



# Better care together

Leicester, Leicestershire & Rutland health and social care

A five year plan for Health and Care across Leicester,  
Leicestershire and Rutland  
2014-2019

**Update – January 2015**

**Leicester City Health and Wellbeing Board**

More information at:

[www.bettercareleicester.nhs.uk](http://www.bettercareleicester.nhs.uk)





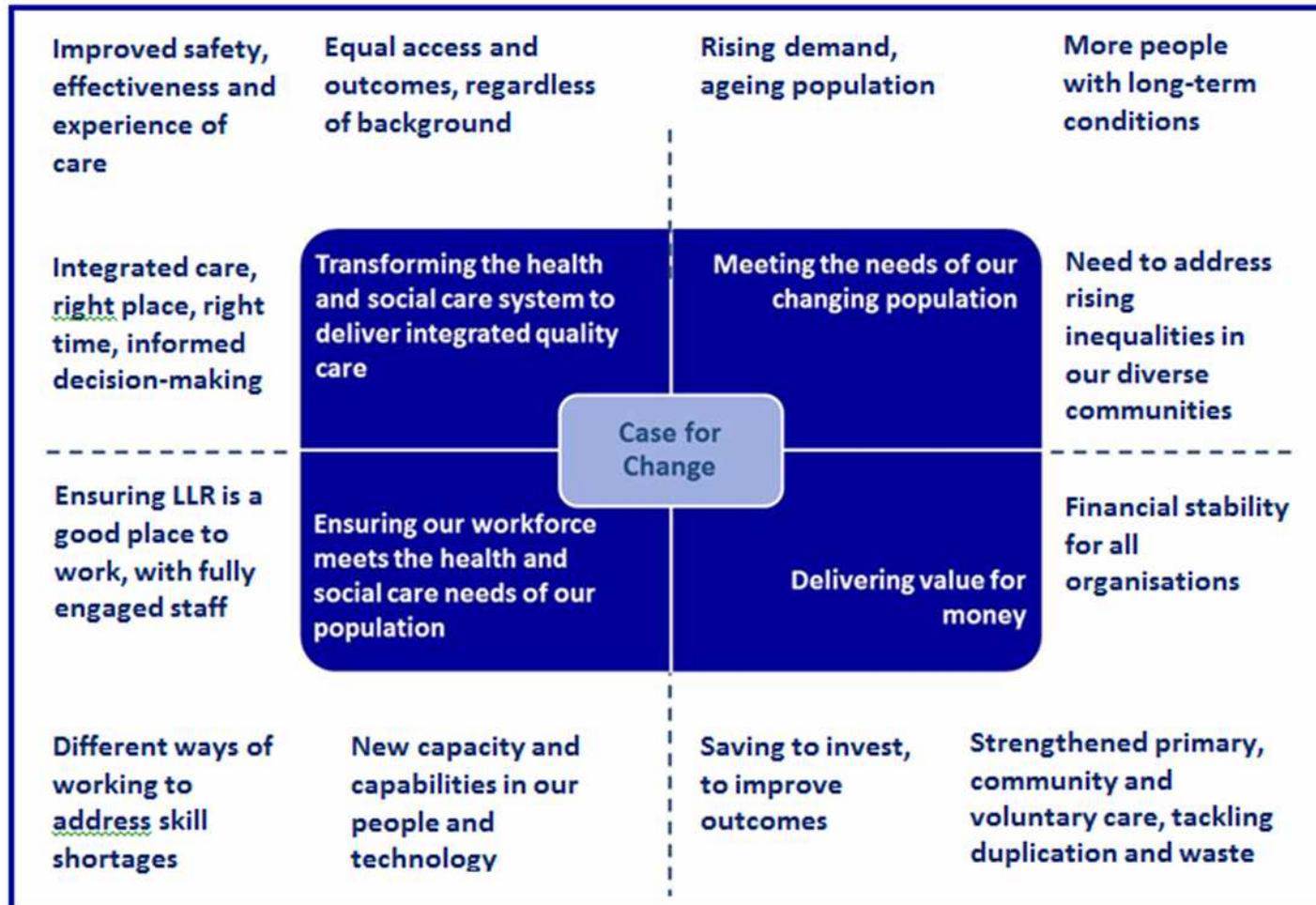
## Vision 'NHS and Social Care service that supports you and your community through every stage of life'

