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.

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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.

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 efficient 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.

Modifiable risk factor	Preventable diseases						
	CVD	T2DM	Respiratory	Cancer	Frailty	Dementia	Falls
Smoking	●	●	●	●	●	●	
Alcohol	●	●		●	●	●	●
Overweight	●	●		●	●	●	
Physical activity	●	●		●	●	●	●
Social isolation and loneliness					●	●	
Vaccination			●	●	●		
Support for carers					●	●	
Blood pressure control	●	●				●	●
AF detection & management	●				●	●	●
T2DM detection & management	●	●			●	●	●

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.
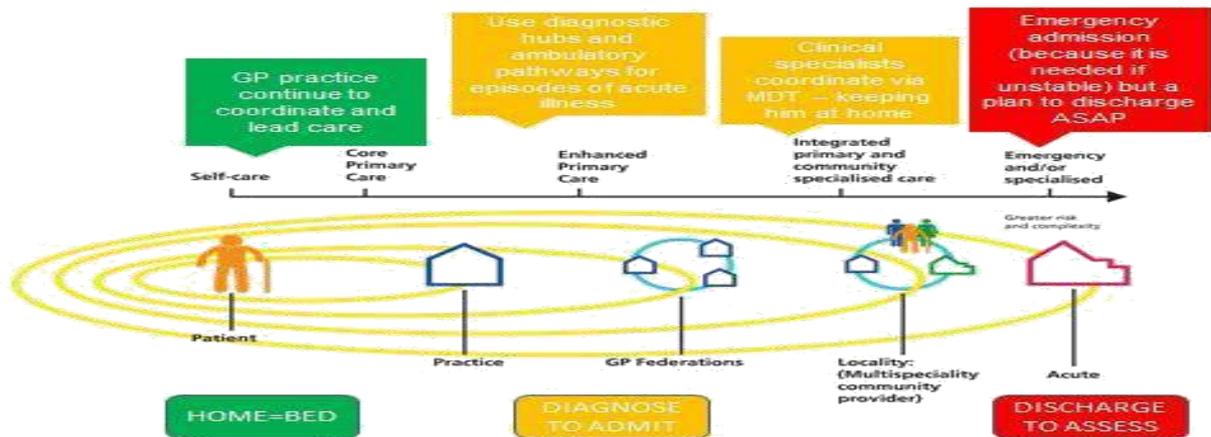
Concrete actions

- **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 assumed 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
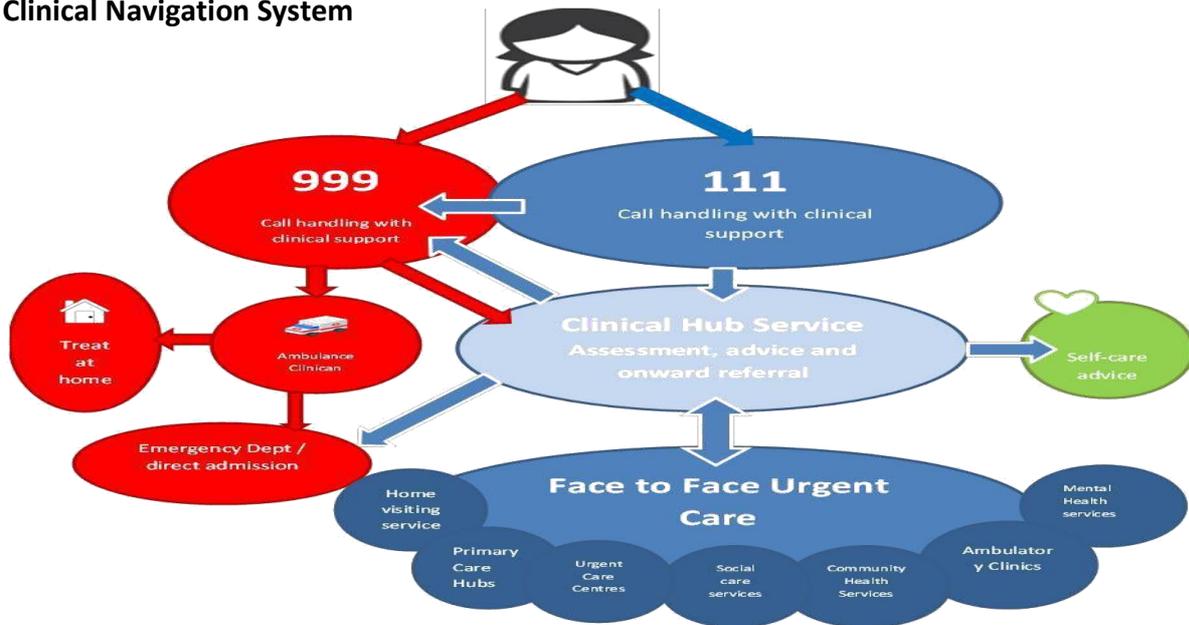
Improving NHS Constitutional Performance

