Working together to provide high quality, cost effective primary healthcare services

2018 PROSPECTUS

DURHAM DALES HEALTH FEDERATION

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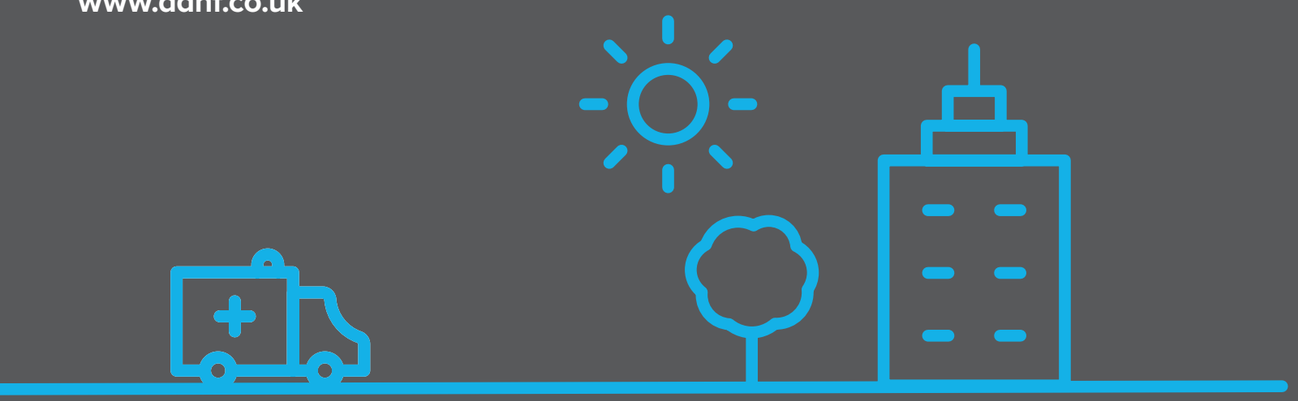

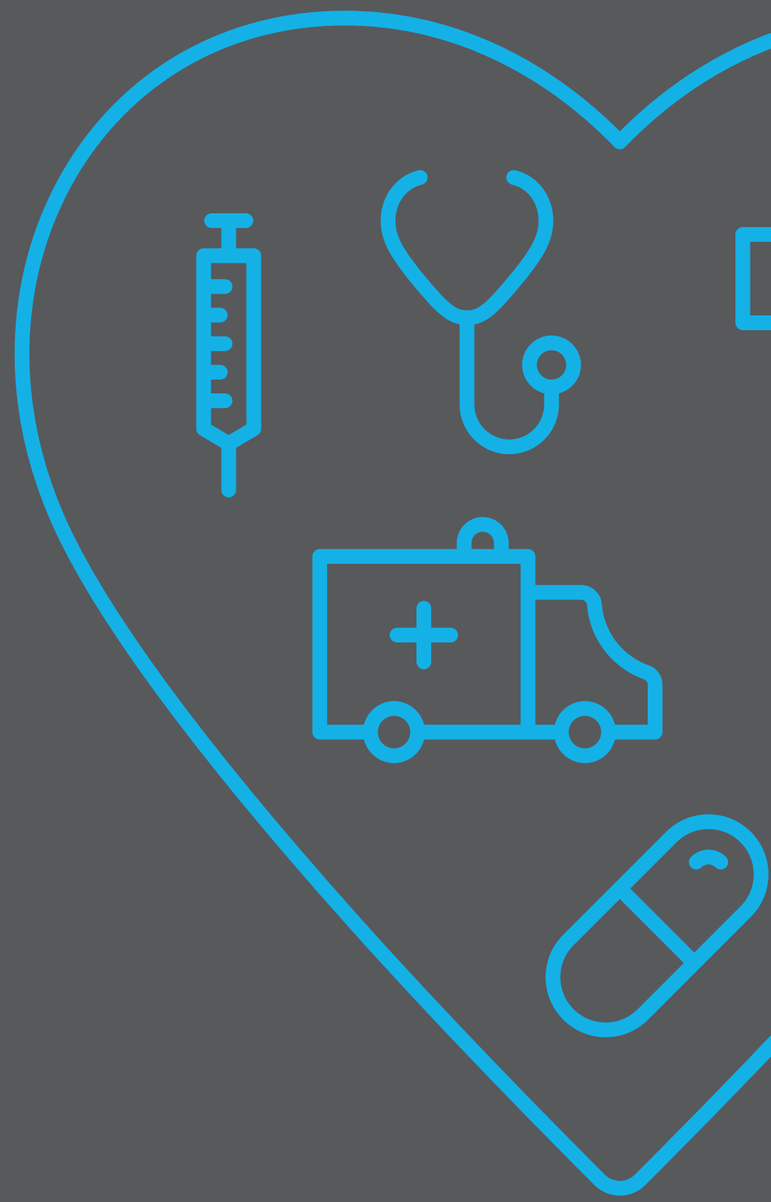

DDHF
DURHAM DALES HEALTH FEDERATION

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Contents

Durham Dales Health Federation (DDHF) is a formal collaborative of the 12 General Practices in Durham Dales that have agreed to work together to coordinate and provide some elements of patient care jointly across the whole area.

Business Description

The purpose of the Durham Dales Health Federation is to ensure, maintain and develop the provision of General Practice and Primary Healthcare Services across the Durham Dales area, in order to better serve our communities as we approach an increasingly uncertain and challenging future.

Our mission is to meet and exceed our high performance standards for all our services, become the preferred support partner for our member practices and neighbouring GP federations and become the preferred provider and employer for community primary care services in the Durham Dales.

Over the past three years, we have built an effective and lean management and support infrastructure, enabling our clinical team to deliver high quality and efficient care. We employ a range of clinical professionals and have developed a working environment in which they can thrive and develop their skills, including GPs, Nurse Practitioners, Emergency Care Practitioners, Pharmacists, Health Care Assistants and Care Coordinators.

