Livewell Southwest

One year on....

Integrating Health and Social Care Services in Plymouth

The Health and Social Care Act 2013 and Care Act 2014 places an emphasis on health and social care services to deliver joint services that will ensure people receive the right care, at the right time, in the right place.

In April 2015, adult social care staff transferred to Livewell Southwest from Plymouth City Council. This publication is designed to share some of our early success stories with you from our experiences of integrating health and social care in Plymouth.

This first year has been about laying down the foundations for a new type of service for people who need our help and support. Staff teams have been learning about each other's professions and roles, sharing ideas and listening to one another's perspectives and views on how to develop and deliver a joint service. We have a strong management team with the leadership skills needed to deliver real change and a workforce hungry to make it happen.

Bringing health and social care services together and building integrated teams is exciting as well as challenging. Along with the practical challenges of moving so many teams across the city, both have different working cultures and practices, they use separate IT systems and terminologies and are governed by different legislation.

As an employee-led organisation, we recognise that our workforce is our greatest asset. At every turn we involve staff and managers in shaping the way in which our new services are delivered and more importantly, through our 'friends and families' test, we routinely seek feedback on how well we are doing from the people who use our services.

About Us

Livewell Southwest is one of the largest social enterprises in England delivering publicly funded health and adult social care services in Plymouth. Over the last twelve months our organisation has grown to include the delivery of community health services in South Hams and West Devon.

With over 2,800 staff and more than 80 services, our organisation is a multispecialist community provider, covering a diverse range of clinical care, community physical and mental healthcare, adult social care, as well as some professional services in areas where we have specialist expertise.

In January 2016 our organisation rebranded from Plymouth Community Healthcare CIC to Livewell Southwest CIC to reflect the growing diversity and geographical spread of our social enterprise.

Our approach to integration

Integrating health and social care is complex and our approach has been to divide the work into two areas - **Co-locating Services** and **Designing New Services**.

Not everyone receiving a healthcare service will need support to address their social care and support needs. A significant number of people that Livewell Southwest supports are able to live independently, despite requiring a specific healthcare intervention at some point in their lives. Equally, not everyone needing care and support will require a secondary healthcare intervention.

Our starting point therefore, has been to identify the groups of people for whom the provision of **both** *healthcare* and *care and support* is likely to be needed.

Key areas of work

One Team - One Referral

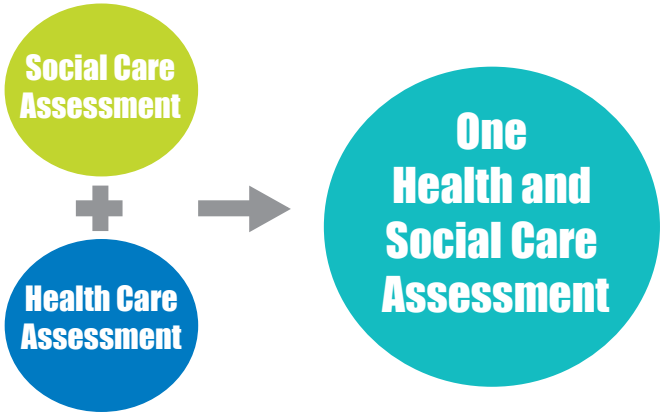
Reduce duplication by integrating and streamlining health and social care referral, triage and assessment processes

Over the last 12 months we have learnt that over 70% of the people who receive support from adult social care, also receive support from a healthcare professional. We also know that the majority of these people are over the age of 65 and are living with a range of complex health issues.

By integrating services for older people we will be able to greatly reduce the number of professionals involved, unnecessarily, in people's lives. Instead of *multiple* teams, all working with people separately, we will have *single* teams, working together, around the needs of the person, only asking for information *once*.

What we are working on:

- A single, digital care record for everyone
- Joint health and social care triage, assessment and documentation
- Single points of contact for our integrated services
- Integrated performance data



Organisation and Structure

'MAGIC IN THE ROOM'...

.. a strong value base and a focus on keeping people safe well and at home as a practice.

