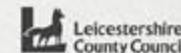
'It's about our life, our health, our care, our family and our community'

Better care **together**

Leicester, Leicestershire & Rutland health and social care

Leicester, Leicestershire and Rutland Value Proposition



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Programme Summary

The Vanguard Programme is focused on the delivery of a simplified, integrated system of urgent and emergency care that wraps itself around the patients, is easier for patients and staff to navigate across organisational boundaries. The current system is overly complex, containing a number of different entry and exit points and multiple inter service transfers. The Vanguard Programme seeks to implement the recommendations of the Keogh review, with an emphasis on better self-care, a more consistent, seven day urgent care system and a redesigned emergency department (ED). A Keogh route map is contained within Appendix 7.

The Vanguard Programme sits within the Leicester, Leicestershire and Rutland (LLR) Better Care Together Programme (BCT), which is the major change programme for the health and social care economy. BCT plans will form the LLR Sustainability and Transformation Plan for the next five years. In addition the programme has key dependencies and synergies with the Better Care Fund (BCF) and appropriate governance structures have been developed to ensure cohesion between the schemes. The Vanguard governance structure is contained within Appendix 2.

Our Vanguard Programme has been organised into six strands which together will deliver our transformation work on urgent care. Of these, four focus on large-scale service redesign. These are:

(1) Integrated Community Urgent Care
(2) Leicester Royal Infirmary Front Door
(3) Mental Health
(4) Seven Day Services.

In addition two are key enabling work strands:

(5) Contracting for Transformation and
(6) Predictive Modelling

Our Vanguard builds on a strong history of collaborative working across LLR and, as we take the work forward, we will move further towards developing an integrated system approach. Together these six strands will deliver a step change in the way that urgent and emergency care is delivered within Leicester, Leicestershire and Rutland.

Patient flow

Real time predictive modelling enabling demand and capacity management

111

999

Navigation hub

Integrated community care

'Walk-ins'

Improved Mental Health Crisis Support & responsiveness of service

7 day services- increased flow & reduced variation by day of week

New contracts to enable system change

Strand 1

UCC

Majors

Resus

Strand 6

Strand 2

Strand 3

Strand 4

Strand 5

High level Vanguard Programme Model

High-level impact

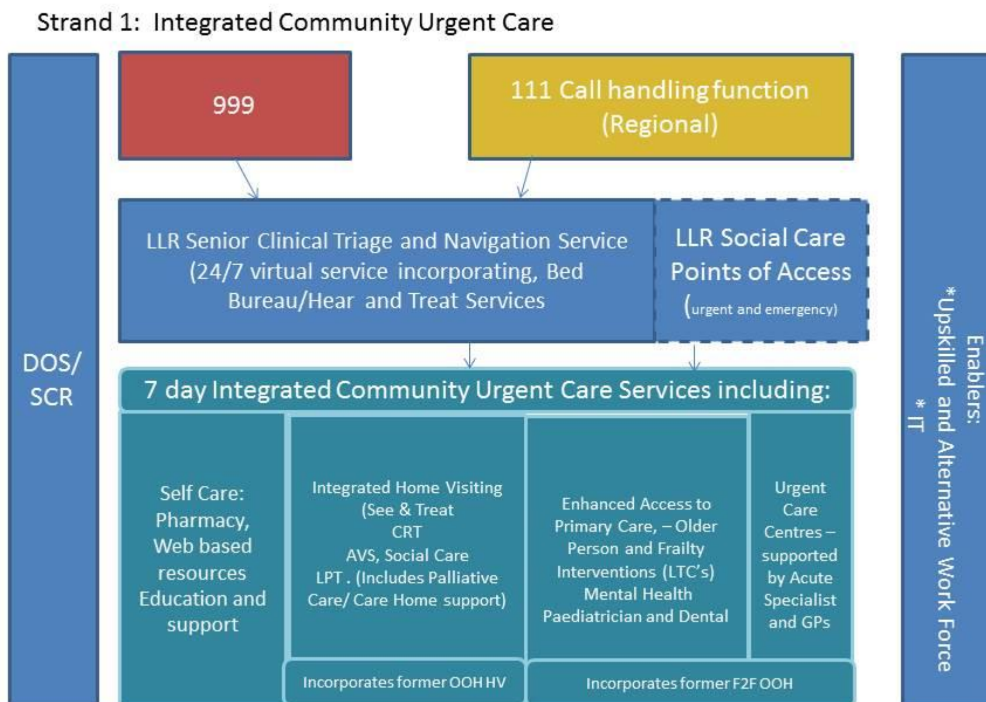
The primary impact of the Vanguard Programme will be to improve patient experience and outcomes: A simply designed and integrated system which provides a seamless service to our patients with access to the right care at the right time. The impact will be consistent, high quality integrated care across seven days a week. We aim to deliver improvements in a set of key patient and service outcomes, including reduced mortality rates and reduced ED attendance, admission and re-admittance rates. Improved quality and safety will be achieved via services which are clearly centred on the needs of the patient, with reduced variation, supported by a culture of continuous improvement and team working. Significant progress will be made towards parity of esteem and care in Mental Health across all ages, improving access to care through increased clinical triage, emergency service support, responsiveness to crisis and improved community support.

This more efficient model of care will result in reduced growth in inappropriate demand for emergency care through increased self care and earlier access to urgent care services in community and primary care settings. Increased use of NHS111 and greater consistency of advice through a single point of access for streaming, Urgent Care Centre (UCC) and minors will reduce ambulance demands and conveyances and will increase same-day access to primary care seven days a week for patient-perceived urgent care needs. ED attendances and costs will reduce through 'channel-shifting' to UCC and ED handovers will be faster, safer and more appropriate for patient needs. The service outcome measures will include a reduction in hospital admissions and readmissions, including those related to Mental Health, and improvement in waiting times. As an impact of patents being treated in the most appropriate place for their needs, patient flow will be spread across the most appropriate services, resulting in fewer patients attending ED; therefore waiting times within ED will decrease.

In addition, greater integration and improved efficiency of cost and effort will be achieved through services working together under a shared clinical governance umbrella to provide a seamless service, irrespective of the provider organisations. We will align organisational incentives to system outcomes through the new contract payment model and exploration of an alliance based approach to contracting, with appropriate incentives, and through the sharing risk of risk and information across the system. Predicting and pre-empting system pressure will enable improved workforce rotas, matching staffing with demand.

Strand 1: Integrated Community Urgent Care

Strand 1 will deliver the integration of pathways across ambulance, NHS111, Out of Hours (OOH) and the Single Point of Access (SPA) services for health and social care, via a telephony based senior clinical navigation service providing clinical triage, advice and signposting (See Appendix 5). In addition, the strand will develop an integrated, seven day community urgent care offer. The new model of care will deliver senior clinical triage and will be supported by local services that offer patients early access to appropriate health and social care. The clinical navigation service will offer a multi-disciplinary approach including GPs, hospital generalists with specialist skills, Mental Health practitioners, crisis response practitioners, pharmacists and dentists as well as social workers, who will triage, advise and deliver best healthcare pathway information to patients.



Clinical triage specialists will also provide support for front line clinicians, GPs and other health and social care practitioners and advise on the most suitable clinical pathways available within and across LLR. This may include the use of telemedicine/telehealth. Non-urgent clinical calls will be diverted to the clinical navigation service via NHS111 at an early stage in the call. The senior clinical team will offer early clinical triage and intervention that may include specialist advice, self-management advice (including navigation to supportive voluntary groups and interactive/web based resource), arrange an appointment at a GP practice for the next day or walk in appointment for the same day, and where required prepare a prescription to collect at their practice the same/next day, thus offering the right care in a timely manner and where possible avoiding unnecessary attendances to hospital. This supports patients living in a rural setting across LLR. The new models of care will be supported by a robust and seamless IT infrastructure including a shared patient record and knowledge of local services (Directory of Services – DOS). This will include wider availability and use of Summary Care Records (SCR) across the seven day service to all clinicians and associated health professionals including paramedics, crisis team and other practitioners.

Integrated community urgent care services will be achieved by the remodelling of current primary and community care service pathways, building on what currently exists within primary care services, walk in centres and urgent care centres and incorporating the out of hours response. We will increase same-day access for urgent primary care needs and ensure consistent access to seven day primary care. Our high level service model has been developed in partnership and following detailed consultations with primary, secondary and social care. The aim is to deliver a consistent model of care across LLR, which can be delivered by integrated provider collaborations at locality level and remain responsive and flexible to local population needs. We are exploring models that consider and incorporate both Multi-specialty Community Providers (MCP) and Primary and Acute systems (PACs) to deliver some elements of the integrated urgent care offer and will build this into our test phase.

Impact & Outcomes

More appropriate attendances and referrals to ED, including reducing avoidable ambulance conveyances

Assumption: This will be achieved by a system approach to redesign which includes clinical navigation and triage at an early stage following a call to NHS111, supported by integrated 24/7 urgent care services which include extended GP access, seven days a week and practice-based telephone or web based consultation, with greater emphasis on support for self-care and direction to pharmacy for advice and treatment where possible. A greater level of patient satisfaction is expected as a result of timely, safe and appropriate care pathways.

Increase in activity : Urgent care centre/walk in centres

Assumption: Clinical navigation services from NHS111 will result in an increase in appropriate primary care referrals rather than inappropriate ED attendance and subsequent avoidable admissions. We will build on the investigations available in community settings including radiology/pathology and ECGs and further develop an alternative workforce, which will allow a greater range of conditions to be managed without an ED conveyance.

Easier access for primary care clinicians(GPs) to Acute /Generalist with Specialist skills via web interface/telephony centre including access to urgent out patient appointments

Assumption: Improved clinical effectiveness and efficiency, continuity of care for patients, reduction in duplication of effort and increased clinical confidence. The availability of Hot Clinic slots with an acute physician, patients having previously been triaged through the clinical navigation service. This will be overseen with a coordinated joint clinical governance structure.

Increased patient engagement, improved experience of care

Assumption: Using the voice of patients who use services by collecting and understanding their experiences and what matters most to them in designing and delivering future services will lead to services which are more patient-centred and offer better patient experience. More consistent services with enhanced 7 day access will increase patient satisfaction

Improved self care leading to improved patient outcomes (reduced avoidable admissions/readmissions/attendances)

Assumption: Improved support for self-care, including pharmacy advice and use of technology (telemedicine) will reduce the use of other urgent care services and will improve overall patient outcomes. We will target patients with Long Term Conditions/complex needs and improving shared care plans, supported with better technology including telemedicine and on-line advice .

Greater system integration and efficiency, less duplication and fragmentation

Assumption: A more consistent service, with providers collaborating to offer a more standardised service across LLR will increase service integration and achieve efficiencies, with decreased and simplified hand-offs between service providers and removal of service duplications. Service offerings such as clinical advice, home visiting and face to face urgent care appointments will be provided in a more consistent way with few separate points of access. Overall service costs will be reduced by streamlining provision and contracts.

Greater consistency of advice through single points of access (SPoA)

Assumption: Through single points of access with shared protocols there will be greater control over advice given across the system. This will join up social care and health in a coordinated, timely manner, offering access to both health and urgent care seven days a week.

Improved quality and safety

Assumption: Establishment of a centralised clinical governance structure covering the system will improve quality and safety, whilst allowing easier access to the latest Summary Care Records (SCR).

Improved patient experience

Assumption: Delivery of a service that simplifies navigation of the system and reduces the number of patient transfers will improve patient experience.

Milestones

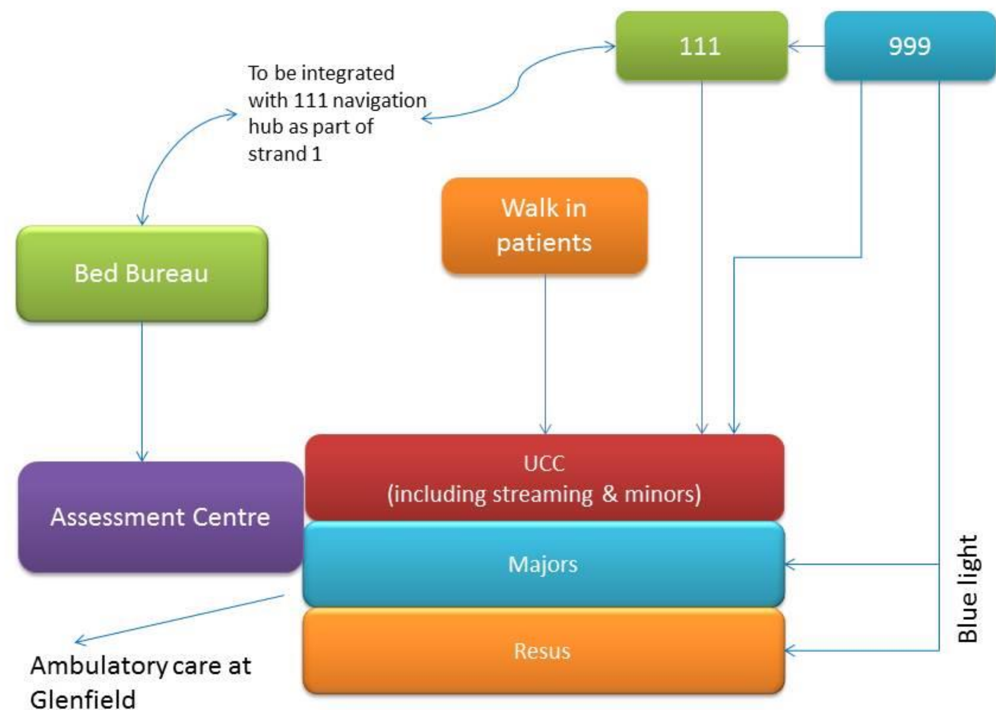
Milestones	Date
Vanguard Strand 1 Project Group Meeting, agree test options	January 2016
Clinical triage workshops to develop clinical model	March 2016
Agree test model and footprint and services being tested	April 2016
Agree provider arrangements for test models and commissioning arrangements	May 2016
Commence mobilisation of elements of telephony based clinical navigation service	July 2016
Commence full testing clinical navigation service	Q2 TBC
Introduce testing of integrated urgent care services	May 2016 - Sept 2016
Double running period	July 2016 – April 2017
Initial evaluation of tests	October 2016
Test findings of clinical triage and evaluation presented to stakeholders	December 2016
Full implementation of New Models of Care across LLR	From April 2017

The high level programme plan can be found in Appendix 10. In addition a logic model for Integrating LLR Points of Access can be found in Appendix 5.

Strand 2: Leicester Royal Infirmary Front Door

Through the redesign of the Leicester Royal Infirmary (LRI) front door a simplified service will be developed, providing a single service to assess, stream and treat all patients who attend LRI ED and who do not require majors or resus. The model described is similar to one that has been trialled in similar forms in other acute hospitals across the country which will see the streaming, OOH, primary care and UCC service integrated with minors into a single cohesive service. We will adapt and learn from their experiences. In parallel with the transformation work of the Vanguard, a physical redesign of the emergency floor at LRI is being undertaken. These capital works have key dependencies with Strand 2 and the two projects will work closely together to optimise patient flow.

The integration will make the LRI model consistent with the rest of the UEC system including the configuration of out of hospital services and the emergency pathways flowing from ED. The service will have a strong primary care ethos and will be integrated within UHL's ED, operating under a shared clinical governance structure. The complexity of conditions treated within the UCC is dependent upon access to a range of diagnostics including x-ray. Based on a review of HRG codes it is anticipated that 56% of patients attending the LRI campus will be treated within the new integrated UCC model.



