UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON MONDAY 22 DECEMBER 2014 FROM 10AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Please note the new time for the public meeting and the new running order

Public meeting commences at 10am

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**APOLOGIES AND WELCOME**	**-**	**Chairman**	
	To receive apologies for absence from Dr A Bentley, Leicester City CCG Representative, and Professor D Wynford-Thomas, Non-Executive Director.			
2.	**DECLARATIONS OF INTERESTS**	**-**	**Chairman**	
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
3.	**MINUTES**			
	Minutes of the 27 November 2014 Trust Board meeting. *For approval*	**A**	**Chairman**	
4.	**MATTERS ARISING**			
	Action log from the 27 November 2014 meeting. *For approval*	**B**	**Chairman**	10am – 10.05am
5.	**CHAIRMAN'S MONTHLY REPORT – DECEMBER 2014** *For noting*	**C**	**Chairman**	10.05am – 10.10am
6.	**CHIEF EXECUTIVE'S MONTHLY REPORT – DECEMBER 2014** *For noting*	**D**	**Chief Executive**	10.10am – 10.15am
7.	**KEY ISSUES FOR DECISION/DISCUSSION**			
7.1	**EMERGENCY CARE PERFORMANCE REPORT – INCLUDING THE LLR HEALTH ECONOMY ACTION PLAN FOLLOWING RECOMMENDATIONS FROM DR I STURGESS** *For discussion and decision*	**E**	**Chief Operating Officer**	10.15am – 10.50am
7.2	**UHL 5 YEAR PLAN REFRESH** *For discussion and decision*	**G**	**Director of Strategy**	10.50am – 11am
7.3	**DELIVERING THE 5 YEAR STRATEGY – PROPOSED GOVERNANCE** *For discussion and decision*	**H**	**Director of Strategy**	11am – 11.05am

7.4	**BETTER CARE TOGETHER PROGRAMME – STRATEGIC OUTLINE CASE AND PROJECT INITIATION DOCUMENT** *For approval*	**I**	**Chief Executive**	11.05am – 11.15am
8.	**QUALITY AND PERFORMANCE**			
8.1	**QUALITY AND PERFORMANCE REPORT – MONTH 8** *For discussion* The Non-Executive Director Chairs of the Quality Assurance Committee and the Finance and Performance Committee will be invited to highlight any month 8 issues from their most recent meetings (held on 15 and 18 December 2014 respectively). Minutes of the 26 November 2014 Finance and Performance Committee and Quality Assurance Committee meetings are attached. The Trust Chairman will then invite the Chief Executive to identify key priority issues from within the month 8 report, for Trust Board consideration.	**J** **J1 & J2**	**QAC Chair/ FPC Chair** **QAC Chair/ FPC Chair** **Chairman/Chief Executive**	11.15am – 11.40am
8.2	**2014-15 MONTH 8 FINANCIAL POSITION** *For discussion*	**K**	**Director of Finance**	11.40am – 11.50am
9.	**WORKFORCE**			
9.1	**QUARTERLY UPDATE ON WORKFORCE AND ORGANISATIONAL DEVELOPMENT PLAN** *For discussion*	**L**	**Director of Human Resources**	11.50am – 12noon
10.	**RESEARCH AND DEVELOPMENT**			
10.1	**QUARTERLY UPDATE ON RESEARCH AND DEVELOPMENT ISSUES** *For discussion*	**M**	**Medical Director**	12noon – 12.10pm
11.	**GOVERNANCE**			
11.1	**DUTY OF CANDOUR/FIT AND PROPER PERSONS TEST** *For approval*	**N**	**Director of Corporate and Legal Affairs**	12.10pm – 12.20pm
11.2	**BOARD AND BOARD COMMITTEE GOVERNANCE** *For approval*	**O**	**Director of Corporate and Legal Affairs**	12.20pm – 12.25pm
11.3	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For approval*	**P**	**Director of Corporate and Legal Affairs**	12.25pm – 12.30pm
12.	**TRUST BOARD BULLETIN – DECEMBER 2014**	**-**	**-**	-
13.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Chairman**	12.30pm – 12.40pm
14.	**ANY OTHER BUSINESS**		**Chairman**	12.40pm – 12.45pm
15.	**DATE OF NEXT MEETING**			

	The next Trust Board meeting will be held on Thursday 8 January 2015 from 9am in the C J Bond room, Clinical Education Centre, Leicester Royal Infirmary site.			
16.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 17-22).			
Comfort break 5 minutes				
17.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
18.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 27 November 2014 Trust Board meetings. *For approval*	**Q**	**Chairman**	
19.	**MATTERS ARISING** Confidential action log from the 27 November 2014 Trust Board. *For approval*	**R**	**Chairman**	12.50pm – 12.55pm
20.	**REPORT FROM THE DIRECTOR OF FINANCE**	**S**	**Director of Finance**	12.55pm – 1pm
21.	**REPORTS FROM BOARD COMMITTEES**			
21.1	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 26 November 2014 meeting for noting and endorsement of any recommendations. *Commercial interests*	**T**	**FPC Chair**	-
21.2	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 26 November 2014 meeting for noting and endorsement of any recommendations. *Personal information*	**U**	**QAC Chair**	-
22.	**ANY OTHER BUSINESS**	**-**	**Chairman**	-

Kate Rayns
Acting Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 27 NOVEMBER 2014 AT 9AM IN SEMINAR ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Present:
Mr K Singh – Trust Chairman
Mr J Adler – Chief Executive
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director (from Minute 295/14)
Dr K Harris – Medical Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Mr M Traynor – Non-Executive Director
Mr P Traynor – Director of Finance
Mr M Williams – Non-Executive Director
Ms J Wilson – Non-Executive Director

In attendance:
Ms K Bradley – Director of Human Resources
Mr J Clarke – Chief Information Officer (for Minute 311/14)
Ms J Fernihough – IBM Executive Partner (for Minute 311/14)
Mr P Gowdridge – Head of Strategic Finance (for Minute 311/14)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 306/14)
Dr S Jackson – Chief Medical Information Officer (for Minute 311/14)
Ms H Leatham – Assistant Chief Nurse (for Minute 299/14/1)
Ms U Mehta – Haematology Nurse Practitioner (for Minute 299/14/1)
Mrs K Rayns – Trust Administrator
Ms P Richards – IBM Executive Partner (for Minute 311/14)
Ms K Shields – Director of Strategy (from part of Minute 297/14)
Mr N Sone – Financial Controller (for Minute 303/14/1)
Ms E Stevens – Deputy Director of Human Resources (for Minute 311/14)
Ms H Titman – Haemoglobinopathies Clinical Nurse Specialist (for Minute 299/14/1)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

293/14 APOLOGIES AND WELCOME

Apologies for absence were received from Dr A Bentley, Leicester City CCG representative, Dr D Jawahar, Leicester City CCG representative, and Professor D Wynford-Thomas, Non-Executive Director. The Trust Chairman welcomed Mr P Traynor, Director of Finance to the meeting.

294/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

There were no declarations of interests relating to the public items being discussed.

295/14 MINUTES

Resolved – that, subject to the removal of a duplicated entry in the attendance list, the Minutes of the 30 October 2014 Trust Board (paper A) be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR**

296/14 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution.

At the invitation of the Trust Chairman, the Chief Nurse provided an update in respect of items 19 and 20 (Minute 259/14/2 of 25 September 2014 refers), advising that a report was provisionally scheduled to be provided to the 15 December 2014 Quality Assurance Committee meeting on the implementation of the complaints engagement event action plan and arrangements for strengthening the ways in which patients and the public could raise concerns about patient care and other issues of concern.

The Trust Chairman noted opportunities to refer some of the remaining Trust Board matters arising to other groups and he requested the Director of Corporate and Legal Affairs to explore this further. **DCLA**

Resolved – that (A) the update on outstanding matters arising and the timescales for resolution be noted, and

(B) the Director of Corporate and Legal Affairs be requested to explore opportunities to refer any Trust Board matters arising to other Groups. **DCLA**

297/14 CHAIRMAN'S OPENING COMMENTS

The Chairman introduced paper C, outlining the key areas of focus for the Trust Board over the coming months. He particularly drew members' attention to the following issues:-

(a) the Trust Board development session on 22 December 2014 would focus on engagement and would include the exploration of opportunities to harness Non-Executive Directors' existing networks to expand engagement opportunities;
(b) part of the January 2015 Trust Board development session would focus upon innovation and opportunities to increase the current emphasis on innovation at UHL;
(c) the importance of increasing internal transparency and understanding of the costs of the services provided by the Trust, and
(d) UHL's responsibility as an employer, service provider and public body to listen to public voices in the community and respond in a considered and structured manner to the issues raised.

Resolved – that the position be noted.

298/14 CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – NOVEMBER 2014

The Chief Executive introduced paper D, briefing the Trust Board on the following key issues (some of which featured later in the agenda as substantive items for discussion):-

(a) a re-invigorated approach to system wide emergency care performance (Minute 300/14/3 below refers);
(b) the Trust's RTT performance would also be covered later in the agenda (Minute 300/14/1 below refers), but the headline message was that the milestone to achieve admitted performance by November 2014 had been missed;
(c) month 7 financial performance (Minute 300/14/2 below refers) had remained relatively stable and discussions with Commissioners were ongoing regarding the arrangements to de-risk the year-end position;
(d) good progress with the development of the Better Care Together Strategic Outline Case and Project Initiation Document, which were expected to be presented to the 22 December 2014 Trust Board meeting for approval. The process for subsequent TDA approval was less clear thereafter (pending next year's general election);
(e) the NHS 5 Year Forward View (as published on 28 October 2014) had been endorsed

by Monitor, the TDA, the CQC and all the Royal Colleges. In summary this document set out proposals for reducing reliance upon the acute care sector and creating more community based care;

(f) feedback from the annual conference and exhibition of the Foundation Trust Network held in Liverpool on 18 and 19 November 2014 (as attended by the Chief Executive, Chief Operating Officer and Director of Strategy), noting national recognition of the current NHS climate and the consultation on the 2015-16 national tariff, and

(g) the recent launch of MyNHS by the DoH, expanding the arrangements for publication of Consultant level patient outcomes and a related press release relating to positive aspects of UHL's vascular services. Discussion took place regarding the arrangements for the Trust Board to be sighted to such feedback and assurance was provided that the mechanism for this was through the daily press release bulletins (which also included postings on the NHS Choices website). In addition, this feedback was triangulated with patient feedback and reported to the Quality Assurance Committee on a quarterly basis. The Director of Strategy advised that a briefing paper was being prepared on the expected implications of the MyNHS data and she undertook to circulate this document to Trust Board members (once it became available). **DS**

In discussion on the Chief Executive's monthly report, members sought and received additional information regarding the positioning of the Better Care Together Programme, and future accountability and governance structures. Confirmation was provided that the current partnership approach was expected to continue. The Chairman noted the intention to focus upon any implications for UHL at a future Trust Board development session and a subsequent formal Trust Board meeting. **Chair**

<u>Resolved</u> – that (A) the positioning of the Better Care Together Programme and the future governance and accountability arrangements be considered at a future Trust Board development session and subsequent formal Trust Board meeting, and **Chair**

(B) the Director of Strategy be requested to circulate an analysis of the MyNHS data to Trust Board members outside the meeting. **DS**

299/14 KEY ISSUES FOR DECISION/DISCUSSION

299/14/1 <u>Patient Story</u>

Ms H Leatham, Assistant Chief Nurse, Ms U Mehta, Haematology Nurse Practitioner, and Ms H Tiltman, Haemoglobinopathies Clinical Nurse Specialist attended the meeting to introduce this month's patient story, a short DVD detailing the experiences of a young male patient who had transferred to the care of the Osborne Day Care unit at the LRI, from the equivalent Children's Unit for his four weekly blood transfusions. The patient himself also attended the meeting for this item, although he had not been named for reasons of patient confidentiality.

Upon transfer, the patient was unable to secure a Saturday morning service in Leicester and began travelling to Coventry for his transfusions to avoid unnecessary time off work. In response to patient feedback, the Osborne unit had since been able to introduce a Saturday service and the patient had been able to transfer his care back to Leicester, thus reducing his travelling time and enabling him to work full-time. The patient story also highlighted the following additional areas where there was scope to further improve the service:-

- extending clinic opening hours mid-week (eg up to 7pm on 1 day per week);
- wider choice of patient meals (particularly for elderly patients);
- additional blood machines to reduce waiting times, and
- free wi-fi access to alleviate boredom during the procedure.

In discussion on the patient story, Trust Board members:-

(1) thanked the patient for his input and for taking the time and trouble to record the DVD and attend this meeting;
(2) sought and received feedback from the staff about the management of change process for implementing a Saturday service and how this had been achieved;
(3) commented upon the long-term nature of many patient conditions treated by this service and queried whether there were any challenges surrounding staff training, recruitment and retention. In response, it was noted that the majority of staff had been in post for a considerable length of time, but students also benefited from the positive atmosphere on the unit;
(4) commented that learning from the specialised Haemoglobinopathy service in Leicester had influenced and helped to shape this service at a national level;
(5) commended the responsive nature of this service in recognising the needs of individual patients and supporting them in their working life (in line with the Trust's values as a corporate citizen);
(6) provided assurance that the capacity to provide free wi-fi to patients was currently being tested and (subject to assurance being provided that there would be no impact on UHL's business continuity) it was hoped to roll this out within the next 12 months, and
(7) noted the relatively low cost of additional blood machines (eg £900 plus giving sets) and commented on the need to improve the approvals process for items of medical equipment below £5,000 in value – the Chief Nurse agreed to meet with the team outside the Board meeting to address this particular shortfall. **CN**

The Trust Chairman thanked the patient and the presentation team for their valued contribution to this meeting.

Resolved – that (A) the Patient Story and the Board's discussion on associated learning opportunities be noted, and

(B) the Chief Nurse be requested to progress the requirement for additional blood machines in the Osborne Day Care Unit. **CN**

299/14/2 UHL Response to NHS England Consultation on the Congenital Heart Disease Review

The Director of Strategy introduced paper F, inviting the Trust Board to consider the key issues arising from the above consultation and to endorse UHL's proposed response for submission to NHS England before the consultation ended at midnight on 8 December 2014.

Particular discussion took place regarding the arrangements to achieve the minimum activity level for a clinically sustainable service (500 cases) and achieve a 1 in 4 on call rota. In respect of the timescale for co-locating children's services onto 1 hospital site, it was expected that NHS England would develop plans in partnership with the relevant Trusts, and that clarity would be provided at each stage of the indicative commissioning intentions.

Opportunities for networking with other centres were being explored and the Medical Director commented that the increased volume of activity would also increase the scope for innovation and research within the specialty of Congenital Heart Disease. The Director of Marketing and Communities sought and received additional information regarding stakeholder engagement and clinical effectiveness.

In summary, the Trust Board endorsed the Trust's response for submission to NHS England and requested that an update on the Congenital Heart Disease Review be provided to the Trust Board in June 2015. **DS**

Resolved – that (A) the Trust's response to the Congenital Heart Disease Review be endorsed for submission to NHS England by midnight on 8 December 2014, and **DS**

(B) a further update on the Congenital Heart Disease Review be provided to the Trust Board in June 2015. **DS**

300/14 QUALITY AND PERFORMANCE

300/14/1 Month 7 Quality and Performance Report

The month 7 Quality and Performance report (paper G – month ending 31 October 2014) highlighted the Trust's performance against key internal and NTDA metrics, with escalation reports appended where required.

In terms of the 26 November 2014 QAC meeting, Dr S Dauncey, Non-Executive Director and Acting QAC Chair, highlighted the following issues:-

(i) breast screening performance against the 62 day target, and
(ii) arrangements for UHL to take over provision of renal dialysis services at Corby Hospital with effect from 1 December 2014 until the scheduled closure of this service in August 2015. Trust Board members noted the requirement for UHL to register these premises with the CQC and the formal requirement for this registration to be brought to the Board's attention.

In addition, the Chief Nurse highlighted concerns relating to the internal threshold for Clostridium Difficile and the potential impact of cleaning quality within the Facilities Management contract. An update on this issue would be provided to the December 2014 QAC meeting. The Medical Director reported verbally on a never event involving a retained thread which was used to tie bundles of surgical swabs together. A full investigation was being carried out but it appeared that the member of staff involved had not been aware that these threads (in addition to the swabs) formed part of the theatre checklist.

The Trust Chairman noted the scope to present more concise reports on quality and performance to future Trust Board meetings and he invited the Chief Nurse and the Medical Director to consider which elements of the existing reporting format were causing the most concern. In response, the Chief Nurse highlighted cleaning standards and the friends and family test analysis data. The Medical Director recommended a focus upon patient mortality and vigilance in respect of any reputational issues. The Trust Chairman requested that any specific issues which the Trust should be vexing about be highlighted within the quality and performance covering sheet in future. **CN/MD /COO/ DHR**

The Chief Executive suggested that the existing reporting format be continued with a greater emphasis on the process for escalating issues of concern and monitoring the responses to ensure that appropriate actions were being taken. He noted (as an example) a long-standing issue with fractured neck of femur performance, which was considered to be symptomatic of wider pressures on the trauma service. However, this team had recently been selected as one of the fourth wave of Listening into Action Pioneering Teams and it was anticipated that this would be one of the catalysts for improving fractured neck of femur performance.

In the context of publishing Consultant outcomes, the Director of Marketing and Communications commented on opportunities to increase transparency regarding site specific differentials in mortality rates, noting the potential impact of case mix and emergency activity upon the LRI statistics. The Medical Director provided assurance that the Mortality Review Committee reviewed detailed mortality data within all specialties and a clear escalation process existed in the event of any concerns being raised. In addition, the quality and performance report detailed the Trust's performance against 9 standard mortality KPIs and escalation reports would be appended to this report in the event of any indicators being RAG-rated as red.

Ms J Wilson, Non-Executive Director and Acting Finance and Performance Committee Chair then outlined key operational issues discussed by the 26 November 2014 Finance and Performance Committee, namely:-

(a) operational performance issues (including admitted RTT, cancer waits, cancelled operations, delayed transfers of care, ambulance handovers and the related exception reports);
(b) financial performance for month 7 and the year to date and the assurance provided in respect of meeting the planned year end deficit of £40.7m, and
(c) consideration of the revised activity assumptions for inclusion in the Emergency Floor outline business case and the letter of support received from Commissioners in relation to the business case.

The Chief Operating Officer highlighted the 3 performance issues which he was most vexed about, namely (1) RTT performance, (2) cancer performance, and (3) emergency performance and he provided a verbal report on progress towards addressing each of these themes.

The Director of Human Resources noted improving performance on staff appraisals which stood at 91.8% for October 2014. She also highlighted opportunities to further analyse the staff friends and family test results to understand the factors affecting those areas with particularly high or low scores in this survey and incorporate this data into the organisational dashboard to monitor CMGs' performance.

In discussion on the issues highlighted above and on the month 7 Quality and Performance report generally, the Trust Board:-

(I) considered the attendance level at corporate induction sessions (98%) and the wide variety of training and development opportunities on offer for UHL staff;
(II) noted the inconsistent approach to monitoring of staff friends and family test scores by other NHS Trusts and that national benchmarking data was not yet available in this area. Once available, this data would be reported to the Executive Workforce Board and a subsequent quarterly update to the Trust Board or appropriate Board Committee;
(III) commented upon opportunities to improve activity forecasting processes, and noting (in response) that elective activity was already modelled on real time referrals and that the recently appointed Director of Performance and Information would be focusing upon the appropriateness of GP referrals in January 2015, and
(IV) noted that a Trust in the Bournemouth area was making arrangements to commence re-charging families for any exceptional delays in discharge and queried whether such measures would be in the best interests of patients. The Trust would continue to work with its partner agencies to address discharge delays for patients whose acute episode of care had been completed – as at 27 November 2014 there were 91 such patients awaiting discharge.

The Minutes of the 29 October 2014 Quality Assurance Committee meeting were received and noted as paper G1.

<u>Resolved</u> – that (A) the month 7 quality and performance report for the period ending 31 October 2014 be received and noted, and

(B) UHL's registration with the CQC for provision of renal services at Corby Hospital be endorsed. **CN**

300/14/2 <u>Month 7 Financial Position</u>

The Director of Finance presented paper H advising members of UHL's financial position as

at month 7 (month ending 31 October 2014), particularly highlighting performance against the Trust's statutory financial duties and the following key issues:-

(a) an adverse in-month variance to plan of £0.3m, and a year to date deficit against plan of £1.7m;
(b) data warehouse issues which had led to the Trust's entire inpatient income being estimated for the month 7 reporting cycle. Since the report had been circulated, income levels had been confirmed and the position had improved by £0.6m;
(c) the contractual position with Commissioners (including fines and penalties) and the work ongoing to identify and agree a revised process for resolution of contractual queries. A key task for the Director of Finance would be to de-risk the contractual position for the 2014-15 year end and the 2015-16 contract going forwards;
(d) strong performance against the Trust's 2014-15 Cost Improvement Programme (CIP) and good progress with the CIP plans for 2015-16.

In discussion on the month 7 financial performance update, the Trust Board:-

(i) noted the views of the Director of Finance on the level of risk surrounding contractual penalties in 2014-15 (within the maximum threshold of £10m), and the level of confidence that greater clarity on this matter would be available before Christmas 2014;
(ii) received assurance surrounding the resilience of the forecast outturn assumptions (provided on page 4 of paper H) and that the forecast year end control total would be met;
(iii) noted the need to stabilise financial performance within the current financial year and improve the trajectory for financial recovery over the next 5 years, and
(iv) received a position statement on bank and agency nursing expenditure from the Chief Nurse, noting the quality and safety benefits of maintaining appropriate ward staffing levels. In addition, temporary nurse staffing costs were currently being off-set by an under-spend in permanent staffing costs whilst the Trust continued to actively recruit to approximately 350 vacant nursing posts.

Resolved – that the month 7 financial performance update be noted.

300/14/3 Emergency Care Performance and Recovery Plan

The Chief Operating Officer introduced paper I providing the monthly overview of emergency care performance, noting that October 2014 performance against 4-hour waits in ED had deteriorated to 89.9% (compared with 91.8% in September 2014). However, November 2014 performance for the month (up to 20 November 2014) had improved to 90.1%.

In summary the main areas of focus were highlighted as (a) reductions in emergency admissions, (b) internal UHL processes and (c) improvements in the discharge function. In respect of (a) and (c), it was becoming apparent that the actions put in place by the LLR healthcare community were not working as planned. In respect of (b) internal processes, it was crucial to achieve certainty that the right processes were in place for the best possible service to patients and some good progress was being made in this area.

A report on the LLR emergency care system had now been issued by Dr I Sturgess. This report set out 80 key recommendations for UHL to address, such as reducing the time to assessment on the medical assessment units, implementation of change management support and a reduction in clinical variability. A briefing note from the Nuffield Trust was appended to paper I, summarising acute activity trend projections and the need for sustainable changes in NHS provision going forwards. The Chief Operating Officer highlighted the need to focus on day case utilisation rates, implement improvements in discharge functions and promote wider use of alternative models of care for intermediate

services in the community.

The Chief Executive briefed the Trust Board on recent developments for re-vamping the arrangements for LLR oversight of emergency care performance. UHL was fully engaged in this process which would include additional programme support and change management resources. It was anticipated that a refined list of key interventions would be agreed by the end of the week for consideration by the system resilience group on 1 December 2014.

The Trust Chairman advised that the January 2015 Trust Board development session would be focusing upon the whole local health economy emergency care system and representatives from UHL's partner agencies would be invited to attend. He requested the Director of Corporate and Legal Affairs to contact the relevant CCG, LPT and local authority representatives (to invite them on his behalf) and confirm the arrangements to Trust Board members. **DCLA**

In discussion on emergency care performance, the Trust Board:-

(a) noted an offer of support from the Healthwatch representative in seeking clarity from key stakeholders in respect of access to community hospital beds, or discharge processes. In response, the Chief Executive invited Healthwatch to scrutinise the LLR plans (once published) to assess whether they would be effective at reducing admissions, improving the pace of safe patient discharges and reducing inappropriate ED attendances;
(b) highlighted an article in that week's Health Service Journal in respect of emergency activity trends for frail older people, admissions avoidance schemes and planning for a scenario in the event that the "left shift" principle of moving more care into the community was not effective;
(c) commented on the impact of the following issues in relation to ED attendances:- (i) availability of appointments at GP surgeries and (ii) standardised DoH advice for schools regarding pupils attending ED in the event of a minor accident;
(d) supported an increased emphasis on alternative models of care at a local and a national level;
(e) sought assurance regarding adherence to internal process and whether any internal metrics would be implemented for monitoring this. In response, the Chief Operating Officer commented upon the current pressures on staff working in the ED, confirming that each of the 8 identified workstreams would have dedicated change management support and would report directly to the weekly Emergency Quality Steering Group which was chaired by the Chief Executive;
(f) noted that the Sturgess report was due to be published on 9 December 2014 and agreed that the arrangements for implementation of the recommendations would be considered at the 22 December 2014 Trust Board meeting, and
(g) supported the recommendations (as outlined on page 4 of paper I) for seeking assurance on the LLR plans for reducing emergency admissions and accelerating discharges.

<u>Resolved</u> – that (A) the update on Emergency Care Performance (paper I) be received and noted and support be expressed for the actions being taken to strengthen performance, and

(B) the Sturgess report on LLR emergency care and the arrangements for implementation of the recommendations be presented to the Trust Board on 22 December 2014. **COO**

301/14 GOVERNANCE

301/14/1 <u>NHS Trust Over-Sight Self Certifications</u>

The Director of Corporate and Legal Affairs introduced the Trust's over-sight self certification

return for October 2014 (paper J refers). Following due consideration, and taking appropriate account of any further information needing to be included from today's discussions (including the month 7 exception reports, as appropriate), the Board authorised the Director of Corporate and Legal Affairs to finalise and submit the November return to the NHS Trust Development Authority in consultation with the Chief Executive. **DCLA/ CE**

<u>Resolved</u> – that (A) paper J, now submitted, be received and noted,

(B) the Director of Corporate and Legal Affairs be authorised to agree a form of words with the Chief Executive in respect of the NHS Trust Over-sight self certification statements to be submitted to the NHS Trust Development Authority by 30 November 2014. **DCLA/ CE**

301/14/2 <u>Board Assurance Framework (BAF)</u>

The Chief Nurse introduced paper K detailing UHL's Board Assurance Framework as of 31 October 2014 and notifying members of 3 new extreme/high organisational risks opened during that month (as summarised in appendix 3 to the report). She particularly highlighted the following key points:-

(a) a gap in the controls associated with principal risk 21 *(failure to maintain effective relationships with key stakeholders)*. The Director of Finance and the Director of Strategy were invited to confirm the actions being taken in respect of the Stakeholder Engagement Strategy to inform the next iteration of the BAF report, and **DF/DS**

(b) principal risks 23 and 24 *(failure to effectively implement EPR programme and failure to implement the IM&T strategy and key projects effectively)* did not have any identified gaps in controls or assurance and the Board was invited to consider whether these risks should be re-scored accordingly. In response, the Chief Executive agreed to consider with the Chief Information Officer whether any additional actions should be documented here to demonstrate the risk mitigations in place. He voiced his view that it was too early in the EPR planning process to reduce the risk score at this time. The Chief Operating Officer suggested that it would be appropriate to make reference to UHL's ability to realise the benefits of EPR within this risk entry. **CE**

The Trust Board then reviewed the strategic objective *'enhanced reputation in research, innovation and clinical education'*, incorporating principal risks 11, 12, 13 and 14 from within the BAF:-

- **risk 11** *(failure to meet NIHR performance targets)* – the Medical Director confirmed that the Trust was managing this risk effectively and that there was nothing more to add at the current time;
- **risk 12** *(failure to retain BRU status)* – the Medical Director reported verbally on recent consideration of the requirements and timescales for maintaining BRU status. He noted the need to update the narrative accordingly (and potentially the risk score) for the next iteration of this report; **MD**
- **risk 13** *(failure to provide consistently high standards of medical education)* – the Medical Director confirmed that the risks were currently captured appropriately. The Director of Human Resources commented upon issues relating to reductions in training numbers and a renewed focus upon the quality of education. This item was expected to feature on the next agendas for the Executive Workforce Board and the LETB, and
- **risk 14** *(lack of effective partnerships with universities)* – the Medical Director advised that some significant work was required to restructure the narrative on this risk to describe the risk more accurately through the appropriate lens. As a result, he would expect the risk scoring to rise in the next iteration of the report. **MD**

In discussion on this strategic objective, the Trust Chairman noted an opportunity for a 2015

Trust Board development session to focus on clinical and nurse education, research and development and links with the higher education sector. He suggested inviting the Vice-Chancellors of the 3 local universities to attend this session. **CHAIR/ DCLA**

Finally, in view of the revised meeting dates for 2015, it was agreed that the next BAF report would be provided to the Trust Board on 8 January 2015.

Resolved – that (A) the BAF for period ending 31 October 2014 and the subsequent discussion on key risks be noted;

(B) the Director of Finance and the Director of Strategy be requested to populate the controls for principal risk 21 *(failure to maintain effective relationships with stakeholders)*; DF/DS

(C) the Chief Executive be requested to liaise with the Chief Information Officer in respect of the narrative for principal risks 23 and 24 *(failure to effectively implement EPR programme and failure to implement the IM&T strategy and key projects effectively);* CE

(D) the Medical Director be requested to update the narrative for risk 12 *(failure to retain BRU status)* and 14 *(lack of effective partnerships with universities)*, MD

(E) consideration be given to holding a Trust Board development session on clinical education, R&D and links with the higher education sector, and CHAIR/ DCLA

(F) the next iteration of the BAF be submitted to the 8 January 2015 Trust Board meeting. CN

302/14 REPORTS FROM BOARD COMMITTEES

302/14/1 Audit Committee

Mr M Williams, Non-Executive Director and Interim Audit Committee Chairman introduced paper L, providing the Minutes of the Audit Committee meeting held on 6 November 2014, drawing the Board's attention to the following key issues:-

(a) concerns raised that the Audit Committee had not been sighted in advance to variations in the timetable for the 2014-15 Internal Audit Plan. Arrangements had since been put in place to prevent this happening in future;
(b) update on the clinical coding service and the need for CMG teams to be appropriately aware of the impact of delays in coding and the importance of accurate coding, and
(c) further work being undertaken in respect of the Internal Audit review of delayed transfers of care. This audit had been carried out on a relatively small sample and had highlighted some data quality issues. An update on this audit and the associated audit rating would be presented to the next meeting of the Audit Committee.

In discussion on the above points, Trust Board members noted the importance of good governance surrounding the Internal Audit plan and received assurance that the newly appointed Director of Performance and Information would be leading a task and finish group to drive improvements in clinical coding. In the interim period, work was taking place to improve staff recruitment and retention within the Medical Records Department and reduce the backlog of clinical coding.

Resolved – that the Minutes of the 6 November 2014 Audit Committee (paper L) and the subsequent discussion be noted.

303/14 CORPORATE TRUSTEE BUSINESS

303/14/1 Final Accounts and Annual Report 2013-14 for Leicester Hospitals Charity

Mr P Panchal, Non-Executive Director and Charitable Funds Committee Chairman introduced paper M, providing the audited annual accounts, Trustee's annual report and letter of representation for the Leicester Hospitals Charity for the year ended 31 March 2014. These reports had been reviewed by the Charitable Funds Committee on 17 November 2014 and endorsed for Trust Board approval (as Corporate Trustee).

The Director of Finance commented upon the timeliness of the External Audit review process and undertook to arrange for improvements to be embedded for future years.

Resolved – that Trust Board approval (as Corporate Trustee) be granted in respect of the audited annual accounts, Trustee's annual report and letter of representation for the Leicester Hospitals Charity for the year ended 31 March 2014. **DF**

303/14/2 Charitable Funds Committee

Mr P Panchal, Non-Executive Director and Charitable Funds Committee Chairman introduced paper N, providing the Minutes of the 17 November 2014 meeting and highlighting the discussions on composition of the Charitable Funds investment portfolio and the wider process for approval of charitable funding expenditure.

The Trust Chairman noted future opportunities to consider and re-confirm the relationship between charitable funds and core NHS funds, in supporting improvement and innovation and direct patient benefits. The Director of Finance noted the need for improved forward planning and the development of a prioritisation process to shape the spending plans for this finite resource. He also raised opportunities to link with the Capital Monitoring and Investment Committee to ensure best use of charitable funds.

Finally, the Director of Marketing and Communications advised that the Charity's Annual General Meeting would be held on Thursday 18 December 2014, confirming that invitations had already been circulated for this event.

Resolved – that (A) the Minutes of the 17 November 2014 Charitable Funds Committee be received and noted and any recommendations endorsed by the Trust Board (as Corporate Trustee), and **DF**

(B) the date of the Charity's AGM be noted as Thursday 18 December.

304/14 TRUST BOARD BULLETIN

Resolved – that the following Trust Board Bulletin item be noted:-

- **Declarations of Interests from Mr P Traynor, Director of Finance and Mr M Williams, Non-Executive Director**

305/14 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

A patient raised a query regarding non-availability of patient case notes when attending multiple outpatient clinics and whether the implementation of the Electronic Patient Record (EPR) would resolve this problem. In response, the Chief Executive apologised that the patient had been affected by this issue and confirmed that one of the key benefits of the EPR system was to facilitate multiple access to patient notes at the same time. However, he noted that the timescale for implementation would be in the region of 3 years, subject to the necessary approvals being granted.

The same patient raised a supplementary question regarding the absence of notes in clinics for the purposes of typing clinical letters and queried whether there were sufficient staff working on this back-office function. In response to this question, the Chief Operating Officer reported on a recent focused workstream with the Renal, Respiratory and Cardiac CMG, during which the backlog of clinical letters (in that CMG) had reduced from 1400 to 400 and the relevant administrative and clerical vacancies had been recruited to. He also advised that a policy was in place for clinics to check whether a patient had an appointment with another specialty in the near future and he commented upon the scope to increase compliance with this policy to prevent such issues arising in future.

Resolved – that the questions and related responses, noted above, be recorded in the Minutes.

306/14 ANY OTHER BUSINESS

Resolved – that no items of other business were raised.

307/14 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 308/14 – 313/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

308/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

There were no declarations of interest in the confidential business being discussed.

309/14 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 30 October 2014 Trust Board be confirmed as a correct record and signed accordingly by the Trust Chairman. **CHAIR**

310/14 CONFIDENTIAL MATTERS ARISING REPORT

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

311/14 REPORTS BY THE CHIEF EXECUTIVE

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests and that public consideration at this stage could be prejudicial to the effective conduct of public affairs

312/14 REPORTS FROM BOARD COMMITTEES

312/14/1 Audit Committee

Resolved – that the confidential Minutes of the 6 November 2014 Audit Committee be received, and the recommendations and decisions therein endorsed and noted respectively.

312/14/2 Quality Assurance Committee (QAC)

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information and that that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

313/14 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Monday 22 December 2014 at a time to be confirmed in Seminar Rooms A and B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 1.40pm

Kate Rayns
Acting Senior Trust Administrator

Cumulative Record of Members' Attendance (2014-15 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh (Chair from 1.10.14)	2	2	100	R Mitchell	9	8	89
R Kilner (Acting Chair from 26.9.13 to 30.9.14)	7	7	100	R Overfield	9	9	100
J Adler	9	9	100	P Panchal	9	9	100
T Bentley*	8	7	87	K Shields*	9	9	100
K Bradley*	9	9	100	M Traynor (from 1.10.14)	2	2	100
I Crowe	9	8	89	S Ward*	9	9	100
S Dauncey	9	8	89	M Wightman*	9	9	100
K Harris	9	8	89	M Williams	2	2	100
D Henson*	5	5	100	J Wilson	9	7	78
K Jenkins (until 30.6.14)	3	3	100	D Wynford-Thomas	9	4	44

* non-voting members

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday, 27 November 2014

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1	298/14	***Chief Executive's monthly report*** An analysis of the Trust's MyNHS data (relating to Consultant level outcomes) to be circulated to Trust Board members outside the meeting.	DS	TB 8.1.15	In hand.	4
2	299/14/1	***Patient Story*** Chief Nurse to progress the requirement for additional blood machines in the Osborne Day Unit.	CN	Immediate	Resolved. The Osborne Unit has been provided with a cost code and advised to order additional machines.	5
3	299/14/2	***UHL Response to Congenital Heart Disease Review*** Update on the review process to be provided to the Trust Board.	DS	TB 4.6.15	Scheduled on the 4.6.15 Board agenda accordingly.	5
4	300/14/3	***Emergency Care Performance and Recovery Plan*** Sturgess report and the arrangements for implementation of the associated recommendations to be presented to the December 2014 Trust Board meeting.	COO	TB 22.12.14	Scheduled on the 22.12.14 Board agenda accordingly.	5
5	301/14/1	***NHS Trust Over-Sight Self Certifications*** Director of Corporate and Legal Affairs and the Chief Executive to update the October 2014 self certification returns using the month 7 quality and performance exception reports and submit these to the NTDA by 28 November 2014.	DCLA/CE	28.11.14	Complete.	5
6	301/14/2 (a)	***Board Assurance Framework*** Named risk owners (and contributors) to update the narrative in relation to risks 12 (MD), 14 (MD), 21 (DF/DS), 23 (CE/CIO), and 24 (CE/CIO).	MD/DF/ DS/CE/CIO	TB 8.1.15	Updated BAF to be reviewed by the Board on 8.1.15.	5
7	301/14/2 (b)	Consideration to be given to holding a TB development session on clinical education, R&D and links with the higher education sector.	CHAIR/ DCLA	Quarter 4 2014-15	Provisionally earmarked for the March 2015 TB development session.	5

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper C

TRUST BOARD – 22nd DECEMBER 2014

Chairman's Monthly Report

DIRECTOR:	Chairman
AUTHOR:	Chairman
DATE:	22 December 2014
PURPOSE:	**(concise description of the purpose, including any recommendations)** To brief the Board monthly on the Chairman's perspective.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** N/A
Objective(s) to which issue relates *	√ 1. Safe, high quality, patient-centred healthcare √ 2. An effective, joined up emergency care system √ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) √ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) √ 5. Enhanced reputation in research, innovation and clinical education √ 6. Delivering services through a caring, professional, passionate and valued workforce √ 7. A clinically and financially sustainable NHS Foundation Trust √ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	As stated in the report.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** √ **Not Featured**

ACTION REQUIRED *

For decision ☐ For assurance ☐ For information √

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **22 DECEMBER 2014**

REPORT BY: **CHAIRMAN**

SUBJECT: **CHAIRMAN'S MONTHLY REPORT**

Festivals

It is right that we should celebrate Christmas both in its religious sense and as an opportunity for families and friends to come together at this time. We should of course also think of those less fortunate than ourselves and I commend the efforts that staff are making in terms of donations and voluntary work. We have a rich mix in the diversity of our population in the City and the two Counties. I am also conscious that since I have taken up this role different communities have celebrated Eid, Divali and Guru Nanaks Birthday with the same spiritual depth or sense of sharing gifts as we celebrate Christmas. As one of the largest employers and public bodies in the area it is appropriate that as a Trust Board we recognise and celebrate this diversity.

Performance and Resources

The various reports being considered by our Trust Board highlight two key challenges.

The first is that there are a number of external factors (and our ability to influence these may be limited for various reasons) and internal factors (for which we must take responsibility) which impact on our performance. In terms of external factors we need to build meaningful relationships with other organisations that yield results and this is only possible if we arrive at a shared vision and perception about what is happening. In terms of internal factors we have to be self critical and transparent about our performance with appropriate accountability. Whilst emergency services are our focus at the present time we have to ensure that this scrutiny is across the entire organisation.

The second is that as a Trust Board we have to focus on the use of resources within the organisation and recognise that in financial terms we need to be strategic with committing resources when making key investment decisions, as we did recently in relation to electronic patient records, but also think about our sustainability as an organisation. In health terms financial expenditure cannot be separated from discussions about the quality of services and this should be the case. However I do not myself subscribe to the view that innovation and improvements in quality always require more resources and we have to encourage this approach.

The implications of both these issues will be that we have to ensure that we consider the right information about the right issues at the right time. As a Trust Board we will be actively considering the nature of the reports that will be needed if we are to make decisions in the future that show we have a clear sense of direction as well as determination to resolve the complex and interrelated challenges which we face.

Karamjit Singh CBE
Chairman, UHL Trust

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper D

TRUST BOARD – 22nd DECEMBER 2014

MONTHLY UPDATE REPORT – DECEMBER 2014

DIRECTOR:	CHIEF EXECUTIVE
AUTHOR:	DIRECTOR OF CORPORATE AND LEGAL AFFAIRS
DATE:	22 DECEMBER 2014
PURPOSE:	**(concise description of the purpose, including any recommendations)** To brief the Trust Board on key issues and identify changes or issues in the external environment.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** N/A
Objective(s) to which issue relates *	[√] 1. Safe, high quality, patient-centred healthcare [√] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [√] 6. Delivering services through a caring, professional, passionate and valued workforce [√] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [√] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [ ] For information [√]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **22 DECEMBER 2014**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – DECEMBER 2014**

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1. In line with good practice (as set out in the Department of Health Assurance Framework for Aspirant Foundation Trusts : Board Governance Memorandum), the Chief Executive is to submit a written report to each Board meeting detailing key Trust issues and identifying important changes or issues in the external environment.

2. For this meeting, the key issues which the Chief Executive has identified and upon which he will report further, orally, at the Board meeting are as follows:-

(a) emergency care performance;

(b) the Trust's RTT performance;

(c) the Trust's month 8 financial position;

(d) Better Care Together;

(e) the Dalton Review : options for providers of NHS care.

3. The Trust Board is asked to consider the Chief Executive's report and, again, in line with good practice consider the impact on the Trust's Strategic Direction and decide whether or not updates to the Trust's Board Assurance Framework are required.

John Adler
Chief Executive

15th December 2014

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper E

TRUST BOARD – 22 DECEMBER 2014

Emergency Care Performance Report and Response to the Sturgess Report

DIRECTOR:	Richard Mitchell , Chief Operating Officer
AUTHOR:	Richard Mitchell and John Adler
DATE:	14th December, 2014
PURPOSE:	a) To update the Board on recent emergency care performance b) To present the Sturgess Report and the Health Economy's response to that report c) To present the new system-wide Operational Plan and the UHL plan within that d) To report on new enhanced programme management arrangements across the system and within UHL.
PREVIOUSLY CONSIDERED BY:	Emergency Quality Steering Group, Urgent Care Board and System Resilience Group
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☒ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Healthwatch representatives on UCB and involved in BCT workstream.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	None undertaken but will be in respect of new pathways within BCT.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☒ **Board Assurance Framework** ☐ **Not Featured**

ACTION REQUIRED *					
For decision	x	For assurance		For information	

♦ **We treat people how we would like to be treated** ♦ **We do what we say we are going to do** ♦ **We focus on what matters most** ♦ **We are one team and we are best when we work together** ♦ **We are passionate and creative in our work*** tick applicable box

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**22 December 2014**

Introduction

- Performance in November 2014 was **89.1%** compared to **88.5%** in November 2013 and **90.3%** in October 2014. November 2014 was the first month in six where performance dropped below 90%.
- December 2014, month to date (11/12/14) is **85.1%**.
- Emergency admissions (adult) continue to steadily rise in November; **216** compared to **215** per day in October and **209** per day the month before.
- Emergency admissions in November 2013 were 193 per day (**now 11.9% higher**).
- Delayed transfers of care have risen recently and are at **5.7%.**

Performance overview

Performance has got worse over the last two months. As stated in the board report last month this is a result of a perfect storm of more medical emergency patients admitted, a lack of capacity outside of UHL for these patients to transfer to and internal process failing at times of extreme pressure. Over the last month, UHL has gone onto an internal major incident (IMI) on four occassions. The response to an IMI is; greater speciality input into ED, an increased focus on discharges across all specialities and improved inreach from community partners. The last IMI was on Tuesday 9 December 2014. GPs from West Leicestershire CCG and East Leicestershire and Rutland CCG came into UHL and took part in the incident response, assisting in increasing the discharge rate. Feedback from GP colleagues was encouraging in terms of the high level of internal engagement in addressing the issues faced.

On 11th December, a formal meeting was held between health economy partners and the NHS Trust Development Authority and NHS England. This reflects a high level of ongoing concern about local performance. The meeting reviewed the new action plan prepared in response to the Sturgess Report (see below). The approach being taken was generally endorsed, with particular emphasis being given to:

- Reducing emergency admissions through effective review of GP referrals by both primary and secondary care
- Alternative approaches to hospital conveyance by EMAS
- More effective surge and recovery response across the whole system
- More focus within UHL on morning and weekend discharges (to maintain flow)
- More effective programme management across the system

Actions are being put in place to pursue or enhance these key points before Christmas.

Sturgess report

Dr Ian Sturgess, an expert in emergency care pathways, was commissioned by East Leicestershire and Rutland, Leicester City and West Leicestershire Clinical Commissioning Groups and University Hospitals of Leicester NHS Trust to provide recommendations on how the emergency pathway can improve. The review was conducted between mid-May 2014 and mid-November 2014 and Dr Sturgess spent time with clinicians and staff in primary care, acute and community hospitals, mental health services, NHS 111 and out of hours care, urgent care centres and social care teams.

System wide recommendations

Dr Sturgess found that the local system is 'relatively fragmented with barriers to effective integrated working'. He stressed the importance of recognising performance against the national 4-hour wait

standard for the Emergency Department as a reflection of the performance of the whole health and care system and he made 183 recommendations for transformation and improvement. His full report is attached as Appendix 1.

The recommendations focus on issues relating to the following themes:

- **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department.
- **Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs.
- **Improving processes within Leicester's Hospitals** – improving the Emergency Department and patient flow within the hospitals to improve patient experience and ensure there is capacity in all areas.
- **Discharge processes across whole system** - ensuring there are simple discharge pathways with swift and efficient transfers of care

A number of Dr Sturgess' recommendations relate to longer term transformation and some improvements are already underway or in development as part of the Better Care Together programme. The recommendations were collated into one document and have been considered in detail by all organisations. In some instances the recommendations have not been wholly accepted but alternative interpretations or recommendations have been considered. Each recommendation has then been ranked on the basis of its impact and how quickly it can be implemented, using a scale of of 1 to 4.

The most urgent, highest impact actions in the Sturgess Report form a new 'LLR operational winter urgent care action plan' (Appendix 2) aligned to outcome measures and metrics to monitor integrated process as recommended within the report. This plan focuses on actions over this winter. The Urgent Care Board will closely track the progress of this plan to ensure that actions and outcomes are aligned and resilient across the urgent care pathway as well as within the clinical pathways. Substantially strengthened programme management arrangements are being put in place to ensure that this is the case. This has been an area of acknowledged weakness in the past. As part of these changes, Toby sanders, Managing Director of West Leicestershire CCG has taken over the chair of the Urgent Care Board.

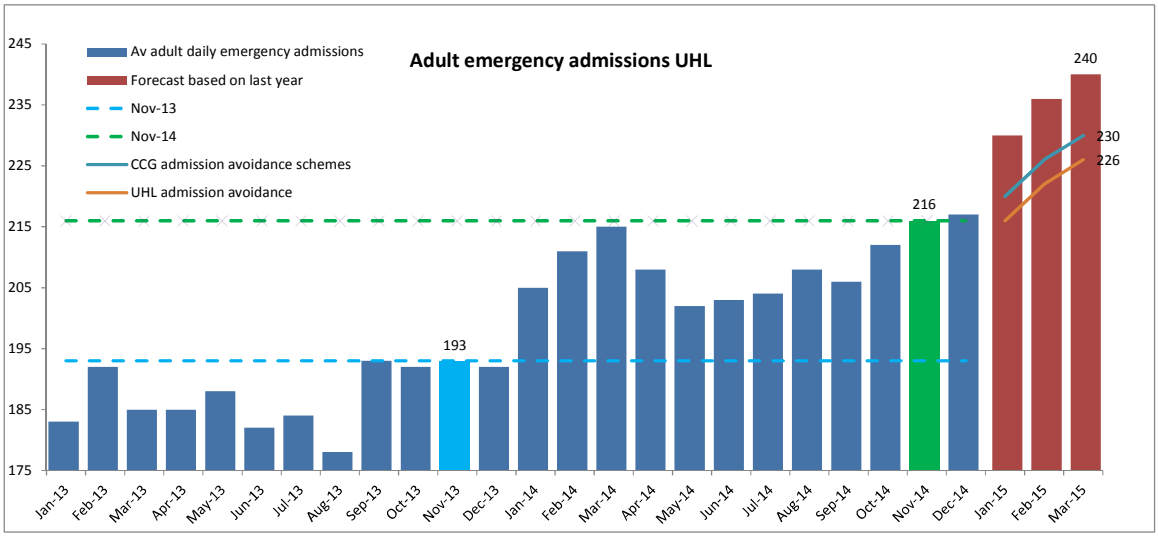
UHL recommendations

Dr Sturgess spent a lot of time at the beginning of his review in UHL and we have therefore had more time to respond to his recommendations. As part of developing the new action plan we have revisted our approach to organising for this sustantial body of work. As a result, we are now working with a small team from Ernst Young to support the project management of our actions and formal programme management arrangements have been put in place. We are focussing on three main workstreams; ED, AMU and base wards and discharge with other secondary workstreams focussing on CDU and Glenfield, surgery, oncology and imaging. These workstreams report into the weekly emergency quality steering group meeting chaired by the Chief Executive. The UHL actions that we are managing form part of the LLR plan at Appendix 2. This arrangement will substantially improve the integration of our actions with those of the wider system.

Conclusion

To achieve sustainable improvement requires all parts of the health economy to improve. The fragile nature of the pathway means that slow adoption of improvements in one part of the health economy will hinder the overall improvement. We need to be ambitious for the level of improvement we require of each other and this is the intention of the new Operational Plan and its supporting arrangements.

The graph below details the average adult emergency admissions at UHL. In November 2013 193 patients were admitted per day and this has risen to 216 in November 2014. If admissions rise at the same rate as last year, this will be 240 admissions per day in March 2015.



It should be noted that the deficit of mitigating actions against the above trend is not as great as it appears as there are are some data artefacts in the headline trend. This means that the "real" rise in emergency admissions is not as great as it appears to be, but it is nevertheless significant and above the level that can be accommodated. We must therefore set challenging expectations for all parts of the health economy (including UHL) and work to ensure these expectations are rapidly met.

Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the contents of the Sturgess report and to confirm that the system wide action plan appropriately addresses the report's recommendations
- **Request** monthly updates against the delivery of the new operational plan, including the UHL element
- **Support** the actions being taken to improve performance

Appendix 1

Dr Ian Sturgess
IMP Healthcare Consultancy
14th November 2014

Dr Dave Briggs
Managing Director
East Leicestershire and Rutland CCG

Toby Sanders
Managing Director
West Leicester CCG

Sue Lock
Managing Director
Leicester City CCG

John Adler
Chief Executive
University Hospitals of Leicester

Dear all

Re: Feedback Report on the Urgent Care Pathway in LLR.

‘Every system is perfectly designed to deliver the results it achieves’

Executive Summary of Key Recommendations

The Leicester, Leicestershire and Rutland (LLR) health and social care system has, for a number of years, faced challenges in the resilient delivery of urgent and emergency care for its population. To improve, the LLR health and social care system will need to focus on collaborative and integrated working to achieve patient, system and population outcome benefits. This is not just about delivering the 4 hour standard, this is about improving patient outcomes based around the ‘domains of quality’, that is, it is not about ‘hitting a target but missing the point’.

There has been some early improvement seen within University Hospitals Leicester (UHL), however, this has not been matched by the rest of the system. The risk is that ‘local optimisation’ by improving processes solely within UHL will create a ‘supply side driver’ increasing activity flowing to the acute sector. The 4 hour Emergency Care Standard happens to be measured within the Emergency Department, yet it is best to consider this ‘performance measure’ as a measure of resilience of the whole health and social system in how that system responds to urgent care needs within the community. If there is ineffective ‘demand management’ and poor flow through the system with multiple ‘hand offs’ and ‘barriers’ to transitions of care, then a queue is guaranteed within the ED, that is the system has been ‘perfectly designed’ to deliver that queue.

The system within LLR is relatively fragmented with barriers to effective integrated working. The development of a clear vision of a high quality responsive urgent and emergency care system which is clinically owned and well communicated across the

system is crucial to support the drive for improvement. The summary recommendations below are not to be seen as a series of quick fixes but as a series of improvements to the system focussing on impact and outcomes rather than a set of 'activities'. The implementation of these processes are to be seen as a part of a 'whole system change' rather than 'pilots' and require effective change management.

With this 6 month independent assessment and an appraisal of the whole system, along with the openness of discussions and responses, there is a clear demonstration of a desire to change with commitment from system leaders.

The system needs to consider the following guiding principles in the transformation of urgent and emergency care:

- Anticipatory care for people with long term conditions and/or frailty needs to be planned and implemented in a timely manner to avoid a minor acute illness becoming a crisis.
- When this group of patients access urgent care services, this provides an opportunity to examine the extent of integration of a system to respond to their needs.
- Acute admission to hospital should only occur if there is an evidence based acute intervention that can only be delivered in hospital. Otherwise, the timely delivery of interventions and care should be provided in the community to avoid unplanned default attendance at Hospital.
- If emergency admission to hospital does occur, then the 'home first' principle applies. Namely, that if someone is admitted to hospital and after necessary interventions and treatment, the system's primary aim will be to return that person to the home address from which they came. If there is a need for on-going assessments around decisions for further care, these take place within the persons 'usual environment' where they are likely to function at their best. This is to avoid 'crisis' decision making about the long term care from a 'hospital bed'.
- A recognition that remaining in Hospital when there is no longer any 'acute' need to remain in Hospital, in particular, for people with frailty risks the development of de-conditioning, which can worsen outcomes.
- There is a need to ensure the application of known effective improvement methodology and organisational change methodology in particular with reference to large scale change (http://www.nhsiq.nhs.uk/8530.aspx).

There are a considerable number of recommendations within this report and summarised here are the key priorities for the system to commence work on immediately to start to gain some traction within the system. So far, admission/attendance avoidance schemes have not delivered sufficiently and are not being rigorously performance managed.

1. Relatively Simple Immediate Individual Organisation/Bilateral Actions

a. Delivering the full potential of ambulatory emergency care as described in the Directory of Ambulatory Emergency Care for Adults. As described in the NHS England Operational and Resilience Plan 2014/15, AEC should be considered the default position.
b. Community Hospital transfers back to UHL. Patients to be seen and examined by Out of Hours service with discussion with on-call Consultant

Geriatrician/Physician or relevant specialty Consultant for treatment advice aiming for a 60-80% reduction in 're-presentation' to acute sector. This requires all patients transferred to Community Hospitals to have an expected date of discharge and criteria for discharge on transfer, the transfer of the Patient records with the patient (or a copy thereof) and seamless continuation of rehabilitation from the plan set prior to transfer.

c. Appropriate category calls conveyed by East Midlands Ambulance Service (EMAS) to the Loughborough Urgent Care Centre (UCC). This can be through a design of a set of simple rules which both parties follow.
d. Simplify referral to Community services with a 'referrer decides' with same day access, this could be rapidly facilitated via the 'frailty' team approach, see below. Rapidly improve Single Point of Access (SPA) response times to accommodate demand.
e. Simplify the equipment ordering contract with the provider to allow any member of the Inter-disciplinary team (IDT) to order appropriate equipment.
f. Leicestershire Partnership Trust (LPT) to minimise unscheduled episodes from planned care impinging on the unscheduled care/ICS team by improving 'anticipatory care' of planned care. Aim to significantly increase (50-100%) flow through the 'virtual ward' with a 30/70 or 40/60 split between admission avoidance and early supported discharge
g. Merge 'front door' streaming between UCC and the Emergency Department (ED) at the Leicester Royal Infirmary (LRI) at the 'Minors Desk'. Streaming to appropriate clinical teams with both delivering 'see and treat' model of care. Aiming for 80-90% completed care within 2 hours. Commission the Out-of-Hours service (OOH) to provide mutual aid to UCC both at LRI and at Loughborough, the latter can be implemented by unifying the contract.
h. Implement GP to Consultant (0800 to 2100 hrs) telephone discussions for all but immediate life threatening referrals for acute assessments with the availability of alternative non-admitted pathways (same/next day rapid access clinics, community provision, advice etc.)
i. At UHL, admitting Consultant presence matched to the patient arrival profile, for example the Consultant Physicians covering the assessment units until 2300hrs.
j. Continuity of care for patients who remain on the assessment units/short stay for the first 24 hours. This requires the evening Consultant Physician to review those patients that remain on the Assessment Units or Short Stay at 0800 hrs the next morning.
k. Every admitted patient having an expected date of discharge and clinical criteria for discharge set and owned by the clinical teams within 12-24 hrs as a maximum.
l. Daily Consultant led assertive Board rounding and one stop ward rounding on all acute wards. The aim being to progress case management and to identify and deal with any constraints to flow. This includes an 0800 hrs start to 'capture' new patients and facilitate early discharge in preparation for the 0900 Board Round.

m. Peer to Peer review of patients with 'trigger' length of stay. The trigger points require internal definition and this is necessary within both UHL and Community Hospitals.

2. Immediate Interventions Requiring Multi-agency Actions

a. 'Front Door' frailty team. Aiming to capture **all** patients with frailty and thus at risk of a long length of stay. This team then tracks these patients through their journey aiming to achieve optimal early transfer of care. Availability determined by demand profile of arrivals of target population. The aim is 'transfer of care' home as soon as stable for transfer to avoid in-hospital deconditioning. The transfer of care process will require same day transfer to community based services. The metric for success is a significant reduction in the number of beds occupied by patients aged 65 and over who have been in hospital 10 days or more. Effective interface management across the system minimises the risk of re-admission.

b. Simplification and standardisation of the processes around transfer of care with a move to 'needs assessment' and funding decisions around Care Act 2014 eligibility criteria taking place in the patient's own home. That is home based 'discharge to assess' rather than the 'completion' of these assessments in Hospital. This process to include assessments for NHS Continuing Care.

c. Care Home urgent and emergency care responses. The default will be to ensure that all residents have advanced care plans, which describe the actions to be initiated for acute exacerbations of long term conditions with the aim that the care goes to the resident. Telemedicine options, for example from Airedale, have resulted in an over 50% reduction in ED attendances with high satisfaction rates.

3. **Complex Changes Requiring Planning and Implementation**

a. Formation of federation of Primary Care Practices with stream management. Consider configuration may be different for the City versus the County with alignment with Community services in the former and with both Community and Acute in the latter.

b. Development of robust 'registers' of people with long term conditions and/or frailty with realisable anticipatory care plans which clearly identify the response needed for predictable urgent care scenarios.

c. Commission a more integrated liaison mental health service avoiding unnecessary stays in the acute hospital sector.

d. Invest in developing an improvement expertise across the system. There is an opportunity to link with NHS Improving Quality, the Universities and regional and national industries with expertise in quality improvement to build a 'Leicester Improvement Academy'. This would aim to build improvement methodology skills amongst health and social care staff as well as equipping graduates in health and social care with these skills for the future.

Introduction

IMP Healthcare Consultancy was commissioned by the three CCGs and UHL to provide feedback and support on improvement of the urgent and emergency care system from mid May 2014 to mid November 2014. The aim of this report is to stimulate a system that has the potential to be a 'high performing health and social care system'. The risk is that the observations and comments contained herein could be used to create a 'finger pointing and blaming culture' across the system. The opportunity lies 'between the heads' of the leadership of the system to use this report to stimulate a progressive, outcomes focussed quality improvement programme for the urgent and emergency care system within Leicester, Leicestershire and Rutland (LLR). System leaders will need to promote collaboration, vision, communication, enablement of improvement and supporting ideas from the 'grass roots'. The improvements will be about the 'many not the few' with a focus on a 'new future' that is so compelling that engagement will continuously grow.

The LLR system has faced challenges across the urgent and emergency care pathway for some considerable time. The LLR urgent and emergency care pathway lacks cohesion with multiple re-assessments, limited effective exchange of clinical information and patients becoming stuck during parts of their journey through the system resulting in avoidable harm and potential avoidable mortality. 'Good systems' recognise the potential for avoidable harm and mortality whilst 'poor systems' attempt to deny that potential. The advantage of the former is that it 'drives continuous improvement'. Although some indicators have shown a relatively low risk adjusted rate of emergency admissions per head of population, there has been a significant rise in emergency admissions over the last 12 months. A system wide urgent and emergency care pathway requires the whole system to be engaged in aligning the key inputs to the urgent care needs of the population of LLR.

It does appear that organisational relationships across they system have been improving over the last year or two, however, there remains a level of mistrust across the system which is impeding effective integration of processes, this is evidenced by the frequency of repeat assessments across the patient's journey resulting in the patient having to repeat the same information. The providers across the urgent and emergency care pathway operate in relative isolation with some operational processes that 'protect' the impact on the provider rather than focussing on optimising the patient journey. This is akin to 'pulling up the drawbridge and patrolling the borders' to protect costs. LLR non-elective risk adjusted admission rates have been lower than average according to Dr Foster but from data sourced from NHS England on Benchmark Performance reported in Better Care Together it appears that admission rates are average. On reviewing the NHS England source information packs for both Local Authorities and Clinical Commissioning Groups, it does appear that the rate of long term care placements for over 65 year olds has deteriorated between the generation of the two data sets (2013 vs 2014) in all three LA areas.

There have been a number of new initiatives put in place across the system to either manage demand or to support discharge. However, the impact metrics for these new processes do not appear to be effectively monitored nor performance managed,

for instance the 'Doctor in a Car' or 'Clinical Response Team' has been in place since early this year with an expectation of 16 assessments per day to aim to reduce admissions, on average this process has seen 2 patients per day since inception and the performance of this team has not been discussed at an Urgent Care Board. In addition, it is apparent that a number of the initiatives have actually compromised flow across the system; these will be highlighted under the relevant sections. Transfer of care from hospital for all but the simplest of discharges has become over complicated and confused with the generation of many complex rules. These are 'classic' examples of attempts at 'local optimisation' which have had an adverse impact on flow and quality productivity.

Up to 60 to 70% of emergency admissions are in people with long term conditions and/or frailty. These patients are 'known' to the system and as such there is the potential to have discharge planning, as a generic process, in place before they are admitted with 'pull' out of hospital on the same day as a patient is declared fit for discharge. As such, how the system supports discharge as an area for improvement will be reported on in this feedback as it is the system outside of the hospital which can facilitate discharge for these patients.

The key drivers for improvement, mapped against the NHS England Domains (http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/), in the urgent and emergency care pathway are:

1. Patient Safety – preventing avoidable harm and death – Domain 4
2. Patient experience – 'Everyone counts' – Domain 5
3. Timeliness – 'Respecting patient's time' Domains 3, 4 and 5
4, Effectiveness – early delivery of known effective clinical interventions without unnecessary delay - Domains 1 and 3
5. Efficiency – reduction of multiple assessments, excessive handovers, unnecessary investigations etc. Domains 3, 4 and 5
6. Equality – valuing individuality and choice - Domains 1-5

The 'Learning Lessons to Improve Care' identified opportunities for improvements in patient care to reduce harm and mortality. The urgent and emergency care pathway for older people with frailty is an area of significant opportunity for improvement. The current pathway for this group of patients is heavily bed based and results in a number of moves for patients around the system. The extent of deconditioning/decompensation of older people with frailty occurring across this pathway is potentially significant and resulting in longer length of stay and poorer outcomes at higher cost. The extent of 'fast track' and CHC placements appear to be higher than the national average, the former being reported, until recently, to be 4 times the national average. Could these high rates of high levels of care indicate an opportunity to minimise deconditioning?

The purpose of this integrated report is to describe what is happening at the moment and to describe the opportunities for improvement. The statements made follow direct observation of the system and utilising multiple sources of observations by clinicians in the system. Nothing mentioned herein should be used to 'blame' elements of the system since no one part is perfect. The whole system has to accept that it has considerable issues in every single sector of health and social

care. In addition, there is fragmentation of services across Leicester, Leicestershire and Rutland (LLR) with complex rules governing access that even experts have difficulty navigating. The systemic issues require an integrated system response focussed on delivering the highest possible quality of care and outcomes for patients who have urgent care needs as close to home as possible.

The public make choices about how they access health care for urgent care needs based on their experience of services, ease of access and convenience. Attempting to 'divert' them to other 'services' to 'avoid inappropriate' attendances elsewhere is fraught with challenges when those alternatives do not deliver the inputs when the person needs/wants that input.

LLR as a system will only improve when there is trust and co-operation and collaboration across the system towards a mutually agreed and well communicated vision for the future which is owned by clinicians across the system. There is much that can be done in the preventative, health promotion and very early response to urgent need that can deliver significant 'demand' control of patients deteriorating to a level of urgent/emergency need which then results in Emergency department attendances and acute admissions. However, these inputs need to be consistent and consumer friendly.

The population of LLR is diverse with Leicester City having a more culturally diverse population, higher levels of deprivation and inequalities in life expectancy compared to the less deprived areas of Leicestershire and Rutland. Long term conditions burden in each of the CCGs are either similar to or significantly less than NHS England average apart from high levels of Diabetes and Mental Health prevalence in the City, depression in the West and Diabetes, heart failure and atrial fibrillation in the East and Rutland (http://ccgtools.england.nhs.uk/cfv/flash/atlas.html). There is still much to be achieved in health promotion, preventative healthcare and pre-hospital care that could significantly impact on the outcomes of the population and its subsequent utilisation of high cost secondary care when preventable acute ill health has developed or because of responsiveness or accessibility or perceptions of appropriateness patients choose to access the Emergency Department for their 'urgent care needs' where other choices might have been more appropriate. The NHS England Report 'Five Year Forward View' released in October 2014 (http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf) has stressed the importance of 'getting serious about prevention', creating a new relationship between the service and people and communities and new models of care.

In LLR there is an excessive focus on the '4 hour standard' and an inappropriate interpretation that it is an 'Emergency Department (ED)' problem rather than actually understanding that it is an 'integrated metric' measuring the capability of the whole health and social care system across LLR that happens to be measured in the ED. The risk of the excessive simplistic focus on the 4 hour standard as an ED or just as an UHL metric will result in the generation of a 'supply side driver' whereby improvements in the flow through the ED and the Hospital will pull more patients in to the Hospital as a consequence of not holding the rest of the system to the same level of accountability.

Complex systems should be governed by simple rules. If there are multiple complex rules attempting to govern a complex system, the result is chaos. An understanding of variability, both the types and how variability can be both planned for and managed is crucial in improving quality of care. There are, in essence, two types of variability (http://www.nhsiq.nhs.uk/media/2402957/final_part_ii-blink_rcl.pdf):

1. Special cause variation. One off events or infrequent events that perturb the system briefly in either a negative or a positive way.
2. Common cause variability, this can be both inherent e.g. the variability of the frequency that patients become unwell, or those that are added to the system by the variability with which processes are managed by the system.

Special cause variability requires specific mention here. Changing the processes that manage common cause variability in a system to deal with a one off or infrequent negative special cause variability is guaranteed to increase the common cause variability and thus the likelihood of a poorer outcome. The way to deal with negative special cause variability is to put in place a mitigation to prevent that event occurring or to manage it as a one-off whilst ensuring that the change does not impact on the processes for the 99.9% of other patients going through the system. For positive special cause variability, i.e. when something goes spectacularly well, the process for that event needs to be examined to see if there is any learning that might be generalizable to improve the whole system. This can and must only be tested through the application of improvement methodology to see if the new proposed process actually does improve the whole system before it is widely implemented. Sadly, the health services around the World are littered with 'fixes' for special cause variability that have totally perturbed common cause variability.

The LLR system, as well as UHL specifically, has had significant input from the Emergency Care Intensive Support Team and 'Right Place Right Time Consulting'. These have both identified the key processes that need to be improved to deliver an effective emergency care pathway. However, these recommendations have not been embedded in a consistent manner with a real time information feedback loop to show how the new processes are working and to make visible the variance between clinical teams in their effectiveness of delivery of these processes. There is a need to understand the reasons why 'good advice' has not been realised in to real improvement. There has been a degree of learnt helplessness/hopelessness along with a 'cultural' block to change, it does appear, over the course of the 6 months of this review, that there is a burgeoning desire to change and improve.

For patients attending at any part of the 'urgent care system', the key principle is 'assess once, investigate once if necessary, decide once, and deliver'. Multiple assessments, none targeted investigations, multiple handovers/ward moves, poorly managed referral processes and lack of focus on the delivery of the case management plan result in very poor patient experience, increased harm and the potential for increased mortality.

For admitted patients, observations are made from the perspective of the four questions they should be able to answer soon after being admitted, namely:

1. **What is wrong with me or what are you trying to find out?** This is achieved by timely competent assessment by a decision making clinician who discusses and explains their findings with the patient:

2. **What is going to happen now, today and tomorrow?** This is achieved by the construction of an end to end case management plan by a senior clinical decision maker in partnership with the patient who ensures that these 'inputs' occur in a timely manner..
3. **What do I need to achieve to go home?** This is achieved by setting individualised patient focussed clinical criteria for discharge whilst maintaining timely monitoring of the progress of the patient and ensuring early intervention if there is any negative deviation from the expected recovery pathway. The aim is to create expectation akin to that seen with the 'enhanced recovery programme' in elective care.
4. **When am I going home?** This is achieved by setting the expected date of discharge which does not include the unnecessary waits known within the system. For admitted patients, assertive board rounding and one stop ward rounds ensure that all tasks are completed on time and that as little of the patient's time is wasted waiting for the necessary inputs to occur. Unnecessary waits are highlighted and managed within the team and if not these waits are escalated.

Some organisations have converted these 4 questions in to a patient held information card which also has the name of the Doctor and Nurse in charge of their care and a contact number.

There are a number of excellent clinical, non-clinical and social care leaders across the whole system who are very committed, have and are investing a considerable amount of time and energy in attempting to improve the situation. These individuals have demonstrated the drive for improvement in the pathway, seeking suggestions for improvement with supportive challenge and hold to account those whose practice falls short of what is expected. These leaders need to be thoroughly supported by the LLR system as they pursue the challenge of modernising and improving the urgent and emergency care pathway.

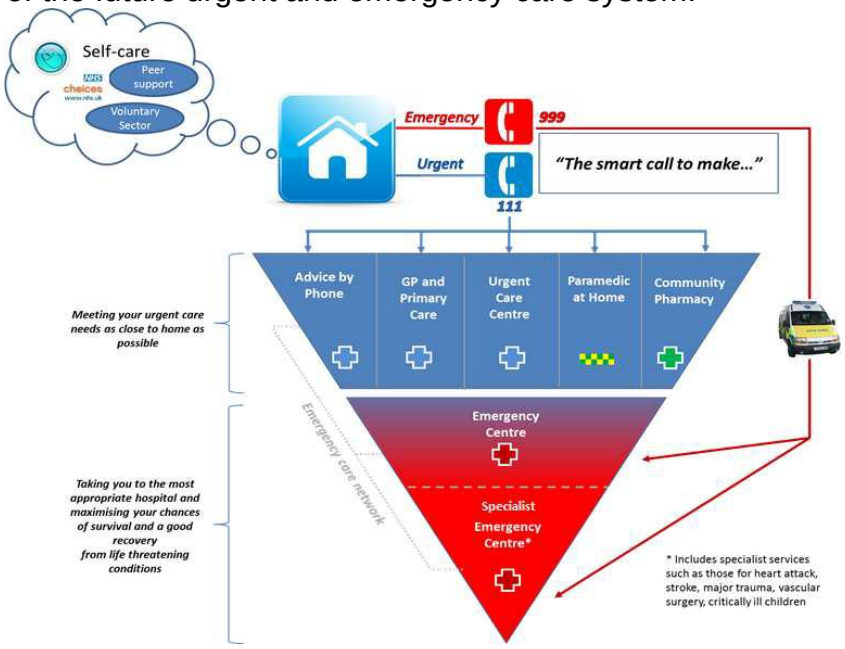
There are three things that are amenable to change:

1. Structure – structural change alone rarely delivers any actual benefit.
2. Process – optimising processes focussing on what adds value to the patient is the main element of any improvement programme.
3. Patterns – relationships, behaviours, motivation, peer to peer support and challenge. This is a crucial element to deliver sustainable improvement. Top down enforced process changes will never sustain, whilst bringing about a desire to see improvement in a collegiate atmosphere drives sustainable improvement.

There is particular attention on urgent and emergency care at a national level following the publication of NHS England's 'Transforming urgent and emergency care in England. Urgent and Emergency Care Review: End of Phase 1 Report' (http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf) and the 'Update on the Urgent and Emergency Care Review' (http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf) in which the vision for urgent and emergency care is described:

1. Firstly, for those people with **urgent but non-life threatening needs** we must **Provide highly responsive, effective and personalised services outside of hospital.** These services should deliver **care in or as close to people's homes as possible**, minimising disruption and inconvenience for patients and their families. Secondly, for those people with **more serious or life threatening emergency needs** we should ensure they are treated **in centres with the very best expertise and facilities**, in order to **maximise their chances of survival and a good recovery**.

2. Underneath this vision we described, in visual form, the shape and structure of the future urgent and emergency care system:



3. In order to move from the current to the future system we proposed five key elements of change. These should apply to all patients, regardless of their age, location, co-morbidities or physical and mental health needs:
   - Providing **better support** for people to **self-care.** See the Health Foundation report on 'Person centred care: from ideas to action' (http://www.health.org.uk/public/cms/75/76/313/5018/Person-centred%20care_from%20ideas%20to%20action.pdf?realName=06z1oQ.pdf)
   - Helping people with urgent care needs to get the **right advice** in **the right place, first time.**
   - Providing **highly responsive urgent care services outside of hospital** so people no longer choose to queue in A&E.
   - Ensuring that those **people with more serious or life threatening emergency need**s receive **treatment in centres with the right facilities and expertise** in order to maximise chances of survival and a good recovery.
   - **Connecting urgent and emergency care services** so the overall system becomes **more than just the sum of its parts.**

The feedback will comprise two main sections, the first is around strategic ‘set up’ and recommendations, the second is around observations of the system and recommendations. Both are equally important, failure to focus on the key elements of strategic ‘setup’ risk an improvement programme developing without focus and direction with resultant disintegration in to frustration and disillusionment amongst the early adopter/early majority group of staff who are keen to progress with change.

1. Strategic Intent

Providing clear leadership and description of strategic intent aiming to deliver a high performing health care system is a key attribute in bringing about large scale change across systems. There have been a number of reviews of high performing health care systems which have sought to identify these key attributes (http://www.kingsfund.org.uk/sites/files/kf/roles-of-leaders-high-performing-health-care-systems-ross-baker-kings-fund-may-2011.pdf,). The common themes were:

- Consistent leadership that embraces common goals and aligns activities throughout the organisation.
- Quality and system improvement as a core strategy.
- Organisational capacities and skills to support performance improvement.
- Robust primary care teams at the centre of the delivery system.
- Engaging patients in their care and in the design of care.
- Promoting professional cultures that support teamwork, continuous improvement and patient engagement.
- More effective integration of care that promotes seamless care transitions.
- Information as a platform for guiding improvement.
- Effective learning strategies and methods to test improvements and scale up.
- Providing an enabling environment buffering short-term factors that undermine success.

The system has started to a clear vision in the form of impact across the system with regard to the urgent and emergency care pathway which is clinically led and well communicated. The Better Care Together process and the Better Care Funds are an opportunity for creating a unifying vision. Although the BCF programmes do have a suite of metrics and to some extent these are reflected in Better Care Together, it is difficult to have absolute clarity of 'what good will look like' at the end of implementation. The outcomes metrics on Pages 9-13 of the June 2014 version of the BCT 5 Year Plan lack clarity. For instance, the percentage reductions in admissions, attendances and occupied bed days are open to differential interpretation. For instance a 25% reduction in emergency admissions for chronic diseases can be influenced by changes in coding practice, and does this represent an absolute or a relative reduction based on demographic changes? The evidence base for the reduction in emergency admissions to hospital is not strong apart for certain specific conditions such as heart failure and chronic obstructive pulmonary disease. The strongest evidence is for the potential marked reduction in occupied hospital bed days through effective integration of processes aligned to minimise the delays in patient journeys through hospital. At the work stream review by the Clinical Reference Group of the BCT programme on the 25th Septe4mber 2014, the members were asked to enunciate the key objectives/improvement aims/system level impacts that the work would deliver. There was clarity regarding the financial challenge to the whole system over the next 5 years but this did not appear to be matched by a clear statement of intent with regards to the quality improvements to be gained by the process.

The CCG/Local Authority Better Care Fund submissions also provide strategic direction and more clearly defined metrics, most of which are defined at the national level. However, a number of the aspirations expressed in these documents have been delivered by other systems before the Better Care Fund programme was

commenced. The challenge to the system is to deliver at pace within the next 6 months the older people with frailty agenda as it is this pathway which is most broken in this system. The principles of an effective system for people with frailty are described by the King's Fund paper 'Making our health and care systems fit for an ageing population' (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf) with its 'Ten components of care for older people' (see below) and the 'Silver Book: Quality care for older people with urgent and emergency care needs' (http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf). A commitment to reducing by 50% the 'stranded patient' metric described below within 6 months. That is, less than 100 beds occupied by patients aged 75 years and older within UHL who have been in hospital 10 days or more with no increase in re-admissions nor in long term care placement. A better improvement aim is a 50% reduction in the same metric across all acute and community 'therapeutic' beds, however, as of to date, the 'joining' up of the journeys between acute and community hospital beds is not available.

The 'Home First' principle, i.e. the home address you came from will be the address to which you will return, for discharge from Hospital is still not embedded within the system as a key principle and as a result the very significant constraint of 'hospital based deconditioning' is continuously being embedded within the patient journey. This is resulting in poor outcomes.

Recommendations

- **Utilise the principles of 'large scale change' models to create an inspirational and motivating 'story' of what the future will look like. Consider using the NHS Change Model:**

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- **Or using Kotter's 8 steps of change :**

- **Increase urgency by providing clarity about the challenges faced. Focus on describing these using a quality framework such as the Institute of Medicine's 6 domains of quality described in the 'Crossing the Quality Chasm'**

(www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf), and the IHI Triple Aim objectives (http://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx). Financial drivers alone will not create a social movement for improvement across 'multiple agencies'. A compelling story of improved outcomes for large groups of patients will generate the 'will, ideas and execution' for change. The NHS is awash with 'improvement changes' for the select few e.g. patients with strokes, myocardial infarction or major trauma, real system change is to deliver marked improvements for the 'many' usually the disadvantaged or those suffering discrimination, the latter most commonly older people.

- **Build the guiding coalition. There will be formal leaders but high performing systems also crucially recognise their 'secondary leaders and group leaders' who will demonstrate the need for change from the compelling story. It is these 'secondary leaders' who will want to form coalitions across the system to deliver the changes. It is these 'secondary leaders' who through their actions and behaviours create the 'social movement' for change. Their enthusiasm can be inhibited in a hierarchical system. This is where a 'blaming culture' can do so much to inhibit the coalitions, in systems where there have been long term 'performance' issues, the pressure applied to these systems can result in a blaming culture developing.**
- **Get the vision right. The guiding coalition becomes the central force in creating a change vision and change strategies and describing how the improved models will work. By a relentless focus on the 'what good will look like' with continuous feedback of improvements supported by 'humility' in recognising that others across the system can deliver better, learning from so called 'junior partners' demonstrates a 'learning leadership' that lacks the arrogance of 'hierarchical leadership'.**
- **Communication Strategy – See below.**
- **Empower action. Ensure that the strategic team create the opportunities for changes to take place by removing obstacles to change, for example IT, cross organisational operational policy that 'conflict', referral processes. Leaders who make doing the right thing easier to do and feedback about the improvements delivered will motivate staff.**
- **Create short-term wins. The challenge for the LLR system is the extent of sceptics and 'historians' who have 'heard it all before' and place a 'brake' on opportunities for improvement. Empowered people, feeling a sense of urgency and guided by the vision and strategies, focus their actions on achieving a continuing series of visible and unambiguous successes, starting as quickly as possible. With visibility to as many people as possible, and with a lack of ambiguity that makes it difficult to argue whether these are real successes on the journey to the vision.**
- **Maintain momentum. Early successes, while desirable, also create the danger of complacency. Since a few successes never take you the distance to achieve a vision of significant change, such complacency must be avoided at all costs. In successful large-scale change efforts, that problem is anticipated and effort is directed to keeping urgency up, keeping the wins coming, and never letting up until all the necessary**

changes have been made. Only when the organization has achieved the change vision, and only after its success is clear to all, does effort shift to the last step.

- **Make change stick. A new order of operating is always fragile at first. Sustainable delivery of a new model of care across a system needs to be in place for as minimum of 3 years for there to be the potential of having achieved sustainable change.**

Developing a Suite of Metrics

Developing meaningful metrics understood by clinical teams and managerial teams alike which tell the journey through the system assists in supporting the improvement programme. As a guide, consideration of the following order of metrics:

- Outcome/Impact – the expected gains from the improvements, thus mortality, harm, re-admission/re-attendance, new institutionalisations from hospital, complaints etc. These should always be presented first to re-enforce the message of what the organisation is trying to achieve. 'Hard red lines' of improvement goals will need to be clearly visible. There should be SMART (specific, measurable, attainable, relevant and time-bound) aim statements attached to the programme that set out clearly how you will measure success. However, not everything that is important can be measured – qualitative feedback from patients and staff is just as important.
- Demand – volume and time profile of the demand. The demand dictates the profile of the capacity.
- Capacity – in Primary Care the capacity is the number of available appointments, better still is the 'bookable minutes' for each demand profile, in ED and assessment areas capacity is defined by senior decision maker available time and the 'processing' time for each patient by this senior decision maker. For admitted patients, capacity is defined by flow i.e. journey time profiles. Capacity can be 'consumed' by added value processes and non-added value processes.
- Flow – linked to the relevant streams be that in Primary care or Secondary care, e.g. admitted vs. non-admitted in ED, short stay + ambulatory emergency care (daily run charts of zero LOS discharges and discharges with LOS 2 days or less) vs. sick mono-organ specialty vs. acute frailty (beds occupied – not discharges) by patients aged 75 and over with LOS 10 or 14 days or more) as defined in the work-stream profiles above. Total beds occupied by emergency admissions across all specialties are an outcome and a flow metric as well as 'work in progress'.
- Processes – the inputs required to deliver the outputs which in turn deliver the outcomes. For example, call to GP visit, GP request for transfer to arrival at ED, door to nurse, door to doctor, door to Consultant times for assessment units.
- Balancing – the unintended consequences of any changes. The commonest will be re-admissions or re-attendances.

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Wherever possible these metrics should be available in real time with appropriate historical data to ensure that seasonal and cyclical changes are not misinterpreted as improvement/deterioration. This data then provides the in-day position for operational management. In addition, forward projection using 6 week rolling averages or more sophisticated models to provide for tactical management of the system.

Without re-describing all the metrics in the BCT and BCF frameworks, there are some key principles to be considered to ensure that the expected benefits are realised and are focussed on quality rather than just finance:

i. Ensure that there are appropriate measures of demand, capacity, activity and flow across the system.
ii. Consider using the Institute of Healthcare Improvement's 'Triple Aim' framework as a guide to the metrics strategy as described in the IHI Guide to Measuring the Triple Aim White paper (http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx):

Dimension	Measure
Population Health	1. Health/Functional Status: single-question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12, EuroQol)
	2. Risk Status: composite health risk appraisal (HRA) score
	3. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions; summary of predictive model scores
	4. Mortality: life expectancy; years of potential life lost; standardized mortality rates. *Note: Healthy Life Expectancy (HLE) combines life expectancy and health status into a single measure, reflecting remaining years of life in good health. See http://reves.site.ined.fr/en/DFLE/definition/*
Patient Experience	1. Standard questions from patient surveys, for example: -Global questions from US CAHPS or How's Your Health surveys -Experience questions from NHS World Class Commissioning or CareQuality Commission -Likelihood to recommend
	2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered)
Per Capita Cost	1. Total cost per member of the population per month
	2. Hospital and ED utilization rate

iii. The metrics need to be defined as outcome, process or balancing metrics. The IHI white paper talks of the first two; however, there has been recognition that measurement of the unintended consequences is always necessary with change.
iv. Outcome metrics being described use the 'aim statement' structure of 'how much improvement by when by how measured'.
v. The importance of ensuring that the 6 domains of quality described by the Institute of Medicine, see table above, are represented within the metrics suite.

Outlined here are some measures the system may wish to consider in addition to those described by NHS England (http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf):

a. **Outcome Metrics**

- Reducing Mortality:

  Moving towards recording all deaths within 30 days of an 'urgent care' contact' rather than just for those who are admitted to hospital. As well as the potential years of life lost as per the NHS England Outcomes Benchmarking Support Pack. In the first instance, as a consequence of data capture difficulties in Primary Care, this could be recorded for all contacts with 111, Out of Hours and East Midlands Ambulance Service contacts.

- Reducing Harm

  Measuring harm across systems is not well done in the NHS despite there being many tools to assist in the identification of harm e.g. the NHS Institute's Trigger Tool for Primary Care (http://www.institute.nhs.uk/safer_care/primary_care_2/introductiontoprimarycaretriggertool.html). The evidence from the Health Foundation is that approximately 1-2% of consultations in Primary Care result in harm (http://www.health.org.uk/public/cms/75/76/313/3079/Levels%20of%20harm%20in%20primary%20care.pdf?realName=Hc6Loc.pdf).

- Increasing Independence

  The BCF plans all include an increase in the number of people remaining at home 91 days after a discharge from hospital in to a re-ablement/rehabilitation service. It would be better to have this mirrored with the proportion of all patients who are discharged from Hospital aged 65 and over who remain at home 91 days after discharge. Both figures need to improve and again the 'Home First' principle will support this priority. The increases described in the BCF in independent living after re-ablement/rehabilitation are relatively small.

- Reducing long term care placements.

  BCF National Metric 1. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population. The reductions identified within the BCF are relatively small and not very ambitious.

  In parallel, a reduction in the rate of applications for the use of Deprivation of Liberty (DoL) is necessary. The national variation in DoL applications in 2012/13 ranges from 65.8 per 100,000 people aged 65 and over in London to 155.6 per 100,000 people aged 65 and over some 2.4 times higher in the East Midlands (http://www.cqc.org.uk/sites/default/files/documents/dols_2014.pdf). Balancing this metric, there would need to be an assurance that Deprivation of Liberty, either not authorised or not notified was not occurring.

  Driving the principle of 'Home First' across the system will assist in delivering this metric. Effective urgent and emergency care for older people with frailty is the key to preventing deconditioning which can result in functional decline with an increased risk of institutionalisation. Delivering the principles of the 'Silver Book' in acute care for older people with frailty has the potential for a dramatic impact in the LLR system. The metric for admitted frailty patients is to aim to reduce the current number of beds occupied by patients aged 75 and over who have been in-patients for 10 days or more across the total

journey, i.e. super spell, this is presented as a daily run chart. This group represents the 'stranded patient' whose functional status risks progressive deterioration the longer they remain in hospital. The aim would be to achieve a 50% reduction in this metric within 6 months

- Reducing Re-attendances and Re-Admissions

  Reducing re-attendances through appropriate navigation and case management through the system avoiding the current routine re-presentation to the ED. This re-attendance at ED is all too frequently happening, often with the description of 'failed discharge'. Re-admitted patients tend to have longer lengths of stay and poorer long term outcomes. Reducing re-admissions and re-attendances is achieved by improved interface management and sharing of information and risk. Alternatives to ED re-attendance and re-admission need to be designed in to the system to facilitate a 'semi-planned' approach.

- Reducing complaints and increasing compliments – Improving Patient Experience

  Aiming to increase the quality of experience for patients provided within an integrated manner focussing on needs and with the 'locus of control' with the person/patient. The Friends and Family Test metrics as well as other more formal assessments as described by the Health Foundation should be utilised. (http://www.health.org.uk/public/cms/75/76/313/4300/Measuring%20patient%20experience.pdf?realName=7qM8Wm.pdf).

b. **Integrated Process Metrics**

- Reducing Attendances at the Emergency Department.

  Effective alternatives to attendance at an Emergency Department (Type 1) will reduce attendance and the system needs to ensure high quality care be that through health promotion and prevention, improved long term condition management and alternative provision. It needs to be assessed whether alternative provision results in a greater risk of re-attendance within 7 days or prolonged journey times for an acceptable or unacceptable proportion of patients. These metrics needs to be described ideally as an absolute reduction rather than a relative reduction. As a subset of aiming to deliver and absolute reduction in all ED attendances (Type 1), a focussed metric around attendances (and subsequent admissions) of patients with long term conditions and/or high risk and/or those on a 'frailty register', and very specifically all attendances from Care Homes would be appropriate.

- Reducing Emergency Admissions to Hospital

  Nationally, there have been drives to reduce emergency admissions for over 15 years and yet there have been ever increasing numbers of emergency admissions. There is a need to standardise the way emergency admissions are counted. Over the last 15 years, there has been an almost continuous rise in emergency admissions, the vast majority of this increase is due to an 126% increase in short stay, less than 2 days, admissions over this time period, whilst for those admissions for patients with a length of 2 days or more has only increased 14% (http://www.nao.org.uk/wp-

content/uploads/2013/10/10288-001-Emergency-admissions.pdf). Short stay admissions comprise two groups, those admitted assessment and 'rule out' of at risk conditions and those admitted for intense early treatment. The former could be described as an 'admit to decide' group whilst the latter are a 'decide to admit' group. The former group have the potential for pathways of 'non-admitted' immediate access to diagnostics and specialist opinion, whist the latter may be amenable to 'ambulatory emergency care' with immediate access to diagnostics and interventions. Reducing admissions overall with a subdivision of reductions in short stay admissions whilst also reducing longer stay admissions, it having to be noted that a proportion of current short stay admissions where longer stay admissions in the past. A reduction in emergency bed days used across the system would provide an integrated metric of both reducing admissions and reducing length of stay. It has to be recognised that over the last 15 years despite the increase in admissions, there has been a 30% reduction in occupied bed days for emergency admissions. The evidence base for reducing emergency admissions is variable based on randomised controlled trial evidence but there are systems that have succeeded in achieving significant reductions e.g. Jonkoping County (http://www.longwoods.com/product/download/code/20144), Intermountain Health, Kaiser Permanente, and Canterbury District Health Board. A selection of the Cochrane database has reported the following:

a. Education to patients attending ED with acute asthma produces a modest reduction in future admissions (2007 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003000.pub2/abstract).
b. Hospital at Home admission avoidance for generic cases failed to reduce emergency admissions (2008 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007491/abstract).
c. Case management of patients with heart failure does reduce re-admissions at 6 months (2012 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002752.pub3/abstract)
d. Hospital at home to manage patients with acute exacerbations of COPD did reduce hospital readmissions (2012 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003573.pub2/abstract).
e. Hospital at Home: Home based end of life care did increase the rate of patients dying in their own home but did not appear to reduce hospitalisations before death (2011 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009231/abstract).

This is achieved by a combination of processes. 60-70% of admissions are for people with long term conditions and/or frailty in which it can be assumed that an acute exacerbation constitute a 'break down' of case management control and is thus a measure of pre-hospital care. Delivering reductions in the ambulatory care sensitive conditions firstly requires clarity on what is included, the most commonly used set in the NHS being those described by the Victoria Department of Health, Australia and the variance in admission rates have been described by NHS England (http://www.england.nhs.uk/wp-

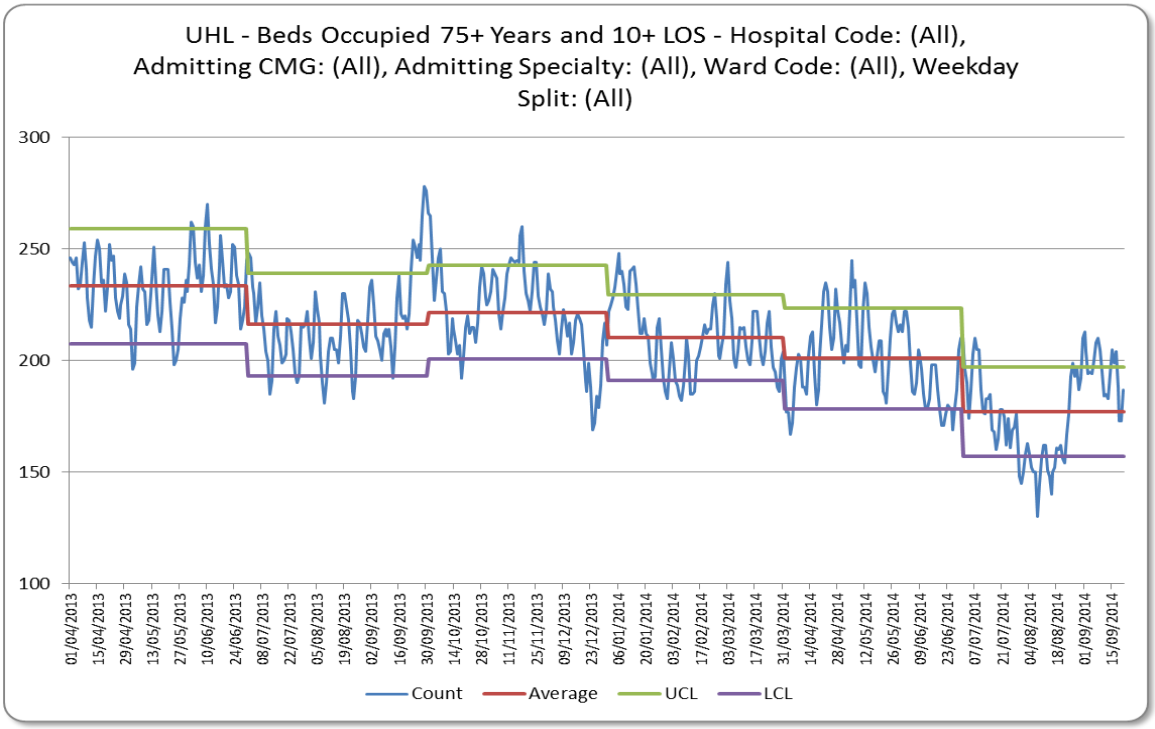
content/uploads/2014/03/red-acsc-em-admissions-2.pdf). Again, the prevention of the admission is a measure of pre-hospital care. Converting acutely ill patients who have been previously admitted overnight in to either a zero length of stay or better still in to a non-admitted same day pathway, is the basis for the Directory of Ambulatory Emergency Care for Adults (http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,181.htm) and requires a system response. There are overlaps in the diagnoses within the two groups with ACSC having 21 diagnoses and the Directory of Ambulatory Emergency Care describing 49 clinical scenarios. However, where there is overlap, the difference in the approach is that with ACSC the aim is to prevent the patient getting ill enough to feel they need to go to an Acute Hospital, although one means of reducing admissions is early senior assessment in the ED. Whilst with Ambulatory Emergency Care (AEC) patients, currently, are deemed to require attending Hospital. Managing AEC patients without an overnight stay requires co-operation and collaboration between the acute sector and the rest of the system. A proportion of the scenarios within the Directory e.g. Care Home admissions, end of life care can be managed without attendance at Hospital. It is noted that there has been some improvement in achieving some of the Gold Standard Framework. Many of the scenarios within the Directory of AEC require same day access to senior opinion and rapid diagnostics.

- Reducing Bed Occupancy for Older people with Frailty

  Delayed Transfer of Care, although a required metric nationally, does not assist in driving alternative pathways for the management of patients with complex needs. Recognition that a significant proportion of patients who end up as 'Delayed Transfers of Care' have actually de-conditioned within Hospital (acute or community) because the system has not case managed them effectively to discharge to their usual address. A philosophy of 'Home First' as the principle for all patients admitted via the non-elective pathway will assist in driving early effective intervention for these patients to prevent in hospital deconditioning.

  As mentioned earlier in this paper, the frailty pathway is in need of considerable improvement. A better metric would be defined around a reduction in the number of beds occupied by patients aged 75 (or 65) and over who have been in hospital 10 days or more. Although only 3-5% of 65-75 year olds have frailty rising to 25-40% depending on which 'frailty' model is used, it is likely that patients aged 75 and over with frailty will be over represented in this metric as frailty increases the risk of a long length of stay and a poorer outcome. These represent 'stranded' patients who have potentially suffered and are at on-going risk of in hospital de-conditioning. The run chart below represents this metric for acute beds only, the system needs to ensure that this metric is inclusive of all 'therapeutic beds'. For the acute sector this metric needs to rapidly reduce to less than 100 within the next 3 – 6 months and reduce further thereafter. The combined Acute and Community Hospital average for this metric is likely to exceed 300 (and considerably more if the age is adjusted to 65 and over). Again an improvement aim of reducing this metric by 50% within 3-6 months, with no or minimal increase in re-admissions and a fall in long term care placements

would indicate a system focussed on optimising independence. This would be supported by other metrics such as % of those remaining at home 91 days after discharge from Hospital and could be further supported by an appropriate PROMS.



Recommendations

- **Building a suite of metrics which describe with clarity what a 'good system' will look like at the end of the improvement programme. These could be based around the 'Triple Aim' principles in combination with those contained within the Outcomes Benchmarking Support Packs from NHS England.**
- **All measures should be seen as 'measurement for improvement' and not as 'measures for judgement'. As soon as measures are used for judgement their utility to support quality improvement is rapidly diminished.**
- **Clarity of the metrics based on whether they are outcome/impact, process or balancing metrics. Ensure outcome/impact metrics are SMART.**
- **Ensuring the ability to 'drill down' from these high level metrics to service level measures will be essential. This needs to be 'embedded' within the metrics strategy.**
- **Outcome metrics constructed around the 'aim statement principle' of 'how much, by when and how measured'.**
- **Develop a systems operations centre suite of measures based on the categories above which 'tell the story' of the system and organisation performance at a glance.**
- **Co-develop the metrics strategy with the clinical trams ensuring the utility of the metrics for the front line to manage its business.**

- **Provide visibility of key outcome and flow metrics both at system, organisational level and at team/ward/individual. Data at team/ward/individual level is of crucial importance to support change, making the variability visible between teams' supports peer to peer support and development.**
- **Train clinical and managerial leaders in the appropriate use of the metrics**
- **Aim for the use of the data at key meetings e.g. bed meetings, team briefings etc. to drive the improvements.**

c. Communicating the Vision

Crucial to the success of the improvement programme will be the need to implement an effective and continuous communication strategy. This will need to ensure that the case for the 'urgency' of the need to improvement is well received and accepted based on the quality and safety issues identified above. This will aim to achieve a compelling 'story' of the need to change, importantly including both successful and unsuccessful patient journey stories. This will link the high level objectives to the individual patient and make the story personal for all staff members. The purpose is to engender a unifying vision generating a 'social movement' for the need to change within the system which then becomes engaged in supporting the delivery of the vision. Making the 'present' uncomfortable and the 'future' appealing will be the mainstay of the communication strategy. Success of the communication strategy can be measured by the extent that peers challenge peers around the drive to the new way of working. Once improvement commences, the communication strategy will move to 'celebrating' the success stories and promoting and encouraging other to continue with their own improvement work.

