Better care together

Leicester, Leicestershire & Rutland health and social care

Outcomes Roadmap

Anticipated changes to health and social care services across Leicester, Leicestershire and Rutland in support of the five year strategy

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For May Partnership Board

Accurate as at April 2015

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Rutland County Council

healthwatch

Leicester City Council

Leicestershire County Council

NHS

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Background:

Better care together (BCT) is a five year major change programme aiming to improve both the quality and sustainability of Health and Social Care delivery across Leicester, Leicestershire and Rutland. The BCT programme encompasses projects run by the Health organisations, three CCG's, two provider Trusts and the ambulance Trust supporting the region, and the three Local Authorities and by creating an environment where these organisations can work together to a shared set of goals supports the implementation of beneficial integrated changes.

Delivering Outcomes:

The BCT programme was launched in 2014 and during an engagement campaign that took place in early 2015 outlined seven key outcomes to the citizens of Leicester, Leicestershire and Rutland. These are:

- We will ensure the very best start in life
- We will help people to stay well in mind and body
- We will provide faster access, shorter waits and more services out of hospital
- We will be there when it matters and especially in a crisis
- We will know people's history and plan for their needs
- We will improve care for the most vulnerable and frail
- We will provide improved support when life comes to an end

During the first quarter of 2015, following the approval by all Partner organisations of the Strategic Outline Case and strategic plan at the end of 2014, teams from across the Partner organisations have been developing detailed plans that will improve the delivery of health and social care across the region. It is expected that some of these plans will be implemented in 2015 and that the majority, those requiring Public Consultation, will be implemented after that Consultation, autumn 2015, and therefore from 2016 onwards.

The following tables provide Partner organisations with a summary of how these detailed changes will come together to make the service changes required to deliver the outcomes described above. During the next quarter the Partner teams will develop the narrative that describes the overall service changes in preparation for Public and staff consultation.

Readers should note that this is the position as of April 2015 and plans are still in development. Proposed changes need to undergo cross Partner triangulation, assurance and scrutiny; including assessment of affordability and value for money, as change will need to be funded and beneficial. These activities are presently underway in preparation for Public Consultation. As a result of these activities and Public Consultation plans will be reviewed and are subject to modification. The final description of services that will change will only be available post Public Consultation.

Points to Note

- The proposed changes to services outlined in the following pages are plans and are subject to change as a result of internal and external assurance and scrutiny. They are presented to provide a view of the roadmap of change to support the assurance and scrutiny process.

- For many of the proposed changes Public Consultation is required and this will determine the final set of changes that will be put in place. A final plan cannot therefore be agreed prior to Public Consultation

- In a number of areas plans are still developing and as a result the roadmap will change over time to include further initiatives to support improving health and social care in Leicestershire, Leicester and Rutland

- The various councils forming part of the Better care together partnership have identified different needs for the population they serve. As a result the proposed changes will in places differ between the three councils, Rutland, Leicester and Leicestershire as they respond to differing public and patient needs.

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Outcome: We will ensure the Very Best Start in Life

Vision

From what mums have told us we know that they want more choice about where they give birth and the reassurance that there is specialist expertise close by if anything should go wrong. So, we will be looking at how we can support expectant mothers to have their babies at home; how we can give mums the option to a midwife-led birth and how we can better support new families in the first year of having a baby. We also understand that older children and young people sometimes require services which are different to adults, so we will plan for services which are available in the community and which look after our young people's state of mind as well as their physical health.

Delivery plan

	2015	2016	2017	2018	2019
Parent and Baby	Support given to prospective parents is of universal quality and consistent across LLR	Pregnant women will access services at an earlier stage			Agreed changes to the provision of maternity services implemented
	Strategy for future delivery of maternity services agreed	Via Public health improved approaches to reduction of smoking in pregnancy and other behavioural issues implemented Mothers will be more prepared for parenthood through parenting support via antenatal classes			
		Improved approaches to perinatal care implemented			

	2015	2016	2017	2018	2019
Children's physical health	Pilot of integrated health and social care services for disabled children	Further roll out of integrated health and social care services for disabled children	More visible provision of acute paediatrics in place		
	Revised constipation/continence planned care pathway implemented	Revised hepatitis B vaccination planned care pathway implemented			