High level LRI front door model

The initial step change (Phase 1) towards the delivery of this model has already been implemented: A new front door streaming service and change in UCC provider, working in partnership with UHL.

Phase 2 will seek to expand the operation of the streaming service to deliver a consistent service 24/7, enabling this to become the customary route for patients, testing out new pathways and approaches and blurring the lines between OOH, minors and the UCC ahead of their eventual merger. This phase will also include testing an 'extensivist' model of streaming at the Glenfield CDU front door to improve how patients are assessed and treated, aiming to reduce admissions and length of stay.

Phase 3 will see the delivery of the final model - streaming, OOH, primary care and UCC services integrated with minors into a single 24/7 cohesive service appropriate for all ages at the front of LRI. All patients (except blue light emergency patients) will be cared for within the service, treating 56% of all acute site attendees.

Impact & Outcomes

Work is being undertaken to clarify the service specification that will be required to enable a more detailed modelling of the impact that the service will have. Initial expectations are based on the HRG codes that will be treated within the new UCC service. The service will focus on assessing patients rapidly and effectively and providing the most appropriate level of clinical care, supported by access to primary care records and the ability to liaise with the patient's ongoing care team. Currently approximately 75% of attendees to the LRI campus self-refer. As such the model will include redirection and diversion of some patients to primary care or other services from the front door. Initial modelling is for a 6% expected reduction from diversion from the LRI campus to primary and community care destinations off site. It is noted however that impact of this will be limited, and patients attending with primary care needs will be accommodated within the UCC as one of the primary care access hubs for the city. It is therefore anticipated that through the work of this strand the number of attendees to the LRI campus will remain roughly in line with current footfall, with the diversion of patients helping to manage increased demand at a lower cost rather than resulting in a net decrease to current attendance levels. Further development of the model is required to integrate the pre-existing Assessment Centre (a service that accepts and assesses GP referrals) and Bed Bureau functions within the scope of Strands 1 and/or 2.

The delivery of savings will be supported by Strand 5 (Contracting for Transformation). Currently there is an exploration of payments being based on HRG code activity rather than treatment location. Development of dis-investment plans will be in line with the clarification of the model and service specification. The timescales for this are outlined within the project plan. The initial assumed impact levels are listed below. These are based on HRG codes and the experience of similar service models already in operation, for example the UCC at West Middlesex Hospital which typically sees and treats 60% of all attendees who would otherwise have presented at ED.

Reduced ED costs though channel shifting to UCC

Assumption: The staffing mix and clinical approach in the integrated UCC will be more cost effective than traditional ED, with rapid throughput of patients and reduced reliance on unnecessary investigations, supported by senior primary care expertise. Ability to access patients' records and care plans and liaise with community services should reduce numbers of unnecessary short stay admissions and reduce pressure on ED.

Greater integration and improved efficiency

Single point of access for steaming, UCC and minors.

Assumption: ED floor redevelopment will enable the UCC to be the only entrance to ED for all ambulatory patients. 'Blue light ambulance' patients will conveyed directly to the minors or resus area as appropriate.

Services working together under a shared governance umbrella to provide a seamless service, irrespective of the provider organisations which operate them.

Assumption: The provision of services on site will have a single clinical governance structure and a whole system approach to delivery and management of surge and demand.

Greater reliability (and sustainability)

Consistent, high quality integrated care delivering the best outcomes and experience for patient carers and families, during or out of normal office hours. There will not be any variation in delivery due to provider choice but only due to patient choice.

Assumption: Integrated service delivery under a single clinical governance structure and clinical pathways 24/7 will deliver consistent results.

Improved quality and safety

Services which are clearly focused on meeting the clinical needs of the patient and centred around care conditions, with processes to address systems learning and development, ingrained in a culture of continuous improvement. A bundle of metrics that address the dimensions of quality will be used as part of the national pilot to measure care delivered.

Improved patient experience

Rapid assessment and treatment from the right professional, with reduced waiting times and queuing in the ED and measured through Patient Related Experience Measures. The new service will remove the duplication and handovers that exist in the current LRI pathway, providing a seamless service to our patients with no visible boundaries, and a shorter overall stay in the service.

Better value

Reducing duplication of effort and cost to deliver better value for the taxpayer.

Assumption: Currently 36% of patients seen in the LRI UCC are transferred to the ED, where they generate additional costs in the system. Approximately 56% of patients currently treated at LRI have HRG codes VB09Z (one investigation with category 1-2 treatment) and VB11Z (no investigation with no significant treatment) and could be treated within UCC at a lower cost with the same quality outcomes. Minors, streaming, OOH and UCC functions currently contain a significant amount of duplication which will be removed through merging of services and functionality.

Milestones

Milestone	Date
Front door streaming service live	November 2015
Streaming service expanded hours	April 2016
New front door operational	August 2016

The high level programme plan can be found in Appendix 10.

Strand 3: Mental Health

The development and redesign of the UEC system will enable a set change towards parity of care between physical and Mental Health. Current provision for crisis response does not cover children and young people and the service for adults is only accessible to patients through GP referral, resulting in patients experiencing acute Mental Health symptoms attending the ED in crisis. The current Liaison Psychiatry service within the acute hospital is an adult only assessment service in the ED. This responds to patients within a reasonably timely manner but is unable to provide any intervention or treatment. This frequently means that the hospital is unable to adequately meet their needs, which is both distressing and provides sub-optimal care for patients and has a negative impact on the staff working in the department. Strand 3 contains the following areas of focus:

- All age liaison psychiatry
- 999- community triage
- CAMHS community crisis
- Improved access to crisis support via NHS11
- All age Place of Safety Assessment Unit

Though links with other strands we will scope IM&T interoperability between all partner organisations and develop a sophisticated and fully populated DOS. Work is ongoing to develop an integrated electronic patient record between Mental Health liaison, ED and UCC (currently 3 systems are in use). Clinician reported outcome measures are currently recorded under the Mental Health minimum dataset. Patient reported outcome and experience measures are not routinely collected at present: We will seek to rectify this.

All Age Liaison Psychiatry

Additional workforce recruitment and further refinements of the service offer within the acute hospitals will see Mental Health services providing the Core 24 service model. This will build upon the already well established Mental Health triage nurse service in the ED and the Frail Older People's Assessment and Liaison Service (FOPALS) by providing consultant psychiatrist input and enabling assessment, initial treatment and prescribing to take place. It will improve the current two hour response time to one hour in the ED. The clinical standard for seven day services within urgent and emergency care will be met whereby "*Where a Mental Health need is identified following an acute admission the patient must be assessed by a psychiatry liaison within the appropriate timescales 24 hours a day seven days a week: Within 1 hour for emergency care needs, within 14 hours for urgent care needs."* The Core 24 service will align with alcohol workers in the ED who have been commissioned by Public Health for those people with Mental Health and alcohol problems. The Core 24 model does not include post-discharge follow-up clinics for patients as with Rapid Assessment Interface Discharge (RAID), preferring instead to build links at primary and community care levels. This model is an 'all-age' model as opposed to the 16+ RAID model in Birmingham. Training of non-Mental Health ED staff will be an integral part of the liaison psychiatry team's role. It is recognised that these additional Mental Health posts have historically been difficult to recruit to and this has been taken into account within the 'ramp up' timescales for the work of the strand. Additional support will be sought from the Better Care Together workforce lead, to work with and enhance the design and approach of the recruitment campaign.
The London School of Economics (LSE) evaluation[1] of the Birmingham model aggregated the saving at £6.4m per year against a cost of service on £1.4m (this is where the often quoted "invest £1 and save £4" originates). This was for 2009/2010 and the basis for this was an Occupied Bed Day (OBD) cost of £200 per day. All of the cost savings

[1] http://www.bsmhft.nhs.uk/our-services/urgent-care/rapid-assessment-interface-and-discharge-raid/lse-report-on-raid (viewed 3rd February 2016).

which have been estimated in the RAID evaluation stem from reductions in acute in-patient bed-days, however this by no means exhausts all the possible impacts of the service. Quantifiable savings from the Birmingham RAID model come from 3 areas:

	Minimum Savings (£m)	Maximum Savings (£m)
Reduced Length of Stay	1.5	3.0
MAU admission avoidance	0.3	0.3
Reduced re-admissions	1.5	6.2
Total Savings	**3.4**	**9.5**

The LSE stated that "It seems reasonable to conclude that allowance for the omitted effects described above would on balance increase rather than decrease the estimated total savings associated with RAID." The overall conclusion was that "…the service generates significant cost savings and is excellent value for money."

Community Mental Health Triage

The community triage element will see the development of best practice with ambulance and police triage pilots and work with NHS11 to ensure that patients living with Mental Health problems receive parity of care. LLR has been noted as a national trail blazer with its original work on the development of the existing police and Mental Health workers triage work partnership. An example of the success of this has been the reduction in use of Section 136 of the Mental Health Act 1983. The police can use this power to take people to a place of safety when someone is in a public place, if they think the person may have a mental illness and is in need of care. Use of this power has reduced from 90 per month in 2012 to 9 per month in 2015. The community triage scheme will seek to build on this work, expanding best practice to include the ambulance service in a similar way. In addition, an algorithm will be developed to ensure that the correct service or support is identified within the NHS111 call centre. This could include the use of Mental Health staff or ambulance service if necessary. This complements the senior clinical triage offered within Strand 1: Integrated Community Urgent Care. From the review of a similar service within Lincolnshire the following outcomes were achieved. It is anticipated that the community Mental Health triage will achieve similar results of shifting patients away from ED.

Disposition	Pre-Service	Post service Implementation
ED	66%	12%
Crisis Pathway	2%	31%
Home	7%	11%
GP	6%	3%
S136	5%	3%

Crisis Support and Home Treatment for Children and Young People

This will see increased access to crisis support and home treatment for children and young people (the transition between children, young people and adult services is based on service users' needs). A new service will be developed, offering a crisis support service and home treatment. The service will work closely with social care and education. As part of alternative transformation within the Better Care Together Programme the designated Place of Safety Assessment Unit (PSAU) will be upgraded to meet national standards in order to accommodate people of all ages, ensuring that it is fit for purpose. This will be operational by April 2016, resulting in no further risk of children or young people being inappropriately held in police cells or ED. The transformational plan for Mental Health and wellbeing services for children and young people (November 2015) aims to establish a multi-agency team that will support families at risk of a crisis due to the Mental Health or disturbed behaviour of a child or young person. The standard is for the team to operate seven days a week from 8am until 11pm. The team will reduce the number of children and young people presenting at ED with acute Mental Health or behavioural problems.

Impact & Outcomes

The development of community triage will enable parity of esteem for Mental Health within urgent care. We will merge the best practice from an ambulance Mental Health triage pilot service in Lincolnshire and the police Mental Health triage service in LLR. This will be linked with the work from Strand 1 (Integrated Community Urgent Care), enabling us to develop a community triage service. This means that patients needing the Mental Health crisis team will have a police/ambulance response dispatched in a coordinated way to provide the best treatment options. Further financial modelling needs to be completed on this element to better understand the potential savings. Current data on Mental Health crisis support is sparse. This service development will result in faster resolution of crisis through intervention by trained staff, leading to reduction in time that emergency response units are required on the scene, a reduction in ED attendances and on a wider scale will also have a positive impact on police service resources.

The national guidance for services, based on the RAID model, is that for every £1 invested £4 is saved. A work stream will be established to understand how different the LLR approach is from the original RAID model to enable an estimate of potential savings. The national RAID model shows savings are made through the FOPALS element of liaison psychiatry. Within LLR there is already a substantial FOPALS element of liaison psychiatry in place. The financial modelling will also factor in its impact on the whole system solution and value that can be achieved. There is an expected impact on the number of Mental Health inpatient beds required. It is anticipated that the improved pathways and crisis support will result in either a reduction in bed numbers or reduction in out-of-area beds used. The modelling for the impact that will be had is yet to be completed.

Liaison Psychiatry

Increased responsiveness of the interface between physical and Mental Health operating seven days per week, achieving Mental Health assessments in ED within 1 hour and within 14 hours on wards.

Assumption: Funding to enable seven day provision is confirmed.

999- Community triage

Providing a collaborative approach to street triage, resulting in a reduction in ED conveyances and providing suitable signposting for patients in a Mental Health crisis. Data from Lincolnshire showed that 84% of all the activity that ambulances deal are signposted to the appropriate pathway for the patient, for example a referral to see a GP or a crisis nurse, without conveyance to ED. The following metrics (amongst others) will be monitored:

- Response times
- Reduction in ED attendances
- Reduction in admissions to acute beds
- Reduction in use of S136 suites

Assumption: Funding is secured and the Lincolnshire model is replicable in Leicestershire

CAMHS community crisis

Providing urgent Mental Health and social care assessments for children and young people with acute Mental Health and / or behavioural difficulties where there is a risk of serious harm to self or others.

Providing appropriate and short-term intensive therapeutic and social support for children, young people and their carers where there is risk of serious harm or admission to hospital or residential care due to the child or young person's Mental Health and / or behavioural difficulties.

Providing appropriate and short-term intensive therapeutic and social support for children, young people and their carers when the child or young person is discharged from hospital / leaves residential care and requires temporary enhanced support.

The following metrics (amongst others) will be monitored:

- Reduction in Mental Health hospital admissions
- Reduction in Mental Health length of stay
- Reduction in inappropriate ED attendance

Assumption: Once the model has been developed (April 2016) it is reliant on funding decisions.

NHS11- Improved access to crisis support

Three options are currently being explored:

1. Mental Health clinical expertise located within the NHS111 Call Centre
2. Link the NHS111 call centre to the Mental Health Crisis Team
3. Link police and ambulance triage together with NHS111

The final option is to be decided upon by the Better Care Together Partnership Board

The following metrics (amongst others) will be monitored:

- Reduced ED attendances
- Reduced Mental Health hospital admittance
- Increase in appropriate and safe care pathways

Assumptions: Pilot work can be replicated locally.

Milestones

Milestone	Date
NHS111/999 Algorithm developed	April 2016
NHS111/999 service commencement	August 2016
CAMHS model complete	April 2016
CAMHS system live	December 2016
Liaison Psychiatry service live(core 24)	Jan 2018

The high level programme plan can be found in Appendix 10.

Strand 4: Seven Day Services

UHL is a designated nation early implementer site for 7 day services. Strand 4 seeks to enable this change and encompass it within the whole system integration work of the Vanguard. It will achieve the following standards from the Keogh review by March 2017:

(2) Time to first consultant review: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.
(5) Diagnostics: Hospital inpatients must have scheduled seven day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: Within 1 hour for critical patients; Within 12 hours for urgent patients; Within 24 hours for non-urgent patients.
(6) Intervention/key services: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear protocols, such as: Critical care; Interventional radiology; Interventional endoscopy; Emergency surgery.
(8) On-going Review: All patients on the Acute Medical Unit (AMU), Surgical Assessment Unit (SAU), Clinical Decisions Unit (CDU), Gynaecology Assessment Unit (GAU), Trauma Assessment Unit (TAU) and Children's Assessment Unit (CAU) must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, and others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined, based on objective criteria, that this would not affect the patient's care pathway. All patients must have an Expected Date of Discharge (EDD) set within 14 hours of admission. There is an assumption this may not be met in some cases and variation will be monitored based on HRGs to learn from and refine the model.