Strong values and culture is delivering best practice with a real authentic integrated team work approach to integration.

Lyn Romeo, Chief Social Worker Department of Health

Clear accountability for delivering new integrated services

The last 12 months has seen a significant period of change for the management team in Livewell Southwest.

We are creating a new offer for people who need health and social care support and not merely merging existing teams; to do this we will need a new approach to leadership with clear accountability for delivering better outcomes for people.

Shared Culture - Shared Language

Build a new, shared use of terminology and understanding across health and social care

There have been over 60 years of separation between the NHS and Local Authority Social Services. In this time both professions have developed and evolved their own cultures and use of terminologies as well as different models of care.

As a social enterprise and employee-led organisation, we believe that we are ideally placed to address the historic divide in professions. We will do this by talking and listening to each other, by respecting and valuing our differences and, through doing so, we will create something new.

What we are working on:

- **New team names**
- **New team meeting formats**
- **Glossary of terms used in health and social care**
- **Joint group supervision**
- **Multidisciplinary working and learning**
- **Team building and closer working relationships**

Workforce Development

Ensure that our staff have the knowledge, skills and support to deliver our new integrated service

As we ask our managers and front line staff to work in new ways, we will ensure that they are given the tools needed to do the job. This means ensuring that we have an adequate training programme in place, as well as on-going support, through supervision and peer support mechanisms.

We already have an excellent learning and development team with a track record of delivering high quality training. To supplement this, we have also appointed a principle social worker, who is responsible, alongside our other professional leads, for driving up the quality of our professional workforce.

Our new integrated services

Delivering care in your home and community

Our integrated services in Plymouth are all responsible for delivering both health and social care services, 'under one roof'. Throughout the last 12 months, our main focus has been to co-locate teams to begin this process; our ultimate aim is to create fully integrated services, where the support we provide is seamless, fully coordinated and more efficient.

Our health and social care staff in Plymouth are co-located across the city in four localities. Each consists of a core team which includes Social Workers, Community Care Workers, District Nurses, Health Visitors, Therapists, Long Term Conditions Nurses and Community Mental Health Teams.

Locality teams are telling us that integrated working is already proving to be a positive experience, helping to see the degree of 'overlap' between health and social care services, deliver more efficient and effective ways of working and more importantly providing a better experience for people.

East Plymouth Locality Case Study

Arthur was diagnosed with Motor Neurone Disease with rapid deterioration and was already being supported by a long term conditions nurse. The nurse recognised that Arthur's wife and main carer was beginning to struggle to provide the support he needed and, through discussion with a social worker in the team, a joint assessment visit was arranged quickly.

Before integration, arriving at this simple and effective plan would have taken considerably longer, as the nurse would have needed to make a separate referral to adult social care, which would in turn have triggered a further process of triage and allocation…all of which would have been coordinated via emails and telephone.

The social worker and the nurse were able to meet with Arthur and his wife together, eliminating the need for the family to 'tell their story twice' (and separately) to both professionals. This not only greatly reduced the time taken to assess Arthur's situation, it also improved the quality of the experience for the family and sped up the decision making process that followed.

In the end, as a consequence of the advanced progression of Arthur's illness, it was identified that he was entitled to receive continuing healthcare funding, until he eventually passed away.

Integration is a brilliant thing because it smooths the patient journey and makes us all work in a more efficient and effective way

