



Better care together

Leicester, Leicestershire & Rutland health and social care



Our Five Year Plan in Leicester, Leicestershire and Rutland

2019



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

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Foreword

By the managing directors of clinical commissioning groups (CCGs) and chief executives of NHS providers in Leicester, Leicestershire and Rutland (LLR).

The NHS providers and three clinical commissioning groups in Leicester, Leicestershire and Rutland, working alongside local councils and a range of other independent and voluntary and community sector providers, combine to look after a population of more than one million. They do this through the Better Care Together (BCT) programme – the local Sustainability and Transformation Partnership (STP). In line with the NHS Long Term Plan, our STP will evolve over the next two years into an Integrated Care System (ICS) for LLR.

Since 2014, when the Better Care Together programme commenced, we have had some success at improving services and outcomes for our population. Most noticeably attracting capital to build a new emergency department at Leicester Royal Infirmary and a new child and adolescent mental health (CAHMS) unit; reducing our delayed transfers of care to one of the best in the country; developing integrated neighbourhood teams to support care for patients with long term and complex conditions; introduction of a referral support service for planned hospital care ensuring patients are seen by the most appropriate professionals; introduction of clinical triage in our NHS 111 service; and opening of a female psychiatric intensive care hospital to enable women to be treated locally.

However, we know that we have more to do to improve outcomes, reduce inequalities and unwarranted clinical variation. This five-year plan has given us the opportunity to take stock of our progress to date, restate our priorities over the next few years and respond to the requirements of the NHS Long Term Plan. This plan is our strategic intent on how we will work together to improve outcomes for our population. In support of this, operational plans will be produced each year setting out the detail of delivery in the coming year.

It is important to say that we are not at the beginning of a journey – it is an evolution from our Better Care Together programme. Many of the NHS Long Term Plan priorities are Better Care Together priorities. However, we feel that the step change that the NHS Long Term Plan requires, including the need to move to a mature ICS by April 2021, gives us the opportunity to break down barriers that have often got in the way of integrated care. To support this we describe in chapter one how we will evolve into an ICS over the next 18 months and how we will develop a care alliance of providers working together to transform and deliver care. Alongside this we are committed to implementing a different contractual form for 2020/21 that will enable the system to focus on transformation and cost efficiency.

Across LLR we have strong clinical leadership who will be at the forefront of this transformation. Each priority area has clinical leadership as well as wider clinical input into the design of services. Each organisation's most senior clinician is part of the System Leadership Team (SLT), the executive team overseeing this plan. Supporting the system is a Clinical Leadership Group (CLG). We have

adopted a single approach to organisational development through establishing a person-centred leadership framework to drive forward quality improvements and reduce health inequalities and promote prevention.

The increase in funding over the next five years gives us the opportunity to move the dial from 'reactive' medicine to 'proactive' care. This means putting more funding into prevention, mental health, primary care and community care, and less of our growth funding into hospital care. Focusing attention in these areas should in the long term reduce health inequalities and improve outcomes for patients. The way we have shaped our growth in funding over the next four years will support this shift, with more growth in primary, mental health and community services and less in acute than has historically been made in the previous few years.

Our planning is based on achieving the NHS Long Term Plan requirements over the next five years. Despite increased funding over these five years, given the pressures we have, our financial plan does not balance in the first four years. However, by year five (2023/24), the LLR system will be back in balance. More detail can be found in chapter four. While this is disappointing, we believe investment in the right places in the early years will improve patient outcomes, reduce health inequalities and unwarranted clinical variation, and lead to increased efficiency.

To support the transformation across LLR we urgently need to improve and reconfigure our estate to ensure clinical sustainability and safe care environments for patients. Our plan sets out the need for over £1bn in capital funding over the next few years within the period 2019/20 to 2023/24 the requirement is £780,000m. This is over and above the level of funding which has already been allocated to LLR. Our estates plans feature two large programmes - to reconfigure our three acute hospitals onto two main sites and to re-provide outdated mental health inpatient facilities.

We recognise that our plans are based on having the right staff, in the right roles, at the right time for our patients and population groups. Despite our staff working really hard we still struggle to meet some national targets. In the future we need a more flexible and adaptable workforce supported by strong training and education, and recruitment and retention policies. As providers begin working more collaboratively through the Care Alliance we recognise the opportunity to share resources so that staff follow the patient rather than be bound by organisational barriers. More information on our workforce plans is detailed in chapter five.

Over the next five years we want to embrace innovation to drive both clinical outcomes and efficiency. We have a strong research foundation in LLR which is described in chapter three. Through our digital plans we will be able to deliver a shared record solution by 2023/24. In addition we have plans to bring technology into services to reduce the need for patients to travel to unnecessary appointments and support independence, self-care and improved access. In doing this we will also be impacting on the NHS's target to reduce carbon emissions.

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

patients and will continue to ensure their voices are heard and acted upon going forward. More information on how public engagement has informed this plan can be found in chapter five.

We are in no doubt about the work involved in delivering this plan, but believe it is the right one for the people of LLR and the staff who work in our services. Our aim is to develop a health and care system that keeps people well and out of hospital, moves care closer to home, provides care in a crisis and delivers the best specialist care possible.

East Leicestershire and Rutland Clinical Commissioning Group

East Midlands Ambulance Service NHS Trust

Leicester City Clinical Commissioning Group

Leicestershire Partnership NHS Trust

West Leicestershire Clinical Commissioning Group

University Hospitals of Leicester NHS Trust

Chapter one: Moving to a Leicester, Leicestershire and Rutland Integrated Care System

In this section we describe our integration journey to date and our plans to evolve into an Integrated Care system.

Better Care Together – Our vision for health and care across Leicester, Leicestershire and Rutland

LLR's Better Care Together Programme is a collaboration of partners aiming to transform health and care and create a financially sustainable health and care system for the future. The vision of the Better Care Together programme is: *To develop an outstanding, integrated health and care system that delivers excellent outcomes for the people of Leicester, Leicestershire and Rutland.*

History of the partnership, 2014 to the present

We formed our Better Care Together Partnership in 2014. At that time national health policy was focused on the *Five Year Forward View (FYFV)* which set out a number of models of care that the NHS was expected to implement across England.

Since this time, health policy has evolved further. Better Care Together is currently one of 44 sustainability and transformation partnerships operating across the NHS in England, each of which is due to transition to become an Integrated Care System. Some parts of the country have already developed an ICS. Others, including LLR, will need to achieve this by 2021.

In August 2018 the LLR BCT partnership published *Next Steps to Better Care in Leicester, Leicestershire and Rutland* which set out our progress in developing an effective integrated health and care system in LLR, in accordance with the FYFV models of care.

In January 2019 a new *NHS Long Term Plan* for England was published. This set out priorities for investment and modernisation over a ten-year period.

In this, our latest LLR BCT publication, *Our Five Year Plan*, we summarise how the LLR health and care partnership is addressing the NHS Long Term Plan, in particular how we will:

- Continue to improve and transform health and wellbeing outcomes, the quality of our services and the overall financial sustainability of health and care
- Become an Integrated Care System.

Health and social care structures and the LLR geography offer ideal opportunities for delivering outstanding integrated care. The current organizational structures and their co-terminosity with local authorities are comparatively simple to other STPs. Across LLR we have two main NHS providers - one for acute care and one for community, mental health and learning disability services - and two regional NHS partners in East Midlands Ambulance Service and Derbyshire United Healthcare.

In addition we have three upper tier local authorities providing children and adult social care services and a range of other services that relate to the wider determinants of health and wellbeing (such as those related to public health, economic development, transport and housing).

The partnership cares for a population of more than one million people, with an NHS workforce of more than 20,000, and a social care workforce (including many independent providers) of 32,000.

There is considerable variation in the health of people and life expectancy across LLR. More people in Leicester City live in deprivation and experience early mortality, than in Leicestershire and Rutland.

In LLR, through our Better Care Together partnership, we have jointly designed a new model of health and care (see chapter two) that will comprise a much more comprehensive primary and community care sector, one which supports people to maintain their independence, taking a 'home first' philosophy.

Primary and community care will be connected efficiently and effectively with our acute and specialist services via improved referral, treatment and discharge pathways, with services users and the whole health and care system benefiting from major improvements to buildings and digital technology.

Better Care Together partners

Our partners are:

Leicester City CCG (LCCCG): responsible for commissioning health services in Leicester City to a population of 415,213 with 58 GP practices.

East Leicestershire and Rutland CCG (ELRCCG): responsible for commissioning health services in East Leicestershire and Rutland to a population of 321,188 with 30 GP practices.

West Leicestershire CCG (WLCCG): responsible for commissioning health services in West Leicestershire to a population of 397,441 with 48 GP practices.

University Hospitals of Leicester (UHL): responsible for delivering the majority of acute services for Leicester, Leicestershire and Rutland patients.

Leicestershire Partnership Trust (LPT): responsible for delivering all-age community services and mental health care and learning disability services in Leicester, Leicestershire and Rutland.

East Midlands Ambulance Service NHS Trust (EMAS): providing emergency transport across the East Midlands, including LLR.

Leicestershire County Council: an upper tier local authority responsible for commissioning and providing social and population and public health services to residents of Leicestershire.

Leicester City Council: an upper tier local authority responsible for commissioning and providing social and population and public health services to residents of Leicester City.

Rutland County Council: an upper tier local authority responsible for commissioning and providing social and population and public health services to residents of Rutland.

Derbyshire Health United: providing a range of urgent care and general practice services across the system.

We are also working closely with other partners such as the voluntary and community sector and three local universities (De Montfort, Leicester and Loughborough).

Our vision, goals and principles

The aim of the BCT partnership is to improve the provision of health and care in Leicester, Leicestershire and Rutland by bringing together NHS organisations and other partners, including local authorities and the voluntary and community sector to deliver better, more efficient services. The following diagrams explain our vision, principles and goals for a sustainable, affordable system that is fit for purpose. These have been developed by the clinical leadership group and have been agreed by all partners.



Our principles: How we are working together



The challenges we face

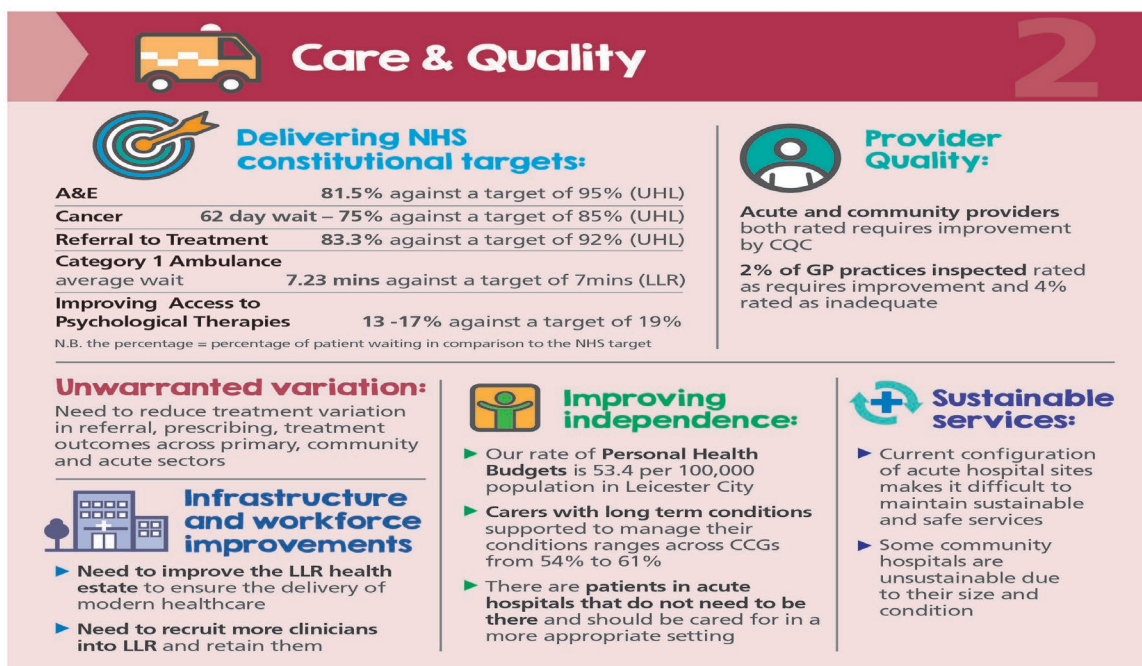
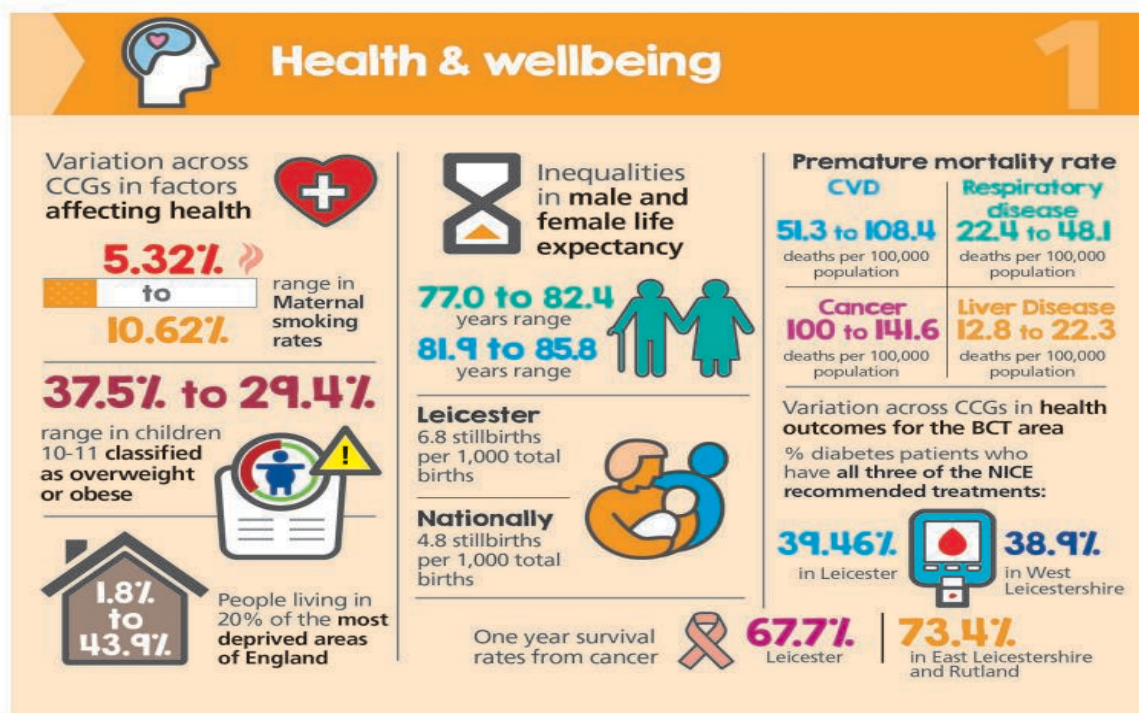
NHS and social care staff in LLR work extremely hard to meet the needs of citizens. Overall we do an excellent job in providing high quality, safe care for the local population, but we are not yet delivering excellence in all service areas including the delivery of NHS Constitution targets, and people's experiences still vary too much.

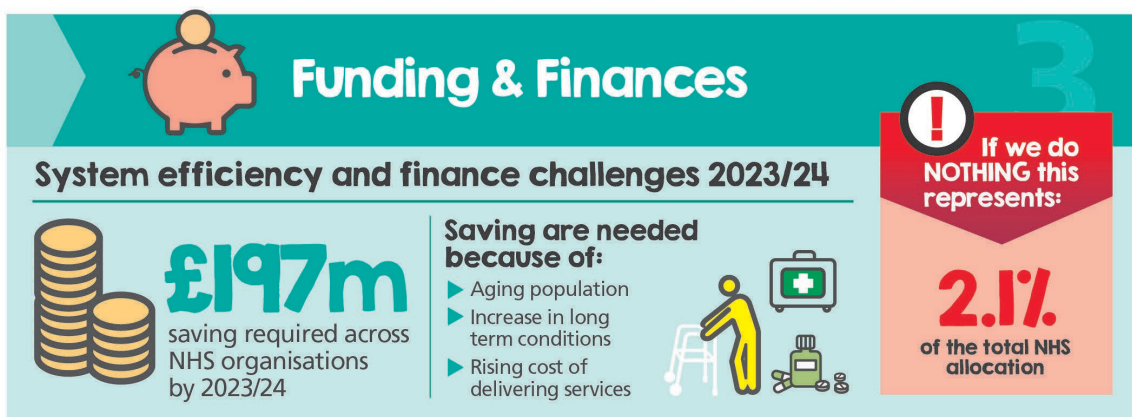
While BCT partners can demonstrate many achievements since 2014, and these are already benefiting local people, we are struggling to meet ongoing increases in demand. This is due to the profile of our (ageing) population, the increasing prevalence of long term conditions and other complex needs, and all the ongoing advances in care and treatment.

Quality of care is variable across LLR with both main providers and some general practices rated as requiring improvement by the Care Quality Commission. In addition there is often variability in care resulting in some patients receiving sub optimal or differential care. Like much of the health and social care sector we suffer from workforce shortages particularly in nursing and general practice.

If we do not take further action now to extend our service transformation plans, then services will decline and our service models, financial plans, workforce plans, buildings and technology will not be able to sustain services adequately for the future.

Some of the key challenges faced by the partners in LLR are described below.

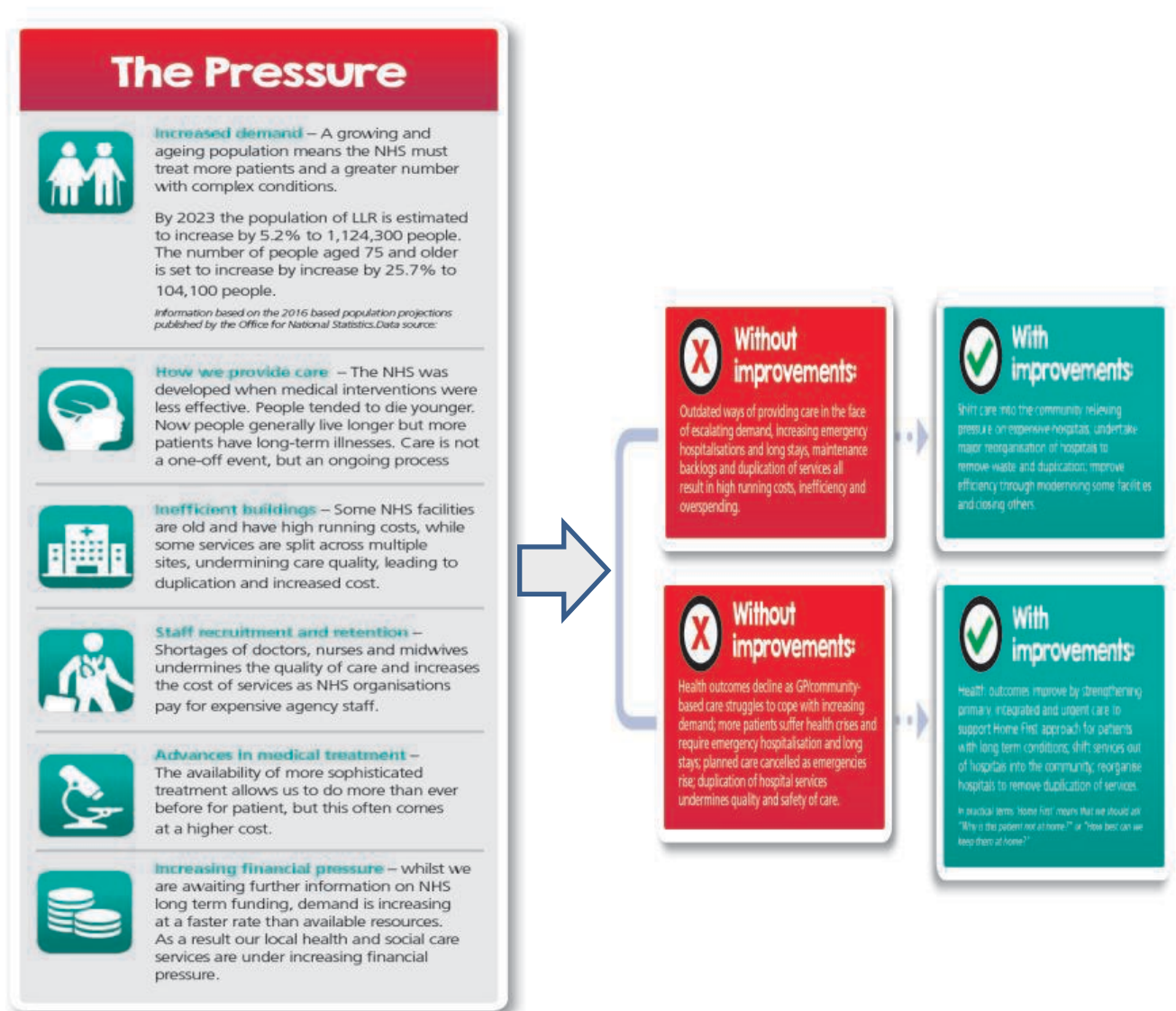




The NHS cannot stay the same

The NHS nationally faces unprecedented demands for health and care services, which we are also experiencing locally. This is making it harder to deliver high quality services and control costs. As a result:

- There is a need to redesign care, including to empower patients to take control of their own health and wellbeing, be active partners in managing their chronic conditions and to utilise new technologies in support of their care and treatment
- With a growing and ageing population there are simply more people year-on-year needing urgent and emergency services
- There are still areas of waste and inefficiency that can be tackled within the health and care system, and we are determined to do this to release the maximum amount of staff time and other resources to front line care
- Hospital staffing levels have risen, but the number of patients being looked after has increased faster than the uplift in the workforce to date, plus the profile of our workforce needs to change in line with the new models of care. In addition, in the last few years GP numbers nationally have fallen (with a 15% drop in people entering GP training, while demand for GP appointments has increased by 40%).



Health and care staff are working extremely hard, often at their personal limits and beyond, to ensure patients get the care they require, but with the increasing challenges we have described it is no longer sustainable for people to be asked to work even harder and take on even more demands and responsibility.

However we do require people to work differently in the future; for example:

- Reaching across organisational boundaries to become effective multi-agency teams, making health and care joined up and seamless for the people we serve
- Different NHS organisations and their partners able to work together to improve outcomes for our population and take more joint accountability
- Pooling our resources and skills
- Developing ideas and solutions jointly, once, that can then benefit all partners in the system and our shared workload.

The next part of this plan describes how we will do this in LLR.

Developing into an Integrated Care System

Our journey to become an ICS began in 2014 when the BCT programme was originally established. We have a strong track record of working together in LLR to transform services and improve patient outcomes and have already made good progress to integrate health and care in a number of service areas.

To respond to all the challenges we face, and to adapt our work in light of the NHS Long Term Plan, this journey needs to continue. We need to focus not only on outcomes associated with improved health and care service delivery, but those outcomes that are concerned with the wider determinants of population health and wellbeing. Many of these outcomes can only be achieved by taking a unified partnership approach, either in terms of how care is co-ordinated and delivered, or how it is commissioned.

In each ICS the NHS has been asked to reconfigure into three tiers:

- System (LLR-wide)
- Place (upper tier authority geography)
- Neighborhoods (local populations of approximately 30,000-50,000 people, comprised of groups of neighbouring GP practices, known as primary care networks).

System – Leicester, Leicestershire and Rutland: the level at which NHS organisations will work with partners to set overall priorities and outcomes to improve the health and wellbeing of the whole population. It is also the level at which NHS organisations will be held collectively accountable for their financial and operational performance, and the footprint on which national NHS resources will increasingly be allocated into LLR.

LLR NHS Care Alliance: NHS providers collaborating to deliver improved integrated models of care across LLR

Place – Upper Tier Local Authorities: the level at which NHS organisations will work with upper tier local authorities and other partners to improve health and wellbeing outcomes for their specific populations, and, where appropriate, integrate the delivery and commissioning of health and care.

Neighbourhoods - Groups of GP practices in LLR, operating as 25 Primary Care Networks: the level at which NHS primary and community care services work together, along with social care and many other agencies, to coordinate and manage the care of individuals close to home.

What do we mean by the LLR system?

The overall footprint for our local ICS is Leicester, Leicestershire and Rutland (LLR). For NHS organisations it will become the level at which local NHS organisations will be jointly held to account - there will be collective responsibility across NHS organisational boundaries for financial delivery, (via an NHS system control total for LLR), and operational performance.

The system footprint will be used as the basis on which national NHS resources will be increasingly allocated and accessed for each ICS including allocations for NHS capital and technology.

This is also the level at which strategic commissioning within the NHS will operate, for example, where commissioning for NHS performance and outcomes apply across the LLR population as a whole, such as acute care provided in hospitals.

Working together with our partners, NHS organisations will:

- Be accountable to NHS England and NHS Improvement for the overall performance of the NHS in LLR
- Analyse and understand population health and care needs across LLR's one million-plus population, and set and measure outcomes at the LLR system tier
- Lead the response to the NHS Long Term Plan in LLR
- Lead the overall strategic direction for the Better Care Together programme
- Understand where to allocate NHS resources to 'places' or the Care Alliance in line with need identified
- Support local NHS providers to form a local NHS Care Alliance, and in due course commission certain services via the NHS Care Alliance
- Take ownership and demonstrate leadership in addressing local system challenges.

The three LLR clinical commissioning groups are currently reviewing their structures and functions so that expertise and resources are re-configured into system, place and neighbourhood tiers under the leadership of a new joint CCG accountable officer.

Places – upper tier local authority boundaries

At this level NHS organisations will work with upper tier local authorities and other partners to:

- Be active partners in the leadership team at place level, in particular via the Health and Wellbeing Board
- Collaborate with local authorities and other partners on the wider determinants for health and wellbeing, so that the health and wellbeing needs of local populations are understood and addressed, and place-based outcomes are improved
- Ensure that the LLR-wide BCT strategy, outcomes and priorities meet with expectations and priorities in each LLR place
- Design and deliver integrated health and care services within the place including the Better Care Fund
- Develop and implement the place-based prevention offer

- Undertake joint commissioning across NHS and local authority organisations, using pooled budgets where applicable.

For NHS organisations this will also be the level at which budgets are likely to be set and distributed and population outcome requirements agreed by the NHS strategic commissioners, against which the NHS organisations will be expected to deliver.

Neighbourhoods – primary care networks

Neighbourhoods are the cornerstone of integrated care across LLR. They are based on 25 groups of GP practices, known as primary care networks. These networks will draw on a wide range of professionals such as district nurses, therapists, community-based mental health teams, social care staff, housing services, and other voluntary and community sector organisations, working together alongside general practice to deliver care at a local level. They will:

- Understand their specific neighbourhood's population health and care needs
- Deliver effective and consistent core general practice services, working collaboratively where it makes sense to do so
- Deliver enhanced primary care services either as individual practices or across a primary care network that enables patients to receive care closer to home - this may include some outpatient and diagnostics
- Design and deliver integrated health and care services with a range of partners (including social care and the NHS care alliance) to meet the needs of the population
- Develop a fully functioning integrated team or network of primary and community care staff, aligned with social care and other community-based services, to support citizens with the most complex needs to stay as independent, and as close to home, for as long as possible.

For NHS organisations it is also the level at which payment for services will be made by the strategic commissioner and/or the Care Alliance. More information on how we are developing our primary care networks and integrated teams can be found in chapter two.

Care Alliance

Within LLR we have two main local NHS providers - University Hospitals of Leicester which provides acute hospital-based care and Leicestershire Partnership Trust which provides community, mental health and learning disability services. At a regional level we have two main providers in East Midlands Ambulance Service, our emergency transport provider, and Derbyshire Health United, a provider of primary, out-of-hours and urgent care services. The newly formed primary care networks are also provider organisations.

Although there has been a tradition to date, through our Better Care programme, to plan and redesign services across partners, provision has been focused on individual organisations. We believe that in order to meet our challenges a new approach is needed and more collaboration between providers is required.

To deliver this we will develop a NHS Care Alliance across LLR. Work is ongoing to develop our Care Alliance but it is likely to have a core membership of our main local NHS providers including our primary care networks. Other NHS providers will need to consider whether they formally become part of the Alliance or want to be partners collaborating where it makes sense to do so. Local authorities and other providers such as the voluntary sector are likely to be organisations with which the Care Alliance will work collaboratively to deliver some services particularly at place and neighbourhood level.

The Care Alliance will:

- Receive from the strategic commissioner the NHS allocated budget, have a longer term contract for delivering services and receive the outcomes required to be delivered
- Work with the core membership and where appropriate other organisations to design, transform and deliver services and care that will meet the outcomes set, all deliverable within the allocated budget
- Be accountable to the strategic commissioner for the delivery of outcomes and financial performance.

Although there is further work to do on developing our Care Alliance we can draw on experience from the current LLR Elective Care Alliance which has been in place since 2014. The key steps and indicative timeline we are taking to develop our Care Alliance are:

- Identify resources to take forward the development of the alliance(s) across LLR – **by end of September 2019**
- Agree formal membership of our alliance – **by end of December 2019**
- Agree an alliance framework in which they will operate – **by end of January 2020**
- Undertake one or two service redesign projects across a shadow alliance to test how a provider network would operate – areas under consideration include developing a system-wide therapy offer; and designing respiratory services – **August 2019 to August 2020**
- Undertake a programme on organisation development with alliance members – **ongoing**
- Commissioners to provide shadow Care Alliance with commissioning intentions and outcomes for shadow year – **by end of December 2019**
- Commissioners to provide shadow Care Alliance with shadow budget – **by end of February 2020**
- Memorandum of understanding in place between strategic commissioner and Care Alliance to manage the shadow year including how funding will flow – **by end of March 2020**
- Memorandum of understanding in place between the participants of the NHS Care Alliance setting out expectations and how funding will flow in the shadow year – **by end of March 2020**
- Commence the shadow alliance period – **during 2020**
- Ongoing development to move from shadow to full – **April 2020 to March 2021**
- Formal commencement of Care Alliance – **by April 2021**
- Understand how local providers will work with county providers where our patient flows include out-of-LLR organisations - **ongoing**.

NHS England Direct Commissioning

We will be working with NHS England Direct Commissioning Team to support the commissioning of services for populations. Regional NHS England commissioners are accountable and responsible for more than £5 billion of NHS services of which LLR are part of, including specialised services, health and justice, primary and secondary dental care, pharmacy services, optometry and screening and immunisation services.

We are identifying those specialities and programme areas where providers of acute and complex specialist care will work together to hold delegated budgets and deliver more standardised care for a wider population. In addition we will identify through analysis of variation in access, outcomes and value for specialist care, a joint understanding of services that would benefit from a single network delivery model. A programme of work will be developed in 2019/20. Mobilisation of this will take place in 2020/21 with full integration by 2021/22.

NHS-led Provider Collaboratives are expected to be managing the majority of specialised mental health services by the end of the period covered by this plan. Services within LLR are fully engaged in the existing programmes to develop provider collaboratives for secure, children's Tier 4 and Adult Eating Disorder Services and will extend this to other services, such as perinatal, as the programme extends. This approach will support the strategic development of services that are less reliant on beds, focus on integration with community provision and support service users (patients) to receive treatment closer to home.

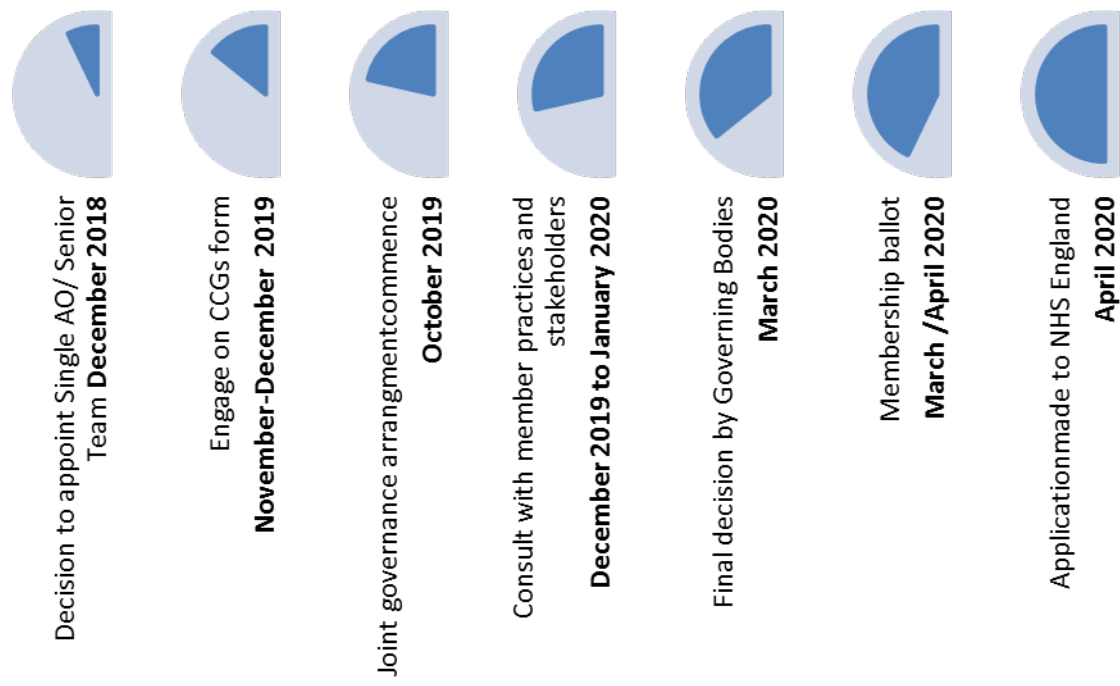
Progress towards a strategic commissioner

The three local CCGs have been working together to determine the future form of healthcare commissioning across LLR. In December 2018 they took the decision to appoint a single accountable officer and management team to oversee the running of the three organisations. The new joint accountable officer has been appointed and work is ongoing to appoint to the senior management team which is likely to be completed by end 2019. Structures will be put in place that enables the CCGs to move into the role of a strategic commissioner and support the development of the new ICS and provider landscape.

From October 2019 joint governance arrangements across the three CCGs will be in place which will enable more consistent and streamlined decision-making to take place across the three CCGs and support the move to a single management team across the three organisations.

In line with the NHS Long Term Plan to move commissioning to a more strategic role, the three CCGs are currently considering the future form of the organisations. Following discussions between the three LLR CCG Governing Bodies we will embark on an engagement with member practices and stakeholders on a preferred option which is expected to be a move to a single CCG across LLR. Engagement with stakeholders and member practices will be undertaken in November and December 2019; with CCG governing bodies considering the outcome of the engagement in January 2020 and formal consultation commencing in January 2020. Final proposals will be approved by governing bodies in March 2020 with a view of balloting members, if required in March/April 2020

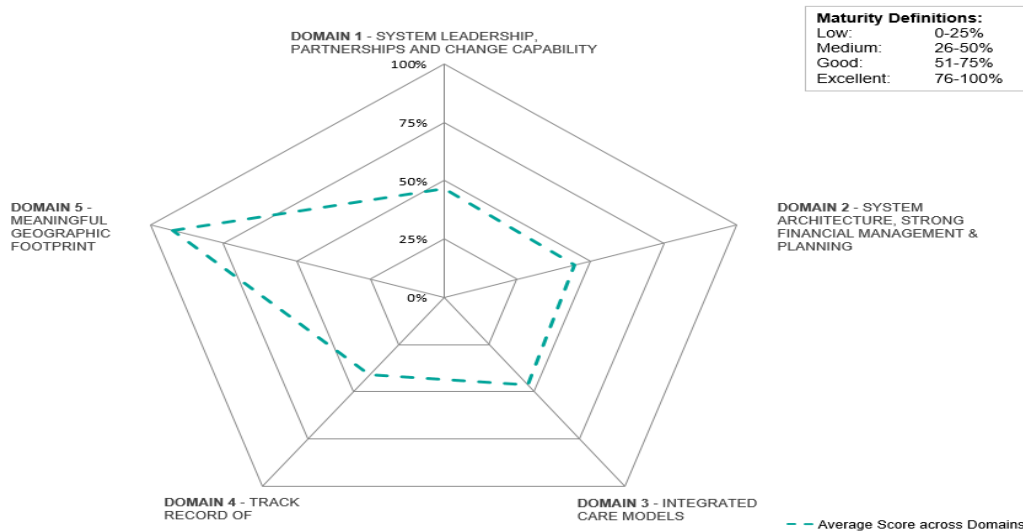
and making an application to NHS England in May 2020. A newly-formed CCG for Leicester, Leicestershire and Rutland could come into effect from April 2021.



