Better care together

A partnership of Leicester, Leicestershire & Rutland Health and Social Care

Better Care Together:

The five-year strategic plan

(Phase 2 discussion and review)

2014-2019

26 June 2014

Contents

1 Executive summary 5
2 Introduction 15
2.1 Purpose of this document 15
2.2 Submission details and status 16
2.3 Key lines of enquiry 17
3 Our case for change 19
3.1 Public and patient involvement in developing the case for change 20
3.2 Our changing population 21
3.3 Workforce change 24
3.4 Developing quality, integrated care 25
3.5 Value for money 29
4 Our vision for LLR 35
4.1 Values and principles 35
4.2 Overview of vision 35
4.3 Strategic aims and objectives 36
4.4 Settings of care 36
4.5 Primary and social care 40
4.6 Better Care Fund 40
4.7 Alignment of plans 44
5 Achieving a sustainable local system 45
5.1 The six characteristics 45
5.2 Meeting the seven improving outcome ambitions 46
6 Improvement interventions 48
6.1 Urgent care 49
6.2 Frail and older people 52
6.3 Long-term conditions 55
6.4 Planned care 58
6.5 Maternity and neonates 61
6.6 Children, young people and families 64
6.7 Mental health 67
6.8 Learning disabilities 70
6.9 Summary of interventions 74
6.10 Implementation of interventions 77

7 Enabling strategies 80
7.1 Estates 80
7.2 IM&T 93
7.3 Communications and engagement 95
7.4 Procurement and contracting 99
7.5 Workforce planning 99
7.6 Voluntary and community sector (voluntary sector) engagement 101
8 Governance 103
8.1 Overarching governance 103
8.2 The Better Care Together Strategy Board 104
8.3 Supporting structures 104
8.4 Public, Patient, Service User Involvement 105
8.5 Equality and diversity 105
8.6 Health and Wellbeing Board Involvement 106
8.7 Clinical reference group 106
8.8 Managing risk 107

Figures

Figure 1: Sources of commissioning intelligence and citizen engagement 16
Figure 2: Submission details 16
Figure 3: Case for change summary 19
Figure 4: Population of LLR by local authority 21
Figure 5: Age breakdown of population, 2014 22
Figure 6: Age breakdown of population, forecast 2019 22
Figure 7: Prevalence of disability and long term conditions 23
Figure 8: Staff survey findings on standard of care 27
Figure 9: Selective performance measures 27
Figure 10: RTT performance, April 2014 28
Figure 11: Local authority social care indicators 29
Figure 12: Aligning service pathways to settings of care 36
Figure 13: Patient benefit by intervention 74
Figure 14: Financial impact of the interventions 75
Figure 15: Changes in bed numbers 75
Figure 16: The 250 bed shift to community patient profiles 76
Figure 17: Current NHS estate 81
Figure 18: Backlog maintenance 82
Figure 19: Cost of estate 82
Figure 20: Two phase implementation of UHL efficiency changes 87
Figure 21: LPT estates principles 88

Figure 22: LPT hub and spoke model 89
Figure 23: Governance structure 103

Tables

Table 1: Answering the key lines of enquiry 17
Table 2: Ethnicity 21
Table 3: Friends and family test results, April 2014 26
Table 4: Staff survey results, 2013 26
Table 5: 'Do nothing' financial gap 2014-19 31
Table 6: Better Care Better Value indicators for UHL 32
Table 7: Better Care Better Values indicators for CCGs – primary care performance 32
Table 8: Commissioning for Value benchmark savings 33
Table 9: Better Care Funds 40
Table 10: Reflecting the six characteristics 45
Table 11: Delivering the seven improving outcome ambitions 46
Table 12: Urgent care financial impact (£000s) 51
Table 13: Long-term conditions and frail and older people financial impact (£000s) 57
Table 14: Planned care financial impact (£000s) 59
Table 15: Maternity and neonates financial impact (£000s) 62
Table 16: Children's, young people and families financial impact (£000s) 65
Table 17: Mental health financial impact (£000s) 69
Table 18: Learning disabilities financial impact (£000s) 72
Table 21: Workstream impact of estates 83
Table 22: IMT initiatives support to clinical change initiatives 95
Table 23: Stakeholder engagement channels 97
Table 24: Action plan for launch of directional five year strategy 98
Table 25: Risk management 107

Appendices

Appendix 1 – Glossary
Appendix 2 – Alignment of plans
Appendix 3 – Evidence of scale of ambition
Appendix 4 – Evidence base and modelling assumptions
Appendix 5 – Better Care Fund plans
Appendix 6 – Model methodology and outputs

1 Executive summary

This document is a **directional five year strategy** for Leicester, Leicestershire and Rutland (LLR). It represents the outputs of ongoing collaborative working between health and social care partners across LLR, and is the basis for more detailed planning through the summer of 2014. As such, there will be further extensive engagement of LLR public, patients, social care clients, staff and other stakeholders. This document is therefore a first draft of a strategy, and in September 2014 a revised version, with more detailed implementation plans, will be published.

The document is submitted by the NHS Clinical Commissioning Groups (CCGs) for Leicester, West Leicestershire and East Leicestershire and Rutland. The contents of the document have been prepared with the involvement of local authorities, NHS providers, the NHS Area Team and local Healthwatch bodies.

There is a clear **case for change** in health and social care services across LLR:

- We need ***integrated quality care*** – most people already get good quality care, but we know there are areas where we can improve. People want to be fully engaged in making positive choices about their own health and lifestyles, and to participate in the shaping and development of health and care services. People expect access to transparent and accessible data and advice about health and services, and to be able to choose which health services they can use and how to access them. Performance needs to improve across a number of key operational indicators, such as waiting times. While health and social care outcome measures show a mixed picture, with good performance as well as areas to be improved, there is scope for a step change in quality and outcomes.
- We need to ***change the workforce*** – addressing a future forecast shortfall in the local and national workforce, through different ways of working across settings of care. We need to develop capacity and capabilities, in our people and the technology that supports them.
- We need to meet the ***changing needs of the LLR population*** – there is a rising demand for health and social care, with the LLR population forecast to grow by 3% over 2014-19, with a changing age profile - 12% growth in the over-65 population. More people are living with single and multiple long-term health conditions, and there are rising health inequalities. While county areas will see growth in the elderly, the city has a population where many die early from preventable illness.
- We need to ensure ***value for money*** - health and social care organisations need to achieve financial sustainability to support the improvements in outcomes we want to make, against a background of financial constraint. We recognise that the local authorities in the LLR system face very significant financial pressures. There is a forecast financial gap of £398m in NHS services and a forecast savings requirement of £177m in local authority services by 2019 if the system does not change. Commissioners need to make phased savings to deliver investments in the models of care that will provide the highest quality and best outcomes for patients and citizens. We need to strengthen primary, community and voluntary sector care, to deliver integrated care, optimising the use of physical assets such as estates, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste.

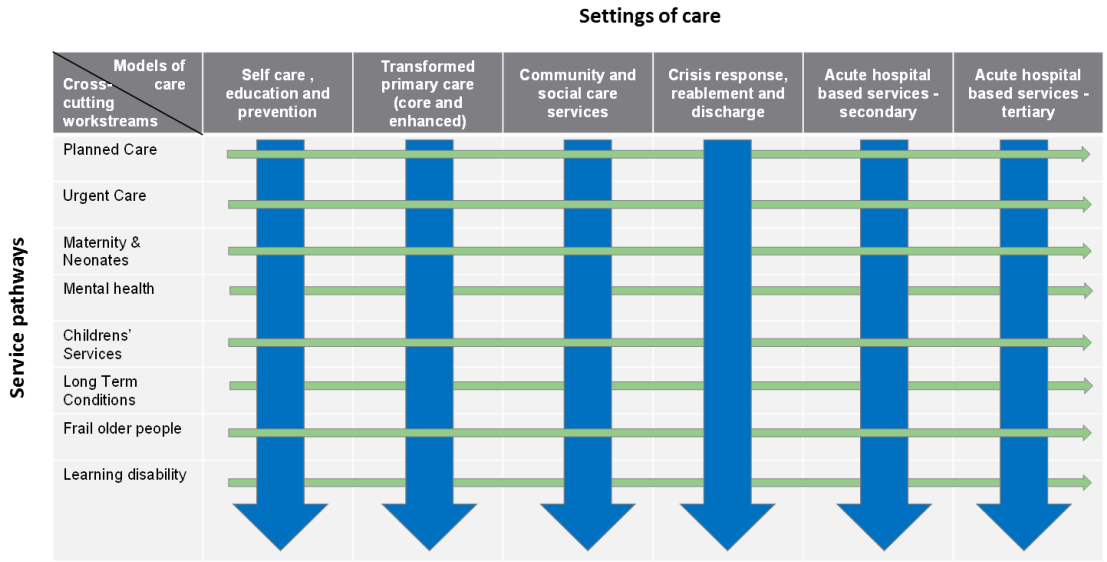
The case for change creates a real opportunity for us to redesign the way services are provided and to achieve our **vision** for LLR:

> *…to maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings.*

The vision has been agreed by all partner organisations and reflects extensive engagement of citizens, patients, social care clients and staff. The vision drives six strategic **objectives**:

- ***System Objective One*** - to deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital.
- ***System Objective Two*** - to reduce inequalities in care (both physical and mental) across and within communities in LLR resulting in additional years of life for citizens with treatable mental and physical health conditions.
- ***System Objective Three*** - to increase the number of those citizens with mental and physical health and social care needs reporting a positive experience of care across all health and social care settings.
- ***System Objective Four*** - to optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system
- ***System Objective Five*** - all health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate.
- ***System Objective Six*** - to improve the utilisation of our workforce and the development of new capacity and capabilities where appropriate, in our people and the technology we use.

To realise the vision means changes in the **settings of care**, that is, a series of transformations in self-care, education and prevention; primary care; community and social care services; crisis response, reablement and discharge; and acute services both secondary care and tertiary care.



Threaded through the settings of care are eight overarching **service models**, each reflecting the current situation and desired outcomes in five years' time, and setting out how change will be made. The service models are urgent care; frail and older people; long term conditions; planned care; maternity and new born services; children's services; mental health; and learning disabilities. Further work is planned for parallel developments in primary care and social care services.

The service models align with and are partially enabled by the plans for the use of the **Better Care Fund** (BCF) across LLR. In particular, they address common BCF themes:

- Citizen participation and empowerment
- Prevention and early intervention/detection
- Integrated crisis response
- Improving hospital discharge and reablement
- Integrated, proactive care for people with long term conditions.

All three CCGs have committed to supporting BCF for the five years covered by this plan and not the two year period mandated nationally. The vision for sustainable care in this five year plan maps to the key quality improvement metrics set out in the BCFs, such as reduction in avoidable emergency admissions, delayed transfers of care and residential admissions; as well as improved effectiveness of rehabilitation after discharge and improved patient/service user experience.

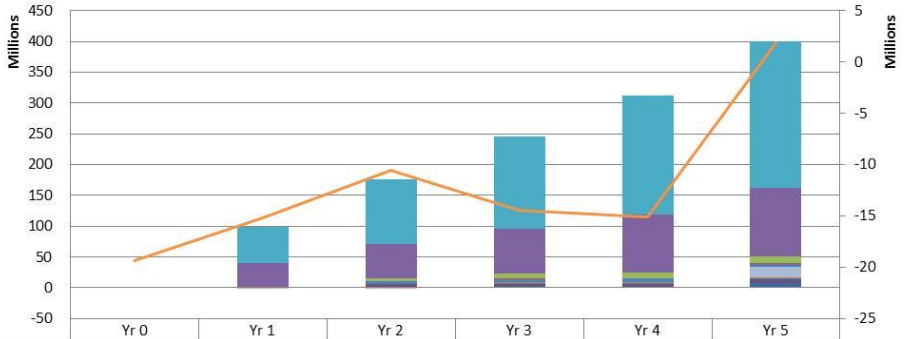
Similarly, the plans address the issues raised through **citizen engagement**, and the views of health and social care staff. **Priority** areas for development – agreed through engagement processes – underpin the models of care and the specific interventions set out in this document. A summit held in January 2014 identified cardiovascular disease, respiratory disease, mental health, dementia and cancer as priority areas. These reflect the health assessments set out in the **Joint Strategic Needs Assessments** (JSNAs) of the three local authority areas. These priorities have been retained and incorporated within the wider eight overarching service models.

Sustainability of the local system will be delivered through implementation of the vision, changes to settings of care and new service models, alongside provider efficiencies, commissioners' QIPP and use of the BCFs. Specifically, the case for change will be met in terms of quality improvement, better integrated care, a resilient workforce and services designed to meet changing population needs. Specifically, the financial change will be met as follows:

- Provider efficiencies that will deliver £238m
- QIPP savings of £110m
- Bed reconfiguration savings of £11m
- Interventions of £33m
- Sundry savings £7m.

The phasing of these savings is illustrated below.

Impact of interventions (BCT/QIPP/CIP) over the next five years; surplus (deficit) in year shown on second axis



	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
CIPs	0	58,067,897	105,106,243	149,942,642	193,516,035	238,371,599
QIPP	0	38,441,479	56,301,458	73,701,153	93,497,810	110,324,320
Bed reconfiguration	0	1,101,702	4,249,454	7,502,719	9,449,628	11,019,887
LD Workstream	0	11,216	66,818	1,108,516	1,153,974	1,201,520
MH Workstream	0	0	4,930,508	5,213,781	5,446,361	5,687,933
New contracting models	0	0	0	0	0	16,435,634
LTC/FOP Workstream	0	288,775	603,924	957,602	1,336,549	1,747,968
Urgent Care Workstream	0	0	0	1,953,043	2,016,544	2,107,603
Planned Care Workstream	0	0	5,374,849	5,445,839	5,475,219	5,495,711
Maternity Workstream	0	68,159	142,663	226,533	237,200	248,358
UHL Womens & Childrens Repatriation	0	78,057	62,994	51,065	38,570	24,855
Children's Workstream	0	-11,217	-18,970	23,248	222,460	328,607
NHSE investment	0	0	0	0	0	7,000,000
After Interventions: Health economy surplus (deficit)	-19,342,986	-15,200,199	-10,524,819	-14,446,356	-15,095,541	1,880,082

['NHSE investment' in the table above relates to investment in primary care.]

The savings plans of trusts provide the largest share of projected benefits. For UHL and LPT a critical success factor will be the movement in bed numbers across the LLR system in response to improvements and changes to the way existing services are delivered. This is discussed further under section 6.

Aligned with each of the eight service models, a number of **interventions** have been designed:

Changes and interventions	Outcomes
Urgent care	
• 'Choose Well' - helping people to choose the right service when they need help and encouraging them to look after themselves when appropriate. Local people will be supported to do this through more effect signposting of services. • 'See and treat' – supporting the ambulance service to 'hear and treat' and 'see and treat' more people without conveying them to hospital. • 'Targeting of those most at risk' - supporting to those who need it through case management and greater primary care interventions • 'Community-based urgent care' - developing more services to support people at home or in the community including developing integrated crisis response services • 'Consistency' - making urgent care services across LLR consistent e.g. consistent range of interventions offered and consistent opening times. • 'Effectiveness' - supporting A&E to be as effective as possible including delivering seven day consultant-led services.	• National targets being met with 4 hour targets consistently met • More people being treated in the right place - shift of 25% of A&E attendances (minors) being seen in an urgent care setting rather than an A&E setting by 2018/19 • Better patient experience - redevelopment of the A&E department • Simpler system for people to understand (professionals as well as the general public) • A 25% reduction in emergency department (ED) admissions for chronic diseases (see Frail Older People and Long Term Conditions interventions) • Less time spent in hospital - 10% reduction in non-elective length of stay for those people who still need admitting
Frail and older people	
• 'Tackling social isolation and promoting health' - developing programmes to support people to participate in society aiming to help them to be healthy and active for longer • 'Risk stratification and early intervention' - building systems to predict those most at risk of developing or accelerating the onset of frailty and proactively targeting interventions for the identified cohorts of the population • 'Care planning' - developing care plans together with patients and their families, to improve health outcomes to the best they can be. • 'Multi-disciplinary working' – the implementation of care plans through community based multi-disciplinary teams • 'Community-based crisis response' - crisis services which are wherever possible home or community based including access to specialist support and support to those who fall	• Improved independence and wellbeing amongst the frail and the elderly as measured by fewer care home admissions • More older people with agreed and managed care plans • Fewer older people going into hospital - 15% reduction in admissions • Reduced delayed discharged and length of stay • A reduction in readmission rates • Increased dignity as evidenced through patient surveys • An increase in the number of people who die in a place of their own choosing

Changes and interventions	Outcomes
• 'Shortening hospital stays' - services and pathways which enable people to leave hospital as soon as they are medically fit, including reablement; intensive community support and supported discharge • 'Choice at the end of life' - being clear with people who will not recover from their ill health and developing end of life care plans that reflect their wishes.	• More older people with agreed and managed care plans
Long term conditions	
• 'Education' - Work with patients and primary care to increase education around risk factors associated with long term conditions • 'Prediction' - building systems, including screening programmes, to predict those most at risk of developing or accelerating the onset of long term conditions, including health checks; chronic obstructive pulmonary disease (COPD) screening; atrial fibrillation (AF), heart failure (HF) and HF and cancer • 'Care planning' – joint development of care plans to improve health outcomes to the best they can be supported by a community multi-disciplinary team approach • 'Ambulatory pathways' – plans to ensure efficient pathways for ambulatory conditions based on treating people in the right care setting • 'Innovation' – using telehealth and telecare as well as techniques such as coaching to support people with long term conditions (LTCs) • 'Services available when required' - ensuring that medical outreach and rehabilitation are available when required • 'Choices and plans at the end of life' - being clear when people move into the palliative phase of their disease and plan for that circumstance.	• An increased number of care plans in place and people on disease registers • More people reporting higher personal resilience and support for self-management • More people with long term conditions (LTCs) support by telehealth and telecare services • A reduced number of admission and readmission associated with LTCs • Shorter inpatient stays for LTCs across LTC and Frail Older People, which would equate to 30% of bed days with continued length of stay greater than 15 days (delayed transfers of care, or DTOCs; ambulatory care sensitive conditions, or ACSC) • Reduce dependency on access to care in acute settings for people with LTCs
Planned care	
• 'Education' – work with Public Health and others to devise patient and public education • 'Better referrals' – work rigorously with primary care to increase timeliness for referral • 'Alternatives' – introduce a range of appropriate alternative services • 'Settings of care' - provide activity in the most appropriate setting based on clinical need; access and cost effectiveness • 'Easier pathways' – eliminate unnecessary steps in patient pathway and reduce duplication	• Increased day surgery / 23 hour rates and reduced inpatient surgery rates. • There will be a 40% shift of care into the community in the County • National standards (targets) being consistently met for referral to treatment • Shortened length of stay for people requiring elective surgery

Changes and interventions	Outcomes
• 'Enhanced recovery' - introduce an enhanced recovery programme to facilitate a timely and quality discharge • 'Follow-ups' reduce unnecessary follow ups • 'Innovation' - where follow ups are necessary, introduce non face to face where appropriate • 'Productivity' - improved productivity and efficiency in secondary care; outpatient and theatre utilisation, reduce length of stay where appropriate, reduce DNA and cancellation rates.	• Consistent application of elective care protocols • Fewer clinically unnecessary follow-ups - 10% of services will be decommissioned • Lower hospital acquired infection rates
Maternity and neonates	
• 'Promoting choice' – promoting options for home births and increasing the number of babies born at home • 'Engaging with local people' - reviewing and consulting on future shape of maternity and neonatal services • 'Improving outcomes' - continue with the multi-agency programme of work to improve outcomes for early babies in Leicester city.	• A sustainable long-term model for maternity and neonatology services that complies with national standards • A 1% shift from Consultant to Midwife led births, by 2018/19 • An increase of 50% in the number of home births by (equivalent to 110 births per annum) , by 2018/19 • Improved uptake of antenatal and parenting support, particularly in hard to reach groups • Improved perinatal outcomes in Leicester city •
Children, young people and families	
• 'Pathways' - improved Children and Adolescent Mental Health Services (CAMHS) pathways and interfaces with non-specialist services • 'Self-care' - facilitation of self-care by empowering individuals and building family capacity through patient education and community support • 'Innovation' – increased use of technology to support service delivery for young people • 'Health and wellbeing' - developing a strategy around optimising children's life chances through public health interventions.	• Improve health and wellbeing for children, supported into adulthood • Improve life expectancy and independence throughout their lives for children we support • Reduce duplication of structures and maximise productivity • Increase the number of children and young people who have coordinated care • Reduce inpatient admissions by 10% by 2018/19 • Reduce hospital based outpatient activity by 30% by 2018/19

Changes and interventions	Outcomes
Mental health	
• 'Better support' - effective low level support services including peer support • 'Capacity and capability' - in primary care and community services through support networks focused on detection, planned care and recovery • 'Anticipatory care' – the introduction of a planned anticipatory care model which effectively manages people whose needs deteriorate minimising the impact and requirement for inpatient stays • 'urgent care' - increased capability and capacity in A&E, crisis services and acute liaison services. • 'Timeliness' - crisis response services which act in a timely manner to support recovery, reduce length of stays and delayed transfers of care • 'Repatriation' - repatriation of out of county mental health placements to be managed in a newly designed LPT pathway.	• Reduced incidence of mental health conditions escalation (25-50% of all adult mental health illnesses may be prevented through early intervention in childhood and adolescence) • Realise the economic benefits of early childhood interventions at an estimated ratio of 1:6 above their costs. • Improved physical health and life expectancy in people with serious mental illness • Addressing the particular needs of our diverse population, including BME specific needs • Support individuals to seek help at appropriate times and settings • Reduced crisis escalation episodes, with quicker response times when required • Reduced delays in discharge and lengths of stay • Integrated pathways and case management for people to keep them close to home. • Increase in parity of esteem, time effort and resources allocated commensurate with need • Improve the provision of mental health assessments for those in crisis in the community • Reduced reliance on acute services and increase focus on recovery
Learning disabilities	
• 'Intervene early' – we will offer early interventions to help people with a learning disability (LD) to function more independently when they reach adulthood • 'Strengthen the primary care offer' – work with the primary care workforce to equip them with the skills to support more people with LD	• The potential of individuals to lead independent and fulfilling lives to be recognised as being the norm

Changes and interventions	Outcomes
• 'Access' - provide locality based care • 'Dedicated LD services' – review the potential to develop an integrated, dedicated LD service based in each locality • 'Efficiency' - provide locality based care with a model which could indicate reduction in the number of teams to the most appropriate number without compromising quality of services • 'Control' – consider pooled personal budgets and personal health budgets for people with LD • 'Settings of Care Policy' – ensure people with LD are cared for in a cost effective way • 'Carer support' – consider a single short break service; flexible and responsive with clear eligibility criteria • 'Continuing healthcare' – introduce clear agreements and frameworks for CHC • 'Support in a crisis' - consider LLR wide provision of short term intensive crisis support including a bed based option • 'Offender health' - high quality services for people with LD in prisons • 'Market management' – a joint market strategy to ensure a fair price is paid to providers • 'Mainstreaming' – ensuring our hospitals are confident in providing support to and that they make reasonable adjustments for, people with LD • 'Local provision' – develop pathways which incorporate specialist provision such as the Assessment and Treatment and Outreach to support people to live in their local community for as long as possible.	• People with learning disabilities and family carers have expectations and experiences which are comparable to the general population • Support to be tailored support to peoples' individual needs • Equitable access to mainstream services • Improved physical health and life expectancy in people with learning disabilities • Reduce spend per head by matching support setting to individual needs • Good quality service provision is available in LLR at the right time and at the right price

Interventions relating to primary care and social care will be developed during the next phase of work.

Implementation of the interventions is planned in three phases:

- Phase 1 – preparation and planning - the current phase of developing a directional plan for further discussion
- Phase 2 – discussion and review, including refining proposed changes and developing business cases – by end September 2014
- Phase 3 –implementation and consultation – from October 2014.

A series of enabling strategies underpin the initiatives, service models and changes in settings of care:

- ***Estates*** – the current portfolio of estates is costly and not aligned with the required models of care. We will develop plans for estates reconfiguration across UHL and LPT. We will rationalise the use of premises across both health and social care, to help meet the financial pressures faced by local authority and NHS organisations. We expect, for example, a smaller, more specialise, acute estate. We will include estates implications in our proposed review of primary care.
- ***Information management and technology*** (IM&T) will be developed as a means of supporting reconfigured and integrated models of care, and to improve the productivity and efficiency of the workforce.
- ***Communications and engagement*** of stakeholders across health and social care will ensure that plans are co-created and developed in ways that meet the needs and aspirations of the users of health and social care services.
- ***Procurement and contracting*** models will be changed to move away from a 'tariff based' payment system to an 'outcome based' payment system developed around programmes of care across organisations boundaries.
- ***Workforce planning*** will be undertaken to develop new staffing models for integrated care across settings of care, training and development initiatives for new and existing staff, reducing use of premium cost agency staff.
- Working with the ***voluntary sector*** to ensure that their expertise in service design and patient/service user needs is properly leveraged.

Governance of the five year strategy will be led by the Better Care Together Programme Board, supported by groups for operational delivery, financial planning and programme management. Each workstream – for the service model changes – will report through and be held accountable by a pan-LLR structure.

Within the governance structure, **patient, service user and public involvement** will be integral, with close working with local Healthwatch groups. Similarly, the programme will continue to formally link with, and reflect the views of, Health and Wellbeing Boards and a Clinical Reference Group.

2 Introduction

2.1 Purpose of this document

This five year strategy, developed jointly by the Leicester, Leicestershire and Rutland (LLR) Better Care Together Programme Board, sets out our plans to reform health and social care services for the people in the LLR area. It is a single strategy to realise a shared vision. It represents a stage in an ongoing process of collaboration across health and social care in LLR.

Through this strategy we identify where the health and social care systems can be rebalanced to improve services and to ensure more people are supported at home or in the community. We identify key service changes within health and social care and a rebalancing of resource use.

Higher quality, accessible care giving early detection, treatment and management of patients in community settings is consistent with more efficient deployment of clinical resources - and therefore is better value for money. This means that better clinical outcomes can be achieved at a lower cost if the model and settings of care are fundamentally shifted from an overtly acute setting to a community and primary care setting whilst continuing to ensure access to high quality acute care for those patients that need it.

The strategy is aligned to three local authority (Leicester City, Leicestershire County and Rutland County) Joint Health and Wellbeing Strategies and Better Care Fund (BCF) plans, all sharing an emphasis on reducing avoidable admission to hospital; the redesign of care pathways; and developing care outside of hospital settings. Working together in a larger unit of planning, organisations within LLR have the benefit of much stronger connections and strategic alignment.

We have made sure that local citizens have been fully included in the development of our plans. We have spoken with our public through our 'Call to Action' events and through a series of workshops and summit style meetings. We have worked with the LLR public, with clinical and social care networks and with the clinical leadership of CCGs, local authorities, primary and secondary care to ensure involvement of patients and clinical staff in the development of our plans. This process was launched at a joint health and social care system and public and patient summit in January 2014 at which the strategic context was agreed. The clinical and social care 'case for change' developed by the Clinical Reference Group and supported by the Public Patient Involvement Reference Group has set the strategic objectives.

The development of the plan has been developed and supported through evidence based system led workshops, external led support and summit events. Public and patient representative support has been integral to this process. Over 200 attendees including clinicians, patient, community and voluntary sector representatives have attended each of the workshop programmes and summit events to date.

To support the prioritisation and phasing of the programme a set of appraisal criteria have been developed through the system workshops and reviewed by the BCT clinical and public and patient involvement reference groups (quality, access, scalability, achievability, return on investment, level of pathway change).

The specific interventions outlined in our plans have been formed using a range of commissioning intelligence as well as what our citizens have been telling us:

Figure 1: Sources of commissioning intelligence and citizen engagement

Commissioning Intelligence	Citizen Engagement
Commissioning for Prevention	Call to action events across LLR
Joint Strategic Needs Assessments	Strategy Summit events
'Any town' model	Strategy workshops – wide stakeholder groups
Local Authority Outcome Improvement Packs	Strategy workshops – expert groups
Commissioning for Value data sets	CCG consultations on Better Care Fund
Levels of Ambition Atlas	CCG consultations on Operational Plans
A Call to Action: Achieving Parity of esteem; transformative ideas for Commissioners	Direct liaison with each Health and Wellbeing Board
A Call to Action: Improving General Practice	Direct liaison with each HealthWatch group
A Call to Action: The NHS belongs to the people	

The public across LLR have told us they wish to be independent, sustain their health, have confidence in their own well-being and to ensure that the services they need are accessible, readily available and of high quality. As a result this strategy has a strong focus on the continued development of alternatives to acute admission, including prevention; aimed at minimising acute exacerbation and deterioration from established disability or health conditions or from complex social care needs. Our focus is to ensure that children have the healthiest possible start in life and that adults will be able to live well and longer.

2.2 Submission details and status

The strategy builds upon the draft strategy submitted in April 2014. It has been formulated as a directional plan, that is, it sets out a direction of travel, upon which we will engage stakeholders in discussion and debate through the summer of 2014. It has been prepared by the Better Care Together Board as a blueprint for discussion and review on behalf of the Leicester, Leicestershire and Rutland health and social care partners.

Figure 2: Submission details

Submitted by	With the involvement of	
• NHS Leicester City Clinical Commissioning Group (LCCCG) • NHS West Leicestershire Clinical Commissioning Group (WLCCG) • NHS East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)	• Leicestershire County Council • Rutland County Council • University Hospitals of Leicester NHS Trust (UHL) • Leicestershire Partnership Trust NHS Trust (LPT) • Leicester City Council	• NHS England Local Area Team Commissioners of Primary Care & Specialist Commissioning • Leicester City Healthwatch • Leicestershire County Healthwatch • Rutland Healthwatch

In case of enquiry, contact:

Dr Simon Freeman,
Editor-in-Chief and Managing Director, Leicester City Clinical Commissioning Group
8th Floor St Johns House
East Street
Leicester
LE1 6NB
Simon.Freeman@LeicesterCityCCG.nhs.uk

Geoff Rowbotham,
Interim Programme Director, Better Care Together
4th Floor St Johns House
East Street
Leicester
LE1 6NB
Geoff.rowbotham@nhs.net

This version of the five year strategy has been formulated as a **'directional' plan**, that is, it sets out a direction of travel to inform a process of engagement over the summer of 2014. Through engagement, plans will be refined and a more detailed approach to implementation will be developed. Formal 'sign-up' will be given by local health and social care organisations. A final five year strategy document will then be issued in September 2014. The implementation process is discussed at section 6.10.

This document in its draft state has been informed by:

- The East Midlands Clinical Senate Review of CCG Strategic Plans (June 2014)
- East Midlands Clinical Senate Review of Strategic Plans for Leicester, Leicestershire and Rutland Health and Social Care Economy (May 2014)
- The NHS England Area Team Five Year Plan Feedback Meeting with Leicestershire CCGs (May 2014).

2.3 Key lines of enquiry

The document addresses the *Everyone Counts* key lines of enquiry (KLoE) as follows:

Table 1: Answering the key lines of enquiry

KLoE		Chapter/ section reference
Submission details	Which organisation(s) are completing this submission?	Section 2.2
	In case of enquiry, please provide a contact name and contact details	Section 2.2
System vision	What is the vision for the system in five years' time?	Section 4.2
	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models	Section 5.1

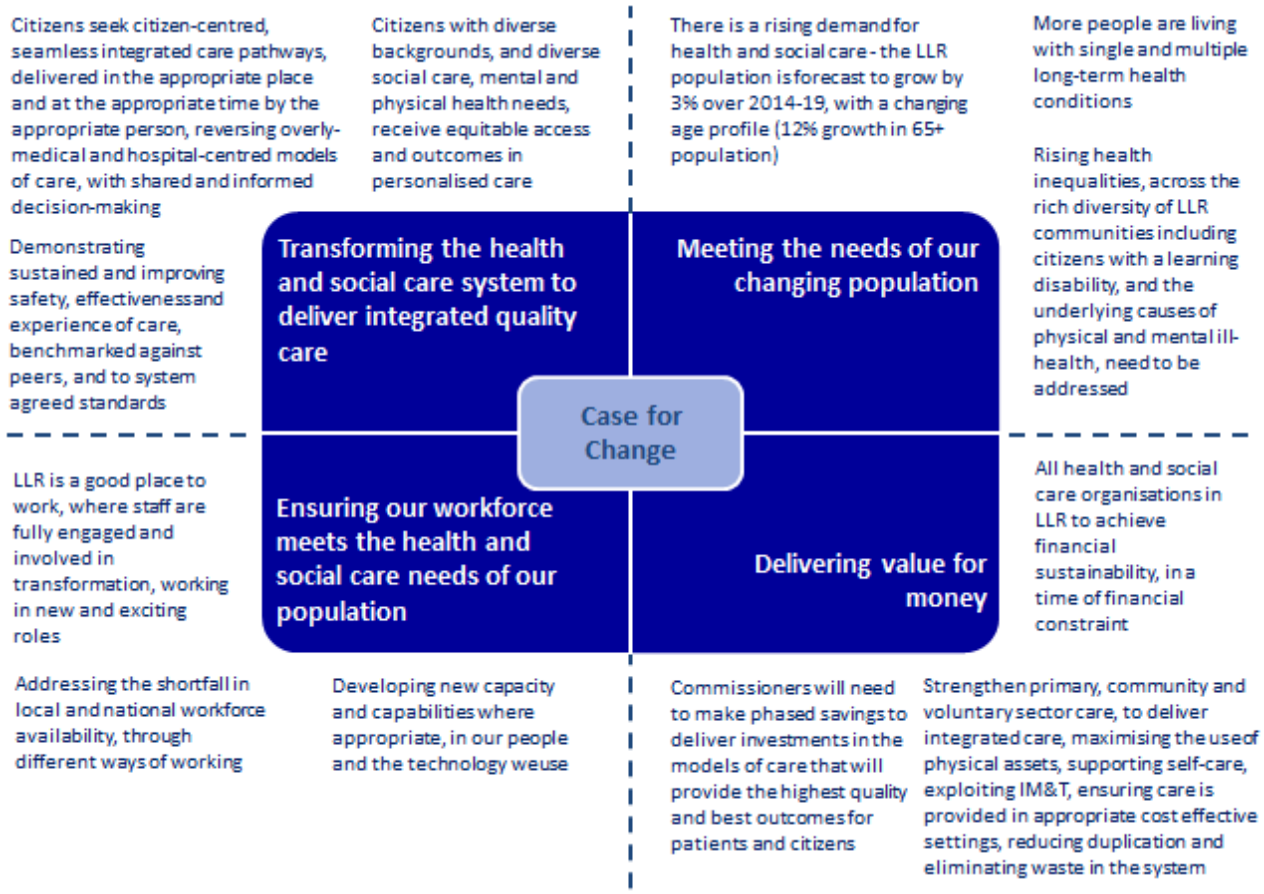
KLoE		Chapter/ section reference
	Who has signed up to the strategic vision? How have the Health and Wellbeing boards been involved in developing and signing off the plan?	Section 2.2 Section 8.6
	How does your plan for the Better Care Fund align/fit with your five year strategic vision?	Section 4.6 Appendix 2 Appendix 5
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	Appendix 2
	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?	Section 3.1
Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	Chapter 3
	Do the objectives and interventions identified below take into consideration the current state?	Chapters 4, 5 and 6
	Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?	See two year plan
Improving quality and outcomes	At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?	Appendix 6
	How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	Section 2.1 Sections 4.6, 4.7 Sections 8.4, 8.7
	What data, intelligence and local analysis was explored to support the development of plans for improving outcomes and quantifiable ambitions?	Section 2.1 Appendix 3 Appendix 4
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	Section 4.7
	How have the Health and Wellbeing boards been involved in setting the plans for improving outcomes?	Section 4.7, 8.6
Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	Chapter 5
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	Appendix 2
	Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?	See individual commissioner and provider submission
Improvement interventions	Please list the material transformational interventions required to move from the current state and deliver the five year vision.	Chapter 6
Governance review	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	Chapter 8
Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	Section 4.1

3 Our case for change

We have reviewed the local health and social care economy, by examining various data and by listening to stakeholders – our patients, the LLR public and NHS and social care staff. This has led us to develop an understanding of the opportunities that we have to improve care, and to redesign a local health and social care system around the future needs of patients, in a way that is sustainable.

Our Clinical Reference Group, which brings together senior clinicians, public health professionals and social care service leaders, and patient and public involvement representation, has led the development of our clinical and social care case for change. The case has been co-produced with the active contribution of our Patient and Public Involvement Reference Group, to ensure that the case for change is driven by clinical and social care imperatives. Our approach ensures that citizens, patients, the public and wider stakeholders are involved in shaping the fundamental direction of the programme.

Figure 3: Case for change summary



Given the circumstances in LLR, relating to models of care, workforce, population needs and financial constraints, we believe that the case for transformation of the local health and social care economy is strong.