- Meeting the clinical and social care case for service change for Leicester, Leicestershire and Rutland
- Closing a potential health financial gap of £400m
- Addressing historic local issues ie meeting the differing needs of our communities
- Working in partnership across the health and social care system
- Moving at sufficient pace ie translating plans into delivery and implementation

**We have a draft plan. We have increased confidence in delivery. We are addressing known risks to the quality of our plan and to our ability to deliver**



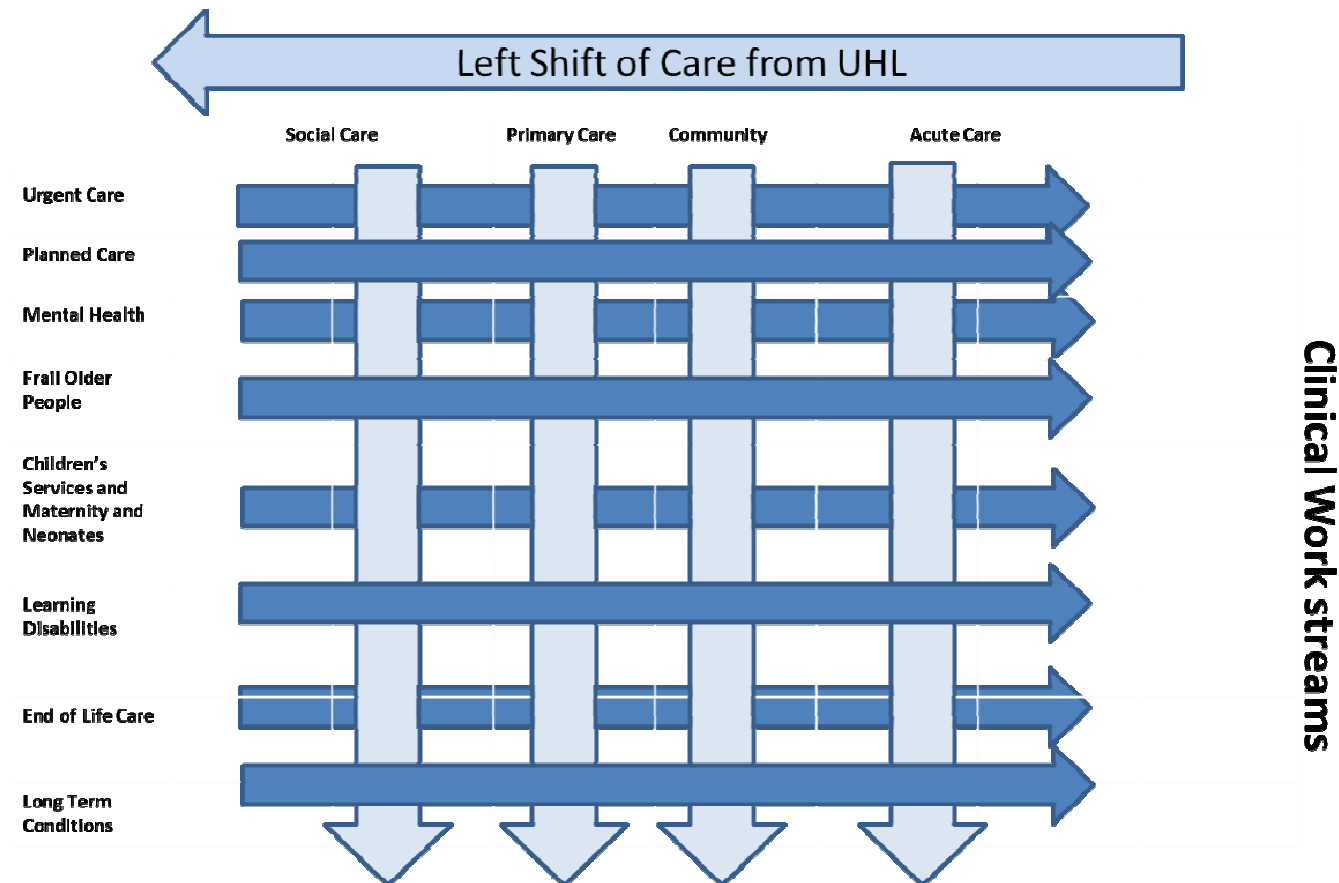
# A vision and plan built around the clinical and social care case for change





# A framework for developing our service change

The Better Care Together Programme sets out plans for eight clinical work streams, and within four different care settings





# Developed into proposed Clinical pathway work streams

Each of eight clinical pathway work streams has worked to the same format of describing our existing service, the interventions we intend to make and the resulting outcomes.

