Estimated population size of 750,700 (estimated 2011)

Vision for Integrated Services in Leeds
Why we are doing this

• Big changes in partnership working across Primary, Secondary & Community Health & Social Care in Leeds.
• Passion & commitment of staff to take integration from a concept to reality. This change has been staff led.
• We’ve recognised the strengths of each partner organisation and built this into the model.

South East Initiative

• Facilitation of Wider Integration
  - Community Nursing
  - Community Therapy
• Key Drivers
  • Right care, right time, right place
  • Wrapping care around patients and practice populations
  • Key worker model – consistency for the patient
  • Avoidance of duplication and waste
  • Releasing time to care (LEAN methodology)
  • Clinical co-ordination of patients
Workstreams

• Beds,
• Case Management,
• ICT/Reablement,
• Neighbourhood Teams,
• Out of Hours,
• Rapid Response,
• Referral Pathways (Gateway)

Case management

• Sir John Oldham
• 3 anticipated benefits:
  – Service utilisation
  – Health outcomes
  – Patient experience
• Framework:
  – Costed case studies focusing on the 3 benefits and including efficiency savings where they have been delivered.
  – A field on SysmOne and, eventually, CIS which is connected to CareTrak to support evaluation
**Definition**

“Case management is the identification of a professional from the neighbourhood team who will proactively coordinate the care and support of a patient/service user with complex health and/or social needs. By working in partnership with them, their family and/or carer(s) and bringing in additional professionals as appropriate, case managers will ensure that personalised plans and goals are set on the basis of the assessed needs, preferences and choices of the individual and reviewed as necessary.”

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**Clinical Outcomes**

- Regular monitoring and review to enable early intervention
- Reduced dependency / full withdrawal of / change to appropriate medication
- Use of appropriate assistive technologies
- Improved long term care management
- Diagnosis of conditions leading to appropriate care plans put in place
- Reduced duplication due to better communication and liaison between professionals / agencies
- Steps to ensure public safety – removing driving licence from service user known to drive unsafely
- Fewer hospital admissions
- Prevented long term care admission
- Fewer GP & Community Matron visits
- Appropriate Dementia / Mental Health support in place
- Reduced ICT involvement following discharge
**Individual outcomes**

**IMPROVED**
- Increased voluntary sector involvement
- Personal safety
- Activities of Daily Living
- Independence
- Support to look at service users’ financial problems
- Quality of life
- Mobility
- Nutrition
- Continence management
- Restored carer and service user confidence in care team

**REDUCED**
- Anxiety
- Symptoms
- Carer stress
- Panic attacks
- Risk of hospital admissions
Unforeseen benefits

• Bringing staff together
• Understanding one another’s roles
• Overcoming “cultural” barriers
• Team development

Results, Positive outcomes and long term impact

• Person centred and asset based. Considers the strengths of the individual, what is important to them and their support networks.
• Joined up caseload across primary care and neighbourhood teams
• Reduction in unplanned hospital admissions
• Proactive care enabling individuals to remain in their own homes
• Increased staff satisfaction and morale
• Cost effective
• Optimum use of the Leeds Pound
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