Health and Care Integration

Stakeholder e-bulletin

Summer 2015

Welcome to the third edition of the Health and Care Integration stakeholder bulletin.

In this edition:

Housing support at LRI | The lightbulb housing project | Assistive technology | Improving care at home | Innovation in home care services | Avoiding hospital admissions | Launch of Care and Health Trak | Developing health & care integration in localities

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Welcome from Professor Mayur Lakhani, Chair of West Leicestershire Clinical Commissioning Group and the Leicestershire Integration Executive

I am delighted to introduce the third 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.

Keeping people at the centre of our work, making integrated care a reality for individuals and their families and carers is what drives our integration programme.

We have developed "Emma's Story" to illustrate how changes to health and care integration will support people like Emma to maintain their health, wellbeing and independence at home for as long as possible. You can view the animation at: https://youtu.be/AU8CK-LT3dU

I am pleased to report that we have made significant improvements in reducing delayed discharges from hospital and in May 2015 we achieved our best performance since April 2011 and achieved the target for improvement within the Better Care Fund Plan.

We still have much work to do across Leicester, Leicestershire and Rutland to sustain an improved position on hospital discharge and reduce the number of people being admitted to Leicester's hospitals, but the work undertaken over the last year on our urgent care system has focused all partners on one joint action plan. The investments and activities from Leicestershire's Better Care Fund are starting to make a real difference.

Our integration programme is also about how integrating health and care services more effectively with housing support can lead to improved outcomes. One of the key aspects of Emma's Story is about how she can stay safe and well in her own home.

We used the findings of Leicestershire Health and Wellbeing Board's *Housing Offer to Health* report, which was developed in conjunction with the Chartered Institute of Housing, as the basis of our approach to integrate housing into health and care services. You can view the report at:
http://politics.leics.gov.uk/Published/C00001038/M00003837/AI00036448/$HousingOffertoHealthAppAf.pdfA.ps.pdf

One of the important areas we have considered is how housing expertise can be targeted more effectively to improve hospital discharge. In our second edition of this bulletin we explained the very positive work we have been undertaking at the Bradgate inpatient mental health unit to support hospital discharge.

In this edition of the bulletin we feature improving discharge with housing support at Leicester Royal Infirmary and the progress we are making with the Lightbulb Programme.

Also in this bulletin you can find out more about our work on preventing admissions due to falls, how home care services are being transformed for 2016, how our new local area coordinators are already making an impact in the community, and how in August we enter a new era of data sharing.

With my best wishes

Mayur Lakhani

Our achievements from January – June 2015:

169 avoided admissions through assessments at the Loughborough Older Persons' Unit	134 paramedics trained on the falls assessment - 376 admissions to hospital prevented
211 referrals to the Integrated Crisis Response Night Nursing Service resulting in 197 avoided admissions	50% reduction in service users awaiting home care between March and June reducing delayed discharges from hospital

Housing support at Leicester Royal Infirmary

In December 2014, a housing support officer was located at Leicester Royal Infirmary to find out what sort of housing issues were affecting hospital patients and the type of advice and support needed. They found that 42% of the patients they spoke to reported a housing or welfare issue that would impact on their ability to go home from hospital and remain there safely and comfortably.

Recognising the impact this has on successful hospital discharge, a joint initiative has since been set up by the three CCG's across Leicester, Leicestershire and Rutland, Blaby District Council and Leicestershire County Council.

Initially two full time housing experts were employed and based at the Royal Infirmary to assess the support needed and help people with their housing needs, including welfare and benefits advice. The early success of this initiative in terms of improving discharge and reducing readmissions has already led to a third full time post being funded.

A community support worker has also been employed to help people once they are discharged and back at home, ensuring support continues so they can remain well and avoid readmission.

Examples of the needs and issues the team are collectively addressing include: homelessness, support to move to a more suitable property and support to move furniture in order for patients to return from hospital.

For more information contact, Quin Quinney - Community Services Group Manager at quin.quinney@blaby.gov.uk or by calling 0116 2727595.

