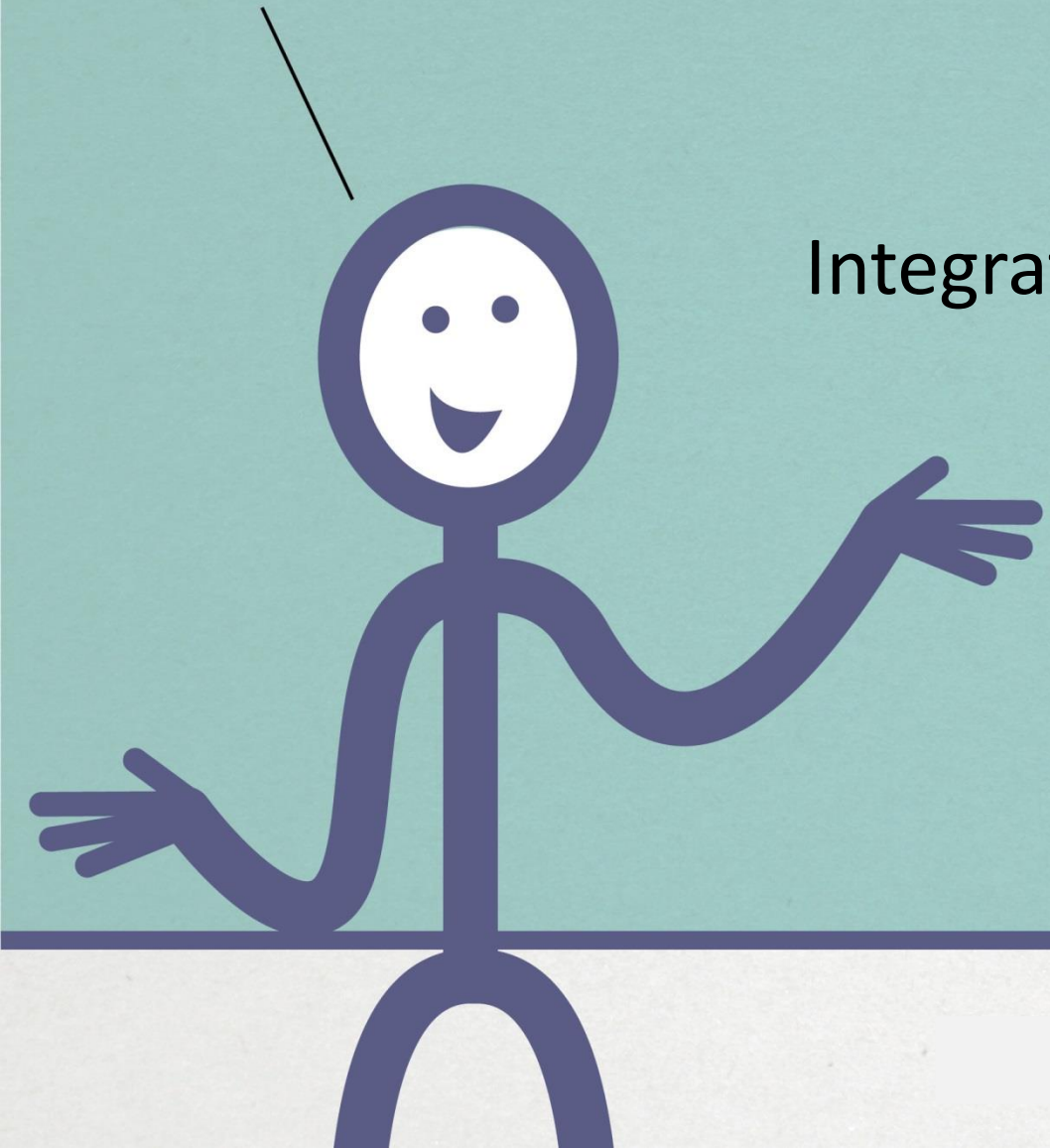
'It's about our life, our health, our care, our family and our community'

Better care together

Leicester, Leicestershire & Rutland health and social care



Integrated Neighbourhood Teams

Leicestershire HWB

November 2015

Rutland County Council

Leicester City Council

Leicestershire County Council

NHS

Better care together
Leicester, Leicestershire & Rutland health and social care

Presentation content:

- National and local vision for integrated teams
- Progress towards delivery
- Leicestershire teams model – what, how and when
- Next steps for development plan

Rutland County Council healthwatch Leicester City Council Leicestershire County Council NHS

NHS Long Term Plan – Integrated Community Care

- ‘With primary care networks as their cornerstone, bring together community, social, secondary care, mental health, voluntary and wider services to provide proactive and integrated care to local communities which keeps people well and out of hospital.’
- ‘New investment will fund *expanded community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices’*
- ‘The result will be the creation – for the first time since the NHS was set up in 1948 – of fully integrated community-based health care.’

