Leicester, Leicestershire and Rutland CCGs

Community Services Redesign – future model of care, implementation and next steps

1. Introduction and background

Community health services play a vital role in caring for people living at home or in care homes, supporting GP practices in meeting the needs of thousands of people who are living with ongoing health problems or recovering from a crisis but who do not need the level of acute or specialist type of care provided in secondary care. The three CCGs across Leicester, Leicestershire and Rutland have been working on a project to review adult community health services over the last year. The project was initiated to make sure that services were providing a model of care that could meet patients' needs both now and in the future, and in particular, could provide care that joined up with the way that GP practices and social care services will work in future.

The services in scope of the work so far include; the majority of non-specialist adult community health services, including community nursing and therapy teams, district nurses, the Intensive Community Support Service, inpatient beds in community hospitals across LLR. In addition, our work has looked at community stroke rehabilitation and primary care co-ordinators.

This paper describes the Community Services Redesign (CSR) project to date, including how we went about the work, and the engagement with local residents and other stakeholders that has fed into the work. It sets out the future model that the CCGs will commission and describes how we will put that model in place over the coming months and years, describing what impact that will have on the care people receive and what that will mean to other parts of the health and care system in LLR. Finally, this paper sets out the next steps in our work on community health services.

2. Objectives

The key aims of the Community Services Redesign are to:

- Set out a clear model of community services in LLR, which delivers a 'Home First' approach, and supports the integration of services.
- Ensure that community services wrap around local populations and facilitate integrated working at neighbourhood level
- Articulate the bed-based capacity required in LLR now, and in the future, and specify the clinical/care model required in bed based services
- Deliver efficiencies and have a positive impact on acute and emergency services
- Deliver improved outcomes in relation to patient care and patient experience, through a strong evidence base for redesigned services
- Ensure services are affordable and represent value for money, by reducing duplication, preventing admission, enabling rapid discharge and supporting people to live as independently as possible
- Enable a discharge to assess approach across community services – ensuring that people can leave hospital when they are able to do so from a medical perspective
- Embed a re-ablement approach throughout community services
- Support trusted assessment and information sharing between services to deliver seamless patient care
- Support the identification and management of frailty in the community, in line with a consistent, system wide frailty strategy

- Be sustainable in terms of workforce, supports staff retention and increased satisfaction
- Describe the outcomes and key deliverables/targets to be delivered by community health services in future.

In addition to the above, the CSR also enables the CCGs to deliver some of the changes set out in the NHS Long Term Plan published in January 2019, specifically:

- Configuring community health services so that they align with Primary Care Networks (PCNs), and work alongside PCNs as part of extended, integrated teams to meet the needs of the local population
- Removing the barriers between primary care and community services
- Delivering a 2 hour response to people in crisis in the community.

3. Project approach

The Community Services Redesign is a CCG-led project, but has been taken forward very much as a collaborative piece of work with Leicestershire Partnership Trust, social care teams, and other providers and stakeholders. The CSR reports into the Integrated Community Board, one of the workstreams of the LLR Better Care Together Sustainability and Transformation Programme. A Clinical Reference Group has been established, including clinicians from primary, community and secondary care, to secure clinical input into defining the new clinical model.

The work commenced in summer 2018, with a series of workshops with different stakeholders across the system, mapping out what a good model of integrated community care in LLR should look like and ensuring continuity with existing strategic plans within the BCT programme, for example; integrated teams and Home First.

The project was fortunate to have access to consultancy support from Deloitte (funded by NHS England). Deloitte undertook a best practice evidence review of integrated community services looking at examples of successful community services models elsewhere in the UK, which helped shape the design of the future model. In addition, Deloitte undertook some modelling of the impact of introducing a new integrated community services model, looking at what activity could take place within community teams and what would be the likely impact on acute services and community inpatient beds.

We included the findings of previous service reviews, for instance the LLR bed utilisation review and a review of the Intensive Community Support (ICS) service in 2017. In parallel with the Deloitte work we carried out clinical reviews of some existing services to understand how well they were working.

Patients, carers, staff and the public have been involved through one-to-one interviews, focus groups, as well as public events. People have shared their experiences and what matters most, as well as their views. The engagement we have undertaken is described in section 5.

