MEETING OF THE LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

DATE: **TUESDAY, 4 SEPTEMBER 2018**
TIME: **10:00 am**
PLACE: **Meeting Rooms G.01 and G.02, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Cutkelvin (Chair of the Committee)
Councillor Chaplin
Councillor Cleaver
Councillor Fonseca
Councillor Dr Moore
Councillor Pantling
Councillor Dr Sangster

Leicestershire County Council

Dr R.K.A.Feltham CC (Vice-Chair of the Committee)
Mrs A Hack CC
Mr D Harrison CC
Dr S Hill CC
Mr T Barkley. CC
Mrs J Richards CC
Mrs M Wright CC

Rutland County Council

Councillor G Conde
Councillor Miss G Waller

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:
Julie Harget (Democratic Support Officer):
Tel: 0116 454 6357, e-mail: Julie.harget@leicester.gov.uk
Kalvaran Sandhu (Scrutiny Support Manager):
Tel: 0116 454 6344, e-mail: Kalvaran.Sandhul@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Julie Harget**, Democratic Support on (0116) 454 6357 or email Julie.harget@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

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USEFUL ACRONYMS RELATING TO
LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG LCCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
HWLL	Healthwatch Leicester and Leicestershire
JSNA	Joint Strategic Needs Assessment
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
RSE	Relationship and Sex Education
STP	Sustainability Transformation Partnership
TASL	Thames Ambulance Service Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

NOTE:

This meeting will be webcast live at the following link:-

http://www.leicester.public-i.tv

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http://www.leicester.public-i.tv/core/portal/webcasts

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 27 April 2018 have been circulated and the Committee is asked to confirm them as a correct record.

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, petitions, or statements of case in accordance with the Council's procedures

6. EAST MIDLANDS AMBULANCE SERVICE (EMAS) 'SHAPING OUR VISION' **Appendix A (Pages 1 - 18)**

Members are asked to receive a presentation from the East Midlands Ambulance Service (EMAS) entitled 'Shaping our Vision'. A copy of the presentation and supporting papers are attached and the Committee is invited to comment as they see fit and give their views on the key questions as detailed in the presentation.

7. THAMES AMBULANCE SERVICES LTD (TASL) - UPDATE ON THE PROVISION OF SERVICES **Appendix B (Pages 19 - 26)**

The Director of Urgent and Emergency Care submits a report that provides an update on the provision of services by Thames Ambulance Services Limited (TASL) to the Leicestershire, Leicester City, and Rutland (LLR) healthcare geography as at August 2018. The Committee is asked to receive the report and comment as it sees fit.

A minute extract of the meeting of the Leicestershire County Council Health Overview and Scrutiny Committee held 28 February 2018 is also attached.

8. PLANNED CARE POLICIES **Appendix C (Pages 27 - 76)**

The Director of Performance and Corporate Affairs, West Leicester Clinical Commissioning Group (WLCCG) submits a report on Planned Care Policies. The report explains that the Planned Care Policies enable the Clinical Commissioning Groups to prioritise their resources using the best evidence about what is clinically effective and to provide the greatest proven health gain. The Committee is asked to receive the report and comment as it sees fit.

9. BETTER CARE TOGETHER (BCT) - UPDATE ON THE SUSTAINABILITY AND TRANSFORMATION PROGRAMME **Appendix D (Pages 77 - 122)**

The Committee is asked to receive a report from the West Leicester Clinical Commissioning Group that aims to provide an update on Better Care Together (the Sustainability and Transformation Partnership for Leicester, Leicestershire and Rutland), and the work being undertaken by partners to improve the health and wellbeing of people locally. An additional report entitled 'Next steps to better care in Leicester, Leicestershire and Rutland' is also attached. The Committee is asked to:

- Note this update and the work of the Better Care Together partners
- Note the publication of the Next Steps document
- Note the on-going work to co-ordinate business cases for acute and maternity reconfiguration, which will be subject to formal public consultation once capital funding is identified
- Note the on-going work of BCT work streams, and engagement and

consultation activities.

10. ANY OTHER URGENT BUSINESS

East Midlands Ambulance Service NHS Trust

Shaping our Vision

Will Legge, Director of Strategy and Transformation

Appendix A

Involving you in setting our future, ambitions and aims

Feedback to: communications@emas.nhs.uk

Why we need to define a vision for EMAS

- Give EMAS a **clear sense of direction**, purpose and focus (funding)
- **Enthuse and energise staff and stakeholders** and unite everyone towards achieving a common set of goals, which can be translated easily into individual roles and objectives
- Build **trust and confidence** in EMAS and our people, and improve the organisation's reputation (as a provider and an employer)
- Demonstrate organisational **leadership at a system level**, and move away from a more inward, operational focus
- Enable us to **prioritise** and deprioritise accordingly
- **Align our strategic priorities** with those of the system, and vice versa (where appropriate)
- **Manage expectations** where we are not prioritising activities
- **Accelerate improvements** in our performance and quality of care
- **Enhance staff satisfaction** and morale

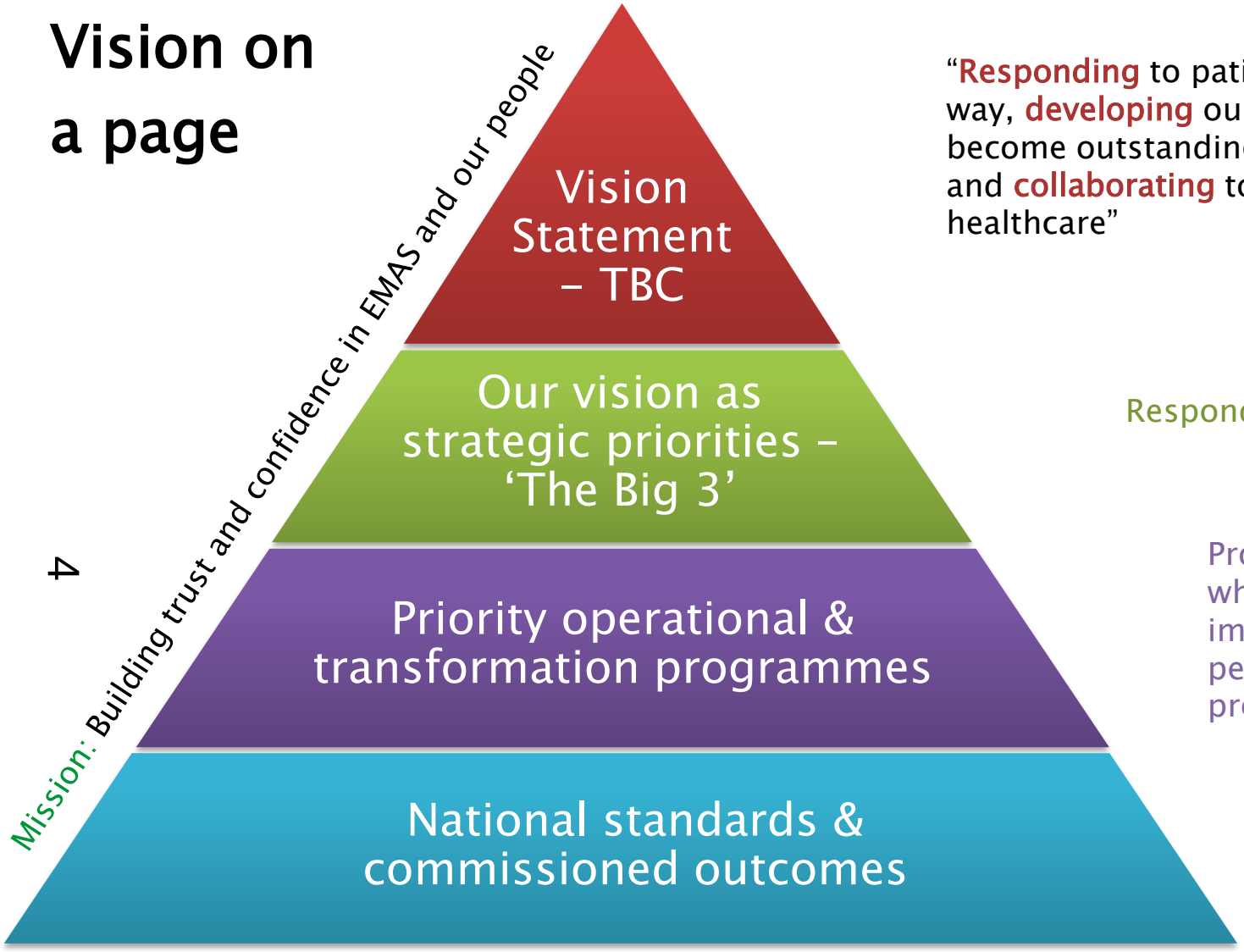
Introducing the draft vision

Assume we have met our standards

3

– what next…?

Vision on a page



"**Responding** to patient needs in the right way, **developing** our organisation to become outstanding for patients and staff, and **collaborating** to improve wider healthcare"

Respond | Develop | Collaborate

Programmes and projects which support improvements in current performance as well as prepare us for the future

Licence to operate

EMAS Values: Respect | Integrity| Contribution | Teamwork | Competence

Revised values

Our values have been updated to reflect our commitment to encouraging innovation, team and partnership working, and looking outwards as well as inwards

(The text in red/italics shows where updates have been made)

EMAS has five values which underpin everything we do, including the way we deliver our services and how we all work with others. By living these values and supporting others to do the same, we will help to make sure that EMAS is an organisation we can all be proud of.

Respect: Respect for our patients and each other

Integrity: Acting with integrity by doing the right thing for the right reasons

Contribution: Respecting and valuing *everyone's contribution, and encouraging innovation*

Teamwork: Working together, supporting each other, *and collaborating with other organisations*

Competence: Continually developing and improving *our competence*

The Big 3: Respond | Develop | Collaborate

"Together, we will respond to patient needs in the right way"

We will know we have achieved this when:

- We are making full use of the care pathways available and maximising the number of patients treated at home or close to home
- We have the right number of staff in post with the right mix of skills, knowledge and training to respond flexibly to all patient needs
- We have the right number, type and age of vehicles on the road
- We have access to the right equipment, ambulances and staff to meet patient demand and need

The Big 3: Respond | Develop | Collaborate

"We will develop our organisation to become outstanding for patients and staff"

We will know we have achieved this when:

- Our patients report consistently high levels of satisfaction
- Our staff and volunteers report that they are proud to work for EMAS
- We are consistently delivering the Ambulance System Indicators (including patient quality measures), and the NHS Oversight Framework
- Our workforce is well, healthy, engaged and satisfied, and everyone exemplifies the EMAS values in all that we do
- Our staff and volunteers have access to opportunities, education and training to support their career development
- We have realised benefits from developing and modernising our estate
- We have achieved a CQC rating of 'outstanding' and are consistently meeting our financial targets

The Big 3: Respond | Develop | Collaborate

"We will collaborate with partners and other organisations to reduce healthcare demand and improve wider healthcare"

We will know we have achieved this when:

- We have led and contributed to improvements in key areas of healthcare that matter most to EMAS, our patients and our partners across the area we serve. *We will insert specific areas of focus to be determined with system partners during engagement, e.g.*
  - *More patients treated at home or closer to home (non-conveyance)*
  - *Closer collaboration between the two regional clinical hubs (999 and 111)*
  - *Mental health (prevention and demand management)*
  - *Improve pathways (but which ones?)*
  - *Reduce the number of 111 referrals into 999*
- Our local communities are accessing emergency and urgent care services in a way that reflects their clinical needs

What do we want to become leaders of in five+ years' time? *(We may not have even started this yet). Suggestions:*

- Our use of **technological solutions** to address wider healthcare issues and drive improvement
- Our proactive work on **mental health** – patients (prevention and management with partners), and staff (health and wellbeing)
- Becoming national leaders for our work on **patient safety**?
- Achieving **equality and diversity** within our workforce?
- Demonstrating international best practice for our clinical outcomes for patients with **cardiac arrest**?
- Developing and embedding the **paramedic skillset** in multi-disciplinary team approaches across wider healthcare (led by EMAS)?
- Developing a **positive organisational culture** that means staff want to work here and have high levels of satisfaction?
- Identifying and managing **sepsis** (across all geographies), building on the success of our pilot within Lincolnshire?

Shaping our vision: Who we plan to engage with

- Our staff and volunteers
- Health Overview and Scrutiny Committees
- All Healthwatch organisations across the East Midlands
- Our healthcare partners and commissioners – including local authorities and social care and our Sustainability and Transformation Plan partners (STPs)
- MPs
- Police, Police and Crime Commissioners and fire service partners
- More than 3,000 patients who have chosen to become members of our Trust
- Our patient voice group which is a representative group of patients from across the East Midlands

Do you feel that these parties are the right stakeholders for us to engage with on this strategic piece of work?

Key Questions

- What would members of the OSC like to see within our vision for the future?

- What feedback you have on the emerging vision?
  - What do you like?
  - What would you change?

- Do you feel that the parties listed on the previous slide are the right stakeholders for us to engage with in developing our vision?

East Midlands Ambulance Service NHS Trust

Engagement Programme

Sequencing – Engagement Programme

Development through engagement - July to September

June 2018

Board kick off

- Agree approach
- Agree general principles for vision, core purpose and strategic priorities

SLT

- Share emergent thinking – vision and priorities (prioritised)
- Check and challenge
- Further development
- Review any major challenges/changes with Board

All EMAS people - staff & volunteers

- Share draft proposals
- Check and challenge
- Add more detail/refine

Partners and Public

- Share emergent direction of travel
- Check and challenge
- Discuss and agree top system priority(ies)
- Align respective strategies and priorities

Sept/Oct 2018

Board sign off

- Discuss feedback and agree changes
- Finalise vision, strategic priorities
- Prioritise and align corporate priorities and activities
- Align communications and engagement activities
- Align governance

October 2018

Launch and implementation

- Staff and stakeholder engagement
- Align organisational activities

Key Events and Activities

- Board meeting 5/6
- Exec time out 11/6
- Exec time out 25/6
- Board – share final mats

- SLT time out I 28 Jun
- SLT time out II ??
- Leadership summit TBC

- TU mtg 19 Jun and Aug
- Activities by division/EOC/corporate/ other areas to include:
  - Conversation cafes Jul
  - Bitesize CCs Aug/Sept
  - Colleague voice groups
- CFRs and vols activities
- All staff 'survey' Aug
- Intranet/Enews Aug/payslips etc

- Public Board updated 7/8
- Health partner 'survey'
- Commissioner event Jul
- STP mtgs/health partners
- OSCs Jul/Aug
- Healthwatch Regional July/Aug
- EMAS Patient Voice group mtg Jul
- E-News articles
- EMAS e-members survey
- MP meetings Jun-Aug
- CFR activities TBC
- Wider s'holder 'survey' Aug e.g. PCC/police/fire
- AGM activity August

- Board Development session 4 September
- 2 October public Board
- Review governance
- Prioritise activities

- Communications and engagement plan – multi-stakeholder events and activities
- Refresh IBP TBC

Feedback to: communications@emas.nhs.uk

East Midlands Ambulance Service NHS Trust

Paper to the Overview and Scrutiny Committee, July 2018

Shaping a vision for EMAS

In May 2018, healthcare commissioners confirmed that additional funding would be made available to EMAS to address significant gaps in our resources. This amounted to up to £19million additional funding every year to be targeted on front-line services. This funding will be phased in over the next two years (up to £9m available in 2018/19) and is linked to performance trajectories.

Not only will this new funding enable us to realise significant improvements over the next two years in our responsiveness and the quality of care we provide, but it represents a major opportunity to look beyond immediate operational challenges and develop a fresh, aspirational and exciting vision for the future.

Over the next three months, EMAS is speaking with key external parties, our staff and volunteers to explore what our future aims might be. We hope to enthuse and energise the people who work for and with us towards delivering a common goal or goals that are meaningful to the communities and people we serve.

EMAS is looking forward to sharing with you the latest thinking at your next Overview and Scrutiny Committee meeting. As the vision is being developed on an iterative basis through engagement, we will share a presentation with you on the day which reflects what people have said so far.

As part of our engagement process we are planning to involve across the East Midlands:

- Our staff and volunteers
- Health Overview and Scrutiny Committees
- Healthwatches
- Our healthcare partners and commissioners - including local authorities and social care and our Sustainability and Transformation Plan partners (STPs)
- MPs
- Police, Police and Crime Commissioners and fire service partners
- More than 3,000 members of our Trust
- Our patient voice group which is a representative group of patients from across the East Midlands

We then plan to share our new vision widely with all our stakeholders, including members of the public, from November 2018.

We would like to ask members of the Committee:

- Do you feel that the parties listed above are the right stakeholders for us to engage with on this strategic piece of work?
- What would members of the OSC like to see within our vision for the future?
- What feedback you have on the emerging vision, which we will share with you when we meet?

Should you have any queries about our vision at any time, please contact Will Legge, Director of Strategy and Transformation, or Jo Yeaman, Strategy and Communications Advisor for EMAS as follows:

will.legge@emas.nhs.uk
07879 628973

joyeaman@nhs.net
07813 941933

Richard Henderson
Chief Executive

Pauline Tagg
Chair

Appendix A2

Get involved in shaping our vision – what might our future look like in 5+ years time?

Vision on a page

Discussion questions:

1. What do you think should be in our vision statement?
2. Can you suggest a vision statement that might work for EMAS? We need something that is inspirational and describes a goal we all want to achieve

Revised values

Our values have been updated to reflect our commitment to encouraging innovation, team and partnership working, and looking outwards as well as inwards

(The text in red/italics is where updates have been made)

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Discussion questions:

1. Are the values well-known to everyone across EMAS?
2. Does everyone live by the values now? What works well and what doesn't?
3. How can we embed our values more effectively within our organisation?
4. How can we improve the way we use our values?

What do we want to become leaders of in five+ years' time? *(We may not have even started this yet). Suggestions:*

- Our use of **technological solutions** to address wider healthcare issues and drive improvement
- Our proactive work on **mental health** – patients (prevention and management with partners), and staff (health and wellbeing)
- Becoming national leaders for our work on **patient safety**?
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- Identifying and managing **sepsis** (across all geographies), building on the success of our pilot within Lincolnshire?

Discussion questions:

1. What important aspect of our work could EMAS focus on, so that we stand out from the rest in five or more years' time? This might be an area where we're making good progress, or something we haven't started yet.
2. Do you think we should choose something to focus on – perhaps all of these things are important?

You can send your thoughts and ideas to: communications@emas.nhs.uk

Get involved in shaping our vision – what might our future look like in 5+ years time?

The Big 3: Respond | Develop | Collaborate

"Together, we will respond to patient needs in the right way"

We will know we have achieved this when:

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The 'Big 3' is our vision expressed as three strategic priorities

Discussion questions

1. What do you like about the Big 3?
2. What don't you like?
3. What would you change/how would you improve them?

Appendix B

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Title of the report:	Thames Ambulance Service Ltd (TASL) Non-Emergency Patient Transport Services Update
Report to:	Joint City and County - Leicester, Leicestershire and Rutland (LLR) Health Scrutiny Committee
Date of the meeting:	4th September 2018
Report by:	Mr Mike Ryan, Director of Urgent and Emergency Care, LLR
Presented by:	Mr Mike Ryan, Director of Urgent and Emergency Care, LLR

PURPOSE

1. The purpose of this paper is to provide update to the Joint Health Scrutiny Committee regarding the provision of services by Thames Ambulance Services Limited (TASL) to the Leicestershire, Leicester City, and Rutland (LLR) healthcare geography as at August 2018.

INTRODUCTION/BACKGROUND

2. The Non-Emergency Patient Transport Services (NEPTs) commissioning and procurement "market" is characterised as being difficult with a small number of accredited providers available nationally, and both quality and service delivery issues experienced fairly widely across the country. At the same time, operationally these services are interdependent upon how well logistics are organised and managed by individuals and/or organisations who book transport on a daily basis.

3. Non-Emergency Patient Transport Services play an important role across the health and social care system in ensuring patients can be discharged from hospital effectively with appropriate transportation, and/or be transported to/from hospital for outpatient appointments or regular visits based on health needs.

