NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Draft Integrated Community Services Strategy

Listening. Responding. **Delivering.**

Draft Integrated Community Services Strategy

Foreword

When we talk to local people about what's important to them about healthcare, we often hear that they want us to ensure there are good quality services close to home, services which put the needs of patients first and recognise people often need support from more than one service across health and social care.

We also know that people want to be at home and stay at home whenever they can. Clinical evidence tells us that many people recover much better and faster at home too; in order for people to receive this type of care we need to make sure we have the right community healthcare services.

Alongside the feedback we receive from local people and key partners, are the challenges of an ever-increasing elderly population many with multiple long-term conditions and a future health and social care financial gap of millions of pounds if local services are not effectively transformed.

We know changes need to be made in order to provide the highest quality healthcare for local people within resources available. The proposals set out in this draft strategy are designed to do just that. We want to ensure that care is provided at 'home first', supplementing this with an increase in community-based clinics, therapy, preventive services and other local support for people's wellbeing. By doing this we believe we can achieve a fully integrated, co-ordinated model for health and social care, delivering seven-day services that puts people's care needs at the centre.

Under our plans, and based on our research and clinical evidence, we believe the majority of people will not require inpatient care. They will be treated by expert staff in their own home or visit a community healthcare facility as an out-patient. This is not only a more efficient way of treating more people but it is exactly the type of care that the majority of people tell us they want. Of course for those people who do need inpatient care, we will ensure that high quality care is available to respond to their needs as well.

We know that to get the transformation of community services right we must continue to engage with local people, patients, carers, clinicians and staff. This draft strategy is a blueprint for how we might achieve change and we will be undertaking a significant period of discussion to ensure our plans are influenced further by both those who receive care, those who deliver care and those who work with us.

We look forward to hearing your views as we work towards improving community services.

Mr Graham Martin, Chair

Dr Dave Briggs, Managing Director

Dr Richard Palin, Clinical Vice Chair

Dr Andy Ker, Clinical Vice Chair

Executive summary

Why are we writing this strategy?

National policy, evidence and best practice tells us that innovation and creativity is required if we are to progress beyond the structural changes that were made as part of the transforming community services programme, and towards the transformation element of the policy.

Locally, as nationally, there is an ageing, frail population and an increasing prevalence of chronic disease. The results of pre-engagement in East Leicestershire and Rutland (ELR) and Leicester, Leicestershire and Rutland (LLR) wide tell us that people want care closer to home and a wellness service, not just an illness service. However care closer to home / out of hospital care will only work if sustainable community solutions are in place.

At the same time, the financial challenge facing the health and social care economy cannot be underestimated.

The purpose of this Community Services Strategy is to:

- Agree and confirm what this transformation means locally, with our patients and stakeholders – and ask: Have we captured the right themes? This will enable us to see clearly what we have all agreed and keep us on track in delivering it
- Ensure alignment of strategies and initiatives across partner organisations
- Ensure that we have a shared understanding of where we are going and how we will know when we have got there
- Make a contribution to achieving financial balance and toward delivery of the draft *Better Care Together: five-year strategic plan*
- Provide a tool for engagement and communication.

What is the vision and model of care?

The Kings Fund evidence tells us that a service response that is fit for the future requires reorientation away from acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated. Additionally, many people are dealing with multiple issues requiring integrated working to ensure the right mix of services in the right place at the right time. The statement below sets out a draft Vision Statement for the delivery of community services, particularly for the frail elderly and those with long-term conditions.

Vision statement

The long-term vision is for a fully integrated, co-ordinated model for health and social care, delivering seven-day services, that puts people's' care needs at the centre. The aim is to meet the needs of an increasing older population, particularly the frail and those with long term conditions. Services will be delivered to the citizens of East

Leicestershire and Rutland in a co-ordinated way that recognises people often need support from more than one service.

Model of care

ELR CCG is committed to improving the quality of patient care. By focussing the goals of this strategy on clinical effectiveness, patient safety and patient experience this Community Services Strategy aims to deliver excellent health services and improve the quality of patient care.

The model of care describes the shape of the model, how services will be delivered and a description of what success will look like.

The overarching aim for delivery of care is ‘home first’ along with use of community based in-patient facilities where ‘home first’ is not possible.

Integrated services provided by multi-disciplinary teams of primary, community and social care services will be ‘wrapped around’ the patient who is at the centre of care. There will be increased emphasis on early intervention, harnessing the power of the wider community, the independent and third sector and enabling patients to understand and manage their own care. This will be aligned with reablement and promoting independence following illness.

Staff will deliver caring and compassionate care, supported by training and education to take on new roles to deliver integrated health and social care. The use of new technology will be embraced to enable patients to continue to live independently wherever possible.

How will services be delivered?

The proposed structure for service delivery combines wrapping community services (health and social care) around locality-based teams that are grouped around primary care and natural geographies with ‘seamless’ delivery of care that is integrated across organisations. The platform for delivery of services across ELR CCG will be the Primary Care localities and GP hubs (GP groups within the localities, each with a registered population of 30-35,000). Services will be delivered through co-ordinated pathways of care with integrated working within healthcare and across health and social care where possible.

What will success look like?

If we agree the vision and model of service delivery, how will we know whether we have been successful, what will be changed or improved? The outcomes for success against which delivery of the service model will be measured will include:

- Patients will have an understanding of their condition and use self-help wherever possible

- ‘Home first’ will be delivered through care at home where possible, eg, auditing to demonstrate that ‘home first’ is considered as the first option. Have inappropriate in-patient admissions been avoided?
- The model will be outcome focused. Success will be measured against clinical, qualitative and quantitative measures that demonstrate a sustainable shift in resources from hospital to the community sector, along with positive patient and carer experience
- Members of the public understand and support the principle of ‘home first’
- The model is sustainable and affordable – with reduced demand on secondary care services
- The workforce is able to take on new, integrated roles to deliver health and social care.

Our plans to deliver the Community Services Strategy

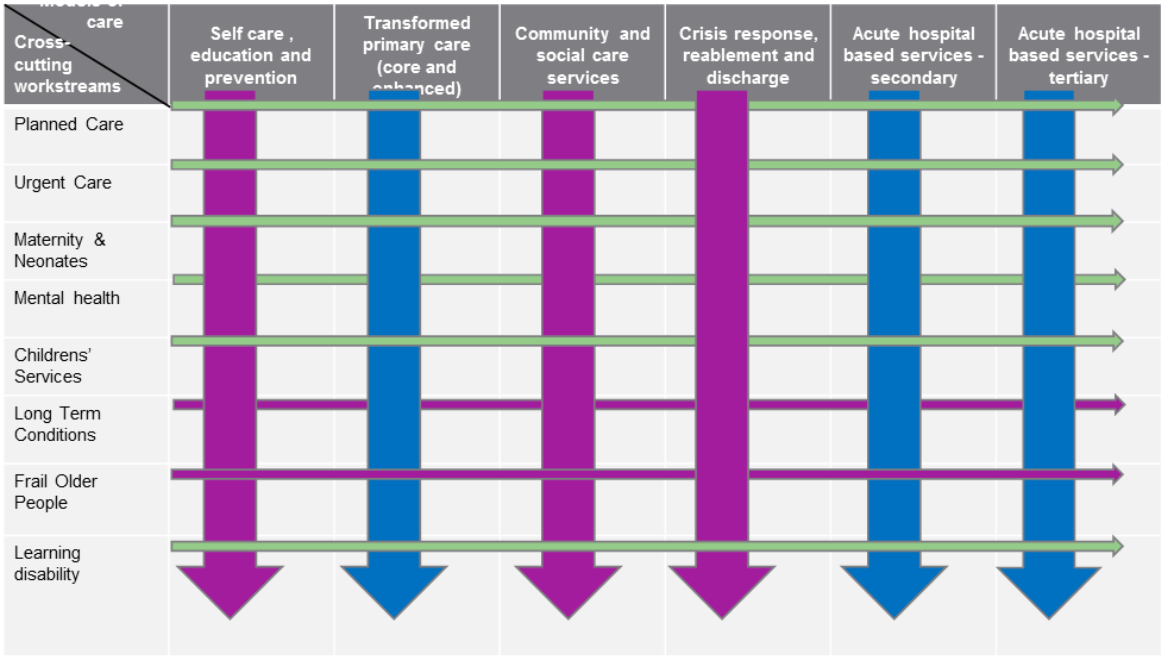
Historically services have been delivered through separate service specifications by the Provider of Community Health Services and by Local Authority Social Care Services. Community Health and Social Care have worked alongside Primary Care to deliver a wide range of health and social care services; however these have been delivered under separate organisational structures and sometimes lacked coterminous boundaries with primary care.

The Better Care Fund is a key platform to support the shift towards delivery of care in the community along with a more integrated approach to delivery of community health and social care services. Some early initiatives are being implemented in 2014/15 including the appointment of Integrated Care Co-ordinators to work alongside GPs. These roles form the basis of the model for locality based multidisciplinary working and establish key lines of communication between professionals involved in the patient’s overall care, including the use of a model of risk stratification.

The draft *Better Care Together: five-year strategic plan* published in September 2014 summarises delivery of care under eight service pathways of care delivered across six settings of care.

This Community Services Strategy is primarily concerned with the service pathways for Frail Older People and Long-Term Conditions delivered in the settings of ‘Self Care, Education and Prevention’, ‘Community and Social Care Services’ and ‘Crisis Response, Reablement and Discharge’. We have highlighted these in purple on the five-year strategy delivery framework below.

Final Service Delivery Framework



Better Care Fund Plans for each of the settings of care are summarised in the draft *Better Care Together: five-year strategic plan*, demonstrating how the opportunities presented by the Fund can be maximised in order to deliver the five year vision.

Enablers to support delivery

Enablers to deliver the strategy include a well prepared workforce, information technology (both assistive technology and electronically shared care plans) and effective use of the community estate. Robust co-production with partner agencies, patients and the public will also be key to effective delivery of the Community Service Strategy.

Robust methodologies will be developed to monitor and evaluate the impact of existing services together with services being planned through the Better Care Fund initiative to ensure that they are meeting the outcomes and objectives of both this strategy and the *Better Care Together: five-year strategic plan*.

These services and initiatives will be carefully monitored, reviewed and evaluated in order to identify what else we should do to ensure effective delivery of the Community Services Strategy.

Format of the Strategy

The Strategy is organised as follows:

Section 1: The case for change outlines why change is needed. It then goes on to suggest what good would like, in the form of the Kings Fund's Ten Components of Care and 'What We Know Works' in each of those areas.

Section 2: The current position describes the current position in terms of services we have in place now.

Section 3: Vision and future model of care proposes a vision and direction of travel, and identifies the recent service developments that have been implemented which start us on this journey. It goes on to highlight planned service developments that will continue us on that journey. It finishes with a short discussion of the gap that remains after those developments have been implemented.

Section 4: Further development of the strategy suggests next steps for engagement, clarification of the gap and how to close it.

