East Leicestershire and Rutland Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
Leicester City Clinical Commissioning Group

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

21 JANUARY 2019

REPORT OF BETTER CARE TOGETHER COMMUNITY HEALTH SERVICES REDESIGN

Introduction

1. The Community Services Redesign project (CSR) is a piece of work led by the three Clinical Commissioning Groups (CCGs) in Leicester, Leicestershire and Rutland (LLR), looking at the future model of community health. The scope of the work centres on adult community services provided by Leicestershire Partnership Trust (LPT), but also has implications for services provided in primary care, social care and other community based providers.

2. This paper provides an overview of the Community Services Redesign project. It summarises the service issues, case for change and project methodology. It also describes the work undertaken to date, in line with the methodology, to review community services including the significant engagement to support development of proposals for the future.

3. The report also outlines the principles of the proposed community health services model which is emerging from the ongoing work.

4. The Joint Health Scrutiny Committee is asked to note the progress to date in reviewing and redesigning community health services.

Background

5. Community Health Services in LLR are delivered under a block contract by LPT. District nursing teams provide a planned nursing service, largely within people's homes, concentrating on the frail and housebound population.

6. In addition, there is an Intensive Community Support (ICS) service, which was commissioned to provide enhanced nursing care to support people at home at a time of crisis, to prevent admission or facilitate rapid discharge from hospital. It was intended to provide an alternative to staying in a hospital bed – sometimes referred to as a 'virtual ward' model. The ICS service was set up as a largely nurse-led service, with limited social care and therapies within the team and delivers rapid response nursing rather than an integrated crisis

response and reablement approach, working to a 10 day length of stay, which limits reablement.

7. Community hospital beds provide a ‘step down’ from acute hospitals i.e. the next phase of care before people are living independently at home. There are currently 233 community hospital beds across LLR, split across 12 wards in eight community hospital sites. Patients are admitted where they have a need for continued hospital care but not in an acute setting (approximately 40%) or rehabilitation needs (60%), although these categories are not mutually exclusive and most patients have both needs to a degree.

8. In addition to community hospital beds, ‘Pathway 3’ reablement beds provide 24/7 bed-based care in a residential or nursing home setting with in-reach therapy for patients who are not yet well enough to be cared for at home.

Why are we looking at Community Health Services?

9. In 2018 we celebrated 70 years of the NHS. Things have changed a lot in that time with perhaps the greatest success of the NHS being the dramatic change in life expectancy. In 1948 the average male died at 66 - it’s now 77.

10. However, people are living with more than one health condition and their needs are more complex. There are more of us, we are older and as we age we pick up illnesses that stay with us including heart disease, respiratory disease and diabetes.

11. With advancements in technology and knowledge, the NHS can do more than it ever could before. But people don’t want to be ill. They tell us they don’t want to have to go to hospital and have long stays in an acute or community hospital bed. They want support to stay healthy, be discharged quickly and many prefer to receive more of their care at home.

12. Clinical evidence also shows that patients achieve their maximum potential and/or recover fastest when they are in the right setting for their needs. The evidence shows that this should be the least acute setting possible and at home where appropriate.

13. In addition to this, to deliver more joined-up care for patients to aid both their outcomes and experience, greater integration is required between health and social care services. This has been the clear national and local direction for some time and significant progress has been made through close partnership working under the LLR Better Care Together (BCT) Strategic Transformation Partnership to deliver a range of improvements across a number of services.

14. Community health services in LLR however, have not been reviewed or redesigned for a number of years. The current model does not support some of the key strategic changes within the LLR Better Care Together Strategic

Transformation Partnership which aim to deliver improved care through a model which sees as much care as possible provided at home or close to home. Nor does the current model deliver the kind of care people tell us they want and which evidence shows is best for them.

15. Within the BCT plan a number of work streams were attempting to deliver more integrated community based services, most importantly the Integrated Locality Teams (ILT) work and the Home First programme. Both of these work streams have significant implications for core community health services and without a clear commissioning strategy in relation to the services provided by LPT, they have not been able to achieve the desired progress towards better integrated care models.

16. The original STP plan published in November 2016 did not have a clearly articulated community health model, which would meet current and projected demand, support the strategic shift towards more care delivered close to home, and address the issue of bed capacity requirements both within community hospitals and acute settings.