Through dependencies on other Vanguard strands we will also achieve:

(7) Mental Health: Where a Mental Health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: Within 1 hour for emergency care needs; Within 14 hours for urgent care needs. This will be achieved through the work on Strand 3 (Mental Health).
(9) Transfer to community, primary and social care: Support services, both in the hospital and primary, community and Mental Health settings must be available seven days a week to ensure that the next steps in a patients care pathway, as determined by the daily consultant led review, can be taken.

The Vanguard will also include seven day services within social care linked to discharge within the scope of this strand. The creation of seven day services within the acute and primary care sector has the potential to create a bottleneck within social care services and limit the impact of the work unless the whole system takes the changes forward in unison. Scoping work and discussions are currently underway with the Local Authorities to understand the changes that can be made and the potential impact (this will also include looking at the availability of the independent sector to response to requests over 7days).

Impact

Reduced variation in admissions by day of week

Faster access to diagnostics and interventions, and timely reviews by consultants will result in reduced admissions.

Assumption: This is based on the assumption that there are a number of avoidable admissions due to access to diagnostics, interventions and consultant review. Further work is required to measure the level of impact that the reduced variation will have.

Reduced variation in

(a) Average length of stay (ALoS) by day of week
(b) Mortality by day of week
(c) Re-admittance by day of week

Seven day services will result in reduced variations due to a consistent service available seven days a week.

Assumption: It is assumed that seven day services will enable a standardisation in ALoS, mortality and re-admittance by day of week. Additional factors will also impact upon the success of these factors, for example the ability for primary and social care to have a similar services offer to the acute sector seven day service and therefore not result in system 'bottlenecks'. The success of other schemes in reducing attendances at ED could see a rise in ALoS and mortality rates as the beds contain sicker patients.

Timely diagnostics

A service offer seven days a week will enable timely diagnostics.

Reduced delays in clinical decision making

A standardised availability of clinical staff seven days a week will enable timely clinical decision making.

Reduction in decompensation, especially for the elderly

The reduced variation in ALoS of stay will result in an overall reduced acute stay for patients and therefore a reduction in decompensation and the risk of falls and hospital acquired infection.

Assumption: The reduced ALoS achieved will be of a length of time that can reduce these risks. It should be noted that the reduced ALoS may be impacted on by increased access to diagnostics and other Vanguard strands meaning that sicker patients are admitted, which could result in an increased ALoS (but fewer admissions).

Increase in Zero Day Length of Stay and Short Stay length of stay

Increased consultant reviews and reduced variation in access to diagnostics and interventions will result in an increase in Zero Day Length of Stay and Short Stay patients.

Reduced Average Length of Stay and bed occupancy

The reduced variation in length of stay will result in an overall reduced acute stay for patients. Current modelling estimates this to reduce the ALoS by 0.2 days. **Assumption:** Reduced ALoS may be impacted on by increased access to diagnostics and other Vanguard strands meaning that sicker patients are admitted, which could result in an increased ALoS (but fewer admissions). In order to capitalise on this and realise the savings associated with a 0.2 day reduction, discharge process in the hospital will need to be robust.

Metrics are being developed to measure the success and impact of the strand. The initial metrics and targets are outlined below. As the table shows, some areas do not have a fully worked up metric yet in place - work is ongoing to clarify this. In addition no statistic has yet been defined to measure the patient experience. Rather than use the Friends and Family Test, which is not valid for ED (as stated by NHS England), further work is being carried out to look at the development of specific Patient Centred Outcome Measures (PCOMs) to better reflect the impact on patients.

Metric	Description	Data source	Baseline 14/15	Target				
				15/16	16/17	17/18	19/20	20/21
Clinical Standard (02) 90% of patients seen within 14 hours of admission by suitable consultant on admission units in scope	6 monthly audits of patient notes	Patient notes	CCU 36.7%	20%	90%	90%	90%	90%
			CDU 21.7%	43%	90%	90%	90%	90%
			AMU 42.2%	80%	90%	90%	90%	90%
			SAU 29.3% (LRI)	63%	90%	90%	90%	90%
			GAU 54.1%	70%	90%	90%	90%	90%
			TAU 41.4%	61%	90%	90%	90%	90%
			CAU 35%	55%	90%	90%	90%	90%
Clinical Standard (05) Reduce variation in availability of key diagnostic services Includes x-ray, ultrasound, CT, MRI, echocardiography, endoscopy, bronchoscopy, and pathology: Within 1 hour for Critical Patients; Within 12 hours for urgent patients; Within 24 hours for non-urgent patients	TAT Measured against Standards (not currently measured in format of clinical standard)	CRIS - (Data taken from IT System) Reporting system needs to be set up to measure against the standards.	1 Hour	tbc	90%	90%	90%	90%
			12 hours	tbc	90%	90%	90%	90%
			24 hours	tbc	90%	90%	90%	90%

Clinical Standard (06) Key Interventions available 24 hours with timely access (as determined by speciality guidelines). Includes Critical Care, Interventional Radiology, Interventional endoscopy, Emergency General Surgery, Renal Replacement Therapy, Urgent Radiotherapy, Thrombolysis, PCI, Cardiac Pacing	For this standard we are gathering evidence against speciality standards. We already provide all the services listed and are available 24/7		100%	100%	100%	100%	100%	100%
Clinical Standard (08) - 90% patients on AMU SAU CDU GAU TAU CAU seen and reviewed by a consultant twice daily (patients transferred to general wards seen every 24 hrs, 7 days a week – unless it has been determined that this would not affect the patient's care pathway)	6 monthly audits of patient notes	Patient notes	Trust average 62%	TBC	80%	80%	80%	80%
Measure and monitor key outcomes across 7 days 1. Monitor variation in LOS across 7 days 2. Monitor Mortality across 7 days (deaths by day of admission) 3 Monitor readmission across 7 days (30 and 7 day) (currently we are looking at variation across specialities - this will be available at the beginning of Jan. At this point we will look at targets as applicable at	Monthly Dashboard (in development)	HISS (Patient Centre)	1. No measure	minimal variation	TBC	TBC	TBC	TBC
			2. No Measure	minimal variation	TBC	TBC	TBC	TBC
			3. No Measure 7 days	Variation 1.8% between highest and lowest number across 7 days	TBC	TBC	TBC	TBC

speciality level)	3. No Measure 30 days	Variation 2.6% between highest and lowest number across 7 days	TBC	TBC	TBC	TBC

Further work is required to develop a business case around the impact of seven day services and the required funding. It is anticipated that seven day services will lead to a saving at LRI through a reduced requirement of bed numbers and savings though variation in income related to readmitted patients. There is further work to be carried out to understand the level of savings that seven day services may achieve through release of bed days versus the costs of achieving the required staffing levels. Staffing costs required to deliver the above metrics are covered within the finance section and appendix 9.

The Vanguard is requesting funding towards the enabling costs of the strand's work. The funding for staffing will be requested from NHS as an early implementer site. It is noted that funding will need to be in place until the seven day services become part of tariff. Should the full level of funding not be available, the scope of the scheme will be revisited to look at the development of a pilot that will enable the establishment of an evidence base to inform a future seven day services business case.

Milestones

Milestone	Date
Options/ Business case submitted	April 2016
Implementation plans completed	July 2016
Monitoring against targets commenced	May 2016

The high level programme plan can be found in Appendix 10.

Strand 5: Contracting for Transformation

Contracting for Transformation focuses on the development and implementation of the new three part (plus incentives) payment mechanism to incentivise and enable the change required within the system. The contract will comprise:

- Fixed income
- Activity based payment
- Outcomes based payment
- Risk/Gain Sharing element of payment

Impact

The modelling of the direct impact that these contracts will have is not possible. The new contracts will be a tool that will enable the delivery of the financial savings foreseen through other work streams, both encouraging and enforcing change. The expected impact of the new contracts and payment models will be:

- Risk/ gain share associated with the Vanguard transformation
- Supporting integration of services across the Vanguard, both operationally and clinically
- Reducing hand-offs and encouraging innovation
- Supporting delivery of financial targets through incentivising best practice and transformation agenda
- Improved provider productivity
- Contractual relationships that explore relationships between providers, focusing the system on shared objectives
- Networked system of providers with aligned outcomes and performance measures that are patient and condition centred
- Explore Alliance type model of collaboration between commissioners and providers, for example, for frail older people with defined population level outcome measures
- Removes perverse incentives
- Shares risk and reward across system
- Aligns organisational incentives to system outcomes
- Develop integrated practice units for conditions that span multi-disciplinary provision and explore payment bundles

The new contracts and payment models will be developed hand-in-glove with the project strands to ensure that the best outcomes are achieved.

Milestones

Milestone	Date
Contract developed for integrated community care	April 2016
Contract live	April 2017
Contract developed for UHL	March 2016
Contract live	April 2016

The high level programme plan can be found in Appendix 10

Strand 6: Predictive Modelling

Strand 6 will deliver a UEC system heat map, which makes use of historical and real-time data to predict future demand. This will be matched with the development of pre-emptive escalation triggers. This means that we will have a way of managing predicted patient flow within the UEC system, deploying resources and altering pathways to best fit demand. This will enable a more efficient model of care delivery with reduced surge risks, through pre-empting system pressure and allowing real-time distribution of workforce and activity to better meet demand. At present no predictive modelling exists covering the LLR urgent and emergency care system and individual organisations (East Midlands Ambulance Service (EMAS)/UHL) have localised organisational historical data that is used in 'silos'. Routine joining-up and sharing of individual organisational historical activity data will be established, together with modelling of workforce.

Through a system wide shared clinical governance structure, clinical risk will be appropriately managed. A review of the capabilities of differing care settings will produce useable pathways and the real-time data will feed into a centralised IT system. These will enable whole-system triggers, not based on organisations but system needs. It will assist with addressing flow, through real time redistribution of risk and through gap analysis to build redundancies into systems to address future changes in flow.

From a patient perspective, the modelling tool will allow the NHS111, 999 and acute services to better deploy their resources and make best use of system pathways and services. This will reduce waiting times and ensure that the right care is delivered in the right place at the right time.

The system will see a reduction in ambulance - ED handover time, reduced ED wait times and better workforce rotas matching appropriate clinicians with predicted demand, therefore increasing flow. Improved flow will impact on patient safety parameters by addressing evidence based management (right person in the right place at the right time) against evidence based medicine (providing the right care). In itself the project will not reduce attendance, admission or call volume, but through better information it will reduce the system risks caused by demand surges. Developing a number of scenario responses in partnership with strands 1 to 4 will enable proactive management of the whole emergency care system. As more partners are connected to the predictive modelling system, greater system benefits will be realised due to more advanced movement and placement of activity across a wider and longer set of pathways.

In addition to this the Vanguard will be working with Pi (company name)[2] using their 'Data-driven Decision Automation Platform'. This software will enable us to process large amounts of data, recognise patterns, predict outcomes and generate insights. Although a substantial amount of data is currently collected across health and social services, this information is not always used effectively to provide commissioners with insights into the functioning of the care system. We will use the Pi tool to review patient journeys through the system, analysing the key touch points of each journey. The data used is based on NHS numbers. Unfortunately these are not collected uniformly in all services within health and social care at present so the data will not capture 100% of journeys, however the aggregated data will provide useful insights into the pathways patients take within the system. This ability to track a patient from the start of their journey through to the final package of care that is delivered will provide a far greater degree of insight into the developments of true pathway alternatives and future service model designs. When linked to the predictive modelling tool showing time driven activity and costings data, it will help decrease waste and improve the cost inefficiencies in the system.

[2] www.p-i.net/about-us

Impact

- Shift in operational resource deployment to mirror predicted demand changes
- Better system communication and resilience
- Consistent escalation capacity/ management across the LLR UEC system
- Effective patient flow and capacity management
- Informed workforce development planning and improved staff rotas based on system-wide demand patterns
- Shared ownership and understanding of demand, capacity and resource management to enable proactive planning and strategic intervention
- Forecasting plans for activity peaks
- Understanding the causes and impact of variation in demand on the UEC system
- Faster ambulance hand overs
- Reduced service waiting times in emergency care – hospital and prehospital; unblocking known obstacles to patient flow
- More efficient model of care delivery
- Clinical risk is appropriately spread across the system
- Reduced risk of non-delivery of strands 1 – 4 and potential future projects
- Patient pathways within the system mapped

Milestones

Milestones	Date
System design scoped	Apr-16
Triggers developed	Oct-16
System live	Dec-16

The high level programme plan can be found in Appendix 10.

Key Performance Indicators and Metrics

In order to measure the success of the Vanguard, we are developing a set of key metrics aligned to the logic models and strategic objectives of the programme. We have been working with the central vanguard team in relation to the development of system measures for UEC. We do not have a full set of system measures yet, but will review and adopt these once they become available and set targets as appropriate.

The key outcome metrics that we will be using to measure the success of the programme at a macro level are:

- Reduced A&E attendance
- Reduced hospitalisation rate across the population (stratified by age group)
- Reduced re-attendances and re-admission (including A&E and UCC)
- Reduced hand-offs and inter-provider referrals
- Improved patient experience

We are working with public health to define exact indicators for all and set the baseline and target improvements for these outcomes. Further work is required in the development of a complimentary set of patient experience metrics as described within the communications, patient involvement and insights section of this document.

Modelling – impact on activity and outcomes

We have worked with GEM and Arden CSU to create an activity model for the LLR UEC system. This includes assumptions about the impact of the vanguard interventions would have, applied over and above the do nothing scenario which includes demographic and non-demographic growth until 2021. (The evidence base for these assumptions is covered in more detail in the Bain hypothesis work, appendix 1). We have compared this to the cost of activity in the do nothing scenario to assess the savings available from channel shifting and demand management. The financial consequences are described in the Finance section of this document. The table below quantifies the impact that we will have on key activity metrics in each year. Some of these can be used as a proxy for outcomes while we complete the work outlined above.

	Vanguard Impact on activity				
Service	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**
Activity Changes (All Providers)					
NHS 111/ clinical triage & navigation	1.33%	8.61%	7.61%	7.56%	7.83%
Ambulance (excluding hear and treat)	-0.09%	-16.91%	-16.55%	-16.80%	-16.54%
Urgent Care Centres	1.81%	8.03%	11.79%	12.29%	12.79%
LRI Front door - UCC	3.20%	16.93%	37.21%	38.21%	39.09%
A&E Departments	-6.79%	-26.85%	-37.77%	-38.22%	-38.38%
Emergency Admissions	-1.03%	-1.79%	-0.83%	-1.49%	-2.10%

EM Admissions (Medical, Surgical, Women & Children - UHL Only)					
Average LOS	0.00%	-1.25%	-2.50%	-3.75%	-5.00%
Total Bed Days	0.00%	-1.25%	-2.50%	-3.75%	-5.00%
Daily Bed Days	0.00%	-1.25%	-2.50%	-3.75%	-5.00%

A more detailed summary of the data modelling is within appendix 6.

Within Strand 6 we will seek to take the metrics that are gathered and look at how these can be used proactively to predict demand and develop a system that can respond in a proactive way to surges in demand. We are also working closely with Pi to develop software that will collate the data we receive, enabling us to track patient journeys within the UEC system.

Finance

Our current financial modelling taking into account the activity modelling described above shows that there is a positive financial case for investment in the Vanguard Programme within LLR. We expect the Vanguard Programme to realise annual savings of £11m at the end of a 5 year period. This shows a good return on non -recurrent investment requested.

The financial investment required to develop and implement the 6 programme strands across Leicester, Leicestershire and Rutland have been costed using current information and assumptions. These costs are detailed within the attached appendix and summarised below.

The recurrent funding for the LLR system transformations is expected to come from a number of sources.

