Community Committee

Leeds CITY COUNCIL

Report of: Shona McFarlane, Chief Officer Access & Care Delivery, Adult Social Care

Report to: Outer West Community Committee, Calverley & Farsley, Farnley & Wortley, Pudsey

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Date: 15 June 2016 **To note**

Outer West Community Committee Briefing Neighbourhood Teams – June 2016

1. Purpose of report

1.1. This report highlights steps taken to provide an integrated service for District Nursing, Community Matrons, Intermediate Care Services and area-based Social Work which formerly operated operated to geographical populations with therapy services spread across intermediate care and domiciliary physiotherapy.

2. Leeds Neighbourhood Model

2.1. The reasons for integrating are well documented:

- Better joined up care for the Citizens of Leeds
- A reduction in unplanned admissions into acute care
- Smoother discharge pathways
- Supporting people for longer in a community setting
- Government policy including The Care Act

3. Previous model

3.1. Formerly separate, citywide services such as District Nursing, Community Matrons, Intermediate Care Services and area-based Social Work operated to geographical

populations with therapy services spread across intermediate care and domiciliary physiotherapy.

4. Main issues

4.1. What does the Leeds model look like today?

4.1.1. Adult services are now organised on a neighbourhood level working together in teams of Community Nursing, Community Therapy & Social Work known as "Neighbourhood Teams".

4.1.2. There is one single point of access into the system and the 13 Neighbourhood Teams wrap around the GP practices they support.

4.1.3. The Neighbourhood Teams link with other specialist services brought into the local community e.g. Reablement, Geriatrician, Mental Health Liaison, Memory Support & Carers Support.

4.1.4. Teams work closely with family, friends, carers & other support networks, community, voluntary and 3rd sector organisations and with other Health & Social Care providers/partners.

4.2. What is working well?

4.2.1. There is an understanding and recognition that the issues are broader than just physical health and are based on a range of factors including choices, opportunities and aspirations all of which must be addressed to deliver improved health and wellbeing.

4.2.2. The teams adopt case management principles to integrate services around the needs of individuals and citizens benefit from a targeted, community-based approach to care that involves assessment, care planning, care co-ordination and review.

4.2.3. Monthly multi-disciplinary meetings are well established and attended by wide range of professionals including voluntary sector and both staff and service users have been involved in building and shaping the service model.

4.2.4. These services are beginning to embed within natural community settings and deliver a personalised approach based around the way people want to live their lives.

4.2.5. From the very beginning relationships have been built with community groups e.g. neighbourhood networks and liaison roles facilitate improved understanding and engagement.

4.2.6. The Neighbourhood Teams are developing strong links with New Wortley Community Centre and Mental Health Staff from Leeds & York Partnership Foundation Trust (LYPFT). New Wortley Community Centre has been a starting point with its café, room booking, housing drop in's and new building.

4.2.7. Good relationships also exist with Pudsey Live at Home, Bramley Elderly Action, Farsley Live at Home and the GP Practices in Pudsey.

4.3. **Continuing to develop the model**

4.3.1. As the new processes are further tested and developed there are a number of things that all teams will continue to work on to support effective partnership working, including:

- Continuing to develop close working relationships with GP practices
- Strengthening case management meetings
- Building stronger links with Area and Citywide teams
- Developing an asset-based community focus
- Exploring New Models of Care

5. Benefits - Individual Outcomes

- Connection to community groups reduces social isolation
- Restored confidence of carer and individual in care team
- Improved diet and nutrition
- Addressed personal safety concerns
- Increased independence
- Improved home environment

6. Benefits – Clinical Outcomes

- Reduced dependency/full withdrawal of/changes to appropriate medication
- Regular monitoring and review enabling early intervention
- Fewer GP or community matron visits
- Fewer hospital admissions
- Prevented long term care admission
- Appropriate dementia support in place

7. Conclusion

7.1. A period of consolidation will enhance relationships within teams as the services continue to grow together and the development of a Neighbourhood Leadership Community will help provide strategic direction.

7.2. Work will continue with primary care and mental health services and the development of a shared performance culture and a service specification for neighbourhood teams and will help drive the improvement of patient outcomes.

7.3. Social Care intervention brokered by health colleagues will allow services to be put in place to support independence rather than to reactively manage emergencies.

7.4. Better and more systematic use of third sector and community services will continue to sustain independence and promote an asset-based approach.

8. Recommendations

8.1. That Elected Members note the above update

8.2. That Elected Members note the desire to return to the Community Committee Chairs Forum in July with a summary of this round of updates and also a proposal to open discussions about the possibility of holding Integration Workshops involving members, citizens, health and adult social care professionals, volunteer and third sector representatives and other partners.