The 'Lightbulb' housing project

The Lightbulb project aims to integrate housing support into one easy to access service across Leicestershire, which demonstrates a clear, positive impact on health and wellbeing.

Two initial pilot schemes are in place across Blaby and North West Leicestershire. The team is integrating the different elements of the service and expertise traditionally offered by multiple agencies, bringing them together to work side by side for the first time. The focus for these pilots is on improving how adaptations in the home are assessed and undertaken. This can be anything from stair lifts, to handrails, to changes to a bathroom.

The project is already finding practical solutions to streamline the often lengthy processes and waiting times that can occur between agencies, which we know cause delays and frustrations for both residents and professionals.
By improving housing support we hope people can remain independent in their home for longer, reduce pressure on hospital services and provide more preventative services within the home e.g. warm homes advice, handyperson services and falls prevention.

The Lightbulb team is based at Blaby District Council and includes technical housing and grants officers, occupational therapists and adaptations specialists, bringing together county council and district council staff into one co-located team.

Using learning from the adaptations service improvements in Blaby and North West Leicestershire the pilot roll out will continue into Hinckley and Bosworth, where the model will focus on integration with GP practice.

For more information contact Tine Juhlert, Programme Manager – Lightbulb Tine.Juhlert@blaby.gov.uk or call 0116 272 7683.

Assistive technology – pendants, alarms and gadgets to make life easier

There are a number of different systems and devices that can help a person to remain safe and supported in their own home. They are designed to help people continue living independently, support carers and delay or eliminate admission to residential or nursing care.

Assistive technology can be a special phone that calls for help to a carer or emergency service, pendants that can raise an alarm, or equipment that tracks long term conditions by sending regular readings to a health care professional such as monitoring blood sugar or blood pressure.

Various teams operating across health and social care can access and supply assistive technology, but historically this has not been a joined up process between agencies.

Recently, Leicestershire County Council invited partners to come together to discuss the different types of equipment used, identify opportunities to work together and consider how we can expand the range of equipment offered.

This workshop generated some excellent ideas and a commitment was made to joint working across health and care going forward. Short term actions include a pilot of assistive technology within care homes and a roll out of medication dispensers working with pharmacists. Longer term the hope is to develop a joint commissioning strategy which will include, for example, how teleconsultations could help patients, carers and community staff communicate in the future.

For more information about our approach to assistive technology. Please contact Tracy.Ward@leics.gov.uk or call 0116 3057563 Carole.Lomas@leics.gov.uk or call 0116 3055173

Improving care at home

A new approach by social care staff has reduced the number of people waiting for care packages at home.

Since September 2014, all those receiving a package of home care from an independent provider e.g. following discharge from hospital or via a community referral, have received a review of their care package after two weeks. The reviewer ensures the service user's support needs are being addressed and that the services being provided are still appropriate and proportionate to their needs.

By proactively reviewing these service users, it has been found that packages of home care support can often be reduced, and any hours of care that are no longer needed can be released creating more capacity in the home care market , meaning that new service users in need of support can access their care package more quickly.

The findings from this approach, which has now been operating for over nine months in Leicestershire, demonstrates the original care package can often be reduced by over 50% at the two week review.

The impact of this has been significant, in that new service users waiting for care have dropped from over 100 in March to less than 50 in July improving hospital discharge.

The principle of undertaking a two week review for all service users has been adopted into the contract for Leicestershire's new model of home care called "*Help to Live at Home*". You can read more below.

2016 to bring innovation in home care services

Over the past six months, we have been developing a new model for delivering home care services across Leicestershire, known as *Help to Live at Home.*

We have considered and explored a range of issues in developing the new service:

- how to commission for outcomes rather than the traditional "time and task" approach
- the problems providers face in this market
- how best to organise care across the geography of Leicestershire
- how reablement works in practice
- how home care pathways connect with hospital discharge and prevention services.

We have been meeting regularly with over 100 home care providers to outline the benefits of *Help to Live at Home*, and prepare the market for the new model, which aims to keep people independent at home for as long as possible.

If approved, the new *Help to Live at Home* service will be procured during the winter of 2015/16 with a go live date to be confirmed later in 2016.

