Health and Care Integration

Stakeholder e-bulletin

June 2018 edition

In this edition:

Taking a new partnership approach to frailty & multi-morbidity | Joint Strategic Needs Assessment 2018-21 | Prevention at Scale | LLR Falls Programme update | Staying stable, Being Able - launch | New supporting carers leaflet

Welcome from Dr. Andy Ker

This edition highlights the new approach being taken to frailty across LLR and how we are updating Leicestershire's Joint Strategic Needs Assessment (JSNA), which will be used to help determine what actions all partners need to take to meet local health and social care needs, and will inform and underpin the Joint Health and Wellbeing Strategy of Leicestershire.

The Prevention at Scale project will be working with GP surgeries to develop insights into the value of preventative services through in-depth customer interviews and qualitative analysis.

There is an update from the LLR falls programme, on its work to improve the treatment pathway for people, either identified as being at risk of suffering a fall, or those who have experienced a fall. This includes work to embed specialist therapy triage, the continued development of the Steady Steps programme and e-FRAT, and a pilot project to develop a non-emergency falls response service for Leicestershire and Rutland. The East Midlands Academic Health Science Network (EMAHSN) is delivering a year-long Falls Prevention and Management Demonstrator project in the Leicester, Leicestershire and Rutland (LLR) STP area which will go live in August.

Finally I'd like to draw your attention to a new information leaflet – Supporting Carers, being distributed to GP surgeries in Leicestershire and Rutland by the CCGs that has been developed in response to feedback from carers' forums and the latest Adult Social Care service user survey.

Also available in our Resources section is the Better Care Fund (BCF) Plan on a page for 2017-19.
http://www.healthandcareleicestershire.co.uk/download/BCF-Plan-on-a-Page_2017-19.pdf

Further information about our Integration Programme, including the Better Care Fund is available on the Integration Programme main page: http://www.healthandcareleicestershire.co.uk/health-and-care-integration/

A presentation highlighting our achievements over the past two years is also available at:
https://prezi.com/view/4S3DihUuIx4Oo860Mrfu/

For previous editions of this bulletin please follow this link:

www.healthandcareleicestershire.co.uk/health-and-care-integration/health-and-care-integration-newsletters/

Taking a new partnership approach to frailty & multi-morbidity

Under the leadership of the LLR System Leadership Team, the LLR health and care system has formed a new 'Frailty Task Force' with the mandate of designing and implementing a system of care for frail and/or multi-morbid patients.

The Task Force and associated working group will be chaired by John Adler, the CEO of UHL, and includes members of each of the related Better Care Together work streams – this includes Home First, Integrated Locality Teams and Primary care. The design of the system will be clinically led and assessed through the LLR Clinical Leadership Group.

The first Task Force meeting took place on June 13th with the objective of understanding what each work stream is currently delivering, the interdependencies within and between the work streams and how the system would work differently to bring together a standard offer for frail and/or multi-morbid patients.

The first Frailty working group will meet on June 27th with the intention of driving the delivery of tangible service improvements in the short term. For example, members of the working group are already working across the system to ensure that we can identify this patient group and put plans into place to ensure they are treated in the right place at the right time.

For more information contact Rachna Vyas, Head of Strategic Development, University Hospitals of Leicester NHS Trust.

Joint Strategic Needs Assessment 2018-21

The Joint Strategic Needs Assessment (JSNA) is a statutory process by which a Local Authority and Clinical Commissioning Groups (CCGs) assess the current and future health, care and wellbeing needs of the local community to inform local decision making. The JSNA integrates a range of data, such as health, housing, transport, employment, education and much more, to identify needs of strategic importance to the health and wellbeing of Leicestershire.

What is the Purpose of the JSNA?

The purpose of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It should be viewed as a continuous process of strategic assessment and planning with the aim to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities.

How will it be used?

It will be used to help to determine what actions Leicestershire County Council, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing. The JSNA will inform and underpin the Joint Health and Wellbeing Strategy of Leicestershire.

Who is involved in producing the JSNA??

As many of the relationships required for the JSNA in Leicestershire are wide ranging, involving representation from Leicestershire County Council, NHS England, CCGs, Leicestershire Partnership Trust, University Hospitals of Leicester, District Councils and the voluntary sector, a JSNA Reference Group has been established. This Reference Group will oversee the JSNA process and ensure that the development of the JSNA meets the statutory duties of the Health and Wellbeing Board. The Integration Executive will oversee the work of the Reference Group and take on an assurance role.

What format will the JSNA take?