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:
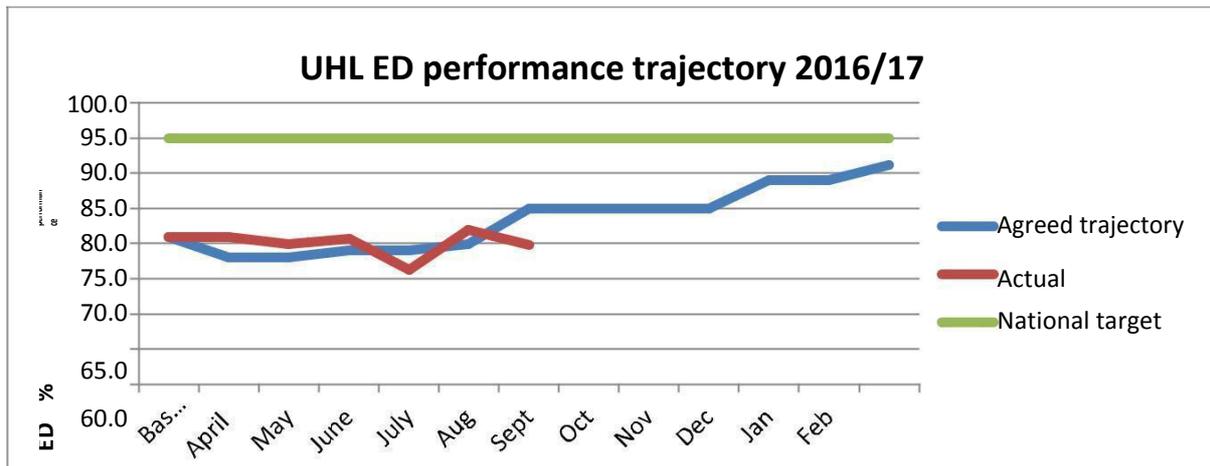
Concrete Actions

- 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.
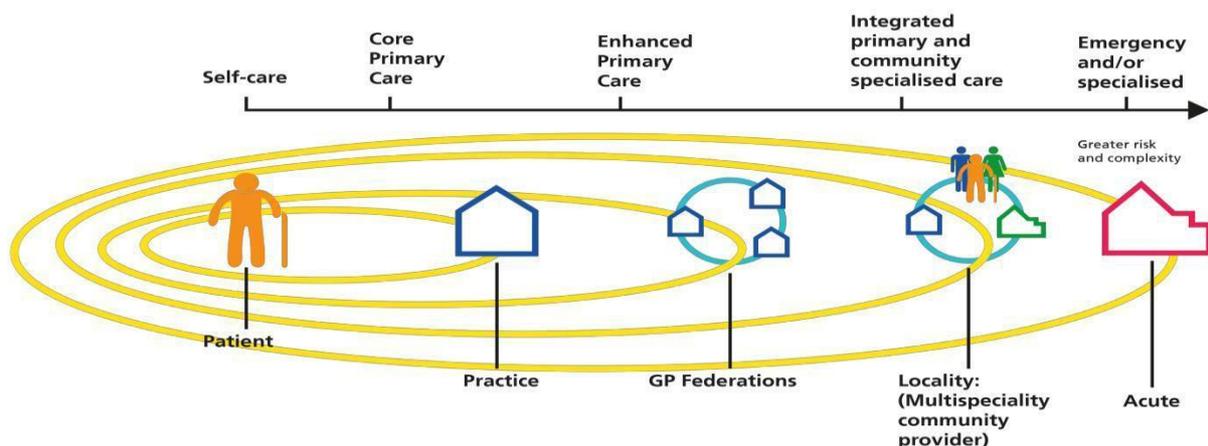
In our model the general practice and primary health care team will remain the basic unit of care, with the individual practice list retained as the foundation of that care. Our integrated locality teams are the geographical unit at which care is commissioned, coordinated and provided. Whilst a proportion 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.
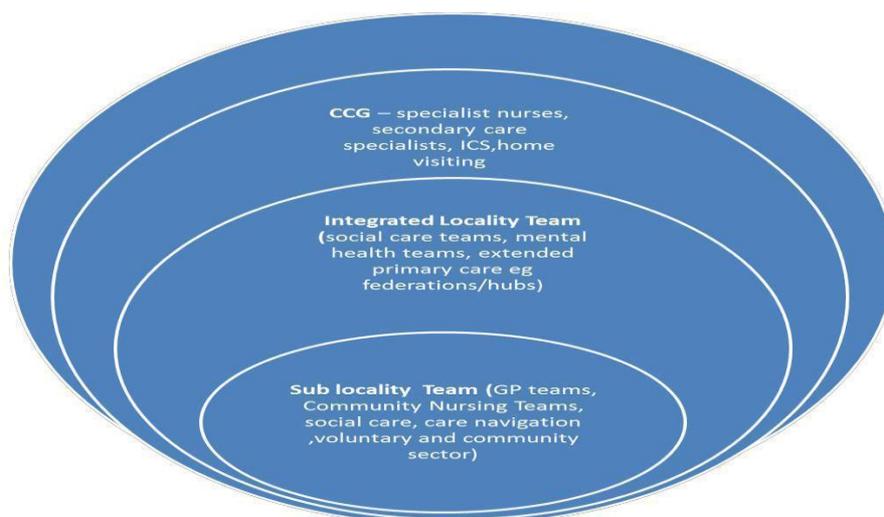
The development of integrated locality teams in the initial phase is about bringing existing health and social care teams together to build a new integrated model of provision. Through the effective use of existing resources including the targeting of Better Care Funds, integrated teams will:

- 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
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	**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.

