

Lancashire's approach to local area co-ordination

Strategic context

Lancashire and its CCG partners are jointly commissioning integrated locality-based "preventative" services for people with long-term conditions.

JSNA for people with long-term conditions:

They have published a JSNA which not only analyses the prevalence data and needs of people with specific clinical conditions, but also recommends new models of working, in some detail. The overview document includes proposed actions relating to: (1) sharing intelligence, (2) prevention (including health promotion) (3) urgent care, (4) long-term conditions model of care, (5) empowerment.

<http://www.lancashire.gov.uk/corporate/web/?siteid=6117&pageid=35411&e=e>

The JSNA is characterised by its very strong emphasis on ensuring that people are informed and empowered. For example:

"Making sure that people have access to, and are able to understand and interpret basic (...) information empowers them to look after their own health. It is also important for people to know what services, including those within the third sector, are available to them to help support empowerment and self-care. This health literacy can build resilience in individuals and communities and is a key determinant of health and health equality".

The Joint Strategy

Partner agencies in Central Lancashire (including 2 CCGs, serving a population of approx 0.5 million) have a shared vision, to achieve *"sustainable shifts in activity from the acute sector to the community, and at the same time improve the capacity and resilience of individuals, families and communities"*. The vision is an ambitious one, that will involve significant service re-design, and shifts of activity and spend within and between agencies.

To steer this work, the multi-agency Boards responsible for Urgent Care and Long Term Conditions have been merged, to achieve a more coherent programme, focussed on joining up services in each locality. A number of specific “**high impact changes**” has been identified, with each partner agency taking lead responsibility for at least one of the identified changes. Three of these are:

- **Systematic risk profiling**
- **The development of integrated neighbourhood teams**
- **Promoting self-care/shared decision-making.**

The Better care Fund (BCF) will be used to accelerate this work, through the creation of a **pooled budget** that will be used to build local capacity and infrastructure. It will be invested in a range of jointly planned services that – through their preventative impact - will allow health and social care resources to be shifted over time.

The Connect4Life scheme featured here (which has received a one-off investment from the council of £250k in 2013/14) is one of the initiatives that will be prioritised in the BCF plan.

“Local Area Co-ordination”

The work to develop integrated preventative services has several dimensions. In essence, plans are based around neighbourhoods - with relevant resources in each neighbourhood being identified and re-designed.

For example, **integrated neighbourhood teams** have so far been established in 11 places. These include community health professionals and social care representatives, and are working to achieve joined-up case management (which will be supported eventually by shared records).

Some other existing services and budgets are also being reviewed – to ensure there is coherence within each neighbourhood, to make sure there is no duplication of effort and to ensure funding is targeted to achieve the best outcomes.

Finally, the **Connect4Life** service (which was initiated during 2013) is introducing active case-finding and asset-based work. This will put extra voluntary sector capacity into the heart of each neighbourhood team.

Connect4Life

The future vision is that people who are at risk of acute admission (or regarded as at a “tipping point” where they might need expensive social care support) will be identified at an early stage. Resources wrapped around the local GP practice (including voluntary sector and other community assets) will be deployed, to support the identified people and help them self manage.

The initiative aims to operate in 66 GP practices by the end of 2014.

Structure

The initiative began in 2013. In these early stages of development, Central Lancashire have put some strategic resources into building capacity within the voluntary sector and communities. These comprise:

- Two “**Community Connectors**”, whose work is described below;
- A small grant to **Salvere**, an experienced community interest company, who are helping to develop and co-ordinate the scheme.

At district level:

- Each district has a multi-agency **stakeholder group** that has very wide representation – e.g. from Healthwatch, the police, Adult Learning, Leisure Services, independent sector providers, housing associations, the volunteer bureau etc. (Stakeholder group meetings are intended to be vibrant opportunities for information exchange, and are so far well-attended).
- Four **voluntary organisations** (British Red Cross, Age UK, West Lancashire CVS and Age Concern Central Lancashire) have been recruited as the main implementation partners – one for each district. Each has a lead person known as a **Connect4Life organiser**. They are responsible for receiving referrals from GPs and using an “asset-based” approach to link people to local resources including volunteers.

