early:** Programmes to support General Practice in identifying and recording actual prevalence and supporting patients through better management of Long Term Conditions. Early detection programmes and preventative public health strategies and programmes

working closely with patient-led groups, self-help groups and community and voluntary organisations.

- **Primary prevention reducing incidence of disease before it occurs:** Tackling unhealthy behaviours through effective communication with the public, building on approaches such as PHE's Sugar Swap campaign, Dry January and "one You", alongside programmes to reduce alcohol consumption, obesity and support the availability of smoking cessations in acute and well as community settings, and the availability of advice and support through lifestyle hubs. Develop asset-based approaches to working with local communities, maximising their capabilities and resources to enhance health and well-being, improving their networks and resilience and developing social prescribing. Ensure that Making Every Contract Count is maximised.
- **Secondary prevention reducing the impact of disease:** Extend what we know works including better chronic disease self-management, care management to support people with long-term conditions such as AF and hypertension, improved day to day management of patients with complex needs through the development of integrated placed based teams, early disease identification through programmes such as NHS Health Checks co-ordinated with lifestyle services, and the Diabetes Prevention and Structured Education Programme maximising numbers of patients on the schemes.
- **Workforce health:** Develop workforce capability by implementing new approaches to workplace health, maximising the crucial role that staff at all levels play in promoting health and well-being.

How will these interventions close the gaps identified

Gaps	Widerdetermin antsofhealth	Make betterusofriskpr ofiling	Detecting early	Primarypr evention	Secondaryp revention	Workfor cehealth
Reducing the variation in life expectancy						
Reducing the variation in health outcomes						
Reduce premature mortality						
Improve early detection of cancers						
Chronic disease management to prevention						

What our Prevention programme means for local people

The focus on prevention will lead to a wide range of positive health outcomes for local people:

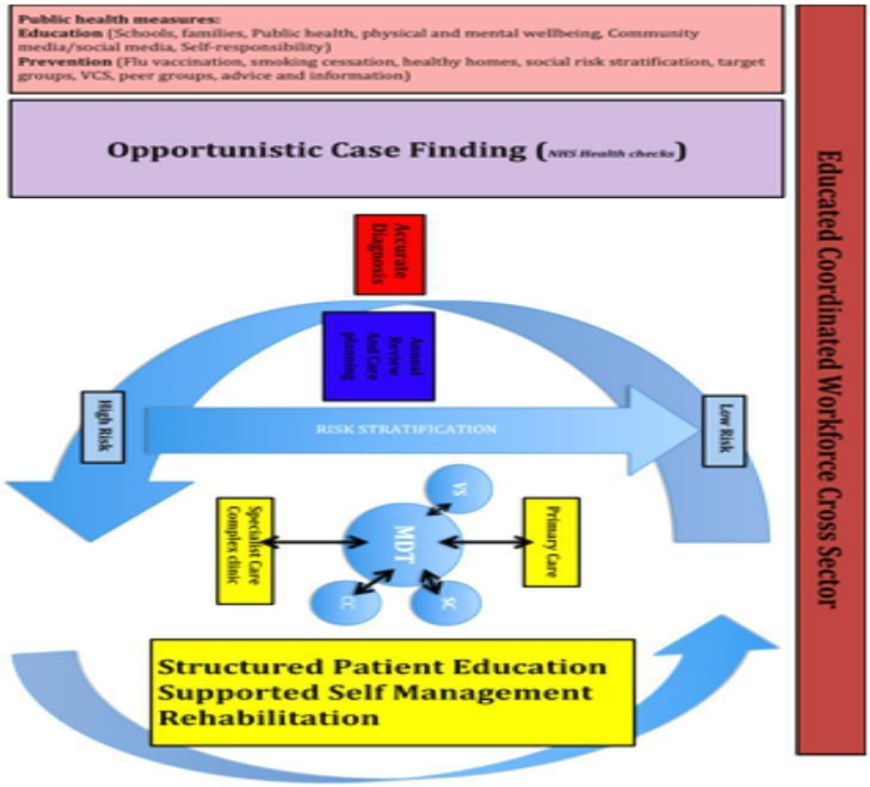
- Improved lifestyle though the reduction in smoking; alcohol; obesity and increases in physical activity will led to less heart disease, lung problems, diabetes and cancer.
- People will have more confidence to manage their own health.
- Less people will develop complex conditions.
- Reducing the likelihood of people with complex conditions going to hospital because of their condition.
- Creating an equal standard of care for all, with less variation in the quality experienced by advantaged and disadvantaged groups.

Long Term Conditions

Current model of care for most long-term conditions are reactive, episodic and fragmented. The result is a hospital and consultant centric service. This does not provide holistic, high quality, cost effective care, nor is it economically sustainable. People with long-term conditions contribute significantly to the pressures on emergency care. Prevalence rates are currently below those expected for example for CKD the actual prevalence rate for Leicester City is 2.77 compared to 5; Atrial Fibrillation in West Leicestershire actual is 1.73 compared to expected of 2.51; and COPD in East Leicestershire and Rutland actual is 1.9 compared to expected of 3.1.

Our vision for long term conditions is person centred, integrated care utilising as its foundation the methodology of the Chronic Care Model;

- Proactive case finding
- Stratification of severity and complexity
- Circular pathways encompassing annual review
- Shared care planning
- End-to- end whole disease pathways
- Cross Cutting and prevention activity
- Learning from patients and carers



Concrete actions

- **Prevent:** in partnership with Local Authorities and Public Health we will scale up a proactive approach to Health Promotion and primary secondary and tertiary ill-health prevention. This will include the implementation of the National Diabetes Prevention Programme.
- **Avoid:** enhance our community-based treatment model and focus on patients with a history of frequent hospital use where same day specialist input and specialised diagnostics are required. We plan to see more patients on an ambulatory basis, involving and supporting

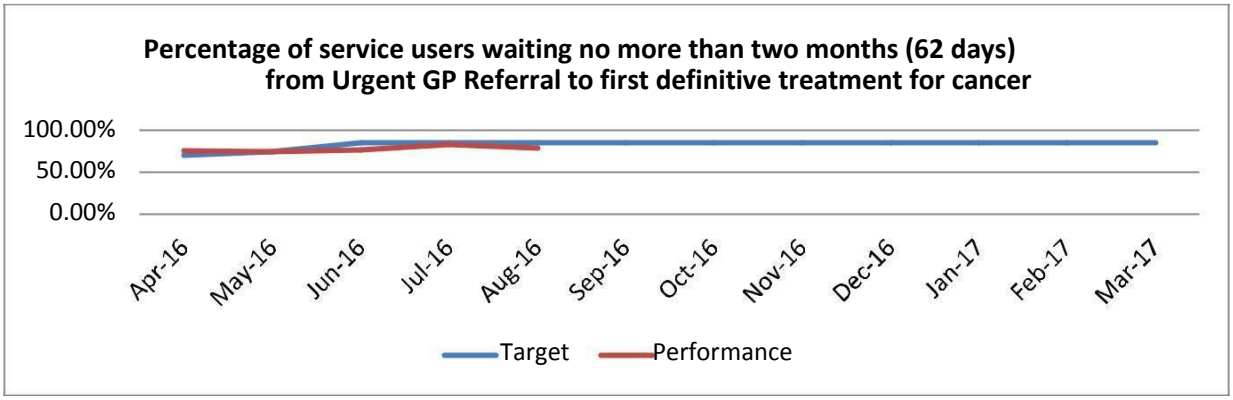
them through education, peer support, health coaching and development of care plans. This will include development of an integrated cardiorespiratory community service, timely specialist interventions through integrated teams from acute and community services. The expansion of the Rapid Access Heart Failure Clinic, Rapid Access Atrial Fibrillation, breathlessness clinic and part of the crisis response management, a low risk ambulatory service at CDU.

- **Reduce:** when exacerbation of long term condition does occur resulting in acute admission, it is our intention to keep the period spent in hospital for as short a time as possible through home crisis support and reablement. This will include the integration of cardiology and respiratory services and the development of an integrated LLR community rehabilitation service for stroke and neurology.

Cancer

Our work on Cancer also forms part of the Better Care Together Long Term Conditions work-stream. Cancer outcomes vary across Leicester, Leicestershire and Rutland. Of the three CCGs Leicester City has the worst outcomes and East Leicestershire and Rutland have the best. All three CCGs have poorer performance in some areas of cancer outcomes compared to the England or Strategic Clinical Network rates. Our one-year survival rates range from 70% in East Leicestershire and Rutland to 66% in Leicester City with a requirement to achieve 75% by 2020. Diagnosing cancer early not only saves lives but limits treatment costs. When ovarian cancer is detected at Stage 1 the five year survival rate is nine in ten with treatment costs of £5,300. However if detected at Stage 4 the five year is one in ten with treatment costs of £15,100. By 2030 LLR will have 50,200 people who are survivors of cancer.

Meeting the NHS Constitutional Cancer standards has been challenging and we have a Recovery Action Plan that will deliver compliance with all standards by March 2017. This action plan will be signed off by our Cancer Board shortly. This will support both the improvements required from acute providers alongside the understanding from the commissioners around where the biggest impact can be made by each tumour site.



We are developing solutions that will not only meet the NHS Constitutional Standards but will also prevent and detect more cancers early and support patients through treatment and into survivorship. We are implementing the Achieving World Class Cancer Outcomes Strategy 2015/20.

Concrete actions

- **Deliver the Constitutional Standard Recovery Action Plan:** to ensure compliance by March 2017.

- **Prevention:** develop and continue to run programmes to prevent and early detect cancers and reduce the risk factors such as smoking.
- **Improve the early detection of cancers:** we will do this through a programme of prevention and early detection, raising the profile of symptoms, improving pathways and access to diagnostics.
- **Develop a survivorship and health recovery offer:** to support patients following diagnosis and treatment including the provision of treatment summaries, health and wellbeing events and cancer care reviews.
- **Review and redesign pathways:** to meet the 2020 requirement that all patients should have access to high quality services working with our local Cancer Alliance.
- **Ensure sufficient capacity** to meet the 2020 standard of 95% of people with a suspected cancer should receive a definitive diagnosis or otherwise within four weeks of referral.

Mental Health

Mental illness is the single largest cause of disability in the UK with one in four people suffering from a mental health problem each year. Our objective is to reflect the Five Year Forward View putting mental health on par with physical health and close the health inequalities gap between people with mental health problems and the population as a whole. We will create an all age response to address the needs of younger, 'working age' and older people.

We will also work to achieve specific planning guidance to maintain mental health access standards, eliminate out of area placements and reduce the incidence of suicide.

Concrete actions

- **Widen choice and effectiveness in crisis response and reduce demand for beds:** Remodel Community Mental Health Teams, review Psychiatric Intensive Care provision, and strengthen; IAPT, Liaison Psychiatry, Perinatal and Eating Disorder services and develop NICE compliant services for First Episodes in Psychosis and Personality Disorder.
- **Increase clinical efficiency and partnership processes**: to create alternatives to acute admission and enable flow through acute hospital beds, including care management, access and support to mainstream and potentially bespoke accommodation.
- **Reduce suicide and increase resilience and promote recovery and independence:** to enable people to manage their health more effectively we will develop awareness and support skills in the population and develop recovery networks, social prescribing and workplace health.
- **Meet rehabilitation needs locally**: we will develop a local integrated offer enabling fewer placements out of area and by conducting rigorous reviews so that people have appropriate care packages closer to home at reduced cost, potentially using this redirected investments to build local infrastructure.

Learning Disabilities

In line with national guidance on Transforming Care, we have a comprehensive plan to transform care for people with learning disabilities, including implementing enhanced community provision, with a corresponding reduction in inpatient capacity, and undertaking our care and treatment reviews. By 2018/19, our aim is to produce and deliver responsible, high quality, safe learning disability services and support that maximise independence, offer choice, are person-centred, good value, and meet the needs and aspirations of individuals and their family carers.

Concrete actions

- **Provide proactive, preventive care**, with better identification of people at risk, and early intervention. We will empower people by expanding personal health budgets and through independent advocacy and a greater choice in housing.
- **Provide specialist multi-disciplinary support** in the community including intensive support when necessary to avoid admission to mental health inpatient settings through the provision of a refocused and enhanced Learning Disability Outreach Team which will reduce the need for inpatient beds.
- **Improve health and wellbeing** of people with Learning Disability and their family carer(s) through reviewing short break provision and ensuring engagement with preventative health initiatives.

Children, maternity and neonates

Our focus is on improving outcomes in maternity, children's emotional health and wellbeing, young people and family services. This involves a range of organisations working together efficiently to improve productivity across universal, targeted and specialist services to improve outcomes for children and young people.

Concrete actions

- **Continue to improve the quality of maternity and neonatal services:** improved access and outcomes for women and their babies based on the principles within Better Births including the formation of a Maternity Network and the development to of integrated pathways between primary and secondary care to provide continuity of care. In addition, and subject to consultation, all obstetric-led inpatient maternity services will be delivered from one site, and options on the provision of midwifery led units will also be consulted on. See Service Reconfiguration Section. Work will be undertaken to further consolidate and develop the neonatal service to meet the responsibilities of being the lead centre for the Central Newborn Network.
- **Delivery of Future in Mind:** our transformational plan to improve the mental health and wellbeing of children and young people focuses on improving resilience; enhancing early support; improving access to the specialist CAMHS service; enhancing the community eating disorder service; developing a children's crisis and home treatment service and developing the workforce.
- **Care in the right place at the right time:** the population of children and young people with general and complex health needs that require clinical intervention is increasing. Work is underway to review The Children Hospital Model to meet the increasing demand, remodelling work will consider where services will be based; increasing the admission age to 18 and 365 days for those who have a complex condition and Special Educational Need; review pathways to consider the best environment for delivery; and deliver the Children's Emergency Care Pathway and the Single Front Door to ensure robust streaming and assessment and delivery of clear pathways for ambulatory care.
- **SEND:** review therapy service for young people aged 16-18 years old to ensure young people transitioning to adult services have access to the appropriate provision; and ensure that personal health budgets are offered to children and young people with Continuing Healthcare Needs.

Continuing Health Care and Personalisation

Leicester, Leicestershire and Rutland has benchmarked in the lower quartiles for Continuing Health Care (CHC), with both numbers and costs of packages being high. Over the last year we have done a considerable amount of work to improve this position but more needs to be done. We also acknowledge that there needs to be a shift in the model to much more personalisation and away from CHC to Personal Health Budgets and Integrated Personal Commissioning. Not only will this give patients better control and choice over their care but it will also support the delivery of a number of the BCT work-streams where tailored care is part of the solution.

Concrete actions

- **Continuing Health Care:** revise, consult and implement new settings of care policy; improve discharge processes so that assessments are completed out of hospital and review high cost placements.
- **Personal Health Budgets:** deliver a minimum of one Personal Health budget per 1,000 of the population. This equates to one thousand across LLR. We are planning to move to an offer that is based on a PHB being the default rather than an option.

Specialised Commissioning

Midlands and East Regional Specialised Commissioning serves a total population of 17m and has a yearly budget of £3.7b, there are 72 trusts and 61 CCGs in the area. As with all sectors of health care specialised commissioning has a range of challenges including growth in demand and cost, growing population with chronic disease, ageing population, and new technologies. There is a predicated funding gap nationally of £0.9b by 2019/20. The split in commissioning responsibilities between NHS England and CCGs can mean fragmentation of the patient pathway and misalignment of incentives, particularly a lack of focus towards prevention. Improving this will require collaboration at a local level and more joined up innovative commissioning across pathways focused on value.

Concrete actions

- Work with the local Specialised Commissioning Team to identify priorities for collaborative commissioning including the expectation within the Commissioning Intentions for 2017/18 and 2018/19 for Prescribed Specialised Service to have collaborative commissioning arrangements covering at least one of the priority service areas (Cancer, Mental Health and Learning Disabilities).
- Explore how collaborative commissioning can improve outcomes and value across the whole pathway for the services described above.
- Work with the local team to identify services that could potentially benefit from being commissioned on a STP footprint.
- Learn from other areas about what works.

Strand 4 Operational Efficiencies

Ensuring we make best use of our resources is key to delivering financial sustainability across the system by 2020/21. Many of our plans set out how we can redesign services and reconfigure our acute and community hospitals to make best use of resources. In this part of our STP we describe how we will improve and back office functions to drive the efficiency agenda further forward.

The Carter Review into the productivity of English non-specialist acute hospitals found that there is significant unwarranted variation across all main resource areas. UHL has plans to implement the recommendations and LPT, although not an acute trust is using the findings as a foundation for its productivity plans.

Provider CIP

Providers have developed plans that are based on benchmarking, analytics and opportunities from national best practice such as Getting It Right First Time, Carter Review and Digital First schemes.

Concrete actions

Beds: For UHL the beds cross-cutting work stream targets the effective and efficient use of the Trusts bed stock. This workstream builds on a number of existing best practice improvement projects on efficient flow and discharge process including the SAFER bundle, integrated and streamlined discharge processes and improved sign-posting. Readmission improvement projects developed throughout 2016/17 will continue into 2017/18 delivering further reductions in the demand on inpatient bed capacity. The programme is also likely to work with community beds to reduce the overall composite LOS across LLR. A particular focus will be on reducing unnecessary variation within the way different wards and their teams practice.

In addition to schemes that are active in 2016/17 additional projects targeting Ambulatory Emergency Medical patients and Same Day Surgical discharge rates will also contribute to reduced demand on inpatient acute wards.

Quantification of the level of improvement has been produced using analytical information from recent (up to Q1 16/17) length of stay datasets. This data has been benchmarked against relevant peers and where the Trust has longer length of stay the opportunity to improve to the upper quartile has been used.

For LPT redesign of clinical services will also result in reduced length of stays.

Theatres: The theatres workstream incorporates efficiencies across all theatres within UHL. Some of the active projects from 2016/17 will continue to deliver increased benefits, such as the improvements in scheduling, utilising best practice tools from NHSi (IMAS) and improved control and escalation systems to reduce wasted time in theatres. A particular focus will be on reducing unnecessary variation within the way different Theatres and their teams practice.

In addition to these projects there will be additional improvements from developments in Day Case Surgery and actions stemming from the Getting It Right First Time Review. These look to improve multiple facets of theatre productivity both utilisation, but also important elements of non-pay expenditure.

Quantification of the level of improvement has been produced based on increase in utilisation of theatres. Estimated 50% achievement of this target level of productivity is projected for 2017/18 with the remainder in 2018/19.

Outpatients: The Outpatients workstream incorporates a UHL wide scheme to improve booking processes that commenced in 2016/17. This will continue into 2017/18 alongside additional schemes on the reduction in conventional face to face follow-up appointments. All elements of the outpatient work stream will overlap with technological developments and reference back to the achievements described in the Digital First strategy as well as UHL's own IM&T strategy. As within the other work streams there will be a significant focus on reducing variation by ensuring the standardisation of clinic templates across the specialities.

Quantification of these large schemes of work have been derived from benchmarking and analytics that moves booking efficiency to 95% and achieving the peer median on all outpatient specialties for New: Follow-up ratio. The full opportunity for this is split across the two years.

Non-pay and Procurement Target: Centrally and CMG led procurement projects will include the development of a category management strategy, as well as more transactional improvements in non-pay cost reduction. This will also incorporate national programmes focussing on reducing price per unit for common consumables, most notably working closely on the Carter procurement standards.

Estates: For UHL **i**mprovements in estate management and upkeep, together with rationalisation and procurement schemes will be delivered across 2017/18 and 2018/19. These schemes will interrelate with the Beds, Theatre and Outpatient workstreams as each area delivers benefits. The Trust has a well-developed site reconfiguration programme which is where most of the financial strategy exists and delivers Carter benchmarks for clinical and non-clinical estates use. A further major area within Estates is the delivery of energy efficient estate.

LPT will continue to implement their 5 year estate strategy which will see rationalisation of the estate using technology to increase productivity and reducing the reliance on physical premises and community hospital reconfiguration.

Corporate and Back Office: Going further than what is suggested within the Carter review, the corporate and back office schemes will deliver improvements in cost where duplication and waste occur, rationalising the total resource required across the two years. This programme will re-examine and redefine the role of corporate and back office functions, leveraging better use of technology to support a whole new model. Some of this model is likely to lead to significant collaboration within partners across LLR and potentially beyond.

CMG led: Smaller grouped improvement schemes delivered in the CMGs will be delivered as part of day to day management. These schemes although smaller in size are greater in number and vary in nature, therefore are captured as one overall work stream.

Workforce: For UHL workforce improvements contained in other cross cutting streams such as Beds, Theatres, Outpatients, are described as part of those programmes. However, in line with the Carter programme, more centralised control systems review, role redesign and rota management projects will also deliver benefits across the Trust. Identification of these areas to improve has come from NHSi agency workforce review tools, as well as utilising HRD network and other national exemplar practice. Benefits will largely manifest themselves in the form of more effective, efficient and greater value for money clinical staff and reduce the total capacity of staffing required.

For LPT focus will the on greater use of bank staff to reduce spend on agency staff.

Across LLR we will be considering the development of a local NHS Bank, across both providers, to collectively reduce spend on agency staff.

Medicine Optimisation

Over the last three years the CCGs have implemented a range of evidence based prescribing measures. This has included medicine switches, reducing wastage and implementing guidance. Work in these areas will continue over the life of the STP. However we recognise that more could be done to improve medicine optimisation working collaboratively with our provider partners for example nationally 6.5% of emergency admissions and re-admissions are caused by avoidable adverse reactions to medicines; there is over £150m a year of avoidable medicines wastage and only 16% of patients taken their medicines as prescribed.

Concrete actions

- Consider the move to an LLR wide prescribing team and greater collaboration working across organisations.
- Better manage the high cost drug budget to support the growth in drugs with NICE Technical appraisals.
- Ensure that the medicine impact of both "left shift" and increased prevention are understood and accounted for.
- Maximise the use of the pharmacy workforce to support clinical services and staff and also increase the use of non-medical prescribers.
- Work together to tackle waste across the system.
- Use real time data analysis tools to improve quality of outcomes for patients and cost efficiency.
- Support patients to take an active role in medicines taking to increase compliance
- Promotion of the self-care agenda to empower patients to manage themselves more effectively.
- Maximise the use of prescribing analysis support tools to reduce polypharmacy which leads to preventable hospital admissions.
- Consider whether cost effective alternatives to medicines could be provided, for example coping strategies for some patients suffering pain.

Back Office Efficiencies

Partners have committed to review back office functions to consider whether they can be carried out more effectively by doing so collectively for example through a shared business service. The aim is by 2018 so that no more than 7% of income will be spent on back office functions with this reducing to 6% by 2020. A Senior Responsible Officer has been appointed to take this work forward and the back office efficiencies programme is part of the formal STP governance structure. The agreed scope and project support will be completed by the end of November 2016 with a target date of end of January 2017 for the completed Outline Business Case and for phased implementation from June 2017 onwards.

