Leeds CITY COUNCIL

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Report of Adult Social Services

Report to South (Outer) Area Committee

Date: Monday 4th February 2013

Subject: Update on Development of Integrated Neighbourhood Health and Social Care Teams and the use of risk stratification

Are specific electoral Wards affected? If relevant, 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. Integrated neighbourhood health and social care teams have been operating across three neighbourhoods in the city for six months.

2. Rollout to a further nine neighbourhoods is underway with citywide coverage by the end of the year.

3. The ability to discuss cases with colleagues and access one another's expertise has been one of the early benefits of this work. Co-location has allowed health and social care colleagues to share knowledge and signpost individuals quickly to appropriate support.

4. Work is now underway to develop more integrated care management system and a neighbourhood model for integrated teams clustered around GP practices and their patients

Recommendations

Outer South Area Committee are asked to note the progress in developing integrated health and social care services in Leeds, endorse the direction of travel in developing and delivering improvements in how health and social care services are provided to Leeds residents and offer their support to these developments.

1 Purpose of this report

1.1 This report provides an update on the rollout of integrated neighbourhood health and social care teams. It describes progress to date and future plans for development.

2 Background information

2.1 Many people who receive both health and social care support have to cope with two sets of professionals coming to see them, asking similar questions and assessing them for many of the same conditions and problems. Most of these people are living with one or more long-term conditions – and many are elderly.

2.2 In some parts of the country, health and social care teams have begun to work closely together in a more integrated way. They have found that this more streamlined, joined-up approach often results in services which patients and carers say are better for them – and fewer people ending up in hospital or in long-term residential care. The White paper 'Caring for our Future: Reforming Care and Support' sets out a vision for a reformed care and support system with integrated services. The Government has made available funds to support the transformation of services and plans to invest a further £100 million in 2013/14and £200 million in 2014/15 in joint funding between the NHS and social care to facilitate development of better integrated care and support.

2.3 In Leeds we are looking at how we can work together more effectively by developing integrated health and social care teams. The development of integrated teams is being progressed together with two other key aspects of work: risk stratification – understanding the needs of the population and identifying those most at risk of needing high levels of health and social care support; and co-production and self-care – empowering individuals to take control of their treatment, care and support.

2.4 GP practices, health workers, social care staff and patients are working more closely together to improve outcomes and quality of care for older people and those with long-term conditions.

2.5 This paper looks at progress to date since the first neighbourhood health and social care teams went live in April and describes some of the key plans for progressing this work further over the coming months.

3 Main issues

3.1 **Demonstrator sites.** In April 2012 health and social care staff were co-located in three areas of the City – Kippax/Garforth, Pudsey and Meanwood. These sites were established as demonstrators, working closely together to try out more integrated ways of working. Social workers have been working alongside district nurses, community matrons, interface geriatricians[1] , GPs and other practice staff to consider how we provide more joined up care and support.

3.2 One of the early success stories with this work has been the ability to discuss cases with colleagues and access one another's expertise. Co-location has allowed health and

[1] geriatricians who spend part of their time working in a hospital setting and part of their time working in the community

social care colleagues to share knowledge and signpost individuals quickly to appropriate support.

3.3 Health and social care staff have also been able to carry out joint assessment visits to individuals in their own home. This reduces the number of times that an individual has had to tell their story but it has also enabled health and social care staff to develop a much greater understanding of one another's roles.

3.4 Members of the integrated neighbourhood teams have also been forming links with local community groups and voluntary sector organisations, particularly neighbourhood networks.

3.5 Staff from three existing demonstrator sites (Kippax/Garforth, Pudsey and Meanwood) have been looking at what impact establishing the demonstrator sites has had on ways of working so far. The intention now is to build on this approach and begin to test out a model of new, more integrated ways of working, between now and March 2013. Staff will firstly need to get an understanding of what input patients and service users *currently have* from different members of the team. They will then look at ways of working which will reduce the number of visits and professionals needing to be involved in that person's support on a regular basis, with a view to moving to one individual staff member being able to carry out an assessment on behalf of more than one professional group. The team will also ensure there is a named link through to specialist services and a single link to each GP practice. As new referrals are received the team will identify those who have complex needs and require a joined-up response. Assessment and care planning processes will be considered to see how these can be more joined-up, and staff will consistently consider support available through the voluntary sector.