3.1 Public and patient involvement in developing the case for change

Over the course of the last few years significant engagement with our patients and the LLR public has been undertaken over the immediate priorities for change, much of which has been set in the context of the financial challenge that the NHS and the public sector is working within. The plans outlined in this document build on much of this engagement with a strong resonance to the priorities identified by a broad range of stakeholders, particularly in the settings of care and key interventions. We have built on this during the development of the strategy, the following engagement has taken place:

- Two summits have been held between January and June 2014 to identify key priority areas, these involved over 200 people with participation from the public; patients; clinicians; carers and the voluntary sector. The first summit also developed the vision for the Better Care Together Programme, the second workshop approved the case for change and the appraisal criteria for prioritisation of workstreams.
- Workshops during February to June 2014 built on the priorities that came out of the first workshop, identifying in more detail the interventions required for each priority. Again these involved LLR public; patients; clinicians; carers and the voluntary sector
- A Public and Patient Involvement Reference Group has been established within the formal governance arrangements of the Better Care Together programme chaired by the Chair of Rutland Healthwatch. The group advises the Better Care Together Programme on patient, service user, carer and public involvement representation, it also exists to challenge and /or confirm the programme on its engagement, involvement and consultation of patient, service users, carers and the public. This group also provides representation of all the groups within the Better Care Together governance structure.

During the next phase of the Better Care Programme, June to September 2014 further discussion and review is planned before the final version of this strategic plan is completed, this will include:

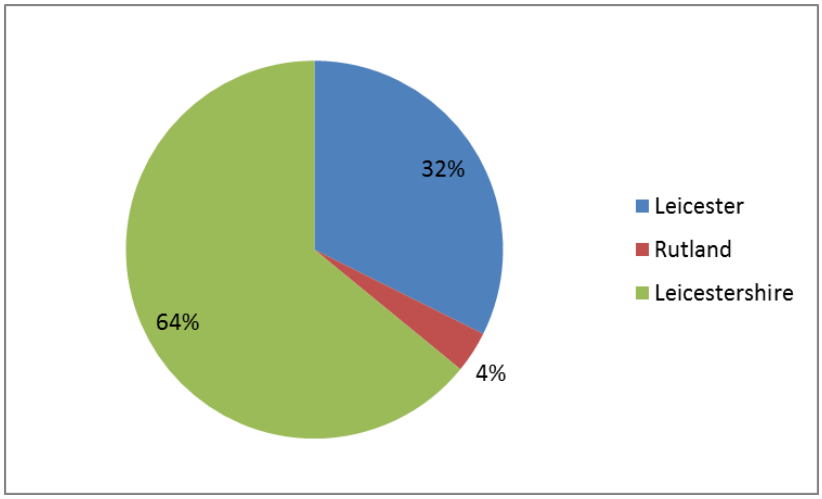
- Discussion of the proposals across all organisations including Health and Wellbeing Boards and Overview and Scrutiny Committees;
- Patient user groups will be established for each of the key intervention workstreams together with patient representation on the Project Group of each workstreams;
- A voluntary and community review will be undertaken in early July 2014 to determine how this sector can further contribute to the development of the strategy and interventions.

Elements of the case for change are discussed below.

3.2 Our changing population

LLR has a population of 1.03 million. The 2014 breakdown of population across the three local government areas is shown below:

Figure 4: Population of LLR by local authority



Source – ONS, 2012 forecasts

Around one third live in the city, with two thirds in the counties.

In terms of ethnicity, the City of Leicester is much more diverse than the county areas:

Table 2: Ethnicity

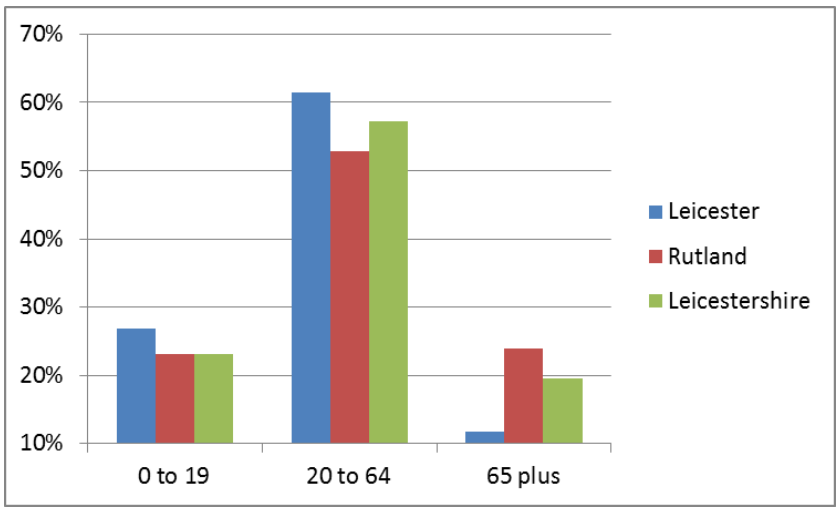
	White	Gypsy / Traveller / Irish Traveller	Mixed / Multiple Ethnic Groups	Asian / Asian British: Indian	Asian / Asian British: Pakistani	Asian / Asian British: Bangladeshi	Asian / Asian British: Chinese	Asian / Asian British: Other Asian	Black / African / Caribbean / Black British	Other
Leicester	50.4%	0.1%	3.5%	28.3%	2.4%	1.1%	1.3%	4.0%	6.2%	2.6%
Rutland	97.0%	0.2%	1.0%	0.3%	0.1%	0.0%	0.3%	0.2%	0.7%	0.2%
Leicestershire	91.4%	0.1%	1.3%	4.4%	0.3%	0.4%	0.5%	0.7%	0.6%	0.4%

Source – 2011 Census

Service design and delivery must respond to this diversity; particularly in terms of access to services.

The age breakdown of the population at 2014 is summarised below:

Figure 5: Age breakdown of population, 2014

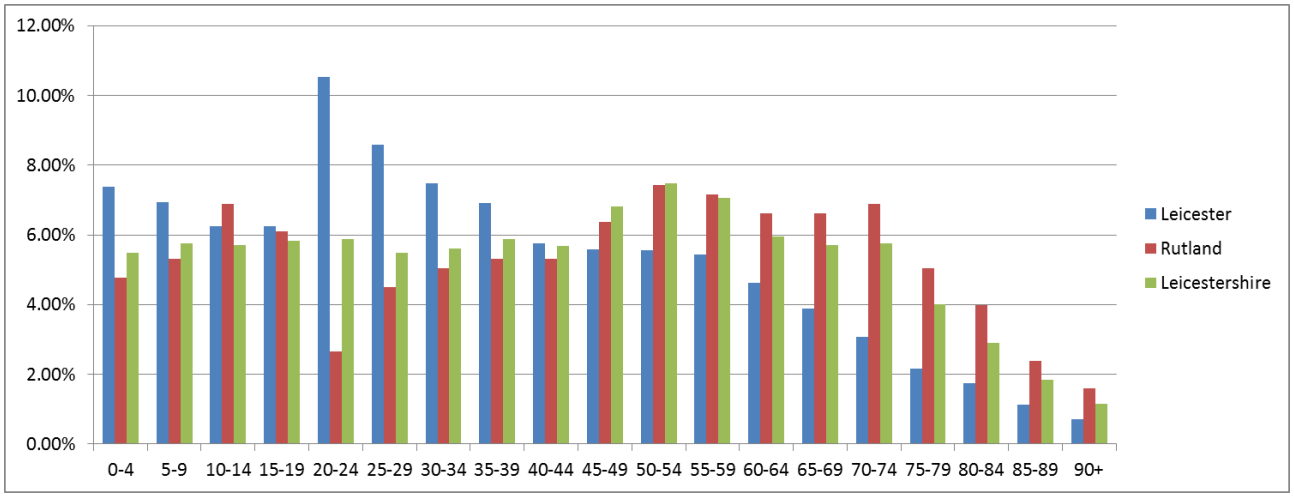


Source – ONS, 2012 forecasts

The overall population is forecast to grow by around 32,000 (3%) by 2019. This represents a rate of growth slightly lower than that for England as a whole.

The City of Leicester has a younger population, with the county areas markedly older. This difference will continue to 2019, with the city having a markedly larger proportion of younger adults and a smaller proportion of older people:

Figure 6: Age breakdown of population, forecast 2019



Source – ONS, 2012 forecasts

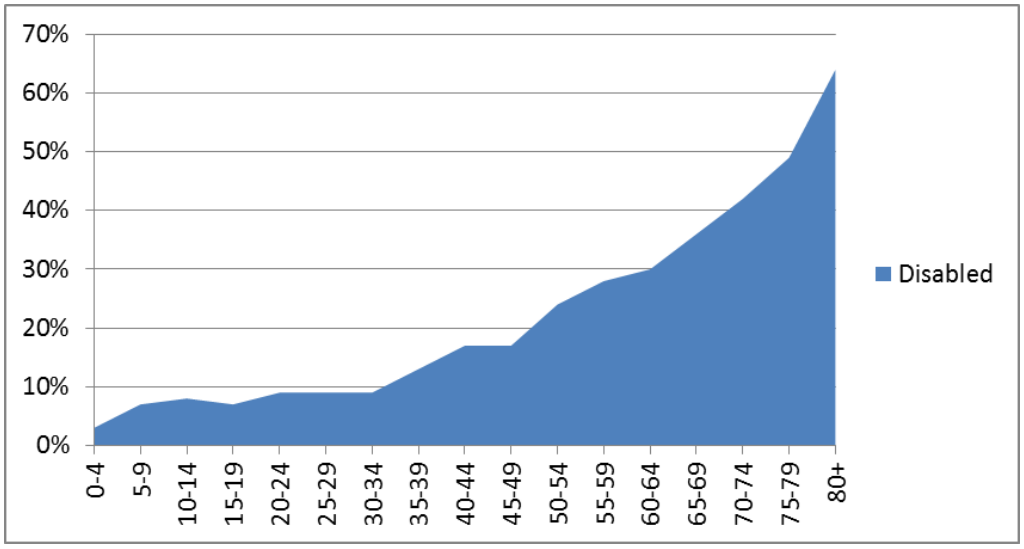
The population profile of Leicester City reflects the fact that compared with the county areas, people in the city die earlier, particularly from circulatory diseases, cancers and respiratory disease. Poor health is driven by deprivation and exacerbated by lifestyle factors. Leicester is ranked 25th worst out of 326 local authority areas in England on the national Index of Deprivation (2010). Health

inequalities within Leicester and compared to England as a whole have proved enduring. There are also areas of deprivation outside the city – notably certain wards of north west Leicestershire.

Though there are clear demographic differences across LLR, in general the next 20 years is forecast to see an increasingly ageing population, particularly in the county areas. Of the total population growth of 32,000 to 2019, 22,000 will be in the over-65 group. This is largely a challenge in the county areas. By contrast, the key challenge in Leicester City will continue to be premature preventable death and disability, through earlier detection and better access to services.

With ageing, there is a continuing shift in the pattern of disease towards long-term conditions, as illustrated below, with reference to national data. As people age, the prevalence of disability including long term health conditions increases:

Figure 7: Prevalence of disability and long term conditions



Source – Family Resources Survey, 2011/12

As people grow older, there is a higher preponderance of long term illness and disability. The numbers of people living with long term conditions will grow as a population ages. Furthermore, many people will have multiple conditions, meaning their care needs are more complex.

Currently, most acute hospital bed days are used for people with long term conditions such as COPD, heart failure, coronary heart disease, diabetes and asthma. With service redesign, many of these conditions are amenable to care in community settings, closer to home, through:

- Prevention of illness, self-care, and, earlier access to treatment before illness becomes more serious
- Risk stratification of those at risk and care planning and management
- Reduction of acute exacerbations, reducing admissions
- Earlier discharge from hospital.

Unless purposeful action is taken to address the needs of an increasingly elderly population in the county areas and a deprived and sicker population in the city areas, and to develop alternatives to

expensive (i.e. frequent, lengthy) acute admissions, the health and social care economy will become unsustainable.

Service redesign must also recognise the differences within the LLR population, summarised as:

- The needs of a younger and ethnically diverse population in the city, dying prematurely
- The needs of an older population in the counties, living longer but with long term health conditions.

Demographic differences manifest themselves as inequalities, which appear to be rising despite recent attempts at their reduction. For example, life expectancy is rising in the city but not as fast as it is in the county areas or across England as a whole. Inequalities include:

- In access rates between different ethnic communities (for example the South Asian population is under-represented in mental health services)
- In accessibility between people living in rural areas, particularly the rural poor, and those living in urban areas
- In outcomes between city and county (life expectancy in the city is 5.6 years less than in Rutland amongst men and 2.5 years less amongst women: years of 'healthy life' show similar variation)
- In outcomes between different localities within both the city and the county (within Leicester life expectancy is 9.4 years lower for men and 5.0 years lower for women in the most deprived areas of Leicester than in the least deprived areas)
- In outcomes between vulnerable groups and the wider population (people with enduring mental illness are likely to have worse general health and to die over ten years earlier).

The case for change - key demographic change factors

- There is a rising demand for health and social care - the LLR population is forecast to grow by 3% over 2014-19, with a changing age profile (12% growth in 65+ population)
- More people are living with single and multiple long-term health conditions
- Rising health inequalities, across the rich diversity of LLR communities including citizens with LD, and the underlying causes of physical and mental ill-health, need to be addressed

3.3 Workforce change

The combined NHS and social care workforce is one of the largest groups of employees across LLR, accounting for approximately one in ten of the working population. The workforce is both our greatest asset and our greatest cost (representing approximately 70% of total health and social care spend). There are a number of challenges related to the national NHS and social care workforce that will have a local LLR impact over this planning period[1]:

[1] These challenges are drawn from from the King's Fund publication, *NHS and Social Care Workforce: meeting our needs now and in the future?* 2013.

- The health care workforce can be relatively inflexible, with strong demarcation of roles and a working model often centred on single episodes of treatment. However, those placing the greatest demand on services – both now and in the future – are older people with multiple conditions.
- An increasing number of UK-trained doctors, nurses and allied health professionals choose to move abroad, particularly to Australia, New Zealand and the United States. Every year since 2005/6, more nurses have left the UK than have arrived from abroad.
- By 2021 there will be a shortfall of between 40,000 and 100,000 nurses and there could be 16,000 fewer GPs than are needed. While it is forecast that there will be an oversupply of approximately 2,000 hospital consultants by 2020, there is today a shortage of consultants in some specialities including geriatrics.
- The ageing population means that by 2025 the national social care workforce will need to increase from 1.6 million to 2.6 million.

A key issue is the changing nature of work undertaken by staff. As the population generally ages, they will need to care for more people with complex needs. For example, one in four hospital inpatients have dementia.

We recognise that in future we could face shortages of staff in some key disciplines and that those staff we do employ will need to work differently: they will need to work much more in multi-disciplinary teams that treat the 'whole person' and not just the presenting condition, and they will need to be more productive, perhaps through use of new and emerging technologies.

The case for change - key workforce factors

- Addressing the shortfall in local and national workforce availability, through different ways of working
- Developing new capacity and capabilities where appropriate, in our people and the technology we use

3.4 Developing quality, integrated care

We also need to change models of care in response to rising public expectations. The NHS Constitution, a consumerist society and scandals such as Mid Staffordshire have created an environment in which the public rightly expect an NHS that can deliver world class services with minimal delay in a setting the patient chooses. We know that citizens want to be fully engaged in making positive choices about their own health and lifestyles; participating in the shaping and development of health and social care services; well served by access to transparent and accessible data and advice about health and care services; and able to choose which services they can use and how to access them. We know that the public want a much greater say in how services are organised, and we know that patients and their carers want much more say in how their personal care is delivered[2].

[2] Everyone Counts Planning for Patients 2014/15 to 2018/19, NHS England, 2013

As discussed in section 2.1, engagement of members of the LLR public has shown us that they wish to be independent, sustain their health, have confidence in their own well-being and to ensure that the services they need are accessible, readily available and of high quality.

We need to use the opportunities afforded by the introduction of personal budgets for social care, Patient Choice for planned care, greater public engagement, the emergence of 'big data' and other technological innovations to respond to rising public expectations.

There are many things which are good about health and social are services in LLR. We meet the needs of most people most of the time quickly, efficiently and effectively. But there are times when performance falls below the standards to which we aspire.

A *friends and family test* is set for all acute providers in England. It asks patients 'whether they would recommend the NHS service they have received to friends and family who need similar treatment or care'. Local results indicate some strengths and some scope for improvement:

Table 3: Friends and family test results, April 2014

	University Hospitals of Leicester	England	Commentary
Inpatient care	70	73	About the same
A&E care	69	55	Better
Maternity care	47	65	Worse

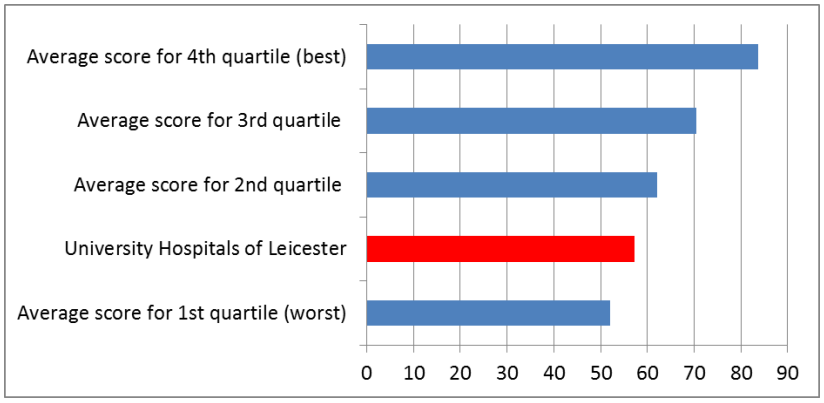
The NHS staff survey also asks for assessments of service quality. Again, some scope for improvement is indicated.

Table 4: Staff survey results, 2013

	UHL	All acute trusts	LPT	All MH & LD trusts
Percentage feeling satisfied with the quality of work and patient care they are able to deliver	74%	78%	66%	76%
Recommendation (out of 5) of the trust as a place to work or receive treatment	3.51	3.71	3.38	3.85

For acute services, the staff survey analysed the percentage of staff who strongly agree or agree with the question 'if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation'. UHL performance is towards the lower end.

Figure 8: Staff survey findings on standard of care



The results of friends and family tests and staff surveys are by no means definitive, but they can indicate where attention may need to be paid. On a range of more specific measures, taken from NHS England data on outcomes benchmarks, there is evidence of some strong performance and weaker performance.

Figure 9: Selective performance measures

Stronger	At or close to average	Weaker

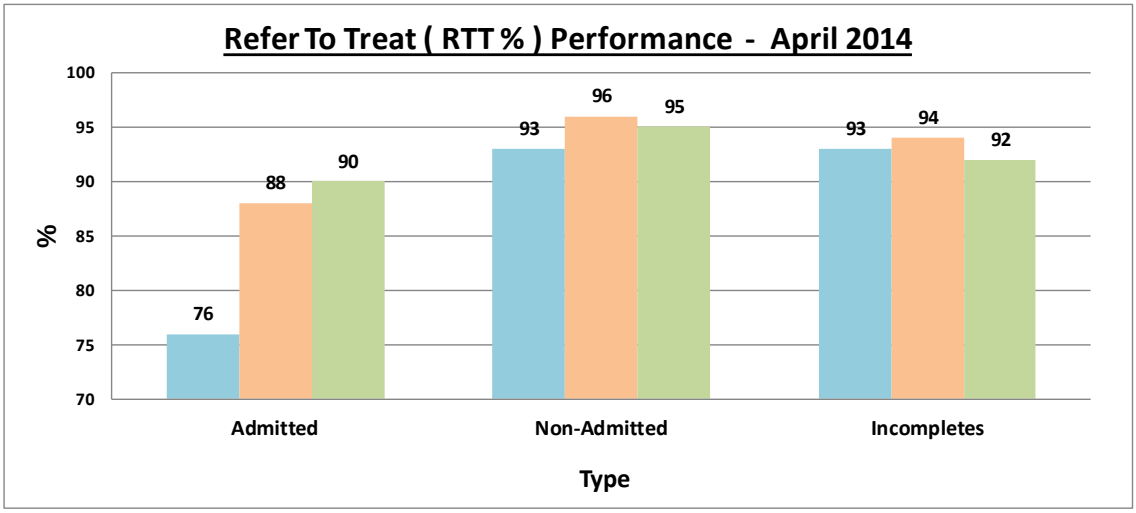
Measure	Leicester City	West Leicestershire	East Leicestershire & Rutland
Non-elective admission rates			
Health related quality of life with long term conditions			
Feeling supported to manage a condition			
Unplanned hospitalisation for chronic ambulatory sensitive conditions			
Unplanned hospitalisation for asthma, diabetes or epilepsy in under-19s			
Emergency admissions for conditions that should not normally require hospital admission (adults)			
Emergency readmissions within 30 days of discharge			
Patient reported outcome measures – hip replacement			
Patient reported outcome measures – knee replacement			
Patient reported outcome measures – groin hernia			
Emergency admissions for children with lower respiratory tract infections			
Patient experience of GP services			
Patient experience of GP out of hours services			
Patient experience of dental services			
Patient experience of hospital care			
Incidence of MRSA infection			
Incidence of C-Difficile infection			

While performance across the CCGs cannot be described as poor, in some cases performance should be improved. For indicators such as admission and readmission rates, to reflect good practice and best use of resources, performance should be at top decile. Our case for change sets out the need not only to shift care from acute to community settings, but to prevent acute admissions.

Local performance against key operational measures such as the four hour wait in A&E and referral to treatment (RTT) performance needs to be improved. Performance against the A&E target at UHL (including the urgent care centre) has improved through 2013/14 but remains well below the national target.

Referral to treatment (RTT) performance for admitted and non-admitted patients (measured as % within 18 weeks) is also below the English average:

Figure 10: RTT performance, April 2014



	Admitted	Non-Admitted	Incompletes
LLR	76	93	93
England	88	96	94
Standard	90	95	92

These performance data are indicative of the pressure on acute services (rising demand and resource constraints) set out in the case for change.

Waiting times are also above where we want to be in many community and mental health services. This reinforces the points in the case for change relating to strengthening community services.

Local Authority indicators can be used to measure the performance of the combined health and social care system. A summary drawn from NHS England data is shown below for each of the three local authorities, indicating a mixed performance versus cluster peers – bearing in mind that this represents not so much organisational performance but the relative level of challenge in different areas.

Figure 11: Local authority social care indicators

Stronger	At or close to average	Weaker

Measure	Leicester City	Leicestershire	Rutland
Average quality of life score			
Permanent admissions to residential care (ages 18 to 64)			
Permanent admissions to residential care (ages 65 plus)			
Satisfaction with services			
Feel safe			

The case for change - key changing and rising expectation factors and current performance

- People want to be fully engaged in making positive choices about their own health and lifestyles
- People want to participate in the shaping and development of health and care services
- People expect access to transparent and accessible data and advice about health and services
- People expect to be able to choose which health services they can use and how to access them
- Performance needs to improve across a number of key operational indicators, such as waiting times
- Health outcome measures show a mixed picture, with good performance as well as areas to be improved
- Social care outcomes are mixed reflecting particular pressures in city and county areas

3.5 Value for money

Nationally, if the NHS continues with current operating models and fails to make any further productivity improvements, it will facing a funding gap between projected spending requirements and resources available of around £30bn by 2020/21. This challenging economic climate means that for the foreseeable future local NHS commissioners are unlikely to receive 'growth' funding in line with historical levels. Whilst health budgets are ring fenced and CCGs can expect to receive modest growth in capitation funding, local authorities are already experiencing and will continue to face significant real terms cuts to funding received from central government.

The local health and social care system is already facing financial pressures – the health economy is one of 11 "financially challenged" economies identified by NHS England with currently financial pressures manifesting themselves particularly clearly in a deficit at UHL.

Since formation in 2000, UHL has narrowly broken even every year with the exception of 2013/14 when it posted a £39.7m deficit. UHL plans for the short and medium term are to address both the

financial deficit and problems with operational performance – discussed earlier - without detriment to outcomes.

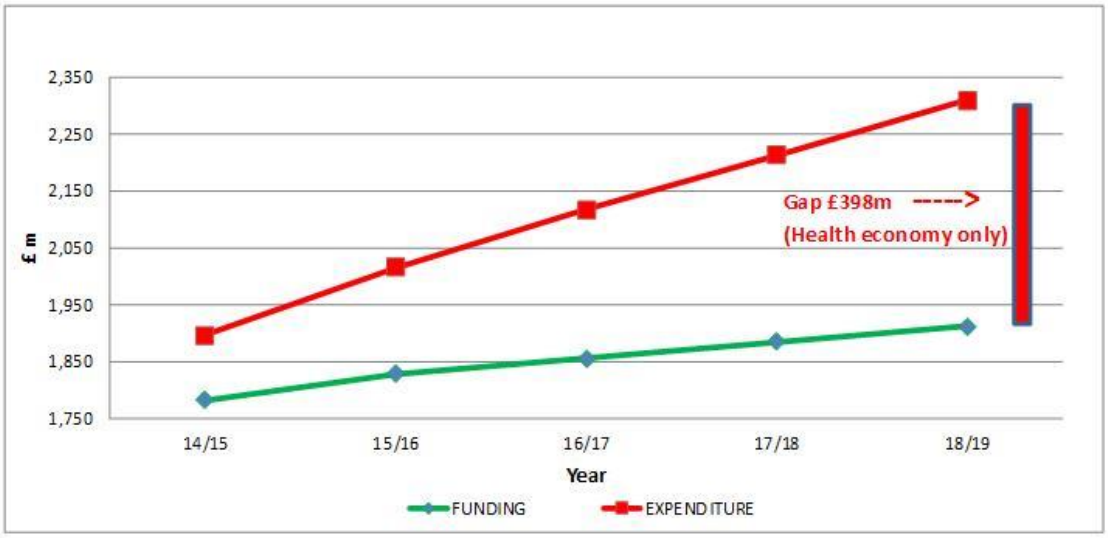
The Trust's future success as a sustainable NHS foundation trust requires rapid and significant change to the fundamentals of the underlying business and clinical models currently in place. Given the scale of deficit the Trust has developed a medium-term financial recovery plan (five to seven years) as part of the Trust's Integrated Business Plan (IBP). The plan is to first make substantial changes to the elements of the business most directly within the Trust's gift, such as reducing length of stay, seven day services, increasing day case volumes, standardising clinical protocols for discharge, and rapid turnaround of tests.

UHL will then address the economic drag of running three sites and build on a clinical consensus for a reconfigured estate by consolidating all acute services. This will enable patients and clinicians to benefit from properly co-located services and thereby removing double and sometimes triple running costs of three acute hospitals. Estates reconfiguration across UHL and Leicester Partnership Trust (LPT) is discussed in section 7.1 of this document.

Based on an outturn deficit of £39.7 million for 2013/2014 UHL's financial plan for 2014/2015 is a deficit of £40.8m. This position reflects investment in workforce in response to the nursing acuity review, delivery of an internal cost improvement programme of £45m, robust cost control including vacancy management, targeted recruitment campaigns for the key professions (to reduce premium spend) and increasing the productivity of fixed costs already in place.

For the Leicester, Leicestershire and Rutland (LLR) Unit of Planning system, a Long Term System Model (the "Model") has been constructed to articulate what would happen when faced with the challenges described in the "A Call to Action" NHS England document as applied to LLR. If no action were to be taken namely; to improve the quality, outcomes and value for money of services currently provided to patients; to develop new services, then the model predicts a financial gap over the next five years that rises to £398m by 2018/19.

Table 5: 'Do nothing' financial gap 2014-19



	£ m				
INCOME & EXPENDITURE	14/15	15/16	16/17	17/18	18/19
FUNDING	1,783	1,829	1,856	1,885	1,912
EXPENDITURE	1,896	2,016	2,117	2,213	2,310
"DO NOTHING" GAP	(113)	(187)	(261)	(328)	(398)

We recognise that the local authorities in the LLR system face very significant financial pressures. This being a result of the continued reduction in funding allocations received to the extent that by 2018/19 a collective savings requirement of £177m is predicted (Leicester City Council £64m, Leicestershire County Council £110m, Rutland County Council £3m). This estimate excludes any pressures from the Care Act 2014 and could be impacted by increasing demand for statutory Adult Social Care services and inflation. These factors will need to be taken into account and be incorporated into the next iteration of the model.

It means that in addressing the £398m challenge attributed to NHS-related services we also need to work closely with local authorities and in particular with Adult Social Care (ASC) services to ensure that the overall health and social care system remains in balance. To that end the next version of this submission will include a social care strategy which will describe the interventions necessary to address any impact on ASC services from the financial challenge facing local authorities. Therefore, we will need to work together to ensure we achieve the best possible outcomes all partners across the health and social care system.

The solution must be a combination of:

- Existing commissioner savings plans e.g. CCG QIPP plans
- Provider cost improvement plans (CIPs)
- Additional whole health and social care economy interventions (see chapter 6).

An initial indicator of the potential to deliver quality improvements to services as well as value for money can be derived from Better Care Better Value (BCBV) indicators and Commissioning for Value

packs. The quarter two 2013/14 BCBV indicators relating to UHL and the three CCGs are shown below.

Table 6: Better Care Better Value indicators for UHL

Indicator	Rank	Financial Opportunity (25th percentile)	Financial Opportunity (10th percentile)
Reducing Length of Stay	73	£3,800,000	
Emergency Readmission (14 day)	148	£3,700,000	£4,600,000
Managing First Follow Up	55	£2,300,000	£4,300,000
Pre-Procedure Non-Elective Bed Days	123	£947,349	£1,500,000
Pre-procedure Elective bed days	141	£317,067	£372,786
Outpatient Appointment DNA	42	£259,261	£624,910
Increasing Day Surgery Rates	128	£253,769	£375,292
Sickness Absence – Provider		£0	
Total opportunity (quarterly)		**£11,577,446**	**£11,772,988**
Total opportunity (annualised)		**£46,309,784**	**£47,091,952**

Table 7: Better Care Better Values indicators for CCGs – primary care performance

Indicator	Rank	Financial Opportunity (25th percentile)	Financial Opportunity (10th percentile)
NHS East Leicestershire and Rutland:			
Outpatient Appointments	19	£1,400,000	£2,200,000
Emergency Admissions	9	£665,289	£1,200,000
Managing Surgical Thresholds	49	£258,991	£364,526
Leicester City CCG:			
Outpatient Appointments	199	£2,000,000	£2,700,000
Emergency Admissions	197	£1,400,000	£2,000,000
Managing Surgical Thresholds	152	£172,158	£238,351
West Leicestershire CCG:			
Outpatient Appointments	113	£1,400,000	£2,300,000
Emergency Admissions	86	£782,139	£1,300,000
Managing Surgical Thresholds	126	£289,053	£396,617
Total commissioner opportunities (quarterly)		**£8,367,630**	**£12,699,494**
Total Commissioner opportunities (annualised)		**£33,470,520**	**£50,797,976**

BCBV indicators suggest that if UHL and commissioners performed at 25th best percentile, there would be a total annual saving of £79.8m for the health economy (£46.3m at UHL and £33.5m across the CCGs). If these organisations performed at 10th best percentile, there would be an annual saving of £97.9m. The largest provider opportunities come from reducing emergency readmission and managing first follow up rates. The largest CCG opportunity comes from managing outpatient appointment rates.

The Commissioning for Value packs suggest potential commissioner savings of £17.5m if organisations performed at the average for the "similar 10 CCGs peer group". If organisations performed at the average of the best five CCGs in the "similar 10 CCGs peer group" there are additional potential savings of £28.3m. Value opportunities are based on areas where a LHE is an outlier compared to national data, suggesting these areas will most likely yield the greatest improvement to clinical pathways and policies.

The *Commissioning for Value* data packs provide an alternative cut of potential commissioner savings by focusing on disease groups rather than settings of care. Nevertheless the results triangulate with the BVBC indicators and indicate commissioner LLR-wide savings of £47m are possible based on achieving the average of the best five of ten "peer" CCGs, as shown below:

Table 8: Commissioning for Value benchmark savings

LLR, £000s	Elective admissions	Non-elective admissions	Prescribing
Cancer	3,426	1,869	20
CVD, circulation	5,892	7,095	796
Endocrine, nutrition, metabolic	156	630	3,191
Gastrointestinal	604	3,222	1,841
Genitourinary	594	3,304	174
Maternity, reproductive	488	-	48
Mental health	-	-	507
Musculoskeletal	-	672	611
Neurological	1,654	3,366	369
Respiratory	1,115	2,622	868
Trauma	-	1,569	166
	13,929	**24,349**	**8,591**

Source - Commissioning for Value insight packs, Leicester, West Leicestershire and East Leicestershire & Rutland CCGs

Whilst this data by nature is indicative and imprecise, there is clearly scope for investigation and targeting of initiatives. Nevertheless, making productive improvements to current services alone will not wholly address the financial challenge.

In addition to Commissioning for Value, we have used a range of resources to support the planning process for this five-year strategy, aligned to the process used for the two year Operational Plans and our Better Care Fund plans. Acknowledging the scale of the challenge we face over the next five to 10 years in achieving the goals set out in *Everyone Counts* (such as a 15% reduction in emergency hospital activity, seven-day working models of care and modern models of integrated care), we recognise the need to think differently and radically. We need to enable a move towards a sustainable model of care locally and to do so; we have used a range of information, guidance and support, including national and international evidence-based examples of best-practice. These are set out in Appendix 3.

In 2013, healthcare modelling work predicted that the scale of the financial challenge could only be addressed through a fundamental re-design of services, while providers deliver cost improvements. Our more recent analysis re-affirms that conclusion. Consequently, the strategic interventions described in the 2013 work (including assumptions therein) form the basis of the care models discussed in chapter 4 of this document and the interventions discussed in chapter 6.

The case for change – value for money

- All health and social care organisations in LLR need to achieve financial sustainability, in a time of financial constraint
- Commissioners will need to make phased savings to deliver investments in the models of care that will provide the highest quality and best outcomes for patients and citizens
- The scale of the financial challenge facing LLR can only be addressed through a fundamental redesign of services coupled with provider cost improvement programmes
- Strengthen primary, community and voluntary sector care, to deliver integrated care, maximising the use of physical assets, supporting self-care, exploiting IM&T, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system

4 Our vision for LLR

4.1 Values and principles

The LLR strategy is based on the following values and principles:

- We will work together as one system to realise our vision
- We will put citizen participation and empowerment at the heart of decision making
- We are committed to addressing the inequality between mental health and physical health services
- We will improve outcomes and reduce inequalities for our citizens by striving to be 'best in class', using evidence-based models which comply with our equality principles
- We will maximise value for our citizens by rigorously assessing how we allocate and use our resources.

These values and principles have underpinned the process of working together to develop a vision, our strategic aims and objectives, for delivery across our settings of care.

4.2 Overview of vision

Our vision for the system is to:

> *…maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings.*

This vision has been agreed across all partners on the BCT Board, with every underpinning programme described further in this strategy contributing to making this vision a reality.

The partner organisations on the Better Care Together Programme Board recognise the scale of the challenge that lies ahead for this health and social care economy. The Board is committed to delivering the transformative system reform required without compromising on the outcomes of our citizens or the quality of services that are available.

Underpinning our vision are the 'big ideas' that have been modelled to enable us to reach our vision. Using both the commissioning intelligence detailed above and that of the economic modelling undertaken to date, these ideas are presented below.

4.3 Strategic aims and objectives

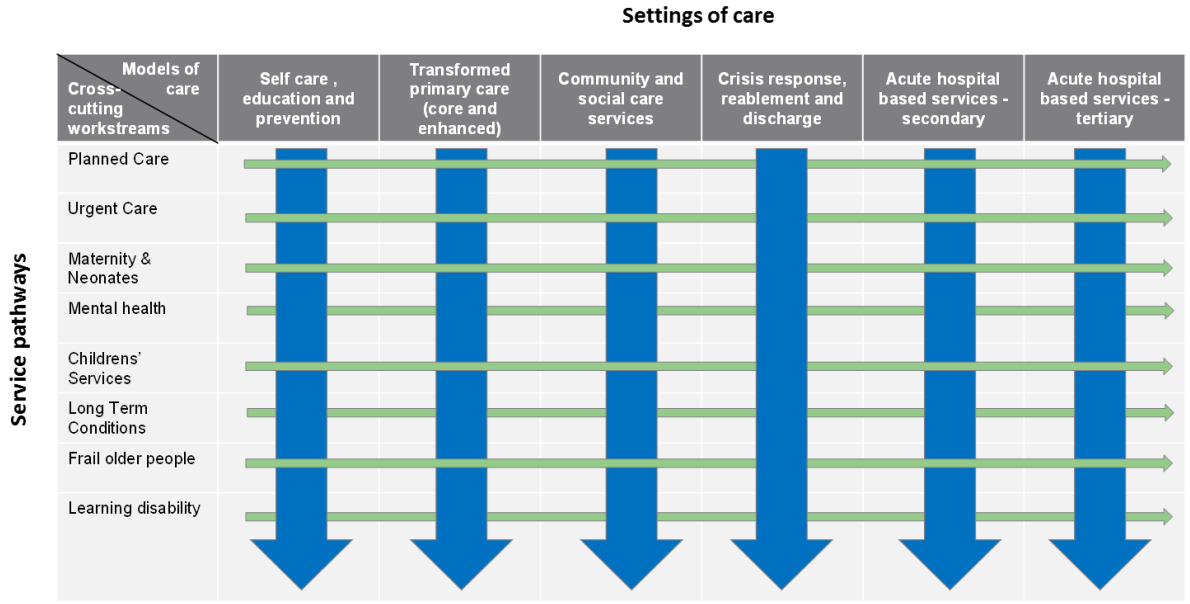
The system objectives which will deliver our vision, are as follows:

- **System Objective One** - to deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital
- **System Objective Two** - to reduce inequalities in care (both physical and mental) across and within communities in LLR resulting in additional years of life for citizens with treatable mental and physical health conditions
- **System Objective Three** - to increase the number of those citizens with mental and physical health and social care needs reporting a positive experience of care across all health and social care settings
- **System Objective Four** - to optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system
- **System Objective Five** - all health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate
- **System Objective Six** - to improve the utilisation of our workforce and the development of new capacity and capabilities where appropriate, in our people and the technology we use.

