*Your quarterly update about partnership work in the Leicester, Leicestershire and Rutland ICS*

# Health & Care Together

January 2022 | *Issue 1*

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# Bringing health and care together

How integrated working across Leicester, Leicestershire and Rutland is already leading to better outcomes for the communities we serve.

**Welcome to the first issue of Health & Care Together, our new quarterly magazine for the Leicester, Leicestershire and Rutland Health and Wellbeing Partnership.**

It is primarily aimed at the 70,000 plus health and care staff who work across our system, as well as anyone else who might have an interest in our work. Through it, we hope to bring to life the principles of our partnership: closer working across and between health and care organisations and the integration of services in ways that puts patients first. In doing this they will deliver better care and outcomes for all.

The changes are not about governance or structures or hierarchies. At its heart, it is about empowering staff, alongside patients and the public, to spot the things that all too often get in the way of delivering great joined up care and working together to solve these challenges and make a real difference.

It builds on and accelerates collaboration that we've seen developing in recent years – both between different parts of the NHS and, more recently, the NHS and social care. It seeks to finally address the inequalities, or unwanted variation in health and outcomes, that have persisted within our city and parts of the counties for too long.

It's early days but we are making good progress. In this inaugural edition there are five examples of initiatives that exemplify the ethos and spirit of our partnership. You can read about outstanding work between NHS and care colleagues to help keep vulnerable care home patients safe and avoid unnecessary transfers to hospitals, as well as nationally pioneering work to support frail or older patients who have suffered a fall.

You can also read about the role volunteers have played as the unsung heroes of our Covid vaccination programme, how clinical teams have adapted throughout the pandemic to provide virtual wards for patients with heart and lung disease, as well as improvements to local mental health services that are bringing partners together under one roof.

**David Sissling**
Independent Chair, Leicester, Leicestershire and Rutland ICS

We hope you enjoy reading about them and we would, of course, welcome your feedback. But, more importantly, we want your examples of other work that is taking place across the system that shares these same values so that we can showcase those too. You can send your feedback and suggestions to the email address on the back cover.

In the meantime, on behalf of all our system partners, I'd like to thank you for everything you've done during another extraordinary year.

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### Future editions

If you and your team have a story to tell about the health and wellbeing partnership across Leicester, Leicestershire and Rutland, email us at **llrccgs.corporatecomms@nhs.net**

## Free mental health and wellbeing support for all staff

Did you know that we have an LLR Staff Mental Health and Wellbeing hub which offers confidential and free of charge support for all health, emergency services and social care staff in Leicester, Leicestershire and Rutland?

**Helpline**

Staff can contact the hub's helpline:

**Tel: 0116 2544388**

**Email: mhwb.hub@nhs.net**

Visit the hub website for access to a wide range of advice and support:

**www.llrstaffwellbeing.org**

# Virtual ward like winning the lottery, says Leicester gas engineer

## Phillip Walker from Leicester felt like he had won the lottery after being told he could go home after a week in hospital with Covid.

Gas engineer Philip, 57, was experiencing a high heart rate and breathing difficulties after contracting the virus, and was admitted to Glenfield Hospital for treatment in November.

After a week of treatment, his doctors felt he was well enough to be cared for remotely from his home in Aylestone through an innovative technology-led virtual ward scheme.

Pioneered at the height of the pandemic, the virtual wards help patients with breathing problems get home from hospital more quickly – or even avoid a stay in the first place.

Under the scheme - a partnership between University Hospitals Leicester and community provider Leicestershire Partnership Trust - patients who are medically fit for discharge from hospital but still need oxygen or other additional support, are able to leave hospital and be monitored remotely in their own homes using digital technology.

They are given access to software which enables them to fill out a daily questionnaire about their symptoms, using their mobile phone or tablet. If they don't have access to one, they are loaned one for as long as they need it. They are also given a thermometer and an oxygen monitor which clips on to their finger in order to record these details on the system.

Patients are monitored for 14 days, or longer if needed, and can contact the team at any time if they have concerns.

The first virtual ward was set up in response to the pandemic and was so successful that readmission rates were half those seen on wards where this service wasn't available. Over 300 patients have now been discharged onto this service, with around 50 being monitored at any one time during the peak of the pandemic.

It is now being introduced for patients with Chronic Obstructive Pulmonary Disease (COPD) and will work in a similar way, although the team will also be able to monitor people deemed at risk of a hospital admission, which could prevent them from ending up in hospital in the first place.

Irene Valero-Sanchez, Consultant Respiratory Physician and Clinical Lead for Integrated Care, University Hospitals of Leicester, said: "The feedback we have received from patients has been fantastic and the figures speak for themselves. Readmission rates were really low, in part because people felt confident that they were being supported also because they had direct access to a specialist team to address their concerns.