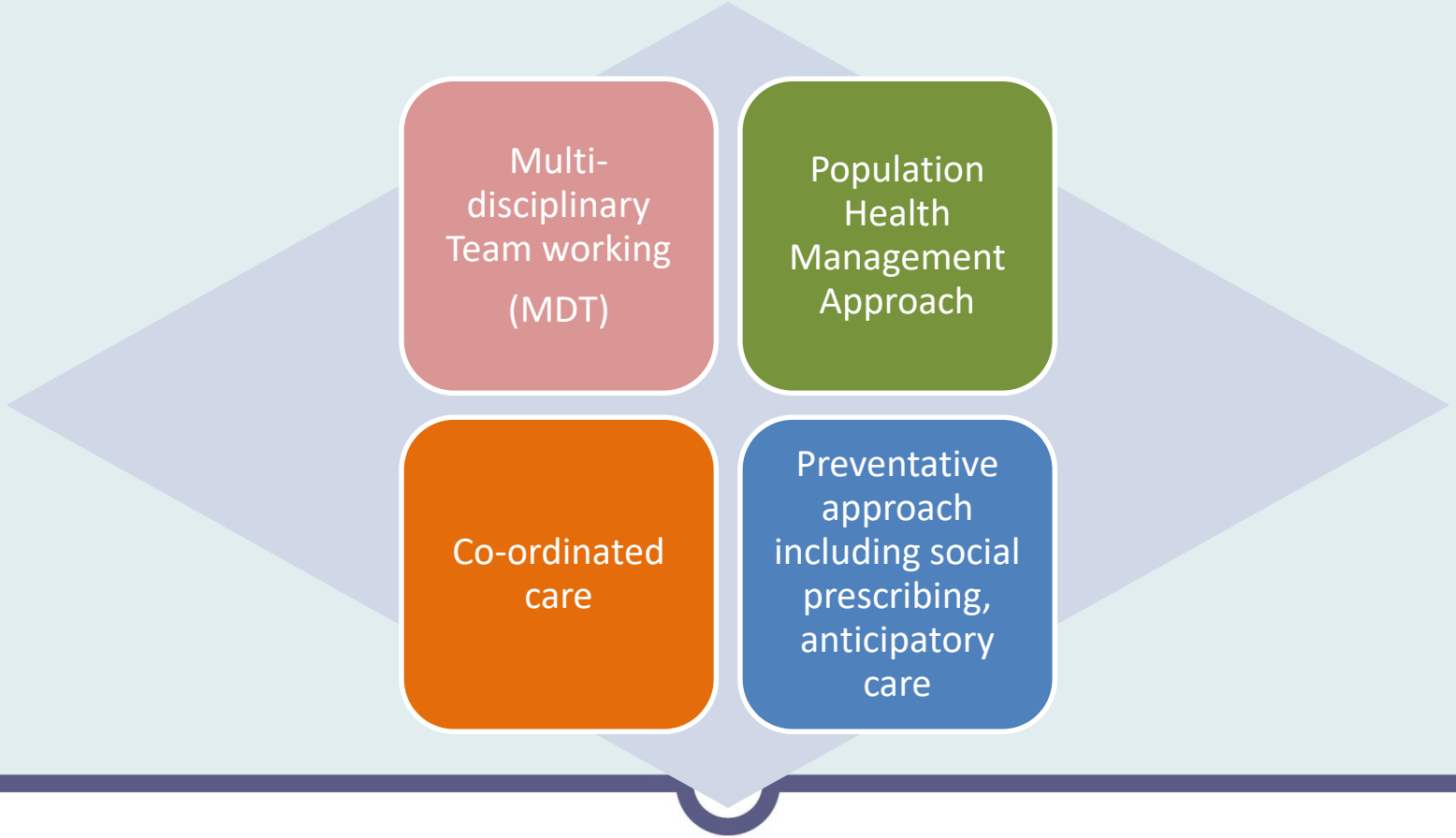
The Integrated Team

Core Team consisting of;

- GP and practice team
- Community Matron
- Senior Nurse Complex Needs
- Adult Social Care
- Therapy Lead
- Local Area Coordinator
- Care Coordinator

Care-co-ordinator links with other care professionals depending on patient need

Neighbourhood Teams – what do they do?



The LLR Vision for Integrated Teams

We will develop health and social care teams, supported by specialists and the voluntary and community sector, clustered around groups of general practices within identified placed based communities.

