



Winter 2015/16 edition

In this edition:

Evaluation study | The 'Lightbulb' housing project | Improvements to hospital discharge in Leicestershire | Local Area Co-ordinators | Falls prevention | Integrating care & health information | Integrated locality teams | Integrating Leicester, Leicestershire and Rutland Points of Access

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

I am delighted to introduce the fourth 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 during 2015 including the introduction of Local Area Coordinators, the huge improvements made to hospital discharge, excellent progress on integrating data and locality teams, and how other parts of the country are looking to Leicestershire innovations (such as our approach to evaluation and integrated housing support) as national exemplars.

During 2015 we pooled money, staff and leadership to break new ground in partnership working, and delivered some demonstrable areas of success through our Better Care Fund plan.

We are now in the process of refreshing our Integration Programme for 2016/17. This involves reflecting on what has worked well and where we need to make further improvements, as well as confirming and challenging the scale of our ambition and our collective return on investment assumptions as a health and care system.

Clearly our performance on reducing admissions to hospital remains a challenging area. With admissions continuing to rise generally in 2015 in Leicestershire, and our four admissions avoidance schemes not yet delivering to their full potential we must renew our joint focus on this component of our integration programme if we are to deliver an impactful and sustainable 'left shift' of resource, away from acute care into integrated, preventative community alternatives.

In the meantime we should not underestimate the substantial progress we have made during 2015, as illustrated in this edition of our bulletin.

With my best wishes for a happy and successful 2016

Mayur Lakhani



For previous editions of this bulletin including the [Emma's Story animation](#) and the case studies featured in our Summer edition –please follow this link: www.leics.gov.uk/healthwellbeingboardnews.htm#hwbbbbulletins

Evaluation study: avoiding emergency admissions

As part of the Better Care Fund programme, we are testing the impact and effectiveness of the new health and care pathways in the community, including four emergency admissions avoidance schemes.

The Research Centre of Service Management at Loughborough University, partnering with Healthwatch Leicestershire and Leicestershire County Council, were awarded an Enterprise Project Grant worth £100,000 by the University's Enterprise Office to conduct a major new study in 2015. The grant is being used to evaluate how emergency admissions to hospitals can be reduced by using alternative pathways of care in the community. The study uses modelling and simulation techniques to test the effectiveness of care pathways as well as testing the experiences of service users. The evaluation will focus on;

- how emergency admissions to hospitals can be reduced
- improvements to the patient journey through new integrated pathways of care in the community

Four care pathway evaluation workshops have been undertaken, where simulation models of each pathway were reviewed, and the impact of the four emergency admissions avoidance schemes was assessed.

The workshops had positive engagement from all stakeholders, where they were able to review performance against targets, process current tasks, define demand, capacity, unmet demand, benefits and current risks and issues. Each of the evaluation workshops generated a series of findings and actions showing how the pathways could be improved from the perspective of providers and commissioners.

Service user workshops have also taken place to understand the experience of patients and carers when using the four new integrated care pathways. The findings from the service user workshops, which were facilitated by Leicestershire Healthwatch, are expected in January 2016.

Findings from both sets of workshops will identify which impactful changes should be applied to the schemes to improve how they operate in the next phase of the Better Care Fund in 2016. Leicestershire partners are also undertaking some other aspects of evaluation such as clinical audit.

Our evaluation programme aims to assess the impact of Leicestershire's Better Care Fund, inform future health and care commissioning plans, and provide learning for other parts of the country. The methodology we have developed and our findings will be disseminated nationally during 2016.

For more information please contact Suzanne Dean, Programme Lead at Suzanne.dean@nhs.net or call 0116 305 0326

The 'Lightbulb' housing project update

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



A number of pilot projects are in progress to develop and test more effective ways to integrate, co-ordinate and streamline the different elements of housing support and expertise traditionally offered by multiple agencies; bringing them together to work side by side for the first time.