Blue Print for General Practice
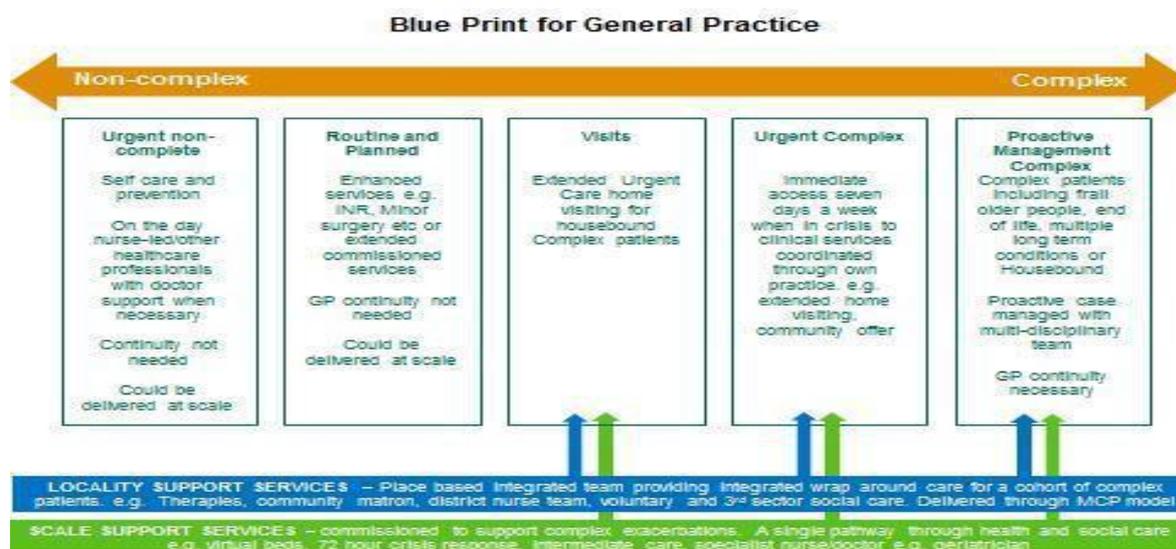
This model of general practice maintains the general practice team at the centre of care with all practices providing a level of urgent primary care access as well as planned services and should support patients in self-care management as well as accessing other appropriate health services. To meet the 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.

Levels of Diagnostics

All GPs	High Volume/ low cost Level 1	To support referral management and primary care ECG, Spirometry, Phlebotomy, Pulse Oximetry, Peak Flow, Phlebotomy
Community Hubs Community Hospitals/ GP hubs	Medium volume/ medium cost Level 2	To support referral management and triage and treatment ECHO, 24 hr ECG monitoring, 24hr BP monitoring, Near Patient testing, +/- X-ray, +/- Ultrasound, Phlebotomy
Community Super Hubs	Complex medium/ medium high cost Level 3	To support care closer to home and community shift ECHO, 24 hr ECG monitoring, 24hr BP monitoring, Near Patient testing, X-ray — extended hours, Ultrasound, Phlebotomy, MRI, +/- CT
UHL	Complex High Cost Level 4	To support secondary and tertiary care diagnosis and management All diagnostics for complex patients, 24/7 X-Ray and near patient testing in ED

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

Bed bridge chart:
- Bed Baseline 1940
- Elective 25
- Day case 19
- Non Elective 159
- Paediatrics 4
- Maternity 3
- Elective Length of Stay -44
- Non Elective Length of stay -90
- Intensive Community Support -65
- Planned Care -22
- Stroke Beds to Evington Centre -15
- Integrated Teams -128
- Ambulatory Care Models - 12
- BCT Clinical Workstreams - 77
- New Baseline 1697
- 210
- -453
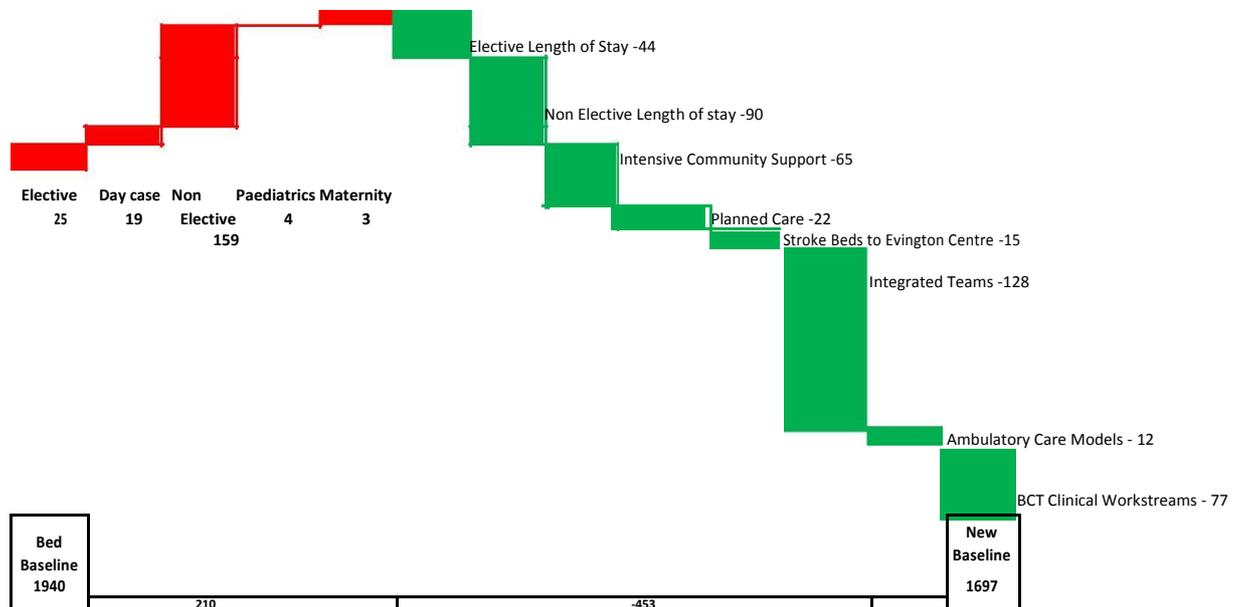
This has led us to conclude that the fundamental drivers behind the plan to consolidate acute services on to two remains the same. However, we are aware of the constraints on capital availability nationally and we have therefore worked to reduce our capital requirement including the use of alternative 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.

