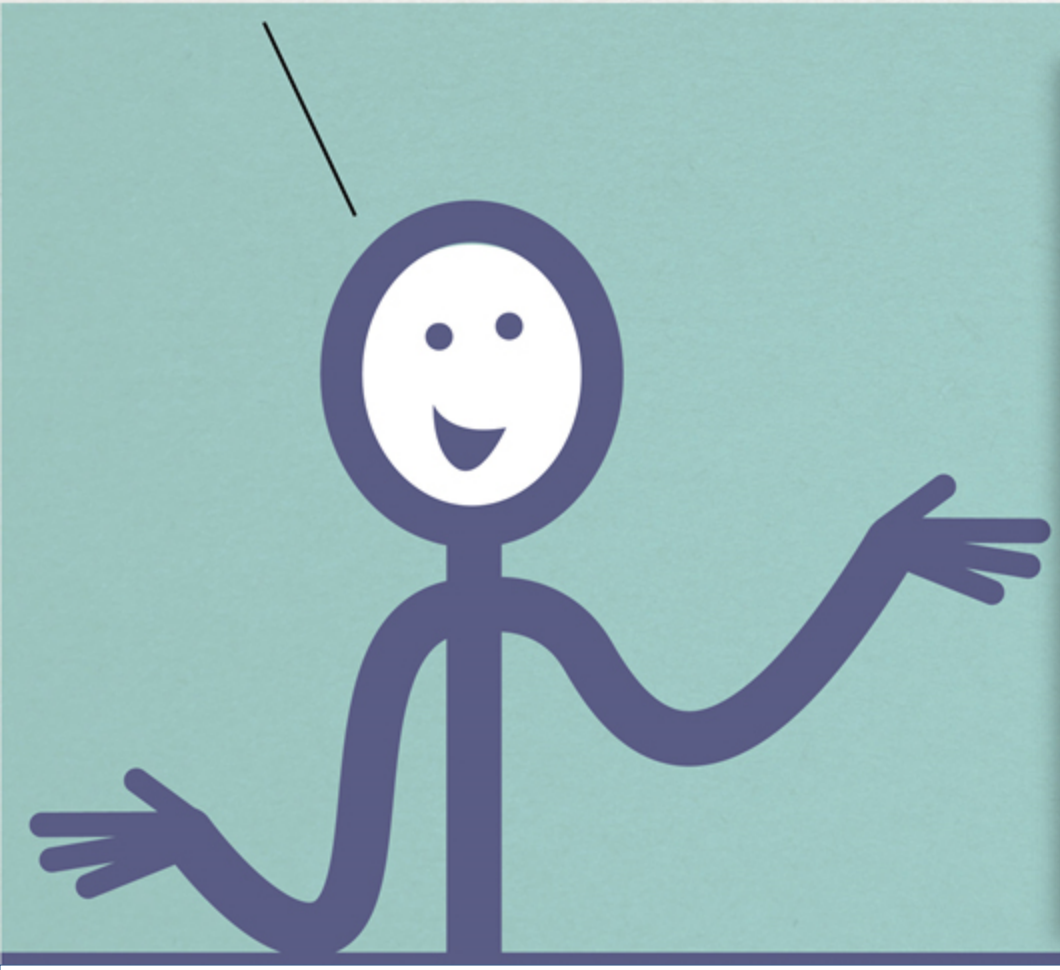
'It's about our life, our health, our care, our family and our community'

Better care together
Leicester, Leicestershire & Rutland health and social care



STP Footprint:

Leicester, Leicestershire & Rutland (No.15)

Region: Midlands & East

Nominated Footprint Lead:
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Organisations within footprint:

NHS East Leicestershire and Rutland Clinical Commissioning Group

NHS Leicester City Clinical Commissioning Group

NHS West Leicestershire Clinical Commissioning Group

University Hospitals of Leicester NHS Trust

East Midlands Ambulance Service NHS Trust

Leicestershire County Council

Rutland County Council

Leicester Partnership NHS Trust

Leicester City Council

LLR context

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- Leicester, Leicestershire and Rutland has a well established whole system strategic transformation programme in place called Better Care Together (BCT)
- This health and care programme was stimulated by the nationally supported Challenged Health Economy work in 2014 and is now in its third year
- LLR has been externally recognised as having made huge progress over recent years in strengthening relationships and system leadership
- On 10 March senior representatives from the BCT partners came together to review progress to date and identify next step areas of focus:

✓ Strong partner support
✓ Clear work streams with clinical & patient involvement
✓ Good early delivery in some areas (e.g. BCF & reducing DTOC)
✓ Clear proposals for acute reconfiguration
✓ And difficult choices re number and configuration of community hospital inpatient wards
✓ Aiming for formal public consultation summer 2016

× Some early implementation not having anticipated impact (e.g. LRI UEC)
× Some work stream plans not clear (e.g. older people) or ambitious enough (e.g. shared records/care plans)
× Decision making and governance complicated
× Pace of implementation generally too slow, impacted on by organisational position and funding
× Some issues not adequately addressed (e.g. model of general practice)
× Some opportunities not fully exploited (e.g. public sector estate)

- Strong local consensus that the BCT programme is already addressing some of our systems underlying and long standing issues (e.g. acute hospital configuration) but that there is much more to do and the scale of the challenge has increased given the public sector financial climate
- Therefore collective agreement to approach STP development as BCT 'Phase II'

1. Leadership, Governance and Engagement

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Collaborative leadership and decision making:

- The LLR STP is being developed through our existing BCT leadership and decision making arrangements. These include:
  - An overarching Partnership Board, independently Chaired, and including senior clinical, patient, managerial and lay/NED input from all partner (NHS, LA and Healthwatch) organisations
  - A Clinical Leadership Group which brings together senior medical and nursing leads to shape clinical service models
  - A Chief Officers Group with executive authority for managing development of the programme
- Our STP lead is supported by a nominated CCG strategy exec lead (Sarah Prema), the BCT Programme Director (Mary Barber) and PMO. Wider partner support is provided through a new fortnightly STP Task Group comprising senior managerial input from all organisations
- Decision making arrangements are being strengthened by moving the Commissioning Collaborative Board to being a formal Joint Committee of each of the 3 LLR CCGs with delegated authority to enable decisions to be taken post consultation

An inclusive process:

- The initial shape of our emerging STP has been developed through an open and inclusive conversation across the system
- Individual STP discussions, focused on identifying the key local challenges that the STP needs to address, have been held during April with Board/exec teams/strategy groups of NHS and LA partners
- STP development will build on existing patient and wider community involvement mechanisms including an active Patient Involvement Group, Equalities Group and voluntary sector forum
- Initial areas of focus have been shaped by recent Healthwatch intelligence (e.g. 'Your Voice Matters' survey)

Local government involvement:

- The three upper tier local authorities in LLR are all active partners in the BCT programme and governance
- All 3 LAs have been involved during April in the initial thinking around the shape and areas of focus of our STP
- HWB Chairs are Partnership Board members and we have agreed that wider formal member engagement will be through the 3 HWBs supplemented by using scheduled informal member and political briefings
- Health is not currently a main focus of local devolution proposals for Leicester and Leicestershire but there is the potential for this to broaden through the STP process (see section 4)

Engaging clinicians and NHS staff:

- The BCT work streams are clinically led and have input from a range of acute, community and primary care health and care professionals
- STP thinking around new models of care was the focus of a major local Kings Fund supported event on 6 April attended by c.200 clinicians, patients, lay members and managers

2a. Improving health and wellbeing

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Issues

- Variation in health outcomes, deprivation levels and health inequalities across the system
- CVD, Cancer and Respiratory disease are the main causes of death and premature mortality
- More than 50% of the burden of strokes, 65% of CHD; 70% of COPD; and 80% lung cancer are due to behavioural risk
- Variation in the early detection rates for cancer across the system and tumour sites
- Variation in the prevalence rates of diseases compared to expectation
- Infant mortality rates in the city are significantly higher than the national average
- Limited exploration of community assets and social prescribing to support prevention, self-care and resilience
- Not exploiting the strength of the NHS workforce in being advocates for healthier life styles

Getting it right in the NHS and social care:

- Develop and embed what we know works in primary and secondary prevention
- Support the NHS workforce to be healthy exemplars
- A step-change in patient activation and self-care including expansion of existing programmes such as Personal Health Budgets, Making Every Contact Count

Making the most of the local government contribution to prevention, building on the work of public health and the role of HWBs:

- Support local councils to build health into the local environment, making healthy behaviour the norm
- Clear pathways to local integrated lifestyle services (smoking, healthy weight, physical activity, mental well-being)
- Redesign public health commissioned services to provide better integration with primary care and community initiatives
- Build on existing services (e.g. 0-19 integrated children's public health service) renewed focus on 6 high impact areas & multi agency LLR programmes of work

Through the STP process develop plans to maximise the joint contribution of health and local government:

