# BRIEFING NOTE ON BETTER CARE TOGETHER

FROM THE Interim Head of Communications and Engagement

To all Senior Stakeholders

Tomorrow (22 January 2105) is Better Care Together's first Partnership Board meeting in public at the Peepul Centre. Ahead of that, I wanted to share a briefing with you including latest developments about the programme.

**Senior Stakeholder briefing**

I am pleased to attach below the latest briefing about Better Care Together, the five year transformation programme for health and social care in Leicester, Leicestershire and Rutland, launched in late June 2014.

**Introduction: The context and vision for Better Care Together**

As the Chief Executive of NHS England said recently when he set out his five year forward view,

"Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making… we need to take a longer view…"

Local health and social services are under increasing pressure because more people than ever before require our help. In part, this should be welcomed because people are living longer as a result of the improvements in health and social care which have taken place over the last twenty years.

Locally we have some brilliant services which would be the envy of many other health economies, but there are also things which do not work well for people and their families. We have world class diabetes and heart services, but we also struggle with some of the basics like access to GP appointments, A&E overcrowding, and above all, gaps between different parts of the NHS and social services. This often means that people spend too long waiting for things to happen or struggle to find their way around the different services.

Better Care Together was created to address these issues, specifically the over reliance on acute hospitals; the changing needs of an older and often sicker population, austerity and the public's desire to have more services available in their local communities.

**Our 5 year vision for a local health and social care service is one which "*Supports you and your community through every stage of life".***

We want to create communities and services which…

- Support children and parents so they have the very best start in life

- Help people stay well in mind and body throughout their life
- Know patient’s histories to help anticipate and plan for their health needs
- Care for the most vulnerable and the most frail citizens
- Are there when it matters most and especially in a crisis
- Help support people and their loved ones when life comes to an end.

**The very best start in life:** From what mums have told us we know that they want more choice about where they give birth and the reassurance that there is specialist expertise close by if anything should go wrong. So, we will be looking at how we can support expectant mothers to have their babies at home; how we can give mums the option of a midwife-led birth and how we can better support new families in the first year of having a baby. We also understand that older children and young people sometimes require services which are different to adults, so we will plan for services which are available in the community and which look after our young people’s state of mind as well as their physical health.

**Helping people stay well in mind and body:** Everyone knows that prevention is better than cure, but we still spend most of our time and money treating illness. We all need to focus more on wellness. In future we want local people to have the best education and support to stay healthy regardless of their age or background. This means more time and effort spent on training and educating people to overcome issues which will affect their health and wellbeing… so, whether it’s support to eat more healthily, lose weight, drink less, stop smoking or get active… we want to help people to do the right thing.

**Knowing people’s history and planning for their needs:** Often a crisis like a fall for an older person or a worsening of an existing illness is predictable, yet for too many people the result is a hospital visit.

In future we are going to work with those patients and their carers who we know are at risk to make sure that they have personal care plans completely focused on them and their needs. And we will make more services which have traditionally been based in the City hospitals, available in the community. This will mean that a spell in hospital becomes the exception in all but the most complex situations.

**Caring for the most vulnerable and frail:** We know that there are more older people living locally than ever before, and whilst many are enjoying healthy and independent lives, for some old age is lonely and beset by health problems. We know that people want to live independently, preferably in their own homes for as long as possible and we will support them to do this. We will make sure we know who the most vulnerable people are and give them the most support. We will work with carers, and especially those who are looking after people with dementia, to make sure that they get the help they need. And we will respond to calls for help from the most vulnerable quickly to avoid them reaching the point where a stay in hospital is the only option.

**Be here when it matters and especially in a crisis:** A lot of our plans are about avoiding a health crisis by getting the right services to people more quickly, but even then some people will still become poorly. When they do our community crisis response teams will be there quickly. They will discuss the options with people and where possible organise specialist teams to care for people in their own homes or a care/nursing home rather than hospital. If a trip to hospital is required then from the winter of 2016 patients will be looked after in the UK's only purpose built 'frailty friendly' A&E. And when it is time for them to go home we will make sure that all the services they need to continue to live independently, are in place.

**When life comes to an end:** It happens to us all and yet it is a subject which patients, doctors and nurses sometimes struggle to talk about. Most people at the end of life would prefer to die at home with friends and family around them, but they need support to make that choice and support in their last days for them to have the best death possible. We will make sure that doctors, nurses and other professionals are properly trained to have these difficult conversations and carers, and that patient's wishes are honoured at the end of their life.

**Latest Progress: The Strategic Outline Case**

As we move from vision to plans, each clinical work stream, (e.g. maternity / end of life care / Frail Older people) in Better Care Together is working with doctors, nurses, managers, patients and stakeholders to consider what the best clinical solutions are.

Some of this more detailed thinking has been captured and presented in the draft Strategic Outline Case, (SOC).

The SOC is an important milestone in the development of the Better Care Together programme and though it is by no means 'the plan' it does set out the scale of our ambitions. The draft SOC will be reviewed and hopefully endorsed by both the NHS Trust Development Authority and NHS England… in that sense it should give us the support to develop the plans in more detail and ultimately where appropriate consult with the public and stakeholders on those plans.

The SOC has been endorsed by all health and social care bodies in Leicester, Leicestershire and Rutland. So, throughout November and December the SOC has been to all three Health & Wellbeing Boards, to the three CCGs and two main provider Trusts for comment and approval. This was finally approved in its draft form on 22 December and was sent as a draft to NHS England and the NHS Trust Development Authority for their views.

**The draft SOC on Finance:**

An important element of the SOC was a detailed financial prediction which looked at what would happen if the local NHS and social care did nothing to address issues of demand and available resources.

