To:	**Trust Board**
From:	**Chief Executive, LLR PCT Cluster**
Date:	**28 June 2012**
CQC regulation:	**As applicable**

Trust Board Paper D

Title:	**Better Care Together**

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Purpose of the Report:

The paper informs the University Hospitals of Leicester Trust Board on the progress of the LLR Reconfiguration work

The Report is provided to the Board for:

Decision		Discussion	√
Assurance		Endorsement	

Summary / Key Points:

- **"Better Care Together" making good progress in deliverables**
- **Communication and engagement**
- **Significant project management capacity resourced to support workstreams.**
- **Overall project plan and milestone tracker to be signed off 21 June.**

Recommendations:

- **To note the title of the programme "Better Care Together"**
- **To note commencement of public engagement; Leicestershire County Council Overview and Scrutiny Committee on 19 June 2012, and Leicester City Council 28 June 2012**
- **To note the work of the LLR Reconfiguration Programme and support its overall direction.**

Previously considered at another corporate UHL Committee ?

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR)

Assurance Implications

Patient and Public Involvement (PPI) Implications

Equality Impact
Information exempt from Disclosure
Requirement for further review ?

LEICESTER, LEICESTERSHIRE AND RUTLAND PCT CLUSTER

University Hospitals of Leicester Board Meeting
28 June 2012

'Better Care Together'

1. COMMITMENT TO SERVICE IMPROVEMENT – WHY CHANGE?

The health and social care partners across Leicester, Leicestershire and Rutland are working together on a service transformation plan with the aim of achieving benefits for our population, patients and clinicians. The drivers for this change include:

- The demographic time bomb of an increasingly elderly population with the resultant increase in people with long term conditions and dementia.
- The resultant substantial financial challenge facing the LLR system due to this increased demand at a time of financial constraint.
- A desire from primary and secondary care clinicians to work together on improving clinical pathways.
- Commitment to provide more patient centred responsive services.
- Optimising the use of modern technologies including tele-medicine and tele-health.
- The need to improve ability to recruit and retain staff.
- Reducing the operating costs for UHL as a result of its current service configuration.

A Service Transformation Programme Board has been established under the leadership of the cluster chief executive. It has a senior medical leader and executive director from each of the partners together with public health, public and patient representatives. The CCG Commissioning Collaborative has allocated a £2 million budget to resource project management and consultation and engagement costs.

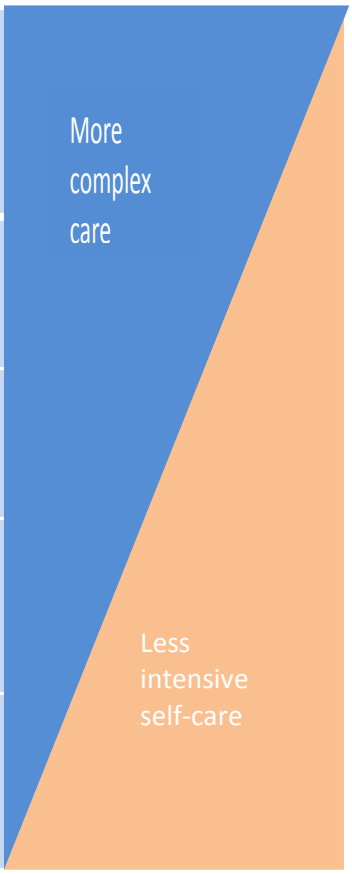
2. A LONG STANDING LLR VISION

In 2008 an extensive consultation with public patients and clinicians was undertaken under the banner 'Excellence for All'. The key themes that emerged at that time are still applicable today.

- Patients the public and communities will be fully involved in improving their health and in the quality of local health services.
- Health services will be fair, effective, personalised and safe.
- People will be supported to make healthy choices and stay healthy.
- Services will need to become increasingly integrated across primary and secondary care and local authorities.
- Services will be provided locally where possible and centralised where necessary.

These themes have been translated into an outline vision shared by NHS LLR and this is shown below:

Acute Care Consolidation	▪ Complex care consolidated on 2 main UHL sites and removed off the LGH ▪ Fundamentally redesigned LGH including ambulatory care centre for City patients'. Significantly smaller footprint
Integrated Care Centres/Community Hubs	▪ Rationalisation of community estate according to demographic needs ▪ Focusing on care of the frail elderly and specific end-to-end care pathways
Outpatients and homecare	▪ As much outpatient activity delivered closer to home as is feasible ▪ Care provided in lower cost settings where safe and appropriate
Integrated Community Health and Social Care	▪ Multi-disciplinary, inter-agency community teams across health and social care partners. ▪ Systematic adoption of Integrated Care Pathways – one system
Knowledge transfer and self -care	▪ NHS 111 and Single Point of Access ▪ Knowledge transfer between secondary and primary care to reduce requirement for acute care. Integrated IT.