	2015	2016	2017	2018	2019
Children's and young people's emotional health and wellbeing	Agree model for consistent high quality support provided via schools and community settings to increase resilience in children and young adults	Implementation of consistent high quality support provided via schools and community settings to increase resilience in children and young adults			
	Agree multi agency emotional health and wellbeing strategy	Expanded helpline available for professionals			
	Improved support available for vulnerable young people and troubled families				
	There will be improved access to care at appropriate time and level for children and young people				

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Outcome: We will help people stay well in mind and body

Vision

Everyone knows that prevention is better than cure, but we still spend most of our time and money treating illness. We all need to focus more on wellness. In future we want local people to have the best education and support to stay healthy regardless of their age or background. This means more time and effort spent on

1. Improving people's life chances: Ensuring that the conditions in which people are born, grow up and live in are conducive to good health i.e. through better housing, social environments, education, training and employment for all and;
2. Facilitating better life choices: Including training and educating people, strengthening their resilience to overcome issues which will affect their health and wellbeing. This could be achieved through partaking in "five ways of wellbeing"; eating more healthily, exercising and becoming active, achieving optimum weight, drinking responsibly, and stopping smoking.

We want to help and support people to make healthy choices in their lives and we will work in partnership with them to increase their resilience against mental and physical illness irrespective of their age and background.

Delivery Plan

	2015	2016	2017	2018	2019
Public Health: Improving health resilience for all	Various initiatives to • Support five ways of wellbeing • Provide social prescribing • Increase mental health awareness training • Reduce mental illness stigma • Strengthen workplace health • Tackle social isolation • Prevent suicide and self-harm				
Integrated health and social care (BCF)	Rutland: Assistive technology tele care offering in place	County: Revised information and advice offer available			
	City: Integrated mental health step-down service launched				
	City: All GP practices have access				

	to the “Lifestyle” hub County: Unified Prevention Offer available				
For those with Learning Disabilities	First occupants use specialist Agnes unit for complex learning disabilities and to continuing health care step up and step down facilities	New short breaks service procured			
	Properties for learning disabilities Step Up/Step Down provision purchased				
For those with Mental Health issues	Two new Recovery colleges opened	One additional Recovery college opened			
	New crisis house and crisis pathway changes in place and impact evaluated	Proposal for liaison psychiatry being made with providers and commissioners			
	4 hour and 2 hour crisis targets being met				
	1st episode of psychosis targets met				
	Improving Access to Psychological therapies target met				
	Place of safety review complete				
	Psychiatric intensive care units review complete				
	Evaluation of bed configuration and capacity requirements complete				
	Relocation of High Dependency services initiated				
For Children and young people		Consistent high quality support provided via schools and community settings to increase resilience in children and young adults			
		Commence work with primary care to look annual children asthma management			
For People with long term		Early detection of cardio-vascular disease increased via Health checks			

conditions		Heart failure virtual advice service in place			
		County: Risk identification and profiling to identify people at risk of requiring social care interventions in place			

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Outcome: We will provide faster access, shorter waits and more services out of hospital

Vision

For procedures and treatments which are planned in advance and therefore not an emergency – like hip replacements and cataracts – we often hear that while the end results are good patients can spend too long waiting for their first appointment or the procedure itself or even in hospital before being allowed home. We are also cancelling too many planned operations at the last minute because of emergency demand. If future we will start to separate planned or "elective" care from emergency care by moving some services into community hospitals and creating a dedicated centre for procedures that can be completed in a day.

Delivery Plan

	2015	2016	2017	2018	2019
Primary Care reconfiguration	Primary care services work together as federations, health needs neighbourhoods or hubs	In Leicester City primary care is developed to support additional services	Leicester city practices provide Out of hours care and specialist care including in some cases planned outpatient care and diagnostics		
		Across East Leicestershire and Rutland 7 day primary care services are available for patients with complex conditions			
Community and acute Service reconfiguration	Additional intensive community support services implemented	Further additional intensive community support services Implemented			Acute services provided from two hospitals for LLR
		Changes to the model of care in some community hospital settings to provide more sub acute care			
		Configuration of community services and community	New community services offering in place at some		New models of community services and hospital