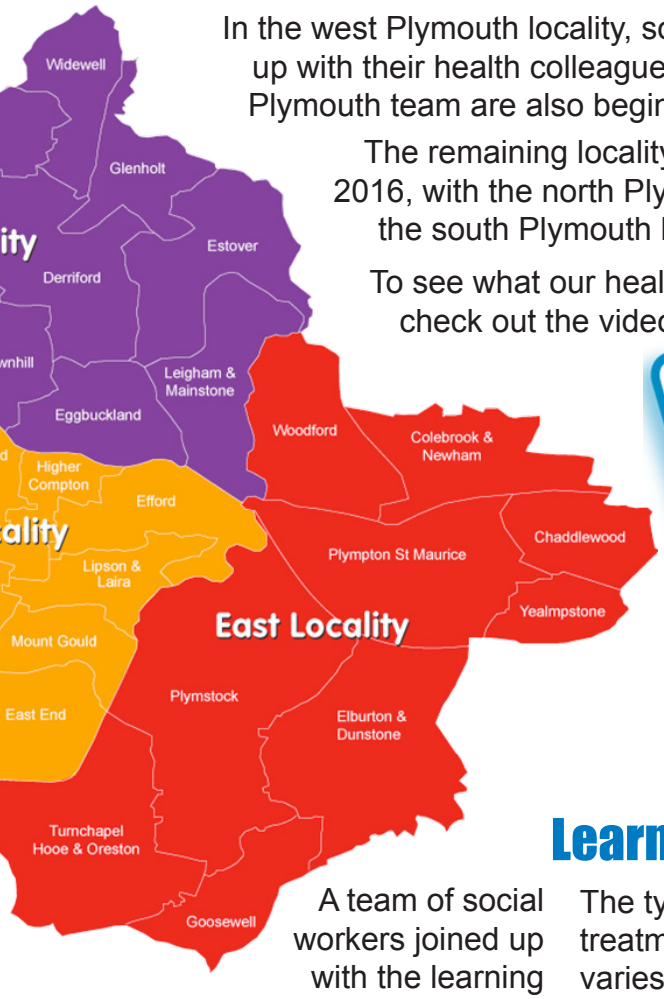
Locality teams provide support to the majority of people in need of care support and treatment. The locality model is central to everything we are aspiring to do; our aim is to bring support closer to the communities we serve.

In our east Plymouth locality, the social care team co-located with the district nursing and community therapy team, and are based in the Plympton Clinic. The team have now established close working relationships, frequently discussing cases and have started to undertake joint assessments, which have already led to improved outcomes for people in a number of cases.

In the west Plymouth locality, social care teams moved into the Cumberland Centre to join up with their health colleagues in May 2015. As with the east Plymouth locality, the west Plymouth team are also beginning to realise the benefits of closer working relationships.

The remaining locality teams are scheduled to be fully co-located by September 2016, with the north Plymouth locality based at Windsor House near Derriford and the south Plymouth locality at the Beauchamp Centre in Mount Gould Hospital.

To see what our health and social care staff have to say about working together check out the video on our integration pages at www.livewellsouthwest.co.uk



Integrated working is definitely the future, in the long term it's going to provide really good outcomes.

Integration is positive, it's engaging with the right people at the right time and it's a very positive experience for staff and for the people of Plymouth.

Learning Disability and Complex Care Team

A team of social workers joined up with the learning disability service in December 2015. The team, which is responsible for supporting individuals with highly complex needs, was already working very closely with the learning disability service before we integrated. It was therefore a natural progression to bring the teams together in one building.

The type of care, support and treatment that people need varies significantly from person to person. As an organisation we provide support to people of all ages, including children. The learning disability service supports people with some of the most complex needs, often requiring significant packages of support to enable them to live as independent lives as possible in their community.

The team's role is to ensure that the rights, freedoms and independence of individuals with significant disabilities are at the forefront, through the provision of forward thinking and progressive models of care, support and treatment. By working together, the health and social care professionals are already achieving better outcomes for people.

Learning Disability Service Case Study

Kyle is a 40 year old man with learning difficulties, mental health problems and a history of repeat admissions to specialist psychiatric hospital facilities. Throughout, he has received support from a social worker in adult social care, as well as input from the healthcare professionals in the learning disability service. In addition, he has received daily support from a private care agency.

Prior to integration, the joint working between the health and social care professionals involved was often fragmented; relying on telephone conversations, exchange of emails and the occasional multi agency meeting. As a result of this poor communication, the support provided to Kyle was, at times, disjointed, with sometimes conflicting advice and opinions being provided to Kyle and the care agency supporting him. Now, Kyle's social worker works in the same team as his community psychiatric nurse and specialist psychologist and, together, they have developed a coordinated and coherent support plan that has helped to prevent Kyle from being admitted to hospital.