4.4 Settings of care

To respond to the case for change and deliver on the strategic aims and objectives we have developed a model based on settings of care and service pathways. Settings of care range from self-care, education and prevention through to acute hospital based tertiary services. Service pathways are the eight service pathways which offer the greatest transformational opportunity; each has been applied to the settings of care to develop improvement interventions in the appropriate setting of care (see section 6). Each of the service pathways will impact across six settings of care as illustrated below:

Figure 12: Aligning service pathways to settings of care



The settings of care, their purposes and standards, are set out below.

4.4.1 Self-care, education and prevention

Purpose and principles of the future model

Overall purpose of this model of care

- Self care and prevention are at the heart of our care system

Principles

Our model of care will enable:

- A good start - for everyone to have a good start in life
- Living well - for people to live well, making healthier choices and living healthier lives
- Coping well - that people cope well and have help and support people to improve their own health and wellbeing, to be independent and reduce their need for traditional health and social care services where we can

Required standards

- 2% of high risk patients to have a care plan
- IAPT access rates of 17% 2014/15 and 20% 2015/16
- Increase in cancer diagnosed at Stage 1 and 2
- Increase in self reporting of well being
- Increase in the health related quality of life for older people
- Increase in diagnosis rates for people with dementia
- Reduction in falls and injuries in people aged 65 and over
- Increase take up of Health Checks

Aspirational standards

- People have less reliance on residential and nursing care
- Increased use of assistive technology
- Increase in number of patients accessing lifestyle advice

4.4.2 Transformed primary care

Purpose and principles of the future model

Overall purpose of this model of care

- National service direction is for wider primary care services provided at scale, recognising the challenge that smaller standalone providers face in dealing with rising population need within constrained financial resources.

Principles

- To reduce unjustified variation in quality of services
- To reduce unjustifiable inequalities in health outcomes and access to services for vulnerable groups
- To increase citizen participation and empowerment in primary care services
- To improve the quality of life for older people and those with long term conditions though implementing GP contract changes
- To improve access to primary care services and secondary care dental services
- To reduce unjustified variation in funding received by providers

Required standards

- Secure additional years of life for people with treatable mental & physical health conditions
- Improve health-related quality of life for people with one or more long-term conditions
- Reduce avoidable time in hospital through better more integrated care in the community
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people having a positive experience of care outside hospital
- Reducing health inequalities
- Parity of esteem
- Implement GMS contract changes for 2014/15 e.g. personalised care for older people and those with complex needs

Aspirational standards

- Proactive care management of at least 2% of patients with complex needs and at the high risk of emergency admissions (supporting the Community and Social Care Services aspirational standard around risk stratification)

4.4.3 Community and social care services

Purpose and principles of the future model

Overall purpose of this model of care

To deliver integrated, co-ordinated care which places the patient and their carers at the centre. From a patient's point of view '*My care is planned with people who work together to understand me and my carers, put me in control, and co-ordinate and deliver services to achieve the best outcomes for me.*'

Principles

- Locality based care to ensure people receive care as close to home as possible, supported by specialised services and unscheduled care
- Integrate pathways and teams with Adult Social Care
- Smooth patient journey which delivers high quality care in an efficient way, meeting patient expectations and clinical need; new approach to referrals, assessment, care planning, delineation between planned/unscheduled care, required interventions, self-care, standardised MDT approach and transfer/discharge
- Workforce that is fit for purpose and has the skills to deliver high quality and effective care to patients and work in new ways; competency-based assistant practitioners, some specialist roles becoming multi-faceted, standardisation of roles, flexible working and mobile working
- Embedding a common culture and principles that allows community services to achieve its aim; staff engagement to create a culture statement and shared statement of principles

Required standards

- Reduce unnecessary attendances, admissions and lengths of stay at UHL
- Improve community hospital provision and rationalise estate
- Deliver integrated care for frail older people/LTCs; locality-based MDT teams with community-based specialists (supported by secondary care clinicians)
- Develop clear step up & down protocols for community beds/packages of care
- In-reach into planned/unscheduled care teams

Aspirational standards

- Systematic use of risk stratification and case finding (supporting the Transformed Primary Care aspirational standard around proactive case management)

4.4.4 Crisis response, reablement and discharge

Purpose and principles of the future model

Overall purpose of this model of care

- To improve the experience of urgent care for frail older people, and those with multi-morbidities, bringing care closer to home where it is clinically and financially viable to do so. It will be used to avoid unnecessary admissions and provide early supported discharge in line with "discharge to assess" principles

Principles

- We will integrate pathways, offering our population the safest, lowest cost option
- We will work together, across service, setting and organisational boundaries, to improve outcomes
- We will keep patients and services users at the centre of our model and focus on maximising recovery
- We will simplify the urgent care system and its pathways
- We will add capability into existing core community services to respond rapidly
- We will offer ambulatory care pathways that meet the need

Required standards

- 7 day working in hospital discharge services and associated supporting services
- Ambulatory Care pathways captured in the institute handbook
- DTOC's
- Upper quartile performance on LOS for the cohort (2, 7, 21)
- Shared access to care plan and NHS number recording
- Deliver a reduction in the overall number of permanent admissions to residential and nursing care homes .
- Reduce the number of falls
- Readmissions rates
- Mortality

Aspirational standards

- Everyone who may benefit from it receives an intensive, integrated reablement service
- Increase utilisation of rehabilitative services to optimise older adults outcomes
- Reduce use of CHC to cover service gaps
- Improve beyond upper quartile performance on LOS for the cohort (2,5,15)
- Pre-operative or intervention rehabilitation

4.4.5 Acute hospital based services – secondary care and tertiary care

Purpose and principles of the future model

Overall purpose of this model of care

Smaller, more specialised acute hospitals where enhanced recovery pathways, short length of stay and smooth transfer of care back to primary care is the norm. The majority of elective services will be delivered outside an acute hospital, in the local LLR community optimising the benefit of the Alliance Contract.

Principles

For local services we will reduce the reliance on acute in-patient care

- People will only be in an acute hospital bed when clinically necessary
- Reorientation of pathways away from the current model on acute, episodic hospital based care towards prevention, self-care in the home, improved access and performance in primary/community care.
- Early supported transfer of care into the most appropriate, lower acuity and cost setting will be the norm.

For Specialised services we will simplify, standardise and share

- Rationalise number of providers through the consolidation of services into fewer, higher acuity settings, sharing resources, serving a larger population, driving up clinical standards and improving outcomes.
- UHL will co-locate appropriate service lines within the Trust (e.g. cardiac and vascular)
- UHL will work with other specialised services and the Academic Health Science Network across the East Midlands (north and south) to speed up the pace with which translational research is put into practice
- We will proactively respond (and exceed) nationally set service specifications and achieve the necessary scale and pace of change to in cost efficiency and outcome improvement.

Required standards

- Meeting the recommendations of the Keogh review
- 90% compliance with BADs basket of procedures
- Multidisciplinary safe staffing levels including College of Emergency Medicine standards around A&E staffing levels
- 7 day services
- Compliance with performance standards e.g. ED, RTT
- Reduction on the amount of time people spend avoidably in hospital by 10% (LLR POaP)
- 20% increase in the productivity in elective care (LLR POaP)
- Elimination of avoidable death in hospitals caused by problems in care
- Increase in the number of people with mental and physical health conditions having a positive experience of hospital care
- Financial breakeven by the end of 2018/2019

Aspirational standards

- Upper quartile performance across key performance measures for elective surgery; and where upper quartile is already being achieved, aspiration to reach top decile
- Utilisation of physical assets to ensure care is provided in the most appropriate setting
- Reduction in the LLR footprint by 40-50%, including a reduction in acute and community hospital sites
- 20% reduction in hospital emergency activity and a 20% increase in productivity of elective care (LLR POaP, March 2014)

4.5 Primary and social care

As a result of developing the case for change, the strategic aims, and the purposes and standards for each setting of care, we have recognised that, as the health and social care system, we need to develop strategies for primary and social care provision, that are aligned to the case for change and our transformation proposals. We will, within such a new system, respond to:

- The differing profiles of existing services provided and requirements for future service provision for both city and our rural based communities
- The requirement for a strategic response to primary medical services, recognising alongside this the importance of developing the full range of primary care services, i.e. pharmacy, dentistry, etc. to align with the proposed new models of community and secondary care
- The present and future requirements will need to include key areas, including future workforce requirements and service and site configuration
- The requirement for social care to build on the existing Better Care Fund two-year plans by identifying next steps, future service models and activity and capacity requirements. Within this review we will consider the future impact of the Care Act
- The opportunity to ensure 'care closer to home', 'best practice' and 'external learning ' informs the review, such as the findings of Claire Gerada relating to inner city London practices.

It is proposed that this strategy development will build on the discussion from the June 2014 LMC primary care summits, and be scoped in July 2014 by the CCG chairs, supported by the Better Care Together partners (managing directors/operations directors/local authority leads) and with representatives from the LMC and the Area Team. Wider partnership and public engagement on the proposed scope will be agreed by the end of August and a proposal approved for the reviews to commence in September.

4.6 Better Care Fund

All three CCGs and local authorities are implementing service model changes associated with the Better Care Fund (BCF) – see appendix 5. These will each have an impact all settings of care, except perhaps for tertiary care. All three CCGs have made a five rather than two year commitment to using BCF to drive change (see appendix relating to modelling assumptions). The size of BCF funds for the next two years is summarised below.

Table 9: Better Care Funds

Local authority	Fund (£m)	
	2014/15	2015/16
Leicester City	14.8	23.2
Leicestershire	18.2	38.4
Rutland	0.8	2.2
Total	**33.8**	**63.8**

Source: Planning information provided by LLR CCGs

The three BCF plans reflect broadly similar ambitions, mirroring those of the five year strategy, but allowing for flexibility of local implementation. The plans outline how we will maximise the

opportunities presented by the fund to lever real transformational change, thereby delivering our five year vision.

The fund will be used to drive integration and improve outcomes for patients, service users and carers. People rarely need support from a single service as they age, or if they are vulnerable through ill health, disability, injury or social exclusion/isolation. Our aim is to provide information, services and support in a coordinated way across agencies and to provide it as early as possible, anticipating future needs as well as addressing immediate needs in the most appropriate setting.

We want people to be able to access a range of support early enough, including through social and community networks, thereby empowering them to take control of their health and wellbeing, live healthier lives and maintain their independence for longer.

By investing in prevention we expect to see a reduction in the number of people accessing services in a crisis or inappropriately, and an increase in the provision of care interventions that offer optimum independence within a supportive community.

The strategic objectives listed at 4.3 underpin successful delivery of our BCF plans. They will support maximisation of the major opportunity presented by the BCF to really do things differently.

We have combined our priorities and activities into themes, under which sit a range of interventions that will support implementation, including: single point of access, 24/7 services integrated across health and social care, urgent community response services within two hours, and case management for over 75s. The themes generally across the three BCFs are:

- Citizen participation and empowerment
- Prevention and early intervention/detection
- Integrated crisis response
- Improving hospital discharge and reablement
- Integrated, proactive care for people with long term conditions.

These themes will directly contribute to both a high quality sustainable model of care. The performance and effectiveness of the changes will be measured through:

- Reduction in avoidable emergency admissions
- Reduction in delayed transfers of care
- Reduction in residential admissions
- Improved effectiveness of rehabilitation after discharge from hospital
- Improved patient/service user experience.

Whilst each of the three Health and Wellbeing Boards has set area-specific targets for each measure, a total cumulative impact across LLR is also being measured. These performance measures will also contribute to the delivery of specific outcomes from the NHS, Adult Social Care and Public Health Outcomes Frameworks.

In **Leicester** the Better Care Fund is a key strategic driver to the delivery of the Better Care Together Strategy particularly in the Frail Older People, Long Term Conditions and Urgent Care workstreams (see section 6). The following outcomes will be achieved from the Better Care Fund interventions:

- Prevention, early detection and improvement of health-related quality of life:
- Reducing the time spent in hospital avoidably:
- Enabling independence following hospital care:

The **Leicestershire** Better Care Fund plan is a countywide plan. The aim of which is to deliver support to the citizens of Leicestershire in a co-ordinated way when they find themselves in need of services. The plan recognises that people rarely need support from a single service as they age or if they are vulnerable through mental ill health or disability. In the past our populations have told us that they find it difficult to navigate between services and feel that there are barriers in the way as they move between health, social care and other statutory services. The barriers that citizens find as they try to access different statutory services are not understandable or acceptable to the population we serve. As a result, this plan aims to reduce and eventually remove those barriers by working towards a fully integrated service provision with people at the centre of the services that we deliver

Rutland Council and East Leicestershire and Rutland Clinical Commissioning Group are using the Better Care Fund as an enabler towards the Rutland Better Care Fund Vision:

"By 2018 there will be an integrated social care service that has significantly reduced the demand for hospital services and puts prevention at its heart"

The three key themes are – Early Intervention and Prevention, Step up/step down care and Long term conditions. The projects for these themes are in development and initial plans include developing information and advice services to manage demand, an integrated crisis response service that will contribute to admission avoidance, Reablement services joined up with health teams to improve discharge from hospital, an integrated health and social care hub locally to make the most efficient use of resources and improve user experiences.

Examples of how the BCF plans, aligned with this five-year strategy, deliver real benefits for patients and social care clients across LLR, are provided in the box below.

Mrs Smith is 78 years old and lives alone following the death of her husband two years ago. She is known to her GP but does not have any underlying health conditions. She has been fit and active with normal coughs and colds and the occasional chest infection.

One day in early June 2014, she felt unwell at about 6pm, feeling feverish and lethargic and suffering from lower back pain. She felt unwell enough to call 999. EMAS took the call and Mrs Smith was clinically triaged by the Clinical Assessment Team. The nurse who completed the triage downgraded her call from a G1 (serious but non-life threatening) to a G3 call (non-life threatening, non-emergency) and dispatched the Clinical Response Team.

The CRT GP arrived within 20 minutes of Mrs Smith's call and she was assessed and treated with antibiotics. The GP also noted that Mrs Smith was unlikely to be able to cope on her own over the next few days and so referred her to the Unscheduled Care Team (UCT) for a full holistic assessment of need to keep her safe and well at home for the next 72 hours. The team provided the following:

- *Full assessment, including assessment by physiotherapist relating to concerns about patient's ability to transfer safely.*
- *Put in package of support to help with personal care, .with meal preparation and assistance to drink.*

- *Perching stool ordered.*

Upon further investigation by the UCT, it was discovered that Mrs Smith was also mismanaging her medicines because she was confused as to which ones she should still be taking and when to take them. The UCT requested Mrs Smith's own GP to provide an urgent medicines use review and this was sorted out over the next 24 hours.

After three days Mrs Smith was well enough to be discharged back to routine care with no residual package. Prior to the Better Care Fund services being in place Mrs Smith would more than likely been taken to hospital and admitted.

Chris is 46. He had been living with his mum but she died suddenly around six months ago. Chris had worked at a local factory but has subsequently been dismissed for non-attendance. Attending the property it is found to be in very poor state, the electricity and gas have been disconnected through none payment of bills and the landlord is seeking to take possession of the property. Chris is an avid Dr Who fan, he has all the episodes on tape and DVD and can tell you who played which part , he is also very keen on the following the stock market prices but he has never paid a bill, his mum did all of that. His neighbours have said he was very close to his mum and they went everywhere together.

Chris has never been ill before. His GP can't find any record of him attending surgery since his early teens, although his mum had been a patient through her short illness.

Chris is in hospital. He was brought to the hospital last night by the police and has been detained under the Mental Health Act for assessment.

He is agitated and very distressed and workers are struggling to connect with him.

How has Chris ended up in this position?

In the case study of Chris, it is clear that Chris's mother was his carer and supported him to meet his activities of daily living in such a way as to mask his basic lack of competency in this area. Her death almost inevitably led to a sequence of events where Chris spiralled into increasingly difficult circumstances that were well beyond his capacity to cope with. From the point she died Chris needed our support to ensure that he could carry on supporting himself, but he was largely invisible to us with the current service configuration that we have. The Better Care Fund has ambitions to help people like Chris by configuring our service offering differently.

This case is an example of where Local Area Co-ordination (LAC) can make a difference. If LAC were available to GP's, when Chris's mother illness became very serious, her GP could ask the question 'what is her main worry about her illness'?

4.7 Alignment of plans

The vision, objectives and new care models set out in this document align with a range of other plans, and with the outcomes of public engagement. In summary, there is alignment with:

- Operational Plans across Leicester City, Leicestershire and Rutland
- The "Call to Action" engagement programme.

These alignments are set out in more detail in Appendix 2.

4.7.1 Alignment of our ambitions to clinician, staff and citizen views

Citizen participation is a key principle of the LLR Better Care Together strategy programme recognising the scale of our ambitions for transformative change, we have adopted a bottom up approach to the development of our plans for the next five years.

A launch event with over 200 LLR patients, stakeholders, staff and public was initially held to outline the magnitude of the challenge faced. Five key conditions were introduced and prioritised by the attendees:

- Cardio vascular disease
- Respiratory disease
- Mental health
- Dementia
- Cancer.

Following this launch event, we held a series of workshops for each condition involving many patients, stakeholders, staff and the public, ensuring full engagement and involvement of clinicians across primary, community and secondary care. The objective of these workshops was to determine the key interventions for each of these five areas which would result in improve outcomes and result in a financially sustainable system. This work is aligned with the whole Better Care Together programme through the Long Term Conditions, Frail Older People and Mental Health pathways.

4.7.2 Alignment of our ambitions to local Joint Strategic Needs Assessments

The five year strategy is underpinned by the JSNAs developed by Leicester City Council and Leicestershire and Rutland County Councils. The Health and Wellbeing Boards have identified a number of key priorities that have been collaboratively agreed in their health and wellbeing strategies. The strategic decisions that are made across LLR are all underpinned by a comprehensive JSNA as the starting point for the priorities.

The five themes identified are similar for all three Health and Wellbeing Boards and are based on the individual JSNAs for the area. The JSNAs have a significant commonality of themes. The relationships between the current strategic priorities have been mapped to the five year strategy. Full implementation of the five year strategy will have a positive contribution to the three JHWS and help to address the health and wellbeing needs identified in the JSNAs.

5 Achieving a sustainable local system

By 2019, realisation of the vision, through implementation of new models of care – exemplified by the interventions discussed later in chapter 6 – will mean that LLR will be a significantly changed health and social care system. In this chapter we show how these changes will result in a sustainable system, having responded to the case for change described in chapter 3:

- Transforming the health and social care system
- Meeting the needs of our changing population
- Ensuring our workforce meets the health and social care needs of our population
- Delivering value for money.

The first three are discussed with reference to:

- The six characteristics of a high quality, sustainable health and care system
- NHS England's seven improving outcome ambitions.

5.1 The six characteristics

In *Everyone Counts: Planning for patients 2014-2019*, NHS England specify six key characteristics of a high quality, sustainable health and care system. Our models of care (and the initiatives that support them) will mean that the LLR health and social care economy will reflect these characteristics.

Table 10: Reflecting the six characteristics

Characteristic	Reflected by
A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	Citizen engagement has been fundamental to preparation of this directional strategy. It will continue to be. This is shown in sections 2.1, 3.1, 0, 7.3 and 8.4.
Wider primary care, provided at scale	The development of primary care is fundamental to the 'left shift' of care discussed in this plan. Changes in primary care – alongside community-based health and social care services – are discussed in sections 4.4, 4.5 and through chapter 6.
A modern model of integrated care	Again, the modernisation of health and social care is reflected in the vision, objectives, settings of care changes and service models (4.2, 4.3, 4.4). They are then exemplified by the interventions set out in chapter 6.
Access to the highest quality urgent and emergency care	New models and interventions for urgent and emergency care are described at 4.4 and 6.1; and are reflected in changes to care for the frail and elderly and for long term conditions in sections 6.2 and 6.3.
A step-change in the productivity of elective care	Elective care changes are discussed at 6.4.

Characteristic	Reflected by
Specialised services concentrated in centres of excellence	The shift to more appropriate use of acute facilities is implicit and explicit through discussion of settings of care, service models and interventions. Specific reference is made in section 4.4

5.2 Meeting the seven improving outcome ambitions

NHS England has set out seven ambitions for the five year planning period. This strategy addresses these, as shown below.

Table 11: Delivering the seven improving outcome ambitions

Ambition	Addressed by
Improving health – working together with the Health and Wellbeing Board to ensure the key elements of commissioning for prevention are delivered	The need for change to meet the needs of the population is discussed in chapter 3, with linkages to HWB planning in sections 4.7, 8.6 and Appendix 2. Prevention is a key element of the service models and interventions set out in this strategic plan.
Increasing the proportion of older people living independently at home following discharge from hospital	This is fundamental to the changed settings of care and new service models – sections 4.4, 6.2 and 6.3.
Securing additional years of life for the people of England with treatable mental and physical health conditions	The need for securing a longer, healthier life was discussed in chapter 3. This has been translated into specific developments in 4.4 and underpins the interventions in chapter 6.
Improving the health-related quality of life of the 15 million+ people with one or more long-term conditions, including mental health conditions	Again - sections 4.4, 6.2 and 6.3; as well as 6.7.
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	The settings and models of care are designed to deliver a marked left-shift to community-based care – sections 4.4, 6.1, 6.2, 6.3, 6.6, 6.7 and 6.8.
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Section 4.4 addresses the development of high quality and safe hospital care, in terms of secondary and tertiary care.
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Section 4.4 and 6.7 address quality and safety of care in mental health settings.

As well as meeting the seven ambitions, the LLR strategy addresses additional key measures:

- **Parity of esteem –** ensuring patients with mental health problems have their physical and mental health needs addressed equally
- **Reducing health inequalities –** ensuring the most vulnerable in our society get better care and better services through integration, in order to get better health outcomes.

It also evidences **citizen engagement**, as the contents of this plan have been designed with the input of a range of stakeholders; and will be further refined through 2014 with further engagement of LLR patients, social care clients, public, staff and others.

In chapter 6, the specific interventions that we will take to achieve the above are outlined in greater detail. In the following chapter, we illustrate how the strategy and service models will achieve a sustainable high-quality health and social care economy, by 2019.

6 Improvement interventions

This chapter outlines the transformational interventions – aligned with the new service models described in chapter 4 – that we will implement to help move the LLR health and social care economy from the current state to delivery of our vision. These interventions when combined with existing QIPP plans and provider CIPs will deliver the scale of financial saving required and will transform the quality of care.

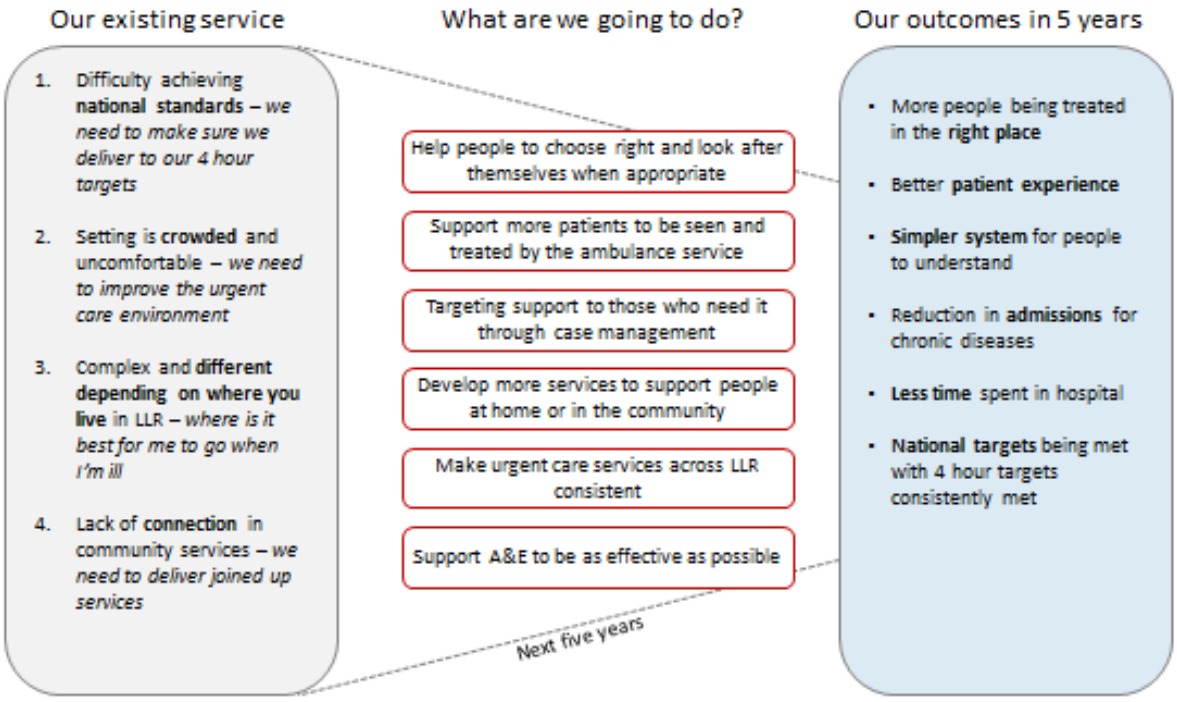
The Better Care Together Programme Board recognises that the gap between our current state and where we need to get to is substantial and the scale of these changes reflects this. The need to make brave decisions that will ultimately benefit our citizens is the challenge that we will face throughout this process and we are committed to putting our citizens at the heart of these conversations in a transparent manner.

As we progress on this journey, we will further refine the information presented in this chapter, ensuring triangulation of each intervention between quality, finance and outcomes. This will include further analysis of the scale of the interventions to ensure that they are of sufficient scale to deliver our objectives as well as concurrent pathway and process analysis to identify any potential negative impacts within the system. We will also continue to gather feedback from our citizens and apply this where possible to our ongoing programmes of work.

The overall impact of our interventions will be to achieve a “left shift” of activity by reducing the amount of activity undertaken in settings such as acute hospitals and shifting activity “to the left” i.e. into alternative settings of care. Although the focus of our strategy is often portrayed as reducing the use of the acute sector it is important to recognise that the “left shift” principle also applies to other settings of care for example, reducing length of stay in community hospitals for the current cohort of community hospital inpatients and encouraging self-care to free up capacity in primary care.

Each set of interventions is discussed below, while appendix 4 provides the evidence base underpinning the interventions.

6.1 Urgent care



6.1.1 Case for change

Our rationale for changing the way urgent care is delivered across LLR is based on five challenges:

- We are experiencing difficulty achieving national standards, for example we need to make sure we deliver to our four hour targets
- Existing urgent care settings are crowded and uncomfortable – citizens tell us that we need to improve the urgent care environment
- Navigating the urgent care system is complex and different depending on where you live in LLR, for example alternatives to A&E can be confusing with different models in place between different urgent care and minor injuries units. Patients and their families need to know where is it best for them to go when they are ill
- Urgent care services are not well connected to community health services – we need to deliver joined up services so, for example the ambulance service is aware of elderly frail patients being case managed by community staff
- We need to deliver on the national ambition to reduce emergency admissions to hospital.

6.1.2 Our key aims and the link to our vision and objectives

Our urgent care intervention aims are to deliver high quality safe urgent care for the population of Leicester, Leicestershire and Rutland, delivered to common standards regardless of setting (minor injuries unit, urgent care centre etc). Urgent care will be delivered using best practice models in locations that are easily accessible to local population. The new model will also ensure better integration between primary and secondary care services.

Our urgent care interventions will contribute towards the delivery of all six LLR strategic objectives. Much of the work that will deliver our urgent care agenda is covered in the Frail Older People and

Long Term Condition workstreams. These patients are most at risk of presenting at A&E and in many cases if a different model of care, more suitable to their needs, was available, they would be able to stay at home or in the community. In addition to Frail Older People and Long Term Condition workstreams, an Urgent Care Action Plan has been developed which sets out the action partners across LLR will undertake over the next 12 months to deliver a sustainable A&E position. This Action Plan covers demand management, 'flow' within A&E, hospital bed flow and delayed transfers of care. It supports the delivery of our strategic aims and objectives, in particular by:

- Delivering urgent care in the appropriate place and at the appropriate time by the appropriate person (objective one)
- Reducing the inequalities in accessing urgent care that currently exist across LLR (objective two)
- Helping to increase the number of people with a positive experience of urgent care services (objective three)
- Improving the use of physical assets (objective four)
- Reducing urgent care costs to commissioners (objective five)
- Developing new capacity and capabilities amongst our workforce (objective six).

6.1.3 The changes we will make

Our proposed changes within this workstream are:

- 'Choose Well' - helping people to choose the right service when they need help and encouraging them to look after themselves when appropriate. Local people will be supported to do this through more effect signposting of services.
- 'See and treat' – supporting the ambulance service to 'hear and treat' and 'see and treat' more people without conveying them to hospital.
- 'Targeting of those most at risk' - supporting those who need it through case management and greater primary care interventions
- 'Community-based urgent care' - developing more services to support people at home or in the community including developing integrated crisis response services
- 'Consistency' - making urgent care services across LLR consistent e.g. consistent range of interventions offered and consistent opening times.
- 'Effectiveness' - supporting A&E to be as effective as possible including delivering seven day consultant-led services

6.1.4 The outcomes we expect

We expect our urgent care interventions to deliver the following outcomes:

- National targets being met with 4 hour targets consistently met
- More people being treated in the right place – shift of 25% of A&E attendances (minors) being seen in an urgent care setting rather than an A&E setting by 2018/19
- Better patient experience - redevelopment of the A&E department
- Simpler system for people to understand (professionals as well as the general public)
- A 25% reduction in emergency department (ED) admissions for chronic diseases (see Frail Older People and Long Term Conditions interventions)

- Less time spent in hospital – 10% reduction in non-elective length of stay for those people who still need admitting

6.1.5 Financial impact

The cumulative financial impact of our interventions is summarised below.

Table 12: Urgent care financial impact (£000s)

	2014/15	2015/16	2016/17	2017/18	2018/19
Saving	£0	£0	£1,953	£2,017	£2,108

6.1.6 Timescales and milestones

Urgent care schemes will be introduced in years two, three and five.

6.1.7 Enablers and links to other workstreams

Our urgent care plans rely on changes in a number of enabling areas.

IM&T

- Single point of access
- Mobile devices to support mobile working
- Shared information systems required
- Need for a single care record which is accessible by those with a need to know across the H&SC community.

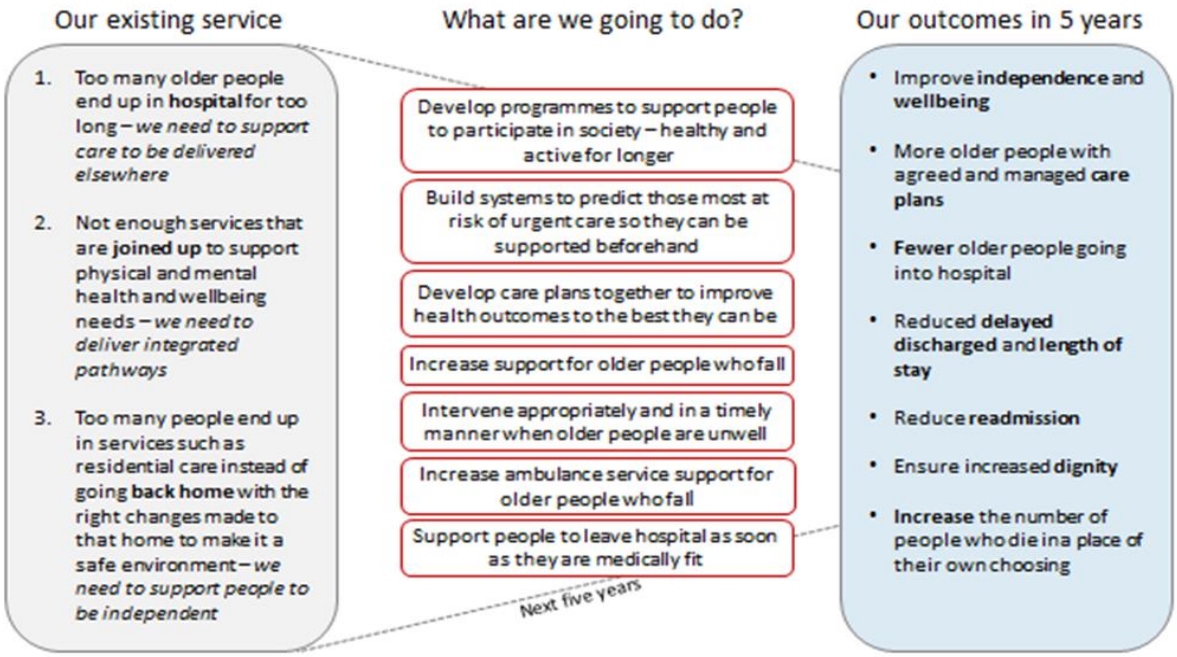
Estate

- Expanded ED planned for delivery
- Additional estate to support the shift out of acute setting (PC)

Workforce

- Acute physicians required to deliver 24/7 standards
- New roles and significant training, including primary care

6.2 Frail and older people



6.2.1 Case for change

We need to change the way we provide health and social care services to frail and older people because:

- The number of elderly people is forecast to rise in city and county
- Locally too many older people end up in hospital for too long – we need care to be delivered in or close to home
- Too many people end up in services such as residential care instead of going back home with the right changes made to that home to make it a safe environment – we need to support people to be independent
- Not enough services that are joined up to support physical and mental health and wellbeing needs – we need to deliver integrated pathways
- We accept the international and national evidence that integrated care pathways are needed to better support people with complex and multiple needs

6.2.2 Our key aims and the link to our vision and objectives

We aim to deliver high quality safe care for frail older people that is based on best practice; which is easily accessible; and which is joined-up. Our interventions will contribute towards delivering the LLR strategic objectives (see section 4 above) by:

- Delivering high quality, citizen centred, integrated health and social care pathways, delivered in the right place at the right time by the right person (objective one)
- Improving care outside of hospitals to the extent that we can reduce the time spent in hospital by the elderly and the frail (objective one)
- Reducing the inequalities in accessing care for older people that currently exist across LLR (objective two)

- Helping to increase the number of people with a positive experience of physical health, mental health (dementia) and social care services (objective three)
- Improving the use of physical assets by collocating different services to enable integration (objective four)
- Integrating health and social care services thereby eliminating duplication such as repeat assessments (objective four)
- Reducing urgent care costs to health and social care commissioners (objective five)
- Developing new capacity and capabilities amongst our workforce (objective six).

6.2.3 The changes we will make

Our proposed changes within this workstream are:

- 'Tackling social isolation and promoting health' - developing programmes to support people to participate in society aiming to help them to be healthy and active for longer
- 'Risk stratification and early intervention' - building systems to predict those most at risk of developing or accelerating the onset of frailty and proactively targeting interventions for the identified cohorts of the population
- 'Care planning' - developing care plans together with patients and their families, to improve health outcomes to the best they can be.
- 'Multi-disciplinary working' – the implementation of care plans through community based multi-disciplinary teams
- 'Community-based crisis response' - crisis services which are wherever possible home or community based including access to specialist support and support to those who fall
- 'Shortening hospital stays' - services and pathways which enable people to leave hospital as soon as they are medically fit, including reablement; intensive community support and supported discharge
- 'Choice at the end of life' - being clear with people who will not recover from their ill health and developing end of life care plans that reflect their wishes.

6.2.4 The outcomes we expect

These interventions will deliver the following improvements:

- Improved independence and wellbeing amongst the frail and the elderly as measured by fewer care home admissions
- More older people with agreed and managed care plans
- Fewer older people going into hospital – 15% reduction in admissions
- Reduced delayed discharged and length of stay
- A reduction in readmission rates
- Increased dignity as evidenced through patient surveys
- An increase in the number of people who die in a place of their own choosing
- More older people with agreed and managed care plans

6.2.5 Financial impact

The financial impact of this intervention is shown together with the impact of long-term conditions schemes in section 6.3.5 below.

6.2.6 Timescales and milestones

These schemes will be commenced in year one.

6.2.7 Enablers and links to other workstreams

Our plans rely on changes in a number of enabling areas.