For more information please contact Trish.McHugh@leics.gov.uk or call 0116 305 0291

Avoiding hospital admissions by thinking 'Home First'

Colleagues across health and social care have been working together to identify further opportunities to avoid hospital admission and improve care for frail and older people.

All agencies are promoting a "Home First" approach, making sure community services are used as alternatives to hospital admissions – including safely diverting patients who attend A&E into suitable community alternatives.

A workshop with A&E nurses in June has led to improvements in the triage function in A&E.

Healthcare professionals will assess patients as usual in A&E, ensuring they have the necessary "safe and well" checks. If they approve a "Home First" approach they now have two additional options they can consider, and can make an immediate referral:

- Arranging a next day appointment at the Older Persons' Assessment Unit, where a more in depth assessment and diagnostics can take place, with an advanced nurse practitioner and community geriatrician. Patient transport is provided to and from the unit. The assessment can be completed in 2-3 hours and the outcome and care plan is then updated with the patient's relative/carer and GP

- Referring patients direct from A&E who do not need a hospital bed but require overnight support - to Leicestershire Partnership Trust's community night nursing service, from where they can be assessed and referred into routine community services the following day as needed.

For more information please contact Donna.Brewer@westleicestershireccg.nhs.uk or call 01509 567746

Local Area Co-ordinators: now in 8 localities

Local Area Co-ordinators are now working in eight areas across the county:

Blaby District	Charnwood Borough
• Enderby • Braunstone Town/Thorpe Astley	• Hastings • Thorpe Acre
Hinckley and Bosworth	**Melton**
• Desford/Newbold Verdon • Barwell	• Asfordby • Melton

What does a Local Area Co-ordinator do?

- Supports up to 60 people at any one time in their local community - typically older people, those with low-moderate mental health needs, those who are vulnerable or socially isolated
- Work in community bases
- Spends time to understand a person's strengths and achieve their vision for a good life
- Identifies community assets and resources which individuals can access or have available to them
- Link individuals to sources of informal support
- Supports individuals to access other relevant services where required.

Leicestershire's Local Area Co-ordinators have been holding engagement events with residents, stakeholders and partners in the pilot areas. The events have demonstrated that there is a wide interest in the benefits of the Local Area Coordination approach and helped to identify the variety of local community assets in each area.

Each of the Local Area Co-ordinators is already working with a number of people in their area with numbers growing daily.

For more information please contact Simon.Dalby@leics.gov.uk or call 0116 305 6650

Avoiding hospital admissions: integrated working for falls

The falls admissions pathway continues to avoid approximately 62 admissions on a monthly basis. To date, 134 East Midlands Ambulance Service (EMAS) paramedics have been trained to use the new falls assessment tool, enabling rapid handover of patients to Leicestershire's integrated health and care community teams, rather than EMAS taking the patient by default to A&E.

Since January 2015, 376 admissions to hospital have been avoided. For more information please contact Suzanne.Dean@nhs.net

For more information on how to prevent a fall, see our falls leaflet at www.leics.gov.uk/preventing_falls_a5_leaflet.pdf

The launch of Care and Health Trak: integrating data for better outcomes

Care & Health Trak, a new integrated data tool, provides our local health and care system with the very first joint database which is able to track the type and location of care received across the multiple health organisations and local authorities across Leicester, Leicestershire and Rutland (LLR).

The new system went live on 10th August allowing users of Care & Health Trak to see how people treated within LLR move between services provided by different agencies and how these interconnect.

This means that partners can plan services more effectively to deliver care when and where it is needed. It will be possible to see which services people have used before reaching a crisis point such as a fall or attendance at A&E and which services they use afterwards. This is helpful in showing if services designed to change the way patients are treated are successful, such as those aiming to deliver more care closer to home.

The organisations that are sharing their data include University Hospitals Leicester, Leicestershire Partnership Trust and East Midlands Ambulance Services as well as social care services across LLR.

The information will be used to support a range of joint initiatives such as those supported by the Better Care Fund pooled budgets, and the wider system changes planned under the Better Care Together Programme.