- CCG current new investment has been set aside to support delivery of Mental health services in relation to Liaison psychiatry and CAMHs crisis response and primary care hubs
- Services recurrently funded from CCG resources are to be re-invested in order to deliver more effective and efficient services to more patients for the same cost
- Funding for services that will no longer be required once the new system is in place, has been made available to recurrently fund the new system

To make the required system changes while ensuring patients receive a quality safe service, a level of non- recurrent funding to support double running, short term premium payments, IT enablers, project management and stakeholder communication is required.

The LLR urgent care programme is requesting £7.8m funding in 2016/17 from the New Models of Care Vanguard programme to support these elements of the transformations.

Capital funding has been requested via the CCG capital returns to support the SPA and Clinical Decision Making Hub, this totals £1.2m in each of 16/17 and 17/18.

Funding also requires identifying to support the clinical workforce expansion associated with 7 day working, a source for this has yet to be agreed.

Savings generated by the LLR Urgent care programme have been identified in terms of disinvested and re-invested funds being greater than those required to run the new service, and in terms of the change in contract costs due to the change in overall contract costs and activity resulting from the service transformation.

Both sets of finances contain assumptions regarding the speed of cost removal and workforce identification.

Overall new investment will equate to savings by partway through 18/19, however it is highly probable that some cost savings will involve the removal of fixed or semi variable costs and hence require more time to remove from the system. This will delay the payback period.

The redesigned system is not only expected to reduce the cash costs to commissioners of urgent care services it is also expected to assist with the delivery of system wide financial stability by reducing LOS as well as admissions and therefore contributing to the proposed consolidation of acute hospital sites across the area. There is a mechanism for continual review of these figures and assumptions through the Better Care Together Finance Directors forum.

Total requested from Vanguard	7,810,222	2,070,842	1,200,520	813,453	556,323
Required from othe National Sources - UNIDENTIFIED	2,695,434	3,597,761	2,888,761	2,180,761	2,180,761
system new investment	1,300,000	1,548,000	1,523,000	1,498,000	1,498,000
system re-investment	8,297,575	15,697,479	16,320,704	16,942,929	16,878,598
Capital Requested for SPA & Clinical Decision Hub- Strand 1	1,200,000	1,200,000			
Activity savings	-3,631,477	-6,538,404	-4,277,328	-5,923,850	-7,397,607
redesign savings	0	-236,604	-2,943,504	-3,556,052	-3,556,052
Total Savings	-3,631,477	-6,775,008	-7,220,832	-9,479,902	-10,953,658
Net position agsinst NEW investment (incl 7 day)	8,174,179	441,595	-1,608,551	-4,987,688	-6,718,574
Net position agsinst NEW investment (excluding 7 day)	5,478,745	-3,156,166	-4,497,312	-7,168,449	-8,899,335

Communications, Patient Involvement and Insights

What we are going to do

We will inform the development of the Vanguard Programme by undertaking in partnership, innovative and outstanding involvement activities with patients, carers and staff, using Experience Led Commissioning methodology to collect meaningful insights. Communications will also play a key role in providing clarity, reassurance and confidence among health and social care professionals and voluntary and community sector in the processes and new and enhanced services which support urgent care services. To support this we will implement a staff and stakeholder engagement programme working with organisations, beyond health and social care, which support patients and carers. We will communicate directly with patients, including those who need the service most and who are often not those whose opinions are heard. We will also communicate indirectly through partners to provide patients and carers with a better understanding of the urgent care services, focusing on prevention. We will also create a robust governance process around communications and engagement in LLR. Communications and engagement leads across partner organisations will work in new ways to help break down boundaries and coordinate activities collectively to support the health and wellbeing of patients and their carers.

We will collate and deploy comprehensive communications and engagement strategy and targeted plans to reach a wide external audience, monitored through the formalisation of an existing winter pressures Communications and Engagement Group. This bi-monthly group will be enhanced and established as a key part of the NMC governance process. Coordination will be undertaken by the existing Communications, Engagement and Involvement Manager for WLCCG, which is the lead for urgent care. Two days per week will be given to NMC. In addition two days per week will be deployed by the Patient Experience and Quality Support Officer. Further support will be provided by extending the provision of an interim communications manager position on a full time basis for a two year period. Strong alliances will be formed with key agencies including Healthwatch and Voluntary Action Leicester.

Impact

- Deep understanding of peoples' experiences of urgent care and what matters most to them
- Co-designed project strands, especially but not limited to strands 1-4
- Person-centred outcome measures integrated into new urgent and emergency care contracts
- Informed New Models of Care partners and staff, sharing best practice and learning across Leicester, Leicestershire and Rutland and beyond
- Informed and knowledgeable public able to self-care, and to access and navigate urgent and emergency care services appropriately
- Increased mobility for patients improving their outcomes for patients and better support their carers
- Health and social care staff and voluntary and community sector clear, informed of and assured of benefits of new ways of working and using and referring to the new and enhanced alternatives to ED
- Communications and engagement community across LLR, working across their organisational boundaries, delivering the actions of the communications and engagement strategy
- Planning approach for LLR offers good opportunity for replicability
- Will be used to test and refine new ways of working

National Replicability

The approach taken within the LLR Vanguard can be replicated. The integration approach that is central to the programme can be scaled and adapted to fit other systems. The programme has followed an approach and developed a model that could be franchised and cascaded throughout the NHS. The key elements that allow this are:

- The innovations are based on integrating services with similar functions, removal of duplication and a focus on efficiency
- Innovations are based on best practice, evidence and system expertise, both local and national
- Our modelling shows that there is a positive return on investment within three years, with recurrent savings thereafter
- The programme approach is modular/strand based, with dependencies monitored. This would enable other systems to pick which individual strands are most relevant, and knowing the potential impact and dependencies of implementation
- The programme team are keeping a 'lessons learned' log of the schemes and will be able to describe to other organisations delivering similar schemes pitfalls and areas of focus
- It represents local implementation of the Keogh review, with relevance for other areas
- It will be informed through local evaluation and further construction of the evidence base to inform other areas in assessing the replicability of the initiatives
- It will be assessed through a small number of outcome/metrics that could be adopted by other systems, along with the new urgent care system measures, to assess the impact
- Through the adoption of logic models, value hypothesis and value propositions, we have developed a transparent and replicable plan. This gives us confidence in the validity and reliability of our solutions and findings and allows us to share best practice nationally
- In addition, within the East Midlands we have a regular Vanguard Leads Meeting, hosted by the East Midlands Academic Health Science Network (EMAHSN). This forum allows us to share learning across the different Vanguards particularly around simple solutions to common problems, but also through the EMAHSN and their links with non-Vanguard sites and other Academic Health Science Networks

Summary and conclusion

The LLR Vanguard programme is broad and ambitious, delivering our strategy for an improved urgent care system which addresses the requirements of the Keogh review while reflecting the needs of patients across LLR and responding to the local situation. We have based our plans on engagement with local people and system leaders as well as national evidence for what works. We have a strong culture of local collaboration and innovation and will build on this in taking forward the Vanguard plans at pace. Whilst it is ambitious, our programme is achievable. We have already begun to make some of the changes we have described in this document, and will begin to put in place further test stages in 2016/2017.

Our modelling shows that the programme will deliver improvements to patient outcomes and deliver recurrent savings over its lifetime, providing value for money compared to the required investment in change, and will provide a better value urgent care system for LLR people.

Appendix 1:

Leicester, Leicestershire & Rutland: Value generation hypothesis tree

LLR proposal of building a network of urgent care infrastructure enabled by integrated services & outcome-based commissioning should receive investment as it will simplify & enhance care navigation across providers, thus ensuring patients can access the right care at the right place & time

Clinical outcomes will be improved through developing integrated, 24/7 urgent care services to better navigate patient care

Strands 1& 2 (New Models of Care and redesigned LRI front door; improving safety, health and social care across LLR) will result in:

- Earlier and appropriate interventions reducing ED attendances and admissions
- Reduced ambulance call outs

Strand 3 (999 community mental health triage, POSAU, liaison psychiatry, crisis support and home treatment for all ages) will reduce in:

- Increased use of non-acute crisis care
- Reduced ED attendances
- Reduced time to treatment

Strand 4 (For patients on UEC pathway, ensuring appropriate access to a senior clinical decision maker over 7 days and 24/7 access to urgent diagnostics and interventions) will result in

- Reduced average time to diagnostics and interventions
- Reduced variability in, admissions and mortality and ALoS by day of week

Patient experience will be improved through increased access to self-care and an integrated urgent care service, nearer home

Strands 1& 2 will result in:

- Improved patient satisfaction from increased clarity in UEC system navigation and timely safe and appropriate care pathways
- Increased self care

Strand 3 (999 community mental health triage, POSAU, liaison psychiatry, crisis support and home treatment for all ages) will result in:

- Increased use of non-acute crisis care
- Reduced ED attendances
- Reduced time to treatment

Strand 4 (For patients on UEC pathway, ensuring appropriate access to a senior clinical decision maker over 7 days and 24/7 access to urgent diagnostics and interventions) will result in

- Reduced average time to diagnostics and interventions
- Reduced variability in ALoS by day of week

Safety/quality will be safeguarded through shared patient records and care closer to home that prevents avoidable care failures

Strands 1& 2 will result in:

- Greater synergy between health and social care and consistency of advice
- Integrated clinical governance structures
- Reduced hand offs and inter-provider referrals

Strand 3 will result in:
Reduced time to treatment

Strand 4 will result in:
Reduced variability in mortality by day of week

Strand 5 will result in:
Support for whole system to achieve the transformation agenda

Strand 6 will result in:
Stratification of system risks from movement of capacity to meet demand

Resource requirement of £2.7M is reasonable and required workforce can be put in place

- **£7.4M of VG fundingin 2015/16 and £12.051M total funding through till 2020** is reasonable and accurately reflects financial needs of the site, supporting:
  - £4.5m – strand 1
  - £1.5m strand 2
  - £1.6m strand 3
  - £0.347m strand 4
  - £0.158m strand 5
  - £1.7m strand 6
  - £2.1m PMO
- Additional funding of £81.5M will be secured from system re-engineering and CCG investment
- Current clinical staff can be shifted and/or re-trained to support effective delivery of this model

Resource sustainability will be realised through integrating and expanding out-of-hospital urgent care, improving patient flow & A&E demand

- **Financial gross savings of £27.8M by 2020 to be developed from:**
  - ED to UCC activity shift
  - Reduced A&E attendance and admissions
  - Improved ambulance handovers
  - System integration
- **Non-financial sustainability** through:
  - Outcome based contracts incentivising providers to work together
  - Empowered patients better managing own care preventatively and reducing burden on healthcare facilities
  - Integrated systems, governance, workforce and ways of working, delivering improved decision making
  - Improved system resilience through better demand management and navigation of patient flow

DRAFT

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1 NHS

Bain – Clinical Outcomes

Clinical outcomes will be improved through developing integrated, 24/7 urgent care services to better navigate patient care					
Assertion	**Sub assertion - will result in**	**Evidence Available**	**Further evidence to be gathered**	**Metrics**	**Target**
Strands 1 & 2 New Models of Care and redesigned LRI front door; improving safety, health and social care across LLR	Appropriate and earlier interventions in a primary and community setting, enabled by easier access to specialist advice for front line clinicians - thus reducing ED attendances and admissions	(1) UHL HRG codes demonstrate 56% of top presenting conditions treated at ED could be treated in UCC (2) NHS Bolton's GP urgent care dashboard provides an analytical tool that tracks attendance patterns in real time from multiple sources including ED, walk in centres and out of hours services. The approach helps clinicians mobilise more appropriate care and support to ensure patients access the most appropriate urgent care services. In 2009 ED admissions fell 3% against a regional increase of 9%. Unscheduled hospital admissions fell 4% (Imison et al, 2011).	Test of new integrated model - in development. From October 2016 We will measure referrals from 999 for non urgent calls into the clinical triage hub throughout LLR and test some elements of 7 day services locally.	(1) Reduced ED attendances (2) Reduced ED admissions (3) Increased use of UCC	(1) Reduction in ED attendances of 8.24 by Q2 2017, 32.65% by Q2 2017, 45.9% by Q2 2018 (2) Reduction of ED admissions of 1.03% by Q2 2017, 1.79% by Q2 2018, 2.1% by 2020 (3) Increased use of UCC of 9.42% by Q4 2016, 38.02% by Q2 2018 and 53.15% by Q2 2019
Strands 1 & 2 New Models of Care and redesigned LRI front door; improving safety, health and social care across LLR	Reduced ambulance call outs	"system gearing" can result in small changes in primary care, which includes general practice, can give rise to a much greater effect on the activity in hospitals (secondary care). A 1% increase in Primary and Urgent Care Centres can result in a 20% in Secondary Care. Research has shown that urgent care centres that are able to see and treat patients within one consultation, rather than patients being seen by various people demonstrated improvement in the patient experience	Test of new integrated model - in development. From October 2016 We will measure referrals from 999 for non urgent calls into the clinical triage hub throughout LLR and test some elements of 7 day services locally.	Number of ambulance call outs	Reduction in number of ambulance call outs of 16.91% by Q2 2017
Strand 3 999 community mental health triage, POSAU, liaison psychiatry, crisis support and home treatment for all ages	Reduced ED attendances and admissions	Mental illness is estimated to be the primary cause of around 5% of ED admissions and alcohol misuse a further 10%. A substantial number of people who attend ED multiple times are already known to Mental Health services, suggesting that if they struggle to get support elsewhere, many people seek help through ED. Furthermore, many liaison psychiatry services in ED are insufficiently resourced and providing an inadequate response (Barret et al 201; Care Quality Commission 2015). Lincolnshire Community Mental Health triage system improvements referenced on p12 of VP.		(1) Reduced ED attendances (2) Reduced admissions to acute MH beds (3) Reduced number of hours spent by children or young people at ED (4) Reduced number of children and young people presenting at ED for acute Mental Health or behavioural problems	(1) Reduction in (All provider) ED attendances 38% by 2018/19 (2) No child or young person will stay at ED more than 4 hours 2018/19 NB targets 1 & 2 refer to the overall programme targets (not specifically to Mental Health)
Strand 3 999 community mental health triage, POSAU, liaison psychiatry, crisis support and home treatment for all ages	Increased use of non-acute crisis care	Mental illness is estimated to be the primary cause of around 5% of ED admissions and alcohol misuse a further 10%. A substantial number of people who attend ED multiple times are already known to Mental Health services, suggesting that if they struggle to get support elsewhere, many people seek help through ED. Furthermore, many liaison psychiatry services in ED are insufficiently resourced and providing an inadequate response (Barret et al 201; Care Quality Commission 2015). Lincolnshire Community Mental Health triage system improvements referenced on p12 of VP.		(1) Use of CAMHS crisis service (2) Use of ED as a Place of Safety by children or young people (3) Reduction in use of S136 suites	(1) No use of ED as a Place of Safety for children or young people from July 2016 (2) CAMHS For 15/16 and 16/17 target remain the same as the 14/15 baseline year (3) CAMHS for 17/18 10% reduction (4) CAMHS for 18/19 reduce further 15% reduction)
Strand 4 For patients on UEC pathway, ensuring appropriate access to a senior clinical decision maker over 7 days and 24/7 access to urgent diagnostics and interventions	Reduced time to diagnosis and interventions	Keogh review of acute 7 day services and UK policy directives	From May 2016 we will monitor time to consultant review in Assessment units (within 14 hours); Variation in diagnostic services; Ongoing consultant reviews.	Clinical standards 2,5,6,8; Baseline average (2) 37.2% (average across admission units in scope) (6) 100% (8) Trust average 62%	Achievement of clinical standards (2) 56% (average across admission units in scope) by Q2 2016, 90% by Q3 2017 (5) 90% by Q3 2017 (6) 100% already achieved and will be sustained throughout 2016-2021 (8) 80% by Q2 2017
Strand 4 For patients on UEC pathway, ensuring appropriate access to a senior clinical decision maker over 7 days and 24/7 access to urgent diagnostics and interventions	Reduced readmission rates	Keogh review of acute 7 day services and UK policy directives	From May 2016 we will monitor variations in outcomes across 7 days (LOS, readmissions, deaths by day of admission);	Reduction in readmissions	Variation 1.8% between highest and lowest number across 7 days from Q2 2016; Targets 2017-2021 TBC

Appendix 1.2: Bain – Patient Experience Outcomes

Patient experience will be improved through well informed patients and carers who are able to access appropriate and timely information, self care advice and treatment.

