NHS
Leicester, Leicestershire and Rutland

Our Five-Year Plan 2023/24 – 2027/28

Contents

Foreword

We are pleased to present the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board's Five-Year Plan which sets out how we will improve care and outcomes for patients, reduce the equity gap across LLR and become financially sustainable. The emphasis within this plan is on partnership, integration and continuous improvement.

We have made considerable progress since we were established in July 2022. We have delivered significant improvements to the urgent care pathway; reduced planned care waiting lists; modernised mental health services and offered one of the highest appointment rates for primary care in the country. Many of these achievements reflect effective joint working across the LLR health and care system. We now commit to build on this progress as we know we still have a lot more to do.

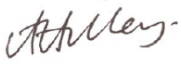
We face a number of challenges which will require concerted responsive action in both the short and the longer term. Some of these challenges relate to access for primary care, hospital and mental health services. And we are particularly conscious of the extended waiting times for some children and young people's services. Another challenge concerns our workforce which is populated by colleagues working with outstanding dedication and professionalism. But we currently have a very significant number of vacancies which affects our ability to meet demand. Perhaps our biggest challenge, however, is to ensure we focus to much greater extent on the prevention of ill-health whilst reducing the stark health and wellbeing inequities which currently exist.

We are confident we can respond to the challenges described above. However, this will require well planned continuous change. It will also require strong partnership working involving the NHS, the wider public sector and the community and voluntary sector. Finally, it will require us to work ever more closely with the public, individually and through their communities.

The plan sets out a number of pledges that we commit to deliver over the next five years. These are based on the things the public have told us are really important. In addition, the plan sets out our key focus areas (Chapter 3) that we believe will enable us to overcome our challenges and improve access and equitable outcomes for the people of Leicester, Leicestershire and Rutland in a financially sustainable manner.

Over the next five years we intend to strengthen and further develop our collaborations. We envisage, for example, ever more closer working with our Local Government partners, through the LLR Health and Wellbeing Partnership and at a Place level in Leicester City and the counties of Leicestershire and Rutland. We will also be developing strategic alliances with neighbouring ICBs where there is benefit in doing so. And we will work collaboratively with other ICBs at an East Midlands level on those services where commissioning responsibility is being delegated from NHS England to Integrated Care Boards.

In order to deliver on this plan our commitment to the people of Leicester, Leicestershire and Rutland is work together and to focus, at all times, on your interests and your health and wellbeing.

Andy Williams Chief Executive LLR Integrated Care Board 	David Sissling Independent Chair LLR Integrated Care Board 
Angela Hillery Chief Executive Leicestershire Partnership Trust 	Richard Mitchell Chief Executive University Hospitals of Leicester 

Our Pledges to local people

Our Pledges to local people

Over the next 5 years, we will:

Improving health equity

Pledge 1

Improve the health of our most deprived communities and **narrow the gap** between those who have the best and the worst health

Preventing illness

Pledge 2

Spend more money on **preventing people becoming ill** in the first place

Keeping People well

Pledge 3

Identify the **frailest in our communities** and wrap care and support around them

Right care, right time, right place

Pledge 4

Improve and maintain access to **routine general practice appointments**

Pledge 5

Reduce Category 2 (emergency calls such as stroke patients) **ambulance response times**

Pledge 6

Reduce and maintain waiting times in the **Accident & Emergency** department

Health and Wellbeing Hubs

Pledge 7

Provide more joined up, holistic and person-centred care, **delivered closer to home**

Elective care

Pledge 8

Reduce **waiting times for consultant-led hospital treatment**

Learning Disability & Autism

Pledge 9

Increase the percentage of people on GP **learning disability** registers who receive an annual health check and health action plan

Mental Health

Pledge 10

Reduce **inequity in access to mental health services** across each of our neighbourhoods

Children & Young People

Pledge 11

Improve access to, experience of, and outcomes of care for **children and young people** - with a special focus on driving up health equity

Women's Health, including Maternity

Pledge 12

We will engage with, listen to, **empower and co-produce services with women and girls**

Our People

Pledge 13

We will shape **our people** and services around the needs of our population by **improving workforce retention, reducing agency usage and growing our workforce** to ensure we are fit for the future.

Our progress in meeting these Pledges will be tracked and reported on at the ICB meetings in public

Our Plan on a Page

Our Vision: Working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives

Core Purpose of our ICS (Our Strategic Objectives)

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development	Deliver NHS constitutional and legal requirements

Our Principles : Everything we do is centred on the people and communities of LLR and we will work together with respect, trust, openness and common purpose to:

Ensure that everyone has equitable access to health and care services and high quality outcomes	Make decisions that enable great care for our residents	Deliver services that are convenient for our residents to access	Develop integrated services through co-production and in partnership with our residents	Make LLR health and care a great place to work and volunteer	Use our combined resources to deliver the very best value for money and to support the local economy and environment

Our Delivery Priorities

Improve Health Equity	Preventing Illness	Keeping People Well	Right care at the right time	Health and wellbeing Hubs	Elective Care	Learning Disabilities and Autism	Mental Health	Children and Young People	Women's Health and Maternity	Our People

Our Pledges to local people

Pledge 1 Improve the health of our most deprived communities and narrow the gap between those who have the best and the worst health	**Pledge 2** Spend more money on preventing people becoming ill in the first place	**Pledge 3** Identify the frailest in our communities and wrap care and support around them	**Pledge 4** Improve access to GP appointments **Pledge 5** Reduce ambulance Response times **Pledge 6** Reduce A&E waiting times	**Pledge 7** Provide more joined up, holistic and patient-centred care, delivered closer to home.	**Pledge 8** Reduce waiting times for consultant-led hospital treatment	**Pledge 9** Increase the percentage of people on GP learning disability registers who receive an annual health check and health action plan	**Pledge 10** Reduce inequity in access to mental health services across each of our neighbourhoods	**Pledge 11** Improve access to, experience of, and outcomes of care for children and young people - with a special focus on driving up health equity.	**Pledge 12** We will engage with, listen to, empower and co-produce services with women and girls	**Pledge 13** We will shape our people and services around the needs of people by building a one team and culture to maximise the people potential of the LLR population

Chapter 1: Introduction

1.1 The purpose of this document

This five-year plan (the Plan) sets out how NHS services will be arranged and delivered to meet the physical and mental health needs of local people in LLR over the next five years i.e., 2023/24 to 2027/28. The LLR Integrated Care Board (ICB), which includes our NHS Trusts, is accountable for the delivery of this Plan, working with our Councils and wider partners.

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires our ICB and our partner trusts to prepare this Plan before the start of each financial year. 2023/24 is the first year of this Plan, which will be updated each year, from 2024/25 onwards.

We face significant health and care challenges in LLR, and these are described in Chapter 2. Working with our Councils and wider partners, we have developed an Integrated Care Strategy that sets out the direction of travel to address these challenges for LLR. Our three upper-tier Councils (also known as our Places) have also worked with partners to develop Joint Health and Wellbeing Strategies (Leicester City Council JHWS; Rutland County Council JHWS; Leicestershire County Council JHWS) that focus on the specific challenges in each of their areas, as identified through their Joint Strategic Needs Assessments (JSNA) (Leicester City Council JSNA; Rutland County Council JSNA; Leicestershire County Council JSNA. Furthermore, we are working with district councils to develop Community Health and Wellbeing Plans.

This document supports the delivery of the Integrated Care Strategy and Joint Health and Wellbeing Strategies, as well as the national NHS commitments. It sets out how, over the next five years, we will practically transform the delivery of NHS care to improve performance and outcomes, reduce inequity in health and healthcare, and achieve financial sustainability.

1.2 Who this document is for

We have made every effort to write this document as clearly and plainly as possible. However, it does contain some detailed and technical information regarding our future plans. Where this is unavoidable (for example, the inclusion of detailed data to support our clinicians and Partners), we have included links to supporting information.

No single document can meet the needs of every reading audience and, therefore we will also produce separate summary documents and bespoke resources for specific audiences to explain our future plans.

Audiences for whom this document should be particularly helpful include:

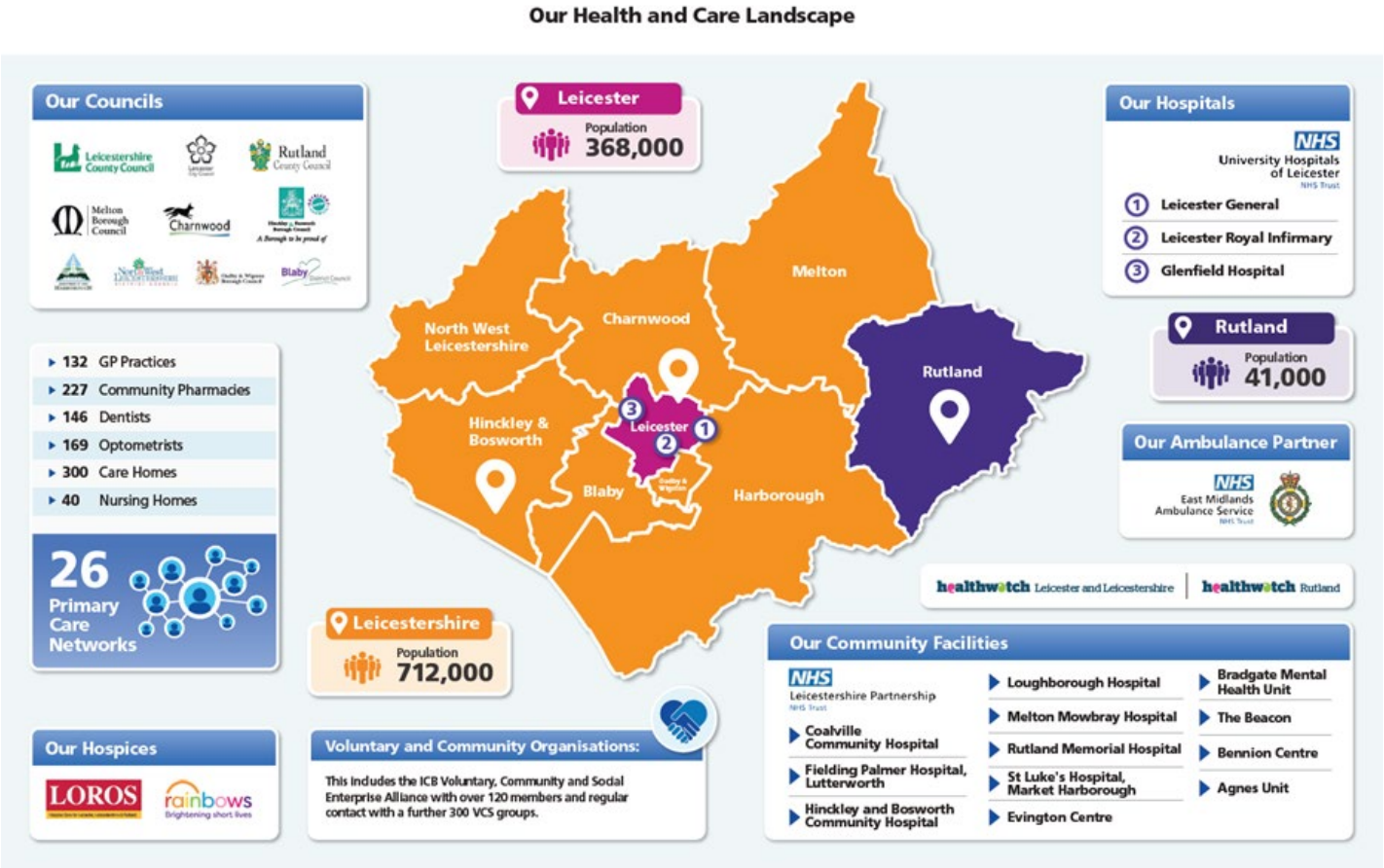
- Our patients and local people
- NHS and social care staff and teams
- NHS leaders at all levels and across all our organisations
- Clinical leaders across primary, community, mental health, hospital and specialist services
- NHS Board non-executive members
- County and district council councillors and executives
- Local authority housing, education, planning and environmental services leaders
- Voluntary and community sector leaders
- Healthwatch and patient group leaders
- Health and care focussed charities
- Police and fire and rescue services leaders
- Health and Wellbeing Board members

- NHS England
- Local Authority Health Overview and Scrutiny Committee members
- Universities, higher and further education leaders

1.3 About us

About LLR

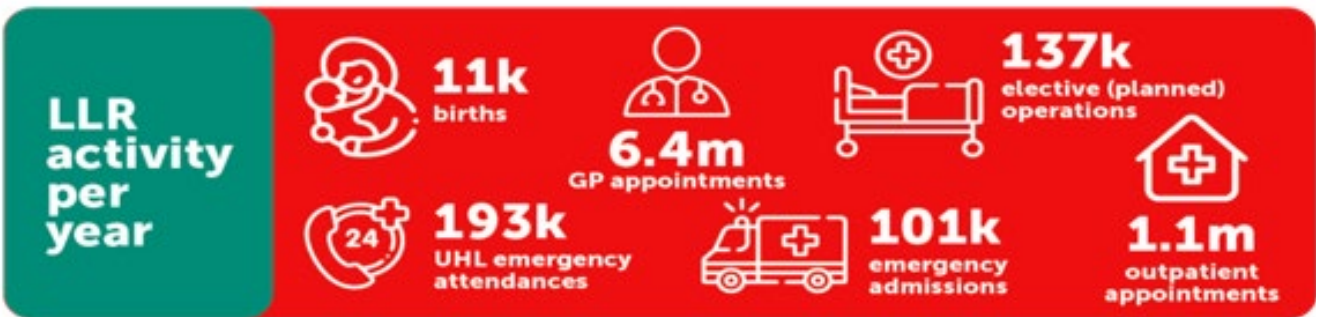
We serve 1.1million people across rural, market towns and urban areas.



Figures accurate as of March 2023

Key facts and figures

LLR is a busy place…



(2021/22 data)

About the LLR ICB

Our ICB (known as NHS Leicester, Leicestershire and Rutland) is a statutory body created to provide infrastructure support to the NHS. We do not directly provide care (although a lot of our work supports the delivery of care). We spend over £2 billion on health and care services for the 1.1 million people of LLR every year. Our contribution to the front line is delivered by discharging our responsibilities effectively and efficiently through our main providers of NHS services and by working with our wider partners.

Our ICB's role can be summarised as working with partners to:

- Identify the health and care needs of its population;
- Develop service plans to meet those needs, reflecting national and local priorities;
- Support the implementation of those plans and service delivery more widely;
- Evaluate the effectiveness of services and take action to correct or improve these where required; and
- Be accountable to NHS England and our local population for the public funds it spends and the outcomes and outputs of the services it commissions.

About the LLR ICS

The ICB is part of the LLR Integrated Care System (ICS) alongside our local NHS trusts and councils. GPs, other health and care providers, Healthwatch and the voluntary and community sector also play a critical role in coming together to plan and deliver joined up (integrated) health and care services to improve the lives of local people. We manage this work through the LLR Health and Wellbeing Partnership.

Integrated care puts the patient or service user at the centre by removing traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care and, in some cases, poor experience and outcomes. It's about giving people the support they need, joined up across local councils, the NHS, and other partners.

The core purpose of our ICS (Our Strategic Objectives), therefore, are to bring partner organisations together to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access to health and care
- Enhance productivity and value for money
- Help the NHS support the broader social and economic development in an area
- Deliver NHS constitution and legal requirements

The ICB's strategic objectives support our overall vision and provide an overarching set of goals that we aim to achieve. The delivery of our strategic objectives will be underpinned by our values and principles. The pledges describe what we will measure to determine the extent to which our strategic objectives have been achieved. Our Board Assurance Framework will describe the principal / strategic risks that could impact the ICB achieving its strategic objectives if the strategic risks were to materialise.

Our system operates at three levels:

Neighbourhood
Neighbourhoods' are the cornerstone of our ICS. Based on 26 groups of GP Practices, known as primary care networks, they work together to manage care closer to home for populations of 30-50k patients. They develop multidisciplinary teams working with councils, the community and voluntary sector, to care for those with long-term conditions. GPs, practice and community nurses and staff will work with partners to wrap care around the most vulnerable.

Place
At the 'place' level, care alliances, including hospitals, local authorities (Health and Wellbeing Boards), urgent care, mental health and community services, transport providers and the newly formed primary care networks, plan the delivery of healthcare in response to local need.

System
At a system level the statutory Integrated Care Body and its partners will analyse need, set priorities and desired health outcomes, and allocate funding.

1.4 Our Vision, Principles and Life Course approach

We worked closely with partners and stakeholders to develop a shared vision and principles that act as a 'golden thread' for how we operate in LLR: for how we focus on a better future for local people; for how we transform and improve health and care; and for how we interact with each other.

Our Vision

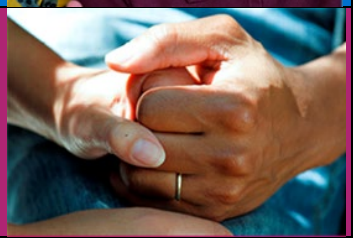
Working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives

Our Principles

Everything we do is centred on the people and communities of LLR and we will work together with respect, trust, openness and common purpose to:		
Ensure that everyone has equitable access to health and care services and high-quality outcomes	Make decisions that enable great care for our residents	Deliver services that are convenient for our residents to access
Develop integrated services through co-production and in partnership with our residents	Make LLR health and care a great place to work and volunteer	Use our combined resources to deliver the very best value for money and to support the local economy and environment

Our Life Course approach

Adopting the life course approach means identifying opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at important life stages, from the perinatal period through early childhood to adolescence, working age, pre-conception and the family-building years, and into older age. It also capitalises on the potential to deliver an inter-generational approach to health improvement and reduce health inequalities from generation to generation and improve conditions of daily life.

Best start in life		We will focus on the first 1001 days of life to enable more equity in outcomes as we know this is critical to a child's life chances	
Staying healthy and well		We will support our residents to live a healthy life and make healthy choices to maintain wellbeing and independence within their communities	
Living and supported well		We will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently.	
Dying well		We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families.	

1.5 A clinically led approach

We have ensured that the development, implementation and ongoing delivery of services for local people are clinically led and underpinned by a clinical strategy.

Our clinical strategy (currently drafted and being discussed widely with clinicians) sets out 'guiding principles' that underpin and, thereby deliver our life course approach (see 1.4). These principles are: "*population health*", "*management of illness*" and "*clinical culture*" (Table 1, below).

Table 1: Summary of our clinical strategy guiding principles

LLR Clinical Strategy: Guiding Principles		
Population Health **Our focus will be on:**	**Management of Illness** **Our focus will be on:**	**Clinical Culture** **Our focus will be on:**
Prevention of disease and promotion of health and wellbeing	Shared Decision Making	Research and Innovation
Aims of Population Health Management	Support for the clinical team	Stewardship of healthcare resources
The broader social determinants of health	Patient and carer activation/engagement	Professional Support
Improving health equality	Healthcare Integration	Scrutiny of outcomes
Public health risks	Well supported primary care	Communication and Transparency
Community Engagement	Hospital care	

The clinical strategy represents our "thinking" about how health and care should be provided, whereas this Plan details the actions (the "doing") that will be undertaken to deliver the clinical strategy and the process by which decisions about these actions are prioritised. The clinical strategy aligns with the Integrated Care Strategy, but also extends the broad objectives set out in that document by providing specific and enduring clinical values which, we believe, will maintain a clear direction for the work of the ICB in the coming years.

Figure 1: Our LLR Clinical Model

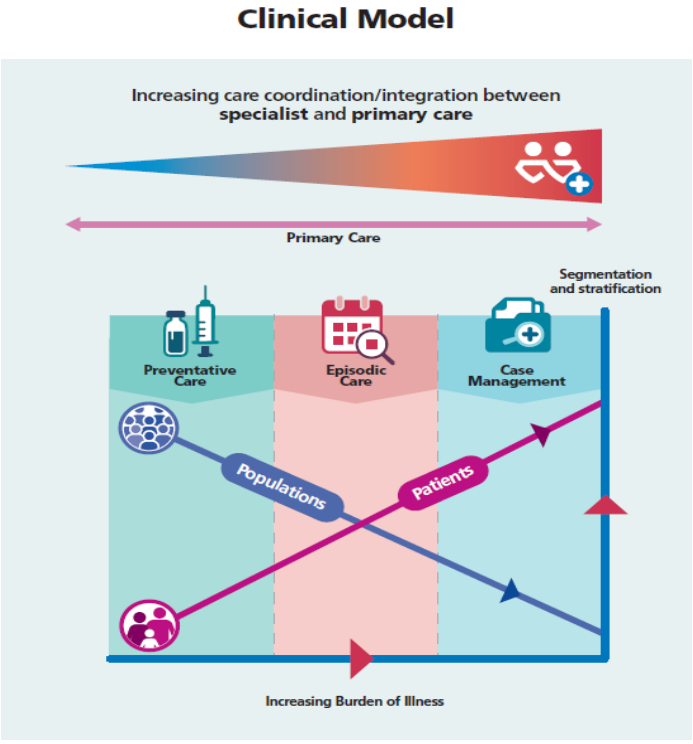


Figure 1 summarises our overarching clinical model. It describes the broad role of the ICS in promoting population health and managing individual illness. It demonstrates the critical role that stratified prevention interventions make, at a population level, to maintain and optimise general population health, as well as the increasing need to stratify smaller cohorts of patients, for individual case management, as multimorbidity increases. All of this is underpinned by the central role of primary care.

1.6 Our approach to developing this plan

Aligning to wider system partner's ambitions

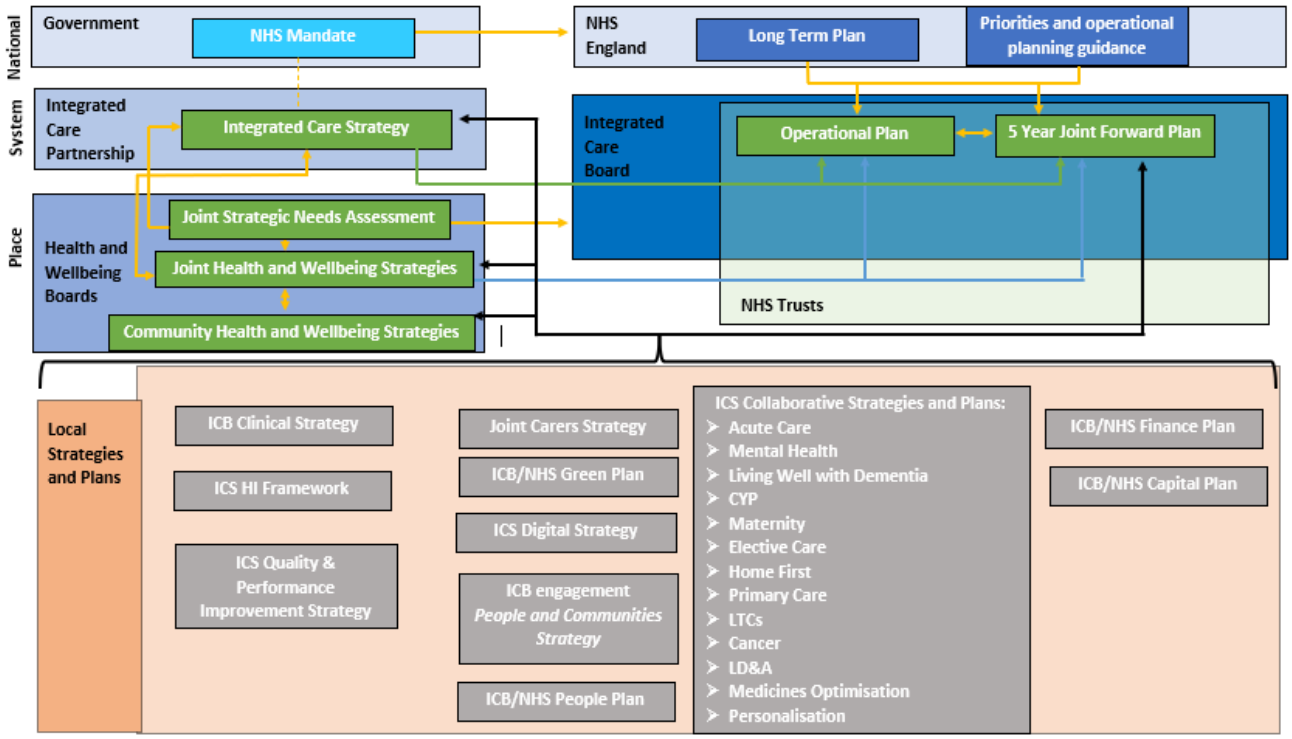
This Five-Year Plan is a shared delivery plan: for universal NHS commitments; for the ICB's commitments within our LLR Integrated Care Strategy; as well as for our commitments within the Council's Joint Health and Wellbeing Strategies. We have ensured that all key stakeholders, including Health and Wellbeing Boards, our NHS Trusts, Councils, primary care, Healthwatch, clinical leaders and NHS England have had the opportunity to influence the development of this Plan.

At the beginning of Chapter 3, we have included a summary table to demonstrate how this Plan (including the detailed local strategies and plans that underpin it – see Figure 2, below) takes account of partner's ambitions, as well as how our agreed LLR system-wide priorities are translated into deliverables

Reflecting universal NHS commitments and building on existing local strategies and plans

Figure 2, below, demonstrates how this is the delivery Plan for universal NHS commitments, as well as our ICB local priorities and our system partner's ambitions. We have also ensured that this Plan ties together and presents a cohesive picture for delivery of our local clinical, enabling, financial and collaborative strategies and plans.

Figure 2: Relationship of our 5-yearfive year plan with other strategies and plans



Delivery focused

Chapter 3 (Delivery Plan) focusses on how we will deliver our commitments across the range of services and areas, over the coming years. We have been deliberately specific, ensuring that aims, actions and outcomes are evidence based and measurable in order that we can track our progress against what we said we would do.

1.7 How we have used insights and engagement to shape this plan

This Plan is underpinned by firm foundations of involvement, engagement and co-production with people and communities, over the past years. It has also been built on an inclusive learning culture, to understand the needs of our population and design services appropriate to those needs.