Our maturity as an Integrated Care System

The System Leadership Team (SLT) has been working to build relationships and resilience across the local system to support the development of integrated approaches to health and wellbeing. As part of this work we have undertaken an assessment based on the national ICS maturity matrix to determine our level of maturity as an integrated system. The results of this are shown in the diagram below, it shows that we have done some good work in developing our relationships and integrated working during the last few years. But it demonstrates that we have a way to go to fully develop these into a mature ICS by April 2021 and in particular improve our system performance against national targets and system finances.

Average Maturity Across Domains in the Footprint



To do this we have developed an action plan based around the key domains for the ICS maturity matrix with a view of becoming a shadow ICS by April 2020 and a mature ICS by the date required in the NHS Long Term Plan of April 2021. The implementation of this action plan is being overseen by the SLT and is summarised below.

By end of October 2019	By end of March 2020
<input type="checkbox"/> Establish Partnership Group to oversee the work of the ICS	<input type="checkbox"/> NHS Care Alliance framework in place, OD commenced and in shadow from 1/4/2020
<input type="checkbox"/> Review system governance and propose any necessary changes to support the ICS	<input type="checkbox"/> Pilot approach to service redesign underway
<input type="checkbox"/> Develop population health management capabilities and provide PCNs with data	<input type="checkbox"/> System Operational Plan for 2020/21 in place
<input type="checkbox"/> Finalise system plan, commissioning intentions, outcomes and contracting form	<input type="checkbox"/> Decision on CCG form and application made to NHS England
<input type="checkbox"/> CCG joint governance operating	

So what will this mean?

This chapter of our five-year plan has outlined our approach to transforming the LLR health economy from the current STP arrangements to an ICS. The progression to an ICS will have a number of positive implications for population health outcomes. The diagram below outlines the benefits that progressing towards an ICS will bring for our population, how this will be achieved and how our population will notice the difference.



The progression towards an ICS will ensure that all partners collaborate to improve health outcomes for the entire population and utilise our available resources to tackle health inequalities. As an ICS we will develop a provider alliance to remove traditional organisational barriers and ensure all partners work collaboratively to deliver excellent patient care.

As a system we are not waiting until ICS infrastructure is developed to unlock these benefits and have initiated a review as well as redesign process for a number of clinical pathways across our health economy. Planned (musculoskeletal) and unplanned (Home First rehabilitation/prevention) therapies have been identified as a pathway suitable for transformation. We will be working with all partners across the system to design a new, improved model of care for these therapy pathways and recommend a lead provider. This care will be closer to home and will support the NHS to reduce its carbon footprint. This change will ensure our patients only have to provide their details once and will experience greater levels of continuity of care.

Chapter two: A new service model for the 21st century

In this part of our plan we describe our model of care and how this will meet the challenges of the NHS Long Term Plan. All of our programmes will undertake an Equality and Quality Impact Assessment (EIA).

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

The model will strengthen primary care and the provision of GP services through the development of primary care networks (PCNs). The GP surgery with its registered patients will remain the central point of local care. Recruitment to new roles within the PCNs, supported by integration of care for people with long-term conditions through multi-disciplinary teams and practices working closer together, will increase the capacity available.

We anticipate that multi-disciplinary teams including staff from social care and the voluntary sector, working on a place-based model of care through primary care networks will reduce the number of emergency admissions. We are also working with community hospitals and specialists clinicians to provide support to patients with long-term conditions to deliver care in a planned care setting and prevent unnecessary admissions.

Population health management will be used to help us target care for those most likely to benefit. It is a process which takes a defined population, analyses its needs in detail and, as a result, creates tailored health and social care services and interventions.

Working with local authorities and the voluntary sector, prevention of ill health and maximisation of wellbeing is integral to our model. Those with minor illnesses or long-term conditions will have the confidence to manage their own health, be supported through social prescribing, personalised care and support planning or have their needs met in primary care by a pharmacist, general practice or other provision (such as an optometrist or podiatrist).

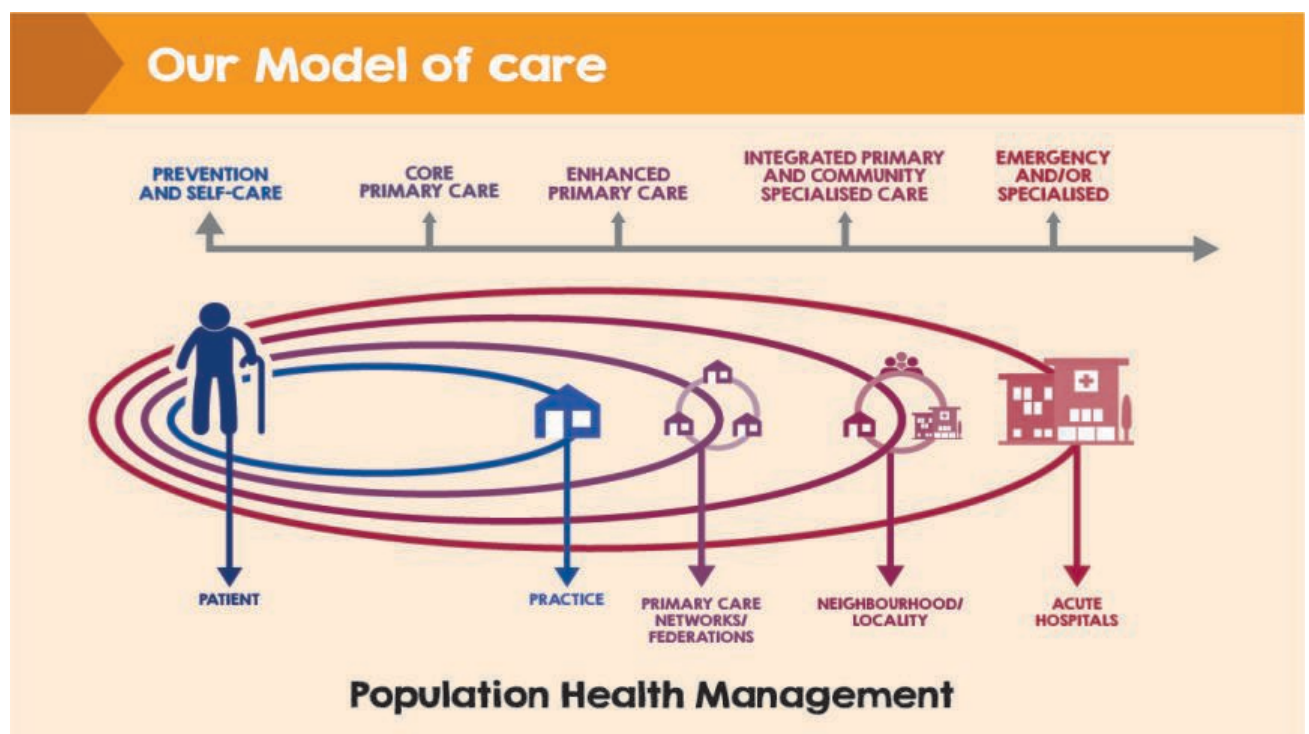
Our care model will deliver a shift in emphasis from reactive acute focused care to proactive care. Those with long-term conditions will discuss their needs with clinicians and contribute to the development of their care plan with targeted self-management programmes. This shift in our care model will be supported by measuring the degree to which patients are actively involved in their care and monitoring their progress as outcomes are achieved.

Focusing on a philosophy of ‘home first’, we will deliver care as close to home as possible. We recognise that some people will require on-going care. For this group, continuity of care is important, with all care staff needing access to shared information. Primary care networks will

develop relationships with their local community hospitals providing outpatient services and diagnostics appropriate to population need.

As the complexity of a patient’s needs increases, we will work with the individual and their family/carers to develop an integrated care plan to keep them independent in their own home as long as possible. And when it is time to do so we will plan with patients and their families an end-of-life care plan that supports their wishes.

Where either a planned or unplanned hospital attendance is necessary, the aim will be to provide care and treatment without recourse to an admission, but if an admission is required, the discharge and support will be co-ordinated to minimise the amount of time spent in hospital. Where a planned care admission is required, we will optimise the health of patients to ensure timely and quality discharge. We will utilise our estate across LLR to ensure that care and treatment is in the most appropriate setting, embracing technology to reduce the need for travel.



The following sections describe each point of our model.

Population health management in an Integrated Care System

The above model focuses on the use of population health approaches to support improved health for patients and deliver financial sustainability in the NHS.

Local organisations have already taken major steps towards becoming a successful ICS. For LLR this journey represents a continuation of the Better Care Together programme, bringing together our key social care and health partners to focus jointly on improving health and wellbeing.

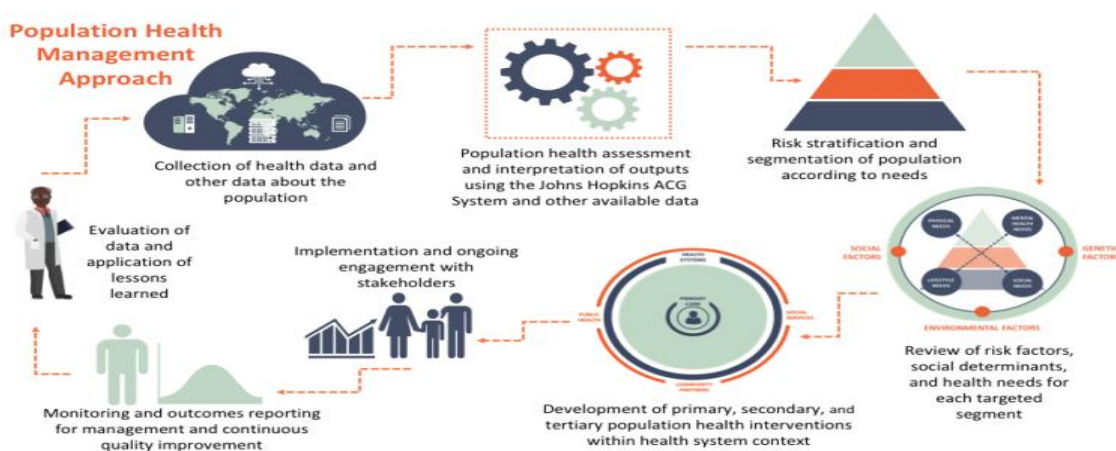
Locally there have been real strides in improving access, integrated care co-ordination for complex patients and delivery of medicine management strategies through the development of integrated teams. These locality teams are in their developmental phase, but are acknowledged to have already facilitated better local working relationships, the removal of organisational barriers for clinicians and the increased ability for patients to be treated holistically as individuals.

These service improvements are supported by a renewed approach to clinical and non-clinical multi-disciplinary team working, underpinned by the use of risk stratification tools, including local clinical intelligence (such as the Joint Strategic Needs Assessments), public health intelligence and segmentation to support targeted, proactive planning and interventions. This links together primary and secondary care health data with prescribing data. Plans to link health and social care data have recently been authorised by NHS Digital.

With the use of population health data and management we believe we can make even greater improvements to the population’s health and wellbeing. We see this as an enabler to delivering our model of care across LLR. Key steps are:

- Create population profiles at place and neighbourhood level for each primary care network incorporating risk stratification, social care and information on wider determinants of health
- General practice and primary care networks will use this data to identify at-risk patients and review their care, hold multi-disciplinary team meetings and where necessary put the appropriate support in place
- General practice and primary care networks will use this data to understand and reduce variations in outcomes for their populations and to ensure accurate clinical coding to support better care planning.

We expect that across the whole system, population health data will be used to plan and deliver improvements in care. At a strategic level this data will be used to inform outcomes required and inform funding allocations. At an operational level this data will be used to support delivery of care that will improve health and wellbeing outcomes of the population. At an individual level it will improve the care of individual patients. This strategic approach is summarised in the following diagram.



Action on prevention and health inequalities

Everyone knows that prevention is better than cure. Similarly, the long-term sustainability of the NHS depends on doing all we can to keep people healthy for as long as possible and away from dependency on NHS services. We will do this by close working with public health teams within authorities for the STP area - Leicester City Council, Leicestershire County Council and Rutland County Council – and with the voluntary and community sector.

Our aims are to:

- Ensure that preventing illness is at the forefront of local policy planning and commissioning of all clinical pathways across LLR
- Embed prevention as a fundamental part of all professionals' roles across LLR
- Support people to increase their sense of control and resilience in their lives
- Take action to tackle specific challenges to population health and wellbeing
- Promote action that will help people with long-term health conditions to be able to self-manage. This will enable individuals to be more independent and prevent or reduce the need for health and care services
- Prevent or reduce the need for health and care services
- Reduce health inequalities across LLR.

Health across Leicester City, Leicestershire and Rutland

The health of people across LLR varies considerably and presents a number of challenges to the health system, and to our efforts to improve the health and wellbeing of the population. The following information is taken from the Public Health England Local Authority Health Profiles (2018).

Leicester City is one of the 20% most deprived districts/unitary authorities in England and about 23% (17,100) of children live in low income families. Across 32 indicators in the health profile, 15 are significantly worse than the England average including life expectancy at birth for men and women, age under 75 mortality (all cause and cardio-vascular disease), hip fractures in older people, physically active adults, infant mortality and cases of tuberculosis.

Life expectancy for both men and women is lower than the England average with a gap in life expectancy gap of 7.2 years for men and 6.6 years for women from the most to the least deprived areas. The main causes of death in Leicester are heart disease, stroke, cancers and respiratory diseases. Together these account for nearly two-thirds of all deaths. Cancer is the main cause of premature deaths (in the under 75s), accounting for more than a third of early deaths, followed by heart disease and respiratory diseases. Additionally, tackling the prevalence of diabetes is a priority. Leicester is an ethnically diverse city with 48.6% of the population from an ethnic minority group, compared to 13.6% nationally.

Conversely, the health of people in Leicestershire and Rutland is generally better than the England average. Life expectancy for both men and women is higher than the England average, although

both authorities experience a difference in life expectancy between their most and least deprived areas not dissimilar to Leicester City; Leicestershire, life expectancy is 6.2 years lower for men and 5.3 years lower for women in the most deprived areas of Leicestershire than in the least deprived areas.

Across the 32 health indicators for Leicestershire none are significantly worse than the England average. For a number of indicators (life expectancy at birth (males), under 75 mortality (all causes), alcohol-specific hospital stays (under 18s), smoking prevalence, under-18 conceptions, year six obesity), for instance, Leicestershire's performance is significantly better than the England average. For Rutland, only one indicator is significantly worse than the England average – killed and seriously injured on the roads.

Both Leicestershire and Rutland have populations older than the national average. For instance, in Rutland, 24.2% of the population is aged 65 or over, compared to a national average of 17.9%. The ageing population, particularly in Leicestershire and Rutland, presents additional challenges to the health system.

Both national and local evidence suggest that multi-morbidity more than age is a key driver of cost, activity and future risk. However, it is wrong to characterise all older people as being frail, or to categorise multi-morbidity and frailty as just being about older people. Although prevalence of frailty and multi-morbidity increase with age it is not an inevitable part of the ageing process and can be prevented and impact reduced dependent on how care and support is managed. Certainly within Leicestershire and Rutland, there are as many people aged under-65 living with two or more chronic conditions as there are over-65.

Multi-morbidity and frailty

Longer term action to keep people healthy, addressing the issues set out above, is important. Of equal importance is making sure we do all we can to keep those with existing health conditions as healthy as possible, for as long as possible.

It is well known that the cost of health care is not evenly distributed across the population; the cost of secondary care over a period of one year is concentrated in a relatively small population. Around 5% of the population of Leicestershire County, for example, (about 30,500 people) accounts for around half (51%) of all secondary care costs over a year. Furthermore, almost a fifth (19%) of secondary care costs are concentrated in just 0.5% of the population of Leicestershire (about 3,000 people), while most of the population (80%) account for just 13% of costs. The table below demonstrates Leicester City's distribution which identifies that the more long-term conditions a patient has, known as co-morbidities, then the likelihood of hospitalisation is higher and so are the costs of treatment.

LTC Count	Number of patients	% of patients	Average (mean)									
			Emergency admissions	Elective Admissions	A&E attendances	Outpatient attendances	Total APC cost	Emergency admission cost	Unique Prescription types	Risk of Emergency Admission	Risk of Persistent High Cost	
0	250,269	61.7%	0.0	0.0	0.3	0.4	£ 50.55	£ 34.56	1.0	6%	1%	
1	69,065	17.0%	0.1	0.1	0.4	1.1	£ 169.42	£ 90.81	2.8	12%	3%	
2	32,849	8.1%	0.1	0.2	0.4	1.8	£ 301.89	£ 138.95	4.8	17%	7%	
3	19,067	4.7%	0.2	0.3	0.5	2.4	£ 490.95	£ 214.77	6.7	22%	13%	
4	12,041	3.0%	0.2	0.4	0.5	3.0	£ 664.20	£ 310.83	8.3	27%	20%	
5	7,739	1.9%	0.4	0.5	0.7	3.8	£ 995.25	£ 483.40	9.9	33%	29%	
6	4,893	1.2%	0.5	0.7	0.7	4.5	£ 1,318.20	£ 702.84	11.3	39%	37%	
7	3,289	0.8%	0.7	0.8	0.9	5.3	£ 1,867.63	£ 1,108.36	12.5	46%	45%	
8+	6,452	1.6%	1.4	1.0	1.6	6.9	£ 3,795.74	£ 2,716.70	15.1	61%	61%	
Total	405,664	100%	0.1	0.1	0.3	1.1	£ 237.66	£ 137.25	2.7	11%	5%	

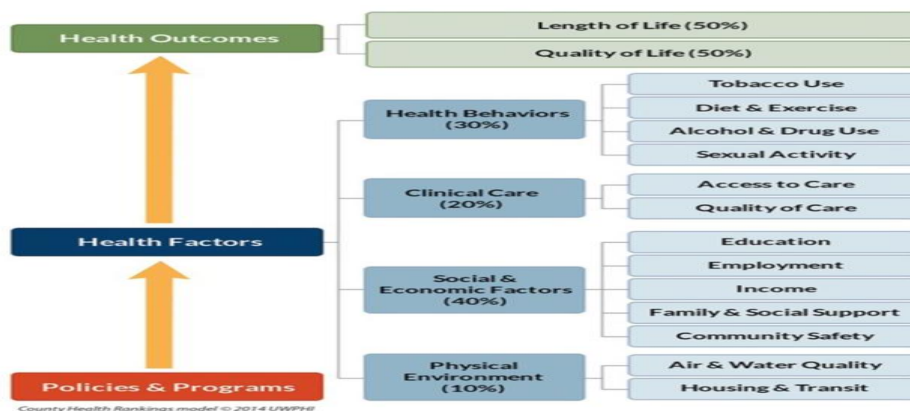
Our prevention programme will ensure that the work of partners around prevention is targeted on those cohorts where it is possible to intervene to reduce dependency on health services and reduce unnecessary admissions. We recognise that some cohorts of patients living with multiple conditions may not be amenable to preventive intervention and that 'good care' and case management will be their priority.

Our priorities

Through the LLR STP Prevention Board, we have set ourselves ambitious objectives, maximising the NHS contribution to health outcomes and prevention.

We recognise that public health teams in local authorities are the lead commissioners for many preventative services that respond to local health needs on obesity, smoking, alcohol and sexual health.

More broadly we know that the NHS, on its own, can only play a limited role in improving health and wellbeing, see diagram below. Potential improvements are more likely to be obtained through economic and social issues that are the domain of local government. Local authorities deliver many of the interventions with longer term impact (10-15 years), including those tackling the wider determinants of health - including economy, housing, educational attainment, transport, recreation, air quality, regulations regarding food, alcohol and tobacco, and working to create an environment that supports community wellbeing.



Local authorities also have a role in promoting mental wellbeing, reducing social isolation, supporting carers and promoting healthy ageing including support for vulnerable groups such as the frail elderly and those with dementia. This will include commissioning for other council departments and partners. We will work with our voluntary sector groups to further align and develop the available resources in our community, linking to community assets to support self-care and preventative ill health.

Our key prevention objectives are:

Leading the system: We will work with our key partners within the system to ensure that prevention is not a standalone. This involves leadership with other BCT areas of work including integrated community services, primary care, long-term conditions, place-based groups and Health and Wellbeing Boards. This will oversee progress of prevention work at the NHS system (LLR) level and ensure prevention is aligned with place-based health and wellbeing strategies.

Population health management: The Prevention Board will be a key contributor to population health approaches, working alongside our data and business intelligence strategy. We will take a lead role in supporting the system and work programmes to understand which cohorts of the population can be best supported to prevent admissions, and the interventions that will help achieve that.

Social prescribing: We will work across each place to develop a co-ordinated, systematic social prescribing offer that maximises the opportunities of primary care networks' social prescribing link workers. This will increase access to prevention services across the system and build on Making Every Contact Count Plus.

Smoking: We have good smoking cessation services across LLR and these will be maintained. To complement these and ensure joined up services between acute and community settings, we will implement an inpatient smoking cessation provision so that patients in hospital can get support to quit smoking during their stay in hospital and then receive ongoing support. We will do this in 2020/21, over a year before the commitment in the NHS Long Term Plan using financial support from the local Cancer Plan. Increase in system funding allocations will then be used to maintain the service. Our maternity and neonates section of this plan sets out how we will support pregnant women who smoke to quit.

Cardiovascular disease: We will continue to develop a cardiovascular disease (CVD) programme across LLR to improve the overall integration of primary and secondary CVD prevention work and develop a more co-ordinated approach to the treatment and management of CVD and its risk factors. This will include maximising the reach and impact of the NHS Health Check programme and developing the hypertension pathway.

Alcohol treatment services: We have in place a community alcohol treatment service which provides specialist advice and support. Through our quality premium work and Making Every Contact Count programme we will strengthen existing referral pathways to alcohol treatment services so that people in hospital (physical and mental health care) as a result of alcohol or

substance misuse can be quickly referred by frontline hospital staff. Given that in some areas we have significantly more alcohol-related harm hospital stays than the England average we will be making a bid for targeted funding for an Optimal Alcohol Care Team in our acute hospital from 2020/21 to 2023/24.

Make Every Contact Count Plus (MECC): Working across the NHS, local government and wider partner organisations, we are putting in place an extended MECC programme that provides brief advice on a range of health and social issues, such as debt and welfare advice. Prevention and social prescribing will become a fundamental part of all professionals' roles and frontline staff will also be encouraged to support patients to address wider determinants of health through our enhanced social prescribing offer.

Self-care: We will develop new approaches to supporting self-care, including apps and technology assisted care and will continue to implement a Healthy Living Pharmacy scheme.

Diabetes: We have an extensive programme of support using Diabetes Prevention Programme transformation funding and CCG allocations to support improvements in identification, diagnosis, self-care and treatment for diabetes - see chapter three for more details. Given the high level prevalence of diabetes in some areas we will be making a bid for the Enhanced Weight Management Support Offer to support people whose have a BMI of 30+ and have Type 2 diabetes or hypertension and enhanced tier three services for people with more severe obesity and co-morbidities.

Antimicrobial resistance: Our local prevention plans are well established and we are in the top quartile nationally. We are now focusing on further proposals to improve antibiotic prescribing (including increasing vaccination rates).

Communications: Self-care campaigns to educate the public will be implemented throughout the year on various themes, developed by partners including public health and supported by all organisations in the health economy.

Air pollution: Our local authorities have air quality actions plans that are health-focused and we are working through our Air Quality Forum to implement these plans. In addition we have plans to redesign our outpatient offer, see the Transforming Elective Care section, which will introduce alternatives to hospital visits and reduce travel to our sites.

Tackling health inequalities

We have previously noted in this report how public health indicators demonstrate the differences between the most and least deprived areas – and this is seen in the diagram below.

Indicator	Period	England	Leicester	Leicestershire	Rutland
Healthy life expectancy at birth (male)	2015-17	63.4	60.3	65.2	69.8
Healthy life expectancy at birth (female)	2015-17	63.8	59.2	65.7	68.4
Life expectancy at birth (male)	2015-17	79.6	77.0	80.8	82.4
Life expectancy at birth (female)	2015-17	83.1	81.9	84.1	85.8
Inequality in life expectancy at birth (male)	2015-17	9.4	7.7	6.6	
Inequality in life expectancy at birth (female)	2015-17	7.4	6.9	5.5	
Gap in life expectancy at birth between each local authority and England as a whole (male)	2015-17		-2.5	1.2	2.8
Gap in life expectancy at birth between each local authority and England as a whole (female)	2015-17		-1.3	0.9	2.7
Under 75 mortality rate: all causes	2014-16	333.8	420.7	285.2	237.8
Deprivation score (IMD 2015)	2015	21.8	33.1	12.5	9.6

Better	Similar	Worst
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Best				Worst
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To support further work on reducing health inequalities and to meet the requirements of the NHS Long Term Plan, over the next 12 to 18 months we aim to:

- Use public health data and the Public Health England Place Based Approaches for Reducing Health Inequalities tool to undertake an assessment of health inequalities across our system to agree priority areas
- Set system level outcomes by the strategic commissioner for places, neighbourhoods and the Care Alliance
- Work at place level and neighbourhood level to identify the interventions needed using Public Health England's Menu of Interventions to Reduce Health Inequalities. This will need to take into account the three levels of interventions set out in the Place Based Approaches tool of civic, service-based and community centred interventions
- Set specific metrics and an action plan for each priority area based on this tool.

To support this approach £500,000 of funding has been allocated within our financial plan supported by further funding for prevention.

We have recently tested this in tackling inequalities in Oadby and Wigston. Here, a local interest in the life expectancy gap in the borough saw local GP leaders, CCG colleagues, borough council and County Council colleagues come together to explore issues and propose local actions.

Our ambition is to deliver the universal implementation of the Comprehensive Model of Personalised Care across England, which fully embeds the six standard components – shared decision making, social prescribing, personal health budgets, supported self-management, personalised care and support planning, and enabling choice – across the NHS and the wider health and care system.

Shared decision making: We will ensure that patients are as involved as they wish to be in decisions about their care. This will be measured in the GP survey and CQC inpatient survey. The CCGs will also ensure staff receive accredited personalised care training which includes shared decision making.

Social prescribing: We will ensure that primary care networks have a social prescribing link worker that dovetails effectively with the existing social prescribing ‘offer’ across LLR. Our longer term vision is for link workers to be embedded within the social prescribing systems for LLR and that the bulk of the 30% of GP appointments where patients attend for non-medical reasons, are directed to appropriate support, ideally before they reach the surgery, and the GP. We will strive to ensure that the care co-ordination and social prescribing models work well together, avoiding duplication and confusion to patients. By 2023/24 we will have 87 social prescribing link workers with at least 17,634 patients having social prescriptions.

Personal health budgets (PHBs): PHBs are the default option for adults and children in continuing healthcare and continuing care. We are also supporting the delivery of Personal Wheelchair Budgets. Work has begun across LLR on a proposed integrated approach between NHS and local authority partners. In 2019/20 the focus is on developing joint principles and integrated governance structures. Subsequently a shared strategy will be developed, followed by planning for cultural and technical change, identification of early wins and stakeholder engagement including service users and patients. Subject to the strategy’s approval and support of local offers, implementation will take place by 2023/24. The approach will facilitate the achievement of the CCG target of 3,180 by 2023/24.

Supported self-management: Through our prevention work we will co-design self-management programmes for specific cohorts, including awareness campaigns for healthier living and self-care. Additionally, we will assess and co-design mobile technology to support self-management for specific cohorts.

Personalised care and support planning: There are many acute specialties within LLR that are creating personalised care and support plans for their service users -these include maternity, cancer services and mental health. We will conduct a full review to identify which areas are already creating support plans, audit adherence to these plans and identify areas for further expansion. This work will be supported with training in support planning with the aim of achieving 19,405 personalised care and support plans by 2023/24.

Enabling choice: Patients who book an outpatient appointment online will be supported to exercise their choice and identify a service to meet their needs (utilising e-RS). We will remain compliant with

the minimum standards in the Choice Planning and Improvement Guide throughout the period of the NHS Long Term Plan.

Patient activation measures: We will ensure that all primary care networks use the Patient Activation Measure tool. This tool enables patient outcomes to be measured, recorded and reported electronically. Programmes of training and support will be provided to help achieve optimum goals. By 2023/24, 19,405 patients will have recorded a patient activation score. Use of this tool will help patients with long-term conditions increase their knowledge and skills in self-management. In addition, we estimate that this tool could help lead to 9% fewer GP appointments and 19% fewer A&E attendances.

Core general practice and primary care networks

Development of new primary care models in LLR began prior to NHS England’s publication of the *General Practice Five Year Forward View (GP5YFV)*. The focus and finance galvanised our system to produce our *Blueprint for General Practice* in 2017.

Our five-year plan for general practice enabled us to deliver new models of care at a faster pace. These new models of care have resulted in improved access and a redesigned workforce. The new GP contract and our *Primary Care Long Term Strategy 2019/24* are a natural step in the progression of primary care (approved by NHS England and submitted for reference).

Our vision for general practice is that it will continue to be the foundation of the local health system, maintaining its position as the bedrock of the NHS, retaining its identity and registered list. We will build on this by working in larger groups, known as primary care networks (PCNs), to achieve sustainability, as part of wider primary and community teams and in partnership with local authorities, and voluntary and community groups across a range of sites, delivering care with improved quality, outcomes and access. The table below highlights our five-year strategic objectives for primary care.

By 2023/24 our vision for general practice will be:

- **Empowering patients and the public:** We will enable patients and carers to play a more active role in their own health and care, involving local communities at neighbourhood/PCN footprints, in shaping services, giving people greater involvement in GP services.
- **Empowering clinicians:** We will ensure high quality support for innovation and improvement, developing PCNs to allow more rapid spread of innovation, supporting general practice in developing new models of provision, and releasing time for patient care and service improvement.
- **Defining, measuring and publishing quality:** We will improve information about quality of services to strengthen accountability to the public, provide clarity on what the public can expect, and support clinical teams in continuous quality improvement.
- **Joint commissioning:** We will work as a system to develop a joint, collaborative approach to commissioning general practice and PCN level services, with a stronger focus on local clinical leadership/ownership and allowing more optimal decisions about the balance of investment across primary, community and hospital services.
- **Supporting investment and redesigning incentives:** We will support a shift of resources towards

By 2023/24 our vision for general practice will be:

general practice, PCNs and 'wraparound' community services, developing the new national GP and PCN contract to support delivery of the NHS Long Term Plan.

➤ **Managing the provider landscape:** We will ensure that all general practices and PCNs meet essential requirements, responding effectively to improving the quality of care. We will work closely with acute and community service providers, enabling feedback mechanisms to and from primary care to further improve services.

➤ **Workforce, premises and IT:** We will work with national and local partners to develop the new and broader general practice workforce, develop improvements in primary care premises and sustain improvements in information technology services and the digital offer for patients.

We recognise the importance of continuity of care and long term relationships with patients. We will support our practices and the developing PCNs to find the best model for individual neighbourhoods and provider development.

Our primary care environment is an integral part of the current drive to develop a modern integrated out-of-hospital sector, meeting the needs of whole populations. General practice will be at the centre of co-ordinating this care through proactive management of population health, linking and driving service improvement and patient outcomes. Key features will be integrated locality teams and a 'home first' approach rather than hospital.

Our new primary care model will be based on the GP as expert clinical generalist working in the community. The GP will have a pivotal role in tackling co-morbidity and health inequalities but increasingly they will work with specialists co-located in primary and community settings. These specialists either co-located in primary and community settings or available via phone or technology will be supported by community providers and social care to create integrated out-of-hospital care.

The model of delivery has started to adapt. National evidence shows that patients with complex needs, whether long-term conditions, mental health or frailty, require a co-ordinated package of care that necessitates advanced care planning and regular proactive interventions and support. This type of care is best provided by a multi-disciplinary team with the GP acting as the care co-ordinator for the most complex or vulnerable patients.

As described in chapter one, our system will work at three levels, primary care networks will work at a neighbourhood level.

Primary Care Networks

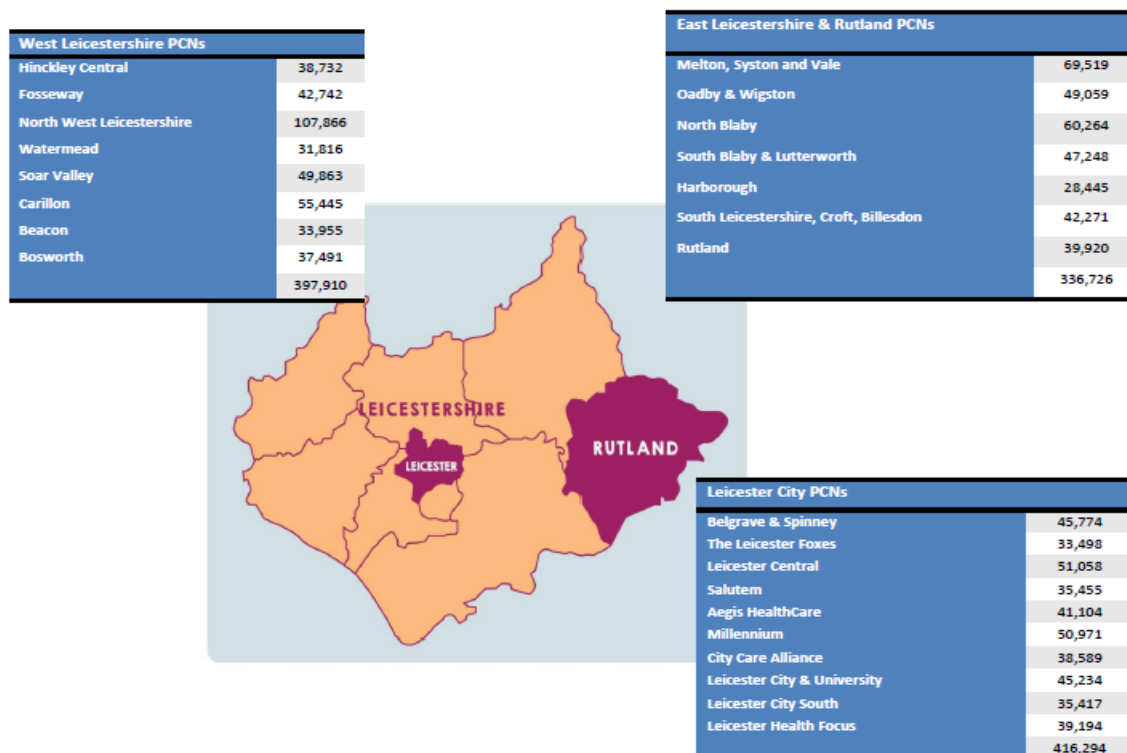
PCNs are a key part of the NHS Long Term Plan and integral to our model of care. They build on current primary care services and enable greater provision of proactive, personalised, co-ordinated and more integrated health and social care at a local level. Clinicians describe this as a change from reactively providing appointments to proactively delivering care for their population.