## URGENT CARE (ACCIDENT AND EMERGENCY)

Our existing service	What are we going to do	Our outcomes in 5 Years
<p>Difficulty achieving <b>national standards</b> - <i>we need to make sure we deliver to our 4 hour targets</i></p> <p>Setting is <b>crowded</b> and uncomfortable - <i>we need to improve the urgent care environment</i></p> <p>Complex and <b>different</b> depending on where you live in LLR - <i>where is it best for me to go when I'm ill</i></p> <p>Lack of <b>connection</b> in community services - <i>we need to deliver joined up services</i></p>	<p>Help people to choose right and look after themselves when appropriate</p> <p>Support more patients to be seen and treated by the ambulance service</p> <p>Targeting support to those who need it through cases management</p> <p>Develop more services to support people at home or in the community</p> <p>Make urgent care services across LLR consistent</p> <p>Support A&amp;E to be as effective as possible</p> <p style="text-align: center;">Next 5 years -----&gt;</p>	<p>More people being treated in the <b>right place</b></p> <p>Better <b>patient experience</b></p> <p><b>Simpler system</b> for people to understand</p> <p>Reduction in <b>admissions</b> for chronic diseases</p> <p><b>Less time</b> spent in hospital</p> <p><b>National targets</b> being met with 4 hours targets consistently met</p>



# That are built on best practice and have the patient at the centre

The urgent care, frail older people and long-term conditions work streams used the Kings Funds' Ten Components of Care to frame service transformation

## Urgent care example...



1 Age well and stay well	2 Live well with one or more long term conditions	3 Support for complex co-morbidities / frailty	4 Accessible, effective support in crisis	5 High quality, person centred acute care
FOP LTC	FOP LTC	FOP	FOP LTC UC	UC
6 Good discharge planning and post discharge support	7 Effective rehabilitation and reablement	8 Person centred, dignified, long term care	9 Support, control and choice at end of life	10 Integrated services to provide person centre care
FOP	FOP LTC	FOP	FOP LTC	FOP LTC UC



## In summary what have we achieved so far?

First Phase- 'Developing the Plan' through to 'Discussion and Review'

Through the support of Leicester, Leicestershire and Rutland (LLR) NHS and Social care partners, clinical and patient representatives

1. The engagement of clinicians, patient and voluntary representative groups in developing the proposals
2. A BCT five year strategic plan approved by all Health and Local Authority organisations which describes our shared plans to reform health and social care services across LLR;
3. A strategic outline case (SOC), published in December 2014, which sets out the financial case for the BCT programme as being the preferred way forward to deliver the plans set out in the five year strategic plan.
4. A BCT Partnership Board and Clinical Leadership Group with supporting programs representing Health and Social care partners, public and patient representative groups
5. External reviews supporting the approach ie Health and Wellbeing Boards, Clinical Senate, NHS England, Trust Development Authority, Office of Government Commerce
6. Delivering early service reconfiguration patient benefits and financial savings





# A recent patient story by introducing the Crisis Response team for 2014/16 – Frail Older People work stream.

Two scenario's of a 78 year calling 999 with back pain, feverish and lethargic. Here is his pathway before and after the revised pathway

## Usual patient pathway:



EMAS responds within 30 mins



Transport patient to hospital



Patient in ED for 4 hours

## What actually happened via the revised pathway:



999 call at 6.45pm. CRT GP responds within 20 mins



Assessed and treated at home. Referred to Urgent Care Triage for holistic assessment



Unscheduled Care Team responded within 2 hours, provided 72 hours of care



Patient discharged from care with full independence. GP informed.



# A patient story under development through the Planned Care work stream 2015/16

**Patient present at GP/ Optometrist with problem with their eye**

**Usual patient pathway:**



**GP refers patients to eyes specialist out patient unit in UHL**



**Patient waits weeks for appointment to see eye specialist**



**Patient attends A&E as an emergency.**

**What actually happened via the revised pathway:**



**Optometrist/GP attends PEARS Scheme to gain accreditation to treat patient.**



**Optometrist/GP delivers treatment to patient.**

**Patient discharged!!**



**Optometrist/GP attends course every 3 years for on going accreditation**



**Reductions of A&E attendances by 2000 per year!!**



# A proposed patient story for Long Term Conditions work stream 2016/17.

## Usual patient pathway:

### Story one: Patient presents at hospital with Breathing Problems



- Patient admitted into hospital for specialist review
- Specialist advise patient on a course of self management treatment for COPD condition
- Patient leaves hospital after 10 days

## What actually happened via the revised pathway:

### Story two: Patient attends GP surgery and is risk assessed



- GP advises patient to attend an out patient clinic to complete self management course.
- Specialist Respiratory nurse advises on a structured approach to self management
- Patients confident raised. Now has more skills to deal with management of condition
- Patient has better quality of life !! & Less A&E admissions .