3.6 **Rolling out the model to other areas**. The demonstrators were the first wave of a rollout of the neighbourhood team model across the City. In September an integrated neighbourhood team went live in Armley, Hunslet and Chapeltown will 'go live' in October with co-location in the remaining six areas planned through November and December to give citywide coverage by the end of the year. The slides at **Appendix 1** summarises the next steps for neighbourhood teams and a full rollout timetable is provided at **Appendix 2.**

3.7 **Multi Disciplinary Team meetings.** The development of integrated teams has been progressed with two other initiatives. The first is the introduction of a tool (risk stratification tool) into GP practices which allows GPs to see the pattern of health service use for all of the patients in their practice. To date this has focused on access to a particular group of health services which are weighted within the tool to help identify people who are high users of health services now or may be in the near future. From November this year we will be expanding the number of health services that are included and also be incorporating information on use of social care services to give a much fuller picture of the range of support an individual receives at **Appendix 3**.

3.8 The addition of these services will not affect the weighting of individuals but will help in our goal of delivering better co-ordinated care as we can see at a glance who is involved in supporting an individual. It will also give us a much fuller picture of those individuals that the tool has highlighted will be high users of health services in the future. Where an individual is accessing lots of different services we will be able to use multi disciplinary team meetings with members of the integrated neighbourhood teams and GPs to discuss

whether all of these interventions are effective. Where an individual is only accessing one or two services we will be able to consider whether this is appropriate to meet their needs or whether the addition of preventative support now may reduce the need for more intensive support later.

3.9 **Supported Self management**. The other work being progressed in parallel with the development of neighbourhood teams and the use of the predictive modelling tool described above is the development of a series of initiatives around supported self management. This work is being progressed in partnership with voluntary and community groups, including Neighbourhood Networks. Projects include social prescribing and *timebanking*, see **Appendix 4**.

3.10 **Evaluation.** An External evaluation has been commissioned to consider the success of integration from different perspectives. The University of Birmingham and the Social Care Institute for Excellence have carried out some work to look at initial views of staff and the people who use services to the integration of health and social care. A report is currently being produced but initial findings suggest that staff are generally optimistic about what can be achieved through integration. People who use services and their carers have more mixed views on the impact that integration will have for them. Some people see integration as a good thing but others wonder whether it will really make a difference to patient experience and outcomes. The University of Leeds is supporting the evaluation of the impact that integrated teams have on use of the health and social care system, notably how it impacts on hospital admissions and long term care placements.

3.11 **Customer feedback.** Through this work we want to ensure that improvements to processes and changes in the way health and social care are delivered make a noticeable difference to the people that use our services. We are collating questions and have developed a Frequently Asked Questions sheet. We are also interviewing people who are happy to share their experiences. Some of these stories are included in the appendices.

3.12 **Communication.** With change on this scale communication is a challenge. Within Leeds we have a large health and social care system and some staff are much more directly engaged with change at the moment than others. A number of different methods are being used to keep staff groups updated and engaged including leaflets, reference groups, workshops and engagement events, newsletter, website and Youtube links.

3.13 **Next steps.** Some of the next steps have been described above. Whilst still in development the agreed neighbourhood team model will be rolled out across the City. The experience of staff in demonstrators will be used to test out and inform more integrated ways of working. In addition to this we will be matching caseloads. This will involve health and social care staff considering the individuals they both support and working together to:

- discuss the person's needs
- think about whether that person would benefit from any additional support, and
- make sure that the support the person *already* receives is as coordinated and seamless as it could be.

