This is an update about the Better Care Together programme which aims to transform health and social care in Leicester, Leicestershire and Rutland. Issued on behalf of partner organisations.

Better care together

Leicester, Leicestershire & Rutland health and social care

BCT Bulletin

July 2018

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Welcome to the latest newsletter for Better Care Together, the Sustainability and Transformation Partnership for Leicester, Leicestershire and Rutland

This week NHS organisations in Leicester, Leicestershire and Rutland (LLR) have been marking the 70th year of the NHS. That has included recognising the remarkable efforts of skilled and dedicated staff both today and in years gone by, while also celebrating its many achievements.

At the same time discussion has also focused on what the NHS needs to do to improve further and remain sustainable over the next 70 years. In Leicester, Leicestershire and Rutland NHS organisations are driving this forward with their partners to create new care pathways and more efficient and effective services which have patients at their centre as part of an integrated approach to health and care.

The challenges to this work are well documented, but nonetheless we are seeing real progress as a result of moving towards a joined up approach.

This newsletter highlights regularly the ongoing achievements of Better Care Together (BCT) partners. In the next few weeks we will also be publishing *'Next Steps to better care in Leicester, Leicestershire and Rutland' - a* document that will combine an update on the progress with a refreshed strategic direction that responds to the feedback on our initial proposals made in November 2016. The details of the content of the document was referred to in a statement we issued at the beginning of June, which you can read on our website (http://www.bettercareleicester.nhs.uk/the-bct-plan/whats-changed/.

The Next Steps document will be published on our website and circulated to stakeholders and partners.

If you would like more information on the work of our BCT Partnership, visit http://www.bettercareleicester.nhs.uk/ and subscribe to our mailing list to receive future information about the Leicester, Leicestershire and Rutland Better Care Together Partnership.

Supporting people at risk of suffering a fall

Nearly 2,000 people who have had or are in danger of a fall have been helped by a local service designed to manage people's conditions and keep them safe in their own homes.

The aim of the LLR falls programme is to improve the treatment pathway for those identified as being at risk of suffering a fall, or those who have experienced a fall. This is being achieved by enabling quicker access to treatment and advice, ensuring those needing specialist care have as short a referral time as possible, and providing information and services for people to help them reduce their risk of falling, such as how to restore and improve their own strength and balance.

Research and evidence including via the National Institute for Health and Care Excellence (NICE) has consistently demonstrated that people reduce their risk of falling by addressing these aspects.

Over 300 people have benefited from attending the Steady Steps postural stability

programme. In addition over 1,600 referrals have been made into consultant clinics and triaged by a Falls therapist over the last 18 months through programme including during the pilot stage. This has resulted in over 50% of people being fast tracked to receive specialist therapy falls prevention care within 2 to 4 weeks of the referral.

The falls programme provides for both professionals and patients the tools they need to ensure that the most appropriate course of action is taken to help each individual maintain their independence and, as much as possible, to avoid a falls related admission to hospital. This includes:

- Prompt specialist therapy triage and assessment for all referrals into the Consultant Falls clinics to enable quicker therapy treatment to be given. This way of working by partners is being embedded into day-today practices of teams.
- Specialist therapy and falls prevention training for care home staff developed jointly by Leicestershire Partnership Trust and Leicestershire County Council's Adult Social Care.
- The continued development of the local falls management exercise programme, known as "Steady Steps". This is delivered in partnership with Public Health, and is designed to give people skills and strategies to reduce their risk of suffering a fall in the future.
- Work to develop and extend access to an electronic Falls Risk Assessment Tool (e-FRAT) . e-Frat is a simple App that helps to identify the appropriate care a vulnerable person needs to reduce their risk of falling. Phase 1 is a roll out into East Midlands Ambulance Service.
- Initiate a pilot project to develop a non-emergency falls response service for Leicestershire and Rutland. This service is for people who have fallen, and following a call being placed to the Ambulance Service have been triaged as having no medical needs, but who require support to be lifted from the floor. Currently this cohort of patients can wait a long time to be assisted from the floor, which in turn impacts upon their ability to recover from the fall.
- Partnering with the East Midlands Academic Health Science Network (EMAHSN) to implement a variety of interventions and self-assessment pathways, to promote healthy ageing and falls prevention. Additionally, discussions are taking place to understand how these elements can be adopted by Primary Care to support the frailty reviews within GP practice.