		hospitals agreed	locations		configuration live across LLR

	2015	2016	2017	2018	2019
Children and young people	Revised constipation/continence planned care pathway implemented	Revised hepatitis B vaccination planned care pathway implemented			
	Improved access to Emotional health and wellbeing support services				
Maternity		Pregnant women will access services at an earlier stage			
Long term conditions	County: Realignment of social care teams in Leicestershire to reflect community health services	Improved availability of COPD care in the community			
		Heart failure rehabilitation service implemented			
Planned Care	Revised referral process for orthopaedic s implemented	New referral processes for hearing services and ENT balance services implemented			
	Revised referral process for gastroenterology implemented	New referral process for ENT services implemented			
	Increased availability of treatment for back pain in community settings	Urology: increased availability of cystoscopy in community settings			
	Increased availability of endoscopy in community settings				
	Revised referral pathways for hernia services implemented				
	Implementation of Tinnitus guidelines for ENT				
	Reduction in follow-up appointments by using virtual clinics/open access follow ups and remote follow up methodologies				

	New referral process for ophthalmology implemented				
Adult Social Care	City: Crisis in-reach to support discharge from acute care settings				
Technology	Roll-Out of technology in primary care to support changes of Planned Care referral pathways				

Outcome: We will be there when it matters and especially in a crisis

Vision

A lot of our plans are about avoiding a health crisis by getting the right services to people more quickly, but even then some people will still become poorly. When they do our community crisis response teams will be there quickly. They will discuss the options with people and where possible organise specialist teams to care for people in their own homes rather than hospital. If a trip to hospital is required then from the winter of 2016 patients will be looked after in the UK's only purpose built "frailty friendly" A&E. And when it is time for them to go home we will make sure that all the services they need to continue to live independently are in place.

Delivery Plan

	2015	2016	2017	2018	2019
Integrated health and social care (BCF)	Integrated crisis response teams in place across LLR	Multi-disciplinary teams of shared nurse and social care workers in place to aid transfer from hospital			
	Access to a GP in a crisis				
Children and young people	Develop appropriate model to deal with young people in crisis	Crisis team implemented		More visible provision of acute paediatrics in place	
Long term conditions	Access to emergency ambulatory care for patients with respiratory disease and heart failure increased	Community heart failure rehabilitation services implemented			
Mental Health	Changes to mental health crisis response network in place				
	New mental health urgent care clinic established				
	Crisis house opened				

Delivery Plan

	2015	2016	2017	2018	2019
Urgent Care	Acute Visiting Service (County West) GP clinical response service (City)	New 111 service goes live	Review and redesign of out of hours services complete	New ambulatory care pathways are implemented	Single point of access, same day access and integrated clinical triage available via primary care
			Urgent care services all work to same high standards and services available are clearly recognisable	Urgent care offer in place via primary care	
			Crisis response services across the county are optimised		
			Patient education programme for urgent and emergency care options is in place		
Service reconfiguration		New emergency floor at Leicester Royal Infirmary opened			
Technology			Unified care plans shareable between organisations		

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Outcome: We will know peoples history and plan for their needs

Vision

Often a crisis like a fall for an older person or a worsening of an existing illness is predictable, yet for too many people the result is a hospital visit. In future we are going to work with carers and their patients who we know are at risk to make sure they have personal care plans completely focussed on them and their needs. And we will make more services that have traditionally been based in City hospitals available in the community. This will mean that a spell in hospital becomes the exception in all but the most complex of situations.

Delivery plan

	2015	2016	2017	2018	2019
Adult Social Care	City: We will have social worker teams aligned to GP populations for planned care				
For People with Long term conditions		Targeted intervention to improve bowel and breast cancer screening take up			
		Improved availability of COPD care in the community			
		Community heart failure rehabilitation services implemented			
For those at the End of Life	Unified advanced care planning for those at end of life and training in place	Extended care planning to patients with cardiovascular disease			
		Shared care plans increased for patients at end of life			
Frail Older People and Dementia	Care Plans in place for people most at risk of admission				
	Rapid support and assessment for people when they fall				
For Children	Pilot of integrated health and social care services for disabled children	Roll out of integrated health and social care services for disabled children			