- Build local platforms to communicate effectively with the public, building on approaches such as PHE's Sugar Swap campaign
- Utilise risk profiling to target communities and places with the worst health to close the health gap & reduce health inequalities
- Harness the strength of communities to provide social support, through community asset based approaches, drawing together health and local government through integrated approaches to social prescribing
- Implementation of the Diabetes Prevention Programme (June 2016)

2b. Improving care & quality of services

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The Leicester, Leicestershire and Rutland health and social care system have identified the following as the key challenges that contribute to our care and quality 'gaps':

- Rising demand for all forms of health and social care, which is creating an imbalance between demand and capacity
- Sustainability of urgent and emergency care in the context of rising demand
- Focus is on individuals rather than pathways which leads to lack of service integration between health and social care for complex and frail older patients
- Clinically unsustainable acute service configuration e.g. maternity, children's, intensive care services
- Sustainability and funding of social care, particularly in the context of supporting people to remain independent and to help with hospital discharge
- Sustainability of primary care, particularly in the context of growing demand both from patients and service redesign, workforce issues and reduced share of NHS funding
- Inappropriate clinical variation across all sectors which impacts on outcomes for patients
- Improving the integration of mental health services with physical health
- Continued growth in demand for CHC services and impact of current model on recovery and re-ablement outcomes
- Transition between settings of care which often lead to patients telling their story more than once and poor outcomes
- Information sharing – being able to have access to information no matter what care setting a patient is presenting in
- Acute adult mental health pathway which results in too many patients being placed out-of-county
- Acute child and adolescent mental health care pathway requiring a better crisis response and improved local inpatient capacity
- Unsustainable community hospital inpatient configuration across eight county town and city sites
- Insufficient dementia capacity which will not secure a two thirds diagnosis rate for people with dementia, diagnosis within 6 weeks of referral, and improved post diagnosis treatment and support
- End of life services which offer limited patient choice of services and have insufficient capacity to enable people to choose to die at home
- The management of an increasing number of people who have long term conditions and co-morbidities
- Developing a workforce that can respond to the challenges faced in health and social care and the transfer of services from the hospital to community settings

2c. Improving productivity and closing the local financial gap

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Financial challenges

- Previous modelling (2014 EY, updated 2015) developed an five year 'do nothing ' model for LLR which produced a financial gap of c.:
  - £0.5 billion for the NHS
  - £0.2 billion for Adult Social Care

  This is being updated post allocations and 16/17 contracts to inform the development of the STP
- Current 'structural deficit' at UHL supported in 16/17 through £23m national STF

Current financial solutions identified

Currently identified plans to deliver savings through:

- BCT system wide work: pathway redesign in eight clinical and six enabling work-streams and reconfiguration of acute services
- Organisational CIP and QIPP for example through primary care prescribing; theatre utilisation and length of stay improvements
- Local authority MTFS plans to achieve savings, including a 2% council tax precept for social care

Opportunities

- Reduce the need for and reliance on inpatient care by stemming admission growth by increasing the community and home offer and reducing length of stay
- Focus financial growth and investment in out of hospital and primary care services
- Developing new models of care that support integration and reduce duplication in the system
- Improve the utilisation and rationalise the public sector estate – "one public estate"
- Manage the growth in CHC
- Focus on prevention and promote a self-care culture to ensure longer term sustainability
- Work towards a place based control total
- Commissioner /Provider collaboration to reduce overheads
- IM&T solutions that improve care quality and efficiency
- Supporting carers to reduce reliance on social care services
- Improving access to information and advice, enabling people to help themselves
- Utilising support from families and the community before resorting to support from formal public services

Current plans that support sustainability – note some of these are subject to the outcome of formal public consultation

- Acute hospital footprint reduced from three to two sites
- Consolidation of community hospital estate and increased hospital at home services
- Reconfiguration of maternity services
- Improved support for people with Learning Disabilities to live in community settings and reduction in inpatient beds over time
- Improved mental health services for all focussing on prevention, resilience and improving crisis services
- Development of dementia services to improve quality of life
- Improve the quality and choice of end of life services
- Working with individuals to deliver cost effective, personalised care and maximise independence
- Working with local communities and providers to develop local community based support
- Develop an integrated housing offer, to support individuals in their own home