For further information contact Mark Dewick, Health and Care Integration Programme Manager – mark.dewick@leics.gov.uk

Getting frail patients and those will multiple conditions the right care to prevent an admission to hospital

BCT partners are working at pace to design and implement an improved system of care for frail and multi-morbid patients to support the expected pressure over the winter period.

It is well known that around 20% of our most vulnerable patients – the oldest and those with the most serious and complex health conditions - take up approximately 80% of resources across the health and care system.

These patients are more likely to end up in A&E, and be admitted and stay in hospital for a longer period of time than they need to be. This often leads to worse outcomes for them.

Working with many of the BCT work streams including Home First, Integrated Locality Teams and Medicines Optimisation, we are enhancing services provided in the community for patients who require complex support, are frail or who have a multiple number diseases e.g. diabetes and heart disease to prevent a hospital admission becoming necessary.

If an admission is required we are ensuring we are responding effectively in a crisis, enhancing discharge processes and the support provided after discharge to prevent a readmission.

A time-limited Frailty Task Force was set up in May to concentrate on delivering 16 specific improvements across the health and care system before winter 2018/19. These include finding a consistent way of identifying the patients across LLR who could benefit most from a more standardised, effective and efficient intervention and then ensuring that a robust care plan is visible to everyone involved in delivering their care.

In addition, if patients do find themselves in crisis and in acute care we will ensure their discharge is planned from an early stage with services in place to prevent a readmission.

With winter only 17 weeks away this work provides the opportunity to prioritise and allocate resource to an important area of work across health and care organisations to support patients and their carers.

Professor Mayur Lakhani, GP and Chair of the Clinical Leadership Group for BCT said: “Caring for our most vulnerable people is vital. As a GP I know that inappropriate admissions and unnecessarily long periods in hospital can be

very harmful to my patients as they may deteriorate to a point where a return to their home is no longer an option. Getting services right for people living with frailty has become a priority for BCT partners. This joint work across a range of health professionals will ensure that we understand the particularly needs of frail people, prevent them deteriorating in a compassionate way and, if a hospital admission is necessary then arrange a discharge quickly."

Delivering improved integrated care close to home

The three Clinical Commissioning Groups in LLR - NHS Leicester City, NHS East Leicestershire and Rutland CCG and NHS West Leicestershire CCG - are to work with patients, clinicians and healthcare staff to develop proposals that will support improved integrated care for patients at home and in local communities by redesigning a number of existing community healthcare services.

The redesign builds on existing work and will involve a lot of partners including Leicestershire Partnership NHS Trust (LPT), as the main provider of these community services as well as social care, primary care and acute services.

Community health services play a vital role in the health and care system, and feedback from local people is that they value the high quality care provided to them, but services don't always work together as well as they should.

We recognise that people often need support from more than one service across health and social care. One of the objectives of the redesign will be to ensure we can deliver better services that are joined up and wrap around the needs of patients.

We know that people want to be at home and stay at home whenever they can, and a number of reviews have shown that we aren't always managing patients in the best setting for them.

Clinical evidence tells us that many people recover much better and faster at home too. In order for people to receive this type of care we need to make sure we have the right community healthcare services, working in partnership with social care and primary care.

The challenges of an ever-increasing elderly population, many with multiple long-term conditions, mean a future health and social care financial gap of millions of pounds if the local system is not effectively improved. Building on work already taking place within LPT, changes will need to be made across the health and social care system in order to continue to provide the highest quality healthcare for local people within the resources available, and to manage demand for acute and

emergency care.

We have not undertaken a fundamental review of community health services in LLR for a number of years, and it is now timely to do this to ensure that services will be able to respond to demographic changes and increased moves towards integrated care and home based care.

This work will build on work already underway to gain a better understanding of how services may need to be redesigned to support the delivery of BCT priorities around 'Home First' care and Integrated Locality Teams:

- District Nursing Services
- Intensive Community Support (ICS)
- Community Hospital Beds (including stroke beds)
- Community Therapy Services (not including MSK physiotherapy)
- Community integrated Neuro and Stroke Service
- Primary Care Co-ordinators

The redesign work will also include reviewing the clinical model for bed based services, providing clarity on the type and number of community beds needed to complement a strengthened home based support services in future.

