County Durham Accountable care network

NHS

Durham County Council

Bulletin

Edition 3 August 2017

Welcome to the latest edition of the Accountable Care Network bulletin designed to keep you up to date with integrated care in County Durham.

In this edition:

Edition 3

Making the Change with Teams Around Patients

The 13 Teams Around Patients (TAPs) cover 69 GP practices across County Durham. Team configurations and staff alignment have been confirmed. A comprehensive toolkit for the TAPs has been developed and distributed to Primary Care Home leads in Durham Dales, Sedgefield and Easington areas. The toolkit includes the following information:

- Statement of common purpose
- Operating principles and values
- Staffing lists
- Clinical scenarios
- Multi-Disciplinary Team levels
- Terms of Reference
- Agenda templates
- Frequently asked questions (FAQs)

Given the different size and scale of TAPs across County Durham it has been easier for some areas to mobilise more quickly than others. However, development sessions to move forward with TAP implementation in other areas are being planned.

The new GP Clinical Leadership model recently championed by North Durham area will be important in advancing TAPs development and implementation across North Durham with support from members of the Integration Steering Group.

Locating care and support

Do you work with people who may need help to live as independently as possible?
Please remember to encourage them to visit Locate.

The 'My needs' feature encourages people to think about their own needs and to consider how or where they may require a little extra help in their daily lives. By answering a few simple questions they may find services that could help meet those needs.

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Case study: referral for IC+ bed

This case study provides a good example of care and support being given in the right way, at the right time and in the right place.

Mrs J lived at home and was the main carer for her husband who has Alzheimer's Disease

GP visited Mrs J at home following several falls, the latest one where she laid on the floor unable to use the Care Connect alarm. GP referred her to Intermediate Care+ (IC+), requesting an IC+ bed.

The main issue following the falls was the discomfort when moving for which the GP had prescribed a patch for pain relief.

During the home visit by IC+ therapist, which found that Mrs J was able to:

Complete positional changes	Move around using a walking stick
Stand and transfer independently	Able to use toilet independently
Able to transfer on / off bed independently	Be supported with showering and meals by carers
Manage steps and stairs	

Mrs J's family were requesting an admission into an IC+ bed and for Mr J to go into respite. However as outlined above Mrs J had demonstrated that she was able to transfer independently, and was mobile, although it was acknowledged that this was slowly due to the pain and stiffness. Mrs J had stated that she only got up once during the night for the toilet. Unfortunately due to limitations in space there was no room for equipment (commode) in the bedroom.

Discussion with Mrs J regarding options:

Mrs J didn't want an IC+ bed, preferring to be at home and accepted overnight support.

Following an x-ray at the hospital discussions took place regarding equipment to support her rehabilitation.

Within a few days the pain was under control and Mrs J was provided with exercises and pieces of equipment to support her around the home. IC+ staff also liaised with the appropriate social service team, with Mrs J's consent, for a review of their overall care and support needs, to support Mrs J in her role as carer for Mr J.

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Frequently Asked Questions

Q Who manages the Teams Around Patients (TAPs)

A There is no one person or discipline that manages the TAPS as the focus is on operational collaboration in order to produce positive outcomes for patients and families

Q How will the TAPs communicate with their membership and staff from acute services?

A Day to day communication will be conducted through the normal channels. However, the Intermediate Level TAP MDT Meetings will be an important vehicle for communication and discussion. Specialist health care professionals from acute or community services could be Invited to Intermediate Level TAP MDT Meetings as necessary to address particular case issues or themes.

Q What is the purpose of the Intermediate Level TAP MDT Meeting?

A The Intermediate Level TAP MDT encompasses a broad MDT membership including Social Care, Intermediate Care and Therapy Services where discussion and action planning on operational issues and themes emanating from risk stratification and performance take place which are central to improving system and patient outcomes.

Q What referral arrangements are in place for the TAPs and out of hours/weekend working?

A Existing arrangements will continue as normal.

Q Who will collate case examples, issues or themes for the Intermediate Level TAPs MDT meeting?