Main Sites
Leicester, Leicestershire and Rutland
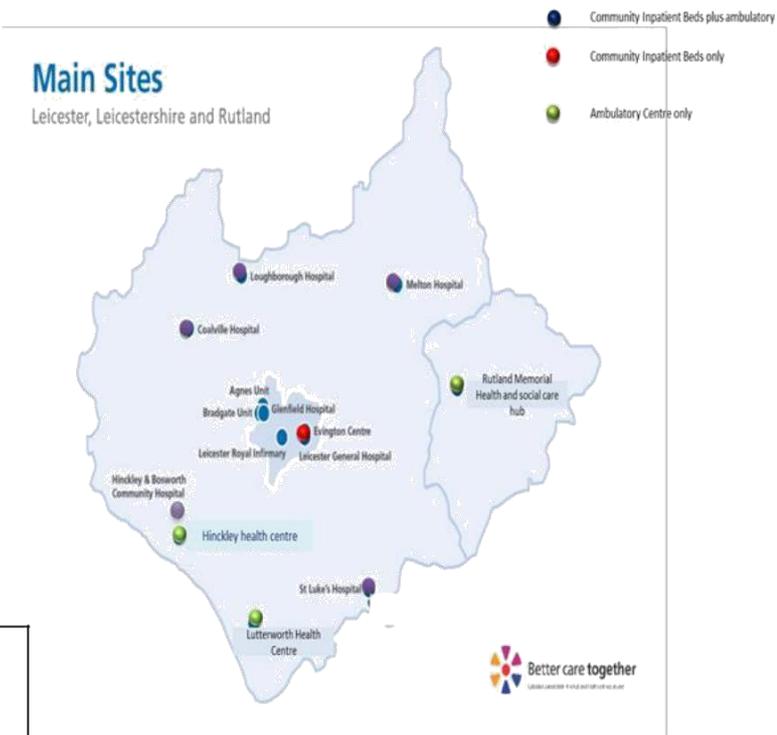
West Leicestershire sites

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:

Rutland	•Giving children the best start in life •Enabling people to take responsibilityfor their health •Helping people to liver longer and healthier lives
Leicestershire	• Tackling wider determinants of health • Getting it right from childhood •Improving mental health and wellbeing, and services for people with learning disabilities
Leicester	• Giving childre the best start in life • Reducing early deaths and health inequalities •Improving mental health and wellbeing

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	Wider determinants of health		Make better use of risk profiling	Detecting early	Primary prevention	Secondary prevention	Workforce health
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
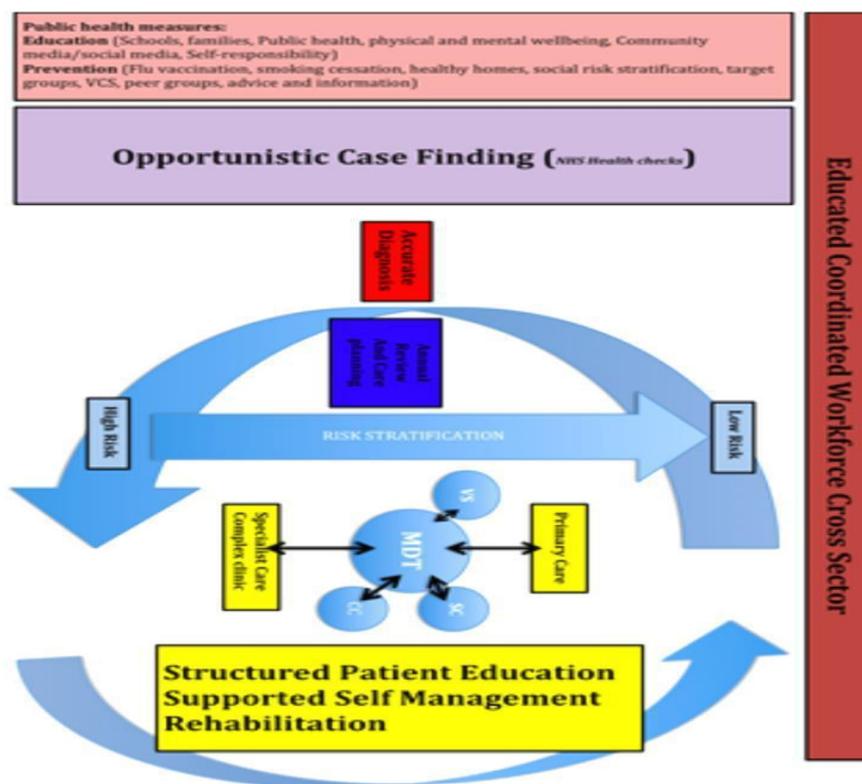
Concrete actions

- **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.