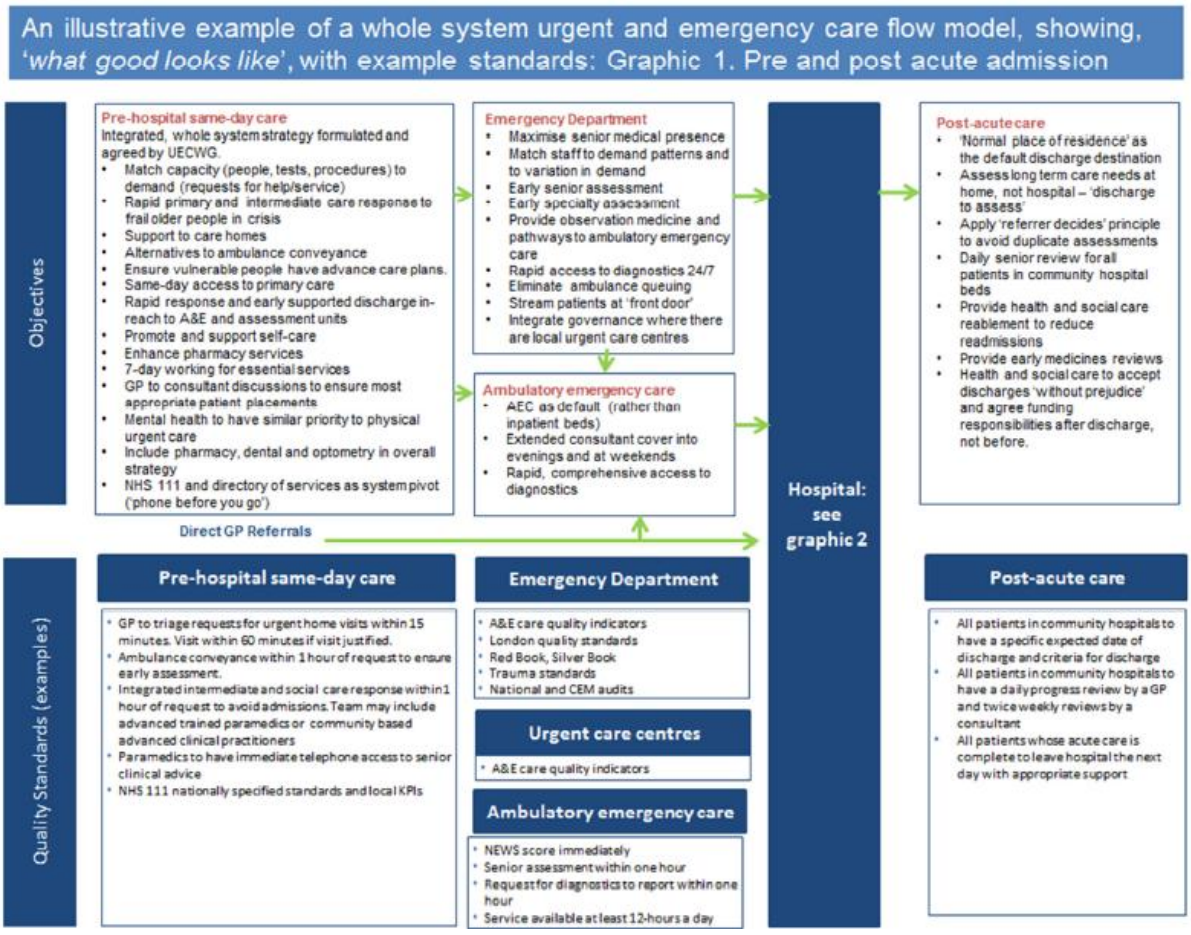
Recommendations:

- **Develop and institute a comprehensive communication strategy aiming to ensure that all staff members across the system are fully conversant with the vision for the organisation and have had the opportunity to comment and add to that vision.**
- **This will need to be embedded within the communications strategy presumably being put in place around the BCG and the Better Care Together programmes,**
- **Communicating the fact that there are no 'quick fixes' for the whole system and that progression towards the vision needs time and consistency whilst demonstrating any early wins in focussed areas and showcasing the improvement impact of 'system level teams'.**

d. **Governance and Leadership Behaviours**

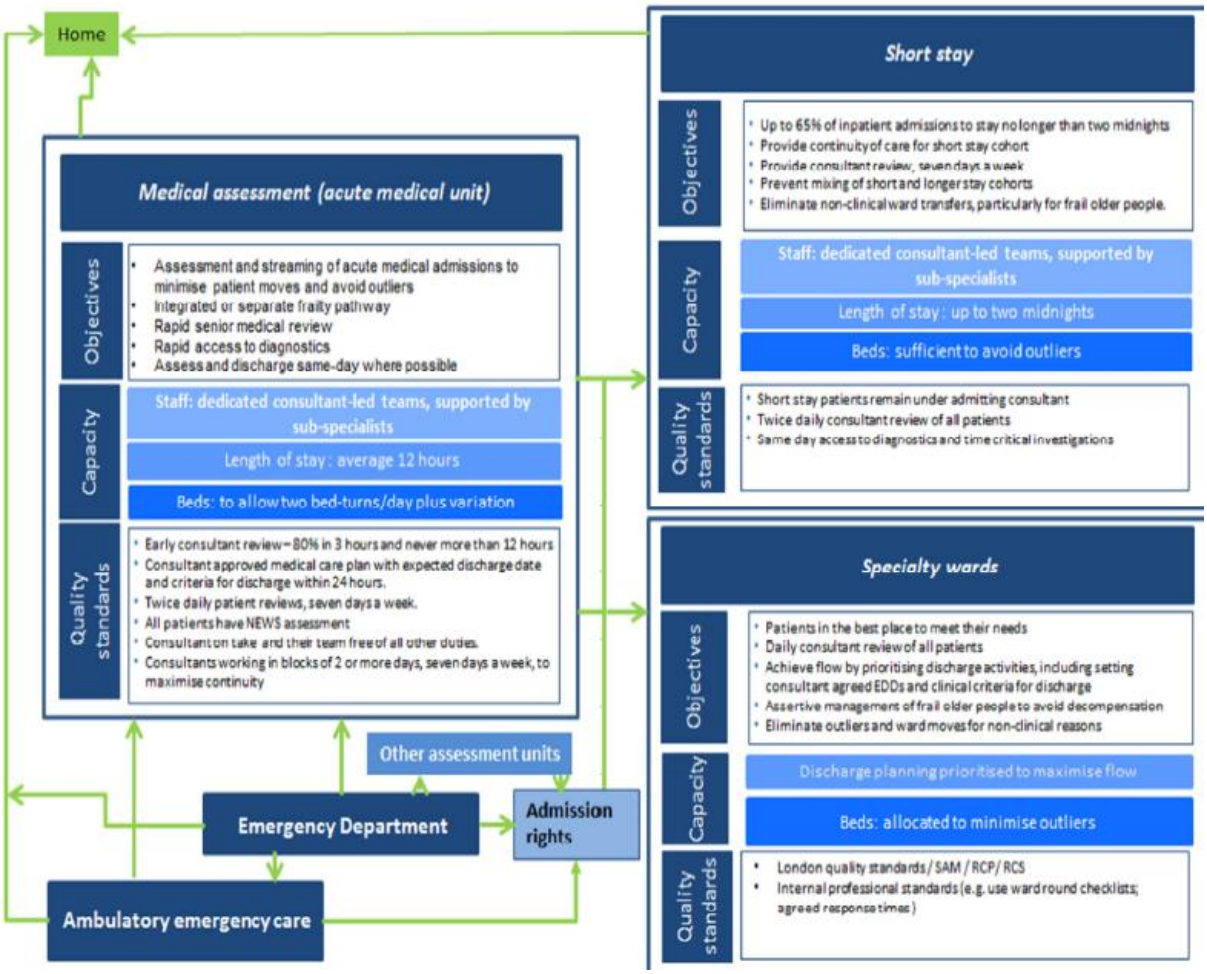
Although there have been significant improvements in the senior leadership relationships over the last 1-2 years, unanimity of vision remains relatively disjointed, although the Better Care Together and the Better Care Fund programmes could assist in resolving this issue. Moving through the organisational structures there do appear to be increasing levels of fragmentation resulting in duplication and waste across the system. This is not helping collaborative nor integrative working.

There has been an Urgent Care Board, currently undergoing re-structuring to align with the work streams within 'Better Care Together'. There has been excessive focus on the 4 hour standard with insufficient rigor of holding to account the whole system in facilitating the flows of patients across the urgent and emergency care pathway. With the re-alignment to the work streams within BCT should provide better focus for the new structure focussing on patient level and system level impact metrics rather than an access target. This group and the System Resilience Group need to ensure that the key recommendations within the Operational Resilience and Capacity Planning for 2014/15 from NHS England are in place and actively monitored and performance managed (http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf).



For those patients admitted acutely, there is guidance from NHS England on developing a demand:capacity plan linked to an improvement model:

Graphic 2. Acute admission (with examples of objectives and standards).



Finally, there have been some joint case note reviews, two of which appeared to be being used as opportunities to learn across primary and secondary care as to whether there were opportunities for the development of alternative pathways. This is good practice. There have also been a series of re-coding meetings of variable value and linked to contract negotiations. These meetings had the potential to consume a considerable amount of senior clinician's time with no direct benefit for patients. Best practice in coding is by utilising the entirety of the case record for that episode, at times, coding is undertaken from the discharge summary only. Agreement on common coding practice across the system guided by an appropriate external audit might be a more appropriate way forward.

Recommendations

- **System Leaders will need to develop and communicate a unified vision of an improved system, whilst continuing to move towards a collaborative and integrated model of care with appropriate accountability across the system, recognising that there is no one part of the current system that is working optimally.**
- **Ensure that the System Resilience Group and the Urgent Care Board are aligned to the key elements within the NHS England Operational and**

Resilience Planning framework (http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf)

- **System leaders being prepared to state that the system has been perfectly designed to deliver the results it is achieving as a system not as elements within the system.**
- **System leaders accepting the responsibility that future improvements can only be achieved by collaboration and the utilisation of recognised improvement methodology focussing on relieving the constraints in the system.**
- **System leaders communicating the vision that delivery will not be a 'quick fix' but will require the re-building of improved pathways of care focussed around the patient and not the individual services.**
- **Discontinuation of re-coding exercises whilst encouraging joint notes reviews to promote the opportunities of developing alternative care pathways. Consider an external audit of coding practice.**
- **For UHL, developing an 'action based' programme board, this behaves more like a process rather than a structure. Work-streams should be encouraged to be frequent and brief focussing on actions for the next few days e.g. further rapid cycle tests of change, spread and adoption, peer to peer support/challenge processes etc. These work-streams will work to achieve specific impact goals which collectively will achieve the high level outcome metrics. An over-arching steering group should be focussed on the high level outcome and integrated process metrics with reports on actions with impact effect from each of the work-stream groups. The Work stream Groups comprise:**

  1. Organisational – covering communication strategy, high level metrics, organisational development, customer service processes (both internal and external customer relationships). This group will also be the group to which the other work-streams would refer cross boundary (internal) issues for first level arbitration – within one week of an issue being defined and not resolved by the work stream. If this Group is unable to resolve the issue the issue is escalated to the Steering Group for resolution.

  2. Assessment, initial investigation, decision making, referral and short stay. This comprises the Emergency, medical and surgical assessment units and any other acute/emergency assessment areas, short stay including EDU (http://www.aomrc.org.uk/doc_view/9450-the-benefits-of-consultant-delivered-care). The product of this group will be to 'assess once, investigate once and decide once'. Expected improvements from this group will be a 5-10% reduction in ED referrals for admission from the non-GP referred stream (http://www.londonhp.nhs.uk/wp-content/uploads/2013/03/ED-Case-for-change_FINAL-Feb2013.pdf). For the admitting specialties, for medicine for example, the aim of this work-stream with earlier senior review (https://www.rcplondon.ac.uk/sites/default/files/documents/acute-care-toolkit-4.pdf) will be to achieve 30% of discharges within 12 hrs of referral, with a further 40% discharged with a length of stay of 2 midnights or less. The delivery of effective ambulatory emergency care

will be a key process for this group. Key outcome metrics will be deaths and harm events within the first 48 hours and re-admission numbers/rates.

3. Base Wards/Mono-organ Specialty. This work-stream will be responsible for designing and delivering effective case management delivery for non-short stay admissions, minimising the impact of handover between the assessing team and the base ward team (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-1-handover.pdf), and ensuring that all internal 'waits' are abolished, e.g. delays for writing up discharge summaries and drugs to take home (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-2-high-quality-acute-care.pdf). The two key processes to optimise within this group will be the effective delivery of the 'board round' and the 'one stop ward round'. Effective case management delivery will improve patient outcomes and experience and the impact metric for flow will be the demonstration of a reduction in beds occupied by patients aged under 75 with the aim to reduce this by 10-20. Key outcome metrics will be deaths and harm events after the first 48 hours, re-admissions and new long term care placements.

4. Frailty Stream. The fastest growth in admissions in the UK is of the older people with frailty population. There is an overlap between this group and the assessment and base ward groups but this group will be tasked with optimising inputs and flow for all older patients with frailty admitted to any specialty in the emergency pathway. The main purpose of this group will be to reduce the 'deconditioning' impact of hospitalisation by early and assertive management of patients with frailty. (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-3.pdf and http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf) The overall impact of this group will be a marked reduction in the number of 'stranded' patients, defined as the number of beds occupied by patients aged 75 and over who have been in hospital 10 (or 14) days or more, with an aim to reduce this by 25-50% within 3-6 months. Key outcome metrics will be deaths and harm events after the first 48 hours, re-admissions and new long term care placements.

e. Building capacity and capability in Improvement Methodology in the System

For a variety of reasons a number of 'quick fixes' have been put in place across the system which have actually created perturbations of the system with negative consequences. Journey times for patients across pathways have been increased and as a consequence patient and system level outcomes have been compromised. This has taken place over many years and requires a systematic approach to unravel the problems. For example, a bed bureau process that facilitates GP referrals for 'admission' does significantly reduce the time GPs spend on the phone making referrals, perversely, since this route is comparatively easy it will have the potential risk of increasing admissions when alternatives may be more appropriate. The process by which a Consultant Physician now takes these calls during 9am to

5pm has assisted in streaming to alternatives but is not robustly in place in any other specialty nor is it matched to the demand profile. The 'discharge to assess' beds spot purchased in Care Homes for ongoing assessments, particularly for CHS Decision Support Tool assessments, may appear to be logical. The end result has been a process that has assisted in perversely impacting on the Nursing Home market whilst generating a 'queue for a queue' of patient's waiting transfer, which has been as high as 15 patients, when a proportion of these 'discharge to assess' processes can be delivered in the patient's own home. A final example, is the generic re-direction of all ambulant patients without overt injury to the Urgent Care Centre based at the LRI, this was aimed at reducing 'foot fall' at the ED which it achieved for a period of time, however, this process has resulted in an unacceptable transfer rate of between 15-30% back to the ED at the LRI. One of the key issues in LLLR has been the failure to apply systematically known improvement methodology techniques across the system to ensure that changes put in place actually bring about the benefits intended. The starting point for any improvement work is a joint analysis of actually where the problems are both by the utilisation of effective metrics but also by 'walking the patients journey' and observing processes and asking those providing care what are the 'blocks' to the processes of care. The risk is always in the creation of assumptions based on 'old think' that re-enforces silo mentality across a system.

The systematic application of improvement methodology does bring about significant improvements in flow and outcomes across urgent and emergency care systems. System leaders who focus on building capability and capacity and ensuring the routine application of improvement methodology has been key to the success of organisations such as Salford Royal NHS Foundation Trust, Intermountain Health in Utah, Jonkoping County in Sweden and Canterbury District Health Board in New Zealand. There are no quick fixes to bringing about sustained high quality change across systems. The Kings Fund paper 'Reforming the NHS from within: Beyond hierarchy, inspection and markets' (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/reforming-the-nhs-from-within-kingsfund-jun14.pdf) highlights some of the benefits achieved amongst many of these high performing systems. It requires a long term vision of what the future needs to look like with 'investment' in time and effort in building capability and capacity in improvement methodology. In the early 1990's Leicester had some of the leading national expertise in Quality Improvement Methodology but over the years appeared to lose its way. In LLR currently there are pockets of expertise in Quality Improvement Methodology in which there is an opportunity to coalesce in to a Leicester Improvement Academy to provide the training and development across the system to support ongoing improvement.

The impact of building capacity and capability in improvement science applied to urgent and emergency care has been highlighted by the Health Foundation's 'Flow Cost Quality' programme (http://www.health.org.uk/public/cms/75/76/313/4196/Improving%20patient%20flow.pdf?realName=T67pC0.pdf). Of particular note, in view of the challenges faced by the frailty pathway is the specific programme from Sheffield which resulted in marked improvements in flow and quality for older people (http://www.health.org.uk/media_manager/public/75/publications_pdfs/Improving%20the%20flow%20of%20older%20people.pdf).

Recommendations

- **Build capability and capacity in improvement methodology, coalesce the pockets of improvement teams and align to clinical work streams of improvement.**
- **Invest in developing an improvement structure across the system. There is an opportunity to link with NHS Improving Quality, the Universities and regional and national industries with expertise in quality improvement to build a 'Leicester Improvement Academy'. This would aim to build improvement methodology skills amongst health and social care staff as well as equipping graduates in health and social care with these skills for the future.**

2. Observations and Recommendations

General Recommendations

- **In all steps of the patients journey, quality improvement work needs to be aiming to ensure that patients are able to answer the 4 key questions of:**
  - **What is wrong with me or what are you trying to rule out?**
  - **What is going to happen to me now, today and tomorrow to get me better?**
  - **What do I need to achieve to be able to return to my usual self?**
  - **How long will this take?**

2.1 Primary Care

- This cannot be an exhaustive review of the entirety of primary care. Only a small number of Practices have been visited along with Locality meetings. The focus of the visits has been on urgent care processes within Primary care.
- Primary Care in Leicester City is under particular pressure with a significant number of single handed Practices and problems with some Practice estate and recruitment. In Leicester County, the 'health' of Primary Care is better.
- Variability of the quality of care in Primary care is as great as that in Secondary care.
- The Primary Care Patient management System in LLR is Systmone or EMIS.
- An understanding of the 'streams' of patient groups presenting to primary care needs to be considered. There are many descriptions of these streams within the literature and these can be summarised as; children, adults with single issues, adults with long term conditions and/or frailty, children and adults with mental health issues. From any one of these groups urgent care needs may arise.
- In response to these 'streams' of patients there are a limited array of primary care responses with standard appointments, long term condition clinics and a small range of other alternatives.
- The Quality Outcomes Framework (QoF) for Primary Care was intended to incentivise improvements, unfortunately QoF is in effect an 'inputs framework' not an outcomes framework. Nationally, there is evidence that QoF has not delivered the potential gains to the system that were perceived (http://www.kingsfund.org.uk/sites/files/kf/Impact-Quality-Outcomes-Framework-health-inequalities-April-2011-Kings-Fund.pdf)
- LLR had extensive input from the Primary Care Foundation within the last 5 years specifically examining urgent care responsiveness. It was reported by the Practices visited that the extent of delivery of the recommendations from that work has been variable.
- Booking of appointments differed across every Practice varying from a development of 'Advanced Access', through full telephone triage, through to a process equivalent too 'first come, first served' booking. In all Practices the same day appointments were invariably booked within 30 minutes to an hour of the lines opening. Some Practices have 'own list' booking for a named GP for every patient. This results in significant loss

of capacity of appointments. The evidence base for reducing admissions with continuity of GP is predominately in patients with long term conditions and/or frailty.

- Identification of patients with frailty is not well done across the system and can be improved.
- There is a plan to review 2% patients who have been identified as at high risk of admission to hospital. It was not exactly clear how the risk stratification has been carried out. Of the review meetings observed, there did not appear to be any means of identifying whether the interventions where going to have any impact. With small volumes in each practice it is likely that Federations of Practices with total list sizes of at least 30,000 and probably closer to 60, 000 would be required before any meaningful impact was measurable.
- There is variability in the 'offer' from Primary Care for those at risk of admissions with some having clear 'red flag' identification, advanced care planning and rapid response to these patient's needs. Although there is the roll out of advanced care plans, their utility and impact is variable and some reviewed have been somewhat simplistic. However, it is difficult for very busy GPs to provide extensive input in to ACPs as well as delivering everything else that is needed of them. This is yet another example of the potential for federation to support this type of work.
- None of the Practices visited were recording 'dropped call' rates, which is the missed demand which may 'escalate' to another level of care.
- The review of information provided to Practices on a daily basis on HERA is variably utilised. This system, amongst other information, provides Practices, via a dashboard similar to that developed in Bolton, with information on that Practices patients use of Out of Hours services, Urgent Care Centre, the Emergency Department and emergency admissions. This provides an opportunity for information sharing across the system as well as feedback opportunities to inform patient choices.
- Practice response to urgent care need is also variable for those unable to come to the Practice. Ranging from a GPs in a Practice providing all visiting cover during the day aiming to provide early review for those patients who cannot get to the Practice. Others have utilised a 'paramedic' rapid response service, originally provided by EMAS but 'degraded' due to need to respond but this has been set up again. Finally, through to a 'standard' response of visits after morning and afternoon 'surgery'. There is a need to obtain robust data on impact on the system of the various non-traditional schemes.
- There is also the 'GP in a Car' service (Clinical Response Team CRT) in Leicester City which has not been directly reviewed but has been discussed with both EMAS and Leicester City CCG. The aim has been to take Green 3 and 4 calls and currently this has been delivering a 70% non-conveyance rate. The volume expected to be seen was 16 per day, since inception the numbers have never been higher than an average of 2 per day. There is a move to start to take more R2 to G4 calls as well as calls from Care Homes and this is due to begin in November. It has to be noted that South Central ECPs are reported as delivering a non-conveyance rate in excess of 70% for all Green calls and this has been replicated in other Ambulance Services.

- There is a need for significant investment in Primary Care, particularly in the City. This is both capital and revenue investment, which in these cash constrained years can only come about by significant shifts in patient flows and activity with re-alignment of resources with improved outcomes for patients delivered through better integration.

Recommendations

- **Re-evaluate the input from the Primary Care Foundation as to urgent care booking processes in Primary Care to ensure that 'demand' is met appropriately and consistently across the system.**
- **SystmOne provides an opportunity to link to the electronic Frailty Index (eFI) which has been developed from research from Bradford and Leeds and has support from Professor John Young (http://www.tpp-uk.com/wp-content/uploads/2014/06/ResearchOne-Document-Frailty.pdf). The eFI is being externally validated using the THIN database which uses data from a different clinical management system, Vision from INPS Ltd. If this is not utilised then the Edmonton Frail Scale has been reasonably well validated in the Primary Care/Community setting. See NHS England's document 'Safe, Compassionate Care for frail older people using and integrated care pathway' (http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf).**
- **Building a register of older people with frailty then provides the opportunity to test models of care to provide care closer to home rather than transfer to Hospital.**
- **Co-develop with community services, out of Hours providers, EMAS and Specialist Geriatric Medicine services a much more comprehensive approach to Care Homes appropriately minimising transfers in to secondary care. This same process would be applied to patients in Community Hospitals.**
- **Sharing of clinical information above that of 'special notes' and the core items of a summary record are required across the system to allow the 'unheralded' patient to become a 'heralded' patient no matter how they present to the system.**
- **The formation of federation of Practices to a cumulative list size of at least 30,000 but more usefully 60,000 needs to be considered. There is a Toolkit to support the development of primary care federations from the Kings Fund, Nuffield Trust and Hempson's Solicitors provides some guidance (http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/19A1F84B41A04DFE8AAAF2F65FD3D757.ashx). The opportunity from Federations are highlighted in this paper and on the RCGP website. What could be considered is a means of managing the streams of patients, children adults with single issues, adults with LTC or Frailty etc. could be managed by specific teams within the federation with opportunities to link with Secondary Care Specialists and the wider community services to provide better integration of care focussed around the patient,**

rather than the patient 'traversing' the system to obtain the necessary inputs.

- **The NHS England '5 Year Forward View' has made similar recommendations :**
- ***'One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the Multispecialty Community Provider. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.'*** **This option would be more appropriate for Leicestershire County/Rutland in view of the rurality.**
- ***'A further new option will be the integrated hospital and primary care provider - Primary and Acute Care Systems - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.'*** **This option may be more appropriate for Leicester City.**
- **The formation of federations of practices would make alignment and integration of community health and social care teams to a population served very much easier. The development of skill mix within this much larger team of GPs, Practice Nurses, Specialist Nurses, Planned and Unscheduled Teams and the Social care teams has the potential to extend the capacity of the 'local' system to manage the streams of patients presenting to primary care as well as the opportunities for health promotion.**
- **Since nationally QoF is not delivering the outcome benefits expected, create integrated long term care/frailty stream programmes with appropriate standardisation, feedback loops, and patient information systems. These integrated models have been shown to have a significant impact on outcomes be that admissions, beds occupied and progression of disease burden. The operational evidence from Intermountain Health, Canterbury District Health Board, Jonkoping County and others is that outcomes for these long term conditions can be improved with fewer bed days and admissions.**
- **Ensure that call rates are monitored and the call answer capacity is matched to the demand to ensure 'capture' of all demand be that 'urgent' or 'routine'.**
- **Ensure that same day capacity for true 'urgent care need' is mapped appropriately to that demand. It would be worth refreshing the work carried out by the Primary Care Foundation.**
- **Align Primary Care response to urgent care need in older people with frailty to the standards set out in the 'Silver Book', that is a visit if required within 30-60 minutes of request. The sooner such patients are assessed, have necessary treatment initiated or are transferred to hospital for necessary specialist assessment and**

initiation of treatment the higher the likelihood of avoidance of deconditioning.

- **From 0800 to 2200 hrs, GP to Consultant discussion of all urgent/emergency referrals (unless immediately life threatening) to consider alternative non-admitted pathways.**
- **Care Home non-life threatening 999 calls to be supported by a clinical response co-ordinated by the EMAS clinical desk to ensure 'advanced care plans' are activated.**
- **Review the cost effectiveness of the CRT system for the City of Leicester.**

2.2 NHS 111/Out of Hours

- NHS III for Leicester is provided by Derbyshire Health United Ltd which provides this service to Derby/Derbyshire, Northampton/Northamptonshire Leicester/Leicestershire and Nottingham/Nottinghamshire, serving a population of approximately 4 million. DHU Ltd also provides the Out of Hours Primary Medical Services for Derby/Derbyshire.
- The information system used by DHU Ltd is ADASTRA and as with all NHS 111 services, and as with all NHS 111 providers the clinical assessment system is NHS Pathways.
- Adastra has an alert process for patients with 'special notes' to which provides additional information usually from the patient's own GP which may assist in case management out of hours. All calls for the Out of Hours Service go via 111, in Derby/Derbyshire since there is an integrated service, this allows the NHS 111 provider to directly book what is necessary, whilst with all other Out of Hours providers, there is a secondary call to manage the provision of service be that telephone advice, appointment etc.
- NHS 111 has been live for Derbyshire for almost 3 years, approximately 18 months for Nottingham and Northampton and just under a year for Leicester. The Leicester launch was delayed due to the national concerns regarding some of the implementation of NHS 111.
- On handover from NHS Direct, it is reported that there was little in the way of operational performance data provided to NHS III to be able to model likely capacity needs. Although now reasonably well resolved, this is a lesson for when any significant changes in provider are being considered.
- At the outset of the service the Directory of Service (DoS) was an issue around extent and type, availability and free capacity. DHU Ltd have their own DoS Leads to continuously update and develop the DoS, however, available capacity is still an issue for the DoS.
- With some modifications of NHS Pathways and ongoing development of staff ambulance activation rate has fallen from 11% and is now down at 8% which was reported as the best in the country.
- Between 23 and 27% of the LLR population will ring NHS 111 in a year which is at the contract volumes but not at the target volume which is aimed at 30%.
- Although not 'usual business' there has been some re-classifying/re-triage of calls with EMAS using their Advanced Medical Priority Dispatch System (AMPDS). From discussions with EMAS, this appeared to be an

agreed process, with discussion with DHU Ltd, it appeared that this was part of REAP escalation when call levels reach CRP3 level, with re-direction of calls either back to NHS 111, the website or even to make their own way to an Urgent care Centre or the Emergency Department (East Midlands Ambulance Service 'Capacity Management and Escalation Plan' Sept 2013). A possible solution to this latter problem would be a two way link for re-direction aiming to optimise capacity across the two providers.

- For Primary Care Practice Education Days, in Northampton NHS 111 has the contract to take the calls on the afternoons all the practices have education sessions. For LLR, Nottingham and Derby, there are separate private call handling providers before 6 pm but after 6 pm calls revert to NHS 111. However, since patients find remembering NHS 111 easier than the alternative providers, NHS 111 frequently receives the calls despite not having the contract to do so.
- During the day NHS 111/Out of Hours response vehicles remain relatively idle. Notwithstanding the insurance and equipment issues, is this not an opportunity for EMAS to use available vehicle capacity during the day, particularly in the morning.
- The Out of Hours Primary Medical Services for Leicester/Leicestershire/Rutland is provided by Central Nottingham Clinical Services. Out of Hours Primary Medical Services are provided from the following localities Leicester Royal Infirmary – Clinic 1, Loughborough Urgent Care Centre, Hinckley & Bosworth Community Hospital, Lutterworth Community Hospital and Rutland Memorial Hospital in Oakham. These require appointments to be made via the Communications Centre at Fosse House. Minor injuries at both Loughborough UCC and Oakham Minor Injuries Unit can arrive without an appointment.
- There are at times significant volumes of patients referred by the Out of Hours Service in the Clinic 1 area to the Emergency Department, particularly specialty referrals when the bed holding specialty do not respond to accept the patient.
- When and if the Urgent Care Centre has overload, there is no process for mutual aid and support from the Out of Hours provider. This will almost certainly be down to contract or governance reasons, both of which do not make sense to patients who are waiting.
- The OOH service provides cover for the Community Hospitals and it has been reported every Community Hospital visit that the response to any acute problem is to recommend transfer back to the Acute sector. A significant proportion of these transfers could be managed without transfer with forward planning and appropriate skill sets co-located with the Community Hospitals.

Recommendations

- **NHS 111 and EMAS continue to work together to reduce the impact of escalation in isolation on the operational performance of each other.**
- **EMAS considers the opportunity, notwithstanding the insurance issues, of using NHS 111 vehicles which are not utilised during the day.**

- **Increase the joint training and development across NHS 111 and EMAS to increase the level of mutual understanding and to explore further opportunities of operational support.**
- **LLR to consider commissioning intent with regard to NHS 111 and OOH Provider or to consider facilitating NHS 111 having direct booking to OOH appointments.**
- **LLR in conjunction with providers to ensure that the Directory of Services provides real time information on capacity within the system, even if this is just a 'yes/no' flag for being 'open' for new referrals.**
- **OOH services to provide face to face contact with patients in Community Hospitals and Care Homes before requesting transfer to UHL, providing that LPT ensures that all patients have a 'what if plan' recorded for the OOH team to operate against. If this is not achievable then an alternative process of medical cover is provided for these inpatients.**

2.3 Ambulance Service

- There can only be a brief overview of the ambulance service from this review, however, there continue to be opportunities for improvements and better integrated working especially with NHS 111.
- As with the rest of the UK East Midlands Ambulance Service operates on the 'Anglo-American' model as opposed to the 'Franco-German' model of Emergency Medical Services. In essence the difference between these two models is that in the former the patient is taken to the Hospital whilst in the latter the 'Hospital' is taken to the patient. There is little evidence of any significant difference in outcomes between these two models of care, yet there are fewer transfers to Hospital in the Franco-German model. Differences between the two models are becoming more blurred with the rise in the development of pre-hospital medical care in the UK and US.
- Notwithstanding consistency of offer by the Urgent Care Centres not co-located at the Leicester Royal Infirmary, there are opportunities for an increase lower category calls to be conveyed to these units rather than the main Emergency Department, if they cannot be managed at scene. Particularly stark is for this opportunity at Loughborough, which as a locality generates the 2nd largest number of calls after Leicester City within LLR. With an Ambulance station directly opposite the Urgent Care Centre, there is a significant opportunity to increase conveyance of appropriate level calls to that unit. As a consequence there would be a significant reduction in journey and turnaround times releasing response vehicle time back in to the system to respond to R8 and R19 calls more rapidly.
- It was reported that 90% of calls are responded to within 5 seconds, this is a significant improvement over previously.
- There is an average 32 second dispatch time which needs to be improved further. Fortunately the demise of call connect dispatch has reduced the extent of multiple activations of vehicles.
- There have been significant improvements in East Midlands Ambulance Service response times although they are not resilient. Releasing more

resource back in to the 'response vehicle pool' after handover is one of the key improvement aims.

- Ambulance turnaround times are not consistently measured across the East Midlands system where there are some areas with RFID activation of the clock start for turnaround but this is not the case in LLR. For this to be consistent RFID activation must be achievable whether there is a queue of ambulances attempting to access the ED. Standardisation is the key to turnaround times following the principles of the Emergency Care Intensive Support Teams paper on turnaround time (http://www.england.nhs.uk/wp-content/uploads/2013/08/amb-hand.pdf) and the guidance from NHS Confederation ' Zero Tolerance' (http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Zero_tolerance061212.pdf).
- The Clinical Desk at EMAS takes Green 3 and 4 calls re-directed to them to attempt to manage as 'hear and treat'. This team is currently being augmented and there has been an increase in the 'hear and treat' closure of calls.
- A very significant impact on operational performance is the number of calls for falls including from Care Homes, where 'no lift' policies are in place. There have even been occasional calls from Community Hospitals when there has not been significant injury.
- There does appear to be some batching of ambulance arrivals at the ED the underlying cause of which is not immediately clear and occurs on a variable basis. Likewise, GP referred patients, although on average the arrival times peak at around 2 pm, there are times when these patients arrive in a batch late afternoon. This appears to be the case in particular when the EMAS is under pressure from volume of calls. The EMAS Capacity Management and Escalation Plan Sept 2013, but still live on the EMAS website as of July 2014 (http://www.google.co.uk/url?sa=t&rct=j&q=emas%20capacity%20management%20action%20plan%202014&source=web&cd=1&cad=rja&uact=8&ved=0CCYQFjAA&url=http%3A%2F%2Fwww.emas.nhs.uk%2FEasysiteWeb%2Fgetresource.axd%3FAssetID%3D56627%26type%3DFull%26servicetype%3DAttachment&ei=J08-VMrZFZWtacLogfgM&usg=AFQjCNHBEoNDLn9wbo0PwuqHF2b_4KkMJg&bvm=bv.77412846,d.d2s), does indicate that GP calls requiring transfer to hospital may well state to the GP that unless they deem the call a 999 status may result in a standard 4 hour response time rather than a 2 hour response at certain levels of escalation. Inevitably, this will result in batching of some GP requested transfers to Hospital.

Recommendations

- **The system needs to ensure that turnaround time data collection and reporting are effectively monitored. To this end a formal review of turnaround times by ECIST or by Dr Anthony Marsh, CEO WMAS, is recommended.**
- **Direct transfer of patients to Urgent Care Centres with appropriate handover minimum data sets is an easy win across a system working effectively as an integrated system e.g. 24 hour surgery and St John's Ambulance in Christchurch, New Zealand. With**

Loughborough being the second largest ambulance callout locality within LLR and with an ambulance station just opposite the UCC, there is a clear opportunity for improved flows to this UCC as opposed to conveyancing to the LRI.

- **Patients with long term conditions with clear case management plans can be transferred to their own GP during normal working hours, again this is evidenced from the COPD and CHF pathway management in Christchurch, New Zealand.**
- **The LLR system urgently needs to consider an integrated falls response process to minimise the impact of falls on EMAS. This needs to consider a 'lifting' service to Care Homes.**
- **Further development of pre-hospital medical care with a reduction in conveyance to the Acute sector needs to be further developed. This requires improved integration between the Ambulance service, primary care, community providers, and pre-hospital emergency medicine specialty services.**
- **As a strategic intent, GP referred patients to UHL need to arrive at the Hospital as soon after the referral as possible since there is the potential for up to 40-60% of these patients to be managed as a zero length of stay having had appropriate diagnostics and senior review with a definitive case management plan. Late arrival significantly increases the risk of an overnight stay. This is particularly important for older people with frailty who should be conveyed to Hospital within 60 minutes of a GP request.**

2.4 Urgent Care Centres

- There are significant variances across the Urgent Care Centres (UCC) within LLR, that have been visited during this review, which were those based at Loughborough Hospital, the LRI and Rutland Memorial Hospital. The extent of the variance makes some of these services not fit for purpose. There are, however, good examples of provision but these are actually away from the central service based at the LRI, most notably at Loughborough.
- It appears that the basis for the contract shift to the Urgent Care Centre at the LRI was based on an attempt at 'local optimisation' to reduce 'foot fall' at the LRI ED. This was considered to be a safety imperative and is an area of 'local optimisation' that has had a perverse impact.
- There are issues with the UCC model at LRI which are predominately down to its non-alignment with the key quality indicators described by the Primary Care Foundation's report 'Urgent Care Centres – What works best' http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf. The reporting of key performance indicators from the UCC are relatively opaque.
- The contract stipulates that all 'ambulant non-injury patients' be directed to the UCC without their being a joint front door 'initial assessment process'. As a consequence a significant number of patients walk down from the ED to the UCC only to walk back up again an hour or two later. This is

fundamentally flawed and is indicative of a process redesign without understanding of patient flows. The re-direct rate of patients from the UCC to the ED at the LRI varies between 15-30% some of which are due to failures of specialties accepting referrals from the UCC GPs.

- There are issues with the 'triage process' within the UCC which is protracted, fails to identify patients who should be in the ED and there have been a number of clinical incidents reported of potential risks. There are a significant proportion of patients re-directed from the UCC after 'triage' that are transferred late, and a proportion very late i.e. beyond 90-120 minutes. A re-direct rate of <2.5% from the UCC is an acceptable goal.
- The UCC process is that of a 'triage and wait' model. The 'triage' process is excessively long and adds little value to the patient's journey. In addition, it is at this step that re-direction should take place, however, all too often the patients are not re-directed until they have been seen a definitive clinician.
- There have been a number of clinical incidents of patients with significant pathology being transferred late. The model needs to change urgently focussing on safety and effective streaming at the point of access.
- On occasions the ED staff provide mutual support to the UCC if waiting times increase within the UCC. This is occurring on an increasingly frequent basis and is causing a drain on processing capacity within the ED.
- The UCC does have the facility to book in to a patient's usual GP urgent slots with practices holding up to 2 appointments per day for this function. In all the Primary Care Practices visited, they all reported that this had never been used. This is wasted Primary Care urgent care capacity.
- Filling clinician 'slots' at the UCC at the LRI has been problematic with capacity gaps occurring far too frequently resulting in protracted journey times. These capacity/staffing gaps have been reported late to the ED resulting in batches of already delayed patients beyond 2 hours arriving in the ED.
- Mutual aid from the co-located OOH service in Clinic 1 does not occur when there are clear opportunities to do so and this opportunity is highlighted in the Primary Care Foundation's report on UCC.
- The UCC at Loughborough sees approximately 45000 attendances per year of which 1500 are fractures. The service is run by CNCS. There is a GP with a special interest in injuries who provides specialist support to the UCC in Loughborough and also to the UCCs at Market Harborough and Oakham. The fracture service provided is deemed to be of high quality by the ED at the LRI. The service is dependent on this one individual and is thus vulnerable if he were to become unavailable. During the day the service aims to be predominately an injuries service re-directing minor illness back to their GP. Out of hours there is a two track service both run by CNCS to two different contract arranged by two CCGs resulting in parallel services with loss of flexibility. The UCC at Loughborough for its injuries service is dependent on access to radiology, which is currently available from 0900 to 1700 Monday to Friday, which does not match the demand profile. In addition the costing arrangements for radiology impact on the financial status of the model. The UCC at Loughborough provides

a high quality local service and maintaining its viability must be seen as a priority for the system in view of the volume of cases seen.

- There had been an arrangement for EMAS to bring Category 3 patients to the UCC at Loughborough but this does not appear to be occurring.

Recommendations

- **The UCC co-located at the LRI should co-develop with the ED a true joint front door as opposed to the 'single decision front door' currently in operation.**
- **This joint front door should stream patients to the appropriate clinical teams based on clinical need.**
- **An acceptable re-transfer rate is <2.5% for cases in whom there is not an attempt by the UCC to refer to an in-patient specialty.**
- **For patients in whom the UCC is attempting to refer to an in-patient specialty and there is no response within 30 minutes by that specialty, then the '30 minute rule' should be automatically invoked.**
- **The UCCs and the ED should develop a joint clinical governance framework to promote trust and mutual aid across the urgent/emergency floor.**
- **The OOH service in Clinic 1 and the UCC should be providing mutual aid and support to each other.**
- **The UCC should review demand and capacity and refresh processes to ensure that dispersal profiles achieve 90% completion by 120 minutes**
- **A minimum of data reporting as outlined in the Primary Care Foundation's report on UCC should be made available across the system with the same time availability as that of the ED. It has to be considered whether UCC should use EDIS for tracking purposes.**

2.5 Unscheduled Care Community Health Services

- Referral to community services is via the Single Point of Access (SPA). Users within the system comment that there can be extensive delays in accessing the SPA via the telephone. Referrals can be faxed but users have commented that a proportion of referrals via Fax seem to get lost. There has been recent work on building up capacity and standardisation of processes within the SPA. This has resulted in improvement in response times from SPA, however, there is still considerable room for improvement.
- The services comprise the Unscheduled Care Team and the Intensive Community Support Service (ICS). There is a Therapy team, which used to be integrated with the nursing team as an Intermediate Care Team, and it is still known as the 'Intermediate Care Team' (ICT). The first two are integrated whilst the therapy led ICT operates in a partially separate manner. It is not clear why the 'Therapy Team'/ICT have been separated from the Unscheduled Team, although there is some routine domiciliary services.
- The separation of the unscheduled and scheduled case load occurred earlier this year. In essence, the planned service is a predominately the District Nursing service providing wound management/dressings, injections e.g.

insulin and Vitamin B12 and some palliative care support. If there is an unscheduled 'event' relating to the planned case management, e.g. a wound dressing becoming saturated or becoming dislodged, then the service user contacts the Single Point of Access which is manned by non-clinical staff, who logs the call as a task for the unscheduled care team. The demand for the unscheduled care team was initially expected to be 5-6 calls per day per team. All 4 teams visited so far have reported a rate far in excess of this and not infrequently exceeding 30 calls per day. In addition, since the task is logged and there is little opportunity to 'manage the task load', each team stated that on visiting at least 50% of the visits were unnecessary and others could be managed by pro-active planning. This is reported by all the teams visited (5), and the managerial team supporting and developing these teams, to be consuming in excess of 60-80% % of the nursing team's capacity.

- In view of the excess tasks being generated for the unscheduled care team from the predictable unplanned episodes from the planned process, the Intensive Community Support is struggling to manage its virtual ward caseload. In addition, there are at times difficulties in transferring care to a less intense support teams/care packages (health or social care or both) with resultant inability to clear capacity to take on the next patient.
- The Unscheduled Care Team and ICS and Intermediate Care use SystmOne however their records are not integrated, likewise with the planned care teams. This results in the need for duplication of logins and increases the risk of wasted capacity. The unscheduled nursing team and the ICT therapy teams used to be an integrated team but are currently managed separately.
- There had been an issue with the remote working software, Briefcase, in which complete assessments were not infrequently lost and had to be re-entered on return to base. This resulted in teams' not entering information in real time but updating on return to base. The recently implemented 'mobile working' appears to be more robust with data being stored and then uploaded in to records on accessing a Wi-Fi server. However, the ability to view full community records from other teams remains limited.
- Response times for the nursing team for the unscheduled needs are measured in a few hours. For the ICT (Therapy Team) there is a 'contract' arrangement of 72 hours. This 'contract' arrangement was reported by each of the Therapy teams visited and when challenged was robustly confirmed. This is of no value and affects the utility of the team to support early discharge.
- The ICS/ICT(Therapy Team) referral form is two sides of A4 and is too long as a consequence. It includes the question, if the patient lives alone, 'Do they need assistance at night?' with the response that if yes 'refer to community hospital'. Night assessments in the strange environment of a Hospital will significantly over estimate the need for night time assistance. This question and its advisory response to the answer 'yes' will be driving bed based care and thus deconditioning.
- The referral form is faxed to the SPA and the ICS or ICT decide whether they are going to accept the referral. This adds a further delay in to the system.
- Across the teams in the community and with the interface with both the community and acute hospitals teams there are multiple re-assessments, likewise with the Social Care HART and ICRS teams. This results in considerable wasted capacity.

- Equipment delivery was reported as reasonable, i.e. the next day, but there are 'constraints' in the system as it was reported that 'nurse can't order frames' and 'physiotherapists can't order beds'. This forces multiple assessments and re-enforces silo multi-disciplinary working rather than the much more flexible inter-disciplinary working.
- All teams reported that there was an expectation that the 'virtual wards' are running at near full capacity. This has resulted in delays in step down from this service and thus reduces availability to respond to the next patient.
- In all, there appears to be a degree of inflexibility built in to the system that results in significant lost capacity, which could be as high as 50% or even more.

Recommendations

- **The SPA improvement programme needs to progress to ensure that all calls are responded to within a pre-set time limit. Secure email for referrals needs to be considered.**
- **The unscheduled aspect of planned care needs review. It is likely that a significant proportion of these 'unscheduled tasks' could be avoided with an improvement in the quality of the planned contact, anticipatory planning in the case of change, and alternative responses to the 'task' assignment via SPA.**
- **Facilitate equipment access for multi-disciplinary teams to prevent duplicate assessments.**
- **The assessment for night time needs should not be determined in a Hospital setting but once the patient has returned home which may include technological solutions.**
- **Create consistency of offer across community teams. The ICRS Leicester City social care in-reach process to pull patients back in to the community needs to be replicated across the system In addition, an integrated health and social care in-reach process could pull significantly more frail older people back home, provided an appropriate diagnosis and treatment plan has been initiated.**
- **LLR needs to consider the potential of effective operational integration. In New Zealand, Canterbury District Health Board's standardisation, improvement methodology and integration of health and social care processes has brought about significant improvements. This has resulted in no increase in ED attendance or Emergency admissions for patients aged 65 and over for over 5 years despite a greater increase in the over 65 population than the rest of New Zealand. There have been fewer long term care placements and life expectancy at 65 is growing faster than the national average. These same processes when applied to patients with COPD resulted in a 30% reduction in occupied bed days within one year of implementation of the change programme. (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf).**
- **Unscheduled care teams/ICS/ICT with ICRS and HART need to align with the PCC and UHL therapy teams and the Geriatricians**

to identify patients at risk of a long length of stay at the point of admission and provide daily challenge to remaining in-hospital. This requires a service/team that is integrated and prepared to provide continuity for patients as they journey through the hospital. When a similar model was implemented in Plymouth some 6-8 years ago it released 4 wards worth of beds,

2.6 Community Hospital Beds

- There are approximately 250 Community Hospital beds over 8 sites. Two of the sites have stroke rehabilitation facilities, Coalville Hospital in Coalville and St Luke's Hospital, Market Harborough. Medical cover is provided by Consultant Geriatricians with twice weekly rounds although this can be variable especially when annual leave is being taken. Day to day cover is provided by Advanced Nurse Practitioners, who also provide day to day cover for the ICS Team.
- There is a proposal to provide additional virtual supervision by a tele link to a Consultant. This is about to be trialled and is worthy of testing with regard to impact on flow.
- The vast majority of inpatients have been referred from the Acute Trust using the BB1 form. There is an option for the Community Hospitals to decline referrals.
- A significant proportion of the patients referred to the Community Hospitals could have been managed through a direct discharge home route. Direct discharge home would be the case if expected date of discharge and clinical criteria for discharge had been set, along with assertive case management from the point of arrival, along with supported discharge, on the day required for those who need it, were the processes in place for older people with frailty. For many patients, the process in place is that of delayed initiation of case management without clear EDD and CCD to prevent in-hospital deconditioning. In addition, patients who have not as yet 'achieved baseline' or who have perceived 'in-hospital' night time needs are referred for rehabilitation in the Community Hospitals when alternative home based rehabilitation is an alternative. This then creates a perceived need for rehabilitation and further deconditioning occurs. This then results in a transfer to a community hospital.
- As already mentioned under the Out of Hours Primary Care section, medical cover out of hours is provided by the OOH service. However, the main response to contact is to arrange transfer back to UHL.
- The pace at the community hospitals is slow although there has been some reduction in length of stay over the last year. Average length of stay and benchmarking against other Community Hospitals is of limited value. The flow through the Community Hospitals as with the acute sector needs to improve further. For a variety of presentations there are some guides for length of stay, for instance 32 days for patients presenting with falls. This will result in some regression to the mean and although the multi-disciplinary teams stated that they were only guides it became apparent on the visits that patients 'drifted' towards discharge in the community hospitals visited.

- It was reported at a number of Community that patients arriving on a Friday do not routinely receive a therapy assessment and can subsequently spend 3 days without effective mobilisation resulting in significant deconditioning.
- The 'standard' for therapy assessment is within 48 hours of arrival.
- There are daily Board rounds during the working week with the ANP, Nursing Staff and AHPs in attendance. There are multi-disciplinary meetings when the Consultant geriatricians do their rounds. The Board rounds observed did not appear to be appropriately focussed and lacked challenge to delays.
- There was one exception at one Community Hospital where a multi-disciplinary board round was observed with clear focus on clinical criteria for discharge and an expectation of discharge.
- The extent of 4 times per day double handed packages of care being stated as required by the multi-disciplinary teams reflected the same rate as that requested within the UHL. There were also high rates of plans to move to long term care placements either Discharge to Assess, CHC or Fast Track.
- In a number of Community Hospitals there were observed a number of patients who were mobile either independently or with minimal assistance who in other systems would have been discharged home.
- The most risk averse to discharge within the Community Hospitals appeared to be the Therapy Teams. As with UHL Therapists there were considerable instances of delay in discharge because the patient was not 'back to baseline'. At the one Community Hospital observed having an focussed 'board round', the therapy team were planning discharge with ICS/ICT input for patients still requiring the assistance of one on transfer. At UHL this would have triggered a referral to the Community Hospital for ongoing rehabilitation. The most frustrating issue for the team at the Community Hospital with the 'focussed team', with over 75% of the patients on the Board Round observed going home rather than in to care, was the delay in social care provision.
- As a consequence of the extent of de-conditioning across the frailty pathway the extent of long term placement and use of the 'bed based Discharge to Assess' process from the Community Hospitals as well as CHC and Fast Track placement is high.
- There are patients who are transferred to the Community Hospitals in whom the diagnosis is not clear. This then results in a further re-work up of the patients and further risks of de-conditioning. There were examples of 'over-working up' of patients and the problems they had had for many years. For example, one lady's discharge was being delayed for a week whilst her house was tidied up from the 'hoarding behaviour' she had had for years. A better solution would have been discharge home with her home being tidied up with her consent whilst she was at home. This sort of issue was also identified at UHL. This has the potential for being a 'deprivation of liberty' through stealth.
- It is apparent that transfer to a Community Hospital is being used as a 'discharge process' rather than arranging discharge direct.
- There is a significant amount of resource tied up in the community hospitals but the closure of beds before there has been the commencement of the optimisation of the frailty pathway will result in increased over-crowding at UHL. Optimisation of the frailty pathway needs to be achieved before consideration of the future use of Community Hospital beds is being considered.

Recommendations

- **The National Audit of Intermediate Care categorises four types of (http://www.nhsbenchmarking.nhs.uk/projects/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php): intermediate care: crisis response – services providing short-term care (up to 48 hours); home-based intermediate care – services provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists; bed-based intermediate care – services delivered away from home, for example, in a community hospital; and reablement – services to help people live independently which are provided in the person's own home by a team of mainly care and support professionals.**
- **Ensure that there are appropriate levels of 'step up' and 'step down' in intermediate care and that there is an appropriate balance between bed based and home based levels of care. This is achieved by having system level clarity of 'how a well functioning system' should operate with clear system level outcome/impact metrics.**
- **As part of the changes required to the frailty pathway (see below) there needs to be a significant increase in flow through the Community Hospital beds.**
- **Referrals to Community Hospitals should not state a '6 week duration of stay' and referral should include a clinically determined expected date of discharge and clinical criteria for discharge. Referrals should be based on the 'Home First' principle, that is the patient and family are informed from the commencement of their journey in UHL that the discharge destination will be assumed to be their usual address.**
- **The pre-set length of stay guidance should be abandoned and expected date of discharge and clinical criteria for discharge need to be used with assertive case management to minimise wasted in-patient time. Patients should be commencing active mobilisation and rehabilitation from the day of arrival.**
- **Continue to drive the 'Home First' principle and develop a culture across the teams of home based intermediate care.**
- **Therapy plans set by the referring service should be continued by the receiving Community Hospital from the time of arrival.**
- **Whilst in-patients the clinical teams need to consider proactive planning if an acute event occurs aiming for an appropriate reduction of transfer back to UHL. This may well need to involve a discussion with the on-call Geriatrician. The 'contract' with OOH should involve a standard that patients are seen and examined by the OOH service, with criteria for immediate 999 calls if necessary. If patients are to be transferred to UHL they should go direct to an assessment unit on the basis of the OOH clinical evaluation.**
- **Discharge planning should be a continuous process from the referring Hospital and based around the EDD and CCD set prior to transfer and refreshed purely on clinical need.**

- **Geriatrician cover for the Community Hospital beds needs to be more robust with a focus on driving to discharge. Virtual supervision, which is being tested, is one option to provide this level of cover.**
- **It is likely that with the drive to minimise harm from deconditioning during a hospital stay the need for Community Hospital beds by patients will fall. A large resource would then be available to further align with the 'Home First' principle.**

2.7 Mental Health

- The observations contained here are based around the interface between mental health and urgent and emergency care services.
- There are considerable concerns regarding mental health both in hours and out of hours and in addition there are particular waits for CAMHS for ED referrals. There is considerable confusion as to how the service operates. Mental health presentations for a considerable amount of workload for the ED and improving the mental health responsiveness will be of considerable benefit. This is for both in-patients and within the ED at UHL.
- From 0800 to 2300 hrs there is a Mental Health Triage team based within the ED who take referrals up to 2215 hrs. They provide a brief assessment and support direct discharge of a significant proportion of referrals. However, if a more detailed assessment is required then this team refer the patient to the Deliberate Self Harm Team, part of the Crisis Intervention Team, who are available from 0800 to 00:00 hrs and take referrals up to 2300 hrs. The DSH team will assess all patients with mental health problems in the ED and EDU and not just deliberate self harm.
- In-patient acute wards are only covered by the DSH team, who access this service through the Crisis Team Single Point of Access with variable response rates.
- After 2300/00:00 hrs, all mental health referrals go to a Junior Doctor who is part of a 'central duty roster' held by Liaison Psychiatry. This Junior Doctor is rarely of sufficient capability to be a decision maker and if further assessment and decision making is required, there is then a referral to the Crisis Team.
- These processes result in considerable delays for patients with duplication of assessments and delays in definitive decision making.
- There are recruitment issues within the CAMHS team.
- There are long delays in waiting for assessments and again if there is an in-patient bed required.
- The ED, EDU and Paediatric ED are effectively being used as holding bays for patients waiting assessments. For patients who no longer need physical interventions or monitoring, these environments are not conducive to good mental health outcomes, in particular for children.
- From a Primary Care perspective the service is perceived as of poor quality being transferred via SPA to Crisis Team. The response times from these teams are described as delayed and at times 'executive decision making' being made have at times been of concern to GPs. There is a concern that there are limited opportunities for direct discussions with Psychiatrists. The end result is that some GPs have reported that they and patient's carers can

be left 'holding the risk' for patients with quite severe acute mental health problems.

- The ED is an identified Place of Safety Assessment Unit and there is a Place of Safety Assessment Unit at Glenfield Hospital for patients requiring assessments under Section 136 of the Mental Health Act. Ensuring the correct patients go to the appropriate Place of Safety setting is crucial. ED should only be used where there is a need to assess an urgent physical co-morbidity.
- An innovative approach has been the 'triage car' with a mental health professional from LPT ad a Police Officer. It is reported that this has reduced detentions under Section 136 by around 40%.
- FOPAL provides an in-patient mental health for older people liaison service to assist in the management of challenging behaviour, delirium, older patients with psychosis and also, on occasion, for expert evaluation of capacity when there is doubt or difference of opinion. This service is well received but is only available 5 days per week.
- Applications under Deprivation of Liberty safeguarding have increased significantly this year due to clarification in the legislation after a Supreme Court Judgement. This Judgement is a highly supportive instrument for the delivery of the 'Home First' principle. In an emergency, the management of the hospital may grant itself an urgent authorisation, but must apply for a standard authorisation at the same time. This urgent authorisation is usually valid for seven days, although the supervisory body may extend this for up to another seven days in some circumstances. The DoLs Teams at Leicester County Council and Leicester City Council are currently stretched to deliver the authorisation of urgent DoLs within the 14 day time frame and this is despite utilising independent assessors.
- There have been observed high levels of supervision of patients with dementia who are wandering where there is a concern that the person may fall, this is both within UHL and Community Hospitals. This level of supervision which involves some restrictions would require a DoLs authorisation.

Recommendations

- **Commissioning of a more effective acute mental health services that integrate with other services needs to be a priority, made ever more relevant in view of the national focus on ensuring that mental health is given the same priority as physical health.**
- **Guidance on high quality liaison mental health services can be found at http://www.rcpsych.ac.uk/pdf/Standards%204th%20edition%202014.pdf**
- **The principle for patients who are presenting to the ED with mental health problems who no longer require physical health monitoring or interventions which of themselves would require them to remain in an Acute Trust should either be cleared for discharge or transferred, if necessary, to an appropriate mental health facility in 4 hours or less. This should be a system priority.**

- **Aiming for a single assessment and decision making process between the Mental Health Triage Team, DSH Team and the overnight Junior Doctor in Mental Health cover.**
- **Evaluate the impact of extending FOPAL to 7 days per week.**
- **Ensure that the ED is used appropriately for the Section 136 following the standards from the Royal College of Psychiatrists http://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf**

2.8 Social Care

- Leicester City, Leicestershire County and Rutland County will be reported together, where there are substantial differences, these will be highlighted. Adult social care will be the focus and children's services will not be discussed further other than to state that the Children's ED is not an appropriate setting for children to wait when there are safeguarding issues to be resolved.
- For each Local Authority there is a single point of contact for social care referrals. From the Hospital, Section 2 are issued via ICM.
- From this point on the process becomes increasingly complex and fragmented across the whole system, although there does appear to be greater consistency within Leicester City.
- The under-utilisation of multi-disciplinary owned Expected Date of Discharge and Clinical Criteria for Discharge (Keogh Standard 3), the frequent changes in discharge destination, the variance between the clinical teams on what the patient's needs are make planning by Social Care almost impossible. The end result is the issuance of Section 5 notifications late in the pathway with 'rushed' transfers of care resulting in re-admissions. A well designed system with effective collaborative working with a frailty focus can result in the almost complete abolition of the need for Section 5 notifications
- There is a high level of risk averse behaviour and requesting of excessive levels of care packages by the Hospital Teams. Clinical teams are also making recommendations around long term placement. There are also inappropriate statements made to families that 'care packages will be free for 6 weeks'. There appears to be a mis-understanding that request for social care are assessed against eligibility criteria.
- All Local Authorities (LA) in LLR, Rutland changing this in September 2014, have set their eligibility threshold as 'substantial' meaning those with low or moderate needs are not eligible for LA funded care although those clients will be 'sign-posted' to services for private purchase if they so wish. Substantial need is defined as:
    - There is, or will be, only partial choice and control over the immediate environment
    - Abuse or neglect has occurred or will occur
    - There is, or will be, an inability to carry out the majority of personal care or domestic routines
    - Involvement in many aspects of work, education or learning cannot or will not be sustained
    - The majority of social support systems and relationships cannot or will not be sustained

    - The majority of family and other social roles and responsibilities cannot and will not be undertaken
- Eligibility criteria are guided by the DH 2010 publication 'Prioritising need in the context of *Putting People First:* A whole system approach to eligibility for social care' (http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113155.pdf).
- It has been recognised that the extent of interpretation of the guidance within this document has resulted in a post code lottery of eligibility for LA funded social care provision. As a consequence and as part of the Care Act 2014 (http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf), there will be national standards set for assessing and determining eligibility (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209595/National_Eligibility_Criteria_-_discussion_document.pdf). The Act and its guidance are due to come in to force in April 2015. This will also convert a Section 2 notice to a 'Referral Notice' and a Section 5 to a 'Discharge Notice' to simplify the terminology.
- It is likely that there will be an increase in the need for face to face assessments as a consequence of the Care Act 2014. The presence of Care manager support across the Hospital sector is variable between the City and the County, with the latter having a greater visibility, however, this is somewhat undermined by the process described in the next paragraph.
- Leicestershire has a Customer Services Team who take the referrals and will action care packages from direct recommendations from Hospital OTs. 70% of discharges within Leicestershire County are managed without face to face contact with minimal 'Discharge to Assess' home based processes in place to ensure that the care package is appropriate. This results in high resource utilisation. Some team members have reported that the implementation of the Customer Services Team has resulted in a de-personalisation of the service and a spatial separation from the rest of the multi-disciplinary team.
- For all Social Care teams, there are delays in contact back to the referring team when a Section 2 or a Section 5 is issued. This is both from Social care and the inability to contact the referring team member. There are at times slow allocation of a care manager in some areas in response to a Section 2. It was reported by the Social Care Teams that assessments are not infrequently delayed until deemed that the patient is ready for assessment. Since there is limited face to face contact this assumption of suitability for assessment is inappropriate.
- There are an excessive number of Section 2 notifications being issued almost as a routine for many older patients who were independent pre-admission and are highly likely to return to independence.
- There has become a relative degree of dis-connect between the social care teams and health for a variety of reasons. This has contributed to the extent of the break down in processes around planning for discharge. There is a greater presence of the County Social Care Team on the UHL sites, however, this is still not operationally optimised.

- This is not an exhaustive description regarding the interface between health and social care but is set out here to demonstrate the extent to which the processes have become incongruent.
- There has been a daily 'delayed transfer of care' (DTOC) tele-conference' which is supposed to resolve the issues. There has been no improvement in the DTOC metric across the system of any significant extent.
- The end result of this is that older people with frailty become 'stuck in the system' resulting in prolonged length of stay, developing 2nd and 3rd phase illness and deconditioning with an increased risk of a poor long term outcome. This is evidenced by the extent of CHC and Fast Track funded placements.
- No one part of the system is responsible for this situation, it has been designed by the system for the system and it will take collective integrated responsibility to resolve the issues.
- Moving on to services provided by Social care to support discharge:
- The City has a range of services under the banner of independent Living Services. This includes a community re-ablement service. A Hospital Discharge Holding Team is also available as part of this service; this is a bridging function whilst care packages start. However, the service is restricted to those with a Care Agency identified to take on the care. This team can take on the care of patients with high needs e.g. hoist and 4 times a day visits.
- The City also has intermediate care beds at Brookside Court (27) and Kingfisher Assessment Unit (10). This is a bed based re-ablement service.
- The City is implementing a Team of Care Navigators for people over 75 with frailty and complex home based needs. There is also a Practical Help at Home service for assistive technology, minor adaptations, and LeicesterCare (alarm service).
- Integrated with these services across the City and County are Social Care Occupational Therapists who provide adaptions, equipment and support by adapted re-housing. Also providing maintenance for major equipment and they work closely with Housing Staff and contactors.
- Integrated Crisis Response Service. This is designed to provide immediate support for patients who need care support and act as a 'bridging' support until an appropriate package of care is in place. It appears the ICRS will not take on 'bridging' unless a date has been provided for the commencement of a package of care from a Care Agency. Recently, the City ICRS has provided in-reach in to UHL to provide support for early discharge of patients. This then enables a 'Discharge to Assess' at home support. This has not been mirrored by the County Team. At times the ICRS teams across the system have insufficient capacity to take on new cases, some of which is an inability to step clients down to the next appropriate level of care.
- County Home Care Assessment and Re-ablement Teams (HART). These teams are designed to provide up to 6 weeks (up to 12 weeks for clients with dementia) of re-ablement within the patient's own home. HART comprises a series of managers, programme arrangers, Occupational Therapists, Senior Home Care Assistants and Home Care Assistants. It was reported by Therapy Team/ICT that there was a need to have a link therapist from their team to support HART. HART, like ICRS, have to hold a number of clients due to inability to step clients down. Outcomes reported by Leicestershire

were stated to be 50% discharged without any further support except may be assistive technology, 22-26% referred on a reduced care package, and 20-21% re-admitted to hospital, with either a new illness or still unwell on discharge.

- Packages of Care from Care Agencies. In Leicestershire County, there is described a 'crisis in care' due to the lack of availability of care workers and approved agencies. The extent to which packages of care are over prescribed on discharge from hospital due to risk averse hospital based assessment, concerns over re-admission and a mis-understanding of the assessment of needs rather than wants. There are a variety of other reasons financial, operational, social, etc. that have had an impact on the availability of care workers for the LLR system.

Recommendations

- **Within Social care as much as with Health care, the 'Home First' principle needs to be accepted as one of the drivers for change.**
- **Between health and social care, there needs to be a re-design of the discharge process to simplify the process and to remove the barriers to effective delivery of discharge.**
- **The minimum data set proposed is 13 pages long but is completed electronically. The vast majority of patients involved in a medium or complex discharge will already be known to the system. As such, the demography and all other pre-admission information for the minimum data set should be pre-populated.**
- **The minimum data set and the 3 stream discharges appears to contradict the 'Home First' principle. The vast majority of 'Discharge to Assess' should be back to the patient's usual residence.**
- **ICRS across LLR should emulate the in-reach process put in place by the City ICRS Team, to support 'Discharge to Assess' in the patient's usual residence.**
- **In conjunction with a 'front door frailty' team who track older people with frailty through Hospital to ensure near immediate delivery of discharge as soon as the patient is ready and supporting them at home through a 'Discharge to Assess' process. This is a very brief description of the discharge process developed in Sheffield (http://www.health.org.uk/media_manager/public/75/publications_pdfs/Improving%20the%20flow%20of%20older%20people.pdf) and there is a need to emulate this in Leicester.**
- **There is a need for LLR to consider how the different Social care teams and the LPT unscheduled care and ICS/Therapy Team (ICT) can operate in an operationally integrated manner to deliver the above.**
- **There is a very wide range of services across both Social Care and Community Health where there are clear examples of overlap and the risk of duplicate assessments. Simplification of structures and rules and merger of these teams has the potential for significantly improving the capacity in the ability of these services to rapidly support older people with frailty at home during a crisis and provide**

very early supported discharge for patients having completed their in-hospital treatment.

- **The further development of creative models of 'care worker' provision, tele-monitoring, tele-health and other assistive technology to support people to live in their own homes is required.**

2.9 Primary Care Co-Ordinators

- The Primary care co-ordinators (PCC) have been in place since 2005. They are based solely at LRI and comprise a Band 7 (30hrs) and 20 WTE Band 6 of which 3 are out for recruitment and 3 are for secondments.
- They did cover Glenfield Hospital for a period of time but were only being referred 6-7 patients per week for assessment which was non-viable to base a service on that site.
- This is a 7/7 365 day 0800 to 1830 hrs service for the assessment of frail older people presenting to ED, EDU, AFU (Ward 33) and Short Stay (Ward 34). There was an attempt to offer a service to 20:00 hrs; however, due to lack of availability of therapists and Social Care, this was not productive at that time.
- Note Occupational Therapy at UHL take their last referral at 15:30 and Physiotherapy take their last referral at 16:00 hrs as does Social Care. Thus discharge critical support expertise is not available when the majority of patients will be arriving or having had their initial medical and nursing assessments. This scheduling of last referral times will cause an overnight stays that are unnecessary and will result in deconditioning. It has been suggested that later presence of therapists has been attempted but did not add value, however, in view of the risk averse nature of therapy services in LLR; this might not be a surprise. What is required is a clear focus on balanced risk early discharge of older people with frailty to prevent deconditioning.
- For September 2014 the PCC saw 587 patients of which 329 were on AFU (Ward 33) and 67 on Short Stay (Ward 34). There were 153 seen in EDU (Observation Ward in ED) and the rest were seen within ED. 564 were seen between 4 and 24 hrs after arrival at the LRI. 325 went home with minor support or advice. However, only 14 went home with ICS/ICT whilst 62 went to a bed based facility.
- The PCCs do not cover Wards 15/16 or the Surgical Assessment Unit. These units have 2 'acute admissions specialist' nurses. These patients are in effect being denied access to a specialist frailty.

Recommendations

- **In conjunction with a 'frailty strategy' the PCCs, Therapists, relevant matrons and the Geriatricians formulate and test a process of rapid identification of ALL patients with frailty and thus at risk of decompensation and prolonged length of stay. This identification needs to take place at the point of access for patients being considered for referral for admission.**
- **If the patient cannot be discharged home on the day of first contact then the 'team' need to follow the patient through their**

journey aiming to maximise the opportunity for early discharge home using the 'home first' principle.

- **Work in partnership with the ICS/Therapy Team (ICT) from Leicester Partnership Trust and ICRS and HART from Social Care to plan and test new ways of working to deliver very much earlier supported discharge aiming to prevent in hospital deconditioning.**

3. University Hospitals Leicester – General Recommendations

- **In all steps of the patients journey, quality improvement work needs to be aiming to ensure that patients are able to answer the 4 key questions of:**
  - **What is wrong with me or what are you trying to rule out?**
  - **What is going to happen to me now, today and tomorrow to get me better?**
  - **What do I need to achieve to be able to leave hospital?**
  - **When am I leaving?**
- **At all steps of the patients journey, Internal Professional Standards are set which are aspirational (i.e. cannot be delivered immediately but can be achieved by continuous improvement) and are monitored. These ISPs should be simple sets of rules for optimal performance at that step.**
- **Provide written roles and responsibilities for team members, again simply articulated, at each of the step.**
- **Of particular concern is the pace of response to 'discharge critical' internal specialty referrals for in-patients (this excludes ED referrals which should have a 30 minute response time) not including radiology. The current 12 hour standard for registrar to registrar referral and 24 hours for Consultant referral is not fit for purpose. The only acceptable standard is one which states for life/limb critical response is immediate or at worst <1 hour, for all other discharge critical (referring Consultant determined not Specialist registrar) the response time should be 4 hours.**
- **Measurement against ISPs by individuals, teams and services should be visible and used as 'supportive challenge' to improve and not used for judgement.**
- **Understanding the admitted flow streams:**
  - **Short Stay Stream: all potential short stay patients, with an anticipated length of stay of two midnights or less, should be streamed to this pathway. Continuity and consistency are key to delivering high quality patient care for this group. Short stay patients should have twice daily senior review to account for rapid clinical changes, results of investigations and specialty opinions. It is to be expected that at least 65% of acute medicine patients can be discharged within 56 hours (or two midnights) if the principles of high quality care are applied.**
  - **Sick Specialty/General Stream: this stream is for patients requiring sub-specialist care for more than two midnights. Segregating these patients from those requiring short stays is essential when optimising length of stay (LOS). The specialty should be expected to create capacity on the specialist ward to allow patients to move to the ward where on-going care can best be delivered (i.e. there should be a 'pull' system). The specialist team should ensure that the patient is reviewed at the weekend by a senior doctor (good practice is that this is a consultant).**

- **Frailty Stream: This is for older people with multiple co-morbidities, including dementia, who often have fragile social support. This cohort requires early identification and the implementation of assertive case management plans. We recommend that you develop an 'in-take' process direct to the assessment unit and/or the ED to identify frail elderly patients on arrival and put in place pro-active comprehensive geriatric assessment and assertive case management as close to the time of access as possible. There is an increasing body of evidence in relation to frailty pathways (including *The Silver Book – Quality Care for Older People with Urgent and Emergency Care Needs*) that sets out the principles and recognised good practice in this area.**

3.1 Bed Meeting

- Attendance – site managers, specialty business managers and some nursing staff. The only consistent presence of senior Medical staff comes from the CD for the General Medicine and Emergency Department CMG.
- Executive sponsor is the COO.
- Predicted admissions for that day only so no forward tactical view.
- Planned admissions or transfers are passively accepted without structure or challenge.
- No use of performance data e.g. ED admit breaches by specialty and then holding the Division to account
- This meeting appears to be mostly transactional and is well structured and driven by the Senior Site Manager.
- Data is used to drive action on that day alone and not tactically across the week.

Recommendations

- **Implementation of a Gold:Silver:Bronze operational and tactical management process to support appropriate standardisation and delivery.**
- **Attendance at the bed meeting should include key senior clinical leaders from the organisation.**
- **Operationally and tactically, Divisions need to have their previous day and week performance visible for all to see and then these Divisions held to account for improvement in performance both in-day and tactically for the next week.**
- **Data regarding demand, flow, bed occupancy and 4 hour performance, with forward prediction, needs to be visible daily and used daily to drive change.**
- **The data provided to the Operations Centre should be visible to all via the intranet and as a 'pop up'/screensaver function.**

3.2 Breach Analysis

- There is little new learning from the breach analysis. The 'allocation' to ED process, bed availability etc. is crude.

- There is little in the way of collating themes to inform and improvement programme.
- A number of the 'clinical breaches' are not appropriately categorised as such being either ED process, decision making, specialty decision making etc.
- Opportunities or learning are being lost by not undertaking reviews of patient journeys where the 'system got it right', this can assist in identifying what needs to be replicated.

Recommendations

- **The setting up of a weekly Journey Meeting which should be attended by senior clinical leaders which examines both 'successful journeys' as well as 'protracted journeys' to gather learning from both.**
- **Admitted vs. non-admitted processes should be reported and examined**

3.3 Emergency Department

- There are a small number of streams of patients coming to Emergency Departments who can be identified very early in their journey , these are:
  - Going home after a brief intervention.
  - Going home after a one or two treatment cycles e.g. nebulised broncho-dilators, one or two doses of IV antibiotics, etc – mostly within the 4 hour timeline and a proportion through an ED Observation Unit. A small proportion of these 5-10% will end up being admitted as they have not improved sufficiently in the timeframe needed..
  - Definite admission and physiologically stable, early transfer to admitting specialty bed without duplication of assessment (mostly done by the admitting specialty).
  - Definite admission but physiologically unstable, early co-management between ED and admitting specialty within the Emergency Department, transfer when stable to do so.
  - Remain undifferentiated after initial rapid assessment, need ED work up and decision.
- The Emergency Department functionality is being compromised by processes and behaviours outside of its control, predominately from Departments and Specialties within UHL, which includes directing GP referrals to the ED rather than direct to specialty, specialty 'ping pong' and some inter-departmental behaviours that have the potential to breach GMC Guidance. There are also 're-directs' from the Urgent Care Centre which result in a 2nd delayed queue of patients awaiting assessment in the ED. The extent of compromise by these non-ED processes and behaviours is far more extensive than previously seen in many other Emergency Departments across the country.
- There are some 'immature' assumptions around 'conversion rates' from the ED to admission. ED conversion rate without reference to standardised admission ratios etc. is a meaningless concept.
- There is a relative lack of standardisation between the Consultant and Nurse Shift co-ordinator with marked variability between team members.

- There is variability in the way in which the EPIC (Doctor in Charge) role is undertaken. This sometimes compromises the effectiveness of the department even when there is good flow to the assessment units.
- There has been mapping of Consultant time to demand profile but this should be refreshed by reviewing the 6 week rolling profile of attends on a regular basis and used to map all staff rosters.
- There has also been an extensive paper on demand:capacity mapping which is an excellent piece of work and has made assumptions about an uplift in 'productivity' of the ED team members by between 10-20%.
- This paper then provides a gap analysis between the demand based on an 80th centile and the capacity assuming the 10-20% 'productivity gain'. Without any changes in processes including better collaborative working this would require a very significant uplift in staffing levels for the ED.
- However, a workforce plan in isolation of the necessary improvements in the total patient journey would re-enforce silo thinking.
- Ensuring Bed Bureau/GP arranged referrals for assessment to admitting specialties never or only rarely (other than those with physiological instability) went through an ED process, better collaborative working from the admitting bed holding specialties and the ED with a marked reduction in re-work (duplicate assessments, over investigation etc.) with much earlier co-management and pull through from the ED by admitting Specialties would dramatically reduce the need for additional ED staff.
- A joint clinical governance and better pathway management between the Urgent Care Centre and the ED can be expected to result in a marked reduction (<90% reduction) of the re-directs to ED after the extensive triage assessment process and others after the GP assessment process (http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf). For the former, the joint governance process would ensure these patients completed their episode within the UCC rather than being re-directed to the ED. In the latter group after GP assessment, the main issue appears to be onward referral to specialty. These referrals should be managed in the same way as GP Bed Bureau patients, i.e. not going to ED but being seen direct by the specialty. Again this
- There are two periods of 'timeout' for the teams, one is at approximately 6-7pm for breaks and the other is at 9pm for handover. During both time periods there is marked reduction in 'decision making capacity' on the floor.
- There is a relative lack of standardisation between the Consultant and Nurse Shift co-ordinator with variability between team members.
- There is incomplete separation of the Urgent Care Centre stream with, variably reported, up to 15% (or even up to 30%) re-directs from the UCC to the main ED. Not infrequently these are late transfers with waits of already over 2 hours by the time they are re-directed.
- The ED majors assessment area has become the common pathway for the vast majority of patients, with flow streams that should be managed elsewhere, that is UCC re-directs, GP arranged via specialty, minors identified by paramedic crews (in the last two weeks these are now being

directed straight to Minors), GP direct to Emergency without discussion with a Specialty and some arriving as their discharge letter states 'if you have any problems either contact your GP or come to Emergency'.

- The Assessment Bay (7 trolleys) aims to provide Early Senior Assessment (ESA), however, there is variability amongst the Consultants of how this is delivered. In addition, the 'takt' time does not appear to have been factored in to how the process should be set up. If including all GP referrals (currently predominately attending via Emergency rather than direct to assessment units) the reported 85th centile of assessment attendances is 14 per hour. This equates to a Takt time of 4 minutes meaning a single senior decision maker would need to process a patient every 4 minutes to prevent a queue forming (assuming egress from the area is not blocked), two senior decision makers would need to process a patient every 8 minutes, and 3 would need to process every 12 minutes. Consultant led ESA must add value to the patient and not just be a streaming process, the latter can be utilised if ESA is not feasible and can be performed by a Senior Emergency Nurse streaming to 'definite admit' and 'probable discharge' streams.
- Referral standardisation – i.e. discussion with Consultant until Consultant shift end or ST4 and above after that of all requests for transfer or opinion. There is a degree of this but this could be tightened up.
- Response process from admitting teams. There is relative lip service to this response standard. There are multiple examples of 'specialty Ping-Pong' with poor response times to ED requests. **This consumes a huge amount of senior decision maker time within the ED.**
- Specialty 'visibility' in the ED is very limited apart from the 'funded' sessions to cover gaps in the shifts by Medical Consultants. This latter process is at very high cost. The reasons for the lack of specialty visibility are variably reported but some of this has been as a consequence of the 4 hour standard being seen as an ED problem.
- There is a 'watershed' policy for managing the referral process for scenarios where there is perceived doubt as to which specialty ED should refer some of these 'watershed conditions'. This is an extensive document, whereas in most other organisations it is a very brief set, and creates a significant number of 'complex rules' in its own right. It is not infrequently ignored by Specialties and of particular note and frequently contested is the statement within the 'policy' that the ED Senior clinical decision maker managing the floor has the final decision.
- The ED EDU should only have patients entering these beds on a protocoled pathway allowing discharge when certain criteria are met. There are opportunities to expand the range of ED managed cases going through the ED EDU e.g. cellulitis needing IV antibiotics whilst community IV therapy is being set up, low risk pneumonia, etc. many of these clinical scenarios are identified within the Directory of Ambulatory Emergency Care for Adults. The second group of patients in the ED EDU are the 'remnants' of the Emergency Frailty Unit prior to its move up to the Acute Frailty Unit on the 5th Floor. The functionality of the EFU is well received amongst the ED Team, although impact metrics based on beds occupied and patient level outcomes have not been robustly put in place.

Recommendations

- **For the admitted flows from ED, 90-95% of the improvements in the system are out with the ED.**
- **ED will be unable to maintain improvements in its own processes until there is a 4-6 week period of zero or absolutely minimal bed delays, specialty 'Ping-Pong' and delivery of all (unless physiologically unstable) GP/Bed Bureau/UCC patients to the relevant assessing specialty. For Medicine and Surgery this means direct admission to the relevant assessment areas, utilising the relevant Emergency Care Standards of 'time to initial assessment, time to treatment as well as time to Consultant review.**
- **The critical metric to reduce hospital over-crowding (**www.coll**emergency**med.ac.uk/code/document.asp?ID=6296**) and the associated risk is to reduce bed occupancy by improving processes on base wards and assessment units, ensuring that the short stay, sick mono-organ specialty/general and frailty admitted flow streams are optimised.**
- **ED is provided with data sets on a daily basis (constructed in conjunction with the Emergency) to assist in its understanding of demand, capacity, and flow ideally split by admitted vs. non admitted.**
- **An ED quality improvement metric would be to reduce ED conversion to admission downstream of the ED Short Stay Unit by 10% (http://www.aomrc.org.uk/doc_view/9450-the-benefits-of-consultant-delivered-care), possibly more, by implementation of standardised floor management, standardised Consultant review of referrals, RAT/ESA process and improved ED use of the ED Short Stay Unit. This would be further facilitated by specialty in-reach in to the ED by the relevant high volume admitting specialties of Medicine, General Surgery and Trauma and Orthopaedics.**
- **ED refreshes the capacity mapping of decision makers by reviewing the hour of arrival demand profile for the ED on a six week rolling average data set to assist in capacity planning. This should be provided to ED daily.**
- **ED tests and implements an ESA process mapped to the demand profile and Takt time. The output from ESA needs to be defined e.g.:**
  - Bundle 1 – Diagnosis/differential, investigation (necessary for immediate management) and treatment.
  - Bundle 2 – dispersal plan:
    - Immediate home
    - Probably home after treatment and observation of improvement after <4 hrs. in main ED or maximum one overnight stay in the ED EDU on a protocoled pathway.
    - Definite admit – stable – direct to admitting specialty – no need for further ED work up.
    - Definite admit – unstable – stabilisation in ED in partnership with admitting team.

  - Unsure of diagnosis or dispersal – needs work up.

- **ED standardises floor management with a written roles and responsibilities paper for both the Nurse co-ordinator and the Consultant in charge of the floor.**
- **ED considers enhancing the range of ED short stay pathways to improve utilisation of the ED EDU.**
- **ED standardises referral management. Patients assessed by grades of Doctor of below ST4 are to discuss patients with the Consultant on the floor or the ST4 after midnight. The decision is for referral for 'advice' to assist discharge or 'request for transfer'. This standardisation of senior review (not re-assessment as in most cases this will be dealt with by a discussion) will assist in demand control, for admissions. The referral process should ideally be based on an RSVP or SBAR communication tool. The response from the referred to specialty will be 'yes' 100% of the time with abolition of 'specialty ping pong'.**
- **As a general rule, ED is <u>NOT</u> to be used by other specialties as an admission route for patients from outpatients or community services unless the patients clinical situation would of itself trigger a 999 call in the community.**
- **If the ED referral is a 'request for transfer' approved by an Consultant/SR then bed holding specialties have 30 minutes to respond with either a bed available or a review in ED. If the admitting team reviewing doctor does not arrive, this constitutes 'permission to transfer' after the 30 minutes has lapsed. With the proviso that there has been a safety confirmation step which will include a full set of observations prior to transfer, adequate pain relief, appropriate iv fluids commenced. Physiologically unstable patients will not be transferred. This policy would have to be endorsed by CMG Clinical Directors and the receiving specialties all made aware that the clinical governance responsibility lies with them since they have not responded in a timely manner. Every delayed response by a receiving team is to be considered a breach of clinical governance and the organisation will need to consider how these breaches of governance are to be investigated.**
- **With the locus of control for patients not admitted from ED being predominately within the ED, the ED should be aiming for 99%+ of these patients being discharged in 4 hrs. or less. The ED is predominately responsible for this standard, although investigation wait times and waiting for advice prior to discharge does have an impact.**
- **For admitted patients, if the ED has seen and assessed and a decision formulated within 140 minutes (Emergency Services Collaborative metric), the locus of control is with the admitting specialties. The admitting specialties are responsible for delivering 95% admissions within the total 4 hour time frame. Recognising that some 5% of referrals may be late from ED due to an attempt to get the patient home but insufficient improvement occurred or considerable time has been needed to stabilise the**

patient (joint management should be occurring in this situation) and the request for a bed is thus delayed.

- **Once the whole of pathway improvements have occurred, i.e. no GP bed bureau patients via ED, collaborative co-management with admitting specialties, no waiting for bed or specialty delays etc., as well as those elements specific to ED, 10-20% productivity improvement, standardised floor management and ESA, then the demand:capacity gap analysis needs to be repeated to evaluate any staffing needs.**

3.4 Rapid Assessment Unit/Acute Medical Unit/Acute Frailty Unit

- Medicine, from Assessment Units to Base Wards, at the LRI is significantly compromised with multiple handovers, variable delivery of some of the standards for assessment, decision making and lack of formalised handover and case management. There is confusion of admitted flow stream management.
- As a result, the patient pathway across Medicine at the LRI are at risk of generating the potential for significant harm and excess mortality due to clinical processes and behaviours.
- Having the 3 Assessment Units for Medicine on the 5th Floor albeit in the same Block as the ED risks creating an 'admitting' culture rather than an assessment culture. The proposed relocation to behind a new ED, along with very significant changes in processes, is very logical. The Assessment Units are effectively bed based with a small clinic area, rather than a mixture of beds, chairs and trolleys, which would give an impression of fast turnaround for the less sick.
- Notwithstanding the above, there are clinical leaders within Medicine who are totally focussed on quality outcomes for the patients and are keen to bring about the necessary changes to the clinical processes. There is however, passive and even some active resistance to improvement.
- These three assessment areas essentially should run the process of assessment and decision making with the latter specifically designed to capture frail older people to optimise early management via comprehensive geriatric assessment. However, the functionality of these units is variable and impeded by the working processes on the Units and excessive variability amongst the senior medical staff on how the process should run. The units are tending to operate more like admission units rather than the expected pace of assessment and decision making units.
- Not infrequently there are beds in the Base Wards but no beds on the assessment units with delayed decision making and little in the way of pull from the Base wards. This is compounded by the 'batch processing' by ward rounding rather than continuous roving senior assessments and decision making.
- Many assessment unit ward rounds take all day starting at the beginning and going to the end rather than targeting the very sick first, then the discharges/transfers. The routine process is for Consultants only to review patients who have been clerked by Junior Doctors, whereas the RCP Standard is very clear that all patients referred to Medicine are to be reviewed by a Consultant before going off shift whether they have been

formally clerked or not (RCP Acute Medicine Task Force Report 2007 https://www.rcplondon.ac.uk/sites/default/files/documents/acute_medical_care_final_for_web.pdf) and whether they are on the Assessment Unit or still in the Emergency Department awaiting transfer to the Assessment Units..

- Consultant presence on the assessment units when they are rostered to be present is variable with some in the evening leaving the site before the 9pm currently set and some being absent during the afternoon of their rostered sessions on The AMU. This is totally unacceptable.
- The Acute Frailty Unit provides input in to those patients who can access the unit whilst there are as many again who are unable to access the skills of this unit.
- Patients who are on the AFU who need the Primary Care Co-Ordinator team to assist in discharge can only receive this if they remain on the AFU, rather than the PCC process following the patient to the Short Stay Unit
- There is a structured clerking proforma with Consultant first review which requires the completion of a case management plan including EDD, however, the Expected Date of Discharge is variably completed.
- Review processes are predominately by ward rounds which can last all day without roving reviews with delayed decision making as a consequence.
- There are no written roles and responsibilities for the Consultant covering the Assessment Unit delineating clearly the function of the Consultant with regard to rolling reviews, ensuring flow and decision making etc.
- There is a Consultant taking the calls from GPs to access the Acute Clinic. It does need to be considered whether this clinic has become a 'supply side' driver of outpatient activity rather than the intended pure acute process. Some Consultants consider it necessary for patients to be clerked before they can be seen in the clinic.
- There is relatively little development, as yet, of some of the key Ambulatory Emergency care pathways beyond cellulitis, TIA, DVT and pulmonary embolism.
- Consultants on the Acute Medicine rota work in blocks of 5/2 days although there is some swapping of this process. Patients with short stay potential are being moved to Base wards rather than the short stay unit with the likelihood of increased length of stay. In addition, there are multiple hand overs along the patient's journey with one patient being assessed 7 times medically before a definitive case management plan was put in place.
- The 1700 to 2100 hrs rostered presence of a Consultant Physician on the Assessment Units has been variably delivered, although this appears to be changing.
- The understanding is that the 1700 to 2100 Consultant is also the overnight on-call, but rarely reviews their admissions the next day, resulting in a completely new assessment by another Consultant the next day.
- Likewise the weekend on-call Consultant does not review the patients they have seen over the weekend on the Monday morning, with a second Consultant re-assessing these patients on their Acute Assessment Unit session on the Monday morning.
- Even when running the 2 and 5 day split week there are frequent handovers of patients between Consultants on the assessment units.

- This frequent handover of short stay patients between Consultants is particularly deleterious to flow, let alone the risk associated with handover of seriously ill patients between Consultants.
- Handover of patients to Base wards, and thus almost invariably to another team, is based solely around 'arrival' on the Base ward rather than a structured 'pull' process which ensures the case management 'baton' is not dropped.
- The 'Acute Care Beds' (ACB) on Ward 16 have been developed by Medicine to cater for physiologically unstable patients who need close monitoring. It does not meet the requirements of a Level 2 Critical care facility. There are a number of patients transferred back from Base Wards to this facility whose level of care needs ought to be met by a Base Ward alone and in some with input from Critical Care Outreach. This 'back flow' in to the ACB results in a significant consumption of assessment team capacity.
- There is effectively no Level 2 Critical Care provision for Medical patients at the LRI with access to the Level 2 and 3 Critical Care Beds in the ITU perceived by the Physicians as problematic.
- On Friday 13th June 2014, the Clinical Leaders within Medicine called an extra-ordinary Physicians meeting to set and agree a series of quality standards across the patient journey which were aspirational but needed to be worked towards. These standards included door to nurse time, door to doctor time, door to Consultant time, the construct of the Consultant decision to ensure that EDD and CCD are captured. In addition, they agreed that all patients referred to service would be reviewed by a Consultant before they went off 'shift' even if still in the Emergency Department.
- In addition, two Consultants volunteered to run a test of a 'new process' for short stay patients ensuring that these patients remained under the care of the admitting Consultant. This is a crucial improvement.
- On one ward, there has been an early trial of the 'ticket' home including the four key questions patients should be able to answer.
- In addition, Medicine instituted a series of governance processes which need to be embedded and continuously delivered. These are, senior leader rota of the assessment unit floor at 2000 hrs linked to a re-enforcement of the role of the Consultant on the 'floor', a long LOS review process (which requires more robustness and then adaptation), and an early form of a Board round review process. The Heads of Service and the CD for the CMG now meet weekly to discuss actions to deliver improvements. These actions are good practice and must be developed further. These are not short term processes but are to be embedded in the system for a minimum of two years of delivery of the quality improvements required.

Recommendations

- **Monitor the improvement towards the internal standards of 4 hours to Consultant review and setting of EDD and CCD by Consultants. Ideally aiming to report performance daily at handover.**

- **All patients leaving the assessment units moving to downstream wards must have a complete end to end (i.e. to discharge) case management plan with EDD and CCD (Keogh Standard 3 - http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf).**
- **Ensure that all patients 'referred to service' who are in the Hospital but who have not been assessed by a Junior Doctor receive a 'rapid review' assessment by the Consultant before they leave including those referred but not yet transferred from ED. (See RCP Acute Medicine Task Force Report - https://www.rcplondon.ac.uk/sites/default/files/documents/acute_medical_care_final_for_web.pdf).**
- **Consider making the GP call management by Consultants more robust and not dependent on a single individual and extended to 2200 hrs.**
- **Ensure that Consultant presence on the Assessment Units is continuous with roving rounds and decision making, which includes streaming to the relevant flow pathway, i.e. immediate discharge, discharge in 12 hrs, discharge with short LOS (2 midnights or less) and those for Base Wards. Breaks for 'comfort' and mealtimes (30 minutes maximum) are acceptable. If all patients have been reviewed and no-one in ED awaiting referral, then a 'downtime' for 'administration' can be taken, with the proviso that if 2 or more patients are referred to the area covered by that Consultant, they return immediately.**
- **Consultant presence on the Assessment Units should match the demand profile of 80% of admissions from 0800 hrs, currently this requires Consultant presence until 2300 hrs.**
- **The evening on-call Physicians should return to the Assessment Units/Short Stay unit at 0800 hrs to review those of their patients who have remained on the units overnight to facilitate early discharge.**
- **Aim for 15-20 empty beds across Wards 15/16/AFU every morning including Monday morning.**
- **Develop an Ambulatory Emergency Care (Ambulatory Emergency Care) strategy which sets AEC as the default (https://www.rcplondon.ac.uk/sites/default/files/acute_care_toolkit_10_-_ambulatory_emergency_care.pdf and http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,181.htm) for the Assessment Units and monitor AEC delivery. The aim should be for 25%-30% of medical acute admissions being resolved and discharged home within 12 hours.**
- **Test and implement a process whereby patients identified as short stay where by a further 40-45% of the acute medical admissions are discharged with a length of stay of 2 midnights or less (http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,192.html) and are managed and reviewed by the admitting Consultant until discharge.**

- **ACB should only take 'incoming patients from ED or GP referrals and not accept patients from Base Wards, to deliver this will require re-skilling of Base Wards in some areas, ensuring sufficient Critical care Outreach to support Level 1 care on the wards and the consideration of developing more Level 2 Critical Care (http://www.ics.ac.uk/ics-homepage/guidelines-and-standards/), from a combination of improved step down from the current Level 2 (reduced bed occupancy on Base wards), and possibly coalescing current so-called 'level1/2' facilities in to a single unit meeting the necessary criteria.**
- **Progress the acute frailty pathway (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-3.pdf and http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf) aiming to include all patients with frailty, initially admitted through Medicine and then surgical specialties. The key outcome metric is a 25-50% reduction in beds occupied by patients aged 75 and over who have been in-hospital 10 days or more.**
- **Test and implement the Primary Care Co-ordinator process following the patient linking to a 'front door frailty team'.**
- **Metrics provision for Medicine (General Medicine and all sub-specialties combined with drill down) : daily demand run chart with forward prediction for 7 days (based on 6 week rolling average as a minimum), 4 or 6 week rolling average of demand by hour of day (based on arrival time of primary care referrals and time of referral from ED), capacity (available time of senior decision makers X process time), flow (daily zero LOS discharges for ambulatory care, discharges with LOS 2 days or less for short stay, all beds occupied by Medicine (all specialties), beds occupied (not discharges) by Medicine (all specialties) aged 75 and over to represent potentially stranded frail older people.**

3.5 Base Wards

- Board Rounding is 'structurally' in place on a number of wards, but the process varies markedly between wards with some areas focussing on discharge and the key actions to deliver this effectively as well as highlighting unnecessary internal waits. Board rounding is an effective process if delivered well and supported by all the Consultants, simply put, if board rounding is not resulting in a reduction in bed occupancy it is not being done effectively. It does require clearly constructed case management plans with clinical criteria for discharge and expected dates of discharge.
- There has recently been discussion on the implementation of the 'ticket home' concept around the 4 patient questions. This should not be considered a general medicine initiative but an organisational initiative and supports the concept of 'enhanced recovery' for the acute care pathway.
- Referral timelines are far too loose with 12 hours for a Registrar to Registrar review and 24 hours for a Consultant review. There is a degree of over referral.

- New patients arrive on Base wards every day yet there is no standardised process to have a senior review either before the end of the working day for those who have arrived on the ward before 1700 hrs or early the next morning for those who have arrived after 1700 hrs.
- There is variable delivery of the 'one stop' ward round concept, where all tasks are completed (except major procedures) during the round rather than Junior Doctors writing lists of tasks to be performed. The aim is to 'deliver this hour's work this hour'. Successful implementation of one stop ward rounds results in nursing staff rarely if ever having to call Junior Doctors back to complete discharge summaries/drugs to take home.
- It has been reported and observed that there are issues around the functionality of the Computer on Wheels, both battery life and Wi-Fi connectivity as well as 'boot' up speed of relevant software.
- There does not appear to be a process of peer to peer review of 'long length of stay' reviews using a structured proforma to be placed in the patients notes.
- Gastro-enterology are not on the acute medicine rota and are not within the same Clinical management Group. They are within the CHUGS CMT, however, even here, there alignment is less than optimal with the Gastro-enterology base wards at the LRI not co-located with the upper and lower gastro-intestinal surgical teams. Gastro-enterology HRGs are usually the 3rd or 4th most common acute admitting diagnoses after respiratory, cardiology and poisoning (deliberate self harm). There is, as with other medical specialties e.g. neurology, no 'attending principle with direct 'pull' of specialty patients from ED and the Medical assessment Units. The process of accessing these specialties is via referrals, with barriers to access, approximately 5-10 years out of date of modern practice.
- The Gastro-enterologists operate a 'bleeding rota' for emergency access to therapeutic endoscopy. The 'pathway' for the referral requires a very significant number of steps before the Gastro-enterologists become involved in the care of these patients. In their own published data set over a 6 month period, only 18 out of hours (1700 to 0800 hrs) emergency endoscopies were performed.

Recommendations

- **Standardise the Board Round process, using a script if necessary and other training opportunities. It is understood the there was a video made 3 years ago of an effective Board Round but this has not been used as a training instrument.**
- **Aim to spread the 'assertive board rounding' principle across all specialties.**
- **Implement one stop ward rounds based on the RCP guidance (https://www.rcplondon.ac.uk/sites/default/files/documents/ward-rounds-in-medicine-web.pdf)**
- **Once robustly in place for 5 days per week, consider how this might be achieved across 7 days per week to support 7 day discharges.**
- **Capture unnecessary delays (commencing with internal delays) at these Board rounds and resolve them at the Board Round, if they**

can not be resolved escalate the same morning for resolution by the afternoon and then design these out of the pathway.

- **Rapidly test and implement the ticket home in one or two clinical areas with a spread and adoption strategy.**
- **Implement a standardised process to review new patients on Base wards by a Consultant including an 0800 start, the 'golden hour' review (https://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-2-high-quality-acute-care.pdf)**
- **Implement the 'long length of stay' review process which ensures a formalised review of patients who are 'stranded' within the system. In essence, this process should answer two questions –**
  1. What is being done now to resolve the issues preventing this patient leaving hospital?
  2. What could and should have been done both pre-hospital and in the first few hours and days of admission to prevent this patient becoming stranded.
  This initiative will need to have an escalation process embedded within it, e.g. first review at X days with a fellow Consultant and charge nurse, second review at Y days with the clinical lead and nurse manager, third review at Z days with Divisional lead and Director of Nursing. This process should start at day 6 of an admission. This process, when delivered robustly at St Thomas Hospital, London, resulted in considerable improvements in flow. Again, this strategy is not specific for general medicine and should be tested followed by a spread and adoption programme.
- **For medical specialties not on the acute medicine rota e.g. Gastro-enterology, Neurology, rapid (within 1-2 months) implementation of an 'attending' Consultant input to the assessment units on a daily basis and to see referrals within 30 minutes of referral from these units to facilitate flow. Cardiology and Respiratory Medicine from the Glenfield will likewise need to consider a referral management process for the LRI site which is equally responsive and for Diabetes and Endocrinology, Geriatric Medicine and other LRI centralised Medical Specialties, a similar process is required for the Glenfield site. Multiple transfers of patients for non-interventional fixed equipment dependent consults is not an efficient use of resources.**
  - **The upper GI bleeding pathway needs to be altered to ensure early Gastro-enterology specialist input (http://www.nice.org.uk/guidance/cg141/resources/guidance-acute-upper-gastrointestinal-bleeding-management-pdf) for any patient with a modified Blatchford score greater than zero.**

3.6 Surgical Assessment Unit

- The SAU is based on the 3rd Floor of the Balmoral Wing. It is based on ward with beds, although there is a chair and trolleyed area at the entrance to the unit.
- There are three surgical teams using this unit, upper GI surgery team, lower GI surgical Team and the Vascular team. The first two work as a

fixed pair team and cross cover providing a high level of Consultant visibility on the SAU particularly in the morning.

