

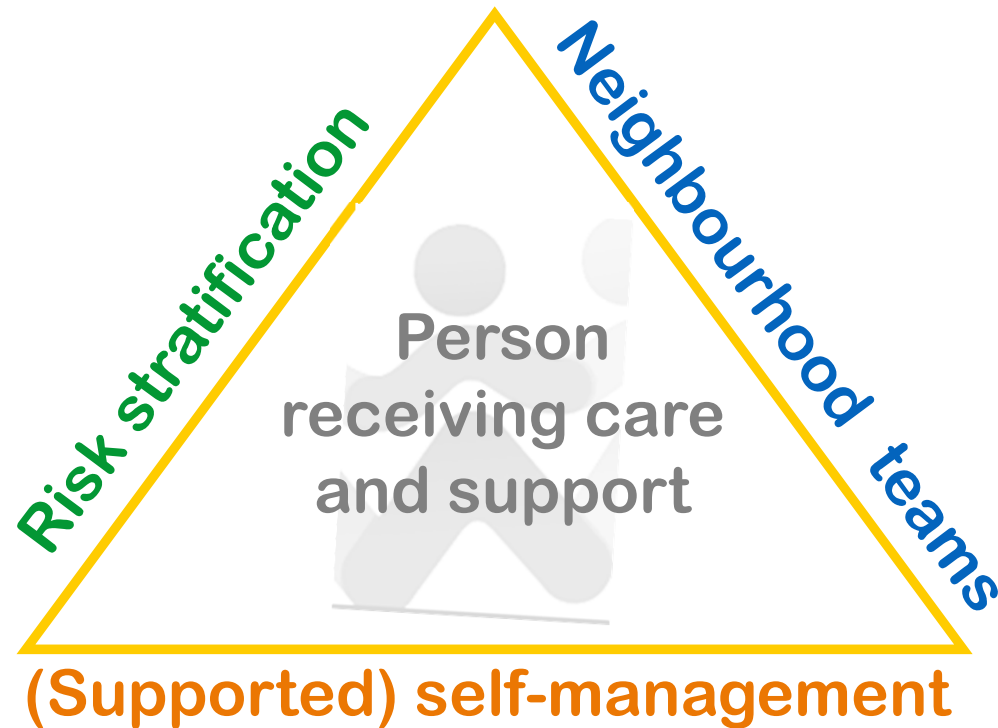
Transforming health and adult social care in Leeds

# Next Steps for Neighbourhood Teams



# Supporting older people and people with long-term conditions

– the *Sir John Oldham* model



## A 3-strand approach

- § **Risk stratification** – understanding who's at risk of having higher health needs in the future so we can support them at an earlier stage, to minimise this risk.
- § **Integrated neighbourhood teams** – social workers, district nurses and community matrons taking a joint approach to supporting people at risk.
- § **Supported self-management** – ensuring people have the right tools, information and support to manage their symptoms and improve their quality of life.



# Who is involved?

- NHS Airedale, Bradford and Leeds
- Leeds Community Healthcare NHS Trust
- Leeds City Council Adult Social Care
- Leeds Teaching Hospitals NHS Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds North Clinical Commissioning Group
- Leeds South and East Clinical Commissioning Group
- Leeds West Clinical Commissioning Group

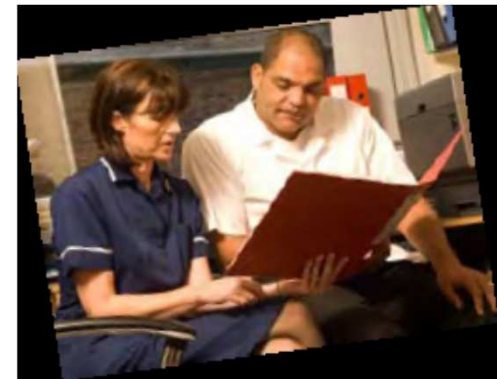
+ People who use services and their families

+ Voluntary and community organisations



## Neighbourhood teams – where are we now?

- Started with 3 demonstrator sites
- Now 12 teams across city
- Mix of health and adult social care staff
- Working with local GP practices and voluntary and community groups
- Patient/service user at the heart



# Multi-disciplinary team meetings

## What are they?

A meeting of a mix of different professionals who discuss the care and support of a person whose needs may soon increase (from risk stratification)

## Who attends them?

The most appropriate mix of staff based on the person's needs



## An example of how MDTs work

### Mr R's story:

Mr R is an 86-year-old man who lives in his own home with his wife, who is his main carer. He has hearing problems, a chronic breathing disorder and mental health issues including depression. He frequently falls, and his wife calls 999 for help.



## Multi-disciplinary Team Meetings *continued*

- *At the meeting Mr R's condition was discussed, and the following plan agreed:*
- Staff will work together with Mr and Mrs R to look at how best to keep Mr R safe and reduce his risk of falls.
- Mr R shows early signs of dementia, so will be referred to the Alzheimer's Society for extra support.
- Adult Social Care will review his care plan and look into arranging personal and domestic care.
- An emergency carer's plan will be put together to support Mr R's wife if he does have to go into hospital.
- A personal budget may be set up to help Mr R and his wife find suitable and enjoyable daytime activities.





## Neighbourhood teams – next steps

- § Continuing to **learn lessons** from our integrated sites
- § Further developing the **integrated neighbourhood team model**
- § **Joining up case management** for people with complex needs
- § Creating a **single ‘gateway’** to our services
- § Integration of **intermediate care** and **reablement services**



## Neighbourhood teams: next steps – continued

### Further developing the integrated neighbourhood team model

- § Staff from first 3 demonstrator sites looking at what impact these have had so far on ways of working.
- § Exploring how to reduce the number of visits made to people's homes by different members of staff
- § How many staff need to be regularly involved in a person's support?

