# Health and Care Integration

Stakeholder e-bulletin

## Spring 2016 edition

**In this edition:**



### Welcome from Professor Mayur Lakhani, Chair of the Leicestershire Integration Executive

I am delighted to introduce the fifth edition of our Integration Bulletin and to update you on the wide range of work Leicestershire partners are delivering, to join up health and care for the benefit of local residents.

In this edition, we report on a number of significant achievements including:

- The 'Lightbulb' service, where housing support innovations are being designed and tested locally, to improve health and wellbeing in the home
- The 'Help to Live at Home' service, set up to enable people to remain independent for as long as possible through assistance with personal care in the home, including support after a hospital stay
- Our programme of work to improve hospital discharge in Leicestershire and the forthcoming 'Discharge Summit'
- The falls prevention programme, reducing the number of people admitted to hospital as a result of falls
- Improving health and wellbeing outcomes for Leicestershire families
- How First Contact has developed into First Contact Plus – a one stop shop for social prescribing
- Support for Dying Matters Awareness Week 2016, which runs from 9-15 May

Since the last edition of the bulletin we have refreshed our integration programme for 2016/17. Leicestershire's Health and Wellbeing Board approved the submission of the plan to NHS England on May 3rd, in line with the national timetable. Partners have committed £39m to the better care fund pooled budget for 2016/17, to continue to deliver our vision of integration for Leicestershire:

> We will create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens.

Best Wishes,
Professor Mayur Lakhani



*For previous editions of this bulletin–please follow this link:*
*www.leics.gov.uk/healthwellbeingboardnews.htm#hwbbbulletins*

## The 'Lightbulb' housing project

The 'Lightbulb' service aims to improve housing support for individuals and offer preventative services within the home. This enables vulnerable people to remain independent in their home for longer and reduces pressures on hospital services.

In the last bulletin, we announced that the next phase of the Lightbulb project will focus on developing a more co-ordinated housing support offer, including a wider range of housing support. There are several pilot schemes currently running across Leicestershire, some of which are working closely with colleagues in health, to identify vulnerable people who would benefit from housing related support. Experts from different agencies are working together to improve adaptations in the home; this can be anything from stair lifts, to handrails, to changes to a bathroom.

**Natasha Preston, Housing Support Coordinator said**: "Back in January, while I was holding one of the Lightbulb Service drop-in sessions at Barwell surgery, Mr A approached me requiring some grab rails around the home to help his wife. He also mentioned that, although they have smoke alarms, these were fitted a while ago and the batteries appear to have stopped working. We agreed that firstly, an urgent request via First Contact would be completed to replace smoke alarms, followed by a visit the following week, to fully assess the home."

"Once a full home assessment was completed, in addition to fitting grab rails around the home, further referrals were also completed to address other issues raised via the visit. This included enrolling Mr and Mrs A on local groups to enable them to be more connected to their community, as well as arranging access to a computing course."

The work carried out by the team shows that the Lightbulb pilots are making a significant difference in people's health and wellbeing, allowing them to remain independent in their home for longer. It also shows the benefits of a holistic approach to the home visit, where a number of social prescribing needs can be identified and then a response coordinated in conjunction with First Contact Plus.

**Next Steps :**

The future plans for Lightbulb include a business case proposal for partners, as well as refining the service model through the ongoing multi-agency design work. Further engagement with customers will also shape the final approach. The Lightbulb team are hosted at Blaby District Council and include technical housing and grants officers, occupational therapists and housing support coordinators.

For more information contact Teresa Neal, Service Manager at Teresa.Neal@blaby.gov.uk or 0116 272 7687

## An innovative approach to home care is moving a step nearer in Leicestershire

Known as Help to Live at Home, the service will support people to remain independent for as long as possible, through assistance with personal care including providing help when discharged from hospital.

Leicestershire County Council will oversee the service along with East and West Leicestershire clinical commissioning groups (CCGs). This new joint approach to commissioning personal care in the home for Leicestershire residents will reduce the number of contracted providers from approximately 150 to a maximum of 18.

The Help to Live at Home service providers will work in seven district areas around the county where GP services, community nursing and adult social care teams already operate, meeting the needs of around 3,500 people.

Interested care providers have now submitted their initial bids. It is anticipated that contracts will be awarded in August with the new service coming into operation from November this year.

Dr Andy Ker, from the East Leicestershire CCG, said: “This is a big programme of integration work between health and social care and will support the best use of joint resources as well as strengthening partnership working.