3.14 This work will start in Meanwood before rolling out across all 12 neighbourhood teams. It will allow us to build on the joint working staff have already been doing, but with a wider caseload. It will help staff develop their skills in managing patients with complex needs, and is expected to make a lasting, positive difference for the patients themselves.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 Consultation and engagement is taking place across the programme of work. There is a Patient and Public Involvement Lead appointed to co-ordinate engagement activity across the projects and a Charter for Involvement has been co-produced. There is also a virtual reference group of people interested in the work.

4.1.2 Staff are involved in a number of reference groups and workshops that are running throughout the programme timescale to capture views and incorporate staff experience into the design of services. Key stakeholders are represented on the Integrated Health and Social Care Board. The external evaluation includes capturing staff and service user views and experiences.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The model being developed will have a consistent citywide approach with flexibility in the system to be responsive to local needs. For example work with Neighbourhood Networks is helping to build strong local relationships and understand the supports available within a local area.

4.2.2 An Equality Impact Assessment will be undertaken as part of this programme of work.

4.3 Council policies and City Priorities

4.3.1 This proposal is about working more effectively in partnership with other organisations to improve outcomes for the citizens of Leeds and is line with the City Priority Plan 2011 – 2015.

4.4 Resources and value for money

4.4.1 The integrated care pathways model aims to develop efficient streamlined services. These new pathways will remove duplication in management and in service delivery. This will improve the experience for service users in accessing a single service that can meet a range of support needs whilst maximising use of resources.

4.5 Legal Implications, Access to Information and Call In

4.5.1 There are no specific legal implications that arise from this report.

4.5.2 This report is not eligible for call in.

4.6 Risk Management

4.6.1 Formal project management methodologies are being applied to this work and project assurance is provided by the NHS Leeds Programme Management Office on behalf of

the City Transformation Board. Governance arrangements are in place and all elements of project delivery report into the Integrated Health and Social Care Board which meets on a monthly basis and has representation from all stakeholder groups.

5 Conclusions

5.1 Development of integrated services in Leeds is moving quickly. We have had teams integrated in three neighbourhoods for six months and now rolling out across Leeds to establish citywide coverage by the end of the year.

5.2 We have taken early learning and are building on this to further integrate the support that people with a mix of health and social care needs access.

5.3 This work is being progressed in collaboration with staff and service users.

5.4 Early evidence from patients and Service users is that more integrated working brings benefits in the quality of those services and improvements in patient experience.

6 Recommendations

6.1 Outer South Area Committee is asked to note the progress in developing integrated health and social care services in Leeds, endorse the direction of travel in developing and delivering improvements in how health and social care services are provided to Leeds residents and offer their support to these developments**.**

7 Background documents[2]

7.1 There are no background documents associated with this paper.

[2] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author..

