



**Leicester, Leicestershire  
and Rutland**  
Integrated Care Board

# Clinical Strategy

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A proud partner in the:



**Leicester, Leicestershire  
and Rutland**  
Health and Wellbeing Partnership

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## 1. What is the Integrated Care Board (ICB)?

Our ICB (known as [NHS Leicester, Leicestershire and Rutland](#)) is a statutory body created to provide infrastructure support to the NHS and (to some extent) other Partners in LLR. It does not directly provide care (although a lot of its work supports the delivery of care). It commissions £1.6 billion of health and care for the 1.2 million people of LLR every year. Its contribution to the front line is delivered by discharging its responsibilities effectively and efficiently.

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 improve this where required; and
- Account to NHS England and our local population for the public funds it spends and the outcomes and outputs of the services it commissions.

The ICB is part of the LLR Integrated Care System (ICS) alongside our local NHS trusts and councils. GPs, district councils, 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. It's about giving people the support they need, joined up across local councils, the NHS, and other partners.

The purpose of our ICS, therefore, is to bring partner organisations together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access to health and care
- Use the resources available for health and care services to get the most from them
- help the NHS support the broader social and economic development in an area

## 2. Purpose of this document

Our ICS priorities are:

<b>1</b>		<h3>Best start in life</h3> <p>We will support you to have a healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition and healthcare, and support from birth to adulthood.</p> 
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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.

2



## Staying healthy and well

We will help you to live a healthy life, make healthy choices, within safe and strong communities, and maintain a healthy quality of life.



We will support our residents to live a healthy life and make healthy choices to maintain wellbeing and independence within their communities.

3



## Living and supported well

We will support you through your health and care needs to live independently and to actively participate in your care.



We will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently.

4



## Dying well

We will ensure you have a personalised, comfortable, and supported end of life with personalised support for your carers and families.



We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families.

The purpose of this clinical strategy is to set out the **principles** that should underpin the development, implementation and maintenance of clinical and care services for people in LLR and, thereby, deliver our four priorities.

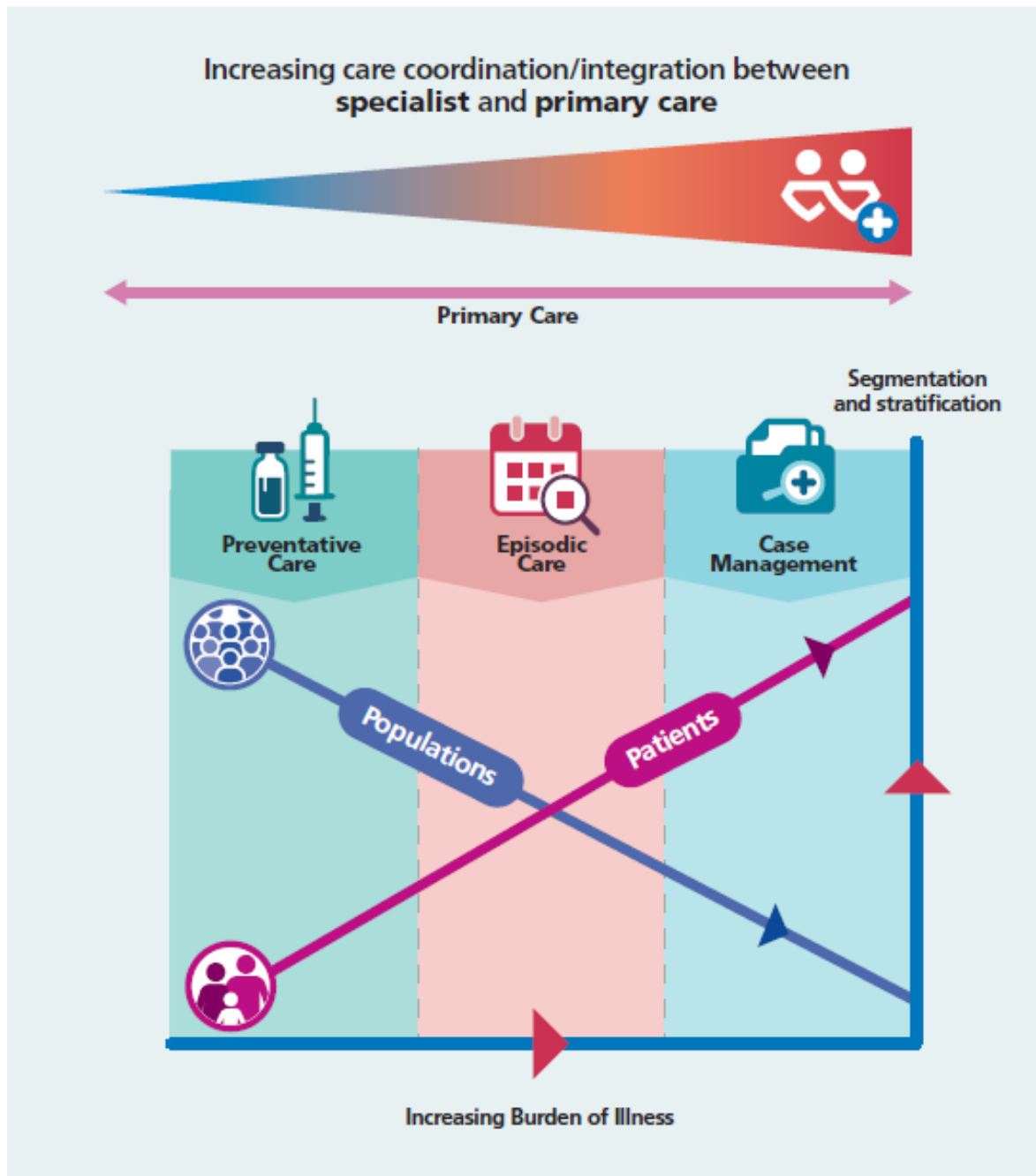
Our clinical strategy aligns with the [LLR Health and Wellbeing Partnership's](#) Integrated Care Strategy [\[insert link once ICS published\]](#), as well as our three upper-tier Council's Joint Health and Wellbeing Strategies ([Leicester City Council JHWS](#); [Rutland JHWS](#); [Leicestershire JHWS](#)) that focus on the specific challenges in each of their areas. However, this clinical strategy extends the broad objectives, within those strategies, 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. We expect that this strategy will be a "living document", which can be extended and revised as the landscape of NHS service integration develops and scientific advances offer opportunity to improve population and individual health.