4. In June 2017 Thames Ambulance Services Limited (TASL) were awarded the LLR Non-Emergency Patient Transport Services contract following a procurement exercise led by the Midlands and Lancashire Commissioning Support Unit. TASL began providing services on the 1st October 2017, and in its first year has under-performed against expectation in terms of both performance and quality.

SUMMARY UPDATE:

5. TASL has established a good and positive working relationship with other providers including University Hospitals of Leicester (UHL) and Leicestershire Partnership Trust (LPT), with performance improving on a monthly basis. Whilst performance has slowly improved, concerns have remained in relation to quality as well as TASL's long-term financial sustainability.

6. In the current first year of provision, the provider's performance has regularly been below expected standards including impact upon the quality of the service as well as overall patient experience. It was recognised that performance in the first year would be challenging due to the implementation period and winter pressures whereby there is a significant increase in demand on services, with commissioners closely managing the provider. It was further recognised by the Collaborative Commissioning Board and individual CCG Governing Bodies that the procurement decision was taken in accordance with the market and short-listed bidders in recognition of the level of risk and the assurances/mitigations typically associated with non-elective patient transport services.

7. TASL has been challenged financially in its first year which has caused some concern regarding the ability for TASL to live up to the commitment of a five-year contract within LLR. Commissioners are working closely with TASL to assure the continuity of patient care and separately have established appropriate arrangements in place for contingency provision (if required).

8. Commissioners continue to utilise appropriate contract levers to improve performance, and a recovery action plan is in place with control and monitoring arrangements between commissioners and TASL, with close working to ensure any risks and issues are identified and resolved as soon as possible.

9. As at August 2018, there is an acknowledged greater stability within TASL's leadership, with clear plans in place for improvement across both performance and quality.

10. As part of regular governance and audit processes, through internal audit the CCGs are auditing the procurement process undertaken in early 2017 for assurance that the process was thorough, consistent, and represented best practice.

11. LLR continues to work closely with TASL and neighbouring commissioners to ensure the service to patients improves further. This includes ensuring we learn the lessons from previous incidents elsewhere from other providers to avoid pitfalls and unnecessary mistakes, and will take the opportunity to further learn locally what improvements can be made.

PROVIDER MANAGEMENT

Operational Performance

12. Performance on the whole has slowly improved since the start of the contract. Performance was either maintained or improved for all six 'time on vehicle' key performance indicators (KPIs) in June, and the KPI that was not met related to 4 patients who missed the KPI by just 3 minutes. June has been the busiest month for both arrival and departure journeys which has impacted upon KPI's in only marginally for arrivals on time within a range of maximum 7%.

13. There were 5,658 Renal patient journeys booked in June 2018 which equates to 37% of all bookings. Performance against the range of KPIs was quite sporadic and regularly the fluctuation in performance was negligible by 1% in most cases.

14. Commissioners have compared performance at year 1 against the previous provider using the first 9 months of TASL's performance data. The data reveals that the previous provider performed better than TASL in some areas, whereby TASL has performed better in other areas.

Quality

15. Shortly after the start of the LLR contract, the CQC served a warning notice to TASL on the 26th of October 2017 under Section 29 of the Health and Social Care Act 2008. Although this was by way of a CQC inspection and a different health system's contractual arrangement, as a provider it is relevant to the LLR system and carries a risk whereby TASL could be instructed to cease from operating if quality improvement is not achieved, representing a significant risk to all commissioners of TASL services across the country. TASL were asked to take action under the following regulations:

    a. Regulation 12 HSCA (RA) regulations 2014 safe care and treatment
    b. Regulation 16 HSCA (RA) regulations receiving and acting upon complaints
    c. Regulation 17 HSCA (RA) regulations 2014 Good Governance
    d. Regulation 18 HSCA (RA) regulations 2014 staffing

16. TASL were asked to submit an action plan to address these concerns on the 1st of December 2017. CQC have completed further inspections to assess compliance and have noted that there has been some improvement with the quality of care provided for patients in some areas and note that there have been significant changes to the management structure including the recent appointment of the CEO who commenced on the 5th of March 2018. CQC have

given TASL an extension to their notice as they feel that they are now in a better position to improve. The CCGs have not yet received an update following the last review meeting.

17. Commissioners receive monthly reports outlining a number of quality indicators, including patient complaints and incidents. In May, 33 concerns were received into the service with a notable theme of late patient collection, and it is reported that all complaints are acknowledged within 3 working days and represent a small proportion of overall bookings (circa 15,000/month) and contact with patients each month. No serious or major incidents have been reported.

18. The LLR CCG quality team undertook a quality visit on the 4th of July 2018, which highlighted some minor areas requiring improvement:

    a. Inefficiencies in planning between the control room;
    b. Practical issues e.g. lack of internet access;
    c. Mandatory training gaps;
    d. Lack of senior management visibility and communication;
    e. Lack of internal audits; and
    f. Positive feedback was give upon their incident reporting process

19. An action plan has been established in order to monitor progress against the identified themes/issues.

Financial Stability

20. TASL have confirmed internal financial pressures, including operating at a financial deficit. The CCGs are working closely with TASL and NHS England to ensure appropriate action is taken to mitigate any risks from this position toward a more positive position and conclusion.

21. TASL have identified an internal cost improvement programme that is focused on generating more internal efficiency, with recent actions recently reducing this internal deficit.

Governance and Assurance Actions

22. As a system of statutory bodies, LLR continues to manage the provider to ensure the continuity of service and patient care in keeping within contractual and quality standards. The CCGs are undertaking the following governance and assurance actions to ensure both the procurement exercise and the management of TASL is robust and in keeping with requirements. This includes:

a. Formal contract management meetings to review performance and contractual activity to enable visible management of risks and issues, as well as visibility of internal operational and corporate data/information.
b. Fortnightly interface meetings between providers, including UHL, LPT and TASL with commissioner support to enable continuous improvement and facilitation of operational changes.
c. Internal audit review of procurement process to assure the process was robust and in keeping with best practice.
d. Legal advice sought to ensure contractual arrangements and decisions to date are consistent with legal and statutory responsibilities.
e. Establishment of contingency or succession planning arrangements if required to ensure service provision.
f. Liaison with colleagues in neighbouring CCGs to share information and learning, as well as weekly contact with TASL executives.

Benchmarking Services and Stimulating the Market

23. LLR and neighbouring commissioners have met with the Independent Ambulance Association (IAA) to discuss their aim to promote the need for a national Patient Transport Services (PTS) framework for both commissioners and providers. It was acknowledged that the PTS market was complex with a number of factors both internal and external impacting upon its ability to perform to a high standard and meet both patient and public expectation in which to commission.

24. LLR is engaged in discussion on a regional and national level to support the need to match service provision to expectation, through the establishment of a prospective, future national framework including service specifications that can be adjusted for local variations but will provide consistency within commissioning.

CONCLUSION

25. Commissioners have confirmed support to continue to work with TASL to seek a suitable solution to manage and overcome current challenges. At this stage, commissioners are not prioritising contract termination recognising the existing contractual relationship, as well as the complexity of the market and challenges in providing a PTS service across LLR. Commissioners have established contingency arrangements should this provision need to be utilised at any point.

26. Commissioners NHS England are engaged and maintain a strategic co-ordination role and responsibility as per the NHS Act 2006 (as amended), and LLR are working in hand to ensure appropriate and informed decisions can be taken to safeguard the continuity of patient care.

Leicestershire County Council

LEICESTERSHIRE COUNTY COUNCIL HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 28 FEBRUARY 2018

EXTRACT FROM THE MINUTES

NON-EMERGENCY PATIENT TRANSFER SERVICE - TASL

The Committee received a report from Thames Ambulance Services Limited (TASL) which provided an update on the post-mobilisation of the Non-Emergency Patient Transport Services contract with TASL in Leicester, Leicestershire and Rutland. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

Representatives from TASL had been invited to the meeting however they were unable to attend due to the adverse weather conditions. Tamsin Hooton, Director of Urgent and Emergency Care, Leicester, Leicestershire and Rutland CCGs answered questions on the report from a commissioner's perspective.

Arising from discussions the following points were noted:

(i) Meetings had taken place with the parent company of TASL (HTG) who had given reassurance that they intended to invest in the ambulance service in the long term and they had not been deterred by the difficulties which arose on mobilisation.

(ii) Due diligence enquiries had been undertaken into TASL prior to the contract being awarded. The CCG had contingency plans in place for transporting patients to urgent appointments should TASL be unable to fulfill the contract. It was noted that performance had improved month on month since mobilisation and that TASL was on track to meet all targets except for call pick-up time in the call centre.

(iii) The eligibility criteria had not fundamentally changed since TASL were awarded the contract though effort was being made to ensure that it was applied consistently recognising that there was sometimes a need for flexibility. Members were of the view that the eligibility criteria flow chart as set out on the WLCCG website was difficult to follow and Tamsin Hooton agreed to give this further consideration.

(iv) The CCG were reassured by actions TASL were taking to address recruitment gaps such as using third party providers. However, further work needed to be carried out to ensure TASL had the ability to recruit and retain an adequate workforce and there was a need to communicate a positive view of the company to encourage more applicants for roles.

RESOLVED:

(a) That the update on the post mobilisation of the Non-Emergency Patient Transport Services contract with Thames Ambulance Services Limited be noted, and the improvements made since the previous report to the Committee be welcomed;

(b) That officers write to Thames Ambulance Service Limited and forward the questions and comments now made regarding the report.

Appendix C

Front Sheet

Paper XX

Title of the report:	Planned Care Policies
Report to:	Joint HOSC
Section:	
Date of the meeting:	4th September 2018
Report by:	Ket Chudasama, , WLCCG, Director of Performance & Corporate Affairs
Sponsoring Director:	
Presented by:	Ket Chudasama , WLCCG, Director of Performance & Corporate Affairs Dr Hilary Fox, Planned Care GP, ELRCCG

EXECUTIVE SUMMARY

1. Clinical Commissioning Groups (CCGs) are responsible for commissioning healthcare services that meet the reasonable requirements of their population. The Planned Care policies enable CCGs to prioritise their resources using the best evidence about what is clinically effective and to provide the greatest proven health gain.

2. This paper covers the:
    a. policy review process and outcomes;
    b. activity and financial impact;
    c. engagement plan and how patients can get involved;
    d. next steps.

3. A three stage review process was undertaken over a period of six months, led by the three LLR CCGs, in partnership with clinicians from local hospitals, GPs, public health and patient representatives.

4. Following the clinical review, it has been agreed that:

    - 2 existing policies will be changed and these are Hip and Knee Replacement and the Male Circumcision.
    - 50 new policies of the 79 that have been reviewed in stages 2 and 3 will be introduced.
    - 49 existing policies have been reviewed and will not be changed

5. The financial benefit of implementing this policy is small as it mainly reflects current practice and is estimated to impact 86 patients across LLR.

6. It is clear from the policy review that LLR CCGs are not entirely stopping certain interventions outright for everybody and we are clear and comfortable with the clinical rationale and thresholds underpinning each policy that have been supported in primary and secondary care; therefore an engagement period of six weeks was proposed.

7. Public engagement commenced on 20th August and runs through to 26th September 2018. In this time we are seeking people's views on the 101 policies. The engagement document (attached and an appendix) identifies how the public can access the draft policies and survey:

8. Three public events have been organised for patients to come and learn more about the policies and share their thoughts.

9. The CCGs will review the feedback received from the public and stakeholder engagement, and make changes to the policies where clinically relevant. The final policies will be approved by the LLR CCGs in their public meetings in October.

10. Patients will be given four weeks' notice before the new approved policies come into force. It is expected that the new policies will be implemented by 1st December 2018.

LEICESTER, LEICESTERSHIRE AND RUTLAND PLANNED CARE POLICIES

PURPOSE

1. Clinical Commissioning Groups (CCGs) are responsible for commissioning healthcare services that meet the reasonable requirements of their population. The Planned Care policies enable CCGs to prioritise their resources using the best evidence about what is clinically effective and to provide the greatest proven health gain.

2. This paper covers the:
    a. policy review process and outcomes;
    b. activity and financial impact;
    c. engagement plan and how patients can get involved;
    d. next steps.

BACKGROUND

3. Planned care is the term used to describe the non-emergency operations and treatments that are carried out in hospital and in the community, with appointments arranged in advance. Patients could be treated as an outpatient in a clinic or may have to stay overnight in hospital. Some examples of these are hip and knee replacements, operations to correct a cataract, joint injections and varicose vein surgery.

4. It is important to have policies in place so that doctors have clear guidance on treatments and to make sure that decisions are made consistently and in the same way for each patient. This is not about “rationing” or reducing access to treatment.

5. We want to make sure that patients only have procedures, such as operations, where we know that this will be effective for their particular medical problem and circumstances. Any procedure carries a small risk of complications, so we need to know that a treatment is right and will help the patient. Policies also make sure that NHS resources are used in the best possible way and are used fairly for everyone.

6. The development of Planned Care policies is not unique to the Leicester, Leicestershire and Rutland (LLR) CCGs. All CCGs have a range of policies which provide GPs and hospital doctors guidance to which procedures/ treatments have clinical thresholds which the patient needs to reach before treatment will be funded or which procedures/ treatments are not funded by CCGs. Examples of the current policies in place are botunlinum toxin for wrinkles frown lines or ageing neck and tonsillectomy.

7. A three stage review process was undertaken over a period of six months, led by the three LLR CCGs, in partnership with clinicians from local hospitals, GPs, public health and patient representatives.
    a. Stage 1
        - We reviewed 51 existing policies, making sure that they were still clinically relevant. Of the existing policies, 49 did not require any changes and two required updating.
    b. Stage 2

- We reviewed data on 40 procedures/ treatments provided by NHS England to identify opportunities to add other procedure/ treatments to the LLR policy document. An example of a policy added to the Planned Care policy document includes alopecia (hair loss)

c. Stage 3
   - We reviewed 39 policies from other CCGs to identify opportunities to add to the LLR policy document. Examples of the policies added to the Planned Care policy document are restless legs syndrome and vaginal prolapse.

8. The outcome of stages 2 and 3 was an inclusion of 50 additional policies to the Planned Care Policy document. The majority of these policies reflect current University Hospitals of Leicester NHS Trust (UHL) clinical practice, so including these as policies formalises this.

NHS ENGLAND CONSULTATION

9. NHS England (NHSE) is currently consulting on 17 procedures/ treatments, they are recommending that four are not routinely funded and the remaining 13 have threshold criteria for treatment. The consultation ends 28th September 2018.

Not Routinely Funded

- Snoring Surgery (in the absence of Obstructive Sleep Apnoea)
- Knee arthroscopy for patients with osteoarthritis
- Injections for nonspecific low back pain without sciatica
- Dilation and Curettage for heavy menstrual bleeding

Threshold Criteria

- Breast reduction
- Removal of benign skin lesions
- Grommets for Glue Ear in Children
- Tonsillectomy for recurrent tonsillitis
- Haemorrhoid Surgery
- Hysterectomy for heavy menstrual bleeding
- Chalazia Removal
- Arthroscopic shoulder decompression for subacromial shoulder pain
- Carpal Tunnel Syndrome
- Dupuytren's Contracture release
- Ganglion excision
- Trigger finger release
- Varicose Vein Surgery

10. LLR Public Health consultants have reviewed the NHSE guidance against the Planned Care Policies. There are only two procedures from the NHS England list that are not included in the LLR Planned Care Policies:

a. Dilation and Curettage (D&C) for heavy menstrual bleeding in woman. This procedure is not performed at UHL therefore there will be little impact of not routinely funding this procedure
b. Arthroscopic shoulder decompression for subacromial shoulder pain. Work is underway with the Orthopaedic department at UHL to understand the implications of NHS England's recommendation.

11. The LLR CCGs will consider the outcome of NHSE consultation before finalising these 17 procedures as part of the Planned Care Policies.

POLICY REVIEW AND PROCESS OUTCOMES

12. All the policies have been reviewed by a team of 45 GPs, hospital consultants, public health consultants and patient representatives working in Leicester, Leicestershire and Rutland. They have looked at:

- All relevant national standards, medical guidance and any other evidence that shows whether the operation or treatment is likely to work
- How much individuals or patient groups are likely to benefit from the treatment
- Whether the operation or treatment provides good value for money
- The potential risks of complications for the treatment
- Whether the operation or treatment is being provided in the right place for the individual and for their particular medical problem.

13. Following the review, it has been agreed that:

- 2 existing policies will be changed and these are Hip and Knee Replacement and the Male Circumcision policies (see Appendix 2 of the Planned Care Policies Engagement Document) so that patients receive better care. Any treatment that is given will be based on best medical advice and be the right decision for their individual medical problem.
- 50 new policies of the 79 that have been reviewed in stages 2 and 3 will be introduced (see Appendix 3 of the Planned Care Policies Engagement Document). The majority of these new policies describe what is already happening in LLR although they do not currently have a formal policy in place. It means that from now on, it will be clearer which operations and treatment will be carried out and it will be fair for everyone.
- 49 existing policies have been reviewed and will not be changed (see Appendix 4 of the Planned care Policies Engagement Document).

ACTIVITY AND FINACIAL IMPACT

14. The financial benefit of implementing this policy is small as it mainly reflects current practice. However as with the decommissioning of acupuncture etc for low back pain in December 2017, it is the right thing to do for the LLR health economy. LLR CCGs should not commission services where there is limited clinical evidence of effectiveness or cost effectiveness.

15. The table below identifies the estimated activity and spend reduction assuming a 5% reduction of activity for these procedures by CCG.

	2017/18	**5% reduction (FYE)**

	Activity	Spend (£)	Activity	Spend (£)
ELRCCG	592	1,640,796	30	82,039.80
LCCCG	541	1,311,679	27	65,583.95
WLCCG	584	1,714,581	29	85,729.05
TOTAL	**1717**	**4,667,056**	**86**	**233,352.80**

16. It is difficult to quantify the reduction as savings will only be made if:

- A procedure is not undertaken, that previously was funded – there are no policies that fall in to this category
- If there is evidence that the provider performed a procedure outside of the clinical threshold therefore commissioners do not fund that activity if evidenced following an audit through the contracting arrangements.

17. Due to the growing waiting list size at providers, it is more likely that the theatre time released will be substituted to treat other patients who are already waiting on waiting lists, thus reducing the waiting list size and waiting times for patients.

COMMUNICATIONS AND ENGAGEMENT

18. It is clear from the policy review that LLR CCGs are not entirely stopping certain interventions outright for everybody and we are clear and comfortable with the clinical rationale and thresholds underpinning each policy that have been supported in primary and secondary care; therefore an engagement period of six weeks was proposed. The engagement process also acts as an education campaign for the public and reassures them that those who meet the thresholds will still receive treatment.

19. The Stakeholder Engagement document is attached as appendix A and has been prepared on behalf of the LLR CCGs.

20. Public engagement commenced on 20th August and runs through to 26th September 2018. In this time we are seeking people's views on the 101 policies. The engagement document identifies how the public can access the draft policies and survey:

- By contacting Leicester City CCG - 0116 295 1116
- By email - beinvolved@leicestercityccg.nhs.uk
- By the following web address - http://bit.ly/plannedcareLLR

21. Three public events have been organised for patients to come and learn more about the policies and share their thoughts. The events are taking place on the following dates:

Date	Location	Time
Tuesday 18th September	Falcon Hotel, 7 High St E, Uppingham, Oakham LE15 9PY	3pm to 6pm
Thursday 20th September	Voluntary Action LeicesterShire, 9 Newarke Street, Leicester, LE1 5SN	10am -1pm
Thursday 20th September	Ramada Hotel, 22 High Street, Loughborough, Leicestershire, LE11 2QL	3pm to 6pm

EQUALITY AND QUALITY IMPACT ASSESSMENTS

22. The equality impact assessments have been assessed at a clinical service level in consultation with the Midlands and Lancashire Commissioning Support Unit, Equality and Inclusion Business Partner. The quality impact assessment has been undertaken, in consultation with the Leicester City Clinical Commissioning Group Lead Nurse. Two quality impact assessments have been completed:
    - procedures/ treatments that are not routinely funded
    - procedures/ treatments with clinical thresholds.

23. At this stage in the process there have been no equality issues identified and the quality impact assessment has identified two main risks that need to be considered.