"Evidence shows that people recover better in the comfort of their own homes and for the Covid patients in particular, it was so important to get them back home and out of hospital where they'd been through what was, for many, one of the most frightening experiences of their lives."

**322** 322 Covid-19 patients have been discharged after a hospital admission with remote monitoring at home with only eleven people being re-admitted to hospital during their 14-day monitoring period (2 November 2020 – 19 November 2021)

The virtual wards are part of a wider plan to improve digital health services for people with long term conditions, aiming to improve outcomes by detecting and addressing signs of deteriorating health earlier, whilst empowering patients to take more control of their own care. Leicestershire Partnership Trust is also working on schemes to remotely monitor the health of those with COPD and heart failure on a continuous basis, not just when they need or have had a hospital admission.

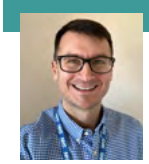
> "Because I had Covid I was just stuck in my hospital bed. I wasn't allowed any visitors and couldn't go for a walk, so when I was told I could go home I felt like I'd won the lottery! It was a great relief."

**Philip Walker**
Gas engineer

> "Patients' symptoms and measurements are analysed and triaged in to a red, amber or green category, with those flagged up as red or amber receiving a call and/or a visit from the community team that day."

**Irene Valero-Sanchez**
Consultant Respiratory Physician and Clinical Lead for Integrated Care, University Hospitals of Leicester.

> "The virtual ward has been a real success. Not only has it helped with patient flow across the system and eased some pressure on the hospital it has had an immeasurable impact on patients' wellbeing and recovery."



**Alex Woodward**
Deputy Cardio-respiratory Lead at Leicestershire Partnerships Trust.

Better, faster falls service aims to avoid unnecessary admissions

# Huge pick me up for elderly and frail who fall

A new service in Leicestershire and Rutland is helping people like Anne get back on their feet more quickly after a fall.

Currently, patients who have fallen but are not injured often only need the right help to get up from the floor safely – and at the moment that can mean a very long wait for the ambulance service.

The new Urgent Falls Response team hopes to make this a thing of the past. The team can be contacted by care staff, health workers and East Midlands Ambulance Service, and aims to get to a patient within two hours or less.

This was the case for 74-year-old Anne* who fell one morning while doing housework and was unable to get off the floor, even with the assistance of her husband.

The couple called 999 for help and were referred to the response team who arrived in just over an hour. A clinician carried out a full assessment and, once it was safe to do so, Anne was lifted from the floor using a specialist lifting cushion. She was able to stand independently and use a walking frame to reach her chair. Her medications and general health were checked, and the clinician made sure she could safely get in and out of her chair.

"Previously, the only option when someone, like Anne, had fallen and couldn't get up was to call an ambulance, even if that person didn't necessarily need any medical treatment," said Alison Brooks, the service lead.

"The aim of this service is to get to these people faster and give them a much more appropriate response. They will still be seen and thoroughly checked over by a clinician but it avoids lengthy waits for ambulances, which can lead to further problems, and often means that person can avoid an unnecessary hospital admission and the distress that can cause too."

The Urgent Falls Response Service is a pilot project and is provided by DHU Healthcare, the organisation that also provides community healthcare on behalf of GPs out-of-hours.

**Richard Lyne,** Divisional Director for Leicester, Leicestershire and Rutland at East Midlands Ambulance Service, said:

*" This collaborative project has created a service that has improved the speed of response, thus reducing avoidable admissions to hospital whilst also allowing our emergency crews to prioritise the most life-threatening patients."*

Registered care workers, health professionals and social care staff can call the team if they are with someone who has fallen and can't get up, but doesn't have a serious injury – whether that be in a care home or in their own home.

A call-taker will take the patient's details and complete a checklist, which is then passed to a clinician who will contact the caller within 15 minutes. If the clinician identifies a need for emergency care an ambulance will be called

If an ambulance is not needed, a car containing the clinician and a healthcare assistant will be dispatched to visit the patient within two hours.

Liz Daft, DHU Healthcare Advanced Nurse Practitioner, said: "This service just makes sense. Frail and elderly people deserve to be cared for with dignity which we are able to provide with a much quicker response. It's better for the rest of the health system too as it means ambulance crews are freed up to attend more urgent, life-threatening calls."

There are currently two falls response vehicles, based in Oakham and Loughborough. Each is equipped with lifting/patient handling equipment, along with medications commonly used in urgent care.

