Appendix A

Leicester, Leicestershire and Rutland
Integrated Care Board

Our Five-Year Plan
2023/24 – 2027/28

Contents

Foreword

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

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

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

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

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

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

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

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

Our Pledges to local people

Our Pledges to local people

Over the next 5 years, we will:

Improving health equity

Pledge 1

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

Preventing illness

Pledge 2

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

Keeping People well

Pledge 3

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

Right care, right time, right place

Pledge 4

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

Pledge 5

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

Pledge 6

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

Health and Wellbeing Hubs

Pledge 7

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

Elective care

Pledge 8

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

Learning Disability & Autism

Pledge 9

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

Mental Health

Pledge 10

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

Children & Young People

Pledge 11

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

Women's Health, including Maternity

Pledge 12

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

Our People

Pledge 13

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

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

Our Plan on a Page

Delivered Across Our Life Course Approach

Best Start in Life

Staying Healthy and Well

Living and Supported Well

Dying Well

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

Core Purpose of our ICS (Our Strategic Objectives)

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

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

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

Our Delivery Priorities

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

Our Pledges to local people

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

Chapter 1: Introduction

1.1 The purpose of this document

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

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

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

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

1.2 Who this document is for

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

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

Audiences for whom this document should be particularly helpful include:

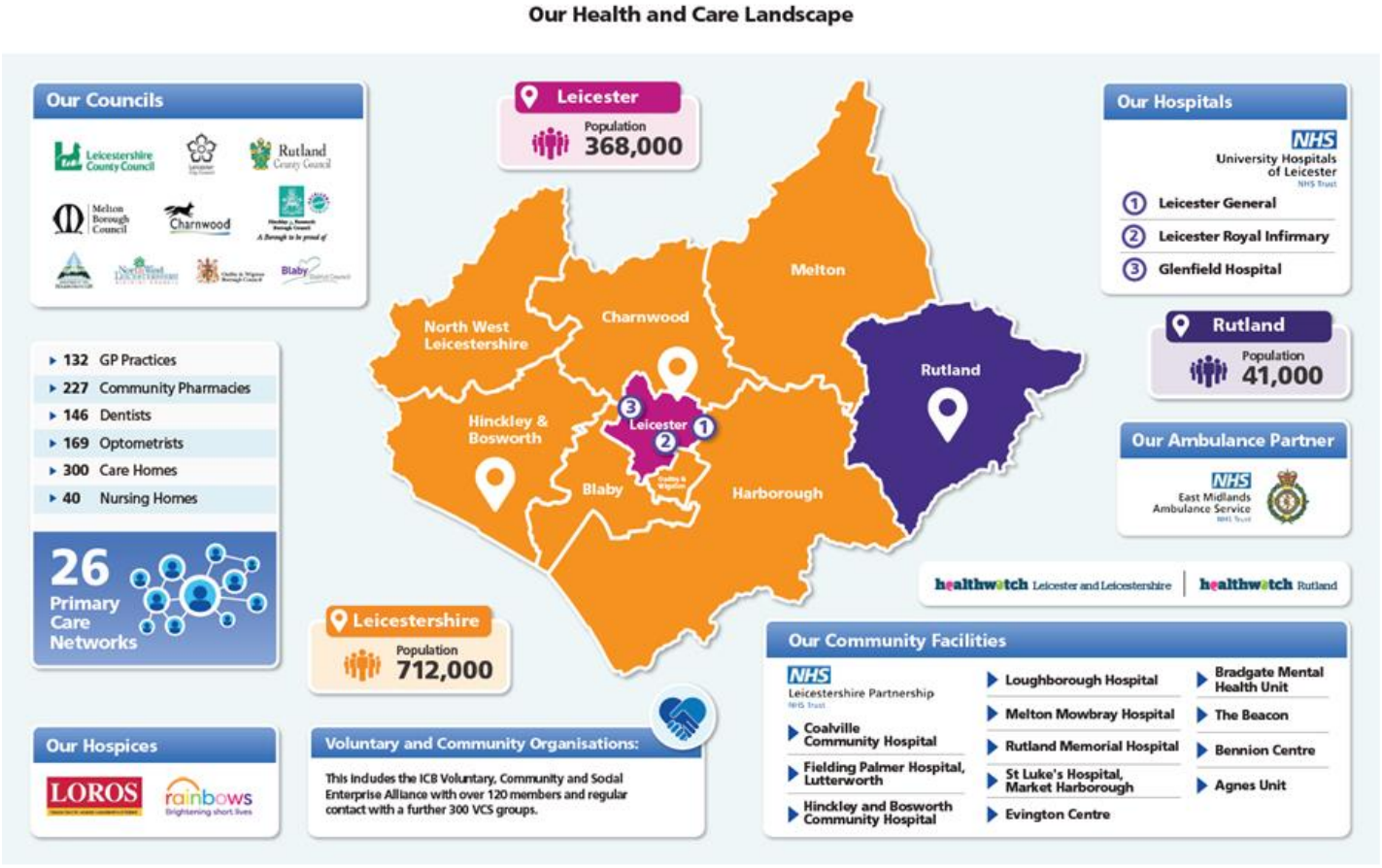
- Our patients and local people
- NHS and social care staff and teams
- NHS leaders at all levels and across all our organisations
- Clinical leaders across primary, community, mental health, hospital and specialist services
- NHS Board non-executive members
- County and district council councillors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

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

1.3 About us

About LLR

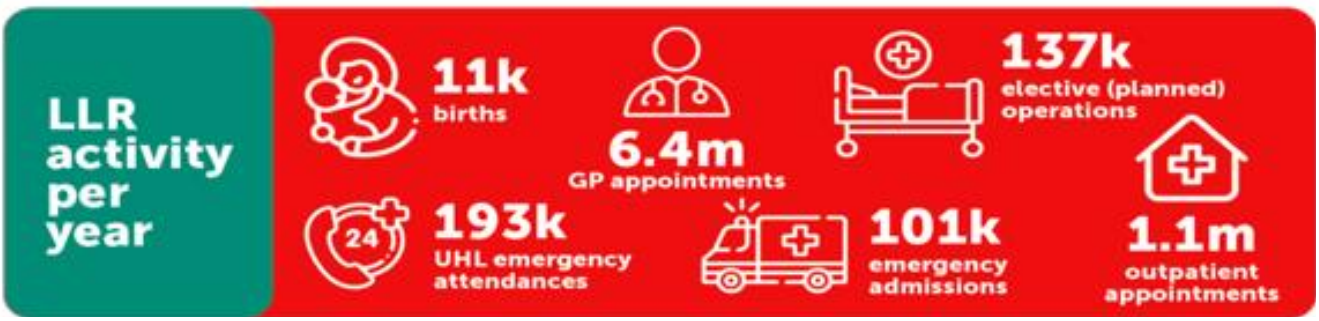
We serve 1.1million people across rural, market towns and urban areas.



Figures accurate as of March 2023

Key facts and figures

LLR is a busy place…



(2021/22 data)

About the LLR ICB

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

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

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

About the LLR ICS

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

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

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

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

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

Our system operates at three levels:

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

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

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

1.4 Our Vision, Principles and Life Course approach

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

Our Vision

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

Our Principles

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

Our Life Course approach

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

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

1.5 A clinically led approach

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

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

Table 1: Summary of our clinical strategy guiding principles

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

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

Figure 1: Our LLR Clinical Model

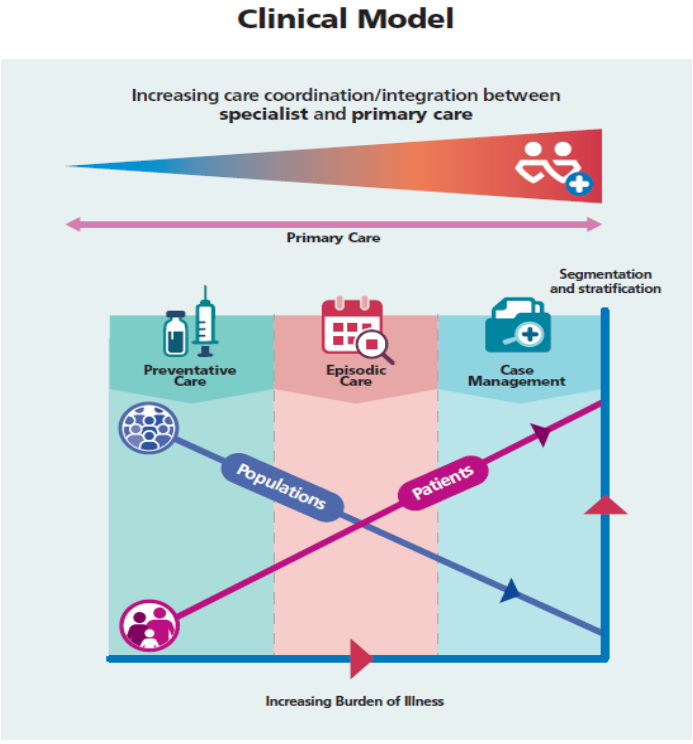


Figure 1 summarises our overarching clinical model. It describes the broad role of the ICS in promoting population health and managing individual illness. It demonstrates the critical role that stratified prevention interventions make, at a population level, to maintain and optimise general population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

1.6 Our approach to developing this plan

Aligning to wider system partner's ambitions

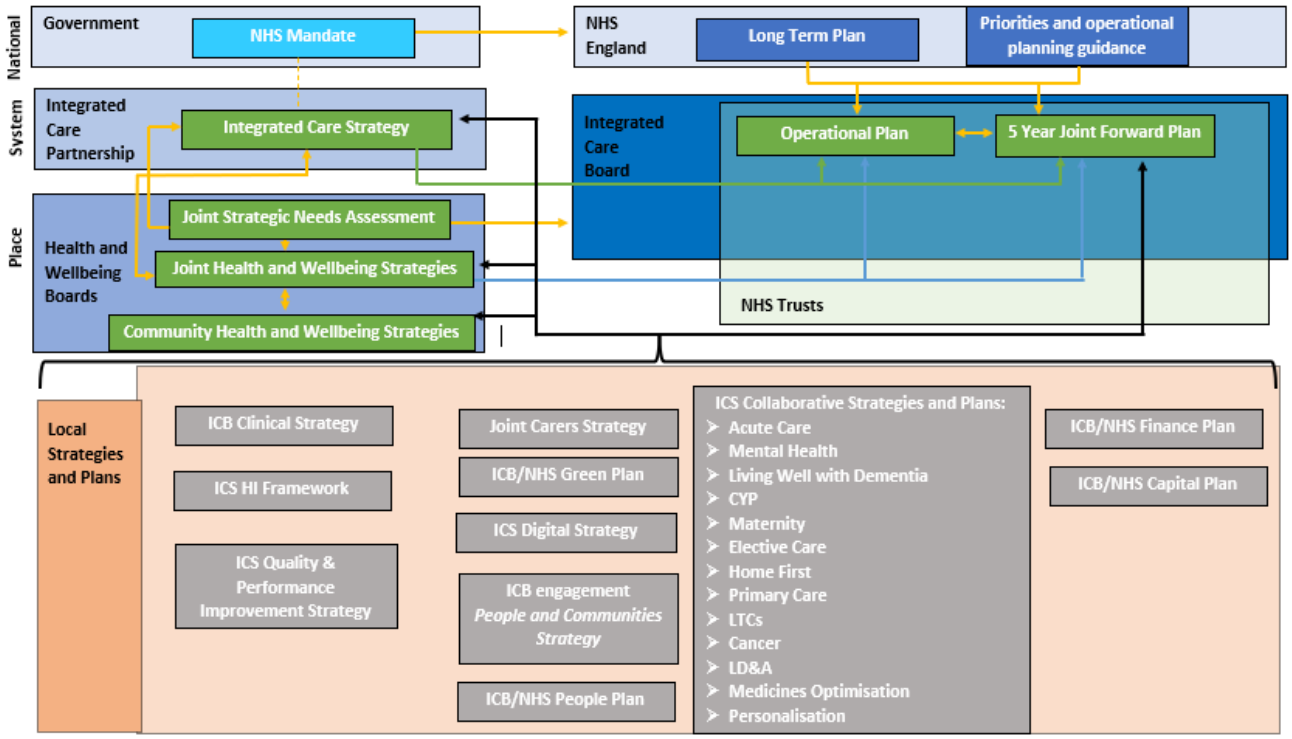
This Five-Year Plan is a shared delivery plan: for universal NHS commitments; for the ICB's commitments within our LLR Integrated Care Strategy; as well as for our commitments within the Council's Joint Health and Wellbeing Strategies. We have ensured that all key stakeholders, including Health and Wellbeing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

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

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

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

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



Delivery focused

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

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

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

Local people's insights have informed this Plan

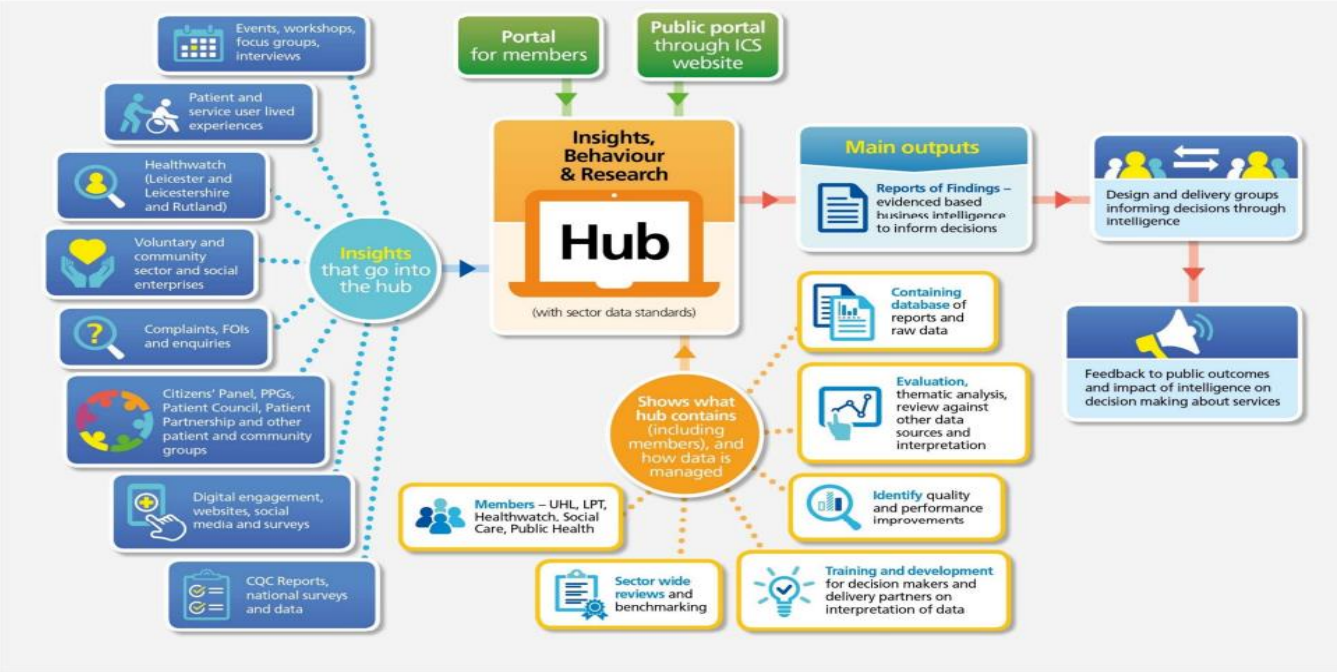
We have undertaken large-scale involvement projects, with local people, over the last 3 years. The insights and data from this work is evidenced and has informed the service-specific future arrangements within this Plan. These projects have seen quantitative and qualitative data gained from nearly 50,000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

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

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

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

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



The Voluntary, Community and Social Enterprise Alliance (VCSE)

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

The VCSE alliance:

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

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

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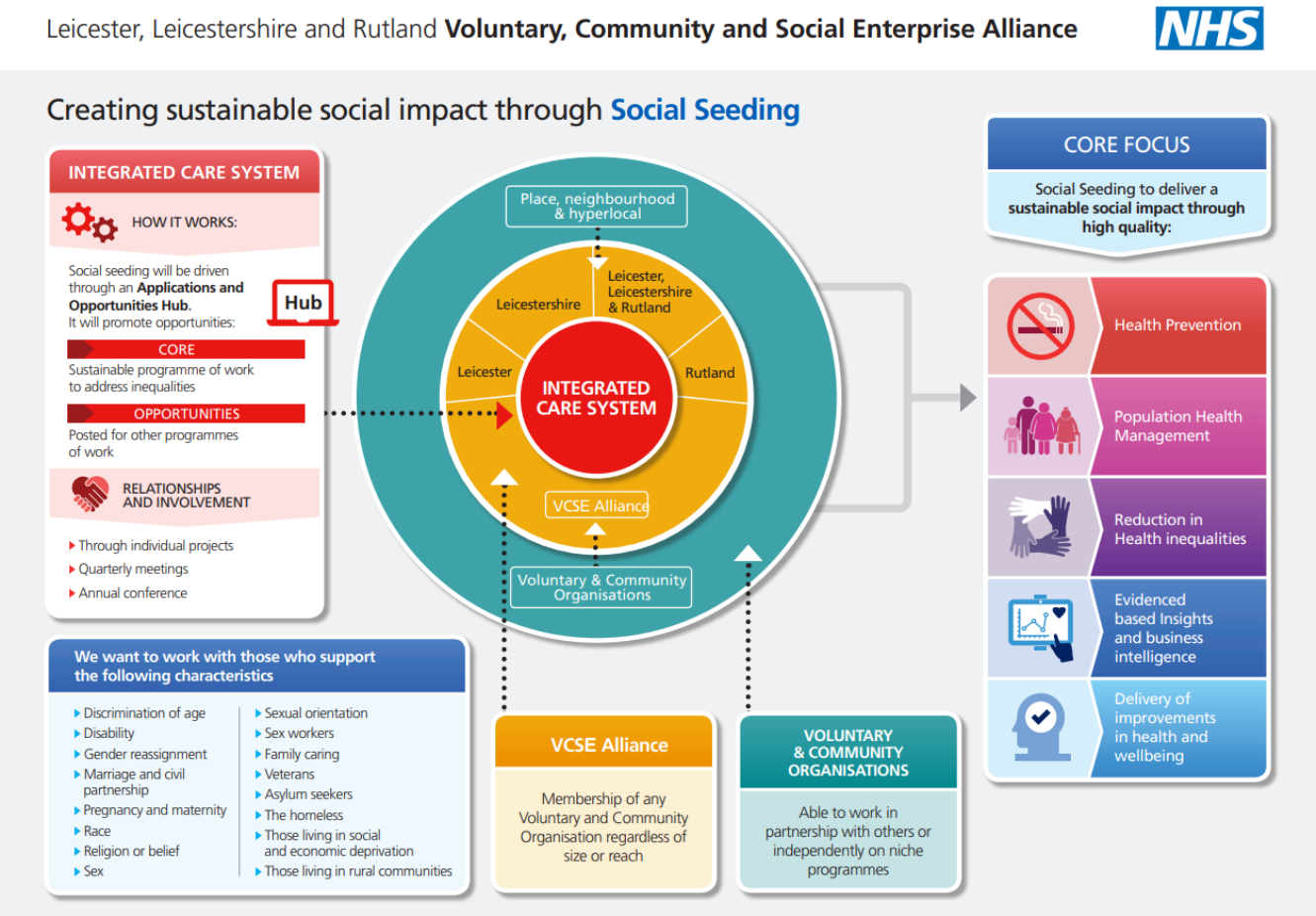
Figure 4, below, describes a co-designed model of how this diverse and creative sector are effectively involved in service redesign work, governance, system workforce, population health management and leadership and organisational development plans.

Figure 4: The LLR VCSE model



Involving our stakeholders in validating this Plan

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

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

1.8 Statement of support from HWBs

Leicestershire County Council HWB

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

Leicester City Council HWB

The statement from Leicester City Council HWB is pending.

Rutland County Council HWB

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

Chapter 2: Where we are now

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

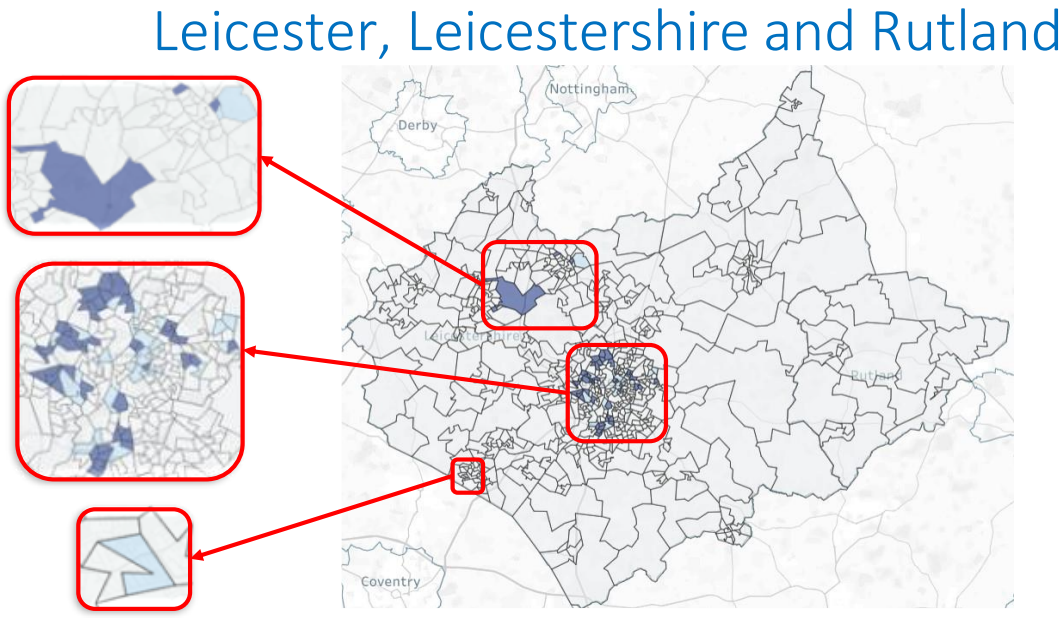
2.1 Overview of health and wellbeing

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

Summary of deprivation

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

Figure 5: Most deprived neighbourhoods in LLR



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

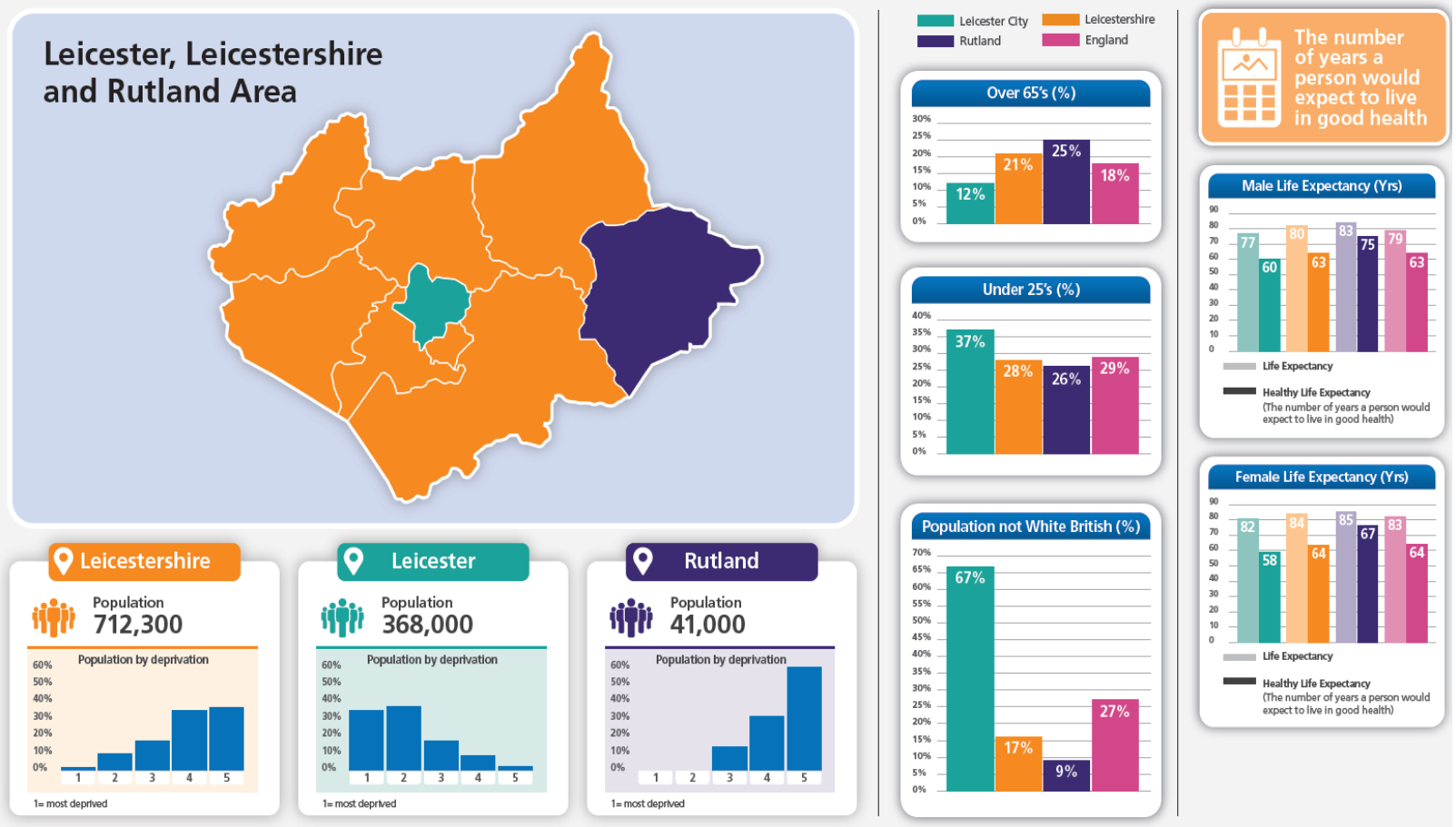
Interactive version can be viewed in tableau https://tabanalytics.data.england.nhs.uk/#/site/viewpoint/views/PopDemo_CORE20/CORE20?:iid=1 (OKTA account required)

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

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

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

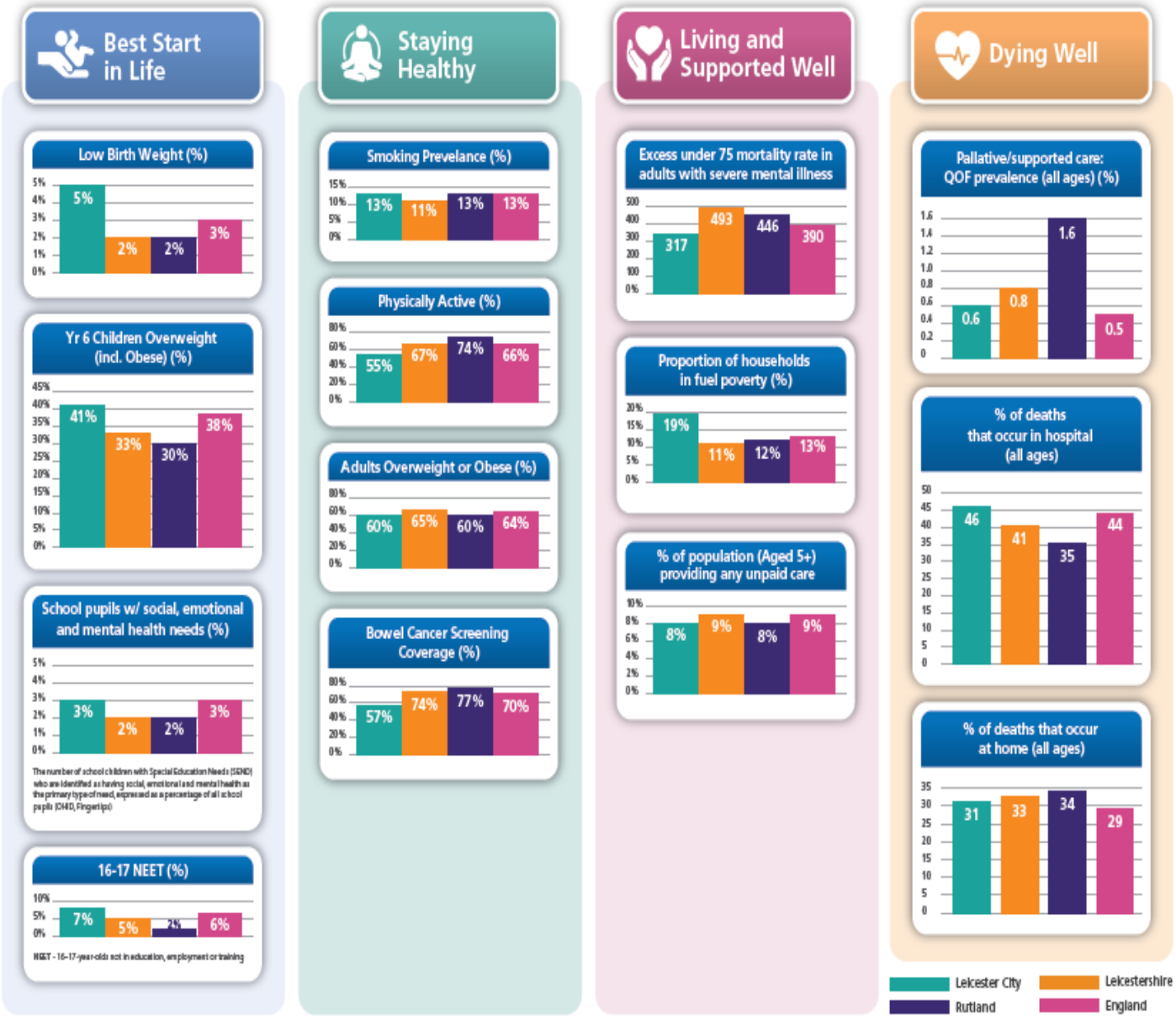
Summary of health and wellbeing facts and figures



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

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

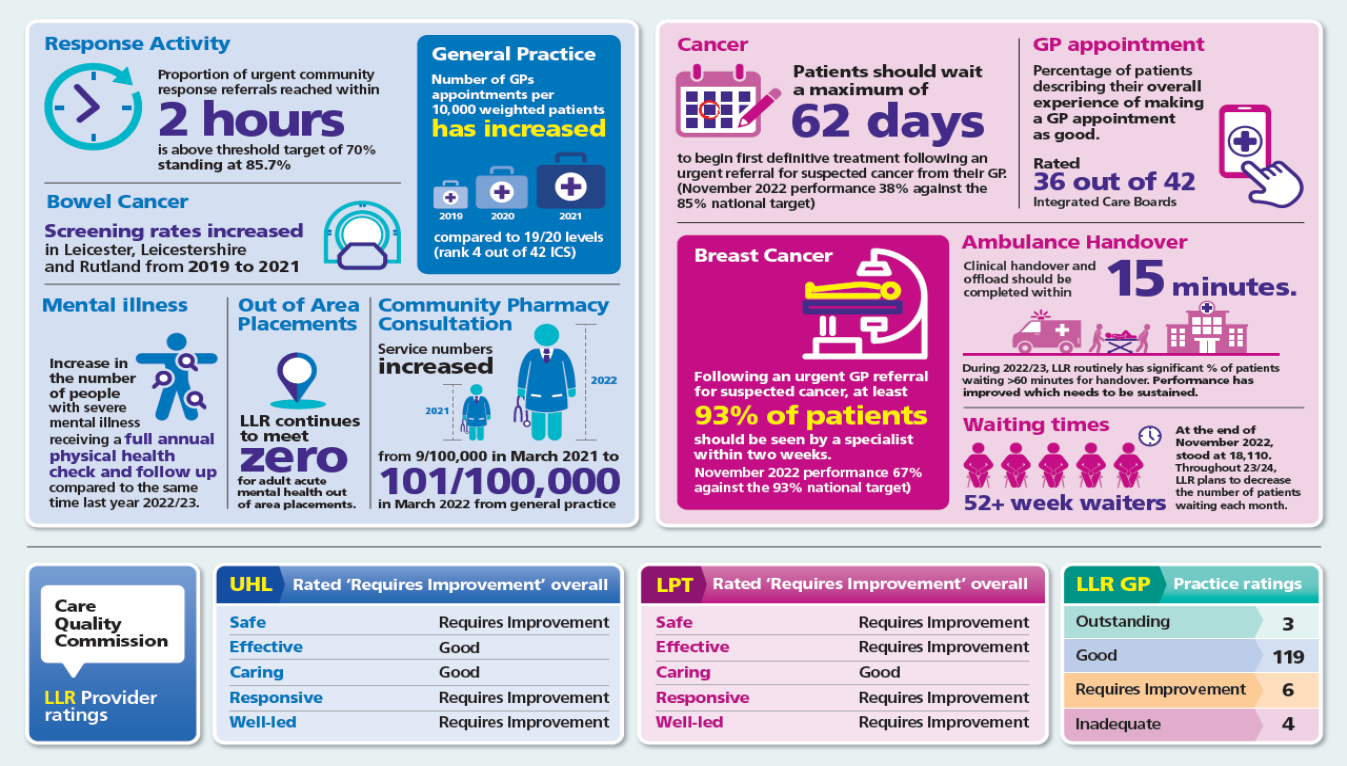
The infographic, below, describes how each of Leicester, Leicestershire and Rutland currently performs against key health and wellbeing indicators at each of the four-life course stage (see 1.4).



2.2 Our Performance

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

Our Performance and Quality



2.3 Our Finances

Local and national context

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

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

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

Our numbers

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

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

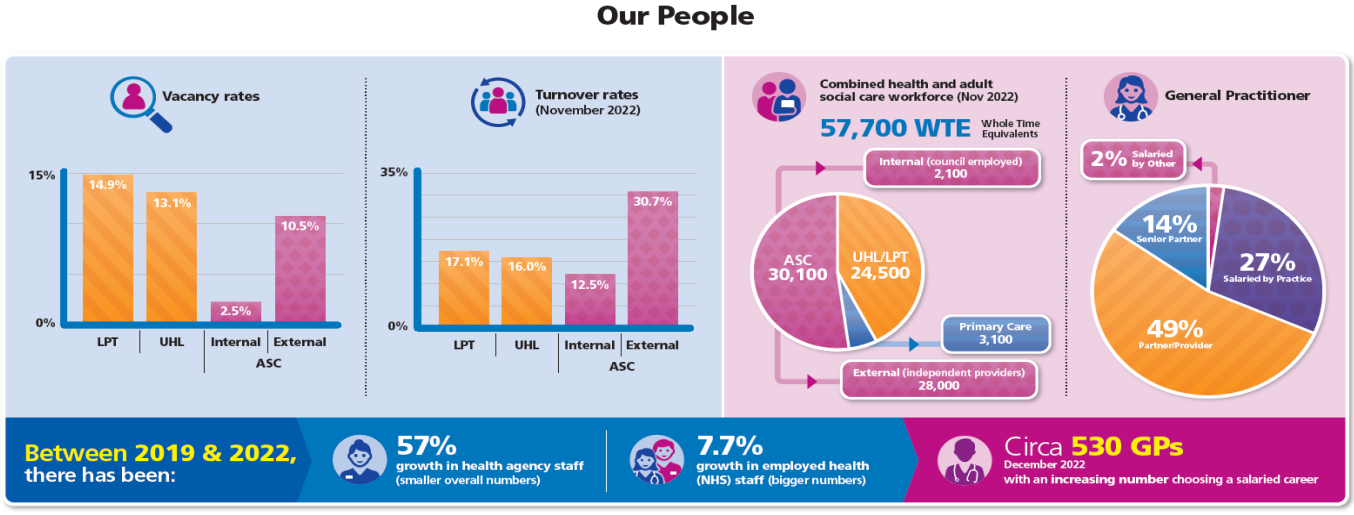
- reduced funding
- increased pressure on urgent care;
- increased mental health need;
- elective waiting list recovery;
- recruitment to safer staffing models of care;
- high levels of inflation;
- agency staff costs; and
- lack of funding for social care manifesting impacting on out of hospital discharge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

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

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

2.4 Our People

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



Chapter 3: Delivery Plan

Delivering a realistic and pragmatic transformative plan for LLR

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

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

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

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

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

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

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

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

3.1 Preventing illness

What do we mean by Prevention?

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

Primary (Prevent)

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

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

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

Local context

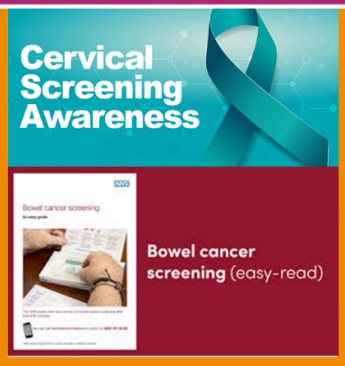
Between 2017 and 2019, there were 3,734 preventable deaths in under 75 year-olds in LLR (the Office for Health Improvement & Disparities), an average of 1245 per year and 45% of all deaths in under 75 year olds. Cancer, cardiovascular disease and respiratory disorders are the three most common causes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

Our approach

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

Case Study

Preventing illness – Tackling health inequalities in cancer screening



What was the issue?

There is poorer uptake of cancer screening by people from communities where health inequalities are greatest, for example, Bangladeshi, Polish, the homeless, travellers, sex workers and carers.

Intervention

Public Health staff and community groups set up a project in Charnwood to explore the reasons behind poor uptake of cancer screening.

A series of focus groups explored the barriers people faced and the things that would make it easier for them to attend.

Impact

The results of the project are being used to make changes to services and help improve uptake across these communities. For example, some practices are offering:

- Extra clinics
- Extended hours of access
- Outreach support
- Information in different formats and languages.

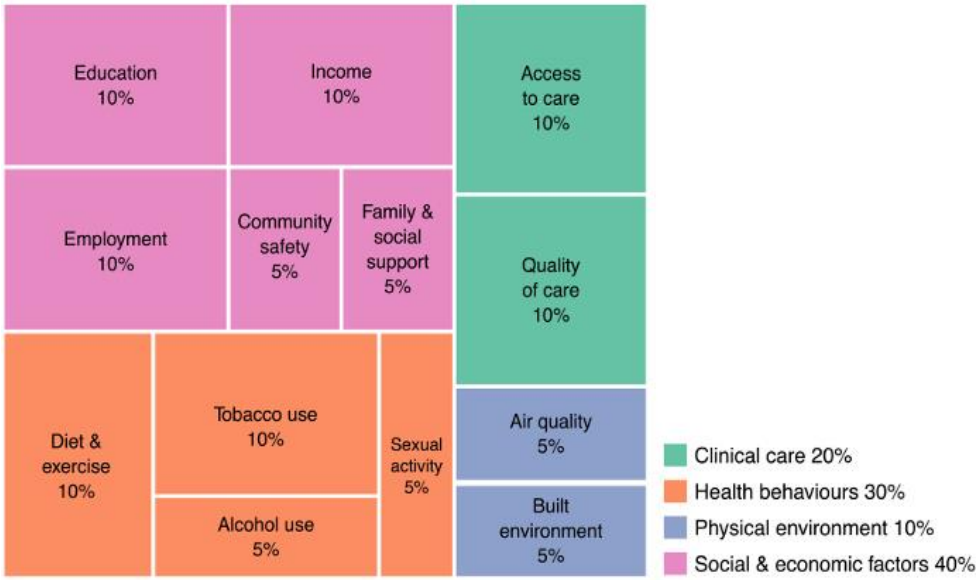
Applying the learning

The team are now working with UHL to adopt a similar approach to engaging with people who miss respiratory appointments, in order to fully understand the barriers they face. Further plans to explore other key priority areas in the community are also being considered.

The NHS as a local prevention Partner

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

Figure 6: Factors that influence a person's health



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

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

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

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

Summary of key interventions

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

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

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

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

Table 4: Summary of key prevention interventions we will make

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

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

3.2 Keeping people well

Effectively managing long term conditions, multimorbidity and frailty

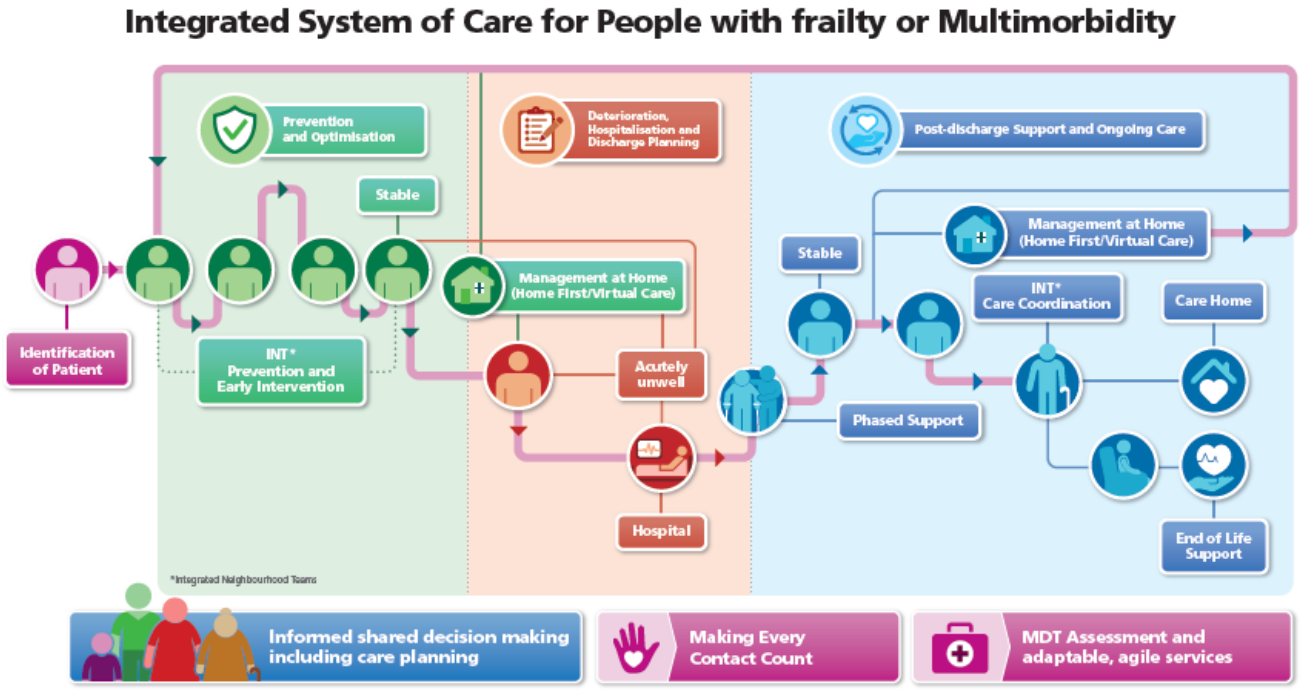
Local context

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

Population Health Management approach

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

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



Effectively managing multimorbidity and frailty

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

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

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

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

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

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

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

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

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

Summary of key interventions

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

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

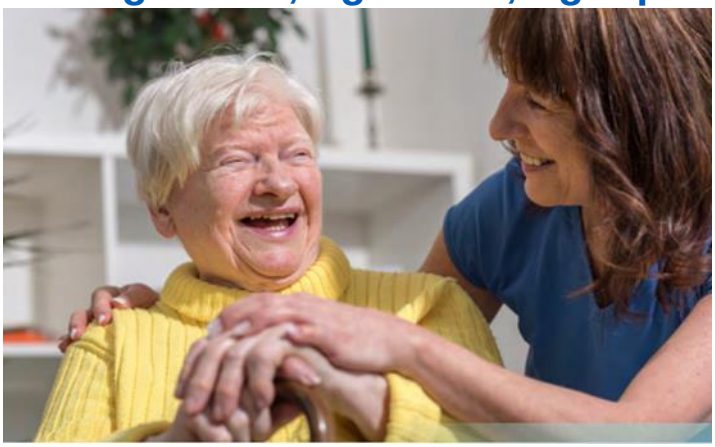
Table 5: Summary of key interventions we will make to keep people well

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

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

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

3.3 Right care, right time, right place



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

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

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

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

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

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

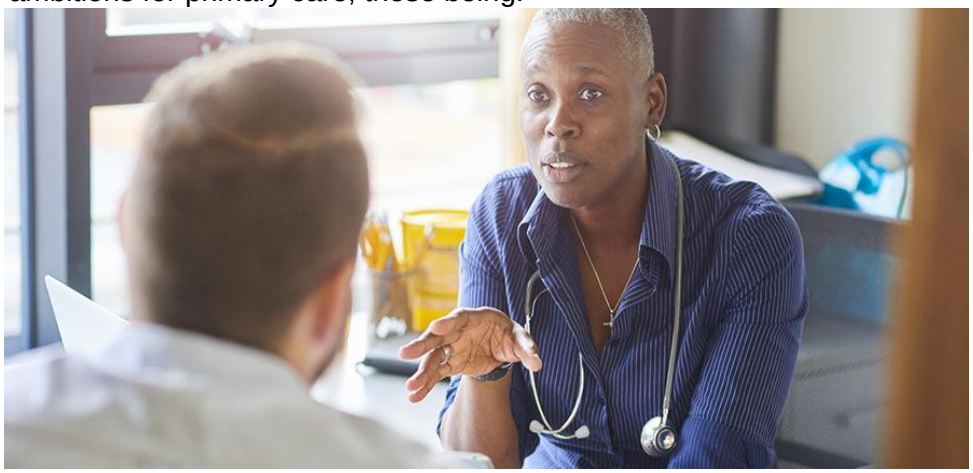
Primary Care

A new strategy for primary care (General Practice)

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

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

3.4 Integrated community health and wellbeing hubs

Creating the right environment for community health and wellbeing

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

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

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

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

Summary of key interventions

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

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

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

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

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

3.5 Optimal Pathways for Elective Care

Local context

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

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

Our approach

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

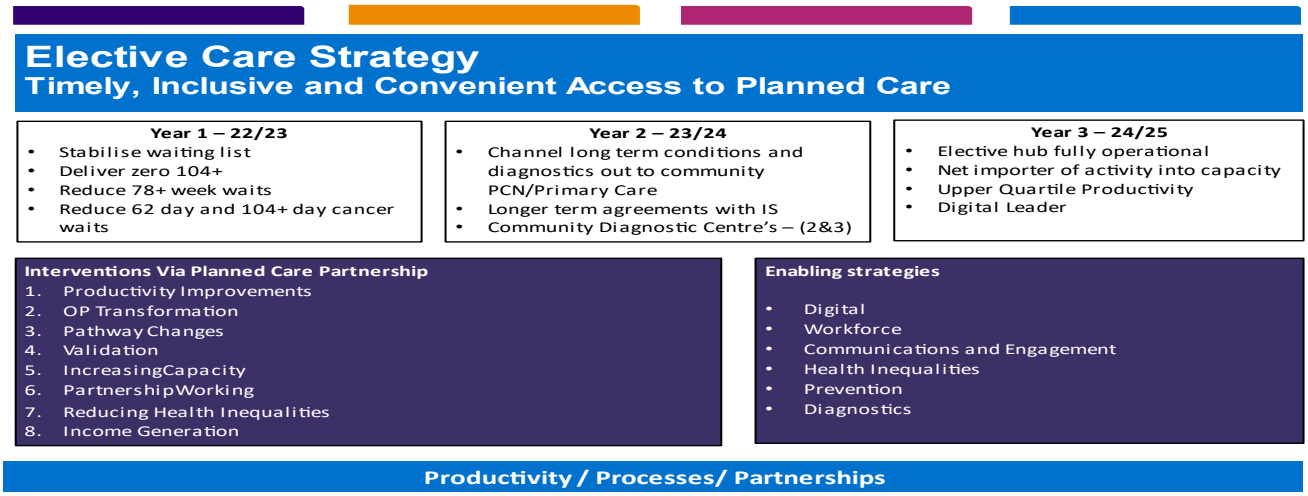
- Since March 2022, over 50,000 people, who would have been waiting over 78 weeks by April 2023 for their care, have been treated
- From October 2022 to April 2023 the number of people waiting for elective care decreased by 7,118 to 133,514
- As of April 2023, the number of patients waiting over 62 days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

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

Summary of key interventions

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

Figure 8: Our elective care strategy



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

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

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

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

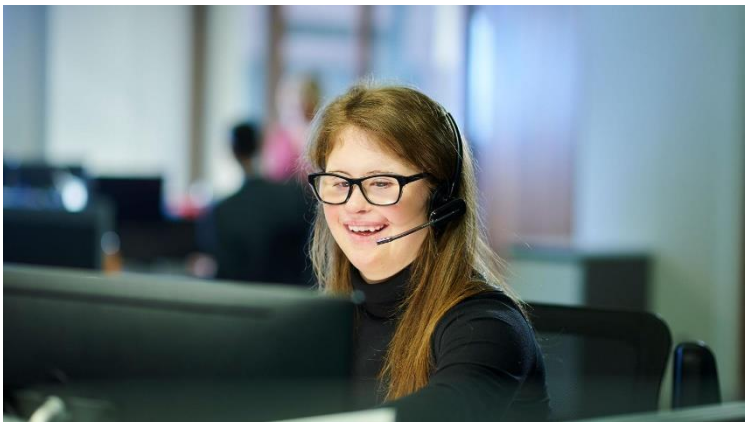
	• Work with EMCA to implement targeted lung health checks	
	• Develop case for Community Diagnostic Centre 3 if required • To become a net importer of activity to the East Midlands Planned Care Centre supporting the wider Region	25/26 & 26/27
	• Transformation of third tranche specialty end-to-end pathways	

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

3.6 Learning Disabilities & Autism

Local Context

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



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

Our Ambition for people with LDA, their Families and Carers

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

Our approach

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

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

Summary of key interventions

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

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

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

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

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

3.7 Mental Health

Children and young people, adults and older people

Local Context

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

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

Leicestershire:

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

Rutland:

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

Leicester City:

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

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

Our Ambition for mental health

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

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

Our approach

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

Case Study

Mental Health – Crisis Cafés

What was the issue?

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

Intervention

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

Impact

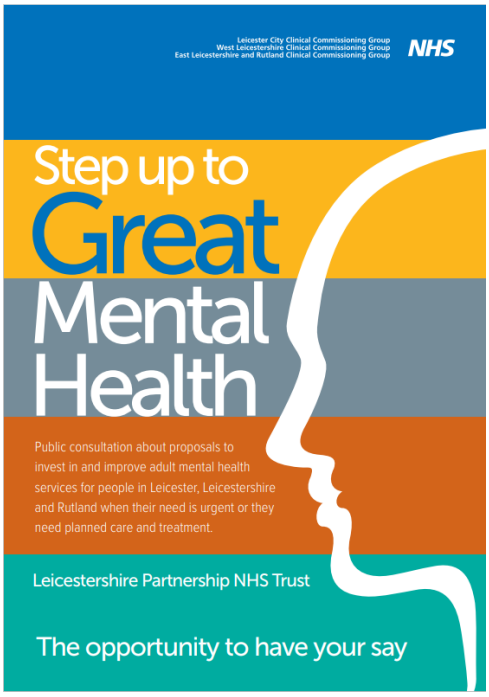
Café clients attend for a wide variety of reasons (loneliness, anxiety, depression, isolation, IT help, warmth) and staff provide support, advice, signposting and referrals.
Client testimonials suggest that the service is appreciated.

Applying the learning

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

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

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



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

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

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

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

Summary of key interventions

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

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

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

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

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

3.8 Children and Young People

Local context

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

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

The impact of Covid19 and the continuing pressure on services has resulted in delays in access to treatment, increasing the number of children and young people on waiting lists. Therapies, Mental health, Neurodevelopmental pathway and community paediatrics have seen a 30% increase in referrals. There is clear evidence that the full spectrum of more intensive services for children and young people across LLR are seeing a significant increase in demand, whether in the form of requests for social care, mental health support, community health services or urgent and emergency care. Not only does this represent a significant impact on the LLR population in terms of poor life experience and the potential for ongoing dependence on services, but the increase in demand is also pushing many of these services to the brink in terms of their capacity, while the associated costs are threatening the financial stability of all partners across the health and care system.

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

Our vision for children and young people's services

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

Case Study

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

What was the issue?

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

Intervention

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

Impact

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

Applying the learning

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

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

Our approach

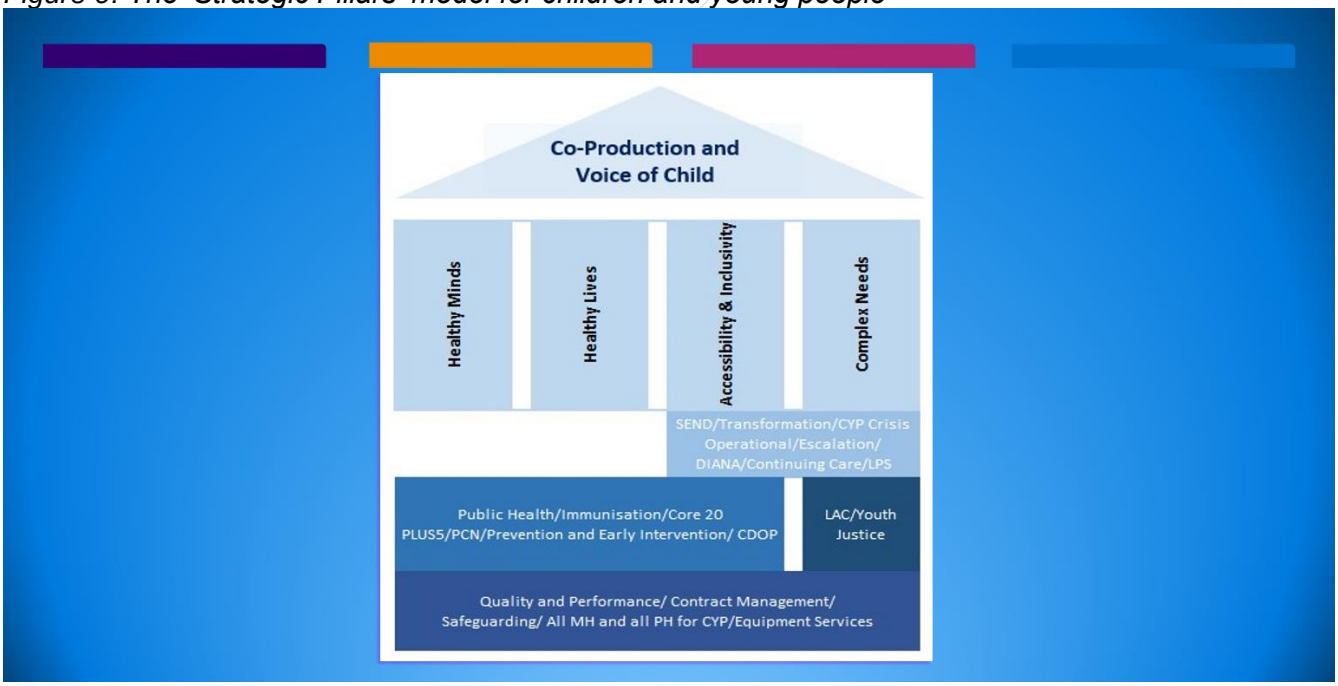
We will reshape the children and young people's portfolio, bringing all components across health and care together into a children and young person's collaborative partnership. This `collaborative` will have the voice of children and young people at its centre and will bring clinical and senior colleagues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

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

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

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

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



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

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

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

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

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

Summary of key interventions

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

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

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

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

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

3.9 Women's Health, including Maternity

Local context

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

Women's health through a life course approach

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

Our vison for women's services

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

Our vision for maternity services

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

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

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

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

Summary of key interventions

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

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

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

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

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

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

3.10 Measuring and monitoring success

Managing delivery

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

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

Delivering our Pledges to local people

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

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

Table 13: Measuring success against our Pledges

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

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

Conclusion

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

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

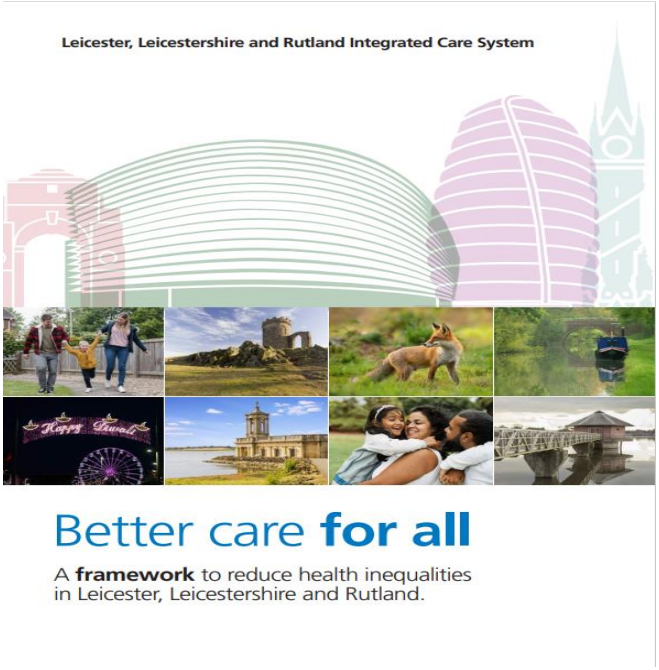
Our success will be measured, not just in the traditional dashboards of inputs and outcomes, but also by looking at people's experiences of the care that they receive. We will have succeeded when people who need access to health and care on the same day receive it; those who need care within a hospital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

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

Chapter 4: Cross cutting themes

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

4.1 Improving health equity



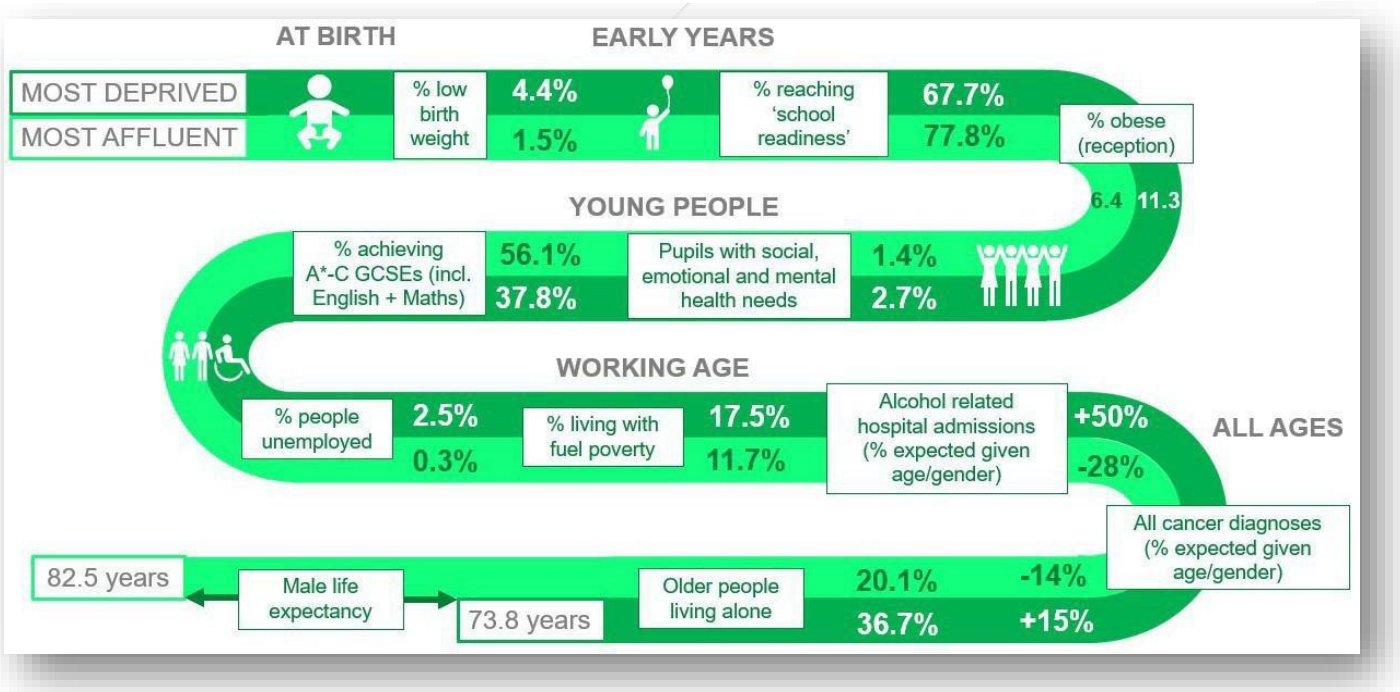
What do we mean by health equity?

