NHS
Leicester, Leicestershire and Rutland

Transformation at scale

Thought paper

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

A realistic & pragmatic 5 year plan

Years 1-2

- Management of ‘demand’ across health and care
- Recovery of quality / experience of care
- Backlog elimination
- Financial stability
- Workforce recruitment & retention
- Supported by all system strategies inc. clinical strategy, estates, workforce, digital etc

Year 2-5

- Co-management of holistic, person-centred ‘need’
- Increase quality and experience across life course
- Manage seasonal demand effectively
- Grow specialist elective offer
- Financial stability
- Integrated models of workforce across health and care
- All system strategies embedded within plans

Building an all-age ‘system of care’

Issue:

- Every external review this system has had speaks about good partnerships but fragmented care
- One of our key aims has been to have the right patient in the right place at the right time. Every day some of our patients find themselves in the wrong place at the wrong time, at no fault of their own
- This means disproportionate pressure across the system, with capacity in some areas and complete over-burden in other areas

Not including mental health/LD/children’s/maternity

Integrated Health & Social Care teams in each locality

Issue:
- Fragmented pathways of care, poor access

Requirement:
- A single health and care centre in each ‘locality’ to support integrated care

Deliverable:
- Vertical integration of services across primary care, elective and acute pathways, including same day access to care & diagnostics
- Supports delivery of local community health and wellbeing plans
- Ability to ensure care is delivered in a ‘locality’, linked to integrated pathways across health, care & vol sector
- Better use of public sector estate, opportunity for integrated recruitment, better use of resources

Integrated Health & Social Care teams in each locality

Our approach

Developing effective, resilient, neighbourhood-based same-day access to urgent care that can serve as an easily-accessible first point of contact for patients with routine issues.

- Excellent triage
- Appropriate clinicians
- Patient experience and satisfaction
- Quality of care
- Overcoming local barriers
- Staffing

Leading to…

Enhanced Access Hubs – same day urgent appointments that can be accessed digitally and include multidisciplinary teams that work until 8pm weekly and across the weekends;

Urgent Community Response - for our more complex and frail patients we will provide an MDT rapid response approach to help patients avoid the need to be transported away from their home and into an acute hospital;

Community Diagnostic Hubs – working across Place we have developed models of diagnostics that are placed within local communities, including outreach models such as working with the homeless communities who can now access mobile Hep C screening and liver testing as well as Covid Vaccination from an outreach Community Team;

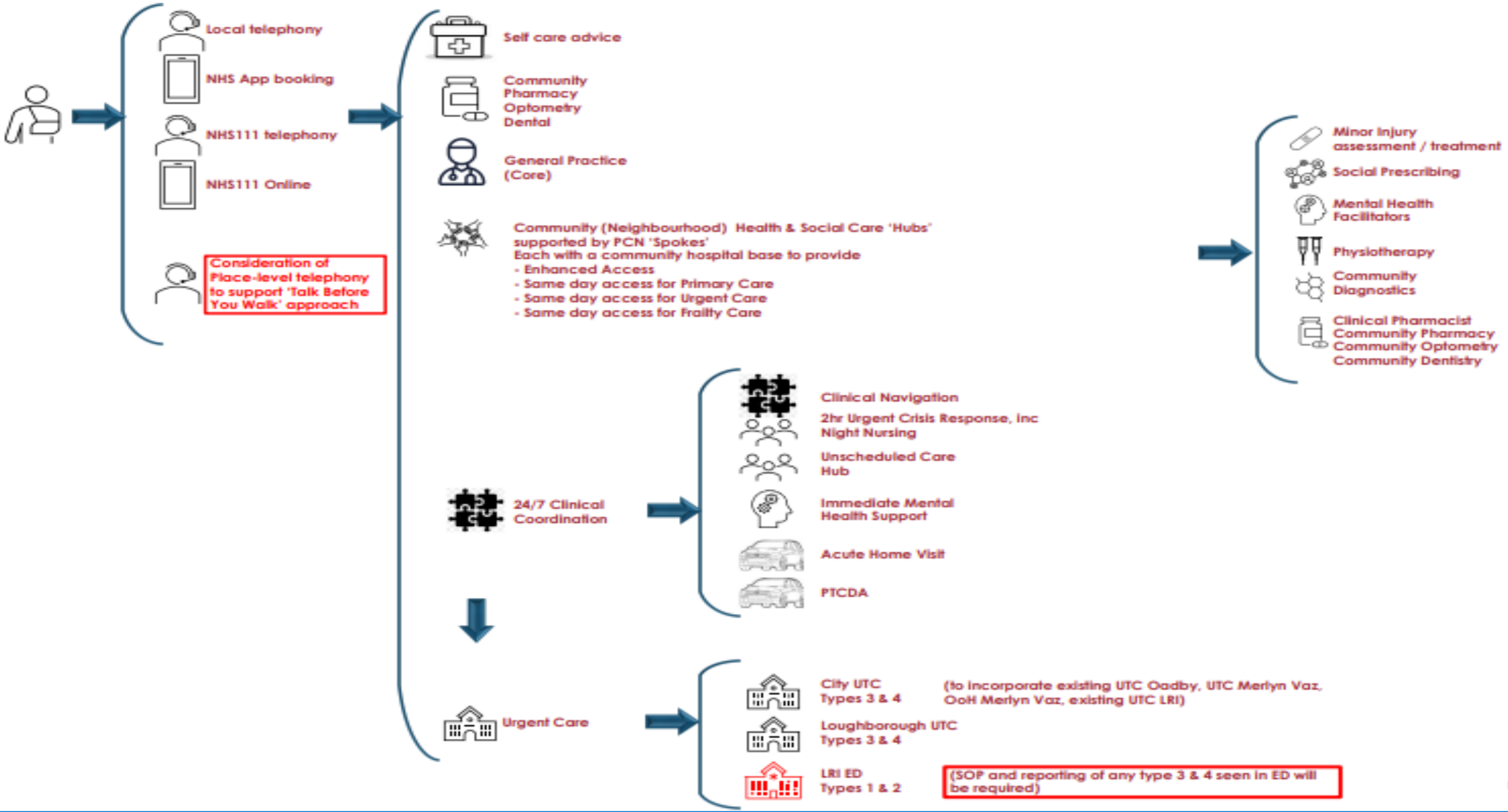
Care Homes – we have implemented an MDT approach to the management of care for these residents, particularly those who are more complex requiring extra support to avoid hospital admission;