For more information please contact: Brenda Howard, project manager on 07884 473 017 or email brenda@howardconsultancy.co.uk

Developing integrated health and adult social care teams in localities

The 'early implementer' pilot to test out new ways in which Community Health Services (CHS) and Adult Social Care can work more closely together has now been 'live' for eight months.

The pilot has shown that there are many opportunities to better coordinate our joint shared caseload, especially during discharge from hospital and when we share complex cases in the community.

We are therefore rolling out new ways of working across all localities, which involve engaging staff from health and social care in joint planning and team-building events.

In mid-July changes were made to improve services and align models. Work is now categorized as planned, urgent or crisis and different workers deal with each type of work. Early reports suggest this is leading to improvements in locality working and staff feel very positive about the benefits this change will bring.

To help embed these changes Locality Managers and Team Seniors are taking part in training events to equip managers with some proven principles and tools for leading and managing change. Further follow-on training modules for Team Seniors are also planned.

To support the embedding and continuous improvement of our new model of care, we also plan to establish Learning Sets. The sustainability of new ways of working is dependent on how well we embed them, to ensure they become '*how we do things around here'.* The Learning Sets will help enable this to happen.

For more information please contact Brian Jopling, Project Lead on 07889 256265 or by email at jopling2@aol.com

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:
http://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 http://www.bettercareleicester.nhs.uk/

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

Health and Care Integration

Case studies

Through the integration of health and care services, we are working towards avoiding costly hospital admissions through a range of initiatives which support people to stay in their own homes and within the community for longer. Below are some example case studies demonstrating the positive impact the different initiatives have been making.

Integrated Crisis Response Service (ICRS) overnight service – Ms L

Ms L, an 81 year old lady living alone deemed to be near end of life wanted to die in her own home. She had completed 72 hours with the ICRS and a referral had been made to Continuing Health Care to provide an ongoing package of care to meet her needs.

At 10pm, no one had arrived as planned so her friend called the 'single point of access. Her friend had looked after her all day and was exhausted and did not want to leave her alone in fear that she would die.

There was a spare ICRS bed available so a nurse went in for overnight support and Ms L passed away peacefully during the night. The friend was so grateful for all that ICRS had provided.

Loughborough's Older Persons Unit (OPU): GP referral – Mr N

Mr N, a 91 year old gentleman was referred to the OPU by his GP after being short of breath, dizzy and frequent falling.

He had a complex medical history including Ischemic heart disease (IHD), Chronic kidney disease (CKD), Chronic obstructive pulmonary disease (COPD) and diabetes.

At the OPU a full clinical assessment was completed with blood tests, a chest x-ray and an ECG.

Mr N was describing symptoms of hypoxia. He was assessed by the physiotherapists and ambulatory oxygen saturation measurements revealed his saturations dropped to less than 85% when exerting. His chest x-ray suggested fibrotic lung disease.

The Advanced Nurse Practitioner (ANP) ordered home oxygen which was delivered within four hours of the completed referral.

Mr N's medication was altered and a package of care was offered but declined. The GP was advised to complete a respiratory referral.

A follow up appointment was arranged in the OPU to evaluate these changes. Mr N had felt much better using oxygen therapy and had experienced no further dizziness or collapse.

His wife wrote the following comments on our satisfaction survey:

"The care and attention we had today has been wonderful. My husband has been relaxed the whole time and is happy."

Carer's wellbeing service - Mrs W

Mrs W is a carer to her mother who suffers from Vascular Dementia. Her mum lives with her.

On a visit to her local surgery, Mrs W picked up a carer's services leaflet. She called the Wellbeing service in June requesting some advice as she was finding it difficult to look after her mum.

She was contacted the same day and had a very lengthy conversation about her caring role and the difficulties she was experiencing. She was feeling very stressed and got upset during the conversation.

Mrs W gets little sleep due to her mother waking up several times during the night. She has also had to reduce her working hours in order to look after her mother and had even thought about giving up work altogether. Mrs W was completely exhausted and didn't know which way to turn. Mrs W felt better being able to speak to someone who was able to listen and understand her situation. She felt reassured that there was help available.