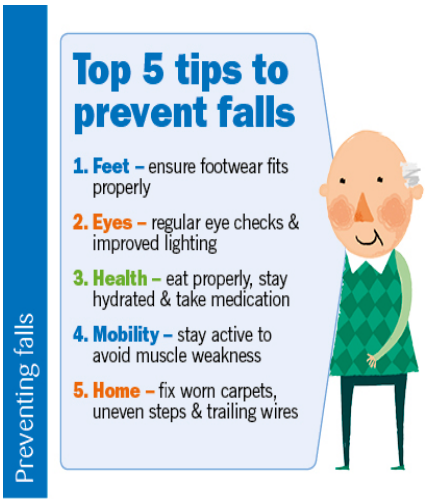
“We have also spoken to people receiving home care and their carers as we wanted their views on how the service should be developed.”

For more information please contact Trish McHugh on: 0116 305 0291 or email: Trish.Mchugh@leics.gov.uk

## Falls Prevention

Around 60,000 older people are injured in falls each year in the UK, with the most common injury being hip fractures. Apart from the pain, discomfort and inconvenience, the after effects of a fall, for older people in particular, can be life changing.

The Leicestershire Better Care Fund promotes joint working between health and social care organisations to prevent falls. Falls assessment clinics, as well as a six week falls prevention programme, are provided to those at risk of a fall. This will focus on things such as improving strength, balance and confidence to reduce the risk of falling and avoiding hospital admissions due to falls.




Since the falls programme started, the co-ordinators have successfully helped many patients from reaching crisis point, giving them advice on how they can prevent themselves from tripping and falling.

Here we share a few of the real life success stories:

1 .Mr ‘A’ arrived at the falls clinic with mobility problems and a history of five falls in the last 12 months. On discussing Mr A’s falls history, it was found that all his falls were due to tripping in and outside the home. Although it was identified that part of the shuffling was due to confidence, it was also due to poor fitting footwear. Mr A’s shoes were assessed to be too big and the only way he could keep them on when walking was to shuffle. He was advised to change his footwear and the falls service team would see him at home to practice his walking technique.

Mr A’s mobility was reassessed and with some advice he was able to pick his feet up sufficiently, which stopped the shuffling and reduced the risk of him tripping and falling. He then attended the falls prevention programme and no further falls were reported.

2. Mrs ‘B’ was 83-years-old and was referred to the falls service due to recurrent falls in the home. Mrs B was diagnosed with a cataract in her eye. On discussing the patients falls history, it was identified that she was falling during the night when going to the bathroom. Mrs B also stated that she didn’t put a light on when walking to the toilet as it may disturb her husband. She was advised of the impact of her reduced vision on mobility and balance and that by walking in the dark she remains at high risk of falling over. Mrs B was recommended to have a lamp at the side of her bed and a nightlight on the landing. All advice was carried out and the patient reported that she was benefiting well from these small changes, and felt more confident when walking to the bathroom.

For more information about the falls prevention programme, please contact Andrea.Baker@leics.gov.uk or call: 0116 305 6841

## Integrating Leicester, Leicestershire and Rutland Points of Access

A key part to improving health and social care is ensuring service users, patients and professionals can easily access services. The integrated points of access project has engaged with a wide range of stakeholders from across health and social care to understand how service users currently contact organisations, and how these enquiries are handled.

In January, a number of co-design workshops were held with stakeholders, including GPs, nurses, CCGs, federation managers, providers, front line call handling staff, carers, service users and patients. We have captured their ideas on how changes could be made to improve customer service, as well as exploring the possible options for providing a more integrated service to customers and the barriers to change. Staff were overwhelmingly positive about how we could improve the current offer for our residents, from simple changes through to radical process redesign.

Following the workshops, we have been working with each of the call centres to finalise the information gathering from performance data, staffing and financial information through to understanding the current information and technology systems used across Leicester, Leicestershire and Rutland (LLR). This information has been used to develop options and present a business case to the project board in early May 2016.

This project is aligned to the LLR Urgent Care Vanguard (work stream 1), which is developing the vision for integrated community urgent care. The Integrating LLR Points of Access project will report through to the Vanguard project board to ensure alignment between the two projects and the management of risks and dependencies.

For more information, contact Gemma Whysall at Gemma.Whysall@leics.gov.uk or call 0116 305 5673.

## Improving the lives of Leicestershire families

The National Troubled Families programme was launched in December 2011 by the Prime Minister. Leicestershire's response was the creation of the Supporting Leicestershire Families service (SLF).