IM&T

- Single data set for discharge
- Real time data on admissions and discharge
- Single point of access
- Mobile devices to support mobile working
- Shared information systems required
- Need for a single care record which is accessible by those with a need to know across the health and social care community.
- Increased use of booking services

Estate

- Expanded nursing home and care home capacity
- Fit for purpose Estate
- Co-location with local authority staff- locality hubs
- Additional estate to support the shift out of acute setting

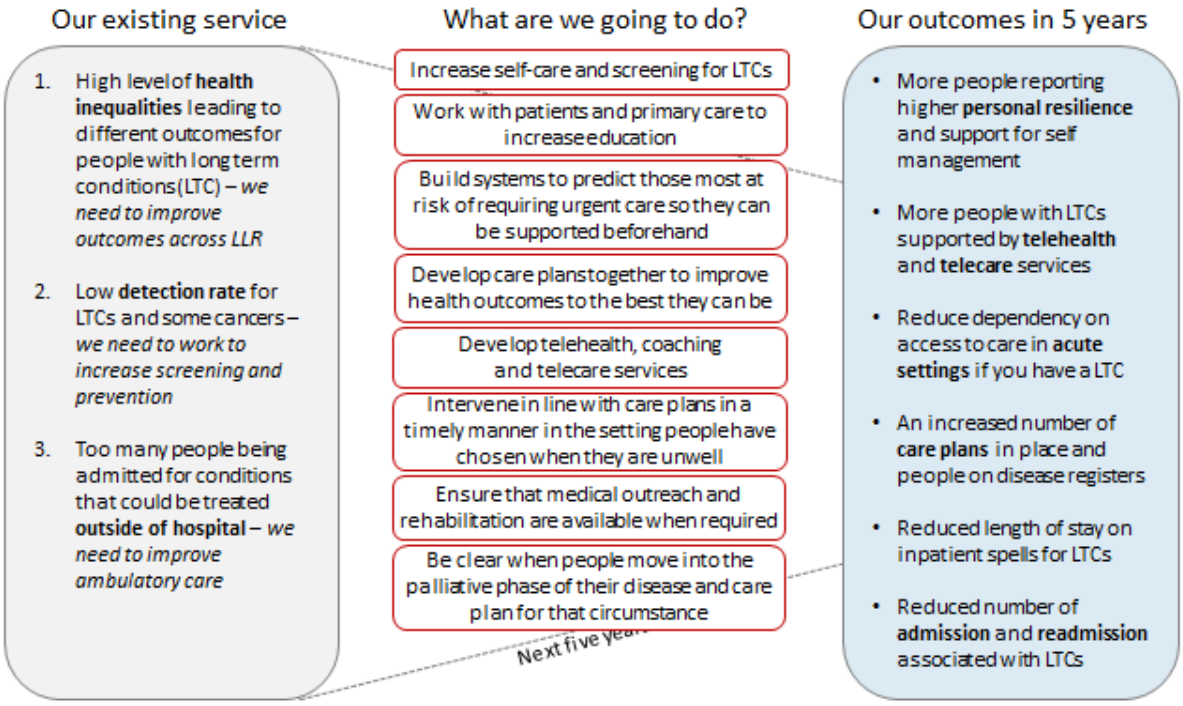
Workforce

- Acute physicians required to deliver 24/7 standards
- Consideration of joint appointments or “system wide appointments” for certain roles
- New roles and significant training
- Ensuring workforce reflects the diverse population in Leicester City
- Ability to co-locate staff

Contracts

- Develop new models of outcome based commissioning for population cohorts to align incentives to deliver care in the right setting
- Consider alternative contracting opportunities for delivering integrated and quality care
- Commissioning pathway based care
- Improve contract management for voluntary and community sector.

6.3 Long-term conditions



6.3.1 Case for change

The case for change in the way we serve people with long-term conditions is clear:

- There is a high level of health inequalities between different areas of LLR leading to different outcomes for people with long term conditions – we need to improve outcomes across the whole of LLR
- We need to work to increase screening and prevention for LTCs in response to current low detection rate for LTCs and some cancers
- Too many people are being admitted for conditions that could be treated outside of hospital – we need to improve ambulatory care

6.3.2 Our key aims and the link to our vision and objectives

Our aim is to create a system that delivers high quality safe care for people with LTCs that is based on best practice, is based on an integrated service model spanning health and social care and which is easily accessible (both geographically and at different times of the day/ week). Our interventions will contribute towards delivering the LLR strategic objectives (see section 4 above) by:

- Delivering high quality, citizen centred, integrated health and social care pathways, delivered in the right place at the right time by the right person (objective one)
- Improving care outside of hospitals to the extent that we can reduce the time spent in hospital by people with LTCs (objective one)
- Reducing the inequalities in accessing care currently experienced by people with LCTs (objective two)

- Helping to increase the number of people with a positive experience of physical health and social care services (objective three)
- Improving the use of physical assets by co-locating different services to enable integration (objective four)
- Integrating health and social care services thereby eliminating duplication such as repeat assessments (objective four)
- Reducing costs to health and social care commissioners (objective five)
- Developing new capacity and capabilities amongst our workforce (objective six).

6.3.3 The changes we will make

Our proposed changes within this workstream are:

- 'Education' - Work with patients and primary care to increase education around risk factors associated with long term conditions
- 'Prediction' - building systems, including screening programmes, to predict those most at risk of developing or accelerating the onset of long term conditions, including health checks; chronic obstructive pulmonary disease (COPD) screening; atrial fibrillation (AF), heart failure (HF) and cancer
- 'Care planning' – joint development of care plans to improve health outcomes to the best they can be supported by a community multi-disciplinary team approach
- 'Ambulatory pathways' – plans to ensure efficient pathways for ambulatory conditions based on treating people in the right care setting
- 'Innovation' – using telehealth and telecare as well as techniques such as coaching to support people with LTCs
- 'Services available when required' - ensuring that medical outreach and rehabilitation are available when required
- 'Choices and plans at the end of life' - being clear when people move into the palliative phase of their disease and plan for that circumstance.

6.3.4 The outcomes we expect

Our interventions are designed to deliver the following:

- An increased number of care plans in place and people on disease registers
- More people reporting higher personal resilience and support for self-management
- More people with LTCs supported by telehealth and telecare services
- A reduced number of admission and readmission associated with LTCs
- Shorter inpatient stays for LTCs across LTC and Frail Older People this would equate to 30% of bed days with continued length of stay greater than 15 days (delayed transfers of care – DTOCs' ambulatory care sensitive conditions – ACSC)
- Reduce dependency on access to care in acute settings for people with LTCs

6.3.5 Financial impact

The cumulative financial impact of our long-term conditions and frail and older people interventions is summarised below.

Table 13: Long-term conditions and frail and older people financial impact (£000s)

	2014/15	2015/16	2016/17	2017/18	2018/19
Saving (£000s)	£289	£604	£958	£1,337	£1,748

6.3.6 Timescales and milestones

These schemes will be commenced in year one.

6.3.7 Enablers and links to other workstreams

Our plans rely on changes in a number of enabling areas.

IM&T

- Single data set for discharge
- Real time data on admissions and discharge
- Single point of access
- Mobile devices to support mobile working
- Shared information systems required
- Need for a single care record which is accessible by those with a need to know across the health and social care community.
- Increased use of booking services.

Estate

- Fit for purpose Estate
- Co-location with local authority staff- locality hubs
- Additional estate to support the shift out of acute setting.

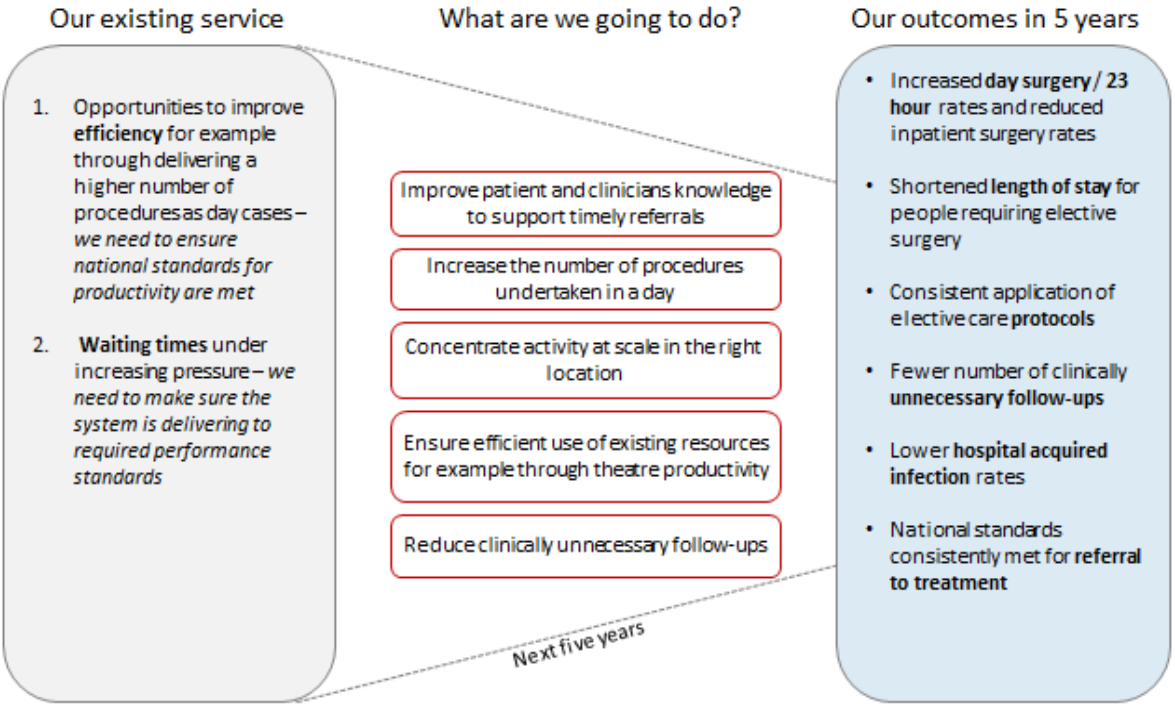
Workforce

- Acute physicians required to deliver 24/7 standards
- Consideration of joint appointments or “system wide appointments” for certain roles
- New roles and significant training
- Ensuring workforce reflects the diverse population in Leicester City
- Ability to co-locate staff.

Contracts

- Develop new models of outcome based commissioning for population cohorts to align incentives to deliver care in the right setting
- Alliance contract efficiencies will need to be driven out, together with consideration of other alternative contracting opportunities for delivering integrated and quality care
- Commissioning pathway based care
- Improve contract management for the voluntary and community sector.

6.4 Planned care



6.4.1 Case for change

There is a clear case for improvement in planned care. Firstly there are opportunities to improve efficiency, for example through delivering a higher number of procedures as day cases (see the BCBV indicators), and secondly waiting times for planned care are under increasing pressure (for example, RTT times are rising).

6.4.2 Our key aims and the link to our vision and objectives

Our aims are simple:

- To deliver high quality safe planned care for local people
- To deliver planned care that is based on best practice
- To offer increased access to alternative services
- For services to be easily accessible to local people
- To provide an appropriate infrastructure to deliver safe care
- To integrated planned care services between primary and secondary care.

By delivering these aims we will contribute towards the LLR goals:

- Delivering services in the right place to promote accessibility, at the right time i.e. shorter waiting times, and reducing the need for overnight stays (objective one)
- Reducing inequalities to eliminating differences in referral rates and waiting times between different communities (objective two)
- Helping to increase the number of people with a positive experience of services by reducing waiting times and improving outcomes (objective three)
- Extending the use of day case surgery and outpatient procedures (objective four)

- Eliminating unnecessary repeat investigations (objective four)
- Reducing costs to health and social care commissioners (objective five)
- Developing new capacity and capabilities amongst our workforce (objective six).

6.4.3 The changes we will make

Our proposed changes within this workstream are:

- 'Outcomes focus' - outcome based commissioning across a system or programme of care e.g. musculoskeletal (MSK)
- 'MDT working' - clinically led multi-disciplinary team (MDT) pathway hubs delivering specialist integrated care and managing the wider pathway (including supported self-care and voluntary sector provision, amongst other functions)
- 'Education' – work with Public Health and others to devise patient and public education
- 'Better referrals' – work rigorously with primary care to increase timeliness for referral
- 'Alternatives' – introduce a range of appropriate alternative services
- 'Settings of care' - provide activity in the most appropriate setting based on clinical need; access and cost effectiveness
- 'Easier pathways' – eliminate unnecessary steps in patient pathway and reduce duplication
- 'Enhanced recovery' - introduce an enhanced recovery programme to facilitate a timely and quality discharge
- 'Follow-ups' reduce unnecessary follow ups
- 'Innovation' - where follow ups are necessary, introduce non face to face where appropriate
- 'Productivity' - improved productivity and efficiency in secondary care; outpatient and theatre utilisation, reduce length of stay where appropriate, reduce DNA and cancellation rates.

6.4.4 The outcomes we expect

These interventions are designed to deliver the following outcomes:

- Increased day surgery / 23 hour rates and reduced inpatient surgery rates.
- There will be a 40% shift of care into the community in the County
- National standards (targets) being consistently met for referral to treatment
- Shortened length of stay for people requiring elective surgery
- Consistent application of elective care protocols
- Fewer clinically unnecessary follow-ups – 10% of services will be decommissioned
- Lower hospital acquired infection rates.

6.4.5 Financial impact

The cumulative financial impact of our interventions is summarised below.

Table 14: Planned care financial impact (£000s)

	2014/15	2015/16	2016/17	2017/18	2018/19
Saving (£000s)	£0	£5,375	£5,446	£5,475	£5,496

6.4.6 Timescales and milestones

Planned care schemes will all be phased over the five years of the planning period.

6.4.7 Enablers and links to other workstreams

The following enablers are required.

IM&T

- Real time data on admissions and discharge
- Shared information systems required
- Technology assisted virtual interactions will need to be undertaken utilising pads etc.
- Need for a single care record which is accessible by those with a need to know across the H&SC community.
- Increased use of booking services.

Estate

- Ensuring the estate can support the shift out of acute setting
- Ensuring a differentiated county and city model to support DC and OP shift.

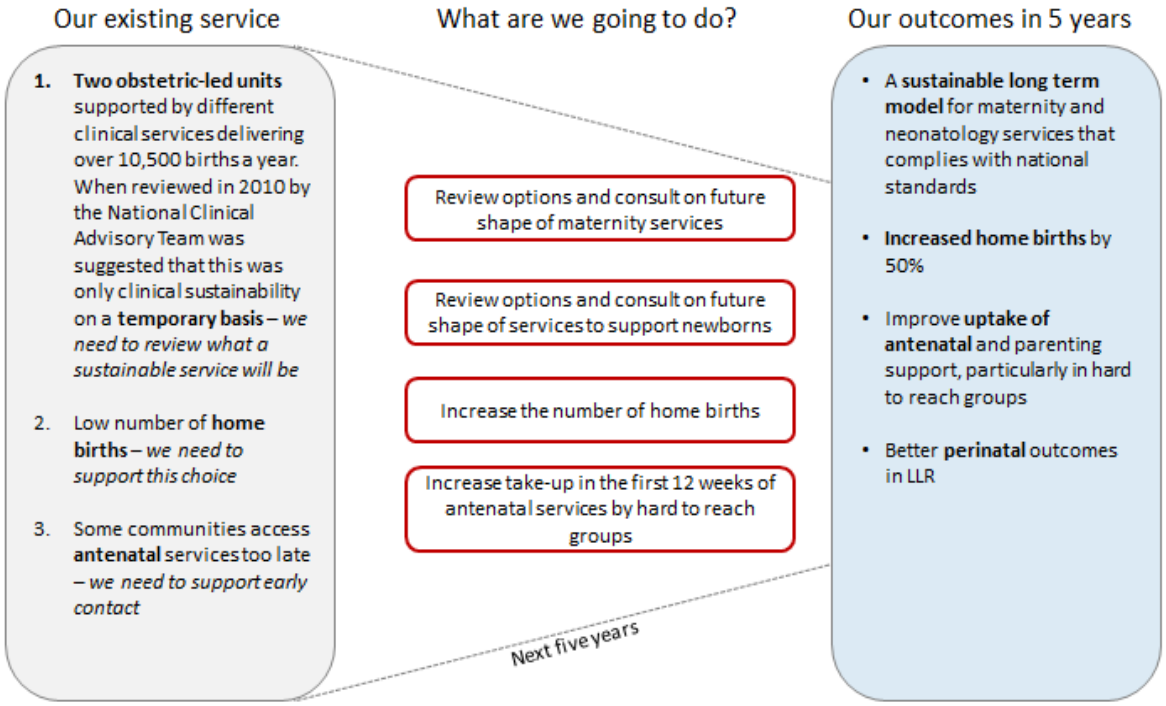
Workforce

- New roles and significant training.

Contracts

- Deliver efficiencies through the use of the new Alliance contract.

6.5 Maternity and neonates



6.5.1 Case for change

In Leicester we have two obstetric-led units operated by UHL but each supported by different clinical services between them delivering over 10,500 births a year. When reviewed in 2010 by the National Clinical Advisory Team it was suggested that this service configuration was only clinical sustainability on a temporary basis. We therefore need to review what a sustainable service would look like. We also know that whilst we support the offer of choice for expectant mothers that only a very few mothers chose a home birth. Finally some communities are accessing antenatal services too late: we need to find a way of encouraging contact earlier in pregnancy.

6.5.2 Our key aims and the link to our vision and objectives

Our aims are to provide high quality safe maternity and neonatal services based on best practice and which are easily accessible. These services will be supported by the appropriate infrastructure to deliver safe care and will be better integrated between primary and secondary care. We also need to provide sufficient capacity to care for babies requiring tertiary care, whilst consolidating and further developing neonatal services. These ambitions link to our strategic objectives (see section 4 above) and will aid delivery as follows:

- Mothers will be offered choice over where to give birth and babies needing specialist neonatal care will be treated at the right level (objective one)
- Inequalities in accessing services will be addressed to ensure all expectant mothers can and do access services at an early stage in their pregnancy (objective two)
- Helping to increase the number of people with a positive experience of services by offering choice and care that is better integrated between primary and secondary services (objectives three and four)

- Ensuring the maternity and obstetric workforce of the future meets growing local needs (objective six).

6.5.3 The changes we will make

Our proposed changes within this workstream are:

- 'Promoting choice' – improve uptake of midwifery lead care options by promoting home births and midwife-led provision
- 'Engaging with local people' - reviewing and consulting on future shape of maternity and neonatal services
- 'Improving outcomes' - continue with the multi-agency programme of work to improve outcomes for premature babies in Leicester City.
- 'Partnerships' - work in partnership across health and social care to reduce infant mortality
- 'Health promotion' - promote the importance of healthy lifestyle and early access to achieving a healthy baby
- 'Under 18s' - reduce under 18 conception rates and provide targeted support for teenage mums
- 'Transition to parenthood' - health and social care to support women and families with the transition to parenthood, particularly hard to reach groups
- 'Workforce ' - build the skills and capacity of the workforce to meet national standards
- 'Maternal mental health' - work with adult mental health to develop an integrated maternal mental health pathway for mothers and families
- 'Tertiary services ' - work with regional providers to develop networks for tertiary provision.

6.5.4 The outcomes we expect

As a result of the changes we plan we will deliver:

- A sustainable long-term model for maternity and neonatology services that complies with national standards
- A 1% shift from Consultant to Midwife led births
- An increase of 50% in the number of home births by (equivalent to 110 births per annum)
- Improved uptake of antenatal and parenting support, particularly in hard to reach groups
- Better perinatal outcomes in Leicester city
- A sustainable long term model for maternity and neonatology services that complies with national standards.

6.5.5 Financial impact

The cumulative financial impact of our interventions is summarised below.

Table 15: Maternity and neonates financial impact (£000s)

	2014/15	2015/16	2016/17	2017/18	2018/19
Saving (£000s)	£68	£143	£227	£237	£248

6.5.6 Timescales and milestones

Implementation of these changes will start in year one.

6.5.7 Enablers and links to other workstreams

The following enablers are required.

IM&T

- Mobile devices to support mobile working
- Shared information systems required
- Technology assisted virtual interactions will need to be undertaken utilising pads etc.
- Increased use of booking services.

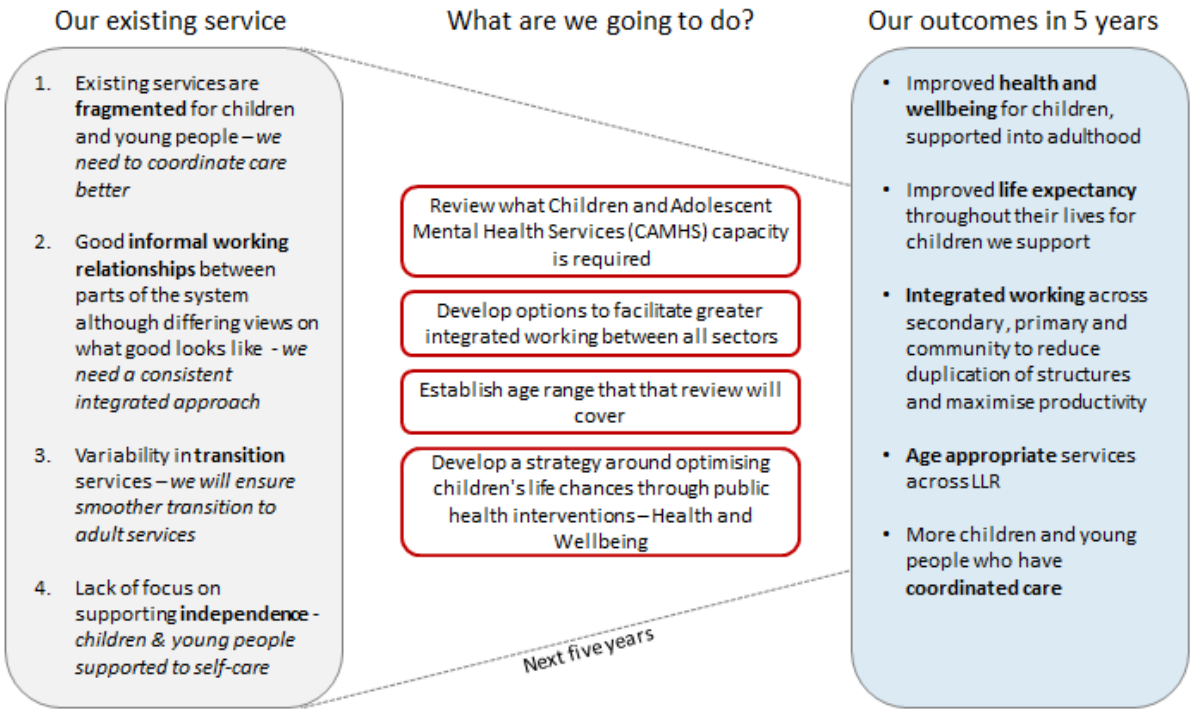
Estate

- Capital for potential changes to post-review configuration of maternity.

Workforce

- Obstetricians required to deliver 24/7 standards
- Maternity care support workers
- Neonatologists
- Ensuring workforce reflects the diverse population in Leicester City.

6.6 Children, young people and families



6.6.1 Case for change

These services need to change because current services are fragmented, and suffer from poor coordination amongst teams and organisations. The service model varies across LLR and whilst some local variation will always be needed, we believe greater consistency is essential not least because it reduces duplication. Transition services, which help patients move from children's to adult's services, could be better coordinated, to ensure people do not lose contact with services and do not suffer from gaps in their care. Current services lack a focus on supporting independence: we need to ensure children and young people are supported to self-care.

6.6.2 Our key aims and the link to our vision and objectives

We have a clear set of aims for these services. We aim to:

- Establish integrated pathways across primary and secondary care thereby reducing duplication and maximising productivity
- Reduce inpatient activity and hospital-based outpatient contacts
- Develop clear pathways for transition from children's services to adult services
- Develop appropriate adolescent services
- Continue to work together to fulfil our responsibilities under the Children and Families Act 2014
- Enable all children and young people to maximise their capabilities and have control over their lives
- Develop networks with regional providers to ensure children and young people have access to appropriate tertiary services.

Achieving our aims for these services will also help us achieve our strategic objectives (see section 4 above) by, for example:

- Delivering services in the right place to promote accessibility (objective one)
- Reducing inequalities between different age groups by ensuring services exist for all needs at all ages (objective two)
- Addressing the particular needs of our diverse population, including BME specific needs (objective two)
- Improving outcomes by strengthening transition processes and services (objective three)
- Introducing a more consistent service model to reduce duplication (objective four)
- Reducing costs to health and social care commissioners (objective five)
- Developing new capacity and capabilities amongst our workforce (objective six).

6.6.3 The changes we will make

Our proposed changes within this workstream are:

- 'Pathways' - improved Children and Adolescent Mental Health Services (CAMHS) pathways and interfaces with non-specialist services
- 'Self-care' - facilitation of self-care by empowering individuals and building family capacity through patient education and community support
- 'Innovation' – increased use of technology to support service delivery for young people
- 'Health and wellbeing' - developing a strategy around optimising children's life chances through public health interventions.

6.6.4 The outcomes we expect

By making these changes we expect to:

- Improve health and wellbeing for children, supported into adulthood
- Improve life expectancy and independence throughout their lives
- Reduce duplication of structures and maximise productivity
- Increase the number of children and young people who have coordinated care
- Reduce inpatient admissions by 10% by 2018/19
- Reduce hospital based outpatient activity by 30% by 2018/19.

6.6.5 Financial impact

The cumulative financial impact of our interventions is summarised below.

Table 16: Children's, young people and families financial impact (£000s)

	2014/15	2015/16	2016/17	2017/18	2018/19
Saving (£000s)	-£11	-£19	£23	£222	£329

6.6.6 Timescales and milestones

Changes to these services will start in year one, with further initiatives being implemented in years two and three.

6.6.7 Enablers and links to other workstreams

The following enablers are required.

IM&T

- Single data set for discharge
- Real time data on admissions and discharge
- Central call and recall systems
- Single point of access
- Mobile devices to support mobile working
- Shared information systems required
- Technology assisted virtual interactions will need to be undertaken utilising pads etc.
- GPs able to effectively use READ codes on their patient records to plan for LD services.
- Need for a single care record which is accessible by those with a need to know across the health and social care community
- Increased use of booking services.

Estate

- Co-location with local authority staff- locality hubs
- Estate to support the shift out of acute setting
- Need for a differentiated county and city model to support DC and OP shift.

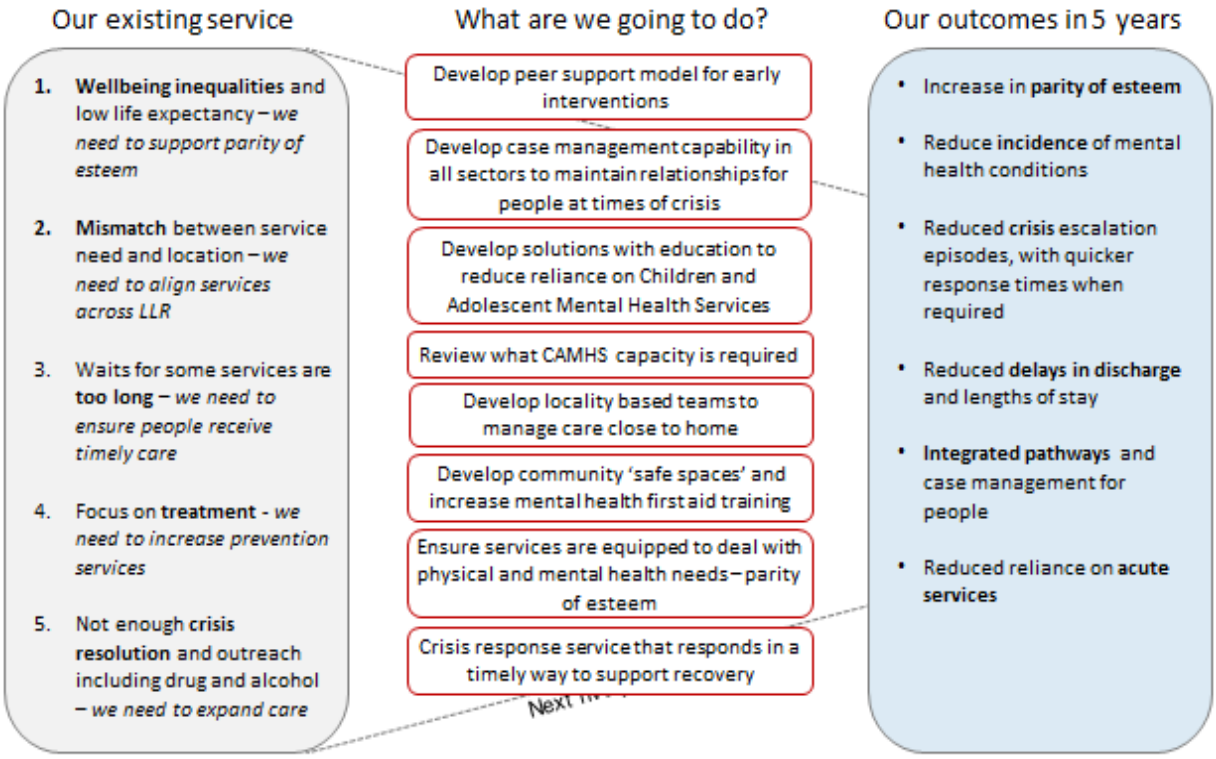
Workforce

- Paediatricians required to deliver 24/7 standards
- Consideration of joint appointments or “system wide appointments” for certain roles
- New roles and significant training
- Recruit sufficient nursing staffing
- Coordinate non-elective and elective paediatrics rota across two sites
- Ensuring workforce reflects the diverse population in Leicester City
- Ability to co-locate staff.

Contracts

- Commissioning pathway based care
- Improve contract management for the voluntary and community sector.

6.7 Mental health



6.7.1 Case for change

People with enduring mental health problems have far worse health outcomes than the rest of the population and they die younger – we need to reduce these inequalities and support the national push for parity of esteem. We also know we need to do more to focus on prevention and early intervention, whilst also providing alternatives to admission, such as better crisis services and better outreach particularly for people with dual mental health and substance misuse issues. Finally across LLR there is a mismatch between service need and location, and the waits for some services are too long.

6.7.2 Our key aims and the link to our vision and objectives

Reflecting parity, our aims for mental health services are very similar to those for physical health services: we aim to deliver high quality safe mental health services, which is more joined-up across the primary care and secondary care interface, which is based on best practice, is easily accessible to those in need, and which reduce duplication and maximises productivity. Such a service will deliver against our strategic objectives (see section 4 above) by:

- Delivering high quality, citizen centred, integrated health and social care pathways, delivered in the right place at the right time by the right person (objective one)
- Improving care outside of hospitals to the extent that we can reduce the time spent in hospital by people with mental health problems (objective one)
- Reducing health and life expectancy inequalities amongst people with mental health problems (objective two)
- Reducing the inequalities in accessing care currently experienced across City and Counties, and amongst our diverse communities such as BME(objective two)

- Helping to increase the number of people with a positive experience of mental health, physical health and social care services (objective three)
- Improving the use of physical assets by co-locating different services to enable integration (objective four)
- Integrating health and social care services thereby eliminating duplication such as repeat visits and assessments (objective four)
- Reducing costs to health and social care commissioners (objective five)
- Developing new capacity and capabilities amongst our workforce (objective six).

6.7.3 The changes we will make

Our proposed changes within this workstream are:

- 'Better support' - effective low level support services including peer support
- 'Capacity and capability' - in primary care and community services through support networks focused on detection, planned care and recovery
- 'Anticipatory care' – the introduction of a planned anticipatory care model which effectively manages people whose needs deteriorate minimising the impact and requirement for inpatient stays
- 'Urgent care' - increased capability and capacity in A&E, crisis services and acute liaison services.
- 'Timeliness' - crisis response services which act in a timely manner to support recovery, reduce length of stays and delayed transfers of care
- 'Repatriation' - repatriation of out of county mental health placements to be managed in a newly designed LPT pathway.

6.7.4 The outcomes we expect

By making these changes we expect to:

- Reduced incidence of mental health conditions escalation (25-50% of all adult mental health illnesses may be prevented through early intervention in childhood and adolescence)
- Realise the economic benefits of early childhood interventions at an estimated ratio of 1:6 above their costs.
- Improved physical health and life expectancy in people with serious mental illness
- Support individuals to seek help at appropriate times and settings
- Reduced crisis escalation episodes, with quicker response times when required
- Reduced delays in discharge and lengths of stay
- Integrated pathways and case management for people to keep them close to home.
- Increase in parity of esteem, time effort and resources allocated commensurate with need
- Improve the provision of mental health assessments for those in crisis in the community
- Reduced reliance on acute services and increase focus on recovery.

6.7.5 Financial impact

The cumulative financial impact of our interventions is summarised below.

Table 17: Mental health financial impact (£000s)

	2014/15	2015/16	2016/17	2017/18	2018/19
Saving (£000s)	£0	£4,931	£5,214	£5,446	£5,688

6.7.6 Timescales and milestones

Mental health changes will be implemented in years two and three of this plan.

6.7.7 Enablers and links to other workstreams

The following enablers are required.

IM&T

- Real time data on admissions and discharge
- Single point of access
- Mobile devices to support mobile working
- Shared information systems required
- Technology assisted virtual interactions will need to be undertaken utilising pads etc.
- Need for a single care record which is accessible by those with a need to know across the health and social care community.

Estate

- Co-location with local authority staff- locality hubs
- Estate strategy which encompasses utilisation of non-traditional sites and facilities.

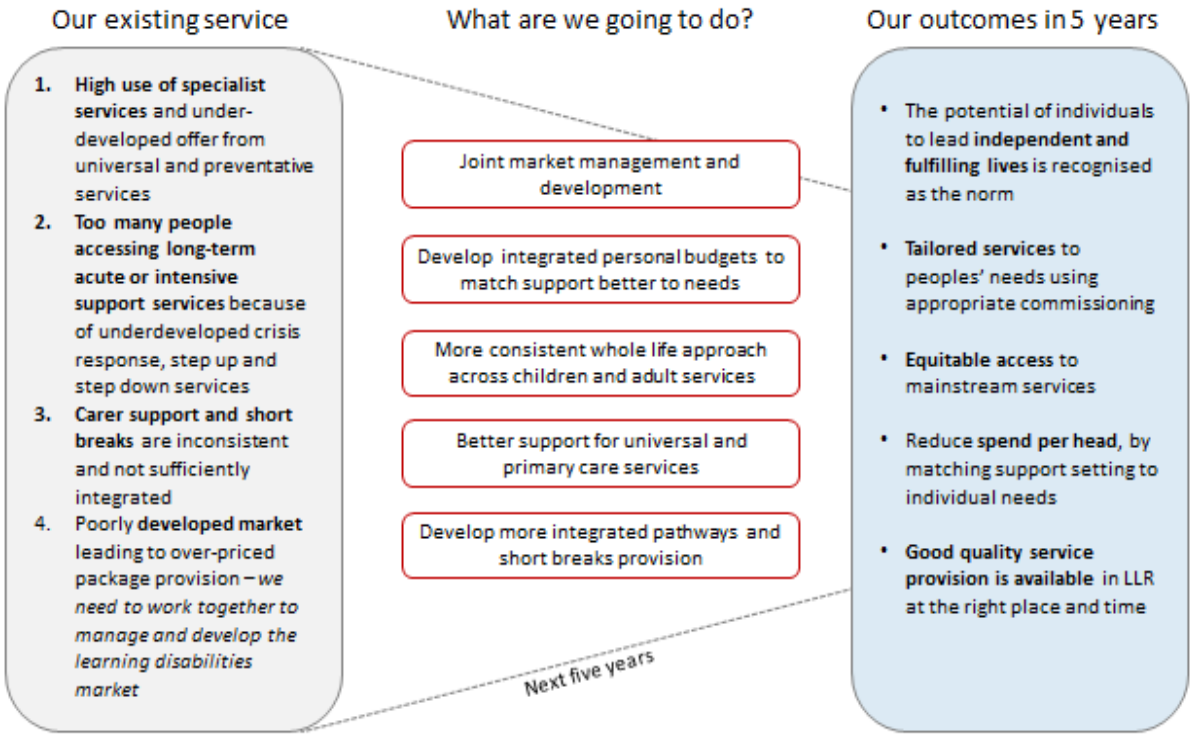
Workforce

- Radically different roles and approaches at all stages of the pathway
- Ensuring workforce reflects the diverse population in Leicester City
- Ability to co-locate staff.

Contracts

- Consider alternative contracting opportunities for delivering integrated and quality care
- Commissioning pathway based care
- Improve contract management for the voluntary and community sector.

6.8 Learning disabilities



6.8.1 Case for change

People with learning disabilities are more likely to experience high rates of mortality, poorer life outcomes than others. National policy over successive years, including the 2012 report "Transforming Care: A national response to Winterbourne View" and other Government policy have encouraged the development services and support which promotes rights, choice, independence and empowerment.

There are a range of specialist services that can effectively support people across LLR however, universal and preventative services are underdeveloped and these could reduce the need for acute specialist services, and further reduce the time that people spend in specialist learning disability health settings.

A large number of people with learning disabilities are supported in the family home saving the health and social care economy millions of pounds each year. Short breaks are vital in enabling family carers to continue in their role, and these are currently provided through traditional costly arrangements.

The local provider market across learning disability is underdeveloped leading to a high unit cost of care and a limited choice of provision for those seeking bespoke person centred packages of care.

6.8.2 Our key aims and the link to our vision and objectives

Once again our aims for this service are consistent with our aims for other health and social care services. We want to deliver a high quality safe learning disability service to the population of LLR. The service we want will be more joined up across primary and secondary care helping to reduce duplication and maximise productivity. The service will be based on best practice and will be easily accessible.

By creating this type of service we contribute to delivery of our strategic objectives (see section 4 above), by:

- Delivering high quality, citizen centred, integrated health and social care pathways, delivered in the right place at the right time by the right person (objective one)
- Improving care outside of institutions (objective one)
- Reducing health inequalities between the general population and people with a learning disability (objective two)
- Reducing access inequalities between different localities in LLR (objective two)
- Help to increase the number of people with a positive experience of services (objective three)
- Integrating services thereby eliminating duplication such as repeat visits and assessments (objective four)
- Reducing the costs of placements and packages of care (objective five)
- Developing new capacity and capabilities amongst our workforce (objective six).