- There are Consultant rounds in the morning such that all upper and lower GI and Vascular patients both on the SAU and on the Surgical wards are reviewed every day by a Consultant
- The overnight on-call is shared between the upper and lower GI surgeons for the general surgery take and the vascular surgeons have, appropriately, an independent rota.
- At the Leicester General Hospital, there is a general Surgical take, run by a lower GI team, and a Hepato-Biliary take, although sick unstable hepato-biliary patients arriving via ED are admitted to the LRI SAU and transferred, at a variable time, to the LGH.
- There are delays in obtaining ultrasounds at weekends but much less so in the week.
- There are delays in obtaining ERCPs for patients at the LRI as these are only carried out at the LGH after an appropriate centralisation of this service to one site. Patients on the LRI SAU were seen awaiting transfer to the LGH for ERCP. However, the processes for ERCP need to be improved to ensure no unnecessary in-patient delays, this could include discharge home of patients with painless obstructive jaundice without high risk markers until ERCP is performed within 1 week.
- The trolley and chair based area is used as Registrar and senior nurse led Surgical triage. – which has reduced admissions at the LRI site by 30%. A build of two consulting rooms earlier this year occurred to support the implementation of an 'Ambulatory Surgical Emergency Care', currently named Surgical Triage, for abscesses, abdominal pain ? cause, groin pain, low volume rectal bleeds etc. The process would have been Consultant delivered with the Consultant taking the GP calls, focussed on rapid assessment with rapid diagnostics supporting early decision making with the potential for same or next day procedures. The process was due to be launched earlier this year after much debate and general agreement but this was postponed as it appears one surgical team felt they could not contribute. It is currently being operated on same days of the week, when there are two Registrars on-call for upper and lower GI surgery. This is not in-place at weekends
- The concept of the 'Ambulatory Surgical Emergency care' service is absolutely correct and results in significantly improved patient experience as well has having the potential to reduce non-elective surgical bed occupancy by up to 20-30%. However, with the current Registrar triage the extent of this improvement may not be as extensive, but still very worth exploring. In addition, the presence of a Consultant on the SAU running the ambulatory service also provides opportunities for Consultant decision making on the Unit if the on-call Consultant is, quite rightly, in theatre.
- There is one emergency theatre (NCEPOD list) available all day and this is utilised by multiple surgical specialties. Theatre utilisation of this NCEPOD list is likely to be sub-optimal but has not been directly observed. There are frequent overnight if not two overnight delays for access to this list for the Upper and Lower GI Surgical Teams

Recommendations

- **Through a rapid cycle test of change process, implement the 'Ambulatory Surgical Emergency Care' service, commencing with the enthusiasts. The ASGBI and RCS 2014 Commissioning Guide Emergency General Surgery (acute abdominal pain - https://www.rcseng.ac.uk/healthcare-bodies/docs/emergency-general-surgery-commissioning-guide), states that up to 30% of the general surgical take can be managed in this way**
- **Review the obstructive jaundice/pancreatitis pathway to minimise/remove delays in hospital to ERCP and arrange to manage some patients with low risk factors on an ambulatory basis.**
- **Collaborate with radiology on how access to ultrasound scans at weekends can be improved to facilitate flow.**
- **Collaborate with ED to facilitate the pathway for co-management and transfer of ED identified surgical referrals, some of whom could also go through the ambulatory process above.**
- **Review the NCEPOD theatre utilisation and increase capacity either by optimising utilisation of the single theatre or by having a second theatre available for emergency cases. The only acceptable rate of delayed time to theatre of one additional overnight stay (never two) is for this to happen no more frequently than once every two weeks for all specialties**

3.6 Surgical Base Wards and Kinmonth Unit

- There are daily wards rounds of all upper and lower GI surgical and vascular inpatients by a Consultant 13/14 days, with the 14th day being delivered by a Registrar. For the GI Surgeons this is a large volume of patients with an average 'process time' of 3 minutes. This makes one-stop ward rounding for TTOs impossible to deliver as the processing time for the TTOs is between 4-6 times longer than the patient:surgeon contact time.
- ENT, Ophthalmology, Maxillo-facial surgery and Plastic surgery do not have daily Consultant led rounding on their in-patients including their 'high risk' patients on Kinmonth ward. This is a potential clinical risk.
- Tissue viability Team response times for complex wounds appears to be sub-optimal with at times significant delays.
- Responses from other specialties for 'discharge critical' opinions is measured in days rather than hours and is totally unacceptable for an emergency care pathway. Life and limb critical referrals should be responded to immediately and all others that are discharge critical should be responded to in less than 4 hours. Notable exceptions to this are the well-received response times from the Acute Oncology Service and the Palliative care Service.

- Patient transfers to other sites for opinions without any specific 'kit' required are occurring, this is a waste of resource and patients time and wherever possible the specialty should go to the patient unless non-transportable specialist kit is required.
- There are a number of external constraints to discharge that the wider system needs to resolve.
- The Vascular ward has a clear set of rules to prevent graft sepsis and the over-crowding of the hospital with the placement of potentially 'infected' patients on this unit is a safety risk
- Elective and non-elective patients are mixed on a number of surgical wards, in some this is appropriate, e.g. Vascular, in others this has an impact on both pathways.
- Level 1 and Level 2 critical care as a process has not been strategically implemented and there are a variety of 'work-arounds' to this issue.
- The 'Rapid' bed cleaning service for contaminated areas, i.e. after a patient with diarrhoea has been discharged, is anything but Rapid. Side-rooms are a premium and the turnaround of the cleaning of these beds should be less than 30 minutes of the bed being vacated.

Recommendations

- **The surgical team have suggested a parallel team of a pharmacist along with the development of 'physician assistant' from amongst the nursing team to deliver TTO prescriptions. This is very worthy of rapid cycle tests of change. There are in essence on three types of TTO's, same drugs as admission with, maybe, one or two additions, a significant change in medication and finally complex regimes.**
- **As stated in the General recommendations section, the response times to 'discharge critical' referrals to other specialties should be set at 4 hours maximum for non-limb/life threatening referrals.**
- **As stated under the Medicine section, there is a need to move towards a Level 1 and Level 2 critical care strategic implementation plan**
- **The Vascular Ward rules for outliers are to be honoured 100% of the time by ensuring a fall in overall bed occupancy across the Trust. This will also facilitate ITU step down.**
- **Through Rapid Cycle tests of change a 30 minute turnaround time for 'contaminated bed space cleaning' needs to be implemented.**
- **Processes at the Leicester General Hospital in both General Surgery and Hepato-biliary surgery have not been reviewed as yet, it is, however, extremely likely that there will be as much opportunity to optimise processes there as at the LRI.**

3.7 Oncology

Many of the solutions being proposed here are in absolute alignment with the RCP RCR document 'Cancer patients in crisis: responding to urgent needs' 2012 (https://www.rcplondon.ac.uk/sites/default/files/documents/cancer-patients-in-crisis-report.pdf) and the RCP 'Acute Care Toolkit 7' 'Acute oncology on the acute medical

unit' October 2013 (http://www.londonhp.nhs.uk/wp-content/uploads/2013/03/ED-Case-for-change_FINAL-Feb2013.pdf).

- In Oncology, the vast majority of chemotherapy is delivered on an ambulatory basis, this is good practice, with only the rare high dose methotrexate with critical timing of folinic acid rescue – although in the US there are centres that are delivering this on an ambulatory basis.
- The Oncology Assessment Unit has a 'chaired area' for rapid assessments and interventions with early discharge home in as short a time as 2-4 hours. This is good practice although the area is not ideal for patient confidentiality/privacy whilst receiving infusions etc.
- You have attempted to introduce an 'ambulatory neutropaenic sepsis' pathway based on the internationally evidenced based MASCC risk stratification instrument. This risk stratification allows same day discharge of a small proportion of patients with neutropaenic sepsis based on a score >21 which identifies them as low risk. This process has been introduced cautiously, with a single overnight stay being the default for this low risk group. Despite some enthusiasts this process has not been widely adopted and there is now a need to accelerate the implementation of this evidence based practice over the next few months.
- The acute oncology service (AOS) which constitutes a senior specialist Oncology nurse backed up a number of hours per week by a Consultant Oncologist. This service also comprises the Consultant of the day covering the Oncology Assessment Unit. The AOS thus provides a reviewing service for the oncology acute assessment unit and will see up to 8-10 'consults' on other wards throughout the LRI of broadly 4 groups of patients.
    - Patients with cancer who have stable or progressive cancer but who have been admitted with another acute medical/surgical problem. Their 'oncology need' would be met on an ambulatory basis. These patients do not require repatriation to Oncology.
    - Patients with cancer whose disease progression has resulted in them entering an End of Life phase of their illness in whom planning of this phase of their illness is required. The vast majority of these patients do not need repatriation to Oncology, although some may e.g. those requiring very rapid palliative radiotherapy may need repatriation, although in other systems these patients remain under their admitting specialty also, with everyone focussed on what absolutely needs to be done today and tomorrow so that there is 'no wasting of the patients time'.
    - Those patients with acute oncology emergencies who are still in a treatment phase, this includes patients already known to service who present acutely with acute physiological or functional change due to disease progression and some patients whose first diagnosis of cancer is during their 'incident' acute admission and have a need for immediate/near immediate oncological intervention e.g. acute cord compression, or newly diagnosed lung cancer with rapidly progressive Superior Vena Caval obstruction and a risk of airway compromise. These may well need repatriation to oncology, but there are services nationally where the intervention is co-ordinated

in partnership with the admitting specialty – with the simple rule that if the admitting specialty wishes to discharge the patient, they are discharged but if the Oncology service feels they must remain, then Oncology repatriate. This means that Oncology can not 'use up' another services bed days.

- Finally a group of patients whose cancer is diagnosed during their acute admission BUT in whom there is no immediate or near immediate need for oncological intervention. In this scenario, the acute need is resolved by the admitting specialty who discharge the patient and the oncological service carries out the necessary processes in parallel (but not adding any days/hours to the LOS) and after discharge.

- GCSF use in parallel to chemotherapy to reduce the potential for neutropaenic sepsis. The practice is that for the first cycles you do not use GCSF but if a patient in the treatment phase develops a single episode of neutropaenic sepsis, then subsequent cycles are 'covered by GCSF'. If the patient enters a palliative phase then the GCSF cover is stepped down. This seems an appropriate balance between the cost of the GCSF (high cost medication) and the mitigation of the risk of neutropaenic sepsis as a consequence of high dose chemotherapy aimed at 'cure'. It was not clear if this approach is 'standardised' or if there is variability in the approach between different Oncologists.
- Oncology have considered 'hot clinics' or just adding additional patients to clinics for patients with an urgent need but who can be managed away from the in-patient service. The recommendation would be for the latter rather than the former in the first instance with 'control' of access with your community oncology nursing team to start with and then for GPs. The reason for this is that a 'hot clinic' without a control mechanism will create a supply side driver and patients will attend this clinic who should have gone through a more appropriate pathway.
- On the in-patient wards, there are 'boards' amenable to 'assertive 'board rounding', however, the effectiveness of the 'board rounding' is variable. All patients do have an EDD but clinical criteria for discharge, which allows patient triggered discharge, are not routinely in place.
- One stop ward rounding on the Oncology Base ward is not the norm with Junior Doctors storing up lists of tasks to complete and the nursing staff then having to chase for TTOs etc. This is not an efficient ward process. It was reported that the Computers on Wheels are working well with good WiFi signal and battery life, this should facilitate one-stop ward rounding.
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Recommendations

- **On the Oncology Assessment Unit there is a Junior Doctor and an SpR . There is a 'door to doctor' principle measured in % achieved within 2-4 hours, reported at 92% achievement. The national ED Quality Indicators are for a Door to Treatment (assessment commencing by a doctor of decision making capability) is 1 hour and this is the same if the patient is for admission or not, the latter being not very sick. For patients being admitted as an emergency, we have to accept that these patients should be at the 'sick/very sick end of**

the scale' and as such a measure for improvement of % patients commencing medical assessment within 30 minutes is an appropriate timescale. This will not be achievable immediately and is a standard to be improved towards. Medicine have agreed this standard also for their emergency admissions. This metric is not a 'measure for judgement' and is not to be used as such, but demonstrating variance (in a non judgemental manner) is part of the improvement methodology.

- **The consultants variably round in the morning and equally, or even more variably, round in the evening. There is insufficient 'demand' based on the 85% centile of the admissions (16 per day – which is inflated by patients who can be admitted elsewhere) to require a continuous presence of a Consultant within the Oncology Assessment Unit, however, as a minimum twice daily ward rounds delivered consistently across the Consultant body covering the Unit is a process you ought to move towards. The function of the SpR during the day is to maintain safety and some definitive decisions whilst the function of the Consultant is to ensure that there are definitive decisions (including an end to end case management plan along with clinical criteria for discharge and an expected date of discharge) on all admissions and to further ensure safety.**
- **Accelerate the implementation of the MASCC risk assessed process for low risk patients with neutropaenic sepsis (http://www.ncbi.nlm.nih.gov/pubmed/20596732?dopt=Abstract).**
- **Standardise wherever possible the utilisation of GCSF across oncology taking the same risk:cost:benefit approach outlined above.**
- **Implement, through rapid cycle tests of change 'urgent' 'over-booking' in outpatients for patients with urgent need but in whom ambulatory care is feasible.**
- **On the in-patient wards, implement, through rapid cycle tests of change, effective Board Rounding.**
- **On the in-patient wards implement, through rapid cycle tests of change, the principle of the 'one stop ward round', where all tasks, including discharge letters and TTOs, are completed at the bedside except for major procedures.**
- **There are 15 Oncologists and technically it is feasible to have 15 different Consultants attempting to round on a few patients each. There are a number of specialist services that have moved to an 'attending model' where day to day case management (i.e. not the very sub-specialist highly complex processes) is carried out by one or two Consultants which rotates through the team (weekly or monthly). The hyper-specialist input is delivered through a co-management process with good MDT working and communication.**
- **The current default appears to be that patients with known cancer who develop an acute illness are admitted by Oncology, however in a number of these patients the cancer may be relatively incidental to the current acute illness in whom for example an admission for a patient with an exacerbation of COPD who has a 'stable' lung cancer on treatment may well have a shorter length of stay and a better outcome if admitted under Respiratory medicine. This requires a**

process of pathway re-design and identification of patients along their 'cancer' journey in whom a medical admission to the relevant specialty would be more appropriate than admission under Oncology.

3.8 Haematology

- There has been only a limited review of Haematology encompassing the Assessment Unit and the Day Unit.
- The vast majority of lymphoma patients are receiving their chemotherapy on an ambulatory basis.
- For reduced intensity Bone Marrow Transplantation (BMT) patients, who constitute the majority of patients receiving BMT, in-patient treatment is the norm despite there being well established international evidence for ambulatory care being feasible for a significant proportion of these patients. There appears to be a centralised process for day case transfusions in patients who are transfusion dependent, for example, patients with myelo-dysplasia. In many centres, these groups of patients receive their transfusion sin Day Units based within Community Hospitals. This process of centralised transfusion is resulting in 'loss of capacity' within the Day unit to move even more in-patient activity to an ambulatory setting.
- The emergency haematology admissions through the assessment unit vary between 2 and 6 daily with on a few occasions this being higher. There is variability of the extent of early consultant review with it being reported that this may be the next day or even up to two days later. If this is the case, this is not acceptable practice. The volume of admissions to Haematology does not require the continuous presence of a Consultant on the Unit.

Recommendations

- **Rapid implementation of a transfusion service for routine transfusions based within the Community Hospitals. There is no reason why safe and effective delivery for transfusion dependent patients cannot be organised to be delivered in some of the Community Hospitals within 8 weeks. This will require effective collaboration with LPT.**
- **As with Oncology, there is the opportunity for Community based chemotherapy, be that at home with a Community Chemotherapy Nursing Team or in Community Hospitals, especially for Lymphoma patients. This is the norm in many areas and is distinctly under-developed in Leicester.**
- **There are clear opportunities to deliver reduced intensity BMT on an ambulatory basis as there is a large amount of evidence to support its efficacy and safety. This will need careful planning. It is to be understood that a 'rush' to ambulatory care is neither feasible nor safe but a planned implementation is certainly feasible with optimised ambulatory care being delivered within 6-12 months for this group of patients**.
- **On the Assessment Unit, it is not acceptable to have the level of variability of Consultant review of new patients. As a minimum, it will**

be feasible within present Job plans to have a brief twice daily Consultant review of the new admissions to this unit to optimise flow and safety.

- **For both Oncology and Haematology, before re-direction of admissions to more appropriate specialties, it is feasible to reduce bed occupancy on the Haemato-oncology unit by up to 25%, as a conservative estimate, with early senior review of acute admissions, optimised ambulatory care of both acute admissions and for 'semi-elective' patients (e.g. reduced intensity BMT) whilst optimising the release of capacity within the Day unit by re-locating routine transfusions to the Community Hospitals, likewise with patients receiving many forms of chemo-therapy, some of whom could receive their treatment at home with 'community chemotherapy teams'.**

3.9 Glenfield Hospital – Cardio-Respiratory – CDU/CCU

- There are 26 beds on the CDU and a mixture of chairs, monitored trolleys and unmonitored trolleys at the initial assessment step.
- The nursing team attempt to identify likely discharges and definite admits as well as the 'very ill' at the point of access to facilitate stream management.
- The 'take' is a cardio-respiratory take with approximately a 50:50 split through the CDU, there are a small number of direct cardiac admissions to the Coronary care Unit daily.
- The 'take' is serviced by a single Consultant in respiratory medicine supported by a team of SpRs and other Juniors.
- The 'take' varies from a mean of approximately 48 per day to an 85th centile of approximately 60-64 per day. This requires a minimum of two Consultants to maintain decision making and safety.
- The Friends and Family Test indicates high degree of patient dis-satisfaction with the waits in the chair and trolley areas.
- The chair and trolley areas are in effect 'sit-rep' reportable areas as they do not constitute a bed and receive a mixture of heralded and unheralded patients. The clinical risk of an unassessed queue of patients is akin to that in the ED.
- There is a degree of variability of the use of clinical criteria for discharge (CCD) and expected date of discharge (EDD).
- The specialty take is sensibly restricted to under 85 years old although this will still include a considerable cohort of frail older people in whom their 'specialty' issue is not the main problem.
- If beds are tight on the LRI site, the escalation process pushes the 85 year age limit upwards. This may give some short term 'relief' but risks complex frail patients being stranded on the Glenfield site with no frailty expertise available.
- The Respiratory Consultants cover the CDU in a mixture of blocks of a few days with some doing single days. Their presence on the unit is near continuous with roving reviews.
- The pulmonary embolism and pleural effusion ambulatory pathway appears well constructed.

- There are opportunities for further optimisation of the short stay pathway including ambulatory pathways.
- There has been a trial of a Consultant cardiologist supporting the take directly, this needs to be further developed.

Recommendations

- **Embed the use of CCD and EDD as a function of the Consultant generated case management plan.**
- **Test and re-test through rapid cycle tests of change the implementation of a second Consultant (Cardiology) covering the CDU to provide further decision making and quality improvements.**
- **Cardiology has a reasonable tertiary workload and there are opportunities for some optimisation of the secondary workload from within current resources.**
- **Consider a front of house rapid turnaround process for potential ambulatory patients to extend beyond pulmonary embolism and pleural effusions.**
- **Test and re-test a process whereby short stay patients are not handed over, although within single specialty takes a team approach may be sufficient particularly if the person covering the short stay process is particularly effective.**
- **There is the need to consider how 'frailty expertise input' can be achieved at the Glenfield site. When bed occupancy falls at both sites, the need to escalate the take to include over 85 year old patients should disappear.**

3.10 Glenfield Hospital – Cardio-Respiratory Base Wards

- There has been limited time to review the base wards at Glenfield in detail. Currently bed occupancy has been at a reasonable level, although there will always be opportunities to optimise this further.
- There is variability of the presence and efficacy of Consultant Board/Ward rounding on a daily basis at the Glenfield site as at the LRI .
- One stop[ward rounding is also variable as with the LRI site.

Recommendations

- **Ensure robustness of the daily Board rounding process, with Peer to Peer review of the process to ensure focus on delivery of the case management plan and timely discharge.**
- **Implement one-stop ward rounds to end the need for 'call back' for generation of TTOs.**

3.11 Discharge Lounges

- On both sites the discharge lounges are relatively under-utilised before 10am indicating lack of criteria led discharge from the Base wards.
- There is no list generated for the Discharge lounge from the wards 1800 to 2000 hrs for the next day for them to pull patients.
- The Discharge lounge teams do 'trawl' the wards to try and pull patients.

- On the LRI site, there have been occasions where patients have been sent down without TTOs being completed. This is a workaround, or 'Borderline Tolerate Condition of Use', which has potential negative safety implications. A discharge lounge provides one function, a safe place for patients to wait for pre-booked transport or relatives to pick them up. It should have no other function.
- Re-bedding from the Discharge lounge is a 'Leicester phenomenon' and is due to a combination of factors, late preparation, late booking and transport performance against contract.

Recommendations

- **Wards to generate a list of next morning discharges (who can not be discharged that evening) by 2000 hrs.**
- **Wards generate a 2 by 10 and 2 by 12 process for discharges each day and utilise the Discharge Lounge accordingly.**
- **Set the acceptable re-bedding rate as zero and root out and correct all reasons for its occurrence.**

3.12 Diagnostics

- There is a high demand on the diagnostic services from the Emergency care pathway.
- There is clear evidence of excessive pathology requesting and even 2nd and 3rd phase requesting of pathology within the ED, not infrequently requested by bed holding specialties.
- There is near patient testing in the ED with the facility for blood gas analysis including a lactate, blood sugar, calcium, urea, electrolytes but not a creatinine or eGFR and a full blood count including differential count. The Quality Assurance of this service is maintained by Pathology.
- Turnaround time for ED pathology for tests above those offered by near patient testing is reported as slow taking up to 1- 2 hours, this has an impact in particular on the assessment units.
- Radiological requesting appears at times to be less than targeted and is sometimes used as 'hurdle' for ED to overcome before a referral is accepted.
- There do appear to be a number of 'carve outs' and other capacity constraints generated within Radiology with resultant delays in in-patient Ultrasound especially at weekends, Doppler for in-patient rule out of DVT, and CT scanning with multiple phases within CT which delay turnaround time.
- Scan acquisition time for 64 slice CT scanners should not be the rate limiting step, the rate limiting steps are in 'patient changeover time' and reporting. All CT scanner rooms have only one entry/exit point which automatically. The Department my wish to seek advice from the Army Medical Services on how, for instance, poly-trauma contrast enhanced whole body CT scans turnaround times were dramatically reduced in Afghanistan, the principles would apply to all contrast Ct scans and not just poly-trauma. Other units have considered support from Formula Pit

Stop Teams or logistics improvement experts such as Unipart to assist in process re-design.

- On-call radiology appears to be predominately managed by Radiology SpRs and not by Consultants and the routine day appears to be 9am to 5pm 5 days per week. There are examples of 0800 to 2000 hrs 7 day per week routine working accommodating emergency imaging around the country.
- There are successful joint agreed pathways, an audit 2 years ago of CTPA/VQ scan requesting for rule in rule out of pulmonary embolism revealed a 23% positivity rate. The British Thoracic Society guidance on Pulmonary Embolism suggests an appropriate positivity rate of 25%, very significantly below this suggests over requesting and significantly above this suggests under detection of this important and potential fatal condition.
- Radiology in particular and endoscopy services also are an extremely valuable resource and a referral is for a clinical opinion not a demand for a test to be done. Over utilisation of these opinions will result in longer delays for those patients who actually need them.

Recommendations

- **Jointly develop diagnostic algorithms for key presentations and these should follow national guidance.**
- **Consider restricting cross sectional requesting (CT and MRI) to Consultants, ST4 and above from all specialties and to Advanced Nurse Practitioners who have demonstrated the appropriate competencies.**
- **ED requesting of diagnostics must only be relevant for the immediate management and decision making for the patient and never for referral management alone.**

3.13 Hospital Discharge/Transfer of Care

- Placing Transfer of Care as a topic within the wider system feedback report rather than solely within the initial interim draft feedback to UHL has been deliberate. 60-70% of patients who are admitted as an emergency have either long term conditions or frailty or both. As such they should be known to the system, yet the system appears to behave as though it is 'surprised' when a patient with LTC/frailty is admitted to Hospital. The system then goes on to behave that the potential for Transfer of Care of such patients is equally a 'surprise'. The consequence of the multiple delays in the processes results in protracted length of stay with resultant significant deconditioning, these have been highlighted as key national issues within the Kings Fund (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf) and Health Foundation (http://www.health.org.uk/public/cms/75/76/313/4196/Improving%20patient%20flow.pdf?realName=T67pC0.pdf) Reports.
- The use of the term 'discharge' tends to re-enforce the thinking that this process is separate from case management and it is better to use the term transfer of care. It appears that a significant proportion of medical teams

consider their role completed when they declare the patient 'medically fit for discharge'. This term is of little value and planning transfer of care is an integral part of case management delivery.

- There is an 'integrated team' at UHL which comprises a Discharge Team who link with ward based Discharge co-ordinators. The latter are a member of the nursing team given the specific responsibility to plan and deliver discharge. This has re-enforced the dis-location of planning transfer of care from case management delivery. If the ward based Discharge Co-ordinator is on leave or not on shift, there can be a delay in implementing the transfer of care processes as other members of the team do not see this as their primary role.
- There is a heavy reliance on the formal use of Section 2 and Section 5 notifications which has become excessively bureaucratic with resultant retractions and/or changes in information being provided. There is an almost automatic issuance of Section 2 notifications when it is clear that the individual has been previously independent and has not suffered an acute event which is likely to result in care needs requiring Local Authority support. In addition, not infrequently on contacting the ward teams, community or acute, the Transfer of Care destination has been changed.
- There is a perception that Continuing Health Care (CHC) checklists are mandatory before a Section 2 is issued. Far too many CHC checklists are being completed at a time when the patient remains acutely unwell. The national guidance is clear 'In an acute hospital setting, the Checklist should not be completed until the individual's needs on Transfer of Care are clear' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213138/NHS-CHC-Checklist-FINAL.pdf).
- It appears that if the CHC checklist triggers positive then in some areas the Therapy Teams dis-engage from assessing and rehabilitating the patient. This appears to directly contradict the guidance where it has to be considered whether on-going NHS or NHS rehabilitation/re-ablement/packages of care/short term placement in a Care Home may allow improvement in the individual's status.
- The guidance relating to consent or involving family members are involved for those lacking capacity before commencing a CHC checklist is not infrequently breached.
- The process for carrying out discharge assessment and thus the use of Section 2 and 5 was set out in the Community Care (Delayed Discharges etc.) Act 2003 and there has been clear guidance on when this process should commence and who should be involved. This has been set out in the guidance Health Service Circular/Local Authority Circular HSC 2003/009 LAC (2003) (http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4064939.pdf) which states that 'The multi-disciplinary team, including representatives from social services, should be involved in the discharge planning process as early as possible. It is not necessary to wait for a clinical decision of 'medically fit' before referring for assessment of needs and most appropriate care options for patients after leaving acute care. However judgement will be needed about the most appropriate time to begin the assessment'. This document also states 'Hospital is not the ideal place to be while waiting for arrangements for care to be put into place. Hospitals make

people more dependent; there is also an increased risk of them acquiring an infection. Whilst they are away from home, older people's care networks can break down.' As has been identified throughout this paper, there are many patients suffering inordinate delays within the system because of a lack of effective joint working.

- There are team members who feel that assessments or even discussions regarding assessments cannot take place before a patient is medically fit. This is in clear contradiction to the guidance.
- There is a 'non-weight bearing (NWB) pathway' for patients with fractures which is invoked at a high rate and when triggered by the ward team results in the patient being kept in bed until reviewed by Orthopaedics which can take a number of days to occur. This results in significant deconditioning. The 'non-weight' bearing pathway is even triggered for upper limb fractures when there are clear opportunities to continue mobilisation. The Discharge Team run the co-ordination of the NWB pathway with transfer of care options to home with ICT and/or ICRS or a care package. If the patient has dementia on the NWB pathway, interim care home beds are utilised.
- It appears that a 'bed based' 'Discharge to Assess' in local care homes has been implemented to allow for assessment of patients utilising the 'Decision Support Tool' for those patients who have triggered positive on the CHC.
- If care packages are not immediately available there is a culture of requesting interim placement in a care home until a care package is in place. When an interim placement is offered and if the patient turns the offer down, then a 'choice letter' detailing the charges for the costs of remaining in UHL is provided to the patient and/or family. A more appropriate response from the system would be to ensure a 'bridging' process within the person's own home until a care agency can cover the care needs.
- Clinical teams are making recommendations regarding placement and extensive packages of care despite only making assessments of a patient in a hospital setting. Hospital based assessments very frequently underestimate patient's capabilities at home and assessments performed after transfer home with an interim support structure in place, that is home based 'discharge to assess' provide better information on a person's capabilities.
- Fast Track assessments for CHC funding have been reported as 4 times the national average with between 55 and 60% of these patients dying within 3 months. The fees paid to care Homes relating to CHC placement, Fast Track placement and Discharge to Assess have so distorted the market that a number of Care Homes no longer take Local Authority funded clients since the fees for the former are almost twice the latter.
- Ward 2 at the Leicester General Hospital was opened over a year ago specifically to 'lodge' patients who are waiting external care support. This results in yet another move for patients and has resulted in patients' under-going additional assessments and at times patients being transferred in whom the discharge destination is not clear.
- During this disjointed process, patients with frailty are moved from Ward to Ward causing more de-conditioning and it is this de-conditioning, which is preventable to a significant extent, that results in high rates of dependency and ultimately worse as a direct impact of the hospitalisation.

Recommendations

- **Implement across LLR the principle that all patients admitted to hospital will return to their usual place of residence, that is the 'Home First' principle. In parallel to this principle will be the process of 'Discharge to Assess' occurring within that usual residence if that is deemed necessary.**
- **All patients must have an Expected Date of Discharge and Clinical Criteria for Discharge (the latter including functional status as well as physiological parameters) set at the point of admission and there to be clear documentation within the medical notes that the multi-disciplinary team are assertively case managing to achieve the criteria for discharge and are highlighting any internal and external constraints and resolving them on a day to day basis. It needs to be considered that failure to demonstrate effective case management towards a discharge plan in this way will allocate all delays to health and not to social care.**
- **Simplify the transfer of care process and design three routes, simple, moderate and complex as per the minimum data set plan. Ensure the simple and moderate transfers of care are delivered effectively, these account for the vast majority of transfers of care out of hospital.**
- **Close Ward 2 at the Leicester General Hospital.**
- **Re-create the principle that the named Consultant and named nurse along with the named therapists are responsible for delivery transfer of care. In view of the extensive de-skilling that has occurred, this will require a period of re-training and a phased implementation strategy, before dis-banding the ward based 'discharge co-ordinator' function.**
- **Ensure that CHC checklists are only carried out at the appropriate time and ensure that consent is obtained or advocacy for those who lack capacity.**
- **For clarity on this issue, the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care *November 2012 (Revised)* (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf) states:**
- **Hospital Discharge**
  62. In a hospital setting, before an NHS trust, NHS foundation trust or other provider organisation gives notice of an individual's case to an LA, in accordance with section 2(2) of the Community Care (Delayed Discharges etc.) Act 2003, it must take reasonable steps to ensure that an assessment for NHS continuing healthcare is carried out in all cases where it appears to the body that the patient may have a need for such care. This should be in consultation, as appropriate, with the relevant LA.
  63. CCGs should ensure that local protocols are developed between themselves, other NHS bodies, LAs and other relevant partners. These should set out each organisation's role and how responsibilities are to be exercised in relation to delayed discharge and NHS continuing healthcare, including responsibilities with regard to the decision-making on eligibility. There should be

processes in place to identify those individuals for whom it is appropriate to use the Checklist and, where the Checklist indicates that they may have needs that would make them eligible for NHS continuing healthcare, for full assessment of eligibility to then take place.

64. Assessment of eligibility for NHS continuing healthcare can take place in either hospital or non-hospital settings. It should always be borne in mind that assessment of eligibility that takes place in an acute hospital may not always reflect an individual's capacity to maximise their potential. This could be because, with appropriate support, that individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment. Anyone who carries out an assessment of eligibility for NHS continuing healthcare should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs.

65. In order to address this issue and ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few months. It might also include intermediate care or an interim package of support in an individual's own home or in a care home. In such situations, assessment of eligibility for NHS continuing healthcare should usually be deferred until an accurate assessment of future needs can be made. The interim services (or appropriate alternative interim services if needs change) should continue in place until the determination of eligibility for NHS continuing healthcare has taken place. There must be no gap in the provision of appropriate support to meet the individual's needs.

- **In essence Paragraph 62 above does not make it mandatory to have a CHC checklist before a Section 2 is issued, this mis-interpretation by the system needs to be resolved. Paragraph 64 and 65 however, do make it mandatory to consider the potential for a person to regain function with ongoing interventions after discharge from Hospital, recognising that assessments in the acute setting may not always reflect the individual's capacity to achieve their maximal potential. This latter point is crucial.**
- **The Social Care Act 2014 guidance (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf) is very clear, re-affirming the guidance above and states that *'Local authorities and CCGs in each local area must agree a local disputes resolution process to resolve cases where there is a dispute between them about eligibility for NHS CHC, about the apportionment of funding in joint funded care and support packages, or about the operation of refunds guidance. Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be***

provided pending resolution of the dispute'. **In essence, no delays to transfer of care with resolution of funding arrangements taking place after joint care packages have been put in place.**

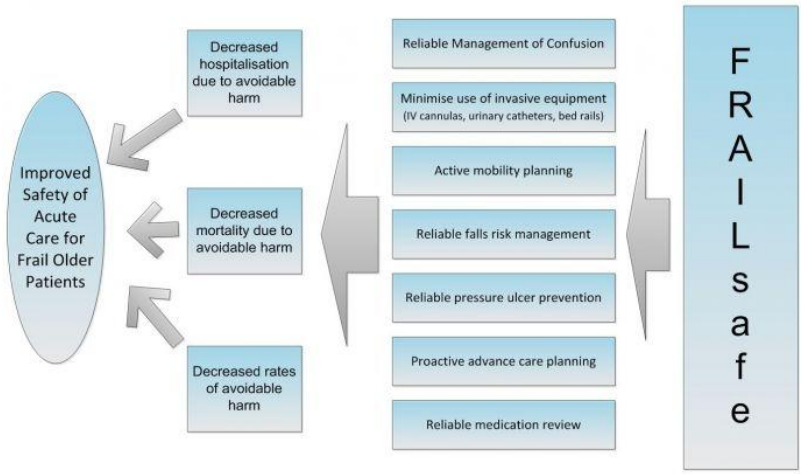
- **Work with social care and the 'frailty tracking' team described below to manage transfer of care of older people with frailty in a balanced risk manner recognising that frequently the opportunity for discharge for these patients is fairly early in the pathway and fairly brief.**
- **For those patients awaiting a 'care package' rather than arranging an interim placement, a more appropriate response from the system would be to ensure a 'bridging' process within the person's own home until a care agency can cover the care needs.**
- **With the embedding of the 'Home First' principle, 'Discharge to Assess' in the person's usual residence, an 'older person with frailty' pathway aimed at minimising decompensation with effective collaborative working across the system, the key outcomes of reducing the 'stranded patient' metric, promoting independence and reduced reliance on long term care placement will be achieved with a parallel reduction in the DTOC metric and the need to issue 'Choice Letters'.**

Older Person with Frailty Journey Through Urgent/Emergency Care

The urgent care pathway for older people with frailty in LLR is fraught with delays. There are delays in accessing assessments for home care, there are delays in primary care responses to urgent needs despite some of the processes put in place. If it is deemed that a patient needs to go to hospital having been referred by their GP, there are delays in the transfer of the patient to Hospital. When the patient arrives at Hospital there are delays through the pathway from front to back of the hospital, despite there being some services aimed at getting such people home quickly. The reason being that the system has not been designed to capture all older people with frailty who access the Hospital from the point of access through to the point of transfer of care. Once admitted a significant proportion of older people with frailty do not undergo comprehensive geriatric assessment, the setting of EDD and CCD is not universal and the 'drum beat' of case management delivery is not robustly delivered to achieve the goals. Even once a patient is moving towards the potential for transfer of care back home there are multiple delays which prolong length of stay. The impact of these delays, compounded by multiple moves, is that patients de-compensate and develop 2nd and 3rd phase illness with the end result that their functional state becomes profoundly impaired resulting in high cost health and social care provision with loss of independence, early transfer in to long term care and in a proportion a deconditioning that results in Fast Track placement.

It has to be the main priority to provide a much more patient centric process for older people with frailty that ensures there are no delays in the system for this group of patients. The development of operational integration of services aligned to the needs of older people with frailty is crucial. The system has to accept the risks of delays with resultant deconditioning and have a pathway in place that ensures that older people with frailty who develop urgent health care need are responded to very promptly and in keeping with the principles of the Silver Book. If older people with

frailty are admitted to Hospital as an emergency, then the system has to remove all delays to prevent deconditioning and deliver transfer of care back to their usual residence without delay 7 days per week. The Health Foundation 'Frail Safe' Collaborative (http://www.frailsafe.org.uk/) is currently testing a checklist akin to the Safer Surgery checklist to provide a check and challenge process for older people with frailty being admitted to Hospital. The aim being to reduce the risks of deconditioning and harm which occur in a disproportionate number of these patients.



The seven interventions highlighted within the 'frailsafe' intervention have an extensive evidence base to reduce harm and improve outcomes in older people with frailty.

Recommendations

- **The system has an opportunity for a significant 'quick win' with personal and system wide benefits by focussing on delivering highly responsive, high quality response to a significant group of patients who, if not managed effectively, have high rates of complications and poor outcomes and consequent high consumption of health and social care resources. This group is the 'older person with frailty'.**
- **Ensure that the system creates a 'register of adults at risk of frailty', provides health promotion and 'independence promoting' interventions, based around socialisation, physical activation and specific interventions for those at risk of falls etc. If these individuals develop urgent care needs, ensure the system responds to prevent deconditioning at every step.**
- **Ensure a Primary care response commensurate with the guidance within the Silver Book for Older People with Frailty and urgent care need.**
- **If older people with frailty do attend the acute sector, they receive rapid assessment by appropriate inter-disciplinary community facing teams that ensure adequate diagnosis, implementation of treatment and a community based case management plan, predominately based within their own home.**

- **If admitted to hospital, the same team track their progress to ensure transfer home occurs at the first available opportunity to prevent in-hospital deconditioning.**
- **This inter-disciplinary team ensures that the 'Frailsafe' principles are delivered to ensure minimisation of deconditioning and patient safety incidents.**
- **In the first instance, this inter-disciplinary team will comprise the integration of ICRS, HART, ICS, Therapy Team/ICT, PCC, GPs and secondary care clinicians who demonstrate the necessary competencies of managing older people with frailty with urgent care needs in a 'balanced risk' approach.**
- **Personal, population and system level benefits to be realised are with increased independent or supported living at home, reduced long term care placement, reduced carer strain and an increase in independent living life expectancy.**

Concluding Comments

The system in LLR is perfectly designed to deliver the results it is achieving. The first step in resolving this is for the system to accept that for a variety of reasons what has been designed is not providing the highest quality of urgent health and social care the population of LLR deserve. There is not a single element of the system that can say that it has 'got it right'.

There are very significant opportunities for quality improvement with reductions in mortality, harm and improvements in patient experience by improving the processes identified by robustly implementing the recommendations.

A focussed and driven improvement programme with clear governance frameworks holding each other to account, supported by managerial and Executive 'grip' to support the clinical 'grip' will bring about rapid and marked improvements in patient safety and experience. Early senior review, clear and time dependent case management delivery whilst holding each other to account to deliver the quality inputs with a focus on delivering the quality outcomes of reduced mortality and harm whilst improving the experience for the patient are easily within reach.

This improvement process needs to be clinically led supported by managerial/Executive/system alignment with as far as possible real time metrics to support continued improvement.

The 4 hour standard for emergency care just happens to be measured in the Emergency Department, it is, however, a measure of the effectiveness of the whole system's management of the urgent and emergency care pathway, and crucially of how long term conditions and frailty are managed in people who spend markedly in excess of 95% of their total life living with LTC/Frailty in the community. If they do become acutely ill enough to need to go to Hospital, it is the systems responsibility to ensure that their stay at the hospital is only as long as required to get them over the critical phase of the acute illness. Once well enough to leave Hospital, the system needs to design a process that delivers the transfer back to the community on the

day they are ready. That is the system delivers for the needs of the patient and not for the needs of the individual component parts of the system.

Yours sincerely

Dr Ian Sturgess FRCP (Lon)

Winter Urgent Care Action Plan 2014/15

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
DEMAND (inflow)									
Leicester City CCG	**Extra capacity & improved access to General Practice**	Discuss the Area Teams Christmas and New Year Extended opening hours scheme with all practices. The aim is to have at least four hubs across the city offering consultations over the Bank Holiday period.	All schemes will contribute to: Reduction in Leicester City CCG ED attendance of 5%, 72 per week leading to a run rate of 1375 per week	Sarah Prema	24th December 2014	Primary Care Delivery Group	General Practice Area Team	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7
		Contact all practices to ensure all patients are offered on line booking.		Sarah Prema	31st December 2014	Primary Care Delivery Group	General Practice		
		Develop and implement an awarness rising campaign aimed at practices and the public to promote the availability of on line booking and repeat prescriptions.		Sarah Prema	31st December 2014	Primary Care Delivery Group	General Practice		
		Undertake quality visits to 18 practices with highest emergency admission rates and develop a plan for improvement, 16 practices by the end of December 2014 and 2 in January 2015.		Sarah Prema	31st January 2015	Quality Review Delivery Group	General Practice		
	Community alternatives to admission	Provide additional resources to expand the capacity of the following community services: 1. Practical Support at Home 2. Assistive Techonology 3. Night Nursing (double the night time capacity) 4. Primary Care Co-Ordinators (2 additional at the Front Door of ED) 5. Additional therapy capacity	Reduction in Leicester City CCG ED admissions of 5%, 32 per week leading to a run rate of 602 per week	Sarah Prema	31st December 2014	BCF Implementation Group	UHL LPT Leicester City Council	ED occupancy over 55 UHL AE Attends UHL EM via AE EMAS non-conveyance rate UHL EM Falls 65+	1,3,4,5,6,7
		Provide a 5 day a week ICRS presence in ED to pull patients into community services.		Sarah Prema	Daily to the end of March 2015	BCF Implementation Group	Leicester City Council		
		Have the Frailty Front Door Team in place a minimum two days a week pulling frail older people into community services. Cover additional days as medical capacity allows.		Sarah Prema	Weekly to the end of March 2015	BCF Implementation Group	UHL		
		Send all practices an information summary setting out the community alternatives to admissions.		Sarah Prema	31st December 2014	BCF Implementation Group	General Practices		
		Review the Directory of Services and update as necessary.		Sarah Prema	24th December 2014	BCF Implementation Group	ELR CCG DHU		
	Care/nursing homes	Implement a revised City Care Nursing Service including the provision of a one session a week UHL Outreach Geriatric service focused on those patients most at risk of admission from Care Homes.		Sarah Prema	31st December 2014	BCF Implementation Group	UHL Care Homes	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7,9,14
		Reissue information to care homes on community alternatives to admissions.		Sarah Prema	24th December 2014	BCF Implementation Group	Care Homes		

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
Leicester City CCG	**Weekly clinical review and feedback**	Weekly clincial peer review of emergency attendances and admissions using real time data for Leicester City and feedback to practices on missed alternatives to admissions.		Sarah Prema	Weekly from January 2015	Primary Care Delivery Group	General Practice	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7
		Weekly review of care home emergency attendnaces and admissions data and feedback to homes on missed alternatives to admissions.		Sarah Prema	Weekly from 15th December 2014	BCF Implementation Group	Care Homes		1,3,4,5,6,7,9,14
East Leicestershire & Rutland CCG	**Extra capacity & improved access to General Practice**	**All day weekend Access for complex patients by:** •Weekend & bank holiday routine surgeries - to support the area team LES during the period 20th December 2014 to 28th February 2015 at set periods on Saturdays and Sundays and Bank Holidays • Weekend and bank holiday extension to 7 day working pilot to run alongside the area team LES for focus on complex and high risk patients during the period 20th December 2014 to 28th February 2015 (practices being offere opp to either or both) •Urgent Home Visiting - 20 practices to provided additional home visiting service every am 8.30-12.30 for most risk of admission	All schemes will contribute to: Reduction in EL&R ED attendance of 5%, 35 per week leading to a run rate of 673 per week	Tim Sacks	20th December Week commencing 5th January 2015	Quality+Performance Committee CCG	CCG/Primary Care/Area Team	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	1,3,4,5,6,7,9,13
	Community alternatives to admission	**Extended Opening Hours for Oadby WIC** To extend the opening hours and access to the Oadby site from 8-Midnight (12am)		Tim Sacks	8 weeks from 5th January 2015	Quality+Performance Committee CCG	NHSE/CCG/WIC	UHL EM Avoidable UHL EM by bed bureau UHL AE attends 65+	1,3,4,5,6,7,9,13
		LTC AF Pathway Use All practices now trained to new standards NOACs now green on LMSG. Expect significant increase in prescribing/AF prevalence and reduced stroke related admissions	Reduction in EL&R CCG ED admissions of 5%, 19 per week leading to a run rate of 362 per week	Tim Sacks	Monthly	MMSG	GP/Primary Care	UHL EM by GP UHL EM by bed bureau	1,3,4,5,6,7,9,13
	Care/Nursing homes	**Care Home/EOL** GP Practice management of patients with Care Plans (100%) working to educate homes and ensure compliance of completed care plans and link with EMAS/OOH/NHS 111 if there are any identified system failures		Tim Sacks	Weekly audits at ED on care home admissions. EMAS care home conveyance rates	Quality+Performance Committee CCG	GP Primary Care/OOH/NHS 111	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
East Leicestershire & Rutland CCG		**3xWTE Care Home/Integrate Care Pharmacist** To undertake reviews/admission avoidance with 2% vulnerable patients. 8 care homes have been visited YTD and plans are for another 5 are to be visited upto the end of February 2014.		Tim Sacks	Ongoing from November 2015	MMSG	GP/Primary Care/LCC	UHL EM Avoidable UHL EM by bed bureau UHL AE attends 65+	
	Weekly clinical review and feedback	**Prospective Peer Review** Every practice peer reviews every patient to ensure all community options are used. This will be undertaken prior to every admission		Tim Sacks	Ongoing from November 2014	Q+P Committee CCG	GP/Primary Care	UHL EM Avoidable UHL EM by GP UHL EM by bed bureau UHL AE attends 65+ UHL EM via GP/BB with 0 day LOS	
	Director of Services (DoS)	**LLR DOS** Updated with current live information to aide practices with urgent care/alternative to admission. This will be updating of new services, review of disposition orders and implementation of the CMS.		Robin Wintle/Tim Sacks	Guide to be sent out w/c 12th January 2015	Quality+Performance Committee CCG	ELRCCG	UHL EM Avoidable UHL AE attends 65+	1,3,4,5,6,7,9,13
	Reduce readmissions to UHL from community hospital	Community Hospital Out ot Hours service (CNCS) to face to face review deteriorating patients prior to transfer (excluding 999 patients)							
West Leicestershire CCG	**Extra capacity & improved access to General Practice**	Extra in-week capacity - additional 100 general practice consultations every weekday	All schemes will contribute to: Reduction in WL ED attendance of 5%, 34 per week leading to a run rate of 644 per week	Angela Bright	12 Dec 14 Funding Decision Area Team 12th January 2015 Provisional Start date	WLCCG Out of Hospital Implementation Board	Area Team	1, 3, 4, 9, 14, 15 and 16	9,11,14, 16 and 17
		Weekend & bank holiday routine surgeries - implement LES during the period 20.12.14 to 28.02.15 for agreed times of Saturdays, Sundays and Bank Holidays		Angela Bright	20-Dec-14	WLCCG Out of Hospital Implementation Board	Area Team	1, 3, 4, 5, 6, 7, 9, 14, 15 and 16	9, 11 and 14
		7 day locality pilots - embed GP led 7 day services. Targets care homes and at risk patients. Seeing 80 per week rising to 860 patients in total by March 2015		Angela Bright	20 Dec 14	WLCCG Out of Hospital Implementation Board		1, 3, 4, 5, 6, 7, 9, 14, 15, 16 and 18	10, 11, 12, 14, 15 and 18
	Maximise Utilisation of Community alternatives to admission	Loughborough Community Hospital - Ensuring we get maximum use out of EMAS support in utilisation of Loughborough Urgent Care Centre and Older Persons' Unit through conveyance diverts to this site		Angela Bright	15 Dec 14	WLCCG Out of Hospital Implementation Board	EMAS CNCS LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	11, 12, 13,
		Older Persons' Unit (OPU) - Implement the new dedicated transport solution to support OPU patients back to their own homes		Caron Williams	w/c 22 Dec 14	BCF Frail Older Persons' Group	LPT St John Ambulance	1, 3, 4, 9 and 16	11, 18, 43, 75 and 76
		Acute Visiting Service - Embed use of new AVS to increase utilisation from 100 rising to 400 by March 2015		Angela Bright	w/c 22 Dec 14	WLCCG Out of Hospital Implementation Board	SSAFFA	1, 3, 4, 5, 6, 7, 9, 14, 15 and 16	11, 12 and 18
		Single Point of Access (SPA) - Task and Finish group developing the SPA, resulting in a reduction in call answering time, dropped calls and target GP calls responded to within 30 seconds		Caron Williams	w/c 26 Jan 15	BCF Step Up Step Down Board	LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	38, 43
		Integrated Community Health and Social Care Crisis Response Service (ICRS) - Night Nursing Assessment Service extension to established provision ensures 24/7 365 day a year crisis service within a 2 hour response time preventing an average of 15 admissions per month		Caron Williams	W/C 8 Jan 15	BCF Step Up Step Down Board	LCC LPT	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	42,43 and 44

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
West Leicestershire CCG		Effective alternatives to ED - LTC Integrated Management Care: • Maximise the capacity in the Rapid Access Heart Failure Clinic at UHL by continually promoting this service to GP's. Increase from an average of 14 - 17 a month from January to March. • Mobilise an Atrial Fibrillation Rapid Access Clinic at UHL from January – March. Reducing admission from by 3 a month from February to March, and reduce LOS from by 1.5 days. • Integrating HF Community and Secondary Care MDT – This will support the management of complex HF patients at home. This will reduce readmissions by 2 a month. • Integrating case management for Complex COPD patients (pilot) – Community Respiratory Nurse meets weekly with Respiratory Consultant. This will reduce follow-up activity for Complex COPD by 2 a month.	Reduction in EL&R CCG ED admissions of 5%, 21 per week leading to a run rate of 404 per week	Angela Bright	w/c 22 Jan 15	WLCCG CVD Delivery Group WLCCG Respiratory Delivery Group	UHL LPT	1, 3, 4, 9 and 16	15, 18
	Care/Nursing Homes	Reducing inappropriate Admissions from Care Homes - extend Acute Visiting Service to take direct referrals from care homes in hours and at weekends (see activity trajectory for 7 day pilot section 1)		Angela Bright	w/c 15 Jan 15	WLCCG Out of Hospital Implementation Board	All Care Homes SSAFFA	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	11, 12, 13
	Weekly clinical review and feedback	• Weekly review of emergency attendance and admissions by GP Board Members using real time data for West patients • Identify and disseminate to practices one top tip each week based on themes from the previous week's ED data • Each practice to receive and review data with suggested alternatives to admission • Board clinical lead GP's to undertake weekly peer to peer feedback and challenge with identified practices		Angela Bright	Ongoing	WLCCG Weekly Clinical Leads Meeting	GEM CI	1, 3, 4, , 6, 7, 8, 9, 12, 14, 15, 16 and 18	13, 17
DHU - NHS 111	**Reduced Attendances and Admissions**	124.5 hours (5 heads) of call advisors to be added to the rota week commencing 8.12.14as due out of training. 550 hours (19 heads)of call advisors to be added to the rota week coming 22.12.14.	Additional hours added into the rota enabling 95% calls answered in 60 seconds	Pauline Hand	1 week 3 weeks	Collaborative Commissioning NHS 111 Group	None	95% calls answered in 60 seconds National Minimum Dataset	
EMAS	**LLR non-conveyance rate**	1. LLR Non-conveyance: Deliver Paramedic Pathfinder (EMAS wide) and Falls Assessment (LLR only) training to support access to appropriate pathways, clinical safety netting and treatment within the community.	LLR Falls Training: 25% by w/e 11/1/15 50% by w/e 18/1/15 75% by w/e 25/1/15 95% by w/e 1/2/15 EMAS Pathfinder Training: 30% by end Jan 15 60% by end Feb 15 90% by end Mar 15	Tim Slater (LLR) Adrian Healey (Falls) Andrew Mills (Pathfinder)	LLR Falls Training - scheduled to finish end January 2015 (subject to IA and REAP 4 impact) Pathfinder Training - continual programme working towards 90% of eligible EMAS staff by March 2015.	Currently providing updates on training to multiple forums including EMAS Locality Meeting, Inflow, Integration Executive, UCB and TDA weekly conference calls. This requires rationalisation to avoid duplication of reporting and performance management.	To be fully effective, this needs a consistent approach across all CCGs. We need a commitment to work to a true single point of access and seamless transition between in and out of hours provision.	EMAS LLR non-conveyance and LRI pre-handover within 15 minutes	

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
EMAS	**LLR non-conveyance rate**	2. Supporting pre-hospital clinical assessment: Both Pathfinder and Falls initiatives are supported by access to a DoS or SPA type approach but there is potential to extend and integrate a practitioner helpline within EMAS's Clinical Assessment Team to reduce the steps and consolidate access routes to provide a more direct and appropriate pathway to alternative services.	Incremental increase in EMAS LLR overall non-conveyance to 50% (trajectory to be set following pilot evaluation)	Tim Slater (LLR) Joe Garcia (EMAS EOC for CAT)	The integration and enhancement of dedicated EMAS LLR CAT is at this stage an aspirational objective with no agreed timeline, but is viable during Q4 2014/15 to Q1 2015/16. This could utilise the capacity provided to support the practitioner helpline but incorporated in to the EMAS CAT provision.	Inflow	CCGs/providers to map out current available capacity to identify practitioner provision to support.	EMAS LLR non-conveyance	
	LLR conveyance rate to UCCs	3. Increase usage of Urgent Care Centres - both earlier in the access to urgent care (e.g. referrals from 111 or HCP contact) and as an outcome of EMAS Hear & Treat and See & Treat	Incremental increase in EMAS LLR overall and LE11 area non-conveyance to 50% and referrals to UCC (trajectory to be set following activity review): 48% by end Jan 15 49% by end Feb 15 50% by end Mar 15 (all data is available on a daily/weekly basis to support KPI monitoring)	Tim Slater (LLR) Ian Mursell (EMAS Consultant Paramedic for care pathway review)	End of March 2015 but supporting reduced ED conveyance through winter.	Inflow	CCGs/UCC provider to review with EMAS the current utilisation and expected levels (including referrals that lead to self-presentation). 111 provider to review DoS to ensure UCC services are correctly signposted where appropriate.	EMAS LLR non-conveyance (specifically destinations other than ED)	
George Eliot Hospital (LRI urgent Care Centre	**Reduced Attendances and Admissions**	1. rearrange clinical audit to inform pathway design. 2. Mov UCC to new premises by 24th December	1. To be determined 2. improve patient journey	Kim Wilding/Julie Dixon/ Josh Sandbach		1. UCC/ED Governance meeting 2.CCG UCC contracting Team	UHL		
LPT	**SPA:** **Improve the response rate within Single Point of Access**	1. Increase wte staff numbers within SPA to reduce healthcare professional answering times	45% of calls answered in 30 seconds (22nd Dec) and 60% by March 2015	Rachel Dewar	22nd December 2014 (40%) 30th March 2015 (60%)	Clinical Network Group		38	18, 11

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
Leicestershire County Council	**UHL Inflow reduction/prevention: From 1 November – operational SW team based at LRI to assess and navigate patients in ED (A&E and Assessment wards) to prevent admission on Saturday and Sunday**	Weekend admissions prevented/ reduced through increased SW capacity in LRI ED	Changes in ED admission rates at weekends	Jackie Wright	1 Nov 2014 onwards	LCC Operational Delivery Group reporting to DMT	UHL ED Ind sector Providers	16, 44	68
	UHL Inflow reduction/prevention: stronger capacity in ED	Doubling of resources to assess and navigate patients in ED (A&E and Assessment wards) to prevent admission. Also, improved use of Hospital To Home service, as an alternative.	Changes in ED admission rates	Jackie Wright	1 Nov 2014 onwards	LCC Operational Delivery Group reporting to DMT	UHL ED Crisis Response	16, 44	68
	Joint work to ensure the right balance of health and social are input into cases.	LCC Crisis Response Service (step up) linked with hospital social work team and PCCs to support admission avoidance. Social Care Team also navigate patients to other appropriate services to avoid admission e.g. family/voluntary etc.	Crisis Response Service support 10 avoidable admissions per week. CRS to record number of interventions that have resulted in advoidance in addmission	Tracy Ward/Carolyn Dakin	01-Dec-14	SUSD Board	LPT UHL EMAS	3, 9, 16	42, 45
FLOW (internal)									
UHL	**Improve front door (UCC/ED) interface/alignment**	1) Continue weekly clinical meetings with UCC team	90% of patients triaged within 20 minutes	Julie Dixon	14-Dec-14	ED subgroup of EQSG	UCC/ GE	Reduce ED occupancy and time in ED	30-36
		2) UCC to triage all patients within 20 mins		UCC	14-Dec-14				30-36
		3) Ensure UCC is supported to manage the '30 min' rule		Julie Dixon	14-Dec-14				30-36
		4) Support the UCC where possible to ensure 'construction handover' date for the UCC takes place on the 19/12 and the move date is 23/12		Jane Edyvean	31-Dec-14				30-36
		5) Ensure ED is not used as an admission route by other specialities from UCC		Julie Dixon	14-Dec-14				30-36
	Improve ambulance turnaround	1) Work with EMAS and CCGs to introduce RFID as the sole data set	50% reduction in waits over 30 mins and 50% reduction in waits over one hour	Rachel Williams	31-Dec-14	ED subgroup of EQSG	EMAS and CCG commissioning team	N/A	25-29
		2) Use the new data set to agree the real scale of the problem		Rachel Williams	31-Jan-15			Reduce time in ED	25-29
		3) Continue to employ additional nurses to work in the assessment bay to minimise handover times		Rachel Williams	14-Dec-14			Reduce time in ED	25-29
	Implement the Ambulatory Emergency Care strategy	1) Cohort six member of AEC network	5% reduction in admissions (circa 4 patients per day)	Lee Walker	31-Dec-14	AMU subgroup of EQSG	CCGs	Reduce ED occupancy and admissions	80
		2) Select priority pathways for implementation		Lee Walker	31-Jan-15				80
		3) Implement priority pathways		Lee Walker	31-Mar-15				80
	Improve the resilience of ED processes	1) Implement improvements to Gold Command	70% of time ED occupancy less than	Julie Dixon	07-Dec-14	ED subgroup of EQSG	None		101-114
		2) Set up a weekly journey meeting which reviews delays in processes within the ED dept		Julie Dixon	31-Dec-14				101-114
		3) Address systematic delays identified in journey meetings (e.g. portering, transport)		Julie Dixon	15-Jan-15				101-114
		4) Ensure consistent application of floor management SOPs		Ben Teasdale	31-Dec-14				101-114
		5) Expand the use of EDU pathways		Ben Teasdale	31-Mar-15				101-114
		6) Ensure ED is not used as an admission route by other specialities		Julie Dixon	14-Dec-14				101-114
		7) Ensure ED is supported to manage the '30 min' rule		Julie Dixon	14-Dec-14				101-114
		8) Implement the 0800 'safety team'		Catherine Free	Complete				101-114
		9) Refresh ED medical staffing recruitment plan		Ben Teasdale	31-Jan-15				101-114
		10) Implement ED SOPs relating to managing activity spikes and when there is exit block		Ben Teasdale	31-Jan-15				101-114

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
		11) Develop and enforce whole hospital response relating to ED exit block (i.e. poor flow)		Andrew Furlong	31-Dec-14				101-114
UHL	**Review ED staffing**	1) Review existing ED staffing to ensure optimum balance of capacity and demand	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	31-Dec-14	ED subgroup of EQSG			101-114
	Increase the proportion of GP bed referrals going directly to AMU	1) Validate and agree with CCG commissioning team that the data set is accurate	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Rachel Williams	31-Dec-14	AMU subgroup of EQSG	CCG commissioning team	N/A	115-127
		2) Ensure senior decision maker presence within acute medical clinic between 0900 and 1700 seven days a week		Lee Walker	31-Jan-15			Improve AMU discharges	115-127
		3) Increasing bed capacity by three within the acute medical clinic (capital scheme)		Jane Edyvean	28-Feb-15				115-127
		4) Keep bed bureau clinic empty overnight enabling improved flow in the morning		Lee Walker	14-Dec-14				115-127
	Reduce the time to assessment by a consultant on the AMU	1) Validate and agree with CCG commissioning team that the data set is accurate	Greater than 40% in Q3 and greater than 70% in Q4 of patients are seen by a consultant within six hours	Rachel Williams	31-Dec-14	AMU subgroup of EQSG	CCG commissioning team	N/A	115-127
		2) Ensure consultant presence on AMU is continuous with roving ward rounds between 0800 and 2100 Monday to Friday and 0800 and 2000 at the weekend		Lee Walker	31-Dec-14			Improve AMU discharges	115-127
		3) Start ward rounds at 0800		Lee Walker	07-Dec-14				115-127
	Improve middle grade staffing resilience on AMU	1) Review remuneration rates for tempory medical staff on AMU	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Lee Walker	31-Dec-14				115-127
		2) Develop more resilient middle grade staffing model for AMU		Lee Walker	31-Mar-15				115-127
	Reduce bed occupancy on the base wards	1) All patients leaving the assessment unit must have a main diagnosis, plan and EDD	Supports 5% (total) reduction in medical bed occupancy by	Lee Walker	31-Dec-14	Base ward subgroup of EQSG	None	Reduce bed occupancy	128- 137, 169-172 and 176-184
		2) Start base ward rounds now at 0830 and then move to 0800 start by 31/3 five days a week		Ian Lawrence	31-Mar-14				128- 137, 169-172 and 176-184
		3) Increase consultant presence on short stay and key speciality base wards (34, 37 and 38) at the weekend		Ian Lawrence	14-Dec-14				128- 137, 169-172 and 176-184
		4) Establish the manpower, rota requirements and finances and necessary support staff for further extension of weekend consultant cover (links to seven day plan)		Ian Lawrence	31-Mar-15				128- 137, 169-172 and 176-184
		5) Implement peer review of ward rounds and long stay patients		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
		6) Ensure that patients 'sit out' or move to the discharge lounge asap and book ambulances when TTOs are complete		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
		7) Use metrics to identify high/ low achieving wards and support low achieving wards to improve		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
		8) Ensure accuracy of real time bed state		Gill Staton	31-Jan-15				128- 137, 169-172 and 176-184
		9) Develop plan to implement electronic bed management system		Rachel Overfield	31-Mar-15				128- 137, 169-172 and 176-184
	Improve the discharge process in medicine and cardio-respiratory	1) Standardise the assertive MDT board round process seven days per week	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	End of March 2015	Base ward subgroup of EQSG	None		128- 137, 169-172 and 176-184
		2) Implement one stop ward rounds		Ian Lawrence	31-Jan-15				128- 137, 169-172 and 176-184
		3) Implement the long length of stay review process		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
		4) Wards to generate a list of next morning discharges with TTOs written the prevous day		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
		5) Eliminate rebeds / failed discharges for non clinical reasons		Maria McAuley	28-Feb-15				128- 137, 169-172 and 176-184
		6) All patients to have an EDD and CCD set at first review on base wards including criteria for nurse delegated discharge		Ian Lawrence	31-Dec-14				128- 137, 169-172 and 176-184
		7) Prioritise therapy and specialist input to expediate simple discharge		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184
		8) Reskill ward staff to facilitate simple discharges		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184
		9) Liberate nursing time to drive discharges		Maria McAuley	15-Jan-15				128- 137, 169-172 and 176-184
	Reduce discharge delays caused by TTOs	1) Increase the volume of TTOs completed the day before discharge	Supports 5% (total) reduction in medical	Maria McAuley	31-Dec-14	Base ward subgroup of EQSG	None		128- 137, 169-172 and 176-184

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
UHL		2) Prioritise pharmacy support to admission areas and base wards		Maria McAuley	31-Dec-14				128- 137, 169-172 and 176-184
DISCHARGE (outflow)									
LPT	**Improve the flow of patients to and through Comnmunity Hospitals**	Community Hospital Matron to work out of UHL to identify suitable patients for discharge	Increase number of patients refered to community hospitals by 4 per day	Nikki Beacher	W/C 26th January 2015	CHS Strategic Development Group	UHL City/County Social Services	38,39,41,42	46,47,
		City CCG - PCCs will attend board rounds on 5 wards to increase rate of discharge	Reduction in excess bed days	Nikki Beacher	w/c 13 Oct one ward/month roll out	Clinical Network Group	City CCG, UHL	38,39,41,72	72,
		The use of pre-set LoS in community hospitals will cease	Reduction in LoS by 4 days	Nikki Beacher	26th January 2015	Clinical Network Group		N/A	46,47.48,49
		The daily community hospital MDT board round process will be reviewed and SOP deployed to standardise processes and facilitate timely discharge	Reduction in LoS by 4 days	Nikki Beacher	19th January 2015	Clinical Network Group		N/A	46,47,48,49
		All community hospital in-patients patients will have an EDD and CCD	Reduction in LoS by 4 days	Nikki Beacher	19th Janaury 2015	Clinical Network Group		N/A	46,47,48,49
	Community Services: improve of patients to and through community services	Community Hospital Matron to work out of UHL to identify suitable patients for discharge	Increase number of patients referred to community services by 4 per day	Nikki Beacher	W/C 26th January 2015	CHS Strategic Development Group	UHL/City and County Social Services	38,39,41,42	41,42,43
		Community staff will follow up patients discharged from ED by PCC to prevent readmission.	100% follow up within 72 hours	Rachel Dewar	W/C 22/12/14	Clinical Network Group		48,49,50	73,41,42,43
	Community Health Services: Community Nursing	Deliver 7 day service 8am to 8pm offering contact and support for children/young people in the community (e.g. IVs, wound assessment and management etc.)	Reduction in UHL admissions of 2 per week	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
		Expedite discharge through discharge coordinators working in CAU and the children's Hospital to community nursing service	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
	Community Health Services: Community Nursing; Respiratory Physiotherapy	Work with a variety of long-term conditions such as neuro-muscular weakness to reduce hospital admissions associated with winter illness	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2015	Children's Clinical Sub Group	UHL, Primary Care		
	Community Health Services: CAHMS Urgent Admissions	FYPC CAMHS operate a 24 hour on-call service to support the assessment of patients at UHL. After 10pm child/young person is admitted to a UHL paediatric bed with assessment by CAMHS the following morning to discharge, admit to CAMHS bed or remain insitu	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
		CAMHS inpatient beds (LPT Tier 4 inpatient unit or an out of area bed) co-ordinated by LPT.	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
		Where the CAMHS on-call service cannot identify a CAMHS bed then the child/young person will need to be admitted/remain in UHL bed.	Reduce LOS for 2 patients a week by 1 day	Helen Perfect	December 2014 to March 2016	Children's Clinical Sub Group	UHL, Primary Care		
	Mental Health: Reduce attendence at UCC/ED for mental health related crisis intervention	Continue with mental health Triage service in UCC/ED to redirect and improve patient flow through UCC/ED.	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58
		Crisis House beds, Crisis Support Telephone line and drop in centre to be fully operational 9 Feb 2015	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
LPT		Crisis team re- modelling Project Implementation Plan agreed and management of change commenced.	Reduction of referrals to MH Triage nurse in UCC/ED - 5 per week from 9 Feb 2015 10 per week from 1 March 2015	David Gilbert	09/02/2015	Acute/Low Secure Ops Group (LPT) and AMH/LD Divisional Assurance Group (LPT)	UHL, Primary Care, CCGs		55-58
LLR CCGs	**Discharge Pathway work**	Weekly monitoring and evaluate the Brookside Court (city pathway 3) pilot making any necessary changes.	Brookside Court 6 pilot beds to remain full.	Jane Taylor	6 month pilot with weekly review 1-2 wks	Discharge Steering Group	CityLA City CCG Strategy, planning and finance leads. CHC lead. LPT communitylead, UHL discharge leads	DTOC rates	No 60,62,63,65,66,
		Set up task and finish group for the implementation of the Catherine Daley (county pathway 3) pilot.		Jane Taylor	1-2 weekly meetings for pilot to start early January	Discharge Steering Group	County LA, EL&R CCG and WL CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	DTOC rates	
		Commence evaluation of the D2A home first pilot (pathway 2) for the county.		Jane Taylor	20 patient pilot - evaluation and the roll out	Discharge Steering Group	County LA, EL&R CCG and WL CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	Patients discharge to admission address	
		Establish task group to prepare the rutland pathway 3 pilot .		Jane Taylor	Pilot for January start	Discharge Steering Group	Rutland LA and EL&R CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge leads	DTOC rates	
	Minimum Data Set	Commense MDS implementation		Jane Taylor	1-2wks	Discharge Steering Group	City, County and Rutland LA. All 3 CCG Strategy, planning and finance leads. CHC lead. LPT community hospital lead, UHL discharge leads, IT leads at each organisation		
		Set up the MDS Cross Organisation Work Group	Electronic sharing and transfer of patient needs assessments	Jane Taylor	1-2wks	Discharge Steering Group			
	Fast Track	Monitor and review the weekly CHC data.	(Aim is to bring in line, over the next 2years to our national bench mark level)	Jane Taylor	2 wks	CHC tasks group	City, County and Rutland LA. All 3 CCG Strategy, planning and finance leads. CHC lead. LPT community lead, UHL discharge and management lead	Weekly activity data for CHC mainstream and fast track	
		Review the results of the CHC finance and quality data cleanse.	Reduce the number of packages of care	Jane Taylor	2 wks	CHC tasks group			
		Agree and implement the process for community nurses to notify the CHC team when CHC funded patients have died or have moved off their case load.	Reduction in CHC packages	Jane Taylor	2 wks	CHC tasks group			

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
LLR CCGs	**Fast Track**	Develop a joint CHC and fast track action plan, incorporating the requested changes.	Reduce the number FT per week (UHL and LPT) Reduce the number of packages of care Reduce the number of hours of care Reduce the number of placements	Jane Taylor	2 wks	CHC tasks group			
		Develop a clear link to the EOL Working Group.	Reduce the number FT per week (UHL and LPT)	Jane Taylor	2ks	CHC tasks group			
		Agree and circulate a uniformed CHC consent form for all provider organisations to use.		Jane Taylor	2 wks	CHC tasks group			
Leicestershire County Council	**Targeted Early Reviews within 2 weeks of hospital discharge to independent sector provision**	All packages of care placed with independent sector providers to be reviewed within a two week timeframe. Review Officers to alert Brokers on a daily basis to capacity created, including number of hours, provider and geographical zone/area.	Reviews completed Cases maintained at same level Cases increased Cases reduced Cases ended Reduced/ended Details of hours released and the provider details to be shared with Care Brokers on a daily basis Cumulative figures to be produced monthly.	Tracey Burton	01-Dec-14	LCC Operational Delivery Group reporting to DMT	n/a	44, 45, 50	70

Organisation	Improvement Requirement	Actions	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Partner support requirements	Contribution to Resilience Plan metrics (no.s 1-50)	Alignment to Ian Sturgess review recommendations
Leicestershire County Council	**STOP specifying timed calls. START specifying time bands.** **Set periods for time critical call and communicate with commissioners.**	Setting time-banded POCs and allowing more felxibility for when the carers go to visit will lead to shorter time spent on the Await Care list, and service users get care quicker. The knock-on effect in HART will be released HART capacity to reable new people. Only time critical calls to be commissioned at specific times, care commissioners and HART to be reminded that calls will be in time brackets am = Morning 7am – 10am, Lunch, 11.30am – 2.00pm Tea, 4.00pm – 6.00pm and Night 7.00pm – 10.00pm. Service users to be advised of these timings and the point of the assessment for the need of care being made. This is an existing process which should be being followed. Embed cultural change and adhere to business process - messaging to service users and managing expectations. Team senior workshops to be held. Commissioning document updated	Number of time-banded vs time-specific commissioned requests. Requests for time critical calls reduced and reduction in await care list through analysis of the HC request forms and the await care list	Tracy Ward	01-Dec-14				
	UHL Outflow: increased ASC staff resources in UHL for s5 responses	Additional staff to respond to any Section 5 notification and immediate requests for discharge of patients (based on escalation levels)	s5 timescale compliance trend Compliance with requirements set by the UHL escalation level	Jackie Wright	01-Nov-14	LCC Operational Delivery Group reporting to DMT	UHL LPT	44, 45, 50	59, 62
Leicester City Council	**UHL Inflow reduction/prevention: stronger capacity in ED**	Doubling of resources to assess and navigate patients in ED (A&E and Assessment wards) to prevent admission	Changes in ED admission rates	Jackie Wright	ongoing				
	Reduced LOS , minimising lost bed days, reduced DTOC levels	Daily Liaison between ASC and UHL base wards to reduce LOS, minimise lost bed days and improve DTOC levels to include the ICRS offer.		Ruth Lake	1 Week			Sitreps	

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper G

TRUST BOARD – 22 DECEMBER 2014
Five Year Plan Refresh

DIRECTOR:	Kate Shields, Director of Strategy
AUTHOR:	Helen Seth, Head of Local Partnerships (BCT Lead)
DATE:	22 December, 2014
PURPOSE:	To brief the Trust Board on the refresh of the executive summary of the Trust's five year plan which reflects the changes in planning assumptions that have occurred since the approval of the five year "directional" plan in June, 2014. It also addresses the areas of refocusing that came out of the Trust Board thinking day in October. They fall into two categories: • Internal drivers: e.g. Consolidation of ITU by December 2015; • External drivers: e.g. Service standards, NTDA feedback, Dalton Review; Overall the executive summary is largely unchanged and as such does not impact on our Strategic Direction or alignment with the Better Care Together programme. The finance and workforce sections are still under review as part of the planning round. These will be reported in early 2015. The Trust Board is asked to **RECEIVE** this report, **NOTE** and **ENDORSE** the changes made.
PREVIOUSLY CONSIDERED BY:	Executive Strategy Board, 9th December, 2014
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [X] 2. An effective, joined up emergency care system [X] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [X] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [X] 5. Enhanced reputation in research, innovation and clinical education [X] 6. Delivering services through a caring, professional, passionate and valued workforce [X] 7. A clinically and financially sustainable NHS Foundation Trust [X] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Patient and public involvement is the guiding principle of project and business case development e.g. in the detailed design of capital developments. This will be the case for forthcoming business cases including the out of hospital community project. This is in addition to Better Care Together Arrangements and UHL stakeholder engagement.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Once the refreshed plan has been agreed an Equality Impact Assessment will be undertaken on the whole plan. In addition to this, an EIA is integral to each individual business case.
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** **Board Assurance Framework** [X] **Not Featured** [ ]
ACTION REQUIRED *	For decision [ ] For assurance [X] For information [ ]

♦ **We treat people how we would like to be treated** ♦ **We do what we say we are going to do**
♦ **We focus on what matters most** ♦ **We are one team and we are best when we work together**
♦ **We are passionate and creative in our work*** tick applicable box

Refresh of the Trust's Five Year Plan (Executive Summary)

INTRODUCTION

1. The purpose of this paper is to update the Trust Board on the refresh of the Trust's five year plan following recent national policy changes, internal operational changes and a refocussing of our intentions following the Trust Board Thinking Day in October.

2. A revised vision has been drafted following the Trust Board Thinking Day (Page 4 of the Executive Summary). This aims to break our intentions down into clarity of thought and action to aid communication.

3. With the exception of the changes referenced in items 11–20 within this paper, the revised executive summary in overall terms is largely unchanged from the June 2014 submission. The revised summary is attached at Appendix 1.

4. It is important to note that the finance and workforce sections are still subject to ongoing refresh as part of the planning round. The Board will be briefed on the outcome of this in early 2015.

BACKGROUND

5. The Trust's five year "directional" plan was published in June 2014.

6. The plan is aligned to the Leicester, Leicestershire and Rutland (LLR) Better Care Together (BCT) programme, national planning guidance and policy direction.

7. Given the pace with which plans were developed prior to the June approval, it was always recognised that there would need to be a period of triangulation, refresh and amendment.

WHY DOES THE PLAN NEED TO CHANGE?

8. No sooner had the Trust's five year "directional" plan been approved than a number of key drivers for change emerged. These have resulted in a revision of our planning assumptions which are now reflected in an amended executive summary. They fall into two categories: external and internal.

8.1 **External**

i. The anticipated requirements of clinical standards for congenital heart services, in particular the need for colocation of children's services on one site (July 2014).

ii. Publication of NHS England's Five Year Forward View (November 2014) and the Dalton Review (December 2014) which outline a number of alternative organisational forms that providers may consider to support service integration and sustainability.

iii. The challenge to the Trust from the NHS Trust Development Authority (NTDA) to go "further, faster" in the delivery of our plans with the aim of achieving recurrent balance by 2018/2019.

8.2 **Internal**

i. A significant increase in the level of clinical risk associated with the current configuration of ITU services, in particular the inability to sustain a safe staffing rota for ITU services at the Leicester General Hospital beyond December 2015.

TRUST RESPONSE –REFRESHED PLANNING

9. It is important to note that there is no alteration in the direction of travel described in the Trust's Strategic Direction (November 2012): "*In five years' time we expect to be delivering better care to fewer patients, we will be significantly smaller, more specialised, and financially sustainable*" (Executive Summary).

10. The actions required in response to the CQC report (January 2014), the LLR Quality Review (August 2014) and the recently published Sturgess Report (December 2014), will form an integral part of plan.

KEY CHANGES

Refocused vision statement

11. Following the Trust Board Thinking Day in October a refreshed vision was produced that aims to contextualise our vision and make it easily understood both inside and outside of UHL.

Development of a single-site children's hospital

12. The capital plans associated with a single Children's Hospital are being progressed and are currently at the stage of project brief. This work programme is expected to run from 2015/2016 – 2018/2019. We are doing this in response to NHS England's review of congenital heart services.

13. Additionally the Trust is carefully considered the best operational model for congenital heart services. The Trust is establishing a strategic alliance with Birmingham Children's Hospital. This will be based on a collaborative model of delivery, governance, research and development and is in line with some of the options outlined in the Dalton Review. Active discussions are taking place about how we achieve minimum numbers of procedures in line with NHS England's future commissioning intentions.

ITU Consolidation

14. The Trust has established a discrete workstream to support the relocation of ITU (and interdependent services) from Leicester General Hospital by December 2015. The capital, revenue and project management implications are currently being developed in detail.

15. In order to accommodate the re-provision of the Leicester General ITU to the LRI there is a need for a significant estate footprint to be released. Two key actions, both of which must be delivered to release sufficient space, are being progressed to facilitate this: acceleration in the transfer of patients who no longer require acute care to alternative settings and bringing forward the Trusts plans for a discrete Treatment Centre.

Developing a Treatment Centre

16. The plans for this development have been brought forward with work starting in 2015/2016. As part of the business case development Clinical Management Groups (CMG's) have been asked how much of their planned treatments could be undertaken in this facility (part new build/part refurbishment). The Treatment Centre will bring all elective day case work together and will provide a dedicated facility for high volume planned care.

Accelerating transfer of care for patients no longer requiring acute intervention

17. As part of the Trust and BCT plan, LLR partners have agreed to work together to support the early transfer of patients who no longer require acute care, ideally in their home.

18. Several bed utilisation reviews identified the potential for up to 250 beds worth of activity to shift to out of hospital community alternatives over a three year period (starting in 2015/2016).

19. Based on the need to release estate footprint to relocate the LGH ITU and the challenge from the NTDA to go "further, faster" the Trust is working with Leicester Partnership Trust (LPT) to deliver this change over two years. This would start with a shift in 130 beds worth of activity to non-bedded alternatives in the community.

20. Maintaining safe, high quality care throughout the patient journey will be paramount as will the management of transition so that beds in UHL are not removed until the alternative has reached the scale expected on a sustainable basis.

FUTURE DIRECTION

21. The Dalton Review published on the 5th December 2014 outlines a number of alternative organisational structures that the Trust has not yet had the chance to consider in any degree of detail. This includes the potential for examples such as an urgent and emergency care network and a primary and acute care system (PACS). Plans are in place to explore this further in the New Year across the Executive with the Trust Board.

22. It is also important to note that the review creates the opportunity for Clinical Commissioning Groups to manage primary care budgets and contracts (previously undertaken by NHS England). This represents a material change which may have a knock on effect to the Trust, which we will need to actively engage with.

RISK AND MITIGATION

23. Delivery of the new models of care for our specialised (e.g. congenital heart) and local services (e.g. transfer of patients no longer requiring an acute intervention) will require the Trust and its partners to work as a 'system', working together to jointly design and safely deliver effective services that are tailored according to need. The scale of change required far exceeds anything the Trust has done before and it is therefore essential that robust governance arrangements are in place to monitor progress and clear metrics agreed so that the delivery by all can be clearly demonstrated.

24. The current contracts in place between commissioner and provider will not support the necessary flow of funds to support and incentivise the out of hospital transformation. UHL will require transitional funding to mitigate the impact of income loss, whilst LPT and Social Care need to be incentivised to support early movement of patients out of UHL. These costs are not accounted for in the BCT Strategic Outline Case (SOC) and it is therefore essential that a more appropriate contractual form is agreed that will support and incentivise all partners to deliver their part of the change.

25. The NTDA challenge to go "further, faster" and the need to secure ITU consolidation means that robust delivery plans must be in place including detailed risk and mitigation. It will be essential that resilience is built into all plans so whilst the Trust will work with LPT to secure delivery it makes sense that as system we explore the option to engage supplementary community providers who could inject additional pace of change or could support remedial action when necessary. This is currently being explored.

RECOMMENDATION

26. The Trust Board is asked to:

- **RECEIVE** this report;
- **NOTE** the key changes to the executive summary of the five year plan;
- **NOTE** that the changes do not impact on our Strategic Direction;
- **NOTE** the alignment to the Better Care Together programme;
- **NOTE** that updates on finance and workforce will be presented in early 2015;
- **ENDORSE** the changes made;

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Five Year Integrated Business Plan Executive Summary 2014 – 2019 Version11.0

December 2014

1. Executive Summary

Background

University Hospitals of Leicester NHS Trust is one of the ten largest Trusts in the country and a leading teaching hospital with one of the strongest research portfolios outside of the London. The Trust provides specialised and general local services to the people of Leicester, Leicestershire and Rutland (LLR), the wider population of the Midlands and East and for some services, an even larger national catchment.

The Trust is already recognised for the strength of its clinical services, particularly cancer, cardiac, renal, respiratory and diabetes. It employs 12,444 people (headcount) which equates to 10,683 whole time equivalents (WTE) (November, 2014). The Trust operates across three main hospital sites in the city of Leicester and satellite units, including St Mary's Birthing Centre in Melton and renal dialysis units in Loughborough, Grantham, Corby, Kettering, Northampton, Peterborough, Boston and Skegness. It also delivers clinical services at the ten community hospitals distributed across Leicestershire County and Rutland as part of the new, innovative 'LLR Elective Care Alliance', delivering multi-speciality services in a community setting.

The Trust was formed in 2000 by the merger of the City's three acute hospitals. Since then the Trust has narrowly broken even every year with the exception of 2013/14 when it posted a £39.7m deficit. The forecast position for 2014/2015 year end is £40.7m deficit, which is in line with the agreed financial recovery plan (month 7 financial update to the Trust Board) and assumes the delivery of £40m cost improvement.

In terms of operational performance, the Trust generally has a good track record of delivery with the long standing exception of the A&E four hour standard and more recently the Referral to Treatment (RTT) and cancer sixty two day standard. The need to improve urgent and emergency care reflects a key challenge not only for the Trust but the whole of the health and social care system of Leicester, Leicestershire and Rutland (LLR). Following a six month review, the world-renowned clinical expert Dr Ian Sturgess commented that the LLR system has the *"potential to be 'high-performing' but is 'relatively fragmented' with barriers to effective integrated working"* (December, 2014). This is consistent with the "Learning Lessons to Improve Care Review" (July, 2014) which highlights the need for system-wide co-operation and collaboration in order to identify solutions and make improvements to clinical care.

Actions to address the financial deficit, emergency care performance and partnership working are especially prominent in the rest of this document.

Despite all of the above, the Trust has achieved significant improvements in core quality of care including reduced infections, patient falls, pressure ulcers and mortality. In addition, very significant improvements have been made in levels of staff engagement through the "Listening into Action" programme, which has been in operation since April 2013 and seeks to ensure that all staff are central to making improvements and feel more valued as a result.

From the merger in 2000 to 2007, the Trust pursued a major PFI building and reconfiguration plan called, 'Pathway'. In 2007 when the total cost of the project was projected to be in excess of £900m, the Board stopped the procurement.

From 2007 and the collapse of 'Pathway' up to the turn of the year in 2012/13 the Trust struggled to articulate its long term strategy and financial plan.

However in 2012/13, coinciding with arrival of a new Chief Executive and other new Board members, the Trust produced its 'Strategic Direction' which set out at a high level the vision for Leicester's Hospitals. Since then work has continued to develop this Strategic Direction and this 5 year plan represents the next level of detail on the Trust's journey to become an organisation that can genuinely say that it is delivering, 'Caring at its Best'.

The Trust's internal strategy development has been taking place in parallel with the refinement of a system wide health and social care strategy for LLR, which has similarly suffered from a lack of clear direction since the demise of Pathway. LLR was previously identified as a "challenged health economy" by national regulators and was provided with external support to rectify this. As a result, a new 5 year system plan and Strategic Outline Case have been produced under the banner of "Better Care Together". UHL's strategy is entirely consistent with this wider plan.

In response to the changing service specifications and to maintain access to high quality, sustainable services as close to home as possible, the Trust is actively exploring strategic alliances with other acute providers. Examples include working in collaboration with the congenital heart services at Birmingham Children's Hospital, paediatric intensive care and neonatal intensive care services at Nottingham University Hospitals and cancer services in Northampton. This is in line with the recently published Dalton Review. In addition the Trust is at a very early stage of exploring how similar models of service provision could be extended to our local, core clinical services.

The Trust's Vision and Values

> *"In the next 5 years UHL will become a successful Foundation Trust that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience…*
>
> we call this 'Caring at its Best"

The Trust's vision is underpinned by a set of corresponding values which are designed to encapsulate the behaviours and actions that the Trust as a whole and each member of staff will need to embrace to make the vision a reality.

The values were developed with staff and reflect the things that matter most to them and the Trust. Most importantly they will characterise how the Trust will be seen by others.

Figure 1: Our purpose and values

Our values haven't changed but the world has. There are more people and they live longer but often with illness; we have more information at our fingertips to help us live healthier lives but we don't always take heed; increasingly we expect our public services to take account of our busy lives and we know more about our public services than ever before.

Alongside the wider societal changes, as a major acute, teaching Trust there are some very specific issues which we need to solve if we are to deliver on our pledge to provide 'Caring at its best'.

We need to sort out emergency care not only because our patients deserve better from us but also to liberate the Trust from the current drain of time and resource which managing day to day demand places upon us.

We need to work with social services and primary care to radically redesign community services so that only those patients who require specialist acute care come into our hospitals.

We need to take a hard look at the way we work and ask ourselves is this the best we can do and if not, who is doing it better?

We need to recognise that our clinical expertise is our most valuable commodity but if we don't open up the access to that expertise, we are limiting its potential for doing good.

And **we need to understand that money is scarce**

That is the backdrop to our vision…

Developing the Strategy

The strategy development process consisted of six key phases comprising evidence gathering, analysis, synthesis, planning, review and refresh. This process was launched by the Director of Strategy in November 2013 and was underpinned by on-going engagement with the Trust's Clinical Management Groups.

Flowing from the evidence available and the analysis came a clear sense of strategic priorities, which are called the Strategic Objectives. These are described in more detail in the Strategy Chapter but are summarised in the strategic triangle below.

Figure 2: UHL's strategic objectives

In the evidence gathering phase of the development of the UHL strategy it became clear that in order to provide the very best services to the local population of Leicester City, Leicestershire County and Rutland UHL needed to play a major role in re-shaping local services and ensuring that only those patients who need to be cared for in an acute setting are in one of the Trust's hospitals. UHL has therefore engaged actively in shaping and responding to the Leicester, Leicestershire and Rutland 5-year plan. The Trust is working closely with Leicester Partnership Trust to put new community pathways in place for patients to make sure that they only come into one of our hospitals when they really need to.

Analysis to inform the strategy

In developing the strategy the Trust has worked hard to better understand the environment within which it operates; the needs and aspirations of patients and staff; the intentions of commissioners and the drivers that will shape the future. The key headlines from the market analysis are captured below.

UHL NHS Trust operates predominantly in two core markets. These are:

1. Local services for the population of Leicester, Leicestershire and Rutland (LLR) where it is the major provider of local secondary care services
2. The wider Midlands and East regional economy (and beyond) where the Trust is a key provider of specialised adult and children's services

The summary market position is outlined below:

- 85% of the Trust's overall annual income is derived from clinical activity
- 69% of this comes from the three local Clinical Commissioning Groups (CCGs) and relates to local, core service provision

- 31% stems from NHS England, reflecting income associated with nationally prescribed specialised service activity

At an aggregate level the Trust's market share has remained stable over the last three years.

Service line reporting data (for all specialties where income is in excess of £4m) indicates that some key services which would be expected to return a profit are operating at a loss. Other key measures of performance include a high overall operating deficit. This means that the Trust has work to do to understand how effective and productive it is internally.

In respect of health need, the local population is rapidly expanding and is increasingly more ethnically diverse. There is marked variation in life expectancy between the least deprived areas of the Counties of Leicestershire and Rutland and the most deprived areas of Leicester City with the main factors contributing to premature mortality being cardiovascular disease (CVD), respiratory disease and cancer.

A particular area of concern for future planning is the increase in long term conditions. Across LLR, there are currently over 24,000 people estimated to have COPD, over 89,000 estimated to have CVD and nearly 19,000 people are on GP cancer registers. Long term conditions account for circa 70% of health and social care costs.

With an ageing population, LLR is facing a continuous rise in the numbers of people with LTC's which together with increasing expectations creates pressure on NHS resources. Despite significant improvement there are persisting inequalities in the health of people with LTC in Leicester. For example in 2009-2011 emergency admissions from Leicester for COPD were almost 5 times higher in the most deprived population of the city when compared to the most affluent. In contrast, people in Leicestershire and Rutland generally enjoy better health and wellbeing than their urban counterparts however there are high levels of inequality in specific geographical areas and/or communities created by poverty, lack of easily accessible services, poor public transport, social exclusion and/or economic changes.

The picture of significant health need together with forthcoming GP retirements and gaps in GP training positions particularly in Leicester City creates a once in a lifetime opportunity to transform the way in which we work with our partners.

The headline strategy

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

"Overall Leicester's hospitals will become smaller and more specialised and more able to support the drive to deliver non-urgent care in the community. As a result of centralising and specialising services we will improve quality and safety… this will be done in partnership with other local health organisations and social care though the Better Care Together programme. We will save money by no longer supporting an old expensive and under used estate and we will become more productive."

Since then the Trust has worked on the development of its 5 year plan which seeks to ensure that the vision of "smaller more specialised hospitals" become a reality, and that the ongoing issues with emergency and urgent care are solved and that the Trust returns to financial balance.

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

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

Two bed utilisation reviews of unscheduled care on medical wards were undertaken by the Trust in 2012 and 2013[1]. Both reviews showed very substantial opportunities to alter the balance where care is provided, to the benefit of patients.

Based on the findings of the two bed utilisation reviews the Trust is working with Leicester Partnership Trust to redesign pathways and provide out of acute hospital alternatives for sub-acute care to ensure that patients either do not spend too long in hospital or avoid a hospital admission altogether. This will require a shift of a substantial number of beds and equivalent resource and expertise to community settings and will drive greater integration of services around the patient e.g. an Integrated Service for patients with Chronic Obstructive Pulmonary Disease (COPD).

Becoming *smaller*:

More care will be delivered in people's homes and other community settings, using improved care pathways supported by Trust staff. This will require health and social care providers to work together to jointly design and deliver safe, effective services that are tailored personalised to a patient's age, and ethnicity and health and social care needs.

In five years' time we expect to be delivering better care to fewer patients, we will be significantly smaller, more specialised, and financially sustainable. By making our specialist expertise available to primary and social care we will work together to jointly design and deliver safe, effective services that are tailored personalised to a patient's age, and ethnicity and health and social care needs. We will play a much bigger role in preventing illness and supporting patients before they reach a point of crisis. This will reduce the need for people to come into hospital, reduce the number of beds and ultimately enable us to run our specialist services from two, rather than three big hospitals.

We will only provide in hospital the acute care that cannot be provided in the community. For those patients who do need hospital treatment they will find that our services are quicker, easier to navigate and higher quality, largely as a result of being able to focus on our specialisms, our slicker processes, our better use of

[1] Utilisation Review 2012 and 2013

technology and because we will no longer expect our specialist staff to spread themselves across three sites.

We will invest in our buildings so that patients and staff feel a sense of pride in their local NHS. We will build a new A&E, a Treatment Centre, a new children's hospital, a new maternity centre and a new multi storey car park. At the same time we will, with our LLR health and social care partners transform the General Hospital into a 'multi-speciality community provider', which will bring together community clinical teams to provide the kind of care which, especially for frail older people, reduces the risk of hospital admission.

Becoming more *specialised*:

The Trust's assessment is that the specialised portfolio is where the greatest opportunities for growth lie. It will build on those services where we already excel and seek innovative care solutions with academics universities and other partners, such as the pharmaceutical industry, in order to increase quality of care and improve patient outcomes.

As a consequence of shifting our focus to specialist work and using our expertise outside hospital we expect to attract increased research funding and clinical talent to our hospitals. We will create partnerships and networks with other regional hospitals; we will support district hospitals to maintain their services locally and in doing so increase referrals into our tertiary services and expand the potential for population based research.

Some of the Trust's services will become both more consolidated and specialised, examples being women's and children's services.

The long term vision for the women's and children's service is to have a consolidated facility for patients who require hospital care in a single Women's hospital and in line with new draft national standards, a single Children's hospital, whilst optimising the care given to patients outside of a hospital environment. This will include working jointly with local partners to meet the growing needs of children presenting with conditions such as obesity and birth conditions such as coeliac disease, who need paediatric gastroenterology services.

Improvements to the care pathway for children requiring urgent assessment and treatment will be achieved by the emergency floor development which will include the integration of the Children's Emergency Department and the Children's Assessment Unit.

To meet the needs of women with complex maternal complications in other parts of the East Midlands, the trust aims to increase referrals for foetal and maternal medicine along with the development of the East Midlands Congenital Heart Centre to provide the very best standard of clinical care for the patients that need it.

The combined effect of these material changes to the provision of services and their underpinning business models is expected to return the Trust to a breakeven position from 2018/19.This represents a prudent assumption.

Timescale and phasing of the Strategy

The Trust is planning a two phase implementation of the headline strategy described above (see diagram below). Following feedback from the National Trust Development Authority (NTDA) the Trust has revisited that phasing of its plans with a view to going "further, faster". In the first phase, lasting two years the Trust will focus on in hospital efficiency and productivity with the aim of repositioning key clinical services from outliers in terms of benchmarked data (for example length of stay and day case rates) to top quartile. In complement, The Trust will work with partners to support the safe transfer of patients who no longer require acute care, into out of hospital, community settings.

Included in phase one will be four urgent developments: the Emergency Floor at the Royal Infirmary, the transfer of vascular services from the Royal to Glenfield Hospital, the consolidation of ITU services on to the Royal Infirmary and Glenfield Hospital site and the establishment of a Treatment Centre on the Glenfield Hospital site. The Emergency Floor development will be a key plank of the health system's plan to resolve its longstanding problems whilst the vascular development will create an integrated cardiovascular service, which will be at the cutting edge of modern medicine and surgery. The establishment of an elective Treatment Centre will create the opportunity for a Multi-specialty Community Provider Service for the City and release estate footprint to accommodate the transfer of ITU Services (and interdependent clinical services e.g. major cancer surgery) from the Leicester General Hospital.

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

Building on clearly articulated clinical consensus the Trust will consolidate its main acute services onto two sites, enabling patients and clinicians alike to benefit from properly co-located services and eliminate the inefficiencies of running multiple acute sites. This level of reconfiguration will require substantial investment in the hospital estate, currently estimated to be in the region of £320m. Included within this would be the development of the Emergency Floor, a new Treatment Centre and an investment in a new Children's Hospital and maternity service.

There will be a number of options available which would fulfil this vision and the Trust will work on these with partners and stakeholders and the wider community over the remainder of 2014 and into 2015 to establish these options. Although the Trust will appraise all options, the direction of travel to date would indicate that it is likely that the Royal and the Glenfield will emerge as the two main acute sites. If this is the case, it would enable the General Hospital site to be developed to further support integrated community services and the Diabetes Centre of Excellence as well as continuing to provide a home for East Midlands Ambulance Service and for the existing services provided by Leicestershire Partnership NHS Trust.

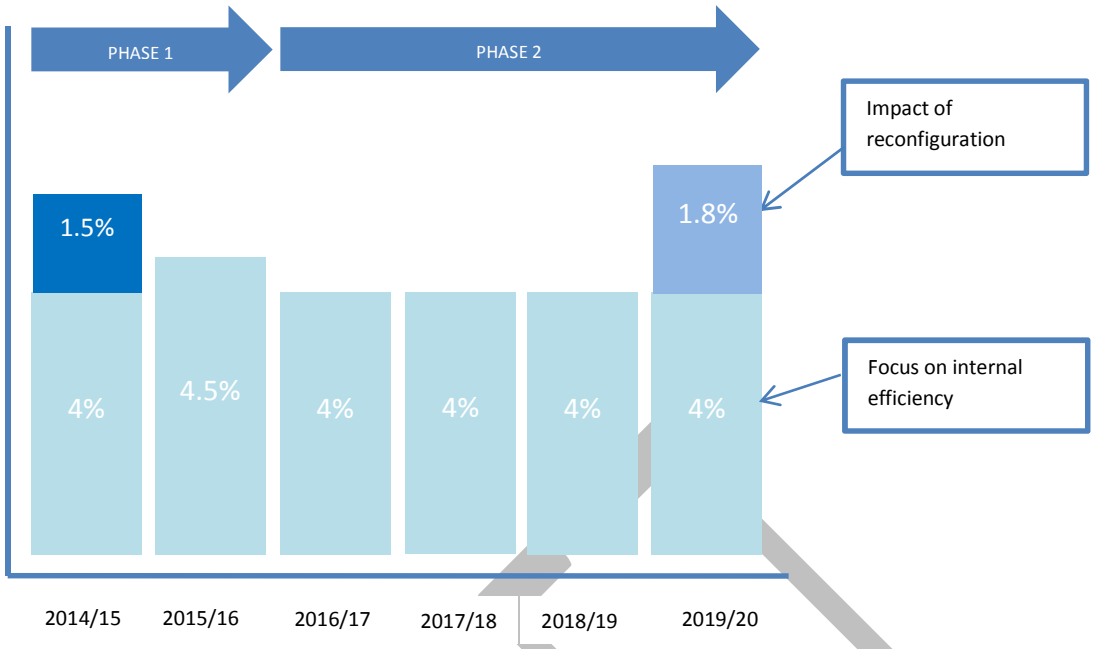


Figure 3: Cost Improvement Profile associated with strategy implementation 2014 – 2020 [DN do I leave this in or take out as finances haven't been reworked yet]

Delivering the Strategy

The execution of this strategy will be a long term and complex task. It will therefore require the Trust to be focussed and well-organised. To that end, all of the Trust's improvement and development activities have recently been organised under an over-arching programme called "Delivering Caring at its Best". This has four domains – Quality, Performance and Finance, Strategy and Workforce. Using this framework will allow the Trust to marshall our activities so that improvements are delivered on time and the different aspects are effectively integrated.

Strategic Outcomes

The final piece in our strategic 'jigsaw' is to be clear about what success looks like. This will help to be clear about why the Trust is pursuing this strategy. The Trust has expressed this through looking at success through the eyes of our most important stakeholders, our patients, present and future; our staff, public members and Board, our partners and our regulators.

