Leicestershire Partnership NHS
NHS Trust

Two-Year Operational Plan (2017/18 and 2018/19)

1. Activity Planning

1.1 Demand

Within the local STP process, public health teams have provided CCGs and NHS Trusts with five year population projections, which provides two-year demand growth forecasts as follows:-

Area	Leicester	Leicestershire	Rutland	LLR
Children & Young People's Services	+1.76%	+1.28%	+0.48%	**+1.44%**
Adult Services	+1.08%	+0.56%	-1.20%	**+0.68%**
Older People's Services	+4.68%	+4.32%	+4.80%	**+4.44%**

1.2 Access – Referral to Treatment Times for Diagnostic Services

Waiting list trajectories for diagnostic (Audiology) services are agreed through service patient tracking lists (PTLs) and forecast a compliance trend of 99% of patients being seen within six weeks. We expect to maintain this performance in both 2017/18 and 2018/19.

1.3 Access – Referral to Treatment Times for Consultant-Led Services

Waiting list trajectories for consultant led (Asperger's and ADHD) services are agreed through service PTLs and forecast a compliance trend of above 92% of patients waiting 18 weeks. We expect to maintain this performance in both 2017/18 and 2018/19.

1.4 Access – Referral to Treatment Times for Children's Eating Disorders Service

The new mental health access and waiting time standard required that from April 2016 children requiring access to CAMHS eating disorder services will be treated with a NICE approved care package within one week (urgent) and four weeks (routine) of referral. In 2016/17 Q2, the Trust breached the standard when one child referred for routine treatment was not seen within four weeks. However, this was an isolated case and the performance in October 2016 of 100% (urgent) and 90% (routine) is expected to be maintained in both 2017/18 and 2018/19. During the period of this plan, the service will be preparing for self-referrals from 2020 and the anticipated increased demand.

1.5 Access – Referral to Nice Concordant Package of Care (First Episode in Psychosis Service)

The new mental health access and waiting time standard for first episode in psychosis requires that from April 2016 more than 50% of patients will be treated with a NICE approved care package within two weeks of referral. Performance of 80% in October 2016 is expected to be maintained in both 2017/18 and 2018/19.

1.6 Capacity – Adult Mental Health

Mental health proposals within the local STP support the left shift of activity away from the acute setting, by enhancing community and primary care services. This will require more effective low level support services and having primary/community services focused on detection, planned care and recovery. An anticipatory care model which effectively manages people whose needs deteriorate will minimise the impact and requirement for inpatient stays. Increased capability and capacity in accident and emergency (A&E), crisis services and acute liaison services will be there for patients who require urgent care and will support operational resilience.

PTLs will enable services to quickly identify if they are at risk of not be able to meet growing demand. The local Urgent and Emergency Care Vanguard is creating a new alliance-based care system where all providers work as one network. This will bring together services to ensure that patients get the right care and the repatriation of out of county mental health placements will be managed with a newly designed pathway. LPT is also working with primary care colleagues and commissioners to repatriate patients in Clusters 1, 2, 3 and 11 in order to further release capacity.

1.7 Capacity – Learning Disabilities

Two beds at the Agnes Unit have already been decommissioned in 2016/17 with a further two beds to be decommissioned in 2017/18, leaving 12 beds locally. The local *Transforming Care for People with Learning Disabilities* workstream is scoping step down care to reduce the impact of delayed transfers of care at the Agnes Unit. The new community learning disabilities outreach team is in place to prevent admissions and the Blue Light system acting as a gatekeeping process is not expected to have much impact on reducing admission based on the 2016/17 patient flows.

1.8 Capacity – Older People's Services

Analysis of demand and capacity indicates that there is broadly adequate capacity to meet the demand for community nursing services, mental health services for older people and inpatient care within the community hospitals. However there are demand/capacity gaps in long term condition, heart failure, respiratory, musculoskeletal, podiatry and domiciliary therapy services. These require additional investment to bolster clinical capacity to meet the growing demand (see 1.1).