6.8.3 The changes we will make

Our proposed changes within this workstream are:

- 'Intervene early' – we will offer early interventions to help people with a learning disability (LD) to function more independently when they reach adulthood
- 'Strengthen the primary care offer' – work with the primary care workforce to equip them with the skills to support more people with LD
- 'Access' - provide locality based care
- 'Dedicated LD services' – review the potential to develop an integrated, dedicated LD service based in each locality
- 'Efficiency' - provide locality based care with a model which could indicate reduction in the number of teams to the most appropriate number without compromising quality of services
- 'Control' - develop pooled personal budgets and personal health budgets for people with LD
- 'Settings of Care Policy' – ensure people with LD are cared for in a cost effective way
- 'Carer support' – offer a single short break service; flexible and responsive with clear eligibility criteria
- 'Continuing healthcare' – introduce clear agreements and frameworks for CHC
- 'Support in a crisis' - flexible LLR wide provision of short term intensive crisis support including a bed based option
- 'Offender health' - high quality services for people with LD in prisons
- 'Market management' – a joint market strategy to ensure a fair price is paid to providers
- 'Mainstreaming' – ensuring our hospitals are confident in providing support to and that they make reasonable adjustments for people with LD
- 'Local provision' – develop pathways which incorporate specialist provision such as the Assessment and Treatment and Outreach to support people to live in their local community for as long as possible.

6.8.4 The outcomes we expect

By making the changes listed above we expect:

- The potential of individuals to lead independent and fulfilling lives to be recognised as being the norm
- People with learning disabilities and family carers have expectations and experiences which are comparable to the general population
- Support to be tailored support to peoples' individual needs
- Equitable access to mainstream services
- Improved physical health and life expectancy in people with learning disabilities
- Reduce spend per head by matching support setting to individual needs
- Good quality service provision is available in LLR at the right time and at the right price

6.8.5 Financial impact

The cumulative financial impact of our interventions is summarised below.

Table 18: Learning disabilities financial impact (£000s)

	2014/15	2015/16	2016/17	2017/18	2018/19
Saving (£000s)	£11	£67	£1,109	£1,154	£1,202

6.8.6 Timescales and milestones

These changes will be introduced in three waves from year one.

6.8.7 Enablers and links to other workstreams

The following enablers are required.

IM&T

- Real time data on admissions and discharge
- Single point of access
- Mobile devices to support mobile working
- Shared information systems required
- GPs able to use READ codes effectively on their patient records to plan for LD services
- Need for a single care record which is accessible by those with a need to know across the health and social care community.

Estate

- Co-location with local authority staff- locality hubs
- Estate strategy which encompasses utilisation of non-traditional sites and facilities.

Workforce

- Radically different roles and approaches at all stages of the pathway
- Supporting GPs to enable them to support more people with LD in primary care
- Ensuring workforce reflects the diverse population in Leicester City
- Ability to co-locate staff.

Contracts

- Commissioning pathway based care
- Improve contract management for the voluntary and community sector
- Single health and social care approach to LD commissioning and market management.

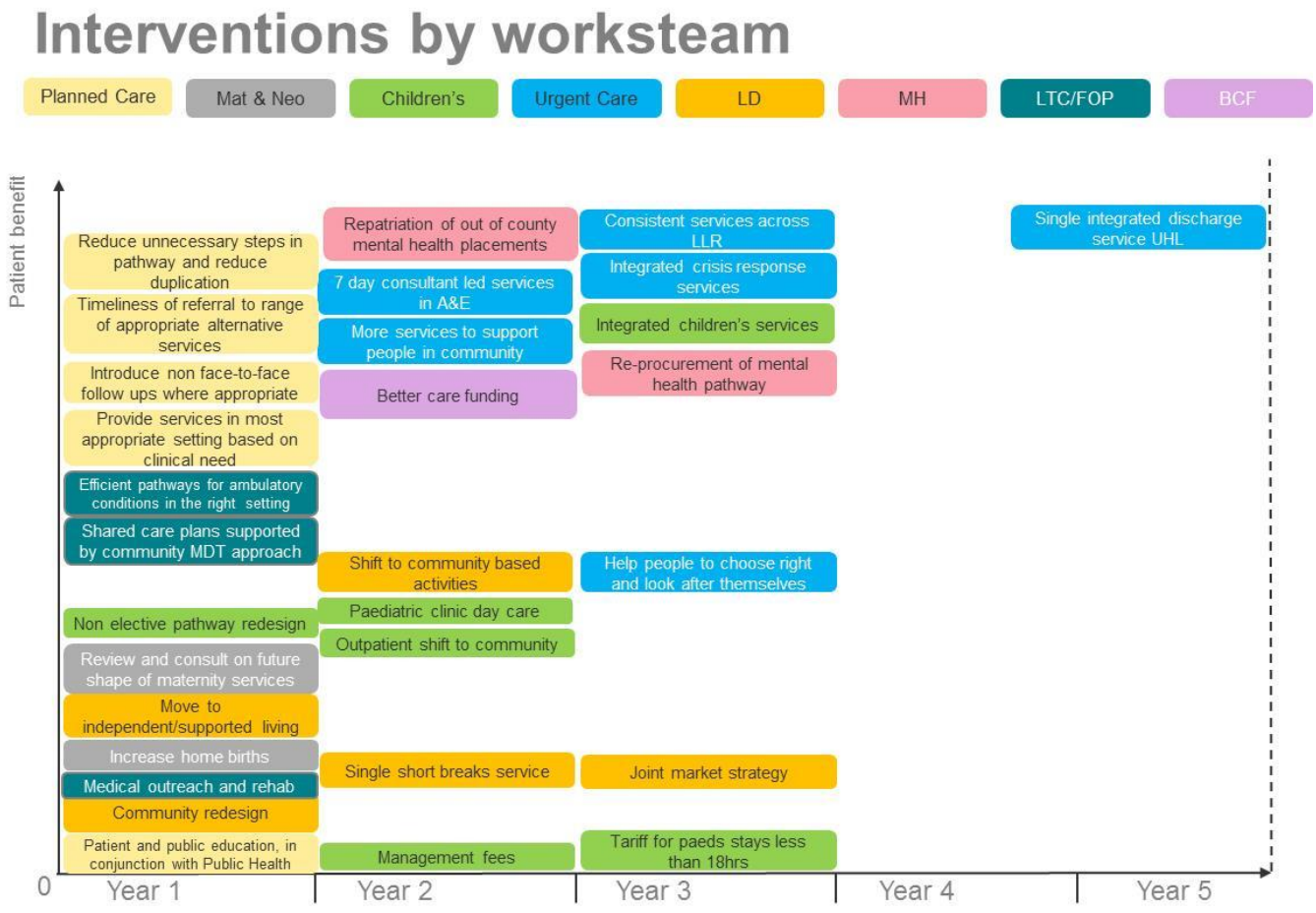
6.9 Summary of interventions

The interventions are designed to respond to the case for change and deliver the models of care by:

- Improving the quality of care, outcomes, and experience of local people thus meeting their expectations
- Address pressures related to the workforce
- Address pressures associated with changing demographics and resulting population needs
- Helping to bridge the financial gap that will occur if we 'do nothing'.

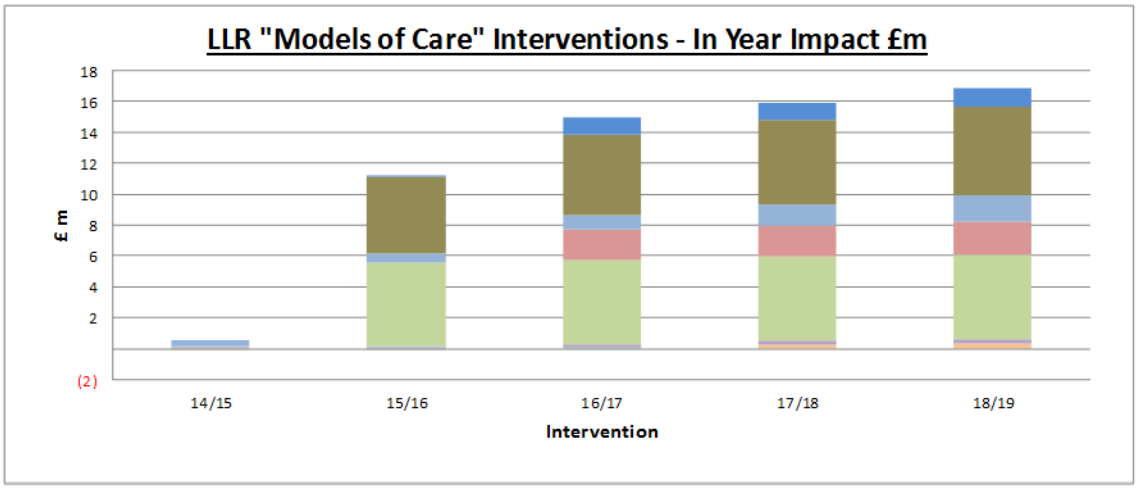
By doing this, overall value for money will be improved, with patients receiving care in more appropriate settings, rather than high cost settings. The diagram below illustrates the degree to which each intervention will deliver patient benefits and the approximate timing of implementing each scheme.

Figure 13: Patient benefit by intervention



The financial impact of the other interventions is summarised as follows:

Figure 14: Financial impact of the interventions



	£ 000				
MODEL OF CARE	14/15	15/16	16/17	17/18	18/19
CHILDREN'S	(11)	(19)	23	222	329
UHL WOMEN'S & CHILDREN'S REPATRIATION	78	63	51	39	25
MATERNITY	68	143	227	237	248
PLANNED CARE		5,375	5,446	5,475	5,496
URGENT CARE			1,953	2,017	2,108
LTC / FRAIL ELDERLY PEOPLE	289	604	958	1,337	1,748
MENTAL HEALTH		4,931	5,214	5,447	5,688
LEARNING DISABILITIES	11	67	1,109	1,154	1,202
TOTAL	**435**	**11,164**	**14,981**	**15,928**	**16,844**

The interventions will result in a change to the number of beds utilised across the health system. Indicative changes to the bed base are illustrated below.

Figure 15: Changes in bed numbers

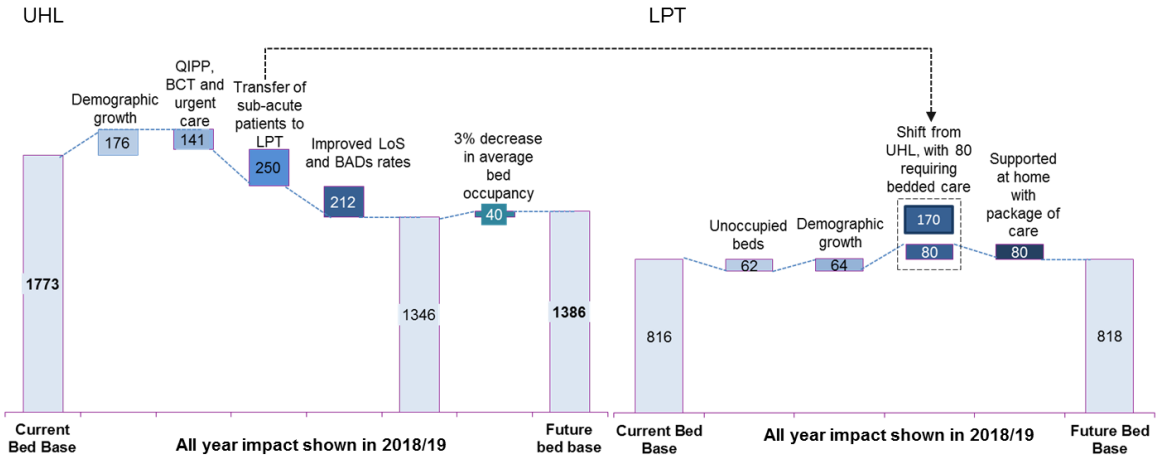
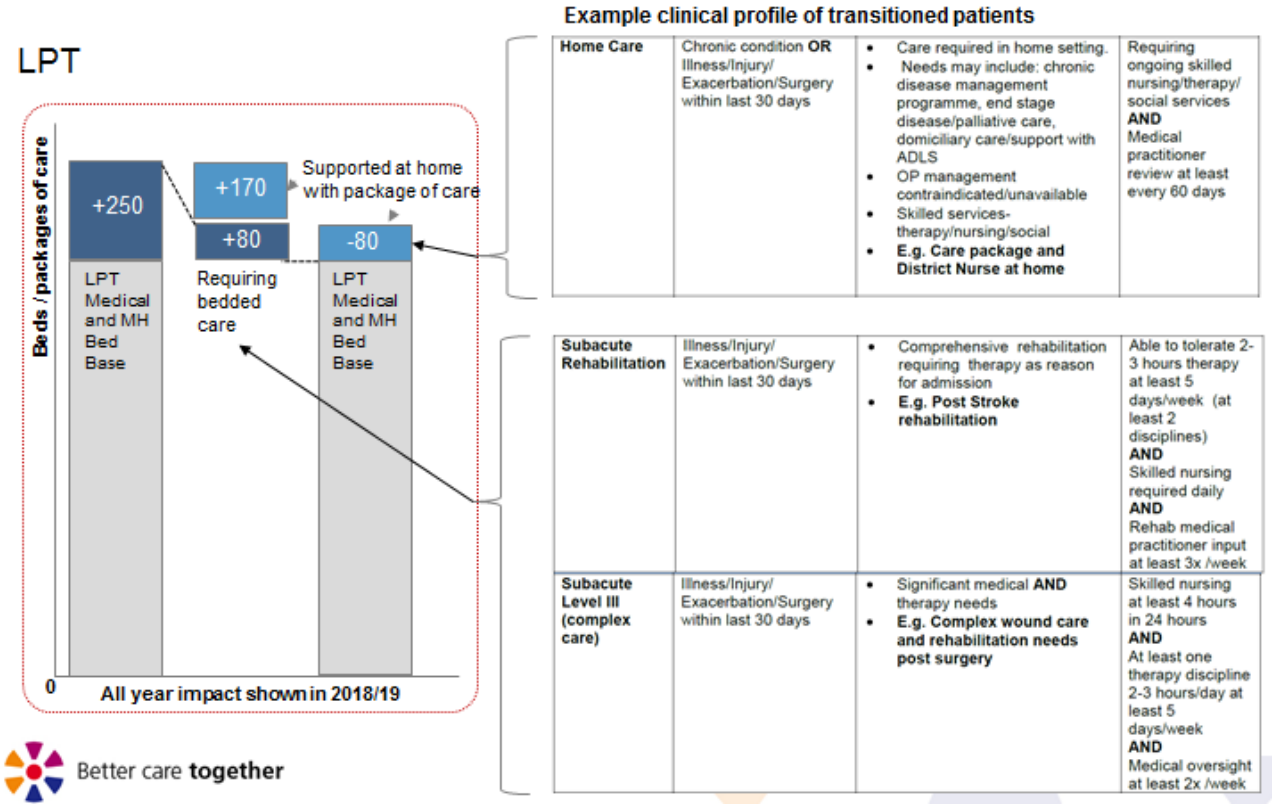


Figure 15 above, and figure 16 below, are indicative of the level of change over the five year planning period. The detailed figures are subject to further review, and will be refined as detailed business cases and implementation plans are developed. The diagram above demonstrates a reduction in acute hospital beds at UHL from 1,773 current beds to 1,346 as a result in internal UHL

efficiencies (e.g. length of stay reductions, improvement in day case rates) and a transfer of 250 beds worth of activity to the community provider, LPT. LPT's bed numbers will remain static: the provider will achieve a transfer of 80 beds worth of existing activity out of community hospitals to community teams freeing up 80 beds to be back filled by ex-UHL activity. The difference between the 250 beds worth of activity transferred from UHL to LPT and the 80 beds back filled is 170 beds worth of activity which will in future be cared for in community settings by expanded LPT and social care teams. This is illustrated below.

Figure 16: The 250 bed shift to community patient profiles



This reconfiguration would lead to a saving by 2018/19 of £11m.

Section 7.4 below identifies Procurement and Contracting as a key enabler for the delivery of our strategic plan. We have established new contractual arrangements – the 'Alliance contract' – for the integrated delivery of planned care in a community setting, for Leicestershire and Rutland patients. We will, over the five year planning period, explore alternative procurement and contractual arrangements for promoting integrated high quality care. Although these savings are attributed only to year 5, in practice there will be opportunity for pulling savings forward into earlier years across the planning period. Indicative savings through improved procurement and alternative contractual arrangements would lead to a saving by 2018/19 of £16m.

In addition to savings from our interventions and reconfiguration of beds, we anticipate that 87% of the projected savings will continue to be addressed through on-going organisation savings programmes (CIP / QIPP). In other words 87% of the challenge will be addressed through savings that NHS organisations are already expected to make, annually, as publicly accountable bodies. Such savings requirements will be reflected in the individual long term plans of organisations.

Typically those efficiencies come from initiatives that focus on reducing our reliance on agency (temporary) workforce; efficiencies in the way that our estate is used to deliver services; savings from the procurement of our goods and services used in the providing care as well as from on-going reviews that focus on ensuring that both our clinical and non-clinical workforce remain as effective and efficient as possible when delivering services to patients. Finally our NHS commissioners, as part of the their on-going public sector efficiency obligations, will look to new and alternative models of contracting (section 7.4) as well as ensuring that what they commission for their populations, remains at the right level and value.

Indicative savings through CIP and QIPP would lead to a saving by 2018/19 of £349m.

6.10 Implementation of interventions

As discussed in chapter 8, the implementation programme is underpinned by a performance and governance process, with an established cross health and social care partnership programme board and reference groups (clinical, public patient involvement, finance and political) enabling groups (workforce, estates, communication and engagement, IM&T) and delivery groups.

The Better Care Together programme is also supported by an established programme management group. With supporting programme management processes now agreed and established including Business Case, Project Initiation Document, Performance management dashboard and Risk register.

The implementation is planned in three phases.

6.10.1 Preparation and planning - Development Phase 1 (January –June 2014)

The Better Care Together Programme Board (BCT) has led the development of this first draft directional plan. As stated earlier at section 2.1 this process was launched at a joint health and social care system and public and patient summit in January 2014.

The Better Care Fund programme and alignment of provider and commissioner savings proposals have both been recognised as key parts of the delivery of a sustainable health and social care economy and therefore aligned within the proposals. To support the prioritisation and phasing of the programme a set of appraisal criteria have been developed and reviewed by the BCT clinical and public and patient involvement reference groups (quality, access, scalability, achievability, return on investment, level of pathway change). A further summit was held in June 2014, where strong endorsement was given to the clinical and social care case for change, the direction of travel, and to the appraisal criteria.

6.10.2 Discussion and review - Phase 2 (July-September 2014)

A review and discussion process has been agreed by the Better Care Together Board of the draft directional plan covering key NHS partner boards, clinical representatives groups, local authority partners, Health and Well Being boards, Healthwatch representatives, overview and scrutiny committees and the voluntary and community sectors. The review process will provide an additional

'confirm and challenge' process to ensure that proposed major service change meets the four government test for reconfiguration i.e. strong public and patient engagement, consistency with patient choice, clear clinical evidence base and clinical commissioning support.

The Better Care Together Programme has access to support from the NHS England Lincolnshire and Leicestershire Area Team, the National Clinical Advisory Team (NCAT) and the local clinical senate. The plan will go through an assurance sense check with the Area Team, exploring the case for change and the consensus for change. The sense check will determine the subsequent level of independent assurance advice, including Gateway Review, giving assurance on programme management arrangements and the strength of the business case. The clinical senate will review the strength of the clinical and social care case and alignment with clinical guidelines and best practice, and may draw on the support of the NCAT.

Outline business cases for proposed Phase 1 programmes will be developed, led by partner organisations and clinical leaders supported by patient user and voluntary and community groups.

A primary and social care strategy development proposal, responding to the emerging service changes, will be scoped by the CCG chairs supported by the Better Care Together partners (managing/operations directors, local authority leads, representatives of the LMC and Area team).

In addition to the areas outlined above we have identified a number of key areas to ensure that we support the successful implementation of the plan, including:

- LLR CIP/QIPP delivery and resourcing plan
- Transitional funding requirements, including double running cost funding, working capital, and investment in interventions
- Establishing an LLR workforce plan.

Adoption of this five year directional plan by the appropriate NHS partner organisations, Local Authority and patient representative groups, including the identification of, and system approach to, any service changes requiring formal consultation is planned for completion by September 2014.

6.10.3 Implementation and consultation - Phase 3 (September onwards)

This will include:

- Implementation, monitoring and reporting of approved Phase 1 programmes
- Monitoring and reporting of the outcomes across the Better Care Funding and system savings plans for year 1 (CIP/QiPP)
- Development of the approach and timescales for areas where formal consultation is required.

The Area Team will undertake a formal assurance of our plan in advance of any wider public consultation or decision to proceed with a particular option. The plan will be reviewed against the four tests described in the Discussion and review section above. It will include independent input from the clinical senate, NCAT and Gateway Review, as appropriate, in giving assurance of the proposed plan.

Elements of the plan which do not require formal consultation will be implemented in a phased way, in order to deliver quality benefits as soon as possible. Any required formal consultation is unlikely to take place until after May 2015, at the earliest. A detailed appraisal of options will be undertaken, before seeking the views of the LLR public and partners through formal consultation.

7 Enabling strategies

We cannot make changes to the way we deliver health and social care without a series of 'enabling developments'. These changes which cover our estate; our IM&T; our workforce; how we engage with local people and other stakeholders; and the way we procure and contract for services, are set out below.

7.1 Estates

During the development of the draft Leicester, Leicestershire and Rutland Draft five Year Strategy work has been undertaken to understand the current estate portfolio; develop a set of estate principles; and how the estate will need to change as the service strategy emerges. This work has involved NHS providers; commissioners, local authorities and support by estate and property expertise.

7.1.1 The current estate portfolio

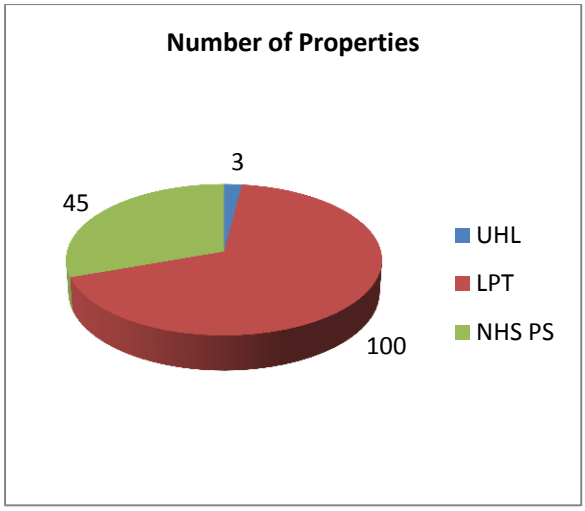
Since the reorganisation of the NHS in April 2013 property is now owned or leased by either NHS providers, NHS Property Services, Community Health Partnerships or in the case of the primary care estate often by GPs. Commissioners (for example CCGs) no longer own assets. All three local unitary authorities also own a range of property, used for both service and support functions.

In 2012/13 the estate management function across the NHS in Leicester, Leicestershire and Rutland was market tested and Interserve appointed to undertake the operation and maintenance of buildings and associated facility management functions such as catering; portering and car parking. Both NHS Property Services and Community Health Partnerships are utilising the Interserve contract for their estates.

Overseeing the contract on behalf of partners is NHS Horizons, a jointly funded estate management organisation, hosted by University Hospital Leicester. In addition NHS Horizons provide a range of services to partners, including capital development and property management. Both LPT and UHL have retained strategic estate capability and capacity to develop medium and long term planning in relation to estate and in particularly how the estate can support service requirements.

As part of phase 1 of the development of the Leicester, Leicestershire and Rutland Draft five Year Plan the Estate Enabling Group has developed a data set to identify the; range; cost; and size of the health estate. The following graphs provide a summary of the current NHS estate; information has been collated by NHS Horizons.

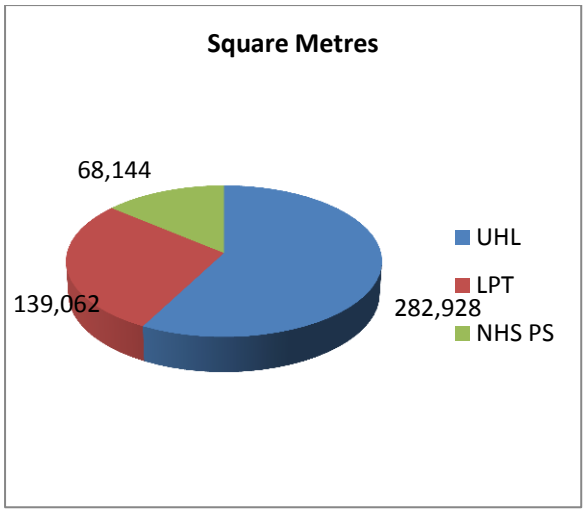
Figure 17: Current NHS estate



The total number of NHS properties is 148, this is based on the three University Hospital of Leicester sites being classified as three buildings (rather than as blocks within sites).

Any planned disposals are included in these numbers.

Within LPT and NHS Property Services there is a mixture of tenure; in UHL assets are owned.

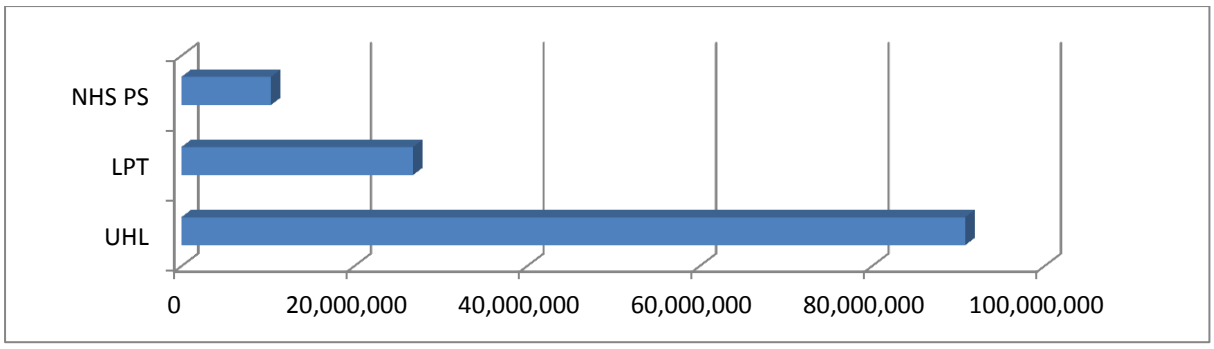


The total size of the estate is 490,134 square metres. UHL have the highest level at 58% of the estate; LPT at 28% and NHS Property Services at 14%.

A space utilisation review was undertaken in 2011 which identified that much of the estate was under-utilised, with rates as high as 50% in some areas. This included both clinical and administration/back office areas.

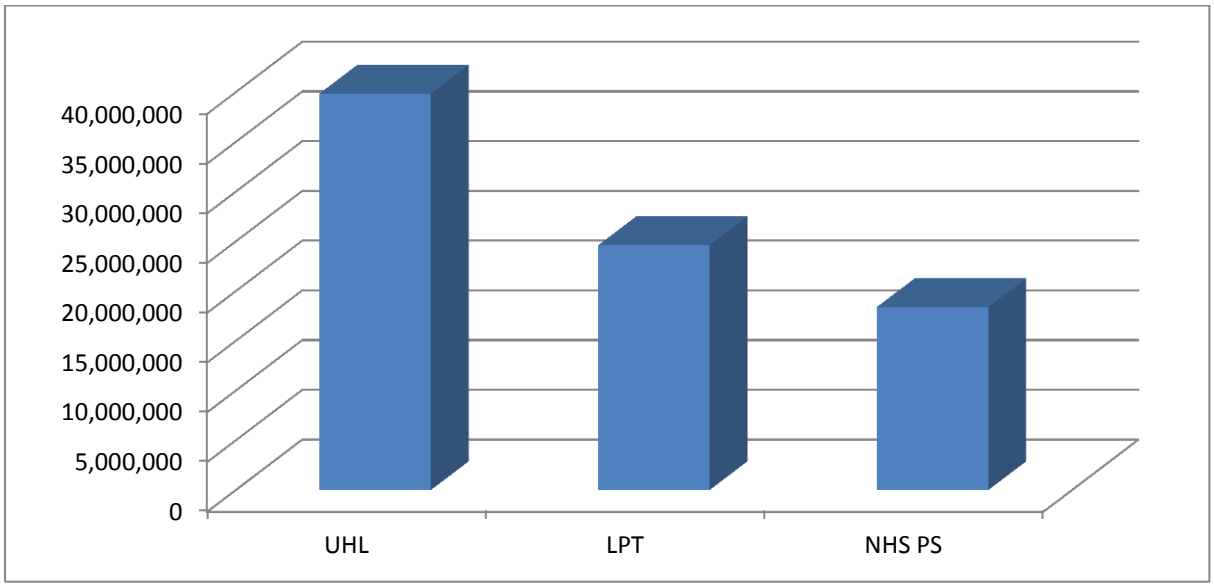
Over the last few years investment in the local NHS has been variable; there are some examples of investment including the redevelopment of mental health beds through the "Centre of Excellence" programme; the LIFT initiative in Leicester City which has provided seven new health centres across the city; re-development of community hospitals in Market Harborough; and the expansion of paediatric intensive care and reconfiguration of maternity areas within the acute sector. However this investment has not been able to keep pace with the backlog maintenance requirements across the estate as demonstrated in the chart below. The total backlog maintenance amounts to £128m, to bring the estate to a fit for purpose condition. The condition and age of the primary care estate is also variable.

Figure 18: Backlog maintenance



The total cost of the estate is £82.8m per annum which represents an average cost per square metre of £169.04, which is broken down per organisation in the chart below. Of the total £36.8 m represents the cost of the Interserve facilities management contract; £14.5m, £23.6m is rental costs and £5.3m are variable costs, for example utilities and water.

Figure 19: Cost of estate



In addition to the above analysis of the estate geographical mapping has been undertaken in phase 1 of the estate enabling work. The NHS and local authority estate has been mapped so that a greater understanding of opportunities across the whole public sector can be seen. This has identified that in certain geographical areas there is considerable opportunity to consider the whole public sector estate to identify efficiencies through shared use of space and better utilisation of existing estate.

West Leicestershire Clinical Commissioning Group is commencing work to identify the future shape of services in the Hinckley area. Supporting services in the area are two community hospital sites and a number of local authority sites; in determining how the local estates can support the future shape of services joint work will be undertaken to ensure effective utilisation and efficiency of the whole public sector estate

7.1.2 Estate principles to support the Better Care Together

The following principles have been developed by the Better Care Together Estates Enabling Group to the approach to estates within the programme.

- We will have a mixed tenure of estate that can adapt quickly and effectively to changes in service need
- The use of technology will be maximised to support efficient and agile working practices and to reduce dependence on fixed office accommodation
- Utilisation rates should be a minimum of 85%.
- Occupancy rates for office accommodation should be based on the NHS England Standard
- Where it is economic to do so we will maximise the use of public sector assets based on geographical areas
- We will develop a just in time culture for goods
- Services should be delivered from estate which meets clinical need; is accessible; and offers value for money, is of acceptable quality and meets safety and legislative compliance
- Where ever possible, buildings will be designed to be flexible to adapt to changing needs over time
- We will minimise the use of physical assets wherever possible
- Where it is value for money to do so we will invest in environment and sustainable solutions that reduce our recurrent variable estate costs

7.1.3 How will the emerging service models impact on the estate?

The emerging service models in the Leicester Leicestershire and Rutland 5 Year Strategy will require the UHL estate to adapt to enable the new models of care to be implemented, the impacts are described below.

Table 19: Workstream impact of estates

LLR 5 Year workstream areas	Potential impact of estates
Urgent Care	To deliver improved efficiencies and patient flow and address capacity issues and clinical adjacencies a redevelopment of the emergency floor is required. In sizing this development the impact of the changing service models needs to be considered, in particular for frail older people and long term conditions. A consistent approach to urgent care and minor injuries may impact on the accommodation requirements.
Planned Care	The shift of outpatients and daycases into the most appropriate setting is likely to lead to a reduction of activity in the acute hospital setting to the community. In addition increased occupancy and utilisation rates will impact on estate requirement. The solutions for the city and the counties will be different.
Frail Older People	More people being cared for in the community and in their own homes is likely to lead to changes in the numbers and types of beds required; reduced readmissions and reducing length of stays. This is likely to impact on both hospital and community beds (see section 6.9).

LLR 5 Year workstream areas	Potential impact of estates
Long Term Conditions	Better management of long term condition; ambulatory sensitive conditions and services in the community and at home when people go into crisis is likely to lead to changes in the numbers and types of beds required; reduced readmission and reducing length of stays. This is likely to impact on both hospital and community beds (see section 6.9).
Children Services	Better integration and a community based focus on outpatients is likely to reduce acute hospital based planned care and may require additional accommodation in the community.
Maternity and Neonates	Currently there are two obstetric-led units supported by different clinical services delivering over 10,500 births a year. When reviewed in 2010 by the National Clinical Advisory Team was suggested that this was only clinical sustainability on a temporary basis – we need to review what a sustainable service will be.
Mental Health	The focus on anticipatory care models and improved crisis support is likely to lead to a reduction in people with mental health problems presenting at the emergency department, and impact on beds.
Learning Disabilities	None identified

7.1.4 What do we need to do?

This section sets out the major drivers for estate change for those partners that have asset bases and where appropriate describes how the emerging service models within the Leicester, Leicestershire and Rutland five year strategy will impact on estates. It is not intended to act as a solution focused section, rather identify those areas that will need further work as the Better Care Together Programme moves into the next phase, between July and October 2014.

Primary Care

Primary care will be integral to the delivery of our strategic plan. The interventions described in this plan will have implications for the primary care estate. The proposed strategy development for primary care, as set out in section 4 above, will include the implications for estates.

University Hospital Trust

University Hospitals Leicester NHS Trust (UHL) is one of the largest teaching hospitals in the county and operates across three main sites; Leicester Royal Infirmary; Glenfield Hospital; and the Leicester General Hospital. The trust provides a range of services across its three main sites including a number of tertiary care services. All three of the sites are large and contain a range of inpatient and outpatient services, some services such as maternity and neonates are provided from more than one site. In addition services such as imaging and theatres are duplicated across sites.

In November 2012 the Trust published its 'Strategic Direction' which set out at a high level the future shape of UHL's clinical services…

> "Overall Leicester's hospitals will become smaller and more specialised and more able to support the drive to deliver non-urgent care in the community. As a result of centralising and specialising services we will improve quality and safety… this will be done in partnership

with other local health organisations and social care though the Better Care Together programme. We will save money by no longer supporting an old expensive and under used estate and we will become more productive."

Since then the Trust has worked on the development of its five year plan which seeks to ensure that the vision of "smaller more specialised hospitals" becomes a reality, solves the ongoing issues with emergency and urgent care, and returns the Trust to financial balance.

2014 The headline strategy:

In the evidence gathering phase of the development of the UHL strategy it became clear that in order to provide the very best services to the local population of Leicester City, Leicestershire County and Rutland the Trust would be required to play a major role in re-shaping local services to ensure that only those patients who need to be cared for in an acute setting are looked after in one of the Trust's hospitals.

Whilst the Trust has responded to growing demand, analysis has shown that a significant proportion of hospital beds are occupied by patients whose clinical needs could be met more appropriately in alternative care settings[3].

Typically, this applies first, to those patients who have been successfully treated and stabilised for their acute illness but then require on-going care for a few days afterwards. And second it applies to those patients who are not acutely unwell but are admitted to hospital because there is no other option available.

Two bed utilisation reviews of unscheduled care on medical wards were undertaken by the Trust in 2012 and 2013. Both reviews showed that:

- Based on a snapshot (10 days) 1201 bed days were identified as not being appropriate for continued stay in acute care.
- 19% of this opportunity (24 beds) related to patients who required a level of *care not currently available* in Leicester or Leicestershire most notably the requirement for step down medical care (e.g. for continuation of multiple IV antibiotics).

Based on the findings of the two bed utilisation reviews the Trust is working with Leicester Partnership Trust to redesign pathways and provide out of acute hospital alternatives for sub-acute care to ensure that patients either do not spend too long in hospital or avoid a hospital admission altogether. This will require a shift of a substantial number of beds and equivalent resource and expertise to community settings. See section 6.9 above.

Becoming *smaller*:

- As a consequence of the shift to community settings with fewer patients, the Trust intends to consolidate acute services onto a smaller footprint and grow its specialised, teaching and research portfolio, only providing in hospital the acute care that cannot be provided in the community. In doing this the Trust expects to significantly increase the efficiency, quality and ultimately the financial sustainability of key services; shrink the size of the required

[3] Utilisation Review 2012 and 2013

estate; significantly rebalance bed capacity between acute and community settings, and thus reduce total costs.

- The combined effect of these material changes to the provision of services and their underpinning business models is expected to return the Trust to a breakeven position from 2019/20.

Becoming more *specialised*:

Further, the Trust's assessment is that the specialised portfolio is where the greatest opportunities for growth lie. There are a number of drivers that support the belief in this opportunity and these include:

- Significant evidence that smaller, district general hospitals will be unable to achieve the standards required by regional and national designation
- Advancements in technology and practice that are increasing the opportunities to offer specialised care and intervention to children and adults who would historically not have survived their illnesses e.g. long term ventilation in children
- The Trust's strong research credentials underpinning many of its specialised services.