Risk Identified	**Mitigation**
Clinician awareness (primary and secondary care) of the policy and all the procedures with in the policy	• On line access to the policy document via CCG websites • PRISM pathways • Policy to be circulated to all Clinical Management Groups at UHL in October • UHL to include the policy on their internal intranet site
Lack of support for our strategic partners	Ensure communications with: • 3 HOSCs and Wellbeing Boards, • Voluntary sector organisations • Patients support groups • Carer groups • MPs and Councillors • Healthwatch and LMC

NEXT STEPS

24. The CCGs will review the feedback received from the public and stakeholder engagement, which ends on 26th September and make changes to the policies where clinically relevant. The final policies will be approved by the LLR CCGs in their public meetings in October. The final versions will be published and be available of the LLR CCGs websites for clinicians and the public to access.

25. Patients will be given four weeks' notice before the new approved policies come into force. It is expected that the new policies will be implemented by 1st December 2018.

Appendix A

Planned Care Policies in Leicester, Leicestershire and Rutland

We would like to hear your views about 101 policies that describe when and how planned care is carried out. Planned care is the non-emergency treatment and operations that are carried out in hospital and in the community, with appointments arranged in advance.

A partnership of:

- Leicester City Clinical Commissioning Group
- West Leicestershire Clinical Commissioning Group
- East Leicestershire and Rutland Clinical Commissioning Group

Contents

Introduction: Planned Care Services in Leicester, Leicestershire and Rutland

We would like to hear people's views about **101 policies** that describe when and how planned care operations and treatment are carried out.

Planned care is the term used to describe the non-emergency operations and treatment that are carried out in hospital and in the community, with appointments arranged in advance. Patients could be treated as an outpatient in a clinic or may have to stay overnight in hospital. Some examples of these are hip and knee replacements, operations to correct a cataract, joint injections and varicose vein surgery.

Policies are used by health professionals to give clear guidance on when a referral should be made for treatment in hospital.

There are 51 existing policies that have been reviewed, of which two have been changed. There are also 50 new policies being introduced because they do not currently have a proper policy in place.

This work is being led by the three NHS clinical commissioning groups (CCGs) responsible for planning and buying health services for people across Leicester, Leicestershire and Rutland, in partnership with local hospitals, GPs, public health and patient representatives.

Why are we doing this?

It is important to have policies in place so that doctors have clear guidance on treatments and to make sure that decisions are made consistently and in the same way for each patient. This is not about "rationing" or reducing access to treatment.

We want to make sure that patients only have procedures, such as operations, where we know that this will be effective for their particular medical problem and circumstances. Any procedure carries a small risk of complications, so we need to know that a treatment is right and will help the patient. Policies also make sure that NHS resources are used in the best possible way and are used fairly for everyone.

We want to know whether patients are aware of these policies and understand them, whether they have any questions about them and if there is anything else that they think should be included.

Tell us your views

Patients can tell us their views from **17th August until 26th September 2018,** through a survey and through public events**.** More information on all of this can be found on page 5.

During the survey period we will be examining all of the feedback received. If any concerns are raised about any wording in the individual policies we will allow more time to consider these.

Policies

Policies are used in all areas of the country to describe when and how particular operations or treatment will be carried out. They are used by health professionals to give clear guidance on when a referral should be made for treatment. This is important to ensure that, wherever patients live, they are treated consistently and to make sure that they don't undergo procedures if there is unlikely to be a significant benefit.

Our local doctors have looked at a range of policies to decide whether they are suitable for patients in Leicester, Leicestershire and Rutland. The policies cover the following areas of medicine:

- Dermatology: problems with the skin
- Ear, nose and throat
- Gastroenterology: related to the stomach and intestines
- General surgery: a wide range of surgery which includes: surgery of the stomach and intestines; breast problems; kidney, pancreas and liver transplantation; trauma to the abdomen and thorax; certain skin problems and general childhood surgery
- Gynaecology: related to the female parts of the body used to make babies
- Imaging: taking pictures of the inside of the body. For example x-ray, ultrasound and MRI scans
- Maxillofacial: related to the mouth and jaw
- Neurology: related to the brain and nervous system
- Ophthalmology: related to the eyes
- Orthopaedics: related to the bones, joints and muscles in the body
- Paediatric surgery: related to children

- Pain
- Plastics: plastic surgery and enhancing appearance with or without surgery
- Podiatry: related to the feet, ankles and lower legs
- Respiratory: related to the lungs
- Urology: In women – related to the kidneys, ureters, bladder. In men, also related to the prostate and penis.
- Vascular: related to the heart and blood system
- plus a small number of other policies.

Following the review, it has been agreed that:

- 2 existing policies will be changed (see Appendix 2) so that patients receive better care. Any treatment that is given will be based on best medical advice and be the right decision for their individual medical problem.
- 50 new policies will be introduced (see Appendix 3). These new policies simply describe what is already happening in Leicester, Leicestershire and Rutland although they do not currently have a formal policy in place. It means that from now on it will be clearer which operations and treatment will be carried out and it will be fair for everyone.
- 49 existing policies have been reviewed and will not be changed (see Appendix 4).

How have the policies been reviewed?

All the policies have been reviewed by a team of GPs, hospital consultants and public health consultants working in Leicester, Leicestershire and Rutland. They have looked at:

- All relevant national standards, medical guidance and any other evidence that shows whether the operation or treatment is likely to work
- How much individuals or patient groups are likely to benefit from the treatment
- Whether the operation or treatment provides good value for money
- The potential risks of complications for the treatment
- Whether the operation or treatment is being provided in the right place for the individual and for their particular medical problem.

How can patients get involved?

Patients are invited to review the policies and let us know if they have any comments to make about any of them, using an online survey.

- Paper copies of each draft policy and the survey are available by calling 0116 295 1116 (Monday to Friday 9am to 5pm), or by emailing beinvolved@leicestercityccg.nhs.uk.

- You can also view the policies and complete the survey on the following web page: http://bit.ly/plannedcareLLR

- You can make comments on as many of the policies as you wish but you will need to complete a separate survey for each policy you are commenting on.

The survey closes on **26th September 2018.** The policies will then be amended to take into account what people have said and final versions will be published.

During the engagement we will be examining all of the feedback we received and if any concerns are raised about any wording in the individual policies, or if patients raise issues that they believe have been missed, we will allow more time to consider these.

Events

We are holding three events to discuss the proposed policy changes. One event will take place in Leicester, one in Leicestershire and one in Rutland. At these events patients can come and learn more about the policies and other changes that we might make to local services in the future. (See Appendix 5 for more information about future changes).

The events are taking place on the following dates:

Date	Location	Time
Tuesday 18th September	Falcon Hotel, 7 High St E, Uppingham, Oakham LE15 9PY	3pm to 6pm
Thursday 20th September	Voluntary Action LeicesterShire, 9 Newarke Street, Leicester, LE1 5SN	10am -1pm
Thursday 20th September	Ramada Hotel, 22 High Street, Loughborough, Leicestershire, LE11 2QL	3pm to 6pm

***Please let us know if you would like to attend as places are limited.** Call 0116 295 1116 (Monday to Friday 9am to 5pm) or email beinvolved@leicestercityccg.nhs.uk

Questions you may have

When will the policies be implemented?

Some of the policies are already in place, and It is expected that the new policies will be implemented by 1st December 2018.

Patients have until 26th September 2018 to comment on the policies. Following this, the clinical commissioning groups will review the comments and make changes to the policies. The final policies will be approved by the three clinical commissioning groups in their public meetings in October and then final versions will be published. Patients will be given four weeks' notice before the new approved policies come into force.

What will happen to patients already receiving treatment or on waiting lists?

Any patients that are already in the process of receiving treatment, or are on a waiting list, will continue receiving that treatment. Any new patients will be referred for treatment in line with the new policies once they have been approved.

Will any more policies be introduced in the future?

The clinical commissioning groups will be continuing to review our policies in the future. This is good practice to make sure NHS resources are being used in the best possible way. The CCGs will be engaging or consulting with patients about every policy as appropriate and patients can ask to be kept informed about these.

How will the policies be published?

Any approved policies that are used locally will be published on each CCG's website:

- www.leicestercityccg.nhs.uk
- www.westleicestershireccg.nhs.uk
- www.eastleicestershireandrutlandccg.nhs.uk

The draft policies can all be reviewed on the following web page:
https://www.leicestercityccg.nhs.uk/get-involved/consultations-and-surveys/current-consultations-and-surveys/planned-care-policies-for-leicester-leicestershire-and-rutland/draft-referral-policies/

Will patients be negatively affected by the implementation of the policies?

No. This is about strengthening and improving existing policies to make sure they are as appropriate as they can be or making sure that a policy exists to govern an area of care that is already being delivered across Leicester, Leicestershire and Rutland.

This means that patients will not be negatively affected by introducing the new or changed policies. Instead it will be clearer what operations and treatments will be carried out and when, so that it is fairer for everyone.

Will there be any changes to Planned Care in the future?

In the future, we will be looking at how we could change some planned care services to make them better for patients. With these policies in place, any changes will be more successful because services will already be working more efficiently. It also means that we will be able to do more with any extra resources we receive in the future. This is an important piece of work for the Sustainability and Transformation Partnership, known locally as Better Care Together.

You can read more about this, and how you can get involved, in Appendix 5.

I've heard in the news about national changes to planned care – how will that affect what's happening locally?

CCGs decide what policies they put in place for their patients. NHS England sometimes makes recommendations about what CCGs should think about introducing.

At the beginning of July, NHS England launched a consultation about 17 interventions that it would like clinical commissioning groups (CCGs) to introduce policies for. This consultation will help NHS England to put their recommendations together.

Most of these interventions are already included in our local policies, or are planned to be introduced in the review that's covered in this document. We have started to consider NHS England's proposed policies locally, and if we think changes should be made, we will engage or consult with local patients.

NHS England's consultation will be running until 28th September 2018. Patients are also encouraged to take part in this.
https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/

Appendix 1: Number of policies by area of medicine

The areas of medicine that the policies fall under are listed in the table below.

Specialty	Number of existing policies with no change	Number of existing policies with amendments	Number of new policies	Total
Dermatology	9	0	5	**14**
Ear, nose and throat (ENT)	3	0	3	**6**
Gastroenterology	1	0	1	**2**
General surgery	2	0	1	**3**
Gynaecology	3	0	2	**5**
Gynaecology / Urology	1	0	1	**2**
Imaging	0	0	1	**1**
Maxillofacial	0	0	2	**2**
Neurology	0	0	2	**2**
Ophthalmology	1	0	5	**6**
Orthopaedics	4	1	9	**14**
Other	0	0	5	**5**
Paediatric surgery	0	0	1	**1**
Pain	0	0	4	**4**
Plastics	21	0	2	**23**
Podiatry	0	0	1	**1**
Respiratory	1	0	0	**1**
Urology	2	1	2	**5**
Vascular	1	0	3	**4**
Total	**49**	**2**	**50**	**101**

Appendix 2: Policies that have changed

Paper copies of individual draft policies and the survey are available by calling 0116 295 1116 (Monday to Friday 9am to 5pm) or emailing beinvolved@leicestercityccg.nhs.uk. You can also view our policies online by visiting: https://www.leicestercityccg.nhs.uk/get-involved/consultations-and-surveys/current-consultations-and-surveys/planned-care-policies-for-leicester-leicestershire-and-rutland/draft-referral-policies/

Two existing policies have been changed. These are:

- Circumcision – Male: The removal of a man's foreskin from the penis.
- Hip and Knee Replacement

Both of these are **threshold policies**; this describes the different levels of treatment that can be given depending on the nature of the patient's individual medical problem. For example, some treatment will only work in certain situations.

**** If you are reading this online, click on the policy name to read the full policy***

Urology

Policy	Type
Circumcision – Male	Threshold

What has changed in the policy?

In the current policy, circumcision is only funded if the patient has the following medical problems: pathological phimosis (abnormally tight foreskin), recurrent paraphimosis (when the retracted foreskin will not return to its normal position over the tip of the penis), trauma (zipper injury), urinary tract infections (UTI) that keep coming back.

The proposed policy continues to cover all of the same medical problems but has also been extended to include circumstances where there have been three episodes of balanoposthitis.

Orthopaedics

Policy	Type
Hip and Knee Replacement	Threshold

What has changed in the policy?

The current policy requires patients to score below a threshold number on the Oxford Score (to rate the severity and effects of joint symptoms and monitor the effectiveness of treatment) before they are referred. This score does not have to be included in the new policy, although the Oxford score continues to be one of the ways a doctor might help a patient decide whether surgery is right for them.

The following have been added to the policy:

- Patients with any existing medical problems should be in good health, e.g. for example, anaemic patients should bring their iron levels within normal range.
- The patient should have undergone three months of non- surgical treatment which includes exercise, mobility aids, lifestyle advice and medication.
- The patient should confirm that they are willing to have surgery. Questionnaires such as the Oxford Score should be used to help them decide whether the operation is right for them.
- Referrals should only be made if the severity of the patient's medical problem meets a certain level, based on:
  - The patient's symptoms and how they are impacting on their life.
  - How well the patient is able to move and carry out activities
  - The findings of medical examinations
  - Whether there is visual evidence (e.g. x-ray or ultrasound) showing the patient has a disease that has slowly been getting worse (such as arthritis).
- Patients with severe symptoms and a lack of ability to move or carry out normal activities, will be seen more quickly.

Appendix 3: New policies that are being introduced in Leicester, Leicestershire and Rutland

Paper copies of individual draft policies and the survey are available by calling 0116 295 1116 (Monday to Friday 9am to 5pm) or emailing beinvolved@leicestercityccg.nhs.uk. You can also view our policies online by visiting: https://www.leicestercityccg.nhs.uk/get-involved/consultations-and-surveys/current-consultations-and-surveys/planned-care-policies-for-leicester-leicestershire-and-rutland/draft-referral-policies/

50 new policies are being introduced. Policies for these procedures are already in use in other areas of the country and have been reviewed by a team of local doctors to ensure they are fit for purpose.

Care is already being delivered in this way but there is no formal policy in place. **This means that patients will not be affected by introducing these new policies. It will be clearer what operations and treatment will be carried out and it will be fair for everyone.**

- **Threshold policies:** A threshold policy is one that describes the severity of the condition before treatment can be given, depending on the nature of the patient's individual medical problem. For example, some treatment will only work in certain situations. There are 40 policies in this category.
- **Not routinely funded:** 10 policies are described as being *not routinely funded.* This means that they would not normally be carried out and funded by the NHS unless exceptional circumstances are met. Clinicians can request that treatment is funded if the patient has exceptional circumstances. Requests will be considered by a review panel.

If you are reading this online, click on the policy name to read the full policy

Dermatology

Policy	Type
Actinic Keratosis A skin problem consisting of rough patches of skin caused by damage from years of being out in the sun.	Threshold
Alopecia	Threshold

A general term for hair loss.	
Hyper pigmentation – treatment of Hyperpigmentation is flat, darkened patches on the skin that are light brown to black in colour, and can vary in size and shape.	Threshold
Rhinophyma Where the nose swells and becomes lumpy.	Threshold
Vitiligo Loss of skin pigment so that white patches appear on the skin.	Threshold

Ear, Nose and Throat (ENT)

Policy	Type
Ear Wax Removal Removal of wax build up in the ear.	Threshold
Non-Cosmetic Nasal Treatment Treatment of the nose for medical reasons.	Threshold
Vocal Cord Management Two folds in the throat. When air passes over them they produce sound known as your voice.	Threshold

Gastroenterology

Policy	Type
Gastric fundoplication for chronic reflux oesophagitis A procedure to stop acid from the stomach washing backwards into the oesophagus (tube that food travels along from the throat to the stomach). This causes inflammation, swelling, pain and damage to the oesophagus.	Threshold

General Surgery

Policy	Type
Abdominal Hernia in Adults A weakness in the muscle, causing the tissue underneath to bulge through.	Threshold

Gynaecology (see also below: Gynaecology/Urology and Imaging)

Policy	Type
Utero vaginal prolapse When the womb (uterus) hangs down into the vagina.	Threshold
Vaginal pessaries A device made of rubber (latex) or silicone is inserted into the vagina to support the vaginal walls and pelvic organs in the case of pelvic organ prolapse – where the womb (uterus), bowel, bladder or top of the vagina slip down and bulge into the vagina.	Threshold

Gynaecology / Urology

Policy	Type
Sterilisation – Female and Male An operation to permanently prevent pregnancy. In a woman, the fallopian tubes are blocked or sealed to prevent the eggs from reaching the sperm and becoming fertilised. In a man, the tubes that carry the sperm are cut or sealed (vasectomy).	Threshold

Imaging

Policy	Type
Magnetic resonance guided focused ultrasound for uterine fibroids Used to identify the location of and treat non-cancerous tumours in the womb using heat created by an ultrasound beam.	Not Routinely Funded

Maxillofacial

Policy	Type
Mandibular/ Maxillary osteotomy Lower jaw or jaw bone.	Threshold
Temporo-Mandibular Joint Dysfunction Where the jaw joint (where the lower jaw meets the temple area) does not work properly causing pain, limited mouth opening and joint noises.	Threshold

Neurology

Policy	Type
Botulinum toxin for chronic migraines in adults An injection that relaxes the muscles and smooths out the skin.	Threshold

Also known as Botox or Botos.	
Restless legs syndrome Restless legs syndrome is a problem with the nervous system that causes an overwhelming urge to move the legs. It can also cause an unpleasant crawling or creeping sensation in the feet, calves and thighs. Occasionally, the arms are affected too.	Threshold

Ophthalmology

Policy	Type
Chalazion – removal of A chalazion is a cyst (swollen area of tissue filled with fluid) that develops on the eyelid.	Threshold
Intraocular Lens Implants (Cataract surgery) Cataracts are when the lens of your eye, a small transparent disc, develops cloudy patches. Cataract surgery involves removing the cataract, and often replacing the cloudy lens inside your eye with an artificial one.	Threshold
Laser treatment for myopia User of lasers, for example to remove a growth.	Not Routinely Funded
Ozurdex Intravitreal Implant Where medicine is injected into the eye to treat swelling.	Not Routinely Funded
Scotopic sensitivity syndrome Unpleasant visual symptoms when reading, especially for prolonged periods. It can also cause sore eyes, headaches, frequent loss of place when reading and difficulty understanding.	Not Routinely Funded

Orthopaedics

Policy	Type
Bunions Bunions are bony lumps that form on the side of the feet.	Threshold
Hip Arthroscopy Keyhole surgery on a joint in the body.	Threshold
Hip Resurfacing This involves removing the damaged surfaces of the bones inside a joint and replacing them with a metal surface.	Threshold
Hybrid Hip Replacement and Revision Replacement or revision of the hip or knee is where a replacement	Threshold

hip or knee is replaced again.	
Hybrid Knee Replacement and Revision Replacement or revision of the hip or knee is where a replacement hip or knee is replaced again.	Threshold
Knee Arthroscopy Keyhole surgery on a joint in the body.	Threshold
Knee Resurfacing This involves removing the damaged surfaces of the bones inside a joint and replacing them with a metal surface.	Threshold
Low Back Pain - Surgical Intervention Where an operation or surgery is carried out on the back	Threshold
Ultrasound - low intensity for bone healing Using sound waves. For example, an ultrasound scan converts sound waves into a picture.	Not Routinely Funded

Other

Policy	Type
Botulinum toxin – the use of An injection that relaxes the muscles and smooths out the skin. Also known as Botox or Botos.	Threshold
Complementary and Alternative Therapies Treatments that have not been subject to the normal tests and research trials. These medicines and treatment range from acupuncture and homeopathy, to aromatherapy, meditation and colonic irrigation.	Not Routinely Funded
Second and Third specialist opinion for same condition	Threshold
Surgical Mesh A loosely woven sheet which is used as a permanent or temporary support for organs and other tissues during surgery.	Threshold
Topical negative pressure for wound closure Use of suction to help heal a wound.	Threshold

Paediatric Surgery

Policy	Type
Tongue Ties – surgery When the strip of skin connecting a baby's tongue to the floor of	Threshold

their mouth is shorter than usual. This makes it difficult for them to breastfeed.	