Appendix 1

Transforming health and adult social care in Leeds

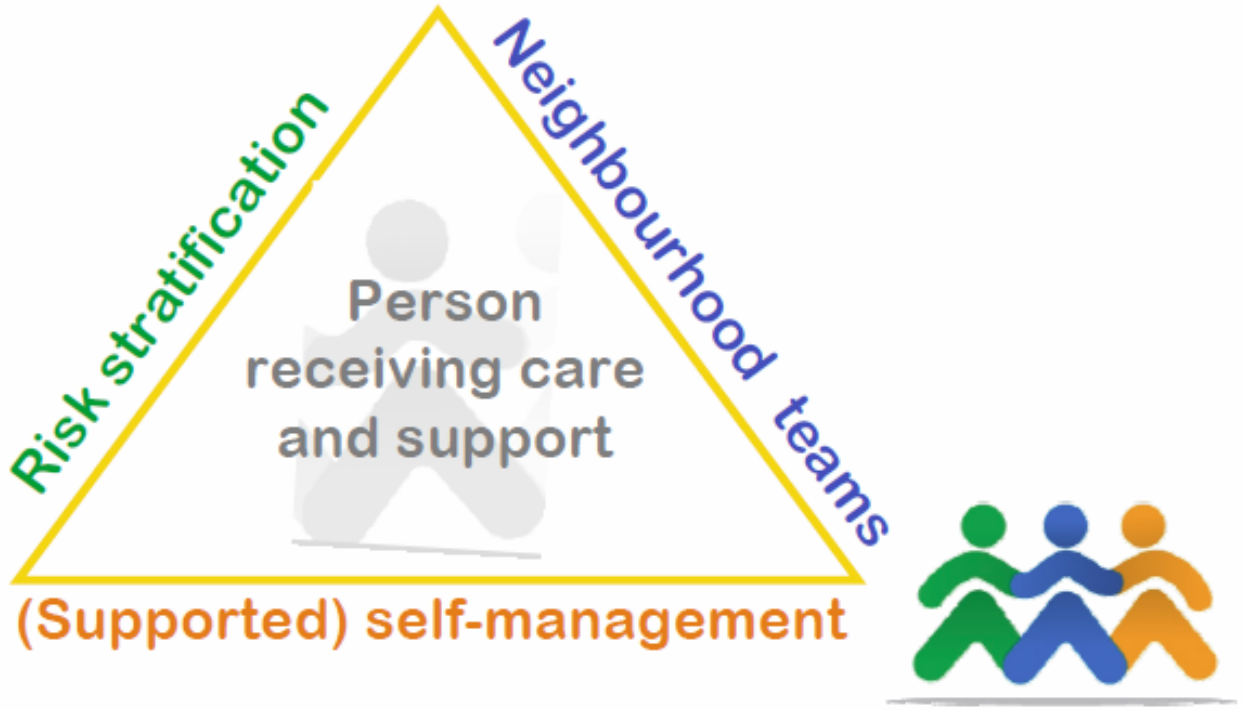
Next Steps

for

Neighbourhood Teams

Supporting older people and people with long-term conditions

– the ***Sir John Oldham*** model



A 3-strand approach

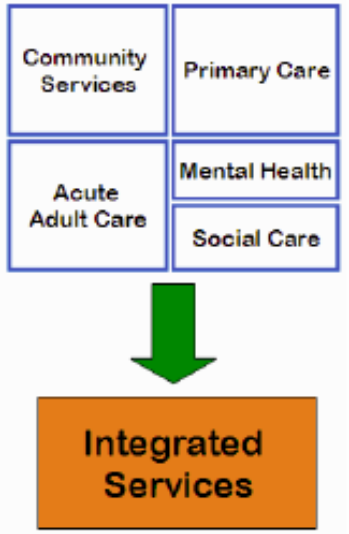
- **Risk stratification** – understanding who's at risk of having higher health needs in the future so we can support them at an earlier stage, to minimise this risk.
- **Integrated neighbourhood teams** – social workers, district nurses and community matrons taking a joint approach to supporting people 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 can 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 …

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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 … broke I ended up speaking to about five different … to actually get to the person who I needed to come out and deal with … 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 … there if you need them.

'Back when what happened to me happened, I didn't think I had choices. It was like … 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 … a lot of other disabled people and at one time, you used to get sent equipment by the … often sit in the corner and never get used. But people would …

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

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!

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NHS

… 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


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"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.


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'Joined-up working? Bring it on!'

Lynne Chambers and Anne-Marie Ward

Closer 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

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NHS

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
- Email healthandsocialcare@leeds.gov.uk

Integrated Neighbourhood Team Rollout Plan

Appendix 2

West CCG

Team Name / Area	Pudsey	Armley	Middleton	Woodsley
Expected Go live	**(1) April 2012**	**(2) 10th September**	**(3) 7th November**	**(4) 10th December**
Wards Covered	Pudsey Calverley & Farsley Bramley & Stanningley	Armley Farnley & Wortley Bramley & Stanningley	Morley South Morley North Middleton Park Ardsley & Robin Hood	Weetwood Adel & Wharfedale Kirkstall Headingley Hyde Park & Woodhouse City & Hunslet