Concrete actions

- The first stage of this work involving Information Services, Procurement and Finance functions will release £2million across the system.
- Further financial analysis is being undertaken across additional areas of possible collaboration including Information Services, IM&T and Human Resources.
- Over the longer term a review is planned to assess the potential for integration across organisations to reduce duplication in planning, contracting and strategy.

- Further areas for exploitation have identified. These are complaints and legal governance, business planning, quality assurance, health and safety, safeguarding, risk management and clinical governance.
- Consider the development of an LLR Shared Business Service Unit to incorporate the above services and more if it makes financial sense.
- Improvement in productivity by aligning processes and templates used across the system will be explored for potential to create synergies between co-located and collaborating teams, through increased standardisation, to be realised as standardisation across organisations increases.

Section 9 of our Local Digital Roadmap sets out actions in each year to deliver the above.

Strand 5 Enablers

This section describes the key enablers that will support the delivery of our STP.

Estate

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

The impact of our plans on community hospitals is described earlier. However in addition Leicestershire Partnership Trust has an Estates Strategy than aims to consolidate and rationalise all of their estate over the next five years. We also recognise that more can be done to better utilise the public sector estate across LLR and we will work with our partners to ensure we get more efficiency.

Concrete actions

- Implement, following formal consultation, the reconfiguration plans we have for both acute and community estate
- Improve utilisation of the estate using the Carter principles to ensure we are getting best value
- Identify opportunities for co-location, rationalisation and consolidation with the wider public sector local authorities, ambulance and fire services.

Information Management and Technology

To date the LLR community has focused on improving IM&T in four areas – sharing care records, population data analysis, system wide efficiencies which improve integrated working; and supporting BCT workstreams. Our digital road map sets out our vision for the future both for IM&T that supports the delivery of care and using technology to support patients.

Concrete actions

- Shared access to paperless patient records at all clinical interfaces across LLR to improve patient outcomes and support integrated working, alongside removing the use of paper.
- Implementation of a comprehensive Electronic Patient Record within UHL to improve quality and efficiency and facilitate sharing of records across boundaries.
- Encourage patient empowerment to drive up the use of technology to support greater self-care, improvements in health and wellbeing and access to services, alongside developing alternatives to face to face consultations.
- Support independence of patients through the use of technologies such as telehealth and assistive technology.
- Use real-time and historic data to support predictive modelling and improvements in clinical service delivery at the point off care and to support population health analysis and management for effective commissioning.

In 2016/17 to support the delivery of DRM we have made and been successful in making applications to the Estates and Technology Transformation Fund for clinical system migration and

sharing of care plans across the health sector in LLR. Our priorities for 2017/18 include GP system to GP system interoperability, MIG V2, Mobile DOS and SCR in social care.

Health and social care joint commissioning and integration

Over the last few years there has been increasing joint working between local authorities and CCG's including joint work on our Better Care Fund programmes. Increasingly this work is progressing into joint commissioning with both the city and county areas jointly commissioning domiciliary care and exploring joint commissioning work in relation to residential care. We see that there is much more opportunity in the future to develop our joint commissioning and integration and these are some of the areas we are going to explore:

- Joint commissioning of residential care placements
- Learning Disabilities, including the implementation of the Transformation Plan
- Mental Health, including mental health recovery and resilience hubs and the implementation of the CAMHS Transformation Plan
- Voluntary sector contracts
- Integrated health and care personal budgets including integrated personal commissioning
- Integrated commissioning for prevention
- Development of placed based integrated teams supported by integrated points of access
- Integration through digital for example the electronic summary care record, interoperability programmes and using shared data.

This agenda is not about moving to a combined authority or single LLR health and social care organisation. Some of the above will be done at a local level between the respective CCGs and local authorities but where it makes sense to do things at an LLR level we will do.

Workforce

Delivery of our STP will require strong system leadership, changes in culture and significant changes to workforce capacity and capability.

In summary, the STP will have the following impacts on workforce:

- Shift of activity
    - Increasing the capacity within primary and community/social care before capacity can be released in acute settings.
    - The projected increase in primary care workforce is around 10% by 2020/21 with a reduction in secondary provider workforce of around 5% over the same period. The overall workforce numbers remain stable against a 2015-16 baseline.
- Change of location – more care provided in patient's home/locality
    - More autonomy for staff
    - Training needs to take into account exposure to different care settings
- Roles and skills mix
    - Potential of new roles and career paths
    - Mitigation of recruitment challenges
- Re-skilling, including for new technology
- Working across organisational boundaries

The above impacts raise a number of challenges for the system to respond to. A summary of workforce challenges and associated actions, which form the basis of the workforce strategy is included below:

Challenge	Approach
Ensuring the future workforce supply, aligned to new models of care	• Integration of BCT workforce enabling group and establishment of LWAB • Developing a system-wide approach to attraction and retention,

Ensuring the system can make the capacity shifts required	• Workforce planning – developing a view of the capacity and capability changes required
	  ○ Establishing a clear baseline
	  ○ Strategic workforce modelling and capacity planning
	  ○ Functional mapping and workforce profiling
	• Developing the ability to move people around the system
	• Developing the Primary Care workforce

Ensuring staff have the right skills and capabilities to perform in the new system	• Developing the curriculum to support both short and long-term skills development and future workforce supply

Ensuring effective management of change and development of the 'system' culture	• Developing a mechanism to provide ongoing support to clinical work streams during implementation
	• Developing Culture
	  ○ Setting vision and direction
	  ○ Staff engagement and change management
	  ○ System leadership capacity
	  ○ System Development and the LLR way

The workforce enabling work stream has established a programme of work to support workforce transformation. This is detailed in the LLR workforce strategy and plan, with the working structure summarized below.

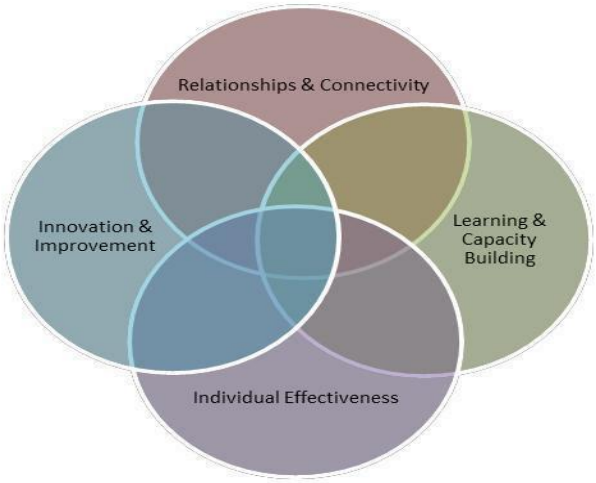
200 clinical and care leaders came together in April 2016 to further consider the potential of new models of care and the support required to deliver them. The outputs of that session started to describe the culture that LLR can begin to work towards.

The 'hard' and 'soft' elements of culture are interdependent and work together to form 'how we do things around here' – this is the totality of the potential 'LLR way'

Some of these elements are already in progress and informed our STP and new governance arrangements. The Clinical Leadership Group has worked with the LLR Organisational Development group to consider an approach to facilitating progress.

In September 2016, clinicians and care leads again met to consider 'Integrated Care across LLR'

In particular they considered aspects of leadership in a system context and validated the below framework for systems leadership development. This framework will underpin a programme of development to be delivered system-wide.



An overall approach to development and culture change was approved by system leaders in November. The approach builds on the outputs from engagement with staff, creating an overall framework for development of the 'LLR Way.'

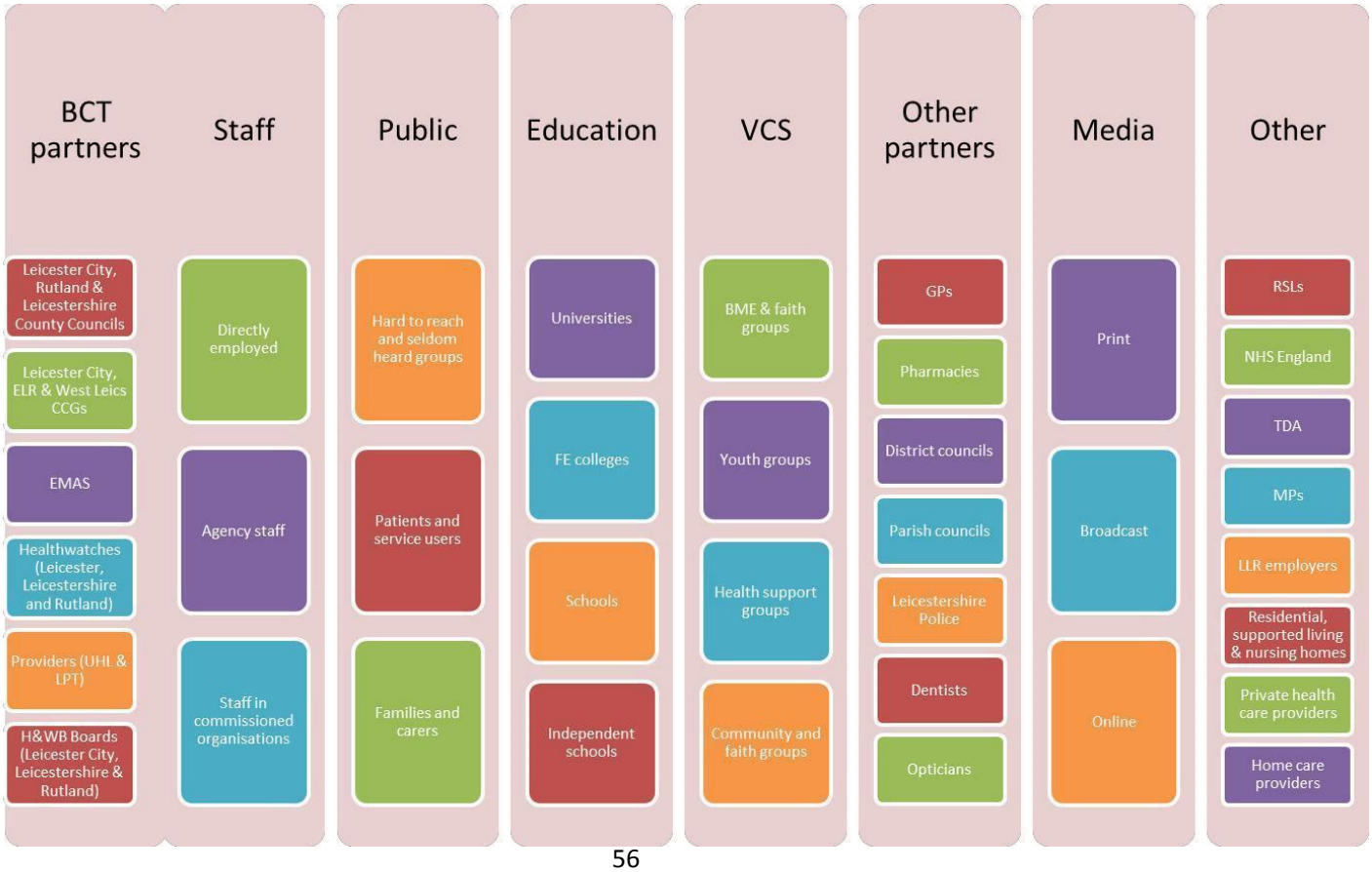
Engagement

Engagement has been integral to the STP process and the associated Better Care Together programme. A wide variety of stakeholders have been involved ranging from statutory bodies, elected officials, local authorities, the voluntary and community sector, right through to patient and public groups and clinicians within the health economy.

Engagement has ensured that our plans have been honed and developed to meet the needs of our community and stakeholders but have also acted as a sounding board to shape key plans.

During spring 2015, a large-scale public campaign was launched across Leicester, Leicestershire and Rutland which explained the current position of health and social care services in the area, and to ensure that the priorities of the local communities and other stakeholders, matched the direction of travel of the Better Care Together programme. The document took the format of both a written document and an online version, to maximise the number of people able to contribute their views. During the campaign over 1000 responses were received, and a population reach of over 375,000 was achieved through various engagement techniques. The data was comprehensively analysed by Arden & GEM CSU, and its outputs were fed into workstreams and the programme's governance structure to ensure the outcomes were contributed into the wider planning of the programme.

In total, a substantial amount of wider engagement has taken place in a number of formats at both work-stream and at a wider Better Care Together programme level, all of which has been recorded, comprehensively analysed and then fed into the programme, with monitoring in place to ensure the engagement themes are fully reflected in the programme plans. To summarise the engagement undertaken as part of BCT, a stakeholder engagement map has been produced, a summary of which is below.



The overall plan for engagement and communications across the health and social care system is overseen by a dedicated Communications and Engagement group, made of the communications and engagement leads for all of the partner organisations. This ensured a joined up and sustained approach to engagement which could draw upon lessons learned from previous large-scale engagement campaigns. To summarise, our engagement included:

- Summary system-wide plans already shared with partner organisation Boards.
- Commissioning of voluntary organisations to engage with each of the protected characteristics.
- Patient and Public Involvement (PPI) representatives via their monthly meeting and the wider patient and public involvement network, and the Leicester Mercury newspaper Patients Panel.
- Voluntary, Community and Faith sector networking events and virtual forum.
- Staff engagement events, briefings, protected learning time, and a dedicated staff webpage.
- Briefings for local councillors and MPs.
- Public facing website and associated social media for people to feedback on and interact with.
- Regular updates and briefing at the health and wellbeing boards and HOSC's

This engagement conducted over a sustained 18 month period as part of Better Care Together has since been further built upon as part of the STP planning process. Our engagement on the STP has made use of existing links and relationships across LLR. Specific engagement on specific elements of the STP has continued such as with individual community hospitals, as has overall engagement on the STP.

The STP engagement process has been devised by communications leads across the Leicester, Leicestershire and Rutland (LLR) STP partners and then monitored and discussed by the programmes Patient and Public Involvement group and Partnership Board.

As many of the plans in LLR's STP build on plans within the previous Better Care Together programme, there has been an opportunity for sustained conversations and engagement with key stakeholders as well as the public on key elements of plans such as the future of the 3 acute hospitals in Leicester, reconfiguration of maternity services and elements of the hospital reconfiguration plans. Key stakeholders engaged in plans include NHS boards, CCG governing bodies, Local Authority Health and Wellbeing Boards, councillors, MPs, staff, and the voluntary and community sector.

Once feedback has been received from NHS England on the LLR STP, the document will go to the LLR System Leadership Team in November (a private meeting) and then to extraordinary public board meetings of STP partners at the end of November 2016. At this point the plan will be in the public domain, and will be accompanied by a public facing summary. In order to maintain momentum on engagement and implementation, a provisional consultation date has been planned for early 2017. This timeline will however flex accordingly dependent on the exact dates when feedback is received from NHS England.

Feedback loops and evaluation procedures have also been put in place to ensure that the system is able to capture the feedback from stakeholders on the engagement and incorporate that into

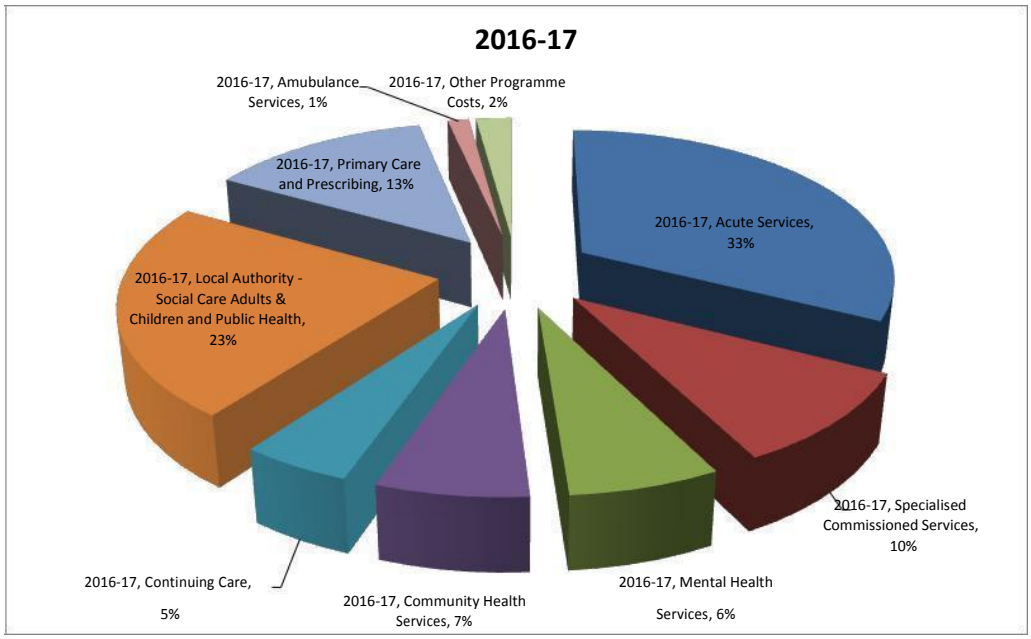
planning, as well as recording all engagement taking place in order to evidence stakeholder involvement and input.

There is a good degree of consensus among the general public (drawing on the results of the large-scale engagement campaign in 2015) that health and adult and children social care services need to evolve to meet the needs of a changing population. Given also that the plans have been discussed and formulated as part of Better Care Together over a number of months or years, there is also a good consensus amongst the partner organisations within the STP. However, Local Authorities are often frustrated at the perceived lack of pace to implement the proposed changes.

Finance

How we spend our money

In 2016-17 LLR will spend £2,420m on health and social care. This is split as follows;



Five year financial gap

All of the health and social care organisations in LLR face financial challenge, as demand and demographic growth for services out-strip the increased resources available year on year.

While there is an expectation in the health sector that the funding available will rise by c. 2% each year, equating to an additional £200m over the time of the plan, predictions for the growth in both cost and demand range from 0.5% in some areas rising to 4.73% in more specialist areas of medicine, year on year.

The social care sector also faces similar challenges with demand in growth matched to a flat or reducing level of funding available to support social care services.

Without developing new ways of working the impact of increased demand creates a financial gap for health and social care over the five year timeframe of this plan of £399.3m

Of this healthcare accounts for £341.6m of the gap, whilst social care gap equals to £57.7m over the same timeframe.

The LLR system has been aware of this continuing demand/resource gap for some years and has developed a number of plans to mitigate this through the local transformation programme, Better Care Together. This plan builds on the earlier Better Care Together plan, which covered the period up to 2018-19. This refresh takes into account the latest information issued regarding the availability of sustainability and transformation funds, and capital availability.

Overall the impact of the growth on the system is primarily in acute and specialised services, this is where the solutions are targeted, and investing in community based services. The table below shows the organisational impacts.

	Do Nothing' Growth	Savings Schemes	Net Planned Growth
UHL	25%	23%	1.92%
LPT	15%	17%	-2.06%
EMAS	19%	11%	8.06%
CCGS	20%	10%	10.32%
Specialised	31%	15%	15.98%
Local Authorities	14%	11%	3.35%

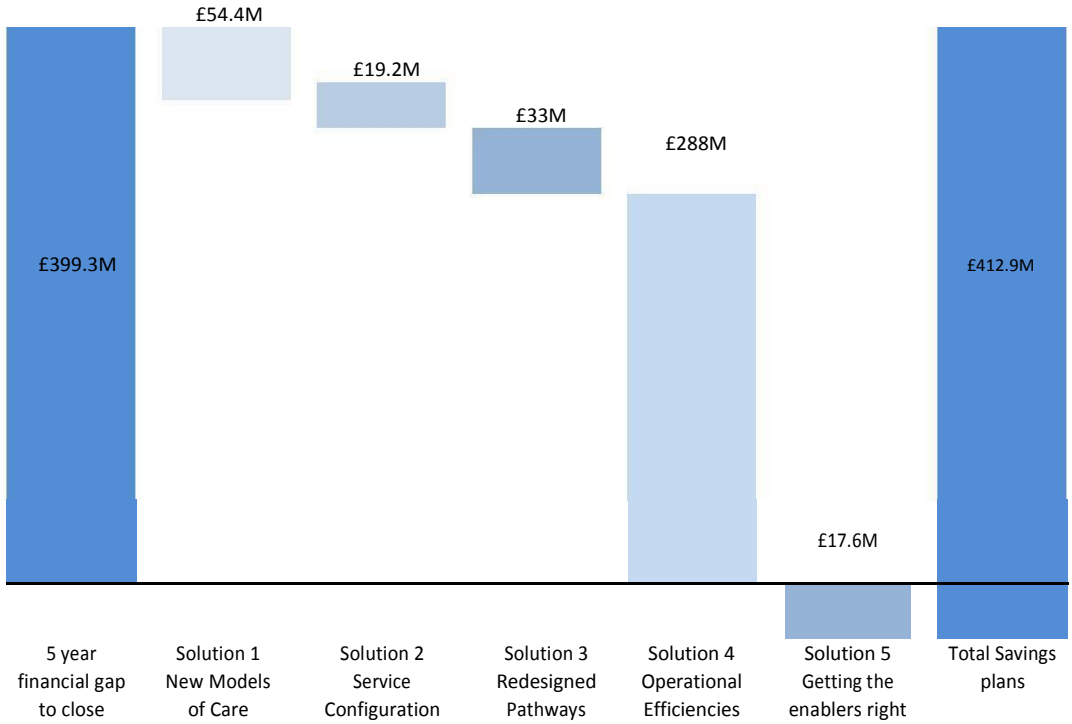
Closing the Gap

Solutions to close the gap are mapped into New Models of Care, Service Configuration, Redesigned Pathways, Operational Efficiencies and Getting the Enablers Right. Savings plans for LLR Local Authorities and for specialised services are included within these solutions.

Schemes for the first two years of the plan are already well developed in both the cost reduction and demand management areas. Those for latter years are agreed in principle; the delivery plans for these will be developed further in the coming months.

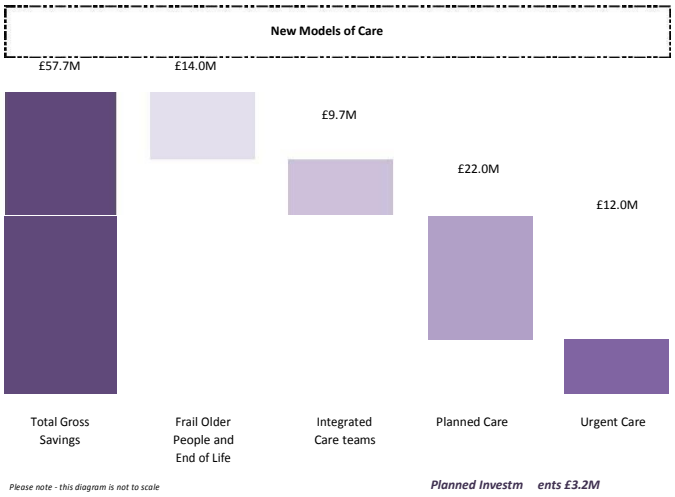
CIP schemes are in place to deliver c. £175m of the required savings. The single largest scheme in LLR is the move from three to two acute sites for UHL. This deals with both quality and workforce issues created by duplicating services over two or more sites. Once the reconfiguration is complete the directly attributable cost saving from this will be around £25.6m each year.