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

Why focussing on this is important to us

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

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



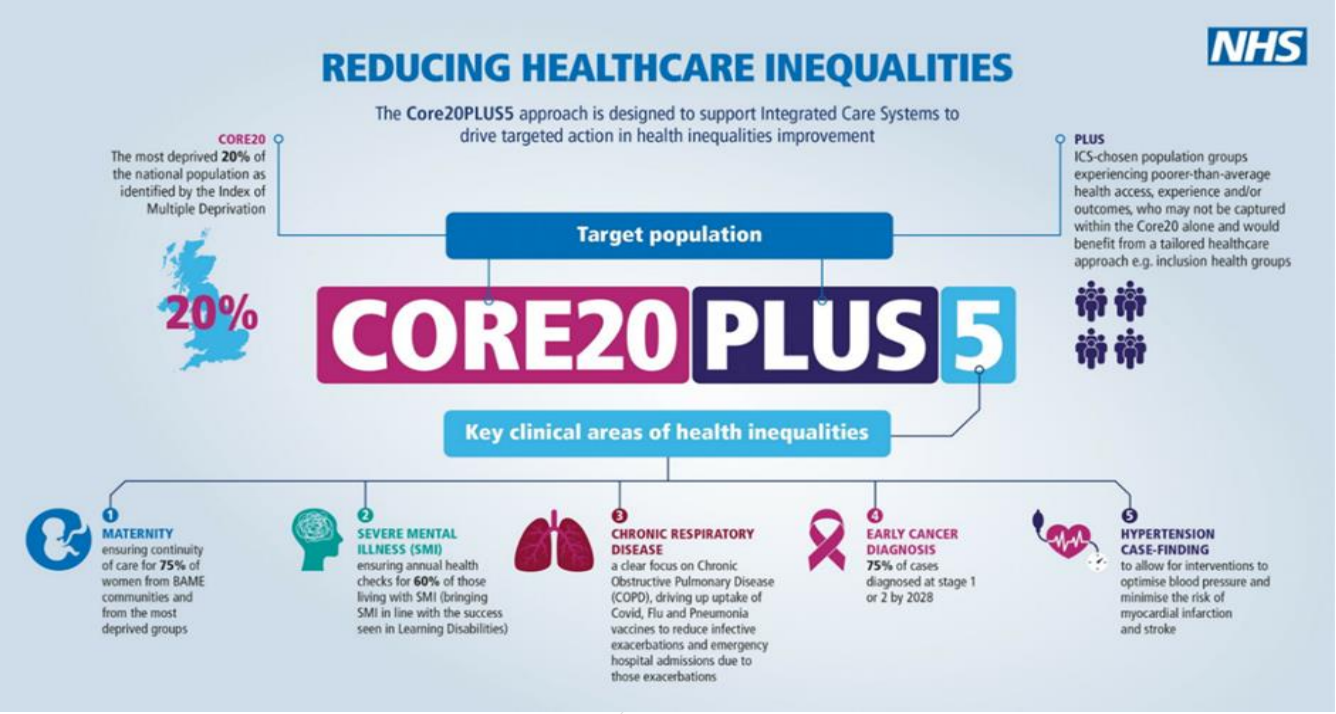
We want local people to be healthier, with everyone having a fair chance to live a long life in good health. Therefore, this Plan aims to 'level up' services and funding.

Our approach – Core20PLUS5

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

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

Figure 11: The Core20Plus5 approach to improving health equity



System-wide interventions to improve health equity

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

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

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

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

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

Case Study

Improving health equity – Covid19 vaccine hesitancy in St Matthews

What was the issue?

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

Intervention

In-reach pop up clinic at a local faith centre

Community engagement:

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

Impact

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

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

Applying the learning

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

4.2 Population Health Management

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

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

PHM includes two key tools – segmentation and stratification:

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

Principles of our Population Health model

The "Manage Need, Not Just Demand" model

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

Our approach

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

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

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

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

Population needs profiling

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

Integrated Care for a targeted cohort

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

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

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

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

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

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

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

Case Study

Population Health management – better end-of-life support

What was the issue?

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

Intervention

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

Impact

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

Applying the learning

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

4.3 Quality Improvement

Core Responsibilities and Functions

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

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

Our Priorities for quality improvement

Patient Safety

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

Infection Prevention and Control

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

Serious Violence Duty

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

Safeguarding

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

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

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

Special Educational Needs and Disability (SEND)

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

As an ICB we will:

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

Our NHS health organisations will:

- Supporting identification and support for children and young people requiring SEND provision and promote Individual Health Care Plans (IHCPs)
- Responding to requests for advice for EHC plans within the required time frame
- Working with local authorities to contribute to the local offer of SEND services available
- Working closely with: Parent Carer Forums supporting groups that represent young people with SEND; Health Watch; the voluntary sector; and community groups.
- The ICB SEND Designated Clinical Officer (DCO) is a dedicated role that supports Leicester, Leicestershire & Rutland and LLR ICB in implementing and embedding-statutory responsibilities for children and young people with SEND. The DCO supports health colleagues across the ICB and our health providers to ensure children and young people 0-25 with SEND have the right health support to achieve the best outcomes they possibly can. The DCO also works with the local authorities in making decisions at all key stages for EHC plan and agrees the health services within an EHC plan.

Medicine Optimisation and Safety

We will enable transformation and support the pharmacy workforce to:

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

- Reduce patient harm from medicines.

Maternity

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

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

Strategic Commissioning

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

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

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

Direct Commissioning Delegation

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

Quality assurance: measuring and monitoring quality

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

Figure 12: The three core elements of quality

1. Effectiveness

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

2. Patient and Public Experience

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

3. Safety

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

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

Quality and Safety Committee

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

System Quality Group

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

Clinical Executive Group

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

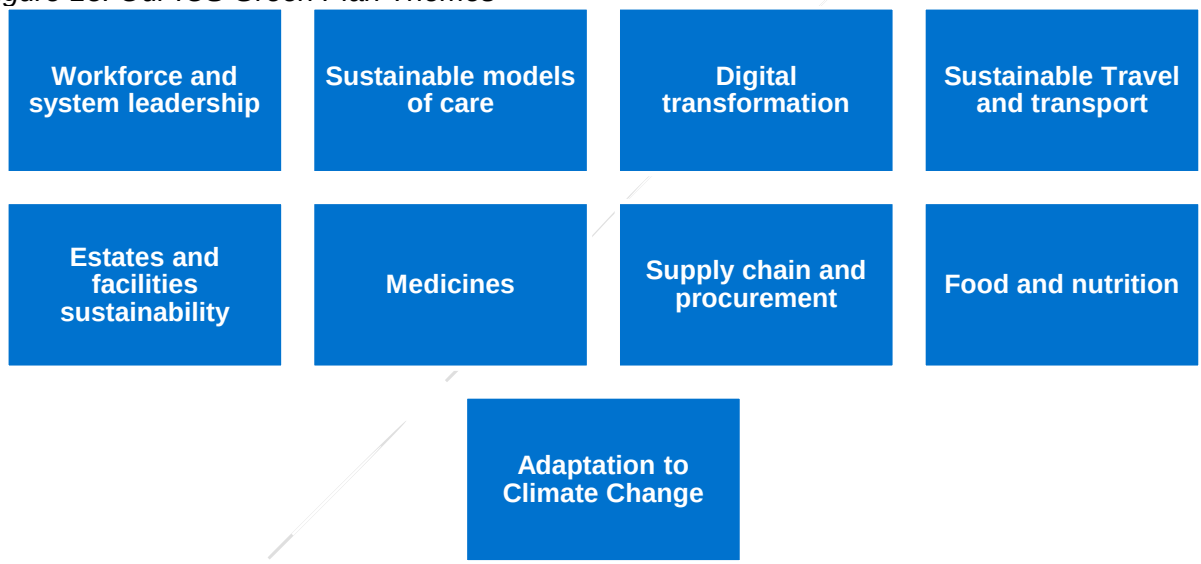
4.4 Delivering a Net Zero NHS

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

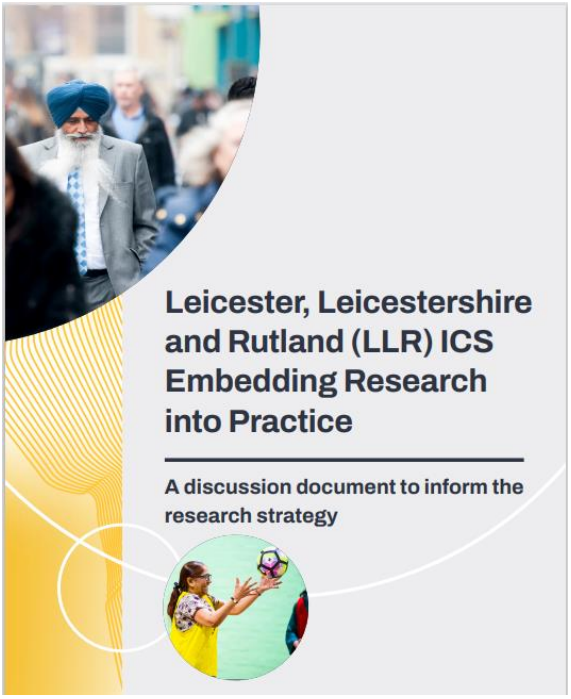
- Plans to deliver against the targets and actions in the Delivering a Net Zero NHS report.
- Supports the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions
- Plans to prioritise interventions which simultaneously improve patient care and community wellbeing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

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

Figure 13: Our ICS Green Plan Themes



4.5 Research and innovation



Our vision

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

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

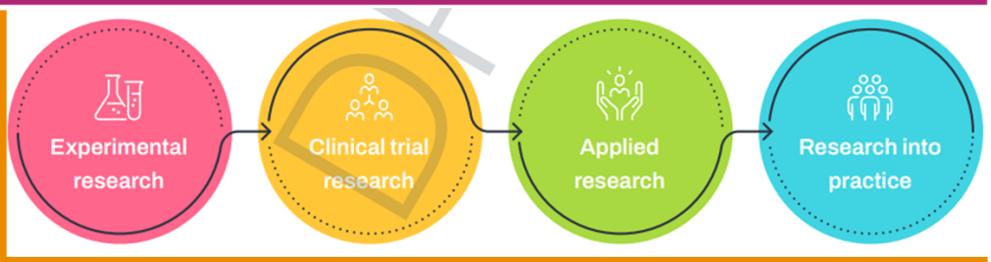
Principles underpinning our ICB research approach:

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

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

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

Research into practice in LLR



Developing new treatments for cancer – Immunotherapy for mesothelioma

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

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

4.6 Supporting broader social and economic development (anchor institutions)

What are anchor institutions?

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

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

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

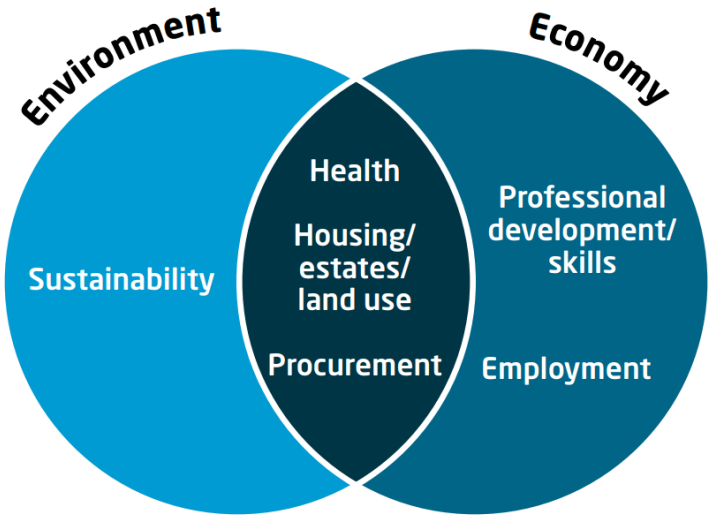
Figure 14: The Wider Determinants of Health, The Dahlgren-Whitehead rainbow model

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

Our current actions and plans for this area inlcude:

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

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



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

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

Chapter 5: Enabling delivery of this Plan

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

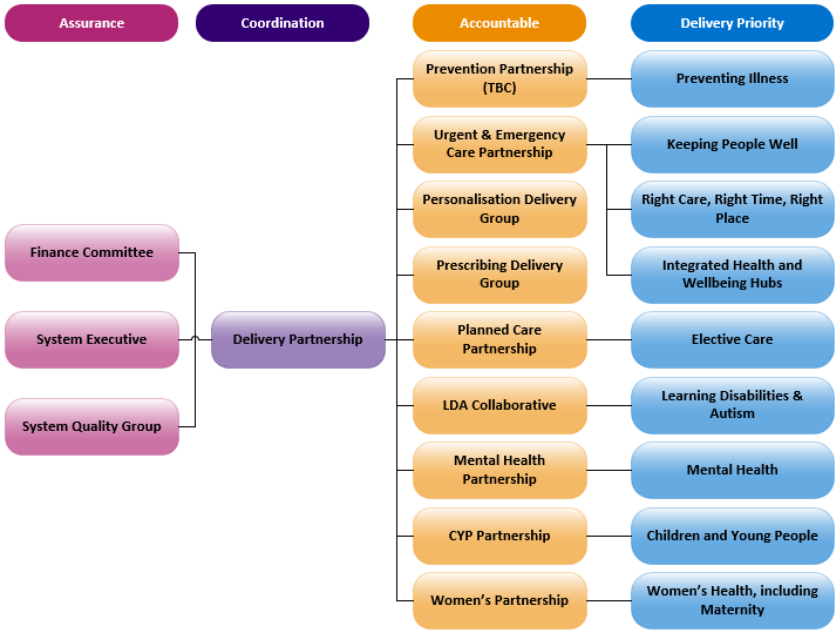
5.1 Our approach to transformation

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

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

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

Figure 16: Our Partnership structure:



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

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

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

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

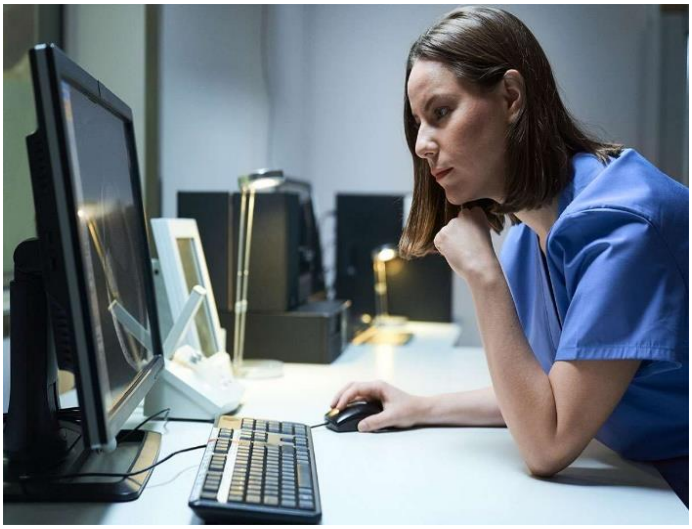
Each transformation programme uses a quality improvement methodology and seeks to implement an inquiry led approach, rather than an advocacy led approach, ensuring that decision-making process is of high quality, and is underpinned by sound and rational analysis of both need and impact.

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

5.2 Digital and data

Our digital vision

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



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

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

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

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

System-wide digital and data interventions

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

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

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

5.3 Our estate

What is the 'estate'

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

An overview

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

Our Estates Strategy

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

Planning for growth

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

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

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

Changing working practices

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

One Public Estate

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

Effective utilisation of our estate

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

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

UHL reconfiguration programme

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

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

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

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

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

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

Primary Care Estate Strategy

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

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

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

System-wide estate interventions

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

Table 16: Our key system-wide estate interventions

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

Chapter 6: Our Finances

Local context

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

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

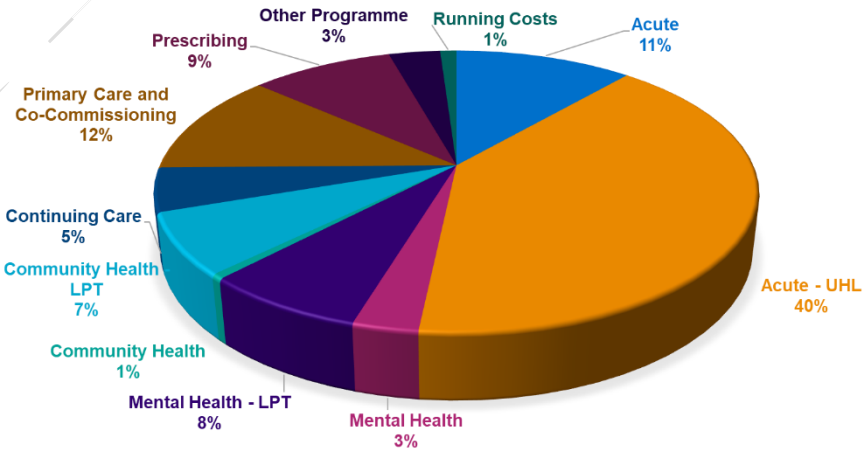
As a system, we are working well, collectively, and there is transparency and openness in the management of the financial position. We fully intend to retain these strong relationships and build further on them.

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

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

How we currently spend our resources

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



Achieving our financial goal

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

We will do this by:

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

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

Financial Principles

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

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

Our financial challenge

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

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

Table 17, Modelling our system financial challenge

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

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

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

Our proposed financial strategy – 5 year summary

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

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

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

Table 18: 5 year financial strategy summary

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

Our proposed financial strategy – Year-by-year

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

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

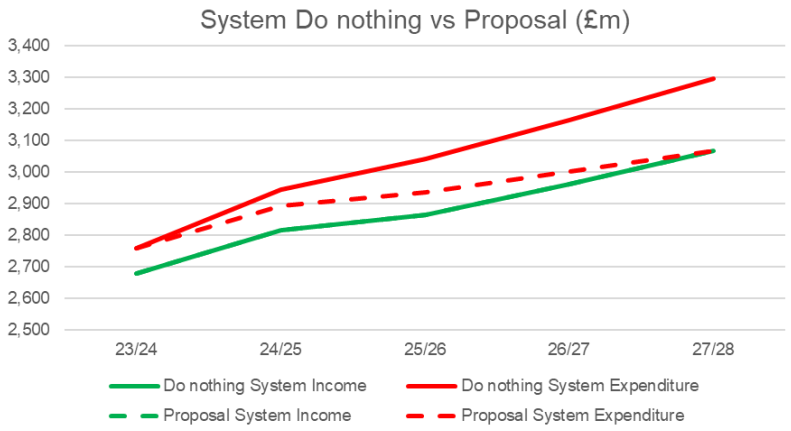
	24/25	25/26	26/27	27/28
Recurrent cost pressures	(10,000)	(10,000)	(10,000)	(10,000)
Recurrent Investment	(14,700)	(14,700)	(14,700)	(14,700)
3% Efficiency	75,603	77,008	79,127	80,581
Financial position	(77,226)	(71,947)	(40,575)	10

The following assumptions have been made:

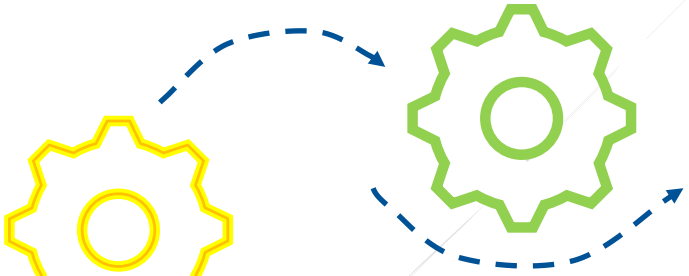
- Inevitable cost pressures to mitigate clinical risks have been provided for, recurrently, at £10m a year;
- Transformational investments have been funded, recurrently, at £14.7m a year; it is assumed the focus of these investments will be in line with strategic intentions of the five-year plan; and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

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

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



Method of delivery - Partnerships



System Support for the Strategy

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

Organisations lead on creating viable financial models

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

Partnerships lead on system action to recycle the money

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

Chapter 7: Our People

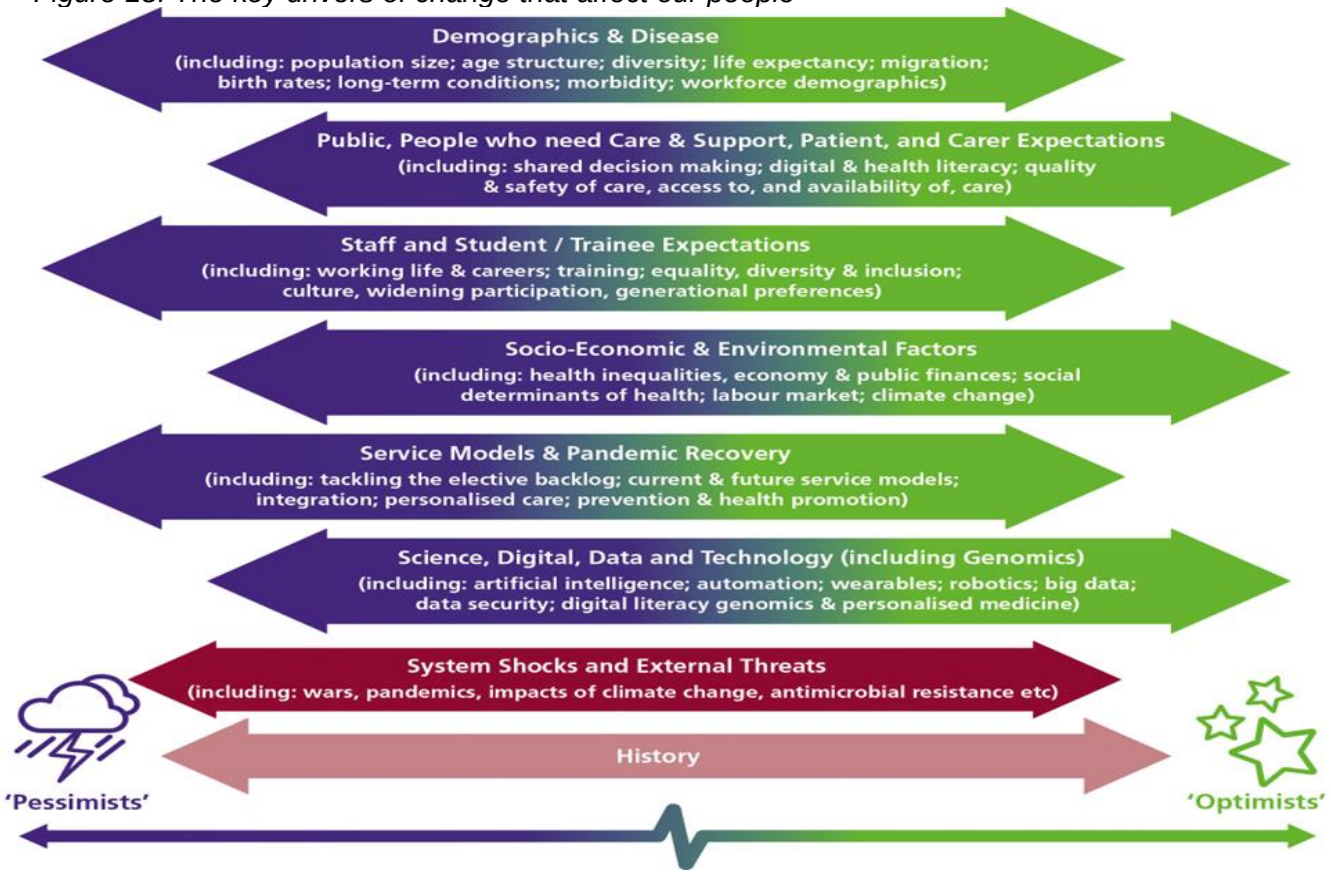
Local context

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

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

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

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



Our People vision

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

This is supported by our people vision:

Shaping our people & services around the needs of our population

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

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

Our people vision is underpinned by the following principles:

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

Our approach

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

Case Study

Our people – *Developing diverse leaders*

What was the issue?

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

Intervention

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

A holistic programme that includes:

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

Impact

The programme is ongoing, however, reported impacts include:

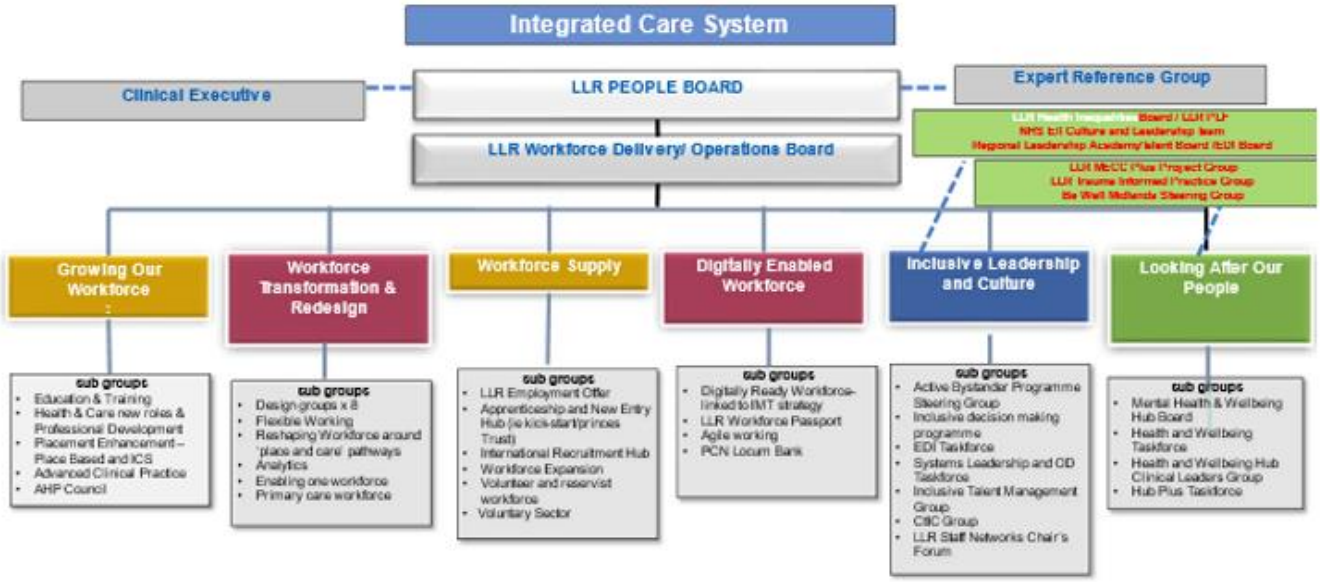
- Relationships and trust has developed within the groups, consolidating into ongoing peer-to-peer support
- Participants have reported key 'moments of impact' and increased confidence levels
- opportunities for reflective practice have been welcomed, and many participants are already sharing their new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

Applying the learning

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

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

Figure 19: Our people intervention programmes



Organisational, leadership and people development

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

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

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

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

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

Chapter 8: Governance

Overview of governance

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

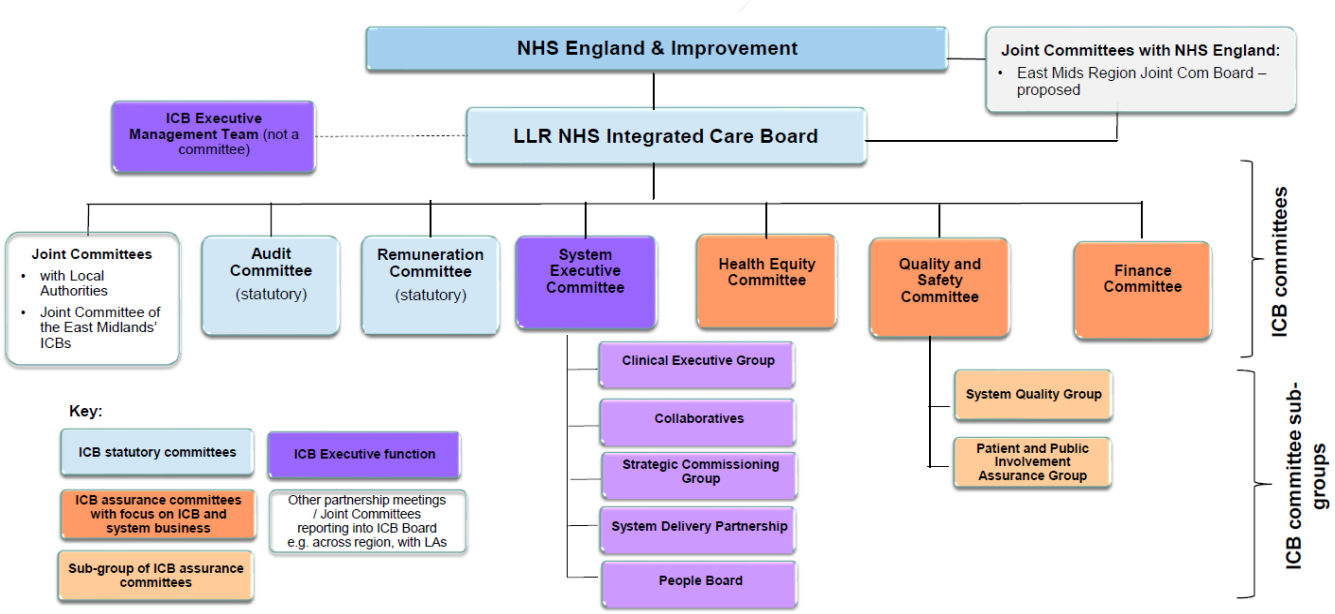
Our delivery framework

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

Our approach to risk management

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

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



Glossary of terms used

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

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

Appendix B

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

LLR ICB Vision and Plan for Local Healthcare in Lutterworth

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

1. Primary Care Transformation
2. Community Health and Social Care Integration
3. Planned Care in the Community
4. Mental Health
5. Access to Pathways
6. Maternity and Children’s
7. Enablers to Fit for the Future Local Healthcare

Primary Care Delivery (2022-2023)

- ❑PCN expansion through Additional staff roles (Pharmacists, pharmacy technicians, nurse associates, care co-ordinators, mental health practitioners and first contact physio) with further expansion in 23/24
- ❑Improved and quicker access to diagnostics (FENO testing, Spirometry, Ambulatory BP and ECG)
- ❑Ensure primary care is responsive using additional PC professionals and non f2f appointment methods
- ❑Improved access to MH services and strengthen prevention and resilience to support growing population
- ❑Partnership working (PCN/Local Partners)

Primary Care Estates (2022-2024)

- ❑Develop sustainable estate solutions to support the growth in population
- ❑Develop the Primary Care Network estate strategy to identify options for space utilisation and maximise estate
- ❑Develop a solution to the accommodate the expansion of primary care Additional Roles members of staff
- ❑Develop plans to utilise the S106 monies from developers (£1.765m) which will be released in 2026

Our Aim:
1. Transform local Primary Care

- Pro Active Health Inequalities Focus
- Technology and data Enabled
- New roles and ways of working
- More operational space to deliver care

Home First Approach (2022-2023)

- ❑Mobilisation of Falls Crisis Response Service
- ❑Implement Ageing Well Urgent Crisis Response 7-day therapy
- ❑ Raise local awareness to Integrated Community Specialist Services
- ❑Expand virtual ward model with at least 408 beds across LLR by December 2023 (including palliative care beds starting in Dec 2022).
- ❑Care co-ordination with joined up working across health (HomeFirst) and ASC (Homecare Assessment Reablement Team)

Integrated Neighbourhood Working (2022-2023)

- ❑Embed anticipatory care to jointly manage frail, complex and high-risk patients
- ❑Develop an Integrated neighbourhood leadership team
- ❑ Increase Frailty identification and assessment with RISE team
- ❑All vulnerable patients have quality care plans

Care in the Community (2022-2023)

- ❑Review and develop rehabilitation models
- ❑Digital Technology in local Care Homes
- ❑Revision of Carers Strategy to ensure carers of all ages are identified early and supported – consultation underway
- ❑Work to support a sustainable increase in referrals to the Community Pharmacy Consultation Service
- ❑Increase the local Voluntary and Community Sector offer in Lutterworth
- ❑ASC proposals include an Extra Care scheme (70 beds) and Supported Living Scheme (10 beds) to support the Lutterworth SDA
- ❑Improvements to delivery of Physical Activity support – alignment of a Community Health and Wellbeing Officer and Community Facilities Officer to Lutterworth
- ❑Young persons Health and Wellbeing Strategies refresh – planning until 2025

Our Aim:
2. Integrate Community Health and Social Care

- Technology and data enabled
- Voluntary and Community Sector
- Enhanced Care in Care Homes
- Integrated Neighbourhood Leadership
- Anticipatory Care
- High Risk Focus

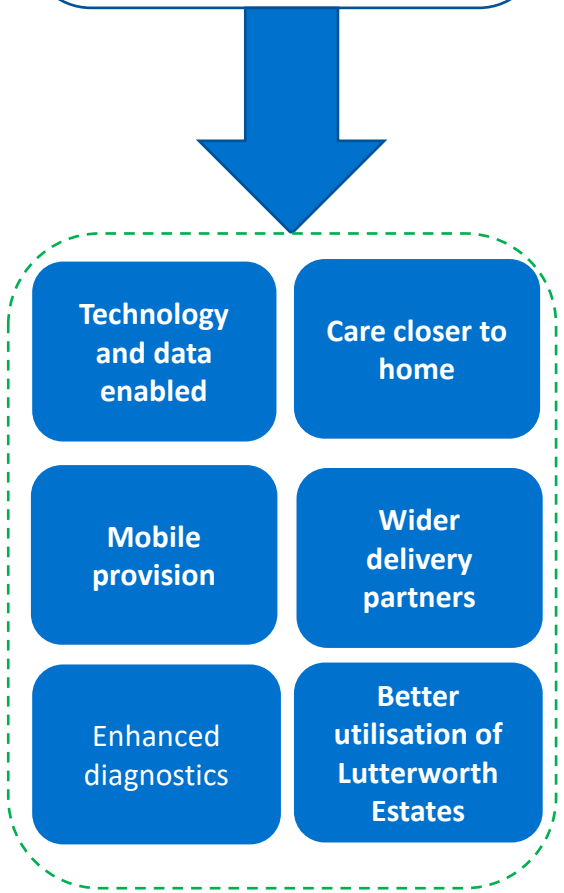
Expand Diagnostics (2022-2023)

- ❑We are working with the GP practices to develop additional diagnostics for Cardiac and Respiratory investigations.
- ❑Explore opportunity to bring more diagnostics closer to home, including (but not limited to):
  - ENT diagnostics
  - Endoscopic urology diagnostics
  - Audiology diagnostics
  - Phlebotomy
  - Ultrasound
- ❑Develop a case for moving appropriate high demand activity into the most clinically appropriate place for the patient.
- ❑Work jointly with our neighbouring ICSs to agree a digital solution to diagnostic pathways not within LLR.

Expand Outpatients (2022-2024)

- ❑Develop a plan for assessment clinics in Lutterworth for patients to enable them to be seen closer to home.
- ❑We will review clinic activity across key including dermatology, ophthalmology, gynaecology and audiology to assess viability for more services delivered in Lutterworth
- ❑Work with High Street Optometrists to consider local Outpatient provision in Lutterworth.
- ❑Review the intravitreal therapy to improve or stabilise vision in Lutterworth to support age related Macular Degeneration

Aim:
3. Planned Care closer to the local community



Primary Care Pathways (2022-2024)

- ❑New Enhanced Access service resulting in more appointments available until 8pm on weekdays and 9am-5pm on Saturdays.
- ❑Improved and quicker access to diagnostics
- ❑Continue to use the proactive Population Health Management approach focussing on support for patients with dementia and reducing A&E attendances, and provision of complex and Long Term Condition Care
- ❑Focus on digital approach to PC provision including appointment and prescription management, access to medical records and test results and vaccination records.

Mental Health Pathways (2022-2023)

- ❑Deliver a local mental health pathway for people living in Lutterworth to reduce long waits for specialist support.
- ❑Identified as one of only 4 innovator sites in LLR, we will pilot in Lutterworth the 3 conversation approach to mental health aiming to eradicate organisational boundaries and reduce hand offs across the system

Urgent Care Pathways (2022-2023)

- ❑Develop an enhanced access model that supports access to same day appointments
- ❑Review Minor Injury Service provision and Urgent Treatment Centre provision to support reduced need for ED access
- ❑Identify the highest utilised ED's out of county including reasons and reviewing those pathways
- ❑Increase the utilisation of the Community Pharmacy Referral Scheme
- ❑Expand the number of Clinical Pharmacists working locally who can treat Minor Illness

End of Life Pathways (2022-2024)

- ❑Strengthen the community palliative and end of life care offer
- ❑Support more people to die in their place of choice through RESPECT planning
- ❑Improve access to end-of-life care provision through developing 24/7 advice line for patients, carers, and professionals
- ❑Enhancing the end-of-life discharge pathway through testing an integrated EOL social care bridging and co-ordination offer
- ❑Quality and co-production review of patient and carer experiences at end of life. Support training and support
- ❑Refresh the LLR all age end of life strategy

Our Aim:

4. Mental Health

5. Improve access to local pathways

- Technology and data enabled
- Enhance and strengthen models of access
- Multi agency Care Planning
- Same day provision
- Increase utilisation of Pathways
- Minor illness provision

Children's and Young People Transformation (2022/23)

- ❑Young persons Health and Wellbeing Strategies refresh – planning until 2025
- ❑Asthma Hub rollout across LLR
- ❑Improve provision of weight management services (Tier 2 low-level provision and Tier 3)
- ❑Develop a CYP integrated workforce across the system to deliver improved outcomes for SEND/LD patients

Maternity Transformation (2022/23)

- ❑Midwifery continuity of carer (MCofC) rollout – 75% of BAME /deprived groups by March 2024
- ❑Working across Maternity Primary Care to improve the uptake of covid and flu vaccination rates, especially those at most risk
- ❑Develop maternal digital strategy
- ❑Strengthen the perinatal mental health service and increase referral rates

Our Aim:
6. Children's and Maternity

- Technology and Data enabled
- Integrated working
- Increase utilisation of pathways
- High risk focus

Strategic Estates Solutions (2022 – 2024)

- ❑Undertake strategic site feasibility review of local Health Estates including Feilding Palmer Hospital to quantify potentially available free space and compare with criteria to deliver future healthcare services
- ❑Identify venues for colocation of services e.g., MH Staff, primary care additional roles. This could include our Local Authority partner sites.

Digital Innovation (2022-2024)

- ❑Work towards enabling the discharge teams to share key information relating to an individual's care between all health care settings and Leicestershire County Council staff
- ❑Develop SystmOne Community Module in support of new ways of Integrated working
- ❑Implement remote monitoring and patient questionnaires for appropriate Cardiovascular conditions using text facilities or an app

Cross Border Working (2022-2023)

- ❑Work with neighbouring Integrated Care Systems (ICSs) to share information consistently across local infrastructure plans to maximise potential for CIL/S106 contributions
- ❑Undertake an Out of Area contract review of LLR CCG commissioned services to inform future plans
- ❑Work with out of county providers and commissioners to discuss neighbouring area plans for Minor Injury Services, Community Diagnostics, Primary Care New Models, Hospital Outpatient Transformation
- ❑Embed Early Intervention Service referrals for Children between health and care to appropriate in and out of area local authorities

Our Aim:

7. Develop a fit for the future local healthcare offer

- Long term infrastructure planning
- Improve partnership working in and out of area
- Technology and data enabled teams and patients
- Model and understand population health impacts

What will this mean for Feilding Palmer Hospital?

Service Provision in Feilding Palmer Hospital

OUTPATIENTS	DIAGNOSTICS	SERVICES
Cardiology services	Adult Audiology	Cardiology
Audiology services inc ear syringing	Children's Audiology	General Surgery
Dermatology services	ENT	Gynaecology
UV light therapy	Endoscopic urology diagnostics	Dermatology
Gynaecology services inc colposcopy	Echocardiogram	Ophthalmology
Ophthalmology Intravitreal therapy	Phlebotomy	Audiology
Urology	Dermatology	Physiotherapy
Assessment clinics		Out of hours access
	Vascular doppler	Covid vaccination clinic
	A range of diagnostics delivered in GP practices to include: • 24/48 hr Tapes and Blood Pressure • ECGs • FeNO Testing • Phlebotomy • Ultrasound	

Feilding Palmer Inpatient Beds

❑Feilding Palmer inpatient beds remain closed following Covid-19, due to constraints complying with Infection, Prevention and Control (IPC) guidelines.
❑Due to capacity of beds, the staffing model is closer to that of an ITU than a general medicine ward (due to lone working needing 2 qualified nurses).
❑Backlog maintenance costs are significant (>£3m) before any improvements are made
❑Local GPs fully supportive of expanding community services for the local population

Expansion of Community Services

❑Expansion of community services would benefit more patients by increasing outpatient provision, diagnostics, and out of hours provision as a hub for care for people in Lutterworth.
❑The number of patients who benefit from expansion of community services would be significantly higher than if the beds were reopened
❑Increasing community services would

1) Offer care closer to home
2) Reduce unnecessary car journeys to UHL and UHCW
3) Improve links between Primary and Secondary care
4) Increase availability for patients from other areas, therefore increasing utilisation.

❑The frequency of clinics could be increased as the population of Lutterworth East SUE increases

Our Vision and Plan for Local Healthcare at Feilding Palmer Hospital

1. Expand Outpatients
2. Expand Diagnostics
3. Access to Pathways
4. Strategic Enablers

1. Expand Diagnostics Services (2022-2023)

❑Explore opportunity to bring more diagnostics closer to home, including ENT diagnostics, Endoscopic urology diagnostics, Audiology diagnostics, Phlebotomy and Ultrasound.

❑Work jointly with our neighbouring ICSs to agree a digital solution to diagnostic pathways not within LLR

2. Expand Outpatients Services (2022-2024)

❑Develop a plan for assessment clinics in Lutterworth for patients to enable them to be seen closer to home.

❑We will review clinic activity across key including dermatology, ophthalmology, gynaecology and audiology to assess viability for more services delivered in Lutterworth

❑Review the intravitreal therapy to improve or stabilise vision in Lutterworth to support age related Macular Degeneration

3. Access to Pathways (2022-2023)

- ❑ Develop Local Enhanced Access service encompassing same day access for Primary Care, Urgent Care, including (Minor Injuries), and Frailty Care
- ❑ Minor Injury Service provision and Urgent Treatment Centre provision to ensure it meets the needs of the local population and reduces the need for presentation at ED
- ❑ Deliver a local mental health pathway for people living in Lutterworth to reduce long waits for specialist support.
- ❑ Strengthen the local community palliative and end of life care offer

4. Strategic Enablers (2022-2023)

❑Undertake strategic site feasibility review of local Health Estates including Feilding Palmer Hospital to quantify potentially available free space and compare with criteria to deliver future healthcare services

❑Identify venues for colocation of services e.g., MH Staff, primary care additional roles.

❑Work with out of county providers and commissioners to discuss neighbouring area plans

UHL Reconfiguration / LPT Estates Strategy / NHS Operational Planning / Technology Enablement / Lutterworth Local Housing Growth

Our Aim: The Right Care Closer to Lutterworth Residents

- Urgent Care
- Minor Injuries
- Outpatient Clinics
- Access to Pathways
- Community Health Services
- Enhanced Diagnostic Capability

Short Term Actions

Conversations are underway to agree how the space within the Feilding Palmer can be utilised in the short term whilst the longer solution is developed. Discussions are underway with:

❑Lutterworth GPs and the PCN – to explore the opportunity to utilise the space for the ARRS (or other) roles within primary care. A visit is being arrange for the GPs to view the space which could be utilised by primary care

❑LLR Alliance – to assess the opportunity to utilise the space for additional Alliance outpatient activity

❑UHL – in conjunction with the discussions with the Alliance to assess the opportunity for additional outpatient activity

❑LPT – to explore whether we are maximising the use of the facilities for community activity

❑Analyse the outcome of the feasibility study and develop proposals for future estate solution

Longer Term Actions

❑Engagement with the people of Lutterworth on the proposed model of care and estate solution

❑Agree delivery plan and responsibilities

❑Develop a Business case

Appendix C

Becoming the best

NHS
University Hospitals of Leicester
NHS Trust

Our 3 Year Quality Strategy and Priorities

2019-2022

This document is designed to give everyone who works in our Trust, our partners and the public, a clear sense of where the Trust is heading, what we consider to be important, how we're going to get there and how long it might take.

Introduction

We work in interesting and challenging times for perhaps the only national organisation anywhere on the planet that can justifiably say it is involved in the lives of every citizen in the country.
Every day we are party to joy and despair, often in equal measure; we bring babies into the world, fix broken bodies, relieve suffering, cure illness and at life's end we try to give people a good death.

On the whole the public recognise this, despite what they see in the media, our staff perform major and minor miracles on a daily basis almost unnoticed; though of course when we get things wrong, it makes the news.

All of which means that anybody working in the NHS, and at Leicester's Hospitals, should be proud of their contribution to the health and wellbeing of the people we serve, regardless of the jobs they do. Sure, doctors, nurses and other health professionals are at the centre of care, but let's not forget that the cleaner who pays particular attention to their ward is playing their role in infection prevention; the clinic clerk who makes sure their clinic operates like clockwork is helping to manage waiting lists, and the porter who wheels a patient to theatre and chats on the way is soothing a troubled mind.

So, for every lifesaving procedure which takes place in theatre there is a cast of hundreds of people who contribute in some way and we should therefore recognise that when 'the team' is at their best, they are unbeatable.

Caring at its best

This document is designed to give everyone who works in our organisation, our partners and the public, a clear sense of where we are heading, what we consider to be important, how we are going to get there and how long it might take.

What you will read in this booklet builds on the earlier 'Delivering Caring at its Best' (our 5 year plan), and therefore is a development of our thinking rather than a change in direction; that is a very important point because we have known through the work we have done over many years what our objective is: to create a clinically and financially sustainable Trust with the right clinical services on the right sites in support of our ultimate goal - to deliver "Caring at its Best" for every patient, every time. That has proved easier to say than do! We know that to reconfigure the hospitals will require money, around £400m in fact, and though we are quietly confident that our case for investment is well positioned nationally we are some way off approval.

But whilst reconfiguration to finally address the flaws in our historic distribution of services is crucial it is by no means our only strategic imperative.

Contradiction and contrast

Our Trust has many strengths; some of our clinical services are genuinely class leading in terms of their clinical outcomes, many of our specialist services are underpinned by strong research portfolios and perhaps most of all we recognise, as do others, (the CQC for example) that our teams are overwhelmingly caring and compassionate.

And yet, despite these inherent strengths we have struggled to achieve and particularly maintain consistently high standards of quality and performance. Which is why in two successive CQC inspections we have been fairly judged as 'Requires Improvement'.

Some of this arises out of the historic lack of investment in Leicester's Hospitals. So, for example it is interesting to contrast how cutting edge technology and equipment has been designed into our new Emergency Department and at the same time our outpatient clinics are reliant on an army of people pushing around patient notes in trolleys.

In the same vein, the fact that our staff are recognised as being caring and compassionate is creditable but if we don't have enough staff, it makes creating the time to care more difficult.

Whilst it is recognised that some of the issues we want to address require significant investment, or in the case of staffing, simply more new nurses out of training, there are many other improvements we can make that don't necessarily carry a huge price tag.

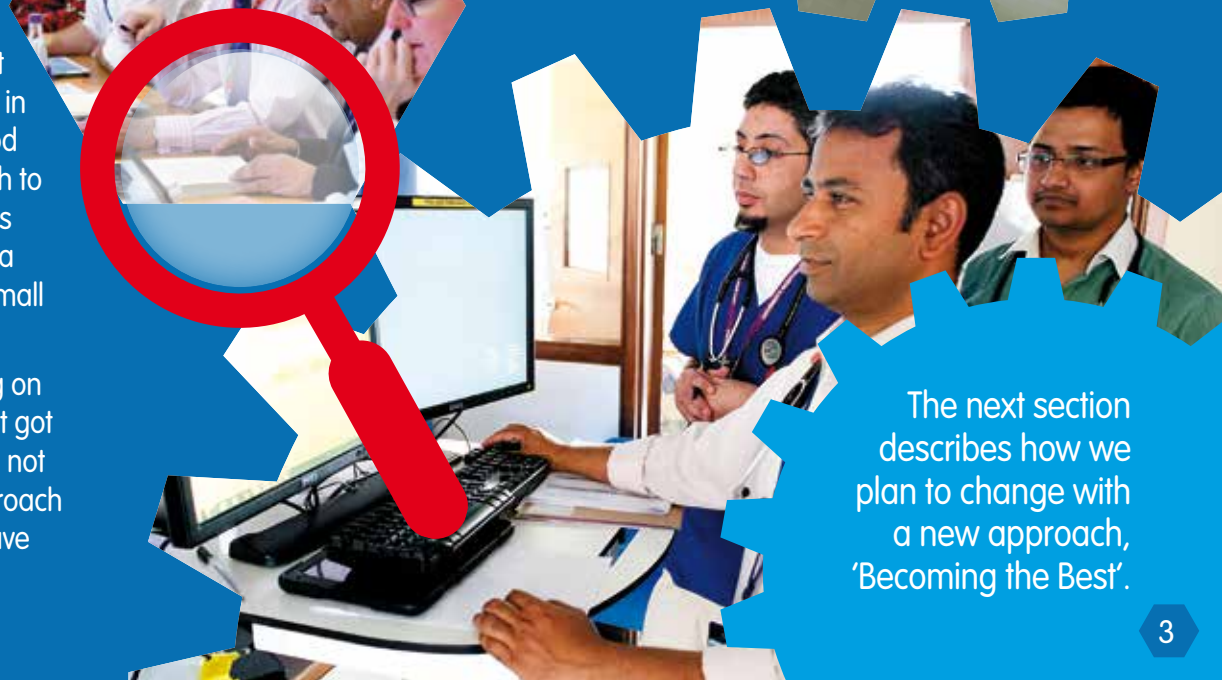
If that is the case, the question is why have we struggled to do it?

Organisation and focus

We have spent a great deal of time lately looking at the characteristics of successful and high quality hospitals; in doing so, some themes emerge, most notably that the best hospitals have two things in common. First, a clearly understood and universally practised approach to Quality Improvement (QI) that starts with the Trust Board. And second, a determined focus on a relatively small number of key quality priorities.

That being the case, and reflecting on our approach to date, we have not got this right, yet. Specifically, we have not had a universally understood approach to quality improvement and we have tried to do too much at once.

Our Trust has many strengths, yet despite this we have struggled to maintain consistently high standards of quality and performance



The next section describes how we plan to change with a new approach, 'Becoming the Best'.

