Health and Care Integration

Stakeholder e-bulletin

February 2019 edition

In this edition:

Hinckley & Bosworth ILT – Fosseway Neighbourhood MDT | New Integrated Care (Reablement) Team | Prevention at Scale project update | Steady Steps case study | Support to tackle loneliness

Welcome from Dr Geoff Hanlon

Welcome to the first edition of 2019. The Hinckley and Bosworth Integrated Locality Team (ILT) offer us a glimpse into their approach to multi-disciplinary team (MDT) working, through members of the Fosseway Neighbourhood MDT. The benefits to patients coming out of hospital are highlighted in our article from the new Integrated Care (Reablement) Team – a joint Health and Social Care service between Leicestershire Adult Social Care Service and the NHS Partnership Trust.

We also have an update from the Prevention at Scale Project on their work to provide an insight into why patients visit their GP for a non-medical intervention. Plus, we have a case study demonstrating the benefits to the participants of the Steady Steps Programme (part of the falls prevention pathway).

I would also encourage you to take a look at the work being done locally to reduce loneliness and social isolation – "Within Your Gift to Give" – is a social media campaign to encourage people to take simple steps to reduce the feeling of loneliness in others and themselves.

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/

Also available in our Resources section is the latest version of the Better Care Fund (BCF) Plan on a page for 2017-19: http://www.healthandcareleicestershire.co.uk/wp-content/uploads/2018/10/BCF-Plan-on-a-page-2017-19-rev.102018.pdf

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

Hinckley & Bosworth Integrated Locality Team (ILT) – Fosseway Neighbourhood MDT

In the last edition, we highlighted the approach to multi-disciplinary team (MDT) working in Hinckley and Bosworth, one of three early implementer sites across Leicester, Leicestershire and Rutland.

For this edition of the bulletin we spoke to Dr Darren Jackson (Senior Partner at Barwell & Hollycroft Medical Centres), Jo Earle-Marshall (Community Services Matron), Annette Wagg (Service Manager, Adult Social Care), Kerry Smith (Local Area Coordinator, Public Health/Leicestershire County Council) and Alan Plumpton (Hinckley & Bosworth ILT Patient Rep) who have all been key to setting up the Fosseway Neighbourhood MDT. We asked them about the MDT's progress so far and how their work will meet the needs of local people by delivering a range of interventions to improve their care and overall health and wellbeing, closer to home.

Tell us about your progress since December?

Dr Darren Jackson, "We have made considerable progress in setting up the neighbourhood MDT and planning our approach. The MDT is now established with a core team of me as the GP Clinical Lead, Adult Social Care Service Manager, Community Services Matron and a Care Coordinator/Local Area Coordinator.

Securing the resources for care coordination was only possible due to our Public Health colleagues agreeing to

support neighbourhood MDT working and an innovative, flexible approach involving Local Area Coordinators. We have now begun induction and training for the Local Area Coordinators, introducing them to new systems for identifying patients and started to build the patient/service user case load.

We have engaged with the two hospital sites aligned to our neighbourhood, Leicester Royal Infirmary and George Eliot Hospital and they are now making referrals into the neighbourhood MDT. We have engaged with local Patient Participation Group members to develop a patient/service user information leaflet explaining what a neighbourhood MDT is and a checklist for the Local Area Coordinators to use in their interactions with patients, families and carers. Finally, we have agreed what data and information we need to collect to demonstrate the impact of neighbourhood MDT working."

What do you anticipate will be the main benefits for patients and for GPs through working as a neighbourhood MDT?

Dr Darren Jackson, "For patients, carers and their families, they will experience their care being delivered in a more coordinated way. Our proactive approach identifies people that are at risk of a hospital admission and following a review and assessment an urgent or planned meeting of the neighbourhood MDT is arranged. We are also focussing on ensuring better coordination of care for those frail patients discharged from hospital who don't have other ongoing care arrangements in place. Through a care coordinator contacting patients within 48 hours of discharge and running through a checklist to ensure good holistic care, we are hoping to avoid unnecessary readmissions, ensure better preventative care closer to home and improve overall patient experience and satisfaction.

One benefit for GPs is that through a more coordinated, holistic approach to care, patients will receive advice and guidance regarding non-clinical support available within their community. The Local Area Coordinators are well connected within our local community and will discuss these options with patients, service users, carers and families when they meet. It is anticipated that this approach might free up GP appointments.

MDT working ensures that we make the best use of all the health and social care teams within our neighbourhood to meet the needs of the local population. Bringing together the various health and social care professionals, supported by the voluntary sector to work as one team, will improve communication and support more efficient working."

What do you anticipate will be the main benefits for service users and adult social care services through working as a neighbourhood MDT?

Annette Wagg, "The main benefits for Adult Social Care is that people will be seen earlier before they get into crisis, identifying preventative measures to be put in place to reduce or delay the need for long term adult social care services.

From the service users' perspective, they will only have to tell their story once which will enable workers to get the right service to the person, at the right time and will prevent the need for more formal support.