In mitigation, a number of efficiency and productivity improvement initiatives have been put in place to enhance capacity including a transformational programme that ensures the integration and effective alignment of community services, as well as integration with social care and mental health services. Regular review of referrals, contacts and clinical capacity in order to reallocate and prioritise resources in favour of the areas of need, use of local decisions unit for the effective triage and appropriate direction of referrals to clinical services will all have an impact. PTLs will maximise clinical capacity and the use agile working arrangements and digital technology (eg Nerve Centre and Telehealth) will improve productivity. Our community health services transformation project is being supported by Newton Europe.

1.9 Winter Resilience Planning

Services across the Trust have plans and processes in place to respond to surges in demand as part of the local Accident and Emergency Delivery Board, which maintains and reviews the local urgent care surge and capacity plan, and strategically manages the demand on capacity throughout winter pressures. As such, planning for the winter period is conducted collaboratively and provides support such as the winter 4x4 vehicle that ensures our community staff can reach out to all patients in adverse weather.

The Trust's Winter Contingency Plan is stress tested through internal table top exercises and participation in external exercises with the wider emergency planning community. This plan is reviewed during the winter period to ensure accuracy and validity of triggers and responses. Services also have local business continuity plans which can be mobilised in the event staffing to meet the demand becomes a risk. The Trust actively conducts a Flu Fighting campaign in line with the Public Health England national campaign to provide extra resilience against staff absenteeism.

2. Quality Planning

2.1 Approach to Quality Improvement

Accountability for assuring delivery of the quality strategy rests with the Chief Nurse/Deputy Chief Executive. Our Quality Strategy (2016/17 to 2018/19) has recently been refreshed and takes account of the local and national context of service change that we know will critically affect the quality of care for all our patients. It focuses on four strategic aims:-

- Ensure that we meet or exceed all national and local standards and targets.
- Embed an effective self-regulation system that establishes a culture of personal ownership for quality.
- Demonstrate year-on-year improvements in patient satisfaction and patient involvement.
- Deliver our Quality priorities through an annual quality improvement plan that is communicated to all staff and stakeholders.

Over the next two years the Trust will deliver its quality priorities through an annual quality improvement plan. Delivery will be supported through our governance arrangements so that we can be assured that the care and treatment delivered by our services is safe, effective, and focused on positive outcomes. Our approach to quality improvement is integral to our research, clinical audit, patient experience and involvement plans and is underpinned by our People Strategy (2016/17 to 2020/21) and associated workforce plans. The LPT quality priorities are ensuring our services are safe, effective and person centred.

The Care Quality Commission (CQC) rated LPT as *Requiring Improvement* in 2015 and following this inspection an improvement plan was implemented. A further CQC inspection took place in November 2016 and the Trust has responded to the regulator's initial concerns letter. Actions are underway to address environmental issues on the acute wards at the Bradgate unit, improving opportunities for learning, improving staff understanding in relation to clinical supervision, the use of the Mental Capacity Act and improving evidence of patient involvement in care planning.

Following receipt of the CQC report (circa February 2017) a comprehensive action plan will be put in place to ensure local delivery. Findings will be triangulated with 2015 and 2016 intelligence. A revised governance framework will be established to monitor progress with implementing the action plan in 2017/18.

In April 2016, the Trust launched a refreshed quality assurance system. Self-Regulation now acts as the primary driver for quality improvement and provides internal assurance of the quality of care across all clinical services, in order to ensure that:-

- Patients are protected from abuse and avoidable harm.
- Patient's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best evidence.
- Services are organised so they meet patient's needs.
- Staff treat patients with compassion, kindness, dignity and respect.

- Leadership, management and governance of the organisation makes sure the delivery of high quality person centred care supports learning and innovation, and promotes an open and fair culture.

