


Better care **together**

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

For discussion and review

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

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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)
- Leicester City Council
- West Leicestershire CCG
- Leicestershire County Council
- East Leicestershire and Rutland CCG
- Rutland County Council
- University Hospitals of Leicester
- Leicestershire Partnership Trust
- 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 www.bettercareleicester.nhs.uk.

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).

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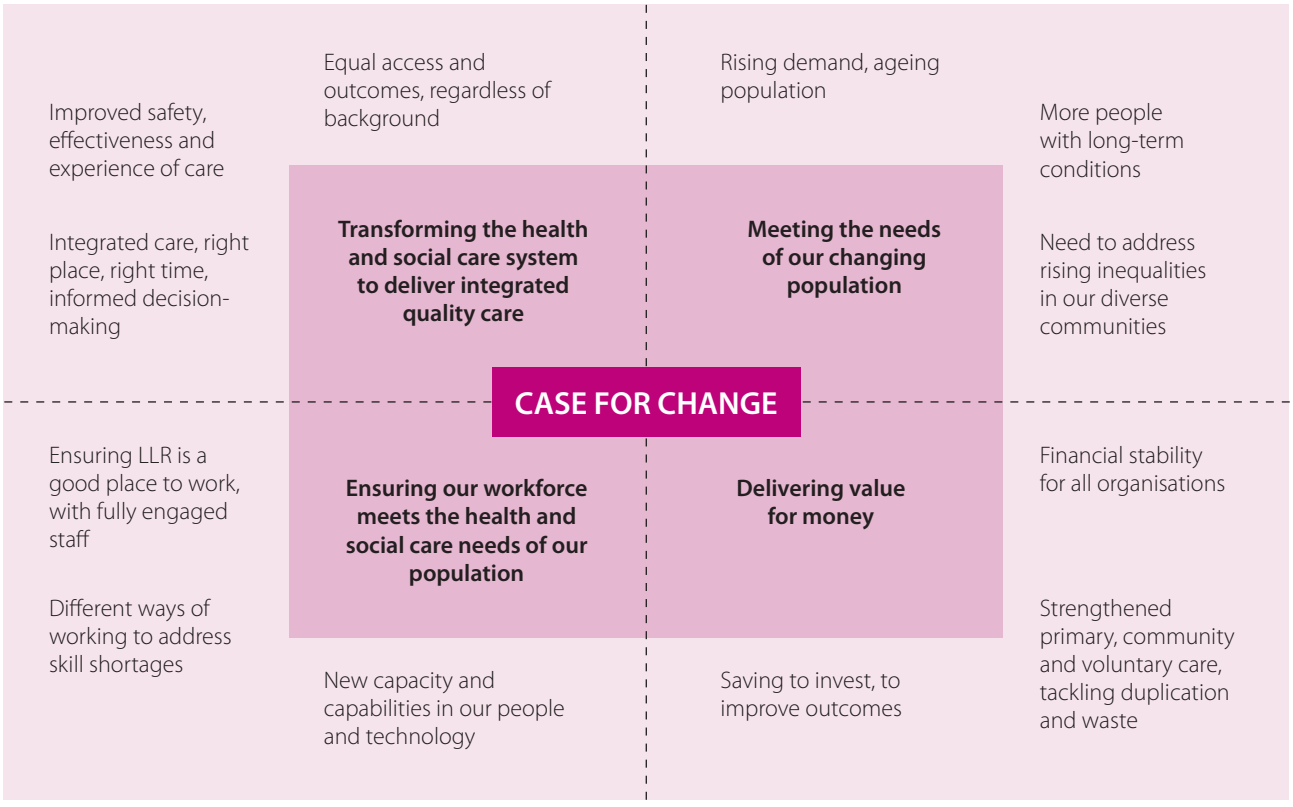
THE CASE FOR CHANGE

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 in-house 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).

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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

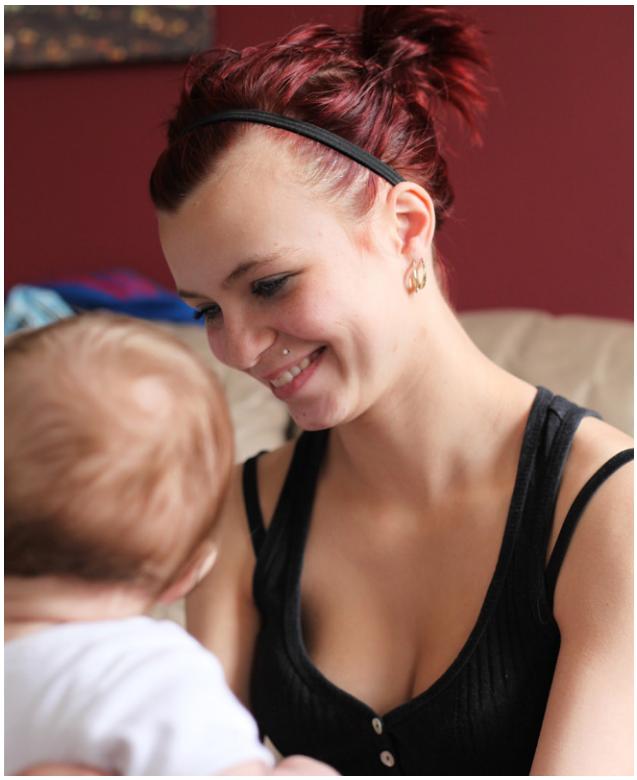
RECOVERY

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	What are we going to do	Our outcomes in 5 Years
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*	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 cases 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 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 hours targets consistently met