Community Services – plan on a page

PRINCIPLES

- Home first
- Wrap around the patient
- Quality of Care
- More options for out of hospital care
- Where not possible: care closer to home
- A wellness not just an illness service: Prevention
- Seamless service provision
- Left shift

HOW IT WILL HAPPEN

- Co-production – work with Healthwatch, patients and public to agree strategy and produce implementation plan
- Shift in resources from hospital to community
- MDTs: Primary, Community, Social Care and Third Sector
- Community Services (health and social care) wrap around locality based team and deliver co-ordinated, integrated, seamless services
- Platform is primary care localities and GP hubs
- Seven-day services
- Integrated, co-ordinated care planning and assessment
- Early intervention: Risk stratification
- Public health campaigns

AS A RESULT

- Patients understand their condition and use self help where possible
- More people are cared for at home
- More people live independently at home following discharge
- Those who enter hospital return home...sooner
- The power of the wider community and third sector is harnessed
- Fewer avoidable hospital admissions and readmissions
- Improved quality of life for people with LTCs
- Better use of resources available to us

OUTCOMES

- **We will have a plan to meet the challenges of the future**
- **Supports delivery of outcomes in all three outcomes frameworks:**
  - **NHS**
  - **Adult Social Care**
  - **Public Health**
  - **some of which overlap**

Enablers:
IT and new technology - Workforce training and development - Integrated care records - Estates

How the strategy supports the delivery of the three National Outcomes Frameworks

NHS

Enhancing Quality of Life for people with long-term conditions:

- Ensuring people feel supported to manage their condition
- Reducing time spent in hospital by people with LTCs
- Enhancing quality of life for carers, people with mental illness and dementia
- Improving functional ability:

Helping people to recover from episodes of ill health or following injury:

- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency readmissions: 30 days
- Helping older people recover their independence after illness or injury
- Improving recovery: Injuries, trauma, stroke, fragility fracture

Ensuring that people have a positive experience of care:

- Improving people's experience of outpatient care
- Improving the experience of care for people at the end of their lives
- Improving people's experience of integrated care

Adult Social Care

Enhancing quality of life for people with care and support needs:

- **People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs**

Delaying and reducing the need for care and support:

- **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs**
- **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services**
- **When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.**
- **Over 65s at home 91 days**

Ensuring that people have a positive experience of care and support:

- **People who use social care and their carers are satisfied with the experience of care and support services**
- **People know what choices are available locally, what they are entitled to, and who to contact for help**
- **Support sensitive to individual circumstances**

Public Health

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities:

- **Fewer injuries due to falls in people aged 65 and over**
- **Self-reported wellbeing**

The population's health is protected from major incidents and other threats, while reducing health inequalities:

- **Population vaccination coverage**

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities:

- **Emergency re-admissions within 30 days of discharge from hospital**
- **Health related quality of life for older people**
- **Hip fractures in people aged 65 and over**
- **Excess winter deaths**
- **Estimated diagnosis rate for people with dementia**

Section 1: The case for change

Purpose – Why a community services strategy for ELR?

There are a number of drivers for the production of this draft strategy. National Policy, evidence and best practice tells us that innovation and creativity is required if we are to progress beyond the structural changes that were made as part of the transforming community services programme, and toward the transformation element of the policy.

We need to agree and confirm what this transformation means locally, with our patients and stakeholders - Have we captured the right themes? Having an agreed strategy will enable us to clearly see what we have all agreed and keep us on track in delivering it. It will ensure we have a shared understanding of where we are going and how we will know when we have got there, and it will ensure alignment of strategies and initiatives across partner organisations.

Of course, the financial challenge facing the health and social care economy cannot be under estimated, and this strategy needs to make a contribution to achieving financial balance and toward delivery of the draft *Better Care Together: five-year strategic plan*.

Finally, the existence of a strategy provides a tool for engagement and communication. In addition to this we know that:

- The results of pre-engagement in ELR and LLR wide tell us that people want care closer to home and a wellness service not just an illness service
- An ageing, frail population requires a service response fit for the future
- Care closer to home/out of hospital care only works if community solutions are in place
- We need to build on existing good work
- We need sustainable solutions
- Co-production will ensure solutions are owned
- There is a need to remove barriers and duplication
- New models need to wrap community services around primary care, with care co-ordination delivered through integrated health and social care teams.

National policy

The NHS belongs to the people: a call to action:

In July 2013, the NHS and its partners launched *The NHS belongs to the people: a call to action* which set out the challenges and opportunities faced by health and care systems across the country over the next five to ten years. It highlighted the need to find ways to raise quality of care in our communities to the best international standards while also closing the potential funding gap of around £30 billion by 2020/21. This was a call for creativity, innovation and transformation and requires a significant shift of resources from the hospital sector to the community.

NHS Planning Guidance 2014-2019:

In December 2013, NHS England published the planning guidance for 2014/15 to 2018/19 entitled *Everyone Counts: Planning for Patients 2014/15 to 2018/19*. This set out for the first time ever, the requirement for commissioners to work with providers and partners in local government to produce strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care for all. The planning guidance sought:

- Strategic plans covering a five year period, with the first two years at operating plan level
- An outcomes focused approach, with stretching local ambitions and credible, costed delivery plans
- Citizen inclusion and empowerment
- More integration between providers and commissioners
- More integration with Social Care, eg, through Better Care Funds
- Plans to be explicit in dealing with the financial gap and risk and mitigation strategies.

The guidance went on to describe seven specific delivery ambitions:

- Securing additional years of life for people with treatable mental and physical health conditions
- Improving health related quality of life for people with one or more long term condition, including mental health conditions
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

NHS England has identified in the guidance that any high quality, sustainable health and care system in England will have the following six characteristics in five years time:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care

- Specialised services concentrated in centres of excellence.

The Strategy proposed here supports delivery in line with national policy.

The evidence base

In order to produce this draft, we have reviewed a range of documents and drawn particularly on the three Kings Fund documents. These are summarised below.

Kings Fund – Transforming our health care system (April, 2013)

This Kings Fund document stated that 'the ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated'.

The paper went on to outline ten priorities for action, noting that the common feature of them all is the degree to which they require change in primary care, and the way primary care relates to the rest of the system. The document further identified four common themes across the ten priorities. They are:

- More systematic and proactive management of chronic disease
- Active engagement and empowerment of patients
- A population based approach to commissioning: resources directed to those in greatest need
- More integrated models of care: Teams, budgets, organisations

Taking action on the ten priorities will help CCGs to make progress on many of the outcomes in the CCG Outcomes Indicator set, the authors argue. The ten priorities are:

- Active support for self-management
- Primary prevention
- Secondary prevention
- Managing ambulatory care-sensitive conditions
- Improving the management of patients with both mental and physical needs
- Care co-ordination through integrated health and social care teams
- Improving primary care management of end-of-life care
- Medicines management
- Managing elective activity – referral quality
- Managing urgent and emergency activity

In Section three we outline the contribution that community service developments locally could make to delivery in line with these priorities and outcome indicators.

Kings Fund – Making our Health and Care systems fit for an ageing population (2014)

This publication argues that we have a system that has failed to keep up with the dramatic demographic shift that has occurred in recent years (eg, the number of people over 85 doubling in the past three decades), and that is designed around single issue consultations, when many people are dealing with multiple issues. The authors call for a fundamental shift towards care that is co-ordinated around the full range of an individual's needs and that truly prioritises prevention and support for maintaining independence. They go on to say that 'achieving this requires much more integrated working to ensure the right mix of services is available in the right place at the right time'. The report outlines ten key components of care and within each one identifies 'what we know can work'. We have produced a summary of these in the table below. During the pre-engagement workshops to date, there has been broad support that the ten components of care are right for East Leicestershire and Rutland and should form the basis of our strategy. This will be further tested during Engagement.

Component of care	What we know can work
Healthy, active ageing and supporting independence	. Life-course approaches to health and wellbeing that address the wider determinants of health . Ensuring that we get housing right for older people .Preventing social isolation and promoting age-friendly communities . Cold weather planning . Promoting healthy lifestyles and wellness . Adequate treatment for 'minor' needs that limit independence . Vaccination . National screening programmes
Living well with simple or stable long-term conditions	. Providing continuity and care co-ordination . Using population risk stratification . Case management delivered through integrated locality-based teams . Involving older people and their families in planning and co-ordinating their own care . Personal care budgets and direct payments . Telehealth . Providing support and education for family and volunteer carers . Ensuring that older people receive the same care and support as younger people with the same condition . Improving care and treatment for the common conditions of ageing
Living well with complex co-morbidities, dementia	. Recognising the importance of frailty . Using frailty risk assessment and case finding . Using proactive comprehensive geriatric assessment and

and frailty	follow up for people identified as frail . Falls prevention . Providing good care for people with dementia . Reducing inappropriate polypharmacy
Rapid support close to home in times of crisis	. Promoting continuity of primary care . Providing urgent access to primary care . Providing urgent, co-ordinated social care . Ensuring that ambulance services implement shared care strategies with other services . Using admission-prevention Hospital at Home services . Using virtual or community wards . Providing telecare for older people at risk . Discharge to assess models . Providing rapid access ambulatory care clinics . Using community and interface geriatrics
Good acute hospital care when needed	.Using comprehensive geriatric assessment . Focusing on older patients with frailty . Specialist elderly care units and wards . Liaison and in-reach services for frail older people under other medical and surgical specialities . Maximising continuity of care . Improving safety and preventing avoidable deaths . Minimising harms of hospitalisation . Improving care for inpatients with dementia and mental health problems . Focusing on dignified person-centred care
Good discharge planning and post-discharge support	. Early senior assessment, assertive discharge planning, and a clear focus on patient flow . A concerted focus on discharge planning throughout hospital stay, and the ability to discharge seven days a week . Involving older people and their carers in discharge plans . Ensuring integrated information systems and structured multi-professional communication . Strengthening post-discharge assessment and support . Reducing delayed transfers of care
Good rehabilitation and reablement after acute illness or injury	. Shared and comprehensive assessment of needs and personalised plans . Implementing evidence-based best practice . Commissioning for outcomes . Providing home based rehabilitation and reablement . Providing community hospital based rehabilitation and reablement . Using alternative providers of rehabilitation and reablement . Providing workforce training in reablement . Successful ending of and transition from rehabilitation and reablement
High quality nursing and residential care for	. Preventing avoidable admissions to long-term care . Active commissioning of health and mental health care for

those who need it	care home residents . Information-sharing . Conducting holistic assessments . Providing support and training for care home staff . Using evidence-based frameworks for assessment of quality of life and improvement of relationship-centred care
Choice, control and support towards the end of life	. Providing workforce training and support . Identifying people in the last year of life . Ensuring effective assessment and advance care planning . Strengthening co-ordination and discharge planning . Ensuring adequate provision of specialist palliative care services . Supporting care home residents to die in the care home rather than in hospital . Providing home-based services . Improving end of life care for people with dementia . Improving end of life care in hospitals . Management of the dying phase and the crucial importance of involving patients and families
Integration to provide person-centred co-ordinated care	**Lessons from Experience – Making Integrated Care happen at Scale and Pace** . Find common cause with partners and be prepared to share sovereignty . Develop a shared narrative to explain why integrated care matters . Develop a persuasive vision to describe what integrated care will achieve . Establish shared leadership . Create time and space to develop understanding and new ways of working . Identify services and user groups where potential benefits from integrated care are greatest . Build integrated care from the bottom up as well as top down . Pool resources to enable commissioners and integrated teams to use resources flexibly . Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector . Recognise that there is no ‘best way’ of integrating care . Support and empower users to take more control over their health and wellbeing . Use the workforce effectively and be open to innovation in skill mix and staff substitution . Set specific objectives, and measure and evaluate progress towards them . Be realistic about the costs of integrated care . Act on all these lessons together as part of a coherent strategy

Source: Kings Fund

Kings Fund – Community Services: How they can transform care (February 2014)

The Kings Fund recognised that the Transforming Community Services policy of 2008 had, out of necessity, focused mainly on the structural changes required at the time. They therefore convened a working group of community services providers to consider the next stage – what is required to develop community services in a way that will deliver the transformation element of the policy. The main steps they have identified are:

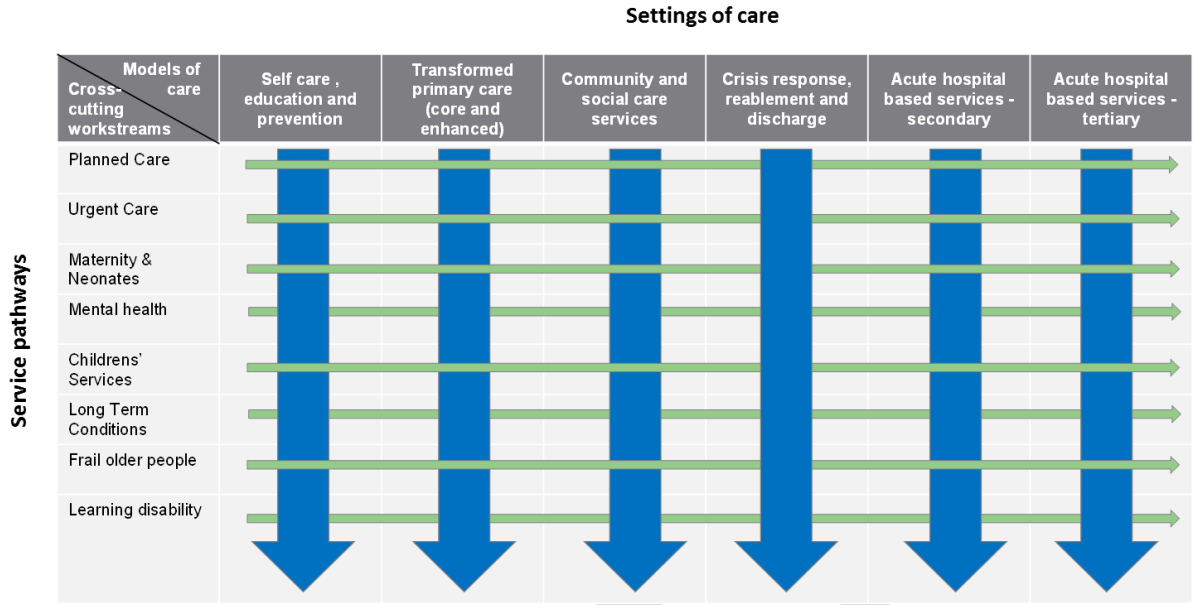
- Reduce complexity of services
- Wrap services around primary care
- Build multi-disciplinary teams for people with complex needs, including social care, mental health and other services
- Support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions
- Create services that offer an alternative to hospital stay
- Build an infrastructure to support the model based on these components including much better ways to measure and pay for services
- Develop the capability to harness the power of the wider community

The report goes on to say that this approach requires locality-based teams that are grouped around primary care and natural geographies and with a multi-disciplinary team, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social services. These teams need to work in new ways with specialist services (both community and hospital based) to offer patients a much more complete and less fragmented service. The new services need to be capable of a very rapid response and to work with hospitals to speed up discharge.