	Sub assertion - will result in	Evidence Available	Further evidence to be gathered	Metrics	Target
HUB - New Models of Care and redesigned LRI front door; improving safety, health and social care across LLR	Improved patient satisfaction of the care/advice/signposting received, as a result of clarity of how and where to access services and timely, safe and appropriate care pathways		Test of new integrated model - in development. From October 2016 We will measure referrals from 999 for non urgent calls into the clinical triage hub throughout LLR and test some elements of 7 day services locally.	number of hand offs between services, number of calls to NHS111; PCOMS	Reduced number of hand offs between targets - as per VP baseline currently being established; (2) 59% increased in calls to 111/ clinical traige hub over baseline by 2021 (3) Further targets and metrics to be developed as a result of the test of the new intergrated
HUB - New Models of Care and redesigned LRI front door; improving safety, health and social care across LLR	Reduced wait times "Ability to receive appropriate care when needed by time, distance or availability"		Test of new integrated model - in development. From October 2016 We will measure referrals from 999 for non urgent calls into the clinical triage hub throughout LLR and test some elements of 7 day services locally.	4 hour wait target	Consistent achievement of the 4 hour wait target by 2018
HUB - New Models of Care and redesigned LRI front door; improving safety, health and social care across LLR	Increased self care		Test of new integrated model - in development. From October 2016 We will measure referrals from 999 for non urgent calls into the clinical triage hub throughout LLR and test some elements of 7 day services locally.	Number of patients offered self care advice by NHS111	(1) Increased in amount of patients given self care advice by NHS111 5% by Q2 2017, 8%% by Q2 2017, 12% by Q2 2020
MENTAL 999 community mental health triage, Place of Safety Assessment Unit, all age liaison psychiatry, crisis support and home treatment for all ages	Reduction of wait times within ED by patients being treated in the right place	Mental illness is estimated to be the primary cause of around 5% of ED admissions and alcohol misuse a further 10%. A substantial number of people who attend ED multiple times are already known to Mental Health services, suggesting that if they struggle to get support elsewhere, many people seek help through ED. Furthermore, many liaison psychiatry services in ED are insufficiently resourced and providing an inadequate response (Barret et al 201; Care Quality Commission 2015). Lincolnshire Community Mental		4 hour wait target	Consistent achievement of the 4 hour wait target
MENTAL 999 community mental health triage, Place of Safety Assessment Unit, all age liaison psychiatry, crisis support and home treatment for all ages	Improved access to crisis response	Mental illness is estimated to be the primary cause of around 5% of ED admissions and alcohol misuse a further 10%. A substantial number of people who attend ED multiple times are already known to Mental Health services, suggesting that if they struggle to get support elsewhere, many people seek help through ED. Furthermore, many liaison psychiatry services in ED are insufficiently resourced and providing an inadequate response (Barret et al 201; Care Quality Commission 2015). Lincolnshire Community Mental		Reduced response time for crisis support AND Mental Health Community Survey Q22: "When you tried to contact them (crisis team), did you get the help you needed?	90% patients by 2018 say crisis team provided the help they needed
7DAYS - For patients on UEC pathway, ensuring appropriate access to a senior clinical decision maker over 7 days and 24/7 access to urgent diagnostics and interventions.	Reduced Average Length of Stay, due to increased access to diagnostics.	Keogh review of acute 7 day services and UK policy directives		Reduction in average length of stay (baseline 4.1 days)	Reduced average length of stay by 0.2 days by 2020

Appendix 1.3: Bain – Safety & Quality Outcomes

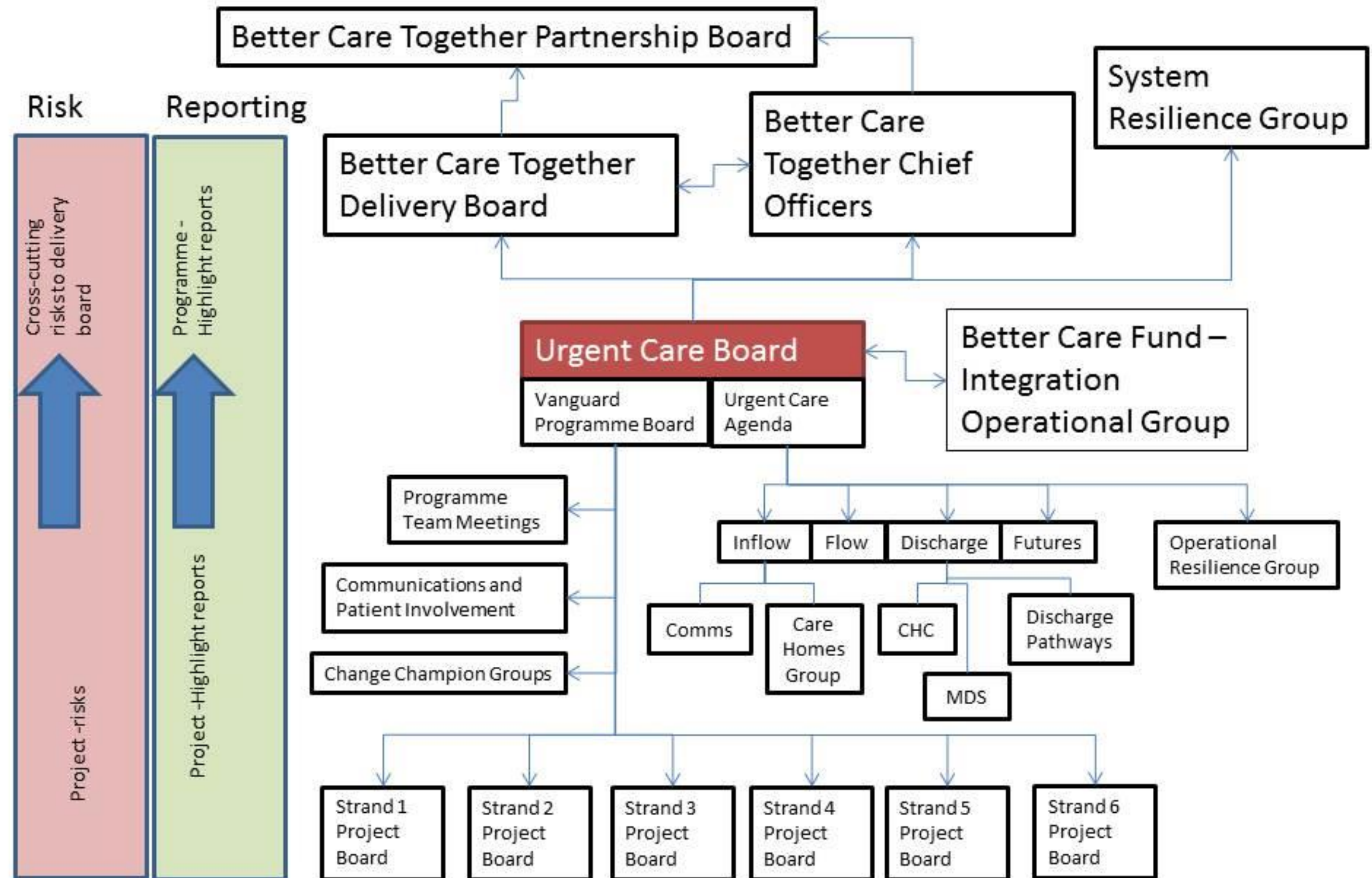
Safety/ quality will be assured through offering patients appropriate care earlier in their patient journeys, supported by an improved and joined up IT infrastructure

	Sub assertion	Evidence Available	Further evidence to be gathered (Where possible, indicate exactly what will be evaluated & how; including any baselining needed)	Safety/quality metrics	Quantitative target (set date, creates framework for evaluation & tracking)
HUB - New Models of Care and redesigned LRI front door; improving safety, health and social care across LLR	Greater synergy between health and social care and more appropriate and consistent care pathways; Tracking of full patient pathway/journey, resulting in reduced hand offs and inter provider referals		Pi tool being developed to capture details on patient pathways and handovers.	number of hand offs between services, number of calls to NHS111; PCOMS	Reduced number of hand offs between targets - as per VP baseline currently being established
HUB - New Models of Care and redesigned LRI front door; improving safety, health and social care across LLR	Integrated clinical governance structures	Ham and Smith (2010) AND Goodwin (2011) describe establishing effective clinical leadership and establishing new forms of organisation and governance as crucial for integrating UEC.		intergrated clinical governance structure in place and operational	intergrated clinical governance structure in place and operational by 2017
7DAYS - For patients on UEC pathway, ensuring appropriate access to a senior clinical decision maker over 7 days and 24/7 access to urgent diagnostics and interventions.	Reduced variation in readmission rates by day of the week	Keogh review of acute 7 day services and UK policy directives	From May 2016 we will monitor variations in outcomes across 7 days (LOS, readmissions, deaths by day of admission);	Number of admissions by day of the week	Variation 1.8% between highest and lowest number across 7 days from Q2 2016; Targets 2017-2021 TBC
PRED MODELLING - a UEC system heat map using historical and real time data to predict future demand	Stratification of system risk from movement of capacity to meet demand		Initial trial using UCC, EMAS and ED - will then be rolled out to wider scale DATES	Reduced frequency of UHL Internal Incidents and EMAS CMP level 4/5 incidents	10% reduction of UHL Internal Incidents and EMAS CMP level 4/5 incidents by 2017 and 25% by 2021.

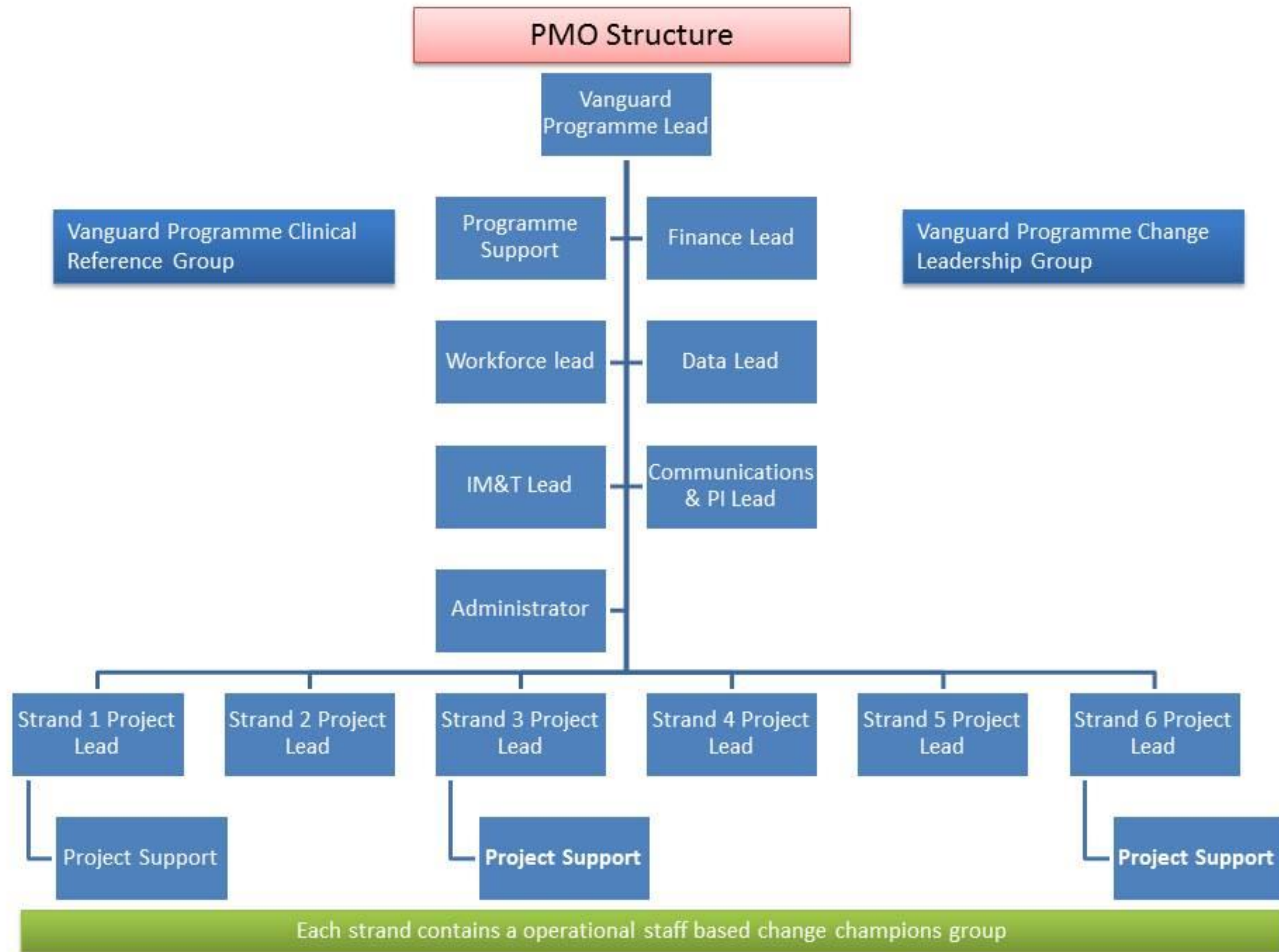
Appendix 2: Governance Structure

The Vanguard work is aligned both to that of the LLR System Resilience Group, the Better Care Fund and the Better Care Together Programme. The BCT programme will form the basis of the LLR Sustainability and Transformation Programme over the next five years, with the Vanguard driving the Urgent Care workstream of BCT.