Strategic outcomes	
Benefit for our patients	• Highest levels of quality care, as assessed by clinical outcomes, patient satisfaction and patient safety • Clinically led decision making on delivery of services, using accurate, relevant and timely information in the assessment of the profitability of clinical service • Overall productivity improvement of 20% in theatre throughput and LOS, with all patients referred only when fit/ready for treatment • Consistent achievement of quality and performance standards (including ED 4 hour target and RTT) • Significant increase in the proportion of short stay patients on ambulatory and best practice pathways (length of stay less than 2 days) • Significant reduction in patients with long lengths of stay (greater than 6 days) • Increased dignity and independence for the older person • Reduced fragmentation and duplication • Improved integration
Benefit for our staff/members/ Board	• Consistent achievement of quality and performance standards • Consolidation of teams driving higher levels of job satisfaction, clarity about what is expected and retention • Shared agenda with Commissioners, primary care and other providers for the management of patients along pathways of care • Development opportunities – in reach and outreach • Opportunities to participate and develop research and innovation in practice • Positive reputation • Financially sound • Established partnerships with other sectors to promote the early transfer of patients to a lower acuity setting and/or a suitable alternative environment for on-going care
Benefit to partners	• Delivery of high quality, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, resulting in a reduction in the time spent avoidably in hospital by 30% • Services that represent value for money • Delivery closer to the patient, delivered in partnership with others • Consistent achievement of quality and performance standards
Benefits to regulators	• Compliance with all CQC and Monitor requirements • Delivery of NICE guidance • Financial health and a positive risk rating • Reputationally sound

Table 1: UHL's Strategic Outcomes

Conclusion

In the Care Quality Commissions inspection report for University Hospitals of Leicester NHS Trust, the Chief Inspector of Hospitals, Professor Sir Mike Richards, said: "We found that the University Hospitals of Leicester NHS Trust was providing services that were safe, effective, responsive, caring and well-led. Staff we spoke to were positive, and patients we spoke to were positive about the care that they had received at the trust."

Nonetheless, the Trust Board and the Executive Team recognise that without a solution to the longstanding issue of emergency care delivery, capacity and the Trust's ability to cope with significant peaks and troughs in emergency admissions, then the good and often excellent work of the clinical teams will continue to be overshadowed. This requires action across LLR – in the home, in GP surgeries, in community hospitals. The action described in our plans must overcome these barriers and support the implementation of improved pathways that ensure that

Acute admission to hospital only occurs if there is an evidence based acute intervention that can only be delivered in hospital. Otherwise, the timely delivery of interventions and care should be provided in the community to avoid unplanned default attendance at Hospital.

Alongside and linked to this most pressing of strategic issues is the deficit. So, similarly, the Board and Executive know that UHL's future success as a sustainable Trust requires rapid and significant change to the fundamentals of the underlying business and clinical models currently in place within the Trust and throughout the wider health economy. This will not be an easy journey.

However, as the market assessment shows the Trust is in a strong position with a large turnover, relatively little competition and therefore reasonably predictable revenues for the next 5 years. The task is therefore clear; first make substantial changes to the elements of the business most directly within the Trust's gift, mainly through getting the basics right. Then, the Trust will consolidate the location of its services to ensure that it can continue to provide the highest possible quality of care within the available resources, with the long term sustainability of clinical services being the key driving factor.

None of this will happen without a whole health and social care system plan and without the understanding and support of all stakeholders; as such the Trust is working hard to build system-wide co-operation and collaboration in order to identify solutions and make improvements to care through the Better Care Together programme banner.

In summary, this document proposes an ambitious but achievable plan which moves University Hospitals of Leicester from its current position to that of an efficient, effective healthcare provider working in partnership with local organisations as well as other hospitals trusts across the Midlands.

The Trust will become an integrated provider of local acute and where appropriate, community services focussing on the parts of the patient pathway that an acute inpatient and ambulatory service can add greatest value. In complement the Trust will establish strategic alliances for some of our specialised services and will explore similar opportunities for some of our local services.

Our greatest asset, our workforce will be invested in to develop the skills and abilities they require to work differently, to work smarter and to develop their services to their full potential.

This is our plan to ensure that people living in Leicester, Leicestershire and Rutland have access to the services they deserve and that meet their changing needs over the 5 year time scale.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper H

TRUST BOARD – 22 December 2014

Delivering the Five Year Strategy – Proposed Governance

DIRECTOR:	Kate Shields
AUTHOR:	Ellie Wilkes
DATE:	22 December 2014
PURPOSE:	To brief the Board on the outcome of the Department of Health Gateway Zero review recommendations and to describe the actions taken to address them. The Trust Board is asked to; • Review the Programme Brief and provide approval for the document • Agree to the proposed governance arrangements • To have 'Delivering the Five Year Strategy' as a standing item on the Trust Board
PREVIOUSLY CONSIDERED BY:	Executive Strategy Board
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision [x] For assurance [x] For information [ ]

♦ **We treat people how we would like to be treated** ♦ **We do what we say we are going to do**
♦ **We focus on what matters most** ♦ **We are one team and we are best when we work together**
♦ **We are passionate and creative in our work**

***** tick applicable box

Delivering the Five Year Strategy – Proposed Governance

Summary

1. The attached programme brief was presented and approved at Executive Strategy Board (ESB) on 9th December 2014 as part of a paper to outline the proposed governance arrangements for overseeing delivery of the Five Year Strategy.

2. The programme brief is in direct response to the recommendations of the Gateway Zero review that was in October 2014 which rated the Trust as Amber-Red.

3. The governance structure described is proposed to be the main vehicle through which all activities pertaining to delivering the Five Year Strategy are tracked.

Background

4. A Department of Health Gateway Zero review of UHL's reconfiguration programme was carried out from 20 October 2014 to 23 October 2014 at the Leicester Royal Infirmary. The primary purpose of a Health Gateway zero review is to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

5. The review concluded that UHL needed to appoint a Programme Director and establish an overarching governance structure in line with a recognised methodology (Prince 2/MSP) to provide assurance to the Trust Board and external bodies of ability to deliver within the timescales.

6. The plans to reduce activity and reconfigure will require significant amounts of work to realise the vision. The Better Care Ttogether (BCT) programme has a series of workstreams established to drive system change. However UHL has not as yet set up a similar governance structure to oversee the various activities (through workstreams) required to realise the five year reconfiguration strategy

Proposal

7. In response to the Gateway review a number of actions have been undertaken to provide assurance to the Trust Board and external bodies in relation to the ability to deliver the five year strategy;

    - A Programme Director appointed for 12 months to establish the governance arrangements
    - A programme brief produced – including initial governance proposals and timelines

8. The Programme Brief included in this paper articulates the overarching governance structure including workstreams and reporting.

9. To deliver the programme a Strategy Programme Management Office (PMO) is being established and will focus on supporting the workstreams to formalise, develop and implement reporting functions to monitor progress and align with the BCT PMO to ensure system wide tracking. A Programme Key Performance Indicators (KPI) dashboard will be developed as the Programme progresses to ensure activities undertaken are delivering against plan and in line with Trust Strategic benefits.

10. Following approval of the programme brief the Programme Initiation Document will commence. This requirement is also a recommendation from the Gateway review team and will be completed by the end of January 2015 for review through February by the ESB and Trust Board ahead of a follow assessment by the team.

Recommendations

11. The Trust Board is asked to:

- **Review** the programme brief and provide approval for the document
- **Agree** to the proposed governance arrangements
- **Agree** to having 'Delivering the Five Year Strategy' as a standing item on the Trust Board

University Hospitals of Leicester NHS
NHS Trust

Programme Brief for establishing the Governance arrangements for overseeing the delivery of the Five Year UHL Strategy
December 2014
Version 0.3

Purpose of document

1. This paper provides an overview of the proposed arrangements governance arrangements for the delivery of the five year strategy including the overarching governance framework, reporting instructions, programme management arrangements and key milestones.

Background

Better Care Together (BCT)

2. The BCT programme is a partnership of NHS organisations and local authorities across Leicester, Leicestershire & Rutland (LLR). It is driven by a shared recognition that major changes are needed to ensure that services are of the right quality and capable of meeting the future needs of local communities.

3. The LLR Five Year Strategy was jointly developed under the programme name of BCT. The plan sets out to reform health and social care services through a shared vision for the population of LLR, over the next five years.

4. The strategic outline case (SOC), published in October 2014, sets out the case for the BCT programme as being the preferred way forward to deliver the plans set out in the five year strategic plan. The SOC is designed to be a "wrapper" for all the future transformation business cases which will be required for the system to realise its vision.

5. The plans set out in the LLR SOC will see a significant "left-shift" of care out of acute settings, allowing UHL to concentrate on providing care to complex patients and improving the provision of sub-acute services in community hospitals, and the development of greater capacity in community teams allowing patients to live more independently in their homes.

6. The performance and effectiveness of the changes made will be measured through reduction in avoidable emergency admissions/readmissions, delayed transfers of care, residential admissions, and improved effectiveness of rehabilitation after discharge from hospital and patient/service user experience.

UHL Five Year Strategy

7. In line with the overall BCT Five Year Strategy, the Trust developed and submitted its five year plan in June 2014 which seeks to ensure that the vision of "smaller more specialised hospitals" becomes a reality and the on-going issues with emergency and urgent care are solved and that the Trust returns to financial balance. This will require UHL to go from three sites to two by 2018/19.

8. It has been calculated that UHL will need to reduce its bed base by approximately 462 beds in order to reduce the overall estate footprint.

9. There will be a number of work streams that fall into three categories: enabling works, refurbishment and strategic capital developments that will all support the reconfiguration from three to two sites;

10. It is anticipated that a number of system wide changes to current provision of care in the community plus efficiency gains in the acute setting will enable this left shift of activity and reduce the number of acute beds by 571 by 2018/19. This equates to a physical reduction of 462 beds at UHL by 2018/19. The current planning assumptions indicate that the reductions in activity will be achieved through three main workstreams:

    - **Internal UHL efficiencies** - 212 beds (Daycase/LOS): cross cutting workstreams established to support delivery

    - **Reconfiguration** - 250 beds (left shifts): Joined up approach to delivery working with LPT to identify appropriate sub-acute patients to move out

    - **Managing future demand** - reduce future need for an additional 109 beds: this is being led by primary care

Department of Health (DH) Gateway Zero review recommendations

11. A DH Gateway Zero review of UHL's reconfiguration programme was carried out from 20 October 2014 to 23 October 2014 at the Leicester Royal Infirmary. The primary purpose of a Health Gateway zero review is to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

12. The review (appendix A) concluded that UHL needed to appoint a Programme Director and establish an overarching governance structure in line with a recognised methodology (Prince 2/MSP) to provide assurance to the Trust Board and external bodies of ability to deliver within the timescales.

13. The team also recommended that a Programme Initiation Document (PID) be produced before a follow up assessment at the end of February 2015. The purpose of the PID is to define the governance structure and delivery mechanisms of the programme including reporting and workstream functions.

14. The plans to reduce activity and reconfigure will require significant amounts of work to realise the vision. The BCT programme has a series of workstreams established to drive system change see appendix B. However UHL has not as yet set up a similar governance structure to oversee the various activities (through workstreams) required to realise the five year reconfiguration strategy

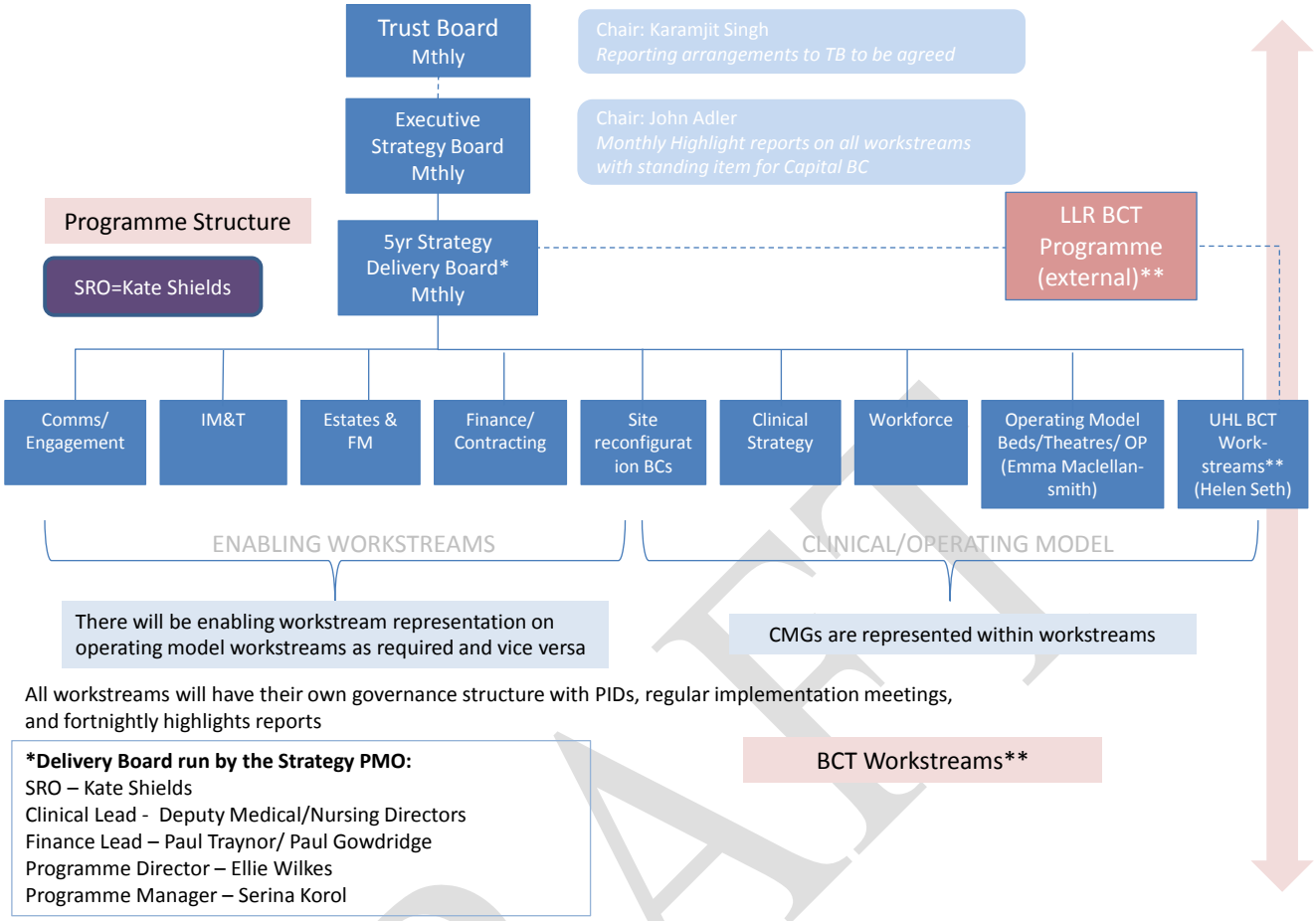
15. A DH Gateway zero review of the Better Care Together programme was held between 3rd and 6th November 2014.

Trust wide Programme Governance

16. The Programme Brief is an overview of how the governance arrangements for the delivery of the five year strategy will be implemented. Once the principles of the governance are agreed then the development of the PID will commence.

17. The proposed governance structure for the Programme is described in the organisational chart below:

Governance structure for delivering the UHL five year strategy – DRAFT V0.2



18. It is proposed that a series of workstreams are formally established and report in to the Delivery Board. These fall broadly into two categories;

- **Future Model Reconfiguration** (Operating Model including Beds, Theatres and Outpatients, Workforce and Clinical Strategy)
- **Enabling workstreams** (Finance, Estates, IM&T, Communications / Engagement, Site Reconfiguration Business Cases)

19. There will be a direct link with the BCT programme through the Strategy Programme Management Office to align reporting, support information flows and track progress in line with wider system changes. The Head of Local Partnerships and Programme Director (Strategy) will be the main points of contact for the Programme at the delivery level.

20. The Delivery Board will meet monthly; it is essential that this Board has sufficient seniority and authority to hold workstreams to account.

21. The Delivery Board will report to Executive Strategy Board on a monthly basis using a highlight reports (as mentioned in section four) and any issues/risks will be escalating with mitigating strategies for Executive awareness and resolve.

22. Appointed workstream leads will be expected to attend the Delivery Board on a monthly basis and to send an agreed deputy in their absence. This will ensure that the Programme Board, Executive Strategy Board, and ultimately Trust Board, will have oversight of the entire Programme in order to monitor and track progress against plan

Membership of the Delivery Board

23. It is proposed that the Delivery Board will be co-chaired by Kate Shields, Director of Strategy and SRO, and Andrew Furlong, Deputy Medical Director. The meeting will be supported by the Programme Director.

24. Named leads (or deputies) for all workstreams (future operating model – to include clinical/CMG representation) must be present at every meeting.

High level programme plan

25. There are a number of key milestones within the first 3-6 months (see appendix d for the plan).

- Establish the UHL Strategy PMO (by end December 2014)
- Complete the '5 year strategy' PID (by end January 2015)
- Workstreams established and project charters complete (by end December 2014)
- First 5 year strategy Programme Board (January 2015)
- Workstream Project Initiation Documents/plans complete (end February 2015)
- Gateway review assessment (end February 2015)

26. A more detailed Programme plan will be developed to map out the initial stages of the programme (3-6 months) and then to incorporate the key milestones across two years. When workstream project plans are agreed then aggregated milestones will be incorporated to a 'master' programme plan. All plans will be correlated against the BCT programme key milestones.

Programme Management Office (PMO)

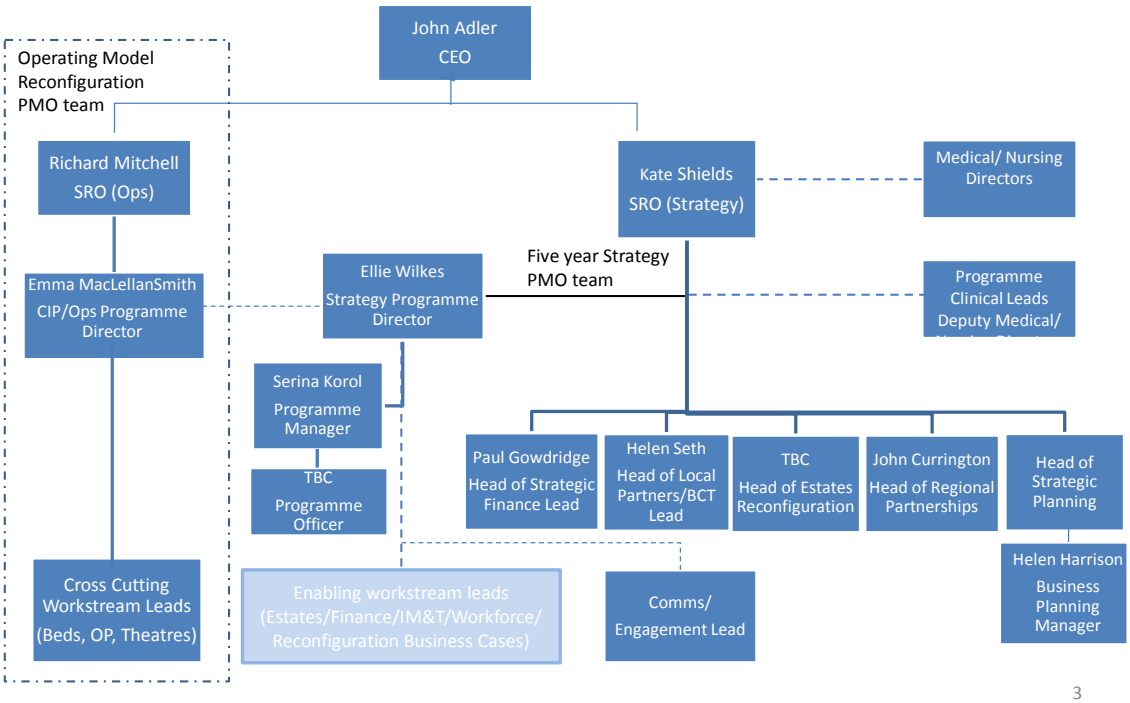
27. A PMO will be established to support the establishment of the governance structure and monitor progress. The PMO will be responsible for running the Trust wide Programme Governance for delivery of the 5 year strategy and will be accountable to the Trust Board through the Executive Strategy Board.

28. The PMO will be led by Kate Shields (Director of Strategy) as SRO with full time support from a Programme Director and Programme Manager. A number of other posts will need to be filled to support the running of the Programme on a full or part time basis. A suggested structure is illustrated in the organisational chart below.

29. The PMO will run in line with the principles of MSP and Prince2 methodology and its structure will be tested through the initiation document and Gateway Review follow up.

30. It is proposed that the PMO be set up as described in the organisational chart below.

Overarching PMO for delivering the 5 year strategy – DRAFT v0.3



Roles and Responsibilities

31. The key roles and responsibilities within the PMO are shown below. Subject Matter Expertise (SME) will be sourced as and when required. Best practice guidance is followed in establishing and managing the programme. The Office of Government Commerce recommends identifying certain key project roles at the outset.

- The **Investment Decision Maker** takes the investment decision for use of resources. This is the Trust Board
- The **Senior Responsible Owner** defines the scope of the programme and is the individual who is personally accountable for its success
- The **Programme Director** is responsible for day to day management and decisions on behalf of the Senior Responsible Owner to ensure that the programme's objectives are delivered
- The **Programme Manager** has a full time commitment to the programme managing and coordinating the integrated Programme Team on a day to day basis

32. There will be several layers to the PMO to support the establishment of the programme and ongoing monitoring, tracking and risk management. There will also be a direct link between the UHL PMO and the BCT PMO for monitoring and reporting. The PMO management structure is described in appendix C.

Workstreams

33. The governance chart described earlier includes a number of expected workstreams which will be in place to deliver different parts of the overall 5 year strategy. It may be that additional ones are identified through the design phase as part of developing the PID.

34. All workstreams will have to go through an approval process for initiation. This will involve completing a project charter and project initiation document. Key responsibilities will include:

- Enabling the 5 year strategy at a specialty, CMG and Trust level
- Working with other workstreams to ensure one interdependent and cohesive strategy at specialty, CMG and Trust level
- Ensure the workstream delivers its component of the 5 year strategy on a clinical, operational, corporate and financial basis

35. Workstreams will be held to account for delivery and will be expected to complete all required documentation plus attend the Delivery Board on a monthly basis. Each workstream will have a named Director to ensure accountability is maintained.

36. Through the Head of Local Partnerships there will be a reporting link with the wider BCT workstreams. This role will oversee delivery of UHL's element of the BCT workstreams and provide information to other workstreams through the Delivery Board.

Reporting and Template

37. The PMO will be responsible for ensuring that all aspects of the programme are reported on, both internally to ESB and ultimately the Trust Board and externally to the BCT programme.

38. All workstreams will be expected to complete a number of templates to properly establish the project in line with best practice. These include a project charter, project initiation document and project plan. All documentation will be signed off at the Programme Board. In addition workstreams will be expected to complete a fortnightly highlight report. Guidance will be produced to support workstreams fulfil the requirements of the PMO.

Programme Scope and Deliverables

39. Included within the scope of the Programme is the oversight of the future model reconfiguration workstreams, site reconfiguration and enabling workstreams

40. Outside of the scope of the Programme is managing the deliverables of the BCT programme and development/delivery of CMG CIP schemes

41. Key deliverables of the PMO: PID, established PMO with robust governance structures, comprehensive workstream plans, overarching programme plan, risk management process.

Decisions required;

42. The Executive Strategy Board is asked to:

- Agree the overarching governance proposal within this Programme Brief
- Agree the workstreams and sponsors/implementation leads
- Give approval to proceed with development of Programme Initiation Document

Appendix A – Gateway Zero review

See separate PDF document

Appendix B- BCT programme workstreams

Sets out plans for eight clinical workstreams and within four different care settings Social Care, Primary Care, Community and Acute Care

Planned care	Mental health	Maternity and neonates	Children and young people
• Implementation of PRISM system to improve referral quality • 40% left shift of acute activity into community • 10% of outpatient activity attendances will be decommissioned • 50% of out of county OP/DC repatriated to LLR (excluding City CCG). • Reviewing pathways for 18 specialties • Introduce non-face to face where appropriate • Full compliance with BADS • UHL OP and daycase elective care hub	• Strengthen prevention and self-help services to improve resilience • Implement Crisis House, step down beds, discharge team and changes to inpatient pathway to reduce out of county placements • Increased access to alternative services, for example through IAPT; • Reduce alternative health placements by 40%, • Providing more step-down support post-discharge, for example step down beds and crisis house facilities.	• Development of single obstetric unit at UHL • Maximise the uptake of midwifery led care options by promoting home births and midwife-led provision – the key system intervention is redesigning how community based midwife led services are delivered to ensure that there is a sustainable model for community based midwife care • Continue with the multi-agency programme to improve perinatal outcomes in Leicester. • Develop an integrated maternal mental health pathway	• Merger of Children's ED and CAU to become a single Ambulatory care unit and deliver Children's acute care provision from a single site • Increasing the provision of counselling and emotional health and wellbeing services to reduce the number of children escalating to tier 3 CAMHS • Reduce out of area placements • Redesigning the hepatitis B pathway to shift 100% of activity from to primary care • Develop options to deliver integrated provision

Learning disabilities	Urgent care	Long term conditions	Frail older people
• Review team to benchmark and analyse the cost and content of high cost packages of care • Reconfiguration of short break services for LD patients / service users • Implementation of an Outreach Team that will work between the community and the Agnes Unit for challenging individuals LLR approach to enable carers to be involved in service development and planning • Flexible LLR wide provision of short term intensive crisis support • Pooled personal budgets and personal health budgets	• New emergency floor at LRI to ensure there is sufficient space to support the flow of "majors" and to offer dignified care and create a positive working environment. • Improving system navigation by boosting NHS111, out of hours medical cover and local single point of access • Increasing the availability of ambulatory care options • Boosting the urgent out of hospital options for at risk patients; • A "Choose Well" public campaign to help people to make the right urgent care choices.	• Based around principles of "Education", "Prediction", "Care planning", "Ambulatory pathways", "Innovation", "Services available when required", and "Choices and plans at the end of life" • Specific interventions include: integrated COPD team cover primary, community and acute care avoiding hospital admissions, including ambulatory care wherever possible. • Exercise medicine to improving levels of activity, giving people access to integrated reablement services • Workplace wellness proof of concept in UHL	• Primarily based on existing BCF plans • Age well and Stay well: Introduce Unified Prevention Offer • Risk stratification, Early diagnosis and referral, and the increase in the number of quality care plans • Care Navigators, Local Area co-ordinators and the development of integrated pathways for Dementia. • Clinical Response team, the Falls service, Integrated Crisis response • Assistive technology. • Good discharge planning and post discharge support

Appendix C - **PMO Management Structure**

There will be several layers to the PMO to support the establishment of the programme and ongoing monitoring, tracking and risk management:

Programme Management Office Team:
Programme Director, Programme Manager, Programme Officer, Head of Strategic Finance, Head of Local Partnerships, Business Planning Manager

- To set up and run the Programme Management Office
- To prepare the Programme Board including reporting
- To establish and oversee benefits tracker
- To be the main contact point for the BCT programme (information/reporting)
- To provide reports on progress to BCT programme (in an agreed format/depth of content)

Programme Core Management:
Programme Director (Strategy), Head of Strategic Finance, Programme Director (Ops/BCT), Head of Local Partnerships (Strategy/BCT), Head of Informatics, Director of Capital Reconfiguration, Assistant Director of Workforce, Head of Communications

- To meet fortnightly and oversee the running of the Programme including contributing to the ongoing development of the structure and materials
- To address any issues/ monitor progress and ensure activities aligned with BCT
- Ensure the link with internal business planning and IBP refreshes.

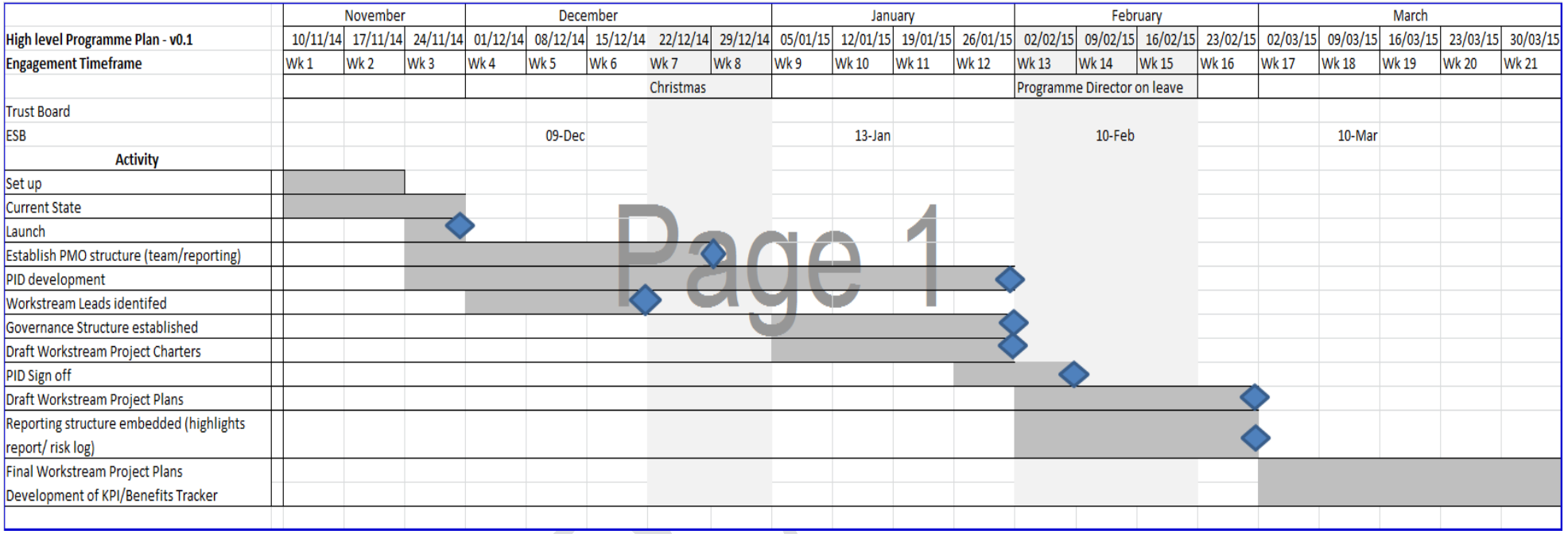
Programme Board:
As above and including the SRO, Clinical Lead, Director of Finance, Workstream leads and ad hoc representatives as required

- To meet monthly to report on progress against delivery using highlights reports (completed fortnightly) and raise any issues/risks with mitigating strategies
- To track milestones and deliverables through updated project plans (feeding into an overarching programme one) and through a dashboard (to be developed)

Implementation workstreams
Membership will vary according to the specific workstream but will need to include as a minimum; a Director sponsor, clinical lead, senior management lead, nursing lead, representation from CMGs/workforce/finance/IM&T/estates and other corporate functions as required.

- To meet fortnightly/monthly to design project, agree deliverables and milestones
- To complete project initiation documentation and update the project plan and risks/issues log on a regularly basis
- To attend the programme Board and submit completed and timely reports as outlined by the PMO.

Appendix D – High Level Programme Plan



Health Gateway Review 0: Strategic assessment (Early)
Programme Title: University Hospitals of Leicester Reconfiguration
Health Gateway ID: DH 806

Department of Health

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Version 3.0 (Issued) July 2013

Health Gateway Review
Review 0: Strategic assessment

Version number: Final

Date of issue to SRO: 23 October 2014

SRO: Kate Shields (Director of Strategy)

Organisation: University Hospitals of Leicester NHS Trust

Health Gateway Review dates: 20/10/2014 – 23/10/2014

Health Gateway Review Team Leader:
Stuart Douglas

Health Gateway Review Team Members:
Gerald Clemence
Debbie Glenn

Health Gateway Review 0: Strategic assessment (Early)
Programme Title: University Hospitals of Leicester Reconfiguration
Health Gateway ID: DH 806

Background

The University Hospitals of Leicester NHS Trust (UHL) was formed in 2000 from the merger of the city's acute hospital Trusts located at:

- Leicester Royal Infirmary
- Leicester General
- Glenfield Hospital

The Trust provides acute health services to the population of Leicester, Leicestershire and Rutland (LLR).

In recent years, the Trust had worked with a private sector partner (via a Private Finance Initiative) to develop proposals to modernise its facilities, however the programme was abandoned in 2008, as they were unaffordable.

After a long pause, UHL has now commenced working on a 5 year plan and a associated Reconfiguration Programme (RP) which is intended to bring about the long awaited modernisation of services and facilities.

The UHLRP forms part of a wider programme 'Better Care Together' (BCT) which is being progressed as a partnership between local health, council and associated agencies to plan a whole LLR economy reconfiguration of health and social care services into a modern, viable and efficient configuration.

The aims of the programme:
The key objectives of the UHL Reconfiguration programme are to:

- Move from 3 to 2 Acute Hospital sites with enhanced community based services
- Create a single co-located children's service
- Create a larger single site maternity unit
- Create a new day case hub for elective care
- Create a new emergency floor (subject to the separate DH796 Health gateway)
- In overall terms, to remove 462 beds from the acute service profile.

The UHL Reconfiguration programme comprises 16 investment projects and is expected to cost circa £322m.

Health Gateway Review 0: Strategic assessment (Early)

Programme Title: University Hospitals of Leicester Reconfiguration

Health Gateway ID: DH 806

The driving force for the programme:
The reconfiguration responds to the following drivers:

- Services being provided by the right organisations (leading in many cases to a migration of activity to a community setting)
- Provision of safe and sustainable services in clinical and financial terms
- The need to modernise the estate to a compliant and efficient standard which aligns with the models of care
- The need to respond to changes in demand for care (maternity, children's services, day case activity etc.)

The procurement/delivery status:
Of the 16 projects identified within this programme, 2 have advanced to the point of completing the Outline Business Case and of having a procurement strategy.

- The Emergency Floor Project (circa £48m investment) is progressing on the basis of a partnering arrangement with Interserve, who have been appointed following a full OJEU selection process to work with the Trust to complete the design, package tendering and construction process.
- The Vascular Services Project (circa £12.5million investment) is using the same procurement approach

The RT was advised that no decision has been made on procurement of the remaining 14 projects as they are at an early stage of development.

Current position regarding Health Gateway Reviews:
This is the first Health Gateway Review for the UHLRP. A Health Gateway Review was completed for the Emergency Floor project in June 2014.

Purposes and conduct of the Health Gateway Review

Purposes of the Health Gateway Review
The primary purposes of a Health Gateway Review 0: Strategic assessment, are to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

Appendix A gives the full purposes statement for a Health Gateway Review 0.

Conduct of the Health Gateway Review
This Health Gateway Review was carried out from 20 October 2014 to 23 October 2014 at the Leicester Royal Infirmary. The team members are listed on the front cover.

The people interviewed are listed in Appendix B.

The Review Team would like to thank the UHL Reconfiguration Programme Team for their support and openness, which contributed to the Review Team's understanding of the programme and the outcome of this review.

Delivery Confidence Assessment

The health economy in Leicester, Leicestershire and Rutland is currently running at a substantial deficit.

After a long period of inactivity, local health and social care organisations have been brought together to plan and implement a programme of change 'Better Care Together' (BCT); which will see services and facilities modernised and brought into an affordable configuration.

The Review Team was pleased to note that this economy wide programme is being led and supported by the NHS Trust Development Authority and NHS England and that it is widely and actively supported by local health and social care organisations.

UHL's Reconfiguration Programme represents a major component of BCT, and is aimed at providing a modern and viable configuration for the Trust's future operations. It currently comprises 16 projects, involves an investment of £322million, and needs to be complete within 5 years to meet the NHS Trust Development Authority's strict deadline for achieving a break even position.

The RT found that whilst this vital programme is being taken forward by an experienced and committed SRO with some management support, it is far from being properly resourced. Immediate steps must be taken appoint a Programme Director and a supporting Programme Office facility. This should enable the Programme to be properly defined, and to have clear management and governance arrangements as the basis for progression in conjunction with the BCT Programme.

In the same vein, a Resource Plan should also be developed to identify the nature and scope of additional skills / support required across the Programme to ensure that they can be procured to meet the needs of each of the constituent projects.

The RT noted that the Reconfiguration Programme is progressing within very tight parameters, which create significant risks to delivery, including:

- The scope of change is material, including moving from 3 acute sites to 2 and making significant reductions in acute inpatient capacity
- The timescale for delivery is very ambitious
- The capital investment profile is large and likely to come under close external scrutiny (which could delay progress)
- Capital investment allocations are at the lower end of the benchmark scale for development
- There are significant interdependencies between organisations for planning and delivery of major changes (such as bed reductions)

- A formal Public Consultation will be required to inform the final change profile and is likely to mean that the bulk of proposals will not be put forward until post-election.

The RT concludes that progressing a mission critical programme with this type of risk profile and without the required resources, means that the successful delivery must be in doubt. On this basis, the rating to be applied is **AMBER RED**.

However, with the leadership and support being provided by the NTDA, NHS England and local partners, Delivery Confidence could increase if appropriate Programme leadership and resources are secured promptly. The RT hopes that the Trust will not miss this unique opportunity to step up to the plate.

Colour	Criteria Description
G	Successful delivery of the project/programme appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly
A	Successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery
A	Successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme/project if addressed promptly.
AR	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed.
R	Successful delivery of the project/programme appears to be unachievable. There are major issues on project/programme definition, schedule, budget, required quality or benefits delivery, which at this stage do not appear to be manageable or resolvable. The project/ programme may need re-baselining and/or overall viability re-assessed

A summary of recommendations can be found in Appendix C.

The RT was pleased to note as an example of good practice, that the NHSTDA and NHS England had facilitated development of a wrap-around Strategic Outline Case to demonstrate the case for investment in a system wide change to achieve a transformation of a challenged local health economy to deliver an affordable and sustainable configuration.

Findings and Recommendations

1: Policy and business context

University Hospitals Leicester NHS Trust (the Trust) is one of the largest teaching hospitals in the country. As the only acute Trust in the area it provides district general hospital services to the diverse population of Leicester, Leicestershire and Rutland (LLR) as well as specialist services to the wider population of the Midlands and East.

For a number of years it has been clear that major reconfiguration of services across LLR is required, with poor performance in a range of key performance indicators. Between 2000 – 2007 the Trust planned significant reconfiguration through a major PFI[1] procurement and reconfiguration plan called 'Pathway'. However in 2007, when the total costs were estimated in excess of £900m, the UHL Board halted the procurement and momentum for change was lost. Whilst a small level of service development has taken place more recently, UHL continues to face significant financial and operational pressures missing several key targets and posting a £40m deficit in 2013/14.

The Better Care Together (BCT) Programme was established 2-3 years ago to enable health and social care organisations to jointly deliver system wide change. Previous public consultations have described the challenges facing the system and resulted in general awareness and acceptance of the need for change. However this has not been followed up with specific proposals or an agreed system wide change plan.

Due to the lack of major service reconfiguration over the last 10 – 15 years and the annual growth in demand the LLR system continues to struggle. It has been designated as one of the 'challenged' health systems in the country. This, along with advent of the Better Care Fund has resulted in a renewed focus on joint working. The BCT Programme has been refreshed and a 5 year joint plan has recently been agreed. External consultants are supporting development of a Strategic Outline Case (SOC) with an investment value understood to be in the region of £600m. This covers a system wide transformation across eight joint clinical work streams as well as the Trusts own £322m RP. The NTDA and NHS England expect to receive the BCT SOC shortly.

The £322m UHLRP forms part of its June 2014 Integrated Business Plan (IBP) and Long Term Financial Model (LTFM), and is designed to deliver clinical and financial sustainability within 5 years. It sets out a major change programme which concentrates acute services onto two sites instead of three. One site will, in the main, co-locate emergency services, and the other planned and specialist surgery. The third site will then be designated for community health and non-acute services.

[1] Private Finance Initiative

The programme will also involve significant changes to care pathways and service models.

Operational pressures have meant that work has already begun on redesigning emergency services (the Emergency Floor project). In addition it has recently become apparent that level 3 Intensive Treatment Unit (ITU) cannot be sustained across all three acute sites beyond December 2015; creating another major operational pressure and catalyst for change.

As a result of these and other recent developments a sense of momentum is building across the system, with widespread agreement of the need for change sooner rather than later. Aspects of the BCT plans will require formal public consultation, the detail of which is being worked through by the communications and engagement enabling work stream.

The UHLRP involves complex, large scale change and requires robust programme governance. The current, early stage, governance arrangements need strengthening. Whilst the IBP provides a short overview of the aims and initial investment there is no Programme Brief that captures the overall picture including:

- Objectives and background: the main vision and purpose, key drivers and deliverables, timescales and success criteria
- Scope: list of individual projects making up this change programme
- Benefits: identification and quantification of key benefits
- Timeline, critical path and key dependencies (internal and external)
- Key assumptions and constraints
- Finance: for individual projects and the overall programme
- Risks and issues: the main risks/issues identified and management processes
- Stakeholders: a stakeholder map and approach to communications & engagement
- Governance: roles and responsibilities of decision making bodies and key players

Recommendation 1: Prepare a Programme Brief to define scope, required benefits / outcomes and delivery arrangements.

2: Business case and stakeholders

Business Case

The RT was advised that NTDA and NHS England have facilitated the BCT Programme's development of a wrap-around SOC in support of investment proposals to achieve system wide change, and this includes the full scope of the UHLRP.

This provides a very helpful means of providing the wider context to changes to be delivered by local health and social care partners and it is understood that with this in

place, NTDA has authorised UHL to proceed with Outline Business Cases (OBC) for the specific projects within the UHLRP.

Whilst this provides an agreed way forward, it is important that the UHLRP recognises that 2 of its 16 projects still exceed the £50million threshold for seeking Department of Health and HM Treasury approval. Accordingly, activities will need to be re-planned to absorb the additional approvals period (or to negotiate additional time for delivery with NHSTDA).

Discussions indicated that the current programme is capital investment led, whereas there is a recognition that the focus needs to be changed to make the process clinically led, and for estate proposals to be built on the clinical service transformation. The RT endorses this policy.

Stakeholders

The RT was advised during interviews that a Stakeholder Management Plan and Communications Strategy is being developed for the BCT programme and that it is intended for this to cover the needs of the UHLRP.

During discussions it was recognised that some UHLRP components, such as the Multi Storey car park project, will not necessarily be covered by the BCT document. Accordingly, the UHL needs to develop its own supplementary plans for embracing the full breadth of UHLRP proposals.

The RT was able to confirm during interviews that the East Midlands Ambulance Service NHS Trust (EMAS) is involved in planning the BCT and UHLRP programmes. It should be noted however that the recent BCT Blueprint document does not include EMAS in the list of local partners. This omission should be addressed in future publications to do justice to the far reaching involvement and buy in to the programmes.

Public Engagement and Consultation

By way of background, the RT noted that various engagement and consultation exercises have previously taken place and as a result there is a general recognition of the need for reconfiguration. This has clearly generated a good foundation for the work which is now being progressed.

The RT was provided with details of the Better Care Together 5 Year Plan, which was published in June 2014 as the basis for engaging with the public on the BCT Programme proposals.

The RT was advised that a joint working group has been set up to plan future engagement and the formal consultation process(es) to follow.

In discussions it was made clear that the impact of the General Election in May 2015 is likely to mean that the bulk of proposals will not be put forward until post-election.

This generates a degree of uncertainty in planning a number of projects, but in particular, plans to gain approval to transfer level 3 ITU services from the Leicester General Hospital to the Glenfield and Leicester Royal sites.

The RT was advised that discussions with Health Overview and Scrutiny partners indicated an understanding of the proposals and recognition that exercises in previous years may enable some matters to be allowed to progress without further examination.

In light of the potential delays and consequences (in particular clinical) which could be generated through challenges to the process, and the need to move quickly, the RT recommends that legal advice should be sought to inform selection of the changes to be submitted and the strategy for progression of the Consultation process.

Recommendation 2: Seek legal advice to assist in evaluating the scope of the proposed consultation and strategy for implementation.

3: Management of intended outcomes

The UHLRP is currently being progressed by the SRO with very limited resources, and provided in part through an external consultancy. Whilst it is known that some work is being done to identify resource for the programme office function, this is only recent and comes at a late stage.

Given the nature and scope of changes proposed through the Programme, and its importance to the future sustainability of the organisation, UHL should take immediate steps to adequately support the management of the programme. This should include:

1) appointing a permanent dedicated Programme Director preferably with a strong background of NHS programme delivery
2) appointing Programme Office staff, with the capacity to support the Programme with:

    a) programme documents (e.g. brief, benefits, definition document)
    b) project management documents (e.g. brief, initiation document)
    c) programme and project reporting
    d) programme and project planning
    e) risk coordination, tracking and reporting
    f) benefits planning, tracking and reporting

These appointments should support the Trust's wider strategy of building up its own skill base and achieving a transfer of knowledge from external consultants, to create longer term delivery capability.

Recommendation 3: Appoint a dedicated Programme Director, together with supporting Programme Office support.

With the Trust mobilising to take forward a broad range of service and estate development proposals, it is vital that the Programme Director should oversee development of a resource plan for areas of support, for both internal and external staff / service providers, to support the delivery of required outcomes. This would include external professional advisors such as healthcare and workforce planning, design team, legal advice and planning advice.

This will also involve significant input from Trust staff and it will be essential that these staff are given sufficient time, away from their usual duties, to contribute to the development of the project plans. This will involve a range of staff including HR, communications, general managers, finance and clinicians. It will be particularly important to recognise that clinicians will have an important role in the service design phases of the projects and may require support to ensure patient activity is not compromised.

Recommendation 4: The Programme Director should lead process of developing a resource plan including a strategy for recruitment / procurement.

As part of developing the Programme Plan, it is important that all the interfaces and dependencies with other programmes and projects are mapped and any implications fully understood: Although it is known that many of the changes and efficiencies can be achieved by the Trust without any external assistance. There are a number where the Trust cannot deliver the required outcomes without actions being undertaken by other organisations, such as emergency admission avoidance.

It will also be important for the Trust to be clear about the priority and phasing of the 16 UHLRP projects. It is understood that the Emergency Floor and Vascular projects are well advanced and that OBCs have been completed for each and are with the NTDA for approval. Recent events, such as the level 3 ITU beds and the proposed change to Children's services, will have an impact on the phasing of the remaining projects. These will need to be discussed internally and with BCT partners, to agree the dependencies and to finalise the phasing.

Both of the above measures will assist with developing the Programme Plan, project timelines and the critical path.

4: Risk management

The RT was advised that at this early stage in UHL RP lifecycle, no formal risk management arrangements are in place at Programme level. However risk registers do exist for current projects (eg Emergency Floor).

Given the importance of this Programme in delivering clinical and financial sustainability for the Trust, the large capital investment involved, tight timescales, emerging operational risks (e.g. Level 3 ITU), and the key internal and external dependencies (BCT Programme) it is critical that a well-resourced and robust risk management approach is developed.

The RT would anticipate the following features of a successful arrangement:

- A robust, systematic method of identifying and managing the risks and issues. This needs to align with the Trust's risk management strategy, and feed into other linked Programmes (BCT).
- The UHLRP Programme Office to lead and coordinate the risk management process at project and programme level (including maintaining and updating risk and issue logs).
- An escalation process which ensures risks are raised at the right levels of the organisation for attention.
- Appropriate skills and resources to manage this process (eg risk manager)

Recommendation 5: Develop and implement robust risk management arrangements, including appropriate arrangements for escalation and linkage to other Programmes.

The RT noted the prevailing risk profile for the programme includes:

- The scope of change is material, including moving from 3 acute sites to 2 and making significant reductions in acute inpatient capacity
- The timescale for delivery is recognised as being very ambitious
- The capital investment profile is large and likely to come under close external scrutiny (which could delay progress)
- Capital investment allocations are recognised as being at the lower end of the benchmark scale for development
- There are significant interdependencies between organisations for planning and delivery of major changes (such as bed reductions)
- A formal Public Consultation will be required to inform the final change profile and it is likely that the process will not be able to complete for the majority of proposed changes until after the 2015 General Election

5: Readiness for the next phase: Delivery of outcomes

Interviews indicated that that the Reconfiguration Programme has gained momentum over the past few months after a period of inaction. The RT heard from a range of

key external stakeholders that they supported the UHL change programme and that this should now be delivered at the earliest opportunity. These changes, linked with the other initiatives being undertaken as part of the overarching BCT Programme, would deliver a sustainable future for the Trust and the local health and social care economy.

Interviews indicated that relationships between the health and social care partners in the BCT Programme were improving. It is important that this continues, not only at senior staff levels but also between those staff who will be delivering the changes across the health economy. This is an issue that will require careful management by all the organisations involved and will be assisted by the BCT Programme having clear objectives and agreed delivery plans.

The UHLRP includes substantial transformation of clinical services. The RT noted that the Emergency Floor project included a process of securing independent assurance in relation to its planned service transformation. The RT commends this approach and would recommend that this be extended to apply to all projects, ensuring that a process is in place to appraise the impacts on all affected services.

An Assurance of Action Plan should be completed within 4 months of this review.

The next Health Gateway 0 Review is expected within 12 months of this review.

APPENDIX A

Purposes of Health Gateway Project Review 0: Strategic assessment

- Review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to the overall strategy of the organisation and its senior management.
- Ensure that the programme is supported by key stakeholders.
- Confirm that the programme's potential to succeed has been considered in the wider context of the organisation's delivery plans and change programmes, and any interdependencies with other programmes or projects in the organisation's portfolio and, where relevant, those of other organisations.
- Review the arrangements for leading, managing and monitoring the programme as a whole and the links to individual parts of it (e.g. to any existing projects in the programme's portfolio).
- Review the arrangements for identifying and managing the main programme risks (and the individual project risks), including external risks such as changing business priorities.
- Check that provision for financial and other resources has been made for the programme (initially identified at programme initiation and committed later) and that plans for the work to be done through to the next stage are realistic, properly resourced with sufficient people of appropriate experience, and authorised.
- After the initial review, check progress against plans and the expected achievement of outcomes.
- Check that there is engagement with the market as appropriate on the feasibility of achieving the required outcome.
- Where relevant, check that the programme takes account of joining up with other programmes, internal and external.

APPENDIX B

Interviewees (University Hospital of Leicester NHS Trust unless otherwise stated)

Name	Role
1. Kate Shields	Director of Strategy and Programme SRO
2. Richard Kinnersley	Major Capital Projects Technical Director
3. John Jameson	Consultant Surgeon (Surgical Clinical Director)
4. Jeff Worrall	Portfolio Director (NHSTDA)
5. Mick Connell	Director of adults and Communities (Social Services), Leicestershire County Council
6. Dr Peter Miller	Chief Executive of Leicestershire Partnership NHS Trust
7. Paul Gowdridge	Head of Strategy Finance
8. Richard Mitchell	Chief Operating Officer
9. Ian Turnbull	Deputy Director of Strategy & Planning (East Midlands Ambulance Service)
10. Richard Power	Consultant Orthopaedic Surgeon
11. John Adler	Chief Executive
12. Christopher Allsager	Consultant Anaesthetist
13. Toby Sanders	Managing Director (West Leicester Clinical Commissioning Group)
14. Mick Cawley	Director of Finance (Better Care Together)
15. Sue Locke	Acting Managing Director (Leicester City Clinical Commissioning Group)
16. Mark Wightman	Director of Communications
17. Ellie Wilkes	Health Care Advisory Section, Ernst & Young
18. Emma MacLellan-Smith	Health Care Advisory Section, Ernst & Young

APPENDIX C

Summary of recommendations

The suggested timing for implementation of recommendations is as follows:-

Do Now – **To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately.**

Do By – To increase the likelihood of a successful outcome the programme/project should take action by the date defined.

Ref. No.	**Recommendation**	**Timing**
1.	Prepare a Programme Brief to define scope, required benefits / outcomes and delivery arrangements.	Do now
2.	Seek legal advice to assist in evaluating the scope of the proposed consultation and strategy for implementation.	Do now
3.	Appoint a dedicated Programme Director, together with a supporting Programme Office support.	Do now
4.	The Programme Director should lead process of developing a resource plan including a strategy for recruitment / procurement.	Do by Dec 14
5.	Develop and implement robust risk management arrangements, including appropriate arrangements for escalation and linkage to other Programmes.	Do by Jan 15

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper I

TRUST BOARD – 22 DECEMBER 2014

Better Care Together, Strategic Outline Case, Project Initiation Document – Key Issues for University Hospitals of Leicester NHS Trust

DIRECTOR:	John Adler, Chief Executive; Kate Shields, Director of Strategy
AUTHOR:	Helen Seth, Head of Local Partnerships
DATE:	22 December, 2014
PURPOSE:	To present the Strategic Outline Case and Programme Implementation Plan (PID) for Leicester, Leicestershire and Rutland health and social care partners (LLRHSSC) and to highlight the implications for UHL.
PREVIOUSLY CONSIDERED BY:	Executive Strategy Board, 9th December, 2014
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [x] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [x] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [x] 5. Enhanced reputation in research, innovation and clinical education [x] 6. Delivering services through a caring, professional, passionate and valued workforce [x] 7. A clinically and financially sustainable NHS Foundation Trust [x] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Patient and public involvement has been an integral part of the development of the LLRHSC plans to date. This will continue on a project by project basis during implementation.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Once the overall plan has been agreed, an Equality Impact Assessment (EIA) will be undertaken on the whole plan. In addition to this an EIA will be integral to each individual business case.
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [x] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED * For decision [X] For assurance [ ] For information [ ]	

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do ♦ We focus on what matters most ♦ We are one team and we are best when we work together♦ We are passionate and creative in our work* tick applicable box

Better Care Together
Strategic Outline Case (SOC) and Project Initiation Document (PID)

PURPOSE

1. The purpose of this paper is to seek approval for the Better Care Together Strategic Outline Case (SOC) and Programme Implementation Plan (PID) for Leicester, Leicestershire and Rutland health and social care partners.

2. The paper identifies key issues and mitigations that the Trust Board will want to be aware of and provides an opportunity for the Board to consider whether the governance arrangements and structures within UHL and external to it are sufficiently robust to oversee the transformation of local services and assure long-term clinical, operational and financial viability of the LLR system and UHL.

BACKGROUND

3. The SOC and PID are the key approval documents developed by the Better Care Together Partnership Board. These documents effectively form LLR's vison for the future of which an integral component is UHL's own 5-year plan. They align to the planning assumptions within our own 5 Year Plan and are completely compliant with the national policy direction set out in the 'NHS Five Year Forward View'.

4. There is nothing suggested in the SOC which is not included in our own 5-year plan.

5. The SOC is designed as a "wrapper" for all the future transformation business cases which will be required for the LLR system to achieve its five year vision.

6. The purpose of the SOC is to describe the case for change for service configuration across LLR and to describe a high level programme of work for making this happen.

7. The PID is essentially a programme management document. Amongst other things, it addresses the issues raised during the largely positive programme Gateway review. The Chief Executive has been involved in the development of the PID and related resourcing discussions in his role as joint Senior Responsible Owner of the BCT Programme. He is satisfied that the PID appropriately describes the structures and processes required to take forward the programme. The key policy issues therefore relate to the SOC rather than the PID.

KEY ISSUES AND DISCUSSION POINTS

7. **Vision for services in LLR**-The BCT vision for the future is one in which the community model of care is transformed, with a greater emphasis on prevention and far more provision of care taking place outside of hospital within primary, community and home care settings. The consequence of this will be less reliance on the acute sector. This aligns to the Trust's vision of becoming of "smaller and more specialised".

8. The case for a smaller acute hospital base is supported by several bed utilisation reviews and more recently by the detailed analysis undertaken to understand the likely cohorts of patients whose care could be contained or continued in alternative settings.

9. What will need to be very carefully managed is the transition from the current model of care to future models of care. **It is essential that beds are not removed from the system until the alternatives have sustainably reached scale and are delivering the level of care and outcomes anticipated**.

10. Eight clinical pathways have been described in the SOC and these set the vision for revised service models in the future. Examples include new models for urgent care, planned care, long term conditions and care of frail older people.

11. The vision for clinical services across LLR is completely compliant with the recently released national policy direction.

12. **Working in partnership to secure delivery**-Delivery of the new models of care will require health, social care and commissioners to work as a 'system' and to jointly design and safely deliver effective services that are tailored according to need.

13. It will require new pathways of care to be developed that have less reliance on acute and in patient models of care. This will require UHL to work in different ways both inside our organisation and outside it. It also creates a co-dependence between UHL and other health and social care partners – this represents a step change from current models of care and will require a cultural shift in practice and behaviours within and across organisations.

IMPLICATIONS FOR UHL

14. **Bed reductions**-The LLR strategy will realise a significant proportion of the health economy benefits through a reduction in the number of acute beds and the associated physical assets. The current bedded model of service provision across the LLR system includes 1773 acute beds across 3 acute hospital sites, 660 community and mental health beds in eight community hospitals and one mental health hospital. The shift of activity to community settings will involve UHL releasing a total of 571 acute beds (taking account of demographic growth), this equates to 462 physical beds. This is achieved through a combination of a) increases in internal productivity , b) provision of alternative services to avoid acute admission and c) earlier discharge to sub-acute services delivered in community hospitals or people's own homes.

15. **Workforce changes**-Workforce will be a key enabler to the delivery of the LLR strategy and will require a significant shift in skill mix from secondary to community care with new ways of working across organisational boundaries and traditional disciplines. The scale and pace of change required will create the greatest challenge to delivery.

16. **Transitional and transformational funding**-The financial case in the SOC sets out the need for external funding once existing sources of funding within the health economy have been exhausted.

17. The funding required is split between £255.8m of revenue (including deficit funding) and £430.3m of capital. Within this the funding for UHL is £175.2m to support the forecast deficit, £88.5m as transitional revenue funding and £286.3m capital resource. This temporary support will be required throughout the period to 2018/19.

18. Due to the forthcoming election in May 2015, it is very likely that the SOC will not be approved until after that.. This causes a tension with there being a growing need for some of UHL's major business cases to be delivered earlier than previously anticipated. It is intended that the SOC used as a "wrapper" for the UHL business cases and therefore any delay in the approval of the SOC may delay the progress of the business cases. This is an issue which is currently under discussion with the NTDA. In addition, there is likely to be a need to for transitional and transformational support prior to the approval of the SOC. How to resolve this timing conflict is being discussed with both the NTDA and NHS England.

19. The SOC is predominantly focused on additional revenue expenditure associated with the transformation programme e.g. major business case development, project management, capital charges, premium staffing and service transformation. It may not fully not reflect all of the income loss UHL is likely to experience before the Trust is in a position to take out fixed costs. This transitional income relief will need to be negotiated with LLR partners as part of contractual negotiation.

20. **Dependence on partners**-Delivery of the changes outlined in the SOC will only be achieved if all partners play their part; UHL will not be able to achieve the bed reductions identified without commissioners and primary care managing flow into UHL, with Leicester Partnership Trust and Social Care supporting timely egress from UHL. The Trust is critically dependent on all partners doing their part in order to secure our vision of moving from 3 acute sites to 2.

21. **Clinical and financial sustainability**-The SOC explored a number of alternative options for delivering the vision set out in the five year strategy including organisational efficiencies and ceasing delivery of non-agreed services. The outcome of the evaluation is that the BCT programme is the only viable option to deliver the qualitative benefits for patients and service users, in a way which is achievable and affordable. For UHL this means that the vision of moving from 3 acute sites to 2 and becoming smaller and more specialised is the only realistic option to secure clinical and financial sustainability.

KEY MITIGATIONS

22. There are a number of very significant implications for UHL in the BCT SOC. It is essential that we develop robust risk and mitigation plans. In summary these include:

23. **Contractual form and structure**-The current contracts in place between commissioner and provider will not support the necessary flow of funds to support and incentivise the transformation outlined. UHL require transitional funding to mitigate the impact of income loss whilst LPT and Social Care need to be incentivised to support early movement of patients out of UHL. Discussions are on-going to agree a more appropriate contractual form that will support and incentivise all partners to deliver their part of the change. These new models are intended to be in place for the 2015/16 contracting round.

24. **Clear metrics**-As the delivery of the plan requires all partners to deliver their part it is essential that there are clear metrics developed to show progress over time for all of the work streams identified. This will support and drive accountability between all partner organisations.

25. **Clinical leadership**-Clinical leadership will be critical to success. Active engagement of UHL clinicians in driving clinical change is essential and is already growing particularly is support of the out of hospital community shift between UHL and LPT.

26. **Governance**-A robust governance structure is already in place for the BCT programme and is aligned to our own governance structures and processes. This has been enhanced recently through the development of a UHL PMO for reconfiguration.

27. Organisational responsibilities – The NHS "Forward View" sets out a number of organisational models which could be used to effectively implement the kind of radical change described in the SOC. How best to use such models locally is the subject of ongoing discussion within the local health economy and will be further debated at a Trust Board Development session in the New Year.

RECOMMENDATIONS

27. The Trust Board is asked to:

- **RECEIVE** this paper;
- **DISCUSS** the issues and mitigations and confirm that they adequately address the key factors identified;
- **APPROVE** the Better Care Together SOC and PID**AUTHORISE** the Chief Executive to pursue the key actions set out in this paper in conjunction with partners

Better care together

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

November 2014

Better Care Together

Strategic Outline Case

November 2014 v4.5

For discussion and review

Contents

List of Tables

Glossary of Terms

Term	Definition	Term	Definition
A&E	Accident and Emergency	LETC	Local Education and Training Council
ASC	Adult Social Care	LIFT	Local Improvement Finance Trust
BADS	British Association of Day Surgery	LLR	Leicester, Leicestershire and Rutland
BCBV	Better Care Better Value	LoS	Length of Stay
BCF	Better Care Fund	LPT	Leicester Partnership NHS Trust
BCT	Better Care Together Programme	LRI	Leicester Royal Infirmary
CAMHS	Child and Adolescent Mental Health Services	LTCs	Long Term Conditions
CCG	Clinical Commissioning Group	MH	Mental Health
CEO	Chief Executive Officer	MIU	Minor Injuries Unit
CFO	Chief Finance Officer	NEL	Non-Elective
CIP	Cost Improvement Programme	NPC	Net Present Cost
CQUIN	Commissioning for Quality and Innovation	OBC	Outline Business Case
CRL	Capital Resource Limit	OGC	Office of Government Commerce
CSF	Critical Success Factors	PDC	Public Dividend Capial
DMU	De Montfort University	PH	Public Health
DNA	Did Not Attend	PID	Programme Initiation Document
DTOCs	Delayed Transfers of Care	PMO	Project Management Office
EMAS	East Midlands Ambulance Service	PPI	Public and Patient Involvement
FBC	Full Business Case	QIPP	Quality, Innovation, Productivity & Prevention
GP	General Practitioner	RTT	Referral to Treatment
HEI	Higher Education Institution	SOC	Strategic Outline Case
HSCE	Health and Social Care Economy	TSA	Trust Special Administrator
IM&T	Information Management and Technology	UCC	Urgent Care Centre
IO	Investment Objectives	UHL	University Hospitals Leicester NHS Trust
LD	Learning Disabilities	WIC	Walk in Centre

1 Executive Summary

1.1 Introduction and scope of this document

In June 2014 the Local Health and Social Care Economy (LHSCE) developed a 5 year strategic plan setting out its ambition to transform local services in line with the models of care set out by the Better Care Together (BCT) programme.

BCT sets out a vision to improve health and social care services across LLR (Leicester, Leicestershire and Rutland), from prevention and primary care through to acute secondary and tertiary care. Successful delivery of this programme will result in greater independence and better outcomes for patients and service users, supporting people to live independently in their homes and out of acute care settings. The vision set out by the programme is in line with the strategic direction set out by NHSE's Five Year Forward View, and responds to the challenge set out more widely in A Call To Action, delivering sustainable clinical change at a time of growing financial pressure.

The purpose of this Strategic Outline Case (SOC) is to appraise whether the BCT programme is the best way of addressing the local case for change. In assessing the programme against a range of Critical Success Factors (CSF) it finds that the path laid out in the five year strategy is the only viable way of achieving clinical and financial sustainability in LLR. The document makes the case for the external funding that will be collectively required through the transition period from 2014/15-2018/19. It should be read in the context of BCT's Programme Initiation Document (PID) and the 5 year strategy which preceded it, both of which are key building blocks for this business case.

This document is the result of extensive collaboration and is jointly authored on behalf of East Leicestershire and Rutland Clinical Commissioning Group (CCG), Leicester City CCG, West Leicestershire CCG, Leicestershire County Council, Leicester City Council, Rutland County Council, Leicestershire Partnership NHS Trust (LTP) and University Hospitals of Leicester NHS Trust (UHL). A partnership approach is vital to the development and delivery of BCT as the problems faced by the LHSCE cannot be solved by any of these organisations working independently. EY have supported the development and compilation of the SOC in partnership with the Programme PMO and the organisations listed above. During this process all assumptions and figures have been signed off at regular stages with CFOs, COs and AOs to ensure clear oversight is maintained.

The SOC is designed to be a "wrapper" for all the future transformation business cases which will be required for the system to achieve its five year vision. The period of development has allowed local organisations to come together in the joint design of more detailed implementation plans, adding detail to the system projects set out in the 5 year strategy, and identifying the transitional support required to deliver these sustainably.

Further work will be required following the submission of this document to prepare for the series of organisational business cases that will need to be produced. These business cases will need plans to be worked through in granular detail, and the plans will need to be predominantly taken forward under the joint governance already established by BCT. This will help mitigate the risks posed by the interdependencies set out in the SOC, particularly in areas such as the beds reconfiguration, and a joint approach will help with the vital task of assessing the likely impact of NHS plans on local social care organisations, and conversely of the impact on the NHS of the significant efficiency savings required from local government over the same period.

1.2 Structure of this document

The SOC has been prepared using the Office of Government Commerce's (OGC's) Five Case Model to provide a structured approach in producing the SOC.

The five perspectives that the Five Case Model explores are set out below:

- **The Strategic Case** explores the case for change – exploring why the proposed investment is necessary in the LHSCE and how it fits with the overall local and national strategy
- **The Economic Case** asks whether the solution being offered represents value for money – it requires alternative solution options to be considered and evaluated
- **The Commercial Case** reviews the different approaches to funding the programme and also reviews the relevant commercial arrangements to the decision making process.
- **The Financial Case** asks whether the financial implication of the proposed investment is affordable and sets out the requirements for Non-Recurrent funding to support the developments described
- **The Management Case** highlights implementation issues and demonstrates that the LHSCE is capable of delivering the proposed solution

1.3 Strategic case

The strategic case builds on the models of care developed in the 5 year strategy, and sets out how the BCT vision will be achieved. This vision is:

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

The vision for the LHSCE is to improve outcomes for patients and service users whilst maintaining an affordable system which can be safe for future generations. It sets out a case for change for the health economy which requires broad changes to models of care to change the traditional reliance on acute-based care, develop more services in the community, and improve primary prevention and identification of people at risk of significant deterioration in their health and quality of life earlier than ever before.

The financial challenge set out in this document is significant. Modelling conducted during the development of the 5 year strategy shows that the total gap between income and expenditure for the NHS element of the LHSCE in 2018/19 is £398m before any CIP/QIPP or other projects are modelled. This was in the context of virtually no anticipated increases to real terms funding over the 5 years, and anticipated increases in the forecast demand brought about by the ageing population and greater numbers of people living with multiple long term conditions. In addition to this, cuts to local government funding have been even more severe, with councils under pressure to radically change the provision of adult social

care over the next 5 years. The overall impact of this funding shortfall in local government is not yet fully known as it is dependent upon political decisions at both a national and local level and the impact of the recent Care Bill is yet to be fully assessed, however it is clear that the way we currently deliver services will not be sustainable in the future.

The strategic case develops a vision for the future in which the community model of care is transformed, with far more provision of care taking place outside hospital in primary, community and home care settings. Reviews which have taken place at UHL suggest that a significant number of patients currently in acute beds do not require this enhanced level of care, and that patients can often deteriorate, with increasing levels of dependency the longer they stay in hospital. The plans set out in the strategic case, if fully enacted, will see a significant "left-shift" of care out of acute settings, allowing UHL to concentrate on providing care to complex patients and improving the provision of sub-acute services in community hospitals, and the development of greater capacity in community teams allowing patients to live more independently in their homes. This "left shift" is planned across the spectrum of prevention and care, supporting as many people as possible to live independently through better education and preventative programmes.

The drive to improve health and social care integration has begun. The Better Care Fund (BCF) will begin to support independent living for patients and service users and the LHSCE will look to develop this model further. The joint health and social care fund has been introduced in 2014/15 and will be expanded in 2015/16 to cover a range of health and social care projects. Many of these changes to services will be targeted at the frail older population and therefore a number of the initiatives are captured in the section of the strategic case which describes the frail older people (FOP) workstream. The BCF is a key enabler to change and represents the co-dependence of NHS and adult social care services. The 5 year strategy modelling recognised this importance by assuming that the funding associated with the BCF would be continued through the latter years of the plan, however further work is required to ensure that sufficient support is available to social care over the period of transformation.

It is anticipated that these changes will lead to the reduction of 427 beds at UHL, and allow the organisation to achieve its vision of moving from 3 to 2 acute sites by 2018/19, a core strategic objective. However, these changes will require a significant increase in capacity in primary care, social care and community care, and in order to affect these changes at a time when services will necessarily be undergoing disruption requires that plans are put in place during this transition period to allow the changes to the model of care to be made safely and sustainably.

Local estates, IM&T and workforce across health and social care will undergo significant changes over the 5 years of the plan with opportunities for greater sharing of resources including the estate. Some of these have already formed the basis of detailed plans, such as the series of estates changes planned across the UHL sites (e.g. the new emergency floor), however a number of stages of new community estates development are now captured in the SOC to ensure existing facilities are fit for purpose. This is particularly the case for primary care, where CCGs will transform the current offer to improve access for the most complex patients, with some services developed at a locality or "health neighbourhood" level to improve quality.

Workforce remains the single biggest challenge for the transformation of services. New community facilities, services and teams will require significant recruitment and much of this will need to come from the existing workforce as more services are provided outside of an acute setting. The emerging models of care will require a review of both generalist and specialist skill balance; the need to ensure a supply of nurses becoming community focused

over time; and the need to ensure more social care staff are available to support people at home.

1.4 Economic case

The economic case explores the potential alternative options for delivering the vision set out in the five year strategy. Three alternatives are considered:

i) Delivery through the BCT strategy;
ii) Delivery of financial balance through organisational efficiency alone (do minimum option); or
iii) Ceasing delivery of non-agreed services to regain financial balance.

It finds that when set against the CSF adopted by the programme and set out in the PID, the BCT programme option is the most able to deliver the qualitative benefits for patients and service users, in a way which is achievable and affordable. Delivery of financial balance through organisational efficiency alone, without working as part of system, would require internal organisational savings programmes well above the level deemed sustainable, and in addition would pose significant risks to the integrated working which has underpinned the programme so far. An alternative option of ceasing delivery of non-agreed services was also considered, however the impact on patient safety and the risks posed by an uncertain legal process were considered to be too great for the LHSCE to take on.

Given this qualitative discussion, the BCT programme was economically assessed against the "do minimum" option. The do minimum option assumed that organisations attempted to make savings until such point as they were deemed to be unsustainable, at which point it was probable that an external party would place one or both local providers into an administration process, adding further cost and delay to the decision to find a sustainable solution. The anticipated impact of this delay and additional uncertainty has been calculated in the economic case and the net present cost was compared against the BCT option, as below:

Costs/(Benefits)	RANK	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)	Total (£m)
BCT Option	1	(31,580)	74,785	93,990	103,778	19,166	(78,422)	(66,711)	115,007
Do Minimum Option	2	(29,878)	84,079	101,808	106,918	16,677	(62,014)	(84,946)	132,644

The conclusion of the economic case is therefore that the LHSCE should support the BCT programme as the only viable way of achieving quality and financial sustainability across LLR.

1.5 Commercial case

At this stage the commercial case has been limited to a discussion of potential options for financing the transition support set out by the programme. The most likely procurement route to be followed for this scheme is through a combination of existing Capital Resource Limited (CRL) funds and additional Public Dividend Capital (PDC) loans. This offers flexibility to organisations within LLR around fully shaping the design of services and assuring a focus on quality. Utilisation of internal NHS funds has the benefit of being the cheapest form of long term capital likely to be available for such projects.

1.6 Financial case

The financial case sets out how the BCT programme will allow the health economy to respond to the £398m identified gap by 2018/19. It is vital that this challenge is understood

as one which is owned by all organisations. The approach to modelling has been to formulate a single health economy wide understanding, based upon agreed assumptions concerning demographic growth and known funding levels. The interrelationship between the work being taken forward within each clinical workstream and the significant savings required from each organisation is key. The NHS organisations cannot achieve collective financial surplus without working closely together.

Although in the financial breakdown the majority of savings that need to be delivered are shown against UHL and LPT, in reality these organisations will not be able to achieve this without the system projects which are being led by each of the 8 clinical workstreams. The workstreams' impact feeds into the beds reconfiguration programme which allows UHL to consolidate from 3 to 2 acute sites and therefore make a significant recurrent saving by 2019/20.

The financial case sets out the case for external funding required, split between **£255.8m** of revenue (including deficit funding), and **£430.3m** of capital, once existing sources of funding within the health economy have been exhausted. This temporary support will be required throughout the period to 2018/19 where the health economy will reach recurrent surplus.

It is important to note that the projected gap of £398m only reflects the NHS impact of the changes that are taking place. Further work is needed to understand the implications of this programme on local government budgets, and in addition to understand the future impact of significant changes to social care services on corresponding health services. This will be the subject of an ongoing joint programme of work.

1.7 Management case

The management case sets out the importance of managing the BCT programme in a joined up and inter-dependent way. The joint health and social care governance structure establishes the importance of the clinical workstreams as the drivers of change across the health economy, and represents the significance of their role in enabling the major changes to take place at UHL and LPT.

The programme will be overseen by the BCT Partnership Board, overseen by the joint SROs who have been in place since July 2014. A joint approach to risk and benefits management has been developed and the jointly funded PMO established to ensure that the complexities and interdependencies of the programme are appropriately managed.

1.8 Conclusion

The conclusion of this SOC is that after a qualitative and quantitative assessment of viable alternatives, the BCT programme represents the only viable way of ensuring the clinical and financial sustainability of services across LLR. Further work must now be completed on individual business cases and detailed organisational and workstream plans, to ensure a collaborative and coordinated approach is taken to the redesign of the health and social care system.

2 Strategic Case

2.1 Introduction to the strategic case

This section of the business case sets out the strategic context across the LLR LHSCE and makes the case for transformational changes to models of care. The new models proposed are then fully described before setting out the investment objectives, risks, constraints and dependencies associated with the BCT programme.

2.2 National strategic context

Health and social care services in England are at a seminal point in their history. The combined pressures of a growing and ageing population, rising public expectations and the ongoing squeeze on public finances mean that commissioners and providers must cooperate to commission and provide different service models.

The Keogh urgent and emergency care review[1]

Demand for health and social care services has been rising year on year – the following quotes are taken from the recent Keogh review into emergency and urgent care services:

- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008, indicating greater demand and complexity in primary care;
- There were 6.8 million attendances at walk-in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12 per cent annually since data was first recorded a decade ago;
- Attendances at hospital A&E departments have increased by more than 2 million over the last decade to 16 million;
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million; and
- Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13.

Growth in demand is set to continue as people live longer with increasingly complex, and often multiple, long term conditions (LTCs). This will have a profound impact on both NHS and social care budgets.

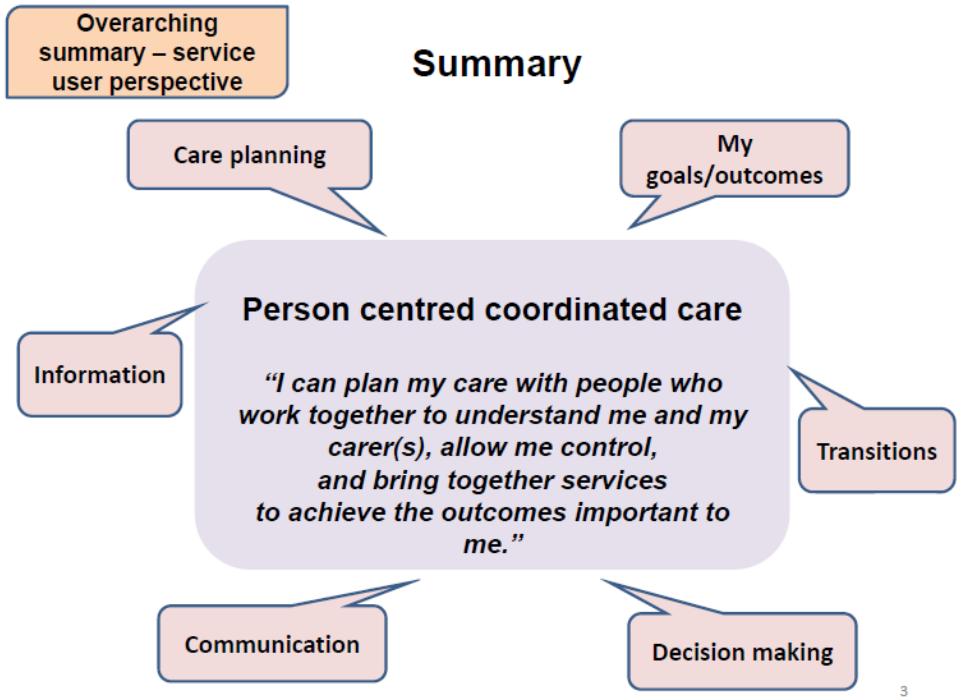
People's expectations are also rising. The NHS Constitution, a consumerist society and scandals such as Mid Staffordshire have created an environment in which the public rightly expect an NHS that can deliver world class services, with minimal delay in a setting the patient chooses. It is acknowledged that citizens want to; be fully engaged in making positive choices about their own health; participate in the shaping of health and social care services; have access to reliable data and advice about health and care services; and be able to choose which services they can use and how to access them.

[1] http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx

Person centred coordinated care

The public expect health and care services to be joined-up, but the system is fragmented between different commissioners and different providers. Work by National Voices on a "narrative for person-centred co-ordinated care"[2] demonstrates that this lack of integration and co-ordination is unacceptable to the public: instead people want co-ordinated care as summarised below.

Figure 1: Person centred co-ordinated care summary



Source: A Narrative for Person-Centred Coordinated Care, NHS England, 2013

National financial challenge

The government's deficit reduction plan involves significant cuts in public spending. The 2010 Government Spending Review[3] set out plans to reduce government funding for councils by 26% by 2014/15, whilst the 2013 Spending Round resulted in council resources being cut by a further 10% in 2015/16. Adult social care accounts for 18% of local authority spending, meaning that the pressure to reduce costs will inevitably impact on social care.

The settlement for the NHS has been more generous with the NHS budget being ring-fenced. However, the growing and ageing population, and rising expectations have resulted in demand for health services increasing by up to 5% each year. If demand continues to rise at historic rates, the NHS will face a growing budgetary shortfall despite its budget being protected. The 2011 "Nicholson Challenge"[4] represented the initial response with £20bn

[2] http://www.nationalvoices.org.uk/defining-integrated-care
[3] https://www.gov.uk/government/publications/spending-review-2010
[4] http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/512/51208.htm

being targeted from a budget of circa £110bn. The NHS is on track to deliver against the challenge by March 2015 but is now faced with the need to make further savings.

The government's response to these pressures has been a series of reforms to the public sector coalescing around the Health and Social Care Act (2012) and The Care Act (2014). Key points impacting on this business case are:

- The creation of the BCF bringing together elements of health and local authority funds, aimed at promoting integrated care;
- The promotion of joined-up commissioning;
- The introduction of a standard minimum eligibility threshold for social care;
- The introduction of a legal right to have a personal budget;
- Placing a legal responsibility of local authorities to issue a care and support plan to everyone receiving care, and a support plan for all carers; and
- Introducing a responsibility on local authorities to assess carer needs.

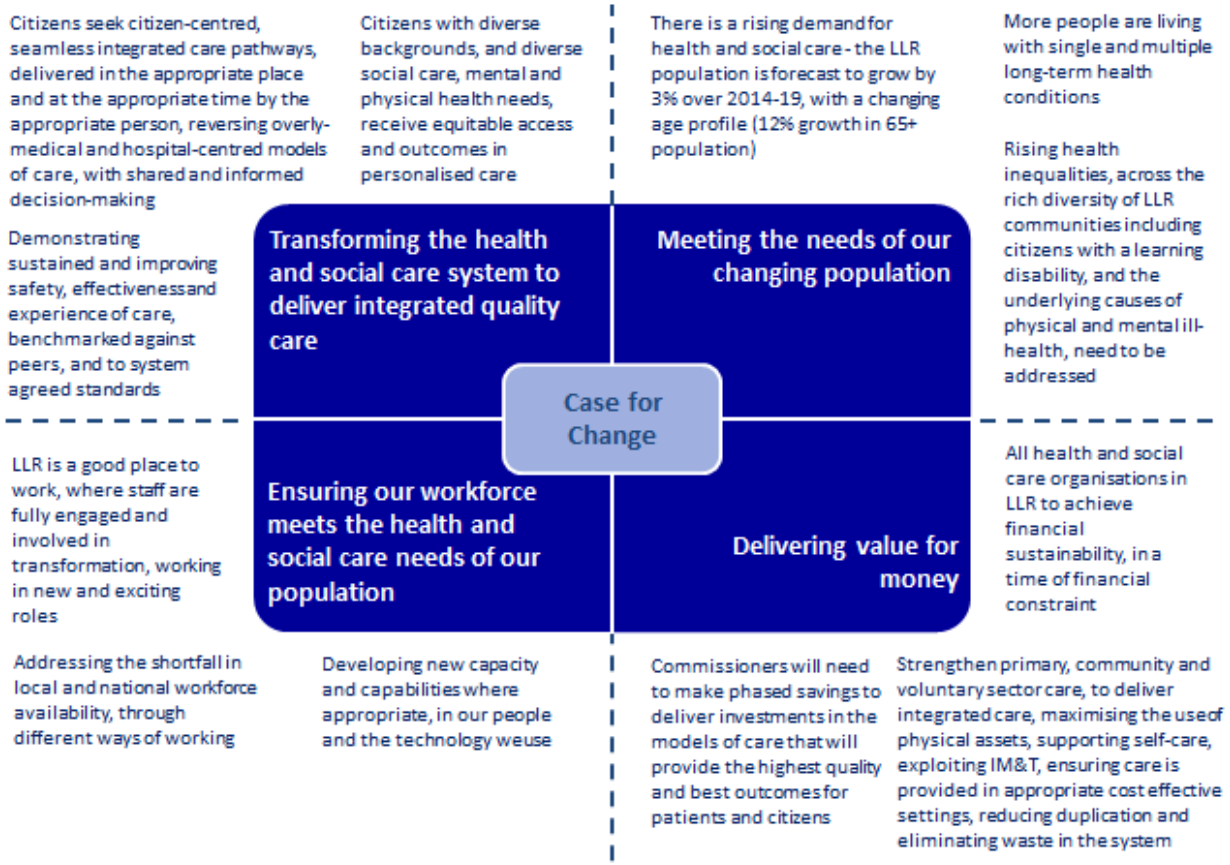
In NHS England's recently released Five Year Forward View[5], it is stated that "a combination of a) growing demand, b) no further annual efficiencies, and c) flat terms real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30bn a year". This requires organisations to find different ways of working to address these growing pressures and sets out a call for action on demand, efficiency and funding.

2.3 Local strategic context

The section above set out the national context. In this section the local case for change is set out. The following diagram provides a summary of the reasons the LLR system must change – each quadrant of the diagram is discussed in more detail below.

[5] NHS England 5 year view, October 2014, http://www.england.nhs.uk/ourwork/futurenhs/

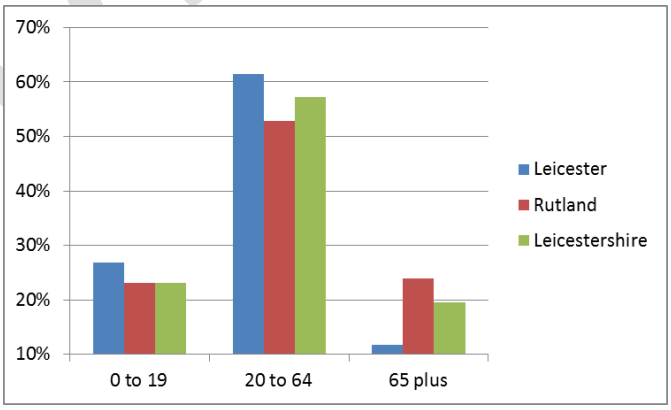
Figure 2: Summary case for change



2.4 Meeting the needs of our population

LLR has a population of 1.03 million with 32% of people living in the city, 64% in Leicestershire and 4% in Rutland. There are important differences between Leicester City, Leicestershire and Rutland – firstly the City of Leicester has a younger population; the county areas are markedly older.

Figure 3: Age breakdown of population, 2014[6]



[6] 2012 population estimates, Office of National Statistics

Secondly, the city of Leicester has a much more ethnically diverse population than county areas.

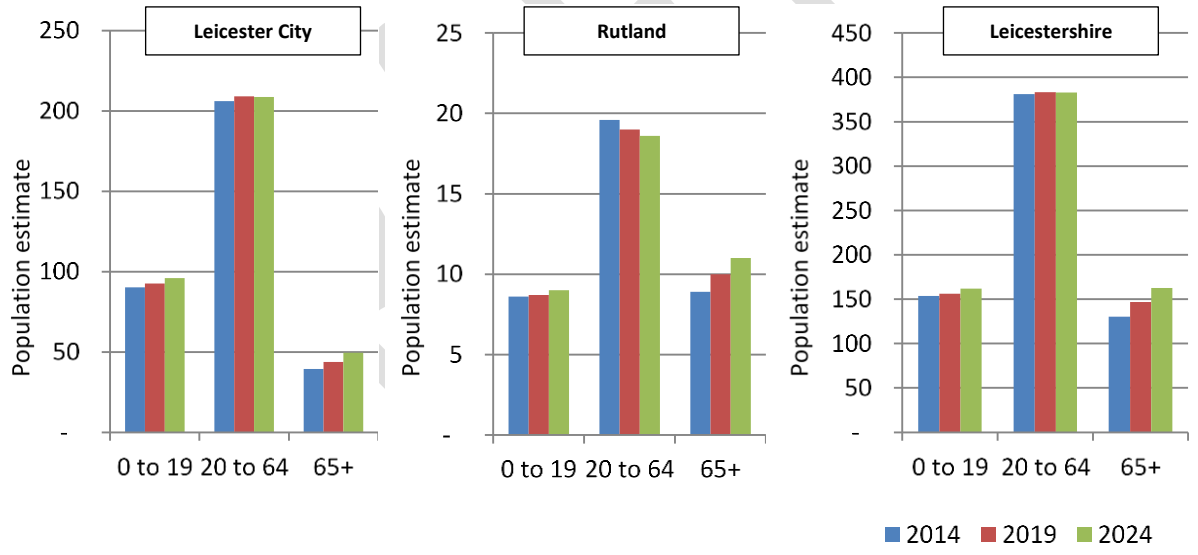
Figure 4: Ethnicity[7]

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

Service design and delivery must respond to these important differences particularly in terms of access to services – culture and language being potential barriers amongst minority ethnic communities in the city; poor access to transport being a potential barrier for older people living in Leicestershire and Rutland.

The population is also changing. The LLR population is forecast to grow by 32,100 (3%) by 2019. Expected growth rates vary marginally between the three local authority areas and more materially between different age groups.

Figure 5: actual forecast population change[8]



Relative demand for different health and social care services will be affected by these varying rates of demographic change. Whilst population growth is not particularly high overall, factors of more importance to note are as follows:

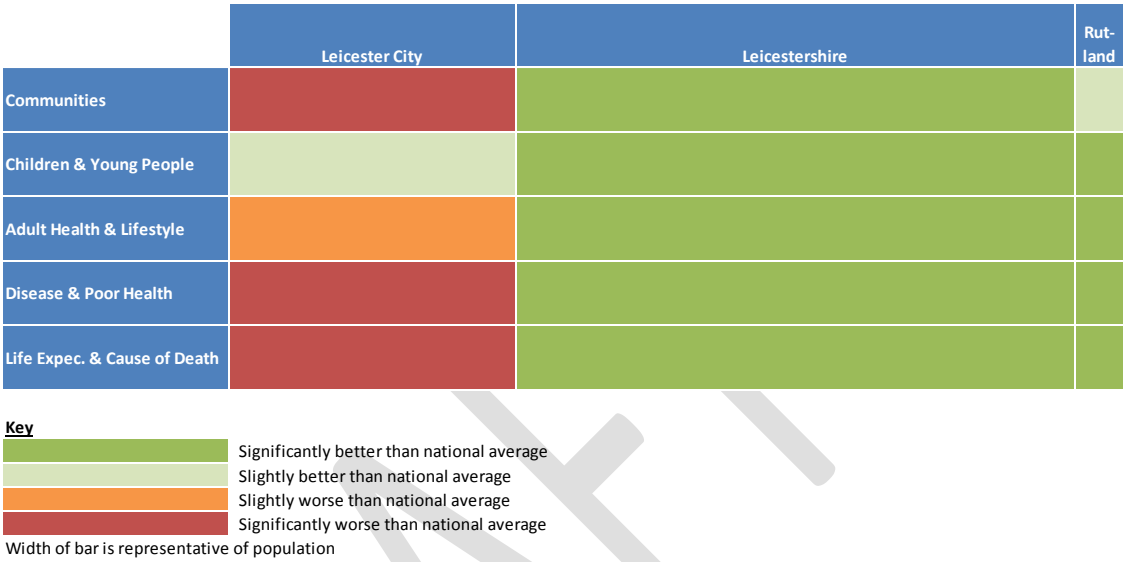
- A much higher percentage growth rate amongst the over 65s who are disproportionately represented in both NHS and local authority services;
- A faster rate of growth amongst young people in the city than elsewhere, which will impact upon services such as school nursing and paediatrics; and

[7] 2011 Census, Office for National Statistics
[8] Subnational population forecast 2012, Office for National Statistics

- Almost no growth in working age adult population, which suggests providers will need to look outside of LLR when recruiting the extra staff needed to cope with rising demand.

The relative demand for health and social care services, and the relative mix of service provided is also affected by underlying health of different populations. The diagram below provides a visual representation of which areas experience better or worse overall health compared to the national average.

Figure 6: Health profile 'heat map' of LLR[9]



Key underlying themes are summarised below.

Leicester city:

- 75 per cent of people are classified as living in deprived areas;
- There are significant problems with poverty, homelessness, low educational achievement, violent crime, long-term unemployment, poor diet, lack of exercise, alcohol and drug misuse, diabetes and tuberculosis;
- People suffer from both physical and mental ill health, and die much younger than the national average. Mortality rates are particularly high for heart disease and stroke: there is also a high level of infant deaths; and
- Barriers to people accessing services are primarily cultural.

Leicestershire:

- Just over 70 per cent of people are classified as living in non-deprived areas, although there are pockets of deprivation particularly in the north-west of the county;
- There are moderate concerns over educational achievement, increased and higher-risk drinking, incidence of malignant melanoma and excess winter deaths;
- There is resultant high life expectancy for males and females and low level of infant deaths; and

[9] NHS England health profiles, 2013

- Barriers to people accessing services are low, with the exception of some of the more rural areas to the east of the county.

Rutland:

- Over 90 per cent of people are classified as living in non-deprived areas;
- There are moderate concerns over educational achievement, malignant melanoma, excess winter deaths and road injuries/deaths;
- There is resultant high life expectancy for males and females and low level of infant deaths; and
- Barriers to accessing services are associated with the rural nature of the area.

Demographic and socio-economic differences manifest themselves as inequalities, which appear to be rising despite recent attempts at their reduction. Inequalities are recorded in:

- Differing access rates between different ethnic communities;
- Accessibility between people living in rural areas, particularly the rural poor, and those living in urban areas;
- Outcomes between city and county (life expectancy in the city is 5.6 years less than in Rutland amongst men and 2.5 years less amongst women; years of 'healthy life' show similar variation);
- Outcomes between different localities within both the city and the county (within Leicester life expectancy is 9.4 years lower for men and 5.0 years lower for women in the most deprived areas of Leicester than in the least deprived areas); and
- Outcomes between vulnerable groups and the wider population (people with enduring mental illness are likely to have worse general health and to die over 10 years earlier).

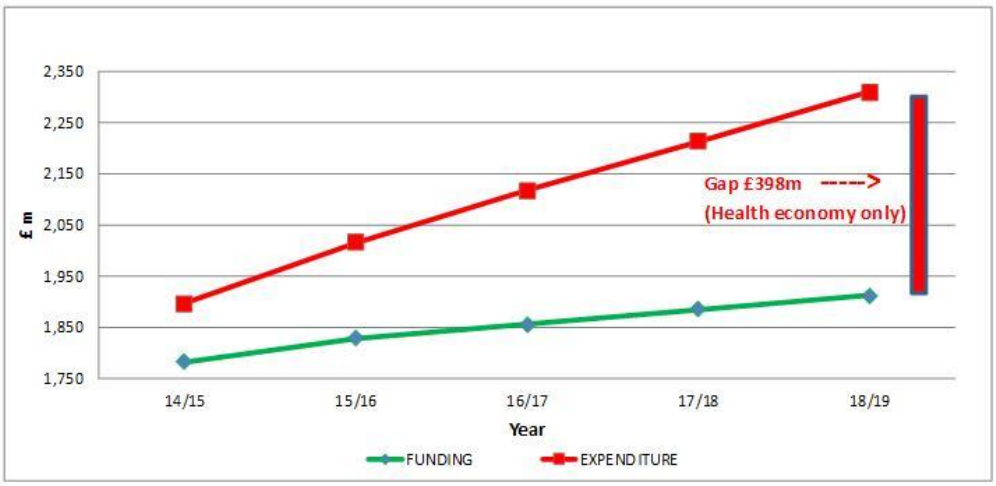
2.4.1 Delivering value for money

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

Since formation, UHL has narrowly broken even every year with the exception of 2013/14 when it posted a £39.7m deficit. The Trust's financial recovery plan requires moving from 3 to 2 acute sites by 2018/19, and to do this will require both system led change around a joint beds reconfiguration programme, and internal efficiencies such as reducing length of stay, increasing day case rates, standardising clinical protocols and rapid turnaround of tests.

Modelling has been undertaken to articulate what would happen to the finances of the LLR health system (UHL, LPT, Leicester City CCG, East Leicestershire and Rutland CCG, West Leicestershire CCG and Leicestershire and Lincolnshire Area Team (direct commissioning of primary care and specialised services)). If no action were to be taken to improve the quality, outcomes and value for money of services currently provided to patients a financial gap of £398m has been identified by 2018/19.

Figure 7: "Do nothing" financial gap 2014 - 2019



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

The local authorities in the LLR system also face very significant financial pressures to the extent that by 2018/19 a collective savings requirement of £177m is predicted (Leicester City Council £64m, Leicestershire County Council £110m, Rutland County Council £3m). The broader cuts to local government funding will inevitably have an impact on adult social care, which currently constitutes between 33-42% of expenditure. The savings figures above also exclude any pressures from the Care Act 2014. These are currently being assessed.

Local authorities have been engaged throughout the development of the 5 year strategy. The organisations are represented in all key programme governance groups and have been actively involved in developing and challenging new models of care.

In identifying the potential to deliver health economy efficiencies, the Better Care Better Value (BCBV) and Commissioning for Value indicators were used to benchmark LLR organisations against peers. BCBV indicators suggest that if UHL and commissioners performed at upper quartile, there would be a total annual saving of £86m, and if these organisations performed at best decile there would be an annual saving of £104m. The Commissioning for Value data packs provide an alternative view of potential commissioner savings by focusing on disease groups rather than settings of care. Nevertheless, the results triangulate with the BVBC indicators and suggest commissioner LLR wide savings of £47m are possible based on achieving the average of the best 5 of 10 peer CCGs.

The scale of the financial gap facing LLR emphasises the need to move to a sustainable model of care.

2.4.2 Ensuring our workforce meets the health and social care needs of our local population

The combined NHS and social care workforce is one of the largest groups of employees across LLR. Organisations struggle to recruit to some key posts and agency staff use is higher than expected. There is also too much silo working which can result in less than optimal communication between teams, as well as duplication of roles and effort. Looking ahead there are a number of workforce challenges that will have a local LLR impact:

- The health care workforce can be relatively inflexible, with strong demarcation of roles and a working model often centred on single episodes of treatment. However, those placing the greatest demand on services are older people with multiple conditions who require support from a range of services;
- An increasing number of UK-trained doctors, nurses and allied health professionals choose to move abroad;
- By 2021 there will be a national shortfall of between 40,000 and 100,000 nurses and there could be 16,000 fewer GPs than needed;
- The ageing population means that by 2025 the national social care workforce will need to increase from 1.6 million to 2.6 million; and
- The nature of work undertaken by staff is changing. As the population ages, our staff will need to care for more people with complex needs and multiple co-morbidities.

LLR recognise that in future they could face shortages of staff in some key disciplines and that staff currently employed will need to work differently. They will need to work much more in multi-disciplinary teams that treat the “whole person” and not just the presenting condition; they will need to have more generic skills; and they will need to be more productive, partly through use of new technologies.

In addition to the challenges in recruiting the right numbers of key staff the BCT strategy requires a significant “left shift” in activity from acute settings into the community. This will entail a similar transfer of staff so that more nurses and other professionals are working outside of a hospital setting. This in itself will pose a major workforce challenge to the health economy. Social Care will face a similar challenge to recruit and train the additional staff to provide support in the community.

2.4.3 Transforming the health and social care system through quality integrated care

While the health and social care services within LLR are currently meeting the needs of most people most of the time quickly, efficiently and effectively, there are times when performance falls below the desired standards.

On a range of quality measures from various sources, there is evidence of mixed performance across LLR. Some of the more notable results are as follows:

- UHL performed low on the NHS staff survey on standards of care;
- Emergency readmissions are at or below average across the 3 CCGs; and
- Below average patient experience of GP out of hours services in both Leicester city and East Leicestershire and Rutland

In some cases performance should be improved, and for indicators such as admission and readmission rates LLR aspire to performance in the top decile. The relatively poor results relating to primary care indicate that LLR need to pay particular attention to making improvements here.

Local performance against key operational measures, such as the 4 hour wait in A&E and referral to treatment (RTT), needs to be improved. Performance against the A&E target at UHL has improved through 2013/14 but remains well below the national target. Waiting times are also above required levels in many community and mental health services, for example tier 3 child and adolescent mental health services (CAMHS).

BCBV national benchmarks show that UHL is ranked 57th in terms of performance on length of stay. Length of stay has continued to rise at a rate of 19% in the last financial year for patients staying 11 days or more, with the majority of these patients aged over 65. Critically, a hospital stay of 11 days or more is detrimental to frail older people in terms of increasing their levels of dependency while in hospital; reducing their potential to return to their usual place of residence and reducing their potential to maintain their previous baseline of functioning. Long stays are often linked to delayed transfers of care and the local health and care economy's performance on delayed transfers of care has deteriorated in quarter one 2014/15.

There is both national and local evidence to suggest patients are using acute services inappropriately. The Keogh Urgent and Emergency Care Review[10] found that 40 per cent of patients who attend an A&E department are discharged requiring no treatment, and could have been helped closer to home. In addition, the results of 2 bed utilisation reviews of unscheduled care patients admitted to medical wards in UHL showed that many inpatients did not require acute care.

In summary, there is a clear case for change for a transformative programme to put in place new models of care to improve outcomes and ensure the financial and clinical sustainability of healthcare in LLR.

[10] http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx

2.5 Vision, values and system objectives

LLR have developed a vision to:

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

This vision has been agreed across all partners on the BCT Partnership Board. The partner organisations recognise the scale of the challenge that lies ahead for this health and social care economy. The Board is committed to delivering the transformative system reform required without compromising on the outcomes for LLR citizens or the quality of services that are available.

LLR recognise that transformative change is required and this will need organisations to work together in new ways. In order to reflect this, the following value and principles have been agreed and offer a consistent approach to developing new models of care:

- Work together as one system to realise our vision;
- Citizen participation and empowerment at the heart of decision making;
- Commitment to addressing the inequality between mental health and physical health services;
- Improve outcomes and reduce inequalities for our citizens by striving to be 'best in class', using evidence-based models which comply with our equality principles; and
- Maximise value for our citizens by rigorously assessing how we allocate and use our resources.

In line with these values and principles, and to achieve the vision, a number of system objectives have been developed:

- **System objective one** – to deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital.
- **System objective two** – to reduce inequalities in care (both physical and mental) across and within communities in LLR resulting in additional years of life for citizens with treatable mental and physical health conditions.
- **System objective three** – to increase the number of those citizens with mental and physical health and social care needs reporting a positive experience of care across all health and social care settings.
- **System objective four** – to optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system.
- **System objective five** – all health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate.

- **System objective six** – to improve the utilisation of workforce and the development of new capacity and capabilities where appropriate, in the people and the technology used.

The following section describes the proposed new models of care, detailing the changes that will be made and how they will support delivery of the over-arching programme objectives.