The programme's first pilot project aims to streamline the way people can get advice and help with adaptations in the home. This is being achieved through collaborative working between Leicestershire County Council and the surrounding district and borough councils.

Continued ...

The second phase focusses on developing a more co-ordinated housing support offer which includes a wider range of housing support. Two Housing Support Co-ordinators are now in place to test this model and their role will involve taking a more holistic look at all aspects of the practical housing support that someone might potentially need, to keep them warm, safe and independent in their home. They will then help service users to source, navigate and co-ordinate the range of housing services that will best meet these needs.

The programme is working closely with health colleague's e.g. to provide a simple link between the range of housing support co-ordinated by Lightbulb and GP practices, hospital discharge and community nursing teams.

By using the well-established 'First Contact Plus' route as the entry point to the service, we are helping build a broader set of preventative services from one easy access point.

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, handy person services and falls prevention.

For more information contact Tracey Montgomery, Service Manager at Tracey.Montgomery@blaby.gov.uk or 0116 272 7685

Major improvements to hospital discharge in Leicestershire

Over the past 12 months, a number of actions and interventions have been implemented across Leicester, Leicestershire and Rutland (LLR) to focus on changing working practices and to reduce the number of delays in discharging patients from acute and community hospitals into the community. The following is a summary of the changes we have made:

- taking a 'home first' philosophy to all hospital discharges
- having a clear, consistent definition of 'medically fit for discharge' and 'ready for discharge' between agencies
- implementing an agreed minimum data set to achieve smooth and safe discharges between agencies
- simplifying discharge routes - we now have only five core pathways for discharge
- reviewing domiciliary (home care) packages, two weeks post discharge to ensure service users are receiving the right level of support to promote independence
- health and social care assessors working together to support patients who previously were transferred to a nursing home for a continuing health care assessment. These patients now go 'home first' and then receive their assessment following a short period of recovery
- integration of community nursing teams with adult social care teams in Leicestershire's localities. These teams provide case management and care planning to patients and service users including supporting their transfer back into community services after hospital discharge
- adult social care dedicated acute hospital sites team operate seven days a week
- hospital to home, a voluntary sector provided service supporting vulnerable people in transition from hospital to home, through practical and emotional support to avoid readmission to hospital (this contract has been extended to March 2017)
- dedicated housing support and expertise to enable effective discharge planning from acute settings such as the Leicester Royal Infirmary and the Bradgate Unit targeted to patients who need rapid support to resolve housing problems.

These changes have had a significant impact on our local performance resulting in Leicestershire achieving the required rate of improvement on delayed bed days per 100,000 population by June 2015, as measured in our Better Care Fund plan. This has been an important contribution in tackling the ongoing pressures affecting the performance of the Urgent Care system as a whole in LLR.

For more information contact Jackie L Wright, Head of Service - Promoting Independence at Jackie.Wright2@leics.gov.uk or 0116 3054979



Local Area Co-ordinators are now strengthening communities in Leicestershire

Eight Local Area Co-ordinators have been recruited across Blaby, Charnwood, Melton and Hinckley & Bosworth to help strengthen communities and reduce social isolation amongst the most vulnerable.

The aim of Local Area Co-ordination is to improve health and well-being and help prevent people from reaching crisis point - resulting in costly care and support services.

Here are some stories of how the Local Area Co-ordinators have already been helping in local communities.

Reducing loneliness:

Mrs S regularly contacted her GP and arranged home visits because she was lonely. The GP contacted the Local Area Co-ordinator, who arranged a visit to get to know Mrs S and find out about her hobbies, interests and who she had contact with.

Mrs S said that she loved to knit but would find it difficult to get involved in any local groups as she was worried about going on her own. The Local Area Co-ordinator found a local knitting group and arranged to take Mrs S along to the next meeting at the local library. She now regularly attends the group and really enjoys it. The group has allowed her to make some new friends who she regularly meets for coffee at other times of the week. Following the Local Area Co-ordinators work the GP has reported that she no longer requests home visits.

