Better care together

Leicester, Leicestershire & Rutland health and social care

Community Services Offer

Summary of proposed improvements

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Appendix 1: Submitted to Leicestershire HOSC to support community services offering discussion

Rutland County Council

healthwatch

Leicester City Council

Leicestershire County Council

NHS

1. Background:

Community care services consist of a wide range of services that are available to patients either via referral by their GP or on discharge from hospital. In Leicestershire they include

- Planned care including minor operations and rehabilitation support
- Crisis support to prevent hospital admissions
- Step down services including Intensive community support delivered in a patients home
- Unscheduled care such as dealing with a blocked Catheter
- Inpatient beds for stroke rehabilitation
- Inpatient beds for rehabilitation and care of the elderly
- Inpatient beds for palliative care

The design work that has taken place as part of the Better care together (BCT) programme and the Leicestershire Better Care Fund (BCF) has identified that across the county a number of these services need to be improved and re-organised if the local health care system is to improve quality of care, increase sustainability and cope with an ageing population with a prevalence of long term conditions.

Overall the change will be positive for the residence of Leicestershire with more services being offered in accessible community settings as opposed to City hospitals. This paper describes how each of the relevant BCT work-streams plan to increase and improve care provided in this care setting.

2. The Evidence Base for change

The Reconfiguration of Clinical Services is an evidence-based review by the Kings Fund, which looked at the drivers of reconfiguration and the underpinning evidence. It builds on a major analysis commissioned by the National Institute for Health Research (NIHR) and reviews of service reconfigurations conducted by the National Clinical Advisory Team (NCAT).

For community health services, the evidence base is as follows:

- There is strong patient satisfaction associated with virtual ward programmes and case management programmes. Available evidence points to a positive impact of integrated care programmes on the quality of patient care and improved health or patient satisfaction outcomes. Patients are more satisfied with hospital at home than with inpatient care because it was possible to provide a more personal style of care and staying at home was considered to be more therapeutic.

- A significant proportion of hospital beds are occupied by frail older people and people with Long-term conditions who would be more appropriately cared for in the community. For some conditions, admissions can be avoided with more proactive care, and in many cases, length of stay could be reduced if there were more services to support rehabilitation and

discharge. This would deliver a much better patient experience.

- Evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking.

- However, there is a lot of evidence to suggest that it can be hard for community-based initiatives, including changes to primary care, to significantly reduce hospital admissions. Delivering improvement seems to require new ways of working across a system, including within hospitals, supported by good continuity of primary care. Even with successful implementation, there is little evidence to suggest that more community-based models of care will generate significant savings. Future workforce projections also present challenges to community-based models of care.

- There is mixed evidence on the capacity of community and primary care-based initiatives to reduce unplanned hospital admissions and help keep people at home. A recent literature review found that continuity of care (being able to see the same professional) reduced unscheduled secondary care. The table below outlines the areas BCT needs to focus on to have an impact on hospital admissions.

Table 2 Summary of evidence on the impact of community-based initiatives on unplanned admissions

Intervention	Impact on unplanned admissions	Disease area/client group	Evidence source
Case management	Reduces	Heart failure and some older frail people	(Purdy *et al* 2012) (Purdy 2010)
Care co-ordination as part of integrated health and social care teams	Reduces	Older frail people	(Philp *et al* 2013)
Specialist clinics	Reduces	Heart failure	(Purdy *et al* 2012)
Education and self-management	Reduces	Adults with asthma and COPD	(Purdy *et al* 2012) (Purdy 2010)
Exercise and rehabilitation	Reduces	COPD and cardiac	(Philp *et al* 2013) (Purdy *et al* 2012)
'Virtual integration'	No significant reduction	Diabetes +/or over 75	(Curry *et al* 2013)
Virtual wards	No impact	High risk	(Bardsley *et al* 2013)
Vaccine programmes	No impact	Asthma, COPD, older people	(Purdy *et al* 2012)
Medication reviews	No impact	Older people, people with heart failure or asthma	(Philp *et al* 2013) (Purdy *et al* 2012)
Falls prevention	No impact	Older frail people	(Philp *et al* 2013)
Integrated care pilots	Increases emergency admissions Decreases elective admissions	Varied	(Roland *et al* 2012)
Hospital at Home	Increases	Older patients with a range of conditions	(Purdy *et al* 2012)

Table 3 Impact of primary care factors on unplanned admissions

The table summarises findings from Purdy (2010) in a review of the evidence on avoiding hospital admissions.

