# **BETTER CARE TOGETHER**

A Blueprint for Health and Social Care in Leicester,
Leicestershire and Rutland 2014-2019

For discussion and review

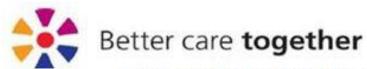












#### Introduction

Better Care Together is the biggest ever review of health and social care in Leicester, Leicestershire and Rutland (LLR).

The programme is a partnership of NHS organisations and local authorities across the area. It is driven by a shared recognition that major changes are needed to ensure that services are of the right quality and capable of meeting the future needs of local communities.

The aim is to improve services and people's experience of them by focussing on community-based prevention and care – while at the same time addressing major financial challenges.

The partners in Better Care Together are:

- Leicester City Clinical Commissioning Group (CCG)
- o Leicester City Council
- o West Leicestershire CCG
- o Leicestershire County Council
- East Leicestershire and Rutland CCG
- o Rutland County Council
- University Hospitals of Leicester
- o Leicestershire Partnership Trust
- o NHS England Local Area Team
- Healthwatch (across LLR)
- Health and Wellbeing Boards for Leicester City, Leicestershire and Rutland



Doctors, managers and a wide range of other professionals have worked over several months, with input from patients, public and voluntary groups, to produce a single strategy to deliver the shared vision of all these organisations. This work is supported by some key principles which are summarised here:

- We will work together
- We will involve local people in our decision-making
- We will address inequality between mental and physical health services
- We will make improvements by striving to be the best
- We will be rigorous in ensuring value for money

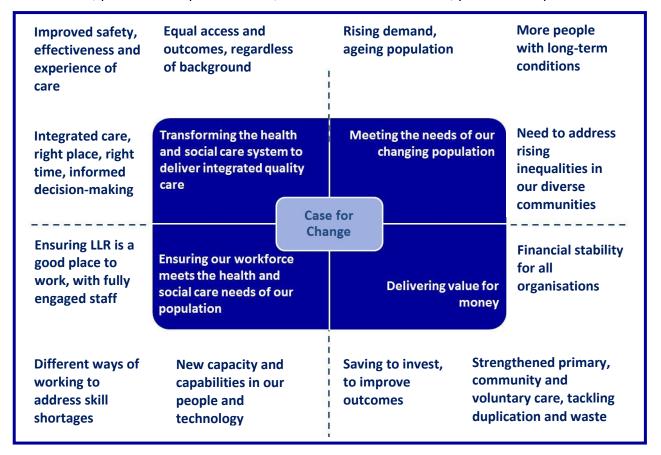
The result is a five-year plan, setting out ideas for how care could be delivered in future. This document is a summary of that plan. The full version, which includes a lot more detail, can be found alongside other information at <a href="https://www.bettercareleicester.nhs.uk">www.bettercareleicester.nhs.uk</a>.

The following pages outline the main points of the plan, which is very much work in progress. While there are proposals and aspirations, no final decisions have yet been taken. Local people are being invited to give their views, which will help to shape detailed options for change (see page 11 for more information).

## The case for change

There are compelling reasons why health and social care in Leicester, Leicestershire and Rutland needs to change. Dealing with current pressures creates opportunities to improve care by redesigning a system around the future needs of patients, in a sustainable way.

The case for change is summarised in the diagram below. It has been developed by senior clinicians, public health professionals, social care service leaders, patients and public.



- Changing population: The LLR population is ageing (12% more over 65s by 2019). This means more long term, complex illness and disability increasing demand for health and social care. There is also inequality, with deprived communities experiencing more illness and shorter lives than those in more affluent areas.
- Workforce: Skilled professionals are in short supply, particularly in some specialties.
   Ways of working are also quite inflexible. Staff will need to work differently, in mixed teams that treat the 'whole person' rather than just one condition at a time.
- Quality: Services need to achieve the highest possible standards and be more joined up, to provide excellent results and experience for the people using them.
- Value for money: We need to do more with less. The LLR health and social care economy is deemed to be 'financially challenged', with particular pressure in Leicester's hospitals. If no action is taken, by 2019 the funding gap for the NHS locally will be around £400m.

For all these reasons, the way services are currently delivered is neither sustainable nor equipped to meet the future needs of local people. This is why things must change.

## How this plan was produced

Work began on this plan in January 2014. A dedicated Better Care Together team was established, supporting staff from across the partner organisations and overseen by a Programme Board. Key features of the work are listed here.