In late summer we will start engaging with patients, carers, staff and communities to understand what matters most to them with the aim of their insights influencing recommendations for any service changes later in the year.

As the work commences other community health services may be looked at as part of a second phase of work.

If you have any questions about the work to redesign community services please email: communityservicesredesign@westleicestershireccg.nhs.uk

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Supporting people and their families in later stages of life

End of life care aims to support people, their families and carers in the later stages of their life. Making sure the right care is available both in the lead up to death and afterwards for patients, family and carers makes a huge difference to all those affected at such an upsetting time.

In LLR, a new approach to care for the people at the end of their life, brings together the expertise of the local NHS, local authorities, Marie Curie and LOROS to provide a more joined - up, personalised service which puts the needs of patient, family and carers right at the centre of this care.

The End of Life workstream for Better Care Together reviewed how we provided end of life and palliative care services for our patients. An essential part of this was to ensure we took into account the preferences of patients, their families and carers from national research and local insights to create a shared vision across the three Clinical Commissioning Groups who commission services and Leicestershire Partnership NHS Trust (LPT), University Hospitals Leicester, the three local authorities and the voluntary sector, who support the delivery of services.

The vision is now becoming reality as we develop an Integrated Community Palliative Care service that is patient centred and designed to respond quickly to their needs, which will commence in the Spring of 2019.

The newly integrated service is made up of colleagues from existing services including LPT, LOROS and Marie Curie who provide a coordinated palliative care service, 24 hours a day 7 days a week, based on need.

Clinicians, patients and carers can access now palliative care input for referrals and for general enquiries using one telephone number, rather than having a different number for each organisation.

The service will provide rapid response to support patients who can be quickly discharged from hospital as well as support those who need urgent care in the community to allow them to end their life in the place of their choice.

Increasing the update of screening of colorectal cancer

In order to improve mortality and ill health from colorectal cancer we have to find out about it earlier.

The only way is to pick up cancer in patients before they are symptomatic i.e. to increase the uptake of screening.

From February this year patients who have symptoms of change in bowel habits and abdominal pain are required to have a FIT test (Faecal Immunochemical Test). FIT has been considered as a way to assess the risk

to patients and reduce demand for colonoscopy

For patients whose test were reviewed by their GPs as positive then a 2 week wait referral will be made to University Hospitals of Leicester.

The tests are processed and analysed by the East Midlands Screening Hub (Nottingham) and the GP is informed if the results are positive or negative.
Negative tests give a 99.7% chance that the patient does not have cancer and does not require further invasive diagnostic tests.
Positive results mean the patient needs to be referred under a 2 week wait for a CT
Colon Scan to determine a definitive diagnosis.

Of the 701 patients who went through the service between February and the end of April 2018, 70% of them have not needed a referral.

BCT partners joined a debate at De Montfort University

BCT partners from UHL, primary care and the clinical commissioning groups joined a discussion and debate on different aspects of health care at an event held in June.

Coordinated by the Health Policy Research Unit at Leicester's De Montfort University, health professionals discussed with academics, patients and carers the new model of care being introduced locally. Particular focus was given to the work to strengthen primary care helping people make the right lifestyle choices and improve access to GPs and practice teams. We also discussed the support being provided to patients at home and in the community and the proposals to reconfigure Leicester's acute hospitals to provide the best patient outcomes in a high quality and safe environment that is affordable.

BCT partners would like to thank Sally Ruane and staff at the Health Policy Research Unit for coordinating the event and inviting staff to participate in the lively debate.

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Local leaders backed by regional academy

Our system leaders are embarking on development opportunities to integrate local services and benefit their patients.

The Integrated Teams workstream is already benefiting from access to the Leading Across Boundaries programme during 2017/18. This has enabled initial locality leaders across social care, primary care and community nursing to have access to a joint leadership development programme, in small groups, at a critical stage in the formation of a new model of care in LLR.

East Midlands Leadership Academy has now expanded this work to offer additional development opportunities which include "*One team, tackling barriers to integration*", "*The LLR Model of Care Coordination*" and "*The wraparound prevention offer*" as well as looking at analysing the impact of the service improvements that are being introduced.