All of our clinicians work across a range of contracted and non-contracted services, ensuring that good practice is shared, that the team can respond flexibly to the demands across services, and that silo working is avoided. We have invested heavily in training and professional development for our staff, and have been successful in ensuring that our whole nursing team have, or are working towards, an independent prescribing qualification. We encourage team members to pursue individual interests as part of an overall career plan, which has led one of our health care assistants to develop skills in dementia assessment and several of our ECPs to work closely with one of our member practices to gain knowledge of the primary care medical model.

Our management and support team draws from a diverse pool of skills and experience, including primary care, urgent medicine, and commercial sector project management. This allows us to bring new perspectives to primary care delivery, while maintaining a detailed knowledge and understanding of the unique features of general practice and community provision. We have a proven ability to develop and implement services rapidly and effectively. Our executive and senior management teams include:

TEAM BIOGRAPHIES

Chairman

DR DAVID ROBERTSON

MB BS, MRCGP, BMedSci,
DCH, DRCOG

As GP partner at a large rural surgery, and secretary of the County Durham and Darlington LMC, David has a thorough understanding of the primary care landscape and the particular local issues affecting the area. David provides strategic direction to the federation, and maintains good relationships with key local stakeholders, including CCG accountable officers and Trust Chief Executives.

Managing Director

Vicky Watson

BSc (Hons)

Prior to becoming a Practice Manager, Vicky was a Director of Services with regional responsibility for a national provider of public health related services. She is currently the Managing Partner at The Weardale Practice with successful experience of implementing change in GP practice management.

Vicky is responsible for the development and implementation of organisation strategy, day to day organisational direction, overall performance management, and ensuring that DDHF remains compliant with all relevant statutory and mandatory requirements (CQC, HR, etc.)

Operations Director

Dave Hall

BEng (Naval Architecture), PGCE Maths, FInstLM, MAC

Previously a Founding Director of Sampson Hall Ltd, a consultancy specialising in strategic business development, Dave has taken up a full time position within DDHF. Dave has over 25 years of leadership and management experience in diverse and challenging operational environments.

He is responsible for DDHF's strategic organisation and infrastructure development, and business continuity and organisation risk management; ensuring the right systems and processes are in place to deliver our services and achieve our required outcomes in a dynamic operational environment.

Finance Director

Kevin Lee

BA (Hons), MBA (DUBS), MILT, FCCA

Founder and Managing Director of KL Accountants Limited, Kevin has over 20 years' experience of strategic management in large corporate organisations and was a former partner at Harland Accountants prior to setting up his own accountancy firm in 2014.

Kevin is responsible for strategic financial management and corporate compliance.

Community Services Manager

Craig Hay

Craig has over 15 years of experience as a paramedic in both UK and overseas environments. He pioneered the NHS Community Paramedic Role, integrating paramedics and other healthcare professionals within the rural setting.

He is currently the Community Services Manager for DDHF, managing the operational delivery of clinical and non-clinical services by a multi-disciplinary team ensuring, maintaining and developing the provision of General Practice in both the rural and urban environment.

Service Support Manager

Joanne Taylor

Formerly PA to the PCT Chair and Board and medical secretary at Bishopgate Medical Centre for over ten years, Joanne has vast experience in practice administration, is an expert in SystmOne.

Our Service Support Manager manages and coordinates all DDHF support and administration functions. Joanne is a CIPD qualified HR manager with an interest in performance management, selection and appraisal.

Business Intelligence Manager

Andrew Dowson

Andrew worked in general practice for over 8 years before moving to North East Commissioning Support Unit as an accredited SystmOne trainer, and has extensive experience working with EmisWeb. He has comprehensive knowledge of primary care, and has developed easy-to-use and intuitive monitoring and recording systems for clinical staff.

Andrew is responsible for design, development and implementation of SystmOne strategic reporting. He leads our internal data-led quality and improvement process for driving efficiency and service change.

Practice Support Manager

Joanne Petch

With over seven years experience working in general practice as a Practice Support Worker and Administrator at Willington Medical Group, Jo became an Emis Web Super-User and was responsible for the training and development of new and existing administrative staff.

As Practice Support Manager, Jo liaises with Member Practices to ensure extra clinical and non-clinical support during periods of pressure. Jo has developed the educational training programme which is delivered to the DDHF team and Durham Dales Member Practices offering a wide range of mandatory, statutory and educational training topics.

Business Development Manager

Ross Hetherington

BA (Hons), ACMI

Ross has a keen interest in public sector strategy and transformation, including health policy and public management. Ross has experience managing complex services, liaising with commissioners to develop primary care delivery, and health procurement as a provider and purchaser.

Ross is responsible for ensuring DDHF business and service development meets the requirements of commissioners whilst addressing system demand pressures and being aligned to NHS strategy.