The teams aim to improve health outcomes and wellbeing, increase our citizens', clinician and staff satisfaction and at the same time moderate the cost of delivering that care.

Progress towards implementation

- Integrated Locality Teams have been in place in LLR since 2018, meeting regularly
- Community Services Redesign aligns community health teams around primary care networks at neighbourhood level
- Supported and evaluated three Early Implementers of integrated neighbourhood MDTs
- Teams are receiving risk stratification data to support a population health management approach
- Care co-ordination in place in each CCG, different models
- PCNs recruiting social prescribing staff to support prevention offer

The future look of Community Health Services

Centred around your needs

Locality Decision Units

Health and care teams working together to decide on the right personalised care of patients together with patients and their family carers.

Hospital Discharge Teams

Integrated Neighbourhood Team

- Manage the majority of care of patients in the community.
- Community nursing would work in the team alongside staff from social care and primary care neighbourhoods (groups of GP practices with between 30,000 – 50,000 patients).

Home First

- Integrated Health & Social Care Crisis Response and Reablement Services
- Deliver intensive, short term care for up to six weeks.
- Health and social care services will assess need and deliver co-ordinated packages of care.

Community Bed Based Care

Delivered:

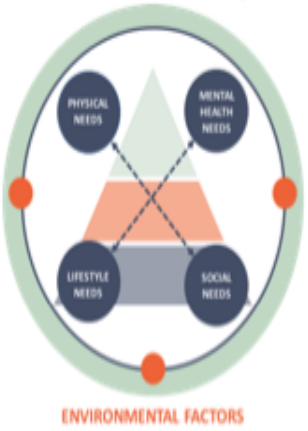
- In community hospitals for patients requiring medical rehabilitation needing significant 24/7 nursing care and on-site therapies.
- In reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support.

Population Health Management Approach

Collection of health data and other data about the population

Population health assessment and interpretation of outputs using the Johns Hopkins ACG System and other available data

Risk stratification and segmentation of population according to needs



Review of risk factors, social determinants, and health needs for each targeted segment

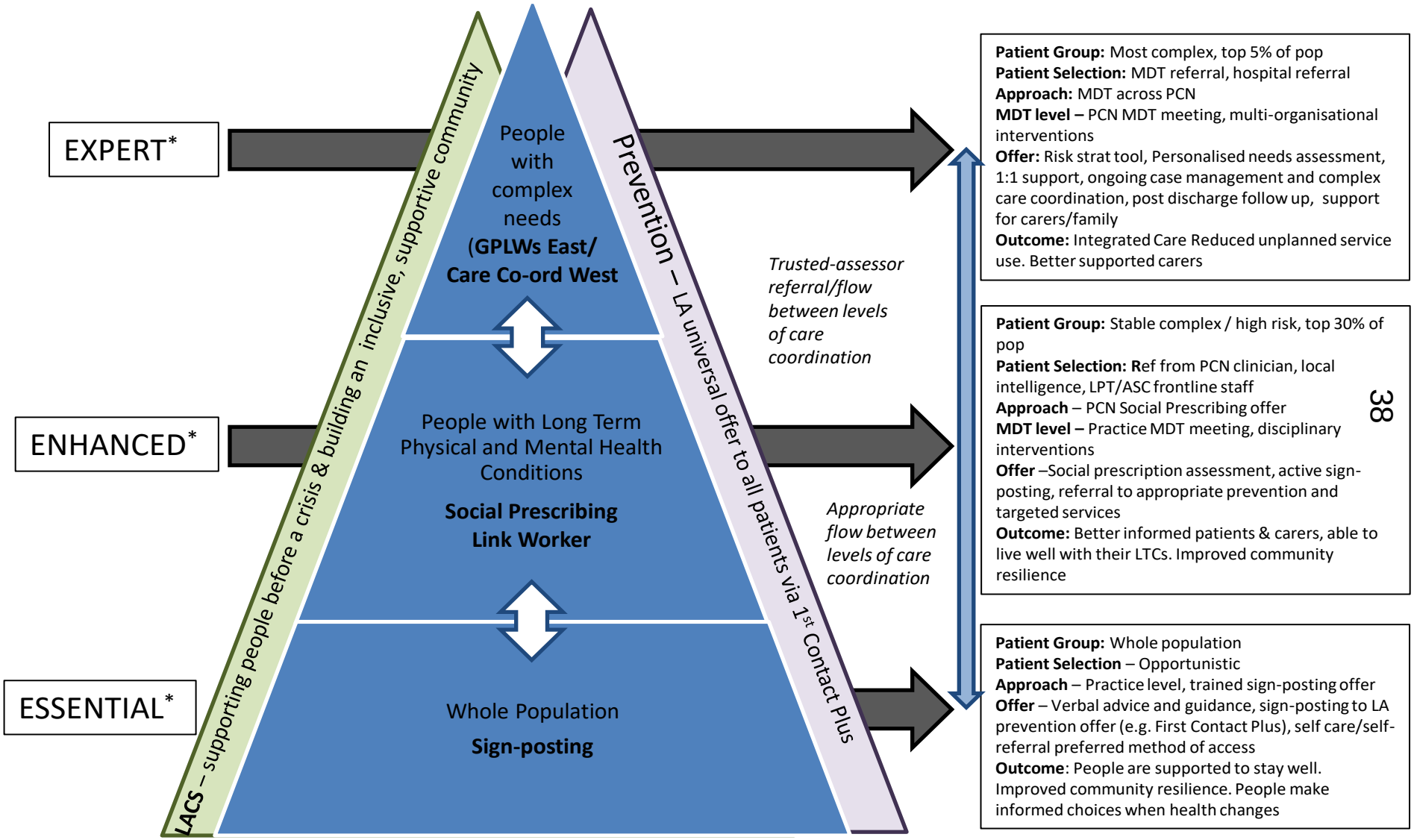
Development of primary, secondary, and tertiary population health interventions within health system context