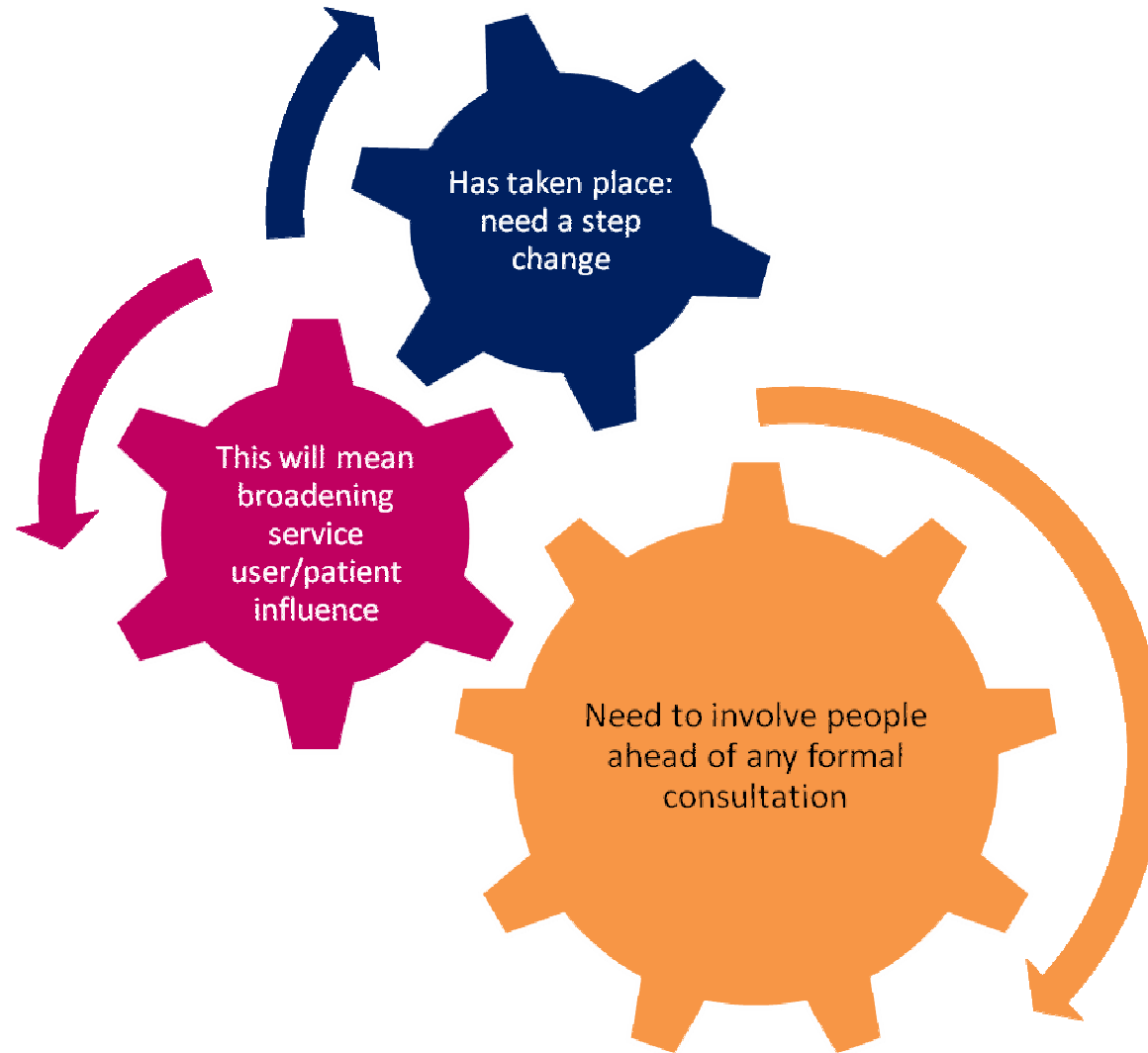
## Service Reconfiguration – Implementation phase being initiated