Frailty Models of Care - we have developed key ambitions for frailty services that work with our local communities and carers to deliver urgent care in frailty that allow people to stay at home for longer safely.

Anticipatory Care Models – using our new digital risk stratification we can better target those most at risk of admission and attendance into the Urgent Care system

Future Direction For Integrated Urgent and Primary Care in LLR – Architecture

Draft v0.7 for discussion



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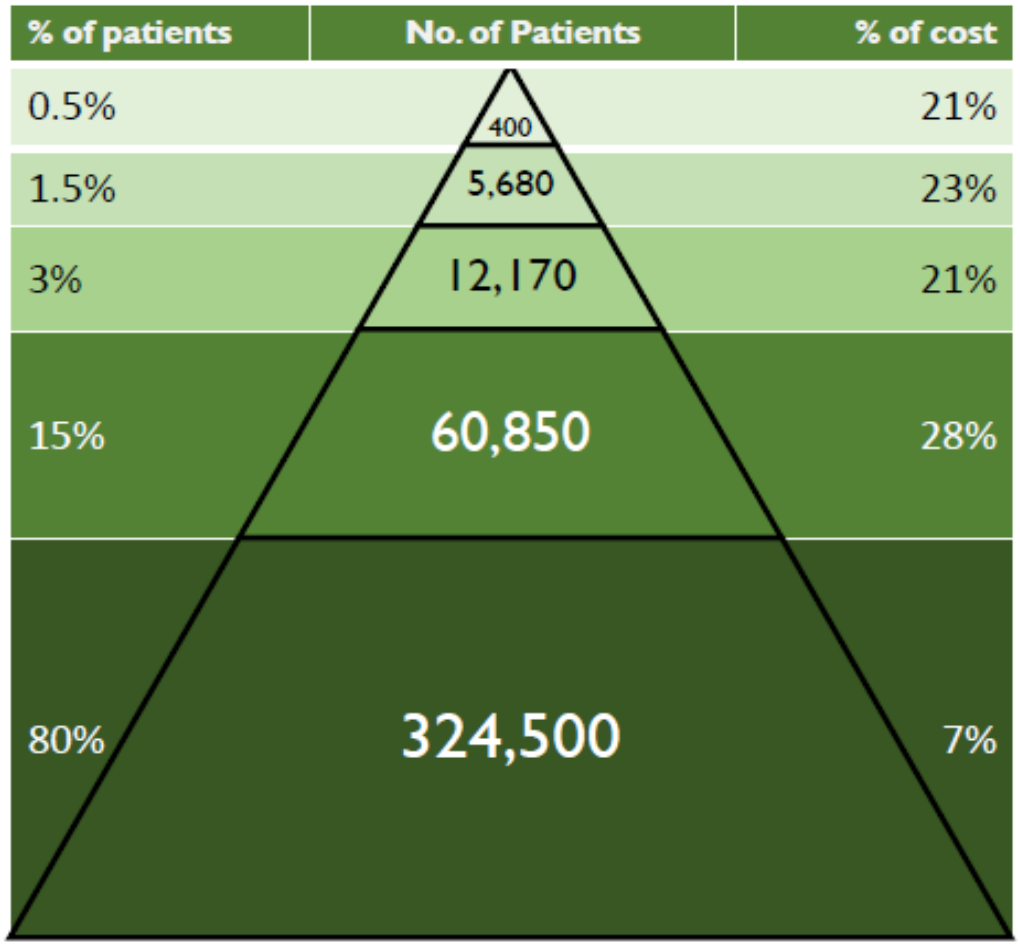
Building an all-age 'system of care'