#### **Benchmarking**

Assessing the performance of existing services and looking at what is being done in other parts of the country to see what can be improved locally.

#### **Understanding**

Using all available information to inform plans, including understanding the health needs of the local population and using evidence about what works well.

#### **Public involvement**

Seeking input from patients, public and voluntary organisations — both at larger events and in small working groups.



#### **Supporting projects**

Developing plans to support successful change, covering areas such as primary care, workforce, information technology and property (see page 10).



#### Alignment

Ensuring this plan is pulling in the same direction as others – including Better Care Funds (a different scheme with a similar name), where local NHS and council budgets are being pooled to provide joined-up support services for older people to prevent the need for emergency care

#### **Financial analysis**

Identifying the precise scale of the financial challenge, then working out what savings can be achieved through inhouse efficiencies and what requires bigger changes across the whole system.

#### Pathway redesign

Identifying opportunities to improve services by reshaping how they are actually delivered for specific areas of healthcare (see pages 6-9).

## **Transforming services**

Better Care Together aims to make improvements right across the different settings of care, as described here.

#### Self-care, education and prevention

Giving everyone a good start in life, helping them to live well and make good choices, and supporting their wellbeing and independence as they get older.

#### **Primary care**

Improving access, reducing unjustified variation in the quality of services and working at scale to meet all needs.

#### **Community and social care**

Putting people and their carers in control, as close to home as possible and with health and social care services working together.

#### **Urgent care**

Delivered closer to home where that is clinically and financially viable, with a simpler system and fewer admissions to hospital.

#### **Acute services**

Smaller, more specialised hospitals for people who are only admitted when they really need to be, stay for less time and have well-supported transfers back to the community.



#### This approach can be summarised as follows:

#### **PREVENTION**

Information and support for independence

#### **INTERVENTION**

Acting early to avoid a crisis

#### **ACUTE CARE**

Rapid treatment when truly needed

#### **RECOVERY**

Minimum hospital stay, smooth discharge

#### **FOLLOW-UP**

Support at home to restore independence

We have ambitions for transforming eight different areas of care (known as pathways). These are explained on the next four pages.

#### **Urgent Care** (Accident and Emergency)

#### Our existing service

- Difficulty achieving national standards – we need to make sure we deliver to our 4 hour targets
- Setting is crowded and uncomfortable – we need to improve the urgent care environment
- Complex and different depending on where you live in LLR – where is it best for me to go when I'm ill
- Lack of connection in community services – we need to deliver joined up services

#### What are we going to do?

Help people to choose right and look after themselves when appropriate

Support more patients to be seen and treated by the ambulance service

Targeting support to those who need it through case management

Develop more services to support people at home or in the community

Make urgent care services across LLR consistent

Support A&E to be as effective as possible

Next five years

#### Our outcomes in 5 years

- More people being treated in the right place
- · Better patient experience
- Simpler system for people to understand
- Reduction in admissions for chronic diseases
- · Less time spent in hospital
- National targets being met with 4 hour targets consistently met

## **Frail and Older People**

#### Our existing service

- Too many older people end up in hospital for too long – we need to support care to be delivered elsewhere
- Not enough services that are joined up to support physical and mental health and wellbeing needs – we need to deliver integrated pathways
- Too many people end up in services such as residential care instead of going back home with the right changes made to that home to make it a safe environment—we need to support people to be independent

#### What are we going to do?

Develop programmes to support people to participate in society – healthy and active for longer

Build systems to predict those most at risk of urgent care so they can be supported beforehand

Develop care plans together to improve health outcomes to the best they can be

Increase support for older people who fall

Intervene appropriately and in a timely manner when older people are unwell

Increase ambulance service support for older people who fall

Support people to leave hospital as soon as they are medically fit

Next five years

- Improve independence and wellbeing
- More older people with agreed and managed care plans
- Fewer older people going into hospital
- Reduced delayed discharged and length of stay
- Reduce readmission
- Ensure increased dignity
- Increase the number of people who die in a place of their own choosing

### Long Term Conditions (eg diabetes, respiratory disease, heart failure)

#### Our existing service

- High level of health inequalities leading to different outcomes for people with long term conditions (LTC) – we need to improve outcomes across LLR
- Low detection rate for LTCs and some cancers we need to work to increase screening and prevention
- Too many people being admitted for conditions that could be treated outside of hospital – we need to improve ambulatory care