North CCG

Team Name / Area	Meanwood	Chapeltown	Wetherby	Yeadon
Expected go live	**(1) April 2012**	**(2) 22nd October**	**(3) 12th November**	**(4) 10th December**
Wards covered	Moortown Alwoodley Roundhay Chapel Allerton	Burmantofts & Richmond Hill Chapel Allerton Gipton & Harehills City & Hunslet	Wetherby Harewood	Otley & Yeadon Guiseley & Rawdon Horsforth Adel & Wharfedale

South & East CCG

Team Name / Area	Kippax	Hunslet	Seacroft	Beeston
Expected go live	**(1) April 2012**	**(2) 19th November**	**(3) 19th November**	**(4) 17th December**
Wards covered	Kippax & Methley Garforth & Swillington Harewood	City & Hunslet Rothwell Middelton Park Ardsley & Robin Hood Beeston & Holbeck	Temple Newsam Killingbeck & Seacroft Harewood Roundhay Cross Gates & Whinmoor	Beeston & Holbeck Morley North City & Hunslet

GREEN – completed

AMBER – completed but some remaining IT and telephony issues as at 20.12.12

Appendix 3

RISK STRATIFICATION PROJECT – UPDATE TO SCRUTINY BOARD

1. Introduction

1.1 The Risk Stratification project is a key component of the Leeds Health and Social Care Transformation Programme and provides essential data to help to identify patients who are most at risk of needing services in the future and would therefore benefit from a more proactive approach to diagnosis and management of disease.

1.2 This report details what risk stratification is and how it will benefit services within Leeds. It outlines progress to date, an overview of the planned action to implement phase 2 of the risk stratification tool, the work that has been completed to support use of risk stratification outputs by integrated health and social care teams, and proposals for further development of the approach to risk stratification in Leeds.

2. What is Risk Stratification?

2.1 Risk Stratification is based on an algorithm that brings together various elements of data about patients and uses it to calculate their risk of needing a greater level of support within the following 12-month period. Within Leeds the model used is the `Adjusted Clinical Group' model developed by John Hopkins University. It assigns people to unique categories based on patterns of disease and the expected resources that will be needed to treat and support that person.

2.2 Within Leeds, Phase 1 of the tool incorporated the age, sex, primary care data (diagnosis, pharmacy), hospital data (care episodes) and healthcare cost for each patient providing information to help identify those people with complex clinical needs, and recording their current and future clinical profile, cost and risk of hospitalisation.

2.3 The tool supports primary care teams to manage their patients, measuring the health needs of individuals to help us plan how best to support them, allocate resources where needed most, and address health inequalities across the city.

2.4 A further key aim of the tool is to give us a view across the wider health economy using diagnostic and pharmacy data to get a clear picture of the local population profile and disease burden, as identify how resources are used and can be managed effectively.

3. Benefits of the Risk Stratification model

3.1 Within Leeds risk stratification is being utilised to identify those patients most likely to be high future resource users, and those who could benefit from more intensive interventions. In effect, the risk stratification tool can assist the integrated health and social care teams to target intervention where it can have the greatest effect, enabling a proactive approach aimed at supporting people living independently at home for longer.

3.2 A further benefit is to realise the potential uses of risk stratification outputs to inform future commissioning. The tool can assess what resources are being used to support people and can aggregate resource consumption at any level in the health system, including GP practices and at CCG level. Resource allocation can be made on the basis of actual need, built up from patient level. This will enable the tool to forecast costs and financial risk within a given period.

4. Implementation of risk stratification in Leeds

4.1 Roll out commenced in the three demonstrator sites for integrated health and social care teams and now 111 out of the 112 GP practices across Leeds have got risk stratification in place. An intensive training programme for practices and members of integrated health and social care teams has been implemented to support the effective use of the risk stratification tool.