This clinical strategy has also been developed in concert with our 5 Year Joint Forward Plan (JFP) [\[insert link once JFP published\]](#). This strategy can be considered to represent our "thinking" about how health and care should be provided whereas the JFP details the actions (the "doing") that will be undertaken to deliver this strategy, as well as the process by which decisions about these actions are prioritised.

Figure 1 summarises our overarching clinical model. It embodies the broad obligations of the ICS, both to promote population health and manage individual illness, underpinned by the central role of primary care.

Figure 1: Our LLR Clinical Model

## Clinical Model



### 3. Why is this strategy needed?

Whilst there is broad agreement on the four ICS priorities (which align to the “triple aims” required of NHS bodies: 1. Improvement of Health and wellbeing (including addressing inequality); 2. Service quality; and 3. Cost effectiveness), this clinical strategy has been developed in recognition that the current provision of health and care does not always meet these objectives. For example:

- Health inequalities remain wide (between socio-economic and other disadvantaged groups) and are a source of excess healthcare cost. The COVID-19 pandemic has heightened these inequalities.
- Insufficient resource is provided for population health improvement and prevention rather than treating illness.
- There is unwarranted variation in healthcare provision across place and neighbourhood and within anchor institutions such as hospitals.
- Transitions of care between acute, community and primary care services remain a focal point of omission and duplication, especially for people with long term conditions.
- Long term condition management remains insufficiently pro-active especially for those individuals with unstable conditions that require frequent use of acute care.
- A desirable shift of the locus of care from hospitals to communities has not been sufficiently matched by a rebalancing of resources.
- The quality and quantity of communication between professionals working in different parts of the health and care systems has deteriorated.
- Commissioning decisions have often been framed by short term business cycles and service crises (for example in acute care) rather than considerations of relative value and long term sustainability and health improvement

The establishment of integrated care systems offers an opportunity to address many of these problems through:

- More streamlined and evidence based prioritisation of service commissioning;
- Rapid incorporation of cutting edge scientific development and sophisticated use of healthcare data through collaboration with academic partners;
- Better integration and coordination of healthcare (for example vertical integration between hospitals and primary care and horizontal integration for people with multi-morbidity) and between health and social care;
- Prioritisation of prevention and improvement in population health with the dual aim of improving the health and wellbeing of our communities and reducing the future burden on acute healthcare services;
- Understanding and sharing of clinical risk across the healthcare landscape (primary, secondary, community and social care);
- Development of a professional culture that communicates and understands the pressures experienced by colleagues working in different parts of the health and social care system; and
- Reduced waste and improved efficiency and cost effectiveness

This clinical strategy provides guiding **principles** that will allow the ICB and its partners to bring about this transformation. These principles are categorised into “population health”, “management of illness” and “clinical values/behaviours”.

These principles are necessary but not sufficient in themselves to deliver the improvements in health and care that the ICS seeks to achieve. This will also require linkage to a framework of implementation and service re-organisation, together with the requisite supporting resources. Failure to do so is likely to result in the continued worsening of health inequality in our communities, continued rise in the use of acute services and the deterioration of morale in the health and care workforce.

