Section 7.3.6 Inpatient activity model

Section 1: Introduction

The mantra for reconfiguration and particularly for right sizing the hospitals is that we should be 'big enough to cope but no bigger than necessary'. Of course 'big enough' is largely determined by activity and the models of care managing that activity.

Section 2: The revised bed requirement

Taking into account what we have learnt over the last 18 months from the original PCBC to this final version and recognising our new opening bed position, the projected bed requirement is 2,333 beds by 2023/4. This is the unmitigated number i.e. without efficiencies factored in.

In calculating this we took the following into account:

- Opening bed position as of winter 2019 is **2,033** beds.
- Activity growth assumptions have increased from **1.4% to 3%** in line with those contained in the LLR system Long Term Plan. Emergency activity across the UK has grown between 2% and 6%, with the majority of peer Trusts showing a growth rate of c4%. Whilst UHL has noted year on year growth rates of between 4-5% in the first 2 quarters of 19/20, this includes significant pathway changes which have influenced the growth rate. To mitigate against the impact of these pathway changes UHL has modelled and applied a growth rate of 3%. This growth rate is also higher than most of our regional peers have included in their plans.
- Occupancy levels of **93%** for electives, 93% day case and **90%** emergency which will allow more flexibility to improve flow. Noting that the BMA review of the busiest months over winter 2017/2018 suggested that an 85% non-elective occupancy level is unachievable, (British Medical Association, "Beds in the NHS" 2018), we have applied a more realistic occupancy rate of 90% for emergency. Our efficiency plans are targeted to improve flow to enable us to reduce our non-elective occupancy rate.

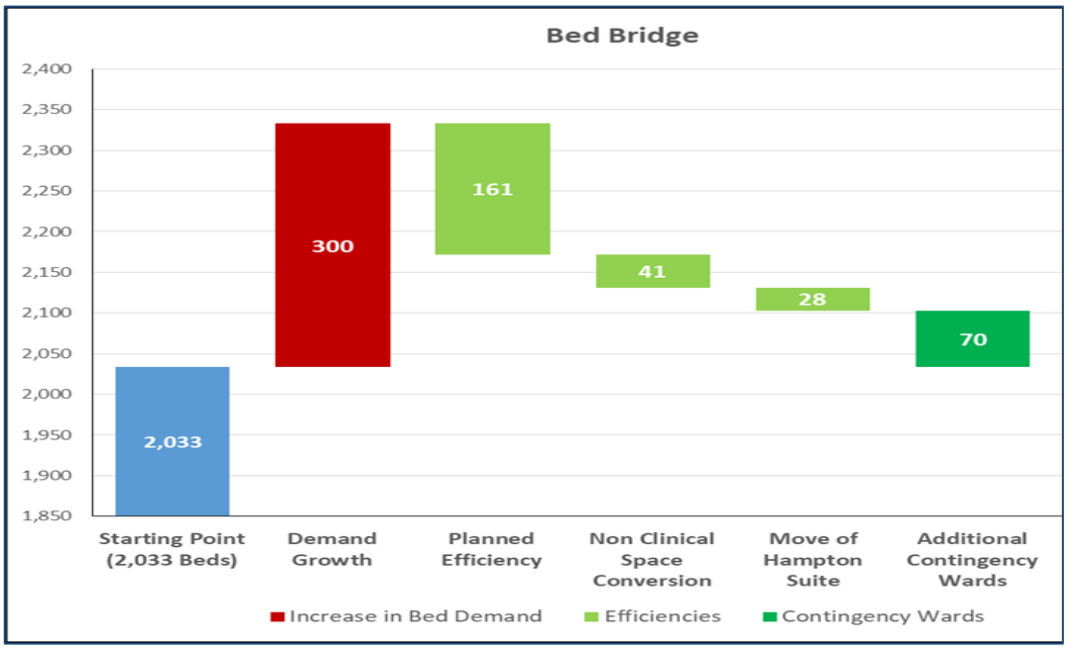
The impact of this change in occupancy levels and growth assumptions means the unmitigated **bed gap is 300** beds at its highest during peak winter months in 2023/4. Conversely during summer months the bed gap reduces significantly.

Bridging the gap

To bridge the gap we have two types of intervention; the first is designed to increase actual physical bed capacity above the current baseline of 2,033 whilst the second will reduce the number of beds required through improvements to clinical pathways and changes to length of stay, (LoS).