Reducing falls:

Mr K was introduced to his Local Area Co-ordinator through a lunch club. Whilst talking he mentioned to

the Local Area Co-ordinator that he was scared of falling over whilst having a bath due to his shower being broken. He said that he didn't have the energy to sort out different quotes and didn't want to have people he doesn't know in his home.

The Local Area Co-ordinator helped Mr K to get quotes and was present when the plumber visited to do the repair. Mr K said that he is now back to his old self and that he doesn't feel so fearful anymore. He continues to attend the lunch club and meet with his friends.

Improve Health and Well-being:

A village lunch club was finding it challenging to continue to offer meals on a weekly basis due to their cost. The meals came from 20 miles away in heat proof containers which made them costly due to transport and meant they weren't as fresh as they could be. The Local Area Co-ordinator spoke with a local retirement group. A member of the group had just retired from being a school cook and said she would happily cook once a week for the group. This has meant the meals are cheaper, as they no longer need to be transported, and they are fresher. The number of people using the lunch club has increased as a result of these improvements, meaning more people are receiving warm good quality food.

Simon Dalby
Local Area Co-ordination Manager
Leicestershire County Council
email: Simon.dalby@leics.gov.uk
Tel: 0116 3056650



Falls Prevention Workshop

At the beginning of October, a multidisciplinary group of professionals including geriatricians, therapists, commissioners and representation from the voluntary sector came together to look at what the Leicester, Leicestershire and Rutland (LLR) falls programme should consist of.

The workshop started with a presentation by Joyce, a patient referred to Ashby Falls Clinic who shared her experience of attending the six week falls prevention programme, a key part of the current LLR falls service. Prior to the course, Joyce found herself falling frequently and gradually heading towards being socially isolated as she feared leaving the house. The course gave her the confidence to start socialising again and she has been able to take up some of her hobbies again.

At the workshop attendees discussed the current pathway in LLR, some of the pressures and issues affecting the services, and where redesign work should be prioritised. As a result of the workshop three task and finish groups have been created to focus on the following:

1) A robust referral and triage process for fallers/those at risk of falling

This group will review and redesign the referrals and triage process across LLR to ensure that the patient is referred to the most appropriate service for their needs. Currently we have a falls clinic where patients are initially assessed, plus the option of the six week falls prevention programme provided by Leicestershire Partnership Trust (LPT). The group will also consider the introduction of an electronic referral form in order to improve the quality of the referrals process.

2) Directory of services

This piece of work will focus on consolidating and improving the directory of services information relating to falls across the whole LLR system to ensure ease of navigation according to patient need. The directory will detail all the supporting advice and information across agencies as well as the formal locality and district resources in place such as physical activity classes. This group will also review how the needs of people with dementia and learning disabilities are met.

3) Continuing Community Falls Prevention initiative

The continuing community falls prevention initiative will work with a cohort of patients who have completed the formal six weeks falls prevention programme provided by LPT and offer them an informal route for ongoing support. This is designed to further increase their core strength and balance, and provide some peer support and ongoing motivation within a community setting. Working in partnership with the third sector, a weekly exercise or social group will operate in the community for these patients. The group will also signpost individuals to consider the wider resources they need to proactively manage their own health and social care needs. Options such as a DVD specifically for frail older people to support them to continue exercising at home are also being explored.

The LLR falls work will require some in depth analysis of the capacity and demand for falls prevention services in the future. It is recognised that the referral clinic capacity and the locality based slots available on the formal six weeks programme provided by LPT, may be insufficient given the future demands of our ageing population. It will be important to understand the scope we have to achieve a greater level of impact on admissions avoidance due to falls, especially as approximately 4,000 people fall each year in Leicestershire.

