Integrated Locality Teams

Leicester, Leicestershire and Rutland

APPENDIX B

LLR Integrated Teams Programme Board Bulletin No. 4: May 2017

Welcome to the fourth edition of the Leicester, Leicestershire and Rutland (LLR) Integrated Locality Teams bulletin. This edition focuses on the decisions of the April Programme Board and key pieces of work completed over the last month.

Development of Integrated Locality Teams – how to guide

The 'how to guide' is currently being distributed through Integrated Locality Teams and GP practices.

Further work is continuing to develop the specific information needed by individual professionals e.g. concentrating on the roles/requirements of GPs, social care staff and community health service staff. This will also be shaped by the work in test beds across LLR.

Summary Care Record (SCR 2.1) and Integrated Care Planning

The Programme Board received an update from Clare Sherman (IM&T Lead - Leics City CCG) on Summary Care Records.

The three CCGs have successfully bid for funding under the Estates Technology Transformation Fund (ETTF). This will enable the delivery of shared records across LLR between health and social care colleagues.

The first stage is the implementation of the new Summary Care Record functionality (SCRv2.1) - this functionality allows additional information to be added to a patient's Summary Care Record, once patient consent is obtained.

A related piece of work is the new 'Integrated Care Plan' template which will allow clinicians to record consent and enter additional information for key areas such as Long Term Conditions and End of Life.

It is anticipated this work will allow faster access to information, along with quicker diagnosis and treatment for patients.

The programme will be completed in three phases:

Phase 1 - SCR 2.1 is being rolled out across LLR GP practices
- All SystmOne practice training will be completed by the end of April 2017
- EMIS practice training to be completed by mid-May 2017

Phase 2 - Provider services and secondary care - focuses on providers viewing the data captured by practices through the most appropriate tool

Phase 3 – Adult Social Care – the information shared will not allow for read and write functionality, but will enable colleagues to be able to view – this will be helpful for the work of ILT's

Test beds

The Programme Board were updated on the test bed proposals received and informed that some great ideas had been received.

The ILT test bed proposals will be signed off and monitored by each CCG's governance implementation group – the Programme Board will not approve these. Progress of the approved test beds will be monitored through reports at future Programme Boards.

Approved test beds	Scope	ILT/ CCG	Objectives
One Home One Practice and wrap around services for Care Homes	The focus cohort will be care home patients across both Oadby and Wigston. There is the potential for improvements in wrap around services and also an opportunity to explore a One Home One Practice model in Oadby. The aim of the project is as a locality to explore the adopting of a one home one GP practice model where feasible. In addition the team will look at the wrap around services in support of the care home and how the various teams can work smarter to improve not only the care given but also the working practices for the teams.	Oadby and Wigston - ELRCCG	The objective of the test bed is to understand and significantly improve the structure and access to health and social care services wrapped around care home patients. To restructure registration of care home patients to match one care home to one practice across the locality with the aim of standardising GP capacity for care home patients and approach to care plan management.
MDT working	The focus cohort will be care home patients across both Oadby and Wigston. There is the potential for improvements in MDT working. The aim of the project is as a locality, and initially as a locality team, to look at MDT working and how to integrate and facilitate care homes in MDT practice.	Oadby and Wigston – ELRCCG	The objective of the test bed is to understand and significantly improve the engagement and implementation in MDT working.
Wellness Advisors	The focus for this test bed will be patients who have registered or walk-in access to Rutland GP practices. The project will provide access to non-clinical help and advice / support services for these patients. The aim of the project is to test the model of embedded staff within a GP practice who provide help and support to patients who are in need of support but not necessarily of a clinical nature.	Rutland - ELRCCG	The objective of the test bed is to provide access to help and advice / support services for registered patients within GP practice.
Teleconference/ video conference MDT	The test bed will test primary care based Multi-disciplinary Team (MDT) meetings for risk stratified red/amber End of Life patients under the care of South Blaby practices. The focus cohorts will be: • Green, Amber and Red EoL patients • 3-5 patients monthly who community nurses are concerned about	Blaby and Lutterworth – ELRCCG	The objective is to improve attendance at complex care planning MDT meetings across the sub-locality, improving engagement in End of Life care planning, proactive care planning reviews and crisis management. These planned activities will enable other aspects of the EoL and Urgent Care system.