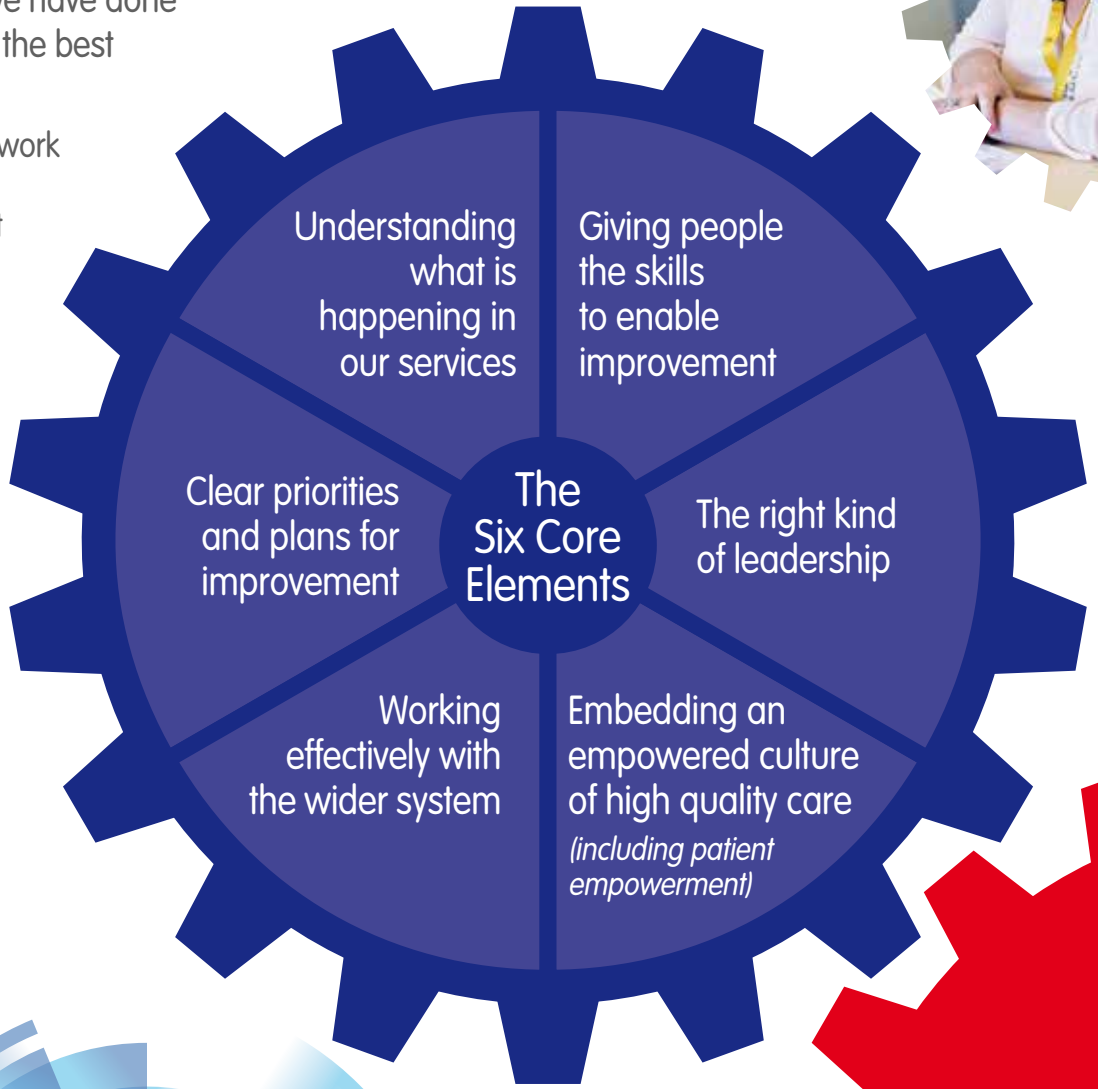
‘Becoming the Best’: Our Quality Strategy

The purpose of our quality strategy is to address the issues we have **just talked about** and thus move us closer to our ultimate goal - delivering “Caring at its Best” for every patient, every time. It is a major shift away from how we have done things in the past and reflects how the best hospitals work.

‘Becoming the Best’ provides a framework for conversations across the Trust. These conversations will be important in harnessing the collective expertise of everyone in our organisation, not least because it is most often the people doing the job who know best about how to improve it.

Becoming the best

There are six core elements which will frame these conversations:



Let’s look at those in a little more detail...

The Six Core Elements

Understanding what is happening in our services

In order to decide what needs to be improved, it is essential to understand what is really happening in our services. Let's be honest, we are not short of data when it comes to measuring performance and processes, but we often confuse data with 'insight'. Data might well tell us that something has happened, but it is insight that leads us to understand why; and whether it is likely to happen again.

Sometimes the opposite is also true and we accept received wisdom as fact when the data shows that the truth is something entirely different... this leads to problems 'hiding in plain sight'.

Thus the cornerstone of our new approach to Quality Improvement (QI) will be to properly investigate and understand the nature of the things we want to change before we set about thinking about how to change them.

Clear priorities and plans for improvement

For the last five years, our priorities for improvements in the quality and safety of our services have been set out in our Quality Commitment, whilst other priority schemes were captured in our 'Annual Priorities'. This year and for the future we have changed that approach in favour of a unified set of priorities all of which are all designed to improve quality and safety, either directly or in a supporting way.

At the same time we have been more realistic about the number of priorities we will pursue and thus we will focus on six quality priorities and six supporting priorities during 2019-2022. (See diagram on page 7).

The right kind of leadership

The CQC report "Quality Improvement in Hospital Trusts" states that "the most important determinant of quality of care is leadership. Leaders must model appropriate improvement-focused leadership behaviours and a visible, hands-on approach." Leadership here includes leaders at all levels, not just those in senior positions.

Embedding an empowered culture of high quality care *(including patient empowerment)*

Successful, sustained improvement requires not only the right skills/methodology, but also the right culture.

Feedback from our last two CQC inspections indicates that our staff have a good understanding of the values and vision of the organisation. But scores for engagement and empowerment remain moderate. Equally we often hear from staff who have tried their best to get an improvement idea off the ground but have felt thwarted at every turn by the 'system' or our own internal structures.

Changing and sustaining a renewed culture takes time, energy and effort but will be central to the success of the Quality Strategy.

Giving people the skills to enable improvement

Improvement or just simple 'change' is difficult, largely because it starts with the idea that whatever currently exists could be bettered, and if you are part of the current set up you may think it is perfectly fine as it is. Improvement in healthcare can also be complex, involving lots of moving parts, so upskilling staff to take part in, or lead, improvement work means we have to equip them with tools that enable them to deal with both operational complexity and the equally complex nature of human relationships.

Working effectively with the wider system

Within our local system there have been, and continue to be, good examples of collaborative, cross-boundary, improvement work. Examples include the frailty and multi-morbid pathway improvement programme, work to reduce the number of stranded patients and improve discharge processes.

Recognising that there is little that we do in hospital that does not have an impact on other players in the system, we will expect all of our QI activity to have considered and included the implications for the system in the work.

Involving patients, the public and stakeholders

In Quality Improvement methodology the central role of patient involvement is explicit and in the construction of our 2019-22 priorities the voices of patients and stakeholders were influential. Our reconfiguration plans have been informed over many years by patient feedback and when we receive permission to formally consult on those plans we will once again test them with our stakeholders.

As we said at the very start, the NHS is unique insomuch as it is involved in the lives of every citizen in the country. It is also unique in another way, though being 'free at the point of need'; it is in fact for many people a service which they have paid for through taxation, years in advance of being frequent users. With that in mind, being asked about, and involved in, the planning of services is both a 'right' and an expectation.

In saying that we also need to be clear that the outcome of involvement, engagement and consultation rarely, if ever, pleases all parties largely because it seeks to navigate a path between what is clinically safe and acceptable, what is most desirable for the many and the few and ultimately what is affordable. Nonetheless, our desired approach has to be that given the significant changes in health and social care that we want to bring about, we should recognise that we stand a greater chance of 'getting it right' if we involve the people who use our services in the planning of those services. This is particularly important when considering the population we serve. It is only by actively engaging with our many and diverse local communities that we can understand their experience of health care and build services that are mindful of their needs and expectations.

Resource for Quality Improvement

There is no shortage of talent in our hospitals but time is often our scarcest commodity. The day job feels all-consuming and can stand in the way of the time required to think and plan for an alternative, better future. It is noticeable and with hindsight, obvious, that some of our most successful improvement work, for example the recognition and treatment of sepsis, has been enabled by committing dedicated resource to the project.

But resource doesn't have to mean 'more', it can also be created by thinking differently about the resources we already have and being absolutely clear about what the priorities are.

So, whilst we absolutely will be putting money into resourcing for Quality Improvement (over £1m in fact), the more important thing to bear in mind is that our greatest resource is the 16,000 people who work for our hospitals and if we can harness their ambition, drive, creativity and passion then we will have created a real force to be reckoned with.

Focus and stamina

We are one of the top five largest Trusts in the country, with 66 different clinical services, three large hospitals, 16,000 staff and an income of nearly £1 billion. In that context deciding where to focus our quality improvement work was no easy task. That said the guiding principle was that we know we have to focus on fewer things and execute them brilliantly.

We also had in mind that if the things we chose as priority areas for improvement were easy to accomplish, we would have done them by now; so in a significant change to previous years we have narrowed our focus down to 12 priorities and set ourselves up to three years to achieve them.

We are one of the top five largest Trusts in the country, with 66 different clinical services, three large hospital sites, 16,000 staff and an income of nearly £1 billion.

Our Priorities 2019-2022

Our priorities for the next three years are depicted in this diagram.

You will see that there are six quality priorities and six supporting priorities.

Sitting below the priorities in the diagram are the Quality Improvement Methodology and our long standing and well regarded Values.

In other words the priorities are the **WHAT** we are going to do; the method is the **HOW**; and the values govern how we behave on the journey called 'Becoming the Best'.

Linking the cogs together is the chain of Patient and Public Involvement which reminds us that our patients and the wider public are the people we are trying to get this right for.

Our quality priorities

"We want to make sure that no matter which ward or clinic you are cared for in that they all have the same standards, processes and approach to caring for our patients. Making sure that all of our wards are delivering safe, high quality, compassionate care is central to this work."

Carolyn Fox
Chief Nurse

We will embed safe and effective care in every ward and clinic by introducing a Trust wide **assessment and accreditation** framework

There are 100 wards across our three hospitals and hundreds of outpatient clinics. One of the things which they have in common is that overwhelmingly the staff are caring and compassionate. However there is also too much clinical variation across wards and outpatient clinics meaning that best practice in terms of quality, safety and patient experience is not as universally applied as it ought to be. The assessment and accreditation scheme will support wards, clinics and their leaders to understand and address issues where they find them and measure the success of their improvements in a standardised way.

"Patient harm in healthcare is one of the top ten causes of death and disability in the world. Reducing harm is everyone's job and has been high on our agenda for the last few years but we still have serious Patient Safety Incidents and Never Events which would have been entirely preventable if individuals and clinical teams had properly followed checking processes designed to keep patients safe. This has got to change - we wouldn't get on a plane if we thought the pilot and crew weren't doing the pre-flight checks properly and it should be no different in healthcare for our patients.

We are determined that through training, support and learning from these mistakes, we will make our hospitals safer for our patients so that Never Events become a thing of the past."

Andrew Furlong
Medical Director

We will consistently implement the **safest practice for invasive procedures,** with a focus on consent, NatSSIPS* and the Five Steps to Safer Surgery; and we will improve our learning when things go wrong

It is often said, but not always fully understood, that hospitals are inherently dangerous places. Medicines, if wrongly administered can be toxic; infections can spread easily without the right degree of personal and environmental hygiene and invasive procedures can put patients in harm's way if safety checks are not followed. It is therefore the duty of all of us who work in hospital to minimise the risks to patients at all times.

It is hard to argue with that, yet we still see too many occasions where something has gone wrong which would have been entirely avoidable if only the right procedures had been followed. In the most serious cases these are called 'Never Events' and are defined as 'a serious incident or error that should not occur if proper safety procedures are followed'. For clarity this is not about missed diagnosis or the failure to spot a deteriorating patient, rather it is a failure to abide by simple, common sense rules that are designed to make it impossible to, for example, carry out a procedure on the wrong patient; leave a swab in a patient post procedure or insert the wrong device into a patient.

**NatSSIPS (National Safety Standards for Invasive Procedures)*

We will implement **safe and timely discharge** for all patients in our care, seven days a week, by embedding safer discharge processes and eliminating avoidable delays

On the whole, nobody would want to stay in hospital a moment longer than is absolutely necessary. For many patients a delay to their discharge is not just frustrating and inconvenient, it is actually detrimental to their health and independence.

We discharge between 150 and 300 patients a day and though most of those patients will have a good experience of the discharge process, a significant minority will not. Medications To Take Out (TTOs) are often not written up early enough, the discharge summaries which explain to GPs what has happened to a patient and what needs to happen next are sometimes of poor quality, and the process can take so long that the patient who was expecting to go home or to a care home has to be put back into one of our beds for another night.

Recognising that discharges are increasingly complex because our patients are increasingly complex, we know that this is as much an issue for the system to resolve as it is the Trust. Nonetheless, we must make sure that our end of the process is better managed, so amongst other improvements we will expect that all patients admitted to hospital will have an Expected Date of Discharge set the day they are admitted.

"20% of pensioners who attended an outpatient appointment reported feeling worse afterwards because of the stress involved in the journey alone."

Royal College of Physicians

"A patient over 80 who spends 10 days in hospital loses 10 per cent of muscle mass – equivalent to 10 years of ageing"

Dr Stephen Powys, NHS England Medical Director

We will provide high quality and timely diagnosis and treatment for patients on **cancer pathways** by redesigning those pathways in conjunction with our partners

In the last few years we have seen unprecedented growth in the numbers of patients referred to us for cancer diagnosis and treatment. At the same time our teams have worked hard to keep up with the demand, but with, for example, a 10 per cent a year increase in referrals for Urology and 18 per cent in skin cancers, we know that just trying to do things in the same way only faster will not work.

Instead, through a combination of investment and innovation we will seek to redesign our key cancer pathways to eliminate delays and unproductive waits for patients and the clinical teams.

Our quality priorities

We will work as a system to create safe, efficient and timely **urgent and emergency care,** with a focus on embedding acute frailty and same day emergency care

Despite having the most modern Emergency Departments in the country, our performance against the 4 hour standard remains poor. The fact that most of the rest of the NHS is now also struggling with the target and that the target itself is being reviewed does not change the fundamental issue that too many patients wait too long before being seen, treated, discharged or admitted.

Clearly it is a complex problem and not all the solutions will be within our direct control, but that does not absolve us of the responsibility to improve, especially those things that are directly under our own control. Hence we will seek to better understand what is driving demand and prioritise changes across the system whilst at the same time ensuring our internal pathways are as safe and as efficient as they can be.

Much of the growth in admitted emergency activity is for frail and multi-morbid patients who spend one to two days in hospital. Many of these patients could be safely and effectively managed using a 'same day emergency care' approach which aims to deliver assessment, diagnosis and treatment on the same day, without an overnight stay. Recognising and streaming these patients to the right service will be a key factor in improving emergency care performance, not to mention clinical outcomes.

We will provide high quality, efficient integrated care by **redesigning pathways** in key clinical services to manage demand, improve use of resources and deliver financial improvement

We provide 66 different clinical services across the Trust, more if we include sub-specialties. In a perfect world we would have the time and resource to devote to improvement activity, pathway redesign and productivity in each service but the world is not perfect and therefore we have to focus our efforts where the opportunity is greatest.

Over the last year, using information from our own performance and quality metrics, supplemented by national peer comparisons from the likes of the 'Getting it Right First Time' (GIRFT), programme, we have begun to focus on a number of services which in the round have the greatest potential for quality, performance and financial improvement.
We call them the 'Vital Few'.

It is important to recognise that in most if not all of our services, activity is increasing whilst our ability to cope with the activity is not keeping pace. As a consequence a key principle of the work on integrating and redesigning care pathways is that we should only bring patients into hospital for work that cannot be done safely and effectively elsewhere. This may seem problematic given that every patient we see brings income to the Trust, but the fact is that as we move ever closer to becoming a genuinely Integrated Care System, we will increasingly need to plan our services in such a way that we continue to serve the best interests of our patients but then elevate what is 'best for the system' over what is 'best for the Trust'.

"We will increasingly need to plan our services in such a way that we continue to serve the best interests of our patients but then elevate what is 'best for the system' over what is 'best for the Trust."

Mark Wightman

Mark Wightman
Director of Strategy and Communications

The system through which we are paid is being changed to make it easier for us to do that.

A major part of the work to integrate and redesign care pathways will centre upon outpatients. We currently see almost 1 million outpatients a year... most of them are follow up appointments. In the NHS as a whole outpatients has been somewhat overlooked so whilst resource, time and innovation have gone into improving emergency care, cancer treatment, stroke and other high profile services, the delivery model for the vast majority of our patient contacts has remained largely the same since the birth of the NHS 71 years ago.

For example, we routinely bring multi-morbid patients into single disease outpatient clinics; we routinely follow up patients face to face rather than in virtual/ telephone/ multimedia enabled clinics; and we rarely use patient initiated follow ups which would give patients some control over the management of their condition.

The NHS Long Term Plan clearly sets out the expectation that there should be a 30 per cent reduction in outpatient appointments over the next five years. That is not about rationing, rather about targeting time and resources effectively to the people who need it most instead of perpetuating a model that has had its day.

"Much of the growth in admitted emergency activity is for frail and multi-morbid patients who spend one to two days in hospital, many could be safely and effectively managed using a Same Day Emergency Care approach which aims to deliver assessment, diagnosis and treatment on the same day, without an overnight stay."

Rachel Marsh

Rachel Marsh
Clinical Director for Emergency and Specialist Medicine

Our supporting priorities

Underpinning the six direct Quality Priorities, are six Supporting Priorities

We will begin implementation of our new **Quality Strategy,** focussing initially on developing the right culture, leadership and skills to encourage and enable improvement

The first part of this document explained in some detail the approach we are taking in the Quality Strategy. Suffice to say that, 'Becoming the Best' is not a flash in the pan initiative that is here today and gone tomorrow, but a concerted, resourced and evidence-based approach to quality improvement that we will follow with rigour and stamina.

We will implement our **People Strategy,** with a focus on attracting and retaining the staff that we need and developing new roles where these will help improve care

It has become a cliché to say that staff are the NHS's greatest asset but it is nonetheless true; without the right staff, with the right skills in the right numbers, the job is harder and sometimes nigh on impossible to do.

Using nursing as the example, we recognise that whilst the job is rewarding, it is hard work physically and intellectually and often demands extraordinary degrees of emotional resilience. We currently employ 99 per cent of the nurses who train locally, but when retirements and leavers are factored in we are really only treading water.

Our People Strategy seeks to address this, not only in nursing, but across all roles. Our aim is to encourage more people from all disciplines to consider our Trust as their employer of choice by promoting our Values, being explicit about career development opportunities and supporting people to be their best. We can achieve this by being creative in thinking about new roles and enabling people to operate at the full extent of their potential and by being as flexible and innovative as possible in recognition that family, children and friends and having the time to take care of oneself should not suffer when work is hard.

Our People Strategy goes beyond legal compliance as we strive to achieve excellence in equality, diversity and inclusion in all that we do.

Our supporting priorities

We will **invest in our current estate** in order to provide safe and effective care including delivering the next stages of our **reconfiguration** and pursuing the business case for our longer term plan

Our overall reconfiguration plan should be well known, (for a reminder see page 14). But whilst we continue to refine our case for the major investment, there is still work to do.

Following the interim intensive care and associated services investment (£30m) that we received in 2018, work is underway. We are moving Level 3 intensive care and associated services from the General to the Royal and Glenfield Hospitals. Construction work for the scheme started in February 2019 with a final completion date of March 2020. Detailed planning work has started across the Trust for the delivery of a series of complex service moves between sites. The service moves are currently expected to take place in early 2021. Arising from this we expect significant benefits will be delivered by streamlining patient pathways and improving our delivery of daycase services.

At the same time the first phase of our plan to create a standalone Children's Hospital, the only one in the East Midlands, will begin this year as we start the enabling work on the Kensington Building so that we can bring the East Midlands Congenital Heart Centre from Glenfield to the Royal in December 2020.

Whilst it is encouraging that we are making continual, incremental improvements to our estate, it should also be recognised that we are in a slightly precarious position whereby the more time that elapses between our current configuration and where we need to be when fully reconfigured, the more the pressures and risks build in some key clinical services and key infrastructure.

For example, we recognise that in neonatology the current split site working between the Royal and the General is causing significant issues with our ability to effectively manage consultant on call rotas, in simple terms we have too few neonatologists, spread too thinly across two sites.

In our Intensive Care Unit at the Royal we know that we are well short of the required capacity to manage expected caseloads and as a consequence we are routinely living hand to mouth in terms of available beds.

More mundane, but still critically important to our ability to function, is the fact that our 'backlog maintenance' list grows larger and more expensive the longer we are caught between current and future state. This means that our estates colleagues are constantly having to create sticking plaster solutions to issues that really require a permanent solution.

We are confident that reconfiguration will happen but in the meantime, we are balancing our very limited capital with increasing levels of clinical and estates risk.

We will support safe and effective care by progressing our **e-Hospital** plans to implement user friendly and integrated solutions that make people's jobs easier to do

For those of us working in the NHS it is interesting and often frustrating to consider the comparative ease with which we are able to use technology to take the hassle out of life outside work (online banking, travel, school reports, shopping etc). Whilst patients using our services are often surprised that their information and records are not readily accessible to all those people who are involved in their treatment and care.

We know that technology, even at its simplest, has the potential to improve the quality and experience of care, to improve safety and to make people's jobs easier to do. We have long held the ambition to have a single Electronic Patient Record accessible to all clinical teams so that clinical decisions can be made with full access to all relevant information; so that lost and duplicate notes are a thing of the past; and to avoid us having to ask patients for their name/ date of birth/ NHS number and address at every contact. As such by 2022 we aim to have all information available about a patient through a robust single patient record.

To support and hasten the integration of health services across the local system we will introduce an easy access system for GP/ partner information. And to improve safety we will automate clinical escalation so that our teams are prompted when results and monitoring show that a patient is at risk of deteriorating.

This will mean that our staff will spend less time looking for information because the information will be readily available in an easy to read manner. We will spend less time writing to patients and more time contacting patients using their preferred method. Patients will spend less time and be less frustrated with our administrative processes because they will be increasingly in charge of their data and bookings.

We will maximise the opportunities for our patients to benefit from **research,** including launching our new 'Academic Health Science Partnership'

We have a good research track record exemplified by our status as a Biomedical Research Centre, but we think we can take that further by working with our partners in the University of Leicester and Leicestershire Partnership NHS Trust.

For research to thrive it has to be seen as core business rather than an adjunct to our clinical services and therefore in part, the research we do must contribute to our ability to care for our patients and wider population in an effective, high quality and sustainable way. As such we are embarking on a new and exciting venture to create an Academic Health Science Partnership which will focus on population health management, genomics, frailty and multi-morbidity and 'big data'. The success of this partnership and the themes we wish to pursue will attract funding and talent to Leicester, which in turn will benefit the local economy and the health and wellbeing of the local population.

"Leicester massively over-punches in terms of both our cutting-edge clinical research and in the quality of training for medical and allied health professionals. This is reflected in the Shanghai Index that ranked us as one of the top centres for clinical medicine in the world – the highest ranked UK centre outside the Oxbridge-London 'golden triangle'.

Our success is built on the strengths of the partnerships between the University of Leicester and the NHS trusts in our city. The creation of the Leicestershire Academic Health Science Partnership is the next step in the evolution of our relationship, as together, we seek to provide the very best possible care for our population."

Prof Philip Baker
Pro-Vice-Chancellor and Dean of Medicine

We will provide more effective and efficient **corporate services** to support our staff and Clinical Management Groups

There is a tendency in the NHS to group staff into two categories; 'frontline' and 'back office' and as such we often hear that the 'frontline' must be protected even at the expense of the back office. That distinction is false. There are very many people working in our hospitals who have little or no patient contact and are therefore invisible to the average patient or member of the public, but if they were not there, the 'frontline' would very soon grind to a halt. Many of these people are embedded in our Clinical Management Teams and do crucial jobs like scheduling the smooth running of our operating theatres; making sure that supplies arrive on time, maintaining waiting lists and booking clinic appointments.

Then there are 'Corporate' services like Human Resources, Finance and Procurement and Estates and Facilities; these corporate functions ensure that staff are paid on time, that new recruits are successfully inducted, that bills are settled, equipment ordered and essential maintenance is carried out, all of which is crucial to maintain the smooth running of our hospitals.

Hazel Wyton
Director of People & Organisational Development

"Our drive to improve the quality and effectiveness of our clinical services has to be matched with an equivalent ambition for our corporate services.

Our plans include faster recruitment processes, better payroll systems and improved finance and business information to support our clinical management teams."

Hazel Wyton

So far we have looked at how we will adopt a universal Quality Improvement approach to our work and where we will focus that effort over the next three years in terms of our priorities. Now here is a reminder of our longer term reconfiguration plans...

A reminder of our reconfiguration plans

To understand what we want to do in the future, it is important to understand how got to where we are now.

Our three city hospitals,

the Royal, Glenfield and General, merged in 2000 to form the University Hospitals of Leicester NHS Trust. Whilst the merger was successful in many ways one fundamental issue remains unresolved to this day, namely that the current clinical configuration is an accident of history rather than design. This means that many of our services are duplicated or triplicated; we spread our staff and equipment too thinly, we have gaps in rotas, patients are bounced between sites for different aspects of their care and it is really expensive to run.

Our first attempt

to sort this out for all of our services hit the buffers in 2007, it was called 'Pathway' but the scheme collapsed when the investment required from government reached £900m.

There was then a 10 year period of minimal investment. This ended in 2017 when we opened the first phase of the new Emergency Floor at the Royal. This was followed in 2018 by the second phase, bringing the total investment to £50m.

We also spent £14m

creating a new base for our Vascular service and a hybrid theatre at Glenfield. And as described earlier, work is underway with plans to move our level 3 intensive care and associated services, and relocate congenital heart surgery, bringing the total investment to date in our hospitals to **over £108m.** Although we have made progress, there is much work still to do.

Our Plans

So far we have described some of the improvements that have either happened or are in progress now. Here are some of the main building blocks of what still needs to be done

Glenfield Hospital

Treatment Centre

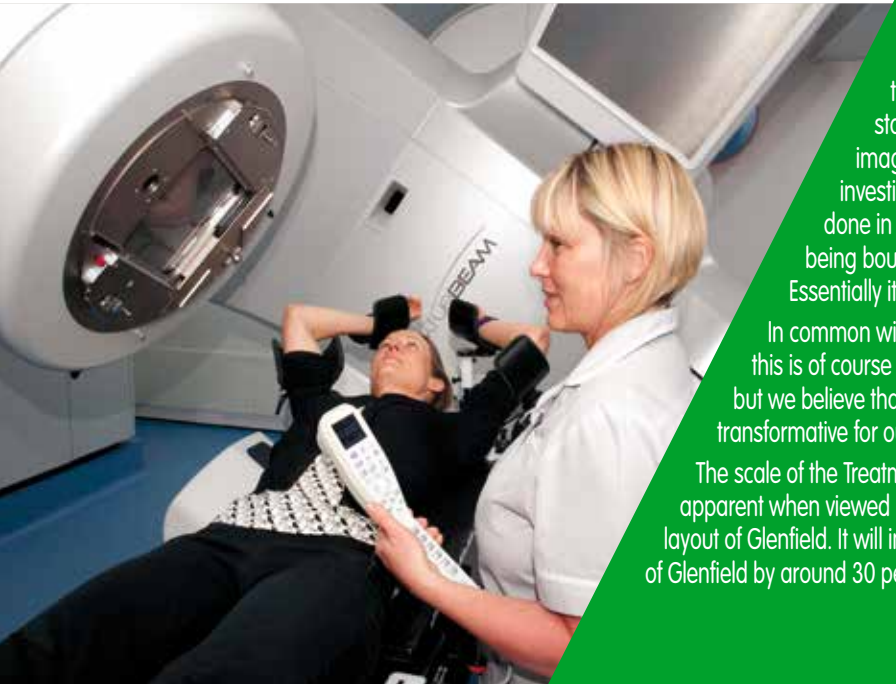
The core of our long held clinical strategy is to separate emergency and planned care so that the one does not overwhelm the other when demand is at its highest.

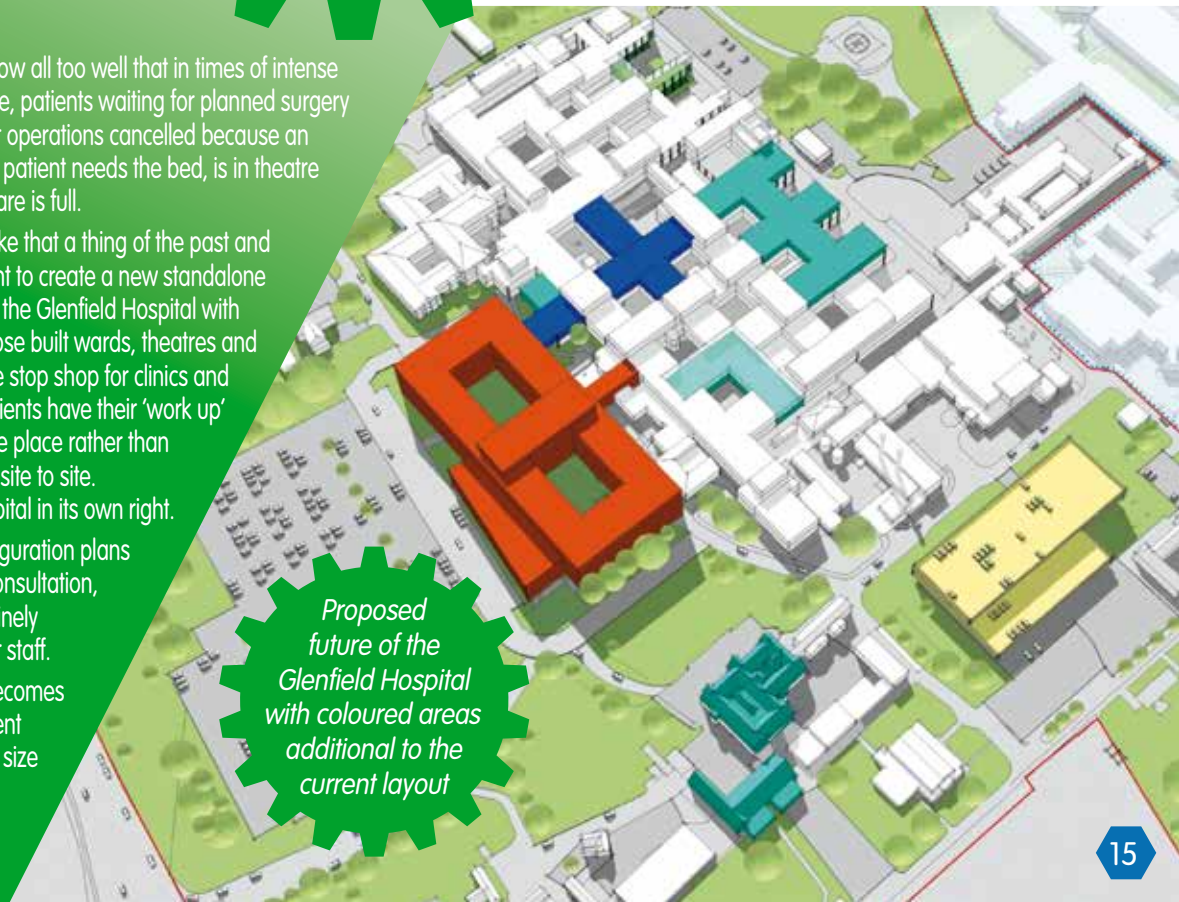
We know all too well that in times of intense pressure, patients waiting for planned surgery have their operations cancelled because an emergency patient needs the bed, is in theatre or intensive care is full.

We want to make that a thing of the past and to do that we want to create a new standalone treatment centre at the Glenfield Hospital with state of the art, purpose built wards, theatres and imaging facilities; a one stop shop for clinics and investigations so that patients have their 'work up' done in one day and in one place rather than being bounced around from site to site. Essentially it is a day case hospital in its own right.

In common with all of our reconfiguration plans this is of course subject to public consultation, but we believe that it would be genuinely transformative for our patients and our staff.

The scale of the Treatment Centre only becomes apparent when viewed alongside the current layout of Glenfield. It will increase the overall size of Glenfield by around 30 per cent.





Proposed future of the Glenfield Hospital with coloured areas additional to the current layout

Royal Infirmary

New Intensive Care Unit

Our existing ICU at the Royal is very cramped and does not have enough bed capacity for all the patients that require intensive care.

We therefore plan to spend £30m creating a new ICU which will have 48 beds in comparison to the current 21. The new unit will have much larger bed spaces to create an environment which is better for both patients and staff.

The increased capacity will mean that patients who need ICU care will get it, which will in turn relieve pressure on our other wards. The expansion at the Royal will be complemented by expansion of the ICU at Glenfield.

Proposed future of the Royal Infirmary with coloured areas additional to the current layout

Royal Infirmary

New Maternity Hospital

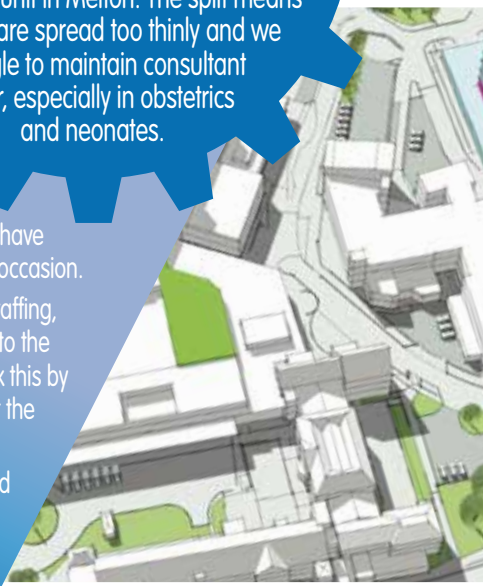
Our maternity and neonatology service is currently split across two main sites at the General and the Royal, with a small midwife led birthing unit in Melton. The split means that staff are spread too thinly and we struggle to maintain consultant cover, especially in obstetrics and neonates.

In the longer term that is not good for safety or sustainability as the CQC have pointed out to us on more than one occasion.

At times of high demand and/or low staffing, our maternity units have to divert mums to the other site for their deliveries. We want to fix this by bringing maternity and neonates together at the Royal in a new dedicated Maternity Hospital.

This would allow us to offer obstetric led birth and a co-located midwife led unit with neonates in the same building. This would mean that women could choose a less 'medical' delivery but be close enough to the staff and equipment to support them should something go wrong whilst their baby is being born. Just as importantly, it concentrates skilled staff and expensive equipment in one place, meaning we are less pressured when demand is high.

Separately, we will consult on closing the Midwife Led Birthing Unit in Melton which is under used – just one baby delivered every two and a half days – and move the service to the General where we think it will be better used and be better accessed for more of the local population.



Royal Infirmary

Leicester Children's Hospital

We want to create a new standalone Children's Hospital.

Proposed standalone Children's Hospital

We have the biggest Children's Hospital in the East Midlands, but you would not know it. Not least because the majority of our children's services are dotted around the Royal Infirmary amongst adult inpatient areas. Then of course we have children's heart surgery based at the Glenfield.

So the plan is that when we vacate the Kensington Building and move the maternity services into the new maternity hospital, we will turn the Kensington Building into a new standalone Children's Hospital. As with all our plans the key theme is getting all the right services into the right place. With the Children's Hospital this is doubly important because not only does it mean we have all the children's clinical team together at last but it also means we can create an environment that is age appropriate, welcoming and less scary for our youngsters.

General Hospital

The General

When this plan is complete (which will not be for seven to ten years), the General will no longer house acute services in the way that it does now. Instead it will be a smaller campus with a focus on community health.

In future, the General will be home to:

- The Diabetes Centre of Excellence
- A GP led community hub with on-site imaging and diagnostics
- The Stroke Rehabilitation Service
- A Midwife Led Birthing Unit, *(subject to the outcome of consultation)*
- The City Community Crisis Response Teams
- Some Trust corporate functions

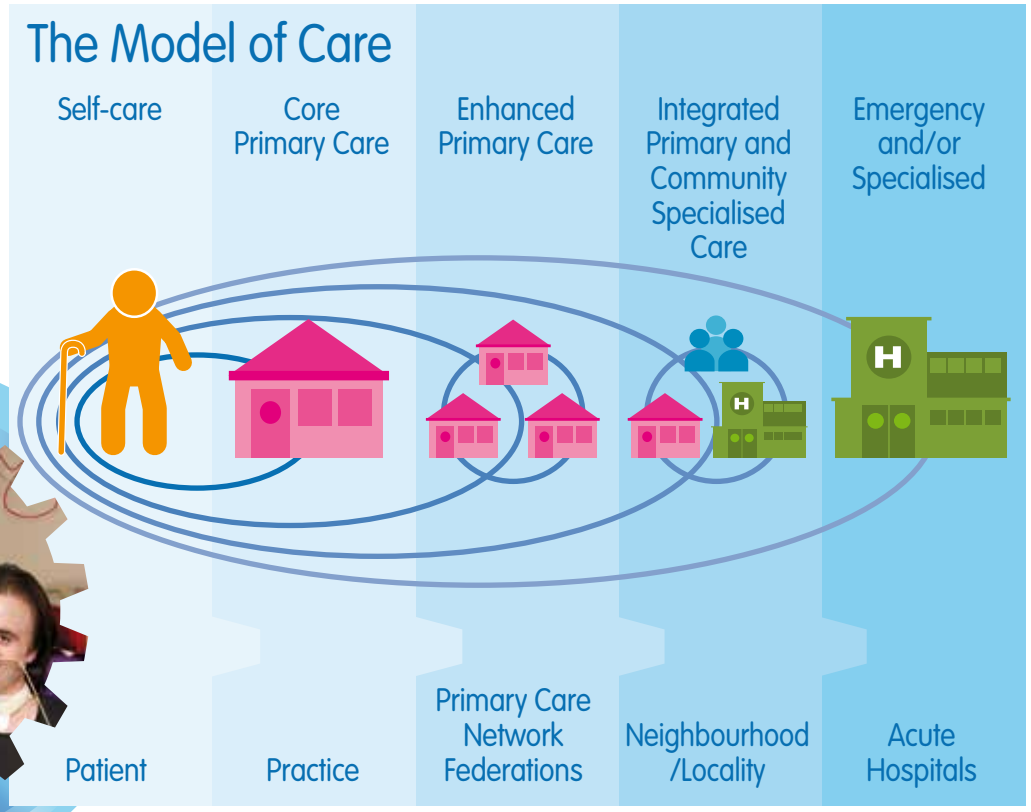
The spare land which will eventually be freed up by this will then be sold for housing including key worker and affordable homes and the money raised will be reinvested into our hospitals. In the meantime and in advance of the creation of the fully fledged Treatment Centre at the Glenfield we will move some daycase activity to the General to create an interim daycase unit.

Given the long term nature of this plan, it is very important that whilst it is being implemented, we continue to fully support the work of the General and the services based there. This is likely to mean investing in additional staff to ensure that safe services can be maintained, and ongoing investment in the estate. As mentioned earlier, some day case care will be moved to the General to provide an interim solution.

Proposed Leicester General Community Hub

Our role in the wider health and social care system

One of the key themes running through our priorities, our reconfiguration plans and our overall approach to improvement, is that none of the work we need to do will be truly successful if it is only successful in the context of our hospitals.



So what does this really mean?

Well, think about it this way; the National Health Service from the point of view of a big acute hospital could probably be more accurately called the 'National Treatment Service'. In other words, much of the work we do in hospital is triggered by patients who have reached a crisis point in their health, meaning that they need an admission to hospital and treatment. As a consequence, over the years, hospitals have used up resources and staffing to cope and other parts of the system, like primary, community, mental health and social care, have struggled.

In turn, this has created a model of health care which is overly focused on treatment at the point of crisis and not on prevention.

The old proverb that 'prevention is better than cure' has never been more relevant than it is now. The NHS is waking up to the fact that the current model of care that most of us have grown up with is out of date, costly and worst of all can actually be detrimental to a growing cohort of patients.

Think tanks, like the King's Fund, have pointed out, it is relatively easy to predict which patients in a population are likely to be most at risk of a hospital admission because they share certain recognisable characteristics, like their degree of frailty or the number of long term conditions they have. Knowing this, the challenge then becomes how do we move from responding to their needs at the point of crisis to responding to their needs to avoid the crisis in the first place? This is called 'population health management'.

The model of care shown above shows the approach we are taking as a system.
By increasing the resource, skills and expertise of primary, social and community teams, we should be better able to support and maintain a person's health in the community and reduce the need for hospitalisation. In that sense, the change required is to stop thinking about hospital as the default destination for anyone who is a too complex for community and start thinking that hospital is the place of last resort and every unplanned admission a failure.

By increasing the resource, skills and expertise of primary, social and community teams, we should be better able to support and maintain a person's health in the community and reduce the need for hospitalisation

The NHS Long Term Plan, published in January 2019, is explicit about the future direction for our services:

"The longstanding aim has been to prevent as much illness as possible. Then illness which cannot be prevented should, where possible, be treated in community and primary care. If care is required at hospital, its goal is treatment without having to stay in as an inpatient wherever possible. And, when people no longer need to be in a hospital bed, they should then receive good health and social care support to go home".

This 'population health management' or just 'integrated care' is in its infancy and whilst it appears to most of us as the logical response to caring for an increasingly older, sicker and frailer population, delivering it effectively and at pace is not without its difficulties.

Perhaps foremost amongst them is that the current architecture of health and social care is almost perfectly designed to make the integration of services harder. Locally 'Primary care' (GPs) are managed by Clinical Commissioning Groups; Community and mental health is run by Leicestershire Partnership NHS Trust; Social Care is managed by the City and County Councils and we are an organisation in our own right too. Each of those seven organisations have their individual budgets and responsibilities, and more often than is comfortable, that fact can pull us in different and contradictory directions.

In recognition of this, the NHS Long Term Plan states that by 2021 there will be 'Integrated Care Systems' everywhere in the country.

Integrated Care Systems are a way of working, collaboratively, between a range of health and social care organisations, to help improve people's health. It's when organisations work together in a shared way; sharing budgets, staff, resources where appropriate, to best meet people's needs.

Put simply, in Leicester, Leicestershire and Rutland, there is an increasing clinical consensus about the right way to plan and orchestrate our services and pathways to deliver the best possible care for our population; the job for those of us leading those organisations is to make the right way easier to achieve.

Finally, whilst we have described how we will care for over one million people in Leicester, Leicestershire and Rutland as part of an integrated system; we must not forget that we also provide specialised clinical services for a much larger population in the wider East Midlands and, for some highly complex services, nationally.

We also have a responsibility to work in partnership with other local district general hospitals to actively support the continuation and development of services for their patients in their hospitals. Patients should only have to travel to Leicester when they need to receive the most specialised treatments that only a large university teaching hospital can provide.

We are really excited about our new approach and are keen for you to get involved...

Patients/Public

Interested in taking part or to find out more, sign up to our membership mailing list.

Follow this link to sign up for free:

www.leicestershospitals.nhs.uk/members/become-a-trust-member/

www.leicestershospitals.nhs.uk/BecomingTheBest

Staff

Visit INsite and click on the Becoming the Best logo on the homepage

Becoming the best

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University Hospitals of Leicester
NHS Trust

If you would like this information in another language or format such as EasyRead or Braille, please telephone **0116 250 2959** or email **equality@uhl-tr.nhs.uk**

اگر آپ کو یہ معلومات کسی اور زبان میں درکار ہیں، تو براہِ کرم مندرجہ ذیل نمبر پر ٹیلی فون کریں۔

ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਨੰਬਰ 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

إذا كنت ترغب في الحصول على هذه المعلومات بلغةٍ أخرى، الرجاء الاتصال على رقم الهاتف الذي يظهر في الأسفل

Aby uzyskać informacje w innym języku, proszę zadzwonić pod podany niżej numer telefonu

જો તમને અન્ય ભાષામાં આ માહિતી જોઈતી હોય, તો નીચે આપેલ નંબર પર કૃપા કરી ટેલિફોન કરો.

Design and photography by UHL 0116 258 5904 With thanks to Beth Walsh for some of the photographs

Appendix D

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Population Health Management Risk Segmentation

The Wycliffe Practice and
The Masharani Practice combined

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Population Health Management - Overview

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Population Health Management (PHM) enables us to understand and look for the best solutions to people's needs, not just medically but also socially, including the wider determinants of peoples health. The PHM Risk Segmentation tool enables us to segment the population through data-driven decision making, supported by Acorn classifications or through pre-set criteria aligned to locally or nationally defined priority areas or disease pathways.

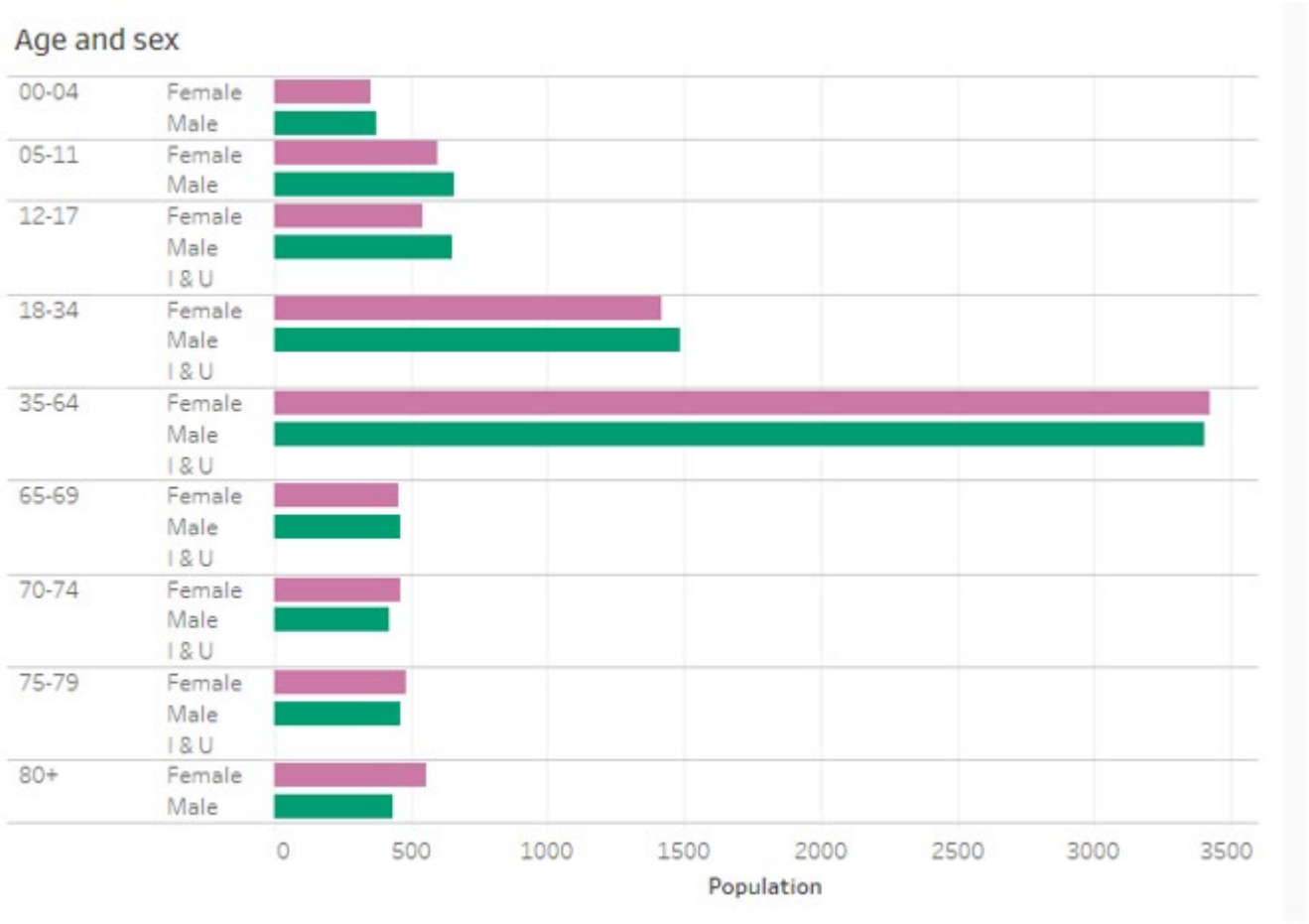
By segmentation, we can group the local population by what kind of care they need as well as how often they might need it.

The Population Health Management (PHM) Risk Segmentation tool is used to help understand the needs of the Lutterworth population so that services can be better planned and delivered, and when we carry out our public consultation we will also be able to ensure that we are targeting these groups of the population.

Age and Sex - Lutterworth

The population health management segmentation tool has been used to show the breakdown of age and sex for patients registered to the two Lutterworth GP practices (The Wycliffe Medical Centre and The Masharani Practice)

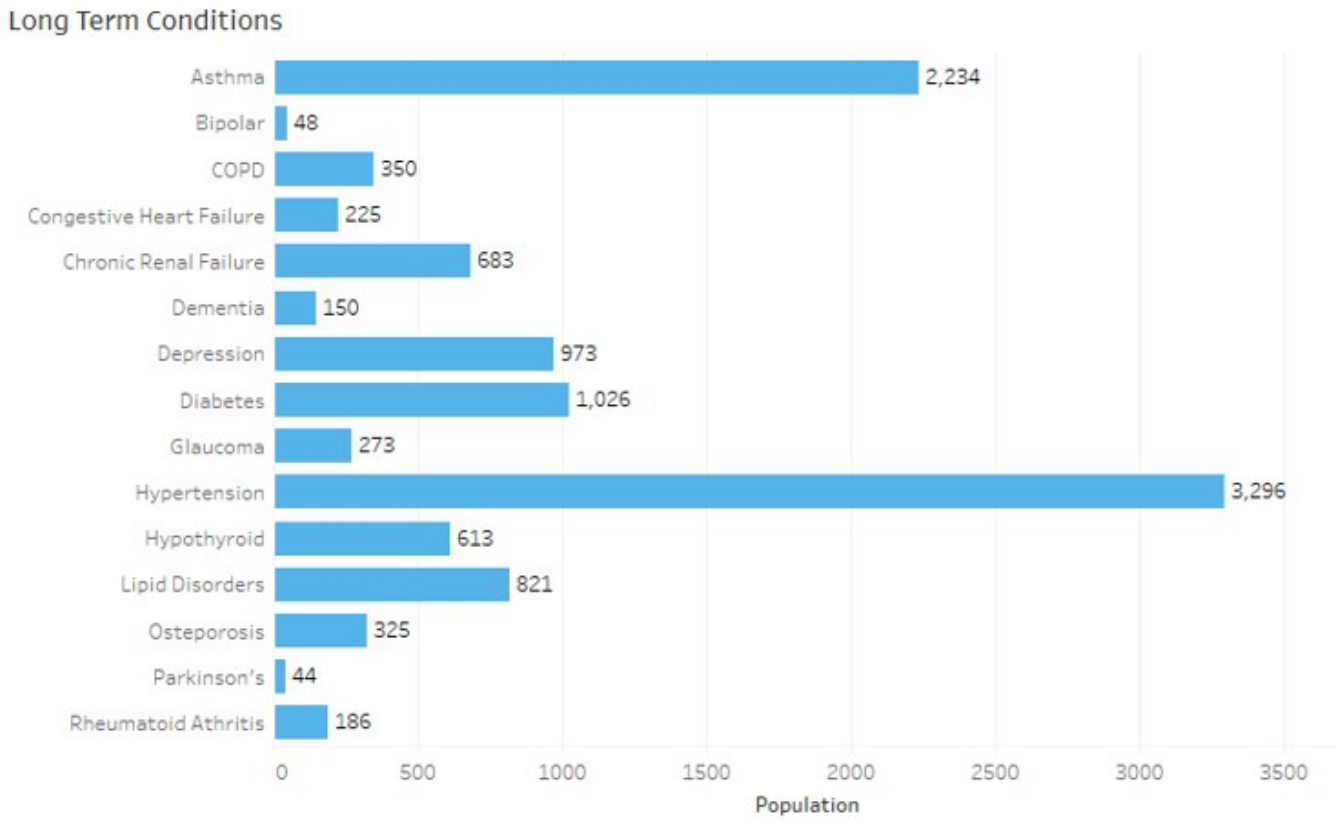
There is an even split across the genders in the 35-64 age group, with slightly higher numbers of males in the younger age brackets, and higher numbers of females in our older age brackets.



Long Term Conditions- Lutterworth

The population health management segmentation tool has been used to show the breakdown of long term conditions for patients registered to the two Lutterworth GP practices (The Wycliffe Medical Centre and The Masharani Practice)

Hypertension is a condition that is most prominent in the cohort, followed by asthma, diabetes and depression.



Population Health Management Segmentation - Lutterworth

PHM Segmentation Matrix

		Infants (0-5yrs)	Children (6-17yrs)	Working age adults (18-64yrs)	Older Adults (65+yrs)
Generally Well	Generally Well - Low Risk	582	1,355	2,809	220
	Generally Well - Higher Risk	164	318	1,062	71
	Generally Well - Other	44	83	426	34
Managed LTCs	Managed LTCs - Low Risk	62	355	2,796	689
	Managed LTCs - Higher Risk	22	116	777	179
	Managed LTCs - Other	5	22	396	96
Complex Health Issues	Complex Health Issues - Lower Risk	4	26	930	1,601
	Complex Health Issues - Higher Risk	2	15	368	554
	Complex Health Issues - Other		1	169	288

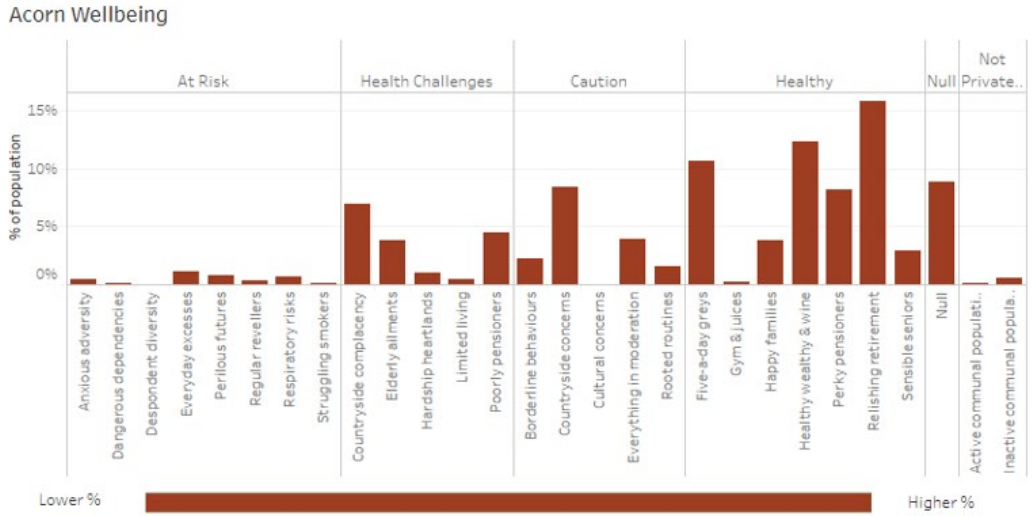
The Geodemographic map above identifies where patients live who are registered to the two Lutterworth GP practices (The Masharani Practice and The Wycliffe Medical Centre). The majority of registrations are from within Lutterworth with fewer patients in the surrounding areas (indicated by the lighter shaded circles). This also shows that there are 16,641 patients registered to the two practices.

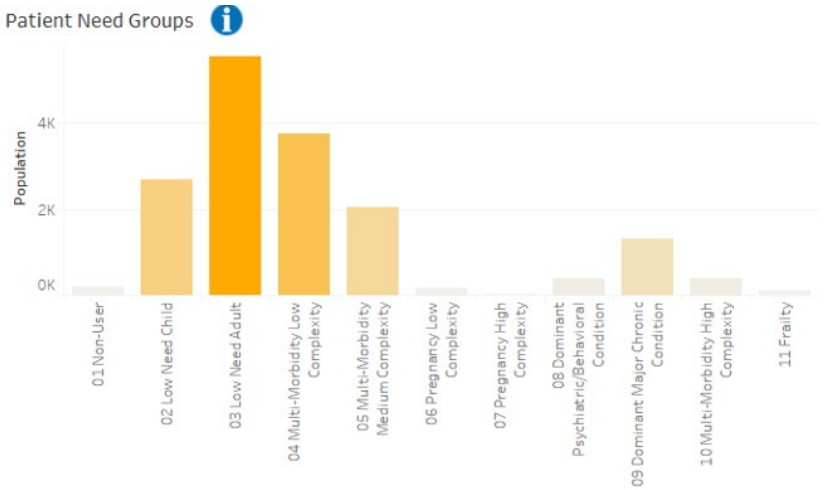
The PHM segmentation matrix, also on slide 2, demonstrates by life course (Infant, Children, Working age adults and Older adults), the number of patients who fall in to the following categories:

- Generally well (low risk/ higher risk/ other)
- Managed Long Term Conditions (low risk/ high risk/ other)
- Complex Health Issues (lower risk/ higher risk/ other)

The largest cluster of patients, 7168, fall into the generally well category (4966 categorised a low risk, 1615 as higher risk, and 587 as other)
5515 patients fall into the managed LTC category (3902 low risk, 1094 higher risk and 519 as other)
3958 patients are identified as having complex health issues (2561 lower risk, 939 higher risk, 458 as other)

Acorn Wellbeing Profiles - Lutterworth





The Acorn Wellbeing Profiles segment the population into 4 groups (Health Challenges; At Risk; Caution; Healthy) and 25 types describing the health and well being attributes of each postcode across Britain. The data here shows the proportion of the Lutterworth population falling within each profile type.