Our new integrated services

Urgent Care Services

Our urgent care services provide a range of support to people to prevent them from being admitted to hospital, and to enable them to return home after an admission, as quickly and as safely as possible.

We have already developed a number of innovative new services to efficiently deliver 'person centred' coordinated care. Our integrated services works under a 'multidisciplinary' team structure which includes a mix of health and social care professionals including GPs, nurses, social workers, occupational therapists, community support workers and pharmacists.

Since adult social care staff joined our organisation from Plymouth City Council in April 2015, this has enabled us to develop a range of new integrated urgent care services for Plymouth.

This means we can more effectively manage peoples care needs, reduce acute hospital admissions, minimise the duplication of assessments and, most importantly, deliver better quality care.

Integrated Hospital Discharge Team

Our Integrated Hospital Discharge Team has been co-located at Derriford hospital since April 2015. The team, which comprises a mix of health and social care professionals, is responsible for coordinating the support needed to help people with complex needs to leave hospital, with the appropriate level of support in place. This is a fast-paced and challenging environment, where the well reported pressures in our A&E departments have led to an increase in the numbers of people in need of assessments. By working together, the team has significantly increased the number of discharges from hospital over the past 12 months, persistently exceeded targets and making a vital contribution to relieving some of the pressures in our acute hospital.

Robin Community Assessment Hub

Robin Community Assessment Hub is a community based service that has been specifically designed to enable treatment and tests to be completed without the need for a hospital stay. Based at Mount Gould Hospital, the Robin team consists of Nurses, Occupational Therapists, Physiotherapists, Social Care staff and an Acute GP. Some, or all of these, may have some involvement in the delivery of care.

Robin Case Study

Mary, a 91 year old lady, was found on the floor by her carer who called 999. An ambulance crew attended and the lady was found to have reduced mobility and cellulitis of her legs. The paramedic contacted Robin Community Assessment Hub directly and discussed Mary's condition with the team over the phone.

Mary was taken to Robin Community Assessment Hub by ambulance where she received an assessment by the multi-disciplinary team. Following blood tests she started on antibiotics for her cellulitis. She was referred to the Community Crisis Response Team with a view of a longer term nursing care placement to allow her to fully recover from the cellulitis. She stayed one night at Mount Gould Hospital whilst a care home was being identified.

Mary was medically reviewed the next morning and was fit for discharge. Transport was arranged to the nursing home and her relatives were informed. Her medication was reviewed by the Acute GP and Pharmacist and her medicines went with her when she left.

The treatment Mary received meant that she was able to return home quicker and avoided an admission to Derriford hospital.

Community Crisis Response Team

The Community Crisis Response Team provides support to people experiencing a crisis in relation to their health, who would otherwise require an admission to hospital. As with all the integrated services, knowledge of adult social care eligibility criteria, as well as approaches to promoting independence, are well understood and shared within the team.

Brian is an active 82 year old man who works as a volunteer in his local community. During 2015, he became acutely unwell and was found lying on his floor by the police, appearing very confused and unable to walk.

He was admitted to the Robin Community Assessment Hub, where he was diagnosed with a urinary tract infection, requiring immediate treatment. Rather than being admitted to hospital, the team agreed with Brian that his recovery could better be supported in a nursing home.

Whilst in the home, he received support from an Occupational Therapist and Physiotherapist who, alongside the nursing home staff and specialist support workers, were able to work with him on his goal of returning home.

Within four weeks he was able to walk with the support of a walking aid and to look after himself as before. To support the transition home, the team organised the provision of equipment and small adaptations to his home, along with carers visits 3 times a day to support his recovery and regain confidence. After just two weeks he was, once again, fully independent and looking forward to getting back to volunteering.

"I could not have asked for anything more from the crisis team, I just wanted to remain independent. Thank you for everyone's help to get me there."

The Intermediate Care and Reablement Team

The Intermediate Care and Reablement Team support people who have been discharged from hospital by offering rapid post discharge support and interventions to enable people to return and remain at home.

The team comprises a mix of occupational therapists and community care workers, who help to identify people with long term care and support needs and work with them to ensure that support is provided to help them regain as much independence as possible.