Organisation Chart

CHAIRMAN
DR DAVID ROBERTSON

MANAGING DIRECTOR
VICKY WATSON

OPERATIONS DIRECTOR
DAVE HALL

FINANCE DIRECTOR
KEVIN LEE

CLINICAL LEAD: URGENT MEDICINE
DR SHASHIKIRAN CHANDRASEKHAR

CLINICAL LEAD: INFORMATION TECHNOLOGY
DR ANDREW HETHERINGTON

CLINICAL LEAD: DIABETES
DR MATTHEW HACKETT

NON EXECUTIVE DIRECTORS
X8 GPS AND PMS FROM MEMBER PRACTICES

COMMUNITY SERVICES MANAGER
CRAIG HAY

BUSINESS INTELLIGENCE MANAGER
ANDREW DOWSON

BUSINESS DEVELOPMENT MANAGER
ROSS HETHERINGTON

FINANCIAL CONTROL OFFICER
TOM LEE

PRACTICE SUPPORT MANAGER
JO PETCH

SERVICE SUPPORT MANAGER
JOANNE TAYLOR

MENTAL HEALTH TEAM LEAD
EMMA HEMINGBROUGH

MENTAL HEALTH TEAM
x4 NURSES AND SOCIAL WORKERS

DIABETIC SPECIALIST NURSE

SENIOR CLINICAL PHARMACIST

CLINICAL PHARMACIST
TEAM x2

NURSING TEAM LEAD
CLARE EDWARDS

COMMUNITY NURSES
TEAM x8

HEALTHCARE ASSISTANT
TEAM x1

ASSISTANT PRACTITIONER
TEAM x1

EPCA SALARIED GP
DR JULIA PICKWORTH

EMERGENCY CARE PRACTITIONERS TEAM LEAD
HELEN DAWSON

EMERGENCY CARE PRACTITIONERS
TEAM x3

HEALTH CARE COORDINATOR TEAM LEAD
TRACEY STORES

HEALTH CARE COORDINATORS /COMMUNITY WELLNESS COORDINATOR
TEAM x3

SENIOR ADMINISTRATOR
TANIA CALLARD

ADMINISTRATORS
TEAM x5

Service Descriptions

Community Wellness Team

Intensive Support for High Risk Patients

The Community Wellness Team is a nurse-led, multidisciplinary team that supports registered patients at greater risk of hospital admission (primarily those aged over 75, or those on the unplanned admissions register) to remain in their preferred place of care, whether that be in their own home, living with relatives, or in a residential home.

The Community Wellness Team consists of Nurse Practitioners, Specialist Nurses, Healthcare Assistants and Care Coordinators, and is an expansion of DDHF's pilot service for "vulnerable" adults, VAWAS. Referral to the service is determined by an individual's emergency risk score, as calculated by the RAIDR risk stratification tool, or by the clinical judgement of their GP. Referrals can be made through the SystmOne Community Module, or by email contact with our Care Coordinators.

We operate a nurse-led telephone triage service for requesting visits, which enables us to convert a significant number of contacts to advice only. This has reduced the volume of visits required by approximately 25%. In fact, in the Durham Dales area, our practices carry out very few care home visits themselves: the Community Wellness Team picks up almost all of these. The service operates 7 days a week and 365 days a year.

Community Wellness Team (VAWAS)

Service Aims:

To assign each service user a Care Coordinator to carry out an initial assessment and create a personalised care plan:

This includes individual care requirements, medications review, risk assessment of the home environment and specific needs or concerns raised by the individual in the event of their admission to hospital.

Care plans will be discussed with both the patient and any health care professionals or informal carers involved in their care.

To identify eligible service users through liaison with practices and practice registers.

To supply service users and/or their carers with contact details for their named Care Coordinator, should they need to discuss routine or urgent care.

To review care plans as appropriate to the service user's medical condition or as a minimum every 6 months.

To coordinate different providers and services to provide an holistic approach to care.

To provide regular home visits, where appropriate.

To attend acute visits when medical attention is required.

To deliver rapid response care packages for up to 48 hours.

To use their close knowledge of service users to support their GP and other healthcare professionals involved in their care.

To maintain transparency of information with member practices regarding Community Wellness Team visits and interventions.

Community Wellness Team (VAWAS)

Service Outcomes:

By establishing a rapport with service users and gaining a close knowledge of their needs and concerns, the Community Wellness Team aims not only to help individuals avoid unnecessary hospital admissions, but also to empower them to keep well in their preferred place of care, ensure that they feel well supported, reduce social isolation and generally improve wellbeing for the more vulnerable individuals in our community. Furthermore, through optimisation of treatment plans and attendance of acute visits, the Community Wellness Team hopes to ensure that our member practices feel well supported in providing high quality care to these patients.

The VAWAS is DDHF's longest running service, has been in operation since 2014, and continues to expand and develop.

1369
biannual reviews carried out
(from 2014-2016)

2463
personalised care plans created
(from 2014-2018)

470
GP sessions = 1,880 hours delivering acute visits
(since March to December 2017)

3757
interventions across the Durham Dales
(since March to December 2017)

20%
reduction in avoidable hospital admissions

15%
reduced average hospital stay
(patients under CWT)

Practice Aligned Mental Health Service

Exceeding National Standards for Mental Health

The Practice Aligned Mental Health Service was launched in April 2016 to help provide high quality care and support in the community for those with mild to moderate risk mental health conditions.

In doing so, the service aims to fill a significant gap in service provision for people who are unable to access IAPT (Improving Access to Psychological Therapies) services and who also do not fit the criteria for secondary mental health services. This service has been delivered in partnership with Tees, Esk and Wear Valley Mental Health Trust, and has shown that collaborative working and primary care operational control can deliver efficient and effective community services.

Between October 1st 2016 and October 1st 2017, 814 people were referred to the service, of which 86% attended. The average waiting time for a routine assessment is 12.7 days. Compared to a national standard of 18 weeks for similar services.

Practice Aligned Mental Health Service

Service Aims:

To stem the demand on secondary mental health services.

To provide continuity of treatment and intervention not requiring an inpatient or secondary care setting.

To carry out an initial assessment of service users and create comprehensive, personalised care plans which are regularly reviewed, along with medical prescriptions.

To support discharge from secondary mental health services with a step-down approach to management of patients in a timely manner.

To provide regular contacts in the service user's preferred place of care, e.g. at home or at their GP practice, promoting their autonomy.

To support individuals to maximise their use of community based provision (asset based management).

To coordinate different services to provide an holistic approach to care, thereby reducing unnecessary duplication.

To improve mental health and wellbeing for patients in the DDES area by offering early intervention in response to their mental wellbeing.

To refer patients onto relevant services in a timely manner, where appropriate.

To reduce waiting times for access to mental health interventions and treatment.

To support GPs in delivering high quality care using a close knowledge of service users and their care requirements.

Practice Aligned Mental Health Service

Service Outcomes:

Evaluation of this service has shown a high volume of patient referrals and follow-up rates across the 12 practices served by DDHF. Of these patients, 84% were referred by their GP. Of 697 patients assessed, 32 were seen in their own homes due to pain, mobility issues, or their mental health impacting their ability to attend. 646 patients have been discharged from the service since November 2016.

