Better care together

Leicester, Leicestershire & Rutland health and social care

Summary of East Leicestershire and Rutland CCG Community Services Strategy

Appendix 3: BCT HOSC 9th Sept 15

Owner: Mary Barber

APPENDIX

1. Background

East Leicestershire and Rutland (ELR) CCG have a detailed strategy for the future of community services that they commission. The document describes the situation today and outlines a future model of care and the workforce challenges that need to be addressed to achieve that goal. This is not yet a public document so the Case for Change and a summary of the future services and workforce challenges are described here.

2. The case for change

The CCG's review of current models that are being delivered by providers including engaging with local partners and stakeholders has clarified the problems encountered by patients, carers and GPs when accessing health services locally.

There is widespread acceptance and agreement that change is both necessary and desirable.
There is equal recognition and acceptance by all concerned – including the CCG – of the importance of engaging with local stakeholders as part and parcel of agreeing and implementing the final decisions on how to proceed in detail.

The principles and factors which will influence the design of a proposed service model are:

- Home First as a prominent principle of service delivery;
- Demographic pressures – more people in the CCG area 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 reablement;
- Patients find accessing care confusing and setting up a care package for a patient is complicated and time consuming for primary care;
- Recruitment of GPs is becoming more difficult and it is likely that recruitment locally will not be able to keep pace with demand;
- GPs will be managing a higher acuity patient in the home;
- Significant and unacceptable variation in response times across the area covered by the CCG;
- Communication between GPs and community service staff is reported to be sporadic at times and as a result is felt to be inefficient;
- Significant recruitment and retention issues in community nursing workforce with a high vacancy rate;

- Community services set up to deliver care aimed at providing an alternative to and avoiding hospital admissions is impacted by inability to recruit staff and the pace of Better Care Together changes;

- Current condition of estate across ELR is variable and is – in parts - poorly utilised;
- Small numbers of physical beds are spread across four sites which risks compromising clinical quality (limited peer review, isolation of staff) and is not cost effective; (HBN Adult 0401 – 24 beds); and

- Under-utilisation of current Intensive Community Support (ICS) beds.

3. Future model of care

Model Overview

It is acknowledged that the 32 GP practices within ELR CCG are starting to work more closely together to support the delivery of a different and improved model of primary and community services. Locally, there are networks of practices working together to develop innovative methods of general practice, but although these networks will strongly influence local patient needs, there is a move towards a single ELR-wide federation which would be a key partner to deliver the needs of patients for both primary and community services, This service would be delivered for group/hubs of patients up to 40,000 in size to ensure local universal cover. The CCG aims to deliver 'wraparound community services'. 'Wraparound' can be defined as a team of individuals / services who are relevant to the care of an individual collaboratively developing and implementing an individualised plan of care, known as a wraparound plan. 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 enabling services to be designed around general practice as the centre of patient care.

We are proposing for discussion a hybrid model where community teams will work with and be answerable to general practice groups. Under this proposed model, it is envisaged that teams can be reconfigured in terms of bases to be near to the populations that they serve.
There will be an expectation that teams will be required to be locality specific and be co-located (and integrated) with social care staff. Jointly appointed Community Matrons (GP provider contract) will help to bridge the gap in accountability.

This type of proposed model lends itself to the development of a single service specification for community health services with a possibility to include social care provision in agreement with local authority partners. This will support the development of outcome based contracts. The requirement to undertake risk assessments and preventative work will be strengthened.

It is suggested that a future community service model could have 3 main Levels:

Level 1 - Local Wraparound Services (Hub);
Level 2 - Medium Scale Services including rehabilitation and reablement; and
Level 3 - Large Scale Services including sub-acute care.

Level 1 and 2 may be interchangeable depending on patient needs and numbers of practices covered.
Joint training and education across practices will support professional development and changing service requirements.

Level 1 – Local Wraparound Services

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 Matrons; and
- Community geriatrician support.