Primary care model	Pre-hospital model	Same day access model	Admission model	Discharge model
• ?Single door to primary care at place • 2 sets of patients – general + complex • Streaming of appropriate cases to CPCS, online, self care, MH CAP, physio, specialist CYP etc • Leaving GP to deal with continuity of care • ***Delivers Fuller principles***	• ?Single door for all ?acute requirements – combined UCH / bed bureau / navigation hub / PTCDA / MH car • Streaming of appropriate cases to right place, right time, right clinician, linked to locality model • ***Delivers 'No Wrong Door' + UEC strategy***	• ?Single door into the LRI campus, run by primary care first • Streaming of acute patients into ED, non-acute into MIAMI or locality model off-site or straight to MH services (40/60 split) • ***Delivers Sturgess + CQC + Fuller principles***	• ?Single pre-admission team in ED • Streaming of all appropriate patients 'Home First' • Expansion of Home First ethos to children • ***Delivers Sturgess + CQC + Fuller principles***	• Single discharge team, working across UHL, LPT and LA • Assessment of every complex patient live, streaming patients onto the right discharge pathway, adults and children, MH and physical health • ***Delivers NICE Intermediate care + Sturgess + RRR model***

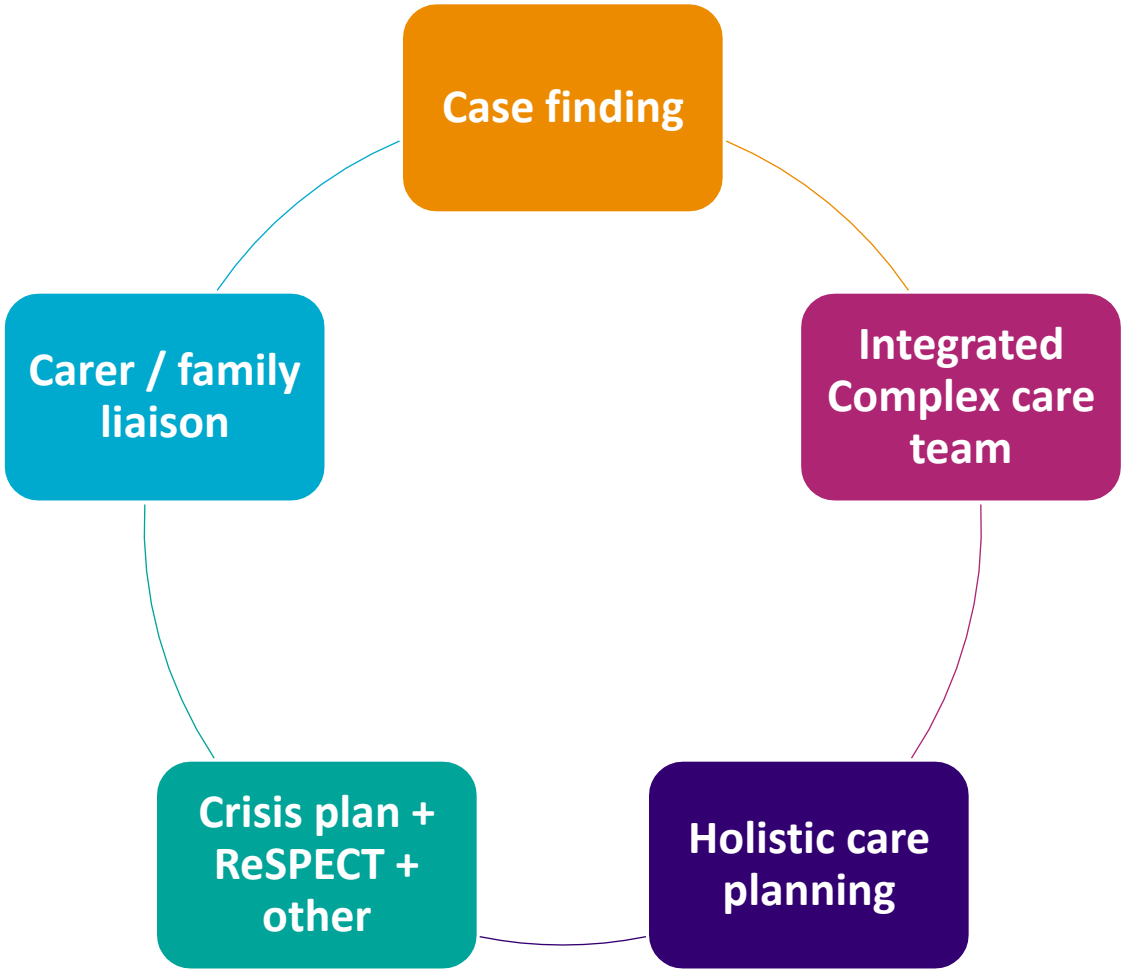
Integrated system of care for complex patients (1)