## 4. Principles

### 4.1 Population Health

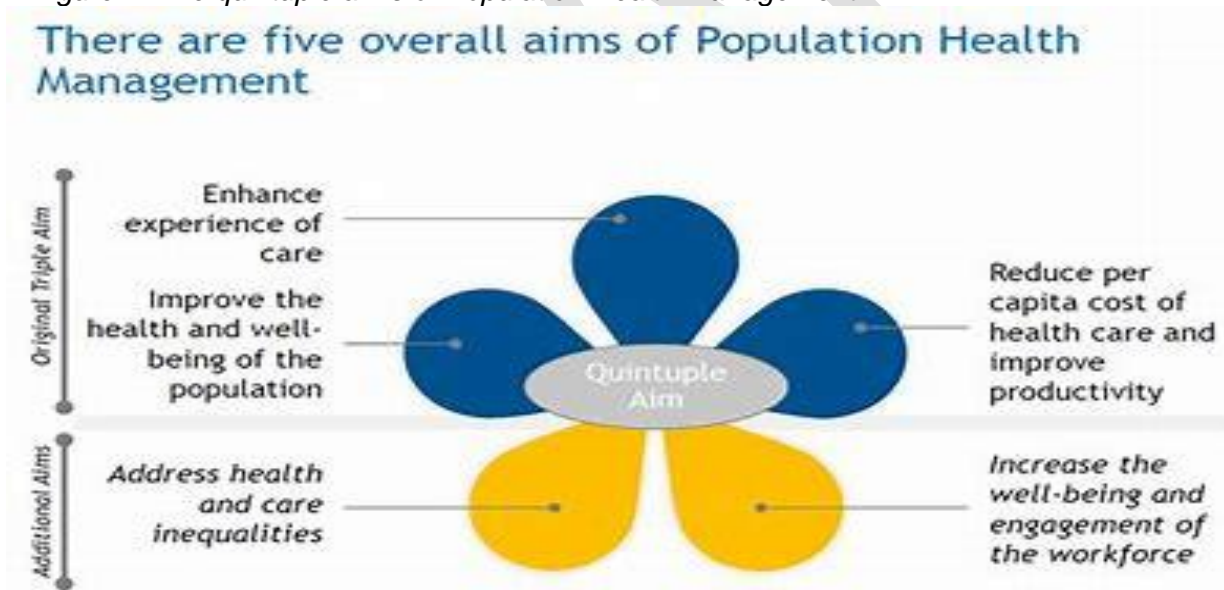
#### a) Prevention of disease and promotion of health and wellbeing

This should be a core aim of all our work. Clinicians in LLR, of all disciplines and levels of experience, have an essential role, in any consultation or contact with patients, to address relevant issues of health promotion and disease prevention and, by so doing, to combine the practice of their specialism with a wider public health role to deliver the greatest benefit possible. There is a clear relationship between increasing levels of ill-health and increasing risks of harm and healthcare utilisation. We will take effective and consistent prevention and health promotion actions, at a population level, so as to slow or prevent people's progression to more complex ill health. We will undertake population health interventions at the geographical and community level appropriate to the problem at hand (system wide, place, and neighbourhood).

#### b) Aims of Population health management

Overall, we want our population health approach to achieve, over time, all five domains of the NHSE quintuple aims of Population Health Management (Fig 2). We will develop outcome metrics that capture these 5 aims to help us measure whether we have been successful. We believe attention to population health management is the only way in the long term to attenuate the rise in demand on acute services and the rise in the costs of healthcare. We will build appropriate timescales into the recording of these outcomes to ensure expectations of the impact of our actions are reasonable and avoid "short termism" in our commissioning decisions.

<sup>1</sup>Figure 2: The quintuple aims of Population Health Management

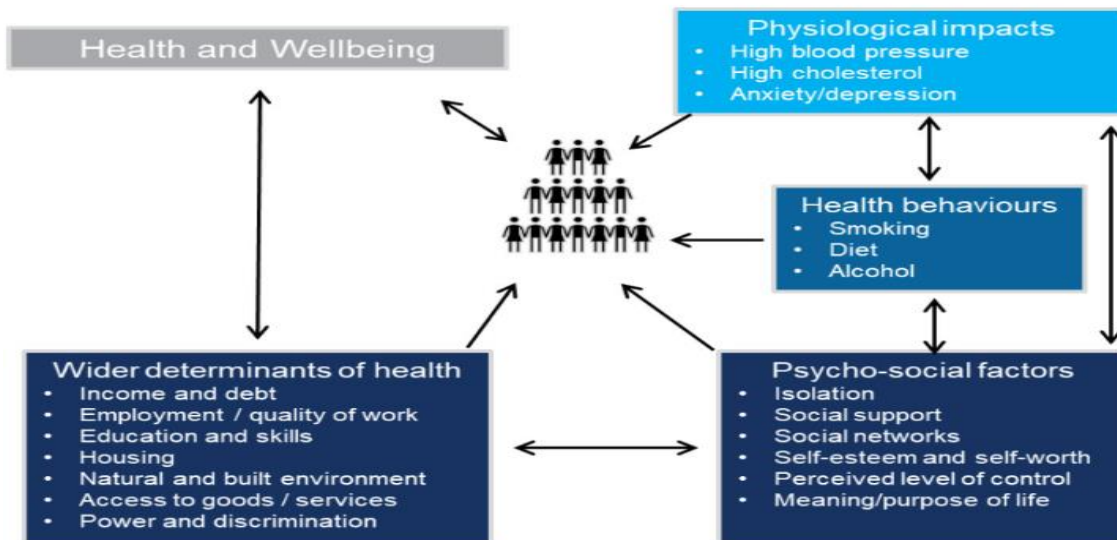


#### c) The broader social determinants of health

The establishment of integrated care systems offers the opportunity to integrate Local government and the NHS in developing population health management approaches. Through this collaboration, we will seek to address the wider social and environmental determinants of health (see figure 3) where these lie within the remit of the ICB and its partners. Considerations of environment and sustainability will be central to the actions we take.

<sup>1</sup> NHS England – Quintuple aims of population Health Management

<sup>2</sup>Figure 3: System map of the causes of health inequalities



#### d) Improving Health Equality

Resource allocation for population health and health equity interventions will be aligned to the [LLR health inequalities framework](#). We will seek to make resource allocation decisions based on the principle of “proportionate universalism” (Marmot report<sup>3</sup>) defined by equity vs equality (figures 4 and 5 below).