Factor	Impact	Disease area/client group
Small and single-handed practices	Depends on condition – can increase admissions	
Continuity of care	Reduces admissions (but some studies less conclusive)	Ambulatory care sensitive conditions
Out-of-hours care – clinician factors	Wide variation in admission rates between GPs	
Out-of-hours care – change in GP contract	None	
Quality of primary care as measured by the Quality and Outcomes Framework (QOF)	Evidence inconclusive	

Ref: The Kings Fund, The reconfiguration of clinical services 2014

The Kings Fund also describe that there is evidence that community

- Poor implementation is a key obstacle to community-based initiatives achieving significant impact on rates of admission (Bardsley *et al* 2013). There are also risks of supply-induced demand (Roland and Abel 2012).

- The key to reducing the use of acute beds lies in changing ways of working across a system, including changes within hospitals, rather than piecemeal initiatives (Edwards 2014; Imison *et al* 2012; Simmonds *et al* 2012).

This national experience of service reconfiguration has been taken into account in the design of future services. The lack of evidence that such changes to community services improves system financial sustainability highlights the need for the BCT partnership to be conscious of where financial savings will be delivered and to drive them out throughout the change process. These financial benefits may be found in various parts of the whole system which is in line with the evidence that reducing acute beds requires system change.

Locally, work has been done to establish an evidence base for change. A number of utilisation reviews have previously been conducted in University Hospitals Leicester (UHL) and Leicestershire Partnership Trust (LPT) which illustrate the potential for change within the system. These studies identified the potential for shift in activity from acute to community settings if admission protocols and settings of care are improved out of hospital, and inappropriate admissions and inappropriate continued stays in both organisations were addressed.

A series of ward audits have been completed. These audits covered 160 patients across 6 UHL wards and identified a quantum of patients that do not need to be cared for in an acute setting. The audit work has focussed on establishing these patient's needs to inform the model of care that needs to be in place for care to transfer safely and effectively to the community.

The ward audits identified that 43 out of 160 patients could be cared for by the LPT Intensive Community Support Service (ICS), if the service could meet a specific set of patient needs. This is shown in the diagram below.

The MDT ward audits identified that 43 out of 160 patients could be cared for at home if the following needs could be met by ICS

- No triggers in the last 24hrs
- EWS of 0 or 1
- Less than QDS observational monitoring
- Oxygen requirements can be met
- Nebs can be managed
- Chest physio (daily only)
- No drains/mini trachy/suctioning
- Low flow CPAP can be managed
- Non-community available meds required (except IV chemo)
- No cardiac intervention (monitoring)
- No renal replacement
- No continuous IV fluids
- No fluid balance monitoring
- No additional biochemistry monitoring
- Dietician input can be managed
- No NGT/parenteral/drains
- No additional monitoring other than standard
- No radiological requirements
- Specialist team involvement can be managed
- Extensive TVN input can be managed
- IV therapy requirements can be managed

Row Labels	Count of Number
15 - respiratory	12
28 - cardiology	2
31 - medicine	9
38 - diabetology	5
43 - medicine	15
Grand Total	**43**

Row Labels	Count of Number
Cardiology	2
Diabetes	5
Medicine	24
Respiratory	12
Grand Total	**43**

Agreement from group that this is a reasonable list of needs to be met by ICS

These finding support the increase in the availability of ICS services that will be described later in this document.

3. Relationship with UHL Strategic Plan

The achievement of the UHL strategic plan is dependent on the reconfiguration of community services and thus on the BCT consultation. An additional dependency is the planned re-configuration of women's services including maternity, which will be consulted as part of the BCT public consultation.