A carer's assessment was completed over the telephone which revealed how much care Mrs W was actually providing for her mum and the effect it was having on her own life.

Social Care contacted Mrs W to arrange an appointment for a home visit assessment. The outcome of this granted Mrs W a personal budget. There was also a referral made for a Community Psychiatric Nurse (CPN) and both the allocated worker and the CPN visited to assess her mum's mental health.

The Carers Wellbeing service has allowed Mrs W to carry on working and feel supported as a carer. She is happy that support is in place and this has reduced the pressure and she is happy to continue to care for her mum.

Integrated Crisis Response Service (ICRS) overnight service – Mrs C

Mrs C, aged 82 accessed ICRS after she was diagnosed with mantle cell lymphoma, following the discovery of a lump on her neck. Her condition deteriorated and she became bedbound, unable to move her legs and in a lot of pain. As she was also a carer for her husband, who suffers from dementia, her family was finding it hard to cope.

At first her GP advised admitting Mrs C to hospital, but her end of life plan was to die at home and she was very clear that she did not want to be admitted. Based on this the family decided that they would try to continue to provide care themselves at home, rather than have to take her to hospital. At this stage, Mrs C's GP suggested the new ICRS Overnight Service. Kim, Mrs C's daughter explains:

"The overnight service started that night and it was a relief for my mum as she knew she was safe. It was a big thing for all of us as we had been on our own and we were scared.

They were very caring as if they were looking after their own mother. Nothing was ever too much trouble. Knowing that a nurse was looking after my mum, who would phone if we needed to come, meant I could go home for a few nights.

"We never needed to ask anything as we were told every step of the way what was happening, what was going on, where mum was at on her journey and it was just so nice. The trust was there and the rapport was there. It wasn't like nurses coming in, it was just like a family."

Mrs C also received care from Hospice at Home during the day time, providing her with integrated care across 24 hours. A respite home was also found for Mrs C's husband, allowing the family to focus on her. Following nine days of care from these services, she passed away at home and with her family in accordance with her wishes.

Kim continued, "There was that much love around she felt happy where she was. She passed away so peacefully. It was sad, but if I said, if there was ever such a thing as perfection in someone passing away, she got it. It's so important that this service goes 24/7 and it continues because without it I don't know where we would have been. It's helped me to come to terms with things and carry on."

Loughborough's Older Persons Unit (OPU): Mrs S

Mrs S aged 78, attended the unit following a series of falls. Her GP was unable to find anything clinically wrong with her, but was still concerned, so referred her on to the unit for further tests.

Mrs S said, *"I fell last week and couldn't get up and it wasn't the first time, I'd a couple of falls in the last few weeks. I went to the doctor this morning, and he couldn't find anything wrong. He wanted a more in-depth examination as he thought I've fallen too often. I came straight to the unit and was seen really quickly. I didn't expect that, there was no waiting."*

Mrs S was diagnosed with osteoarthritis of the knee which was causing her knees to give way, explaining why she was falling over. The centre prescribed pain medication and contacted her GP with a recommendation for Mrs S to be referred to a specialist osteoarthritis clinic.

Mrs S added: *"It's great to be able to make use of the unit, I had no idea that they had this kind of thing here. I think it's wonderful, everyone has been very kind and helpful. So often older people aren't dealt with properly, and they're not given enough time. But this time I was treated right, this is much better. I felt really reassured by everything, it's a really good service. It should be available for everyone."*

Assistive Technology – Mrs H

Mrs H suffered from epilepsy which meant her family needed to be with her at all times.

HART carried out an initial assessment and referred her for a lifeline connect+ with a personal trigger and a fall detector. The lifeline was programmed to phone Mrs H's mum and eldest son.

A further visit was made to Mrs H a week later to drop off a Pivotell medication dispenser so that Mrs H can take her medication at regular intervals throughout the day so that her medicines work properly at the right time.

This equipment has enabled Mrs H's 2 younger sons to go to school with piece of mind that someone will be alerted and respond when their mum has a seizure. It has also enabled Mrs H to be less reliant on others.

This equipment should enable Mrs H to remain independent and reduce the need for further care services.

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

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