The PCNs will have expanded neighbourhood teams which will comprise a range of staff including GPs, pharmacists, district nurses (physical and mental health), community geriatricians, dementia

workers and allied health professionals such as physiotherapists, joined by social care and the voluntary sector. The development of PCNs will mean that patients will be able to access:

- High quality care from local clinicians and health and care practitioners with more services provided out-of-hospital and closer to home
- More comprehensive, integrated services, that anticipate rising demand and support high levels of self-care
- Appropriate referral and more one-stop shop services where all of their needs can be met at the same time
- Different care models for different population groups (such as frail older people, adults with complex needs and children) that are person-centred rather than disease-centred.

Our LLR practices have formed into 25 PCNs, details below, ranging in size from 31,816 to 107,866, all with clinical directors in place to lead their development.



2019/20: The focus will be on establishment and organisational development of the PCNs, delivering extended hours access across each PCN, and starting recruitment to pharmacist and social prescribing roles. They will also work with the local community provider and wider partners to establish integrated teams.

2020/21: The focus will be on delivering the national specifications to support care for those in care homes, those with complex needs and those that have multiple medications, in addition to early diagnosis of cancer and delivering more personalised care. PCNs in 2020/21 will support delivery of the Long Term Plan through the Network Investment and Impact Fund which will focus on reducing

avoidable A&E attendances and emergency admissions, support timely hospital discharge and outpatient redesign, and reduce prescribing costs.

2021/22: PCNs will start to deliver national service specifications to support patients with cardiovascular disease and reduce health inequalities.

We expect our PCNs to be key members of the ICS Care Alliance to enable a whole pathway approach to service transformation and delivery.

Primary Care Network development

It is paramount that PCNs become the delivery foundations for our ICS. They are in the early stages of formation and are tasked with re-organising what has historically been a complex environment into a simple model, bringing clarity to patients and staff.

During this initial period for the new PCNs and their accountable clinical directors (ACDs), the challenge is for the CCG to provide the right programme of support while allowing PCNs to develop their own individuality and the space to operate independently.

The intention is to create a PCN organisational development programme aligned with an ACD leadership development programme. These programmes will be established within a framework model to deliver 25 mature PCNs across LLR with the ability to meet the specific needs of individual organisations and leaders.

A Primary Care Board and Primary Care Commissioning Group, both with membership from across the ICS, are established with the responsibility to work collectively to design and provide this support covering key elements of organisational start-up including governance, new workforce, information, contract management, documentation, process and leadership development.

In the immediate period this support offer includes a regular ICS ACD forum enabling access to personal development, networking opportunities and facilitated development sessions with non-primary care partners. ACDs will be encouraged to access relevant locally and nationally available training opportunities via organisations such as the East Midlands Leadership Academy and The King's Fund. PCN development funding will enable facilitation of local improvement priorities for enhancing the PCN infrastructure (for example, data sharing enablement) in readiness for service specification mobilisation from 2020/21.

All ACDs have been introduced to the PCN maturity matrix and offered practical support to begin the readiness self-assessment process. The outputs of this work will offer further insight into the variation in organisational maturity across the system and the gaps for personal and organisational development. The maturity matrix enables the CCGs to have a clear understanding of the journey the PCNs need to undertake as a collective to ensure the ICS can operate as intended in the future.

Digital primary care

We recognise that information management and technology (IM&T) is a key enabler to facilitate the re-shaping of primary care. We have a number of system-wide initiatives underway and early implementation has delivered successes for patients through our IM&T work programme as set out in our Local Digital Roadmap (LDR). Examples of successes are:

- Summary Care Record v2.1 (SCR 2.1) with an integrated care plan template has been implemented across LLR primary care. SCR is enabling integrated working between Acute and out-of-hours services through access to clinical information
- A single clinical platform (SystemOne) will ensure seamless data flow across all key ICS partner organisations. To date, we have 88.6% of our registered population's records accessed using this system
- We are using digital solutions to drive our reduction in clinical variation programme. More than 100 pathways within our local referral system, PRISM, have delivered a reduction in variation of referrals to secondary care.

The below information demonstrates where LLR is in relation to some key digital primary requirements.

- **GP online consultations:** Our ambition is to ensure that 75% of our practices are enabled with online consultations by March 2020. The remaining practices will all be enabled giving full coverage across LLR by September 2020
- **Online access to GP records:** Across LLR all GP practices are online service enabled and are able to offer patients their detailed care record
- **Electronic repeat prescriptions:** All practices have implemented electronic repeat prescriptions
- **Appointments online:** We are seeking to achieve 25% of all appointments being delivered online by 2020
- **Online presence for all practices:** All LLR practices have a website and a range of associated digital services such as GP online and repeat prescriptions
- **Patient access to online correspondence:** We are working as a system towards fully electronic clinical pathways, key to this is delivery of electronic correspondence which we expect to have delivered by April 2020
- **Fax machines:** We will work with our providers to remove fax initiated requests for services by April 2020
- **MHRA CAS alerts:** All LLR practices have a generic email enabled that allows them to receive CAS alerts and therefore are ready to change over to the new system
- **Patient Activation Measures:** Over the next five years it is expected that at least 19,405 patients with long-term conditions will receive targeted support through a self-management programme. We will support the primary care networks to apply for PAM licenses.

To support the development of primary medical care and delivery of the above commitments we have committed in our five-year financial plan to increase funding by circa 5% over the next five years. In addition we are assuming £9.8m of targeted funding.

Transforming out-of-hospital care – redesigned community services

Redesign work commenced in 2018 to ensure that community services in LLR are able to deliver the BCT objectives of providing more support closer to people's homes, and integrating with primary care and social care.

The first phase of the programme has involved significant stakeholder and public engagement, and a co-production approach, leading to the design and agreement of a new model of community services. This work has set out a five-year plan from 2019/20 to transform community health care.

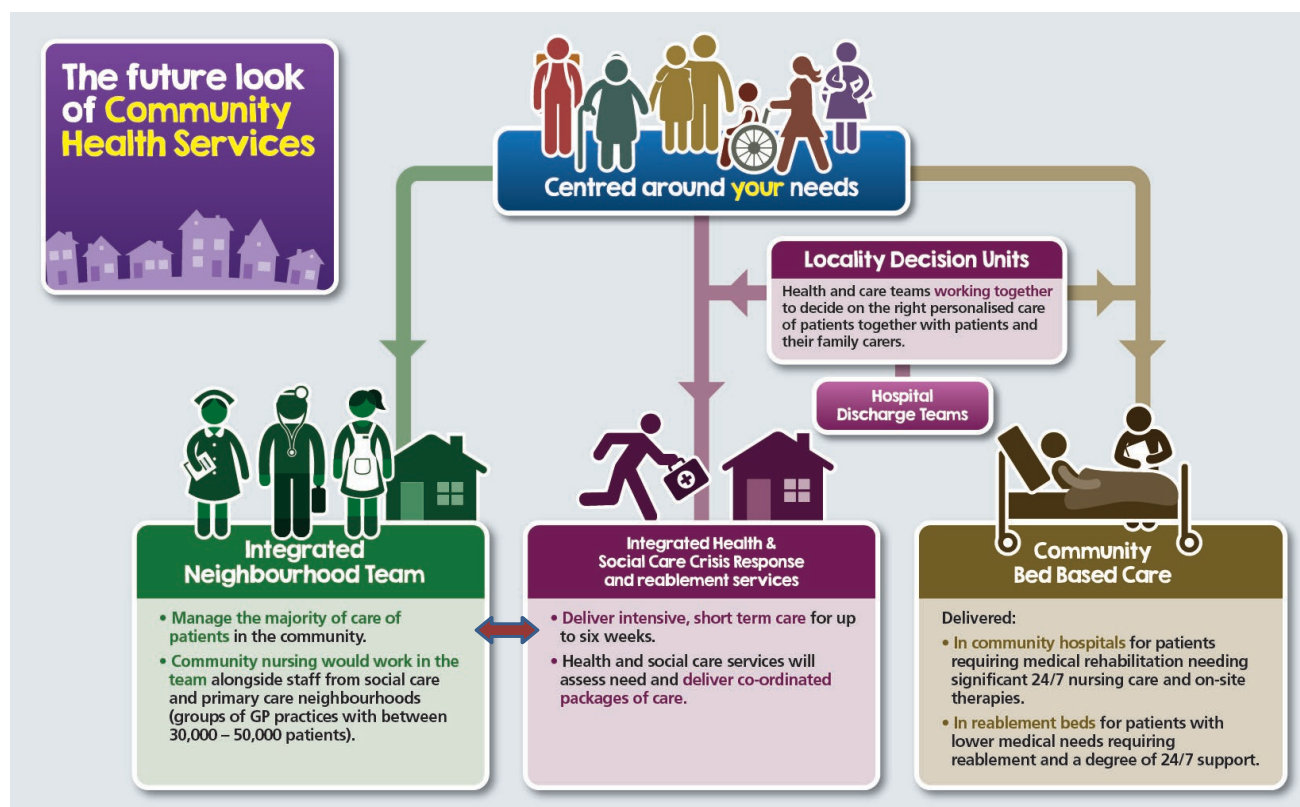
This work will deliver three important elements of the Long Term Plan:

- Community health services will be configured around PCN footprints, and will support the removal of barriers between primary and community care
- A two-hour response time will be commissioned for patients who require rapid support in a crisis or when clinically assessed. Home First teams will commence reablement within two days
- The five-year financial model for redesigned community services includes investment that will begin to re-balance expenditure away from acute services into primary and community care. We will meet the national expectation that there is increased investment in community-based services which will see 3.9% more funding in community services by 2023/24.

The community services redesign work involves significant transformation of our community services, delivering a model integrated with primary care and adult social care services. LLR community health services in future will be structured into the following service models:

- **Community nursing and therapy teams:** aligned with PCNs, providing both a same day urgent and routine, planned response. Where required, a two-hour response time will be delivered. Staff will work as part of integrated neighbourhood teams with PCNs. Integrated working with primary care and social care will enable a focus on population health, at both neighbourhood and place
- **Home First services:** enhanced 'step up and step down' services offering crisis response nursing and therapy as part of an integrated team offer with social care re-ablement and crisis response. Home First services will be commissioned and delivered at 'place' level, responding to different population needs and social care structures in each of the LLR local authority areas
- **Locality decision units:** single access points into multi-disciplinary triage, assessment, care planning and treatment for Home First services in each local authority area, as well as access to community hospital and health reablement (known as pathway three) beds.

The diagram below shows the new model of care.



Our model will enable a shift towards population health management and integrated teams focused on supporting the needs of their local populations and crucially avoiding unnecessary hospital admissions.

The full implementation of the model will be phased, starting with:

- A re-organisation of existing community teams in 2019/2020 to create strengthened community nursing and therapy as part of an Integrated Neighbourhood Team, and an integrated Home First crisis response and reablement service
- Additional medical capacity commissioned through PCNs, to enable the new community teams to deliver the Home First model of care, and support people at home following discharge or to prevent admission
- Increases in capacity in the new model from 2020/2021 onwards to support a step change in the number of patients being managed at home or in pathway three beds, with a corresponding reduction or changes in use of community hospital beds.

The new model will be commissioned to deliver a two-hour crisis response, although delivering this consistently at all times will represent a significant challenge. As we begin to implement the model from 2019/20 we will work with community health services and social care partners to understand the demand and capacity required and adjust our plans for 2020/21 and beyond.

The implementation of the model will require us to support the development of integrated team working at PCN and place level, to genuinely embed a population health management approach. To successfully deliver the LLR vision, we will need to address workforce and organisational development challenges. We have established a workforce group which is generating proposals to meet the workforce challenge, including developing a shared health and social care reablement workforce.

The new model supports the delivery of integrated working at the level of PCNs. This model is based on four 'building blocks' of integrated care:

- Risk stratification as part of a population health management approach
- Multi-disciplinary team working including care planning, with a focus on frailty and multi-morbidity. This will support the delivery of anticipatory care
- Care co-ordination for patients with complex needs, particularly those at highest risk of admission, or recent discharge from hospital
- A proactive and preventative offer, supported by a local prevention offer and social prescribing.

Successfully embedding this approach to integrated team working will require a significant level of collaboration from partners in the system. Following a review of our three early implementer sites for integrated neighbourhood team model, we will develop and deliver a plan to support the further development of integrated teams at PCN level across LLR, working with the Primary Care Board and other system partners.

The next phase of our work will also look at some of the other services not included in the scope of phase one which form part of the wider out-of-hospital model. This will include reviewing how the core generalist teams work with the specialist community services including heart failure and respiratory services, and how these can be more integrated at a local level.

We will be seeking to agree and deliver a consistent model of mental health support for integrated neighbourhood teams. We will review and change the way that hospital-based staff work, moving to a model where specialists, consultants and acute therapy staff are seen as part of the community teams, and contribute to the continuity of care for people in the community, rather than only being concerned with patients once they are admitted or referred into secondary care. In 2020 we will focus on integrated therapy services and geriatrician support to the Home First model.

Alongside our work on delivering this new model, we will review (with a view to redesigning) our community hospital estate.

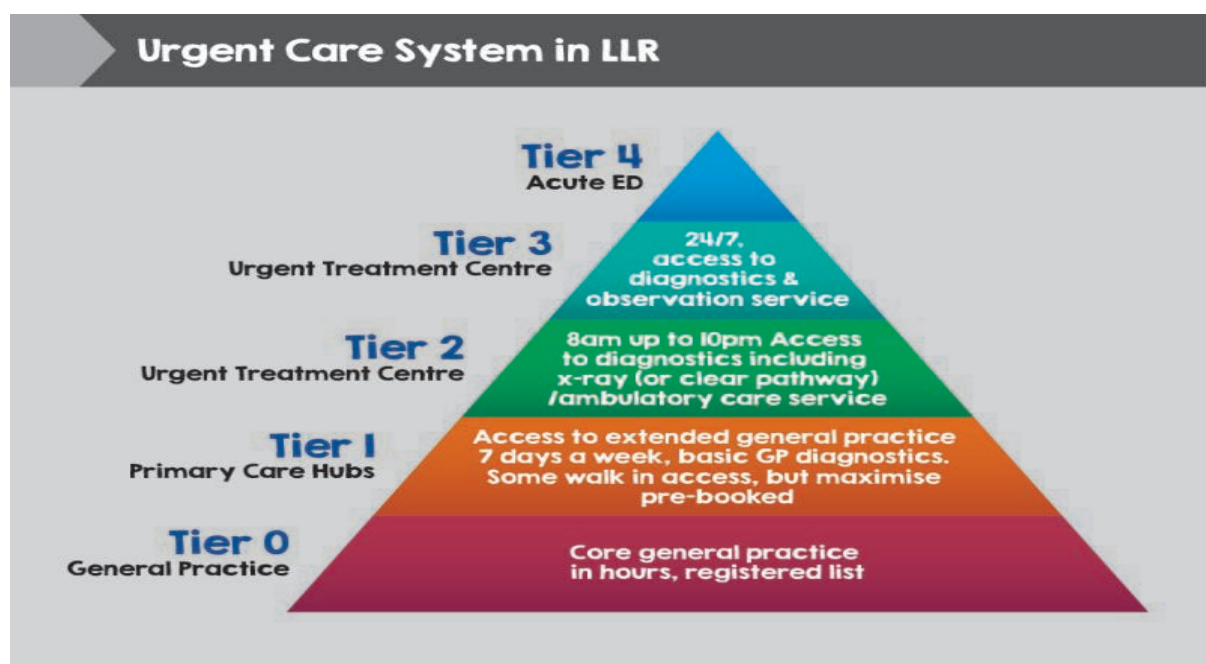
The community services redesign links to the work we are doing to redesign end-of-life services, with integrated palliative care services supporting the generalist care delivered by the community nursing teams. End-of-life support will be accessed through a triage and co-ordination hub drawing on the resources available to enable people to remain at home if that is their choice.

We are addressing the model of care in care homes through the Care Homes Sub-Group of the Integrated Community Programme, and have developed a number of positive interventions which

are supporting reductions in admissions from care homes) 16% reduction in the first half of 2019/20). Proposals to address remaining gaps, including arrangements for each care home to be supported by one practice, will be developed in 2019/20.

Reducing pressure on emergency hospital services

In LLR we have seen an increase in the demand for acute services with a significant rise in A&E attendance, non-elective admissions and growth in ambulance activity. Although the ambulance service has maintained a good non-conveyance rate of 42% (against a national range of between 25% and 50%), overall activity has continued to increase which has then impacted on overall performance. UHL performance against the national four-hour standard has not been met with a system performance of 73.8% UHL and 82.6% LLR (national ranking 100) in July 2019. To mitigate the pressure we have created a whole system approach demonstrated in the diagram below:



To reduce demand and improve care for patients at each level, we will deliver the six key transformation projects.

Integrated urgent care: Focuses on reducing demand on our acute emergency service. We will work to develop a new model of care (including improved access to extended primary care) which will ensure that those who can be managed on the same day are discharged within 24 hours (Same Day Emergency Care, SDEC) in a setting that is most appropriate to the presenting need.

Reducing demand on our pressured emergency department and secondary care services is a key priority. We will use technology to maximise use of alternative options (primary care, SDEC). This will include the implementation of signposting software such as MIDOS, which will help our population to access local responsive services. In addition we have implemented a Clinical Assessment Service which links to the NHS 111 service to ensure that patients are directed to the most appropriate care for their needs.

We know that the largest increase in emergency department usage has occurred amongst those aged between 18-25 (this is influenced by the proximity to our Universities) and we will work to design new pathways of care that avoid the need to access emergency services. This includes engaging with young people to access preventative interventions and improving self-care. Although this is an area that we want to make in progress it is not this cohort of patients that utilises most resources, this the multi-morbid population of which our focus is on population health management approaches including identification, care planning, care management support in the community including specialist care when required.

Our emergency department is frequently seen (in the absence of alternatives) as a place of safety for those in mental health crisis. The delivery of transformation such as core 24 and extending access to mental health crisis services through our clinical navigation hub service will reduce the pressures on our emergency department. Furthermore our crisis response home treatment service will offer open access and direct referral from NHS 111. We will also work with East Midlands Ambulance to add greater levels of clinical assessment to lower complexity (category three and four calls) activity to ensure that only the necessary patients are transferred to the emergency department.

Our developing PCNs will play a significant role in reducing demand on emergency secondary care services. We will work with PCNs to ensure full extended primary care cover during 2019/20. We will review the advice we provide to GPs to ensure they are fully aware of local alternatives to urgent and emergency secondary care. Our PCNs will be perfectly placed to support two of the major drivers of urgent and emergency secondary services - redesigning primary/preventative care for long-term conditions/multi-morbidity patients and reducing the number of re-admissions to hospital following 30 days after discharge from a recent emergency inpatient stay.

The above work will support us to ensure that less than 1% of our population's interaction with the local NHS is A&E by default.

Urgent treatment centres: In 2019/20 we will review the LLR Urgent Treatment Centre (UTC) offer as part of our tiers of care review. We will reach LLR-wide agreement on future plans for our three designated UTCs by December 2019 including any changes to services necessary to fully implement the UTC model.

Ambulance services: EMAS recognises that ambulance services need to change to be fit for the future and to support the ambitions of local systems to improve the health and wellbeing of their populations, improve the quality of care, developing primary and community services to offer care closer to patients' home, and to ensure best use of health and care resources locally. With this in mind, EMAS has undertaken a refresh of its organisational approach to providing integrated care, starting with a review of its vision, values and ambition, moving through development of the clinical operating model and advanced practice model.



EMAS has developed its Clinical Operating Model as a framework for the development of three core building blocks for the future response model:

- **Right response to the right patient:** Specialist and Advanced Practice Roles
- **Intelligent Clinical support and Oversight:** Enhanced Clinical Hub and Dispatch Intelligence
- **Developing Our People and Skills:** Revised Clinical Leadership Model

East Midlands Ambulance Service is an integral part of the healthcare system; the clinical operating model reflects the need for greater integration with key partners. It grasps the opportunity to develop and utilise the full breadth of enhanced paramedic practice, including primary care rotation, along with the opportunities technology affords to better manage, diagnose and treat patients in and out of the hospital environment. Whilst demand for services continues to increase, it is recognised that the ambulance can play a role in influencing the flow of patients across the system through integration with wider health and social care services.

Under the current clinical model only 3 or 4 patients out of every 10 who call EMAS require the services of an Accident and Emergency department or require admission to hospital, yet 7 out of every 10 responses are conveyed to hospital. Whilst there are many reasons for this, the service recognises that it can help to redress the balance and ensure patients get to the most appropriate care first time, every time, by doing a number of things over the next five years to:

- Create the right conditions for change and equip the clinical workforce with the skills, capacity and capability to deliver more care at home
- Work in partnership to develop integrated care pathways, supported by senior clinical decision support and access to alternative pathways for those patients who do not require emergency care within an acute hospital environment
- Ensure EMAS has the right mix of skills and resources to deal consistently with the increasingly complex needs of patients

The EMAS Clinical Operating Model better reflects the needs of patients and aims to ensure the right response is sent first time to meet that need. The aim is to improve how the service assesses and

triages patients' condition on the telephone. This may take a little more time to do once it is established that the patient's condition is not immediately life-threatening, to ensure the right staff with the most appropriate skills are dispatched. Where patients do not need to go to an emergency department, skilled paramedics may treat them at home or access a more appropriate care pathway. In some cases, patients may be referred directly to specialist services. EMAS will work as part of an integrated health and social care system to access the right care first time for patients.

The EMAS model ensures that the most appropriate resource will be utilised / dispatched to meet the needs of individual patients with a view to delivering more proactive care and/or referral on scene and reduced conveyance to Emergency Departments where alternative pathways are available.

We aim to:

- Increase the level of hear and treat through better triage, clinical intervention referral to appropriate pathways
- Increase the level of see and treat following face:face assessment with access to enhanced decision support and alternative referral pathways
- Ensure patients are treated in the right place first time and in doing so reduce the number of patients unnecessarily taken to Accident and Emergency departments

We aim to build this model by 2025 through:



In addition Commissioners, University Hospitals of Leicester (UHL) and EMAS are working together to reduce local ambulance handover delays and to resolve issues such as inadequate patient flow through our hospital that causes patients to wait in ambulances at periods of high demand. We will ensure that all ambulance handovers occur within 30 minutes.

Building on work begun in 2018/19, we will increase the digital maturity of EMAS so that clinicians on scene and working in the CAT team have access to patient information (SCR, PDS and EPR) and electronic prescribing.

Hospitals: LLR will improve flow - the emergency department four-hour standard is a key objective in 2019/20. In order to do this successfully we will deliver SDEC services within UHL that operate at least 12 hours-a-day, seven days-a-week by September 2019 and enhance our frailty service so that it operates effectively and for a minimum of 70 hours a week by December 2019.

We are already delivering 30% of non-elective admissions via SDEC at UHL. We know that our hospital Bed Bureau service has worked very hard to keep pace with the many changes to the urgent and emergency care system over the past years – in 2019/20 we will review this function and ensure that it meets the needs of patients and staff and effectively supports maintaining system flow of patients to the most appropriate services within UHL through better clinical decision-making.

Our hospitals will share information more effectively with partners and agencies and we will carry out ‘perfect ward’ MADE (multi-agency discharge) events. We will reduce the number of aborted non-emergency patient transport journeys by improving discharge processes, and we will achieve more than 50% discharge across medicine before 12 noon by March 2020.

Reduce length of stay: LLR has made significant improvements in reducing delayed transfers of care and reducing the number of long stay patients in inpatient settings. We want to build on that success and continue to maintain the positive progress we have made by ensuring that we maintain our level of performance and deliver a 40% reduction in long stay patients and long stay beds by March 2020.

This will be supported by continued roll-out and use of the care home bed state tracker. Our local priorities for reducing length of stay include early discharge planning, supported by multi-disciplinary/multi-agency discharge teams and trusted assessors. We will help patients to get home quicker and stay at home for longer through our Home First and Discharge to Assess (D2A) offer. We will help people who live in care homes to stay healthier at home through our enhancing health in care homes work. This includes increasing the number of care homes with access to nhs.net email and ensuring that care home staff use our dedicated 24/7 health care professional (HCP) telephone service to access advice and help patients avoid unnecessary admissions to hospital.

Digital: Our digital priorities will help to deliver many of our other five priorities. In 2019/20 we will complete work begun in 2017 to ensure that our Integrated Urgent Care (IUC) system is fully interoperable, with electronic appointment booking available for all face-to-face consultations in urgent care settings. In 2019/20 we will go further and ensure that our emergency department is fully resourced and able to implement direct electronic appointment into extended primary care appointments. Record sharing is also a key priority. Building on past success, we will increase the number of patients who consent to share additional information through e-SCR. Emergency department and every e-prescribing pharmacy in LLR will have access to extended patient data via the summary care record. Our urgent treatment centres and emergency department will have

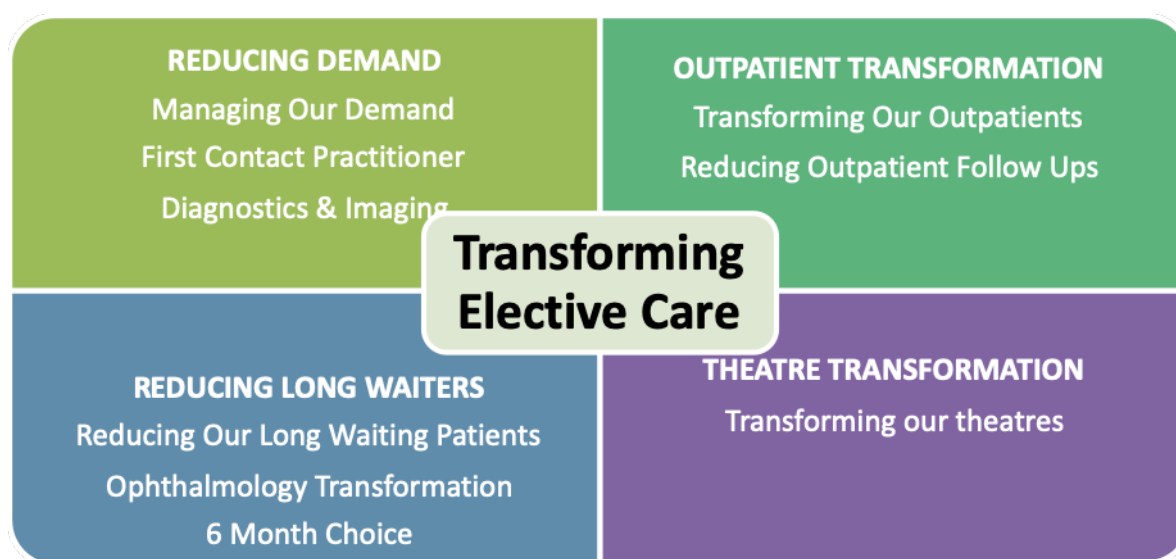
access to primary care records, mental health crisis and end-of-life plan information. Finally, we will ensure that the Emergency Care Data Set is implemented in all our T1 and T3 departments.

Our UEC Transformation Plan, approved by NHS England, is submitted for reference.

Transforming elective care

The planned care programme supports patients to have access to safe, high quality and effective care, delivered locally. Planned care covers routine services with planned appointments or interventions in hospitals, community settings and GP practices. We want our planned care services to deliver high quality, personalised care, which enable patients to see the right person, in the right place, at the right time. We want to make sure that patients only go to hospital if they need to and that we have safe, high quality care available in the community.

As a system we will transform planned care services via specific schemes for LLR residents. By changing the way we use community and GP facilities we can bring more care closer to home. This will free-up space at UHL for patients needing emergency and specialist services including treatment for cancer, neurology and complex maternity services. The diagram below highlights the strategic aims of our programme:



Managing our demand: Within our health economy, we have a number of primary and community providers of outpatient clinics that can deliver care closer to home. We will work as a system to ensure patients are offered the most clinically appropriate, local options (therefore reducing the pressure and waiting times at UHL). To deliver elective care closer to home, we will:

- Increase the use of specialist advice and guidance across all elective specialties
- Design a joint musculoskeletal physiotherapy service
- Embed and manage the 102 low value treatments
- Implement Referral Support Services within specialties experiencing high demand to improve the quality and reduce the quantum of referrals into secondary care.

In 2018/19 the Referral Support Service was our largest elective transformation programme and supported the process of directing referrals to the most appropriate location. The Referral Support Service is delivered by clinicians and nurses and was implemented in five specialties during 2018/19. Over the next five years we plan to expand its coverage to all routine elective specialties. Other ways we are moving elective activity to the most appropriate setting include:

- Working with system partners to deflect patients to community-based treatment including GPs with specialist interests, physiotherapists and optometrists
- Rolling process of updating Specialty Directory of Service to reduce inappropriate referrals into UHL
- Supporting the use of PRISM to reduce inappropriate referrals into any provider
- Increasing uptake in GP advice and guidance, leading to increased learning and reduced need for referral
- Reducing outpatient follow-up rates (by more than the required level in the Long Term Plan), moving to alternatives such as non-face-to-face appointments, and thereby freeing capacity to treat patients on incomplete pathways
- Implementing two-way text reminders to improve both clinic utilisation and theatre utilisation, treating patients in a slot that may otherwise have been wasted
- Continuing admitted patient care efficiencies, increasing the elective surgery rate. This includes improvements in scheduling and reduced cancellations (by both the hospital and patients) for clinical reasons by improved pre-operative assessment
- Supporting training and development of GPs and primary care teams to prevent referrals
- Using diagnostics in primary care to reduce the number of referrals into secondary care.

Delivering First Contact Practitioner: The NHS Long Term Plan has identified that physiotherapists (including First Contact Practitioner) within general practice as the first point of contact for patients with musculoskeletal concerns greatly improves experience, reduces pressure on primary care and often removes the need for ongoing treatment.

By 2023/24 all members of the public are required to have access to a First Contact Practitioner within general practice. General practice and the PCNs are being supported to develop First Contact Practitioner services. This will ensure that from the 1 October 2019 we will have 150,603 patients with access to a First Contact Practitioner. During 2019/20 we will work with all partners and patient groups to develop a full system plan to ensure 100% coverage by 2023/24.

Diagnostics and imaging: There is notable variation in the requests for diagnostic/imaging investigations among our GPs and secondary care doctors. Research from NHS London highlighted that this variation frequently results in unnecessary patient investigations. During 2019/20 we are working collaboratively across the system to ensure that every test/investigation is clinically appropriate, does not duplicate previous tests and is in line with recommended guidelines.

Transforming outpatients: as a system, we are committed to transforming how we deliver outpatient services to the population of LLR. Currently we see one million outpatients a year with two thirds of these patients having follow -up appointments. Given the sheer size of the service and the amount of time and resource dedicated to maintaining the status quo, we see that transformed outpatients as a major opportunity for LLR.

We aim to deliver best in class out-patient services, designed around the needs of patients, from a dedicated environment with co-located diagnostics to facilitate one-stop clinics. In making every contact count we will have a single standardised process for booking appointments and self-check-in for patients on arrival. We will optimise the use of digital technology and wherever possible will provide out-patient consultations in a way that is most suited to patient needs, only bringing patients into our hospital sites where this is absolutely necessary.

In 2019/20 the outpatient transformation has five areas of work:

- Increasing outpatient efficiency
- Improving quality and experience for our outpatients
- Implementing technology to remove paper from outpatients
- Delivering the national annual priorities
- Delivering our local BCT annual priorities

Throughout 2018/19 we have implemented technology (SMS/text reminders) across 98% of our outpatient clinics and have seen fewer missed appointments. In 2019/20 and 2020/21 we will implement this technology across community and primary care outpatient clinics. Ensuring that every outpatient clinic is fully utilised is a key priority and through a weekly review process, new scheduling tools and standardising clinic templates we will maximise the number of appointments delivered.

The traditional model of outpatient services will not meet the needs of our growing population with complex conditions within LLR. In response to this we will launch a range of new multi-disciplinary clinics where our patients can receive (in one place and at one time) key information regarding their care options and symptom management. This will prevent patients having to attend multiple outpatients and undertake multiple diagnostics.

Reducing outpatient follow-ups: From 2019 to 2024 we will actively work to transform the way outpatient services are delivered. Central to this will be the delivery of the key NHS Long Term Plan requirement to reduce face-to-face follow-up outpatient appointments by one-third over five years. This will ensure that patients do not have to make unnecessary journeys and will help to meet the NHS carbon footprint challenge. This will ensure clinicians are focused on clinically necessary appointments.

As a system we are taking 11 specialties a year and reviewing existing pathways. We will then undertake a mixture of service transformation and changes to booking rules to ensure follow up outpatient activity is done only when clinically necessary and face to face only when other possibilities are clinically sub-optimal. We will for instance, utilise technology (such as Skype) to develop virtual follow-up appointments post-MSK scheduled shoulder surgery. We will also use our Referral Support Service to ensure appropriate follow-up activity is taking place in specialties such as urology.

We will be working with partners such as the East Midlands Academic Health Science Network to support the development of digital outpatient services and working with services to develop online questionnaires as an alternative to face-to-face appointments. We will also be developing a series of

new booking rules across our system that only support follow-up activity when it can be demonstrated that this is clinically required as well as ensuring all specialties (such as neurology) comply with guidelines such as those promoted by NICE.

Ophthalmology transformation: In 2018/19 NHS England launched a series of high impact interventions within ophthalmology to minimise the risk of harm to patients. Within LLR we have responded by developing a system-wide plan to improve ophthalmology services.

We know that the demand for our ophthalmology services outweighs current capacity. To address the challenges we will redesign our ophthalmology services by the first quarter for 2020/21. This will include:

- Increased provision of safe appropriate ophthalmology services away from acute hospital eye services (within primary and community settings)
- Increased care delivered closer to home
- Redesigned acute hospital eye services
- Improved management of waiting lists and the associated risk of delays to follow-up appointments
- A single ophthalmic electronic patient record (MediSOFT) for hospital eye services in UHL and within the Care Alliance will be introduced.

Theatre productivity: Within our acute provider and community hospitals, we have access to 45 inpatient or day case operating theatres. Our operating theatres are vital to the delivery of excellent cancer care, routine operations and ensuring that our patients wait no longer than necessary for their procedures.

We are aware that our elective theatres are benchmarked in the lower quartile on key measures such as starting and finishing on time and how many operations are undertaken in a four-hour operating period. Our lower quartile of performance has a negative impact on patient care with patients having to wait longer for treatment and recovery. With this in mind, the UHL theatre improvement programme was developed to provide safe, efficient and effective elective operating theatres.

Throughout 2018/19, our theatre programme increased efficiency levels within operating theatres and allowed orthopaedics surgery to continue through the winter (despite the pressures of additional emergency patients).

Our approach to improving theatre productivity is a multi-disciplinary programme that involves surgeons, nurses, administrators within our provider as well as patients and general practitioners. To deliver improvements we:

- Will work with patients to ensure that only those who are medically fit are listed for surgery and/or are aware of what constitutes fit for surgery. This will reduce our comparatively high level of cancelled operations
- Will work with administrators to ensure appropriate levels of patients are booked onto operating lists. This will ensure our operating theatres do not finish earlier than planned

- Will work with ward teams and surgeons and theatre teams to ensure we start surgical lists on time
- Will work with consultants to ensure follow-up outpatients only take place where clinically appropriate.

We believe that there are further efficiencies available. Specifically, we plan to accelerate the efficiencies associated with combining day case activity into one site through the LLR reconfiguration programme.

Managing our waiting lists: We plan to have no patients waiting more than 52 weeks and we are developing processes to ensure that we can offer patients the 26-week choice option.

Our UEC Transform2019/20 STP Elective Care Transformation Plan, approved by NHS England, is submitted for reference.