As a result, over the life of this plan we will both increase the actual bed stock by 139 beds (approx. 4 wards) and decrease the requirement for beds by a minimum of 161 through pathway and LoS improvements. Taken together these interventions bridge the gap.

The table below and subsequent narrative explains this in more detail.



Planned efficiencies

As shown above, we have applied a series of mitigations, including assumptions around LoS & admission avoidance to the likely bed requirement in 2023/24. The work underpinning this looked at changes to individual clinical pathways, approaches to population health management, particularly in frail and multi-morbid patients and internal efficiencies impacting LoS. Taken together this produces a potential efficiency range of **161-237** beds.

The underpinning modelling for each of these schemes takes into account benchmarked data from GIRFT, NHS RightCare, Model hospital and other relevant national and international benchmarks, including a range of population health management tools from the John Hopkins Adjusted Clinical Groups system. The opportunity improvement in our frailty and multi-morbidity programme has been derived using these data sets, overlaid with evidence from various NHS Right Care case studies.

It is important to recognise that for planning purposes we have deliberately taken a conservative approach to the modelling and used the minimum efficiency expectation to define our future bed requirements. In other words if we over achieve against what GIRFT / Model Hospital and our own internal assumptions indicate, there is potential for a beds upside and or reductions in occupancy.

The high level breakdown of efficiencies is shown in the table below. The detail scheme by scheme is set out in appendix below.

Scheme	Bed reduction range 2023/24	Evidence base
Optimal management of frail and multi-morbid patient cohort	57 to 67	▪ Local evidence of delivery ▪ NHS Right Care case study/STP pack ▪ GIRFT data
Optimal length of stay through implementation of Safe and Timely Discharge processes	28 to 51	▪ CHKS benchmarking data ▪ GIRFT data
Optimal BADS pathway	14 to 20	▪ British Association of Day Surgery guidelines
Specialty specific schemes	62 to 99	▪ GIRFT data ▪ NHS Right Care data
Total	**161 to 237**	

Increase in physical beds

As well as efficiency / pathway improvements we have chosen to create more *physical* bed capacity within the revised plan as an insurance policy should it be the case that either the necessary clinical transformation does not happen or that future demand is above the 3% per annum value.

There are three elements to this depicted in the Bed Bridge above.

Conversion of non-clinical space: There are areas, particularly at the Royal Infirmary, where clinical space has been converted into non-clinical space. As such there is an opportunity to reverse that and in doing so create extra bed capacity. The estimate is that this could release the space for the creation of **41 more beds.**

Transfer of services: The Royal Infirmary is home to the 'Hampton Suite', a therapy led reablement ward. Given the nature of the patient cohort, this service could be equally successful if based at the General Hospital. The move would free up **28 acute beds.**

Additional contingency: Taken together the conservative efficiency improvements and the increase in physical beds amounts to 230 beds worth of capacity over and above the 2019 opening position of 2,033 beds. This leaves a potential residual gap **of 70 beds** if, for example, efficiency improvements are actually at the lowest calculated and / or activity growth is greater than 3%. As such the Trust will, if necessary, address this in later years through CRL funding for what equates to 2.5 wards.

Summary of bed model:

The variables impacting the future bed requirements for an acute Trust are numerous. Equally, for a Trust of the size of Leicester even the smallest change to activity / efficiency projections makes a significant difference to bed requirements. For example a half day improvement in length of stay releases 38 beds worth of capacity. Conversely a 1% increase in activity would result in the need for 76 more beds. (For more detail on the upside and downside scenarios see appendix).

That said we are confident that the current model aligns with the direction of the NHS Long Term Plan, insomuch as there are no heroic assumptions over bed reductions; a conservative approach to efficiencies and a pragmatic approach to the creation of extra capacity.

Outpatient activity model

Section 1: Introduction

An outpatient model has been developed which demonstrates the impact of improvements in the delivery of outpatients, alongside expected growth in demand for the period from 2018/19 to 2023/24. The model only focusses on those outpatient specialities that will move as a consequence of site and service reconfiguration. The activity figures presented within the model therefore do not reflect UHL's total future outpatient requirements or our total system ambition to reduce outpatient activity by a third as per the guidance in the NHS Long Term Plan, released since the original version of this plan was written. Further work is ongoing, both internally and across the wider LLR system to ascertain the implications of this mandate, with all specialty level models of care being aligned to this principle.