Structured intervention programme for high risk ILT patients	All practices in N&EL, Central and N&W HNN. The focus cohort will be high risk patients from within the Integrated Locality Teams cohort. Each Practice will be given an allocated number of such patients to proactively call in for care planning and discussion at MDT meetings during the course of the year. The components of this scheme are: *1.* Registration of the PIC GP patients on clinical system and flagging with a code as the intervention group. *2.* Discussion of patient's case at MDT *3.* Proactive invitation to patient (and carer if relevant) to attend for two proactively planned 20 minute appointments during the year for the purpose of care planning and self-management education discussions. *4.* Potential referral to one or more community services such as social care or mental health services or the lifestyle hub depending on the individual's goals.	• North & East Leicester – LCCCG • Central – LCCCG • North West - LCCCG	The objective of the test bed is to: • Create a template to be used on S1 to allow practices to deliver a structured programme of care • Deliver a personalised care plan for each patient on the scheme – a copy to be given to the patient and a copy stored in the clinical record for viewing by relevant personnel • Reduction in emergency attendances and admissions in the intervention group compared to CCG average and to patients previous utilisation • Reduction in average number of medicines prescribed in the intervention group compared to CCG average for this age group
Face to face MDT	The scope of this test bed is to test face to face MDTs through co-ordinating MDTs in practices in the two sub localities in N&EL.	North & East Leicester - LCCCG	The objective of the test bed is to develop an ILT by having face to face MDTs in practices to enhance patient care and prevent unnecessary admissions.
Proposal to test dedicated pharmacy team support for care homes	The focus will be selected Care Homes in NEL HNN. Selection will be based on intelligence from LC CCG Nursing Quality team or City Council Care Home Quality and Contracts Team. The plan is eventually to get to all Care Homes. The focus cohort will be high–risk patients living in identified intervention care homes identified via pharmacist reviews of care records. The second focus cohort will be all care home residents in selected care homes.	North East Leicester - LCCCG	The objective of the test bed is to: • Reduce medicines waste (and therefore cost and potential patient harm) in selected care homes • Reduce burden of polypharmacy in selected patients • Improve prescribing , dispensing and storage of medicines practice
Face to face MDTs	All practices in South HNN. The focus cohorts will be: • PIC GP patients • ILT cohort –	South Leicester – LCCCG	The objective of the test bed is through the South Integrated Teams Programme general practices, social care, acute and community teams will work with commissioners to introduce a new model of care focussing on four key areas:

	- Frailty - Having five or more chronic conditions - Predicted to spend three or more times the average in secondary care • Patients where intervention from ASC and LPT will be valuable • Likewise ASC/ LPT to identify patients who could value GP intervention The test bed will be coordinated through the two sub localities in South – *Meridian* and *Pasley Road*		1. Increasing prevention and self-management 2. Developing accessible and responsive unscheduled primary and community care 3. Developing extended primary and community teams 4. Securing specialist support in non-acute settings
Co-ordination of community care for frail patients discharged from UHL and Loughborough hospitals	The focus cohorts will be: • People with a frailty marker regardless of age • Adults with five or more long term conditions • Adults whose acute care costs are predicted to be three times the average over the next twelve months The project will involve introducing a Hospital Discharge Community Care Co-ordinator and a standard operating procedure to work to. Capacity will be created from existing LPT resources at the appropriate grade.	Charnwood - WLCCG	The objective of the test bed is to: • Develop co-ordinated care for the identified cohort of patients, post discharge from hospital. • Have joined up care for the patients, with clear lines of communication between GP, adult social care, community health and therapy teams. • Explore opportunities and benefits for new ways of working across a multi-disciplinary workforce.
Multidisciplinary 'Best Practice' working across three sub localities in Hinckley and Bosworth	The project will involve testing the benefits of holding quarterly 'Best Practice' meetings with health and social care to discuss case studies, to learn lessons, celebrate what's going well, share service updates and best practice. The focus cohorts will be patients/ service users who fall into a minimum of one of the three cohort's i.e. 1. People with a frailty marker regardless of age 2. Adults with five or more long term conditions 3. Adults whose acute care costs are predicted to be three times the average over the next twelve months	Hinckley and Bosworth - WLCCG	The objective of the test bed is to: • Understand the benefits of holding sub-locality MDTs • Understand what information is most helpful to share • Understand the best ways of sharing information across teams • Determine who needs to be part of a sub-locality MDT