Community Connectors

<https://www.facebook.com/connect4lifelancashire/info#!/connect4lifelancashire>

The two Community Connectors exemplify the “spirit” of this new scheme, as well as having expertise in community development and asset-based approaches. Some of their techniques are described below.

- ***Strategic liaison:***

The Connectors have worked to secure the engagement of a range of statutory and voluntary organisations, and to ensure their active participation in local stakeholder groups. A promising example is a new strategic partnership with the university, who will help to arrange volunteer placements for students within the Connect4Life project (especially those who might be considering careers in public service and the voluntary, community and faith sectors).

- ***Connecting events:***

The Connectors have worked with their stakeholders to organise Celebration Events to give all partners opportunities to promote their organisations. Events fairs are held, which are geared both to recruiting volunteers and to identifying people who might benefit from being more included in their communities; one such event was held at a local bus station, since this is a visible and accessible location that is used by many older people and students.

- ***Community mapping:***

The Connectors work with community groups to have a conversation about what works and what does not work for them. They do this by holding a “community party” (which are also sometimes called “big brew-ups”). The result is a community map – or a co-produced profile of local assets. These maps can be published on a large page or poster, and tend to be based around communities of interest (e.g. mothers with toddlers, people with learning disabilities etc) rather than being geographically based. The team’s philosophy is that “there are as many maps as there are people” (and a parallel technique can in fact be used with individuals, to map their circles of support).

- ***Capacity building:***

The Connectors work with small voluntary and peer-support groups to put them on a stronger footing and develop their capacity. For example, they help groups with:

- Grant applications
- Finding places to meet
- Offering tools and techniques (e.g. asset mapping)
- Use of social media
- Sharing knowledge and contacts – forging relationships.

As an example of their success, a local group for people with multiple sclerosis and their carers has increased its membership and developed its activities, with a relatively small amount of input from the Connectors. Also, a group of people with serious weight-management issues, who “graduated” from a 10 week NHS course, were helped to form a self-help group and stay in touch with each other after the end of the course.

▪ ***Use of social media:***

The Connectors are strong advocates of the use of social media (such as Facebook) to put people in touch with each other and encourage information exchange. Techniques such as encouraging people to take “selfies” where they are helping a neighbour or community group over the winter (and rewarding the best photo) are encouraged as a way of generating enthusiasm. The use of social media has proved successful – for example – in recruiting enthusiastic “Winter Warriors” to volunteer to help in their communities during spells of cold weather. The Connectors believe that in certain situations, this method is more successful than more traditional methods of volunteer recruitment and fostering peer support, since it is becoming a natural way of communicating for many people.

▪ ***Skills development:***

The Connectors have extensive knowledge about “asset-based” approaches including tools to help individuals to identify their personal assets, They are adopting a “training the trainers” approach to cascade their knowledge amongst council and voluntary sector staff. For example, “asset-based” tools are being promoted amongst the Connect4Life implementation partners to help them engage with the

individuals referred to them and formulate ideas that will maximise their contributions and connect them to others.

The Case-Finding approach

The case-finding approach is currently at a pilot stage; some of the early learning is captured below.

▪ **Referrals from GPs:**

The early priority is to engage with GPs, but the ambition is to encourage appropriate referrals from other professionals (e.g. pharmacists) over time. The initial target is to secure the engagement of 66 GPs (in 11 localities) by the end of 2014; during the first six months, 11 GPs have so far been engaged, generating around 70 referrals.

Early learning:

- *Central Lancashire knows that a lot of work will be needed to secure the engagement of all local GPs and help them refer appropriately.*

▪ **The process:**

At practice level, multi-disciplinary teams use their instinct to identify people with long-term conditions who would benefit – for example, because they frequently attend GP practices and appear to be at risk of a worsening situation. Common “triggers” for referral include low-level depression or anxiety, bereavement, social isolation, and risk of carer breakdown.

At present, a council officer from the commissioning team attends these meetings to receive the referrals. They are then screened – for example, to see whether the person is already known to the council - and any new referrals are logged in the system. They are then referred to the Connect4Life organiser for that locality.