The main focus of social care is to reduce the number of people who are entering into long term residential care and to support people to remain in their own home. One of the aims of the neighbourhood MDT is to reduce the need for an unnecessary hospital admission and it is anticipated that this will reduce the subsequent dependence and reliance on institutional, residential care.

An MDT approach will ensure that all professionals have a clear understanding of each other's resources and that the pathway for patients is clearly identified and progressed to achieve better outcomes for all."

What excites you most about working as a neighbourhood MDT?

Jo Earle Marshall, "I have worked as part of the Primary Care Coordination service in the past and that was all about working with patients, families, social workers and community services in getting the right care to the right person at the right time. If a person has been in hospital, this approach contributes to achieving better outcomes for patients when they go home; ensuring their needs have been considered and they can continue their recovery safely at home.

Working as part of a MDT, I remember going home feeling confident that I had done everything I could to achieve the best outcomes for the patient.

Focussed and proactive planning through a neighbourhood MDT and close collaboration between the patient, the family, and the multidisciplinary team will lead to improved patient and carer satisfaction and hopefully avoid a hospital admission in the first place.

I am passionate about Community Services and excited about our role within this neighbourhood MDT. I live and breathe community nursing. Imagine feeling 100% fulfilled every day of your working week…Exciting!"

How has the patient voice been heard in planning and implementing the neighbourhood MDT in Hinckley & Bosworth?

Alan Plumpton, "Having a patient voice on the Hinckley & Bosworth ILT is so important in ensuring that ideas and thoughts are shared with Patient Participation Groups (PPG's) around the Hinckley & Bosworth area. All surgeries receive updates through the Hinckley Patient Locality Group which can then be shared with PPG's in GP Practices. Feedback comes back from Practices to the patient representative and is shared with health professionals via email or at ILT meetings. This ensures that things like information sheets are vetted by "real" patients and help to avoid jargon that people don't understand. Patient feedback also tries to ensure that whatever is planned is there to benefit the patient and not just to benefit administration processes."

What do you think will be the main benefits for patients, carers and their families with services working together as a neighbourhood MDT?

Alan Plumpton, "The development of neighbourhood MDT's is to bring NHS Care, Social Service Care and other support agencies care under the single banner of CARE. As patients we want seamless support and sharing of information. Joined up care is vital in ensuring that patients, health professionals and other support agencies are kept up to date with a patient's progress. Patients should only have to tell their story once. This approach will ensure that patients, carers and families will have confidence that everyone involved is following the same care plan and working together to benefit the patient's recovery."

How will the Neighbourhood MDT engage with and include the voluntary sector and wider community in supporting and improving the health and well-being of local people?

Kerry Smith, "At its heart, Local Area Coordination looks to use a set of principles which assume that people are not passive recipients of care but have gifts, strengths and expertise that can help them to achieve their vision of a good life. This includes the resources naturally found in their local area such as family, friends, neighbours and local groups with community champions. Together we are stronger.

As Local Area Coordinators, we take an asset-based approach and are based in the communities that we work in and therefore have the capacity to develop local knowledge, not only of the professionals, but of those community members that make a difference, those that want to contribute to their community and are around after the working day is done.

Research regularly shows that being connected and resilient play a huge role in both prevention and recovery in health. Loneliness is now being highlighted as having a devastating impact on older people, being linked with raised blood pressure, weakened immune system and greater risk of depression and heart attack. Being connected and valued locally can make a difference, regardless of health conditions, if the person feels that they are heard and not alone.

Bringing these principles into the role of care coordinator as part of the neighbourhood MDT allows these connections to be part of a person's support network according to their own vision. In this way, local connectors and voluntary groups will be brought into conversations, providing a non-clinical approach but supporting the clinical and social care interventions where appropriate."

For more information regarding the Hinckley and Bosworth ILT model and other ILT developments across Leicestershire contact Steve McCue, Service Improvement Manager at West Leicestershire CCG at steve.mccue@westleicestershireccg.nhs.uk

The new Integrated Care (Reablement) Team

The Integrated Care (Reablement) Team is a new Health and Social Care joint service between Leicestershire Adult Social Care Service and the NHS Leicestershire Partnership Trust. The team offers a free short-term service to residents in Leicestershire that assesses people in their own homes. The aim of the team is to:

- Ensure rapid and timely discharges from hospital
- Prevent avoidable admissions to hospital
- Reduce the length of hospital stays
- Prevent readmissions to hospital
- Promote the use of rehabilitation, recovery and reablement to help restore health, wellbeing and independence
- Reduce admissions to residential care homes
- Improve communication and joined up working between Health, Social Care, voluntary sector and housing.
- Improve patient's experience and wellbeing

The team focuses on the existing support that people have around them and supports individuals to do tasks for themselves rather than doing them for them. Staff encourage, enable and assist individuals to regain and relearn the skills essential for their daily life, to do as much for themselves as they are able and remain within their communities.

The team works closely with individuals to develop tailored plans that establish the correct level of support needed, including treatment and support for health conditions, access to Occupational Therapists, assistive technology, equipment or minor adaptation for the person's home that will support them being independent.

We work closely with NHS colleagues and referrals are made to Health Services to ensure that any health needs that may prevent an individual's return to independence are identified and where possible resolved by health staff who visit the person at home to assess how they are managing and if they require any further support such as a nurse or therapist.