For more information please contact Debbie Baker Price at Debbie.Baker-Price@leics.gov.uk or call 0116 305 0681 or Gemma Whysall at Gemma.Whysall@leics.gov.uk or call 0116 305 5673

Integrating care and health information across Leicester, Leicestershire and Rutland

NHS and local authority partners in LLR can now analyse the patient journeys being taken across the whole health and care system using data dashboards from 'Care and Health', our new integrated data tool from PI Ltd. Care and Health includes data from the ambulance service, local NHS provider Trusts such as Leicestershire Partnership Trust and University Hospitals of Leicester, and social services. The tool was launched 14 October 2015 at an event involving over 50 champions from partner organisations across LLR.

The tool will help us collectively understand how patients move across the health and care system, and will help us plan and measure the impact of important service improvements we are making within our LLR five year plan "Better Care Together".

Delegates at the event discussed what has already been achieved by sharing data in this way, the insights this data is already giving us, how to embed the dashboards into day to day working practice, as well as examining the current dashboards we have created and helping champions to push the boundaries even further using the tool.

For a detailed report on progress so far and feedback gathered at the launch event, visit www.lsr-online.org/launch-event---14-october-2015.html

Since the launch we have nominated some of the technical users of the tool in LLR to work alongside each of the workstreams in better care together so that they have dedicated support to develop dashboards that meet their specific needs and we are looking forward to embedding using the PI tool into the day to day work of our business intelligence teams across LLR. In 2016 we anticipate expanding the data sets available within the tool as part of the next phase of this development.

For more information please contact Carrie Pailthorpe, Lead Analyst for health and social care integration at Carrie.Pailthorpe@leics.gov.uk or call 0116 305 4260



Photos from the launch event

Integrated locality teams are now a reality in Leicestershire

Leicestershire County Council's adult social care staff and LPT's community services teams are making good progress in joint working in Leicestershire's localities following an intensive period of cultural and organisational development earlier in 2015.

Joint Multi-Disciplinary Team (MDT) meetings are now taking place monthly in all localities. Covering both community and hospital discharge cases and links with community hospitals continue to increase. Each locality also has a monthly joint meeting to review and build on their progress.

In Loughborough newly appointed workers are now spending time shadowing their health care colleagues as part of their induction.

We are seeing many benefits from joint working including:

- patients and carers benefitting from more seamless support across health and social care
- professionals working jointly and proactively to support vulnerable people and those with complex health and care needs
- reduced length of stay in hospital
- reduced duplication of work
- improved response to urgent cases.

Here's an extract from a recent letter from a community hospital ward manager to an adult social care locality manager:

"Thank you. I think we now have great, productive joint working which is actually fun! And I'm sure this is only the beginning. Our patients and services cannot help but benefit, but most of all it is only achieved by the individual's contribution and commitment. I just wanted you to know I do recognise that and appreciate yours'."

For more information contact Brian Jopling, Project Lead at jopling2@aol.com or call 07889 256265.

Integrating Leicester, Leicestershire and Rutland Points of Access

Across Leicester, Leicestershire and Rutland (LLR) we are working together to improve people's experiences of health and social care – whilst at the same time addressing major financial changes.

Better Care Together is the biggest ever review of health and social care in LLR. A key part of these changes will be ensuring patients and service users can easily access services.

Following a procurement process, we have now appointed a company to help us review the current way services are accessed, and suggest ways we could improve these in the future. 4OC is a company that specialises in organisational change. They have previously worked on many health and local government projects to design and manage the transformation of customer services. They have a specific aim of supporting organisations to get the best value from public money.

With the help of 4OC we are looking to develop new ways of working that will allow better access to health and social care for both professionals and service users.

The first part of 4OC's work involved them meeting staff from across health and social care to understand how service users currently contact organisations, and how these enquiries are handled. They also asked staff for their ideas on how changes could be made to improve customer service, as well as exploring the possible barriers with them.

Continued...

Over the coming months there will be an opportunity for all organisations involved in the project to take part in designing the new ways of working through a series of co-design workshops.

We will be providing regular updates on the progress of the project.

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

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