Timescale and phasing of the strategy

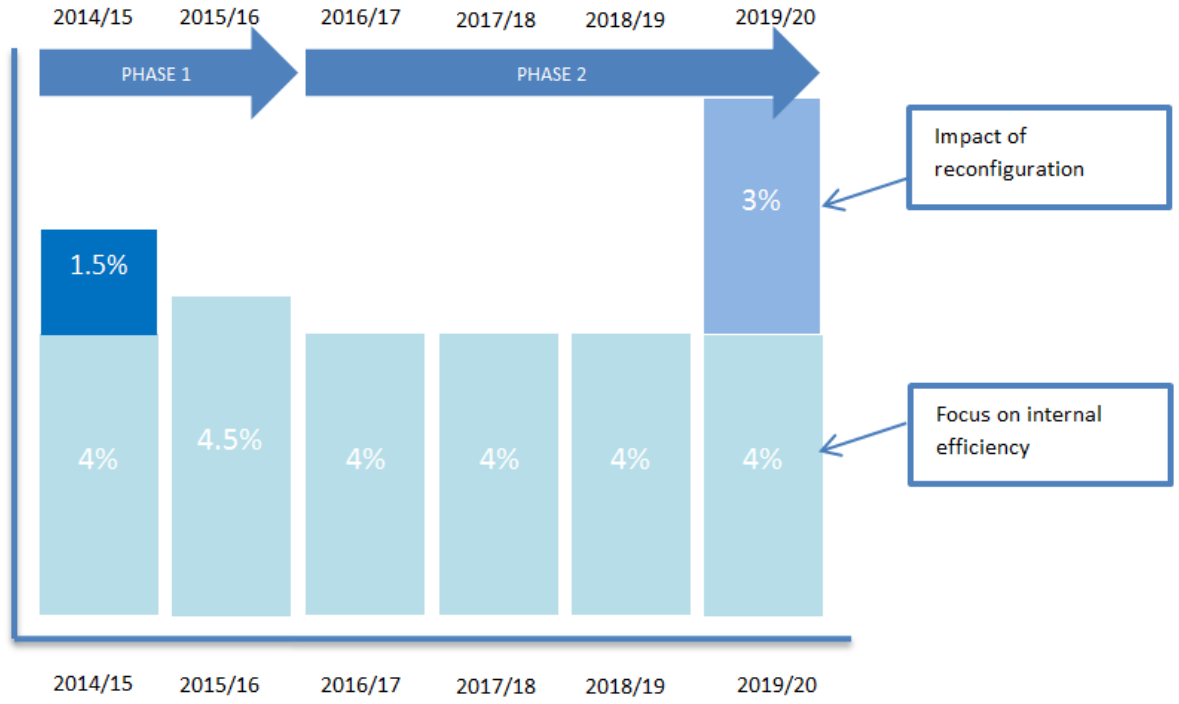
The Trust is planning a two phase implementation of the headline strategy described above, (See diagram below). In the first phase, lasting two years the Trust will focus on in-hospital efficiency and productivity with the aim of repositioning key clinical services from outliers in terms of benchmarked data (for example length of stay and day case rates) to top quartile. Included in phase one will be two urgent developments – the Emergency Floor at the Royal Infirmary and the transfer of vascular services from the Royal to Glenfield Hospital. The latter will secure integrated cardiovascular services, which will be at the cutting edge of modern medicine and surgery, and with the potential for the inclusion of renal services at a later date.

Phase two from 2016 onwards is to enact a major reconfiguration of the hospital estate which coincides with other services coming on line in the community and allows the Trust to safely rebalance bed numbers (i.e. reducing acute bed numbers and making better use of community capacity), and repurpose or move out of buildings which are no longer required and therefore reduce double and triple running costs.

Building on the clinical consensus for a reconfigured estate, the Trust will consolidate its main acute services onto two sites, enabling clinicians and patients alike to benefit from properly co-located services and eliminate the inefficiencies of running multiple acute sites. There will be a number of options available which would fulfil this vision and the Trust will work to establish these with partners and stakeholders and the wider community over the remainder of 2014 and into 2015. Although the Trust will appraise all options, the direction of travel to date would indicate that it is likely that the Royal and the Glenfield will emerge as the two main acute sites. If this is the case, it would enable the Leicester General Hospital site to be developed to further support integrated community services and the Diabetes Centre of Excellence, as well as continuing to provide a home for East Midlands Ambulance Service, the UHL Young Disabled Unit, and for the existing services provided by Leicestershire Partnership NHS Trust, such as inpatient rehabilitation, inpatient mental

health services, specialist psychological therapies including Cognitive Behaviour Therapies and mental health outpatient services for older people.

Figure 20: Two phase implementation of UHL efficiency changes



Conclusion

The Trust's market assessment shows that UHL is in a strong position with a large turnover, relatively little competition and therefore reasonably predictable revenues for the next 5 years. The task is therefore clear; first make substantial changes to the elements of the business most directly within the Trust's gift, including but by no means exclusively, reducing length of stay, increasing day case volumes, standardising clinical protocols for discharge, rapid turnaround of tests… in short, getting the basics right. Then, the Trust will consolidate the location of its services to ensure that it can continue to provide the highest possible quality of care within the available resources, with the long terms sustainability of clinical services being the key driving factor. None of this will happen without a whole health economy plan and without the understanding and support of all stakeholders; as such the Trust is working hard with LLR colleagues under the Better Care Together programme banner to make that plan a reality.

Leicestershire Partnership NHS Trust

Leicestershire Partnership Trust (LPT) has an asset base which serves both their mental health services and community provision. It includes a range of office bases; inpatient beds and community based clinic accommodation. LPT also have a number of units for the provision of specialist mental health services and learning disability services.

LPT's objectives for their estate are to:

- Maximise the utilisation of our estate and the estate across the LLR public sector
- Operate from buildings that are fit for purpose for service users (location and the facilities); and
- Deliver £14 million reduction in revenue cost from our estate.

Our approach will intend to:

- Explore all opportunities (including with other organisations and sectors) to utilise our estate 24/7
- Form partnerships with other organisations to share space and adopt fair pricing practice (at cost rather than profit)
- Adopt agile and mobile working practices to reduce dependence on fixed office accommodation.

In order to ensure that buildings are fit for purpose we will:

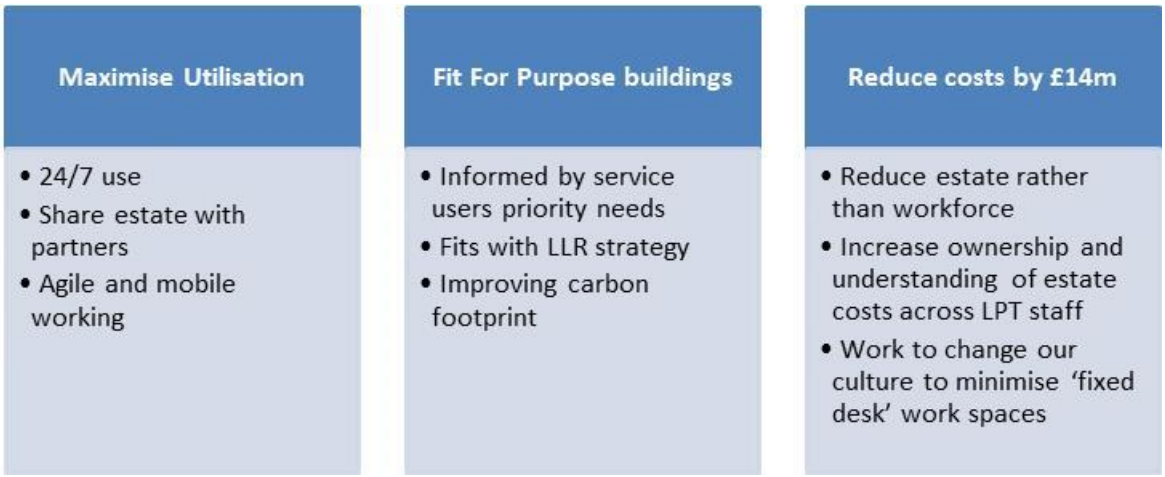
- Actively improve our carbon footprint
- Ensure our estate usage is informed by the LLR wide Better Care Together programme
- Ensure our use of buildings is shaped by informed service users who are aware of competing pressures and priorities.

In reducing cost from our estate we will:

- Focus on reducing estate cost in preference to requiring greater workforce reductions
- Increase ownership and understanding of estate cost across all staff groups by providing detailed information and devolving responsibility for reducing estate costs
- Work to change our culture to minimise 'fixed desk' work spaces.

These aims and guiding principles have been summarised below.

Figure 21: LPT estates principles



At a fundamental level, LPT envisages a hub and spoke model broadly as follows.

Figure 22: LPT hub and spoke model

Factor	County-wide hub	Community hub	Satellite /FYPC team base
Types of service	Highly specialised services e.g. eating disorders, personality disorders, single point of access	Specialist nursing, urgent care, paediatric therapies, CMHTs, community beds	Community nursing, community therapies, older people's CMHTs, FYPC team base,
Population covered	1,000,000	Average 115,000 (county) 60-75,000 (city)	Average 35,000 (county) In city satellite bases may be absorbed into community hubs
Accessibility	Within one hour drive-time of 80% of population	Within 15 minutes' drive-time of 80% of population	Within 10 minutes' drive-time of 90% of population
Links into	Acute Trust Community Hubs	County-wide hub Acute Trusts Satellites Voluntary sector Social care	Community hub Acute Trusts Primary care Voluntary sector Social car
Type of space	Offices, limited clinic space	Clinics, possibly minor injuries, diagnostics, rapid access centre, inpatient wards & offices	Consulting room, team bases,

The impact of the Better Care Together service models is that more people will be treated in the community and the acute sector will become smaller and more specialised. This does not mean there will be more bed provision in the community or even the current bed provision in the community is right; services that are right for the patient will be delivered. This will be achieved by increasing the specialist elements of care that are routinely required to deliver care closer to home for an ageing population and to be able to 'step up' support to ensure that people are not drawn into acute settings if it is not required. But also to include more volume and specialist elements in 'step down' care to support people to routinely be able to return to their own home from acute care after an episode of ill health.

As people age, surgical and medical interventions take a little longer to get over and whereas a normally fit and hale person may be able to 'walk' out of hospital to return to their home where they can feed, clothe and wash themselves and safely wait for outpatient appointments or follow up care, some older people struggle with the elements of self-care required to allow them to go home in a timely fashion.

Not all of older adults require a bed in a hospital or a community hospital to provide that level of care. But traditional intermediate care services are targeted at people who require rehabilitation to ensure that they recover their previous abilities. There are a growing group who require temporary support to enable them to safely get home and in the past when they were younger and had an underlying strength greater than their current levels, that care need might have been met by 1 call from a nurse or care worker per day. However, when they are older they may require 3 or 4 calls per day over a short period of time to achieve the same levels of safety. These people do not benefit from being in a hospital bed, indeed they may lose skills and become subject to the infectious ill health of others around them making them more ill the longer they stay.

The next level of care that older adults have recently begun presenting with is as people who do require rehabilitative support to get over their episode of ill health but have a cognitive impairment or are subject to environmental confusion out of their own home due to moderate degrees of dementing disease or a previous stroke. These people currently are all rehabilitated in community hospitals but find it hard to translate what they have learned back into their own home environment. They are subject to extended lengths of stay in community hospital and often end up moving from there into residential or nursing care. Some of that journey is necessary to meet their future care needs but some of it is because there is no option for them to return home directly from an episode in an acute hospital with sufficient support to relearn skills in their own home where they will retain them better and are less confused because of the familiar surroundings.

The final cohort of patients who are ill-served by current service configurations are people who required a short stay in community hospitals but then find it difficult to get home since there spell in the hospital has not removed all of their care needs but there is not enough care available close to their own home for them to return home as soon as they are fit to do so. These people are then subject to a longer stay in a community hospital than is necessary and subject to the risks listed above. 43% of people who are currently sitting in a community hospital bed find themselves in this situation. (Community Hospital utilisation review EMPACT 2012).

To ensure we have the right services in place LPT will work with commissioners and UHL to develop plans for this in the next phase of the Better Care Together Programme; this will include the impact on the estate.

Leicester City Council (LCC)

The Council has a number of service driven reviews which Property Services support. The major reviews include the Accommodation Strategy and Transformation of Neighbourhood Services.

The **Accommodation Strategy** is driven by the requirement to vacate New Walk Centre, the main headquarters building, due to structural failure. Services have been relocated to a number of buildings around the city centre, with an emphasis on reducing the office space footprint through the introduction of modern working practices. The New Walk Centre site will create development opportunities, and a selected development partner is currently being chosen.

Transforming neighbourhood services is a response to substantial funding reductions. In order to meet the challenge, the Council is undertaking a fundamental review of neighbourhood-based services. This is being done in consultation with communities to shape services to meet needs. The

scope of the services includes libraries, community services, adult skills and learning and the neighbourhood based customer service points. It also considers services and buildings managed by partners.

The Council has set out a clear and ambitious vision for transformational change of its **Adult Social Care (ASC) services**. At the heart of this change programme are the following actions;

- Reduction in reliance on expensive residential and in-house care
- Ensuring people in Leicester can exercise choice and control
- Enhanced partnership working with Health and other LCC providers
- Maximising the use of universal services and promoting social inclusion and community cohesion
- Developing local community based alternative services to support people in their own homes.

For each customer group there will be a series of disinvestments and reinvestments in services to achieve an up to date and leaner service. Central to achieving the vision will be changes to both the ASC and wider LCC estate. As reliance on in-house service decreases it is anticipated that far fewer buildings will be required for service delivery. Those that do remain may require investment to create high quality, fit for purpose buildings located in the right place to support the effective delivery of social care services.

There are several smaller scale service-based reviews, and an ongoing general rationalisation of property needs. These include:-

- Police operating from touch down bases in several council properties
- Accommodating Health authority staff co-located with council public health staff
- Football Foundation project creating new five-a-side pitches which entailed liaising with local football clubs, the FA, Sport England
- Building Schools for the Future now working towards extended opening hours and services.
- Several community asset transfer
- Developments such as Phoenix Square, Curve, Cross Corners, Dock and the Market Food Court.

Finally, the Council is proposing to the Ashton Green development which is seen as the most significant and innovative housing scheme in Leicester in more than 30 years and will enable substantial progress towards delivering the 20,000 new homes needed in the City over the next 20 years.

Ashton Green is a planned sustainable urban extension of 2,500 homes for the city. It will shape Leicester as Britain's sustainable city by delivering a distinctive, safe, green and well-connected place. It will become a thriving, prosperous mixed community with a dynamic heart and strong identity within the city.

This exciting new development has the potential to make a significant contribution towards Leicester becoming a truly low carbon city and raising its profile as the place to do business in the East Midlands. The site also has the potential to deliver the highest quality of built environment

whilst protecting and enhancing the natural surroundings in this part of the city. In addition to the much needed new homes, the development will bring new jobs, economic, regeneration and social benefits for the wider community.

In 2008, there was a renewed commitment to make Ashton Green a reality through a new vision with the aim of becoming the region's leading example of sustainable development. The masterplan vision (2010) for Ashton Green and the outline planning permission (2011) were the outcomes of thorough research and extensive public consultation over a three year period with continuous political support and the commitment of resources to bring forward this exciting development opportunity. Recently there have been changes to planning conditions which will help expedite the scheme.

Ashton Green by its very size will have resourcing implications for all the public sector in Leicester including health.

Leicestershire County Council

The County Council undertakes a proactive strategic view of all its property assets ensuring that only those required to support Corporate and Service delivery are retained and used as effectively and efficiently as possible.

Our recently completed Office Strategy focused on open plan working and changing the way we work including intensifying the layout and utilisation of desks. These changes resulted in the following key outputs:

- Net internal area per FTE reduced from 12.9m2 to 9.9m2
- Overall reduction in net internal area of office buildings of 21%
- Reduction in office buildings from 56 to 16 and enabled the provision of effective locality bases through partnership working with Districts and Borough Councils
- Net revenue saving of £800k pa.

However, the challenges currently faced by the public sector are such that they require a dynamic approach and accordingly, our Strategic Vision focuses on providing a framework for the delivery of the Council's corporate aspirations in addition to pursuing further efficiencies and securing value for money.

Within this framework there are five main themes. The primary consideration being the delivery of Asset Strategies that complement the four main Leicestershire Together priority outcomes by supporting the Leicestershire economy, recognising the challenges of an ageing population and, enhancing community wellbeing. This linked to the maximisation of opportunities recognised through the concept of "total local public asset" and the provision of property services that are available to all public partners will provide a co-ordinated approach to service delivery.

Further, by developing policy through engagement with partners it is possible to more readily identify innovative occupation, procurement and commissioning models. In addition, it is recognised that in order to secure enduring partnership relationships Leicestershire needs to develop a reputation for delivering quality facilities and services that its people value and are proud to use and own.

This vision will be realised by the delivery of strategies informed by a renewed asset challenge and underpinned by the development of an Area Based Asset Strategy which will facilitate earlier and more constructive engagement with potential partners from all sectors. As such LCC Property Services has welcomed the opportunity to work on the base-lining and sharing asset data with Health colleagues as part of Better Care Together to identify and map all assets to start to identify partnership, co-location and rationalisation opportunities through the public estate as the programme continues.

One specific area in development is a the completion of a campus strategy for County Hall, which will offer further potential for co-location to the site by healthcare sector partners in support of the Better Care Together initiative.

Rutland County Council

Rutland County Council have been working closely with external partners and organisations that support the activities of the Council for the past few years, with recent projects to assist in the co-location of a surgery within the county into a Council Library and is now actively working with the Police and Probation Services to review opportunities for co-location within council assets.

The success of the surgery project has identified how working with partners can support (both financially and through complimentary services) the corporate estate being utilised as much as possible.

Rutland County Council is reviewing the estates base to ensure we are utilising our asset base as efficiently as possible, this is supported at a strategic level throughout the authority.

The plans within the Better Care Fund and within the People First review of services will include ways to develop co-location, more efficient use of resources and integration of health and social care services. Each of the work plans will include consideration of better use of assets.

7.1.5 Next Steps

During the next phase of the Better Care Together Programme, June to October 2014, further work will be undertaken to understand the impact of the emerging service models on the estate and develop options where necessary to support these changes.

7.2 IM&T

7.2.1 Overview

IM&T is an important enabler of our plans particularly in supporting provision of safe, integrated care for people with LTCs and the elderly (shared records etc); in driving innovation in service delivery (telehealth, telecare, telemedicine, mobile working etc); and in the use of 'big data' in support of risk stratification and other targeted interventions. IM&T can be used to transform virtually every aspect of healthcare delivery: how and where it is delivered, by whom and, when.

- How – IM&T is a powerful tool for automation and standardisation of processes
- Where – IM&T can be used to reduce reliance on physical healthcare locations and minimise unproductive travel time for patients and practitioners

- Who – IM&T allows specialists to be present in multiple locations either directly through remote consultation facilities, or indirectly through protocol driven logic designed by experts or analytics-driven clinical decision support systems using the latest best practice guidance and research to give real-time advice
- When - e-mail and social network-type sites (e.g. MyHealthSpace) allow asynchronous communication removing the need for both parties to be available at the same time.

The existing Leicester Leicestershire and Rutland IM&T Delivery Board is being used to support BCT. During 2014/15 the board will:

- Produced plans to a 'quick win' around implementing a patient clinical records sharing service for primary and secondary care across LLR. The service will allow clinicians from different 'provider types' across the health economy to view each other's clinical records
- Produced a report and plans which:
  - Identify major gaps in current services or plans
  - Setting out best practice from elsewhere that could be bought in or replicated
  - Outline short-term and longer-term options for closing identified gaps

The groups short-term work plan is to focus on primary Care Records Sharing Implementation using MIG, including work with MIG to expand the solution, for example to include social care. In the short to medium-term we will:

- Produce a LLR-wide information sharing specification to support integrated care
- Create single care planning standards to enable co-production / sharing
- Introduce real-time spine links for social services / EMAS / UHL to obtain NHS numbers

In the medium term we will:

- Issue a care planning specification and amend associated templates
- Continue to progress initiatives to pilot and widen patient access to general practice systems
- Further develop the 'Digital first' initiative.

Longer term we will:

- Develop an LLR-wide patient-centred (not organisation-based) integrated digital care record with shared and inter-operating systems as appropriate
- Consider further development of clinical portal functionality for the sharing of UHL, LPT, social care, EMAS, and primary care out-of-hours data
- Review clinical codes used within NHS provider organisations
- Introduce a 'Clinical Contact Service Centre'
- Develop 'clinical analytics' to allow patients, the public, commissioners and care providers access to comparative performance information spanning all health and social care activity.

7.2.2 IMT Initiatives Delivery Framework Impact Assessment

The table below indicates the coverage and support given by the IMT initiatives to each element of the BCT service delivery framework for service pathways and settings of care:

Table 20: IMT initiatives support to clinical change initiatives

Short term options	Service Pathways								Settings of care					
	Planned care	Urgent Care	Maternity & Neonates	Mental health	Childrens' services	Long Term Conditions	Learning Disability & CHC	FOP	Self care, education and prevention	Transformed primary care (core and enhanced)	Community and social care services	Crisis response, reablement and discharge	Acute hospital based services - secondary	Acute hospital based services - tertiary
Care planning	YES	YES		YES	YES	YES	YES	YES	YES	YES	YES	YES		
LLR-wide information sharing model	YES	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES
Digital first - phase 1	YES	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES
Primary Care data sharing	YES	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES		
Full NHS numbers in Social Services	YES	YES	YES	YES	YES	YES	YES	YES			YES	YES		
Current patient access plans	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES				
Full NHS numbers in UHL	YES	YES			YES	YES		YES					YES	YES
Full NHS numbers in EMAS		YES				YES		YES				YES		
Medium/Longer term options														
LLR-wide Electonic patient	YES	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES
Clinical portal	YES	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES
Digital First - phase 2	YES	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES
Review provider clinical coding	YES	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES
Clinical Contact Service Centre	YES	YES	YES	YES	YES	YES	YES	YES	YES		YES		YES	YES
Clinical analytics	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES			YES	YES
Analytical Tools	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES		
BCT clinical focus areas - info flow	YES	YES		YES		YES	YES	YES	YES	YES	YES	YES	YES	YES
ePrescribing development	YES	YES	YES	YES	YES	YES		YES					YES	YES
OOH procurement	YES	YES	YES	YES	YES	YES	YES	YES		YES				
Strategic patient access plans	YES	YES	YES	YES	YES	YES	YES	YES	YES					
Digital inclusion	YES	YES	YES	YES	YES	YES	YES	YES	YES					

The options for the IMT initiatives were also evaluated using the agreed BCT appraisal criteria of Access; Quality; Achievability; Value for money / Return on investment; Scalability / Level of Coverage.

7.3 Communications and engagement

7.3.1 Overall approach

Providing care in a more efficient way does offer opportunities to improve the quality and convenience of services for patients. However, some of the changes to achieve this will be radical. There is a need to think differently; highly effective communications and engagement will be essential to ensure understanding and acceptance of the need for change across a range of stakeholders – and then to conduct successful public consultation.

A communications and engagement plan has been developed to set out a coherent shared approach for all such activity. It has been jointly developed by communications professionals from local health and social care organisations, together with Healthwatch.

A number of key principles will be followed:

i. The implementation of communications and engagement "best practice"
ii. The embedding of communications to ensure that decision-makers are receiving and heeding advice on all related issues
iii. Strong collaboration between Better Care Together partners and communications teams
iv. Consistency of approach and strong discipline in how that is applied
v. Segmentation of audiences and adaptation of tactics to engage with them
vi. An emphasis on dialogue, where stakeholders are both informed and can contribute

Objectives have been set towards achievement of the overall aim:

- Raise awareness and understanding of Better Care Together and its work
- Increase public and political acceptance of the need for radical service change
- Manage and mitigate any reputational risks arising from the BCT strategy
- Respond consistently across the LLR economy to requests for information about BCT
- Ensure all key stakeholders are fully engaged and informed at an appropriate level
- Create advocates for BCT within the LLR economy through effective engagement
- Ensure and demonstrate meaningful patient and public involvement in BCT, to directly inform its work
- Plan and implement effective public consultation as required, supporting the successful implementation of proposed service change

The primary forum for overseeing this activity is the Communications Group, which is part of the BCT Programme Management Office. The senior communications representatives of all LLR NHS organisations and local authorities are members of the group, supported by the BCT's dedicated communications and engagement lead.

The primary stakeholder groups for Better Care Together have been identified as:

- Patients, recipients of social care and their carers
- The wider LLR public
- All those working in the LLR health and social care economy – including staff directly employed by partner organisations, independent contractors such as GPs and the voluntary sector
- News media covering Leicester, Leicestershire and Rutland
- Local politicians – both councillors and MPs
- Relevant national agencies (eg NHS England and Trust Development Authority)

It is also recognised that these core groups can be sub-divided in many different ways - for example: by geography, demography, organisation or role. Where it is required, specific activity will be tailored to reach particular groups. PPI networks and Healthwatch databases will also be used to maximise reach.

As much as possible, BCT partners' existing communications will be harnessed to ensure effective use of resources. To support this approach, the range of available channels has been mapped for their potential to reach the main stakeholder groups:

Table 21: Stakeholder engagement channels

Stakeholders	Channels						
	1	2	3	4	5	6	7
Patients and carers		X	X		X	X	X
Public		X	X		X	X	X
Staff	X		X		X		
News media			X	X	X		
Politicians			X	X	X		
National agencies				X	X		

Channels:

1. Partners' internal channels (listed in Appendix 3)
2. Partners' external channels (listed in Appendix 3)
3. BCT website
4. Proactive briefings (written and/or face to face)
5. News media
6. Outreach activity (using existing opportunities)
7. Outreach activity (originating opportunities)

Specific messaging will need be produced and shaped according to changing circumstances and audiences. *Better Care Together* is the biggest ever review of health and social care in Leicester, Leicestershire and Rutland. It is a top priority for all the organisations involved. A wide range of doctors and other care professionals have been heavily involved. Wherever possible, clinicians will be used to articulate the case for change - both in BCT materials and via the news media.

Effective communication of the case for change will not on its own ensure public acceptance of proposals resulting from *Better Care Together*. It is important that the people of Leicester, Leicestershire and Rutland can contribute directly to the debate about the future of services.

Publication of the BCT directional plan in June 2014 will be followed by the development of more detailed options for change. Local citizens will be involved in the development of detailed options for change, prior to any required formal consultation.

A programme of engagement will therefore be developed and implemented following publication of the BCT plan, as a pre-cursor to public consultation.

There are three distinct phases to BCT-related communications and engagement:

1. Publication of the BCT directional plan on 26 June 2014.

   Communications will focus on the reasons for *Better Care Together*, the compelling case for change and the work undertaken by BCT so far. This will include a public-facing version of the directional plan.

2. Preparation of detailed options for change, by late September 2014.

   Articulation of the case for change will continue, supported by more detailed engagement work to provide patient and public input into the development of detailed options for change. There will also be a substantial amount of work to prepare for consultation - finalising an agreed narrative, producing materials and planning activity.

3. Statutory public consultation, at a date to be confirmed.

   This will be an intensive period requiring proactive engagement with all key stakeholder groups, particularly the wider LLR public. Any options presented will be in the context of the case for change and the influence of engagement carried out in phase two, to prove the options have not been developed in isolation.

7.3.2 Engagement on this document

Publication of this strategy represents an opportunity to further engage with the wider community on the future of health and social care across LLR. A communications plan for publication has been signed off, containing key messages. The action plan for launching the strategy is summarised below.

Table 22: Action plan for launch of directional five year strategy

Action	Date
Production of public-facing version of BCT plan in Word, for publication along with this strategic plan	w/c June 23
Short summary of plan for use in other communications products/channels	w/c June 23
Production and circulation of updated Q and As	w/c June 23
Proactive briefing of MPs: Collate contact details Prepare briefing materials Send materials and offer briefings Deliver briefings	 By June 20 By June 23 w/c June 23 June 23 onwards
Briefing for Health Scrutiny Committees	As required

Action	Date
Brief staff:	
Prepare briefing materials	By June 20
Send materials	By June 24
Brief via internal channels	June 25 onwards
Brief staffside/union reps	June 25 onwards
Proactive media briefing:	
Arrange	w/c June 16
Deliver	w/c June 23
Press release:	
Prepare, sign-off	w/c June 16
Distribution	For w/c June 23
Media spokespeople:	
Identify	By June 13
Prepare/brief	w/c June 16

The communications teams of all partner organisations will support the engagement of staff around *Better Care Together*. Materials will be produced in advance and cascaded via members of the BCT Communications Group, for use from June 25 onwards. In this way, staff can hear about plans before learning about them via the news media.

7.4 Procurement and contracting

The procurement and contracting processes currently in place across LLR lead to a fragmentation of services across patient pathways that inhibit integration and innovation whilst building in unnecessary delay, duplication and cost.

The scale and pace of change that is required to deliver the outcomes of Better Care Together and ensure a sustainable health and social care economy necessitates a new approach to procurement and contracting that drives collaboration and integration whilst setting an expectation of and rewarding provider innovation. It is envisaged that this will lead to a move away from a 'tariff based' payment system to an 'outcome based' payment system developed around programmes of care across organisations boundaries. Contractual models that are focussed on integration, such as the Alliance contract, will be a key vehicle for delivery; given the lead time to deliver an enabling group will be established to progress this work at pace.

7.5 Workforce planning

The emerging models of care discussed in earlier chapters highlight a number of workforce considerations. For example, shifting care from secondary to community settings will require a review of both generalist and specialist skill balance, the need to ensure a supply of nurses becoming community focused over time and the need to ensure more social care staff are available to support people at home. It is therefore essential that there is a clear understanding of the impact on Workforce across the LLR Health and Social Care system. The Better Care Together Workforce

Enabling Group will provide support, leadership and delivery of the development of a workforce planning and education commissioning strategy across the LLR system. Its core membership is based on the Leicester, Leicestershire and Rutland Local Education Training Committee (LETC), supported by Health Education East Midlands (HEEM), with support from health provider organisation Directors of Human Resources, social care (Local Authorities and Skills for Care), CCGs and local universities.

The group has developed an action plan that includes two key work streams:

- A short term workforce intelligence gathering exercise, to highlight and prioritise the immediate workforce issues in LLR (May –June 2014)
- A longer term piece of work to identify the strategic workforce development initiatives arising from the emerging Service Delivery Framework and the suggested future models of care (July-September 2014).

The emerging models of care highlight a number of workforce considerations that will need to be addressed; and the advantage of utilising the existing LETC governance arrangements is that this provides a ready built mechanism to incorporate the Health Education East Midlands infrastructure and LETB governing body to ensure alignment with educational investment priorities. It also provides a link and some synergy with similar transformational programmes across the wider geography.

Short term work key recent findings:

The LETC, leading the work has begun to identify priority areas for workforce development

- Primary Care Workforce (GP and practice nurses) - (GP fill rate 66%; LLR FTE practice nurse to 1,000 population ratio is lower than neighbouring organisations and England as a whole)
- Wider workforce development (Bands 1 to 4 and equivalent)
- Integration (secondary, tertiary, primary and social care, medical and non-medical)
- Agency and other elements of the non-substantive workforce (current agency spend is c. 8%)
- Community nursing capacity (15.2% of qualified nurses in LLR work in the community).

Subsequent areas for development on a short term basis are:

July to September – production of a workforce plan that outlines the impact of any proposed change in workforce numbers and roles in acute, primary, community and social care with the impact of external factors including:

- Achieving a reduced reliance on agency and locum usage
- Improved recruitment and retention of staff.

It is recognised that a variety of staffing and organisational models will be required to support this service change building on wider NHS experience and best practice.

Key specific initiatives being developed to respond to the transition of our workforce include:

- Different staffing and organisational models to support this service change
    - Translating and articulating the future workforce in the right numbers, in the right place and with the right behaviours to best support patient care
    - Review of both the specialist and generalist skill balance
    - Ensuring that the supply of nurses and other health care professionals are more community focussed over time
    - Changing professional skills in primary care settings
    - Developing skills and competencies that support more integrated working (across professions, acute and community settings and other healthcare boundaries including social care)
    - High acuity, specialist led services in an acute setting.
- Utilising Educational and Training Opportunities to support emerging workforce development
    - Ensure investment in areas like Learning Beyond Registration, Wider Workforce Funds, Education Commissioning and other funding streams are aligned to the transformation agenda, e.g. recent analysis on LBR spend on Frail Elderly was 4% of total budget when it has been identified as a high priority for the local healthcare community
    - Ensure practice placements and support for mentors, supervisors and educators support multi professional and multi-agency solutions
    - Ensuring the LLR workforce meets the health and social care needs of our population as expressed by the Clinical Reference Group of the BCT programme.

7.6 Voluntary and community sector (voluntary sector) engagement

The voluntary sector has long been a source of advice on user experience with regard to a specific condition or patient group, or acting as a conduit for patient and public engagement. However, the voluntary sector also provides commissioners with data analytical support and clinical expertise, in support of transformational change and system re-design. By voluntary sector, we mean local, national and regional charities, local community organisations and social enterprises, also known as the third sector.

The voluntary sector provides a wide range of services to patients, carers and the wider public. Like public sector organisations, the voluntary sector is currently operating in a challenging financial environment. This places constraints on the voluntary sector in several respects, including availability for engagement. Through the Better Care Together Programme we will work collaboratively in order to find the most appropriate ways for engagement, and to ensure the best outcomes for patients and most efficient use of resources.

The voluntary sector has the potential to provide expert, niche advice that is firmly grounded in the needs of patients:

- Use of data and patient and stakeholder engagement to identify current unmet need, anticipate future trends, and contribute to decision-making that is evidence-based
- Use of best practice in terms of data analysis; appropriate use of national and local datasets and up-to-date knowledge of valid process and output measures
- Bring condition-specific expertise to quantitative data analysis
- Translate data into practical next steps and anticipate the impact on patients
- Bring understanding to the patient journey across care settings
- Act as a neutral and trusted broker to initiate dialogue with service users
- Provide access to clinical expertise
- Involve local partners and advocates
- Collate the expertise of various voluntary sector organisations to provide evidence about a group of service users (and not only a single disease or age group).

The voluntary sector can help us to access some hard-to–reach groups and they have a high level of commitment and a willingness to deal with seemingly intractable problems.

During the lifecycle of Better Care Together and the future developments of health and social care within LLR it is fundamental we engage with the voluntary sector, to capture their voice in the early planning of future models of care. We recognise that there are different types of voluntary sector organisations and the programme needs to align itself with as many as is possible.

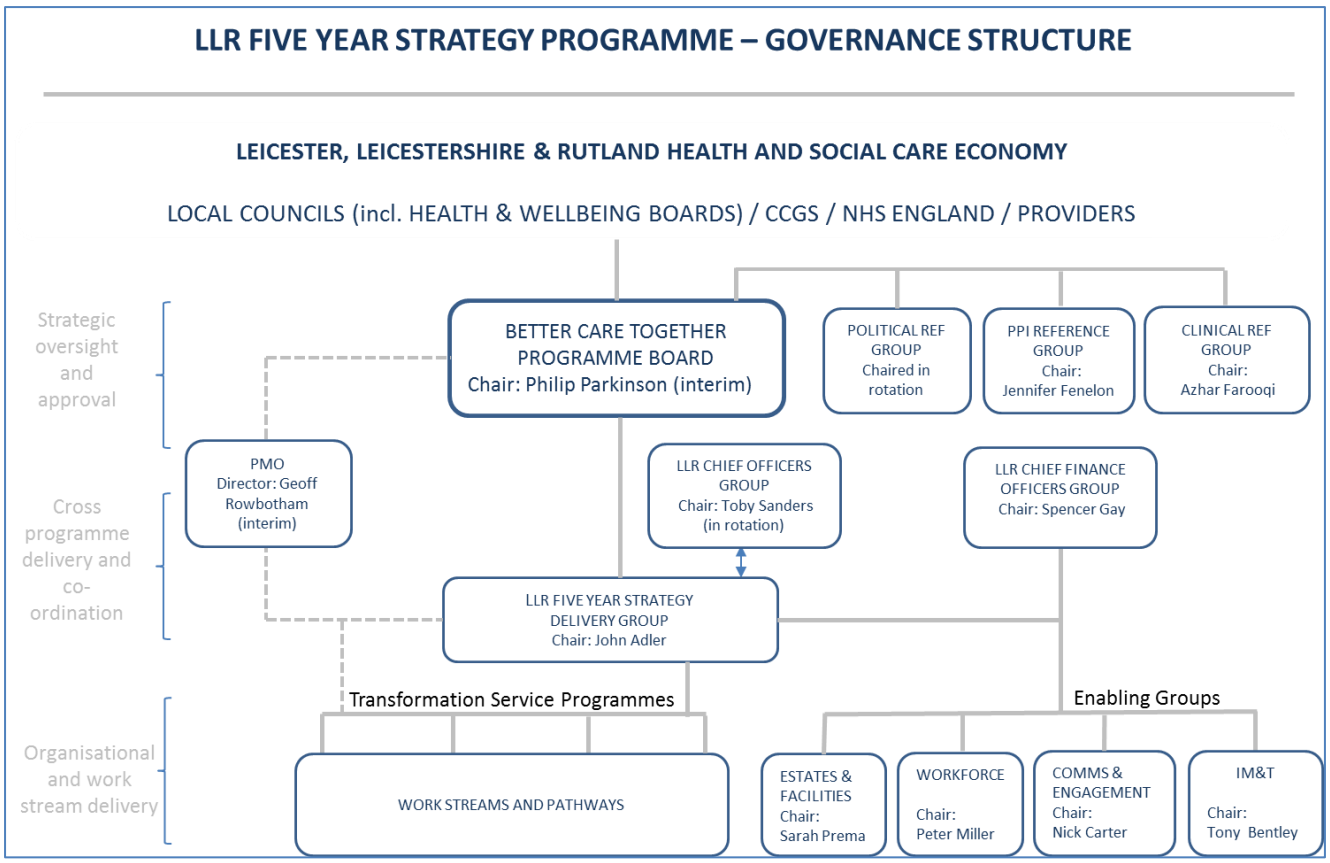
The local authorities and CCGs are fundamental partners in developing a relationship with the voluntary sector, with extensive links to national local and community groups but the programme will need to link further to faith groups, local neighbourhood and community/residents associations, rotary clubs etc, which will also become key partners. The programme will engage through existing local authority networks. The programme already has links to Healthwatch and a PPI Group for user and voluntary sector comment in the initial development stages of the programme. As the programme starts to move into implementation we will increase our involvement with voluntary sector, for example where there are changes to pathways.