Pain

Policy	Type
Epidural Injections for patients with Radicular Pain An epidural is an injection in the back to numb the nerves which make you feel pain in part of your body.	Threshold
Facet Joint Injection Facet joints are small joints at each segment of the spine that provide stability and help guide movement. A facet joint injection involves injecting a small amount of local anaesthetic (numbing agent) and/or steroid medication, to block the pain.	Threshold
Medial Branch Block and Therapeutic Facet Joint Injections An injection of a strong local aesthetic into the nerves that supply the facet joints (small joints at each segment of the spine).	Threshold
Thermal Radiofrequency Denervation An injection that uses heat at the end of the needle to change how the nerves in the back supply the small joints at each segment of the spine (facet joints) to reduce pain.	Threshold

Plastics

Policy	Type
Calf augmentation Surgery to increase the size of the calves.	Not Routinely Funded
Gluteal augmentation Surgery to increase the size of the buttocks.	Not Routinely Funded

Podiatry

Policy	Type
Fungal Nail Infection (Onychomycosis) An infection of the toe or finger nails	Threshold

Urology

Policy	Type
Asymptomatic Scrotal Swelling (Variocele) Swollen veins, below the testicles, that are not causing any	Threshold

symptoms.	
Erectile Dysfunction -Treatment of Erectile dysfunction, sometimes known as impotence, is the inability to get and keep an erection so that sexual intercourse can take place.	Threshold

Vascular

Policy	Type
Endoscopic thoracic sympathectomy for facial flushing/ sweating An operation to cut the nerves that cause the facial blood vessels to dilate (widen).	Not Routinely Funded
Endo-Vascular Aneurysm Repair Operation to repair a swelling in an artery (tube that carries blood away from the heart). These usually happen in the abdominal aorta which is the artery that leads from the heart, through the tummy to the rest of the body.	Threshold
Venous angioplasty for MS An operation to widen the veins (tubes that carry blood to the heart) to improve blood flow in patients with Multiple Sclerosis or MS (Where someone has problems with vision, arm or leg movement, sensation or balance).	Not Routinely Funded

Appendix 4: Policies that have not changed

Paper copies of individual draft policies and the survey are available by calling 0116 295 1116 (Monday to Friday 9am to 5pm) or emailing beinvolved@leicestercityccg.nhs.uk. You can also view our policies online by visiting: https://www.leicestercityccg.nhs.uk/get-involved/consultations-and-surveys/current-consultations-and-surveys/planned-care-policies-for-leicester-leicestershire-and-rutland/draft-referral-policies/

49 existing policies will not be subject to any change as they are considered to be fit for purpose. Again these fit into two categories; either threshold policies of those which are not routinely funded.

- **Threshold policies:** A threshold policy is one that describes the different levels of treatment that can be given depending on the nature of the patient's individual medical problem. For example, some treatment will only work in certain situations. There are 28 policies in this category.
- **Not routinely funded:** 21 policies are described as being *not routinely funded.* This means that they would not normally be carried out and funded by the NHS unless exceptional circumstances are met. Clinicians can request that treatment is funded if the patient has exceptional circumstances. Requests will be considered by a review panel.

The policies not proposed to change are as follows:

* ***If you are reading this online, click on the policy name to read the full policy***

Dermatology

Policy	Type
Benign Skin Lesion Non-cancerous skin growth.	Threshold
Congenital pigmented lesion of the face Birthmark	Threshold
Epidermoid/pilar (Sebaceous cyst) Sebaceous cyst. A lump that is a sac filled with fat.	Threshold
Laser Treatment User of lasers, for example to remove a growth.	Threshold

Lipoma – Removal of A non-cancerous tumour made of fat.	Threshold
Dermabrasion and/ or Laser Resurfacing Using a rapidly turning device to sand the outer layers of skin.	Not Routinely Funded
Hair depilation for excessive growth (hirsutism) Hair removal.	Not Routinely Funded
Hair Transplantation A procedure to move hair from an area unaffected by hair loss to an area of thinning or baldness.	Not Routinely Funded
Photodestruction or Electrolysis of Lesion of Skin To destroy something using light.	Not Routinely Funded

Ear, Nose and Throat (ENT)

Policy	Type
Myringotomy with or without grommets A small operation to relieve pressure in the ear drum or drain fluid from the ear.	Threshold
Prominent Ears (Pinnaplasty) An operation to correct prominent or sticking out ears	Threshold
Tonsillectomy and Adenoidectomy An operation to remove the tonsils - two small oval lumps of spongy tissue, one on each side at the back of the mouth. Or An operation to remove the adenoids – a mass of tissue at the back of the nose.	Threshold

Gastroenterology

Policy	Type
Endoscopy for Dyspepsia A common medical procedure that is used to examine your body from the inside with a tiny camera.	Threshold

General Surgery

Policy	Type
Rectal Bleeding From the rectum. The lower part of your large intestine where your body stores poo.	Threshold

Cholecystectomy – Asymptomatic Removal of the gall bladder when it is not causing any symptoms.	Not Routinely Funded

Gynaecology (see also Gynaecology/Urology on page 18)

Policy	Type
Cryopreservation – Gamete and Embryo Freezing a man's sperm or a woman's eggs to be used to make a baby at another time.	Threshold
Intra Uterine Insemination and Donor Insemination A fertility treatment that involves placing sperm inside a woman's uterus (womb) to make it easier for the egg to become fertilised.	Threshold
Mirena for the Treatment of Heavy Menstrual Bleeding Mirena is a type of birth control (contraception) where a plastic frame is inserted into the uterus (womb) and releases a hormone. It is also used for treatment of heavy periods and for hormone replacement therapy.	Threshold

Gynaecology / Urology

Policy	Type
Reversal of sterilisation – male and female An operation to permanently prevent pregnancy. In a woman, the fallopian tubes are blocked or sealed to prevent the eggs from reaching the sperm and becoming fertilised. In a man, the tubes that carry the sperm are cut or sealed (vasectomy).	Not Routinely Funded

Ophthalmology

Policy	Type
Cataracts Where the lens of the eye becomes less and less see-through (more opaque/frosted), resulting in blurred vision.	Threshold

Orthopaedics

Policy	Type
Carpal Tunnel Syndrome The carpal tunnel is a channel in the wrist that a nerve passes through.	Threshold

Dupuytren's Disease A disease of the palm of the hand which can cause nodules that may pull the fingers in towards the palm.	Threshold
Ganglion – Hand and Wrist A ganglion is a swelling on top of a joint or tendon (tissue that connects muscle to bone). It looks like a sac of liquid (cyst). Inside the cyst is a thick, sticky, clear, colourless, jellylike material.	Threshold
Trigger Finger A problem with the hand where one or more fingers become claw like and locks. The tendon gets caught during the movement of the finger and then snaps free.	Threshold

Plastics

Policy	Type
Abdominoplasty and apronectomy Also known as a "tummy tuck". An operation to make the tummy thinner and more firm. The surgery involves the removal of excess skin and fat from the tummy. Or An operation to remove the large "apron" of excess of skin and fat which hangs down below the tummy. The procedure is needed mostly for patients that have lost a lot of weight.	Threshold
Breast Asymmetry Breasts that are a different size and shape from each other.	Threshold
Breast Implants Removal and Insertion A sac of gel-like or fluid material that is put behind or in place of a female breast to change the size and shape.	Threshold
Breast Reduction An operation to reduce the size of the breasts.	Threshold
Brow Lift (Blepharoplasty) An operation to correct defects, deformities and disfigurations of the eyelids by lifting the brow.	Threshold
Male Breast Reduction An operation to reduce the size of the breasts.	Threshold
Scar reduction	Threshold
Botulinum Toxin for wrinkles, frown lines or ageing neck An injection that relaxes the muscles and smooths out the skin. Also known as Botox or Botos.	Not Routinely Funded

Policy	Type
Chin Implant (genioplasty, mentoplasty)/ Cheek implants An operation to make your cheekbones look fuller and higher. It builds on your existing bone structure by inserting a piece of silicone or bone over the top of your cheekbones. Or An operation to reshape the chin (genioplasty) or increase the size of the chin (mentoplasty), by adding a piece of bone, fat or silicone around a patient's existing chin bone.	Not Routinely Funded
Collagen implant Collagen is a protein found in the skin and other tissues. It can be injected as a liquid into the skin to raise the skin tissue and make scars and wrinkles appear less visible.	Not Routinely Funded
Correction of nipple inversion An inverted nipple is where the nipple is pulled inward into the breast instead of pointing outward.	Not Routinely Funded
Cranial banding for positional plagiocephaly A band worn around the head to improve the shape of a baby's head as it grows.	Not Routinely Funded
Earlobe Repair Repair to soft tissues at the bottom of the ear	Not Routinely Funded
Excision of Skin for Cosmetic Indicators (Facelifts, Buttocks Lifts) An operation to remove skin.	Not Routinely Funded
Facelifts An operation to lift up and pull back the skin to make the face tighter and smoother.	Not Routinely Funded
Fat Grafts An operation where fat cells are removed from one area of the body using a needle and injected into a different area of the body to make it bigger.	Not Routinely Funded
Gender reassignment – Not included in original packages of care Operations or treatment to change a person's physical sexual characteristics to that of the opposite sex. For example to change from male to female or female to male.	Not Routinely Funded (but considered on a case by case basis)
Labiaplasty, vaginoplasty and hymen reconstruction An operation to reduce the size of the flaps of skin either side of the vaginal opening. Or	Not Routinely Funded

Policy	Type
An operation to construct or reconstruct the vagina.	
Mastopexy (Breast uplift) This is an operation to remove excess skin from the breast in order to change its shape and lift the nipple.	Not Routinely Funded
Suction assisted lipectomy (Liposuction) An operation to suck out unwanted body fat.	Not Routinely Funded
Thigh lift, Buttock and Arm lift – excision of redundant skin/ fat An operation to remove excess skin from the thighs, buttocks or arms.	Not Routinely Funded

Respiratory

Policy	Type
Screening for obstruction sleep apnoea Stopping breathing for short periods whilst asleep, due to partial blockage of the airway.	Threshold

Urology

Policy	Type
Lower Urinary Tract Symptoms Bladder, prostate and urethra	Threshold
Phalloplasty An operation in hospital to build or rebuild a man's penis.	Not Routinely Funded

Vascular

Policy	Type
Varicose Vein Surgery Veins are tubes in the body that carry blood to the heart. Varicose veins are veins that have become bigger and dilated because the valves that stop back flow of blood are not working. The term often refers to the veins on the leg, although varicose veins can occur elsewhere.	Threshold

Appendix 5: Planned Care Services in the Future

In the future, patients will be able to get involved in redesigning the steps that are taken or the parts of the NHS that are used for a patient to receive their treatment.

These are sometimes known as pathways. For example, this could be about where any tests or investigations are carried out - in hospital or in a clinic closer to home.

Patient representatives have already been involved in this work, but we want to widen this out to a larger group of patients to ensure that changes truly reflect the needs of our local population.

We will be redesigning care in 12 areas of medicine:

- Dermatology
- Ophthalmology
- Cardiology
- Orthopaedics
- Gastroenterology
- Urology
- Ear, Nose and Throat
- Respiratory
- General Surgery
- Haematology
- Audiology
- Physiotherapy

All of this is an important piece of work for the Sustainability and Transformation Partnership, known locally as Better Care Together (BCT), and is being led by the three NHS clinical commissioning groups (CCGs) responsible for planning and buying health services on behalf of local people.

We believe that by doing things better and differently in these areas, we will be able to improve patients' experience and the care they receive.

If you would like to be involved in helping to redesign care in these areas, please register your area of interest by calling 0116 295 1116 (Monday to Friday 9am to 5pm) or email beinvolved@leicestercityccg.nhs.uk.

You will also be able to learn more about this work at the events below:

Date	Location	Time
Tuesday 18th September	Falcon Hotel, 7 High St E, Uppingham, Oakham LE15 9PY	3pm to 6pm
Thursday 20th September	Voluntary Action LeicesterShire, 9 Newarke Street, Leicester, LE1 5SN	10am -1pm
Thursday 20th September	Ramada Hotel, 22 High Street, Loughborough, Leicestershire, LE11 2QL	3pm to 6pm

***Please let us know if you would like to attend as places are limited**

You can keep up to date with the progress of the planned care transformation and opportunities to be involved by visiting our website at: https://www.leicestercityccg.nhs.uk/get-involved/consultations-and-surveys/current-consultations-and-surveys/ or www.bettercareleicester.nhs.uk

LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE MEETING

Update on Better Care Together – the Sustainability and Transformation Partnership for Leicester, Leicestershire and Rutland

Purpose of the report

1. This report aims to provide an update on Better Care Together (the Sustainability and Transformation Partnership for Leicester, Leicestershire and Rutland), and the work being undertaken by partners to improve the health and wellbeing of people locally.

Background

2. Back in November 2016 the local NHS organisations published draft proposals to improve health services for patients in our area. That was as part of a national initiative to produce what were called Sustainability and Transformation Plans (or STPs for short) for 44 areas across the country.

3. Known locally as Better Care Together, we engaged with local people and staff on these draft proposals. The overall direction of improving care quality and safety while integrating services by breaking down artificial organisational barriers was welcomed. However, people told us they had concerns about the number of hospital beds planned for the future, as well as the capacity of general practice and community services to support planned new service models.

4. Since then national policy has refocused these STPs, moving the emphasis from being about producing plans to concentrating on ongoing partnership working to improve services and care for patients through more integrated care in local places.

5. Whatever acronym is used, locally the NHS partners in Better Care Together have taken forward a significant amount of work over the 18-month period since the document was first published.

6. We've opened a new treatment centre in Market Harborough, enhanced the NHS111 service which provides more access to clinicians and created 2,000 extra appointments each week with GPs and nurses at hubs in Leicester City. We have secured £48 million for the new A&E department at Leicester Royal Infirmary as well as a commitment to fund around £2 million of improvements at general practice premises. Last year, we also secured £8 million for a purpose-built mental health ward for children and young people with a focus on eating disorders and £30 million for new intensive care units and a new ward at Glenfield Hospital. We've also started changing the way that the NHS organisations work together, so that we operate more as one team working for the people of Leicester, Leicestershire and Rutland in a less fragmented way.

7. However, the last 18 months have also seen local NHS finances and performance challenged in many services and organisations, particularly during the winter period.

8. Nationally, the Government has recognised the pressure local NHS services are under and so we welcomed the announcement, in March this year, of the development of a

long-term plan and funding settlement for the NHS. Later this year more detailed information on what the NHS can, and can't do, with any increased level of funding will be published.

9. Set against this context, the local NHS partners decided that our Better Care Together partnership needs to continue its ongoing work to improve care for patients. We also decided not to produce a detailed long-term 'blueprint' for all NHS services by creating a 'final' version of our original STP plan. This is because the outcome of the national funding review could have a direct and significant impact on what it is possible to afford; and therefore, some of the choices that we may need to make.

10. In the meantime we felt it important to update local people and stakeholders on the work that is being done by the Better Care Together partners. This is why we have published the *Next Steps to better care Leicester, Leicestershire and Rutland* document.

11. The Next Steps publication:

- provides an update on the progress we have already made to deliver high quality, sustainable services.
- sets out our refreshed strategic direction which responds to the feedback on our initial proposals and the actual experience of services.
- summarises our plans to improve the health and wellbeing of our diverse population which is centred around our model of care that has been evolving over recent years. The model focuses on keeping more people well and out of hospital, providing more care closer to home, providing care in a crisis and providing high quality specialist care.
- explains how we are working together across NHS organisations, and in partnership with others, in a more integrated way that is focused on doing the right thing for local people not necessarily individual organisations.
- it is open about those areas where we are still doing ongoing work to develop care models and the implications of these for local services, for example some community services and hospitals.

Reconfiguration of acute and maternity services

12. One of the key elements that our draft STP proposals focused on in 2016 was the need for improvement in our NHS buildings. We've already had some success in securing funding for the new A&E department at Leicester Royal Infirmary as well as commitment of around £2 million for improvements to general practice premises. Last year we also secured £8 million for a purpose-built ward for children and young people with a focus on eating disorders and £30 million for new intensive care units and a new ward at Glenfield Hospital.

13. However, work continues on business cases totalling more than £350 million for the configuration of services provided by University Hospitals of Leicester, maternity services, and some community hospitals.

14. We are currently applying for national funding to support the acute and maternity services reconfiguration. This includes moving acute clinical services onto two sites, Leicester Royal Infirmary and Glenfield Hospital and retaining some non-acute health services on the site of Leicester General Hospital. Also remodelling maternity services to create a new maternity hospital at the Leicester Royal Infirmary and subject to the outcome of the consultation, a midwife-led unit at Leicester General Hospital.

15. If successful, under national NHS capital guidance we will then be able to undertake formal public consultation that we remain committed to doing, which we hope to announce in 2019. Unfortunately national rules now mean that consultation cannot start until we have a level of surety regarding the potential availability of the required capital investment.

Engagement and consultation

16. As we are making and proposing significant improvement to how we deliver healthcare in LLR, experience shows that listening to patients and understanding what matters most to them leads to more efficient and effective services.

17. In addition involvement of key stakeholders including the voluntary and community sector, patient groups including Healthwatch and councillors is essential to enable communities to shape services and the care that people receive.

18. We plan to hold in the autumn, deliberative events in Leicester, Leicestershire and Rutland to enable elected member councillors, members of Health and Wellbeing Boards and Scrutiny Committees to receive a BCT update and share their views and give us an understanding of the impact of proposals on the people they represent.

19. This type of informal engagement has been a key feature of BCT since 2014 particularly through each BCT work stream. We are commencing shortly a further engagement programme to improve a range of adult community health services provided by Leicestershire Partnership NHS Trust.

20. Where formal consultation is required in addition to the major reconfiguration work, we involve the public to understand the impact of proposals. We have recently launched engagement on proposed changes to some planned care services across LLR, which we are promoting online and at events.

Enhancing collaborative arrangements

21. BCT is about partner organisations and our health and care staff working together to share responsibility for the planning and delivery of improved and sustainable health and social care for people of LLR within the resources available to us.

22. To support us to operate in this way, the clinical commissioning groups in LLR are discussing options to enhance their collaborative arrangements. A review of the current governance structure of BCT, which has been in place since 2016, is also underway. Any proposed changes will ensure that partners are more responsive to the needs of the population and able to improve services while tackling the financial and operational issues we face.

Conclusion and summary

23. The LLR Joint Health Scrutiny Committee is asked to:

- **NOTE** this update and the work of the BCT partners
- **NOTE** publication of the Next Steps document
- **NOTE** Ongoing work to co-ordinate business cases for acute and maternity reconfiguration, which will be subject to formal public consultation once capital funding is identified

- **NOTE** on-going work of BCT work streams, and engagement and consultation activities.

Appendix D1

70 YEARS OF THE NHS 1948 - 2018

Better care together

Leicester, Leicestershire & Rutland health and social care

Next steps to better care in Leicester, Leicestershire and Rutland

August 2018

"Our life, our health, our care, our family and our community"

CONTENTS

Next steps to better care in Leicester, Leicestershire and Rutland

Foreword

By the managing directors of NHS Clinical Commissioning Group (CCGs) and chief executives of NHS trusts and the ambulance service in Leicester, Leicestershire and Rutland (LLR)

The three NHS trusts and three clinical commissioning groups in Leicester, Leicestershire and Rutland, working alongside a range of other independent, voluntary and community sector providers and local councils, combine to look after a population of more than one million people. They do this through Better Care Together (BCT) – the local Sustainability and Transformation Partnership (STP).

More than 22,000 dedicated NHS staff alongside a further 32,000 social care staff work exceptionally hard every day to provide the best care to residents in our area and those who seek treatment here.

As leaders in these NHS organisations, we are proud of their efforts and the health and care services they collectively deliver.

Skilled and dedicated, they save and improve the lives of local people. Their service is typical of the great efforts of committed and talented individuals, who have helped deliver 70 successful years of NHS care in our country and in LLR.

There is no doubt that fantastic staff will continue to be the cornerstone of the NHS in the next 70 years, too.

But, we face unprecedented challenges, which come with an ageing population and dramatic increases in the number of people with long-term and complex conditions.