Local people's insights have informed this Plan

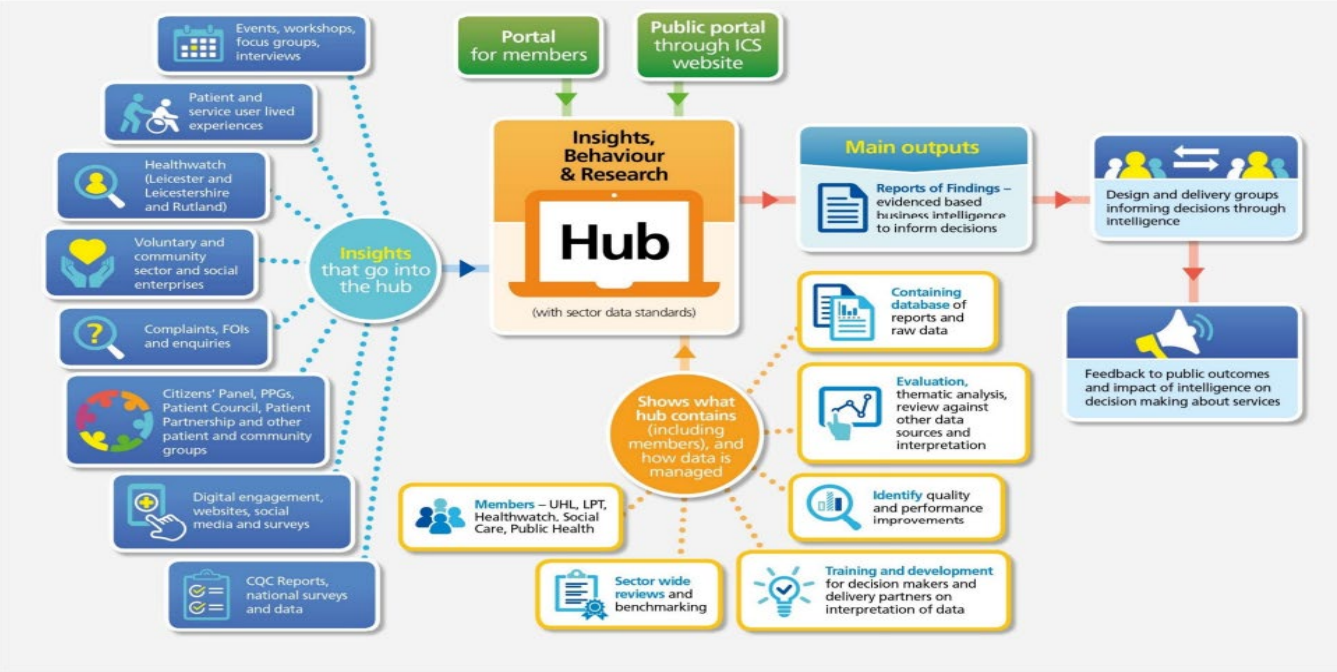
We have undertaken large-scale involvement projects, with local people, over the last 3 years. The insights and data from this work is evidenced and has informed the service-specific future arrangements within this Plan. These projects have seen quantitative and qualitative data gained from nearly 50,000 people including patients, service users, staff and carers, as well as seldom heard people and work with communities who represent people with protected characteristics.

Engagement and consultation, between 2020 and 2023, has included:

- Building Better Hospitals for the Future (2020, 5,675 people)
- Step Up to Great Mental Health (2021, 6,650 people)
- Covid-19 hesitancy engagement (2020, 4,094 people)
- Local primary care survey (2021, 5,483 people)
- National primary care survey (2022, 14,426)

In addition, numerous smaller insight projects undertaken by system partners and Healthwatch Leicester and Leicestershire and Healthwatch Rutland have influenced this Plan, as have the insights from the three consultation exercises undertaken by our councils in respect of their Joint Health and Wellbeing Strategies. Figure 3, below, summarises how we capture insights and how these are then used to support service improvement.

Figure 3: How engagement and insights inform the design and delivery of local health and care services



The Voluntary, Community and Social Enterprise Alliance (VCSE)

The VCSE Alliance aims to facilitate better partnership working between the ICB and the VCSE sector, as well as enhancing the role of the sector in strategy development and the design and delivery of integrated care.

The VCSE alliance:

- Encourages and enables the sector to work in a coordinated way;

- Provides the ICS with a single route of contact and engagement with the sector and links to communities; and
- Better positions the VCSE sector in the ICS and enables it to contribute to the design and delivery of integrated care and have a positive impact on heath priorities, support population groups and improve health equity.

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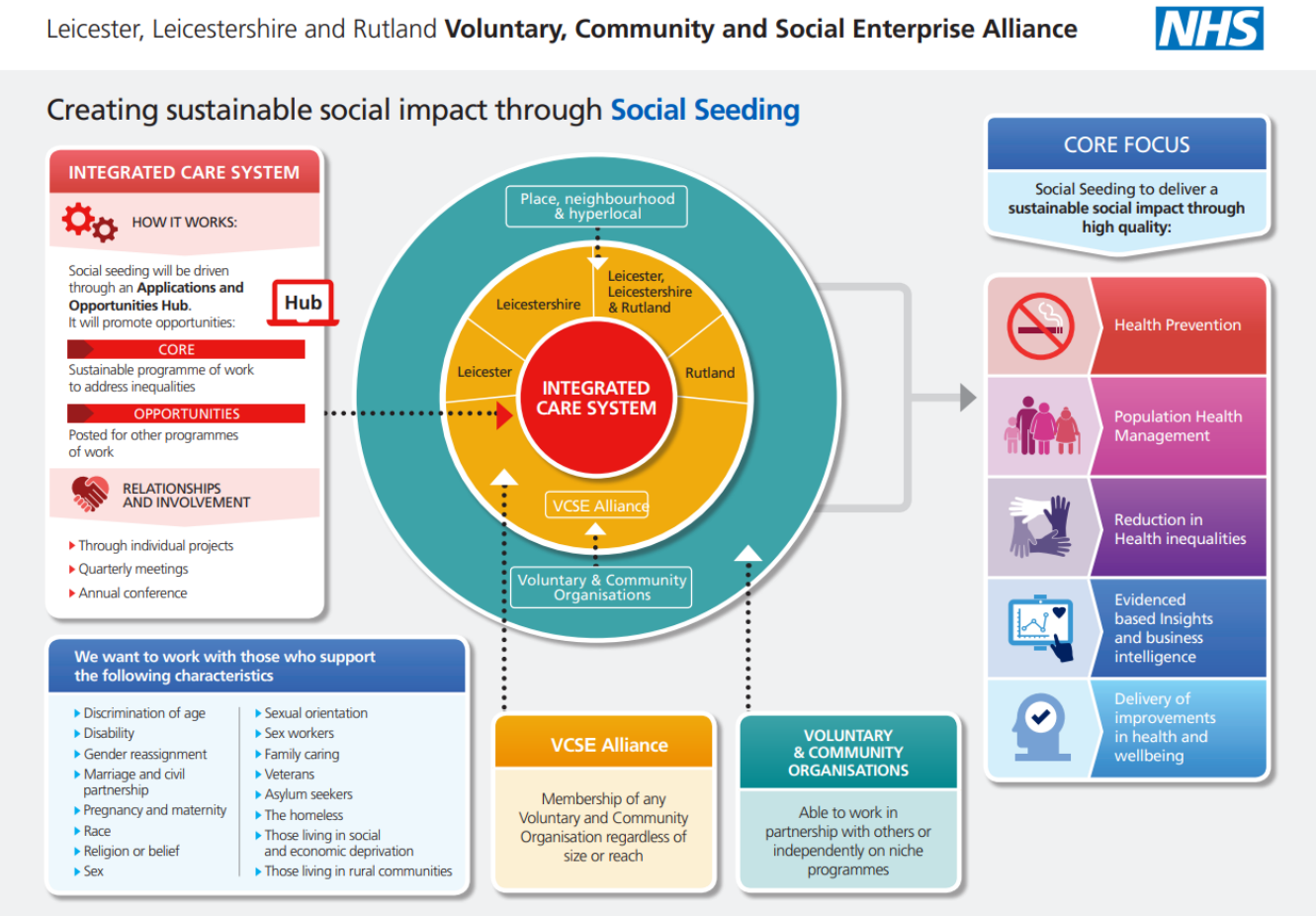
Figure 4, below, describes a co-designed model of how this diverse and creative sector are effectively involved in service redesign work, governance, system workforce, population health management and leadership and organisational development plans.

Figure 4: The LLR VCSE model



Involving our stakeholders in validating this Plan

We wanted to validate our understanding of the insights collected, and gain assurance that these have influenced, not just specific parts of this Plan, but also the overall scope and direction of the Plan itself. To do this, we have implemented a comprehensive engagement process with key stakeholders, as well as with wider audiences, between May and June 2023, to gain their feedback on this Plan, before it is finalised. We will prepare and publish a summary of engagement findings, however, some of the feedback we received, and which resulted in changes to the Plan include:

- Stronger references to our role in supporting the Armed Forces Covenant;
- Incorporating measures that can be used to demonstrate success in delivering our Pledges;
- Acknowledgement of national and local NHS dental services issues and that we will produce a plan to address these, locally;
- Sharpening the interventions we will make and adjusting timelines to provide more focus on actions that need to be taken in the short-term; and
- Strengthening our prevention plans, including in respect of physical activity.

1.8 Statement of support from HWBs

Leicestershire County Council HWB

The HWB agrees that the Five-Year Plan takes account of the Leicestershire Health and Wellbeing Strategy

Leicester City Council HWB

Members of Leicester's Health and Wellbeing Board have been consulted on the draft Leicester, Leicestershire and Rutland Integrated 5-year plan. The 5-year plan aligns with, and takes account of, Leicester's Health, Care and Wellbeing Strategy 2022-2027 and complements this, for example with the focus on prevention, improving health equity and reducing inequalities, a life course approach, a focus on mental health and wellbeing, and the importance of community engagement, co-design and co-production.

Rutland County Council HWB

The Rutland HWB agrees that the Five-Year Plan takes account of the Rutland Joint Health and Wellbeing Strategy

Chapter 2: Where we are now

In this chapter, we provide an overview of health and wellbeing in LLR, as well as a snapshot of our performance, our finances and workforce.

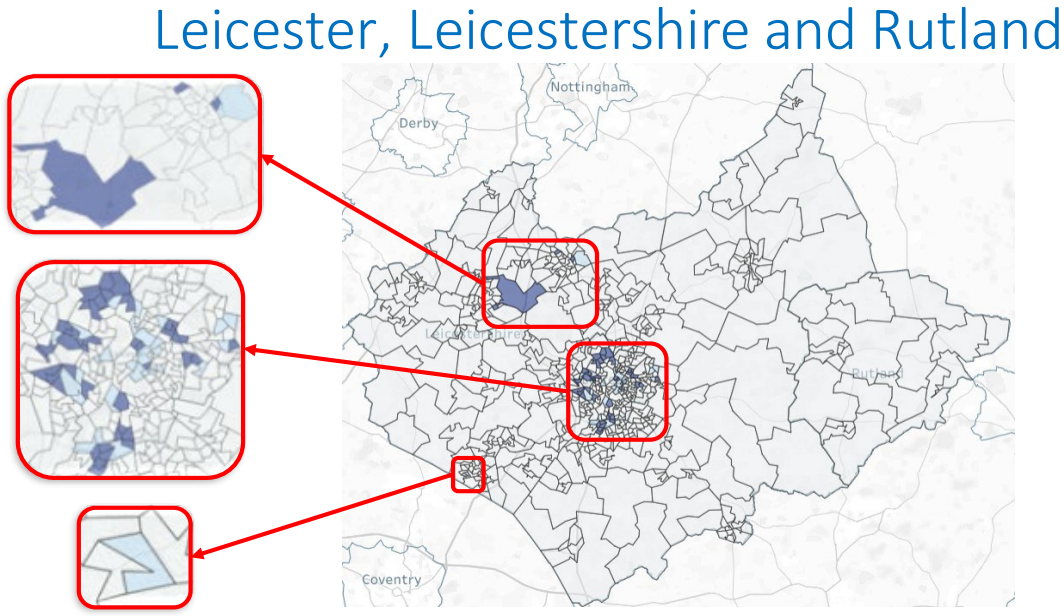
2.1 Overview of health and wellbeing

We highlight, here, key facts relating to the health and wellbeing of our population. We have produced a more detailed Overview of Health and Wellbeing in LLR document, and our council's Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (see 1.1) contain detailed analysis of wellbeing and need.

Summary of deprivation

Figure 5 shows those areas of LLR where the population is in the most deprived 20%, nationally, as identified by the Index of Multiple Deprivation (IMD).

Figure 5: Most deprived neighbourhoods in LLR



STP/ICS map showing neighbourhoods (LSOAs) in 2019 Index of Multiple Deprivation deciles. Dark blue is for the most deprived decile, light blue is for the second most deprived decile. Other deprivation deciles are left unshaded.

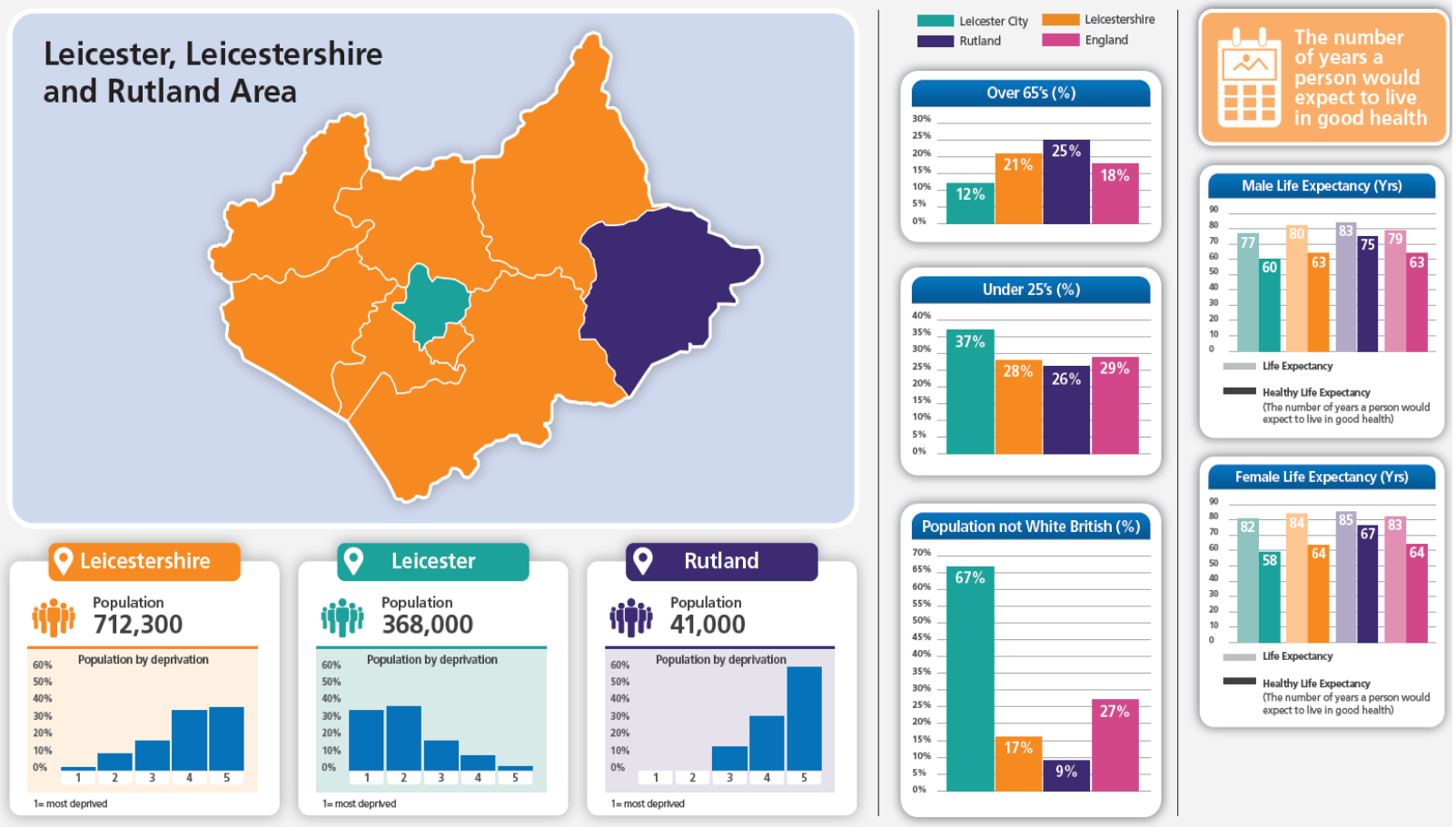
Interactive version can be viewed in tableau https://tabanalytics.data.england.nhs.uk/#/site/viewpoint/views/PopDemo_CORE20/CORE20?:iid=1 (OKTA account required)

13% of our registered patients (153,284) live in the 20% most deprived neighbourhoods in England (see Table 2). 85.3% of those (130,794) live in Leicester, 14.6% of those (22,321) live in Leicestershire and 0.1% of those (169) live in Rutland.

Table2: LLR registered patients and those that live in the 20% most deprived areas in England

	Registered patients living in 20% most deprived areas in England	Total registered patients	% of total registered patients
Leicester	130,794	413,074	31.7%
Leicestershire	22,321	688,401	3.2%
Rutland	169	40,035	0.4%
Total for LLR	153,284	1,141,510	13%

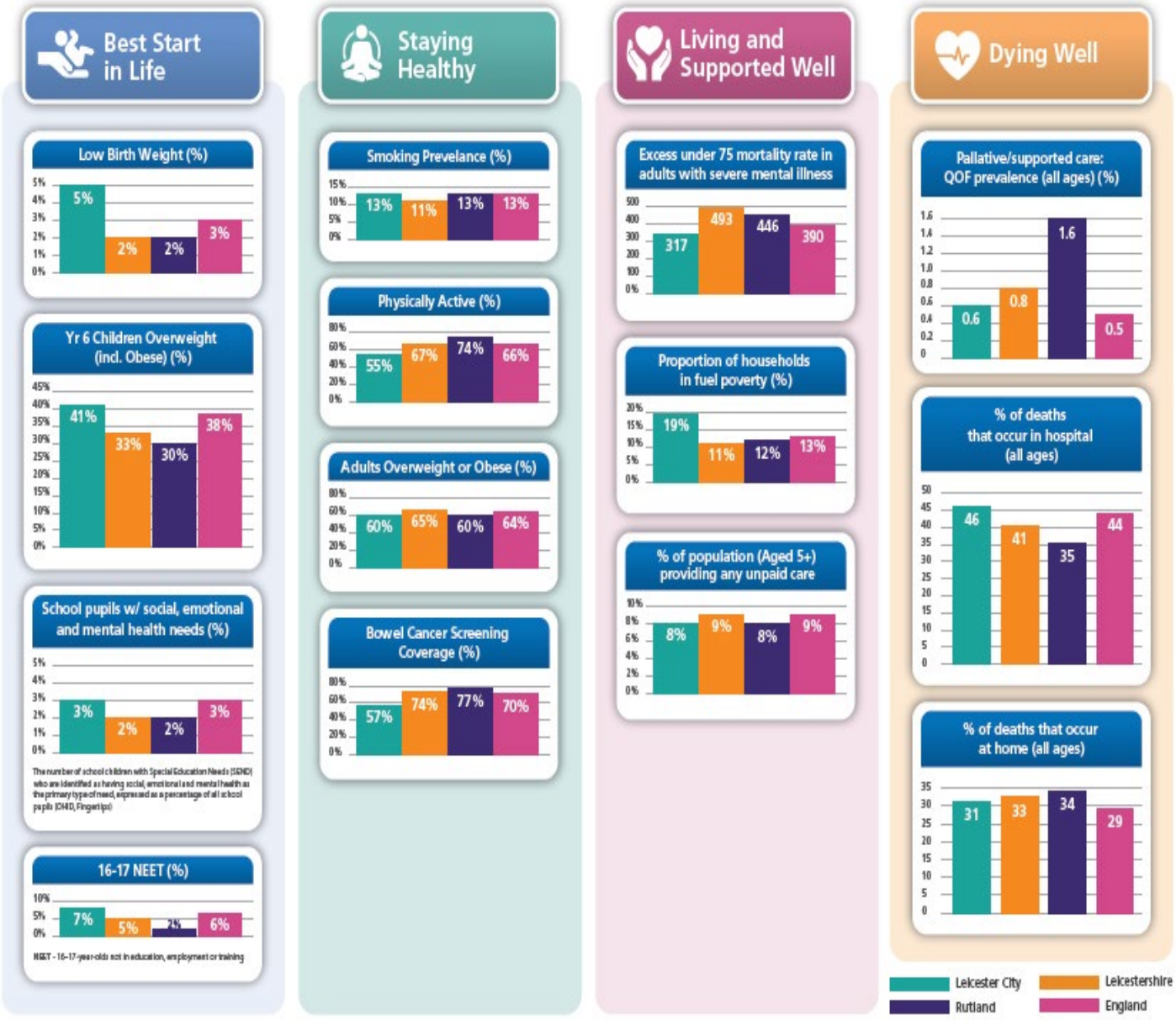
Summary of health and wellbeing facts and figures



The above infographic describes deprivation across Leicestershire, Leicester and Rutland, in blocks from 1 to 5, with block 1 being the most deprived and block 5 being least deprived.

This (right hand side) infographic describes the the number of years a person would expect to live in good health compared to their life expectancy. For example, a male living in leicester might expect to live (on average) for 77 years, of which 60 years would be in good health.

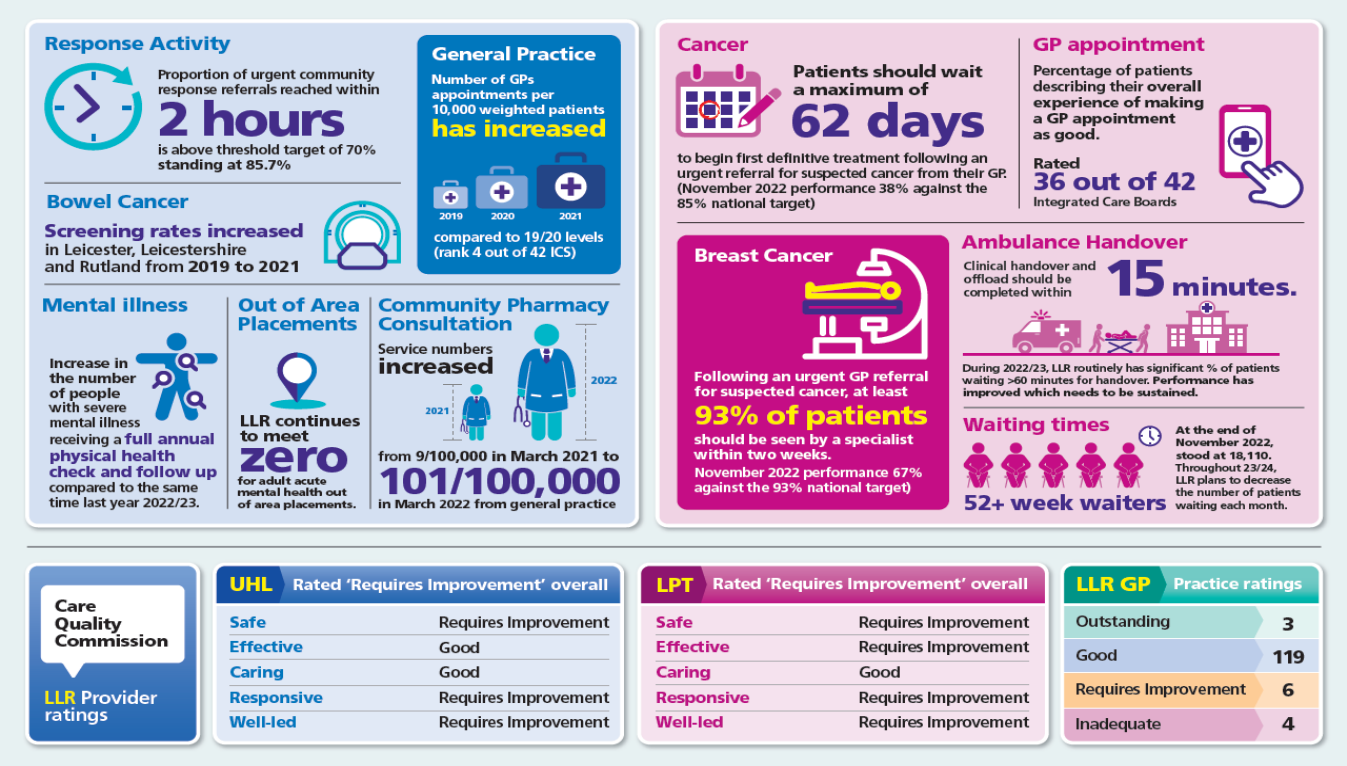
The infographic, below, describes how each of Leicester, Leicestershire and Rutland currently performs against key health and wellbeing indicators at each of the four-life course stages (see 1.4).



2.2 Our Performance

We highlight here some key areas where we are performing well and key areas where our performance needs to improve.

Our Performance and Quality



2.3 Our Finances

Local and national context

We have a history of financial challenges, the causes of which are not unique to LLR.

These challenges must be addressed for us to become financially sustainable in the longer term. National and local pressures that impact on LLR finances include:

- current cost of living crisis across all service provision;
- cost inflation beyond funded levels;
- workforce shortages;
- intense pressures on urgent care and primary care;
- supply and demand challenges within social care;
- waiting lists at an unprecedented level;
- mental health services capacity;
- expectations on quality, access and better health and social care at a time of increased operational pressure; and
- an uncertain outlook with significant pressure across public finances

Our numbers

In recent history, LLR has incurred financial deficits (overspends) in each year. In 20/21 and 21/22, a combination of extra funding for Covid-19 and reduced elective care costs (as appointments and surgeries were cancelled) has enabled the system to achieve a break-even financial position.

In 22/23 we planned to break-even and ended the year with a deficit of £15m. We were unable to keep within our planned resources, despite utilising significant non-recurrent revenue streams and financial mitigations, for the following reasons:

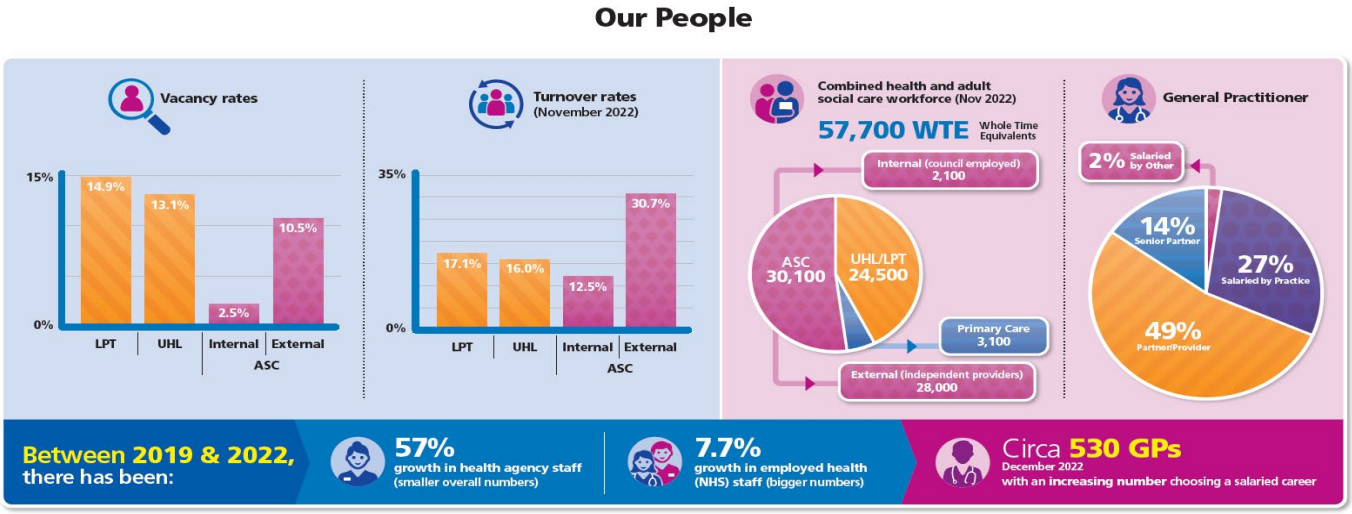
- reduced funding
- increased pressure on urgent care;
- increased mental health need;
- elective waiting list recovery;
- recruitment to safer staffing models of care;
- high levels of inflation;
- agency staff costs; and
- lack of funding for social care manifesting impacting on out of hospital discharge pathways.