The next stage of engagement will test support for this and provide some specific examples.

3. OUTCOMES AND BENEFITS

Our aim is to provide high quality, accessible cost-effective and sustainable health services.

What will be better for patients?

- More integrated and preventative care for frail elderly
- Better patient experience through modern technology and communications
- Less requirement to attend UHL for routine outpatient appointments and follow ups
- More opportunity to have minimally invasive day case procedures closer to home avoiding a trip to main acute hospital.
- Better access to services
- Improved outcomes from rapid assessment diagnosis and treatment

For clinicians within the Trusts the programme will provide the following benefits.

- Deliver better quality care and move away from "crisis management"
- A shared and clear whole system approach to care
- A partnership with primary care and community services to coproduce care pathways and new ways of working
- The opportunity to transform as well as transfer care to new settings
- Generation of investment in new ways of working

- Creates the opportunity to resolve the urgent care pathway and interdependencies within UHL
- Enables UHL to focus on being the centre of excellence at the centre whilst a partner and supporter of primary care in a delivery of secondary care in local settings.

4. PRINCIPLES

The LLR Service Transformation Programme Board has collectively agreed the following principles to underpin the project:

- We will put patient experience and quality of care first
- We will tackle health inequality through effectively targeted services
- We will deliver care closer to home where it is possible, suiting patients' needs
- We aim to excel in all we do
- We will make changes based on sound evidence of clinical need access and value for money
- We will deliver affordable change

These will now form the basis for all communications, engagement and consultation activity, and will only be amended subject to feedback received from public and stakeholders through pre-engagement work.

5. CRITERIA TO ASSESS OPTIONS

It is important to have some criteria against which to assess options for any change in service. The intention is to engage the public, clinicians on these from the outset. The following criteria have initially been suggested by the Programme Board to measure the effectiveness of decisions.

The weighting factor will be determined following engagement on the relative importance people attribute to these.

	Criteria	Description and Examples	Weighting Factor	Scoring
1	Quality	Improved treatment pathways with access to all relevant technology on site		
2	Access	Closer to home. Travel times for patients.		
3	Deliverability	If requires unrealistic capital, unrealistic change or impractical solutions – may not happen		
4	Sustainability & Affordability	Best use of estate long term. Sustainability of clinician or nursing resource		
5	Productivity	Streamline, standardise and simplify the process. Efficient use of clinician's time.		
6	Clinical Inter-dependencies	Requirement for diagnostics, on-call anaesthetist, emergency services for example		

6. ECONOMIC ANALYSIS

It is important that an economic analysis is undertaken from the outset to demonstrate that the vision will deliver higher quality care at a lower operating cost and a piece of work has been commissioned to achieve this. In addition a submission is underway to the Strategic Health Authority for strategic transitional support to reflect the fact that it will take some time to reach the end point and that in the meantime the LLR system will struggle to achieve the right level of cost improvements with the current fixed points with regard to service configuration.

7. EARLY DELIVERABLES AND PROGRESS

Short term deliverables (2012/13)

1. To move OPD clinical 1-5 to General Hospital to free up space for an integrated urgent care service
2. Assessment of which specialties can then move which elements of care to local settings
3. 5 priority 'ology's: dermatology, diabetology, gastroenterology, ophthalmology, respiratory medicine – scope what can transfer
4. Determine the requirements of City residents to continue to access services at LRI and General Hospital
5. Create an integrated UHL Emergency Floor with assessment, senior decision makers and diagnostics at the front door
6. Priority day case reprovision out of LRI to create the opportunity to expand ITU in preparation for single site surgical take
7. Transfer of Mental Health Services from the Brandon Unit to the Centre of Excellence at the Bradgate Unit. This could be explored as a solution for clinics 1-5.
8. Reprocurement of elective care bundle by East Leicestershire and Rutland CCG and West CCG
9. Review of community hospitals and services by West CCG
10. Solution for intermediate care for Leicester City CCG
11. IT Infrastructure plans to facilitate system wide transformational change in urgent care, planned care closer to home and/or agile working (e.g. tele-health, electronic transcription)
12. Explore the current configuration of maternity services and determine any short term changes.

