Better care together
Leicester, Leicestershire & Rutland health and social care

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Future community health services model: **a summary**

September 2015

What this summary is about

It is about potentially making a difference to how community healthcare is delivered, based on local need, providing care at home - or closer to home - whenever possible and clinically correct. We call this approach ‘Home First’.

We are East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG), the NHS body which plans and pays for many of the main healthcare services in our area.

We are working on significant change to future community and primary care (GP) services, bringing them to work together more closely to become more efficient and effective.

Our work so far is based on our own published strategies and national ones. We are also encouraged in this work by the emergence of ‘GP federations’, that is, practices forming groups to co-operate on improving healthcare. GP primary care is at the core of our potential future model.

We have already engaged with a range of local stakeholders in developing this new potential model.

Our engagement has enabled us to understand current issues and the potential for bringing together community and primary care services. It is our aim to have the right services to meet the needs of local patients.

We have also identified the issues and areas that need to be addressed to ensure a solid foundation for community services.

Our proposed new model is likely to require significant organisational change both within each locality of GPs and by community service providers, requiring leadership, time, skill and resources to ensure change is achievable.

We believe there needs to be widespread further engagement so as many people as possible can have an input into the future model of care.

The current system of community health services

‘Community health services’ is the name given to a wide range of healthcare available in community hospitals, such as inpatient treatment and outpatient clinics, as well as through visits by healthcare professionals to people’s homes and care homes. It further includes the work of staff like school nurses, district nurses and health visitors.

Leicestershire Partnership NHS Trust (LPT) currently provides the area’s planned and unplanned community nursing care, mental health, community based inpatient care and therapy services. Care-at-home assessments and social care are provided by Leicestershire and Rutland’s county councils.

The services provided by the councils and LPT are independently delivered but the two organisations work in partnership to deliver a whole package of care to enable individuals to be looked after in the home.

Across the area covered by ELR CCG there are 88 inpatient beds located within four community hospitals, under a contract with LPT. This is supplemented by 48 ‘virtual’ home-based ‘beds’ attended by clinicians from LPT.

Figure 3 shows where the physical beds are and what they are for.

Figure 3

Location	Number of Beds	Care Pathway
Fielding Palmer Hospital, Lutterworth	13	Rehabilitation/Care of the Elderly Includes 1 designated Palliative Care bed
Melton Mowbray Hospital	17	Rehabilitation/Care of the Elderly Includes 1 designated Palliative Care Bed
Rutland Memorial Hospital	22	Rehabilitation/Care of the Elderly Includes 1 designated Palliative Care Bed
St. Luke’s Hospital, Market Harborough	20 15 1	Stroke Rehabilitation Rehabilitation/Care of the Elderly Palliative Care

East Leicestershire and Rutland residents access primary care services primarily through their registered GP practice as well as the Out-of-Hours Services and Urgent Care Services.

The current system of primary care

GPs are not included in the normal definition of ‘community healthcare’. They are part of the system of ‘primary care’.

Each GP practice operates as an independent business in its own right, employing their own administration and clinical staff. They meet as ‘locality groups’, ie, practices in the same geographic area, to share some information and learning.

