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Report of Director of Adult Social Services and Chief Executive Officer Leeds Community Healthcare NHS Trust

Report to Scrutiny Committee

Date: 28 March 2017

Subject: Integrated Health and Social Care Teams

Are specific electoral wards affected? If yes, name(s) of ward(s):	☐ Yes ☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes ☐ No
Is the decision eligible for call-in?	☐ Yes ☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes ☒ No

Summary of main issues

1. Significant progress has been made in developing cohesive neighbourhood teams. Health and social care staff are co-located, supporting strong working relationships which in results in more cohesive care management for people with both health and social care needs.
2. There is no plan to integrate structures or management across Adult Social Care and Leeds Community Healthcare NHS Trust as part of the development of neighbourhood teams. The focus going forwards is on team members building effective working relationships with other organisations in the neighbourhood and strengthening ties with local communities.
3. Further benefits can be achieved by adopting an integrated approach to culture change with a place based approach in moving from ‘doing to’ to ‘working with’ approaches. A consistent model of service delivery including strengths based social care, health coaching and supported self-management will set new expectations of health and social care services.

Recommendations

1. Note the progress since the report to Scrutiny Committee in July 2015.

2. Support the aspiration to build effective working relationships between neighbourhood teams and local communities, noting the progress made in innovators such as Armley.
3. Support the shift to ‘working with ‘ approaches which provide individuals with the tools to take control of their health and support needs, reducing reliance on statutory services and increasing early, proactive support.

1. Purpose of this report

1.1 This report serves as a progress update to Scrutiny Board (Adult Social Services, Public Health, NHS) on partnership working in neighbourhood health and social care teams.

2. Background information

2.1 Adult Social Care and Leeds Community Healthcare NHS trust (LCH) brought a report to Scrutiny Committee in July 2015. This detailed the work that had been progressed between 2012 and 2015 to establish teams of health and social care professionals who supported the same population, on a local neighbourhood basis.

2.2 At the time there were a number of outstanding actions that needed to be undertaken to fully embed teams in local communities and ensure citizens benefitted from this new approach. Some of these actions were practical tasks around ensuring staff were co-located together whilst others focused on building a shared culture and establishing positive local working arrangements.

2.3 A further update in the form of a Members' Briefing was circulated in December 2015. At the request of Scrutiny Committee this provided more detail on the current position within each neighbourhood team together with a Citywide update.

2.4 In the July 2015 report a number of actions were detailed that had been agreed by the Programme Board:

- Refine the vision and required outcomes based on current evidence and thinking. Define a clear vision and required outcomes.
- Define and implement a clear performance management framework against which teams can be measured (singly by organisation and as a joint service).
- Implement a clear and consistent model across Leeds, learning from the best, that defines 'what good looks like' in a neighbourhood team, that is also flexible enough to be responsive to local needs.
- Enable positive and proactive leadership at every level to achieve shared objectives.
- Continued engagement with customers to ensure their needs are at the heart of everything the neighbourhood teams do.
- Consideration of how to better engage with other partners – including GPs, mental health services, neighbourhood networks and other voluntary and community groups.

2.5 Progress around these actions is detailed briefly in section 3.

2.6 In the July Scrutiny Board Members also heard about plans to develop New Models of Care which further developed the idea of integrated working and moved towards a 'population health management' model. In this model people are increasingly managed within their own community by a team that knows them and knows the services available locally, with specialist help brought in as needed. Early implementers are now starting to test out some of these ideas in communities in Leeds. This will be discussed in section 3.

3. Main issues

3.1 Refine the vision and required outcomes based on current evidence and thinking. Define a clear vision and required outcomes.

3.1.1 In the intervening time since July 2015 the health and social care landscape has changed again with the requirement to develop a Sustainability and Transformation Plan (STP) for West Yorkshire and a Leeds Plan for the City. The neighbourhood teams have been used as a footprint for the development of local community health and social care services.

3.1.2 Leaders have also taken this opportunity to reinforce the importance of working together on shared cases as a means for strengthening the work happening across the City. This in turn would provide strong foundations on which to build new models of care delivery.

3.2 Implement a clear and consistent model across Leeds, learning from the best, that defines 'what good looks like' in a neighbourhood team, that is also flexible enough to be responsive to local needs.

3.2.1 Teams established 'share and learn' events across neighbourhood team members and GP practice staff. These events were organised quarterly and allowed members of the multi-disciplinary teams to come together and share what was working well. These sessions predominantly focused on case management. They have proved successful and have been continued into 2017.

3.2.2 Each neighbourhood team developed local agreements with individual GP practices within their neighbourhood. These agreements followed a standard template but enabled practices to shape their preferred means of engagement with their neighbourhood team taking account local variations in practice and population.