#### What are we going to do?

Increase self-care and screening for LTCs

Work with patients and primary care to increase education

Build systems to predict those most at risk of requiring urgent care so they can be supported beforehand

Develop care planstogether to improve health outcomes to the best they can be

Develop telehealth, coaching and telecare services

Intervene in line with care plans in a timely manner in the setting people have chosen when they are unwell

Ensure that medical outreach and rehabilitation are available when required

Be clear when people move into the palliative phase of their disease and care plan for that circumstance

Next five year

#### Our outcomes in 5 years

- More people reporting higher personal resilience and support for self management
- More people with LTCs supported by telehealth and telecare services
- Reduce dependency on access to care in acute settings if you have a LTC
- An increased number of care plans in place and people on disease registers
- Reduced length of stay on inpatient spells for LTCs
- Reduced number of admission and readmission associated with LTCs

#### Planned Care (non-urgent operations)

#### Our existing service

- Opportunities to improve efficiency for example through delivering a higher number of procedures as day cases – we need to ensure national standards for productivity are met
- Waiting times under increasing pressure – we need to make sure the system is delivering to required performance standards

#### What are we going to do?

Improve patient and clinicians knowledge to support timely referrals

Increase the number of procedures undertaken in a day

Concentrate activity at scale in the right location

Ensure efficient use of existing resources for example through theatre productivity

Reduce clinically unnecessary follow-ups

Next five years

- Increased day surgery / 23 hour rates and reduced inpatient surgery rates
- Shortened length of stay for people requiring elective surgery
- Consistent application of elective care protocols
- Fewer number of clinically unnecessary follow-ups
- Lower hospital acquired infection rates
- National standards consistently met for referral to treatment

#### Maternity and NeoNates (care of newborn and young babies)

#### Our existing service

- 1. Two obstetric-led units supported by different clinical services delivering over 10,500 births a year. When reviewed in 2010 by the National Clinical Advisory Team was suggested that this was only clinical sustainability on a temporary basis we need to review what a sustainable service will be
- Low number of home births – we need to support this choice
- Some communities access antenatal services too late - we need to support early contact

#### What are we going to do?

Review options and consult on future shape of maternity services

Review options and consult on future shape of services to support newborns

Increase the number of home births

Increase take-up in the first 12 weeks of antenatal services by hard to reach groups

Next five years

#### Our outcomes in 5 years

- A sustainable long term model for maternity and neonatology services that complies with national standards
- Increased home births by 50%
- Improve uptake of antenatal and parenting support, particularly in hard to reach groups
- Better perinatal outcomes in LLR

## **Children, Young People and Families**

#### Our existing service

- Existing services are fragmented for children and young people – we need to coordinate care better
- Good informal working relationships between parts of the system although differing views on what good looks like - we need a consistent integrated approach
- Variability intransition services – we will ensure smoother transition to adult services
- Lack of focus on supporting independencechildren & young people supported to self-care

#### What are we going to do?

Review what Children and Adolescent Mental Health Services (CAMHS) capacity is required

Develop options to facilitate greater integrated working between all sectors

Establish age range that that review will cover

Develop a strategy around optimising children's life chances through public health interventions – Health and Wellbeing

Next five years

- Improved health and wellbeing for children, supported into adulthood
- Improved life expectancy throughout their lives for children we support
- Integrated working across secondary, primary and community to reduce duplication of structures and maximise productivity
- Age appropriate services across LLR
- More children and young people who have coordinated care

#### **Mental Health**

#### Our existing service

- Wellbeing inequalities and low life expectancy – we need to support parity of esteem
- Mismatch between service need and location – we need to align services across LLR
- Waits for some services are too long – we need to ensure people receive timely care
- Focus on treatment we need to increase prevention services
- Not enough crisis
   resolution and outreach
   including drug and alcohol
   we need to expand care

#### What are we going to do?

Develop peer support model for early interventions

Develop case management capability in all sectors to maintain relationships for people at times of crisis

Develop solutions with education to reduce reliance on Children and Adolescent Mental Health Services

Review what CAMHS capacity is required

Develop locality based teams to manage care close to home

Develop community 'safe spaces' and increase mental health first aid training

Ensure services are equipped to deal with physical and mental health needs – parity of esteem

Crisis response service that responds in a timely way to support recovery

#### Our outcomes in 5 years

- Increase in parity of esteem
- Reduce incidence of mental health conditions
- Reduced crisis escalation episodes, with quicker response times when required
- Reduced delays in discharge and lengths of stay
- Integrated pathways and case management for people
- Reduced reliance on acute services