Financial Gap and Savings Plans 2017-2021



In addition to the above solutions the system has assumed net investment of STF funding in 2020-21 of £66M, in order to deliver transformed services. This gives a net gap of £333M saving and net saving of £343M. Currently we have requested additional STF funding in other years as set out in the table under opportunities, challenges and risks and in the finance template submitted.

Strand 1 - New Models of Care Net Savings £54M



Savings in this area are drawn from the following areas;

Integrated place based teams – joining multi-organisation teams from health and social care, eliminating duplicate processes, and expanding the workforce to ensure wrap around care avoids emergency admissions.

Planned Care – targeting best practise new/follow-up ratios and redesigning pathways to ensure appropriate triage of patients, targeting 10% decommissioning.

Urgent Care – Vanguard programme designed to reduce demand in A & E and emergency admissions.

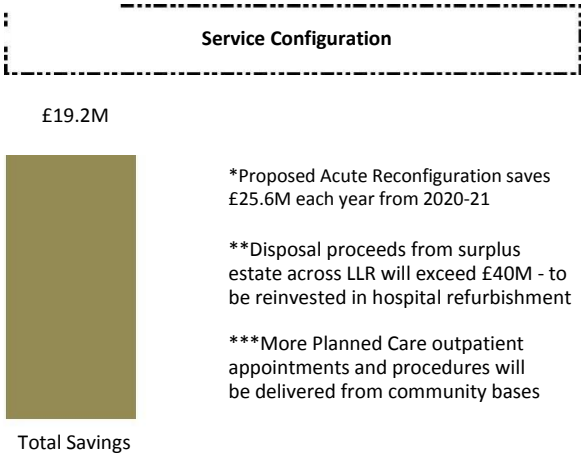
Strand 2 - Service Configuration Net Savings £18.9M

Net savings of £19.2m comprise of the savings made during the configuration, less the additional costs added into the 'as is' running costs.

The acute reconfiguration is expected to deliver gross savings of £25.6M by 2020-21

Community inpatients and planned care provision will account for further gross savings of £8.6M.

This is offset by capital charges in the period 2017-18 to 2021 of £15.1m

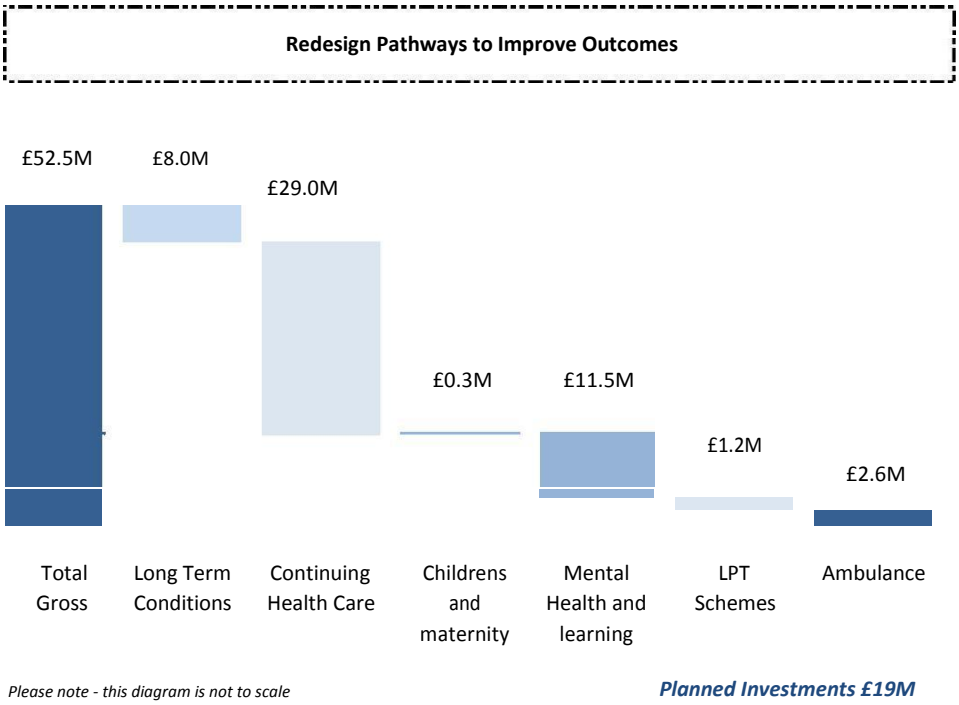


The changes will result in;

- More outpatient appointments and diagnostics will be delivered through a network of community bases, freeing up floor space in acute hospitals
- UHL will provide acute services from two sites
- A single point of access will be created to navigate patients to the right part of the system
- Right size community wards
- Supported by Home First principles and investment in integrated care teams

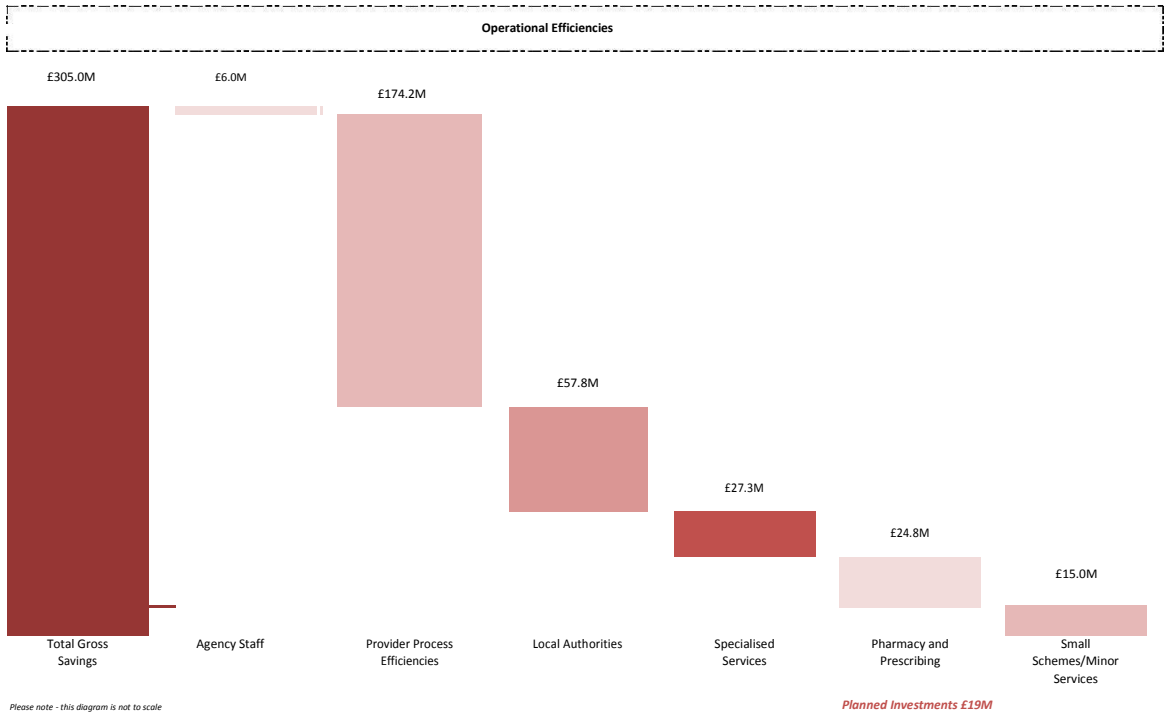
Alongside this staff will be trained to deal with the changing needs of the patients (more multiple long term conditions in an aging population) and able to work flexibly between inpatient and outpatient or patients' homes as the setting for care.

Strand 3 - Redesigned Pathways Net Savings £33M



BCT work streams concentrate on improved health outcomes, particularly for people with long term conditions, Learning Disabilities, and Mental Health Services generating savings for reducing escalation of acute episodes of ill health, saving £38.6M for the period to 2020-21.

Strand 4 - Operational Efficiencies Net Savings £288M



This category covers the efficient use of all the LLR health and social care resources, reducing length of stay, improving theatre productivity, prescribing, etc. This strand also includes;

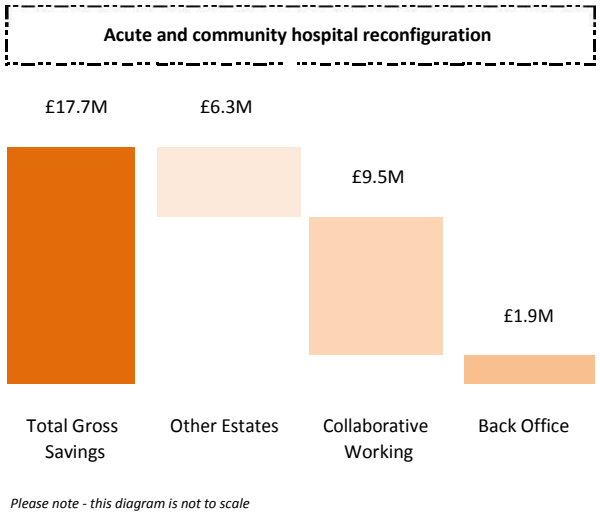
Local authority efficiencies

The Local Authorities have a range of programmes to reduce costs, reviewing commissioning of services, equipment services, applications of technology, and an ambition to regionalise some services across the range of public health and social care services saving £57.8M.

Specialised commissioning savings

Improvement programmes are forecast to deliver a recurrent saving of £27.3M.

Strand 5 – Getting the Enablers right £17.6M



There are a number of key enablers to support the delivery of all of the solutions including joint working, merging both back office functions and some clinical services, aligning workforce, introducing new IM & T solutions and integrating health and social care commissioning. Some investment will be required especially on IM& T solutions and organisational development programmes which will enable the release of £37.7M in savings.

Opportunities, challenges and risks

Sustainability and transformation funding has been made available to the providers for 2017-18 and 2018-19 totalling £23m to support the NHS provider organisations in delivering surplus control totals. For the STPs as a whole a further £1.1 billion has been set aside to support transformation programmes including the delivery of national priorities included in the Five Year Forward View, 7 Day working implementation and Mental Health. The LLR system also has a number of local transformation programmes which will require supporting funding across the 5 year programme to achieve delivery. The table below sets out the recurrent and non-recurrent investment required to deliver all of these priorities:

	17/18		18/19		19/20		20/21	
Investment requirements for transformation	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
	Non Rec	**Rec**	**Non Rec**	**Rec**	**Non Rec**	**Rec**	**Non Rec**	**Rec**
National Priorities								
Seven day services	-	3,500	-	3,500	-	3,500	-	3,500
GP Forward view & extended GP access	-	4,000	-	4,000	-	5,000	-	5,500
Increase Capacity CAMHs and Implementing Access & Waiting Times	-	750	-	750	-	750	-	750
Implementing Recommendations of MH Taskforce	-	500	-	500	-	500	-	500
Cancer Taskforce strategy	500	1,000	500	1,000	-	2,500	-	4,000
National Maternity Review	300	700	300	700	-	1,000	-	1,000
Investment in prevention - Childhood, Obesity, Diabetes Diagnosis and Care	-	1,750	-	2,750	-	3,500	-	4,000
Local Digital Roadmaps and Point of Care Electronic Health Record	2,000	-	350	300	-	400	-	400
Local Priorities								
Planned Care Referral Mangement Hub	200	1,500		1,500		1,500		1,500
Reablement including Social Care support		2,000		2,000		1,500		1,500
Establishment of a joint bank function	500							
Back office efficiency - scoping the options	200							
Community hospital reconfiguration support	250		250					
UEC - Out of Hospital support for reducing demand on Acute services		1,000		1,000		1,000		1,000
System Leadership and Management for Reconfiguration	1,000			1,000		1,000		1,000
Integrated Community Teams (MSCPs)	3,000		4,000		3,000			
Other Investments								41,350
Total	**7,950**	**16,700**	**5,400**	**19,000**	**3,000**	**22,150**	**-**	**66,000**
Total Non Recurrent and Recurrent		**24,650**		**24,400**		**25,150**		**66,000**

Currently the LLR system has an indicative allocation of £66m for transformation funding (some of which will be allocated to the priorities detailed in the table above) to be made available from 2020-21 but without earlier release of these funds there is a risk that some of the solutions will not deliver at the pace needed to achieve transformation and deliver the required savings.

There is a high level of risk of delivery on some of the ambitious plans set out in the solutions, including the implementation of new models of care in a system that continues to see increased demand. Additional demographic and activity growth has been accommodated in the 'do nothing' model in an attempt to mitigate this risk.

Top three financial risks for LLR:

- Funding to develop the capital estate within LLR
- Delivery of a high level of CIP and QIPP programmes to achieve the control total requirements both organisationally and as a system.
- Access to reasonable levels of STF funding in each year of the plan to maximise the chances of success.

LLR Capital Plan

Acute Hospitals Reconfiguration

It is proposed that in the future the acute hospital services in Leicester are delivered from two sites, the Leicester Royal Infirmary and Glenfield Hospital. The table below details the projects required to achieve the reconfiguration plan, with their costs, from 2017-18.

Total Estate Reconfiguration Capital Cost	279,581
Funded by Disposal Proceeds	(28,350)
Net Capital Requirement	**251,231**
ROI	10.20%
Payback Period	11.43 years

Individual project cost and profile

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
LGH					(28,350)	**(28,350)**
Emergency Floor - BAU in STP		0	0	0		0
Reprovision of clinical services	6,600	10,000	10,000	5,000		31,600
Vascular Services	0	0	0	0		0
ICU Service Reconfiguration	12,906	0	0	0		12,906
Planned Ambulatory Care Hub	1,728	2,880	19,001	34,000		57,609
ITU LRI	503	7,000	8,300	0		15,803
Women's services	1,966	3,277	22,288	38,000		65,531
Childrens' Hospital	2,577	11,000	4,000	0		17,577
Theatres LRI	1,058	3,500	6,400	0		10,958
Entrance LRI	0	0	2,000	10,000		12,000
Wards/Beds LRI	500	5,800	7,000	7,500		20,800
Wards/Beds GH	552	5,746	5,500	5,500		17,298
Other reconfiguration projects	1,000	3,000	4,500	9,000		17,500
TOTAL ACUTE HOSPITAL RECONFIGURATION CA	**29,389**	**52,203**	**88,989**	**109,000**	(28,350)	**251,231**

The projects are designed to address clinical and financial sustainability inherent within the current configuration and will, in the areas affected, modernise facilities and make better use of the remaining estate footprint. Each project is independent but related in that they will collectively change the overall way in which some services, particularly inpatient services, will be delivered with the aim to reduce the number of bed days and number of emergency admissions experienced by the patients.

It is clear from the table above there are 2 projects which are responsible for nearly half of the total cost; a Planned Ambulatory Care Hub (PACH), providing outpatient and day case procedures in one purpose built facility and consolidation of the majority of Women's services on to the LRI site.

Key Risks

Increased demand and the lack of availability of capital are the key risks to the acute reconfiguration.

Sources of Funding

Significant capital investment is needed to deliver this change and whilst UHL has planned some investment from internally generated capital, it is not possible to fund all of the required investment in this way and as a result some external funding is required.

All funding solutions available to the Trust have been explored with two preferred main options emerging. Primarily the Trust can seek funding in the form of interim capital support loans from the Department of Health but due to changes in the national availability of capital, the Trust has explored and identified PF2 as a potential suitable alternative for the financing of suitable projects, namely the PACH and Women's Services. The Trust is currently in the process of exploring this in more detail.

Dependencies

A number of the STP programmes are designed to lessen the demand on acute services to complement the reconfiguration. The delivery of these work streams will free up sufficient physical capacity to allow the reconfiguration of services and use of the acute estate.

Community Hospital Inpatient Services and Planned Care Reconfiguration

Currently the community service reconfiguration proposes delivering services from six sites, rather than the current eight sites, however there is further emerging thinking around the future model, the detail of which will be considered over the next few weeks and may result in changes to the proposed model included within this submission. The proposed changes will be subject to public consultation and it is therefore envisaged that the first changes will take place in 2018-19, commencing with the extension of facilities in Market Harborough.

A summary of the schemes are shown below:

Total Estate Reconfiguration Capital Cost	19,950
Disposal Proceeds	(14,000)
Net Capital Requirement	**5,950**
ROI* (Based on investment cost before disposal proceeds)	15.60%
Payback Period (based on investment before disposal proceeds)	6.39 years

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
Lutterworth (LPT)					(3,000)	(3,000)
Melton (NHSPS)			3,850		(7,000)	(3,150)
Market Harborough (NHSPS)		8,600			(4,000)	4,600
Evington Centre (LPT)				7,500		7,500
TOTAL COMMUNITY HOSPITAL RECONFIGURATION CAPIT		**8,600**	**3,850**	**7,500**	(14,000)	**5,950**

2018-19

Market Harborough (£8.6 million) – a proposed refurbishment and extension to create a 21 bed rehab/sub-acute ward to replace the existing Victorian ward and to accommodate the rehabilitation/sub-acute services transferring from Lutterworth Community Hospital, as part of the proposed safety/sustainability reconfiguration of the community hospital wards.

2019-20

Melton Mowbray (£3.8 million) – a proposed extension to allow for a 21 bed rehab/sub-acute ward on the site to accommodate the rehabilitation/sub-acute services transferring from Oakham

Community Hospital, as part of the proposed safety/sustainability reconfiguration of the community hospital wards.

2020-21

Leicester Evington Centre (£7.5 million) – Conversion and/or extension of a mothballed mental health services for older people ward into a 15 bed ward and gym for stroke/neuro rehabilitation to accommodate the services transferring from Leicester General Hospital, as part of the proposed three-to-two acute site reconfiguration.

Key Risks

The key risks to the scheme are the outcome of a public consultation and the availability of capital funding over the planned reconfiguration period.

Sources of Funding

The ownership of the estate described above is varied therefore the discussions with the various landlords will inform the sources of funding for the development. For those sites owned by Leicestershire Partnership Trust financing will be sought from either the Department of Health, or private financing. This may include financing by local authority partners.

Hinckley and District Ambulatory Care and Diagnostics

A review of service provision in Hinckley was undertaken in 2015 to establish the options available to deliver planned care outpatient services in the town. The proposed service would be an extension of the diagnostics available in Hinckley and Bosworth hospital, and an extension of Hinckley Health Centre. The preferred option, requiring statutory public consultation, if supported would see a move to modern planned care facilities in Hinckley, and result in the closure of Hinckley and District hospital.

Total Capital Cost	7,701
Disposal Proceeds	(2,000)
Net Capital Requirement	**5,701**
ROI	4.67%
Payback Period	21.6 years

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
Hinckley & Bosworth Ambulatory Care Refurbishment		4,236				4,236
Hinckley Health Centre Equipment		300				300
Hinckley Health Centre Refurbishment		3,165				3,165
Hinckley and District Hospital Disposal					(2,000)	(2,000)
Hinckley and District		**7,701**	**0**	**0**	**(2,000)**	**5,701**

Key Risks

- Public consultation response leading to difficultly in implementing preferred option (including hospital closure and sale)

- Ability to mobilise in a timely way, due to the complexities of aligning infrastructure changes on three sites, requiring interaction with NHS Property Services and their capacity to undertake required work
- Availability of capital funding across three organisations

Sources of Funding

The source of capital for this project is dependent on the ownership of the asset. It is likely that the request to NHSPS, for Hinckley health centre refurbishment will be cost neutral, as there is an opportunity to dispose of part of the site.

Alternative sources of funding are being sought for the refit of the community hospital to allocate space for planned care. It is likely that the equipment requirement will be NHSE funded.

Oakham and Lutterworth Ambulatory Care and Diagnostics

Total Capital Cost	2,350
Disposal Proceeds	(4,758)
Net Capital Requirement	**(2,408)**
ROI* (Based on investment cost before disposal proceeds)	15.60%
Payback Period (based on investment before disposal proceeds)	6.39 years

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
Lutterworth			1,000			**1,000**
Lutterworth Imaging & Diagnostics Equipment			350			**350**
Oakham disposal (current net book value)					(4,758)	**(4,758)**
Oakham				1,000		**1,000**
Total Capital Investment			**1,350**	**1,000**	**(4,758)**	**(2,408)**

2019-20

Lutterworth (£1.0 million) – Extension of Lutterworth Medical Centre to include an ambulatory clinic rooms to accommodate the services transferring from Lutterworth Community Hospital as part of the proposed safety/sustainability reconfiguration of the community hospital wards.

2020-21

Oakham (£1.0 million) – Conversion of the old ward space at the hospital into ambulatory clinic rooms and team base so that health and social care services elsewhere in the town can be co-located on the site as part of a place-based initiative to have a single health and social care campus in the town. Discussions are currently taking place with Rutland Local Authority regarding purchase of the Oakham site.

Risks

While the capital to refurbish the sites is relatively low, it is dependent on the relocation of inpatient services, which requires £16.3m.

Savings may erode if tariff for outpatients new and follow-up appointments decrease significantly.

Sources of Funding

Alternative sources of funding, including local authority partners, are being explored for the required capital investment.

Dependencies

Capacity becoming available by the reconfiguration of inpatient services in the east of the Leicestershire and Rutland.

Electronic Patient Records

UHL have completed a business case process for the purchase and implementation of an Electronic Patient Record (EPR) system working in partnership with a managed business partner, IBM. The business case is due to commence in 2016/17 and be delivered over 2 phases which will conclude in 2018/19. The funding for 2016/17 investment is not yet confirmed, as a result, the delivery timescales are likely to be delayed consistent with the delay in approval.

As the table above shows the scheme has a payback period of less than 6 years as a result of the way in enables service efficiency and effectiveness.

University Hospitals of Leicester

	£000
Total Capital Cost	28,356
ROI	31.40%
Payback Period	5.81 years

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Total £000
EPR phasing	**26,751**	**1,605**			**28,356**

Funding Source

UHL have organised a finance lease arrangement with the supplier as a funding mechanism for the approved business case which will alleviate the need for additional cash funding, however this will require Department of Health Capital Resource Limit allocation. It has therefore become subject to significant delay as a result of capital funding shortages.

Key Risks

The EPR business case is independent of other reconfiguration projects but will be complimentary in terms of enabling services to transform the way in which they deliver care. However there is a risk that executing estate reconfiguration at the same time as implementing an EPR solution is 2 major change projects happening at the same time. As a result UHL has developed a detailed implementation plan with partners IBM and included within the business case significant investment in business change and redesign resources.

Other Capital Schemes

OTHER CAPITAL SCHEMES

ROI and Payback period for the following schemes tbc

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Total £000
CAMHS relocation		8,000			8,000
City Hub	2,000			2,000	4,000
Total Cost of Other Capital Schemes					**12,000**

The operational rationale for this schemes has determined the need to include these projects as part of the capital requirements for LLR but these schemes are still under development and details of ROI and payback periods have not been included.

CAMHS (£8.0 million) – Development of a 15 bed Tier 4 inpatient unit on the Glenfield General Hospital site to accommodate the LLR unit which is temporarily accommodated at Coalville Community Hospital, as part of the LLR initiative to co-locate all-age inpatient mental health services.