Level 2 – Medium Scale Services - including rehabilitation and reablement

In total we are suggesting that ELR CCG requires up to 8 substantive administration bases for community and social care services each serving a population of around 25-45k. This would mean aligning administrative bases for community teams to the geographical areas that they cover as part of implementation planning. At this level services could be shared across larger groups of practices. This could include:

- Centralised complex patient lists with designated GP leads for care coordination;
- Specialised asthma, diabetes, cardiac, musculoskeletal, respiratory and cancer services;
- Rehabilitation and reablement; and
- Community geriatrician support.

All 8 areas could provide co-located health and social care teams comprised of social care, therapy services, planned and unscheduled care teams, mental health teams and voluntary sector. The CCG will obviously want to engage and work with the GP practices, the LLR Alliance and the Local Authority to determine a final settled agreement on sites for the delivery of selected outpatients' services.

Links between community and acute care could be strengthened to give planned and unscheduled care teams a stronger remit to work with local providers to either prevent admission or bring patients out into the community earlier supporting the direction of the Better Care Together Programme and the Urgent Care Workstream.

Level 3 – Large Scale Services - Sub Acute

Some services may need larger critical mass to be viable. This group of services includes:

- Access to acute consultant advice - systems for 24/7 support across ELR CCG;
- Ambulatory services; and
- Physical beds.

A wider range of ambulatory services are suggested for Melton, Rutland, Lutterworth and Market Harborough Hospital sites subject to the critical mass being available to make the service sustainable and the results of clinically-led engagement. Services may include:

- Lower volume out patients;
- Diagnostics – (plain film x-ray, ultrasound, ECG);
- Podiatry;

- Therapies;
- Specialist nurse teams;
- Intravenous administration; and
- Urgent Care and 7-day service offer.

Work undertaken through the LLR Better Care Together Programme has confirmed that the current bed base in the community does need to be maintained to enable the left shift of activity from Leicester General Hospital enabling patients from the 'sub acute ' category to be cared for in a community hospital instead. The current configuration of community hospital beds means that ward teams are geographically isolated and resources including staffing are used inefficiently.

In addition the CCG Community Services Strategy emphasises the research showing the benefits of avoiding hospital admissions for the elderly and those with chronic disease. Particularly important are the links between the disruption and stress caused by a hospital admission including the increased risk of health care acquired infections which delays recovery associated with longer stays in hospital beds. The category of patient who previously may have been admitted to a community hospital bed will be able to receive their care in their own home. The current 88 physical beds are, at the present time supplemented by 48 virtual beds. This virtual bed number is likely to at least double over the next 3 years.

Patients in virtual beds could benefit from full multidisciplinary care for up to 24 hours if necessary, targeted to individual needs to enable recovery and rehabilitation within their own environment. The consolidation of physical beds described above is supported in the LLR Better Care Together Strategic Plan and also reflects the future model of care proposed by LPT.

It is envisaged that physical beds will, in future, be on no more than 2 sites, yet to be confirmed. The precise location of these will be subject to further engagement and consultation as part of Better Care Together

4. Workforce

Workforce features heavily in the proposed community services model and is one of the greatest areas of risk of implementation.
A Better Care Together Workforce Enabling Group has been established to support, leadership and delivery of a workforce planning and education commissioning strategy across the LLR system.

This is clearly a positive approach to addressing health economy wide workforce issues, however ELR CCG will need to have specific workforce plans in place to address current and future issues and meet the requirements of a new model including:

- Addressing the high vacancy rate for community nursing;
- Current under resourcing of ELR CCG's primary care and community nursing workforce;
- Integration of primary, community, social care, medical and non-medical workforce;
- Lack of transparency of actual nursing numbers available to the CCG;
- Perceived poor use of current workforce with excessive administration and duplication of tasks; and
- Integration with telehealth and telecare.

A full review of workforce will be undertaken to identify capacity and workforce requirements across Leicester, Leicestershire and Rutland.
The outputs from this review will indicate the levels of recruitment, training and movement of staff between different sectors and at different skill levels and will include future community and primary care workforce requirements