8 Governance

8.1 Overarching governance

The overall programme structure is summarised below.

Figure 23: Governance structure



We have based our programme around eight major collaborative work streams of service reform, which are interwoven with the three LLR Better Care Funds:

- Service Reform workstream 1: Urgent Care
- Service Reform Workstream 2-3: Frail Older People, Long Term Conditions
- Service Reform Workstream 4: Planned Care
- Service Reform workstream 5-8: Maternity and Neonates, Children's services, Mental Health, Learning Disability

These are supported by four enabling work streams:

- Enabling workstream 1: Estate reconfiguration
- Enabling workstream 2: IM&T and technology
- Enabling workstream 3: Workforce
- Enabling workstream 4: Communications and engagement

Each CCG has developed its own QIPP plan, each provider has developed its own CIP and Service Development Initiative plan, and each local authority has developed its on Medium Term Financial Savings plan. These, together with the enabling work streams, support the delivery of the eight major collaborative work streams.

The work streams, enablers and savings plans, are all highly interdependent.

8.2 The Better Care Together Strategy Board

The Better Care Together strategy programme is a collaborative partnership which brings together local leaders in Leicester, Leicestershire and Rutland to deliver the shared vision for system reform across health, public health and social care.

The partners committed to delivery of this strategy are:

- NHS Leicester City Clinical Commissioning Group (LCCCG)
- Leicester City Council
- NHS West Leicestershire Clinical Commissioning Group (WLCCG)
- Leicestershire County Council
- NHS East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
- Rutland County Council
- University Hospitals of Leicester NHS Trust (UHL)
- Leicestershire Partnership Trust NHS Trust (LPT)
- Leicester City Health and Wellbeing Board
- Leicestershire Health and Wellbeing Board
- Rutland Health and Wellbeing Board
- Healthwatch (across LLR)
- NHS England Local Area Team.

Collaborative working and system alignment will reduce the risk that the action of individual organisations inadvertently compromises the overall quality and efficiency requirements within the LLR health and care economy as a whole.

8.3 Supporting structures

A ***Chief Officers Group***, covering social care and health, commissioners and providers, oversees the planning for, and delivery of, improving health and wellbeing outcomes for the citizens of Leicester, Leicestershire and Rutland.

A Better Care Together ***Strategy Delivery Group*** leads and reviews the development of the five year strategy and the strategy implementation plan. It oversees all supporting transformation service programmes and work streams.

A ***Chief Finance Officers Group*** oversees an affordable longer term planning framework within which partner organisations of the BCT Programme can deliver sustainable health and social care services to the population of LLR.

A ***Programme Management Office*** (PMO) is accountable for supporting the Programme Board and the whole programme for the development, implementation and monitoring of the health and social

care strategy and plan. Its areas of work on behalf of the Programme Board include establishing programme processes, performance management of the programme delivery and promoting best practice and bench-marking. It supports the Board and all constituent groups and work streams in realising the programme vision and addressing the case for change.

8.4 Public, Patient, Service User Involvement

8.4.1 Overview

We are working closely with the three Healthwatch organisations that operate within LLR. They have supported us through the engagement process that we have undertaken to get to this point in the five year plan's development. We value the support they offer and the scrutiny and challenge they provide to keep patients at the heart of all of our changes. We feel this will help us deliver a robust action plan that ensures the involvement of the LLR public, patients and service users. This involvement informs the design and development of new services or improvements in the quality and structure of current services included within this plan. We are proposing to each Healthwatch body that a general meeting is held, where members from all patient and public involvement organisations and correspondence groups are invited for general discussion on the Programme, and formal engagement between Better Care Together and the three Healthwatch bodies.

8.4.2 Patient and Public Involvement Reference Group

The programme's Patient and Public Involvement (PPI) Reference Group ensures that citizens, patients, the public and wider stakeholders are involved in the early stages of developing planning proposals and in discussing proposals with a variety of stakeholders. It represents LLR service users, patients, carers and the public, working in partnership with Programme commissioners and providers, in line with national policy.

The Group advises the BCT Programme and BCT Programme Board on patient, service user, carer and public involvement. It exists also to challenge and/or confirm the Programme on its engagement, involvement and consultation of patients, service users, carers and the public.

The Group includes representatives from the three local Healthwatch bodies, Clinical Commissioning Group and GP PPI and PPG networks, voluntary sector bodies, Voluntary Action groups for Leicestershire and for Rutland, condition or pathway specific patient/service user representatives, diversity representatives, public interest groups and carers.

8.5 Equality and diversity

The BCT Programme is working with Equality and Diversity leads from member organisations, to agree a consistent, appropriate and proportionate approach to undertaking an Equality Impact Assessment (EIA) of the directional 5 year strategic plan and, once developed, intervention business cases. This approach will be articulated in an Equality and Diversity Strategy for the Programme.

BCT will undertake an Equality Impact Assessment (EIA) of the directional 5 year strategic plan during the discussion and review period. The plan submitted for approval by Health and Wellbeing Boards, CCG Governing Bodies, member Boards and others in September 2014, and by the Programme Board, will be accompanied by an EIA. The EIA will consider how the draft strategic plan addresses the needs of LLR's diverse communities, and assess the impact of the plan on individuals and communities. It will use the evidence base provided in the three JSNAs plus, as appropriate,

other sources of evidence for the plan's actual or potential impact. The accompanying EIA will document the engagement undertaken, and how the strategic plan has been amended in response.

The BCT programme will engage with special interest groups as part of its EIA for the strategic plan. The areas of particular engagement will focus on:

1. Age (pathways for: Urgent Care, Planned Care, Long Term Conditions, Frail Older People, Maternity, Children; bed reconfiguration).
2. Disability (pathways for: Long Term Conditions, Frail Older People, Mental Health, Learning Disability).
3. Gender (pathways for: Maternity).

We will work with the PPI Reference Group to identify mechanisms for exploring with protected characteristic groups, how the pathways not referenced above might have any potential hidden or unintended impact by Age, Disability and Gender. We will work with the PPI Reference Group to identify mechanisms for exploring with Ethnicity, and other protected characteristic groups, how the strategic plan addresses their needs and any potential hidden or unintended impact.

An EIA will be undertaken for the business case developed for each intervention. We will engage with the appropriate section(s) of the community, as relevant to, and proportionate to, the proposed pathway changes. We will pay due regard to equality in the development of each business case. We will expect commissioning and provider partners engaged in service redesign as part of the implementation of the strategic plan, once approved by members and the Programme Board, to ensure that the needs of communities are addressed in commissioned changes.

8.6 Health and Wellbeing Board Involvement

The Leicester, Leicestershire and Rutland H&WB Boards were established in shadow form in April 2011 and published their strategies in 2012/13 to improve health and wellbeing outcomes for the local population (based on JSNA findings). In April 2014 they published their priorities for utilising the Better Care Funding to support improvements in integrated care pathway working.

The H&WB Boards have been and continue to be closely involved in the development of the clinical commissioning intentions and operating plans and we have as a result an integrated approach in the ongoing review and development of health and social care planning. This is achieved through a joint membership approach on respective and appropriate Boards and Committees. The Better Care Together Board's membership includes the Chairs of the H&WB Boards and the health partners are also represented at Board level on the H&WB Boards. H&WB Board members and their wider teams are also active participants across the governance structure in supporting the development and implementation of the LLR Better Care Together programme

The H&WB Boards have regular reviews on the development of the LLR 5 Year Plan and attended the workshop and summit development sessions that have produced the draft LLR 5 Year Plan. They are part of the formal review process for approval of the 'review and discussion' document.

8.7 Clinical reference group

The programme's Clinical Reference Group brings together senior clinicians, public health professionals and social care service leaders, and patient and public involvement representation.

The Group ensures that the outcomes of the Better Care Together programme are clinically driven and delivered within the required timescales for the benefits of all of the patients and service users in LLR. It equally ensures that, collectively and individually, the Better Care Together proposals to change clinical services are robust, clinically safe and in the best interests of patients, service users and the public.

It ensures that LLR citizens, patients, public and wider stakeholders are involved in the early stages of developing planning proposals. Its membership includes medical and nursing clinicians, public health and social care professionals, from each of the Clinical Commissioning Groups, each of the Local Authorities, from University Hospitals of Leicester NHS Trust, Leicestershire Partnership Trust and primary care (GP practices).

8.8 Managing risk

Effective risk management is recognised as key to ensuring effective and safe outcomes within agreed timescales. The approach to establishing a risk management strategy is being established around the OGC Best Practice - Gateway to success principles. The risk register has been established, with the major programme risks to be identified and mitigated during the Programme Brief development stage, July to September 2014.

Table 23: Risk management

Stage	Key actions	Timescale
Programme Mandate Start and scoping	Better Care Together Board • Governance framework and risk register established • Governance and Terms of reference completed and approved for all programme groups • Programme Plan established • Performance dashboard established	April to July 2014
Programme Brief development	Better Care Together Board • Programme Initiation Document established and approved • Detailed performance dashboard established • Major risks identified and mitigated	July to September 2014

During this stage it is planned that external reviews based on the Planning and delivering service changes for patients December 2013 are undertaken (see section 6, Implementation of interventions).

Appendix 1 – Glossary

A&E	Accident and Emergency
AF	Atrial fibrillation
BCF	Better Care Fund
BCBV	Better Care Better Value
BCT	Better Care Together
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
C.diff	Clostridium difficile
CHC	Continuing Health Care
COPD	Chronic Obstructive Pulmonary Disease
DC	Day care
DTOC	Delayed transfer of care
EL&RCCG	East Leicestershire and Rutland Clinical Commissioning Group
FOP	Frail older person
HF	Heart failure
HWB	Health and Wellbeing Board
IM&T	Information Management and Technology
JSNA	Joint Strategic Needs Assessment
KLoE	Key Lin e of Enquiry
LCC	Leicestershire County Council
LCCCG	Leicester City Clinical Commissioning Group
LD	Learning Disabilities
LLR	Leicester, Leicestershire and Rutland
LMC	Local Medical Committee
LPT	Leicestershire Partnership NHS Trust
LTC	Long-term condition
MRSA	Methicillin-resistant staphylococcus aureus
NCAT	National Clinical Advisory Team
OP	Out patient
PPI	Patient and Public Involvement
RCC	Rutland County Council
RTT	Referral to Treatment Time
UHL	University Hospitals of Leicester NHS Trust
WLCCG	West Leicestershire Clinical Commissioning Group

Appendix 2 – Alignment of plans

Alignment of our vision with Operational Plans across Leicester City, Leicestershire and Rutland

The CCG and provider two year plans along with the BCF plans lay out the platform for the stepped change required to redesign and develop community based provision in order to deliver on seven-day working and provision of services that are proactive and integrated with social care.

Our key priorities over the next two years are to redesign community services and transform primary care in order to reduce our acute footprint. This supports the movement toward reducing the number of sites from which we operate and the consolidation of community beds in order to implement a model of delivery that is less bed dependent.

Alignment of our vision to the "Call to Action" engagement programme

The NHS Belongs to the People: A call to action challenges all NHS providers and commissioners, the public and politicians to help the NHS meet future demand and tackle the funding gap through 'honest and realistic debate'. It states clearly that the NHS must change, with a shift in focus from buildings to patients and services. The NHS can increasingly deliver care at home and yet too often patients have to travel to and around buildings.

A call to action identifies a number of challenges requiring a response: An ageing society, the rise of long-term conditions, rising expectations, increasing costs of providing care, limited productivity coupled with the pressure of constrained public resources that the NHS and the Local Authorities face, in particular to address the variation in quality of care across the health and social care system.

However it also outlines a range of opportunities in terms of:

- Quality at the core
- A health service not just an illness service
- Giving patients greater control over their health
- Harnessing transformational technologies
- Exploiting data potential
- Moving away from a one size fits all model of care.

Therefore the focus of our plans as a health and social care economy is to address these challenges locally. This strategy and the associated Plan on a Page outline how we will do this, informed by local engagement. The table below summarises the themes that emerged from that engagement. Each item is cross referenced in the table below to the objectives in the Plan on a Page, with further detail to support each objective available in section 6 of this document – Improvement Interventions.

Area	Objective					
Leicester City	**1**	**2**	**3**	**4**	**5**	**6**
Patients require a holistic assessment of all of their needs, including health and social care, mental health and how to take care of themselves.	X	X	X	X	X	X
The workforce needs to be trained differently around the needs of the patient.	X	X	X	X	X	X
The patient would like continuity of care, including access to the same GP, to be regularly checked and followed up and knowing who to contact	X		X	X	X	X
Care should be integrated into the community, e.g. day centres, voluntary sector	X			X	X	X
West Leicestershire						
Empower patients to shape services and the care they receive	X		X	X	X	X
Support members to deliver excellent primary medical care	X	X	X	X	X	X
Build on our proactive approach to managing complex and multiple long term conditions	X	X	X	X	X	X
Introduce new models to deliver planned care in primary and community settings	X	X	X	X	X	X
Ensure all our providers deliver high quality, great value care for all our patients	X	X	X	X	X	X
Integrate discharge and reablement support to maximise recovery and independence	X	X	X	X	X	X
Expand community urgent response to reduce pressure on emergency services	X	X	X	X	X	X
East Leicestershire and Rutland						
Ensure high quality services by working closely with our providers and clinicians	X	X	X	X	X	X
Raise our performance across the NHS Outcomes Framework domains and Quality Premium	X	X	X	X	X	X
Deliver safe high quality services	X	X	X	X	X	X
Deliver value for money – meeting our financial challenges as a health and social care economy	X	X	X	X	X	X
Focus on helping people to remain healthy for longer through promoting independence and supporting more patients to remain at home	X	X	X	X	X	X
Taking a more life-long approach to supporting people, rather than providing only a disease-specific approach	X	X	X	X	X	X

The feedback mechanisms that have been used to show those engaged how their perspective and feedback has been included comprise:

- Through our membership magazine sent out to our 12,000 members across 3 CCG's

- Through our CCG GP membership newsletters
- Through our engagement event with our PPG Chairs who then cascade information to our PPGs
- Through our staff newsletter sent to all CCG staff
- Through our regular meetings with Healthwatch
- Through the publication of our Local Accounts
- Regular meetings with service users reference groups
- Regular meetings with the voluntary sector
- Through a variety of stakeholder engagement exercises and 'listening' events run by Leicestershire Partnership Trust and University Hospitals Leicester as well as regularly capturing and reporting on feedback from patients and service users.

These mechanisms will continue to ensure that our citizens are kept fully engaged and informed about the system reforms taking place.

Alignment of Better Care Fund schemes to our plans

The BCF is a key enabler of our plans. Each CCG has recognised this and has made a five rather than two year commitment to the BCF. The diagrams below show the alignment of BCF schemes to the settings of care.

Leicestershire

Self care, education and prevention	Transformed primary care (core and enhanced)	Community and social care services	Crisis response, reablement and discharge	Acute hospital based services (secondary and tertiary)	Cross cutting
• First contact (£161,600) • Carers service (£450,000) • Carers assessments (275,000) • Specialist support to people with dementia and carers (£320,000) • Strengthening autism pathway (£94,900) • Assistive technology (£995,000) • Local area coordination (£600,000) • Housing Offer – Disabled Facilities Grants (£1,739,000)	• Expanded Role of Primary Medical Care (£750,000)	• Protection NHS– LD Short Breaks (£844,000) • Proactive Care (West Leicestershire) for those with LTCs(£540,000) • Integrated Model for Long Term Conditions (East Leicestershire) £460,000) • Improving Quality in Care Homes(£501,300) • Protection SC – Nursing care packages (£3,360,600) • Protection SC – Sustainable community services (£1,876,000) • Protection SC – Increasing demographic pressures (£4,584,000) • Protection SC – protection of community care packages (£3,852,000)	• Integrated Crisis Response Service (Health & Social Care) (£2,000,000) • Health & Social Care for Frail Older People (£2,000,000) • Ambulance falls prevention (£100,000) • HART Reablement (£432,000) • Intermediate care team (£580,000) • Integrated residential reablement (£556,000) • Hospital to Home (£72,000) • HART Scheduling System (£130,000) • Bridging Service (£750,000) • Strengthening Mental Health Discharge Provision (£260,700) • Protection NHS- Step Down (£529,000) • Protection NHS - Intensive Community Service (£1,821,000) • Protection NHS- Assertive In Reach (£569,000) • Protection NHS- Reablement (£4,132,000) • Protection SC- Residential Care Respite (£742,600)		• IT Enablers – data sharing, care plans, telehealth & telecare (£650,000) • Protection SC - Cost pressures linked to new models of working (£1,640,000) • BCF programme leads (£112,800)
£4,635,500	**£750,000**	**£16,017,900**	**£14,674,300**	**£0**	**£2,402,800**

Leicester City

Self care, education and prevention	Transformed primary care (core and enhanced)	Community and social care services	Crisis response, reablement and discharge	Acute hospital based services (secondary and tertiary)	Cross cutting
• Assistive technologies for falls, COPD and hypertension (£211,000) • Patient education programmes • Risk stratification (£54,000) • Bring our preventative services together - Leicester City Lifestyle Hub (£100,000) • Carers funding (£650,000) • Disabled facilities grants (£1,001,000)	• Invest an additional £5 per head of population (subject to approval) which will be funded outside of the BCF	• Integrating health and social care systems and data (£4,000) • Patient and service-user satisfaction surveys to include a wider range of services • Integrate community health "single point of access" and local authority "single point of contact" (£211,250) • Improve ability to manage and track outcomes for population • Specific condition-management plans - res home population, then identified by risk stratification • Care navigators - create a network of 10 new Joint Integrated Teams keeping people independent at home, referring to H&SC services, linking with VCS (£250,000) • Commission community geriatric support for the whole pre-hospital pathway System integration post (£63,178) • Mental health community support (£132,000) • Existing ASC transfer (£5,633,000) • 2015/16 increased ASC transfer (£5,650,000)	• Commission a Non-Elective Team (24/7 integrated crisis response service) to build on ICRS • Increase the capacity of the Non-Elective Team • Review and then strengthen our reablement offer across both health and social care (£389,216) • Reablement LPT (£1,125,000) • Reablement funds (£825,000) • Invest in the current Intensive Community Support service - discharging patients home to virtual beds (£389,000) • Commission one virtual team of up to six local GP - to respond to 999 calls deemed clinically appropriate, seven days a week between 8am and 10pm (£1,365,000) • Enhanced night nursing (£90,000) • Mental health discharge liaison team (£42,000) • Integrated mental health step down service (£300,000) • Intensive community support beds (£485,000)		• ASC capital grants (£876,000) • Contingency (£2,841,356)
£1,015,000	**£0**	**£12,944,428**	**£5,584,216**	**£0**	**£3,717,356**

Rutland

Self care, education and prevention	Transformed primary care (core and enhanced)	Community and social care services	Crisis response, reablement and discharge	Acute hospital based services (secondary and tertiary)	Cross cutting
• Community Agent and In Touch Service (£200,000) • Joint commissioning approach to prevention services (TBC)		• Integrated Care Model – risk stratification (£39,000) • Housing Related Support – support in people's own homes rather than institutional settings (£180,000) • Integrated Hub Approach - single specification and model of delivery that will integrate the planned and unscheduled elements (£405,000) • Integrated dementia pathway - improvement in early diagnosis carer support, improving patient and service user experience and falls prevention (£100,000) • Learning disability – integrated LD pathway (£84,000) • Telehealth and telecare (£82,000)	• Reablement (£486,000) • Integrated Crisis Response (£500,000)		• Programme support (£50,000) • NHS number and data sharing (£100,000)
£200,000	**£0**	**£890,000**	**£986,000**	**£0**	**£150,000**

Appendix 3 – Evidence for Scale of Ambition

Each of the three CCGs will develop and present its own trajectory for change; representing the selected Levels of Ambition for each local area.

The NHS Levels of Ambition Atlas

This Atlas provides a range of baseline and time-series data that we have used to develop the levels of ambition set out in this plan. We have also used the atlas to inform the data for the indicators aligned to the Better Care Fund Plans.

The data within this Atlas tells us that we have made improvement in the quality of care provided to our citizens but that there is still much work to be done to enable a sustainable financial future for the health and social care economy.

CCG/Local Authority Outcomes tool

These tools provide interactive access to detailed analysis of NHS outcomes and other relevant indicators at a CCG level. We have also used the local authority packs in conjunction with the CCG tool, to map our ambitions against the NHS, local authority and public health outcome frameworks.

The intelligence used from these tools has been used, with the Atlas described above, to determine our ambitions for improvement.

Other resources used

Transforming participation health and care: a toolkit developed by NHS England with a wide range of stakeholders and partners with a purpose is to support commissioners to improve individual and public participation and to better understand and respond to the needs of the communities they serve. We will use this toolkit to develop further our citizen participation strategy, designed to fulfil not only our statutory responsibility but to seize the opportunity to deliver personalized and responsive care to all.

Learning Collaborative: we have actively using the new NHS England Learning Collaborative, which allows CCGs to collaborate, share best-practice and test ideas with peer areas in an online forum. We will continue to use this resource as a vital tool for both our Better Care Fund and delivery of the improvements outlined in this plan.

We will work closely with best practice within local government – including with the Local Government Association, the Association of Directors of Adult Social Care (ADASS), Think Local, Act Personal (TLAP), Skills for Care and the Social Care Institute for Excellence (SCIE) guidance.

Appendix 4 – Evidence base and modelling assumptions

Urgent care

Proposal	Key changes to pathway	Evidence base	Assumptions
11% shift in A&E attendances to co-located and stand alone UCC and MIU applied to County only	• Help people to choose right and look after themselves when appropriate and greater effectiveness of signposting • Make urgent care services across LLR consistent	• McKinsey Report suggested 60% shift, however this was deemed to be ambitious • NHS England review suggested 25% could be shifted	• **11% shift in total attendances (~64 attendances per day)** • **Shift in each of the following minors only; HRGs VB11Z, VB09Z, VB08Z, VB07Z (equating to a 25% shift in each)** • Shift from UHL A&E to UCCs (excluding FOP/LTC) • **Reduction staggered across years 3, 4 and 5, by 4%, 4% and 3% respectively** • Excludes FOP/LTC • **Excludes children (under 18) as new workstream added to children's** • **Impact modelled on 13/14 data (post introduction of co-located UCC)**

Proposal	Key changes to pathway	Evidence base	Assumptions
25% reduction in ED admissions (reduction of 13 admissions per day) **applied to County only**	• Support A&E to be as effective as possible including delivering seven day consultant-led services	• McKinsey Report 2013 • Supported by EMPACT Utilisation Review	• Avoiding 13 of 100 ED admissions per day • Conversion rate of 17.6% from A&E attendance • 25% reduction in all converted admissions • Excludes FOP/LTC • **Excludes children (under 18)**
6% reduction in NEL LoS	• Develop more services to support people at home or in the community including developing integrated crisis response services	• McKinsey Report 2013 • Supported by InterQual Report 2014 suggesting 789 inappropriate bed days across UHL sites	• **Based on a reduction of 10% of all attendances, reduced to exclude FOP/LTC and children (under 18)**

Frail people and long-term conditions

Proposal	Key changes to pathway	Evidence base	Assumptions
Reduce acute headache admissions	• Ensure efficient pathways for ambulatory conditions which are based in the right setting • Develop care plans together to improve health outcomes to the best they can be supported by a community multi disciplinary team approach • Ensure that medical outreach and rehabilitation are available when required	• Review of Ambulatory Care Sensitive Conditions	• Reduction of 1.2% per annum years 1-5 • HRG AA31Z only • 1,083 admissions in 2013/14
Reduce cellulitis admissions		• Review of Ambulatory Care Sensitive Conditions	• Reduction of 12.1% per annum years 1-5 • HRGs JD03C, JD04C, JD05C, JD03B, JD04B, JD05B • 643 admissions in 2013/14
Reduce COPD admissions		• Review of Ambulatory Care Sensitive Conditions	• Reduction of 10% per annum years 1-5 • HRG DZ21A-K • 4,456 patients with COPD in March 2011

Planned care

Proposal	Key changes to pathway	Evidence base	Assumptions
10% of **outpatient** services decommissioned	• Reduction in unnecessary steps in patient pathway and reduced duplication	• McKinsey Report 2013 • Workshop discussions • Better Services, Better Value; Benefits Framework	• This is across all three CCGs • There will only be a 1% decommissioning in Year 1 • This will rise to the full 10% from Year 2 and will be maintained until Year 5
50% repatriation of activity **into UHL** from outside of the health economy	• Work with Public Health and others to devise patient and public education in relevant areas	• McKinsey Report 2013 • Better Services, Better Value; Benefits Framework	• It is expected that this will bring around £30m into the health economy • There will be a 10% repatriation in Year 2 • This will increase to 50% from Year 3 • All repatriated activity will be subject to left shift and decommissioning

Maternity and neonates

Proposal	Key changes to pathway	Evidence base	Assumptions
1% shift from consultant led to midwife led	• Increased home births from 2% to 3%	• 2010 OBC – demographic and case mix growth	• There will be a 25K saving Year 1 (0.33% shift) • There will be a 50K saving in Year 2 (0.66% shift) • There will be a 75K saving in Year 3, 4 & 5 which is the full saving (1% shift)
Increase of choice for home births	• Review and consult on future shape of maternity services	• 2010 OBC – demographic and case mix growth • 2010 OBC – choice preferences	• There will be a 1% shift to home births – total of extra 110 births at home. • 37 of these will be in Year 1 • Another 37 in Year 2 • The final 37 in Year 3 (total 111 home births)

Children, young people and families

Proposal	Key changes to pathway	Evidence base	Assumptions
Non elective pathway redesign including single front door and GP training (admissions avoidance)	• Develop options to facilitate greater integrated working between all sectors	• Front door business case • Expected return off investment put into consistent paediatric training for GPs	• Estimated saving of 220K • It is assumed that only 25% of this will be saved in Year 1 (55K), 50% (110K) will be saved in Year 2 and then 100% (220K) in Year 3, 4 & 5
Integrated Children's Services **– 10% reduction in paediatric admissions**	• Develop options to facilitate greater integrated working between all sectors	• Care coordination associated with case management is shown to provide returns • Further work on the Sheffield model of care and benchmarking to confirm figure	• **There will be no reduction in Year 1 & 2** • **Reduction in Year 3 will be 5%** • **In Year 4 & 5 this will be 10%** • **No investment has been factored in**
Management fees	• Develop options to facilitate greater integrated working between all sectors	• See above children's workstream's view of duplicated costs associated with double management structures	• The total saving will be £500K • **Year 2 saving will be 5%, Year 3 50% and in Year 4 & 5 100%**

Proposal	Key changes to pathway	Evidence base	Assumptions
Outpatient – shift to community	• Develop options to facilitate greater integrated working between all sectors	• Revised down McKinsey Model assumption • Differentiated between city and county model	• There will be different reductions in the city and the county. • County: - Year 2 5% - Year 3 10% - Year 4 15% - Year 5 15% • City: - Year 4 15% - Year 5 15% • The services will be provided at a 20% lower tariff
Increase of paediatric clinic day care - reprovision of 30% of global paediatric day care (dressings, IV, BP, hormone injections) in alternative setting of care split and phased in the following way for all County paed OP	• Develop options to facilitate greater integrated working between all sectors	• Revised down McKinsey Model assumption	• **County:** - **Year 2 - 5%** - **Year 3 - 10%** - **Year 4 & 5 - 15%** • **City:** - **Years 4 & 5 - 15%**

Mental health

Proposal	Key changes to pathway	Evidence base	Assumptions
Reduced LOS and admission prevention	• Repatriation of out of county mental health placements to be managed in a newly designed LPT pathway	Based on ongoing West Leicestershire CCG project work. Information to be shared following internal QA by West Leicestershire CCG.	• Reduced LOS and admissions avoidance as a result of the redesigned service for out of county placements expect to generate savings worth £4m • Require more information on the number of beds that will be saved • More detail on the activity shift required for the model and the number of beds reduced as a result of the improvements in LOS • Any disputes with the contracts also need to be resolved in order to fully understand the QIPP/CIP savings • This is currently included in the model however further investigation is required to confirm its inclusion. We need to understand the element of the CIPs/QIPPs generated
Procurement saving (Alliance contract)		**Government Procurement efficiency paper (YouGov website)**	• **Proposed £12m procurement saving will be generated as a result of the new Alliance contract** • **It is included in the updated model however the detail such as the impact on activity, settings of care this saving relates to, the net impact of costs on the organisations involved is still required**

Learning disabilities

Proposal	Key changes to pathway	Evidence base	Assumptions
Shift from house day services to community based activities		Leicester City Council LD work	• Shift will release £450,000 of savings by 2016 • Savings are net of investment required • Savings are net of possible redundancy costs • More information around activity shifts required to add detail to the model
Move from residential care to independent / supported living		Leicester City Council LD work	• 20 people to make the shift to independent living, saving £600 per person • Shift will release £12,000 of savings in each year • Savings are net of investment required • More information around activity shifts required to add detail to the model
Community Redesign		LPT CIP work (SDI)	• Reduction in staffing costs of £500,000 by the end of 2016 (£175k in 2014/15 and £325k in 2015/16) • Equivalent to 5% cut from LD team budget (excluding admin)
Joint market strategy		Assumptions agreed by LD stakeholders	• 5% saving on total spend on CHC and joint funded long term LD care packages • Total saving of £1,397,049

Proposal	Evidence base	Assumptions
Shift from house day services to community based activities	Leicester City Council LD work	• Shift will release £450,000 of savings by 2016 • Savings are net of investment required • Savings are net of possible redundancy costs • More information around activity shifts required to add detail to the model
Move from residential care to independent/supported living	Leicester City Council LD work	• 20 people to make the shift to independent living, saving £600 per person • Shift will release £12,000 of savings in each year • Savings are net of investment required • More information around activity shifts required to add detail to the model

Appendix 5 – Better Care Fund

Leicester City

Leicester City is a relatively young population, with about 60% of the population under 40, however the over 65 population is steadily increasing; it is ethnically diverse with nearly 50% of our total population from black minority backgrounds compared to 15% nationally. There are high levels of deprivation across the city with almost half of the population being classified as highly disadvantaged. Such deprivation has profound social effects and impacts on people's health and wellbeing. Although we are a young city the life expectancy gap in the population is below the national average; this often results in the over 65 population suffering ill health and chronic disease earlier and people dying prematurely.

Changing this picture is the priority; the current model of care leads to too many people presenting late with poor outcomes and often in a hospital setting when they do not need to be. It often provides unaffordable and variable quality of care, placing a high demand on hospitals. Our resources are concentrated on crisis and statutory services, rather than designed to keep people independent. Typically, our services are not coordinated in a manner which serves our population; this leads to duplication of effort across agencies.

We need to move the emphasis to prevention; early detection; intervention; treatment; and supporting independence which will improve patient outcomes and result in a more sustainable system. It will move us towards a long-term, high quality and affordable model of patient care. It will enable our citizens to remain independent for longer; reduce the time spent in hospital avoidably and enable the health-related quality of life for our citizens to be improved.

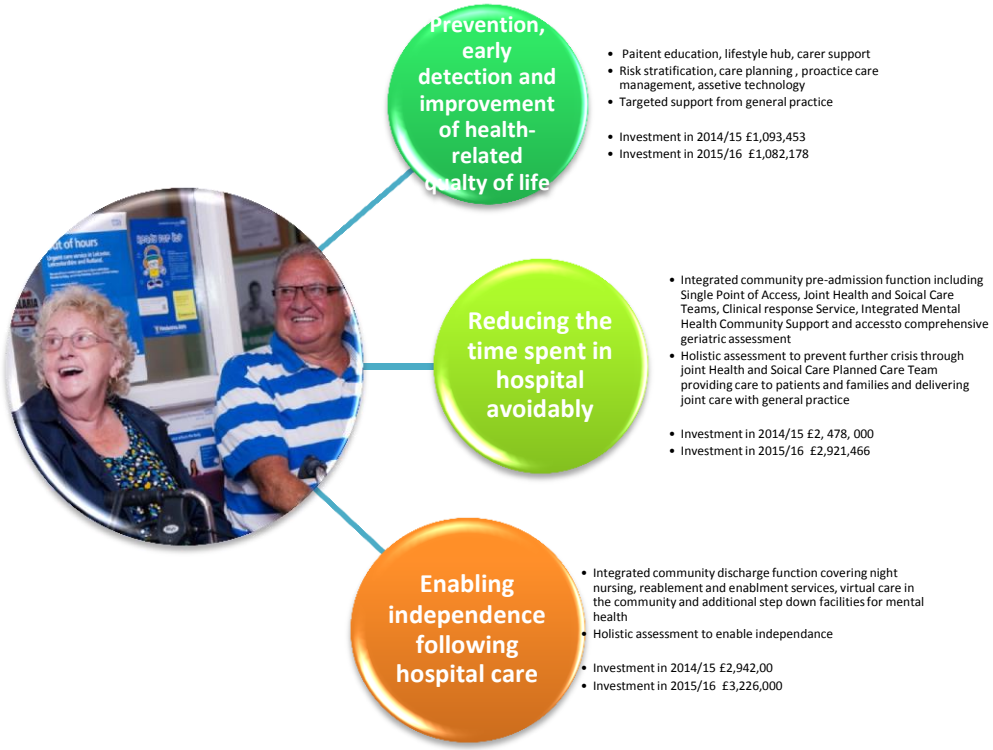
Work has already been implemented in Leicester City which supports this move through the "3T" approach. This is where general practice are taught and trained to identify particular symptoms or disease that could be treated and cared for in primary care. An example of this is in Diabetes care where all general practices have been trained to improve their care and detection of diabetic patients; some have also been trained to provide an enhanced level of care. This will result in 956 patients being cared for in primary care instead of in hospital allowing the hospital service to concentrate on providing more complex care to those who need it.

The next stage is to use the Better Care Fund to focus on an integrated approach to care for all those over 60; who have dementia; or 18-59 year olds who have three or more co-morbidities. Our aims through the Better Care Fund are to:

- Design and commission services centred on our patients, public and carers.
- Empower our population to be both better informed and better manage their own health and wellbeing using a range of traditional and digital media and technology.
- Develop a new model of primary care that provides a more proactive, holistic and responsive community service across physical and mental health.
- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care.
- Reduce the amount of time spent in hospital avoidably by our citizens.

- Ensure that people are able to remain independent for as long as possible following hospital care.
- Provide safe, transparent and open data sharing across our system, enabling proactive coordination of care for our citizens.

The key interventions that will achieve these aims are:



In addition to the above interventions £8,256,000 in 2014/15 and £16,001,356 in 2015/16 will be invested to ensure sustainable social care services and provide disabled facilities grants.

The Better Care Fund is a key strategic driver to the delivery of the Better Care Together Strategy particularly in the Frail Older People, Long Term Conditions and Urgent Care workstreams; many of the interventions detailed in these workstreams will be delivered through the Better Care Fund. The following outcomes will be achieved from the Better Care Fund interventions:

Prevention, early detection and improvement of health-related quality of life:

- Increasing the number of people identified as ‘at risk’ and ensuring they are better able to manage their conditions, including out of hours, thereby reducing demand on statutory social care and health services. This will include both physical and mental health.
- Delivering ‘great’ experience and improving the quality of life of patients with long term conditions using available technology and patient education programmes, reducing avoidable hospital stays.
- Enabling the use of the NHS number as a primary identifier for all patients, linked to high-quality care plans for our frail elderly patients or those with complex health needs.

Reducing the time spent in hospital avoidably:

- Ensuring every person in the cohort experiences coordinated unplanned and planned care from an integrated team, ranging from health to social care to housing and financial services, which responds in a coordinated way to ensure care is delivered in the community and around the individual. This includes increasing capacity in General Practice.
- Reducing the number of avoidable hospital admissions through the provision of rapid community responses, instead of a 999 response. This will focus primarily on those over 60 years of age.

Enabling independence following hospital care:

- Ensuring timely hospital discharge via the provision of in-reach teams to swiftly repatriate people to community based services and maintain independence.
- Increasing the number of patients able to live independently following a hospital stay.

In addition to these improved outcomes for patients the Better Care Fund will deliver £5.5m of savings in the next two years.

The following story illustrates how Better Care funding will impact on our patients.