<sup>4</sup>Figure 4: Representation of equality and equity



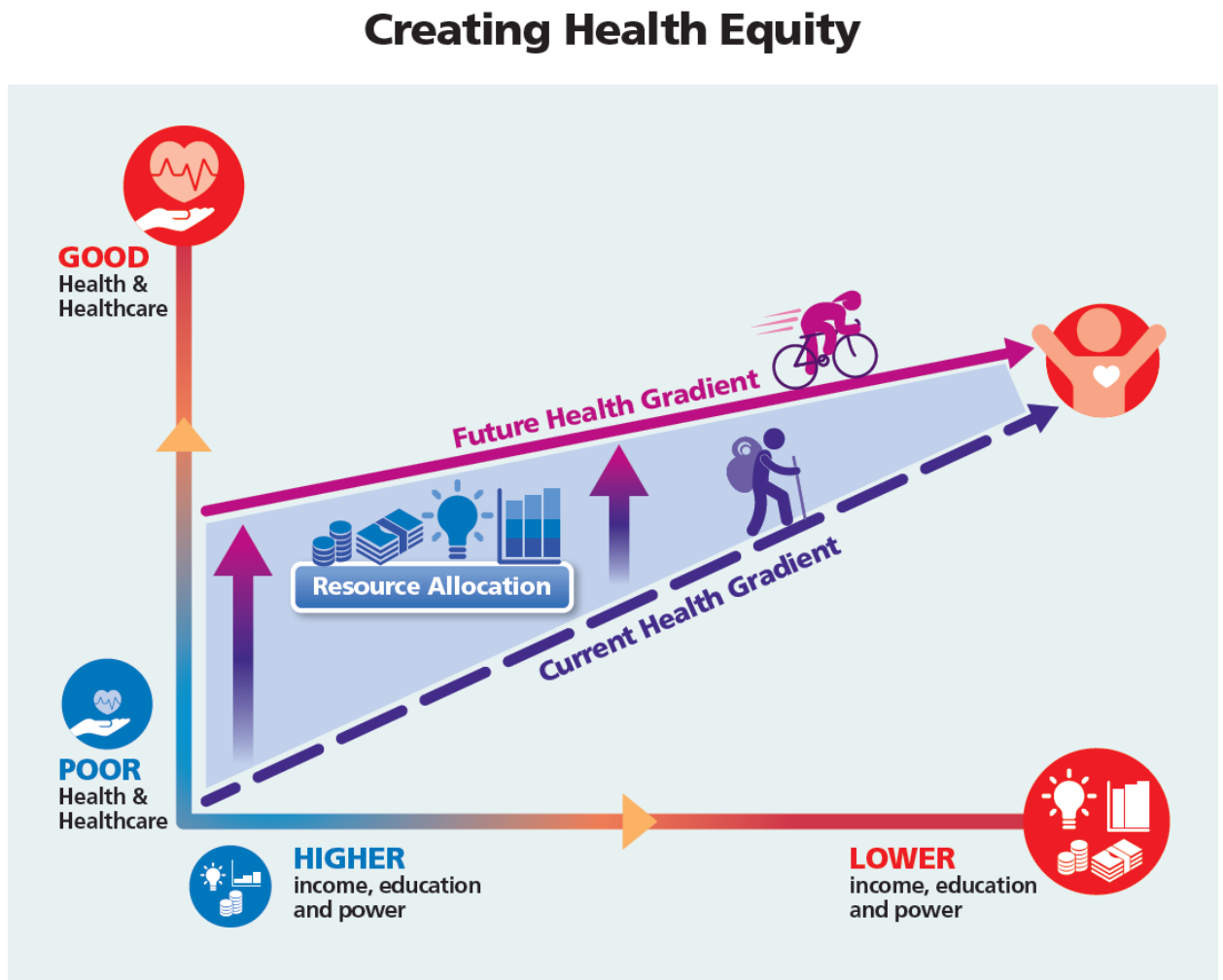
<sup>2</sup> Adapted by Public Health England from Labonte R. Heart health inequalities in Canada: Modules, theory and planning 1992

<sup>3</sup> Marmot MG. Fair society, healthy lives: the Marmot review; strategic review of health inequalities in England post-2010. Marmot Review, 2010.

<sup>4</sup> Reproduced with authorisation from Robert Wood Johnson Foundation (Better Bike Share, 2017)



<sup>5</sup>Figure 5: Transforming health systems to reduce health inequalities



#### e) Public Health Risks

Our population health management approach will take appropriate account of future national and local health risks including those relating to climate change and infectious disease taking into account the learning from the COVID-19 pandemic.

#### f) Community Engagement

We will work with communities across LLR by developing a clear engagement and communications strategy. Our clinical model acknowledges that the more activated and engaged patients are, the better their outcomes from health and care services are likely to be. We will work with patients, their carers/families and community groups so that we understand how best to act collaboratively to bring about these good outcomes.