City Hub – Development of an ambulatory diagnostic hub to deliver enhanced primary care to reduce demand on the ED department at the LRI.

Summary of Overall Capital Requirement for Leicester, Leicestershire and Rutland

Overall the total capital requirement to deliver the reconfiguration programme across LLR totals £321.7 across the next four years. Unfortunately funding from the Department of Health is limited and the request nationally for support, from NHS organisations, far outweigh the funds available. In order to reduce the 'ask' LLR is considering alternative funding sources which includes looking to

local authority partners for support, commercial funding and selling off unsuitable and surplus estate. The tables summarise the programmes and the potential sources of funding:

Acute Configuration

				Included in STP				
		Prior years	16/17	17/18	18/19	19/20	20/21	Total
		£m	£m	£m	£m	£m	£m	£m
Reconfiguration programme		62.9	20.5	29.4	52.2	89.0	109.0	363.0
Approved to date		(50.7)	-	-	-	-	-	(50.7)
Internally funded		(12.2)	(4.5)	(4.7)	(9.2)	(18.6)	(10.8)	(60.0)
External funding requirement		**-**	**16.0**	**24.7**	**43.0**	**70.4**	**98.2**	**252.3**
Site disposal		-	-			-	(28.4)	(28.4)
PF2		-	-			(27.2)	(70.2)	(97.3)
Welcome Centre		-	-			(2.0)	(10.0)	(12.0)
DH funding requirement		**-**	**16.0**	**24.7**	**43.0**	**41.2**	**(10.4)**	**114.5**

Community Configuration

	16/17	17/18	18/19	19/20	20/21	Total
	£m	£m	£m	£m	£m	£m
Lutterworth reprovision	-	-	-	1.4		1.4
Diagnostic/Primary Care Hub	-	2.0	-	-	2.0	4.0
Hinckley (inc day case theatre)	-	-	7.7	-	-	7.7
East ward reconfiguration -Melton	-	-	-	3.9		3.9
East ward reconfiguration -Harborough	-	-	8.6	-	-	8.6
CAMHS	-	-	-	-	8.0	8.0
Relocation LGH stroke to evington	-	-	-	-	7.5	7.5
Rutland	-	-	-	-	1.0	1.0
External Funding Requirement	0.0	2.0	16.3	5.3	18.5	42.1
Disposals			(6.0)		(14.8)	(20.8)
Commercially funded	-	-		(1.0)	-	(1.0)
Local Authority funded	-	(2.0)	(3.4)	-	(1.0)	(6.4)
DH funding requirement	-	-	**6.9**	**4.3**	**2.7**	**13.9**

Summary of Total Requirement

	£m
UHL Reconfiguration	252.3
Less: Alternative funding	(137.7)
Total UHL DH requirement	**114.6**
Community Hospital & CAMHS reconfiguration	42.1
Less: Alternative funding	(28.2)
Total Community DH requirement	**13.9**
Total LLR DH Capital requirement	**128.5**

Governance, Implementation and Risk

This section describes how we will deliver the solutions set out in this STP.

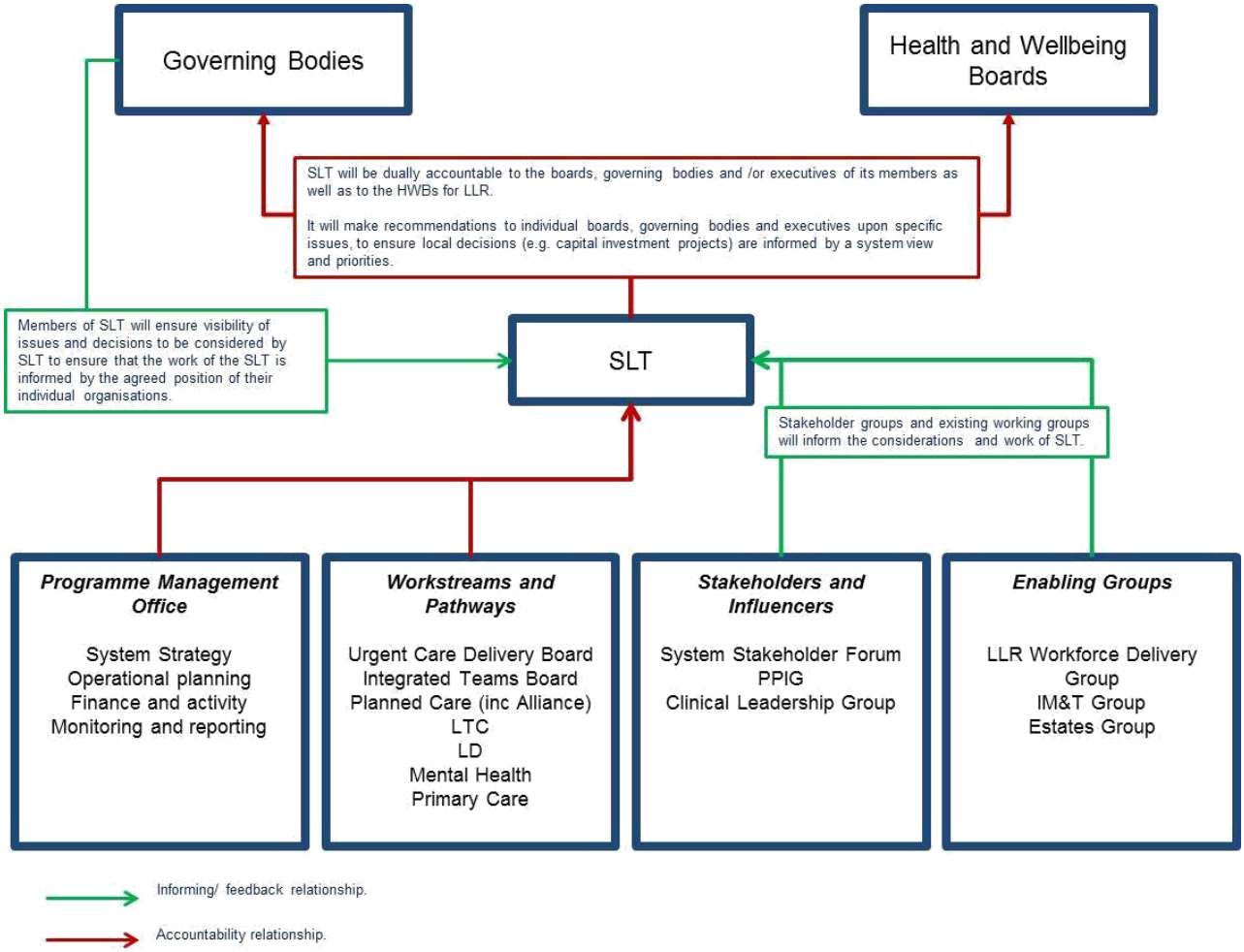
Clear, joint governance with delegated authority

Our STP is deliverable but only if we make a deliberate, concerted and sustained effort now to move to a more collaborative set of delivery and leadership arrangements across the LLR health and care community. We need all parts of the system to move at the same time and direction to achieve the STP goals. We need to send an absolutely clear message to all our staff that we care about and are committed to achieving the same things for local people.

In support of this, we have used the period of developing the STP to review our governance arrangements. This has involved open discussion across partners using a range of forums including: the BCT Partnership Board, individual health and wellbeing boards, partner governing bodies, informal development session and the BCT patient and public involvement group. From these conversations a number of common principles have emerged which have shaped our thinking:

- Need to build on what we have developed through BCT
- Think and act 'best for LLR' first wherever feasible
- But reposition BCT as a 'brand/strapline' not Programme
- And change current arrangements for next phase to accelerate implementation of the STP
- Focus on smaller number of key deliverables
- More formal authority for collective decision taking
- Clearer role for HWB and HOSC
- Must be resourced within existing costs (PMO and organisational)
- Decide and move to new arrangements swiftly.

Based on these, a new set of governance arrangements has been developed which is illustrated in the diagram below.



These new arrangements will involve the following key strengthened elements:

- Replacing the previous separate BCT Partnership Board with a new dual-accountability to the existing statutory governing bodies and health and wellbeing boards
- Creating a new System Leadership Team (SLT) as a joint programme board with membership from the five NHS partner organisations and the three upper tier local authorities.
- We are currently working with legal advisors to refine the \Terms of Reference for this new joint clinical and managerial group which will include clarity regarding its responsibilities and authority ahead of a first meeting on 17 November 2016.
- A new System Stakeholder Forum (SSF): The SSF will be open to all members of Trust and CCG Boards, the Health and Wellbeing Boards for LLR, the Clinical Leadership Group, HealthWatch organisations within LLR, and PPI leads. It will meet three times a year to support the shaping of the strategic direction; identification of priority areas; feedback and sense check on current engagement; identify future issues and test the SLT's thinking on current wicked issues.

A strategic direction towards closer commissioner and provider collaboration

Through the development of our STP we have recognised that there are areas where the NHS organisations locally duplicate functions and processes. Our BCT programme to date has consciously

avoided getting into a discussion about organisational running functions because of the potential distraction factor from the real focus of delivering wholescale change. However, given the scale of financial challenge and the need to support consistent implementation there is a recognition that we need to explore the scope to deliver greater efficiencies in two areas.

From a commissioner perspective, the three LLR CCGs already have well established collaborative arrangements and a number of joint functions. However, there are other areas that we undertake separately which adds duplicative cost into the system overhead. Elsewhere across the Country CCGs are exploring and moving to a range of scenarios across the integration spectrum. Our local thinking is at early stages but will be progressed over the coming months.

From a provider perspective, the main LLR organisations currently operate in a much more autonomous way. There are now examples across the Country of provider networks coming together, including in some cases with new primary care at scale organisations, to form groups that operate in a much more joint way. There is a similar range of possibilities here to the commissioner discussion and local thinking is also at relatively early stages.

Across both the commissioner and provider sectors there is a growing level of interest to explore more openly the potential options across the integration spectrum, the potential implementation and financial benefits, and the feasibility of realising these.

Translating the STP into an aligned two year local contracting arrangement

This STP sets what needs to be done to deliver the required system control total by moderating demand, managing unwarranted clinical variation and reducing cost. This will only be realised if the individual organisations are able to translate this system level plan into a set of two year operational plans and contract agreements. Achieving this, given the scale of the financial challenge and requirement for each organisation to meet its financial duties as required by national planning rules, will be incredibly challenging.

There is a commitment across local NHS clinical commissioners and main NHS providers (UHL and LPT) to seek to change the 'terms of trade' in order to align more effectively the incentives across all parts of the system (rather than continuing the zero sum activity/income mechanisms of historical contract arrangements). Effectively, what we are seeking to do is construct a local two year 'system deal' that hardwires the distribution of the 'LLR pound' to the strategic transformation model and direction set out in this Plan. In headline terms, this would result in substantially lower levels of financial growth over the period into the acute hospital sector than has been the case over recent years in order to enable a greater proportionate shift of resources into primary care and out of hospital services.

Seeking to develop such an approach will require a balance to reflect the relative control over the drivers that impact on demand and activity risk. This will be an iterative process over the coming weeks that will require:

- Working together across organisations to rapidly develop the detailed implementation plans for the schemes that will contribute to moderating demand growth in planned and unplanned care

- Testing and translating this fully into the level of activity detail required to understand the impact on different parts of the system
- Devising systems which allow control and the holding of risk to be aligned
- Reflecting the organisational impact up front in contract envelopes that, taken together, are affordable to the system as well as putting each organisation in a position to meet their individual financial duties
- Seeking to capture these contract values for UHL and LPT in two year block arrangements
- Seeking to create a stronger alignment between the funding of elements of general practice and community health services, and the effectiveness of their respective contributions to moderating demand growth and utilising new service models effectively
- Seeking to create a system level risk pool (through use of existing organisational contingencies and performance related funds) and administering this through the System Leadership Team to help mitigate the consequences of under delivery against demand moderation
- Monitoring (and adjusting where required) organisational control totals throughout the year on a quarterly prospective basis in order to facilitate a system-level focus.

The detail of this system 'deal' is being worked through now ahead of the 23 December 2016 contract agreement deadline. We are under no illusion that this will be an easy task. Or that contract arrangements of themselves will deliver our STP. But what we do believe is that we need to create the conditions where clinicians across the system, can focus on increasing efficiency, moderating demand and reducing unwarranted variation without the penalty of income loss (during the transitional two year period) affecting the viability of their business unit.

There is a clear connection between this desire to change the "terms of trade" and the potential collaborative arrangements described in the previous section. It is recognised that changing organisational responsibilities may unlock some of the current contractual "blockers" to change. The implications do however require further detailed consideration which will take place over the next period.

Significant risks to delivery

As with STPs up and down the country, this is a very ambitious plan. It needs to be in order to seek to balance the various pressures of: continued growth in patient demand; historically low levels of financial growth, and; a requirement to recover and maintain delivery against national access and quality standards.

Not surprisingly therefore a plan of this nature comes with significant risks to delivery:

1. Individual organisational financial positions deteriorate during remainder of 2016/17, impacting on underlying position going into start of 2017/18
2. NHS commissioners and providers fail to agree two year black contracts within which providers can deliver and the system/CCGs can affordability
3. Lack of financial headroom in the system constrains ability to support cost of transformation/transition thereby limiting scale and pace of implementation
4. Activity management plans insufficient to moderate growth in acute activity leaving acute trust exposed to operational pressure between demand and capacity
5. Availability and willingness of clinical and social care workforce to take on new roles in different settings

6. Ability to undertake formal public consultation on major service reconfiguration and successfully take decisions at the end of this
7. Availability of, and ability to secure, access to national capital funding to enable required investment estate modernisation and reconfiguration.

Report No. 32/2017

Report to Rutland Health and Wellbeing Board

Subject:	**Cambridgeshire and Peterborough Sustainability and Transformation Plan**
Meeting Date:	**31 January 2017**
Report Author:	**Scott Haldane, Interim Executive Programme Director, Cambridgeshire and Peterborough Sustainability and Transformation Plan & Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG**
Presented by:	**Jo Fallon, Workstream Support Manager**
Paper for:	**Note / Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

1.0 PURPOSE

1.1 The purpose of this report is to update the Health and Wellbeing Board on the latest Sustainability and Transformation Plan (STP), published by the Sustainability and Transformation Programme on 21 November 2016.

2.0 BACKGROUND

2.1 Cambridgeshire and Peterborough's latest five-year Sustainability and Transformation Plan (STP) to improve local health and wellbeing was published on 21 November 2016.

2.2 Led by local clinicians, the STP has been developed by all local NHS organisations and local government officers, and through discussion with our staff and patients. It aims to provide solutions to the county's challenges to deliver the best possible care to keep the population fit for the future and take joint responsibility for improving health and wellbeing.

2.3 The plan addresses the issues highlighted in our Evidence for Change (March 2016) and the main reasons why changes are needed in the local health and care system. It details how we propose we could improve services and become clinically and financially sustainable for the future.

2.4 Following on from the interim STP summary published in July 2016 where we forecasted that as a system we will have a £250m financial deficit by 2020/21, the STP outlines that this is in addition to £250m of savings and efficiency plans individual Trusts and the Clinical Commissioning Group (CCG) need to deliver over the same period. This makes a total system-wide financial challenge of £500m over the next four years. It also estimates the need to invest £43m to improve services over these four years, which increases the total system-wide financial challenge from £500m to £543m.

2.5 The scale of the changes required is significant and we all recognise the delivery will be challenging.

3.0 KEY ISSUES

3.1 Memorandum of Understanding

All leaders from across the system are being asked to sign a Memorandum of Understanding (MoU) as a demonstration of their commitment to work together, share budgets, deliver agreed clinical services and ensure that together we provide health and care services that are clinically and financially sustainable. The MoU was published in October 2016 and can be read here.

3.2 Four priorities, delivered through a 10-point plan

Through discussion with our staff, patients, carers, and partners we have identified four priorities for change as part of the Fit for the Future programme, and developed a 10-point plan to deliver these priorities.

Four priorities	10-point Plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

3.3 We have translated this Fit for the Future programme into improvement projects, each of which reports to a delivery group

Our priorities will be delivered through eight delivery groups, responsible to Accountable Officers who are Chief Executives from across the health and care system.

The groups cover clinical services, workforce and support services. The clinical delivery groups include public health and care services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do.

Delivery Groups

Urgent and Emergency Care Accountable Officer: Roland Sinker, CUH	**Women & Children** Accountable Officers: Matthew Winn, CCS & Wendi Ogle-Welbourn, CCC & PCC	**Elective** Accountable Officer: Tracy Dowling, C&PCCG	**Primary Care & Integrated Neighbourhoods** Accountable Officer: Aidan Thomas, CPFT
Shared Services Accountable officer: Stephen Graves, PSHFT	**Digital Delivery** Accountable Officer: Stephen Posey, PHT	**Workforce & Organisational Development** Accountable Officer: Matthew Winn, CCS	**System Delivery Unit** Accountable Officer: Lance McCarthy, HHCT

Improvement projects

The groups have identified over 50 improvement areas which are being scoped and measures for success developed, including quality key performance indicators and targets, and key milestones.

Sustainability and Transformation Plan – Overview of improvement projects

Service area	Improvement projects
Urgent and emergency care	Reduce demand for hospital care through: • Integrated NHS 111 and out of hours with clinical hub • Develop and deliver a mental health first response service to enable 24/7 access to mental health • Re-design the clinical model for intermediate care (community beds, re-ablement and therapy) • Ambulances: dispatch on disposition, hear and treat, divert to community services • Reduce re-admission rates through supported discharge • Extent and enhance ambulatory care services as alternatives to admissions • Develop primary and urgent care hubs in rural communities • Reduce length of stay in hospital
Women and children	• Introducing a 7-day-a-week paediatric community nursing (for children who would otherwise require emergency/urgent care in the hospital setting) • Maternity developments such as the 'saving babies lives' care bundle • Improving the care models for children with asthma and children's continence services • Developing an integrated children and family health and wellbeing service for 0-19 year olds (universal services) • Improve the mental health support for children and young people

Elective care	• Achieve shorter, faster, more effective treatment pathways • Models of care to enable GPs and consultants to share decision making • Develop GP referral support to address unwarranted variation in referral practice • Maximise clinical thresholds for effective services • Standardise high volume elective treatment pathways (hip, knee, arthroscopy, cataract, glaucoma, cardiac, ENT) • Reduce outpatient follow-up activity through virtual clinics, technology for results • Deliver productivity gains in provider trusts
Primary care and integrated neighbourhood teams	• CVD and stroke prevention • Improve identification and management of patients with hypertension and atrial fibrillation • Improve uptake of NHS Health Checks • Improve uptake and completion of cardiac rehabilitation • Mental Health • Implement enhanced primary mental health care (PRISM) • Ensure mental health service model matches capacity and demand • Implement mental health strategy across the system • Diabetes • Support self-care, provide enhanced patient education and virtual patient reviews • Develop a proactive integrated model of care for people with long term conditions • Design and implement the 8 diabetes NICE care processes • Respiratory • Improve respiratory patient identification • Develop specialist community expertise • BLF 'Love your lungs' and spirometry testing • Implement new medicines management and prescribing practices including minimise triple therapy for COPD
Shared services	• Merger of HHT and PSHFT to enable shared service savings • Explore back office consolidation across primary care at scale • Implement a single approach to procurement across C&P • Develop and sign off strategic estate plans, (including potential for primary care co-location, including other public services like Citizens Advice)
Digital delivery	• Digital opportunities: tele-medicine, tele-monitoring, GS1, remote monitoring, internet of things • Shared Wi-Fi, infrastructure for professional and citizen – all health and care locations • Paper free care delivery
Workforce & Organisational Development	• Develop a system wide Workforce Investment Plan, in which all providers commit to investment priorities in relation to Apprenticeships (via LEVY), Pre-Registration, CPD and wider workforce transformation • Link to supply improvement programme and design a tailored

	programme for primary care, linking to case load management trailblazers

3.4 Following the submission of the STP, feedback has received from NHS England stating that it is a good strategic plan, that there is evidence of good engagement and system leadership and that it represents a comprehensive plan in order to ensure good clinical quality and a financially sustainable service by 2020/21.

The feedback notes that the system has significantly improved communications with stakeholders and comments that this should continue. It goes on to highlight the challenge for the system, which is to implement the strategy outlined; ensuring that the operational plan is delivered. It states that it is positive that an independent chair has been appointed and that there is a good PMO in place. It notes that a permanent programme director is required.

Further comments state that the STP plan provides a "good demonstration of the benefits to patients and the link with mental health and physical health strategies". Finally it states that the system is aware of the financial challenges it faces and is working collaboratively with NHSI and NHSE to address these.

4.0 SOURCE DOCUMENTS

Source Documents	Location
• Cambridgeshire and Peterborough Sustainability and Transformation Plan – October 2016 • Sustainability and Transformation Plan summary document – updated, November 2016 (also attached as a PDF) • Frequently Asked Questions – Third edition, November 2016	All available at www.fitforfuture.org.uk/what-were-doing/publications/

Financial implications:

5.0 IMPLICATIONS

5.1 If the Trusts and CCG meet their savings and efficiency plans, and all aspects of the STP are delivered, this will achieve the savings and efficiency target (of £500m) and produce a small NHS surplus of £1.3m (by 2020/21).

5.2 Due to the high levels of acute hospital activity, and resulting deteriorating financial position in our system, we are looking at ways to accelerate the pace of change and focus early investment on the areas that will have greatest impact on reducing hospital activity levels.

5.3 Our priorities are to increase the amount of care delivered closer to home and to keep people well in their communities.

5.4 There will be more opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change and to be involved with any formal consultation process.

5.5 The proposals will be further developed over the next few months. If patients and carers want to be part of the discussion please contact the team via email: contact@fitforfuture.org.uk

Recommendations:

That the board:

1. Comments upon and notes the Cambridgeshire and Peterborough Sustainability and Transformation Plan

Comments from the board:

Strategic Lead:	

Risk assessment:

Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	
Profile	L/M/H	
Equality & Diversity	L/M/H	

Timeline:

Task	Target Date	Responsibility

Fit for the Future

Working together to keep people well

How health and care services in Cambridgeshire and Peterborough are changing

This is an update to the Sustainability and Transformation Plan Interim Summary, published in July 2016

@fitforfuturenhs
fitforfuturenhs
fitforfuture.org.uk

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

NHS

1 Why do we need to change?

Our health and care services face challenges

Ours is one of the most, if not ***the*** most, challenged health systems in England, making it essential that we work together to develop robust plans for long-term change.

The population of Cambridgeshire and Peterborough is growing rapidly. Our population is diverse, it is ageing, and it has significant inequalities. There are also more people with long term conditions, such as diabetes, and there are higher levels of obesity.

In addition, we are facing practical challenges:

- healthcare is not as good in some places as in others, and does not always meet the standards that it should
- recruiting and retaining staff is a challenge for all health and care services
- our health, local authority, and other care services are not always joined up. They do not always meet people's individual needs, and they do not always balance physical health with mental health and wellbeing
- local needs are growing and changing. Our average age and levels of sickness are all growing, and faster than in other parts of the country
- overall, we spend too much of our time and resources treating illnesses which can be prevented or kept under control in better ways
- The current health system is financially unsustainable. The local system has a total annual budget of more than £1.7billion for NHS services, but we spend about £160million more than that each year. We need to deliver our current plans and radically change the way we provide services. If we don't do both of these things the deficit is projected to increase to £500million by 2020/21.