Our self-regulation approach presents a risk based step down or step up process, and facilitates the utilisation of improvement plans and methodologies to improve standards. This approach aims to deliver a cultural change as well as a focused approach to inquiry and improvement, within every service utilising a self-assessment and peer review validation process.

LPT also promotes a common approach for quality improvement within the organisation. Services currently utilise Process Mapping and Plan, Do, Study, Act (PDSA) cycles to support change. We are training staff in the use of our *We-Improve* change model to create capability and skills to support the delivery of improvement projects and initiatives.

All staff have access to an e-learning module, which includes a broad spectrum of foundation knowledge, from an introduction, to the concepts of quality improvement and the model for improvement, to a more detailed understanding and application of some of the tools for improvement. Next level training includes a range of in-depth sessions around the practical application of quality improvement methods, from examples of methods, tools and techniques that engage multi-disciplinary teams in quality improvement initiatives through to behaviour change.

Our monthly Integrated Quality & Performance Report (IQPR) includes our performance against national, regulatory and local quality requirements and staff management information. The report provides a trend analysis of performance against all NHS Improvement, CQC, local commissioning and internal LPT standards/targets, including CQUINs and the commissioner quality schedule. The LPT indicators include patient feedback, patient safety incidents, staff feedback and service targets.

The Board's Quality Assurance Committee (QAC) provides assurance in relation to quality governance, and defines and influences expectation with regard to overall assurance in relation to the quality of our services. Each of our service directorates has an assurance group which oversees quality assurance across the range of local service improvement plans and priorities. QAC monitors and assures management of risks in the delivery of the Trust quality improvement plans through LPT's risk management framework, so that all risks are identified and appropriately managed. Delivery of both quality and financial goals are achieved through an effective and robust performance review process with our three clinical directorates.

2.2 Summary of Quality Improvement Plan

Our quality improvement plan is structured around our three priorities which are informed through the identification of Trust specific quality improvement priorities, commissioner quality schedule, and commissioner CQUINs. We will be implementing the national CQUINS that apply to all of our services. In framing our local quality priorities we have derived our focus utilising the five key questions that the CQC ask and linked these to the three key aspects of effectiveness, patient experience and safety. Each service negotiates specific targeted goals to deliver these improvements and these are detailed in our Quality Account on an annual basis. We have agreed local priorities:-

- Improve clinical recording and care planning to support safe and effective patient centred care.
- Improve discharge planning and follow up to support safe transfer of care.
- Evidence improved engagement in clinical supervision for all staff delivering care.

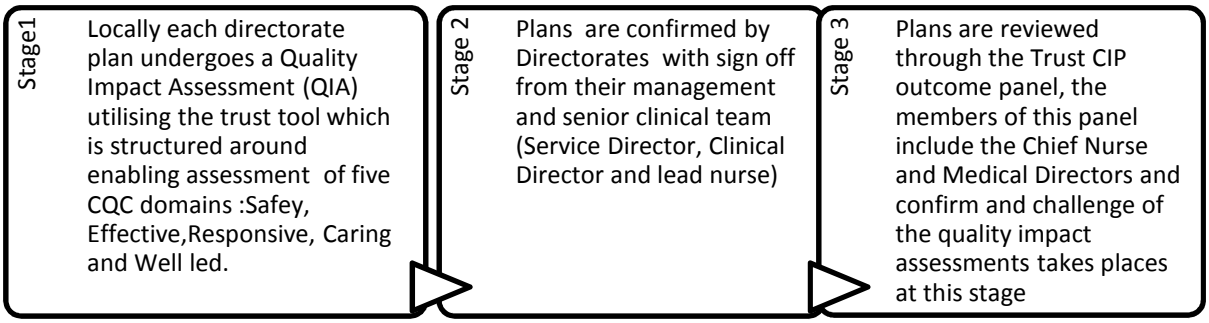
Alongside our improvement priorities we will implement our overarching patient experience and involvement strategy across the organisation and participate in the in national clinical audits as they apply to our services. Our quality improvement plan includes the following national priorities:-