Furthermore, individual case studies have shown that through support from the service, users have:

Accessed specialist mental health services tailored to their individual needs

Accessed a range of community support services

Optimised use of medications

Reunited with family members

Increased their social involvement

Been given the confidence to access therapy

Returned to full-time employment

Testimonials from health professionals have been similarly outstanding, reporting highly positive patient feedback, evident patient benefit, ease of referral and timely access, clinical excellence and positive impact on GP workload.

Personal testimonials from service users have praised reduced waiting times, staff excellence, efficiency and support.

One user reported:

"Help and support is the best I've ever received".

Service Descriptions

Integrated Diabetes Service

A County Wide Alliance for Diabetes Care

The Integrated Diabetes Service is a comprehensive service designed to help provide specialist, integrated care in the community for those living with type 1 and/or type 2 diabetes.

The service is delivered by a County Wide Alliance, made up of the local acute trusts and GP federations. The Durham Dales locality has achieved some of the best outcomes for diabetic patients, while also significantly reducing costs. Furthermore, through robust education and prevention programmes the service aims to help prevent the development of diabetes in those identified as being “at risk”. This service is an expansion of previous work carried out by our diabetic specialist nurse, and is based on the “Super Six” service design first implemented in South East Hampshire and Portsmouth. The service is delivered by a specialist team comprising of a Consultant, a Diabetic Specialist Nurse and a named GP and Practice Nurse within each of our member practices.

Integrated Diabetes Service

Service Aims:

To equip the named member practice GP and Practice Nurse with the relevant expertise to deliver certain aspects of specialist diabetes care in a primary healthcare setting.

To facilitate personalised care planning and regular reviews, through in-practice nurse-led clinics, or home visits where appropriate.

To support practices with available advice and expertise from the affiliated Consultant and Diabetic Specialist Nurses.

To advise “at-risk” service users on preventative measures and where appropriate refer them to relevant support services.

To refer all newly diagnosed diabetic patients to recognised structured education programmes.

To help establish a parity of esteem between mental and physical ill health in individuals with diabetes.

To coordinate both generalist and specialist services to provide an holistic approach to care.

To empower service users to self-manage their condition where possible through education and personalised care planning.

Integrated Diabetes Service

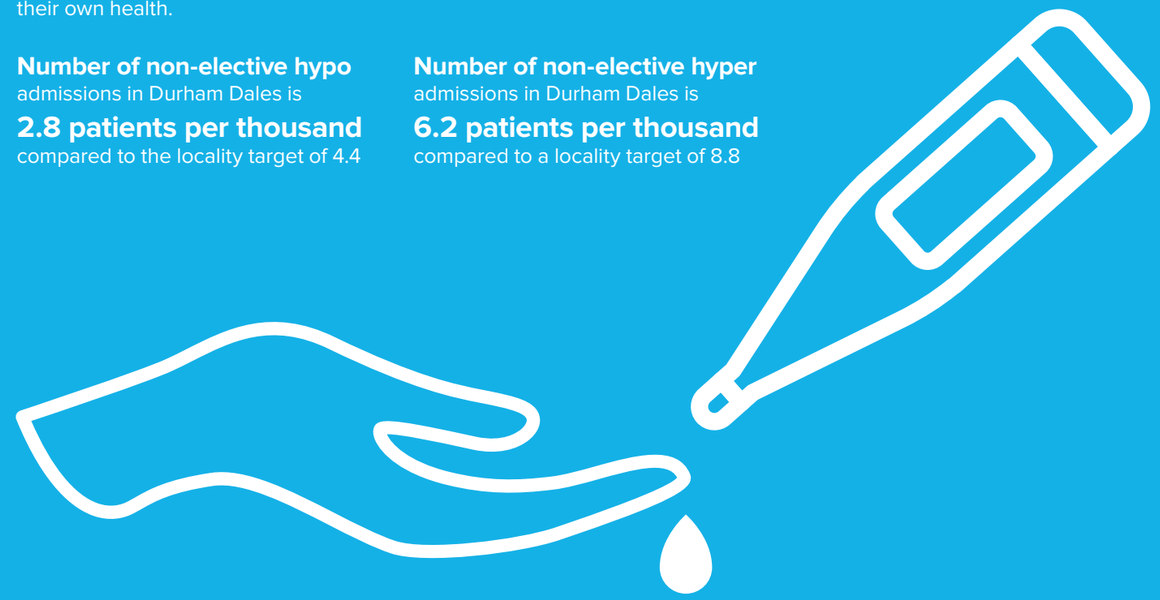
Service Outcomes:

As of October 2017, 64% of diabetic patients in the Durham Dales have achieved an appropriate HbA1C level of below 59 mmol/l. Drugs costs have reduced by 4.5% in 2017/18 as compared to 2016/17, at a time when national average costs have increased.

In delivering the Integrated Diabetes Service, we hope to ensure that patients in the Durham Dales are able to access high quality, personalised diabetes care and prevention in the community. In doing so, we hope that all aspects of a service user’s care requirements can be addressed in a holistic way and that they feel well supported by their GP practice and empowered in looking after their own health.

Number of non-elective hypo admissions in Durham Dales is **2.8 patients per thousand** compared to the locality target of 4.4

Number of non-elective hyper admissions in Durham Dales is **6.2 patients per thousand** compared to a locality target of 8.8



Furthermore, we hope that by having a robust, community-based diabetes service, the requirement to travel long distances to outpatient appointments will be removed and the incidence of major health complications and hospital admissions as a result of diabetes will be reduced.

Practice Support

Working at scale to support Practice Resilience

The DDHF Team offers all practices in the Durham Dales both clinical and administrative support as and when they may need it.

This helps to ensure that our member practices feel well supported and are able to deliver patient services efficiently and effectively under all circumstances.

DDHF have also been successful in securing participation in the NHS England Clinical Pharmacist in General Practice Pilot, enabling us to provide support to our practices to free up GP time and build a multidisciplinary primary care team.

Practice Support

Service Aims:

Providing extra clinical support i.e. from healthcare professionals currently employed by DDHF, such as our specialist nursing team or pharmacist, or by procurement of locum Nurse Practitioners or GPs.

Providing extra non-clinical support if required e.g practice reception staffing and administrative duties.