#### Overall aims:

- can one staff member carry out an assessment on behalf of more than one professional group?
- there's a named link to specialist services and to each GP practice
- How can we make assessment and care planning more joined-up?
- What further support might be available through the voluntary sector?



## Neighbourhood teams: next steps – continued

### Joining up case management for people with complex needs

- § Building on our existing approach to become more joined-up.
- § Identifying people with long-term conditions who are supported by more than one member of the neighbourhood team.
- § Considering ...
  - How can we effectively co-ordinate their support?
  - Who is best place to lead this?
  - How can we make sure the service is as seamless as possible?
- § Starting in Meanwood before rolling out across all 12 neighbourhood teams.



## Neighbourhood teams: next steps – continued

### Creating a single ‘gateway’ to our services

- § People tell us there needs to be a joined-up ‘front door’ to health and social care services.
- § This would allow professionals access to *all adult community health and social care services through a single phone call or electronic referral.*
- § People’s needs considered holistically, not separately – offered full range of services.
- § Increasingly important as services become more integrated.
- § LCH has a single point of urgent referral (SPUR) to community health services.
- § LCH and ASC now looking at how to develop this into a single gateway.



## Neighbourhood teams: next steps – continued

### **Integrating intermediate tier and reablement services**

- § Joining up services to remove any gaps or duplication
- § improved outcomes for people who use rehabilitative services
- § more people supported to live independently at home
- § reduced need to use other health and social care services
- § more efficient service provision and improved cost effectiveness
- § Staged approach – being planned out now.



# Why work in a more integrated way?

It can be better for people we support ...

I ended up speaking to about five different people before I got what I wanted!



**Leeds** CITY COUNCIL

**NHS**

### Karen's story: 'To me, integration means choice'

"I've been using a wheelchair since I was younger and for years now, it's been like, who do you go to first? Who's your first contact? And then you end up with one person doing this job and another person doing that job, and then sometimes there's an overlap..."

'As you get older, the more you're bombarded with overlapping information, the more confusing it can become. My mother has Parkinson's, and when her car broke I ended up speaking to about five different people to actually get to the person who I needed to come out and deal with the hoist! I got there in the end but it's so frustrating when you constantly get another phone number to dial.

'This is one of the biggest problems. I'd like to see an initial contact for people so instead of so many different people telling you different things and some of them overlapping, you have one person that you deal with. I hope that things will be different in the future. I've seen some changes in 30 years but not as many as I would have liked.

'To me integration means 'choice'. It's like you're empowering people by giving them back that control. I think that's the positive side of integration as staff will talk to each other and people will have more choice. When you haven't got that say in your life anymore, you feel vulnerable. I'm very independent, I wouldn't want anyone doing things for me, but I want to have someone there if you need them.

'Back when what happened to me happened, I didn't think I had choices. It was like doctors were gods. Whatever the consultant said was law. It was pretty much left up to the consultant to decide what he was going to do and unfortunately, for me then, it was the wrong choice. I didn't get a choice – I think it's that what will make a difference.

'I remember years ago, I was on a committee where they were looking into equipment. I talked to a lot of other disabled people and at one time, you used to get sent equipment by the ... sit in the corner and never get used. But people would

You end up with one person doing this job, another one doing that job, sometimes there's an overlap...

You need *one* person that you deal with, not lots of different people telling you different, overlapping things!

... and it can make life easier for staff too!

“The family member only had to make one call – the community matron was able to pass on the information to the social worker.”  
– a community matron

“Faster exchange of information, less delay ...”  
– a social worker

“Working together, we get a better understanding of each other’s pressures”  
– a district nurse

“It’s so useful to have a health perspective – it’s easier to get more information about health needs” – a social worker




**“When people have support from a range of different care services, integrated working is absolutely fundamental.”**

If someone needs to use a range of health and social care services provided by different staff, the success of their treatment can depend on staff talking to each other, sharing crucial information about medication changes, prescriptions and support needs.



**‘Joined-up working? Bring it on!’**



Close working relationships among health and social care staff are already starting to make a difference for people who use local services, according to staff working at the city’s first integrated site.

Lynne Chambers, clinical lead for district nursing, and Anne-Marie Ward, social worker, are based at Kippax Medical Centre, the first of three sites in Leeds where district nurses, community matrons and social care staff now work closely together in a multi-disciplinary team.

## Self-management – what does it mean for neighbourhood teams?

- § **A closer relationship** with voluntary and community organisations
- § **Opportunity to work pro-actively** with people at an earlier stage
- § **Thinking differently** – how can this person be a partner in their own care and support? How can they be supported closer to home?
- § **Not about people being ‘left on their own’!!**
- § About **helping people to help themselves** – with support.
- § Neighbourhood networks; community groups:  
[www.leedsdirectory.org](http://www.leedsdirectory.org)





Eileen is 77 and has several ongoing health conditions.

She's had frequent unplanned trips to hospital in the past, but now has more support to stay in her own home.

"I have carers that come and help me to get washed. They want you to have your independence but they're there if you need them.

I've also got equipment to help me at home. I've got a machine that checks my temperature, blood sugar, blood pressure, pulse and oxygen levels. If there are any problems it sends an 'alert' to Sue, my community matron.

If it's a choice between this and hospital, I'll choose to be at home with people supporting me when I need it. If they'll let me do that, then I'm satisfied."



## How to find out more or share your views

- Monthly bulletin for neighbourhood teams
- Look out for other regular articles and events – staff newsletters, local community bulletins and more.
- Visit [www.leeds.gov.uk/transform](http://www.leeds.gov.uk/transform)
- Email [healthandsocialcare@leeds.gov.uk](mailto:healthandsocialcare@leeds.gov.uk)