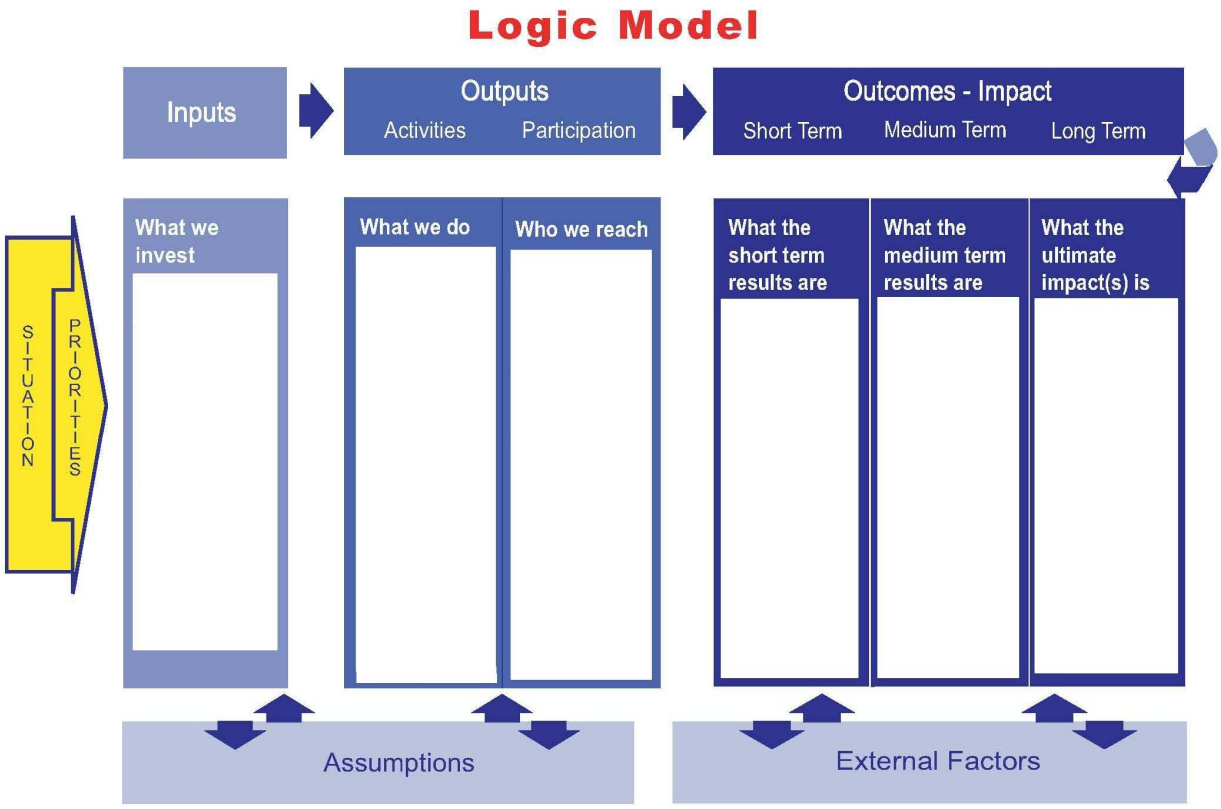
Practice pharmacist completing medication reviews for care home residents	The test bed will be tested with one GP practice and one care home in the first instance and use the learning to expand the PDSA to further care homes if successful. The focus cohort will be care home residents who fall into a minimum of one of the three cohort's i.e. 1. People with a frailty marker regardless of age 2. Adults with five or more long term conditions 3. Adults whose acute care costs are predicted to be three times the average over the next twelve months	Hinckley and Bosworth – WLCCG	The objective of the test bed is to test the feasibility of a practice pharmacist undertaking medication reviews for residents in a care home.
Locality multi-disciplinary networking	Locality level multi-disciplinary networking to involve all ILT care partners. The scheduled monthly NWL Federated Locality Meetings will be re-structured with one hour of the meeting being dedicated to Integrated Teams to offer an opportunity for networking and improvement. Feedback from all multi-disciplinary partners indicated that the most useful part of previous "MDT meetings" and larger group discussions was that they enabled communication and relationship building which, in turn, highlighted and spread good practice and enhanced understanding of what services and/or interventions were available – all improving patient outcomes and experience.	North West Leicestershire - WLCCG	The objective of the test bed is to: • Improve and focus communications and working relationships between all ILT care partners • Increase awareness and understanding of care partners across all ILT care partners • Generate inclusively agreed ideas/topics for further test bed PDSAs

Logic Model

A logic model has been developed to describe the Integrated Locality Team programme's inputs, outputs, outcomes, assumptions and interdependencies.

Logic models are a useful, graphical, way to summarise the relationships between the different components of a programme. They help to explain the 'theory of change' or in other words, how the 'intervention' will lead to the intended outcomes.

Logic models come in many shapes and sizes - below is an example logic model template. It is a live document/framework and will be updated as we learn more from the pilot teams



Each test bed will be asked to develop its own logic model to enable the programme to monitor the interventions and outcomes, and take a consistent approach to overall programme performance.

QIPP

Gill Killbery provided an update to the Programme Board on the QIPP savings. An STP level review of the QIPP is currently being completed – an updated QIPP for ILT's will be presented to the next Programme Board.

Memorandum of Understanding (MoU)

A draft MoU has been developed to help facilitate the work of ILT's. The Programme Board have been asked to review and comment on the document. Programme board will consider all feedback received at the May Board. The outcome will inform a paper to SLT in due course.

Implementation Plan

An implementation plan has been finalised at LLR level for the Integrated Locality Team's programme, which details key milestones across 2017/18. This is also designed to help inform the development of local implementation plans across each CCG footprint.

For more information about the development of Integrated Locality Teams in LLR visit our webpages:

www.healthandcareleicestershire.co.uk/health-and-care-integration/integrated-locality-teams/

To find out about the local arrangements and work in progress in your area please contact the relevant CCG implementation lead in the first instance:

- **West Leicestershire** (Charnwood, NW Leicestershire and Hinckley and Bosworth) – Arlene.Neville@westleicestershireccg.nhs.uk
- **East Leicestershire and Rutland** (Melton/Rutland/Harborough, Oadby and Wigston, Blaby and Lutterworth) - Paula.Vaughan@EastLeicestershireandRutlandccg.nhs.uk
- **Leicester City** – Rachana.Vyas@leicestercityccg.nhs.uk

If you have any feedback about this edition of the bulletin, or suggestions for future bulletins, please contact our communications lead sally.kilbourne@leics.gov.uk.

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