Hospital based acute services

UHL is the LLR provider of hospital based acute services. It is one of the largest and busiest NHS trusts in the country, providing both secondary and tertiary services to the local, regional and national population. It currently provides care from three acute sites (the General, Glenfield and Royal Infirmary hospitals). UHL has numerous strengths - some clinical services are genuinely class leading in terms of clinical outcomes, many specialist services are underpinned by strong research portfolios, and it is recognised (by the CQC for example) that its staff are overwhelmingly caring and compassionate.

Despite these inherent strengths, UHL has struggled to achieve and maintain high standards of quality and performance. Some of this arises out of a historic lack of investment in Leicester's hospitals. We can contrast how cutting edge technology and equipment has been designed into the new emergency department, yet outpatient clinics are reliant on paper patient notes in shopping trolleys. In the same vein, while staff are recognised as being caring and compassionate, if we do not have enough staff, it makes creating the time to care more difficult.

In response to these challenges UHL has developed the *Becoming the Best* clinical strategy which focuses on:

- Investing in and growing specialist services
- Separating planned and emergency activity by transferring work to community/primary care and centralising other work in a new treatment centre
- Working with community partners to cap or reduce emergency activity by addressing patients at risk of admission, transferring our specialist skills into the system and providing same day emergency care.

UHL will also make its key clinical services sustainable by focusing efforts on the 'vital few' services with the most to gain in quality, performance and finance terms.

The reconfiguration plans that underpin this clinical strategy mean that UHL will ultimately consolidate services and staff onto two rather than three large acute sites (making us 'just big enough', but no bigger than necessary).

To deliver high quality, safe services, which are affordable, we are considering how best we provide hospital and maternity services in LLR in the years ahead. Since these proposals will be subject to public engagement, and where appropriate consultation, we have developed a pre-consultation business case identifying some significant clinical changes. This has been robustly scrutinised and supported by the Clinical Leadership Group in LLR, the East Midlands Clinical Senate and regional NHS England and NHS Improvement teams. We are now awaiting the confirmation of capital funding before we can submit it to NHS England/NHS Improvement for approval at a national level. Once we get this approval, it will allow us to start the formal public consultation process.

Our proposals are to:

- Reconfigure acute hospitals to move acute clinical services onto two sites, Leicester Royal Infirmary and Glenfield Hospital, and retain some non-acute services on the site of the Leicester General Hospital
- Re-model maternity services to create a new maternity hospital at the Leicester Royal Infirmary and subject to the outcome of the consultation, a midwife-led unit at the Leicester General Hospital. We propose to close the birthing unit at St Mary's Hospital, Melton Mowbray
- Double intensive care capacity in recognition that the need for ITU beds is growing exponentially
- Create a standalone treatment centre at the Glenfield hospital for high volume elective work to separate elective and emergency flows
- Create a standalone children's hospital at the Royal Infirmary.

What will the plan mean for Leicester's acute hospitals?

The current three acute site configuration reflects the history of how hospitals in Leicester evolved over time and is sub-optimal in clinical, performance and financial terms. Medical and nursing resources are spread too thinly making services operationally unstable. The duplication and triplication of clinical and support services is inefficient and expensive. Many planned and outpatient services run alongside emergency services, and when emergency pressures increase, it is elective patients who suffer delays and last minute cancellations. The proposal to reconfigure the hospitals will require major investment to provide safe, high quality specialist care for years for come. The capital requirement for this is costed at £456 million.

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

As well as the strategic need for reconfiguration it is recognised that our hospitals suffer from significant backlog of maintenance and these proposals, if supported by national bodies, would allow the Trust to invest in the two acute sites and modernise our facilities. Running two efficient hospital

sites, compared to the current scenario, would deliver about £20 million of net savings a year and help make our hospitals financially sustainable by as much as £100m over 5 years.

What would it mean for maternity services?

The proposal is to re-model services to create a new maternity hospital at the Leicester Royal Infirmary and subject to the outcome of consultation, a midwife-led unit at the Leicester General Hospital. At present, maternity services are spread across units at the LRI and LGH and it is challenging to maintain adequate staffing in neonatology and maternity over two sites, adding pressure to our revenue budgets. A number of external service reviews, including the CQC, do not consider this sustainable.

The facilities themselves require modernisation to cater for increased demand. Maternity facilities at UHL were designed to cater for approximately 8,500 deliveries a year, but deliveries now total approximately 10,500 per year. This increased service demand is expected to continue.

Reviews of maternity services have identified that the standalone birthing centre at St Mary's in Melton Mowbray is not accessible for the majority of women and is under-utilised with just one birth taking place every two days. However, it is recognised that many women may prefer to choose to have their baby in a community-based standalone midwifery birth centre. We will consult on offering a midwife-led unit at the General Hospital as an option which provides best equity of access for the women of LLR.

So what will be different?

Our service transformation plans are captured in the following patient story.

“Following a few weeks in hospital after a fall, my dad was discharged. The hospital discharge team had worked with staff from health and social care and with my dad and I, to decide on the right personalised care needed.

“When my dad arrived home he received visits from the integrated health and social care crisis response and reablement service. For six weeks a physiotherapist helped my dad improve his mobility and a community nurse dressed his wound. A social worker also helped us to make decisions about how my dad could live as independently as possible.

““First Contact were also later instrumental in assisting and directing me to some extra services, which was extremely helpful when trying to remain in work.

“I have been very fortunate that whilst caring for my Dad I have a manager that understands and is willing to provide a degree of flexibility which has proved invaluable. This has helped me to remain in work, reduced the need for sick leave, lessened my anxiety and has therefore also benefited the organisation that I work for.

“The majority of mum's care is now provided by an integrated neighbourhood team so our doctor and other practice staff are also now helping to ensure that my mum hopefully avoids a crisis resulting in being admitted to hospital.

“My employer, coupled with support from health and social care, has assisted me as a carer and assisted my Dad to quickly regain a level of independence, allowing him to remain in his own home. It has provided a level of assurance that he is safe, eating and drinking and keeping as well as he can be.”

In this section we set out how we will transform services to meet the needs of the NHS Long Term Plan. Our plans will deliver improved care, support improvements in health outcomes, reduce unwarranted variation, reduce health inequalities and meet NHS Constitutional Targets. All of our programmes will undertake an Equality and Quality Impact Assessment (EIA).

Carers

Our carers play a vital role in the delivery of healthcare to the LLR population. The importance of carers has been recognised by the NHS Long Term Plan and this recognition is reflected in the key role carers will play in the shaping of new care models.

Within LLR, 105,000 individuals identified themselves as carers. A total of 67% of the 105,000 carers (70,350) provided care for between one-19 hours a week. Of the 105,000, 57% are female (59,850) and 2% (2,000) are aged between 0-15.

In 2018, the LLR health and social care economy developed a joint carers strategy (2018-21), submitted for reference. This strategy, *Recognising, Valuing and Supporting Carers in Leicester, Leicestershire and Rutland*, is focused on supporting our carers to continue to play this key role in the care of our population. The strategy contains eight guiding principles:

- **Carer identification:** we will raise awareness of the importance of carers with all our health and social care organisations and the individuals that work in them
- **Carers are valued and involved:** we will recognise the role of carers across all clinical pathways
- **Carers are informed:** we will ensure our carers have access to all relevant information
- **Carer friendly communities:** we will support the development of local initiatives to improve the experience of carers
- **Carers have a life alongside caring:** we will promote the role of carers among non-health and social care organisations as well as look to provide flexible carers respite
- **Carers and the impact of technology products and the living space:** we will involve carers in housing assessments and understanding carers' requirements
- **Carers can access the right support at the right time:** we will work collectively as a system to ensure carers can access the required support at the right time
- **Supporting young carers:** we will raise awareness and support our young people by focusing on the entire family.

The table below highlights how we will respond to the challenges related to carers in the NHS Long Term Plan:

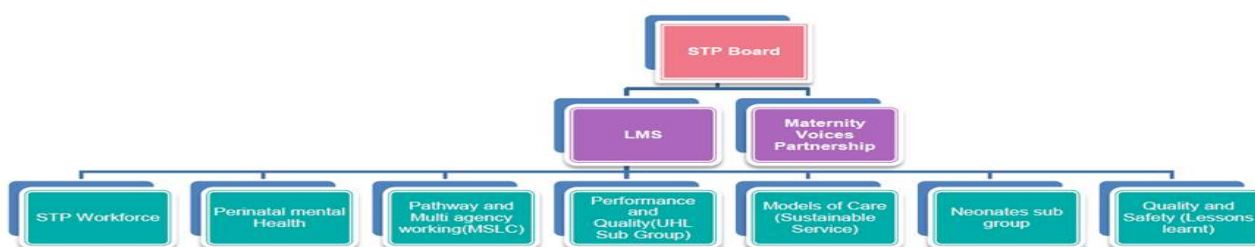
Long Term Plan requirement – physical health	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Improve carers identification and develop local interventions to improve carer outcomes	The LLR carers strategy outlines the requirement for the development of further information and communications to be shared with NHS and social care organisations. This expansion of communications and understanding of carers will support an increase in the number of carers identified in LLR as well as the number of carer assessments undertaken.		●			
Ensure families and carers are co-producers of care plans for children	The LLR carers’ strategy requires all NHS and social care organisations to develop care plans collaboratively with parents and carers of our children. This will be audited to ensure all partners support this requirement.		●			
Develop a carers friendly NHS	The LLR carers’ strategy outlines how carers will play a central role in all NHS commissioning decisions. NHS and social care organisations as well as local communities will also be encouraged to support carers at all points.		●			

Maternity and neonates

Within LLR 11,165 new-born babies were delivered in 2018/19 (10,500 of which were at UHL). A total of 2% of these were home births with the remaining 98% taking place in health facilities.

The LLR Local Maternity System (LMS) transformation plan, also known as the *Better Births Plan*, is now in its third year, moving from the planning to implementation phase. The plan was co-produced with local women and families through the creation of a Maternity Voices Partnership (MVP). It sets out how we will transform maternity and neonatal services to achieve the recommendations outlined in *Better Births: A Five Year Forward View for Maternity Care (2016)*, submitted for reference. To ensure services are joined up we are developing plans to expand our LMS to include neonatal services and pathways. The Better Births programme requires the Local Maternity System to be established on the same footprint of the local Sustainability and Transformation Partnerships (STP). In response to this the governance for the Leicester, Leicestershire and Rutland Local Maternity System is embedded into the STP governance structure and includes an identified Senior Responsibility Officer (SRO) at Director Level (who subsequently reports to the Senior Leadership Team-SLT). Details of this structure can be seen below.

Governance Structure



Interdependencies:



Delivery of the plan will take place through a number of sub groups that report directly into the Local Maternity System board (which monitors progress and escalates to the Senior Leadership Team where appropriate). Our Local Maternity System has agreed a monthly board which is chaired by the Senior Responsible Officer and governed by an agreed terms of reference.

To meet the requirements of the NHS Long Term Plan and improve care for women and their babies, we have set the following goals and timelines:

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Continuity of Carer	<p>As of March 2019 19.3% of women chose to follow our Continuity of Carer (CofC) pathways, this is an increase of 17% since the programme started. We will continue to increase the number of women accessing CofC pathways, in line with the target of 35% by March 2020. By 2021 we will ensure that the pathway is modified to meet the needs of women and their babies to achieve the target of 51%.</p> <p>We will continue to offer choice options and personalisation of services for all. Our continuity of carer programme will be supported by the re-modelling of pathways, including home births, midwifery led units and obstetrics led/midwifery standaside units.</p> <p>We also have a specific pilot programme, commencing in November 2019, with our CofC pathways aimed at vulnerable and at risk BAME women, this will account for 1-2% of women. Following the pilot we will take the learning to ensure that 75% of women from BAME and the most deprived groups have access to CofC.</p>	●				

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Saving Babies Lives Care Bundle (v2)	We have implemented the <i>Saving Babies Lives</i> version one, bundles one-four across LLR. The focus now is on delivering version two by March 2020. This will enable us to work towards a 20% reduction in stillbirths, maternal mortality, neonatal mortality and serious brain injury by 2021 and 50% by 2025. This will include working with partners to review and if necessary re-design and/or expand neonatal critical care services across LLR.		●			
UNICEF Baby Friendly initiative	We will implement the UNICEF Baby Friendly initiative across the whole system. UNICEF assesses compliance against this initiative and provides a gold, silver or bronze rating. The ratings of our providers and partners currently range from bronze to gold and we will work towards full gold compliance.					●
Neonatal critical care services	Once the findings of the review into neonatal critical care services has been completed, we will work together to review and meet any requirements locally.			●		
Integrated support for families during neonatal care	Our re-design of neonatal pathways will result in the full implementation of care co-ordinators to support the active involvement of families in the care of their babies.				●	
Postnatal physiotherapy and multi-disciplinary pelvic health clinics	To meet the requirement of postnatal physiotherapy, we will build on our current postnatal physiotherapy support offer which includes specialist clinics and support on wards/delivery suites. We will also look to review the total post-natal offer and work with our partners to develop and enhance post-natal pathways.					●
Perinatal mental health	A new specialist perinatal mental health pathway has been re-designed and implemented across LLR through the utilisation of wave two funding and the perinatal mental health allocations. This enabled us to reach the 2019/20 target and we are now working to ensure we can meet the targets set over the next four years. We have in place a joint perinatal mental health and maternity clinic serviced by a strong multi-disciplinary team from across UHL and LPT. We will use the model to extend our offer in providing outreach clinics. We will put ourselves forward as a trailblazer to enable further development of the model and share our learning.	●			●	

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
	<p>To support a redesign of extended perinatal support we are currently undertaking a workforce, demand and capacity review.</p> <p>We are working with our IAPT and adult mental health providers to consider how we can support partners of women accessing specialist perinatal mental health services.</p>					●
Maternal medicine hub	Our recent expression of interest for developing a maternal medicine hub has been successful and we are now developing the phase two bid. If successful, this should enable us to ensure that women with acute and medical problems have timely access to specialist advice and care during pregnancy.			●		
Smoking cessation	All women who smoke during their pregnancy are now offered smoking cessation services support to help them quit.			●		
Digital	<p>All women have an individual care plan and we are now working to ensure all elements of this plan are available electronically. We are also now focusing on ensuring that by 2023/24 all women will have access to their maternity notes and information through smart phones or other digital devices.</p> <p>We are also ensuring that there is improved connectivity and information management across all out maternity pathways.</p>					●

In addition to the above, a key enabler to improving care and outcomes for women and babies in LLR is to reconfigure our two maternity units onto one site at the Leicester Royal Infirmary – see chapter two.

What will this mean for our mothers and babies?

The delivery of our maternity and neonatal transformation programme will ensure that babies born in LLR have the best possible start in life. This programme will also ensure that mothers are able to have their babies in the location of their choice (home or NHS facilities). Expectant mothers will experience continuity of care and services delivered from state-of-the-art facilities. Where required, babies will receive lifesaving care from excellent level three neonatal facilities. We expect the transformation of maternity and neonatal services to reduce rates of stillbirths, neonatal deaths,

maternal deaths and incidence of brain injury during birth, creating the best start in life for our children.

Services for children and young people – physical health

There are around 250,000 children and young people up to the age of 18 across LLR. The population with general and complex health needs that requires clinical intervention is increasing.

In response, our focus is supporting children and their families to enable them to become as independent as possible in adulthood. This aim requires multi-organisational working to deliver efficient and sustainable universal, targeted and specialist services across LLR. To achieve this we are a developing children’s transformation programme that integrates the maternity and *Future in Minds* transformation programmes. This will deliver on our vision to improve outcomes and reduce inequalities for children, young people and families, with physical, emotional and mental health needs, through an integrated community care system ensuring they are safe, independent, have ambition and live the best life they can.

By the end of 2019 we will have developed a Leadership Board to bring together local leaders from across the NHS, local government, education and other partners to drive this work forward. We will develop a work plan outlining key priorities and how these will be commissioned through joint arrangements. This will reduce duplication and fragmentation in commissioning and deliver a preventative approach with early intervention leading to robust transition and efficiencies across all organisational boundaries.

We want to put ourselves forward for the NHS England programme to develop an evidence-based integrated approach to children and young people.

Work continues to deliver a new children’s hospital model at Leicester Royal Infirmary.

To meet the requirements of the NHS Long Term Plan and improve care for children and young people we will:

Long Term Plan requirement – physical health	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Developing age-appropriate integrated care	<p>We will design and implement integrated pathways of care that support the physical, behavioural and emotional needs of our children and young people that are outcome based, person-centred and offer age appropriate care. In particular we are working on flexible approaches for young people transitioning from children to adults.</p> <p>This involves assessing and agreeing an appropriate age for transition between the ages of 18-25, ensuring a smooth transition into adult services for physiotherapy, mental health, neuro disability, occupational therapy and speech and language therapy.</p>		●			

Long Term Plan requirement – physical health	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Improving care for children with long-term conditions	<p>We will continue to have a multi-agency approach working with the Children’s Clinical Network, to redesign pathways for long-term conditions including cancer, asthma, epilepsy and diabetes.</p> <p>Working with public health we will focus on prevention in the areas of weight management strategies, immunisations and dental health.</p> <p>Our approach to age appropriate integrated care described above also supports this agenda.</p>		●			
Treating and managing childhood obesity	We will continue to work with public health to design and deliver local weight management strategies including targeted support for children with obesity and co-morbidities. In addition we will develop specialist tier three provisions.			●		
Improving outcomes for children and young people with cancer	We are working with NHS England Specialised Commissioning and the Cancer Network to redesign cancer pathways to improve the outcomes experienced by children, this will include in-reach and outreach provision for families.					●
Children’s palliative care	We plan to work across the system to review our children’s palliative care pathway, working with the East Midlands Palliative Care Network to improve the quality of service, family support and respite care. This work will support our ambition of moving towards a level four service.					●
Improve performance of children screening and immunisation programmes	We will support public health in the promotion of screening and immunisation ensuring all health colleagues reviewing and assessing children and young people promote uptake.			●		

What will this mean for children and young people?

We aim to ensure that all children and young people and their families have early identification of need and access to the services that meet those needs. This will support children and young people to have improved outcomes and reach their potential.

Services for children and young people – emotional health

In LLR 10% of children and young people have a diagnosable mental health disorder and many more have emotional and wellbeing needs which are not recognised.

The LLR *Future in Mind* transformation plan describes the system-wide pathway delivered by a range of organisations and professionals to promote, protect and improve our children's and young people emotional mental health and wellbeing, submitted for reference. Our ambition is that children and young people will have access to the right help at the right time through all stages of their emotional and mental health development. For this to happen, we have developed a whole system approach to delivering a range of emotional, mental health and wellbeing services that meet all levels of need.

Long Term Plan requirement – mental health		19/20	20/21	21/22	22/23	23/24
Increasing access for children and young people accessing NHS funded services by 2023/24	<p>Over the last two years we have undertaken considerable work to transform the services offered to children and young people. We have improved access and early intervention supported by a triage and navigation service with a phased implementation. Working with partners we have also introduced early intervention in schools, expanded capacity in core services and redesigned specialised crisis services.</p> <p>By January 2020 we will fully implement the new triage and navigation service which will improve timely access to the right care for children and young people.</p> <p>This will help us achieve 34% increase of patients accessing mental health services (7237 in 2019/20) and 35% (7450 in 2020/21).</p>		●			
Achievement of 95% children and young people eating disorder standard in 2020/21	<p>To achieve this we are undertaking a full review of the current eating disorder service including the service model demand and capacity. The new model will be designed to meet the specific needs of users including introducing early intervention for children and young people with disordered eating, and recovery services to enable sustained improvement.</p> <p>The aim is that the redesigned service will enable the national standard to be achieved.</p>		●			
Mental health support teams to cover between one-quarter and one-fifth of the country	We will implement the school service and bid for any available resources.					●

Long Term Plan requirement – mental health		19/20	20/21	21/22	22/23	23/24
by 2023/24						
100% coverage of 24/7 crisis provision	<p>From 2016 LLR has been delivering a crisis and home treatment service which can be accessed through NHS111, GPs, schools and early Intervention. All children and young people experiencing crisis have access to crisis care 24 hours a day, seven days-a-week.</p> <p>From 2019, we are beginning to see a reduction in the number of children and young people attending A&E where there is no physical need, as well as a reduction in the length of stay on our CAMHS in-patient unit.</p> <p>By 2020 our ambition is to introduce intensive home support in addition to the home treatment service we currently deliver and to undertake research into the development of a ‘safe place’ for de-escalation and a crisis café for children and young people, to be delivered, depending on findings, by 2021.</p>					

What will this mean for children and young people?

The *Future in Mind* programme will ensure that our population has access to age suitable mental health services. They will have quicker access to services leading to an earlier diagnosis and treatment together with important mental health resilience to take them into adult life.

Improving mental health services

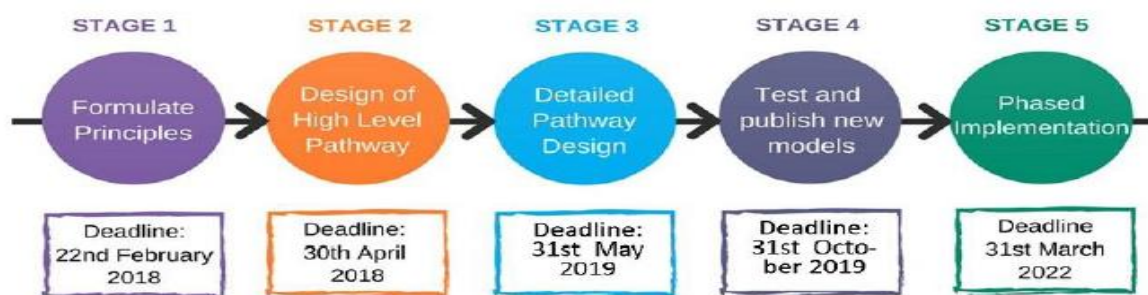
Almost one in four people in the UK experience at least one mental health problem each year. 168,000 people in LLR are estimated as having a common mental health problem, such as anxiety, panic disorders or depression. Furthermore, there are just under 10,000 patients identified as having a severe and enduring mental illness (such as schizophrenia, bipolar affective disorder and other psychoses).

While some services in LLR meet demand and are delivering good quality care, many consistently struggle with long waiting lists, difficulties in meeting service demand and not meeting service user expectations. This has been evident in previous Care Quality Commission findings as well as service user and staff surveys. To start to tackle this across LLR we embarked on an All Age Transformation Programme in 2017 – the biggest mental health and learning disabilities transformation journey we have ever been on. We are working in partnership with staff, service users, carers and stakeholders

to create a radical difference in the way we support people who need mental health and learning disability services.

We will have distinct specialities within our mental health and learning disabilities services that provide specific expertise to groups of service users who, through particular life stages or other reasons, have commonality in their needs. However in recognition that everyone is different and people's needs change over time, we will also work together. We will share expert knowledge, collaborate across services, and bring expertise together around each user. The majority of service users will receive care through geographically organised teams that are linked and aligned to the primary care networks to help increase joint working with GPs and other community services. Service users will always have an individual within LPT's mental health and learning disabilities services co-ordinating care and support.

The programme has five stages:



Stage one: we began the journey by focusing on what excellent mental health and learning disabilities services would look like around how people access services, how their needs are assessed and understood, how they get the treatment they need and how they leave services. This involved engagement with 1,000 people across LLR.

Stage two: we extensively engaged with service users, carers, staff and stakeholders to develop a high-level pathway which gave us an outline of the services we need and how they should operate.

Stage three: we used the high level pathway established in stage two to co-create the detailed designs. This includes what our services should look like, how they should run and the resources they need.

Stage four: we are seeing the newly co-designed model tested against the likely demand, amount of resource available and different scenarios, as well as engagement with staff and the public. The aim is for this modelling to be completed by end October 2019.

Stage five: phased implementation of the programme will commence at the end of 2019 and continue to March 2022.

To support this programme and to deliver the requirements of the NHS Long Term Plan we will:

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Confidential

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
By 2020/21 100% population access to 24/7 crisis care required	<p>24/7 crisis care is already in place across LLR and we have recently received fair share transformational funding to improve our services in the following areas:</p> <ul style="list-style-type: none"> • Early supported discharge • Four-hour response • More intensive home-based treatment • Open access 		●			
The development of local mental health crisis pathways including alternative to hospital services	<p>We already have a number of services to support users in crisis. This includes Crisis House, move on accommodation, Crisis Helpline and a new pilot Crisis Café in the city.</p> <p>Our focus will be to ensure that these offers are used effectively and consider the need for a Crisis Café in the county. We also have a programme of work that is improving timely flow through acute hospitals. In addition we will work with partners to consider opportunities for housing.</p>		●			
Develop integrated adults and older people primary/community care pathways	<p>As part of our All Age Transformation Programme we are redesigning all our care pathways. Community mental health teams will be aligned to primary care networks ensuring better management of both physical and mental health. The mental health facilitators that support patients in primary care will also be part of this integrated team.</p> <p>Work is ongoing to ensure that physical health checks are undertaken and we have a targeted programme working with the lowest performing general practices to improve take up rates to enable use to meet the standard by 2023/24.</p>		●			
Continuation of the individual placement support wave funding	<p>Following a successful bid to expand our individual placement support offer we will implement the changes necessary to increase service provision by 150% over the next two years. As part of this work employment specialists will be integrated into our community mental health teams to enable greater integrated working.</p>		●			

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Implement enhanced suicide prevention initiatives and bereavement services	Our suicide prevention strategy sets out priorities to reduce the incidence of suicide and support families. Working in partnership with public health, the focus is on enabling people to manage their health more effectively, developing awareness, reducing stigma and developing population skills. We have a bespoke website for help and support and we are starting a bereavement service from October 2019.		●			
Develop a mental health strategy for rough sleepers	Leicester City has made an application to be a Pathfinder area to support and expand on the work being undertaken to support rough sleepers. In the city we have a specialist primary care service for the homeless; we invest in the voluntary sector who support homeless people and there is a specialist mental health service. However we would like to do more through the Pathfinder bid.		●			
IAPT	From 2020/21 we plan to meet all IAPT targets including access, waiting times and recovery. This includes the expansion to the offer for people with long-term conditions.		●			
Achieve 60% of early intervention psychosis activity by 2021	We already achieve this standard and plan to meet the 95%, Level 3 EIP, by 2022/22.	●				
Core 24 standard	Following a successful bid, LLR are currently implementing plans to ensure the standard is met and sustained from 2021.			●		
Mental health professionals supporting ambulance assessment	We will work with East Midlands Ambulance Service to embed mental health professionals in ambulance assessment, learning from the pilots that are currently underway across the East Midlands.	●				
100% coverage of 24/7 age appropriate crisis care via NHS 111	As part of our All Age Transformation Programme we will have open access arrangements and a 24/7 helpline for crisis care. This will be linked to our NHS 111 service. The intention is to implement this approach from 2020/21. Discussions are ongoing about a pilot during the winter of 2019/10.		●			

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Improve patient outcomes and experience of inpatient care	<p>As part of the All Age Transformation Programme we are reviewing all our inpatient services and offer to improve access to peer support work and occupational therapists. This will support the delivery of the national average length of stay to 32 days by 2023/24.</p> <p>Our plans around improving the environment for inpatient accommodation will also improve experience of inpatient care.</p>					●
Out-of-area placements	We currently have a number of out-of-area placements and we have a programme to ensure that this is reduced. The focus is on improving discharge processes and strengthening crisis offer and early supported discharge to support the delivery of the required elimination of inappropriate out-of-area placements by March 2020.		●			
Dementia diagnosis rates	We will continue to meet the dementia diagnosis rates and continue to offer a post-diagnosis support service which is currently being reviewed to ensure it meets future need.	●				
Digital	<p>Our digital priorities for mental health are:</p> <ul style="list-style-type: none"> • Providing agile working for the crisis teams • Improving information between our main providers • Apps to support prevention and self-care 					●
Provider collaboration networks	See Specialised Commissioning Section – page 17					
Comprehensive 0-25 support offer by 2023/24	<p>We will design and implement integrated pathways of care that support the physical and emotional needs of children that are outcome based, person-centred and offer age appropriate care. In particular we are working on flexible approaches for young people transitioning from children to adults.</p> <p>This involves assessing and agreeing an appropriate age for transition, commencing at 14 years old, between the ages of 18-25, ensuring a smooth transition into adult services for physiotherapy, mental health, occupational therapy and speech and language therapy.</p>					●

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24

To support the above work to take place we have planned to meet the Mental Health Investment Standard with an average of 4.6% growth going into the sector each year until 2023/24.

Inpatient re-provision

In addition to the service transformation described above there is an urgent need to reconfigure inpatient sites due to standards and safety issues.

LPT's acute inpatient mental health services are currently provided in 17 wards located across the city on the Glenfield Hospital, Leicester General Hospital and Gorse Hill Hospital sites. Following inspections in November/December 2018, the CQC raised serious concerns about these services, in part related to the standards and safety of the accommodation. It is difficult for LPT to further improve facilities to address outstanding issues highlighted by the CQC without major capital investment. Current accommodation does not comply with NHS standards due to privacy and dignity issues and the ability for nursing staff to observe patients and keep them safe.

Consequently, the trust board is currently determining the best place(s) in Leicester where new facilities, to be designed and built to required standards, would accommodate future acute inpatient mental health and learning disability services. To support this, a strategic outline case is being developed before moving into the outline business case stage. It addresses the current issues with trust accommodation and will propose appropriate, sustainable solutions. Once approval has been given to the strategic outline case then the Trust will:

- Conduct public consultation on short-listed site options
- Select preferred site(s)
- Develop high level designs
- Split the proposed scheme into phases, ensuring that proposed work is considered as a manageable number of capital bids and each capital bid is less than £50m
- Apply for capital funding and go through the formal national approval route for each phase.

The programme is likely to be phased over a nine-year period, incorporating development, design, approval and construction, starting in January 2020 and finishing in December 2029.

To support the work to re-design and transform services, LPT is currently implementing a quality improvement strategy focused on ensuring all services consistently deliver high quality care. This strategy is titled *Step Up To Great* and focuses on the following areas:



DN: This is currently being updated – final version to be include in the final version of Our Long Term Plan

A collective leadership approach is central to this journey and the ability to deliver change which will improve the quality of care for patients. This spans every element of LPT whatever their role, level or frequency of patient contact. A number of specific improvement plans will be collaboratively produced with patients and their families/carers to ensure progress is delivered.

What will this mean for our patients?

By 2023/24 our population will have timely access to psychological therapies (IAPT). For those with a diagnosed mental health condition, they will be supported by a multi-disciplinary community team which is resourced to provide regular support. At times of crisis our population will not need to seek support in the emergency department, unless appropriate to do so for physical health needs, but will instead have access to a 24/7 crisis response service. Finally, if admission to an acute mental health hospital is necessary this will be to a state-of-the-art facility and local services where they will only stay for as long as necessary.

Learning disabilities and autism

By 2020, within Leicester 7,918 adults between the ages of 18-64 will be living with autism and/or learning disabilities (3.4% of our total population). For Leicestershire, it is anticipated that by 2020

14,025 adults will be living with autism and/or learning disabilities (3.48% of the population). For children 1.1.% have a diagnosis of autism and 0.8% have a diagnosis of learning disabilities.

Through our All Age Transformation programme and the Transforming Care programme in LLR we seek to improve health and social care services for people with learning disabilities and or autism, who display behaviour that challenges, including those with a mental health conditions.

To support delivering the principles of this strategic programme, in March 2020 we will publish a LLR strategic vision for people with a learning disability and/or autism. Implementation of this strategy will take place from 2020 to 2023. Our strategy will support the local transition of the Transforming Care Programme (TCP) into business as usual, and ensure that individuals with a learning disability and/or autism are supported to live as independently as possible and achieve a fulfilling life.

The expansion of the LLR Crisis Response Home Treatment Service will also increase expertise in learning disabilities and autism so that the cohort of this population who are also experiencing mental health difficulties can be appropriately supported at a time of crisis.

To meet the requirements of the NHS Long Term Plan and improve care for adults with learning disabilities and/or autism we will:

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Outline required further reduction inpatient usage and beds	<p>At present 27 patients are accommodated in inpatient beds and we have plans to ensure that wherever possible only those that need to be in an inpatient bed are.</p> <p>To support this we have multi-agency discharge processes in place to ensure timely discharge and are making plans to increase availability of supported living accommodation across LLR.</p>				●	
Learning disability and autism physical health checks for at least 75% of population aged 14 and over	<p>We will continue to work with our primary care providers and the primary care liaison team to meet the target of 75% of people with a learning disability and/or autism diagnosis receiving an annual health check.</p> <p>For children and young people we are working with our practices to ensure they are flagged to primary care at diagnosis stage.</p> <p>We have specialist primary care nurses in place that work with practices to increase their knowledge and skills to enable them to undertake the checks. We also complete a quality review of the checks to ensure the reviews meeting requirements.</p>		●			

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Ensure alignment of learning disabilities and/or autism functions with mental health and SEND services	<p>We will continue our work to deliver the Special Educational Needs and Disabilities (SEND) Code of Practice (2015) and ensure alignment with our mental health transformation programme</p> <p>Key areas of work include support in schools, improving timelines for ASD diagnosis and development of a multi-agency neuro-developmental pathway.</p>			●		
The local offer for autistic young people. People with a learning disability and their families	<p>We have a specialist learning disability and autism for young people team in place which provides case management and key workers to support young people and their families.</p> <p>We are undertaking a review by multi-agency partners as part of the re-design of the neuro-developmental pathway considering pre-diagnostic and post-diagnostic support.</p>					●
How NHS-led provider collaborative will be developed locally	See Specialised Commissioning Section – page 17					●
Digital	We are working to expand the coverage of the reasonable adjustment digital flag in the patient record across LLR.		●			
Support pilot work for community services for both adults and children and young people 2020/21	<p>A Learning Disabilities Outreach Crisis Team is in place with seven days-a-week coverage. Using a risk of admission register there has been a significant fall in children and young people being admitted to an inpatient bed.</p> <p>We will also review and where required re-design community service provision for our learning disability and/or autism population. In addition we are working on a one-year pilot of delivering personal behavioural support to be evaluated in 2020/21.</p>			●		
Develop keyworkers for children and young people with the most complex needs	We will ensure every child and young person with learning disability, autism or both with most complex needs has a designated key worker. Initially this will be for children and young people in inpatient units with full roll-out of the service by 2023/24.					●

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Further 'catch up' in the number of Learning Mortality Reviews (LeDeR) in 2019/20	We will actively work with all partners to ensure compliance with LeDeR targets and take learning that will improve the quality of health and social care services for people with learning disabilities, that help reduce premature mortality and health inequalities for people with learning disabilities.			●		
Roll-out, as part of new PCN arrangements, the Stopping Over Medication of People (STOMP) with a learning disability or autism	<p>We will lead a multi-agency programme to stop over-medication of people with learning disability or autism.</p> <p>There are six key actions that we are taking as a system to ensure delivery these are:</p> <ul style="list-style-type: none"> ➤ Offering a medication review to service users when they access primary care for their annual health checks ➤ Offering a medication review for service users when they access specialist learning disability services for health reviews ➤ Creating a framework where clinicians in primary care and secondary care can collaborate better on making the right decisions about medications ➤ Considering the use or overuse of medications during MDT discussions including CETR/LAEP meetings ➤ Creating a learning and development framework to raise awareness and prompt clinicians' interest in medications reviews ➤ To enable an effective communication campaign that raises awareness about STOMP/STAMP. 		●			
Test the model for taking eye, hearing and dental services to young people in residential schools from 2021/22	We will work with SEND leads in public health, local authorities and education providers to bring hearing, sight and dental checks to children and young people with a learning disability, autism or both in special residential schools by 2023/24.		●			

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Capital investment for 2019/20 and 202/21 to support the development of new housing options and suitable community	We are currently in the design phase ahead of a bid to NHS England to develop a supported living accommodation with seven units.		●			
Reviewing our respite provision	During 2019/20 we have undertaken an extensive piece of work to consider the future form of our respite care. This has involved engagement with users and their families and takes into account the changing needs of people and the move to more personalised health budgets. We will be undertaking a formal 90 day consultation from November 2019 with decisions being made in March 2020 on the agreed option.	●				

What will this mean for adults with learning disabilities and/or autism?