3.2.3 Work has been undertaken on developing electronic tools which aid communication between teams and GP practices to improve patient care. This includes development of shared templates on the NHS case management systems and circulation of cases for discussion at multi-disciplinary meetings in advance of meetings so that practices can prioritise resource to appropriate meetings.

3.2.4 This approach is now being taken further in Crossgates and Beeston as part of the New Models of Care work. The people with the most complex health needs are being proactively case managed by a multi-disciplinary team to identify how best to support them in managing their own condition and to reduce unplanned use of acute care services. One important element of this model is making connections with local community groups and services and tackling issues of social isolation in this population.

3.3 Define and implement a clear performance management framework against which teams can be measured (singly by organisation and as a joint service).

3.3.1 South and East CCG have developed a clear service specification for the LCH elements of the neighbourhood team underpinned by performance measures.

Work was undertaken to scope a 'balanced scorecard' for the neighbourhood team but this proved harder to achieve as many of the system level outcomes involve more partners than Adult Social Care and LCH. Work continues to identify the most appropriate performance measures which will reflect activity of the teams.

3.4 **Enable positive and proactive leadership at every level to achieve shared objectives**.

3.4.1 Regular meetings of local health and social care managers were established to agree local priorities and develop action plans to tackle these together. They were supported by a group of more senior operational managers who brought issues to a Citywide forum to ensure learning was shared and problems tackled once.

3.4.2 With the aspiration to work differently and start to develop New Models of Care West CCG worked with key people within the Armley neighbourhood to develop the idea of local health and social care leadership teams who could come together to find solutions for the particular challenges of the neighbourhood. The Armley Leadership team – now called the Armley Community Wellbeing Leadership Group – brings together representatives from Adult Social Care, Public Health, Housing, primary care and the mental health and community trusts with members of local voluntary and community groups and Cllr Lowe. The group is tasked with looking at ways of working together differently to tackle health and social care issues that all agree are an issue in their community. In Armley the group has agreed an initial focus on mental health issues. This model is being used as a blueprint for other areas and work is now underway to establish a leadership team in the Aire Valley part of the Yeadon neighbourhood.

3.5 Continued engagement with customers to ensure their needs are at the heart of everything the neighbourhood teams do.

3.5.1 Engagement continues on a one to one level. The multi-disciplinary approach means that people have to repeat their story less. Improved knowledge of one another's roles means that frontline staff can quickly recognise when a customer would benefit from the input of a colleague. Questionnaires and 'friends and family' test are used to check current levels of customer satisfaction.

3.5.2 Neighbourhood teams regularly capture case studies that demonstrate how they work together and how multi-disciplinary meetings and joined up case management benefits individuals, delivering positive outcomes. An anonymised example of a case is included at appendix one.

3.6 Consideration of how to better engage with other partners – including GPs, mental health services, neighbourhood networks and other voluntary and community groups.

3.6.1 The work described in 3.2 has seen increasingly strong partnerships developed between neighbourhood teams and GP practices.

3.6.2 Neighbourhood teams have benefitted from access to mental health liaison workers and memory support workers who have proved to be very valuable members of the team.

3.6.3 One of the strengths of the work in Armley has been the engagement of the neighbourhood team with other support services and community groups. A number of workshops were held to engage with local providers and the community wellbeing group are taking a broad view on health to ensure that groups and services not necessarily engaged in delivery of health and care services are engaged in helping to find solutions to local challenges.

3.6.4 Other initiatives that have been running in some of the neighbourhoods across the City have also helped to develop this approach of broader engagement and a more preventative approach. This is clearly something that is welcomed by team members but there is concern that the demands of providing a service make it difficult to sustain this broader partnership working.

3.7 New Approaches – Strengths Based Social Care

3.7.1 Over the past twelve months the social workers in the Neighbourhood teams have been leading an initiative to change the way that social care is provided in Leeds – the new approach is called Strengths Based Social Care. Adult Social Care recognised that we have a strong and vibrant voluntary and community sector in Leeds but this was not utilised to the level it could be.

3.7.2 With strengths based social care we are in the process of turning this on its head. Now everything is being centred on the quality of the conversation we have with people – ensuring we check what is important to them, understanding what is working well and helping them to connect to the right solutions.

3.7.3 We chose Armley as our early adopter, partly because of the work that was already underway with the Community Wellbeing group. The Armley team have built links with New Wortley Community Centre, where they now offer appointments for people to come in for a conversation if they don't need a home visit.

3.7.4 This new approach is now being tested across a number of Adult Social Care teams with rollout planned in the Autumn.

3.7.5 At the same time health colleagues are looking at a different approach in working with people. For a while now health coaching approaches have been used with some people who have chronic health problems such as diabetes to help them to manage their own conditions better. This is now being applied more widely across health services allowing for a different conversation which is more holistic in approach. The new approach recognises that many of the problems which lead to long term health problems can originate from or be exacerbated by environment and social issues.