17. Staff are working really hard to deliver good care, however the current service is not configured in a way which enables it to deliver the best support to patients at home. The CCGs have therefore been working for some time to consider the improvements that are needed for reconfiguring services currently provided to people by LPT.

18. To address all of the issues described, CCGs, working with our partners, need to change the way we do things to redesign services for our needs in the 21st century, invest in the right services and provide them in the right place to match needs and improve care for local people.

Current service issues

19. Patients tell us that they want to be cared for at home where it is suitable for them. Clinical evidence shows this is better for them. Over time however, capacity within the district nursing service to deliver care at home has been reduced. A review of community nursing establishment in late 2017 demonstrated vacancy gaps. As a result, the community nursing service 'offer' is limited and district nursing teams do not have the capacity to respond fully to the needs of patients. The ICS service has absorbed much of the day to day unplanned or urgent care needs referred by GP practices, rather than delivering a 'virtual ward' model to acutely unwell patients who would otherwise be in a hospital bed. This reduces continuity of care and means that neighbourhood community nursing teams do not have the capacity to deliver the preventative and joined up care that we aspire to deliver in ILTs.

20. Reviews of the current ICS service show that it does not fulfil its intended function and is not integrated with social care crisis response and reablement services. While there are examples of excellent close working between the ICS service and social care intermediate care services, such as Intensive Crisis Response service in Leicester City, the core ICS service does not support the Home First blueprint agreed within BCT.

21. People tell us that to be as mobile as they can be is essential. Being active is important and it also supports emotional wellbeing. However, benchmarking data indicates that LLR has roughly half the number of community physio and occupational therapists compared to the national average. This leads to long waits and limitations to the input people receive at home.

22. The medical cover within the ICS service is both limited and unclear. When it was set up, the ICS service was commissioned to take clinical responsibility for patients admitted to it but does not have any dedicated medical staffing. This has led to lack of confidence in the service from acute consultants and lack of clarity and variability within GP practices about the nature of their responsibility for care when patients are being looked after.

23. An ICS service case note review (September 2017) and subsequent ICS clinical audit (November 2018) reinforce the necessity to redesign the ICS model. The audit showed that over 50% of ICS activity was actually delivering a same day core community nursing function.

24. There is significant reliance in LLR on community hospital beds to provide 'step down' from acute hospital i.e. the next phase of care before people are living independently at home. This differs from the model in other areas of the country, where there are more discharges directly home or into intermediate care services.

25. Community Hospitals are currently used as part of an LLR wide bed base with patients placed in available beds that are not always near to where they live, dependent on patient choice and system demand. For example 2017/18 data shows 45% of Leicester City patients in community hospital beds are in community hospitals outside of the city, and 32% of patients in City beds live in East and West CCG areas.

26. Community hospitals have an average 88% occupancy rate. However a number of local audits have demonstrated that patients in these settings are not in the most appropriate place.

27. In July 2017 an extensive bed audit covering 86% of UHL beds and all community hospital beds showed that 31% of UHL patients and 55% of LPT community hospital bed patients were not in the best setting of care for their needs.

28. A review of the discharge pathways in LLR has shown that we could improve access to 'Pathway 3' reablement beds (which provide 24/7 bed based care in a residential or nursing home setting with in-reach therapy for patients who are not yet well enough to be cared for at home). This would help to prevent admission and provide step down care from community hospitals.

29. The service issues described support the case for improving community health services by redesigning them to better suit patient needs, aligning them with aspirations to provide more continuity of care within locally based services, and providing better joined up crisis response services with social care (Home First).

CSR project and methodology

30. The CSR project was initiated by the CCGs in LLR in April 2018, in order to address the identified issues with core community health services and to ensure services are configured to deliver the best possible care for patients in community settings.

