LLR System Annual Operational Plan 2019/20

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Executive Summary Paper N

Context

As part of regulatory planning guidance, the Leicester, Leicestershire and Rutland System was required to create and submit a System Operational Plan, comprising of a narrative document and supporting templates covering finance, activity, workforce and triangulation. Drafts of this plan have been discussed at Trust Board meetings and Trust Board Thinking Days between January 2019 and March 2019, as well as through UHL Executive Boards with comments incorporated. Final submission of the LLR System Operational Plan was made on 11th April 2019.

High level feedback has been received on this System Plan with further work required through Quarter 1 of 2019/20 to resolve queries. These predominantly concern the fact that the commissioner and provider activity plans do not yet align due to uncontracted QIPP schemes. A 'System Sustainability Group' has been tasked with the oversight of ensuring this gap is sustainably reduced with a focus on schemes designed to take costs out of the system, rather than traditional QIPP/CIP schemes.

There is also a requirement for the system to produce a system wide demand, activity, capacity and workforce plan which will underpin the system's 5 year clinical and financial strategy. This is expected by September 2019.

Input Sought

Trust Board is asked to:

- **Note** the submitted LLR System Annual Operational Plan
- **Note** the requirement on UHL to contribute to the further work required through 2019/20 to reach a sustainable system position
- **Note** the requirement of an LLR 5 year Clinical and Financial Strategy by September 2019

For Reference

The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

This matter relates to the following *governance* initiatives:

Organisational Risk Register	[No]
Board Assurance Framework	[No]

Related **Patient and Public Involvement** actions taken, or to be taken:	[Not Applicable]
Results of any **Equality Impact Assessment**, relating to this matter:	[Comply]
Scheduled date for the **next paper** on this topic:	[Monthly]
Executive Summaries should not exceed **1 page**	[Comply]
Papers should not exceed **7 pages**	[Does Not Comply]

'It's about our life, our health, our care, our family and our community'

Better care together

Leicester, Leicestershire & Rutland health and social care

Leicester, Leicestershire and Rutland

Integrated Care System

FINAL 2019/20 Operational Plan

April 2019

NHS

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SECTION 1

EXECUTIVE SUMMARY

Section 1: Executive Summary

The vision of the Leicester, Leicestershire and Rutland (LLR) Better Care Together (BCT) programme – the local Sustainability and Transformation Partnership (STP) - is '***To develop an outstanding, integrated health and care system that delivers excellent outcomes for the people of Leicester, Leicestershire and Rutland".***

In August 2017 the BCT partnership published its Next Steps to Better Care in Leicester, Leicestershire and Rutland document which set out the progress we had made on our plans and the next steps in developing an effective integrated health system in LLR. With the publication of the NHS Long Term Plan in January 2019 our BCT partnership is reviewing its plans to ensure they will be able to respond to the requirements of the Long Term Plan and we will publish a new five year plan in the Autumn of 2019.

In the meantime this Integrated Care System Operational Plan sets out an overview of what the system will deliver for its population with its share of NHS resources for 2019/20 and the progress the system expects to make over the year towards its long-term transformation objectives. It also sets out how we intend to develop our Sustainability and Transformation Partnership into an Integrated Care System (ICS) across Leicester, Leicestershire and Rutland.

The STP is a collaboration of system partners brought together to create a place based care system in which we rise to the challenges and deliver a transformation that improves and integrates care and makes us operationally and financially sustainable over the long term. We first formed our Better Care Together Partnership in 2014 and the plans set out here are built from that early work.

Health and social care structures and the geography offer ideal opportunities for delivering outstanding integrated care. Across LLR we have two main providers one for acute care and one for community, mental health and learning disability services. In addition we have three local authorities providing children and adult social care services. Together we provide care for over a million people and have a NHS workforce of over 22,000 and a social care workforce of 32,000. There is considerable variation in the health of people and life expectancy across LLR. An example of this is more people in Leicester City live in deprivation and experience early mortality than in Leicestershire and Rutland.

In LLR we have agreed a new model of care (Section 3) that is focused on a stronger system of primary and community care connected with specialist care. This is based on an established culture of GP practices working together in localities moving towards Primary Care Networks.

Our plans are based on the following priorities:

- Keep people well and out of hospital
- More care closer to home
- Care in a crisis
- High quality specialist care

SECTION 2

INTRODUCTION TO LEICESTER, LEICESTERSHIRE AND RUTLAND

Section 2: Introduction – Our Partners

Our Better Care Together Partners are:

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

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

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

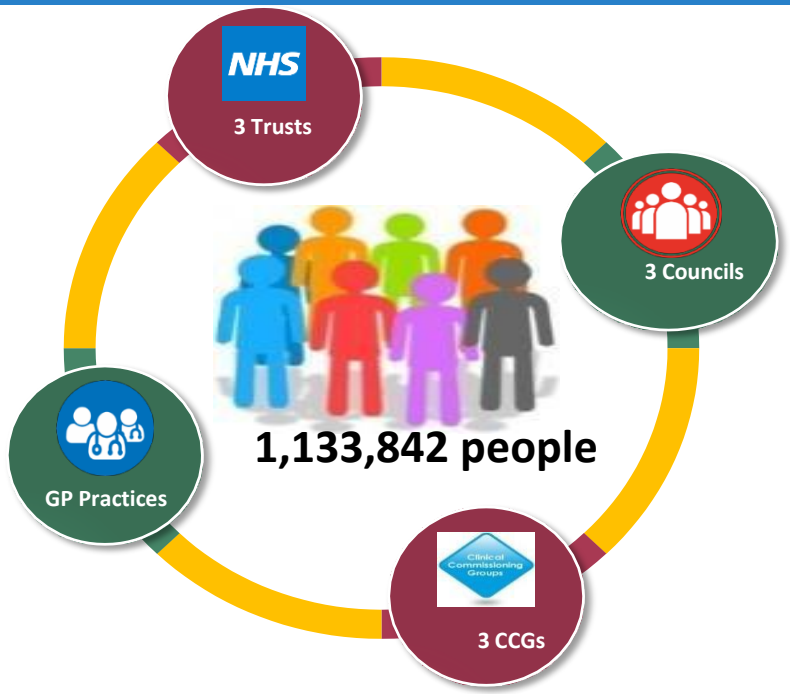
University Hospitals of Leicester (UHL) responsible for delivering the majority of acute services for Leicester, Leicestershire and Rutland patients.

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

East Midlands Ambulance Service NHS Trust (EMAS) who provide emergency transport.

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

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



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

Derbyshire Health United (DUH) provide a range of urgent care and general practice services across the system and are due to become partners in the Better Care Together Programme from March 2019.

Section 2: Our vision, goals and principles

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

Our vision

Our goals

Keep more people well and out of hospital through better public health and prevention of illness, early detection and management of disease, support for patients at home and in their community.

Care in a crisis from NHS 111 to 999, urgent care to the emergency department, including an urgent and emergency response for people experiencing mental health episodes.

More care closer to home from the management of long term conditions to planned procedures and follow-ups.

High quality specialist care to support patients in their homes, community facilities and hospitals to get the best possible outcomes.

Our principles: how we work

Work as One Team
Across boundaries, united in overcoming challenges and sharing responsibility to provide the best service and outcomes to patients. We want people to move through the system seamlessly, unaware that different organisations are working together to care for them.

High Quality, Person-Centred Care
For local people across that patch from home to hospital and back again. We want to maintain the health and wellbeing of local people, ensure the best possible outcomes for them when they need treatment or care, wherever they live throughout Leicester, Leicestershire and Rutland.

Efficiency and Best Value
To make the most of every pound we have to spend in Leicester, Leicestershire and Rutland by sharing resources, cutting duplication, waste and delay and innovating to overcome the challenges we face. This includes setting up new systems to care for people at home and in their local community, as well as using IT to share patients' records and offer new services.

Support and nurture a committed health and social care workforce
By helping staff to develop new skills and understanding, encouraging them to be the best, promoting high morale and managing talent and resources. We will be asking staff to work in different ways, in different places and with different people and organisations. We want to give them the skills and set up the system in a way that allows them to do a great job for local people.

Section 2: The key system challenges we face

In Leicester, Leicestershire and Rutland, and throughout England, the NHS faces unprecedented demands for health and care services. This is making it harder to deliver high quality services and control costs. Our plans for LLR have been developed by clinicians to meet this rising demand and provide safe, high quality care in a sustainable way. A summary of the challenges we face is detailed below.

Increased demand – a growing and ageing population means the NHS must treat more patients and a greater number with complex conditions. By 2023 the population of LLR is estimated to increase by 5.2% to 1,124,300 people. The number of people aged 75 and older is set to increase by increase by 25.7% to 104,100 people.

How we provide care – the NHS was developed when medical interventions were less effective. People tended to die younger. Now people generally live longer but more patients have multiple long-term illnesses. Care is not a one-off event, but an ongoing process, involving a multitude of health and care agencies. We also have opportunities to use digital technology to improve care and outcomes.

Inefficient buildings – some NHS facilities are old and have high running costs, while some services are split across multiple sites, undermining care quality, leading to duplication and increased cost.

Staff recruitment and retention – shortages of doctors, nurses, midwives and paramedics undermines the quality of care and increases the cost of services as NHS organisations pay for expensive agency staff. Providers are also competing with each other to attract the same workforce.

Advances in medical treatment - the availability of more sophisticated treatment allows us to do more than ever before for patients, but this is often at a higher cost.

Increasing financial pressure - demand is increasing quicker than available resources. As result our local health and social are services are under increasing financial pressure.

Section 2: The health issues we face

Leicester

The 2017 population estimate for Leicester is 353,540, of which 50% are female and 50% male. Leicester's population is relatively young compared with England; a third of all city households include dependent children, 20% of Leicester's population (71,400) are aged 20-29 years old (13% in England) and 12% of the population (41,500) are aged over 65 (18% in England). The large proportion of younger people in Leicester reflects the student population attending Leicester's two universities and inward migration to the city.

Leicester has a diverse population, 28% of the population do not define English as their main language in comparison to the National average of 8%. Almost half of the population define themselves as non white, with 37% defining themselves from the Asian Community and 3.8% from the African Community.

In 2011, over a quarter (32,447) of city households included a person with a long-term health problem or disability that limits the person's day-to-day activities, and has lasted, or is expected to last, at least 12 months. This includes problems that are related to old age.

A quarter of Leicester households in which at least one person has a long-term health problem or disability (7,909), also include dependent children. As expected, the incidence of disability in the City is highest in areas where the population is older (such as Thurncourt), and lower where the population is younger (for example, City Centre). According to Leicester's 2018 Health and Wellbeing Survey, almost three in ten residents (28%) have a long-standing illness or disability. Of these, two thirds (66%) say this limits their day to day activities in some way.

Leicester has a high level of deprivation compared to the country as a whole and is ranked 21st out of 326 local authority areas in England, on the 2015 national Index of Deprivation (where 1 is worst). Leicester has 18 lower super output areas that are in the 5% most deprived in the country. 44% of Leicester's population live in the most deprived 20% of areas in England and a further 32% live in the 20-40% most deprived areas. Only 1% of the Leicester population live in the 20% least deprived areas.

Life expectancy in Leicester is significantly lower than the England average and although it has continued to improve over the past decade, it has shown a slower improvement than England overall. In the period 2006-08 to 2015-17, life expectancy in Leicester increased by 1.3 years; for men this is an increase from 75.7 to 77, and for women from 80.2 to 81.9. However, in England life expectancy increased by 1.8 years for men to 79.6 and 1.3 years for women to 83.1. Overall, the gap between Leicester and England has been widening, reaching a peak in 2008-10, however this has shown a small improvement in subsequent years.

The main causes of death in Leicester are heart disease and stroke, cancers and respiratory diseases. Together these account for nearly two thirds of all deaths. Cancer is the main cause of premature deaths (in the under 75s), accounting for over a third of early deaths, followed by heart disease and respiratory diseases. The proportion of deaths from heart disease and stroke in Leicester are slightly higher than nationally in all ages and in under 75 year-olds, whilst the proportion of deaths from cancers is slightly lower in Leicester. However, Leicester residents are on the whole dying at a younger age and have a lower life expectancy than average.

Smoking is the greatest single cause of preventable death. The average number of smoking related deaths in Leicester City is 412 (2014-2016). Smoking prevalence rates are higher in more deprived areas and areas to the west of the city. Smoking prevalence is significantly higher amongst those of white ethnicity and significantly lower in under 19s, over 65s and Asian ethnic groups.

Section 2: the health issues we face

Leicestershire

At the end of 2017 the population of Leicestershire was 690,212, with the county having a higher than national average level of older adults (those falling in the 45-74 years old age bands). The population of Leicestershire is projected to increase by 15.8% to 787,500 by 2041 (an increase of 107,100). Leicestershire will see higher levels (than both the East Midlands as well as National average) of growth during this time period. It is anticipated that the greatest level of growth (to 2041) will be within the 65+ age group.