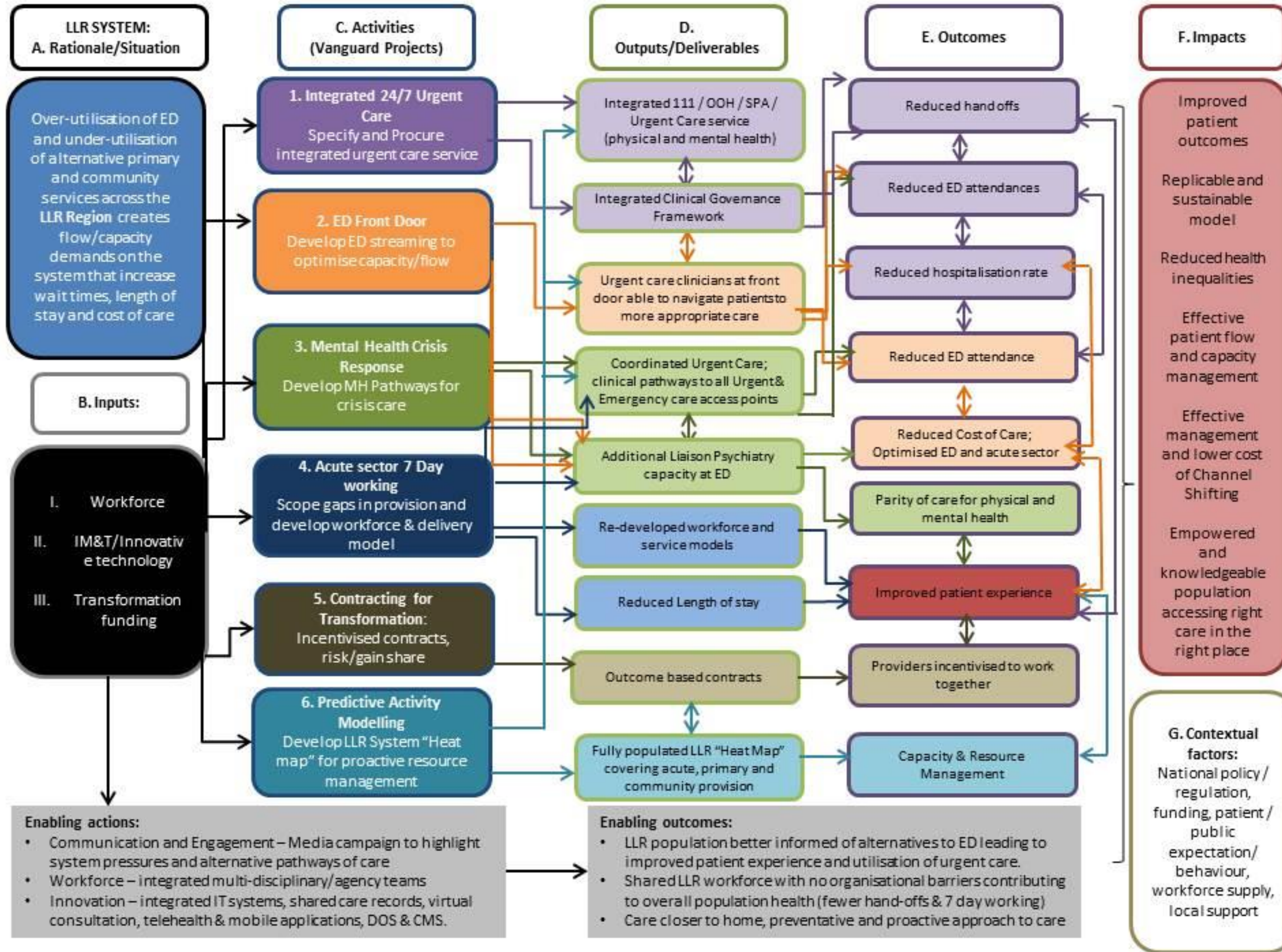
Our SRG and Urgent Care Network arrangements are well established, having been in place for more than 18 months. Toby Sanders, SRO for the Vanguard chairs the SRG as well as the East Midland UEC Network, so there is good continuity of leadership across the Urgent Care Network and the Vanguard.



Appendix 3: PMO Structure

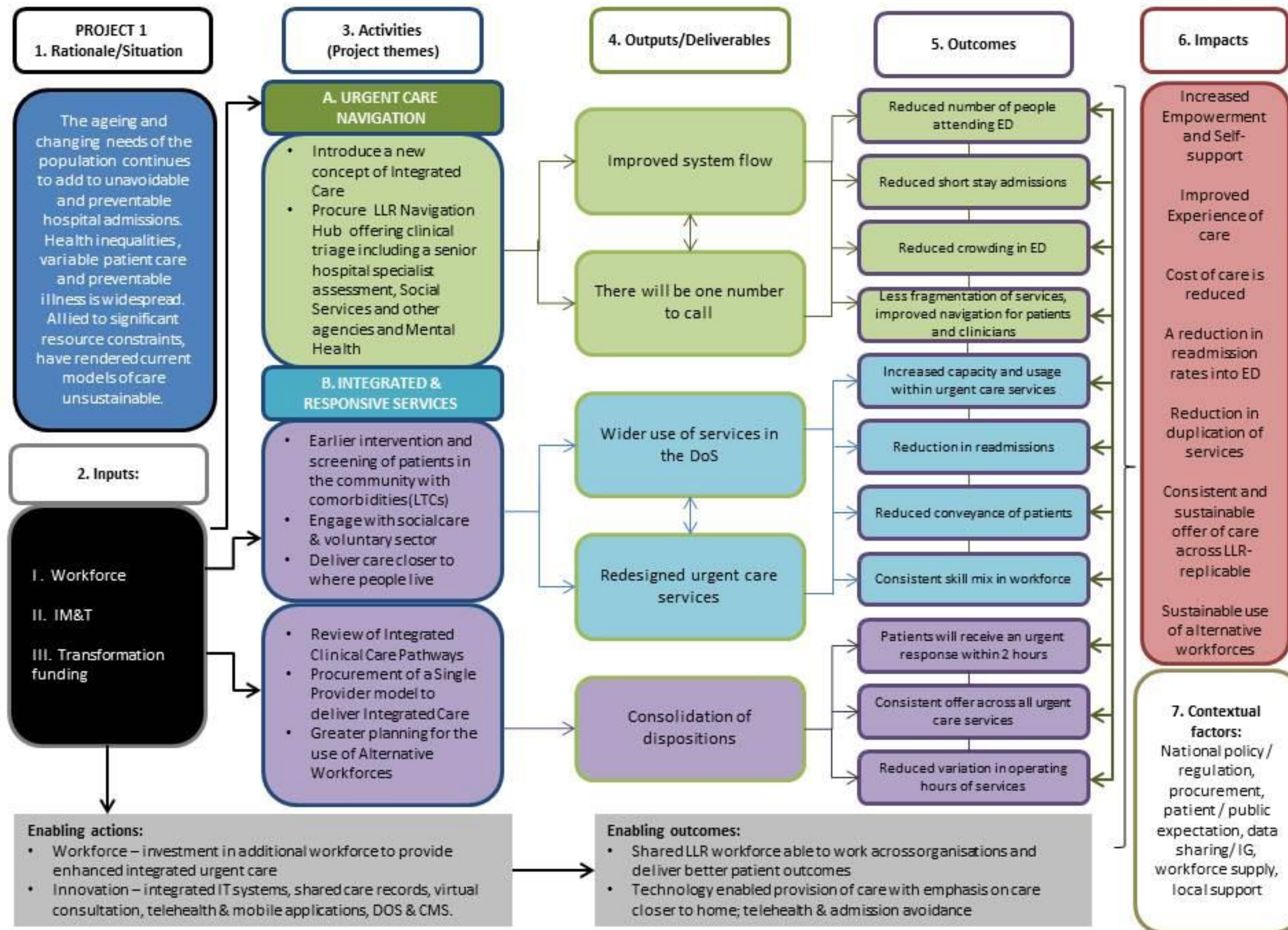


Appendix 4: Programme Logic Model

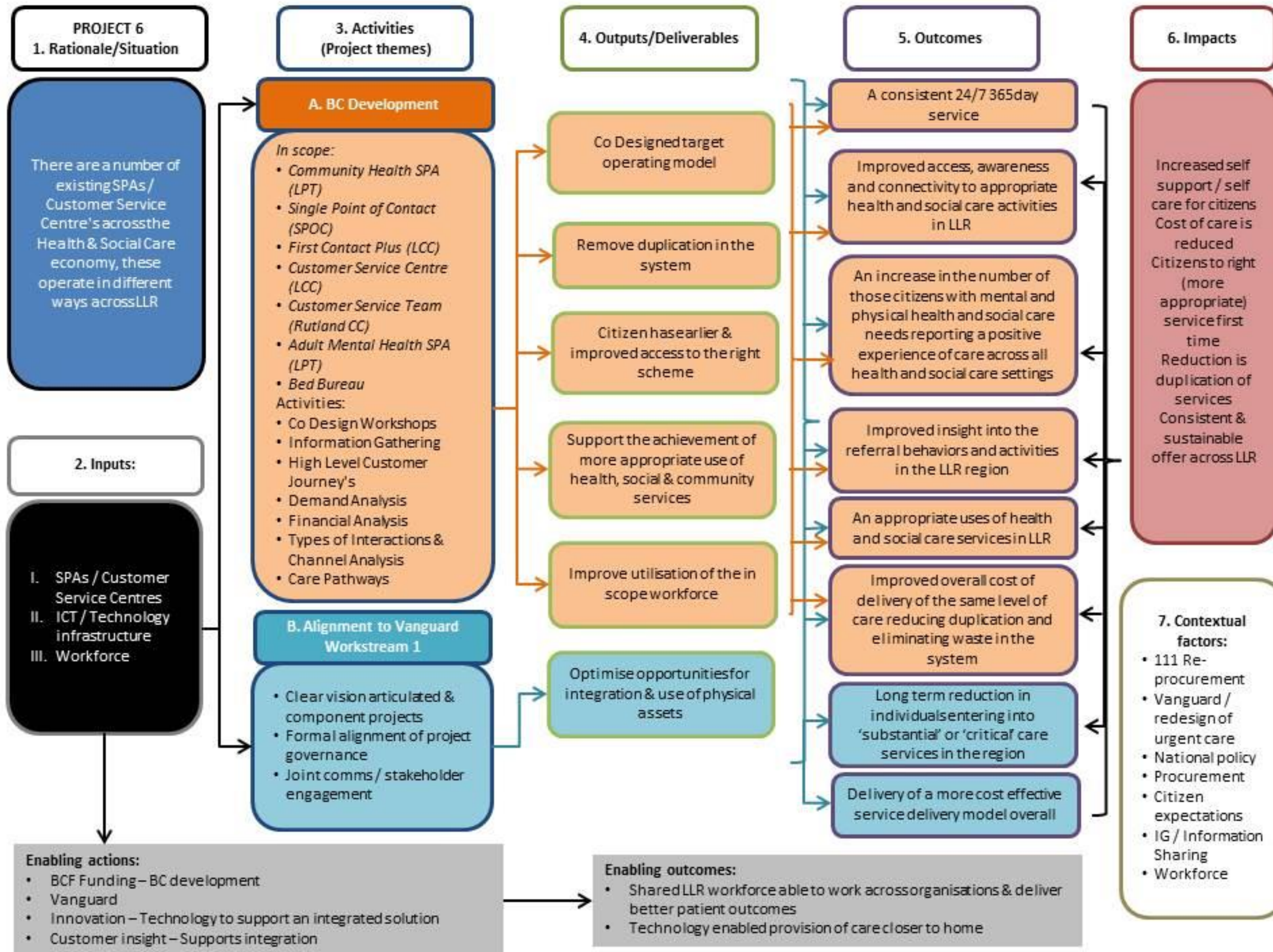


Appendix 5: Strand Logic Models

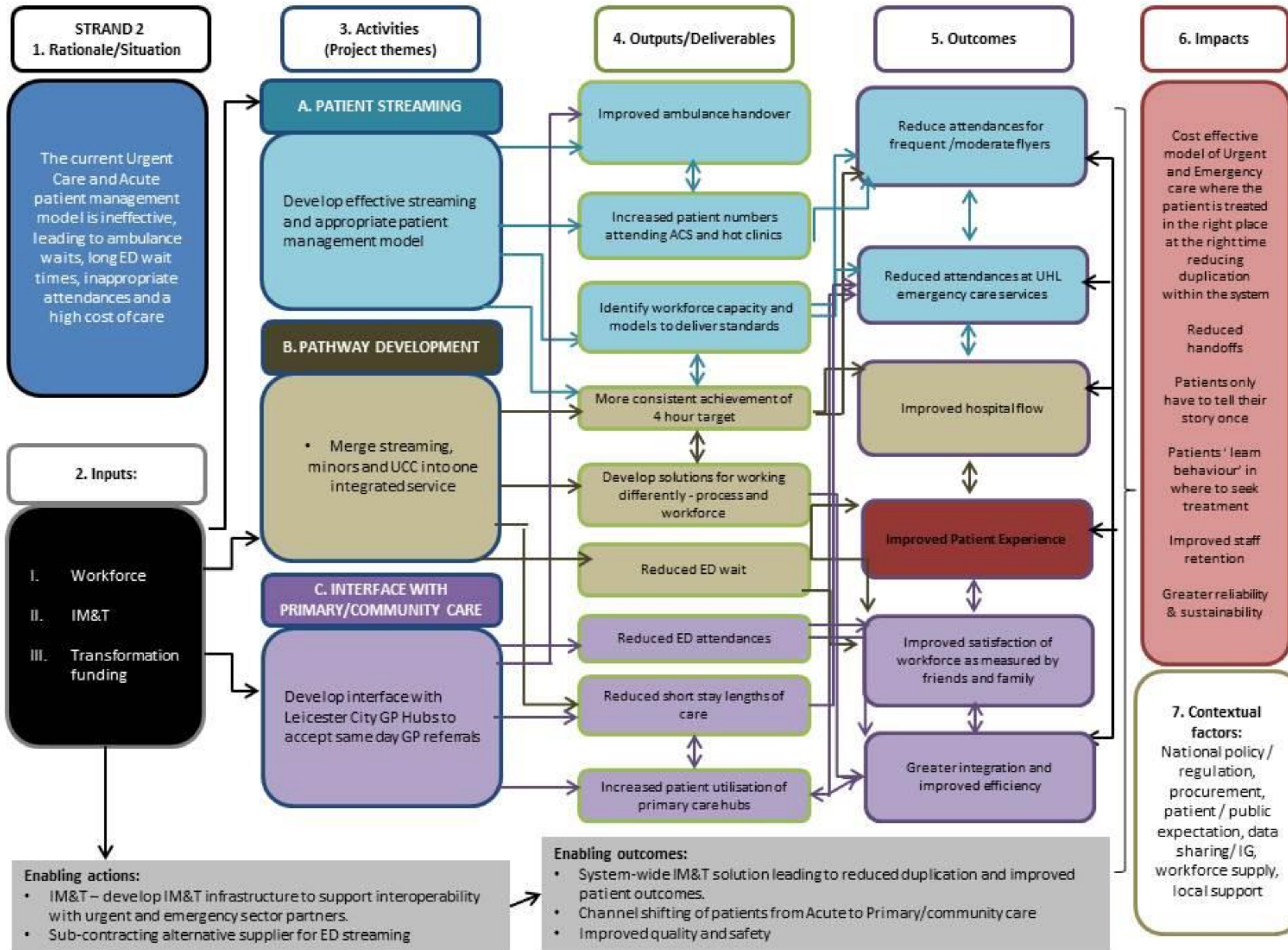
Strand 1: Integrated Community Urgent Care (1)