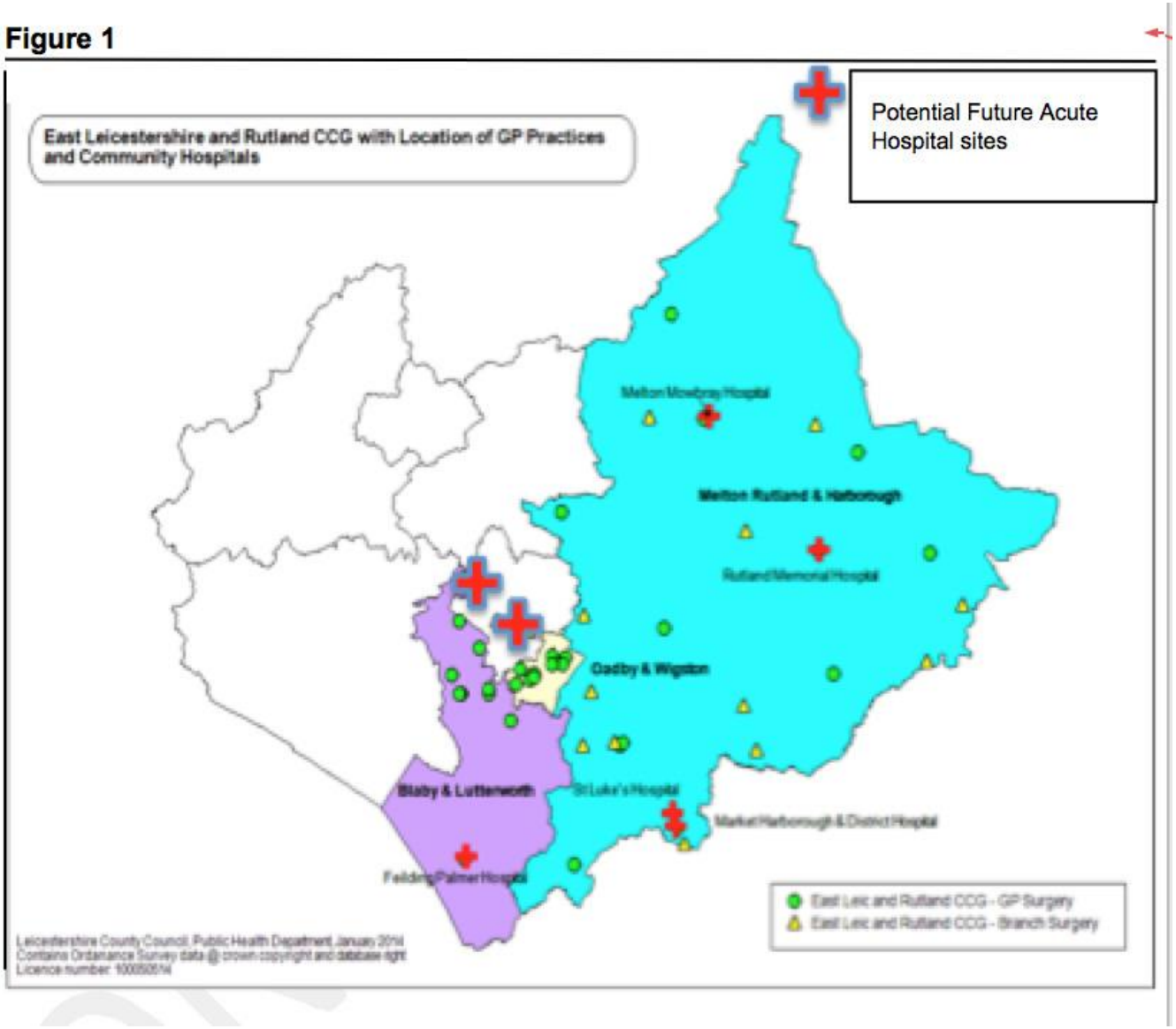
ELR CCG’s area has around a third of Leicestershire population with 32 general practices serving around 315,000 patients.

The three main localities serving the ELR CCG population are:

- Blaby and Lutterworth;
- Oadby and Wigston; and
- Melton, Rutland and Harborough.

Figure 1 shows these localities, plus community hospitals and the site of the likely future major hospitals.

Figure 1



The challenges to the current system of primary and community care

Demand is rising. More people in East Leicestershire and Rutland will be over 70 years of age by 2030 and many of those people will be living with a range of complex health issues requiring rehabilitation and re-ablement.

Patients find accessing care confusing.

Setting up a care package for a patient is complicated and time-consuming for busy GPs. There is only limited sharing of clinical expertise between practices and they do not share administrative or any other functions.

Recruitment of GPs is becoming more difficult and it is likely that locally it will not keep pace with demand. There are also significant recruitment and retention problems in the community nursing workforce, which has a high vacancy rate.

GPs will be managing more patients with serious / complex health conditions who are living at home, or in a care home. We have drawn up a proposed future model which would give GPs greater influence on how community health services are delivered for their patients. It would mean a major re-organisation of the way services are commissioned, integratrated and managed

GP-led multi-disciplinary team meetings to discuss patients are reported to be in the main poorly attended by community healthcare staff.

Given the increasing complexity of patients being managed in the community and in hospital beds, the need for external clinical and shared care will increase.

Communication between GPs and community service staff is reported to be sporadic at times, and as a result is felt to be inefficient. For instance, there is significant and unacceptable variation in response times to requests for care and support across the area.

Fast access to specialist expertise and review is currently limited for GPs. Often it is only the individual professional 'relationships' with hospital consultants that influences the level of support given. There is no formalised contracted support network in place for GPs. The remoteness of some GP practices is a further issue.

Home-based community health services, set up to deliver an alternative to hospital admissions, is affected by problems recruiting staff, as well as the pace of change in other parts of the Leicester, Leicestershire and Rutland healthcare system.