In 2015 an exercise was undertaken to identify the level of deprivation within the county and the outcomes of this process demonstrated that in overall terms Leicestershire is not a deprived county (being ranked in the upper-tier of deprivation). However, within the county there are pockets of deprivation with 12,500 people being identified as living in the most deprived national deciles. Across the key JSNA parameters the Leicestershire health economy ranks equally or better than the national average. The following are areas where Leicestershire performs below the national average and which require focus from both local authority and the NHS:

- **Cardiovascular diseases -** Leicestershire performs below the national average for the number of new hypertension that have received a cardiovascular risk assessment.
- **Diabetes** -Leicestershire GP practices on fewer occasions (both type 1 & 2) record the smoking status of diabetic patients. Fewer Type 1 and 2 diabetic patients (in comparison to the national average) within Leicestershire receive all recommended 8 care processes. Diabetic patients in Leicestershire are less likely (than the national average) to record a blood glucose level of 48mmol/mol. Finally, diabetic patients in Leicestershire are less likely to have their BMI recorded (than the national average).
- **Early Years** - Children (0-1 & 1-4 years old) in Leicestershire attend A&E on more occasions than the national average.

Rutland

The population of Rutland in 2016 was 38,606, an increase of 1.5% since 2015. Rutland has an older population with almost a quarter, 23.9%, of the population aged over 65 compared to 17.9% nationally. The population of Rutland is projected to grow by 7.9% by 2039 which is below the expected national increase of 14.6%. The number of people aged 85 and over in Rutland is predicated to grow by 142.9% which is higher than the predicated national rate of 127.1%. The military population accounts for 5.8% of the population. 23.8 % of the population live in a rural town and fringe; 28.1% in urban city and town; and 48.1% in rural village and dispersed. 65.5% of the population live in neighbourhoods in the three least deprived deciles nationally. The county is ranked 148th our of 152 upper tier authorities in England where 1st is the most deprived. Compared to the national average the rate of premature mortality is significantly lower and both life expectancy and healthy life expectancy is significantly better than the national average.

The plans that are set out in this System Operational Plan are designed to impact on the key system challenges and the health issues within Leicester, Leicestershire and Rutland.

SECTION 3

CARE REDESIGN

Section 3: Overview of the Leicester, Leicestershire and Rutland Clinical Care Model

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

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

We anticipate that multi-disciplinary teams including staff from social care and the voluntary sector, working on a place-based model of care through Primary Care Networks will reduce the number of emergency admissions.

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

Working with our local authorities and the voluntary sector prevention of ill health and maximisation of wellbeing is integral to our model.

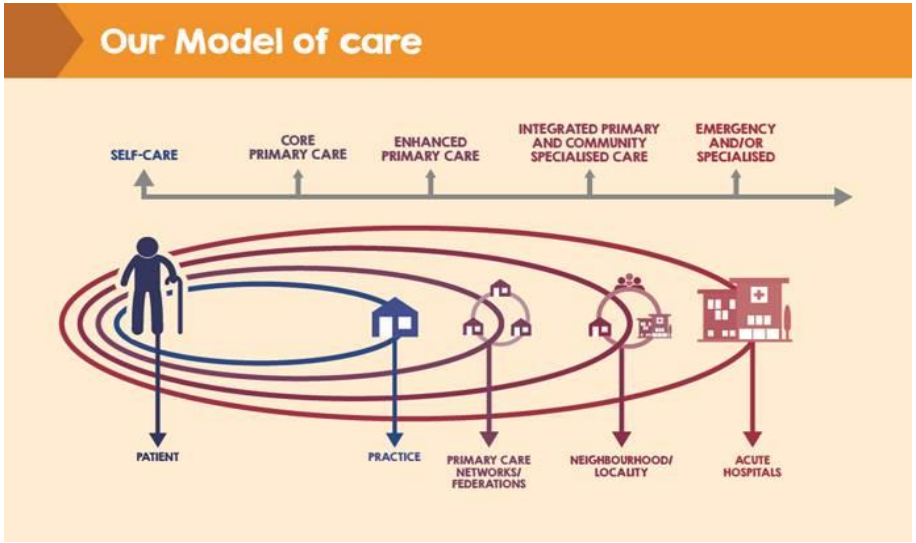
Those with minor illnesses or long term conditions will have the confidence to manage their own health or have their needs met in primary care by a pharmacist or a general practice.

Our care model will deliver a shift in emphasis from reactive to proactive care where those with long term conditions will discuss their future needs with clinicians and contribute to the development of their care plan.

Focusing on a philosophy of “Home First” we will deliver care as close to home as possible. We recognise that some people will require on-going care. For this group, continuity of service is important where all who deliver their care have access to shared information.

As the complexity of a patient’s needs increases, we will work with the individual and their family to develop an integrated care plan to keep them independent in their own home as long as possible.

Where either a planned or unplanned hospital admission is necessary both the admission and the discharge will be co- ordinated to minimise the amount of time spent in hospital.

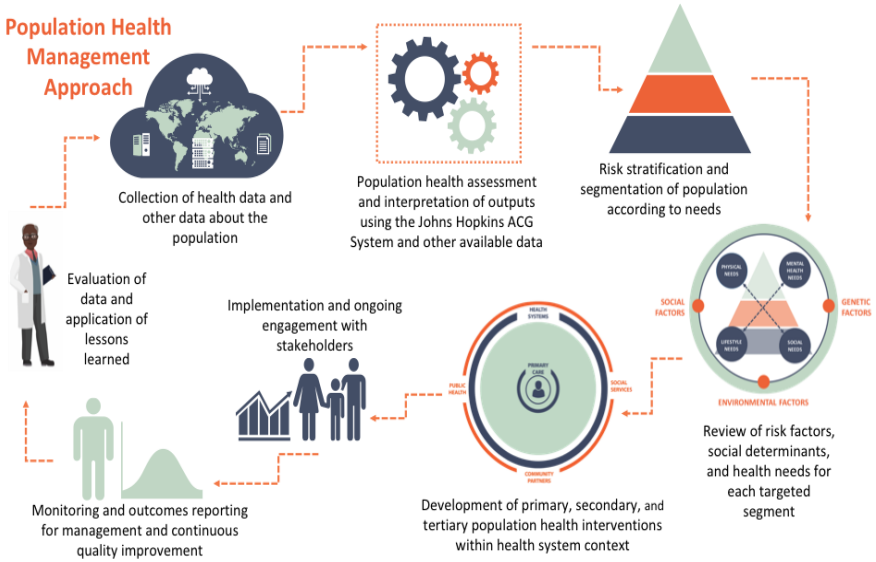


Section 3: Our clinical care model focuses on population health management

The NHS Long Term Plan focuses on the use of population health approaches to support improvement in outcomes for patients and financial sustainability in the NHS.

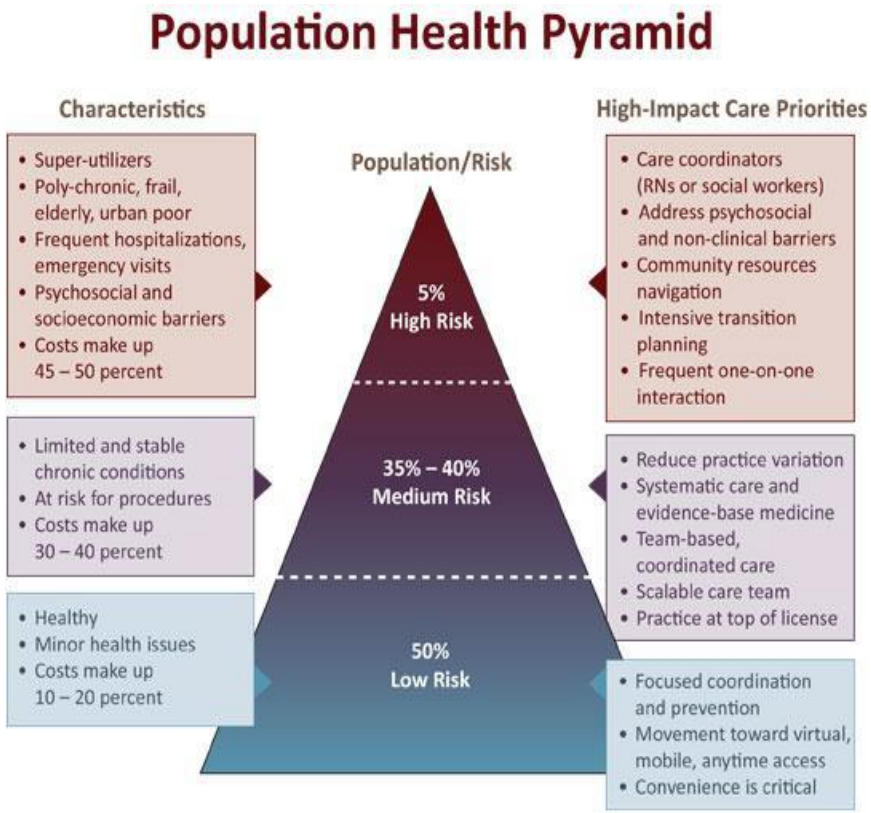
In LLR, Leicester City CCG, has been using a population health management approach over the last three years to support those that are high risk of admission to hospital, those with complex needs and those that are frail. Risk stratified data is available to each practice to enable them to target and proactively manage patients. This is supported by investment into social and community services through the Better Care Fund and an enhanced service within General Practice.

By using a population health management approach we are able to target support and interventions to the right patients. We are now expanding this approach across all LLR CCGs.



All practices across LLR now have access to risk stratified data which will enable them to target support.

We are also using data at a strategic commissioning level to understand the numbers of patients in each risk category, the cost of providing care attributable of to the risk categories and what services are required to respond to need. This is informing how we use Better Care Funds, develop Primary Care Networks and the current review of community health services. It will be an integral part of how the CCGs will move into a more strategic commissioning role in the new NHS architecture.



Section 3: Integrated Care System

Our Integrated Care System (ICS) journey began in 2014 with the development of our Better Care Together (BCT) programme which has built a strong collaborative partnership across the health and social care sector within LLR. In November 2016 the BCT partnership published its draft proposals for the development of local health and social care services. In it we described how we will work together on the triple aims of the NHS Five Year Forward View. These include improving the health outcomes of people, providing better quality care and ensuring financial sustainability.

The basis for our redesigned system is described below and we are developing our models at each level, the main components of which are the infrastructure to enable the Integrated Care **System** to function effectively by bringing partners together to agree how we will operate as an ICS. At a **place** level considerable work is being done to redesign our community based physical and mental health services working with our councils to ensure that where services need to be provided at a place level these are effective and complement the rest of the system offer. At **neighborhood** level we have already developed locality teams which are providing integrated care to complex patients but we know we could do better, and through our work to develop Primary Care Network we will redefine our neighborhood offer based on a population health management approach.

Level	Population Size	Purpose
Neighborhood (Health Needs Neighborhood and Localities)	30,000 to 50,000	• Deliver high quality primary care. • Proactive care via integrated locality teams for defined populations and cohorts. • Asset based community development to support health, wellbeing and prevention.
Place Leicester City Leicestershire County Rutland	37,000 to 610,00	• Based on upper tier authority boundaries. • Delivery of specialised based integrated community services, including social care. • Delivery of reablement, rehabilitation and recovery services. • Prevention services at scale.
Systems (Leicester, Leicestershire and Rutland)	1,000,000+	• System strategy, planning and implementation. • Work across the system on specialist areas such as cancer, mental health and urgent care. • Make best use of all our combined assets including staff and buildings. • Manage performance and system finances. • Establish a system framework for prevention.

Section 3: Developing our Integrated Care System

The System Leadership Team (SLT) have been working to build relationships and resilience across the whole local system in order to develop fully integrated approaches to health and well-being. It intends to develop a plan for delivery across the different organisations by September 2019 and be ready to work in shadow form as an Integrated Care System by April 2020. We have used the Good Governance Institute Maturity Matrix to assess where we are and what actions we need to take. This has identified the following key activities for 2019; (1) Purpose & Clarity of Remit (Element 1) - Rearticulate vision, purpose and principles; (2) System Infrastructure, leadership, financial framework (Element 8); (3) Governance and decision making (Element 9) including establishing transparent oversight arrangements and a Memorandum of Understanding; (4) Internal & External stakeholder Engagement (Elements 5 & 6) including joint approaches to communications and engagement activities with staff and stakeholders; and (5) Priorities and outcomes (Element 10) including tangible programmes of joint work . A programme for this work is detailed below.

In addition the CCGs are undertaking a Commissioning Capability Programme to support the future commissioning arrangements.

Quarter 1

- Review and agree vision, purpose and values
- Develop behaviour expectations
- Oversight structure agreed
- Agree priority areas of work
- Co-creation workshop
- Review and agree Terms of Reference for SLT
- Develop OD and engagement strategies

Quarter 2

- Identify key risks areas and how these will be managed
- Review progress on maturity matrix
- Establish shared governance and accountability
- Agree a Memorandum of Understanding
- Engage on five year plan
- OD programme

Quarter 3

- Develop system leadership skills
- Establish outcomes
- Agree financial frameworks
- Review progress on maturity matrix
- OD programme

Quarter 4

- Review progress on maturity
- Prepare for shadow year
- OD programme

Section 3: Our emerging community model

In 2018/19 the CCGs have undertaken a review of community services to develop a future model. The reasons for this change are:

- There is not enough capacity in community nursing and therapies to respond to patients' needs in the way needed to deliver a preventative and reabling model that also supports continuity of care for the frail population and those with multiple long term conditions. Local bed audits have shown 30% of patients in bed based care are in the wrong place to best meet their needs.
- Services are not designed to support integrated care, or to work closely with GP practices as part of neighbourhood teams or deliver a population health management approach.
- There is insufficient medical support to achieve the potential for patients to be cared for well at home, preventing admission and ensuring high quality care after discharge from hospital.
- The current model is not well aligned to a future integrated care system approach.