1. Health Challenges

Limited living
Poorly pensioners
Hardship heartlands
Elderly ailments
Countryside complacency

These areas contain the population with the greatest levels of illness and consequently, those with the greatest health challenges and risky behaviours now and in the past. They contain some of the oldest people in the most deprived neighbourhoods. This group contains some of the highest levels of smoking and the lowest levels of fruit and vegetable consumption. Issues around isolation and mental wellbeing are most prevalent here with many lacking a support network in their communities.

7% countryside complacency
4% elderly ailments
1% hardship heartlands
4% poorly pensioners

2. At Risk

Dangerous dependencies
Struggling smokers
Despondent diversity
Everyday excesses
Respiratory risks
Anxious adversity
Perilous futures
Regular revellers

These neighbourhoods do not generally have high incidences of illness. However, multiple unhealthy behaviours, as a result of their lifestyles, could put their health at risk in the future. They have the highest rates of smoking in the country along with some alcohol concerns. Social issues such as unemployment, debt and dissatisfaction with life overall contribute to one of the lowest scores on the mental wellbeing scale.

1% everyday excesses
1% perilous futures
1% respiratory risks

3. Caution

Rooted routines
Borderline behaviours
Countryside concerns
Everything in moderation
Cultural concerns

These are areas where the health and wellbeing of the residents are generally good. Some behaviours do create health risks and may result in lifestyle related ailments in time. There are lower levels of smoking and generally below average incidence of illness. They are less likely to have high blood pressure but tend to be overweight and have high cholesterol.

2% borderline behaviours
8% countryside concerns
4% everything in moderation
2% routed routines

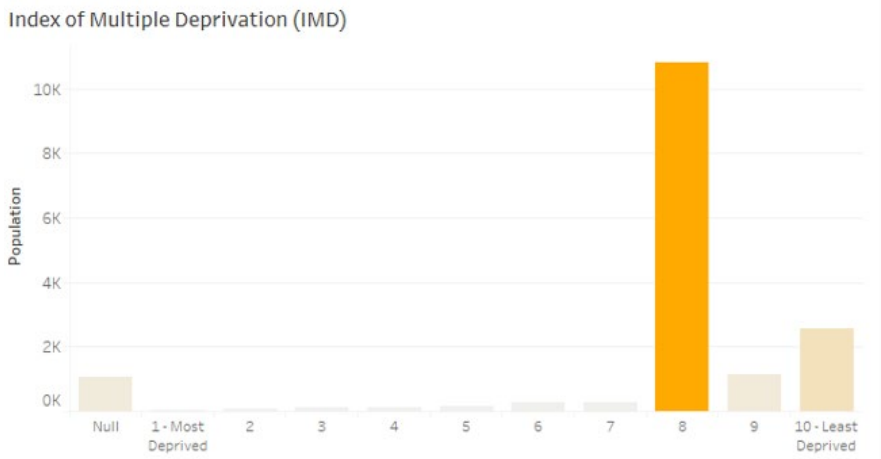
4.Healthy

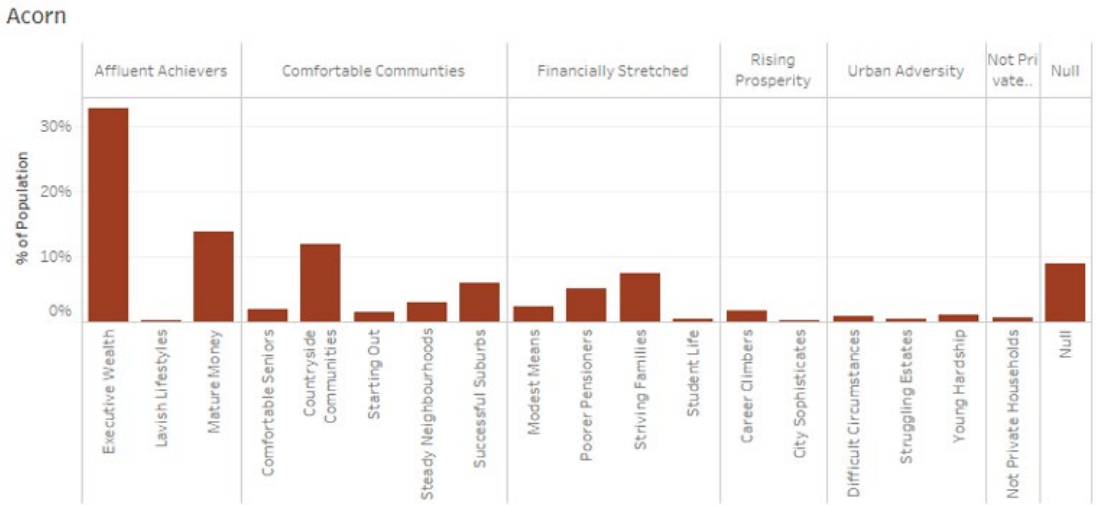
Relishing retirement
Perky pensioners
Sensible seniors
Gym & juices
Happy families
Five-a-day greys
Healthy, wealthy & wine

These neighbourhoods are more affluent, often with older residents. Their health, given their age, is especially good with very low levels of illness and good lifestyle behaviours. Smoking is very low and consumption of fruit and vegetables are extremely high. There are, however, issues with alcohol intake, particularly for women.

11% 5-a-day greys
4% happy families
12% healthy, wealthy and wine
8% perky pensioners
16% relishing retirement
3% sensible seniors

Acorn Communities Profiles - Lutterworth





The Acorn Communities Profiles highlight type across a wide range of demographic, behavioural and attitudinal attributes. Data from the left hand chart has been summarised under the classification type below. The percentages show the proportion of the Lutterworth population falling within each profile type.

1. Affluent Achievers

Lavish Lifestyles
Executive Wealth
Mature Money

These are some of the most financially successful people in the UK. They live in wealthy, high status rural, semi-rural and suburban areas of the country. Middle aged or older people, the 'baby-boomer' generation, predominate with many empty nesters and wealthy retired. Some neighbourhoods contain large numbers of well-off families with school age children.

33% executive wealth
14% mature money

2. Rising Prosperity

City Sophisticates
Career Climbers

These are generally younger, well educated, and mostly prosperous people living in our major towns and cities. Most are singles or couples, some yet to start a family, others with younger children. Often these are highly educated younger professionals moving up the career ladder.

2% career climbers

3. Comfortable Communities

Countryside Communities
Successful Suburbs
Steady Neighbourhoods
Comfortable Seniors
Starting Out

This category contains much of middle-of-the-road Britain. Generally people own their own home. Most houses are semi-detached or detached, overall of average value for the region. Incomes overall are average, some will earn more, the younger people a bit less than average. Those better established might have built up a degree of savings or investments.

2% comfortable seniors
12% countryside communities
1% starting out
3% steady neighbourhoods
6% successful suburbs

4. Financially Stretched

Student Life
Modest Means
Striving Families
Poorer Pensioners

This category contains a mix of traditional areas of Britain. Housing is often terraced or semi-detached, a mix of lower value owner occupied housing and homes rented from the council or housing associations, including social housing developments specifically for the elderly. This category also includes student term-time areas.

2% modest means
5% poorer pensioners
7% striving families

5. Urban Adversity

Young Hardship
Struggling Estates
Difficult Circumstances

This category contains the most deprived areas of large and small towns and cities across the UK. Household incomes are low, below the national average. The level of people having difficulties with debt approaches double the national average. The numbers claiming Jobseeker's Allowance and other benefits is well above the national average. Levels of qualifications are low.

1% difficult circumstances
1% young hardship

6. Not Private Households

Group R

These are postcodes where the bulk of the residents are not living in private households.

- Active communal population
- Inactive communal population
- Business addresses without resident population

1% not private households

Appendix E

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

LLR: Feilding Palmer

Options Appraisal Process - Creating a Preferred Way Forward

29 March 2023

BEAUMARIS CONSULTING

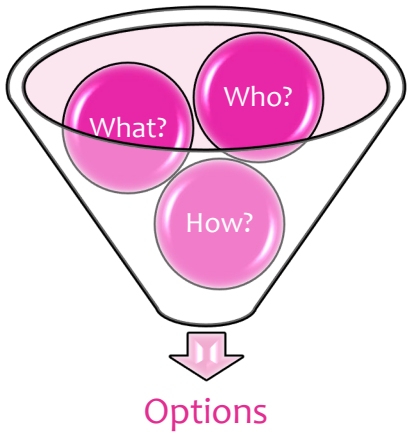
Objectives of the workshop

- To identify and develop the choices that define the **Preferred Way Forward (PWF) option** for the Lutterworth Pre-Consultation Business Case (PCBC)
- To identify other options for short listing (including do nothing/minimum)

Methodology

- To apply the HM Treasury Green Book methodology and guidance (updated March 2019), using the required Options Filter Framework in a workshop to be held with stakeholders

Strategic Options Filter Framework methodology



When constructing the long-list, options **should not** be fully specified as an end-to-end solution immediately. Instead, they should be built up by considering the choices summarised below:

Option Choices - broad description			
1a	**Scope**	**What?**	Coverage of the service to be delivered
1b	**Scope**	**Where?**	Where the service is to be delivered
2	**Solution**	**How?**	How this may be done
3	**Delivery**	**Who?**	Who is best placed to do this
4	**Implementation**	**When?**	When an in what form can it be implemented
5	**Funding**	**£££s?**	What this will cost and how shall it be paid for

Mix and match approach

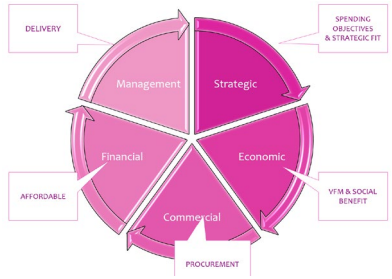
The Green Book methodology therefore endorses the use of the Strategic Options Filter Framework to demonstrate:

- Objectives
- Transparency
- Evidence based decision making

The Strategic Options Filter Framework provides a structured approach to identifying and filtering a broad range of options

Step 1

- Determine the **Investment Objectives** and **Critical Success Factors (CSFs)**
- Identify **Dependencies and Constraints**
- Determine which CSFs are relevant to each **Question**



Step 2

- Determine the **Options** within each **Question** (the what/how/who/when and funding questions).

E.g. for 'What' determine the service options, such as 64 bed mental health unit. Consider Do Minimum choices through Intermediate choices through to the Do Maximum

Option Choices - broad description			
1a	Scope	What?	Coverage of the service to be delivered
1b	Scope	Where?	Where the service is to be delivered
2	Solution	How?	How this may be done
3	Delivery	Who?	Who is best placed to do this
4	Implementation	When?	When an in what form can it be implemented
5	Funding	£££s?	What this will cost and how shall it be paid for

Step 3

- For each Question, **assess** the Options against the CSF's relevant to that question

Score only one Choice for each Question as Green (preferred) plus others as either Amber (meets CSFs but is less attractive) to be carried forward, or Red (fails to meet CSFs), to be dropped from options analysis

Rate choices red amber or green
red = drop, amber = carry forward
green = preferred way forward

Green	✓ Meets CSFs *Preferred way forward*
Amber	? Meets CSFs but Is less attractive *Carry forward*
Red	x Fails to meet CSFs *Drop*

Select the shortlist – preferred way and other viable options combine green and some amber choices

- Business as Usual (the counterfactual)
- Do-minimum
- Preferred way forward
- Other viable option(s)

Step 4

- Use the results to determine the **Preferred Way Forward** (the Green from each Question)
- Use the results to determine the **short-listed options** (bau, do minimum and PWF as a minimum)

Step 1: Investment Objectives

Extract from HM Treasury 'Green Book'

SMART objectives

4.1 Clear objectives are vital for successful policies, programmes and projects. Identifying objectives begins at the outset or when making the case for change (part of the **strategic dimension** in HM Treasury Business Case guidance). A lack of clear objectives limits effective appraisal, planning, monitoring and evaluation. Objectives should be SMART:

- ☐ Specific
- ☐ Measurable
- ☐ Achievable
- ☐ Realistic
- ☐ Time-limited

4.2 **Up to 5 or 6 SMART objectives should be established**. More than this means an intervention is likely to be poorly focussed and could under-deliver. Usually SMART objectives are expressed as *changes in outcomes an intervention is designed to produce* (the consequences of change in service or policy) and in some cases the expected outputs (e.g. the levels or quality of service delivered). *When part of a wider programme, project objectives may need to be described as outputs*.

Chapter 8 extract: 'Without verifiable and measurable objectives success cannot be measured, proposals will lack focus and be less likely to achieve Value for Money.'

Step 1: Investment Objectives

Investment Objective Type	IO Ref	Investment Objectives	Measure	Time
Service provision - local population	1	Maximising access to services through developing existing services and/or provision of new services.	Improved access to effective care. Create access to increased service provision. Provide care closer to home. Reduce travel times from 40 minutes to 10 minutes	By autumn 2025 (measure in 26/27)
Clinical need - facilities	2	Modernise the environment and design facilities to suit clinical need. Also improves the working environment for staff.	Adherence to HBNs/HTMs	
Estates utilisation	3	Improve utilisation of space across the Trust with more effective use of resources	Co-location of services and increased integrated ways of working, maximising the use of financial, human and estates resources. Increase occupancy rates in current estate.	
System Benefits	4	Improved strategic fit of services	Service provision meet the requirements of the Lutterworth Healthcare Plan & the Joint Forward Plan.	
Estates - efficient use of resources	5	Reduced backlog maintenance and modernising infrastructure to support the net zero carbon objectives.	Estimated costs for backlog maintenance of c£1.5m over next 10 years (with 75% of spend in the first 4 yrs) to be addressed through the development and revised use.	

Step 1: Constraints and Dependencies

Constraints and dependencies

A1.10 Constraints and dependencies will affect which options are feasible. They should be identified and understood at the earliest possible stage and taken into account when developing a long-list. Constraints might include legality, ethics, social acceptability, practicality and coherence with wider public policies and strategy. Dependencies are factors that an option relies on to be successful. They are external and outside of direct control, but the successful delivery of objectives depends on them (for example, infrastructure).

Constraints

1	Need to maintain stakeholder support
2	Physical constraints of site/building
3	Funding
4	
5	
6	

Dependencies (task cannot start until another is finished)

1	May lead to temporary relocation of services if/when building works required
2	
3	
4	
5	

No further constraints or dependencies identified

Step 1: Critical Success Factors (CSFs)

CSF1: Strategy	CSF2: Economic	CSF3: Commercial	CSF4: Financial	CSF5: Management	CSF6: Access	CSF7: Quality & Safety
Compulsory (per Green Book)					Project Specific	
Strategic fit and meets business needs	Potential VfM/benefits optimisation	Supplier capacity and capability	Potential affordability	Potential achievability	Access	Quality & Safety Standards
(i) Meets the investment objectives	(i) VfM modelling	(i) Matches the ability of potential suppliers to deliver the required services	(i) Can be financed from available funds	(i) Needs to be achievable within required timescales and constraints	(i) Improves access to effective care	(i) High quality accom provided within HBN and HTM standards
(ii) Ensure the services provided meet the needs of the local population, taking into account the increased population in the Lutterworth East region	(ii) Optimises social value (maximises societal benefits including most effective use of financial, human and estates resources)	(ii) Appeals to the supply side	(ii) Aligns with strategy of the funders	(ii) Deliverability of the required permitted development rights/ planning permission	(ii) Reduces unplanned admissions to hospital	(ii) Provides services in a location that are linked to local commissioning plans and local estates strategy of ICS
	(iii) Meets tne requirements for energy efficiency, reduces carbon footprint and estates running costs	(iii) Enables construction/ refurbishment, dealing with site constraints and planning risk	(iii) Minimises capital and revenue costs exposure to LLR	(iii) Matches the level of available skills for successful delivery	(iii) Creates a community hub, where both patients and professionals can access a wide range of community care	
	(iv) Provides flexibility for the future, adaptable to future healthcare delivery patterns	(iv) Limits phasing and timeframe of the build/refurbishment	(iv) Aligns with resourcing constraints and minimises risk of a termination in funding			

CSFs used to assess the various options when reviewing the scope, solution, implementation, delivery and funding options

Assigning CSFs

			Workshop		Post Workshop		
			What	How/Where	Who	When	Funding
Ref.	Type	Description	Service scope	Service solution: location(s)	Delivery: How to be delivered?	Timing options	Funding options
CSF 1	Strategic	Strategic fit and meets business needs	■			■	
CSF2	Economic	Potential VfM/benefits optimisation		■			
CSF 3	Commercial	Supplier capacity and capability		■	■	■	
CSF 4	Fianncial	Potential affordability		■			■
CSF 5	Management	Potential achievability		■	■	■	
CSF 6	Access	Access		■			
CSF 7	Quality/Safety	Quality & Safety Standards	■				

CSFs assigned to the various questions

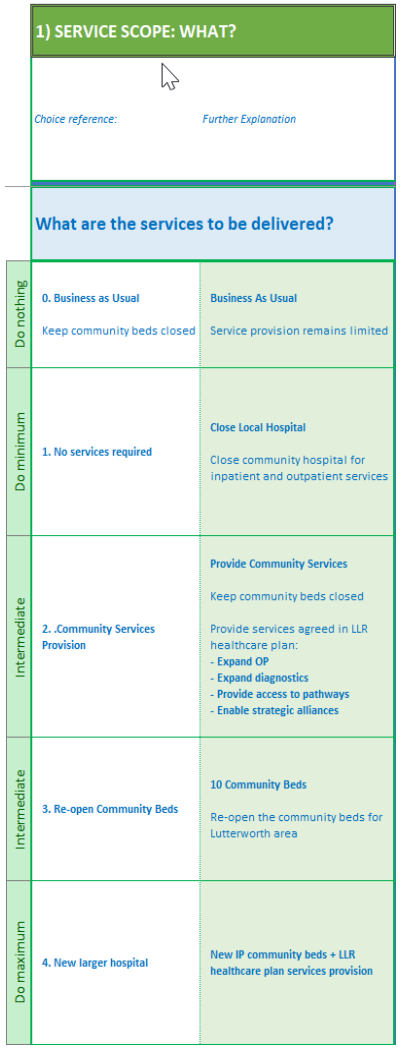
(E.g. To assess the service scope, the options are reviewed against CSF 1 and CSF 7)

Step 2: Identify long list within each question.

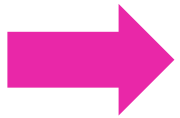
When assessing the long list, the workshop looks at the business as usual, do minimum, do maximum and any intermediate options to then assess against the CSF criteria .

Once the first question/filter has been assessed (service scope), the long list of the second question/filter (solution) is completed, to be able to determine the service solution that delivers the Preferred Way Forward as identified in the first question/filter.

This process continues through the 5 questions in the framework filter.



1) SERVICE SCOPE: WHAT?		
Choice reference:	*Further Explanation*	
What are the services to be delivered?		
Do nothing	0. Business as Usual	Business As Usual Keep community beds closed Service provision remains limited
Do minimum	1. No services required	Close Local Hospital Close community hospital for inpatient and outpatient services
Intermediate	2. .Community Services Provision	Provide Community Services Keep community beds closed Provide services agreed in LLR healthcare plan: - Expand OP - Expand diagnostics - Provide access to pathways - Enable strategic alliances
Intermediate	3. Re-open Community Beds	10 Community Beds Re-open the community beds for Lutterworth area
Do maximum	4. New larger hospital	New IP community beds + LLR healthcare plan services provision



2) SERVICE SOLUTION: HOW? WHERE?	
Ref	
How are the services to be delivered?	
Current (Business as Usual)	Use existing site without refurbishment
Feilding Palmer Refurbishment	Refurbish Feilding Palmer to meet current needs and provide flexible accommodation for future healthcare needs
Expand to out of area existing sites	Provides services in fit for purpose locations, but outside of local provision
Lutterworth Medical Centre	Refurbish/extend the Lutterworth Medical Centre ,adjacent to the current Feilding Palmer site

Step 3: Assessing the Options

What?
Where?
How?
Who?
When?
Funding?

Option Choices - broad description			
1a	Scope	What?	Coverage of the service to be delivered
1b	Scope	Where?	Where the service is to be delivered
2	Solution	How?	How this may be done
3	Delivery	Who?	Who is best placed to do this
4	Implementation	When?	When an in what form can it be implemented
5	Funding	£££s?	What this will cost and how shall it be paid for

Workshop

Post Workshop

Scope- What?

Key	Assessment
✗	Does not meet the CSF
✓	Meets some of the elements of the CSF
✓ ✓	Meets many of the elements of the CSF
✓ ✓ ✓	Fully meets CSF

Key:

- Carry Forward - Business as Usual
- Preferred Way Forward
- Carry Forward - Short List
- Discounted

			Critical Success Factors			
			CSF1: Strategy		CSF7: Quality & Safety	
	1) SERVICE SCOPE: WHAT?		Strategic fit and meets business needs		Quality & Safety Standards	
	Choice reference:	Further Explanation	*(i) Meets the investment objectives (ii) Ensure the services provided meet the needs of the local population, taking into account the increased population in the Lutterworth East region*		*(i) High quality accom provided within HBN and HTM standards (ii) Provides services in a location that are linked to local commissioning plans and local estates strategy of ICS*	
	What are the services to be delivered?					
Do nothing	**0. Business as Usual** Keep community beds closed	**Business As Usual** Service provision remains limited	- No benefit to population - Does not meet needs of local population - Limited access to services	✗	Services not in location that link with local commissioning plans and local estates strategy of ICS	✗
Do minimum	**1. No services required**	**Close Local Hospital** Close community hospital for inpatient and outpatient services	- No benefit to patients - Local community hospital beds are not available - Does not respond to current and growing population needs - No access to service - Benefits of keeping patients at home is reduced	✗	- Vacant building - Does not respond to current and growing population needs	✗
Intermediate	**2. .Community Services Provision**	**Provide Community Services** Keep community beds closed Provide services agreed in LLR healthcare plan: **- Expand OP** **- Expand diagnostics** **- Provide access to pathways** **- Enable strategic alliances**	- Meets needs of local population and provides services agreed in Lutterworth Healthcare Plan	✓ ✓ ✓	Provides refurbished accommodation meeting HBN/HTM standards and first with local estates strategy	✓ ✓ ✓
Intermediate	**3. Re-open Community Beds**	**10 Community Beds** Re-open the community beds for Lutterworth area	- Provides IP community palliative care - Expensive model of care - Does not respond to needs of growing pop of Lutterworth East development	✓	- Hospital layout ineffective for modern healthcare -Ward does not meet regulatory requirements and is not cost effective for small number of beds (plus training/skills development is low for staff)	✗
Do maximum	**4. New larger hospital**	**New IP community beds + LLR healthcare plan services provision**	- Number of Lutteroworth patients requiring IP beds is small - Not aligned to Lutterworth Healthcare Plan - Not a cost effective solution - Benefits of keeping patients at home is reduced	✓	- Would provide high quality estate, but at a cost	✗

Scope- What?

Key	Assessment
✗	Does not meet the CSF
✓	Meets some of the elements of the CSF
✓ ✓	Meets many of the elements of the CSF
✓ ✓ ✓	Fully meets CSF

Key:
- Carry Forward - Business as Usual
- Preferred Way Forward
- Carry Forward - Short List
- Discounted

			Critical Success Factors					
			CSF1: Strategy		CSF7: Quality & Safety			
	1) SERVICE SCOPE: WHAT?		Strategic fit and meets business needs		Quality & Safety Standards			
	Choice reference:	*Further Explanation*	*(i) Meets the investment objectives (ii) Ensure the services provided meet the needs of the local population, taking into account the increased population in the Lutterworth East region*		*(i) High quality accom provided within HBN and HTM standards (ii) Provides services in a location that are linked to local commissioning plans and local estates strategy of ICS*		*Assessment Result (only one choice to be identified as Green)*	
	What are the services to be delivered?							
Do nothing	**0. Business as Usual** Keep community beds closed	**Business As Usual** Service provision remains limited	- No benefit to population - Does not meet needs of local population - Limited access to services	✗	Services not in location that link with local commissioning plans and local estates strategy of ICS	✗	**Carry forward - BAU**	Not fit for purpose, but c/fwd as the benchmark. **C/fwd as benchmark.**
Do minimum	**1. No services required**	**Close Local Hospital** Close community hospital for inpatient and outpatient services	- No benefit to patients - Local community hospital beds are not available - Does not respond to current and growing population needs - No access to service - Benefits of keeping patients at home is reduced	✗	- Vacant building - Does not respond to current and growing population needs	✗	**Discounted**	Does not meet strategic aims. **Reject.**
Intermediate	**2. .Community Services Provision**	**Provide Community Services** Keep community beds closed Provide services agreed in LLR healthcare plan: **- Expand OP** **- Expand diagnostics** **- Provide access to pathways** **- Enable strategic alliances**	- Meets needs of local population and provides services agreed in Lutterworth Healthcare Plan	✓ ✓ ✓	Provides refurbished accommodation meeting HBN/HTM standards and first with local estates strategy	✓ ✓ ✓	**Preferred Way Forward**	Substantially meets strategic CSFs and correctly managed is deliverable, subject to site constraints. **Prefered Way Forward.**
Intermediate	**3. Re-open Community Beds**	**10 Community Beds** Re-open the community beds for Lutterworth area	- Provides IP community palliative care - Expensive model of care - Does not respond to needs of growing pop of Lutterworth East development	✓	- Hospital layout ineffective for modern healthcare -Ward does not meet regulatory requirements and is not cost effective for small number of beds (plus training/skills development is low for staff)	✗	**Discounted**	Does not sufficiently meet CSFs **Reject.**
Do maximum	**4. New larger hospital**	**New IP community beds + LLR healthcare plan services provision**	- Number of Lutteroworth patients requiring IP beds is small - Not aligned to Lutterworth Healthcare Plan - Not a cost effective solution - Benefits of keeping patients at home is reduced	✓	- Would provide high quality estate, but at a cost	✗	**Discounted**	Does not sufficiently meet CSFs **Reject.**

Scope- What?

Commentary

0. Current (BAU)	The temporary services provided (a short-term solution) remain. The accommodation is not fit for purpose (unused wards reprovisioned). Backlog maintenance currently c£1.5m would still need to be addressed. Does not cater for services required in the growing Lutterworth East area. This does not meet the appropriate CSFs and would be rejected but c/fwd as a benchmark, in accordance with HM Treasury guidelines.	C/Fwd as comparator
1. No services required	This option assumes that there is no demand or requirement for services to be delivered in the Lutterworth area, meaning that the Feilding Palmer site would be vacated, and no new service provision is required. This does not meet the requirements of the LLR strategy or the Lutterworth Healthcare Plan and does not fit with current demand and supply. This does not meet the appropriate CSFs.	Reject
2. Community Services Provision	This option provides community services in the local Lutterworth area, with the provision of outpatient services and diagnostics. This also provides access to pathways and enables strategic alliances with appropriate organisations/partners, all in a community setting (releasing pressure from acute services and providing services nearer to home). This is consistent with the LLR strategy and the Lutterworth Healthcare Plan. This meets the appropriate CSFs.	Preferred Way Forward
3. Re-open Community beds	This option reopens the 10 community beds to make Feilding Palmer a community inpatient bed site. However, the accommodation is not fit for purpose and is not consistent with national policy where there is a preference to provide more community provision in the patient's home. Also, the ability to keep the beds occupied at the required 93% (to provide the most cost effective solution and best practice) means that the service would need to be offered to patients from further afield in LLR. As a result, this would increase (not decrease) travel times. Having relatively small sites also creates staffing issues, with recruitment, cover, training and education particularly difficult (e.g. lack of mix of patients to develop nursing skills). The LLR ICS considers that the best solution is to work with the third party organisations, such as those who have raised funds for local investment of palliative care beds. This does not meet the appropriate CSFs.	Reject
4. New larger hospital	This option combines options 2 and 3 above and represents the 'do maximum' option. Again, the reasons against the provision of 10 community beds outlined in 3 above also apply in this option. This is also a far more costly solution. It was felt that this would be beyond the scope of this project and would not represent best value for money. This does not meet the appropriate CSFs.	Reject

Next Filter:

We have therefore established that the Preferred Way Forward (PWF) for the service provision is to provide community services in the local setting, that can be adaptable for the future needs of the local Lutterworth population (taking into account the increase in population in the Lutterworth East area).

The next step in trying to determine the end-to-end solution of the PWF is to look at where and how the PWF for the service provision identified above can be delivered and where (i.e. items 1b and 2 in the table below). We have combined this analysis and assessed the options on the next slides.

Option Choices - broad description			
1a	Scope	What?	Coverage of the service to be delivered
1b	Scope	Where?	Where the service is to be delivered
2	Solution	How?	How this may be done
3	Delivery	Who?	Who is best placed to do this
4	Implementation	When?	When an in what form can it be implemented
5	Funding	£££s?	What this will cost and how shall it be paid for

Scope/Solution – Where/How?

2) SERVICE SOLUTION: HOW? WHERE?

Ref		CSF2: Economic		CSF3: Commercial		CSF4: Financial		CSF5: Management		CSF6: Access		CSF7: Quality & Safety	
		Potential VfM/benefits optimisation		Supplier capacity and capability		Potential affordability		Potential achievability		Access		Quality & Safety Standards	
How are the services to be delivered?		*(i) VfM modelling (ii) Optimises social value (maximises societal benefits including most effective use of financial, human and estates resources) (iii) Meets tne requirements for energy efficiency, reduces carbon footprint and estates running costs (iv) Provides flexibility for the future, adaptable to future healthcare delivery patterns*		*(i) Matches the ability of potential suppliers to deliver the required services (ii) Appeals to the supply side (iii) Enables construction/ refurbishment, dealing with site constraints and planning risk (iv) Limits phasing and timeframe of the build/refurbishment*		*(i) Can be financed from available funds (ii) Aligns with strategy of the funders (iii) Minimises capital and revenue costs exposure to LLR (iv) Aligns with resourcing constraints and minimises risk of a termination in funding*		*(i) Needs to be achievable within required timescales and constraints (ii) Deliverability of the required permitted development rights/ planning permission (iii) Matches the level of available skills for successful delivery*		*(i) Improves access to effective care (ii) Reduces unplanned admissions to hospital (iii) Creates a community hub, where both patients and professionals can access a wide range of community care*		*(i) High quality accom provided within HBN and HTM standards (ii) Provides services in a location that are linked to local commissioning plans and local estates strategy of ICS*	
Current (Business as Usual)	Use existing site without refurbishment	Very few benefits as services can't be configured correctly to benefit patients/staff/professionals.	✗	N/A - no building works		Backlog maintenance still needs to be applied.	✓		✓	Limitations due to ward spaces . Would not be able to offer expanded services	✗	Limitations due to ward spaces . Would not be able to offer expanded services	✗
Feilding Palmer Refurbishment	Refurbish Feilding Palmer to meet current needs and provide flexible accommodation for future healthcare needs	Provides the best solution for patients and staff, allowing fit for purpose facilities for the local population with a cost effective solution, nearer to home.	✓ ✓ ✓	Supplier capacity and capability not expected to be a problem. Few planning risks.	✓ ✓ ✓	Limited capital funding available	✓ ✓	Internal management experienced in capital programme delivery, with use of external subject matter experts where required.	✓ ✓ ✓	Meets all the requirements of the access CSFs	✓ ✓ ✓	Refurbishment will be carried out within the necessary HBN and HTM standards	✓ ✓ ✓
Expand to out of area existing sites	Provides services in fit for purpose locations, but outside of local provision	Limited social value as requires patients to travel further afield.	✗	Supplier capacity and capability not expected to be a problem. May have planning risks, depending on site.	✓ ✓	Limited capital funding available	✓ ✓	Internal management experienced in capital programme delivery, with use of external subject matter experts where required.	✓ ✓ ✓	Out of local area means that the access CSFs are not met, increasing time/travel/inconvenience and delivering healthcare further from home,	✗	Whilst adherence to HTMs/HBNs may be achieved (depending on site), providing the service outside the local commissioning plans and local estates strategy of the ICS means that this CSF is largely not met.	✗
Lutterworth Medical Centre	Refurbish/extend the Lutterworth Medical Centre ,adjacent to the current Feilding Palmer site	Won't provide VfM to same level as Feilding Palmer due to site constraints	✓	Supplier capacity and capability not expected to be a problem.	✓ ✓ ✓	Limited capital funding available	✓ ✓	Conflicting requirements of existing/expanding primary care service make this an unviable option	✗	Not sufficient space to allow this CSF to be achieved	✓	Location good (next door to Feilding Palmer) but not enough space. Current need for expansion for existing primary care means not a viable option	✗

Scope – Where/How?

2) SERVICE SOLUTION: HOW? WHERE?

Ref		CSF2: Economic		CSF3: Commercial		CSF4: Financial		CSF5: Management		CSF6: Access		CSF7: Quality & Safety			
		Potential VfM/benefits optimisation		Supplier capacity and capability		Potential affordability		Potential achievability		Access		Quality & Safety Standards			
How are the services to be delivered?		*(i) VfM modelling (ii) Optimises social value (maximises societal benefits including most effective use of financial, human and estates resources) (iii) Meets tne requirements for energy efficiency, reduces carbon footprint and estates running costs (iv) Provides flexibility for the future, adaptable to future healthcare delivery patterns*		*(i) Matches the ability of potential suppliers to deliver the required services (ii) Appeals to the supply side (iii) Enables construction/ refurbishment, dealing with site constraints and planning risk (iv) Limits phasing and timeframe of the build/refurbishment*		*(i) Can be financed from available funds (ii) Aligns with strategy of the funders (iii) Minimises capital and revenue costs exposure to LLR (iv) Aligns with resourcing constraints and minimises risk of a termination in funding*		*(i) Needs to be achievable within required timescales and constraints (ii) Deliverability of the required permitted development rights/ planning permission (iii) Matches the level of available skills for successful delivery*		*(i) Improves access to effective care (ii) Reduces unplanned admissions to hospital (iii) Creates a community hub, where both patients and professionals can access a wide range of community care*		*(i) High quality accom provided within HBN and HTM standards (ii) Provides services in a location that are linked to local commissioning plans and local estates strategy of ICS*		*Assessment Result (only one choice to be identified as Green)*	
Current (Business as Usual)	Use existing site without refurbishment	Very few benefits as services can't be configured correctly to benefit patients/staff/professionals.	✗	N/A - no building works		Backlog maintenance still needs to be applied.	✓		✓	Limitations due to ward spaces . Would not be able to offer expanded services	✗	Limitations due to ward spaces . Would not be able to offer expanded services	✗	**Discounted**	Ther required servces cannot be delviered from the existing site without significant spend/refurbishment. **Reject.**
Feilding Palmer Refurbishment	Refurbish Feilding Palmer to meet current needs and provide flexible accommodation for future healthcare needs	Provides the best solution for patients and staff, allowing fit for purpose facilities for the local population with a cost effective solution, nearer to home.	✓ ✓ ✓	Supplier capacity and capability not expected to be a problem. Few planning risks.	✓ ✓ ✓	Limited capital funding available	✓ ✓	Internal management experienced in capital programme delivery, with use of external subject matter experts where required.	✓ ✓ ✓	Meets all the requirements of the access CSFs	✓ ✓ ✓	Refurbishment will be carried out within the necessary HBN and HTM standards	✓ ✓ ✓	**Preferred Way Forward**	Substantially meets the various CSFs and provides the best service deliver option. Various sub-options required for variations within FP to deliver the required services (to be assessed separately) **Preferred Way Forward.**
Expand to out of area existing sites	Provides services in fit for purpose locations, but outside of local provision	Limited social value as requires patients to travel further afield.	✗	Supplier capacity and capability not expected to be a problem. May have planning risks, depending on site.	✓ ✓	Limited capital funding available	✓ ✓	Internal management experienced in capital programme delivery, with use of external subject matter experts where required.	✓ ✓ ✓	Out of local area means that the access CSFs are not met, increasing time/travel/inconvenience and delivering healthcare further from home,	✗	Whilst adherence to HTMs/HBNs may be achieved (depending on site), providing the service outside the local commissioning plans and local estates strategy of the ICS means that this CSF is largely not met.	✗	**Discounted**	Does not meet the required standards, particularly around local provision. **Reject.**
Lutterworth Medical Centre	Refurbish/extend the Lutterworth Medical Centre ,adjacent to the current Feilding Palmer site	Won't provide VfM to same level as Feilding Palmer due to site constraints	✓	Supplier capacity and capability not expected to be a problem.	✓ ✓ ✓	Limited capital funding available	✓ ✓	Conflicting requirements of existing/expanding primary care service make this an unviable option	✗	Not sufficient space to allow this CSF to be achieved	✓	Location good (next door to Feilding Palmer) but not enough space. Current need for expansion for existing primary care means not a viable option	✗	**Discounted**	Does not sufficiently meet CSFs **Reject.**

Scope/Solution - Where/How?

Commentary

0. Current (BAU)	This solution assumes that the proposed community services can be provided from the current Feilding Palmer Hospital, without refurbishment. This is not considered to be possible given the limitations of the current ward spaces. It was felt that the expanded service provision would not be possible. This does not meet the appropriate CSFs.	Reject
1. Feilding Palmer Refurbishment	This solution allows the current Feilding Palmer Hospital to be refurbished to meet the required building standards and provide fit for purpose, flexible space, ensuring any service provision is flexible and adaptable for future needs. Importantly, this maintains a 'health campus' approach, with healthcare services provided from Feilding Palmer Hospital and the adjacent Lutterworth Medical Centre (and its resident 2x GP practices and supporting services). This would also significantly address/resolve any backlog maintenance issues in the current building.	Preferred Way Forward
2. Out of area sites	The provision of services could be provided in out of area NHS (or alternative) locations. This is not consistent with LLR strategy or the Lutterworth Healthcare Plan. This does not meet the appropriate CSFs.	Reject
3. Lutterworth Medical Centre	This medical centre, adjacent to Feilding Palmer, was considered but rejected, as space is currently at a premium and there are already considerable conflicting pressures on space, especially given the residential developments that are leading to an increase in population in the east of Lutterworth. This does not meet the appropriate CSFs.	Reject

Summary:

We have therefore established that the Preferred Way Forward (PWF) for the service provision is to provide community services in the local setting, that can be adaptable for the future needs of the local Lutterworth population (taking into account the increase in population in the Lutterworth East area).

We have also identified that refurbishing Feilding Palmer Hospital is the best solution and PWF for where and how the service provision above is to be delivered.

The results are summarised in the next slide.

Option Choices - broad description			
1a	Scope	What?	Coverage of the service to be delivered
1b	Scope	Where?	Where the service is to be delivered
2	Solution	How?	How this may be done
3	Delivery	Who?	Who is best placed to do this
4	Implementation	When?	When an in what form can it be implemented
5	Funding	£££s?	What this will cost and how shall it be paid for

Summary: What, Where, How?

1) SERVICE SCOPE: WHAT?

Option	Choice	Description	Conclusion	Result
0	0. Business as Usual Keep community beds closed	Business As Usual Service provision remains limited	Not fit for purpose, but c/fwd as the benchmark. C/fwd as benchmark.	Carry forward - BAU
1	1. No services required	Close Local Hospital Close community hospital for inpatient and outpatient services	Does not meet strategic aims. Reject.	Discounted
2	2. .Community Services Provision	Provide Community Services Keep community beds closed Provide services agreed in LLR healthcare plan: - Expand OP - Expand diagnostics - Provide access to pathways - Enable strategic alliances	Substantially meets strategic CSFs and correctly managed is deliverable, subject to site constraints. Prefered Way Forward.	Preferred Way Forward
3	3. Re-open Community Beds	10 Community Beds Re-open the community beds for Lutterworth area	Does not sufficiently meet CSFs Reject.	Discounted
4	4. New larger hospital	New IP community beds + LLR healthcare plan services provision	Does not sufficiently meet CSFs Reject.	Discounted

2) SERVICE SOLUTION: HOW? WHERE?

Option	Choice	Description	Conclusion	Result
0	Current (Business as Usual)	Use existing site without refurbishment	Ther required servces cannot be delviered from the existing site without significant spend/refurbishment. Reject.	Discounted
1	Feilding Palmer Refurbishment	Refurbish Feilding Palmer to meet current needs and provide flexible accommodation for future healthcare needs	Substantially meets the various CSFs and provides the best service deliver option. Various sub-options required for variations within FP to deliver the required services (to be assessed separately) Preferred Way Forward.	Preferred Way Forward
2	Expand to out of area existing sites	Provides services in fit for purpose locations, but outside of local provision	Does not meet the required standards, particularly around local provision. Reject.	Discounted
3	Lutterworth Medical Centre	Refurbish/extend the Lutterworth Medical Centre ,adjacent to the current Feilding Palmer site	Does not sufficiently meet CSFs Reject.	Discounted

Next Steps

The next steps include:

- Review and confirm the services to be provided in the refurbished Feilding Palmer Hospital
- Review the development options for the refurbishment to identify the solution which represents the best value for money
- Continue the Strategic Options Filter Framework with the internal project team to identify the Preferred Way Forward by assessing the following with against the appropriate CFS
    - Implementation (Strategic, Commercial, Management CSFs)
    - Delivery (Commercial, Management CSFs)
    - Funding (Financial CSF)

- Identify the short list of options, arising from the Strategic Options Filter Framework appraisal, for inclusion in the PCBC.

Attendees (via Teams, 29.03.23)

Attendee	Title	Organisation
Mike Achillea	Advisor	Beaumaris Consulting
Andy Bingham	Advisor	Beaumaris Consulting
Nikki Beacher	Deputy Director, CHS	Leicestershire Partnership Trust (LPT)
Joanna Clinton	Head of Strategy and Planning	LLR ICB
Giuliana Foster	Patient representative	On Behalf of Lutterworth Town Council
Carrie Harris	Planning Manager	LLR ICB
Graham Johnson	GP	Wycliffe Medical Centre
Vicki Quinn	Head of Business and Transformation, CHS	LPT
Susan Venables	Head of Engagement and Insights	LLR ICB
Matt White	Finance Lead	LPT

Appendix F

East Midlands Clinical Senate

Clinical Senate Review of the Community Services provided at the Feilding Palmer Community Hospital

Report of the Independent Clinical Senate Review Panel (29th June 2023)

July 2023

england.eastmidlandsclinicalsenate@nhs.net

Glossary of abbreviations

ICB	Integrated Care Board
ICS	Integrated Care System
IPC	Infection Prevention and Control
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
MDT	Multi-Disciplinary Team
PCN	Primary Care Network
UHL	University Hospitals Leicester

Contents

1. Foreword by Dr Ben Pearson, Clinical Review Panel Chair

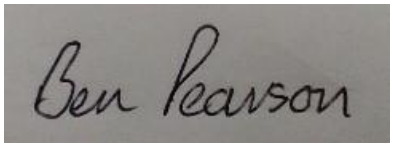
Clinical Senates have been established as a source of independent and objective clinical advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

Clinical Senates are minimally staffed and built on the voluntary engagement and goodwill of local clinicians and other health and care professionals to ensure that the wider NHS can benefit from this expertise and experience.

We would like to thank the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) and Leicestershire Partnership NHS Trust (LPT) for engaging with the Clinical Senate to bring independent, external advice and guidance to support the development and evaluation of the proposed service model for a community healthcare hub in LLR. It is with thanks to all colleagues who presented on the day and supported the panel's walk around of Feilding Palmer Hospital. The conversations with panel members in the afternoon were of great value.

It is also with thanks to our clinical review panel for their participation and continuing commitment and whose expertise was drawn from both the East Midlands and West Midlands Clinical Senates to ensure that the full potential of independent clinical advice could be maximised.

We wish the system success with its transformation plan, and we would be happy to offer further assistance if in any way required.



Dr Ben Pearson
Clinical Senate vice Chair

2. Clinical Senate Review Panel summary and key recommendations

The Clinical Senate wish to thank all who gave their time to take part in this review. The panel clearly saw the passion and dedication in all representatives present from the sponsoring organisations to drive improvement in community services for the local area which was commended. The information provided and conversations had during the day were very open and insightful which was greatly appreciated by the panel.

There was clearly a large quantity of work undertaken to get this programme to its current position. The engagement across a broad range of stakeholders from very early on in the programme was highly commended by the panel and taken as recognition of the importance of agencies and stakeholders beyond the NHS in the effective delivery of community services. The panel heard about an array of plans and work in the pipeline to bring innovation to the delivery of services to the local area, demonstrating a determination to do things differently. The drive to ensure patients receive the best possible services locally and support care closer to home was unquestionable with the wider delivery of community services across LLR providing valuable experience and support to influence plans in this locality. Patient travel was a clear and recurrent theme which the system wished to address by bringing care closer to home which aligned to national recommendations.

Overall, the panel were impressed and took assurance in what they heard through the day. However, this report details some areas of concern which the panel strongly recommend the system explore in more detail to support future work on this programme. The core of these concerns was the fundamental challenges and constraints presented by the Feilding Palmer building. The panel were concerned whether these can be realistically overcome or mitigated in a robust and affordable manner to deliver high quality care in the approach described during the review. The other main concern was regarding the lack of granularity of the plans. Many options appeared to still be on the table for consideration regarding service provision for the proposed refurbished site. This inhibited clarity on the actual content and functionality of the proposed community hub, meaning that limited conclusions could be drawn on its short and long term viability.

The system demonstrated an understanding of population health management. The panel would encourage the system to take this to the next level to refresh their thinking and ensure that population health was sufficiently profiled to allow for service delivery to be targeted to meet the priority needs of the whole population. The panel would encourage further exploration with local public health colleagues to consider potential hidden needs, those of the most vulnerable groups within the population and ways to avoid the risk of widening the health inequalities gap. The panel also encourages the system to change the focus of its messaging from an explanation of what was being lost to a positive message about what would be gained.

The workforce and infrastructure ramifications of the proposed plans are significant. The panel expressed concern regarding if these had been worked through in detail alongside planned service delivery to see if suitable solutions and mitigations were firmly in place.

Finally, the panel were unanimous in their conclusion that the 10-bed inpatient facility at the Feilding Palmer site should be permanently closed.

3. Background and advice request

3.1 Description of current service model

Admissions to the 10 bedded inpatient facility (including one palliative care suite) within Feilding Palmer hospital were suspended at the beginning of the Covid-19 pandemic in response to a review against the national Infection Prevention and Control (IPC) guidance. This had an impact on outpatient appointments and the community hospital beds. The specific challenges at Feilding Palmer are described in the case for change below.

3.2 Case for change

The Leicester, Leicestershire and Rutland (LLR) system would like to consult with the public to permanently close the inpatient ward, creating a community healthcare hub providing more outpatient activity, diagnostics and procedures to support more patients locally by bringing care closer to home which would reduce travel and waiting times[1].

Since the pandemic, when face to face activity was reduced due to social distancing and strict IPC measures, the services delivered from Lutterworth have reduced. This has had an impact on outpatient appointments and the community hospital beds at Feilding Palmer.

The Challenge

There are several key challenges for the inpatient facilities at the Feilding Palmer hospital which was built in 1899 (with later extensions) as summarised below:

Area	Challenge
Estates	- Beds do not meet all regulatory requirements. - Site does not give the flexibility of modern health care. - Backlog maintenance - £1.544m over the next 10 years (75% of this within the next 4 years).

[1] The case for change has been described to the Clinical Senate in written form and is copied verbatim here. This helps to shape the Terms of Reference at the outset of the process, which engages the Clinical Senate and the exact nature and ask of the clinical review team.

Clinical	- IPC standards cannot be met (bed spacing, sluice/dirty utility, handwashing and ward size). - Patient privacy and dignity challenges hindering provision of properly segregated single sex areas and wards.
Workforce	- Not an attractive location for staff (lack of managerial support onsite). - Building and environment makes it an unsuitable place to deliver inpatient care. - Filling shifts on the inpatient ward were always a challenge. - Workforce preferred to provide care in more modern facilities. - 2 Registered Nurses (RN) and Health Care Assistants (HCA) for a 10 bedded unit is significant resource. This is against a system context of high turnover, retention of staff, carrying high vacancies.
Financial	- Inefficient workforce model: 2 RNs and 2 HCAs for 10 beds. - Running costs are high – disparity to other LLR facilities – not an effective use of taxpayers' money.

When the ward was open, at any one time there were only 2 or 3 Lutterworth patients occupying the beds in Feilding Palmer with the remaining beds being occupied by patients from elsewhere in LLR.

Despite the temporary closure of the inpatient ward, patients from Lutterworth can access a wide variety of services based upon their care needs. Patients requiring medical rehabilitation with significant 24/7 nursing care are supported in an alternative LLR community hospital bed or, in a 'Pathway 3' reablement bed for patients with lower medical needs. The Home First service in LLR also provides integrated health and social care crisis response and reablement services. For patients requiring reablement, they deliver intensive, short-term care for up to six weeks. Home First services are accessed via Locality Decision Units, with health and

social care services working based on trusted assessment and delivering coordinated packages of care.

Population Growth

Within the next 5-10 years, there will be significant housing growth within Lutterworth because of the Lutterworth East Sustainable Urban Extension[2] (SUE), resulting in 2,750 additional dwellings (an estimated 6,710 residents). This will increase Primary Care activity and demand for outpatient activity. Patients are currently travelling out of Lutterworth to other hospital sites within LLR and across the borders into Coventry and Warwickshire to receive their outpatient care (40 minutes to Leicester (LRI), 20 minutes to Rugby (Hospital of St. Cross), 27 minutes to Coventry (University Hospitals Coventry and Warwickshire)).

Prior to Covid-19 the following services were running from the facility:

- 10 community inpatient beds
- Cardiology outpatient appointments
- General surgery outpatient appointments
- Gynaecology outpatient appointments
- Community paediatric outpatient appointments
- Physiotherapy
- Out of Hours access

The LLR proposal is to repurpose the inpatient ward space to provide an enhanced procedure suite along with additional consulting rooms. The specialties that could be carried out from the facility are:

- Ophthalmology
- Gynaecology
- Trauma and Orthopaedics
- Cardiology

[2] SUE is defined as separate neighbourhoods that incorporate local centres, employment and other facilities, whilst being integrated with existing communities and built-up areas, supporting the town as a whole.

- General Internal Medicine
- Rheumatology
- Dermatology
- Respiratory medicine
- General surgery
- Physiotherapy
- Urology
- Out of Hours access
- Community paediatrics

A formal options appraisal process has been conducted which has concluded that the preferred way forward is to permanently close the inpatient beds at Feilding Palmer to allow for a refurbishment of this site which will bring about an expansion of outpatient activity and diagnostics, support access to specific pathways and enable strategic alliances to function.

3.3 Scope and limitations of review

The areas in scope of the review are all community services provided by the LLR system which changes to the service provision of the Feilding Palmer facility could potentially impact upon. The clinical review team acknowledge that the inpatient beds at the Feilding Palmer site have been closed for over 3 years with this service need being met elsewhere in the system. Thus, the focus was not on determining if these beds should reopen but firmly on if sufficient, robust and appropriate services had been put in place and/or included in the community healthcare service plans to fully meet the needs of the Lutterworth population served by LLR.

Specifically, the clinical review team was asked to review the information provided by Leicester, Leicestershire and Rutland (LLR) ICB, with support from Leicestershire Partnership NHS Trust (LPT) to consider the following key areas:

- *Is the refurbishment of the Feilding Palmer facility and revised community service model likely to address the challenges reported at the Feilding Palmer*

facility and deliver a positive impact on the quality of care of the local population and are there any factors that have not been considered?

- *Has the closure of the 10 bed inpatient facility at the Feilding Palmer site been appropriately mitigated in the planned expansion of the community services across LLR (with specific reference to community clinics expansion at the Feilding Palmer site)?*
- *Does it align to best practice, national guidance and direction of travel for the provision of community services?*
- *Are there any unintended consequences or risks that have not been identified and mitigated in the proposal (including any impact on populations currently accessing the services provided or peripheral service provision)?*
- *Has it considered the demographics of the population served, taking into account the needs of that specific population and ensuring equity of access and a positive impact on health inequalities?*
- *Does the proposed model appropriately consider predicted demand for services and provide sufficient flexibility and adaptability to meet these needs?*

4. Methodology and governance

4.1 Details of the approach taken

The sponsoring organisations (Leicester, Leicestershire and Rutland (LLR) ICB with support from Leicestershire Partnership NHS Trust) engaged with the Clinical Senate on 16th February 2023 (Jo Clinton, Head of Strategy and Planning and Carrie Harris, Planning Manager (Strategy and Planning), Leicester, Leicestershire and Rutland Integrated Care Board (ICB)) and Emma Orrock (Head of Clinical Senates). It was agreed that a full day's review would be required (9.30am to 4.30pm) to assess the proposed permanent closure of the Feilding Palmer inpatient beds and planned community hub and subsequently, the 29th of June 2023 was identified for the clinical review panel. Panel members and patient representatives were identified from the East Midlands and West Midlands Clinical Senate Councils and Assembly memberships.

On the 21st of June the Clinical Senate received direct correspondence from an individual stating they represented the local group called The Mary Guppy Group. The Head of Clinical Senates informed the ICB with permission from the Group. This is a fairly rare occurrence for the Clinical Senate to be contacted directly by a local group representing patients and the public, however, it was agreed that the additional papers provided in their email correspondence would be shared with the panel for their consideration along with the covering email. The ICB advised the Clinical Senate that The Mary Guppy Group are a member of their steering group and the ICB plan had been presented to the group as part of their local pre-engagement. The panel were asked to give appropriate consideration to the additional evidence with particular involvement from the Senate panel's patient representatives. The Clinical Senate thanked the individual for their correspondence and confirmed to them that the Clinical Senate had been engaged on a very specific basis through an agreed Terms of Reference as an independent clinical advisory body who will provide an opinion on the ICB's proposed model. The Senate review report is not published by the Clinical Senate until the express permission of the sponsoring organisations is given and as set out in the agreed Terms of Reference. As the body who has statutory responsibility for public and patient engagement the Senate directed the individual accordingly to the ICB.

The panel member representing Local Authorities had to withdraw from the panel less than 24 hours before the review meeting, preventing the identification of an alternative representative. A Local Authority Director of Adult Social Care who is also a West Midlands Clinical Senate Council member reviewed key elements of the evidence submitted and provided some key questions to the Head of Clinical Senates prior to the review (which was discussed in advance with the panel Chair). These were fed into the question and answer session on the day to ensure that key Local Authority input was still provided to the review.

A draft report was sent to the panel members and the sponsoring organisations to check for matters of accuracy. The final report was submitted to the Senate Council (and ratified on 20th July 2023).

This report was then submitted to the sponsoring organisations, Leicester, Leicestershire and Rutland (LLR) ICB and Leicestershire Partnership NHS Trust on 21st July 2023. This was somewhat earlier than the timeline agreed in the Terms of Reference due to the quick turnaround by the Senate team and sponsoring organisations within the process.

The East Midlands Clinical Senate will publish this report on its website once agreed with Leicester, Leicestershire and Rutland (LLR) ICB and Leicestershire Partnership NHS Trust. The anticipated publication date is 31st August 2023.

4.2 Original documents used

The full list of documents provided by the sponsoring organisations for the clinical review panel can be found in Appendix B. The documents covered the clinical case for change and various elements of service provision in Lutterworth where Feilding Palmer is located. Documents from the original submission and an additional submission on 23rd June following feedback from the panel pre-meet on 16th June are detailed. Three additional documents received on behalf of The Mary Guppy Group are also itemised in Appendix B.

5. Key findings from the clinical review

The Clinical Senate panel Chair opened the day with thanks to the sponsoring organisations for hosting the clinical review team. The Chair extended thanks to the review panel for dedicating their time to attend and sincere appreciation to the sponsoring organisations for the significant amount of work that was evident to the panel in the breadth and volume of evidence submitted.

The Chief Officer of Strategy and Planning (LLR ICB) opened the executive presentation by providing some context for the current position. They described Lutterworth as a market town with around 11,000 residents, served by two GP practices with 16,600 registered patients between them. They described a large development which was planned on the east side of the town that would include a minimum of 2,750 new homes and approximately 6-7,000 new residents. This represented a considerable population increase over the next 15 to 20 years. This was a key driver for the changes to the provision of community services, ensuring that a plan was in place which was both right for the current population and would meet future needs.