All this enabled the project team to set out a high level proposal for changes to how community health teams support people living in their own homes, or care homes in December 2018, to deliver a different model of care as described in section 4. The CCG Collaborative Commissioning Board CCB supported the high level model and the

direction of travel within the CSR work, and gave approval to further work up the new model of home based support, including a more detailed assessment of the cost implications of implementation.

4. Summary of the proposed new model of Community Health Services

4.1 The future LLR model of community health service delivered in people's homes can be broadly described as being composed of the following three services:

Neighbourhood community nursing and therapy services, aligned to Primary Care Networks, which will offer planned nursing and therapy and same day community nursing, working closely with primary care and social care as part of integrated teams.

Home First services – enhanced 'step up and step down' services offering intensive nursing and therapy as part of an integrated team offer with social care reablement and crisis response. Home First services will typically see people who need a more intensive, short term level of care and intervention to avoid admission or to provide support after a period of hospital stay.

Locality Decision units: access points into multi-disciplinary triage, assessment, care planning and treatment for Home First services in each local authority area. The Locality Decision Units (LDU) will determine whether a person can be safely and well supported at home or whether they need to be admitted to a re-ablement bed or community hospital bed, and if so, will arrange this admission or a package of care to be delivered by Home First. LDUs will work as the interface between hospital staff, GPs or other health professionals referring into Home First. They will work closely with hospital discharge processes on a 'push/pull' basis, proactively arranging the support required on step down from hospital.

The new community health service structure is shown below:

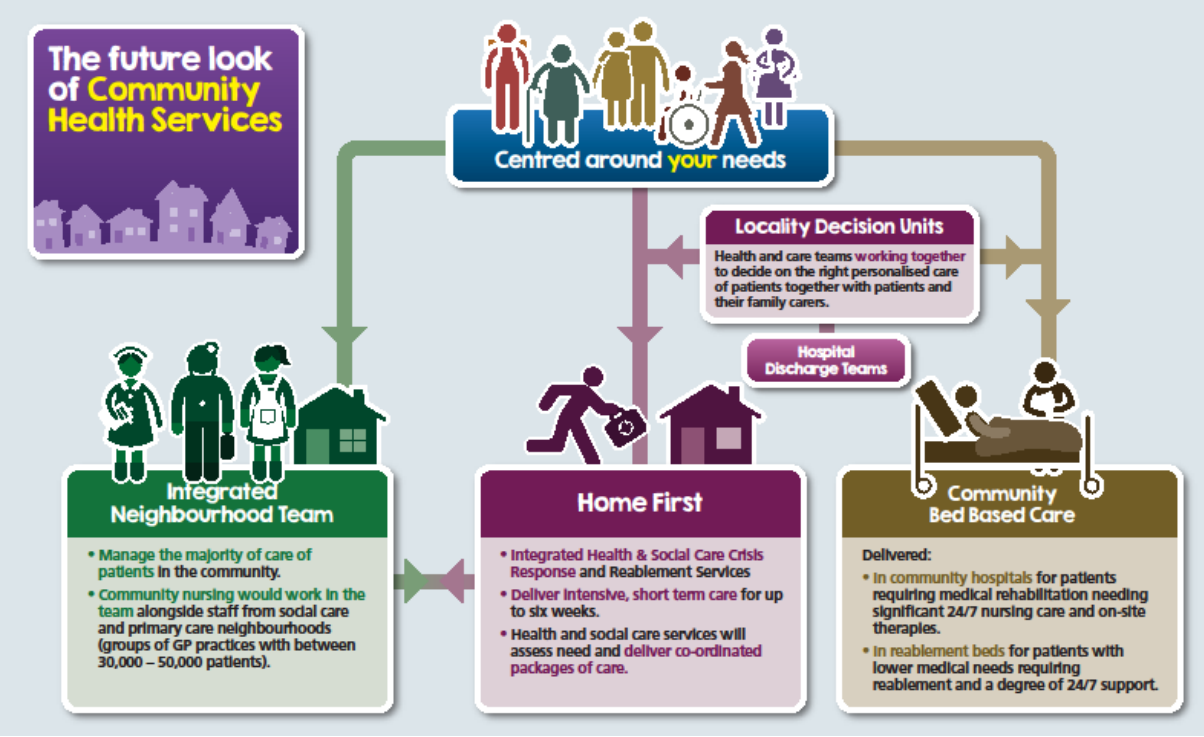

Figure 1: The redesigned Community Health Services Model

These new services will replace the current community and district nursing teams, therapy teams and the Intensive Community Support Service (ICS). The capacity and staff in existing teams will be reorganized into the new team structures and there will be no loss of service offer/function in the new model. ICS will no longer be commissioned in its current form as a stand-alone service. Instead, an urgent same day response will be provided by the core community teams, with Home First providing more intensive care for those who need it.