In 2019/20 CCGs, together with system partners, will start to implement the new LLR model of care for core community based services. The future model of care has been designed with strong clinical leadership and reflects significant engagement with stakeholders, patients, carers and staff. The model has been developed based on evidence on best practice models of integrated community care both nationally and locally.

The new model is based on a number of key building blocks:

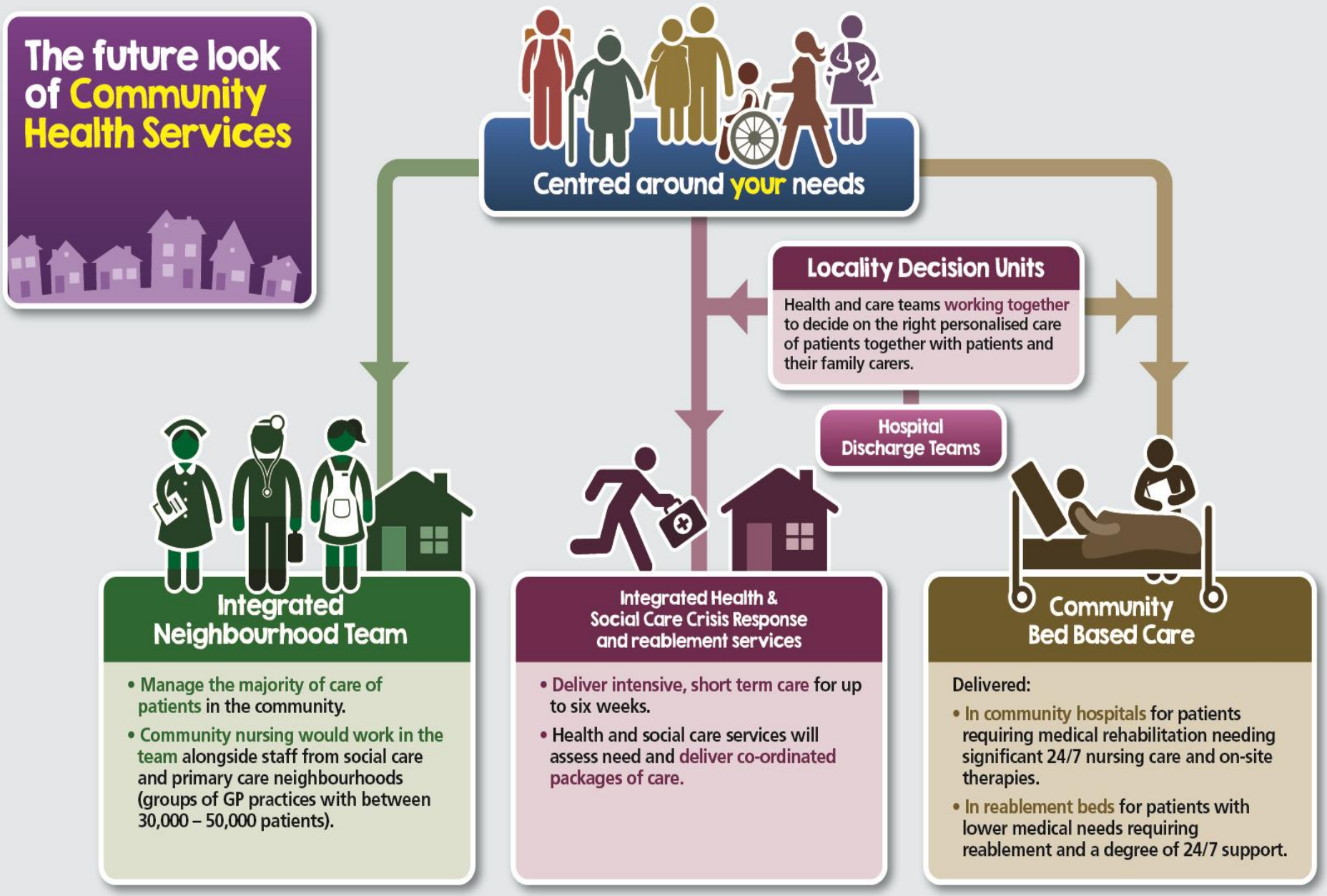
Community bed based care: delivered either in community hospitals for patients requiring medical rehabilitation or needing significant 24/7 nursing care and on-site therapies, and in 'Pathway 3' reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support. We will review the medical model of support to community hospitals.

Improved discharge processes: from UHL and close working with community locality decisions units will enable clinician to clinician conversations that support patients to be discharged faster and hospital admissions avoided.

Community support to primary care networks: will include a genuine multi-disciplinary team inclusive of GPs, practice nursing, community nursing and therapy, social care, care co-ordinators, mental health support, housing and voluntary sector support. These teams will manage the majority of care for people with frailty, long term conditions, and complex needs (including end of life), who can be managed in a community setting. Over a number of years it is anticipated that these local neighbourhood teams will move towards managing resources locally. We will develop a new model of care co-ordination to support patients and the professionals working in these teams to proactively deliver care in the right setting at the right time.

Home First services: will be 'place' based aligned to local authority areas. These will be 'integrated health and social care crisis response (including virtual ward) and reablement services, which would deliver intensive, short term care for up to 6 weeks. These services will be accessed when a patient is at risk of hospital admission or requires multi-disciplinary intensive support to enable them to be discharged from hospital before stepping down to neighbourhood team support. By routing all referrals for Home First services and community beds through the same clinically manned decisions unit people will be treated in the most appropriate setting. With health and social care services working on the basis of trusted assessment and delivering co-ordinated packages of care. Medical responsibility will remain with the GP, but additional investment will be made in primary care to strengthen the medical offer to the Home First service.

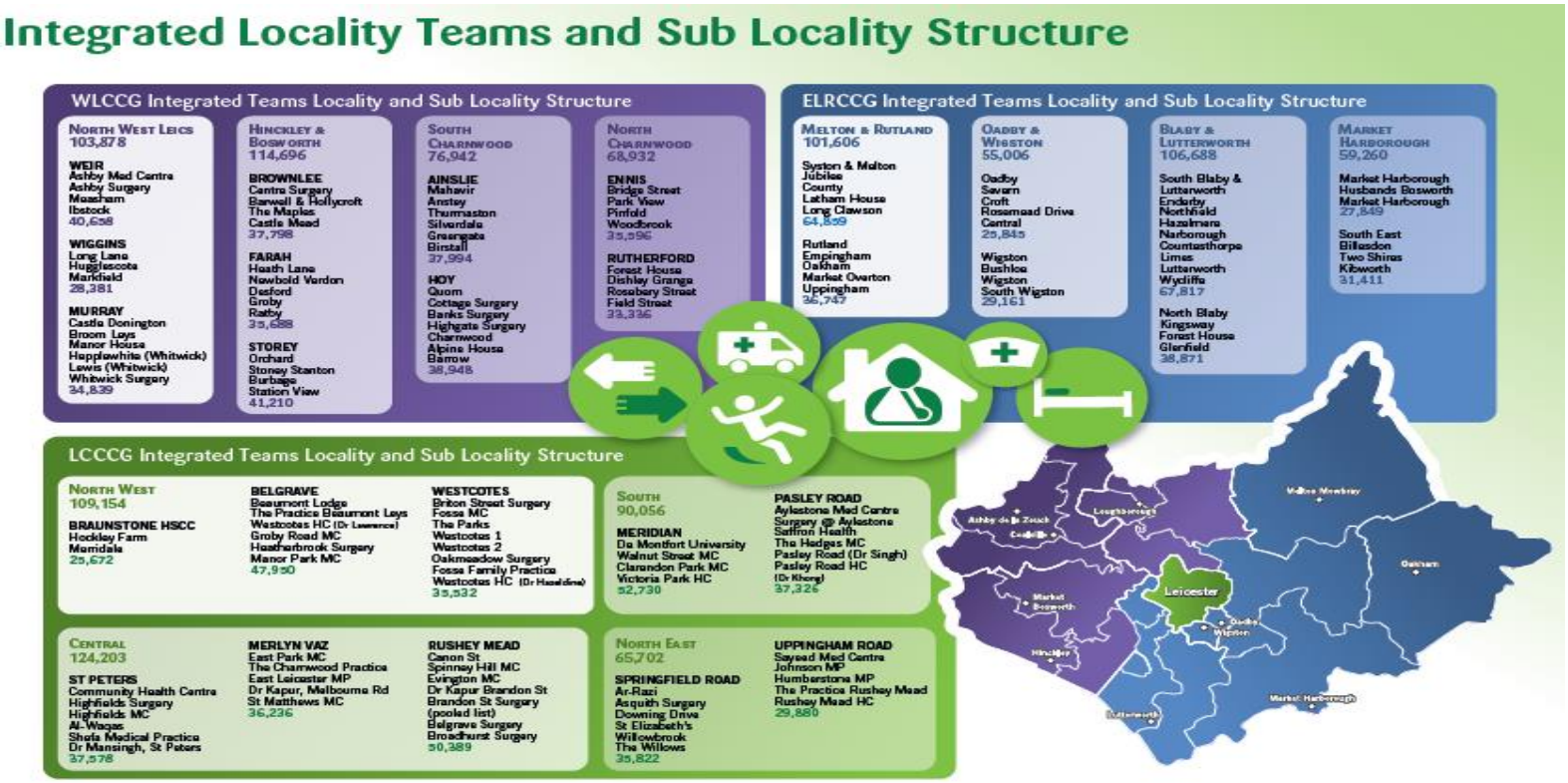
Section 3: Our emerging community model



Section 3: Our emerging primary care networks

Primary Care Networks (PCNs) will involve groups of practices and other local health and social care providers working in partnership, as one team, to provide proactive, personalised, coordinated and more integrated primary and community services to improve health outcomes of their population. Practices will work together with other local health and social care providers around natural geographical communities of between 30,000 and 50,000 registered patients. They will deliver expanded neighbourhood teams comprising of a range of staff including GPs, primary care staff, pharmacists, district nursing, community geriatricians, Allied Health Professionals joined by social care and the voluntary sector. This will be supported by a network contract. In LLR considerable work has been done over the last three years to develop our neighbourhood offer, known as Integrated Locality Teams, discussions are ongoing with practices to develop Primary Care Networks with a view to confirming the geography of each Primary Care Network by 31st May 2019.

The existing footprints are based around community nursing and social care localities and over the last twelve months more multi disciplinary work has been undertaken by these teams to support patients with complex needs. The development of Primary Care Networks will be overseen by the Better Care Together Primary Care Board.



SECTION 4

OUR KEY PRIORITIES AND KEY DELIVERABLES

Section 4: Our priorities and key deliverables

The following sets out our system priorities for 2019/20, these are drawn from our Better Care Together work-streams and form the key deliverables within individual organisations ' Operational Plans.

Integrated Care System Development led by the System Leadership Team

Enablers	Transformation Programmes
Finance and Contracting	Planned Care
IM&T Digital	Cancer
Workforce	Urgent Care
Communications and Engagement	Integrated Community Services
Estates	Primary Care
	Mental Health
	Learning Disabilities
	Children and Adolescent Mental Health
	Children's, maternity & neonates
	Prevention and health inequalities
	Medicine Optimisation

To deliver the plans set out in this Operational Plan the following governance arrangements are in place.

At a system level: The overall delivery of the plans are overseen by a Senior Leadership Team made up of Chief Executives from providers; CCG Managing Directors; very senior representation from local authorities; and a clinical lead from each of the NHS organisations.

Each member of SLT has a sponsor role to a number of key schemes set out in this Operational Plan. They are responsible for the overall delivery of their schemes supported by a Senior Responsible Officer and Implementation Leads.

At a scheme level: There is an Executive Senior Responsible Officer for each scheme to ensure delivery. For clinical programmes there is a lead clinician and where appropriate there are clinical leads from commissioners and providers. An Implementation Manager is in place to oversee the day to day implementation of the programme. A group or board oversees the development and implementation of each programme.

Programmes are supported by enabling work-streams.

The following pages set out our key priorities for 2019/20 in these programmes. Our plans for developing our Integrated Care System and Integrated Community Services are detailed in section 3.

Section 4: NHS Constitutional Standard Performance & Assurance Process

As a system our current performance concerns include Accident &Emergency (A&E), Referral to Treatment Times (RTT), 62 day & 31day (surgery) cancer waits and increasing Improving Access to Psychological Therapies (IAPT) access rates.

Performance trajectories have been reviewed with key providers to agree realistic trajectories, alongside improvement, plus a process of transformation with key deliverables.