- Embed our mortality review framework and improve the quality of incident investigation and subsequent learning and actions.
- Continue to review our safer staffing work plans and implement tools to support implementation of care hours per patient day monitoring tools as they apply to our services.
- Review the current psychological therapy provision/use of resources and consider how access to psychological therapy services can be improved.
- Implement our improvement work programmes relating to infection prevention and control and anti-microbial resistance management, falls prevention and our sign up to safety campaign priorities, Sepsis management and education, pressure ulcers prevention, the End of Life Care strategic case for change and the associated vision and pathway for the best quality palliative care across the health community.

We have undertaken a review of our baseline position in respect of provision of seven day care across all of our services. We will focus on sharing of existing practice where services are delivered over seven days (see 3.7) and in 2017/18 we will develop a plan for the full roll out of the four priority clinical standards across all of ours hospital and community services by 2020.

2.3 Summary of Quality Impact Assessment

The Trust has an effective quality impact assessment process in place and this enables on-going monitoring and review of service changes and their impact on quality.



Our cost improvement and service development plans are developed at service level with a high level of clinical engagement and a three stage process detailed above. Ensuring that our Cost Improvement Programme (CIP) is delivered in a clinically safe manner is the responsibility of both our Quality Assurance Committee, which ensures no detriment to quality and the Finance and Performance Committee, which ensures financial deliverability.

All schemes are subject to a Quality Impact Assessment (QIA) and rated using the Trust's risk scoring tool. The QIA framework requires assessment of impact against the Trust quality priorities of safe, effective and person centred care. The approach involves consideration of responsiveness and well led domains determined by the CQC. Key indicators for each scheme are identified during the QIA process, such as:-

- Safe – Safeguarding , incidents, harm, infection control, clinical workforce and safer staffing.
- Effective – Evidence based practice, variation, clinical leadership, pathways, waiting times, access, clinical audit outcomes, workforce information, clinical supervision and appraisal targets.
- Person Centred – Patient experience, complaints, concerns, patient feedback and survey outcomes

CIP progress is reported back to the Executive Team who oversee the overall programme and recommend the programme for approval. The Finance and Performance Committee is kept appraised of the CIPs and the Trust Board signs off the programme annually.

QIAs are scrutinised through directorate management teams and signed off by the clinical director and the lead nurse for the service. The Trust's CIP Outcomes Panel has a core membership of Chief Nurse/Medical Director, Director of Finance and Service Directors. This group meets monthly to scrutinise scheme impact and consider emerging or potential risks relating to trust schemes. The group also monitors delivery of in-year schemes through progress reports and monitors key performance indicators post scheme implementation, agreeing remedial action where necessary.

On-going monitoring of quality impact is also undertaken at local governance groups and QAC oversees the quarterly monitoring of all programmes to ensure maintenance of quality and safety of services. Each directorate's delivery of CIP schemes is monitored at regular performance and accountability reviews, which includes the assessment of impact.

2.4 Triangulation of Quality, with Workforce and Finance

Key metrics and quantitative outcome measures are detailed through our monthly IQPR, which is regularly reviewed to ensure metrics are contemporaneous and fit with emerging priorities which include local priorities, national CQUINS and quality schedule requirements. The IQPR is considered at Trust Board on a monthly basis and includes the following indicators:-

Quality, Safety & Experience	Workforce	Operational performance
Incident Data	Staff Appraisal Rate	Waiting Times
Incidents Harm	Mandatory Training	Bed Occupancy
Health Care Associated Infections	Vacancy Rates	Length of Stay/Delayed Transfers of Care
Complaints, Concerns, Compliments	Sickness Absence Rates	CPA 7 day Follow-Up
Friends and family Test	Staff Turnover	CRISIS Gatekeeping
Survey Feedback (Staff and Patients)	Temporary Staffing Rates	Financial Position

The IQPR triangulates the Trust's performance against national, regulatory and local quality requirements and staff management information. The report provides a trend analysis of performance against all quality indicators, workforce and financial indicators and is considered at both QAC and FPC on a monthly basis prior to presentation to Trust Board.