### **Supporting work underway**

- Social care -integration/alignment of services scoping started
- Primary care- Review of service proposals being approved
- Improving Quality of Care- End of Life Care, Learning Lessons programs being established
- Workforce - New Roles, Recruitment and Cultural change programs commenced
- Quality and Risk assurance- Ongoing external reviews ie Safeguarding Boards, Clinical Senate, OGC
- Voluntary Sector – Joint Engagement event planned April 2015



## Engagement so far





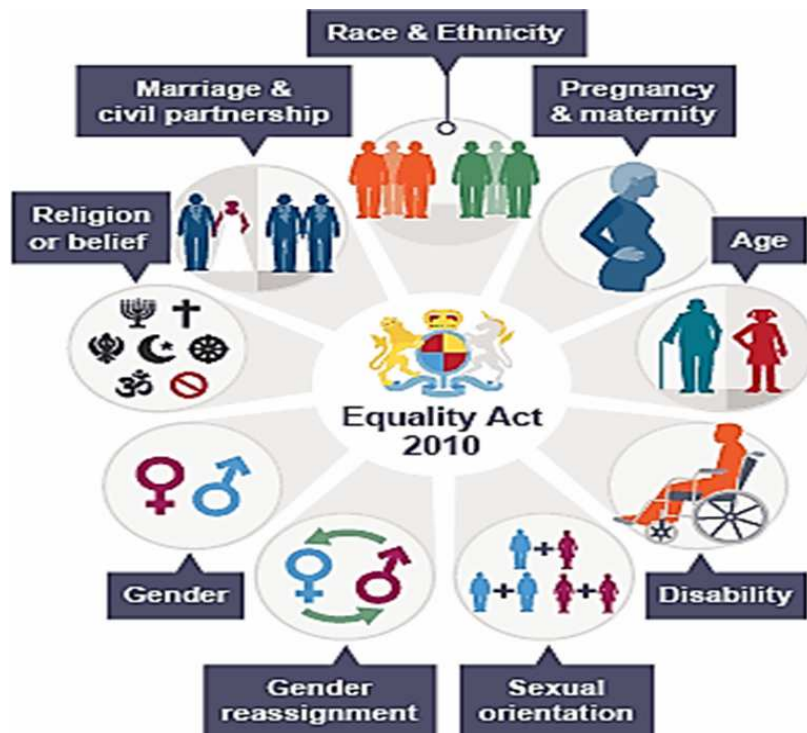
# Patient and Public Involvement and Communication and Engagement Workshop: feedback informing next phase







Wider awareness raising being planned with health watch groups Feb/March 2015







# New public led creative designs narrative being launched February 2015



Know your history to help anticipate and plan for your health needs



Help support people and their loved ones when life comes to an end.



Are there when it matters most and especially in a crisis



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



Help people stay well in mind and body throughout their life



Care for the most vulnerable and the most frail citizens

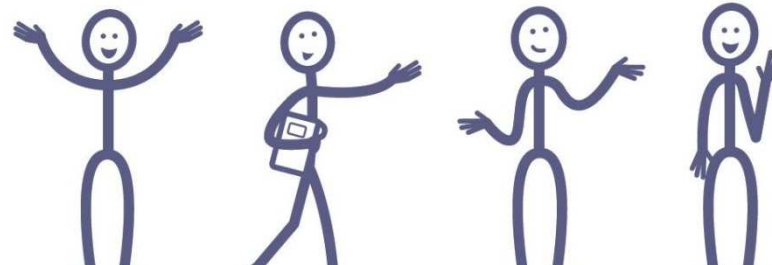
CHARACTER FACIAL EXPRESSIONS



CHARACTER DIALOGUE WINDOW



CHARACTER POSES EXAMPLES



**In development**



## Consultation process plan under development – February to May 2015

- Work stream agrees an engagement and consultation plan using **'intent form'**.
- Plans submitted to **Implementation and communications and engagement groups** – these are checked against legal and equality considerations
- Task and Finish – Review consultation plans
- Plans submitted to **Partner Boards, Partnership Board, HWBB, OSCs,**
- Task and Finish – Review consultation(s) groups
- Plans are implemented
- Results of consultation have an **independent analysis ie NHSE, OGC**





What methods should be used?