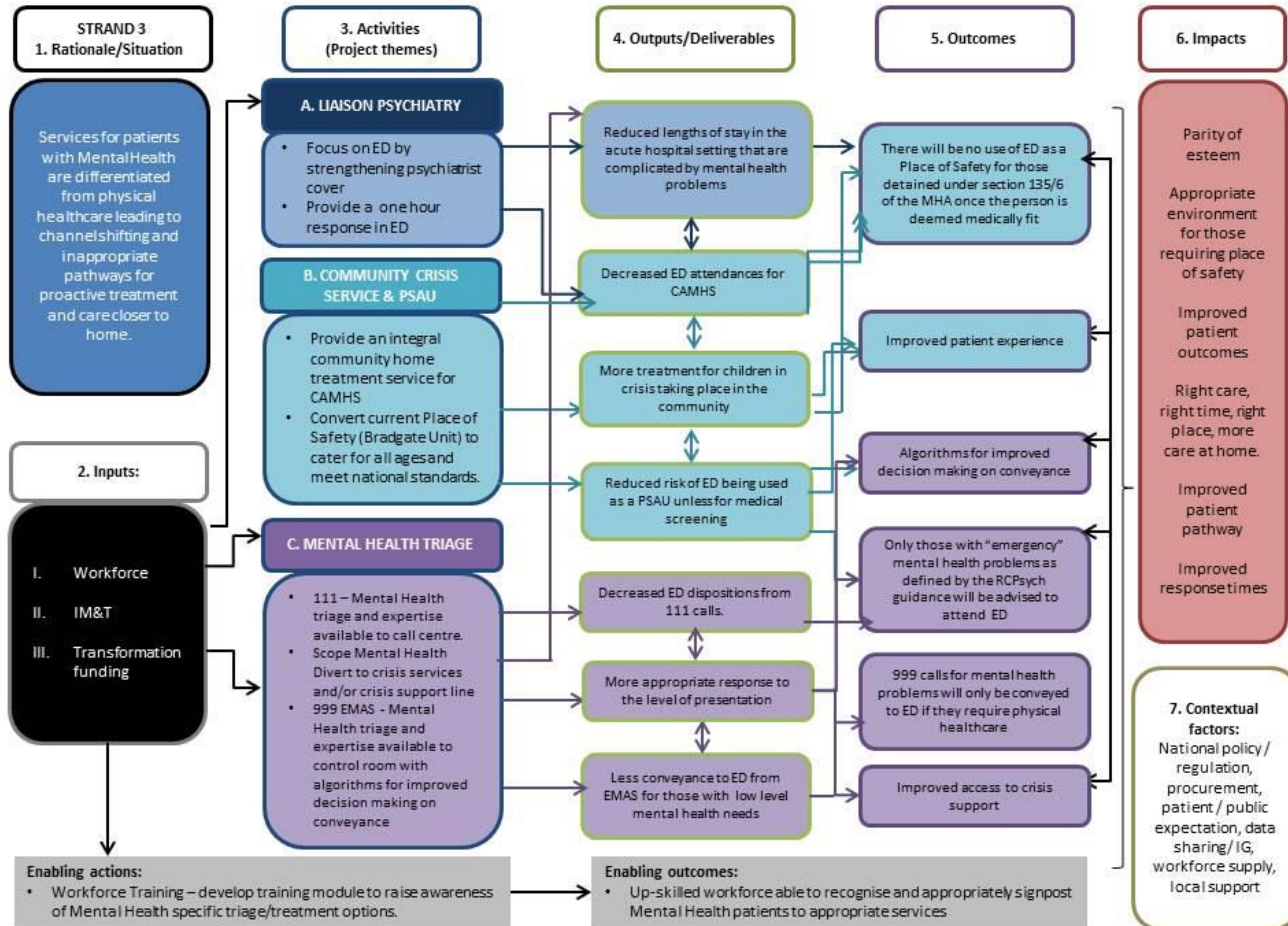
Strand 1: Integrated Community Urgent Care (2) - Integrating LLR Points of Access