3. Workforce Planning

3.1 Workforce Plan Summary

The workforce plan for 2017/18 shows an increase of 12 wte registered nurses, a reduction of 10 wte nursing support and a reduction of 6 wte managers and administration staff. There are smaller changes in other staff groups. The changes result from increased substantive and bank staffing to reduce agency use, increased staffing due to skill mix (more staff at lower bands), increased staffing due to CCG investment and demographic growth, along with CIP reductions.

3.2 Workforce Planning Methodology

The LPT workforce plan is developed in line with the Trust's planning process which in turn is driven by the local Sustainability and Transformation Plan (STP). It takes into consideration service development plans, financial challenges and known system-wide changes. Inputs come from a range of teams and individuals including clinicians, finance, human resources, learning, development and

resourcing. The workforce plan provides a single point of reference to track and forecast workforce progress against agreed workforce changes.

Services develop their workforce plans with patient care at the heart of decision making. All service development initiatives are assessed for quality and financial impact by the Trust's Service Transformation Group (STG) before they are implemented. STG is comprised of service directors and senior leads from all services. Final sign off before implementation is undertaken by the Trust's Medical Director and Chief Nurse.

LPT is working with partner organisations to assess and plan the future health and social care workforce across LLR. The strategic workforce planning group are developing mechanisms to support a system wide approach for collaborative workforce planning across the LLR health and social care community.

3.3 Underpinning Workforce Strategy

The strategic aims of the Trust's recently refreshed People Strategy (2016/17 to 2020/21) are:-

- Provide a workforce that is flexible, efficient and at the right capacity, to meet the changing needs of the population.
- Ensure the Trust has a diverse, skilled, educated and capable workforce.
- Develop a culture where the workforce is engaged, committed and supported.
- Ensure the application of high quality management and leadership practices and behaviours.
- Create a culture & environment that empowers and enables staff to improve the services we provide.

In terms of workforce planning the focus is on ensuring a workforce that is flexible, efficient and at the right capacity by:-

- System-wide planning with our STP partners.
- Developing innovative approaches to recruitment and retention.
- Developing our temporary staffing capacity and new generic roles to create flexibility.
- Driving productivity and efficiency across the workforce.

3.4 Governance Process

The workforce plan is agreed by the Trust Board each year and is reviewed and adjusted by divisional workforce groups throughout the year, making it a live document that is responsive to changing demands. The plan is reviewed by the Board's Strategic Workforce Group at least every six months. This governance process allows regular review and input from clinical leaders and service managers as well as strategic oversight from the executive team and non-executive directors.

Relevant workforce indicators are reviewed monthly in relation to any impact on quality and safety and where concerns are recognised, these issues are escalated to the Trust Board where appropriate. As well as internal scrutiny, the Trust also has a significant level of external monthly scrutiny and assurance by our commissioners, where all the quality indicators are reviewed including any impacts from the workforce indicators.

3.5 Workforce Efficiency

Outlined in the People Strategy are the primary areas of focus to improve workforce productivity:-

- Reduction in Sickness Absence – We will implement a range of interventions and initiatives to improve the health and wellbeing of our staff.
- More Effective Rostering – *HealthRoster* is already in place for all inpatient areas where we will continue to focus ensuring information generated from *HealthRoster* is used appropriately to drive improvements and will consider further roll out of the system.
- Annual Leave – Ensuring a balanced approach so leave is evenly distributed across the year.
- Greater Consistency and Standardisation of Roles – Work is already underway to develop standardised job descriptions to ensure consistency across different services and to make it easier to move staff around the organisation.