The Chief Officer talked about the strategic direction for the ICB which had transferred over from the CCG as being care closer to home. The “Home First” programme was discussed with the focus being on services such as mental health, end of life care and integrated teams. The purpose of the service redesign was to ensure that the strategic vision was delivered effectively at a local level. Patient travel was identified as a core element of this work. Post Covid-19, a new community model for Lutterworth was deemed a priority with a steering group put in place. This involved key community groups as stakeholders. It ensured that the model of care was co-designed with the local population engaged throughout the process to design a community hub that would increase usage of the Feilding Palmer facility across a broader range of the population. They stated that the involvement of a large number of people in the development of the proposal had led to a lot of support clinically and from the community. They stated that the need for an alternative use of the facility and different ways to deliver services had come about in part because of a recognition that only 2 to 3 patients from the local area were using the inpatient

facility pre-Covid-19 with the rest coming from the wider LLR area. This did not align to care closer to home. The new service model for Lutterworth would expand primary care to support both the capacity needed following the housing expansion and also the new roles and services primary care are now asked to provide. The new model would also expand outpatient capacity and capacity for services such as minor procedures closer to home.

The Director of Strategy and Partnerships went on to state that LPT own the Feilding Palmer building which they want to repurpose as a health campus with all NHS services on site. They stated that an alliance was already being built. They described the impact of the Covid-19 pandemic and the “wake up call” it had given the team with the total inability to meet the IPC guidance on that site. It had afforded them the opportunity to rethink how care was provided in this facility given the stark and considerable challenges the facility presented. These challenges were described in detail and were extensive. They covered a multitude of core NHS service requirements from privacy and dignity to the basic challenge of not being able to move a bed around the facility; requiring patients to be moved onto trolleys in order to move them around the site. It was stated that these constraints were such that no options existed to make internal alterations to the building that would enable it to comply with modern healthcare requirements such as IPC and privacy and dignity. This meant that the delivery of inpatient care from this facility was not possible. The running costs of the facility were described from both a maintenance and ongoing resourcing perspective to demonstrate that it was a very expensive and inefficient model that did not represent value for money. This included the workforce needed to run the facility where it was stated that there were constant challenges attracting staff to work at the facility, leading to a lack of consistency in staffing which did not impact positively on service delivery. It was stated that there is a strong commitment to having good community hospitals to align with the changing population and changing ways of working.

It was stated that partners such as adult social care were involved in conversations regarding wrap around services. It was stated that alternative community hospital provision was in place for patients who needed that level of care. There was a detailed description of the services which could be located in the community campus

once in place. A clear desire to ensure flexibility was articulated. This was stated as critical to future proof services due to the local needs changing rapidly over time along with the evolving available and recommended clinical enhancements.

A local GP partner provided a detailed explanation of the current set up of primary care in Lutterworth with both practices being part of a PCN along with three other practices in LLR covering 47,000 patients in total. They stated that both local practices and the PCN were supportive of the proposed model. They described their personal experience of working in the Feilding Palmer facility and reiterated the low usage of this facility by the local population with bed usage stretching across the entirety of LLR to make it work historically. They described the extensive travel currently required by a large proportion of Lutterworth patients for outpatient services both within LLR and into neighbouring ICS geographies with very poor public transport links to support patients. They described particular services such as ophthalmology, rheumatology and mental health where treatment was often required every few weeks. This required regular travel by patients with conditions that impacted on their ability to do so easily. They stated that a large number of such procedures could be conducted locally if often low-tech equipment or facilities such as a clean room were installed in the community hub, or if wrap around services were present in the locality. This would support many agendas including a significant decrease in the carbon footprint of the services. A description of the Lutterworth population was provided with the new housing development expected to mirror that of developments seen in the last 10-15 years, bringing a further influx of families and patients under 75. Their needs are predicted to be heavily weighted towards primary care and diagnosis with less need for inpatient care and step-down care. It was stated that the volume of patients that would make use of the services in a community hub for outpatient services or diagnostics would vastly exceed any need for inpatient services even if it were viable. This would increase the value for money of the site significantly.

It was stated that there was an increasing body of evidence regarding the risks of deconditioning for elderly patients in inpatient facilities with a strong emphasis on the importance of mobilising these patients at the earliest opportunity to enable a return to their homes. The benefits of adjacencies between primary care and consultants to

enhance and expand the work carried out in primary care was described. The benefits of a community healthcare services campus for patients were described with travel, parking and waiting times specifically mentioned. There was a description of how the proposed model meets each of the five key tests of the NHS.

Following the executive presentation there was a question and answer session with the panel which is summarised below.

The panel heard that work was being done to look at the potential for a one stop shop approach and how the community diagnostic strategy fits with the integrated care strategy. A specific example was given regarding the cardio-respiratory pathway. A programme was planned for implementation in the next two months at PCN level in 17 locations across LLR. This would deliver key diagnostics local to home. Current services such as echocardiograms and ultrasounds were being delivered by independent sector providers. It was stated that this gave sufficient capacity across the county but was not as local as it could be which the new provision would address. It was stated that there were no radiology services locally at the time of the review, but other close neighbours had this service. The desire to utilise more mobile imaging services and expand this was expressed. Currently, mobile services could be anywhere in LLR which could have significant travel implications. Thus, plans would bring mobile services to more local destinations. The development process was likened to building a jigsaw around the area to piece together the services in an appropriate manner. This was said to be supported by patients and GP feedback and would also support reductions in waiting times. It was stated that though the plans would not introduce one stop shops in their purest sense, it would bring diagnostics and outpatient clinics closer to home which would reduce the frequency that patients had to travel outside of the local area in their pathway.

The panel asked if the expansion of the community services and aspirations described would include traditional community services in the shared spaces. It was stated that the healthcare hub would include all community services. Community nursing offices were currently in Enderby, but the plans would allow space for health and social care to be brought together which would increase the scope for an MDT

approach. It was stated that the extensive travel time was strongly linked to the high level of vacancies in the Community Nursing team. It was hoped that having this local touch-down point would help address this. The panel heard that the “Home First” partnership worked collaboratively in a virtual ward approach. This was available for several pathways with a desire to expand this into falls and care homes being articulated. A pilot for palliative care was mentioned to support reduced entry into acute care. The core aim of the virtual wards was to prevent unnecessary hospital admissions and increase step-down care away from this setting. It was stated that the number of beds across LLR had been increased prior to last winter with another increase planned prior to this winter which will further support an increased offer across the board for patients.

The panel heard that Lutterworth is close to the centre of England, surrounded by excellent transport routes which results in it being a massive distribution hub for businesses which continues to expand. This was felt to attract a population that would not be largely home workers, rather would have jobs in this industry and their warehouses. It was stated that whilst Rugby was in a different ICS boundary, they were also focussed on place-based plans to expand care in their local area and reduce the patient footfall into the large acute trusts, supporting the patient choice agenda. The panel heard that clinical networks were under development across disease specific areas to support IT connectivity and the sharing of diagnostic data; further supporting the patient choice agenda. This was a Midlands wide project.

The panel enquired about the support to families to reduce their travel for patients in palliative or end of life care. The panel heard that an integrated specialist palliative care team was in place which worked with the community nursing team. It was stated that there were beds available 11 miles away in Hinckley and also facilities in Market Harborough to support these patients along with the nursing home support in place locally. The specialist Hospice LOROS existed across the other side of Leicester which some patients choose to use. Historically, there was one bed in Feilding Palmer for this service which was not efficient to run. The loss of this very limited resource had not been missed due to the provision of MDT style wrap around care in the community. If the patients’ needs were greater than the current provision could support, it would also be too great for Feilding Palmer to have met historically and the

patient would need to enter hospice care. The panel heard that terminal care was available in residential care homes. Both care homes and nursing homes were on a framework to support and upskill staff to manage such patients. The number of beds in these settings has increased in the last 18 months and there is a commitment to support further development.

The panel heard that the Local Authority was a key member of the steering group which included domiciliary care, public health and prevention services with the prevention agenda being a core part of plans as they progress. It was stated that the co-location of services would be a positive step with health and social care being on one site and no longer scattered as they currently are. It was stated that the panel walk around of the Feilding Palmer site would help demonstrate that it could accommodate all the services suggested.

The panel heard that the system executive team meet fortnightly. This group includes the Chief Executive Officers, Directors of Strategy and Directors of Finance from the three constituent NHS organisations (ICB, LPT and UHL). Discussions include the affordability of proposals in the current climate, a look at financial modelling and the prioritisation of work programmes. It was stated that this project had been identified as the top priority for capital spend and had been deemed affordable. There was a description of the Leicester Royal Infirmary re-organisation in progress and the commitment to sustainability across all three organisations. It was stated that if 50% of the Lutterworth outpatient activity was repatriated back to the local area, this would save over 300,000 miles travelled by patients a year. This looked beyond the NHS saving and into what it means for the patient experience. It was stated that there was experience of community diagnostics being provided more locally, having been achieved recently in neighbouring areas. This was stated to demonstrate that the benefits are achievable.

The panel heard that the evidence submitted for this review was focused on a part of the overarching LLR community services plans that Feilding Palmer link into and the system had not described the full list of community services which are already in place in LLR in homes or schools for example. With the population health in mind and the predicted future population makeup, the system stated they were clear on

the opportunities in primary and secondary prevention across the life course of the population. They stated that they planned to increase services such as health visitors as the population changes over time. It was stated that conversations around such areas were occurring. The current population was described as higher than the national average for over 65 years of age in the largest GP practice, thus a high number of long-term conditions and chronic disease existed which require diagnostics and outpatient facilities. The gradient in deprivation prevalent in LLR was mentioned along with a desire to avoid generalist strategy conversations around health inequalities by ensuring they are instead appropriately nuanced. The importance of ensuring that strategic plans include how the progression and advancement of multi-morbidity affects patients was mentioned.

The panel heard that ophthalmology was the service with greatest need for outpatient capacity (quoted at one-third of all outpatient activity), making it a critical service to provide locally. There was a discussion regarding the staffing needs and skill mix to realise the aspirations around activity increases. It was stated that LLR did not have a problem recruiting staff and that staff liked to work close to home but there was an issue attracting medical staff to the Feilding Palmer site in its current state. It was stated that a revamp of this site was hoped to address staff willingness to work there.

The panel heard that the system had invested a lot of time in community engagement to talk through proposals and ensure parties understood the model. Originally the local MP had concerns about the possible closure of the site/beds but they are now supportive of a model that provides more community based clinics following a detailed explanation of the rationale behind it. Regardless of the facility in use, it was explained that given the size and needs of the local population there is no need for an inpatient facility in Lutterworth as demonstrated by local utilisation of the beds in the Feilding Palmer facility pre-Covid-19.

The panel heard a description of the community pharmacy provision in Lutterworth. Both pharmacies close at 6pm on weekdays with only one being open on a Saturday until 3pm. There was no pharmacy provision on Sundays. GP practices do not have a dispensing service. There have not yet been discussions with these pharmacies regarding the plan to expand services and the availability of the medications

necessary for patients attending these services. The closure of community pharmacies being seen nationally was identified as a risk by the system. There was a discussion about the significant cost increase of outpatient prescriptions outside the acute setting. The system was looking at ways to meet this need beyond community pharmacy and stated that community pharmacy commissioning moving to ICBs will help the development of future plans. A pilot was being introduced to look at delivering medications directly to patients' homes for specific drugs.

The panel heard that the system did not have any concerns regarding ensuring that the workforce can increase to meet demand and service expansion. They articulated a clear commitment to increase services in line with population increases and demand. Support from the alliance and repatriation of the workforce was mentioned with staff groups operating more as an MDT. It was stated that the workforce plan was being led by UHL. It was stated that new ways of recruiting must be employed as traditional methods were less effective. It was stated that not all care needed to be consultant led and that different ways of working such as GPs with specialist interests (GPwSI) and Advanced Practice for non-medical clinicians was being developed to support growth in the community facility. The use of the independent sector such as high street optometrists was also described. The evaluation of activities unnecessarily carried out in theatres was described with support to move this activity into a more appropriate setting with the workforce being used more effectively. It was stated that current experiences of changing the workforce had given the system confidence that their plans were achievable. A medium to long term view was being progressed to look at ways of growing talent and developing the local community to become the workforce of the future.

The panel enquired about the support in the system to ensure that rehabilitation in care homes was robust to avoid the conversion of patients into residents. The panel heard that community beds were still available for the right patients to use. It was stated that the region was recognised as high performing in terms of short delays for patients exiting acute care with good sustainable outcomes. It was stated that LLR currently had a 350 gap in acute beds which would, in part, be addressed through effectively using rehabilitation facilities and ensuring patients were sent into the correct services. It was stated that there was a lot of work needed to improve this. It

was stated that evidence has shown that rehabilitation in care homes in LLR had good outcomes and a drive to continue to improve this was articulated. A new procurement to increase discharge to assess beds and strengthen reablement in care homes was mentioned. It was stated that Local Authority colleagues were being brought into this process to make the assessment more robust.

Following the question and answer session, the panel were taken on a tour of the Feilding Palmer facility. The panel then split into two groups to meet with a range of staff involved in the community service. The Senate had requested to meet frontline clinicians and staff who had been or would be impacted by the closure of the Feilding Palmer beds and the proposed future model. It was noted that the afternoon groups did not include any such staff and were smaller than had been detailed to the Senate. The themes of these conversations are provided below:

- The panel heard that the proposal was not what would be desired for community services in the area if the current estate did not exist. Partners were clearly united in agreeing on the proposal but it was felt to be more of the best compromise rather than best option.
- The panel heard all members of staff agree that Feilding Palmer was not fit for purpose and a clear desire for care to be delivered locally, closer to home.
- The panel heard that regardless of which option was progressed, staff felt there was a gap in Lutterworth community services which needed addressing.
- The panel heard that the system is looking at outpatients through a different lens and consequently looking at a different workforce. The panel heard a variety of mechanisms including training pathways and supporting advanced practice being explored to create the workforce needed. This was described as a need to “think outside of the box”.
- The panel heard about work to address digital technology issues where problems are foreseen in the immediate future but improvements are occurring. The staff were clear that they will face difficulties as they “push the envelope further” but the benefits in progressing services made it an important step.

- The panel heard lengthy descriptions of ways to run services differently in terms of procedures and pathways, locations/co-location and workforce that were being discussed internally and worked through.
- The panel did not see or hear any data or information specific to Lutterworth patients. However, the panel heard that 7 other sites in LLR had successfully delivered community services closer to home for their locality which was felt by staff to demonstrate it was possible in Lutterworth.

The day concluded with high level feedback from the panel Chair which is detailed in section 6 below.

6. Conclusions and advice

The Chair drew the day to a conclusion, consolidating the panel's opinions from the written evidence and information gathered on the day. The panel looked to answer the questions posed in the Terms of Reference that had been agreed with the sponsoring organisations. The aim of the conversations throughout the day had been to provide the clarity and detail necessary to convince the panel that the proposals are the right way forward for the system. The questions posed in the Terms of Reference and challenges faced are multifaceted. Thus, the panel's conclusions below are split into the key defined areas. The passion and desire to drive change was clear across all members present from the system. This was laudable. However, upon speaking to individuals, the clarity on the specifics and, in essence, what the system would be consulting the local population on seemed less clear.

The Closure of the 10 Bed Inpatient Facility at the Feilding Palmer Site and mitigations

The panel were fully assured that the Feilding Palmer site was not fit for modern day healthcare, that the inpatient beds should remain closed and that there was no need identified for an inpatient facility in this locality. No evidence was submitted which indicated that these beds were fully utilised or in the right place for either the Lutterworth population or wider LLR area. The panel fully appreciated the enormity of the constraints presented by this site on multiple levels including fundamental "deal breaker" issues such as compliance with IPC guidance, privacy and dignity and even equitable access and patient safety due to the basic layout of the building.

The panel were not completely clear on what services specifically had been provided by this inpatient facility historically. Only a high-level snapshot of previous inpatient diagnoses had been provided. Thus, the panel could not be fully assured that the loss had been completely mitigated in the wider LLR service provision. However, the panel felt confident in the services described across LLR and the availability of appropriate community beds to be unconcerned on this point, whilst acknowledging that this did not address the patient travel issues described during the day in the short term.

The Refurbishment of the Feilding Palmer Site

The Feilding Palmer site was clearly an asset to the system which should be made best use of. The panel heard a clear emphasis on what could be done differently with the building with a clear steer towards increased outpatient activity. The panel heard many options for delivering outpatient care differently and would encourage the system to ensure that these ideas are forward thinking including things such as Patient Initiated Follow Up as opposed to the traditional NHS follow up mechanisms. The panel explored with both groups during the afternoon how community services would work if Feilding Palmer did not exist and would something different be required in this locality with a resounding “Yes” clearly heard. However, it is a Victorian building with all the significant challenges and constraints that come with its age and design. These appear to be particularly acute in this situation which led to concern from the panel regarding if anything of sufficient capacity and flexibility could realistically be created, to bring the site up to the necessary standards for today and most definitely for the future. There was concern that persistent problems with the fundamental structure could hamper the level of service delivery the system clearly aspires to.

The panel expressed concerns that the cost to refurbish this building to the necessary standard to deliver high quality modern healthcare across the services described would be significant. Caution must be applied to ensure this is not underestimated, with the potential to unintentionally overpromise and underdeliver. Likewise, the ongoing cost of the facility to both maintain it and allow evolution of services as populations, demands, pathways, best practice, technologies etc change in the next 5/10/15 years was also likely to increase. It was clear that if money were no object, the plans would be very different. However, all partners had reviewed the proposed options, with refurbishment being the preferred compromise, strongly driven by the constraints of the building and affordability which the panel felt was very understandable and pragmatic. The panel reflected that there may be additional options not described which would make best use of a refurbished facility with stronger future proofing in mind. The panel suggested that the system would benefit from challenging itself on the cost effectiveness of the model now and over the next 15 years, evaluating the true value for money and both patient and staff needs of fitting everything within the plan into one Victorian building. The panel encouraged

the system to reflect upon a strongly forward-facing view and question if the future direction of travel for the delivery of outpatient services in the next 10-20 years is reflected boldly and robustly enough in its current plans.

The system's proactiveness to use the "wake-up call" following the necessary closure of the facility during Covid-19 to reflect and rethink healthcare provision in the locality was laudable. The panel agreed that there is a gap in community service provision in Lutterworth and also agreed with the principles discussed during the day regarding the need to provide community services differently to meet the nuanced needs of the local population. This needs to be both for now and for a carefully forecasted future population.

The Revised Community Services Model

The panel commended the collaborative nature of the system's processes which had ensured that a broad range of partners had been included in the development work from its infancy. The work with the alliance was clearly integrated and well established. The alliance was understood to be a central pool of UHL staff who then operate as a roving team to support a range of off-site services to provide a standard approach. The panel strongly believed that the engagement and collaborative work was an asset to this programme and would be a very positive factor in the future success of working differently. It was recognised that a large proportion of community care takes place outside of the NHS. Thus, involving key stakeholders beyond the NHS to look at wider local providers in the community was clearly an important and vital step.

The panel acknowledged the success of LLR in establishing a convincing community rehabilitation and reablement service, wrapping MDT teams around the patients and the "Home First" model. The panel believed that this would naturally be beneficial to the population of Lutterworth and the experience of the system would support this work. However, the panel did not feel that they had seen a detailed model specific to Lutterworth. The panel noted a general lack of data in the evidence provided meaning that the granular detail relating directly to Lutterworth patients was missing. The panel urged the system to ensure that data and narrative presented in any future business case and consultation documentation clearly explains the information from

both an LLR and Lutterworth perspective in great detail. The panel were impressed with the level of understanding shown with regard to population health management and demography of the population. However, the panel suggested that a fresh look at the available data would be beneficial to robustly map out the population's needs now and at 5 year intervals into the future. The final offer put forward should reflect the needs of the entire population with clear initiatives to ensure services are nuanced and targeted to bridge the health inequalities gap, supporting those most in need. With this as the cornerstone, plans would be focused on the changing needs of the population, rather than the risk of focussing the plans on what can be accommodated and provided in the available estates first and foremost.

The panel heard a vast array of potential options for services to be delivered from the redesigned community hub covering a huge number of outpatient services, social care services etc. The panel heard that the vision was for all health and social care services to be co-located in one hub. In light of this the panel expressed concerns on a number of points:

- the size and the fundamental footprint and structure of the actual building was such that there were significant concerns regarding its ability to house the quantity of services in a flexible and adaptable manner that would not result in the facilities becoming outgrown or outdated rapidly.
- the current lack of clarity of the specific location of services. Thus, the interdependencies and effect of co-location of services was a significant unknown which poses risks and potential unintended consequences if not clearly defined with input from the services and stakeholders involved to carefully work this through.
- the ability of the infrastructure of the town and site to cope with the influx of traffic and people if the planned increase in activity was realised.
- the fundamental structure of the building and potential risks around equitable access for all patients. The panel considered the scenario where you have a wheelchair user and a patient using crutches attempting to pass each other in the corridors. Would the building be able to cope with a large increase in footfall?

- the risk of widening health inequalities, particularly hidden ones, which are known to be prevalent in the incumbent population if services are not carefully targeted.

The panel were supportive of the overarching plan and need to redesign community services. However, there was a lack of clarity and granularity of detail regarding all aspects of the final proposed hub to assure the panel that this option was both viable and the right way forward. The high volume of options still under consideration combined with uncertainty about the exact outpatient services and procedures to be provided with phased timescales, left the panel unclear on what the local population would be consulted on. The panel strongly suggested that this detail is firmly and robustly articulated in preparation for the business case and that a final option is presented which includes the definitive list of services which would be located on the site. The panel also suggested that prior to any further consultation, any documentation was carefully worked through to ensure that all the questions heard previously or envisaged are answered in detail to provide a coherent and very specific picture to patients. This would avoid further confusion, allowing patients to understand their specific circumstances at a pathway/service level and determine what the implications for them would be, even if this would be travel to a service out of Lutterworth. The panel also recommended that consultation shifts its focus from what was happening following the loss of a facility to be focused on what will be gained by the proposals and the positive impact for the locality to support a shift in mindset.

Unintended Consequences

In support of the principles laid down during the review visit the panel wished to highlight the following potential risks and unintended consequences to ensure they were on the system's radar:

- workforce was a large factor with many potential unintended consequences and risks from repatriating staff or changing staff working patterns. UHL are carrying many vacancies. If specialist support from the acute provider was required at the community hub or staff moved across to support services in Lutterworth, there would be a risk to the stability of acute services where vacancies are more challenging to fill.

- whilst the panel heard a high level of confidence regarding LLR's ability to recruit staff, a lot of faith was placed on the attractiveness of a revamped/refurbished site. There was a risk that this may not have the intended positive impact, with the changes not creating the level of interest required to secure the necessary workforce. The panel were not assured that there was any mitigation should the latter be the case.
- the panel highlighted the risk of widening the health inequalities gap through the provision of all health and social care services in one very specific location which may benefit the majority of the population but not represent targeted enough service delivery to support the most vulnerable and in need members of the community.
- the panel felt that engagement overall had been very good. However, more clarity and detail needed to be provided to ensure support services such as pharmacy and social care had sufficient time and capability to put in place mechanisms within their own services to adapt and evolve as needed for the change in service provision within Lutterworth. Otherwise, gaps in care and service provision will negatively impact on the overall provision of community services.

Workforce

Workforce was a recurrent theme throughout the day. The panel were assured to hear the innovative system thinking regarding both programmes to build a new workforce for the future and thinking about effective and appropriate use of the current workforce to deliver the right care in the best location. The panel acknowledged the large numbers of vacancies being carried by organisations and shortages across several professional groups nationally. However, the panel felt that it had not heard or seen sufficient detail nor evidence to share the system's level of confidence that the expansion of services planned could be robustly staffed now nor safeguarded for the future.

7. Recommendations

7.1.1 Recommendation 1

The panel recommend that the inpatient facility on the Feilding Palmer site remains closed permanently and that future plans for community service provision in Lutterworth do not include inpatient facilities (based on current evidence of provision and population need).

7.1.2 Recommendation 2

The panel recommend that the system reflect on the volume of potential services planned for delivery from the Feilding Palmer site; to take a future view, working through each service and consider all aspects from finance, infrastructure, patient demand and volume, required adjacencies and implications to patient experience and need. The outcome should determine what is viable, cost effective and sensible for the present and future of community services. This should consider the national steers and best practice.

7.1.3 Recommendation 3

The panel suggest that the system refreshes an analysis of the local population health data to look at the present and future population modelling to understand the nuances in less visible population health needs and health inequalities. This should inform decisions regarding patient needs and service provision to ensure no future plans unintentionally widen the health inequalities gap.

7.1.4 Recommendation 4

The panel recommend that the system ensure that the data and narrative presented in the business case and consultation documents is highly detailed, covering both the wider LLR geography but very specifically the Lutterworth patient population. This should provide a significant degree of clarity for patients to understand the impact on them as individuals and for all involved in the project to have a robust understanding of what is proposed.

7.1.5 Recommendation 5

The panel suggest that workforce development considerations are expanded to include the impact on the wider system of repatriation of staff into Lutterworth (with particular reference to the acute provider) and mitigation for potential ongoing unwillingness to work at the Feilding Palmer site post refurbishment.

Appendix A: Clinical Review Panel Terms of Reference

CLINICAL REVIEW TERMS OF REFERENCE

Title: Clinical Senate Review of the Community Services Provided at the Feilding Palmer Community Hospital

Sponsoring Organisation(s): Leicester, Leicestershire and Rutland (LLR) ICB with support from Leicestershire Partnership NHS Trust

Clinical Senate: East Midlands

NHS England region: Midlands

Terms of reference agreed by:

Name: Emma Orrock/Ben Pearson **on behalf of clinical senate and**

Name: Jo Clinton/Sarah Prema and David Williams **on behalf of sponsoring organisation(s)***

Date: 6th April 2023

Clinical review team members

Chair: Dr Ben Pearson, Consultant Geriatrician and Executive Medical Director, Derbyshire Community Health Services (DCHS) NHS Foundation Trust and Clinical Senate vice Chair

Panel members:

Name	Role	Organisation
Anne-Maria Newham	Deputy Chief Executive Officer	Nottinghamshire Healthcare Foundation Trust
Claire Greaves	Divisional Director, Ambulatory Care Division	Nottingham University Hospitals NHS Trust

* Written email confirmation approving these TORs must be received by the Head of Clinical Senates from each sponsoring organisation by the named person in these TORs or their nominated deputy/deputies.

Ian Lawrence	Clinical Director for integration Chief Clinical Information Officer	Derbyshire Community Health Services Foundation Trust (DCHS)
Jane Youde	Consultant Physician	University Hospitals of Derby and Burton NHS Foundation Trust
Jason Evans	Acting Chief Officer for Integrated Urgent & Emergency Care, West Midlands Region	Black Country ICB
Jo Watson	Assistant Director of Nursing & Workforce	NHS England
Kat Telford	Medical Educator	University of Nottingham
Kerry Bareham	Nurse Consultant	St Barnabas Lincolnshire Hospice
Mandy Clarkson	Deputy Director Public Health	NHS Midlands
Paul Jenks	Chair, Community Pharmacy Lincolnshire Chair, National Pharmacy Competency Group Vice Chair, Lincolnshire Primary Care Advisory Group	Lincolnshire Community Pharmacy
Paul Midgley	Patient and Public Involvement representative	East Midlands Clinical Senate Council
Salil Parkar	Therapy lead Inpatients	NHS Birmingham Community Healthcare NHS Foundation Trust

Sarah Raistrick	GP	NHS Coventry and Warwickshire ICB
Saul Hill	Integrated Community Manager	Derbyshire Community Health Services NHS Foundation Trust
Susan Edge	Patient and Public Involvement representative	East Midlands Clinical Senate
Suzanne Avington	Associate Director Allied Health Professionals	Nottinghamshire Healthcare NHS Trust

Background

Prior to the COVID-19 pandemic the following services were running from the Feilding Palmer facility:

Services
10 community inpatient beds
Cardiology outpatient appointments
General Surgery outpatient appointments
Gynaecology outpatient appointments
Community Paediatric outpatient appointments
Physiotherapy
Out of Hours access

Admissions to the 10 bedded inpatient facility within Feilding Palmer Hospital (including one palliative care suite) were suspended at the beginning of the Covid-19 pandemic in response to a review against the national Infection Prevention and Control (IPC) guidance. This had an impact on outpatient appointments and the community hospital beds.

The facilities at Feilding Palmer do not meet all regulatory requirements. The Victorian Cottage Hospital still retains much of the feel of an historic building which does not give the flexibility of modern health care. The layout of the building is reported by the sponsoring organisations to be not conducive to the provision of modern health care standards, with small, cramped corridors and reduced ability for patient flow. The IPC guidelines also affect the ability to meet current standards on

space and ward size thus affecting bed availability at Feilding Palmer. The building presents issues to patient privacy and dignity due to the lack of properly segregated single sex wards. Mitigations to address these issues would lead to a further reduction in the number of beds.

The hospital operates a high-cost staffing model because of the low number of beds (closer to the cost of a High Dependency Unit). To maximise productivity and reduce waiting lists, activity is being consolidated at alternative sites. This is because there are insufficient nurses and doctors to run clinics that are not at full capacity or wards which have low patient to nurse ratio. The inpatient facility at Feilding Palmer is reported to be an unattractive location for the workforce due to the size of the ward with poor in-patient provision and a feeling of isolation as there is a lack of senior managerial support onsite. The building and environment make it an unsuitable place to deliver inpatient care, and filling shifts on the inpatient ward has always presented a challenge. The workforce preferred to provide care in more modern facilities. When the beds were open to admissions (pre-COVID) the number of local patients occupying them was between 2 or 3 (25-33%), with the remaining beds being used by other patients within LLR.

As part of the design process for a proposed future service model, the system has undertaken significant engagement over the last 18 months to involve the population across Leicester, Leicestershire, and Rutland. Key projects are reported to have seen qualitative information gained from patients, service users, staff, and carers, including work with communities including those with protected characteristics. A local community campaign group attends each steering group, which is leading the project, and a stakeholder briefing has been provided following each meeting. This has been shared with Parish, Town and County Councillors, patient groups including local Patient Participation Groups, voluntary sector organisations, local MP's office, Steering Group members and other key stakeholders. Agreement to this approach has been confirmed by all representatives.

In addition, there are predicted further demands on services within Lutterworth once the 2,750 Lutterworth East Sustainable Urban Extension (SUE) dwellings (an estimated 6710 residents) are populated resulting in an increase in Primary Care

activity, demand for outpatient activity and an ageing population and, therefore, an increase of people with more complex care needs/conditions associated with ageing. The LLR system would like to repurpose the facility to create a community healthcare hub to support more patients locally to access diagnostics and outpatient appointments, reduce waiting lists by bringing care closer to home. This is a request on a local footprint which has clinical support (local GP and secondary care), local MP support, Primary Care Network (PCN) support and wider ICS partner support. Community capacity is available and has been tested due to temporary bed closures since June 2020 in response to Covid-19.

The future proposed service model will focus on preventable care for those people living with long term conditions, who will be actively supported to manage their own care and avoid acute exacerbations of disease wherever possible. The journey for patients needs to be seamless and easy to navigate and discharges from services need to be coordinated and well communicated. To achieve this vision both the shape of community services and the workforce delivering them needs to change. The proposed new model, to replace the bed provision, is based around the following services:

- Neighbourhood community nursing
- Home First services
- Community bed-based care
- Specialist palliative care
- Outpatient services

Aims and objectives of the clinical review

The system has a timeline in place for design, consultation, PCBC development and implementation of a new service model. The LLR system has proactively engaged with the Clinical Senate to commission a clinical review as an element within the overall timeline to bring independent, external advice and guidance to support the development and evaluation of the proposed service model. The system request that the Clinical Senate assess the proposed future service model and proposed closure of the 10 inpatient community beds in the Feilding Palmer facility, considering the current service provision and challenges, predicted needs of the population going forwards and national direction of travel/guidance to determine if it represents the

best and most appropriate provision of high-quality care closer to home for the local population.

The Clinical Senate review team has been asked to review the information provided by Leicester, Leicestershire and Rutland (LLR) ICB, with support from Leicestershire Partnership NHS Trust to consider the following key areas:

- *Is the refurbishment of the Feilding Palmer facility and revised community service model likely to address the challenges reported at the Feilding Palmer facility and deliver a positive impact on the quality of care of the local population and are there any factors that have not been considered?*
- *Has the closure of the 10 bed inpatient facility at the Feilding Palmer site been appropriately mitigated in the planned expansion of the community services across LLR (with specific reference to community clinics expansion at the Feilding Palmer site)?*
- *Does it align to best practice, national guidance and direction of travel for the provision of community services?*
- *Are there any unintended consequences or risks that have not been identified and mitigated in the proposal (including any impact on populations currently accessing the services provided or peripheral service provision)?*
- *Has it considered the demographics of the population served, taking into account the needs of that specific population and ensuring equity of access and a positive impact on health inequalities?*
- *Does the proposed model appropriately consider predicted demand for services and provide sufficient flexibility and adaptability to meet these needs?*

Scope of the review

The areas in scope of the review are all community services provided by the LLR system which changes to the service provision of the Feilding Palmer facility could potentially impact upon.

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical

outcomes/quality[3])? For example, do the proposals reflect:

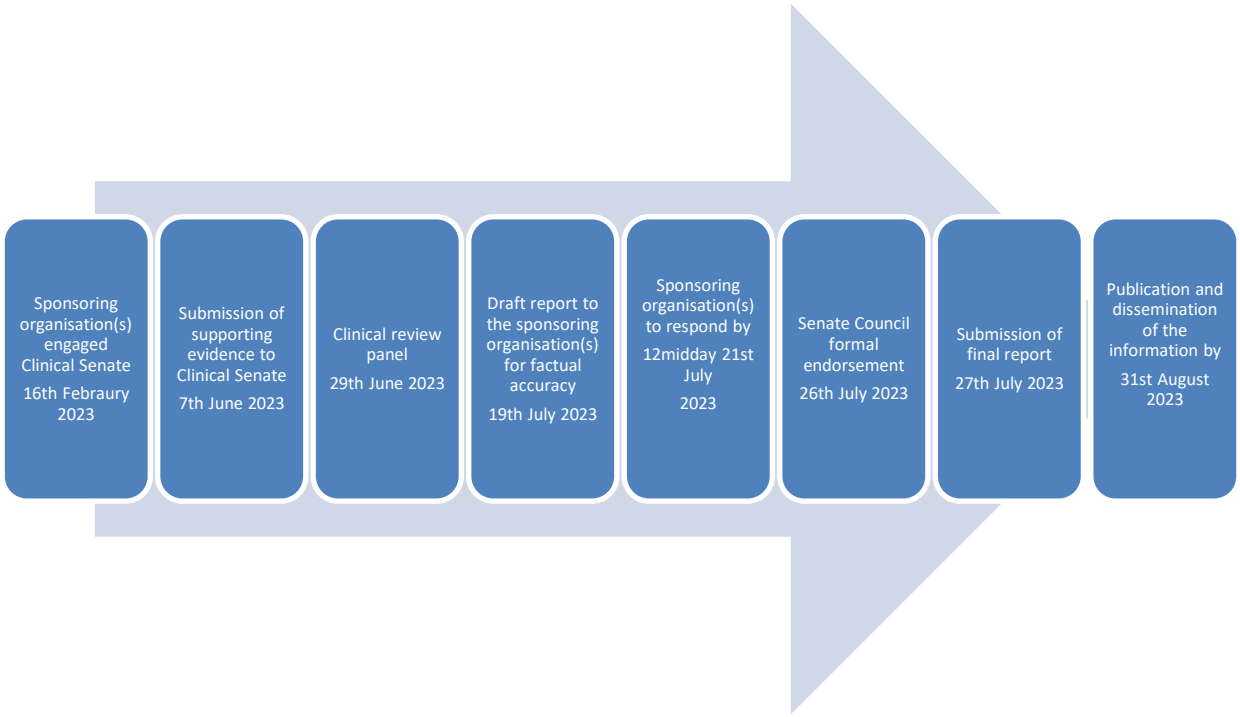
  - The rights and pledges in the NHS Constitution?
  - The goals of the NHS Outcomes Framework?
  - Up to date clinical guidelines and national and international best practice e.g. Royal College reports?

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? For example:
  - Do the proposals align with local joint strategic needs assessments, commissioning/ICB plans and joint health and wellbeing strategies?
  - Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?
  - Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals meet the current and future healthcare needs of their patients?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Do the proposals consider the workforce requirements and transformation required to deliver this new model?

The Clinical Review Panel should assess the strength of the evidence base of the clinical case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

[3] Quality (safety, clinical effectiveness and patient experience)

Timeline



Reporting arrangements

The clinical review team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.
Clinical Senate Council will report to the sponsoring organisation(s) and this clinical advice will be considered as part of the NHS England assurance process for service change proposals (if appropriate).

Methodology

The sponsoring organisation(s) has agreed to collate and provide the following supporting evidence to the Clinical Review Panel, and to reference the evidence base wherever possible when drawing on clinical guidelines and national best practice. The evidence submitted will be meaningful and credible. To support the development of the evidence submission, the sponsoring organisation(s) will have consulted the Suggested Minimum Evidence Requirements document provided by the Senates team as part of the review process. *The duty is on the sponsoring organisation(s) to make sure the supplied material is only relevant to the review.*

- Clinical case for change and a summary of the current position and proposed alternative service/care model

- Information pertaining to/copies of any evaluation criteria used to shape the proposals/options appraisal required for the Pre-Consultation Business Case such as the hurdle criteria (please see document provided entitled “Suggested Minimum Evidence Requirements” where relevant)
- Impact of withdrawing/reconfiguring services, including risk register and mitigations
- How proposals reflect clinical guidelines and best practice, the goals of the NHS Outcomes Framework and Constitution
- Alignment with local authority joint strategic needs assessments and a narrative around health inequalities and demographics e.g. HEAT Tool (Health Equity Assessment Tool) and Equality Impact Assessment (EIA)
- Evidence of alignment with organisational/system plans
- Evidence of how any proposals meet future healthcare needs, including activity modelling, pathways, and patient flows
- Demonstrate how patient access and transport will be addressed
- Demonstrate how any implications on the Ambulance Service will be addressed
- Consideration to a networked approach
- Education and training requirements
- Implications on workforce (to be able to demonstrate alignment to new ways of working, and to describe how the future workforce will look to support any new models of care/reconfiguration proposed)
- Implications for the workforce (to describe how the workforce will be engaged, supported and motivated to work in new ways and in new places that support any new models of care/reconfiguration proposed)
- Implications for the clinical support services and those staff (e.g. clinical engineering, radiology, pharmacy)
- SHAPE (Strategic Health Asset Planning and Evaluation) Place Atlas, which helps organisations to consider the evaluation of the impact of service configuration on proposals and assess the optimum location of services
- Core service inspection reports (i.e. CQC)
- Public, patient and staff engagement plans and particularly, evidence of patients’ experiences of services

- Evidence of consideration to the sustainability and environmental impact of these proposals
- Clinical framework for presenting evidence and considering multiple site single service models of care (recommended clinical framework can be found here: Midlands Clinical Senates - Proactive Projects (midlandssenates.nhs.uk))

All evidence should be submitted three weeks prior to the review date as specified in the TORs. Any allowances to this should be agreed with the Head of Clinical Senates (or one of their deputies) and only in exceptional circumstances can we consider a late submission. Any evidence received within 48 hours of the review will likely not be shared with panel members and may not be considered within the review process unless prior agreement with the Head of Clinical Senates (or one of their deputies).

Report

A draft clinical senate report will be circulated within 14 working days of the final meeting - to team members for comments, to the sponsoring organisation(s) for fact checking.

Comments/corrections must be received within a further 1.5 working days.

The final report will be submitted to the sponsoring organisation(s) by 27th July 2023.

Communication and media handling

The clinical senate will publish the final report on its website once it has been agreed with the sponsoring organisation(s). The sponsoring organisation(s) is responsible for responding to media interest once in the public domain.

Disclosure under the Freedom of Information Act 2000

The East Midlands Clinical Senate is hosted by NHS England and operates under its policies, procedures and legislative framework as a public authority. All the written material held by the clinical senate, including any correspondence you send to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

Resources

The senate(s) office will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation(s).

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate's accountability and governance structure.

The East Midlands Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation(s).

The sponsoring organisation(s) remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation(s) may wish to fully consider and address before progressing with their proposals.

Functions, responsibilities and roles

The **sponsoring organisation(s)** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projections, evidence of alignment with national, regional and local strategies and guidance
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review. Additionally, all communication (verbal and written) throughout the whole process should be addressed to the Head of Clinical Senates or an appropriate identified deputy
- submit the final report to NHS England for inclusion in its formal service change assurance process (if appropriate)
- arrange and bear the cost of a suitable venue and light refreshments (as advised by the senate(s) office) for the panel

Clinical senate council and the sponsoring organisation(s) will

- agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and final report
- provide suitable support to the clinical review team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation(s) with a draft report to check for factual inaccuracies
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
- keep accurate notes of meetings

Clinical review team members will undertake to

- Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare, to the chair or lead member of the clinical review team and the Head of Clinical Senates, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix B: Summary of documents provided by the sponsoring organisations as evidence to the panel

The following evidence was submitted by the sponsoring organisations for this review on 7th June and disseminated to the panel on the same day:

- 1.1 Summary of Current Position and Case for Change.pdf
- 1.2 Lutterworth Reference Pack.pdf (updated version sent on 8th June)
- 2.1 Risk Assessment Paper 2020.pdf
- 2.2 Feilding Palmer Risk Register Report June 2020.pdf
- 2.3 Equality Assessment.pdf
- 3.1 Draft LLR ICB 5YJFP.pdf
- 4.1 Joint Strategic Needs Assessment Overview.pdf
- 4.2 Equality Impact Assessment.pdf
- 4.3 Lutterworth PHM.pdf
- 5.1 Lutterworth Insights.pdf
- 5.2 Draft Lutterworth Comms and Engagement Strategy.pdf

Following the panel pre-meet on 16th June and subsequent feedback to the sponsoring organisations, the following additional evidence was submitted to the Senate on 22nd June and disseminated to the panel on 23rd June (the slight delay was due to the senior team in the Senate being committed elsewhere that afternoon and evening):

- A0 – Additional Information – Summary of Documents.pdf
- A1 – Lutterworth Communications and Engagement Strategy V3 210623.pdf
- A2 – LLR Digital Strategy.pdf
- A2.1 – Patient use of digital technology.pdf
- A3 – Emergency Readmissions.pdf
- A4 – Review of best practice.pdf
- A5 – UHL 5 Year Strategic Workforce Plan.pdf
- A6 – Pre-Pandemic Case Mix.pdf
- LLR Clinical Senate Presentation – 29June23.pptx (this was updated and recirculated on 27th June)

Additional documents submitted by Mr David Fish of The Mary Guppy Group and were disseminated to the panel on 22nd June:

- Clinical Senate 29623 v4.docx
- Lutterworth plan pre-consult business case v2.docx
- 2000 Survey Feb 2022 v3.docx

Appendix C: Clinical review team members and their biographies and any conflicts of interest

Name	Role	Organisation	Conflict of interest
Anne-Maria Newham	Deputy Chief Executive Officer	Nottinghamshire Healthcare Foundation Trust	Anne-Maria was the Director of Nursing at LPT in 2019.
Ben Pearson	Executive Medical Director, Responsible Officer and Caldicott Guardian	Derbyshire Community Health Services	None
Claire Greaves	Divisional Director, Ambulatory Care Division	Nottingham University Hospitals NHS Trust	None
Ian Lawrence	Clinical Director for integration Chief Clinical Information Officer	Derbyshire Community Health Services	Ian provides ad hoc consultancy for the Royal College of General Practitioners (RCGP) GP Development Service
Jane Youde	Consultant Physician	University Hospitals of Derby and Burton NHS Foundation Trust	None
Jason Evans	Acting Chief Officer for Integrated Urgent & Emergency Care, West Midlands Region	Black Country ICB	None
Jo Watson	Assistant Director of Nursing & Workforce	NHS England	None
Kat Telford	Medical Educator	University of Nottingham	None

Kerry Bareham	Nurse Consultant	St Barnabas Lincolnshire Hospice	None
Mandy Clarkson	Deputy Director Public Health	NHS Midlands	None
Paul Jenks	Chair, Community Pharmacy Lincolnshire Chair, National Pharmacy Competency Group Vice Chair, Lincolnshire Primary Care Advisory Group	Community Pharmacy Lincolnshire	None
Paul Midgley	Patient and Public Involvement representative	East Midlands Clinical Senate Council	None
Salil Parkar	Therapy lead Inpatients	NHS Birmingham Community Healthcare NHS Foundation Trust	None
Sarah Raistrick	GP	NHS Coventry and Warwickshire ICB	None
Saul Hill	Integrated Community Manager	Derbyshire Community Health Services	None
Susan Edge	Patient and Public Involvement representative	East Midlands Clinical Senate	None
Suzanne Avington	Associate Director Allied Health Professionals	Nottinghamshire Healthcare NHS Trust	None

Clinical Senate Support Team

Emma Orrock – Head of Clinical Senates, NHS England

Carly Mellors – Senior Programme Manager, East Midlands and West Midlands Clinical Senates, NHS England

It was agreed between Emma Orrock, Head of Clinical Senates, and Jo Clinton, Head of Strategy and Planning, Leicester, Leicestershire and Rutland ICB, that Gail Rose, Deputy Director of Clinical Delivery, NHS England, could observe the review day process.

Biographies

Anne-Maria Newham

Previous Executive Director of Nursing AHPs and Quality

Anne-Maria has worked in the NHS for over 38 years holding several roles including Ward Manager, Neonatal Sister, Children's Intensive Care Manager, Director of Children's Community Health Services, Chief Nurse in Derbyshire CCG, Director of Nursing, AHPs and Quality for Lincolnshire Partnership Foundation Trust, interim Chief Executive Officer at Lincolnshire and until recently, Executive Director of Nursing AHPs and Quality at Nottinghamshire Healthcare Foundation Trust. In 1996 she was instrumental in setting up the first Children's Intensive Care Unit in Leicester. She was awarded a Florence Nightingale Leadership award in 2011 and Travel Scholarship in 2014 looking at End of Life Care. She was voted Inspirational leader by the Leadership Academy in 2014 and shortlisted as Clinical Leader of the year by the Health Service Journal 2017. After receiving a Winston Churchill Fellowship in 2015 she travelled to New Zealand to understand their progressive integrated care system and bring the findings back to the UK. She has published widely in several journals and is currently on the editorial board of the British Journal of Nursing. In 2017 she was invited to speak at the 2nd Nursing World Conference in Las Vegas and in 2018 in Rome. Anne-Maria was awarded an MBE in the 2018 Queens Birthday Honours for services to Nursing.

Ben Pearson

Executive Medical Director, Responsible Officer and Caldicott Guardian

After gaining a zoology degree from Durham University, Ben trained in medicine at Kings College London, qualifying in 1993. He worked in London, Lincoln and Nottingham and took up a consultant post in geriatric and general (internal) medicine at Derby in 2004. Leading the development of acute medical services, Ben introduced senior clinical decision making and ambulatory care for acute medicine.

Ben was the secondary care doctor on the Mansfield & Ashfield and Newark & Sherwood CCG Governing Body from pre-authorisation until May 2019, serving for 7 years. In 2010, he was awarded a Master's degree in clinical medical education.

In June 2019, Ben took up his current position as Executive Medical Director for Derbyshire Community Health Services NHS Foundation Trust. He is the trust Responsible Officer and Caldicott Guardian. Ben is the Vice Chair of the Joined-Up Care Derbyshire System Quality Group and a Vice Chair of the Clinical and Care Professionals Leadership Group. Within a diverse portfolio Ben has a particular interest in developing clinical governance and quality and performance management methodology.

Claire Greaves

Divisional Director, Ambulatory Care Division

Claire is a Consultant Clinical Scientist with many years of experience working in a range of different NHS Trusts. Claire specialises in Nuclear Medicine and leads the Medical Physics & Clinical Engineering (MPCE) service in Nottingham University Hospitals NHS Trust but has had a broader role as Clinical Director for the Science and Technology Pathway comprising: Bowel Cancer Screening, MPCE, Sterile Services, and the Trent Simulation and Clinical Skills Centre. Claire is also the Chief Scientist at NUH. Claire is an Honorary Associate Professor in the University of Nottingham School of Medicine. Over her Career, Claire has supported a number of national committees (British Nuclear Medicine Society, Institute of Physics in Engineering in Medicine, Administration of Radioactive Substances Advisory Committee) and has been a Technical Advisor for UKAS supporting the development of BS70000 and the accreditation systems for scientific services. Claire is currently supporting the regional and ICS work relating to Diagnostics.

Ian Lawrence

Clinical Director for integration

Chief Clinical Information Officer

Ian is the Clinical Lead for Team up Derbyshire which is a wide ranging ‘bottom up’ programme that uses strengths-based approaches to integrate neighbourhood teams across General Practice Community Health and adult Social Care.

He is also the Chief Clinical Information Officer at Derbyshire Community Health Services Foundation Trust (DCHS).

Ian is GP by background but left direct clinical practice in 2019, he has been a GP partner in rural North Wales and in Derbyshire. He led the integration of three GP practices into DCHS.

Ian was a CCG Governing Body member from 2011 to 2015 and retains a strong system leadership role with a particular focus on community service integration.
He volunteers every summer with Festival Medical Services, a charity who provide voluntary medical cover at Music Festivals and use the proceeds to support charities worldwide.

Jane Youde
Consultant Physician/Clinical Lead for Enhanced Care in Care Homes Derbyshire and Deputy Chair of the Gender Equality Network
Jane has been a Consultant in Medicine for the Elderly in Derby since 1999 with a special interest in falls. She has had many posts locally, regionally and nationally including being the Clinical Director for Rehabilitation and Elderly Care Business Unit, clinical lead for the Falls and Bone Health QIPP work stream for East Midlands SHA and involved with the Older People with Frailty work stream for East Midlands AHSN. She was a collaborator in the writing of the BGS Fit for Frailty guidance and has been the co-chair of the British Geriatric Society Falls Section. She has been the secondary care representative on the Nottingham West CCG Board.
She was involved in the National Falls Audit in different roles for over 10 years and involved in many of the QI projects associated with this. She has been the Clinical Director for Audit and Accreditation for the Royal College of Physicians and oversaw the delivery and development of the 3 National Audit programmes and the 5 accreditation programmes hosted by the RCP. She is currently Clinical Lead for ENCH as part of Ageing Well in Derbyshire.

Jason Evans
Acting Chief Officer for Integrated Urgent & Emergency Care, West Midlands Region
Jason is Acting Chief Officer for West Midlands Integrated Urgent and Emergency Care (IUEC) Service, for Black Country ICB. He has over 25 years of experience in community development, public health and NHS senior management.
His current role includes responsibility for implementing national best practice for IUEC and responding to policy requirements of NHS England for 999 and 111 services. The role includes ensuring delivery of national and regional targets for 999 and 111 services and instigating performance management strategies where

expectations are not met. This work is delivered on behalf of the commissioning partners of the IUEC Alliance and 16 Clinical Commissioning Groups.
Jason also holds the executive lead for Emergency Preparedness Resilience and Response (EPRR) for Black Country ICB, which included coordinating the ICS COVID-19 Incident Coordination Centre and being SRO for EU-Exit.

Jo Watson

Assistant Director of Nursing and Workforce

Jo is a children's nurse with over 20 years' experience working with children and young people. Jo has experience of working in a number of different areas across both acute and community sectors. Jo spent a significant period working at Birmingham Children's Hospital as Deputy Head of Nursing where she developed a number of new services including a Hospital at Home team and a regional long-term ventilation team. Jo was Lead Nurse for Paediatrics at University Hospitals of Derby and Burton and oversaw the merger of both trusts within all children's areas.
Jo completed her first Masters at the University of Manchester in Advancing Nursing Practice in 2012. Since then, she has completed a Post Graduate Certificate in Strategic Workforce Planning and is currently completing a further Masters in NHS Leadership at the University of Birmingham on the Elizabeth Garrett Anderson Programme, with the NHS Leadership Academy.

Kat Telford

Medical Educator

Kat is a junior doctor and medical educator who graduated from St Georges Medical School in London in 2018 and undertook her foundation training in Nottinghamshire and Lincolnshire. Since then Kat has progressed her academic portfolio and currently works for the University of Nottingham as an Assessment team Medical Education Fellow.

Kerry Bareham

Nurse Consultant

Kerry is a Nurse Consultant in Specialist Palliative Care for St Barnabas Hospice in Lincolnshire. She holds qualifications in advanced practice as a SPQ District Nurse, Independent Prescribing, and an MSc in Frail Older People.

Kerry is extremely proud to be a Queens Nurse and is passionate about raising the profile of nursing and the very real difference that high quality community nursing and person-centred care has on improving outcomes and tackling health inequalities for people throughout their life.
Her specialist areas of interest include palliative and end of care, long term conditions management, frailty and championing diversity.

Mandy Clarkson
Deputy Director Public Health
Mandy is a consultant in health care public health and Deputy Director, providing advice and support to the NHS at regional and local system levels. She is a registered adult nurse, with a background mostly in community nursing. Mandy began her public health career in health protection before training in the East Midlands and subsequently working in various local authority and NHS roles.

Paul Jenks
Chair, Community Pharmacy Lincolnshire
Chair, National Pharmacy Competency Group
Vice Chair, Lincolnshire Primary Care Advisory Group
After registering as a pharmacist in 1997, Paul worked for several years as a pharmacist manager on Lincolnshire's East Coast before undertaking several different field and national roles.

He currently leads a team at the Boots Support Office in Nottingham, looking after the professional and clinical development needs of colleagues across the UK.

He joined Lincolnshire Local Pharmaceutical Committee (now Community Pharmacy Lincolnshire) as a committee member in 2008 and was elected as Chair in 2010 – a role in which he continues to work, representing around 120 pharmacy contractors across a large, rural county and working closely with key stakeholders including local authority commissioners, the ICB and ICS.

He also works as a local tutor for the Centre for Pharmacy Postgraduate Education, producing HEE funded training solutions for pharmacy professionals, and has recently finished his second and final term as Vice-Chair of the Royal Pharmaceutical

Society Membership Committee. He is a member of the Royal Pharmaceutical Society Community Pharmacy Expert Advisory Group and is Chair of the national Pharmacy Competency Group.

Paul Midgley

Patient and Public Involvement representative

Paul has been involved in patient leadership since 2006 when he was appointed to the board of Principia CIC (Practice Based Commissioning Group for Rushcliffe, Notts).

Paul is a patient member on the Nottingham & Nottinghamshire ICS Digital Notts and Greener Notts boards, East Midlands Clinical Senate Council, Rushcliffe Primary Care Network (PCN) Board, chair of Rushcliffe PCN PPG Chairs Group, and chair of Musters Medical Practice PPG.

Previous voluntary roles have included Notts CCG PPEC member, prioritisation panel at Nottinghamshire Healthwatch and various committees at Principia and NHS Rushcliffe CCG including the Clinical Reference Group and Finance and Performance committee.

In working life, Paul has recently set up his own business providing NHS insight services. Prior to this, Paul was a Principal Consultant within Wilmington Healthcare's Thought Leadership Group, where he chaired joint NHS and industry events around service transformation and supported partnership-based improvement projects.

Paul spent over 15 years after graduating from Leeds University with a BSc in Biotechnology working in various commercial roles with the Pharmaceutical Industry prior to leaving in 2000 to set up his own training consultancy, which was acquired by Wilmington plc in 2013.

Salil Parkar

Therapy Lead Inpatients

Salil is a physiotherapist by profession – with specialism in Stroke and Neurology. He has experience of working as clinician mainly in Community Hospital and Outpatients. His current role involves Clinical and Operational leadership for Therapy

teams across community hospitals at Birmingham Community Health Care NHS Foundation Trust.
Salil is an events officer for the Chartered Society of Physiotherapy – Black Asian and Minority Ethnic network. He is also the co-chair for NHS Midlands – AHP Ethnic Minority Network.

Sarah Raistrick
GP
Sarah is a GP based in Coventry. Prior to qualifying as a GP, she was a surgical registrar (MRCS) and holds MRCGP, DRCOG and DFFP and Advanced University Diploma in Primary Care Mental Health.
She is a generalist but is especially interested in minor surgery and mental health (including peri-natal and teenage mental health) as well as AF and COPD. She is involved in working with local community leaders to embed primary care within the community, focussing on population health models and building on community assets and individuals' own resources and networks to improve health.

Saul Hill
Integrated Community Manager
Saul is an Integrated Community Manager and Wound Clinic Service Manager for Derbyshire Community Healthcare Services NHS Foundation Trust. A major provider of complex wound care services to the people of Derbyshire with 65,000 service user contacts per year, the service is an integral part of the Trust's Integrated Community Services.
After serving in the British Armed Forces, Saul began his career as a Registered Podiatrist, and has since worked as a clinician and senior manager within Community Health Services focusing on clinical research, multidisciplinary team working, and integrated care systems. Between these appointments Saul has published widely, lectured at the University of Salford, and holds a position on the Medicines and Medical Devices Committee for the Royal College of Podiatry.

