integrated working

JIGSAW

PIECING TOGETHER CARE IN WEST SUFFOLK

JULY 2016

ADULT COMMUNITY SERVICES

SUPPORT TO LIVE AT HOME

By Joe Cross, Communications Officer, Suffolk County Council

Support to Live at Home is a Suffolk County Council service that provides home care in Suffolk. In line with the values set out in our Supporting Lives, Connecting Communities approach our aim is to deliver care and support which meets peoples' needs in a way that concentrates on their wellbeing. We work with a combination of local, regional and national providers to deliver and develop sustainable home care.

This service is available to people in Suffolk who need support to live at home. The Council provides support to people across Suffolk by helping customers to make choices about their care and support needs in a way that works best for them. If you or anyone you know wants to find out more about the service and how it could help them, please contact Customer First on 0808 800 4005 or visit our website www.suffolk.gov.uk/adult-social-care-and-health/your-care-and-support.

All of the providers we work with have to meet CQC standards and we are continually monitoring the quality of care and support being provided to our customers. One particular customer's feedback was very encouraging, with the quality monitoring report stating 'the customer is very happy with her care provider. She cannot fault her carers, describing them as kind, experienced, always on time and never missing a visit. The lady was particularly pleased that the company provided her with a rota, so she is well informed and knows who to expect in her next visit. The individual particularly stressed how helpful and professional her carers have been since she has been discharged from hospital, when she was extremely weak. Her carers enabled her to get stronger again and to walk confidently, without being afraid of falling'.

Whilst there are national and local challenges in providing care, we are continually striving to improve the experience of customers who wish to receive council managed care. Adult Community Services (ACS) is committed to the aspirations and values underpinning the Support to Live at Home service and will continue to work with customers, providers and partners to make the provision of home care better for those people that need it now and in the future.

MDT MEETINGS

By Tracey Rowe, Cluster Team Manager, Adult Community Services (ACS)

Moving towards a model of health and social care integration is occurring at all levels in Adult and Community Services and healthcare services. Some of this is at a strategic level but there is also development on the ground; the Bury Rural ACS Team and community health colleagues are working together using the Connect approach. The aim of Connect is to improve the experience of the customer/ individual by working in an integrated manner. One way of achieving this is by ACS practitioners regularly attending multi-disciplinary meetings at GP surgeries. Below is a description from Alison Burbridge who is a Community Care Practitioner with Bury Rural neighbourhood team.

Welcome to JIGSAW

A newsletter for staff working in the health and social care system in West Suffolk. There is a lot happening to bring hospitals, community, mental health, voluntary sector and the West Suffolk Clinical Commissioning Group (CCG) together to help patients.

'I attend monthly meetings at 2 GP surgeries. Some surgeries have lunch time meetings, some meet early in the morning before morning surgery. We generally go through unexpected hospital admissions in the past month and if I am able to update with information about care provided on discharge I do. Otherwise I will check on my return to the office. We also discuss palliative customers and others on the GSF list.

The District Nurses, Community Matron and also workers from the Hospice attend and it is good to put faces to the names when meeting practitioners that I speak to when on duty. The GP's are able to highlight anybody to me that they feel may need a Social Care assessment and I am also able to discuss situations who I or my team-mates think the GP may need to be aware of – which they invariably are.

Meeting on a monthly basis allows some continuity and sharing of information and ideas about how to improve outcomes for the people we work with and reduce duplication'.

A DAY IN THE LIFE OF...

By Gemma Spall, Nurse Coordinator, NHS Continuing Healthcare

As a nurse coordinator for the NHS Continuing Healthcare (CHC) team, my role involves assessing patients' health needs for entitlement to CHC funding in Suffolk.

Patients are referred to the team when a checklist and consent form has been completed, usually by a nurse, doctor, other qualified healthcare professional or social worker. My role is to assess patients within the community, including those residing in their own homes, residential homes and nursing home settings.

My workload can vary and this is subject to the demands of the service. A working day might include a multidisciplinary team (MDT) meeting booked for a patient living in a nursing home.

