Lincolnshire Health and Care
Shaping services to meet your needs into the future

Neighbourhood Teams

Health Scrutiny Committee

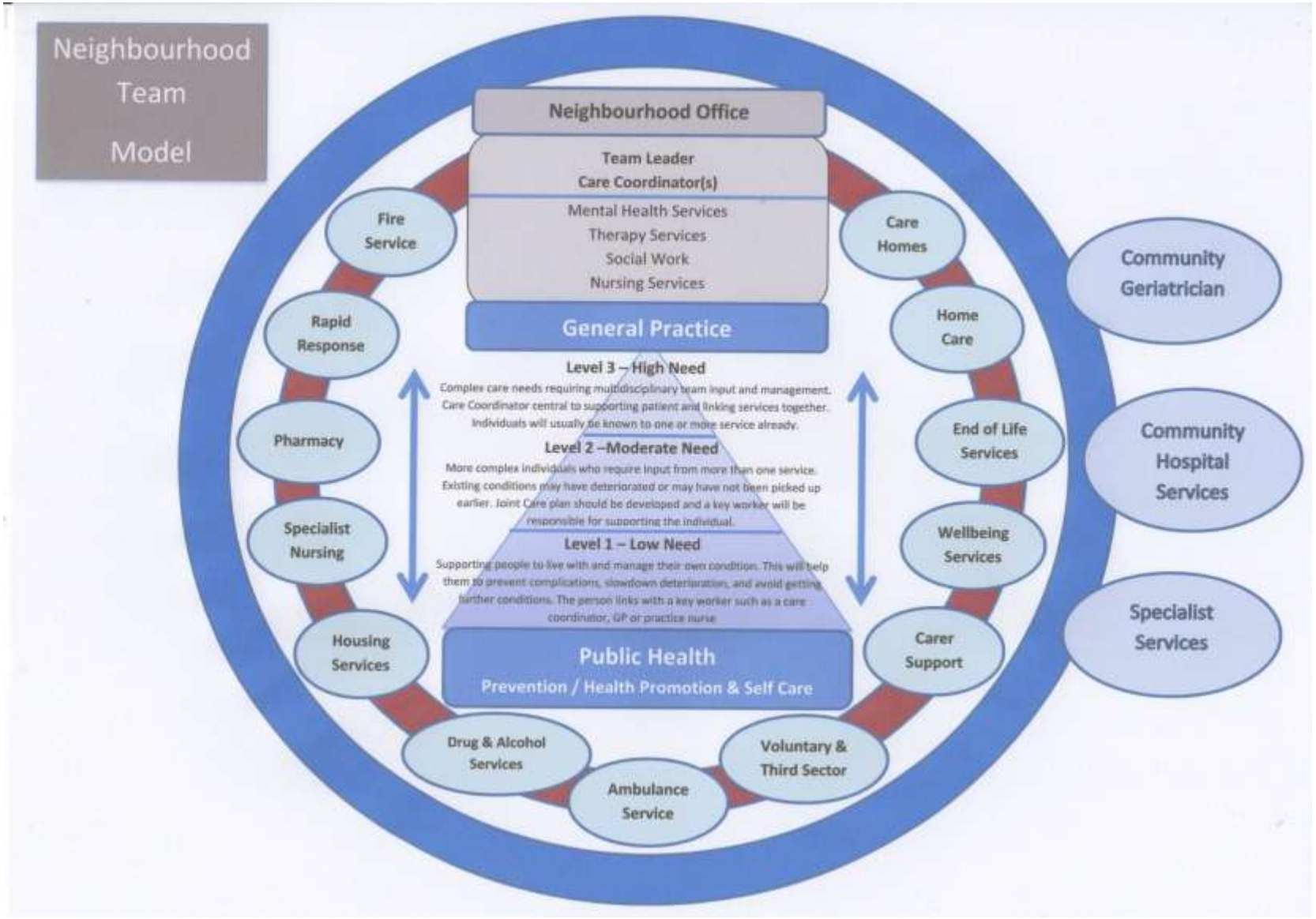
11th June 2015

Tony Hill

Background

- There are a number of challenges facing Lincolnshire, including **an aging population with increasingly complex needs and great financial pressures**.
- The current system of health and social care in Lincolnshire **is not sustainable**.
- It is common for those admitted to hospital to report having **bad experiences** due to the **high demand, stretched resources and low number of step up and step down beds available**.
- Support in the community is currently **fragmented** due to organisations **working in silo**.

The Solution



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Neighbourhood Teams and wider services

Self care: Guiding principles for supporting people to self-care, self-manage, lead healthy lifestyles and be supported, valued carers are that-

The **community is the heart** of the neighbourhood team

The community are equal partners in changing behaviours, building resilience and providing mutual support.

Staff involved in neighbourhood teams have an equal journey in changing behaviours, building resilience and providing mutual support to each other.

The approach involves all ages and is not just focused on people already receiving health or care services

This builds on the assets (social as well as physical) that already exist in the community

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At present Neighbourhood Teams are established in:

- Skegness
- East Lindsey Coastal
- Sleaford
- Grantham Town and Grantham Rural
- Stamford
- Long Sutton/Sutton Bridge
- Lincoln City South
- Lincoln North

Current proposals are for there to be 12 Neighbourhood Teams across the county by September 2015.