## **Learning Disabilities**

#### Our existing service

- High use of specialist services and underdeveloped offer from universal and preventative services
- Too many people accessing long-term acute or intensive support services because of underdeveloped crisis response, step up and step down services
- Carer support and short breaks are inconsistent and not sufficiently integrated
- Poorly developed market leading to over-priced package provision – we need to work together to manage and develop the learning disabilities market

#### What are we going to do?

Joint market management and development

Develop integrated personal budgets to match support better to needs

More consistent whole life approach across children and adult services

Better support for universal and primary care services

Develop more integrated pathways and short breaks provision

## Next five years

- The potential of individuals to lead independent and fulfilling lives is recognised as the norm
- Tailored services to peoples' needs using appropriate commissioning
- Equitable access to mainstream services
- Reduce spend per head, by matching support setting to individual needs
- Good quality service provision is available in LLR at the right place and time

## **Buildings**

There are 148 NHS properties across Leicester, Leicestershire and Rutland, costing more than £80m a year to run. The proposed changes described on the previous pages would significantly affect the way some of these facilities are used, to reflect the greater focus on care closer to home.

#### **Acute Hospitals**

LLR has three acute hospitals – Leicester Royal Infirmary, Leicester General and Glenfield, also in Leicester. All are run by the University Hospitals of Leicester NHS Trust (UHL).







The Better Care Together plan is designed to ensure that people are only admitted to hospital when they really need to be. This means there will be fewer patients for UHL to treat and the hospitals will have to adapt. Possible changes include:

- Smaller hospitals overall, as a result of shifting a substantial amount of the workload and equivalent resource and expertise to the community.
- Fewer acute hospital beds largely by shortening the length of time patients stay in hospital and doing more day surgery.
- o A greater focus on specialised care, teaching and research.
- Redeveloping the Accident and Emergency department at the Royal Infirmary.
- o Concentrating acute services on two sites rather than three. There are various ways this could be done, but it most likely to involve the Infirmary and Glenfield Hospital.
- A re-shaped General Hospital if this change happens, with a wide range of services including – community beds, the Diabetes Centre of Excellence, rehabilitation, psychological therapies, outpatient clinics and a base for the ambulance service.

This vision is supported by doctors because it would benefit patients, by increasing both the quality and efficiency of services. It would take several years to implement and could be achieved in a number of different ways. At this stage, no firm decisions have been made.

#### **Community Hospitals**

There are ten community hospitals in Leicestershire and Rutland – in Ashby, Coalville, Hinckley, Loughborough, Lutterworth, two in Market Harborough, two in Melton Mowbray and Oakham. Some are owned by NHS Property Services, some by the Leicestershire Partnership NHS Trust (LPT), which provides local community and mental health services.

The greater emphasis on supporting people at home will mean an expansion of teams in the community, rather than in beds or buildings. Work to ensure more effective use of these facilities is ongoing and a decision was recently taken to close Ashby Community Hospital. Any further options for change will be developed in consultation with the public.

#### **Next Steps**

Health and social care services in Leicester, Leicestershire and Rutland are on a journey. This has only just begun and local people have a major part to play in deciding precisely which course is taken.

There are three distinct phases to Better Care Together:

- 1. Developing this plan, which examines the challenges being faced and shows a direction of travel rather than firm proposals.
- 2. Further discussion and review during the summer, leading to the development of more detailed options for change by the end of September 2014.
  - This discussion includes the people of Leicester, Leicestershire and Rutland. Healthwatch organisations, patients and members of the public will continue to be involved in the work of Better Care Together. However, we also want to hear your views about this plan. See below for further details.
- 3. The final phase will be about starting to implement plans, once they have been prepared in more detail. There will be formal consultation with the public before any significant changes are made. When this happens is still to be determined.

If you want to express an opinion, ask a question or get involved in the detailed design of services, email: <a href="mailto:bct@eastleicestershireandrutlandccg.nhs.uk">bct@eastleicestershireandrutlandccg.nhs.uk</a>.

You can also send an email via the Better Care Together website at:

## www.bettercareleicester.nhs.uk

On this website you will also find the full Better Care Together plan and supporting information — including answers to questions you may have.











## Better care together

A partnership of Leicester, Leicestershire & Rutland Health and Social Care