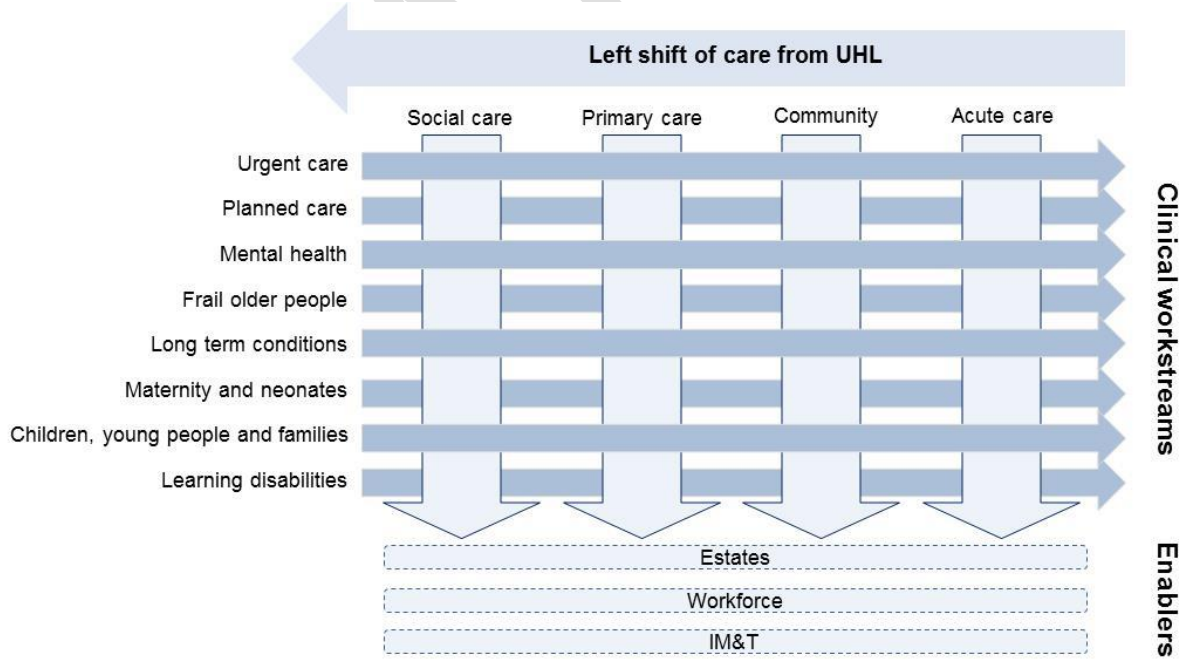
2.6 Health economy strategy – new models of care

2.6.1 High level description of new model

The previous section described the case for change in LLR. It articulated the national and local context for the programme and some of the demographic and social-economic characteristics of the LLR population. It also highlighted the significant financial pressures facing the health and social care system and potential opportunities to ensure services deliver value for money in the future.

In response to this case for change, the BCT programme developed a model based on settings of care and service pathways. Settings of care range from self-care, prevention through to acute hospital based services. The simplified diagram below shows the interaction between workstreams and settings of care, with workstreams responsible for the whole patient pathway from public health through to hospital based services:

Figure 8: Aligning service pathways to settings of care



This section of the strategic case describes the proposed changes to service delivery for each pathway. It begins by outlining the financial benefits that the programme will deliver before articulating the key changes that will be made in the service pathways over the next five years to deliver these. It describes some of the specific projects that have been developed by the programme's clinical workstreams, to provide a clear view of some of the proposed pathway changes.

The section then moves on to describe the changes that will take place in LLR's settings of care over the next five years; in UHL, LPT, primary care and social care. These changes are required for successful implementation of the proposed service pathways, and to ensure high quality and sustainable care can be developed in the future.

Finally, the section describes how the 3 enabling workstreams - estates, workforce, and IM&T – will support delivery of these changes. Without these enabling groups, the programme will not be able to implement these transformational changes.

2.7 Clinical models of care driving delivery

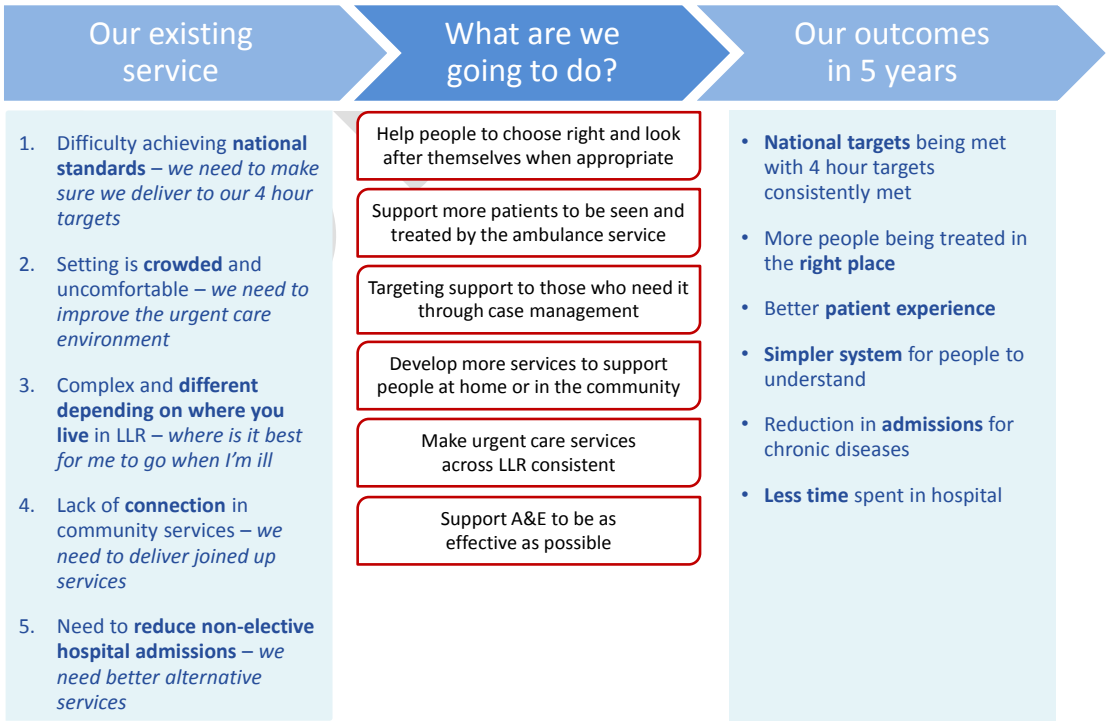
The new models of care will deliver significant benefits to local people and to health and social care commissioners and providers. As explained further in the economic and financial cases, the health economy needs to close a projected financial gap of £398m across the 5 years of the plan. If all of the elements of the strategy are delivered the health economy will achieve a surplus of £1.88m by 2018/19. Further efficiencies delivered by the UHL reduction in overhead from moving to 2 acute sites will release a further £30.8m of recurrent savings for the trust which will be realised in 2019/20.

Each workstream that will support delivery of the new model of care is described in detail below:

2.7.1 Urgent care

Urgent care refers to the range of services under non-elective medicine and emergency surgery for adults. Areas in scope include System Navigation, EMAS, the single point of access, NHS 111 and the out of hours service.

Figure 9: Urgent care summary



Objectives

There are many interdependencies between the urgent care workstream, and the long term care and frail older people workstream. These 3 groups have worked together closely to ensure the individual plans are coordinated and aligned, and come together to form a coherent model of care. This has been achieved by using an overarching model which is based on ten key components of care[11]. Research has identified these areas as central to designing health and care systems for this cohort of people:

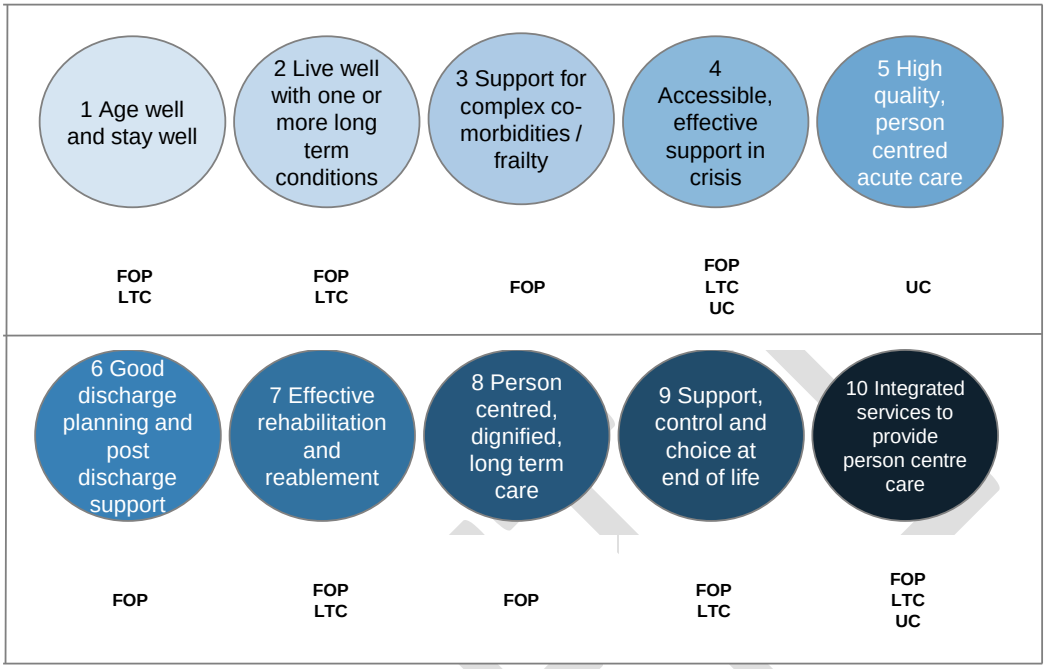
- Age well and stay well, which is linked to Public Health outcomes;
- Live well with one or more long term conditions;
- Support for complex co-morbidities/frailty;
- Accessible effective support in crisis for patients and carers;
- High quality person-centred acute care;
- Good discharge and post discharge support;
- Effective rehabilitation and re-ablement;
- Person centred, dignified long-term care;
- Support control and choice at end of life;
- The tenth component is “integration”. The BCF will be vehicle used to help drive local integration across the system and this workstream is strategically aligned to Leicestershire county, Leicester city and Rutland BCF plans.

Figure 10: Ten components of care

[11] http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population, March 2014

The diagram below shows how the 3 workstreams have worked together to deliver these 10 components:

Figure 11: Ten components of care – urgent care



The urgent care workstream is focussed on delivering component 5 of the model "high quality person centred acute care". The objectives for urgent care are:

- To deliver the highest quality safe urgent care service for the population of LLR with the resources that are available, within a five year timeframe;
- To make that urgent care offer understandable, accessible, consistent and measurable by using best practice and common frameworks in settings that the public find easy to get to and use;
- To maximise the benefits of integrating primary and secondary urgent care to ensure that best experience and quality of care is offered to patients whilst best value is extracted and duplications of resource are removed;
- To reduce the proportion of beds dedicated to the delivery of urgent care.

<u>What will happen across LLR to deliver these objectives</u>

Treating more people in the right place with the right offer will ensure LLR meets its objectives of delivering a better patient experience and improving outcomes. Key changes that will take place in the urgent care system are:

- Reconfiguring the emergency floor at LRI to ensure there is sufficient space to support the flow of "majors", offer dignified care and create a positive working environment;
- Improving system navigation by boosting NHS111, out of hours medical cover, local single point of access triage;
- Increasing the availability of ambulatory care options i.e. alternatives to admission;

- Introducing ambulatory care pathways for the conditions listed in the directory of ambulatory and emergency care medicine for adults[12];
- Boosting the urgent out of hospital options for at risk patients;
- Increasing seven day coverage in primary and community urgent care services;
- Increasing the use of a "see and treat" approach by the ambulance service to treat people on site when conveyance to hospital will not improve care outcomes;
- A "Choose Well" public campaign to help people to make the right urgent care choices.

Detailed projects developed by the BCT Urgent Care workstream

The following project has been developed by the urgent care workstream to support the changes to urgent care:

Figure 12: Urgent care – projects

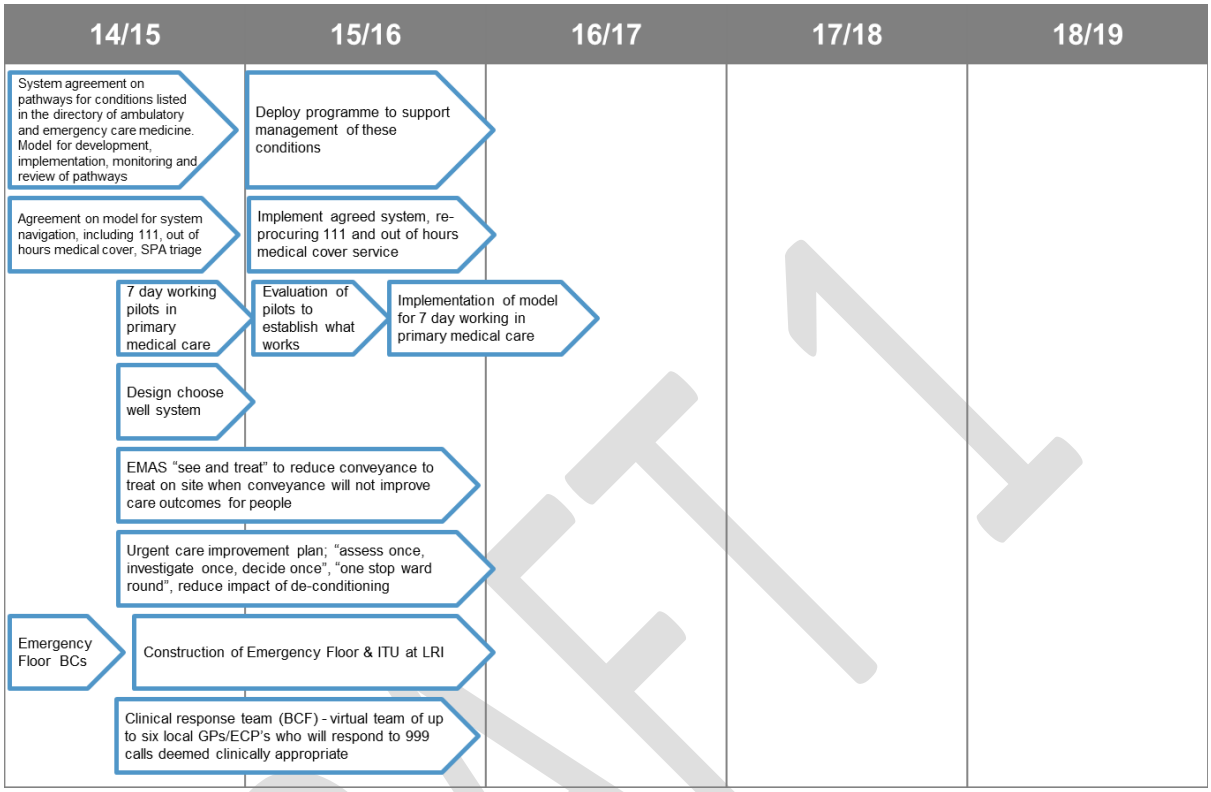
Project	Description	Net annual saving
Ambulatory care sensitive conditions	A full programme to support the management of Ambulatory Care Sensitive Conditions will be deployed in line with the handbook guidelines.[13] This will provide the system with a baseline of resilient preventative primary medical care interventions for at risk patients, and the delivery of 'home first' principles for all people who are safe to be treated in the community in line with best practice. This will increase the amount of ambulatory care we deliver and shorten the length of stay for this cohort of patients.	£1,000,000 (due to reduced admissions for ACS conditions and reduction of 26 beds)
Directory of Ambulatory and Emergency Care Medicine for Adults	The second system wide project focuses on ensuring that system navigation in LLR is effective and safe, directing people to the most appropriate setting for their care. The most appropriate model for system navigation is currently under consideration, but through this programme we aim to maximise the benefits of enhanced clinical triage at the point of first contact. The project will smooth patient journeys, ensuring that people have every opportunity to avoid attending A&E if it is not beneficial for them to do so, but also ensuring that people who need an emergency intervention get rapid and timely access to emergency support.	This will enable the reconfiguration of services that needs to take place within UHL
	Total	£1,000,000

[12] http://www.ambulatoryemergencycare.org.uk/Directory
[13] http://www.ambulatoryemergencycare.org.uk/Directory

Timeline for delivery

The diagram below sets out the timeline for delivering the proposed changes to urgent care:

Figure 13: Urgent care timelines



Outcomes

The resulting benefits to patients and professionals will be; urgent care interventions available closer to home; an improved fit for purpose emergency care environment; fewer admissions and better outcomes for patients with ambulatory care sensitivity conditions; easier system navigation; shorter waiting times in emergency departments; and shorter lengths of stay for people still requiring acute hospital intervention. This will support the system to:

- Reduce beds needed for non-elective patients;
- Improve mortality rates and treatment outcomes;
- Resource switch from unplanned to planned care.

The table below shows how these benefits support delivery of the overall BCT objectives:

Figure 14: Urgent care – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Urgent care	• Easier access to urgent GP appointments • More attendances at UCC/WIC • Community alternatives to A&E integrated with community services • EMAS aware of alternatives to A&E	• Urgent care available more locally in county and Rutland	• System easier to understand and navigate • Less pressure on A&E	• Improved use of community hospitals e.g. UCC/WIC	• Fewer admissions saving CCGs money • Reduced non-elective LoS saving UHL money • Fewer residential admissions saving local authorities money (may be offset by increased support required in the community)	• Enhanced skills in primary care • A&E staff able to focus on more serious cases • Integration of IT

Enablers

The urgent care plans rely on changes in a number of enabling areas:

- IM&T – electronic directory of services to support the single point of access; mobile devices to support mobile working; and the ability to share information;
- Estate – LRI emergency department floor scheme and changes to the community estate to support the shift of activity out of acute settings;
- Workforce – recruiting sufficient staff to deliver 7 day services and to expand community and primary care alternatives. There will also be a likely social care impact which will need to be managed.

2.7.2 Frail older people

Frail Older People covers community based frail older people services, dementia services and end of life care (including palliative and continuing care for adults, and hospice care). It has not sought to address hospital-based care (covered in urgent/planned care as appropriate) or end of life hospital episodes.

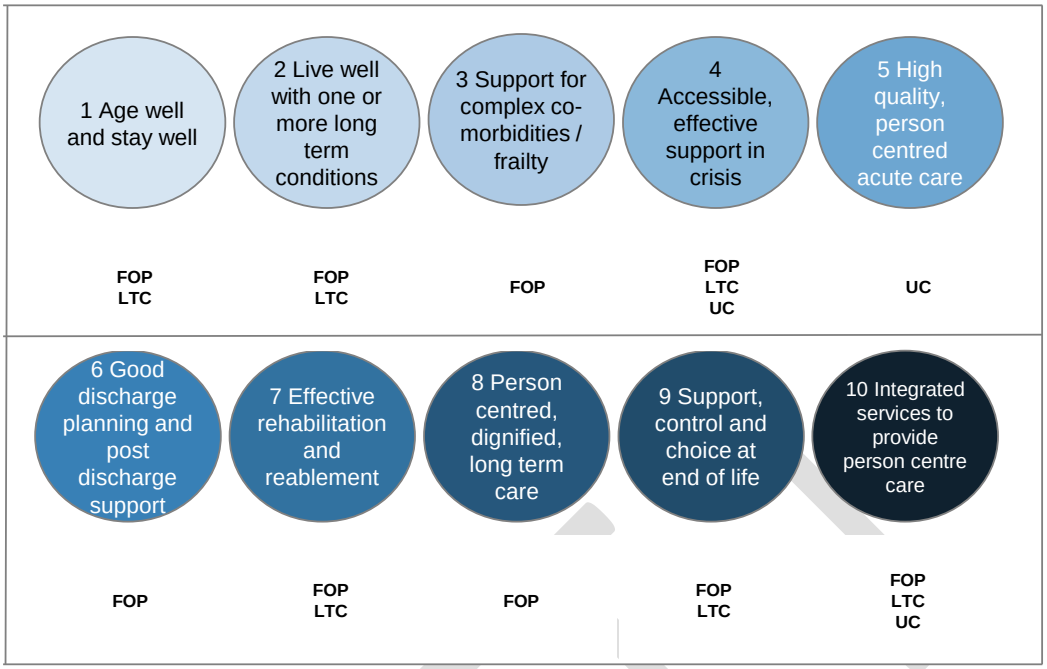
Figure 15: Frail older people – summary

Objectives

Health and social care organisations across LLR must work in partnership to change the way services for older people are delivered to address the threat of destabilisation posed by the ageing population. Too many people are admitted to hospital and care homes, often because services are fragmented, which also means that older people remain in hospital too long with implications for their overall outcomes. In addition, at the current estimated rate of prevalence, there will be 850,000 people with dementia in the UK in 2015. The current economic and political climate puts those delivering dementia services under very significant pressure to reduce costs and develop a sustainable pathway which is fit for the future.

The frail older people workstream contributes to delivery of all the components of the overarching model of care, except component five which will be delivered by the urgent care workstream.

Figure 16: Ten components of care – frail older people



The objectives of this workstream are to:

- Deliver high quality, citizen centred, integrated health and social care pathways, delivered in the right place at the right time by the right person;
- Improve care outside of hospitals to the extent that we can reduce the time frail older people spend in hospital;
- Reduce existing inequalities in accessing care for older people;
- Help increase the number of people with a positive experience of physical health, mental health (dementia) and social care services;
- Improve the use of physical assets by co-locating different services to enable integration;
- Integrate health and social care services thereby eliminating duplication such as repeat assessments;
- Reduce urgent care costs to health and social care commissioners;
- Develop new capacity and capabilities amongst our workforce.

<u>What will happen across LLR to deliver these objectives</u>

The Better Care Fund (BCF) is a primary driver of projects to address the frail older population. The fund is a single pooled health and social care budget to incentivise the NHS and local government to work more closely together, bringing improved integration to existing services. People rarely need support from a single service as they age, or if they are vulnerable through ill health, disability, injury or social exclusion/isolation. The workstream will coordinate the existing BCF plans to provide information, services and support in a coordinated way across different teams and organisations. The plans being developed will need to link in with public health, for example through the Age Well and Stay Well project.

A number of projects to improve services for frail older people have already been developed outside of the BCT programme e.g. through commissioner QIPP plans and the BCF plans that have been developed by each Health and Wellbeing Board in LLR.

As an example, “Accessible effective support in crisis” will be delivered through a number of BCF projects. The City plan will fund and drive the implementation of an Unscheduled Care Team and the County plan includes provision for an Integrated Crisis Response Service. These services are tailored to support the needs of the differing populations they will serve, but both focus on supporting frail older people in crisis in the community, to achieve a 3.5% reduction in total hospital admissions and a 15% reduction in hospital admissions for older people.

The table below shows how existing plans will deliver the components of care:

Figure 17: Frail older people – delivering components of care

Project	Description	Net annual saving
Age Well and Stay Well	The Age Well and Stay Well project has numerous associated programmes/projects which are themes within the BCF. Unified Prevention Offer is a theme and within this are various projects a) First Contact and the new b) Local Area Co-ordination, which focuses on improving self-care, education and prevention, the savings associated with this project will be achieved by improving independence and well being amongst frail older people.	BCF Initiative and Public Health budgets being better targeted
Live well with one or more LTC	The initiatives that are associated with the Live Well with one or more LTC are the Carers service, Risk Stratification, Early diagnosis and referral, and the increase in the number of quality care plans for the 65 and over or those who are at high risk of admission.	BCF Initiative
Support for complex co-morbidities/frailty	The initiatives that support complex co-morbidities/frailty are the Care Navigators, Local Area co-ordinators and the development of integrated pathways for dementia. The dementia pathway will be redesigned to ensure that diagnosis, care, monitoring and support for people with dementia is provided in the most appropriate setting and support for carers is improved.	BCF Initiative
Accessible effective support in Crisis	The BCF projects that will assist in the development of support Frail Older People in a crisis are the Unscheduled Care Team the Clinical Response Team, the Falls service, the Integrated Crisis response service along with the development of 24/7 coverage in the community linked to assistive technology. LLR will work alongside EMAS and community services to reduce the number of people accessing secondary care.	BCF Initiative
Good discharge planning and post discharge support	To achieve good discharge planning and post discharge support there is a need across LLR to maximise the use of assistive technology. Within BCF the development of Intensive Community Support services and Planned care teams will assist patients back into the community once they no longer	BCF Initiative

	require specialist services.	
Effective rehabilitation and reablement	Leicestershire and Rutland are developing a “help to live at home" programme which forms part of the reablement and rehabilitation programme across LLR.	BCF Initiative
Person-centres dignified long term care	Though some people make a positive choice to enter long-term care, older people should only generally move into nursing and residential care when treatment, rehabilitation and other alternatives have been exhausted. New discharge to assess pathways will ensure that older people receive high quality rehabilitation and reablement on discharge prior to making a decision about long term care arrangements.	BCF Initiative
Support control and choice at end of life;	LLR will deliver projects outlined in the Learning the Lessons action plan	BCF Initiative
	Total	Financial benefits already contained within existing BCF plans, forming part of CCG QIPP

The new model of care will also offer people choice at the end of life, working with people and their families to develop end of life care plans that reflect their wishes. There is a recognition across LLR that end of life care is not just applicable to frail older people. As a result, the programme is going to develop a new and separate workstream to focus on developing and implementing changes to the way end of life services are delivered in LLR.

Detailed projects developed by the BCT Frail Older People workstream

As described, a number of the projects to deliver the objectives of this workstream are already in place through existing BCF plans, with other projects phased to commence during 2014/15. The Frail Older People workstream has therefore not focussed on developing new projects. The group has instead consolidated this work and aligned it to an overarching model of care.

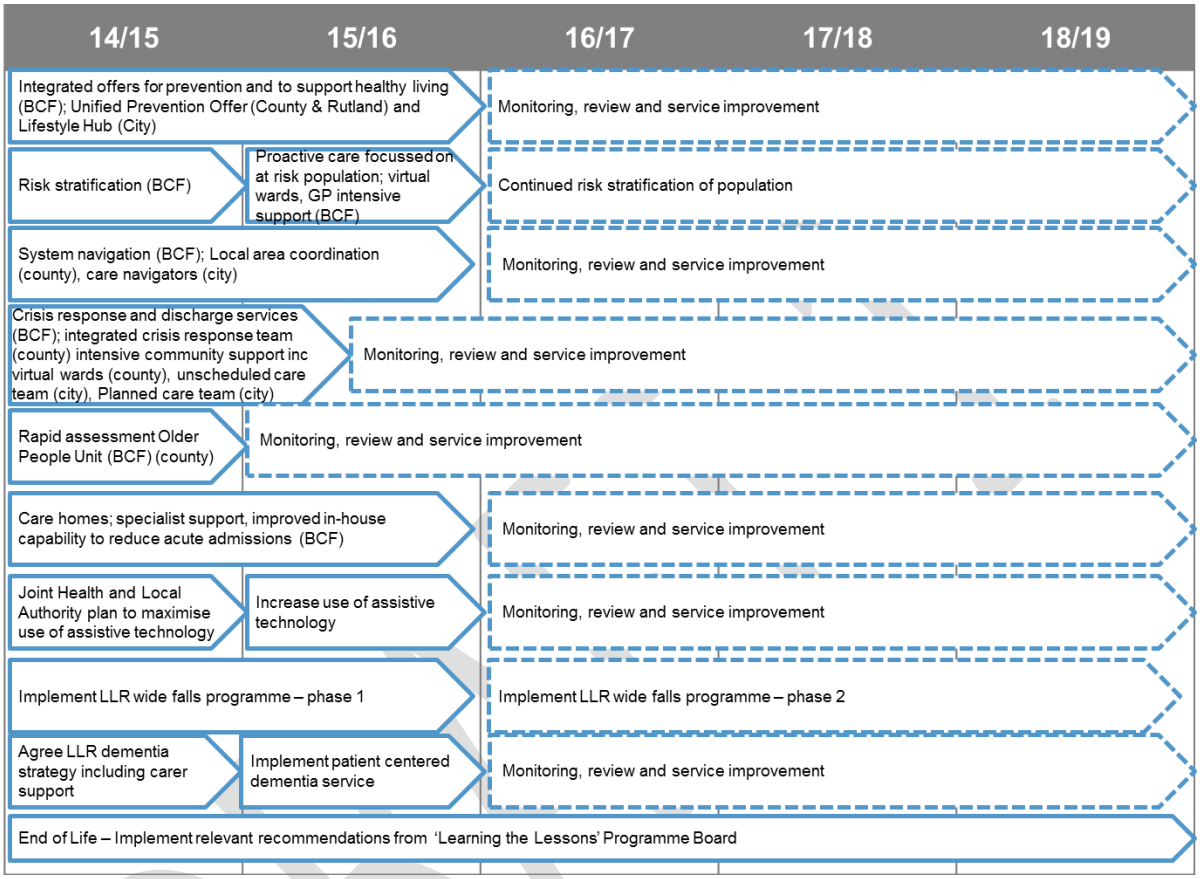
However, in gathering information on existing plans, the workstream identified a system gap around dementia services. This will be taken forward over the next few months and the workstream will develop an LLR wide approach to dementia care. This will include:

- Increasing the number of people who are diagnosed with dementia;
- Early and on-going support for those diagnosed with dementia;
- Increasing the number of people who have a positive experience of care;
- Support for dementia carers.

Timeline for delivery

The diagram below sets out the timeline for delivering the proposed changes to frail older people services:

Figure 18: Frail older people timelines



Outcomes

The benefits these changes will deliver are:

- Improved independence and wellbeing, as measured by fewer care home admissions and a 15% reduction in hospital admissions;
- Increase in dementia diagnosis rates;
- Shorter stays for those who do require hospital admission and fewer readmissions, reducing likelihood of functional decline and institutionalisation;
- A reduction in acute hospital bed numbers which will contribute towards UHL's plans to reduce from three to two sites;
- A reduction in the cost of care home placements, which will support local authorities in meeting their financial challenge;
- Improved patient and service user experience;
- A reduction in inequalities relating to access to care;
- An increase in life expectancy and "years of healthy life".

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 19: Frail older people – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustain-ability	Objective six Workforce & IT capability and capacity
Frail older people	• One anticipatory care plan • Joined-up delivery across health & social care (planned care) • Urgent care services aware of care plan	• More care delivered closer to where people live • Targeted proactive delivery of services based on risk stratification	• Personalised care plans co-designed with people & their carers	• Improved use of community hospitals • Less duplication between different teams e.g. trusted single assessment • Standardised care pathways	• Fewer admissions saving CCGs money • Reduced non-elective LoS saving UHL money • Fewer residential admissions saving LAs money	• Enhanced skills amongst primary and community care staff • Integration of IT across primary, community, secondary and social care sectors

The frail older people workstream overlaps with some of the changes that will be implemented by the LTCs and urgent care workstreams. In developing the specific workstream projects these three groups have worked together closely to ensure projects are coordinated and aligned, and that there is no double count of financial savings. Each workstream will continue to work closely together to ensure that changes are effectively planned and implemented.

Enablers

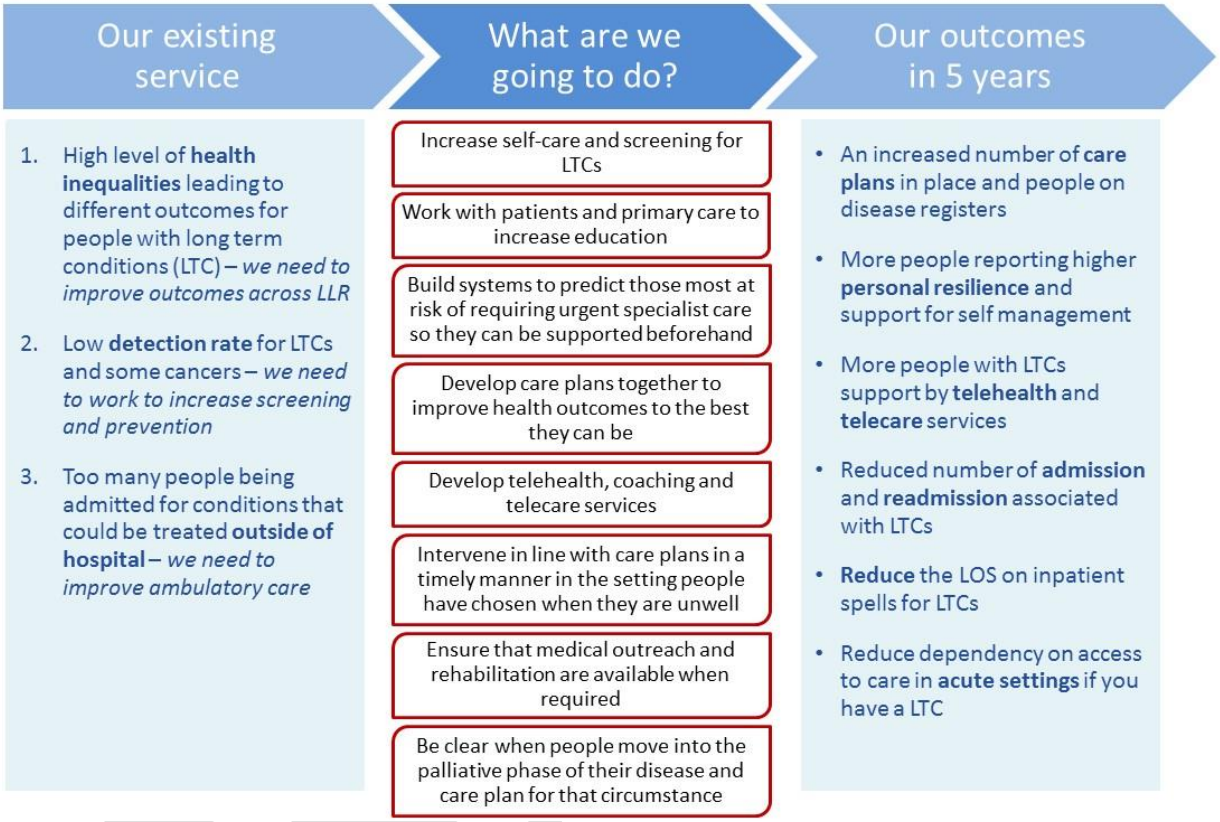
The changes to frail older people services require changes in a number of enabling areas.

- IM&T – electronic directory of services to support the single point of access; the ability to share information; tele-health and tele-care developments; and mobile devices;
- Estate – changes to the community estate to support the shift of activity out of acute settings, for example the co-location of teams in community hubs to support integrated working;
- Workforce – recruiting sufficient staff to deliver seven day services and to expand community and primary care support for older people, the development of new roles and consideration of joint appointments or “system wide appointments” for certain roles. There will also need to be a focus on enhanced support for carers who are a core element of the initiatives being described above.

2.7.3 Long term conditions

Long term conditions covers patients requiring long term care for chronic illnesses, such as Respiratory Disease (Includes asthma, COPD and pneumonia), cardiovascular disease (Includes heart failure, angina and atrial fibrillation), diabetes, stroke, neurology and cancer.

Figure 20: Long term conditions summary

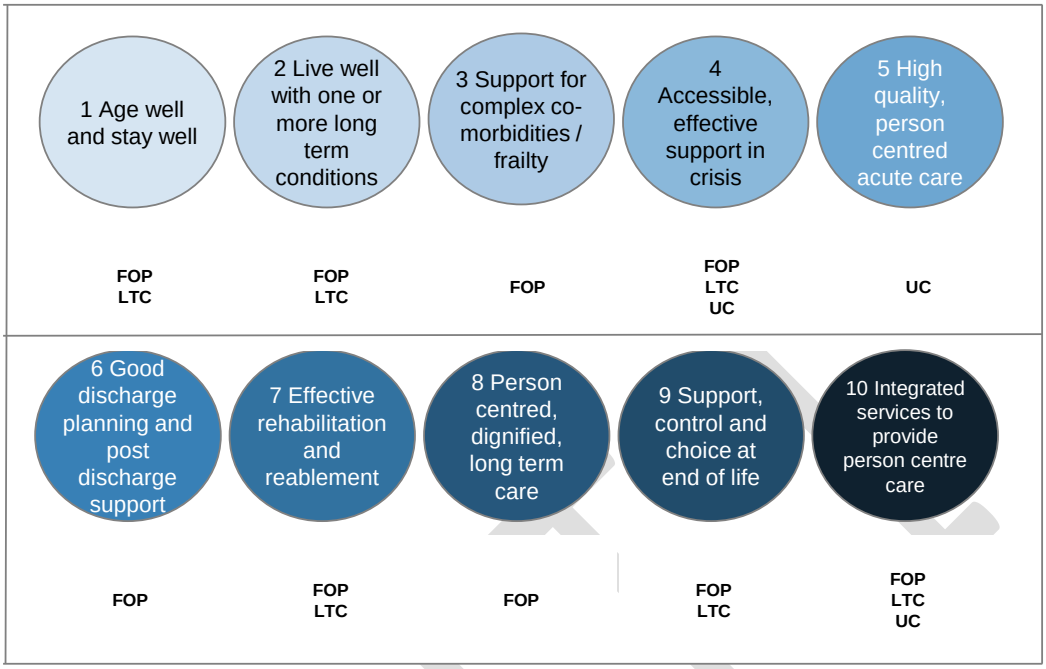


Objectives

Demographic change means that the number of people with LTCs will increase over the next ten years. A more sustainable model of care for people with LTCs is needed because “no change” is unsustainable. There is also a high level of inequality between different areas which leads to different outcomes. In part this reflects the need for better screening and prevention, but also the fact that too many people are being admitted for conditions that could be treated outside of hospital.

The LTC workstream contributes to six of the components of care, as shown below;

Figure 21: Ten components of care – long term conditions



The objective of this workstream is to create a system that delivers high quality safe care for people with LTCs based on best practice, using a service model spanning health and social care and which is easily accessible (both geographically and at different times of the day/week). Our projects will contribute towards delivering the LLR strategic objectives by:

- Delivering high quality, citizen centred, integrated health and social care pathways, delivered in the right place at the right time by the right person; including ensuring that healthy lifestyles and self care become a common feature of all treatment;
- Improving care outside of hospitals to the extent that we can reduce the time spent in hospital by people with LTCs;
- Reducing the inequalities in accessing care currently experienced by people with LTCs;
- Helping to increase the number of people with a positive experience of physical health and social care services;
- Improving the use of physical assets by co-locating different services to enable integration;
- Integrating health and social care services thereby eliminating duplication such as repeat assessments;
- Reducing costs to health and social care commissioners;
- Developing new capacity and capabilities amongst our workforce.

<u>What will happen across LLR to deliver these objectives</u>

The things that will change to deliver these objectives across LLR are:

- “Education” – working with patients and primary care to increase education around risk factors associated with LTCs and strategies to support self-care;

- "Prediction" – building systems, including screening programmes, to predict those most at risk of developing or accelerating the onset of LTCs. These will include health checks; and screening for chronic obstructive pulmonary disease (COPD), atrial fibrillation (AF), heart failure (HF) and cancer;
- "Care planning" – jointly developing care plans with patients and carers to improve health outcomes to the best they can be. Delivery of the care plan will be through a system-wide multi-disciplinary team approach;
- "Ambulatory pathways" – efficient pathways for ambulatory care-sensitive conditions based on treating people in the right care setting and avoiding hospital admission wherever possible (see urgent care above);
- "Innovation" – using new technologies such as tele-health and tele-care as well as techniques such as coaching to support people with LTCs;
- "Services available when required" – ensuring that medical outreach and rehabilitation are available when required';
- "Choices and plans at the end of life" – being clear when people move into the palliative phase of their disease and plan for that circumstance. LLR recognises that end of life is not just applicable to those with LTCs. As a result, the programme is going to implement a new and separate workstream to focus on developing and implementing changes to the way end of life services are delivered in LLR.

The LTC workstream will also take forward and coordinate ongoing work to redesign pathways for three key clinical areas identified at the Health Summit event in January 2014; respiratory disease, cardiovascular disease (including stroke) and cancer. Bringing this work into the programme will ensure that LLR develops a robust and effective overall approach to managing LTCs. The ongoing work will be complemented by the specific projects developed by this workstream, which are described in the next section. The two other areas identified at the Health Summit were dementia and mental health. These are being taken forward by the frail older people and mental health workstreams, respectively.

Detailed projects developed by the LTC workstream

The LTC workstream has developed a number of plans for system wide projects related to LTCs:

Figure 22: Long term conditions – system wide projects

Project	Description	Net annual saving
Integrated COPD team	This team will cover primary, community and acute care and will deliver care for patients with COPD in the community wherever possible, avoiding hospital admissions, including ambulatory care wherever possible. This will contribute towards UHL's bed reduction plans and the move from three sites to two; by tackling out of hospital care, in hospital processes and efficient discharge this project will deliver a reduction of approximately 49 beds.	£240,000 (excludes bed saving)
Exercise medicine	There is a strong evidence base that improving levels of activity, giving people access to integrated reablement services and encouraging them to exercise leads to improved health outcomes and savings for health economies.	£975,000
Workplace Wellness	Supporting NHS employees with LTCs to reduce absenteeism and presenteeism and the associated spend on agency cover (proof of concept in UHL).	£138,000
Specialist oxygen review and prescription services	Reviewing specialist oxygen and prescription services to ensure patients are receiving an appropriate level of care.	£111,000
Stratified cancer pathways	Redesigning services and end to end care pathways for those living with or beyond cancer.	£12,000
Remote monitoring of cardiac devices	Community based monitoring of appropriately risk stratified patients with cardiac devices, reducing the need for out-patient appointments.	£2,000
Home administration of intravenous diuretics to heart failure patients	Implementing community based resources to deliver intravenous diuretics for heart failure patients.	£38,000
Evidence based cardiovascular disease screening and treatment	Increasing capacity of screening for cardiovascular disease leading to increased early diagnosis, supporting better outcomes for patients and reducing high cost treatments associated with late diagnosis	£50,000
NICE Hypertension guidelines	Ensuring LLR is compliant with new NICE guidelines for the management of hypertension (a risk factor for stroke), improving outcomes for patients and financial savings through effective management of the condition.	£118,000
	Total	£1,684,000

Timeline for delivery

The diagram below sets out the timeline for delivering the proposed changes to long term condition services:

Figure 23: Long term conditions – timeline 1/2

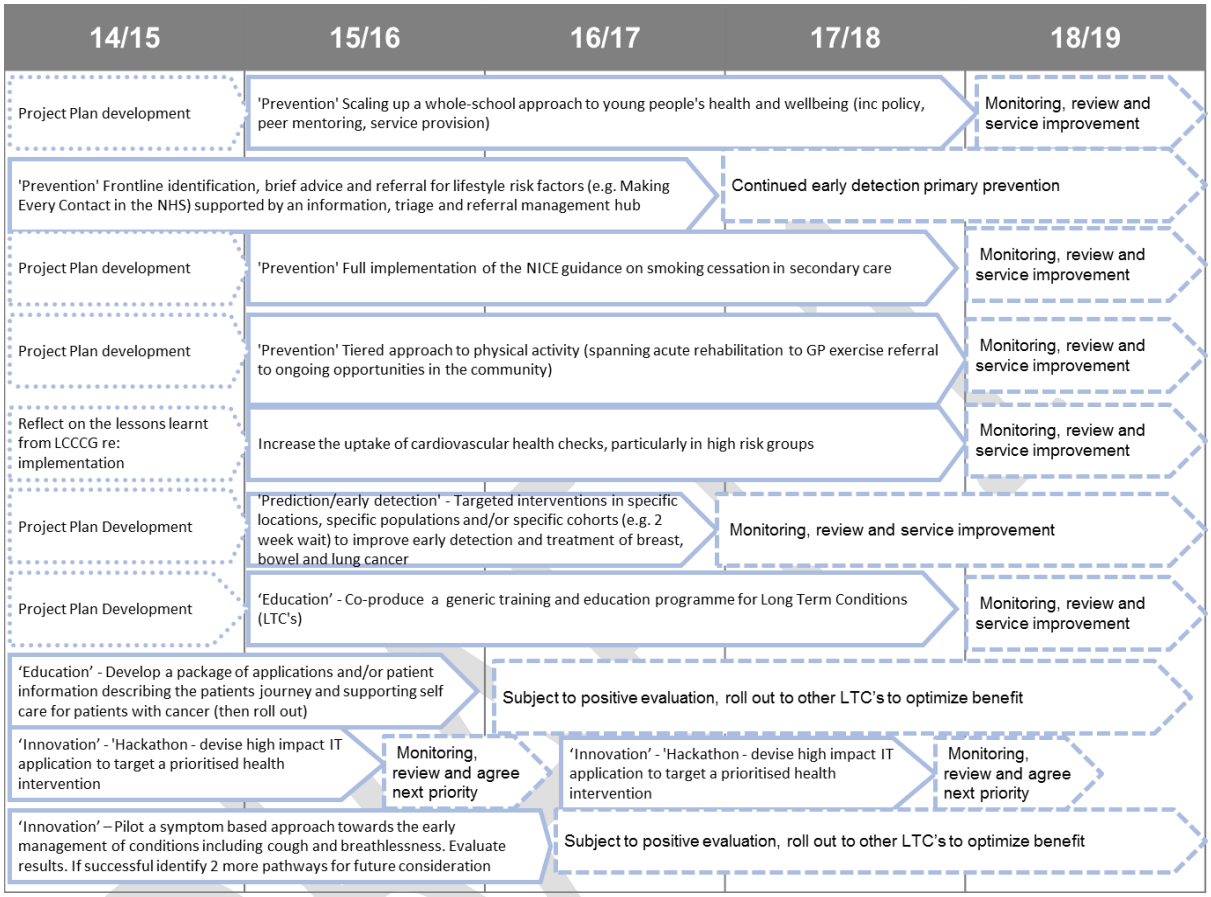
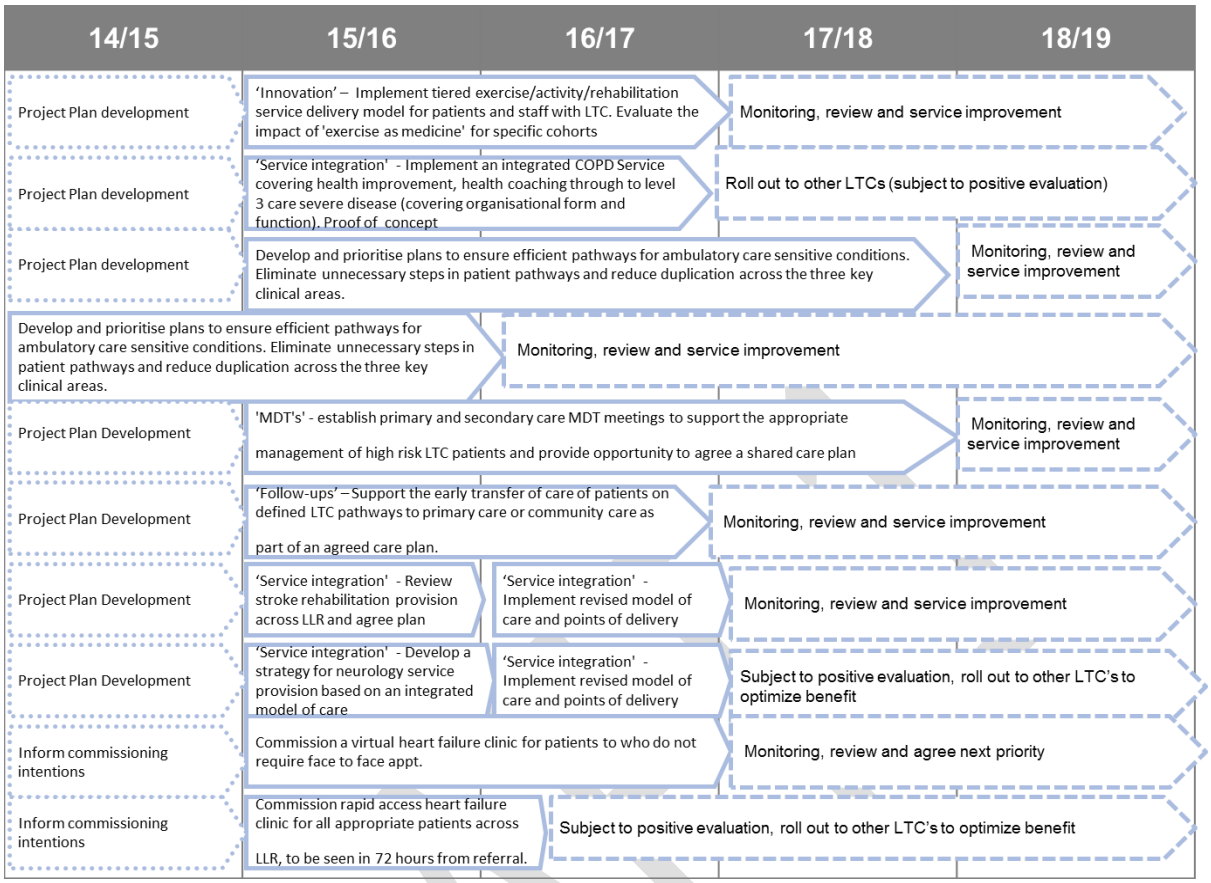


Figure 24: Long term conditions – timeline 2/2



Outcomes

The benefits for local people with LTCs will be an increase in the number of people with co-designed care plans in place and who are listed on primary care disease registers. We expect that more people will report higher personal resilience and that they feel supported to self-manage their condition.

The system benefits resulting from our projects will be a reduction in the number of admissions and readmissions associated with LTCs, and shorter inpatient stays for those people who still require admission. Together with changes in frail older people's pathways this will equate to 30% reduction in bed days for a length of stay of greater than 15 days – as a direct result UHL will be better placed to deliver its ambition to collocate clinical services and thereby reduce from three sites to two sites.

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 25: Long term conditions – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Long-term conditions	• One anticipatory care plan • Joined-up delivery across health & social care (planned care) • Urgent care services aware of care plan	• More care delivered closer to where people live • Targeted proactive delivery of services based on risk stratification	• Personalised care plans co-designed with people & their carers	• Improved use of community hospitals • Less duplication between different teams e.g. trusted single assessment • Standardised care pathways	• Fewer admissions saving CCGs money • Reduced non-elective LoS saving UHL money • Fewer residential admissions saving LAs money (possibly offset by increased cost of provision within the community)	• Enhanced skills amongst primary and community care staff • Integration of IT across primary, community, secondary and social care sectors

The LTC workstream overlaps with some of the changes that will be implemented by the frail older people and urgent care workstreams. Each workstream will work together closely to ensure that changes are effectively planned and implemented, and that financial savings are not double-counted.

Enablers

The plans for LTC rely on changes in a number of enabling areas.

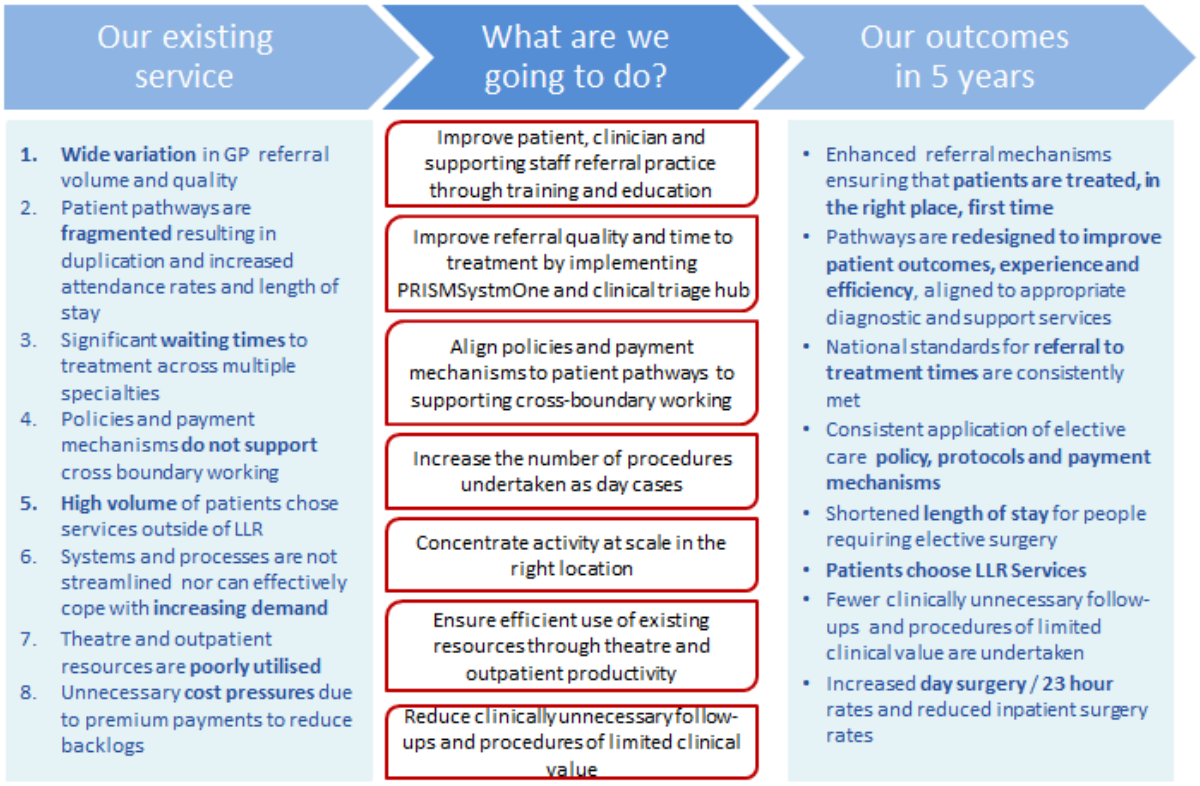
- IM&T – electronic directory of services to support the single point of access; the ability to share information e.g. real-time data on admission and a single dataset on discharge; telehealth and telecare developments; and mobile devices;
- Estate – changes to the community estate to support the shift of activity out of acute settings, for example the co-location of teams in community hubs to promote integrated working;

- Workforce – recruiting sufficient staff to deliver seven day services and to expand community and primary care support for patients with long term conditions and consideration of joint appointments or "system wide appointments" and generic workers across health and social care for certain roles.
- Community ambassadors – many of the projects proposed will be focused on those areas where health inequality is greatest. To support this we intend to work with community leaders and 'community ambassadors' to ensure that a sustainable community infrastructure is established.

2.7.4 Planned care

Planned Care seeks to improve care pathways across a range of 18 specific specialties. It covers improved access to diagnostics, development and implementation of referral policy, establishment of a pathway management service, training and education for referrers, patients and support staff, commissioning of community based care provision and support provider implementation of enhanced recovery and improved productivity and efficiency in secondary care. The workstream does not cover planned paediatric services (covered in children's services) or existing provider CIP initiatives.

Figure 26: Planned care summary



Objectives

Transformational change is required within planned care to ensure that patient experience and outcomes can be enhanced. Patient pathways, systems and protocols must be redesigned to ensure that key performance measures, such as referral to treatment time and length of stay can be significantly improved. The planned projects will ensure that treatment

is delivered in the right place, by the right clinician, first time without the requirement for unnecessary appointments and hospital visits, while reducing costs and driving improvements in quailty and patient outcomes. These significant improvements will encourage patients to make LLR their first choice when accessing healthcare and support the repatriation of activity back into the local health economy. In addition, the successful delivery of the planned care workstream will contribute signficantly to UHL's strategy to move from three site to two by shifting acute activity into community settings.

The planned care workstream will:

- Deliver high quality, patient centered, integrated care pathways, delivered in the appropriate place at the appropriate time by the appropriate person, supported by staff/patients, resulting in a reduction in time spent avoidably in hospital;
- Increase the number of patients reporting a positive experience when accessing planned care services across all pathways and provider organisations;
- Optimise opportunities for intergration and use of physical assets across the health and social care economy, ensuring care is provided in the most appropriate cost effective setting, reducing duplication and eliminating waste in the system;
- Improve the utilisation of the workforce and the development of new capacity and capabilities where appropriate, in our people and the technology used;
- Ensure that patient pathways, systems and protocols are patient focused, aligned/integrated and support cross-boundary working and payment mechanisms;
- Support the consistent achievement of all associated targets and quality indicators, with a particular emphasis on referral to treatments time;
- Make LLR planned care service provision attractive to patients to support the repatriation of activity and income from patients who currently chose services outside of LLR.

<u>What will happen across LLR to deliver these objectives</u>

The following changes across LLR will enable the delivery of these objectives.

- Implementation of PRISMSystmOne to improve referral quality by providing GPs with comprehensive referral guidelines and training to facilitate standardisation and reduction in variation;
- The establishment of a Clinical Triage Hub to support "better referrals" by eliminating unnecessary referrals, pathway steps and increase the timeliness to referral;
- Working with patients, clinicians and supporting staff, in conjunction with public health, to devise and implement a comprehensive training and education programme;
- Review and redesign patient pathways within eighteen clinical specialties to eliminate unnecessary steps, reduce duplication and ensure integration/alignment of services and payment mechanisms;
- Introduce a range of alternative community-based services to support the shift away from acute based care and ensure activity is provided in the most appropriate setting based on clinical need, access and cost effectiveness;
- Provide non face-to-face follow-ups where appropriate, for example open access, virtual and remote follow ups, to reduce unnecessary patient attendances and DNAs;

- Review and redesign systems and protocols, where appropriate, to support the sharing of information between primary, community, acute and social care services to support effective decision making;
- Enhance health and social care integration linked to pre-assessment prior to surgery;
- Development of locally agreed tariffs for treatments, procedures and care pathways to support integrated cross-boundary working and cost reduction for activity
- Full compliance with BADS;
- Establish an outpatient and daycase elective care hub to increase ambulatory elective work undertaken;
- Support the introduction of an enhanced recovery programme to facilitate a timely and quality discharge;
- Support the improved productivity in secondary care; outpatients and theatre utilisation, reduced length of stay, DNA and cancellation rates;
- Develop and implement comprehensive evaluation mechanisms to measure Workstream impact and support learning and dissemination to stakeholders.

This programme will have a significant impact upon and facilitate the successful delivery of provider efficiencies which will be supported by the Alliance. The Alliance Partners (UHL, LPT & LLR PCL) were commissioned to re-provide outpatient, day case and clean room service in community hospitals around LLR. This will support significant shifts in elective services to lower acuity and lower cost settings closer to the patient's homes. Priorities for the Alliance include pain management, general surgery, ophthalmology, gastroenterology and dermatology.

Detailed projects developed by the BCT Planned Care workstream

The following projects have been developed in detail by the planned care workstream:

Figure 27: Planned Care – system wide projects

Project	Description	Net annual saving
10% reduction in outpatient appointments	The reduction in outpatient appointments across 18 specialties will be delivered through the integration of PRISMSystmOne and a clinical triage hub that will ensure patients are seen in the right place first time and support referral to treatment times. This combined with pathway redesign within the 18 specialties and the implementation of enhanced referral management policies will also reduce unnecessary referrals and reduce steps in patient pathways. The implementation of this work will commence in year 1 and be phased across years 2 and 3.	£2,863,000 (based on reduction in activity: 5% reduction in 6 specialities in Q1 2015/16, 10% reduction in Q2 2015/16; 5% reduction in a further 6 specialities y Q3 2015/16 and 10% reduction by Q4 2015/16)
Repatriate 50% of outpatient and daycase activity	Whilst acknowledging that some patients will chose to access services across borders, this targeted activity spans 18 specialties and consists of non-specialised procedures only. The redesign of these pathways will focus on providing accessible services as close to the	£2,602,000 (based activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond and 50% repatriation of day case activity by 2018 and beyond)

	patient's home as possible, improving waiting times and reducing unnecessary steps in pathways, which is in direct response to patient feedback in relation to what can improve the attractiveness of LLR service provision to patients. An analysis of current waiting times confirmed that average waiting times within LLR are longer than those within surrounding areas. For example, the non-admitted waiting time in gastroenterology at UHL is 11 weeks compared to only 6 weeks in surrounding areas including Derby, Nottingham, Kettering, Lincolnshire, Coventry and Warwickshire.	
40% left shift into community and primary care	The left shift of outpatient activity is a key enabler to UHL reducing its footprint from three sites to two as it will facilitate the reduction of outpatient space required within an acute setting, allowing the transfer of services from the closing site. This shift will also contribute to the increased utilisation of community hospitals, making them more cost effective and supporting the care closer to home agenda and the delivery of repatriation described above.	There is no financial saving, but it is a key enabler of UHL reducing their sites.
Reduction in procedures of limited clinical value.	Reduction of £5k per quarter for 18 months - procedures currently under review	£30,000 (based on a reduction of £5k per quarter for 18 months)
	Total	£5,495,000

Timeline for delivery

The planned care workstream will be delivered in three phases as shown below:

Phase one – to March 2015:

- Re-design pathways for 6 specialities by March 2015;
- Establishment of pathway management service – pilot 2 specialties by March 2015;
- Development and Implementation of LLR Education Programme by March 2015;
- Development and implementation of PRISM across primary care services by March15;
- Implementation of enhanced referral management policies by March 2015.

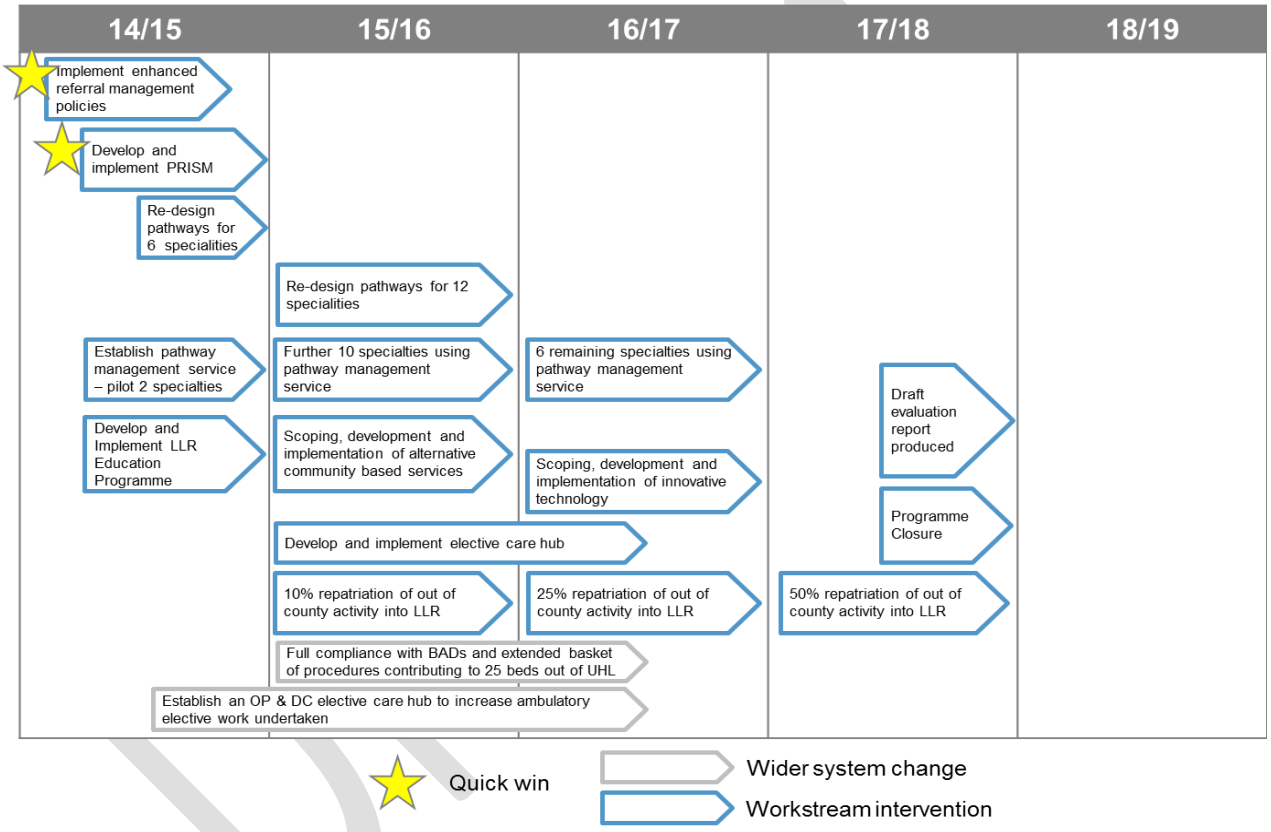
Phase two – April 2015 to March 2016:

- Re-design pathways for remaining 12 specialities by March 2016;
- Further 10 specialties using of pathway management service by March 2016;
- Scoping, development and implementation of alternative community based provision by March 16;
- 10% repatriation of out of county activity into LLR by March 16.

Phase three – April 2016 to March 2017 (and beyond):

- 6 additional specialties using pathway management service by March 2017;
- Support the scoping, development and implementation of innovative technology by March 17;
- Support the review and implementation of improvements to utilisation of secondary care, outpatients and theatres by March 17;
- 25% repatriation of out of county activity into LLR by March 17 and 50% by March 18;
- Draft evaluation report produced by March 18.

Figure 28: Planned care – timeline



Outcomes

This progamme of work will focus on redesigning care pathways to eliminate unnecessary step, standardising protocols to reduce variation and improving efficiency to increase capacity and ensure key performance indicators are consistantly achieved. The planned projects will ensure that treatment is delivered in the right place, by the right clinician, first time without the requirement for unnecessary appointments and hospital visits, driving improvements in quailty, patient outcomes and experience, and achieve significnat cost savings. This range of improvements will encourage patients to make LLR their first choice when accessing healthcare and support the repatriation of activity back into the local health economy. Both county CCGs expect a 40% “left shift” of acute activity into community settings as a result of the planned projects which will help improve the utilisation of the community estate and will contribute towards UHL’s goal of reducing its estate footprint in

Leicester. UHL will also benefit from efficiencies such as higher day case rates and fewer outpatient DNAs.

The table below shows how these benefits support delivery of the overall programme objectives;

Figure 29: Planned care – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Planned care	• Integrated pathways between GPs, diagnostics, community services and UHL • Health and social care integration linked to pre-assessment prior to surgery	• Less unjustified variation in referral rates and quality • Consistent application of protocol	• Shorter waiting times • More appropriate follow-up methods • Reduced steps in patient pathways	• Greater use of community hospitals resulting from pathway redesign and reprovision of services (clinics & diagnostics) • Adherence to NICE/ RCS pathways reduce waste • Supports reduction of UHL, three sites to two • Support the improved productivity in secondary care; outpatients and theatre utilisation, reduced length of stay, DNA and cancellation rates	• Higher day case rate saving UHL money • More procedures in primary care saving CCGs money • Reduced tariffs resulting from renegotiation and new payment models • Utilisation of existing resources for clinical triage hub once established	• Enhanced skills in primary care • Roll out and further development of PRISMSystm One • Establishment of Clinical Triage Hub

Enablers

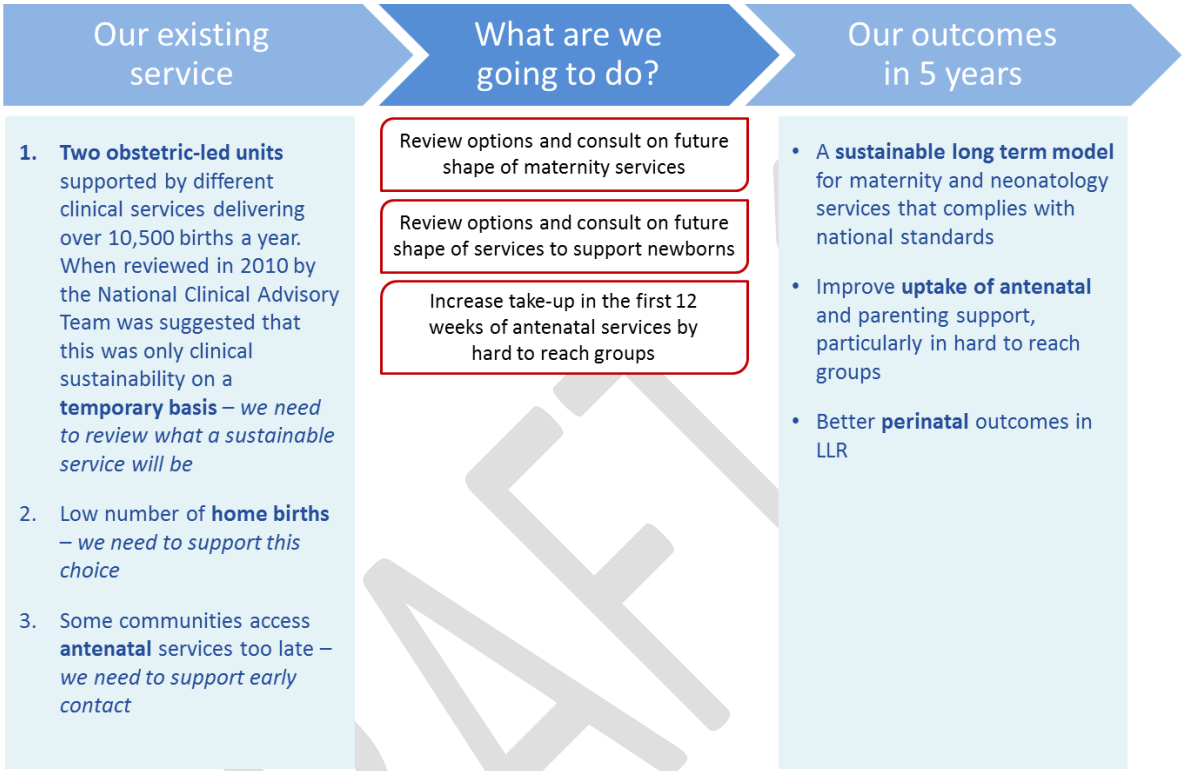
These plans rely on changes in a number of enabling areas.

- IM&T - real time data on admissions and discharge; shared information systems; technology assisted virtual interactions; and increased use of booking services;
- Estate - ensuring the community estate can support the “left shift” out of acute setting;
- Workforce – significant workforce implications will result from the 40% left shift of elements of planned care into community settings. This will require clinical staff to work from different locations and in a more integrated with community colleagues.

2.7.5 Maternity and neonates

The work stream addresses antenatal, intrapartum, neonatal and infant care (birth up to and including the immediate postpartum period) as well as post-natal care both routine and specialist. Pre-conception is not addressed.

Figure 30: Maternity and neonates – summary



Objectives

The case for changing maternity and neonates services is that LLR is currently not providing expectant mothers with as much choice as some other areas, and too many mothers are presenting to services late in their pregnancy. There are also concerns about the sustainability of running two obstetric-led maternity units in the city and concerns about the sustainability of the St Mary's Birthing Centre.

The aims for this service pathway are to:

- Maximise access to services to ensure all mothers are seen by a midwife at an early stage in their pregnancy;
- Improve the identification of babies at risk of poor perinatal outcomes will be developed;
- Offer personalised holistic care that is integrated between primary and secondary services;
- Ensure that babies needing specialist neonatal care continue to be treated at the right level;
- Work with partners across the East Midlands Neonatal Network to ensure adequate cot capacity;

- Expand neonatal outreach services to enhance the support to paediatric wards and to parents at home;
- In the context of wider UHL site reconfiguration plans, develop plans to consider consolidating all women's and neonatal services on a single site.

6What will happen across LLR to deliver these objectives

These objectives will be delivered by:

- Engaging with local people to review and consult on future shape of maternity and neonatal services as part of the acute site review;
- Maximising the uptake of midwifery led care options by promoting home births and midwife-led provision;
- Continuing with the multi-agency programme of work to improve perinatal outcomes in Leicester city;
- Working in partnership across health and social care to reduce perinatal and infant mortality;
- Promoting the importance of healthy lifestyle and early access to achieving a healthy baby;
- Providing targeted support for teenage mums and assist other services in reducing under 18 conception rates;
- Working with health and social care to support women and families with the transition to parenthood, particularly hard to reach groups;
- Working with adult mental health to develop an integrated maternal mental health pathway for mothers and families;
- Working with regional providers to develop networks for tertiary provision;
- Building the skills and capacity of the workforce to meet the needs of the local population;
- Rationalising the number of health and social care staff that women and their family have contact with, reducing handoff's and improving patient experience.

Detailed projects developed by the BCT Maternity and Neonates workstream

The maternity and neonates workstream has developed the following specific projects:

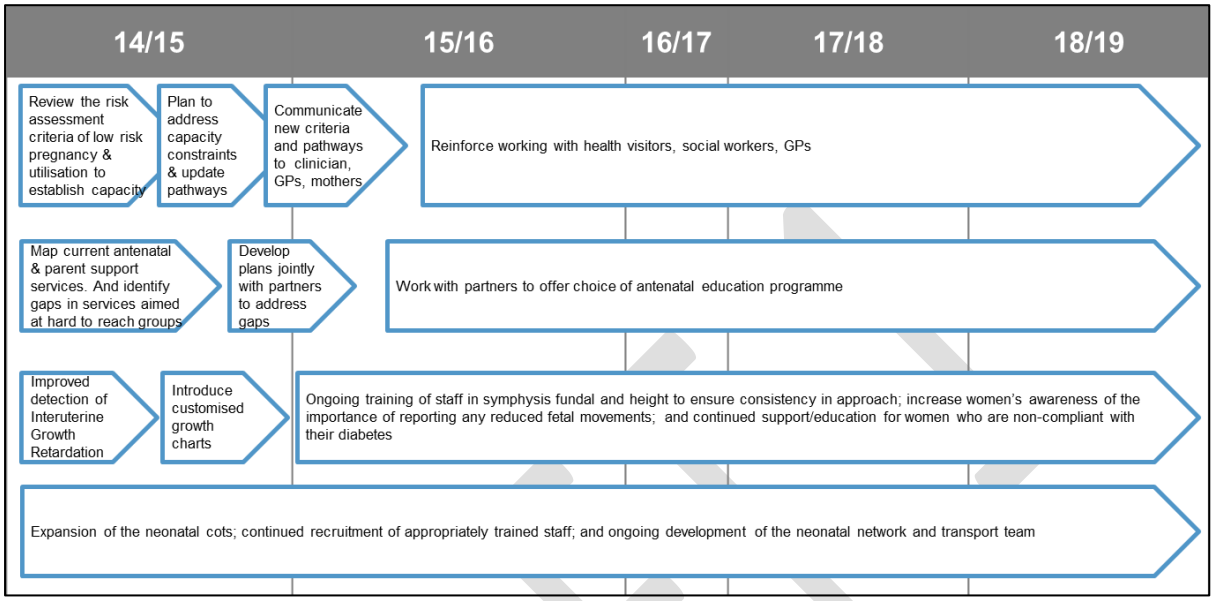
Figure 31: Maternity and neonates – system wide projects

Project	Description	Net annual saving
Changes to community based midwife led services	Redesigning how community based midwife led services are develivered to ensure that there is a sustainable model for community based delivery of midwife led care, which offers women in LLR real choice and access to high quality and sustainbale services.	£378,000
	Total	£378,000

Timeline for Delivery

The diagram below shows the timeline for delivering the proposed changes to maternity and neonatal services:

Figure 32: Maternity and neonates – timeline



The maternity and neonates plan has some interdependencies with plans for elective and emergency gynaecology which sits with the urgent care and the planned care workstreams, and links into the mental health workstream. These workstreams will work together closely as plans are finalised and implemented to ensure a joined up and coordinated approach.

Outcomes

These changes will deliver greater choice for mothers in LLR about how they deliver their babies. Some groups will also receive targeted support, for example teenage mums and other hard to reach groups who may need help making the transition to parenthood. Ensuring services are accessible and mothers access services at an appropriate point, and working in partnership with agencies across LLR will improve perinatal outcomes, particularly in hard to reach groups. The changes will also deliver a sustainable long-term model for maternity and neonatology services in LLR that complies with national standards

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 33: Maternity and neonates – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Maternity and neonates	• Improved links between neonatal services and paediatrics	• Targeted support for hard to reach groups to reduce late presentations	• More choice of high quality services for expectant mothers	• Consider consolidation of estates to ensure future sustainability of services	• Consider consolidation of estates to ensure future sustainability of services	• Greater resilience in community midwifery team

Enablers

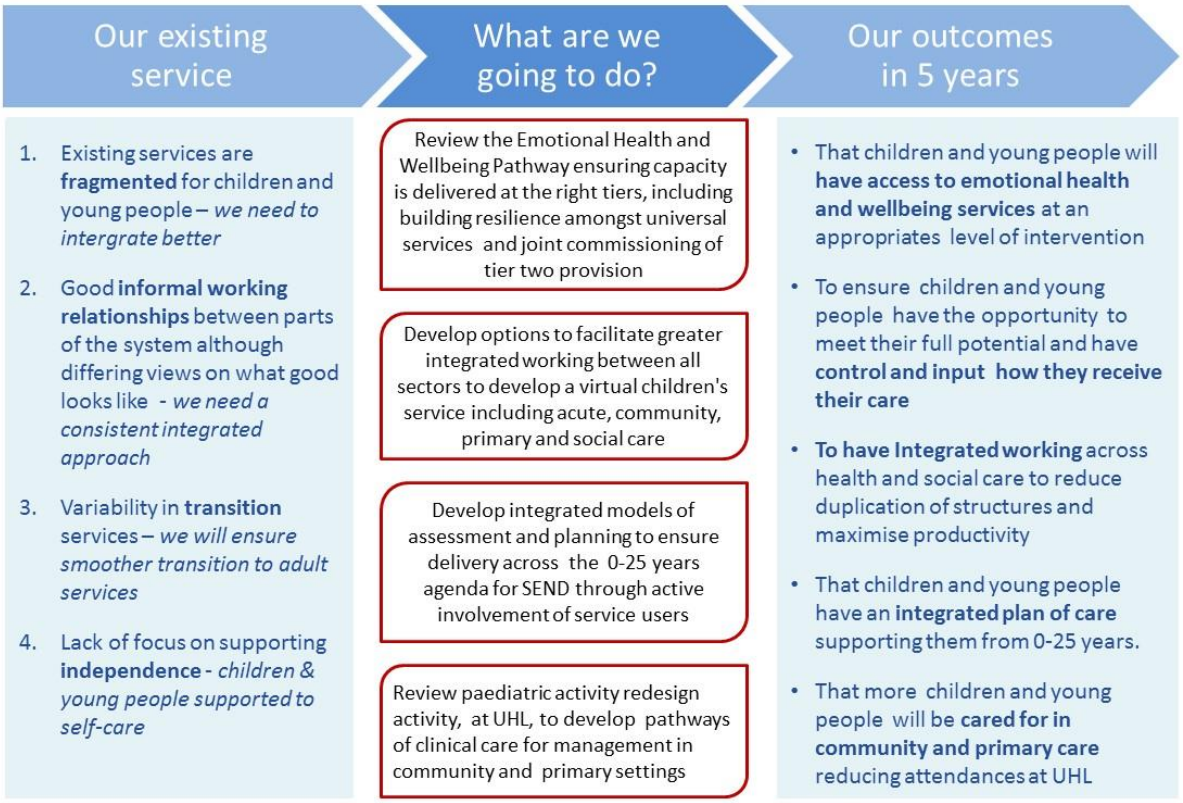
Implementing our plans for these services is dependent upon work of the estates enabling group to support potential consolidation of sites, subject to public engagement and consultation.

The workstream will also work alongside the workforce group to build the skills and capacity of the workforce to meet the needs of the local population.

2.7.6 Children, young people and families

The work stream covers all children and young people up to the age of 18 and in specific circumstances to the age of 25 years who reside in Leicester, Leicestershire and Rutland. It looks at paediatric primary care services (including urgent/unscheduled and planned/routine), Health Visitors and Early Years Providers (Children's Centres), Community paediatrics and children's community nursing care (including those receiving social care) and educational for children with long term health needs (including physical disabilities). Urgent and Planned and outpatient paediatric care are covered alongside emotional health and well-being.

Figure 34: Children's services – summary



Objectives

The child health agenda is vast and complicated and the current health care system is not designed to adequately address the unique needs of children. The needs of children are dealt with by a range of organisations including health, social services, education and the voluntary sector. These services need to change because current services are fragmented, and suffer from poor coordination across teams and organisations. The service model varies across LLR and whilst some local variation will always be needed, greater consistency is essential to reduce duplication. Current services lack a focus on supporting independence: children and young people need to be supported to self-care. The workstream aims are:

- Establish integrated pathways across primary and secondary care thereby reducing duplication and maximising productivity;
- Reduce inpatient activity and hospital-based outpatient contacts;
- Children and young people have an integrated plan of care supporting them from 0-25 years;
- Continue to work together to fulfil our responsibilities under the Children and Families Act 2014;
- Enable all children and young people to maximise their capabilities and have control over their lives;
- Children and young people will have access to emotional health and wellbeing services at an appropriate level of intervention.

What will happen across LLR to deliver these objectives

These aims will be delivered through the following programme of work:

- Facilitation of self-care, by empowering individuals and family capacity through patient education and community support by offering personal health budgets to eligible individuals;
- Increase access to tier two emotional health and wellbeing services which will be jointly commissioned to reduce the need for access to tier three CAMHS;
- Reduce out of area placements by developing sustainable specialised children's and young people's services within LLR, for example complex eating disorders and perinatal mental health;
- Improve delivery of planned care through redesign of pathways to reduce activity in an acute setting;
- Develop options to deliver integrated provision across all children's service providers;
- Develop a joint framework for assessment, planning and commissioning across agencies;
- Merger of Children's Emergency Department and Children's Assessment Unit to become a single Ambulatory care unit and deliver Children's acute care provision from a single site;
- Deliver Local Authorities requirement to deliver targeted early help to prevent the need for specialist services.

Detailed projects developed by the BCT Children's workstream

The following projects have been developed by the children's workstream:

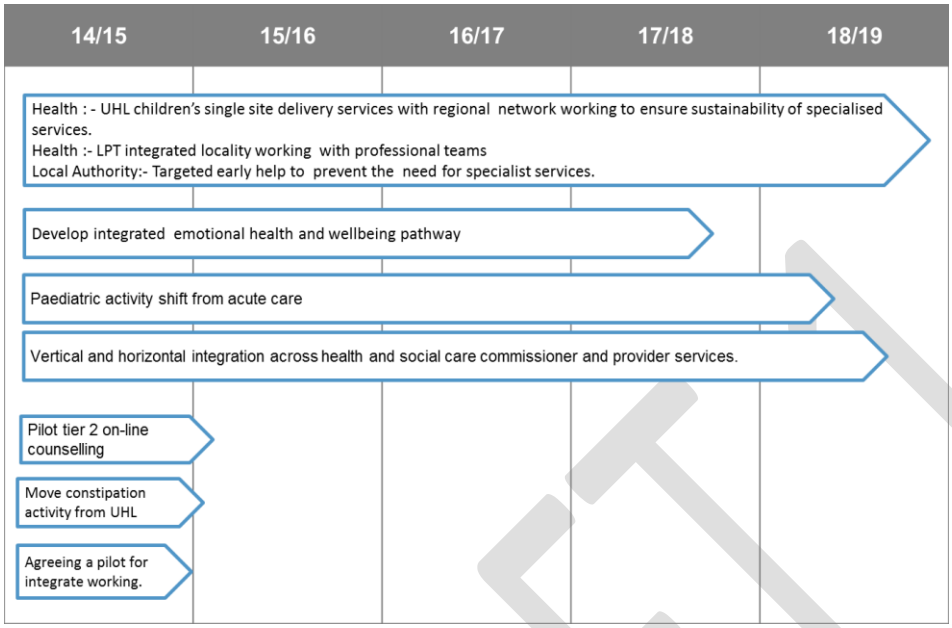
Figure 35: Children's services – system wide projects

Project	Description	Net annual saving
CAMHS	Increasing the provision of counselling and emotional health and wellbeing services to reduce the number of children escalating to tier 3 CAMHS serivces.	£73,000 (saving based on reducing referrals by 40 people at a cost of £2,333 per person and reducing the CAMHS tier three generic team caseload by 2.2%. Saving is net of costs of implementing improved counselling services.)
Hepatitis B ward attenders	Redesigning the hepatitis B pathway to shift 100% of activity from UHL and to primary care, so that in the future vaccinations are delivered by GPs	£3,000 (based on 100% activity moving out of UHL into primary care)
Eating disorders	Implementing a community based eating disorders team with capacity to support 120 children and their families each year. This will significantly improve the quality of care these children receive and reduce the number of children sent out of the county to receive inpatient care.	£60,000 (based on reducing admissions for patients with eating disorders by 50% and length of stay by 30%.
Bowel management services	Redesign the outpatient pathway for bowel management to increase the number of nurse led appointments by 50%, reducing the number of appointments that are consultant led.	£13,000 (based on reducing consultant led provision by 50% and increase nurse led provision by 50%)
Provider integration	The workstream will continue to engage with stakeholders and partners across LLR to increase the integration of children's services. This will focus on integrated working and joint commissioning by developing an overarching joint commissioning strategy across LLR, and this plan will be taken forward over the next couple of years.	£100,000 (based on savings due to rationalisation of management posts across LPT & UHL to reduce two band 7 posts costed at £46,346 plus £3,500 non pay costs)
Health and social care integration	Increased integrated working between health and social care providers to reduce the duplication of activity.	£50,000 (based on savings of 2 band 3 HCAs costed at £21,977 plus £3,500 non pay costs)
	Total	£299,000

Timeline for Delivery

The timeline for making these changes is set out below:

Figure 36: Children's services – timeline



Outcomes

These changes will improve health and wellbeing for children, leading to improved life expectancy and independence, and more children and young people will benefit from joined-up personalised care. There will be reduced duplication in the system, greater productivity, reduced inpatient admissions and less hospital-based outpatient activity.

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 37: Children's services – meeting system objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Children, young people & families	• Joined-up delivery across health & social care	• More support for carers • Services targeted at areas of most need	• Services more joined-up	• Less duplication between different teams • Standardised care pathways	• Reduced variation leads to savings amongst providers	• More partnership working across health & social care • More generic workers

Enablers

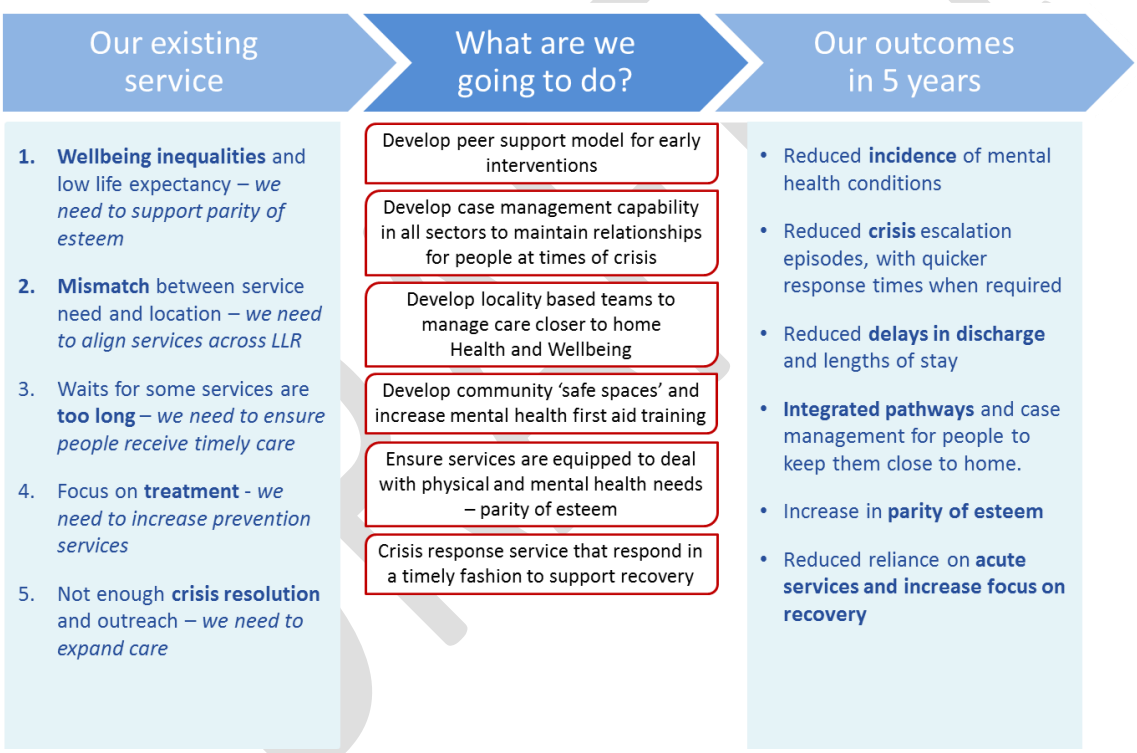
Implementing these proposed changes is dependent upon supporting changes in enabling areas:

- IM&T – technology to support a single point of access; mobile working devices; and the ability to share electronic records between providers;
- Estate – teams will need to be co-located in community settings to encourage integrated working;
- Workforce – developing new roles across health and social care; recruiting enough paediatricians to deliver 24/7 standards; consideration of joint appointments or "system wide appointments" for certain roles; and new roles and associated training.

2.7.7 Mental health

The mental health workstream addresses adult mental health services (primary, community and acute) and Liaison psychiatry and acute hospital In-reach. It does not cover dementia (part of the frail older people workstream), substance misuse or children's mental health services.

Figure 38: Mental health – summary



Objectives

The mental health service case for change is built around the need to achieve a "left shift" by moving activity from secondary care to community and primary care services. Central to this aim is a need to refocus on prevention and early diagnosis. When people need help from specialist services waiting times can be too long and those in crisis cannot always access services as quickly as they would like. Alternatives to hospital admission will also be provided to ensure people are treated in the least restrictive environment.

What will happen across LLR to deliver these objectives

The aims for mental health services are very similar to those for physical health services, and are focussed on delivering equal health status for people with mental health problems. The programme aims to deliver high quality safe mental health services; more joined-up across the primary care and secondary care interface; based on best practice; are easily accessible to those in need; reduce duplication and maximise productivity. The aims will be achieved by:

- Improving resilience within the population and individuals by strengthening prevention and self-help services;
- Enabling earlier intervention and more timely support in the event of crisis, through enhanced primary care capacity, backed-up by excellent acute care services;
- Increased access to alternative services, for example through IAPT;
- Improved education and knowledge within Primary Care through enhanced support to GPs;
- Offering a broader range of recovery options including peer support, the Recovery College and third sector services;
- Creating an integrated network of care services encompassing the third and statutory sectors;
- Refocusing community mental health teams to support primary care;
- More timely discharge of people from secondary care back to community and primary care services with support from the third sector and self-help groups;
- Providing more step-down support post-discharge, for example step down beds and crisis house facilities.

Detailed projects developed by the mental health workstream

The mental health workstream has worked alongside LPT to develop a suite of projects that will deliver both the LPT mental health CIP target and the workstream savings target. These two savings components were brought together to reduce the risk of double count and ensure that opportunities to improve quality of care and deliver efficiency savings within mental health were maximised. The workstream projects described in this section therefore fully support and enable delivery of the LPT mental health CIP savings.

Figure 39: Mental health – costed projects

Intervention	Description	Net annual saving
Implement Crisis House, step down beds, discharge team and changes to inpatient acute pathway to reduce out of county overspill placements	Investing in step down care, including a crisis house and step down beds, to enable a reduction in DTOCs and changes to the acute inpatient pathway, leading to the repatriation of patients out of county placements. The crisis house will provide face to face and telephone support for service users in crisis, either by appointment or on a drop-in basis. Additional services will provide overnight accommodation for up to 7 nights as an alternative to hospital admission. This will be supported through enhanced provision of urgent response with primary care, investment in social prescribing and short term increases in capacity in psychological therapies.	£2,800,000
Reduction in spend on alternative health placements	The programme will work to reduce alternative health placements by 40%, returning to their 2012/13 level, through repatriation; accelerated pathways; improved procurement.	£2,160,000 (based on a reduction in spend on alternative health placements phased at 30% in 15/16 and further 10% in 17/18)
Reduce staffing costs within IAPT	Agency staffing used currently. Assumes increased capacity for transitional period will reduce waiting times and improve efficiency	£100,000
Urgent patient clinics	This development is required to support deflection of patients from CRHT to CMHTs and to ensure urgent response is available i.e. within 24 hours	(£150,000)
Additional workstream productivity savings through new models of care to be developed	Target savings assigned to year 4 and year 5	£778,000
	Total	£5,688,000

Outcomes

The benefits for the LLR population will be increased resilience amongst those at most risk from mental ill health; more choices about how and where they receive help; a more timely response when in crisis and less need to access services outside of LLR.

For the system, the benefits will be less reliance on bed-based treatments and greater resilience within the LLR population leading to a smaller secondary care estate. The timelines associated with the mental health plans are set out below.

The table below shows how these benefits support delivery of the overall programme objectives:

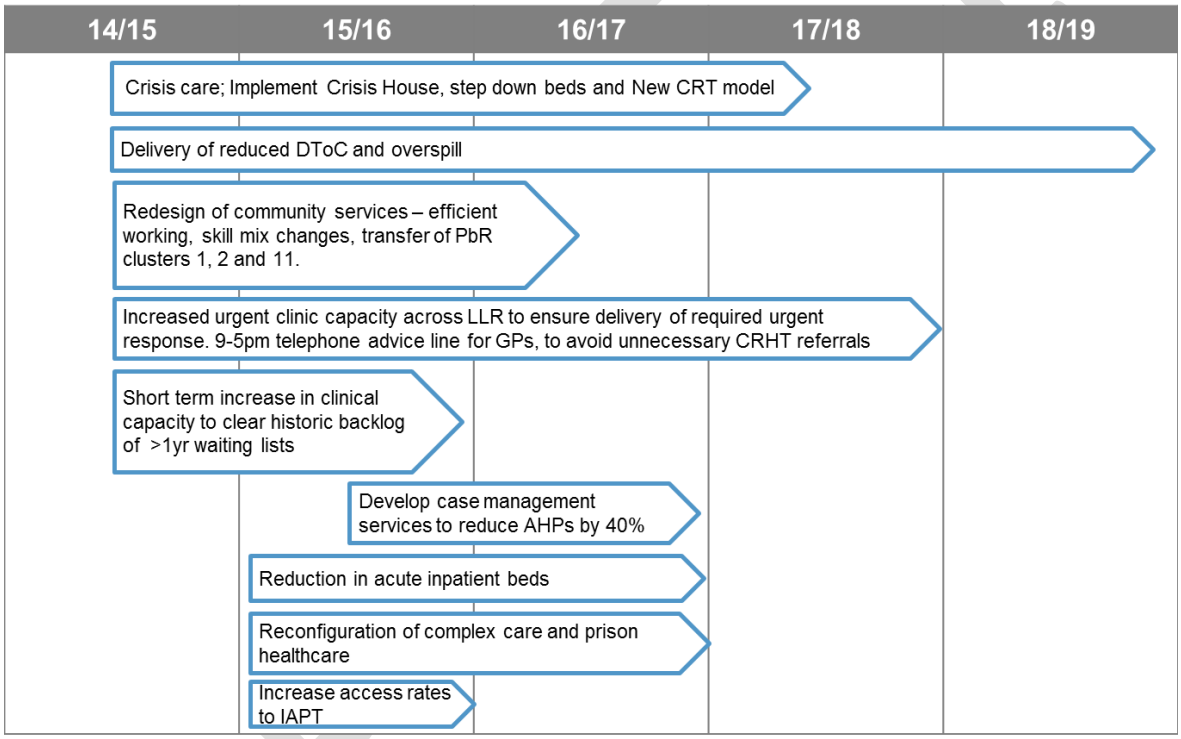
Figure 40: Mental health – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Mental health	• Joined-up delivery across health & social care	• More emphasis on tackling physical ill health	• Services more joined-up • Less reliance on admission	• MH clusters reduce variation in care	• Fewer admissions save LPT money	• New types of MH worker introduced

Timeline

The timeline for delivering these changes is shown below:

Figure 41: Mental health – timeline



Enablers

There are a number of links with enabling workstreams:

- Workforce – the mental health workforce skill mix will be reviewed to use consultants in consultancy and supervisory roles; reduce very senior staff numbers; up skill and extend the role of nurses including an assistant practitioner role; and develop the role of support workers. We will also build the role of peer support staff;
- IM&T – development of a universal connectivity to support remote working and access across clinical systems and create a culture and technology infrastructure to support performance management;
- Estate – exploit opportunities arising from the Centres of Excellence development and reduce the use of other inpatient sites and community bases. Community based staff will increasingly be co-located with colleagues.

2.7.8 Learning disabilities

The workstream seeks to address services for adults and children with learning disabilities (both community and residential based), supported housing (e.g. extra care housing), support for carers and Individual commissioning by social care and health.

Figure 42: Learning disabilities – summary

Objectives

The case for change for learning disabilities (LD) services is based on the need to provide care and support that is better co-ordinated and integrated between different health services and across the health and social care divide. The LLR-based provider market for learning disability is disjointed and underdeveloped leading to a high unit cost of care and a limited choice. In the future health and care services must fully embrace the principles of "Valuing People" and the personalisation agenda, to better support people to access universal services as standard practice rather than diverting to specialist LD services.

The aims for this workstream are to deliver responsive, high quality safe learning disability services and support that maximises independence. Services will support informed choice, be person centred, good value and meet the needs and aspirations of individuals and their family taking into account the diversity and changing demographics across LLR.

Services and support will be more joined up across social care, independent and voluntary sector providers, and between primary and secondary care helping to reduce duplication, maximise productivity and keep people local. Services will be based on best practice, easily accessible and quality assured by:

- Working with partners to ensuring practice is responsive to national policy and guidance including the Care Act, The Children and Families Act and the Winterbourne View joint improvement programme; Working with individuals, families and providers to develop local services and support that is outcome focussed;
- Providing enhanced support and information for carers, including access to short breaks;
- Reducing the number of joint funded out of county placements, which is likely to have a knock on impact on the need for transport to out of county settings;
- Maintaining the target for the number of health checks completed and improving the number of health action plans;
- Developing information systems for ensuring LD status are included in referrals to secondary and community care;
- Working with partners to consider options for improving effectiveness of autism pathways;
- Promoting the use of personal health and social care budgets.

What will happen across LLR to deliver these objectives

The follow projects will be implemented to deliver these objectives:

- 'Early identification and intervention for people with a learning disability (LD) to live more independently when they reach adulthood and prevent reliance on formal, specialist services 'Market Management' – LLR approach to stimulating and managing the market to meet changing aspirations and needs;
- Develop pathways which incorporate specialist provision such as assessment and treatment and outreach to support people to live in their local community for as long as possible, including the introduction of clear agreements and frameworks between health and social care for meeting people's needs;
- LLR approach to enable carers to be involved in service development and planning, including modernising the provision of short breaks, information, advice and guidance;
- Flexible LLR wide provision of short term intensive crisis support based on need;
- Develop locality based care, support and workforce, including primary care and secondary care, to broaden the offer and improve the experience for people with LD;
- Pooled personal budgets and personal health budgets for people with people with LD that meets needs in a cost effective and person centred way.