SLF is funded by a pooled budget which is made up of partnership contributions which include two Clinical Commissioning Groups, Public Health, Leicestershire County Council, Job Centre Plus, Leicestershire Police, the Troubled Families Unit (TFU) and Payment by Results (PBR) funding. The Partnership is committed to improving the lives of Leicestershire families, particularly the most vulnerable whilst reducing public sector costs.

SLF has started to work with some GPs to identify families who would benefit from the intensive service, and would like to develop this work further. The benefits of this type of intervention include reducing the pressures placed on GP surgeries, social care and improvements in health and wellbeing outcomes for the families themselves.

**One GP states:** "The family seem much improved…dad is no longer on the scene, mum and kids are improving, attending appointments and a degree of stability has been achieved. The most successful part has been the worker ensuring appointments are attended, advice implemented and undertaking liaison with different agencies. It would have taken much longer to achieve this level of engagement, subsequent stability and improvement without SLF".

For more information, please contact: 0116 305 5971 or visit: www.leics.gov.uk/index/children_families/early_help.htm

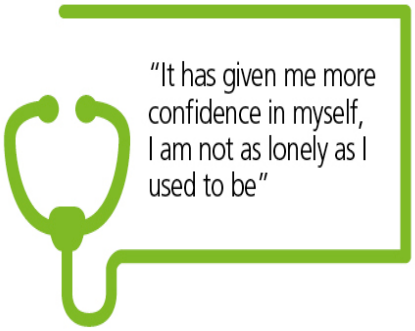
## Integrated Care

Integrated Care is a partnership between social care, community nursing and GPs throughout East Leicestershire and Rutland. The aim is to provide a chance for patients to address, not only their specific long term health conditions, but also how these affect all aspects of their life and the people around them.

Patients who have complex needs, involving multiple long term health conditions, and whose care may deteriorate without proactive support and review, are identified using a risk assessment tool along with GP knowledge of their condition(s) and case history. They are then contacted by their local Integrated Care Co-ordinator to discuss their current situation and needs, using an assessment tool co-designed by health and social care staff.

This information is then used in multi-disciplinary team meetings in each surgery involving GPs, community nursing and other partners, so that care is carefully planned and coordinated between professionals, the patient and their carer/ family members.

Evidence obtained from similar approaches in other parts of England, including the King's Fund Integrated Care model, demonstrates the impact of this approach on supporting people and maintaining their quality of life for as long as possible.




In addition, patient questionnaire feedback demonstrates that the approach is successful and that the work of the Integrated Care Team is well received.

**Dr Andy Cook, Senior Partner at Central Surgery Oadby, said**: "We wholeheartedly endorse the work of the Integrated Care Team. Our local Integrated Care Team co-ordinator has been taking referrals from us for some time now, and we have found her input into our patients with complex biopsychosocial difficulties invaluable."

"The Care Co-ordinator has frequently been able to access help and support for our patients that we had not previously been aware of, as well as helping to facilitate multidisciplinary working between agencies. We have found our meetings with her to discuss patients referred into the service very useful."

For more information about the Integrated Care Service please contact: Aiden Neaves, Team Senior Integrated Care, on: 0116 305 4832 or email: Aiden.Neaves@leics.gov.uk

## The vision for integrated health and care in Leicestershire localities

During 2015 we have started to put in place the foundations for a new model of integrated care in Leicestershire's communities and in 2016 we will be consolidating it.

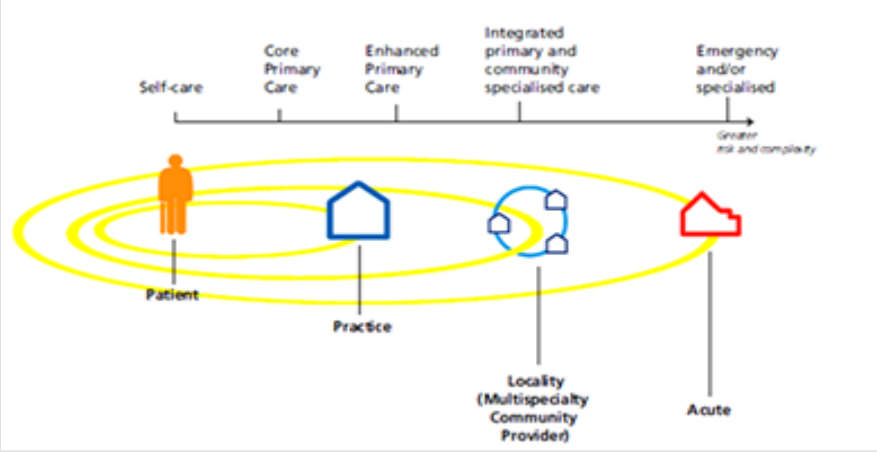
The new model will place the patient/service user at the centre, with the GP as the primary route for accessing care. The GP will also be the accountable professional for the most complex or vulnerable patients in community settings with support from care coordinators as described in the section of the bulletin above

Our model of integration wraps around the patient and their GP practice, extending the care and support that can be delivered in community settings through multidisciplinary working.