Helping practices prepare for times of increased demand.

Continuously scoping potential new services or developing existing ones to best meet the needs of both our patients and our practices.

Providing relevant media and communications materials to practices for their distribution e.g. information regarding vaccinations or changing health behaviours.

Offering a wide range of training days for member practice staff including mandatory CPR training.

Offering financial advice from our in-house accountants.

Assistance in addressing demand management at practice, PCH and locality level.

Practice Support

Service Outcomes:

Between April and November 2017, DDHF staff gave

2259.25

hours of support to our member practices.

In the same period, DDHF organised training for

458

staff members both within our organisation and across member practices.

This included **65 GPs** and **223 administrative staff.**

Quotes from practices:

“It is helpful for small surgeries to know that there is back up in the event of someone being on holiday and an unexpected staff absence.”

“Our Practice values the support offered by the Federation and looks forward to continued development of services and a close working working relationship in the future.”

Service Descriptions

Extended Primary Care Access:

Improving access to primary care, 365 days a year

Through the Extended Primary Care Access contract, DDHF has supported our member practices to extend their working hours, thereby improving access and the ability to seek same day medical care for patients across the Durham Dales. This robust service has facilitated a significant transfer of activity from urgent care to primary care, whilst establishing 7 day GP provision and supporting the achievement of the 5 Year Future View (5YFV) for Primary Care.

Extended Primary Care Access

Service Aims:

Support and enable our 12 member practices in three geographical PCHs, allowing for shared workload and resources, and improved patient access.

Extended GP services from 6pm - 8pm weekdays, plus Saturday - Sunday and bank holidays from 8am - 1pm at Weardale, Bishop Auckland Hospital and Barnard Castle, serving the three DDHF Hubs.

DDHF support member practices to triage and see patients with an Overflow Response Team consisting of 1 GP and 2 x Emergency Care Practitioners (ECP) or Advanced Nurse Practitioners (ANP). Currently this is a static clinic based at Bishop Auckland General Hospital, that member practices can book patients into.

Encouraging use of NHS 111 to book appointments and to coordinate access to the most appropriate route of care.

Integration of current daytime Urgent Care caseload into member practices current daytime 8am - 6pm provisions.

Enhanced availability of same day urgent appointments with a patient's registered GP practice or a nearby Hub practice.

The development of clear pathways for patients to book appointments, eradicating walk-ins.

Extended Primary Care Access

Service Outcomes:

Through the DDHF Hub system, we aim to support GP practices working together from common single sites to serve larger populations and improve patients' timely access to services.

2086

patients attended our overflow provision at Bishop Auckland Hospital, between April and December 2017.

4032

patients have been seen by the service since April 2017.

In addition, through Extended Access we hope to improve triage of patients to the most appropriate route of care, reduce walk-in attendance at A+E and improve access to same day or urgent appointments within a setting closer to home.

94%

of patients were extremely likely to recommend our service.

94%

of patients rated the care received as excellent.

97%

of patients feel the DDHF Care Service is easy to access.

One user reported:

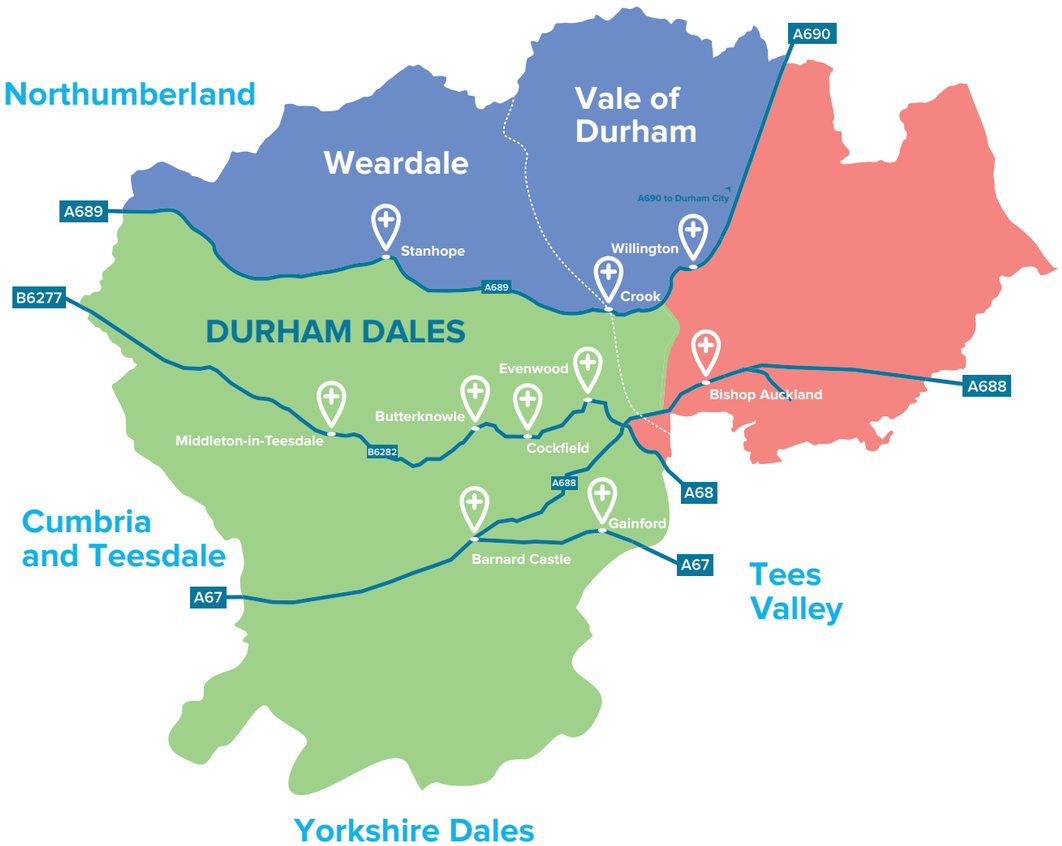
"I had a good response by telephone to my request."

"Very efficient service which put you at ease."

