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

LLR System Priorities	Integrated Care Strategy	Leicester JHWS	Rutland JHWS	Leics. JHWS	This Plan Chapter 3: Delivery Plan: 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)

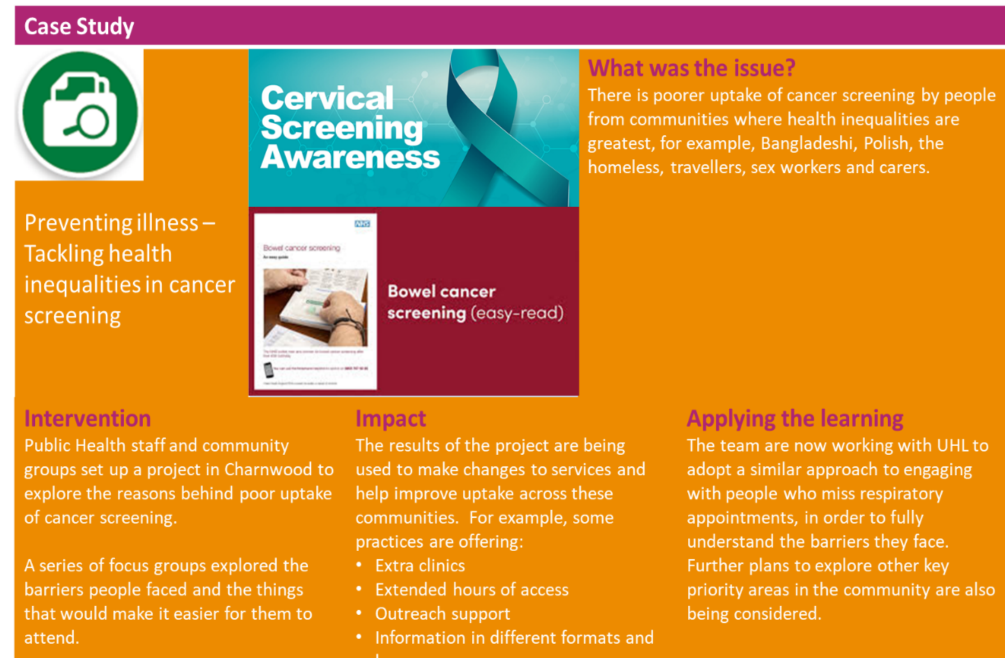
Secondary (Reduce) - Increasing the early detection and diagnosis of disease to achieve better outcomes; slow or reverse disease progression, for example, cancer screening programmes and targeted weight management services (Secondary prevention)

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

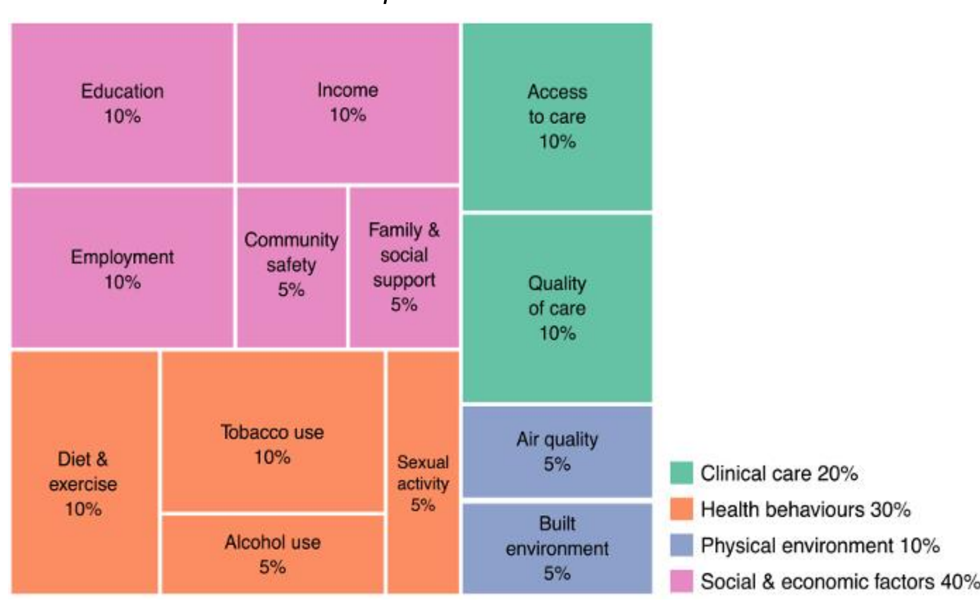


We plan to shift the dial toward focusing more on preventative services and interventions. Although our finances are challenged (see Chapter 6), we believe that more upstream investment in prevention is critical if we are to have an impact towards healthier lifestyles, effectively manage long term conditions 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
	23/24 to 27/28

7. Obesity - Supporting people to access the NHS Digital Weight Management Programme 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 9. Cardiovascular disease and Respiratory - Improve detection and management of atrial fibrillation, hypertension and high cholesterol 10. Implement a focussed tuberculosis programme aimed at eradicating TB in LLR	23/24 to 27/28 23/24 to 27/28 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