Issue:
We are still treating each of these patients separately in primary care and secondary care and community care and social care. The boundaries of care are not fluid and do not provide coordinated, holistic care, leading to poor experience, poor outcome and increased long term costs for health and social care

5% of the Leicester population accounts for 65% of all secondary care costs, circa 18,250 people
21% of secondary care costs are concentrated in just 0.5% of the population, circa 400 people
95% of the population account for 35% of all secondary care costs

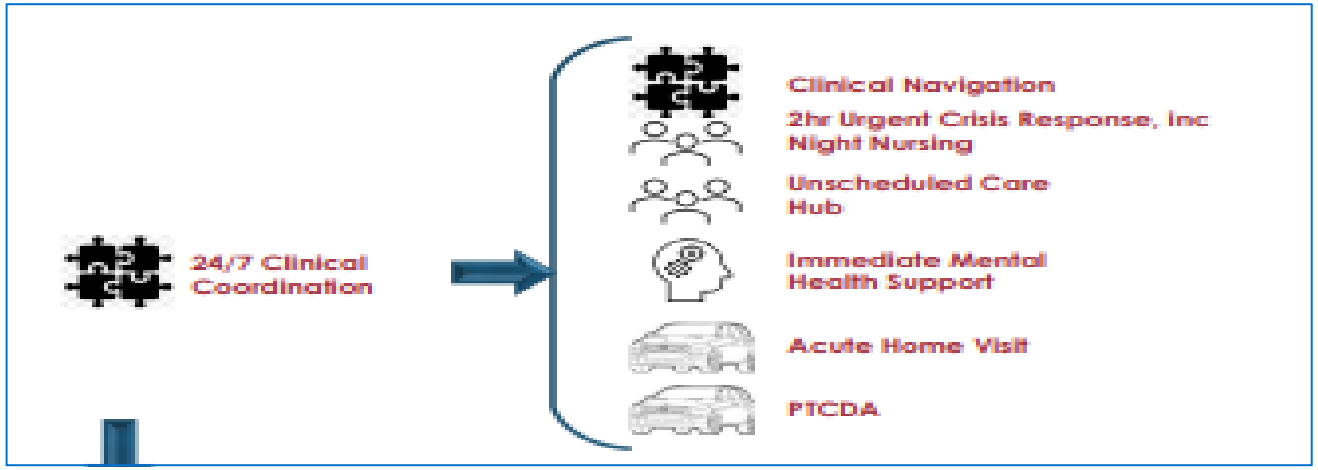
Integrated system of care for complex patients (2)