3.6 Reduction in Agency Use/Costs

All temporary staffing is managed by the centralised staffing solutions team. This enables central oversight of temporary staffing spend, training and performance. Temporary staffing is monitored at service level, by the Executive Team and by the Trust Board. We have undertaken significant work in terms of reducing agency spend in 2016/17 and has identified the following high impact actions that will support a further reduction of 28 wte agency workers in 2017/18 and 5 wte agency workers in 2018/19:-

Increasing substantive and bank supply	• Regular rolling recruitment of registered and unregistered nursing for substantive and bank posts. • Utilise Recruitment and Retention Premia (RRP) to attract retain workforce in city. • Utilise bank staff pay incentives to compete with agency. • Forensic review of rosters including unused hours and annual leave planning to maximise current workforce capacity.
Managing agency use	• Review of use of dynamic risk assessment within the services before going to agency. • Review of long term agency use (including admin and clerical agency use) within the services. • Embargo on booking new agency staff within corporate services. • Increase agency supply through mastervend solution for nursing, AHP, medical locums and admin and clerical.
Medical staffing	• A new process for sourcing temporary medical staff which requires clinical leads to complete a locum request form and gain approval of Medical Director. • Introduce a weekly teleconference, chaired by the Medical Director where the usage of locums will be scrutinised. • Provision of a weekly locum report to Head of Employment Services and Medical Director. • Development of a medical workforce model for acute inpatient areas. • Creation of an internal bank of doctors. • Consideration of employing additional doctors with flexible duties. • Investigate doctors rostering programme for senior doctors to support Clinical Leads in managing medical staffing.

3.7 Workforce Transformation

Service transformation plans are all outlined in the Trust's five year plan. Some of these plans will require changes to the workforce. Our adult mental health services have identified a need to make better use of their most senior staff and want to develop Advanced Nurse Practitioners and Nurse Prescribers within CMHTs. Mental health clinicians will be embedded within community physical health care settings to promote parity between physical health and mental health care. In our services for families, young people and children, agile working practices will be adopted which will require a cultural shift and different ways of working.

System-wide transformation of services, including shifting care from hospital to the community, the creation of integrated teams, the reconfiguration of community hospital beds and the redesign care pathways are all outlined in the local STP. To achieve these major shifts in service delivery a range of actions are already underway. These include system-wide workforce planning, development of new approaches to recruitment, retention and training, and crucially the development of a system culture and system leadership capacity.

To enable a long-term sustainable transformation within the LPT workforce during 2017/18 and 2018/19, we will continue to embed a grow our own culture. This means supporting and nurturing our staff to become the workforce needed for the future. This will mitigate against staffing supply issues and help embed a culture of continual learning and growth. Actions taken include planning for use of the Apprenticeship Levy to support staff development, successfully becoming a pilot site for the new Nurse Associate role, creating career development pathways and developing an in-house talent management programme (*WeNurture*).

3.8 Local Workforce Action Board

The Local Workforce Action Board is supported by Health Education England East Midlands with membership from health provider organisation. LPT representatives sit on each of these groups.

3.9 Seven Day Hospital Services Priority Standards

LPT has undertaken a review of its baseline position in respect of its provision of seven day care across all of its services. The process involved the use of the online seven day services self-assessment tool developed by the NHS IQ. LPT is part of the local Urgent and Emergency Care Vanguard and is developing an all-age psychiatric liaison service which will be an integral part of the local A&E service. The Trust will also develop its community paediatric, adult mental health and older peoples services further as part of the admission prevention and facilitated discharge elements of the vanguard.

In 2017/18, the Trust will develop a plan for the full roll out of the four priority clinical standards (with progress made on the other six standards) across all of its hospital and community services by 2020 so that patients will receive the same standards of care, seven days a week. This will cover all mental health, learning disability and community services and how enhanced consultant level cover will assist in reducing any excess deaths during weekends.