The specification for the new services to be provided by Leicestershire Partnership Trust was approved by the three CCGs in their July meetings.

4.2 Medical Support to Home First

In addition to the changes to the LPT service, an intrinsic element of the CSR model is the provision of consistent and responsive medical support to patients on the Home First caseload, who may have additional medical needs which must be appropriately managed in order for them to be supported to remain at home. Reviews of the ICS service showed that without this level of medical support, acute discharge teams were reluctant to discharge people straight to their own home, as they were not confident that medical plans would be always followed through and that any unexpected change in a patient's condition would be promptly and appropriately treated.

The CSR clinical reference group considered a number of different options for enhancing medical cover for patients being managed at home, including consultant and Advanced Nurse Practitioner (ANP) models, as well as dedicated GP with special interest cover for Home First. The preferred model for delivering enhanced medical cover for Home First is for this to be provided by GP practices, as an enhancement to general medical support in primary care. A business case has been agreed by the three LLR CCGs to commission enhanced medical cover, via PCNs, for one year, to test this model of care, and £1.4m will be made available over the first year of implementation to commission the new model of support and fund additional capacity in primary care.

5. Engagement

Extensive engagement activity has been undertaken to hear the views on how a new integrated model of community care changes the experiences of staff, family carers and patients and people who use the service. This engagement has fed into the case for change and the design of the new model.

Prior to the CCGs agreeing to implement the changes above in June 2019, engagement work to support the redesign included:

- Face-to-face qualitative interviews (n. 156)
- Online qualitative survey (n.66)
- Examined 22 existing reports in line with community services from research in LLR representing 4,300 people
- Presented findings at 3 workshops to capture insights regarding travelling communities, Asian family carers of people with learning disabilities and Hinckley PPG locality group – total of 21 people

Through February and March 2019, the insights gathered were presented at six public workshops held across LLR and further insights were gathered from 169 people (patients, family carers and staff). These events were well received by the public as an opportunity to provide feedback on the new community model (figure 1), and were

attended by staff working in acute or community settings, social care staff, domiciliary care workers, GPs, care home staff, patients and family carers receiving or with an interest in community care and people working in voluntary and community organisations. Key messages from public and patients were:

- People want to stay in their own homes, but confidence in support from services in the community to manage this well is sometimes lacking
- Recognition that social care and primary care are fundamental to delivering improved community based care
- Family carers often articulate negative experiences of the support they and their loved one get.
- Family carers, care home staff and domiciliary care staff expressed the need to be more involved in decision making concerning patients.
- People want stronger links between emotional welfare and physical recovery. They place importance on therapy services that support mobility recognising that increased mobility improves their mental wellbeing.
- People want better communication between family carers, staff and internally to include: explanation and advice when required, Appropriate language and use of interpreters when required,
- Improved relationships with other health and social care teams through integrated working across teams to improve a number of concerns, including discharge; managing in a crisis and carers seeking further help when required.
    - There are some concerns over rurality and a desire to see more services delivered in local settings for local populations
    - A view that community hospital beds are a 'safe' option for sicker people
    - Scepticism that we can tackle long standing issues and make a positive change
    - LPT staff were concerned over potential loss of the specialism in ICS through the transfer of capacity into the core neighbourhood CHS model.

The intelligence gathered from the engagement work was fed into the model design, for instance the specialism in ICS will be continued into the Home First model. People's feedback on their experience of care is also being addressed in the implementation plan for the CSR, particularly in respect of ensuring that we pay attention to the way that the new services work. For instance, we are placing great emphasis on therapy and support for mobility as part of the model, and have an organisational development plan to support the new teams to build integrated ways of working to support their relationships with primary care and social care. Integrated teams are supported to build relationships and ways of working, and in the continued specialism of Home First services.

The detailed engagement reports are publicly available to view at the following link: http://www.bettercareleicester.nhs.uk/getinvolved/engagement-and-consultation/ongoing-engagement-and-consultation/community-services-redesign/.