Due to the use of non-recurrent revenue streams and other non-recurrent financial benefits to support 22/23, we now face a much greater challenge in 23/24 and beyond. Our plan for 23/24 is to deliver a £10m deficit as a system, this includes an extremely challenging savings target of £131.5m which is equivalent to 6.4% of our system allocation.

Chapter 6, Our Finances, describes our plans to achieve longer-term financial sustainability.

2.4 Our People

Our people are our greatest asset, and we highlight below some key local workforce information and indicators. Chapter 7, Our People, considers our future people planning.



Chapter 3: Delivery Plan

Delivering a realistic and pragmatic transformative plan for LLR

Every part of our health and care system is facing a challenge like never before. We have emerged from the Covid-19 pandemic in a weaker state across the nation, with every system reporting severe pressures. Despite best efforts across the health and care, demand continues to outstrip capacity, leading to poorer access to care, poorer experience of care and poorer outcomes for local people. Whilst this is universally reported, research has shown a deeper impact on those who have faced historical inequity.

Insights from our staff and our communities tells us that we must focus on three key areas – making it easier to **access care** when it is needed, making it easier for our **teams to be able to deliver this care** in an effective and efficient manner and ensure this care will **deliver equitable outcomes** for local people.

We have notable examples of this focus being delivered in each of our places and neighbourhoods. This should give us confidence that it is possible to reimagine how we receive and deliver care to our communities; our challenge will be to grow these local initiatives into systematic models of care, whilst retaining a local focus at the heart of design and delivery.

In this Chapter, we describe how we begin that journey, by setting out a vision for an integrated system of care which allows enough flexibility to take the needs of our local communities into account but, at the same time, enables us to set and meet an equitable standard of care and outcomes for those we serve.

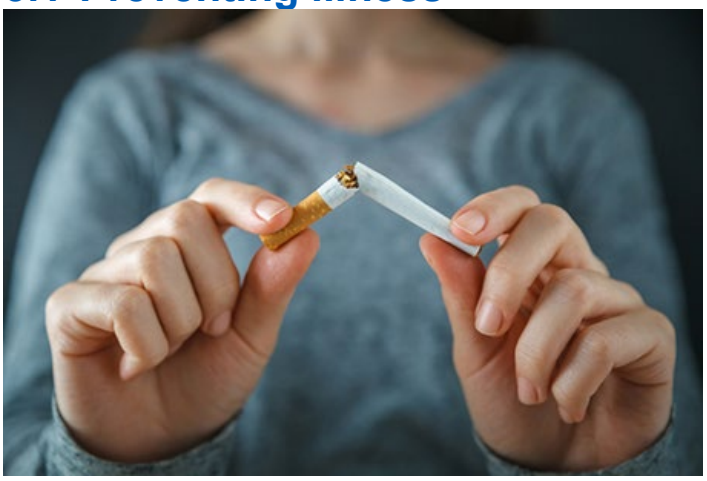
We know that we deliver the best outcomes when people, communities, clinicians, practitioners and local teams come together to tackle a challenge, no matter the size. The freedom to innovate, trial, assess, evaluate and re-align, (often in the face of significant pressure to simply put a *sticking plaster* solution in), has underpinned our most successful improvements across LLR. We must, therefore, continue to be brave, to support this evidence-based approach and enable our teams to work with our communities to reimagine service delivery at pace.

The subsequent sections within this Chapter focus on the interventions we intend to make, across key service areas, to deliver a truly integrated system of care. Table 3, below, demonstrates how this Plan translates our system-wide priorities, as well as partner's JHWSs into deliverables.

Table 3: Chapter 3 alignment with system priorities and partner ambitions

					This Plan Chapter 3: Delivery Plan:								
LLR System Priorities	**Integrated Care Strategy**	**Leicester JHWS**	**Rutland JHWS**	**Leics. JHWS**	**Prevention**	**Keeping people well**	**Access the right care**	**Integrated teams**	**Elective care**	**LD&A**	**Mental health**	**Children & Young People**	**Women's health**
Improving health equity	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Preventing illness and helping people to stay well	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Best start in life		☑	☑	☑	☑		☑	☑			☑	☑	☑
Living and supported well	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Dying well		☑	☑	☑		☑	☑	☑					
Championing integration	☑		☑		☑	☑	☑	☑	☑		☑		☑
Mental health		☑	☑	☑	☑	☑	☑	☑		☑	☑	☑	☑
Access to services	☑	☑	☑		☑	☑	☑	☑	☑	☑	☑	☑	☑
Our role as an '*Anchor*' organisation	☑		☑	☑									

3.1 Preventing illness



What do we mean by Prevention?

It's helpful to think of prevention as having three elements:

Primary (Prevent)

Reducing the risk factors that contribute towards ill health, for example, through clean air legislation or immunisation programmes (Primary prevention)

Secondary (Reduce) - Increasing the early detection and diagnosis of disease to achieve better outcomes; slow or reverse disease progression, for example, cancer screening programmes and targeted weight management services (Secondary prevention)

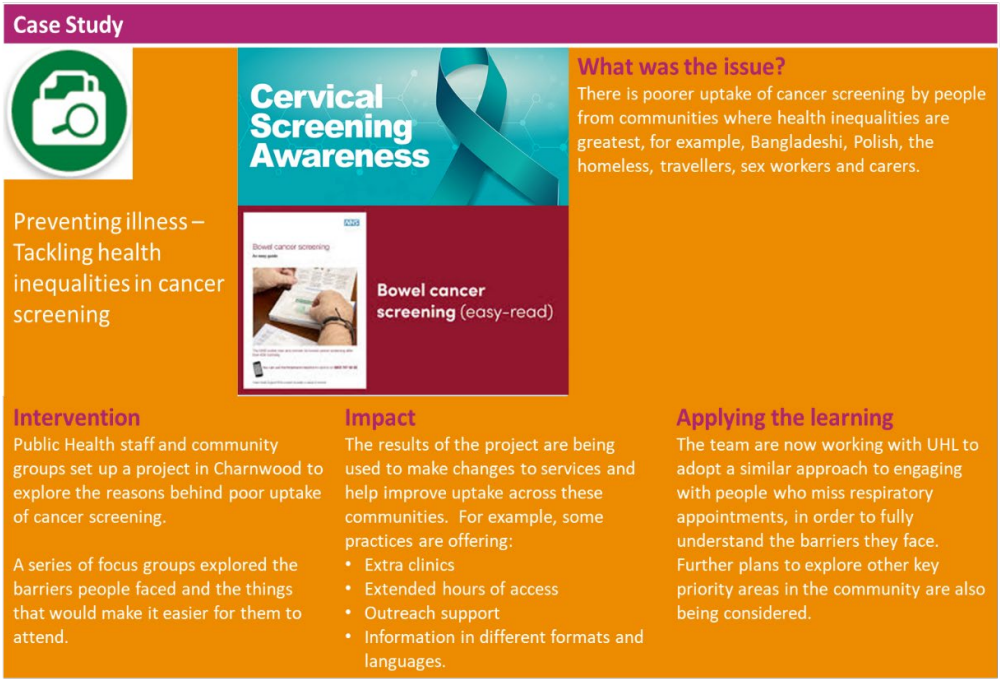
Tertiary (Delay) - Provide appropriate support and interventions for people living with long-term conditions, for example, stroke and cardiac rehabilitation programmes (Tertiary prevention)

Local context

Between 2017 and 2019, there were 3,734 preventable deaths in under 75 year-olds in LLR (the Office for Health Improvement & Disparities), an average of 1245 per year and 45% of all deaths in under 75 year olds. Cancer, cardiovascular disease and respiratory disorders are the three most common causes of local preventable deaths – all three are linked to the building blocks of health also known as the wider determinants of health. To have a healthy society, we need all of the right building blocks in place: stable jobs, good pay, quality housing and education. Missing and weakened building blocks disproportionately impact communities with the highest health inequities. For example, in Leicester, household incomes per person are 37% lower than the UK average (2018 data).

Our approach

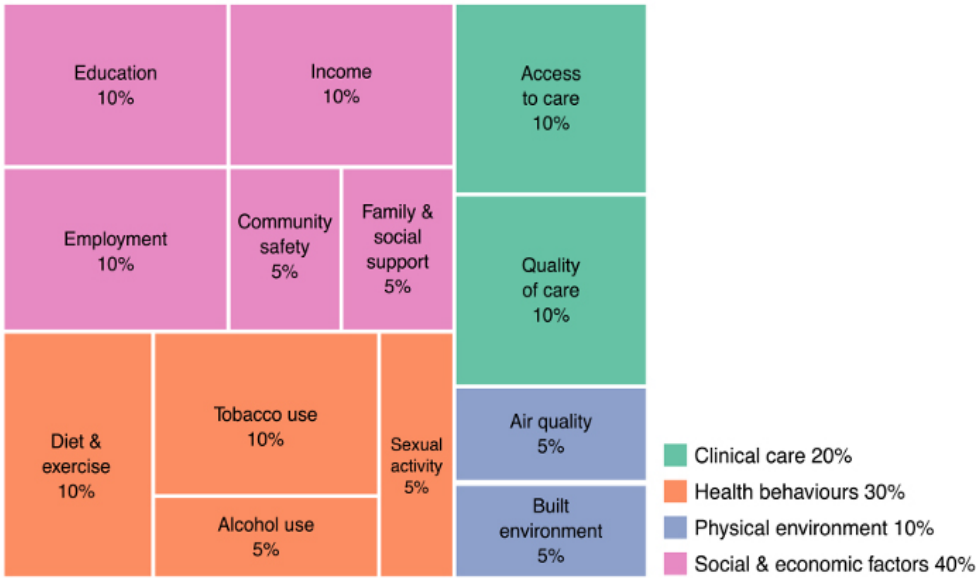
We plan to shift the dial toward focusing more on preventative services and interventions. Although our finances are challenged (see Chapter 6), we believe that more upstream investment in prevention is critical if we are to have an impact towards healthier lifestyles, effectively manage long term conditions and frailty (see 3.2) and improve health equity (see 4.1). It makes sense to intervene to keep people as healthy as possible for as long as possible. Furthermore, unless we make this change, our urgent and emergency care system (see 3.3) will never be large or efficient enough to cope with the numbers of older and increasingly unhealthy people.



The NHS as a local prevention Partner

Access to and the quality of healthcare accounts for about 20% of what influences a person's health. The other 80% is influenced by the physical environment, social and economic factors and a person's lifestyle choices (see Figure 6). Our NHS interventions complement the important role that individuals, communities, local government and national government play. The NHS can also play a major role in its local community through providing high quality employment across the full range of communities it serves, supporting a healthy workforce in a way that improves health equity, as well as supportive ways to help people into work through skills development. It also plays a big part in the local economy through procurement; housing, estates and land use; and sustainability. For instance, improving air quality through how organisations encourage staff to travel to work and the feasibility of using public transport to get there.

Figure 6: Factors that influence a person's health



Our councils' public health teams lead on many local prevention programmes, including weight management, mental health and physical activity. Active Together is the LLR programme that supports and enables physical activity and sport. Our councils also work on early intervention work, smoking, substance misuse and sexual health services.

Public health teams are also responsible for commissioning programmes such as 0-19 Healthy Child Programme including school nursing. Our councils also deliver many upstream prevention interventions to create an environment that supports community wellbeing, including those that tackle the wider determinants of health.

More information regarding our prevention work can be found in the Joint Health and Wellbeing Strategies and Community Health and Wellbeing Plans (see 1.1), as well as in Better Care for All, our health inequalities framework (see 4.1).

What people have told us matters to them
People tell us that they want to be empowered to play a greater role in caring for themselves and preventing ill-health, so they can make informed decisions that improve their health and wellbeing. People need better information, explanation and an understanding of their condition based on a foundation of good relationships between people and health and care staff, trust and empathy, tailored to acknowledge and appreciate cultural backgrounds and traditions. They need to be signposted to appropriate support services and local community groups. Carers told us that they need consistent information and be involved and better enabled to care for their loved ones, preventing deterioration and further ill-health.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 4 below summarises the key system-wide interventions we intend to make, over the coming years that will

have the greatest impact on prevention and improving health equity, and for which the local NHS is the lead Partner for delivery.

Specific interventions relating to, for example, keeping people well, mental health or children and young people, can be found within those sections of this Chapter.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 4: Summary of key prevention interventions we will make

Intervention	Timeline
Strategic and infrastructure interventions	
1. Redirect a proportion of annual growth allocation monies to prevention	24/25
2. Explore, with our Partners, the potential benefits to be gained from developing an LLR system-wide prevention strategy	23/24
3. Expand Healthy Conversation Skills training and embed in all organisations (Making Every Contact Count Plus) as a key prevention enabler	23/24 to 27/28
4. Capitalise on our dynamic research LLR community to maximise and embed benefits of research into prevention	23/24 to 27/28
Risk factor interventions	
5. Alcohol – Establishment of Alcohol Care Teams, providing an in-reach service. Ongoing development, monitoring, expansion, oversight and service improvement	23/24 to 27/28
6. Smoking – Deliver tobacco dependence identification and treatment services in secondary care, including across inpatient, maternity and mental health services	23/24 to 27/28
7. Obesity - Supporting people to access the NHS Digital Weight Management Programme	23/24 to 27/28
8. Diabetes - Supporting people at risk of type two diabetes to access the NHS Diabetes Prevention Programme and expand provision of diabetes structured education, including through digital and online tools	23/24 to 27/28
9. Cardiovascular disease and Respiratory - Improve detection and management of atrial fibrillation, hypertension and high cholesterol	23/24 to 27/28
10. Implement a focussed tuberculosis programme aimed at eradicating TB in LLR	23/24

How the above interventions will contribute to improving health equity
We know that unhealthy lifestyle choices tend to cluster and compound one another, and that these lifestyle choices tend to cluster more often in people from lower socio-economic groups. (See, for example, Meader, N., King, K., Moe-Byrne, T. et al. A systematic review on the clustering and co-occurrence of multiple risk behaviours. BMC Public Health 16, 657 (2016)). By (a) Focusing on co-producing accessible and culturally effective services to address the key risky lifestyle choices and (b) proportionately providing those services according to population need, we will directly address the main proximate causes of variation in life expectancy and healthy life expectancy seen between the most and least affluent parts of LLR.

3.2 Keeping people well

Effectively managing long term conditions, multimorbidity and frailty

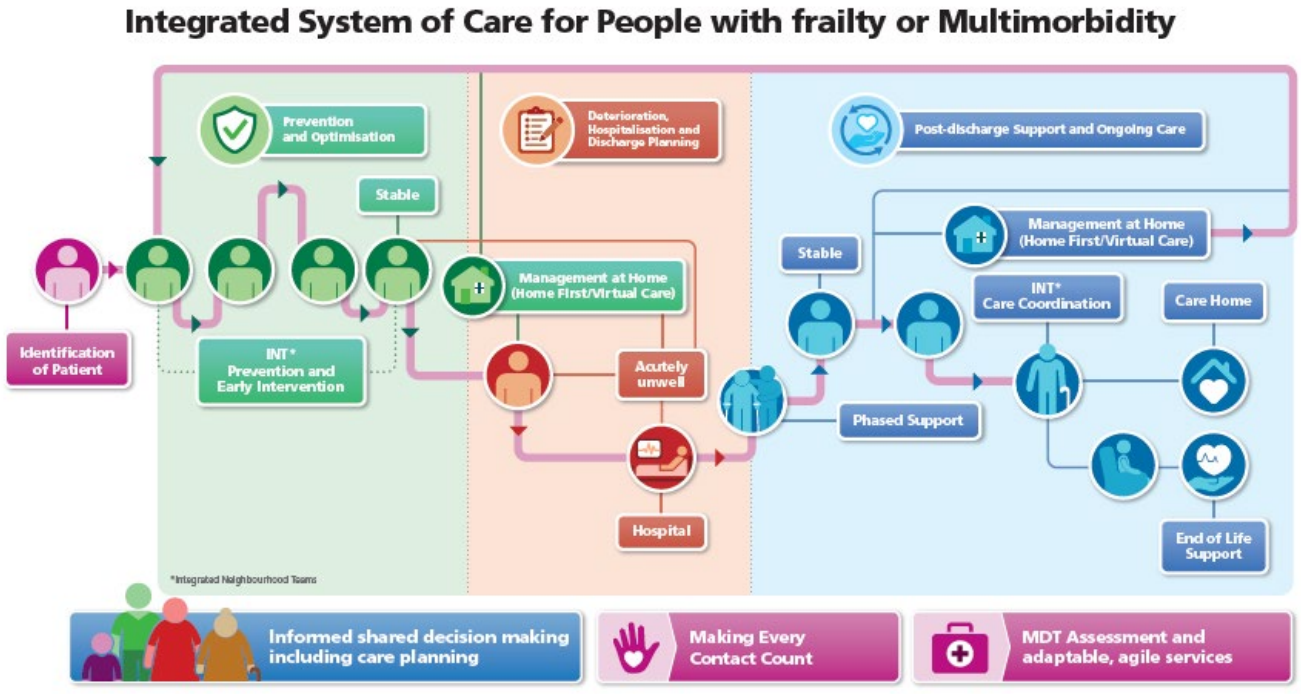
Local context

Much of the difference in life expectancy and healthy life expectancy, both between communities within LLR (due to health inequity) and when we compare LLR to other places and regions, occurs because of the prevalence, growth, and impact of long-term conditions and frailty.

Population Health Management approach

Our approach to keeping people well focuses on using a Population Health Management approach (see 4.2) to **case-find and diagnose people (including older people) with a long-term condition early**, optimise their care to delay further deterioration or development of further disease and ensure that they, and their carer(s) are supported in the right place with the right care in a crisis (see Figure 7).

Figure 7: Our care plan for people with long term conditions, multimorbidity and frailty



Effectively managing multimorbidity and frailty

We know from our local insights that once a person develops more than a single long-term condition, the care they receive can become fragmented as different specialist care professionals look after different diseases. People with multimorbidity, including older people and their carer(s), have told us that they want to be looked after by the same health and care professionals with continuity where possible.

We will deliver a **structured and holistic care plan for people with multimorbidity and/or frailty,** covering a range of interventions, provided in a local care setting, where possible, with the person's

named GP supported by a care coordination function. This will be a pre-cursor to the launch of the **proactive care service** through primary care networks in the next few years.

The proactive care service will include, for example, structured medication reviews, care planning, assessment for wider needs such as assistive technology, support for remote monitoring, personalised care packages and a crisis plan. The service will integrate the proactive and reactive offers of support across health, care and wider community services, taking account of the needs of the person's carer(s). Whilst people may be identified as potentially suitable through the risk stratification process, the person's GP will retain clinical judgement about final inclusion in this cohort.

We are reviewing our end-of-life strategy to ensure that people have a personalised and comfortable end-of-life with appropriate support to carers and families.

This service will be available for any person with five or more long term conditions or those with a clinical frailty score of 7.

More recently, primary care networks have been resourced to provide support to this cohort of patients in a comparable manner. Wrapping this up into one framework will support our providers to deliver care and our patients to understand what support is available to them in a holistic way.

This focus on structured, check-listed care is not new; simply a way to support people to access preventative care earlier and to ensure that they, and their carer(s)/support network, know what to do when a crisis occurs.

What people have told us matters to them
People living with long term conditions want to be able to look after themselves, where possible, but also know that support exists for them, when they need it. People are anxious when they first request help, and they can experience delays in receiving an initial assessment or diagnosis, including those with a mental health condition or autism. People and family carers need improved, appropriate and accessible information, support and advice throughout the illness, from a trusted source and to develop a relationship with health and care professionals to build confidence about caring for themselves. They also need professionals to have more knowledge about their condition and a greater understanding of the impact of their illnesses on their carers, families and communities.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 5 below summarises the key interventions we intend to make over the coming years.

A Delivery Plan underpinning these interventions can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 5: Summary of key interventions we will make to keep people well

Intervention	Timeline
With a focus on improving health equity:	
1. Undertake modelling to understand the qualitative and spend shifts that would result from delivering more up-stream evidence-based treatments	23/24
2. Drive up primary care identification of people with diseases (and their carers) to expected prevalence levels	23/24 & 24/25
3. Improve disease management in Primary care	23/24 & 24/25
4. Expand self-management and self-care programmes	23/24 & 24/25
5. Implement a proactive care framework	23/24 to 27/28

Successful implementation of 1 to 5, above, will allow us to: 6. Reduce the prevalence of an initial long-term condition leading to multimorbidity 7. Begin to slow the rate of increase in the incidence of long-term conditions	 From 27/28 From 27/28

How the above interventions will contribute to improving health equity
"The burden of non-communicable diseases reduces both the life expectancy and healthy life expectancy of adults across England, disproportionally affecting people by age, gender, ethnicity and socio-economic status. This is driven in part by the high and unequal prevalence of morbidity and underlying risk factors among the population". Research and analysis Annex C: data on the distribution, determinants and burden of non-communicable diseases in England OHID December 2021 The interventions described above to improve diagnosis and management of chronic disease will be undertaken proportionate to population need – recognising that the barriers to living successfully with chronic disease are greater for some groups than for others. Proportionately allocating resources to those with the greatest need will ensure that, as we improve the health of all our people, nobody is left behind.

3.3 Right care, right time, right place

Access to same-day health and care in our communities – an overview

People tell us that access to most care, particularly same-day care, is challenging, complex and frustrating, with the easiest access point at times being the Emergency Department. Some of our primary and community teams tell us of their frustration of having to refer patients to a hospital because they do not have access to the right diagnostics or referral rights to a particular service, leading to a poor patient experience of care. Our emergency department teams say that it is, sometimes less time-consuming to admit a patient than to find the right community service for their patient, especially when these services are "full". Our ward teams describe their difficulties in preparing patients for discharge and our social care teams regularly talk about their frustration in discharging patients onto a sub-optimal pathway, impacting on their experience of delivering care and the patient's longer-term outcomes.

Every part of our urgent care pathway is under constant pressure; demand outstrips capacity, resulting in patients often attempting to access care through multiple channels across the traditional boundaries of general practice, community based urgent care centres and/or acute services.

Our ambition is to break down these siloed services and create an integrated same-day access service based on local needs, an expanded and integrated care system outside of hospital settings and a system-wide discharge hub, enabling people to be seen in the right place at the right time. This will not only improve access to care across LLR, it will also allow us to consider local needs within communities, adapting to meet neighbourhood needs as we learn.

This overarching system of care will be made up of a set of integrated and seamlessly interlinked triage functions, with a clinical navigator directing and redirecting patients to the most appropriate care setting with the most appropriate clinician onto the right care pathway. This will be supported by a local 'directory of services,' accessible 24 hours a day, seven days a week to all access points, outlining the appropriate service based on the need described.

This approach will enable us to provide systematic right care at the right time in the right place, with a strong focus on the needs of local communities.

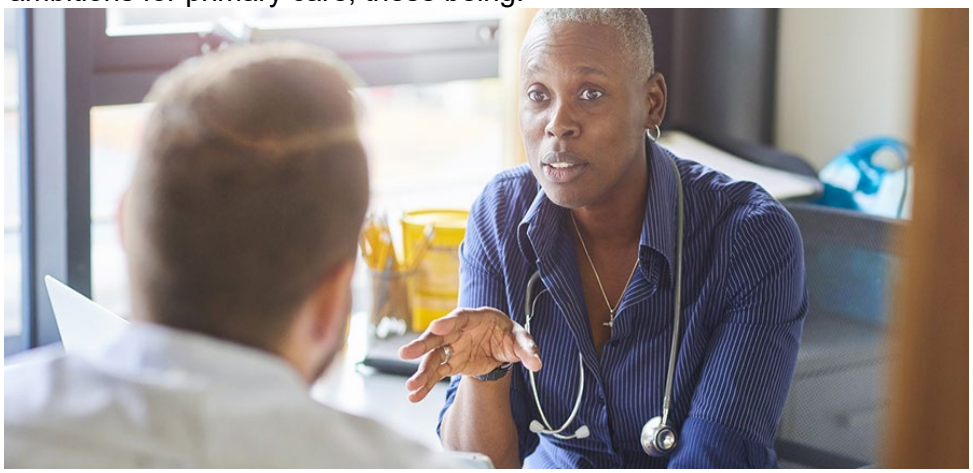
Primary Care

A new strategy for primary care

The gap between what people and communities want and need from primary care and what we are currently able to deliver is simply too big. To bridge this gap, we have developed a Primary Care Strategy to translate our vision for primary care into a framework for action that provides a mechanism to assure delivery of national and local requirements, including those set out by NHS England in the Delivery Plan for Recovering Access to Primary Care. Our Primary Care Strategy will address:

- National changes, contract reforms and the changing structures of the health and care system affecting primary care;
- Key system challenges; many of which are also present in primary care; and
- New models of care driven by changing public expectations, patient need and a focus on improving population health.

The Strategy will deliver our ambitions for primary care, these being:



- Breaking down traditional barriers and eradicating the historic divide in health and social care;
- Building on our collaborations; working with people, staff, partners and communities to understand what we need to do differently, working with them as equal partners to shape, design and deliver care;
- Improving health equity, closing the gap in variation and consistency of services to enhance people's experience;
- Developing a model of care that is fully integrated, multi-disciplinary and responsive to the specific needs of the population, focussed on prevention, self-care and shared health outcomes;
- Providing timely access to anticipatory and same day urgent care when it is needed;
- Ensure urgent care is safe, coherent, streamlined, locally accessible and a convenient alternative to A&E for patients who don't need hospital care;
- Make mental health and wellbeing services an integral part of primary care;
- Implement new models of care for key patient groups, including older people, the vulnerable and those with long term conditions;
- Give due regard to the Armed Forces Covenant, engaging with, enabling access and meeting the needs of the armed forces community
- Build services around people, in their neighbourhoods, closer to home;
- Empower people to play an active role in managing their own health, supporting the prevention and self-care agenda;
- Grow our multi-disciplinary primary care workforce, attracting, retaining, and developing staff, ensuring they are valued and supported through a positive culture;
- Make best use of our limited resources, providing care in the right place, in the right way, at the right time; freeing up our clinicians to care for the most acutely unwell; and
- Make primary care services available and accessible to our communities in local, fit for purpose premises which can offer a range of services and facilitate integrated teams.