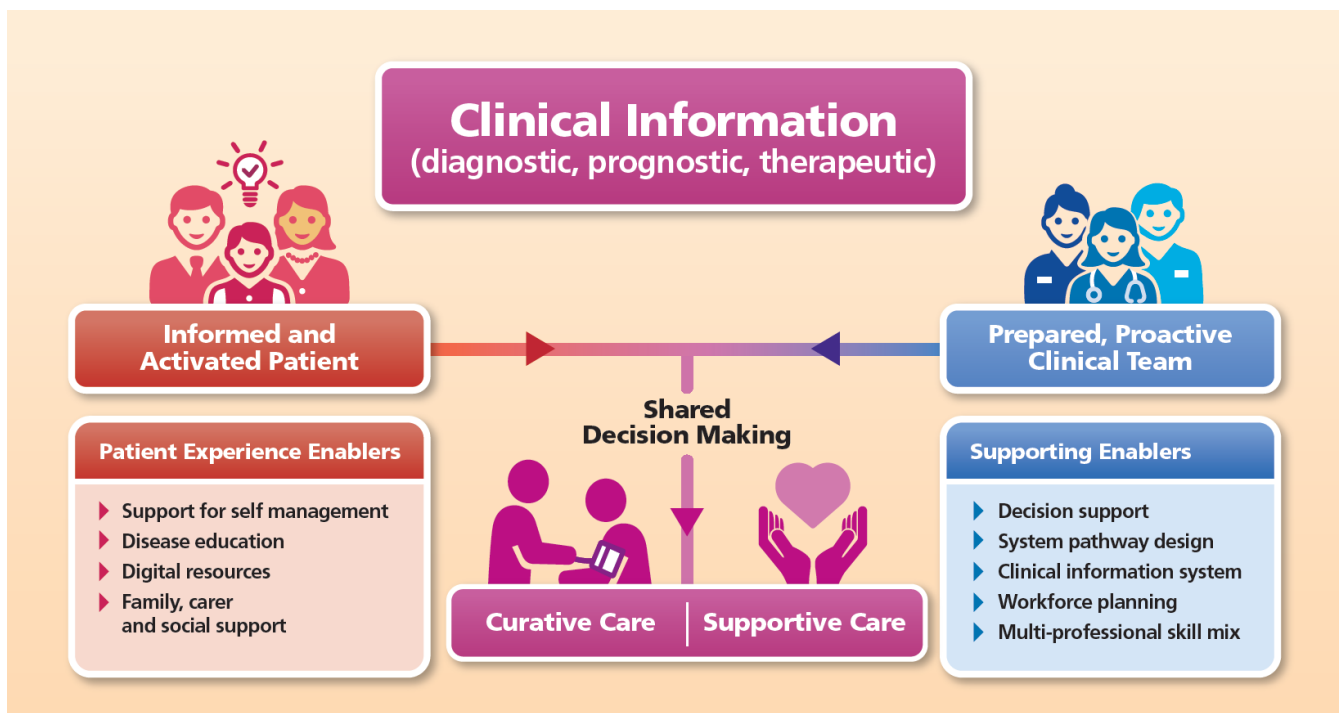
<sup>5</sup> Transforming health systems to reduce health inequalities. Authors: John Ford, A Sarah Sowden, B Jasmine Olivera, C Clare Bamba, D Alex Gimson, E Rob Aldridge F and Carol Brayne G Future Healthcare Journal 2021

## 4.2 Management of Illness

### a) Shared Decision Making

We will prioritise and support the productive interaction between a prepared/connected healthcare team and an informed/activated patient as articulated in the Chronic Care Model (see figure 6). The optimum outcome in each case will be reached through “personalisation of care” – where diagnostic and treatment options are co-produced in an environment that supports shared decision making.

<sup>6</sup>Figure 6: Chronic Care Model



### b) Support for the clinical team

Our proposed model requires provision of key enablers that support the healthcare team:

*i Deployment of a range of healthcare professionals appropriate to the problem at hand.*

This should include professionals from a variety of clinical disciplines and from different health and care organisations within LLR as appropriate. The needs of the patient rather than his/her place of residence should determine membership of the multi-professional team.

*ii Clear, simple and accessible system delivery (pathway) design.*

Such pathways should be informed by scientific evidence and articulated in easily accessible guidance documents for professionals. Pathway design should be “end to end” – in other words encompass care needs across a range of disease severities and a range of likely care settings.

*iii A unified clinical information system*

We will seek to establish well coded and maintained patient healthcare records that are visible to the relevant clinical team regardless of where they work. Clinical records will be supported by remote healthcare monitoring to enable “virtual care” where this is appropriate, safe and evidence based.

<sup>6</sup> Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract.* 1998;1(1):2-4.

#### *iv Workforce support and training*

We will seek to empower professional decision making through transparent and accessible decision support (guideline dissemination) and access to peer support. In tandem with the principles underpinning our clinical culture (outlined below), this will help professionals work with patients to manage clinical risk and uncertainty.

Access to training and peer support (including understanding their role in prevention and health promotion) will also help enhance the wellbeing and engagement of the health and social care workforce, one of the 5 aims of population health management outlined above.

#### **c) Patient and carer activation/engagement**

We will seek to increase participation of patients and carers in managing their health (activation) through:

##### *i Disease Education*

We will develop suitable and broadly deployed disease education programmes that support self-management and self-care at all possible stages of the life course. Additional support for patients and carers where activation/engagement cannot be fully achieved because mental capacity is diminished or absent due to cognitive, mental illness or learning disability will also be developed. Likewise appropriate support for parents and families caring for children and young people will be offered.

##### *ii Digital resources*

Where appropriate, we will use digital resources to enhance the interaction between patients and the healthcare team. Where appropriate this will include digital symptom and physiological monitoring in long term conditions and during recovery from acute illness (“virtual care”). We will consider the risks (and potential mitigations) of widening inequalities resulting from the “digital divide” when planning these interventions.