31. The objectives of the CSR are to:

- Develop better integrated services with better patient outcomes
- Support integrated locality services which manage the majority of patient care
- Deliver a 'Home First' approach through integrated step-up and step-down services
- Reduce use of non-elective services
- Address the future model and number of community hospital beds which could be needed in future

32. The scope of the redesign work includes the following LPT services:

- District nursing services – which provide home-based patients with ongoing nursing care for long-term conditions or end-of-life care, with treatments such as wound care and continence care
- ICS service – a 'virtual ward' providing healthcare services in a patient's own home
- Community hospital beds (including stroke beds)
- Community physiotherapy services (not including MSK physiotherapy)
- Community stroke rehabilitation service
- Primary care co-ordinators – who work in hospitals to support staff to help get patients home as quickly as possible once they are ready to leave hospital
- Single Point of Access

33. The terms of reference for the redesign recognise that, in attempting to move towards better integrated services, there will be implications for other

services, particularly primary care and social care, as well as acute hospital services.

34. The CSR work has reported into the Integrated Communities Board (ICB), one of the BCT work streams. The ICB is a system-wide group with executive membership from each of the adult social care departments, which steers the development of integrated care across LLR, through ICB members' roles linking back to their own organisations. The ICB also has representation from Healthwatch and the BCT Public and Patient Involvement group. The project has been led by the CCGs working on a co-design basis with LPT staff and other stakeholders.

35. Due to the complexity of the work, achieving significant change is being seen as a two to three year transformation programme, following a systematic process to a set methodology and has included to date:

- A review of best practice models and the evidence base for integrated community services, undertaken in July 2018
- Co-design workshops with key stakeholder and BCT work streams in June to August 2018, involving staff from social care, primary care and provider trusts among others
- Clinical Reference Group which has generated options for a clinical model, meeting August 2018 onwards
- A high level model set out in September to support further discussion and engagement with stakeholders on the clinical model
- Demand and capacity modelling supported by Deloitte UK in November 2018
- Audits of current pathways – both in 2017 and Autumn 2018
- Initial costing of potential impact for CCGs, December 2018
- Engagement to support development of the proposals, which is detailed in the next section, and which includes:
    - Review of existing engagement insights
    - In-depth structured interviews with patients, carers and staff
    - Online survey
    - Further public events to present insights and seek views are planned for early 2019
- Initial consideration of proposals by the CCGs' Collaborative Commissioning Board in December 2018, and decision making on next steps

Engagement to support development of proposals

36. Engagement was undertaken with patients, carers and staff between August and October 2018. We identified the journey of care by asking evidenced based questions and now have the stories of people experiencing community

services and those providing community services. The key question we were answering was: *"How will a new integrated model of community care change the experiences of staff, family carers, patients and people who use the services."*

37. We captured the experiences and feelings of the following groups, in relation to ten emotional touchpoints and identified what matters most to people about their care. 160 in-depth one-to-one or small group interviews were undertaken with:

- People receiving community services in their own home, in community and acute hospitals, in the ICS service and other settings
- GPs
- Acute staff referring into community services
- Social care staff
- Domiciliary care workers
- Family carers
- Care home staff

38. An online survey designed for patients, family carers and front line staff also ran between 25 September and 21 October 2018 with 66 responses in total.

39. An independent report analysing the findings from the interviews and survey was commissioned from Arden GEM Commissioning Support Unit.

40. In addition, we examined 22 existing reports relating to community services. This review of an existing knowledge base, using research undertaken by various organisations (NHS, Healthwatch, LGBT etc.) represented feedback from 4,300 people.

A summary of themes highlighted by people in a place they call home

41. In general the picture relayed by patients in their own home is mixed. Patients would prefer to stay in their own home, but their level of confidence is dependent on support from family and external agencies which can vary.

42. Relationships with services, including their GP, are important. The inability to get timely appointments and to see the same GP is a frustration. Also services not arriving on time and the lack of communication are all mentioned as issues. However, people feel that an improved relationship with health and care services would give them more confidence.

43. Falls and deteriorating health are frequently mentioned as a cause of crisis. Issues highlighted which could be improved to help service users to manage in

their own home include assistive technology and home adaptations, and timely communications from services, improved relationships with staff and a better language/cultural understanding. A range of other services including better support out of hours and in rural locations are also mentioned.

44. Patients can be left feeling stressed and social isolation is experienced by this group of people. They would like to do the things they were once able to do or at least have the best mobility it is possible to have. Socialising and involvement in external agencies are important. Mobility is everything and having support to enable people to keep busy and as physically active as they can are seen as important to improve both physical wellbeing and reduce the emotional impact on their condition. Physiotherapy and occupational therapies are seen as particularly important.