Local Strategies

Better Care Together: five-year strategic plan

The LLR directional *Better Care Together: five-year strategic plan* suggests a number of cross-cutting workstreams to be delivered across six cross-cutting settings of care. This is illustrated in the Settings of Care diagram below.



The most significant interventions for the Community Services Strategy are planned interventions for two of the eight identified workstreams, namely the Frail Older People and Long Term Conditions clinical workstreams.

ELR Two-year Operational Plan

The ELR CCG Two-year Operational Plan places the development of community services firmly at the centre. In order to reach the ambitions outlined in the two-year plan, developing and enhancing community capacity is a central platform for success.

Local authority strategies

Leicestershire County Council is currently developing a new Communities Strategy which will outline the council's vision and approach for working in partnership with communities. Two priorities and a third enabling priority are identified as part of this developing strategy:

- Helping communities to support vulnerable people
- Helping communities to design and deliver services
- Effective commissioning of, and support for, the voluntary sector

This signalling of the intention to build the capacity of communities to support themselves and vulnerable individuals and families will contribute to the self-care, education and prevention part of the model of care.

Rutland County Council has recently undertaken a full review of the services provided by its People Directorate. This involved extensive consultation with a range of stakeholders. A summary of messages and comments gathered through the review process specifically relating to health and wellbeing include:

- Concern about the level of support for those suffering from dementia and Alzheimer's
- Carers – seen as a huge resource under pressure
- Real concern about withdrawing any support for carers
- Need to improve information and advice available
- Real gaps for some special groups eg diabetics
- People should take responsibility for their own health and wellbeing
- Explore the concept of 'Health Champions'
- Rutland Memorial Hospital (RMH) is a vital resource – protect it and develop it
- Make better use of GP surgeries to give out advice and information
- Support for a health and wellbeing hub and spoke model
- Investment in home care sector – need to develop the market
- Need to look at alternatives to day care
- Is there sufficient provision in the County for residential care?
- Real concern about the level of support for people with mental health problems.

As a result, and in recognition that any activity in relation to health and wellbeing needs to align with the *Better Care Together: five-year strategic plan* and Better Care Fund plans, there will be a focus on:

- Integration of services
- Supporting independent living
- Ageing well
- Early intervention and prevention
- The contribution Public Health can make

Engagement

Elective care engagement report

In spring of 2012, a six-week engagement exercise took place to identify what services local patients and the public want delivered from their community hospitals. The main theme from completed surveys highlighted the preference for services to be local and the importance of services to be delivered as close to home as possible.

The majority of respondents ranked local GP practice as the most preferred location for diagnostic, day case and out-patient services.

Further to this, respondents asked for excellent, up to date equipment and treatment and more of it, saying that they are more likely to attend appointments if they can get treatment locally. It was suggested that diagnostics and outpatient appointments should be undertaken locally, with more complex treatments and operations to take place at larger hospitals.

Call to Action events

The NHS Belongs to the People: A call to action challenges all NHS providers and commissioners, the public and politicians to help the NHS meet future demand and tackle the funding gap through 'honest and realistic debate'. It states clearly that the NHS must change, with a shift in focus from buildings to patients and services. The NHS can increasingly deliver care at home and yet too often patients have to travel to and around buildings.

A call to action identifies a number of challenges requiring a response: an ageing society, the rise of long-term conditions, rising expectations, increasing costs of providing care, limited productivity coupled with the pressure of constrained public resources that the NHS and the local authorities face, in particular to address the variation in quality of care across the health and social care system.

However it also outlines a range of opportunities in terms of:

- Quality at the core
- A health service not just an illness service
- Giving patients greater control over their health
- Harnessing transformational technologies
- Exploiting data potential
- Moving away from a 'one size fits all' model of care.

Therefore the focus of our plans as a health and social care economy is to address these challenges locally. The themes that emerged from that engagement for ELR are:

- Ensure high quality services by working closely with our providers and clinicians
- Raise our performance across the NHS Outcomes Framework domains and Quality Premium
- Deliver safe high quality services
- Deliver value for money – meeting our financial challenges as a health and social care economy
- Focus on helping people to remain healthy for longer through promoting independence and supporting more patients to remain at home
- Taking a more life-long approach to supporting people, rather than providing only a disease specific approach.

Better Care Together engagement

The draft *Better Care Together: five-year strategic plan* was published in September 2014. It sets out plans to reform health and social care services for the people of LLR. It contains proposed priority areas for development agreed through engagement processes, and these underpin the proposed models of care and interventions. Further extensive engagement is planned with LLR patients, public, users of social care services, staff and other stakeholders as the plan develops.

A key tenet of the directional plan is rebalancing, to improve services and to ensure more people are supported at home or in the community. Our proposed direction of travel for community services is aligned to this ambition of the five-year directional plan.

Higher quality, accessible care giving early detection, treatment and management of patients in community settings is consistent with more efficient deployment of clinical resources – and therefore is better value for money. This means that better clinical outcomes can be achieved at a lower cost if the model and settings of care are fundamentally shifted from an overly acute setting to a community and primary care setting whilst continuing to ensure access to high quality acute care for those patients that need it.

Local citizens have been included in the development of the *five-year strategic plan* through call to action events and a series of workshops and summit-style meetings. This process was launched at a public and patient summit in January 2014.

Outcomes frameworks

NHS, Public Health and Adult Social Care outcomes frameworks

In November 2012 the DH published *Improving Health and Care – the role of the outcomes frameworks.* This document introduced the three new outcomes frameworks: NHS, Public Health and Adult Social Care, and highlighted the complementary nature of all three. The document asserted that improved outcomes across the whole of the health and care system can only be achieved when all parts of the system work together. It noted that while each part of the system has its own outcomes framework, for the first time, all three were being refreshed at the same time with a greater emphasis on the use of shared and complementary indicators, highlighting shared goals and facilitating joint working.

The most important set of tools now used by the Department of Health for assessing the performance of the system are these three outcomes frameworks for the NHS, public health and social care, and sitting beneath these the CCG Outcomes Indicator set.

The three outcomes frameworks, individually and then mapped across each other, appear in Appendix 1, along with the CCG Outcomes Indicator set. This proposed strategy supports delivery of a number of these outcomes - see table on page 11 above. It also supports delivery of some of the Better Care Fund outcomes which are:

- Reduction in avoidable emergency admissions
- Reduction in delayed transfers of care
- Reduction in residential admissions
- Improved effectiveness of rehabilitation after discharge from hospital
- Improved patient/service user experience.

Section 2: The current position

Demographics

In 2009, the *Leicestershire Joint Strategic Needs Assessment* (JSNA) highlighted the challenges posed by the ageing population in the county. In the 2012 JSNA 'adapting service provision to the needs of the growing population, and in particular the growing older population' was highlighted as our most pressing commissioning challenge.

In the last 10 years the population of Leicestershire has increased by over 7% percent and is predicted to grow by a further 11% by 2026. By 2026 over 22% of the population will be over 65 compared to 16% in 2011. By 2026, the number of very old people (90+) is predicted to increase by 125%, from just over 5,000 people to around 11,500, the number of 70-74 year olds by a third (from 27,500 to 36,500) and the number of 65-69 year olds by almost a fifth (from 35,700 to 42,300). This poses challenges for the demand on our health and social care services and the complexity of the services they provide.

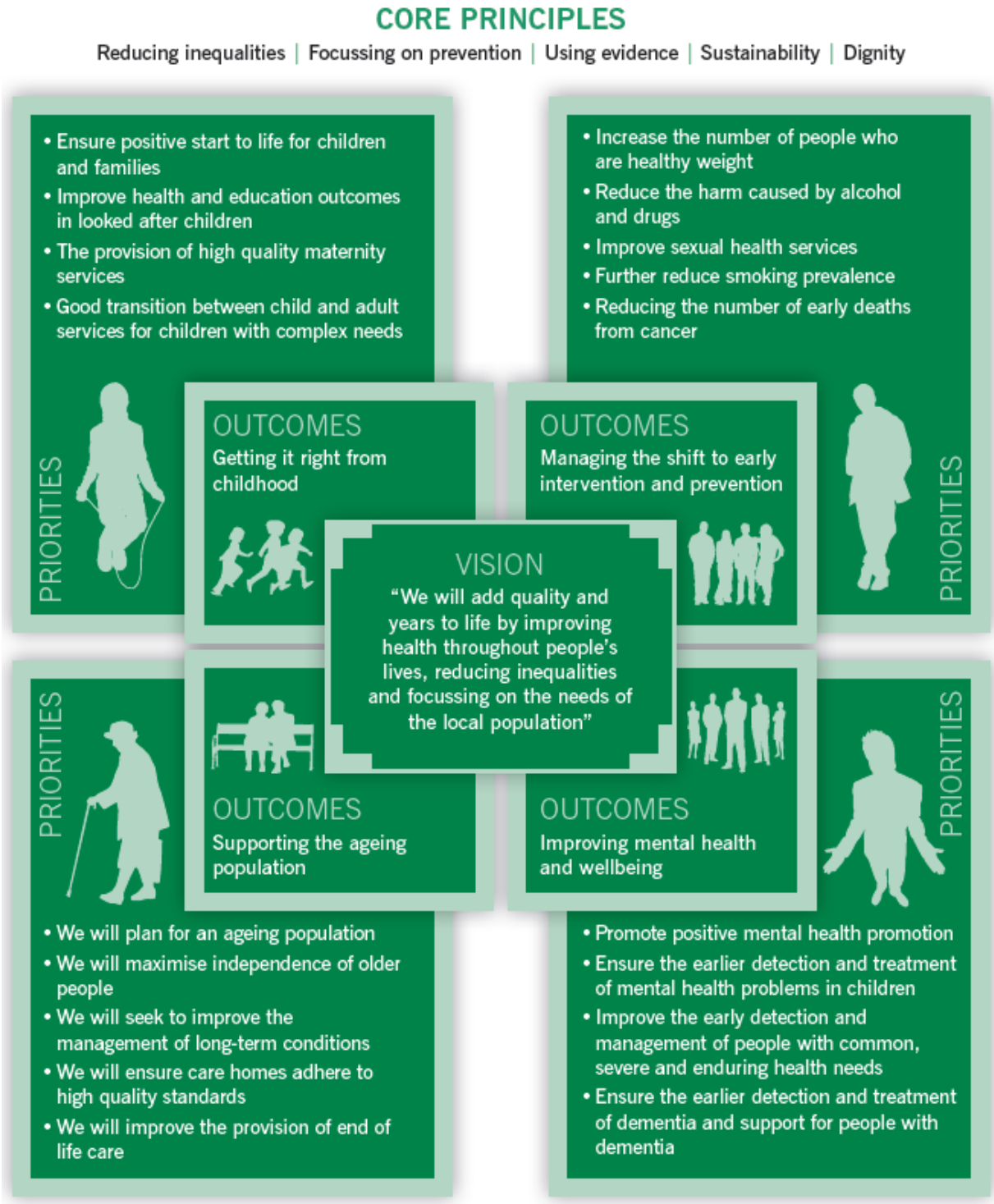
Similarly, the *Rutland JSNA* predicts an overall population growth between 2010 and 2030, with the population aged 70 and over predicted to increase more, both in terms of numbers and as a proportion of the whole population. The JSNA highlights the need to plan health, social care and broader support for the increasing number of older people.