Susan Edge

Patient and Public Involvement representative

Susan was involved in the further, adult and work-based learning sector for over 30 years and gained significant experience of quality assurance and quality improvement. Subsequently she was the Patient and Public Involvement member of her local clinical commissioning group's governing body for 8 years and was also a public contributor for the National Institute for Health Research.
Currently co-chair of the East Midlands Patient and Public Involvement Senate, hosted by the East Midlands Academic Heath Science Network, Susan is also a lay partner for Health Education England in the East Midlands. She is a member of the Education, Training and Practice Committee of the UK Council for Psychotherapy.

Suzanne Avington

Associate Director Allied Health Professionals

Suzanne is a physiotherapist by background. She has worked in the NHS for 27 years across a variety of rehabilitation services across secondary and primary care. She has worked at University of Nottingham as a lecturer on the BSc programme for Physiotherapy for a short period before taking up new clinical and leadership roles within therapy services in the community at the advent of Intermediate Care. Her clinical specialisms at the time were neurological rehabilitation, stroke, falls and older person's care.

She has had always had a keen interest in the effective working of the wider multidisciplinary team which has led to project lead roles in integration and of professional support to the Allied Health Professionals. In her current role as Associate Director for AHPs she is accountable for AHP Governance, including quality, workforce capacity and capability, education, professional standards and regulation for 10 of the 14 AHP professions.

She is currently Chair of the Nottingham and Nottinghamshire ICS AHP Council and an inaugural member of the AHP faculty.

Suzanne is also a registrant assessor for Physiotherapy with the Health Care Professional Council.

Appendix G

NHS
Midlands and Lancashire
Commissioning Support Unit

Equality and Health Inequalities Impact and Risk Assessment (EHIIRA)

Stage 2 Template for Services, Policies & Functions

Title of Service / Policy / Function:

Feilding Palmer Hospital

1. Assessment Overview

Name of organisation: Leicester, Leicestershire and Rutland Integrated Care Board

Assessment Lead Contact: Jo Clinton

Responsible Director/Board Member for this assessment:

Sarah Prema

Other contacts involved in undertaking this assessment:

Carrie Harris

Start Date: **24/04/2023** **Completed Date:** **02/05/2023**

Who is impacted by this service / policy / decision?	Yes	No	Indirectly / Possibly
Patients / Service Users	☑	☐	☐
Carers or Family	☑	☐	☐
General Public	☑	☐	☐
Staff	☑	☐	☐
Partner Organisations	☑	☐	☐

Summary information of the service / policy / decision being assessed:

The Feilding Palmer hospital is a community hospital in Lutterworth, Leicestershire. Admissions to the 10 bedded inpatient facility (including one palliative care suite) within Feilding Palmer hospital were suspended at the beginning of the Covid-19 pandemic in response to a review against the national Infection Prevention Control (IPC) guidance and these remain closed. The decision for an EIA assessment is in relation to repurposing the inpatient bed space in favour of an enhanced procedure suite and additional outpatient facilities resulting in removal of the10 inpatient beds.

What are the aims and objectives of the service / policy / decision being assessed?

Case for change background:
Since the pandemic, when face to face activity was reduced due to social distancing and strict IPC measures, the services delivered from Feilding Palmer reduced. This had an impact on number outpatient appointments and the community hospital inpatient beds were closed to admissions and alternative community inpatients. The beds remain closed.
Lutterworth will see substantial housing growth over the next 10-15 years with a Sustainable Urban Extension (SUE) being built resulting in 2750 new homes bringing an estimated 6710 new residents into the area which will in turn increase primary and secondary healthcare demands.

Prior to Covid the following services were running from the facility:
Services
10 community inpatient beds
Cardiology outpatient appointments
General Surgery outpatient appointments
Gynaecology outpatient appointments
Community Paediatric outpatient appointments
Physiotherapy
Out of Hours access

Covid-19 dramatically changed how outpatient care was delivered in health care settings this was to reduce the risk of transmitting the virus to either patients or health care workers. Providers deferred elective (non-urgent) and preventative activity. As a result, the services in all community hospitals across LLR, including Feilding Palmer, was reduced. The table below shows those services that continued or commenced during the Covid-19 pandemic in Feilding Palmer:

Services
Physiotherapy
Out of hours access
Covid Vaccination clinic

In recent months, outpatient activity has increased as the covid-19 guidelines have been relaxed and additional clinics are running from the hospital, however the ICB would like to increase this further. In order to do this, the proposal is to permanently close the inpatient beds in favour of an enhanced procedure suite and additional outpatient clinic rooms which would provide more care to the current and growing population (as a result of the Lutterworth East SUE) closer to home.

Proposed Services
Enhanced procedures:
- Dermatology
- ENT
- General Internal Medicine
- General Surgery
- Gynaecology
- Ophthalmology
- Rheumatology
- Trauma and Orthopaedics
- Urology

Outpatient clinics:
- Ophthalmology
- Trauma & Orthopaedics

- General Internal Medicine
- Dermatology
- General surgery
- Urology
- Gynaecology
- Cardiology
- Rheumatology
- Respiratory Medicine

INPATIENT BEDS – CASE FOR CHANGE

As previously stated, the IPC guidelines affect the ability to meet current standards on space and ward size thus affecting bed availability at Feilding Palmer. The building presents issues to patient privacy and dignity due to the lack of single sex wards. Undertaking the backlog of maintenance will have no effect on current standards (space and ward size) or on the cross-infection risk.

There are workforce challenges within health and social care which are being managed; to maximise productivity and reduce waiting lists, activity is being consolidated at alternative sites as there are insufficient nurses and doctors to run clinics that are not at full capacity or wards which have low patient to nurse ratio. The inpatient facility is not an attractive location for the workforce, and due to the size of the ward there is lack of managerial support onsite. The building and environment makes it an unsuitable place to deliver inpatient care, and filling shifts on the inpatient ward was always a challenge. The workforce preferred to provide care in more modern facilities.

The facilities at Feilding Palmer do not meet all regulatory requirements. The Victorian Cottage Hospital still retains much of the feel of an historic building which does not give the flexibility of modern health care. The layout of the building is also not conducive to the provision of modern health care standards, with small, cramped corridors and reduced ability for patient flow.

Financial balance and sustaining financial health is a priority for LLR ICB. The NHS faces increasing pressure on resources; continued transformation of services and joint working across both health and social care services will be required to deliver a financially stable health economy over the coming years. The requirement for 2 Registered nurses along with healthcare assistants for the 10 bedded unit is significant resource. Running costs are high, and are 4 times higher than at St Lukes in Market Harborough (£508 per m2 at Feilding Palmer vs £124 at St Lukes) and 1.6 times higher than Loughborough (£508 per m2 at Feilding Palmer v's £312 at Loughborough

If this assessment relates to a review of a currently commissioned service or an existing policy, what are the main changes proposed and what are the reasons for the review?

N/A

What engagement work is planned (or has already been carried out)? How will you involve people from protected characteristics, vulnerable groups, and groups that experience health inequalities to ensure that their views inform this decision-making process?

We have undertaken significant engagement over the last 18 months to involve our population across Leicester, Leicestershire, and Rutland. Key projects have seen qualitative information gained from patients, service users, staff, and carers, including work with communities including those with protected characteristics. A local community campaign group attends each steering group, which is leading the project, and a stakeholder briefing has been provided following each meeting which has been shared with Parish, Town and County Councillors, patient groups including local Patient Participation Groups, VCSE, MPs office, Steering Group members and other key stakeholders. Agreement to this approach has been confirmed by all representatives.
A full public consultation is also scheduled to run between September - November 2023 as part of the Pre-Consultation Business Case.

Is this proposal likely to affect health inequalities – either positively or negatively? YES ☑ / NO ☐

Please provide rationale for your answer below:

Removing the inpatient beds will have an impact on access to inpatient facilities in the community. Prior to their temporary closure due to Covid-19, an average 2 or 3 of the 10 beds were usually occupied by a patient living within Lutterworth, with the remaining beds occupied by patients from other areas within LLR. Mitigations are in place for inpatient care – see section 3, impact groups.

Removing the palliative care bed will have an impact on access to a local palliative care bed in a community hospital. Mitigations are in place – see section 3, inclusion health groups.

Bringing more services into Lutterworth will reduce travel times to the larger acute sites and improve access for those in and around Lutterworth who use public transport, have disabilities or low income households. Patients who are negatively impacted by having to travel long distances by public transport to attend their hospital appointment and/or the cost associated with this will benefit from increased service availability at Feilding Palmer.

2. Evidence Section

What evidence have you considered to inform your decision-making within this assessment?

The more evidence you are able to provide in this section, the better informed your decision-making will be. Such evidence may include NICE guidance, clinical research, literature reviews, quality and performance data, workforce metrics, engagement findings, demographic data, community intelligence, health inequalities data (RightCare profiles, JSNA), etc.

NHSE IPC standards: The IPC guidelines affect the ability to meet current standards on space and ward size thus affecting bed availability at Feilding Palmer.

NICE Quality Standard for Privacy and Dignity: The building presents issues to patient privacy and dignity due to the lack of single sex wards.

Health Building Note (HBN) Standards : The facilities do not meet all regulatory requirements for inpatient care and does not give the flexibility of modern health care. The layout of the building is also not conducive to the provision of modern health care standards, with small, cramped corridors and reduced ability for patient flow.

Strategic Health Assets Planning and Evaluation (SHAPE) tool: Areas surrounding Lutterworth (within South Blaby and Lutterworth PCN are in the highest deprivation category for barriers to housing and services, along with living environment deprivation. Education, skills and training deprivation is in the second highest deprivation category in Lutterworth West, and income deprivation for children and older adults fall within the 3rd deprivation quintile in areas surrounding Lutterworth.

NHS Long Term Plan: To make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment. The new housing development, Lutterworth East, will bring approximately 2,700 new houses to Lutterworth (equating to over 6700 new residents) over the next 10-15 years. The population increase will also increase demand across NHS services, including secondary care services. Currently patients have to travel long distances into UHL and across the boarder to Coventry and Warwickshire.

Steering group meetings have taken place bi-monthly to discuss the Lutterworth Healthcare proposals. A local community campaign group attends each Steering Group meeting and a stakeholder briefing has been provided following each meeting which has been shared with Parish, Town and County Councillors, patient groups including local Patient Participation Groups, VCSE, MPs office, Steering Group members and other key stakeholders. Further evidence will be sought via the public consultation which will take place in September 2023.

If this assessment relates to a policy / strategy, has an equality statement been added (or is it planned to be added) to the document? YES ☐ / NO ☐ / N/A ☑

If you have answered 'No', please explain why not: N/A

3. Impact Assessment

This section should record any identified and/or potential impacts on protected characteristic groups, groups experiencing health inequalities, and other groups at risk of experiencing poorer health outcomes. Both positive and negative impacts should be recorded for each of the groups defined below where applicable.

Think about any barriers to access, areas of inequity, and how different groups may be disproportionately impacted by this proposal. Conversely, think about how certain groups may benefit or see better health outcomes as a result of this proposal.

Protected Characteristics

Age Groups impacted may include young people, older people or working-age population.	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☑	☐

Community Hospital inpatient beds will no longer be available in Lutterworth, however mitigations are in place with alternative care models: HomeFirst community nursing and therapy provision, care home beds and community hospital inpatient beds in neighbouring districts (St Lukes, Market Harborough and Hinckley and Bosworth Community Hospital). As the beds were closed at the beginning of the Covid-19 pandemic, this model of care has been tested.

Increased access to outpatient services closer to home will benefit older adults who find it difficult to attend appointments in an acute setting which require a long journey. This will also benefit younger people who may be affected by cost of travel. The time required to attend the appointment will be reduced due to shorter journeys and smaller hospital site, which will increase their likelihood of attendance. Similarly, children and young people, who require an adult to attend with them will be positively impacted as there will be less time commitment for the appointment.

Disability Groups impacted may include people with physical / learning disabilities, long term conditions, or poor mental health	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☑	☐

Travel to the local inpatient facility will impact some patients with a disability. Mitigations are in place via the Non-Emergency Patient Transport service to assist patients in these cases.

Existing corridors and access points within the building do not currently comply with all Health Building Notes (HBN) standards. By repurposing the facility, this will be addressed.

Travel for outpatient appointments will be reduced, which will make it easier to attend appointments.

Many patients with chronic and complex conditions may have reduced mobility or may not be able to access transport, making travel to hospital challenging. Those with particularly severe disability may be reliant on the availability of a carer, who is able to drive them to and from the hospital, and stay with them during their appointment. With a national carer shortage for basic support packages, patients often have to rely on family / friends to take them to and from hospital appointments. This burden can impact wider family members' lives and their ability to work. If there is no-one able to take a patient to their appointment they could miss critical health treatment and guidance on how to manage their condition, leading to worsening outcomes.

The increase in availability of home care (HomeFirst) will positively impact patients with disabilities as it will enable more patients to receive their care at home reducing the need to travel.

Sexual Orientation Groups impacted may include gay / bisexual men, lesbian / bisexual women, or heterosexual people	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

We do not envisage any negative impacts on this protected characteristic, but we will monitor to ensure that any negative impact will be mitigated.

Gender Reassignment This includes people proposing to undergo, who are undergoing or have undergone gender reassignment.	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

We do not envisage any negative impacts on this protected characteristic, but we will monitor to ensure that any negative impact will be mitigated.

Sex (Gender) Groups impacted may include males or females – or specific gendered groups such as boys and girls.	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

There is a positive impact on privacy and dignity as there is no longer a concern regarding the mixed gendered ward.

Race Groups impacted may include different ethnicities, nationalities, national identities, and skin colours.	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

Within the South Blaby and Lutterworth PCN there is a small proportion of the population who are Asian/Asian British or Black/African/Caribbean/Black British

Northfield Medical Centre: 3.3%

Hazelmere Medical Centre: 1.6%

Countesthorpe Health Centre: 0.8%

The Wycliffe Medical Practice: 1.1%

The Masharani Practice: 1.1%

We will ensure that translation services are available for people who need this.

Religion & Belief Groups impacted can include all recognised faith groups and those who do not follow any religion or belief system	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

There will be a positive impact for people of Muslim faith due to there no longer being a risk of mixed sex accommodation.

Pregnancy & Maternity Groups impacted may include pregnant women, people on maternity leave and those caring for a new-born / young child	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

We do not envisage any negative impacts on this protected characteristic, but we will monitor to ensure that any negative impact will be mitigated.

Marriage & Civil Partnership This includes people within a formal legal partnership – same sex and opposite sex	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

We do not envisage any negative impacts on this protected characteristic, but we will monitor to ensure that any negative impact will be mitigated.

Inclusion Health Groups

The services we commission should be available to all and as inclusive as possible. Your proposal should also consider any other population groups that are (or are at risk of being) socially excluded. This can include carers, people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers and many other socially excluded groups.

Think about which other inclusion health groups may be impacted by your proposal. Select from the drop-down list in each section below or manually state which other socially excluded groups you are considering. Select the table and click the blue '+' symbol in the bottom right of the table to add more sections if required.

For more information about inclusion health groups, please refer to our EHIIRA Guidance document.

Looked After Children & Young People	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☐	☐	☑

We do not envisage any negative impacts on this inclusion health group, but we will monitor to ensure that any negative impact will be mitigated.

Carers	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☑	☐	☐

People with particularly severe disability will be reliant on the availability of a carer, who is able to drive them to and from the hospital, and stay with them during their appointment. With a national carer shortage for basic support packages, patients often have to rely on family / friends to take them to and from hospital appointments. This burden can impact wider family members' lives and their ability to work. If there is no-one able to take a patient to their appointment they could miss critical health treatment and guidance on how to manage their condition, leading to worsening outcomes. By providing more services closer to home the impact on carers will be reduced.

People living in rural/remote communities	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☑	☑	☐

People living in rural and remote communities will be able to access outpatient care closer to home which will require less travel into acute settings which will address one of the health inequalities that were identified via the SHAPE tool.

Patients who require a community inpatient bed may be impacted by travelling further and the costs associated with this, however Non-Emergency Patient Transport (NEPT) is available to mitigate this where required.

Other - please state	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider.	☐	☑	☐

Palliative Care Patients Requiring Inpatient Bed

Removing the 1 palliative care bed will have an impact on access to the local community hospital palliative care bed. Mitigations are in place via the End of Life Pathway for LLR which has the following offer:

- Specialist Palliative care and advice for patients in the community, LPT/LOROS 24/7
- Specialist Palliative care and advice for staff, LPT/LOROS/UHL, 24/7
- 31 In patient Unit beds (IPU), Hospice, LOROS
- Emergency admissions to IPU beds
- Hospice at Home, LOROS
- Face to face specialist care advice and assessment, LPT/UHL/LOROS
- 9 Providers (21 Care Homes) on the current Nursing Home framework
- Increase community capacity including night provision
- Palliative and EoL virtual ward to support step up/down

Core20PLUS5

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the '**Core20PLUS**' – and identifies '**5**' areas of clinical focus requiring accelerated improvement.

Core20 refers to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation (IMD)

PLUS refers to ICS-chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach.

The **5** areas of clinical focus are as follows:

1. **Maternity** - Ensuring continuity of care for 75% of women from ethnically diverse backgrounds and from the most deprived groups.
2. **Severe Mental Illness** - Ensuring annual health checks for 60% of those living with SMI (bringing this in line with success seen in learning disabilities)
3. **Chronic Respiratory Disease** - A clear focus on COPD driving up uptake of COVID, flu and pneumonia vaccines
4. **Early Cancer Diagnosis** - Ensuring that 75% of cases are diagnosed at Stage 1 or Stage 2 by 2028.
5. **Hypertension Case-finding** - Allow for interventions to optimise blood pressure and minimise risk of myocardial infarction and stroke.

More information about Core20PLUS5 can be found using the following link - https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

Please record any identified or potential areas of impact – both positive and negative – for the target cohorts and any relevant clinical areas defined below and consider how your proposal may be able to contribute to making improvements in these priority areas.

Core20 - Deprivation The most deprived 20% of the population as identified by the national Index of Multiple Deprivation (IMD).	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

Whilst the overall Index of Multiple Deprivation (IMD) score is low, areas of deprivation are present in the area in relation to income deprivation (for older adults and children) and access to housing and services. Increasing access to outpatient services and outpatient procedures will benefit these cohorts of people by requiring less travel (resulting in lower travel costs) and increasing access to services more locally.

PLUS Any other locally determined population groups experiencing poor health outcomes – examples are listed above. **Please state which groups you are considering in your response.**	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

The barriers to housing and services deprivation indicator in this area is higher than other areas in Leicester, Leicestershire and Rutland (LLR). By increasing service availability at Feilding Palmer, more people will be able to access care closer to where they live which will impact positively.

3. Chronic Respiratory Disease Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

Increased access to cardio pulmonary rehab, and outpatient appointments closer to home increasing likelihood of receiving care in the right place at the right time.

4. Early Cancer Diagnosis	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☑	☐	☐

Increased outpatient appointments and outpatient appointments closer to home thus increasing likelihood of earlier cancer diagnosis

5. Hypertension Case-finding	Positive impact	Negative impact	Neutral impact
Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	☑	☐	☐

Increased outpatient appointments and outpatient appointments closer to home thus increasing likelihood of earlier hypertension case finding.

4. Compliance with Legal Duties

Has the organisation given due regard and consideration to the following areas?

Eliminating unlawful discrimination, harassment and victimisation YES ☑ / NO ☐

Unlawful discrimination takes place when people are treated 'less favourably' due to having a protected characteristic.

Advancing equality of opportunity between people who share a protected characteristic and those who do not. YES ☑ / NO ☐

This means making sure that people are treated fairly and given equal access to opportunities and resources.

Fostering good relations between people who share a protected characteristic and those who do not. YES ☑ / NO ☐

This mean creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference.

Are there any Human Rights concerns? YES ☐ / NO ☑

If you have answered '**Yes**', please seek advice from the Equality and Inclusion Team to discuss carrying out a specific Human Rights Assessment

Compliance with the NHS Standard Contract? YES ☑ / NO ☐

In relation to Service Condition SC13 which includes the NHS Accessible Information Standard

Please provide a supporting narrative to support your responses to the above questions: This section must be completed

The ICB and the Trusts providing services from the Feilding Palmer have robust policies in place which they adhere to across all hospital sites. These can be found via their organisation websites. The activity that they carry out is contracted via the NHS Standard Contract and therefore the service conditions are applied.

5. Equality Related Risk

If you have identified an area of actual or potential equality-related risk due to your proposal, please use the matrix below to work out the risk score and tick the corresponding box. If the area of risk gives a score of 9 or above, this should be escalated using the organisation's risk management procedures.

Risk score is calculated as the likelihood of risk multiplied by the level of consequence.

For more information about how to calculate a risk score, please refer to the EHIIRA Guidance document.

Likelihood of risk ➔ Level of consequence ➔	RARE = 1	UNLIKELY = 2	POSSIBLE = 3	LIKELY = 4	HIGH = 5
NEGLIGIBLE = 1	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
MINOR = 2	2 ☐	4 ☐	6 ☐	8 ☐	10 ☑
MODERATE = 3	3 ☐	6 ☐	9 ☐	12 ☐	15 ☐
MAJOR = 4	4 ☐	8 ☐	12 ☐	16 ☐	20 ☐
CATASTROPHIC = 5	5 ☐	10 ☐	15 ☐	20 ☐	25 ☐

Please provide a narrative to explain the risk score relating to your proposal:

There is a high risk based on age due to the closure of the inpatient beds. The level of consequence is deemed minor due to the robust mitigations that are in place as outline in this document. It is estimated that 2-3 patients per month who live in Lutterworth will be impacted by the closure of the hospital beds but as noted we have put mitigating measures in place.

6. Equality Action Plan

Please outline any actions or recommendations arising from this assessment of the proposal.

A target completion date is required for all actions and recommendations

	Lead Person	Target Date	Further Comments
We will monitor the areas where we have identified a negative impact and ensure that the mitigations are in place	Sarah Prema	31/01/2025	This will take place if the business case is approved and the changes are implemented
We will monitor the areas where we have identified a positive impact and ensure that these continue to be in place	Sarah Prema	31/01/2025	This will take place if the business case is approved and the changes are implemented
We will monitor the areas where we have identified a neutral impact to ensure that their status has not changed or improved.	Sarah Prema	31/01/2025	This will take place if the business case is approved and the changes are implemented

7. Approval

Below fields to be completed by E&I Team upon receiving assessment:

Date received by E&I Team for assurance check: **25/04/2023**

Name of E&I Team member completing assurance check: Shaun Cropper

Date of completed assurance check: **02/05/2023**

8. What Next?

1. **Regularly review the action plan and update the EHIIRA accordingly.**

2. **Save a finalised copy for your records and share via your governance pathways and with the E&I Team.**

Follow any specialist advice or guidance from the E&I Team (if provided).

Appendix H

NHS
Leicester, Leicestershire and Rutland

'Have your say on proposed improvements to health services in Lutterworth'

Public consultation about proposed improvements to the access of community health services in Lutterworth

V13 26 September 2023

Contents

Page No :

Service improvements being consulted on – at a glance

Other service improvements – at a glance

The proposals step by step –

- Increase the number of outpatient appointments provided in Lutterworth
- Provide more inpatient care at home or in the place people call home
- Work already underway to expand and transform GP practice services that support the proposals
- Creation of the Lutterworth Health Campus

How we propose to fund the improvements

How we arrived at the proposal

- The conversation with health staff, service users, carers and other stakeholders
- Options Appraisal
- Clinical assurance
- Ensuring equality of care

Section 4

The consultation

- How to get involved
- What happens after the consultation?

Section 5

Consultation questionnaire (including equality questions)

Glossary

SECTION ONE

We want your views

Health and care services face significant challenges. To meet these challenges the NHS has developed proposals with a range of partners to improve, increase and enhance local health services in Lutterworth.

We have been listening to what people want from their local services and have put together some proposals. This public consultation sets out the proposals to invest and improve health services in Lutterworth, including those provided in your own home, at Feilding Palmer Hospital and in other locations in Lutterworth.

This is your chance to find out more about what is being proposed and have your say. This will help the local NHS to understand what the changes would mean for you and help us to make a final decision.

This consultation **will run from 23 October 2023 to 14 January 2024**. We want to know what you think about proposals to close the 10 inpatient beds permanently and refurbish Feilding Palmer Hospital using the space to provide outpatient (an appointment in a hospital or clinic, but you do not stay overnight) and diagnostic services (a test or procedure to identify a disease or condition a person maybe suffering from). These services would benefit over 20,000 Lutterworth patients.

You can:

- Read this document which tells you what is proposed and why. More information is available on our website at www.haveyoursaylutterworth.co.uk. The website will also have details of the consultation's events. You can complete the questionnaire in this document or on the website.
- To request a copy of the questionnaire for you to fill in at home or to arrange to complete the questionnaire with a member of staff, telephone us on 0116 295 7572 or email: llricb-llr.beinvolved@nhs.net
- Email us your views at llricb-llr.beinvolved@nhs.net

For up-to-date news on the consultation, follow us on social media:
@NHS Leicester, Leicestershire and Rutland
@NHS_LLR

Are we speaking your language?

This document is available in an easy read format, on video, as a Word document for use with screen readers, and as a large print Word document. We can also support translation. These versions can be accessed on our website: **www.haveyoursaylutterworth.co.uk.**

SECTION TWO

About this consultation

This public consultation is being led by NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB).

The ICB is the organisation responsible for buying (commissioning) and making decisions about healthcare services in Leicester, Leicestershire and Rutland on your behalf. This includes many of the services provided by Leicestershire Partnership NHS Trust (LPT). LPT provide community health services including adult nursing, physiotherapy, and occupational therapy. These services are provided at home, in clinics, and in inpatient wards in community hospitals, including Feilding Palmer Community Hospital. It also includes services provided in a community setting by staff from University Hospitals of Leicester (UHL). UHL is known as an acute trust - an organisation caring for the sickest patients. It is mainly spread across three sites (Leicester General Hospital, Glenfield Hospital, and Leicester Royal Infirmary) but also in some other settings.

This document aims to:

- Set out why we need to make changes and maximise access to local health services in Lutterworth, some of which are delivered in partnership with other organisations.
- Explain the proposals to increase access to community health services in Lutterworth and join them up.
- Explain the proposals to close the inpatient beds in Feilding Palmer Community Hospital and remodel the space to expand outpatient and diagnostic services.
- Tell you about other services in Lutterworth that we aren't consulting on, but are linked to the proposals.
- Explain how patients and organisations who use or may use the services can get involved in the discussion.
- Outline what would happen after the public consultation.
- Seek your views by asking you to complete the questionnaire online at www.haveyoursaylutterworth.co.uk or to request a copy of the questionnaire for you to fill in at home. To arrange to complete the questionnaire with a member of staff, telephone us on 0116 295 7572 or email: llricb-llr.beinvolved@nhs.net

The proposals for Lutterworth are part of a much wider health and care improvement programme that is being delivered through the Integrated Care System (ICS) for

Leicester, Leicestershire and Rutland. The ICS is a partnership of NHS organisations working with local councils and others.

What is covered in this consultation?

This public consultation is about:

- Community services that improve both physical and mental health conditions. These would be provided in a number of locations in Lutterworth including the GP surgeries, Feilding Palmer Hospital and within patients' own homes or in a care home.
- Finding a better way of using the current space in Feilding Palmer Hospital to provide outpatient and diagnostic services for over 20,000 patients replacing the current 10 inpatient beds.
- Overtime creating a Lutterworth Health Campus on Gilmorton Road, Lutterworth to include health and care services – mental health, GP practices, local authority services, optometry, and dentistry.

These plans are specifically designed to:

1. respond to the expected growing demand for local services which will come from people living in the 2,700 new homes being built in the future.
2. improve support to people who need physical and mental health services.
3. provide more services closer to home.

What is not covered in this consultation?

This public consultation does not cover all mental or physical health services outside of Lutterworth and the immediate surrounding areas. We do tell you in the document about other services provided in Lutterworth, to help you have a more detailed view of the proposals and how they link to other services which include those:

- delivered at the Wycliffe Medical Practice and The Masharani Practice.
- social care services delivered in local care homes, home care, home assessment, and reablement and crisis response services.

SECTION THREE

Background

The NHS of the future will be fundamentally different from the NHS of today. This is partly due to the huge and existing possibilities for continuing advancement in medical treatments and better care outcomes for people.

It will also be due to the NHS response to the challenges we face. For example, people are currently waiting longer for a diagnosis and treatment. Access to services is sometimes difficult and the NHS is trying to ensure it can cover the cost of providing high quality health services with a well-trained workforce.

In addition, the NHS is planning for the local population to grow significantly while making sure that people have equal access to health services. This situation is very relevant to Lutterworth, as it is expected that the population will increase in the near future.

We, therefore, need plans to tackle these current and future challenges. In response, the NHS proposes to increase the number of health services available to people in Lutterworth and join care up to improve patient experiences and improve the health and wellbeing of the local population.

Since 2014, we have had conversations with people about physical and mental health services. We have listened to what people have told us about their experiences of services and what matters to them.

People told us:

- *"I need staff to understand me and my family and friends and to focus on my care needs."*
- *"I want to live the best life I can, achieve my goals and live independently."*
- *"I need staff to work together to help me achieve my goals and meet my needs."*
- *"I want services to be easy to access and to understand how I can receive more information, so I am confident to care for myself."*
- *"I would like as much care as possible to be provided near to where I live and be organised around my needs and the needs of my local community."*
- *"As a carer, I need support to care for my loved one and not have to tell my story a number of times."*

This feedback has helped us to develop these proposals to ensure that they meet the needs of local people. Full details of the engagement are available [insert link to Pre-Consultation Business Case on website].

About the current community health services

Services provided at your GP practice

A range of health services are currently delivered in Lutterworth, from a variety of locations and by a number of different providers.

Lutterworth Medical Centre is on Gilmorton Road. There are two GP practices within the medical centre: Wycliffe Medical Practice and The Masharani Practice. The two Lutterworth practices serve just over 17,000 registered patients. Both practices work with other GP practices through a network called the South Blaby and Lutterworth Primary Care Network (PCN). There are 5 GP practices in the network.

The table below provides more information about the services offered by Lutterworth GP practices:

Appointment methods	Digital services available through online internet access	Enhanced primary care services
✓ Face to face. ✓ Telephone. ✓ Online.	✓ Booking appointments. ✓ Cancel appointments. ✓ Repeat prescriptions. ✓ Change nominated pharmacy. ✓ View test results. ✓ Access GP medical records. ✓ Complete questionnaires. ✓ View vaccination records. ✓ Change contact details. ✓ View NHS number.	✓ Learning Disability health check. ✓ Minor surgery. ✓ Home first. ✓ 24-hour blood pressure monitoring. ✓ 24-hour ECG (checks the heart). ✓ Spirometry (checks lung condition). ✓ FENO (checks to see if you have inflamed airways). ✓ Ear syringing. ✓ First contact physiotherapy. ✓ Mental health practitioner. ✓ Enhanced access to services between 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays

Community Health Services

Community health services cover a wide range of care for people from their birth to end of life. Community health teams play an important role in supporting people with complex health needs to live independently in their own home for a long as possible. Many services involve staff working in partnership across health and social care teams. These partnerships are made up of lots of professionals including community nurses, district nurses, therapists and social care workers.

Many community health services are provided at several locations in Lutterworth including in peoples' homes, care homes and at the GP practices. They are also provided at Feilding Palmer Hospital, which is owned by Leicestershire Partnership NHS Trust. The services delivered out of the hospital are provided by staff from both Leicestershire Partnership NHS Trust and University Hospitals of Leicester.

Prior to the pandemic the following services were provided in Feilding Palmer Hospital; however, there was a limited number of sessions held. For example, cardiology services were only provided monthly and general surgery was provided twice a month:

- Abdominal aortic aneurism screening
- Dermatology
- Dietary
- Echocardiogram (ECHO)
- Gynaecology
- Heart Failure
- Mental Health
- Musculoskeletal (MSK) physiotherapy
- Out of Hours
- Paediatrics
- Parkinson's care
- Psychiatry
- Psychiatric nurse service
- Speech and language therapy (adults and children)
- Stoma

The pandemic meant we had to dramatically change services to stop the virus from spreading, so many services ceased. However, many services are running again. Currently provided in Feilding Palmer Hospital either on monthly or bi-monthly basis are:

- Abdominal aortic aneurism screening
- Attention deficit hyperactivity disorder (ADHD)
- Dermatology
- Dietary

- Echocardiogram (ECHO)
- Heart Failure
- Mental Health
- Musculoskeletal (MSK) physiotherapy
- Out of hours
- Paediatrics (children)
- Parkinson's care
- Psychiatrics
- Psychiatric nurse
- Pulmonary and cardio rehabilitation
- Speech and language therapy (adults and children)
- Stoma
- Walking aid clinic

There were also beds for overnight stays provided at Feilding Palmer Hospital called inpatient beds. They were provided in one ward which had 10 beds. One of the beds was in a suite and was used for caring for terminally ill patients, known as palliative care. These beds have remained closed as the building no longer meets infection prevention and control inpatient standards, which help prevent infections and harm to patients.

There are several providers of social care services which provide personal care and practical assistance to meet the needs of people in Lutterworth. These services are provided by four care homes. There are also four organisations providing services in peoples' homes. These are all described later in this document.

People are also receiving care from other social care providers outside of Lutterworth including in the wider districts of Harborough and Blaby.

Leicestershire County Council also provide services in Lutterworth and surrounding areas. They include:

- Home Assessment and Reablement Team (HART) service which is a short-term domiciliary care service supporting someone in their own home. It is designed to help people develop the confidence and skills they need to live as independently as they can. It supports people to do social care tasks for themselves, rather than doing it for them, including personal care (washing and dressing) and preparing food and drink. This service is available for people to prevent them being admitted to hospital as well as those who are being discharged from hospital.

- Crisis Response Service is a short-term service which supports people who are experiencing a health or social care crisis within their own home and who, without help, may be admitted to hospital or a care home. The service is available 24 hours, 7 days a week, helping people to remain independent and living at home. The service is available for a maximum of 3 days.

The reasons why we need to make changes and improve the health services provided in Lutterworth

There are lots of reason why health services need to change and improve:

- **Our population's health and care needs are changing**

The Joint Strategic Needs Assessments for Leicester, Leicestershire and Rutland tell us about the health profile of the Lutterworth population.

- The life expectancy of men and women is expected to go down.
- There are some council wards, of which there are seven in and around Lutterworth, where childhood obesity is higher than in other areas. These are Lutterworth East and West, Ullesthorpe and Dunton Bassett. There are also more alcohol episodes resulting in hospital admissions in people under 18. A higher number of adults are overweight or obese than the England average.
- There is a higher risk of loneliness for some parts of the population.
- Hip fractures in people aged over 65 are all significantly worse than regional or England averages, as are diabetes and dementia diagnoses.

- **Our population numbers are growing**

Lutterworth currently has a population of approximately 9,500. There will be a significant growth in the population of Lutterworth in the next few years, as there are estimated to be 2,750 more homes being built. This development is part of the Lutterworth East Development Area. The age group of people moving to the new homes is expected to be of working age. This will significantly increase the number of people living in the area who will require diagnostic, outpatient and GP services, rather than intensive treatment and rehabilitation provided when staying in a community hospital bed.

– **The locations where services are provided are no longer fit for the 21st Century**

Hospital conditions

- Cramped, congested and poorly laid out.
- No single sex wards and shared bathrooms for males and females.
- Disability access is restricted in some areas.
- Building environment makes it unsuitable to deliver inpatient care.
- Ward size is small and restricted and there is insufficient space between beds.
- Wards and bathrooms do not provide expected privacy and dignity for patients.
- Narrow doors and corridors unsuitable for trollies and bed movement.
- Inadequate ventilation is only provided in the dirty utility room (the sluice).
- There are no 'clean' areas for cleaning. A 'clean area' is where items that will usually come in to contact with patients are kept, where they are sterile and ready for use.
- Internal damage due to having a pitched roof.
- Limited staff welfare facilities.

The problems

- Significant financial resource would be needed to modernise inpatient services so that they meet national regulations.
- Building doesn't meet infection prevention and control standards as people would be at risk of cross-infection.
- Not an attractive place for staff to work as staff do not like working in the inpatient ward, making filling shifts very difficult.
- A small single ward is expensive to run compared to larger wards, due to overheads costs and minimum staffing requirements.
- No privacy and dignity for patients in inpatient beds.

The poor condition of the current facilities is demonstrated in the photographs below:

Example of poor infrastructure in ward corridor. Narrow and impossible to move beds around

Lack of privacy and dignity - corridor with W.C. shower facilities (male and female)

Lack of privacy and dignity for patients in the ward area

Lack of privacy and dignity with Jack and Jill shower room for both males and females accessed through different doors

'Dirty' utility and no 'clean' area

Inadequate ventilation for a hospital, with a vent far less powerful than the vent in a standard family bathroom.

- **More services are being provided at home or in the place people call home**

We need to keep more people at home through periods of crisis or deterioration. People recovering at home have better outcomes and they can maintain relationships with friends, family and social networks when they are in a familiar place. People are also at less risk of infection at home and in most cases the body copes better, particularly when moving about. Muscles are less likely to weaken and the strength of your bones is maintained. Movement also helps with digestion (how your body breaks down your food).

We also need to increase the number of people discharged from an acute hospital bed, like those provided in the large hospitals in Leicester, directly into their own home to help them recover quicker and avoid so they avoid illness or a deterioration in their health. For the same reason, people also need periods of reablement in residential homes.

Since the pandemic, the palliative care previously provided in Feilding Palmer has been provided at home, in a care home or in a local LOROS hospice. We would continue this service as it has allowed people to stay in the place they feel most comfortable - surrounded by memories and the people they love, rather than a hospital environment.

- **Lower numbers of people from Lutterworth and immediate surrounding areas were using inpatient beds at Feilding Palmer Hospital**

Inpatient beds were closed temporarily during the pandemic. They have not reopened as they do not meet infection prevention and control standards. The number of people using Feilding Palmer Hospital for overnight stays pre-pandemic had declined year on year. When the beds were open in 2019/20, 99 from people from the Lutterworth area were admitted to a community hospital, of which only 31% (31) went to Feilding Palmer. More residents of Lutterworth and South Blaby chose other community hospitals rather than Feilding Palmer. A higher number of people are also choosing to receive care at home.

- **A higher number of people are choosing to receive care at home rather than in hospital**

There has been a downward trend, since the pandemic, of people using community hospital beds in general and a reduction in the demand for inpatient beds at Feilding Palmer Hospital. There has also been an upward trend in people receiving more care in the place they call home.

Recent Department of Health and Social Care information on hospital discharges and community support identifies that 95% of people are likely to be discharged

home, of which 50% require no new or additional support and 45% need additional packages of care or their care prior to going into hospital restarted.

In addition, Feilding Palmer Hospital is not able to accommodate some patients. This includes those who are bariatric (classed as having obesity) and people with high levels of acuity (the sickest patients) who require a lot of equipment, which can't be provided due to limited space.

- **There are long waits for diagnosis and treatment**

People are currently experiencing long waits to receive a diagnosis and for treatment. Many people living in and around Lutterworth are travelling out of the area to receive a diagnosis and treatment. If Feilding Palmer Hospital is remodelled, they could be diagnosed or treated locally as an outpatient or a day case procedure. This is often older patients, living with long term conditions, who are making long journeys to the main hospitals. They are reliant on family and friends to take them, who then experience parking and access difficulties. Services in Lutterworth would not only reduce this traumatic burden, but it would also reduce the demand at acute hospitals such as those in Leicester, as well as reducing the carbon footprint.

- **Our community services don't link together**

Local services are disjointed and don't link up with each other very well. People tell us that they have problems accessing services and find it difficult moving from one service to another. Those services often don't talk to one another, so people have to repeat their story. They tell us that services often aren't personalised to their needs, particularly if they are complex. They also tell us they want to be able to keep themselves as well as they can be and prevent ill health. Overtime, creating a Health Campus on Gilmorton Road should help with some of the communications problems that exist.

- **Current way of providing inpatient care is expensive**

The small capacity of just 10 beds in a community hospital like Feilding Palmer means that we still have to meet minimum staffing requirements. If we compare the number of nurses with the number of patients being cared for at Feilding Palmer it is closer to the staff to patient ratio in an Intensive Treatment Unit, which is a special ward providing intensive care for people who are critically ill.

- **There is more demand for services provided at GP practices**

Since the pandemic, we know there has been more demand for services including those provided at your GP practice. We need to do something different to respond

to this demand. To make them more efficient, we are joining services up. GPs and their teams provide services in the community and are working with other providers to provide a range of services that help people avoid a hospital admission and get people discharged from hospital quicker.

- **Need to deliver local and national plans**

There are a number of local and national plans that outline the ambitions for the NHS. The plans identify the need to work differently including making better use of data and digital technology and prevent ill health and tackle health inequalities. They also involve increasing our workforce and keeping the staff we have by making the NHS locally a better place to work. We need to relate these plans to Lutterworth to improve services and enhance the health and wellbeing of the local community.

What improvements are being made to services in Lutterworth?

Service improvements being consulted on – at a glance

The table below show how services are provided now and how we propose to provide them:

Service we are consulting on	How it is provided now	How we propose to provide it
Increase the number of outpatient activity providing in Lutterworth	The following services are provided at Feilding Palmer Hospital: • Abdominal aortic aneurysm (AAA) screening • Attention deficit hyperactivity disorder (ADHD) support • Dermatology • Dietary • Echocardiogram (ECHO) • Heart Failure • Mental Health • Musculoskeletal (MSK) physiotherapy • Out of Hours • Paediatrics (children) • Parkinsons care • Psychiatrics • Psychiatric nurse • Pulmonary and cardio rehabilitation • Speech and language therapy - adult and children • Stoma • Walking aid clinic Other diagnostic and outpatient services are provided outside of Lutterworth, e.g. acute hospitals.	In addition to the 17 services currently provided at Feilding Palmer hospital, we would add new services, providing approximately 325 patient appointments per week. In the first phase, we would add the following 5 services: • Additional dermatology services • Gynaecology • Ophthalmology • Trauma & orthopaedics • Urology We would later add the following 5 services: • Cardiology • General internal medicine • General surgery • Respiratory medicine • Rheumatology
Provide more inpatient care at home or in the place that people call home	The following services were provided pre-pandemic at Feilding Palmer: • 10 inpatient beds, including palliative care suite The following care homes provide beds: • Wood Market House (42 beds) • Lutterworth Country House Care Home (66 beds) • Hunters Lodge (beds 17). • Brook House Care Home (41 beds) The following organisation provide care at home: • Home Instead Rugby • Help At Home (St Marys House) • Helping Hands Market Harborough There are also a number of care and nursing home in the districts of Blaby and Harborough. Leicestershire County Council provide the following services: • Home Assessment and Reablement Service (HART)	The 10 inpatient beds would close permanently and the space would be used to provide outpatient and diagnostic services (shown above). We would continue to use the care homes, care at home providers, Leicestershire County Council services, and community hospital inpatient beds shown in the left column. We would continue to increase the number of beds at our other community hospitals. With existing and proposed growth this would provide a total of additional 52 beds. This would increase our intermediate care offer (services provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital) to support reablement, rehabilitation and recovery.

	• Crisis Response Service Community hospitals with inpatient beds are located in: • Market Harborough, • Hinckley	

Other service improvements – at a glance

Expand and transform GP practice services	Wycliffe Medical Practice and The Masharani Practice provide the range of general medical care, along with the following: • Learning disability health check. • Minor surgery. • Home first. • 24-hour blood pressure monitoring. • 24-hour ECG (checks the heart). • Spirometry (check lung condition). • FENO (checks to see if you have inflamed airways). • Ear syringing. • First contact physiotherapy. • Low-level mental health support.	Continue to provide all current services and expand services to include: • More access to urgent, same-day care and advice from a range of staff depending on need. • Increase appointments provided in the before 8am, after 6.30pm and on a Saturday. • More joint working with other providers of services. • In response to the increase in housing, work will happen at the practices to increase the capacity of patients registered.

The proposals – step by step

Increase the number of outpatient appointments provided in Lutterworth

We propose the following services are provided in Feilding Palmer Hospital in Lutterworth, with a greater number of sessions provided on a weekly and monthly basis:

- Abdominal aortic aneurysm (AAA) screening
- Attention deficit hyperactivity disorder (ADHD) support
- Dermatology
- Dietary
- Echocardiogram (echo)
- Heart Failure
- Mental Health
- Musculoskeletal (MSK) physiotherapy
- Out of Hours
- Paediatrics (children)
- Parkinsons care
- Psychiatrics
- Psychiatric nurse

- Pulmonary and cardio rehabilitation
- Speech and language therapy - adult and children
- Stoma
- Walking aid clinic

In addition to the 17 services currently provided at Feilding Palmer hospital, we would add new services. In the first phase, we would add the following 5 services:

- Additional dermatology services
- Gynaecology
- Ophthalmology
- Trauma & orthopaedics
- Urology

We would later add the following 5 services:

- Cardiology
- General internal medicine
- General surgery
- Respiratory medicine
- Rheumatology

These services equate to approximately 325 patient appointments per week and mean that procedures that currently people have to travel to receive would be done in Lutterworth. For example, endoscopies of the bladder, uterus and nose (the insertion of a long, thin tube directly into the body to observe an internal organ or tissue in detail). Also, dermatology treatments, which are conditions that affect the skin, hair and nails. Some biopsies will also take place (taking a small sample of tissue to examine under a microscope) for conditions on the skin, head, neck and other parts of the body. Also, injections and some ultrasound (scan that creates an image of the inside of the body) examinations would be available.

To reduce the number of times a patient has to attend appointments to discuss their condition, they will be provided, as far as possible as a 'one-stop shop'.

In order to provide these services, the 10 inpatient beds would permanently close and the space will be refurbished. The refurbished space, which would meet building standards will provide a fit for purpose, flexible space to provide many more outpatient and diagnostic services needed by the community.

The increase in the number of outpatient and diagnostic services at Feilding Palmer Hospital is estimated to reduce the number of miles travelled by patients by 200,000 per year, reducing the carbon footprint.

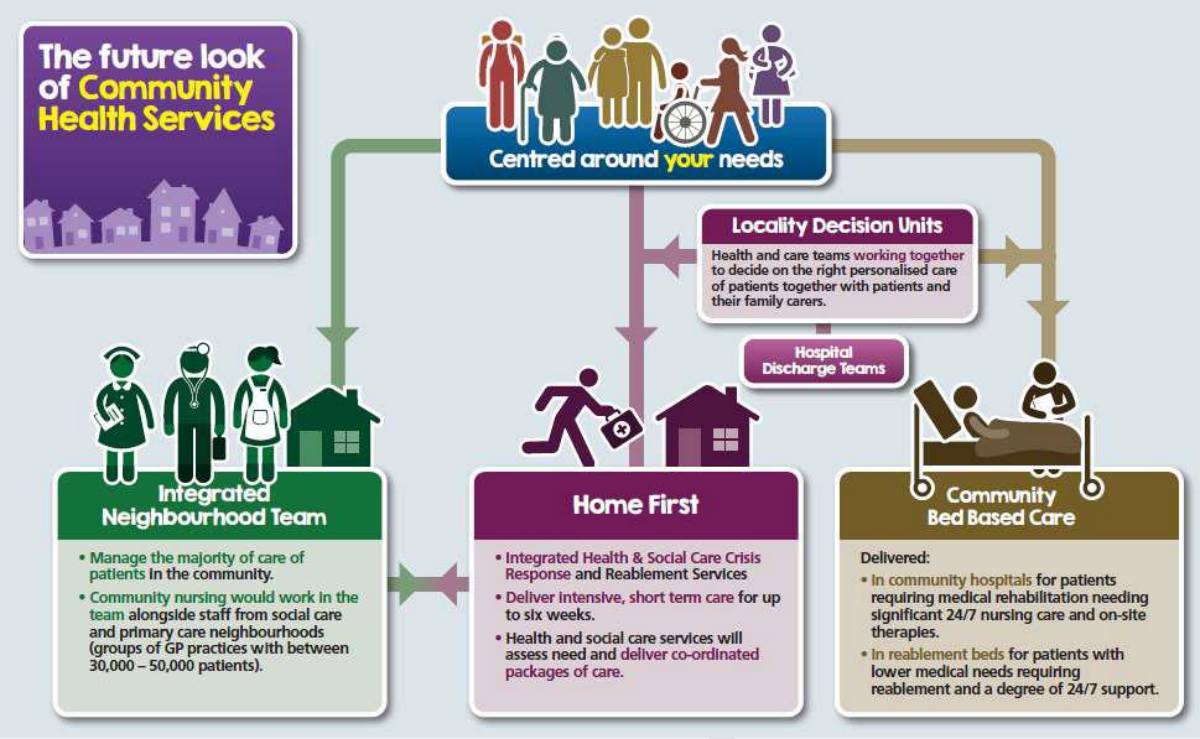
Provide more inpatient care at home or in the place people call home

Leicester Partnership NHS Trust (LPT) has changed the way services are provided for frail and vulnerable patients to prevent people going to hospital and helping them to get discharged from hospital quickly. They include:

- Community crisis response – urgent 2-hour response – a target that we are already exceeding.
- Physiotherapy and occupational therapy
- Rehabilitation
- Community palliative care (end of life). This is provided in the community, hospice at home, hospice inpatient beds, care home beds and virtual ward
- Falls prevention and assessment

The new model of providing services is based around the following:

- **Neighbourhood community nursing** - managing the majority of care of patients in the community, working closely with social care and primary care networks (PCNs).
- **Home First services** - integrated health and social care crisis response and reablement services, which would deliver intensive, short-term care for up to six weeks. Home First services are accessed via people working in a Locality Decision Units. Health and social care services work to one assessment, delivering co-ordinated packages of care. Since Home First was first introduced, we have seen an increase in people using it year after year. Over the next 10 years, we will continue to invest and strengthen the service.
- **Community bed-based care** – delivered in reablement beds, in care homes or the patient's own home. Suitable for patients with lower medical needs requiring reablement and a degree of 24/7 support. This service is available to people who require urgent personal care, have fallen but don't require a hospital assessment or treatment, or are at risk of further fall. Also, those who require support with prescribed medication or who have become confused or distressed and require assurance and personal care, or those who need assistance to support them with urgent nutritional issues.



What this means for residents of Lutterworth is a focus on preventing people from becoming ill or deteriorating. People who are living with a long-term condition will be supported to manage their own care, avoiding an urgent hospital admission wherever possible.

When there is a requirement for an urgent and immediate response this will be delivered by skilled specialists either in the patient's home or a community location. Where there is a need for an acute hospital stay people will be returned home where possible or into a community facility where they will be rehabilitated so they have every chance of recovery and get back to living independently.

To ensure receiving care is easier, the communications and relationships between organisations providing services will be enhanced.

Where people need a bed, the provision in Lutterworth includes:

The following care homes provide beds:

- Wood Market House (42 beds)
- Lutterworth Country House Care Home (66 beds)
- Hunters Lodge (17 beds)
- Brook House Care Home (41 beds)

The following organisations provide care at home:

- Home Instead Rugby
- Help At Home (St Mary's House)
- Helping Hands Market Harborough

There are also several social care providers including home care a nursing and care homes in the districts of Blaby and Harborough.

The follow care homes provide beds:

- **Care Homes (Blaby):**
  - Woodway House (32 beds)
- **Care Homes (Harborough):**
  - Herons Lodge (10 beds).
  - HF Trust - Cromwell Crescent (3 beds).
  - Lenthall House (40 beds).
- **Nursing Homes (Harborough):**
  - Peaker Park Care Village (137 beds).
  - The Willows Nursing and Residential Home (57 beds).

The follow organisations provide care at home:

- **Home Care (Blaby):**
  - Medacs Healthcare Leicester.
  - Carelink Healthcare Professionals Ltd.
- **Home Care (Harborough):**
  - Carewatch (Harborough).
  - CT Care Ltd.
  - Freedom Support.
  - HF Trust - Leicestershire DCA.
  - New Horizon Care.
  - TML Care Solutions Ltd.
  - Welland Place.
  - Xcel Homes Ltd.
  - Yourlife (Market Harborough).

When people are at the end of life, there would be services to support them, including:

- Specialist palliative care and advice for patients in the community provided 24 hours of the day, 7 days per week. This is provided by staff from LPT and LOROS.
- Inpatient beds provided in a hospice including LOROS emergency admissions.
- Hospice care provided at home by LOROS.
- Overnight care for people at home.
- Virtual ward support for people at home after discharge and preventing them from having to go to hospital.

There are a number of community hospitals close to Lutterworth including:

- Market Harborough Community Hospital (14.9 miles or 25 minutes' drive from Lutterworth)
- Hinckley and Bosworth Community Hospital (13.6 miles or 28 minutes' drive from Lutterworth
- University Hospitals of Coventry – Walgrave Hospital (19.7 miles or 31

minutes' drive from Lutterworth)

We are implementing additional beds in the community hospitals in Leicester, Leicestershire and Rutland which will increase our intermediate care offer by 52 beds to support reablement, rehabilitation and recovery.

Work is already underway to expand and transform GP practice services that support the proposals

GP practices are already working closely together as primary care networks (PCNs) The PCN for Lutterworth is called South Blaby and Lutterworth PCN. It has 5 practices working together to improve and increase local services. All 5 of those practices are supportive of the plans to increase services in Lutterworth.

GP practices services are already expanding and transforming which supports our proposals as it is integral to the way that most care would be provided in the local community.

The PCN covering the Lutterworth area has a wide team of health professionals that have become involved in patients' care. This includes **clinical pharmacists, physiotherapists**, **physician associates**, **community paramedics** and **social prescribing link workers,** who look after patients day-to-day.

GPs and the health professionals in practices work together with others in their group, as well as with other health, social care and voluntary sector organisations, to plan the care patients need and prevent ill-health. These wider teams include pharmacists, district nurses and specialists who care for certain types of conditions or groups of patients with particular needs.

GPs will always care for the most seriously ill patients or those with more complicated illnesses. But it is not always the best use of their time and expertise if they see patients that other members of the practice team are qualified and experienced to manage. People contacting their practice are advised who is the most appropriate person to see. If people are seen by one professional, but then need further care or a second opinion, this will happen safely.

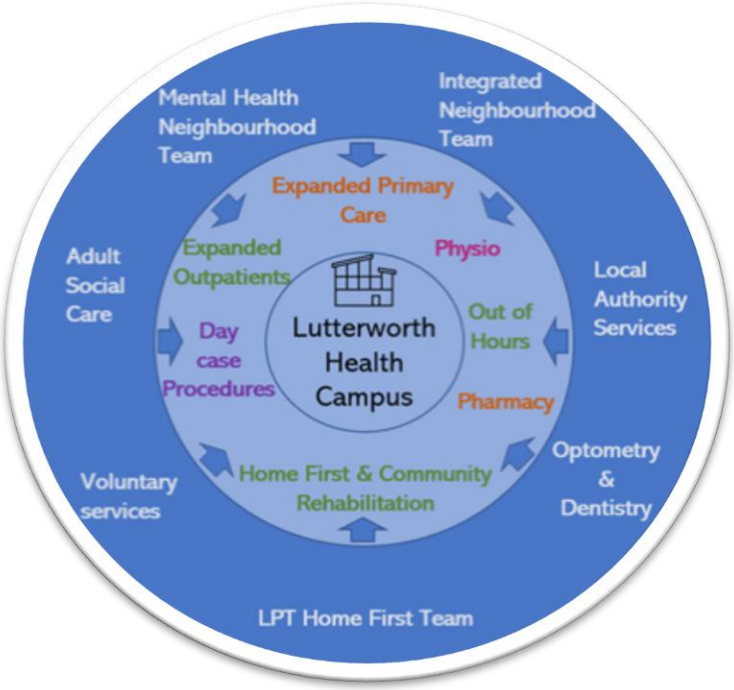
All PCNs now provide an increase in access to GP services between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays.

This service is providing many benefits, such as improved access and more care closer to home provided by a patient's own GP staff or staff from other practices within their local PCN.

Creation of the Lutterworth Health Campus

Overtime, the healthcare improvements being made in Lutterworth, described in this document, would result in the creation of a Lutterworth Health Campus. The services shown below will be provided in Lutterworth, with many located on Gilmorton Road.