The outputs from the model have been used to inform future clinic space requirements for the planned Treatment Centre and maternity services. As with inpatient activity and the bed model, the modelling shows that without fundamental changes to the Models of Care, internal efficiency and system wide pathways, outpatient demand will be above what is affordable to the local health economy and sustainable for the UHL in terms of capital funding and staffing.

In completing the model a number of system wide transformation and internal efficiency opportunities have been considered, taking into consideration the aspirations and planning assumptions of the BCT planned care programme. The focus for this area of work is to shift to a transformative approach focussed on eliminating waste through improved use of funded capacity/sessions coupled with the drive to improve system funded capacity. This will also feature a move of activity to a lower cost setting and the implementation of new models of provision, with the predominant use of UHL capacity for complex cases that require secondary care.

Section 2: Outpatient modelling 2018/19 to 2023/24

Consideration of growth

Between the writing of the previous PCBC and this updated version, the NHS Long Term Plan has been released outlining a mandate to reduce outpatient activity by a third; and the LLR Planned Care Workstream has implemented various schemes, successfully managing demand in certain specialties. The implication of these two factors has been taken into account and unmitigated growth levels have therefore been agreed with LLR commissioners.

These differ from the growth assumptions in the previous PCBC of a flat 2% growth rate plus some specialty specific growth; the resultant model shows projected unmitigated demand to grow as follows:

Point of Delivery	Baseline activity for specialties within reconfiguration 18/19	Unmitigated activity levels 2023/24 (original PCBC)	Unmitigated activity levels inc speciality growth 2023/24 (original PCBC)	Revised growth levels agreed	Unmitigated activity level in 2023/24 (refreshed)
New Outpatients	138,302	142,937	147,565	0.5%	141,794
Follow ups	311,166	325,472	332,520	1.4%	333,565
Outpatient procedures	102,055	95,326	97,707	9.8%	162,871
Non face to face	47,618	51,687	54,972	0.7%	49,395
Total	**599,141**	**615,422**	**632,764**		**687,625**

The outpatient model starts from the baseline outturn for 2018/19 of 599,141 total outpatient attendances at UHL for the specialties involved in reconfiguration. Taking into account growth levels over the five year period, the modelling shows that demand for outpatient attendances (including face to face and non-face to face activity) will increase to 687,625 attendances.

The original projected growth showed in earlier versions of the PCBC identified a maximum number of outpatient attendances as 615,422; this was the activity scheduled for the Treatment Centre and maternity hospital, and is therefore reflected in the capital plan. As our plans develop over the next year, we expect that this number will reduce by a third as per planning parameters in the NHS Long Term Plan. This would reduce the projected number of outpatient appointments to 507,882; at this stage, our plans for this reduction are in being tested with revised system-wide clinical models of care under design.

We will adjust the capacity of the centre and reflect this in our capital assumptions as our

clinical plans for this reduction become clearer.

Section 3 – Transformation of planned care services

Recognising that the unmitigated growth is both unsustainable and does not enable the Trust to reduce activity by a third as per the Long Term Plan, the next section explores our transformation plans in more detail.