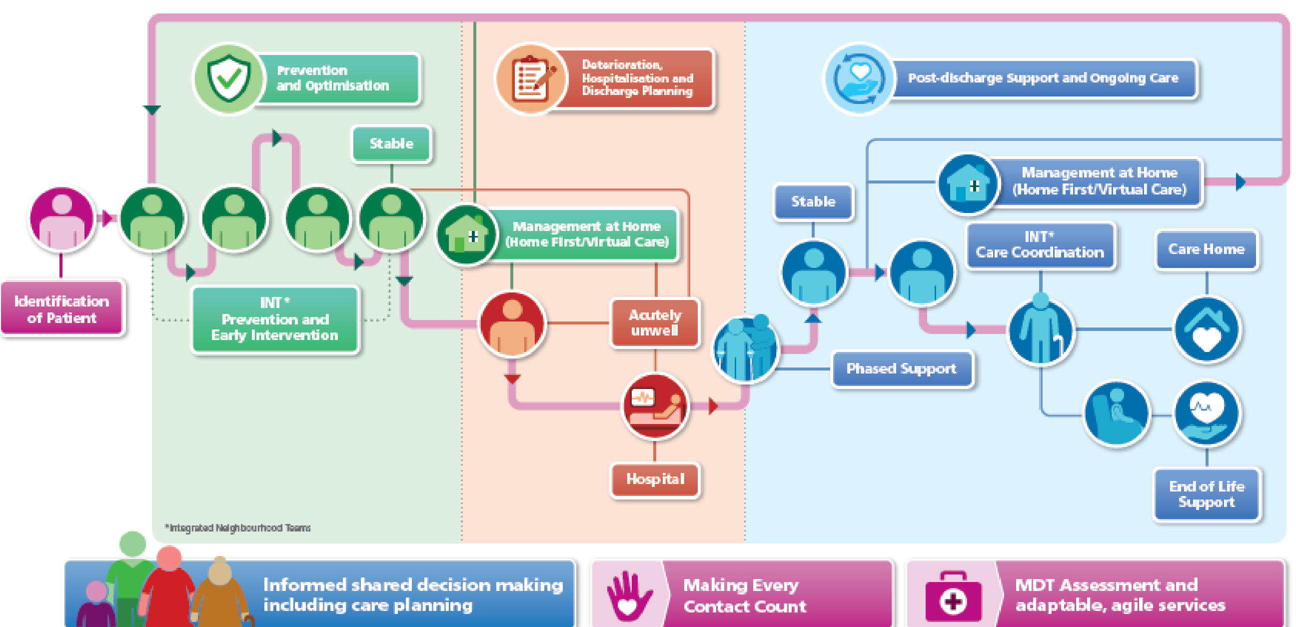
Local context

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.

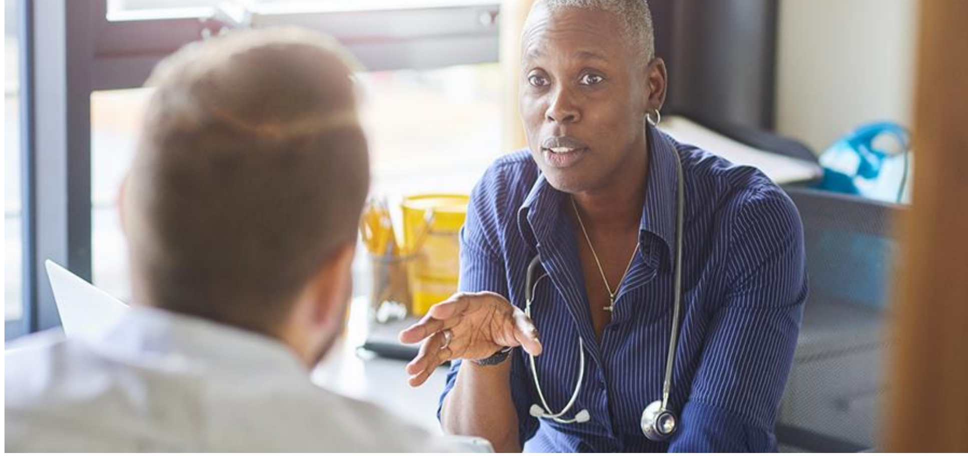
Primary Care

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

Elective Care Strategy
Timely, Inclusive and Convenient Access to Planned Care

Year 1 – 22/23	Year 2 – 23/24	Year 3 – 24/25
• Stabilise waiting list • Deliver zero 104+ • Reduce 78+ week waits • Reduce 62 day and 104+ day cancer waits	• Channel long term conditions and diagnostics out to community PCN/Primary Care • Longer term agreements with IS • Community Diagnostic Centre's – (2&3)	• Elective hub fully operational • Net importer of activity into capacity • Upper Quartile Productivity • Digital Leader