Following delivery of our Transforming Care programme our population will have access to highly personalised services provided by a multi-disciplinary team of physical and mental health professionals. Only those who truly need an admission to hospital will be admitted, and this will be in the least restrictive environment as possible and for the shortest time. Others will be supported to live in the community, close to home and will be supported to have fulfilling lives.

Cancer

In 2016/17 there were 5,205 LLR individuals newly diagnosed with cancer. In March 2018 there were 27,549 cancer patients on LLR GP registers. The prevalence of our population with cancer ranges from 1.5% within Leicester City, 3.2% in East Leicestershire and 2.8% in West Leicestershire.

Within Leicester, cancer is the second most common cause of death, accounting for 25% of all deaths and 35% of deaths in under-75 year-olds. These averages in Leicester are lower than the England-wide equivalents, where cancer accounts for 28% of deaths in all ages and 40% of deaths in under-75 year-olds. Lung cancer claims the highest number of lives per year in Leicester. The next highest number of cancer deaths is from colorectal, breast, prostate and oesophageal cancers.

Within Leicestershire, cancer accounts for 28.5% of all deaths in East Leicestershire and Rutland, and 26.9% of all deaths in West Leicestershire. Cancer accounts for a third of deaths in under-75 year-olds. These averages in Leicestershire and Rutland are statistically similar to the England-wide

equivalents, where cancer accounts for 28% of deaths in all ages and 40% of deaths in under-75 year-olds. Lung cancer claims the highest number of lives per year in Leicestershire. The next highest number of cancer deaths is from colorectal, breast, prostate and oesophageal cancers.

Screening coverage in Leicester is significantly lower than nationally and the lowest in the East Midlands. While our one-year survival rates have been improving slowly over the last few years, we do not currently meet the national target by 2020 of 75%. In 2015 the rate in Leicester was 67.3%, in East Leicestershire and Rutland 73.3.% and in West Leicestershire 71.6%.

To tackle these challenges we have developed a LLR cancer strategy, submitted for reference, to improve outcomes for cancer patients. The strategy focuses on the following areas:

- **Prevention:** reducing the number of preventable cancers by promoting and facilitating lifestyle changes and reducing inequalities
- **Earlier diagnosis:** improving our earlier diagnosis rates is recognised as the single most important factor in improving cancer survival
- **Ensure access to treatment of excellence:** increasing our research portfolio so patients can continue to access innovative treatments in a centre of excellence in LLR
- **Deliver the personalised care agenda:** offering every patient diagnosed with cancer a holistic needs assessment and the opportunity to develop a personalised care plan.

To meet the requirements of the NHS Long Term Plan and implement our cancer strategy we will:

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/2	20/2	21/2	22/2	23/2
Improving the one-year survival rate	Our cancer strategy is focused on making progress to increase one-year survival rates by improving screening uptake and improving early detection across LLR. This will include working with public health to commission stop smoking services, physical activity advice and interventions, weight management services and healthy eating advice. We will also use social media, health and education events, engagement with our local communities and education in schools to amplify prevention messages.					●
Improving bowel, breast and cervical screening uptake	We are committed to increasing screening uptake rates with a focus on cervical and bowel. To achieve this we are increasing awareness and improving education on the benefits of screening and signs and symptoms to reduce late presentations. Our work includes using a range of innovative techniques such as social media, drop-in community clinics to maximise uptake, targeted screening in areas in populations with low uptake and education and support to health professionals.		●			

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/2	20/2	21/2	22/2	23/2
	We are also targeting cancer screening in areas where there is low uptake numbers through local community and GP practice champions and through religious leaders.					
Roll-out of FIT and HPV testing	LLR has successfully introduced, in June 2019, a new simple test for detecting very small amounts of blood in a patient's faeces, known as the FIT test. HPV testing will be rolled out in quarter three of 2019/20.	●				
Improving GP referral practice	All cancer two-week wait referrals have to be made using our PRISM referral system which ensures a systematic and standardised approach to referral. We have regular education sessions at GP events and we will support GPs to undertake significant event analysis following emergency presentations.	●				
Implementation of faster diagnosis pathways (FDS)	<p>Prostrate: We have seen sustained increase of around 20% in the number of prostate cancer referrals. To support this we will roll out the RAPID prostate pathway in a phased approach to October 2019.</p> <p>Lung: We will roll out the optimal lung cancer pathway by end of October 2019 to decrease the number of emergency presentations and increase early detection rates and improve overall and one-year survival rates.</p> <p>Bowel: FIT has been introduced across LLR.</p> <p>Radiotherapy: UHL are part of the East Midlands Radiotherapy Operational Delivery Network. This is the regional leadership group tasked with improving radiotherapy services. Initial focus will be on improving upper GI pathway and the development of rapid diagnostics.</p>	●				
Improving access to high quality treatment services	This is one of the four pillars of our cancer strategy. The focus is on improving pathways and patient experience through developing leading edge capabilities in surgical techniques and infrastructure, developing innovative service models in diagnostics, radiotherapy and chemotherapy and developing our research.		●			
Roll-out of personalised care	31,107 people in LLR are currently living with and beyond cancer. By 2020 every patient diagnosed with cancer will have been offered the opportunity to complete a holistic needs assessment and develop a personalised care plan. Standardised treatment summaries will be available for every patient and their GP following each modality of treatment. Cancer care reviews will be offered to every patient within six months of their diagnosis.		●			

Long Term Plan requirement	Leicester, Leicestershire and Rutland approach	19/2	20/2	21/2	22/2	23/2
	<p>We will offer access to information and opportunities to support overall health and wellbeing and maximise the quality of life including access to exercise, physiological therapies and return to work support.</p> <p>There will be cancer champions across LLR and we will roll out the HOPE programme into communities and long term carers.</p>					
Work with cancer alliances to reduce clinical variation	The LLR clinical commissioning groups have a close relationship with the East Midlands Cancer Alliance (at commissioning officer and clinical level). We will build on this relationship and collaboratively address clinical variation. Also see improving GP referral practice section.		●			
Fully roll out lung health checks	The Corby health economy is the East Midlands pilot site for this programme and UHL are prepared to treat those screened in Corby and subsequently diagnosed. In LLR we will take the learning from this pilot to roll-out the pathway in LLR in due course. Patients diagnosed through the pilot are being treated in our local hospital.			●		
Work with the Cancer Alliance to implement Rapid Diagnostic Centres (RDC)	A bid has been made to support the development of rapid diagnostics across LLR. We will actively work with the East Midlands Cancer Alliance on developing our proposals for implementation over the next two years.			●		

What will this mean for patients?

We believe that by delivering our new LLR-wide cancer strategy we will improve the outcomes of patients by diagnosing early, having timely treatment, support including being provided with personalised information and being involved in decision-making. As a result we expect to reduce the number of cancers detected at late stages and reduce the premature mortality rates for cancers.

Long-term conditions

The main causes of illness and death across our health and social care system are the diseases of respiratory, cardiovascular (CVD) and diabetes within the range of illnesses referred to as long-term conditions (LTC). While supporting our population with the management of these conditions is a central element of our five-year plan, it is clear that 80% of our healthcare system resources are

utilised by 20% of individuals with two or more long-term conditions. Our approach to long term conditions will need to evolve to support those with two or more long-term conditions (what we call multi-morbidity).

Our LTC programme will deliver redesigned and improved pathways of care at a system, place and neighbourhood level. This will ensure the right care is delivered, to the right patient at the right time, wherever they live, through the provision of seamless care across our system.

The LTC programme will focus on redesigning pathways across CVD and respiratory services to improve outcomes for our population. Specific pathways in focus include pulmonary rehabilitation, COPD, bronchiectasis and asthma, pneumonia, chest pain (non-cardiac), heart failure, atrial fibrillation, familial hypercholesterolemia, hypertension, diabetes and stroke.

The local drivers underpinning the need to transform clinical services across LLR, reflect an emphasis on developing new models of care, integrating teams to establish sustainable long-term services that avoid unnecessary admission to acute hospital and, bringing care closer to home including using community hospitals and facilities. In doing this we will:

- Develop pathways that address changing needs to support long-term management, improved well-being and self-management where appropriate
- Develop more planned and integrated care, provided earlier to our population in settings outside of acute hospital where possible
- Provide proactive, high quality care, delivered comprehensively, to the wider population with long-term cardio-respiratory conditions. This will reduce subsequent healthcare resource use, including the need for acute admission to hospital
- Improve the variation in quality, access and standards ensuring that services are centred on the patient
- Use digital technology to support patients in their own home, such as the use of websites and apps to support their self-management to improve care and support independence.

In addition to the above we will specifically respond to the requirements of the NHS Long Term Plan by:

Long Term Plan requirement – CVD	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Increasing the number of people at risk of heart attack and stroke who are treated for cardiovascular high risk conditions	<p>We will maximise primary care case finding to support the identification of at-risk patients who will benefit from reviewed and improved pathways.</p> <p>We will use practices system searches to identify at-risk CVD patients and review their care accordingly.</p>		●			

Long Term Plan requirement – CVD	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
	We will utilise a regular national programme care audit, called <i>CVDprevent</i> that will make it easier for practices and primary care networks to systematically identify people whose treatment could be improved and risk reduced.					
Testing the use of technology to increase referral and uptake of cardiac rehabilitation from 2021/22	We will review existing technology to identify suitable products to support the increase in referrals and uptake of cardiac rehabilitation.			●		
Pilot schemes in 2020/21 and 2021/22 to increase access to echocardiography and improve the investigation of those with breathlessness	We are currently undertaking a full system diagnostics review and redesign programme to ensure our models of care are fit for purpose, deliver closer to home testing and are in line with primary care network development.		●			

Long Term Plan requirement – stroke care	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Targeted funding to support roll-out of ISDNs will be available from 2021/22	Our system-wide clinically-led Stroke Pathway Group is reviewing its terms of reference and membership in order to meet the requirements of the Integrated Stroke Delivery Networks (ISDNs).		●			
Targeted funding for developing and testing improved post-hospital rehabilitation models	We already provide early supported discharge services and a community integrated neuro and stroke service which supports rehabilitation at different points of the patient pathway. We will actively work with system partners to improve this. To strengthen our rehabilitation offer, we are interested in becoming an early implementer site.		●			

Long Term Plan requirement – diabetes	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
Support for more people living with diabetes	We have an extensive programme of support for people living with diabetes across LLR including education programmes for our newly-diagnosed type 1 and type 2 diabetics, education to family and carers of type 2 diabetics, bespoke courses aimed at our younger adult population (18-35) and education around faith and fasting. In addition, through transformation funding, an extensive programme of clinical support and mentorship, along with training and upskilling, is being provided to primary care professionals to enable more people to be effectively supported to control their diabetes.	●				
Targeting variation in the achievement of diabetes management, treatment and care processes	We actively work with all system partners to benchmark performance against the eight diabetes care processes and support those who do not meet expected levels of performance, particularly with the three NICE recommended treatment targets. The national diabetes transformation fund is being used to expand this work. In areas of high prevalence we also have diabetes mentors.	●				
Addressing health inequalities through the commissioning and provision of services	We will use a population health management approach to identify and optimally manage patients with diabetes and to identify those at risk. In addition we currently commission, and will continue to do so, services targeted at particular groups including women with gestational diabetes, BAME patients, and children and young people with type 1 diabetes. We will continue to actively work with our local communities to support better management of diabetes and advice and guidance around diet and exercise.	●				
Expanded provision of access to digital and face-to-face structured education	As a system we have used transformation monies to expand the offer of structured education and to target ‘hard-to-reach groups’. This included: <ul style="list-style-type: none"> ➤ Development of an online self-referral form for type two diabetics 					

Long Term Plan requirement – diabetes	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
	<ul style="list-style-type: none"> ➤ Piloting an online education programme for pre-conception ➤ New online programme for women who had gestational diabetes during a recent pregnancy ➤ Targeted programme for 18-35s ➤ Education around faith and fasting ➤ Recruit, train and support a team of South Asian diabetes community champions. <p>We will roll out national online programmes when available, such as NDPP online course for pre-diabetic patients.</p>			●		
Providing access for those living with type two diabetes to the national HeLP diabetes online self-management platform	As a system, we will proactively signpost our patients to online tools that support the management of their health. This will include the HeLP diabetes tool when launched in quarter four of 2019/20.	●				
Ensuring universal coverage of multi-disciplinary foot care teams (MDFTs) and diabetes inpatient specialist nurses	Within LLR we deliver a NICE compliant multi-disciplinary foot care service and are in the process of improving the pathway based on an independent peer review.		●			
Enable up to 20% of people living with type one diabetes who are eligible, to access flash glucose monitoring devices	In line with the Regional Medicines Optimisation Committee criteria, the use of Freestyle Libre (flash glucose monitoring system) has been available to LLR patients since January 2019. We will continue to encourage increased access to eligible patients.	●				
There will be targeted funding for MDFTs and DISNs transformation projects	<p>Within LLR we deliver a NICE compliant multi-disciplinary foot care service and are in the process of improving the pathway based on an independent peer review.</p> <p>NHSE transformation funding has supported us to</p>	●				

Long Term Plan requirement – diabetes	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
	improve the DISN service, expanding to a seven-day diabetes inpatient service.					
Targeted funding to support delivery of the three recommended treatment targets	We were successful in securing transformational funding from NHS England to improve the achievement of the three treatment targets. We have a targeted programme in place to support practices on an individual basis through complex patient clinics, virtual clinics and audit tools. In addition to this, an extensive training programme has been developed and is on offer to all healthcare professionals.	●				
Target tied funding to test low calorie diets for obese people with type two diabetes	Given the high incidence of diabetes in LLR we are currently preparing a bid for targeted funding to test low calorie diets for obese people with type two diabetes.	●				
Ensuring that pregnant women with type one diabetes are offered continuous glucose monitoring (where clinically appropriate)	We will work with system partners to ensure that all eligible pregnant women are offered continuous glucose monitoring.		●			

In addition to the above we will work with public health teams to redesign the tier three obesity service in LLR to address current gaps in the service, in line with NICE guidelines. This will focus on developing a multi-disciplinary team in order to adequately manage obese individuals, particularly those who have complex co-morbidities to increase capacity of this service from one which is currently principally perioperative. It aims to improve weight loss among these people and improve the control of their co-morbidities and prevent progression of chronic conditions as well as reducing the development of others.

Long Term Plan requirement - respiratory	Leicester, Leicestershire and Rutland approach	19/20	20/21	21/22	22/23	23/24
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<p>Targeted funding for a number of sites to expand pulmonary rehabilitation services and test new models of care</p>	<p>We have redesigned and expanded the community pulmonary rehabilitation offer to ‘breathlessness’ rehab for both COPD and heart failure patients. This will support the reduction in admissions and re-admissions for COPD and work towards meeting current demand. The service will require further expansion following the new Quality and Outcomes Framework indicator for referrals to pulmonary rehabilitation.</p>		●			
<p>Targeted funding available to increase spirometry training via new primary care training hubs</p>	<p>As we progress with our system-wide diagnostics review and redesign programmes, spirometry will be considered a key element of this model. There will be increased delivery of spirometry within a community/primary care setting through the respiratory programme where funding resources for training/accreditation will be considered.</p>		●			

What will this mean for patients?

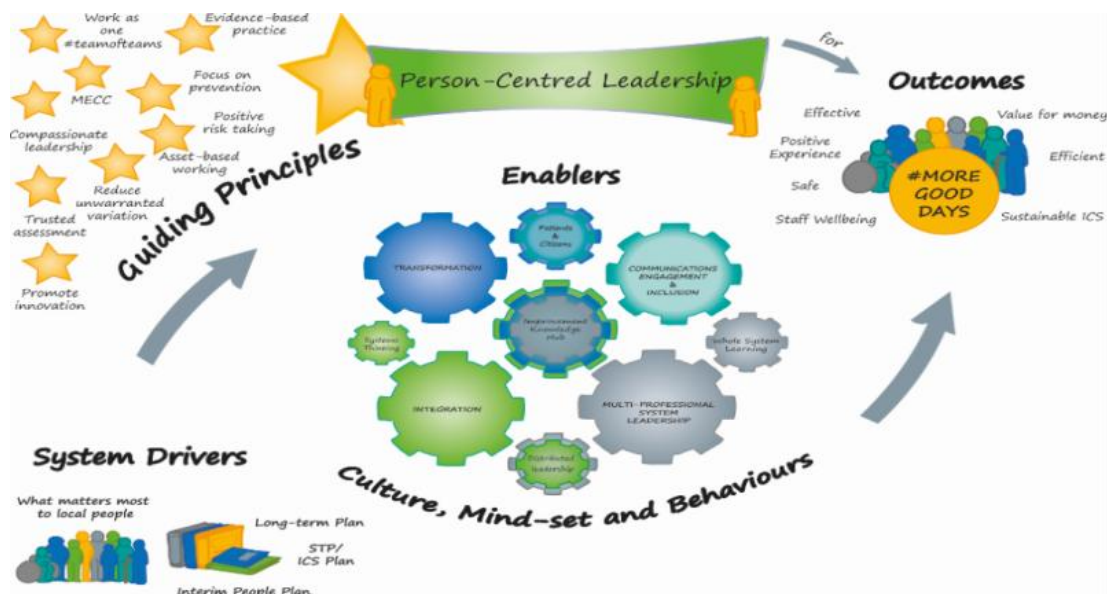
The delivery of our long-term conditions transformation programme will mean that our population receives person-centred, integrated care. This integrated care will support our population to remain at home living an independent life for longer, increase the healthy life years of our population and reduce the number of people prematurely.

Patient safety

The focus of the recently published Patient Safety Strategy (July 2019) is to build on two foundations: a patient safety culture and a patient safety system by:

- Improving understanding of safety by drawing intelligence from multiple sources of patient safety information – **Insight**
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system – **Involvement**
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas – **Improvement.**

To support this in LLR we have approved a system-wide Person-Centred Leadership Framework which has, at its core, a focus on outcomes and is built on a platform of positive culture, a systems mind-set, and behaviours that support collaborative working. Through this we are hoping to create *more good days* for the patients, citizens and staff of LLR.



We will develop and implement an improvement knowledge hub which will serve as an important initiative for supporting and implementing transformational change, through organisational development expertise and quality improvement leadership. The hub, with a distributed leadership approach, will drive and co-ordinate change throughout the system.

The hub will link with the regional Leadership Academy and other key national stakeholders to identify knowledge and skills gaps and develop the strategic plan to address the system’s requirements.

To support this programme we have been awarded funding from the NHS England/Improvement Place Based System Leadership Development programme.

Research and innovation to drive outcomes improvement

UHL and LPT are research active provider organisations. Working with partner academic institutions and primary care colleagues, the trusts deliver academic activity across LLR in a range of areas reflecting the individual and combined academic strengths.

There are combined research strengths, especially in cancer, cardiovascular disease, diabetes and lifestyle, kidney disease, mental health and respiratory disease. There is a strong focus on long term conditions and impact of ethnicity in healthcare and disease. These areas of research focus are completely aligned with the aspirations of the NHS Long Term Plan.

There is substantial underpinning research infrastructure across LLR. UHL hosts a National Institute Health Research (NIHR) Biomedical Research Centre, an NIHR Clinical Research Facility and a Cancer Experimental Medicine Centre. With the support of academic partners, the University of Leicester and Loughborough University, these facilities support early translational experimental medicine studies across LLR. Both trusts work closely with the National Centre for Sports and Exercise

Medicine based in Loughborough and with the East Midlands CLAHRC to facilitate early implementation of research findings into practice.

Supporting public and patient involvement (PPI) is key to the research strategies of LPT and UHL and their academic partners, where PPI is embedded closely alongside research teams and in the Biomedical Research Centre (BRC), Clinical Research Facility (CRF) and Experimental Cancer Medical Centre (ECMC). UHL has established a Patient Research Engagement Panel to advise on PPI strategy at trust level rather than speciality level. LPT has developed a cohort of research partner service users and carers who assist with the co-production of research.

The University of Leicester has established new clinical academic posts with both LPT and UHL, including at chair level in each trust. These support key clinical areas of mental health, child health and women's health. In addition, there has been a drive in both trusts to enable healthcare professionals from a wide range of professions to gain research higher degrees and thus building the future research leaders.

Both UHL and LPT work closely with East Midlands Clinical Research Network and recruit into NIHR portfolio studies. The aim is to increase recruitment year-on-year. For example, in 2018/19 UHL recruited approximately 13,550 participants and LPT recruited 562 participants into portfolio studies. Investigators in both trusts also contribute to a large portfolio of primary care studies in LLR.

The University of Leicester together with LPT and UHL have recently signed a memorandum of understanding to establish Leicestershire Academic Health Partners (LAHP). The overarching vision for LAHP is to create an integrated partnership which harnesses academic excellence in an environment that facilitates the implementation of excellent research, enterprise and education and delivers real impact on the lives of people who live in LLR. LAHP will also provide a platform for productive interactions with the East Midlands Academic Health Science Network (EMAHSN) and industry to accelerate bringing innovations into the local NHS system.

Through our planned care workstream we are working EMAHSN to deliver digitally-enabled outpatient services and technological innovations such as fibro scanning for liver disease.

Genomics

UHL was an active recruiter into the 100,000 Genomes Project. This activity has driven significant clinical transformation of clinical genetic services. Accordingly, local genomic medicine services are now delivered by UHL as a partner in the East Midlands and East of England Genomic Laboratory Hub.

Volunteering

We have around 800 volunteers across UHL who perform a wide variety of roles, all of which help patients to have a better stay in hospital, for example, transporting patients and visitors around the hospitals in one of our four buggies, and providing a bit of pampering with a hand massage or a new hairdo. Some of our volunteers help patients with nutrition and hydration, support patients living with dementia or those who are at end-of-life.

This year we have introduced a new project for young volunteers aged 16-21 who are volunteering for the first time. This role is for those that have little or no experience of a work environment and are less confident in their ability to go straight into other volunteering roles.

We constantly seek feedback and monitor our services to ensure that our volunteers are supporting patients in the most meaningful way. We have recently received external funding which will allow us to begin new initiatives. This will not only benefit patients but will also give us the opportunity to provide staff training and to raise awareness about how volunteers can be utilised.

As we develop our social prescribing offer across LLR this will give us further opportunities to benefit from local volunteers.

Wider social impact

Health and justice system

LLR has a system-wide approach bringing together providers, commissioners, public health and the early support and the youth offending services to deliver work on trauma-based interventions. The work is co-ordinated through maternity, children's and *Future in Minds* transformation and is working directly with youth justice commissioners at NHS England/NHS Improvement. LPT through its children's, adolescent mental health service is working with local authority youth offending services to deliver intensive support to children and young people with complex needs in the criminal justice system.

Veterans and the Armed Forces

In LLR we are committed to supporting Armed Forces personnel and veterans. We support and deliver a programme of accreditation for GP practices focusing on bespoke support. In Rutland (where there are two army bases and a high proportion of veterans as residents), all four practices have been accredited and proudly display the following badge:



The programme has been shared widely across LLR and is part of training and development programmes. There is a well-developed network across the region and a quarterly forum for all stakeholders to design and support local services for veterans. In LLR we are fully signed up to the Armed Forces covenant and will embrace the new guidance on personalised care and CHC for Army veterans. This complements the work we have done locally on veteran's mental health and well-being.

Working with our local voluntary sector

We recognise the importance of the voluntary sector in supporting health and wellbeing. From national organisations that are undertaking vital research to very local groups providing direct

support to individuals in their community, they all have the potential to impact on outcomes for patients and their families. They also provide volunteering opportunities for people, they are often able to provide insight and evidence on community needs and can sometimes reach people that mainstream services cannot.

As we develop more services locally through our Care Alliance, we need to develop a new way of working with the voluntary sector that enables them to contribute to the delivery of redesigned pathways. To support this we have developed the following principles on which we would commission services from the voluntary sector.

We will commission services from the voluntary sector that:

- **Contribute to the delivery of the priorities set out in the LLR Long Term Plan**
- **Address identified health need, including tackling the wider determinants of health, in a population, whether at place or neighbourhood level**
- **Do not duplicate services already commissioned**
- **Provide specialist support or bespoke services for an identified need, such as a gap in provision, that cannot be met by mainstream services or deemed to be best met by the voluntary sector**
- **Offer value for money**

The responsibility for reviewing and commissioning the majority of these services will be at place level, in partnership with local authority colleagues and other relevant stakeholders, LLR workstreams, Care Alliance and neighbourhoods, through primary care networks, to identify need. Where there is a need across all areas then the places will work together to secure the right services.

To give more stability and sustainability we will increasingly move away from yearly grant allocations and move to longer term partnerships and contracts. In return we will need to ensure ongoing value for money and delivery of outcomes against a service specification for each service.

From time to time we may also commission ad hoc and short term services that respond to a particular need.

Health and the environment

Within the LLR footprint we have two provider trusts which have Sustainable Development Plans (SDMPs). As large public sector organisations, they fully recognise that they have a key role in leading the necessary reduction in carbon emissions. UHL is registered as a full participant of the Carbon Reduction Commitment Energy Efficiency Scheme.

UHL's work with associated partners has resulted in a reduction in their CO² emissions and overall carbon footprint and this will continue in the future. The focus is on five areas including reducing the utility carbon footprint by 28% by 2020 (based on 2013 baseline), and water consumption by 10%, the correct use of anaesthetic gases, reducing waste, recycling and transport.

LPT's focus is on sustainable transport solutions, reducing carbon emissions, better use of energy, recycling and better use of water.

Through our redesign work we will use technology to reduce the need for patients to travel and where travel is needed this will be to local sites wherever possible.

Executive Summary – Financial Plan

This section of our plan sets out how the LLR system will return to financial balance over the period of this plan and also meet the requirements of the NHS Long Term Plan (LTP) in doing so.

It outlines the approach which strikes a balance between ambition and realism

- Ensuring that appropriate investments are made in line with delivering the requirements of the Long Term Plan and addressing local priorities
- Ensuring significant savings are delivered exceeding national expectations in order to also return the system to financial balance.

The approach to developing this plan is described which is based on recognising the full extent of the financial pressure within the system and a sensible trajectory to recover the system position. The length of time to improve the financial position could be questioned, however the allocation growth into the system is fairly evenly spread across the years whereas cost increases in the first year or two are higher than in the latter years of this plan. Cost increases which are higher in the initial years are made up of:

- Mental Health Investment Standard – this is 1.7% higher in the first year of the plan than subsequent years
- Agenda for change Pay inflation – this is 0.7% and 0.8% higher in the first 2 years
- The need to recognise underlying financial pressure and create a contingency in 2020/21.

This plan uses historical spend as a starting point, recognising the level of underlying financial pressure that exists within our system. Interventions which are built into the model (both investments and savings) largely aim to change the pattern of growth we have seen in recent years. We need to move from an Acute centric growth model to one which sees a larger growth in funding into Primary Care, Community Services and Mental Health Services in line with the NHS Long Term Plan.

In order to see this shift the system recognises the need to and is committed to developing a new contractual and operational approach to ensure delivery of transformational savings required through collaboration.

The following section outlines how we meet the financial requirements of the long term planning guidelines.

Meeting the financial requirements of the Long Term Plan

The LLR Financial Plan has been developed to deliver the 5 Tests within the Long Term Plan

1. *Organisations will maintain or return to financial balance. All providers deliver 1.1% cash releasing productivity benefit.*
2. *Providers in deficit deliver an additional cash-releasing productivity benefit of 0.5%*

Both of the NHS providers within LLR are set to deliver efficiencies of 1.6% per annum throughout the plan in order to bring the system back into financial balance before the end of the planning period. The system collectively will return towards financial balance over the lifetime of this plan, achieving balance in the final year. Presently some organisations are predicted to have a surplus whilst a deficit is expected to be present at UHL at the end of the period. UHLs deficit is expected to be resolved after the end of this planning period as it is smaller than the “structural deficit” that UHL incurs in relation to operating across 3 sites.

3. *Plans to incorporate system actions to maximise efficiencies and support appropriate reductions in growth*
4. *Reduction in variation across the health system*

System actions include various strategic work streams tasked with redesign and avoidance of excessive growth particularly within the acute sector; this will be supported and enabled through a new contractual and operational approach which aligns incentives towards a joint focus on demand management. This work will also support reduction in variation across the health system.

5. *Better use of capital investment*

In addition, the Specific Financial Requirements in the Long Term Plan have been met.

1. Mental Health Investment Standard (MHIS)

Mental Health service spend has been increased above allocation growth plus 1.7%. (additional investment over and above this minimum of £11.8m is planned over the period). Investments have been planned from baseline and LTP funding in line with National Guidance.

2. Community, CHC and Primary Care Investment requirements

Planned investment in Community, Continuing Health Care and Primary Care services is above the level of overall CCG allocation growth prior to application of commissioner QIPP savings. QIPP savings over the lifetime of the plan reduce the net level of investment by circa £40m.

In addition, Primary Care Co-commissioning delegated budgets are planned to be fully spent within Primary Care in each year of the plan.

3. Running Costs reduction

Running Costs have been reduced in line with the decrease in allocation anticipated in 2020/21. From that point it is assumed additional savings will be made to nullify the effects of inflation in each year.

4. Contingency

A contingency of 0.5% of total CCG allocation has been set aside. A further 0.5% contingency has also been created within each Provider. It is assumed these contingencies will be spent non-recurrently

Local Context & Financial Challenge

LLR is a system facing a significant financial challenge, the planned financial position for 2019/20 (prior to receipt of PSF, FRF and MRET funding) is a £48.7m deficit as shown in the table below.

Organisation	Gross Control Total	Receipt of Centralised Funding (PSF, FRF & MRET)	Control Total
	£m	£m	£m
UHL	-48.7	38.1	-10.7
LPT	0	2.1	2.1
LCCCG	0	0	0
ELRCCG	0	0	0
WLCCG	0	0	0
LLR STP Total	-48.7	40.2	-8.5

The system is currently finding it difficult to deliver this plan and therefore has developed a Financial Recovery Plan in year which aims to deliver £30m of improvement in the forecast financial position. If the position does not improve the system will face a circa £80m deficit this year prior to the receipt of central funding. It has been recognised, as we look to future years, that this level of improvement is going to be difficult to achieve during 2019/20 and that a significant part of the achievement is going to be non-recurrent in nature. As a result of this difficult starting point, the system expects to see deterioration in the planned deficit for 2020/21.

The financial challenge being experienced in the LLR system has largely been driven by significant growth in the Acute sector and related costs in recent years, set against a background of limited funding increases into the system as a result of austerity. Looking forward in the lifetime of this financial plan, additional funding growth that is appropriately invested is expected to allow the system to return to financial balance over time.

The financial plan

The financial plan “bottom line” for the system by organisation is shown in the following table, showing the net (deficit)/surplus within each year of the plan. This demonstrates how the system overall will return to balance by 2023/24.

The financial position planned for 2020/21 is a larger deficit than was planned for 2019/20 due to underlying pressures being recognised as well as significant investment, particularly within Mental Health services, Primary Care and expected pay increases planned during 2020/21.

Organisation	19/20 Forecast Outturn £'000	20/21 Plan £'000	21/22 Plan £'000	22/23 Plan £'000	23/24 Plan £'000
ELR CCG	0	(10,350)	(2,854)	1,443	3,411
LC CCG	1,420	(405)	1,290	5,589	6,691
WL CCG	(0)	(15,399)	(4,848)	186	2,356
UHL	(10,885)	(54,616)	(36,135)	(23,810)	(17,034)
LPT	262	(1,407)	804	2,599	4,577
Grand Total	(9,203)	(82,178)	(41,744)	(13,993)	0
Removal of Central Funding	(40,331)				
Gross Position	(49,534)	(82,178)	(41,744)	(13,993)	0

The table above also shows that UHL is expected to significantly reduce its deficit over the lifetime of this plan, the expected deficit in the final year within UHL is offset by projected surpluses elsewhere in the system. It is expected that ultimately (after the period of this plan), UHL will be able to return to a balanced financial position in its own right if significant planned capital investments are able to proceed – the capital investments related to UHL reconfiguration are expected to result in a beneficial revenue impact in excess of £20m.

East Leicestershire and West Leicestershire CCG's face a significant deterioration in financial position in 2020/21 largely as a result of recognition of underlying pressures and also significant investment, particularly into Mental Health services and Primary Care. This is very different to the Leicester City CCG position which is almost breakeven, despite also needing to meet required investments. The differential between CCGs is reduced significantly over the planning period as a result of additional funding set to be received by the County CCGs (relative to City) – this is due to distance from target differentials which mean that additional funding growth is being received by County CCGs in comparison to City.

Expected Expenditure Growth

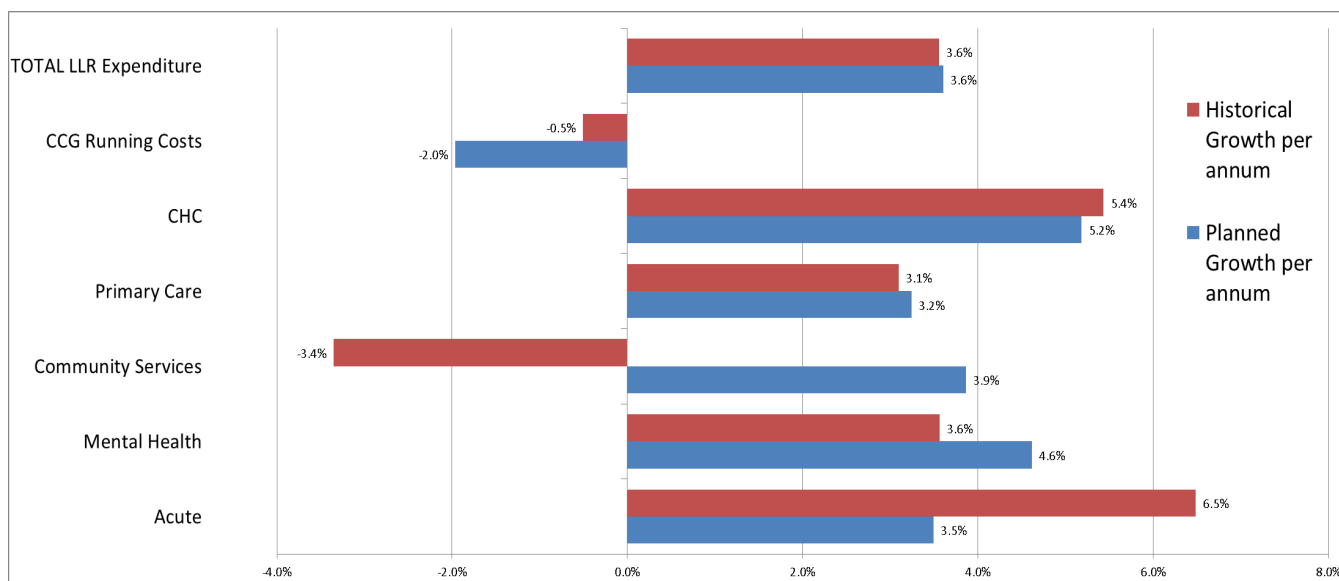
Expenditure by sector by year is shown in the following table:

Sector	19/20 Recurrent Spend	20/21 Spend	21/22 Spend	22/23 Spend	23/24 Spend	Average Annual Growth
Acute	(1,265,941)	(1,324,919)	(1,362,138)	(1,403,346)	(1,452,401)	3.5%
Community Services	(110,138)	(116,359)	(108,963)	(110,493)	(118,437)	2.0%
Continuing Care	(87,066)	(91,654)	(96,490)	(101,402)	(106,570)	5.2%
Mental Health	(150,613)	(160,282)	(166,094)	(171,991)	(181,271)	4.7%
Mental Health and Community	(60,676)	(61,490)	(63,055)	(67,595)	(70,876)	4.0%
Other Programme	(64,724)	(77,923)	(81,656)	(82,694)	(84,241)	7.1%
Primary Care	(188,882)	(199,094)	(201,527)	(202,931)	(204,006)	2.0%
Co- Commissioning	(148,629)	(155,222)	(162,372)	(170,422)	(179,424)	4.8%
Running Costs	(21,885)	(20,167)	(20,167)	(20,167)	(20,167)	-2.0%
Grand Total	(2,098,553)	(2,207,111)	(2,262,464)	(2,331,040)	(2,417,393)	3.6%

The above shows:

- All sectors of spend increasing over the planning period (other than CCG Administration/Running Costs)
- Most investment into Mental Health, Community Services and CHC in percentage terms but financially the largest increase is into the acute sector (followed by Primary Care)
- A larger increase in expenditure in 20/21 than any other year (due largely to investment into Mental Health Services, Primary Care (through PCNs) and the larger Agenda for Change pay inflation applied during that year.