6. Impact – benefits and risks

6.1 The benefits of the new model are:

- Increased resource in neighbourhood teams to offer a same day response to GP referrals, enabling greater continuity of care, where previously this was delivered through ICS as a separate nursing team. For example, end of life patients will benefit from a consistent community nursing team meeting all their non-specialist care

needs, which will improve communications and enhance relationships with patients and their carers.

- Greater alignment of the community health model with PCNs, with increased capacity for assessment, planning and provision of care generated through neighbourhood multi-disciplinary team and risk stratification approaches. This will support a more person-centred approach support better communications and improved relationships between staff, patients and family carers. Complex care nurses and community matrons will have the ability to offer time limited clinical case management to restore clinical stability for patients and/ or offer proactive care in response.
- An integrated access point (locality decisions unit) into an integrated health and social care Home First offer in each local authority area, offering clinical triage and packages of care and support at home as well as referral into non-acute beds. This creates a single process through which the decision about whether a person's needs can be supported at home or not will be taken.
- More rapid, more intensive therapy input as part of a Home First rehabilitation offer. Therapy contacts per patient receiving the Home First offer will increase. This will improve the service's ability to deliver genuine rehabilitation and reablement, moving closer to the national model for rehabilitation (National audit of Intermediate Care Summary report- England, 2017) and reducing risk of admission/ readmission to hospital.
- Increased numbers of patients receiving this more rapid, more intensive Home First rehabilitation offer. 44% of patients currently on the planned therapy caseload meet Home First criteria and will therefore receive a rehabilitation offer within 2 days, with increased patient contacts. Access to therapy for these patients through the Home First offer, will facilitate faster discharge from acute and community hospitals, where currently patients are held onto longer to deliver more therapy pre discharge in acknowledgement of longer community waits.
- Reduced handovers between Home First and planned therapy by fully meeting rehabilitation needs in an intensive Home First offer (compared to ICS with short length of stay in which rehabilitation goals cannot be fully met and patients are then subsequently referred onto planned therapy). This will:
    - reduce potential for patients' function to reduce following initial rehabilitation whilst on a long waiting list for planned therapy
    - reduce risk of admission/ readmission to hospital
    - reduce duplicated effort in re-assessing
    - reduce instances where patients wait for planned therapy following ICS and find at point of care delivery that initial rehabilitation goals are no longer achievable.
- Deliver 7 day therapy provision to support 7 day clinical triage in the Home First locality decisions units and 7 day Home First crisis response to prevent admissions.
- This improved offer will be achieved through increased efficiency in the therapy workforce through roll out of LPTs Community health service transformation programme increasing the average contacts per day that each professional can do
- Care delivered in the most appropriate setting of care and lower levels of ongoing care needs due to the improved home based offer. More patients supported to be discharged straight home from hospital rather than into bed based rehabilitation in community hospitals.

6.2 Disbenefits/limitations

Although the new model brings some real benefits in terms of increasing the number of patients who will get rapid 2 hour/2 day access to therapies for those patients who require a fast, intensive offer to respond to a crisis or prevent deterioration and admission to hospital, the current capacity within therapies means that we are not able

to improve waiting times for patients who have less severe needs. The contractual waiting time for planned therapies (those patients who don't meet the criteria for a Home

First response) will be a maximum of 18 weeks, although patients will be clinically prioritised within this for a more speedy response. End of Life patients will get a maximum two day response. For some patients, therefore there may be a longer wait than currently for non-urgent therapies and this is something that the CSR work will need to look at again for 2020/2021.

6.3 Anticipated impact on settings of care

The community services redesign work has been supported by modelling undertaken by Deloitte and the CCG team which looked at local and national evidence on the activity impact that developing a model of integrated home based care would have on overall demand for both community health and emergency acute care. The modelling indicates that there would be a 10.5% reduction in non-elective admissions for a cohort of frail and medical emergency patients over 5 years, compared to the 'do nothing' position, which takes account of anticipated increases in activity in each year of 2%.

The Home First service is expected to have the impact of increasing services' ability to keep people at home through periods of crisis or deterioration as well as to increase the numbers of patients who can step down from an acute ward direct to their own home. Modelling shows 720 more patients a year being discharged directly home in 2 years' time.

In addition to the above the CSR modelling, supported by previous audits of bed utilisation, shows a shift in the use of community reablement beds, and an additional 661 patients a year being discharged into reablement 'Pathway 3' beds in care home settings rather than the current community hospital inpatient beds. A period of reablement in a residential home can provide an important bridge between hospital and home and is a more homely setting which can help people regain some of their independence before returning home after a period of illness.