Very often, people can lose confidence after a serious illness or accident that required hospital admission. By working intensively with people during this critical period, the team are often able to reduce and prevent the need for long term care being put in place. This approach achieves positive outcomes for the person as well as a reducing the cost of care.

"Excellent person centred care with experienced attentive staff assisting with all aspects of care. The focus of the multidisciplinary care achieved positive results because communication was so good between team members. Staff were friendly, polite and professional and treated my wife with kindness and maintained her dignity at all times. This is a well thought out and much needed facility.
Very innovative!

A BIG thank you for all your care and attention. We think you are all lovely, whether you have visited or spoken to us on the phone. We think this is a brilliant service and fantastic that it meant Mark didn't have to go into hospital.

I have recently had my hip replacement revision at Derriford. Due to complications I was unable to commence physio before my allotted five days on the ward but a fantastic new system has recently been started called Recovery at Home. Nurses, Physiotherapists, Healthcare Assistants and Occupational Therapists visited me at my daughter's home."

What next?

Our integration journey in Plymouth has so far seen staff and professional groups from across the city coming together to learn about each other's professions, roles and jobs, sharing ideas and learning. In South Hams and West Devon, while adult social care staff are not part of our workforce, we are working in partnership with colleagues within the system to join up health and social care. This has proved exciting and challenging, with the workforce enthusiastic to make a difference.

Our services now cover a diverse range of health and care professionals, including community nursing; social workers; health visitors; health promotion/community development workers; therapists and professions allied to medicine; Acute and Community Mental Health Services; Specialists in Older People; Community & Clinical Pharmacists; Urgent Care responders; Podiatry; Rehabilitation and Reablement teams; Dentists and GPs, as well as some professional services in areas where we have specialist expertise. We also manage two community hospitals in Kingsbridge and Tavistock and host the Local Care Centres at Mount Gould and Ernesettle and the Cumberland Centre in Plymouth.

Implementing Shared Health Records & Advancing Technology

People tell us that they only want to tell their 'story' about their care and support needs once. Using a single health record and a common assessment process between professional groups will improve efficiency and reduce duplication and ultimately provide people with a more seamless approach to care between agencies. It will also ensure that every person has access to the same quality of assessment, diagnosis, treatment and review seven days a week. It is envisaged that over the next year, care delivered in defined neighbourhoods, will be led by a single Care Co-ordinator for that neighbourhood.

We are exploring 'joined up' investment in technology to improve communication and education between health and care professionals, attempting to secure a single health record accessible in all care settings, and providing a range of technological self-help / telecare options for patients.

Ben Gummer, Minister for Care Quality

"It has been a pleasure to visit Livewell Southwest. Like the NHS, high quality patient care is clearly their number one priority. But what particularly impressed me was how empowered staff are - to constantly improve the quality of care they deliver, take up exciting career opportunities and feel part of the organisation.

This is helping to not only retain a committed workforce, but meet the healthcare demand of the local community."

Workforce development and training

We are committed to ensure that our workforce has the practical skills and qualifications that is needed both now and in the future to meet the needs of the communities we serve.

A new workforce planning group has been established to shape our future workforce through developing our staff and recruitment.

We are looking at E-learning packages that will enable us to develop and deliver our own in-house e-learning training packages for staff that will help developed a truly integrated workforce.

Plymouth, South Hams and West Devon System Priorities for Health and Care are:

The landscape for health and social care provision in our region continues to develop under the Devon-wide Sustainability and Transformation Plan. In Plymouth, South Hams and West Devon a system-wide plan is underway that identifies seven key priorities for our area that put the needs of our population at the heart of transformational change, to ensure local people can receive the right care, at the right time in the right place.

1. Review and redesign the **Urgent Care System**.
2. Transform services for **Children & Young People**.
3. Redesign and remodel the system of **Elective Care**.
4. Reduce the amount spent on **Individual High Cost Packages of Care**.
5. Develop an integrated system of **Health and Wellbeing Hubs**.
6. Implement the Five Year Forward View for **Mental Health**, embed in all priorities and align to the Complex Needs System.
7. Develop and redesign **primary care** as part of the system of health and wellbeing.