Detailed projects developed by the learning disability workstream

The workstream has developed the following projects:

Figure 43: Learning disabilities – system wide projects

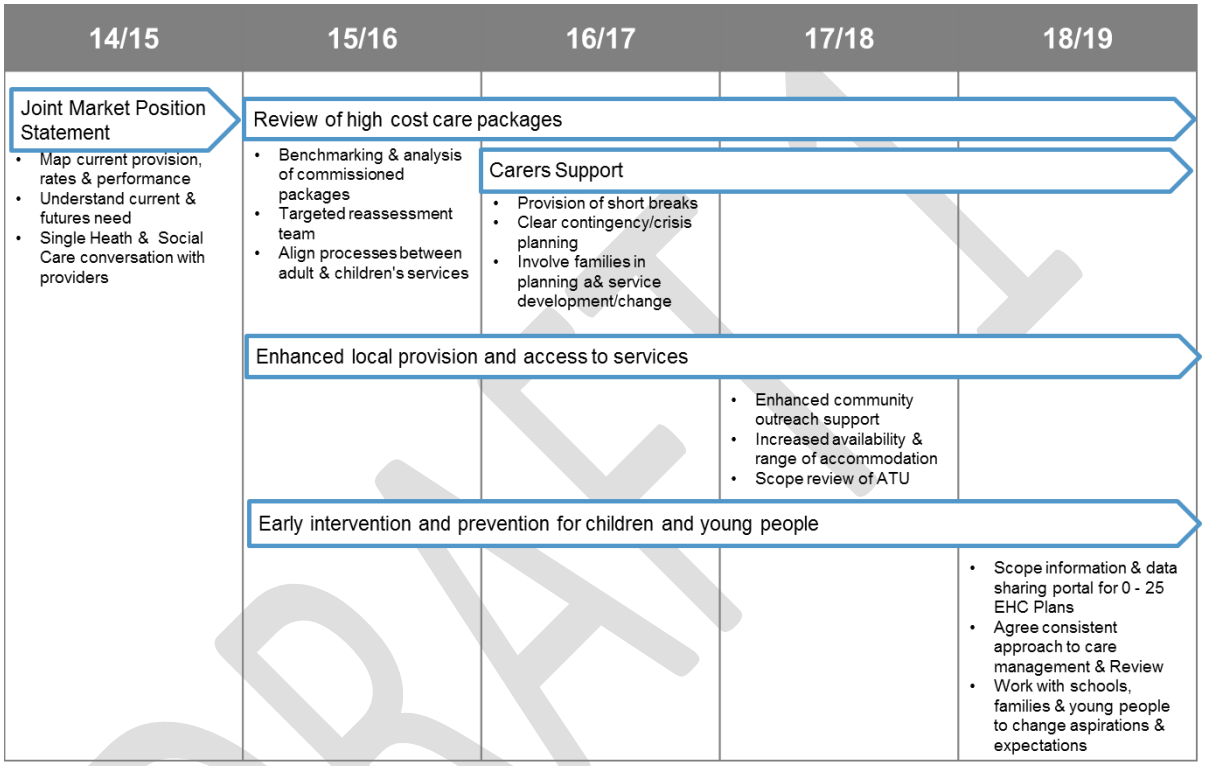
Intervention	Description	Net annual saving
High cost CHC packages	Putting in place a review team to benchmark and analyse the cost and content of high cost packages of care, focussing on consistency across health and social care. In conjunction with the development of a joint market position statement, this will ensure that health and social care leverage their combined resources to ensure best value for money is achieved for service users receiving packages of care.	£756,000 (based on a 5% reduction in expenditure)
Reconfiguration of short break services for LD patients / service users	A plan to reconfigure the provision of short break services for LD service users, ensuring a consistent approach across LLR. This will enable carers to be involved in service development and planning, including modernising the provision of short breaks, information, advice and guidance.	£969,000
LD Outreach Team	Implementation of an Outreach Team that will work between the community and the Agnes Unit for challenging individuals who require additional support. This team aims to reduce the number of admissions into the Agnes Unit by working with individuals in a community setting who are not suitable for admission, yet require additional support. The team will also help to reduce the length of stay in the unit by	£134,000 (based on a decommissioning of 4 beds and releasing 1 WTE Band 6 Nurse= £44,512 6 WTE Band 5 Nurse= £ 219,930 12 WTE Band 2 HCSW = £291,768) Offset against outreach team

	providing support to challenging individuals.	cost of £422,000 (6.6wte plus non-pay costs)
	Total	£1,859,000

Timeline for delivery

The timeline for delivery of these proposed changes is shown below:

Figure 44: Learning disabilities – timeline



Outcomes

These changes will enable individuals and their families/ carers to have more independence and control over their lives. Support will be tailored and joined-up across agencies and carers will benefit from better access to a range of respite services (short breaks) that are responsive and dependable. Services and planning arrangements will support people with LD and their families in times of crisis, reducing the need for admission to inpatient care. The majority of care and support will be provided locally and the need to travel outside LLR to access services will be reduced. People with LD will have their rights respected and upheld and will receive the same care and support as all other citizens.

These changes will also generate efficiencies through integrated service delivery and better collaborative working. Commissioners will gain better value for money from an improved marketplace offering greater choice and competition.

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 45: Learning disabilities – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Learning disabilities	• Joined-up delivery across health & social care	• More support for carers	• Services more joined-up	• Less duplication between different teams	• Market development reduces placement costs saving commissioners money	• More partnership working across health & social care • More generic workers

Enablers

The key enablers underpinning these changes are:

- IM&T – technology supporting a single point of access; mobile devices to support mobile working; and shared information systems including access to records and support plans for individuals and families;
- Estate – the co-location of health and local authority staff;
- Workforce – new roles and approaches at all stages of the pathway; marketing the benefits of working in health and social care across all sectors; and support to GPs to enable them to support more people with LD in primary care.

2.8 Provider impact

2.8.1 University Hospitals of Leicester NHS Trust

A significant proportion of the health economy benefits will be delivered through organisational savings at UHL and LPT, however the delivery of these savings is reliant upon the broader delivery of the workstream projects, which will be required to enable the significant transformation programme set out here. More detail on trust savings programmes is set out in the Financial Case.

UHL has the following vision:

> *"In the next 5 years UHL will become a successful Foundation Trust that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience…*

The trust's "strategic direction" was published in November 2012[14]. This set out at a high level the future shape of UHL's clinical services:

> *"Overall Leicester's hospitals will become smaller and more specialised and more able to support the drive to deliver non-urgent care in the community. As a result of centralising and specialising services we will improve quality and safety… this will be done in partnership with other local health organisations and social care though the Better Care Together programme. We will save money by no longer supporting an old expensive and under used estate and we will become more productive."*

The trust's plans to deliver against its vision and strategic objectives are set out in its five year Integrated Business Plan which seeks to ensure that the vision of "smaller more specialised hospitals" becomes a reality, and that ongoing issues with emergency and urgent care are solved and that the trust returns to financial balance. Whilst the trust has responded to growing demand, analysis has shown that a significant proportion of hospital beds are occupied by patients whose clinical needs could be met more appropriately in alternative care settings – the models of care described above are the route by which UHL will work with the rest of the health and social care community to provide treatment in more appropriate community settings for these patients.

The result of the shift to community settings will be less need for acute hospital beds and associated physical assets. The trust intends to use the resulting opportunity to consolidate acute services onto a smaller footprint and to grow its specialised, teaching and research portfolio; only providing *in hospital* the acute care that *cannot be provided in the community*. In doing this the trust expects to significantly increase the efficiency, quality and, ultimately, the sustainability of key services; shrink the size of the required estate; significantly rebalance bed capacity between acute and community settings, and thus reduce total costs. This refocus will also allow the trust to concentrate on the other element of its strategic direction, "to become more specialised".

The shift of activity to community settings involves UHL releasing 571 acute beds. In order to release those beds UHL needs to undertake a number of initiatives, primarily focussed on reducing the average 'Length of Stay' (LoS) of its' patients. The areas that UHL have focused on are reducing delayed transfers of care (DTOC) and increasing day surgery activity in line with BADS guidelines. The eight workstreams are also leading on ensuring that less activity arrives at UHL due to earlier intervention and providing more appropriate settings of care. Underpinning these initiatives and the eight workstreams is UHL's capital programme, which is a key enabler, to UHL being able to shift activity into the community. The programme entails 17 different business cases for a variety of estate changes. These include new builds and refurbishment of existing estate which enable UHL, to rationalise their sites from three to two.

In order to be able to receive the increased activity, LPT, Primary Care and Social Care will need to adapt their capacity to be able to receive more patients with more complex needs.

[14] UHL Strategic Direction, November 2012

2.8.2 Leicestershire Partnership NHS Trust

LPT's vision is to:

> "*To improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental health care pathways".*

The Trust's clinical strategy[15] has the following objectives:

- Care that is effective, safe and personalised;
- Integrated care in the community
- Helping people to stay healthy and well;
- A focus on recovery-based approaches;
- Working and learning together; and
- Research and innovation.

These objectives will, in part, be delivered through three transformation programmes aligned to BCT:

- Co-ordinated community health services – creating effective, more integrated pathways for frail older people and adults suffering from chronic conditions;
- Creating effective, more integrated pathways for children and young people; and
- Creating effective, more integrated pathways for adults with acute and enduring mental health conditions and those with complex learning disabilities.

As a consequence of delivering the eight BCT clinical workstreams, LPT expects its bed base to reduce by around 87 beds over the period, as more people who are currently treated in acute hospital settings will be treated at home by integrated mental health or physical health locality teams. The trust's community hospitals will also become hubs for co-located health and social care community teams, as venues for outpatient and diagnostic activity, and as settings for step down and step-up inpatient services. Whilst these sites experience more activity and become better utilised, this does not mean that the number of community hospital beds will increase.

LPT's efficiency programme includes a drive to reduce the length of stay, and need for admission for the existing cohort of community hospital inpatients, by providing more support through expanded community teams. Community hospital beds no longer required for these patients would then become available to be utilised by part of the cohort of patients who are currently admitted to UHL. The consequence will mean an overall reduction in the need for beds at UHL and an overall increase in the number of people cared for at home.

[15] LPT Clinical Strategy, March 2014

2.8.3 Bed reconfiguration summary

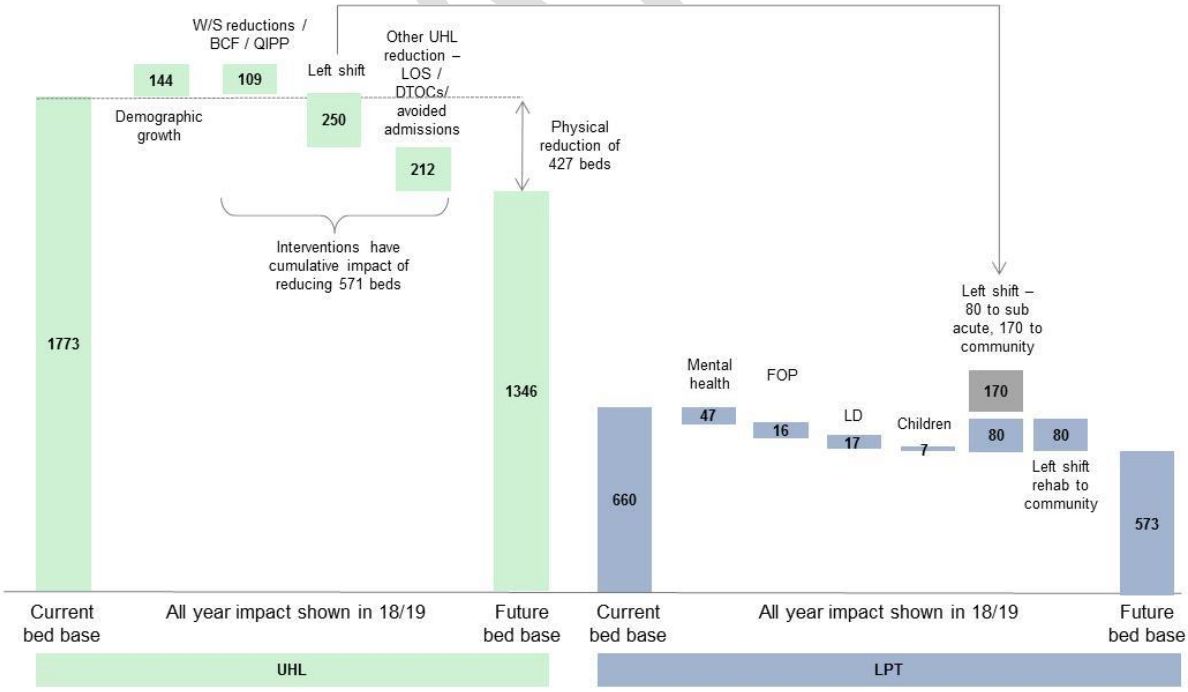
The LLR LHE strategy outlines a new model of care which results in a reduced number of acute beds and a shift of care into a community setting. The current bedded model of service provision across LLR includes 1773 acute beds across 3 acute hospital sites and 660 community and mental health beds in eight community hospitals and one mental health hospital.

The current plan is to re-provide the bedded activity through a smaller number of acute beds by increasing the level of acuity of patients treated within community hospitals and providing more support closer to home through community nursing teams and community based support.

In total, actions need to be taken across LLR to remove 571 beds from UHL. This is made up of:

- 462 beds related to UHL efficiency reductions and left shift of sub-acute patients to LPT;
- 109 beds related to workstream efficiency reductions. Overall, this will mean that UHL's bed base will reduce by 427 beds because some of this reduction is required to reduce anticipated activity growth over the five years of the plan. The graph and table below illustrates the left shift:

Figure 46: LLR bed bridge



The current phasing of beds to be taken out of UHL is as follows, however further details will be provided over coming months in order to develop a comprehensive beds strategy.

UHLs detailed bed reduction

Figure 47: Profiled bed reductions

Year	Physical beds reduced
15/16	203
16/17	122
17/18	61
18/19	41
Total	**427**

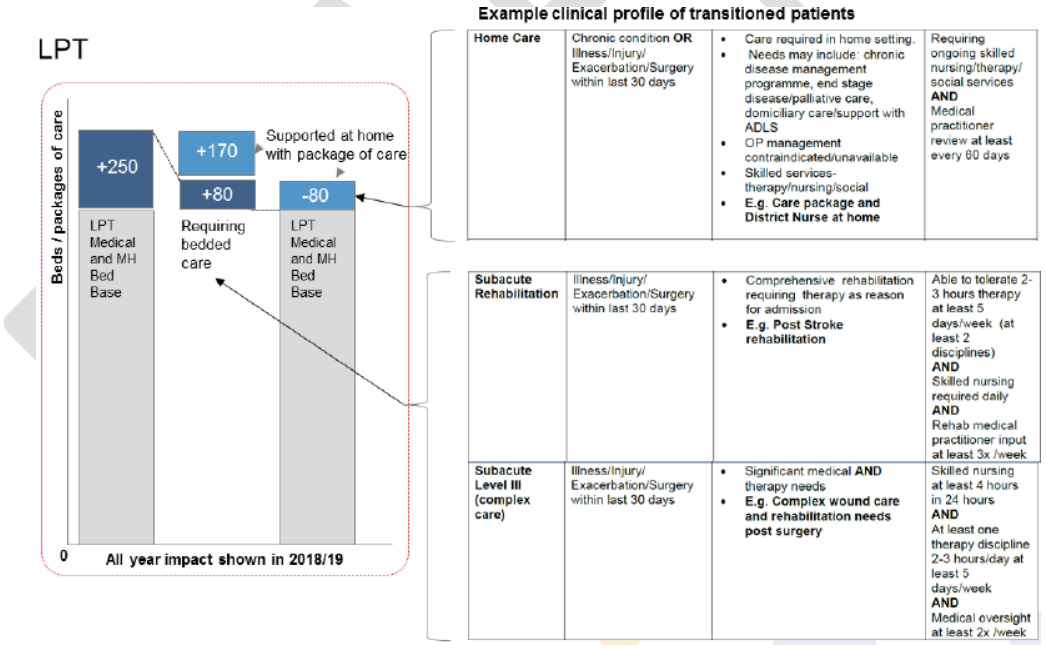
Left shift into the community

UHL and LPT have agreed that 250 beds worth of patients can be cared for outside of an acute setting. The 250 beds are broken down as follows:

- 170 where patients can be treated by expanded community teams;
- 80 "sub-acute" beds, where patients need to be treated in an existing community hospital bed, with enhanced home care support.

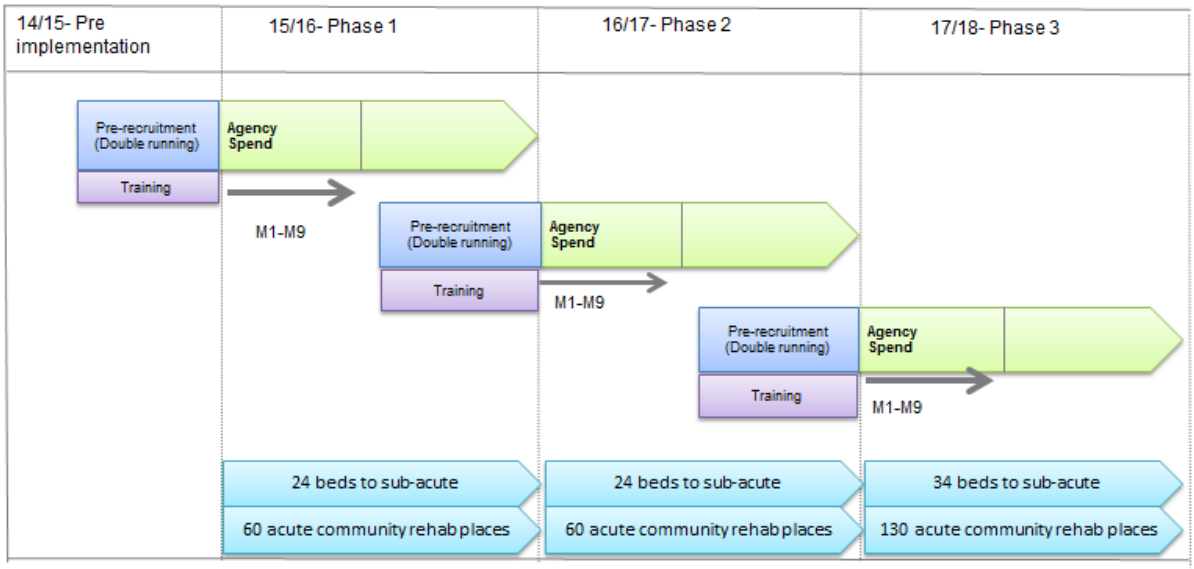
The shift is illustrated below:

Figure 48: LPT bed shift



Plans are being put in place to move patients from UHL to LPT in three phases. This is to allow time for sufficient staff recruitment to take place, and to give time for existing rehab patients currently being seen in community hospitals to be discharged from existing rehab beds to be treated in a community setting.

Figure 49: UHL reductions through efficiency gains and working more closely with different partners in the system



In June UHL identified 462 beds worth of activity which could be delivered outside of an acute setting. Of this 462, 250 have been agreed with LPT (as outlined above) to form the left shift to community settings, and a further 212 can be closed due to improvements in internal efficiencies. There are two main drivers for this reduction:

- BADS reductions – where activity that was previously provided in an inpatient "elective" setting in UHL can in the future be provided as a "day case", preventing the need for beds;
- Length of stay reductions, where the overall length of stay can be enabled through improved working with other partners in the system and greater efficiency at UHL. This will be achieved through reducing excess bed days, working with partners to reduce delayed transfers of care (DTOCs) and treating patients on ambulatory care pathways, where they are not admitted to a bed upon arrival at the hospital.

Workstream efficiencies

109 beds need to be removed through admissions avoidance, which will primarily cancel out the effects of forecast increases in activity growth at UHL over the next five years. This reduction will be achieved through planned work taking place driven by CCG QIPP and BCF initiatives, in addition to the system projects which have been identified by the clinical workstreams. The current reductions are outlined below:

Figure 50: Required efficiencies

Workstream	Initiative description	Bed impact assumptions
Urgent Care	Community based unscheduled care teams will be able to deliver care for patients with ambulatory care sensitive conditions, targeted at those patients with an existing length of stay of between 0-5 days.	24
QIPP – Better Care Fund plans	3 x BCF plans will reduce NEL admissions by 1013, 1911, 70 (total 2,994 admissions). Bed reduction based on ALOS of 3 days and reduced for 93% utilisation.	26

The numbers in the table above total 50 beds, which means that a gap currently exists against the 109 target. Currently other workstream initiatives have been discounted from this breakdown due the risk of double-counting patients, however further work is taking place to develop actions which will reduce the full number of beds as required.

Financial impact

An £11m benefit to the health economy has been identified against the elements of the beds reduction identified by UHL, encompassing BADS avoided admissions through treating patients in an ambulatory care setting, LOS reductions and patients shifted out to community settings. This is assumed to be broken down as follows:

Figure 51: UHL bed reductions – financial impact

Category	Bed reduction	Health economy impact	CCGs impact	LHE benefit
Left shift to LPT	250	• UHL loses margin on activity (-£2.3m), LPT gains additional contribution through providing at lower marginal cost (£4.3m) • No impact on commissioners	N/A	£2.01m
BADs	67	• UHL saving as daycase assumed to have a marginal cost of 50% of tariff compared to IP at 70% (£1.02m saving)	N/A	£1.02m
UHL efficiency gains	145	• Activity completely removed from UHL so lost contribution (£2.3m) (includes an additional financial impact equivalent to 32 beds after growth applied to 18/19) • Commissioner saving of tariff related to activity (£9.3m)	£9.3m	£7.98m
Total	**462**		**£9.3m**	**£11.01m**

Further work is required over the coming months to confirm the exact cohorts of patients affected by these bed reductions to ensure that LPT and UHL are completely aligned around the left shift and where changes to the model of care are required.

2.8.4 Primary care

Primary care is provided in community settings by a range of practitioners, including general medical services, dentists, pharmacists and optometrists. For the purposes of this section, the initial focus is the development of general medical services, with CCGs developing strategies in accordance with the NHS England Leicestershire and Lincolnshire Local Area Team framework for primary care (July 2014). CCGs have also applied the learning from best practice elsewhere[16].

While each CCG is different – i.e. different geography, different populations, and different history – there is a common theme of collaboration across primary care to overcome workload pressures, offer accessible local alternatives to acute care, and to prevent illness or exacerbation. All three CCGs have engaged GPs and others in setting out a vision for the future of local primary care.

The three CCG primary care strategies are summarised below:

Figure 52: Primary care – summaries

Leicester City	The vision is to develop a fit-for-purpose primary medical care service that will contribute to improving health outcomes and reducing health inequalities across the City. We are considering establishing four 'neighbourhoods' defined by health need. The proposed delivery model is for patients to be streamed to appropriate healthcare individuals; with the more complex seeing a GP. Resources across practices may be pooled and collaboration between practices would be encouraged though not enforced. Demand and capacity planning will be undertaken to establish the right standards of workforce, premises, skills and resources required for this new primary care delivery model. Discussions are ongoing about the development of a 'quality' contract based upon measurable improved health outcomes for those services over and above the core primary care contract. Through effective commissioning we will ensure that all patients have access to a uniform range of services, matched to their health need and delivered to a consistent level of quality. We shall do this by designing a framework with varying levels of delivery, as shown below. Elements of service delivery for Urgent Care, LTC, FOP and Planned Care will be delivered across primary care, with a mixed economy of individual practice delivery and local hubs for more complex services.

[16] NHS England, The Heart of Patient Care, Transforming Primary Care in Essex http://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2014/05/print-trans-prm-care-1.pdf, viewed 24 September 2014.

West Leicestershire	We have a clear vision for the future of primary care in our CCG in which general practice is the foundation of a strong, vibrant and joined up health and social care system. This new system is patient centered, and provides accessible high-quality, safe, needs-based care. This is achieved through expanded – but integrated – primary and community health care teams, offering a wider range of services in the community with increased access to rapid diagnostic assessment, co-located specialists and crucially patients taking increased responsibility for their own health and wellbeing We believe that the vast majority of health problems in the population – including mental health – could be dealt with by primary and community care. Currently we have not fully realised the potential of general practice and too often patients receive care in hospital that could be safely provided in the community, coordinated through their general practice, supported by the wider health and social care teams. Over the next five years our new model for general practice will be realised - the practice and the primary healthcare team will remain the basic unit of care, with the individual practice patient list retained as the foundation of that care. However, whilst a large proportion of care will remain within a patient's own practice thereby recognising the importance of the therapeutic doctor – patient relationship, an increasingly significant proportion will be provided by practices coming together to collaborate in federated localities, using their expertise, sharing premises, staff and resources to deliver care for and on behalf of each other. In this way, it will be possible to improve access and provide an extended range of services to our patients at scale.
East Leicestershire & Rutland	The vision for primary care is for general practices to work together to provide services at a greater scale across a local area, bringing more specialists and wider primary care professionals together, in order to provide better integrated care particularly for those patients with complex needs. General practice will be fully integrated, proactive, coordinated and sustainable; with a model of service provision delivering seven day services 'wrapped around' each patient. Continuity of care will be offered by a named GP. ELR's plan involves the development of up to 11 hubs, with extensive support to agree a contract to provide Community Based Services to a population of 25,000 – 45,000. Working at scale enables key specialist nursing and medical staff to be brought to this level to work with the GPs. It enables a more integrated way of working with the community services hubs already structured in this way, and offers broad career opportunities which will make ELR much more attractive to GPs and others, increasing our ability to recruit and retain a high quality primary care workforce.

How will improved primary care support the delivery of the clinical workstreams?

Three specific workstreams have been identified as having a particular overlap with the continuing development of primary care services.

Figure 53: Workstream contribution to primary care

Workstream	Primary care contribution
Urgent care	In ELR a streamed service will likely mean greater access for patients who need immediate care. Four urgent care hubs will be commissioned from April 2015 which will greatly increase both in hours evening and weekend access for patients. This will reduce the burden on ED departments for non- emergency patients. Leicester City is putting plans in place to pilot 7 day working across the 4 health need neighbourhoods, subject to securing additional winter funding from NHS England. In addition, the seven day working pilots already underway in West Leicestershire will be used to help inform the wider rollout of seven day working in primary care and community settings which is a key component of the Urgent Care Work stream.
LTC / FOP	In East Leicestershire and Rutland the patients who are streamed into the "complex" group will have greater GP and nurse/ MDT access with detailed plans in place for all aspects of their care. This service is planned to be offered 7 days per week for these complex patients to reduce the need for emergency services. Pilots have already commenced in 2014. Leicester City has begun to look at a model where all 62 practices undertake core sets of services and are able to apply to undertake additional community based services on behalf of their own patients and others. It is anticipated there will also be hubs which provide more complex services, delivered by a small number of accredited providers. In West Leicestershire the Primary Medical Care Plan identifies the need for greater integration and collaboration and the provision of integrated care at a locality level. Using the four localities as the geographical unit at which care is commissioned coordinated and provided we will build on existing structures such as virtual wards and Federations to support patients with frailty and the move to deliver more sub-acute care outside of an acute setting. Our overarching philosophy is that admission to secondary care should be the last resort for any patient where it is clinically appropriate and that discharge home from acute care should be achieved as quickly and efficiently as possible. In our model we will increase the proportion of care patients receive close to home through effective, timely interventions. This will require increasing access 7 day care management and where appropriate over a 24 hour period, developing flexible models that enable care to be provided in both a scheduled and unscheduled manner to meet the needs of patients and at the time they require it.
Planned care	Appropriate peer review, improved diagnostics and specialists working in an out of hospital setting will help to reduce the need for patients to be referred in for Outpatients. This will need to be managed in line with local alliance / federation contracts. Working in this way has the potential to support the planned care workstream through improving the quality of referrals, up skilling GPs and supporting the development and implementation of new pathways.

Improving efficiency in primary care

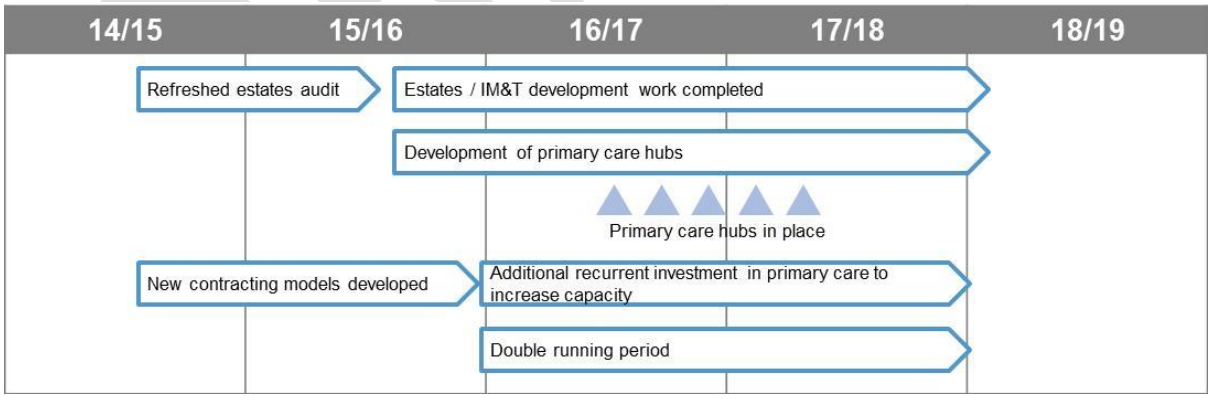
Discussions from across LLR suggest that:

- Significant clinical time could be saved through better organisation and a redesign of the general practice model;
- It may be possible to stop up to 10% of GP contacts by organising better and improving access to other health professionals, allowing GPs to focus their time on those patients who need them the most;
- A significantly greater number of patients could be empowered to self-care through developing a new model in general practice;
- The model of funding and delivering primary care is complex with Core, DES, Local investment and Community-Based services all paying for elements of the service provided. Any changes will enable simplification and scale, reducing duplication and the need for as many non-clinical staff. This will create an opportunity for re-investment into new or differently skilled clinical staff to support the practices /hubs;
- The new model will require a broader range of clinical skills both within general practice and in the ancillary services. Within general practice there will need to be more highly trained nurses and GPs with broader skills for both planned and complex care. This will require new investment alongside the reinvestment of any efficiencies;
- Delivering the same GP system across all practices, community services and urgent care centres in East Leicestershire and Rutland will enable clear information sharing and ability to manage patients appropriately first time without any delay.

Driving forward transformational change in primary care

The transformation plans set out for all three CCGs will require significant planning in order to significantly increase capacity. The below timeline sets out the expectations for how this development will be phased over the next 4 years:

Figure 54: Primary case phasing of transformation



Additional funding to support the changes in primary care

It is anticipated that significant additional funding will be required, both recurrently and non-recurrently, to enable the transformation in primary care which is planned across LLR. The non-recurrent elements of this are being worked through in further detail but are likely to be broken down into:

Double running costs to deliver the change in capacity required by primary care to enable the left shift
Estates costs of improving existing premises and developing primary care hubs
Any associated **IM&T costs** associated with new equipment / services

Double running costs

During the period where capacity is increasing in primary additional non-recurrent funding will be required as new services develop and new staff are trained. This funding will cover the following categories:

- Education and training;
- IM&T improvements and alignment to support development of hubs;
- Management costs, including legal;
- New equipment;
- Time and motion studies to enhance the model.

Broad estimates have been made on the overall level of non-recurrent funding required to support this shift, on the assumption that the left shift will require a similar level of support for primary care as in other care settings.

Estates

Across Leicestershire there is a need for new estates development as hubs develop. In East Leicestershire there are currently 33 practices, of which half have previously been identified as in need of significant estates development. The CCG estimates that the required capital will be around £29m.

The West Leicestershire Primary Medical Care Plan clearly identifies that investment in primary care premises is crucial to the successful implementation of the plan. Investment is needed both 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 the wider health economy transformation. In order to make this a reality where possible we will explore with our partners options for utilising existing facilities more effectively however there is still a clear need for capital investment in primary medical estate to support primary medical care to work at a greater scale as outline in the Better Care Together 5 Year Strategy.

In West Leicestershire it is estimated that £9.25m is required to expand 3 high risk premises in North Charnwood, the expansion of two high risk premises in South Charnwood, and additional investments in HWL and Hinckley and Bosworth.

Leicester City CCG anticipates that around £8m will be required for new buildings, expansion and refurbishment, enabling the facilities to undertake planned care activities. This is based on an assumption of £2m for each of the four health need neighbourhoods.

IM&T

Data and information are at the heart of any drive to improve quality and patient service. Across West Leicestershire and East Leicestershire and Rutland there is a need to align GP systems. Having all practices, community services and urgent care centres on the same system would enable clear information sharing and ability to manage patients appropriately first time without any delay. West Leicestershire estimates that it will cost £500k to move all practices to one IT system and in ELR this figure would be around £300k. In Leicester City and West Leicestershire the CCGs estimate that £0.15m will be required to increase access to virtual consultations, and in the City an additional £0.15m will be used to prepare for hub working, improving system configuration.

2.8.5 Social care

Social care is a critical element to the successful delivery of the Better Care Together programme. Working together, health and social care partners across LLR aim to provide integrated, high quality services, delivered in local community settings where appropriate, whilst improving emergency and acute care.

What is adult social care?

Some people need extra care or support - practical or emotional - to lead an active life, do everyday things and to fully participate in local communities. Adult social care aims to provide care for those who need extra care and support, and enable people to retain/ regain their independence and dignity.

Adult social care provides support for adults, including unpaid carers, who are in need of support because of serious illness, physical disability, learning disability, mental health problems or frailty because of old age. Access to adult social care is subject to rules about needs and ability which determine eligibility for support and whether a person needs a short period of support to prevent, maintain or improve their independence, or whether longer term support is required. If the person has ongoing needs, a Needs Assessment will be carried out to determine how needs can be met.

What does social care provide now?

Adult social care services provide advice and information, assessment and support for all adults over 18 years of age. Provision focuses on offering accurate advice and information for individuals to make informed choices.

Re-ablement services are time limited projects aimed at minimising the impact of disability or illness. This approach aims to support individuals to regain new skills and adapt to their conditions through a period of intensive support and/ or provision of equipment.

Crisis response services work with partners to support people experiencing a health or social care crisis within their own home. This flexible and responsive approach aims to deal with urgent needs that without support could result in a residential or hospital admission.

People with eligible needs can receive financial support to meet their assessed social care needs through a Personal Budget. Adult social care has a responsibility to ensure there are

services and goods available in the market for people to buy using their personal budget, which can support them to meet their outcomes.

In Leicestershire, Leicester and Rutland, policies and procedures are in place to ensure the relevant agencies and services work together to prevent abuse and to help and support adults with community care needs who may have been the victim of abuse.

Figure 55: Social care – services and outcomes

Support	Services	Outcomes (ASCOF)
Primary Prevention (universal services)	Information and Advice	Ensuring that people have a positive experience of care and support
Secondary Prevention (targeted towards those at risk of needing support)	Low level mental health support, support groups, lunch clubs, carer services – promoting carer health and wellbeing.	Delaying and reducing the need for care and support
Tertiary Prevention (minimising impact of disability)	Re-ablement Assistive technology, equipment and adaptations. Intermediate Care – Crisis Response Services, Carer Support	Delaying and Reducing the need for care and support
On-going support (access via assessment of eligibility, need and allocation of resources – Personal Budgets)	Personal Budgets (Cash or Managed) Home Care Community Life Choices Shared Lives Service Home Care/ Domiciliary Care Residential Care Supported Living Support for carers - Respite	Ensuring that people have a positive experience of care and support Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm. Enhancing quality of life for people with care and support needs

Service Utilisation

The adult population in Leicester, Leicestershire and Rutland is forecast to grow by around 28,300 (3%) by 2020, the majority of which will be people aged over 65yrs. There is a rising demand for health and social care, with the local population growth being much more significant (12%) in the over-65 population as illustrated below:

Figure 56: Social care – utilisation

	13/14 Receiving Care	Leicestershire	Leicester	Rutland
Aged 18 – 64yrs	Community Based Services	2,705	2,175	165
	Nursing/Residential Care	515	430	25
	Total Care	3,220	2,605	190
	% of 2014 population	**1%**	**1%**	**1%**
Aged	Community Based Services	4,825	2,620	480

65yrs or over	Nursing/Residential Care	1,695	930	135
	65+ Total Care	**6,520**	**3,550**	**615**
	% of 2014 population	**5%**	**9%**	**7%**

What is the vision for social care?

The aim of adult social care is to promote the wellbeing and maximise the independence of older and disabled people. This means improving outcomes for vulnerable people and ensuring that publically funded care and support is provided where it is cost effective and only when it is really needed. These objectives are most likely to be met through integration of commissioning and services with the NHS. Integration is required across the whole health and care system and will require an agreed approach to sharing risks, costs and benefits, for example through pooling of resources. Commissioning strategy will be directed towards improving outcomes through appropriate incentives for providers, and moving away from using the historic time and task approach which will become unsustainable.

Social care will support the “left shift” by managing demand and helping to ensure that there is an effective unified prevention offer that enables communities, families, carers and service users to be self-supporting. It will also work with the NHS, housing bodies and other partners to provide more targeted secondary preventative approaches for people at risk of losing their independence. These approaches will ensure scarce care and support resources are directed effectively. The model for delivering longer term support will continue to promote independence, choice and control; and will seek to improve outcomes for service users and their families whilst remaining cost effective. Enabling people to access support in the appropriate housing will be key to success.

A strong communication and engagement strategy with the workforce, communities, service users and carers will be needed to achieve the delivery of this vision for social care.

Performance

All adult social care departments use the Adult Social Care Outcomes Framework (ASCOF) to measure progress in the delivery of care and support. The ASCOF is a national framework written by the Department of Health and it helps support our understanding of the outcomes and experiences of people who use care and support, based on information collected from all councils providing social care across the country which is then published.

The Care Act 2014

The Care Act 2014 seeks to consolidate existing social care and health laws and introduce new duties to local authorities to ensure that wellbeing and equitable provision is delivered across England to all those with eligible needs. From April 2015 this will include unpaid carers and people in custodial establishments. The Care Act 2014 will also reform the funding of social care provision, in particular, how care is charged for and how much people will have to pay towards their care costs.

The Care Act 2014 also assists people and their families with low level needs by ensuring adequate information, advice and guidance is developed and delivered. A focus on

preventing need and reducing decline will ensure that people can live independently for longer and have choice over the support they receive.

Key risks to delivery

The demographic changes driving demand for the NHS also drive demand in social care. The increasing numbers of frail older people and younger people with complex needs will continue to increase demand for service into the long term. These demand pressures are not reflected in the resources allocated to councils to meet local need.

The current economic situation continues to be extremely challenging, resulting in significant and on-going reductions in Government funding. With an increasing demand for services, further duties under the Care Act 2014, reduced funding and a need to achieve efficiency targets, social care faces difficult decisions in order to deliver its savings commitments.

In Leicestershire County (the third lowest funded County Council) the savings target over the next four years for the adults and communities department alone is £21million (16% of its total budget) even though £40million of savings have already been achieved.

Since the onset of funding cuts in 2011/12, Leicester City Council has approved plans to reduce its expenditure by £85m per year. Whilst there is no certainty beyond 2015/16, if the current trajectory of funding cuts continues, the Council will need to make reductions amounting to a further £60m per year by 2017/18. It is unclear at this stage what the impact on social care will be.

Rutland County Council has a five year medium term financial plan and by 2018/19 will be required to save up to a minimum of £3m (c10%) of its current budget to maintain spend within a reduced level of resource. As a low cost Council whose spend per head on all services and on adult social care is lower than the national average, this target will be challenging. The Council has undertaking a review of its People Directorate and will be making savings in this area but further savings may be required.

The situation is similar in Rutland where 33% of current council expenditure is on adult social care. Significant savings across all three councils will impact on corresponding health services, although this process will be assisted by the expansion of the BCF fund in 2015/16.

The implementation of BCF plans will act as a catalyst to integrating health and social care provision, in addition to offering protection for critical adult social care services. The fund will further progress integrated locality working resulting in a more efficient and coordinated service for the people of Leicester, Leicestershire and Rutland. Social care has a key role in managing pressures in acute care and failure to manage the demand and budget pressures on councils will have a significant impact of hospital discharges and DTOC.

The Care Act 2014 consolidates over sixty years of social care legislation and reforms the way care is funded. The Act brings many challenges and opportunities, although work to determine the costs of implementing new/ revised duties so far indicate a significant shortfall in funding compared to cost.

Funding concerns can be summarised as follows:

- Increased demand for information and advice, assessments and carers' support services will have a significant financial impact, particularly in light of reductions in councils' overall baseline spending power;

- Understanding the volume and behaviour of carers and self-funders locally needs to underpin local planning and preparation;
- Financial assessments;
- Capping costs;
- Deferred payment agreements.

Significant change is required to meet these challenges and needs to be delivered with customers at the heart of service redesign.

Market issues

Although traditional service models are still in the majority, the social care market place is changing. Providers will need to be less reliant on block contracting arrangements as these opportunities will reduce; replaced with direct arrangements between providers and people using services. Within these conditions there remains a commitment to ensure the independent sector provides high quality services, which is reinforced through clear contractual agreements and monitoring requirements. For home care service provision has been mapped and commissioning aims to meet appropriate quality and ethical standards.

Changing demand and commissioning arrangements will see a shift towards a more diverse market place with opportunities for providers to offer more creative, non traditional service models. Business models will need to reflect the move away from block contracting; marketing services directly to those that will be using them, including those that fund their own care and support.

The integration agenda will challenge providers to look at ways in which they can meet both health and social care needs. Newly commissioned services will be outcome focused, supporting individuals to maximise their independence and minimise reliance on statutory services.

The Care Act formalises Local Authority responsibilities to work with the market to support and shape its development to meet the needs and choices of local people.

Contribution to the Better Care Together Programme

Adult social care has a critical role to play in delivering an enhanced community offer that will lead to a reduction in demand for higher cost and more acute services. The left shift needed within the health and care economy will only work if social care plays its full part. The significant financial challenges and increased levels of demand faced by social care are significantly compromising the community offer, even though there is a necessity to increase resources to successfully support independent living. The opportunities to secure investment through the Better Care Together programme must be maximised to ensure a robust and high-impact community offer which effectively and measurably reduces and delays the need for health and social care support. This will be particularly key as activity shifting towards the community and requiring increased social care provision will not be met by BCF (in itself not guaranteed beyond 2016/17). Social care will continue to compete for funding within Local Authorities which are facing multiple budget pressures.

Key priorities for delivery through BCF are the integration of unscheduled and planned care across social care and community health services. This includes the creation of coterminous locality teams and crisis and out of hour's responses. Significant activity is already underway

to develop more integrated customer/ patient pathways across many areas, including frail older people, long term conditions, learning disabilities and mental health, where the role of adult social care is critical if positive outcomes are to be achieved. An example of successful integration in the city is the Integrated Crisis Response Service, delivering a rapid, joined up project to avoid hospital admissions. In the county, an overnight nursing assessment service has been launched to complement the local social care crisis response service, aiming to further reduce hospital admissions.

Adult social care is contributing to the reduction in need for care through clear integration agendas. Better Care Fund services supporting this work are varied across the authorities and include:

- Enhanced crisis services to avoid hospital admissions;
- Support for assistive technology and equipment to reduce and delay need;
- Proactive care management in aligned planned care teams;
- Carer support;
- Care navigators to focus on over 75s;
- Early support for those diagnosed with dementia.

The overall aim of Better Care Together is to ensure organisations work together to provide more support at home, reducing the risk of serious illness requiring admission to hospital, but this needs investment. Enhancing the social care offer will not only keep people well, but also improve their quality of life. Social care must have a central role in the Better Care Together approach if a truly customer centred approach is to be achieved.

What does Adult Social Care need from the NHS?

The scale of funding reductions in Government funding facing local authorities is unprecedented. The 3 LLR councils have all prioritised services for vulnerable people and afforded Adult Social Care with a significant level of protection from budget reductions. It will not however, be possible for Councils to maintain service levels or to meet increasing levels of demographic need without financial support from the NHS. The BCF plans already contain a significant element of protection of services, but more will be required if there is to be an effective Adult Social Care offer in the left shift to community and preventative services.

Adult Social Care cannot deliver effective outcomes for service users/patients without appropriate therapeutic and clinical input from health services. For example there is an emerging evidence base that outcomes and long term care costs can be significantly improved by targeted and timely physiotherapy input as part of social care reablement. This will require increased access to these therapeutic service and appropriate levels of investment in staffing and joint training and development.

Effective two way sharing of information and intelligence held by the NHS and councils will be required so that ASC and NHS can provide the right care to the right people, and also gain a better understanding of end to end care costs. There needs to be a much more structured programme for the management of data and business intelligence across integrated health and care interventions which supports impact assessment/ROI/evaluation, costing integrated pathways, risk stratification, case management/care planning. Information

sharing agreements in LLR are outdated and inhibiting progress and need to be replaced by a new integrated approach that includes the adoption of NHS number as a key enabler.

Workforce

Through greater integration and the left shift towards prevention a different skill set will be required from staff, and there will be key challenges relating to merging of health and social care cultures; ensuring clear communication, ensuring a clear customer focus and employing the key principles of promoting wellbeing/ reducing need will help to ensure success.

Most staff in adult social care in LLR work in the independent sector. As demand for social care has increased this workforce has expanded proportionately. The status of direct care staff is however not sufficiently high, and this is reflected in relatively poor pay and conditions. Many care staff are paid close to the minimum wage and zero hours contracts are often the norm. Increasingly some sectors face real challenges in recruiting and retaining staff with the required competencies. The availability of staff will be a key constraint on the capacity of the market to deliver the service volumes and quality standards required to provide the required level of effective community services.

Actions to address these issues are outlined in the workforce enabler of the BCT programme.

Implementation of the Care Act 2014 will have significant implications for the adult social care workforce including:

- An increased demand for carers assessments and services
- Increasing challenges relating to retention of staff
- Staff will need to be multi-skilled in order to support greater levels of integration

Measuring success

By 2019 we will have fully co-ordinated and effective services, a skilled workforce, seamless provision from a customer perspective; we will be effectively delaying/ reducing the need for formal health and social care projects. We will be able to demonstrate efficient delivery of services – ensuring that investment across health and social care is successfully reducing need and managing demand. There will be a demonstrable change in our spending patterns with a shift from areas we traditionally fund into preventative services that keep people well and living in their local communities.

2.8.6 Better Care Fund

LLR CCGs and local authorities have made a five rather than two year commitment to using BCF to drive change. The size of BCF funds for the next two years is summarised below:

Figure 57: BCF components

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

Source: Planning information provided by LLR CCGs

The three BCF plans reflect broadly similar ambitions, mirroring those of the five year strategy, but allowing for flexibility of local implementation. The plans outline how opportunities presented by the fund will be maximised to lever real transformational change, thereby delivering the five year vision.

The aim of the BCF is to enable people to access a range of support early enough, including through social and community networks, thereby empowering them to take control of their health and wellbeing, live healthier lives and maintain their independence for longer.

By investing in prevention a reduction in the number of people accessing services in a crisis or inappropriately is expected alongside an increase in the provision of care interventions that offer optimum independence within a supportive community.

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

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

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

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

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

In Leicester the Better Care Fund is a key strategic driver to the delivery of the Better Care Together Strategy particularly in the frail older people, long term conditions and urgent care workstreams. The following outcomes will be achieved from the Better Care Fund projects:

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

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

The following section describes the plans that have been developed by the BCT programme's four enabling workstreams; estates, workforce, IM&T and contracting. This section has described the changes that will take place in the settings of care over the next five years. These changes, and the proposed changes to the service pathways, are dependent on changes that will be delivered by these enabling workstreams. Without these system wide enabling developments it will not be possible to change the way health and social care is delivered in LLR.

2.9 Estates Strategy

Estates – case for change

The health care estate case for change has two key drivers; the first is to enable the estate to respond to the service pathways being developed as part of the Better Care Together programme. The second is related to the estate itself.

Responding to the service pathways

The BCT service pathways set out how the system will change over the next five years. A key enabler to that change is ensuring the estate is fit for purpose, located in the right place for the patient, whilst maximising efficiencies. The table below describes the key impacts the service pathway changes will have on the estate:

Figure 58: Estates impact summary

Service Pathways	Impact on estates
Urgent care	To deliver improved efficiencies and patient flow, and address capacity issues and clinical adjacencies, a redevelopment of the emergency floor is required. In sizing this development the impact of the changing service models needs to be considered, in particular for frail older people and LTCs. A consistent approach to urgent care and minor injuries may impact on the accommodation requirements. In addition, improving the urgent care pathway will result in the need for fewer non-elective beds. There will be a need to provide more services outside of hospital which will impact on the estate requirement in the community.
Planned care	The shift of outpatient and day case activity into the most appropriate setting is likely to lead to a reduction of activity in the acute hospital setting but will require more to be done in community settings. In addition, increased occupancy and utilisation rates will impact on the estate requirement. The solutions for the city and the counties will be different.
Frail older people and long term conditions	More people being cared for in the community and in their own homes will lead to changes in the numbers and types of beds required; reduce readmissions and reduce length of stays. This is likely to impact on both hospital and community beds. This is supported by recent bed utilisation reviews which have shown that many patients in acute hospital beds could be cared for in alternative settings. Co-location of teams across health and social care will support the delivery of improved pathways for frail older people; this will require an estate solution to support integrated working such as community hubs.
Children's services	Better integration and a community based focus on outpatients is likely to reduce acute hospital based planned care and may require additional accommodation in the community. Teams may be co-located in community settings to encourage integrated working.
Maternity and neonates	Currently there are two obstetric-led units supported by different clinical services delivering over 10,500 births a year. When reviewed in 2010 by the National Clinical Advisory Team was suggested that this was only clinical sustainability on a temporary basis. The system needs to review what a sustainable service looks like and how many sites it should be delivered from.
Mental health	The focus on anticipatory care models and improved crisis support is likely to lead to less reliance on bed-based treatments and greater resilience within the LLR population, leading to a smaller secondary care estate and community sites. Community based staff will increasingly be located within integrated teams.
Learning disabilities	Improving joined up services across health and social care will mean more staff are co-located.

Overall, the service pathway changes require more work to be done in the community and less in acute hospital settings. The Strategic Direction of University Hospitals Leicester NHS

Trust (UHL) supports this: “overall Leicester’s hospitals will become smaller and more specialised and more able to support the drive to deliver non-urgent care in the community”. Leicestershire Partnership Trust, the providers of community services, are developing an estate strategy to respond to more services being delivered in the community through the hub and spoke model and better utilisation of assets.

The case for change describes how a very large number of properties are being used to deliver care across LLR; in total 148 estates, with a variety of tenure, totalling 283,000 square metres. Many of these properties are under-utilised and in some cases as much as 50% of the space is not being used efficiently. Over the last few years investment in the estate has been variable and most of the estate is in a poor condition. The current total backlog maintenance is £128m across the health sector. The health estate costs circa £82.2m per annum and the two biggest costs are facilities management and rental charges.

Given the estate implications of both the service pathway changes, and the fact that the current estate remaining as-is is not a feasible option, the estate has to change.

The future estate

In response to the service pathway changes and the estate challenges outlined in the previous section, the estate needs to change over the next five years. The key features will be:

- **A smaller but more specialised acute estate**, with consolidation of services onto two sites, enabling clinicians and patients to benefit from co-located services and eliminate the inefficiencies of running multiple sites. This will result in fewer beds in acute hospitals. Internal UHL efficiencies will reduce the bed base from 1,773 beds to 1,346 beds.
- **An adapted community bed base that will** transfer 250 beds worth of activity from UHL to LPT. Services will be expanded to enable patients to be cared for in their own homes (equivalent to 250 beds worth of current activity, 170 direct from the current UHL activity and 80 from the existing community hospital activity). Figure 46 summaries the changes in bed numbers.
- **Hub and spoke model for the community** based on three levels of estate. The county wide hub will be for a population of one million plus, these will house highly specialised services and will have offices and clinic space. Community Hubs will serve an average population of 115,000 in the counties and 70,000 in the city. They will provide specialised services with clinics, diagnostics, and in some cases inpatient wards. Team bases will cover a population of 35,000 and be a base for more generic community services with clinic rooms and offices (in the city these may be provided alongside the community hubs).
- **Adapting the primary care estate** to support the service pathways will be required to support the left shift of services, this may include the development of hubs, refurbishments, premises improvement grants and in some areas new builds.
- **A more efficient estate** by 2018/19 with improved efficiency and utilisation rates. To support this LLR will develop an estate base and process for booking of shared clinical space.

- **A smaller health care estate footprint** will result from all the impacts described above. There is also likely to be a reduction in the square metre and number of properties across the health sector.

Phasing

The acute sector changes will be managed in two phases. In the first phase, lasting two years, UHL will focus on in-hospital efficiency and productivity with the aim of repositioning key clinical services from outliers in terms of benchmarked data to top quartile. Phase one will include two urgent estate-based developments – the emergency floor at the Royal Infirmary and the transfer of vascular services from the Royal with the potential for the inclusion of renal services at a later date.

Phase two, which will be delivered from 2016 onwards, will enact a major reconfiguration of the hospital estate. This will coincide with other services coming on line in the community and allow the trust to safely rebalance bed numbers (i.e. reducing acute bed numbers and making better use of community capacity). They will repurpose or move out of buildings which are no longer required and this will reduce double and triple running costs. The options to consolidate main services onto two sites will be worked through with partners and the wider community in 2015. Although the trust will appraise all options, the direction of travel to date indicates that it is likely that the Royal Infirmary and the Glenfield will emerge as the two main acute sites. If this is the case, it would enable the Leicester General Hospital site to be developed to further support integrated community services and the Diabetes Centre of Excellence. The General would also continue to provide a home for East Midlands Ambulance Service, the UHL Young Disabled Unit and Leicester Partnership Trust services.

As a consequence of the shift to community settings with fewer patients, UHL intends to consolidate acute services onto a smaller footprint and grow its specialised, teaching and research portfolio, only providing acute care in hospital when it cannot be provided in the community. In doing this the trust expect to significantly increase the efficiency, quality and ultimately the financial sustainability of key services, shrink the size of the required estate and significantly rebalance bed capacity between acute and community settings, reducing total costs.

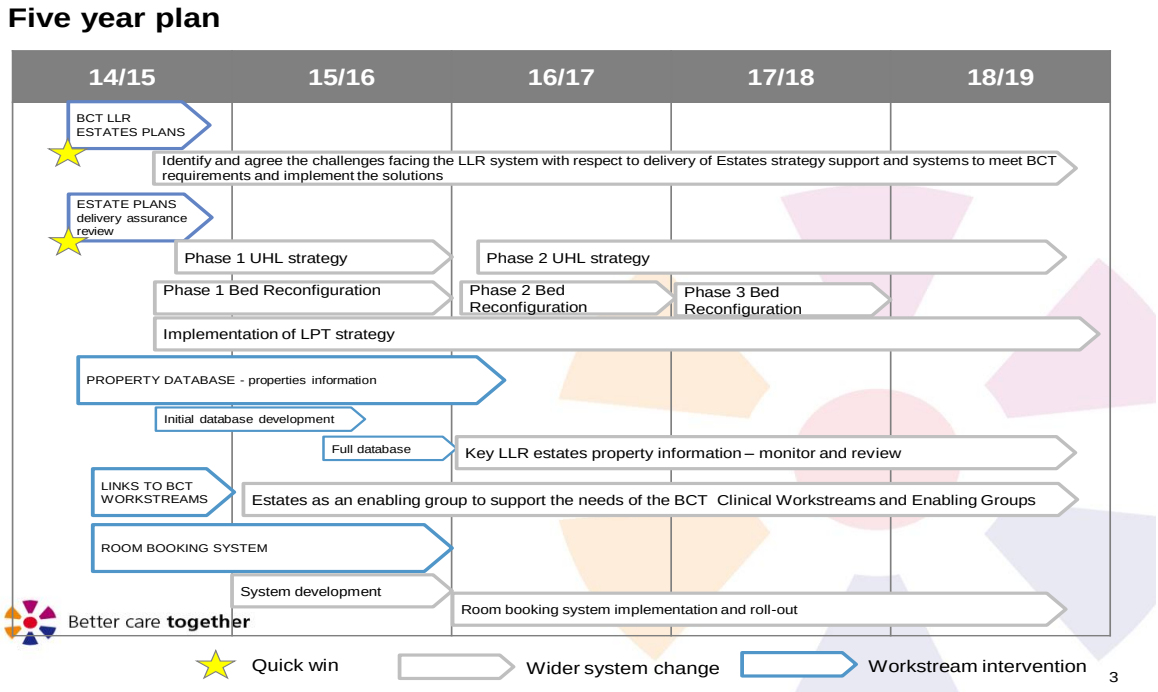
Leicestershire Partnership Trust is currently undertaking a clinically driven review of their estate. This will take forward the development of the hub and spoke model described above and ensure efficient and effective use of the estate. The first draft of this is due at the end of November 2014 and will be used to phase the estate impacts into the Better Care Together Programme. Indicative capital costs have however been included in the Strategic Outline Case.

An integral part of the Strategic Outline Case is the delivery of the bed reconfiguration between UHL and LPT, as shown in figure 46. This shift will be achieved by providing more services into patients' homes and the provision of sub-acute beds in the community; this will not increase the overall community bed base but use it in a different way. The change will be phased over three years, with the first 60 beds being released from UHL by 31 March 2016; the second 60 beds by 31 March 2017; and the final 130 beds by 31 March 2018. During these phases the appropriate level of community based support and sub-acute provision will be made available prior to releasing the beds.

To support the efficient use of space a data base of information will be compiled and maintained; this work will be commenced in 2014/15 and be fully implemented by April 2016. This will include a system for booking of clinical space.

The following diagram demonstrates the high level phasing for the estate enabling work:

Figure 59: Estates – timeline



2.10 Workforce strategy

The Better Care Together programme has identified workforce as a key enabler in delivering the size and scale of change required across LLR to ensure our workforce meets the health and social care needs of our population. To deliver a workforce in LLR that supports care delivered out of hospital, a greater focus on prevention and supporting healthier communities the programme has recognised the significant challenge in supporting the capacity and capability to support the development of new pathways across secondary and primary care.

By delivering the BCT programme it is acknowledged that, as a health care community, we will also need to inspire a new generation within our workforce to work across organisational boundaries and with a greater focus on community provision and working with the 3rd sector to support a patient profile that has increasing co-morbidities.

To articulate the future state a range of work is already underway and is detailed in the workbook focussed around new role development and a series of initiatives already supported by Health Education East Midlands. These include

- Support to double the number of apprenticeships in LLR by April 2016 (236);
- Support to deliver 200 Assistant Practitioners in LLR by April 2016 in UHL & LPT;

- New Role Development – up to 50 Physician Associates (with the majority in Leicester), 24 Urgent Primary Care Practitioners (12 in Leicester), GP Nursing programme run at DMU, plus ring fenced monies for Advanced Practice and a supporting Clinical Framework;
- Primary Care Taskforce to support practice learning opportunities in General Practice and in Nursing and Residential Homes and the development of Community Provider Education Network (working collaboratively with HEIs, CCGs and the LETC);
- Innovative solutions to Medical Workforce Challenges – making LLR a more attractive place to work, learn and train, developing fellowships and other appropriate out of training experiences for medical trainees and developing multi professional solutions in conjunction with the University of Leicester and De Montfort University;
- Development of a Strategic Training, Education And Learning Transformation Hub (STEALTH) project in conjunction with our local HEIs to analyse, model and develop appropriate educational experiences to support the “left shift”, sub-acute clinical pathways and more integration with social, primary and the third sector.

The health care workforce case for change has two key drivers; the first relates to underlying workforce challenges across LLR. The second is to enable the workforce enabling group to respond to the service pathways being developed as part of the Better Care Together programme:

- The health care workforce can be relatively inflexible, with strong demarcation of roles and a working model often centred on single episodes of treatment. However, those placing the greatest demand on services are older people with multiple conditions who require support from a range of services;
- An increasing number of UK-trained doctors, nurses and allied health professionals choose to move abroad;
- By 2021 there will be a national shortfall of between 40,000 and 100,000 nurses and there could be 16,000 fewer GPs than are needed (nationally produced figures, local impact on staff groups continues to be assessed);
- The ageing population means that by 2025 the national social care workforce will need to increase from 1.6 million to 2.6 million;
- The nature of work undertaken by staff is changing. As the population ages, our staff will need to care for more people with complex needs and multiple co-morbidities;
- We recognise that in future we could face shortages of staff in some key disciplines and that those staff we do employ will need to work differently. They will need to work much more in multi-disciplinary teams that treat the “whole person” and not just the presenting condition; they will need to have more generic skills; and they will need to be more productive, partly through use of new technologies;
- BCT recognises the importance of clinical, non-clinical and managerial leadership development across LLR, continuing to support local leadership initiatives and the support to the East Midlands leadership academy.

Responding to the BCT service pathway requirements:

Figure 60: Workforce impact summary

Service Pathways	Impact of workforce
Urgent care	With the planned redesign of the emergency floor the resulting service models and workforce requirements need to be considered. There will be a need to provide more services outside of hospital which will impact on the workforce requirement in primary, community and social care.
Planned care	The shift of outpatient and day case activity into the most appropriate setting is likely to lead to a reduction of activity in the acute hospital setting but will require more to be done in community settings and will impact on workforce requirements.
Frail older people and long term conditions	More people being cared for in the community and in their own homes will lead to changes in the numbers and types of beds required; reduce readmissions and reduce length of stays. This is likely to impact on both hospital and community beds. This is supported by recent bed utilisation reviews which have shown that many patients in acute hospital beds could be cared for in alternative settings. Co-location of teams across health and social care will support the delivery of improved pathways for frail older people; this will require a workforce solution to support integrated working such as community hubs.
Children's services	Better integration and a community based focus on outpatients are likely to reduce acute hospital based planned care and development of new pathways will lead to workforce requirements for recruitment, development and training.
Maternity and neonates	Currently there are two obstetric-led units supported by different clinical services delivering over 10,500 births a year. When reviewed in 2010 by the National Clinical Advisory Team was suggested that this was only clinical sustainability on a temporary basis – we need to review what a sustainable service will be and what the resultant workforce requirements will be taking into consideration the planned increase in home births.
Mental health	The focus on anticipatory care models and improved crisis support is likely to lead to less reliance on bed-based treatments and greater resilience within the LLR population. Community based staff will increasingly be located within integrated teams with an associated impact on workforce development requirements.
Learning disabilities	Improving joined up services across health and social care will result in impacts on the workforce requirements for recruitment, development and training.

In addition the BCT workforce group aims are to ensure that the LLR health and social care community:

- Employs the right workforce with the right skills, in the right place, at the right time and with the right numbers;
- A workforce with the appropriate values and behaviours;
- Collaborates to reduce vacancies and agency usage to deliver high quality, safe and patient focussed outcomes with appropriately skilled workforce;
- Develops an appropriate primary and community workforce to support the "left shift";

- Maintains and develops the acute and sub-acute workforce;
- Supports and develops appropriate education, training and workforce development to support social care (e.g. support local authority policies around carers, offering appropriate support, development and valuing the contribution).
- Is supported around improving Organisational Development – an additional £200k has been set aside in the funding requirements for the LHSCE.

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

The Better Care Together Workforce Enabling Group will provide this understanding by providing leadership and delivery of a workforce planning and education commissioning strategy. Its core membership is based on the Leicester, Leicestershire and Rutland Local Education Training Committee (LETC), supported by Health Education East Midlands (HEEM), with support from health provider organisation directors of human resources, social care (local authorities and Skills for Care), CCGs and local universities. The group has undertaken the following key pieces of work:

- Development of a LLR workforce capacity plan, highlighting and prioritising the immediate workforce issues in LLR;
- A workforce plan/framework across years 1 and 2 that identifies the immediate workforce requirements and gaps across the LLR health and social care system;
- A longer term piece of work to identify the strategic workforce development initiatives arising from the emerging service models.

Immediate priority areas for workforce development are:

- Innovation and development within the primary care workforce (e.g. GP and practice nurses) – the local GP fill rate is 66% and the LLR practice nurse to 1,000 population ratio is lower than neighbouring areas and England as a whole;
    - Refocused use of primary care workforce through up-skilling and releasing GPs to focus on the more complex cases;
    - Development of primary care federations and hubs, allowing an increased level of services within primary care;
- Wider workforce development e.g. the Cavendish Carer Certificate (Bands 1 to 4 and equivalent). This will help address the problem associated with the recruitment of the harder to source higher band level resource;
- New role development for a generic post (band 3-4) across health and social care, providing apprenticeships, career pathway development and looking to improve staff retention;
- Development of multi- specialist skills e.g. nurse to enable a broad range of conditions to be managed by a single community based healthcare professional ideally in one appointment;
- Integration (secondary, tertiary, primary and social care, medical and non-medical);

- Reduction of costs associated to agency and other elements of the non-substantive workforce (current agency spend is c. 8% of turnover);

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

- Different staffing and organisational models to support service change:
  - Translating and articulating the future workforce in the right numbers, in the right place and with the right behaviours to best support patient care;
  - Review of both the specialist and generalist skill balance;
  - Ensuring that the supply of nurses and other health care professionals are more community focussed over time;
  - Changing professional skills in primary care settings;
  - Developing skills and competencies that support more integrated working;
  - High acuity, specialist led services in an acute setting;
  - Supporting the workforce to deliver technology enabled solutions and, where appropriate, to support more patient led self-care.
- Utilising educational and training opportunities to support emerging workforce development:
  - Ensure investment in areas like Learning Beyond Registration, Wider Workforce Funds, Education Commissioning and other funding streams are aligned to the transformation agenda;
  - Ensure practice placements and support for mentors, supervisors and educators support multi professional and multi-agency solutions.

Ensuring the LLR workforce meets the health and social care needs of our population as set out in the BCT programme.

2.11 IM&T plan

IM&T – case for change

The Information Management and Technology (IM&T) case for change takes into account a number of national priorities that have an effect on the informatics agenda as well as factors influencing strategic thinking at a local and regional level as part of the Better Care Together programme. It forms part of a key enabling vision for the transformation of health and social care services in Leicester, Leicestershire and Rutland by providing professionals with the information they need to enable them to work more productively and share collective information around the needs of the individual.

In the case for change section we described a number of reasons that changes were required in relation to IM&T. These focused on problems caused by information systems that do not “talk to each other”; systems that do not mirror workflows; and a general lack of innovation concerning the use of new and emerging technologies such as smart tech, “big data” and social media.

It is recognised that across the local health and social care economy there will always be different IT systems and processes in place as a result of a complex environment, which

spans multiple organisations and settings. Whilst these may be rationalised over time, with joint working across organisations, the IM&T enabling strategy aims to deliver a set of solutions to join systems and information up, where it makes sense to do so collectively, to deliver high quality care.

We recognise that IM&T is an important enabler to changing models of care, particularly in its ability; to support the provision of safe, integrated care for people with LTCs and for older people (shared records etc); to drive innovation in service delivery (telehealth, telecare, telemedicine, mobile working etc); to enable better use of "big data" in support of risk stratification and other targeted projects. We believe that IM&T can be used to transform virtually every aspect of healthcare delivery: how and where it is delivered, by whom and, when.

- How – IM&T is a powerful tool for automation and standardisation of processes;
- Where – IM&T can be used to reduce reliance on physical healthcare locations and minimise unproductive travel time for patients and practitioners;
- Who – IM&T allows specialists to be present in multiple locations either directly through remote consultation facilities, or indirectly through protocol driven logic designed by experts or analytics-driven clinical decision support systems using the latest best practice guidance and research to give real-time advice;
- When – e-mail and social network-type sites (e.g. MyHealthSpace) allow asynchronous communication removing the need for both parties to be available at the same time.

Responding to the BCT service pathway requirements:

Figure 61: IM&T impact summary

Service Pathways	Impact of IM&T
Urgent care	• Mobile working programme for LPT – increasing the access to mobile systems by clinical community staff to provide maximum efficiency; • Scheduling/handling system - increased utilisation of the SPA – winter plan funded and started the process to fund people resources. The new service will require an IT system to help manage capacity and demand. The system should be able to do real-time scheduling.
Planned care	• Referral Hub – Enable sharing of data from the GP to the referral hub, set up IT infrastructure for referral hub; • Pathways - Computer upgrade across hospitals to support new pathways, implantation of PRISM.
Frail older people	• Upgrades to RIO within LPT, ensuring spine compliance and utilisation of Choose and Book; • Health and social care systems sharing information about the person; • Improved data capture; • Improved data reporting and greater use of risk stratification.
Long term conditions	• Health improvement – Easy access to data, links with public health, University of Leicester APPs to check treatment, write down questions, shared with consultants prior to meeting, shows pathway; • Self care – telecare / telehealth – COPD pilot in the City, Digital First, Virtual health coaching; • Patient at high risk – sharing of the care plans and sharing of MDT meetings; • Acute Care – virtual ward approach, seeing the community and discharge information.
Children's services	• Virtual clinics; • Teleconsultation; • CQUINS; • APPs to support school nurses.
Maternity and neonates	• Mobile Working – improvements in infrasture to support this; • Data sharing - access to data across clinical systems; • Performance Management – systems and tools to support this.
Mental health	• Mobile Working - Developed universal connectivity to support remote working; • Data sharing - access to data across clinical systems.
Learning disabilities	• Improvement in referals - developing information systems for ensuring LD status are included in referrals to secondary care.

The LLR IM&T enabling group will ensure that the full benefits of IM&T are realised by:

- Producing plans for a "quick win" around implementing a patient clinical records sharing service for primary and secondary care across LLR. The service will allow clinicians from different providers to view each other's clinical records;
- Producing reports and plans which:
    - Identify major gaps in current services or plans;

- Set out best practice from elsewhere that could be bought in or replicated;
- Outline short-term and longer-term options for closing identified gaps.

The groups' short-term work plan (to be delivered within six months) is to focus on primary care records sharing implementation using the medical interoperability gateway (MIG), including work with MIG to expand the solution, for example to include social care. The group will also focus on PRISM; ensuring full use of NHS number in EMAS and social care; providing a secure e-mail account for Leicestershire police; care planning standards and templates; agreeing a LLR-wide information sharing specification; "Digital First" phase one; real-time data interchange initiative for primary care data; and e-conferencing.

In the medium term the group will:

- Review and analyse needs of the BCT Clinical Workstream and prioritise initiatives;
- Issue a care planning specification and amend associated templates;
- Continue to progress initiatives to pilot and widen patient access to general practice systems;
- Focus on improving clinical analytics;
- Develop system integration of primary care out of hours' services;
- Develop a strategic plan for patient access and involvement;
- Introduce analytical tools;
- Further develop the "Digital First" initiative.

In the longer term the group will:

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

As well as looking for new solutions and systems we will also look to explore and encourage best use of existing systems. Improving their utilisation and effectiveness will ensure best value is delivered from existing resources which may also support the drive for quick wins in the first two years of the programme.

2.12 Summary of financial benefits which will be delivered by this programme

Our new models of care will deliver significant benefits to local people and to health and social care commissioners and providers. As explained further in the economic and financial cases the health economy needs to close a projected financial gap of £398m across the five years of the plan. The way in which this will be achieved is broken down below. The table shows that if all of the elements of the strategy are delivered the health economy will achieve a surplus of £1.88m by 2018/19. Further efficiencies delivered by the UHL estates programme will bring a further £30.7m of recurrent savings for the trust which will be realised in 2019/20.

Figure 62: Benefits summary by source

Type	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	19/20 (£'000)	20/21 (£'000)
Expected funding gap (without interventions)	(113,246)	(187,345)	(260,572)	(327,486)	(398,114)	(475,308)	(559,759)
Adjustment to investment plan	10,118	11,826	12,457	12,865	13,637	13,637	13,637
Net Funding Gap (without Interventions)	(103,128)	(175,518)	(248,115)	(314,621)	(384,477)	(461,670)	(546,121)
LTC Workstream	0	255	1,102	1,694	1,684	1,684	1,684
FOP Workstream	0	0	0	0	0	0	0
Children's Workstream	0	55	300	300	300	300	300
LD Workstream	0	932	1,273	1,657	1,857	1,857	1,857
Maternity & Neonatal Workstream	0	0	378	378	378	378	378
MH Workstream	680	3,615	4,910	5,299	5,688	5,688	5,688
Planned Care Workstream	0	957	2,585	4,614	5,495	5,495	5,495
Urgent Care Workstream	0	(295)	352	1,000	1,000	1,000	1,000
CIPs	58,068	105,106	149,943	193,516	238,372	263,951	326,162
QIPP	28,323	44,475	61,244	80,633	96,687	115,957	138,622
Bed reconfiguration	1,102	4,249	7,503	9,450	11,020	11,020	11,020
UHL site running costs reduction	0	0	0	0	0	30,700	30,700
Additional Efficiencies	(246)	5,642	4,078	984	23,874	23,874	23,874
Revised position	**(15,202)**	**(10,526)**	**(14,448)**	**(15,097)**	**1,878**	**235**	**658**

2.13 Risks, constraints and dependencies

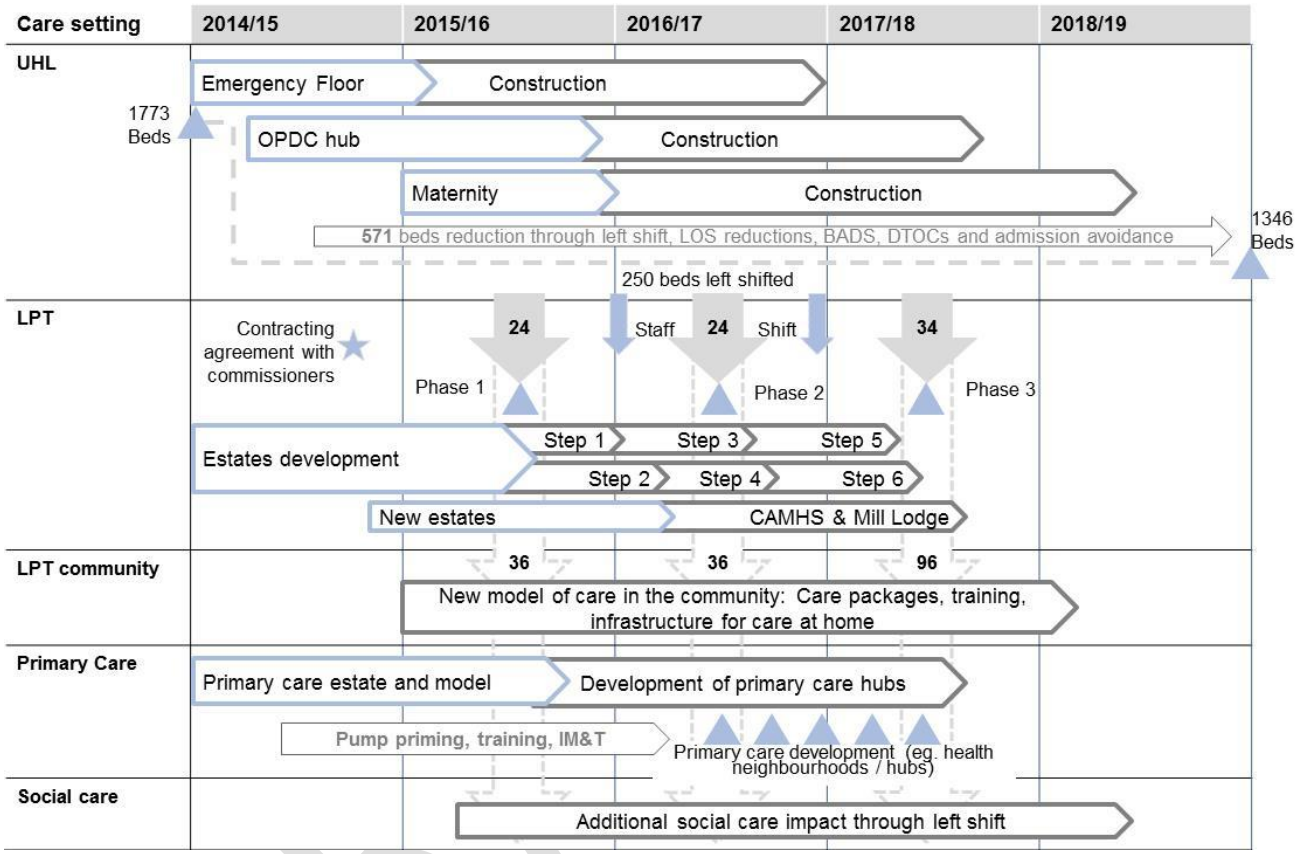
In order to deliver benefits to close the £398m gap across LLR it is imperative that all of the different organisations work together to deliver the projects set out in the strategy. Many of the changes will be enabled through the beds reconfiguration programme, which looks to ensure that patients who do not need to be in an acute setting can be discharged safely and treated in either community beds or by community nursing teams.

The significant change to the model of care which is proposed will enable delivery of the savings programmes required by LPT and UHL. The key to this programme is ensuring that care is developed and improved in a way which enables efficiencies to be delivered within providers. The transition support required by the programme is predominantly aimed at helping to ensure that organisations remain viable during the period of change and double running, and to deliver the services and initiatives required in the community which will help to transform the model of care without impacting on the sustainability of individual organisations.

Figure 63 shows the critical path for the programme which needs to be achieved in order for the health economy to reach financial surplus by 2018/19. Estates changes at UHL are

predicated on more care (and healthcare providers) being in the community, and by improving services such as the new emergency floor and obstetric unit UHL will be in a position to provide the highest quality complex care in a sustainable way which will be able to meet future healthcare demands.

Figure 63: BCT critical path



3 Economic Case

3.1 Introduction

The purpose of the Economic Case at SOC stage is to set out why the BCT programme should progress to the next stage of planning, assessing its ability to deliver value for money (VFM). Going forward this will mean the progression of individual Outline Business Cases (OBCs) and Full Business Cases (FBCs) which support the delivery of the chosen model of care. The shortlisted options will be assessed at this stage to determine the best value for money (the balance of cost, benefit and risk) and affordability (revenue and capital). This section describes:

- CSF used alongside Investment Objectives (IOs) to assess the long list of options;
- The rationale behind moving from a long list of options to the short listed options;
- Economic Appraisal of short listed options (including detailed assumptions);
- Sensitivity analysis for short listed options;
- Qualitative risk assessment for short listed options and comparison to CSF and IOs.

3.2 Critical success factors

In addition to the Investment Objective set out in Section 3.4, the Partnership Board identified a number of factors which, while not direct objectives of the programme, would be critical to its success, and would be relevant in judging the relative desirability of options.

In doing so, the Partnership Board considered the possible CSF suggested in the five-case model best practice guidance and, as recommended in the guidance, selected the CSF that were most applicable and relevant to this particular programme.

The original project CSF contained within the PID have been compared to OGC best practice guidance to demonstrate that all relevant criteria are covered:

Figure 64: Critical success factors

Original PID Criteria	PID Definition
Business Needs	Critical to us realising the new operating model
Strategic Fit	With local and national priorities
Affordability	Deliverable within allocated resources, delivering necessary savings or benefits whilst delivering value for money
Achievability	Achievable within the allocated time, resources and circumstances
Impact on clinical quality	Enables the six dimensions of high quality care
Impact on access	The ease with which the individual uses the health or social care service

3.3 Option appraisal

Three alternatives were initially considered as the method to deliver financial and clinical sustainability for the programme and achieve the CSF outlined above;

- Delivery through the BCT strategy;
- Delivery of financial balance through organisational efficiency alone (do minimum option);
- Ceasing delivery of non-agreed services to regain financial balance.

The following considerations were made in order to arrive at the final shortlisted options

Option 1 – Delivery through the BCT strategy

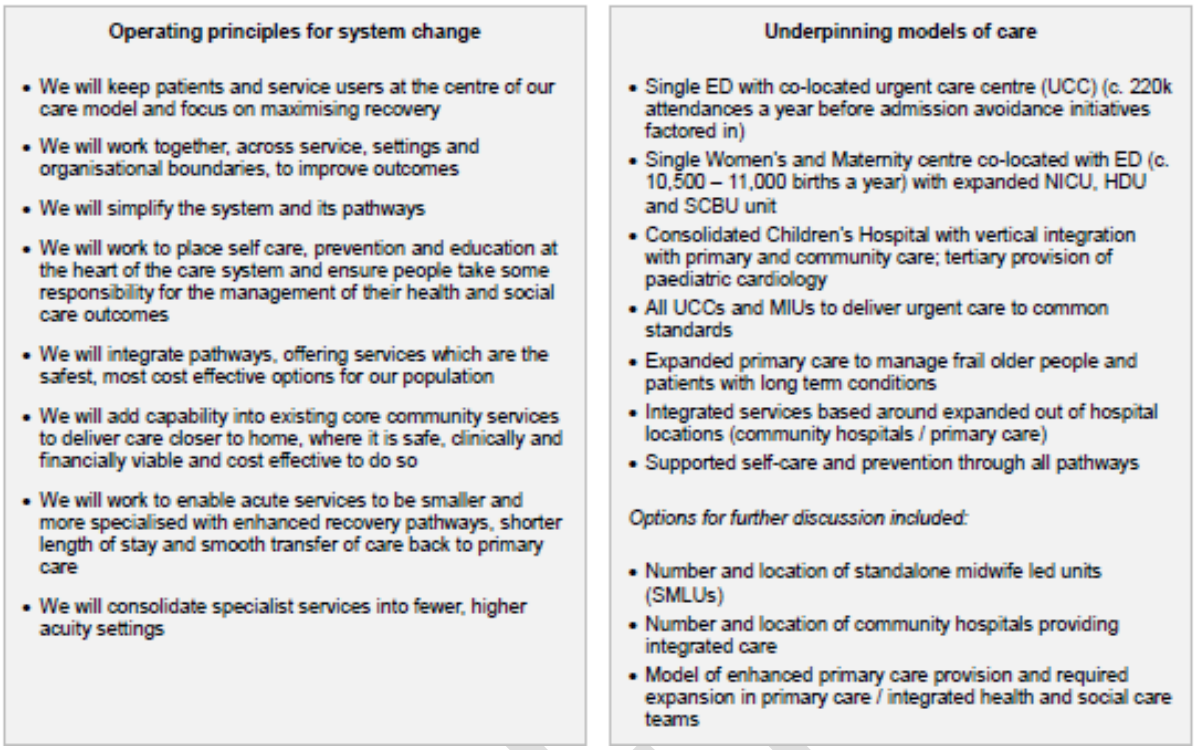
There are a number of clear reasons why the BCT programme agreed on the models of care set out in the five year strategy as the preferred solution.

If change is to be delivered successfully it will require all parts of the health economy to commit to changing the way services are delivered and the location they are delivered from. In order to improve the quality of care in a sustainable way, clinicians have been involved from an early stage to develop the required clinical models that would drive the required change.

The key drivers for change are;

- The NCAT Review of Maternity Services concluded the only long-term sustainable maternity services solution is a single-site, centralised maternity service;
- Centralisation of Maternity and Paediatrics, allowing specialisation and flexibility;
- The requirement to ensure adequate ED capacity supporting the new models of care;
- A “left shift” of patients into more appropriate settings, seeing more flexible care offered closer to home. A review of acuity suggests that the equivalent of 250 beds worth of patients can be moved from University Hospitals Leicester to Leicester Partnership Trust;
- Centralisation of Surgery – greater efficiency will be enabled by separating planned and unplanned surgery, including a dedicated day case facility.

Figure 65: BCT option characteristics



Option 2 – Achieving financial balance solely through organisational efficiency (do minimum option)

The second option considered was whether the constituent organisations could deliver the LHSCE challenge through individual efficiencies without any major changes to how and where services were delivered, and with no significant estates reconfiguration.

The scale of the quality challenge alongside the need to identify efficiencies of £398m within five years is deemed much greater than can be delivered solely by individual organisations alone. This would have equated to an efficiency requirement for both main providers of 7-8% each year. More than 5% savings is not sustainable based on international evidence, and this approach would bring further delivery risks to the health economy and have an adverse impact on patient experience.

Secondly the need to find additional savings would incentivise providers to take a more independent and competitive approach, seeking additional income streams rather than working collaboratively. This would put at risk the drive to change models of care and the ability to deliver the required activity shifts.

Finally this option would not address any of the underlying issues of service quality as outlined in the case for change. There is much that can be done through organisations working together to reduce inappropriate admissions and attendances, however the financial constraints would prevent organisations from having the ability to plan far in advance to tackle these issues and change the model of care.

Option 3 – Ceasing delivery of non-essential services

The third option considered to make the health economy financially sustainable entails undertaking a detailed review for each service across the Health Economy, before making a series of decisions to reduce or remove services considered to be “non-essential”. At the same time a decision to allow non-compliance against performance targets could ease the financial pressure on the system. This option was appraised and discounted for the following reasons;

- There is no agreement on a list of protected services across the Health Economy;
- The inability to ensure continuity of service quality whilst reducing or removing services in a structured and co-ordinated way;
- The non-existence of a single source of information that would enable robust decisions to be made under this option;
- This approach had been attempted to various degrees before and has not delivered the required outcomes;
- Failure to meet performance and access targets would have a significant, adverse impact on the quality of patient care and would be politically unacceptable.

In addition any approach to radically alter the services that are offered would require public consultation which would delay the implementation of the proposed changes, particularly as this option would be opposed. This option will have a substantial negative impact on the general population as access to services will be reduced.

The local decision around any services which would be protected would be open to legal challenge given the lack of precedent around this process in the NHS. Any process which defines “designated services” has only been enacted during a period of special administration, which operates within a different statutory framework. This makes the approach inherently more risky due to the uncertain outcome.

3.4 Meeting the CSF and investment objectives

The table below compares each of the three described options against both the investment (system) objectives and the CSF. The assessment seen below was undertaken by EY in response to the discussion of issues within several CFO forums. It is qualitative in basis and as such offers an opinion of how each option meets IOs and CSFs:

Figure 66: Option comparison

Ref	Criteria	Option 1 – Better Care Together	Option 2: Organisational efficiency alone	Option 3 Ceasing delivery of non-essential services
IO1	Quality of Care out of Acute Hospitals			
IO2	Reduction in Inequalities			
IO3	Improved Patient Experience			
IO4	Efficient delivery of Care			
IO5	Financial Sustainability			
IO6	Developed workforce			
CSF1	Business Needs			
CSF2	Strategic Fit			
CSF3	Affordability			
CSF4	Achievability			
CSF5	Impact on clinical quality			
CSF6	Impact on access			
Assessment				

The analysis above leads to the conclusion that the only viable option for delivering the investment objectives is through the BCT programme.

Implementation options

Having identified the preferred option though a qualitative assessment, consideration was also given to a "counter factual". Given the experience from elsewhere a "do minimum" option, including an attempt to achieve financial balance through other means would place providers in LLR at risk of being placed into special administration. In this instance an

administrator would be appointed for each provider organisation. Therefore two options have been assessed in the economic appraisal:

- the proposed Better Care Together programme; and;
- A "do minimum" option, which is likely to result in a Trust Special Administration (TSA) process being initiated for the two NHS trusts – given the appraisal to date it is considered a TSA would conclude that the BCT programme is the best route to clinical and financial sustainability.

3.5 Transitional costs

Transitional costs for each organisation and work stream have been summarised below in three main categories.

3.5.1 Capital

The external capital requirement for each organisation can be seen in the below table. These are broken down in more detail within appendix 12, the assumptions behind relevant capital programmes can be viewed within Appendix 14 (UHL), Appendix 16 (LPT), Appendix 23 (Primary care) and Appendices 1-13 (for workstreams).

Figure 67: Capital requirement

Org	Project	14/15 (£'000)	15/16 ('000)	16/17 ('000)	17/18 ('000)	18/19 ('000)	Total (£'000)
UHL	Total Requirement	**46,530**	**120,221**	**125,672**	**117,834**	**72,121**	**482,378**
	Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	**167,707**
	External Capital Requirement (Gross)	**12,023**	**86,921**	**92,372**	**84,534**	**38,821**	**314,671**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
LPT	Total Requirement	**14,636**	**14,652**	**23,000**	**48,944**	**52,332**	**153,564**
	Use of capital resource limit	14,636	10,908	12,608	10,108	10,108	**58,368**
	External Capital Requirement (Gross)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
	Receipts	-	-	-	-	-	**-**
	External Capital Requirement (Net)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
Primary Care	Total Requirement	**-**	**4,625**	**13,875**	**13,875**	**13,875**	**46,250**
Planned Care	Total Requirement	-	-	250	-	-	**250**
Urgent Care	Total Requirement	**-**	2,070	-	**-**	**-**	**2,070**
Long Term Conditions	Total Requirement	-	200	-	-	-	**200**
	External Capital Requirement (Net)	**-**	**6,895**	**14,125**	**13,875**	**13,875**	**48,770**
OVERALL	Total Requirement	**61,166**	**139,698**	**164,867**	**180,653**	**138,328**	**684,712**
	Use of capital resource limit	49,143	44,208	45,908	43,408	43,408	**226,075**
	External Capital Requirement (Gross)	**12,023**	**95,490**	**118,959**	**137,245**	**94,920**	**458,637**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**95,490**	**118,959**	**137,245**	**66,570**	**430,287**

UHL's anticipated receipt attributable to the disposal of land has been included in18/19 as a capital advance. (The capital receipt value has been based on current estimates to provide a basis for planning. It is anticipated that best value will be sought at time of disposal and, as such, the final value is likely to be subject to variation.)

The investments for each work stream include;

- Planned care: Establishment of a Referral Hub – Alliance will own the asset;
- Urgent care: Mobile working technology and scheduling system – LPT ownership;
- Long term conditions: Tele-health equipment – LPT ownership.

3.5.2 Transitional revenue support

The table below sets out the level of transitional revenue support that will be required to deliver the programme. A breakdown of the assumptions behind the bed reconfiguration plans for both trusts can be seen within Appendices 15 (UHL) and 17 (LPT). A detailed breakdown of work stream funding requirements is within Appendices 1-13.

Figure 68: Revenue requirement

		14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Total (£'000)
LPT		131	3,614	4,558	5,218	2,920	**16,441**
UHL		1,200	19,707	21,880	22,836	22,920	**88,543**
Work streams	Planned Care	118	2,276	470	88	0	**2,952**
	Urgent Care						**0**
	Mental Health	94	1,262	713	182	177	**2,428**
	LTC	137	550	550			**1,237**
	FOP						**0**
	Maternity & Neonates						**0**
	Childrens		172	100	50		**322**
	Learning Disabilities	13	731	289	118	95	**1,246**
Central PMO		1,539	997	997	997	997	**5,527**
Primary Care		0	3,000	6,000	3,000	3,000	**15,000**
Consultation Costs		0	200	200	100	100	**600**
Enablers		366	616	446	224	224	**1,292**
TOTAL REVENUE		**3,598**	**33,125**	**36,203**	**32,813**	**30,433**	**135,588**

The current working bed reconfiguration plan assumes 250 beds worth of patients can be cared for outside of an acute setting. The transitional revenue support calculations contained in this document are based on the shift completing by 2018/19. At the time of writing consideration is being given to the feasibility of this shift occurring by 2017/18. This is at a very early stage of discussion and as such it would be inappropriate to account for this in the financial calculations. However if after due consideration an acceleration of the 250 bed shift is considered feasible, it would have an impact on the financial calculations contained in this document. The transitional revenue support calculations would require review and potential revision. The most likely figure(s) to be impacted would be the UHL and LPT revenue requirement calculations.

3.5.3 Cash deficit funding

The table below sets out UHL's current requirement for cash deficit support:

Figure 69: Deficit funding requirement

		14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Total (£'000)
Cash	UHL Deficit support	40,700	36,100	34,300	33,300	30,800	**175,200**
	DEFICIT SUPPORT TOTAL	**40,700**	**36,100**	**34,300**	**33,300**	**30,800**	**175,200**

Note: UHL have submitted an application to the Trust Development Authority for 2014/15 deficit support. This application also included capital resource and £5.5m cash to ease liquidity pressure.

3.6 NPC analysis of two potential options

Treasury Green Book guidance requires a baseline option against which VfM can be benchmarked.

A detailed review of the benefits and costs associated with programme delivery has been undertaken. The detailed view of this can be seen within Appendices 19-20. Presented below is the high level comparison of the two main options that formed the short list.

The overall "total" figures demonstrate the Net Present Cost (NPC) of total programme benefits set against the transitional costs required to deliver them. This clearly demonstrates the BCT delivery option has the lowest NPC and therefore represents the best value for money over the appraisal period.

Figure 70: NPC comparison

Costs/(Benefits)	RANK	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)	Total (£m)
BCT Option	1	(31,580)	74,785	93,990	103,778	19,166	(78,422)	(66,711)	115,007
Do Minimum Option	2	(29,878)	84,079	101,808	106,918	16,677	(62,014)	(84,946)	132,644

3.7 Assumptions

Assumption 1 – Inflation

In accordance with best practice for quantitative assessments for the economic case, the forecasts for each option exclude the effects of inflation - all values included in the forecasts are in real terms.

Assumption 2 – Discount rate

The discount rate used in NPC calculations is 3.5% in real terms, in accordance with Treasury Green Book guidance for the purposes of discounting forecast values for quantitative assessments.

Assumption 3 – CIP/QIPP inclusion

For the undertaking of the quantitative analysis it has been assumed that all CIP/QIPP and work stream savings are a direct result of investment in the programme. In reality there are elements of savings contained within the CIP/QIPP classification that would be for each organisation to deliver as part of the general NHS efficiency regime.

Assumption 4 – Timing of savings realisation

For the "do minimum" option the work stream savings have been delayed by 12 months to represent the delay arising from winding down the current BCT programme and the need to re-engage in a different programme.

It has been assumed for the purposes of the NPC calculation that CIP/QIPP savings set out within the original modelling will be delivered.

It has been assumed that the benefits relating to work streams will not continue to increase after achieving their planned year five value.

Assumption 5 – Pay and non-pay

Pay and non-pay costs have been included from each organisation as per the modelling work undertaken at the time of the 5 year strategy. These were based upon organisational LTFMs and were subject to agreed inflationary/efficiency factors where necessary.

For the purposes of extending the modelling work to include year's 2019/20 and 2020/21, the level of inflation/efficiency has been rolled forwards from 2018/19 to future years. The exception to this rule was work stream savings which were deemed to have reached full delivery by 2018/19 (as mentioned in assumption 4).

Assumption 6 – Depreciation

Depreciation is not normally included in the NPC calculation since it is an accounting adjustment rather than a cash flow. A comparison of originally modelled capital plans and those that have been used for the SOC has been undertaken. UHL have stated that any differences are not deemed sufficiently material to alter revenue consequences, whilst LPT have built the increase in revenue costs associated with increased capital investment into their transitional cost submission.

Assumption 7 – PDC dividend

The quantitative assessment excludes material cash flows that are circular in nature, such as PDC dividends. Such cash flows are considered to have a neutral effect and have been excluded from economic forecasts for each of the options from which the NPC has been derived.

Assumption 8 – Redundancy costs

Redundancy costs of £9.27m (UHL) and £7.7m (LPT) have been excluded from the economic forecasts for the purpose of this assessment, in accordance with Treasury guidance provided by the Department of Health.

Assumption 9 – Administration cost

A figure of £6m per annum for administration has been added from years 2 to 4.

Assumption 10 – Capital expenditure

The capital cost estimates have been taken from UHL/LPT submissions. The capital figures used in the economic appraisal of each option exclude VAT, as it is a circular cost and does not include inflation.

Capital works are expected to require immediate funding under the BCT option. It is inevitable that there would be a delay in carrying out any but the most urgent capital investment under the administration option**.** It has therefore been assumed that with the exception of backlog maintenance, all capital expenditure will be incurred 12 months later under the "do minimum" option.

Assumption 11 – Land, residual values and opportunity cost of land

The benefits associated with the disposal of the UHL land are assumed as a Capital receipt of £28.35m. This has been provided through work undertaken by GDA Grimleys, Holbrow Brookes and Mark Ryder Bucknell.

The revenue benefits of this disposal are forecast to deliver cash reductions of site running costs (£8.2m), capital charges & depreciation (£7.5m) and reduction in pay costs (£15m).

As per assumption 6 the benefits of a reduction in capital charges and depreciation has been excluded from both options.

3.8 Sensitivity analysis

It is necessary to understand the risks associated with each of the two options. Seven specific sensitivities were agreed and applied to the Economic case for LLR;

Sensitivity 1: Assuming the "do minimum" option, workstream capital expenditure is delayed by a further 12 months due to increased lead time in authorisation and agreement with general direction of consultation;

	7 years **BCT Option** **NPC** £'000	7 years **Do Minimum Option** **NPC** £'000
Baseline NPC	115,007	132,644.4
Sensitivity 1 Workstream Capex and benefits delayed further 12 months	114,894.7	131,698.7
Sensitivity 1 - Rank	**1**	**2**

Under this option the BCT programme remains the favourable choice.

Sensitivity 2: Assuming the "do minimum" option, cost of workforce increases due to increased staff turnover. Covered by temporary staffing at a premium. The overall staff spend has been split for both UHL and LPT based upon UHL's 2013/14 Annual report;

Nursing Staff = 37%

Medical Staff = 32%

Non-Clinical Staff = 31%

A 4% increase in clinical staff spend has been applied to both organisations as this reflects previous trends witnessed in organisations that have entered administration. The increase has been assumed to exist between 2015/16 and 2017/18 until stability has been regained.

	7 years **BCT Option NPC** £'000	7 years **Do Minimum Option NPC** £'000
Baseline NPC	115,007	132,644.4
Sensitivity 2 Agency Premium cost	114,139.2	190,467.6
Sensitivity 2 - Rank	**1**	**2**

The increased cost equates to around £19m per annum across both Trusts.

Sensitivity 3: Including increased synergies from site rationalisation

This sensitivity asserts that the current benefits for site rationalisation (which are as follows);

- Site running cost reduction (£8.2m per annum);
- Reduction in pay costs (£15m per annum);
- Reduction in depreciation and cost of capital (excluded as non-cash).

The sensitivity explores what would happen under each option if 10% additional benefits were realised:

	7 years **BCT Option NPC** £'000	7 years **Do Minimum Option NPC** £'000
Baseline NPC	115,007	132,644.4
Sensitivity 3 Additional site rationalisation synergy	112,251.8	130,786.6
Sensitivity 3 - Rank	**1**	**2**

Sensitivity 4: Non-achievement of 10 % CIP has been modelled in order to demonstrate level of overall risk;

	7 years **BCT Option NPC** £'000	7 years **Do Minimum Option NPC** £'000
Baseline NPC	115,007	132,644
Sensitivity 4 10% CIP/QIPP shortfall	147,053.2	165,524.2
Sensitivity 4 - Rank	**1**	**2**

The reduction equates to £8m in 14/15, £5.7m 15/16, £5.4m in 17/18 and reduces as the discount factor takes effect.

Under this option the BCT option remains favourable.

This sensitivity analysis clearly shows that BCT remains the preferred option under any sensitivity scenario.

3.9 Qualitative assessment of benefits

We have undertaken a qualitative assessment of benefits and risks associated with each of the two short-listed options. In doing so we have identified the following three critical areas to be evaluated:

- Impact on travel times;
- Impact on health inequalities;
- Impact on health outcomes.

Qualitative assessment of benefits: Better Care Together programme

The option to progress with the Better Care Together programme is expected to offer potential benefits to health outcomes. There will be significant benefits through the development of new services at UHL, particularly through the development of a single larger maternity hub and the new Emergency Floor. Care will be provided in a more appropriate setting for many patients with new services in place to treat people more effectively at home. This will be coupled with a significant improvement in primary care, making more services available more often for those who need them.

In summary, LLR will benefit from a unique opportunity to focus finances, resources, expertise and equipment to better serve patients. It will provide the capacity and impetus to review and improve delivery models. Specific benefits include the following:

- Greater integration through having a joined up programme to deliver more care closer to home, with a signed up plan to treat people in the community rather than in a hospital setting where dependency will increase and their condition could deteriorate;
- More appropriate referrals ensuring that patients are treated by the right team in an integrated way. 18 elective pathways will be redesigned around patients to ensure a better experience of care and fewer unnecessary hospital appointments;

- Greater collaboration between professionals within the larger organisation which will drive superior provision of care for patients, reduce costs to the organisation and create a more satisfied workforce;
- Better care for those with the highest needs through a range of services to identify those requiring more care through risk stratification through to enabling them to live more independently till later in life;
- Better treatment for mental health patients with physical health needs.

Qualitative assessment of benefits: "do minimum" option

The "do minimum" option assumes that providers will not be able to continue to operate in their current form and continue to be financially sustainable. This is the basis for the assumption that an administration process would be required, however at this stage it is not possible to pre-empt the TSA recommendations. Whilst this option may ultimately deliver similar benefits this remains dependent on the TSA recommendations over which there is significant uncertainty.

Evidence from previous TSA at South London Healthcare NHS Trust and Mid Staffordshire NHS Foundation Trust is that the legal requirements and requirement to scope further options will lead to duplication of work but also increase pre-implementation timescales (and as a result cost) considerably. This cost would be seen in the form of additional resource, required by the TSA, to appraise all options but also in maintaining fragile services over an extended period.

Although assuming similar benefits would be achievable, a TSA led process may lead to short term loss of benefits and further risk as recruitment and retention of staff may become more difficult leading to considerable clinical risk. The uncertainty during a TSA process (during which multiple options will need to be appraised) may lead to a number of staff members leaving already fragile services. This could lead to an increasing reliance on more costly temporary staffing and a deterioration of service delivery. The existing fragility of services and this deterioration may lead to increased demands on capacity at surrounding providers which could detrimentally impact the whole health economy.

The scope of the TSA will be to maintain services through Business As Usual. Maintaining this will not deliver the step change improvements (financially and clinically) until the proposed solution is developed and agreed.

A TSA process may lead to an improvement in the governance at the organisation as a TSA is appointed as sole accountable officer which will be a step change to the existing accountability framework.

There is currently a lack of alternative options that could lead to a positive turn around for the LLR health economy in the near future. Therefore there is a high likelihood that the proposed solution by the TSA will be the same as that proposed by the Better Care Together programme.