If the new home based model is successful in having this impact there will be a reduction in the occupancy of community hospital inpatient beds, potentially of up to 50%. Commissioners will therefore need to review the clinical model and number of beds provided from the current community hospital wards and make proposals for any changes required. This is discussed further in section 9.

7. Implementation

The CSR proposals have the following implications in terms of changes to services:

i) A reorganisation of existing community teams in 2019/2020 to create strengthened community nursing and therapy as part of an Integrated Neighbourhood Team, and an integrated Home First crisis response and reablement service

ii) Additional medical capacity to enable the new community teams to deliver the model of care well, and support people at home. This will be commissioned through Primary Care Networks

iii) Increases in capacity in the new model from year 2 onwards to support a step change in the number of patients being managed at home or in Pathway three, with an expectation that there will be a resultant reduction or changes in use of community hospital beds.

The new model of care will be introduced in 2019/2020 with i and ii becoming operational from December 2019. In 2019/2020, the current LPT community teams will be restructured. In 2020/2021 additional funding will be required to support an expansion of capacity in community services to manage increased activity to improve patient outcomes, deliver the anticipated response times and support increased numbers of patients being cared for at home or in a care home setting. The CCGs have approved this investment in principle, and a more detailed business case for 2020/2021 investment will be prepared for the 2020/2021 planning round, informed by the learning from the implementation of the new model in Q3.

Figure 2: LPT Operational Delivery Model 19/20

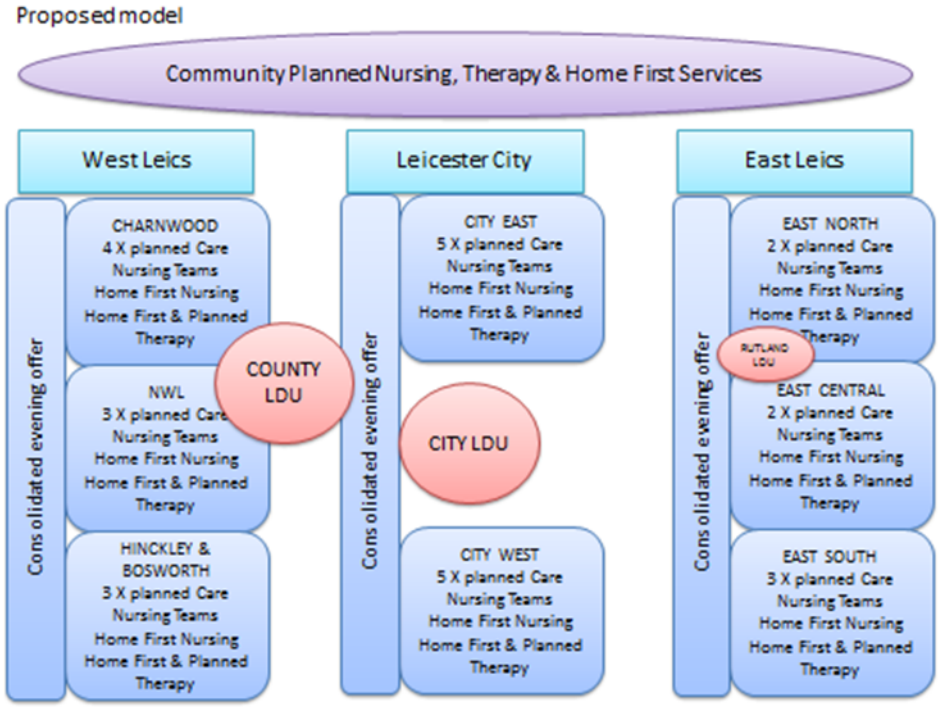

Table 1: Implementation timetable 2019/2020

Action	Timeline
Community nursing, therapy and Home First	
New specification agreed by CCGs and written into LPT contract	July 2019
Testing of new models of care prior to full workforce change • Piloting integrated locality decisions units in county and city for step down referrals (with extension to offer LDU approach with Rutland) • Piloting 'on the ground' integration in Home First offer • Piloting new ways of working in integrated neighbourhood teams	April – Dec 2019
Staff engagement and organisational development, including UHL and primary care networks	March – Dec 2019
LPT workforce change process and staff consultation	July – Oct 2019
Reconfiguration of existing staff to new team structures	Oct – Dec
Staff operational in new teams and CSR model operational	1st Dec 2019
Medical Model	
Commence medical model implementation i.e. recruitment	October 2019