4. Financial Planning

4.1 Financial Position (2016/17)

The Trust approaches 2017/18 and 2018/19 from a position in previous years where a surplus position had been planned and consistently delivered.

The 2016/17 the financial plan was set following the outcome of an informal mediation process, regarding the LLR CCG contract offer and planned to deliver a surplus of £2,000. The plan included a CIP plan (including cost efficiencies) of £10.6 million or 4% of turnover. The Trust accepted £1.640 million of STF funding and the surplus/control total was revised to £1.642 million in the final plan submission in June 2016.

As at Month 7, the Trust had delivered the planned in year surplus of £652,000 and forecast delivery of the planned year end surplus, contingent on receiving the full STF funding in year. The CIP plan as is delivering £5.5 million of savings (95% of plan) and is forecasting a £10.1 million (96% achievement) out-turn. There are a number of pressures that could impact on delivery this year:-

- Out of county placements for adult mental health patients.
- Ward overspends related to patient acuity and observation levels.
- Un-commissioned activity on adult mental health wards, including female PICU.
- Ward closures for capital works (response to CQC inspection) and subsequent loss of income.
- DTOC and impact on length of stay CQUIN.
- Estates costs.

Some risk to delivery remains, but mitigation actions include:-

- Centralised booking of bank and agency staff.
- Vacancy controls and freeze on enabling staff recruitment.
- Restrictions on redundancies.
- Expenditure control forms for non-clinical, non-pay spend and admin agency above £250.
- Postponement of internal investments.
- Review of asset lives and approach to capital charges.
- Stretch targets for services, so that they deliver a higher bottom line contribution.

The Trust was set an agency ceiling of £7.7 million in 2016/17. The Trust provided a reconciliation that showed if non-recurrent or specifically funded projects were included, then a ceiling of £9.8 million was realistic. As at Month 7, the Trust is reporting a ceiling overspend of £1.4 million. The Trust continues to work hard to reduce agency spending. We have built on the success of the master vendor approach which was introduced for agency staff last year, and is now in place for medical staffing and allied health professionals. All of the master vendor leads comply with pay caps and wage caps. Incentives have been introduced to encourage staff/agency workers to join the Trust's bank, this has led to a 40% increase in the WTE paid through bank between 2015/16 and 2016/17, and an increase in spend of 22%.

Cash has been a high risk issue for the Trust in 2016/17 and at Month 7 the closing cash balance was £1.5 million, equivalent to 2 days' operational expenditure cover. The Trust has requested an EFL adjustment as the original planned figure is unlikely to be delivered.

4.2 Financial Modelling (2017/18 and 2018/19)

The control totals assigned to LPT are:-

	2016/17	2017/18	2018/19
Control Total Surplus	£1.6 million	£3.1 million	£3.1 million *
STF Funding	£1.6 million	£1.7 million	£1.7 million
Agency Control Total	£7.7 million	£7.7 million	£7.7 million

Modelling the Trust's assumptions through, the financial plan delivers the following Single Operating Framework metrics:-

Metric	2017/18 Plan	2018/19 Plan
Capital Service Capacity	2	2
Liquidity	2	2
I&E Margin	1	1
Variance From Control Total	1	1
Agency Spend	2	1
Overall Score	2	1

4.3 Efficiency Savings (2017/18 and 2018/19)

The table above shows draft Cost Improvement Programme (CIP) values for the next two years and discussions continue across all services to ensure that robust schemes are devised to close the current gap. Schemes are managed and quality/finance risk assured as described above (see 2.3).

Metric	2017/18 Plan	2018/19 Plan
Pay	£1.865 million	£1.085 million
Non-Pay	£2.304 million	£0.514 million
Income	£0.400 million	None
Opportunity	£3.453 million	£4.800 million
Total	£8.022 million	£6.399 million

The Trust has volunteered to be part of the pilot Carter review in relation to mental health and community NHS Trusts.