##### *iii Support Networks*

We will work to integrate networks of health, social care and voluntary sector support for patients with long term health problems so that patients and their families know where and how to access help when they need it. For people with long term conditions, we will aim to deliver that support through clinical and social care teams that know and can access relevant information about the patient.

#### **d) Healthcare Integration**

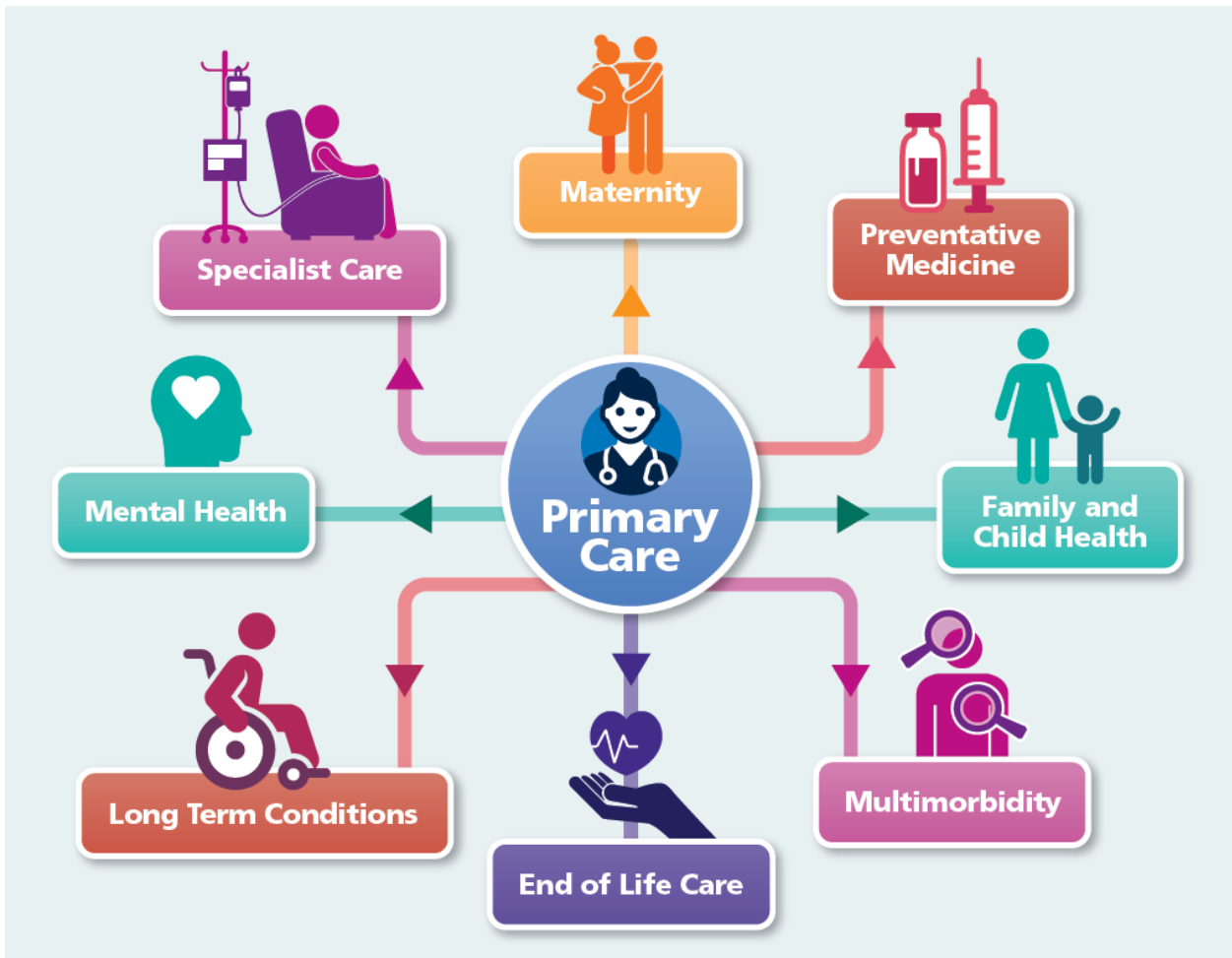
For those with long term conditions, the locus of care (specialist vs primary care) will be determined by evidence-based disease stratification prioritising metrics that identify modifiable risk and therapeutic opportunity (see summary in figure 1). Specialist care does not imply hospital care; we will propose and support as much as is practicable, integrated working of specialists in community settings. As the person’s burden of illness and multi-morbidity increases, our model calls for more seamless care from teams across organisational boundaries. The aim is to deliver clarity of treatment aims and continuity of clinical intent depending on the needs of individuals at different points along the continuum between having little or no need of healthcare to those with complex patterns of concurrent illnesses, frailty or those approaching the end of their lives.

#### **e) Well supported primary care**

Primary Care is the foundation on which this organisation of care rests. The complexity of the roles primary care undertakes is illustrated in figure 7. The capability of primary care is substantial (although varies widely) but capacity is frequently significantly constrained. We will provide additional resource for primary care by deploying specialist and social care in primary care and community settings. This will be tailored to the capacity and expertise available to primary care teams and will be informed by place and neighbourhood assessments of outcomes and performance.

