Agenda Item 9

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

HEALTH AND WELLBEING BOARD: 27 SEPTEMBER 2018

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) CCGs

OUT OF HOSPITAL PROGRAMME

Purpose of report

1. The purpose of this report is to update the Health and Wellbeing Board on the arrangements for a new LLR Out of Hospital Workstream, and to provide an overview of the work it will lead and oversee.

Link to the local Health and Care System

2. The Out of Hospital Workstream is part of Better Care Together, the LLR Sustainability and Transformation Partnership.

3. The new Out of Hospital workstream incorporates the former Integrated Teams and Home First Programmes. It will also cover the changes being proposed by the CCGs' Community Services Redesign project. As such, it is a key element of delivering the LLR strategy for health and care services to be delivered in the community.

Recommendation

4. The Leicestershire Health and Wellbeing Board is asked to note the changes to the Better Care Together workstreams, and the scope and priorities of the new Out of Hospital workstream.

Policy Framework and Previous Decisions

5. Strengthening community services and care outside of hospital is one of the main strategic aims of the LLR Better Care Together Programme, often phrased as 'left shift'.

6. Within the Better Care Together governance arrangements, there have historically been a number of workstreams related to improving and redesigning services delivered across primary care, community health and social care settings.

7. A new LLR Out of Hospital workstream was proposed in order to bring these pieces of work together, recognise their synergies and interdependencies, and manage them as part of a single programme.

8. The LLR System Leadership Team supported this proposal in July 2018. The transition to the new Out of Hospital Board will take place in September. The existing programme boards for Integrated Teams and Home First will be closed, with their last meetings having been held in August.

Proposals

Scope of the workstream

9. The role of the Out of Hospital workstream is to:

a) Co-ordinate the development of the LLR BCT strategy for services delivered in primary care and community settings, with a particular focus on care for adults who need continuity of care from multiple agencies over time, rather than those receiving elective/episodic care.

b) Take forward a programme of work to ensure that out of hospital services across LLR are commissioned and delivered in a consistent way, to support key aims of the STP and maximise the principles of 'Home First', discharge to assess and trusted assessment between agencies.

c) Progress the development of integrated, place based health and care services which support population health management and deliver preventative and co-ordinated care for local populations.

d) Support the financial sustainability of the health and care economy, ensuring that out of hospital services are affordable, contribute to overall system resilience and represent value for money.

e) Ensure there is good engagement with patients, the public and key stakeholders in developing integrated community based services and new models of care.

f) Be responsible for managing interdependencies with other workstreams including:
   i. Communicating and engaging on emerging new models of care and the implications of these for other services or pathways;
   ii. Ensuring that changes required to enable the objectives of other workstreams to be achieved are delivered through the Out of Hospital Care programme;
   iii. Conversely, where successful delivery of out of hospital changes requires action within the remit of another workstream, ensuring that the required changes are included in the relevant workstream and escalating any delivery issues, directly through the relevant workstream in the first instance, or through the System Leadership Team where this is not successful;
   iv. Identifying the IMT, workforce and premises implications of the future model, ensuring these are taken through the appropriate BCT groups.

10. The workstream will not be responsible for other BCT priority areas (e.g. mental health, learning disability, maternity or planned care), although it will need to ensure that universal or all age out of hospital services are delivered in a holistic way and that the right specialist support is accessible, whatever people's needs.

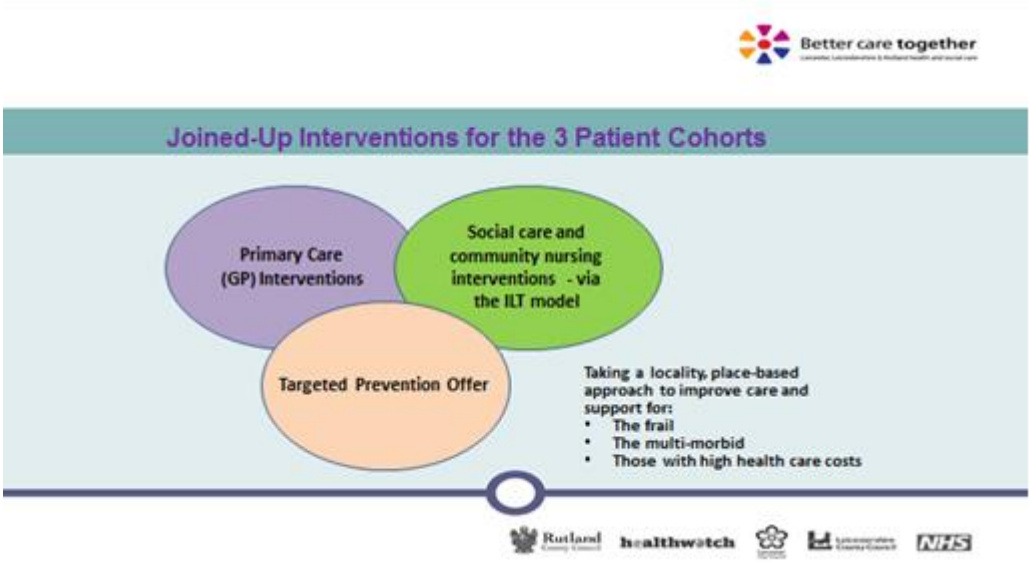
Key changes being led by the workstream:

11. The key areas of work that will be taken forward within the workstream include:

Integrated Locality Teams (ILT)

12. The ILT work aimed to support the development of integrated multi-disciplinary health and care teams, which will support the care of their local populations. The ILT work so far has concentrated on the organisational development of teams and has developed four 'building blocks' of integrated team delivery, which are:
    - Care co-ordination;
    - Risk stratification;
    - Multi-disciplinary team (MDT) working;
    - Preventative care.

13. The diagram below shows how the integrated locality team will provide a range of interventions to frail and multi-morbid patients.



14. The Out of Hospital workstream will continue this work, focussing on the operational implementation of locality team working. To progress this, the workstream has identified three 'early implementer sites' to test out the ILT model of care, focussing on identifying and delivering the model of care to frail and multi-morbid patients (i.e. those patients with multiple long term conditions).

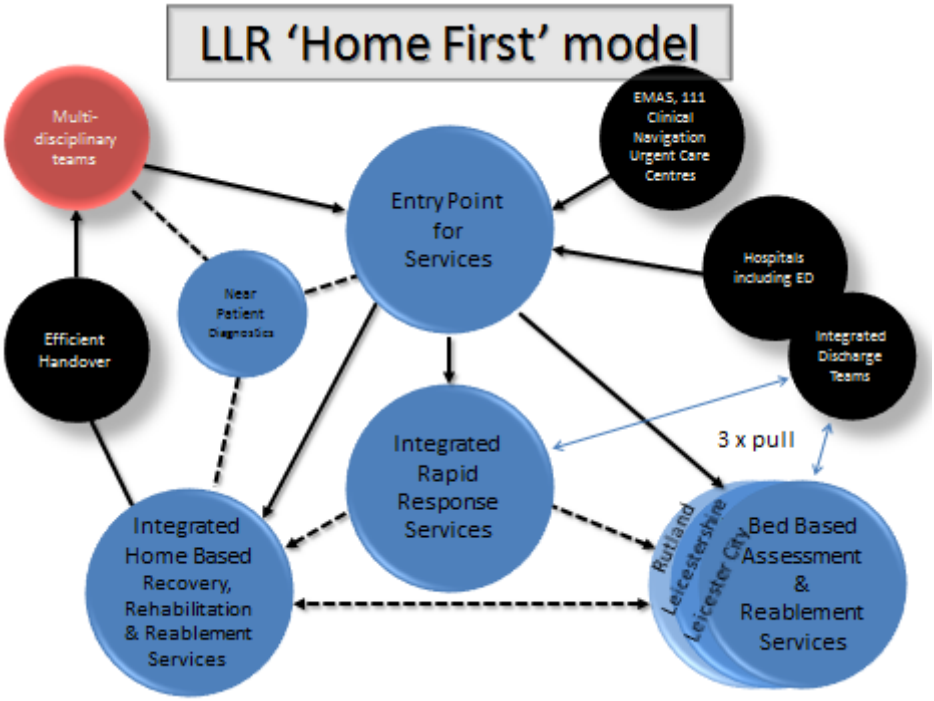
15. A particular question for the early implementer sites to address is: 'what is the most effective scale for co-ordinating the care of frail and multi-morbid patients?' This in turn will inform the wider community services redesign work. For example, one of the outcomes of the community services redesign work will be to specify how the community nursing offer should be configured to best support ILTs in the future.

16. The development of ILTs will continue to require organisational development support, which will be part of the Out of Hospital work programme.

Home First

17. The Home First workstream's remit was to design a model of care which, wherever possible, enables people to remain at home during a period of illness or during a social care crisis, or to return to their normal place of residence in a timely way after a hospital admission.

18. The workstream has developed a 'blueprint' for the LLR offer of community based care to to deliver the Home First approach, and has been working through three delivery groups in each of the three upper tier local authority footprints across LLR in order to make the changes to local services that are required to deliver a consistent offer in each locality. A diagram showing the model at an LLR level is shown below:



19. The Leicestershire Home First delivery group has been concentrating on redesigning and integrating existing services for rapid response, recovery and reablement.