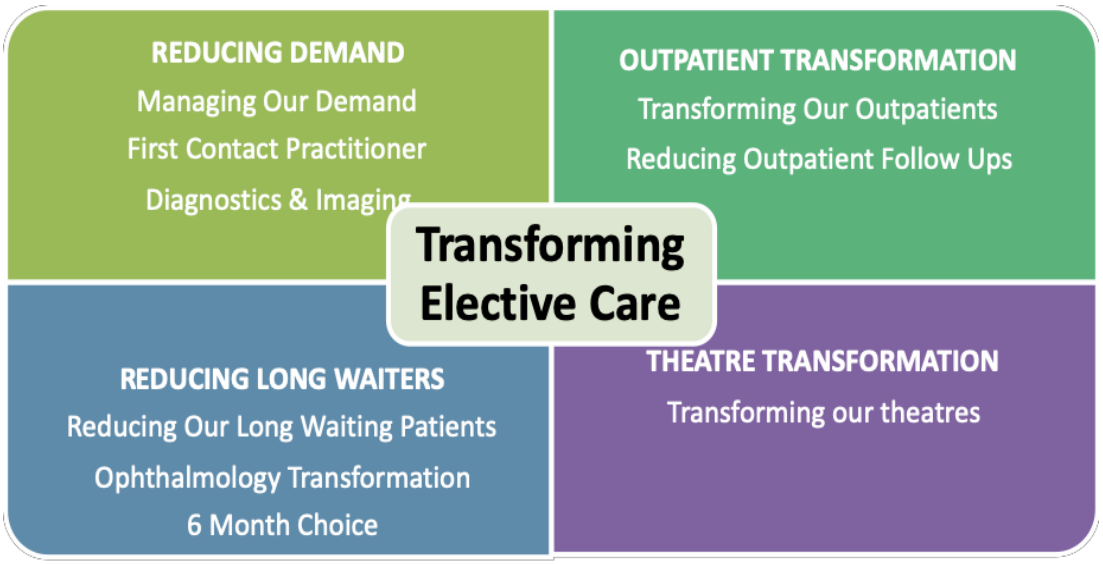
Efficiency schemes in place

Section 7.3 outlines the process undertaken in the development of revised Models of Care, which fall into models supporting transformation across LLR, and those internal to UHL. The outcome from this work has been the establishment of a number of schemes which will support the mitigation of future outpatient demand and ensure that the right patients are seen within UHL.

LLR wide schemes (incorporating UHL internal work on models of care)

UHL is an active partner in delivering the BCT Planned Care Programme supporting 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 where possible in local community settings or virtually.

The diagram below highlights the strategic aims of the LLR Planned Care programme:



1. **Reducing demand**

Work by the BCT Planned Care Board is aimed at reducing the demand, over the next 3 years, in GP initiated new outpatient and referral activity by 20% (over 31 specialities). A number of initial best practice schemes have been implemented during 19/20:

***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.

Delivering the new MSK physiotherapy model: bringing together the existing teams from UHL and LPT. The model incorporates:

- Patient self-referral.
- Telephone triage within two working days via a virtual hub.
- Telephone management, where appropriate, including patient information, exercises, guidance towards websites which demonstrate exercises they need to do. This is followed up by a further phone call to support the patient. Patients are either discharged at the point or referred on for a face-to-face appointment.
- Face to face physiotherapy access as part of this scheme is ensuring that all localities have local physiotherapy based in community / practice buildings.

Another initiative supports the management of demand for ophthalmology services which is not being met and continues to grow. New patients are often prioritised and this can result in delays for patients who require follow up and for some of these patients this could lead to adverse outcomes e.g. visual loss and blindness. In 2018/19 NHS England launched a series of high impact interventions within ophthalmology to minimise the risk of harm to patients. UHL in conjunction with partners across LLR have responded by developing a system-wide plan to improve ophthalmology services.

2. Reducing long waiters

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)
- 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.

3. Outpatient transformation

UHL is implementing a significant programme of transformation in order to ensure these efficiency schemes are delivered which has informed the future size and design of the Treatment Centre at GH. The co-location of services, coupled with the use of technology to support patient care and information sharing in a paperless environment will be a significant enabler of these initiatives.

The vision for outpatient transformation is:

"As a system wide approach to our outpatient Transformation programme 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."

Through the development of their future Models of Care, services have focussed on changes and improvements in pathways that deliver benefits for their patients. There are a number of speciality specific schemes which will deliver clear improvements in outpatient productivity, these are summarised below together with the impact on reducing outpatient activity or delivering care in a different way or alternative setting.

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

Through this we have focussed on:

- Increasing the use of specialist advice and guidance across all elective specialties
- Implementing a joint musculoskeletal physiotherapy service
- Embedding and managing the 102 low value treatments
- Progressing the roll out of 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 one of the largest elective transformation programmes and supported the process of directing referrals to the most appropriate location. The Referral Support Service is delivered by clinicians and nurses and has been implemented in five specialties during 2018/19. Over the next five years there are plans to expand its coverage to all routine elective specialties. Other ways in which activity is being moved 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
- Ensuring a rolling process of updating the Specialty Directory of Service to reduce inappropriate referrals into UHL
- Supporting the use of PRISM to reduce inappropriate referrals into UHL
- Increasing the uptake of GP advice and guidance, leading to increased learning and reduced need for referral
- Working with system partners to reduce outpatient follow-up rates (by more than the required level in the Long Term Plan) moving to alternatives such as non-face-to-face or patient initiated follow up appointments,
- Maintaining the integrity of two-way text reminders to improve both clinic utilisation and reduce non attendances (DNA rates).