Mrs Smith is 78 years old and lives alone following the death of her husband two years ago. She is known to her GP but does not have any underlying health conditions. She has been fit and active with normal coughs and colds and the occasional chest infection.

One day in early June 2014, she felt unwell at about 6pm, feeling feverish and lethargic and suffering from lower back pain. She felt unwell enough to call 999. EMAS took the call and Mrs Smith was clinically triaged by the Clinical Assessment Team. The nurse who completed the triage downgraded her call from a G1 (serious but non-life threatening) to a G3 call (non-life threatening, non-emergency) and dispatched the Clinical Response Team.

The CRT GP arrived within 20 minutes of Mrs Smith's call and she was assessed and treated with antibiotics. The GP also noted that Mrs Smith was unlikely to be able to cope on her own over the next few days and so referred her to the Unscheduled Care Team for a full holistic assessment of need to keep her safe and well at home for the next 72 hours. The team provided the following:

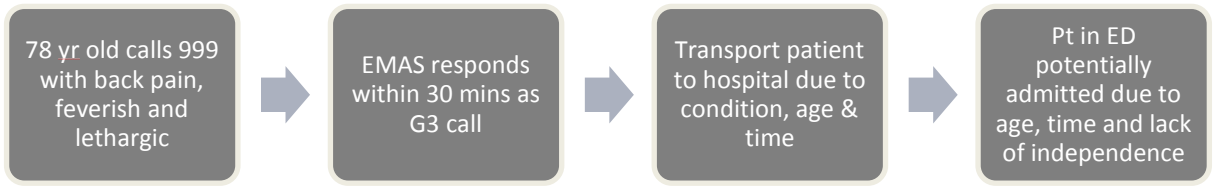
- *Full assessment, including assessment by physiotherapist relating to concerns about patient's ability to transfer safely.*
- *Put in package of support to help with personal care, .with meal preparation and assistance to drink.*
- *Perching stool ordered.*

Upon further investigation by the Unscheduled Care Team, it was discovered that Mrs Smith was also mismanaging her medicines because she was confused as to which ones she should still be taking and when to take them. The UCT requested Mrs Smith's own GP to provide an urgent medicines use review and this was sorted out over the next 24 hours.

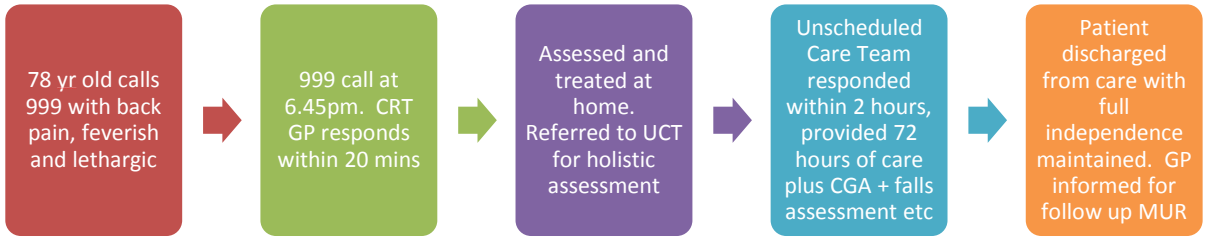
After three days Mrs Smith was well enough to be discharged back to routine care with no residual package. Prior to the Better Care Fund services being in place Mrs Smith would more than likely been taken to hospital and admitted.

The diagram below demonstrates the old and new pathway for this case study.

Usual patient pathway



What actually happened via the BCF pathway



Leicestershire

Background

The Better Care Fund plan is a Leicestershire countywide plan. The aim of which is to deliver support to the citizens of Leicestershire in a co-ordinated way when they find themselves in need of services. The plan recognises that people rarely need support from a single service as they age or if they are vulnerable through mental ill health or disability. In the past our populations have told us that they find it difficult to navigate between services and feel that there are barriers in the way as they move between health, social care and other statutory services. The barriers that citizens find as they try to access different statutory services are not understandable or acceptable to the population we serve. As a result, this plan aims to reduce and eventually remove those barriers by working towards a fully integrated service provision with people at the centre of the services that we deliver.

In order to deliver to this aim we have adopted the following principles:

- I tell my story once
- I am always kept informed of what the next steps will be
- I always know who is coordinating my care
- I have one first point of contact
- I can see my health and care records at any time
- I know how much money is available to me for care and support and can determine how this is used.

Early work on this integration journey has commenced, for example during 2013/14 all of the planned services that support Long Term condition management, were combined into a single specification to enable the delivery of planned support to long term condition patients. This service specification included the case management components both health and social care. This work created locality based neighbourhood teams that work in an integrated fashion with community health and social care delivering a defined service around a defined set of GP practices. This steadily developing piece of work has made a significant contributed to the reduction in attendance and admission in ambulatory case sensitive conditions that West Leicestershire CCG (WLCCG) has experienced 2013/14. The development of this piece of work enabled East Leicestershire and Rutland (ELRCCG) to add to their integrated team by using the shared learning that the local authority WLCCG and ELRCCG developed together.

This success has created the blue-print for our combined plans going forward in the Better Care Fund (BCF). Our BCF plan looks to finding solutions for people in 4 areas:

- Unified prevention offer
- Pro-active management of Long Term Conditions
- A unified crisis resolution service
- Discharge and reablement support for people who have had an acute spell.

Crisis Resolution – Investment and Long Term Conditions 2014/15 £14,269,000; 2015/16 £32,888,000

During 2014/15 we will integrate all of the specifications and service lines that contribute to urgent care knowing we have a full service offering in place from September 2014. This service will avoid unnecessary admission and attendance and allow us to reduce LOS for people in an acute trust. This service will be called Integrated Response Service.

Therefore Leicestershire County Council, East and West Leicestershire CCG will work together to combine the following specifications into a single service delivery and shape it to deliver around appropriate GP localities in Leicestershire. Those specifications are Intermediate care, intensive community support (including night cover), reablement (health), reablement (Social Care). The benefits of combining small services into a single larger service are as follows:

- We can provide a needs lead service
- We will provide a single service managed through a single co-ordination point which is 7 days a week for 24 hours a day.
- This will create a team of sufficient size and scale to respond to presenting/escalating patient need within 2 hours
- This will ensure savings targets for commissioners are providers can be delivered.
- There will be process efficiencies in referral times and choices- by providing the acute trust with a single discharge service
- There will be process efficiencies in referral times and choices – by providing GP's, social care and community health services with a single service to avoid unnecessary acute admissions

- There will be savings in duplications between teams, and inter-team referrals and better options for people to receive skills training to enable them to better meet the need needs that are presenting as the population ages
- This will allow the ability to manage peoples escalating health needs in a risk stratified way which matches their need with resources required rather than requiring services to decide whether patients are eligible for care
- We will produce an outcomes focussed specifications that includes not excludes people, so they know where they are and who will be caring for them in their time of crisis.

Underlying these activities will be a full programme of works around work force engagement to ensure that people are clear about their roles and relative contributions to the delivery of the new service specification and a skills profiling activity and training programme to maximise the early benefits of deployment.

We anticipate that the further maturing of the planned care elements delivered around GP surgeries combined with the deployment of services to cover the service gaps in urgent care with the work force strand of work over 2014/15 will deliver a 5.5% reduction in avoidable admissions (national definition, composite measure, on 2012/13 out turn) for 2014/15.

Some of the individual component parts of the service offer, currently have a high unit cost. Through 2014/15 we will be working with public health to evaluate the benefits of the model both qualitatively and quantitatively to ensure that we are able to consider the interventions that add the most value and produce the most benefits for people through the specification period. This will form the ongoing basis of service improvement that we will follow through 2015/16 for this integrated service pathway, to ensure we are adding and delivering best value to the people of Leicestershire.

The current plans that we have set a direction of travel, by 2015 those plans will have reached sufficient maturity to allow us to expand our service offer during 2015/16 for Frail Elderly patients in the county.

When we add together the following component parts:

- GP's case managing all over 75's at risk.
- Long term conditions teams integrated around a locality base of GP case managers
- 2 hour response time,7/7 urgent care coverage with 24 hour capability that can meet peoples care needs for up to 72 hours

It can be observed that the work we have been undertaking together since 2012 is creating a pathway of support for Frail Older adults, which allows us to proactively manage their long term conditions and support their crisis around exacerbations for up to 72 hours in the community. This cohort of people is often subject to diagnostic uncertainty since their ill health might be accompanied by a fall or a UTI or be caused through a change in their social or psychological circumstances. What 72 hours of support in the community buys for people and commissioners is an opportunity to change the context of their care.

That context change is that whereas currently people subject to this type of diagnostic uncertainty are cared for by being routed through an A&E department at the Leicester Royal Infirmary, the above changes allow the option to move interventions for elderly patients from an urgent care setting to an planned intervention not in an A&E department.

Discharge and Reablement: Primary medical care in Leicestershire is of a very high quality, and already GP's routinely manage complex issues for older patients. However, when older patients become unwell they need investigations and medical supervision as well as intensive nursing support for a short period of time. They are not acutely ill in the traditional sense of what hospitals are designed for but end up there because there are very few options that can offer diagnostics, medical supervision and intensive nursing input other than urgent care in an acute hospital.

This is very disruptive for older people and as a result there are often issues that surface through a hospital stay that make it difficult for people to return home in a timely fashion. There is a considerable weight of evidence that demonstrates that if older people are cared for close to home and their time out of their own home is minimised that not only is their mortality at 4 months much improved but they maintain stability in their mental health and well-being. The evidence around resource use is less well evidenced. That is primarily because very few places have managed to construct a pathway that covers the totality of frail elderly needs from primary care to secondary care investigations that include social care and the well-being component to care that this totality brings. The high unit costs of separate components of care have made that a difficult step to take in most systems.

However, there is a growing body of evidence that suggests reductions in LOS in acute trusts to levels below 15 days reduces mortality and ongoing costs of managing the care of older people, since their chances of regaining previous functional baselines improves. Also there have been local service developments in areas surrounding Leicestershire that demonstrate that if crisis can be avoided less resource is used by patients to recover their pre-illness baseline function (up to 10 days rather than 6wks post hospital stay) and the elderly frailty unit at Burton has seen a significant reduction in LOS and care costs for the patients in West Leicestershire who have used it.

Therefore during 2014/15 business cases for the development of a county based Elderly Frailty Unit will be constructed, working with primary medical care, social care, community health services, acute providers and the ambulance trust. This will be programme managed through the Step-Up programme board, which is a shared resource between Leicestershire County Council, East and West Leicestershire CCG's.

The benefits of this piece of work are as follows:

- People will not be subject to the disruptive and de-stabilising effects of an urgent care episode since their care will be managed in a timely planned fashion.
- People will be subject to reduced disability and disruption to their mental health and well-being since they will spend less time away from their own homes
- We will aim to reduce social care spend on residual care needs by reducing disability and the institutionalisation effects of care on the over 75's population
- We will reduce the admission to residential and nursing homes that predominantly result from a disruptive unplanned hospital stay.

- This will allow people to make more planned decisions about their entry into residential care
- We will reduce the health spend overall on the pathway for frail elderly patients by moving care into more planned settings which allow providers of care to staff services effectively and reduce the use of agency and bank staff.
- We will support our providers to more effectively recruit to new care models and permit them to 'grow' their own staff where new skills are required.
- We will make better use of our system resources such as buildings which are currently under-utilised.
- This will permit our providers to make more planned decisions on the maintenance and use of their own estates resources which will allow them to make the cost savings they need to.

These pieces of work have formed the foundation of the BCF plan and have a trajectory that follows in depth and detailed work that has been on- going since 2011. They have responded to the challenges of pro-actively managing Long Term Conditions, resolving crisis as it occurs and enabling people to return home in a timely fashion after an episode of ill health. However, in developing the BCF plan this year we did identify that there was considerable scope for reducing the risk of entry into health and social care services in the prevention agenda. Therefore our BCF plan has a forth strand of activity which is around prevention.

In addition to the patient outcomes described a saving of £10,845,000 will be achieved in the next two years.

Unified Prevention Offer – Investment 2014/15 £ 3,730,000; 2015/16 £5,479,000

In the area of prevention we will be consolidating all social care prevention offers into a single offer. We will be working with our housing colleagues to enhance the housing offer to health and will be developing services around local area co-ordination to ensure that people who are not currently eligible for social care services can access a preventative option which delays their entry into eligible social care services, by preventing episodes that could and should be avoided for them. In addition to the patient outcomes described a saving of £6,048,000 will be achieved in the next two years.

See the case study, 'Chris is 46, presented in section 4 above, and the 'follow on' case study below.

When Chris' mother was alive and as Chris's carer, it is likely that it would have been Chris' mother who would have responded to Chris' needs. Chris' mother's GP would have made a referral to the Local Area Co-ordination (LAC). Meeting with the family early would have allowed the LAC time to think about solutions that might work. In this case the LAC introduced Chris to Jenny.

Jenny is a 68 year old ex-school secretary. Her husband died 18 months ago from a heart attack, and her children have moved away from the area. She was used to being an active and productive member of the community, and since her husband's death had struggled to find a sense of purpose. She had become aware of the LAC scheme by picking up a leaflet in her local grocery shop, and had contacted them hoping there was something she could do to find her sense of purpose again.

Jenny and Chris shared a common bond, the death of a very significant person in their lives, and this helped them forge a relationship of mutual support. Jenny supported Chris to learn how to manage his bills and attendance at work, it helped that she wasn't his mother and could see that he could learn these tasks for himself, given enough time. Over a period of 2 years after his mother's death Chris learned how to care for himself and Jenny regained her sense of purpose. She met a new group

of friends through her work with the LAC and has started a new local group that supports people to maintain their tenancies during tough times.

Local Area Co-ordination is seen to be key to addressing the concerns of our public and our social care colleagues in preventing people being drawn into services.

Rutland

Rutland Council and East Leicestershire and Rutland Clinical Commissioning Group are using the Better Care Fund as an enabler towards the Rutland Better Care Fund Vision:

"By 2018 there will be an integrated social care service that has significantly reduced the demand for hospital services and puts prevention at its heart"

The three key themes are – Early Intervention and Prevention, Step up/step down care and Long term conditions. The projects for these themes are in development and initial plans include developing information and advice services to manage demand, an integrated crisis response service that will contribute to admission avoidance, Reablement services joined up with health teams to improve discharge from hospital, an integrated health and social care hub locally to make the most efficient use of resources and improve user experiences. The key projects and funding are described below.

Theme	Elements	Funding £
Early Intervention and Prevention	Community Agent and In Touch Service	14/15 – 39K
	Joint Commissioning approach to prevention	15/16 – 239K
	Integrated Care model	
	Housing related support	
Step up/step down integrated with reablement	Integrated hub approach	14/15 – 586K
	Integrated crisis response	15/16 – 1.555M
Enhancing quality of life for people with long term conditions	Integrated dementia pathway	14/15 – 50K
	Integrated LD pathway	15/16 – 184K
Enablers	Programme support	14/15 – 113K
	NHS number and data sharing	15/16 – 266K
Total		14/15 – 788K 15/16 – 2.24M

The investment from the Better Care Fund will have the following impact:

- 12% reduction in permanent admissions to residential and nursing homes
- 20% increase by 2015 in proportion of over 65s still at home 91 days after discharge
- 2% reduction in delayed transfers of care per 100,000 population
- 2% reduction in avoidable admissions
- Reduce number of falls by 7%
- Improve patient/service user experience (to be measured in 2015/16)

These will be realised through the projects that are being developed with a focus on hospital avoidance and integration.

Over the next 5 years community healthcare and social care teams will work together in an increasingly integrated way moving towards single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home.

Teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. We will invest in empowering local people through effective care navigation, peer support, mentoring and self-management to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

We will invest in integrated community services that will provide a rapid response to support individuals in crisis and help them to remain at home. Reablement services will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication. The service will introduce individuals to the potential of assistive technologies (devices within the home that can be used to keep people safe or assist them, such as lifeline alarms) and, where these are to be employed, will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of reablement services. The service will be able to:

- Improve the management of demand within both the health and care systems, through earlier and better engagement and intervention;
- Work sustainably within current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals”

Systems will enable and not hinder the provision of integrated care. Providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

In doing so our ambition is to go far beyond using BCF funding to back-fill existing social care budgets. Instead, working jointly to reduce long-term dependency across the health and care systems, promote independence and drive improvement in overall health and wellbeing.

The volume of emergency activity in hospitals will be reduced and the planned care activity in hospitals will also reduce through alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision, will result in the minimisation of delays in transfers of care, reduce pressures in acute admissions and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible."

Appendix 6 – Model Methodology and Outputs

1. Background

For the Leicester, Leicestershire and Rutland (LLR) Unit of Planning system, a Long Term System Model (the "Model") has been constructed to articulate what would happen when faced with the challenges described in the "A Call to Action" NHS England document as applied to LLR (section 3).

It describes and measures the extent to which those challenges will be addressed. This is done by modelling the impact of actions/ interventions that seek to improve the quality of services provided to patients and/or improve the financial value of services (without quality being compromised).

2. Methodology

Introduction

The Model accounts for the impact of changes across the health and social care system from implementing new models of care as well as investment in health and social care through the Better Care Fund. Modelling a whole health and social care economy is complex given the impact that the assumptions of any one organisation can have on the constituent organisations that make up the LLR system. As such we chose to approach modelling of LLR using an integrated model with an automated interplay between organisations. This was underpinned by a shared set of planning assumptions that mirror those used by organisations in their own individual plans.

Modelling Interventions

Wherever interventions such as QIPP or activity changes have been included in the model, we have taken a strict, robust approach to making sure the "double entry" (commissioner- provider or provider – provider impact) on any of these figures is played in and as such the total health economy position is understood. For example, quality improvements/ initiatives that also lead to an impact on activity and/ or costs have been modelled based on the following broad principles:

Impact	**Provider**		**Commissioner**	
	Income Base	**Cost Base**	**Income Base**	**Cost Base**
Improving length of stay (L.O.S)	-	c.70% saving	-	-
A release in management overheads	-	Take cost out from specific expenditure line	-	Take cost out from specific expenditure line
Improvements leading to reduction in bed numbers	Loss at a rate of 100%*	c.70% saving		100% saving

Impact	**Existing Provider**		**Receiving Provider**	
A shift in bed day capacity from one setting to another	**Income Base**	**Cost Base**	**Income Base**	**Cost Base**
-Where shift represents a new service to the receiving provider	Reduction at 100%* (transfer)	c.70% saving	Increase at 100%* (transfer)	Increase in costs at 100% (for new fixed costs)
-Where shift represents an expansion of an existing service to the receiving provider	Reduction at 100%* (transfer)	c.70% saving	Increase at 100%* (transfer)	Increase in costs at 80%

[*100% tariff reduction at HRG level or average specialty level (depending on relevance/ level of detail available)]

Model Output and Individual Organisational Plans

This approach has necessarily driven some small variation in outputs between the whole system model and the five year plans of the individual organisations. Any variations at this stage have been agreed and understood, and are within an acceptable materiality threshold to the individual organisations.

Non LLR/ "Out of Area" Considerations

The model is based on all 13/14 activity from commissioners and providers in LLR. Any changes that would affect in or out of area flows (related to other Units of Planning 5 year submissions) are not factored in, over and above those already factored into partner baseline positions. Where QIPPs affect out of area flows this is reflected in the model where the detail has been provided. The same relates to CIP, such as on specialised commissioning. Cross cutting workstreams have not included changes to out-of or in-area flows associated with the workstreams except where repatriation is a clear intervention, such as mental health and planned care.

Local Authority Considerations: Adult Social Care (ASC) Services

The Model accounts for the impact of changes across social as well as health care. While not presented here in this version of the submission, the Model has also been designed to include Adult Social Care services. This means it can be used as a tool for financial planning purposes.

Model output relating to ASC services has not been included or presented in this version of the submission. Neither is the financial challenge facing local authorities (section 3.4 Value for Money) or any consequential impact on ASC services.

The next version of the strategy will include a social care strategy which will describe the interventions necessary to address any impact on ASC services from the financial challenge facing local authorities. At that time we will incorporate these considerations into the Model. This will be a key aspect in continuing to develop our plan that seeks to bring sustainability across all settings of care.

The model includes planned CCG investment in the Better Care Fund to 2018/19 (See below). Such investments will assist in partly offsetting financial pressures facing local authorities including any consequential impact on Adult Social Care services.

Transitional Support

The Model does not explicitly account for any transitional cost considerations. Specifically:

- Funding to support "double-running" associated with improvement actions/ interventions
- Working capital requirements that may be required by organisations across the planning period as they work to achieving recurrent financial balance by 2018/19
- Any intervention investment requirements that have not been specified in the intervention assumptions (see investment considerations)

However commissioner expenditure within the model includes the intention to spend 1% of their allocations in a non-recurrent way – some of which will be available to support such transitional

costs. We will be working to detail on transitional funding requirements for the Programme as a priority work area between July - September 2014.

Investment Considerations

The impact of interventions in each workstream were quantified through agreement with workstream leads and other members of their teams. Each intervention was stated as a net or gross position, depending on whether investment had been factored in. Investment was classified as either that required up front (pump-priming) or in year investment to support benefits realisation.

In the drivers of our financial challenge graph (see outputs) there are £160m of CCG investments that contribute to the £398m challenge in year 5. A proportion of this is already allocated with expected benefits, such as those against the Better Care Fund (BCF) in years 2 and 3. Outside of these there are also those investments that we have allocated but without stated expected benefits- such as the BCF in years 4 and 5, and a further category of investments that are not allocated to date. In addition, NHS England has identified a further £7m of investment in primary care which is not yet allocated.

Across the eight workstreams the following has been modelled:

- Urgent care: no investment over and above that included in current CIP, QIPP and BCF plans has been factored into interventions
- Long term conditions: no investment over and above that included in current CIP, QIPP, BCF and the bed reconfiguration plans have been factored into interventions. Bed reconfigurations included investment required by each provider for changes, such as greater provision of support packages delivered at home. It is assumed that the BCF in later years will support the delivery of the integrated health and social care interventions
- Frail older people: no investment over and above that included in current CIP, QIPP, BCF and the bed reconfiguration plans have been factored into interventions. Bed reconfigurations included investment required by each provider for changes, such as greater provision of support packages delivered at home. It is assumed that the BCF in later years will support the delivery of the integrated health and social care interventions
- Planned care: no investment over and above that in existing QIPP, CIP and Alliance Contracting plans. Modelled interventions include repatriation. For this investment has not been factored in for increases in capacity over and above LLR capacity limits which would require additional estate. Investment will need to be factored in for up-front investment to deliver in alternative settings of care, planning assumption is that 80% of tariff will remain, and within this would be the investment as being required.
- Maternity and Neonates: investment required for acute care is incorporated in UHL's capital plans and LTFM. Additional capacity has been identified in community support so no additional investment has been identified as required.
- Children's: Investment included for managing NEL (GP training), no investment factored in for greater coordination of care
- Mental Health: Investment included in current CCG plans
- LD: Investment included for City schemes, no investment included for other schemes although anticipated low requirement

Better Care Fund Investments

The Model includes the follow investment profile:

	14/15 £000	15/16 £000	16/17 £000	17/18 £000	18/19 £000
EAST LEICESTERSHIRE & RUTLAND CCG	7,895	16,495	17,513	17,234	17,234
WEST LEICESTERSHIRE CCG	10,355	21,986	23,337	22,966	22,966
LEICESTER CITY CCG	14,769	23,261	23,261	23,261	23,261
TOTAL	**33,020**	**61,743**	**64,111**	**63,461**	**63,461**

[SOURCE: CFOS of LLR CCGs as reflected in their 5 year plan submissions]

High Level Assumptions used in the Model

CCGs

West Leicester CCG

Assumption	2014/15	2015/16	2016/17	2017/18	2018/19
Provider efficiency	-4.00%	-4.50%	-4.00%	-4.00%	-4.00%
Inflation	2.50%	2.90%	4.40%	3.40%	3.30%
Revenue (recurrent) resource limit	3.55%	4.04%	2.41%	2.28%	2.25%
Demographic growth	1.73%	1.78%	1.67%	1.76%	1.74%
Non-demographic growth - Acute	0.00%	0.00%	0.00%	0.00%	0.00%
Non-demographic growth – Continuing healthcare	6.00%	6.00%	6.00%	6.00%	6.00%
Non-demographic growth – Prescribing	4.00%	4.00%	4.00%	4.00%	4.00%
Non-demographic growth – Other non-acute	0.00%	0.00%	0.00%	0.00%	0.00%

East Leicester & Rutland CCG

Assumption	2014/15	2015/16	2016/17	2017/18	2018/19
Provider efficiency	-4.00%	-4.50%	-4.00%	-4.00%	-4.00%
Inflation	2.50%	2.90%	4.40%	3.40%	3.30%
Revenue (recurrent) resource limit	3.54%	4.55%	3.30%	2.81%	2.30%
Demographic growth	1.68%	1.68%	1.75%	1.75%	1.85%
Non-demographic growth - Acute	0.00%	0.00%	0.00%	0.00%	0.00%
Non-demographic growth – Continuing healthcare	8.32%	8.32%	8.25%	8.25%	8.15%
Non-demographic growth – Prescribing	6.00%	6.00%	6.00%	6.00%	6.00%
Non-demographic growth – Other non-acute	0.00%	0.00%	0.00%	0.00%	0.00%

Leicester City CCG

Assumption	2014/15	2015/16	2016/17	2017/18	2018/19
Provider efficiency	-4.00%	-4.50%	-4.00%	-4.00%	-4.00%
Inflation	2.50%	2.90%	4.40%	3.40%	3.30%
Revenue (recurrent) resource limit	3.07%	4.40%	1.92%	1.89%	1.87%
Demographic growth	1.23%	1.36%	1.23%	1.56%	1.45%
Non-demographic growth - Acute	0.00%	0.00%	0.00%	0.00%	0.00%
Non-demographic growth – Continuing healthcare	14.33%	13.64%	5.00%	5.00%	5.00%
Non-demographic growth – Prescribing	3.33%	4.64%	5.77%	5.44%	5.55%
Non-demographic growth – Other non-acute	0.00%	0.00%	0.00%	0.00%	0.00%

University Hospitals of Leicester

Assumption	2014/15	2015/16	2016/17	2017/18	2018/19
Pay inflation	1.50%	2.55%	4.10%	2.50%	2.50%
Non-pay inflation	4.80%	4.80%	4.80%	4.80%	4.80%
Inflation (net)	2.60%	3.30%	4.30%	3.30%	3.30%
Tariff deflator	-1.50%	-1.60%	0.40%	-0.60%	-0.70%

Leicester Partnership Trust

Assumption	2014/15	2015/16	2016/17	2017/18	2018/19
Pay inflation	1.50%	2.55%	4.10%	2.50%	2.50%
Non-pay inflation	4.80%	4.80%	4.80%	4.80%	4.80%
Inflation (net)	2.60%	3.30%	4.30%	3.30%	3.30%
Tariff deflator	-1.50%	-1.60%	0.40%	-0.60%	-0.70%

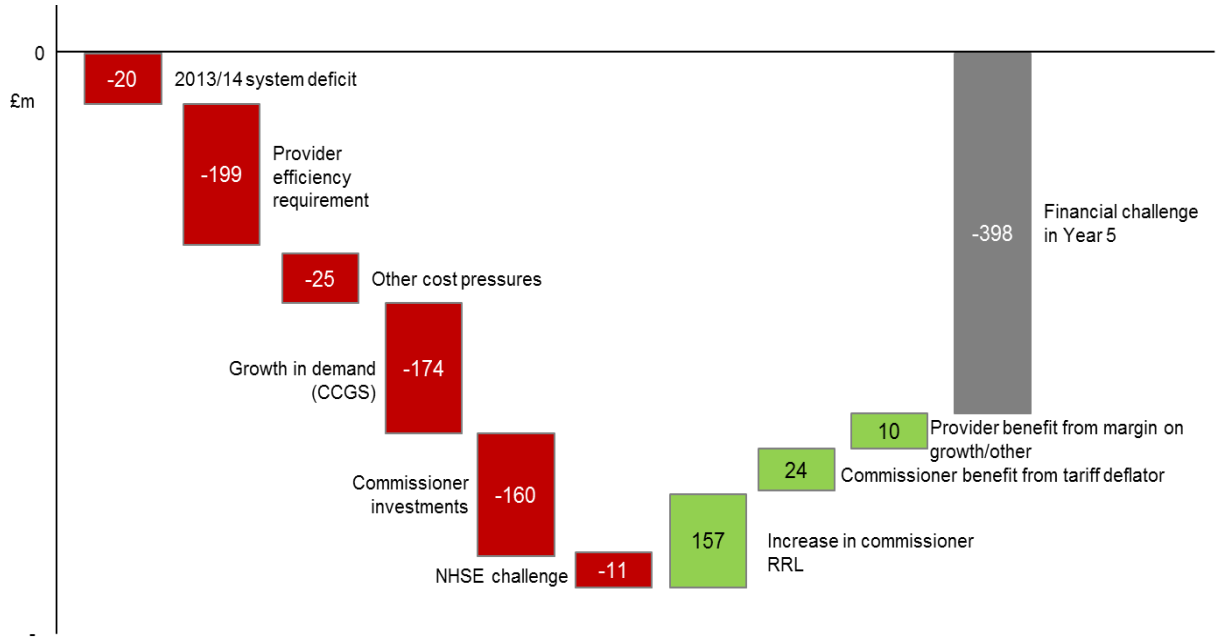
NHS England assumptions used

NHS England (L&L Area Team)

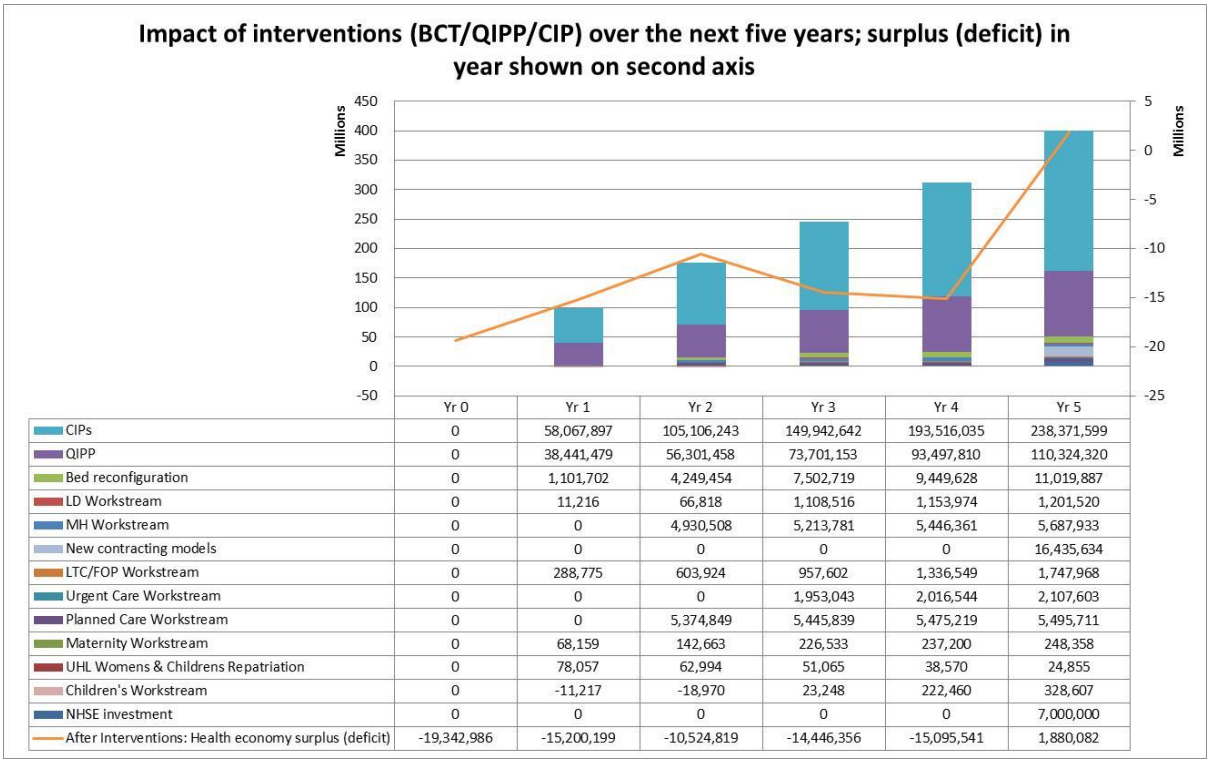
Assumption	2014/15	2015/16	2016/17	2017/18	2018/19
Provider efficiency	-4.00%	-4.50%	-4.00%	-4.00%	-4.00%
Inflation	2.50%	2.90%	4.40%	3.40%	3.30%
Revenue (recurrent) resource limit	0.00%	0.00%	0.63%	0.47%	0.39%
Demographic growth	1.73%	1.78%	1.67%	1.76%	1.74%
Non-demographic growth - Acute	0.00%	0.00%	0.00%	0.00%	0.00%
Non-demographic growth – Continuing healthcare	0.60%	0.60%	0.60%	0.60%	0.60%
Non-demographic growth – Primary Care Services	0.60%	0.60%	0.60%	0.60%	0.60%
Non-demographic growth – Other non-acute	0.60%	0.60%	0.60%	0.60%	0.60%

3. Model Outputs

Drivers of the financial challenge



Impact of bridging initiatives that support the change over the five years



	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
CIPs	0	58,067,897	105,106,243	149,942,642	193,516,035	238,371,599
QIPP	0	38,441,479	56,301,458	73,701,153	93,497,810	110,324,320
Bed reconfiguration	0	1,101,702	4,249,454	7,502,719	9,449,628	11,019,887
LD Workstream	0	11,216	66,818	1,108,516	1,153,974	1,201,520
MH Workstream	0	0	4,930,508	5,213,781	5,446,361	5,687,933
New contracting models	0	0	0	0	0	16,435,634
LTC/FOP Workstream	0	288,775	603,924	957,602	1,336,549	1,747,968
Urgent Care Workstream	0	0	0	1,953,043	2,016,544	2,107,603
Planned Care Workstream	0	0	5,374,849	5,445,839	5,475,219	5,495,711
Maternity Workstream	0	68,159	142,663	226,533	237,200	248,358
UHL Womens & Childrens Repatriation	0	78,057	62,994	51,065	38,570	24,855
Children's Workstream	0	-11,217	-18,970	23,248	222,460	328,607
NHSE investment	0	0	0	0	0	7,000,000
After Interventions: Health economy surplus (deficit)	-19,342,986	-15,200,199	-10,524,819	-14,446,356	-15,095,541	1,880,082

Bed reconfiguration relates to the transfer of activity associated with changes in integrated working from Frail Older People and LTC and does not include further clinical savings associated with major acute site reconfiguration.

UHL Women's & Children's Repatriation: the profile of savings shows the beneficial impact of repatriation will reduce over time when taking account of projected tariff and inflationary effects.

NHSE Investment relates to investment in primary care.

Projected overall impact by workstream on organisation in Year 5

Organisation impact (Yr 5) (£)	Leicestershire & Lincolnshire AT - Q59	NHS East Leicestershire and Rutland CCG - 03W [4]	NHS Leicester City CCG - 04C	NHS West Leicestershire CCG - 04V	Leicestershire Partnership NHS Trust - RT5	University Hospitals Of Leicester NHS Trust - RWE	
QIPP	10,871,335	28,494,516	33,667,398	27,213,171	-588,586	-2,970,904	**£ 96,686,930**
Adjustment to investment plan	0	13,637,390	0	0	0	0	**£ 13,637,390**
CIP	0	0	0	0	45,593,041	192,778,558	**£ 238,371,599**
Children's Workstream	0	26,256	40,160	32,362	65,407	164,421	**£ 328,606**
UHL Womens & Childrens Repatriation	0	1,586	0	-215	0	23,484	**£ 24,855**
Maternity Workstream	0	87,357	85,761	87,334	0	-12,096	**£ 248,356**
LTC/FOP Workstream	0	303,837	1,218,366	334,567	0	-108,803	**£ 1,747,967**
Planned Care Workstream	0	1,919,323	2,591,728	1,595,516	0	-610,855	**£ 5,495,712**
Urgent Care Workstream	0	1,156,152	0	1,188,664	0	-237,212	**£ 2,107,604**
MH Workstream	0	1,792,618	2,787,055	2,256,089	-1,147,829	0	**£ 5,687,933**
New contracting models	0	4,188,428	4,111,900	4,187,322	3,947,984	0	**£ 16,435,634**
LD Workstream	0	354,563	285,777	395,702	165,478	0	**£ 1,201,520**
Bed reconfiguration	0	3,128,980	3,071,810	3,128,154	4,338,537	-2,647,594	**£ 11,019,887**
	£ 10,871,335	**£ 55,091,006**	**£ 47,859,955**	**£ 40,418,666**	**£ 52,374,032**	**£ 186,378,999**	

[4] Technical disclosure adjustment note in respect of East, Leicestershire and Rutland (ELR) CCG QIPP. The long term systems model has been run with an investments figure included in the financial challenge calculation that duplicates growth assumptions already made. (Value = £14m). A correction has been made to compensate for the effect- disclosed as part of the total QIPP systems figure and also in the QIPP amount attributed to ELR CCG (described above as 'Adjustment to investment plan'). Strictly speaking, the correcting adjustment should be to remove the original duplication and this will be done when the Model is run again. Removing the £14m compensating adjustment, leaves a QIPP figure in line with that produced by the CCG's own standalone model.