It is no longer sustainable for people to work even harder and take on more responsibility. We require

people to work differently. An integrated approach, in which different NHS organisations and their partners work together, is essential. This allows us to create new care pathways and more efficient and effective services with patients at their centre.

In November 2016, the BCT partnership published draft proposals for the development of local health and care services. In it we described how we will work together on the "triple aims" of the NHS Five Year Forward View. These include improving the health outcomes of people, providing better quality care and ensuring financial sustainability.

This document describes the progress we have made. It sets out how we will develop an effective integrated health system in LLR along with our next steps for improving health and care for the local population, while meeting the challenges we face now and in the future.

We are confident it is the right approach because, as a healthcare system, we have been working closer together through the BCT partnership since 2014.

We are now seeing real progress as a result of this approach.

Clinicians, staff, patients and partners in LLR have identified new ways of working that not only deliver benefits for patients, but also better value for money for the NHS.

The improvements we have made to urgent care in LLR are a good example.

For many years the number of patients seeking and needing urgent care in LLR, and across the country, has been rising. This has created huge pressure on our acute hospitals and at the emergency department of Leicester Royal Infirmary, in particular.

This winter brought the highest demand for services we have ever experienced in LLR.

It was a struggle to deliver a high-quality service every day and we often fell short of the standards we want to achieve around waiting times. But, the changes we have made were crucial in enabling us to maintain the service even in the face of unprecedented demand.

Thousands of patients are now seen safely away from the emergency department through the introduction of new services including effective clinical navigation via NHS 111 so more people are directed to the right place for care. And working together NHS organisations in LLR have developed alternative treatment options. For example, patients have access to GP services in the evenings and at weekends through primary care hubs. Meanwhile, an Integrated Crisis Response Service in Leicester is providing integrated health and care support.

As part of this integrated approach one of our partners, University Hospitals of Leicester NHS Trust, secured £48 million to upgrade the emergency department at the LRI which is now open.

BCT partners have also worked closely with our local authority colleagues in social care to improve the flow of patients out of hospital and back home to their usual place of residence or into intermediate care.

This integrated approach will improve the care and experience of patients by reducing the number of times that their discharge is delayed. It will also reduce the demand on the acute hospitals.

While we have made some great strides there are things that we don't feel that we do well enough. We are tackling these areas through our priorities.

We are strengthening primary care and developing a proactive and effective approach to planning and delivering care for the most frail and vulnerable people in our community, including those who have long-term and complex conditions. We are also improving access to General Practice for the population as a whole and providing better support for people with mental ill health and more accessible specialist treatment, as well as urgent care when they experience a crisis. We also want to prevent and detect cancers early and support patients through treatment and into survivorship, as well as reduce waiting times for cancer treatment.

We are developing a health and care system that keeps people well and out of hospital, moves care closer to home, provides timely care in a crisis and delivers the best specialist care possible.

To achieve this we need to create a healthcare system that is fit for purpose.

We will be making greater use of Information Technology to provide electronic patient records that can be shared by clinicians across the system, access to healthcare for patients via smartphones and increased use of telemedicine, among other developments.

And we need to develop our estate, subject to significant public investment, so we have appropriate facilities in which to deliver 21st century healthcare as efficiently as possible.

Foreword

We continue to develop our proposals for the reconfiguration of our acute hospitals and improvements to maternity services. We are redesigning a range of services we will need in the community as more care moves out of those acute hospitals closer to people's homes.

While our focus is fixed on patient services, routes through the care system, care and outcomes, we do recognise the scale of the challenge now faced by the NHS. Our staff respond to it every day and night.

Demand is at an all-time high, but over recent years the growth in NHS funding has slowed to an historically low level.

However, the Prime Minister announced in June that the NHS nationally will receive increased funding of £20.5 billion per year over five years (an annual increase of 3.4%). This will have an impact on what we are able to achieve through the plans and priorities of the BCT partnership, which we will assess as the details of this additional spending become clear.

Regardless of further national details on funding we remain ambitious in our plans and feel that we have a great opportunity to continue the ongoing work whilst also maximising the opportunities to secure more resources for the NHS, social care and public health in our area.

> *We need a health and care system that keeps people well and out of hospital, moves care closer to home, provides timely care in a crisis and delivers the best specialist care possible.*

It is set against this context that local NHS partners decided that our BCT partnership needs to continue its ongoing work to improve care for patients. But we also decided that now is not the time to produce a detailed long-term 'blueprint' for all NHS services by creating a 'final' version of our original STP plan. This is because the publication of the national NHS plan is likely to have a direct and significant impact on what it is possible to afford – and therefore some of the choices that we may need to make.

In the meantime we felt it was important to update local people and stakeholders on the work that is being done by the BCT partners. This is why we have published this Next Steps document.

As a health and care system we have matured and evolved and organisations are working beyond their own boundaries to improve services for local communities. To put us alongside other areas in the country we will continue to evolve, joining up health commissioners and providers with social care, the voluntary and community sector, Healthwatch and other organisations and communities to integrate services.

We know the NHS is an institution that people are very proud of and making changes to it causes concern as patients and their families are rightly anxious about the impact they will have. We are committed to listening to and understanding people who use and provide health and social care. We have already co-designed improvements to implement better, more person-centred services by engaging with staff, carers and patients and will continue to ensure their voices are heard.

We are in no doubt about the work involved in delivering this strategy, but believe it is the right one for the people of LLR and the staff who work in our services.

East Leicestershire and Rutland CCG
Leicester City CCG
West Leicestershire CCG
University Hospitals of Leicester NHS Trust
Leicestershire Partnership NHS Trust
East Midlands Ambulance Service

SECTION 01

Introduction – Improving health and care in LLR

The aim of the BCT partnership, set up in 2014, is to improve the provision of health care in Leicester, Leicestershire and Rutland (LLR) by bringing NHS organisations and other partners, including local authorities and the voluntary and community sector closer together to deliver a better service and to do so more efficiently. We serve a diverse range of communities and recognise that they have different needs which have to be considered as we develop our solutions.

The BCT partners include: East Leicestershire and Rutland CCG; Leicester City CCG; West Leicestershire CCG; University Hospitals of Leicester NHS Trust; Leicestershire Partnership NHS Trust and East Midlands Ambulance Service.

They work alongside Leicester City Council; Leicestershire County Council; Rutland County Council; Health and Wellbeing Boards (Leicester City, Leicestershire and Rutland); NHS England and Voluntary and Community Services.

The following diagrams explain our vision, principles and goals for a sustainable, affordable system that is fit for purpose.

Our vision

Our principles: How we are working

Work as One Team

Across boundaries, united in overcoming challenges and sharing responsibility to provide the best service and outcomes to patients. We want people to move through the system seamlessly, unaware that different organisations are working together to care for them.

High Quality, Person-Centred Care

For local people across that patch from home to hospital and back again. We want to maintain the health and wellbeing of local people, ensure the best possible outcomes for them when they need treatment or care, wherever they live throughout Leicester, Leicestershire and Rutland.

Efficiency and Best Value

To make the most of every pound we have to spend in Leicester, Leicestershire and Rutland by sharing resources, cutting duplication, waste and delay and innovating to overcome the challenges we face. This includes setting up new systems to care for people at home and in their local community, as well as using IT to share patients' records and offer new services.

Support and nurture a committed health and social care workforce

By helping staff to develop new skills and understanding, encouraging them to be the best, promoting high morale and managing talent and resources. We will be asking staff to work in different ways, in different places and with different people and organisations. We want to give them the skills and set up the system in a way that allows them to do a great job for local people.

What you have told us

The thinking and new ways of working developed by the partnership contributed to our draft STP, which was published in November 2016, followed by a period of engagement from January to March 2017. Feedback from the public and NHS England identified a number of areas where more work was required, which has influenced this document which sets out Next Steps for BCT. In particular you asked us to consider:

- The design of **community services,** including the type and number of community beds, to support the provision of integrated care, independence and a reduction in hospital admissions and readmissions
- The need to maintain **acute bed capacity** and **access to maternity services** within plans to reorganise the acute hospitals in LLR and create a new maternity hospital
- Improved access to **GP services**, including 'out of hours' and home visits
- A greater emphasis on mental healthcare, in order to achieve 'parity of esteem' with physical healthcare
- Better use of **technology** and in particular the creation of a single patient record
- Recognition that local areas are different and many LLR residents access care from other counties.

Professor Mayur Lakhani, Leicestershire GP, Chair of West Leicestershire Clinical Commissioning Group and Chair of Better Care Together Clinical Leadership Group

"I am proud of the progress we have made to date through Better Care Together, for example the use of blood thinning drugs which have reduced the number of strokes. But we need to go much further as we are determined to provide the best possible quality of health and social care.

The next phase of Better Care Together is therefore a focus on implementation and making things happen. There will be a massive focus on 'home first' – joined up primary and community services. As a working doctor, I know that doing nothing is not an option, I want to do even more for my patients.

I strongly support our plans as a way forward to make LLR one of the best health and care systems in the country by all the institutions working together with the people they serve and using resources effectively."

SECTION 02

Progress we have made

The BCT partnership first brought together the six NHS organisations working alongside the three principal local authorities in LLR in 2014. The partnership has enabled clinicians, NHS and local authority staff, as well as patient representatives, to develop new ways of caring for local people.

This approach has improved services and demonstrated that they can be delivered more efficiently, and at the same time reduce pressure on parts of the health service that feel particular strain.

Some specific achievements include:

We have secured £48 million for the new emergency department at Leicester Royal Infirmary as well as a commitment to fund around £2 million of improvements at general practice premises. Last year, we also secured £8 million for a purpose-built mental health ward for children and young people with a focus on eating disorders and £30 million for new intensive care units and a new ward at Glenfield Hospital.

A new Treatment Centre at St. Luke's in Market Harborough, opened in March 2017. It comprises of a minor injuries unit, GP surgery, X-ray, mental health and outpatient clinics, a specially-equipped physiotherapy suite and podiatry rooms. In the first year of opening 47,000 patient visits have taken place, including 7,400 who have benefitted from the state-of-the-art X-ray suite. That has saved many of these patients a journey into Leicester City.

Planned care ranging from diagnostic tests to minor surgery is already moving from acute hospitals into the community. In urology, for example, 500 procedures to examine the bladder and 120 surgeries have been completed.

12 Integrated Locality Teams, in which specialists from different organisations work together to care for patients with long term and complex conditions, have been established. In 2018/19 these teams will improve the care of these vulnerable patients and reduce emergency admissions.

Over 6,800 patients have been seen within two hours of referral by the City's Integrated Crisis Response Service (ICRS). More than 1,800 responses were to patients who had fallen, with an average response time of less than 28 minutes. This helped to avoid emergency attendances for the vast majority of these patients.

The NHS 111 service, which includes a clinical triage system that provides telephone advice and where necessary, directs patients to the best place for treatment. More than 5,500 people, who would have ended up in the emergency department, have been treated more appropriately elsewhere.

A remote cancer monitoring service for prostate cancer has been introduced which reduces the need for patients to travel to outpatient appointments. In the first three months of this service being set up, 210 patients were followed up in this way.

A female Psychiatric Intensive Care Unit has opened at Glenfield Hospital, which means that female patients can now be treated locally rather than in a unit outside of LLR.

Around 2,000 extra appointments are being made available each week with GPs and nurses at Leicester's healthcare hubs – helping to reduce demand on urgent and emergency services.

We have introduced a new test for patients who have a change in bowel habits. This has resulted in 70% of patients not going on to need a referral for bowel cancer, reducing worry for patients and the cost to the NHS.

Support from the local authorities' adult social care Hospital Transfers Teams has meant that the number of delays in transfers of care has again fallen, which compares well against many other parts of the country. Reducing transfer delays is helping us to make better use of our hospital beds.

We engaged with patients, public and our staff on our draft plans and feedback has been used to further refine and develop our work. And we are committed to continuous patient and service user engagement as we progress our plans.

An advice and guidance service has been launched for 27 specialities. GPs are able to have a conversation with a hospital consultant prior to referring a patient to hospital, meaning that 80% have not needed an outpatient appointment at all.

SECTION 03

The challenges facing the NHS in LLR

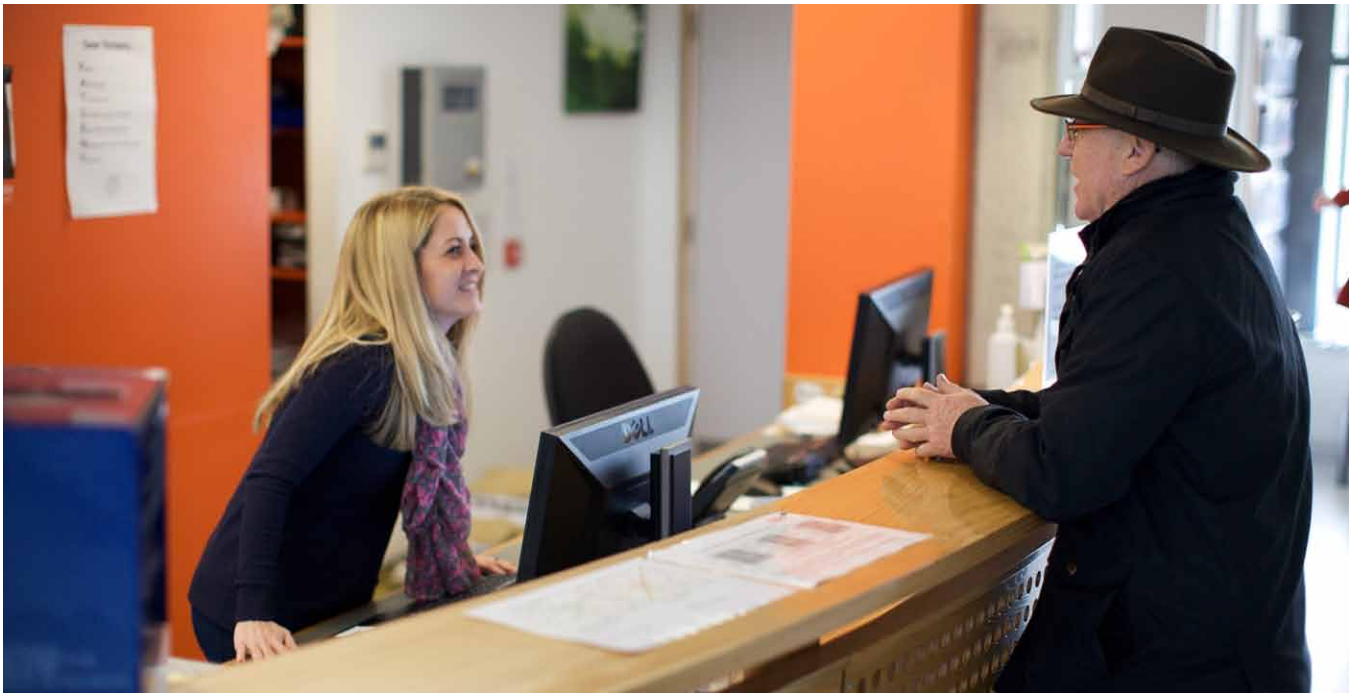
NHS staff in LLR work extremely hard to meet the needs of patients and do an excellent job providing high quality, safe care for the local population.

Whilst BCT partners can demonstrate many achievements, which are benefiting patients, we are struggling to meet continued increases in demand and we anticipate that if we do not take further action now then the services patients receive will decline.

Some of the key challenges faced by the partners in LLR are described on the following pages.

Niki Evans-Ward, patient representative, maternity services

"These are challenging times for the NHS, but the team developing the plans for maternity services in LLR have the best interests of mums and babies at heart. The team are very passionate about what they do and will not compromise on patient safety."



Clinicians, patient representatives, NHS and local authority staff have been working together to find solutions to the challenges faced in LLR. Patients have played a key role in identifying challenges and reshaping services including through the Better Care Together Patient and Public Involvement.

We have talked about some of the things we have already done to meet these challenges in Section 2. And there is more about our future plans in section 5.

> *NHS staff in LLR work extremely hard to meet the needs of patients and do an excellent job providing high quality, safe care for the local population.*

Triple Aim Gaps: Our Challenge

Health & wellbeing 1

Variation across CCGs in factors **affecting health**

7.1% to **11.1%** range in **Maternal smoking rates**

36% to 29.2% range in children 10-11 **classified as overweight or obese**

1.8% to 43.9% People living in 20% of the **most deprived areas of England**

Inequalities in **male and female life expectancy**

77.2 to 80.7 years range

81.7 to 84 years range

Leicester
11.6 stillbirths per 1,000 total births

Nationally
7.1 stillbirths per 1,000 total births

Premature mortality rate

CVD	Respiratory disease
52.2 to 90 deaths per 100,000 population	21.9 to 45.4 deaths per 100,000 population
Cancer	**Liver Disease**
110 to 115 deaths per 100,000 population	11.1 to 18.4 deaths per 100,000 population

Variation across CCGs in **health outcomes for the BCT area**

% diabetes patients who have **all three of the NICE recommended treatments:**

43% in Leicester

41.5% in West Leicestershire

One year survival rates from cancer

67.3% Leicester

73.3% in East Leicestershire and Rutland

This information was collated in June 2018

The challenges facing the NHS in LLR

Care & Quality 2

Delivering NHS constitutional targets:

A&E	**88.2%** against a target of 95% (UHL)
Cancer	**62 day wait – 78%** against a target of 85% (UHL)
Referral to Treatment	**85.8%** against a target of 92% (UHL)
Category 1 Ambulance average wait	**7.49 mins** against a target of 7mins (LLR)
Improving Access to Psychological Therapies	**10 -11%** against a target of 15%

N.B. the percentage = percentage of patient waiting in comparison to the NHS target

Provider Quality:

Acute and community providers both rated requires improvement by CQC

10% of GP practices inspected rated as requires improvement and 3% rated as inadequate

Unwarranted variation:

Need to reduce treatment variation in referral, prescribing, treatment outcomes across primary, community and acute sectors

Infrastructure and workforce improvements

- **Need to improve the LLR health estate** to ensure the delivery of modern healthcare
- **Need to recruit more clinicians into LLR** and retain them

Improving independence:

- Our rate of **Personal Health Budgets** is low at 14.6 per 100,000 population in Leicester City
- **People with long term conditions** supported to manage their conditions ranges across CCGs from 65% to 68%
- There are **patients in acute hospitals that do not need to be there** and should be cared for in a more appropriate setting

Sustainable services:

- Current configuration of acute hospital sites makes it difficult to maintain sustainable and safe services
- Some community hospitals are unsustainable due to their size and condition

Funding & Finances 3

System efficiency and finance challenges 2018/19

£120m
saving required across NHS organisations

Saving are needed because of:

- Aging population
- Increase in long term conditions
- Rising cost of delivering services

If we do NOTHING this represents:

8.43%
of the total NHS allocation

This information was collated in June 2018

SECTION 04

The NHS cannot stay the same

In Leicester, Leicestershire and Rutland, and throughout England, the NHS faces unprecedented demands for health and care services. This is making it harder to deliver high quality services and control costs. The BCT plan for LLR has been developed by clinicians to meet this rising demand and provide safe, high quality care in a sustainable way.

- There is a need to redesign care in the era of empowered patients – able to take care of their own health, chronic health conditions and new technologies.
- With a growing and ageing population there are more people needing urgent and emergency services
- There is waste and inefficiency that can be tackled within the health and care system and we are determined to do this.
- Hospital staffing has risen, but the number of patients being looked after has increased faster. GP numbers over the last seven years have actually fallen.

The Pressure

Increased demand – A growing and ageing population means the NHS must treat more patients and a greater number with complex conditions.

By 2023 the population of LLR is estimated to increase by 5.2% to 1,124,300 people. The number of people aged 75 and older is set to increase by increase by 25.7% to 104,100 people.

Information based on the 2016 based population projections published by the Office for National Statistics.Data source:

How we provide care – The NHS was developed when medical interventions were less effective. People tended to die younger. Now people generally live longer but more patients have long-term illnesses. Care is not a one-off event, but an ongoing process

Inefficient buildings – Some NHS facilities are old and have high running costs, while some services are split across multiple sites, undermining care quality, leading to duplication and increased cost.