Percentage of service users waiting no more than two months (62 days) from Urgent GP Referral to first definitive treatment for cancer
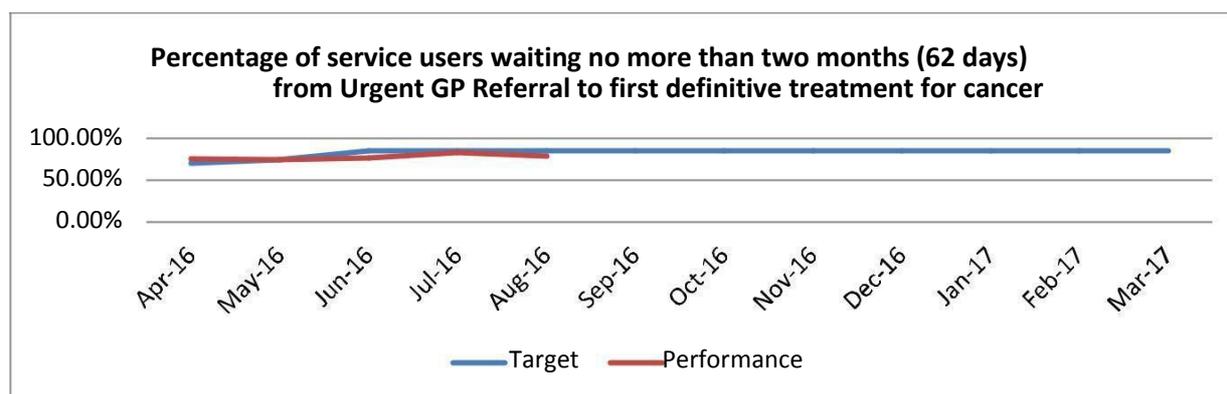
We are developing solutions that will not only meet the NHS Constitutional Standards but will also prevent and detect more cancers early and support patients through treatment and into survivorship. We are implementing the Achieving World Class Cancer Outcomes Strategy 2015/20.

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 improvements 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
    o Increasing the capacity within primary and community/social care before capacity can be released in acute settings.
    o 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
    o More autonomy for staff
    o Training needs to take into account exposure to different care settings
- Roles and skills mix
    o Potential of new roles and career paths
    o 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
	  o Establishing a clear baseline
	  o Strategic workforce modelling and capacity planning
	  o 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
	  o Setting vision and direction
	  o Staff engagement and change management
	  o System leadership capacity
	  o 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.
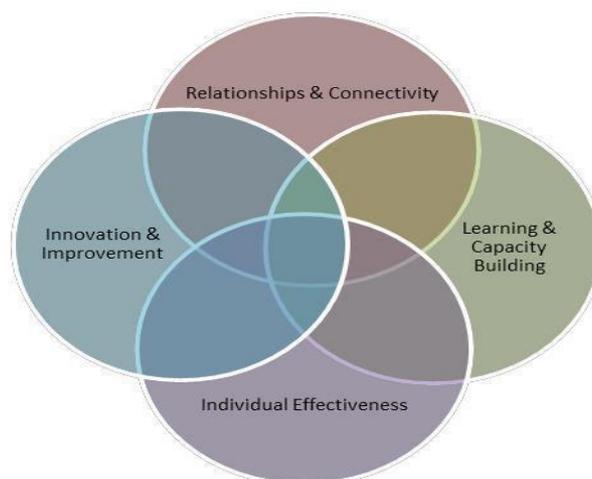
An overall approach to development and culture change was approved by system leaders in November. The approach builds on the outputs from engagement with staff, creating an overall framework for development of the 'LLR Way.'

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.

BCT partners	Staff	Public	Education	VCS	Other partners	Media	Other
Leicester City, Rutland & Leicestershire County Councils	Directly employed	Hard to reach and seldom heard groups	Universities	BME & faith groups	GPs	Print	RSLs
Leicester City, ELR & West Leics CCGs					Pharmacies		NHS England
EMAS	Agency staff	Patients and service users	FE colleges	Youth groups	District councils		TDA
Healthwatches (Leicester, Leicestershire and Rutland)					Parish councils	Broadcast	MPs
Providers (UHL & LPT)			Schools	Health support groups	Leicestershire Police		LLR employers
H&WB Boards (Leicester City, Leicestershire & Rutland)	Staff in commissioned organisations	Families and carers	Independent schools	Community and faith groups	Dentists	Online	Residential, supported living & nursing homes
					Opticians		Private health care providers
							Home care providers

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;