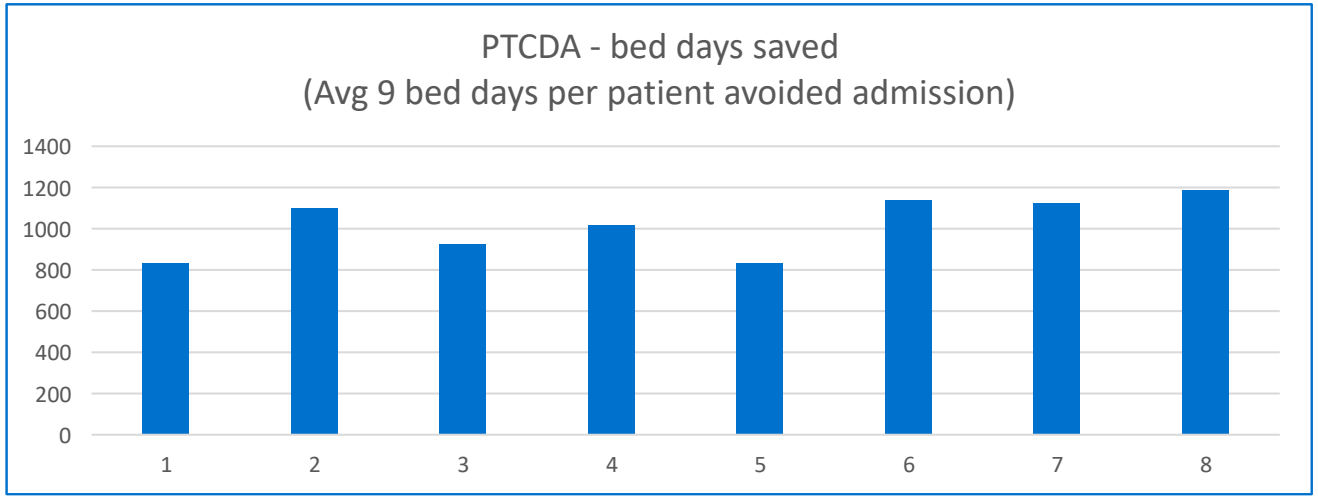


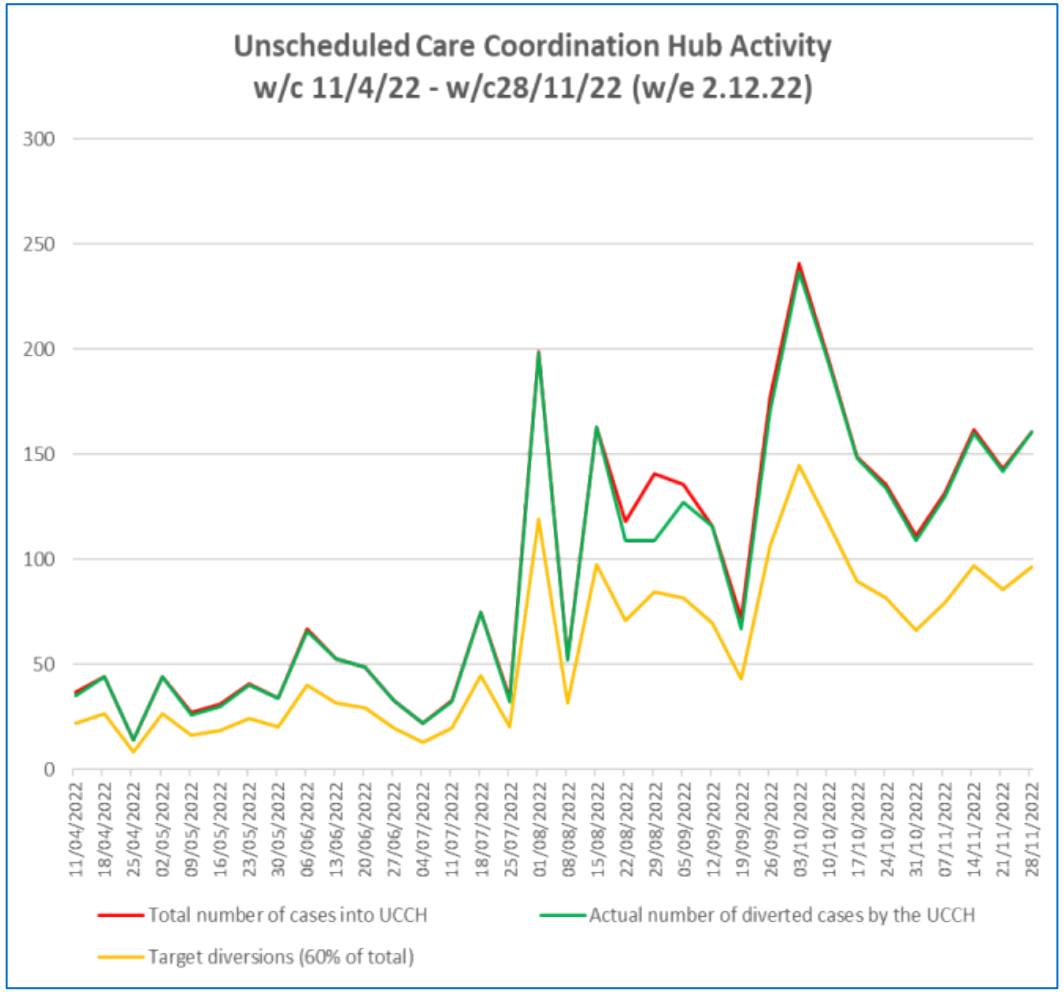
- Requirement:
  - Standardised / localised system of care for management of frailty / multi-morbidity
  - Optimised patient outcomes for single disease, frail and multi morbid patient cohorts
  - Integrated model of care, integrated workforce

- Deliverables: (based on pilot data)
  - Highest independence PROM score of 3 CCG's
  - Lowest E/A rate of 3 CCG's for 0-1 day LOS
  - Highest reablement success rate