Staff recruitment and retention – Shortages of doctors, nurses and midwives undermines the quality of care and increases the cost of services as NHS organisations pay for expensive agency staff.

Advances in medical treatment – The availability of more sophisticated treatment allows us to do more than ever before for patient, but this often comes at a higher cost.

Increasing financial pressure – whilst we are awaiting further information on NHS long term funding, demand is increasing at a faster rate than available resources. As a result our local health and social care services are under increasing financial pressure.

The NHS cannot stay the same

Without improvements:

Outdated ways of providing care in the face of escalating demand, increasing emergency hospitalisations and long stays, maintenance backlogs and duplication of services all result in high running costs, inefficiency and overspending.

With improvements:

Shift care into the community relieving pressure on expensive hospitals; undertake major reorganisation of hospitals to remove waste and duplication; improve efficiency through modernising some facilities and closing others.

Without improvements:

Health outcomes decline as GP/community-based care struggles to cope with increasing demand; more patients suffer health crises and require emergency hospitalisation and long stays; planned care cancelled as emergencies rise; duplication of hospital services undermines quality and safety of care.

With improvements:

Health outcomes improve by strengthening primary, integrated and urgent care to support Home First approach for patients with long term conditions; shift services out of hospitals into the community; reorganise hospitals to remove duplication of services.

In practical terms 'Home First' means that we should ask "Why is this patient not at home?" or "How best can we keep them at home?"

The NHS has lasted 70 years by continually evolving and has become more efficient, removing waste and duplication and most importantly it has improved the health and wellbeing of local people. To remain sustainable ongoing development is essential.

The national landscape is also evolving and more announcements will be made later this year. As plans develop for the NHS in England, the BCT partnership will need to take account of them in our local plans and priorities.

National picture in brief

A funding growth for the NHS of 3.4 per cent a year over the next five years, amounting to an extra £20.5 billion by 2023/24 was announced earlier in the year.

The NHS has identified five major priorities for the NHS long-term plan due to be published later this year.

This includes:

- mental health, especially services for children and young people, and potentially 'core crisis care.
- Cancer including improving cancer screening services.
- a new focus around cardiovascular disease – stroke and heart attacks.
- renewed focus on children's services, and prevention and inequality as they affect children.
- new objectives for reducing health inequalities including the life expectancy of people with learning disabilities and for rough sleepers and homeless people.

The Government has promised to consult in 2018 on a long-term solution to social care funding for older people in England in a Green Paper (a consultation paper produced by the Government). There will also been a separate process to find out how the social care system can work for working age people.

A new national workforce strategy designed to help secure the long-term supply of nurses and doctors for the NHS will be published this year.

SECTION 05

Our next steps to better health and care for everyone

Our next steps to improving the health and wellbeing of our diverse population is centred around our model of care that has been evolving over recent years. It has the following four key components:

Keep more people well and out of hospital through better public health and prevention of illness, early detection and management of disease, support for patients at home and in their community.

We will strengthen primary care to help people make the right lifestyle choices and improve access to GPs and practice teams.

Integrated teams have been created at a local level, across different NHS organisations, to meet the needs of an ageing population and patients with complex conditions in order to better care for people and reduce reliance on acute hospital care.

More care closer to home from the management of long term conditions to planned procedures and follow-ups.

We will introduce a "Home First" approach to care for people at home or in community facilities, avoiding unnecessary hospitalisation or rehabilitating them after a stay in hospital as they regain their independence.

Some planned care will be moved from acute hospitals to the community and unnecessary follow up and outpatient appointments will be avoided.

Care in a crisis from 111 to 999, urgent care to the emergency Department, including an urgent and emergency response for people experiencing mental health episodes.

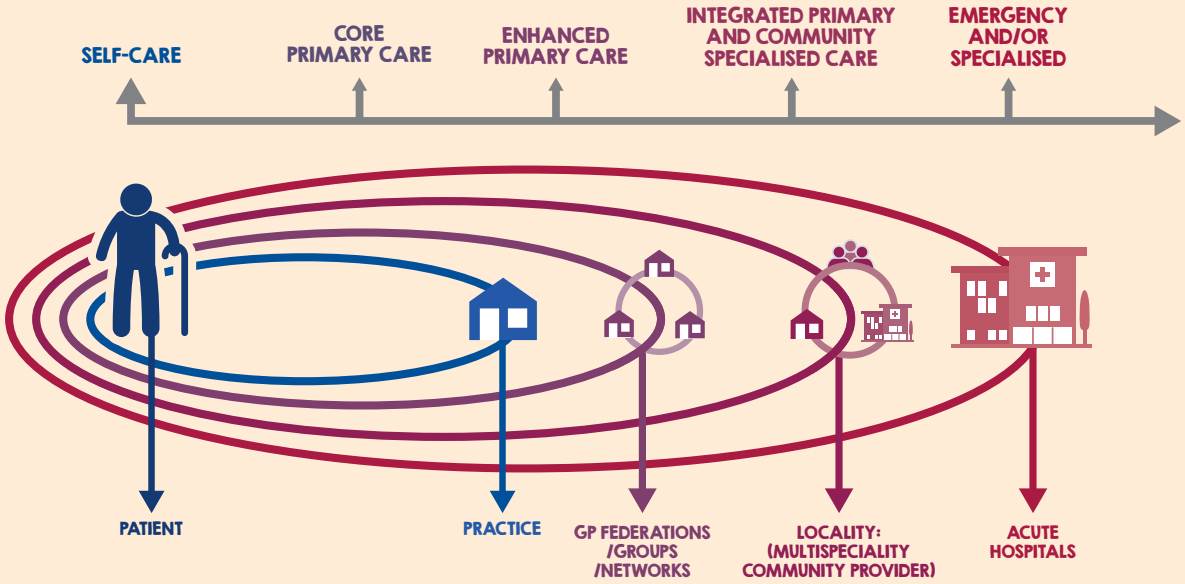
We will improve urgent and emergency care by extending access to general practice in the evenings and at weekends and developing urgent treatment centres in the community.

Pressure on emergency care will be eased through the NHS 111 service, offering GP support at A&E and improving the flow of patients through the hospital.

High quality specialist care to support patients in their homes, community facilities and hospitals to get the best possible outcomes.

We will create specialist pathways, the route that people take through the care system, that include staff from different NHS and local authority organisations to provide joined up, high quality care for children, pregnant mothers, those with mental health needs, learning disabilities, dementia, cancer, long term or multiple conditions.

Our Model of care



The evolving model of care will create a far more clinically effective and cost-efficient system. It will be built around individuals, supporting them to be as active and as independent as they can be. Wherever it is clinically appropriate we will aim to treat people at or close to home. We will always ask 'how best can we keep this person at home?' or 'why is this patient not at home?'

The model will strengthen primary care and the provision of GP services. The GP surgery with its list of registered patients will remain the central pillar of local care. Recruitment to new roles within the primary health care team, supported by integration of care for people with long-term and complex conditions through multidisciplinary teams and practices working more closely together in federations or localities, will increase the capacity available.

We anticipate that multidisciplinary teams including staff from social care, working on a placed-based model of care, will reduce the number of emergency admissions. However, a patient will always receive specialist hospital care when it is required.

The model will strengthen primary care and the provision of GP services. The GP surgery with its list of registered patients will remain the central pillar of local care.

What is integrated care?
It is about operating at three different levels of 'place'

Level	Population Size	Purpose
Neighbourhood (Health Needs Neighbourhood and Localities)	30,000 to 50,000	• Deliver high quality primary care • Proactive care via integrated locality teams for defined populations and cohorts • Asset based community development to support health, wellbeing and prevention
Place (Leicester City, Leicestershire County and Rutland)	37,000 to 610,000	• Based on upper tier authority boundaries • Delivery of specialised based integrated community services, including social care • Delivery of reablement, rehabilitation and recovery services • Prevention services at scale
System (Leicester, Leicestershire and Rutland)	1,000,000+	• System strategy, planning and implementation • Work across the system on specialist areas such as cancer, mental health and urgent care • Make best use of all our combined assets including staff and buildings • Manage performance and system finances • Establish a system framework for prevention

Our goals for each model of care component

Each BCT work stream has goals, which we now describe, that are being progressed during 2018/19:

Keep people well and out of hospital

Demand for health services in LLR is rising. A major factor is that our population is ageing and there is an increasing level of need from people with long-term illness and multiple conditions. At the same time, we have a shortage of doctors and nurses in primary care.

We see the effects of this rising demand and lack of capacity in high levels of admissions to hospital, over-reliance on emergency and urgent care, long waits at some practices to see GPs and inconsistent delivery of care in some areas.

LLR is ranked in the bottom 25% of NHS regions when patients with a long-term condition are asked if they feel supported to manage their conditions.

Our goal is to coordinate the care of people with long-term and complex conditions to avoid deterioration and crises in their health, and to strengthen primary care so it can provide seven-day-a-week access to services and address common causes of ill health.

Integrated Teams

We are creating twelve integrated teams of existing health and social care staff in each part (locality) of LLR to provide more coordinated and comprehensive support in the community.

These teams are comprised of community nurses, GPs, and social care staff, who work hand in hand to support people with long-term conditions, the frail and those with other complex/high-cost health and care needs.

The teams are setting up improved methods of multidisciplinary working in each local area, so that care is planned, coordinated and delivered more effectively for patients, families, carers and the professionals supporting them. In some areas of LLR this work is well underway and teams are receiving and analysing data about those most in need of support, holding case conferences to determine the actions required and coordinating care locally. This means that patients can remain at home for as long as possible. The new approach to joint working means care will be less fragmented and more is done proactively to support people, rather than waiting for a crisis to occur.

The teams will be delivering a range of interventions to improve care and support. These will include, reviewing care plans, undertaking medication reviews, ensuring patients are accessing flu vaccinations, agreeing who to contact and what to do in the event of a deterioration in the patient's condition and liaising with social services.

For patients who have been assessed as frail, additional interventions will be put in place based on national best practice, and in line with a new approach to frailty across the health and care system, which is being rolled out in 2018.

If an admission to hospital is needed, the locality team will liaise with those involved in hospital discharge arrangements to ensure patients are supported on their return home. This will be done in conjunction with other services, such as rehabilitation services, or those supplying equipment or housing adaptations.

In each part (locality) of LLR there are a range of existing community-based services, which are provided by agencies and voluntary sector groups and focus on prevention and wellbeing. Each locality team will advise patients about what is available in their area.

This might include:

- support for self-care when managing a long-term condition such as diabetes or Chronic Obstructive Pulmonary Disease
- advice and support about lifestyle factors such as weight management
- advice on welfare, housing and benefits
- improved home safety, equipment or falls prevention
- activities for people who experience anxiety or loneliness and options for accessing help with shopping or transport

In addition to integrated locality teams, specialist teams will focus on care pathways for those with cardio-respiratory conditions, diabetes, neurology and stroke rehabilitation, improvements to end of life services and the implementation of the new LLR falls prevention and treatment service.

Primary Care

The GP surgery and the patient list will remain the central pillar of local care. However, we are strengthening the system and increasing the capacity available by establishing new roles within our primary healthcare teams. We are also creating integrated teams to care for people with long-term and complex conditions and supporting practices to work more closely together in networks or federations.

A comprehensive baseline of current workforce numbers has been established in general practice and programmes of training, education and development are being identified to help fill gaps.

This will benefit patients. Access to GP services will improve for those seeking same-day and non-urgent appointments by using a broader range of health and social care professionals. This means that GPs can

manage those most complex patients and co-ordinate the care for the rest of their patient population which would be delivered by multi-disciplinary teams including nurse practitioners, health care assistants and pharmacists.

Access for patients will be provided in the evenings and at weekends through hubs established across LLR. There are already four in Leicester City, four in East Leicestershire and Rutland and three in West Leicestershire.

A key challenge facing primary care is managing demand as a result of an increase in patients with long-term conditions and complex illnesses, and rising patient expectations. Practice have identified vulnerable patients. GPs will lead integrated teams of health and social care professionals and be the care-coordinators for these people. The focus on complex patients will enable care to be provided closer to home and interventions can occur early, before a crisis develops.

Preventing ill health

Prevention of illness and disease has the potential to lead to longer, healthier lives for local people and have a substantial impact on the future need and demand for health and social care services.

We have looked at national evidence about what is effective in preventing illness to establish what approaches are most likely to demonstrate the quickest returns on investment (within three to five years).

These include:

- Comprehensive management of people with long-term and complex conditions to prevent crises and deterioration in their health (as described above)
- Creating a more coordinated approach to the treatment and management of cardiovascular disease (the most common cause of death in men) and its risk factors
- Strengthening referral pathways to alcohol treatment services for people in hospital as a result of alcohol or substance misuse
- Making Every Contact Count by ensuring NHS and social care staff are trained and supported to provide advice to patients about healthy lifestyles
- Ensuring patients who need extra support are referred to local services to make lifestyle changes such as stopping smoking, getting active or managing weight
- Developing new approaches to supporting self-care including, a Healthy Living Pharmacy scheme across LLR, which prompts health, wellbeing and self-care
- Combating diabetes, working with Leicester Diabetes Centre and the global Cities Changing Diabetes programme.

The focus on complex patients will enable care to be provided closer to home and interventions can occur early, before a crisis develops.

Care closer to home

Our goal is to provide safe care at home or in the community and to reduce dependency on acute hospitals. To achieve this, we will deliver more short-term health and social care support to help people at a time of illness or crisis and during the recovery and rehabilitation phase at home, at their usual place of residence (e.g. a care home) or within their local community.

In addition, we will improve the provision of planned care, such as tests for certain medical procedures, by streamlining the referral process and making more care available outside hospital and within community settings.

Home First

A key aspect of our model of care in LLR is "home first". We want NHS and our partners in local authorities to ask, "how best can we keep this person at home?" Home First services support people, who may have a chronic condition or multiple illnesses, to remain in their homes when they are having a health or social care crisis, rather than needing to go into hospital or a care home. Home First services also help people return home from hospital quickly and provide them with rehabilitation and reablement to help restore their health, wellbeing and independence. Transitional care will be available in a timely manner through:

Step Up Care

Transitional care services will deliver intensive support when a person's health deteriorates, for example, this may be a period of illness on top of a chronic condition. Specifically, services include crisis support in the person's own home, reablement, short term therapy, community health and carer support. It may also include short-term care in a bed-based service in the community, such as a reablement bed or interim care bed. There are clear procedures to escalate care when necessary, including transfer to an acute hospital.

Step Down Care

These services are aimed at facilitating safe, speedy discharges from an acute hospital when a person no longer requires specialist treatment, but they do need support to regain their strength and independence. Follow-up assessments and support may be arranged in the person's own home or in a care home, which delivers a rehabilitation/ reablement service following a hospital admission. Patients who are well enough to leave the acute hospital, but still require general medical care can stay in a community hospital.

Support for Carers

Carers play a critical role in supporting patients, which provides invaluable support to individuals and families, and also reduces the need for NHS and social care services. It is important to support local carers so they can continue to deliver this vital role. We have identified priority actions, which include: Improving the identification of carers and increasing the number highlighted on GP registers; providing information and guidance to help carers navigate services; promoting health checks for carers and including their input in the care plans of patients to secure the best possible outcomes.

Support people living in a care home

Care homes play an important role in the health and care system. Across LLR there are 300 care homes looking after people in more than 8,000 beds. We recognise we need to work with care home providers to provide more preventative care and support to people living in care homes who are at risk of losing their independence and having an unplanned admission to hospital. Therefore, we have established a care home specific work stream within the Home First programme. The three aims are to ensure that:

- we provide high quality care within care homes
- people have access to the right services to allow a person to live as independently as possible
- we make the best use of resources by reducing unnecessary visits to hospitals and hospital admissions while providing the best care for residents

Planned Care

Planned care is routine services with a planned appointment or intervention which could be in a hospital or a community setting including your GP practice or at your dentist.

In LLR, a high proportion of planned care relies on patients travelling to one of the three city-based hospitals or to the hospitals on the borders of the counties, or beyond and is often hampered by the pressure of emergency demand, which can lead to cancelled operations and appointments.

Demand is increasing and improving the efficiency of planned care is a key component of the BCT partners' financial planning. Planned care pathways will be redesigned so that some outpatient appointments, diagnostic tests and day-case procedures can be carried out in community hospitals and other facilities in primary care. This will reduce unnecessary stays, outpatient appointments and follow-ups in acute hospitals.

We will tackle the duplication of services, improving the flow of work through operating theatres and generating savings by better management of outpatient appointments, including reducing unnecessary face-to-face appointments and conducting some in the community and making best use of medicines.

Planned care will be supported by standardised referral processes and pre-referral specialist advice and guidance to ensure patients are referred appropriately and only when needed.

Continuing Healthcare

New pathways for the determination of eligibility for Continuing Healthcare have been developed in LLR to speed up the assessment process. The new pathway will also provide more consistent decision making in terms of eligibility, improved discharge processes so that assessments are completed out of hospital and review high-cost placements. These pathways are underpinned by a series of standard operating procedures that have been approved by all partner organisations. We aim to make Personal Health Budgets the default offer for all Continuing Healthcare-eligible individuals from April 2019.

Integrated Personal Budgets

We are working to extend the personal health budget offer to other service users who are not eligible for Continuing Healthcare. This will include people with learning disabilities, mental health difficulties and long-term conditions. This work will link to the nationally-led and locally-driven Integrated Personal Commissioning programme that is supporting healthcare empowerment and the better integration of services across health, social care and the voluntary and community sector.

Care in a crisis

Our goal is to predict and manage the demand for urgent care and to deliver it promptly and in the most appropriate way and place; whether that is online, over the telephone, in the community or in the emergency department at an acute hospital.

Managing demand

Our model for urgent and emergency care incorporates strengthening primary care, improving support for self-care and the provision of care closer to home so that fewer patients with long term and complex conditions experience a health crisis, which necessitates an emergency visit to hospital.

Significant local progress has been made over the last year providing a clinical advice and triage service through NHS111, including enabling navigation of services and directing patients to the best place for treatment. The development of NHS111, including raising further awareness of the service, is central to managing demand for urgent and emergency health services.

We will increase the volume of patients contacting NHS111, either by phone or online, and expand the range of conditions passed for clinical assessment. Building on the success of direct transfer of patients to child and adolescent mental health services (CAMHS) and referral to specialist mental health advice for adults, we will introduce direct transfer to adult mental health crisis services.

To support clinical assessment and treatment of urgent care presentations we will ensure clinical information is used to identify and 'flag' patients, who would benefit from speaking to a clinician early on, for example people who have been assessed as frail. This will be supported by proactive care planning by GPs. We will increase the number of appointments directly booked from clinical navigation, including in-hours appointments with GP practices across LLR.

We will work with our provider of NHS111, partners and stakeholders to implement NHS111 Online to improve access for patients to assessment and advice. We will implement telemedicine within clinical navigation to provide remote support to residents of care homes and their carers through a video link.

We will also ensure that healthcare professionals, including GPs, care home staff and EMAS crews, have direct access to urgent care support and guidance. In 2018 through the engagement of our primary and secondary care clinicians we will redesign telephone advice for healthcare professionals, focusing on providing dedicated support to reduce emergency admissions and emergency attendances, and ensure patients are treated in the most appropriate place.

Discharge

Delays in discharging patients result in extended hospital stays and a shortage of hospital beds, which slows the admission of new, emergency cases. Significant progress has been made to improve the discharge process and reduce delayed transfers of care in LLR. To further improve discharge, we are developing a real-time demand and activity model to enable longer-term, responsive planning; we will establish a discharge operations hub bringing together members of the integrated discharge team in one location and we are expanding the trusted assessor role to work with care homes.

Urgent care in the community

We are ensuring that alternatives to hospital emergency Departments are available. Services are organised in a 'tiers of care' model, integrating extended primary care and out of hours care. This will include a consistent offer of extended hours in general practice, out of hours services, urgent treatment centres (UTCs), home-based visiting and crisis response services, which will be implemented during 2018.

Urgent treatment centres will be GP-led and open 12 hours a day. In LLR, our UTCs are at the Loughborough, Oadby and Merlyn Vaz (Leicester) sites. We will increase their diagnostic capability and ensure they meet national standards, including electronic prescribing. We will extend direct booking between urgent care services, with practices accessing services for some patients who need same day appointments.