Early learning:

- *In future, a more formal “risk stratification” method or tool might be developed across agencies. A key issue is that tools based on people’s clinical conditions, (or level of physical and mental ill-health), do not really help to identify whether a person will benefit from this kind of preventative intervention. Other factors - such as their social assets and capacity to manage their own support – are also relevant.*

- *In future, a better referral system is likely to be developed. This should be assisted by local agencies' plan to develop shared records (including a "core personal profile" for each person).*
- *The current system of logging each new referral in the council's system was initially controversial, but is likely to be helpful – for example – in any future longitudinal studies that look at whether this early intervention has an impact on people's support needs over the medium term.*
- ***The role of the Connect4 Life organisations:***

The Connect4Life organisers have an initial conversation with the referred person, and talk about ideas that might help them achieve their goals. The organisers have expert knowledge of the assets and resources in their localities. They also have their own volunteer programmes, with the result that many referred people are ultimately matched to a volunteer or peer supporter.

Case Study 1

Mrs M is an elderly lady who was distressed by her own loneliness and isolation. She suffered regular panic attacks at home and was seeking re-assurance from her GP on a regular basis. She had been referred to the community mental health team.

After her referral to Connect4Life, Mrs M was linked to a volunteer who is interested in befriending elderly people (and is a qualified RSPH health champion). The two ladies got on well and started to share various activities together, both within and outside the house. Mrs M's goal is now to help others, perhaps by getting involved in telephone befriending.

Case Study 2

Brian has had several years of physical and mental ill health and has been unemployed for a long time. His goal is to get back to work and off his benefits, but he has little confidence or energy, and is fearful of becoming more unwell.

After his referral to Connect4Life, his interests and skills were identified. These include considerable computing skills. Brian was introduced to a local community centre and now helps them with their office administration, whilst also helping visitors with their computer questions. He is designing a new website and database for the CVS. He is starting to feel much better, has made a new friend, and has ideas about other activities to take up.

Case Study 3

Mr and Mrs A are a retired couple who became totally isolated two years ago, when Mr A had to have his leg amputated. Since then, they have struggled to get out of the house. Their goal is to “get back out in the community and start living again”. After their introduction to Connect4Life, a volunteer helped Mr Adams to get out using his mobility scooter (which he had never used). The volunteer has also spent time with Mr A while Mrs A has appointments, and both are becoming more confident about going out, alone and together.

Early learning:

- *There is debate about the resourcing that will be needed in future for the voluntary organisations themselves. This links to questions about how they can minimise their expenditure on each case – for example, by limiting the time that the Connect4Life organiser spends with each person and linking people quickly to “free” local resources.*
- *There may be scope to promote “do it yourself” support planning tools, including web-based versions such as that featured on Salvere’s web portal.*
- *There is also debate about the skills that are required for this kind of work, both by the paid organisers and the volunteers. For example, some people are quite hard to engage with, and not very motivated to explore new solutions. This will need to be factored into future training and development programmes.*

Monitoring

Connect4Life has established a deliberately simple (manual) monitoring system, which is co-ordinated by Salvere.

The Connect4Life organisers complete “**journey journals**” for each person to capture qualitative information. This helps with monitoring – for example – the main triggers for referral, and the combination of responses organised.

In addition, the following data are collected:

- Basic demographic information for each referral (gender/client group/age range/ethnicity)
- Reason for referral
- Outcome of referral.
- Referring GP
- The number of times the patient visited their GP in the month before referral
- The number of times the patient visited their GP in the month after referral.

- Customer reported outcomes: these are collected by asking customers to score a simple questionnaire at the time of referral and on exit. The questionnaire has five questions:
 1. Through Connect 4 Life, how involved/connected with your local community do you now feel, e.g. through joining a new group?
 2. Following your involvement with Connect 4 Life, how happy and satisfied with your life overall do you now feel, compared to previously?
 3. Following your involvement with Connect 4 Life, how would you rate your physical health and well-being, compared to previously?
 4. Through Connect 4 Life, do you feel that you now make a greater active contribution to your community, compared to previously?
 5. Through Connect 4 Life, do you feel that there has been a benefit to your family?

Each new referral is also logged by the council. There are hopes that the council’s system will eventually be linked to those of other agencies including the NHS, enabling a combined profile to be developed for each person.