3.7.6 This approach has parallels with Adult Social Care's strengths based approach and highlights the importance of working with communities and other services in localities. Plans are being developed to look at how a place based approach can bring services much closer together in delivering support with a consistent new way of working with individuals no matter which services they access.

4. Corporate considerations

4.1 Consultation and engagement

4.1.1 Scrutiny Board members queried whether local Elected Members were aware of their neighbourhood team and the role it performed in the local community. In June

and July 2016 local managers from the service presented to community committees.

4.1.2 Managers gave a broad overview of what a neighbourhood team was, the professional groups that made up the team and how they worked. They then talked in more detail about the local team, their approach and interaction with the local community. Elected Members were given contact details for the managers in their local areas so that they could continue to strengthen local relationships.

4.2 Equality and diversity / cohesion and integration

4.2.1 New developments such as the one outlined in Armley highlight progress that teams are now starting to make in getting to know their local communities and understanding how to deliver services which pick up on the particular needs of local people without moving towards a postcode lottery where there is an inequity in care provision.

4.2.2 This is mirrored across the City with teams starting to make links with community groups and services.

4.3 Council policies and best council plan

4.3.1 This initiative sits within the 'Delivering the Better Lives Programme' strand of the Best Council Plan.

4.3.2 Adult Social Care and NHS partners in Leeds remain committed to working in partnership to deliver better outcomes for people that access our services.

4.4 Resources and value for money

4.4.1 In the July 2015 report the challenge in finding suitable estates was discussed. Significant progress has been made since. The Estates project team are in the process of moving Chapeltown team to Tribeca House and have just moved Seacroft team to Killingbeck unit 2. With Meanwood team moving to Rutland lodge earlier this year this means that all teams are now co-located. However, some of the sites in the West of the City remain too small to properly accommodate the neighbourhood team long term. A number of options have been explored Any future options for development of public sector office accommodation in those areas needs to consider the teams.

4.5 Legal implications, access to information, and call-in

4.5.1 There are no specific legal implications arising from this report.

4.6 Risk management

4.6.1 Formal programme management of the neighbourhood team development has now ceased. Risks are managed as part of day to day operational risk management protocols.

4.6.2 Regular operational management meetings have been established between the two organisations to ensure that issues are dealt with in a timely fashion.

5. Conclusions

5.1 Significant progress has been made in developing cohesive neighbourhood teams. Health and social care staff are co-located, supporting strong working relationships which in results in more cohesive care management for people with both health and social care needs.

5.2 There is no plan to integrate structures or management across Adult Social Care and Leeds Community Healthcare NHS Trust as part of the development of neighbourhood teams. The focus going forwards is on team members building effective working relationships with other organisations in the neighbourhood and strengthening ties with local communities.

5.3 Further benefits can be achieved by adopting an integrated approach to culture change with a place based approach in moving from 'doing to' to 'working with' approaches. A consistent model of service delivery including strengths based social care, health coaching and supported self-management will set new expectations of health and social care services.

6. Recommendations

6.1 Note the progress since the report to Scrutiny Committee in July 2015.

6.2 Support the aspiration to build effective working relationships between neighbourhood teams and local communities, noting the progress made in innovators such as Armley.

6.3 Support the shift to 'working with ' approaches which provide individuals with the tools to take control of their health and support needs, reducing reliance on statutory services and increasing early, proactive support.

7. Background documents[1]

None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Appendix One – Case Study

History & Background

Mr R is an 89 year old gentleman who was referred to the Community Matron by his GP.

Before Case Management…

- Recurrent hospital admissions
- Increased carer strain (lives with daughter and her children)
- Repeated GP call outs to complex medical and social problems.
- Significant physical deterioration typified by poor mobility with global weakness, exertional dyspnoea, chronic joint pain and worsening tremor
- A degree of low mood.
- Poor compliance with medication due confusion arising from polypharmacy
- Frustration with services and lack of signposting.

Actions and Interventions…

- Discussion at Monthly Case Management Meeting resulted in joint visit with Community Geriatrician with comprehensive medical review, liaison between hospital renal specialists and community practitioners.
- Emergency care plan put in place

Actions and Interventions…

- Referral to Memory Services.
- Referral for Domiciliary physiotherapy to improve leg strength and general conditioning.
- Changed medications into dossette box.
- Adult Social Care assessment for adaptations.
- Referred to neighbourhood network for assistance with disabled badge application.
- Referred to Carers Leeds.
- Registered with Emergency Carer's Service.

Health Outcomes…

- Reduced hospital admission and GP call outs.
- Increased compliance with medication and less risk of medication incident.
- Medical conditions diagnosed, treated and generally improved.

Social Outcomes…

- Reduced carer strain, daughter feels well supported and listened to.
- Appropriate adaptations
- Supported well at home and remains out of permanent care.