This JSNA will take a different approach to the previous JSNA published. It will be published in subject-specific reports throughout a three-year time period on an iterative basis, in line with CCG and Local Authority commissioning cycles. Infographics and data dashboards will supplement the subject-specific reports with further data.

Therefore, the outputs of JSNA 2018-21 will be:

- Subject-specific reports of an assessment of current and future health and social care needs available in pdf format.
- Online infographic summaries of each chapter
- Online data dashboard that is updated on a quarterly basis to allow users to self-serve high level data requests

The last JSNA for Leicestershire was produced in 2015 and can be accessed at: http://www.lsr-online.org/leicestershire-2015-jsna.html

Which reports will be published first?

By the end of the summer 2018, the JSNA Reference Group has agreed the following JSNA reports are to be published on LSR online (http://www.lsr-online.org/):

- Demographics
- Deprivation
- Housing
- Economy

- Mental Health of Children and Young People
- Oral Health of Children and Young People
- Mental Health of Adults
- Oral Health of Adults

A publication timetable for subsequent reports will be made available once it has been approved by the JSNA Reference Group.

For more information, please contact Natalie Greasley, Public Health Business Partner.

Prevention at Scale Project

The Prevention at Scale project is a nationally funded initiative developing insights into the value of preventative services. Following on from the Prevention at Scale Conference held in April, Leicestershire is going to be working with GP surgeries to understand the problem below, through qualitative analysis.

In Leicestershire, evidence shows that up to 30% of GP appointments are categorised as patients seeking non-medical interventions. We want to understand the reasons for this and what solutions can be found to resolve this issue.

In doing so we can support patients and GPs with easy access to the most suitable support for their non-medical needs either via their GP practice and from within other agencies and the community itself, thus releasing more GP capacity/appointments for those activities that only GPs can/should deliver.

Through in-depth customer interviews we will bring together high level findings from 24-28 customer and staff experiences to create personas that characterise the cohort of people attending a GP appointment for non-medical interventions. We will also map out the typical customer journeys from the findings of the interviews.

The Health and Social Care Integration team has designed a questionnaire in consultation with the Research and Insight team at Leicestershire County Council. Interviews are likely to take 1-2 hours each. We will proactively gain consent from patients to participate in the interviews, through the GP's in scope of this exercise. For those volunteering to participate, their contact details will be passed over to the project team, who will then run the interviews.

We are looking at customers between 60-80 years of age, who have visited a GP surgery for a non-medical intervention. This analysis seeks to better understand any barriers to accessing existing preventative services, in the first instance.

As part the questionnaire, we are looking to capture whether the customers feel vulnerable or isolated. We are also looking to understand whether, in this segment/cohort, there were other needs (social care or public health) identified and whether they were met or not.

Participants will live in four different parts of the county which vary in size, demographic and affluence. We are looking to complete this exercise prior to the start of the summer holidays.

Using the central theme, we are looking to understand;

- How do we evaluate the service model based on the personas identified?
- How do we access people in a better way than how we access them now?
- How can we define the prevention model in a better way?
- How do we get to those people that aren't being accessed?
- How are GP's categorising non-medical interventions – is it cause and effect – e.g. flagged as lower-level mental health problems?
- How do we access the 15% that don't need a GP appointment at all?
- How do we make sure we get someone into the system, alongside dealing with non and medical interventions?
- Identify common themes and issues these people have so we can aim to access them from a different angle to GP surgeries?

The findings from this work will inform how prevention services in Leicestershire can best be configured and developed to support patients, practices and integrated locality teams across Leicestershire. If you are interested in further details about the Prevention At Scale project then please contact Richard Smeeton on 0116 305 6465.

Falls programme update

The aim of the LLR falls programme is to improve the treatment pathway for those identified as being at risk of suffering a fall, or those who have experienced a fall. This is being achieved by enabling quicker access to treatment and advice, ensuring those needing specialist care have as short a referral time as possible, and providing information and services for people to help them reduce their risk of falling, such as how to restore and improve their own strength and balance. Research and evidence including via NICE has consistently demonstrated that people reduce their risk of falling by addressing these aspects.