Pharmacy, Optometry and Dental services (PODs)

In April 2023, NHS England delegated commissioning responsibilities for Pharmacy, Optometry, Dental services (PODs) and Secondary Care Dental services to our ICB. Additionally, in April 2024, NHS England will delegate commissioning responsibilities for a number of specialised acute and pharmacy services.

Locally, we are operating with our neighbouring East Midlands ICBs through a joint working arrangement, led by the East Midlands Joint Committee. This provides the platform for multi-ICB strategic planning and decision-making.

Primary care is the front door of the NHS, located in our towns, villages, high streets and communities. Increased autonomy at a local level will permit ICBs to plan and deliver more joined up primary care services that are locally led and locally responsive. This will enable us to deliver better health and care so that people can receive high quality services that are planned and delivered where people need them.

We recognise that local people are currently unable to register as an NHS dental patient. Notwithstanding the national contractual context, we will develop a plan, during 23/24, to address access to local NHS dental services.

Furthermore, during 2023/24, we will:

- **Work with our partners** across Community Pharmacy Leicestershire and Rutland, Local Dental Committee (LDC) and the Local Optometric Committee (LOC) to fully engage, collaborate, scope, plan and capitalise on the opportunities delegation permits.
- **Build networks** across different elements of primary care to work towards more holistic local primary care provision. We will do this by exploring opportunities to strengthen cross-sector working and synergy, for example between General Practice and Community Pharmacy via the Community Pharmacist Consultation Service (CPCS).
- **Build relationships** across both the region and system to increase capacity and capability and develop effective collaboration between colleagues at all levels to support with delegated responsibilities.
- Explore opportunities to **improve health equity** through a system lens, for example, links between oral health, deprivation and health inequalities.
- Opportunities to **review and revamp entire pathways** across multiple same sector providers, for example, ophthalmology with better coordination across primary care, secondary care and the independent sector.
- Explore opportunities for **local transformation**. Whilst recognising that many areas of transformation are restricted by national contracts, there may be opportunities for local transformation especially around workforce (for example opportunities for cross-sector working between primary and secondary dental care) and service provision (for example, out of hours emergency dental care and secondary care infrastructure).
- Define **system-wide workforce transformation** and new ways of working through the development of new operating models and removal of potential barriers including definition of the place and neighbourhood offers.
- Advise and influence an agreed approach to the **clinical and quality ICS priorities and workforce strategy**. This includes supporting the employment and deployment of staff to facilitate movement of staff and develop skills needed to deliver new models of care.
- Work collectively to manage the delegation of **specialised acute and pharmacy services.**
- Collectively produce a robust plan for the **transformation of POD services** for 2024/25 onwards.

Accessing same-day urgent care

People will access services through a range of channels to suit them; NHS 111 online, NHS 111 telephony, a neighbourhood contact centre, local GP practice telephony or the NHS app. People will be signposted to the most appropriate care setting with the most appropriate clinician, for example, pharmacists, GP's, nurses, paramedics and mental health practitioners.

Where self-care is most appropriate, advice will be given, where needed, through a range of channels. If same-day access is needed, an appointment will be booked with the appropriate professional(s) in their community. This could be with pharmacy services, paramedics, nurses, eye care services, mental health services, social prescribers, GP's or straight into community diagnostic services such as x-ray or minor injury. For our armed forces community, we begin piloting a single point of contact during 2023/24.

Where the need is more for planned care and not for same-day care, people will be offered an appointment as needed with the right professional or service.

Where capacity is not available in general practice or wider primary care services, people will be referred into the right services within our walk-in/booked service sites in each place and neighbourhood, such as urgent treatment centres.

Streamlining access in this way will ensure people get access to the right care faster, releasing time for clinical expertise to support those people with long term conditions, older people or those living with frailty, who benefit most from continuity of care.

Accessing same-day community care

People requiring same-day care that cannot be provided in the above services will be referred on to our **LLR Urgent Care Coordination Hub**. From here, services such as our 2-hour health and social care crisis response services, immediate mental health support, access to a virtual ward, physical ward or palliative care support will be arranged with the person and/or their carer/support.

Case Study

Right care,
Right time,
Right place
– Pre transfer clinical discussions

What was the issue?

LLR has a growing population of significantly frail older people living in long-term residential care, as well as in the community. These people may have cognitive and functional impairment, with underlying complex co-morbidity and it is important to minimise admission into hospital.

Intervention

A clinically-led pilot scheme for pre-transfer clinical discussion and assessment (PTCDA) was introduced on 31 March 2020, bringing together system partners from across primary care, community care, secondary care, ambulance service and social care personnel, all working together in new ways to promote both an effective community response and to avoid assessment duplication.
This would often entail a swift clinical discussion with a consultant geriatrician or geriatric emergency medicine consultant for supportive decision-making around hospital admission and exploring safer alternatives that might entail community-led work with other partners.

Impact

- Integrated working has upskilled the knowledge of frailty and end-of-life care, resulting in a significant decrease in the risks posed to care home residents and older people living in the community by hospitalisation.
- It is estimated that the pilot has so far led to the avoidance of 577 hospital admissions, 2,885 bed days and 730 ambulance journeys.
- The collective financial savings of the PTCDA pilot scheme to date total approx. £400k.
- Working closely as a team has created a culture of respect that has helped to reduce the duplication of assessments, benefitting both patients and staff.

Applying the learning

The provision of enhanced community assessment bundles, as an alternative to hospital admission, is often the preferred option for people, their carers and families.
The PTCDA pilot can now be accessed by any community-based clinician who is considering admitting a person with significant frailty/complex comorbidity, whether from a care home or their own home. This includes East Midlands Ambulance Service (EMAS) paramedics and technicians, general practitioners and other practice-based clinicians.

The Hub will access both system-wide services, such as virtual wards, as well as localised service provision within each place and neighbourhood.

The hub will comprise of clinical and practitioner teams, covering physical and mental health, with a strong focus on ensuring the contact concludes with the person in the right care setting.

To enable this, we will **expand community services** such as virtual wards, our 2-hour health and social care crisis response services, our step-up intermediate care offer and our urgent treatment centres to ensure capacity is available in these settings of care. Alongside this, we will expand our **community diagnostic offer,** based on local population needs, ensuring that access is equitable across LLR.

Accessing same-day acute care

People requiring acute care will also be referred through to the right acute care service, following a digitally enabled clinician-to-clinician conversation, accessed through the LLR Urgent Care Coordination Hub. This could be via an ambulance to same-day emergency care services or straight into an acute bedded service, as appropriate.

People who call 999 and do not present with an immediate, life-threatening need or require emergency care, will also be navigated to the right care through the Hub.

If people access walk-in services, such as general practice, an urgent treatment centre or A&E, without being navigated to that service prior to arrival, we will apply the same clinical triage function through our **primary care front door service**. This way, people become clearer on the right service for them, and those who need to be seen in those services, are seen quicker. As exceptions to this approach arise, clinical advice will always be followed.

By signposting people in this manner, we know we can manage demand across primary, community and acute care, make it as convenient as possible for people and their carers and make delivering care a better experience for our teams. This will enable us to deliver a service responsive to people's needs, delivering care in the right place and at the right time.

Expanding our discharge capacity across health and care

We know that some people remain in hospital for longer than necessary. This is not good for their outcomes or their independence. To tackle this, we will ensure that everyone admitted to an inpatient service will have an estimated discharge date and that joined up discharge planning will support discharge in a timely manner.

Case Study

Right care,
Right time,
Right place
– Facilitating hospital discharge

What was the issue?

An 84 year old person was admitted to the Leicester Royal Infirmary following a Stroke. Following recovery, they were moved to a Community Hospital to complete rehabilitation goals. Following assessment by an Occupational Therapist, it was found that there was no space in their home for a hospital bed, hoist, and equipment due a cluttered environment.

Intervention

The Lightbulb Project, hosted at Blaby Council, brings partners together to meet people's health needs inside their homes, for example, installing equipment such as shower chairs and offering energy advice.
The hospital enablement team coordinated a meeting with the Lightbulb project and the person's family, and an agreement was reached on clearance of the hallway and lounge, which happened within a week.

Impact

This enabled hospital equipment to be delivered, along with a specialist chair, and the person was discharged home with a package of care.
The intervention costs were much less than the cost of a hospital bed or a residential placement.

Applying the learning

In 2022/23, the Lightbulb Project helped over 900 people who were being discharged across mental health and acute hospitals.

Firstly, those people who can leave hospital, with no further care needs, will leave in a safe and timely manner. This will involve all our partners within LLR adhering to best practice guidelines for discharge, ensuring that this cohort of people, including older people, is safely discharged in a timely manner, ensuring effective co-ordination and communication with carers and families.

The second cohort of people are those requiring some form of onward care after leaving hospital. These people will be referred into the **LLR Integrated Discharge Hub**, where a group of multi-professional health and care teams will be tasked with ensuring people are discharged in a safe and timely manner, either to their home or to a place in which long-term care decisions can be made with rehabilitation and recovery support, again, ensuring effective co-ordination and communication with carers and families.

We recognise that the current intermediate care offer needs to evolve to support this process. People will be provided with an integrated **intermediate care** offer, designed to help them move from hospital into the right care setting, for example, this could involve domiciliary services, therapy services or home-based reablement. This will be supported by growing our local social care workforce in each of our places and neighbourhoods.

The core of this system of care will be that each of the individual functions act as part of an **integrated system of care**. Our ethos across each of these pathways will be 'right place, right time, right care,'

regardless of which organisation or service the person has accessed. This, and the connections between each service, will be vital to success.

Local evidence base

We have been trialling this system throughout the winter of 2022/23, with positive experiences reported by patients and staff delivering the services.

Some of our general practices have been trialling the use of cloud-based telephony, enabling call waiting times to be reduced significantly and patients navigated efficiently and effectively to the right service.

Northwest Leicestershire Primary Care Network have been navigating patients calling their general practices to their Community Pharmacy Service, freeing up significant GP time for those with more serious needs. People report a highly efficient service and practice staff appreciate the space this creates for other patient cohorts.

At a system level, we have piloted an unscheduled care hub, comprising of multi-professional staff groups who are navigating people, who have originally called 999, to the right place at the right time. 85% of people have been safely navigated to the right care, freeing up ambulance teams and supporting patients in their own homes.

Our central access point for mental health has been triaging and navigating patients to the right mental health service since the Covid-19 pandemic, enabling acute services to be freed up to support those with immediate mental health support. This supports people to avoid the emergency department and access the right care, quickly.

The emergency department, working with our community and primary care providers, have been triaging people at the front door of the department. Those with non-emergency needs are offered a booked appointment at one of our community sites; this means people are treated quickly and safely in an alternative setting and frees up capacity within the emergency department for more serious interventions. This is enabling between 30 and 60 people per day to be seen outside of A&E.

Investing in our social care workforce throughout the winter of 2022/23 has seen a marked increase in staff retention rates across our three places and has enabled hundreds of hours of additional care to be delivered in local settings.

What will this deliver?

Based on the above, if we scale our offer of the system of care described, we expect to see clear improvement against a range of measures, qualitative and quantitative:

- People should report easier access to a range of primary care services; triaged and booked an appointment suitable to their needs in the right timeframe;
- We should see an increase in use of alternative channels, such as NHS 111 / online and the NHS app to access services;
- We should see an increase in localised, personalised care being delivered by a multi-agency, multi-professional team with coordinated continuity of care for the patient and their carer/family. We should see a decrease in presentations to the emergency department and an overall decrease in GP contacts for this cohort of people;
- We should see less people accessing or being referred to multiple access points before a definitive decision, resulting in an effective and efficient experience of care for them and their carer/family;
- More equitable service across the 24-hour period; with local care being provided by local services based on local need, increasing equity of access and in a longer term, equity of outcomes; and
- People should see better longer-term outcomes from the care they receive, as they would be discharged in a safe and timely manner.

We will work at system, place and neighbourhood level to design and implement this model of care, tailored to each community. Deliverables against agreed baselines will also be agreed and monitored to ensure efficacy of service and of experience.

What people have told us matters to them
People tell us that they are frustrated about not being able to make appointments easily and in a timely way. Their GP is seen as vitally important. Often, people want to have an initial consultation with a GP or other health professional to identify their medical issue and for the GP or health professional to then devise a treatment pathway and provide advice about their condition – many people, and their carers, see this as the gateway to them being able to look after their own health more effectively. People and their carers experience 'story telling fatigue', having to repeat information about their health and treatment to each healthcare professional they encounter. People tell us that they need more care closer to home to improve the problems experienced by wider access issues, including travel and transport. However, people and their carers tell us that providing care at home can feel like waiting for the next crisis to happen, if it is done without appropriate support and services being in place, which involves family, carers and community. Many people want care at home to be more appreciative of emotional and cultural issues through trust and empathy. Community hospitals are seen as an important part of people's treatment closer to home. People, their carers and families feel that a supported discharge is essential to recovery and wellbeing, however, they are currently experiencing difficulties with discharges, feeling that there is a lack of process for clear and timely discharge, and joined up working between family/carers, health and social care. Sorting out medication sometimes feels chaotic. Insights from people also tell us that the urgent care system responds to illness rather than supporting health creation. The system should help people to recognise what they can do for themselves, encouraging them to care for themselves, when possible. NHS 111 and other urgent care services can contribute to building community resilience, especially amongst those living with long term conditions and those with young children. People also tell us they are confused about what services are for and where to go, especially for out of hours care and when there is an urgent physical or mental health need.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 6 below summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 6: Summary of key interventions we will make to deliver equitable access to the right care at the right time

Intervention	Timeline
Urgent and emergency care and Homefirst	
1. Streamline to a single point of access for same-day urgent care 2. Implement an Urgent Care Coordination Hub 3. Implement the LLR Integrated Discharge Hub 4. Implement the Urgent Treatment Centre (UTC) model across LLR	23/24 & 24/25 23/24 to 25/26 23/24 24/25

Primary Care	
5. Maximise General Practice capacity to meet demand for services and ensure the patient is seen in a timely manner, by the right service, first time	23/24 & 24/25
6. Streamline access processes including digital access	23/24 & 24/25
7. Optimise triaging to appropriate services, including pathways wider than primary care	23/24 & 24/25
8. Support PCN development, expansion and maturity, with a particular focus on PCNs that are experiencing difficulties	23/24 & 24/25
9. Develop an transition pathway for PCNs to evolve into INTs (Fuller stocktake report)	23/24 & 24/25
10. Undertake PCN estate reviews, leading to understanding of and proposed projects for estate development (Primary Care Estate Strategy)	23/24
11. Develop a plan to address local NHS dental access	23/24 to 24/25
Personalisation	
12. Develop a Personalisation Strategy	23/24
13. Increase Social Prescribing Link Worker capacity and referrals	23/24
14. Liberty Protection Safeguards service:	
a. Develop and deliver training in identifying need	23/24
b. Implement Liberty Protection safeguards service	24/25 to 25/26
15. Embed a working culture that embraces personalisation as the default approach to supporting people	From 23/24
16. Implement processes to create All Age Continuing Care Model	From 23/24

How the above interventions will contribute to improving health equity
The above interventions will improve health equity by creating more capacity in the system for those with complex health needs (disproportionately older people, those from minority ethnic groups, or less affluent neighbourhoods), as those with minor illness/injury will be seen in the right place. Expanded access will better support those for whom standard healthcare offers are inaccessible. The focus on improving the resourcing and stability of healthcare provision in underserved areas will begin to address the “inverse care law” which sees those with the greatest need for healthcare often having the lowest provision.

3.4 Integrated community health and wellbeing hubs

Creating the right environment for community health and wellbeing

To deliver the right care at the right time, we will need to systematically create and embed a 'team of teams' ethos, where teams across health and care work with local communities to embed the right care, right time approach within **community health and wellbeing hubs**. We know from our local pilots that, when our teams work in partnership, outcomes for patients are better and teams report a better experience of delivering services. This is especially true when services are delivered within local communities, using community assets, to focus on holistic, person-centred care.

Bringing teams together into one infrastructure is not a new idea. However, the scale of our ambition will require our health and council partners to think differently under the "one public estate" ethos. Delivery of local community health and wellbeing hubs will require us to look at our infrastructure in a completely different manner, with estates becoming a catalyst to integration, with a focus on health and care need, rather than simple buildings.

What is delivered in each hub would be tailored to local needs. However, if the basic premise of these hubs is to support teams to get patients the right care at the right time in the right place, then they should have direct links into and out of the services described earlier at 5.3. For example, the local primary care network may wish to use facilities to provide a community based, same day access service; the local 2-hour response service could be based there, working in partnership with a consultant out-reach clinic; local practices could run scheduled long term condition management support from these hubs; digital inclusion could be supported through a hub for virtual outpatient appointments. What is important is that provision in these local centres is based on the needs of the local communities, with a clear and unambiguous focus on equity.

What people have told us matters to them
Consistency and continuity of care are important to people. They recognise the need for closer integration between services to avoid 'story telling fatigue'. Delivery of good quality healthcare through a joined-up approach and the exchange of accurate information across organisations is seen as vital. Aligned IT systems is critical, as some people experience poor quality of transfer of information between services. People do want more care closer to home, but that care needs to be accessible. Some services, while physically closer to home, may not be served by public transport or have car parking and drop-off facilities, which are key factors for many.

Summary of key interventions

Responding to the above, table 7 below summarises the key interventions we intend to make over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 7: Summary of key interventions we will make to develop community health and wellbeing hubs

Intervention	Timeline
1. UEC Collaborative to lead engagement with all partners to ensure ownership and agreement of approach	23/24
2. Complete the development of Community Health and Wellbeing Plans	23/24
3. Develop a comprehensive understanding of current primary care and community health and care estate	23/24
4. Undertake a baseline assessment of current health and care staff capacity and skills, based on agreed hub sequencing	23/24 to 25/26
5. Agree geography, location, number and sequencing of Hubs across LLR	23/24
6. Develop Delivery Plans to roll-out all Hubs between 2024/25 and 2027/28	23/24
7. Establish hubs, based on agreed hub sequencing	24/25 to 27/28
8. Establish subsequent wave hubs, based on agreed hub sequencing	24/25 to 25/26

How the above interventions will contribute to improving health equity
Our model of community health and wellbeing hubs is founded on the approach of managing population need and not just healthcare demand. This approach will create an effective and efficient system of care which is person-centred and actively orientated to addressing the wider determinants of health, as well as the presenting problems of immediate healthcare need. The hub approach will allow us to place health and healthcare in their local social context though a "Healthy Conversations" model and the co-location of a variety of non-NHS support offers alongside NHS services.

3.5 Optimal Pathways for Elective Care

Local context

The impact of the Covid-19 pandemic is still being felt locally, in the amount of time people are waiting for routine operations and elective treatment. Waiting lists are significantly longer than they should be and there is much work to do, over the next few years, to reduce lists to pre-pandemic levels.

During the pandemic, resources were prioritised on the most urgent patients and those with cancer. Referrals slowed, as people with potential surgery or treatment needs were more reluctant to come forward. The impact of this was a significant growth in patients waiting longer.

Our approach

We are taking decisive action to address waiting list backlogs. A Planned Care Partnership (see 5.1) has been established to lead our approach, with membership from across our partner organisations, and we are already delivering improvements, for example:

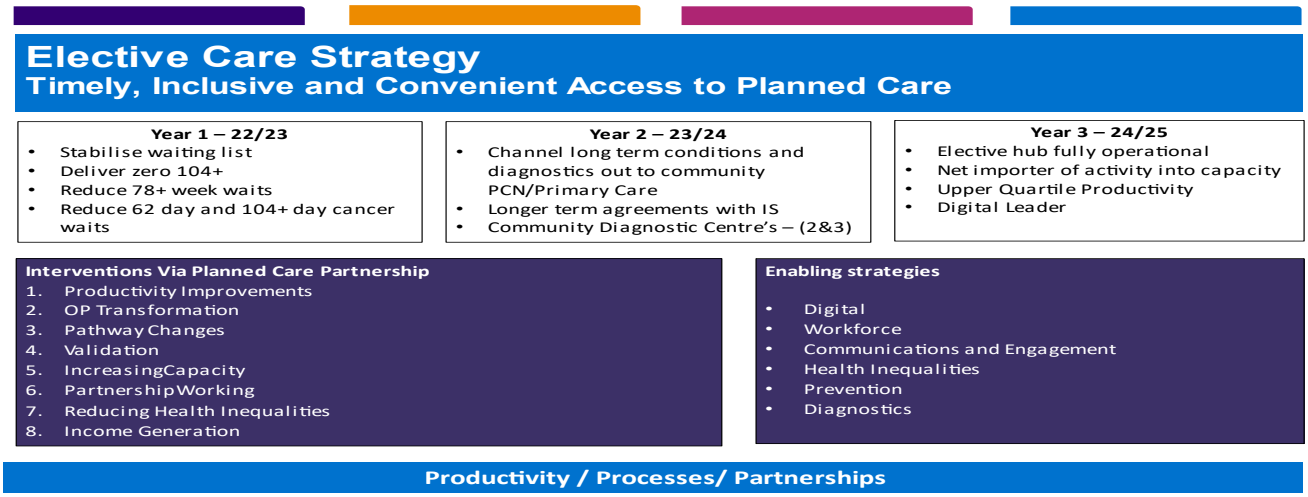
- Since March 2022, over 50,000 people, who would have been waiting over 78 weeks by April 2023 for their care, have been treated
- From October 2022 to April 2023 the number of people waiting for elective care decreased by 7,118 to 133,514
- As of April 2023, the number of patients waiting over 62 days for their cancer treatment is half of what it was in November 2022.

Over the next 1 to 3 years, we expect waiting lists to stabilise, waiting times to further improve and additional capacity to become available.

Summary of key interventions

Our strategy (summarised at Figure 8) is built on delivery of eight key interventions linked to improving process, productivity and capacity.

Figure 8: Our elective care strategy



What people have told us matters to them
People have told us that services do not always meet the needs of people when they first try to access help and some people experience delays in receiving an initial assessment or accurate diagnosis, as well as for the treatment itself. People would like more explanation of tests and treatments before a visit, to reduce confusion and, while they wait for treatment, they would like information and support such as pain management tools to help them cope. They would also like more support and appropriate follow-up after treatment, to help their recovery. Community hospitals are seen as an important part of patients' treatment closer to home to avoid visit to larger hospitals.

High-level deliverables against these eight key interventions (see figure 8) are set out in table 8, below. A more detailed Delivery Plan can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 8: High-level deliverables against the eight elective care interventions, by timeline

Interventions	Deliverables	Timeline
1. Productivity Improvements 2. Outpatient Transformation 3. Pathway Changes 4. Validation 5. Increasing Capacity 6. Partnership Working 7. Improving Health equity 8. Income Generation	• Begin activity flows through the East Midlands Planned Care Centre with further capital work to be fully operational in 24/25 • Build Community Diagnostic Centre 2 at Hinckley for activity to be delivered in 24/25 • Implement a range of community diagnostics in 13 PCNs and introduce GP direct access to diagnostics	23/24
	• Invest in the Referral Support Service to support early triage and shorter outpatient waiting times • Transformation of first tranche specialty end-to-end pathways	
	• Deliver 2023/24 elective priorities including a reduction in 62+ day cancer and 65+ week wait RTT	
	• Strengthen the LLR productivity programme in outpatients, theatres and diagnostics working with the National GIRFT team to meet recommendations	
	• East Midlands Planned Care Centre to be fully operational • Community Diagnostic Centre 2 at Hinckley to be fully operational • Expand the range of community diagnostics to a wider cohort of PCNs	24/25
	• Expand the Referral Support Service for both Elective and long-term condition patients in the community • Transformation of second tranche specialty end-to-end pathways	
	• Deliver 2024/25 elective priorities including 52+ week wait RTT	

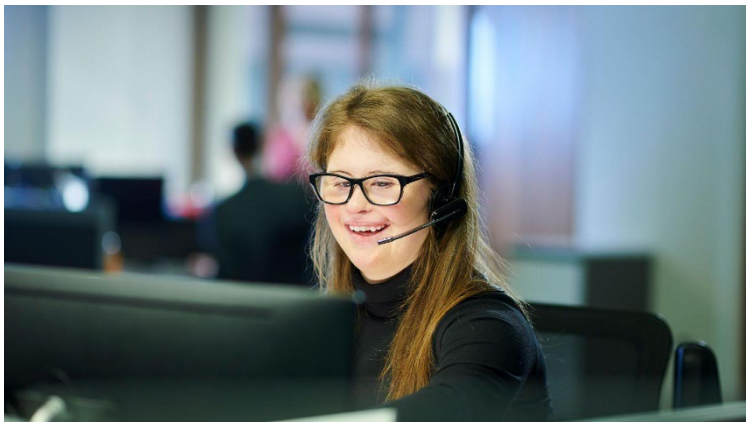
	• Work with EMCA to implement targeted lung health checks	
	• Develop case for Community Diagnostic Centre 3 if required • To become a net importer of activity to the East Midlands Planned Care Centre supporting the wider Region	25/26 & 26/27
	• Transformation of third tranche specialty end-to-end pathways	

How the above interventions will contribute to improving health equity
Ill health and associated disability are disproportionately distributed across our population, with those from the least affluent parts of LLR having the most barriers (including lower health literacy) to equitable access to diagnostic and elective treatment. Making equity impact assessments an essential precursor to elective service redesign will ensure that, as we recover elective performance and design new offers, we resource services proportionate to population need. Equitable access to elective care will reduce unwarranted and avoidable variation in outcomes from conditions amenable to elective intervention.

3.6 Learning Disabilities & Autism

Local Context

We know that there are considerable health inequalities for local people with a learning disability and/or autism (LDA). Our learning from deaths reports tell us that if you live in LLR with a LD, your life will be up to 25 years shorter than other people in LLR.



We believe that there could be even greater inequalities for individuals from different communities and we have more work to do to understand and address inequalities in our services.

Our Ambition for people with LDA, their Families and Carers

We are applying a person-centred, proactive, preventative and population health management approach, to better bring together service users, carers, families, health, social, community and independent partner organisations, thus enabling services to wrap around the person's needs. This means providing timely care and support interventions, better care co-ordination and preventing escalation.

Our approach

We have established a LLR LDA Collaborative to co-ordinate the transformation of LDA health services, as well as oversee the quality, performance, and outcomes of wider LDA services across the system, including ensuring the local implementation of the national Mental Health and LDA Quality Transformation Programme. The Collaborative works closely with the LLR local authorities and other stakeholders and oversees delivery of our LDA Operational Plan. Furthermore, we are part of the East Midlands Alliance for Mental Health and Learning Disabilities, which strengthens joint working and supports delivery across the region.