Commencement of medical model	Dec 2019
Interim review of medical model	March 2020

8. Risks

There are a number of key risks to effective delivery of the model in 2019/20;

- The CSR requires significant system change, including primary care, social care and acute staff as well as teams employed by LPT. Managing the transition to a new way of working is a cultural and operational challenge. A Community Transformation Group has been set up with the involvement of all relevant system partners to oversee the change. Support and staff time will be required from partners to ensure effective delivery.
- Workforce - Any organisational change programme creates risks for staff morale and retention. LPT currently have significant challenges with high vacancy rates in parts of Leicester city. These issues are being actively monitored through the Clinical Quality Review Group for the contract. LPT also employ a range of operational approaches (different hubs taking on a caseload, staff physically moving temporarily, clinics picked up by other teams) to manage these issues ensuring no one area is left with less staff than another. The system transformation group is also overseeing a workforce sub group to ensure robust organisational development, staff communication and workforce development plans across LPT and other affected providers.
- There is no additional capacity in LPT to deliver this in 2019/20, either in terms of investment in frontline staffing to support a transitional period or additional change management resource to deliver the change. This may constrain their ability to fully deliver all aspects of the model in the first year. Commissioners will work closely with LPT to understand the demand and capacity requirements to fulfil our vision for community services, and this will support planning for capacity requirements in 2020/2021 and future years.
- Acute discharge processes may not change sufficiently to deliver the anticipated increase in the numbers of patients supported by Home First. Consultant support to GPs in agreeing discharge medical management plans and the ongoing management of cared for in Home First will also be required. This significant cultural change will be underpinned by an organisational development and communication approach, although this requires changes to ways of working for a significant body of staff and will take time to deliver an impact.
- The medical model commissioned from PCNs will need to operate consistently and effectively in every part of LLR if we are to be able to deliver the high quality, responsive care offer that we plan to do. Ensuring that the primary care offer is commissioned and delivered to the expected level will be a challenge. The CSR team is working with CCG primary care commissioning colleagues and PCN Accountable clinical directors to mitigate this risk.
- Integrated therapy is a key part of the new model. Going beyond the changes in this proposal, there is potential for redesign of the whole therapy model including the acute therapy model and more joint funded posts in community settings. The CSR team has recently seconded a lead with a therapy background to accelerate this work and develop proposals for more integrated pathways. Integrated therapy will also be addressed through the functional mapping work and identification of joint roles between health and social care, along with potential shift of acute therapy roles into community settings.
- Equipment services –It is anticipated that increased responsiveness of services and a shift to manage more patients at home could create greater demand on these services. Where the equipment provider is unable to respond to increased demand this risks potential readmissions. The impact for 19/20 is expected to be small due to

small increases in patients managed at home. Plans are in place to monitor the 19/20 impact to inform the future re-procurement of community equipment services across health and social care, which is being led by the Equipment Management Board.

9. Further work and next steps

9.1 **Implementation of the 2019/2020 changes** has already begun, overseen by the Community Transformation Group. Work is underway to pilot Locality Decision Units in City and County. In the first instance Rutland integrated team will link to the County decision unit for reasons of scale. LPT have begun engaging with staff on new ways of working and transition to new team structures. Implementation will feed into the Community Transformation Group.

9.2 **Phase 2 of the CSR** will include looking at the impact of home based community care on the use of community inpatient beds and Pathway 3 beds. As described in section 6 the modelling undertaken so far indicates that there will be shifts in the number and type of beds required for LLR patients as a result of the community model changes. CCGs will begin to develop options for the community bed model, with the expectation that these will support the production of a Pre-Consultation Business Case (PCBC) It is planned to establish a Pre Consultation Business Case, with input from Healthwatch and system partners including UHL, to oversee this work. This group will also use the insights from patients, family carers and staff to help shape future proposals.

9.3 **Engagement** - In developing the next phase of proposals for community health services, the CCGs will continue to engage with local people, and stakeholder groups. We plan further engagement starting in September to discuss the progress on phase 1 of the work, and also explain our next steps towards proposals for the community bed model. We will involve local people in helping to set the criteria for assessing and choosing between different options for the future provision of community care, which will be used to generate a short list of options for CCG consideration and potential future consultation.