The Provider Performance and Assurance Group (an LLR group made up of Executives; clinical leads and lay member) oversees provider performance including relevant NHS Constitutional Targets. Structures are also in place to manage performance through system owned Boards including the A&E Delivery Board, Planned Care Board, Cancer Pathway Performance Board and the Mental Health STP work-stream.

This provides a clear and robust governance process for managing all key performance areas , including a targeted system owned work-plan for A&E held by the 'A&E Delivery Board', the high level work-plan outlined in the next section with a more in-depth action plan placed in the LLR Operational Plan 2019-20.

As a system the 92% Referral to Treatment (RTT) standard remains below expectation in 2019/20. The plan to address this under performance is an element in all our Operational Plans. Our focus on Planned Care is outlined in the section below, with performance and governance held jointly across the system at the Planned Care Board. Additionally, there will be an ongoing focus to ensure delivery of the second RTT operational standard – to ensure that we do not have any more patients on incomplete pathways at March 2020 than we did at March 2018.

The Cancer Waits standard for 62day and 31day surgery will also be a considerable challenge to the system, the work-plan is outlined in the next section with the more in-depth plan forming part of the LLR Operational Plan 2019-20 with governance held at the 'Cancer pathway performance Board' .

The system is also focusing on more patients to be accessing IAPT services. With jointly agreed trajectories to achieve compliance with the national standard. Detail is outlined in the following section, with grip maintained through the system owned Mental Health STP work-stream.

Structures are in place to manage performance also through our commissioning and contracting teams. Our plans take account of the 2019/20 Planning Guidance requirements and the Operational Plans detail specific actions being taken.

In order to hold the system to account on NHS Performance targets individual CCGs monitor progress through the Integrated Governance Committees and Quality & Performance meetings and escalate to CCG Boards as necessary.

Section 4: Key priorities – Planned Care

Overview	The LLR Planned Care Programme supports patients to have access to safe, high quality and effective care, delivered locally. Planned care can be defined as routine services with planned appointments or interventions in hospitals, community settings and GP practices. We want our planned care services to deliver high quality, personalised care, which enables patients to see the right person, in the right place, at the right time; working with local services to make sure that patients only go to hospital if they need to be there and that we have safe, high quality care available in community settings to improve patient outcomes. The Programme focuses on ensuring appropriate demand in an acute setting and maximising the opportunities in the Alliance, it also considers improvements in patient flow and treatment once on an acute elective pathway.
Why is it an important priority?	As a system we will transform planned care services via specific schemes for LLR residents. Our aim is to improve patient care and health outcomes. By changing the way we use community and GP facilities we can bring more care closer to home. This will free-up space at University Hospitals of Leicester for patients needing emergency and specialist services including treatment for cancer, neurology and complex maternity services. As well as bringing more services into the community, we are improving the way different parts of the local NHS work together. This will give patients more control over their care, and make sure that they are always seen by the right person, in the right place at the right time. We are also working on new ways to help patients take control of their health, helping them make better, more informed decisions about their health and care.
Key deliverables in 2019/20	• Creation and Delivery of a Referral Support Service. • Increased capacity in a Community setting particularly for Dermatology, Ophthalmology, General Surgery, ENT and MSK. • Appropriate usage of pathology and diagnostic services. • Increased GP Advice and Guidance offered by Providers. • Reductions in outpatient follow up rates, moving to alternatives such as non-face to face appointments. • Implementation of 2 way text reminders to improve both clinic utilisation and theatre utilisation. • Continued admitted efficiencies increasing number elective surgery rate. Includes improvements in scheduling, reduction in cancellations from hospital, patient and due to clinical reasons via improved operative assessment. *For specific detail on how these deliverables will be achieved please see Pages 18- 32 of the Leicester, Leicestershire and Rutland (LLR) Operational Plan 2019-20*
Outcomes and benefits	• Improve care by delivering it closer to home. • Improved utilization of available capacity. • Increased efficient use of available resources. • Potential to re-patriate out of county activity.

Section 4: Key priorities – Cancer

Overview	Cancer is a priority across Leicester, Leicestershire and Rutland (LLR). The NHS Long Term Plan makes clear commitments to diagnose cancer earlier and push the prevention agenda. These are local priorities as LLR recognises the need to further improve our services and care for patients. Cancer outcomes vary across the three CCGs with one-year survival rates ranging from 67.3% - 73.3% across the patch but with a national requirement to achieve 75% by 2020. Preventing cancer, diagnosing cancer, screening for cancer and offering high quality treatment in addition to caring for 50,200 people who are survivors of cancer by 2030 must be our priority.
Why is it an important priority?	Diagnosing cancer early not only saves lives but limits treatment costs. When lung cancer is detected at Stage 1 the five year survival rate is more than three in ten with treatment costs of £8,000. However if detected at Stage 4 the five year survival is less than one in ten with treatment costs of £13,100. One of the best ways to diagnose cancers early is through the three national screening programmes. Rates are differential across Leicester, Leicestershire and Rutland – for example for people aged 60-69 screened for bowel cancer in the last 30 months in 2016/17 uptake rates varied from 46% - 65% against a national average of 59% and a 2020 target of 75%.
Key deliverables in 2019/20	• Prevention: Develop and continue to run programmes to prevent and detect early stage cancers and reduce known risk factors such as smoking and obesity. Smoking is the biggest preventable cause of all cancers. • Improve the early detection of cancers: To ensure good progress towards the 2010/21 ambition for 62% of patients to be diagnosed at stage 1 or 2 we will do this through a programme of prevention and early detection in primary care, raising the profile of symptoms, improving pathways and access to diagnostics. • Diagnostics: The system will ensure full implementation of the nationally agreed rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers, ensuring that patients get timely access to the latest diagnosis and treatment. • Providing a dedicated multi-site facility for Clinical Radiology, Diagnostic Radiography and Sonography. • Implementation of FIT testing in primary care; Optimal Lung Cancer Pathway; and the RAPID Prostate Pathway. • Recovery packages and Risk Stratified Follow Up, primarily focused on Lower GI, Breast, Prostate and Lung pathways over the next 2 years. *For specific detail on how these deliverables will be achieved please see Pages 72- 76 of the Leicester, Leicestershire and Rutland (LLR) Operational Plan 2019-20*
Outcomes and benefits	• Improved prevention of cancer. • Earlier detection and treatment of cancer. • Improved experience of patients on the cancer pathway.

Section 4: Key priorities – Urgent Care

Overview	Our vision is to create a health and care system that provides responsive, accessible person-centred services as close to home as possible. We aim to implement a model that will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services, exploiting innovation and promoting care in the right setting at the right time. By doing this we anticipate we can better manage patients with long term and complex conditions and also manage the increasing demand on the Emergency Department and ambulance services. To do this, we have taken forward a significant redesign of community urgent care services in LLR, to deliver services accessible 24 hours per day, seven days a week in community and hospital settings. This includes improving 'Front of House' Frailty Service plus access to the home based support offer with our partners at the point of discharge from hospital.
Why is it an important priority?	We remain committed to resolving the areas that cause under performance within our own gift and working across the system to support a reduction in attendances and admissions alongside returning patients to their home more quickly. Our plans will also maintain that no patient arriving by ambulance should wait more than 15 minutes from arrival to handover. Our model is based on making improvements in 4 major areas based on previous diagnostic work identifying areas of failure that have interlinked but distinct challenges. • Decreasing non-admitted breaches in the daytime (8am – 9pm). • Improving overnight performance (Non-admitted breaches & admitted breaches that are primarily attributed to process). • Decreasing admitted breaches that represent potential short term improvement. • Decreasing admitted breaches , not included elsewhere, that relate to delays associated with flow (excludes clinically appropriate breaches).
Key deliverables in 2019/20	• Investment in the Frailty Front Door Multidisciplinary team to enable improved processing of patients and avoid admission of the most vulnerable patients. • Continuation of acute medical staff input at the front door to increase adoption of Same Day Emergency Care (SDEC) pathways. • Improved organisation and management of the discharge team to enable more consistent staffing levels and approaches, aimed at reducing stranded and super stranded patients. • Investment in flow coordinators – non clinical roles to enable patient flow allowing clinicians to focus on clinical intervention. • Procure an LLR Clinical Navigation Hub to deliver increased and improved clinical assessment across the NHS111 system. • Improve integrated urgent care services through working with EMAS on dispositions; care homes; telemedicine; improved mental health support, skill mix and capacity in services. *For specific detail on how these deliverables will be achieved please see Pages 33- 39 of the LLR Operational Plan 2019-20*
Outcomes and benefits	• To improve access to out of hospital services in order to reduce demand on acute services, the Emergency Department and ambulances (Inflow). • To improve hospital operational processes in order to improve the delivery of national targets, and to reduce patient delays including long stay patients (Flow). Improve Continuing Health Care discharges in Community Hospitals. • To improve patient and carer experience of discharge by improving discharge processes across the system and reducing delayed transfers of care (Discharge).

Section 4: Key priorities – Primary Care

Overview	The LLR vision for primary care as set out in the STP plan. This is much more about how general practice will need to evolve and adapt over the next few years to manage the demand and the changing nature of primary care and an ageing population. This has been detailed in the LLR GP 5 year forward view plan which can be viewed here https://eastleicestershireandrutlandccg.nhs.uk/wp-content/uploads/2018/02/3.-GPFYFVFinal.pdf . This strategy will be updated for 2019/20 onwards with a clear direction for how Primary Care Networks will design, commission and deliver as part of the Integrated Care System. The Primary Care Board within LLR will drive forward this work to ensure resilient and effective General Practice at the centre of the local health care system.
Why is it an important priority?	Primary Care is the key to ensuring our clinical model of care can be delivered. Primary Care is crucial due to its ability to access and support patients providing a differential service according to need. Not every patient requires contact with a doctor or an appointment on the same day. A cohort of patients, especially those with multiple co-morbidities who are at risk of admission for their complex condition require a more pro-active offer that could involve a multi-disciplinary team including social care, community nursing and specialist care. Integrated care combines a range of disciplines across health, social services and voluntary organisations to create person-centred care.
Key deliverables in 2019/20	• Configure and implement Primary Care Networks. • Continue the implementation of the GP Forward View 'High Impact Changes'. • Consolidate Extended Access across the system. • Continue investment into Primary Care. • Support Practices through the Sustainability and Resilience Fund. • Support practices to develop learning and 'good practice' across the system. • Continue to improve recruitment, training and retention of staff in primary care. *For specific detail on how these deliverables will be achieved please see Pages 70- 72 of the Leicester, Leicestershire and Rutland (LLR) Operational Plan 2019-20*
Outcomes and benefits	• Encourage Universal Services across General Practice. • Establish a resilient and stable Primary Care. • Improve access to Primary Care plus bespoke care planning. • More care provided closer to home through the development of integrated primary care networks.

Section 4: Key priorities – Adult Mental Health

Overview	In LLR the Mental Health Partnership Board provides strategic and operational oversight of our health economies mental health programme (including transformation). Mental health proposals within our Better Care Together programme support the left shift of activity away from inpatient acute settings and enhancing community and primary care services. Our All Age Mental Health Transformation Programme will continue to design and implement new pathways, including the use of digital resources, to focus primary and community mental health services on detection, planned care and recovery. These anticipatory care models will proactively intervene where an individual's mental health deteriorates with the aim of minimising impact on the individual and reducing the likelihood of an inpatient stay.
Why is it an important priority?	The LLR Mental Health system benchmarks nationally as an outlier for adult acute Mental Health length of stay, bed utilisation, crisis, and community caseloads (including patient contacts). This position results in poor patient flow across our main provider inpatient services and potential out of area placements as well as Delayed Transfers of Care (DTOC's). In line with NHS England requirements, LLR is required to invest (based on our Clinical Commissioning Group allocation growth) additional resources into mental health. During 2018/19 we have worked with system partners to identify priorities for this additional investment (in 2019/20) and identified the required associated outcomes.
Key deliverables in 2019/20	• Reduction in Acute lengths of Stay. • Liaison Psychiatry (Core 24). • Deliver Early Intervention in Psychosis target. • Increase access to IAPT. • Crisis team enhancements. • Admission Avoidance: in 2019/20 the focus will be on the creation of alternatives to acute admission. • Reduce suicide and increase resilience and promote recovery and independence through working in partnership with public health. • Meet an increased proportion of mental health recovery and rehabilitation needs locally. • Implement an enhanced Individual Placement Support service. • Deliver physical health checks and interventions to people with severe mental illness. • Review Mental Health Workforce. • Develop a Mental Health Digital Strategy to maximise opportunities. *For specific detail on how these deliverables will be achieved please see Pages 58- 62 of the LLR Operational Plan 2019-20*
Outcomes and benefits	• Improved Mental Health access across the system to ensure parity of esteem and better outcomes for patients. • Reduction in acute lengths of stay leading to improved recovery and care in the community. • Ensuring the physically as well as mental health needs are being met for our populations.