4.4 Capital Planning

The Trust has undertaken an in-depth review of its five year capital plan in order to ensure that all schemes are related to objectives in its overarching five year plan. The plan has been prioritised to ensure that only essential and transformational schemes have been included in the plan. This is both to reflect the constrained national capital position and also the Trust's commitment to rebuild its cash resources by only investing depreciation balances, external funding or low value equipment disposals in to capital spend.

5. Link to Sustainability & Transformation Plan

5.1 Local STP Vision

The Leicester, Leicestershire & Rutland (LLR) Sustainability and Transformation Plan commits the local health and social organisations to five strands of work to close our five year forward view local health/well-being, care/quality and funding/efficiency (£399 million) gaps:-

- New Models of Care (saving £54 million) – Focused on prevention and moderating demand growth, this strand is using new models of care to bring about system wide transformation, moving efforts upstream to reduce dependency through prevention, self-care, resilience and better care management. The impact of this will be about bending the demand curve for acute hospital admissions and bed days as well as reducing high cost placements in health and social care and impact on other public sector services, particularly the police. This strand will also provide redesigned high quality pathways that will make a major contribution to improving health outcomes and reducing health inequalities.
- Service Configuration (saving £19 million) – To ensure clinical and financial sustainability, this strand will focus on the reconfiguration of acute and community hospitals to ensure that right

services are in the right setting of care which optimises the use of public sector estate and ensures clinical adjacencies that deliver safe high quality care and the lowest estate cost possible.

- Redesign Pathways (saving £33 million) – To deliver improved outcomes for patients and deliver core access and quality pathways across a number of clinical work streams. This work will continue under the Sustainability and Transformation Plan. This also includes work on prevention which cuts across the Better Care Together work streams, continuing healthcare and personalisation.
- Operational Efficiencies (saving £288 million) – The focus of this strand is about becoming more efficient at the things such as theatre utilisation and working collaboratively to reduce costs in areas with functional duplication. This includes back office functions across providers and commissioners as well as collaborative efficiencies between the three CCGs and joint commissioning with local authorities.
- Enablers (saving £18 million) – To create the conditions for success in order to support the delivery of the above strands of work, there are a number of key enablers these include workforce, IM&T, estates, clinical leadership, patient and public involvement, organisational development and health and care commissioning integration.

Locally there has been a governance structure in place for a number of years to promote and oversee local transformation and sustainability initiatives (*Better Care Together*). These governance arrangements are being refreshed to focus on delivery.

A pre-consultation business case is largely complete and ready to send to NHS England if LLR is selected as one of the STP places that can proceed with major service reconfiguration. The health economy is in a state of readiness for starting public consultation within 2 months of that decision.

5.2 Impact on LPT's Two-Year Operational Plan

The five delivery strands in the local STP will have a big impact on the Trust's community health services and adult mental health services.

Our out-of-hospital community health services will increasingly be focused on patients with five or more long term conditions, a frailty marker and/or predictions of high cost care. These services will in the future be part of place based multi-speciality community provision in 11 localities across LLR. This will be in conjunction with local authority social care, district/borough council house services and the larger voluntary sector organisations.

The STP proposes significant changes to our community hospital services, such that public consultation will be required during 2017/18. If supported, then both rehab/sub-acute and stroke inpatient services will be reduced in favour of left shift and a Home First approach. The level of ambulatory diagnostic and clinic based services will be significantly increased.

Our mental health services are already part of the local Urgent and Emergency Care Vanguard and will increasingly provide an all-age response to mental health problems and 7-day working. Our community mental health teams will continue to provide specialist support to patients being cared for by the 11 placed based locality teams (see above). We will be reducing our learning disability inpatient beds by 25% and making good progress in preventing out-of-county placements for adults with acute mental health problems.

Working in partnership with other organisations, the Trust will be an active and leading participant in the local collaborative efforts to address issues such as workforce, medicine optimisation, back-office efficiencies, estates rationalisation and IM&T.

January 2017