Qualitative assessment of benefits: conclusion

In conclusion, the BCT option is expected to deliver a higher level of benefits more quickly and with a lower level of uncertainty. The cost and risk of the TSA process will be greater due to uncertainty around staffing and the need to scope further options and comply with the additional legal requirements. It is therefore ranked above the "Do Minimum" option in the qualitative assessment of benefits.

3.10 Qualitative risk assessment

Both of the proposed solutions will involve a number of risks that will need to be mitigated.

The first key risk is the lack of a health economy wide approach to workforce planning given the scale of services that will be provided outside of hospital. This will require joined up programme management around recruitment and training, as well as the shifting of staff from an acute setting to a lower-acuity setting.

Secondly, there is a need to ensure that the beds programme is actively managed by all of the partners in the health economy. The current plans require a reduction of 427 beds at UHL, 80 of which will be into new sub-acute wards in the community and 170 of which will be cared for through the new primary care hubs and community teams. This is a significant undertaking and requires coordination between the CCGs and providers.

The scope of the TSA will be to appraise all potential options and recommend a preferred solution whilst maintaining business as usual. The key risks during the administration will relate to maintaining safe services where it has already been shown that "do nothing" is not a viable option.

Uncertainty could lead to a loss of key staff and a deterioration of services. The TSA process is a high cost process and there is a high likelihood of a similar solution being developed particularly given the detailed scoping of options already undertaken in LLR.

It should also be noted that implementing a recommended solution from the "do minimum" option is likely to incorporate the same risks as the Better Care Together programme (albeit at a later stage). The delay may increase the risks given the potential deterioration of services in the interim.

The additional risks of the "do minimum" option can also be mitigated although there is an unavoidable additional risk from implementing this option.

In conclusion, the additional risks associated with the "do minimum" option result in it ranking below the Better Care Together option in the qualitative risk assessment.

Qualitative assessment of capital risk

The capital programme is assumed to be the same under both options with the exception that there is an assumed 12 month delay under the "do minimum" option reflecting the time

required for the administrator to be appointed and make recommendations and for the implementation of those recommendations. The 12 month delay has not been applied to Backlog Maintenance due to the urgent nature of the works.

3.11 Conclusions

The BCT programme approach has a lower net present cost of delivery than the “do minimum” option and is able to avoid a number of the delivery risks around workforce, service disruption and timing uncertainty that are inherent to the “do minimum” option.

It is the conclusion of the Economic Case that the BCT option is the preferred method of delivery for the programme based on the above assessment.

4 Commercial Case

4.1 Introduction

The Commercial Case sets out the approach that the health economy will be taking to ensure there is a market for the supply of services. The aim of this section is to prove that a commercially viable position can be reached that will allow the programme to deliver good value for money.

4.2 Procurement strategy

Until a preferred option is agreed the procurement strategy for the programme will be an examination of possible options. This will develop alongside increased certainty around specific developments.

4.3 Private sector partnership

Partnership with a private provider under a Private Finance Initiative (PFI) has been a favoured route of procuring large scale development solutions in many areas of healthcare and local government. Under such an arrangement the LLR health economy would contract with a named developer to work with stakeholders to undertake a development scheme and the developer funds the associated capital costs themselves. In return, the developer would seek an annual rent payable over a long lease term.

The current public private partnership vehicle takes the form of PS2 which aims to provide a faster and more transparent model of infrastructure procurement. Some of the characteristics of PS2 are as follows:

- An 18-month time limit on PFI bidding processes. If the process is not complete during this time, the funding may be lost;
- PF2 project companies publishing their revenues and profits.

Existing contractual arrangements should also be considered as they can add complexity to joint delivery of a PS2 solution. It should be noted that long term contracts exist between UHL and IBM, with additional long term contractual service provision between Interserve and UHL/LPT.

The framework that UHL have with Interserve for estates and FM services is inclusive of capital consultancy and construction. This runs for a period of 7 years from March 2013 to 28 February 2020. There is market test provision on the framework component in 2017 but FM services are for the full 7 years.

The provision of estates and FM services is encapsulated in a contract for the 7 years. UHL have rights to terminate services for poor performance or breach should they so require, but in this latter scenario UHL would be liable to contractual terms.

The Lot 2 component which relates to external consultancy (design and construction) is at both UHL and LPT's full discretion with no exclusivity given.

Similarly whilst UHL do not envision that their contract with IBM would immediately halt a PFI solution it would likely be a key consideration as to whether IM&T would be involved in any such agreement.

4.4 LIFT

The LIFT model is an alternative to PS2 and takes a long term strategic approach to local health provision which combines the benefits of national support and local control. A LIFTCo is a local joint venture made up of local stakeholders (typically CCGs, Local Authorities and GPs) and a private sector partner. The LIFTCo takes ownership of the premises it builds or refurbishes and then leases the space to health and social care providers.

LIFT is not seen as the preferred way of progression for required capital schemes for either UHL or LPT.

4.5 PDC/loan finance

The most likely procurement route to be followed for this scheme is through a combination of existing CRL funds and additional PDC loans. This offers flexibility to organisations within LLR around fully shaping the design of services and assuring a focus on quality. Utilisation of internal NHS funds has the benefit of being the cheapest form of long term capital likely to be available for such projects.

A full break down of costs for individual organisations can be seen in the following appendices: UHL (Appendices 14-15), LPT (Appendices 16-17), workstreams (Appendix 1-13) and Primary Care (Appendix 23).

If internal NHS funding is deemed to be the preferred procurement route, then further detailed planning of requirements will be needed as soon as the SOC is approved.

Private financing arrangements could be considered however this is unlikely to be attractive because:

- The existing Interserve agreement precludes third party provision of FM services;
- Given the nature of proposed developments – all being within the existing estate footprint/ extensions to existing buildings it would be difficult to deliver the required risk transfer that would enable a solution to offer value for money.

5 Financial Case

5.1 Introduction

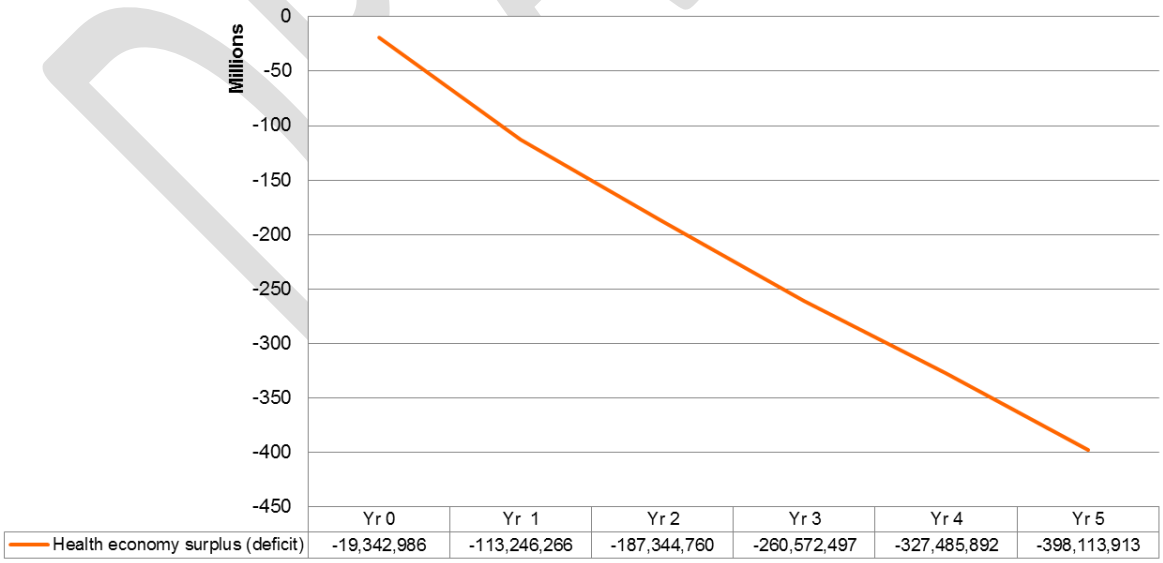
The purpose of the Financial Case is to set out clearly the financial impact of the investment proposal. It details the capital costs and the revenue implications of not only the preferred way forward but also the other short-listed options arising from the appraisal. There are also details of the "do minimum" option to allow a true comparison of the proposed investment. Finally the section also includes the assumptions that have been made at this stage of planning from which the capital and revenue costs have been derived.

5.2 Financial challenge facing the health economy

Economic modelling was undertaken alongside the production of the five year strategy to ensure that a common understanding of the upcoming financial challenge was shared across all parts of the LLR LHSCE. The approach to modelling has been to formulate a single Health Economy wide understanding based upon agreed assumptions concerning demographic growth, funding levels etc. The key focus has been to express the interrelationship between savings and efficiency schemes on all organisations across the LHSCE rather than each in isolation.

The resultant financial position for LLR shows that the total gap between income and expenditure in 2018/19 is £398m before any CIP/QIPP or other projects are modelled. This has been calculated and agreed by the Finance Directors of all commissioner and provider organisations in LLR.

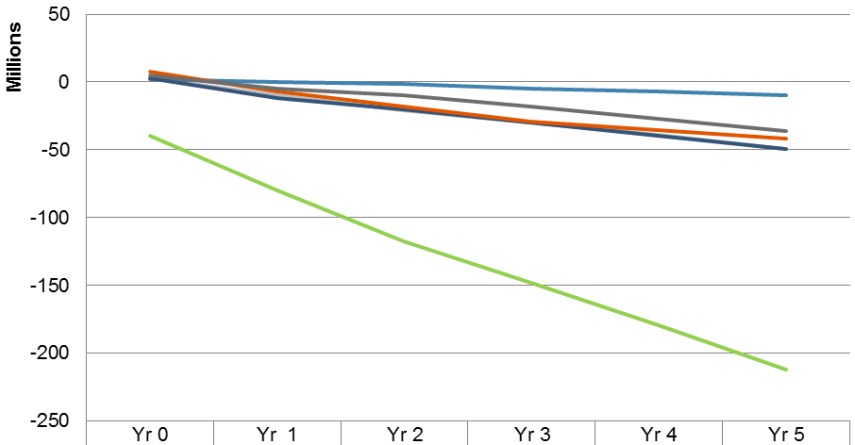
Figure 71: Position at 2018/19 with no savings or productivity improvements in LLR



	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Health economy surplus (deficit)	-19,342,986	-113,246,266	-187,344,760	-260,572,497	-327,485,892	-398,113,913

Figure 45 shows how the £398m financial challenge is split across organisations. The graph shows that in year 5, UHL would have a deficit of £212m if no plans were successfully implemented.

Figure 72: Individual LLR organisation position (excluding savings / productivity)



	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Leicestershire Partnership NHS Trust - RT5	2,911,000	-9,636,734	-20,530,145	-30,043,441	-39,242,889	-49,231,090
University Hospitals Of Leicester NHS Trust - RWE	-39,794,000	-79,961,955	-117,137,721	-148,294,360	-179,203,169	-212,295,747
Leicestershire & Lincolnshire AT	1,937,000	164,556	-1,497,553	-5,147,624	-7,296,649	-9,482,978
NHS East Leicestershire and Rutland	3,045,862	-11,743,514	-20,273,471	-29,698,708	-39,297,623	-49,529,196
NHS Leicester City CCG	7,627,648	-7,198,785	-18,218,003	-29,323,088	-35,577,569	-41,615,324
NHS West Leicestershire CCG	4,929,504	-4,869,834	-9,687,867	-18,065,276	-26,867,994	-35,959,579

Eliminating the gap of £398m would require reducing spend by approximately £1 for every £5 currently spent. This cannot be achieved by 'general' organisational CIPs of 3-4% alone.

The whole health economy model has shown that if the BCT cross system initiatives deliver according to the initial plans, and all organisations deliver a 3-4% CIP (some of which is dependent upon the BCT projects), then the economy as a whole would deliver a £1.9m surplus in year five before the UHL reconfiguration benefits of £30.8m in year 6.

Commissioner and provider positions are improved through reconfiguration of beds, with delivery of CIPs further improving provider positions. In some cases the BCT workstreams and commissioner QIPP are beneficial to commissioners but represent a loss of margin to providers. However, the workstreams have a positive net impact on the whole health economy position.

Managing this is subject to ongoing discussions regarding transition and transformation funding requirements.

5.3 Capital costs and requirements

The overall net capital requirement that cannot be funded through combined Trust Capital Resource Limits (CRL) equates to £428m. UHL will require an advance of £28.3m in 2018/19 against their disposal receipt in 2019/20.

This encompasses LPT's Community Hospital Estates Transformation as well as the 17 individual business cases that will enable UHL to deliver the new Emergency floor, planned care and maternity and children's developments.

Figure 73: Capital requirements by organisation

Org	Project	14/15 (£'000)	15/16 ('000)	16/17 ('000)	17/18 ('000)	18/19 ('000)	Total (£'000)
UHL	Total Requirement	**46,530**	**120,221**	**125,672**	**117,834**	**72,121**	**482,378**
	Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	**167,707**
	External Capital Requirement (Gross)	**12,023**	**86,921**	**92,372**	**84,534**	**38,821**	**314,671**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
LPT	Total Requirement	**14,636**	**14,652**	**23,000**	**48,944**	**52,332**	**153,564**
	Use of capital resource limit	14,636	10,908	12,608	10,108	10,108	**58,368**
	External Capital Requirement (Gross)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
	Receipts	-	-	-	-	-	**-**
	External Capital Requirement (Net)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
Primary Care	Total Requirement	**-**	**4,625**	**13,875**	**13,875**	**13,875**	**46,250**
Planned Care	Total Requirement	-	-	250	-	-	**250**
Urgent Care	Total Requirement	**-**	2,070	-	**-**	**-**	**2,070**
Long Term Conditions	Total Requirement	-	200	-	-	-	**200**
	External Capital Requirement (Net)	**-**	**6,895**	**14,125**	**13,875**	**13,875**	**48,770**
OVERALL	Total Requirement	**61,166**	**139,698**	**164,867**	**180,653**	**138,328**	**684,712**
	Use of capital resource limit	49,143	44,208	45,908	43,408	43,408	**226,075**
	External Capital Requirement (Gross)	**12,023**	**95,490**	**118,959**	**137,245**	**94,920**	**458,637**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**95,490**	**118,959**	**137,245**	**66,570**	**430,287**

UHL's projected transformational capital spend across the five years is £482.4m (including all transformational business cases and the installation of the enabling EPR system. UHL's gross requirement above CRL has been reduced by the forecast receipt of £28.4m due to sale of one acute site (as a result of reduction from 3 sites to 2). Within the above table this is shown as a capital advance in year 5. As mentioned above the initial requirement is offset by usage of UHL's CRL to leave a final requirement of £286.3m. (The capital receipt value has been based on current estimates to provide a basis for planning. It is anticipated that best value will be sought at time of disposal and, as such, the final value is likely to be subject to variation.)

Three work streams have forecast a need for capital funding. Planned care has identified a need to develop a referral hub with a forecast cost of £0.25m in 2016/17. In 2015/16 urgent care require a £2.1m investment in technology to enable mobile working as well as a scheduling system. Long term conditions plan to spend £0.2m on Telehealth equipment in 2015/16.

The element requested for primary care transformation equates to £46.3m. The assumptions behind these figures can be seen within Appendix 23.

As a result of the above the overall external capital requirement for the programme is £430.3m.

5.4 Assumptions made for revenue impacts

Initial planning was undertaken (within the 5 year strategy) to model the over-arching financial position of the health economy. Since this point workstreams and organisations have continued to produce increasingly granular plans that better reflect the likely profiling of benefits. These can be seen below (with CIP/QIPP included as it was set out during economic modelling) mapped savings can be seen within Figure 75:

Figure 74: Benefits by workstream to 2020/21

Type	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	19/20 (£'000)	20/21 (£'000)
Expected funding gap (without interventions)	(113,246)	(187,345)	(260,572)	(327,486)	(398,114)	(475,308)	(559,759)
Adjustment to investment plan	10,118	11,826	12,457	12,865	13,637	13,637	13,637
Net Funding Gap (without Interventions)	(103,128)	(175,518)	(248,115)	(314,621)	(384,477)	(461,670)	(546,121)
LTC Workstream	0	255	1,102	1,694	1,684	1,684	1,684
FOP Workstream	0	0	0	0	0	0	0
Children's Workstream	0	55	300	300	300	300	300
LD Workstream	0	932	1,273	1,657	1,857	1,857	1,857
Maternity & Neonatal Workstream	0	0	378	378	378	378	378
MH Workstream	680	3,615	4,910	5,299	5,688	5,688	5,688
Planned Care Workstream	0	957	2,585	4,614	5,495	5,495	5,495
Urgent Care Workstream	0	(295)	352	1,000	1,000	1,000	1,000
CIPs	58,068	105,106	149,943	193,516	238,372	263,951	326,162
QIPP	28,323	44,475	61,244	80,633	96,687	115,957	138,622
Bed reconfiguration	1,102	4,249	7,503	9,450	11,020	11,020	11,020
UHL site running costs reduction	0	0	0	0	0	30,700	30,700
Expected CCG allocation growth	0	0	4,333	8,667	13,000	13,000	13,000
Additional Workstream efficiencies	0	2,500	5,000	7,500	10,874	10,874	10,874
Revised position	**(14,956)**	**(13,669)**	**(9,193)**	**85**	**1,878**	**235**	**658**
Position originally forecast by Economic Modelling	(15,202)	(10,526)	(14,448)	(15,097)	1,878	235	658

Two additional benefit lines have been added to the breakdown shown in the table above to represent an updated health and social care economy view of how the £398m gap will be closed. These benefits are based on a prudent assessment that the previous savings allocated to a) the development of new contracting models and b) additional funding available from NHSE around primary care, were not sufficiently robust. The additional ways to close the gap shown above reflect the following:

1. **The opportunity for significant additional savings to be delivered through clinical workstreams**. The number of £10.5m includes the financial impact once initially calculated benefits are grown in line with anticipated inflation to 18/19 (£2.5m), in addition to a prudent estimate that there is potential to deliver new projects totalling savings of at least £8m. This was assessed based on additional opportunities identified but not yet developed into detailed initiatives.
2. **Likely changes to CCG allocations CCGs following recent announcements from NHSE**. The allocations for CCGs were prudently set to grow by 1% each year in the original health economy model. Based on the alternative scenarios set out in the 5 Year Forward View it is now estimated that CCGs can expect to receive at least a 1% increase in allocations above that originally set out. In addition, any increase in the pace of movement towards target CCG allocations would constitute an source of funding given that CCGs in LLR are currently on average of 5% under allocation. These two funding effects have been estimated as having a minimum 1% impact each, which would be equivalent to at least £22m for CCGs. The impact prudently forecast to be £12.5m in the benefits breakdown above.

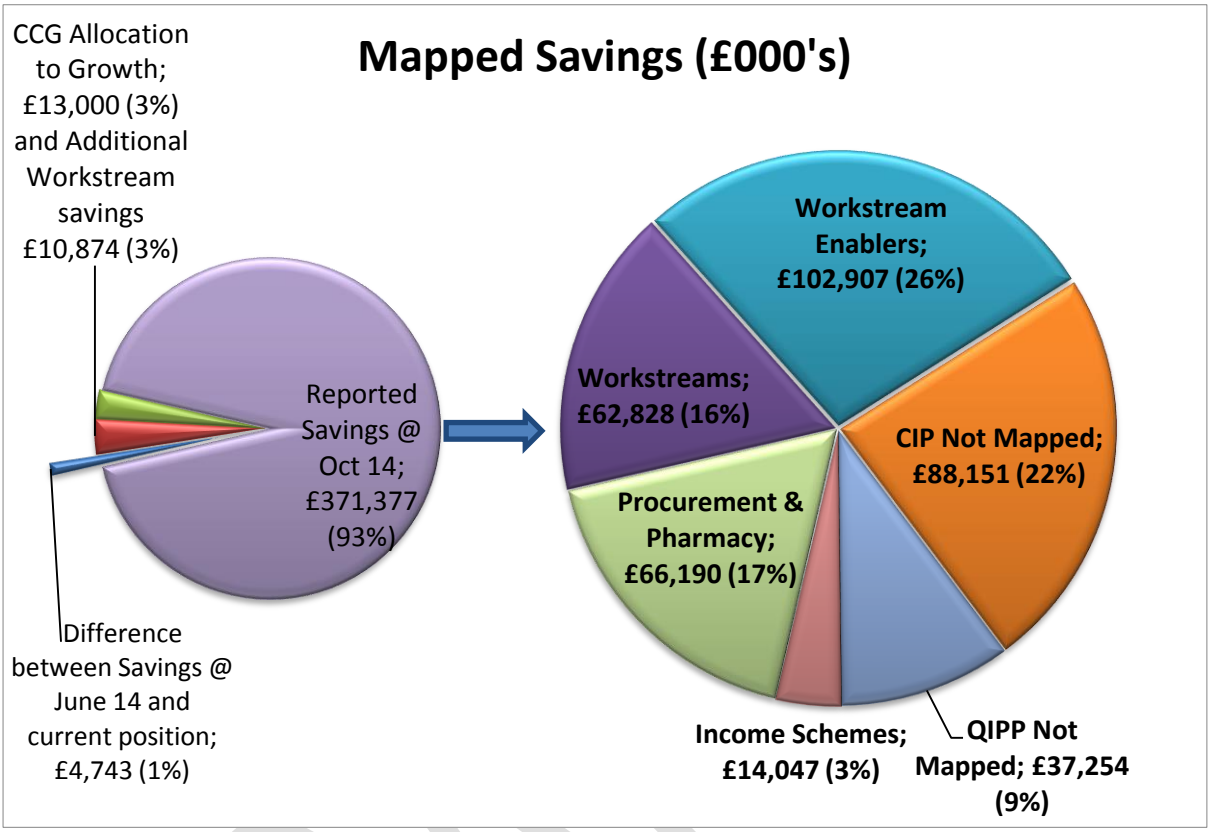
The overall risk of under-achievement of benefits across the programme is a risk that will be proactively managed by BCT. The sensitivities section of the Economic Case (section 4.8) models downside risks of under-achievement and this is also captured within the programme risk register (Appendix 21).

Organisational CIP/QIPP Schemes

Alongside the work stream savings numbers above the BCT programme will enable the delivery of organisation's own CIP/QIPP efficiency targets.

The below table sets out the values that are currently planned for CIP/QIPP delivery across LLR and how these plans can be mapped to specific work streams. Please note that the figures below do not exactly match the planned 5 year CIP/QIPP figures due to slight changes to plans since the original health economy modelling.

Figure 75: Organisation CIP/QIPP planning



The PMO has worked alongside each individual organisation to show the linkages between CIP/QIPP values, originally agreed through Economic modelling, to defined workstreams.

Figure 75 shows (at most recent assessment) the mapping of £371.4m of originally designated workstream and organisational CIP/QIPP savings to the key work stream areas which they enable;

- 45% (£166m) of organisation specific plans can be directly map to supporting the delivery of workstream objectives
- The remaining 55% (£206m) relate to areas of focus around pharmacy, income generation or general efficiency that cannot be mapped directly to work streams.

Further information on Trust specific costs can be seen in Appendix 14 and 15 (UHL) and 16 and 17 (LPT), whilst workstream requirements can be reviewed in Appendix 1-13

Figure 76: Transitional cost requirement summary

Support Type	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Total (£'000)
UHL Deficit funding	40,700	36,100	34,300	33,300	30,800	**175,200**
LPT revenue support	131	3,614	4,558	5,218	2,920	**16,441**
UHL revenue support	1,200	19,707	21,880	22,836	22,920	**88,543**
Work streams	362	4,991	2,122	438	272	**8,185**
Central PMO	1,539	997	997	997	997	**5,527**
Consultation Costs	0	200	200	100	100	**600**
Primary Care	0	4,500	6,000	3,000	1,500	**15,000**
Enablers	366	254	224	224	224	**1,292**
TOTAL REVENUE/(CASH) REQUIREMENT	**44,298**	**70,363**	**70,281**	**66,113**	**59,733**	**310,788**
Funded by						
Uncommitted CCG Transformation funds	0	3,280	3,484	3,684	3,885	**14,333**
Independent Trust Financing Facility (deficit support already applied for by UHL in 14/15)	40,700					**40,700**
Remaining External Funding Requirment	**3,598**	**67,083**	**66,797**	**62,429**	**55,848**	**255,755**
	44,298	70,363	70,281	66,113	59,733	**310,788**

The value of external funding required for 2014/15 does not include the £40.7m of deficit support that UHL have applied to the Independent Trust Financing Facility to cover.

Transformation fund values represent transformation fund values within CCG 5 year strategic returns, less CHC Risk Pool contributions and an assumption that 20% of the balance will be committed to other areas of transformation. 14/15 confirmed as entirely committed.

The additional external requirement to support the programme over future years is therefore **£225.8m**, representing a remaining **£134.5m** of UHL deficit funding and **£121.3m** of programme revenue costs (net of uncommitted CCG transformation funds).

The current working bed reconfiguration plan assumes 250 beds worth of patients can be cared for outside of an acute setting. The transitional revenue support calculations contained in this document are based on the shift completing by 2018/19. At the time of writing consideration is being given to the feasibility of this shift occurring by 2017/18. This is at a very early stage of discussion and as such it would be inappropriate to account for this in the financial calculations. However if after due consideration an acceleration of the 250 bed shift is considered feasible, it would have an impact on the financial calculations contained in this document. The transitional cost requirement calculations would require review and potential revision. The most likely figure(s) to be impacted would be the UHL and LPT revenue support calculations.

Social care impact

There is significant uncertainty related to the delivery of the BCT plan in respect of its impact on adult social care, particularly given the current funding environment and the dependence on political decisions, both locally and nationally. Over the next 5 years both health and social care organisations are facing significant financial pressures which will mean services need to be provided in different ways. Any changes and cuts made across health and social care will inevitably have an impact on each other's' ability to provide corresponding services safely and in a sustainable way.

Work has begun to make estimates to quantify this impact, and this has begun by reviewing the current beds programme. One of BCT's objectives is to provide care for patients in the community who were previously being treated in an acute inpatient setting in UHL. Provisional work has suggested that the financial cost to social care of treating these patients in the community could be around £5m, based on a weighted average of the current cost of care packages. This will only be one element of the joint impact of the changes taking place however this highlights the need for careful planning and coordination between the different services. Further work will be required as the programme moves forward.

In order to mitigate an element of this risk, the health economy model has assumed that funding for the BCF will continue into the final years of the plan (current BCF values indicated below). However, given the large amount of uncertainty surrounding the impact of the cuts to both services a joint programme of work is required to collectively ensure that potential disruption and risk is minimised.

6 Management Case

6.1 Introduction

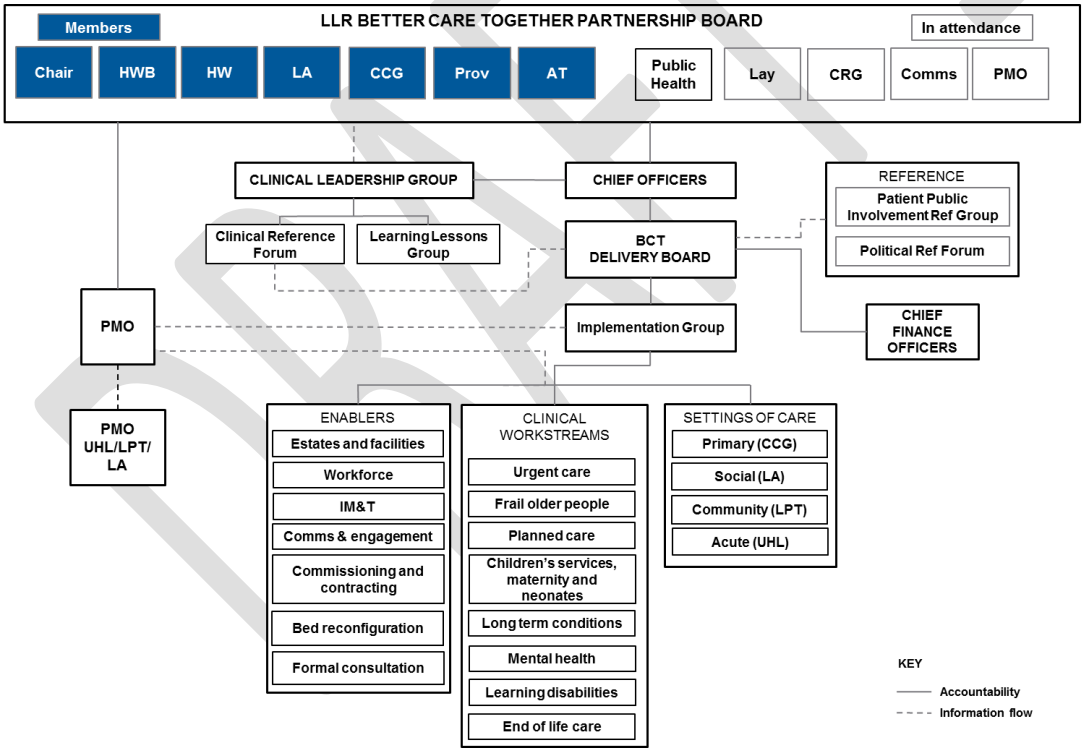
This section of the SOC addresses the deliverability of the programme. Its purpose is to set out the proposed actions that would be required to ensure the successful delivery of the programme.

The programme comprises a number of individual business cases and developments. The structures and processes set out in this section describe the overall proposed programme approach to ensure the programme runs successfully, despite key responsibilities sitting with a range of organisations. Further detail can be found in the separate Programme Initiation Document (PID).

6.2 Outline programme governance structure

The programme requires a clear governance structure and lines of responsibility to ensure that it is able to deliver the required outcomes. This is set out in the diagram below;

Figure 77: BCT programme structure



6.3 Group membership and outline programme roles and responsibilities

There is a clear understanding, within the above structure, as to the responsibility that each element possesses. These were first set out in the PID and will continue to be a key part of the governance process for the programme. The responsible body / person(s) and their responsibilities are summarised below.

Figure 78: Programme roles and responsibilities

Role	Responsibility
LLR Partnership Board	Ultimately accountable for the success of the Programme. Recommending the investment in the BCT Programme to partner organisation boards, cabinets and Executives. Ensuring the Programme remains aligned to LLR strategy. Directing the BCT Delivery Board through the joint SROs. Ensuring the Programme remains worthwhile and viable. Representing and promoting the Programme. Authorising the closure of the Programme.
Chief Officers	Leading their staff through the turbulence and emotion of transformative change. Delivering the BCT Programme outcomes within their organisations. Supporting the Chair of the Partnership Board in providing a supportive LLR environment for the BCT Programme.
Joint SROs	Ensuring the Programme realises the vision and achieves its objectives. Directing the Programme, through the Programme Director.
BCT Delivery Board	Supporting the joint SROs. Driving the Programme forward to deliver the changes and benefits required to achieve the Programme's objectives. Ensuring that Programme planning and control is satisfactory. Authorising the Programme Director to progress to the next stage. Obtaining adequate external assurance. Monitoring and, if necessary, correcting the progress of the Programme.
Programme Director	Managing the Programme, day-to-day, on behalf of the Delivery Board Leading Programme staff.
Chief Financial Officers	Planning and managing financial aspects of the system-wide change to a new operating model of health and social care.
Partner Organisations	Committing resource. Maintaining delivery of routine services while delivering change. Through the workstreams and projects: • delivering the changes required by the Programme; • realising the benefits from the changes; • incorporating the benefits into their new routine services.
Clinical Workstreams and Enabling Groups	Planning and delivering the changes in their area of responsibility that will yield the benefits required for the Programme to achieve the six system objectives (Section 2.5.2).
Political, Clinical and PPI Reference Groups, other stakeholder fora and User Groups	Engaging with and supporting the LLR Case for Change, providing assurance and user input to help the Programme deliver successfully and meet user needs and expectations.
The PMO	Providing control of the Programme to the Programme Director. Facilitating successful delivery of the Programme by coordinating and synchronising Programme resources, work and achievement of objectives. Establishing processes, setting standards and promoting best practice.

6.4 Risk management approach

The programme will apply the following principles in its management of risk;

- The risk management process will feed back to LLR partner organisations.

- The BCT Partnership and Delivery Boards will use a Board Assurance Framework (BAF). The BAF will allow those Boards to assess for themselves the adequacy with which Programme risks are being managed. This assurance of risk management will inform the view of those Boards on the overall deliverability of the Programme.

- Risks in well defined areas will be owned by the relevant or appropriate body in the Programme governance structure, such as clinical risks being owned by the Clinical Reference Group.

- Risk will be managed at the lowest possible level of the organisational structure. An escalation and de-escalation mechanism will link the levels of projects, workstreams and the BCT Programme. The Programme's reporting of risk will be compatible with the reporting mechanism used by LLR partner organisations.

Risk management – process

The risk management process enables the partners to understand and minimise the impact of risks, and provides assurance that risks are proactively and effectively managed.

The risk management approach that the programme will follow is set out below;

- **Identify the context of the risk and the risk** – the risk may be a threat or an opportunity. The objectives or benefits determine the relevance of a threat or opportunity.

- **Assess the risk** – this step may be divided into estimating the likelihood and impact (together the severity) of the threat or opportunity and evaluating the net effect of the aggregated threats and opportunities on an activity. The proximity of the risk may be added to the estimating step.

- **Plan the response to the risk** – responses to a threat can be categorised as: Remove; Reduce; Transfer; Retain or Share. A combination of responses may be possible to reduce the risk to a level at which it can be tolerated. Responses to an opportunity can be categorised as: Realise; Enhance; and Exploit. 'Realise' seizes an identified opportunity. 'Enhance' improves on realising the opportunity by achieving additional gains. 'Exploit' seizes multiple benefits.

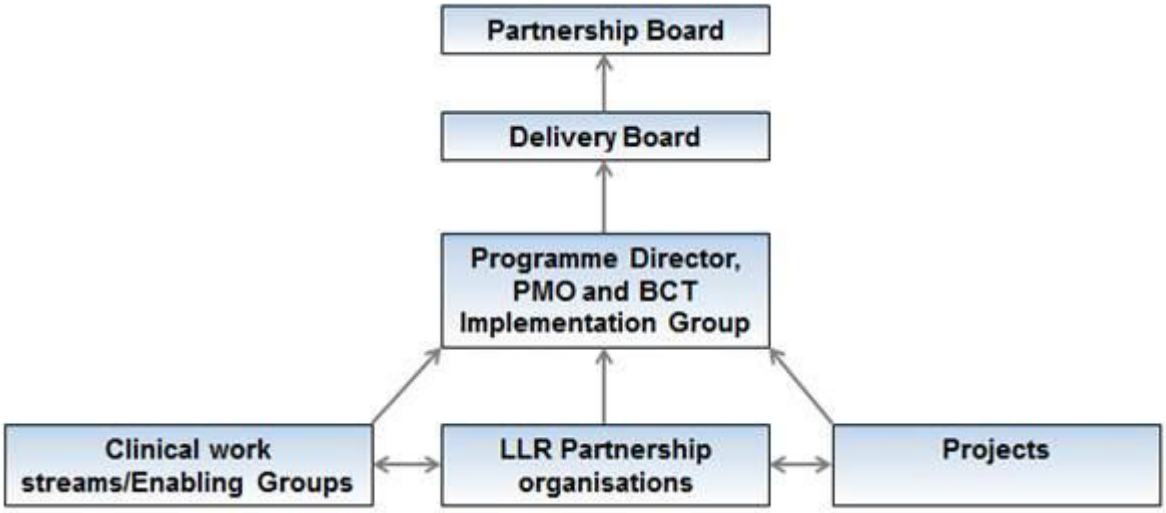
- **Implement the response to the risk** – this step ensures that the planned response(s) is implemented and monitors its effectiveness. If a response to a risk does not achieve the expected result, corrective action will be taken as part of this step.

Risk escalation

In delivering the Programme, the Delivery Board will oversee a core escalation mechanism for: information and performance management; benefits realisation; risk management and issue resolution; quality (programme management and clinical quality); and change control.

The escalation mechanism will be as follows:

Figure 79: Escalation structure



Current risk register

The programme risk register will inform a Board Assurance Framework (BAF) for the Delivery Board. Whereas the programme risk register will be used to control risk, the BAF will be used for the Board to satisfy itself that assurance about risk is adequate.

The programme risk register can be seen within Appendix 21.

6.5 Benefits realisation

The BCT programme will apply the following principles:

- LLR system-wide change and BCT programme-wide change will be benefits-driven;
- benefits will be clearly linked to the six strategic objectives;
- benefits will be measured, tracked and recorded through appropriate performance management arrangements; and
- oversight of benefits delivery is discharged through the BCT Delivery Board.

The BCT programme will realise benefits through a sequence of:

- planning benefits and resourcing their realisation;
- delivering change (elements of transitioning to the new model of integrated health and social care);
- realising the benefits from those changes and embedding the new configuration of infrastructure, organisation, workforce, working practices and relationships; and
- further developing or exploiting those benefits to the advantage of the partnership and its capability to serve its stakeholders.

The Delivery Board will oversee benefits realisation through:

- a benefits plan that maps out the system-wide impact and identifies key dependencies;
- a benefits profile that describes how benefits will be attributed to partner organisations;
- a description of how benefits will be measured, tracked and realised including the name of the responsible owner for delivery; and
- the PMO monitoring the actual realisation of benefits against those planned.

The workstreams projects introduced in the Strategic Case of this document have identified specific key performance indicators, against which performance will be monitored.
These are outlined in the following tables;

Figure 80: Workstream benefits mapping against investment objectives

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
Urgent care	• Increase number of calls to Out Of Hours for over 65's • Increase number of calls to Acute Visiting Service for over 65's		• Increase the number of people feel confident to manage their own condition	• Increase number of contacts dealt by SPA Navigation • Increase GP satisfaction and number of calls into SPA Navigation	• Reduce number of Admitted bed days for Urgent Episodes • Increase number of patients EMAS see and treat at the scene	
Frail older people	• Increase the proportion of older people (65 and Over) still at home 91 days after discharge from hospital into reablement/rehabilitation services. By 15/16 the target is to increase trajectory to 90.0	• More people dying in their place of choice • Reduce injuries due to falls. Target is to reduce emergency admissions in 15/16 by 1700 • More people with dementia living well • Measure new attendance of people to reduce people feeling socially isolated	• Frail Older People identified as being at high risk of admission will benefit from having a Quality Care Plan. Target is to reach 100% care plans for the +75 years old cohort • Improved Patient/Service User Experience. Target is to reach 93.1% satisfaction through surveys	• Decrease Delayed Transfer of Care and Length of Stay. Target is to decrease admissions by 3.0% by 15/16	• Fewer care home admissions. 671 by 15/16 • Reduction in non-elective activity by a total of 1,911 admissions. Target is to reduce Rutland falls admission by 2.4% • Reduce admissions into the Older Peoples Unit-Geriatric Assessment.	

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
Long term conditions	• Reduce dependency on access to care in acute settings for people with LTCs • Improve integrated model of care for COPD Development. Target is to achieve a 1979 spell reduction for HRG DZ21A-K over 5 years	• More people living in their own homes and not in care. The target is to increase this number in Rutland by 93.1% by 15/16	• An increased number of care plans in place and people on disease registers. The target is to reach 100% care plans by all CCGs • More people reporting higher personal resilience and support for self-management. Target is a 30% reduction in re-admissions • Increase in patients reporting activity levels when diagnosed with LTCs. • Positive experience of care. Target is to achieve 66.8% agreement in	• Earlier identification, intervention and escalation preventing delay in treatment. In 5 years the target is to achieve a 30% reduction in the bed days in excess of 15 days	• Shorter inpatient stays for LTCs ; Increase out of hospital care for patients with defined	• More people with LTCs supported by telehealth, telecare and healthcoaching services where it is proven to be of benefit thereby supporting them to self-manage their condition

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
			the CQC Inpatient Survey by 15/16			
Planned care	• Wider health economy transformation including provider CIPs and BADS. Target is 25 bed reductions as per UHL CIP • 40% left shift of acute activity into community			• Reduce face to face follow ups where appropriate	• 10% of outpatient activity attendances will be decommissioned. Target reductions by 2018/19 is £5.17m • 50% of out of county activity (Out patient attendances and Day cases) will be repatriated to LLR (excluding City CCG). Target to reach £6.78m by 2018/19 • Reduced cost of activity due to reductions in acute tariffs • Reduction in elective care cancellations. • Reduction in DNA for follow up appointments.	• Apply consistent application of elective care protocols (Enhanced policy, management and education programme).

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
					Reduce average to 6%.	
Maternity and neonates		• Improve uptake of antenatal and parenting support, particularly in hard to reach groups. Set to reach 21% uptake • Better perinatal outcomes in Leicester City. Target is to achieve 7.6 per 1000 births		• Increase the number of neonates in the right cot and the right time, by a 12-15% reduction each year in neonatal refusals	• Sustainable long term model for maternity and neonatology services that complies with national service specifications.	
Children's services	• Joined-up delivery across health & social care • Reduce number of consultant lead appointment for constipation management • Transfer of Hepatitis B ward attender activity out of UHL. Target is to achieve 0 children attending UHL.	• Children and young people, with the greatest need, will be seen by a specialist emotional health and wellbeing service within the agreed waiting times. Target is 13 week RTT. • All children and	• Reduce referrals to community paediatrics for behaviour management	• Reduce duplication, through workforce integration and better utilisation of facilities to maintain sustainability of children's services. Target is for no children to be on Children's	• Fewer children with eating disorders will be admitted to inpatient beds and will have a reduced stay. Aim to achieve 50% reduction • Reduce attendance/ admissions for childhood asthma and admission for	• A multi skill universal level workforce able to deliver emotional health and wellbeing support to children and young people

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
	• Tier 2 emotional and wellbeing services will be developed to prevent escalation to tier 3.	young people will have an integrated plan of care supporting them from 0-25 yrs. Target is that 100% of children have a plan.		Community Nursing Respite service • Rationalisation of management posts across LPT and UHL • Fewer children and young people will need to access tier three/four specialist provision	respiratory conditions.	
Mental health	• Develop community provision. Target is to negotiate 70,000 contracts.	• Reduce waiting times for community assessment.	• Increase rehabilitation service being provided closer to home. Target is to achieve this for 43 patients.	• Timely crisis and urgent response. Target is to respond within 4 hours and/ or on the same day	• Reduce the demand for bed days. Target is to reach 0 overspill patients	
Learning disabilities		• Increase the number of people with learning disabilities and family carers have expectations and experiences	• Equitable access to the right services and support at the right time, including universal provision. Aim to reach 70%		• Spend her head is proportionate to need and support setting. Target is to be developed and relies on benchmarking on high cost	

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
		which are comparable to the general population. Aim to reach 60% agreement through performance review feedback. • Improved physical/mental health and wellbeing for all people with learning disabilities and family members. Aim to reach 70% agreement through surveys. • Increase the number of individuals to lead independent and fulfilling lives. Target to achieve 60% agreement through surveys.	agreement through surveys • Support to be tailored to individual needs. Aim to reach 80% agreement through surveys.		placements	

6.6 Post implementation review

The programme will continually seek to learn lessons in how it can improve its own performance and how it can find opportunities to realise benefits.

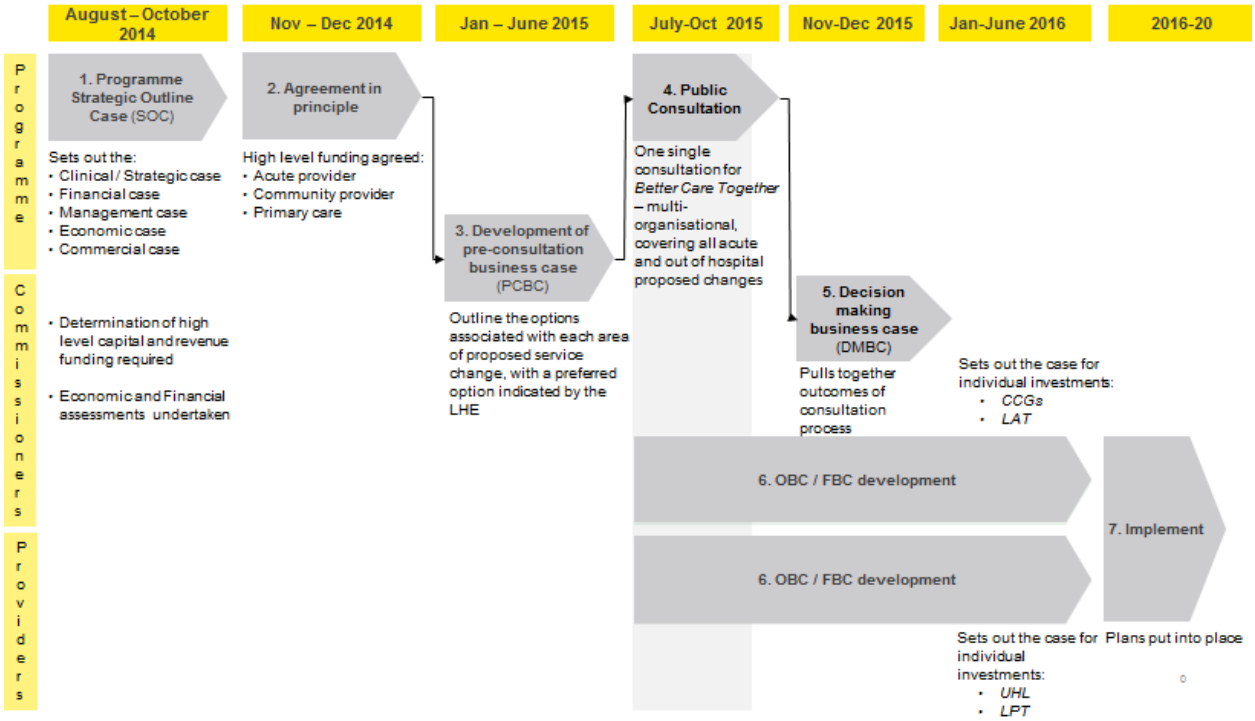
The PMO is to be the custodian, focus and disseminator of lessons learned throughout the BCT programme. This dovetails with the PMO's roles in being the information hub of the programme and in setting standards for the programme.

The Partnership Board will cascade good leadership throughout the programme to create a climate conducive to the good two-way communication that facilitates learning from experience. As part of the Programme Closure Stage, the Partnership Board will arrange for a Post Implementation Review (PIR) of the programme. The PIR will assess the benefits delivered by the Programme and how well the partnership has learned from experience during and after the programme. The PIR may be conducted as part of a larger OGC Gateway Review.

6.7 Business cases

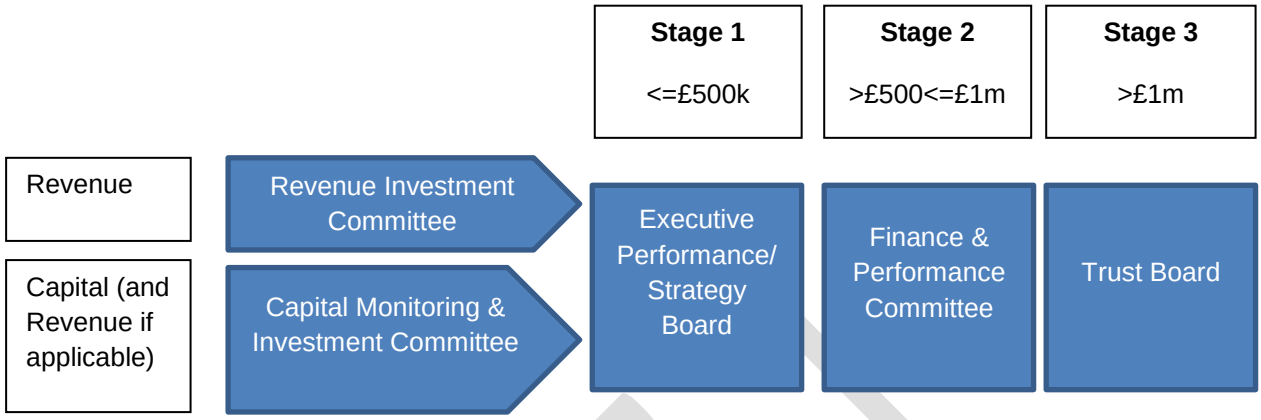
Whilst the SOC forms the overall case for change at a systems level, further detailed work will be required to develop each project referred to in the SOC into either a Request for Funding (RFF), an Outline Business Case (OBC) and/ or a Full Business Case (FBC). This will ensure that ownership of each project passes through the relevant governance, control and monitoring mechanisms of the relevant organisation(s) ultimately charged with delivering the project. The proposed process for major projects that are subject to formal consultation is summarised below:

Figure 81: Overall OBC/FBC approval timeline (re major schemes subject to public consultation)



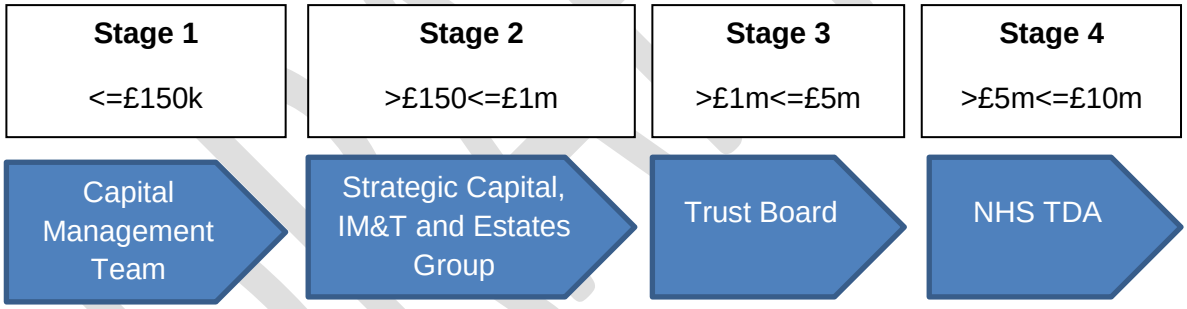
In addition, UHL and LPT's internal authorisation processes are outlined as follows;

Figure 82: UHL business case authorisation structure



UHL uses an initial gateway process based upon whether a project has a capital or revenue consequence. This is followed by a further three levels dependent upon the size of investment that is being bid for. Any request over £5m requires OBC and FBC submission to the National Trust Development Authority (NTDA).

Figure 83: LPT business case authorisation structure



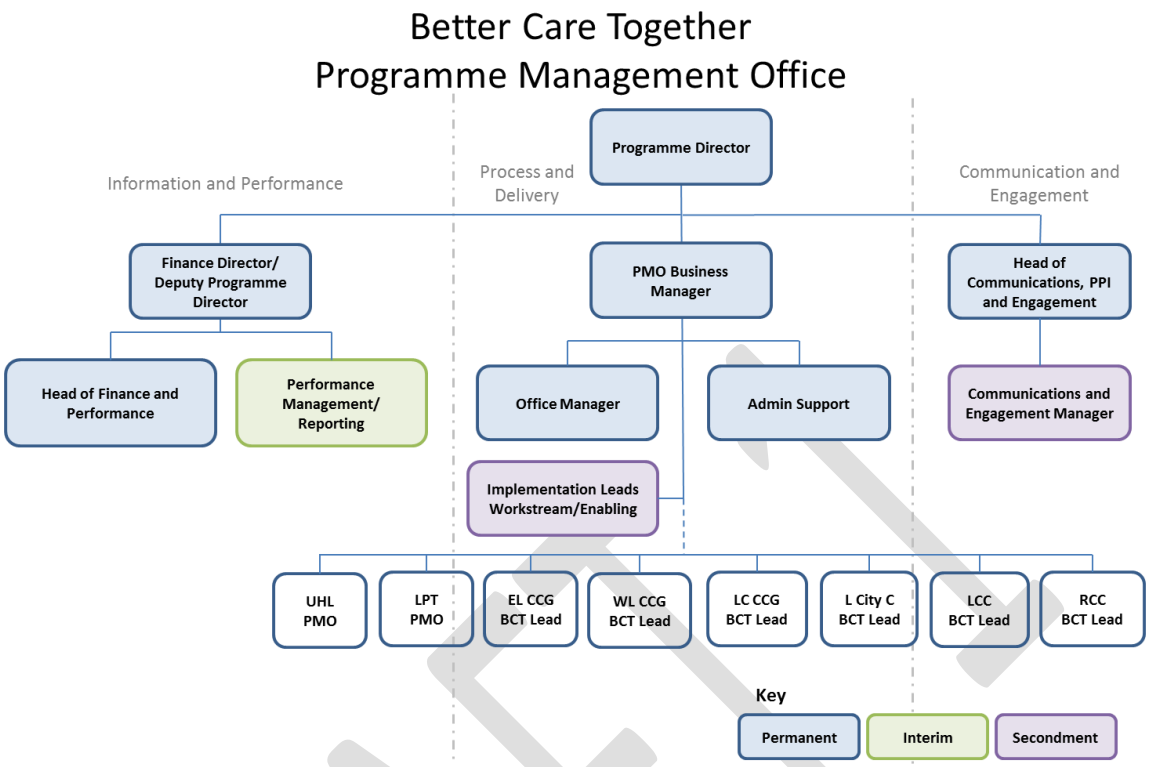
LPT utilises a similar approvals process based dependent upon the size of investment requested.

It will be crucial that the robust authorisation processes within each Trust (and through to the TDA) are satisfied as to the validity of each case as they develop towards OBC and FBC.

6.8 Delivery resource

The diagram below sets out the proposed programme management structure required to deliver the BCT five year strategy.

Figure 84: PMO structure



The programme will be jointly managed through a shared PMO which will be responsible for managing the workstreams across different care settings. This matrix approach will be critical moving forwards to ensure that complex programmes such as beds reconfiguration can be managed in a transparent and effective way across different organisations.

7 Appendices

Appendix 1: Urgent care – benefits

Appendix 2: Urgent care – transition costs

Appendix 3: Long term conditions – benefits

Appendix 4: Long term conditions – transition costs

Appendix 5: Planned care – benefits

Appendix 6: Planned care – transitional costs

Appendix 7: Maternity and neonates – benefits

Appendix 8: Children's services – benefits

Appendix 9: Children's services – transitional costs

Appendix 10: Mental health – benefits

Appendix 11: Mental health – transitional costs

Appendix 12: Learning disability – benefits

Appendix 13: Learning disability – transitional costs

Appendix 14: UHL funding requirements

Appendix 15: UHL transitional cost assumptions

Appendix 16: LPT funding requirements

Appendix 17: LPT transitional cost assumptions

Appendix 18: Detailed capital breakdown

Appendix 19: NPC BCT option

Appendix 20: NPC comparator option

Appendix 21: BCT programme risk register

Appendix 22: Financial positions by organisation

Appendix 23: Primary care funding requirements

7.1 Appendix 1: Urgent care – benefits

Workstream Title:	Urgent Care
Implementation Lead:	Caron Williams
Senior Responsible Officer:	Dave Briggs
Workbook Finance Lead:	Ryggs Gill

Net benefits (Benefits-Recurrent costs)

Benefit /Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Benefit	Non pay	CCGs	Cost savings through reduced admissions for ACS conditions through improved system navigation (investment in scheduling system) and increased productivity of unscheduled care teams in the community (investment in mobile working). Saving based on tariff costs associcated with 12 months activity against ICD10 codes: I48.X, I50.0, I63.9, J18.1, J18.9, J22.X, K59.0, L03.1, N39.0, R07.3, R07.4, R41.0, R54.X, R55.X with length of stay 0-5 days. Activity will be delivered in the community within existing capacity of unscheduled care teams (productivity of teams increased through investment in mobile working)	-	3,899	7,798	7,798	7,798	7,798
Cost	Non pay	UHL	Reduced income from reduced admissions for ACS conditions through improved system navigation (investment in scheduling system) and increased productivity of unscheduled care teams in the community (investment in mobile working). Lost income based on tariff costs associcated with 12 months activity against ICD10 codes: I48.X, I50.0, I63.9, J18.1, J18.9, J22.X, K59.0, L03.1, N39.0, R07.3, R07.4, R41.0, R54.X, R55.X with length of stay 0-5 days.	-	(3,899)	(7,798)	(7,798)	(7,798)	(7,798)
Benefit	Non pay	UHL	Reduced cost base as a result of reduced admissions for ACS conditions through improved system navigation and increased productivity of unscheduled care teams in the community. Reduction of 26 beds based on current length of stay, adjusted for 93% utitilisation, at £50,000 per bed	-	-	647	1,295	1,295	1,295
Cost	Pay	CCG	Increased resource for the SPA team - 9.64 FTE band 3 service coordinators	-	(257)	(257)	(257)	(257)	(257)
Cost	Pay	CCG	System engineer	-	(38)	(38)	(38)	(38)	(38)
NET BENEFIT				-	(295)	352	1,000	1,000	1,000

7.2 Appendix 2: Urgent care – transitional costs

Transitional Costs

Capital/ Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital		Non pay	Mobile working technology to increase productivity of unscheduled care teams in the community	-	770	-	-	-	770
Capital		Non pay	Scheduling system to allow SPA to live allocated resources in the unscheduled care teams	-	1,300	-	-	-	1,300
CAPITAL				-	2,070	-	-	-	2,070
REVENUE				-	-	-	-	-	-
TOTAL COSTS				-	2,070	-	-	-	2,070

7.3 Appendix 3: Long term conditions – benefits

Workstream Title:	Long Term Conditions
Implementation Lead:	Helen Seth
Senior Responsible Officer:	Dawn Leese
Workbook Finance Lead:	Donna Enoux / Gareth Jones

Net benefits (Benefits-Recurrent costs)

Benefit /Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000 Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Costs	Mixed	UHL	Integrated COPD Service Model	-	(200)	(388)	(374)	(361)	(361)
Costs	Mixed	UHL	Workplace Wellness	-	(17)	(34)	(34)	(34)	(34)
Costs	Mixed	UHL	Exercise Medicine	-	(112)	(225)	(225)	(225)	(225)
Costs	Mixed	UHL	Specialist Oxygen review and prescription services	-	(61)	(122)	(122)	(122)	(122)
Costs	Mixed	UHL	Stratified cancer pathways	-	(112)	(223)	(223)	(223)	(223)
Costs	Mixed	UHL	Remote monitoring of cardiac devices	-	(14)	(28)	(28)	(28)	(28)
Costs	Mixed	LPT	Home administration of intravenous diuretics to heart failure patients	-	(20)	(40)	(40)	(40)	(40)
Costs	Mixed	CCG	Evidence based cardiovascular disease screening and treatment	-	(475)	(950)	(950)	(950)	(950)
Costs	Non-Pay	CCG	NICE Hypertension guidelines	-	(1,126)	(2,252)	(2,252)	(2,252)	(2,252)
Benefit	Non-Pay	CCG	Integrated COPD Service Model	-	333	646	624	601	601
Benefit	Mixed	UHL	Workplace Wellness	-	86	172	172	172	172
Benefit	Mixed	CCG	Exercise Medicine	-	0	600	1,200	1,200	1,200
Benefit	Mixed	CCG	Specialist Oxygen review and prescription services	-	116	233	233	233	233
Benefit	Mixed	CCG	Stratified cancer pathways	-	117	235	235	235	235
Benefit	Mixed	CCG	Remote monitoring of cardiac devices	-	15	30	30	30	30
Benefit	Mixed	CCG	Home administration of intravenous diuretics to heart failure patients	-	39	78	78	78	78
Benefit	Mixed	CCG	Evidence based cardiovascular disease screening and treatment	-	500	1,000	1,000	1,000	1,000
Benefit	Mixed	CCG	NICE Hypertension guidelines	-	1,185	2,370	2,370	2,370	2,370
NET BENEFIT				-	255	1,102	1,694	1,684	1,684

7.4 Appendix 4: Long term conditions – transitional costs

Transitional Costs

Capital/ Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000 Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital	IT hardware and software/connectivity	Non-Pay	Equipment - Telehealth (especialy COPD)	-	200	-	-	-	200
Revenue		Pay	Project Team - 1 x 8d Implementation Manager; 4 x 8a Project Management; 1 x Band 4 A&C; 2 PA's per clinical lead 2 x 6; 0.5 Band 7 Finance; 0.5 Band 7 Business Intelligence	137	550	550	-	-	1,237
CAPITAL				-	200	-	-	-	200
REVENUE				137	550	550	-	-	1,237
TOTAL COSTS				137	750	550	-	-	1,437

7.5 Appendix 5: Planned care – benefits

Workstream Title:	Planned Care
Implementation Lead:	Helen Mather
Senior Responsible Officer:	Kate Shields
Workbook Finance Lead:	Sabbir Esat

Net benefits (Benefits-Recurrent costs)

Benefit/Cost	Cost Type (Pay/Non-Pay where	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Benefit		CCGs	10% of outpatient services decommissioned. Expenditure reduction in LLR commissioners. This is based on the following phasing of reduction in activity: - 5% reduction in 6 specialties in Q1 2015/16, 10% reduction Q2 2015/16. - 5% reduction in further 6 specialties by Q3 2015/16 and 10% by Q4 2015/16. - 5% reduction in remaining 6 specialties in 2016/17, 10% reduction in 2017/18.	-	2,937	4,707	5,120	5,170	5,170
Income reduction		UHL	10% of outpatient services decommissioned. Income reduction in UHL. This is based on the following phasing of reduction in activity: - 5% reduction in 6 specialties in Q1 2015/16, 10% reduction Q2 2015/16. - 5% reduction in further 6 specialties by Q3 2015/16 and 10% by Q4 2015/16. - 5% reduction in remaining 6 specialties in 2016/17, 10% reduction in 2017/18.	-	(2,937)	(4,707)	(5,120)	(5,170)	(5,170)
Benefit		UHL	10% of outpatient services decommissioned. Cost reduction in UHL, assuming average marginal cost rate of 69% across three sites and UHL cost reduction phasing of 30%, 50%, 70%, 100%. This is based on the following phasing of reduction in activity: - 5% reduction in 6 specialties in Q1 2015/16, 10% reduction Q2 2015/16. - 5% reduction in further 6 specialties by Q3 2015/16 and 10% by Q4 2015/16. - 5% reduction in remaining 6 specialties in 2016/17, 10% reduction in 2017/18.	-	444	1,275	2,013	2,882	2,882
Benefit		Provider	50% repatriation of outpatient activity into UHL from outside of the health economy. Additional income to provider. The financial benefits are currently under review. The basis for calculation of activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond	-	1,299	3,315	6,707	6,778	6,778
Cost		Provider	50% repatriation of outpatient activity into UHL from outside of the health economy. Cost of delivering the repatriated activity. The financial benefits are currently under review. The basis for calculation of activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond	-	(896)	(2,288)	(4,628)	(4,677)	(4,677)
Benefit		Provider	50% repatriation of daycase activity into UHL from outside of the health economy. Additional income to provider. The financial benefits are currently under review. The basis for calculation of activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond	-	324	813	1,616	1,616	1,616
Cost		Provider	50% repatriation of daycase activity into UHL from outside of the health economy. Cost of delivering the repatriated activity. The financial benefits are currently under review. The basis for calculation of activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond	-	(223)	(561)	(1,115)	(1,115)	(1,115)
Benefit		UHL	Reduction in procedures of limited clinical value. Reduction of £5k per quarter for 18 months - procedures currently under review	-	10	30	30	30	30
Cost			PRISM licence fee. As per quote.	-	0	0	(10)	(19)	(19)
NET BENEFIT				-	957	2,585	4,614	5,495	5,495

7.6 Appendix 6: Planned care – transitional costs

Transitional Costs

Capital/ Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital	Facilities costs e.g. cleaning	Non-Pay	Referral hub set up, mission critical to facilitate repatriation and decommissioning benefits. Includes: - Computer software package to support triage of patients to the right place first time, it will hold all relevant services available to support all 18 pathways. - Computer hardware to support software - Local licences linked to all 18 referral specialties and the alliance - Relocation of chose and book into the hub	-	-	250	-	-	**250**
Capital	IT hardware and software/connectivity	Non-Pay	Computer upgrades to enable new system and cross organisational connectivity	-	-	-	-	-	**-**
Revenue		-	Referral hub development team consisting of clinical lead time, project management, IT support, admin. There is an assumption that this is required for 12 months to enable set up of the referral hub. Efficiencies will be generated across LLR to allow recurrent ongoing support from current workforce.	-	-	156	-	-	**156**
Revenue		-	Non pay costs incurred by referral hub development team, including travel, communications and engagement	-	-	48	-	-	**48**
Revenue		-	Workforce costs as follows to support development of PRISM pathway referral management across 18 specialties: 0.5 x B4 Service Desk Analyst 2 x B7 Product Facilitators 0.5 x B7 PRISMsystm One Integration 1 x B5 PRISMsystm One Trainer	104	156	156	78	-	**494**
Revenue	IT hardware and software/connectivity	Non-Pay	PRISM licence fee during development	14	19	19	10	-	**62**
Revenue	Multi-site staffing during phased bed closure	Pay		-	2,101	91	-	-	**2,192**
CAPITAL				-	0	250	-	-	250
REVENUE				118	2,276	470	88	-	2,952
TOTAL COSTS				**118**	**2,276**	**720**	**88**	**-**	**3,202**

7.7 Appendix 7: Maternity and neonates – benefits

Workstream Title:	Maternity & Neonates
Implementation Lead:	David Yeomason
Senior Responsible Officer:	Karen English
Workbook Finance Lead:	Stuart Shearing

Net benefits (Benefits-Recurrent costs)

Benefit/ Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Benefit	Pay	UHL	Saving of 6 x Band 6 midwives and 5.4 x Band 2 nursing auxiliary from redesigning how mid-wife led services are provided in the community	-	-	**378**	**378**	**378**	**378**
Benefit	Non pay	UHL	Saving of rent from redesigning how mid-wife led services are provided in the community	-	-	**140**	**140**	**140**	**140**
Cost	Non-pay	CCG	CCGs liable for rent payment until alternative use is found for the building	-	-	**(140)**	**(140)**	**(140)**	**(140)**
NET BENEFIT				-	**0**	**378**	**378**	**378**	**378**

7.8 Appendix 8: Children's services – benefits

Workstream Title:	Children's Services
Implementation Lead:	Mel Thwaites
Senior Responsible Officer:	Lesley Hagger
Workbook Finance Lead:	Stuart Shearing

Net benefits (Benefits-Recurrent costs)

Benefit/ Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Overall Total
				Total	Total	Total	Total	Total	(£'000)
Benefit	Mixed	NHSE	Reduced costs from reduced admissions and length of stay for patients with eating disorders, enabled by implementing a community based eating disorders team. Reduce admissions by 50% and length of stay by 30%.	-	375	500	500	500	500
Cost	Pay	CCGs	Cost of implementing a community based eating disorders team. Team consists of Consultant Psychiatrist 0.4WTE, Family Therapist 0.6WTe, Clinical Physiologist 0.8WTE, Nurses 3.0 WTE , Dietician 1WTE, Psychotherapy 0.2WTE, Admin 1.0WTE.	-	(330)	(440)	(440)	(440)	(440)
Benefit	Mixed	CCGs	Saving from reducing number of people referred to CAMHS services through development of improved counselling services. Saving based on reducing referrals by 40 people, at a cost per person of £2,333.	-	-	93	93	93	93
Cost	Mixed	LPT	Cost of implementing improved counselling services to reduce people referred to CAMHS. Cost based on 5-6 sessions for 40 people at a cost of £500 per person. Pump prime funded through transition funding for first year; critical to being able to implement the new service	-	-	(20)	(20)	(20)	(20)
Benefit	Mixed	CCGs	Cost savings from moving consultant led workload within Acute settings to nurse led where possible e.g for bowel management services. Reduce consultant led provision by 50% and increase nurse led provision by 50%	-	7	13	13	13	13
Cost	Mixed	UHL	Reduced income from moving consultant led workload within Acute settings to nurse led where possible e.g for bowel management services. Reduce consultant led provision by 50% and increase nurse led provision by 50%	-	(7)	(13)	(13)	(13)	(13)
Benefit	Mixed	UHL	Reduced cost base from moving consultant led workload within Acute settings to nurse led where possible e.g for bowel management services. UHL have confirmed they can reduce their costs associated with this activity.	-	7	13	13	13	13
Benefit	Mixed	CCGs	Cost saving from moving ward attender Hep B activity out of UHL into primary care, in line with NHSPHE directive re babies with Hep B. 100% of activity moved out of UHL	-	15	15	15	15	15
Cost	Mixed	UHL	Reduced income from moving ward attender Hep B activity out of UHL into primary care. 100% of activity moved out of UHL	-	(15)	(15)	(15)	(15)	(15)
Benefit	Mixed	UHL	Reduced cost base from from moving ward attender activity out of UHL such as Hep B patients. UHL have confirmed they can reduce their costs associated with this activity.	-	15	15	15	15	15
Cost	Mixed	CCGs/primary care	Cost of providing Hep B activity in primary care. Increase capacity in primary and public health support team 0.5 WTE band 2 and agree local payment for GP for vaccination. All costs are included in this estimation.	-	(12)	(12)	(12)	(12)	(12)
Benefit	Pay	LPT	Saving from increased integrated working between health and social care which will deliver efficiencies in terms of number of duplicate visits from health and social care workers. A health and social care worker will attend visits together to support with lifting and deliver all care in one visit, rather than two health workers attending and two social care workers in separate visits. Saving of two band 3 HCAs costed at £ 21,977 plus £3,500 non pay costs (based on assumptions from LPT).	-	-	51	51	51	50
Benefit	Pay	UHL/LPT	Saving from provider integration. Rationalisation of management posts across LPT and UHL to reduce two band 7 posts costed at£46,346 plus £3,500 non pay costs (based on assumptions from LPT).	-	-	100	100	100	100
NET BENEFIT					55	300	300	300	299

7.9 Appendix 9: Children's services – transitional costs

Transitional Costs

Capital/Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Overall Total
				Total	Total	Total	Total	Total	(£'000)
Revenue		Pay	Data Systems Analyst Post	-	50	-	-	-	50
Revenue		Pay	Project Management Support	-	50	50	50	-	150
Revenue		Pay	Release of clinical time	-	50	50	-	-	100
Revenue		Mixed	Pump prime funding to pilot implementation of integrated counselling services, critical to being able to pilot the new counselling service and realise the benefits of reduced referrals to CAMHS	-	20	-	-	-	20
CAPITAL				-	-	-	-	-	-
REVENUE				-	170	100	50	-	320
TOTAL COSTS				-	170	100	50	-	320

7.10 Appendix 10: Mental health – benefits

Workstream Title:	Mental Health
Implementation Lead:	Jim Bosworth
Senior Responsible Officer:	Sue Lock
Workbook Finance Lead:	Chris Poyser

Net benefits (Benefits-Recurrent costs)

Benefit/Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
LPT CIP	Pay and Non Pay	LPT	Reduction in community services cost through reduction in staffing, efficient working, skill mix changes, estate - bringing down from 8/9 sites, more clinic working,mobile working, reduced travel, PbR clusters 1, 2 and 11 transferring to primary care	-	375	750	750	750	**750**
LPT CIP	Pay and Non Pay	LPT	Reduction in acute inpatient beds	-	490	1,410	1,410	1,410	**1,410**
Benefit	Pay and Non Pay	LPT	Crisis House, step down beds, discharge team, changes to inpatient acute pathway to reduce out of county overspill placements	1,150	4,600	4,600	4,600	4,600	**4,600**
Cost	Pay and Non Pay	LPT	Crisis House, step down beds, discharge team, changes to inpatient acute pathway to reduce out of county overspill placements	(450)	(1,800)	(1,800)	(1,800)	(1,800)	**(1,800)**
LPT CIP	Pay and Non Pay	LPT	Reconfiguration of rehabilitation service - beds shift from Mill Lodge to Stewart House	17	100	100	100	100	**100**
Benefit	Non Pay	CCG	Reduction in spend on alternative health placements. This is a phased reduction of 30% from 15/16 and a further 10% in 17/18	-	810	1,620	2,160	2,160	**2,160**
LPT CIP	Pay and Non Pay	LPT	Complex care reconfiguration	-	400	550	550	550	**550**
LPT CIP	Pay and Non Pay	LPT	Reconfiguration of Prison Healthcare	-	170	250	250	250	**250**
LPT CIP	Pay and Non Pay	LPT	Future SDI themes (primarily focussing on efficiencies that can be achieved through skill mix review)	-	-	-	1,000	2,000	**2,000**
LPT CIP	Pay and Non Pay	LPT	Management/administrative efficiencies	150	200	250	250	250	**250**
LPT CIP	Pay and Non Pay	LPT	Reduction in agency spend	870	1,020	1,170	1,170	1,170	**1,170**
LPT CIP	Pay and Non Pay	LPT	Notice served on loss making services	-	100	350	350	350	**350**
LPT CIP	Pay and Non Pay	LPT	Other smaller schemes	-	340	1,333	1,333	1,333	**1,333**
LPT CIP	Pay and Non Pay	LPT	TBC	-	-	-	1,250	2,500	**2,500**
Benefit	Pay	CCG	Reduce staffing costs within IAPT	-	100	100	100	100	**100**
Cost	Pay	CCG	Clinic at end of each day to see urgent patients - 8 clinics each consultant has 1 urgent session a week. A clinic every day across patch (one patch city, one patch county) 5 clinics across city and county per day for 1 hour per clinic b6 / b7 4 WTE from Jan 2015 . This development is required to support deflection of patients from CRHT to CMHTs and to ensure urgent respone is available i.e. within 24 hours	(38)	(150)	(150)	(150)	(150)	**(150)**
Benefit	TBC	TBC	Additional workstream productivity savings through new models of care to be developed	-	-	-	389	778	**778**
NET BENEFIT				**1,700**	**6,755**	**10,533**	**13,712**	**16,351**	**16,351**

The figures above/below represent both system-wide Mental health benefits and also plans within LPT's CIP programme. They have been displayed together to remove the possibility of double counting between both sources. £5.688m of these schemes are specifically attributable to the system-wide element of the workstream and these are:

• Implementation of Crisis House	£2.8m
• Reduction in alternative health placement spend	£2.16m
• Reduction of IAPT staffing costs	£0.1m
• Additional urgent response clinics	(£0.15m)
• Productivity through new models of care	£0.778m
Total	£5.688m

7.11 Appendix 11: Mental health – transitional costs

Transitional Costs

Capital/Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Revenue	Multi-site staffing dur	Pay	Double running to support inpatient bed closures.	0	240	240	0	0	**480**
Revenue	Multi-site staffing dur	Pay	Double running to support tranformational change in delivery of crisis house and step down beds.	0	200	0	0	0	**200**
Revenue		Pay	Develop case management service within LPT to speed up journey through pathway with some AHP patients repatriated into LLR and some services re-tendered. Resource heavy initially, with a reduction in requirements over 3 years.	0	109	163	82	27	**381**
Revenue		Pay	Introduce additional 3 consultants across LLR to include 9-5pm telephone advice line for GPs to deflect referrals from CRHT and to ensure appropriate response from LPT community services. This requires initial investment, with the requirement to reduce outside of the 5 year strategy due to improved knowledge across primary care.	83	330	248	0	0	**660**
Revenue		Pay	Development of Qlikview dashboards to monitor performance	11	11	0	0	0	**22**
Revenue		Pay and Non-pay	Social prescribing roll out across 60 LLR GPs, based on pilot at Hedges Medical Practice	0	25	25	100	150	**300**
Revenue			Co-ordination of 3rd sector and voluntary contacts across LLR to increase health system knowledge of services available	0	74	37	0	0	**111**
Revenue		Pay	Additional clinical capacity for one year to clear backlog due to static waiting lists - 3 x clinical psychologists reviewing caseloads, developing new interventions, change practice and reduce backlog.	0	227	0	0	0	**227**
Revenue			Psychological Wellbeing Practitioners for 6 months within IAPT to reduce waiting times and improve access rates where appropriate.	0	47	0	0	0	**47**
CAPITAL				0	0	0	0	0	0
REVENUE				94	1,262	713	182	177	2,428
TOTAL COSTS				**94**	**1,262**	**713**	**182**	**177**	**2,428**

7.12 Appendix 12: Learning disability – benefits

Workstream Title:	Learning Disability
Implementation Lead:	Yasmin Surti
Senior Responsible Officer:	Sandy McMillan
Workbook Finance Lead:	Richard George

Net benefits (Benefits-Recurrent costs)

Benefit /Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Benefit	Non pay	CCGs	Review of high cost CHC packages for LD patients / service users. Based on a 5% reduction in expenditure, dependent on further analysis around actual packages of care being commissioned	-	380	760	760	760	760
Cost	Mixed		IT software - cost of license for care funding calculator tool	-	(4)	(4)	(4)	(4)	(4)
Benefit	Mixed	CCGs	Reconfiguration of short break services for LD patients / service users. Current service is reprovided during 2016/17, with full year effect being seen in 2016/17. Additional savings in 2017/18 are revenue. No capital implications have been included. Cost of reprovision of short breaks in the independent sector included, and phasing for LPT cost reduction - net health economy saving shown	-	-	385	769	969	969
Benefit	Mixed		Implementation of an Outreach Team which will reduce admissions to inpatient units for patients with LD. Savings released through reduced staffing requirements in inpatient unit and staff will be redeployed in other areas of the services	-	556	556	556	556	556
Cost	Mixed		Implementation of an Outreach Team to include 0.6 Psychiatrist, 1 OT, 0.5 SALT, 0.5 Psychologist, 4 nurses plus non pay costs.	-	-	(422)	(422)	(422)	(422)
NET BENEFIT				-	932	1,275	1,659	1,859	1,859

7.13 Appendix 13: Learning disability – transitional costs

Transitional Costs

Capital/Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Revenue		Pay	Market Development: Project Officer to develop the Market Strategy and write the position statement	13	13	0	0	0	26
Revenue		Pay	Short Break Transformation: Project Officer to lead on C4the LD Short Breaks strategy/implementation	0	23	45	23	0	90
Revenue		Pay	Target Reassessment Team: Review Officers to review CHC packages and users of the Health Short Breaks Service. Resource for 2 years. External resource crucial to the success of reviews and changing culture within LLR	0	149	149	0	0	298
Revenue		Pay	Workforce Development officer to embed skills and learning to commission services in a new way	0	19	0	0	0	19
Revenue		Pay	LD Outreach Team - pump priming for first year to implement team which is then funded recurrently from savings	0	422	0	0	0	422
Revenue		Mix	Development of Safeguarding "Circle of Support": training and expenses for volunteer carers	0	30	30	30	30	120
Revenue		Mix	Stakeholder engagement - based on current costs	-	15	15	15	15	60
Revenue		Mix	Community Health Facilitator - VCS to support people with LD and carers	-	60	50	50	50	210
CAPITAL				0	0	0	0	0	0
REVENUE				13	731	289	118	95	1,245
TOTAL COSTS				13	731	289	118	95	1,245

7.14 Appendix 14: UHL

Workstream Title: UHL Transition costs

Transitional Costs

Cap/Rev	Title	Pay/Non-Pay	Description/rationale	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital	Capital Programme	Non-pay	17 individual business cases in order to move from 3 sites to 2 (inc. professional fees)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
Revenue	Capital Charges	Non-Operating	Cumulative depn, cost of capital and interest charges prior to site disposal		**6,236**	**9,399**	**12,122**	**12,949**	**40,706**
Revenue	Deficit funding	Non-pay	Financing UHL's deficit	**40,700**	**36,100**	**34,300**	**33,300**	**30,800**	**175,200**
Revenue	PMO	Pay	PMO support in relation to the beds reconfiguration	-	**2,300**	**2,300**	**2,300**	**2,300**	**9,200**
Revenue	Transitional support	Pay	Support to UHL during the bed reconfiguration programme	-	**6,577**	**3,953**	**1,976**	**1,328**	**13,835**
Revenue	Transitional support	Pay	Specific posts to support service reconfiguration		**2,100**	**2,100**	**2,100**	**2,100**	**8,400**
Revenue	Premium Staffing	Pay	Costs of maintaining premium staffing to keep vacancies	-	**1,294**	**1,838**	**2,048**	**1,953**	**7,133**
Revenue	Redundancy spend	Pay	Redundancy costs	**1,200**	**1,200**	**2,290**	**2,290**	**2,290**	**9,270**
CAPITAL				**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
REVENUE				**41,900**	**55,807**	**56,180**	**56,136**	**53,720**	**263,744**
TOTAL COSTS				**53,923**	**142,728**	**148,552**	**140,670**	**64,191**	**550,065**

7.15 Appendix 15: UHL transition costs – assumptions

Capital programme assumptions:

1. The extent of service change requires £482m in capital expenditure at UHL over the 5 years of the strategy.
2. The CRL of £167.7m and an anticipated land sale of £28.4m reduces the external capital funding required to £286.3m. Land sale assumed to be in 2018/19 (due to lack of detailed capital plans from 2019/20 onwards this has been shown as an advance in 2018/19 for the purposes of the calculation). The capital receipt value has been based on current estimates to provide a basis for planning. It is anticipated that best value will be sought at time of disposal and, as such, the final value is likely to be subject to variation.
3. It is assumed that the UHL capital strategy will drive delivery of deficit reduction from a 2014-15 (yr 1) starting point of £40m deficit to a 2019-20 (yr 6) breakeven.
4. It is assumed that the capital costs include professional fees at 13-17% which include project management of the builds, architects, financial support, quantity surveying and equipment:

UHL net capital requirement	2014/15	2015/16	2016/17	2017/18	2018/19	TOTAL
	£k	£k	£k	£k	£k	£k
Capital requirement in year	46,530	120,221	125,672	117,834	72,121	482,378
Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	167,707
External capital requirement (gross)	12,023	86,921	92,372	84,534	38,821	314,671
Receipts	-	-	-	-	28,350	28,350
External capital requirement (net)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**

Deficit support assumptions:

1. It is assumed that the savings resulting from reconfiguration from three to two acute sites would bring a further £30.8m per annum net recurrent savings, estimated to deliver in year 6. Site reconfiguration would move UHL to a surplus position by 2019/20.
2. Deficit funding requirements are based on latest UHL projections discussed with TDA in week beginning 6 October 2014.
3. The breakdown of the funding required is illustrated in the below table:

	March 2015 (£m)	March 2016 (£m)	March 2017 (£m)	March 2018 (£m)	March 2019 (£m)	Total (£m)
Revenue deficit	(40.7)	(36.1)	(34.3)	(33.3)	(30.8)	**(175.2)**
Improvement in liquidity	(5.3)	0.0	0.0	0.0	0.0	**(5.3)**
Deficit funding cash required	(46)	(36.1)	(34.3)	(33.3)	(30.8)	**(180.5)**
Capital expenditure	(46.5)	(120.2)	(125.7)	(117.8)	(72.1)	**(482.3)**
Total funding required	(92.5)	(156.3)	(160.0)	(151.1)	(102.9)	**(662.8)**
CRL / depreciation funding	34.5	33.3	33.3	33.3	33.3	**167.7**
Capital receipts	0.0	0.0	0.0	0.0	28.4	**28.4**
Cash funding requirement	**58.0**	**123.0**	**126.7**	**117.8**	**41.2**	**466.7**

Transitional capital charge assumptions:

The extent of increased capital charges, driven by transformational capital investment, has been calculated through comparison of UHL's 2013/14 baseline capital charges figure to future figures which include transformational capital investment. The results are shown below:

Year	13/14 Baseline (£m)	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)	Total (£m)
Depreciation/Amortisation modelled	**31.24**	33.00	34.89	35.25	35.11	33.76	
Depreciation/Amortisation funding required vs 13/14			3.63	4.01	3.87	2.51	**14.02**
Interest Payable modelled	**0.1**	0.71	0.85	0.89	0.93	0.90	
Interest Payable funding required			0.75	0.79	0.84	0.81	**3.18**
PDC modelled	**10.39**	10.43	12.24	14.99	17.81	20.02	
PDC funding required			1.86	4.60	7.42	9.63	**23.50**
Total Capital Costs requiring funding			**6.24**	**9.40**	**12.12**	**12.95**	**40.71**

Only figures relating to 2015/16 onwards have been built into this appendix as 2014/15 revenue support has already been applied for by the trust.

Premium staffing assumptions:

This requirement represents the double running of service and levels of vacancy expected but not possible to fill with substantive employees until redeployment is complete. UHL have provided an assessment of the total proportion of vacancies likely to be affected.

The cover for these posts has been costed at the trust's average substantive cost of £40k inflated by an additional 50% to represent the agency premium incurred through utilising more costly agency staff:

Year	2015/16	2016/17	2017/18	2018/19	Total (£k)
% of workforce	0.2%	0.3%	0.35%	0.35%	
WTE	22	31	34	33	
Cost per WTE (£'000)	60	60	60	60	
Total (£'000)	**1,294**	**1,838**	**2,048**	**1,953**	**7,133**

PMO support assumptions:

1. It is assumed that the recent trend of support costs will continue with projected costs of £1.5m from 2015 onwards, totalling £6m for 4 years. This support is required generally to support internal transformation and the delivery of the beds programme
2. "Change agents" will be required by UHL to offer targeted support to ensure the bed shift occurs in a timely manner. It has been assumed that 20 staff would be needed at band 7 over four years.

Year	PMO support (£k)	Change agents (£k)
2015-16	1,500	800
2016-17	1,500	800
2017-18	1,500	800
2018-19	1,500	800
Total	6,000	3,200
		9,200

Support for transformation plan:

1. UHL transitional support to cover loss in income due to reduction in inpatient activity whilst costs are being taken out of the organisation.

2. The cost of one bed per annum is assumed to be £51k based on figures provided by UHL.
3. UHL have assumed that they will be able to reduce cost following each bed closure based on the following: 30% in year 1 (non-pay) and 28% in year 2 (pay) with remaining costs taken out over years 3 and 4.
4. It is estimated that the non-pay costs will be removed in the first year – no transitional funding to support this.
5. Given the significant agency spend it is assumed that transitional funding only available for first 2 years following bed closure.
6. Staff turnover assumed to be 10%, reducing extent of transition support required.
7. The pay cost element of the £51k per bed is around £36k (70%). Given the 10% turnover rate it is estimated that 10% of this cost, £3.5k can be taken out each year through natural turnover. Transitional support for one bed assumed to be as follows:

Year following bed closure	Pay cost remaining in UHL	UHL estimate on how quickly this cost can be taken out	Before taking into account staff turnover	Reduced through 10% turnover per year	Transitional support required
1	£36k	0 in year 1	0	(3.6)	£32.4k
2	£32.4k	28% of total	(£10k)	(3.6)	£18.8k
TOTAL per bed					**£51.2k**

8. UHL will only be seeking support for the year 1 element of £32.4k per bed and as such the total transitional funding related to beds reduction per year is shown below:

Year	No. of beds reduced (cumulative)	Transitional funding needed (£k)
2015/16	203	6,577
2016/17	122	3,953
2017/18	61	1,976
2018/19	41	1,328
Total	427	**13,835**

Redundancy:

1. 250 of the 462 are shifting from UHL to LPT. Given current vacancy and turnover rates it is assumed that nursing staff who do not move with the activity will not require redundancy. The shift of any clinical staff will be dependent on a period of consultation.
2. Due to the loss of activity it is assumed that corporate (back office) functions will shrink in line with the activity reductions. It is assumed that this would entail a redundancy/voluntary severance scheme (VSS) spend for corporate and A&C staff across the 5 year period.

3. Based on 150 staff over 5 years (total of 10,500 WTE) it is assumed that £6m will be needed over the 5 years, phased equally. This assumes an average band 7 pay with 12 years' service (based on corporate staff averages) resulting in £40k per staff member. This figure is an assumption based on 70 staff being made redundant in UHL in 2014/15.
4. Additional redundancy costs expected to be incurred through the EPR programme, an enabler to the beds reduction. As patient records move to an electronic format, meaning the need for medical records staff is diminished.
5. It is assumed that 50% of medical records staff will be made redundant and 50% redeployed. For the 50% that are made redundant assumed an average pay-out of 12 months resulting in the total redundancy spend.
6. The breakdown of the transitional support required is illustrated in the below table:

Element of transitions support	£k
Normal redundancy	6,000
EPR	3,270
Total	**9,270**

Service reconfiguration assumptions:

UHL have undertaken an assessment of the short term support to provide clinical and managerial leadership throughout the period of transformation. These posts are summarised below;

Backfill for service time	WTE	2015-16 (£'000)	2016-17 (£'000)	2017-18 (£'000)	2018-19 (£'000)	Grade
Consultant	2.8	364	364	364	364	Cons
GM support/backfill	2.8	215	215	215	215	8c
Project manager	7.0	536	536	536	536	8c
Matron	2.8	150	150	150	150	8a
Project support	3.5	126	126	126	126	6
GRAND TOTAL		**1,392**	**1,392**	**1,392**	**1,392**	

Reconfiguration team	WTE	2015-16 (£'000)	2016-17 (£'000)	2017-18 (£'000)	2018-19 (£'000)	Grade
Reconfiguration director	1.0	112	112	112	112	9
HR support	2.0	107	107	107	107	8a
Communications and engagement	1.0	43	43	43	43	7
Finance	2.0	107	107	107	107	8a
Estates & technical project manager	3.0	230	230	230	230	8c
Estates & technical project support	3.0	108	108	108	108	6
GRAND TOTAL		**708**	**708**	**708**	**708**	
OVERALL TOTAL		**2,100**	**2,100**	**2,100**	**2,100**	

7.16 Appendix 16: LPT

Workstream Title: LPT Transitional Funding

Transitional Costs

Cap/Rev	Title	Pay/Non-Pay	Description/rationale	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital	Estates changes	Non-Pay	Existing estates changes	-	3,744	8,908	25,836	42,224	80,712
Revenue	Estate transformatic	Non-operating	Increased capital charges		246	694	2,075	995	4,010
Capital	New estates	Non-Pay	Mill Lodge replacement and permanent CHAMs solution			1,484	13,000		14,484
Revenue	Transitional Costs	Non-Pay	Cost of external expertise		100	200			300
Revenue	Transitional Costs	Pay	Estimated agency staff premium during initial recruitment	-	537	537	972	-	2,046
Revenue	Transitional Costs	Pay	Double running costs and training	70	560	956	-	-	1,586
Revenue	Transitional Costs	Pay	PMO	61	246	246	246	-	799
Revenue	Transitional Costs	Pay	Redundancy	-	1,925	1,925	1,925	1,925	7,700
CAPITAL				-	3,744	10,392	38,836	42,224	95,196
REVENUE				131	3,614	4,558	5,218	2,920	16,441
TOTAL COSTS				131	7,358	14,950	44,054	45,144	111,637

7.17 Appendix 17: LPT transition costs – assumptions

Capital funding:

1. LPT have planned capital expenditure of £153.6m over the five years.
2. It is assumed that the capital resource limit (£58.3m) will be used to reduce the capital requirement from £153.6m to £95.2m.
3. Capital spend is broken down between new estates and changes to existing estates.

	2014/15 (£k)	2015/16 (£k)	2016/17 (£k)	2017/18 (£K)	2018/19 (£K)	TOTAL (£K)
Capital Requirement in year	14,636	14,652	23,000	48,944	52,332	153,564
Use of internal capital resource limit	(14,636)	(10,908)	(12,608)	(10,108)	(10,108)	(58,368)
External Capital Requirement (Net)	**0**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**

Note: The 2014/15 CRL includes capital receipts of £3.3m through sale of former Tower Hospital site

4. Existing estates will incur £80m, to be spent on LPT community hospitals. This number is based on estimates included in the Meant report produced for LPT, to which have been added an optimism bias of 36%. This is to provide assurance since the community hospital capital transformation programme has not reached the Guaranteed Maximum Price stage.
5. Optimism bias has been estimated at the top of the range stated by Treasury guidance given uncertainties surrounding availability of labour in the construction sector, the renegotiation of the P21plus and the lack of detail around current plans.
6. The Guaranteed Maximum Price for the new development for Mill Lodge has been provided by LPT.
7. The Guaranteed Maximum Price for CAMHS has been provided by LPT.

New Estates

Mill Lodge

Category	£k
Build Cost	3,500
Design fees	540
Risk / Prelims / Overhead & Profit	470
Furniture & Equipment	100
Total	**4,610**

CAMHs

Category	£k
Build Costs	7,200
Design Fees	1,330
Risk/Prelims /Overhead & Profit	1,114
Furniture and Equipment	200
Total	**9,844**

Existing Estates Changes

Estates transformation Step 1 to 6

Category	£k
Build Cost	43,323
Planning and Design fees	8,902
Risk / Prelims / Overhead & Profit **(Optimism Bias)**	21,364
Furniture & Equipment	7,121
Total	**80,712**

Revenue funding:

Estates transformation revenue:

1. These costs relate to the revenue consequences of capital expenditure, undertaken as part of transformational change and have been offset against LPT's predicted savings through site rationalisation:

	2014/15 (£k)	2015/16 (£k)	2016/17 (£k)	2017/18 (£K)	2018/19 (£K)	TOTAL (£K)T
Transformational Capital Requirement in year		3,744	10,392	38,836	42,224	
Cumulative transformational capital spend		3,744	14,136	49,228	81,060	
Capital charges assumed at 6.5%		246	919	3,200	5,269	9,631
Expected savings from Estate rationalisation and disposal of surplus properties			(225)	(1,125)	(4,274)	(5,624)
External Funding Requirement (Net)	**0**	**246**	**694**	**2,075**	**995**	**4,010**

Corporate professional fees to develop estates strategy:

2. Estates strategy in development sets out plans to reduce estate by 25% and 40% over 5 years.
3. External expertise is required to deliver the strategy. Broad estimates of funding are set out below:

Capital*/ Revenue	Pay / Non-Pay	14/15 (£K)	15/16 (£K)	16/17 (£K)	17/18 (£K)	18/19 (£K)	Total (£K)
Revenue	Pay	100	200	0	0	0	**300**

PMO support:

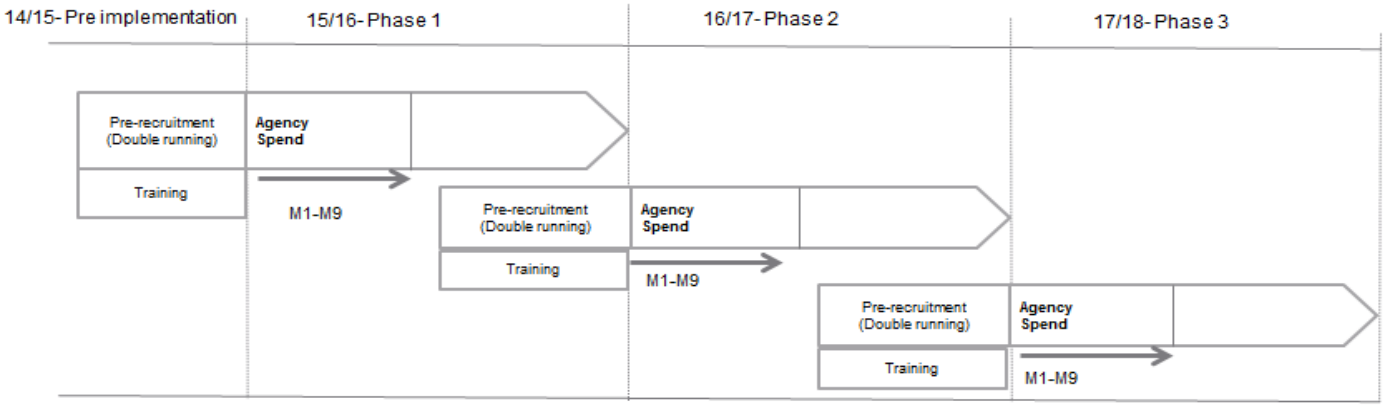
1. It is assumed that LPT will need PMO support funding for the cost that will be incurred to implement the left shift transformation.
2. A small in-house PMO team will be formed to oversee the left shift of beds.
3. The workings include projected cost of a workforce lead; beds shift project manager PMO support and a bed shift admin support. Bandings are as follows: Band 9, Band 8a, band 6 and Band 3 (assumed to cost as shown in the below table) and largely incurred over the three phases of the shift.

Position	Banding	Pre-Implementation 14/15 (£K)	Phase 1 15/16 (£K)	Phase 2 16/17 (£K)	Phase 3 17/18 (£K)	Total (£K)
Bed shift Workforce lead	Band 9	29.4	117.4	117.4	117.4	381.6
Bed shift Project Manager	Band 8a	14.1	56.2	56.2	56.2	182.7
PMO Support	Band 6	9.8	39.1	39.1	39.1	127
PMO Admin	Band 3	5.8	23.2	23.2	23.2	75.3
Non-Pay Costs		2.5	10	10	10	32.5
Total		**61.5**	**245.9**	**245.9**	**245.9**	**799.2**

4.

Beds programme:

1. LPT will need to increase staff numbers in the community to take on the new amount of activity and re-train/re-skill their existing staff in hospital to deal with a higher acuity of patient.
2. The 250 left shift will be phased as follows:
   - Phase 1, 60 beds to LPT community and 24 to LPT beds.
   - Phase 2, 60 beds to LPT community and 24 to LPT beds.
   - Phase 3, 130 beds to LPT community and 34 to LPT beds.
3. To deal with the transformation in service provision LPT will need 202 new WTE posts.
4. The flow diagram, comments and table below, outlines LPT bed left shift.
   - Pre implementation stage – financial year 2014/15



   - Phase 1:
     - Pre-recruitment/double running – 26 WTEs, with a mixed banding of between 2.5 and 6. The average spend will be £2.7k each per month which will cost £70k overall for a month.
     - Agency – 39 WTE which assumes that once the actual phase starts in the initial 9 months the other 50% of staff that could not be recruited substantially will cost an additional agency premium of 40% on top of the substantive cost.

Therefore agency cover will last 9 months over this phase, costing 537k. Agency assumed to then be subsequently covered by substantive staff.

- Phase 2:
  - Pre-recruitment/double running – 26 WTEs, with a mixed banding of between 2.5 and 6. The average spend will be £2.7k each per month which will cost £280k overall for 4 months.
  - Agency – 39 WTE which assumes that once the actual phase starts in the initial 9 months the other 50% of staff that could not be recruited substantially will cost an additional agency premium of 40% on top of the substantive cost. Therefore agency cover will last 9 months over this phase, costing 537k. Agency assumed to then be subsequently covered by substantive staff.
- Phase 3:
  - Pre-recruitment/double running – 49 WTEs, with a mixed banding of between 2.5 and 6. The average spend will be £2.7k each per month which will cost £396k overall for 3 months. This year has more WTE because pre-recruitment straddles financial years, and 2016/17 has 130 beds left shifting
  - Agency – 74 WTE which assumes that once the actual phase starts in the initial 9 months the other 50% of staff that could not be recruited substantially will cost an additional agency premium of 40% on top of the substantive cost. Therefore agency cover will last 9 months over this phase, costing 972k. Agency assumed to then be subsequently covered by substantive staff.
- Training: It is assumed that all 202 WTE new staff will require additional training during the three phases. This is assumed to be 1.5 months of non-productive time at the beginning of each phase, totalling £840k, which is £4.16k per employee (£2.7k a month).
- This transitional support is split by year below:

Transitional cost category	Pre-Implementation 14/15 (£K)	Phase 1 15/16 (£K)	Phase 2 16/17 (£K)	Phase 3 17/18 (£K)	Total (£k)
Double running	70	280	396		746
Agency spend		537	537	972	2,046
Training		280	560	0	840
Total	**70**	**1,097**	**1,493**	**972**	**3,632**

Redundancy:

1. Workforce efficiencies make a majority of LPTs efficiency schemes as pay makes up about 70-80% of LPT's cost base
2. Workforce reductions due to pay efficiencies are anticipated to continue in line with recent year spend. This cost has in the past been supported by transformation funds.
3. A 35 WTE annual reduction through redundancy, at an average redundancy cost of £55k (based on length of service estimates provided by LPT) has been assumed to 2018/19. The efficiencies will not affect front line staff needed for the 250 left shift but are assumed to impact on administrative staff and senior managers.