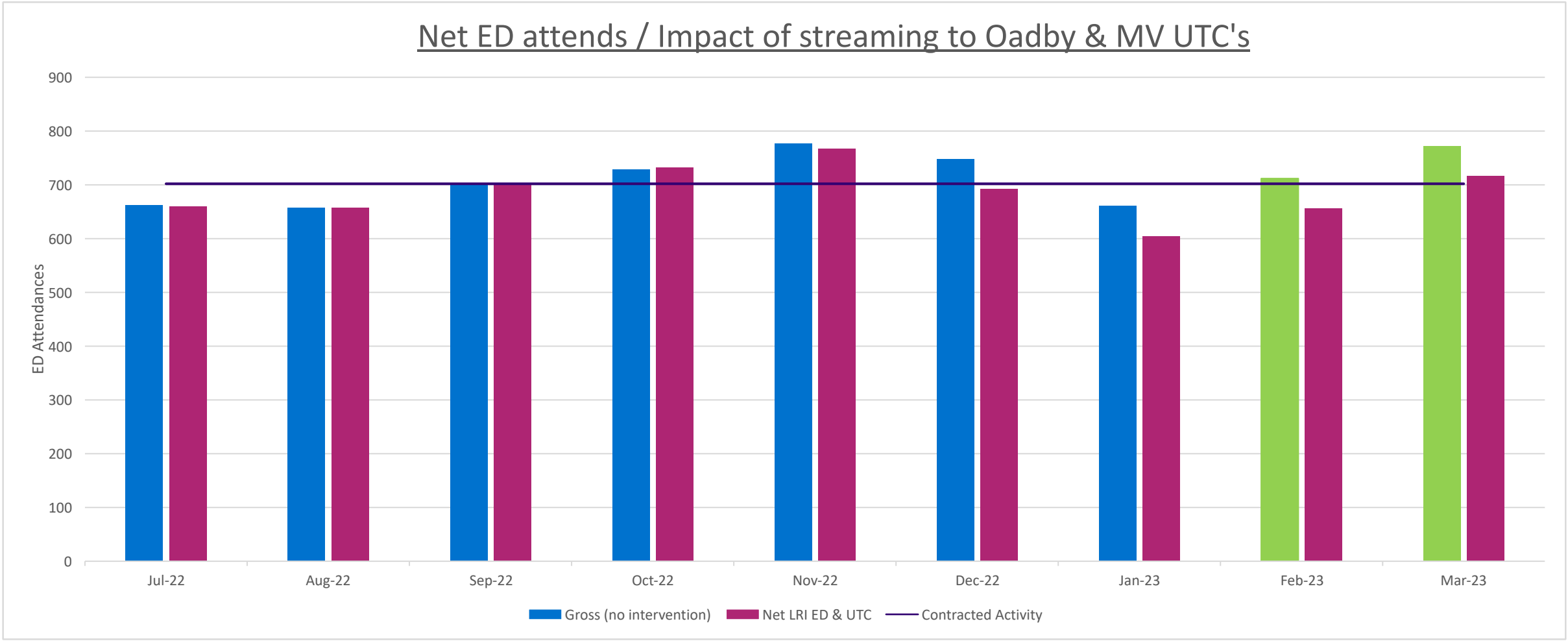
Co-ordinated pre-hospital services



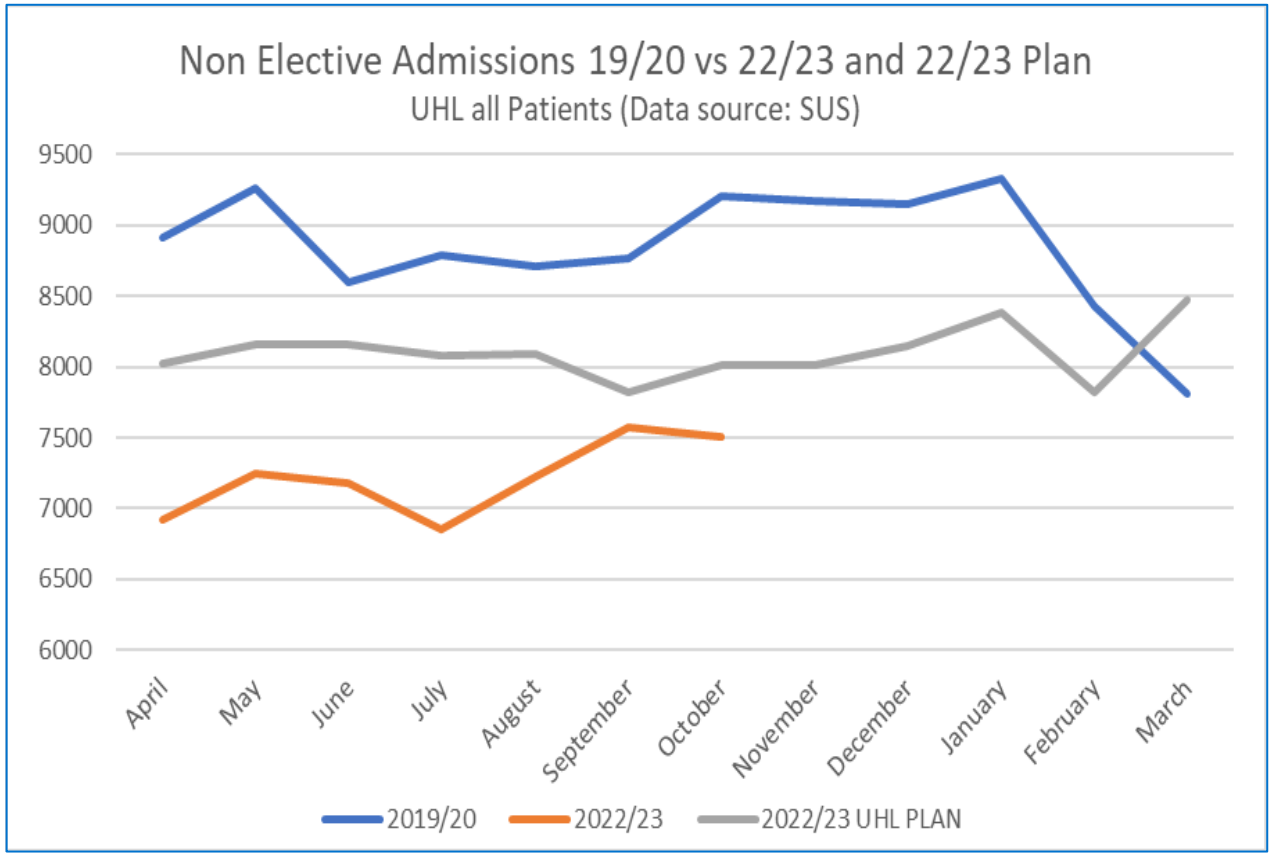


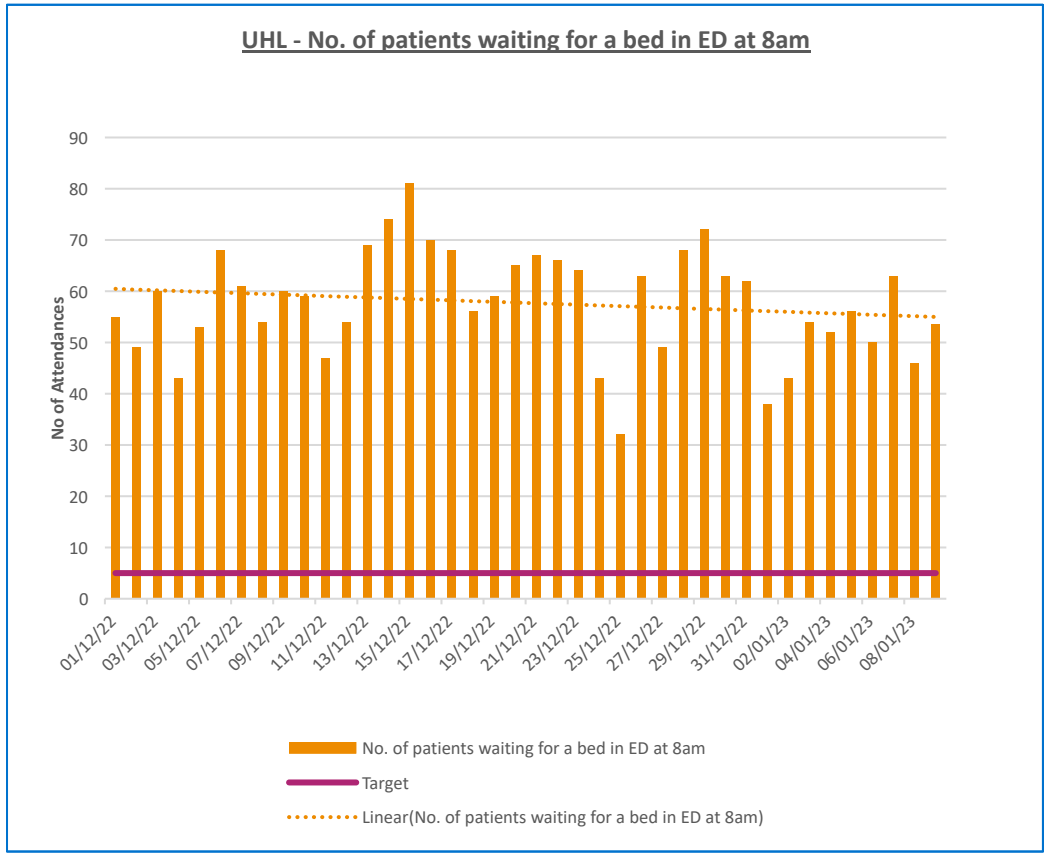


Integrated ED front door

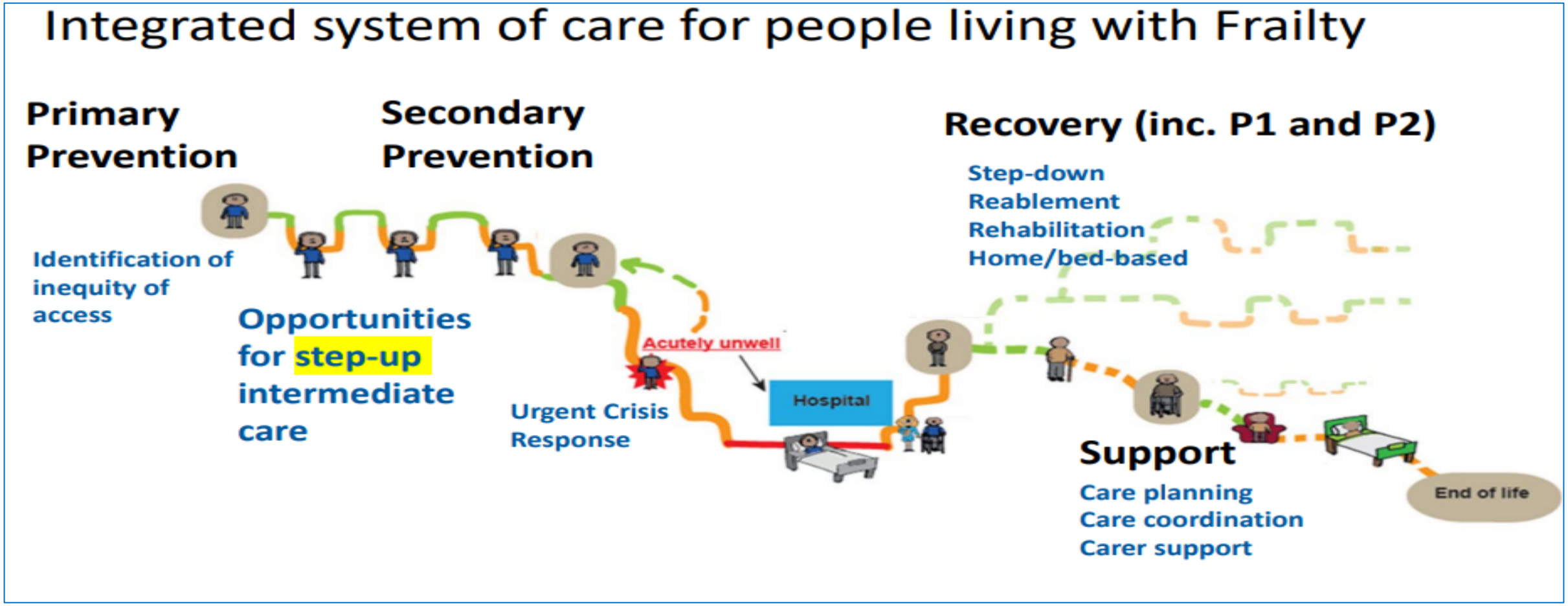


Systematic admission management

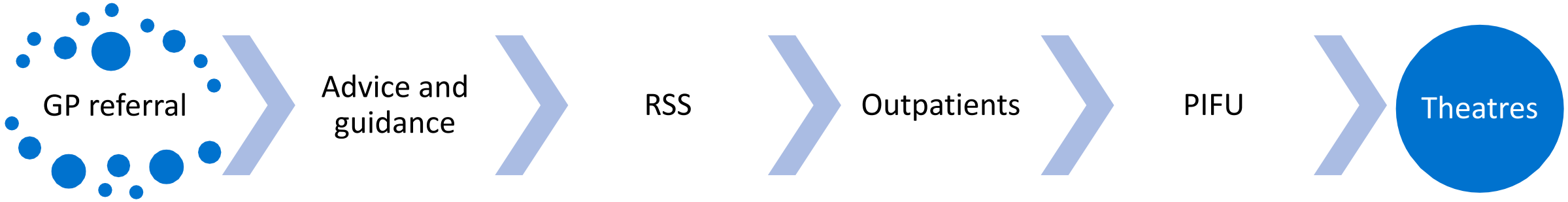




Integrated discharge services + Intermediate care at scale



Modernising elective care



Issue:

Significant variation in referral rates based on ACG system

Requirement:

- Implement a clinically agreed set of principles across the system, covers adults and paeds, mental health and physical health
- Move away from single disease clinics, into holistic care, MDT clinics in localities, specific to local need / equity, underpinned by getting the basics right - with clinical exceptions managed

Deliverable / Outcome:

- Enables us to as a system to move to upper quartile performance and achieve equity for patients in our care

