Scheme	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
Pathway 1 intake model **Initial demand and capacity modelling Aug 22** **Further modelling to increase to pathway 2 impact Sept – Oct 22** **Initial recruitment phase Oct – Dec 22** **LPT therapies capacity modelling Oct – Dec 22**	• Integrated teams supporting people in the community aligned to the 3 R model of care; Reablement, Recovery and Rehabilitation • Supporting people to step down care after a stay in hospital or step-up care at home, (when needs change and/or in a crisis) into a therapy-led model • Joint planning, oversight and review of packages of care at home after an initial period of recovery • Incorporating Crisis response • Development of the case management function to support the rapid assessment of any ongoing needs • Additional brokerage function to improve flow into longer term domiciliary care	• Assessment of people in their own homes to gain better insight into their requirements – both maximising reablement potential and right-sizing pathway 1 domiciliary care commissioning • Helping people to remain in their own home particularly through use of therapy-led services • Partnership led service that can adapt to meet increased needs in the community • Singular case management function improving links to VCS and community services to provide additional / ongoing support • Development and delivery of the Integrated Personalised Care framework	• Reduce the number of unplanned admissions for chronic ambulatory care-sensitive conditions. • Maximising opportunities for reablement and rehabilitation to increase the number of people at home 91 days after discharge into reablement services • Maximising the number of people discharged to their usual place of residence • Reduce the demand on domiciliary care • Preventing admissions to long-term residential care	• Recruitment – Additional funding is contributing to this for 2022/23 and a joint LLR workforce strategy has been produced with health and LA partners for long-term recruitment, retention and workforce development. • Capacity within community nursing and therapy services requires audit and possible re-design in order to support this function. • Realignment of current BCF budgets and spend to accommodate this model • Not realising the reduction in care costs due to unprecedented increase in demands not decreasing.	• Recruitment planning and system-wide retention policy to expand and maintain the existing workforce. • Assessing the current contract provision for therapy and nursing • Demand and capacity modelling taking place with Newton Europe to test initial assumptions on savings

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Growing our virtual wards **SOP development May – Oct 22** **Recruitment phase – May 22 – Mar 23** **Roll-out finishes Dec 23**	• A virtual ward is a team of professionals working to manage a group of patients in the community • It allows patients to get the care they need at home, safely and conveniently, rather than being in hospital • Using a combination of remote monitoring by healthcare professionals and home visits, virtual wards can help prevent hospital admissions or allow for an earlier, supported discharge. • People make a better recovery in their own surroundings and staying in hospital longer than necessary can have a detrimental effect on their condition and their independence. • The virtual ward service has been arranged by NHS Leicester, Leicestershire and Rutland and will be provided by a collaborative of local organisations, including	• By Winter it is hoped that 275 patients will be able to be looked after simultaneously across nine virtual wards including frailty, cardiology, acute respiratory and diabetes. • The number of beds will increase to more than 440 by December 2023. • Increase utilisation of existing virtual ward beds, ensuring appropriate use to avoid admission/ facilitate earlier discharge • Enhance step up and step-down access to virtual ward beds through growing the unscheduled care hub	• Provide safe and optimal care those presenting with urgent or emergent care needs due to intercurrent illness and/ or to manage an exacerbation in an underlying pre-existing long-term condition in their usual place of residence. • Reduce demand for inpatient beds and pressure on Emergency Departments. • Identify patients who are showing signs of early deterioration in the community and with medical oversight to maintain the patient safely at home where the presenting condition is amenable to treatment in usual home environment and/or it is the persons preference to receive management at home. • To enable patients to receive management and to recover within their own familiar surroundings	• Recruitment to 75 new posts, delayed recruitment and unsuccessful recruitment • NHSE funding for 2022/23 not in plan, no longer available including system match funding for 2023/24 cost pressure • Digital technologies not funded for 2023/24 • Revised bed modelling forecasts not meeting NHSE target • Delays to pathways planned start date • Low bed utilisation on some of the existing pathways • Virtual Ward work may impact on other services particularly those within the community • VW will create additional capacity which will create	• Possible delay to timescales for delivery to allow for geriatrician resource recruitment • Ensuring robust plans for when resource is in place • Working with ASC as part of the delivery group to ensure community capacity is well-placed to support

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	University Hospitals of Leicester NHS Trust, Leicestershire Partnership NHS Trust, Local Authorities and LOROS		– for improved experience of care, plus improved person and population health and wellbeing outcomes	additional cost pressures.	
Embedding Integrated neighbourhood working **Population Health Management risk strat Oct 22** **MDT embedding and fully functional – Oct 22** **Leadership team development Mar 23**	• There will be a focus on the four building blocks of integrated care. • Adopting a Population Health Management approach including risk stratification • Delivering co-ordinated care at a local level • Multi-disciplinary teams (MDT) working to deliver better outcomes facilitated by ASC business support team with health investment to support development and recruitment of additional staffing • Delivering a preventative approach to care, with access to a local prevention offer including social prescribing	• Embed operational MDTs and anticipatory care/ population health management approach to jointly manage frail, complex and high-risk patients, ensuring that all neighbourhood teams have well-functioning MDTs in place by October 2022 • Ensure consistent use of care co-ordinators, care navigators and social prescribers to maximise use of VCSE, community and other wellbeing offers • Develop high performing Integrated neighbourhood leadership teams consistently across LLR with full engagement, clear governance, shared purpose and	• INT maturity matrix being developed following discussions at each INT meeting. • Care planning increased to 55% vulnerable patients • Care planning incentive (to 31/3/22) launched across LLR. Training webinar delivered to 260 attendees and considerable dialogue with practices and PCNs around care planning	• Recruitment causes delays to further implementation including within the care co-ordination expansion. • PCN development can be inconsistent depending on area and population density and cohorts • Changes to PCN zones and ongoing associated changes to GP engagement	• Developing a joined-up recruitment strategy • Work to develop common approaches to neighbourhood development for PCN's to apply when ready • Re-aligning and working with City partners to ensure patient needs are met

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		underpinned by a local PHM plan by March 23. • Increase identification of carers enabling support to be offered • Additional care co-ordinators recruited, ongoing work to standardise approach. IG signed off enabling LLR spread • MDT draft framework to be finalised following agreement with IG. • Recruitment of MDT Facilitator role through LAs has started.			