The Sustainability and Transformation Plan (STP) proposes ways in which we can deliver the best possible care to keep our population fit for the future, and address our service and financial challenges.

What you've told us so far

During the last 18 months, we held listening events across our area to seek your views on the health and care system. We heard that:

- you want to be empowered to stay healthy
- you want easy access to information about health
- you want to understand how to use the right health and care service at the right time
- when you need care urgently, you would rather use a local service than be sent to A&E
- you want consistent access, such as opening hours for services
- you want care as close to home as possible
- children's services need to be co-ordinated better
- you would be happy to be sent home from hospital sooner if you had visits from a nurse to support you
- you do not want to be sent home too early with no support – you are concerned about needing to be readmitted
- you need better communication and planning before you leave hospital
- you want the people who provide health and care services to collaborate and work more closely together.

2 Our five-year plan to make Cambridgeshire and Peterborough Fit for the Future

This document tells you about our proposals, both to meet your ambitions for health and care and to make services financially and clinically sustainable.

The NHS and local government officers have come together to develop a major new proposed plan to keep Cambridgeshire and Peterborough Fit for the Future. We have also been asking you how you think we can manage our challenges. Our plan aims to:

- improve the quality of the services we provide
- encourage and support people to take action to maintain their own health and wellbeing
- ensure that our health and care services are financially sustainable and that we make best use of the money allocated to us
- align NHS and local authority plans.

It has been developed by our health and care organisations. We are working together and taking joint responsibility for improving our population's health and wellbeing, with effective treatments and consistently good experiences of care. The work is being led by local doctors and other medical professionals, supported by NHS England and NHS Improvement.

Fit for the Future sets out a single overall vision for health and care, including:

- supporting people to keep themselves healthy
- primary care (GP services)
- urgent and emergency care
- planned care for adults and children, including maternity services
- care and support for people with long term conditions or specialised needs, including mental ill health.

We are well placed to make the changes we need and have a lot to be proud of. Cambridgeshire and Peterborough has a committed and expert health and care workforce. We provide some excellent services to which people travel from other parts of the country. We host groundbreaking research and deliver excellent medical education and training. We have a resourceful voluntary sector, strong organisations, active local communities, and we work alongside research and technology industries which are world leaders in improving healthcare.

3 What are the priorities?

Through discussion with our staff, patients, carers, and partners we have identified four priorities for change and we have developed a 10-point plan to deliver these priorities.

Fit for the Future programme	
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

1 People powered health and wellbeing

We will help people to make healthy choices, keep their independence, and shape decisions about their health and care. We will work with community groups and businesses so that people of all ages have good health, social, and mental wellbeing support.

Our first aim is to prevent illness and support people to take control of their own health and wellbeing. We will develop health services which work alongside patients and carers, social care, and housing providers, and which help to build strong communities.

We want patients to become equal partners with those caring for them, make more decisions about their own treatment and, with advice and support, become increasingly confident to manage their own conditions, supported by technology.

Summary of what we propose to deliver.

Housing and business - working in partnership with communities and businesses to provide employment, housing in new developments, and an environment to keep people healthy.

Where possible, we are influencing the design of new housing developments to reinforce active lifestyles and introduce smart technology that promotes independence for older people.

Prevention - helping people to keep healthy, dealing with problems earlier, and making sure people who are likely to fall ill are supported to keep well.

We will do this by implementing our Health System Prevention Strategy for Cambridgeshire and Peterborough. The strategy sets out practical steps to make this happen.

Psychological wellbeing - making support and treatment for people with mental ill health as available as it is for those with physical health conditions, mainstreaming mental health and prevention.

We will reduce stigma, support employers to have healthy workplaces, and reduce suicides.

Starting young - working together to ensure that there is support for children and young people with mental health and physical health problems, whatever their age.

We are joining up children's services across the NHS and local authorities, including Child and Adolescent Mental Health Services (CAMHS) and emotional health and wellbeing services, children's community health services, and local authority services for those aged 0-19 (which may include children's centres).

Reaching out - engaging those at high risk through the third sector and trusted networks.

Our neighbourhood teams, primary care, and social care will work with the voluntary and community sector to identify those at risk of poor or deteriorating health. Community-based workers will support those with a severe mental illness or dementia, migrant workers, travellers, and our wide range of diverse communities who may need help to access services in a different way.

Self-care - supporting patients to make decisions about their own treatment and become more confident to manage their own conditions.

Our GPs, consultants, and nurses will make it easier for people with long term conditions to manage their own care by adopting best practice for supporting self-care.

Ageing well - we must improve independence and wellbeing in older age and prevent health and care needs from escalating.

To achieve this, we will focus on physical activity and reducing falls, holistic approaches, and care for older people's mental health.

> We need to link up health and social care.
>
> Peterborough Public Workshop

2 Neighbourhood care hubs

More health and care services will be provided closer to people's homes and we will help people stay at home when they're unwell.

We aim to coordinate care better so that it meets the needs of the individual. We aim to pay close attention to the health and care services necessary to keep people living at home successfully, because we know this is the best way to keep people healthy and to maintain their independence.

When people become unwell, we will take every opportunity to spot warning signs and focus local support to help people live with long term health conditions.

We would like to see more joint working between local health and social care, with GPs playing a central role, supported by hospital clinical teams.

As much care as possible must be led by primary care (GPs). We are supporting our GPs to share best practice, work together, access advice from hospital consultants and to provide the enhanced primary and community care that our local people need.

Summary of what we propose to deliver.

Time to care - testbeds to support GPs.

Our 'Time to care' programme aims to support our 105 GP practices to manage increasing patient demand, help them to become more efficient, and to provide better quality of care to their patients. It also aims to improve the way in which GP practices work with local hospital, community, social care, and voluntary sector providers to provide proactive care close to the patients' home.

Neighbourhood teams - multi-disciplinary teams, led by GPs targeting those at risk (such as those with long term conditions, frail, elderly).

We aim to build on our neighbourhood teams which are staffed by district nurses, matrons, social workers, therapists, and pharmacists to provide integrated, proactive care for those with long term conditions, such as the dying, care home residents, and mental health service users.

Community experts - specialist clinicians will support neighbourhood teams.

To support the neighbourhood teams we need an integrated team of community-based experts to care for the more complex patients and provide advice and education. However, more needs to be done to ensure that access to the teams is fair, that the teams can access advice, and clinicians are able to review complex patients together to agree a management plan.

Sharing knowledge - this is a central role of the patient care plan, and electronic access to patient information across the system.

Proactive and person-centred care relies on there being one single care plan, owned by the patient and their family; one electronic care record accessible by all; one set of best practice protocols all can adopt; and one route through which expert opinion can be accessed day or night.

Embedded mental health - ensure community mental health is within neighbourhood teams, and that there are links to liaison psychiatry and recovery.

Our neighbourhood teams already provide joined up community mental health services. We want to join up our community and mental health teams further to make sure the psychological needs of people with long term conditions and the physical health needs of patients with severe mental illness are met consistently.

Learning disabilities – implementing 'transforming lives'.

We have been working closely with the councils to implement 'transforming lives' for people with learning disabilities. The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) is evaluating the use of integrated personal health and care budgets for people with learning disabilities.

Your own bed, not a hospital bed - for end of life and intermediate care.

We aim to provide more rehabilitation closer to, or at, home to retain a patient's independence, and provide more end of life care at home, rather than in hospital.

3 Responsive urgent and expert emergency care

We will offer a range of support for care and treatment which is easily accessible, from telephone advice for urgent problems to the very best hospital emergency services when the situation is life-threatening.

This will be supported by better co-ordination, for example referral through NHS 111, close working with the ambulance service, and clear information provided to patients about which services are available - and how to reach them - when they have an urgent health need.

It is not good for patients to stay in hospital for longer than they need to be there, as it can have a negative impact on their recovery and ability to maintain independence. We must therefore make sure patients in hospital beds really need to be there, and that they are not delayed when moving through the steps on their care plan.

We have been through a process to designate our three A&E departments against the national Keogh urgent care definitions. As a result of this process, we have determined that it is in the best interests of our local population to maintain the current levels of provision, namely a specialist emergency centre at Addenbrooke's Hospital and an emergency department at Peterborough City Hospital. Hinchingbrooke Hospital will retain its A&E department and will continue to be able to manage the current caseload of minor injury and major medical cases, with a physician-led service.

Since our three hospitals are already struggling to meet existing levels of emergency demand, and our volume of planned hospital procedures is significantly above that of similar health systems, we need to improve our community-based urgent care and our emergency services radically such that hospital is a last resort. There are several strands to this improvement work.

Summary of what we propose to deliver.

Ambulance services - alternatives to hospital admission.

We are working with our ambulance teams to make sure that only patients who really need to be transferred to hospital are taken there. We are implementing 'hear and treat', 'see and treat', and 'see, treat, and convey' systems which allow paramedics, supported by other medical professionals, to decide whether options other than transfer to hospital are more appropriate.

Right call, first time - integrated urgent care and clinical hub.

From October 2016, if you call 111 and you need to speak to a clinician you will be able to do so. This service is provided by our expanded integrated urgent care service and clinical hub. The aim is to make sure that patients receive the most appropriate care that best meets their needs. This will ensure that our hospitals' emergency services are reserved for serious/life threatening injuries or illnesses.

Minor injury - walk-in minor injury services.

Following our review of the three Minor Injury Units, (MIUs), in East Cambridgeshire and Fenland, we have undertaken extensive engagement with the public, providers, and other stakeholders on a range of options for the future. Taking this feedback into account, we have identified significant opportunities to deliver more joined-up, effective, and efficient local urgent primary care services which reflect the rural geography, deprivation, and demography.

Whilst no formal decisions have been taken, we are now working with local stakeholders to develop the details behind a number of options, including the development of three rural urgent primary care hubs which will focus initially on integrating local primary, minor injury, and community services. This will move on to include development of point of care testing and consultant support, via telemedicine links. We intend to develop and test the first phase of any new urgent primary care model over the next 12 months, which will inform further engagement and, potentially, consultation. We are also doing an analysis of all options put forward as part of our early engagement work.

Right call, first time for mental health concerns - dial 111 - press 2 if you have a mental health concern.

We are embedding mental health including community crisis services, liaison psychiatry, and Suicide Prevention Strategy. We are investing £2m of urgent and emergency care funding in an evidence-based, community first response service which provides urgent out of hours assessment and support to people in mental health crisis.

More support for people leaving hospital - we have a very high level of people staying in our hospitals for longer than they need to be.

We believe it is not good for any patient to stay in hospital for longer than medically necessary and we are putting in place processes to ensure that patients are discharged on time, including on-site social care staff to support discharge from hospital.

24/7 standards – in consultant-led services

Our three urgent and emergency care hospital departments will meet the government's seven-day service standards with early and daily consultant input to reduce the length of time people spend in hospital.

4 Systematic and standardised care

Doctors, nurses, and other health and care professionals will work together across Cambridgeshire and Peterborough to use the best treatments and technology available.

Where it is important to provide services from several sites across the area, we believe we can use our skills and expertise collectively to achieve better results through doctors and nurses working across more than one hospital site and sharing their expertise.

We expect that maternity services will also remain at the Rosie Hospital in Cambridge, at Hinchingbrooke Hospital, and at Peterborough City Hospital.

Evidence tells us that standardised care is often higher quality and lower cost. Networking between medical professionals will help us to deliver savings, as well as helping to ensure that the additional costs associated with increased clinical standards, especially seven day services, are minimised.

Summary of what we propose to deliver.

Networks of care - where services are provided from more than one site, we will use specialised skills and expertise collectively to raise quality everywhere.

Medical professionals at our hospitals are beginning to agree how to work as operational networks for planned, unplanned, routine, and specialised care. These networks will share information about appropriate patient referrals and the best treatment, and building workforce resilience through better career development and shared out of hours arrangements.

Patient choice hub - improving quality of referrals and align capacity and demand.

A new patient choice hub is being developed with the aim of improving quality of referrals, ensuring that clinical thresholds are adhered to, that capacity and demand are lined-up across available providers, and managing procedures across the health system rather than in organisations.

Centres of clinical excellence - clinical consistent pathways across all providers to improve outcomes and efficiency, with fewer, more specialist centres across our hospitals.

We need to create centres of clinical excellence that use consistent procedures and policies across all service providers. We have identified some quality and efficiency benefits from combining procedures.

- Orthopaedics: We are considering centralising specialised orthopaedic trauma services (such as fragility fractures from falls) at Peterborough City Hospital and Addenbrooke's Hospital, to achieve a higher standard of care.

  We are also investigating the case for reconfiguring planned orthopaedic services, by increasing the number of low-complex procedures at Hinchingbrooke Hospital (such as routine knee and hip replacements), to improve the quality and sustainability of services at all three hospitals. We expect to consult on these proposals in 2017.

- Stroke: National stroke indicators show that we perform below the national average on a number of stroke areas, including access to specialist rehab and early-supported discharge. In addition, inpatient and community bed-based stroke and neurological rehabilitation care is fragmented across multiple sites.

  In order to improve the services offered to our patients we are considering providing all bed-based stroke and neurological rehabilitation on a single site and to establish an enhanced early-support discharge team, so many more patients can receive rehabilitation and support at home. We expect to consult on these proposals in 2017.

  We have also considered whether we need one or two hyperacute stroke units (we have one in Cambridge and one in Peterborough), and have concluded that at present we should retain our two hyperacute stroke units.

Modern maternity - improving quality, choosing home births, standardisation and continuity.

For obstetric and neo-natal services we have considered the viability of our three obstetric (maternity) units, each with a co-located midwife-led unit, and concluded that all three should remain. However, we need to enhance networking between the three units to share knowledge and improve care for expectant mothers and women in labour.

Acute paediatrics - supported by strengthened community services.

Hospital stays for children and young people should be kept to a minimum. We will develop community care with enhanced community nursing, and with GPs and paediatricians working better together.

5 Continued world-famous research and services

We have world-class specialised care, but we are always looking for ways to be better. We will work together with our local research organisations and businesses to make this happen.

We believe we can achieve consistently better results for people with more serious needs, such as for heart and lung services or complex surgery, in fewer, specialist units which make best use of the world-class expertise of our specialist consultants.

Much specialised care is already centred at our two world renowned hospitals: Addenbrooke's Hospital and Papworth Hospital for cardio-thoracic care. For this reason, major changes to specialised services do not feature significantly in our plan. However, there are some specific areas where we can improve, especially due to growing demand.

Summary of what we propose to deliver.
Cancer - improvements in waiting times and best practice services. We are working to implement the recommendations of the Cancer Taskforce Strategy and to achieve world-class cancer outcomes. The establishment of 'Cancer Alliances' is crucial to this.
Specialised mental health - We provide limited specialised mental health locally in a small number of low secure beds and Child and Adolescent Mental Health Services. The East of England region has been identified as one of three areas without a mother and baby unit for those with severe mental health problems following childbirth. We aim to address this, and our mental health strategy also prioritises the development of perinatal mental health services in the community.
Cardiology - Cardiology services will be provided across Cambridgeshire and Peterborough. Papworth Hospital which, following its move to the Cambridge Biomedical Campus next to Addenbrooke's Hospital, will lead the service across both organisations. Together with Peterborough and Stamford Hospitals NHS Foundation Trust, it will provide a vital role in supporting improved 24/7 access to cardiology opinion, as well as community-based services that focus on prevention.

How does the NHS support carers?

Cambridge Public Workshop

Ely Public Workshop

Most of us prefer to travel 100 miles for an operation for someone who's done it before.

Patient stories - how things could look in the future

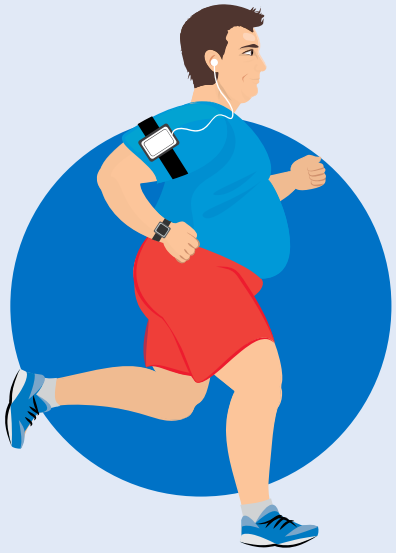
Better safe than sorry

When, on a Sunday morning outing, eight year old Olivia fell off her bike and banged her head, her mother Gemma didn't know what to do. She thought about driving to A&E or dialling 999 but remembered seeing posters saying that 111 was a better option for injuries that were not serious or life threatening.

She called 111 and they arranged for Olivia to see a GP later that morning. The GP, Martin, examined Olivia and advised Gemma about what to look out for following a head injury, and what to do if Olivia's condition changed. Martin directed Gemma to the NHS Choices website for further information.

In the afternoon, and using the information that she had been given, Gemma became concerned that Olivia was getting worse, not better. Following the advice that GP Martin had given her earlier she took Olivia to the hospital. The specialist children's team could access Olivia's notes and details of what had happened so Gemma didn't need to repeat her story. Olivia was observed for six hours and discharged fit, well, and keen to get back to playing with her friends.

Looking forward – keeping active



Mark gave up playing rugby after a broken wrist and had become an armchair fan at the age of 39. He still enjoyed regular evenings out, and was ashamed to admit that his smoking had increased since he gave up sport. But Mark remained convinced he was still fit and healthy – with nothing to worry about.

Aisha, Mark's GP, was not so sure. Responding to an invitation for a regular check-up, Mark was told that he was significantly overweight, with warning signs suggesting he was at risk of developing diabetes. Aisha knew that persuading Mark to make the lifestyle changes he needed would require both a plan and support.

First, she connected him to the local smoking cessation service, which organised drop-in sessions Mark could easily get to, and put him in touch with a fitness coach who could recommend an exercise programme to suit him.

She also realised that Mark's smartphone was his window on the world, and suggested some websites and a wellbeing app to help him plan and stick to his diet and fitness regime.

Care shaped around the patient

After she turned 80, Doreen found her health deteriorating. Doreen has diagnoses of diabetes and emphysema (COPD), as well as early stage dementia. She lives with her husband, Roy, who is 82, who also has diabetes but is otherwise fit and cares for her.

Paul, her GP, invited Doreen for her annual assessment. Based on her increasing frailty, he accepted her onto the caseload for complex, case-managed patients who are supported by a multidisciplinary team in the community. Angela, a member of the community team, is her care coordinator.

Paul and Angela worked with Doreen and Roy to create two plans. The first was a care plan which summarised Doreen's health needs according to her preferences and priorities, and what she and Roy would want in the event of a crisis or deterioration in health. The second, a self-care plan, allowed Doreen to describe her goals and needs for caring for herself safely at home, and identified how she could be supported in doing so by Roy and the health system.

Living beyond psychosis

Jack was becoming increasingly isolated; he had stopped attending school and seeing his friends, and had complained of hearing voices. Following a comprehensive assessment at which he was considered to have developed an early onset psychosis, he was referred to the early intervention service. He began a three-year programme tailored to his needs. The service worked with Jack to deliver a holistic care plan.

Family therapy enabled Jack and his family to understand more about his experiences and to begin to resolve them.

Jack is now aware that he can choose to access a wealth of insight and to share experiences through social media. He is actively involved in monitoring his state of mind, has discussed in advance what he would like to happen in a crisis, and understands what to do if he becomes unwell again. His GP and the practice team are very involved with the care plan and can call on a range of support for Jack. Perhaps the most important connection was with an employment project which supported Jack through his college application. Now, in the second year of his course, Jack can see a much brighter future.

Neighbourhood care hubs

More health and care services will be provided closer to people's homes and we will help people stay at home when they're unwell.

People powered health and wellbeing

We will help people to make healthy choices, keep their independence, and shape decisions about their health and care. We will work with community groups and businesses, so people of all ages have good health, social, and mental wellbeing support.

Partnership worki

Everyone who provi
social and mental h
Cambridgeshire and
plan together and w

Workforce: growing our own

We have wonderful, talented people working in our health and care system. We aim to offer rewarding and fulfilling careers for our staff with opportunities for them to develop their skills and grow professionally. This way we can develop staff, including for those areas where we have some staff shortages.

Using our land and buildings better

We want to bring all our NHS and local government sites up to modern standards. We want to make better use of our out-of-hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

Responsive urgent and expert emergency care

We will offer a range of easily accessible support for care and treatment, from telephone advice for urgent problems to the very best hospital emergency services when the situation is life threatening.

Systematic and standardised care

Doctors, nurses and other health and care professionals will work together across Cambridgeshire and Peterborough to use the best treatments and technology available.

Continued world-famous research and services

We have world-class specialised care, but we are always looking for ways to be better. We will work together with our local research organisations and businesses to make this happen.

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A culture of learning as a system

We are committed to sharing knowledge across the whole health and care system, so the people working in our health and care organisations know they are part of the big picture.

Using technology to modernise health

Good information and advice helps people take control of their health. We will use apps and online tools to provide more rapid and reliable information.

6 Partnership working

Everyone who provides health, social, and mental health care across Cambridgeshire and Peterborough will plan together and work together.

We believe we must work across boundaries: between NHS and local authority social care; GPs and hospital care; and physical health and mental health.

None of our organisations can be sustainable acting alone; our financial challenge is too great. We need to work together in a way that we have never done before. In addition to new ways of working, and a new relationship between medical professional and patient, we can do more to collaborate in our non-patient facing services, including back office and clinical support services, and reduce duplication.

Collaboration between commissioners, including the Clinical Commissioning Group and local councils, NHS providers, and general practices, is crucial. There are examples in our system of where this is already happening and members of these organisations have already begun to work together as equal partners to a far greater extent than ever before.

Summary of what we propose to deliver.

Larger general practices - Many of our GP practices recognise the benefits for sustainability of working together as federations and larger primary care teams. We believe this will enable better access to resources through sharing and specialisation and closer working between GPs and their colleagues in hospitals. Development of the primary care workforce (GPs) is an important part of this.

We also recognise that people are supported by a network of formal and informal care, and aim to work in partnership with local organisations, such as faith groups and the voluntary sector.

Hospitals joining together - Hinchingbrooke Hospital and Peterborough and Stamford Hospitals are looking at coming together to bring about financial efficiencies and also meet their clinical and workforce challenges. They will be making a decision in late November, and, if it is agreed, they will join together in April 2017.

Papworth Hospital is preparing to move onto the Cambridge Biomedical Campus in 2018. This will lead to further formal collaboration with Addenbrooke's Hospital in due course.

Back office - We have started to rationalise overheads and support services. We will establish a shared HR back office that includes healthy workforce. We will also develop a single approach to procurement during 2017/18 and pilot this new approach within orthopaedics through joint procurement of all joint kits.