NHS heroes from Leicester on star-studded charity single

Two NHS heroes from Leicester have joined the likes of Tony Hadley, boyband Blue, UB40 and Beverley Knight to record a charity single to raise funds for healthcare charities across the UK.

Ambulance technician Kuldip Singh Bhamrah from East Midlands Ambulance Service (EMAS), and Vicky Cartwright, ward matron at University Hospitals of Leicester were invited to the iconic Abbey Road Studios in London to record the Beatles classic With a Little Help from My Friends.

The charity single, due to be released on 6 July as part of the NHS's 70th birthday, includes dozens of NHS heroes who have dedicated their lives to the health service – and Kuldip and Vicky were specially selected to appear on the track.

A 90-minute special on ITV documenting the creation of the charity single will also be shown on 4 July, followed by a world record attempt to host the biggest live singalong. Kuldip and Vicky, who live and work in Leicester, were specially selected to be part of the single due to their singing experience.

Kuldip, 65, based at Goodwood station and who has been in the service for 37 years, is well known throughout Leicestershire as 'the singing ambulanceman'. Kuldip, the first Sikh ambulanceman in the East Midlands and recipient of the Queen's Ambulance Medal, still sings to many of his patients and while he is working, as well as at events and at his temple to raise money for community defibrillators and local charities.

He said: "I can't help but sing at work because it is a job that makes me happy

because I like caring for people. Singing to them also helps to relax patients. – especially when I serenade them on the way to hospital."
In 2016, Vicky (41) based at Leicester Royal Infirmary hospital, created a rap about hand hygiene. She came up with the idea driving home from work. Leicester's Hospitals has used the rap in staff campaigns including staff inductions. Other Trusts from around the country have also used the rap.
Vicky started her NHS career in 1998 and began working at Leicester's Hospitals in 2002 as a staff nurse. More recently she has been promoted to matron. Vicky is passionate about hand hygiene and gained a Master in Science (MSc) in Advancing Professional Practice.
Vicky said: "We didn't know that we were going to Abbey Road studios to record the single. Meeting and singing with so many famous faces and NHS staff from around the country was so empowering. To be part of something this special has been the highlight of my year. It has been amazing and a fantastic way to say thank you and Happy Birthday to the NHS!
The ITV documentary will be presented by Ashley Banjo and Sara Cox and aims to capture all the excitement of the recording of a charity with an array of stars including Seal, Beverley Knight, Guy Garvey and many more.
The show will hear exceptional stories from right across the NHS, meet extraordinary patients and NHS staff and deliver plenty of surprises and feelgood moments up and down the country's hospitals as they aim to recruit thousands of voices to swell the ranks of the Big NHS Singalong choir.
This latest mission into the charts follows the NHS Choir's 2015 hit single 'A Bridge Over You', which beat Justin Bieber to that year's UK Christmas number one spot.
The charity single will be released on 6 July. All proceeds will go to the **NHS Charities Together**, a group of more than 100 NHS charities that have come together to celebrate the 70th anniversary of the NHS and raise awareness of the work that NHS charities do to support the NHS.

Mental health arts exhibition for NHS70

Staff and patients at the Bradgate Mental Health Unit were invited to an NHS Big7Tea party on 5 July – 70 years to the day since Nye Bevan's healthcare vision became reality.

They were welcomed with tea, birthday biscuits, celebration cake - and a unique arts exhibition celebrating the NHS story through a ‘walk-round’ timeline of historic NHS events.

The exhibition, currently on a county-wide roadshow of NHS sites, features more than 60 paintings, sketches and poems created by mental health service user artists who worked with participatory artist Scott Hegley.

It was part of a packed programme in the Recreation Room at the unit, on the Glenfield Hospital site. The event marks Leicestershir
e Partnership NHS Trust’s (LPT) part in the evolution of one of the country’s best-loved institutions, and shine a spotlight on the staff who have made it happen.

The artwork will move to Westcotes Health Centre and the Evington Centre on the Leicester General Hospital site before being mounted as a long-term display in Leicester Royal Infirmary at the end of the NHS at 70 celebrations.

Share your news

We know that there are loads of great examples of innovative and integrated ways of work happening right across Leicester, Leicestershire and Rutland. If you have a story that you'd like to share in this bulletin please send us details.

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