Figure 7: Primary care roles

## Central Role of Primary Care



### f) Provision of Urgent and Hospital care

This should be provided where needed but admissions and bed days will be kept to the minimum possible consistent with established good practice and ethical considerations. Figure 8 depicts the complex interaction between long term and acute care provision for people with long term conditions highlighting the need for focused enhanced recovery interventions (including virtual care) and rehabilitation. Urgent care when required should be provided at a timescale and in a setting that matches clinical need (primary care, ambulance provision or emergency department attendance). We will also prioritise interventions that enhance the likelihood of patients managing acute health problems in their own homes through:

#### *i Proactive management of disease exacerbations*

“Exacerbations” of long term conditions and frailty due to respiratory infection or other acute event often prompt emergency admission. These should be considered as “planned but unscheduled” episodes of care. We will seek to model the volume and risk of these events (if not their precise timing) so that tiered community support to avoid admission can be offered and hospital capacity can be planned where it is needed.

#### *ii Transition from acute care*

We will define the duration of an acute episode based on its clinical characteristics, rather than by the location of care (eg hospital or home). This will enable physical discharge from hospital to be supported where safe and appropriate by the provision of “virtual” care in the home setting. Subsequent transfer of care responsibility to primary and community care services can then be undertaken at the appropriate point in the patient’s recovery with appropriate planning and communication between clinical teams.

*iii Pathways of Care*

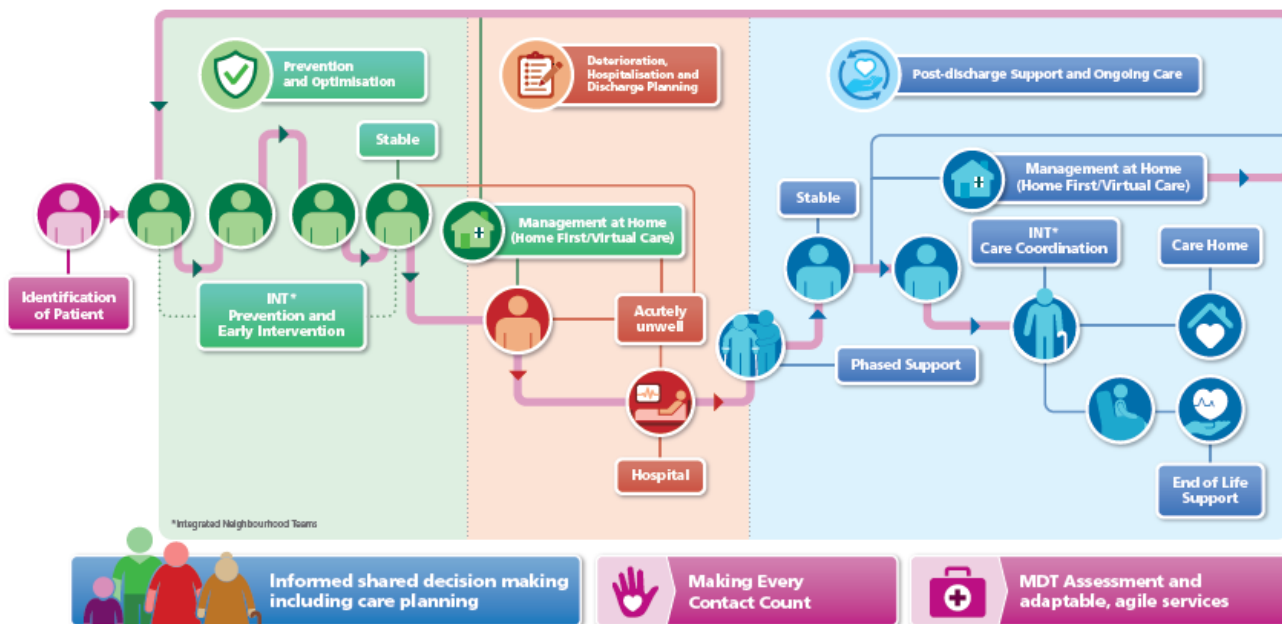
We will develop clearly defined routes of access to both acute care and prevention interventions for all patients including those with Long term conditions and those on elective care waiting lists. These routes will include wider education/support for families, parents and other carers.

*iv Long-term risk-mitigation*

We will take steps to ensure that episodes of acute care (in the context of LTCs but also with respect to other groups especially Children and Young People who make up a significant proportion of ED attendances) are considered “risk identifying” events prompting the identification of therapeutic opportunity for risk reduction especially rehabilitation/re-ablement, secondary prevention and safeguarding.

Figure 8: Comprehensive care planning in LLR

**Integrated System of Care for People with frailty or Multimorbidity**



## 4.3 Clinical Culture

### a) Research and Innovation

Interventions we propose and support will be informed by the best available biological, behavioural and implementation science and informed by robust and impartial evaluation of local healthcare data.

We will support this principle by embedding cutting edge research and data analytic methods to inform population health and therapeutic interventions by collaborating with local academic partners, an area of strength in LLR.

