Health and Care Integration

Stakeholder e-bulletin

August 2017 edition

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Welcome from Dr. Andy Ker

In this edition we have an update from the Home First workstream of the STP on the Integrated Discharge Team that has recently started working on some of the busiest wards at the Leicester Royal Infirmary.

There are also updates from First Contact Plus and the Hospital Housing Enablement Team demonstrating the wide variety of advice and support these services can offer to both individuals in our local communities and patients in a hospital setting.

You can now view our new videos for the eFrat app and the Hospital Housing Enablement Team just follow the links in the articles below or go to the resources section on our website.

We have also received some really positive feedback on the number of people visiting the health and care integration website - www.healthandcareleicestershire.co.uk The number of people using the website has increased by more than 93% during the six months from November 2016 – April 2017 to 2,256 and the site continues to attract new visitors every month. We are currently refreshing the website, so you may notice some new sections being added and existing content being updated.

Further information about our Integration Programme, including the Better Care Fund and our achievements so far is available at: http://www.healthandcareleicestershire.co.uk/resources/local-resources/

For previous editions of this bulletin please follow this link:
www.healthandcareleicestershire.co.uk/health-and-care-integration/health-and-care-integration-newsletters/

Home First: Integrated Discharge Team (IDT)

Since July, the new Integrated Discharge Team (IDT) has been working alongside ward staff on some of the busiest wards at the Leicester Royal Infirmary, providing expert discharge advice and assistance to get people home as soon as they are well enough to leave the acute hospital.

The aim is to create a single integrated discharge service within University Hospitals of Leicester NHS Trust (UHL). The team is made up of county and city hospital social care workers, UHL Specialist Discharge Nurses, LPT primary care co-ordinators and UHL therapists working together to access appropriate health and social care services in the community, regardless of their professional or organisational background.

Members of the IDT will attend board rounds, supporting ward staff to plan straightforward discharges and identify patients who need the involvement of the IDT.

The IDT is not just about aligning existing teams. Over time, it will develop into a truly integrated team of health and social care professionals providing expertise in the discharge process and taking shared responsibility for supporting patients to access the right pathway the first time.

For more information contact the interim IDT lead Ashraf.Osman@leicester.gov.uk or call 0116 454 5416.

Hospital Housing Enablement (HHE) Team

The HHE team works daily with the Integrated Discharge Team to resolve housing problems that can delay a patient's discharge.

Case Study Example

Mr N (over 60) came into hospital after being found unconscious. He was assessed on the ward. He had been living abroad and had come back to the UK to settle. He was supposed to stay with his ex-partner but this had not worked out. Mr N has no other relatives or friends to support him, had limited clothes, no phone, was unable to use the internet independently and had no financial information.

The HHE team sourced accommodation for Mr N in a shared house, inclusive of bills. They assisted Mr N with his housing benefit claim, and with the DWP – pension credit claim, changing banks to the UK and getting set up in the community such as GP registration, joining the local library and accessing clothes.

A short video highlighting the work of the HHE team has been produced and can be viewed here.

For more information contact Tara.Bhaur@uhl-tr.nhs.uk

Update on First Contact Plus

Since the launch of the website in November 2016, over 4,366 users have visited the site and between them, they have viewed 22,267 pages (data to end June 2017).

The number of professional referrals continues to increase and as demonstrated in the case study below signposting by partners to the First Contact Plus website and self-referral by patients improves individuals' access to information, advice and support.

For more information visit www.firstcontactplus.org.uk

Self-referral Case Study

An electronic self-referral form was received from Mrs A in June 2017 via the website after being signposted there by her doctor.

Mrs A is 67 and stated on the self-referral form that she was the main carer for her husband who had recently been diagnosed with Alzheimer's disease and vascular dementia. Mrs A had diabetes, kidney failure and was on haemodialysis three times a week. Mrs A was concerned about her overall health, having put weight on recently, and wanted to look at possible ways to make her lifestyle healthier and combat her recent anxiety.