4.2 The three CCGs have supported the establishment of multidisciplinary (MDT) meetings in all practices, bringing together GPs, other practice staff and members of the integrated health and social care teams to use the outputs from the risk stratification process to identify and review people who would benefit from a more proactive joined-up approach to their care. For this year, all practices are holding a minimum of two MDT meetings, to try out this new approach, and share and spread good practice. It is expected that the frequency of these meetings will increase in the future as we begin to understand what works and how the greatest impact can be gained.

5. Implementation of Phase 2 of the Risk Stratification tool

5.1 Following the introduction of phase 1 of the tool, we collated and took into consideration all of the practice feedback provided. An example of this feedback was the amount of time required to search through a list of patients. As a result the second phase of the tool includes NHS numbers and a patient search function which will greatly reduce the time needed to carry out this work. The inclusion of patient identifiable data and especially NHS numbers is significant as it means there is no longer a requirement for staff to search across clinical databases, during, for example, MDTs.

5.2 Further enhancements include an improved patient summary, including BMI and smoking status. Alongside this is an enhanced timeline that enables the member of staff to see in graphical representation the patient journey over the last 12 months, how many times the patient has been to their GP, number of out patient appointments, whether the patient has attended A&E and so on.

5.3 Finally, a Data Sharing Agreement has been signed off between Adult Social Care, Leeds Community Health Care and Leeds and York Partnership Foundation Trust to enable the uplift of data into the risk stratification tool. This will allow data from these agencies to be incorporated into the risks stratification tool, including the patient timeline, detailed above.

5.4 The expectation is that phase 2 will `go live` to practices by the end of October 2012.

6. Support and training to Integrated Health and Social Care staff

6.1 Between January 2012 and March 2012 473 health and social care staff were given comprehensive training and support to use the Risk stratification tool at various levels of specificity.

6.2 With the introduction of phase 2 of the risk stratification tool, some additional training has been offered to update staff on the additional features of the risk stratification tool. Additional 1:1 training and group staff target sessions will be provided upon request.

6.3 An e- learning package has been created and shared with practices throughout Leeds. This e- learning resource will aid staff whilst navigating the tool.

6.4 A risk stratification helpdesk has been established to provide practices with a specific resource to resolve any incidents that may arise. This will be complemented by an intranet site to be used as an easily accessible information resource to keep staff aware of any developments.

7. Developing a predictor for future social care usage

7.1 The risk stratification tool is specifically a healthcare system and does not currently provide predictive information about future social care usage. In Leeds we are keen to develop our approach so that we have predictive information about an individual's likely future of health or social care services. This has not been done anywhere in the country and so we are currently considering options to support work with an academic partner review and identify how the predictive model may be developed to benefit social care delivery.

James Hoult

Risk Stratification Project Manager

October 2012

Timebanks

A timebank is a system of exchange where people are able to trade skills, resources and expertise. For every hour participants 'deposit' in a timebank by giving practical help and support to others, they are able to 'withdraw' equivalent support in time when they need something doing themselves. A timebank is usually run by a 'broker' who facilitates and records exchanges between individuals and plays an important role in the safe and secure running of the timebank[i].

Timebanks are based on the key principles of co-production, which include:

- Asset model – Timebanks work on the principle that everyone has something to offer and all offers are valued.
- Reciprocity – Timebanks are based on a two-way transaction between people, which fosters a culture of mutual support.
- Social capital – A timebank creates a social network which requires on-going investment by its members.

As part of the health and social care integration pilot in Garforth, the local Neighbourhood Network, Neighbourhood Elders' Team, have developed a timebank 'Time to Share', which will be officially launched in early November. The timebank will be a way for people in the community to come together to share skills with the aim of improving people's self-value. The timebank will be linked with the local GP practice who will refer people to it as appropriate.

Also due to launch in November is the Ladybird Timebank which will operate in Headingley. The timebank received a small start-up grant through Adult Social Care's Ideas that Change Lives investment fund.

[i] Timebanking UK (2011), 'People Can'