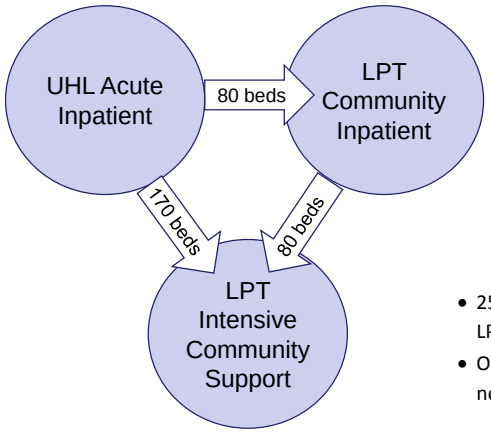
A number of the changes described below will need to be successful for UHL to achieve its strategy and these include

- Planned care activities being increased in community settings
- Improved support of patients with long term conditions to self-care
- Improved diagnostics so that long term conditions can be identified and treated earlier
- Improved admission prevention and support in a crisis

- Increase in the level of Intensive Care Support services in the community
- Implementation of Sub-acute services in the community
- Reconfiguration of the community estate to support overall change in ways of working

The diagram shows the interdependencies between the UHL strategy to become a smaller more specialised service provider with the changes to LPT in patient and ICS community services. For convenience the "currency" of beds is used, however the ICS services are not delivered via physical hospital beds but are services provided at home. Work to explain the relationship between staff levels required to deliver ICS services and number of beds no longer required in an acute setting is ongoing and the present assumptions generate the numbers shown in the model.

- UHL to become smaller and more focused as a Trust, ensuring that local services are integrated with primary and social



- 80 sub-acute beds to be established in community hospitals
- Ability to care for a new cohort of more acute patients in a community inpatient setting

- 250 additional "home beds" to be created in the LPT ICS service
- Operating model in place which meets patient's needs and ensures they can be cared for at home

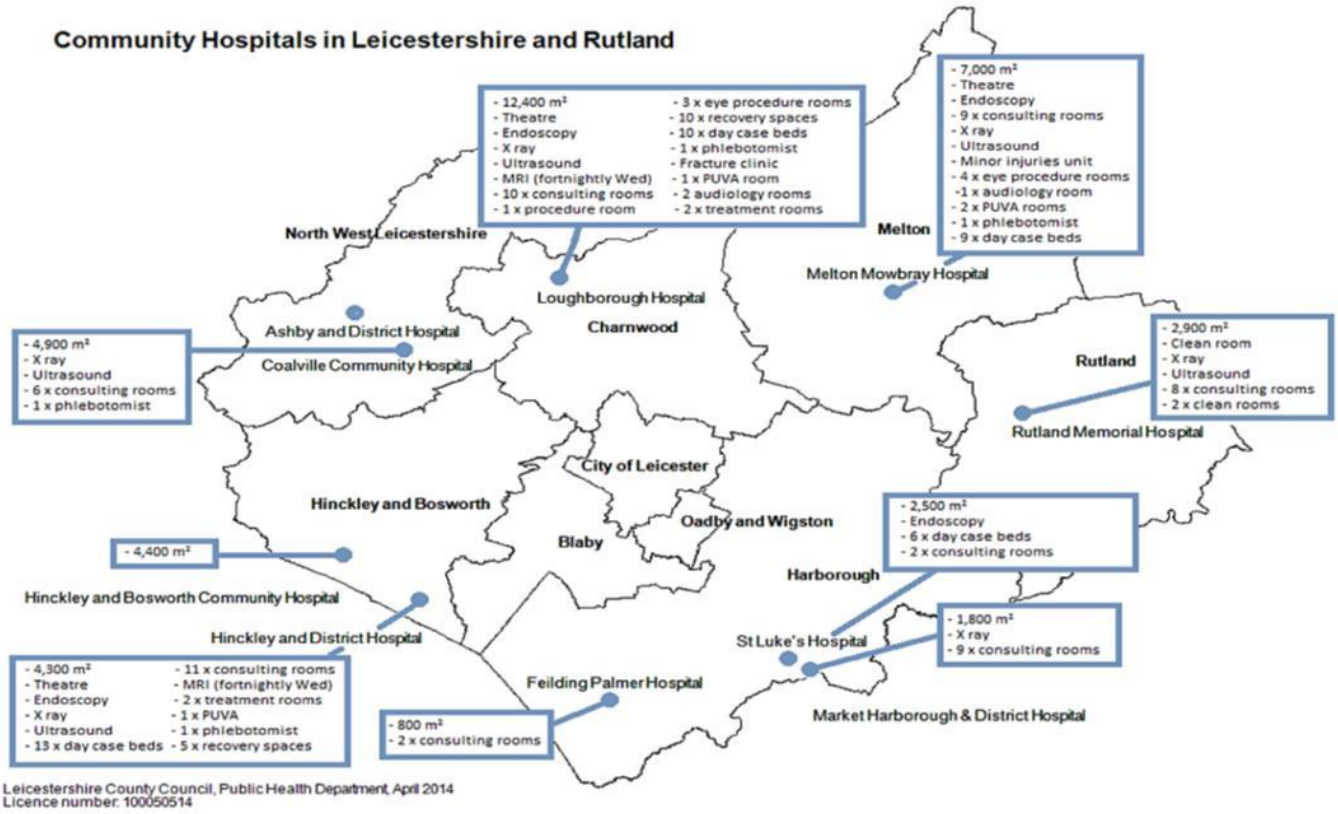
4. Planned Care:

The overarching strategy for planned care is to move more services into community settings out of the acute setting of UHL carry out more day surgery and repatriate patients who presently go out of county for planned care services. The information below is taken from the Planned Care teams' overview of their plans and is being used to develop the narrative for BCT public consultation.

Community strategy for future service model

The impact of these changes on each locality is presently being completed however it is expected that many community hospitals will see an increase in services. The present profile of where planned care is delivered via the Alliance contract and view of proposed changes is described below.

Alliance Community Sites



Potential changes are:

Melton

- Theatre site for ELR Day Case activity done under General Anaesthetic
- Expand endoscopy lists
- Create clean room for additional Day Case activity
- Retain X-Ray, U/S
- Potential for medical day case facility

Rutland Memorial

- Expand as an outpatient site
- Increase diagnostics/one stop shop services
- Develop clean room for Day Case /Out Patient Procedure
- Retain X-Ray and U/S
- Potential for medical day case facility

Market Harborough

- Move Out Patients services to St Luke's new build
- Increase endoscopy activity on St Luke's site
- X-Ray and U/S at St Luke's
- Create clean room in new build for day case and Out Patient procedures

Lutterworth

- Review future of outpatient activity at Fielding Palmer
- Move activity to primary care sites or to Market Harborough
- If site retained as a Hub, potential for medical day case facility?

Implications for sites in West Leicestershire

- The Alliance anticipate continuing to operate from three sites in West CCG (Loughborough, Hinckley and Coalville)
- Case mix of activity may change, potential to concentrate activity in particular specialisms on one or site to maximise use of clinical capacity
- Hinckley needs redevelopment to provide high quality patient environment
- Endoscopy at Hinckley not JAG accreditable, will impact on ability to carry out future work there. Need to consider whether a new endoscopy unit is part of the potential redevelopment of the Hinckley site
- Potential to concentrate General Anaesthetic work in one theatre and use procedure rooms for majority of day case procedures –more modelling and clinical validation required to confirm this
- Alliance could use vacated ward(s) to carry out day case activity such as chemotherapy, infusions etc
- Undertaking review of provision of MRI – economics of mobile MRI
- Engagement with local people via Alliance engagement events and BCT consultation

5. Additional services for those with Long Term Conditions

There are also plans to increase the services for those with Long Term Conditions delivered in community settings. Options presently being considered are