What people have told us matters to them
People have told us that they feel there should be a better understanding of learning disabilities and autism in the NHS and the impact that it has on carers and the whole family. People with learning difficulties feel they are more likely to be digitally excluded. They told us that getting a diagnosis can be a challenge and young people with learning disabilities, in particular, find hospital appointments particularly stressful and disempowering. Both young people and adults want more communications about services in a way they can understand. Family carers want support to care, particularly to avert a crisis happening to their loved one or themselves.

Summary of key interventions

Responding to the local context, business intelligence and insights from people t*able* 9 below summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 9: Summary of key learning disability and autism interventions we will make

Intervention	Timeline
1. Reduce adult and children mental health inpatient numbers through regular review of plans, with system escalation for individuals with a delayed discharge	23/24
2. Reduction in the use of out of county inpatient mental health hospitals	23/24
3. Increase the percentage of people on GP learning disability resisters who receive an annual health check and health action plan	23/24
4. Learning from Deaths Reviews (LeDeR) completed within 6 months and learning shared on a quarterly basis with system partners enabling improvement in services.	23/24
5. Continue to address health inequalities and deliver on the Core20PLUS5 approach	23/24 to 24/25
6. Optimisation of autism assessment services	23/24
7. Ensure appropriate quality assurance processes are in place across the collaborative to strengthen local LDA community health and social care services	23/24 to 24/25
8. Implement No Wrong Door Themes	23/24 to 27/28

How the above interventions will contribute to improving health equity
People with a learning disability or autism, as well as their families and carers, all too often experience unfair and avoidable variation in access, experience of care and outcomes from healthcare in LLR. The above interventions are targeted to address those areas where our performance is poor. The resources deployed, aimed both at people and their carers, will be proportionately allocated so that we make the most progress in taking down barriers to equity. Our “No Wrong Door” approach is founded on our commitment to listening to people with lived experience.

3.7 Mental Health

Children and young people, adults and older people

Local Context

One in four adults experience at least one diagnosable mental health problem in any given year, and the life expectancy of people with severe mental illnesses can be up to 20 years less than the general population.

The Leicester, Leicestershire and Rutland JSNA's and JHWSs (see 1.1) provide a comprehensive picture of local mental health challenges, with some key insights being:

Leicestershire:

- Performs significantly better than England for percentage of school pupils (secondary and primary age) with social, emotional and mental health needs and children in care (<18 years). However, over the last five years, the trend is increasing and getting worse.
- Performs significantly worse than England for the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate.
- Levels of dementia diagnosis are poorer than the national targets set by NHS England.

Rutland:

- Performs better than the England average for most indicators examining mental health risk factors, for example, children living in deprivation and premature morality in adults with severe mental illness.
- The armed forces community experience greater loneliness, in particular spouses of those serving.

Leicester City:

- Performs worse than the England average for most indicators examining mental health risk factors.
- One in ten children report having a mental health problem; many more say they feel stressed or overwhelmed.
- Particular challenges from severe mental illnesses, reported problems with wellbeing and use of opiates.

Across LLR, there are long waits for, and fragmentation of, support and offers. Local people also experience longer than average mental health hospital stays.

Our Ambition for mental health

We are committed to working in partnership with local people to achieve equity across all communities in:

- Increasing **mental wellbeing**;
- Improving the **experience, acceptance and understanding** for people who live with, work with or experience mental health challenges;
- Providing timely access to the **right mental health support** tailored to the individual's needs as locally as possible; and
- Delivering good mental health and physical health **outcomes** to improve the quality and **longevity** of life.

Our approach

We have focused on making material improvements to services for people with mental health needs, supported by a sizeable investment programme. These include:

Case Study

Mental Health – Crisis Cafés

What was the issue?

Support for people who need immediate help with their mental health.

Intervention

Leicestershire Partnership NHS Trust established a network of local Crisis Cafés to support people with immediate mental health needs. The cafes are drop in centres for anyone to talk about their mental health. Trained staff listen and provide practical support and advice.

Impact

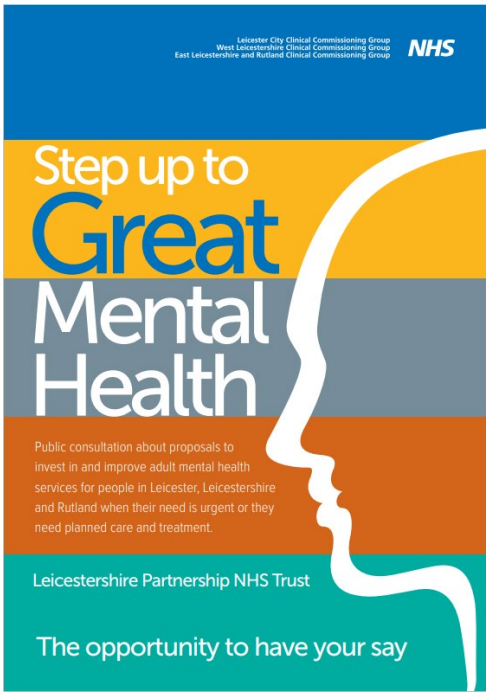
Café clients attend for a wide variety of reasons (loneliness, anxiety, depression, isolation, IT help, warmth) and staff provide support, advice, signposting and referrals.
Client testimonials suggest that the service is appreciated.

Applying the learning

There are currently 14 Cafés across LLR, with plans to provide 25 serving local communities.

- Introduction of a central access point (providing a direct way that people can get access to mental health support);
- Introduction of a mental health urgent care hub to provide a safe and tailored place for urgent help;
- Significant improvements to the environment, care and flow of mental health acute inpatient services, allowing people to be treated locally;
- Development of a community rehabilitation service to support people to live in the least restrictive environment possible;
- Mental health teams to support children's mental health, better and earlier, in their school environment;
- Navigation of children and young people into the best offers available to meet their needs earlier;
- Introduction of important new roles and offers such as Crisis Cafes (see case study), peer support worker, and widespread voluntary sector offers (Getting help in neighbourhoods); and
- Improving the dementia care pathway to support delivery of the Living Well with Dementia Strategy.

We also consulted with local people, during 2021 (see below), to get their views about how we could improve support to adults and older people who need mental and emotional support urgently, as well as about community mental health care and treatment planned in advance.



The consultation demonstrated high levels of support for the proposed changes and insights from people, carers and families have informed our ambition to:

- Organise and deliver most of our services and offers into neighbourhoods, so that they can be joined up and tailored to meet the specific needs of the local communities and individuals, their carers and families;
- Have a clear no-wrong door approach that ensures that wherever people present they are helped to the right support for them;
- Provide clear continuity and joined up support for people that ensures that they are not bounced between services;
- Deliver outcome focused support for people to ensure that offers are meeting their recovery goals, as well as their needs and those of their carers/families; and
- Focus on improving the wellbeing of the different communities to reduce mental health needs, supporting people as early as possible to minimise the escalation of any needs and to deliver high quality support and interventions as locally to where people live as possible.

To deliver our approaches, we have strong collaborative working arrangements between statutory mental health services and the voluntary sector network. We established a Mental Health Collaborative in 2022 to coordinate decisions, strategy and action, both within each place and across LLR. Furthermore, we are part of the East Midlands Alliance for Mental Health and Learning Disabilities, which strengthens joint working and supports delivery across the region.

What people have told us matters to them
Our 'Step up to Great Mental Health' public consultation, to which over 6,500 people contributed during 2021, has provided us with rich insights about what local people think and want. People have told us that mental health services should be treated as being equally important as physical health services. People tell us that they want a simple way of accessing mental health support and want to be able to immediately self-refer to a service if it is a crisis. Information needs to be accessible to everyone and services promoted. Prevention and early intervention are vital, as is appropriate self-help guidance, referrals and improved and timely access. People also tell us that they want to have services that are joined up, provided by proficient staff and provided in more local settings. Continuity of care that involves carers, family and the wider community is vital with no restrictions on access for older people. People value online services, including for diagnosing and consulting, but only when appropriate to their condition. People want the needs of those that are vulnerable to be met with services that reflect the needs of diverse communities.

Summary of key interventions

Responding to the local context, business intelligence and insights from people table 10 below summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 10: Summary of key mental health interventions we will make

Intervention	
1. Reorganise and expand mental health provision into eight neighbourhood teams across LLR	23/24
2. Establish a new neighbourhood approach for children and young people	24/25 to 26/27
3. Deliver a modernised workforce model across all agencies in each neighbourhood	23/24 to 25/26
4. Reorganise mental health inpatient provision to deliver high quality and financially sustainable provision	23/24 to 25/26
5. Deliver expanded, seamless and accessible psychological therapies step 2, 3 and 4	23/24 to 25/26

How the above interventions will contribute to improving health equity
The above interventions will make mental health support much more accessible and delivered in a way that breaks down barriers to engagement for those from the CORE20Plus cohorts, including for children and young people. The focus on better physical health for those with Serious Mental Illness (SMI) and the move to ensure mental and physical health needs are dealt with in an integrated model of care will directly address a known disparity in life expectancy and healthy life expectancy between this group and their peers without SMI. The Neighbourhood model will make services more culturally sensitive.

3.8 Children and Young People

Local context

A growing number of children are living longer with life-limiting and/or complex health conditions. There are also a significant number of children and young people who attend hospital services but could better be cared for within a community or home setting.

There is some duplication of services, staff and equipment across health, social care, education and voluntary sectors, leading to a lack of cohesion, as well as financial and workforce inefficiencies.

The impact of Covid-19 and the continuing pressure on services has resulted in delays in access to treatment, increasing the number of children and young people on waiting lists. Therapies, Mental health, Neurodevelopmental pathway and community paediatrics have seen a 30% increase in referrals. There is clear evidence that the full spectrum of more intensive services for children and young people across LLR are seeing a significant increase in demand, whether in the form of requests for social care, mental health support, community health services or urgent and emergency care. Not only does this represent a significant impact on the LLR population in terms of poor life experience and the potential for ongoing dependence on services, but the increase in demand is also pushing many of these services to the brink in terms of their capacity, while the associated costs are threatening the financial stability of all partners across the health and care system.

Preventing children and young people from reaching the stage where they need health and social care specialist services is a key priority to reduce demand in the system. The three levels of prevention, from universal to tertiary, are all critically important to improving children and young people health and wellbeing outcomes.

Our vision for children and young people's services

Our vison for children and young people (CYP) across LLR is for an equitable health service which are safe, personalised, kinder, professional and more family friendly; where every child and young person can have early access to care as close to home as. We want every CYP to be supported to reach their potential and feel safe and cared for in the family and community. We want our staff to be supported to deliver care, which is family

Case Study

Children and Young People – *Early Help* to children and families

What was the issue?

Our aim is to provide services that strengthen resilience and improve outcomes for vulnerable children and families. However, these services were being provided by different teams across different organisations and locations, leading to a disjointed and uncoordinated experience for children and their families.

Intervention

Development of 'family hubs', where integrated services are delivered to children and families by professionals who work together through co-location, data-sharing and a common approach to their work. Families only have to tell their story once and service provision (e.g. mental health support, SEND family worker, midwifery, computer skills, housing advice, digital access, etc) is integrated.

Impact

- There is 'no wrong front door' for families.
- Families receive the right service at the right time, and at the lowest possible level of service involvement, being able to self help where possible.
- Families and staff have a better understanding of available services and referral pathways
- Staff have a better understanding of the roles and remits of other services and are actively seeking opportunities to co-deliver where to do so will contribute to better outcomes for families.

Applying the learning

Focus on building and developing connections and resources in communities and neighbourhoods and ensuring that we are responsive to local need and listen to the voice of children, families and communities.

centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

Our approach

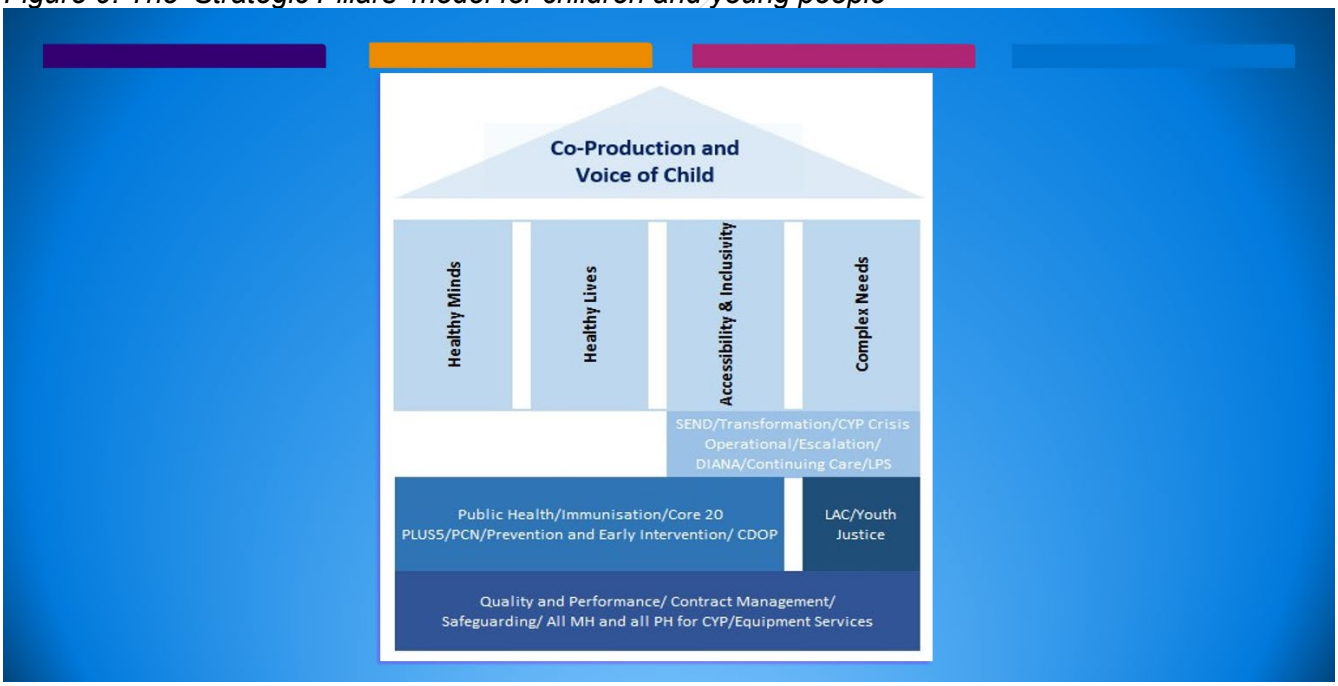
We will reshape the children and young people's portfolio, bringing all components across health and care together into a children and young person's collaborative partnership. This `collaborative` will have the voice of children and young people at its centre and will bring clinical and senior colleagues together from across the health sector, acute and community services, our local authorities, and voluntary sector providers. We have an ambition to address investment in children and young people's services in relation to health investment allocated to the rest of the population and develop a different and innovative commissioning model.

Our emerging strategy for children and young people built upon the `strategic pillars` - Healthy Minds, Healthy Lives, Accessibility & Inclusion and Complex Needs (see figure 9), will have**:**

- The voice of the child at its centre
- Prevention to be a part of every pathway
- Integrated pathways across ICB to support CYP to achieve their potential
- Early interventions and specialist support to effectively manage long term conditions
- Access to timely services delivered as close to home as possible by multi professional teams
- A competent skilled workforce that works across the acute and community system
- Using intelligence to address health inequalities
- Better preparation for adulthood and so improving transition pathways.

Our strategy will align also with Urgent & Emergency Care, Cancer, Elective, Long Term Conditions, Maternity, All-aged Mental Health and Learning Disability and Autism collaboratives plus learning from reviews of serious incidences and child /infant deaths.

Figure 9: The 'Strategic Pillars' model for children and young people



What people have told us matters to them
Children and young people have told us that they want to be listened to, taken seriously and understood. They tell us they want to be informed about their health, spoken to, not through, their parent or carer. They want a health care system which disrupts their education as little as possible,

and to understand that children and young people come with families, who also need to be considered.

They want information about health to be easily accessible and in places where they congregate. If the information is too difficult for a young people to process, then it must be produced in a way which makes sense to child and young person, including easy reads, videos, animation, podcasts and infographics.

Children and young people want staff in healthcare to treat them with respect and be aware of the issues facing them today. They want all professionals, who come into their lives, to recognise that they have a responsibility to support them into adulthood.

The assumption that children and young people are digital experts and, therefore, digital is the solution to engaging with them, is not that clear cut. Safeguarding, access and anxiety of miss-communicating their condition due to lack of knowledge, language and the power dynamic of child to adult conversation, concern young people. Finally, children and young people understand the importance, for all their peers, to have the best start in life followed by staying healthy and well. These are not outcomes; these are realities to them.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 11, below, summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 11: Summary of key children and young people interventions we will make

Intervention	Timeline
1. Enhance the current partnerships and collaboration and alignment to system and place-based strategies	23/24
2. Actively promote the voice of children and young people and their participation in strategic and operational developments	23/24 to 24/25
3. Address variations and equity in our health system using learning and outcomes from preventative programmes such as CORE20PLUS5 programme	23/24 to 24/25
4. Improve neurodevelopmental pathways and services for children and young people	23/24 to 27/28
5. Address barriers to accessing to mental health services for CYP and develop the locality neighbourhood model (See Chapter 3.7)	24/25 to 27/28
6. Remove barriers to accessing acute and community paediatric care pathways	23/24 to 25/26
7. Reduce waiting lists for accessing acute and community paediatric care pathways	23/24 to 24/25
8. Reducing the impact of demand upon children`s urgent and emergency care and develop preventative solutions	23/24 to 26/27
9. Working with regional and local networks and collaboratives to transform paediatric critical care and paediatric care pathways	

How the above interventions will contribute to improving health equity
Our Health Inequalities Framework (see 4.1) emphasises the importance of the best start in life. The above interventions, especially (though not exclusively) those from the CORE20Plus5 programme, will directly address prevalent risks relating to good outcomes for children and young people. This work will be linked to elements of our adult programmes through risk stratification and population profiling (see 4.2) so that support for adults with complex needs will be co-ordinated with support for children in the same households.

3.9 Women's Health, including Maternity

Local context

Across LLR, women live longer than men, however, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. Too often women's voices are not listened to, as detailed in the Ockenden review. Insufficient focus is placed on women-specific issues such as miscarriage or menopause. Locally, services for women's health are fragmented or duplicated across multiple pathways and organisations. Through this plan we make a commitment to improve the health of women across LLR; through better coordinated and tailored services we will make significant improvements to access, experience and outcomes.

Women's health through a life course approach

We will adopt **a life course approach to women's health** ensuring we focus on understanding the changing health and care needs of women and girls across their lives, from puberty to adolescents, young adults to later life, and not on interventions for a single condition often at a single life stage. This aligns with the approach detailed in the Women's Health Strategy for England 2022.

Our vison for women's services

We will ensure that our health and care system listen to the voices of women and girls; their health care needs will be understood, and services will be developed and tailored to meet their specific needs. Integral to this ambition is to drive transformation through a **system-wide women's health collaborative** that brings partners together to plan, design and implement change underpinned by insights and engagement. Key focus areas will be centred around, but not limited to, women's general health and wellbeing, health promotion and education, screening, sexual and reproductive health, maternity, gynaecology, women's cancers, women's mental health, safeguarding and menopause. Over the next five years we a have a clear ambition and plan to improve health outcomes for all women and girls across LLR.

Our vision for maternity services

Our vison for maternity services across LLR is for an **equitable service which is safe, personalised, kinder, professional and more family friendly**; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. We want our staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

We will work to the Three Year Delivery Plan for Maternity and Neonatal Services, continuing to make progress towards the national safety ambitions to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. We will embed the Ockendon and East Kent recommendations, as well as any other national reports and reviews that take place. Our Local Maternity & Neonatal System (LMNS) will continue to provide oversight and respond to MBRRACE recommendations and other internal and external reviews, such as CDOP. This will be done by focusing on improving our maternal and infant mortality rates by working as a system aligned to the

perinatal quality surveillance model. We will monitor and commission (where appropriate) external perinatal/maternal mortality reviews of our serious incidents, to ensure we embed learning. We will ensure that we have sufficient staff in place to realise our maternity transformation ambitions.

What people have told us matters to them
Women and families want to be empowered through the provision of high-quality information, advice and guidance. Mothers tell us they experience inconsistent and often conflicting information which confuses them. They feel that the best way to deliver information is through classes, directly by healthcare professionals, as well as through information online. Pregnant women told us that they need more time for appointments and to see the same midwife. They also want to feel listened to, particularly at the time of labour and giving birth. Antenatal classes are seen as vital for wellbeing and women also value post-natal support including ease of access to mental health services. A better understanding and appreciation of cultural backgrounds is felt to be important to build trust and empathy. Equity for mothers and babies from Black, Asian and mixed ethnic groups and those living in the most deprived areas is vital.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 12, below, summarises the key interventions we intend to make over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 12: Summary of key women's health and maternity interventions we will make

Intervention	Timeline
Women's Health	
1. Establish a Women's Health Collaborative to transform the current fragmented and un-coordinate care into better access, quality, experience and outcomes for women	23/24
2. Build relationships with women's groups, ensuring that we understand their needs and they have a voice in planning services across health care.	23/24
3. Lead the East Midlands Assisted Fertility Policy review and undertake an options appraisal to agree how we will meet new assisted conception recommendations in women's health strategy.	23/24 to 27/28
4 Work with system leaders to agree local models for implementation of women's health hub across LLR, to provide social, emotional and health support, including sexual health, menopause and social prescribing.	23/24 to 27/28

Intervention	Timeline
Maternity	
5. Listen to women and staff with compassion, to include:	
• Co-produce services via the LLR MVNP	23/24 onwards
• All women offered personalised care and support plans	23/24
• Undertake a whole pathway options appraisal on maternity information systems.	23/24 to 24/25
6. Support our workforce:	
• Increase fill rates against funded establishment for maternity staff	23/24 to 27/28
• Recruitment and retention plans in place	23/24
• Develop a positive and dynamic culture	23/24 to 25/26
7. Develop and sustain a culture of Safety:	
• Implement the Ockendon and East Kent actions and recommendations to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	23/24 to 25/26
• Develop clinical leadership	23/24 to 25/26
• Implement NHS- Patient Safety Incident reporting Framework (PSIRF) approach	23/24 to 25/26
8. Meet and improve standards and structures:	
• Maternity digital strategy outlining how women will access their records and interact digitally with their plans	23/24 to 24/25
• We will implement best practice consistently, including the updated Saving Babies Lives Care Bundle and new "MEWS" and "NEWTT-2" tools.	23/24 to 24/25

How the above interventions will contribute to improving health equity
The establishment of a Women's Health Collaborative and undertaking a needs assessment will support focused improvement programmes to address avoidable and unfair variation in access, experience and outcomes, both between women and their male peers, and between women from different ethnic and socio-economic groups. We know that LLR is an outlier in some key areas, such as maternal health amongst women from minority ethnic backgrounds, as well as some CORE20 and Inclusion groups. Specific work to improve this position is included in the above interventions.

3.10 Measuring and monitoring success

Managing delivery

We have established a delivery framework for this Plan (see 5.1), with clear accountability for driving and monitoring success. This means that all interventions, across all the priority areas in this chapter, have a specific Collaborative or Partnership – with multi-professional membership from across our partner organisations – that has responsibility for delivery. For example, the LDA Collaborative is accountable for delivering the LDA interventions.

Annex 1, to this Plan, sets out the key actions and timelines for each intervention, as well as the impact and/or outcomes that each intervention is expected to deliver. Our Collaboratives and Partnerships will monitor progress against this annex and, indeed, will usually have access to a much more granular and bespoke data set, taking into account both local and national performance requirements.

Delivering our Pledges to local people

The Collaboratives and Partnerships will also be accountable for delivering our Pledges to local people. Table 13, below, summarises the measures we have identified and against which each Pledge's progress will be monitored, as well as the Collaborative or Partnership accountable for delivery.

Some pledges will be delivered in one or two years, whereas others, for example *improving health equity*, will be delivered over the longer term. Measures against some pledges are still to be defined, particularly where we are re-organising our focus on a particular area, for example *Children & Young People*, and some measures may change because of national policy, for example ambulance response times or waiting list targets.