Section 4: Key priorities – Learning Disabilities

Overview	During 2019/20 we will continue to ensure the delivery of responsible, high quality, appropriate learning disability services and support in the community that maximises independence, offers choice, are person-centred, good value, and meets the needs and aspirations of individuals and their family carers. In line with national guidance on Transforming Care, our all age approach focuses on transforming the care for people with learning disabilities and/or autism, including implementing enhanced community provision including forensic support, with a corresponding reduction in inpatient capacity, and undertaking our care and treatment reviews.
Why is it an important priority?	2019/20 will also see the publication on an LLR strategic vision for people with a learning disability and/or autism. This will support the local transition of the Transforming Care Partnership programme into "business as usual", and ensure that individuals with a learning disability and/or autism are supported to live as independently as possible and achieve a fulfilling life.
Key deliverables in 2019/20	• Continue to provide proactive, preventive care via Personal Health Budgets and review of short breaks. • Reduce inappropriate hospitalisation. • Continue to provide specialist multi-disciplinary support. • Improve health and wellbeing through prevention. • Improve access to health care checks through our Primary Care Providers. • Development of a new LLR complex care and rehabilitation pathway. • Support for Children and Young People: throughout 2019/20 we will work with partners to provide appropriate support with early intervention to prevent crisis, and admissions and improve pathways for transition. • Care, Education and Treatment Review (CETR): in 2019/20 we will continue to build upon our approach with CETRs to reduce inappropriate hospitalisation. *For specific detail on how these deliverables will be achieved please see Pages 63- 64 of the Leicester, Leicestershire and Rutland (LLR) Operational Plan 2019-20*
Outcomes and benefits	• Improved patient health and experience of healthcare services.

Section 4: Key priorities – Children and Adolescent Mental Health

Overview	Our ambition is that children & young people will have access to the right help at the right time through all stages of their emotional and mental health development. For this to happen, we have developed a whole system approach to delivering a range of emotional, mental health and wellbeing services that meet all levels of need. We have engaged with children & young people and their families and all stakeholders including education, social care, health, police, housing and justice. We have developed a shared work plan with key priorities and joint commissioning. We have improved the interfaces between our agencies to reduce fragmentation in commissioning and service delivery so that organisational boundaries are not barriers to care.
Why is it an important priority?	Children and young people need to have access to the right health through all stages of their emotional and mental health development. In LLR: • 1 in 10 children and young people will have a mental health disorder. • 1 in 20 children and young people will have a conduct disorder. • Approximately 3,000 children and young people will experience emotional disorder.
Key deliverables in 2019/20	• Work together across agencies to transform our children and young people's emotional, mental health and wellbeing services to create a system wide pathway of care. • To work across the system to improve access to the right service to meet their needs and reduce waiting times. • To focus on improving the quality and accuracy of the reporting and data provided to the system, through improved service specifications with key performance and quality indicators. • Increasing Skills and capacity of the workforce - to increase the number of C&YP accessing evidence based interventions. • Commence development of a new CAHMS unit. *For specific detail on how these deliverables will be achieved please see Pages 77- 78 of the Leicester, Leicestershire and Rutland (LLR) Operational Plan 2019-20*
Outcomes and benefits	• Improved Mental Health access across the system. • Reduction in acute lengths of stay leading to improved recovery and care in the community. • Improved service for eating disorders.

Section 4: Key priorities – Maternity, childrens and neonates

Overview	The system's focus is on improving outcomes in maternity, children's emotional health and wellbeing, young people and family services. This involves a range of organisations working together efficiently to improve productivity across universal, targeted and specialist services to improve outcomes for children and young people. The system has developed and continues to develop a New Children Hospital Model. The new model will consider choice and appropriate service delivery for children and young people aged 0 - to 18 and 365 days.
Why is it an important priority?	Leicester has a young population and the city is seeing major increases in the number of children and young people living here. The city is home to 130,726 children and young people aged up to 24 years, an increase of 12.5% since 2015, which is more than double the increase seen in England as a whole. This growth includes a big increase in the number of young children aged 0-4 years which rose by nearly 25% from 20,726 in 2005 to 25,884 in 2015. Life expectancy in Leicester is below the England average, with significant differences in how long people live according to where they live: many of the patterns for this are laid down in childhood. Children's health and well-being is therefore not only important as a goal in itself but is a key priority to improving the overall health of the entire area.
Key deliverables in 2019/20	• Deliver the New Children Hospital Model. • Continue to deliver the Children's Single Front Door Model. • Review joint commissioning arrangements for Children with SEND across LLR. • Develop an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies; a universal offer to all women who smoke during their pregnancy; support work to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. • Support local trusts with a maternity and neonatal service to be part of the National Maternal and Neonatal Health Safety Collaborative, supported by Local Learning Systems. • Roll out the Saving Babies Lives Care Bundle during 2019. To support the progress towards Maternity digital care records. • Continue to work with midwives, mothers and their families to implement continuity of carer. • To ensure maternity services deliver an accredited, evidence-based infant feeding programme. • Our plans to improve emotional health and wellbeing are described in the Child and Adolescent Mental Health sections. *For specific detail on how these deliverables will be achieved please see Pages 79- 81 of the Leicester, Leicestershire and Rutland (LLR) Operational Plan 2019-20*
Outcomes and Benefits	• Simplified and improved access to care. • Prevention strategies to reduce harm for both mother and child. • Improved outcomes for infant and children's healthcare.

Section 4: Key priorities – Prevention

Overview	The public sector has a crucial leadership role around prevention through its role as a major local employer and the priority it gives to prevention as part of core business. We want to accelerate this work locally by making sure that all staff are equipped to provide basic advice about healthy lifestyles and that patients who need extra support to make changes to improve their health and well-being can be referred onto lifestyle services that may help to reduce or slow down deterioration of existing conditions, or prevent other problems from developing. Our current plans focus on many of the key tenants of prevention, however in 2019/20 we will be reviewing and re-focusing our work, jointly with the local authorities to consider the key areas outlined in the Long Term Plan including: • Smoking • Obesity • Alcohol • Air Pollution • Antimicrobial resistance
Why is it an important priority?	The system recognises the key determinants of variations in health demography. As shown in Section 2 there is clear variation in access to health and outcomes, including life expectancy across LLR. The system recognises to target the variation in health outcomes there needs to be clear focus on targeted prevention and self-care provision and services.
Key deliverables in 2019/20	• Develop an inpatient smoking cessation provision. • Specific Pathway changes on: Cardiovascular Disease, Alcohol, Diabetes. • Make Every Contact Count. • Lifestyle services. • Self-care: develop new approaches to supporting self-care, including implementing a Healthy Living Pharmacy scheme across LLR. • Workplace health: prioritise workplace health across public sector providers. *For specific detail on how these deliverables will be achieved please see Pages 82- 84 of the Leicester, Leicestershire and Rutland (LLR) Operational Plan 2019-20*
Outcomes and benefits	Reduction in variation of Life Expectancy across LLR. Improvement in health outcomes.

Section 4: Key priorities – Medicines Optimisation

Overview	Medicines Optimisation is an STP work-stream supported by existing Medicines Optimisation activities in each individual organisation The collaborative work will be led by the LLR Medicine's Optimisation Programme Board. Over the last three years the NHS organisations in LLR have implemented a range of evidence-based prescribing measures. This has included medicine switches, reducing wastage and implementing local and national guidance. We recognise that there is still further work that can be done to improve medicine optimisation by working collaboratively across all NHS organisations both within the STP and beyond. To meet the needs of our population we are developing and implementing a LLR Pharmacy Workforce Strategy across the STP including a Pharmacy framework.
Why is it an important priority?	Nationally 6.5% of emergency admissions and re-admissions are caused by avoidable adverse reactions to medicines; there is over £150m a year of avoidable medicines wastage and only 16% of patients take their medicines as prescribed.
Key deliverables in 2019/20	• Sharing and standardisation (where possible) standards and policies across LLR. • Rationalise and streamline supply of medicines across the primary/secondary care interface. • Standardised Audit tool across LLR based on shared audit standards. • Develop a system wide medication safety strategy. • Reduce waste in primary and secondary care in relation to repeat prescription processes. • Develop effective medication reviews particularly aimed at decreasing admission, readmission and waste. • Improve the timely discharge of patients by piloting new ways of working and improve the appropriateness of prescriptions. • Continue the biosimilar switch programme enabled in 2018/19. • Interface with Care Homes across LLR. • Develop STP wide formularies, including electronic system of pre-approval of high cost drugs. *For specific detail on how these deliverables will be achieved please see Pages 53- 55 of the LLR Operational Plan 2019-20*
Outcomes and benefits	• Strong quality and safety assurance with the respect to the use of medicines. • A competent workforce to deliver Medicines Optimisation maximising benefits of a shared workforce and provision. • The financial investment in medicines will represent value for money and deliver the best outcomes for patients. • Patients will be empowered to be equal partners in all decisions about their medicines. • Reduction in avoidable adverse reactions to medicines. • Improve the timely discharge of patients.

Section 4: Key priorities – Specialised Commissioning

Overview	Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS. The specialised services commissioned by NHS England have been grouped into six National Programmes of Care (NPoC). Each has an NPoC Board which coordinates and prioritises work across the services in that programme of care. The six National Programmes of Care are: ➢ Internal medicine – digestion, renal, hepatobiliary and circulatory system. ➢ Cancer ➢ Mental health ➢ Trauma – traumatic injury, orthopedics, head and neck and rehabilitation. ➢ Women and children – women and children, congenital and inherited diseases. ➢ Blood and infection – infection, immunity and haematology.
Key deliverables in 2019/20	The Specialised Commissioning Strategic Priorities nationally are in development. The Midlands and East priorities have been developed with staff and stakeholders across the Midlands and East. These priorities form the basis of the operational plan and are underpinned by the national operational plan for specialised commissioning. The Deliverables and Enablers that underpin the Strategic Priorities have been developed to support our teams to deliver the national and regional priorities. **Midlands and East** • Cancer (HBP, West Midlands; Head & Neck, East Midlands; Upper GI, East Midlands) • Vascular • Neonatal Intensive Care • East Midlands capacity and configuration • ODN review • CHD Networks supporting Congenital Heart Disease (CHD) • Royal Orthopaedic Hospital • Sandwell & West Birmingham Cancer Services • Gynae Oncology

Section 4: Key priorities – Specialised Commissioning

Key deliverables in 2019/20	**General and Acute Services:** Cancer: • Working with the EMCA, implement the radiotherapy service specification and ODN. • *Work together on the urology pathway for robotic assisted surgery for radical prostatectomies.* • Implement the Children and Young People Cancer Service Specification and network arrangements. • Undertake a quality review of complex gynaecological cancer services and ensure quality standards are met. • Develop options for the head and neck cancer services across the East Midlands. Women and Children: • Review the provision of paediatric critical care and surgery; including addressing gaps in paediatric critical care transport services and setting up of a PIC and Surgery ODN. • Working with the LMS to implement recommendations of the National Maternity Review: Better Births to ensure mothers and babies have the best care; including ensuring capacity in neonatal services through reducing full term admissions; development of a neonatal outreach service (funding dependant); and improvements in system wide flows. Trauma: • Assess if there is a clinical need to change adult critical care pathways. • Embed the complex spinal surgery protocols and ODN, ensuring pathways are defined and there is a consistent quality of care across the East Midlands. Internal Medicine/Blood and Infection: • To set up asthma networks so that specialised asthma services are supporting non-specialised provider to ensure appropriate care. • Implement a lead haemoglobinopathy centre across the East Midlands and work towards ensuring sustainability of the services.

Section 4: Key priorities – Specialised Commissioning

Key deliverables in 2019/20	**Mental Health Services**: Child and Adolescent Mental Health (CAMHs): • Ongoing regional assessment for CAMHs services being undertaken by public health consultant to determine future need across the East Midlands as part of national Mental Health Service Review. • Expansion within East Midlands of CAMHs, PICU and Eating Disorder services**.** Transforming Care: • The Programme continues to work alongside CCG and LA commissioners to develop pathways from hospital to community. • Bed reduction plan work continues with our providers across the East Midlands to align service provision with identified need. • Providing support to local Transforming Care Boards. Adult Mental Health: • Continue to work towards a New Care Model with all providers in the East Midlands for adult secure services. Planned shadow process from April 2019/20 with go live April 2020/21. • Adult Secure Mental Health Service Review to review national capacity and the procurement of secure mental health services. **Future Planning and Services Development** There will be a Strategic Planning Board established by Specialised Commissioning in line with the guidance in early 2019/20 which will include all STPs and Trusts across the East Midlands. This will be used to share priority areas and with a view to aligning pathways and work streams. The local specialised commissioners are members of the STP Cancer Board. The Programme Board for the head and neck cancer project is led by Specialised Commissioning and includes representatives across all of the STPs from the East Midlands. https://www.england.nhs.uk/wp-content/uploads/2018/12/ANNEXE1.pdf

SECTION 5

ACTIVITY ASSUMPTIONS, CAPACITY & WINTER PLANNING

Section 5: Activity assumptions and capacity (Acute only)

Activity

Commissioners have developed a demand plan for 2019/20 recognising that the lead provider is unlikely to have sufficient capacity to meet demand. To mitigate this position the system has produced joint initiatives and an establish pathway review programme. As a system we have then reviewed all provider capacity and overlaid this onto the demand plan. The main challenge in order to deliver care to the assumed demand will be to ensure QIPP delivery and to manage how the released capacity is used in a managed way.