- Additional Bowel scope screening services at Loughborough and St Luke's hospital
- Establishment of community respiratory clinicians and Loughborough hospital as part of an integrated respiratory service
- Specialists nurse/therapists available in the community as part of an enhanced cardio-vascular disease pathway

6. Crisis support to prevent hospital admissions

The approved Leicestershire BCF plan encompasses a number of initiatives that are already increasing services in the community with the goal of preventing unnecessary hospital admissions. These include the following;

- Integrated Urgent Response: These are integrated rapid response community services aimed at avoiding unnecessary hospital admissions for those requiring urgent assistance. Services include a new rapid assessment service for the frail and elderly and people who fall. There is also a plan to develop primary care seven day services that integrate effectively with community based health and care services.

- Hospital Discharge and Reablement: Making significant improvements in the timelines and effectiveness of discharge pathways from hospital especially for frail elderly people, reducing the length of hospital stays. This includes consolidating, integrating and extending community based services into a 24/7 service with a single point of access.

7. Step Down services including intensive community support delivered in a patients home

Sub-Acute Inpatient Care

As part of the overall transformation the community hospitals will increase their provision of sub-acute services which are described below along with LPT's proposed plans which are presently being discussed with the CCG's

Sub-acute care is a relatively new and rapidly growing multi-disciplinary service, which merges the sophisticated technology of a hospital with the efficient operation of a skilled facility in a non-acute setting. Patients with sub-acute needs are those who have had their acute illness, injury or exacerbations treated, but require a short period of complex care and further treatment before they enter the rehabilitation phase of their care pathway. Sub-acute care is less intensive than acute hospital care and more intensive than inpatient rehabilitation – It sits between the two.

Ward audits have identified a number of patients in acute hospital beds, who have sub-acute needs and could be treated closer to home, for a short period of time, in a sub-acute facility if such a facility was available in Leicester, Leicestershire & Rutland. It is proposed to develop two such facilities in Leicestershire as a replacement for acute hospital beds on a like-for-like basis, with the two facilities spread across Leicestershire to give as many patients and their carers the best possible geographical access to this new service. In time, it may be possible to offer sub-acute care at more than two facilities.

Sub-acute patients will receive coordinated services from a multi-disciplinary team including physicians, nurses, therapists and other relevant professional disciplines, with a goal orientated care plan based on their individual needs. Patients will step down to sub-acute care from the acute hospitals in Leicester and will step down again from sub-acute care to local rehabilitation

services provided by an increased level of ICS service in their area (predominantly in their own home, but in their local community hospital if that is not possible).

The location of the two sub-acute wards proposed for Leicestershire is presently in discussion. Both CCG's agree that the existing in-patient bed configuration will need to be re-focused to provide sub-acute care that is presently provided via an acute bed at UHL.

Intensive Community Support:

The intensive community support (ICS) service provides an intensive rehabilitation service to promote independence and recovery for frail older people in an environment that they are most familiar with (i.e. their own home). The multidisciplinary service is advance nurse practitioner led, with medical inputs from the patient's GP as required. The service aims to prevent or reduce the need for permanent or long term care packages, by promoting, supporting and encouraging self-management.

The service is available to all suitable patients registered with a Leicestershire GP. It operates from 8.00am to 10.00pm every day of the year, with overnight support available (through better care funded support). Response time is within 2 hours of referral.

ICS is a scheduled care service, with capacity and phasing as follows:

Year	2014/15	2015/16	2016/17
Beds	126	256	376
Occupancy Rate	90%	90%	90%
Length of Stay	Up to 26 days	Up to 10 days	Up to 10 days

The information below provides examples of the types of interventions delivered by the ICS service. This list is not exhaustive but gives an indication in the types of patients suitable for the service:

- Low Impact – Eye drops, TED stocking reapplications, simple dressings, bladder irrigation, bladder scan, pressure area care, meds prompt, BM check, equipment, leg washing and hosiery application, pessary, meds admin, INR, injection (S/C and I/M), insulin, nephrostomy care, catheter care/bag change, stoma bag, ear drops, safe and well assessment, observations, bloods, care of the elderly, removal of sutures/staples, equipment checks, splinting review.