Project management resource will be supplied as the projects commence. Consideration will also be given to appropriate internal individuals for these positions, and for ensuring that skills and experiences are shared and retained

8. COMMUNICATION AND ENGAGEMENT PLANS

A vision statement and guiding principles have been developed to reflect the aims and ambitions of the programme and provide an over arching narrative for communications and engagement and have been approved by the programme board 24 May 2012.

A Communications Alliance, comprising lead communications staff from the partner organisations, has been established to bring together all workstream and project communications and engagement, ensure a continuity of message and share information.

A brand identity for the programme has been developed and agreed and has been communicated to the Communications Alliance members with guidance on use.

The vision statement and guiding principles is being communicated to staff over the next few days (14 June onwards).

A website www.bettercareleicester.nhs.uk has been created and is being populated with information. This also provides a channel for stakeholder feedback.
OSC and LINks meetings have been set up to present the programme and MP meetings are being arranged for this month.

A public facing document is being developed to provide a better understanding of the programme and will be finalised once the wording for the case for change has been agreed.
Once timelines for workstreams/project deliverables have been agreed by project managers a number of wider stakeholder audience events and communications will be rolled out to communicate the proposals and models developed.

9. DELIVERING CHANGE - WHAT WILL BE DIFFERENT?

Clinicians and members of the public will be asking what will different this time given that there have been numerous attempts to reconfigure services in the past. The National and economic context is now very supportive of achieving change. The local factors include:

- A commitment to clinical, public and patient involvement in the work at every stage.
- A unified will to succeed.
- The economic climate means that the public is more open to the need for change.
- A substantial budget which enables a dedicated change team.
- Enhanced clinical leadership through the CCGs and Trust clinicians.
- A well resourced and executed communications and engagement plan.

10. UPDATE ON ACTIVITIES

10.1 Programme Board

10.1.1 The following additions have been made to strengthen the breadth of representation on the LLR Programme Board:

Tim Davies (Deputy Director of Public Health) and Dr Deenesh Khoosal (Deputy Medical Director, LPT) have been co-opted. CCGs have advised that a nurse or AHP should be a member of the board. Ian Wakeford of LPT IT will be joining the Board as SRO for IT, supported by John Clarke of UHL and Will Legge of LPT.

10.2 Governance

10.2.1 Memorandum of Understanding is now finalised and the Terms of Reference have been finalised to clarify the level of delegated authority with help from Stephen Ward, UHL. The following sentence has been inserted into the Terms of Reference document:

*'The Programme Board shall be empowered to **make recommendations** to its constituent organisations on proposals for developments or variations in the service provided.'*

10.2.2 The PB was informed that a governance diagram has been produced by Dave Briggs showing how the LLR boards interact and this will be added to the Programme Definition Document and circulated with the MOU and TORs. This was ratified at the 24.05.12 PB.

10.3 Programme Scope and Activities

10.3.1 It was confirmed that the priority is to move UHL from a three site to two site acute take and this is the overarching priority for this group. There are eight short term deliverables that will enable this. The programme will need oversight of related projects but only in so far as they impact on the primary goal of a two site acute take UHL configuration. There will still be a considerable range of services on the General site.

11 BUDGET

11.1 A transformation bid of £2m was approved in March to support the Reconfiguration Programme. This will enable the Programme to operate in three key spheres:

- **'DOING'** the PMO will have its own portfolio of projects to deliver. For illustrative purposes these will include whole system modelling, capacity planning, discrete service moves/projects focusing on those that cross organisational boundaries or those that have a material impact on the delivery of the vision

- **'DEVELOPING'** internal capacity and capability, simplifying procurement and standardising processes to support the timely completion of feasibility studies and business cases through knowledge transfer and joint working with external parties as/when necessary

- **'FACILITATING'** and coordinating action across LLR QIPP work-streams to ensure coherent solutions and best value from the resources we have and any investment made.

Spend to end May 2012 is in line with YTD budget.

12 RECOMMENDATIONS

12.1 To note the title of the project "Better Care Together"

12.2 To note commencement of public engagement; Leicestershire County Council Overview and Scrutiny Committee on 19 June 2012, and Leicester City Council 28 June 2012

12.3 To note the work of the LLR Reconfiguration Programme and support its overall direction.

Catherine Griffiths
Senior Responsible Officer, LLR Reconfiguration Service
18 June 2012