An activity triangulation meeting has been in place for the last year to ensure that provider and commissioners can identify and respond quickly to activity variances. It is intended that this group will continue and will report into the director level contract performance meeting. Included within the Activity Planning Assumptions (APA) is an agreed way of working together to manage to (or below) the indicative activity plan in a controlled way. All parties will have incentives aligned.

Capacity

Overall system demand and capacity has been modelled taking into account historic trends and seasonality to inform the plan. Numbers of days per month have also been factored in, as has the impact of the leap year. The system worked together early in 2018/19 to prepare a winter plan which has proved to be effective this winter. The same approach will be taken in preparation for the 2019/20 winter.

The system is well sighted on the demand requirements and available system capacity within the lead provider and Independent Sector (IS) and Out of County (OOC) providers. IS and OOC providers have supported the system to deliver the demand requirements in recent years.

The activity triangulation meeting will provide oversight on progress in terms of meeting the required demand and managing available capacity.

Section 5: Winter Planning Provider Plans

The System Priorities for Winter Planning have been outlined in the Urgent Care section and are managed via the A&E Delivery Board. All key providers are members of that Board including Local Authority, Primary Care, Acute, Community and Ambulance Trusts. Each provider and Local Authority has taken a System approach to Winter and Capacity Planning please see brief descriptions below:

Leicestershire Partnership NHS Trust

Winter planning is conducted collaboratively with partner organisations via the A&E Delivery Board and is supported by the LPT Protocol for the use of 4x4 vehicles which ensures our community staff can reach out to all patients in periods of disruptive weather.

The LPT Winter Contingency Plan is assured and tested through stakeholder table top exercises, and developmental activity with the Local Resilience Forum (LRF). This plan is reviewed during the winter period to ensure accuracy and validity of triggers and responses and is aligned to operational pressures escalation levels (OPEL) guidance. Services have local business continuity plans which are mobilised in the event of disruption to service delivery. The Trust actively conducts a Flu Fighting campaign in line with the NHSI national campaign to provide extra resilience for all frontline staff.

University Hospitals of Leicester NHS Trust

The Trust leads a programme of work across the LLR STP area to design an enhanced system of care for frail and multi-morbid patients across the local health and care system, this will continue into 2019/20. The objective of this 'Frailty task force' will be to ensure that this cohort of patients have access to evidence-based integrated care both pre-, during and post-hospital episodes. Our plans are based on the Kings Fund 'High Impact Interventions' this programme will enable capacity throughout the system but particularly in Winter.

Secondly the Trust is attempting to protect some of the elective capacity by **increasing overall bed capacity** as part of winter resilience plans. We have assumed that we will open the same number of escalation beds as we did as part of the 2018/19 winter plan. This means we plan to open 28 escalation beds at the Glenfield and 2 x 28 bedded wards at the LRI during periods of sustained changes in demand; this will enable us to protect emergency and elective flow. We will use the final 19/20 plans to model the beds required for in 19/20 based on a range of different bed occupancy assumptions.

Local Authorities

The three Local Authorities in LLR have reviewed their allocation for winter funding monies for 2019/20 and made clear plans in conjunction with the System for appropriate expenditure. Examples of how this investment is being prioritised to support system wide winter planning include trusted assessment and telemedicine solutions for care homes, additional placements/packages of care, and investing in the integrated reablement offer (e.g. therapy and case management resources).

SECTION 6

SYSTEM FINANCIAL POSITION, RISK MANAGEMENT, CURRENT SYSTEM EFFICIENCIES & FUTURE SYSTEM ARRANGEMENTS

Financial position

- In 2018/19 all organisations (excluding UHL) are on plan to achieve their control totals.
- Control totals set for CCGs in 2019/20 are proving challenging due to 2018/19 exit underlying positions.
- Realistic control totals have been set for providers which take account of 2018/19 performance.
- All organisations are aiming to achieve control totals set for 2019/20 but CCGs and LPT currently have unidentified QIPP and therefore potential unmitigated net risks of £15.26m

Organisation	Gross Control Total	Receipt of Centralised Funding (PSF, FRF & MRET)	Control Total	Net Unmitigated Risk to achievement of control total
	£m	£m	£m	£m
UHL	-48.7	38.1	-10.7	3.06
LPT	0	2.1	2.1	0.96
LCCCG	0	0	0	
ELRCCG	0	0	0	5.98
WLCCG	0	0	0	5.26
LLR STP Total	-48.7	40.2	-8.5	15.26

Section 6: Current System Efficiencies

Our financial modelling for 2019/20 requires an unprecedented level of system-wide efficiencies to be delivered across LLR to support financial and capacity stability across the system. Many of the system-wide schemes are intended to involve service transformation such as new models of care, service configuration and re-designed pathways. The CCGs and providers have produced a number of schemes and plans to improve efficiency and value for money focusing on Integrated Care, planned care and joint working on areas such as Medicines Management.

The schemes have been developed in partnership across LLR as part of the Better Care Together Programme and system planning process and have undergone a 'confirm and challenge' process to ensure they are clinically safe and financially robust to move the system towards its goals and have been developed in conjunction with the local clinicians. They have considered available benchmarking data such as Rightcare, Model Hospital and GIRFT .

- 2019/20 progress against savings targets is set out below.
- Savings plans are classified between Red, Amber and Green or unidentified based on expected financial delivery at this point in time.
- Against the total level of savings planned of £99m, there is currently a risk of non delivery of £29.6m across the system

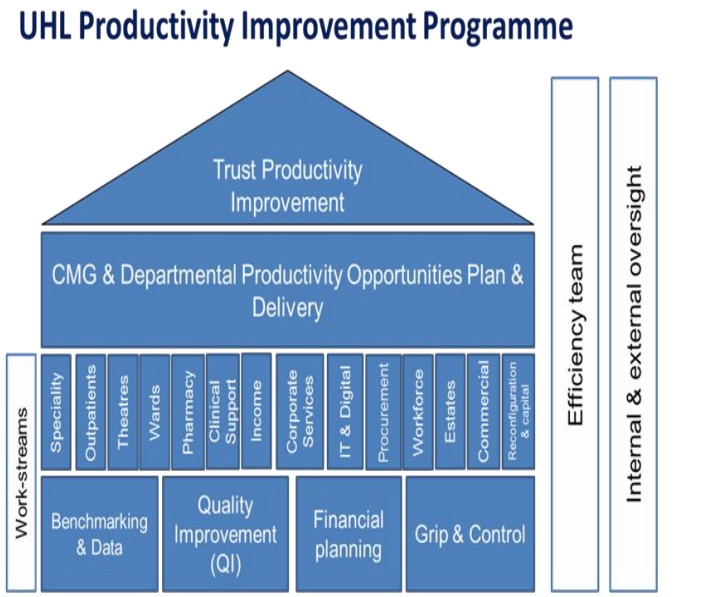
Organisation	RED	AMBER	GREEN	UNIDENTIFIED	TOTAL SAVING PLANNED	RISK (100% Unidentifed, 50% Red, 25% Amber)
	£000	£000	£000	£000	£000	£000
UHL	4,744	11,713	7,125	3,062	26,644	8,362
LPT		2,128	3,929	954	7,011	1,486
CITY CCG	2,809	4,109	10,112	0	17,030	2,432
EAST CCG	2,909	7,527	10,000	5,980	26,416	9,316
WEST CCG	3,060	4,773	9,259	5,264	22,356	7,987
LLR ICS TOTAL	13,522	30,250	40,425	15,260	99,457	29,583

Section 6: Current System Efficiencies Specific to Providers

Specific efficiency savings for 2019/20 for University Hospitals of Leicester

The trust has a comprehensive three year Efficiency Strategy with the aim of achieving upper quartile productivity (compared to peers) across all areas for the Trust. This strategy is based around a wide range of sources including the following:

- NHSI Model Hospital.
- Recommendations for the Carter Programme.
- The Getting it Right First Time (GIRFT) Programme.
- NHSI Theatre Efficiency Programme (using Four Eyes consultancy).
- The Trust's 5 year strategy.



Specific efficiency savings for 2019/20 for Leicestershire Partnership Trust

The planned efficiency saving target for 2019/20 equates to 2.5% of operating costs. Progress in identifying this level of efficiency has proved very difficult in the context of rising operational pressures and with large scale transformation.

Therefore the trust is drafting a long term productivity, efficiency and sustainability plan which will define the work the Trust needs to do to ensure long term transformational change. As this strategy has not yet delivered the framework for long term plans, the Trust may need to deliver the minimum level of CIP requirement in 2019/20.

Quality Impact Assessments and Governance

The commissioners and providers have produced a clear governance and processes to ensure that all defined efficiencies across the system are in line with National Quality Board Guidance. Details are contained within each individual organisations Operational Plan and outlined in their Quality Strategies. The CCGs have engaged in a Joint Clinical and Quality review process for Business Cases and QiPP Initiatives prior to approval. Regular system quality reviews are held with providers through established Clinical Quality Review Group. The Executive Lead for the STP is the Interim Accountable Officer of West Leicestershire CCG.

Section 6: Future System Arrangements & Plans for closing the gap

In relation to the delivery of the LLR System Control Total, the previous slide shows that as a system there is:

- A total of up to £29.6m of risk across all organisations in delivering cost savings and hence control totals.
- Net risk of circa £11.2m within CCG plans.

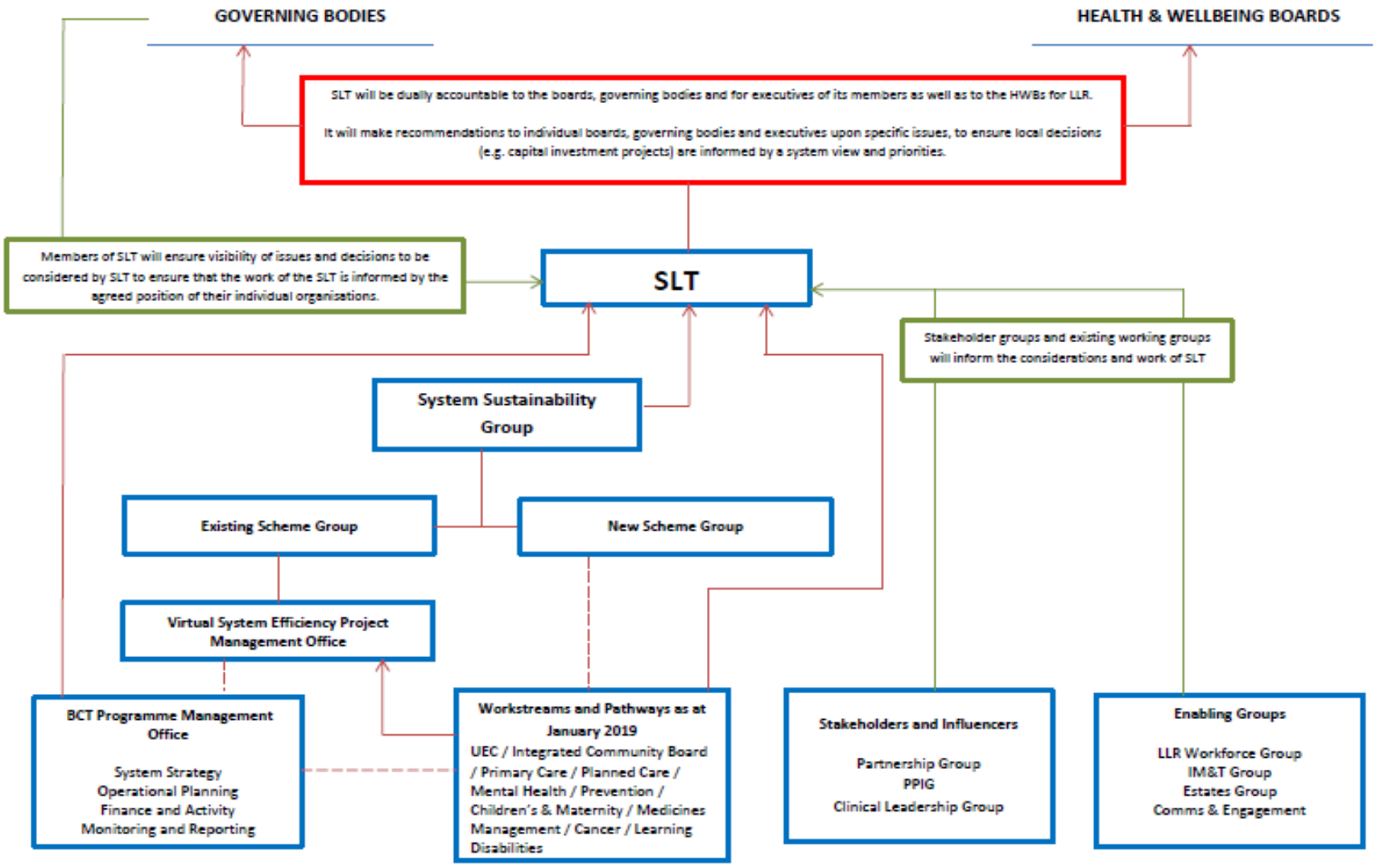
In order to mitigate this risk and deliver the system control total the following describes our high level governance to close the gap, working as a system.