2016-17

- 2016-17, Amubulance Services, 1%
- 2016-17, Other Programme Costs, 2%
- 2016-17, Primary Care and Prescribing, 13%
- 2016-17, Local Authority - Social Care Adults & Children and Public Health, 23%
- 2016-17, Acute Services, 33%
- 2016-17, Specialised Commissioned Services, 10%
- 2016-17, Continuing Care, 5%
- 2016-17, Community Health Services, 7%
- 2016-17, Mental Health Services, 6%
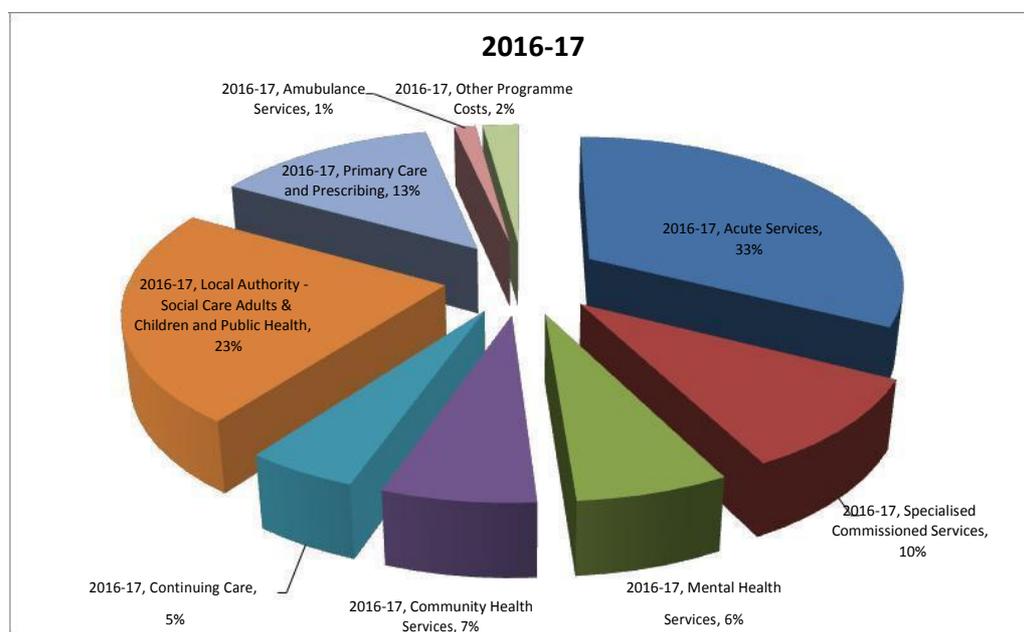
Five year financial gap

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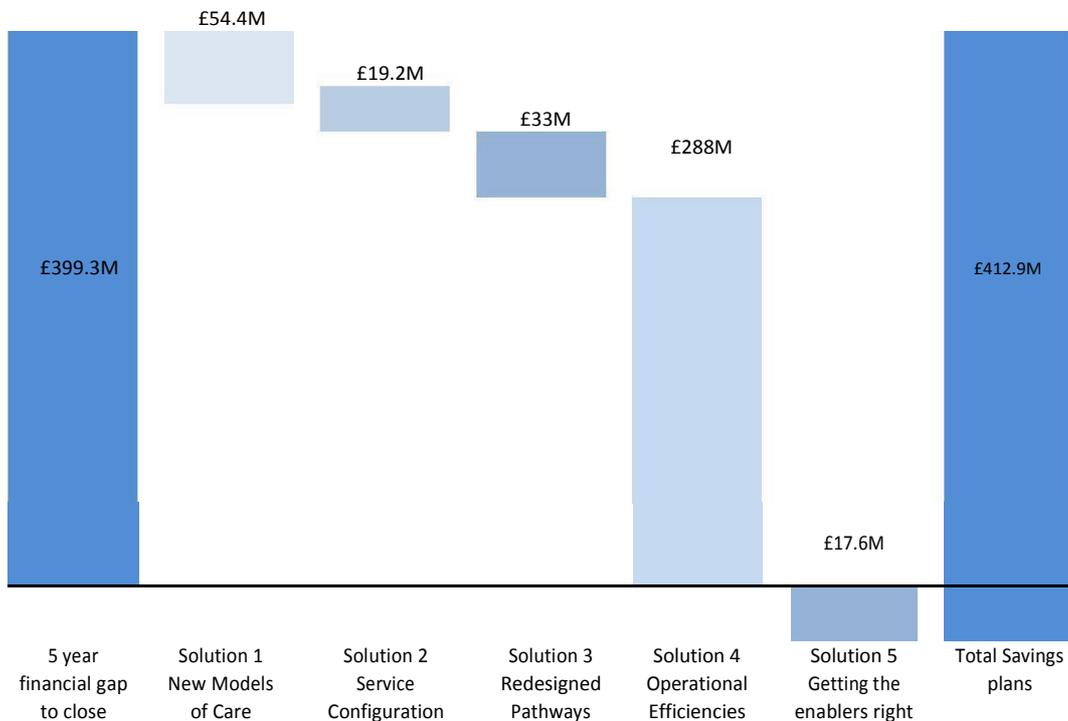
In addition to the above solutions the system has assumed net investment of STF funding in 2020-21 of £66M, in order to deliver transformed services. This gives a net gap of £333M saving and net saving of £343M. Currently we have requested additional STF funding in other years as set out in the table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

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

New Models of Care

£57.7M   £14.0M   £9.7M   £22.0M   £12.0M

Total Gross Savings | Frail Older People and End of Life | Integrated Care teams | Planned Care | Urgent Care