This represents an investments and savings plan consistent with the intentions of the LTP – focussing additional investment into Primary, Community and Mental Health Services and resulting in reduced growth in the acute sector. The planned increases set against historic levels of cost growth in the LLR system are shown below:



It is worth noting that:

- Primary Care in the above table is made up of Primary Care Co-Commissioning which has in excess of 5% growth per annum and CCG funded Primary Care (including prescribing) which has a much lower growth rate per annum (circa 1% due to prescribing efficiencies planned).
- Investment levels above exclude “Targeted Funding” which should be made available to the system to spend delivering certain requirements of the LTP.

How additional funding is set to be used in the planning period

The following table shows how (by organisation) funding growth is being used within the system over the next 4 years in summary form. It can be seen that additional allocation funding of £264m added to £197m of savings which will be generated, means that £461m of additional resource is utilised within our plan. This additional resource utilisation can be broken down as follows:

- £181m funding activity/demand growth
- £151m funding cost inflation for pay and non-pay (and the impact of tariff inflation outside the LLR system)
- £16m in creating a 0.5% contingency
- £69m is required to fund the brought forward position (including underlying pressures and removal of PSF/FRF)
- £44m is planned to be spent on new investments (from baseline funding).

Organisation	B/F Position	PSF/FRF/M RET Funding	Underlying Position	Tariff Impact (outside LLR)	Activity Growth	Cost Inflation (Pay)	Cost Inflation (Non Pay)	Investment s	Creation of Contingenc y(0.5%)	Savings	Additional Allocation	C/F Position
East	0	-	(7,776)	(23,143)	(51,068)	(545)	-	(6,855)	(1,949)	18,048	76,698	3,411
City	1,420	-	(1,893)	(27,703)	(61,154)	(522)	-	(11,070)	(2,570)	18,986	91,196	6,691
West	(0)	-	(8,896)	(26,985)	(64,560)	(433)	-	(8,782)	(3,415)	19,303	96,124	2,356
UHL Income	1,068,423	(38,069)	(4,200)	56,771	143,163	-	-	5,302	-	(23,426)	-	1,207,965
UHL Expenditure	(1,079,308)	-	3,319	-	(147,853)	(64,416)	(52,203)	(22,861)	(6,067)	144,389	-	(1,224,999)
LPT Income	278,497	(2,262)	(16,056)	10,397	9,309	-	-	19,474	-	(13,424)	-	285,935
LPT Expenditure	(278,235)	-	16,056	-	(9,111)	(17,953)	(4,145)	(19,723)	(1,592)	33,345	-	(281,358)
Total	(9,203)	(40,331)	(19,446)	(10,662)	(181,273)	(83,869)	(56,348)	(44,515)	(15,593)	197,222	264,018	0

Key Assumptions/Our approach in building the plan

Overarching Approach

The Plan is underpinned by an LLR Financial Strategy. The strategy has been built on a platform of transparency, with a commitment from all parties to system delivery.

The philosophical approach is one that aims to strike the right balance between realism and ambition; recognising the significant pressure faced by the system presently, set alongside the achievable improvement that is required in order to deliver a balanced financial position by the end of the planning period.

The plan has been co-produced by finance teams from across the system who has agreed and populated assumptions to move the plan forward from a historical spend baseline.

Investments and savings; calculated and assessed using benchmarking, care pathway and disease analysis and with the input of clinicians and managers; have been applied to the system as a whole with individual organisations positions being the secondary consideration at this stage. Prioritisation of resources has focused on strategic system objectives.

The financial model is built on the assumption that we are able to reach agreement on a different contractual form which incentivizes all organisations to work together to pursue saving and demand management opportunities collectively. The system has collectively committed to reach such an agreement – this contractual form and related operational changes are required to be agreed fully alongside agreement of this outline plan.

Cost inflation and Growth assumptions have been used to develop the “do nothing” financial gap. Interventions (additional costs and savings programmes) have then been included, within relevant organisations, to give a system position. The interventions which include local priorities, efficiency programmes and LTP investments change the balance of spend across LLR providers.

Nationally Driven assumptions: The plan utilises national assumptions with regard to:

- Pay and Non pay Cost Inflation

- Tariff Inflation and efficiency (+2.4%-1.1%)
- LTP Requirements (e.g. Mental Health Investment Standard, Community and Primary Care Investment requirements).

Local Assumptions: Local assumptions have been based on historical trends, local system knowledge and benchmarking outputs these include:

- Demographic Growth (0.7%)
- Non Demographic Growth (1.3% Community, 2.7% Acute)
- Cost and Impact of interventions – The financial impact of savings plans and investment priorities have been estimated and applied at organisational level.

Assumption re deficit repayment: It is assumed within the financial model that any deficit arising within a given year will be supported through receipt of Financial Recovery Fund funding, and as such is not repayable. This means that the financial position outlined in a given year does not include any repayment of prior year deficits.

Assumption re Targeted funding: It is important to note that we have assumed receipt of a proportionate amount of Targeted Funding from the funding that is available nationally to support the delivery of Long Term Plan requirements. It is important to note that should this funding not be received it is likely that we will be unable to fulfill the requirements of the LTP in those areas (more detail below in the investments section).

Investments (including funding sources)

Over and above the cost of inflation and demand growth, there are a number of separate investments set aside within the plan.

Investments are being funded by one of three routes:

1. From **Baseline funding** - LLR is set to receive an overall 18% increase in baseline funding over the 5 years of the plan, with Primary Care Co-commissioning receiving 21%. This growth in funding of £264m is shown in the table below in £000's.

Allocation Type	19/20 Plan	20/21 Plan	21/22 Plan	22/23 Plan	23/24 Plan	Total growth £000	Total growth %
Programme Baseline Allocation	1,330,650	1,388,333	1,448,202	1,507,712	1,566,551	235,901	18%
Running Cost Allocation	22,859	20,167	20,167	20,167	20,167	(2,692)	-12%
Primary Care Co-Commissioning Allocation	146,385	153,219	160,303	168,279	177,194	30,809	21%
Total Baseline Allocation	1,499,894	1,561,719	1,628,672	1,696,158	1,763,912	264,018	18%

2. From **LTP Funding (Fair Shares)** – This funding is for specific elements of the LTP, it is allocated non recurrently across the time period. Elements of LTP (Fair Shares) funding have been made available to LLR on a non recurrent basis since 2018/19 (i.e. GP Extended Access

and specific aspects of GP Forward View funds.) Some elements are built into nationally agreed contracts and therefore already committed.

3. From **Targeted Funding** - This funding requires active “bids” from the system before receipt. It is to be used for specific initiatives. These funds have been notified at a national level but not currently split down by system. The funds are NOT explicitly included within the LLR financial plan although we have made assumptions regarding the level that might be available to LLR should we receive an appropriate share of these funds. On that basis, we have assumed we will be able to deliver on the related requirements of the Long Term Plan. If this funding is not received, the interventions to which they relate will not be delivered. Interventions to which these funds will be targeted if received are shown below:

These interventions are assumed to be funded entirely by targeted allocations. Should those allocations not be received (or be insufficient to meet costs) the interventions will not be delivered.	
Mental Health	Includes: - funding for continuation of previous waves such as mental health liaison or Individual placement support funding; pilots as part of the clinical review of standards, and other pilots such as rough sleeping. - funding to be distributed in phases in consultation with regional teams including: funding for testing new models of integrated primary and community care for adults and older adults with severe mental illness, community based integrated care, rolling out mental health teams in schools and salary support for IAPT trainees. See 2.28.
Primary Care	Digital First Primary Care support funding; the Investment and Impact Fund; and Estates and Technology Transformation Programme.
Ageing Well	Targeted funding to accelerator STPs to rollout the Ageing Well models.
Cancer	Development and roll out of innovative models of early identification of cancer (starting with lung health checks); funding for the development of Rapid Diagnostic Centres from 2020/21 onwards; support for further innovations to support early diagnosis.
Technology	Revenue funding for Provider Digitisation and Local Health and Care Records.
Cardiovascular Disease, Stroke and Respiratory	Pilots for improving access to cardiac, stroke and pulmonary rehabilitation services and early detection of heart failure and valve disease.
Maternity and Neonates	Continuity of carer for BME and disadvantaged women from 2021/22; funding to support the UNICEF Baby Friendly Initiative; funding to support the expansion and improvement of neonatal critical care services from 2021/22; funding from 2020/21 for Family Integrated Care; funding to support the rollout of postnatal physiotherapy and multidisciplinary pelvic health clinics from 2021/22 to 2022/23.
Diabetes	Funding to pilot the use of low calorie diets from 2019/20 until 2022/23; funding to support delivery of recommended treatment targets; funding for multi-disciplinary footcare teams and diabetes inpatient specialist nurses (see 4.31).
Learning Disabilities and Autism	Funding to pilot and develop community services for adults and children and keyworkers from 2020/21 to 2022/23; piloting of models to expand Stopping Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes from 2020/21 to 2023/24; testing the model for ophthalmology, hearing and dental services to children and young people in residential schools from 2021/22; funding to reduce the backlog of the Learning Disabilities Mortality Review Programme (LeDeR).
Personalised Care	Targeted transformation funding to deliver the NHS Comprehensive Model for Personalised Care from 2019/20–2021/22.
Prevention	Alcohol Care Teams from 2020/21 to 2023/24; Tobacco addiction services early implementer sites from 2020/21; targeted support for weight management service improvements from 2020/21.

Including funding received from all funding sources, the level of specific investment is shown at summary level in the following table:

<u>Summary Level</u>	<u>Baseline</u>	<u>LTP Funding</u>	<u>Targeted Funding</u>
	£'000	£'000	£'000
Ageing Well	-	(6,032)	(495)
Cancer	-	(1,196)	(8,213)
Childrens and Young Persons	(1,099)	(2,906)	(1,075)
Community Services	(1,000)	-	-
LMS	(150)	(1,042)	(1,277)
Mental Health	(23,561)	(7,124)	(6,015)
Prevention	(1,500)	-	-
Primary Care	(297)	(7,014)	(9,801)
Corporate	1,308	-	-
UHL Business Cases and Reconfiguration	(17,454)	-	-
Technology			(3,683)
Urgent Care	(55)		
Other	(708)	(6,211)	-
Total Investments	(44,515)	(31,525)	(30,560)

(106,599)

The table above shows the cumulative investment total by the final year of the plan. Investment expected by year is as follows:

	Baseline	LTP Funding	Targeted Funding	Total
2020/21 Investment	(21,914)	(10,470)	(19,380)	(51,764)
2021/22 Investment	(26,427)	(14,738)	(22,710)	(63,875)
2022/23 Investment	(32,270)	(21,746)	(25,780)	(79,796)
2023/24 Investment	(44,515)	(31,525)	(30,560)	(106,599)

Savings summary

In assessing the level of savings that can be achieved during the planning period, the LLR system has worked collectively to:

- Review benchmarking information including Model Hospital, GIRFT, Right Care and locally sourced acute activity benchmarking information
- Considered previous levels of success in delivery of cost reduction through Cost Improvement Programmes (CIP) and Quality Innovation Prevention and Productivity (QIPP) schemes
- Considered key pieces of work / business cases currently being progressed which are expected to deliver savings. For example Community Services Redesign, Urgent Care transformation and Planned Care transformation programmes

- Taken account of the limited ability the system has to deliver net reductions in large areas of spend which are prioritised for investment as part of the Long Term Plan (for example, Mental Health, Community Services and Primary Care)
- Acknowledged the time taken to realise additional demand management opportunities through a collaborative approach which will be adopted from 2020/21 for acute demand management.

As a result of this work the system has agreed an outline savings plan as part of this plan which delivers:

- Total savings equating to £197m over the next 4 years, equivalent to 2.1% of the net spend within the system
- A minimum productivity/efficiency saving within each NHS Provider of 1.6% each year, equating to £91m of savings
- A saving of 2% per annum for CCGs focussed on Prescribing and Continuing Healthcare costs equating to £24m
- Transformation savings relating to Community Services redesign, Planned Care and Urgent Care Transformation of £48m
- 50% of the “Right Care” benchmarked opportunity through pathway redesign, equating to £8m
- £26m of savings which are still to be identified which will be delivered through transformation in the latter years of the plan (from 2021/22 onwards).

Capital Programme

The capital programme includes considerable investment to revive estate and offer improvements to patient care and productivity in the future. Significant investment towards the cost of UHL’s reconfiguration plans is included in the capital spend profile during the planning period.

LPT is currently developing an overarching plan to refresh its estate, timings are unknown at present and as such an estimate is included in the final year of the plan for the total amount that is predicted to be spent in the coming years.

The following tables show the Capital spending plans for the two NHS Trusts within LLR and expected funding sources (UHL first followed by LPT).

	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
CDEL Calculation					
Property, Land and Buildings	32,676	20,197	18,335	49,393	107,652
Plant and Equipment	5,648	3,865	8,440	9,640	8,140
IT	4,672	4,500	5,500	6,000	6,000
Other					
Gross Capital Expenditure	40,495	26,062	29,775	62,533	119,292
Disposals / other deductions					
Charge after additions/deductions	40,495	26,062	29,775	62,533	119,292
Less Donations and Grants Received	(300)	(6,600)	(300)	(300)	(300)
Total CDEL	40,195	19,462	29,475	62,233	118,992

Funding Sources of CDEL					
Self Financed - Depreciation	24,288	25,500	26,500	27,500	28,000
Self Financed - other internal capital cash					
Less Capital loan repayments, PFI capital repayments and Finance Lease payments	(6,660)	(6,660)	(6,660)	(6,660)	(6,660)
Other Loans inc Salix	1,000	0	0	0	0
STP Wave 1 - 4 PDC - Approved	21,567	622	0	0	0
Other PDC (incl Major Schemes) - To be Approved	2,500	2,500	12,135	43,893	100,152
Net CDEL	40,195	19,462	29,475	62,233	118,992

	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
CDEL Calculation					
Property, Land and Buildings	9,573	6,208	3,310	3,310	451,305
Plant and Equipment	291	471	371	371	371
IT	7,508	7,422	4,378	3,993	3,993
Other	285	450	1,820	2,105	2,105
Gross Capital Expenditure	17,657	14,551	9,879	9,779	457,774
Disposals / other deductions					
Charge after additions/deductions	17,657	14,551	9,879	9,779	457,774
Less Donations and Grants Received					
Less PFI Capital (IFRIC12)	(100)	(100)	(100)	(100)	(100)
Plus PFI Residual Interest	114				
Purchase/Sale of Financial Assets/Prior Period Adjustments					
Total CDEL	17,671	14,451	9,779	9,679	457,674

Funding Sources of CDEL					
Self Financed - Depreciation	7,342	7,342	7,342	7,342	7,342
Self Financed - other internal capital cash	1,576	674	0	0	0
Less Capital loan repayments, PFI capital repayments and Finance Lease payments	(163)	(163)	(163)	(163)	(163)
STP Wave 1 - 4 PDC - Approved	5,102	2,898			
Other PDC (incl Major Schemes) - To be Approved	3,700	3,700	2,600	2,500	450,495
Residual Interest	114				
Net CDEL	17,671	14,451	9,779	9,679	457,674

*Yr 23/24 includes £450m estimate for LPT estate reconfiguration. Estimate based on the SOC that has recently been produced, but further work will be needed to fully cost up the proposed options. OBCs will then be prepared, which are likely to deliver the preferred options in phases.

In addition to the above UHL will require a further £307m of capital between 2024/25 and 2027/28 to complete their reconfiguration plans.

Activity

A key component of the Leicester, Leicestershire and Rutland (LLR) response to the NHS Long Term plan is the development of a five year financial and acute/non-acute activity plan. This plan will need to demonstrate the anticipated level of patient contacts to be delivered and the financial resources this activity will require. This activity and financial plan will need to present both a 'do-nothing'

(which reflects historic growth) position over a five year period as well as a scenario that reflects the impact of the transformation within the NHS Long Term Plan response.

To produce a Long Term (five year) activity plan, an options appraisal of the available methodologies was produced and reviewed by senior leaders. The summary below provides an overview of the methodology selected to produce an LLR Long Term activity plan:

- A three year overall comparison analysis was utilised to develop a historic yearly growth rate for all Points of Delivery (PODs). This comparative analysis simply compares the outturns across a three year period. A process of adjustment then took place to ensure any major changes in patient pathways (counting and coding) is acknowledged (and the activity impact removed)
- Using the total activity up to month three (June) of 2019/20, a forecast was produced for the remaining months within the current financial year. This forecast was produced by identifying (using the same time period as the comparative analysis) a trend on what 'normally' occurs in the remaining nine months of each comparison year.
- The previously identified average growth rates between each yearly outturn position is then applied to the new 2019/20 forecast outturn to create a five year activity plan.

The below table highlights the growth rates applied to produce a 'do-nothing' five year growth plan.

POD	LTP PROPOSED GROWTH RATE
Elective	-2.80%
Day case	3.70%
Outpatient First	-0.50%
Outpatient Follow Up	1.40%
Outpatient Procedure	9.80%
Outpatient Phone	2.10%
Non-Elective	3.90%
Accident and Emergency	4.10%
Non-Elective/Non-Emergency	-1.20%

The subsequent activity plan has been split by the following groupings:-

- The three Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCG's)
- The two Leicester, Leicestershire and Rutland acute providers (University Hospital of Leicester and Leicestershire Partnership Trust)
- The Leicester, Leicestershire and Rutland Sustainability Transformation Plan footprint.

The Leicester, Leicestershire and Rutland five year activity plan ensures that the system has sufficient capacity to meet the key NHS constitutional standards. The level of growth assigned in the

activity plan is based on historic trends and is in line with the expectations within the NHS Long Term plan (such as moving towards increased levels of same day emergency care and day case elective activity).

Quality Impact Assessment - Leicester, Leicestershire and Rutland

Across the Better Care Together (BCT) programme we will ensure a robust assessment on the impact on quality of proposed savings plans or indeed any service change is undertaken. The need for a formal quality impact assessment process is essential in a system as complex and interdependent as the NHS, where decisions in one part of the service can impact upon another with many co-dependencies that are not always easy to predict or assess. (NHS Providers, 2015). Across Leicester, Leicestershire, and Rutland we will embed Quality Impact Assessment framework as standard practice using a standardised template.

The quality impact assessment will be populated at the beginning of the design phase of an initiative and measured in terms of patient experience, patient safety and clinical quality. KPIs, risk ratings and mitigations will be assigned and agreed by sponsoring individuals and departments and regularly challenged at gateway reviews throughout the development phase.

The risks associated with the deliverability of the schemes and the amount of financial savings to be delivered will be assessed, risk rated and appropriate mitigations identified. A regular reassessment of the quality impact of an initiative will also form an integral part of the monitoring arrangements and the process will include a post implementation review to ensure that lessons learned are incorporated into future plans.

The presence of a gateway process provides the opportunity for several layers of clinical sign off from local clinician(s) who are required to implement the change, through directorate/divisional management teams, clinical senates and Medical and Nursing Directors. The presence of the layers of clinical sign off will be visible prior to authorisation of any QIA and financial plan. The expectation is for there to be evidence of clear engagement with frontline staff and external stakeholders, where appropriate, who are likely to be impacted by any proposal and feedback from meetings should be adequately captured and presented as part of the triangulation of assurance.

In this section we describe the work we are doing across our enabling workstreams that will support the delivery of our plan.

Workforce

Local Context

Our aim is to develop a workforce equipped for a world class 21st century. This plan will predominantly cover how we will ensure we have the right people with the right leadership capability, behaviours and skills to deliver high quality care in LLR and how we will prioritise and address our critical workforce gaps. Essential to this plan is developing a workforce reflective of our patient group and making LLR an attractive employer.

LLR as part of its whole system approach is developing a System-wide Workforce Strategy. The approach has considered all provider workforce issues and reflects the six workforce priority areas set out in the Interim NHS People Plan (2019). As we make strides towards developing a workforce fit for the future, offers the opportunity to radically re-think the workforce composition and skills mix we will need to delivery our new models of care within System, Place and Neighbourhood. We will review, then implement, the opportunities for addressing workforce shortages, outline our new operating model which will see a shift to more integrated working, improve our leadership culture at every level through our established Leadership Framework and, develop a robust OD programme of work, in our strive to make our local NHS the best place to work.

The local health and care system across Leicester, Leicestershire and Rutland (LLR) is currently engaged in re-designing pathways of care to create a more integrated and joined-up system of care. This includes better preventive and supportive care in out-of-hospital settings, improved links between mental health and physical health, better support to people living with multi-morbidity, and support for the frail and elderly population. Shaping the future workforce is therefore an essential component to this. However, the models themselves are evolving and therefore we are developing the system workforce plan in parallel.

Across the STP a number of work-streams set out elements of workforce change which point to developing a new operating model for workforce; the Community Services Redesign programme has been launched which will significantly change how we deliver care with a focus on Home First and community health care rather than acute based care. This will see a full redesign of the workforce to support the changing models of care as they emerge; a Pre Consultation Business Case submission proposes the majority of acute services to be based on two sites which will improve delivery of care and improvements in working conditions for staff; the development of integrated teams that wrap around our 25 Primary care networks will see a great amount of service provision being delivered locally in a more integrated way, through Multi-disciplinary working to deliver well-coordinated

proactive care, and same day urgent response. We acknowledge the need to embrace the advancements in digital technologies, recognising the opportunity this offers to reduce pressure on our workforce in all aspects of care delivery from booking appointments on-line to telemedicine and skype appointments.

There is approximately 20,000 whole time equivalent healthcare staff currently working across the three main NHS provider organisations in LLR. As with Adult Social care, many of the challenges faced by NHS providers of healthcare reflect the national situation. Our aim is to create more integrated joined up workforce, develop career pathways that span the whole system. We will also ensure a focus on developing a sustainable workforce, and be conscious to avoid destabilising one part of the system to accommodate another part through development of new roles.

We will undoubtedly be affected by challenges including the national shortages of certain registered occupations, in particular qualified nursing and specialist roles. How we recruit, retain and develop people will be a key determinant in our ability to provide the highest quality care. Through our aim to develop multi-disciplinary teams that best meet the needs of the patient we will consider options for improved efficiency and the development of new roles and new ways of working.

We also intend to maximise the opportunities that increased digitalisation may afford us, helping to remove unnecessary processes that could be replaced by robotic technology and paperless environments. We are committed to developing a digitally enabled workforce, through skills development. This will enable us to better the working lives of our staff, facilitating recruitment, support retention and reduce our dependency on non-contracted workforce.

Our People

Having the right workforce with the right skills and behaviours in the right place, at the right time is critical to supporting our local population to stay healthy, lead independent lives and reach their full potential. To achieve this the Local Area Workforce Board have established a clear workforce vision for the system:

‘To ensure that the right skills, competencies and behaviours are wrapped around the right patient, in the right place, at the right time within our health and social care system. This will support a patient journey which is efficient, effective and delivers an appropriate high quality outcome’

As we continue to develop our workforce transformation plan we will review the vision to ensure it fully supports a 21st century workforce ambition.

Through appropriate investment and support across the entire span of our workforce, LLR aims to create the right conditions to:

- Attract and retain the highest quality of staff from home and overseas
- Create a positive, inclusive, person-centred leadership with a culture to drive organisational change resulting in improvement and inspiring innovation

- Embed workforce planning and transformation skills at all levels so that it is at the centre of all that we do to develop the workforce and support new roles and new ways of working to deliver 21st century care.

Our future plans also will also address increasing workforce demands, high levels of vacancies, high use of agency staff and the impact of Brexit.

We will know we are successful if:

- We reduce vacancy rates in line with available workforce supply
- We successfully introduce new/enhanced roles, including Nurse Associates and Physician Associates, that support the delivery of our integrated new models of care
- We maximise efficiency across the workforce by considering the generic competencies within roles, such as community and primary care nursing, and the opportunity to develop more of a flexible workforce through this approach, with no threat to diluting the specific role itself
- We increase the numbers of apprentices and those following apprenticeship development programmes
- We have increased the additional workforce into Primary Care Networks to increase workforce capacity and support increased delivery of our proactive care model
- We have empowered managers to develop creative workforce plans using a range of workforce tools
- We reduce turnover rates
- Staff indicate satisfaction with the quality of education and skills development
- Trainees report a positive training environment and experience.

How will it be different if we're successful? The shape of our workforce will be different with a greater variety of roles and career paths for staff, and a resource envelope that better matches both needs and affordability. We are aiming to make LLR an attractive place to work, with a reputation for developing and engaging its people and patients, rewarding positive behaviour and retaining talent.

Making the NHS the best place to work

We are developing plans and set out our offer to the workforce, in making LLR a great healthcare career and a great lifestyle for people who choose to live and work in LLR. We know our staff feel under pressure and work tirelessly to delivery care, this can have a negative impact on health and wellbeing, on their experience of work and consequently on patient care. Our focus is on the following areas: improving retention and recruitment; developing new and integrated roles; creating a healthy, inclusive and compassionate culture; enabling great development and fulfilling careers; and ensuring everyone feels they have a voice, are empowered and can influence.

At a system level we are focusing our efforts on working collaboratively towards long-term solutions to the recruitment and retention challenges faced by the health sector. We will use workforce data and annual NHS Staff Survey to measure the impact of these actions.

Actions include:

- Developing a new people offer to make the NHS the best place to work

- Take a greater focus on staff welfare and well-being. Working as a system to develop impactful health and wellbeing interventions to support the mental and physical health of our staff and to help reduce sickness absence, particularly absence attributed to stress, anxiety and musculoskeletal
- Increasing diversity within our workforce by setting targets for BME representation across its leadership team and broader workforce by 2021/22 and responding to requirements of the new Workforce Disability Equality Standard
- Developing a local plan to address gender equality.

Improving our Leadership Culture

The Leadership Team in its recognition of the importance of workforce and OD requirements of a programme of this scale, have approved a quality improvement strategy to develop a clear plan for organisational development, including key components of integrated working, distributed leadership, clinical leadership and workforce efficiencies, and developing a culture of innovation across and throughout the system. This identifies the need for constantly improving the Leadership Culture and producing strategies to support all staff in a compassionate and inclusive manner, recognising cross sector multi professional leadership. This represents a significant cultural shift in the way we will work.

To improve the leadership culture across LLR we will:

- Establish the cultural values and behaviours expected from senior leaders
- Implementing system-wide processes for managing and supporting talent
- Developing our approach and setting a clear strategy that supports the development of a compassionate and inclusive leadership culture
- Develop and spread a positive, inclusive, person-centred leadership culture across the NHS and Social Care
- Establish a virtual Improvement Knowledge Hub to drive system improvement
- Creation of an LLR Community providing a support network for QI champions across the system, providing a platform for people to connect and come together to drive and implementation the wholesale transformation needed to become a mature ICS.

The overall objective is to promote and support the development of effective integrated working across services including health and social care teams and partners from voluntary and community groups. This requires developing the leadership capacity from Board level to the front line and empowering staff through distributed leadership to drive delivery and change current pathways and models of care, to drive innovation. The work will include a focus on behaviour and attitude change to support the transformational system changes.

Tackling the Nursing Challenge

Nursing vacancies continue to run high and our five year projections show that unless we take action now the gap is likely to increase. With a vacancy rate of 10.3% across UHL and LPT, we now have to explore alternative ways of bridging the gap. This also reflects a similar challenge within general

practice nursing where we face significant challenges. We will work to address this through the development of local actions plans.

Routes into nursing:

- Increase clinical apprenticeship opportunities making best use of the levy across LLR
- Expanding the number of Nursing Associate intakes to three per year to accommodate up to 150 trainees
- Working with local universities to develop the apprenticeship pathway for degree nursing from 2020
- Developing return to Practice programmes for nurses who want to return to work
- Support for non-EUA nurses who are registered nurses in their own country but whose qualifications are not recognised by the NMC to become NMC registered
- International recruitment is supporting the recruitment of up to 40 nurses to UHL bi-monthly
- Continue and accelerate the implementation of the General Practice Nursing Ten point Plan focusing on the recruitment and training the workforce.

Improved Retention:

- Health and wellbeing strategy is being implemented
- Reviewing flexible working options and careers development opportunities
- Maximise the opportunities offered by the expansion of the nursing retention programme into general practice nursing
- Highlighting Mental Health Awareness and Time of Change Champions
- Practical help for staff with back problems and stress/anxiety and depression
- Development of a talent pipeline
- Ensure that staff are clear about their roles and are given regular feedback
- Values based recruitment to ensure our values match those we are employing.

Personal and Career Development:

- Career progression opportunities such as the Nurse Associate role and the growth of the LLR Advanced Clinical Practice unit expanding the capacity to grow ACPs year on year funded via the apprenticeship levy
- On-going growth of our clinical simulation facilities and classroom teaching space for non-medical learners.

Maintain safe staffing:

- Continue to focus on safe and effective staffing, building on existing policy and support to boards and staff in making effective decisions

- In line with Developing Workforce Safeguards undertake Quality Impact Assessments for all new, registered and non-registered roles (e.g. Nursing Associate / Medicines Management Technician)
- Benchmark Care Hours Per Patient Day (CHPPD) and other staffing metrics with peer groups within Model Hospital.

We are acutely aware that in areas, such as mental health, it is difficult to attract newly qualified nurses from our local education providers. We will take develop a clear plan to address how we ensure students have a positive experience whilst on placement and choose to continue working within LLR following qualification.

Workforce efficiency and productivity

Given the existing and future challenges within the healthcare workforce, our developing plans are focused on ensuring that staff are supported to be as productive as possible by:

- Effective use of technology to deploy staff through e-rostering, e-job planning
- Upskilling clinicians to confidently use new technologies to support delivery of care (ePrescribing, EPRS, NerveCentre, digital dictation)
- Designing services in such a way that they avoid duplication of work by enabling teams to work in an integrated way and staff are supported to do so through appropriate policies and OD interventions. Our long term approach to long tem condition management for example sets out the expectation for integrated pathways across specialists teams and a shift to management of these conditions largely taking place in the community
- Enabling agile working supported by the right technology to prevent unnecessary travel time and to give staff more control over their working day
- Reduced sickness absence through strategies such as Mental Health First Aid
- Using technology to enable productivity: Community nursing teams have implemented technology to optimally plan patient visits. As a result of the implementation face-to-face patient contact time increased from 31 per cent of nurse time to 71 per cent; 2.5 hours' of planning time have been saved each day in each of the 30 teams and 12 hours' per day in clinical staff time has been saved. LPT are now looking to roll-out the software to other services including continence, phlebotomy and to the service provided by our 22 volunteer drivers.

Delivering 21st century care

We intend to grow our workforce, with greater and more varied skill mix, new types of roles and different ways of working to support the delivery of a co-ordinated, proactive and personalised care, resulting in better health outcomes, There will be the need for more multi-disciplinary working across organisations which enables health professional to make better use of the full range of their skills. We have already been looking at how we can better use our staff so that they can use the full range of skills and knowledge that they have, and be able to work to the top of their licence.

Workforce Planning for Skill Mix:

- In 2018/19 LWAB commissioned a review of staffing on two medical wards and two mental health wards with the aim of improving understanding of how a different skill mix could support current and future patient needs
- As a result, skill mix on these wards has changed to incorporate registered nursing associates, increased therapy input and extended admin hours, all of which will help support the registered nursing staff on shift and increase care contact hours.

Workforce planning must be grounded in service change priorities and new models of care. We will use appropriate workforce planning methodologies to support services to develop achievable workforce plans that meet the needs of patients. We will facilitate both specialised workforce planning interventions and also support managers to develop workforce planning skills. *The Future Medical Workforce:*

- International recruitment campaign which has resulted in the recruitment of 14 GPs to work across primary care within 2019/20
- University Hospitals of Leicester specifically are developing an international medical recruitment hub to help reduce medical vacancies in their establishment.
- UHL has a number of Physician Associates within the workforce and are currently recruiting to further roles. We will continue to work closely with local education providers to ensure that students graduating are recruited to the available roles
- Detailed workforce planning is underway to establish the best way to integrate Physician Associates into mental health services
- Expansion in the numbers of Advanced Care Practitioners is continuing. As a system work together to set aspiration leadership targets for underrepresented groups which will include BME staff and staff with disabilities. This will be achieved by developing system wide detailed action plan to ensure that the workforce metrics in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality standard (WDES) are improved year on year.

The Future Nursing Workforce:

- Working with education providers to understand supply and retention of newly qualified within area
- Utilise apprenticeship levy to 'grow our own'
- Registered Nursing Associates and other professions to enhance skill mix
- Maximise use of STP funding to implement the General Practice Fellowships: new to practice programme for newly qualified GPs and Nurses.

The Future AHP Workforce:

- Anticipate future demand for AHPs to increase as part of skill mix and provision of more diagnostics in community settings.

The Future Pharmacy Workforce:

- Project commissioned for 2019/20 to review the pharmacy workforce across LLR

- Need for greater understanding of the future demand for pharmacy, particularly within primary care, to ensure sufficient capacity in all sectors, and aligned to increase in PCNs
- Opportunities for developing career pathways that cross system boundaries and for integrated working/rotational posts.

The Future GP workforce and Primary Care Networks

In line with the new Model of Care and the development of Primary Care Networks, Primary Care is developing new workforce models focusing on the ten high impact changes.

A much wider team of health professionals is increasingly becoming involved in patients' care in GP practices. Through primary care networks there will be even more clinical pharmacists, physiotherapists, physician associates, community paramedics and social prescribing link workers looking after patients day-to-day.

Practice staff will also work together with other health, social care and voluntary sector organisations, to plan the care patients need and prevent ill-health in a coordinated way. These wider teams will include pharmacists, district nurses and specialists who care for certain types of conditions or groups of patients with particular needs.

Each primary care network will decide how it will provide care for its patients. This will include developing solutions that might include sharing health professionals between practices or offering appointments at a different practice in the network to improve access— particularly if they have a non-urgent problem or that practice specialises in an area of care they need.

PCNs will become the basis for neighbourhoods, defined populations and geographies, around which integrated care can be planned and delivered between local hospitals, local authorities, primary care, community health and the third sector. Networks will deliver integrated services to people in 'neighbourhoods', as the foundation of an effective health system In 'places' (Upper Tier Local Authority boundaries), interacting with hospitals and local authorities, working together to meet the population's needs (in some systems, federations could operate at the 'place' level to support primary care networks)

The Clinical Directors of PCNs will play a critical role in shaping and supporting the ICS and ensuring GP practices are fully engaged in implementing the Long Term Plan. Through PCNs, practices will play an even greater part in the wider system than they have previously.

Funding for the system will bring in LLRs share of the 20,000 additional staff and equates to 13 new clinical team members per PCN (based on 50,000 patients) This equates to nearly 300 new staff in LLR by 2023/24.