The actions in the plan and approach are based on the LLR system working together on a cost out approach. There are actions that commissioners and providers could take, such as coding and counting actions and provider fines, but at this stage the system has agreed that the solution to financial sustainability is to focus on costs out rather than adversarial approaches that just move the financial problem between organisations. The system will need to agree how it ensures no single system partner is unfairly disadvantaged by taking this approach.

Key Steps

- Commence delivery of current financial plans and efficiencies identified
- Identify further efficiencies and use of contingency to close the gap April to June 2019
- Establish system wide Sustainability Group to ensure system delivery of current plans and identification and implementation of actions required to close the gap

Section 6: Proposed Governance Arrangements for System Sustainability Group & support groups i.e. 'Existing Scheme Group' & 'New Scheme Group'



Section 6: Proposed purpose and responsibilities of the System Sustainability Group

Purpose:
To work together to ensure that Leicester, Leicestershire and Rutland health system can deliver the system control total set by NHSE and NHSI

Responsibilities
Function 1 - Implementing existing Schemes
Function 2 - Developing New Schemes
Function 3 - System monitoring
Function 4 – Escalation

The Group will be jointly owned and supported with:

- A dedicated executive lead (released from current responsibilities) identified to support the delivery of the system wide control totals and efficiency plans.
- A virtual system wide Programme Management Office will be established utilising current commissioner and provider resources.
- System wide reporting process and templates will be put in place to ensure a consistent approach across all programmes and projects.
- Each programme or project will have a Senior Responsible Officer and Implementation Officer and be supported by the relevant finance, contracting, BI and planning expertise.
- Purpose being to maximise delivery of existing QIPP & CIP programmes focussed on a “cost out” approach.

Section 6: Risk Management

The key risks to the system achieving the financial targets are:

- Underlying financial positions of organisations in comparison to control targets set.
- Managing demand growth.
- Making sufficient savings/efficiencies in order to deliver control totals.
- Financial delivery conflicts with other key priorities.
- Delivering in year whilst also ensuring actions are aligned to the Longer Term Strategy.
- Commissioners entering a year of organisational change as they move towards a single management team and explore potential merger.
- Significant changes to financial architecture and Primary Care Commissioning.
- Achievement of Mental Health investment standard and other metrics.
- Successful implementation of the QiPP Programme

SECTION 7

ENABLERS

Section 7: Enablers – IM&T and Digital

Overview	Our ambition is to use an integrated patient record to improve patient care and safety and deliver significant savings to the LLR health and care system in terms of money and time. However, there are a number of challenges to overcome in order to achieve this aim. Within the local health care system organisations have their own IT systems, which in many cases are unable to share and make use of each other's information. This is a significant barrier to creating a transferable care record. It would be far safer and more efficient if clinical systems in use by different health and social care organisations were integrated or just the same. There is currently no national solution to achieve this. Locally we recognise that using existing systems and national initiatives that become available is better than ad hoc or separate systems. The NHS Long Term Plan (January 2019) compliments this locally derived ambitions. In addition, there is a challenge in supporting staff to take up new IT solutions. Previous technological improvements have not been adopted by all of the workforce and full benefit has not been realised. Similarly, communication and engagement is needed with patients to make them aware of the health and social care benefits that are becoming available with better use of technology.
Why is it an important priority?	• Improve communication within Health and Care, e.g. communication between hospitals and GP practices can be refined to highlight actions points to improve the quality of care. By removing the use of paper and moving the majority onto secure electronic communications and deliver paper free at point of care, with a key focus to make the use of fax obsolete as a method of communication. • Not only will this integration and improvement be safer and more efficient in terms of time and money spent by the NHS, it will also make a huge difference to the patient experience, since people will not have to constantly repeat the same information whenever they are transferred from one part of the system to the other. • In addition, the LLR vision includes empowering patients to use technology, like apps, to support self-care but with the promise of direct access to services should the patient require it, as opposed to booked follow up appointments and clinics. • Use of real-time and historic data will help predictive modelling and improvements in clinical service delivery at the point of care. While population health analysis will support the planning and purchase of health services for local people.

Section 7: Enablers – IM&T

Key deliverables in 2019/20	• The LLR IM&T continues to work towards extending TPP SystmOne as the main system supporting pathways in the community and Trusts so that all providers have access to records. • Support the University Hospitals of Leicester in its progress to paperless system management. • Continue to support PRISM as a pathway navigation tool, ensure there is robust governance of SystmOne and EMIS templates, and that there is electronic transmission of that information along the pathway. • Develop through a partnership approach a resource of shared expertise within LLR to blend a mixture of procurement, integration, business change and product development to deliver a set of Digital Self Care products (Apps) supporting patients and clinicians, initial target areas being scoped are Falls, Prevention and Out-Patient Follow Up reduction. • Support the implementation of an LLR business intelligence strategy, including data sources, storage and analytic tools and develop a collaborative approach to the utilisation of this shared resource. • Support the implementation of a Research and Development Primary Care data extraction and analysis service to combine with secondary and social care data. • Commencement of work to move LPT to a single electronic patient record. • Responding to the NHS Long Term Plan in relation to digital offer including assistive technology in the home, new tools for professionals and consumer to use to interact with the NHS and each other and developing business intelligence capabilities. *For specific detail on how these deliverables will be achieved please see Page 87- 89 of the Leicester, Leicestershire and Rutland (LLR) Operational Plan 2019-20*
Outcomes and benefits	• Improved patient experience by increased access to the whole patient record. • Improved patient experience through reduced repetition of their health care needs. • Improved patient experience via reduced unnecessary travel.

Section 7: Enablers - Workforce

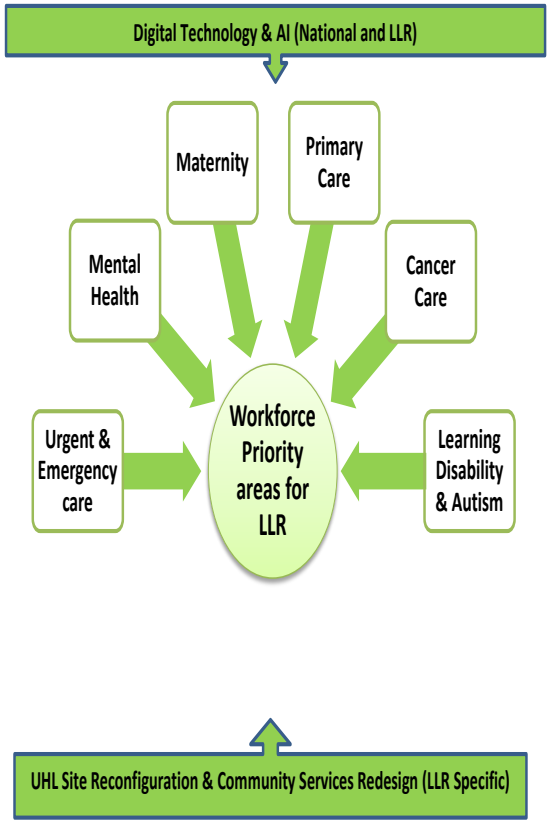
There is approximately 20,000 whole time equivalent healthcare staff currently working across the three main NHS provider organisations in LLR. As with Adult Social care, many of the challenges faced by NHS providers of healthcare reflect the national situation. Private providers contracted to deliver services in LLR are also feeling the effect of workforce challenges. There are recruitment issues and high vacancies across a number of staff ground which are reflective of the national picture.

LLR as part of its whole system approach is developing a System-wide Workforce Strategy. The approach has considered all provider workforce issues and also considered national guidance as outlined in The *Facing the Facts, Shaping the Future (2017)* workforce consultation document which highlighted six workforce priority areas aligned to the Next Steps Five Year Forward View priority areas with the inclusion of Maternity and a spotlight on Learning Disability. Individual provider workforce initiatives including the GP Workforce Plan can be reviewed in the individual organisations Operational Plan.

There are a number of key work-streams across LLR that bring together key improvements in patient care plus improving workforce pressures. For instance, a Community Services Redesign programme has been launched which will significantly change how we deliver care with a focus on Home First and community care rather than acute based care. This will require a redesign of the workforce to support the changing models of care as they emerge. There is also a Pre Consultation Business Case submission which proposes the majority of acute services to be based on two sites which will improve delivery of care and improvements in working conditions for staff. We acknowledge the need to embrace the advancements in digital technologies, AI and genomics. Digitalisation has the ability to take pressure off the workforce in all aspects of care delivery from booking appointments on-line to telemedicine.

We have acknowledged that we cannot continue to grow the workforce in line with population increases and the greater use of digital technologies will support this.

With the recent publication of the NHS Long Term Plan, service commissioners and providers will be reviewing models of care to ensure that we make every attempt to future proof healthcare for future populations.



Section 7: Enablers - Workforce

University Hospitals of Leicester and Leicestershire Partnership Trust

UHL is one of the country's largest acute teaching Trusts and provides health and care services across three sites for the population of LLR, specialised clinical services for the population of the East Midlands and some highly complex services nationally. There is a compelling clinical case for movement of the majority of services onto a two site model allowing greater separation of emergency and elective pathways in order to improve flow and reduce the number of cancellations. The three site models impacts significantly on the workforce, stretching resources and increasing pressure on staff.

Leicestershire Partnership Trust is undertaking the biggest transformation in response to the mental health drivers and the All Age Transformation programme, the Transforming Care Partnership's Learning Disability and Autism strategic workforce plan and the Community Services redesign programme.

UHL & LPT Key Workforce Facts

- The gap in nursing is one of the most significant risks to the healthcare workforce
- UHL has the highest vacancies are in nursing qualified (572wte) and non-qualified (135wte) representing just over half of all Trust vacancies
- Actual contracted nursing WTEs has risen by 1.51% last 12 months
- Overall vacancy rate of 8% (circa 1000 wte) has remained unchanged last 12 months
- Highest medical vacancies in at senior levels in Emergency Specialist Medicine and cardiorespiratory

General Practice

The local picture mirrors the national evidence of significantly lower growth in GPs compared to hospital consultants in the last decade. This creates a shortage of GPs compounded by substantial difficulties with recruitment, both of qualified GPs and GP trainees, with local training places unfilled. There are fewer GPs working full-time in patient- facing General Practice, some working full-time but taking on other responsibilities, including roles in Clinical Commissioning Groups (CCGs), management tasks in their own practice or in a wider federation. There is also a growing demand for GPs to take on substantive posts or provide sessional work within community urgent care provision and out of hours.

General Practice Key Workforce Facts:

- Vast differences in numbers of GPs and other health professionals per 1000 registered patients partly due to historical funding, but also the challenge of recruitment in inner city and more deprived areas
- Significant proportion of GPs and Practice nurses will be retiring in the next 5-10 years, often in areas that are already under doctored
- Practices are finding it increasingly difficult to recruit and retain GPs
- Many older GPs are choosing to retire early and fewer are opting to take full-time clinical work
- Fewer doctors aspire to become partners
- Recruitment and retention challenges of other members of the primary care team, particularly practice nurses and practice managers
- Lack of career progression and/or training opportunities as a practice nurse has made the profession less popular and has led to gaps in capacity
- Fewer GP trainees in the system who wish to become salaried GPs or partners is driving market forces and locum rates are rising disproportionately

Section 7: Enablers - Workforce

East Midlands Ambulance Service

EMAS provides emergency and urgent services for 4.8 million people across six counties of the East Midlands.

EMAS Key Workforce Facts:

- Challenge to meet NHSE workforce trajectory
- Recruiting newly qualified paramedics from Australia
- Recruitment from EU states less successful due to amount of up-skilling required
- Band 6 paramedic posts are being developed to deliver See & Treat, the Frailty pathway and mentorship and this is being done through both external and internal CPD education programmes
- Reviewing our aspiration to have 50:50 split of registered and non-registered staff with a paramedic on every crew – 150 in total
- Supply of NQ paramedics not meeting demand (De Montfort University starting Paramedicine BSc (Hons) commencing September 2019 to attract local trainees)
- Competition for paramedics to work in other parts of the healthcare system such as general practice and urgent care centres further impacts on EMAS workforce
- EMAS currently filling paramedic vacancies with Technician roles and are considering employment of ANPs
- Sickness levels at 5.22% against target of 5.2%
- Exploring retention strategies guaranteed rest day are now in place
- Heavily reliant on private ambulances due to workforce challenges this will continue through Quarter 1 and 2 of 2019/19

Contracted Non-NHS Health and Care Providers

The workforce consists of health advisors, advanced nurse practitioners with GP cover, despatchers, receptionists, admin support officers.

The workforce is moving from complete sessional and agency working to substantive posts, although vacancy rates in the clinical workforce remain high (62%). There is a significant reliance on sessional working and agency workers with a strategy to reduce agency spend and convert agency workers to substantive posts. There are no substantive posts; all posts are sessional or agency. GPs that work in the service are working within general practice which will be putting additional pressure on the general practice workforce which is already understaffed. Since its establishment in July 2018, DHU has recruited 157 new members of staff. The Home Visiting service is predominantly a nursing workforce and tends to be 50:50 agency and substantive.