### b) Stewardship of healthcare resources

We will prioritise interventions in line with the ICB clinical prioritisation and [health inequalities frameworks](#). This proposes prioritisation decisions based on assessments of “value” (Figure 9), patient safety/risk, and health equity but we will also ensure consideration is given to:

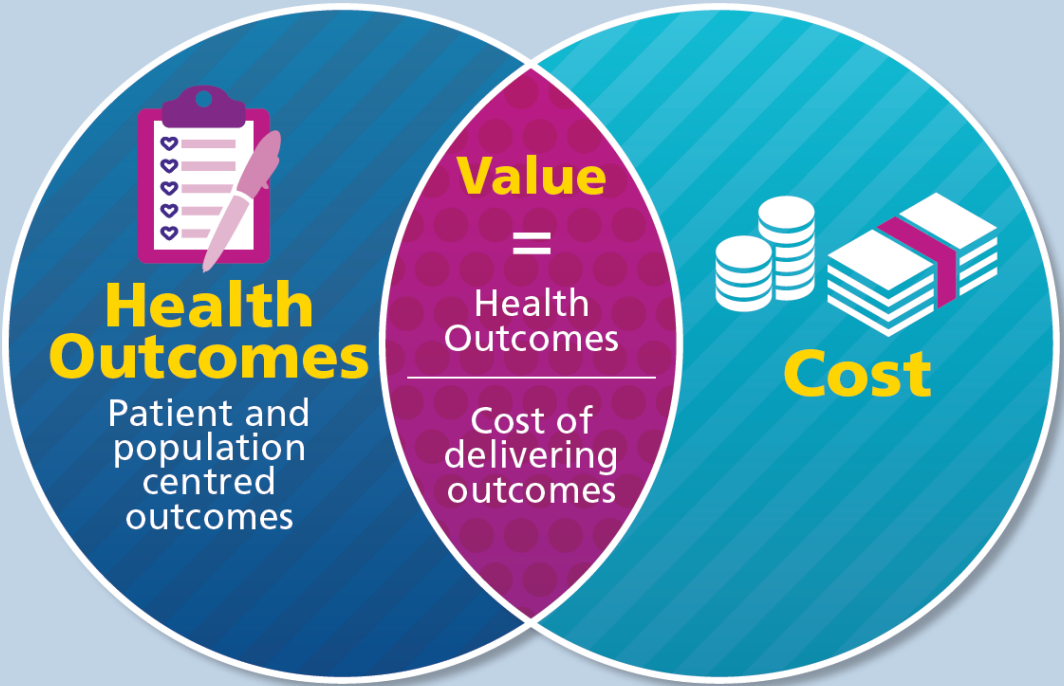
- i Parity of esteem between mental and physical illness reflecting also that physical health and optimisation of therapy are linked to mental health and vice versa.
- ii Parity of esteem between pharmacological and non-pharmacological interventions where evidence suggest these offer the best value.
- iii The extent and quality of scientific evidence supported by in depth analysis of local clinical data where available.

Driving up health equity will be a key strategic aim at every level of the ICS – both as a mechanism for rapidly improving overall access to, experience of, and outcomes from health and care (and as a manifestation of our ethical values as clinicians) but also as a mechanism for achieving cost effectiveness.

<sup>7</sup>Figure 9: *The relative value of interventions*

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<sup>7</sup> British Thoracic Society Reports, Vol 4, Issue 2, 2012. IMPRESS Guide to the relative value of COPD interventions



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### c) Professional Support

We will promote networks of communication, education and mentorship that empower individual clinicians (of whatever professional background) to make shared decisions with patients, manage uncertainty and access support when needed. We will underpin and maintain this support through a network of clinical and care leaders.

Inherent in this approach is:

- I. Ensuring clinicians can engage in reflective practice and learn from mistakes by establishing a “no blame” supporting culture.
- II. Taking steps to ensure that we recognise and manage and prevent “moral injury” in the clinical workforce.
- III. In reaching shared decisions with individual patients about their safety and care needs, we will encourage professionals to balance those individual needs with those of others accessing care where the capacity to provide such care is constrained.
- IV. Likewise, we will encourage clinicians to take account of wider societal and population risks when reaching individual shared decisions with patients, for example the risk of anti-microbial resistance when considering antibiotic prescription and the impacts of clinical care on the environment and climate change.
- V. Pro-actively enhancing and streamlining routes of communication between clinical and care colleagues working in different parts of the healthcare system both to promote effective clinical care for patients and to facilitate better mutual understanding and cooperation across the workforce. We will develop a clear code of practice guiding professional behaviours across the primary/secondary care interface.

### d) Scrutiny of outcomes

We will identify the most appropriate measures of success (and lack of success) taking into account the nature and setting of the clinical activity being measured. We will give particular consideration to:

- I. Patient safety and experience. With respect to the latter, we will seek to deploy robust quantitative metrics.
- II. Impacts of service transformation on health equity.
- III. Health and wellbeing outcomes in comparison to other national and regional data as a measure of local performance. These outcomes will be broad (eg mortality and hospitalisation) but also tailored to specific populations (for example, school attendance, parental leave for children and young people).
- IV. Where scientific evidence exists that an intervention delivers improved outcomes, the principle focus will be measuring the effective delivery of the intervention rather than these outcomes *per se*.
- V. Measurement of the impact of interventions/service developments on health and care workforce experience and moral injury.



#### e) Communication and Transparency

We will involve patients and the public in decisions we make about the provision of healthcare services.

We will seek to do this at the appropriate geographical level (system/place/neighbourhood) relevant to the patient population and the healthcare intervention proposed.

We will proactively and transparently explain our actions to patients and the public especially where changes or transformation is proposed for existing services.

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