- Social Prescribing (2019-20)
- Pharmacists (2019-20)
- Physician Associates (2020-21)
- First Contact Physiotherapist (2020-21)
- Community Paramedics (2021-22)

We will develop career pathways across these new paths, ensuring we do not destabilise one part of the system to accommodate another.

In line with the national picture workforce challenges are impacting on the sustainability and resilience of primary care and our plans need to focus on recruitment, retention and workload. As such our plans will be developed to support our practices in the day to day delivery of core services and bring about transformational change. This will be achieved through:

- Build on successful implementation of International GP Recruitment and role out cohort 2 in early 2020
- Support the 3 training hubs in LLR to develop and play a greater role in our healthcare system
- Maximise the use of fellowship funding to support the retention of newly qualified GPs and Practice Nurses
- Build on our GP retention programme to support GPs in the first five years of work, and develop flexible working to retain GPs who wish to work more flexibly
- Build on our commitment to provide essential training for all general practice staff to support the delivery of core general practice and support the system transformation required to move to new models of care.

Volunteers and Carers

- LPT has over 400 volunteers working with their services and UHL has over 800 volunteers. Within LLR we continue to work closely with a number of voluntary organisations
- As part of service redesign and workforce planning, consideration will be given to how volunteers and carers can support delivery of care to improve patient outcomes.

Workforce transformation

The LLR system is developing its ambitious vision for whole system transformation for which the delivery of the new model of care is fundamental. This will see an increase in workforce across the system, and a move to far more integrated working to support our new model of service delivery fit for 21st century. The local Area Workforce board is providing oversight to system workforce plans.

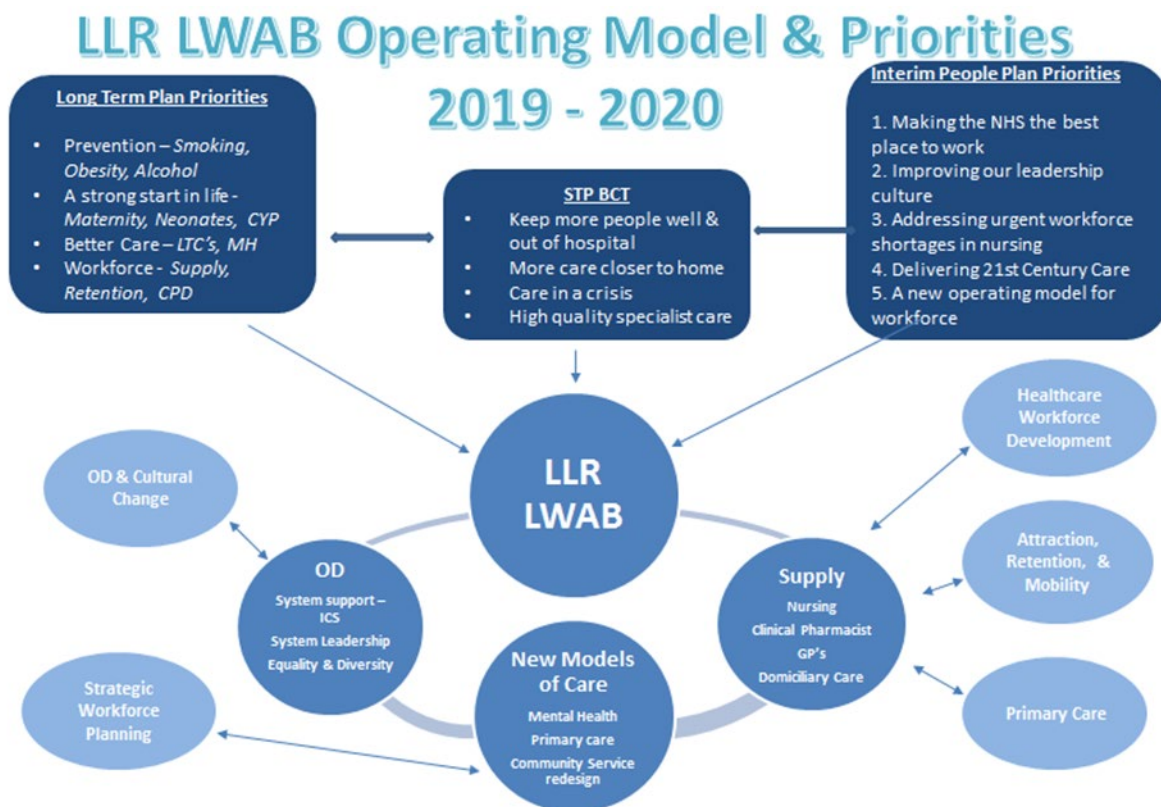
A new operating model for workforce

Integrated Care Systems will take on greater responsibility for workforce and people-related activities, with the appropriate resources. Development of the LLR ICS is underway and we are clear that over time, and within a national framework, ICS will take the leading role in developing and overseeing population-based workforce planning for our local health services.

The LLR Local Workforce Action Board (LWAB) will be responsible for developing the capacity, capability, governance and ways of working of the LLR workforce.

LWAB has reviewed its operating model and priorities for the coming 12 months. It takes into account STP Better Care Together programme priorities, NHS Long Term Plan priority areas and

delivery of the People Plan priorities. It will require closer partnership working with collective responsibility to support the development of an integrated care system (ICS) across LLR.

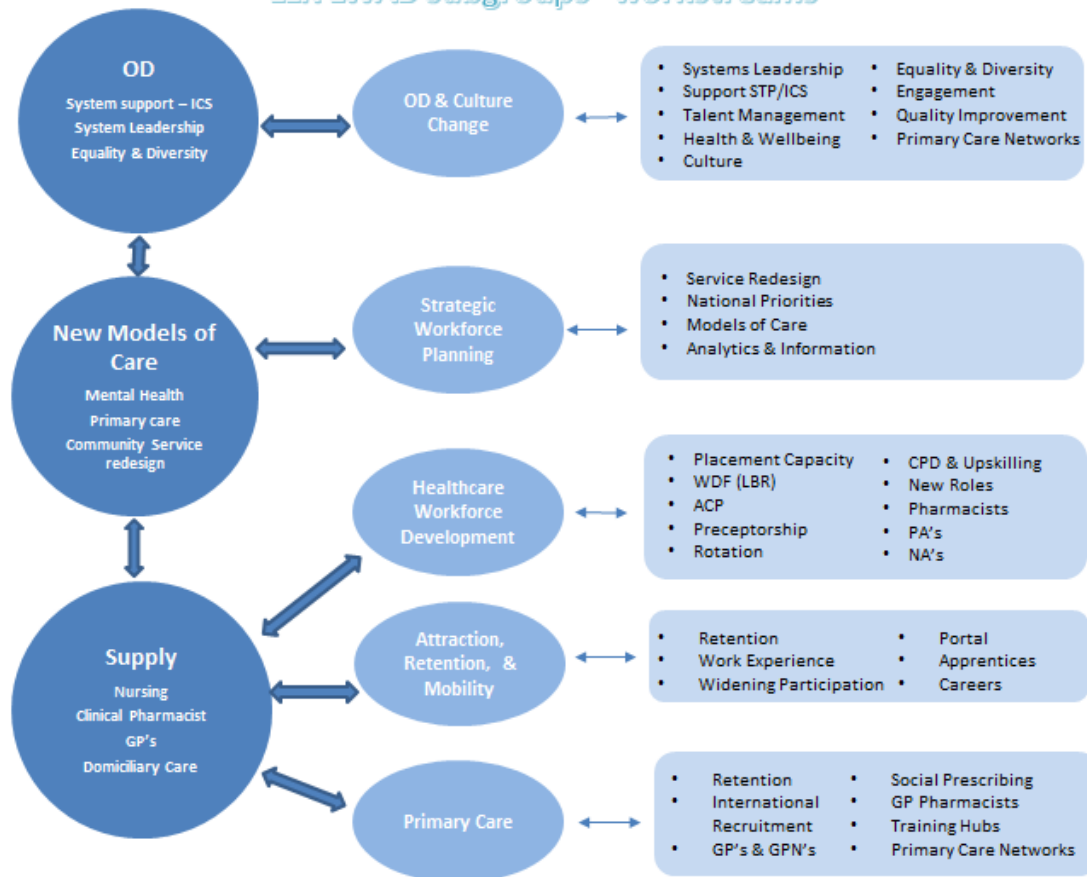


Five sub-groups will form the structure and work streams of the LWAB, each pan- system representation:

- Organisational Development and Culture Change
- Strategic Workforce Planning
- Attraction, Retention and Mobility
- Healthcare Workforce Development
- Primary Care

Through these groups we will use robust workforce analytics and data to inform our strategies, interventions and actions and to monitor our progress of delivery for continuous improvement.

LLR LWAB subgroups - workstreams



As we progress towards shadow form of an ICS we will work through the LWAB business and strategic groups to develop our response in ensuring we drive delivery of a workforce plan that reflects system requirements. An initial priority is on the organisational development support to our local system as it evolves into an ICS, to ensure our workforce is engaged, supported and empowered to deliver care at its best.

Voice of our communities – insights to support our five-year plan

Our five-year plan for LLR has its foundations in extensive past and widespread ongoing public and patient engagement. The activities that have taken place and the insights gained which have helped shape our plan are contained in a detailed report.

This work has been brought together by Better Care Together's communications and engagement workstream as well as the clinical transformation programmes, with significant contributions from local Healthwatch groups, local authorities, and voluntary and community sector organisations.

We have gained insights from diverse communities across our area, including a focus on the experiences of vulnerable groups and people with protected characteristics. This focus has influenced our commitments to improve the provision of healthcare locally.

Engagement and insights

We have undertaken a range of engagement activities giving us a rich seam of insight that tells us what is important to stakeholders, patients, staff and the public.

Activities have included:

- **Engagement by Healthwatch Leicester and Leicestershire and Healthwatch Rutland:** in spring 2019 the local Healthwatch organisations engaged on aspects of the NHS Long Term Plan, including surveying patients with long-term conditions, using online and hard copy surveys, focus groups and interviews. We specifically sought to include people often under-represented in engagement
- **Engagement focusing on community services:** in 2018/19 NHS and social care organisations held focus groups and undertook face-to-face interviews to understand what matters most to people about community services. With partners we held six public events to feedback insights from patients, family carers and staff outlining their experiences of community health services in relation to the NHS Long Term Plan. The insights have been consolidated with existing reports representing 4,200 people from a broad range of communities
- **Activities focusing on acute services:** NHS partners held nine public events in 2018 and attended 20 voluntary sector meetings to discuss plans for acute and maternity services
- **Engagement with MPs and councillors:** there have been ongoing discussions on the local response to the NHS Long Term Plan with the Better Care Together senior leadership group, Health and Wellbeing Boards, Joint Overview and Scrutiny Committees, individual local authority Overview and Scrutiny Committees, clinical commissioning group (CCG) and trust boards, and workstream boards, groups and committees
- **Staff engagement:** organisations are involved in ongoing staff engagement activities. Staff leaders have been supported through *Making Things Happen* events, equipping them with the skills to affect change
- **Analysis of research reports:** examination of 74 research reports, compiled over the last three years, has given us insights from 13,655 patients, family carers, staff and stakeholders
- **Involvement of system leaders:** CCG and trust partners have engaged with their boards, GP members and staff with regard to the NHS Long Term Plan.

Key themes emerging from this engagement

Delivering new service models

- **Care at home:** we have been told by our population that they prefer care in their own home but this is dependent on support from family and the quality of care from services. There are concerns over social isolation at home, the support to be mentally and physically active in sheltered accommodation, and risk of falls leading to crisis care
- **Relations with services:** our public and patients want improved relations with staff and a better language/cultural understanding, improved handover between services, while staff have stressed the need for different IT systems to inter-link with each other. Our population want timely GP appointments, in particular same-day appointments, the availability of a

known GP, and extended hours/services within general practice (particularly valued by those in work)

- **Primary care networks:** our population see a crucial role for patient participation groups in the development of the new networks. This included co-designing new social prescribing interventions
- **Access, transport/mobility:** public transport and car parking are both frequently mentioned by our population as having a major impact on accessing services
- **Urgent care:** our population report that the NHS 111 experience as reassuring and that they have received good advice. They valued triage, being called back by a doctor, and felt more educated about their health as a result
- **Hospitals:** while hospital care is always greatly valued, discharge from hospital can sometimes be seen as 'chaotic'. Our population value the role of therapists in helping their recovery, and the support available in community hospitals, with a concern over the reported loss of some beds. Our public have been engaged extensively over plans to modernise and reconfigure Leicester's acute hospitals. There is a broad recognition that investment is needed and the plans are generally the right ones, although some would like to see formal public consultation take place sooner rather than later.

Focusing on population health

'Population health' includes the whole range of determinants of health and wellbeing, many of which, such as town planning and education, are quite separate from health services.

Prioritising prevention

Our population want to be empowered with information so they are better able to self-care or embrace social prescriptions. Requests have been made for a directory of available services, signposting to other organisations when NHS/social care services do not exist. Carers have struggled when there has been limited understanding about conditions such as dementia or the problems faced by individuals with a learning disability. Our population from BAME communities have stated difficulties due to a 'cultural bias', sometimes intensified by lack of a translator or interpreter. People at the end of their life, and their family carers, have stated the importance of good quality communications, and the need for care to be provided with dignity and respect.

Advancing care quality and outcomes

Our engagement has found:

- Mental health services and services for our population with a learning disability have been meeting demand and delivering good quality care, but many people consistently struggle with long waiting lists, while some services do not meet service user expectations
- Our population with long-term conditions and their carers want improved information and communication regarding their conditions. Our population with mental health problems or autism have found it harder to obtain diagnosis and initial support than those for physical health conditions

- Currently, individuals living with cardio-respiratory issues have a range of experiences. While services might be generally good, there is evidence that people experience frustration, worry and confusion at key touch points
- Our population felt that there are a number of barriers for bowel and cervical screening, including cultural considerations
- Planned care could be improved with more explanation of tests and treatment before a visit to improve understanding, and more support and follow-up after treatment
- Our population with lower back pain stressed the importance of accurate diagnosis and the availability of emotional and physical understanding and support, including advice, pain management tools and approaches such as physiotherapy
- Mothers, families, and expectant/new parents stressed the importance of clear and up-to-date information and advice on maternity matters - there is confusion, for example, about aspects of care such as breast/bottle-feeding, and co-sleeping
- Our staff are seeking more health information on 'looked after children' with particular areas of interest including personal safety, mental health, transition from child to adult health services, sexual health, diet and nutrition, and access to out-of-hours services.

Backing our staff

There is no doubting the dedication, care and commitment of staff throughout LLR. Engagement with staff has seen requests for better communications and involvement on proposed service changes. Health and wellbeing is of crucial importance – linked to this is the availability of resource to recruit to teams where there are staffing vacancies. Workload pressures can reduce the ability to develop good relationships with patients/families. Good working relationships with other teams are essential.

Harnessing digital and technology

Organisational and personal communications, as well as IT systems which support sharing of information across services, are considered by all stakeholders to play an important role in the smooth running of services. Staff, in particular, identified a need for significant improvements in IT to provide joined up accessible records, and a common IT interface. Patients and carers want a more efficient and effective link between GP surgeries and hospitals (they report 'story telling fatigue' by having to repeat information about their care). People want to be assured that there are safeguards in place around security and data protection, but do not want this to prevent the creation of one integrated patient information system.

Next steps

We recognise that engaging our population in conversations about health care is an ongoing activity that improves patient, organisation and health system outcomes. There is a commitment to continuously involve people to co-design and co-produce the care they receive. This will be undertaken during the lifetime of the five-year plan.

We have strengthened our assurance processes locally by introducing a new Public and Patient Involvement Assurance Group. The Group will review activities to assure themselves that engagement has been undertaken and it will assure itself that insights have impacted service design.

In addition, we are developing a Citizens' Panel - an innovative online forum for engaging and involving wider communities in the area. We will also encourage panel members to get involved in offline activities, all of which will complement our existing engagement mechanisms.

Estates

The LLR health economy has access to a widespread clinical and non-clinical estate. The design and delivery of a robust estates transformation strategy is pivotal to successful service transformation over the next few years. The diagram below provides an overview of the full NHS estate within our health economy.

 <p>12 owned 1 leased (PFI) 336k sqm GIA £80,867,919 backlog costs</p> <p>Hospitals (including community)</p>	 <p>7 owned 11 leased</p> <p>Offices</p>
 <p>4 owned 8.514 Ha</p> <p>Land without buildings</p>	 <p>37 owned 12 leased</p> <p>Other / Unknown (includes some offices)</p>
 <p>35 owned 31 leased 56k sqm GIA £1,132,081 backlog costs</p> <p>Health Centres</p>	 <p>71 owned 53 leased 30,169k sqm GIA</p> <p>GP owned or leased from other parties</p>

Our LLR health economy estates strategy supports the delivery of excellent care, while promoting health and wellbeing. Over the next five years we will look to develop our estate and design appropriate facilities in which to deliver 21st century healthcare as efficiently as possible. Central to this strategy will be to complete our proposed reconfiguration of our hospitals, as set out in chapter two.

The vision for our estate is:

- Services should be delivered from an estate which meets clinical need, is accessible, offers value for money, is of acceptable quality, and meets safety and legislative compliance, supporting integrated teams working out of community hubs
- Wherever possible, buildings will be designed to be flexible to adapt to changing needs
- Use of physical assets will be maximised
- The use of technology will be maximised to support efficient and agile working practices and reduce dependence on fixed office space
- Building utilisation rates should be a minimum of 85%

- Public sector assets will be promoted to maximise utilisation
- Property will be invested in, subject to availability, to provide modern, fit for purpose 21st century facilities, reducing backlog maintenance and running costs
- Retain the most appropriate assets and actively dispose of surplus site wherever possible to support housing opportunities, in line with national policy
- Population growth will be planned for with the Better Care Together programme aligning with local authorities' long-term strategic growth plans.

To deliver this vision, it will be essential to complete the following actions:

- Reconfigure acute hospital services in order to deliver the specialist care we need
- Decide how we use community facilities, including community hospitals, to ensure we can look after people when they leave hospital or when they need more support in the community, and deliver integrated, planned and urgent care as well as diagnostic procedures close to home
- Provide quality children and young people, and adult, mental health facilities
- Improve GP surgeries and health centres enabling a wider range of services to be delivered, reflecting population growth over the next few years
- Leverage technology to provide better patient services, with greater productivity
- Work with the One Public Estate Partnership across the public sector to maximise collective opportunities and priorities.

Over the next five years the LLR estates strategy will deliver a number of major transformation programmes to support the delivery of our vision. These are detailed below. Capital requirements for these projects are set out in chapter four.

Wave one project: Child and adolescent mental health service (CAMHS) re-provision - currently under construction

This scheme is to build a new 15-bed CAMHS and eating disorders inpatient facility (with a hospital school); co-located with both LPT acute inpatient mental health services and adult inpatient eating disorder services on the Glenfield Hospital site in Leicester. This facility will replace a temporary facility that has no specialist eating disorder beds. This project will significantly reduce the need for teenagers to go out of county for inpatient beds.

The unit will meet the NHS England service specification, NICE standards for eating disorders and the QNIC standards, deliver financial balance and reduce whole system costs for out-of-area placements.

Wave one project: Interim Intensive Care Unit (ICU) - currently under construction

This scheme is a key enabler for further reconfiguration work on UHL acute sites, and comprises of:

- The expansion of ICU at Glenfield Hospital by 11 bed spaces (a net increase of three ICU beds across the three sites following the reduction at Leicester General Hospital)

- The refurbishment of space at Glenfield Hospital for the development of interventional radiology
- The development of new wards at Glenfield Hospital to support the transfer of hepatobiliary and transplant services from Leicester General Hospital
- The refurbishment of ward space at Leicester Royal Infirmary to support the transfer of colorectal and emergency general surgery services from Leicester General Hospital.

Wave four project one: UHL acute reconfiguration - currently awaiting national approval

This reconfiguration programme underpins our Better Care Together programme and enables the health economy to deliver a sustainable, clinically effective and affordable service in the future.

This will enable UHL to move all acute care onto Leicester Royal Infirmary and Glenfield Hospital while enhancing critical care provision, creating a single-site maternity hospital and protecting planned elective activity, thereby facilitating a change in use of Leicester General Hospital site including disposal of land - some community-based services will remain at Leicester General Hospital. More details can be found in chapter two.

Wave four project two: Hinckley and Bosworth community health services - capital has been allocated, currently developing a business case for formal approval by NHS England/NHS Improvement

The proposal reflects the Better Care Together commitment to delivering and expanding planned and urgent care in local communities, where it is safe and viable to do so. Our aims in expanding services in Hinckley are to:

- Increase the number of day case operations and range of outpatient clinics – moving activity out of UHL into community hospital settings
- Increase the range of endoscopy procedures to include cancer screening
- Extend the range of consultant outpatient services
- Support the development of an urgent care hub within Hinckley and Bosworth
- Implement new models of care to support patients to be discharged home first with improved rehabilitation and re-ablement services in the community
- Upgrade x-ray facilities
- Consolidate the overall community service estate footprint across Hinckley in order to improve productivity by releasing asset value and increase space utilisation
- Introduce an improved clinical environment and lessen clinical risks of cross-infection.

Mental health and learning disabilities inpatient facilities: as described in chapter three, LPT is currently developing a strategic outline case on the re-provision of their mental health and learning disability inpatient facilities. A capital bid will be made to support this development. The programme is likely to be phased over a nine-year period, incorporating development, design, approval and construction, starting in January 2020, finishing in December 2029.

Community hospitals: over the next 12 months we will undertake a review of community hospital provision to determine how we might use these facilities in the future to support our clinical service

model, as described in chapter two. This may result in the need to make a capital bid to support the changes required.

Primary care estate: investment in primary care premises is crucial to the successful implementation of our primary care strategy. Investment is needed in terms of bringing existing primary medical facilities up to date, addressing the growth in the number of new homes and associated population, and in ensuring there are appropriate facilities to support transformation across the healthcare system.

In 2019/20 a primary care estates strategy is being established at practice level collated into PCN footprints. This will provide a detailed baseline, housing growth forecast and PCN level needs assessment, which will enable a system-wide long-term estates implementation plan to be developed. In order to realise any future estate developments, it will make the case for continued investment in primary medical care estate.

Our Estate Strategy and Checkpoint documents are submitted for reference.

Enabling a digital NHS

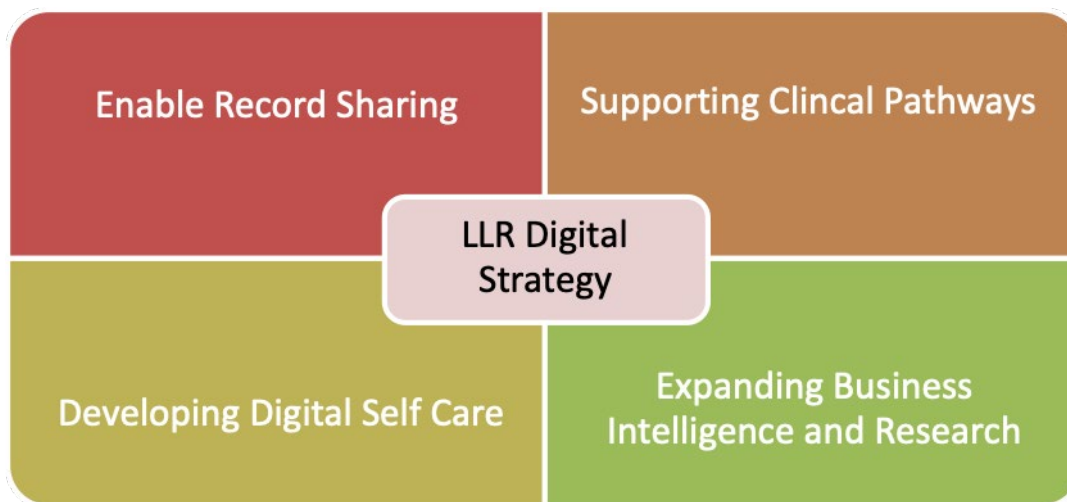
In 2019 the Government's vision of a technical future for the NHS was announced. Key to this vision was the end of IT systems that prevent delivering effective care. This vision will transform the NHS to allow appropriate access to real-time data and enable digital services and data innovations to transform patient outcomes. Within our local health care system, organisations have their own IT systems, which in many cases are unable to share and make use of each other's information.

To respond to the NHS vision, LLR have developed a new digital strategy and road map. We aim to deliver safe and secure transformational digital developments to all citizens and professionals. Our digital developments will support integrated service redesign as well as pathway development and will embed a culture of electronic record sharing for direct care. Key to our strategy will be using our data to understand our population and what interventions are needed and empowering people to digitally self-care.

In line with the national digital vision, we want to reduce the use of paper and make fax machines obsolete. Our vision includes empowering patients to use technology, such as apps, to support self-care. To deliver digital transformation, changes in technology alone will not be enough. Digital inclusion and digital literacy of the workforce, patients and carers are important factors in delivering this change.

What we plan to do

The overarching strategic objectives of our programme are:



Enable record sharing: our work to develop effective record sharing across the system will benefit patients and practitioners by ensuring that we are all viewing the same health and social care information about patients. Our population will be able to contribute to that shared record for others also involved in their care to see and make a more informed decision on options. This can include key clinical and social care information about the person.

The ability to support this model is critical to the successful delivery of integrated locality teams transcending primary, secondary, community and social care boundaries. In LLR, the most pragmatic way to achieve this is by reducing the number of systems for all organisations or support those that enable effective record sharing. By 2023/24 we expect all health and social care staff to have access to the same patient record.

Supporting clinical pathways: sharing information along our pathways from one clinical system to another can only be achieved if information is electronically and consistently collected, regardless of the source system. This allows the next service in the patient journey to receive reliable and complete information, without further requirement to refer back to the sender and also that information is targeted at the correct service. We have three main ways to achieve this:

- Continuing to support and further enhance PRISM as a pathway tool to enable consistent referrals
- Ensure that primary data capture templates are governed and standardised across our system
- Ensure that information is fed back to the beginning of the pathway.

Digital self-care: the LLR healthcare system is well placed to benefit from the proliferation of internet access in the home. Within the UK there is now 90% coverage of internet access in the home and smart phone ownership now exceeds 85% of the UK adult population. With this greater familiarity of technology there is now an expectation from the public to be able to interact with health and care and also perform some level of self-management via digital tools.

Technology is now emerging that is cheap, reliable, secure and non-proprietary that will utilise domestic broadband or smartphones to either allow interaction with health and social care, self-manage conditions, or remotely monitor observation without the need for a health and social care professional. This will give service users a sense of control and empowerment and a more responsive service.

These technological advances can identify and support patients in greatest need and navigate them to the right pathway for their care. Our digital strategy aims to create the environment to foster an acceleration of the shift to digital self-care. It also seeks to provide governance and prioritisation of developments based on greatest impact upon population health and wellbeing.

The greatest challenges will be interfacing the vast digital data environment that self-care will produce. Most of this data will be normal and no cause for concern but where data indicates a health issue for an individual, it is key that this leads to a timely intervention, through an alert to one of our health organisations.

Expanding business intelligence: although we have more to do in moving from paper-based clinical records to full electronic patient record systems in LLR, our system is still rich in data. Our challenge over the next five years is to develop methods of producing system-wide reporting of data.

To design the future pathways of care and monitor whether outcomes are being achieved, we need to plan across health and social care at system, place and neighbourhood level. Our current approach to record sharing only deals with one patient's record at a time, in the context of the patient's treatment. Our business intelligence strategy will focus on delivering a single health and social care data repository to support improved patient outcomes.

Throughout 2019/20 we will develop the building blocks for integrated working. Our business intelligence strategy will initially focus on health and social care data before being expanded to cover wider partners and contexts. This will include population health management indicators for PCNs. Our strategy sets out a framework for how organisations in LLR could work differently as business intelligence partners and provides the opportunity to collaborate on a number of important priorities.

Our LLR transformation programmes rely on taking a system-wide approach to analysis and measuring the impact of transformational change. We know that the ability of partners to generate and interpret joint data to inform the planning and delivery of health and social care is a critical enabler for our plans.

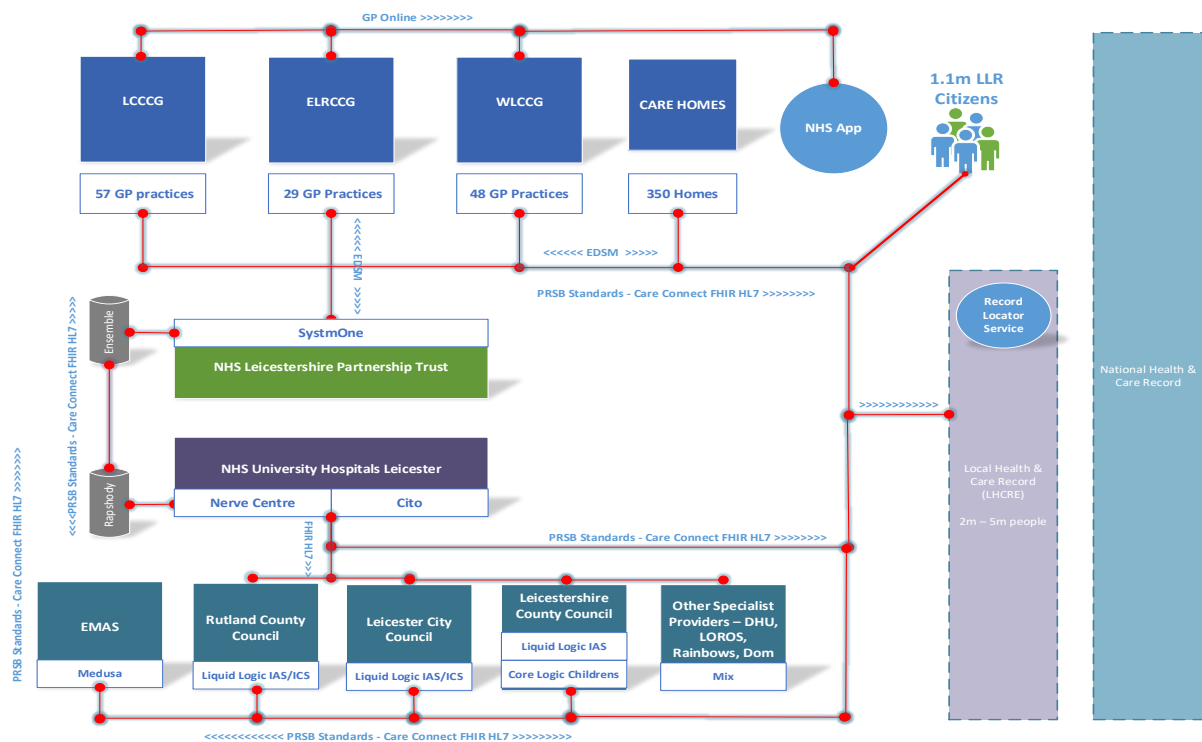
Business intelligence will play a central role in our approach to research and innovation. We will only sanction the release of data in line with the requirements within the Long Term Plan and the information governance requirements within GDPR.

Digital implementation actions 2019-2024

The diagram below provides an overview of our digital actions over the next five years which will enable greater integrated care to be delivered and services transformed.

Our infrastructure: to ensure that we can join up the main electronic patient systems in LLR across health and social care interoperability will be key. We will ensure that we keep abreast of the national standards developments and work towards mapping information with the Professional Records Standards Body (PRSB) core standards for information sharing.

All system planning, development and procurement activity is now reflecting the local and national standards-based ethos which will ensure local contracts for IT systems, digital services and innovations are proposed. The Health Systems Support Framework (HSSF) will be used when undertaking all developments/procurements to ensure that the data and interoperability standards expected by NHS^x can be delivered. Where this cannot be achieved, procurement must at least look to work within HSSF lot service descriptions and mirror HSSF requirements. This will ensure a fit-for-the-future, safe and secure digital foundation is established and there is either electronic patient record (EPR) convergence to a single system platform or standards-based interoperability with the single platform of choice.



In order to use information lawfully for direct and secondary care, we have a dedicated workstream that is focused on protecting people’s privacy and data. This allows us to confidently share information to provide better care. We are resolving fragmentation around information governance (IG) by bringing together expertise into a single IG forum to develop sharing agreements. This underpins our future vision for local, and potentially regional, decision-making around safe sharing of information.

Our cyber security system protects our infrastructure and is underpinned by provider capabilities overlaid by GDPR compliance. We will ensure that provider infrastructure is operating to and compliant with mandated National Cyber Security Standards. Our planned actions are anticipated to see full compliance with Cyber Essentials Plus by all NHS providers working in LLR by 2021. Our providers have commenced Windows 10 rollout. Advanced Threat Protection rollout will be in line with this.

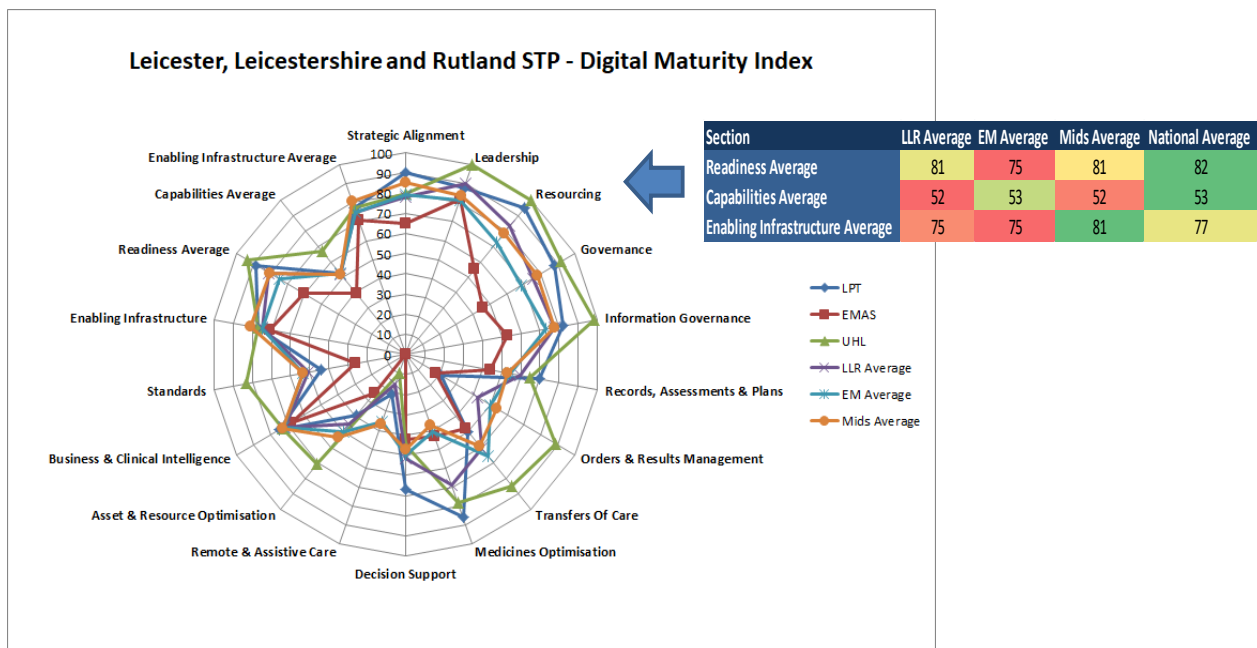
We are committed to working in partnership with current and any new suppliers to ensure their development plans as part of the Care Connect and GP Connect programmes are taken into account in our local plans. This will allow us to standardise clinical content and use nationally published application programming interfaces where the same system between partners is not used. We will stipulate to other potential suppliers to LLR that they must interoperate using national Faster Healthcare Interoperability Resource HL7 standards, must hold required Information Standard Notice mandated information items and ensure that PRSB-headed information is extractable in an open structured data format. This will involve sharing these standards and bringing social care suppliers and local authorities on board with future developments.