Successful implementation of demand management will lead to a corresponding reduction in follow up activity. Further opportunities for follow up reductions will continue to be specified as our transformation work activities become focussed on delivery of a new system wide model of care for outpatients.

A transformed model of care for frail and multi-morbid patients

It has long been acknowledged that 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 2019/20 to 2023/24 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.

Impact of efficiency schemes

The impact of these schemes has been modelled using the evidence base from benchmarking data, local analysis and projecting activity levels for future models of care from the NHS E/I 'elective care transformation programme'.

Modelling suggests that the following impact can be achieved:

Scheme	LLR/UHL	Description	Activity reduction/Impact
Demand management	LLR	20% Reduction in new and follow up attendances	119,828
Implementation of system wide pathway review	LLR	Shift activity to alternative settings	
Specialty specific plans in place			
Follow up reduction	UHL	Cessation of unnecessary Follow Ups Shift to virtual or patient initiated follow up appointments wherever appropriate	7,589
Non-attendance rates	UHL	Target reduction of rates to 5 % or below	8,294
Clinic utilisation & optimisation	UHL	Improve in session utilisation. Achieve 95% resource/capacity utilisation Delivery of single visit/one stop clinics as a consequence if improved clinical adjacencies	8,233
Move to Non Face to Face	UHL	Percentage of ASA1 and ASA2 patients seen non-face-to-face	-736*
Other (Pathway Redesign)	UHL	Change in pathway to deflect at admission to a more appropriate setting than the Trust	3,425
UHL total			26,805
Programme total			146,633
GAP to target demand (inclusive of 30% reduction)			33,110

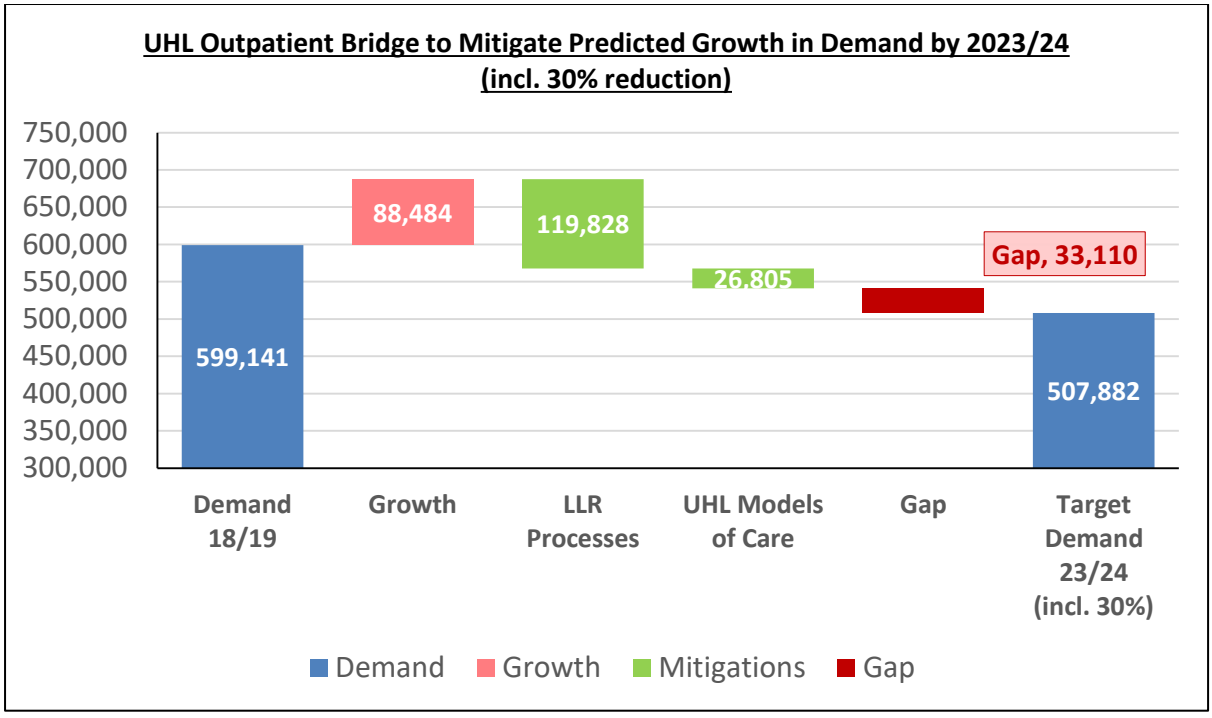
The current schedule of accommodation for the Treatment centre plans for an activity level of 615,422 attendances as per the original modelling. The unmitigated activity level projections show a requirement of 687,625 attendances, a gap of 72,203 attendances. However, we anticipate that our joint UHL-LLR programmes of work will deliver a reduction of 146,633 attendances, covering this gap.