Working in partnership

Livewell Southwest, alongside other provider partners and commissioners, are signed up to a programme of work leading to a Devon-wide Sustainability and Transformation Plan for 2016/17. Together the statutory and independent sector is working to:

- Agree joined up approaches to working on problem areas
- Implement change together
- Strengthening local leadership and building capacity and capability
- Linking developments and innovations to create new care models which optimise the use of resources and staff
- Exploring new funding and contracting models

Plymouth City Council and NHS Northern Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) formed an integrated commissioning function on 1 April 2015, bringing together over £630 million of Plymouth City Council and NEW Devon CCG funding. This is fulfilling the vision of the Health and Wellbeing Board of integrated health and wellbeing.

The aims of the integrated commissioning system are:

- To improve health and wellbeing
- To reduce inequalities
- To improve people's experience of care
- To improve the sustainability of the health and wellbeing system

The strategies apply to health and wellbeing services commissioned for Plymouth and the health services commissioned for South Hams and West Devon.

Making it real

Earlier this year Livewell Southwest joined experts from the worlds of health, social care, politics and academia at the Integration: Making it Real conference, held at Plymouth University.

Steve Waite, Chief Executive for Livewell Southwest, Carole Burgoyne, Director of People for Plymouth City Council and Jerry Clough Chief Operating Officer of NEW Devon CCG presented at the conference alongside renowned speakers including Sir Keith Pearson, chair of Health Education England; Professor Paul Corrigan, adjunct professor of public health at the Chinese University of Hong Kong; and Alf Collins of NHS England.

The conference looked at ground breaking work taking place across the South West to bring health and social care services closer together. A further conference is planned for later this year where we will continue to share our learning and provide an update on the services we are developing.

What are we doing?

Primary Care and General Practice

We are working closely with General Practice across Plymouth, South Hams and West Devon. We are beginning to align health and care teams more closely to enable groups of professionals and volunteers to work together at a larger neighbourhood scale and in a more co-ordinated way, seven days a week, in and out of hours. We believe this improved integrated style of working will ensure sustainability of local services in the years to come. We also believe that an integrated approach enables a host of new education and training opportunities and peer support across professional boundaries.

Our Community Voluntary Sector Partners

We have begun working more closely with our Community Voluntary Sector Partners. There are over 2,240 community voluntary sector groups spread across South Hams, West Devon and Plymouth, providing an estimated million plus hours of voluntary service to people in our urban and rural communities. They are the centres of linked networks which can facilitate and begin conversations and organise capacity to help co-design services with us. We see them as pivotal in working with us in delivering new solutions designed by integrated teams and communities themselves.

Our Hospital

We are working with our commissioners and our acute hospital partners at Derriford to bridge the gap between primary care and secondary hospital care. Working together we are examining all care carried out in the hospital at this time and exploring opportunities to be able to move some care closer to home and optimise the workforce, by developing new roles and career pathways.

One Public Estate

We have started discussions with our local government partners in planning, to see how we can work together to develop new, or modified premises to deliver our health and care services and begun a 'joined up look' at all our existing premises and buildings in local communities and thinking about how we can use this estate in improved ways i.e. health centres, community centres, community hospitals or pop up clinics.

Health and Well Being Hubs

In partnership with our commissioners in health and local government, local communities and the community voluntary sector, we are looking at neighbourhoods to identify existing community hubs in which to build upon. These are spaces which may be owned by the statutory sector, practices, local government or the private sector and bring together joined up resources that enable and support people living in the community to live independently and make choices that will improve their health and wellbeing. These include information and signposting; social care advice; finance and housing advice; employment support; some health interventions; advocacy, primary care; community services, long term conditions management; support models for social prescribing, health coaching and community development.

Your feedback matters!

Your feedback is vital in helping us to shape the future of our services. Please let us know what you think - you can do so in a number of ways:

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Want to hear more from us? Ask to join our mailing list and receive copies of The Vibe, the new magazine from Livewell Southwest.