Contracted Non-NHS Provider Key Workforce:

- High reliance on sessional and agency workers
- Problems with recruitment to substantive posts
- Reliance on general practice and ANPs (already stretched workforce and under-supply)
- DHU has particular issues with attracting high calibre ANPs and is looking to develop its own pathway to recruit and train staff
- High vacancy rates at DHU
- Need to reduce agency spend
- Concerns regarding the number of hours that sessional clinicians and agency workers are working elsewhere
- DHU able to flex staff across the geography and between services

Section 7: Enablers - Workforce

10 LLR System Mitigations

1. A Nursing Associate Programme has been developed in partnership with the local education provider to support a career pathway from HCA to Registered nurse.

2. Return to practice programmes for nurses, doctors and therapists who want to return to work.

3. Increase in Apprenticeship opportunities including clinical apprentices and making best use of the levy across LLR.

4. Career progression opportunities such as the Nurse Associate role.

5. Introduction of more flexible working for staff, particularly medical trainees.

6. Development of new and extended roles such as advanced practitioners and Physician Associates.

7. Better sickness reporting procedures plus support for staff with common ailments e.g. back problems , anxiety, stress and depression.

8. Development of a talent pipeline .

9. Design and development of a LLR wide Pharmacy Workforce.

10. National strategy to recruit more trainee doctors.

10 Specific Provider Mitigations

1. Use of Recruitment & Retention Premium.

2. Systematic processes for the creation and development of New Roles.

3. Identifying and supporting staff who are effected by EU Exit.

4. International Recruitment Programmes.

5. Shared posts from Acute into Community.

6. Reviewing 'hotspots' in regards retention and improving exit interviews.

7. Rotational Trust Grade Programmes.

8. Certificate of Eligibility for Specialist Registration (CESR) Programme for Doctors.

9. Increased internal Medicine training numbers.

10. Implementation of Health & Well-being Annual Plans .

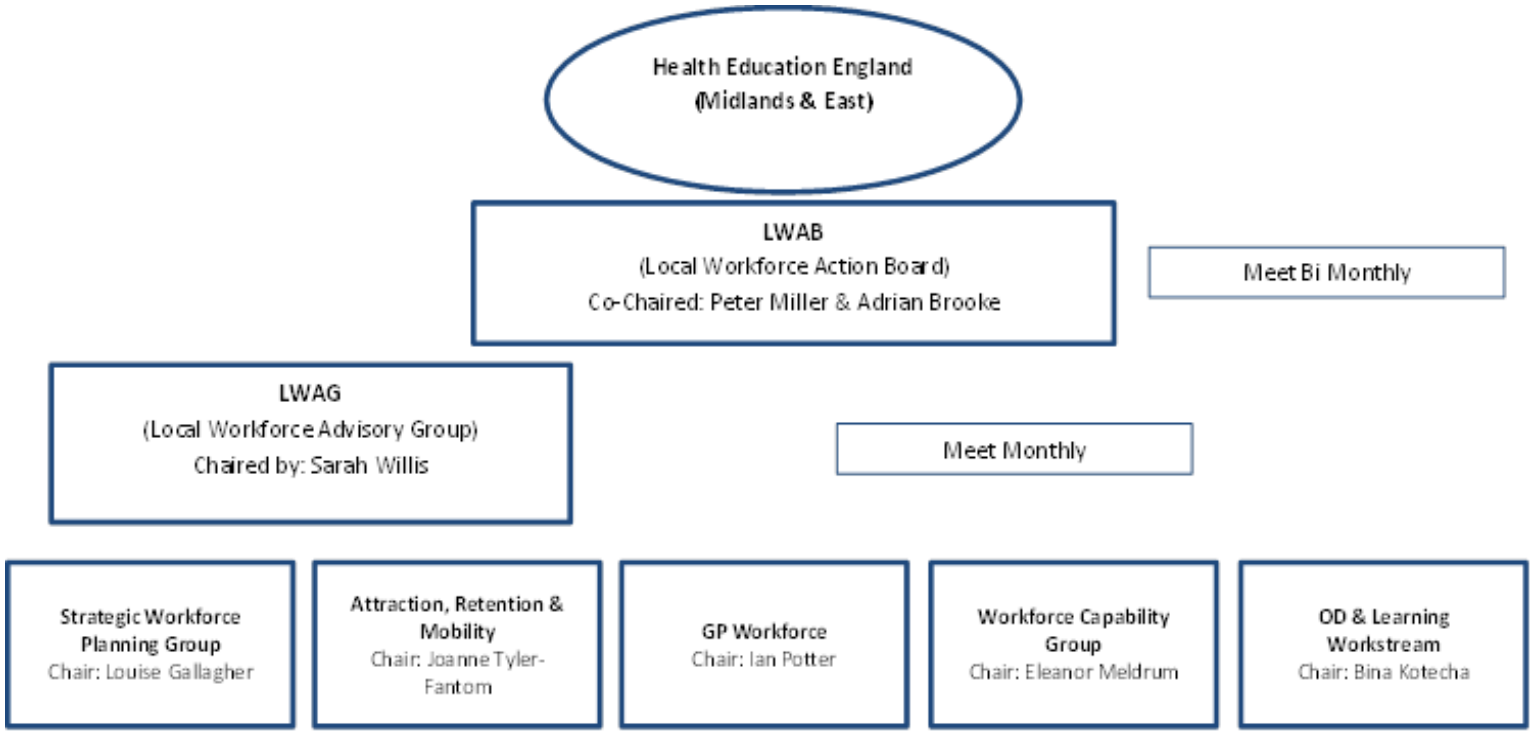
Section 7: Enablers - Workforce

Supporting Transformation of the LLR Workforce: Given the workforce challenges and context locally and nationally, this section outlines how we will organise ourselves locally to deliver the required changes described in more detail in the LLR Workforce Plan. All LLR workforce plans will be developed using The Six Steps Methodology to Integrated Workforce Planning template to provide consistency. Workforce planning and development across LLR is governed through a structure that is responsible for setting the strategic direction of the LLR workforce.

Governance Arrangements:

Health Education England (Midlands & East) is supporting the workforce elements of the Sustainability and Transformation Partnership (STP) through the Local Workforce Action Board (LWAB). Established in 2016, the LWAB will ensure that decisions about the NHS and social care workforce take place in the right place at the right time with the right people to deliver high quality outcomes for our people. LWAB has two areas of responsibility:

- Supporting STPs across a broad range workforce and HR activity.
- Local delivery of the HEE Mandate from the Department of Health and other key workforce priorities in line with national policies.



Section 7: Enablers – Communications and engagement

Engagement has been integral to the Better Care Together Programme (BCT) – the Sustainability and Transformation Partnership for Leicester, Leicestershire and Rutland since it was established. A wide variety of stakeholders have been involved ranging from statutory bodies, elected officials, local authorities, the voluntary and community sector, right through to patient and public groups.

In 2018/19 intensive communication discussing the acute and maternity reconfiguration, the community services redesign and other CCG level projects took place. BCT partners collectively undertook this engagement.

In addition, individually BCT partners have engaged and involved patients, carers, staff and other stakeholder in the various aspects of BCT work stream activities. This work has included engagement on the Carers Strategy, the Dementia Strategy, All Age Transformation for Mental Health and Learning Disabilities. We have also undertaken a formal consultation on Planned Care Policies across LLR.

The insights and business intelligence yielded from this engagement work has been fed into each work stream in order to impact the design of services, and where required the pre-consultation businesses cases to determine the shape of future services.

Engagement in 2019/20

In 2019/20 year there are a number of schemes within Better Care Together that require engagement and involvement with patients, service users, carers and staff to understand their experiences of the care they receive and what matters most to them. In addition, a number of schemes previously engaged on are now at a stage where formal consultation is required.

Topics for engagement and involvement which will be led by either clinical commissioning groups or providers partners are potentially:

- Changes and improvements within primary care.
- Community services review.
- Various planned care services including dermatology and ophthalmology.
- All age mental health transformation.
- Learning Disability.
- Improving Access to Psychological Therapies (IAPT).
- Various schemes within the Integration agenda including Long Term Conditions.

Section 7: Enablers – Communications and engagement

Each area will be reviewed and the appropriate level of engagement and consultation acted upon.

In addition, we continue to work through the processes of approval on the reconfiguration of acute and maternity services provided at University Hospitals of Leicester NHS Trust. We also wait to hear whether our bid for capital funds has been successful. The scheme is working through the processes of NHS England, NHS Improvement, the Department of Health and Treasury. While this process is being followed it is essential that ongoing engagement on these programmes of work continues in order to keep people informed and involved.

The Hinckley Community Services Review will be formally consulted on during 2019/20. The timing of the consultation will be dependent on the approvals process of NHS England.

At a local level we are also responsible for communicating this year the vision and direction of travel of the national Long Term Plan and articulating what the plan means for LLR and how it aligns with our local plans. This work will take place concurrently with the ongoing engagement and consultation of BCT programmes. It will inform the local refresh of our BCT plan, to be produced later in the year.

In order to complement the engagement work undertaken by BCT partners collectively and through work streams we will launch in 2019/20 a BCT Citizens' Panel. The Panel will provide the Partnership with an additional systematic approach to gathering insight and feedback on a range of health and care issues from a representative sample of our circa 1.1 million population. It will also assist in aligning the Patient and Public Involvement Group with the views of citizens that demographically and attitudinally are representative of the citizens of LLR.

We will work with partners to recruit by the end of the financial year 1,100 people to a virtually panel ensuring that representation is statistically and demographically aligned with our entire population as well as in tune with their attitudes.

Section 7: Enablers – Clinical leadership

An LLR wide clinical leadership group has been established since 2014. This has multi-professional representation from primary care, secondary care, local authorities, universities and patient groups.

A programme of work has been developed including quarterly 'MATH' (Making Things Happen) events which are system wide and focused on implementation, development of and participation in several leadership development programmes , through the OD leads in the system and attendance at national STP leads events .

Over 100 clinicians are involved in the BCT programme through nine clinical workstreams. Current plans include:

- Developing the Clinical Leadership Group to meet the needs of the Integrated Care System via a development workshop working with the national STP team.
- Provisional plans to introduce four principal clinical leadership roles in the BCT (GP, consultant, therapist, nursing).
- Rationalisation of GP clinical leadership roles including a LLR GP reference group.

All the CCGs are involved in a NHS Commissioning Capability Programme (CPP).

Section 7: Enablers – Estates

The NHS estate across Leicester, Leicestershire and Rutland totals 464,034m² over 252 sites (mixture of owned and leased) with an annual running costs of circa £146m. Conditions across the sites varies from modern purpose built facilities to converted residential properties. Our acute estate is suboptimal in clinical, performance and financial terms. In order to improve the estate across LLR, tackle the challenges of the current configuration and condition and respond to the future healthcare requirements we have set out a vision and ambition for our estate.

Vision	Ambitions
➢ Services should be delivered from an estate which meets clinical need; is accessible; offers value for money; is of acceptable quality; and meets safety and legislative compliance, supporting integrated teams working out of community hubs. ➢ Wherever possible, buildings will be designed to be flexible to adapt to changing needs over time. ➢ Use of physical assets will be maximised. ➢ The estate is of mixed tenure should be adapt to changes in service need. ➢ The use of technology will be maximised to support efficient and agile working practices and reduce dependence on fixed office accommodation. ➢ Building utilisation rates should be a minimum of 85%. ➢ Public sector assets will be promoted to maximise utilisation. ➢ Property will be invested in to provide modern, fit-for-purpose, 21st century facilities reducing backlog maintenance and running costs.	➢Developing the estate, subject to significant public investment, so there are appropriate facilities in which to deliver 21st century healthcare as efficiently as possible. ➢Continuing to develop our proposals for the reconfiguration of the Sustainability and Transformation Partnership's acute hospitals including a move of services to predominately 2 Acute Trust sites from 3. ➢Ensuring better utilisation across the estate to facilitate improved care in the community including Community Hospitals. ➢Reviewing the facilities we will need in the community as more care moves out of those acute hospitals closer to people's homes. ➢Improving Primary Care facilities enabling GPs to provide a wider range of services. ➢Providing improved inpatient and outpatient services including diagnostics.

Our key priorities for 2019/20:

- Complete the construction of new ITU and associated services by Quarter 1 2020/21.
- Complete the CAMHS and Eating Disorder new unit by Quarter 4 2019/20.
- Gain approval for the Hinckley and Bosworth community services Pre Consultation Business Case and consult on the proposed changes.
- Gain approval for the Pre Consultation Business care for the reconfiguration of acute hospital services.
- Develop primary care estate strategy.
- Continue to support practices who have received funding to improve their premises.
- Work with our partners on the One Public Estate Programme.

Appendices

The Leicester, Leicestershire and Rutland Draft 2019/20 Integrated Care System Operational Plan consolidates the transformation and operational plans from across the system. The System Operational Plan should be read in the context of the LLR Operational Plan, University of Leicester NHS Trust and Leicestershire Partnership NHS Trust Operational Plans