Please note - this diagram is not to scale

Planned Investments £3.2M
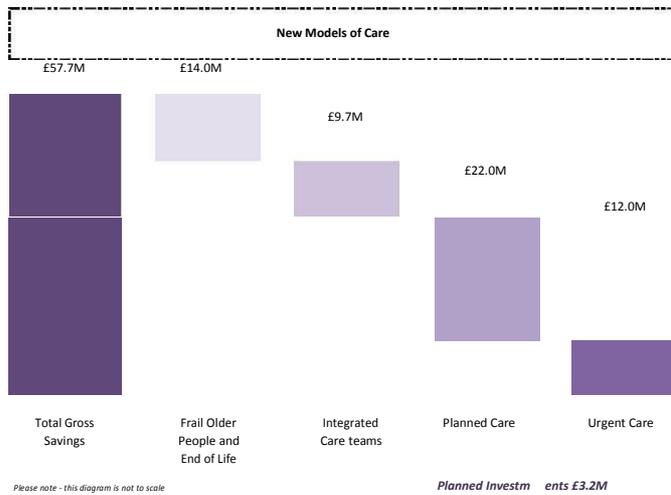
Savings in this area are drawn from the following areas;

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

Service Configuration

£19.2M

Total Savings

*Proposed Acute Reconfiguration saves £25.6M each year from 2020-21

**Disposal proceeds from surplus estate across LLR will exceed £40M - to be reinvested in hospital refurbishment

***More Planned Care outpatient appointments and procedures will be delivered from community bases

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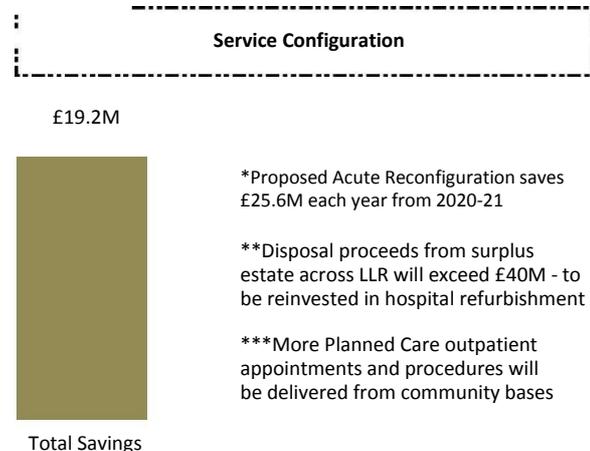
Alongside this staff will be trained to deal with the changing needs of the patients (more multiple long term conditions in an aging population) and able to work flexibly between inpatient and outpatient or patients' homes as the setting for care.

Strand 3 - Redesigned Pathways Net Savings £33M

Redesign Pathways to Improve Outcomes

£52.5M   £8.0M

£29.0M

£0.3M   £11.5M

£1.2M

£2.6M

| Total Gross | Long Term Conditions | Continuing Health Care | Childrens and maternity | Mental Health and learning | LPT Schemes | Ambulance |

Please note - this diagram is not to scale

Planned Investments £19M
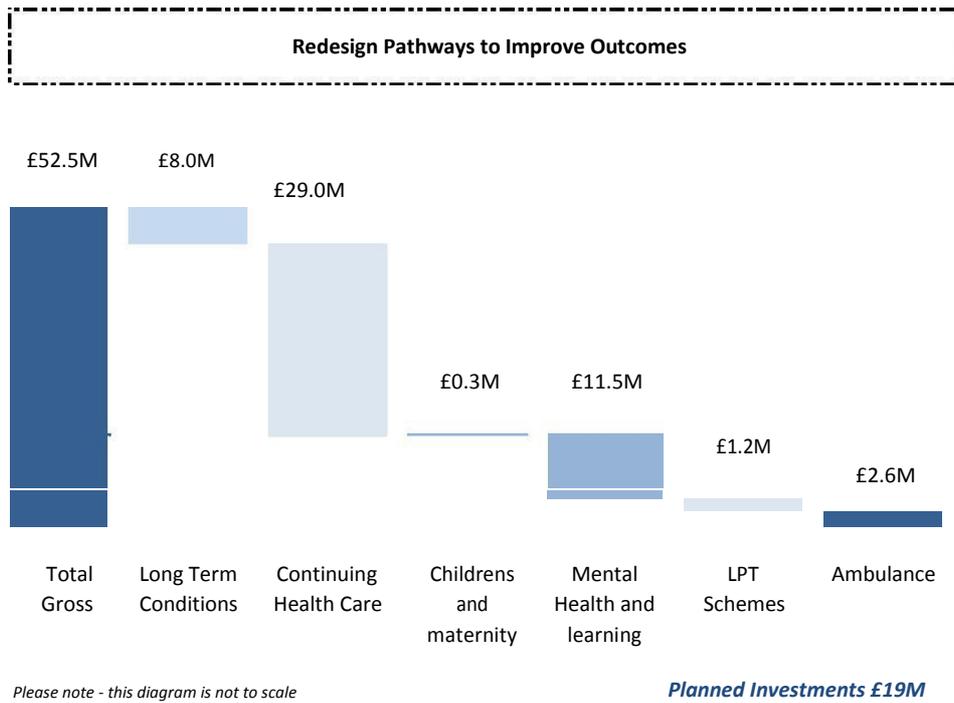
BCT work streams concentrate on improved health outcomes, particularly for people with long term conditions, Learning Disabilities, and Mental Health Services generating savings for reducing escalation of acute episodes of ill health, saving £38.6M for the period to 2020-21.