In addition, a consultation exercise about urgent care access in the community with East Leicestershire and Rutland is underway.

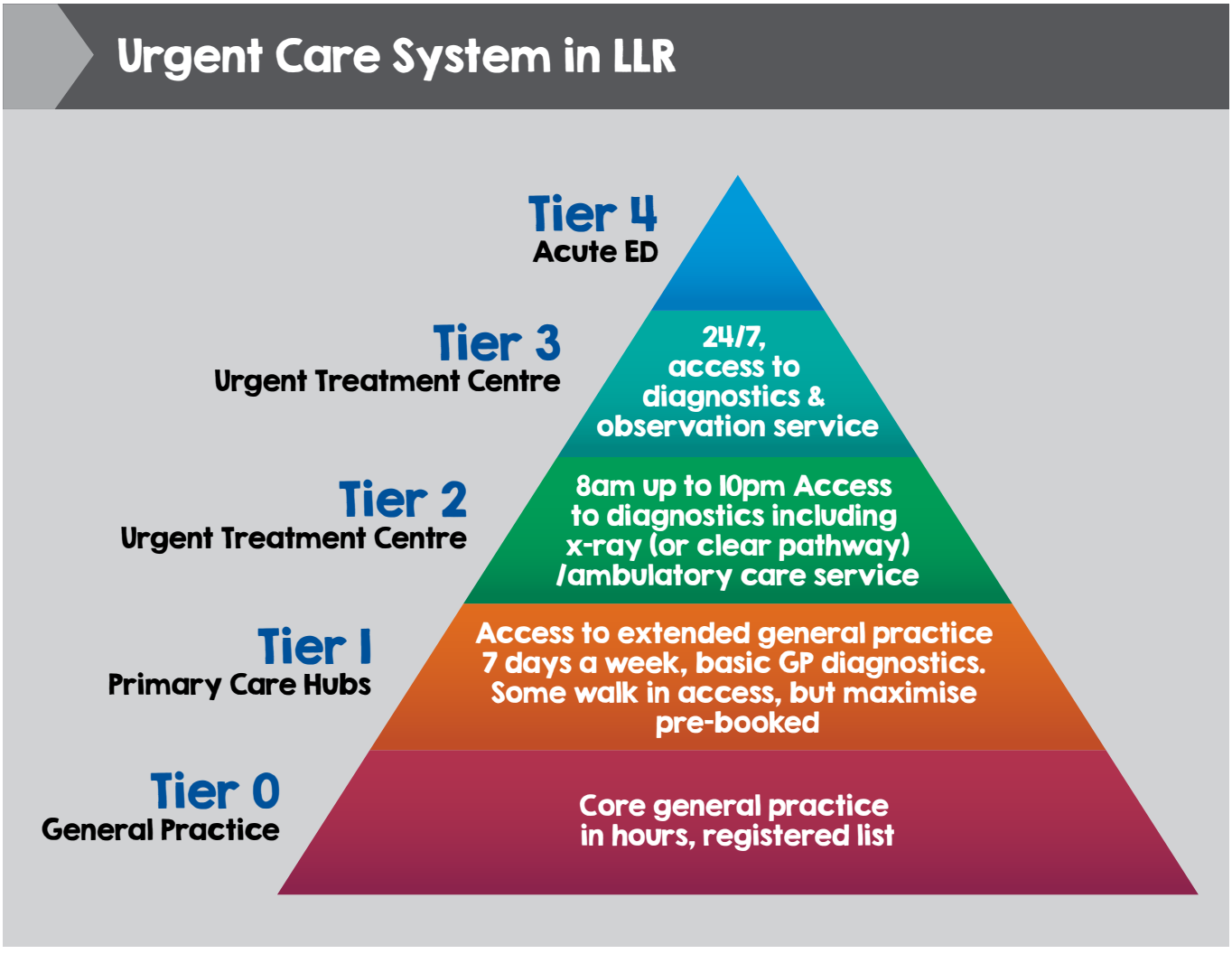
Mental health

People with severe mental ill health are three times more likely to attend the emergency department than the general population and five times more likely to be admitted as an emergency. The right support offered earlier, will increase the number of people who are able to stay in their home environment and recover more quickly.

To deliver this, the crisis service will be expanded to provide more home support and alternatives to hospital admissions for some individuals and we will build on partnerships with the police and ambulance service to provide care for people who present to them with a mental health need. The development of the Crisis House, a 24-hour, 7-day-a-week quick-access service for people in Leicester, Leicestershire and Rutland, has already provided additional support to people needing urgent mental health care.

Mental health practitioner assessment already delivers one-hour response 24/7 within the emergency department and this will be expanded to other wards and clinical areas within our hospitals to meet the national 'Core 24' NHS service standard by 2020/21.

For further information on support for people with mental ill health please see page 25.



Specialist Care

Our goal is to create specialist pathways, incorporating staff from the NHS, local authorities and partner organisations, to meet and deliver evidence based clinical best practice.

The BCT partnership includes workstreams that focus on developing high-quality care in the areas of maternity, children, mental health, learning disabilities, dementia and cancer.

Over the next year, the partnership will publish detailed plans for each area, which have been developed by clinicians, NHS and local authority staff, as well as patient representatives.

Mental Health

Our objective is to put mental health on a par with physical health. Our strategy is informed by a large 'Healthier In Mind' engagement programme, which consulted almost 1,000 people on the priorities for mental health care in LLR.

Prevention

We are focused on improving support to people in LLR in those aspects of their lives that influence mental wellbeing, such as housing, benefits advice, personal finance, diet, exercise, smoking cessation, anti-stigma promotion, avoidance of substance misuse and links with criminal justice.

Collective action between the NHS, local authority and other statutory services, employers, education providers, community groups and the voluntary sector will enable us to address these issues and to deliver the aims set out in the Prevention Concordat for Better Mental Health, published by Government in October 2017.

Specialist Services

We will expand and increase direct access to psychological therapies and deliver wholesale improvement of the acute pathway. Twenty-five percent of people with common mental health conditions (such as depression and anxiety) should be supported by psychological therapies by 2020/21. A five-year transformation programme is underway to co-design with service users, carers, staff and other stakeholders a radically different model of specialist services.

> *The right support earlier will increase the number of people who are able to get the support to stay in their home environment and recover quicker.*

Targeted Early Support

Targeted support can prevent long-term harm to people. We will strengthen the support we offer to new mothers, people who show early signs of psychosis and those at risk of suicide.

In addition, over the next five years there will be enhancements to the mental health support in physical health services (known as liaison) and targeted psychological therapies for people with long-term physical conditions and there will be increased support for checking the physical health of people receiving mental health services.

Cancer

We are developing solutions that will not only meet the NHS standards for cancer treatment, but will also prevent disease, detect it earlier and support patients living with and beyond cancer. We are working towards implementing the recommendations from Achieving World Class Cancer Outcomes Strategy 2015/20

Prevention: We will develop and continue to run programmes, such as screening initiatives, to prevent cancers and reduce the risk factors such as smoking and obesity through activities to raise awareness.

Improve the early detection of cancers: We will raise the profile of symptoms, improve diagnostic tests and pathways, (such as the offer of a FIT test as a tool

within the bowel cancer pathway), and work towards the national optimal lung cancer pathway.

Develop a package to support people living with and beyond cancer: Working with Macmillan Cancer Support, Cancer Research UK and the East Midlands Cancer Alliance, the CCGs will work with the acute trust and primary care to provide a local offer for patients accessing a seamless recovery package.

Review and redesign pathways: We will meet the 2020 requirement that all patients should have access to high-quality and timely services working with our local Cancer Alliance.

Remotely monitor patients: We will continue to check patients who have had prostate and thyroid cancer for whom care has been moved into the community with hospital support and look to develop other tumour groups which can be monitored remotely.

Strengthen the process for cancer two-week referrals: Ensure the utilisation of PRISM (the Pathway and Referral Implementation System, which manages referrals from GPs to specialist services) for all urgent, suspected cancer two-week wait referrals and review the design of the 2 week wait forms so that they contain the relevant information required by the acute trust.

Ensure a regional approach to delivering high quality cancer care: Across specialities we will mirror and endorse the work of the East Midlands Cancer Alliance.

Dementia

It is estimated 13,000 people aged over 65 live with dementia in LLR. This figure is expected to reach 23,000 within 20 years. We are taking a number of actions to meet this challenge. This includes training healthcare professionals within primary care to ensure an early diagnosis in order to meet the national diagnosis target of 67% of prevalence; provide better post-diagnostic support to patients and their families/ carers in acute hospitals and in the community; review the memory assessment pathway to deliver treatment within six weeks of referral; and improve care of patients through the establishment of more dementia-friendly GP practices, which will include the dementia health check.

Learning Disability

Across LLR there are almost 16,000 people living with a learning disability which is set to increase over the next 10 years. In line with NHS England's 'Building the Right Support' national plan we will deliver proactive, preventative care through a number of measures, such as, providing multi-disciplinary support in the community, including intensive support when necessary, to avoid admission to inpatient services and strengthening our crisis response offer by commissioning appropriate services more locally.

We will facilitate discharge from hospital to a step-down service that can be tailored to meet the temporary needs of the patient while awaiting appropriate community provision. In addition, we will look to expand the use of personal health budgets; review local short break provision and provide access to a greater choice in housing for people to live well in the community.

We will facilitate discharge from hospital to a step-down service that can be tailored to meet the temporary needs of the patient while awaiting appropriate community provision.

Our next steps to better health and care for everyone

We will create a system that supports the role of Personal Health Budgets and works with cross-boundary providers and commissioners to facilitate choice.

Our maternity and neonatal services will be developed based on best practice and will be easily accessible. We propose to consolidate all women's acute and neonatal services at Leicester Royal Infirmary in a new maternity hospital supported by appropriate infrastructure and a flexible, multi-disciplinary workforce that responds to changes in volume and complexity.

Children and Young People

Our vision is to improve the health and wellbeing of children and young people, reduce inequalities and support them into adulthood with a focus on independence and improve emotional and mental health and wellbeing. This will be achieved through the implementation of a shared model of care that delivers a system-wide emotional health and wellbeing service for children and young people. Integrated pathways will be established across primary and secondary care as well as public health and social care, thereby reducing duplication and maximising productivity. In addition, projects will focus on reducing in-patient activity and hospital-based outpatient contacts and developing networks with regional providers to ensure children and young people have access to appropriate tertiary services.

SECTION 06

Proposals to reconfigure hospital, maternity and community services

To deliver high quality, safe services, which are affordable, we are considering how we best provide hospital and maternity services in LLR in the years ahead. We are currently developing a business case for some significant changes, which will be robustly scrutinised by the Clinical Leadership Group in LLR and the East Midlands Clinical Senate before it is submitted to NHS Improvement, NHS England and the Department of Health and Social Care for consideration. Should our capital bid to access funding be successful, these proposals will be subject to public engagement, and where appropriate, consultation.

Our proposals are to:

- Reconfigure acute hospitals to move acute clinical services onto two sites, Leicester Royal Infirmary and Glenfield Hospital, and retain some non-acute health services on the site of Leicester General Hospital (LGH).
- Remodel maternity services to create a new maternity hospital at the Leicester Royal Infirmary and subject to the outcome of the consultation, a midwife-led unit at the Leicester General Hospital. We will close the birthing unit at St Mary's Hospital, Melton Mowbray.
- Redesign community services to ensure there is sufficient capacity to meet the needs of patients in LLR as we move care closer to home.

What will the plan mean for Leicester's acute hospitals

The current, three acute site configuration reflects the history of how hospitals in Leicester evolved over time and is suboptimal in clinical, performance and financial terms. Medical and nursing resources are spread too thinly making services operationally unstable and the duplication and triplication of clinical and support services is inefficient. Many planned, elective and outpatient services currently run alongside emergency services, and as a result, when emergency pressures increase, it is elective patients who suffer delays and last-minute cancellations. The proposal to reconfigure hospitals so that acute clinical services will be at Leicester Royal Infirmary and Glenfield Hospital, while retaining some health services on the site of Leicester General Hospital, will require major investment of £367million to provide safe, high quality specialist care for years to come.

An analysis of acute hospital bed numbers now suggests they are likely to increase slightly over the coming years, compared to current levels.

Andrew Furlong, Medical Director, UHL

"Many of our hospital services are where they are as a product of history rather than by design. In some cases this has led to duplication and even triplication of services meaning that care is not provided in the most clinically effective way that makes sense for patients."

Our hospitals suffer from a significant backlog of maintenance and these proposals, if supported by national bodies, would allow us to invest in the two acute sites and modernise our facilities. Operating two more efficient hospital sites would save £24.5 million a year in running costs and help make our hospitals financially sustainable.

Proposals to reconfigure hospital, maternity and community services

What will it mean for maternity services?

Our maternity units were designed for	8,500 births per year
They are currently delivering	10,500 births per year

The proposal is to remodel services to create a new maternity hospital at the Leicester Royal Infirmary and subject to the outcome of the consultation, a midwife-led unit at the Leicester General Hospital. At present, maternity services are spread across units at the LRI and LGH and it is challenging to maintain adequate staffing over the two sites. Already, there are times when the quality of care at either the LRI or LGH is compromised by the availability of resources particularly in neonatology and obstetrics. Service reviews do not consider this sustainable for the long-term.

In addition to staffing, the facilities themselves require modernisation to cater for increased demand. Maternity facilities at UHL were designed to cater for approximately 8,500 deliveries per year, but deliveries now total approximately 10,500 per year. Demand through a rise in the number of births and the complexity of deliveries is expected in the years ahead.

Ian Scudamore, Director of Women's and Children's Services, UHL

"The proposals of the BCT partnership have been developed after extensive discussion and input from consultants, midwives and women themselves. The proposals are intended to develop our maternity services so that they are better for the women and their families that use them and will be so for the long term."

Reviews of maternity services in LLR have identified that the standalone birthing centre at St Mary's in Melton Mowbray is not accessible for the majority of women and it is underutilised with just one birth taking place every two days.

> *As a result, these proposals do not reduce choice for the majority of women in LLR, but increase it by offering many more expectant mothers an option.*

However, it is recognised that many women may prefer to choose to have their baby in a community based standalone midwifery birth centre and there will be consultation on offering this as an option on a site which provides the best equity of access for the women of LLR. We will consult with a view to maintaining this for the long-term if there is sufficient utilisation to ensure its sustainability. As a result, these proposals do not reduce choice for the majority of women in LLR, but increase it by offering many more expectant mothers an option.

What will it mean for community services

Effective community services are crucial to the successful implementation of our model of care. In order to deliver integrated care, keep people well and out of hospital and to move care closer to home, we have to ensure appropriate facilities and services are in place within the community. Therefore, we are considering how community services need to change.

We have engaged with the community of Hinckley and Bosworth since 2014 and have developed proposals for improvements to community services for this population which will be consulted on. The proposals aim to expand services available by increasing the number of day case operations and range of outpatient clinics provided from local facilities.

In order to allow for the expansion of services we do need to change the use of some beds at Hinckley and Bosworth Community Hospital from inpatient beds to day beds.

In addition, we will work with patients, clinicians, partner organisations and staff, to strengthen the provision of integrated care in communities in LLR, supporting independence and reducing hospital (re) admissions. Our proposals will consider how:

- Intensive Community Support services can work more closely with social care rapid response teams and reablement services to prevent an admission to hospital or to support recovery after a stay in hospital. We are developing proposals for integrated services that support the principle of 'Home First'
- District nurses and some physiotherapists can work as part of multi-disciplinary, integrated locality teams to coordinate care for patients who are frail, have multiple health conditions or require additional support. (See the section on Integrated Locality Teams on page 18)
- Community and intermediate care beds can complement home-based support. This work will clarify the clinical model, type and number of beds required.

In developing a model for community services our primary focus is on ensuring we have the right, high-quality care to meet our patients' needs now and in the future. However, with the NHS facing significant financial pressures we need to develop services that are affordable and deliver value for money.

Detailed plans are being developed during the course of 2018. There will be opportunities for local people, clinicians, staff and partner organisations to help shape the future model for community services in Leicester, Leicestershire and Rutland.

Funding the reconfiguration

We propose to make these changes to how we use some sites to improve the quality of health services and ensure they run more efficiently.

We have redrafted our Estates Strategy and updated our priorities to reflect our funding requirements, the approval of which will be decided on at a national level. This remain an iterative process, responding to the needs of the BCT programme to support the changes in care delivery.

SECTION 07

The enablers that improve services for our population

Creating the environment and conditions across LLR that will enable clinical and professional teams to successfully deliver the service improvements that we need for local people at the locality and network levels requires a workforce with the rights skills and behaviours, in the right place. It also requires us to capitalise on advances in technology, attract money and maximise the value of every pound we spend.

Our staff

Our staff are critical to the delivery of high quality patient care and across Leicester, Leicestershire and Rutland there are 21,974 healthcare staff [3751(primary care); 12,988(UHL); 5,235 (LPT)] and 32,100 social care staff.

Having the right workforce with the right skills and behaviours in the right place, at the right time is critical to supporting our local population to stay healthy, lead independent lives and reach their full potential.

Some of our specific responses to the workforce challenge are detailed below. Our future plans also need to resolve challenges which replicate the national picture such as increasing workplace demands, high levels of vacancies, high use of the agency staff and the impact of Brexit. We have summarised some key areas that we will improve:

Vacancies

- **It can be difficult to recruit high quality staff to our local area**
- **It is difficult to recruit trainee doctors into some specialisms such as emergency medicine, frail elderly, GPs, and some cancer specialists**
- **There are high numbers of vacancies in adult social care services**
- **The younger workforce is seeking more flexible hours and work patterns**

Sickness

- **Strategies are being put in place to reduce sickness levels but we still lose a lot of days to staff sickness**
- **The most common reasons given in sickness reporting are back problems, stress and anxiety**

Turnover

- **There is a high turnover of staff in social care, although around two thirds are recruited from within social care settings**
- **Staff often leave because they are attracted by better pay, promotional opportunities or they want to broaden their experience**

We are doing this by:

1

- A nursing Associate Programme has been developed in partnership with the local education provider to support a career pathway from HCA to Registered nurse
- National Strategy to recruit more trainee doctors
- Return to practice programmes for nurses, doctors and therapists who want to return to work
- Increase in Apprenticeship opportunities including clinical apprentices and making best use of the levy across LLR

2

- Career progression opportunities such as the Nurse Associate role above
- Introduction of more flexible working for staff, particularly medical trainees
- Development of new and extended roles such as advanced practitioners and Physician Associates

3

- Health and wellbeing strategy is being implemented
- Time to Change Champions and development of website
- Highlighting Mental Health Awareness
- Better sickness reporting procedures
- Practical help for staff with back problems and stress/anxiety and depression

4

- Development of a talent pipeline
- Ensure that staff are clear about their roles and are given regular feedback

5

- Artificial Intelligence including robotics, genomics and digitalisation could predict which individuals or groups of individuals are at risk of illness and allow the NHS to target treatment more effectively
- Can give all health professionals and patients access to cutting edge diagnostics and treatment tailored to individual need
- Help address the efficiency and funding gap by automating tasks, triaging patients to the most appropriate services and allowing them to self-care
- This could have major implications on the shape and size of the future workforce, as well as investment in training our staff to use new technologies

6

- Adopt a model that will help us to understand what our local population needs are so that we can shape the future health and social care workforce
- Examine our current workforce and identify how we will need to prepare our staff, in the best way possible, to deliver the best care that we can

The enablers that improve services for our population

The workforce plan for Primary Care has been completed and work is underway on both the Mental Health and Urgent and Emergency Care plans.

Work will now begin on the Maternity and the Cancer care workforce plans throughout 2018. There will also be an update to the overarching LLR Workforce Strategy which will look at the NHS and Adult Social Care workforce as a whole. This will help us with understanding how our staff need to work across different organisations and across different models of care.

Technology

Our aim is to provide secure, shared access to a single source of electronic patient records across all systems supporting health and care within LLR, to create a safer, more efficient system, improve patient outcomes and support integrated care by 2021.