Women's health

- Currently fragmented across multiple pathways and organisations
- Integration of service offers could have significant yield in terms of access, experience and outcomes

Prevention / optimal health	Maternity services & post-natal care
Gynaecology	Cancers
Mental health	Menopause / Ageing well

Gathering views on models

Engagement to date

- ICB exec team
- LPT exec team
- UHL ops / transformation / UEC clinical lead / comms / nursing leads
- 5 year plan group (full representation across system)
- District Chief Executives
- System exec development session
- ICB development session
- ICB Clinical leads x 25

Engagement planned

- Place / HWB's – through Feb
- Clinical executive - Feb
- UHL ED and ESM clinical teams - Feb
- Collaboratives by portfolio inc clinical leads – through Q4

Please remember that these are not 'new' models of care but have come from ideas from each collaborative

Initial reactions

- Model broadly supported across those engaged to date
- Key concepts supported, inc understanding of evidence base, locally, nationally and internationally

Reflections:

Scale & complexity of change	Clinical ownership & cultural change required	Changing financial flows across boundaries
Interdependency of models	Timing across 5 year period	Workforce to deliver change & model
Need to prioritise due to scale of challenge	Maintaining engagement with front line	Real need for better business intelligence

Next steps

- Incorporating people and communities in the actual design of services / pathways
- Continue engagement – Wider teams
- Define clinical leadership / ownership
- Draft chapters linked to all other strategies / plans
  - PHM strategy
  - Elective care strategy
  - UEC strategy
  - Fuller
  - ‘No Wrong Door’
  - CYP plans
- Timing of each part of the ‘jigsaw’
- Economic modelling / outcome modelling