4. The breakdown of the cost is £1.9m a year between 2015/16 to 2018/19.

14/15 (£K)	15/16 (£K)	16/17 (£K)	17/18 (£K)	18/19 (£K)	Total (£K)
0	1,925	1,925	1,925	1,925	**7,700**

7.18 Appendix 18: Detailed capital breakdown

Org	Project	14/15 (£'000)	15/16 ('000)	16/17 ('000)	17/18 ('000)	18/19 ('000)	Total (£'000)
UHL	Emergency floor LRI	3,100	27,100	10,000	-	-	**40,200**
	Reprovision of clinical services	7,800					
	Vascular GH	1,500	9,000	2,000	-	-	**12,500**
	OPDC hub GH (inc Womens' OP)	3,000	20,000	32,000	3,000	-	**58,000**
	Imaging GH	-	3,000	3,000	-	-	**6,000**
	MSCP LRI	-	4,000	-	-	-	**4,000**
	Childrens' cardiac GH	-	3,500	-	-	-	**3,500**
	Childrens' IP/OP LRI	-	-	3,000	4,000	9,000	**16,000**
	Outpatients LRI	-	-	-	3,000	2,000	**5,000**
	Inpatients LRI	1,500	2,000	8,000	10,000	2,000	**23,500**
	Theatres LRI	3,000	4,000	4,000	4,000	-	**15,000**
	Pathology GH	-	-	-	3,000	-	**3,000**
	Inpatients GH	-	6,000	9,000	15,000	-	**30,000**
	ITU LRI	500	-	-	14,000	2,000	**16,500**
	Maternity LRI	-	-	20,000	25,000	15,000	**60,000**
	LGH	1,000	-	4,000	4,000	-	**9,000**
	Entrance LRI	-	-	-	2,000	10,000	**12,000**
	EPR Programme	3,100	15,000	10,000			**28,100**
	IM&T (Excluding EPR)	8,300	5,050	2,500	2,000	2,000	**19,850**
	Other Projects	13,730	21,571	18,172	28,834	30,121	**112,428**
	Total Requirement	**46,530**	**120,221**	**125,672**	**117,834**	**72,121**	**482,378**
	Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	**167,707**
	External Capital Requirement (Gross)	**12,023**	**86,921**	**92,372**	**84,534**	**38,821**	**314,671**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
LPT	Community Hospitals Estate Transformation: Step One	-	3,744	-	-	-	**3,744**
	Community Hospitals Estate Transformation: Step Two	-	-	1,976	-	-	**1,976**
	Community Hospitals Estate Transformation: Step Three	-	-	6,932	-	-	**6,932**
	Community Hospitals Estate Transformation: Step Four	-	-	-	25,836	-	**25,836**
	Community Hospitals Estate Transformation: Step Five	-	-	-	-	15,000	**15,000**
	Community Hospitals Estate Transformation: Step Six	-	-	-	-	27,224	**27,224**
	Permanent CAMHS Solution	-	-	884	9,000	-	**9,884**
	Mental Health Workstream: Mill Lodge Replacement	-	-	600	4,000	-	**4,600**
	Other Schemes	14,636	10,908	12,608	10,108	10,108	**58,368**
	Total Requirement	**14,636**	**14,652**	**23,000**	**48,944**	**52,332**	**153,564**
	Use of capital resource limit	14,636	10,908	12,608	10,108	10,108	**58,368**
	External Capital Requirement (Gross)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
	Receipts	-	-	-	-	-	**-**
	External Capital Requirement (Net)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
Primary Care	Total Requirement	**-**	**4,625**	**13,875**	**13,875**	**13,875**	**46,250**
Planned Care	Total Requirement	-	-	250	-	-	**250**
Urgent Care	Total Requirement	**-**	2,070	-	**-**	**-**	**2,070**
Long Term Conditions	Total Requirement	-	200	-	-	-	**200**
OVERALL	Total Requirement	**61,166**	**141,768**	**162,797**	**180,653**	**138,328**	**684,712**
	Combined CRL	49,143	44,208	45,908	43,408	43,408	**226,075**
	Combined Receipts	**0**	**0**	**0**	**0**	**28,350**	**28,350**
	External Capital Requirement (Net)	12,023	97,560	116,889	137,245	66,570	**430,287**

7.19 Appendix 19: NPC detailed BCT option

YEAR		14/15	15/16	16/17	17/18	18/19	19/20	20/21
QUARTER		Total	Total	Total	Total	Total	Total	Total
BENFITS		(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)
	Capital							
	Capital receipts	0	0	0	0	0	(28,350)	0
	Revenue							
	LTC Workstream	0	(255)	(847)	(591)	9	0	0
	FOP Workstream	0	0	0	0	0	0	0
	Children's Workstream	0	(55)	(245)	0	0	0	0
	LD Workstream	0	(932)	(341)	(384)	(200)	0	0
	Maternity & Neonatal Workstream	0	0	(378)	0	0	0	0
	MH Workstream	(680)	(2,936)	(1,295)	(389)	(389)	0	0
	Planned Care Workstream	0	(957)	(1,628)	(2,029)	(881)	0	0
	Urgent Care Workstream	0	295	(647)	(648)	0	0	0
	CIPs	(58,068)	(47,038)	(44,836)	(43,573)	(44,856)	(25,580)	(62,210)
	QIPP	(28,323)	(16,152)	(16,769)	(19,389)	(16,054)	(19,271)	(22,664)
	Bed reconfiguration	(1,102)	(3,148)	(3,253)	(1,947)	(1,570)	0	0
	UHL site running costs reduction	0	0	0	0	0	(23,200)	0
	Additional Efficiencies	246	(5,889)	1,564	3,094	(22,890)	0	0
	IT	0	(100)	0	0	0	0	0
	Estates	0	0	0	0	0	0	0
	Workforce	0	0	0	0	0	0	0
TOTAL BENEFITS		**(87,926)**	**(77,166)**	**(68,675)**	**(65,857)**	**(86,831)**	**(96,400)**	**(84,875)**
COSTS								
CAPITAL	UHL	12,023	86,921	92,372	84,534	10,471	0	0
	LPT	0	3,744	10,392	38,836	42,224	0	0
	Primary Care	0	4,625	13,875	13,875	13,875	0	0
	Urgent care Workstream	0	2,070	0	0	0	0	0
	Planned Care Workstream	0	0	250	0	0	0	0
	Long term conditions	0	200	0	0	0	0	0
	IT	0	0	0	0	0	0	0
	Estates	20	0	0	0	0	0	0
	Workforce	0	0	0	0	0	0	0
REVENUE								
Deficit funding	UHL	40,700	36,100	34,300	33,300	30,800	0	0
Beds reconfig (yr 1 only)	UHL		6,577	3,953	1,976	1,328		
Service reconfiguration	UHL		2,100	2,100	2,100	2,100		
Premium staffing	UHL		1,294	1,838	2,048	1,953		
PMO Support & Change Agents	UHL	0	2,300	2,300	2,300	2,300	0	0
	LPT General Transformation	70	1,097	1,493	972	0	0	0
	LPT PMO	61	246	246	246	0		
	LPT Prof Support	100	200	0	0	0	0	0
	Children's Workstream	0	172	100	50	0	0	0
	LD Workstream	13	731	289	118	95	0	0
	MH Workstream	94	1,262	713	182	177	0	0
	Planned Care Work stream	118	2,276	470	88	0	0	0
	Urgent Care Work Stream	0	0	0	0	0	0	0
	Maternity Work Stream	0	0	0	0	0	0	0
	Frail Older People Work Stream	0	0	0	0	0	0	0
	LTC Workstream	137	550	550	0	0	0	0
	IT	240	90	0	0	0	0	0
	Estates	126	254	224	224	224	0	0
	Workforce	0	272	222	0	0	0	0
Other	Administration costs	0	0	0	0	0	0	0
	CCG Primary Care Support	0	3,000	6,000	3,000	3,000	0	0
	Consultation Costs	0	200	200	100	100	0	0
	PMO Costs	1,539	997	997	997	997	0	0
TOTAL COSTS		**55,241**	**157,278**	**172,884**	**184,945**	**109,594**	**0**	**0**
NET BENEFITS		**(32,685)**	**80,112**	**104,209**	**119,088**	**22,763**	**(96,400)**	**(84,875)**
DCF		**0.97**	**0.93**	**0.90**	**0.87**	**0.84**	**0.81**	**0.79**
NPC		**(31,580)**	**74,785**	**93,990**	**103,778**	**19,166**	**(78,422)**	**(66,711)**

Overall Value	**115,007**

7.20 Appendix 20: NPC comparator option

YEAR		14/15	15/16	16/17	17/18	18/19	19/20	20/21
QUARTER		Total	Total	Total	Total	Total	Total	Total
BENFITS		(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)
	Capital							
	Capital receipts	0	0	0	0	0	(28,350)	0
	Revenue							
	LTC Workstream	0	0	(255)	(847)	(591)	9	0
	FOP Workstream	0	0	0	0	0	0	0
	Children's Workstream	0	0	(55)	(245)	0	0	0
	LD Workstream	0	0	(932)	(341)	(384)	(200)	0
	Maternity & Neonatal Workstream	0	0	0	(378)	0	0	0
	MH Workstream	0	(680)	(2,936)	(1,295)	(389)	(389)	0
	Planned Care Workstream	0	0	(957)	(1,628)	(2,029)	(881)	0
	Urgent Care Workstream	0	0	295	(647)	(648)	0	0
	CIPs	(58,068)	(47,038)	(44,836)	(43,573)	(44,856)	(25,580)	(62,210)
	QIPP	(28,323)	(16,152)	(16,769)	(19,389)	(16,054)	(19,271)	(22,664)
	Bed reconfiguration	0	(1,102)	(3,148)	(3,253)	(1,947)	(1,570)	0
	UHL site running costs reduction	0	0	0	0	0	0	(23,200)
	Additional Efficiencies	246	(5,889)	1,564	3,094	(22,890)	0	0
	IT	0	(100)	0	0	0	0	0
	Estates	0	0	0	0	0	0	0
	Workforce	0	0	0	0	0	0	0
TOTAL BENEFITS		(86,145)	(70,960)	(68,028)	(68,503)	(89,788)	(76,232)	(108,075)
COSTS								
CAPITAL	UHL	12,023	86,921	92,372	84,534	10,471	0	0
	LPT	0	3,744	10,392	38,836	42,224	0	0
	Primary Care	0	4,625	13,875	13,875	13,875	0	0
	Urgent Care Workstream	0	0	2,070	0	0	0	0
	Planned Care Workstream	0	0	0	250	0	0	0
	Long term conditions	0	0	200	0	0	0	0
	IT	0	0	0	0	0	0	0
	Estates	0	20	0	0	0	0	0
	Workforce	0	0	0	0	0	0	0
REVENUE								
Deficit funding	UHL	40,700	36,100	34,300	33,300	30,800	0	0
Beds reconfig (yr 1 only)	UHL		6,577	3,953	1,976	1,328		
Service reconfiguration	UHL		2,100	2,100	2,100	2,100		
Premium staffing	UHL		1,294	1,838	2,048	1,953		
PMO Support & Change Agents	UHL	0	2,300	2,300	2,300	2,300	0	0
	LPT General Transformation	70	1,097	1,493	972	0	0	0
	LPT PMO	61	246	246	246	0		
	LPT Prof Support	100	200	0	0	0	0	0
	Children's Workstream	0	172	100	50	0	0	0
	LD Workstream	13	731	289	118	95	0	0
	MH Workstream	94	1,262	713	182	177	0	0
	Planned Care Work stream	118	2,276	470	88	0	0	0
	Urgent Care Work Stream	0	0	0	0	0	0	0
	Maternity Work Stream	0	0	0	0	0	0	0
	Frail Older People Work Stream	0	0	0	0	0	0	0
	LTC Workstream	137	550	550	0	0	0	0
	IT	240	90	0	0	0	0	0
	Estates	126	254	224	224	224	0	0
	Workforce	0	272	222	0	0	0	0
Other	Administration costs	0	6,000	6,000	6,000	0	0	0
	CCG Primary Care Support	0	3,000	6,000	3,000	3,000	0	0
	Consultation Costs	0	200	200	100	100	0	0
	PMO Costs	1,539	997	997	997	997	0	0
TOTAL COSTS		55,221	161,028	180,904	191,195	109,594	0	0
NET BENEFITS		(30,924)	90,068	112,876	122,691	19,807	(76,232)	(108,075)
DCF		0.97	0.93	0.90	0.87	0.84	0.81	0.79
NPC		(29,878)	84,079	101,808	106,918	16,677	(62,014)	(84,946)

Overall Value	132,644

7.21 Appendix 21: BCT programme risk register - template

No	Date ID'd	Risk Description	Risk Owner	Assessment		Controls	Assessment		Review Date
				Likelihood	Impact		Likelihood	Impact	
Strategic Risks									
Clinical Risks									
Financial Risks									
People, Engagement and Leadership Risks									
Programme Management Risks									

Risk Scoring Matrix

Likelihood	Impact				
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	**2**	**3**	**4**	**5**

Risk Severity	
Score	**RAG**
20-25	RED
14-19	AMBER
8-13	YELLOW
1-7	GREEN

7.22 Appendix 22: Financial positions by organisation

The below figures detail the outputs of the original economic modelling work undertaken.

Current views on work stream delivery have been included within benefits breakdowns in the Economic and Financial cases but the tables below set out work stream plans as existed at the time of modelling. Once more detailed breakdowns exist of specific organisation level benefits of work streams the below tables can be updated.

Leicestershire and Lincolnshire AT - Q59

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Revenue limit (recurrent)	430.0	430.0	432.7	434.7	436.4
Revenue limit (non recurrent)	27.9	27.9	27.9	27.9	27.9
Acute services from activity model	(218.2)	(218.5)	(223.0)	(225.6)	(227.9)
Acute services Other	6.8	6.8	6.9	7.0	7.1
MH services from activity model	(7.1)	(7.2)	(7.3)	(7.4)	(7.5)
MH services Other	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Community services from activity model	-	-	-	-	-
Community services other	-	-	-	-	-
Continuing care services from activity model	-	-	-	-	-
Continuing care services other	-	-	-	-	-
Primary care services from activity model	-	-	-	-	-
Primary care services other	(203.3)	(204.5)	(205.8)	(207.0)	(208.2)
Other programme services from activity model	(24.4)	(24.5)	(25.0)	(25.3)	(25.5)
Other programme services other	(11.2)	(11.3)	(11.4)	(11.4)	(11.5)
Underlying surplus/(deficit)	**0.2**	**(1.5)**	**(5.1)**	**(7.3)**	**(9.5)**
QIPP	2.7	4.6	6.7	8.8	10.9
Surplus/(deficit) after projects	**2.9**	**3.1**	**1.5**	**1.5**	**1.4**

NHS East Leicestershire and Rutland CCG - 03W

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Revenue limit (recurrent)	327.3	342.2	353.4	363.4	371.7
Revenue limit (non recurrent)	3.0	3.3	3.5	3.6	3.7
Acute services from activity model	(152.0)	(148.7)	(151.9)	(153.6)	(155.4)
Acute services other	(11.1)	(11.1)	(11.3)	(11.4)	(11.6)
MH services from activity model	(18.7)	(18.7)	(19.1)	(19.3)	(19.5)
MH services other	(14.6)	(14.6)	(14.9)	(15.1)	(15.2)
Community services from activity model	(25.6)	(25.7)	(26.2)	(26.5)	(26.8)
Community services other	(14.6)	(14.6)	(14.9)	(15.1)	(15.3)
Continuing care services from activity model	0.0	0.0	0.0	0.0	0.0
Continuing care services other	(24.9)	(27.0)	(29.8)	(32.6)	(35.7)
Primary care services from activity model	0.0	0.0	0.0	0.0	0.0
Primary care services other	(54.8)	(59.1)	(63.7)	(68.7)	(74.2)
Other programme services from activity model	(6.7)	(6.7)	(6.9)	(7.0)	(7.1)
Other programme services other	(19.0)	(39.6)	(47.8)	(56.8)	(64.2)
Underlying surplus/(deficit)	**(11.7)**	**(20.3)**	**(29.7)**	**(39.3)**	**(49.5)**
Adjustment to investment plan	10.1	11.8	12.5	12.9	13.6
Revised surplus/(deficit)	**(1.6)**	**(8.4)**	**(17.2)**	**(26.4)**	**(35.9)**
Children's services workstream	0.0	0.0	0.0	0.0	0.0
Maternity and neonates workstream	0.0	0.1	0.1	0.1	0.1
LTC/FOP workstream	0.1	0.1	0.2	0.2	0.3
Planned care workstream	0.0	1.8	1.9	1.9	1.9
Urgent care workstream	0.0	0.0	1.1	1.1	1.2
MH workstream	0.0	1.7	1.8	1.8	1.8
LD workstream	0.0	0.0	0.3	0.4	0.4
Bed reconfiguration	0.3	1.3	2.3	2.8	3.1
New contracting models	0.0	0.0	0.0	0.0	4.2
QIPP	7.7	17.0	20.8	24.6	28.5
Surplus/(deficit) after projects	**6.5**	**13.6**	**11.3**	**6.5**	**5.6**

NHS Leicester City

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Revenue limit (recurrent)	392.1	409.3	417.2	425.0	433.0
Revenue limit (non recurrent)	7.6	7.6	4.2	4.2	4.3
Acute services from activity model	(171.7)	(167.3)	(170.1)	(171.7)	(173.0)
Acute services other	(10.3)	(10.3)	(10.5)	(10.6)	(10.7)
MH services from activity model	(38.4)	(38.3)	(38.9)	(39.3)	(39.6)
MH services other	(16.1)	(16.1)	(16.4)	(16.5)	(16.6)
Community services from activity model	(29.2)	(29.2)	(29.6)	(29.9)	(30.1)
Community services other	(3.8)	(3.8)	(3.8)	(3.9)	(3.9)
Continuing care services from activity model	0.0	0.0	0.0	0.0	0.0
Continuing care services other	(32.7)	(37.1)	(39.6)	(42.0)	(44.4)
Primary care services from activity model	0.0	0.0	0.0	0.0	0.0
Primary care services other	(59.7)	(63.3)	(67.8)	(72.6)	(77.8)
Other programme services from activity model	(16.1)	(16.1)	(16.3)	(16.5)	(16.6)
Other programme services other	(28.7)	(53.6)	(57.6)	(61.9)	(66.3)
Underlying surplus/(seficit)	**(7.2)**	**(18.2)**	**(29.3)**	**(35.6)**	**(41.6)**
Children's services workstream	0.0	0.0	0.0	0.0	0.0
Maternity and neonates workstream	0.0	0.1	0.1	0.1	0.1
LTC/FOP workstream	0.2	0.5	0.7	1.0	1.2
Planned care workstream	0.0	2.5	2.5	2.6	2.6
MH workstream	0.0	2.7	2.7	2.8	2.8
LD workstream	0.0	0.0	0.3	0.3	0.3
Bed reconfiguration	0.3	1.3	2.3	2.7	3.1
New contracting models	0.0	0.0	0.0	0.0	4.1
QIPP	11.8	20.1	24.6	29.1	33.7
Surplus/(deficit) after projects	**5.2**	**8.9**	**4.0**	**3.0**	**6.2**

NHS West Leicestershire

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Revenue limit (recurrent)	380.7	396.1	405.6	414.9	424.2
Revenue limit (non recurrent)	5.3	5.3	4.3	4.4	4.5
Acute services from activity model	(163.2)	(160.1)	(163.5)	(165.3)	(167.0)
Acute services other	(17.6)	(17.6)	(18.0)	(18.2)	(18.4)
MH services from activity model	(24.6)	(24.6)	(25.1)	(25.4)	(25.7)
MH services other	(16.6)	(16.6)	(16.9)	(17.1)	(17.3)
Community services from activity model	(31.6)	(31.6)	(32.3)	(32.6)	(33.0)
Community services other	(20.2)	(20.3)	(20.7)	(20.9)	(21.1)
Continuing care services from activity model	0.0	0.0	0.0	0.0	0.0
Continuing care services other	(28.2)	(29.9)	(32.4)	(34.7)	(37.2)
Primary care services from activity model	0.0	0.0	0.0	0.0	0.0
Primary care services other	(63.7)	(67.4)	(71.3)	(75.5)	(79.9)
Other programme services from activity model	(8.2)	(8.2)	(8.4)	(8.5)	(8.5)
Other programme services other	(17.0)	(34.6)	(39.5)	(47.8)	(56.6)
Underlying surplus/(deficit)	**(4.9)**	**(9.7)**	**(18.1)**	**(26.9)**	**(36.0)**
Children's services workstream	0.0	0.0	0.0	0.0	0.0
Maternity and neonates workstream	0.0	0.1	0.1	0.1	0.1
LTC/FOP workstream	0.1	0.1	0.2	0.3	0.3
Planned care workstream	0.0	1.5	1.6	1.6	1.6
Urgent care workstream	0.0	0.0	1.2	1.2	1.2
MH workstream	0.0	2.2	2.2	2.2	2.3
LD workstream	0.0	0.0	0.4	0.4	0.4
Bed reconfiguration	0.3	1.3	2.3	2.8	3.1
New contracting models	0.0	0.0	0.0	0.0	4.2
QIPP	9.4	8.5	14.2	22.6	27.2
Surplus/(deficit) after projects	**4.9**	**4.0**	**4.0**	**4.3**	**4.5**

Leicestershire Partnership NHS Trust

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Operating revenue from activity model	267.6	267.8	273.0	276.1	278.8
Operating revenue other	0.0	0.0	0.0	0.0	0.0
Operating expense – pay from activity model	(169.2)	(176.2)	(186.1)	(193.8)	(201.8)
Operating expense – pay other (excl PFI)	(36.7)	(37.6)	(39.1)	(40.1)	(41.1)
Operating expense – non-pay from activity model	(18.1)	(19.3)	(20.5)	(21.8)	(23.2)
Operating expense – non-pay other (excl PFI)	(41.2)	(43.2)	(45.3)	(47.4)	(49.7)
Operating expense (PFI)	(0.4)	(0.4)	(0.5)	(0.5)	(0.5)
EBITDA	**2.0**	**(8.9)**	**(18.4)**	**(27.6)**	**(37.6)**
Interest (excl PFI)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)
Interest (PFI)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)
Depreciation and amortisation	(6.4)	(6.4)	(6.4)	(6.4)	(6.4)
PDC	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)
Underlying surplus/(deficit)	**(9.6)**	**(20.5)**	**(30.0)**	**(39.2)**	**(49.2)**
Children's services workstream	(0.0)	0.0	(0.0)	0.0	0.1
LD workstream	0.0	0.1	0.1	0.1	0.2
MH workstream	0.0	(1.6)	(1.5)	(1.3)	(1.1)
Bed reconfiguration	0.7	2.4	3.8	4.3	4.3
New contracting models	0.0	0.0	0.0	0.0	3.9
QIPP	(0.1)	(0.5)	(0.6)	(0.6)	(0.6)
CIPs	13.8	22.1	30.4	37.7	45.6
Surplus/(deficit) after projects	**4.7**	**2.0**	**2.1**	**1.0**	**3.1**

University Hospitals Leicester NHS Trust

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Operating revenue from activity model	695.8	689.9	708.2	721.0	733.6
Operating revenue other	114.2	112.0	110.3	108.6	107.0
Operating expense – pay from activity model	(320.2)	(330.3)	(349.2)	(363.9)	(379.3)
Operating expense – pay other (excl PFI)	(200.0)	(205.1)	(213.5)	(218.8)	(224.3)
Operating expense – non-pay from activity model	(230.3)	(239.5)	(254.9)	(271.7)	(289.6)
Operating expense – non-pay other (excl PFI)	(97.9)	(102.6)	(107.5)	(112.7)	(118.1)
Operating expense (PFI)	0.0	0.0	0.0	0.0	0.0
EBITDA	**(38.4)**	**(75.5)**	**(106.7)**	**(137.6)**	**(170.7)**
Interest (excl PFI)	0.0	0.0	0.0	0.0	0.0
Interest (PFI)	0.0	0.0	0.0	0.0	0.0
Depreciation and amortisation	(31.0)	(31.0)	(31.0)	(31.0)	(31.0)
PDC	(10.7)	(10.7)	(10.7)	(10.7)	(10.7)
Underlying surplus/(deficit)	**(80.0)**	**(117.1)**	**(148.3)**	**(179.2)**	**(212.3)**
Children's services workstream	0.0	(0.0)	(0.0)	0.1	0.2
Maternity and neonates workstream	0.1	0.0	0.0	0.0	0.0
Planned care workstream	0.0	(0.5)	(0.5)	(0.6)	(0.6)
Urgent care workstream	0.0	0.0	(0.3)	(0.3)	(0.2)
LTC/FOP workstream	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Bed reconfiguration	(0.6)	(2.2)	(3.2)	(3.1)	(2.6)
QIPP	(3.1)	(5.2)	(4.5)	(3.8)	(3.0)
CIPs	44.3	83.0	119.6	155.8	192.8
Surplus/(deficit) after projects	**(39.4)**	**(42.1)**	**(37.4)**	**(31.2)**	**(25.9)**

Overall

	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Underlying surplus/(deficit)	**(113.2)**	**(187.3)**	**(260.6)**	**(327.5)**	**(398.1)**
Adjustment to investment plan	10.1	11.8	12.5	12.9	13.6
Revised surplus/(deficit)	**(103.1)**	**(175.5)**	**(248.1)**	**(314.6)**	**(384.5)**
Children's services workstream	(0.0)	(0.0)	0.0	0.2	0.3
LD workstream	0.0	0.1	1.1	1.2	1.2
MH workstream	0.0	4.9	5.2	5.4	5.7
Bed reconfiguration	1.1	4.2	7.5	9.4	11.0
QIPP	28.3	44.5	61.2	80.6	96.7
CIPs	58.1	105.1	149.9	193.5	238.4
Maternity and neonates workstream	0.1	0.2	0.2	0.2	0.2
Planned care workstream	0.0	5.4	5.4	5.5	5.5
Urgent care workstream	0.0	0.0	2.0	2.0	2.1
LTC/FOP workstream	0.3	0.6	1.0	1.3	1.7
NHS England	0.0	0.0	0.0	0.0	7.0
New contracting models	0.0	0.0	0.0	0.0	16.4
Surplus/(deficit) after projects	**(15.2)**	**(10.6)**	**(14.5)**	**(15.2)**	**1.8**

7.23 Appendix 23: Primary care appendix

Capital programme assumptions:

1. East Leicestershire and Rutland CCG estimates a total capital funding requirement of £29m, broken down as follows:
    a. £20m on 2/3 new hubs combining/merging up to 10/12 geographically adjacent practices in new large premises, which will include a wider range of diagnostics, specialist and community care.
    b. £1m on 3 hubs in existing premises, that require upgrading/development to maximise services available for a wider population.
    c. £2m on 2 hubs requiring expansion and development both within their surgeries due to population expansion, but also in adjacent community hospital development to provide a base for hub level services.
    d. £6m on 3 hubs requiring development of existing estate to enable the new methods of providing greater out of hospital care.
2. Leicester City CCG estimates that £8m will be required, made up of £2m for each of four planned Health Need Neighbourhoods.
3. West Leicestershire CCG estimates total capital funding required to be £9.25m, broken down as follows:
    a. £2.5m in Charnwood to support expansion of 3 high risk premises and consolidate services at Loughborough community hospital.
    b. £2m in South Charnwood to support expansion of 2 high risk premises.
    c. £2.75m in NWL to develop Coalville, expand Ashby Health Centre, support Whitwick and Coalville practices.
    d. £2.5m in H&B to consolidate current single handed practices to one site, expand Burbage and potential Hinckley health centre development.
4. Capital costs assumed to be 90% in years 3-5 and the remainder in year 2:

CCG	2014/15	2015/16	2016/17	2017/18	2018/19	TOTAL
	£k	£k	£k	£k	£k	£k
East Leicestershire and Rutland	0	2,900	8,700	8,700	8,700	**29,000**
Leicester City	0	800	2,400	2,400	2,400	**8,000**
West Leicestershire	0	925	2,775	2,775	2,775	**9,250**
Total	0	4,625	13,875	13,875	13,875	**46,250**

Revenue support assumptions:

1. CCGs are planning to increase recurrent spend in primary care services over the next four years as part of the move to increase capacity and treat more people in community and home settings. The plans anticipate increased nursing numbers whilst keeping GP numbers steady, with more staff in the community to help prevent the need for acute care.

2. This increase in recurrent expenditure is expected to take place during 2016/17 and 2017/18, with a period of double running in 2015/16 and 2016/17 to support this expansion during the period where new services models are being developed and collaborative working between GP practices is strengthened.
3. Transitional funding to support this programme is focussed on the non-recurrent revenue support CCGs will require to set up the new services and models of collaboration in the community before these systems are fully up to capacity. Specific costs have been developed by each CCG, which include:
    a. Education and training;
    b. IM&T improvements and alignment to support development of hubs;
    c. Management costs, including legal;
    d. New equipment;
    e. Time and motion studies to enhance the model.
4. Estimates from CCGs have been developed, however the health economy has taken a view that primary care should be in line with the funding to support other settings of care within the BCT programme, and therefore that around £3m per year (approx. 0.8% of the recurrent primary care budget across LLR) will be required during the double running period.
5. Individual assumptions from CCGs range from an estimate of £150,000 per hub per year for East Leicestershire and Rutland, to £600k per locality per year for the first two years in West Leicestershire, dropping to £400k per locality in the final two years.
6. The overall likely sums required have deliberately been spread between each of the three CCGs and therefore may not reflect exact spending over the four remaining years of the plan. Funding requirements have been weighted towards 2015/16 and 2016/17 based on likely recruitment and development timescales. Further details on exact spending patterns will be developed over the next six months.

CCG	2014/15	2015/16	2016/17	2017/18	2018/19	TOTAL
	£k	£k	£k	£k	£k	£k
East Leicestershire and Rutland	0	1,000	2,000	1,000	1,000	**5,000**
Leicester City	0	1,000	2,000	1,000	1,000	**5,000**
West Leicestershire	0	1,000	2,000	1,000	1,000	**5,000**
Total	0	3,000	6,000	3,000	3,000	**15,000**

7. The costs above will also include IM&T development costs, including £0.3m for Leicester City to increase access to virtual consultations and prepare systems for move to hub-based working. For West Leicestershire CCG IM&T costs are estimated as being £0.5m for all practices to move towards a single system, and a further £0.15m to increase access to virtual consultations.
8. A further £80k is set aside for an initial county wide estates audit, and any further primary care estates work will be assumed to be part of the £15m required.

Better care together

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

THE BETTER CARE TOGETHER PROGRAMME

PROGRAMME INITIATION DOCUMENT

02 December 2014

CONTENTS

Executive Summary

This Programme Initiation Document (PID) provides a single source of reference to quickly and easily find what the Better Care Together (BCT) Programme is about. BCT is a partnership of health and social care organisations across Leicester, Leicestershire and Rutland (LLR). The partnership conducts business through a BCT Partnership Board. The BCT Delivery Board will oversee the delivery of the Programme on behalf of the BCT Partnership Board. In June 2014, the Partnership Board set out its vision of health and social care services across LLR for the next five years. That vision has driven the formulation of 'Better Care Together: The Five-Year Strategic Plan 2014-2019'.

The BCT Programme is the strategic vehicle through which the five year strategy has been jointly developed with the Partnership Board. The Programme covers areas of work that cut across existing boundaries of health and social care provision, many areas of work being LLR or system-wide. This whole system change will require a new operating model of health and social care services across LLR. The new model, and the transition to it, requires extensive reconfiguration of our clinical service pathways and their supporting functions. The transition will re-orientate care from an emphasis on buildings to an emphasis on integrated health and social care services delivered closer to home or in the community.

The aim of the BCT Programme is to deliver the blueprint of a new operating model of integrated health and social care across LLR in order to realise the vision for the Programme by autumn 2019. The Programme initially consists of: eight clinical workstreams; five enabling groups; primary, community and social care; and finance. The Programme will be the vehicle for the alignment, coordination and delivery of those four large bodies of work.

The approach of the Programme will be based on the Five-Year Strategic Plan, direction from the BCT Partnership Board, and the Office of Government Commerce (OGC)'s guidance on best practice for the management of projects, programmes and portfolios. The main guidance that the Programme will follow will be that for managing successful programmes. It will be supplemented, where appropriate, by the OGC's guidance for managing portfolios of change. Underpinning successful delivery of the Programme will be a shared understanding of relevant terms. Managing the Programme will focus on a shared vision of the Programme's desired outcome, focussing on the benefits and the threats to realising them, coordinating the main bodies of work, and optimising the use of our resources.

The aim of the PID is to provide the authoritative definition of the BCT Programme that sets out the basis on which it is to be initiated, governed and delivered. The PID sets out the policy of the Partnership Board for the management of the Programme. The PID applies best practice for the management of programmes and portfolios to the LLR's circumstances and requirement. The Five-Year Strategic Plan 2014-2019, the 'wrapper' Strategic Outline Case and the PID are a suite of three complementary documents. The structure of the PID is: introduction; top level requirements; execution; supporting functions; resources; and appendices.

The PID will be reviewed annually by the BCT Partnership Board.

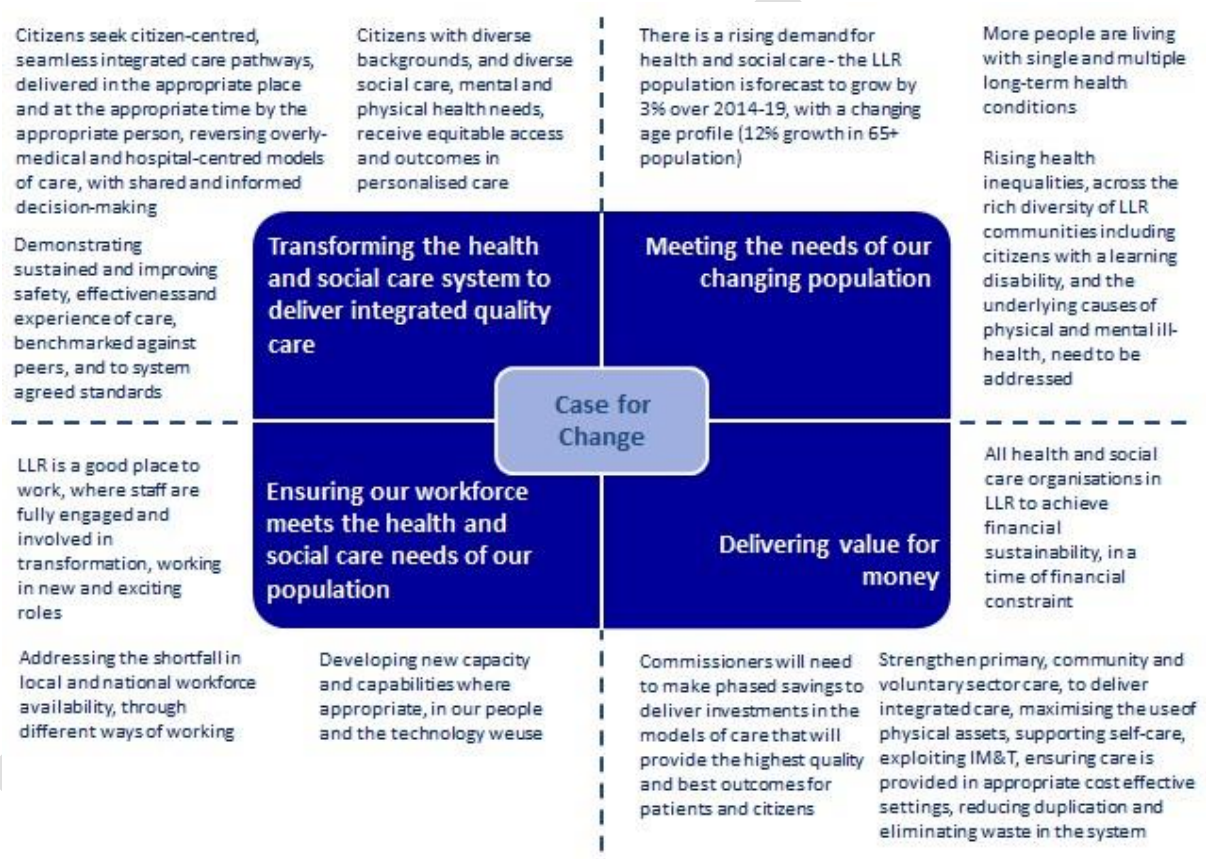
Introduction	
1.1	**Aim of the document** The aim of the Programme Initiation Document (PID) is to provide the authoritative definition of the BCT Programme that sets out the basis on which the Programme is to be initiated, governed and delivered. In doing so, the PID sets out the policy of the Partnership Board for the management of the BCT Programme. The PID provides the single source of reference for stakeholders to quickly and easily find what the Better Care Together (BCT) Programme is about.
1.2	**Purpose** The PID will be used as the benchmark by the Partnership Board to assess the success of the BCT Programme. The BCT Delivery Board is the board tasked with driving the Programme to deliver on behalf of the Partnership Board. The BCT Delivery Board will use the PID to review the continuing viability of the Programme. The PID will be reviewed annually by the Partnership Board, or more frequently if recommended to do so by the joint SROs of the BCT Programme. The PID is designed to be an 'enduring document' over the life of the BCT Programme. This is in contrast to the BCT Programme Plan which will need to adapt as circumstances change over the life of the Programme.
1.3	**Terminology** See Appendix 1 for a glossary of terms. The BCT Delivery Board approved the following definitions for the BCT Programme: • **Programme**: A management structure that coordinates, directs and oversees the implementation of a set of related projects and activities, in order to deliver outcomes and benefits of strategic importance to stakeholder organisations. • **Workstream**: A sub-programme of work beneath the BCT Programme. A workstream incorporates projects that contribute to the delivery of the Programme. • **Project**: A group tasked with the delivery of one or more outputs to a set quality, within time constraints and cost limits. The Project assists in the delivery of workstream objectives.

Top Level Requirements

2.1 **Case for Change and Background**

The Five Year Strategic Plan sets out the case for change in detail. It culminates in an understanding of the opportunities to redesign a sustainable local health and social care system around the future needs of patients. The work that led to this understanding was clinically led. The case for change was co-produced with the Patient and Public Involvement Reference Group.

The case for change is summarised in the diagram below.



To meet this need for change a vision has been shaped for LLR health and social care in 2019. This vision, and a plan to realise that vision, is set out in the June 2014 document, 'Better Care Together: The Five-Year Strategic Plan 2014-2019'.

The Strategic Plan is a directional plan setting out a system-wide solution for the provision of health and social care services across LLR.

Realising system-wide change will rely on five main management disciplines: clinical; financial; workforce; communications and engagement (including Patient and Public Involvement); and programme management.

2.2	**Stakeholders** The main stakeholder groups of the BCT Programme are: • patients, service users and their carers, including the voluntary and community sector; • the BCT Partnership's health and social care staff, practitioners and clinicians; • the wider public and communities; • political representatives, local government and regional administration; and • partner organisations in the BCT Partnership across LLR.
2.3	**Aim of the BCT Programme** The aim of the BCT Programme is to deliver the blueprint of a new operating model of integrated health and social care across LLR in order to realise the vision for the Programme by autumn 2019.
2.4	**Success Criteria** Successful management of the BCT Programme will be defined by: • a clear, commonly understood and shared vision of the Programme's desired outcome; • a focus on the benefits and the threats to delivering them; • effective coordination of multiple workstreams and projects, their interdependencies and aggregated risk; and • leadership and management of the transition to the desired outcome, including cultural change. These success criteria will be monitored by the Programme Director, supported by the BCT PMO. The criteria will be reflected in the Programme's performance management as it is developed and refined in the light of experience.

2.5	**Vision and Objectives**
2.5.1	**Vision** The Five-Year Strategic Plan sets out the vision for the LLR health and social care system as to 'maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring of safe, high quality services into the most efficient and effective settings.' For the BCT Programme, this vision can be broken down into three parts: • improved LLR citizens' health and wellbeing outcomes; • safe, high quality services restructured into the most efficient and effective settings; and • an enhanced quality of care and cost reduced to within allocated resources. Realising the vision will involve a shift in how and where health and social care will be delivered. This will see the following: • health and social care services becoming more integrated; • physical and mental healthcare becoming more integrated; • an expanded primary, community and social care offering reshaped to support more care closer to home; • acute care services provided from a smaller estate footprint, where services focus more on specialist care, teaching and research; • a shift in the emphasis of care from treatment to prevention; and • an overall health and social care estate reconfigured to be more effective. This has been collectively described as 'Left Shift' (Appendix 2) and will be subject to the appropriate public consultation processes. 'Left Shift' represents the necessary programmes of system-wide change. Together, they represent a new operating model for the delivery of health and social care services across LLR. The nature of the change means extensive reconfiguration of our clinical service pathways and supporting functions. It changes the orientation of care from an emphasis on buildings to one of integrated health and social care services delivered closer to home or in the community.

2.5.2	**Objectives** There are six strategic objectives. They are to: • deliver high quality, citizen-centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital; • reduce inequalities in care (both physical and mental) across and within communities in LLR resulting in additional years of life for citizens with treatable mental and physical health conditions; • increase the number of those citizens with mental and physical health and social care needs reporting a positive experience of care across all health and social care settings; • optimise the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost-effective settings, reducing duplication and eliminating waste in the system; • all health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile when appropriate; and • improve the utilisation of our workforce and develop new capacity and capabilities where appropriate, in our people and the technology we use.
2.6	**Funding and Investment** A 'wrapper' SOC is being completed for November 2014. This will set out the case for external financial funding to support the total investment that will be required for the system change to take place. The SOC is expected to cover the following: • the Strategic Case – takes the case for change and explores why the proposed investment is necessary and how it fits the local and national strategy; • the Economic Case – considers and evaluates the value for money offered by the BCT solution against alternative solutions; • the Commercial Case – reviews different commercial arrangements to funding the Programme; • the Financial Case – asks whether the proposed investment is affordable and set out the requirement for non-recurrent funding; and • the Management Case – demonstrates that the proposed solution is deliverable.

2.7	**The Roles of the BCT Partnership Board and the Programme Management Office**
2.7.1	**The Role of the BCT Partnership Board** The BCT Partnership Board represents the partnership of health and social care organisations across LLR. The Partnership Board is the vehicle through which the partnership conducts business and through which the BCT Programme is directed. The Partnership Board is the conduit between the partner organisations and the Programme. The terms of reference of the BCT Partnership Board will be approved by partner organisations. The Partnership Board is ultimately accountable for the success of the BCT Programme. Its other responsibilities are detailed under 'Governance and Organisation' in Section 3.2.2. The Partnership Board recognises that its confidence in the BCT Programme being successfully delivered will be increased by there being a supportive LLR environment for the Programme. The Board will play its part in achieving this supportive environment by promoting the principles of: • good leadership at all levels, paying adequate attention to the cultural factors in leading clinical and non-clinical staff through transformative change to adopt different ways of working; • good communication inside and outside the Programme; • balancing the requirements of current operations ('business as usual') with those of change; and • good engagement with the Programme's external stakeholders. The Partnership Board recognises that the BCT Programme may need to change significantly over its five year life, whereas the vision is not expected to change. Therefore, our success in realising the vision for the Programme will depend on the Delivery Board's ability to adjust the Programme Plan to meet the reality of present circumstances, especially threats and opportunities. The BCT Programme will need to be agile. The Partnership Board will support the joint SROs of the BCT Programme in cultivating the agility of the Programme. Agility comprises responsiveness, flexibility and adaptability. • Responsiveness will enable the Programme to respond to a change in the Partnership environment or the wider political, economic, social, technological or legal environment. The responsiveness of the Programme will have important links to good information management, clear accountability and effective communication up and down the line management chain. • Flexibility will enable the Programme to overcome the unexpected and avoid failure. It will do this by keeping options open as long as possible and by avoiding a course of action that becomes unviable as circumstances change. The flexibility of the Programme will have important links to Programme planning, benefits realisation and risk management. • Adaptability will enable the Programme to recognise the arrival of new circumstances, especially unexpected ones, and to recognise the need to change or reconfigure the Programme's organisation, processes, plan or priorities.

2.7.2	**The Role of the Programme Management Office (PMO)** The PMO will be a central office that coordinates the Programme on behalf of the partner organisations. Across the Programme, it will plan and control work, track and communicate progress, facilitate benefits realisation and risk management, and optimise our use of resource. The PMO will have four core roles. They will be to: • be the information hub of the Programme; • establish and maintain programme management processes and set standards; • give decision support to the Programme Director and BCT Delivery Board; and • establish programme processes, conduct performance management of programme delivery, and promote best practice in programme, workstream, project and risk management. The PMO will carry out the functions of: coordination and integration; information management; strategic alignment, planning and interdependencies; progress monitoring, reporting and forecasting; communications and stakeholder engagement; benefits management; risk management and issue resolution; business cases and investment appraisal; programme budget; change control; version control; and secretarial support to the BCT Implementation Group and the BCT Delivery and LLR Partnership Boards.

Execution	
3.1	**Approach** The approach of the BCT Programme will be based on: the Five-Year Strategic Plan endorsed by the LLR health and social care partners; direction from the BCT Partnership Board; and the Office of Government Commerce (OGC) guidance for the successful management of projects, programmes and portfolios. The BCT Programme will be successfully delivered by following the OGC's guidance for managing successful programmes and, where appropriate, managing portfolios of change. The Programme will follow the principles, governance themes and processes of programme management. For appropriate aspects of system-wide coordination, synchronisation and decision-making, the PMO, Delivery Board and Partnership Board will use the OGC's guidance for portfolio management on the cycles of portfolio definition and portfolio delivery, linked by organisational energy, and on how to sustain progress. Underpinning successful delivery at the workstream, programme and portfolio levels will be a shared, consistent understanding of the terminology of project, programme, portfolio and risk management.
3.2	**Governance and Organisation**
3.2.1	**Governance** The LLR partner organisations own the BCT Programme. The levels of accountability are: • the partner organisations; • the LLR Partnership Board; • the BCT Delivery Board; • the BCT Implementation Group; • Clinical Workstreams and Enabling Groups; and • projects and project team staff. The Terms of Reference of the LLR Partnership Board, BCT Delivery Board and BCT Implementation Group will be aligned. The LLR Partnership Board will be ultimately accountable for the success of the Programme. It will recommend the investment in the BCT Programme to partner organisation boards, cabinets and Executives. The LLR Partnership Board will ensure that the BCT Programme has adequate risk management and assurance processes in place. The BCT Delivery Board will oversee the delivery of the Programme on behalf of the Partnership Board. The joint SROs will chair the Delivery Board and will ensure that the Programme realises the vision and achieves its objectives. The joint SROs will direct the Programme Director. The PMO will carry out its four core roles (Section 2.7.2) across all the levels of accountability above, except for partner organisations.

3.2.2 **Organisation**

A summary of the responsibilities of the key roles in the BCT Programme is as follows.

Role	Responsibility
LLR Partnership Board	Ultimately accountable for the success of the Programme. Recommending the investment in the BCT Programme to partner organisation boards, cabinets and Executives. Ensuring the Programme remains aligned to LLR strategy. Directing the BCT Delivery Board through the joint SROs. Ensuring the Programme remains worthwhile and viable. Representing and promoting the Programme. Authorising the closure of the Programme.
Chief Officers	Leading their staff through the turbulence and emotion of transformative change. Delivering the BCT Programme outcomes within their organisations. Supporting the Chair of the Partnership Board in providing a supportive LLR environment for the BCT Programme.
Joint SROs	Ensuring the Programme realises the vision and achieves its objectives. Directing the Programme, through the Programme Director.
BCT Delivery Board	Supporting the joint SROs. Driving the Programme forward to deliver the changes and benefits required to achieve the Programme's objectives. Ensuring that Programme planning and control is satisfactory. Authorising the Programme Director to progress to the next stage. Obtaining adequate external assurance. Monitoring and, if necessary, correcting the progress of the Programme.
Programme Director	Managing the Programme, day-to-day, on behalf of the Delivery Board Leading Programme staff.
Chief Financial Officers	Planning and managing financial aspects of the system-wide change to a new operating model of health and social care.
Partner Organisations	Committing resource. Maintaining delivery of routine services while delivering change. Through the workstreams and projects: • delivering the changes required by the Programme; • realising the benefits from the changes; • incorporating the benefits into their new routine services.
Clinical Workstreams and Enabling Groups	Planning and delivering the changes in their area of responsibility that will yield the benefits required for the Programme to achieve the six system objectives (Section 2.5.2).
Political, Clinical and PPI Reference Groups, other stakeholder fora and User Groups	Engaging with and supporting the LLR Case for Change, providing assurance and user input to help the Programme deliver successfully and meet user needs and expectations.
The PMO	Providing control of the Programme to the Programme Director. Facilitating successful delivery of the Programme by coordinating and synchronising Programme resources, work and achievement of objectives. Establishing processes, setting standards and promoting best practice.

Responsibilities in managing the BCT Programme, by role and process, are shown in Appendix 3.

The organisational structure of the BCT Programme is set out in Appendix 4. The structure reflects the main areas of work:

- primary, community and social care;
- the clinical service workstreams;
- the enabling groups; and
- finance.

3.3 **Programme Processes and Stages**

Processes. The BCT Programme will follow the OGC guidance for managing successful programmes. This guidance sets out the 'Transformational Flow' that defines the lifecycle of a programme. This transformational flow is a sequence of processes. It is the programme journey. There is a close relation between the processes in the transformational flow and the governance themes. The BCT Programme's processes will be:

- identifying the Programme;
- defining the Programme;
- managing the Stages:
  - delivering the new operating model of health and social care;
  - realising the benefits of the new operating model;
- closing the Programme.

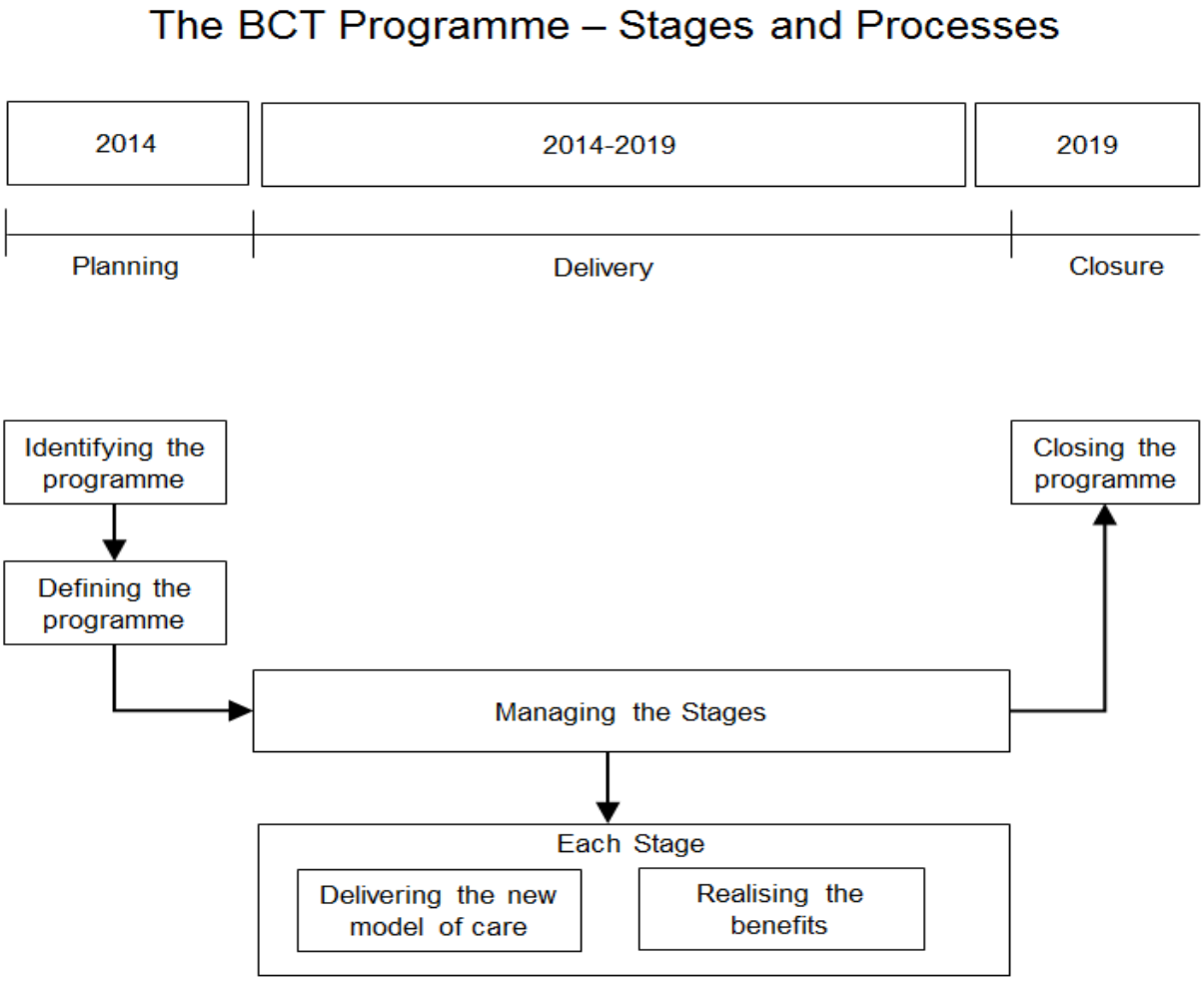
Stages. Delivery of the BCT Programme will be split into Stages. The end of each Stage will be a major review point for the Partnership Board. The start of a new Stage will be a step change in the transition to the new LLR model of health and social care. The Programme Director will present their End of Stage Report and a detailed plan for the next Stage of the Programme to the BCT Delivery Board for its approval. Before giving its approval, the BCT Delivery Board will satisfy itself that the changes planned in the current stage, and the benefits from those changes, have been successfully delivered, and that the plan for the next Stage is sufficient and realistic. Once the Delivery Board has approved progression to the next Stage, the joint SROs will seek the approval of the Partnership Board.

Processes and Stages. The processes in the Programme are expected to be spread over six to eight stages, as follows.

Process	Time	Output
Programme Identification	Apr - Jul 2014	Five Year Strategic Plan
Programme Definition	Aug - Dec 2014	PID, SOC and Programme Plan for Oct 2014 – Mar 2015
Programme Delivery – 3 to 5 stages (TBC in further planning)	Jan 2015 - Feb 2019 (TBC)	Major programme changes and the benefits from the changes
Programme Closure	Mar - Oct 2019 (TBC)	Programme Closure

The Programme Plan to move from the Programme Definition process to the first Delivery Stage over October 2014 - March 2015 is shown in Appendix 5. The first Delivery stage will start in January 2015.

Planning the Programme's Delivery stages between Mar 2015 - Feb 2019 has been started as part of the Strategic Outline Case. Further detailed planning will be conducted over this winter. This planning is expected to be split into three broad areas: deciding the timing of each Programme Delivery stage in line with major step-changes in the partnership's transition to the new model of care; planning the next Delivery stage in detail; and planning the following Delivery stage in outline. The broad timing of the Programme's stages and processes is shown in the following diagram.



3.4 **Planning and Control**

Programme planning and control will be central to successful delivery of the BCT Programme. Planning and control will be treated as complementary functions that depend upon each other for their effect; successful delivery needs them both. Planning and control will both be supported by performance management, which will look at the past, present and future performance of the Programme. Performance management will measure, manage and communicate actual and forecast performance against planned performance and the metrics of success.

Responsibility for planning and control will be held by the PMO, under the direction of the Programme Director. The Programme Director will manage, on behalf of the Delivery Board, the realisation of benefits, the management of risk, and the use of resources across the BCT Programme as a whole.

	The PMO will coordinate, synchronise and align work to achieve the benefits desired from each Stage of the Programme.
3.4.1	**Programme Planning** The BCT Delivery Board is to recognise the key distinction between plans and planning. The plan may change but the planning process will remain essential. The Programme Plan will be a product. Programme planning will be the process that produces the Programme Plan. The role of programme planning will be to: • gather, understand and assess large amounts of information; • consult extensively with subject matter experts and key stakeholders; and • build, maintain and adjust the Programme Plan to deliver success however circumstances change over the life of the Programme. To build and maintain the Programme Plan, the planning process will be to work backwards from the vision for the Programme (Section 2.5.1) and the new operating model of care (Appendix 2). In outline, Programme planning will analyse the blueprint of the new model of health and social care, will identify the changes necessary to realise it, plot the sequence in which those changes will best be achieved, and identify the work necessary to achieve those changes. The Programme Plan will: • provide authoritative clarity on the outcome of the Programme – the vision to be realised; • show the route, or journey, for the partnership to change from the present to the 2019 vision, including the schedule for the main step-changes in the transition and how the step-changes are to be linked together; • show the main bodies of work, and the resourcing, timescale, outputs/outcomes and dependencies of each. These main bodies of work may include not only clinical workstreams and enabling groups but also the migration of infrastructure, culture and organisational development and working practices to more integrated health (physical and mental) and social care; • anticipate the most likely and damaging sources of 'friction' (what may throw the Plan off-course) by considering the major assumptions, risks, control points and contingency measures that may affect the achievement of the Plan; • show how work and the Programme-wide allocation of resources are to be coordinated and directed across time and benefits/outcomes; and • show how the Plan will be reviewed and adjusted in the light of changing circumstances. The Programme Plan is to be realistic (resourced and practicable), timely and understood by those who will play key roles in executing it. The Plan is to command the confidence of those who will execute it. As illustration, and subject to more detailed programme planning, the link between the main activities of the BCT Programme and realising the vision for the Programme is shown at Appendix 6.

3.4.2 **Programme Control and the Use of Business Cases**

Programme Control. The BCT Delivery Board will apply programme controls outside and inside execution of the Programme.

Outside execution of the Programme, the Delivery Board will observe the controls of:

- legislation, relevant regulations and endorsed standards;
- OGC best practice for the management of projects, programmes and portfolios of change; and
- LLR partnership and BCT Programme governance arrangements, including assurance.

Inside execution of the Programme, the Delivery Board will use the controls of:

- programme planning, the Programme Plan and criteria for prioritising work and allocating resource, Programme-wide;
- the use of business cases to control new work being added to the Programme: whether that work should be started, continued or stopped (this is covered in 'The Use of Business Cases' sub-section below);
- the information management and performance management function, including reporting, monitoring and forecasting;
- reviewing the three topics of benefits realisation, risk management and allocation of resource as standing items for the BCT Delivery Board and the Partnership Board;
- the Change Control function, using Requests For Change (Section 4.7); and
- End of Stage reports by the Programme Director when seeking the Delivery Board's 'permission to proceed' to the next Programme Stage.

LLR partner organisations, public and patient groups have agreed the criteria by which work across the BCT Programme will be prioritised and resource allocated. The criteria will be:

- business needs, or its criticality to realising the new operating model;
- strategic fit in the Programme – does it: enable; provide mutual support; or achieve synergy?;
- Return On Investment and Value For Money - how quickly and how much will savings be realised or quality be improved, or the cost-benefit balance;
- affordability and achievability within the allocated time, resources and circumstances;
- impact on clinical quality – the six dimensions of high quality care (Section 4.5.2); and
- impact on access – the ease with which the patient uses the health or social care service, including: choice and speed of communication; transport; opening times and availability; language; gender; and cultural factors.

For programme control purposes, any addition to the BCT Programme will be either a workstream or a project. The first step in proposing any such new work to join the Programme will be to write a Mandate or Brief. A Brief will outline what the work is to do and its context, output, timeframe and cost. To be adopted as part of the BCT Programme, the Brief has to receive approval in principle by the BCT Delivery Board. The Brief will be sent to the PMO for information, central coordination and preparation for the Delivery Board. Once the Brief has been approved it is likely that the planning for the workstream/ project will be further developed. In due course, the Delivery Board will recommend to the Partnership Board the further process for the workstream/ project to seek full approval.

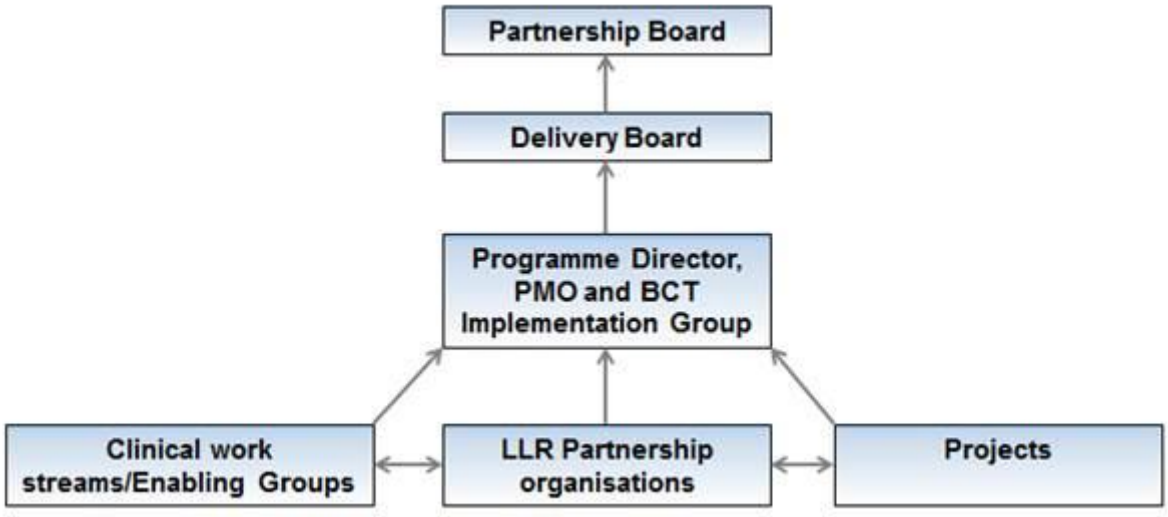
The Use of Business Cases. A business case is the justification for starting or continuing the work, whether it is a project, workstream or programme. The business case will make the case for the validity and viability of the work and the investment of resource. It will be used to assess the merit of any proposed addition to the BCT Programme and its value relative to other uses of that resource. Change to work already part of the Programme will be assessed and controlled through the Change Control function (Section 4.7).

There will be three types of business case used, depending upon the financial cost of the proposed work and its impact on the whole Programme. The types of business case will be a Request For Funding (RFF), an Outline Business Case (OBC) and a Full Business Case (FBC). The difference between them is in the number of elements of the Treasury's 'Green Book' that are to be completed and in the degree of detail they contain. A summary is below.

Use of Business Cases for Workstreams and Projects in the BCT Programme							
Value of work (draft)	**Type of Business Case**	**The Treasury's 'Green Book' 5 Case Model**					**Comment**
		Strategic	**Economic**	**Commercial**	**Financial**	**Management**	
£0-£250k	RFF	Yes	No	No	Yes	Yes	Subject to Delivery and Partnership Board direction
£250-£500k	OBC	In outline	In outline	In outline	In outline	In outline	
Over £500k	OBC and FBC	In detail	In detail	In detail	In detail	In detail	

The detail of the format of an RFF, OBC and FBC, any distinction between revenue and capital, and any other necessary governance arrangements will be resolved by the PMO in consultation with relevant parties. Until the RFF, OBC or FBC is approved, there is no authority to conduct the work or use any resource. Once a project has had its RFF approved, it can move from 'Starting Up' the project to 'Initiating' the project. Whichever type of business case is written, it will specify and appraise the balance of advantage in conducting and resourcing the work, taking account of the criteria set out in the 'Programme Control' sub-section above, what new risks would have to be managed or existing risks would be compounded.

The relation between the business case and planning will be as follows. An outline plan will be included, in progressively greater detail, in the RFF, OBC or FBC respectively. Once the work has been approved, more detailed planning will be done, both for the work as a whole (such as a project plan) and for the next stage of the work (such as a stage plan). Throughout the life of the work, the business case will be maintained and updated, often in End Stage Assessments, and the plans will be adjusted to take account of changes in the Programme or partnership environment, changing higher level priorities, changing levels of resource or developing threats and opportunities.

	Consistent, rigorous and appropriate use of business cases by the Delivery Board will: • guard against the BCT Programme starting and resourcing workstreams or projects that do not make a net contribution to achieving the Programme's objectives; • provide an objective scrutiny of a workstream or project that may be a personal enthusiasm; • put the workstream or project on a defined basis and will promote a shared understanding of what it is for, what is in and out of its scope, what it will cost and when it will end; • produce the optimum balance of benefits, costs, timescale and risks; • guard against scope-creep of the workstream or project, once it has been approved; and will • facilitate the objective assessment of the work's value to the BCT Programme relative to other workstreams or projects, thus helping to optimise use of the Programme's resources. Throughout the life of the project, workstream or BCT Programme, the business case for it will need to be continually maintained and updated. If the business case becomes no longer valid, the Delivery Board or workstream SRO must stop the work, close the workstream or project and release the resource.
3.5	**The Core Escalation Mechanism** In delivering the Programme, the Delivery Board will oversee a core escalation mechanism for: information and performance management; benefits realisation; risk management and issue resolution; quality (programme management and clinical quality); and change control. The escalation mechanism will be as follows. 

3.6	**Learning From Experience** The Programme will continually seek to learn lessons in how it can improve its own performance and how it can find opportunities to realise benefits. The PMO is to be the custodian, focus and disseminator of lessons learned throughout the BCT Programme. This dovetails with the PMO's roles in being the information hub of the Programme and in setting standards for the Programme. The Partnership Board will cascade good leadership throughout the Programme to create a climate conducive to the good two-way communication that facilitates learning from experience. As part of the Programme Closure Stage, the Partnership Board will arrange for a Post Implementation Review (PIR) of the Programme. The PIR will assess the benefits delivered by the Programme and how well the partnership has learned from experience during and after the Programme. The PIR may be conducted as part of a larger OGC Gateway Review.

Supporting Functions

4.1 **Information and Performance Management**

Performance management will depend upon information management and much of the value of good information will be in enabling performance management. The Delivery Board will use performance management in a proactive way to make it easy for the programme's workstreams to deliver the desired outcomes and deliver their outputs to time, cost and quality.

Information Management. The BCT Programme will follow three principles for successful information management. It will:

- create and maintain a 'single version of the truth' to engage the BCT Programme's large number of stakeholders and to coordinate and manage its wide range of activity;
- obtain enough relevant information, and make it available, to manage progress, realise benefits, control risk and make optimum use of our resources – this is the heart of programme management; and
- regulate the volume and flow of information so that it is adequate to control the Programme and to manage quality without the Programme 'drowning in data'.

Those principles will be applied through the PMO in partnership with the other key stakeholders of information management, notably information from BCT partner organisations. Through this coordinated approach, the PMO will be the information hub of the Programme.

On behalf of the Programme Director, the PMO will be responsible for meeting the information requirement to direct, plan and control the Programme. In certain circumstances this may also involve the PMO stating what information is required.

Performance Management. The role of performance management will be to turn information into business intelligence in order to inform decisions by the Programme Director and Delivery Board. Performance management is the function that turns:

- information into business intelligence;
- business intelligence into informed decisions;
- informed decisions into effective action;
- effective action into learning from experience and increased capability.

Performance management will look at the past, present and future. One of its key functions is to forecast future performance and give warning if performance is forecast to fall below that required for the Programme. The Delivery Board will direct the Programme Director to develop a performance management capability that:

- measures, manages and communicates past, present and future performance;
- progressively improves the accuracy of forecast performance;
- promotes a common sense of purpose and working together across the partnership;

	• accurately understands and shows the cause and effect relation of the metrics of programme success and what will lead to success; an example is the relation between the success criteria (Section 2.4) and the six strategic objectives (Section 2.5.2). • promotes accelerated action to rectify shortfalls in performance or forecast shortfalls; and • encourages learning from experience throughout the life of the Programme.
4.2	**Communications and Stakeholder Engagement** Effective communications and engagement will be necessary to ensure understanding of the need for radical change by stakeholders, including patients, service users, carers and the staff delivering services. Our communications and engagement activity is to comply with formal consultation processes, any other mandatory requirements and the Four Tests set out in the 2014/15 Mandate by the Government. The Four Tests are that proposed service changes should be able to demonstrate evidence of: *"strong public and patient engagement; consistency with current and prospective need for patient choice; a clear clinical evidence base; and support for proposals from clinical commissioners."* LLR Partnership lead communicators will develop a strategic plan to ensure delivery of consistent 'best practice' communications and engagement. This will be a 'Marketing, Communications and Engagement Plan', which will be reviewed by Healthwatch and the PPI Reference Group. The objectives of the Plan are to: • raise awareness and understanding of the BCT Programme and its work; • increase public and political acceptance of the need for radical service change; • manage and mitigate any reputational risks arising from the BCT Programme; • respond consistently across the LLR economy to requests for information about the Programme; • ensure all key stakeholders are fully engaged and informed at an appropriate level; • create advocates for the BCT Programme across the LLR economy; • ensure and demonstrate meaningful patient and public involvement in the BCT Programme; • provide suitable reassurance to NHS England and other agencies that the Programme has conducted the right level and quality of communications and engagement; and • plan and implement effective public consultation as required, supporting the successful implementation of proposed service change. The Programme's clinical workstreams and enabling groups will contribute to these objectives through their workbooks. The framework will include the resource requirement, the engagement plan and the mechanism to measure its effectiveness and adjust as necessary. The PMO will coordinate communications and engagement with other supporting functions of the Programme like information management, benefits and risk management, and change control.

4.3	**Benefits Realisation** The BCT Programme will apply the following principles: • LLR system-wide change and BCT Programme-wide change will be benefits-driven; • benefits will be clearly linked to the six strategic objectives (Section 2.5.2); • benefits will be measured, tracked and recorded through appropriate performance management arrangements; and • oversight of benefits delivery is discharged through the BCT Delivery Board. The BCT Programme will realise benefits through a sequence of: • planning benefits and resourcing their realisation; • delivering change (elements of transitioning to the new model of integrated health and social care); • realising the benefits from those changes and embedding the new configuration of infrastructure, organisation, workforce, working practices and relationships; and • further developing or exploiting those benefits to the advantage of the partnership and its capability to serve its stakeholders. The Delivery Board will oversee benefits realisation through: • a benefits plan that maps out the system-wide impact and identifies key dependencies; • a benefits profile that describes how benefits will be attributed to partner organisations; • a description of how benefits will be measured, tracked and realised including the name of the responsible owner for delivery; and • the PMO monitoring the actual realisation of benefits against those planned.
4.4	**Risk Management and Issue Resolution** **Risk Management.** There will be a close relationship between effective risk management and sound governance of the BCT Programme in that risk management will be a subset of the Programme's internal controls. The BCT Programme will adopt a risk management strategy that embraces the principles, approach, and processes of risk management. This strategy will be underpinned by communication and embedding and reviewing the management of risk. Communication will be carried out throughout the whole risk management process. Embedding and reviewing embraces all the steps in the risk management process and reviews the overall effectiveness of the whole process. This strategy will have two main benefits: first, effective management of Programme risks, and second, the Delivery and Partnership Boards being able to assure themselves of the effectiveness of the Programme's risk management. The PMO will link Programme risk management and assurance for the Boards. The PMO will ensure appropriate risk reporting and risk management processes are in place across the BCT Programme.

In outline, the BCT Programme will apply the following principles when managing risk.

- The risk management process will feed back to LLR partner organisations.
- The BCT Partnership and Delivery Boards will use a Board Assurance Framework (BAF). The BAF will allow those Boards to assess for themselves the adequacy with which Programme risks are being managed. This assurance of risk management will inform the view of those Boards on the overall deliverability of the Programme.
- Risks in well-defined areas will be owned by the relevant or appropriate body in the Programme governance structure, such as clinical risks being owned by the Clinical Reference Group.
- Risk will be managed at the lowest possible level of the organisational structure. An escalation and de-escalation mechanism will link the levels of projects, workstreams and the BCT Programme. The Programme's reporting of risk will be compatible with the reporting mechanism used by LLR partner organisations.

The risk management process will be a sequence of four steps.

- Identify the context of the risk and the risk. The risk may be a threat or an opportunity. The objectives or benefits determine the relevance of a threat or opportunity.
- Assess the risk. This step may be divided into estimating the likelihood and impact (together the severity) of the threat or opportunity and evaluating the net effect of the aggregated threats and opportunities on an activity. The proximity of the risk may be added to the estimating step.
- Plan the response to the risk. Responses to a threat can be categorised as: Remove; Reduce; Transfer; Retain or Share. A combination of responses may be possible to reduce the risk to a level at which it can be tolerated. Responses to an opportunity can be categorised as: Realise; Enhance; and Exploit. 'Realise' seizes an identified opportunity. 'Enhance' improves on realising the opportunity by achieving additional gains. 'Exploit' seizes multiple benefits.
- Implement the response to the risk. This step ensures that the planned response(s) is implemented and monitors its effectiveness. If a response to a risk does not achieve the expected result, corrective action will be taken as part of this step.

The Programme will manage risk in a consistent way at three levels: workstream, BCT Programme and Delivery Board. Clinical workstreams and enabling groups will identify risks through their workbooks. Those risks of concern beyond the workstream will be escalated to the Programme risk register. In the Programme risk register, risks of concern to the Delivery Board will be escalated in the Delivery Board BAF. Any risks of concern to the Partnership Board will be escalated in the Partnership Board BAF. The core escalation mechanism for risk management is that shown in Section 3.5.

Clinical workstreams, enabling groups and the BCT Programme will all operate a risk register as the basic tool for managing risk. The PMO will be the custodian of the Programme risk register. The format for the Programme risk register is shown at Appendix 7.

There will be a coherent risk review cycle. Although the Chair of the Partnership Board and joint SROs can initiate a risk review whenever they see fit, this routine cycle will link the BCT Implementation Group, the BCT Delivery Board, special interest groups such as the CRG and PPI Reference Group, and the LLR Partnership Board. The cycle will be a logical progression that matches the rhythm of meetings. Subject to trial and adjustment in the light of experience, this cycle will be:

Board/Group	Frequency of Reviewing Risk
LLR Partnership Board	Quarterly
Special interest Groups (eg CFOs, CRG, PPI)	Quarterly
BCT Delivery Board	Quarterly
BCT Implementation Group	Monthly
BCT PMO	Continual

The Programme risk register will inform the BAF for the Delivery Board. The distinction between the Programme risk register and the Delivery Board BAF is that whereas the Programme risk register is a tool to manage an individual risk in the Programme, the BAF is a tool used for the Board to assure itself, or not, that risk management across the Programme is adequate.

Issue Resolution. The Programme Director will develop an issue resolution process for projects, workstreams and the BCT Programme to capture, assess and resolve issues in a coherent, prompt and effective way. The PMO will maintain a Programme Issue Log to help assess the effectiveness of our risk management. In the event of any dispute in the Programme, the Programme Director will be the arbiter unless the dispute requires escalation to the joint SROs or, in an extreme case, to the Partnership Board.

4.5 **Quality**

Quality is defined in Appendix 1. There are variations in applying quality between the programme management and the clinical domains. The Programme's management of quality will be based on continuous quality improvement.

The Programme will make and implement a Quality Improvement Strategy that embraces the approach, standards, processes and responsibilities for planning and delivering quality across the Programme. This Strategy will link quality in the areas of programme management and clinical quality. As an introduction to the Quality Improvement Strategy, quality in the programme management domain is covered in Section 4.5.1 and quality in the clinical domain in Section 4.5.2.

The effectiveness of quality management will be reviewed and assured by the Partnership and Delivery Boards, together with any external assurance those bodies may commission such as the OGC and the Clinical Senate, and throughout the BCT Programme governance structure.

Responsibilities for quality management in the BCT Programme will be as follows.

Role	Responsibility
Partnership Board	Accountable for all aspects of quality improvement in the Programme.
Joint SROs	Responsible for all aspects of quality improvement in the Programme.
BCT Delivery Board	Supporting the joint SROs.
Programme Director	Responsible for developing and implementing the Programme's Quality Improvement Strategy.
Partner Organisations	Building quality improvement in to every aspect of the Programme, especially though workstream and project workbooks.
The Clinical Senate	Providing clinical assurance external to the LLR Partnership.
The CRG	Providing clinical assurance internal to the LLR Partnership.
The PMO	Facilitating effective management of quality across the Programme. Drafting the Quality Improvement Strategy. Ensuring the Programme complies with relevant regulation and standards. Promoting best practice and setting standards for quality improvement. Arranging the review process, as directed by the Programme Director. Obtaining appropriate assurance, as directed by the Programme Director.

4.5.1	**Programme Management Quality** Programme management quality in the BCT Programme will be the standards, processes and responsibilities that control the Programme's delivery of its changes and benefits. The Programme will apply quality management at the project, workstream and programme levels. It will make quality management integral to its daily activities, supported by information management and version control. Programme management quality will ensure that the BCT Programme's stakeholders are satisfied that the benefits they expect will be realised. Quality management in the BCT Programme will: • support LLR policy and strategy and meet agreed standards; • meet the expectations of the Programme's stakeholders; • optimise the use of resources across LLR partner organisations; and • make consistent use of best practice processes, tools and techniques. Quality will be managed differently at the programme and workstream/project levels. At the BCT Programme level, quality management will focus on achieving the six strategic objectives (Section 2.5.2). During the Programme, these objectives may change in response to LLR circumstances and priorities. In contrast, quality management at the workstream/project level will focus on ensuring that the changes to services meet the business case or the quality criteria defined in the workbooks. The BCT Programme will: • define the expectations of stakeholders, especially those of patients, their carers, clinicians, Commissioners and the public; • define quality or acceptance criteria for the main products of workstreams and projects, such as a redesigned pathway, and will develop service changes against these criteria; • review the proposed service change against the quality or acceptance criteria, and test it through independent internal assurance, such as the CRG, or external assurance, such as the Clinical Senate; • plan flexibly so the plan can be adjusted, if necessary, during delivery of the service change; and • test its delivery of the benefits of change on stakeholders such as patients and the public.
4.5.2	**Clinical Quality** There are several definitions of clinical quality and they have much in common. The Programme will recognise the following definitions. Lord Darzi defined the three domains of clinical quality as patient safety, clinical effectiveness and patient experience. The Institute of Healthcare Improvement has adopted the 'triple aim' of: • improving the experience of care for the individual; • contributing to population health; and • reducing the per capita cost of care.

The six dimensions of clinical quality are that care and treatment is:

- safe;
- clinically effective;
- timely;
- patient-centred;
- efficient; and
- equitable.

These dimensions are supplemented by the five domains of the NHS Outcomes Framework.

NHS Outcomes Framework	
Domain	**Illustration**
Preventing people from dying prematurely	How the proposal helps people to live longer; how it reduces premature mortality.
Enhancing quality of life for people with long-term conditions	How the proposal directly impacts on people living with long-term conditions.
Recovery from episodes of ill health or injury	How the proposal helps people to recover following ill health (including mental illness) or injury.
Ensuring a positive patient experience	How the proposal results in: personalised and compassionate care; meets patient needs; and positive survey results from patients.
A safe environment free from avoidable harm	How the proposal reduces risk to patient safety and wellbeing, including through reduced 'hand-offs'. How having staff trained and systems in place to safeguard patients prevents harm.

Clinical quality will drive the BCT Programme's redesign and reconfiguration of its health and social care services. Two of the system objectives of the BCT Programme are to deliver high quality, citizen-centred, integrated care pathways and to increase the number of citizens reporting a positive experience of care across all health and social care settings. Clinical quality will be embedded in all work streams and contractual arrangements. The Programme's service reconfiguration plans will demonstrate an improving quality of health and social care, benchmarked against agreed standards.

The Programme will follow current best practice for clinical quality. It will adopt these principles.

- Clinical quality is the degree of excellence in health and social care. Clinical quality has to be measured, using shared indicators. The indicators will be one or more of: patient-reported outcome indicators; clinical outcome indicators; and process outcome indicators.
- Quality improvement gives a better patient experience and better clinical outcomes.
- The Programme will approach quality through quality improvement and not through the previous approach of quality control and quality assurance.
- Clinical quality will be delivered using a patient-centred approach. Usually, it will be implemented by working collaboratively in multi-disciplinary teams of health and social care professionals and staff, both clinical and non-clinical.
- Clinical quality does not 'fall out' of systems. It is produced by individuals behaving well, working systematically and basing their clinical work on scientific knowledge and evidence.

	• The keys to improving clinical quality are adaptive leadership and the behaviour of individuals. Adaptive leadership shows the ability to live with unpredictability and to exploit opportunity. The BCT Programme's clinical workstreams will build upon the integrated approach to service planning and delivery already established locally. This will underpin the changes in culture and approach we need. Each workstream lead will ensure that a proposed service change will result in a positive impact for patients and staff. They will test proposed clinical changes on the internal assurance of the Clinical Reference Group and, if appropriate, on the external assurance of the Clinical Senate. Each clinical workstream workbook will address the six dimensions of clinical quality. Workbooks will be assessed against the 'Duty of Quality' outlined in the five domains of the NHS Outcomes Framework.
4.6	**Equality and Diversity** The BCT Partnership Board requires the Delivery Board to ensure that the undertakings for Equality, Inclusion and Human Rights (EIHR) set out in the Five-Year Strategic Plan are met and that LLR Equality and Diversity policy is implemented in the BCT Programme. The Delivery Board will oversee effective execution of all Equality and Diversity responsibilities. The Delivery Board, supported by the PMO, will be the focus for the Programme's implementation of LLR Equality and Diversity policy. Consideration will be given to the needs of the whole LLR community, including those communities whose interests are specifically protected under law. Consideration will be given to assessing and, where required, mitigating the impact of the BCT Programme on the workforce as well as on patients, service users and carers. The Partnership Board's undertakings include: agreeing an Equality Statement; using the evidence base of the three Joint Strategic Needs Assessments; engaging with special interest and 'seldom heard' groups; overseeing the production of Equality Impact Assessments (EIA) as appropriate; ensuring that EIA findings are reflected in the operational plans for clinical changes; and ensuring that those operational plans are updated on an appropriate basis. The Equality Statement for the BCT Programme is shown at Appendix 8. The Delivery Board will be the authority for approving EIAs and mitigation plans. Clinical Workstream and Enabling Group SROs are accountable for addressing Equality and Diversity early on in their workstream. A forum of Equality leads will assure the Delivery Board on workstream EIAs, the aggregated impact of clinical changes in the BCT Programme, and suitable mitigation.
4.7	**Change Control** Change control is a supporting function closely related to Programme Control and the Use of Business Cases (Section 3.4.2) and Version Control (Section 4.8). Change control will provide the Programme a single means of capturing and considering change requests, suggestions, ideas or concerns, and ensuring appropriate action is taken and the decision communicated back to the originator. Throughout the life of the Programme anyone with an interest in the Programme, or its outcomes, may wish to request a change, raise a concern or express a dissatisfaction with work already done. Collectively, these 'programme issues' will be most efficiently addressed though change control. The PMO will be the focus for change control in the BCT Programme. The PMO will capture change requests, assess them and communicate decisions on them to the source that raised them. The authority for deciding what action is to be taken will be, depending upon the scale and significance of the change request, either the Delivery Board, the Programme Director or the workstream SRO. Whatever level of authority takes the decision, they will follow the process of:

	• capturing and logging the change request; • analysing the change request and assessing the implications of implementing it; • proposing the action to be taken; • deciding the action to be taken (approve, reject or defer); and • implementing the action to be taken. In step 2 of the process above, assessing the implications of implementing the change request will consider the overall balance of advantage of: • the benefits from the change against the time, cost, added complexity, and risk of obtaining them; • the relative priority of this change against the priority of work already in the Programme – is the new work a higher priority than any work we are already conducting? The overall assessment will be a product of the impact of the change on the: • whole Programme; • business case for the workstream; • benefits to be derived from the workstream; • risks to the Programme and the workstream, including the possible creation of new risk(s) and the impact on existing risk(s); and • allocation of Programme resource, including the possible dissipation of effort and multiplication of priorities. In deciding the action to be taken, the change request can be approved, rejected or deferred, perhaps to be modified and resubmitted.
4.8	**Version Control** Version control is the activity that controls critical documentation in the BCT Programme. This will be the responsibility of the PMO. It will ensure that version control links closely with the Programme's processes for information and performance management, planning and control, quality management, communications and engagement and change control.

Resources	
5.1	**Resource Allocation** Resource for the BCT Programme concerns funding, staff, skills, time and space. The Partnership Board recognises that this resource is owned by partner organisations, under Chief Officers. Following completion of the SOC, and on an ongoing basis, the Partnership Board will review the existing resource allocation in order to satisfy itself that: • resource is adequate to deliver the Programme's changes and benefits and thereby to achieve the six strategic objectives (Section 2.5.2); • the Programme's allocation of resource is aligned with Programme-wide priorities; and • the use of resources is optimised across the Programme. The Partnership Board will regularly review the Programme's benefits, risks and allocation of resources, including the relation between them, as outlined in Section 4.4.

APPENDIX 1 – GLOSSARY OF TERMS

Term	Meaning
Assurance	All the systematic actions to provide confidence that the object of the assurance is appropriate. Assurance has a level of independence from that being assured.
Benefit	The measurable improvement from a change perceived as an advantage by one or more stakeholders.
Blueprint	A model of the inside of the future organisation, showing its working practices, processes, information flow or contractual arrangements necessary to realise the vision. The blueprint is a design document derived from the vision.
Business as Usual	The way the organisation normally achieves its objectives. Portfolio management seeks to find the optimum balance of business as usual and organisational change.
Coordinate	Bring the different elements of a complex activity or organisation into an efficient relationship. Move the different parts of the body smoothly and at the same time.
Governance	The functions, responsibilities, processes that define how the Programme is set up, managed and controlled.
Issue	An event or development that has happened, that is affecting the Programme and needs to be actively dealt with and resolved.
Portfolio	All the programmes, workstreams and projects being undertaken by the organisation or group of organisations. The totality of the organisation's investment in change.
Programme	A management structure created to coordinate, direct and oversee the implementation of a set of related workstreams, projects and activities in order to deliver outcomes and benefits of strategic importance to the organisation.
Programme Management Office	A central office that coordinates the Programme on behalf of senior management. The information hub and standards custodian for the whole Programme. Across the Programme, it plans and controls work, tracks and communicates progress, facilitates benefits realisation and risk management, and optimises use of resource.
Project	A temporary organisation created to deliver one or more new or changed products or services according to a specified business case.
Quality	All the features and factors that affect the ability of a product, process or service to meet expectations or stated needs, requirements or specification.
Risk	An uncertain event or set of events which, should they occur, will have an effect on the achievement of objectives. A risk can be either a threat or opportunity.
Senior Responsible Owner	The individual with overall responsibility for ensuring that the Programme achieves its objectives and delivers the projected benefits. The owner of the overall business change.
Stage	A section of the Programme's life which produces a step change in the impact of benefits delivered or in the organisation's capability. The end of a stage is a major control point for the Board and milestone for the Programme.
Stakeholder	Any individual, group or organisation that can affect, be affected by, or perceive itself to be affected by, the Programme.
Stakeholder group	A group of stakeholders who share broadly similar interests, influence and disposition towards the Programme.
Transformation	A distinct change to the way in which the organisation conducts its business. The change may affect its 'look and feel', its organisation, its character or its output.
Vision	A picture of the better future, from outside the organisation. The end-goal of the Programme.
Workstream	The level of work beneath the BCT Programme and above the project level. A workstream incorporates a number of projects.

APPENDIX 2 – THE LEFT SHIFT: A BLUEPRINT OF THE LLR 2019 SYSTEM - INTEGRATED HEALTH AND SOCIAL CARE

A financially sustainable LLR system of integrated health and social care that meets the future needs of patients and maximises value for money through safe, high quality services in the most efficient and effective settings

<table>
<tr><td colspan="6">The Clinical Settings of Care</td></tr>
<tr><td colspan="6">The ‘Left Shift’ completed</td></tr>
<tr><td rowspan="2">Self-Care, Education and Prevention</td><td rowspan="2">Primary Care</td><td rowspan="2">Community and Social Care services</td><td rowspan="2">Urgent Care</td><td colspan="2">Acute Care hospital-based services</td></tr>
<tr><td>Secondary Care</td><td>Tertiary Care</td></tr>
<tr><td colspan="3">Primary, Community and Social Care expanded and reshaped to support care at home. The Voluntary Sector well engaged and supportive</td><td>Crisis response, reablement and discharge</td><td colspan="2">Acute Care reduced and reshaped into two hospitals, with fewer beds, that focus more on specialist care, teaching and research</td></tr>
<tr><td colspan="6">Physical and mental health integrated</td></tr>
<tr><td colspan="6">Health and Social Care integrated</td></tr>
</table>

Commissioning that emphasises prevention rather than treatment

The health and social care estate reconfigured and used more effectively

Improved utilisation of our workforce and new capacities and capabilities developed where appropriate

All LLR partner organisations financially sustainable

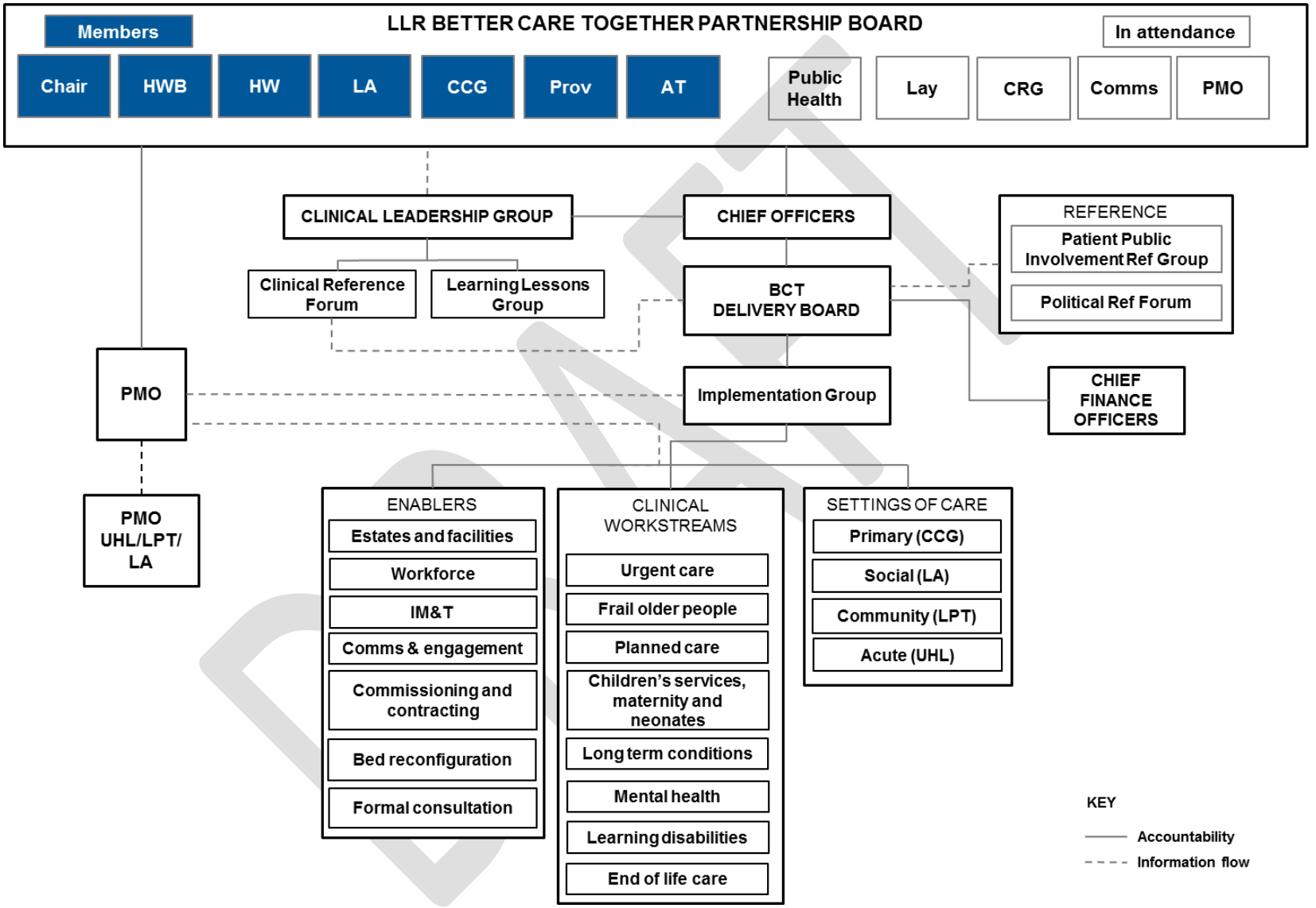
APPENDIX 3

RACI - ROLES AND RESPONSIBILITIES IN BCT PROGRAMME MANAGEMENT BY PROCESS

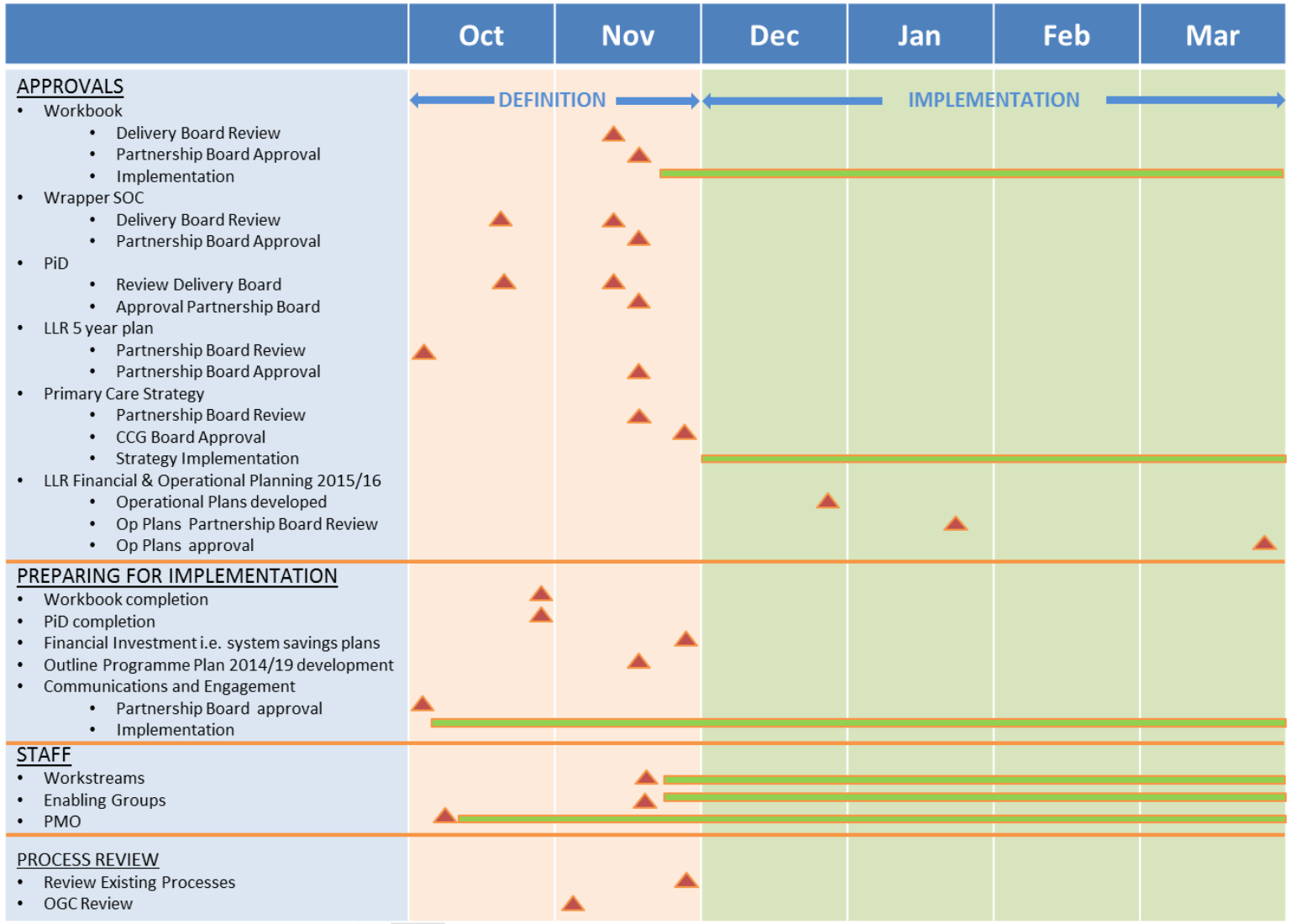
Programme Process	Partnership Board	Joint SROs	Delivery Board	Programme Director	PMO
Defining the Programme					
- establish the infrastructure		A		R	C
- establish the programme team		AR	C	I	C
- develop the Blueprint		A	C	R	C
- develop benefit profiles		A	C	R	C
- select the Stages		A	C	R	C
- design the Programme organisation		A	C	R	C
- develop governance arrangements		A	C	R	C
- make the Programme Plan		A	C	R	C
- prepare for the first Stage		A	C	R	C
- approval to proceed to the first Stage	A	R	C	I	I
Managing each Stage					
- direct work		A	C	R	C
- manage risks and issues		A	C	R	C
- control and deliver communications		A	C	R	C
- manage information		A	C	C	R
- manage people and other resources		A	C	R	C
- monitor, report and control		A	C	R	C
- prepare for the next Stage	C	A	C	R	C
- review at end of Stage and close the Stage	C	A	C	R	C
Delivering the new Operating Model					
- start workstreams and projects		A	C	R	C
- engage stakeholders		A	C	R	C
- align workstreams with Programme objectives		A	C	R	C
- align workstreams with Programme benefits		A	C	R	C
- control and manage delivery		A	C	R	C
- close workstreams and projects		A	C	R	I
Realising the Benefits					
- manage pre-transition		A	C	R	C
- manage transition		A	C	R	C
- manage post-transition		A	C	R	C
Closing the Programme					
- notify Programme about to close	I	A	C	R	I
- review Programme	C	AR	C	C	C
- finish Programme information		A	C	R	C
- confirm redeployment of all Programme resource		A	C	R	C
- approve Programme closure	A	R	C	I	C
- disband Programme organisation and team		A	C	R	

Key
R – Responsible; gets the work done; **R reports to A**
A – Accountable; decides
C – Consulted; supports; has capability required
I - Informed; notified but not consulted

APPENDIX 4 – BCT PROGRAMME ORGANISATION



APPENDIX 5 – BCT PROGRAMME PLAN FOR OCTOBER 2014 TO MARCH 2015



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

APPENDIX 6 – THE LINK BETWEEN BCT ACTIVITIES AND VISION

Line of Activity	The Five Year Strategic Plan's Six System Objectives	Blueprint for 2019	Vision
Primary, Community and Social Care	High quality integrated care pathways, delivered in more appropriate settings, reducing time spent avoidably in hospital	A healthcare operating model that emphasises integrated services delivered closer to home and community	Maximise value for the citizens of LLR by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring of safe, high quality services into the most efficient and effective settings.
Clinical Workstreams (x 8)	Reduce inequalities in physical and mental care across and within LLR resulting in additional years of life for those with treatable mental and physical health conditions Increase reporting of positive experience of care across all health and social care settings		
Enabling Groups (x 5)	Optimise opportunities for integration and use of physical assets across the health and social care economy, providing care in appropriate cost-effective settings, reducing duplication and eliminating waste Improve utilisation of our workforce and develop new capacity and capabilities where appropriate, in people and our technology		
Finance, including CIP, QIPP & Local Authority saving plans	All LLR partner organisations achieve financial sustainability		

APPENDIX 7 – FORMAT FOR BCT PROGRAMME RISK REGISTER

No	Date ID'd	Risk Description	Risk Owner	Assessment		Controls	Residual Assessment		Review Date
				Likelihood	Impact		Likelihood	Impact	
Strategic Risks									
Clinical Risks									
Financial Risks									
People, Engagement and Leadership Risks									
Programme Management Risks									

Risk Scoring Matrix

		Impact				
Likelihood	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5

Risk Severity	
Score	RAG
20-25	RED
14-19	AMBER
8-13	YELLOW
1-7	GREEN

APPENDIX 8 – EQUALITY STATEMENT

The Better Care Together (BCT) Programme is committed to ensuring that equality considerations are embedded in all our actions as part of the Programme. We are committed to: addressing inequality in healthcare; avoiding discrimination against individuals, especially those in 'protected groups'; promoting equality in employment; and complying with Equality, Inclusion and Human Rights legislation.

We will meet our equality responsibilities by:

- assessing the impact of our decisions on different groups of people;
- being clear how we assess and meet individual need;
- not tolerating discrimination that affects our employees or our communities.

We recognise that equality and diversity is fundamental to delivering high quality health and social care that meets the needs of individuals across LLR. We also recognise that equality and diversity is essential in recruiting and retaining the best staff.

We will ensure that the BCT Programme treats LLR service users, patients, carers, visitors, volunteers and employees fairly and with respect. We will ensure that the Programme does not discriminate against individuals or groups on the basis of any of the 'protected characteristics' outlined in the Equality Act 2010. This includes the grounds of disability or by reason of a person's association with a disabled person, gender, marital or civil partnership status, race, colour, ethnic or national origin, age, sexual orientation, gender reassignment, pregnancy and maternity, religion or belief, or any other unjustifiable conditions or requirements.