For more detail on the JSNA and the needs of our population that influence this strategy, the JSNA can be located at www.leics.gov.uk/jsna and www.rutland.gov.uk/rutland_together/health_wellbeing_board/jsna_2012.aspx

Leicestershire and Rutland Health and Wellbeing Strategies 2013-2016

Health and Wellbeing Strategies are driven by the *Joint Strategic Needs Assessment* (JSNA), an overarching assessment of the health and wellbeing needs of the local population across the wider health and social care economy. Strategies are in place in both Leicestershire and Rutland and have been developed by local Health and Wellbeing Boards.

The Health and Wellbeing Strategy for Leicestershire County identifies a number of outcomes for promoting health and wellbeing across the life course and cross cutting themes in support of these objectives including supporting the ageing population. The core principles, vision, outcome and priorities of the Strategy are summarised in the diagram below. Our proposed Community Services Strategy is aligned to these core principles and will support delivery.



Source: Leicestershire Health and Wellbeing Board Annual Report, May 2014

The Health and Wellbeing Strategy for Rutland highlights four key themes:

- Giving children and young people the best possible start
- Enable people to take responsibility for their own health
- Help people to live the longest, healthiest life they can

- Making social care services more accessible

Again, our Community Services Strategy will support delivery of key elements of this Strategy.

Current services

Introduction

Currently community services have been delivered through separate service specifications by the Provider of Community Health Services and Local Authority Social Care services. Community Health and Social Care have worked alongside Primary Care to deliver a wide range of health and social care services; however these are being delivered under separate organisational structures and often lacked coterminous boundaries with primary care.

This section outlines the community health services that are currently provided by Leicestershire Partnership Trust and highlights two recent developments in services in 2013/14 – Integrated Care Co-ordinators and Improving End of Life Care Services.

Community Health Services

A wide range of services are currently provided as individual services by the main provider of community health care, Leicestershire Partnership Trust. These include:

General Services:

- Community nursing
- Community matrons
- Intermediate Care, Domiciliary therapy services
- Primary care co-ordinators (supporting the University Hospitals of Leicester Emergency Department on the basis of clinical need as to whether a patient could be treated and managed in a community setting)
- Rapid Intervention Service (supporting appropriate early discharge form the Emergency Department by providing rapid assessment of patients and access to community services)
- Community hospital in-patient care
- Single Point of Access (SPA) to Community Health Services.

Specialist Services:

- COPD and Home Oxygen Services
- Heart failure service
- Hospice at home
- Palliative Care services (including Marie Curie)
- Specialist stoma care
- The Falls Programme
- Podiatry

- Nutrition and dietetics
- Speech and language therapy (SALT)
- Mental Health Services (including dementia)
- Musculoskeletal services

Recent development – Integrated Health & Social Care Co-ordinators (HSCCs)

In 2013/14 ELR CCG commissioned a platform for integrated health and social care based on a team of Integrated Health and Social Care Co-ordinators (HSCC). This formed the basis of a model for locality based multidisciplinary working and establishing key lines of communication between professionals involved in the patient's overall care.

Each HSCC covers one of the 10 groups of general practices with a combined list size of 30-35,000. Nine of the HSCCs are employed by Leicestershire County Council and one by Rutland County Council (which comprises one of the 10 GP groups).

The HSCCs work with General Practitioners in practices across each GP group to identify patients with emerging frailty at medium risk of potentially avoidable hospital admission utilising the ACG risk stratification tool. These patients are offered a holistic health and social care assessment aimed at optimising their long term health conditions and social circumstances, including provision of assistive technology where this would be of benefit. Patients' health needs are followed up by primary care and community health and social care services, underpinned by individual care plans.

Improving End of Life Care Services, Deciding Right: Planning your care in advance

In 2013/14 ELR CCG worked in partnership with both Leicester City and West Leicestershire CCG's to design and implement Care Plans for patients who are in the last year of life. During the spring of 2014 ELR CCG led further work to refine and further develop these care plan templates to work fully on both of the local primary care IT systems (SystmOne and EMIS web). As part of the planning process, GPs will liaise with the patient and can also liaise with the patients' family and other members of the multidisciplinary team.

The system requires further development to improve information sharing to resolve the following issues:

- The current system does not include a facility to share care plans electronically with EMAS. When called to a patient's home in an emergency situation the decision on whether to admit the patient to hospital is dependent on the ready availability of the patient-held care plan

- The main provider, Leicestershire Partnership Trust (LPT) and the local hospice, LOROS, both use SystmOne but do not use the same care plans as primary care.

ELR CCG is currently working with partner agencies to explore options to resolve these issues and has submitted a bid to the Health Foundation in order to take this work forward to the next stage.

Section 3: Vision, model, direction of travel, service developments, remaining gap

Future direction/vision

The long-term vision is for a fully integrated, co-ordinated model for health and social care, delivering seven-day services that puts people's care needs at the centre. The aim is to meet the needs of an increasing older population, particularly the frail and those with long term conditions. Services will be delivered to the citizens of East Leicestershire & Rutland in a co-ordinated way that recognises people often need support from more than one service.

We know from the Kings Fund evidence that locally, as nationally, there is an ageing, frail population and an increasing prevalence of chronic disease. This requires a service response that is fit for the future with reorientation away from acute and episodic care towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated.

We also know from the Kings Fund documents that the health and social care system has failed to keep up with the dramatic demographic shift that has occurred in recent years and that is designed around single issue consultation, when many people are dealing with multiple issues. Achieving the necessary change requires integrated working to ensure the right mix of services in the right place at the right time.

Care closer to home will only work if sustainable community solutions are in place, developed through co-production to remove barriers, duplication and gaps in service delivery. This is essential to meet the financial challenge.

National evidence suggests that services should be delivered through new models, wrapping community services around primary care, with care co-ordination delivered through integrated health and social care teams.

Key elements of the vision include:

- 'Home first' – community services should be building based only where necessary
- Wrap services around the person
- Wrap community service delivery around primary care

- Citizen inclusion and empowerment
- Focus on prevention and independence – harnessing the wider community
- The patient also has a role in helping to reduce dependency on primary care and community services through healthy lifestyle and an understanding of their condition and how to manage it
- Integration of both commissioning and service delivery (health and social care)
- Improved, 'seamless' pathways of care
- Good quality and patient experience – focus on good quality and the rest will follow
- A workforce that is engaged with and supports delivery of the Community Services Strategy including the concept of 'home first'
- Outcomes focused services
- Affordable services.

Model of care

This section describes the shape of the model of care, a structure for delivery and a description of what success will look like.

What will the model of care look like?

Key components of the model of care will include:

- Co-ordinated services with the patient at the centre of care
- Multi-disciplinary teams (Primary, community and social care) wrapped round the patient/citizen offering 24/7 services
- Focus on early intervention along with reablement and promoting independence
- Specialist medical input as required
- Services that offer an alternative to hospital stay
- Community hospital beds where 'home first' is not possible
- Harness the power of the wider community , eg, 'good neighbour' schemes
- Patients will receive education and support to understand and manage their condition
- Increasing use of Personal Health Budgets
- Carers will receive 'carer assessments' and have their needs recognised (including young carers)
- Harnessing the voluntary and independent sectors in the delivery of services that are co-ordinated with statutory services
- An innovate environment that embraces the use of new technology
- A workforce delivering caring and compassionate care and with the training and education to take on new roles that support the integration of health and social care.

How will service delivery be structured?

It is proposed that the structure for service delivery combines wrapping service delivery around primary care with seamless delivery of care that is integrated across organisations:

- The platform for delivery of services across ELR CCG is the Primary Care localities and GP hubs (GP groups within the localities, each with a registered population of 30-35,000)
- Integrated Care:
  - Co-ordinated pathways of care
  - Integrated services within organisations
  - Integration across health and social care where possible

What will success look like?

This section asks the question: If we achieve the vision for the future delivery of Community Services through this service model, what will be different or better? How will we know that we have succeeded?

The outcomes against which successful delivery of the service model will be measured will include:

- 'Home first' (care at home where possible), eg, auditing to demonstrate that 'home first' is considered as the first option, including use of virtual beds, thereby avoiding unnecessary or inappropriate admissions to an acute or community hospital bed
- Evidence that the model is outcomes focused. Success will be measured using clinical, qualitative and quantitative indicators:
  - Clinical - the health outcomes of care and treatment
  - Qualitative – positive patient (and carer) experience of care outside hospital, quality of care
  - Quantitative - reduction in admissions, readmissions and lengths of stay in acute hospitals, reduction in permanent admissions to care homes
  - A sustainable shift in resources from the hospital to the community sector
- The health system is able to cope with peak demand
- Patients have an understanding of their condition and how to manage it and use self-help
- Shared care plans (patient held and electronic)
- Members of the public have an understanding and support the principle of 'home first'
- The workforce understands and supports the vision and service model, and is delivering services to achieve desired service outcomes
- An affordable service with a robust methodology that measures the financial impact of service delivery

Our Priorities – themes that underpin the strategy

The emerging priorities from national policy, local strategies, the evidence base and stakeholder pre-engagement to date, described in Section One, The Case for

Change have confirmed the direction of travel and emerging priorities for the development and delivery of community services in line with the ten components of care outlined in 'Making our Health and Care Systems Fit for an Ageing Population'.

These include the following:

- An ageing, frail population requires a service response that is fit for the future
- Putting people at the centre of services
- Developing new service models – wrapping integrated community services (health and social care) around locality-based teams that are grouped around primary care and natural geographies
- A sustainable shift towards care at home, or as close to home as possible, based on the concept of 'home first'
- Multi-disciplinary teams offering 24/7 services as standard complemented by highly flexible and responsive community and social services
- Ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Meeting the financial challenge for affordable and sustainable services – reducing demand on secondary healthcare services
- Developing the workforce to deliver an integrated service model of care
- Co-production with key stakeholders

Pathways of Care

The *Better Care Together: five-year strategic plan* identifies a number of cross-cutting workstreams to be delivered across six cross-cutting setting of care. These are illustrated in the Settings of Care diagram on page 8 above.