Table 13: Measuring success against our Pledges

Delivery Priority	Pledge	Measures we will use	Reasoning	Accountability
Improving health equity 	**Pledge 1** **Improve the health** of our most deprived communities and **narrow the gap** between those who have the best and the worst health	1) Life expectancy and healthy life expectancy 2) Gap in life expectancy between most and least deprived populations	These measures are reported, nationally. Therefore, we know the current position (baseline) and we can track improvements in local life expectancy and healthy life expectancy, as well as success in improving equality in life expectancy.	LLR ICB via the Health Equity Committee
Preventing illness 	**Pledge 2** Spend more money on **preventing people becoming ill** in the first place	Under 75 mortality rate from causes considered preventable, targeting: - Cancer - Cardiovascular disease - Respiratory disease Prevention spend measure to be defined during 23/24	Cancer, cardiovascular disease and respiratory disorders are the three most common causes of local preventable deaths (see 3.1). All or most deaths from these causes could mainly be avoided through effective prevention interventions. These preventable mortality rates are calculated, nationally. Therefore, we know the current position (baseline) and we can track reductions in preventable deaths achieved through (amongst other interventions) increased spend on prevention.	Prevention Partnership (TBC)
Keeping People well 	**Pledge 3** Identify the **frailest in our communities** and wrap care and support around them	Proportion of patients with moderate or severe frailty that have a care plan in place	There are no national metrics available. Therefore, we will use local date to construct a baseline of the percentage of patients with moderate or severe frailty and that currently have a care plan in place. Care planning is a good indicator of the effectiveness with which we are supporting frail people. We can then measure progress in increasing the proportaion of people with moderate or severe frailty and that have a care plan in place.	Urgent & Emergency Care Partnership

Delivery Priority	Pledge	Measures we will use	Reasoning	Accountability
Right care, Right time, Right place 	**Pledge 4** Improve and maintain access to **routine general practice**	Trajectory to deliver appointments in general practice	This measure is reported, nationally. Therefore, we know the current position (baseline) and we can track our progress, month-by-month, to deliver our GP appointment targets.	Urgent & Emergency Care Partnership
	Pledge 5 Reduce Category 2 (emergency calls such as stroke patients) **ambulance response times**	Category 2 ambulance response times	Category 2 ambulance calls are those that are classed as an emergency or a potentially serious condition, for example, a person may have had a heart attack or stroke or be suffering from sepsis or major burns. Response times are recorded and reported, nationally, and, therefore, we can track our progress as we seek to respond to 30% of Category 2 calls in 30 minutes for 2023/24.	Urgent & Emergency Care Partnership
	Pledge 6 Reduce and maintain waiting times in the **Accident & Emergency** department	Accident & Emergency waiting times	95% of patients seen in A&E within 4 hours is the national target and which is reported on month-by-month. We can, therefore, track our progress on recovering our local position to reach and maintain the 95% target.	Urgent & Emergency Care Partnership
Health and Wellbeing Hubs 	**Pledge 7** Provide more joined up, holistic and person-centred care, **delivered closer to home**	Measure to be defined during 23/2	Once the geography, location, number and sequencing of Hubs across LLR is clarified, during 23/24, suitable measure(s) can be more readily defined.	Urgent & Emergency Care Partnership
Elective care 	**Pledge 8** Reduce **waiting times for consultant-led hospital treatment**	Referral to Treatment (RTT) waiting times	The amount of time a person waits from when they are referred by a GP to when the consultant-led treatment begins (known as Referral to Treatment (RTT)), are reported monthly. Therefore, we can track our progress in reducing the number of people waiting 18 weeks (the national standard) or more for treatment, as we recover our elective position.	Planned Care Partnership
Learning Disability & Autism 	**Pledge 9** Increase the percentage of people on GP **learning disability** registers who receive an annual health check and health action plan	Number/percentage of learning disability Annual Health Checks carried out for persons aged 14 years or over.	People with a learning disability often have poorer physical and mental health than other people. The Annual Health Check is a GP service to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, which will include producing a health action plan. Data is collected via the Quality & Outcomes Framework (QOF) and we can, therefore, track our progress in increasing the numbers/percentage of people on GP learning disability registers who receive an annual health check and health action plan.	LDA Collaborative
Mental Health 	**Pledge 10** Reduce **inequity in access to mental health services** across each of our neighbourhoods	Budget allocation analysis, with a five-year plan to progressively align mental health investment more proportionately to the most disadvantaged areas in LLR.	Suitable and useable metric(s) to be piloted in 23/24, with implementation from 24/25.	Mental Health Partnership
Children & Young People 	**Pledge 11** Improve access to, experience of, and outcomes of care for **children and young people** - with a special focus on driving up health equity	Interim measure: Waiting times for CYP services in 23/24. During 23/24, we will develop metrics across the CYP Pledge	We are reshaping children and young people's services, bringing all components across health and care together into a children and young people's partnership. The emerging CYP Strategy will help distill the appropriate metrics to deliver our Pledge, during 23/24, and which will be implemented for 24/25 onwards.	Children & Young People's Partnership
Women's Health, including Maternity 	**Pledge 12** We will engage with, listen to, **empower and co-produce services with women and girls**	Maternity Friends and Family Test across four stages of care: - Antinatal care setting - Birth setting - Postnatal ward setting - Postnatal community setting	The Friends and Family Test (FFT) is an important feedback tool that supports people who use NHS services to provide feedback on their experience. Listening to women's views helps identify what is working well, what can be improved and how. The FFT asks people if they would recommend the services they have used and offers a range of responses. The FFT is reported, nationally. Therefore, we know the current position (baseline) and we can track improvements in women's experience of maternity services.	Women's Partnership
Our People 	**Pledge 13** We will shape **our people** and services around the needs of our population by **improving workforce retention, reducing agency usage and growing our workforce** to ensure we are fit for the future.	Measures to be defined during 23/24		LLR People Board

Conclusion

The vision outlined in this chapter may seem a long way off – but the passion with which our people have come together to articulate this vision and associated plans demonstrates our ambition to build a sustainable and equitable future.

Through the pandemic, this system and the people within it, came together to transform services overnight in the most extraordinary manner. We now need to call upon that spirit to deliver this plan so that we realise our original goals – to make it easier to **access care** when it is needed, make it easier for our **teams to be able to deliver this care** in an effective and efficient manner and to ensure this care will **deliver equitable outcomes** for the people of Leicester, Leicestershire and Rutland.

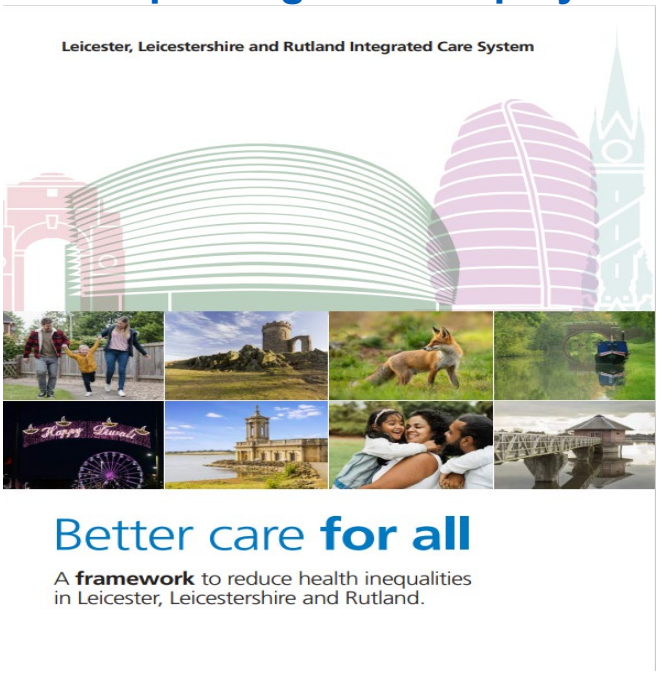
Our success will be measured, not just in the traditional dashboards of inputs and outcomes, but also by looking at people's experiences of the care that they receive. We will have succeeded when people who need access to health and care on the same day receive it; those who need care within a hospital setting receive it in an effective and efficient manner; those living with one or more long term conditions or frailty are supported in their place of choice; every service provided will see a measurable impact against inequity and seek to further address this; people who need a diagnosis receive it in a timely manner; and those who deliver care can do so without moral injury.

Clearly, some of these will continue beyond the life of this five-year plan as we seek to address systemic and historic challenges and, indeed, pivot to tackle any new challenges which arise. However, in partnership with our communities and our teams across statutory, voluntary, community and faith services, we can design, deliver and evidence the success of this vision, building a durable foundation for further improvements in access, equity and outcomes of care.

Chapter 4: Cross cutting themes

In this chapter, we describe how we will address important themes that reach across all the service delivery areas identified in Chapter 3.

4.1 Improving health equity



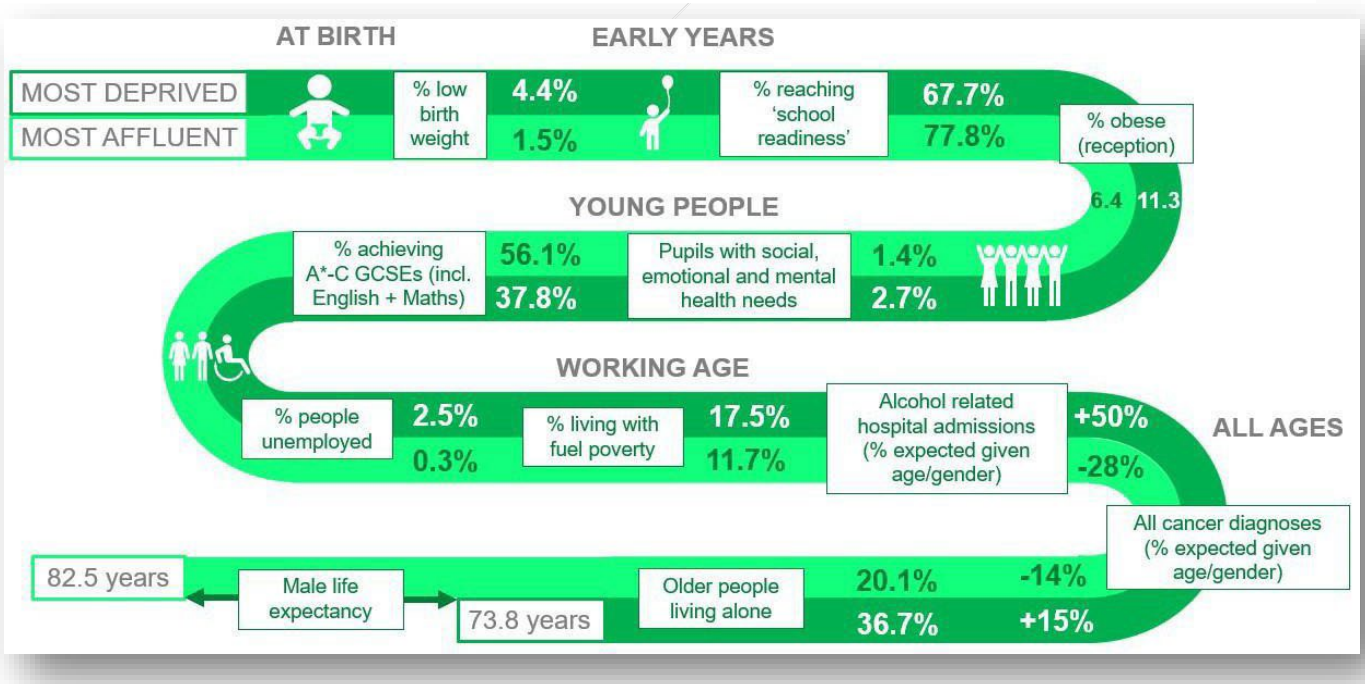
What do we mean by health equity?

Health equity is about removing the avoidable and unfair differences in health between different groups of people. Health equity concerns not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Why focussing on this is important to us

There are stark gaps in health equity across LLR. A boy born today in our most deprived area could be expected to die up to nearly nine years earlier than a boy born in the least deprived area. Furthermore, people from less affluent areas will be spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area (see figure 10).

Figure 10*: Difference in health indicators between the most and least deprived local areas of LLR*



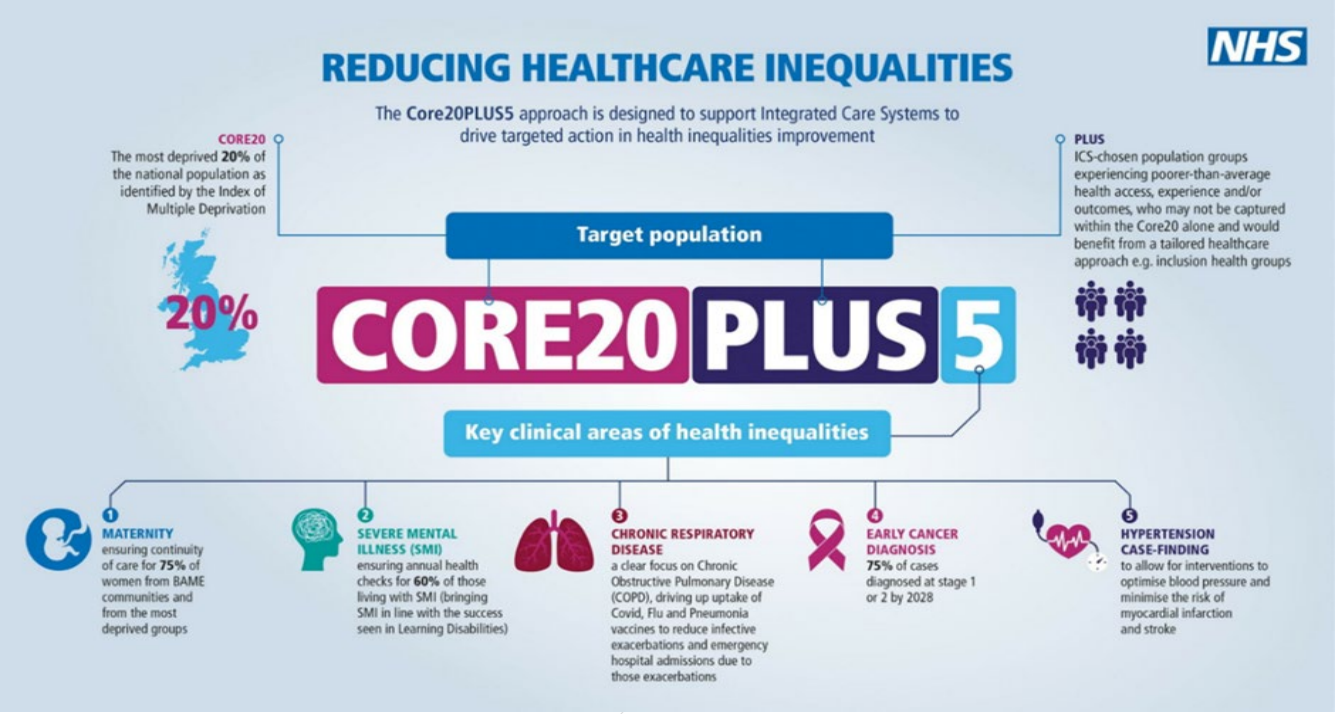
We want local people to be healthier, with everyone having a fair chance to live a long life in good health. Therefore, this Plan aims to 'level up' services and funding.

Our approach – Core20PLUS5

Core20Plus5 is the national approach to improving health equity and focuses on:

1 The people in LLR who live in the 20% most deprived parts of England (whom we know have disproportionately poor access and outcomes);
2 LLR seldom heard and underserved groups with additional barriers to good outcomes, such as those with learning disabilities, ethnic minority groups, carers and older people; and
3 Five key clinical areas (within 2, above) which are known to have the greatest adverse impact on life expectancy and healthy life expectancy (see Figure 11). More information about this approach, as well as on the CORE20Plus5 approach for children and young people can be found in Better Care for All, our Health Inequalities Framework.

Figure 11: The Core20Plus5 approach to improving health equity



System-wide interventions to improve health equity

Action to improve health equity happens at a number of levels. Firstly, we have included interventions, that the local NHS will implement, within the relevant sections of this Plan, most specifically, Chapter 3 (Delivery Plan).

We also work with our councils to support the delivery of health equity improvements highlighted within their Joint Health and Wellbeing Strategies (see 2.1) and Community Health and Wellbeing Plans.

Finally, key system-wide interventions are led by all LLR partners, with the ICB as a core Partner, and these are set out in Table 14, below, with more information available in the LLR Health and Wellbeing Partnership Integrated Care Strategy.

Table 14: Our key system-wide interventions to improve health equity

Intervention [From the LLR Integrated Care Strategy]	Timeline
1. Apply our Health Inequalities Framework principles across our three Places	23/24 onwards
2. Make investment decisions across LLR that reflect the needs of different communities	23/24 onwards
3. Establish a defined resource to review health inequalities across LLR	23/24 to 25/26
4. Ensure people making decisions have expertise of health inequity and how to reduce it	23/24 onwards
5. Improve data quality and use to enable a better understanding of and reduce health inequity	23/24 onwards
6. Health equity audits will inform all commissioning or service design decisions	23/24 onwards
7. Staff will be trained to understand and champion approaches to reducing health inequalities	23/24 onwards

Case Study

Improving health equity – Covid19 vaccine hesitancy in St Matthews

What was the issue?

Covid19 vaccine uptake data by ethnic group demonstrated that Leicester's Somali population had 49% uptake in over 50s, at March 2021, compared with 78% in the population overall. Over half of the Somali population live in two neighbouring areas of the city; St Matthews and St Peters.

Intervention

In-reach pop up clinic at a local faith centre

Community engagement:

- Zoom webinars hosted by a local GP and community leader
- YouTube video cascaded via the local community Whatsapp group
- Written materials sent to local shops, mosques, schools and community organisations
- Information sharing on the COVID helpline by population advocates
- Social media activity

Impact

Within a week of the interventions (by end March 2021), uptake in the over 50s Somali population had increased from 49% to 60%.

By August 2021, dose 1 uptake in the over 50s Somali population had reached 78%.

Applying the learning

The interventions have been used to target other communities and work settings where vaccine hesitancy existed.

4.2 Population Health Management

What do we mean by Population Health Management (PHM)?

At its most basic, PHM uses data – be that health, social care, education, demographic or housing data – to understand the needs of a population. Its main purpose is to help identify groups (cohorts) of people and match them to the correct intervention to improve health outcomes.

PHM includes two key tools – segmentation and stratification:

- Segmentation essentially means dividing people into groups. This could be by common illness, groups of illness, age or other factors
- Stratification is simply another term for sorting, but there is more analysis applied here, as the sorting is into risk factors

Principles of our Population Health model

The "Manage Need, Not Just Demand" model

- Prevention at every stage: Prevent – Reduce - Delay
- Parity of esteem for mental and physical health
- Health as co-production between clinicians, communities, families and individuals
- Relentless transformation for greater health equity - of access to care, experience of care, and outcomes of care. Driving up health equity will require integrated and collaborative work with partners to address the wider determinants of health alongside NHS care
- Focus on value-based commissioning of services with Partners – including a proportionately universal approach to resource allocation
- Evidence-based treatment, at scale where possible – research to fill in the gaps in the evidence
- A "learning culture" to improve the model – rigorous evaluation based on the quintuple aim of PHM
- A life-course approach to optimal health – it's never too late to improve experience of care or outcomes of care

Our approach

Make every contact by the NHS count **(MECC)**

We will use all types of contact that people have with the NHS to promote health and help people prevent illness or manage it effectively (see 3.1).

Self-management and self-care programmes delivered at scale for those with chronic conditions

Living well and staying well when you have a condition that cannot be cured requires practical skills and a knowledge of when to look for support from others. These skills will be taught and refreshed through structured programmes based on the latest theories of learning and behaviour change (see 3.2).

Population needs profiling

We will utilise, for example, JSNAs, risk stratification, segmentation, impact profiling and feedback from people with lived experience.

Integrated Care for a targeted cohort

With multi-morbidity/frailty or evident disadvantages in the wider determinants of health (see 3.3).

Time-bound (though intensive) case-management
For a small cohort of people with emergent instability of symptoms.

A shared record that is well-coded and well-tended
This is essential both for continuity of intent/care AND as the basis for better health equity and evaluation of schemes (see 4.6).

A tiered matrix of out-of-hospital urgent and emergency care
Bring comprehensive assessment and senior decision makers to bear on presenting illness in a timely and appropriate manner. Linked back to risk stratification profiles and self-management programmes (see 3.3).

A well-structured programme of informal carer support
This will include identification, registration, health checks, vaccination, respite, benefits optimisation, training and skills.

Delivering prevention, health promotion and treatment on a household footprint
Rather than to individuals, where possible.

Work in concert with other system Partners to help address issues relating to the wider determinants of health
Beyond the scope of this Plan – though a core part of our approach.

Case Study

Population Health management – better end-of-life support

What was the issue?

The team at Willows Health in Leicester had previously struggled to proactively identify people who were potentially nearing the end of their lives, in order to ensure they are given appropriate care and support

Intervention

The team adopted a PHM approach and, using a new algorithm called the Mortality Risk Score, they were able to identify a number of patients who had not previously been included on the palliative care register.

Impact

This approach has supported care planning work with palliative care patients and enabled the team to provide patient-centred reviews and end-of-life care plans for those with higher levels of risk.

Applying the learning

The team are now able to offer the right support to a greater number of patients who are nearing the end of their life.

4.3 Quality Improvement

Core Responsibilities and Functions

Our approach to quality and performance improvement is underpinned by our Quality and Performance Improvement Strategy, as well as NHS England's Quality Functions and Responsibilities of Integrated Care Systems, which summarises how quality functions are expected to be delivered:

1. Establishing quality governance arrangements, including a System Quality Group
2. Putting in place quality systems and assurance
3. Implementing arrangements to ensure patient safety
4. Improving people's experience of care
5. Ensuring clinical effectiveness
6. Safeguarding arrangements
7. Enacting new duties (abuse and violence, mental health and quality improvement programmes): and
8. Sustainability.

Our Priorities for quality improvement

Patient Safety

Whilst our individual healthcare providers are accountable for their learning responses to patient safety incidents, we work collaboratively, across LLR, to facilitate and provide supportive oversight, including in the implementation of the new Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS's revised approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Infection Prevention and Control

We work collaboratively with our healthcare providers, bringing oversight, leadership, support, and guidance to ensure effective management in the prevention and control of infections.

Serious Violence Duty

We work as a member of the LLR Strategic Partnership Board (SPB) with local authority, police, justice system, fire and rescue and other Partners to share information and collaborate on interventions to prevent and reduce serious violence and crimes. In order to discharge our duties under the Police, Crime, Sentencing and Courts Act 2022, the SPB will develop and implement a Strategy to prevent and reduce serious violence across LLR. At a more local level, we are members of Community Safety Partnerships (CSPs), which provide a multi-agency approach to tackling local issues with the aim of making communities safer.

Safeguarding

It is the responsibility of each of our Partner organisations to ensure that people in vulnerable circumstances are safe and receive the highest possible standard of care. We are committed to promoting the safety and wellbeing of children, young people and adults who may be at risk of abuse or neglect and ensuring the health and well-being of Looked After Children.

Working closely with our Local Authorities, healthcare providers, safeguarding partnership and network of professionals we deliver against agreed Safeguarding Adults and Children's Boards Business plans. This work includes but is not limited to:

- Child Protection-Information Sharing
- Serious Violence Duty
- Female Genital Mutilation
- Prevent
- Modern Slavery and Human Trafficking
- Domestic Abuse
- Child Exploitation
- Mental Capacity
- Child Death Overview Panel

Special Educational Needs and Disability (SEND)

The ICB is working in partnership with Leicester City, Leicestershire and Rutland Councils, University Hospitals Leicester and Leicestershire Partnership NHS Trust, to collaborate in improving services and support for children and young people with SEND, as directed by the SEND Code of Practice 2015 (Children and Families Act 2014).

As an ICB we will:

- Commission services in partnership with our local authorities for children and young people aged 0-25 years old with SEND
- Work with local authorities and NHS health organisations to contribute to the Local Offer and provide information about health care services
- Work closely with: Leicester City and Rutland Parent Carer Forums and Leicestershire SEND Hub; supporting groups that represent young people with SEND; Health Watch; the voluntary sector; and community groups
- Make health care provision available where exceptional clinical health needs related to education are specified in Part C and G of individual Education, Health and Care Plan (EHC plan), as part of our commissioning role
- Work with local authorities in making decisions at all key stages for EHC plans.

Our NHS health organisations will:

- Support identification and support for children and young people requiring SEND provision and promote Individual Health Care Plans (IHCPs)
- Respond to requests for advice for EHC plans within the required timeframe
- Work with local authorities to contribute to the local offer of SEND services available
- Work closely with: Parent Carer Forums supporting groups that represent young people with SEND; Health Watch; the voluntary sector; and community groups.

The ICB SEND Designated Clinical Officer (DCO) is a dedicated role that supports Leicester, Leicestershire & Rutland and LLR ICB in implementing and embedding statutory responsibilities for children and young people with SEND. The DCO supports health colleagues across the ICB and our health providers to ensure children and young people 0-25 with SEND have the right health support to achieve the best outcomes they possibly can. The DCO also works with the local authorities in making decisions at all key stages for EHC plan and agrees the health services within an EHC plan.

Medicine Optimisation and Safety

We will enable transformation and support the pharmacy workforce to:

- Reduce health inequalities through improving access and optimisation of medicines
- Tackling antimicrobial resistance
- Tackling overprescribing and reducing the prescribing of drugs of dependence
- Reduce the environmental impact of medicines and dispensing
- Transform community pharmacy to support acute and elective care pathways
- Develop an integrated system workforce approach driven by the pharmacy faculty; and

- Reduce patient harm from medicines.

Maternity

We will respond to the NHSE Single Delivery Plan for Maternity by listening to our women, growing and supporting our workforce and supporting the positive leadership culture. This will be underpinned by our approach to safety and delivering a personalised, equitable service. Specific focus will be on:

- Improving the Maternity Voices Partnership
- Integrating 1001 days into our maternity transformation programme
- Embedding the learning from national maternity reviews including Ockenden and Kirkup
- Implementing the Saving Babies Lives Care Bundle
- Increasing personalisation and choice
- Improving access to the perinatal mental health service
- Improving the safety culture across our services.

Strategic Commissioning

The planning and delivery of the 5-Year plan and yearly Operational Plans are underpinned by the quality and performance improvement strategy, implementation of quality improvement methodologies and processes that ensure the impact on patients and staff are fully understood and therefore inform decision making, thereby minimising risk and potential harm as a result of competing demands for limited system financial resources.

We will use Equality and Quality Impact Risk Assessment tools and Clinical Prioritisation Frameworks to evaluate any plans and business cases that are developed. By doing so, we ensure that decisions are based on an understanding of the impact on equity, clinical risk and quality, and identification of risk that can be mitigated. The equity focused approach enables us to consider the needs and perspective of all groups, and to address potential health inequalities that may arise.

Our goal is to make informed decisions, promote better health outcomes and a fairer healthcare system for everyone.

Direct Commissioning Delegation

On 1st April 2023, we assumed responsibility for community Pharmacy, Optometry and Dental services (PODS) from NHS England. The aim of delegating POD services is to make it easier for organisations to deliver joined up and responsive care, delivering high quality primary care services for our population. Work is taking place across the East Midlands area to review what this will look like, operationally.

Quality assurance: measuring and monitoring quality

The success of our approach to quality improvement is measured against the three core elements of quality (see Figure 12)

Figure 12: The three core elements of quality

1. Effectiveness

Clear quality improvement priorities based on a sound understanding of quality issues within the context of our local resident's needs, variation and inequalities. This also includes sharing data and intelligence across the system in a transparent and timely way.

2. Patient and Public Experience

Meaningful engagement ensures that people using services, the public and staff shape how services are designed, delivered and co-evaluated. This includes working together in an open way with clear accountabilities for quality decisions, including ownership and management of risks, particularly relating to serious quality issues.

3. Safety

Sharing data and intelligence across the system in a transparent and timely way and moving to a culture of shared learning, review and understanding of care. The safety agenda includes recognising the impact of decisions made at system level given the financial constraints the system may experience. In order to do this effectively LLR is developing a joint equality and quality impact assessment framework to support the assurance of our decision-making which is clinically led.

We have robust quality assurance arrangements in place, the key elements being:

Quality and Safety Committee

Receives intelligence from the System Quality Group and provides assurance to the ICB.

System Quality Group

With membership from across our NHS, primary care and local authority partners, this group has responsibility for sharing quality intelligence, learning, engagement improvement and planning.

Clinical Executive Group

Interdependent, but separate to the ICS quality function, this Group provides clinical leadership to the ICS.