Interventions Via Planned Care Partnership

1. Productivity Improvements
2. OP Transformation
3. Pathway Changes
4. Validation
5. IncreasingCapacity
6. PartnershipWorking
7. Reducing Health Inequalities
8. Income Generation

Enabling strategies

- Digital
- Workforce
- Communications and Engagement
- Health Inequalities
- Prevention
- Diagnostics

Productivity / Processes/ Partnerships

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

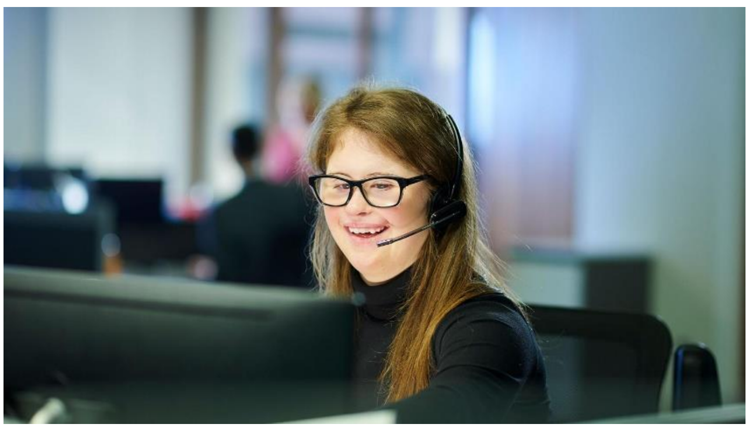
Interventions	Deliverables	Timeline
1. Productivity Improvements 2. Outpatient Transformation 3. Pathway Changes 4. Validation 5. Increasing Capacity 6. Partnership Working 7. Improving Health equity 8. Income Generation	• Begin activity flows through the East Midlands Planned Care Centre with further 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

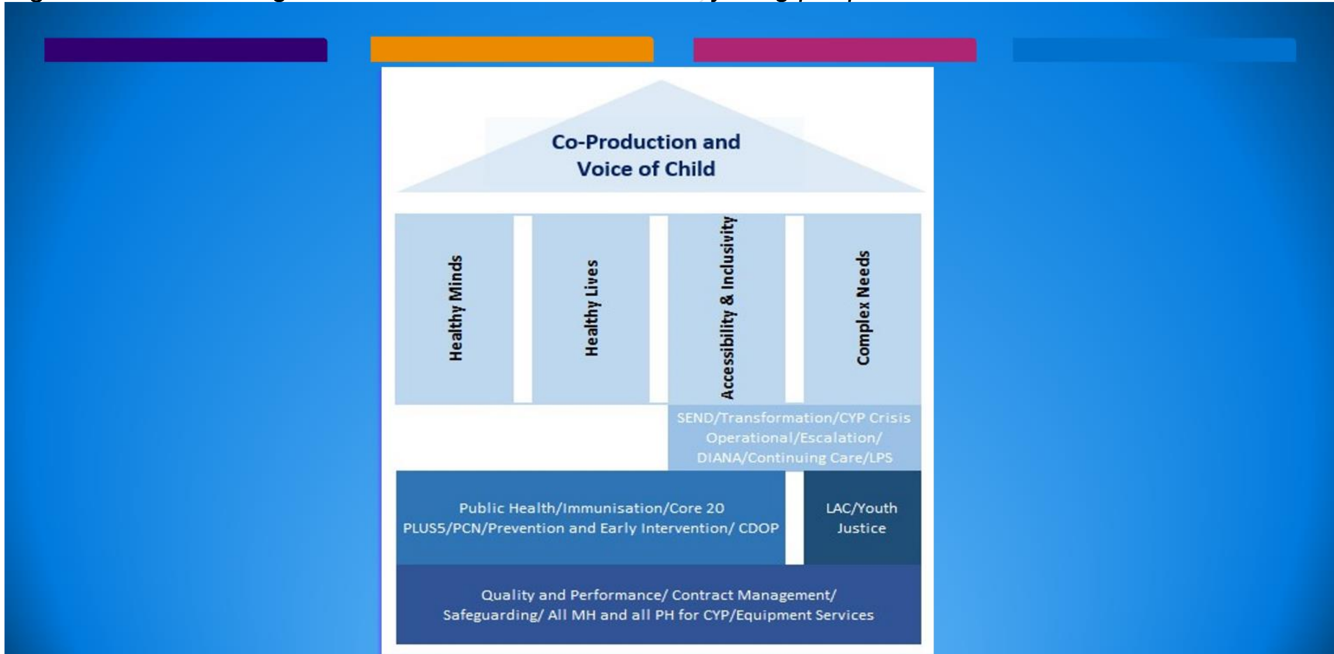
We will reshape the children and young people's portfolio, bringing all components across health and care together into a children and young person's collaborative partnership. This `collaborative` will have the voice of children and young people at its centre and will bring clinical and senior colleagues 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 fraility 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 90% 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 23/24	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.