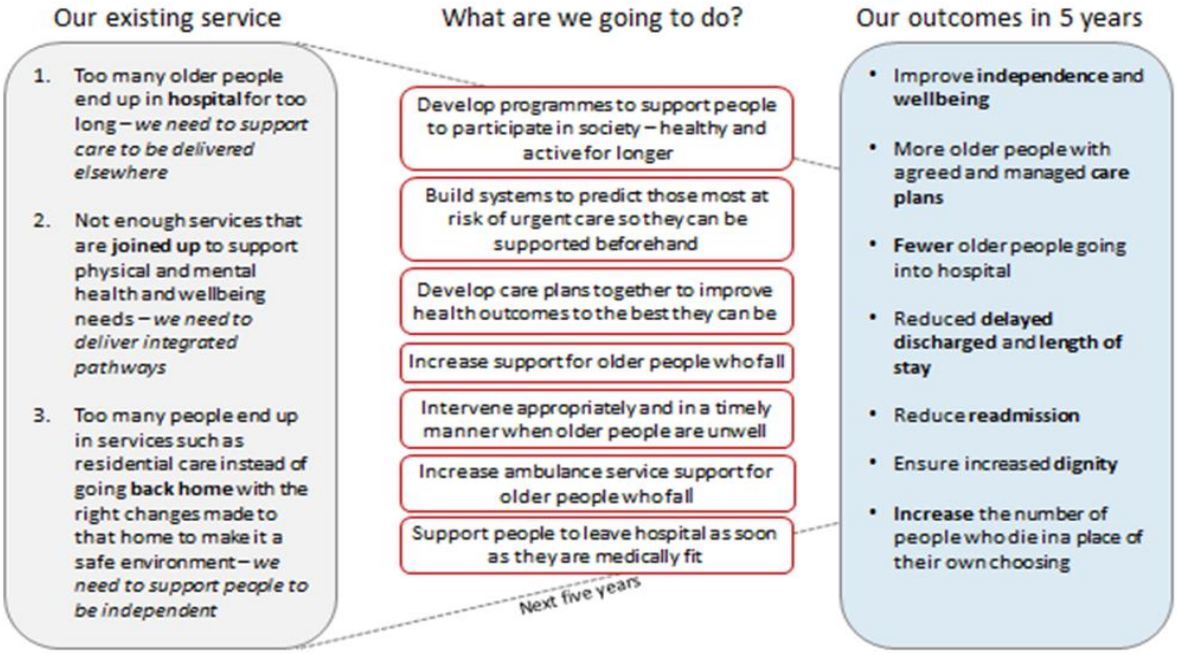
This Community Services Strategy primarily relates to the delivery of models of the workstreams for Frail Older People and Long Term Conditions across three of the six settings of care – self care, education and prevention, community and social care services, and crisis response and reablement.

It is acknowledged that effective delivery of the model of care will require a series of transformations across all six care settings. However three of the settings are outside the scope of this strategy. Transformed Primary Care (core and enhanced) will be developed through the Primary Care Strategy, and Acute Hospital Based Services - secondary and tertiary – are included in the strategy for Urgent Care. It is however critical that this and these other strategies are developed together to ensure consistency and a complementary approach.

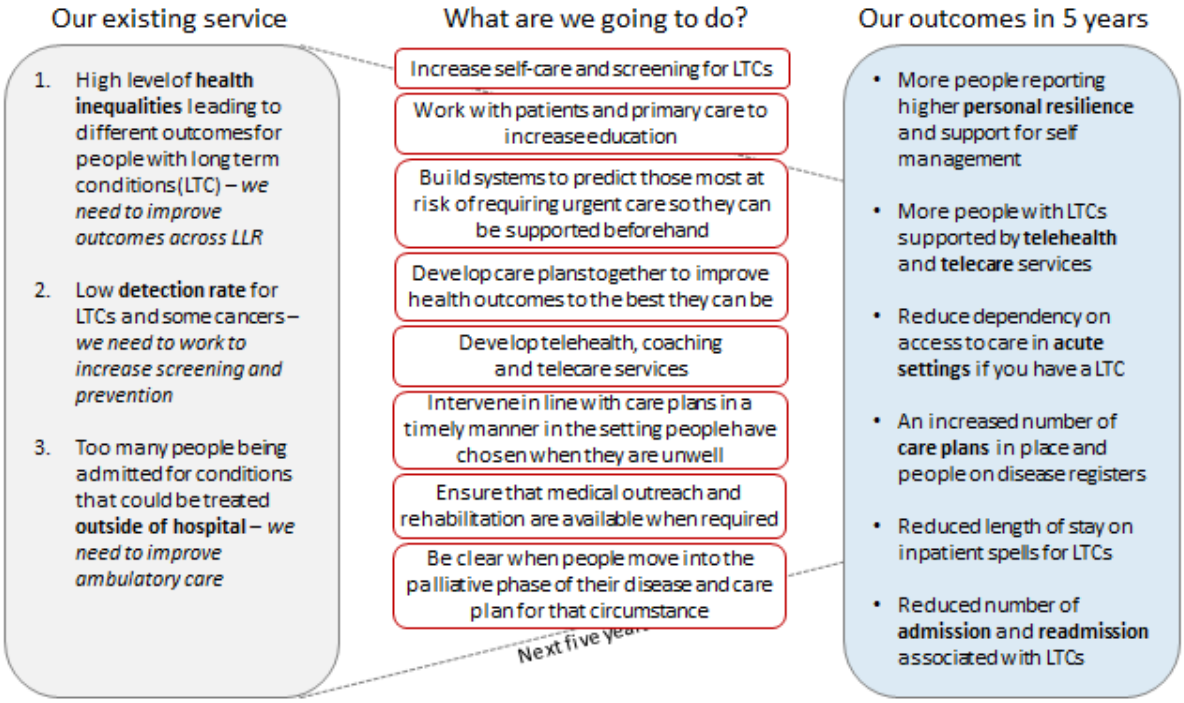
The workstreams to improve pathways of care for frail older people and Long Term Conditions are summarised in the diagrams below which seek to answer the questions:

- Where are we now?
- Where do we want to be?
- How do we get there?

Frail older people



Long-term conditions



Source: Draft *Better Care Together: five-year strategic plan*

Planned service developments 2014 – 2016 (and beyond)

There is evidence to suggest that integration is most effective when it is targeted towards people with severe, complex and long-term needs. It is best suited to frail older people, those with long-term chronic conditions and mental health illnesses and those requiring urgent care. It is most effective when it is population based and approaches the holistic needs of a patient, rather than being based on the patient's condition.

Using the opportunities generated by the introduction of the Better Care Fund, several plans are already underway to establish closer working relationships and foster multidisciplinary working across organisational boundaries. In line with the recommendations of the Kings Fund a first key step is to remove the complexity that has resulted from different policy initiatives over the years. Services are being developed based around primary care and natural geographies, supporting strong multidisciplinary teams that put the patient at the centre, with the aim of offering patients a much more complete and less fragmented service.

Better Care Fund Plans - Leicestershire &Rutland

Summary of Plans and Resources

Over 2014-16 (and beyond) Community Service developments across health and social care will mainly be designed and developed under the umbrella of the Better Care Fund (BCF). The key purpose of the BCF is to improve co-ordination, and be a key enabler to support the establishment of service integration across health and social care.

Joint plans have been developed working in partnership with Leicestershire County Council and Rutland County Council on how we plan to utilise the BCF pooled budget arrangement.

The table below outlines the priorities and schemes to be delivered through BCF.

Leicestershire BCF

Unified prevention offer

Ref:	Scheme	Description	Start Date
UPO1	First Contact	Staff members from the different agencies involved in First Contact frequently come into contact with vulnerable adults. When working with a vulnerable adult, there is an offer to complete a simple checklist, to find out if that person needs any additional support.	Established
UPO2	Carers Service	Support to carers to help maintain their health and wellbeing, including providing practical information and advice, the expanding carers assessments requirement in line with the Care Act and supporting carer respite.	Established
UPO3	Improving Community Based Prevention through Local Area Co-ordination (LAC)	LAC aims to support vulnerable people achieve their vision for a good life, to support people to contribute to their communities and to strengthen the capacity of communities to welcome and include people.	Jan 2015
UPO4	Autism Pathway	Promote and maintain independence whilst avoiding institutional and hospital admissions for people with autism.	Established
UPO5	Assistive Technology	Helps to maintain independence by enabling people to remain at home through the use of monitoring and response equipment and services.	Established
UPO6	Integrated Housing Solutions	A new integrated housing service will offer practical expertise and support for people needing aids, equipment, adaptations, handy person services and advice on energy efficiency/affordable warmth.	2015/16

UP07	Protected Prevention Services	Funds additional short breaks and residential respite places to support carers with their responsibilities and to prevent carer breakdown.	Established

Integrated, proactive care for those with long-term conditions

Ref:	Scheme	Description	Start Date
LTC1	Integrated, Proactive Care (Risk Stratification & Care Management)	Provide support to individuals with long term conditions or frail older people to manage their condition and identify the specific help they need. The engagement with the individual is ongoing and ensures the health risk is kept at bay while supporting the individual to self-manage their condition.	Established
LTC2	IT Enablers – Adoption of NHS Number	Implementation of the NHS number within social care	Nov 2014
LTC3	Improving Quality in Care Homes	The service works with providers of residential and nursing care services to support overall improvements in care homes, and to action any breaches in care.	Established
LTC4	Protected LTC Services	To maintain care package support levels for existing service users.	Established

Integrated urgent response

Ref:	Scheme	Description	Start Date
IUR1	Integrated Crisis Response Service (ICRS)	Provides effective short-term support at the point of a health and care crisis to maintain someone in their own home. The service responds within 4 hours and	Sept 2013

		is available for a maximum of 3 days.	
IUR2	Rapid Assessment for Older Person's Unit	A rapid assessment and treatment service for frail older people operating on an outpatients basis.	Oct 2014
IUR3	Rapid Response Falls Service	The project has three main elements and a full implementation plan is currently in development; • EMAS emergency response to patients that have fallen, • End to end review of the falls pathway; • Prevention pathway and early intervention.	Nov 2014
IUR4	7 days services in Primary Care	7 day services will be available in primary care, co-ordinated by GPs across Leicestershire localities, targeted to frail and vulnerable people.	Oct 2014

Hospital discharge and reablement

Ref:	Scheme	Description	Start Date
HDR1	Integrated Reablement	Provides intensive support to help service users maintain their independence in the community.	Established
HDR2	Protected Reablement Services	To fund existing services with health and social care to provide reablement services.	Established
HDR3	Improving Mental Health Hospital Discharge	Approved Mental Health Professionals to carry out assessments and meet increasing demands on the service.	Established
HDR4	Implementing the Minimum Safe Data Set	A minimum data set to enable the safe transfer of patients between care settings.	TBC
HDR5	Protected Hospital Discharge Services	To fund existing services within health and social care to provide hospital discharge services.	Established
HDR6	Multi-Disciplinary Review Team for Care Packages	Provide early reviews to release domiciliary capacity and increase flow for HART referrals.	Dec 2014

HDR7	Developing the Single Point of Access (SPA)	Improve capacity of SPA to respond to new integrated urgent response services and to EMAS pathways. Extend the scope of the SPA to be able to allocate resource and operate capacity management with live scheduling of activities. Option appraisal for integration with Leicestershire County Council customer services centre	Winter 2014 2015/16 2015/16

Rutland BCF

Theme	Scheme	Description	Start Date
Unified Prevention (UP)	UP1 Community Agents	The scheme will establish a new network of community agents, who will be local contacts across the whole of Rutland, for people requiring health and social care advice and information. Community agents will be points of contact for their local population, and experts at networking to ensure timely and connected information can be available, and used to support people needing services as well as creating community capacity.	Feb 2015
	UP 2 Adaptations	The aim is to provide advice and financial support including adaptations to maximise independence and will contribute to: • Help people live healthier lives • Help people stay well for longer • Improve the patient experience • Avoid hospital and care home admissions	Established

		• Provide a swift response in providing step down care and support on discharge from hospital.	
	UP3 Assistive Technology	Through the Better Care Fund, Rutland County Council (RCC) and the East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) have established a commitment to developing telecare and telehealth options for residents within the County. The proposed service will assess individual's needs to ascertain what type of assistive technology aids and telecare is required to support the person to live in their own home.	April 2015
	UP 4 Integrated Care for people with Long term conditions	The health and social care co-ordinator identify and support high risk patients with complex health and social care needs in the community, and to provide early intervention through targeted advice, information and support to enable the patients and their carers to better manage their health and wellbeing, and to lead more active and better managed lives in the community.	Established
Integrated Urgent Response	IUR1 Integrated Crisis response	To extend an existing service into a 7 day working health and social care integrated crisis response service. The aim is to align and integrate a collection of existing and planned health and social care services to offer 24/7 access to step-up crisis care. An extension to offer an overnight crisis response nursing element and the crisis response services offered by RCC as part of the REACH service.	Established
	IUR 2 Integrated health and social care	A whole system response is required to ensure a fully co-ordinated and integrated service offer is developed. This scheme is to develop pathways, protocols and possibly colocation of health and social care teams to allow the health and social care economy to fully	April 2015

		realise its vision of integrated care.	
Hospital Discharge & Reablement	HDR1 Hospital Discharge	Facilitate discharges to the patients home or Step Down provisions to reduce the length of stay for people in the acute setting and reduce the number of delayed discharges from acute hospital settings.	Established
	HDR2 Reablement	The team works closely with hospitals, NHS professionals, social care teams and the wider community, in order to provide short and intensive Reablement interventions and practical support to those who are discharged or newly in need of home care or personal support.	Established
Long Term Conditions	LTC 1 Learning Disability	The aim of the scheme is to develop a unified approach in ensuring that the health and social care needs of people placed 'out of county' are met robustly improving outcomes for the individual.	April 2015
	LTC 2 Integrated Dementia Hub	The development of a Rutland Dementia Hub where people living with dementia, their families and carers can come to receive advice and support, take part in activities, and access self-help, health and social care services.	April 2015

Planning beyond the Better Care Fund – the gap

Robust methodologies will be developed to monitor and evaluate the impact of existing services and those services being planned with the support of the Better Care Fund to ensure that they are meeting the outcomes and objectives of both the Community Services Strategy and the draft *Better Care Together: five-year strategic plan.*

Reference will be made to publications such as 'the Kings Fund – Making our Health and Care systems fit for an ageing population (2014)' which outlines ten key components of care and within each one identifies 'what we know can work' (see The evidence base, in Section 1).