	2015	2016	2017	2018	2019
Planned Care	Increased availability of treatment of back pain available in community settings	Urology: increased availability of cystoscopy services in community settings			
	Increased availability of endoscopy in community settings				
Community and acute Service Reconfiguration	Additional intensive community support services capacity provided	Additional intensive community support services capacity provided			New models of community services and hospital configuration live across LLR
Frail Older People and Dementia	Ambulance staff trained to use a Falls Assessment Risk Tool and avoid unnecessary admission to hospital				
Technology and information	In Rutland 50% of social care records have NHS number recorded increasing ability for health and social care to share patient data	Ability for GP's to share patient records electronically implemented	New electronic patient record system implemented in acute hospital		
	County: NHS number will be included in social care records	Various initiatives in the city including: Electronic prescribing, Wi-Fi in care homes	Unified Care Plan sharable between organisations		
	County: Technology to provide aggregated activity data across health and social care and support care improvements implemented				

	County: “Nerve Centre” to share performance information across health and social care developed				
Primary Care	Increasingly the majority of patients in care homes have care plans				

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Outcome: We will care for the most vulnerable and frail

Vision

We know that there are older people living locally than ever before, and while many are enjoying healthy and independent lives, for some old age is lonely and beset with health problems. We know people want to live independently, preferably in their own home, for as long as possible and we will support them to do this. We will make sure we know who are the most vulnerable and give them the most support. We will work with carers and especially those who are looking after people with dementia, to make sure they get the help they need. We will respond to calls for help for the most vulnerable quickly to avoid them reaching the point where a stay in hospital is the only option.

Delivery Plan

	2015	2016	2017	2018	2019
For people with Learning Disabilities	First occupants use specialist Agnes unit for complex learning disabilities and to continuing health care step up and step down facilities	New short breaks service procured			
For Children and young people	Improved support for vulnerable young people and troubled families available				
	Pilot of integrated health and social care services for disabled children	Further roll out of integrated health and social care services for disabled children			
	Increase capacity to support young people and their families with eating disorders				
For Frail Older People and those with Dementia	Establish Hospital Liaison support team for Dementia	Early detection of cardio-vascular disease increased via Health checks			
	72 hour crisis response team in place in Leicestershire and integrated crisis response teams in place in Rutland				
	Local area co-ordinators being piloted in Leicestershire and phase 1 of community agents implementation live in Rutland	Heart failure virtual advice service in place			
	Older peoples unit for those with complex health and care needs opened in Leicestershire				

	The dementia Strategy will have been refreshed and we will have a new action plan				
	County: Extension of carer assessment and carers personal budgets to support people to continue to provide care				

	2015	2016	2017	2018	2019
Adult Social Care	Commissioned service for people with dementia – advocacy, advice and information, activity groups and carers				
Integrated health and social care (BCF)	Increased level of integrated care to support enabling people to stay at home in place	Multi-disciplinary teams of shared nurse and social care workers in place to aid transfer from hospital			
		County: Help people to Live and Home and stay well through procurement of integrated home care services across Leicestershire, help to keep more people independent			
		County: Refocussing reablement services to support early discharge from hospital			
For those at the end of Life Care	Access to “Hospice at Home” increased	Shared care plans increased for patents at end of life			
	Unified advanced care planning for those at end of life and training in place				
	100% of patients at end of life have a named GP on discharge from hospital				
	Availability of night care to support patients at end of life increased				
Primary Care	Increasingly the majority of patients in care homes have care plans				

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Outcome: We will provide better support when life comes to an end

Vision

It happens to us all and yet it is a subject which patients and families, as well as doctors and nurses sometimes struggle to talk about. Most people at the end of life would prefer to die at home with friends and family around them, but they need support to make that choice. They also need support in their last days for them to have the best death possible. We will make sure that doctors, nurses and other professionals are properly trained to have these difficult conversations with carers too, so that patient's wishes are honoured to the end of their life.

Delivery Plan

	2015	2016	2017	2018	2019
End of life care and Learning lessons to improve care	Access to "Hospice at home" increased	Shared care plans increased for patients at end of life			
	Unified advanced care planning for those at end of line and training in place	Strategic partnerships with charities in place			
	100% of patients at end of life have a named GP on discharge from hospital				
	Availability of night care to support patients at end of life increased				
Children and Young People			Implement regional model for children's palliative care		
Technology			Increasingly the majority of patients in care homes have care plans		