The aim of this is to reduce the amount of care and support delivered in acute settings, so that only care that should/must be delivered there will be in the future.

The diagram below illustrates how the model of integrated care in localities has been designed. It is anticipated that this will develop in line with the multi-speciality community provider model which NHS England is promoting as part of the Five Year Forward View https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/

**Leicestershire's model of integrated community based care**




For more information please contact Tim.Sacks@EastLeicestershireandRutlandccg.nhs.uk or Angela.Bright@westleicestershireccg.nhs.uk

## First Contact Plus - Our one stop shop for social prescribing

During the last few months, First Contact has developed into First Contact Plus - our 'one stop shop' with one simple referral form, so that primary care can quickly and effectively access Leicestershire's prevention offer.

First Contact Plus is a key part of our vision that, by 2018, we will have a comprehensive offer for community based prevention for the citizens of Leicestershire, funded by bringing together all the resources available to local councils and NHS partners.

The enhanced First Contact Plus service offers signposting, information and targeted referrals where appropriate. We now contact customers after 6 and 12 weeks to follow up on referrals to ensure they have received the services they need and gather individual outcomes.

**A recent case study**: Iris is 81 and has arthritis. On a visit to her GP she mentioned that she was starting to struggle with her household cleaning in addition to caring for her husband who has dementia. Her GP (with her permission) completed a simple referral form and sent it through to First Contact Plus for action. First Contact Plus sent referrals to the Assistive Technology team, Voluntary Action South Leicestershire and Age UK and as a result:

- The Assistive Technology team arranged a home visit to carry out a full assessment. During the home visit a recording reminder (Memorabell) was installed and the reminder set by the Assistive Technology technician as requested by Iris.
- The Support for Carers team contacted Iris to offer her their support and guidance and also referred her husband onto the Memory Advice Service.
- Age UK contacted Iris to discuss the types of services they can provide to help her at home such as: cleaning, shopping and gardening.

First Contact Plus is also the route for Making Every Contact Count (MECC) referrals across Leicestershire and Rutland and operates the Crisis & Emergency Support phone line offering signposting to members of the public in need of emergency support in a crisis such as food, gas, electricity or housing.Our enhanced service offers new pathways to promote healthy lifestyles, so you can refer to First Contact Plus for smoking cessation, reducing and stopping alcohol consumption, healthy weight and healthy eating, physical activity and sexual health advice.Later this year we will be launching our new website that will offer the public a direct self-help service.

For more information contact Debbie Preston, First Contact Plus Manager at: Debbie.Preston@leics.gov.uk or call: 0116 305 8240.

## Dying matters week

We are encouraging staff and partners to support Dying Matters Awareness Week 2016, which runs from 9-15 May.

This year's theme is the 'Big Conversation', with a supporting leaflet explaining why talking about dying, death and bereavement is so crucial, offering tips for initiating and continuing these conversations.

Lots of practical advice is available, which can be taken to put our final wishes in place, as well as how to spread the message through our communities of the importance of discussing what we want to happen at the end of our lives.

A simple way to show support for Dying Matters Awareness Week is to change the header on your Twitter accounts to a Big Conversation one.

For more information about the awareness week, or to download the leaflet, poster and/or Twitter header, please visit:

http://www.dyingmatters.org/page/BigConversationResources

## Major improvements to hospital discharge in Leicestershire

In the last bulletin, we spoke about the improvements we have already made to support patients leaving hospital.

After a very challenging winter period, we are continuing to focus on this area and a "discharge summit" is being planned in May for all partners across LLR, where the agenda will include:

- The time it takes to 'discharge' someone from hospital
- Seven day services
- Readmissions
- Patient Experience

For more information contact Jackie L Wright at Jackie.Wright2@leics.gov.uk or call 0116 305 4979

## Contact us

Follow us on Twitter **@LeicsHWB**

See our website: www.leics.gov.uk/healthwellbeingboard.htm

Download our Better Care Fund plan on a page:
www.leics.gov.uk/leics_county_bcf_submission_supplementary_appendix_b_bcf_plan_on_a_page.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