3a. Emerging thinking - areas of focus

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Major local challenges	3 'gaps'		
	Health and Wellbeing	Care and Quality	Finance and Productivity
Implementing BCT Phase 1	• Shift of all age mental health to prevention and resilience • Secondary prevention and primary care upskilling for LTC's	• Maternity consolidation • Increasing community support for people with learning disabilities • CAMHS transformational plan • Redesign integrate urgent care offer (Vanguard) • Configuration of intensive care	• Acute site consolidation (3:2) • Community hospital reconfiguration • Efficiencies and lowest cost settings for planned care
Current issues where plans are insufficient	• Cancer prevention and early detection • Services for frail older people • Physical and mental health integration • Self care support • Employers offer for staff health and wellbeing (public and large private sector employers)	• End of life services • Access to and variation in general practice • Variation in care home quality • Acute adult mental health pathway • Community response to mental health crisis • Shared records and care plans	• In balance between demand and capacity across all sectors • LRI Urgent Care service model • CHC model and demand • Reducing inappropriate clinical variation/duplication • Capacity in out of hospital services to absorb left shift in activity • Collective culture and approach to service improvement
Potentially unsustainable in 2020	• Public expectations and approaches to accessing health and care services	• Dementia capacity for treatment and support • Care home and domiciliary provider market • Workforce supply (capacity and skill mix) • Urgent and emergency care service 'designation'	• Viability of adult social care model/funding • Model and viability of general medical care services (workforce, finance , business model) • Configuration of specialised services
Potential opportunities to enable transformation	• Capitalising on community and voluntary sector assets to support primary prevention • Place based approach across public sector services and workforce	• Exploiting advances in technology, science and treatment to enable patients to remain well and support independence • New 'paramedic at home ' and wider EMAS clinical delivery model	• New models of care (integrated health and social care teams) • Acute provider networks • Placed based control total • Integration of commissioning between health and social care • Collaborative commissioning arrangements • IM&T interoperability and paperless (Digital Roadmap) • One public sector estate (utilisation and consolidation) • Carter review (productivity)

N.B. some of these 'propositions' will be subject to formal public consultation

3b. Emerging thinking – Top Priorities

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1. **BCT Phase I service reconfiguration** - acute and community hospitals
2. **Public sector efficiency** – within and across providers (Carter) and commissioner collaboration/integration
3. **Prevention** – community asset base, risk targeted and staff wellbeing
4. **Urgent and emergency care** – integrated urgent care, LRI services , designation and EMAS delivery model
5. **Mental health** – acute pathway, all age crisis and dementia
6. **Integrated place based community teams** - multi-specialty and health/care supporting LTCs and older people
7. **Primary medical care** – quality variation, workforce and business model/scale
8. **Digital technology** – shared records/care plans, patient monitoring and self care
9. **Public sector estate** – utilisation, co-location, consolidation and condition
10. **Health and care workforce** – supply, skill mix, flexibility and settings of care
11. **LLR place based system approach** – collective leadership, single control total, 'One LLR' OD/quality improvement way

3c. Emerging thinking – LLR delivery model

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Addressing current system limitations

- Acute hospital focused
- Illness not wellness
- Disease not prevention
- Individual not population
- Organisational not pathway
- Misaligned financial incentives and regimes
- Isolated, separated small primary care units
- Fragmented community teams

By working through these new models

- Harnessing community / voluntary sector assets
- Greater patient self care/activation
- 'Federated' general practice working together at scale
- Provider integration of health and social care teams (specialist and generalist) at locality level
- Acute networks (regional/national)
- Commissioner collaboration across CCGs and with LAs

In order to generate a new LLR way of doing things

- Operating as one integrated system of health and care, delivering improved population level outcomes through a single place based approach and budget

4. Support we would like

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Asks:

- Approval to proceed to formal public consultation on current BCT proposals after the EU Referendum
- Access to capital funding to enable site/service reconfiguration proposals to be implemented
- Planning rules flexibility to allow an element of CCG 1% non-recurrent funding (c.£1.5m) to be committed now to support BCT programme delivery & STF from 17/18
- Empower specialised commissioners to engage on a more local level with STP footprints
- Early conversation about moving more rapidly towards place based control total across LLR NHS organisations and alignment of national regulator oversight/assurance of this
- Input from national clinical and technical expertise to challenge thinking/ambition (e.g. IM&T, older peoples care)
- Consideration of potential models for transferring estates assets from NHS Property Services to local public sector vehicle to support reconfiguration and reinvestment (potentially part of wider devolution deal?)

Offers:

- BCT journey - sharing our experience and lessons learned on collective system leadership over last three years
- BCF implementation – sharing our experience of bringing together local authorities, CCGs and NHS providers to develop, own and implement a successful programme

Key risks:

- Delivery capacity (clinical and managerial) to develop and implement transformation
- Lack of local financial 'headroom' to invest in new models and transition costs
- Access to capital to support service reconfiguration proposals
- Workforce availability and skill mix
- Impact of local authority funding (adult social care, public health & children's services)