A summary of themes highlighted by people in community beds

45. The importance of good communication throughout all stages of the patient journey resounds throughout the insights. It is essential for patients to feel confident, cared for and supported.

46. The need to feel supported is also essential to recovery and wellbeing and discharge is seen as a really low point. People demonstrated their reliance on support not only while in hospital to aid successful recovery, particularly from physiotherapists and occupational therapists, other hospital staff, friends and relatives, but also when they return home. Community hospitals are seen as an important part of patients' treatment closer to home, although some patients were unsure why they were in a community hospital and what treatment they could expect.

A summary of themes highlighted by family carers

47. Family carers want services which are reliable and appropriate to their situation and allow them to support their loved one. However, they report difficulties in getting the help they need and frustration around the processes, including decision making and discharge. Getting further help at times of crisis was a particular challenge for some. They report that providing care at home as simply waiting for the next crisis to happen.

48. Family carers reported mixed relationships with services and staff. They did not always receive consistent information and were not involved and kept informed.

49. The caring role resulted in emotional stress for carers, such that they sometimes did not feel that they could take holidays or have breaks.

50. Particular areas of concern were falls, getting help when their loved ones' health deteriorates and administering painkillers.

A summary of themes highlighted by frontline staff

51. Building good relations and working together with patients and families are important aspects of the role of frontline staff. They try to involve patients in their care, but this can be challenging where patients and family disagree or do not understand the care available. Staff tell us that time and workload pressures reduce their ability to develop a good relationship with patients and families. Providing emotional support can be a very rewarding aspect of the work but more guidance, training and time is needed.

52 Equally, relationships with other services significantly impact on the care given. Good working relationships with other teams are important - where teams work well together and trust each other to do their job the outcomes for patients are improved. Currently, the quality of these relationships varies but is improved where individuals know each other. There can be issues between services, particularly connections between NHS and social care around poor communication, lack of awareness and understanding of services and processes, or where referral criteria are not clear or understood.

53. Staff feedback that good IT can support closer working between services, e.g. how the community clinical IT system, SystmOne, can improve the referral process. Job satisfaction is important to staff, they want to feel that their work is valued and they have made a difference to patients and their family. However, they report feeling stressed and tired, in particular where they are short staffed and there is a high caseload. The job is made easier by supportive colleagues and leaders who work well together and good relationships with other teams.

A summary of themes highlighted by care home and domiciliary staff

54. It is apparent that staff feel very passionate about the care they deliver and the resources and support they subsequently require. Particular low points in the care pathway are around relationships with other health and social care staff and involving the person in decisions about their care.

55. In addition, co-ordination and providing physical and emotional support is an area of concern. Time pressures sometimes prevent these being considered equally.

56. Staff also find it difficult to look after their own health, wellbeing and personal resilience.

57. The importance of having integrated services, good communication and involvement and team working is widely reported.

Proposals for the future of Community Health Services

58. The work undertaken by the CSR project to date, including the insights from patients, carers, staff, clinicians and stakeholders, has enabled the CCGs to:
    - Set out a potential model for the future model of community based health services
    - Make some proposals for initial changes to how community services provided by LPT are organised to improve care for patients
    - Recommend some next steps to further develop the model

59. The proposed new model is based around the following main services:
    Neighbourhood community nursing as part of integrated locality teams, which would manage the majority of care of patients in the community, working closely with social care and primary care neighbourhoods (groups of GP practices with between 30,00 – 50,000 patients).
    Home First services - integrated health and social care crisis response and reablement services, which would deliver intensive, short term care for up to six weeks. Home First services would be accessed via Locality Decision Units, with health and social care services working on the basis of trusted assessment and delivering co-ordinated packages of care.
    Community bed based care - delivered either in community hospitals for patients requiring medical rehabilitation needing significant 24/7 nursing care and on-site therapies, and in 'Pathway 3' reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support.

60. Key features of the model include improvements in:
    - Co-ordinated Care
    - Integrated team working
    - Preventative care, support for self-care
    - Pro-active approach to identifying patients who need co-ordinated care
    - Focus on the frail and 'multi-morbid' patients
    - Trusted assessment – where agencies trust the assessments made by those outside their organisation reducing duplication in assessment
    - 'Discharge to Assess' – ensuring people leave hospital when medically fit
    - Delivery of the 'Home First' principles
    - Capactity in community nursing and development of a sustainable workforce

61. It is important to note, that the evidence review suggests if the community model described were further developed, and had sufficient capacity in the home based teams and reablement beds, there could be reduced utilisation of community hospital inpatient beds in future. This could create a shift towards using community hospital beds predominantly for patients who on discharge from an acute hospital and continue to need 24 hour care with on-site therapies.