Typically, at such an MDT meeting, a patient or their next of kin, who may be representing them, and/or a family carer may be present, together with a social worker and myself. There are open discussions regarding care needs and we work together to establish the appropriate level of need in conjunction with criteria for CHC, set by the Department of Health. There are some disagreements at times, but we work collaboratively to justify recommendations.

To finalise the MDT meeting, the social worker and I will have a discussion regarding the Primary Health Needs Test and we explore key concepts of this test. When we have come to an agreed recommendation, this is explained to the patient and/or their representative. The social worker and I make recommendations regarding care and signpost to other services for concerns/issues raised.

This collaborative working helps to robustly bridge the gap between health and social care by analysing all of the evidence on an individual case basis. At times, a person's needs are not easily categorised but through thorough discussion and debate, we are able to come to a decision with consistent and comprehensive consideration of an individual's needs.

PERSONAL BUDGETS

By Jo Murray, Dementia Cluster Manager (West), Adult Community Services (ACS)

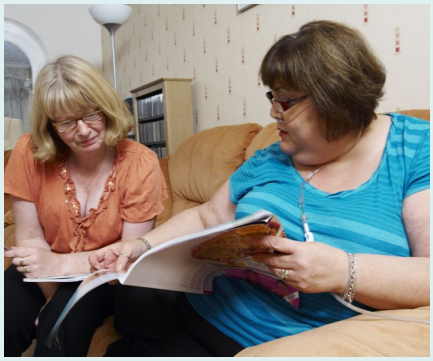
A Personal Budget is the amount of money made available from Suffolk County Council (SCC) to individuals to help meet their eligible care and support needs.

SCC uses a questionnaire to allocate a score, based on the level of support the customer needs. This score relates to a sum of money and is called an "Indicative Personal Budget". A plan is then developed in collaboration with the customer. Once a Personal Budget has been agreed, SCC will work with the customer to plan how they want to spend the money in order to meet their needs. Although the customer can choose how to spend their budget, it must be used to meet their needs, on things such as getting the support they need at home, getting involved in community activities and/or keeping healthy and safe.

The individual may be asked to contribute towards the cost of the Personal Budget. In this instance, SCC will ask them to complete a financial declaration form and this information will be used to assess the weekly contribution required.

If a Personal Budget is approved for an individual or their carer, a Care and Support Plan, showing how the customer is allocating the money to achieve their goals, to live independently and to meet their eligible needs will be developed.

Further information about Personal Budgets can be found at https://www.suffolk.gov.uk/adult-social-care-and-health/budgeting-planning-and-paying-for-care-services/what-is-a-personal-budget/ or by telephoning Customer First on 0808 800 4005.



ONELIFE SUFFOLK

By Hayley Beck, Marketing Manager, MoreLife (UK) Ltd

HELPING LOCAL PEOPLE LIVE HEALTHIER LIVES

OneLife Suffolk is the new integrated healthy lifestyles service that is helping local people live healthier lives.

OneLife Suffolk offer the following services:

Stop Smoking
A 12-week support programme which is completely free to all smokers. Support is provided by trained stop smoking advisers and can be delivered face-to-face or over the phone.

Lose Weight – Adults
Researched and developed by a team of specialists, OneLife Suffolk adult weight management services are designed to create long-lasting shifts in behaviour and give you the support and tools you need to achieve your health goals.

Lose Weight – Children
The OneLife team deliver gimmick-free, interactive programmes which are aimed at children aged 2-18 with a BMI above the 91st centile. Find out a child's BMI at www.nhs.uk/BMI The programmes focus on a whole-family approach to help encourage everyone to improve their health and wellbeing.

Become More Active
Specific support to help adults with long term conditions to become more active. There are also free 'Health Walks' available to all. Full details of these are available on the OneLife website.

NHS Health Checks
A free 'midlife MOT' aimed at adults aged 40-74 without any pre-existing conditions. Contact the team to find out more.

For more information about what OneLife Suffolk can do, please visit www.onelifesuffolk.co.uk, email info@onelifesuffolk.co.uk or call 01473 718193 to speak to a member of the team.

GET INVOLVED

If you have any news or views on any of these projects, please contact the partners through this email address: getinvolved@westsuffolkccg.nhs.uk