This means that health and care teams from GP practices, social care, mental health teams, community teams will be working in very close proximity with each other. This will improve relationships and communications and join services up, which will benefit patients and services users.



How we propose to fund the improvements

The investment to pay for these changes and improvements is £5.8 million. This will fund the internal refurbishment of Feilding Palmer Hospital and has been agreed by local NHS partners.

Details of the finances relating to these proposals are included in the Pre-Consultation Business Case. [insert link to PCBC on website].

How we arrived at the proposal

The conversation with health staff, patients, carers and other stakeholders

Early proposals for Lutterworth were developed as far back as 2016 and were part of the Sustainability and Transformation Partnership. This was the name given to

organisations working together to improve health services in Leicester, Leicestershire and Rutland. This has now been replaced by the Integrated Care System.

These plans have been updated and refined, particularly in the light of the pandemic. Patient and public engagement has taken place over a number of years and has been refined over time with the NHS doing more work to understand the needs of the local population. The insights, learning and business intelligence have been shared and used to inform the design and delivery of care. Ultimately to improve the lives of local people, improving their health and wellbeing.

A summary of top line themes from analysis of multiple sources of data collected during 2020/21, 2021/22 and 2022/23 are shown below. This includes insights from the Community Service Review, Building Better Hospitals, Covid-19 Report, GP Practice Survey (local and national research) and Step up to Great Mental Health. This represents a total number of insights from 52,000 people.

This data has then been examined against 79 local reports, produced by NHS bodies and other local organisations produced during the last 3-5 years.

Leicester, Leicestershire and Rutland Topline Data including Lutterworth insights

Exploring some of the key issues

BLOCKS IN BUILDING STRONG LOCAL NHS SERVICES

ENHANCING COMMUNICATIONS

1. More efficient links and exchanging of information between different healthcare services e.g. GP and hospitals
2. Improved and shared IT systems to allow efficient transfer of records/ access to information
3. Reducing barriers in language and understanding of different cultures
4. Changes and transformation in care and its impact to be communicated in messages tailored to different communities including vulnerable groups.
5. Carers to be an integral part of communications about the person they care for
6. Consistent, simple and clear messaging delivered from source that is trusted by people and tailored to different communities
7. "Joined-up way of working" between services and across borders to deliver care

BUILDING TRUST & RELATIONSHIPS

1. Family carers feel a more relevant and reliable support is needed combined with a better understanding and recognition of their role
2. Ability to build strong relationships with patients / family and other services can enhance care provided by staff
3. Urgent care system - a reassurance if the need is urgent or in emergency – for both physical and mental health users
4. Relations with services, incl. GP are important to people
5. Increased connections between community and healthcare providers

ENABLING SELF-CARE

1. Care at home is important but impacted by lack of confidence and feeling stressed/ isolated
2. Urgent care system seems to respond to illness rather than support health creation/ focus on the person as a whole
3. Reliable and relevant help and guidance to self-care is required for both physical and mental heath users
4. Those with long term conditions want to be able to look after themselves when possible, but be sure that support exists if they need it

PROVIDING A QUALITY SERVICE

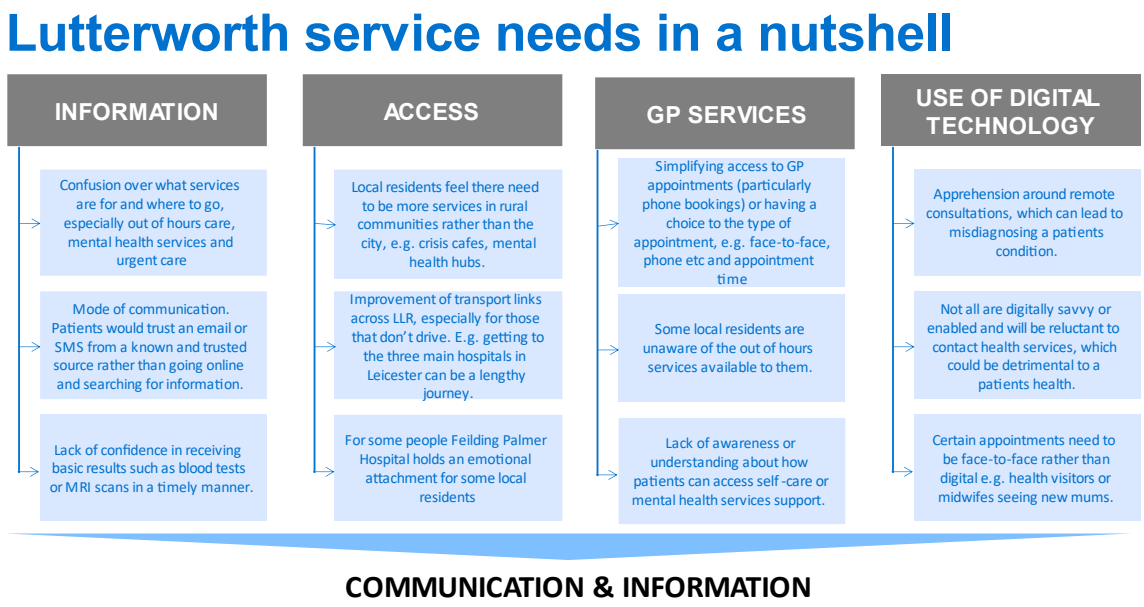
1. Having access to shared records to avoid repeating case history - consistency and continuity of treatment are important
2. Greater integration of services , e.g. transfer between services/ handovers are stressful
3. Improved discharge from hospitals which can be chaotic, e.g. late evening
4. More support for those with complex care needs
5. Improved quality of the end of life experience incl. how people are treated and spoken to
6. Important to have support before planned treatments and appropriate follow -ups
7. Concerns around the "home first" approach; the package of care and paying for care; pressure on family/neighbours

IMPROVING ACCESSIBILITY

1. Mobility and difficulty with transport incl. public transport and car parking are creating access issues
2. Ease of access to primary care is important incl. online, BSL interpretations, translator, ease of booking an appointment
3. Address the equality of access and availability of "closer to home" care
4. Concerns around the access for rural communities and out - of-city residents
5. Waiting times are a concern - timely access to appropriate treatments
6. Digital consultations are supported , but only if appropriate to condition and choice should be offered,
7. Community hospitals are seen as important part of "closer to home" care and should be better utilised

Key themes in their own words

Insights specific to Lutterworth



In February 2023, a Task and Finish Group was established with a range of local stakeholders including voluntary and community sector representatives, stakeholders, Patient Participation Group representatives from two local surgeries, councillors and patients. The group has been responsible for co-designing this the Communications and Engagement Plan and this Consultation Document. The group will continue to influence the implementation of the public consultation.

Options Appraisal

When the NHS develops plans to improve services, it undertakes an Options Appraisal. This appraisal allows a few different alternatives to be evaluated against a set of agreed national criteria. It looks at how strong and weak each option is against the criteria. It also considers whether each option is affordable and will provide a high quality and safe service that meets the needs of the population.

A workshop was held on 29th March 2023 with attendees from key stakeholder organisations, to undertake the Options Appraisal. The results of the workshop are included in the Pre-Consultation Business Case [insert link to website}. They were also shared with the Lutterworth Steering Group, which is the group that oversees the overall improvement programme for Lutterworth.

One of the options reviewed was the development of a new larger hospital. The estimated cost of this option is circa £30 million. This option was rejected as the number of patients in Lutterworth requiring inpatient beds is small and, therefore, it is not a cost-effective solution and the best use of taxpayers' money. In addition, the benefit of keeping patients at home would be significantly reduced.

This public consultation is now asking the public to look at the realistic options and comment on them.

Clinical assurance

In June 2023, our future service model was reviewed by the [1]East Midlands Clinical Senate. The final report from the Senate states:

- The panel were fully assured that the Feilding Palmer site was not fit for modern day healthcare, that the inpatient beds should remain closed and that there was no need identified for an inpatient facility in this locality.
- The Feilding Palmer site was clearly an asset to the system which should be made best use of. The panel heard a clear emphasis on what could be done differently with the building with a clear steer towards increased outpatient activity. The panel heard many options for delivering outpatient care differently and would encourage the system to ensure that these ideas are forward thinking including things such as Patient Initiated Follow Up as opposed to the traditional NHS follow up mechanisms.
- The panel commended the collaborative nature of the system's processes which had ensured that a broad range of partners had been included in the development work from its infancy.
- The panel were assured to hear the innovative system thinking regarding both programmes to build a new workforce for the future and thinking about effective and appropriate use of the current workforce to deliver the right care in the best location.

The Senate review is available to view on the consultation website [insert link]. The Senate report sets out five recommendations for our future work.

In addition, local co-design of the proposals and assurance has been provided by clinicians from LPT and local GPs.

Ensuring equality of care

As both a legal requirement, but also as a moral duty, we have ensured that engagement has reached out to everyone who has an interest in the proposals and encouraged them to get involved.

[1] The East Midlands is one of 12 regional Clinical Senates, who act as a source of clinical leadership and impartial clinical advice to support commissioners and other stakeholders to make the best decisions about health care for their populations.

An initial [2]equality impact assessment was undertaken to ensure that there will be equitable access for everyone, avoiding inadvertently excluding any groups of people (based on protected characteristics, for example). The initial assessment, which considered the requirements placed on the NHS through the [3]Public Sector Equality Duty, will be reviewed and revised at key stages throughout the consultation. [Insert link on website to EIA]

SECTION FOUR

The consultation

How to get involved

This public consultation will run from Monday 23 October 2023 until 11.59pm on Sunday 14 January 2024.

We want to know what you think about these proposals to improve services. Come along to one of our drop-in events.

- Lutterworth Library, George Street, Lutterworth LE17 4ED
  Drop-in sessions for support to complete the questionnaire
  Every Thursday throughout the consultation, 10am – 1pm (except 7th November, 28th December, and 4th January)

- Lutterworth Sports Centre, Coventry Rd, Lutterworth LE17 4RB
  Drop-in session to ask questions or receive support to complete the questionnaire
  Monday 6 November, 2pm – 7pm

- Wycliffe Rooms (Main Hall), George Street, Lutterworth LE17 4ED
  Drop-in session to ask questions or receive support to complete the questionnaire
  Thursday 7 November, 10am – 2pm

Full details will be available on our website: www.haveyoursaylutterworth.co.uk
Complete the consultation questionnaire online at:
www.haveyoursaylutterworth.co.uk
Email your views to: llricb-llr.beinvolved@nhs.net
Telephone: 0116 295 7572

[2] An equality impact assessment is a process designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people

[3] Public Sector Equality Duty requires public bodies and others carrying out public functions to have due regard to the need to eliminate discrimination, to advance equality of opportunities and foster good relations

Write to us at: Freepost Plus RUEE–ZAUY–BXEG, Lutterworth consultation, Leicestershire and Rutland Integrated Care Board, Room G30, Pen Lloyd Building, Leicestershire County Council, Leicester Road, Glenfield, Leicester LE3 8TB
Follow our social channels: @NHS Leicester, Leicestershire and Rutland
@NHS_LLR
Or simply scan our QR code!

This public consultation is being led by NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB). The ICB is responsible for buying (commissioning) and making decisions about healthcare services in Leicester, Leicestershire and Rutland on your behalf.

Further information supporting the consultation is available on our website at www.haveyoursaylutterworth.co.uk.

Due to the volume of responses we expect to receive, we will not be able to write back to every letter, but we will do our best to respond to any questions.

Please be aware that your responses to this consultation will be passed to an independent organisation for analysis so that they can be summarised anonymously as part of our consultation report.

What happens after the consultation ends?

All the feedback we receive from the consultation will be independently analysed and evaluated by an external organisation. They will also undertake a review half-way through the consultation and advise the Integrated Care Board if there are communities that are not being reached. If the review shows any gaps, then we would adjust our engagement plan accordingly.

A final report of the consultation findings will be received by the Integrated Care Board in public meetings and the public consultation will be considered in any decisions they make.

We will promote the Board Meeting to enable people to attend and hear the discussions. All decisions will be made public after the Board Meeting. This work will include communicating the decision via local newspapers, social and broadcast media.

SECTION FIVE

'Have your say on proposed improvements to health services in Lutterworth'

Public consultation about proposed improvements to the access of community health services in Lutterworth

Consultation questionnaire

Thank you for taking the time to give your feedback on our consultation proposals for improving community health services in Lutterworth.

Please read more about our proposals in our Pre-Consultation Business Case which can be accessed here: [insert link].

This consultation questionnaire is your opportunity to give your views about the changes proposed, which we believe will deliver higher quality and safe services to meet the needs of the population of Lutterworth and surrounding areas.

The questionnaire is open to everyone: organisations, representatives and individuals including the general public, service users, carers and staff.

All information received via this questionnaire will be anonymous and your feedback will be independently analysed.

The consultation closes on Sunday 14 January 2023 and all feedback, including completed questionnaires, must be received by or on this date.

Data Protection Statement

The NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB) would like to understand your views on proposals to maximise services in Lutterworth.
The ICB has commissioned an independent organisation to collect, handle and process the responses gathered for this engagement. Any information you provide will be handled in accordance with GDPR and the Data Protection Act 2018.
The questionnaire also asks respondents to provide their full postcode and demographic profiling data (age, gender, ethnicity, etc.). This information is used to ensure the responses are representative of the demographics of the local population. You do not have to provide this information to take part in the questionnaire, but it really helps the ICB to ensure that any decisions made meet the needs of a diverse community.
Any reports published using the insights from the questionnaire will not contain any personal identifiable information and only show feedback in an anonymous format. These anonymised results may be shared publicly, for example on NHS public facing websites or printed and distributed.
Your involvement is voluntary and you are free to stop completing the questionnaire at any time. Only submitted responses will be included in the analysis. You can also refuse to answer questions in this

questionnaire, should you wish. All information collected via the questionnaire will be held for a period of five years from the date of questionnaire closure, in line with the Records Management Code of Practice for Health and Social Care 2020, which all NHS organisations work under.

❒ **Please tick to confirm you agree with the Data Protection Statement. If you do not provide your consent then we will not be able to include your feedback in this consultation.**

About you

Before starting the questionnaire, please tell us about you

A . Which of the follow best applies to you? (Please select one answer only)

□ I am answering this questionnaire as an individual service user or member of the public (move to question D1)
□ I am answering on behalf of another public sector organisation (move to question B)
□ I am answering as an NHS employee (move to question B)
□ I am answering on behalf of a patient representative organisation (move to question B)
□ I am answering on behalf of an NHS organisation (move to question B)
□ I am answering on behalf of a voluntary group, charity or social enterprise (move to question B)

B. If you are answering on behalf of an organisation or as an NHS Employee, please state the name of the organisation (if you are happy to do so) (then move to question C).

C. If you are answering on behalf of an organisation or as an NHS employee, please confirm if this is an official response from your organisation (then move to question D2).

□ Yes
□ No

D1. If you are responding as an individual service user or member of the public, please provide your full postcode (then move to question E).

D2. If you are responding as an organisation or as an NHS employee, please provide your organisation's postcode (this should be the building you are registered at).

E. How did you hear about this engagement (please select all that apply)?

□ Facebook/Twitter/Instagram/YouTube
□ Poster/Radio/Leaflet/Newspaper
□ Through a friend or family member
□ Through a staff communication
□ Event (Please specify details)
Where _____Date_____
□ Other (Please state)_____

Our Proposals

We would like to refurbish Feilding Palmer Hospital, so that we can provide more outpatient and diagnostic services. To create space for these new services, we would permanently close the 10 inpatient beds.

Outpatient: appointment in a hospital or clinic that you do not stay overnight for.
Diagnostic: test or procedure to identify a disease or health condition.
Inpatient: overnight hospital stay.

Q1. To what extent do you agree or disagree with this proposal?

Please tick one box only

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐
Disagree ☐ Strongly Disagree ☐

Q2. Please explain (in the space below) why you agree or disagree with this proposal. Please include any impacts (either negative or positive) that you feel this proposal may have on you, your family or any groups you represent.

We would increase the *number* and *range* of outpatient and diagnostic services provided at Feilding Palmer Hospital.

Overtime the following services would be provided abdominal aortic aneurysm (AAA) screening, attention deficit hyperactivity disorder (ADHD) support, dermatology, dietary, echocardiogram (ECHO), gynaecology, general internal medicine, cardiology, general surgery, respiratory medicine, rheumatology, heart failure, mental health, musculoskeletal (MSK) ophthalmology, physiotherapy, out of hours, paediatrics (children), Parkinson's care, psychiatrics, psychiatric nurse, pulmonary and cardio rehabilitation, speech and

language therapy - adult and children, stoma, and trauma, orthopaedics, urology, walking aid clinic.

Q3. To what extent do you agree or disagree with this proposal?

Please tick one box only

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐

Disagree ☐ Strongly Disagree ☐

Q4. Please explain (in the space below) why you agree or disagree with this proposal. Please include any impacts (either negative or positive) that you feel this proposal may have on you, your family or any groups you represent.

Q5. What other outpatient or diagnostic services do you think we should consider providing in Lutterworth?

We are providing more care to people in their own home or in the place they call home. If there is a need for an inpatient bed, it would be provided in a care home facility near or close to Lutterworth or in a nearby community hospital outside of Lutterworth.

Q6. If you have any specific comments about services provided at home or in a care home, please use this space to tell us.

We are providing more care in GP practices delivered by members of the practice team who are qualified and experienced to manage different conditions. A GP will always care for people with more serious problems, worsening conditions, or complicated illnesses.

Q7. If you have any specific comments about the services provided at your GP practice, please use this space to tell us.

Q8. Do you have any concerns about being able to travel to or access any services in Lutterworth and what would need to happen to make this less of a concern?

Q9. If you have any other specific comments about the proposals for community health services in Lutterworth or if there are any alternative proposals that you think we should consider, please tell us and explain these in the space below.

Equality monitoring questions

We want to make sure that everyone who already receives or who may need our services in the future has had the opportunity of getting involved in this consultation.

Your answers to equality monitoring questions also help us to make our services better. For example, if we find that a certain group of people have had a worse experience of particular services, we can work with them to make improvements.

Please spend a few moments to answer the equality questions below. These questions are optional, but the information provided will be anonymous and will play an important role in improving care.

Q9) What is your sex? (Select one option)

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Prefer not to say

Q10) Do you identify as the gender you were assigned at birth? (Select one option)

- ☐ Yes
- ☐ No (please tell us your gender identity: _____)
- ☐ Prefer not to say

Q11) What is your age? (Select one option)

- ☐ 16 – 19
- ☐ 20 – 24
- ☐ 25 – 34
- ☐ 35 – 44
- ☐ 45 – 54
- ☐ 55 – 64
- ☐ 65 – 74
- ☐ 75 – 84
- ☐ 85+
- ☐ Prefer not to say

Q12) What is your religion or belief? (Select one option)

- ☐ No religion
- ☐ Bahá'i
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Jain
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Prefer not to say
- ☐ Other, please tell us here: _____

Q13) What is your ethnicity? (Select one option)

Asian or Asian British:

- ☐ Bangladeshi
- ☐ Chinese
- ☐ Indian
- ☐ Pakistani
- ☐ Any other Asian background _____

Black or Black British:

- ☐ African background, please tell us here _____
- ☐ Caribbean
- ☐ Any other Black background _____

Mixed:

- ☐ Asian and White
- ☐ Black African and White
- ☐ Black Caribbean and White
- ☐ Any other Mixed or multiple background _____

White:

- ☐ British, English, Northern Irish, Scottish, Welsh
- ☐ Irish
- ☐ Gypsy/Irish Traveller
- ☐ Roma
- ☐ Any other White background _____

Other:

- ☐ Arab
- ☐ Polish
- ☐ Somali
- ☐ Prefer not to say
- ☐ Any other ethnicity _____

Q14) Are you pregnant or have you given birth in the last 26 weeks? (Select one option)

(The Equality Act 2010 protects women who are pregnant or have given birth within

a 26-week period)

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Q15a) Do you consider yourself to have a disability or suffer from poor health? (Select one option)
The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which has a long term (12-month period or longer) or substantial adverse effects on their ability to carry out day to day activities.

- ☐ Yes, I have a disability
- ☐ Yes, I am in poor health
- ☐ Neither
- ☐ Prefer not to say

Q15b) If you have selected 'yes', please tell us which condition(s). (Select as many options as appropriate)

- ☐ Physical
- ☐ Partial or total loss of vision
- ☐ Learning disability/difficulty
- ☐ Partial or total loss of hearing
- ☐ Mental health condition
- ☐ Speech impediment or impairment
- ☐ Long standing illness or condition
- ☐ Other medical condition or impairment, please tell us here

_____

Q16) Do you provide care for someone? (Select as many options as appropriate)

- ☐ Yes - Care for young persons(s) aged 24 or younger
- ☐ Yes - Care for adults(s) 25 to 49 years of age
- ☐ Yes – Care for older person(s) aged 50 or over
- ☐ No
- ☐ Prefer not to say

Q17) What is your relationship status? (Select one option)

- ☐ Single
- ☐ Married/civil partnership
- ☐ Separated or divorced
- ☐ Partnered/living with a partner
- ☐ Widowed/surviving civil partner
- ☐ Prefer not to say

Q18) What is your sexual orientation (preference)? (Select one option)

- ☐ Bisexual (relationship with any gender/s)
- ☐ Gay or lesbian (same sex relationship)
- ☐ Heterosexual/straight (male to female relationship)
- ☐ Prefer not to say
- ☐ Other, please tell us here: _____

Q19) Have you ever served in the Armed Services? (Select one option)

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Thank you for your time.

Please return this questionnaire to arrive by Sunday 14 January 2024 to:
Freepost Plus RUEE–ZAUY–BXEG
Lutterworth Consultation
C/O NHS Leicester, Leicestershire and Rutland Integrated Care Board
Room G30, Pen Lloyd Building, County Hall
Glenfield
Leicester
LE3 8TB

Glossary (A-Z) - need to add to

- ***abdominal aortic aneurism screening –*** or AAA screening is a way of checking if there is a bulge or swelling in the aorta, the main blood vessel that runs from your heart down through your tummy
- **Attention Deficit Hyperactivity Disorder** – or ADHD is a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse
- ***audiology*** – assessing hearing and balance
- ***cardiology*** – diagnosis and treatment of disorders of the heart and circulatory system
- ***carbon footprint*** – it is the total amount of greenhouse gases (including carbon dioxide and methane) that are generated by our actions e.g. travelling and household energy
- ***clinical pharmacists*** - clinical pharmacists are health professionals who train for many years to become specialists in medicines
- ***community paediatrics –*** assesses diagnoses and manages care and treatment of children and young people outside of hospital
- ***community paramedics – relative new service working across primary health care,*** public health and preventive services to provide care in underserved populations in the community
- ***day case surgery*** - the admission of selected patients to hospital for a planned *surgical procedure*, returning home on the same *day*
- **diagnostics/diagnostic test** - procedure performed to confirm, or determine the presence of disease in an individual suspected of having the disease, usually following the report of symptoms, or based on the results of other medical tests for example an x-ray
- ***dietary advice –*** advice from someone qualified to assess, diagnose dietary and nutritional problems
- ***clinical triage/triage assessment*** - understanding what is the matter with a patient, including the degree of urgency and order of treatment required, in order to refer them to the right person or service
- ***dermatology –*** conditions that affect the skin, hair and nails
- ***digital technology –*** technology to improve our health and wellbeing or improve the health system. It includes lot of things, e.g. smartphone apps, wearable devices, computer software to track symptoms like blood pressure
- ***ECHO -*** echocardiogram is a scan used to look at the heart and nearby blood vessels.

- ***ear, nose and throat –*** diagnose and management of a wide range of diseases of the head and neck including ear, nose, throat and neck region
- ***endoscopy*** - the insertion of a long, thin tube directly into the body to observe an internal organ or tissue in detail
- **general anaesthetic** - being put to sleep
- ***general assessment –*** asking questions about your general health and checking things like your height and weight
- ***gynaecology -*** female reproductive system including ovaries and vagina
- ***general surgery*** – covers a wide range of surgery including conditions of the breast, kidney, pancreas and live***r***
- ***infection, prevention and control standards –*** standards to reduce the risk of transmitting infections
- ***health inequality*** – gap in access to health services between different groups of people
- ***inpatient services*** – overnight stays in a community hospital
- ***lay member*** - a representative from the community who has a patient/user perspective (outside) to try to influence the system (inside) and improve things for the people whose interests they articulate
- **local anaesthetic** - numbing an area of the body
- ***long term condition*** – also known as chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, arthritis and hypertension
- ***MSK*** – Musculoskeletal conditions affect your joints, bones and muscles
- ***occupational therapy –*** therapy that aims to improve your ability to do everyday tasks if you're having difficulties
- ***ophthalmology –*** eye conditions
- ***options appraisal*** – in the context of engagement, a technique for reviewing options and analysing the costs and benefits of each one
- ***outpatient clinic -*** where people visit the hospital for a diagnosis or treatment but do not require overnight care
- ***paediatrics –*** dealing with conditions that affect infants, children and young people
- ***palliative care*** – medical care for people living with a serious illness such as cancer or heart failure
- ***Parkinson's disease –*** is a condition in which part of the brain become progressively damaged over many years with symptoms like involuntary shaking, slow movement and still and inflexible muscles

- ***planned care*** - the provision of routine services with planned appointments or interventions within community settings such as GP surgeries, health centres and other community facilities
- ***primary care*** - the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.
- ***physiotherapy –*** helps to restore movement and functions when someone has been injured has a disability or illness
- ***psychiatry –*** a medical field concerned with the diagnosis, treatment and prevention of mental health conditions
- ***pulmonary –*** describes how well the lungs working in helping a person breathe
- ***reable/reablement*** - services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living
- ***rehabilitation*** – people and their family are helped to adjust and recover from injury, illness or disease
- ***respiratory medicine*** – diagnose and treatment of organs that are involved in breathing
- ***rheumatology*** – diagnosis and management of disorders that feature inflammation of the bones, muscles, joints and internal organs
- ***social care services*** – services that support people with personal care and other practice assistance for children, young people and adults who need extra support
- ***social prescribing link workers*** - help to reduce health inequalities by supporting people to unpick complex issues affecting their wellbeing. They enable people to have more control over their lives, develop skills and give their time to others, through involvement in community groups.
- ***speech and language therapy*** – help to support and care for people who have difficulties with communication, eating, drinking and swallowing
- ***stoma –*** an opening in the abdomen that can be connected to either you digestive or urinary system to divert the flow of waste
- ***Trauma and orthopaedics*** – treatment for injuries of the bones, joints, tendons muscles and nerves
- ***ultrasound*** - image of the inside of the body
- ***urgent care*** – an NHS service for patients whose condition is urgent enough that they cannot wait for the next GP appointment (usually within 48 hours) but who do not need emergency treatment at the hospital emergency department (ED)

- ***urology*** – deals with disease in male and female urinary tract (kidneys, bladder, urethra and ureters), also other male organs
- ***virtual wards –*** allows patients to get hospital level care at home

Appendix I

NHS
Leicester, Leicestershire and Rutland

Lutterworth Consultation
Communications, Engagement and Involvement

Public consultation about proposed improvements to health services in Lutterworth

Content **Page number**

1. Context for this consultation plan

This draft consultation plan outlines the steps we intend to take to ensure that we run an appropriate and transparent consultation on proposals to improve health services in Lutterworth, in response to the expected population growth over the next 15 years.

This draft document does not outline the proposals themselves, as these are outlined in the draft consultation document.

The 'accountable' body for the consultation is NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB). They are leading the consultation.

This scheme is part of the overall strategy for the Integrated Care System (ICS) for Leicester, Leicestershire and Rutland (LLR).

The services affected by the proposals are provided by Leicestershire Partnership NHS Trust (LPT) from Feilding Palmer Hospital. University Hospitals of Leicester (UHL), The Wycliffe Medical Practice and The Masharani Practice (Lutterworth Medical Centre) would be impacted by the proposals.

The consultation is being carried out during a period of significant operational challenge in the NHS. The overarching objective of proposals for Lutterworth is to improve the efficiency, quality and value for money of planned care services for the local population. The plans outline a reform in planned community care, required to accommodate predicted increases in need and improve patient outcomes.

The consultation plan has been developed by a Task and Finish Group, comprising of local people and organisations and is centred around Lutterworth. Recent engagement and consultation activity in smaller communities has shown a high level of interest from people who are keen to be involved in things that affect them locally. It is essential, that we continue to adopt innovative solutions, within our overall engagement plan, to ensure that we reach out to some of the most vulnerable people to ensure that they have the opportunity of participating and their experiences are considered and what matters most to them influences the decision-making process post-consultation.

After the close of consultation, the feedback will be independently analysed and results made available to commissioners. The feedback from the consultation will be closely monitored right from the point when the consultation goes live. A mid-consultation review will be undertaken to ensure that we are reaching out to our whole population. Depending on the feedback if gaps are identified then adjustments will be made to this plan.

A final report of the evaluation and analysis of the outcome of the consultation will be published by the LLR ICB, likely to be within 2 – 3 months of the consultation closing, depending on the number of responses received. This is described later in this document.

2. How was this consultation plan developed?

This consultation plan was developed using the Cabinet Office principles for public consultation (updated January 2016) and NHS England guidance 'Planning, assuring and delivering service change for patients' (published in November 2015).

It also takes account of the range of legislation that relates to the LLR ICB decision making including:

- Equality Act 2010
- Public Sector Equality Duty Section 149 of the Equality Act 2010
- Brown and Gunning Principles
- Human Rights Act 1998
- NHS Act 2006
- NHS Constitution
- Health and Social Care Act 2012
- Communities Board Principles for Consultation

In outlining the activities for communications and engagement in this plan, we have paid due regard and consciously considered the equality duty: eliminate discrimination, advance equality of opportunity and foster good relations.

Early proposals for Lutterworth were developed as far back as 2016 and were part of the Sustainability and Transformation Partnership. These plans have been updated and refined, particularly in the light of the pandemic.

In June 2021 the Lutterworth Steering Group was established. The group comprises of clinicians, providers, commissioners, stakeholders (including Town and District Council) MPs office, campaign group and public. The group was established to develop a plan for Lutterworth to respond to the significant housing growth in the area.

Patient and public engagement has taken place over a number of years. Public and patient participation has been refined over time with the NHS doing more work to understand the needs of local populations and share the insights, learning and business intelligence to inform design and delivery of care. Ultimately to improve the lives of local people, improving their health and wellbeing.

A summary of top line themes from analysis of multiple sources of data collected during 2020/21, 2021/22 and 2022/23 are shown below. This includes insights from the Building Better Hospitals (Public Consultation) (June 2021), Covid-19 Report (September 2021), GP Practice Survey (local and national research) (2021 and 2022), Primary Care Survey (September 2021) and Step up to Great Mental Health (Public Consultation) (December 2021). A breakdown of respondents from Lutterworth and surrounding areas can be found in Appendix 3. These reports can be viewed on the ICB website: https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/

This data was collected using a multi-channel approach including on and offline tools and techniques. For some work we commissioned voluntary, community and social enterprises to reach out to seldom heard and often overlooked communities. We have implemented surveys, focus

groups and public events. We have utilised organic and paid for social media through NHS-owned and partner platforms and print and broadcast media. Email marketing and briefings have been used along with more traditional tools.

This data has then been examined against 79 local reports, produced by NHS bodies and other local organisations produced during the last 3-5 years.

In addition, activities have been coordinated in Lutterworth including a public event to gather experiences on community services and presentations to the council. These activities were held on:

- 11 February 2019 (public event attending by 36 local patients)
- 8 February 2022 (presentation to Lutterworth Town Council)
- 12 April 2022 (presentation to Lutterworth Town Council)

Leicester, Leicestershire and Rutland Topline Data including Lutterworth insights

Exploring some of the key issues

BLOCKS IN BUILDING STRONG LOCAL NHS SERVICES

ENHANCING COMMUNICATIONS

1. More efficient links and exchanging of information between different healthcare services e.g. GP and hospitals
2. Improved and shared IT systems to allow efficient transfer of records/ access to information
3. Reducing barriers in language and understanding of different cultures
4. Changes and transformation in care and its impact to be communicated in messages tailored to different communities including vulnerable groups.
5. Carers to be an integral part of communications about the person they care for
6. Consistent, simple and clear messaging delivered from source that is trusted by people and tailored to different communities
7. "Joined-up way of working" between services and across borders to deliver care

BUILDING TRUST & RELATIONSHIPS

1. Family carers feel a more relevant and reliable support is needed combined with a better understanding and recognition of their role
2. Ability to build strong relationships with patients / family and other services can enhance care provided by staff
3. Urgent care system - a reassurance if the need is urgent or in emergency – for both physical and mental health users
4. Relations with services, incl. GP are important to people
5. Increased connections between community and healthcare providers

ENABLING SELF-CARE

1. Care at home is important but impacted by lack of confidence and feeling stressed/ isolated
2. Urgent care system seems to respond to illness rather than support health creation/ focus on the person as a whole
3. Reliable and relevant help and guidance to self-care is required for both physical and mental heath users
4. Those with long term conditions want to be able to look after themselves when possible, but be sure that support exists if they need it

PROVIDING A QUALITY SERVICE

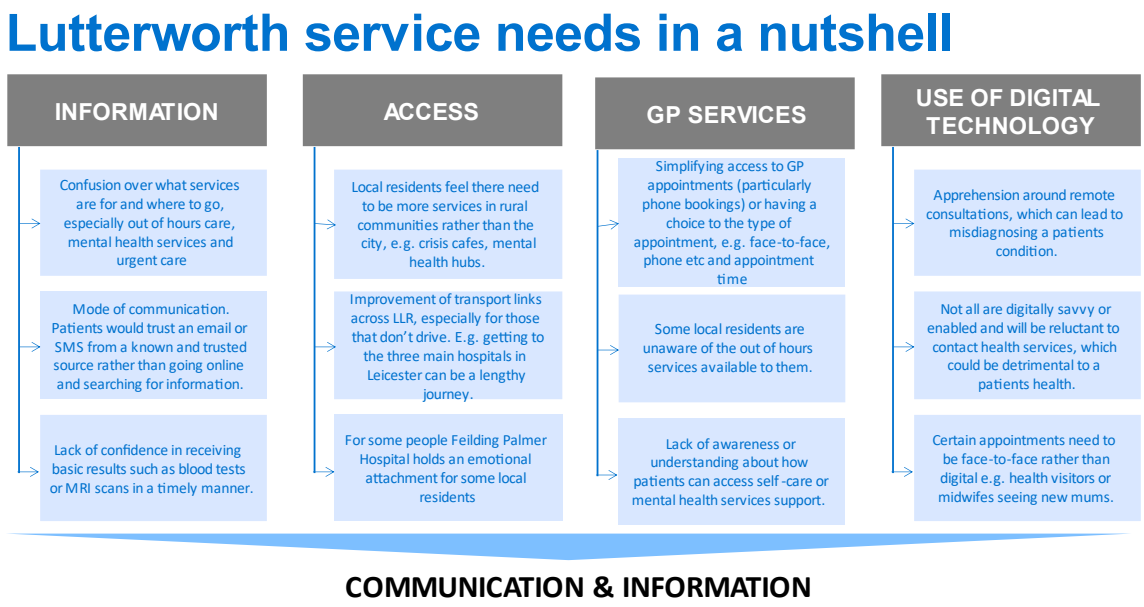
1. Having access to shared records to avoid repeating case history - consistency and continuity of treatment are important
2. Greater integration of services , e.g. transfer between services/ handovers are stressful
3. Improved discharge from hospitals which can be chaotic, e.g. late evening
4. More support for those with complex care needs
5. Improved quality of the end of life experience incl. how people are treated and spoken to
6. Important to have support before planned treatments and appropriate follow -ups
7. Concerns around the "home first" approach; the package of care and paying for care; pressure on family/neighbours

IMPROVING ACCESSIBILITY

1. Mobility and difficulty with transport incl. public transport and car parking are creating access issues
2. Ease of access to primary care is important incl. online, BSL interpretations, translator, ease of booking an appointment
3. Address the equality of access and availability of "closer to home" care
4. Concerns around the access for rural communities and out - of-city residents
5. Waiting times are a concern - timely access to appropriate treatments
6. Digital consultations are supported , but only if appropriate to condition and choice should be offered,
7. Community hospitals are seen as important part of "closer to home" care and should be better utilised

Key themes in their own words

Insights specific to Lutterworth



Engagement has also been ongoing through two key Groups. The Lutterworth Plan Steering Group was founded in June 2021. The group comprises of key stakeholders and was formed to work in partnership to develop a plan for Lutterworth to meet the future needs driven by the significant housing growth expected in the area.

The group has co-designed the plan for Lutterworth. The groups has grown over time and comprises of representatives from:

- Local primary care
- Lutterworth Town Council
- Harborough District Council
- Leicester Partnership Trust
- Mary Guppy Group (Patient/Public representatives)
- MPs office
- Leicestershire County Council

In order to stimulate further engagement and co-design the public consultation and engagement (including this document and the Consultation Document) a Task and Finish Group was established in February 2023.

The group comprises of representatives from:

- Lutterworth Hospital Campaign Group x 3 members
- Lutterworth Town Council x 4 members
- Masharani Practice Patient Partnership Group x 1 member
- Wycliffe Practice Patient Partnership Group x 1 member
- Leicestershire County Councillor x 1 member
- Harborough County Councillor x 2 member

- Save our NHS and other campaign groups x 1 member
- Rural Community Council (voluntary and community sector) x 2
- MPs office x 1 member
- Leicester Partnership NHS Trust x 1 member
- U3A (voluntary and community sector) x 1 member

In turn these representatives are linked to and sit on many other community groups (listed in the Stakeholder Analysis), magnifying our intelligence and communications routes.

The ICB Board will have formal oversight of the consultation and will review the draft public consultation document, summary document and other support materials prior to the consultation commencing.

3. Aims and objectives of consultation

The aim of this consultation exercise is:

- To inform people about how the proposals have been developed
- To describe and explain the proposals for improving community health services in Lutterworth
- To engage with people currently using services and their carers to understand their lived experience and what the proposals mean to them
- To seek people's views, and understand the impact of the proposals on them
- To ensure that a wide range of voices are heard which reflect the socio-demographics of the area, particularly the most vulnerable and those with protected characteristics (see appendix 1)
- To give people the opportunity to sign up for further co-design services post-consultation
- To understand the responses made in reply to our proposals and take them into account in decision-making
- To respond to the feedback received
- To ensure that the consultation process maximises community engagement and complies with our legal requirements and duties

4. The role of consultation in the review process

Public consultation is essential in the development of NHS services. It provides people with an opportunity to be involved and shape proposals for change and improvement and to comment on those proposals before any final decisions are made. This includes those who use services, their carers and advocates; the voluntary, community and social enterprise sector, local government; community leaders and stakeholders, NHS partners and NHS staff.

Public consultation is one of a number of methods used by the NHS to develop better care and better services.

5. Public Consultation with patients, carers and public

The length of time recommended for a consultation in determined by a number of factors. The length of a public consultation should be proportionate and realistic to allow people sufficient time to provide a considered response to proposals. For a programme of work that has some potentially contentious proposals to change the model of care for inpatient services, although also improving and increasing the provision of diagnostic and other community services within a local community hospital, 12 weeks is appropriate to allow the impact of the proposals to be understood.

The timetable leading to the start of consultation takes on the learning of other public consultations locally and nationally. It outlines the minimum number of weeks necessary to prepare for a consultation. (Appendix 2).

It is clear that public bodies need to exercise their functions for the benefit of those they serve and that the NHS needs to adopt a multi-channel approach to ensure that people have the opportunity to participate in the conversation if they wish. The mechanisms we would put in place for the public consultation are proven in a range of recent consultations and will allow us to engage a more diverse range of people. We will use technology that a high proportion of people use on a day-to-day basis to reach a wide range of people. This will be balanced with a range of offline communications using traditional media. We will work in partnership with Leicestershire Partnership NHS Trust and University Hospitals of Leicester to involve patients across all services. We will also work with the local community, through the Task and Finish Group, and with a range of voluntary and community sector organisations who would support us to reach people with protected characteristics.

These routes to involve and consult the public allow us to operate effectively, efficiently and economically. The outcomes from the consultation will allow us to make decisions which will have a positive impact on patient and public outcomes and accessibility to an improved range of services. Equally as important, we need to publicly consult on proposals in a safe, inclusive and responsible manner, so we can understand and improve the health services our communities receive now.

Taking this into account this communications and engagement plan will form an appendix within the Pre-consultation Business Case that allows us to deliver what is required of us legally, but more importantly it will enable us to consult meaningfully with as many people as possible.

We have also developed a consultation document that describes simply and specifically the proposals for improvement. The document includes questions that ask people their views of the proposals and request that they share what the impact of the change is on them, their family and/or carer. It also asks them to identify things that they feel we haven't considered and should.

Stakeholder Analysis and Segmentation

To make sure that the consultation effectively captures views and feedback from the local population, we have taken two approaches to our stakeholder analysis and segmentation. The first, co-designed with the Task and Finish Group, identifies the target audiences that we need to consult with and prioritises and ranks them. This will be used as a basis on which to consult based on their involvement, the impact on them or their interest.

They will all be contacted and their views sought during the consultation period. In addition, we will ask all organisations and groups to act as conduits and to actively help us to promote the consultation (via their communication channels) to any relevant stakeholders in addition to those sitting on the Task and Finish Group.

Demographic information in Appendix 1, will also support us to plan the consultation work and target communities. It will also allow us post consultation to identify whether we have heard from a statistically representative number of the population.

The source of demographic data outlined in Appendix 1 is the Office for National Statistics – Census 2021. While not limited to, it shows data from the following areas:

- Lutterworth
- Lutterworth East
- Lutterworth West

We have also included wider data that includes the above from

- Harborough

In addition, out of the LLR areas, but with populations that have an interest in these developments we have:

- Brinklow, Wolvey and Churchover
- Harborough Magna

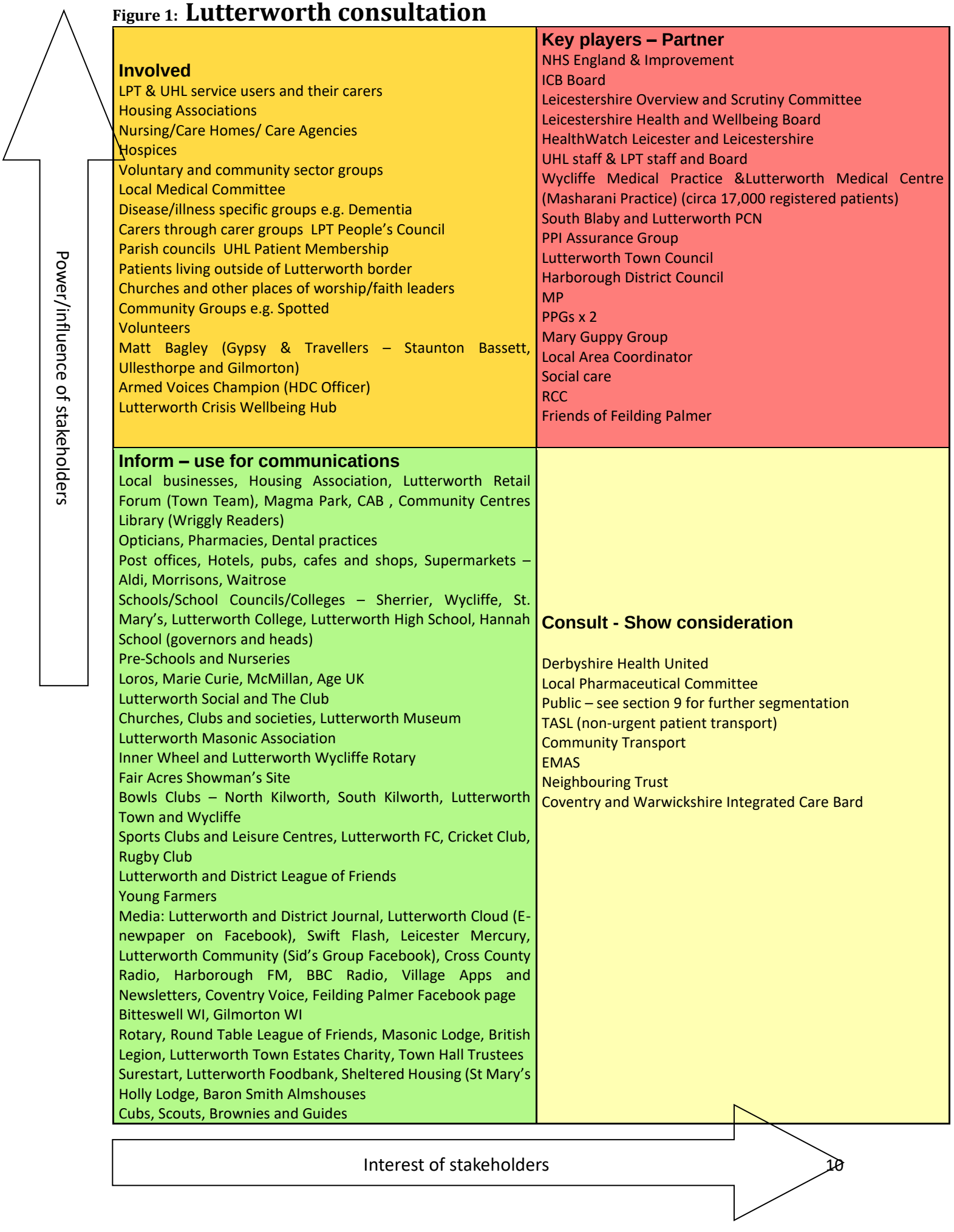
The data includes:

- Number in the population
- Age profile
- Sex
- Household deprivation
- Ethnic group
- Religion
- Disability
- Provision of unpaid care
- Distance travelled to work
- Economic activity status
- Socio-economic classification
- High level of qualification
- Schoolchildren and fulltime students

In addition, we will also allocate grant funding to some key voluntary and community organisations to help us with more in depth engagement with their communities using a variety of communication methods. This approach will support us to engage with vulnerable communities and those representing people with protected characteristics particularly where we require communications support e.g. deaf community.

Figure one shows the high-level segmentation of the target audiences, completed by the Task and Finish Group .

Figure 1: Lutterworth consultation



Fire Service, Market Harborough Hospital	

We have also analysed our communities on the basis of how it may be possible to reach them. There may be a wide range of reasons why people don't want to take part in the consultation. Our challenge is to think about these groups and how we might trigger their involvement. Figure Two in section 9 looks at these communities and methods for engagement which are not mutually exclusive.

6. Key messages

We will use overarching messages through the duration of the consultation process which convey our vision, values and commitment. In addition, specific messages in relation to the proposals will be developed and conveyed in relation to:

About this consultation – the context and case for change

- The need to make it easier for people to access the right support in the right place at the right time while adding value with every contact.
- Increase planned care in the local community (planned care is the name given to health services and treatments that aren't due to an accident or emergency, but necessary following a referral from a GP or other health professional).
- Improve waiting times and access for diagnostics, planned care and treatment.
- A new way of providing community bed-based care including palliative care.
- Provide more care close to home.
- Deliver care and treatment in line with best practice and improve the experience of care ensuring that people report positive outcomes and experiences.
- Ensure that staff delivering care and treatment report positive experiences.
- Address clinical challenges.
- Set in context of system improvements.
- The importance of people having their say on the proposals.

The consultation mandate

- Describes the purpose of the consultation.
- What the ICB wishes to achieve through consultation.
- The specific areas we are seeking to understand what the impact of proposals will be.
- How the ICB will respond to inform their decision and respond to the feedback received.

The proposal(s)

- Description of the proposal.
- Benefits of proposals.
- Within the proposal highlight the need to understand the impact on service users, patients, carers, staff and public.
- Set out clearly what can be influenced, what can't .
- Set out clearly the independencies with other transformation projects.
- Include all changes needed to implement the proposals.
- Set out Funding/financial implications.

How the proposals were developed

- Ongoing engagement and involvement.
- How the engagement and involvement has influenced the proposals.
- Show how the proposal meets financial, clinical objectives.
- Explain what community services in Lutterworth will look like in the future.

Details of the ways that people can get involved in the consultation

- Events
- Outreach
- Online
- Offline

We will endeavour to recognise the motivation of each of our communities and tailor our approaches to what matters most to them. We will also acknowledge that some people will need to be persuaded to participate which will involve us using interesting and creative ways to make the consultation relevant to them.

Testing views

A number of questions will be asked through the consultation providing the public with the opportunity to provide views. A full equality monitoring form will also be included, to enable us to understand who has participated in the consultation and assess gaps. Postcode data will also be collected.

The questions will also be tested in advance with the Task and Finish Group for Lutterworth and the ICB Public and Patient Involvement Assurance Group, which is the system wide group established as part of our governance that assures our plans, outcomes and outputs. It comprises of patients and service users, independently recruited from across Leicester, Leicestershire and Rutland.

In addition, prior to the launch of the consultation we will engage with LPT's People's Council (which is an independent advisory group) and UHL's membership. The groups comprise of patients and carers with lived experiences of services

7. Consultation document and materials

We would develop a consultation briefing document which will convey the key messages outlined in section 7.

We would ensure that the main consultation document is relevant to people who currently use and are likely to use services in Lutterworth in the future.

The document would be developed with the Lutterworth Task and Finish group and discussed with Healthwatch Leicester and Leicestershire, the Public and Patient Involvement Assurance Group and

the LPT People's Council and UHL's membership. The document would explain why change is needed, what the proposals are and what benefits they will bring for people, as well as how the proposals, if agreed, might be implemented.

It also clearly explains how people can participate, feedback comments and asks for further information by post, email, social media, website and telephone.

We will produce an online and a hard copy questionnaire (including an equalities monitoring form) including an easy read version.

People involved in the engagement will be from a variety of backgrounds, therefore there will be a need to ensure that the consultation document is made available in different formats e.g. easy read. With the ability to produce in BSL on request. It will also be provided on-line in a Word format at 20 point font to ensure that people experiencing sight difficulty can read the document. We will also produce a summary document to provide people with a quick overview of the proposals which will be circulated to key outlets e.g. libraries and community venues.

All information produced as part of the consultation will be written in a language that can be easily understood. Technical phrases and acronyms will be avoided, and information will be produced in other formats as required to reflect population needs. Where necessary a glossary of terms will be provided.

All versions of the consultation document will be available on a dedicated section on the ICB website and linked from all partner websites. The site will be promoted via all media including social media channels such as Facebook, Twitter, Linked In, Instagram and YouTube.

We will also produce posters and flyers for distribution, along with displays and stands for use in public places. A video in plain English with subtitles will also be produced to explain the proposals in an audio format, and support understanding, especially for those with low levels of literacy. These can be easily shared on WhatsApp and social media channels and sent out via community groups and networks. This will also be supported by a proactive media campaign to drive traffic to find out more, using key NHS figure heads and community leaders.

We will also offer a telephone interview service, recommended by the Consultation Institute, to support those who may need it to ensure that they are able to understand the information contained within the documents and to ensure that all participants in the consultation have enough information and are able to give informed feedback in a telephone call. If translation is required then this can be arranged.

8. How we will consult – summary of planned activities

Learning from the last three years has shown us how technology can be used to involve and engage the public on a range of issues.

The use of technology to hold meetings, share information and, recordings of meetings, and enable a wider reach across communities has provided additional methods and opportunities to consult or provide information to individuals to whom the services are being or may be provided.

This is in addition to off-line communications and engagement activities essential for a meaningful consultation that reaches people who may not be digitally enabled or active or those that simply aren't comfortable with technology.

In order to support people who may not be digitally enabled to take part in meetings there will be the functionality for people to dial-in via telephone should they so wish. This is essential from an accessibility perspective.

A web platform will be set up to contain information and full details of the consultation including the Pre-consultation Business Case and supporting document (clinical, financial). In addition, arrangements will be made to enable people to feed back their views. This would include an online option via secure software as well as telephone and postal options. Information would be provided in different formats and in appropriate languages.

A multi-faceted approach to communications and engagement would be implemented using market segmentation that enables us to understand in advance of the consultation what a representative response to the consultation would look like (see appendix 2). Using this data, a variety of both online and offline tools and techniques to communicate with the people of Leicester, Leicestershire and Rutland have been developed.

Outlined in this section is a summary of the planned activities we will implement. We will monitor and evaluate the process consistently to ensure that all activities are meeting the requirements of a robust consultation. We will undertake a mid-consultation review to assess whether we are reaching all communities. If gaps are found we will adjust this plan to ensure that we are inviting feedback from all communities.

Figure 2 outlines a further stakeholder analysis including specific communities and methods to reach them. In addition, it outlines methods of engagement additional to the summary.

Existing mechanism

There are a number of mechanisms that ICB partners already have in place which help us provide information and communicate with a range of stakeholders. These mechanisms will be utilised during the consultation process:

- MP through face-to-face (video) and written briefings
- LPT and UHL staff – through a number of methods including briefings, newsletters, presentations at Heads of Meetings etc.
- Local councillors updated through discussions at scrutiny and Health and Wellbeing Boards and through briefings at committee meetings.
- Monthly System Engagement meetings with Healthwatch, providers, Public and Patient Involvement Group Chair and ICB
- Voluntary, Community and Social Enterprise Alliance via online platform, newsletter and quarter meetings
- Local media including TV, radio and newspapers, GP newsletter
- Patient groups and members including LPT service users and UHL service users

- Online Citizens' Panel
- ICB Five on Friday (online newsletter)
- LLR Connect (ICB staff newsletter)
- LPT and UHL Membership
- LPT People's Council
- LPT Youth Advisory Board
- Twitter, Facebook, Instagram, Linked IN and Youtube
- LPT & UHL stakeholder newsletters
- LPTs Patient Experience and Involvement Newsletter (monthly)
- LPT and UHL staff Facebook group
- LPT staff support group networks
- LPT and UHL website and associated websites healthforkids.co.uk, healthforteens.co.uk, healthforunder5s.co.uk

Working with voluntary and community sector

Under the Equality Act 2010, we have a duty to consider potential impacts of service change on people with protected characteristics. In order to help us understand these potential impacts in detail, we will directly commission a number of voluntary and community organisations to reach out to seldom heard and often overlooked communities to encourage and support them to participate (with a focus on vulnerable, carers and protected characteristics of age, race, disability, pregnancy/maternity, sexual orientation). The identification of these organisations would be driven by the findings of the Equality Impact Assessment and market segmentation. Examples of these groups are included in Figures 1 and 2. This approach has been used in a previous consultations and support the involvement of a true representation of our population.

We will produce a toolkit of collateral to support the voluntary and community sector, who undertake outreach and events at a hyperlocal level within communities including Food Banks and community centres.

We will also work with our full database of voluntary and community organisations, who whilst not commissioned to host events and undertake outreach, will articulate our messages to the relevant communities in Lutterworth.

Work with patients

The two Lutterworth practices (The Masharani Practice and Wycliffe Medical Practice) serve circa 17,000 registered patients. They are part of South Blaby and Lutterworth Primary Care Network (PCN), comprising of 5 practices (also including Countesthorpe Health Centre, Hazelmere Medical Centre and Northfield Medical Centre). In addition, Market Harborough and Bosworth PCN and Cross Counties PCN along PCNs in East of the Coventry and Warwickshire ICB area will be patients within an interest in proposals in Lutterworth. These patients have valuable insights and experiences of current services. Representatives of both practices are members of the Lutterworth Task and Finish Group. We will continue to work with the practices and their Patient Participation

Groups to reach their patients to promote the consultation in order to understand how change will impact them and their family carers.

Deliberative events

Over the last three years, there has been a decline in the attendance at deliberative online and face-to-face events. People prefer the localised face-to-face outreach and the use of digital.

We have found the coordination of online briefing sessions at the onset of the consultation e.g. voluntary and community sector stakeholders and parish, district and county councils. They are then able to share their views and give us an understanding of the impact of proposals on them and the people they may represent, at an early stage. They are also able to amplify the consultation to wider audiences.

During the consultation we will coordinate two drop in events in different parts of Lutterworth. The drop-in sessions will be over an afternoon and evening to allow for people who both work or don't work to attend. We will vary the days of the week. NHS staff will be on hand to discuss the proposals individually or as a small group. There will also be the facility for people to fill in the survey on and offline.

Digital methods of engagement increase greatly the number of people we can engage. To ensure we cater for people who work and those that don't, we will hold upt to three online events at differing times, both day-time, evening and weekends throughout the consultation.

All feedback from the events will be captured and the key themes and points of any discussions recorded along with the attendance in terms of equality and diversity requirements. These records will form part of the evidence to inform the final decision-making process. We will also capture any questions and draw up a question and answer section on our website, so that answers can be viewed by everyone.