The team are also able to refer the patient on to the appropriate services for additional support if needed if they feel they are at risk of falling again or may need extra help to remain independent. ●

**The service began on 11 October and is available 8am to 8pm, Monday to Friday, with the aim of expanding to cover weekends too.**

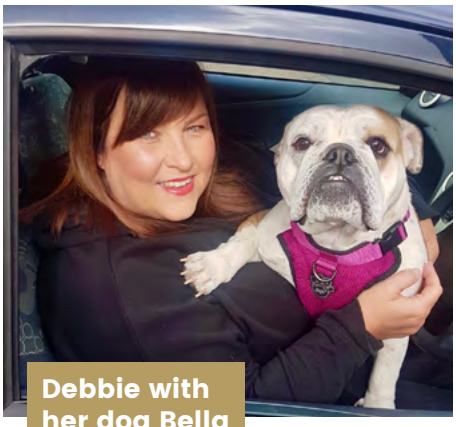
*Not her real name

# Helping others helped me through the pandemic

A Blaby woman who volunteered throughout the pandemic says it helped her through the toughest times.

Debbie, 54, works in the beauty industry and was furloughed for almost 12 months in total. She made the decision to become a volunteer during the first lockdown and has carried out a number of roles – from delivering video equipment to GP surgeries to helping out at vaccination centres.

She said: "Our industry was particularly hard hit during the pandemic and I was furloughed for long periods of time. At first it felt like a bit of a novelty but I soon realised that sitting at home all day just wasn't me. I really needed to get out there and be with people and feel like I was doing something worthwhile.



Debbie with her dog Bella

"It helped me so much and stopped me from becoming really isolated. I always say that I got so much more out of it than they got out of me. It was just a lovely feeling to be part of everyone coming together in that way and I met so many different people from all walks of life.

"I hope we're never in that situation again but I'd do it again in a heartbeat."

Initially, Debbie volunteered as a driver, taking video equipment to GPs surgeries around Leicester, Leicestershire and Rutland, in order to ensure virtual consultations could happen.

She said: "I'd get in the car with my dog Bella and we'd drive around and drop all this equipment off. That was in the early days when everyone was really fearful of what was happening and it just felt really good to be doing something to help."

In the second lockdown she volunteered at vaccination centres, including the one at Leicester Racecourse.

She said: "That was right at the beginning of the vaccination programme and it was crazy. There were days where we'd get over 1,500 through the doors. I'd help with everything from making cups of tea to parking cars."

The health and care sector has always benefitted hugely from volunteers in Leicester, Leicestershire and Rutland (LLR), but the pandemic has shown just how important the voluntary sector is to everyday life.

During the pandemic, through Voluntary Action LeicesterShire, an army of 2,600 non-clinical volunteers stepped up to give a huge 64,000 hours of time to help local people get protected against Covid-19 at 37 vaccination centres across LLR - worth the equivalent of £600,000.

Paul Akroyd, Sector Support Manager, Voluntary Action LeicesterShire, said: "This was the biggest mass mobilisation of volunteers we've ever seen. It's helped shine a spotlight on the critical role the voluntary sector plays, not only in times of urgent need like the pandemic, but more widely in support of the health and care of all our communities across LLR."

**Alice McGee**
ICS lead for Volunteer Recruitment & Engagement

The organisation also registered a further 2,500 volunteers during the lockdown restrictions to help with things like befriending services, food shopping, food banks, making deliveries and preparing food.

Alice McGee, ICS lead for Volunteer Recruitment and Engagement, said: "Voluntary, community and social enterprise organisations are uniquely placed to support people and their communities in many ways - from COVID-19 recovery planning to supporting population health and reducing health inequalities. Their role is critical in our partnership.

"This vaccination programme would not have been possible without the wonderful people who registered in their thousands to volunteer – truly amazing people doing amazing things."

# Partnership project keeping care home residents safe

Hundreds of care home patients have avoided unnecessary trips to hospital thanks to a new partnership project.

The pilot project began in May 2020 and has changed the way that care homes, GPs, East Midlands Ambulance Service, geriatricians working in the Emergency Department at Leicester Royal Infirmary and 111 talk to each other to find ways to help more elderly or frail people receive their care in the community.

They are also working together to make sure those who do need a hospital admission get home more quickly and have rapid access to the right care in the community.

Being admitted to hospital can carry significant risks for these patients so it's important that only those who really need hospital care are admitted. Hospital care focuses on the right issues for each patient based on their personal care plan and wishes.

Under the scheme, patients identified by the ambulance service as potentially needing a hospital admission are first discussed by a hospital consultant, with three potential outcomes:

- Transfer to hospital with a clear management plan, which generally leads to a shorter stay and care tailored to the individual.
- Being managed at home by their own GP under a plan agreed with the hospital geriatrician.
- Further assessment within an hour by a GP with specialist interest in older people's medicine. This can lead to the patient being managed at home or transferred to hospital for further assessment.

The overall aim is to improve the quality and personalisation of care rather than reduce admissions to hospital.