Our plans do not however, fully mitigate the gap between the projected demand in 23/24 when taking into account a full 30% reduction. This projects an anticipated demand level of 507,882 attendances, leaving a gap of 33,110 attendances. Plans to mitigate against this will be part of the global LLR outpatient transformation programme, focussed on specialties out with the reconfiguration programme.

Section 5: Summary outpatient model

As work is in the early stages of development the impact of LLR wide schemes is not yet modelled fully. Capacity will be challenged through the business case process to ensure that the facilities are 'right sized'. Using the growth levels agreed with commissioners at this stage to provide indicative capital costs is therefore seen as a worst case scenario.

At this stage, the outpatient bridge is as follows:



Appendix

Mitigating growth in activity and beds

Efficiency schemes are constantly being identified and implemented and therefore the identified schemes presented are at a point in time. Some schemes will over deliver and some under deliver therefore our modelling has been based on both best and worst case scenarios. This section outlines efficiency schemes both internal to the Trust and system wide schemes.

LLR wide schemes

Optimising pathways for frail and multi-morbid patients

Details of the LLR frailty and multi-morbidity programme are set out in Sections 3.3.1 and 7.2 which describe the Models of Care/transformation proposed as part of the BCTP. The majority of the demand management schemes in place across LLR also focus on ensuring that the holistic care this cohort of vulnerable patients receives is optimised, reducing the need for admission to acute beds. The totality of the frailty and multi-morbidity programme over the 5 year period is expected to prevent 4,300 spells, mitigating the growth by between 57 and 67 acute beds, predominantly in medicine and cardio-respiratory specialties. The programme draws upon benchmarks from local tests of delivery in Leicester City CCG, NICE guidelines and best practice as identified by the NHS Right Care STP pack and frailty case study, British Geriatrics Society and Same day emergency care network.

Further work is being undertaken to explore additional schemes to expand and change care provision in the community setting in order to further prevent admissions and avoid readmissions to UHL.

Table 7.7: Frailty and multi-morbidity programme bed reduction range

Scheme	Bed reduction range 2023/24
Frailty and Multi-morbidity programme	57 to 67

Optimal length of stay through implementation of Safe and Timely Discharge processes

A key Quality priority for the Trust over the next 3 years is to implement safe and timely discharge for all patients in our care, seven days a week, by embedding safer discharge processes and eliminating avoidable delays.

On the whole, nobody would want to stay in hospital a moment longer than is absolutely necessary. For many patients a delay to their discharge is not just

frustrating and inconvenient, it is actually detrimental to their health and independence. We discharge between 150 and 300 patients a day and though most of those patients will have a good experience of the discharge process, a significant minority will not.

Medications To Take Out (TTOs) are often not written up early enough, the discharge summaries which explain to GPs what has happened to a patient and what needs to happen next are sometimes of poor quality, and the process can take so long that the patient who was expecting to go home or to a care home has to be put back into one of our beds for another night.

Recognising that discharges are increasingly complex because our patients are increasingly complex, we know that this is as much an issue for the system to resolve as it is the Trust.
Nonetheless, we must make sure that our end of the process is better managed, so amongst other improvements we will expect that all patients admitted to hospital will have an Expected Date of Discharge set the day they are admitted.

Although the maximum opportunity is 51 beds, the opportunity varies throughout the year with a decreased opportunity over the winter months when bed occupancy is at its highest. The clinical services have been fully engaged in developing this programme of work and the associated efficiency targets.

The number of beds delivered has been reviewed and confirmed by the services.