The analysis showed that the health economy in Leicester, Leicestershire and Rutland receives £1.8bn per year to commission and provide health services. And

the ‘do nothing’ approach would see a financial gap in the Leicester, Leicestershire and Rutland health economy of £390million by 2019.

There is also continuing funding pressures on all three Local Authorities and there needs to be further work to evaluate the costs of adult social care as more service users and cared for in their communities.

However if BCT cross system initiatives, aligned and linked to organisation savings initiatives, deliver according to the initial plans, then the economy as a whole would deliver a £1.9m health economy surplus in year five.

The strategic outline case also makes the case for additional support in order to reconfigure services. In other words to get from where we are now to where we want to be will require additional funding, for example to ‘double run’ services in *both* the acute hospital and in the community until the services in the community are well established.

Alongside this there is the ongoing requirement for capital funding. For Leicester’s hospitals this amounts to £320m over 5 years to support the likes of the new Accident and Emergency Department at the Royal Infirmary and the investment required to consolidate acute care on to two, rather than three sites, (see below).

**The SOC on hospital reconfiguration and Beds:**

Leicester’s hospitals headline strategy is to become smaller and more specialised as fewer people are required to come into hospital and more services shift to the community. As described in June last year this means that all acute services (i.e. the specialist and emergency work) will move to the Royal and the Glenfield Hospitals. This will mean a different future for the General Hospital as an ‘integrated health and social care campus’.

At the same time there will be a steady transfer of beds from the acute hospitals into the community. In essence the principle is that as we create more responsive services in the community for people like the frail elderly, there will be a greater need for beds closer to home or at home than there is in hospital.

This is clearly the ‘holy grail’ for healthcare, not only does it lead to better outcomes it is also substantially more cost effective to prevent or at least have alternatives to hospital admission… but we know there needs to be a ‘safety net’… if for whatever reason, admissions do not decrease in line with bed transfers. As such an important principle in the SOC is that beds will not substantially reduce in the acute hospitals until alternative and proven services are available in the community.

**Other Developments:**

It is important to stress that whilst Better Care Together represents the whole health and social care system 5 year plan, we are not waiting for the final agreement, support and consultation on the plan to get cracking on some of the obvious improvements.

Improvements in community care:
So, already patients and service users in Leicester city, Leicestershire and Rutland are benefitting from £63 million from Better Care Fund projects.

In Leicester, over £23million will be used to improve care closer to home for those who are aged 60 years of age and above, younger adults with three or more health conditions and anyone with dementia.

Most of the schemes in the Leicester City plan are already live. For example:
The unscheduled care team is providing 72 hours of support for increasing numbers of frail and older people in their own homes.

The Clinical Response Team is building up to full capacity so that it can attend referrals from GPs, care homes and 999, where a patient is at risk of a hospital admission. Whilst new 'Care Navigators' are supporting patients at home with a holistic view of both their health and social care needs.

Leicestershire County service users will benefit from £38million with GPs, community nurses, and social services working together in Leicestershire' communities to provide better care, closer to home avoiding admissions to hospital, with services targeted primarily to older people, vulnerable people, those with long term conditions and their carers .

The County's integrated crisis response service is already providing 72 hours of support for people in their own homes when care needs escalate, a new rapid assessment service for older people launched in October, a community falls response, being delivered in partnership with East Midlands Ambulance service, will be in place in time for the winter period, and the county's clinical commissioning groups are testing out how elements of GP service can operate across a seven day period. All of this work will ultimately reduce the demand on our local hospitals.
And in Rutland £2.2million will be providing residents with the right care, in the right place, at the right time, by creating new community services and managing a reduction in emergency admissions to hospitals.

Changes to Intensive Care
Leicester currently has 3 intensive care units, (ITUs), one at each hospital. However the service and clinical teams are spread too thinly across the three. So whilst demand for ITU grows at the Royal and the Glenfield, it has diminished at the General. Over the last few years this has meant that recruiting clinical staff to the ITU at the General has been problematic because new young intensivists want to practice in big, busy units.

The clinical teams have told us that it is time to bite the bullet and that the only way to make sure that ITU at the Royal and the Glenfield is capable of dealing with demand is to shift beds and expertise from the General, (in line with the strategy to have two, rather than three acute hospitals), and invest in two 'super ITUs' at the other hospitals. This therefore is the plan and though it is part of the overall strategy for Better Care Together, it is likely to be something that needs to be executed sooner rather than later, (within 12 months).

**Gateway Review**

Finally we wanted to share the results of the recent 'Gateway Review' of Better Care Together. Gateway Reviews are Whitehall's way of assessing whether major projects like BCT are going to deliver what they set out to do.
Over a period of four days, the Office of Government Commerce (OGC) reviewed Better Care Together. It interviewed 37 individuals from across the Leicester, Leicestershire and Rutland health and social care system, mainly face to face. These included clinicians, GPs, senior local authority representatives and patient and public involvement representatives.

The full report is available but one of the key quotes was:
"Significant progress has been made by this community over the last six months largely due to effective leadership by the joint Senior Responsible Officers and support from [the] Programme Office…we commend this leadership. Many influential stakeholders remarked on how there had been more joint progress across the community in the last six months than the previous ten years."

We wanted to share this with you not out of pride, rather in recognition that as you have told us previously; fundamental change to the health and social care system across Leicester, Leicestershire and Rutland has been talked about for too long and it is high time we actually did something. The Gateway Review recognised that with the right leaders locally and the enthusiasm of clinicians and stakeholders, we are now starting to make meaningful inroads into creating a health and social care system which is genuinely better for local people.

We recognise that this briefing is substantially longer than we would like or you would ideally want to read, however, it does accurately reflect that there is a lot of really positive work going on at the moment.

In the meantime thank you for your continued support and interest in the work of Better Care Together.

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