CCG discussions to date

62. In December 2018, a summary report outlining the work done to date, and considering the benefits and implications of moving towards the future potential model was considered by the CCGs' Collaborative Commissioning Board (CCB).

63. The CCB supported in principle a move towards the model outlined in this paper, but recognised that to fully deliver the vision of improved services, further work needed to be done, including:

- Continued and wider engagement with the public and partners on the potential future community health model and its implications to further develop test and strengthen plans
- Testing some initial operational changes to provide proof of concept for future changes including a move towards more integrated services and the potential to support more patients to be cared for at home. Also a more a robust process to explore the costs and activity implications of the future model
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64. This work will commence in January 2019 with ongoing engagement with partners and a series of public engagement events across LLR planned from February.

65. In the meantime, to deliver the improvements in ICS services for the benefit of patients, carers, staff and clinicians, the CCB also supported the reorganisation of the current LPT nursing teams and specifically redeploying the capacity in the ICS service into enlarged community nursing teams at a locality level.

66. This reorganisation means the treatment delivered by the ICS service will continue to be delivered, with care still provided to patients at home in the way that it is now. There are however anticipated improvements in patient outcomes and experience through improved effectiveness and efficiency and greater capacity in locally based teams to deliver continuity of care. The CCGs will work with LPT to enact this change in the course of 2019/20.

67. To support these initial improvements to ICS services, the CCB also gave approval in principle to:
    - providing dedicated medical support to patients being looked after by Home First services, conditional on approval of further work on costs and proposals for how the medical cover would be organised and employed
    - the creation of care co-ordinator posts in West Leicestershire CCG, in line with the agreed model for ILTs, again conditional on approval of the costs and employment arrangements in January/February.

68. The CCGs believe the changes proposed to the way in which ICS services are organised will have benefits for patients, carers, staff and clinicians. It is important to note, that once enacted, the changes would not preclude or prevent changes to proposals for the future configuration of community health services following further engagement.

Next steps

69. Due to the complexity of the work, achieving significant change to community health services is being seen as a two to three year transformation programme, following a systematic process.

70. In recognition of the importance of the work, and the possible implications for the wider provision of care in community settings, as well as the implications on utilisation of other health services, including inpatient beds, the CCGs will embark on a second phase of work towards a full business case to redesign community health services. This work will include:

    - Further engagement with local people on the future vision and options for community health based services
    - Further engagement with clinicans, staff and partners on the proposals for the future
    - Further work to define how community health services could work with social care crisis response and reablement services to deliver Home First
    - Testing the impact of more redesigned community health services and more integrated care model on patient outcomes and demand for care in different settings
    - Generation of options for further changes to community health services, including assessing the impact of increasing capacity in home based care and reablement beds, which could increase the number of people who can be cared for in their own home
    - Depending on the options being put forward, the CCGs will consider their legal duties in respect of formal consultation on future services changes, particularly if there are proposals to make any significant changes to the community hospital configuration. It should be noted

that in any case there will be ongoing co-design with the public on the proposals.

71. The CCGs are working with local authorities and Adult Social Care departments to discuss how they wish to be further engaged in the development and implementation of the overall model. In parallel with this, the CCGs will continue to work with social care teams and other stakeholders to develop the model of integrated care taking into account the recent publication of the NHS 10 Year plan as we do so. This will include work via the project team engaging with lead council members, leadership teams and, where appropriate Council Cabinets/ Executive Teams and scrutiny functions.

72. Further work will be undertaken to set out the milestones and governance processes for future decision making. This will be done in discussion with Adult Social Care teams and with the System Leadership Team of BCT.

73. The CCGs will continue to engage with the Joint Health Overview and Scrutiny Committee and an update will be brought in due course.

RECOMMENDATION

The Joint Health Scrutiny Committee is asked to:

NOTE the progress to date in redesigning community health services and the next stage of the work.