Financial incentives

Having committed to shared planning and transparency in tracking cost improvements and Quality, Innovation, Productivity, and Prevention (QIPP) delivery in 2016/17, we will look at ways to share risk and align financial incentives.

Health and social care

The Clinical Commissioning Group and local authorities are collaborating with the aim of aligning commissioning arrangements for mental health and healthy child services.

Working with the voluntary and community sector, and support for carers - Key to reduction of hospital admissions is coordinating support for people. Many relevant services and interventions are provided by voluntary and community sector organisations. All commissioners are seeking to work more closely with the voluntary and community sector.

Case Study: Peterborough is leading the way

In Peterborough, an Area Executive Board has been established to oversee nine programmes of work that will integrate care for all ages, spanning child health, ageing healthily, and how hospital is accessed. The programme brings together local GP practices in Greater Peterborough, Peterborough City Council, Peterborough and Stamford Hospitals NHS Foundation Trust, and Cambridgeshire and Peterborough NHS Foundation Trust, and is supported by an external company.

To enable the required change, improvements, and efficiencies in this plan to be delivered we have identified four key things that will need to happen to underpin our work across the system.

7 A culture of learning as a system

We are committed to sharing knowledge across the whole health and care system, so the people working in our health and care organisations know they are part of the big picture.

We want to develop a culture of learning. This means our staff developing a shared understanding of our services, priorities, and challenges, a common approach to analysing opportunities and problems, and finding solutions together.

We believe we can share knowledge and expertise from the specialist services in Cambridgeshire and Peterborough, making the most of our world-class medical and healthcare education and training, and using research to drive improvement.

We know we must invest in system-wide quality improvements. To be successful, our system must develop a shared understanding of all the interrelated issues and must be able to explain what it means to us as individuals and as organisations. Our plans must be understood by all our staff and patients.

We are developing a system-wide quality improvement and organisational development plan which will focus on a common culture and set of values across Cambridgeshire and Peterborough. Ultimately we want our staff to not only identify with their professional group and employer, but as a key partner to the Cambridgeshire and Peterborough health and care system's long-term sustainability.

We need to build on our research heritage and be at the forefront of adopting new therapies and delivery models for the patients of tomorrow.

8 Workforce: growing our own

We have wonderful, talented people working in our health and care system. We aim to offer rewarding and fulfilling careers for our staff, with opportunities for them to develop their skills and grow professionally. This way we can develop staff, including for those areas where we have some staff shortages.

We want staff to choose to work here and to see themselves as part of the whole health and care service in Cambridgeshire and Peterborough - this will help us where we have services that have staffing shortages.

Workforce data and intelligence from other parts of the country has provided us with the building blocks to design a workforce and transformation strategy.

In the short-term we have developed a whole systems approach to 'grow your own' and 'earn as you learn'. We are building on existing programmes and developing career pathways that begin at apprenticeship level and take individuals all the way through to registrant or advanced practitioner level. Our goal is for Cambridgeshire and Peterborough to provide high quality placements for those in training and to become one employer of choice, enabling us to retain those we train.

Over the longer term our system needs to work differently to ensure our staff are supported appropriately and retained. We need to ensure that the contribution of our mature workforce is retained and that they help us to develop competence and confidence in newer members of the workforce.

Many of the emerging new models of care, including our aspiration to operate in networks of care, require both the current and future workforce to work more flexibly across locations, in line with the demand for our services. Our human resources model will need to become more flexible and, where possible, we will do things in common to enable staff to move between organisations more easily.

Case Study: Skills for people-powered care

We have made progress towards training and developing our staff to deliver new roles:

- Funding from Health Education England supports training and research on integrated working in Neighbourhood Teams.
- Cambridgeshire County Council's Early Help Team helps individuals at an early stage, in the community.
- Cambridgeshire Better Care Fund's care home educators are learning from a local pilot and the Care Home Vanguards.

9 Using our land and buildings better

We want to bring all our NHS and local government sites up to modern standards.

We want to make better use of our out-of-hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

We want to explore how we can work together to get more value from our land and buildings, and bring all our sites up to modern standards.

There is a great deal of building development in Cambridgeshire and Peterborough so we see opportunities for new strategic partnerships, such as the planned Hinchingbrooke Health Campus.

We have many community estates, some of which are poorly used, which provides us with the opportunity to reduce the number of buildings used and potentially develop new primary and community care facilities on the larger sites.

We want to promote co-location and shared working spaces which can bring teams together and foster integrated care delivery across health and social care agencies.

We have already started to work in a more coordinated way, not only across health and care but also with partner agencies including the fire and police services.

We want to use our estates to support new models of care. This could be through the creation of larger, modern, family and frailty-friendly hubs, where GPs can work side by side with community and social care staff, have direct access to diagnostics and specialist advice, and are enabled to diagnose and care for more patients without the need to refer to hospital. Over time we expect these hubs to replace much of outpatient care.

Local authority plans to bring NHS and local health and care resources together under one social/community/mental health/primary care roof, will go a long way to providing proactive care, rather than reactive care in hospital.

Similar changes are possible as back office services begin to collaborate more. The sites at Princess of Wales Hospital in Ely and North Cambridgeshire Hospital in Wisbech could be locations for these new neighbourhood hubs. Outline plans, which will help us respond to a growing population, local health needs, and poor current infrastructure, have already been drawn up for these two sites.

10 Using technology to modernise health

Good information and advice helps people take control of their health. We will use apps and online tools to provide more rapid and reliable information.

Shared information will help medical professionals in hospitals, GP practices, community teams, and social care to work together more effectively.

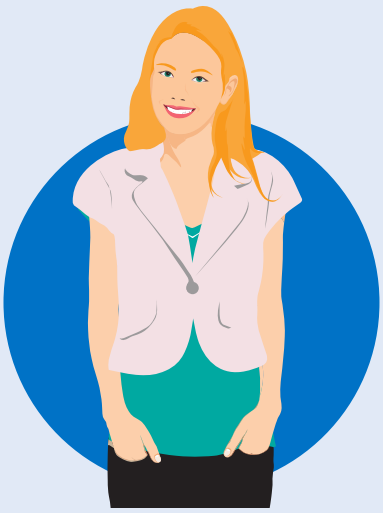
Technology will also help us to provide more reliable information for patients more quickly, and our clinicians will make sure technology is built in to new services.

Our ambition, supported by the 'Local Digital Roadmap' vision, is that by 2020 'patients and citizens, health and social care staff have access to quality, timely, and accurate information, regardless of place or time, to enable improved decision making and ultimately better outcomes for both the individual and the community'. We will deliver this in six themes:

- Data and information sharing
- Health apps
- Telehealth/remote monitoring
- Access
- Real-time information
- Health analytics

Staff stories – how things could look in the future

Making the right call



Joanne supports several people with long term health conditions, enabling them to continue to live independently at home. She has built up a lot of knowledge about signs to look out for and urgent care options, and has always felt that she has valuable insight into how the emergency admission process works and whether it could provide a better experience for patients and carers.

Now working within a larger, multi-disciplinary team she can play a greater role. For example, she has received coaching from a local hospital consultant from whom she can also access immediate support and advice. This includes examples of symptoms which should raise concerns, so Joanne has the reassurance that she knows when it is right to call an ambulance and how she can help to prevent emergencies.

Hospital care at home

Maqsood leads a newly-established team in St Neots. It helps to keep people living independently by providing intensive nursing input at home - so avoiding hospital admission or enabling earlier discharge.

Maqsood knows that the research evidence is clear. Too often, on admission to hospital the care and support networks on which older people depend fall away and with them their ability to live independently. He helped to co-design the service and has worked hard to develop his team, which brings together professionals across several organisations and focuses on each individual patient's needs.

For example, Mrs Barlow was one of the team's first patients, after she was discharged from hospital much sooner than she would have been before it was in place. She was able to recover at home, at first with high-level healthcare and daily contact with support workers, which then stepping down to every other day contact with a nurse. She even received home visits from the pharmacist to make sure her medication was correct.

To stop people going to A&E you must provide alternatives.

Huntingdon Public Workshop

Wisbech Public Workshop

People would be happy to be treated at home if they could get good support.

Peterborough Public Workshop

Ensure health staff on the ground are involved.

Mental Health is a key element to all patient pathways.

Wisbech Public Workshop

Staff stories – how things could look in the future

Joining up physical and mental health

Greg leads part of the liaison psychiatry service, which joins up mental health and physical health care when people need hospital treatment or urgent care. His team works in hospitals across Cambridgeshire and Peterborough.

As well as helping to make sure that the NHS meets its commitment to give mental health the same priority as physical health, Greg believes that his service is based on principles which are fundamental to transforming care services.

When people are admitted to hospital, the liaison psychiatry service focuses on helping them to recover and how they can be supported to return home. This requires a holistic approach - working across mental health and different hospital specialties, in partnership with the patient, and alongside carers, advocates, and social care providers - because keeping people well requires a team effort.

As a clinician, Greg wants to help shape new ways of working and sees his role as a great opportunity – both to help bring about better outcomes for patients, and to develop his own professional skills.

World-class hospital care – delivered closer to home

Visha, a Geriatrician, has always strived to provide the very best care available anywhere and, although they handle an enormous number of patients, she is proud of the outstanding results achieved by her hospital-based team.

Visha was recruited onto the transition team which managed the set up of a new service running satellite clinics. Working with Paul, one of the GP leads, she realised that this challenging change could mean even better treatment and an improved experience for patients. By setting up a buddying system, Visha's specialist expertise and Paul's broader experience were combined and Paul was supported to take on monitoring and care which would previously have required a hospital visit. Visha's team is now on rota to advise local GPs 24/7 via a hotline, so reducing the number of patients reaching them through A&E.

The practice at which Paul is based proved an ideal location for outpatient clinics. As a community 'hub', it is well-equipped and a new IT system enables Visha to access patient records and communicate with specialist colleagues - whether she is in the practice or on her ward.

What these changes mean for our finances

We have reviewed our finances thoroughly, including making comparisons with national figures and looking for opportunities to make savings and organise services more efficiently.

As reported in the summer, by 2020/21 we predict a system-wide £250m financial deficit. This is in addition to £250m of savings and efficiency plans individual trusts and the Clinical Commissioning Group (CCG) need to deliver over the same period. This makes a total system-wide financial challenge of £500m over the next four years.

If the trusts and Clinical Commissioning Group meet their plans, and all aspects of the Sustainability and Transformation Plan are delivered, this will achieve the savings and efficiency target of £500m and will actually produce a small NHS surplus of £1.3m (by 2020/21).

To enable all the proposed service improvements and developments within the STP to be delivered it will require an estimated additional investment of £43m. If this investment is to be locally funded it will need to be paid back, and therefore would increase the total system-wide financial challenge from £500m to £543m.

We believe that success lies in reducing demand, meeting the ambulatory care needs of sick children, people with long term conditions, and the frail elderly, in primary and community care settings, reducing hospital length of stay, improving our workforce utilisation and reducing our overhead costs.

We are confident that there is significant scope to both improve the efficiency of patients being admitted and discharged from hospital by reducing the differences in the care provided and to deliver care more effectively outside of hospitals.

We feel that there is also opportunity to reduce clinical support services costs, through sharing back office costs and organisational mergers, where beneficial.

There are a number of areas that we believe should produce additional benefits, including growing income from commercial opportunities, and by reducing the cost of debt repayments.

Our approach to implementation

Why this time is different

We know that there have been times in the past when we have not delivered plans in the way we intended to. This time it will be different because we have been able to work together, as equal partners across the system, to build collective awareness that a problem exists, to fully understand the root causes of this, and to use this information to identify solutions and build commitment for implementation and action.

We are committed to behaving differently, listening more, being clearer about principles for decision making, and getting better at making whole-system decisions together.

System leadership, system working

We recognise the importance of partnership working in order to implement the changes described in our Sustainability and Transformation Plan. This includes partnership working across our organisations as we move towards greater joint health and social care commissioning and services.

We have made the public commitment to return the health and care system to a sustainable position, and improve care for local residents and healthcare users – through a Memorandum of Understanding. The Memorandum of Understanding (MoU) states:

- **One ambition:** to return Cambridgeshire and Peterborough to financial, clinical and operational sustainability by acting as a single leadership team, with mutual understanding, aligned incentives and coordinated action with external parties (e.g. regulators).
- **One set of behaviours:** all partners agree to exhibit the beneficial behaviours of a single leadership team.
- **One long-term plan:** we are collectively responsible for delivering the plan that will achieve our long-term ambition, including capturing the savings opportunities identified that will enable us collectively and individually to return to financial sustainability.
- **One programme of work:** all system projects will be aligned to the Sustainability and Transformation Plan and under supervision of a Chief Executive Officer-sponsored delivery or design group.
- **One budget:** within NHS contracting, a number of financial incentive options will be considered.
- **One set of governance arrangements:** the Chief Executive leadership group, and the groups reporting to it, will be the vehicle through which system business is conducted.
- **One delivery team:** we have ensured that resources are in place to deliver our system's plan.
- **One assurance and risk management framework:** Strengthening trust and creating a sense of shared accountability.

What these changes mean for local people

We have considered the impact that the changes outlined in our Sustainability and Transformation Plan will have on the different groups within our local population. In particular, we have considered the impact on the patient groups who we feel could receive better services from us, namely those in relatively more deprived areas, those with multiple long term conditions, and the frail.

We have engaged with the public, patients, and carers when thinking about solutions to the problems we face, and worked with them to come up with proposals that are beneficial to our population. This is the beginning of our engagement and we want to do more to involve local people and staff in developing and delivering our plans.

We published our interim Sustainability and Transformation Plan summary in July, 'How health and care services in Cambridgeshire and Peterborough are changing', which was provided to staff, stakeholders, and the public.

Our forthcoming engagement with the public has three key aims:

1. **Publicising our plan:** We will continue to tell people about our vision for health and care, describing what it means for patients in more detail.
2. **Co-designing care models**: We will continue to work with patients and the public to ensure that the care we design has the patient at its heart and promotes independence. We will need to engage fully with the public about service redesign that will change how and where they access services.
3. **Supporting behavioural change among patients and the public:** We will work with the public to promote healthy behaviours and taking individual responsibility for health and wellbeing, stressing to our population the importance of leading healthy lives. We will provide education around appropriate and effective ways of using services including self-care, urgent care, and A&E.

> Regional centres make sense, seeing a specialist who does it often.
>
> Huntingdon Public Workshop

What do the changes mean for our staff?

We have worked through our solutions as a single leadership team. The staff we have involved in developing solutions have been tasked with putting patients first, over and above organisational or professional interests. With the Sustainability and Transformation Plan now developed, it is important that we are clear about what the changes mean for us as individual organisations.

The biggest change will be for the 20,000+ staff employed by our providers. The proposals have been developed by approximately 200 frontline staff and we have already started to plan how we will engage with staff more widely. By putting our patients at the centre, now and in the future, we are confident our staff will respond positively and feel that the opportunities presented are career enhancing.

We know that our workforce will need to grow in order to cope with our increasing population and growing numbers of people with complex health needs. This means that there will be an increase in staff numbers over the next five years, but this growth in head count will be less than it would need to be if we were not working together as a system.

The type of skills we will recruit will also differ in recognition of the need to supplement primary care with non-clinical staff who can focus on care coordination and provide social support. We need to make the best use of our most expensive, and often scarce, consultant workforce by sharing posts where appropriate.

Staff often train in our organisations but do not choose to stay because housing is too expensive, particularly in Cambridge. We are keen to address this and will seek to influence the planned new housing developments so that they include sufficient affordable homes.

Our move towards working as one network will see significantly greater collaboration between organisations. This may mean that we ask staff to work in different locations or with different working patterns. We will work with staff to alleviate any concerns they might have around this and we will ensure that the benefits of this new approach are made clear.

Fit for the Future

Working together to keep people well

How you can get involved

There will be more opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change.

We are committed to being as inclusive and open as possible. We will listen to all contributions and use these contributions to influence the decisions we make. You will be able to have a say in key decisions, including formal consultation.

If you want to be part of the discussion and work with us to develop solutions, please contact us via email on **contact@fitforfuture.org.uk**

You can also register on our website **www.fitforfuture.org.uk**

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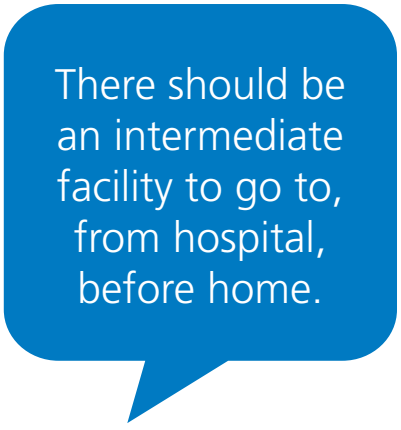
Ely Public Workshop



Cambridge Public Workshop

Our Partners

Cambridgeshire Community Services NHS Trust

Cambridgeshire and Peterborough NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Hinchingbrooke Health Care NHS Trust

Papworth Hospital NHS Foundation Trust

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

Fit for the Future

Working together to keep people well

Produced by Cambridgeshire and Peterborough Sustainability and Transformation Programme.
November 2016

Report No. 33/2017

Report to Rutland Health and Wellbeing Board

Subject:	**Personal Health Budgets Local Offer Briefing**
Meeting Date:	**31st January 2017**
Report Author:	**Maria Smith, Strategic Lead for Personal Health Budgets, East Leicestershire and Rutland Clinical Commissioning Group**
Presented by:	**Maria Smith, Strategic Lead for Personal Health Budgets, East Leicestershire and Rutland Clinical Commissioning Group**
Paper for:	**Approval**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

Forward View into action: Planning for 2015/16 [1] states:

"*To give patients more direct control, we expect CCGs to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit.....CCGs should engage widely and fully with their local communities and patients, including with their local Healthwatch, and include clear goals on expanding personal health budgets within their published local Joint Health and Wellbeing Strategy."*

In addition there is an expectation that CCGs will publish a 'Local Offer' detailing the offer to the local population in relation to Personal Health Budgets that all stakeholders are sighted on and signed up to. Therefore this paper aims to set out for the Board the basis for the CCGs' Local Offer and the plans currently in development to expand on that offer in accordance with national guidance.

Financial implications:

Personal Health Budgets are an alternative way of using existing resources within healthcare services and therefore should be cost neutral in their implementation. The paper describes the careful planning and phased approach taken to the implementation of personal health budgets to maintain financial stability and sustainability of services.

Recommendations:

That the board:

1. **NOTE** the progress made in relation to the local personal health budget offer
2. **AGREE** the plan for further expansion of the personal health budget/integrated personal budget offer into 2017 and beyond

Comments from the board: **(delete as necessary)**

[1] Planning guidance for the NHS, setting out the steps to be taken during 2015/16 to start delivering the NHS Five Year Forward View

Strategic Lead:	Maria Smith	
Risk assessment:		
Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	
Profile	L/M/H	
Equality & Diversity	L/M/H	
Timeline:		

Task	Target Date	Responsibility

Background

A personal health budget is an amount of money to support a person's individual health and wellbeing needs, as agreed between the individual and their local NHS team.

The CCGs' approach to delivering the required expansion of Personal Health Budgets (PHB's) is detailed at Appendix I and forms the basis for the Local Offer for the Health and Wellbeing Board's consideration and agreement.

The LLR CCGs view PHB's as a tool to support personalised care. As such, and to ensure a population level benefit the CCGs will continue to ensure a focus on personalised care planning, which could result in a PHB being offered. Until detailed work is undertaken to restructure contracts and budgets, (in future years the Local Offer will provide more detail on how this will be achieved) there is no capacity to provide direct payments to those receiving services funded through block contracts, although they may benefit from personalised support planning and options regarding a notional budget should be considered.

As at 29th December 2016 there are 105 personal health budgets in place or agreed across LLR, made up of CHC patients and those jointly funded with social care, as well as 4 personal health budgets for children eligible for continuing care.

1. **The Local Offer**

The Government's Mandate to NHS England for 2016-17 and the NHS Planning Guidance for 2016/17- 2020/21 were published in December 2014, re-affirming the Government and NHS England's commitment to the roll-out of personal health budgets.

The Mandate sets a clear expectation that 50,000-100,000 people will have a personal health budget or integrated personal budget by 2020 – this translates to around 1-2 people per thousand of the population. The Planning Guidance requires all CCGs to include personal health budgets and integrated personal budgets in their Sustainability and

Transformation Plans (STPs) as a key mechanism to hand more power to patients. In addition, local plans for Transforming Care need to show how people with a learning disability and/or Autism who have a mental health condition or display behaviour that challenges, are provided with the same rights to choice and control over their health care as everyone else. Through the use of PHBs and integrated personal budgets these groups of people can be supported to live to their full potential within their local community and avoid admission to out of area specialist placements or mental health inpatient settings.

It has been demonstrated that benefit from a PHB derives from the level of need rather than particular diagnosis or condition. The planning guidance for 2015-16 allowed for local flexibility on which groups will be offered personal health budgets and while this has been carried over for 16/17 there is an expectation that CCGs will be able to meet the requirements laid out in the Bubb Review[2]. Therefore there is an expectation that the CCGs' Local Offer will include a cohort of individuals with Learning Disability and/or Autism that have the right to request a PHB. Furthermore it is expected that CCGs will move towards 1- 2 per 1000 people in the population being in receipt of a PHB over the next 3-5 years, which equates to between 1,011 and 2,022 PHBs for Leicester City, West Leicestershire and East Leicestershire and Rutland Clinical Commissioning Groups.

1.1 Adults

The request and provision of PHBs for adults is via a single referral pathway to the Personal Health Budgets Team currently based at ELR CCG.

From 1st April 2014 adults eligible to receive Continuing Healthcare funding have had a 'Right to Have' a PHB and from 1st April 2016 Adults with Learning Disability and/or autism who have a Significant Health Need are able to request a PHB – please see Appendix I for details of the proposed scope of the CCGs' Local Offer with respect to Learning Disabilities in the first instance, moving on to mental health and long term conditions in the longer term.

[2] WINTERBOURNE VIEW – TIME FOR CHANGE Transforming the commissioning of services for people with learning disabilities and /or autism. Sir Stephen Bubb 2014

1.2 Children and young people

The request and provision of Personal Health Budgets for children and young people is via a single referral pathway to the Personal Health Budgets Team currently based at ELR CCG.

From the 1st April 2014 children and young people eligible to receive continuing care funding have had a Right to Have a PHB and from the 1st April 2016 children with Learning Disability and/or Autism who the CCG consider may benefit from money from health, will be able to have a PHB as part of an integrated personal budget through their Education Health and Care Plan. Please see Appendix I for details of the scope of the CCG's Local Offer for this cohort of children.

1.2.1 Significant Health Need

Individuals with learning disabilities and/or Autism, that are not eligible for continuing healthcare or continuing care funding, but still have significant health needs should have the option of a personal health budget, along with support to manage those budgets, that enables them to remain living in the community and avoid out of area placements.