20. The aim is that health and social care teams involved in these services will work more effectively together, via a single referral point, and that they will jointly co-ordinate the appropriate response to keep people at home, or get them home rapidly after a trip to hospital.

21. Some of the early changes being led by the Leicestershire group will come into effect from October 2018, and it is hoped that this will have a noticeable impact on helping to manage service pressures and give residents an improved response over the coming winter

22. The new Out of Hospital workstream will oversee the continued work of the three local delivery groups, helping to ensure consistency in the offer across LLR, particularly in relation to the interface between Home First and other services or pathways. It will also lead on areas that cut across the three local authority areas, such as providing direction and project management support to cross cutting issues such as trusted assessment processes between agencies and teams, and streamlining access points for home first services.

23. The Home First workstream had a Care Homes sub-group, which brought together issues affecting care homes into a single place and action plan, to avoid fragmentation, share information and develop consistent strategies for supporting the quality of care delivered in care homes. This work will transition into the Out of Hospital workstream.

Community Services Redesign

24. The Community Services Redesign (CSR) project has been initiated by the CCGs in order to ensure that community services provided by Leicestershire Partnership Trust (LPT) are, in future, delivered in line with the model of integrated community care being developed within Better Care Together.

25. There is a need for a clear commissioning strategy for community services, which supports a robust approach to planning and delivering the community capacity required to meet the needs of LLR patients, with more care being delivered in the community than before, and will also set out the expectations of a new model of community services.

26. The CSR work aims to enable the successful delivery of Integrated Locality Teams and integrated 'step-up and step-down' services in line with the Home First workstream. One of the reasons for creating the Out of Hospital workstream was to bring these pieces of work together, recognising their synergies and interdependencies, and to manage them as part of a single programme.

27. The CSR project scope includes a range of community services including core district nursing and therapy services, the Intensive Community Support Service Community Hospital Beds, Stroke services and others.

28. Although the project is a CCG led commissioning review, to achieve the objectives of the review, recommendations will have implications for related services in primary care and social care (for instance crisis response and re-ablement services), as well as some UHL hospital discharge functions.

29. The CSR will make recommendations for the future model of community services which will then need to be implemented through CCG contracts in 2019/2020 and beyond. Some of these recommendations will have implications for service lines within the Better Care Fund plans of all three Local Authorities, for instance, in Leicestershire, the redesign of the ICS services and these will be discussed as part of the annual refresh of the BCF.

30. There are also opportunities for the CCGs and Local Authorities to develop joint commissioning approaches to commission the integrated care model going forward

Governance of the workstream, including delivery mechanisms

31. The new Out of Hospital Workstream will be led by and overseen by an Out of Hospital Board, which will have executive membership from the three CCGs and three Social Care departments, UHL, LPT, EMAS and Healthwatch.

32. The workstream will support the Health and Wellbeing Board's agenda in respect of out of hospital care and increasing the integration and personalisation of services, and the delivery mechanisms and sub-group structure of the Board are designed to achieve this. The proposed governance structure for the new LLR Board recognises that, in order to effectively progress implementation, delivery should be aligned to each of the three upper tier local authority areas. For Leicestershire this will organised via the Integration Executive which will discuss how best to configure this at its meeting on 2 October.

33. In particular, within Leicestershire, there is a need to ensure that there is an accepted forum within governance structures which is able to bring together the delivery agenda for elements of the out of hospital workstream, particularly the development of the Home First model and its interface with other out of hospital pathways, such as care co-ordination within ILTs.

Consultation/Patient and Public Involvement

34. The new workstream Board will have input from Healthwatch. One of the duties of the Board will be to ensure there is adequate engagement with the public on this very important aspect of local services.

35. A full communications and engagement plan has been developed for the Community Services Redesign project which includes; an initial review of insight already available from previous engagement undertaken on community services, focussed interviews with patients, carers and staff, and open events to discuss plans to reform community services.

Resource Implications

36. The workstream is supported by West Leicestershire CCG, who will provide dedicated management support to the Board along with programme management for specific projects including ILT and the Community Services Redesign.

37. Successful delivery of changes within the programme requires the input of a number of teams across BCT partners, including all three CCGs and Leicestershire County Council. The workstream will therefore be reliant on existing resources and support from partner agencies.

38. Implications for the Leicestershire BCF plan and pooled budget will be considered as part of the annual refresh of the BCF in Q3 and Q4 of 2018/19.

Background papers

None

Circulation under the Local Issues Alert Procedure

None

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Relevant Impact Assessments

Equality and Human Rights Implications

39. The out of hospital workstream will have particular relevance to the protected characteristics of age and disability, and the Board will ensure due regard is paid to the impact on equalities and Human Rights. As proposals are developed within the workstream, EIA/EQIAs will be undertaken as required.

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