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Benefits

For individuals:

- Patients will only have to tell their story once to gain access to all of the services that they need
- More personalised and less fragmented treatment
- Treated proactively in their locality thus avoiding an admission to hospital
- Discharged earlier from care where a hospital stay has taken place and looked after in their community
- Supported to remain well, independent and safely at home
- Improved patient/service user experience

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Benefits

For Staff:

- Eliminating day-to-day frustrations caused by multi professional liaison
- Delivering improved clinical reasoning and effectiveness
- Cases of more vulnerable patients are better tracked and actions are more coordinated
- Professionals better understand each others pressures and can support each other appropriately
- Information is exchanged in a more joined up way and more quickly
- Integrated workforce plan designed to deliver service strategies
- Fewer barriers to effective decision making

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Benefits

For Organisations:

- Proactive care in the community and an increased focus on prevention will reduce demand on higher cost services
- Reduction in hospital admissions and delayed discharges saving money to the health economy
- Providing a mechanism for health and care organisations to pool resources
- Development of strong relationships between organisations
- Making better use of community assets
- Reducing waste in the system through eliminating the amount of duplication
- Sustainability

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How do we measure our success?

- Measuring the outcomes of integrated care schemes and new ways of working is crucial to be able to understand what is working well locally and what needs to change
- **We need to understand**
  - The sources of need and demand for care and support in each NT, and which sections of the population are at high risk of hospital admissions
  - The potential impact of delivering integrated care through NTs, in terms of changes in activity levels and the consequential quality and financial impact
  - How outcomes data will be used as part of management, oversight and governance structures to track impact across the system
- **The BCF metrics** (% to be confirmed in September)
  - **Improved patient experience**
  - **Reduction in urgent admissions**
  - **Delayed transfers of care**
  - **Reduction in residential & nursing placements**
  - **Reduction in 91 day readmissions (as an indicator of successful reablement)**
  - **Reduction in 30 day intermediate care beds**
- **Other process outcomes**
  - As with all new interventions it will also be important to measure a number of indicators which evaluate process improvements
  - During the LHAC process a framework was discussed and a number of sample metrics proposed

What does this mean to patients?

David and his wife and carer, Susan

- David and Susan live near Stamford.
- David has hearing problems, a chronic breathing disorder and mental health issues, including depression.
- He frequently falls and Susan has to call 999 for help.

- David's GP highlights his situation to his Neighbourhood Team Care Co-ordinator and they agree to review it in more detail at an MDT Meeting.

NTs making a difference for David and Susan

- The **Care Coordinator will work with David and Susan** to look at how best to keep David safe and reduce his risk of falls, helping to reduce hospital admissions
- David is showing early signs of dementia, so **the Team refer him to Alzheimer's Society** for extra support
- **Lincolnshire Adult Social Care review David's care plan** and look into arranging personal and domestic care, which will in turn support Susan too
- An emergency carer's plan is put together to support Susan if David does have to go into hospital
- The **Social Care Team** help to set-up a personal budget to help David and Susan find suitable and enjoyable daytime activities

These actions and the benefits for David and Susan are developed and managed through the coordinated approach taken by the Neighbourhood Team.

Shahana and her husband, Amir

- Amir was 78 in March and is the main carer for his wife Shahana, aged 75, and they live in Grantham
- Shahana has Type 1 diabetes and Parkinson's; she has had recent hypo attacks and has been admitted into A&E three times in the last six weeks.
- Amir is partially sighted in one eye.

- Health and care professionals from the Grantham Neighbourhood Team met following Shahana's most recent admission into hospital.

NTs making a difference for Shahana and Amir

- The **specialist diabetes nurse** has set up a short series of home visits to advise Shahana on her insulin regime and diet, and these visits will include Amir so he knows what to watch out for.
- The **Grantham branch of Parkinson's UK and specialist Parkinson's nurse** will work with Shahana to support her further
- The **Social Care Team** have worked with the couple to provide support with transport and home care when needed
- **Amir has received support** so that he can keep up to date with his eye examinations and update his glasses
- A **carer plan has been agreed with Amir** so he knows what to do and who to call when he needs additional help to care for Shahana.

This joined up approach across the Neighbourhood has helped:

- Shahana to better manage her diabetes day-to-day.
- reduced the number of inappropriate A&E admissions, and made savings to the health economy.

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Developing a community based approach to Self Care

To realise the full ambition of LHAC to deliver Self Care and Carers' Support, the integration and collaboration with voluntary and community sector organisations and groups is essential, with active community participation throughout.

The guiding principles for supporting people to self care, lead healthy lifestyles and be supported, valued carers are:

- The community are engaged and empowered to become active partners at the heart of NTs
- Community organisations are equal partners in LHAC
- NTs are facilitated by wider community partners to provide services and support to people of all ages, and not just focused on patients/users already in receipt of health and care services
- A NT model which builds on the assets, whatever they might be, that already exist in the community and infrastructures and networks already developed or commissioned within the voluntary sector or district/parish council level
- Develop a recognised organisationally agnostic brand (brokerage service) for Self care support understood by the public and professionals