The current condition of healthcare buildings in East Leicestershire and Rutland is variable and in parts they are poorly utilised.

There are small numbers of community hospital beds spread across four sites, which is inefficient. It risks compromising clinical quality, because of the isolation of staff from each other, meaning there is a lack review and support by fellow health professionals, and the system is not cost effective.

A system of home-based care, called Intensive Community Support (ICS), using teams of health professionals on home visits, is under-used.

The changing healthcare landscape

Any changes we make to improve community health services, and to bring them into closer working with primary care and other care services, cannot be made in isolation. They will have to take account of the current and planned changing landscape of the wider health economy.

The most widescale changes taking place are part of the *Better care together* programme. This involves all the healthcare commissioners and providers in Leicester, Leicestershire and Rutland working together to improve the whole system's efficiency and effectiveness.

The *Better care together* programme is aiming to deliver cost savings of £398m by 2018/19 with a phased reduction of 462 major hospital beds by 2018/19. Fundamentally this means changes to current hospital services with these potentially being consolidated on the Glenfield Hospital and Leicester Royal Hospital sites, with a range of non-acute services at Leicester General Hospital. The General Hospital is to the east of the city and is currently the closest point of access to many UHL services for the ELR CCG population.

As a result the existing community hospital beds in East Leicestershire and

Rutland will need to be used for patients who previously may have been in beds in one of the main hospitals.

At the same time, work is being undertaken to agree the numbers of home-based 'beds' required (between 47 and 74) to achieve the reduction in physical beds. These home-based 'beds' will ensure that more patients needing complex care can be cared for without the need for admission to a main hospital.

Another significant change programme, nationally and locally, is called the *Better Care Fund*, aimed at bringing health and social care services together to improve care and reduce the risk of hospital admissions.

The effects of both these change programmes on community services are already evident, with community nursing and therapy services now organised into planned care teams, who pick up the day-to-day core district nursing work; and unscheduled care teams, who pick up any unscheduled sudden need for further care by existing patients. The locations of these teams are somewhat fragmented, however, affecting efficiency.

LPT provides a Single Point of Access system to care professionals to access these teams, but its response efficiency is variable.

Community health services form a large part of the work of the NHS. According to a 2014 Kings Fund report *Community Services - How They Can Transform Care* - around 100 million community contacts take place each year in the UK, ranging from health visiting and school nursing to targeted specialist work in musculo-skeletal services, chronic disease management and intensive rehabilitation after treatment.

The NHS England *Five Year Forward View* clearly explains the drive to provide the right care, while recognising that one size does not fit all. It calls for the breaking down the barriers between primary, community and secondary care, between physical and mental healthcare, and between health and social care.

GP practices are also undergoing change. They are coming together to form federations, sharing resources and expertise. Some are also joining forces with other organisations to become 'Multi-Specialty Community Provider's as the focal point for a far wider range of care for their registered patients.

The case for change

Changing the current model of community services commissioning would give ELR CCG and our local GPs more accountability to influence how services are delivered. We could enhance accountability by creating joint GP/Provider posts.

We would aim for rehabilitation and re-ablement care that moves services from a hospital to people's homes. 'Home First' would be a prominent principle of service delivery.

It would provide an opportunity to provide better access to community services that currently require improvement, including physiotherapy. We would also expand the times when care is available both at home and in health facilities.

The new care model would include clinical support networks and services in hospitals and GP surgeries to identify the needs of patients, like the frail elderly, to enable and manage their and others' complex care locally.

We would be able to make the most of the land and buildings available to deliver local services avoiding unnecessary travel to major city hospitals (in and out of the Leicester, Leicestershire and Rutland area).

It would allow us to draft simplified specifications for, and undertake joint commissioning of primary, social and community services.

It will mean changing the model of community services commissioning to focus on health outcomes of rather than the clinical and care inputs of providers.

Our proposed model is likely to require significant organisational change both within each locality and by community service providers requiring leadership, time, skill and resources to ensure change is achievable. So we would put in place robust governance arrangements including joint working with our two county councils.

To further strengthen and develop our proposed new model of care, we will undertake further engagement with our wider stakeholders and public.

The proposed future model of care

From our clinical and stakeholder engagement work so far we have a vision of how the new model of care will look and the principles on which it is based.

We aim to deliver 'wraparound community services'. 'Wraparound' can be defined as a team of professionals developing and implementing an individualised plan of care for each patient.