The falls programme provides, for both professionals and patients, the tools they need to ensure that the most appropriate course of action is taken to help each individual maintain their independence, and as much as possible to avoid a falls related admission to hospital, including:

- Prompt specialist therapy triage and assessment for all referrals into the Consultant Falls clinics, to provide prompt therapy interventions. The programme is working with partners to embed this into business as usual to continue to improve access to falls prevention interventions for patients.
- Specialist therapy and falls prevention training for care home staff developed jointly by Leicestershire Partnership Trust and Leicestershire County Council's Adult Social Care.
- The continued development of the local falls management exercise programme, known as "Steady Steps". This is delivered in partnership with Public Health, and is designed to give people skills and strategies to reduce their risk of suffering a fall in the future.
- Work to develop and extend access to an electronic Falls Risk Assessment Tool (e-FRAT) smart phone application to partners across LLR. Phase 1 is a roll out into East Midlands Ambulance Service.
- Initiate a pilot project to develop a non-emergency falls response service for Leicestershire and Rutland. This service is for people who have fallen, and following a call being placed to the Ambulance Service have been triaged as having no medical needs, but who require support to be lifted from the floor. Currently this cohort of patients can wait a long time to be assisted from the floor, which in turn impacts upon their ability to recover from the fall.
- Partnering with the East Midlands Academic Health Science Network (EMAHSN) to implement a variety of interventions and self-assessment pathways, to promote healthy ageing and falls prevention. Additionally, discussions are taking place to understand how these elements can be adopted by Primary Care to support the frailty reviews within GP practice. .

The LLR Falls Programme Lead is Mark Dewick, Tom Allison is the Clinical Therapy Lead for the Programme, and Dr Lakhani is the medical lead.

Niki Evans-Ward and Suzanne Horobin represent the East Midlands Academic Health Science Network (EMAHSN) at the Falls Steering Group, and support the falls prevention and management project component of the Falls programme.

For further information contact Mark Dewick, Health and Care Integration Programme Manager.

Staying stable, Being Able - launch

The East Midlands Academic Health Science Network (EMAHSN) is delivering a year-long Falls Prevention and Management Demonstrator project within the Leicester, Leicestershire and Rutland (LLR) STP area.

The key objectives for the project are:

- To reduce the risks of falls through increased early education and interventions.

- To engage with patients, carers and the public early to support and equip them in taking preventative actions, including tailored advice.
- To deliver person centred care and support to self-care to maintain independence.
- To ensure appropriate patient referrals and that patients receive the right care, first time.

A patient pathway has been developed to maximise opportunities for:

- Early engagement and screening
- Assessment of risk factors – including digital gait analysis
- Interventions such as education and the provision of self-care advice
- Professional identification of risk and proactive management

This integrated approach will use proven technologies and processes to promote self-care and maintain independence through a clear patient pathway.

Integrated health and community services will provide support through direct interventions, advice and education whilst ensuring right care, first time. Technology based interventions will include self-screening and support to self-care, professional assessment and advice, vital sign measurement and monitoring.

Once the project goes live in August, patients, carers and the public will be able to complete a quick self-assessment form either online or by telephone to begin their personal falls prevention journey or will be invited to assessment clinics held in GP practices or the community

For further information contact Mark Dewick, Health and Care Integration Programme Manager.

New information leaflet for carers in Leicestershire and Rutland

Leicestershire County Council and the county Clinical Commissioning Groups (CCGs) for East Leicestershire and Rutland (ELR) and West Leicestershire (WL) have been working closely with the Carers Delivery Group and local carers services to develop an information leaflet for carers, funded by a grant from the improved Better Care Fund (IBCF).

The new Supporting Carers leaflet has been developed in response to feedback from carers' forums and the latest Adult Social Care service user survey. It provides information for carers on how to get support in their caring role as well as contact numbers and tips from local carers. Copies of the leaflet will be available in GP surgeries in the county and Rutland and are being distributed by the CCGs.

The aim is to make all unpaid carers who are caring for someone who lives in Leicestershire or Rutland feel valued and supported, so when people take the positive step of identifying themselves as a carer to their GP, they will be given practical advice and information on how to access the support they need to continue in their caring role and maintain their own health and wellbeing.

For further information on the support available for carers in Leicestershire visit www.leicestershire.gov.uk/adult-social-care-and-health/looking-after-someone or www.rutland.gov.uk/my-services/health-and-family/adult-social-care/carers/

For more information contact Nicki Jarvis, Strategic Planning Officer – Carers Lead.

Contact us

Follow us on Twitter **@LeicsHWB**

See our website: www.healthandcareleicestershire.co.uk

Download our Better Care Fund plan on a page for 2017-19

Better care together

To find out more about Better Care Together – Leicester, Leicestershire and Rutland's five year health and care strategy visit www.bettercareleicester.nhs.uk

For enquiries about this bulletin please email BetterCareFund@leics.gov.uk or call 0116 305 5749