FRAIL AND OLDER PEOPLE

Our existing service	What are we going to do	Our outcomes in 5 Years
Too many older people end up in **hospital** for too long - *we need to support care to be delivered elsewhere* Not enough service that are **joined up** to support physical and mental health and wellbeing needs - *we need to deliver integrated pathway* 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*	Develop programme to support people to participate in society - health 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 services support for older people who fall Support people to leave hospital as soon as they are medically fit Next 5 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 **readmissions** Ensure increased **dignity** **Increase** the number of people who dies in a place of their own choosing

LONG TERM CONDITIONS (EG DIABETES, RESPIRATORY DISEASE, HEART FAILURE)

Our existing service	What are we going to do	Our outcomes in 5 Years
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 LTC's 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*	Increase self-care and screening for LTCs Work with patients and primary carer to increase education Build systems to predict those most at risk of requiring urgent care so they can be supported beforehand Develop care plans together to improve health outcomes to the best they can be 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 area available when required Be clear when people move into the palliative phases of their disease and care plan for that circumstance Next 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 increase 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 **readmissions** associated with LTCs

PLANNED CARE (NON-URGENT OPERATIONS)

Our existing service	What are we going to do	Our outcomes in 5 Years
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*	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 unnecessary follow-up Next 5 years →	Increase **day surgery / 23 hour** rates and reduced inpatient surgery rates Shortened **length of stay** for people required elective surgery Consistent application of elective care **protocols** Few 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	What are we going to do	Our outcomes in 5 Years
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 birth** - *we need to support this choice* Some communities access **antenatal** services too late - we need to support early contact	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 if antenatal services by hard to reach groups Next 5 years →	A **sustainable long term model** for maternity and neonatology services that complies with national standards **Increase home births** by 50% Improve **uptake of antenatal** and parenting support, particularly in hand to reach groups Better **perinatal** outcomes in LLR

CHILDREN, YOUNG PEOPLE AND FAMILIES

Our existing service	What are we going to do	Our outcomes in 5 Years
Existing services are **fragmented** for children and young people - *we need to coordinate care better* Good **informal working relationships** between part of the system although differing views on what good look like - *we need a consistent integrated approach* Variability in **transition** services - *we will ensure smoother transition to adult services* Lack of focus on supporting **independence** - *children & young people supported to self-care*	Review what Children and Adolescent Mental Health Services (CAMHS) capacity is required Develop options to facilitate greater integrate working between all sectors Establish age range that review will cover Develop a strategy around optimising children's life chances through public health interventions- Health and Wellbeing Next 5 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 structure and maximise productivity **Age appropriate** service across LLR More children and young people who have **coordinated care**

MENTAL HEALTH

Our existing service	What are we going to do	Our outcomes in 5 Years
Wellbeing inequalities and low life expectancy - *we need to support parity of esteem*	Develop peer support model for early interventions	Increase in **parity of eastem**
Mismatch between service need and location - *we need to align service across LLR*	Develop case management capability in all sectors to maintain relationships for people at times of crisis	Reduce **incidence** of mental health conditions
Waits for some services are **too long** - *we need to ensure people receive timely care*	Develop solution with education to reduce reliance on Children and Adolescent Mental Health Service	Reduced **crisis** escalation episodes, with quicker response times when required
Focus on **treatment** - *we need to increase prevention service*	Review what CAMHS capacity is required	Reduced **delays** in discharge and length of stay
Not enough **crisis resolution** and outreach including drug and alcohol - *we need to expand care*	Develop locality based teams to manage care close to home	**Integrated pathways** and case management for people
	Ensure services are equipped to deal with physical and mental health needs- parity of esteem	Reduced reliance on **acute services**
	Crisis responses service that responds in a timely way to support recovery	
	Next 5 years →	

LEARNING DISABILITIES

Our existing service	What are we going to do	Our outcomes in 5 Years
High use of specialist services and under - developed offer from universal and preventative service **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-price package provision - *we need to work together to manage and develop the learning disabilities market*	Joint market management and development Develop integrated personal budgets to match support better to needs More consistent whole life approach across children and adult service Better support for universal and primary care services Develop more integrated pathways and short breaks provision Next 5 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 **Good quality service provision is available** in LLR at the right place and time

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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.
- A greater focus on specialised care, teaching and research.
- Redeveloping the Accident and Emergency department at the Royal Infirmary.
- 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: bct@eastleicestershireandrutlandccg.nhs.uk

You can also send an email via the Better Care Together website at: www.bettercareleicester.nhs.uk

@bctllr

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