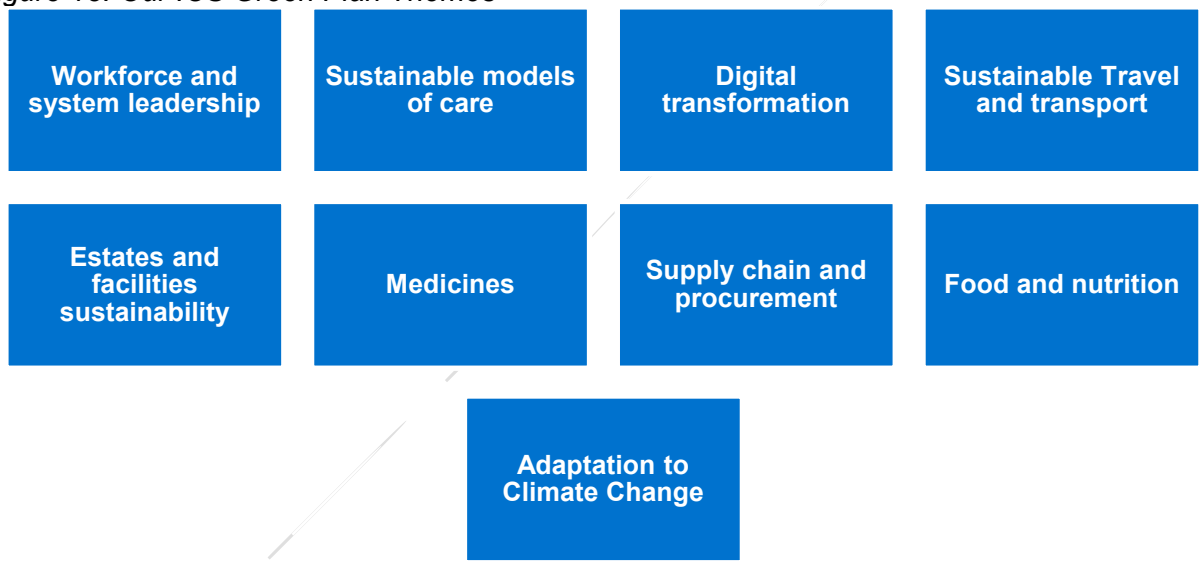
4.4 Delivering a Net Zero NHS

We launched our LLR ICS Green Plan in February 2023 and this sets out how our local NHS:

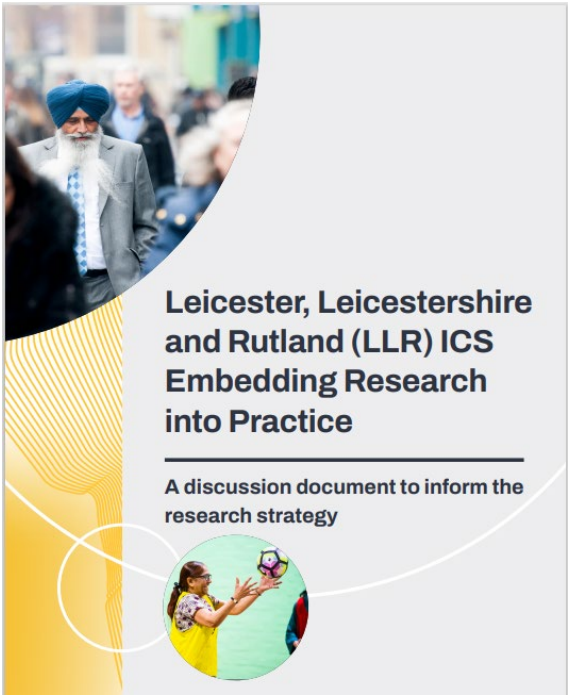
- Plans to deliver against the targets and actions in the Delivering a Net Zero NHS report.
- Supports the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions
- Plans to prioritise interventions which simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues across LLR; and
- Work collaboratively to deliver tangible reductions in emissions and improved outcomes.

The plan articulates where we can lever our collective resources for the widest benefit, including improving health equity. It is structured across nine themes (see Figure 13) each underpinned by a set of key actions.

Figure 13: Our ICS Green Plan Themes



4.5 Research and innovation



Our vision

We will ensure that research and innovation play a central role across our ICS partners. There is already a substantial breadth and scale to research activities across LLR, through our research infrastructure organisations and universities. This work is described in more detail in our discussion document "Embedding Research into Practice"

We have established a Research Strategy Board to steer and oversee the continued development and maturity of our research activities. This Board brings together institutional partners and other stakeholders across the range of health, social care, local authority and higher education institutions. Working with these partners, we will deliver the vision set out in Saving and Improving Lives: The Future of UK Clinical Research Delivery. This will be achieved by building on existing strengths and infrastructure, developing new areas of research and ensuring integration with clinical service and communities.

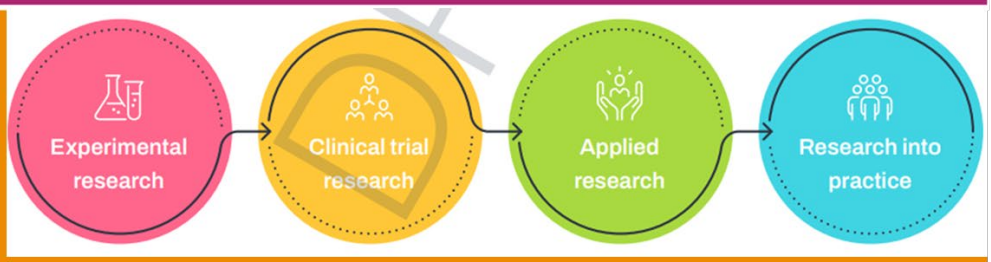
Principles underpinning our ICB research approach:

1. To support research funding applications being made by our academic, health and care partners, where these are relevant to the work of the ICB
2. To support the conduct of research studies undertaken by academic, health and industry partners across the breadth of its work
3. To provide a forum to bring together partners (including research infrastructure such as the Leicester Biomedical Research Centre, Applied Research Collaboration – East Midlands and Leicester Clinical Research Facility) to form productive clinical-academic networks that can work together to respond to specific research calls from national funding bodies (Medical Research Council and National Institute for Health and Care Research) in a timely way
4. Ensure processes are in place to provide robust research governance and quality assurance. We have already taken important steps to achieve this through the integration of our ICB research governance operations with those of UHL
5. Endeavour to facilitate participation in research across all areas of health and social care so that patients are routinely offered participation in research studies as part of their care; and
6. Support (with appropriate data governance) access to clinical data for the purposes of research for our partners.

The ICB is not a research funding body but, where feasible and where resources permit, the ICB will seek to build capacity for research across partners and within the clinical workforce through:

- A focus on promoting and supporting research activity involving primary care and, more generally, into prevention and health inequity
- An ambition to increase the number of non-medical clinicians as participants in our research active communities; and
- Promoting the analysis and utilisation of local clinical and care data through our partnership with academic institutions and research infrastructure, with the purpose of informing service transformation and evaluation, as well as the establishment of new models of care.

Research into practice in LLR



Developing new treatments for cancer – Immunotherapy for mesothelioma

Mesothelioma is a devastating disease caused by asbestos – the only occupation-caused lung cancer. In light of poor treatment options, the National Institute for Health and Care Research (NIHR)-funded James Lind Alliance Mesothelioma priority-setting partnership, identified the top research question as whether boosting the immune system with new immunotherapy agents could improve survival rates. We led a clinical trial called CONFIRM (CheckpOiNt Blockade for Inhibition of Relapsed Mesothelioma) funded by Cancer Research UK & Standup to Cancer. This compared the immunotherapy nivolumab with placebo and received television coverage on Channel 4.

Improved survival was seen and presented as a plenary in the 2021 World Lung Cancer Conference.
Leicester has led at a global level, advances in treatment for mesothelioma. In addition to CONFIRM, the Cancer Research UK funded VIM study, comparing chemotherapy with vinorelbine versus active symptom control, demonstrated benefit and now this drug is used widely in the NHS. Leicester has pioneered therapy for mesothelioma based on the tumour genetic makeup with MIST, the world's first mesothelioma platform trial (funded £3M by the British Lung Foundation). It has demonstrated an improvement in overall survival for patients with relapsed mesothelioma. Nivolumab is now available on the NHS, constituting a change of practice in the UK

4.6 Supporting broader social and economic development (anchor institutions)

What are anchor institutions?

Anchor institutions are large organisations that are likely to remain in an area and have a significant stake in their local area. They have "sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use".

Our NHS partners are anchor institutes, being large organisations and substantial employers with significant spending power. Fully utilising the opportunities of anchor institutions could result in substantial impact on health and wellbeing equity. This can happen through addressing the wider determinants of health in a way that is appropriate to large health organisations and their broader impact than the clinical health and wellbeing outcomes.

Figure 14 shows the wider determinants of health. It shows the interaction between environmental, social and cultural factors on health and wellbeing. Unemployment and the conditions that people live and work in influence people's health and wellbeing. It is in these areas, plus the general socio-economic outlook of an area, where anchor institutions can play a wider role beyond healthcare delivery.

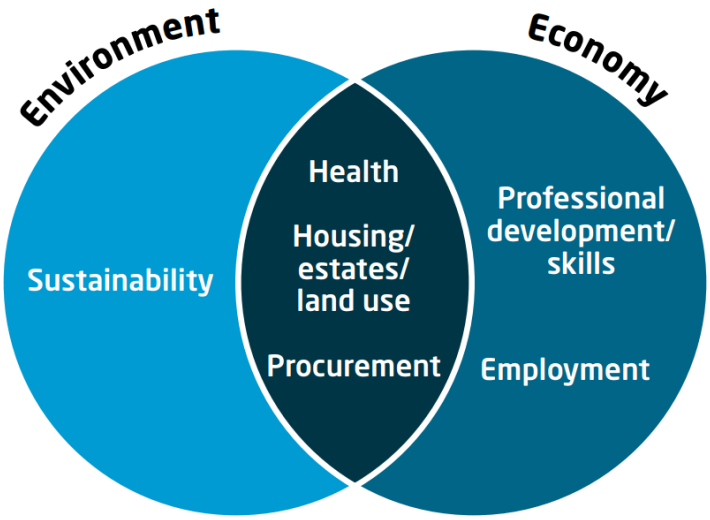
Figure 14: The Wider Determinants of Health, The Dahlgren-Whitehead rainbow model

The King's Fund model for anchor institutions considers two broad categories of the environment and the economy (see figure 15). It sets out a possible structure to develop further thinking and action plans for our anchor institutions.

Our current actions and plans for this area inlcude:

- Bring together partners from the NHS, local authority, primary care, independent care providers, third sector and education to support, develop and grow our local health and social care workforce through the LR ICS 'One Workforce' approach. Working in partnership with local communities to make a difference, for example being a good employer and creating opportunities for local communities to develop skills and access jobs in the local health and care sector, particularly aimed at disadvantaged and under-represented communities.
- Through our Estates programme, we will explore opportunities to better harness NHS buildings and spaces to share benefits, co-locate services with our public sector and voluntary sector partners and support our local communities.

Figure 15: The key areas of interest for anchor institutions in the health and social care sector



- Through the revised procurement practices outlined within our LLR ICS Green Plan, we will promote the redirection of investment to support our local suppliers and economy. Adoption of Social Value Model will ensure that economic, social and environmental wellbeing is a key consideration in our supply chain actions.

- Through the LLR Health and Wellbeing Partnership, we will ensure that the ICB works with our local partners beyond health to cascade good and innovative practice, model civic responsibility across our anchor network. We will influence wider economic development and environmental balance, in order to improve people's health and wellbeing and reduce health inequalities.

Chapter 5: Enabling delivery of this Plan

In this chapter, we describe the building blocks that, put together, provide the essential framework within which we can deliver our preventive work, keep people well, improve health equity and deliver the best possible health and care for local people. We describe how we will maximise the benefits of new digital technologies, as well as how we will make sure our estate is fit for purpose and used effectively.

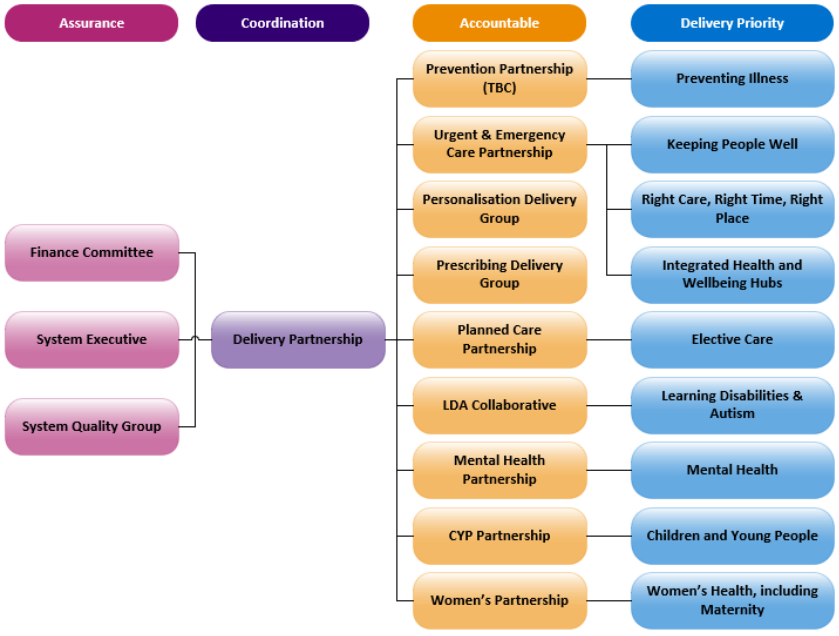
5.1 Our approach to transformation

To deliver this Plan, we have organised ourselves to focus on those services and areas we want to transform. Each of these areas is led by a Collaborative or Partnership (See figure 16) with multi-professional membership from across our partner organisations. Clinical and managerial leadership is also shared across our partners.

The ethos of these groups is to identify areas where outcomes are sub-optimal or could be improved and work together to transform the pathways across the system to address the issue. Ultimately, these Groups are tasked with improving outcomes and health equity, based on a population health management approach (see 4.2) whilst ensuring best value for money across health and care services.

The transformation portfolio is led, predominantly through our ICB transformation teams. However, as we mature as a health and care system, our providers are taking the lead on more programmes of transformation. Regardless of leadership of each programme of work, the objectives for each are agreed collaboratively across the programme of work and read across to both Health and Wellbeing Board objectives in each of our places, as well as individual provider operational plans and strategies.

Figure 16: Our Partnership structure:



Each collaborative or partnership requires system-wide intelligence to function. Our programme infrastructure, therefore, has embedded within each team digital, workforce, estate, finance and other expertise, intelligence and insights, in order to inform a high-quality decision-making process and to evidence both short and medium-term improvements.

We recognise that interdependencies are often missed through this individual programme approach, with vital intelligence missed within and between groups. To ensure that

interdependencies are understood and to allow for system-wide expertise to confirm and challenge programmes of work, the LLR Delivery Partnership brings together each collaborative or partnership monthly. This allows for a coordinated, standardised set of reporting to be taken to ICB sub-committees to either provide assurance on delivery of transformative objectives or seeks support through a standardised escalation process from the sub-committee structure.

For example, escalations can be made seeking support to the System Quality Group or the ICB Finance Committee monthly. This ensures that transformation programmes have a space to evidence delivery but also to escalate any issues impacting on delivery for further senior support. This approach drives delivery, collaboratively, and considers the complexities of working in a matrix fashion across health and care.

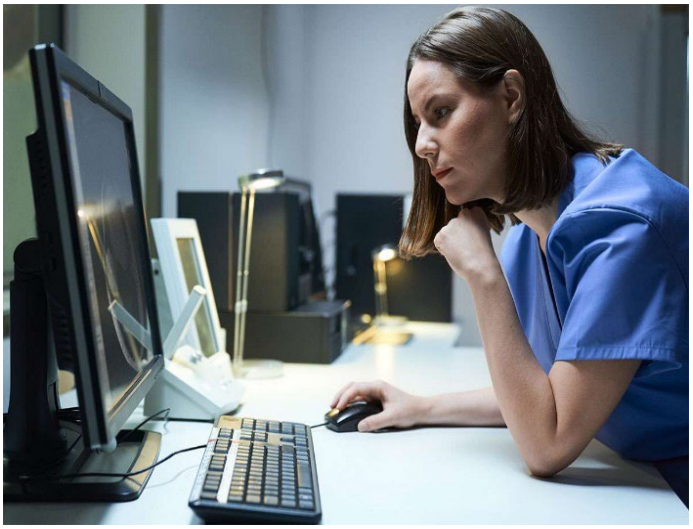
Each transformation programme uses a quality improvement methodology and seeks to implement an inquiry led approach, rather than an advocacy led approach, ensuring that decision-making process is of high quality, and is underpinned by sound and rational analysis of both need and impact.

The complexity of delivering transformation, considering equity, resource utilisation, quality, performance and other national, regional and local mandates, should not be underestimated. Our programme structure and, therefore, infrastructure is as agile as it can be across the multiple layers of governance across health and care. Changes to the structure and infrastructure are implemented at pace, as required, as we seek to deliver this Plan in partnership with all our partners and local people.

5.2 Digital and data

Our digital vision

Our digital approach is enabling and proactive, transforming culture, processes and operating models, harnessing the technologies of the digital age to respond to raised expectations of the public, patients and service users, whilst protecting health equity for all our population.



We are achieving this vision by ensuring we have good digital governance and leadership, delivered through an integrated model for health and social care, linking in with clinical collaboratives to provide a coherent and connected service for local people and our workforce. This will improve patient and service user experience, overall efficiency and value for money.

Our Digital Strategy, which includes our NHS partners and adult social care within scope, will deliver the following seven long-term strategic goals:

- We will have a clear and empowered governance structure
- We will have levelled-up all partners will have a consistent level of digital maturity
- UHL will have a mature Electronic Patient Record (EPR) system with tight integration to niche departmental systems, capable of sharing data with the Shared Care Record
- The ICS will have digital capacity and capability to support future digital needs
- Data quality will have been improved so it can be used for secondary purposes such as Population Health Management
- We will consolidate duplicated systems into a cohesive digital ecosystem; and
- Supported the transformation of care pathways such as maternity, end of life and long-term conditions with digital enablement.

Our digital strategy will require additional investment, over the next three years which will be subject to NHSE allocation announcements or bidding. This will require a collaborative system-first approach, with the endorsement and support of all partner organisations and the resource capacity to focus on the transformation programme.

System-wide digital and data interventions

We have included the service specific digital and data interventions we intend to implement under the relevant section of Chapter 3 (Delivery Plan). Key system-wide digital and data interventions we intend to implement are set out in Table 15 below.

Table 15: Our key system-wide digital and data interventions

Intervention	Timeline
1. Establish an ICS-wide Digital Team	23/24
2. Digitally enabled GP Front door to support Primary Care Access	25/26
3. Data Strategy to support Population Health Management	23/24
4. Tackle Digital Exclusion and increase uptake of NHSApp	23/24 onwards
5. Electronic Patient Record in UHL	23/24
6. LLR Care Record	23/24

5.3 Our estate

What is the 'estate'

By *estate,* we mean the sum total of real property - buildings, land, vehicles, and equipment - which comprises our assets.

An overview

Our Partners are working more closely together as an ICS, and this has provided the opportunity, for the first time, to consider the totality of our NHS, local authority, primary care and other estate. Limitations and constraints that our individual Partners experienced in the past with their estate, can now be considered in a wider context, where the opportunities and resources of scale can bring benefits. For example, we can look at over and under-provision, the proximity of one Partner's buildings to another, as well as the opportunities to expand and contract, across the totality of our estate.

Our Estates Strategy

Each of our Partners have their own estates strategy, including a Primary Care Estates Strategy, developed by the ICB. During 2023/24, we will develop an overarching LLR ICS Estates Strategy, across all our Partners, setting out where we can collectively make the best use of our estate to be ready for implementation by April 2024. Some of the key areas we expect the strategy to focus on are:

Planning for growth

Working closely with our local authority planning partners to understand the scale and timescale for housing growth (Strategic Growth Plan (llep.org.uk), and assessing the associated healthcare needs that this will bring, as well as the need for health estate. We also have a key role in maximising the funding available (S106 funding) for health estate.

Integrated Health and Social Care Teams (or Health and Care Hubs)

Managing the estate implications of bringing health and care teams together to provide more integrated and personalised care to local people (see 3.4).

Changing working practices

Covid-19 enforced changes to working styles, some of which have now become standard practice, and which set the tone for future arrangements. The estate will need to adapt to support these new working styles. This increases the opportunities to move operational and support services to more convenient locations to achieve wider benefits.

One Public Estate

There are opportunities to drive efficiencies, share benefits, and co-locate services with our public sector and voluntary and community sector partners, where this is beneficial to local people, patients and service users.

Effective utilisation of our estate

One of our key priorities will be to ensure that we are making the most effective use of our estate including our community sites and those properties owned by NHS Property Services and Community Health Partnerships. One of our key priorities will be to ensure that we are making the most effective use of our estate including our community sites and those owned and managed by NHS Property Services and Community Health Partnerships. The Strategic Estates Team has built essential

relationships to ensure the ICB receives regular, timely, utilisation data whilst also exploring opportunities for long-term tenancy arrangements seeking to maximise usage. Working collaboratively with our Partners is a crucial step towards achieving this goal.

UHL reconfiguration programme

The reconfiguration programme will deliver the reconfiguration of Leicester's Hospitals to create two acute hospitals: The Leicester Royal Infirmary, and Glenfield Hospital, whilst re-purposing the Leicester General Hospital. It will build on the investment to date to support four main areas of activity, which we aim to complete by 2030. This clinically led programme of transformation will deliver the change that was publicly consulted on in 2020:

- Development of a new women's hospital at the Leicester Royal Infirmary
- Creation of a dedicated children's hospital, also at the Leicester Royal Infirmary
- Expanded intensive care facilities at the Leicester Royal Infirmary and Glenfield Hospitals
- The separation of planned and emergency care services where possible, including new wards, theatres, out-patients and a day case unit with theatres at Glenfield.

The re-purposing of the Leicester General Hospital site will include:

- East Midlands Planned Care Centre high volume, low acuity care (Out-Patients and Day Cases)
- Diabetes Centre of Excellence
- Community Diagnostic hub, including imaging facilities (scans and x-rays)
- Stroke Recovery Services with inpatient beds
- Midwifery Led Unit (re-located from St Mary's in Melton Mowbray).

Over the last five years, over £160 million has been invested to successfully achieve the following:

- The opening of the East Midlands Planned Care Centre (EMPCC) Phase 1 at the General Hospital (May 2023). When the Centre is fully open in late 2024, approximately 100,000 patients will be seen each year
- Interim ICU and associated services move from the General Hospital to the LRI and Glenfield Hospital (2022)
- East Midlands Congenital Heart Centre move from Glenfield Hospital to the LRI (2021)
- The new Emergency Floor and Emergency Department (April 2018)
- The move of vascular services from the Royal to the Glenfield site and the opening of a new Angiography Suite (May 2018)
- A new hybrid theatre (May 2018) offering 'state-of-the-art' imaging equipment to allow a greater proportion of new and complex procedures not previously possible.

Primary Care Estate Strategy

Our Primary Care Estate Strategy aims to support General Practice primary care services, as well as our wider partners, to provide high-quality services delivered from modern, fit-for-purpose and flexible premises. The Strategy objectives are to:

- Gather data and intelligence to understand the condition, capacity and utilization of our GP primary care estate;
- Prioritize those premises in need of improvement, expansion or replacement and implement a programme and framework to drive and support premises improvements;
- Ensure systems are in place to challenge and support GP Practices, NHS and private landlords to maintain and invest in their premises including areas such as addressing backlog maintenance, health and safety and the quality of the premises;
- Improve the quality and condition of the estate and the physical capability and capacity for primary care provision;
- Support the development of Primary Care Networks, Place services and the delivery of new models of care;
- Address population growth/housing developments through maximising the potential of developer contributions to support premises improvements and increased capacity;

- Collaborate with ICS partners to manage and develop our combined estate at system, Place, neighbourhood and individual premises level;
- Reduce risk & improve service resilience at local and system levels;
- Increase efficiencies through improved utilization of existing primary care and the wider
- public estate;
- Rationalise and dispose of surplus or unfit NHS estate;
- Maximise future estate flexibility and develop a greener NHS through smart estate design solutions to support sustainable service models; and
- Support improvements in service efficiency and better outcomes for our residents.

System-wide estate interventions

We have included the service specific estate interventions we intend to implement under the relevant section of Chapter 3 (Delivery Plan). Key system-wide estate interventions we intend to implement are set out in Table 16 below.

Table 16: Our key system-wide estate interventions

Intervention	Timeline
1. Develop an LLR ICS Estates Strategy	23/24
2. Improve the effective utilisation of the health estate	From 23/24
3. Oversee and refine Section 106 application and spending mechanism	23/24
4. Work collaboratively with public sector estates partners	From 23/24

Chapter 6: Our Finances

Local context

In recent history, LLR has incurred financial deficits (overspends) in each year. In 2020/21 and 2021/22, a combination of extra funding for Covid-19 and reduced elective care costs (because, for example, appointments and surgeries were cancelled) enabled the system to achieve a break-even financial position.

In 2022/23, we planned to break-even, but additional challenges from inflation, workforce costs and emergency and mental health demand have led the system to revise our forecast, in year, to a £15m deficit.

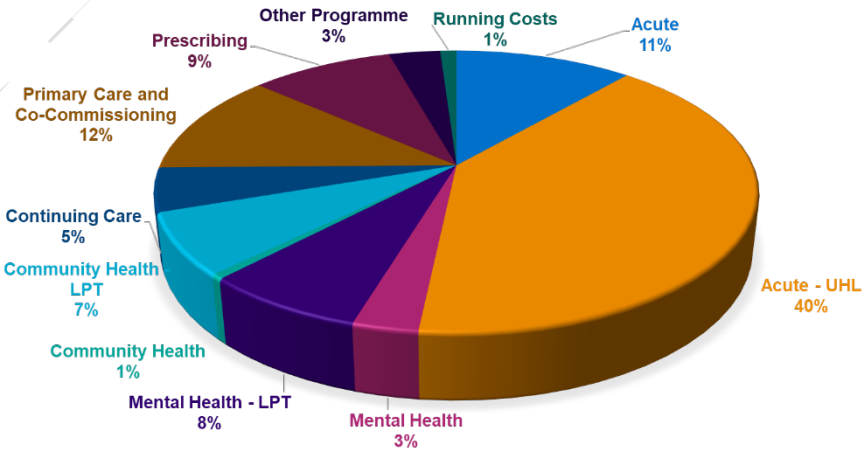
As a system, we are working well, collectively, and there is transparency and openness in the management of the financial position. We fully intend to retain these strong relationships and build further on them.

In 2023/24, our financial plan is extremely challenging, with an efficiency requirement of £131.5m, which is 6.4% of our system allocation. There are significant financial risks (£204m including non-delivery of some efficiencies) at the outset of the year which need to be mitigated to ensure delivery of the £10m planned deficit.

Taking all of the above into account, our financial strategy needs to build upon the system control we have developed and support transformation to bring the system into a sustainable position. The following sections describe how we will achieve that for the local health and care system.

How we currently spend our resources

Of the £2bn LLR has to spend, over half (51%) goes into providing hospital care, with 19% spent on community and mental health services and 21% across Primary Care Services (including Prescribing).



Achieving our financial goal

Our goal is to support the delivery of this 5YP within the resources available to us.