Table 7.8: Optimal length of stay bed reduction range

Scheme	Bed reduction range 2023/24
Optimal length of stay through implementation of safe and timely discharge processes	28 to 51

Trust wide schemes

British Association of Day Surgery guidelines

The provision of a dedicated day case / 23 hour stay facility within the Treatment Centre, coupled with a new Gynaecology unit, will enable the delivery of a modernised day case Model of Care in Gynaecology, Urology, General Surgery and Paediatric Surgery including compliance with British Association of Day Surgery (BADS) guidelines. Through the establishment of a true day case (23 hour stay 6 days a week) model in the Treatment Centre between 14 and 20 beds would be released.

Table 7.9: BADS guideline bed reduction range

Scheme	Bed reduction range 2023/24
Optimal BADS pathway	14 to 20

Speciality specific schemes

Through Model of Care redesign, services have focussed on changes and improvements in pathway that deliver benefits for their patients. Each CMG was asked to identify efficiency schemes from within their CMG and discuss these with the clinical team to ensure that they were realistic, owned by the clinical team and deliverable.

There are a number of speciality specific schemes which will deliver clear improvements in patients' length of stay – these are summarised below together with the range in delivery for bed reductions.

Table 7.10: Specialty specific schemes bed reduction range

Scheme	Description	Bed reduction range 2023/24
End of Life Pathway improvements	Care pathways for patients and fast tracking and rapid discharges. Based on guidance from the Royal College of Nursing and NICE.	3 to 4
Hampton Suite	Implementation of a reablement bridging service designed to get those patients who cannot go home first, to go home fast.	3 to 4
Pre-operative Length of stay	Streamlining of pre-assessment pathways, with increased therapy input for orthopaedic patients.	6 to 8
Post-operative Length of stay	Seven day working of senior medical staff in orthopaedics to facilitate timely discharge.	12 to 13
Joint Replacement	Development of a surgicentre approach at UHL.	0 to 6

Scheme	Description	Bed reduction range 2023/24
GO project	Glenfield Outreach (GO) team of therapists to facilitate early discharge.	2
AMU front door	Provision of a therapy service at ED front door to prevent admissions. Based on guidance from the Kings Fund and NICE.	5
Respiratory Consultant Business Case	An additional Consultant to support increased Consultant input – reducing admissions and length of stay.	10 to 20
Cardiology Consultant Business Case	An additional Consultant to support expanded 7 day service and increased Consultant input – reducing admissions and length of stay. Base on guidance from the Royal College.	10 to 20
Frequent Attender pathway	Targeting of patients who are admitted on a regular basis to ensure a robust package of care and management plan to prevent admission. Base on guidance from the Royal College.	0 to 2
Gynaecology Robot	Reduced length of stay with minimally invasive surgery techniques.	0 to 1
Infectious Diseases pathway improvements	Escalation process around getting our super stranded patients back to their local hospitals once they are smear negative.	1-2
Perfect Ward initiative / Ward accreditation	Enabling wards to function without delays	4-5
Safe and Timely Discharge project	Identifying and addressing delays to discharge	6-7
Total		**62 to 99**

The total combined efficiency opportunity identified is therefore between 161 and 237

beds.

Impact of efficiency schemes

The overall impact of efficiency schemes is summarised in the table below.

Table 7.11: overall impact of efficiency schemes

Scheme	Bed reduction range 2023/24
Optimal management of frail and multi-morbid patient cohort	57 to 67
Optimal length of stay through implementation of safe and timely discharge processes	28 to 51
Optimal BADS pathway	14 to 20
Specialty specific schemes	62 to 99
Total	**161 to 237**

In terms of what we currently know about the effectiveness of those mitigations, it is something of a mixed bag. The work to improve the recognition of frailty and therefore the clinical decision making for frail patients is producing the results we expected *where the optimal interventions have been effectively delivered.* For example the admissions from this cohort in the City (where much of the frailty programme was originally piloted) have been in decline since 2016 with a stabilisation of emergency admission rates for this cohort noted in 18/19 (0.00% growth against the previous year).

This bucks the trend in both West and East Leicestershire & Rutland CCG areas where annual growth of between 2 and 5% was noted between 16/17 and 17/18. Since the launch of the frailty programme, the emergency admission rate for all 3 CCG's has fallen, with an LLR total growth for this cohort of 0.00% seen for 18/19 compared to 17/18. This stabilisation is also in direct contrast to national trends for the same time period where increases of up to 5.4% in emergency admissions were reported. However at scale improvements in LoS have been harder to come by; the trust has therefore realigned its Quality Priorities to focus on deliver of these programmes.