Primary Care Home Variation

The Durham Dales locality covers a large and diverse geographical area. To optimise resources and patient access across our member practices, DDHF is supporting and enabling our 12 practices across the Durham Dales in implementing three PCHs, based on geographical location and patient populus

The Durham Dales Primary Care Homes are:



Dales 1
Dales 2
Dales 3

Dales 1

Population : 29,800

Practices:

- **The Weardale Practice, Stanhope - 7,200**
- **Willington Medical Group, Willington - 9,200**
- **North House Surgery, Crook - 13,400**

Care Homes:

- Crosshills, DL13 2NN, Stanhope
- Parklands, DL15 8QT, Crook
- Bradbury House, DL15 8NL, Crook
- West Lodge, DL15 9SY, Crook
- Willington Care Village, DL15 0PW, Willington

Dales 2

Population : 37,800

Practices:

- **Auckland Medical Group, Bishop Auckland - 14,200**
- **Bishopgate Medical Centre, Bishop Auckland - 13,400**
- **Station View Medical Centre, Bishop Auckland - 10,200**

Care Homes:

- Barrington, DL14 6XX, Bishop Auckland
- Bishopsgate Lodge, DL14 7PU, Bishop Auckland
- Church View, DL14 6SL, Bishop Auckland
- Devonshire, DL14 9HW, Bishop Auckland
- Eden House, DL14 6EN, Bishop Auckland
- Howlish Hall, DL14 8ED, Bishop Auckland
- Sandringham, DL14 6AB, Bishop Auckland
- St Helens, DL14 9DL, Bishop Auckland
- The Fields, DL14 0HA, Bishop Auckland

Dales 3

Population : 22,900

Practices:

- **Barnard Castle Surgery, Barnard Castle - 10,500**
- **Evenwood Medical Practice, Evenwood - 2,000**
- **Gainford Surgery, Gainford - 3,400**
- **Old Forge Surgery, Middleton-in Teesdale - 2,700**
- **Pinfold Medical Practice, Butterknowle - 2,900**
- **Woodview Medical Practice, Cockfield - 2,400**

Care Homes:

- Bowes/Lyons Court, Evenwood, DL14 9ER, Cockfield
- Beaconsfield, DL12 8ES, Barnard Castle
- Kings Court, DL12 8ND, Barnard Castle
- The Manor, DL12 8ET, Barnard Castle

We have drawn data from the Public Health England Fingertips Database to inform us on differences in social demographics and health outcomes between practices and PCHs.

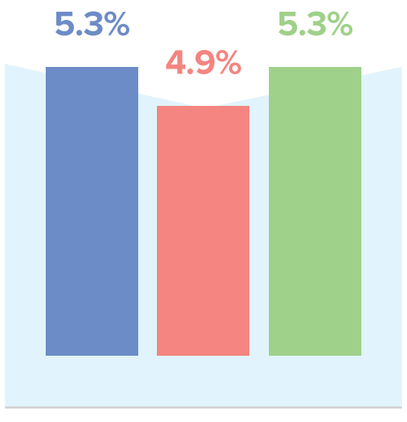
This has demonstrated significant disparities within the Durham Dales, the most striking being the positive correlation between average levels of deprivation and average life expectancy. The Index of Multiple Deprivation (IMD) score appears to be the biggest predictor of life expectancy in our area, and takes into account levels of deprivation across several domains, including income, employment and education. Higher IMD scores indicate higher levels of deprivation.

Consistently, life expectancy is lowest in Dales 2, and highest in Dales 3, with a disparity of 3 years in both men and women. This correlates with Dales 2 being the most deprived area within the Durham Dales, and Dales 3 being the least deprived.

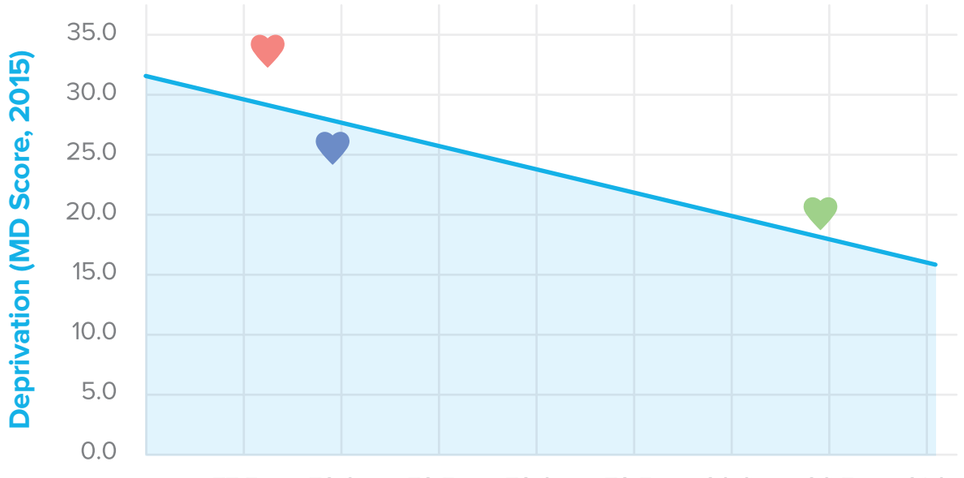
We hypothesised that these disparities could be due to a higher prevalence of unhealthy behaviours in more deprived areas. Some of the data collected regarding health behaviours could support this, for example, Dales 2 has the highest smoking prevalence of DDHF PCHs.

A number of significant health conditions are of higher prevalence in Dales 2, including Diabetes, COPD and Depression. However, this trend is not consistent; conditions such as Cancer, CKD and CHD have a higher prevalence in other PCHs.