Specifically for ELR CCG this means staff from different agencies communicating and operating as one team, including physicians working beyond the hospital walls with colleagues in primary and social care.

Community teams might work with and be answerable to groups of GPs and be based near to the populations they serve, and integrated with social care staff. 'Community Matrons' posts would be created and help to bridge the gap in accountability.

A future community service model could have 3 main Levels:

Level 1 - Local Wraparound Services:

Wraparound' can be defined as a team of services who develop and implement an individualised plan of care, known as a wraparound plan. We have drawn up a proposed future model which would give GPs greater influence on how community health services are delivered for their patients. It would mean a major re-organisation of the way services are commissioned, integratrated and managed . Community nursing teams will be accountable to both their employer and to the GP federation whose patients they serve. In Level 1 some local services will be delivered in individual GP practices or hubs. Services may include:

- Scheduled care community nursing services;
- Centralised complex patient lists with designated GP leads for care coordination;
- Therapy services;
- Pharmacy support;
- Community Matron; and
- Community geriatrician support.

We will also explore ways of using new healthcare technology systems in clinical care.

Level 2 - Medium Scale Services:

These will include rehabilitation and re-ablement. We are suggesting that ELR CCG requires up to eight centres for community and social care services, each serving a population of around 25,000 to 45,000. A wider range of outpatient clinics and services is suggested for Melton, Rutland, Lutterworth and Market Harborough Hospital sites.

Level 3 - Large Scale Services:

These will include more specialised care, but not that requiring a major hospital stay. This group of services includes access to acute consultant advice - systems for 24/7 support across our area, outpatient clinics and services, and physical community-based beds, diagnostics, such as x-ray, ultrasound, plus podiatry and a range of therapies, specialist nurse teams, as well as possible urgent care and seven-day services.

The problems we need to tackle to make the future model work

The right workforce, with the right skills, and of the right number, features heavily in the proposed community services model and is one of the greatest areas of risk of implementation, due to recruitment problems.

We need to tackle the long-standing issue of essential integration of primary, community, social care, medical and non-medical workforces.

The lack of clarity about actual nursing numbers available to our CCG needs to be resolved.

There is a perceived poor use of current community health workforce, which is burdened with excessive administration work and duplication of tasks.

We need to understand how best to use new healthcare technology alongside clinical and social care to improve the health outcomes of our patients.

The next steps

The proposed model of care will require significant joint work and the widescale involvement of stakeholders, backed by the right level of funding and resources, to make it happen. ELR CCG will need to identify and align funding from within its current budget including Better Care Funds and primary care investment funds. Opportunities for non-recurrent funding through exemplar programmes will be vigorously explored

We propose the creation of a dedicated sub-group with the leadership skills to achieve integration across primary, community and social care.

We need to set an agreed governance framework that links the new model with GP federations, local and national strategies, and the *Better care together* five-year change programme.

Subject to our engagement and consultation work, and successful negotiations with all the organisations involved, it is proposed that the new model of care could start during 2016. A possible timetable is show below.

Deliverable	Timescale
Engagement on those elements not requiring formal public consultation	Commenced from July 2015
Initiation of Programme	July 2015
Work streams and supporting governance arrangements to be established	October 2015 onwards
Consultation where necessary – as a fully embedded part of the LLR Better Care Together Progamme	To be confirmed – Better Care Together currently is looking at consultation beginning at the end of November 2015
Development of Business case outlining potential financial and procurement options	December 2015 - February 2016
Commencement of Programme	January 2016 – April 2016

Further engagement and consultation

We wish to undertake further engagement so that the widest possible range of stakeholders, public, patients, their families and carers can understand the vision we are pursuing and provide their views.

We do not believe that most aspects of this proposed model should require formal consultation over and above this robust and widespread engagement, however where there are such aspects, this consultation should and will be taken forward as part of the wider *Better Care Together* programme.

Engagement will begin in September 2015 and run until the end of February 2016. Findings will be fed into the *Better care together* programme, which is currently expected to begin consultation at the end of November 2015.

We have a detailed view of how this engagement should be carried out, including the groups we want to include and the systems we want to employ, including greater use of digital media.

We are introducing a host of new and highly innovative digital tools, techniques and channels - in a fully integrated web, mobile and social media capability. These are designed to transform the ways in which we are able to reach out to people and communities, keep them informed about what we are doing, bring them together with us and each other so we can collectively discuss, learn and build our insight.

To give your comments on this approach, please see our website www.eastleicestershireandrutlandccg.nhs.uk and click on the panel marked **Community Services Model Engagement launched**, pictured here.