Displays and posters

We will arrange for displays to be situated in prominent areas where there is a high footfall to engage with the public providing leaflets, a poster or pop-up banners and signpost them to further information (including the use of QR codes). This includes sites such as libraries, supermarkets, community centres, pub, cafes etc.

Briefings

We will hold online briefings with key stakeholders – including Healthwatch Leicester and Leicestershire, the Public and Patient Involvement Assurance Group (PPIAG), Harborough Council and Lutterworth Town Council (previously mentioned) and any other key interest groups. We aim to

hold these briefings prior to the commencement of the consultation period to enable these stakeholders to cascade information to their membership and contacts and support engagement.

Networks and contacts

The ICB and the Task and Finish Group will work with the network of contacts identified in the Stakeholder Analysis empowering them to publicise the consultation and signpost people to our website and response form. We will also share with them a toolkit, containing articles, social media posting and web copy to support their communications.

Communications activities

We will raise awareness of the consultation, associated engagement activities and call to action through a range of communication channels including media, social media, websites, stakeholder communications channels and by distributing a range of communications materials.

We will work with the local media identified in the stakeholder analysis. Key clinical and non-clinical spokespeople will be identified and trained to enable them to be called upon to undertaken TV, radio and newspaper interviews. They will also need to lead and answer questions at online events. Sufficient time will need to be allocated by these representatives in order to run a successful, but intensive consultation.

Digital

We will implement a variety of digital techniques to raise awareness of the consultation including:

- Search engine optimisation to ensure the website is visible to existing and new content
- Broadcast media including radio and TV
- Remarketing campaign
- SMS text messaging
- Placement of content on local community websites covering areas, towns and villages e.g. Spotted
- Email marketing using ICB, LPT and UHL email lists and sharing of key messages with residents by local authority via their own email lists
- E-Briefing and/or letter to the MP and councillors (district, town and parish) providing information about the proposals, the consultation, and asking for any support in dissemination within their community;
- Email marketing to voluntary and community sector groups, schools and key business across in Leicester, Leicestershire and Rutland;

Advertising

- Only where appropriate and not possible through public relations, we will use offline advertising to reach key areas of the community including niche groups. This includes advertorials across local newspapers, community magazines and newsletters

Staff engagement

- Staff briefings and written communications shared with staff at UHL, DHU, EMAS, LPT, GP practices and local authorities;
    - Online or off-line event to staff directly impacted to understand their views and what matters most just prior to consultation

Reaching different communities

In addition to the main stakeholder analysis, we have further segmented our target communities and outlined below methods of engaging them. It also considers the format of information e.g. different languages, braille, video, Online BrowseAloud and Easy Read.

Figure 2

Who	Methods of engagement
People who live in rural communities	Local display in village stores and other local businesses Libraries Young Farmers Through parish councils Social media e.g. Spotted and Neighbourhood Facebook pages Church and community newsletters, magazines
People who live in urban communities	Local display in library, supermarkets and other business indicated in stakeholder analysis (page xx) Social media pertinent to communities social connections, Whatapp Voluntary and community groups indicated in stakeholder analysis (page xx)
Homeless	Work with voluntary bodies, LPT and local authorities – district, town and parishes
Areas of deprivation	Local support workers – e.g. Local Area Coordinator Through - district, town and parishes Social media Community leaders Voluntary and community organisations
Housebound	Work with district nurses, health visitors, volunteers to raise awareness
Younger people	Use of online social networks Schools and colleges indicated on stakeholder analysis (page xx) Voluntary and community organisations

	Young peoples' forums including the LPT's Youth Advisory Board, Young Farmers, Cubs, Scouts etc. Healthforteens.co.uk – an LPT specific website for young people and @Healthforteens twitter and Instagram account associated to this
Older people	Voluntary sector groups e.g. Age UK Older peoples' forum and similar groups Social care via Homefirst LPT Carer Forums LPT Older Children Forum
Long distance commuters and people living over the LLR boundary	Ensure good online methods are in place via email, website, e-newsletters, online fora, social networks Engage with media over the borders Ensure timing of some events in evening
People with an agenda/campaign groups	Develop the relationships already established through engagement and coordinate online discuss at their community meetings
People without transport	Ensure good online methods are in place via email, website, e-newsletters, online fora, social networks
People who work	Ensure good online methods are in place via email, website, e-newsletters, online fora, social networks Ensure timing of some events are in evening Engage local businesses/employers e.g. Magna Park
People who don't work	Continue to use social groups and networks online and offline e.g. WI, SureStart, Mumsnet, Job Centre and Benefits providers
People with learning disabilities	Through schools and voluntary sector Learning Disability Partnership Boards Ensure Easy Read capability on main website and use of video and illustrations Use of LPT's Learning Disabilities services – direct easy read mail and the Talk and Listen Group and other LPT run groups.
People with physical disability or with a sensory impairment	Through voluntary sector (grant support)and NHS provider organisations Local community groups e
People with long term mental health problems	Through voluntary sector and NHS providers. Existing LPT service users across mental health services LPT's recovery college and recovery networks IAPT networks Veterans Support Groups
People who are pregnant, have babies and young children or have used neonatal services	Maternity and Neonatal Voices Partnership Women and Toddler groups Surestart LPT's perinatal mental health service Social media e.g. Mumsnet Healthforunder5s.co.uk – LPT's website for new mums in LLR

	Health visiting and midwifery services Breastfeeding peer supporters
Lesbian, Gay, Bisexual and Transgender	Through Leicestershire LGBT
Migrant workers and refugees	Through employers – displays and collateral Through voluntary organisations
BAME	Through voluntary and community sector
Adult carers	Through carer groups and organisations including the local authority through their carers passport scheme and LPT Carer Forums, Carers Association, VASL etc.
Child carers	Through carer groups and organisations LPT Young Carer Forums
Travelling communities	Through local authorities and GP practices with registered patients
Walking well	Through local organisations and business e.g. local authority and large businesses. Fair Acres Showman's Site Social media
Staff	Utilising existing newsletters, staff forums, team and staff briefings Engage with Head of Service providing materials to enable them to deliver regular messages at their regular team meetings Outreach and displays LPT, UHL and local GP websites Staff events and outreach

9. Providing support during the consultation

We are very conscious of the difficult and challenging times that we are living in. This consultation may create demand for services and we may encounter people who need support.

We will ensure that we provide online information and signposting to points of access for both physical and mental health services should anyone require support.

10. Equalities considerations

As a legal and moral requirement we will ensure that the consultation process reaches out to all those who have an interest in the proposals and that they are empowered to take part in the consultation.

An equality impact assessment would be undertaken to ensure that the process for consultation and decision making is fully compliant with our legal duties under the 2010 Equality Act and the NHS Act and that we are taking account of people's protected characteristics.

We would also undertake an Equality Risk Assessment to highlight key areas of concern or issues and identify mitigating actions.

As outlined in section 8, consultation information will be made available to all communities in various formats appropriate to the community e.g. Easy Read. Videos have proved particularly successful and can be easily overlaid in various languages.

For all methods of feedback whether online or offline we will ensure that we have asked people to provide socio-demographic and equalities information. This information will be aggregated as part of the consultation to enable us to assess the impact and views from groups that differ from the general population e.g. LGBT, younger people, people living in deprived area. This will be done halfway through the consultation to assess any gaps, which can then be mitigated against. It will also be done at the end of the consultation.

11. Capturing consultation responses

We will secure the services of an independent organisation to handle the consultation data and report the findings to the ICB. The organisation would provide guidance on the development of the questionnaire. The consultation responses from the various online and offline responses will be logged, analysed and evaluated and an independent report of the consultation written. Interim findings will be produced internally halfway through the consultation to ensure that responses are representative of our population. This plan will be adjusted if required to target under-represented communities.

Depending on the number of responses received we would expect the ICB Board to receive the report within circa 8 weeks of the closure of the consultation.

We will ask people to answer on a voluntary basis, as part of their consultation response, specific equality monitoring questions. This will enable responses to be analysed by segmented communities to ensure that we have been inclusive. This analysis will be done throughout the consultation period enabling us to make modifications to this plan if we find that we are not reaching and providing opportunities to our entire communities. This will be identified through a half-point assessment.

After carefully considering all of the feedback received and a period of reflection, the ICB Board will make a final decision at their public meeting(s), which will be promoted. After a decision has been made this will be widely communicated back to the public to ensure they are well informed of the decision.

12. Assurance and evaluation

The consultation plan and consultation materials would be informed by insights gained through the engagement process and through the Task and Finish Group will be discussed and approved by the ICB.

Statutory scrutiny during the consultation will be provided by the Leicestershire Health Overview and Scrutiny Committee, the ICB Board and the Public and Patients Involvement Assurance Group.

The Lutterworth Task and Finish Group will also recommend adjustments, based on intelligence provided.

The consultation will comply with the law which requires NHS bodies to engage with members of the public before making decisions on changes to health services. Currently, separate sections of the NHS Act apply to ICBs. ICBs are governed by section 14Z2 of the NHS Act 2006, which states:

a) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by ICB in the exercise of its functions (commissioning arrangements).
b) The ICB must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways – in the planning of the commissioning arrangements by the group; in the development and consideration of proposals by the group for changes in the manner in which the services are delivered to the individuals or the range of health services available to them and in the decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The consultation will also comply with the Gunning Principles on fairness; these have been established by case law which describe the principles that should underpin consultation. Under the principles consultation should be:

1. Consultation must take place when the proposal is still at a formative stage
2. Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
3. Adequate time must be given for consideration and response; and
4. The product of consultation must be conscientiously taken into account.

The consultation plan has been designed using the Cabinet Office principles for public consultation (updated January 2016) and to comply with the NHS England guidance 'Planning, assuring and delivering service change of patients (published in November 2015).

We are required to show how the proposals meet the five tests for service reconfiguration, four of which were laid down by the Secretary of State for Health in the Mandate, with the fifth one coming into force in April 2017:

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. Clear clinical evidence base to support the proposals
4. Support for the proposals from clinical commissioners

5. Local NHS organisations to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead (although not applicable to this consultation):

    - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
    - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

The regulatory framework is provided by:

- The NHS Act 2006 (as amended)
- The Equality Act 2010, which requires us to demonstrate how we are meeting our Public Sector Equality Duty and how we take account of the nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.
- Secondary legislation

We are required to show how we have taken into account the views and requirements of those who may use our services and their carers, families and advocates; how the proposals will bring significant clinical benefits and improve outcomes and accessibility and how the proposals take into account people's diverse and individual needs and preferences including people with protected characteristics.

13. Impact of consultation outcomes

After the consultation the feedback will be used to help commissioners decide on the final outcome.

This decision-making process will comply with the NHS England guidance 'Planning and Delivering Service Changes for Patients'. It will use the outcome of the consultation as part of the evidence to be considered, alongside clinical benefits of the options put forward and the sustainability and transformation of service.

At the close of the consultation the commissioners will publish a report setting out the major themes emerging from the consultation, a summary of the responses to the proposal, an overview of the process, an explanation of how the final decisions will be taken (including dates of meetings in public) and the timeline for implementing the recommended option, should this be adopted. This report will draw on the independent evaluation report, which will also contain full equality monitoring data. It will be available in hard copy and online. A detailed communications and media plan will set out the actions for commissioners to communicate the decision to patients, carers, staff, local people, partner organisations, stakeholders and the media.

The Leicestershire Health Overview and Scrutiny Committees will also be informed of the outcome.

14. Consultation timetable

The final consultation document and process is subject to approval by the ICB Board and NHS England and NHS Improvement. This plan assumes that the consultation will start when approval of the Pre-Consultation Business Case is known. The consultation will last 12 weeks. There will be a period of deliberation and analysis of findings which will last approximately 8 - 10 weeks, depending on the number of responses made to the survey. The ICB Board will then meet to make their decision on the outcome.

An outline plan of the proposed consultation activities can be found in the Appendix 2.

15. Risks

Risks and mitigations will be managed by the Executive Management Team and the ICB Board. Risks around communications and engagement will be fed into overall Risks log for the project.

Communications and engagement risks will be identified and regularly reviewed and assessed throughout the consultation and mitigating actions put in place to respond to issues.

Risk	**Mitigation**
Failure to engage with relevant stakeholders and meet statutory duties / stakeholders feel they have not been fully involved	Communications engagement plan developed identifying stakeholders and partners with detailed communications activity implemented during consultation period.
ICB do not engage with marginalised, disadvantaged and protected groups	Communications and Engagement plan identifies relevant groups and organisations that we will work with to access these groups and communities
Lack of response / “buy in”	Ensure adequate publicity and support. Ensure accessibility of activities and appropriate feedback mechanisms using a range of online and offline media. Implement mid-point review to assessment responses and modify communications and engagement activities accordingly
Proposal in consultation document perceived as already implemented or a ‘done deal’	Ensure through all communications that public are aware of changes made during the pandemic and have knowledge of the clear rational for the proposal for change

The consultation may be subject to challenge and the lack of options for the public to comment on may be criticised	Appropriate governance policies/standards will be put in place to ensure correct procedure, logging processes and equality analysis are maintained throughout the consultation and that public are fully aware of the engagement that led to the narrowing down of options to the proposal being consulted on
Campaign group(s) challenges proposals	Ensure co-design of proposals. Ensure that consultation documents outline how the proposals have been developed and how they will benefit service users by improving access to mental health services in a crisis or when the need is urgent. Ensure we are following due process and logging all engagement. Ensure that we are prepared through the processes in place to receive any petition

Appendix 1

Brinklow, Wolvey & Churchover

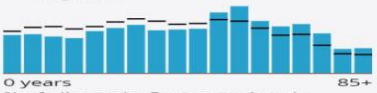
Area map

Population

7,500
people

56,490,000 people in England
Rounded to the nearest 100 people

Age profile



% of all people, 5 year age bands

Sex

Brinklow, Wolvey & Churchover
(England)

Female **48.9%** (51.0%)
Male **51.1%** (49.0%)

% of all people

Household deprivation

Brinklow, Wolvey & Churchover
(England)

Household is not deprived in any dimension **57.1%** (48.4%)
Household is deprived in one dimension **31.6%** (33.5%)
Household is deprived in two dimensions **9.9%** (14.2%)
Household is deprived in three dimensions **1.3%** (3.7%)
Household is deprived in four dimensions **0.1%** (0.2%)

% of all households

Ethnic group

Brinklow, Wolvey & Churchover
(England)

Asian, Asian British or Asian Welsh **6.1%** (9.6%)
Black, Black British, Black Welsh, Caribbean or African **1.2%** (4.2%)
Mixed or Multiple ethnic groups **1.7%** (3.0%)
White **90.0%** (81.0%)
Other ethnic group **1.0%** (2.2%)

% of all people

Religion

Brinklow, Wolvey & Churchover
(England)

No religion **33.9%** (36.7%)
Christian **54.7%** (46.3%)
Buddhist **0.8%** (0.5%)
Hindu **2.6%** (1.8%)
Jewish **0.1%** (0.5%)
Muslim **0.7%** (6.7%)
Sikh **1.4%** (0.9%)
Other religion **1.0%** (0.6%)
Not answered **4.9%** (6.0%)

% of all people

Disability

Brinklow, Wolvey & Churchover
(England)

Disabled under the Equality Act **16.1%** (17.3%)
Not disabled under the Equality Act **83.9%** (82.7%)

% of all people

Provision of unpaid care

Brinklow, Wolvey & Churchover
(England)

Provides no unpaid care **90.6%** (91.2%)
Provides 19 hours or less unpaid care a week **5.6%** (4.3%)
Provides 20 to 49 hours unpaid care a week **1.6%** (1.8%)
Provides 50 or more hours unpaid care a week **2.2%** (2.6%)

% of people aged five years and over

Distance travelled to work

Brinklow, Wolvey & Churchover
(England)

Less than 10km **25.3%** (35.4%)
10km to less than 30km **18.5%** (14.4%)
30km and over **4.5%** (4.3%)
Works mainly from home **39.8%** (31.5%)
Other **11.9%** (14.5%)

% of people aged 16 years and over in employment

Economic activity status

Brinklow, Wolvey & Churchover
(England)

Economically active: In employment **60.4%** (57.4%)
Economically active: Unemployed **1.6%** (3.5%)
Economically inactive **38.0%** (39.1%)

% of people aged 16 years and over

Socio-economic Classification (NS-SeC)

Brinklow, Wolvey & Churchover
(England)

L1, L2 and L3: Higher managerial, administrative and professional occupations **17.7%** (13.2%)
L4, L5 and L6: Lower managerial, administrative and professional occupations **24.1%** (19.9%)
L7: Intermediate occupations **12.6%** (11.4%)
L8 and L9: Small employers and own account workers **13.6%** (10.6%)
L10 and L11: Lower supervisory and technical occupations **5.1%** (5.3%)
L12: Semi-routine occupations **7.6%** (11.3%)
L13: Routine occupations **9.2%** (12.0%)
L14.1 and L14.2: Never worked and long-term unemployed **5.8%** (8.5%)
L15: Full-time students **4.2%** (7.7%)

% of people aged 16 years and over

Highest level of qualification

Brinklow, Wolvey & Churchover
(England)

No qualifications **14.4%** (18.1%)
Level 1, 2 or 3 qualifications **39.6%** (39.9%)
Apprenticeship **7.7%** (5.3%)
Level 4 qualifications and above **36.2%** (33.9%)
Other qualifications **2.1%** (2.8%)

% of people aged 16 years and over

Schoolchildren and full-time students

Brinklow, Wolvey & Churchover
(England)

Student **14.7%** (20.4%)
Not a student **85.3%** (79.6%)

% of people aged five years and over

Source: Office for National Statistics - Census 2021

Lutterworth

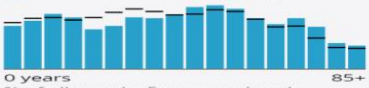
Area map

Population

10,800
people

56,490,000 people in England
Rounded to the nearest 100 people

Age profile



% of all people, 5 year age bands

Sex

Lutterworth | (England)

Female **50.2%** (51.0%)

Male **49.8%** (49.0%)

% of all people

Household deprivation

Lutterworth | (England)

Household is not deprived in any dimension **53.4%** (48.4%)

Household is deprived in one dimension **32.9%** (33.5%)

Household is deprived in two dimensions **11.7%** (14.2%)

Household is deprived in three dimensions **1.9%** (3.7%)

Household is deprived in four dimensions **0.1%** (0.2%)

% of all households

Ethnic group

Lutterworth | (England)

Asian, Asian British or Asian Welsh **2.1%** (9.6%)

Black, Black British, Black Welsh, Caribbean or African **0.7%** (4.2%)

Mixed or Multiple ethnic groups **1.6%** (3.0%)

White **94.9%** (81.0%)

Other ethnic group **0.7%** (2.2%)

% of all people

Religion

Lutterworth | (England)

No religion **39.4%** (36.7%)

Christian **52.5%** (46.3%)

Buddhist **0.2%** (0.5%)

Hindu **0.7%** (1.8%)

Jewish **0.1%** (0.5%)

Muslim **0.6%** (6.7%)

Sikh **0.5%** (0.9%)

Other religion **0.3%** (0.6%)

Not answered **5.8%** (6.0%)

% of all people

Disability

Lutterworth | (England)

Disabled under the Equality Act **16.2%** (17.3%)

Not disabled under the Equality Act **83.8%** (82.7%)

% of all people

Provision of unpaid care

Lutterworth | (England)

Provides no unpaid care **91.8%** (91.2%)

Provides 19 hours or less unpaid care a week **4.6%** (4.3%)

Provides 20 to 49 hours unpaid care a week **1.2%** (1.8%)

Provides 50 or more hours unpaid care a week **2.4%** (2.6%)

% of people aged five years and over

Distance travelled to work

Lutterworth | (England)

Less than 10km **26.4%** (35.4%)

10km to less than 30km **22.3%** (14.4%)

30km and over **7.4%** (4.3%)

Works mainly from home **31.0%** (31.5%)

Other **12.9%** (14.5%)

% of people aged 16 years and over in employment

Economic activity status

Lutterworth | (England)

Economically active: In employment **60.2%** (57.4%)

Economically active: Unemployed **2.2%** (3.5%)

Economically inactive **37.7%** (39.1%)

% of people aged 16 years and over

Socio-economic Classification (NS-SeC)

Lutterworth | (England)

L1, L2 and L3: Higher managerial, administrative and professional occupations **15.3%** (13.2%)

L4, L5 and L6: Lower managerial, administrative and professional occupations **22.0%** (19.9%)

L7: Intermediate occupations **12.5%** (11.4%)

L8 and L9: Small employers and own account workers **10.3%** (10.6%)

L10 and L11: Lower supervisory and technical occupations **5.9%** (5.3%)

L12: Semi-routine occupations **9.7%** (11.3%)

L13: Routine occupations **13.4%** (12.0%)

L14.1 and L14.2: Never worked and long-term unemployed **4.9%** (8.5%)

L15: Full-time students **5.9%** (7.7%)

% of people aged 16 years and over

Highest level of qualification

Lutterworth | (England)

No qualifications **16.4%** (18.1%)

Level 1, 2 or 3 qualifications **42.6%** (39.9%)

Apprenticeship **6.1%** (5.3%)

Level 4 qualifications and above **32.4%** (33.9%)

Other qualifications **2.5%** (2.8%)

% of people aged 16 years and over

Schoolchildren and full-time students

Lutterworth | (England)

Student **19.0%** (20.4%)

Not a student **81.0%** (79.6%)

% of people aged five years and over

Source: Office for National Statistics - Census 2021

Harborough

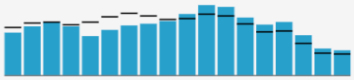
Area map

Population

97,600
people

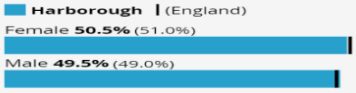
56,490,000 people in England
Rounded to the nearest 100 people

Age profile



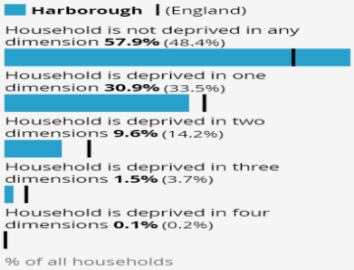
% of all people, 5 year age bands

Sex



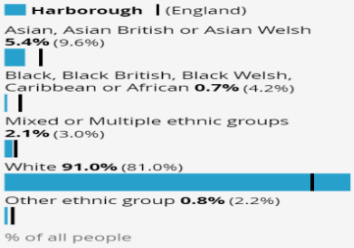
Female **50.5%** (51.0%)
Male **49.5%** (49.0%)
% of all people

Household deprivation



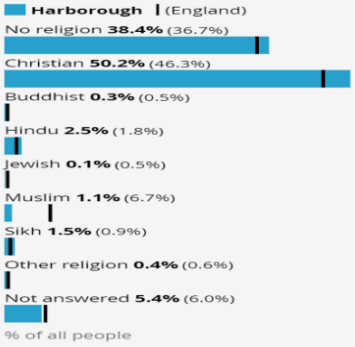
Household is not deprived in any dimension **57.9%** (48.4%)
Household is deprived in one dimension **30.9%** (33.5%)
Household is deprived in two dimensions **9.6%** (14.2%)
Household is deprived in three dimensions **1.5%** (3.7%)
Household is deprived in four dimensions **0.1%** (0.2%)
% of all households

Ethnic group



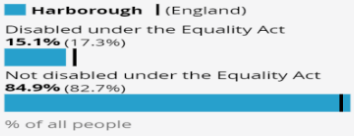
Asian, Asian British or Asian Welsh **5.4%** (9.6%)
Black, Black British, Black Welsh, Caribbean or African **0.7%** (4.2%)
Mixed or Multiple ethnic groups **2.1%** (3.0%)
White **91.0%** (81.0%)
Other ethnic group **0.8%** (2.2%)
% of all people

Religion



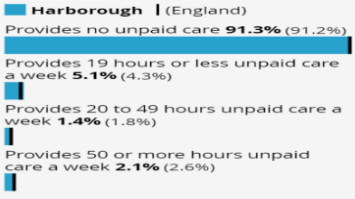
No religion **38.4%** (36.7%)
Christian **50.2%** (46.3%)
Buddhist **0.3%** (0.5%)
Hindu **2.5%** (1.8%)
Jewish **0.1%** (0.5%)
Muslim **1.1%** (6.7%)
Sikh **1.5%** (0.9%)
Other religion **0.4%** (0.6%)
Not answered **5.4%** (6.0%)
% of all people

Disability



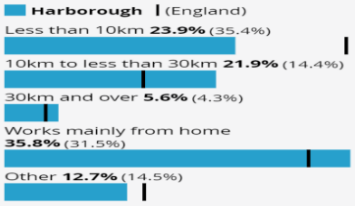
Disabled under the Equality Act **15.1%** (17.3%)
Not disabled under the Equality Act **84.9%** (82.7%)
% of all people

Provision of unpaid care



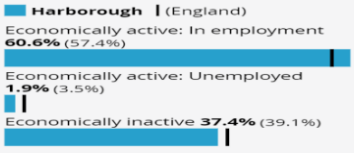
Provides no unpaid care **91.3%** (91.2%)
Provides 19 hours or less unpaid care a week **5.1%** (4.3%)
Provides 20 to 49 hours unpaid care a week **1.4%** (1.8%)
Provides 50 or more hours unpaid care a week **2.1%** (2.6%)
% of people aged five years and over

Distance travelled to work



Less than 10km **23.9%** (35.4%)
10km to less than 30km **21.9%** (14.4%)
30km and over **5.6%** (4.3%)
Works mainly from home **35.8%** (31.5%)
Other **12.7%** (14.5%)
% of people aged 16 years and over in employment

Economic activity status

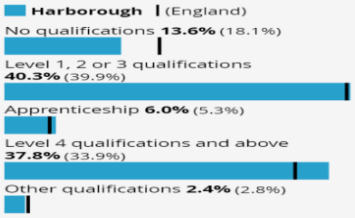


Economically active: In employment **60.6%** (57.4%)
Economically active: Unemployed **1.9%** (3.5%)
Economically inactive **37.4%** (39.1%)
% of people aged 16 years and over

Socio-economic Classification (NS-SeC)

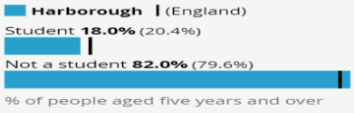
L1, L2 and L3: Higher managerial, administrative and professional occupations **17.8%** (13.2%)
L4, L5 and L6: Lower managerial, administrative and professional occupations **23.9%** (19.9%)
L7: Intermediate occupations **12.0%** (11.4%)
L8 and L9: Small employers and own account workers **12.8%** (10.6%)
L10 and L11: Lower supervisory and technical occupations **4.7%** (5.3%)
L12: Semi-routine occupations **9.2%** (11.3%)
L13: Routine occupations **9.5%** (12.0%)
L14.1 and L14.2: Never worked and long-term unemployed **4.7%** (8.5%)
L15: Full-time students **5.3%** (7.7%)
% of people aged 16 years and over

Highest level of qualification



No qualifications **13.6%** (18.1%)
Level 1, 2 or 3 qualifications **40.3%** (39.9%)
Apprenticeship **6.0%** (5.3%)
Level 4 qualifications and above **37.8%** (33.9%)
Other qualifications **2.4%** (2.8%)
% of people aged 16 years and over

Schoolchildren and full-time students



Student **18.0%** (20.4%)
Not a student **82.0%** (79.6%)
% of people aged five years and over

Source: Office for National Statistics - Census 2021

Harborough Magna

Area map

Population

480
people

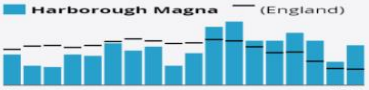
56,490,000 people in England
Rounded to the nearest 10 people (nearest 100 for England)

Number of households

190
households

23,436,100 households in England
Rounded to the nearest 10 households (nearest 100 for England)

Age profile



% of all people, 5 year age bands

Sex

Harborough Magna | (England)

Female **51.8%** (51.0%)

Male **48.2%** (49.0%)

% of all people

Household deprivation

Harborough Magna | (England)

Household is not deprived in any dimension **55.2%** (48.4%)

Household is deprived in one dimension **29.7%** (33.5%)

Household is deprived in two dimensions **12.5%** (14.2%)

Household is deprived in three dimensions **2.6%** (3.7%)

Household is deprived in four dimensions **0.0%** (0.2%)

% of all households

Ethnic group

Harborough Magna | (England)

Asian, Asian British or Asian Welsh **0.2%** (9.6%)

Black, Black British, Black Welsh, Caribbean or African **0.4%** (4.2%)

Mixed or Multiple ethnic groups **1.0%** (3.0%)

White **97.5%** (81.0%)

Other ethnic group **0.8%** (2.2%)

% of all people

Religion

Harborough Magna | (England)

No religion **35.8%** (36.7%)

Christian **57.8%** (46.3%)

Buddhist **0.2%** (0.5%)

Hindu **0.0%** (1.8%)

Jewish **0.0%** (0.5%)

Muslim **0.0%** (6.7%)

Sikh **0.8%** (0.9%)

Other religion **0.2%** (0.6%)

Not answered **5.2%** (6.0%)

% of all people

Disability

Harborough Magna | (England)

Disabled under the Equality Act **24.3%** (17.3%)

Not disabled under the Equality Act **75.7%** (82.7%)

% of all people

Provision of unpaid care

Harborough Magna | (England)

Provides no unpaid care **90.4%** (91.2%)

Provides 19 hours or less unpaid care a week **4.1%** (4.3%)

Provides 20 to 49 hours unpaid care a week **2.8%** (1.8%)

Provides 50 or more hours unpaid care a week **2.6%** (2.6%)

% of people aged five years and over

Distance travelled to work

Harborough Magna | (England)

Less than 10km **25.7%** (35.4%)

10km to less than 30km **23.0%** (14.4%)

30km and over **1.8%** (4.3%)

Works mainly from home **35.4%** (31.5%)

Other **14.2%** (14.5%)

% of people aged 16 years and over in employment

Economic activity status

Harborough Magna | (England)

Economically active: In employment **53.1%** (57.4%)

Economically active: Unemployed **1.2%** (3.5%)

Economically inactive **45.7%** (39.1%)

% of people aged 16 years and over

Socio-economic Classification (NS-SeC)

Harborough Magna | (England)

L1, L2 and L3: Higher managerial, administrative and professional occupations **15.3%** (13.2%)

L4, L5 and L6: Lower managerial, administrative and professional occupations **20.7%** (19.9%)

L7: Intermediate occupations **11.0%** (11.4%)

L8 and L9: Small employers and own account workers **16.9%** (10.6%)

L10 and L11: Lower supervisory and technical occupations **4.2%** (5.3%)

L12: Semi-routine occupations **8.2%** (11.3%)

L13: Routine occupations **12.9%** (12.0%)

L14.1 and L14.2: Never worked and long-term unemployed **7.3%** (8.5%)

L15: Full-time students **3.5%** (7.7%)

% of people aged 16 years and over

Highest level of qualification

Harborough Magna | (England)

No qualifications **19.1%** (18.1%)

Level 1, 2 or 3 qualifications **39.6%** (39.9%)

Apprenticeship **7.1%** (5.3%)

Level 4 qualifications and above **32.1%** (33.9%)

Other qualifications **2.1%** (2.8%)

% of people aged 16 years and over

Schoolchildren and full-time students

Harborough Magna | (England)

Student **10.8%** (20.4%)

Not a student **89.2%** (79.6%)

% of people aged five years and over

Source: Office for National Statistics - Census 2021

Lutterworth East

Area map

Population

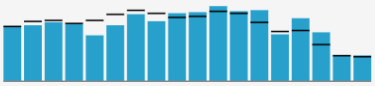
5,400
people

56,490,000 people in England

Rounded to the nearest 100 people

Age profile

Lutterworth East (England)



0 years 85+

% of all people, 5 year age bands

Sex

Lutterworth East | (England)

Female **50.0%** (51.0%)

Male **50.0%** (49.0%)

% of all people

Household deprivation

Lutterworth East | (England)

Household is not deprived in any dimension **51.6%** (48.4%)

Household is deprived in one dimension **33.2%** (33.5%)

Household is deprived in two dimensions **12.8%** (14.2%)

Household is deprived in three dimensions **2.4%** (3.7%)

Household is deprived in four dimensions **0.0%** (0.2%)

% of all households

Ethnic group

Lutterworth East | (England)

Asian, Asian British or Asian Welsh **2.2%** (9.6%)

Black, Black British, Black Welsh, Caribbean or African **0.7%** (4.2%)

Mixed or Multiple ethnic groups **1.9%** (3.0%)

White **94.7%** (81.0%)

Other ethnic group **0.5%** (2.2%)

% of all people

Religion

Lutterworth East | (England)

No religion **41.2%** (36.7%)

Christian **51.8%** (46.3%)

Buddhist **0.1%** (0.5%)

Hindu **0.8%** (1.8%)

Jewish **0.1%** (0.5%)

Muslim **0.6%** (6.7%)

Sikh **0.6%** (0.9%)

Other religion **0.3%** (0.6%)

Not answered **4.6%** (6.0%)

% of all people

Disability

Lutterworth East | (England)

Disabled under the Equality Act **17.3%** (17.3%)

Not disabled under the Equality Act **82.7%** (82.7%)

% of all people

Distance travelled to work

Lutterworth East | (England)

Less than 10km **26.2%** (35.4%)

10km to less than 30km **23.1%** (14.4%)

30km and over **6.4%** (4.3%)

Works mainly from home **30.9%** (31.5%)

Other **13.4%** (14.5%)

% of people aged 16 years and over in employment

Economic activity status

Lutterworth East | (England)

Economically active: In employment **60.3%** (57.4%)

Economically active: Unemployed **2.3%** (3.5%)

Economically inactive **37.4%** (39.1%)

% of people aged 16 years and over

Socio-economic Classification (NS-SeC)

Lutterworth East | (England)

L1, L2 and L3: Higher managerial, administrative and professional occupations **14.3%** (13.2%)

L4, L5 and L6: Lower managerial, administrative and professional occupations **21.2%** (19.9%)

L7: Intermediate occupations **12.0%** (11.4%)

L8 and L9: Small employers and own account workers **10.3%** (10.6%)

L10 and L11: Lower supervisory and technical occupations **6.2%** (5.3%)

L12: Semi-routine occupations **10.3%** (11.3%)

L13: Routine occupations **15.2%** (12.0%)

L14.1 and L14.2: Never worked and long-term unemployed **5.2%** (8.5%)

L15: Full-time students **5.3%** (7.7%)

% of people aged 16 years and over

Highest level of qualification

Lutterworth East | (England)

No qualifications **16.4%** (18.1%)

Level 1, 2 or 3 qualifications **43.7%** (39.9%)

Apprenticeship **6.4%** (5.3%)

Level 4 qualifications and above **30.8%** (33.9%)

Other qualifications **2.7%** (2.8%)

% of people aged 16 years and over

Schoolchildren and full-time students

Lutterworth East | (England)

Student **17.8%** (20.4%)

Not a student **82.2%** (79.6%)

% of people aged five years and over

Source: Office for National Statistics - Census 2021

Lutterworth West

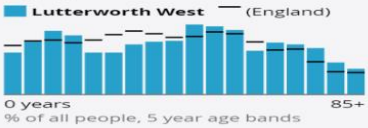
Area map

Population

5,500
people

56,490,000 people in England
Rounded to the nearest 100 people

Age profile



% of all people, 5 year age bands

Sex

Lutterworth West | (England)

Female **50.5%** (51.0%)

Male **49.5%** (49.0%)

% of all people

Household deprivation

Lutterworth West | (England)

Household is not deprived in any dimension **55.4%** (48.4%)

Household is deprived in one dimension **32.6%** (33.5%)

Household is deprived in two dimensions **10.5%** (14.2%)

Household is deprived in three dimensions **1.4%** (3.7%)

Household is deprived in four dimensions **0.1%** (0.2%)

% of all households

Ethnic group

Lutterworth West | (England)

Asian, Asian British or Asian Welsh **1.9%** (9.6%)

Black, Black British, Black Welsh, Caribbean or African **0.8%** (4.2%)

Mixed or Multiple ethnic groups **1.3%** (3.0%)

White **95.2%** (81.0%)

Other ethnic group **0.8%** (2.2%)

% of all people

Religion

Lutterworth West | (England)

No religion **37.5%** (36.7%)

Christian **53.2%** (46.3%)

Buddhist **0.2%** (0.5%)

Hindu **0.5%** (1.8%)

Jewish **0.1%** (0.5%)

Muslim **0.6%** (6.7%)

Sikh **0.5%** (0.9%)

Other religion **0.3%** (0.6%)

Not answered **7.0%** (6.0%)

% of all people

Disability

Lutterworth West | (England)

Disabled under the Equality Act **15.1%** (17.3%)

Not disabled under the Equality Act **84.9%** (82.7%)

% of all people

Provision of unpaid care

Lutterworth West | (England)

Provides no unpaid care **91.9%** (91.2%)

Provides 19 hours or less unpaid care a week **4.8%** (4.3%)

Provides 20 to 49 hours unpaid care a week **1.0%** (1.8%)

Provides 50 or more hours unpaid care a week **2.2%** (2.6%)

% of people aged five years and over

Distance travelled to work

Lutterworth West | (England)

Less than 10km **26.5%** (35.4%)

10km to less than 30km **21.6%** (14.4%)

30km and over **8.4%** (4.3%)

Works mainly from home **31.1%** (31.5%)

Other **12.5%** (14.5%)

% of people aged 16 years and over in employment

Economic activity status

Lutterworth West | (England)

Economically active: In employment **60.0%** (57.4%)

Economically active: Unemployed **2.0%** (3.5%)

Economically inactive **37.9%** (39.1%)

% of people aged 16 years and over

Socio-economic Classification (NS-SeC)

Lutterworth West | (England)

L1, L2 and L3: Higher managerial, administrative and professional occupations **16.4%** (13.2%)

L4, L5 and L6: Lower managerial, administrative and professional occupations **22.8%** (19.9%)

L7: Intermediate occupations **13.1%** (11.4%)

L8 and L9: Small employers and own account workers **10.2%** (10.6%)

L10 and L11: Lower supervisory and technical occupations **5.7%** (5.3%)

L12: Semi-routine occupations **9.1%** (11.3%)

L13: Routine occupations **11.7%** (12.0%)

L14.1 and L14.2: Never worked and long-term unemployed **4.7%** (8.5%)

L15: Full-time students **6.5%** (7.7%)

% of people aged 16 years and over

Highest level of qualification

Lutterworth West | (England)

No qualifications **16.4%** (18.1%)

Level 1, 2 or 3 qualifications **41.6%** (39.9%)

Apprenticeship **5.7%** (5.3%)

Level 4 qualifications and above **34.1%** (33.9%)

Other qualifications **2.3%** (2.8%)

% of people aged 16 years and over

Schoolchildren and full-time students

Lutterworth West | (England)

Student **20.2%** (20.4%)

Not a student **79.8%** (79.6%)

% of people aged five years and over

Source: Office for National Statistics - Census 2021

Appendix 2

When	*Stakeholder/ group/ Audience*	*What*	*What does good look like*	*Lead*	*Status/Update*
Tbc		**Set up** Design and print consultation document and Easy Read Design and print summary of consultation document Design and print leaflets, posters and displays Develop survey (online & off line) Set up method of capturing insights to contribute to final report Develop web pages Set up promotion of events and consultation opportunities Set up event planner of community events and outreach opportunities Commission voluntary and community sector support Set up public events including venues and speakers Set up schedule of newsletters and updates Collate local social media schedule Set up PR schedule Produce miscellaneous materials including vox pops and video clips Set up online Q&A and method of adding to Appoint independent organisation to produce final analysed report	Well prepared consultation activities		
		Online Focus Groups			
tbc	People with protected characteristics and carers	Review the existing communication and engagement networks of the participating organisations to establish how best to engage those people who are seldom heard Use the framework of the nine protected characteristics of The Equality Act (2010) as a guide Identify, approach and commission voluntary, community and other organisations and groups informing them of the consultation and setting up service level agreements to engage their promotion of the consultation. Work with key voluntary sector groups commissioning them to set up specific engagement activities with their audience	Inclusive engagement of all areas of the community Evidence of participation from people with protected characteristics through equality questions in response form		

		Leicestershire Health Overview and Scrutiny, councillors and MPS	
Tbc	Overview and Scrutiny	Attend Leicestershire Overview and Scrutiny Committee to formerly consult Attend any relevant District, Town and parishes meetings Send e-bulletin to launch consultation and coordinate regular updates/ in line with requirements of the committee and /or council	Informed and engaged Overview and Scrutiny
	Health and Wellbeing Board	Bulletin to launch consultation and report on regular basis the progress of the consultation	Well informed Health and Wellbeing Board and representative organisations
	MPs and local councillors	MP virtual briefing and ongoing bulletin to launch consultation and report on regular basis the progress of the consultation	Well informed MPs and councillors
		Online Deliberative events	
Coordination tbc Events held in tbc	All audiences	Oversee coordination of events undertaken by Voluntary and Community Groups. Set up ICB coordinated events Promotional activities including on-line and off-line through press, by invitation, in newsletters, through relevant groups including patient membership Set up method of capturing insights to contribute to final report	100 people attending 4 – 6 events. Community aware and involved in consultation and participating in feeding in views All responses coordinated as part of the overall independent evaluation and analysis
TBC	All audiences	**Advertising** Select and book any key advertising space in online and off line media	Community aware and involved in consultation and participating in feeding in views All responses coordinated as part of the overall independent evaluation and analysis
		Roadshow on sites where there is good footfall	
Coordination in tbc Roadshow held in tbc	All audiences, but particularly patients and staff	Coordinate schedule for displays around local sites including provision of display and information to take away e.g. GP practices, hospital, shops etc..	People aware of consultation, information shared and dialogue generated and feedback received directly or via website

	Vulnerable and those in deprived areas	Work with voluntary and community sector organisations and those identified on stakeholder analysis offer outreach Utilise vaccination centres to provide information	People aware of consultation, information shared and dialogue generated and feedback received directly or via website
	All audiences	**Digital** Search engine optimisation to ensure the website is visible to existing and new content Awareness and prospecting campaign using Facebook, Instagram, You Tube, Google Display Ads Broadcast media including digital radio and TV Remarketing campaign Messaging through community channels	More people involved in consultation
		Website and social media	
Develop in tbc and implementation throughout consultation	All audiences	Coordinate web pages for consultation on ICB website with links to providers and other websites Develop ongoing schedule of web, video and social media content through the duration of the consultation to engage and appeal to different audiences Collate social media plan for duration of consultation linked with aim to generate maximum responses via website Create web copy and distribute to partners to form links to ICB website and maximise number of hits to response form Engage Citizens' Panel to participate in consultation and encourage wider participation.	More people involved in the consultation; viewing partner web pages and responding
		Briefing	
Coordinate in tbc and hold briefings in tbc	Key stakeholders (see section 8 of plan)	Diary in briefings to key stakeholder list in early phase of consultation to enable stakeholders to cascade information to their members/contacts	Informed stakeholders who are cascading information about consultation to their contacts

		Posters and leaflets	
Coordinate in tbc and distribute in tbc	Public	Distribute posters and leaflets in community venues promoting the consultation and ways to get involved Investigate with practices emailing patients to promote the consultation and ways to get involved	Materials distributed in communities promoting consultation yielding 3% response rate
		Press and public relations	
Coordinate in tbc and commence distribution in tbc	All audiences	Meetings and/or regular communications established with journalists to develop ongoing relationships and communicate review Identify different topics of interest generated by consultation pertinent to different audiences. Prepare launch of consultation with media Collate and produce proactive press releases throughout consultation to generate maximum coverage through print, radio and TV Establish key media spokespeople and ensure they are and confident and well briefed in undertaking media interviews	At least 2 press releases per month during duration of consultation yielding coverage
Coordinate in tbc and commence distribution in tbc	All audiences	Widen media database and target appropriate local magazines and newsletter with relevant articles and features, including patient newsletters and local parish councils	Better informed local residents actively participating in consultation
Tbc	All audiences	**Collateral** Produce consultation document including in appropriate formats Produce Q&A Produce on and off line copy Produce slide presentation and script Produce display material Produce web copy and video Set up e-mail marketing **Processes** Set up calendar of activities Set up social media and press schedule Set up process for logging activities and provision of evidence	Well informed public contributing to consultation

		Set up process for ongoing evaluation on weekly basis and make necessary modifications	
Tbc	Service users	**Distribution** Coordinate distribution of leaflets to key outlets e.g. community centres, GPs practices, pharmacists etc.	Well informed households contributing to consultation
Tbc	Specified communities	**Output of half-point review** If half-point consultation review identifies under-represented communities identify communications activities to reach them e.g. telephone interviews, webinars etc. etc.	Mitigation actions implemented targeting under represented communities
		Staff engagement	
Coordinate in tbc and commence briefing in tbc	Health professionals	Work with LPT and VCS and other providers to set up briefings with a cross section of staff	Well information staff contributing to consultation
		General communications	
Coordinate in tbc and produce bi-weekly through consultation starting with launch	All audiences	Use existing newsletters and communications to update on progress on consultation	Well informed audiences contributing to consultation
		Evaluation and analysis	
Coordinate tbc to commence after consultation ends	All audiences	Undertaken independent evaluation and analysis of insights from consultation	Coordination of all business intelligence and production of report

		Post consultation communications	
Tbc	All audiences	Review at 6 weeks to assess reach of consultation and to assess any additional activities needed to attract further participation. Produce final Report of Findings. Undertake period of review and reflection prior to presenting report to ICB Board with recommendations Publicise final outcome post ICB Board Develop communications plan to ensure all audiences are aware of outcome and next steps	Well informed public who are aware of outcome and next steps

Appendix 3

Lutterworth local intelligence

Lutterworth responses

From the raw data available, the following findings for Lutterworth have been taken from the following surveys and consultations :

- **Acute and Maternity Reconfiguration consultation – Building Better Hospitals reported in June 2021**
  - Total 5,675 responses
  - 2,109 responses from Leicestershire
  - 77 responses from Lutterworth
- **Online Covid-19 vaccine hesitancy survey – reported September 2021**
  - Total 3,280 responses
  - 3,096 responses from Leicestershire
  - 23 responses from Lutterworth
- **Step Up To Great Mental Health consultation – reported in December 2021**
  - Total 6,650 responses
  - 2,339 responses from Leicestershire
  - 75 responses from Lutterworth
- **Primary Care Survey reported 2021**
  - 5, 483 responses
  - 3,363 responses from Leicestershire
  - 109 respondents from Lutterworth

Lutterworth responses by age

From the raw data available, the following findings for Lutterworth have been taken from the following surveys and consultations

- **Acute and Maternity Reconfiguration consultation**
  - 77 responses from Lutterworth
  - 16 – 44 year olds, 17 responses
  - 45 – 75+ year olds, 56 responses
- **Online Covid-19 vaccine hesitancy survey**
  - 23 responses from Lutterworth
  - 16 – 34 year olds, 3 responses
  - 35 – 59 year olds, 5 responses
  - 60 – 76+ year olds, 13 responses
- **Step Up To Great Mental Health consultation**
  - 75 responses from Lutterworth
  - 16 – 44 year olds, 18 responses
  - 45 – 75+ year olds, 57 responses
- **Online Primary Care Survey from June – July 2021**
  - 69 respondents from Lutterworth
  - 16 – 44 year olds, 12 responses
  - 44 – 75+ year olds, 57 responses

Lutterworth responses by ethnicity

From the raw data available, the following findings for Lutterworth have been taken from the following surveys and consultations

- **Acute and Maternity Reconfiguration consultation**
  - 77 responses from Lutterworth
  - 76 response were from a white background
  - 1 response was from an Asian background
- **Online Covid-19 vaccine hesitancy survey**
  - 21 responses from Lutterworth
  - 21 responses were from a white background
- **Step Up To Great Mental Health consultation**
  - 75 responses from Lutterworth
  - 73 responses were from a white background
  - 2 responses were from an Asian background
- **Online Primary Care Survey from June– July 2021**
  - 68 respondents from Lutterworth
  - 67 respondents were from a white background
  - 1 respondent was from a Caribbean background

Appendix J1

University Hospitals of Leicester NHS Trust

Leicester Royal Infirmary
Chief Executive's Corridor
Level 3, Balmoral Building
Infirmary Square
Leicester
LE1 5WW

Sarah Prema
Chief Strategy and Planning Officer
LLR ICB

14th June 2023

Dear Sarah

Support for consultation on the redevelopment of Feilding Palmer Hospital

We are writing to express our support for the consultation on the redevelopment of Feilding Palmer Hospital. This redevelopment would allow for the provision of an enhanced procedure suite and additional consulting rooms.

We understand that the inpatient ward at the hospital is not suitable for modern healthcare and that due to the small number of available beds this is an inefficient use of resources (both staffing and financial) and that this capacity will be re-provided. Having the additional available space would allow for the expansion of outpatient and community provision, supporting the ask of providing care closer to home for patients whilst also being more convenient for the local population.

We believe that the redevelopment would create a positive opportunity to impact on the Leicester, Leicestershire and Rutland's patient waiting times and health outcomes, and will provide additional capacity in the system to respond to the growth in population due to the Lutterworth East housing development. By providing the additional facilities within Lutterworth patients travel times would be reduced.

Yours sincerely

Simon Barton
Deputy Chief Executive

Appendix J2

Leicestershire Partnership NHS Trust

David Williams
Group Director of Strategy and Partnerships
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester
LE4 8PQ

Email: David.williams96@nhs.net
www.leicspart.nhs.uk

Sarah Prema
Chief Strategy and Planning Officer
LLR ICB

8th June 2023

Dear Sarah (on behalf of LLR ICB),

RE: Support for the redevelopment of Feilding Palmer Hospital

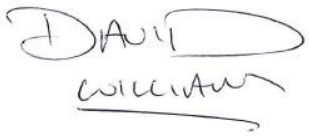
We are writing to express our support for the redevelopment of Feilding Palmer Hospital. This redevelopment would allow for the provision of an enhanced procedure suite and additional consulting rooms.

We understand that the inpatient ward at the hospital is not suitable for modern healthcare and that due to the small number of available beds this is an inefficient use of resources (both staffing and financial).

Having the additional available space would allow for the expansion of outpatient and community provision, supporting the ask of providing care closer to home for patients whilst also being more convenient for the local population. We believe that the redevelopment would create a positive impact on the Leicester, Leicestershire and Rutland's patient waiting times and health outcomes, and will be provide additional capacity in the system to respond to the growth in population due to the Lutterworth East housing development. By providing the additional facilities within Lutterworth patients travel times would be reduced.

Thank you.

Yours sincerely,



David Williams,
Group Director of Strategy and Partnerships

disability confident EMPLOYER

Appendix J3

Dr Vipul Masharani MB BCh, BSc, DipRCOG MRCGP
Dr Svitlana Zhelezna MBBS MRCGP
Dr Punam Kalirai MB ChB MRCGP
Dr Emily Lucas MBBS MRCGP

The Masharani Practice
Lutterworth Medical Centre
Gilmorton Road
Lutterworth
Leicestershire LE17 4EB

Telephone (01455) 552346
www.themasharanipractice.org.uk

Our ref: VM/SG

8th June 2023

Sarah Prema
Chief Strategy and Planning Officer
LLR ICB

Dear Sarah (on behalf of LLR ICB),

RE: Support for the redevelopment of Feilding Palmer Hospital

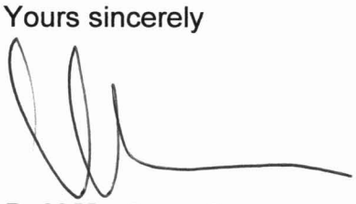
We are writing to express our support for the redevelopment of Feilding Palmer Hospital. This redevelopment would allow for the provision of an enhanced procedure suite and additional consulting rooms.

We understand that the inpatient ward at the hospital is not suitable for modern healthcare and that due to the small number of available beds this is an inefficient use of resources (both staffing and financial). Having the additional available space would allow for the expansion of outpatient and community provision, supporting the ask of providing care closer to home for patients whilst also being more convenient for the local population.

We believe that the redevelopment would create a positive impact on the Leicester, Leicestershire and Rutland's patient waiting times and health outcomes, and will provide additional capacity in the system to respond to the growth in population due to the Lutterworth East housing development. By providing the additional facilities within Lutterworth patients travel times would be reduced.

Thank you.

Yours sincerely



Dr V Masharani

Appendix J4

SB&L PCN

South Blaby & Lutterworth Primary Care Network

Northfield Medical Centre, Hazelmere Medical Centre, Countesthorpe Health Centre, Wycliffe Medical Centre & Masharani Practice

South Blaby & Lutterworth PCN
Northfield Medical Centre
Villers Court
Blaby
Leicester
LE8 4NS

Sarah Prema
Chief Strategy and Planning Officer
LLR ICB

30th May 2023

Dear Sarah (on behalf of LLR ICB),

RE: Support for the redevelopment of Feilding Palmer Hospital

We are writing to express our support for the redevelopment of Feilding Palmer Hospital. This redevelopment would allow for the provision of an enhanced procedure suite and additional consulting rooms.

We understand that the inpatient ward at the hospital is not suitable for modern healthcare and that due to the small number of available beds this is an inefficient use of resources (both staffing and financial). Having the additional available space would allow for the expansion of outpatient and community provision, supporting the ask of providing care closer to home for patients whilst also being more convenient for the local population.

We believe that the redevelopment would create a positive impact on the Leicester, Leicestershire and Rutland's patient waiting times and health outcomes, and will be provide additional capacity in the system to respond to the growth in population due to the Lutterworth East housing development. By providing the additional facilities within Lutterworth patients travel times would be reduced.

Thank you.

Yours sincerely,

Dr Danny Jones

South Blaby & Lutterworth PCN Accountable Clinical Director & GP Partner Northfield Medical Centre

Dr Nick Glover

GP Partner Northfield Medical Centre & PCN Director

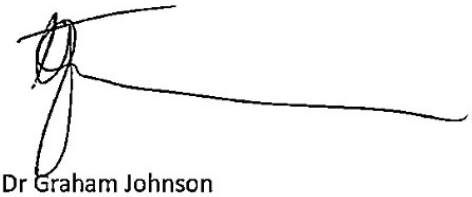
SB&L PCN

South Blaby & Lutterworth Primary Care Network

Northfield Medical Centre, Hazelmere Medical Centre, Countesthorpe Health Centre, Wycliffe Medical Centre & Masharani Practice

Dr Rob Browne

GP Partner Countesthorpe Health Centre & PCN Director



Dr Graham Johnson

GP Partner Wycliffe Medical Practice & PCN Director

Dr Omer Jan

GP Partner Hazelmere Medical Centre & PCN Director

Dr Vipul Masharani

GP Partner The Masharani Practice & PCN Director

James Goode

South Blaby & Lutterworth PCN Manager

Appendix J5

Our vision is to EXCEL at patient care

George Eliot Hospital
NHS Trust

George Eliot Hospital NHS Trust
College Street
Nuneaton
Warwickshire
CV10 7DJ

024 76351351
enquiries@geh.nhs.uk
www.geh.nhs.uk

24 September 2023

Joanna Clinton
Leicester, Leicestershire and Rutland's Integrated Care Board (ICB)
Sent Via Email: Joanna.clinton@nhs.net

RE: Feilding Palmer – Lutterworth

Dear Jo

I am writing on behalf of George Eliot Hospital NHS Trust, to convey George Eliot Hospital NHS Trust support regarding the remodel of services provided from the Feilding Palmer Community Hospital in Lutterworth. We agree that this development would maximise access to health services for the local community.

Yours sincerely

Robin Snead
Chief Operating Officer

Appendix J6

University Hospitals
Coventry and Warwickshire
NHS Trust

Our Ref:

Date: 15th September 2023

Joanna Clinton
Leicester, Leicestershire and Rutland's Integrated Care Board (ICB)
Sent Via Email: Joanna.clinton@nhs.net

University Hospital
Clifford Bridge Road
Walsgrave
Coventry
CV2 2DX

www.uhcw.nhs.uk

Dear Jo,

R.e: Feilding Palmer – Lutterworth

I am writing on behalf of University Hospitals Coventry and Warwickshire NHS Trust (UHCW), to confirm Trust support regarding the remodel of Feilding Palmer Community Hospital in Lutterworth that would maximise access to health services for the local community.

UHCW are fully aware of the possible changes in patient activity that this may present in the future.

Yours sincerely,

Joanne Lydon
Acting Chief Operating Officer