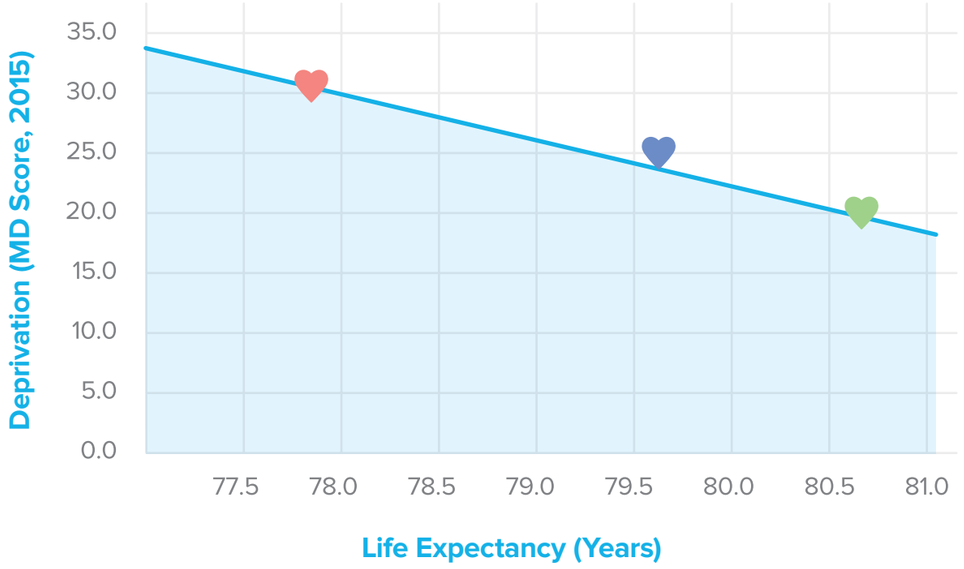
Coronary Heart Disease prevalence-Dales



Relationship Between Deprivation and Male Life Expectancy in DDHF PCHs



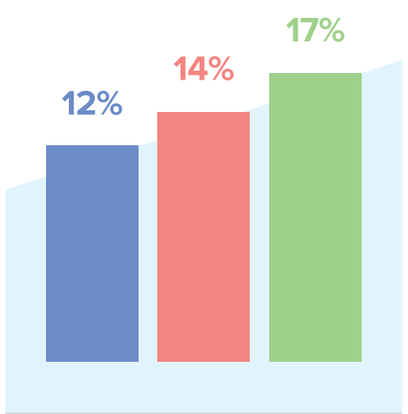
Relationship Between Deprivation and Female Life Expectancy in DDHF PCHs



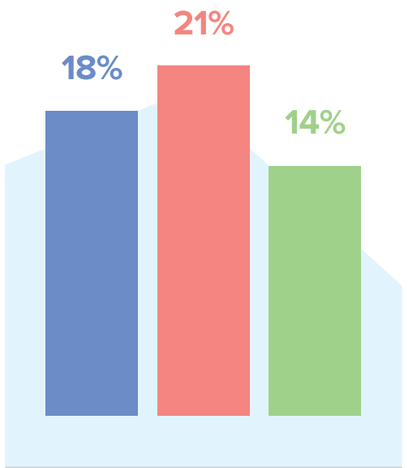
Furthermore, whilst there are differences, there is no consistent variance between the quality of healthcare (measured by the Quality Outcomes Framework) delivered by different PCHs, or the uptake of screening programmes.

We are currently furthering our research into the reasons for this inter-PCH variance, however, an understanding of the current disparities in health outcomes in our area, and the differences in socioeconomic demographics within the Durham Dales will help us to better tailor our services and support our population going forwards.

Prevalence of Obesity in DDHF PCHs



Prevalence of Smoking in DDHF PCHs



Dales 1

Dales 2

Dales 3

Getting It Right in the Durham Dales

This scenario, based on preliminary evaluation work carried out by Northumbria University, examines the life of a typical, fictional patient under the care of the Community Wellness Team in the VAWAS.

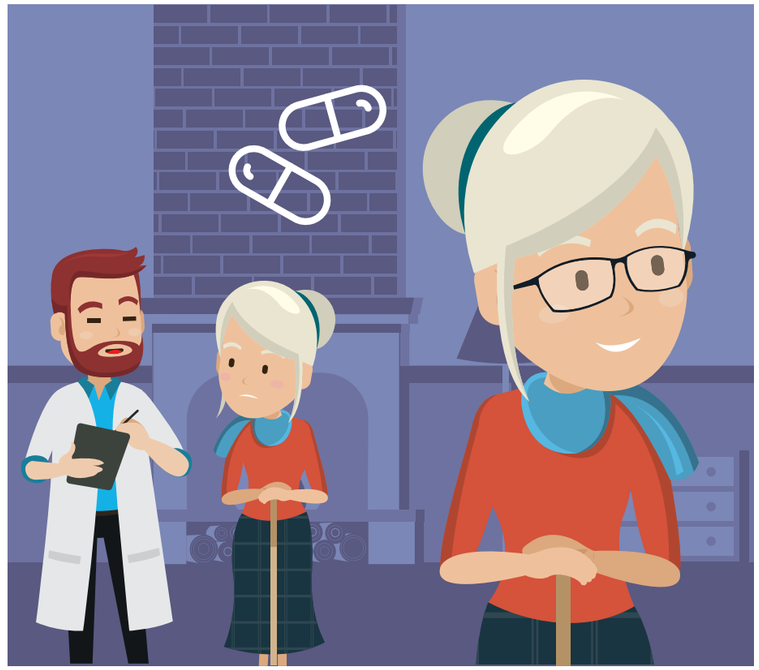
Joyce is 84, and has lived in the same house with her husband, Martin, for nearly 50 years. They live in a small rural community, and know their neighbours well. They have two adult children, who live a long way away but call occasionally. Like most people in County Durham, they are living with long-term health conditions: Joyce has type 2 diabetes and Martin has COPD. Their named GP, using the electronic frailty index and his knowledge of the patient, identified that she was likely to be living with frailty, and at risk of an unplanned hospital admission if something went wrong. The GP referred Joyce to the Community Wellness Team through SystmOne, which also shares her GP record with the District Nursing Service and Integrated Diabetes Service. Joyce is assigned a care coordinator, Stacey, by the CWT, who arranges a time for an initial visit in Joyce's home.