A The Band 7 TAPs Lead Nurse will collate case examples, issues or themes prior to the meeting and liaise with the GP Clinical Lead regarding the agenda items for prioritisation and inclusion at the meeting.

Q What role do the TAPs fulfil in relation to prevention?

A Although the early phase of TAPs operability will be focussed on preventing avoidable admissions to hospital or long term residential /nursing care, and facilitating hospital discharge; as they evolve the TAPs will provide a greater emphasis on improving the broader preventative offer for frail older people and those with long term conditions in order to promote health and wellbeing.

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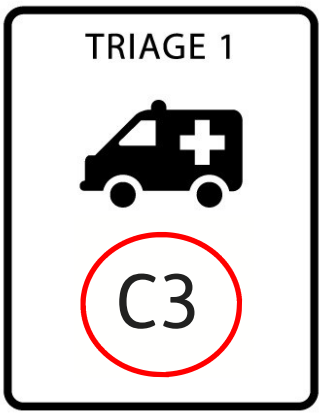
Update on the Care Coordination Centre (C3)

The Care Coordination Centre (C3) is being developed by County Durham and Darlington NHS Foundation Trust to act as a central referral point and clinical triage for a number of services. Currently, there are numerous points of entry resulting in duplication of effort and confusion for both referrers and patients. Additionally, it is not always clear to referrers which service will best meet the needs of a patient because of different service structures in different localities. The aim of C3 is to overcome these difficulties, improving the process for both patients and referrers.



To help C3 achieve its aims and objectives a staff consultation has been completed on bringing together the current points of access for district nursing, intermediate care and the continence service. These 3 services are expected to be the initial services that form C3, with others coming in time.

Recruitment has started to fill vacant administration and clinical triage posts, and planning has started to roll out training for care staff on the different services and systems used. C3 is being temporarily set up at the Whitehouse in Peterlee before moving to the local authority Spectrum 8 building in Seaham once work on IT systems has been completed.

Planning the move and integration of systems is underway, this includes shift patterns, equipment needs, office set up, transfer to a single telephone number and how each stage of integration will be implemented. It is anticipated that the 3 services will be co-located in the Whitehouse from September 2017.

Once the co-location and integration of administration is complete the focus will move to establishing clinical pathways and increasing the number of services that C3 manage.

Cross-agency working in the Durham Dales

The Durham Dales locality, consisting of three TAP hubs, has been an enthusiastic early adopter of integrated working. In particular, the community wellness team (CWT), which provides high level medical and nursing care to frail older people, and the community nursing service, which provides ongoing care to housebound patients, have established positive working relationships and a cross-agency approach to delivering services.

To help in times of high demand, and to make the most efficient use of clinical resource, CWT staff take requests for simple investigations, such as phlebotomy and ECGs, from the community nursing team. This reduces duplication and encourages mutual support and co-operation. Additionally, the CWT and community nursing teams have agreed plans for winter vaccinations, with a view to efficiently covering all at-risk groups and reducing the impact of seasonal diseases.

VCS Engagement: An Update from Durham Community Action

We've been sounding out front line health and social care workers during the summer, to provide some basic information about how the voluntary and community sector (VCS) works in County Durham, and to introduce health staff to the Advice in County Durham Partnership.

These first four workshops have been exploratory and were used to test the levels of knowledge and interest in various disciplines and specialisms in the health and social care sector.

We now have a broad understanding and have identified some potential ideas and opportunities for collaboration between the VCS, health and social care. We are feeding information back into the Integration Steering Group and carrying out some more detailed consultation with colleagues in the VCS, especially through some of our specialist providers, and organisations with community reach and local knowledge.

Hopefully we should be able to produce some more structured feedback from the sector by mid September, and also be able to make the information and resources we have complied about the sector more easily available to front line TAPs staff.

We are also looking at the possibility of providing further workshops for staff who are working with patients in the community or home settings. If you are interested, or would like to know more about the work to involve the VCS, please contact either Kate Burrows or Jo Laverick at Durham Community Action.