Implementation and ongoing engagement with stakeholders

Monitoring and outcomes reporting for management and continuous quality improvement

Evaluation of data and application of lessons learned

Place Based Model for the Function of Care Coordination within PCN/Neighbourhood Teams



*HEE Care Navigation Competency framework

Case Study: Reducing Readmissions

Care co-ordinator contacting patients after discharge

Outcomes: People are supported to live as independently as possible at home and to return home quickly and safely, after a hospital admission

- 84% of patients contacted within 48hrs after discharge
- A 10% reduction in readmissions within 30 days of discharge
- Reduced GP contacts for patients on Care Coordinators caseload
- Increased referrals into non clinical services (LACs, First Contact Plus, local befriending services

Co-ordinated care – Good news for people, families and their carers

"It was very helpful that we received a phone call after my Mother was discharged from hospital, which gave us a contact for any further help we needed" ***–Family Member***

"I was worried about a blood test booked at Rosebery. I did not feel well enough to go on my own and it would have meant a taxi both ways. Eventually a nurse came to my bungalow instead. Thank you" ***–B. 90yrs***

"Help received when Sharon rang was fantastic from contacting Social Services for my Dad, to ringing the ward and supporting my Mum and was still in touch several weeks later. I even spoke with Sharon late in the evening for advice; nothing was too much trouble for her. This service is brilliant." ***–Family Member***

	Key Milestones		
Sep-19	Create an understanding of INT expectations in LTP		
	Understand the journey so far from ILT's		
	Hold an engagement event with partners to help shape the plan		
	Establish Best Practice for 4 building Blocks		
	Configured LPT nursing and therapy service provision around PCN's		
Oct-19	Develop an Implementation Framework		
	Develop an Outcomes Framework		
	Develop a clear ask of PCN's – how do they fit within and INT?		
	Engage with ILT's – how do they see the future?		
	Agree Care Coordination Model		
	Start to implement plan for Care Coordination Model (West)		
	Organisational Development Plan designed and agreed		
Nov-19	Partial transition of ILTs to INT's		Delivery of comprehensive OD programme to increase capacity and capability in Accountable Clinical Directors and PCN teams
	Describe the Ask of PCN's for 2020/21		
	Develop a single "checklist"		
	Mapping of primary care services commissioned across LLR		
Dec-19	Building INT infastructure at neighbourhood level	Understand and improve care planning across LLR	
	Design and test PCN Population Health Information packs		
	PCN's to have drafted neighbourhood plans		
	Home First goes live across LLR		
	Design PCN Intelligence packs that supports ACD to understand their population needs		
	Develop a MDT (meeting) – Best practice guide		
	Identify the cohort – Targeted proactive approach		
Jan-19	Design a LLR Primary Care Commissioning Intentions Plan – supporting GP's to deliver Integrated Care		
	All PCN's to have Social Prescribers in place		
	Implement the PCN Intelligence packs systematically across LLR		
Feb-20	Understand IG / Data sharing issues		
	Agree an LLR Primary Care Commissioning Intentions Plan		
Mar-20	New PCN Specifications to be launched		
	Develop comms plan for Primary Care around new commissioning intentions		
	Support PCN's to deliver new service specifications		
Apr-20	Revise LPT Community Specification		

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