'Significant health needs' with regard to adults with Learning Disabilities and/or Autism will be defined in the first instance by the following criteria:
Learning Disability and/or Autism **AND**

- Individual is currently inpatient under s3 of the Mental Health Act 1983 (as amended 2007) who is fit for discharge and could be supported to live in the community **OR**
- Individual does not meet the criteria for 100% health funded CHC, but has significant health needs deemed above what can reasonably be expected of the Local Authority to provide for.

In order for children and young people to be included in this group there is an expectation that their care requires a multifaceted and multi-disciplinary approach to meet their holistic needs. The CCGs are currently considering the resource implications of setting the following criteria for children and young people with Learning Disability and/or Autism to be offered a PHB:

- A child or young person with Learning Disability and/or Autism **AND**
- A child or young person who is under regular care of a hospital/community paediatrician **AND/OR**
- A child or young person who is under the regular care of any CAMHS Consultant **AND**
- A child or young person who has 2 High level needs identified on the Continuing Care decision support tool.

It should be noted that any personal health budget awarded to a person fitting one of the above criteria is likely to be as part of an integrated personal budget joint funded with the Local Authority, determining percentage or funding splits in line with statutory responsibilities and current local arrangements.

1.2.2 EHC Plans

Education, Health and Care needs assessments and plans have replaced Special Educational Needs assessments and Statements for children and young people with special educational needs or disabilities and are available up to the age of 25. EHC plans specify any additional provision required to meet or facilitate the educational needs of those children or young people and the eligibility criteria for these plans are set by the local authority. EHC plans must focus on outcomes and whilst the process is led by local authorities, they must ensure a multiagency joint assessment and planning process across health, social care and education, which will inform the EHC Plan.

The PHB Team is working with the Children's Commissioning Team, contracting colleagues, Leicestershire Partnership Trust and Local Authority colleagues to explore the current arrangements for options for delivering short breaks to children with complex needs and to find opportunities to join these up through integrated personal budgets. Additionally the PHB Team together with the Children's Commissioning Team intend to explore therapy services for children and whether there is any scope to offer any element of these services as PHBs, to ensure that those with Education Health and Care Plans are able to benefit from additional choice and control as part of an integrated personal budget across health, social care and education.

2. Wider implications; changes to support expansion of PHBs and increased personalisation.

Expansion of PHB's and increased personalisation is dependent on all partners engaging with the detail of how to make change happen. The key partners are set out in the table below, plus Healthwatch and independent sector providers.

2.1 The 2016-17 work plan outline

- Plans are in place through existing target groups/projects (Table 1). Increasing Personal Health Budget uptake figures and measuring progress will be captured to demonstrate improved outcomes and reduced inequality.
- The CCG's uptake of Personal Health Budgets within Continuing Healthcare (CHC) is currently 13.8% of all individuals eligible for CHC and living in the community including Fast Track patients. As Fast Track patients are not routinely offered a personal health budget, when these patients are removed from the figures the percentage within the remaining CHC population increases to 25%. This significant increase in percentage is due to the establishment of the Personal Health Budgets Team and plans are being developed to continue to increase the number of PHBs by embedding them as 'business as usual' for CHC.

- Continued work to raise the profile of PHBs as an enabler to the Transforming Care agenda and the knowledge amongst those care planning for these individuals that PHBs are an option.
- Engagement with the Transforming Care Short Breaks review across LLR health and social care, ensuring that the resultant new models of short break provision are conducive to individuals using a PHB to achieve these outcomes.
- Scoping possibilities to offer PHBs to those with mental health difficulties, starting with s117 funded individuals but also considering commissioned services that may not currently be working for people and how they could be delivered in a different way.
- The development of PHBs will be linked closely with the consultation currently underway regarding the Resilience and Recovery Hubs for mental health as well as the Better Care Together workstream regarding the Integrated Locality Teams for those with complex needs.
- Build on the Peer Network that has been established to support current PHB holders and to provide a reference group to help shape the future PHB offer.
- Work to increase understanding of costs and impacts on current commissioned services.
- Work with providers to explore the potential for internally releasing funds
- Work with Local Authority colleagues to develop and embed joint systems and processes to deliver integrated personal budgets to eligible individuals.

2.2 Current success drivers

- The operational processes for PHBs in CHC are being finalised and embedded to ensure productivity and efficiency in delivery.
- A tender process has now concluded to procure a new CHC/CC/PHB service for this cohort of adults and children – this provides the opportunity to embed a new service

model whereby PHB is the default position for this cohort, which should result in increased numbers. The new service should be operational by April 2017.

- Information and advice about PHB's is available on all three CCGs' websites and a Communications and Engagement Plan is in the final stages of development, to be implemented during 2016-17

- Direct Payment Support Organisations are available and funded for all PHB recipients who require this, as detailed in the PHB Policy. They are able to provide support and advice for PHB recipients regarding recruitment, payroll, HMRC, and other employer responsibilities.

- Peer Support Networks are important for both the individual PHB recipient, and for supporting the development of co-production locally. There are now sufficient PHB numbers to create a fully functioning Network. An initial meeting was very successful, being attended by 12 families at varying stages of the PHB process. The Communications and Engagement Plan details plans to develop the network.

- Good links between the national team and the local PHB Team ensure regular communication regarding resources, tools and expectations from NHS England.

2.3 Risks to the Local Offer

- The operational and governance mechanisms to deliver personal health budgets for groups such those with Education, Health and Care Plans and learning disability cohorts are in progress.

- Additionally, further work is required regarding children's contracts in relation to nursing, short breaks and therapies to ensure funding availability beyond continuing care for those within scope who have a PHB. This work has commenced.

- Case/care management is not in place for all cohorts in scope and is a wider piece of work to plan and implement organisational changes.

- As PHBs are an entirely new delivery model, there is no way of gauging demand and patient appetite for them as the local offer is expanded to new cohorts.

- Work to address the cultural change required is ongoing. This is a considerable piece of work, due to the extent to which PHBs counter much of current NHS culture. This is likely to take several years before PHBs are embedded as an NHS delivery mechanism and promoted effectively.

- There is a considerable amount of work to be done by the PHB Team to promote the benefits of purpose of PHBs and facilitate cultural change. Work planned through the Communications and Engagement Plan should help to address this but allaying fears from clinicians and service providers will take time.

2.4 Expanding PHBs to Mental Health and Long term conditions

Personal health budgets are part of a much wider programme of personalisation in health and social care. It is LLR CCGs' intention to extend the offer and availability of personal health budgets to more people over time. During 17/18 the CCGs have an agreed timeline for implementation of PHBs to more people to include those with Mental Health needs. This offer is just beginning to be scoped to establish who might benefit within mental health and whether any existing services are not meeting outcomes and therefore could be considered for PHBs instead. Similarly, data regarding those with long term conditions for whom current services are not working is just beginning to be scoped to understand numbers, current spend and whether PHBs could be part of the solution.

When planning commences, any changes must be implemented in line with commissioning and contracting cycles and in accordance with the strategic objectives of the CCGs.

The way in which services are commissioned means that funding is tied up in block contracts and any expansion will be dependent on the freeing up of resource to fund budgets from these contracts. This takes time due to logistical, contractual, relational and cultural challenges.

PHBs are not about new money, but using the same allocation in a different way to meet assessed care and support needs. In order for this to happen there needs to be change in systems and thinking at all levels, and the CCG is committed to promoting culture change at all levels within commissioner and provider organisations.

Appendix I

2015/16	a) Continue to identify those individuals in receipt of continuing health care or children with continuing care.
2016/17	a) Children and young people with learning disabilities and who have significant health needs b) People with learning disabilities and significant health needs. c) People with learning disabilities who are inpatient but could be supported to live in the community through a PHB/be supported through a PHB to maintain in the community and prevent further admission d) Continue with year 1 cohort
2017/18	a) People with mental health difficulties – specifics currently being scoped b) Patients subject to S117 after-care as part of the Mental Health Act 1983* for their package of community support c) Wheelchair users in line with national expectation d) Scope children and young people with an EHC Plan who would benefit e) Continue with year 1 and 2 cohorts
2018/19	a) Long term conditions – this has yet to be scoped b) Explore PHBs for those individuals for whom traditional services are not working. c) Continue with year 1, 2 and 3 cohorts
2019/20	a) Continue with above

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Report No. 39/2017

Report to Health and Wellbeing Board

Subject:	**Better Care Fund Programme Update**
Meeting Date:	**31 January 2017**
Report Author:	**Sandra Taylor**
Presented by:	**Mark Andrews**
Paper for:	**Noting**

1. Introduction

1.1 This report updates Health and Wellbeing Board (HWB) members on progress with the 2016-17 Better Care Fund plan and progress on planning for the 2017-18 to 2018-19 Rutland Better Care Fund (BCF) Programme.

2. Recommendation

2.1 The Board is requested to:

2.1.1 Note the content of the report.

3. Policy framework and context

3.1 The Better Care Fund is a joint health and social care integration programme managed operationally by the Rutland County Council People Directorate, in conjunction with the East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) and delivered under the oversight of the Rutland HWB.

3.2 The Rutland HWB approved Rutland's current 2016-17 plan in March 2016. This plan is currently being delivered in line with the NHS's current BCF operational guidance (https://www.england.nhs.uk/wp-content/uploads/2016/07/bcf-ops-guid-2016-17-jul16.pdf

3.3 Planning is now underway for the successor programme, to be delivered across two years to align with the two year CCG operating plans now required by NHS England.

3.4 At the time of writing, the Local Authority BCF allocations have not yet been confirmed (expected imminently), nor has the national BCF guidance yet been published.

3.5 However, the primary NHS planning guidance confirms the continuation of the BCF and the ongoing requirement for the implementation of integration by 2020.

3.6 It was anticipated that a draft BCF submission would be required to be submitted to NHS England by 26 January 2017, with a final submission date anticipated to be late February/early March 2017. However, this timetable has been subject to further slippage.

3.7 It has been confirmed that the assurance process will mirror last year's, with regional

then national assurance, anticipated to conclude by May 2017.

4. 2017-18 to 2018-19 programmes: Strategic and policy context

4.1 The strategic framework for the BCF re-planning process is set by: the BCF national policy requirements, BCF national conditions, BCF metrics, CCG commissioning intentions and Local Authority duties with respect to the Care Act.

4.2 Locally, the new Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Plan (STP) re-frames priorities and financial plans across the LLR health and care economy. The area's three Better Care Fund programmes will be required to align with, complement and support this strategy.

4.3 Although not all the detail of the policy context has yet been confirmed, a number of areas remain priorities within the integration agenda nationally and locally: keeping people out of statutory and acute provision wherever possible, including via prevention activities, sustaining adult social care within new models of care locally, ensuring there is a cohesive plan for data integration at population and care planning levels, implementing seven day services, improving hospital discharge, and developing an infrastructure for joint commissioning.

5. Renewing the Rutland BCF plan

5.1 An initial strategic and financial refresh of the plan is underway, including:

5.1.1 Confirming the minimum required levels of financial allocation to protected Adult Social Care and out of hospital services (including the uplift for inflation across the programme period).

5.1.2 Assessing the affordability of the plan and the opportunities to generate headroom, recognising the financial pressures affecting all partners.

5.1.3 Determining the potential contribution of the plan to key indicators so that realistic yet ambitious targets can be set.

5.1.4 Ensuring alignment with STP activity (including proposals for the Rutland Memorial Hospital), CCG operating plan assumptions, the Vanguard urgent care pathway and local GP plans to join the Primary Care Home approach to delivery of primary care.

5.1.5 Following through the implications of new models of service delivery including:

5.1.5.1 Integrated locality teams across LLR.

5.1.5.2 The 'home first' reablement model

5.1.5.3 The 'Primary Care Home' approach to primary care being adopted in Rutland.

5.1.6 Giving further consideration to the overall integration model which will be adopted as the end point for integration in Rutland and across LLR.

5.2 The refresh is also being informed by a BCF partnership engagement event which was

held on 5 January 2017 (see Appendix 1), which reviewed the performance of the programme during 2016-17 and looked ahead to potential future priorities.

5.3 Most of the BCF plan is committed to core NHS and Local Authority services, so, in large part, the challenge is one of evolution, further developing how services are configured and work together.

5.4 Any more significant changes would need to be incorporated into contracts or delivered through decommissioning/commissioning activities that are subject to the usual timescales, processes and governance.

5.5 No final BCF refresh timetable has yet been confirmed nationally and the BCF guidance, budgets and planning templates have not yet been published, although indicative information has been made available through a BCF webinar by the Better Care Fund Programme team.

5.6 In the interim, work is underway by RCC, working with ELRCCG, on a draft narrative for the new programme, which will be adjusted as required when the national materials are published.

5.7 It may be necessary to progress at speed when national guidance and templates are formally released, in a process which will require HWB sign off.

6. Financial implications

6.1 The financial framework for the Rutland BCF programme is set by the national CCG and Local Authority allocations, the financial model of the LLR STP, the council's Medium Term Financial Plan (MTFP) and the CCG's operating plan financial targets and control totals for 2017-18 to 2018-19.

6.2 The negotiation of the BCF programme will be taking place against considerable and increasing financial pressures for both RCC and ELRCCG.

6.3 The 2016-17 programme consisted of a minimum pooled fund between RCC and ELRCCG of £2.061m, supplemented by £317k of carry forward funding from 2015-16, £200k of which was allocated to one-off projects, with the remaining £117k providing a contingency fund. Alongside this, there was an RCC capital fund of £186k for Disabled Facilities Grants. Excluding the contingency fund, the value of the programme in 2016-17 was £2.447m.

6.4 The risk sharing fund of £101k that was agreed by the partnership, to be associated with emergency admission rates has so far not been required due to good admissions performance in the first three quarters.

6.5 While the exact value of the 2017-18 and 2018-19 programmes has not yet been confirmed, Rutland is anticipating a similar annual financial allocation to 2016-17, with a modest uplift for inflation. Rutland County Council has not been allocated any of the improved Better Care Fund resources for social care (the so-called iBCF), with this being targeted via a national formula towards areas of greater financial need.

6.6 The national recommendation is still that programmes retain a contingency budget, in case of the need to compensate other partners for the cost of poor performance, notably in terms of emergency admissions levels although a formal pay for performance scheme

is not anticipated this time.

7. Recommendations

7.1 That the HWB:

1. Note progress on implementing the Rutland 2016-17 Better Care Fund plan and on shaping the follow-on BCF programme for 2017-19.

8. Risk assessment

Time	M	Owning to national delays, the timetable for BCF plan development is likely to be compressed. However, groundwork is well underway that will accelerate the process of finalising a BCF plan when the relevant guidance and other structuring elements are released by Government.
Viability	L	The current and next BCF programme build on the positive partnership developed and progress made since 2014.
Finance	M	The future Rutland BCF minimum financial allocation is unlikely to increase, other than an adjustment for inflation, meaning that the challenge is one of further evolving the use of existing resources to further progress integrated health and care locally. Any underspend from the current programme can be ring-fenced for future use. In particular, the funding for a small number of delayed projects will be carried forward to allow these projects to be implemented in 2017-18.
Profile	L	The programme has a high profile at national, regional and local level and is well integrated as a complementary part of Leicester, Leicestershire and Rutland Better Care Together activity. The HWB will hold both RCC and ELRCCG to account for the delivery of the BCF.
Equality & Diversity	L	The BCF plan will have a positive impact on members of the Rutland community requiring health, care and wellbeing services and opportunities.

9. Timeline (including specific references to forward plan dates):

Task	Target Date	Responsibility

Appendix 1: Summary of 2016-17 Better Care Fund progress and 2017-19 proposals

A successful BCF planning event was held at Rutland County Council on 5 January to reflect with partners on progress with the 2016-17 Better Care Fund programme and to look ahead to priorities for the 2017-18 to 2018-19 programme. The event, which was well attended, involved around 40 staff and partners spanning a range of Council care services, commissioners from the Council and the CCG, commissioned providers, secondary care, and the community and voluntary sectors.

Attendees worked in three groups, aligned to the programme's current priorities of Unified Prevention, Long Term Condition Management and Crisis, Transfer and Reablement, exploring the successes, challenges and opportunities of this year's programme and pointing the way for future priorities.

There was consensus around sustaining the ambition of Rutland's current programme objective, aiming to achieve a well-integrated and well-understood health and care system by 2018. Financial allocations will not be increasing, so the challenge is one of evolving to progress to the next stage of integration within the current financial boundaries.

1: Unified Prevention

Progress to date

1.1 The strong focus on prevention, aiming to keep people well, active and engaged in their communities, has been a distinctive aspect of Rutland's BCF programme, recognised by the national NHS England Better Care Fund Programme.

1.2 Many Rutland residents have benefitted from the diverse BCF prevention measures (including assistive technology, falls prevention schemes and support from the Community Agents on life issues). New activities such as the Men in Sheds project at the museum and telephone befriending (also as a follow-on to Community Agent support), were also welcomed, including for their anticipated contribution to mental wellbeing and social connection.

1.3 Disabled Facilities Grants (DFGs) for home adaptations continue to be delivered to help people to remain living at home and support their independence and quality of life, with most projects involving the installation of adapted bathrooms, stair lifts and/or ceiling hoists.

1.4 At the same time, there is a need to ensure that services are modelled sustainably and are not over-fragmented, intervene earlier to be truly preventative and reach as many potential beneficiaries as possible.

New projects and approaches

1.5 A number of prevention activities are committed into 2017-19, and are also anticipated to continue to evolve in response to local needs. Assistive technology is now a well-established service, for example, while the Community Agent scheme will continue as part of a wider Community Prevention and Wellbeing contract. Falls prevention activities delivered well in 2016-17, as reflected in reduced falls injuries, but were somewhat fragmented.

A more strategic approach is being pursued, including opting into some LLR wide falls prevention services.

1.6 The discretionary scope of adaptations that can be funded under the DFG scheme is currently being more clearly defined via a DFG policy so that the funding can increase or sustain the independence of more individuals.

1.7 As physical activity is increasingly recognised as the lynchpin for continued good health, work has also been started with local partners to consider what interventions could increase activity levels among sedentary individuals. There was also a need to consider carefully the language used to promote prevention activities to more directly motivate and engage target audiences (e.g. by working directly with target users) and to remove perceived barriers to increasing activity levels, working on the 'nudge' principle – making it easy for people to make good choices.

1.8 Providers of prevention-related services suggested that they would like to work more closely to better support potential synergies – enabling communication, coordination and connection. The Rutland Information Service website improvement project, underway now, was felt to be important for capturing and communicating Rutland opportunities, either directly to target audiences or via community providers and navigators.

2: Long term condition (LTC) management

Progress to date

2.1 Work with patients/service users with ongoing health issues was felt to be going in the right direction, as reflected in key BCF indicators, including a 3% year on year reduction to emergency admission rates and the maintenance of low levels of permanent care home admissions. The core focus this year has been on the further integration of community health and long term social care teams, including through a leadership development programme and increased multi-disciplinary working. There is further potential to build on this by working more strongly with both primary care and voluntary and community services.

2.2 In addition, services have continued to be delivered to support households where an individual has dementia and funding support for carers. Dementia support is about to be strengthened through the recruitment of a specialist Admiral dementia nurse able to provide clinically robust advice and support.

2.3 The Integrated Care Coordinator at the GP surgeries has also continued to provide valued support to people identified by risk stratification as vulnerable and who may not be benefitting from all the services available to them. Recognising that a wider population could benefit from this general approach, including mental health support, new Wellbeing Advisors in GP surgeries have been funded for the next year through an ELR CCG BCF pilot project.

2.4 The connection with work under the prevention strand was also recognised, building on the capabilities of individuals and the assets in their communities for people to live the fullest life they can, in the way they want to, in spite of health challenges. The need for good quality information about local services and opportunities, including volunteering, was also highlighted, ensuring that more people are more easily 'in the know'.

New projects and approaches

2.5 At the heart of long term condition management is developing stronger ways of working between primary care, community health, social care and the community and voluntary sector to deliver more efficient, effective, coherent services that respond in a personalised way to the specific health needs of service users, helping them to manage their health to lead as full a life as possible.

2.6 Again, an aspect of future plans is continuity and evolution, continuing with the Care Coordinator approach, supplemented by the Wellness Advisors, with support for dementia sufferers and carers and with a core of multi-disciplinary integrated working.

2.7 Alongside this, two key local developments provide unique opportunities across the 2017-19 BCF programme to work together to re-imagine and reshape the delivery of primary, secondary and social care for patients in Rutland, particularly those with complex health needs:

2.7.1 Rutland GPs are going forward with the Primary Care Home model, introduced by the National Association of Primary Care, which aims to promote the redesign of primary care around the needs of defined communities, personalising care and further integrating the workforce across primary, secondary and social care.to improve outcomes.

2.7.2 Proposals under the LLR Sustainability and Transformation Plan to reshape the service offering at the Rutland Memorial Hospital are also a catalyst for change.

3: Crisis response, transfer of care and reablement

Progress to date

3.1 The focus of the Crisis Response, Transfer of Care and Reablement priority is on managing and reducing demand for hospital services.

3.2 Rutland progress on systems for hospital avoidance and prompt discharge were reviewed relative to a national hospital admission and discharge maturity model, demonstrating that significant progress has been made during this financial year to avoid unnecessary hospital admissions (e.g. local use of the ICRS night nursing service) and to ensure prompt onward transfers of care when patients are medically fit for discharge.

3.3 Rutland has taken a rapid cycle approach to solving discharge related issues, leading to a highly integrated and effective discharge process with clearer options and pathways, including the flexible call off of interim beds where people cannot return directly home but no longer need hospital care. In six months, this latter initiative has saved over £200k for the wider health and care system, relative to the higher cost of people remaining in acute beds beyond their fit for discharge date.

3.4 Mental health related discharge delays have been a significant issue this year, leading to 233 nights currently classed as discharge delays (the statistics are currently being reviewed). This relates to a number of factors: a lack of clarity across the system about when sectioned mental health patients are transfer

ready, a poor flow of information about these potential discharges and lack of capacity in suitable onward placements.

3.5 Data analysis has been strengthened as a means to track progress with discharge management and has successfully enabled layers of issues to be identified and prioritised for resolution to reduce future delays. A key success factor has been the maturing of relationships and understanding between different discharge professionals and the willingness to reshape actions flexibly in response to evidence, trying new ideas and embedding the ones that work. User engagement has also generated further helpful insights about the discharge experience.

3.6 The resulting incremental system improvement has helped to deliver a progressively stronger discharge response through e.g. introducing the flexible call-off of interim care home beds, establishing a complex case manager role to negotiate more difficult discharges, building stronger relationships with out of area hospitals regularly treating Rutland patients, improving information flows about mental health discharge needs, and identifying discharge options in an integrated way whether the resolution is health or social care related.

3.7 In spite of intensive work, the overall level of delayed transfers of care (DTOCs) has remained higher than target for most of the year, echoing continuing national patterns of high discharge delays. However, bucking wider national trends, we have seen a steep net improvement to DTOC levels in Q3, to a monthly level in November that was within target for the first time this year. While, cumulatively, the annual DTOC target is likely to be exceeded, the number of nights of delays to transfers of care would have been substantially higher without the creative and innovative transfer management work to date. The steep net decline in delays in Q3 also reflects the cumulative impact of system improvements to date which have increased the capability of the system to handle current and future transfers of care.