The suggested actions in this document are being carefully reviewed as an aid to identifying what else we should do to ensure effective delivery of the Community Services Strategy. Areas that have already been identified include:

- Working towards aligning Leicestershire Partnership Trust and County Council services to wrap around GP localities to support risk stratification and multi-disciplinary teams
- All year round planning (, eg,for warm weather), not just cold weather planning
- Recognition and reablement of patients who are in 'slow decline' (eg, gradually getting weaker) to prevent admission to hospital
- Pro-active pre-operative rehabilitation
- Develop shared assessment tools and reablement plans
- Comprehensive geriatric assessment in the community

However, if the plan is to develop services in line with the ten components of care, and to ensure that 'home first' becomes a reality, we need to review existing community services and develop them so that they deliver this.

Review of community services – inpatient beds

An integral part of the Community Service Strategy is an easily articulated vision for when, and how, community hospital inpatient beds are used in the future. National policy and best practice tell us that we should be delivering care closer to home wherever possible. In engagement with our local population they have repeatedly told us they are keen to go home as soon as it is safe for them to do so after a spell in hospital. It is also widely acknowledged that people are more likely to 're-able' and achieve better long-term outcomes when they are supported to do so in their own residential environment.

At the same time however, there is strong evidence to suggest that the timely and effective recovery of a small number of our patients after a particular episode of ill health is extremely complex to manage. These old, frail people who live with ongoing long-term health conditions, and or, who have specific social needs may actually improve better if their rehabilitation takes place in a community-based facility.

It is our responsibility as a publically funded body to make the best use of the resources we have available to us. As part of the consideration of our plans for the delivery of effective patient rehabilitation and the successful management of long term conditions we aim to minimise the percentage of our funds that are spent on buildings and associated overheads so that we can release this money to invest in more front line nurses and care staff that work directly with patients and their carers in their own homes.

To make the changes that we believe will improve the quality of care we commission for our patients it will be necessary to take a phased approach to this part of our strategy over a number of years. The first phase of our strategy will be to review the model of care that defines how rehabilitation care and the management of long-term conditions is provided. We plan to develop a new model of care that can clearly demonstrate how patient outcomes, safety, and experience will change. We will engage with stakeholders to test and refine our proposals and work with a wide range of provider organisations to ensure that the local health and social care workforce is properly trained and equipped to deliver these enhanced services. This phase of the strategy will also include work to understand the detailed implications of the changes we propose to implement in subsequent phases.

Clinical governance and quality

ELR CCG is committed to improving the quality of patient care. By focussing the goals of this strategy on clinical effectiveness, patient safety and patient experience this Community Services Strategy aims to deliver excellent health services and improve the quality of patient care.

Quality, patient safety, clinical effectiveness and the experience of patients underpins the delivery of health and social care services. A number of high profile cases (Winterbourne View [DH, 2012], the Report of the Mid Staffordshire NHS Public Enquiry by Robert Francis QC [2013], and the Saville Inquiry [2013] have identified that vulnerable people were not afforded basic standards of care and their fundamental rights to dignity were not respected. Safeguarding vulnerable people continues to be a focus of ELR CCG, with a range of policies adopted by the CCG to support and underpin our safeguarding arrangements.

ELR CCG recognises the need for service improvements and this strategy aims to support enhancements in the quality of patient care and experience in the long-term, aligned with other ELR CCG strategies, eliminating waste, reducing variation and delivering better value for money.

The *ELR CCG Two-year Operational Plan* references the CCG aim of delivering efficiency by maximising use of community services through an integrated care approach with health and social care, to provide a seamless service for patients. This strategy supports the delivery of this goal through the provision of multi-disciplinary teams of primary, community and social care services. This community services strategy also supports the CCG aim of ensuring the patient is at the heart of everything we do by aiming to deliver a holistic service, wrapped around the needs of the patient, thus delivering a high quality experience for patients. This focus will be

a key part of the Community Services Strategy, ensuring that vulnerable people are supported by integrated, high quality services in the community.

By ensuring cohesive working across all sections of the care pathway, and seeking to improve the quality of care within providers, this strategy aims to deliver safer care and improved outcomes for patients by delivering integrated, co-ordinated and high quality care.

Enablers

Workforce

Delivery of the strategy requires a workforce that:

- Is engaged with and supports delivery of the Community Services Strategy including the concept of 'home first'
- Has the skills to deliver caring and compassionate care, without the constraints of professional boundaries
- Has received training and education to take on new roles that support the integration of health and social care
- Delivers services to achieve desired service outcomes

Key risks include:

- A potential lack of education and training availability
- A potential shortage of some health care professionals , eg, community geriatricians

Information technology and information governance

Shared electronic information such as care plans will be one of the keys to successful delivery of the Community Services strategy. IT solutions must be found to share information across different IT systems. This will be underpinned by robust Information Governance.

Assistive technology, telecare and telehealth will be required for some citizens to enable them to continue to live independently.

Estate

The use of community estate will be reviewed to ensure that it is being used effectively. The requirements of the estate will be informed by the review of in-patient services.

Models such as the integrated estate plans in Hull, East Yorkshire, will be explored to consider opportunities for co-location of services provided by partner agencies.

Working with our partners

Perhaps the most important enabler for the Community Services Strategy is effective working with our partners and key stakeholders.

One of the ten components of care identified by the Kings Fund in 'Making our Health and Care systems fit for an ageing population (Kings Fund, 2014)' is 'Integration to provide person-centred co-ordinated care'. This section of the Kings Fund publication identifies the following 'Lessons from experience – making integrated care happen at scale and pace':

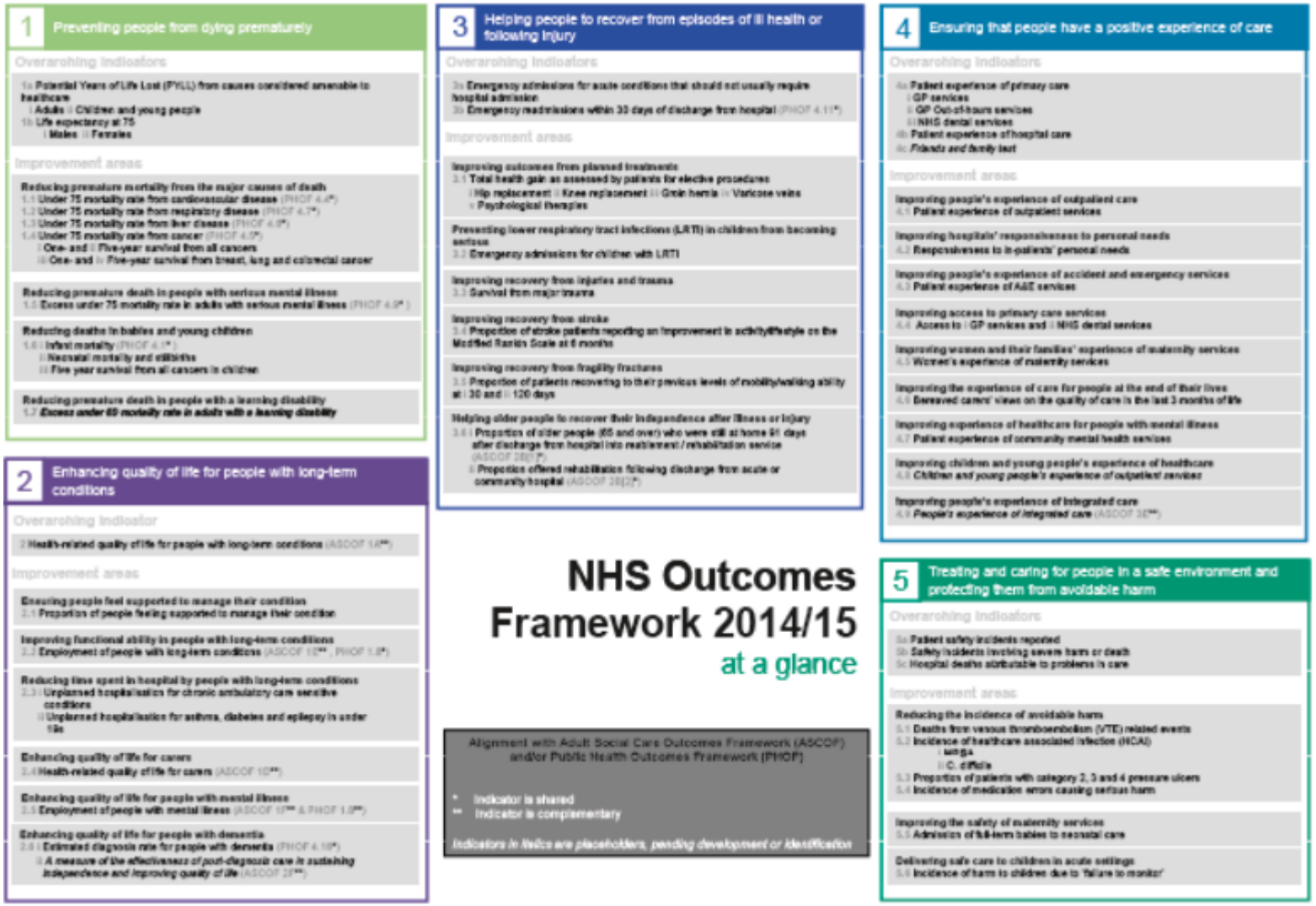
- Find common cause with partners and be prepared to share sovereignty
- Develop a shared narrative to explain why integrated care matters
- Develop a persuasive vision to describe what integrated care will achieve
- Establish shared leadership
- Create time and space to develop understanding and new ways of working
- Identify services and user groups where potential benefits from integrated care are greatest
- Build integrated care from the bottom up as well as top down
- Pool resources to enable commissioners and integrated teams to use resources flexibly
- Innovate in the use of commissioning, contracting and payment mechanism and use of the independent sector
- Recognise that there is no 'best way' of integrating care
- Support and empower users to take more control over their health and wellbeing
- Share information about users with the support of appropriate information governance
- Use the workforce effectively and be open to innovation in skill mix and staff substitution
- Set specific objectives, and measure and evaluate progress towards them
- Be realistic about the costs of integrated care
- Act on all these lessons together as part of a coherent strategy.

Section 4: Further developing this strategy

This document has been produced as a first draft, to capture what the evidence and policy is telling us works for the development of integrated community services. A small amount of pre-engagement has been undertaken with partners, to develop the engagement plan for developing the next draft. During this pre-engagement there has been broad support for developing the strategy in line with the ten components of care and what we know works.

Please see Appendix 2 for a summary of the pre-engagement events to date and Appendix 3 for the Engagement Plan and timescales for the next stage. In addition to this, existing services will need to be reviewed with a view to evolving them to meet the requirements of our vision and the ten components of care.