Below are the areas discussed and the action taken:

- Healthy Weight: Discussed the programmes available through Leicestershire Nutrition Dietetic Service but Mrs A had already attended them. Stated she did very well whilst on the programmes but couldn't keep it up once the programmes finished because she didn't have time to think about or plan meals. Signposted to the Change4Life meal planner which she thought would help her to make better meal choices without taking up too much time.
- Mental Health: Discussed Mrs A's anxiety, she is already on waiting list for Let's Talk Wellbeing and has had telephone befriending from Voluntary Action South Leicestershire (VASL) carers support. The issue was that for telephone befriending it had to be at a prearranged time and often this was not convenient because of hospital appointments and the unpredictable nature of Mrs A's husband's mood. Mrs A stated she does get very lonely but it is difficult to have fixed appointments or go out to groups. Signposted to Silverline, a free 24/7 befriending telephone service that Mrs A could call whenever was convenient for her.
- Carer Support: Mrs A was already in contact with VASL carers support and has had a carers' assessment from Adult Social Care. In receipt of carers one off payment which pays for cleaning support in the property. Husband's Alzheimer's diagnosis is recent and Mrs A stated they have had no support with this. Signposted to Alzheimer's Society for support groups, befriending and advice.
- Benefits: confirmed that Mrs A and her husband were already in receipt of Attendance Allowance.

- Other Issues: Mrs A mentioned feeling guilty as she is no longer able to walk their dog. Signposted to Cinnamon Trust for assistance with dog walking.

For more information on First Contact Plus please contact Debbie.Preston@leics.gov.uk

Triple award nomination for Lightbulb

The Association for Public Service Excellence (APSE) has announced the finalists of the Annual Service Awards 2017 and we are delighted that the Lightbulb integrated housing support service hosted by Blaby District Council has been nominated in three separate categories:

- Best Health and Well-being Initiative (incl. Social Care)
- Best Collaborative Working Initiative (with other public sector or third sector)
- Best Innovation or Demand Management initiative

In order to be shortlisted, finalists had to demonstrate that they are actively implementing innovative ideas, supporting continuous improvement, and developing new strategies to deliver local services. The winner of the Service Awards will be announced on 7 September at the APSE Annual Seminar.

More information on Lightbulb is available on our website or contact Teresa.Neal@blaby.gov.uk or call 0116 272 7687.

eFRAT app film now available

The new video explaining how the eFRAT app (electronic Falls Risk Assessment Tool) works is now available online. It explains how the app benefits both professionals and patients by ensuring that the most appropriate course of action is taken for each individual who has had a fall, to help them maintain their independence and remain in the community.

The initial prototype of the eFRAT app was created at a “hackathon” for health and assisted living organised by Dr Samad Ahmadi from De Montfort University with funding from DS-Cubed limited. These types of event provide an excellent model of collaboration between universities and service providers. They are brilliant problem solving exercises for product developers, volunteers and students. At a hackathon they work together to design and build a solution with a prototype developed such as an app or technology at no cost.

For more information, please contact Andrea.Baker@leics.gov.uk or call 0116 305 6841 or 07460 366 398.

Enhanced Summary Care Records

More than 20,000 patients across Leicester, Leicestershire and Rutland (LLR) have now signed up to share more information about their health and preferences across health and social care organisations.

Healthcare leads across LLR are recommending that all patients consent to the enhanced Summary Care Record which includes information about their long term health conditions, relevant medical history and personal preferences. This provides medical professionals throughout the NHS in England caring for a patient with the information they need to treat them quickly and effectively. This means that whenever and wherever a patient needs care, the clinicians treating them have access to detailed and up-to-date information.

Steve Jackson, Consultant Physician at University Hospitals Leicester said: “I’ve already seen the benefits for patients who consent to an enhanced Summary Care Record, as it means we have quick access to information about their health away from their usual GP surgery. I would encourage patients to find out more and talk to their GP practice about the information they want to share.”

All patients, unless they have opted out, have a Summary Care Record with basic information about their current

medications, their allergies, and bad reactions they have had to medicines. By choosing to have their record enhanced with more information, patients can get better, quicker care if they need health care in an emergency or when their surgery is closed.

Please visit https://www.leicestercityccg.nhs.uk/my-health/data/health-records/ for frequently asked questions and a range of promotional materials for both professionals and the public. For further information please contact James.McKean@leics-his.nhs.uk.

Contact us

Follow us on Twitter **@LeicsHWB**

See our website: www.healthandcareleicestershire.co.uk

Download our Better Care Fund plan on a page: http://www.healthandcareleicestershire.co.uk/download/BCF-strategy-and-progress.pdf

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