As a result, three quarters of care home patients who would have usually been sent to hospital have been cared for in their homes with wrap-around clinical care. Numbers of hospital days have also been reduced, there is better ambulance availability for emergencies, and a better range of options for care in the community.

Mark Pierce and Sarah Smith, Project Co-Leads from LLR CCGs, said: "Covid-19 has changed life in many ways, and continues to do so, yet in this case, it has helped accelerate a new, improved way of delivering care, treatment and support to some of our most vulnerable members of society.

"It's a simple model developed by joining up the learning from previous initiatives across the system. The impact has been remarkable, in terms of the quality of care, outcomes and experience for older people and for staff. It's also improved how people access acute services. We look forward to rolling this our further and sharing our findings with other systems too."

The project covers more than 290 care homes and, while it is early days, plans are in place to roll this model out more widely across LLR for community home care for older people too. This collaboration between a large number of partners in our system offers the opportunity to transform care for older people in LLR by better integrating services and communication."

One care home manager said: "I just wanted to let you know how impressed I am. It was nice to have some support in this difficult situation, as we have at times, felt as though we're on our own with all of this."


***"What this partnership project has shown very clearly is that a simple change to the way we communicate between our services can make a massive difference to way we care for our most vulnerable patients."***

East Midlands Ambulance Service

A new way of supporting people with mental health needs is already having a life-changing impact for people in Leicestershire.

# A new lease of life thanks to life-changing Neighbourhood Team

A new way of supporting people with mental health needs is already having a life-changing impact for people in Leicestershire.

This new neighbourhood approach brings together a range of local support services - GPs, social care, council staff, voluntary organisations and community mental health teams - to pool their expertise and provide support that is built around an individual's needs.

It aims to help people who may otherwise fall through the gaps in traditional health or social care by proactively identifying potential problems at an earlier stage and working collaboratively to solve them.

Social prescribing is a core part of the team's approach - where a person is given a non-medical 'prescription' to help them get involved in activities that matter to them. Social prescribers, who sit on the team, help people make links with groups and activities, accompanying them to sessions until they feel confident enough to go on their own.

Clinical support is still provided as needed, but the aim is to move to a more holistic approach to mental health.

John and Molly, both in their 80s, have been supported by a Neighbourhood Team in Loughborough for the last 12 months.

John, once an active man and keen car booter, has arthritis in his feet and a cyst on his knee which means he can no longer walk independently. After he reluctantly gave up his driving license 18 months ago, he began to feel very lonely and isolated.

His GP referred him to Amy Jones from the Social Prescribing Team in Loughborough. Amy organised assisted technology for John, including a TV loop, flashing doorbell and amplified telephone, set him up with a computer and is teaching him how to access the web and connect with his family overseas.

John said: "This service means a heck of a lot to me. Having the computer has given me something else to do than watch TV. I use it to search for things I'm interested in, like old war medals, and I've also been able to speak to my daughters in Australia who I haven't be able to see or speak to in years."

Amy also acts at a link between him and the GP practice, enabling him to access appropriate healthcare. A carer has been sourced to support John with personal needs, such as showering safely, and he now receives an attendance allowance which he has used to purchase a mobility scooter to get out and about.

Amy said: "John's world has been reopened and he now has something to look forward to. The impact on his health, both physical and mental, has been dramatic."

> "John's world has been reopened and he now has something to look forward to."

Molly, who had been a carer to her husband with dementia for years, felt isolated and had lost connection with her community. She spent most of her days just sitting at home in her chair, feeling very low.

Amy linked Molly into various groups which she now attends four days a week, including a lunch group. She is socialising and feeling she has something to look forward to. It has boosted her confidence enough that she is now the one welcoming people into the group, and has started to go to church again.

**Amy Jones**
Social Prescribing Team

> "I think Social Prescribing is extremely beneficial to the NHS..."

Amy added: "Social prescribing is extremely beneficial to the NHS as we are able to give people time to talk and look at their problems in more depth. We create personalised plans to help them achieve goals which would not be able to be met by primary care. We have the opportunity to make a huge difference in people's lives and drive them forward to enable change."

Joanne Talbot, Senior Social Prescriber, said: "John and Molly are classic examples of how the impact of looking at 'what matters to you' can improve someone's life. Being connected to social groups, friendships, volunteering, your community and things that you enjoy can have a lasting impact on health and wellbeing.

The team has been operating in the Charnwood district since October 2020 and there are plans to eventually create 25 teams across Leicester, Leicestershire and Rutland.

# The health and wellbeing partnership for Leicester, Leicestershire and Rutland.

NHS
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS
University Hospitals of Leicester
NHS Trust

NHS
Leicestershire Partnership
NHS Trust

Leicester City Council

Leicestershire County Council

Rutland County Council