Appendix 1 - NHS, Public Health and Adult Social Care outcomes – individual and complementary



Public Health Outcomes Framework 2013-2016

At a glance

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life
Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System
*Indicator shared with the NHS Outcomes Framework.
** Complementary to indicators in the NHS Outcomes Framework
† Indicator shared with the Adult Social Care Outcomes Framework
†† Complementary to indicators in the Adult Social Care Outcomes Framework
Indicators in italics are placeholders, pending development or identification

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.1 Children in poverty
1.2 School readiness
1.3 Pupil absence
1.4 First time entrants to the youth justice system
1.5 16-18 year olds not in education, employment or training
1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)*
1.7 People in prison who have a mental illness or a significant mental illness
1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(I)- NHSOF 2.2) ††(II-ASCOF 1E) **(II-NHSOF 2.5)†† *(II-ASCOF 1F)*
1.9 Sickness absence rate
1.10 Killed and seriously injured casualties on England's roads
1.11 Domestic abuse
1.12 Violent crime (including sexual violence)
1.13 Re-offending levels
1.14 The percentage of the population affected by noise
1.15 Statutory homelessness
1.16 Utilisation of outdoor space for exercise / health reasons
1.17 Fuel poverty
1.18 Social isolation † *(ASCOF 1I)*
1.19 Older people's perception of community safety †† *(ASCOF 4A)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.1 Low birth weight of term babies
2.2 Breastfeeding
2.3 Smoking status at time of delivery
2.4 Under 18 conceptions
2.5 Child development at 2 – 2 ½ years
2.6 Excess weight in 4-5 and 10-11 year olds
2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
2.8 Emotional well-being of looked after children
2.9 Smoking prevalence – 15 year olds (Placeholder)
2.10 Self-harm
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Successful completion of drug treatment
2.16 People entering prison with substance dependence issues who are previously not known to community treatment
2.17 Recorded diabetes
2.18 Alcohol-related admissions to hospital
2.19 Cancer diagnosed at stage 1 and 2
2.20 Cancer screening coverage
2.21 Access to non-cancer screening programmes
2.22 Take up of the NHS Health Check programme – by those eligible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

3.1 Fraction of mortality attributable to particulate air pollution
3.2 Chlamydia diagnoses (15-24 year olds)
3.3 Population vaccination coverage
3.4 People presenting with HIV at a late stage of infection
3.5 Treatment completion for TB
3.6 Public sector organisations with board approved sustainable development management plan
3.7 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.1 Infant mortality* *(NMSOF 1.6)*
4.2 Tooth decay in children aged 5
4.3 Mortality rate from causes considered preventable ** *(NMSOF 1a)*
4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NMSOF 1.1)*
4.5 Under 75 mortality rate from cancer* *(NMSOF 1.4i)*
4.6 Under 75 mortality rate from liver disease* *(NMSOF 1.3)*
4.7 Under 75 mortality rate from respiratory diseases* *(NMSOF 1.2)*
4.8 Mortality rate from communicable diseases
4.9 Excess under 75 mortality rate in adults with serious mental illness* *(NMSOF 1.5)*
4.10 Suicide rate
4.11 Emergency readmissions within 30 days of discharge from hospital* *(NMSOF 3b)*
4.12 Preventable sight loss
4.13 Health-related quality of life for older people
4.14 Hip fractures in people aged 65 and over
4.15 Excess winter deaths
4.16 Estimated diagnosis rate for people with dementia * *(NMSOF 2.6i)*

Adult Social Care Outcomes Framework 2014/15

At a glance

1 Enhancing quality of life for people with care and support needs

Overarching measure

1A. Social care-related quality of life ** (NHSOF 2)

Outcome measures

People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.
1B. Proportion of people who use services who have control over their daily life

New definition for 2014/15: 1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments

Carers can balance their caring roles and maintain their desired quality of life.
1D. Carer-reported quality of life ** (NHSOF 2.4)

People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.
1E. Proportion of adults with a learning disability in paid employment ** (PHOF 1.8, NHSOF 2.2)
1F. Proportion of adults in contact with secondary mental health services in paid employment ** (PHOF 1.8, NHSOF 2.5)
1G. Proportion of adults with a learning disability who live in their own home or with their family * (PHOF 1.6)
1H. Proportion of adults in contact with secondary mental health services living independently, with of without support ** (PHOF 1.6)
1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like. ** (PHOF 1.18)

2 Delaying and reducing the need for care and support

Overarching measures

2A. Permanent admissions to residential and nursing care homes, per 100,000 population

Outcome measures

Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.

Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.

2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services * (NHSOF 3.6i-ii)

New measure for 2014/15: 2D. The outcomes of short-term services: sequel to service.

Placeholder 2E: The effectiveness of reablement services

When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

2C. Delayed transfers of care from hospital, and those which are attributable to adult social care

*Placeholder 2F: Dementia – A measure of the effectiveness of post-diagnostic care in sustaining independence and improving quality of life*** (NHSOF 2.6i)

3 Ensuring that people have a positive experience of care and support

Overarching measure

People who use social care and their carers are satisfied with their experience of care and support services.

3A. Overall satisfaction of people who use services with their care and support
3B. Overall satisfaction of carers with social services
New measure for 2014/15: 3E. Improving people's experience of integrated care ** (NHS OF 4.8)

Outcome measures

Carers feel that they are respected as equal partners throughout the care process.

3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for

People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.

3D. The proportion of people who use services and carers who find it easy to find information about support

People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

This information can be taken from the Adult Social Care Survey and used for analysis at the local level.

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Overarching measure

4A. The proportion of people who use services who feel safe ** (PHOF 1.19)

Outcome measures

Everyone enjoys physical safety and feels secure.
People are free from physical and emotional abuse, harassment, neglect and self-harm.
People are protected as far as possible from avoidable harm, disease and injuries.
People are supported to plan ahead and have the freedom to manage risks the way that they wish.

4B. The proportion of people who use services who say that those services have made them feel safe and secure

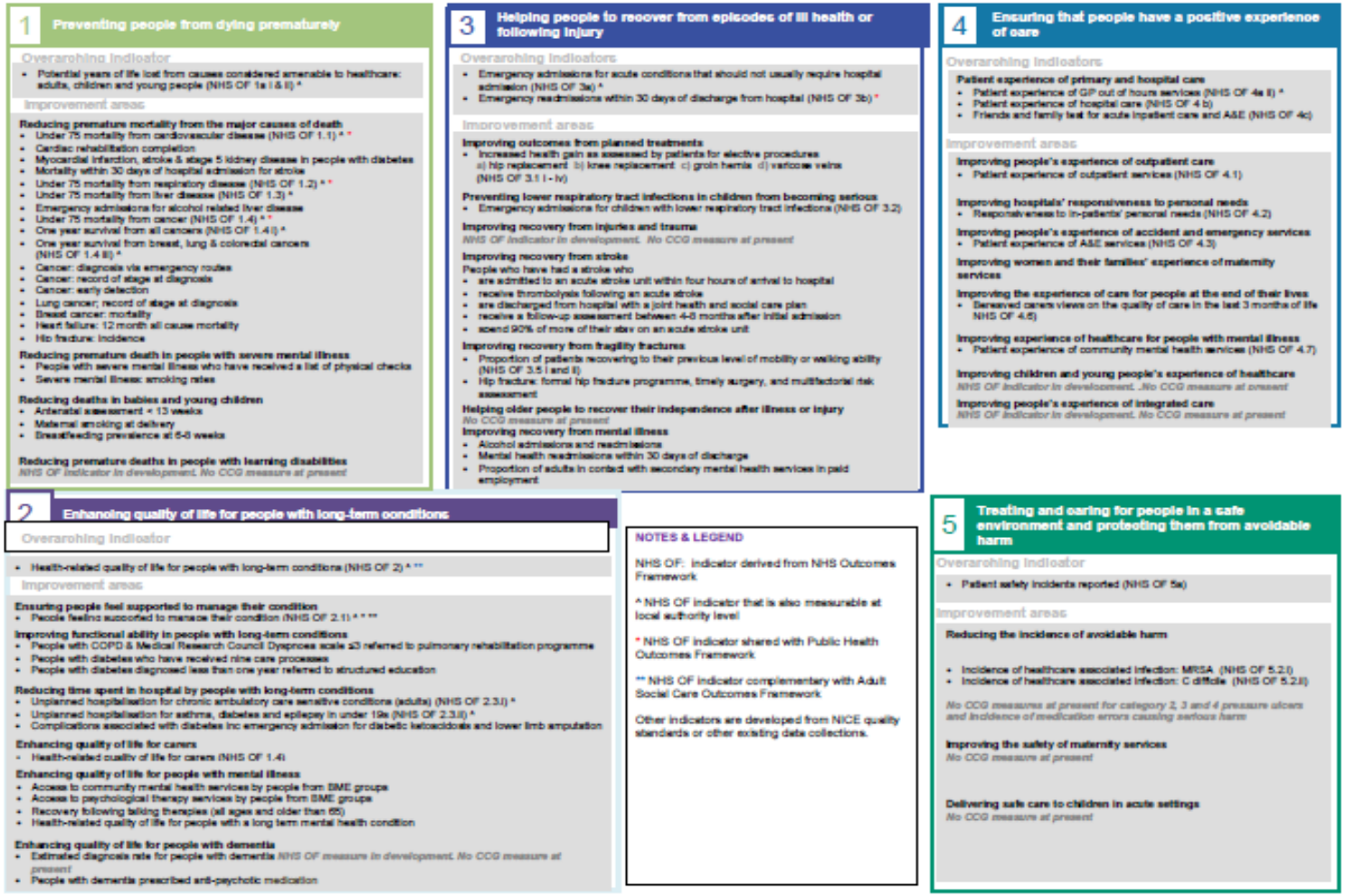
Placeholder 4C: Proportion of completed safeguarding referrals where people report they feel safe

Aligning across the Health and Care System

* *Indicator shared*
** *Indicator complementary*

Shared indicators: The same indicator is included in each outcomes framework, reflecting a shared role in making progress
Complementary indicators: A similar indicator is included in each outcomes framework and these look at the same issue

CCG Outcomes Indicator Set:



1 Preventing people from dying prematurely

Overarching Indicator

- Potential years of life lost from causes considered amenable to healthcare: adults, children and young people (NHS OF 1a I & II) ^

Improvement areas

Reducing premature mortality from the major causes of death
- Under 75 mortality from cardiovascular disease (NHS OF 1.1) ^ *
- Cardiac rehabilitation completion
- Myocardial infarction, stroke & stage 5 kidney disease in people with diabetes
- Mortality within 30 days of hospital admission for stroke
- Under 75 mortality from respiratory disease (NHS OF 1.2) ^ *
- Under 75 mortality from liver disease (NHS OF 1.3) ^
- Emergency admissions for alcohol related liver disease
- Under 75 mortality from cancer (NHS OF 1.4) ^ *
- One year survival from all cancers (NHS OF 1.4 I) ^
- One year survival from breast, lung & colorectal cancers (NHS OF 1.4 II) ^
- Cancer: diagnosis via emergency routes
- Cancer: record of stage at diagnosis
- Cancer: early detection
- Lung cancer: record of stage at diagnosis
- Breast cancer: mortality
- Heart failure: 12 month all cause mortality
- Hip fracture: incidence

Reducing premature death in people with severe mental illness
- People with severe mental illness who have received a list of physical checks
- Severe mental illness: smoking rates

Reducing deaths in babies and young children
- Antenatal assessment < 13 weeks
- Maternal smoking at delivery
- Breastfeeding prevalence at 6-8 weeks

Reducing premature deaths in people with learning disabilities
NHS OF Indicator in development. No CCG measure at present

3 Helping people to recover from episodes of ill health or following injury

Overarching Indicators

- Emergency admissions for acute conditions that should not usually require hospital admission (NHS OF 3a) ^
- Emergency readmissions within 30 days of discharge from hospital (NHS OF 3b) *

Improvement areas

Improving outcomes from planned treatments
- Increased health gain as assessed by patients for elective procedures a) hip replacement b) knee replacement c) groin hernia d) varicose veins (NHS OF 3.1 I - iv)

Preventing lower respiratory tract infections in children from becoming serious
- Emergency admissions for children with lower respiratory tract infections (NHS OF 3.2)

Improving recovery from injuries and trauma
NHS OF Indicator in development. No CCG measure at present