Once care and support are in place an Early Review of Services is undertaken to ensure that appropriate support is in place from health and social care. This review identifies how long the service will be needed and if long-term support is required for the future.

If an individual needs an ongoing package of care beyond the reablement – assessment/period, the team will help them arrange this. Once these long-term needs have been identified, a package of care will be recommended, for which there may be a charge, following the financial assessment.

For more information contact Brigitte Sinnott Brigitte.Sinnott@leics.gov.uk or Carolyn Dakin Carolyn.Dakin@leics.gov.uk

Prevention at Scale project update

The Prevention at Scale project is conducting service user insight to develop a detailed understanding as to why people attend a GP when other options might be available to address their non-medical needs.

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

Leicestershire is working with four GP surgeries in Measham, Kibworth, Hinckley and Loughborough to understand how the system could think differently about how services are provided. Participants will all live in one of these four areas which vary in size, demographic and affluence.

We are looking at customers between 60-80 years of age, who have visited a GP surgery for a non-medical intervention. This is to understand different customer journeys and experiences in accessing health and preventative services, in the first instance.

Once we have completed our detailed interviews with both patients and practice staff, we will evaluate how current prevention services operate based on the personal experience and customer journey of the people we interviewed. We want to identify:

- What other pathways are available to patients?
- How non-medical interventions are categorised – is it cause and effect – e.g. lower-level mental health problems?
- How can we present preventative services to the public in a better way?
- How do we access the 15% of patients that don't need a GP appointment at all?
- What are the common themes and issues people have and what can we offer to support people to access to services away from GP surgeries?

The Prevention at Scale project will run throughout 2019 and will look to redesign services by prototyping solutions with its participants. For more information contact Richard Smeeton on 0116 3056465 or email richard.smeeton@leics.gov.uk

Steady Steps case study

The Steady Steps postural stability exercise programme is part of the falls prevention pathway and is funded by health and care partners.

Coordinated and delivered by Leicester-Shire & Rutland Sport with support from the localities across Leicester, Leicestershire and Rutland the courses provide fallers or those at risk of falls with exercises to improve their strength and balance, therefore reducing the risk of falling.

The benefits of the programme are highlighted in the case study below:

Mrs S is in her 80's and lives by herself. Before the programme she enjoyed activities such as gardening but was finding it increasingly hard to be in the garden for more than 10 minutes at a time without taking a break due to her legs hurting. Whilst gardening Mrs S lost her balance, fell backwards and was unable to get up.

Through a member of her family Mrs S heard about the local Steady steps programme and joined the Hinckley programme.

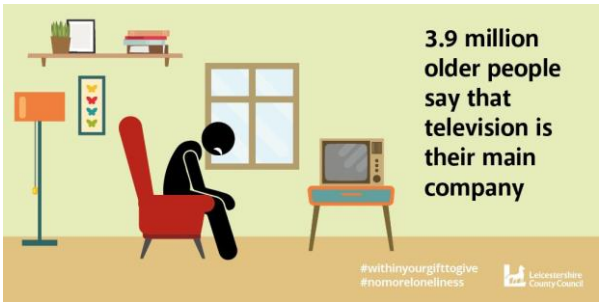
Mrs S completed the 24-week programme and has found that it's helped with her mobility, which in turn has helped her with her favourite activity - gardening.

Since coming to the classes, Mrs S who had smoked for over 50 years has stopped smoking. She said she feels healthier than she has done for a while and has noticed a difference in her breathing.

Mrs S said "I've got more confidence in myself, I love it. If I had been to the class and then had fallen in the garden I would have known how to use the bench behind me to pull myself up."

To find out more about Steady Steps visit www.lrsport.org/steadysteps or contact Richard Smeeton for more information on the Falls Programme on 0116 3056465 or email richard.smeeton@leics.gov.uk

Support to tackle loneliness – within your gift to give



A new campaign aimed at reducing loneliness and social isolation was rolled out across Leicestershire during December.

Within Your Gift to Give was a social media campaign aimed at highlighting statistics around loneliness and social isolation and encouraging people to take simple steps to reduce those feelings in others and themselves.

The campaign followed the loneliness summit that was held in November, co-hosted by the council and the University of Leicester's Unit for Diversity, Inclusion and Community Engagement (DICE), which brought together partners in the public, voluntary, business and education sectors to better understand the impact of loneliness.

More information about the campaign can be found at www.leicestershire.gov.uk/loneliness-and-social-isolation

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

NHS England · NHS East Midlands Ambulance Service NHS Trust · NHS University Hospitals of Leicester NHS Trust · NHS West Leicestershire Clinical Commissioning Group · NHS Leicester City Clinical Commissioning Group · NHS East Leicestershire and Rutland Clinical Commissioning Group · NHS Leicestershire Partnership NHS Trust · Leicestershire Police

Leicestershire County Council · Blaby District Council · Charnwood · District of Harborough · Hinckley & Bosworth Borough Council · Melton Borough Council · North West Leicestershire District Council · Oadby & Wigston Borough Council · healthwatch