## Multi layered approach

- Public & Patient Groups
- Healthwatch
- Voluntary & Community sector
- Outreach ie Local companies
- Coat tailing ie Council Tax bills
- Events & Meeting

Engagement –  
Use what is  
known to work

- Youtube
- Blogs
- Social media
- Connectors & messengers ie ambassadors

Experiment with  
others



Right message



Right audience

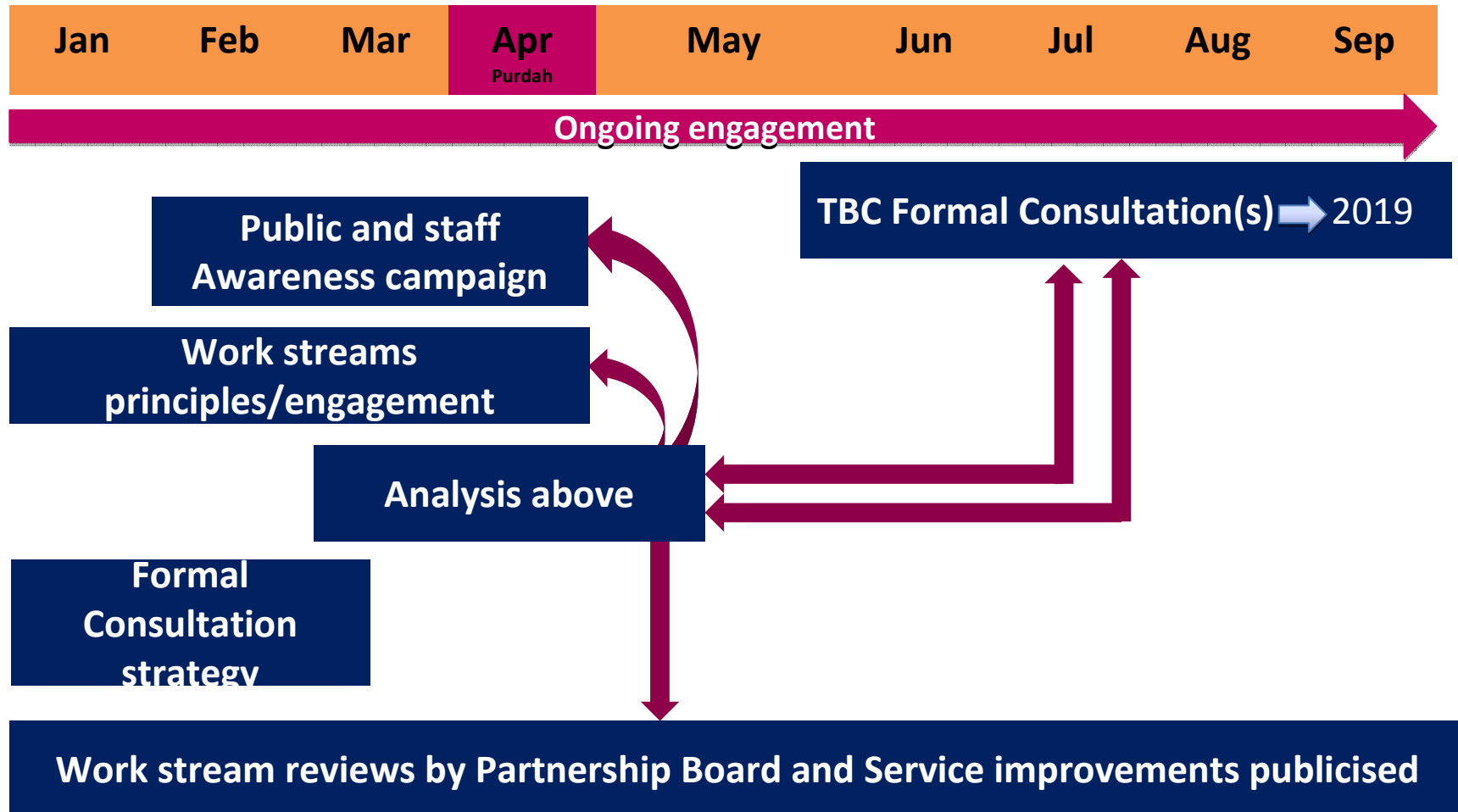


Right time

Campaign Development



## Timeline for next phase





**Questions &  
Comments**