Improving recovery from stroke
People who have had a stroke who
- are admitted to an acute stroke unit within four hours of arrival to hospital
- receive thrombolysis following an acute stroke
- are discharged from hospital with a joint health and social care plan
- receive a follow-up assessment between 4-8 months after initial admission
- spend 90% of more of their stay on an acute stroke unit

Improving recovery from fragility fractures
- Proportion of patients recovering to their previous level of mobility or walking ability (NHS OF 3.5 I and II)
- Hip fracture: formal hip fracture programme, timely surgery, and multifactorial risk assessment

Helping older people to recover their independence after illness or injury
No CCG measure at present

Improving recovery from mental illness
- Alcohol admissions and readmissions
- Mental health readmissions within 30 days of discharge
- Proportion of adults in contact with secondary mental health services in paid employment

4 Ensuring that people have a positive experience of care

Overarching Indicators

Patient experience of primary and hospital care
- Patient experience of GP out of hours services (NHS OF 4a II) ^
- Patient experience of hospital care (NHS OF 4 b)
- Friends and family test for acute inpatient care and A&E (NHS OF 4c)

Improvement areas

Improving people's experience of outpatient care
- Patient experience of outpatient services (NHS OF 4.1)

Improving hospitals' responsiveness to personal needs
- Responsiveness to in-patients' personal needs (NHS OF 4.2)

Improving people's experience of accident and emergency services
- Patient experience of A&E services (NHS OF 4.3)

Improving women and their families' experience of maternity services

Improving the experience of care for people at the end of their lives
- Bereaved carers views on the quality of care in the last 3 months of life NHS OF 4.5)

Improving experience of healthcare for people with mental illness
- Patient experience of community mental health services (NHS OF 4.7)

Improving children and young people's experience of healthcare
NHS OF Indicator in development. No CCG measure at present

Improving people's experience of integrated care
NHS OF Indicator in development. No CCG measure at present

2 Enhancing quality of life for people with long-term conditions

Overarching Indicator

- Health-related quality of life for people with long-term conditions (NHS OF 2) ^ **

Improvement areas

Ensuring people feel supported to manage their condition
- People feeling supported to manage their condition (NHS OF 2.1) ^ * **

Improving functional ability in people with long-term conditions
- People with COPD & Medical Research Council Dyspnoea scale ≥3 referred to pulmonary rehabilitation programme
- People with diabetes who have received nine care processes
- People with diabetes diagnosed less than one year referred to structured education

Reducing time spent in hospital by people with long-term conditions
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (NHS OF 2.3.i) *
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHS OF 2.3.ii) ^
- Complications associated with diabetes inc emergency admission for diabetic ketoacidosis and lower limb amputation

Enhancing quality of life for carers
- Health-related quality of life for carers (NHS OF 1.4)

Enhancing quality of life for people with mental illness
- Access to community mental health services by people from BME groups
- Access to psychological therapy services by people from BME groups
- Recovery following talking therapies (all ages and older than 65)
- Health-related quality of life for people with a long term mental health condition

Enhancing quality of life for people with dementia
- Estimated diagnosis rate for people with dementia *NHS OF measure in development. No CCG measure at present*
- People with dementia prescribed anti-psychotic medication

NOTES & LEGEND

NHS OF: Indicator derived from NHS Outcomes Framework

^ NHS OF indicator that is also measurable at local authority level

* NHS OF indicator shared with Public Health Outcomes Framework

** NHS OF indicator complementary with Adult Social Care Outcomes Framework

Other indicators are developed from NICE quality standards or other existing data collections.

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching Indicator

- Patient safety incidents reported (NHS OF 5a)

Improvement areas

Reducing the incidence of avoidable harm
- Incidence of healthcare associated infection: MRSA (NHS OF 5.2.i)
- Incidence of healthcare associated infection: C difficile (NHS OF 5.2.ii)

No CCG measures at present for category 2, 3 and 4 pressure ulcers and incidence of medication errors causing serious harm

Improving the safety of maternity services
No CCG measure at present

Delivering safe care to children in acute settings
No CCG measure at present

Appendix 2 – Pre-engagement activities to date

Activity	Deadline 2014
Strategy, Planning and Commissioning Committee receive proposed headings for draft strategy	20th May
Strategy, Planning and Commissioning Committee (SPCC) briefed on process for draft strategy development	19th August
First draft of document developed	By 21st August
Commissioners to meet and review themes (CCG/LAs)	21st August
Stakeholder workshop (core) review of themes	21st August
High level Engagement plan produced	21st August
GP Working Group meets to progress Primary Care Strategy including briefing paper giving Community Services Strategy overview/direction of travel	28th August
CMT review	1st September
QCGC review of themes	2nd September
Draft Strategy updated following feedback from Commissioner, Stakeholder and QCGC workshops	3rd September
Updated draft executive summary circulated to Governing Body to inform development session planned for 9th September	3rd September
Governing body to receive and comment on executive summary (Board development session)	9th September
GP evening engagement event to progress Primary Care Strategy including Community Services Strategy overview	9-10th September
Draft Strategy updated following stakeholder workshops, to be circulated to members of SPCC, Quality and Clinical Governance Committee (QCGC) and Governing Body for individual feedback	September
Locality meetings	24th/25th September
Engagement commences	October onwards

Appendix 3: Engagement plan

Background

Recent engagement and consultation with patients and the public has consistently told us that people would prefer care closer to home whenever possible. Examples of this include the recent ELR CCG urgent care consultation and feedback to inform ELR CCG's commissioning intentions. However, as we consider improving integration of local services between health and social care and between acute and primary/community care, it is vital that we engage and consult further with stakeholders, patients and the public to ensure that we co-produce the way services closer to home will be delivered.

Introduction

As plans for the future of community services are being considered, it is important that stakeholders, patients and the public are involved at the earliest point. The high level engagement plan below categorises these people into those we need to partner, those we need to involve, those we need to consult and those we need to keep informed. The more detailed plan below describes when we will communicate and engage with these groups. The timeline for activity may need to be adjusted to accommodate the overall Better Care Together communications and engagement timescale.

The initial scoping exercise is the first step to co-design. This will allow the CCG to consider current themes and trends at a 'grass roots' level, and to check that findings are still the same as previous engagement has shown. As our patients and public become even more aware of financial pressures facing the NHS, as well as the increasing media focus, it is this initial scoping that will identify any new concerns or considerations that patients and the public may wish decision makers to consider.

The second stage is to bring local clinicians together to debate and agree a clinical case for change. As a clinically led organisation it is imperative that everything we do is led by clinicians. This is also mandatory when presenting options for future service delivery to the NHS England clinical senate. It is also essential that stakeholders, patients and the public know that any proposed changes are clinically approved.

The third phase is the pre-consultation phase, where we will give detailed information on the reasons why change is being considered, based on what people have told us and the clinical case for change. During this stage we will gather information from stakeholders, patients and the public on how they feel these changes could be realised, and by working together with ELR CCG leads, options will be developed to take out to public consultation.

The fourth phase is the public consultation. All feedback will be analysed by an independent organisation and fed back to the ELR CCG governing body. The ELR CCG board will then make a decision on the future delivery of community services in East Leicestershire and Rutland.

How we will work with our stakeholders

Stakeholders	Key actions and communications	Channels of communication	Impact
Partner			
• CCG Board and sub-committees including QCGC • Media including social media • Local MPs • Relevant local county and district councillors and officers (, eg, health leads, those with geographical interest) • Clinicians affected by the clinical model • Healthwatch x 2 (Rutland and Leics) • Local Authority Commissioners	• Early involvement • Summary of key issues including case for change, updated as needed • Let us know how you would like to be involved • Let us know your views • We will take your views into account	• One to one briefings/meetings • Media releases/briefings • Presentations to meetings eg, Health watch, PPGs, Health and Wellbeing board • Attendance at Boards, etc • Involvement in engagement events/public meetings • Web information • Locality and local GP practice briefings • Consultation document • Twitter/social media • Case for change materials	• Appropriate involvement of partners and influencers who are key to the delivery of this programme
Involve			
• Patients/service users and the public	• Early information • Summary of key issues	• Electronic/stakeholder briefings	• Appropriate involvement of bodies who need to have an

• Other partner organisation staff • Hospitals NHS Trust (UHL; LPT; Kettering etc) • EMAS • Community Hospitals • Nursing and Care Homes • Staff who will deliver the changes eg social services, acute, community • Local seldom heard groups including Carers • PPGs • General patients and the public • Targeted patients/public groups • Integrated Community Equipment services (jointly provided by health and social care)	including case for change, updated as needed • We are happy to meet with you to discuss further • Make sure team are up to date with latest regulations and requirements for NHS England	• Involvement in engagement events/public meetings • Meetings if requested • Web information • Case for change materials	overview of local health and social care

Consult			
• Patients/service users and the public • Other partner organisation staff • Hospitals NHS Trust (UHL; LPT; Kettering etc) • EMAS • Community Hospitals • Nursing and Care Homes • Staff who will deliver the changes, eg social services, acute, community • Local seldom heard groups incl Carers • PPGs • General patients and the public • Targeted patients/public groups • Integrated Community Equipment services (jointly provided by	• Early information • Summary of key issues including case for change, updated as needed • Information about how to feed back • Clear timescales	• Staff briefings • Locality briefings • Electronic/stakeholder briefings • Staff newsletters • Emails/letters as appropriate • Meetings/events with seldom heard groups • Web information • Posters • Involvement in engagement events/public meetings • Twitter/social media • Case for change materials	• Appropriate involvement of individuals and groups who should have the opportunity to comment and co-create

health and social care)			
Keep informed			
• Neighbouring NHS Trusts, councils and CCGs • Dentists, optometrists, pharmacists • UHL discharge team • EMAS • Arriva • Parish Councils • Voluntary Action Leicestershire (for wider dissemination)	• Early information in form of briefing • Summary of key issues including case for change, updated as needed • Information about how to feed back • Clear timescales	• Electronic/stakeholder briefings • Information via local media • Web information • Staff newsletters • Posters • Public meetings • Consultation document • Twitter/social media	

Draft engagement activity plan and timescales

Date	Action	Activity	Responsibility	Status
August 2014	Workshop to agree stakeholder mapping with key stakeholder groups including the Local Authorities	Workshop	Claire Saul and Wendy Pearson	

Nov 2014	Book venue for clinical event Send out invitation	Preparation for Clinical event	Andrea Clark	
January to February 2015	Scope public opinion on health services/community services	Take listening booth out to places of high footfall and attend seldom heard community groups and meetings. Also outpatient clinics, community hospitals and GP practices	Andrea Clark/Fiona Fretter	
March 2015	Create report for project group	Analyse and format feedback from initial listening booth engagement	Andrea Clark/Fiona Fretter	
February 2105	Clinical event	Present findings from initial engagement insights along with data and rationale for proposed change Include as an agenda item at PLT event Take out to locality meetings Agree with attendees that there is a clinical case for change and how this may look in the future	Project lead/Andrea Clark	

Date	Action	Activity	Responsibility	Status
Purdah	Prepare for engagement phase	Inform NHS England AT of engagement pre possible consultation Inform OSCs ask for agenda slot post election to update on engagement plans (details not to be released during Purdah) Identify any local interest groups such as Civic Societies; historical building associations etc. Plan staff engagement Plan agenda slots on locality meetings Plan agenda slot on PPG chairs meeting Plan agenda slot at Healthwatch Boards Plan agenda slot at Older Persons Engagement network Plan meeting at The Carers Centre with Carers and advocates	Andrea Clark	

		Identify community forums and meetings to go and present at Book venue for public/patient engagement event Plan places for the listening booth to visit Create questionnaire to gain feedback from stakeholders patients and public to inform options for consultation Create communications toolkit: Key messages Staff briefing Stakeholder briefing Press release FAQs Activity	Andrea Clark	
April 2015	Partner key stakeholders Staff/Stakeholders/Patients/Public	Brief local employees and council health leads. Update engagement plan with dates and engagement locations Inform OSC of insights from listening booth and plan for pre-consultation engagement Launch engagement phase		

Mid May 2015	Analyse all feedback for insights on how future services should be delivered	Consider options for consultation	Project team	
July to September 2015	public consultation		Andrea Clark	
End of September to October 2015	Independent analysis of public consultation feedback Report to board	Details tbc	Andrea Clark	

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