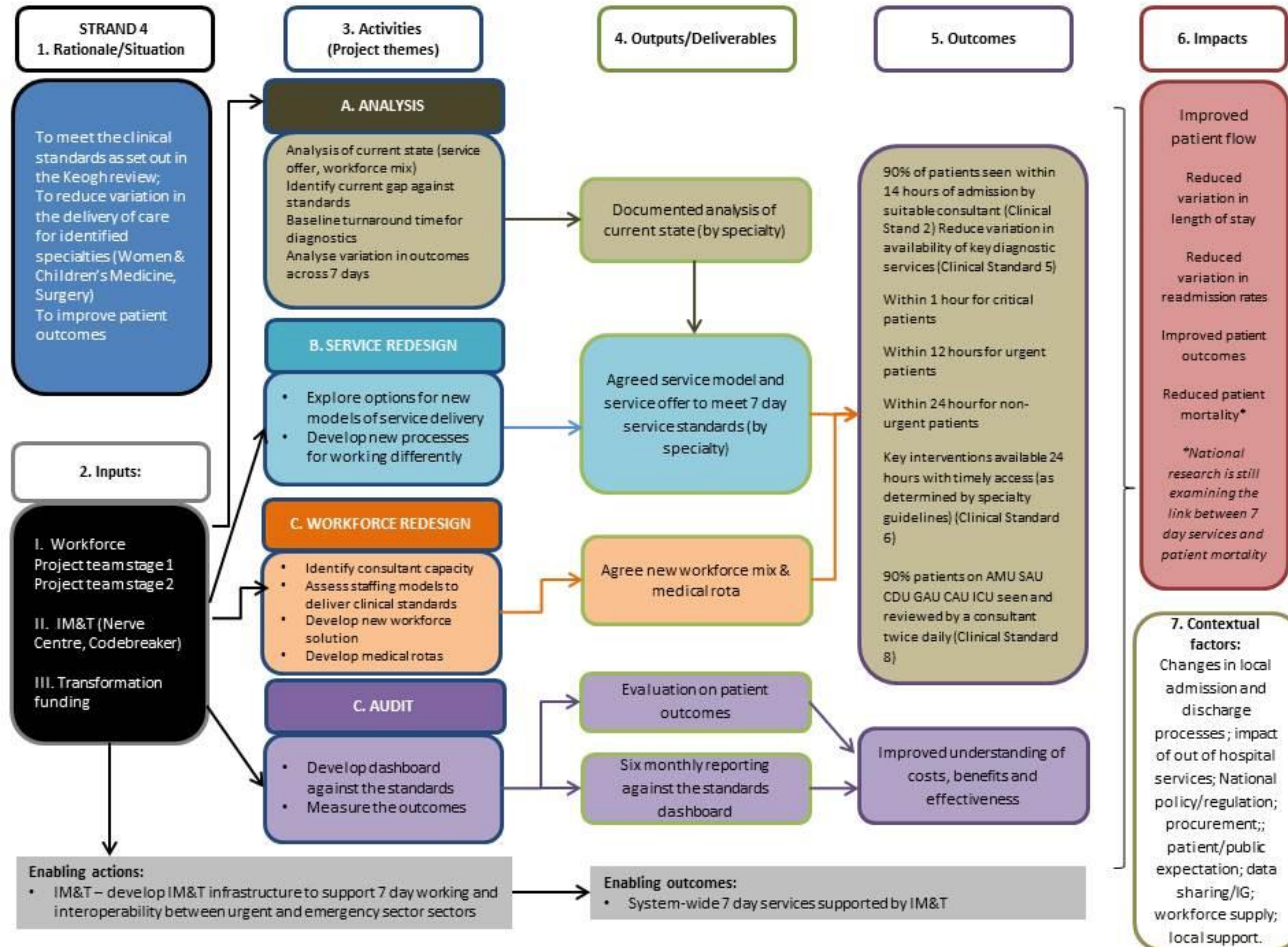
Strand 2: LRI Front Door



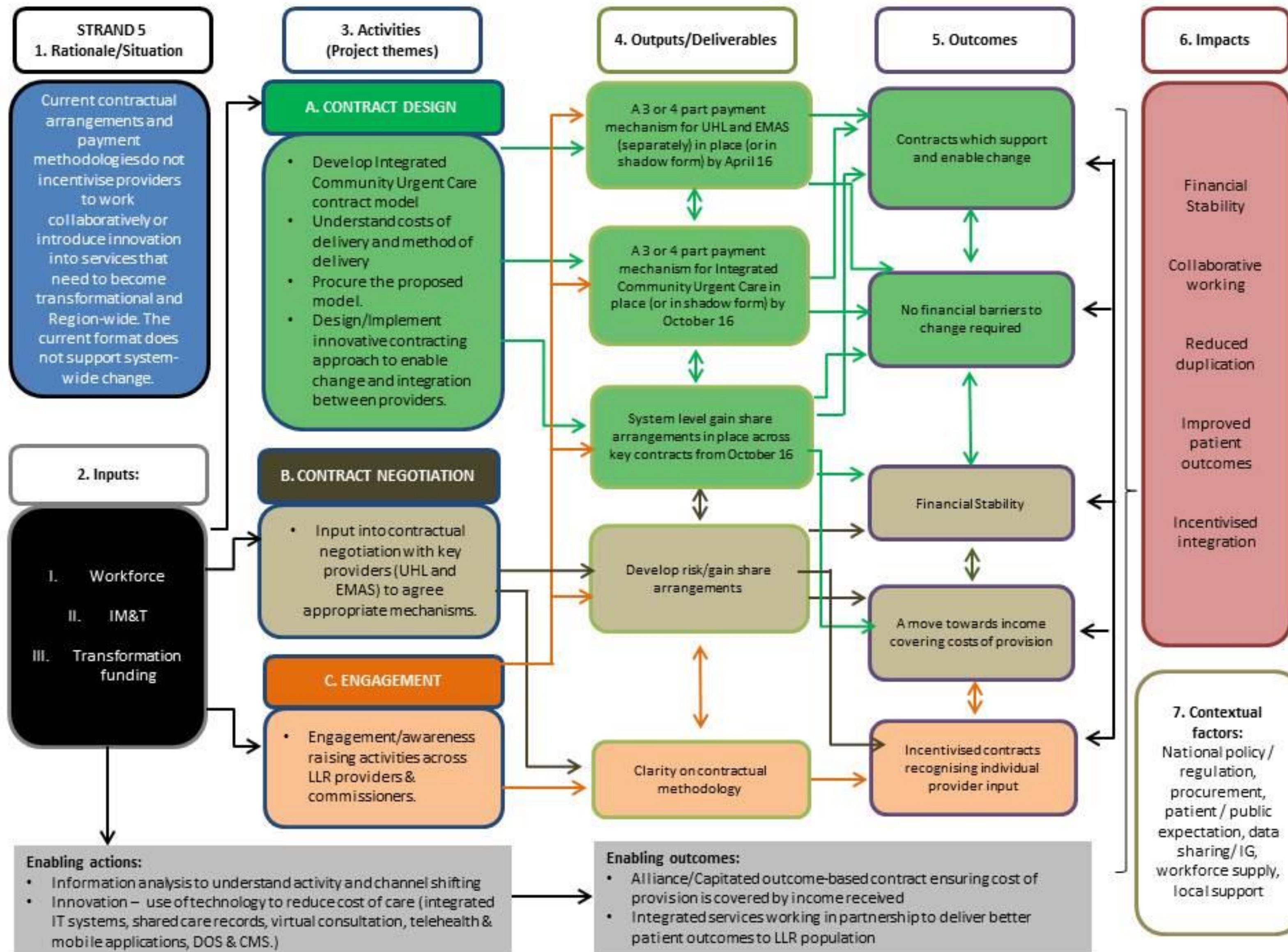
Strand 3: Mental Health



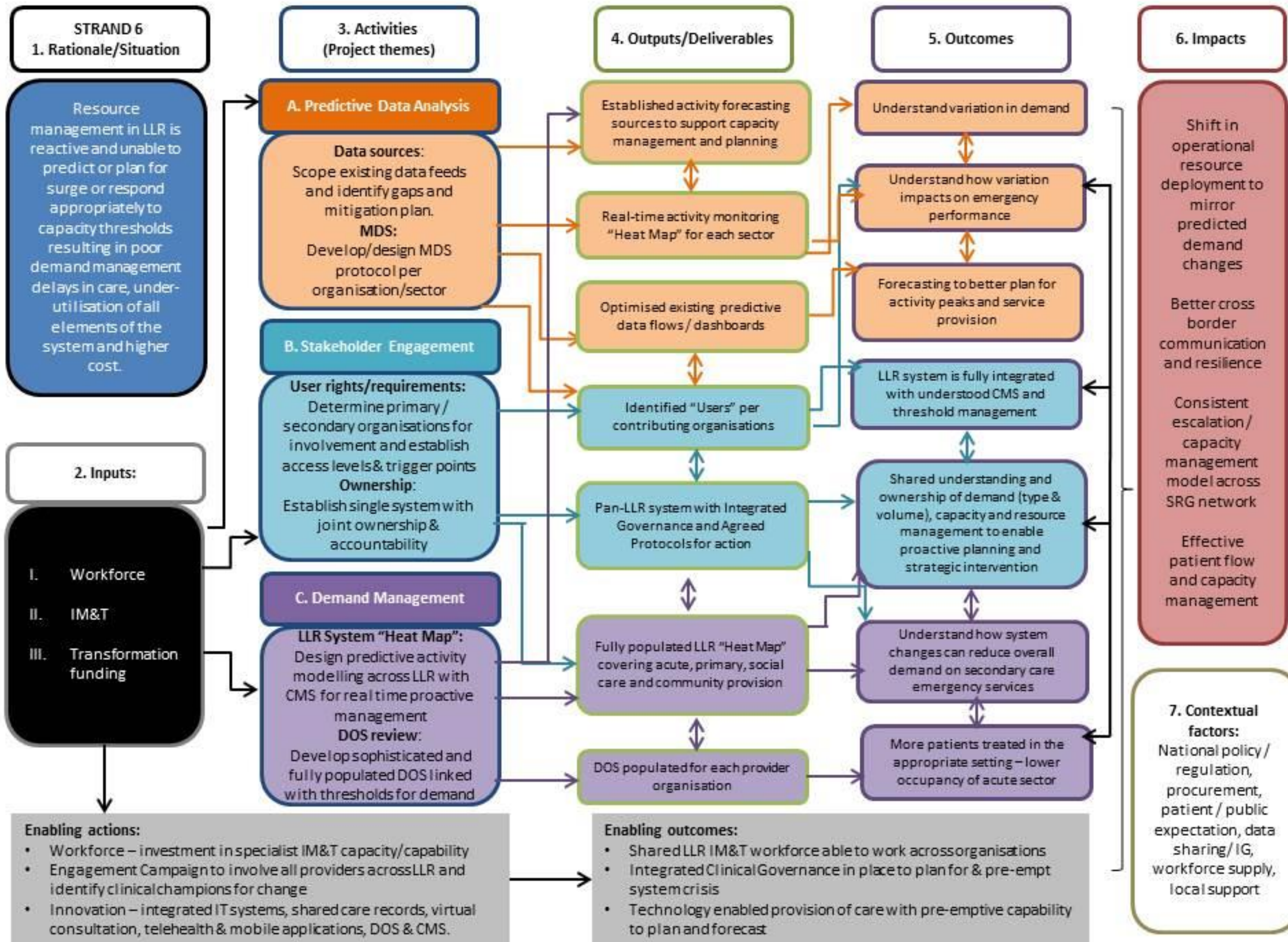
Strand 4: Seven Day Services



Strand 5: Contracting For Transformation



Strand 6: Predictive Modelling



Appendix 6: Activity Data and Modelling of Impact – summary

	Expected Growth					Vanguard Change %					Change in Activity*					New Model					Financial Reduction From Scheme*					Total Finance Change Inc Growth				
Service	Baseline Activity	Baseline Cost	Population Growth	Demand Growth	Total Growth	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21	16/17	17/18	18/19	19/20	20/21
Activity Changes (All Providers)																														
NHS 111	207,974	£2,217,000	0.64%	10.36%	11.00%	-1.33%	-8.61%	-7.61%	-7.56%	-7.83%	3,078	22,056	21,631	23,881	27,432	233,929	278,301	306,063	339,600	377,881	£32,807	£235,122	£230,590	£254,572	£292,429	£276,677	£749,688	£1,045,628	£1,403,134	£1,811,203
EMAS	125,045	£20,498,961	0.64%	2.20%	2.84%	0.09%	16.91%	16.55%	16.80%	16.54%	112	22,369	22,505	23,502	23,791	128,489	109,889	113,514	116,385	120,075	£38,622	£885,934	£921,013	£1,135,199	£1,221,915	£544,331	£296,549	£878,050	£1,297,979	£1,863,411
Urgent Care Centres	196,699	£11,408,542	0.64%	6.77%	7.41%	-1.81%	-8.03%	-11.79%	-12.29%	-12.79%	3,821	18,214	28,740	32,174	35,959	215,101	245,156	272,505	294,008	317,203	£221,640	£1,056,405	£1,666,920	£1,866,078	£2,085,603	£1,067,338	£2,810,491	£4,396,732	£5,643,944	£6,989,214
LRI UCC	98,560	£7,293,440	0.64%	6.77%	7.41%	3.20%	-16.93%	-37.21%	-38.21%	-39.09%	3,387	19,247	45,452	50,130	55,080	317,580	378,116	440,100	475,336	513,205	£29,005	£4,593,490	£8,364,184	£9,307,858	£10,332,712	£1,067,338	£2,810,491	£4,396,732	£5,643,944	£6,989,214
A&E Departments	209,509	£25,385,394	0.64%	5.16%	5.80%	6.79%	26.85%	37.77%	38.22%	38.38%	15,048	62,957	93,718	100,330	106,582	206,613	171,560	154,401	162,179	171,153	£1,690,920	£6,952,406	£10,213,175	£10,998,784	£11,753,817	£218,568	£3,922,304	£5,534,974	£4,576,895	£3,487,105
Emergency Admissions	94,545	£157,455,211	0.64%	5.08%	5.72%	1.03%	1.79%	0.83%	1.49%	2.10%	1,028	1,904	938	1,809	2,724	99,279	104,704	112,573	119,277	126,690	£1,905,737	£3,528,675	£1,737,915	£3,352,296	£5,047,016	£7,003,208	£15,088,587	£27,479,176	£37,460,002	£48,473,013
	932,332	**£224,258,548**									**12,677**	**27,713**	**21,338**	**19,457**	**14,626**	**1,200,990**	**1,287,726**	**1,399,155**	**1,506,786**	**1,626,207**	**£3,409,837**	**£5,481,999**	**£2,610,408**	**£4,057,772**	**£5,312,003**	**£9,740,324**	**£17,833,501**	**£32,661,345**	**£46,872,108**	**£62,638,950**
																				Cumulative	**£3,409,837**	**£8,891,836**	**£11,502,244**	**£15,560,016**	**£20,872,020**	**£9,740,324**	**£27,573,825**	**£60,235,170**	**£107,107,278**	**£169,746,228**
EM Admissions (Medical, Surgical, Women & Children - UHL Only)																														
Average LOS	4.1053	N/A	0.00%	0.00%		0.00%	1.25%	2.50%	3.75%	5.00%	0.0000	0.0513	0.1026	0.1539	0.2053	4.1053	4.0539	4.0026	3.9513	3.9000	£0	£0	£0	£0	£0					
Total Bed Days	322,411	N/A	0.64%	0.00%	0.64%	0.00%	1.25%	2.50%	3.75%	5.00%	0	4,082	8,216	12,403	16,643	324,474	322,469	320,425	318,341	316,218	£0	£0	£0	£0	£0					
Daily Bed Days	883	N/A	0.64%	0.00%	0.64%	0.00%	1.25%	2.50%	3.75%	5.00%	0	11	22	34	46	888	883	877	872	866	£0	£0	£0	£0	£0					

Notes

Negative/red Numbers represent an increase in activity

Costs are at tariff or local prices 15/16

hidden data sheets contain source data and coding

Changes in activity and cost expressed against 'do nothing' i.e. after growth to 20/21

Appendix 7: Keogh Route Map

Urgent & Emergency Care Route map	Deliverables	Local Activity
System Architecture	Establishing U&EC Networks	Active LLR wide SRG and UCB, linking to Regional Network, established since September 2015. LLR SRG chair is also the chair of the Regional network, creating good links between the LLR governance structure and regional network .
	Identifying and piloting system wide outcome metrics	We have identified key metrics for the programme and have been participating in the webinars on the development of Vanguard metrics. We have not yet received a full set of national system outcome metrics and baselines, but will adopt these when available. In the meantime, we are basing our work on local set of outcome measures. Within Strand 6 sought to take the metrics that are gathered and look at how these can be used proactively to predict demand and develop a system that can respond in a proactive way to surges in demand. In addition we are working closely with Pi (company) to develop a tool that will collate the data that we receive in order to be able to track patient journeys within the UEC.
	Develop a new payment system	We are participating in the national workshops and seek to be an early implementer of the new payment models in 2016/2017. Our approach to this will initially be in relation to 2 key contracts (EMAS and UHL) but in 2016/2017 we will seek to introduce new contracting and payment arrangements for the new integrated urgent care basket of service and clinical navigation.
	Enhanced summary care record	Part of Strand 1 to develop a local solution to accessing SCR across the urgent care system. Minor injury units across the county have shown the benefits of introducing SCR within the unit and having access to a patient's medical history when treating a patient and then subsequently prescribing medications this has shown to save time and in some cases of allergies ; lives. The UCC centres across

		LLR will have access to SCR for this very purpose. Patient consent would be easily visible and carried through 111 if that was the route of entry.[3]
Accessing the UEC system	Accessing the UEC System	Integration of urgent care services, 999, NHS111, OOH and UCC is part of the work of Strands 1 and 2, alongside the development of a clinical navigation hub and additional clinical and navigational support for front line clinical staff. Clinical Navigation will be piloted from October 2016.
UEC Centres	Direct booking from NHS111 to urgent care centres	Within the work of Strand 1 will be the ability to book appointments from NHS111/ clinical navigation hub.
	Local Directory of Services (DOS)	DOS development and benefits realisation is part of our Strand 1 work, including mobile DOS.
	Ensure UCCs provide a consistent service	As part of the work of Strand 1 and linked to the pre-emptive escalation work of Strand 6, will be the mapping and standardisation of UCC services, to reflect national and local specifications/standards. Some existing services may be reframed as primary care access hubs.
Paramedic at Home	More patients more appropriately dealt with at home by paramedics Ensure a clinically appropriate response by ambulance services to 999	Additional clinical support to front line clinical staff via Strand 1 will enable more patients to be managed within their home. See and Treat services will be enhanced and integrated with other home visiting services across LLR to increase the proportion of patients dealt with at home without ED attendance or admission. The Clinical Navigation/triage service will include and extended 999 CAS model, diverting appropriate patient calls to senior clinical assessment, with support from home visiting services if required.

	Analytical activity	Within Strand 6 sought to take the metrics that are gathered and look at how these can be used proactively to predict demand and develop a system that can respond in a proactive way to surges in demand. We will also be using the Pi tool to review patient journeys through the system analysing the key touch points of each journey.
	Hospitals providing seven day services across ten identified specialties	UHL is an early implementer of seven day services. Strand 4 will focus on the acute seven day services requirement and achieve the following standards from the Keogh review by March 2017: Standards 2,5,6,7,8 & 9.
Emergency Centres and Specialist Services	Discharge from hospital	Discharge is not explicitly within the scope of the LLR Vanguard Programme (other than the impact that e.g. 7 day services will have). Work on discharge and hospital flow is being undertaken through the Urgent Care Board, with action plans to improve flow, reduce LOS and streamline discharge pathways actively being implemented. We are commissioning new services including Help To Live at Home and Integrated Community Support service and these are linked to the Vanguard via the UCB and Better Care Together programme.
	Ensure patients are treated in the right networked facilities	The LLR new model of care aims to network integrated community urgent care services, this is fundamental to our vision and workplans. Networked services will be developed at a number of levels, including clinical navigation, local integrated urgent care services including UCCs/primary care and visiting services, community and social care services. Examples include developing integrated home visiting services including 999 See and Treat, OOH and Acute Visiting services, as well as developing an integrated Clinical Navigation, Bed Bureau and social care contact hub. Clinical governance, IT and workforce development will underpin this work.
Mental Health Crisis	An access and waiting time standard will be introduced for 24/7 crisis assessment	Strand 3 - hospital liaison psychiatry will see assessments within acute settings within 1 hour as well as opening up the crisis support to include children and young adults.
	An access/ waiting time standard will be introduced for liaison Mental Health services in ED	
	An assessment standard for those with Mental Health needs	
Supporting Self Care	Personalised care and support planning	Personalised care support and planning will be facilitated by “receiving” referral organisations and part of Strand 1. This will be unpinned by the use and access to and of IT across both health and social care, commencing at any entry point of the
	Support for self-management	
	Personalised Health Budgets	

		patient, including the LLR wide Single Points of Access (SPoA). Support for self-management is being taken forward across LLR with targeted support for LTC/comorbidity patients to self-monitor, with individualised care protocols, (early screening) web based interventions, and advanced care plans that will where appropriate take into account and work with a person's Personalised Health Budget where applicable. Personalised Health Budgets across LLR - Over 90% of people with long-term conditions say they are interested in becoming more active self-managers, and over three-quarters would feel more confident about self-management if they had help from a healthcare professional or peer. In this case the LLR S1 Model supports and allows facilitation of the "home visiting service and Crisis Team Models"[4]. PHB not only allow primary care practitioners greater scope to support the self-care of patients but also allow the patient to make where possible greater decisions and flexibility regarding the care they receive.
Independent Care Sector	Local Commissioning Practice	In addition to winter planning, Strand 6 will use metrics that are gathered and look at how these can be used proactively to predict demand and develop a system that can respond in a proactive way to surges in demand.
	Better use of care homes	Discharge is not explicitly within the scope of the LLR Vanguard Programme but work is being undertaken through the Urgent Care Board and the Better Care Programme/BCF. This includes the introduction of a new ICS model of home based admission avoidance and discharge support services, and a Help to Live at Home service is being introduced via the BCF in 2016. Strand 1 delivers an integrated home visiting service which will link to these, and other, domiciliary care services.
	Better use of domiciliary care	

Primary Care	Improved access to primary care	We will improve access to primary care through the work of Strand 1, building on the work undertaken in the Prime Minister's Challenge Fund. Each CCG is developing plans for 7 day access, ranging from primary care hubs working 7 days a week in the City, to evening and weekend access schemes in WLCCG. These services are already operational in 15/16 but will be extended and integrated with other community urgent care access points in 16/17.
	Increased role for pharmacy in urgent care	Minor ailments and emergency supply referrals will be covered within the work of Strand 1, with better advice about using pharmacy services being delivered via the Clinical Navigation hub. In addition, within the workforce planning we will seek to review/ increase the role of pharmacists within staff models.

1. http://systems.hscic.gov.uk/scr/library/miu.pdf
2. http://www.rcpsych.ac.uk/pdf/RCGP%20-%20PHBs%20Guidance.pdf

Appendix 8: Dependencies With Better Care Together

	Children's Service, Maternity and Neonatal	Learning Dis-abilities	Planned Care	Long Term Conditions	Mental Health	Community Hospital Recon-figuration	Frail Older People and Dementia	Urgent Care	End of Life
Strand 1: Integrated Urgent Community Care				Reducing ED attendance by targeting patients with LTC, using technology to create a unique protocol for each patient.	Clinical triage and local navigation hubs provide early, senior clinical input involving GPs, Mental Health and crisis practitioners and pharmacists.		Building on the Frail Older People's Assessment and Liaison Service, providing consultant psychiatrist input and enabling initial treatment & prescribing	Pathway development (receiving referrals and diverting patient flow)	Using technology to create a unique protocol for each patient, incorporating end of life wishes.
Strand 2: LRI Front Door				Reducing ED attendance by targeting patients with LTC, using technology to create a unique protocol for each patient.	Additional workforce recruitment and refinements, building on the existing ED Mental Health triage nurse service.			Pathway development (receiving referrals and diverting patient flow)	
Strand 3: Mental Health	Improved access to Mental Health crisis support, for children and young people. .				Improving access to care through:-(1) Increased clinical triage, crisis response and improved community support. (2) Providing consultant psychiatrist input and enabling initial treatment & prescribing. (3).An all age liaison psychiatry service.		Build on the Frail Older People's Assessment and Liaison Service, and integrate into the all age service.	Improved access to Mental Health crisis support via NHS11, for All ages. All age Place of Safety assessment unit.	
Strand 4: 7 Day Services	Improved access to Mental Health crisis support via NHS11, for children and young people, 7 days a week.			Hospital inpatients will have scheduled 7day access to diagnostic services. Consultant-directed diagnostic tests & completed reporting available 7 days a week.	Enabling achievement of clinical standards 7 & 9, providing patients with assessment by psychiatric liaison 24 hours a day seven days a week.		Increased consultant psychiatrist input, allowing initial treatment and prescribing to take place 7 days a week.	Improved access to assessment, diagnostics and treatment days a week.	
Strand 5: Contracting for Transformation	Contract Development of new contracts and to incentivise transformational change in existing contracts.			Contract Development of new contracts and to incentivise transformational change in existing contracts.	Contract Development of new contracts and to incentivise transformational change in existing contracts.		Contract Development of new contracts and to incentivise transformational change in existing contracts.	Contract Development of new contracts and to incentivise transformational change in existing contracts.	Contract Development of new contracts and to incentivise transformational change in existing contracts.
Strand 6: Predictive Modelling	Provide data on capacity, resources to manage flow Receives data on demand.			Provide data on capacity, resources to manage flow Receives data on demand.	Development of an algorithm to ensure correct dispatch of vehicles for ambulance services and Mental Health expertise available to NHS111 call centres.		Provide data on capacity, resources to manage flow Receives data on demand.	Provide data on capacity, resources to manage flow Receives data on demand.	

Appendix 9: Finance

Finance for VP 20160802.xlsx

Appendix 10: High level Programme Plan

Timeline: 2015 (n, d) | 2016 (j, f, m, a, m, j, j, a, s, o, n, d) | 2017 (j, f, m, a, m, j, j, a, s, o, n, d)

Strand	Sub-strand	Activity
strand 1		Scoping the Test Model
		development of clinical model
		footprint and commissioning of test
		Model Testing
		initial evaluation
		New Models of Care Rolled Out
strand 2	Phase 1	Front door streaming service
	Phase2	extensions of streaming service hours
		merge UCC and Minors pathways
	Phase3	Mobilise New Model of care
		New Model of care operational
strand 3	111/999	Model development
		111/999 Algorithm development
		staff recruitment
		service commencement
	CAMHS	Model development
		Recruitment
		Mobilisation
		system live
	Liaison psychiatry	Recruitment
		Mobilisation
		system live
Strand 4		Project set up and analysis
		Identify Gaps & Analyse variation across 7 days
		Develop Dashboards & audit
		Develop options & Business cases
		Develop & agree action & implementation plans
		Implement plans
		Monitor - evaluate - adjust
strand 5	Integrated Urgent Community	service design
		contract development
		procurement/ mobilisation
		contract live
	UHL Contract	contract development
		contract live
	EMAS Contr	contract development
		contract live
strand 6		analytics review
		interoperability and system design
		system & trigger development
		live

Liaison psychiatry (Recruitment, Mobilisation, system live): Phased implementation and ramp up over 2 years

strand 6 (live): embeding change

Appendix 10: Draft Communications Strategy

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Communications and