3.8 Alongside this, it should be noted that the number of patients needing discharge support appears to be increasing over time. This means that, even as approaches improve, the challenge continues to increase. Teams may be pedalling faster, but the road is also getting longer! Second, against the pattern of delayed discharges, most patients do get discharged on time, often as a result of proactive discharge support. The rate of successful activity is not made visible in the current national approach to monitoring patient flow.

3.9 Finally, following discharge, reablement has continued to deliver successfully, ensuring that around 90% of service users who receive post hospital reablement are still at home 3 months after discharge, against a target of 83.3%. The number of cases receiving reablement services has also been increasing quarter on quarter this year (25 in Q1, 36 in Q2, 47 in Q3).

<u>New projects and approaches</u>

3.10 The proposed approach for 2017-19 is twofold.

3.11 First, the DTOC Action Plan will be renewed as a reference point for partners, setting out the directions of travel for crisis management, transfer of care and reablement. Areas of opportunity or planned change include:

3.11.1 The reshaping of the crisis response night nursing service to focus more tightly on end of life needs, alongside coordinating with the wider LLR Vanguard work to improve the response to wider urgent care needs.

3.11.2 Pre-admission planning for the discharge of elective patients (particularly where e.g. adaptations or reablement will be needed to support the return home)

3.11.3 Improving the information patients receive about discharge so they feel more confident in the discharge process, including promoting the role of advocacy to help patients with limited family or informal carer support.

3.12 Second, partners will continue to work iteratively, informed by data, to identify and address issues and disjoints in transfer of care processes so that discharge delays, and their impact on the wider health care system, are reduced to a minimum.

4: Enablers

Achievements

4.1 A broad range of enabling activities have been actively progressed during 2016-17, addressing areas that partners have agreed were actual or potential barriers to progress on establishing an integrated, effective and well understood health and care system in Rutland.

4.2 There is a clear, prioritised work programme for IT and IG, firmly linked to the LLR IT roadmap. More of the underlying building blocks for integration are in place (e.g. at RCC, IG Toolkit accreditation obtained, interoperable social care system LiquidLogic in place, NHS numbers being obtained and becoming a more routine reference point in social care).

4.3 IT projects are being progressed to support integrated working, notably the joint laptop solution delivered in January 2017.

4.4 Data has been more central to shaping policy responses and we have increased our involvement in wider projects and toolsets able to support evidence based change, including the PI Care and HealthTrak system.

4.5 User engagement in shaping services has been strengthened, notably through the HealthWatch project listening to service user experiences of transfers of care.

4.6 There is an efficient solution to adapting to workforce challenges through proactive working with the social care training provider LSCDG.

4.7 The BCF programme and its activities and achievements have been more widely communicated.

New projects and approaches

4.8 Funding will be limited in 2017-19 for enablers activities, but it is anticipated that many of the above areas can be continued, to help to support integration, e.g. following through on the work to strengthen IG arrangements and IT

integration (activity which it may also be possible to fund eg via applications for national Digital Roadmap funding), and to make greater use of analytics platforms. Cost effective routes to increased user engagement are also a potential priority, helping to inform and target policy and service responses.

Rutland County Council

NOTIFICATION BY A MEMBER OF RUTLAND COUNTY COUNCIL
OR
A MEMBER OF A PARISH COUNCIL WITHIIN RUTLAND
OF
DISCLOSABLE PECUNIARY INTERESTS & OTHER REGISTRABLE INTERESTS

Localism Act 2011 - Part 1, Chapter 7, Sections 28-34 Regulations 2012 – No. 1464

Important Notes

This form can be adapted and used by Town or Parish Councils. Once completed, each Councillor's Register of Interests form should be sent to The Monitoring Officer at Rutland County Council – monitoringofficer@rutland.gov.uk.

- In order to comply with the relevant Council's Code of Conduct, a Member or Co-opted Member must register their disclosable pecuniary interests (DPI's) and interests other than pecuniary interests with Rutland County Council's Monitoring Officer within **28 days** of the date of their election, re-election or co-option and also once a member becomes aware that they have an interest.
- Failure to declare a Disclosable Pecuniary Interest is an **offence**. A member who is found guilty of an offence under Part 1, Chapter 7, Section 34 of the Localism Act 2011 is liable on summary conviction to a fine not exceeding level 5 on the standard scale and a court may by order disqualify a member for a period not exceeding five years from being or becoming (by election or otherwise) a member or co-opted member of any authority.
- If you cease to have an interest that you have previously registered, please re-submit an updated notification form to Rutland County Council's Monitoring Officer.
- If in doubt about whether or not something should be declared, you are urged to err on the side of openness and avoid the risk of not registering something in error.
- If you are a member of any other authority, please complete a separate notification form for each.
- You may complete this form electronically but you must personally sign and return a paper copy of the completed form.
- Once completed this form will be published on Rutland County Council's website and in your Parish in accordance with the Localism Act 2011.
- If you have any difficulty completing any part of this form please contact your Parish Clerk or the Corporate Support team for advice.
- A Member must, within **28 days** of becoming aware of any new disclosable pecuniary interest or other registrable interest or change to any disclosable pecuniary interest or registrable interest as specified above, resubmit a revised notification form to the Council's Monitoring Officer.

Name of Member: (please print)	
Address:	
	Postcode:
Parish Council:	

I hereby GIVE NOTICE that I have the following disclosable pecuniary interests (DPI's) and other interests as are required to be registered by your Council's Code of Conduct and Regulations.

DISCLOSABLE PECUNIARY INTERESTS

These are interests if they are of a description specified in regulations made by the Secretary of State and either it is **your interest or your partner's interest** (partner means spouse or civil partner, a person with whom you are living as husband or wife, or a person with whom you are living as if you are civil partners) within the following descriptions:

(Please state NONE where appropriate and do not leave boxes blank)

1. Any employment, office, trade, profession or vocation carried on for profit or gain. NOTE: Give a short description, including the name of your employer or the person who, or body which, appointed you to an office.	
2. Sponsorship – any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards the election expenses of you. NOTE: This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992. Please disclose the amounts of any payments.	

3. Contracts – any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority - **(a)Under which goods or services are to be provided or works are to be executed;** **(b) and which has not been fully discharged.** NOTE: State briefly the contractor and the subject and length of the contract. You do not need to disclose any financial details.	
4. Land – any beneficial interest in land which is within the area of the relevant authority. NOTE: This includes the land relating to any property you own or rent, including your home, garages, allotments etc. State the address or brief description to identify it and whether you are the owner, lessee or tenant. You should include any property from which rent or mortgage payment is received.	
5. Licences – any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer. NOTE: Please state the address or brief description to identify the land.	
6. Corporate Tenancies – any tenancy where (to your knowledge) - **(a)the landlord is the relevant authority; and** **(b) the tenant is a body in which the relevant person has a beneficial interest** NOTE: Please state the address or brief description to identify the land and name the tenant.	

7. Securities – any beneficial interest in securities of a body where - **a. that body (to your knowledge) has a place of business or land in the area of the relevant authority; and** **b. either, i. the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or** **ii. if the share capital of that body is more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.** NOTE: State the name of the body. The nominal value is the value on the face of the security and is not the value at the time of acquisition or its current market value. Securities held in the name others, but in which you or your spouse or civil partner have a beneficial interest are included. You do not need to disclose the amount of the interest.	

OTHER REGISTRABLE INTERESTS

These interests are what your Council has determined should be entered into their Council's register of interests (Localism Act 2011, Part 1, Chapter 7, Section 28 (2)).

(Please state NONE where appropriate and do not leave boxes blank)

8. I am in a position of general control or management of the following bodies to which I have been appointed or nominated by the authority.	

9. I am a member or hold a position of general control or management in the following bodies: **i. exercising functions of a public nature;** **ii. directed to charitable purposes; or** iii. one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union).	
10. FOR RUTLAND COUNTY COUNCIL MEMBERS TO COMPLETE ONLY – **Any person or body from whom I have received a gift or hospitality with an estimated value of more than £50 by virtue of my office.**	

SENSITIVE INTERESTS

11. I have the following/have no [delete as appropriate] Sensitive Interests as defined by section 32 Localism Act 2011 (an interest the nature of which is such that you, and the Monitoring Officer, consider that disclosure of its details could lead to you, or a person connected with you, being subject to violence or intimidation)	

Signed:

Dated:

Notes

Completing the Notification

In addition to the important notes detailed at the beginning of the notification form, the following guidance notes may help you to complete your notification.

- You should complete the register with sufficient detail to identify clearly what the interest is.
- Do not use abbreviations, initials or acronyms.
- You are personally responsible for the accuracy of the contents of the register. Please ensure you have checked the details of what you have declared.
- You are at risk of failing to comply with the Code of Conduct if an interest is not registered with sufficient clarity.

- Please mark 'none' on the register if you have no interest to register in any category. Do not leave boxes empty.
- Ensure that you have checked and understood the definition of the disclosable pecuniary interests (DPI's).

Offences and Sanctions

The Localism Act 2011 (Part 1, Chapter 7, Section 34) introduces a number of offences that can be applied regarding non-disclosure of pecuniary interests by members.

Any member suspected of having committed an offence under the Localism Act 2011, will be referred to the Police.

A member found guilty of an offence, is liable on summary conviction to a fine not exceeding level five of the standard scale. Details can be found on the following link: http://www.legislation.gov.uk/ukpga/1982/48/part/III/crossheading/introduction-of-standard-scale-of-fines

A member can also be disqualified for a period not exceeding five years from being or becoming a member or co-opted member of any authority.

Offences can be brought forward within 12 months of the date of sufficient evidence being received. Proceedings will not be brought more than three years after the offence was committed or the last date a continuous offence was committed.

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Report No. 34/2017

Report to Rutland Health and Wellbeing Board

Subject:	**Children Young People and Families Plan (2016 – 2019)**
Meeting Date:	**31st January 2017**
Report Author:	**Bernadette Caffrey**
Presented by:	**Bernadette Caffrey**
Paper for:	**Note and to update the Board on the progress of the key priority actions for 2016/2017 in the Children's Trust's Children, Young People and Families Plan (2016 – 2019)**

Context

CHILDREN, YOUNG PEOPLE & FAMILIES PLAN KEY THEMES - 2016-2019

KEY THEME 1	KEY THEME 2	KEY THEME 3	KEY THEME 4
Keep children well and safe	**Fair Society**	**Listening**	**Efficiency**

The Children's Trust Board identified a number of themes and associated priorities for action for March 2016 – March 2017. Priorities are agreed each year and are in work areas where there are measurable improvements to be made and where improvement can be delivered in a multiagency partnership. The priorities may change year on year as the Board reviews the successes, the challenges and the continued or new areas for development. The key priorities for 2016- 2017 are as follows:

KEY THEME 1	Priority Areas for Action 2016-17	
Keep children well and safe	**1**	To be assured that Early Help Services are effectively coordinated across the LSCB Partnership and secure outcomes that reduce pressure on child protection and care services
	2	To champion and support the extension of Signs of Safety (SoS) across the Partnership and secure assurance of the effectiveness of multi-agency processes and working and evidence of positive impact for service users.
	3	To build community safeguarding resilience and be assured that people; families and professionals, living in the community know how to keep children safe
	4	To enhance the health and well-being of children and young people through improved service integration and the delivery of BCT Better Care Together health targets

KEY THEME 2	Priority Areas for Action 2016-17	
Fair society	**1**	To reduce the development and achievement gap at all key stages – championing children and young people to meet their full potential
	2	To improve economic well-being and reduce child poverty levels in Rutland

KEY THEME 3	Priority Areas for Action 2016-17	
Listening	**1**	Increase engagement and participation of young people to be active citizens.

KEY THEME 4	Priority Areas for Action 2016-17	
Efficiency	**1**	To quality assure our practice – through the use of quantitative and qualitative data, engagement of service users, and engagement from front line staff

The Children's Trust Board reviewed the progress against the priority actions in June 2016 and again at its December 2016 Board meeting. At its December meeting of the Board, the progress reports were reviewed using a Signs of Safety approach, (a strengths based methodology adopted by Children Services and across the LSCB partnership), to capture, what's working well, what the concerns are and key actions for the Board to consider and take forward. See more detail in the Priority Actions Progress Report (**Appendix A**).

In summary the headlines are as follows and which the Health and Well Being Board may wish to consider:

- Engagement of key partners in the Children Trust and attendance at meeting is consistent, however schools and police attendance is sporadic and the impact on the business of the Board of more recent representatives, such as the MOD is yet to be tested. The Board recognises the need to capture the voice of children in its deliberations and a further action is to recruit representatives to the Board, from the Rutland parent carer voice group.

- The Early Help (EH) performance framework is in place but it focuses mainly on Rutland Council County (RCC) activity. There is a need to measure more robustly, the impact of EH across the partnership; to this end the Board have asked that Early Help casework across the partnership is a feature of the LSCB multi agency audit programme in 2017. There is increased confidence in EH but evidence suggests that there are still missed opportunities to intervene earlier with families, for example the number of repeat Child Protection cases, (Rutland Q3 figure is 10%, the RCC target is 5%). This warrants further investigation.

- A 'Signs of Safety' approach is embedding in practice in RCC's children's services and there evidence of positive impact in education settings and in families' having a sense of being in control of their care plan.

- The 0 to 19 Healthy Child programme is in place, robust quality assurance and performance measures are being created that will include measuring the engagement of health personnel and their impact on safeguarding and early help. The Board will monitor the results of the integrated health review and wishes to test if mental health and emotional well-being thresholds match safeguarding thresholds. The issue of early tooth decay and obesity in school aged children remains a challenge to be addressed through bespoke programmes through 2017, which the Board would wish to monitor.

- Rutland has an ambition for inclusive education, however the Board recognises the need to build capability of Rutland's schools to support children who are hard to engage, have mental health difficulties, and display disruptive or challenging behaviour.

- Poverty as a result of insufficient income is a feature in Rutland. RCC's Scrutiny panels are taking poverty as a key focus this year, this will include the need to monitor the impact of the 30 hour early years education entitlement for low income families. The Rutland Troubled Families Programme is exceeding its targets. However the Board has asked for evidence of longitudinal impact once families step out of the programme.

- Participation of young people is developed in the Council's children's services; however it needs more consistent application across partnership services. RCC's corporate parenting responsibilities are explicit in its 'Pledges' to young people looked after and to care leavers. A performance framework is in place to monitor progress against the pledges which will be monitored by the Corporate Parenting Board.

- The level of response from agencies to the LSCB Section 11 audit was high; however the process may result in over-optimism, as the audit is self-reporting. The LSCB intends to do a peer challenge and cross reference the experience of front line staff. The LSCB and the Children's Trust Board will work together to create a QA framework in 2017/2018 that has specific indicators for both the Children's Trust and the LSCB.

- New and emerging priorities in the 2017/2018 LSCB Business Plan will be reflected in the Children's Trust Plan, such as safeguarding children with disabilities and the delivery of the Local Offer.

Financial implications:

None

Recommendations:

That the Board:

1. Note the progress of the Children, Young People and Families Plan priority actions
2. Provide direction on any key areas that the Children's Trust Board should identify as priority actions for 2017/2018

Strategic Lead:	Bernadette Caffrey

Risk assessment:

Time	L/M/H	Low - the progress against key priorities is on track

Viability	L/M/H	Low - good and continued engagement from the partnership
Finance	L/M/H	High - given the pressure on safeguarding and special needs services and placements
Profile	L/M/H	High - the work of the Board and the LSCB is subject to continued scrutiny through its regulatory bodies
Equality & Diversity	L/M/H	Low - the Plan addresses the needs of all children and families in Rutland.

Timeline:

Task	Target Date	Responsibility
Report to HWB Board	31st January 2017	Bernadette Caffrey

Theme	Priority Action	Progress and Actions		
		What's working well?	What are we worried about?	What do we need to change?
Keeping Children Safe and Well	To be assured that Early Help Services are effectively coordinated across the LSCB Partnership and secure outcomes that reduce pressure on child protection and care services	• Performance report and framework in place which reflects the LSBC Business Plan priorities • Key programmes such as the Children Centre and the Troubled Families programme are exceeding targets.	• Performance Framework is not measuring impact across the partnership – needs to focus outside the LA • A drop in the number of external partners acting as lead professional, i.e. nurses, midwives • Missing certain groups of children? How many children in CP system that have never been touched by EH and have had missed opportunities? • Emotional mental health thresholds – not matching up with safeguarding thresholds?	• Monitor the take up of early help assessment (EHAs) recommendations by external partners • Creation of a regional Early Help Outcomes Framework underway • Request that Early Help and Children with Disabilities (CWD) cases are subject of LSCB multiagency audit process • Continue to monitor initial contacts and (NFAs) to Children's Services Duty front door and track on going actions • Monitor why there is an increase in CP plans and why children are not picked up by early help • Implement regular case level data sharing with CAMHS to track children and young people open to services
Keeping Children Safe and Well	To champion and support the extension of Signs of Safety (SOS) across the Partnership and secure assurance of the effectiveness of multi-agency processes and working and evidence of positive impact for service users.	Multiagency training to enable implementation of SOS in the conferencing and review process - delivered August/Sept 2016 in Rutland – 30 attendees SOS training has been delivered to all children's services staff (CSC) Guidance in our SC assessments, in supervision; fully embed in reviews and conferences. Families appreciating this and understanding their Plans more clearly SOS starts within our front door (CSC) Recording guidance issued and updated post Ofsted inspection, to further reflect SOS methodology within all our assessments and recording Examples of schools using SOS in children's progress reports (Cottesmore Primary)	• Redesign MARF to reflect SOS approach and thinking by universal services.	• Imbed SOS in social care practice • Get SOS thinking and approach into SEND process • Further promote SOS in partnership working

Theme	Priority Action	Progress and Actions		
		What's working well?	What are we worried about?	What do we need to change?
Keeping children safe and well	To build community safeguarding resilience and be assured that people - families and professionals living in the community -know how to keep children safe	• Volunteering Programme in place in CC • CSE Champions in RCC and schools • Young carers training for schools • New RCC website designed	• Continue to have a high number of initial contacts to children's social care front door from key partners that do not require SC response • Sporadic data collection and information sharing in front line services	• Increase engagement of key partners, such as the police and health in Strategy discussions and CP conferences and reviews • Improve the quality of data and information sharing at case level for those children and young people in the CAMHS system • Implement the recommendations and learning from the recent (December 2016) LSCB case management review • Continue to promote awareness of private fostering arrangements in Rutland
Keeping children safe and well	To enhance the health and wellbeing of children and young people through improved service integration and the delivery of Better Care Together (BCT) health targets	• Future in Minds Transformation Plan in place • 0-19 Healthy Child Programme Contract in place that reflects Rutland needs • Breast feeding rates improving and peer support programme in place • Insight project work completed which identified some key issues re tooth decay • Local Emotional Health and Wellbeing training programmes in place with schools	• The need to get Governors and School Heads involved in pledging to bring in a whole school approach to BCT	• HCP performance and data reporting for new contract being developed and agreed Dec–Feb in preparation of new contract to enable better measures of need and impact. • Need to monitor impact of professionals engaging in EHC safeguarding • Board to receive a report on the integrated review in particular with military families • To measure impact and benefit of local programme for children identified as overweight or very overweight through NCMP • Change BCT terminology – STP instead of BCT
Fair society – to improve economic well-being and reduce child poverty levels in Rutland	To reduce the development and achievement gap at all key stages – championing children and young people to meet their full potential	• Engaged schools Heads in a strategic event in which they confirmed the ESP. Engaging early years providers including childminders • Challenging conversations with governors re disadvantage at an individual institution level • Established forum/working party to address inclusion and means to avoid exclusions	• How can we make sure Early Years providers are involved?	• Articulate vision and ambition for inclusive education in Rutland's schools • Build capability of Rutland's schools to support children who are hard to engage, have mental health difficulties, and display disruptive or challenging behaviour.

Theme	Priority Action	Progress and Actions		
		What's working well?	What are we worried about?	What do we need to change?
Fair society – to improve economic well-being and reduce child poverty levels in Rutland	To improve economic well-being and reduce children poverty levels in Rutland	• Building capacity in voluntary sector. • RCC Scrutiny panels taking poverty as key focus this year • Update report on Poverty for Rutland, influencing commissioning and awarded to RAP. • Work with CL/Children's Services, delivering debt advice. Outreach sessions (11) • Benefit uptake campaign targeted at hot spot places, outreach, worthwhile but not a significant number of new people	• National strategies abandoned • What's happening to CP nationally and locally – not going in the right direction • Criticisms of the TF programme, sustained impact and stay in touch with families longer – not sticking plaster approach • Increase in child poverty in Rutland reflects national picture, poverty as a result of insufficient income	• Continue with heightened campaign on benefit take up • Longer engagement with TF families. Issues around housing and debt. Case study some cases to measure longer term sustainability • Monitor impact of 30 hour offer for low income families
Listening	Increase engagement and participation of young people to be active citizens	• Children and YP involved in decision making • Expanded Children in Care Council (CICC) activity • Vibrant National Takeover day undertaken • Pledge promises for children in RCC care created and owned by RCC • RCC have set up a participation and engagement group to implement a number of organisational pledges across the Council • CICC voice with questions from young people raised at the Corporate Parenting Board and formal responses tracked at each meeting	• How do we reach the children who lack confidence to sit on a group? • Review advocacy model for Children Looked After (CLA)	• Promoting effective engagement to wider services and partnerships. • Ensuring that engagement is meaningful and can demonstrate a clear impact, adopting 'you said we did' • CPB to regularly review Pledges Scorecard to monitor progress and outcomes of Pledges
Efficiency	To quality assure our practice – through the use of quantitative and qualitative date, engagement of service users and engagement from frontline staff	• There are formal agreements with partner agencies to submit information at key points in the year to ensure we have a multi-agency view of performance • Section 11 audit report completed. Best evidence of reported compliance or moving to compliance.	• DA/DV – No localised services for perpetrators in the County • Multi-agency audits of children on child protection plans and on repeat plans - common denominator was DV/DA - shows that family have addressed the issues and stepped down, once stepped down no further monitoring. Toxic Trio a priority in LSCB Business Plan – to understand the interplay between risks and to identify gaps in service. • LSCB not getting quality in data analysis	• To improve the quality of data analysis by those who submit information to assist the Board. • Section 11 audits maybe over-optimistic as the audit is self-reporting. Do a peer challenge event to show evidence and then 12 months do front line event – ask practitioners "does this look like your organisation"? • To ensure the views of children and young people influence decision-making and prioritisation of issues – the impact of

Theme	Priority Action	Progress and Actions		
		What's working well?	What are we worried about?	What do we need to change?
			outside LAs and Health	'children's voice' needs to be extended. • Heavily based on LSCB. Create a QA framework in 17/18 that has specific indicators for Trust and LSCB to obtain full picture • Get visibility of young people in forums – formal meetings may not be the best way; to devise creative ways of doing this