This will enable clinicians to have access to a patient's care record at any point in the care pathway, from GP appointment, to urgent or emergency situations, within hospital and back at their local surgery after discharge. Shared access to patients' records is critical to the successful delivery of Integrated Locality Teams and care pathways that require input from different specialisms and it will improve the patient experience, since they will not have to repeat the same information whenever they are transferred from one part of the system to another.

To achieve this, we are working to deliver a single, core electronic record transcending primary, community, acute and social care with patient access/contribution. This will allow all partners to have one version of the record describing who that patient is, where they are registered and who is actively caring for them.

In addition, we will develop new applications to allow face-to-face consultations and greater self-care with the promise of direct access to services should the patient require it, as opposed to booked follow up appointments and clinics. This digital self-service will be offered via an app or website portal, or through assistive technology used to monitor the patient remotely.

NHS Financial Resources

Last year the local NHS in LLR spent c£1.95 billion on running local health services. This includes paying staff, running our buildings and equipment/IT, and funding treatments and drugs. The greatest proportion of this was spent on acute hospital services, followed by mental health, community, primary care and continuing health care services.

This is clearly a significant sum of public funding and it is also one that increases year on year. However, in recent years the rate of growth in local health funding has been consistently outstripped by increases in demand for services and cost pressures in providing these.

As noted earlier in this document, the population is getting bigger and older, and expectations are rising along with the costs of meeting them. Demographic pressures in the form of a growing and ageing population are key, but only part of, the challenge. Rising public expectations, changing population health needs, and a range of cost pressures from wages, to new drugs and technologies are all creating substantial pressure on local NHS resources.

Alongside these increases in demand and cost pressures, the level of health funding has grown more slowly over the last eight years than in any comparable period since the NHS was founded in 1948. To put this into context, a recent report by the Institute for Fiscal Studies and The Health Foundation (May 2018) found that in the seven years since 2009/10, per-person spending on health nationally grew by 0.6%, compared with average annual increases of 3.3% since the NHS was formed.

Set against this context it is not surprising that after a record sustained period of low funding growth combined with continuous increases in health service demand and cost, the NHS locally and across much of the Country is under considerable financial strain. Put simply, demands on local NHS resources are growing faster than those available; as a result our local health and social care services are under increasing financial pressure.

This was evident locally last year, where for 2017/18 three of our local NHS organisations within the Partnership overspent on their in-year allocations (UHL, ELRCCG and WLCCG).

In terms of this financial year 2018/19, the size of the savings challenge is even greater. This year the scale of the challenge is even greater than ever, with the local NHS organisations needing to save £120 million between them in order to operate within levels of funding allocated to them. We have plans in place to do this by focusing on redesigning services, while cutting waste and reducing inefficiency across a number of areas including:

- Freeing up hospital beds by reducing delays for stages of treatment and enabling timely discharge once patients are medically fit
- Procurement to reduce the cost of goods and services
- Minimising high cost staff spend on agency and locums
- Increasing productivity in operating theatres and outpatients

Financial outlook

- Managing demand to make sure that patients get to the right service, first time, thereby reducing avoidable demand
- Getting best value out of medicines and pharmacy
- Reducing unwarranted variation in clinical quality and efficiency
- Making best use of estates, infrastructure and clinical support services

These financial pressures and the ongoing requirement to make significant year on year savings are not unique to LLR. In response to the scale of financial pressures across the NHS, the Prime Minister set out plans in June this year to increase NHS funding by £20.5 billion over the next five years. This means the NHS nationally will receive an average 3.4 per cent a year real-terms increase (i.e. above inflation) in funding over the next five years. This funding growth will be 'frontloaded', meaning the annual rates of growth will be slightly greater in the first two years (3.6%) and then slightly lower in the later periods. This increased funding will support a new 10-year long-term NHS Plan which is expected to be published later this year and to set out the priorities that the NHS will need to deliver through this period of additional funding growth.

In terms of the NHS financial regime, it is also expected that the 10-year NHS Plan will set out proposals for what the Chief Executive of NHS Improvement, Ian Dalton, has described as a 'new financial architecture' from 2019. It is likely that this will include changes to make NHS financial management fairer, simpler and more effective, including changes to the way some health services are funded in order to align incentives based more on outcomes and efficiency rather than levels of activity.

Locally, this prospect of additional NHS funding is clearly welcomed by the BCT Partners. We will have to wait and see detail later this year of how this will be invested across the service and what it will mean for us locally. This is why we have not published a full system financial refresh as part of this Next Steps document.

Two things are clear though. First, notwithstanding the level of additional funding that may be allocated to LLR, this is unlikely to be sufficient to cover both the costs of additional demand/cost pressures and create the financial headroom needed to support some aspects of service transformation and introducing new models of care.

Second, the new national funding is for the NHS only and will therefore not help ease the pressure on local authority social care budgets which are themselves under arguably even greater financial pressure than NHS services.

So whilst the new funding is absolutely welcome, it is not going to change the ongoing requirement for local BCT partners to work together to make

> *... demands on local NHS resources are growing faster than those available; as a result our local health and social care services are under increasing financial pressure.*

difficult resource choices and improve productivity and efficiency in the way that we provide services to local people. Our priority will be to do this in a way that focuses on maintaining core clinical services and safeguard quality and patient safety. Our approach is also seeing the various local NHS organisations work more closely together than ever through the BCT Partnership, in order to make sure that the overall health budget for our area is spent and managed well. This is about making sure that we make the best use of every 'health pound' in LLR in a way that is best for local patients and taxpayers.

So in summary, our main financial priorities across the BCT Partnership for 2018/19 are delivering our in year savings programmes and then revisiting our long term system financial plan in light of further detail on the new national funding and long-term plan expected later in the year.

Capital and buildings

As part of the financial plan, we have identified that we have significant capital requirements to ensure that the buildings we operate out of are both fit for purpose and support the new ways of working identified in the NHS Five Year Forward View.

Understanding these capital priorities across Leicester, Leicestershire and Rutland and making these support the clinical service strategy has been an important part of the move nationally towards capital resource that is allocated through the partnership rather than to individual organisations.

We have already been notified that 2 of our initial priorities have been supported:

UHL Intensive Care Unit	£30.8m
Leicestershire CAMHS & Eating Disorders Inpatient Unit	£8m

In July this year we submitted our refreshed Draft Estates Strategy for Leicester, Leicestershire and Rutland to NHS England. This identified the three top local priorities for national capital funding as:

1. Reconfigure acute hospitals to move acute clinical services onto two sites, Leicester Royal Infirmary and Glenfield Hospital, and retain some non-acute health services on the site of Leicester General Hospital
2. Improving healthcare facilities in Hinckley Health Centre and community hospital
3. Creating the Leicester Ambulance Hub

These three schemes are being progressed through the national capital allocation process. Additional schemes for other services and sites may be brought forward over time as proposals progress.

Transformation funding

Having access to funds available to enable new ways of working is often a key part of service change. To date we have been successful in securing c£9m of transformation funding from national organisations to support transformation – this is summarised in the table below:

Area	£000
GP 5 Yr Forward View - Extended Access	3,368
GP 5 Yr Forward View - Other	792
Diabetes Transformation	827
Children and Young Peoples Mental Health	1,302
Learning Disability Transformation	399
Urgent & Emergency Care Transformation	1,668
Other	916
Total Funding Received	9,272

SECTION 08

How the Better Care Together partnership will evolve and deliver improvements

How we work

In LLR NHS organisations are working closely together through the BCT partnership, alongside local authorities.

The BCT partnership currently operates in 13 clinical work streams, which focus on different aspects of care and services. Supporting these work streams are five enabling groups. They are led by a representative of a local NHS trust, CCG or council, senior clinicians and social care experts. They bring together the expertise of the whole partnership to identify improvements in the way health and care services are delivered. The proposals made by work streams are subject to clinical scrutiny through the Clinical Leadership Group which is made up of senior doctors and nurses in LLR.

Patient representatives contribute to each work stream. The programme of work and proposals made by work streams are also scrutinised by the BCT Patient and Public Involvement Group.

Leadership

A System Leadership Team (SLT) oversees all aspects of the BCT programme to improve the delivery of health and social care in LLR. The SLT:

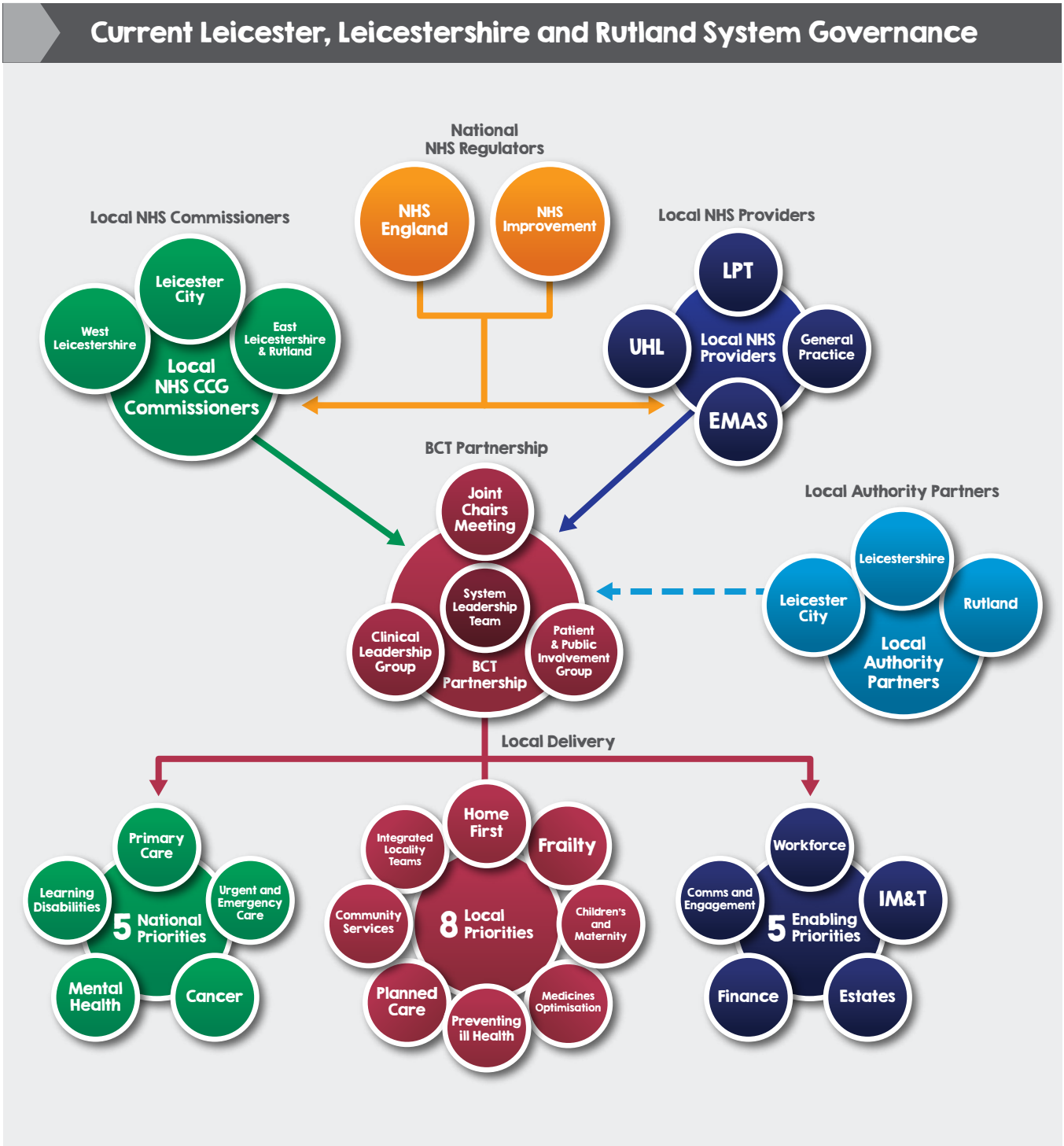
- set the direction and oversee delivery of the strategic plan
- provide collective problem solving and decision making for system wide issues
- provide oversight and monitoring of performance against the total available budget

The SLT meets on a monthly basis. The NHS members of the SLT are the managing directors and clinical chairs of each of the three LLR CCGs, the chief executives and medical directors of the two NHS trusts in LLR and senior managers from the ambulance trust. The meeting is also attended by the senior officers of Leicestershire and Rutland county councils, the chief operating officer of Leicester City Council and the chair of the BCT Patient and Public Involvement Group.

The proposals made by work steams are subject to clinical scrutiny through the Clinical Leadership Group which is made up of senior doctors and nurses in LLR.

Governance

The diagram below illustrates how the various organisational parts of the current health and care system come together to focus on national and local priorities and enablers.



How the Better Care Together partnership will evolve and deliver improvements

As is immediately apparent from the diagram on the previous page, in our local area, as well as across England, we have multiple organisations, with different statutory responsibilities, working across different geographies in LLR.

The role of local organisations and leaders within our BCT partnership is to develop new ways of working within the current statutory frameworks which enable us to operate in a more collaborative way as one system focused on doing the best for the health and care of local people.

Nationally, NHS England and the other arm's length bodies use the language of Sustainability Transformation Partnerships and Integrated Care Systems (ICS) to describe how they see organisations within local systems coming together in a way and over a timescale that makes sense for the local context in each area.

Locally, we talk more about this as the logical progression of the journey that we have already been on through our existing BCT programme.

Whatever you choose to call it, the essence is about partner organisations and our health and care staff working together to take shared responsibility for the planning and delivery of improved and sustainable health and social care for the people of LLR within the resources available to us.

Or more simply, it's about how we work together better as one team to do the right things for local people and tax payers.

We are not talking about creating new organisations. What we want to do is improve the way that the various parts of our system work together in order to operate more as 'one team'.

To support us to operate in this way, the clinical commissioning groups in LLR are discussing options to enhance their collaborative arrangements by reviewing the current governance structure of BCT, which has been in place since 2016, in line with national STP policy. This will ensure that they can better respond to the needs of the population by improving services while tackling the financial and operational issues we face.

Engagement and communications

Improvements to health and care implemented by BCT partners are informed by significant engagement with the public, patients and patient groups as well as decision makers and independent reviews and include two major periods of engagement on BCT in the past three years.

In 2015, thousands of people were reached through a publicity campaign and more than 1,000 respondents completed a detailed questionnaire about the future of healthcare in LLR. In 2016/17, following the publication of a draft Sustainability and Transformation Plan for LLR, an engagement campaign generated 11,000 interactions through publicity, events, targeted meetings, digital and social media.

Patient Experience

As we are making and proposing significant improvements to how we deliver healthcare in LLR, experience shows that listening to patients and understanding what matters most to them leads to more efficient and effective services.

So, when designing, commissioning and implementing services we are committed to a 'co-design approach'. This involves gathering experiences from patients, carers and staff through in-depth interviews, observations and group discussions, identifying touch points (emotionally significant points) and assigning positive or negative feelings. It also involves asking and understanding what matters most to people regarding aspects of their care. It leads to a more person-centred solution and a different way of working that improves the quality of care.

Co-design has been used in a number of BCT clinical work streams employing a variety of methods as adaption is always required depending on the group of people involved, which may include those with mental health problems, dementia, learning disabilities or young people.

Community engagement

Building on the engagement and involvement undertaken by the BCT partnership over the past four years, we remain committed to holding meaningful conversations with communities in order to deliver more patient-centred services.

In partnership with our Patient and Public Involvement Group, we will do more to drive 'people powered' health by enhancing our understanding of local populations to improve integrated health and care services within communities.

The involvement of councillors, voluntary and community sector organisations, patient groups, including Healthwatch, and many others is essential to enable those communities to shape services and the care that people receive. They are best placed to help make positive change happen.

We are also engaging patients so they feel able to take control of their own health and social care and seek the right help, at the right time, by the right people in the right place.

Consultation

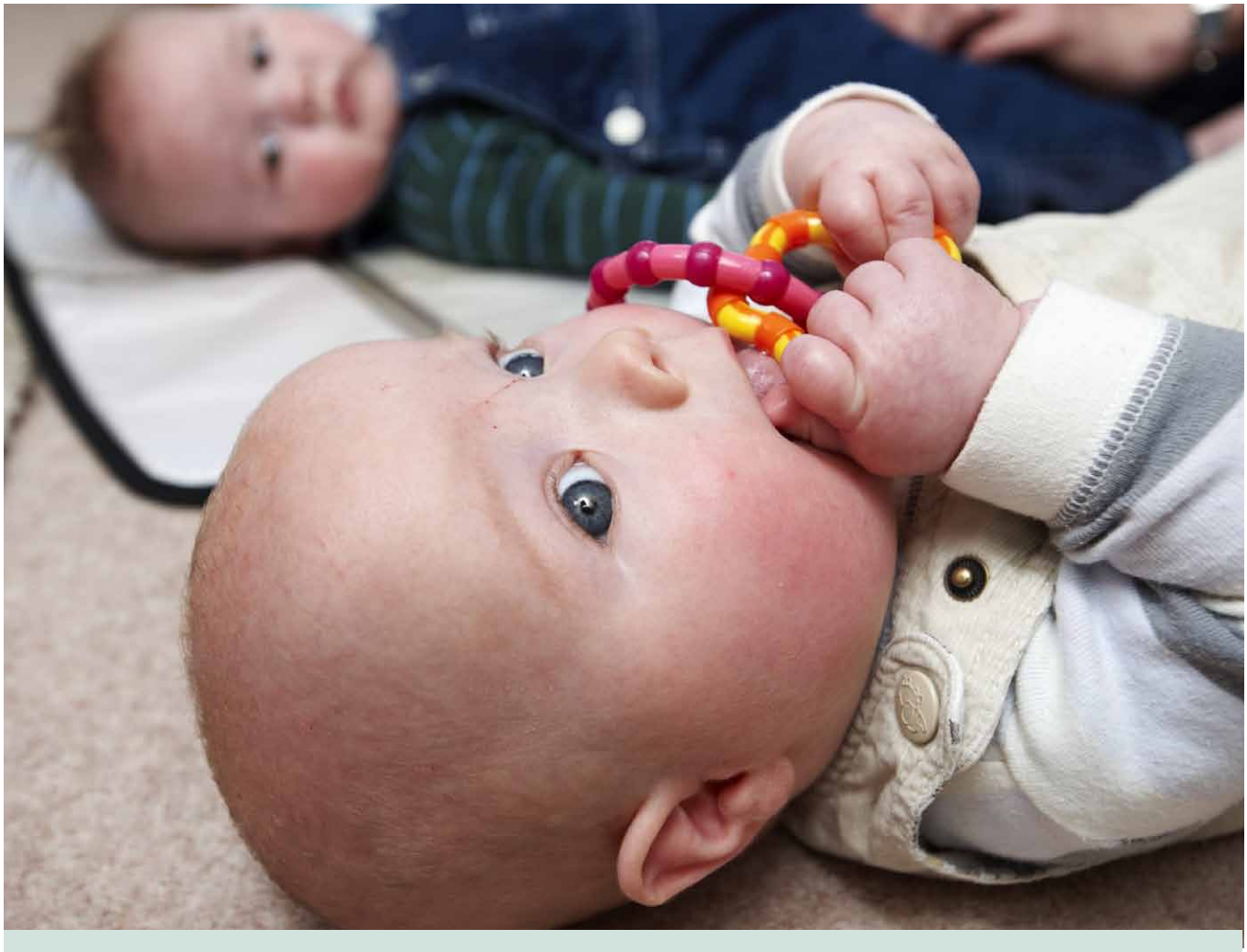
Where a formal consultation is required we will involve the public to understand the impact of proposals to ensure that we provide the best possible care for local people.

We had hoped to consult in 2018 on a number of specific aspects of BCT, but the changes in our circumstances described earlier in this document have also affected the timetable we had for formal consultation. At a point where funding is agreed at a national level and we have an approved business case, we will consult with the public on our plans for acute reconfiguration, maternity services and some community services in Hinckley. Requirements for other formal consultations may also emerge from other service improvement proposals.

Get involved

You can get involved in the development of health and care in LLR in many ways. You can become a member of your local NHS trust, sign up to receive information from your local clinical commissioning group, become a local Healthwatch member or subscribe to receive BCT updates.

Our contact details are at the back of this document or visit our website at: www.bettercareleicester.nhs.uk



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