A major exercise taking place between 2019 and 2022 is a partnership development between UHL and Nerve Centre. This contains a development strategy that will see the trust achieve HIMMS level six by 2022 and make significant progress in reaching 100% Digital Maturity Index (DMI) compliance by 2024. This development is underpinned by a HSSF-mirrored contractual arrangement as the HSSF framework lot one (acute EPR) is not yet available. The delivery of UHL's strategy will enable broader LLR and regional record-sharing and integrated working plans including achievement of mandate for Transfers of Care through the digitisation of UHL outpatients.

Provider plans for digital and associated system investment plans are inherently linked to key domains of the LLR DMI. Our DMI latest position tells us where improvement is required between 2019-2024 to reach full maturity. While LLR is broadly in line with the East Midlands and wider region, we recognise that particular domains require system support to move the providers together (and improving LLR's position). Between 2020 and 2021 the domains of focus are around remote and assistive care, transfers of care, decision support, and records and plans. The diagram below highlights our digital maturity position.

We recognise the significant challenges for providers delivering services regionally and are committed to supporting common partners accelerate and improve their maturity position. We recognise that pooling of funds/joint procurement enabled through regionally-aligned investment decisions is paramount to making this happen. As a member of the East Midlands Accord (LHCR governance component) we will support East Midlands Ambulance Service in developing its organisational and wider partnership digital capabilities over the course of this strategy, and which are reflected in our current strategic investment plans for HSLI.

Our current system digital maturity performance is outlined below:



A range of digital services: we want all digital services that operate in LLR to meet people’s daily needs. To achieve this we have ensured that our strategy is built on what our population have told us they need. Our portfolio is grounded in listening to our patients and clinical workstreams to understand needs and service redesign aspirations.

In-depth research using varied methods, involving more than 5,000 people over the last two years has helped outline key themes for digital services. These themes are supported by a variety of studies undertaken by the NHS and other organisations over the last two years in LLR.

In addition, our clinical workstreams undertake insightful engagement with patients, service users, carers and staff to understand their experiences of health and social care services and what matters most to them. We are committed to ensuring that patients and stakeholders are involved in co-designing digital services. In most cases, engagement and communications to influence proposals for service change has or will be undertaken through the relevant clinical workstreams. This work will be triangulated to ensure that insights and experiences specific to digital transformation are captured and have a strong evidence base and impact on service improvement and redesign.

As these work areas are prioritised then engagement and communications activities will be designed with our population to reach out to the range of target groups. This will involve use of the LLR Citizens’ Panel.

Our programme of work is built upon national solutions such as the Summary Care Record and NHS App alongside local clinically-led services such as PRISM which link into local clinical systems to support consistent referrals via the electronic referrals service (e-RS).

Innovation: throughout the next five years, we will encourage new suppliers to the market where there is a need for innovation. Recent examples of this include use of the NHS procurement hub for

the provision of online consultations for LLR general practice. A further example is the work underway in 2019/20 concerning the development of the NHS Now app. We are developing this application with an innovative supplier which has demonstrated capabilities to develop a solution that meets local patient needs and complies with national standards around using APIs to pull national resources into local apps.

We will expand on our work with the East Midlands Academic Health Science Network over the next five years in other clinical priority areas. This will allow us to identify what exists in the market place and introduce new capable technology for population.

We will ensure that there is space for new suppliers (in compliance with national and local standards). Our Digital Innovation Hub will be pivotal in bringing new innovations beyond concept to reality. The hub will work with partners to ensure that existing best practice is shared and economies of scale are realised. This will involve the creation of a range of capabilities to meet local needs and help with service redesign priorities. This will include electronic patient interaction for those with diabetes and the possible development of a wellbeing online resource for the local population, either in mental health services or to help recovery and prevention of crisis.

We are actively reviewing the Global Digital Exemplars programme, blueprinting scheduling, and have identified areas of learning from others that have achieved accelerated innovation at scale. The main areas that we plan to explore further with clinical workstreams and partner organisations are cancer, mental health, learning disabilities and autism, and outpatient transformation.

Skills and culture: we will ensure the right digital and technical skills are developed in LLR alongside robust business change. There is a strong leadership and change management culture in digital within LLR. We have reviewed our governance arrangements to ensure that we have robust clinical and digital leadership in place. There is work to do around supporting the aligning of workforce priorities to enable the best use of technology in services.

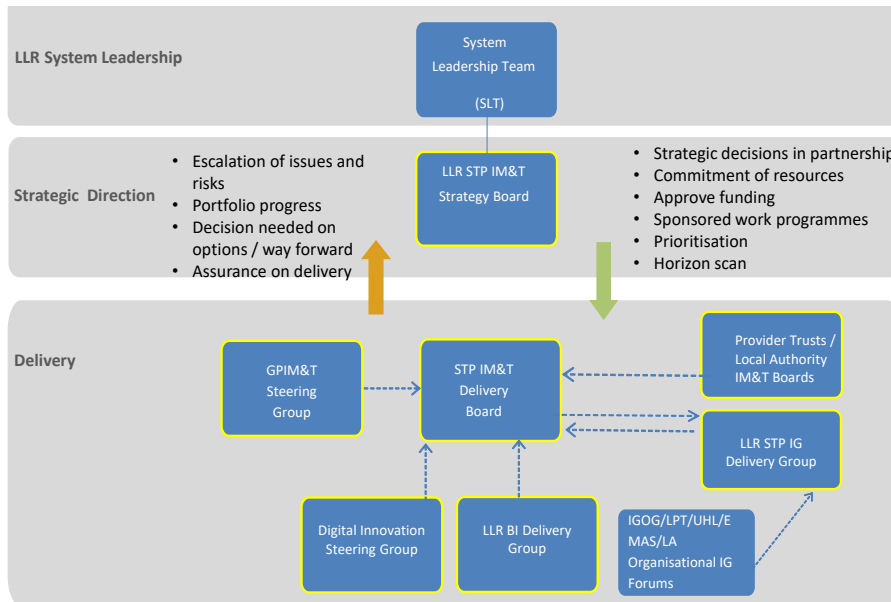
We know that we need to deploy digital solutions for our population at the scale demanded by the Long Term Plan. We need people to be digitally included and literate to get the best care experience and outcomes. For this we will engage our third sector partners and user forums to see how we can embrace community resources in increasing digital skills in the LLR population.

Our digital roadmap is based on the foundations of engagement with stakeholders. Governance arrangements have evolved in line with the development of the Better Care Together programme. We have a strong commitment for patient and clinical involvement in the development and implementation of our strategic vision.

LLR STP leadership and governance structure for digital: we are working with our organisations to support their staff to take up new digital solutions. Previous technological improvements have not been adopted by the entire workforce and full benefits have not been realised. Similarly, communication and engagement is needed with our patients to make them aware of the health and social care benefits that are becoming available through technology.

We will need to consider the impact on our workforce of the digital programme and want to ensure that health and social care staff across the system have the necessary digital skills and are supported to optimise the use of enabling technology. We will look to ensure that system-wide workforce plans are reflective of the digital skills requirements for LLR’s digital strategy.

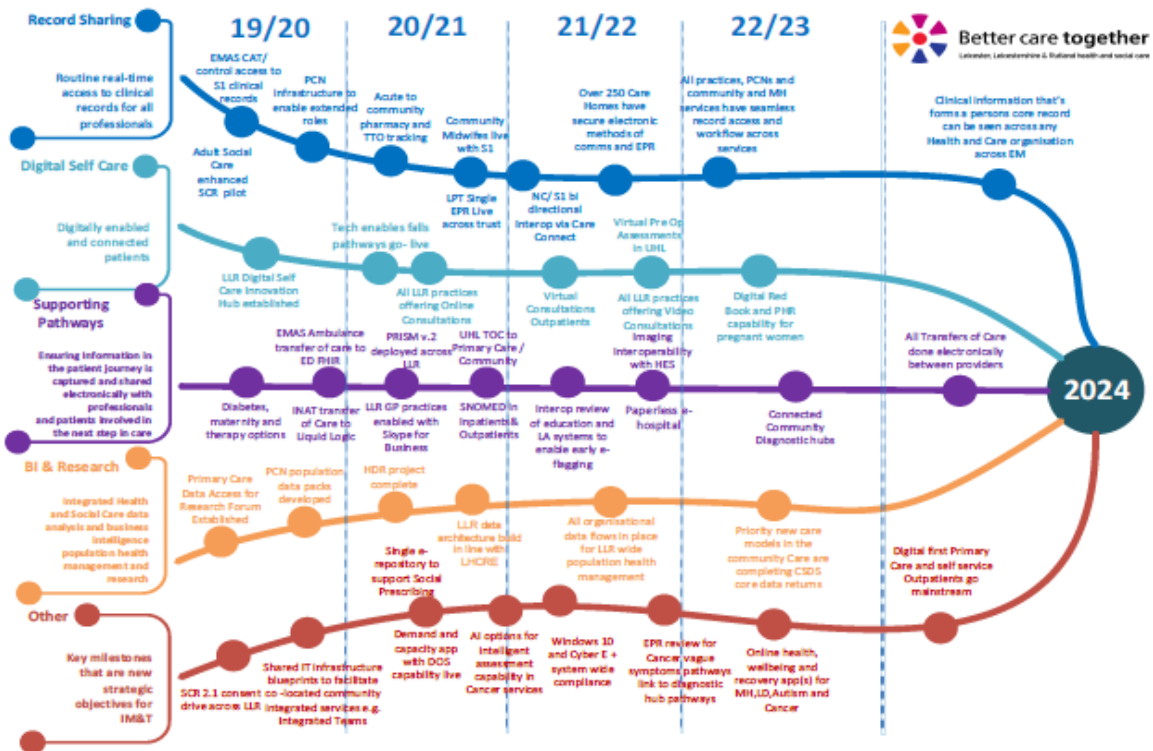
Our governance structure for delivering digital transformation in LLR is detailed below.



Digital transformation programmes: while emergency and urgent care services are of great priority, we also know from local pressures and the NHS Long Term Plan that we will need to transform outpatients services significantly as a system. We know that nearly a quarter of LLR’s population have about three to four visits to our local trusts a year. The NHS Long Term Plan outlines the need for local health and care systems to reduce follow-up outpatient appointments by one-third. We will take action through technology, where appropriate, to reduce hospital visits and enable people to remain supported in the community.

Our digital work programme is linked to our multi-organisational system service transformation plans, which will deliver the NHS Long Term Plan and local priorities. Our infrastructure actions will enable new models of care to become a reality. Integrated working at PCN-level will operate effectively as a single delivery team, with a standards-based approach underpinning these new models.

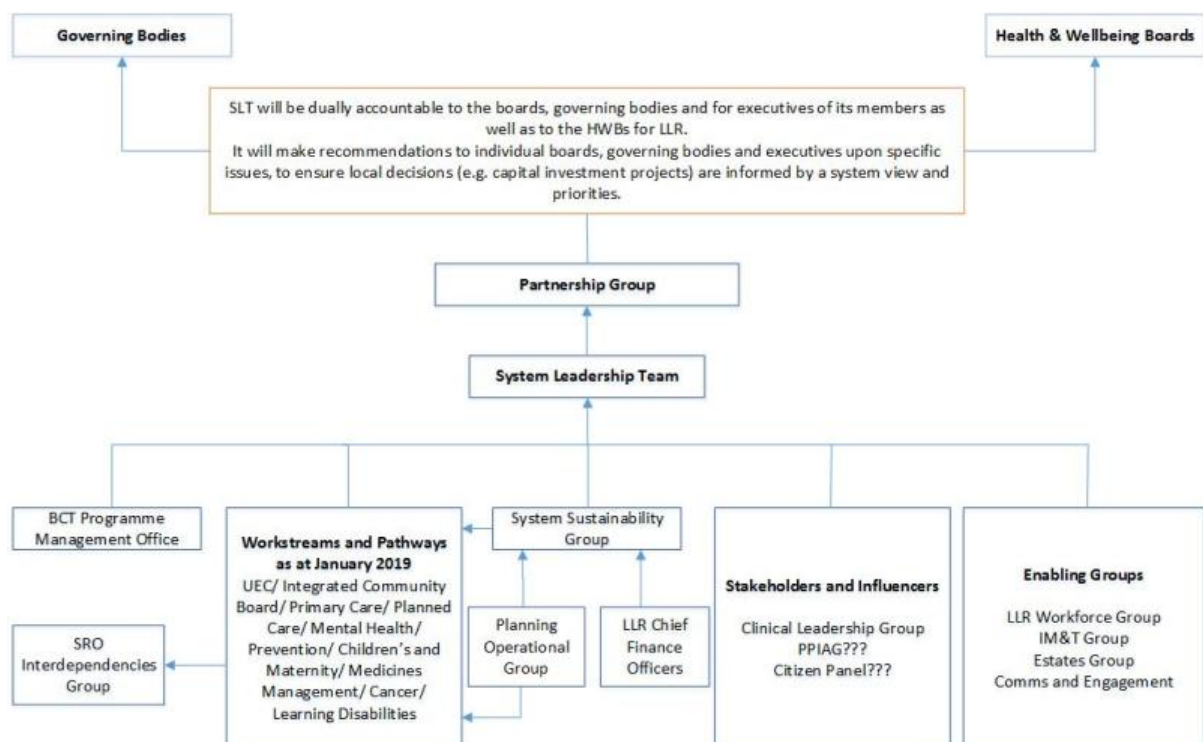
A programme of key activities is detailed in the diagram below.



Chapter six: Governance

The role of local organisations and leaders within Better Care Together is to develop new ways of working within the current statutory frameworks which enable us to operate collaboratively as one system, focused on doing the best for the health and care of local people.

Nationally, NHS England have set out expectations for local partnerships to develop into Integrated Care Systems (ICSs). Chapter one describes how we intend to develop our local ICS. This is a logical progression of the journey we have been on through our existing Better Care Together programme. The diagram below sets out our governance arrangements for Better Care Together. As we develop our ICS we will review our governance arrangements to reflect these changes.



Partnership Group: the purpose of the Partnership Group is to support good governance of the Better Care Together programme, leveraging the experience of participants to support and guide the System Leadership Team to deliver the programme. Membership is NHS trust non-executive directors, CCG lay members and the Health and Wellbeing chairs from each upper tier authority who represent their place.

System Leadership Team: the purpose of the System Leadership Team is to oversee all aspects of the development and delivery of the Better Care Together programme for LLR. Members include chief executives and medical directors from NHS trusts, accountable officers and chairs from clinical commissioning groups, and senior representatives from upper tier local authorities.

Patient Participation Assurance Group: the purpose of this group is to gain assurance that all proposals to change and improve healthcare services in LLR are developed with appropriate and sufficient public and patient involvement and insight. Members are appointed through a formal process.

Clinical Leadership Group: the purpose of this group is to support the Better Care Together programme to make improvements in the quality, safety and experience of patient care, by providing strategic, clinical advice in areas of healthcare challenge. The group’s role includes setting the clinical strategy for LLR and driving cultural change to improve pathways for local people. Members include senior clinical and social care staff from across all partners in LLR.

System Sustainability Group: the purpose of the group is to oversee the development, implementation, monitoring and delivery of the LLR system efficiency and productivity schemes, supporting quality improvement in the delivery of local NHS services. Members are senior finance, contracting and planning leads from NHS providers and commissioners.

LLR NHS Chief Finance Officers Group: the purpose of the group is to create an affordable longer term financial planning framework within which partner organisations can deliver sustainable health and social care services within the financial resource available. Members are the most senior financial officers from each NHS organisation.

Planning Operational Group: the purpose of the group is to lead the system planning processes across NHS organisations within LLR. Members include the senior planning leads from NHS providers and commissioners.

Better Care Together workstreams: each priority area workstream has a group which is responsible for the development and transformation of service models and clinical pathways to improve patient outcomes and/or improve efficiency. Members are drawn from across all partners within the Better Care Together programme, each providing their subject matter expertise. Each workstream has an executive senior responsible officer(s), implementation lead and system leadership sponsor. The workstreams are:

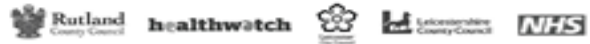
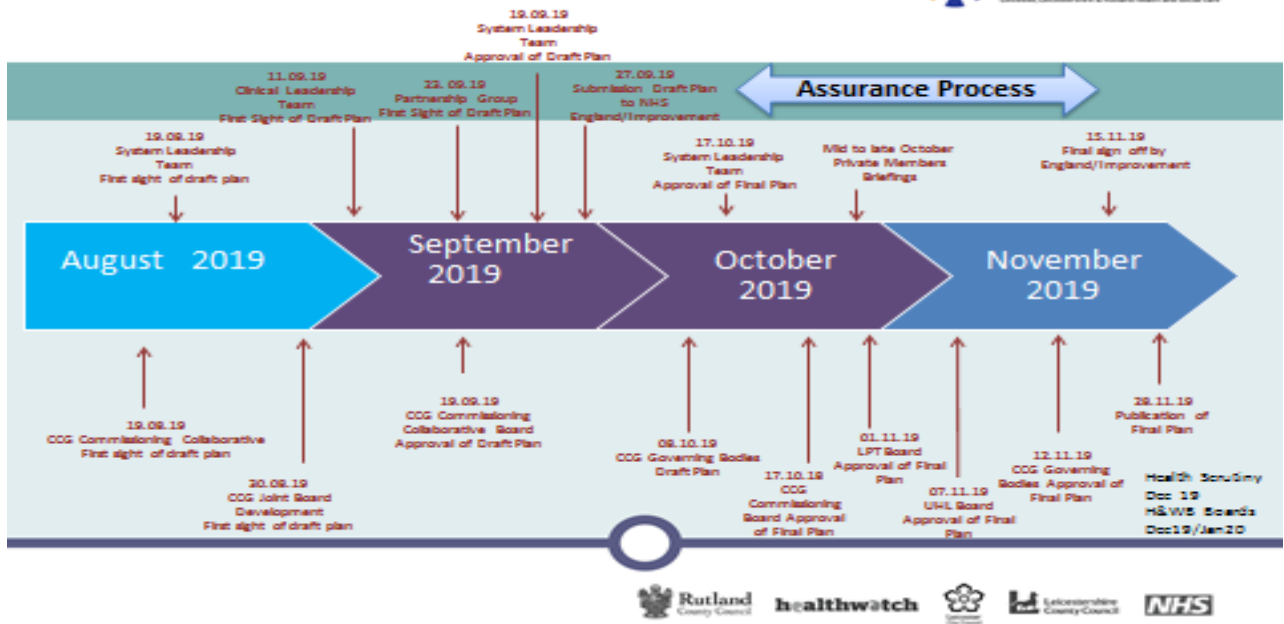
Mental health	Children’s and maternity	Medicines management
Learning disabilities	Primary care	Cancer
Planned care	Urgent and emergency care	Integrated community services
Prevention		

Enabling groups: the purpose of these groups is to drive forward the required improvements in estates, workforce and IM&T, together with providing communication and engagement support to the Better Care Together partnership.

Approval Process

The following diagram details the approval process for Our Long Term Plan

LLR NHS - Long Term Plan Sign Off



Appendix 1 – Headline Metrics

To support the delivery of the NHS Long Term Plan (LTP), a number of headline metrics have been produced to ensure the key commitments within the plan are delivered. These measures (unlike the core thirty Long Term Plan metrics) are not in all instances numerical and are instead transformational in nature. The table below identifies the key headline metrics and which chapter as well as page within the Leicester, Leicestershire and Rutland five year plan that these are addressed:-

NHS Long Term Plan Focus	LLR Five Year Plan Headline Metric	LLR Long Term Plan Chapter
A new service model for the 21st century	Primary and community services (extra £4.5 billion): annual implementation milestones for 5-year GP contract – more detail to be agreed: new community services response times and teams.	Chapter 2: A new service model for the 21st century
A new service model for the 21st century	Comprehensive ICS coverage including a partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate – local authorities, the voluntary and community sector and other partners.	Chapter 1: Moving to an LLR Integrated Care System
A new service model for the 21st century	Emergency care: on agreed trajectory for Same Day Emergency Care (SDEC) and Integrated Urgent Care Services (IUCS).	Chapter 2: A new service model for the 21st century
More NHS action on prevention and health inequalities	Prevention (1): increase uptake of screening and immunisation.	Chapter 2: A new service model for the 21 st century
More NHS action on prevention and health inequalities	Inequalities: inequalities reduction trajectory.	Chapter 2: Moving to an LLR Integrated Care System

NHS Long Term Plan Focus	LLR Five Year Plan Headline Metric	LLR Long Term Plan Chapter
More NHS action on prevention and health inequalities	Prevention (2): alcohol care teams, tobacco treatment services, and diabetes prevention programme.	Chapter 2: Moving to an LLR Integrated Care System
Further progress on care quality, access and outcomes	Maternal and children’s health: on agreed trajectory for 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025.	Chapter 3: Delivering further progress on care quality and outcomes
Further progress on care quality, access and outcomes	Improve cancer survival: Improve one and five-year cancer survival; on agreed trajectory so that 75% of cancer patients diagnosed at stage 1 or 2 by 2028.	Chapter 3: Delivering further progress on care quality and outcomes
Further progress on care quality, access and outcomes	Learning disability and autism: on agreed trajectory for halving inpatient rate by 2023/24 and increasing learning disability physical health checks to 75% of people aged over 14.	Chapter 3: Delivering further progress on care quality and outcomes
Further progress on care quality, access and outcomes	Mental health: on track for locally agreed service expansion, and increase in investment for mental health services as a share of the NHS budget over the next five years, worth in real terms at least a further £2.3 billion a year by 2023/24.	Chapter 3: Delivering further progress on care quality and outcomes
Further progress on care quality, access and outcomes	Implementation of agreed waiting times/clinical standards for urgent and emergency care, elective care, cancer and mental health, from April 2020, and the maintenance and improvement of performance for cancer treatment and A&E until that point.	Chapter 2 and 3: Delivering further progress on care quality and outcomes

NHS Long Term Plan Focus	LLR Five Year Plan Headline Metric	LLR Long Term Plan Chapter
NHS staff will get the backing they need	<p>Workforce metrics will be agreed through development of the NHS People Plan but will include:</p> <ul style="list-style-type: none"> ➤ Staff retention: retention rate to improve by at least 2% ➤ Leadership: CQC well led indicator, and staff engagement indicator ➤ Diversity/inclusion: BME representation, gender, bullying/harassment 	Chapter 5- Enablers, Workforce
Digitally enabled care will go mainstream across the NHS	Outpatient reform: 30% reduction trajectory, outpatient digital role out.	Chapter 3 & Chapter 6- Enablers, Digital
Digitally enabled care will go mainstream across the NHS	Empowering people: Summary care record roll out.	Chapter 5: Workforce, Engagement, Estates, Digital
Digitally enabled care will go mainstream across the NHS	Access to online/telephone consultations in primary care.	Chapter 5: Workforce, Engagement, Estates, Digital
Taxpayers' investment will be used to maximum effect	<p>Test 1: The NHS will return to financial balance:</p> <ul style="list-style-type: none"> ➤ proportion of NHS organisations in financial balance. 	Chapter 4: Finance, Capital and Activity

NHS Long Term Plan Focus	LLR Five Year Plan Headline Metric	LLR Long Term Plan Chapter
Taxpayers' investment will be used to maximum effect	Test 2: The NHS will achieve cash-releasing productivity growth of at least 1.1% per year NHS Long Term Plan Implementation Framework: <ul style="list-style-type: none"> ➤ Annual cash releasing productivity growth of at least 1.1%. 	Chapter 4: Finance, Capital and Activity
Taxpayers' investment will be used to maximum effect	Test 3: The NHS will reduce growth in demand for care through better integration and prevention: <ul style="list-style-type: none"> ➤ With population health management delivering demand growth moderation in line with LTP activity model. 	Chapter 4: Finance, Capital and Activity
Taxpayers' investment will be used to maximum effect	Test 4: The NHS will reduce variation in performance across the health system: <ul style="list-style-type: none"> ➤ GIRFT/Right Care metric to be confirmed. 	Chapter 4: Finance, Capital and Activity
Taxpayers' investment will be used to maximum effect	Test 5: The NHS will make better use of capital investment and its existing assets to drive transformation: <ul style="list-style-type: none"> ➤ Metrics to support this test will be confirmed following the Spending Review and development of the new NHS capital regime. 	Chapter 4: Finance, Capital and Activity

Appendix 2 – Long Term Plan Metrics

To support the delivery of the commitments within the NHS Long Term Plan (LTP), 30 metrics have been released. These metrics are comprised of:-

- Ten system wide measures
- Twelve Clinical Commissioning Group (CCG) only measures
- Four acute/community care provider measures
- One Transforming Care Programme (TCP) measures
- Three Local Maternity Systems (LMS) measures

These metrics cover the period between 2019 through to 2024 with each individual metric having different yearly requirements. The Leicester, Leicestershire and Rutland (LLR) health economy response to these measures has been submitted in a template titled the LTP Collection tool. This appendix provides a summarised version of the Leicester, Leicestershire and Rutland LTP Collection tool. The table below provides an overview of the detail outlined within this Appendix.

COLUMN	DETAIL
Metric Category	Which NHS Long Term Plan category does this metric belong to (System input, CCG input, Provider input, TCP input, Local Maternity System Input).
Metric	Details about the actual metric in question.
National Target	Details regarding any national target associated with this metric (on occasion broken down by year).
Approach & Assumptions Made	Outlines the assumptions made when completing the Leicester, Leicestershire and Rutland response to the NHS Long Term Plan measures. There are a number of measures with no central details provided and in the absence of this, local Business Intelligence Leads have utilised local assumptions.

National target showing as being achieved?	Outlines whether or not the target/requirements within a measure are showing as being met across the Long Term Plan
LLR Risk	Details the risks associated with meeting the level of performance.

There are a number of metrics that the Leicester, Leicestershire and Rutland health economy will have to make substantial service re-design and performance improvement to achieve. These measures have been categorised as at risk of non-delivery:-

- *System Input EA3, IAPT roll-out*- The NHS Long Term Plan IAPT access requirement is substantially above the existing levels of Leicester, Leicestershire and Rutland 2019/20 performance. It is anticipated that a range of interventions including service re-design process will be required to improve performance.
- *System Input E13, People with severe mental illness receiving a full annual physical health check and follow up intervention*- The NHS Long Term Plan physical health check completion requirement is substantially above existing levels of Leicester, Leicestershire and Rutland 2019/20 performance. It is anticipated that a range of full system communications and service re-design will be required to improve performance.
- *CCG & TCP input EK1- Reliance on inpatient care for people with a learning disability and/or autism- CCG Commissioned - and Spec Comm Commissioned Adults & Children* - At present, Leicester, Leicestershire and Rutland are not on track to meet the 2019/20 performance trajectory. A range of supported accommodation developments and community service transformation will be undertaken to improve performance on this trajectory.
- *CCG Input EK3- Learning disability registers and annual health checks delivered by GPs*- Historically the Leicester, Leicestershire and Rutland health economy has struggled to achieve the targets associated with this measure. Steps such as the introduction of specialist nurses within primary care to train and support General Practitioners to improve the identification and delivery rates for those will require an annual health check will improve performance.
- *Provider EH12- Inappropriate adult mental health Out Of Area Placement (OAP) bed days*- All partners within the Leicester, Leicestershire and Rutland health economy are currently working as a system to address the challenges which result in a failure to meet this performance target (such as reduce delays to hospital discharge).

A number of the Long Term Plan metrics contain national targets and require the Leicester, Leicestershire and Rutland health economy to achieve its proportion of this national target. Where this is the case, an assumption has been made regarding the LLR target being based on its proportion of the national population (5 instances). These include:

- System Input EA3- IAPT roll-out.
- System Input EH13-People with severe mental illness receiving a full annual physical health check and follow up interventions.
- System Input EH19-Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illness.
- CCG Input EH9-Improve access to Children and Young People’s Mental Health Services (CYPMH).
- CCG Input EH15-Perinatal Mental Health: Number of women accessing specialist perinatal mental health service.

Metric Category	Metric	National target (taken from Technical Guidance v1.1)	National target showing as being achieved?
System Input EA3	IAPT roll-out	By 2019/20 1.3m adults and older adults accessing treatment. 2020/21 1.5m 2021/22 1.6m 2022/23 1.8m 2023/24 1.9m	Yes - based on share of national target only (20/21 - 23/24)
System Input EH13	People with severe mental illness receiving a full annual physical health check and follow up interventions	By 19/20 a total of 280,000 people receiving physical health checks. 2020/21 280,000 2021/22 302,000 2022/23 346,000 2023/24 390,000 This equates to a target of 60% of people on the SMI register receiving a full and comprehensive physical health checks	Yes - based on share of national target only and 60% achievement

Metric Category	Metric	National target (taken from Technical Guidance v1.1)	National target showing as being achieved?
System Input EH17	Number of people accessing Individual Placement and Support (IPS) (Employment support to people with severe mental health conditions)	By 19/20 16,000 total people accessing IPS 2020/21 20,000 2021/22 32,000 2022/23 44,000 2023/24 55,000	Yes - based on target agreed with NHSE for 19/20- 20/21.
System Input EH19	Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illness	2019/20 to and 2020/21 early adopter sites are required to provide trajectories and report activity as part of the transformation funding assurance process. In 2021/22 at least 370,000 adults and older adults with SMI receiving care from integrated primary and community mental health services 2022/23 257,000 2023/24 370,000	Yes - based on share of national target (from 21/22 onwards)
System Input EM24	Delayed Transfers of Care	The goal over the next two years is to achieve and maintain an average Delayed Transfer of Care (DTC) figure of 4,000 delays per day, and to reduce further over the remainder of the planning period.	Yes - based on maintain performance from 18/19
System Input EN3	Personalised Care and Support Planning	Achievable target of 750,000 personalised care and support plans developed by 2023/24	Yes - based on NHSE requirement

Metric Category	Metric	National target (taken from Technical Guidance v1.1)	National target showing as being achieved?
System Input EQ4	Brain Injury Rate	Achievement of the national ambition of a 50% reduction by 2025 will require the rate to reduce by approximately 6% of the 2017 rate per year.	Yes - based on 6% reduction each year
System Input ER4	Number of people supported through the NHS Diabetes Prevention programme	This work is still ongoing so 5-year projections have not been provided.	Target unknown
System Input ES1	Proportion of patients directly admitted to a stroke unit within 4 hours of clock start	By 2019/20 61% of patients directly admitted to a stroke unit within 4hrs of clock start 2020/21 63% 2021/22 67% 2022/23 73% 2023/24 80%	Yes
System Input ES2	Percentage of applicable stroke patients who are assessed at 6 months	By 2019/20 50% of applicable stroke patients assessed at 6months 2020/21 55% 2021/22 60% 2022/23 >60% 2023/24 >60%	Yes

Metric Category	Metric	National target (taken from Technical Guidance v1.1)	National target showing as being achieved?
CCG Input ED16	Proportion of the population with access to online consultations	March 2020, 75% of practices are offering online consultations to their patients.	Yes
CCG Input ED20	Citizen facing tools: Proportion of the population registered to use NHSApp	We expect that local areas will make available patient facing tools to at least 30% of their eligible population over the period of the long term plan	Yes - 30% by 2023/24
CCG Input ED21	Cyber Security	By Summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.	Yes
CCG Input EH9	Improve access to Children and Young People's Mental Health Services (CYPMH)	In 19/20 63,000 additional CYP aged under 18 accessing NHS-funded services 2020/21 70,000 additional 2021/22 70,000 additional 2022/23 70,000 additional 2023/24 70,000 additional	Yes - based share of national target only

Metric Category	Metric	National target (taken from Technical Guidance v1.1)	National target showing as being achieved?
CCG Input EH15	Perinatal Mental Health: Number of women accessing specialist perinatal mental health service	By 2019/20 at least 32,000 women will have access to evidence-based specialist perinatal mental health care (rate of >4.5) 2020/21 47,000 (rate 7.1) 2021/22 57,000 (rate 8.6) 2022/23 66,000 (rate 10) 2023/24 66,000 (rate 10)	Yes - based share of national target only
CCG Input EH18	EIP Services achieving Level 3 NICE concordance	EIP Services achieving Level 3 NICE concordance (Number of EIP services graded at level 3 or above in the reporting period.)	Yes
CCG Input EH20	Coverage of 24/7 crisis provision for children and young people (CYP) that combine crisis assessment, brief response and intensive home treatment functions.	2023/24 100% coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions. Reported level of CCG progress towards fully comprehensive CYP crisis service provision	Yes
CCG Input EK1	Reliance on inpatient care for people with a learning disability and/or autism - adults - CCG Commissioned	By 2023/24, each CCG is expected to require inpatient capacity for no more than 30 adult inpatients in CCG-commissioned or NHS England-commissioned beds per million adult population (aged 18 and over).	Yes

Metric Category	Metric	National target (taken from Technical Guidance v1.1)	National target showing as being achieved?
CCG Input EK1	Reliance on inpatient care for people with a learning disability and/or autism - adults - Spec Com commissioned		
CCG Input EK3	Learning Disability Registers and Annual Health Checks delivered by GPs	The National target is by the end of 2023/24, 75% of people on the Learning Disability Register will have had an Annual Health Check. There is also a national ambition for the Learning Disability Register to have year-on-year growth.	Yes
CCG Input EN1	Personal Health Budgets	200,000 Personal Health Budgets by March 2024.	Yes
CCG Input EN2	Social Prescribing Referrals & Workforce	over 1,000 trained social prescribing link workers will be in place by the end of 2020/21, rising further by 2023/24, with the aim that over 900,000 people are able to be referred to a social prescribing scheme.	Yes

Metric Category	Metric	National target (taken from Technical Guidance v1.1)	National target showing as being achieved?
Provider Input ED21	Cyber Security	By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.	Yes
Provider Input EH12	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	2020/21 Eliminate inappropriate adult acute OAPs (LPT only)	Yes
Provider Input EH16	Mental Health Liaison services within general hospitals meeting the “core 24” service standard	20/21 100% STP coverage of Liaison Mental Health teams meeting the needs of all ages and 2023/24 70% of Liaison Mental Health Teams achieving ‘core 24’ standard (Number of general hospitals with a type 1 A&E department)	Yes
Provider Input EM23	Ambulance Conveyance to ED Ambulance Provider only	A reduction in the volume of incidents conveyed to ED and an associated increase in hear and treat, see and treat and conveyance to non-ED settings.	N/A
Provider Input EM25	Length of stay for patients in hospital for over 21 days	Reduction in number of patients in a hospital bed for 21 days or more. National and regional reduction of 40% in 2019/20. We will continue to reduce Length of Stay for patients in hospital 21 days and over for the following years.	Yes

Metric Category	Metric	National target (taken from Technical Guidance v1.1)	National target showing as being achieved?
Cancer Alliance Input	N/A for LLR	N/A	N/A
TCP Input EK1	Reliance on inpatient care for people with a learning disability and/or autism - for both care commissioned by CCGs and NHS England for children	By 2023/24, each TCP is expected to require inpatient capacity for no more than 12-15 under 18 inpatients in NHS England-commissioned beds per million under 18 population.	Yes
LMS Input EQ1	Stillbirth rate	A reduction of almost 5% of the 2016 baseline rate is required each year to achieve the 2025 national ambition	Yes
LMS Input EQ2	Neonatal mortality rate	A reduction of over 5% of the baseline rate is required each year to achieve the 2025 national ambition	Yes
LMS Input EQ3	Percentage of women placed on a continuity of care pathway at booking appointment	The baseline position as submitted for assurance of the 2018/19 planning guidance deliverable for 20% of women to be placed onto continuity of carer pathway The need for the <u>majority</u> (majority at 51%) of women to receive continuity of the person caring for them during pregnancy, birth and postnatally by March 2021	Yes