- Medium Impact – End of life care, chemo pump, Doppler, MS and MND, AUR, catheter, continence, ear syringing, safeguarding, exacerbation of long term conditions, chronic and acute wound care, Hick and PICC lines, IVs, bereavement visits, cannulation, PEG, bowel care, end of life assessments, support, non-complex gait re-education, transfer practice, exercise programmes, outdoor mobility practise, equipment assessment and provision, modification of existing splints.

- High Impact – ICS assessment, falls assessment, HART assessment, CHC fast track, other assessments, complex patients, neurological treatment, falls assessment, complex exercise programmes, therapy initial assessment, complex gait re-education, complex initial assessments, splinting assessment and provision, respiratory assessment and treatment, ADL rehabilitation.

- Hyper Impact – CHC assessment, complex interventions in excess of 2 hours, seating assessments, positioning assessment and provision of individualised equipment.

The findings outlined in the evidence base described earlier have been scaled up to establish which specialties the additional 130 beds will come from. This approach has been sense checked by reviewing the total bed base for the targeted specialties, and cross-checking against the percentage of patients in each specialty that were identified as suitable for ICS in the original audit work. This quantitative work has been considered alongside qualitative feedback from the MDT teams completing the audits, and work with the business intelligence teams, and the out of hospital community services project is confident that 130 beds worth of activity can be transferred to ICS in 2015/16.

Specialty	Beds worth of activity to be moved to ICS
Medicine	72
Respiratory	36
Diabetes	15
Cardiology	7
Total	**130**

The BCT plan to increase the level of this service over the next two years and will require changes to staffing levels. The following additional staff numbers are required to implement the additional 130 beds in 15/16:

Year	2015/16
Qualified Nurses	25.79
Physiotherapists	15.47

Occupational Therapists	15.47
Unqualified staff (nursing and therapy)	34.38
Admin	3.00

UHL and LPT have been working together to try to encourage staff to transfer from UHL to LPT in order to allow the first 65 beds to transfer. Open Days have been held with positive levels of interest. Staff have attended Taster Days and a number submitted formal expressions of interest and attended an interview. The process is ongoing and highlights one of the major area of risks to the progress of the programme of changes at pace which is the ability to attract the right staff both in terms of numbers and quality.

The impact on Social Care has also been assessed. Up to one hour of generic social care support per patient per day may be delivered through the ICS model, depending on patient need. This is to ensure the model delivers effective integrated care and efficiently uses our collective resources by reducing duplicated health and social care visits for patients supported by both services. The specific services that will be in scope to be delivered during this hour are currently being developed with all three local authorities.

In-patient beds:

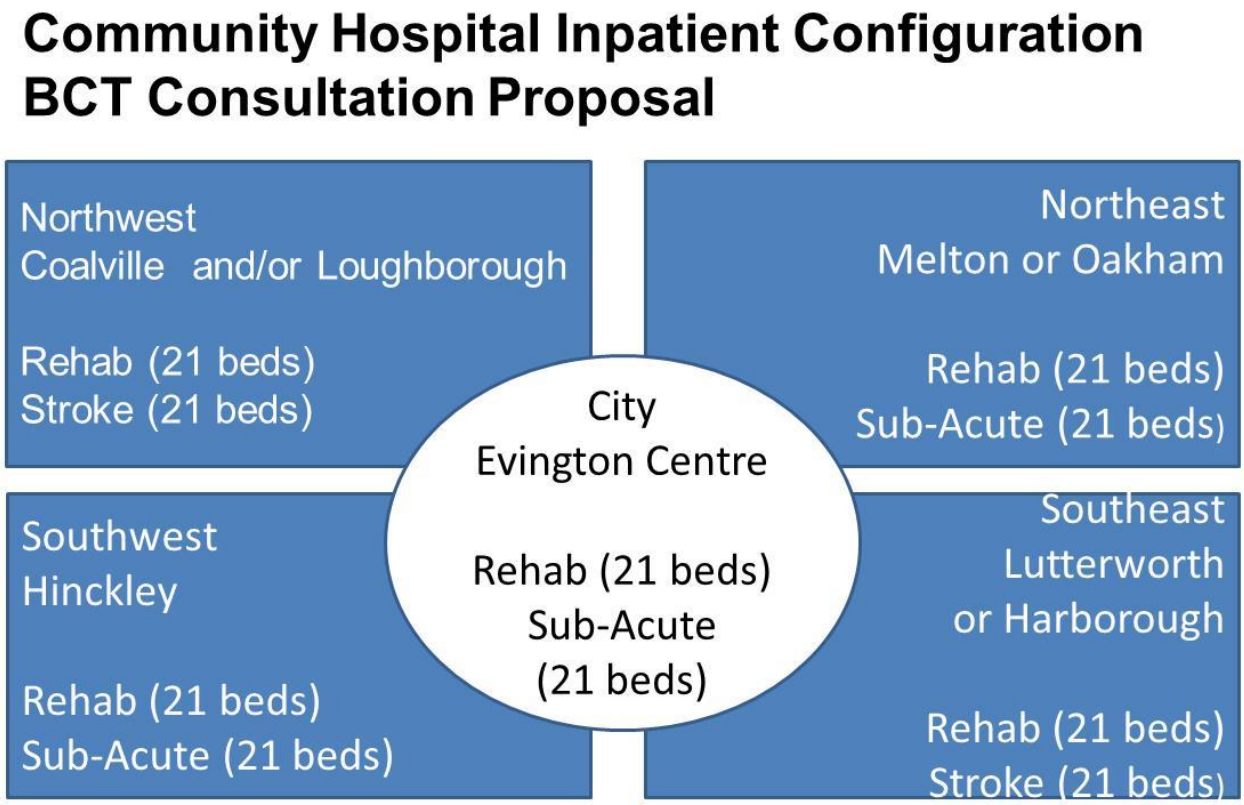
As described above the overall number of in-patient beds in Leicestershire will need to be re-focused to support the improvements to sub-acute care. Additionally there are clinical and workforce drivers that lead to a proposal to reduce the number of community hospitals having in-patient beds.

There are nine community hospitals in Leicestershire & Rutland, each accommodating a range of outpatient, diagnostic and inpatient services. These community hospitals are in Coalville, Hinckley (two), Loughborough, Lutterworth, Market Harborough (two), Melton and Oakham. Over the past decade, more services have been provided in the community setting and there has been less demand for inpatient services in both the acute and community hospital setting.

As such, many of the community hospitals now only have one inpatient ward, operating in isolated conditions which is not felt to be consistently safe for patients nor sustainable in the future from a staffing perspective. Guidance from the Royal College of Nursing on safer staffing for older people wards identifies that community hospital inpatient wards to operate with 1 registered nurse per 7 patients to provide basic safe care and ideally at 1 registered nurse per 5 patients for ideal good quality care. NICE guidance identifies ward size (and layout) as a factor in the provision of safe care and Leicestershire Partnership NHS Trust seeks to have wards that are 21 beds in size to adhere to the RCN and NICE guidance. The sustainability of community hospital inpatient services requires there to be two or more wards on community hospital sites, so that there is sufficient staff to deal with complex clinical and non-clinical situations as they arise and ensure continuous patient safety throughout.

The LPT proposal is that there will be sufficient community hospital inpatient demand for 10 wards (i.e. 5 rehabilitation, 2 stroke rehabilitation and 3 sub-acute care), which will need to be sited in pairs on 5 of the community hospital sites across the whole of Leicester, Leicestershire and Rutland.

The final configuration is still in discussion with the CCGs however the initial principles proposed by LPT are summarised below.



8. Conclusion

As part of the overall change programme known as BCT the delivery of services in the community care service will change over the next 4 to 5 years. The majority of change will be an increase in the availability of services and the moving of some services from an acute setting to a community setting. However there will also be some changes in the utilisation of the overall community estate and the locations where citizens of Leicestershire receive their care. As a result these proposals are in places subject to a public consultation.