Strand 4 - Operational Efficiencies Net Savings £288M

Please note - this diagram is not to scale

Planned Investments £19M
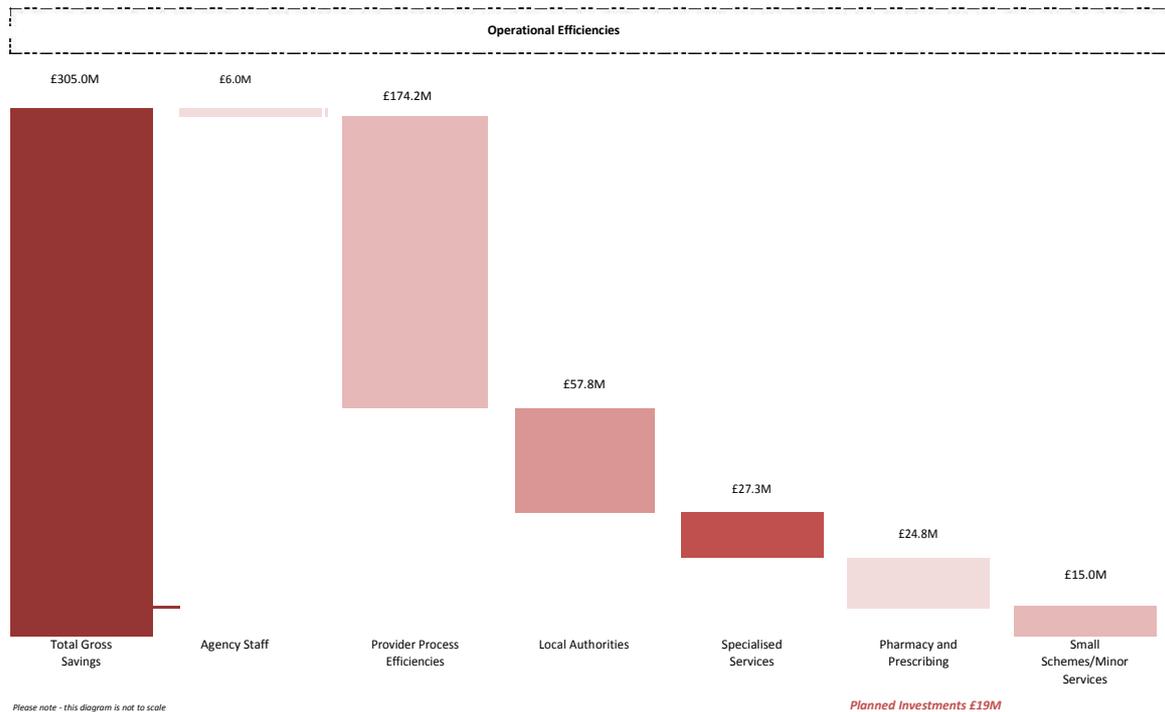
This category covers the efficient use of all the LLR health and social care resources, reducing length of stay, improving theatre productivity, prescribing, etc. This strand also includes;

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

Please note - this diagram is not to scale
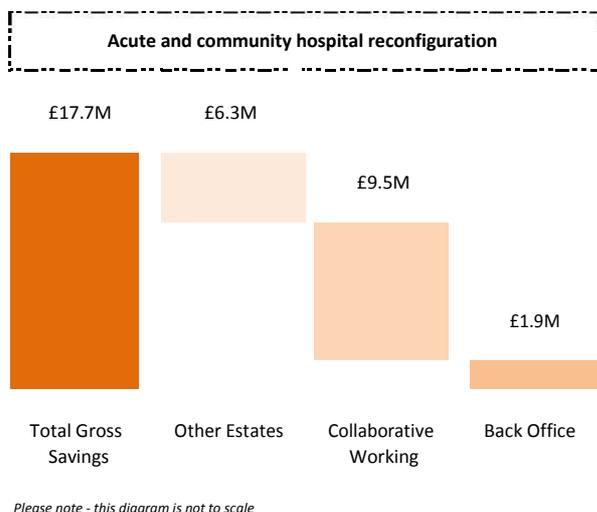
There are a number of key enablers to support the delivery of all of the solutions including joint working, merging both back office functions and some clinical services, aligning workforce, introducing new IM & T solutions and integrating health and social care commissioning. Some investment will be 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:

Investment requirements for transformation	17/18		18/19		19/20		20/21	
	£'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

	Prior years		Included in STP				
		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.

The diagram contains the following boxes and text:

Governing Bodies

Health and Wellbeing Boards

SLT will be dually accountable to the boards, governing bodies and /or executives of its members as well as to the HWBs for LLR.

It will make recommendations to individual boards, governing bodies and executives upon specific issues, to ensure local decisions (e.g. capital investment projects) are informed by a system view and priorities.

Members of SLT will ensure visibility of issues and decisions to be considered by SLT to ensure that the work of the SLT is informed by the agreed position of their individual organisations.

SLT

Stakeholder groups and existing working groups will inform the considerations and work of SLT.

Programme Management Office

System Strategy
Operational planning
Finance and activity
Monitoring and reporting

Workstreams and Pathways

Urgent Care Delivery Board
Integrated Teams Board
Planned Care (inc Alliance)
LTC
LD
Mental Health
Primary Care

Stakeholders and Influencers

System Stakeholder Forum
PPIG
Clinical Leadership Group

Enabling Groups

LLR Workforce Delivery Group
IM&T Group
Estates Group

→ Informing/ feedback relationship.
→ Accountability relationship.

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.