We will do this by:

- Investing in health inequalities and prevention;
- Reducing unnecessary attendances through interventions that keep people at home;
- Better flow – more timely discharge through use of Out of Hospital interventions, social care, etc.;
- New pathways – alternatives to improve the patient journey / digital first;
- Improving productivity/increase value in healthcare;

- Seeing more patients through the existing clinical capacity – repatriate spend on IS etc.;
- Achieving better value from enabling functions e.g. more efficient use of estate, reduced internal transactions;
- Reducing unwarranted variation in the costs of care;
- Investing more in upstream self-care to reduce significant costs and demand for services, as well as downstream, such as intensive hospital care, by ensuring timely and appropriate access to primary care services;
- Right sizing activity by addressing the issues that have occurred during covid such as backlog for elective care – using digital and other means so that this also improves the quality of the clinical experience; and
- Ensuring we have the infrastructure to support this by focusing on improving environment through upgrading our estate, maximising efficiency and best value through effective procurement, reducing carbon footprint and taking advantage of new innovative technologies.

Financial Principles

Our financial strategy is underpinned by the following principles to ensure that a sustainable financial position is achieved:

- Continuing to ensure strong financial control across the system, sharing openly and transparently our financial positions so we can best manage our finances collectively;
- Ensuring we set aside sufficient funding to support growth and to cover the costs of inflation;
- Productivity and efficiency must deliver at least 3% per year through moving to upper quartile in performance and elimination of waste;
- Consider the total resource allocation of £2bn across LLR and not just the use of new growth funds coming to the system;
- Evolve the role of partnerships to devolve resource through 'lead provider' collaborative arrangements as agreed for 'Urgent and Emergency Care';
- Set aside a small amount of additional funds for investment each year which following appropriate prioritisation will enable us to:
    - Invest wisely into programmes that can have a positive impact on our overall financial position and give the best value to local people;
    - Ensure we invest into prevention as well as treatment;
    - Invest in the areas where we can make a longer term impact in terms of both patient and financial benefits;
    - Support specific schemes, using a process for prioritisation and approval that will be consistently applied through a robust business case process; and
    - Focus service reconfiguration to enable reduced demand and reliance on acute services with more resilience in out of hospital and community based services.

Our financial challenge

Our current Medium Term Financial Plan (MTFP) model (see Table 17), projects a recurrent system gap, by the end of 2027/28, of £227m. This is the case if we adopt a 'do nothing' approach to efficiency delivery from 2024/25 onwards. In addition, the plan includes deficit repayments of £22m so that the overall financial challenge, over the next 4 years, is £248m.

If we also include the efficiency challenge in 2023/24 (£131.5m), the full scale of the financial challenge, over the next 5 years, is £380m.

Table 17, Modelling our system financial challenge

	System				
	24/25	25/26	26/27	27/28	5 Yr
23/24 Plan	(10,002)				
Remove 23/24 NR items	(70,706)				
Opening Surplus/(Deficit)	**(80,708)**	**(120,865)**	**(169,965)**	**(197,311)**	**(197,311)**
Tariff Inflation	**(36,798)**	**(38,449)**	**(40,591)**	**(42,411)**	**(158,249)**
Tariff Efficiency	**(7,848)**	**(8,088)**	**(8,334)**	**(8,589)**	**(32,859)**
Growth	**(47,075)**	**(49,325)**	**(52,213)**	**(54,704)**	**(203,317)**
Allocation increase	51,563	69,862	73,793	76,445	271,664
Investments (Elective Hub)	-	(23,100)	-	-	(23,100)
Additional efficiency	-	-	-	-	-
Efficiency schemes	-	-	-	-	-
Recurrent Surplus/(Deficit)	**(120,865)**	**(169,965)**	**(197,311)**	**(226,569)**	**(226,569)**
Deficit repayment	(7,264)	(7,264)	(7,264)	-	(21,791)
Total Surplus/(Deficit)	**(128,129)**	**(177,228)**	**(204,574)**	**(226,569)**	**(248,360)**
Total movement in period	**(47,421)**	**(56,363)**	**(34,610)**	**(29,258)**	

This model starts with an underlying exit position from 2023/24 of £81m deficit (thereby assuming full delivery of the 2023/24 plan).

There are many assumptions underpinning this model and it gives the best estimate we can generate of the scale of financial challenge we face.

Our proposed financial strategy – 5-year summary

The national ask, excluding any local adjustments, represents a pressure of £123m for the system within the 5 year period. Adding in local investments and pre-existing pressures deteriorates the position further to £248m (see Table 17).

Our proposed financial strategy (see Table 18) allows for a level of anticipated cost pressures as well as transformational investment which will support the delivery of a 3% efficiency. This has a beneficial impact on the value of uplifts applied as expenditure is reduced.

A further non-recurrent efficiency of £21.8m will be required to cover the historic deficit repayment

Table 18: 5 year financial strategy summary

5 Year Bridge Exluding 23/24 Risk	System £000
Uplift assumptions on I&E	(394,425)
Allocation increase	271,664
National ask	(122,761)
Elective Hub	(23,100)
Deficit repayment	(21,791)
23/24 Underlying pressure	(80,708)
Do nothing challenge	(248,360)
Cost pressures	(40,000)
Investments	(58,800)
3% efficiency	312,319
Impact on uplifts	13,059
NR efficiency required	21,791
Proposal challenge	10

Our proposed financial strategy – Year-by-year

Table 19 and figure 17 illustrate the year-by-year proposed financial strategy for the system to reach a sustainable breakeven position by 2027/28 via gradual investment and efficiency delivery over the medium term.

Table 19: Year-by-year financial strategy summary (£000)

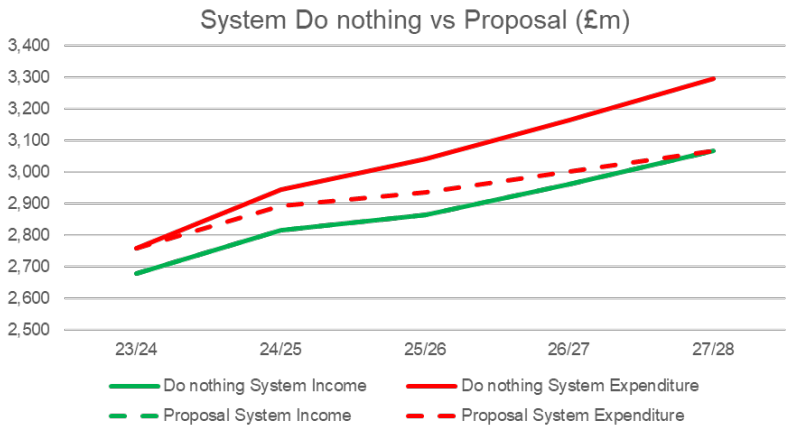
	24/25	25/26	26/27	27/28
Recurrent cost pressures	(10,000)	(10,000)	(10,000)	(10,000)
Recurrent Investment	(14,700)	(14,700)	(14,700)	(14,700)
3% Efficiency	75,603	77,008	79,127	80,581
Financial position	(77,226)	(71,947)	(40,575)	10

The following assumptions have been made:

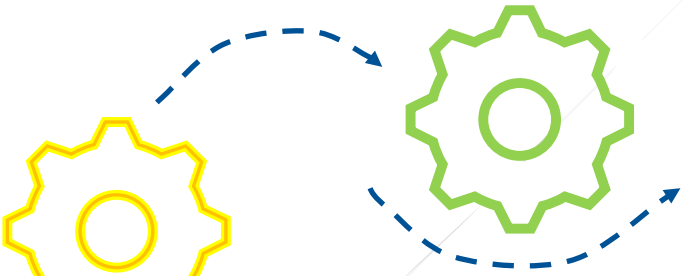
- Inevitable cost pressures to mitigate clinical risks have been provided for, recurrently, at £10m a year;
- Transformational investments have been funded, recurrently, at £14.7m a year; it is assumed the focus of these investments will be in line with strategic intentions of the five-year plan; and
- A 3% efficiency on costs has been applied across all areas and organisations each year.

Figure 17: Year-by-year financial strategy summary (£000,000)

It can be seen, from the above, that investing a small amount and planning to save a realistic amount, recurrently, each year, will result in deficits within each year but will ultimately lead to a sustainable position. As is the case in 2023/24, it is likely we will need to seek further opportunities (non-recurrent or otherwise) to improve the financial position, each year, so that we can attempt to deliver a breakeven position in each year.



Method of delivery - Partnerships



System Support for the Strategy

This strategy will only deliver if all system partners, including LA's are on board.

Organisations lead on creating viable financial models

Organisations employ the clinicians and support staff and deliver the care, so need to be content that the financial model will deliver

Partnerships lead on system action to recycle the money

The opportunity for transformation comes from working across the pathway to minimise cost growth. It is recognised that there may have to be some 'invest to save' to deliver these benefits.

Chapter 7: Our People

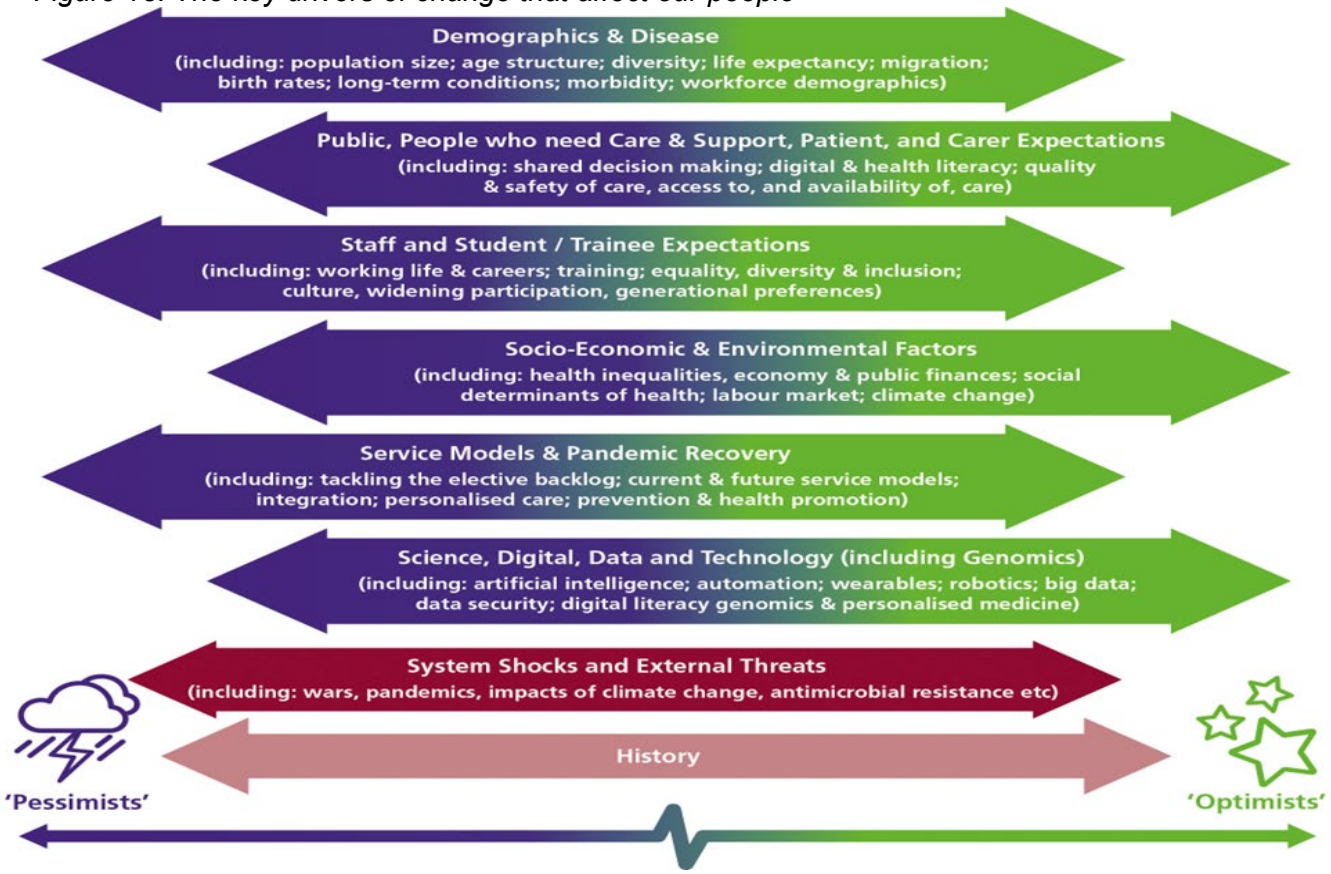
Local context

We have a combined health and adult social care workforce of 57,700 (see 2.4) – this is our greatest asset in providing local health, mental health and care services. These past three years have seen an unprecedented demand on services, as well as on our people, who have adapted and responded magnificently to the Covid-19 pandemic. As we recover and respond to a post-pandemic environment, we face several challenges, the most critical being:

- Retention: retaining the workforce and skills we currently have;
- Attraction: attracting new talent and future pipeline of recruits;
- Growing for the future: to ensure we have the right skills, at the right time, in the right place, delivered by the right person; and
- Supply: filling current vacancies across health and care to address the significant shortfall across GPs, nurses, midwives and other professional groups.

These challenges are significant and are driven by a combination of change factors which affect our workforce, including demographics, the labour market and working life expectations (See figure 18).

Figure 18: The key drivers of change that affect our people



Our People vision

Our aim is to make the LLR health and care system a great place to work and volunteer.

This is supported by our people vision:

Shaping our people & services around the needs of our population

Build a One Team, One People culture
Cultural change - behaviour change — Our collaboration will deliver fantastic care

Maximise the people potential of the LLR population and support wider economic & social recovery (Local Jobs For Local People)

Our people vision is underpinned by the following principles:

- Long term strategic people planning through different lenses: neighborhood, place and system;
- Connecting Multi-Year Education Training and Investment planning (METIP) with workforce growth, future planning and models of care;
- Data informed and evidence-based decision making, and business intelligence driving our focus;
- Attractive and supportive employment packages;
- Sustainable people solutions linked to our LLR people and communities;
- Growing for the future with training at the heart of developing our people; and
- Partnership working across all health and care providers, voluntary services and educational and training sectors.

Our approach

In response to the challenges, our People Strategy is delivering intervention programmes to enable attraction, recruitment, retention and supply of people. At the heart of our plans is ensuring we are looking after our people's health and wellbeing, as well as creating a compasisonate and thriving culture.

Case Study

Our people – *Developing diverse leaders*

What was the issue?

Whilst we have many success stories of colleagues from diverse backgrounds stepping up into leadership roles, our data showed that there are differences in progression to leadership roles in nursing, Allied Health Professionals (AHP) and midwifery, for colleagues from BAME backgrounds, compared to other ethnic groups.

Intervention

A pilot programme - Developing Diverse Leaders (DDL) - for nursing, AHP and midwifery colleagues.

A holistic programme that includes:

- An aligned development programme for the line managers of the participants
- Shared Action Learning Sets for participants and line managers
- Informal networking and support opportunities for participants
- 'drop-in' sessions with Executive Leaders and access to coaching and/ or mentoring via the LLR Leadership Academy
- Ongoing check-ins and career reporting to understand each participants career aspirations and career successes over the next two-years.

Impact

The programme is ongoing, however, reported impacts include:

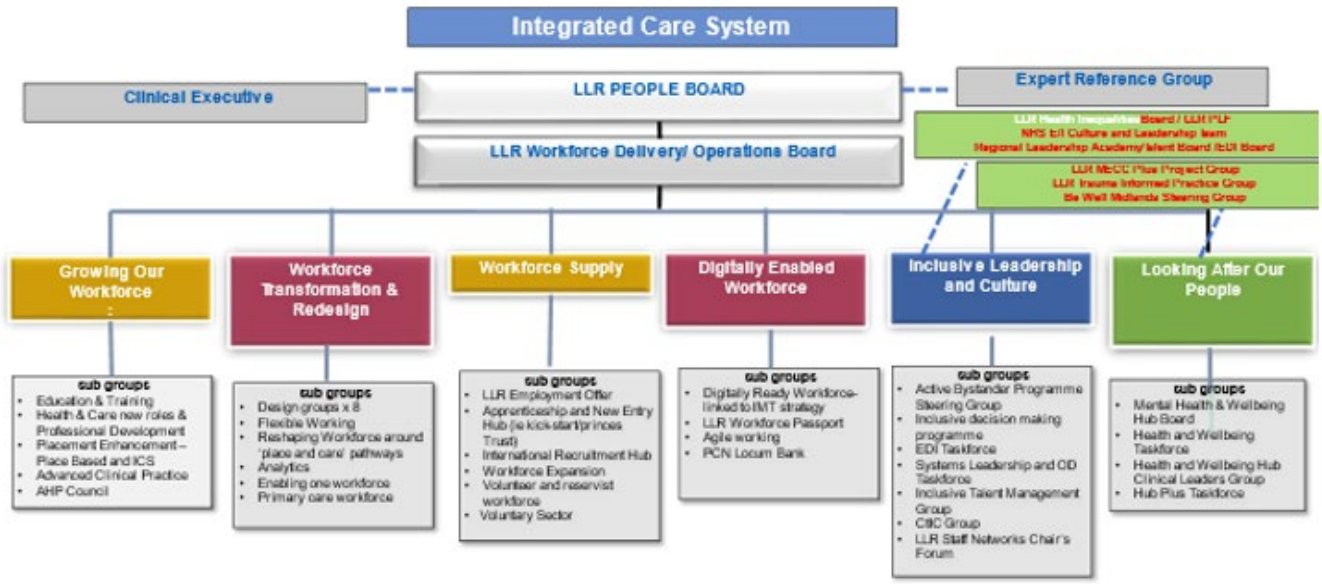
- Relationships and trust has developed within the groups, consolidating into ongoing peer-to-peer support
- Participants have reported key 'moments of impact' and increased confidence levels
- opportunities for reflective practice have been welcomed, and many participants are already sharing their new knowledge and understanding with other colleagues.

Applying the learning

The longer-term outcomes of this programme are being tracked, however, this pilot programme is already demonstrating the power and impact that comes from BAME colleagues having the opportunity to focus on their own development.

Our LLR People Board, which has representation from across all our partners, oversees our people intervention programmes, which are summarised in figure 19.

Figure 19: Our people intervention programmes



Organisational, leadership and people development

We have an amazingly diverse and talented group of people who work for us, and alongside us. We know that, at times, the work is not easy and some of the problems we face cause frustration. And yet we come together, we try, and we find solutions. We observed and experienced this during Covid- 19 – *we don't want to lose that LLR spirit*. We want to build on our reputation as trailblazers, so we make the LLR health and care community the place in which people want to work, make their careers, develop, grow and thrive. When this happens, when staff feel that where they work is inclusive, respects difference and that they belong, people feel valued, and we know that this translates directly into the quality and experience of care that people receive.

We have an ambitious programme of work under the Inclusive Leadership and Culture workstream, as part of our LLR People and Culture Plan, and which will make a difference, on the ground, to our staff. When we can do this more consistently, at the level to which we aspire, we will create the inclusive environment we all want and deserve. We are committed to working together with respect, trust and openness to deliver our BIG three challenges:

- '**Getting the basics right** – the pounds, the waits and the care';
- '**Health Equity** – our defining way of working and our added value'; and
- '**People** – our opportunities to make LLR a great place to work, contributing to society and treating our people well'.

LLR is already building on a strong foundation of innovative and collaborative working, but we are not complacent. Our workforce and local people deserve and have come to expect more of us.

In addition, LLR is jointly collaborating with Higher Education Institutes (HEI's), Further Education Institutes (FEI's), careers and adult education centres, embedding Health and Social Care, Local Authority and School Age Learners, within a joined-up approach to the NHS Long Term Workforce Plan. In aspiration to this plan, LLR will lead the system priorities, aligned to TRAIN, RETAIN & REFORM.

- **Train** - LLR will work in conjunction with the Integrated Care System (ICS) to provide a pathway of Apprenticeships into Health & Social Care, Primary and Secondary Care,

Voluntary, Community and Social Enterprise to ensure we engage local opportunities into health and care careers both clinical and non-clinical.

- **Retain** - The retention of our workforce to be healthy and well, within a culture that provides opportunity to be supported and provide educational competence and confidence, to meet the population health needs and improve access and minimise health inequalities.
- **Reform** - LLR leads the Place and Neighbourhood approach to access, supply and quality of our workforce and how care is delivered to our population through the upskilling the workforce and have the supervision, coaching and mentorship.

From the three areas of workforce priorities, we will enable and influence positive progression across partnerships and utilise workforce development funds, enriched with appraisal conversations, new models of workforce to meet the health needs of our population and the vision for LLR Integrated Care System (ICS) and Integrated Care Partnerships (ICP).

We need to ensure that we understand and appreciate difference and support people from different backgrounds and cultures to have fulfilling careers and feel that they belong. We are enabling our leaders to be inclusive in the culture they create and decisions that they make on behalf of our organisations and LLR. We want everyone who works in LLR, or experiences health and care in our system, to feel valued, respected and that they belong and that together we enable more good days.

Chapter 8: Governance

Overview of governance

Governance arrangements have been established to support the delivery of this Plan in the form of a Delivery Partnership.

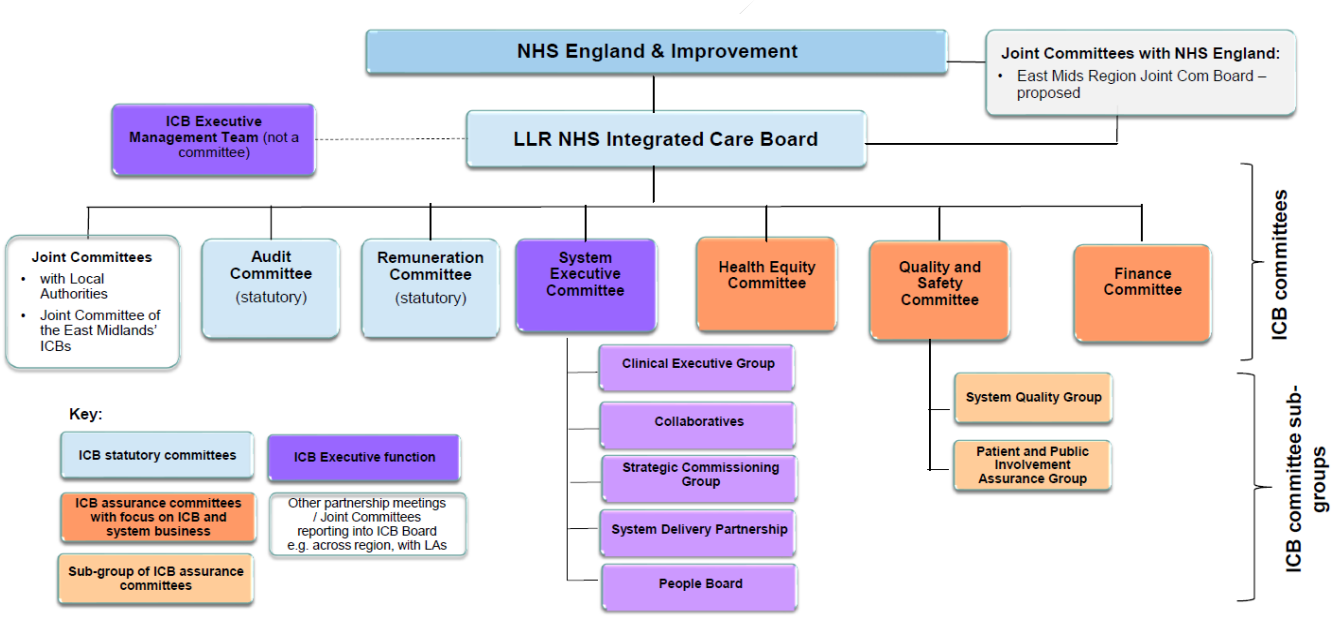
Our delivery framework

The structure included at chapter 4.4, 'our approach to transformation', outlines our delivery framework and accountability arrangements. It also includes arrangements for monitoring and escalation i.e., to the System Quality Group, Finance Committee, etc. when required.

Our approach to risk management

LLR Integrated Care Board has in place a Risk Management Strategy and Policy which sets out the ICB's approach to risk management as an organisation. Effective risk management will be essential in enabling the ICB Board to focus and prioritise resources in order to meet the ICB's strategic objectives as well as delivering the vision and key requirements of the Five-Year Plan. Partner organisations will be responsible for the risk management arrangements within their respective organisations. Risks impacting partners across the system, including the ICB, will be given due consideration through the appropriate governance arrangements which may include for instance consideration of the impact of the risk(s) through an appropriate ICB committee(s), through the appropriate collaborative(s), or through a partner organisation's own internal governance arrangements.

The system governance structure is outlined at figure 20, below.



Glossary of terms used

Acronym	Explanation
A&E	Accident and Emergency
ARC	Applied Research Centre
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CFS	Clinical Frailty Score
CHWP	Community Health and Wellbeing Plans
CPCS	Community Pharmacy Consultation Service
CPF	Clinical Prioritisation Framework
CQC	Care Quality Commission
CSP	Community Safety Partnership
CYP	Children and Young People
EIRA	Equality Impact Risk Assessment
FOIs	Freedom of Information (Requests)
GH	Glenfield Hospital
GIRFT	'Get it right first time'
HIF	Health Inequalities Framework ('Better Care For All')
HWBs	Health and Wellbeing Boards
ICB	Integrated Care Board
ICS	Integrated Care System
IS	Independent Sector
IT	Information Technology
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Children
LBRC	Leicester Biomedical Research Centre
LCRF	Leicester Clinical Research Facility
LD&A	Learning disability and autism
LDC	Local Dental Committee
LGH	Leicester General Hospital
LLR	Leicester, Leicestershire and Rutland
LMC	Local Medical Committee
LOC	Local Optometric Committee
LPC	Local Pharmaceutical Committee
LPS	Liberty Protection Standards
LPT	NHS Leicestershire Partnership Trust
LRI	Leicester Royal Infirmary
LTCs	Long Term Conditions
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MECC	Making Every Contact County
METIP	Multi-year Education Training and Investment planning
MFFD	Medically Fit for Discharge
MIST	Medication Information and Safety Tips
MRC	Medical Research Council
NIHCR	National Institute for Health and Care Research
NHSE	NHS England
OP	Out-patient
PCN	Primary Care Network
PH	Public Health
PHM	Population Health Management

POD	Pharmacy, Optometry and Dental services
PPGs	Patient Participation Groups
PSIRF	Patient Safety Incident Response Framework
QIA	Quality Impact Assessment
QOF	Quality and Outcomes Framework
RTT	Referral to treatment
SPB	Strategic Partnership Board (LLR)
TB	Tuberculosis
UHL	NHS University Hospitals of Leicester
UTC	Urgent Treatment Centre
VCS	Voluntary and Community Sector
VIM	The name of a randomised controlled phase II trial of oral vinorelbine as second line therapy for patients with malignant pleural mesothelioma undertaken by The University of Leicester