Initially, Joyce doesn't really think she needs the help of the CWT, as she's able to manage her activities of daily living with mutual support from Martin but Stacey takes the time to get to know Joyce, spending about an hour discussing her health needs, social situation, and general concerns and worries. Stacey takes this holistic assessment and helps Joyce fill in a 'message in a bottle', a simple care plan that Joyce keeps at home. Stacey leaves her contact number and arranges to visit again in a little while.

Joyce and Stacey speak on the phone a few times before the next visit. During this next appointment, Joyce tells Stacey that there are some things she finds difficult each week, like putting the bins out for collection. Stacey recognises that dragging the bins to the end of the drive puts Joyce at risk of falling, and acting as an advocate, contacts the council to arrange assisted bin collections.

A few months later, Joyce feels unwell, with worsening control of her diabetes and some new pain. Because her work with Stacey has built trust that she can be cared for at home, she calls her GP rather than 999. The GP contacts the CWT, to request Joyce to be visited today. An experienced nurse practitioner visits Joyce, and recognises that Joyce might have a UTI. Following local protocol, a sample is tested, which comes back positive. Joyce is prescribed antibiotics, and soon feels better.

A year later, Martin dies suddenly. Martin and Joyce had been dependent on support from each other for years. Without Martin, Joyce finds it harder and harder to live independently. She discusses her situation with several people, including Stacey, and eventually decides the best thing to do is to move into a local residential home. Stacey stays on as care coordinator, and when the home staff have concerns about Joyce's health, they call the CWT directly, and get telephone advice or an acute visit from the team. Joyce's needs are met more effectively, and she is generally able to remain at home without hospitalisation.



Additional case studies are attached at the end of this prospectus

PRACTICE FEEDBACK

“Practices are stretched as they are, and we’d really struggle to take on any of the work currently done by the VAWAS service.”

A local Practice Manager

PRACTICE FEEDBACK

“I would like to pass on comments about the community services list which appear to be opening to procurement. Most of these services are aligned with and would be best provided by and in primary care services. In particular the current VAWAS service as provided by the DDHF is a great success and should not be broken down. Many parts of the service are disparate and I feel that they should not be clumped together but split into related bundles for providers to offer to provide. Removal of in house physiotherapy services from practices is a huge backward step which will be very unpopular for our patients in particular.”

Local GP

Appendix: Case Studies

Case Study 1

Mr A, Mrs A and daughter R

Mr A is admitted to hospital following a collapse at home.

R is left to look after Mrs A who was thought to have early stage Alzheimer's. Mrs A is actually quite advanced, so it would seem Mr A has been covering the severity of his wife's condition ultimately leading to his collapse.

R is now having to come to terms with two ailing parents. She is waiting for "the call" from Darlington Memorial Hospital to advise that her father has passed away and she has effectively lost her mother as well. Mrs A no longer recognises R as her daughter and regards Mr A as her father not her husband.

During his stay in Darlington Memorial Hospital, Mr A starts to improve. IC+ referral is made and together with the Discharge Management Team (DMT) a package of care is agreed to enable him to return home.

DDHF Health Care Coordinator has maintained regular contact with R, supporting her and guiding her through potential options for the long term care of her parents.

Mr A's discharge package of care will not include care for Mrs A, so he is being sent home to an increasingly deteriorating social situation. R is trying her best but is exhausted.

Through referral and liaising with Social Care Direct (SCD), Care Home and Assisted Accommodation (Extra Care) providers DDHF Health Care Coordinator prepare and ensure Mr A, Mrs A and R have all the information regarding their options and that all required assessments and procedures have been completed and are in place to facilitate the best outcome for everyone.

Outcome: After one week it was apparent Mrs A needed more help than the family could give. She is now a resident at a local care home and Mr A is managing at home with an ongoing package of care.

Appendix: Case Studies

Case Study 2

Mrs R and son, M

Mrs R is admitted to Darlington Memorial Hospital for the third time in six weeks, for non-compliance with medication leading to admission. Referral is received direct from GP advising of hospital admission. Requested to facilitate early discharge on behalf of practice, in addition, how can we prevent recurrent admissions?

DDHF Health Care Coordinator contacts son, M.

M explains that when his mother is discharged home she receives a package of care from the "free" carers (IC+). The times that the carers visit do not suit her, so she locks the door, leaving the key in and the door chain on thus preventing access to the house.

M advises that Mrs R is a fiercely independent lady and would be more likely to accept care if times were agreed to fit her routine and she has funds to pay for her care. He is aware the repeated admissions are due to her missing essential medication and agrees a care package that would oversee her taking her medication would be ideal.

Contact is made with IC+ and the aforementioned situation discussed. As previous attempts to provide a package of care via IC+ have thus far failed they are happy for arrangements to be made independently.

Contact is made with a local care company. An explanation of a suitable package of care is required and confirmation is received that they have availability and could commence immediately on discharge.

Now contact is made with Darlington Memorial Hospital's Discharge Management Team. All information is discussed and agreed. Updates are received regarding discharge status and are passed on to the GP and son.

Care is started with a local company immediately upon discharge.

Home visit is made two days post discharge to ensure the care plan is being followed and that medication is being administered.

Outcome: Mrs R remains at home. Administration of medication continues to be monitored by carers, son and DDHF Health Care Coordinator. GP is kept up to date.

Case Study 3

Mrs M

Mrs M was widowed in 2016. DDHF Health Care Coordinator had been visiting her and her husband since 2015.

Following the death of Mr M, Mrs M grew increasingly withdrawn. GP requested regular DDHF Health Care Coordinator visits to offer support, company and lift her spirits.

Visits continued on a regular basis, usually every two weeks, occasionally three weeks. Eventually, Mrs M felt confident enough to recommence weekly social outings as she had previously done with Mr M.

Mrs M has good family support, however her family have a timeshare holiday which she encouraged them to maintain despite the fact they would be leaving her alone.

Once the family had left, Mrs M became increasingly anxious, making 999 calls and being admitted to A&E before being sent back home. After the third call out, her GP rang DDHF Health Care Coordinator and asked if there was any further support they could give, if not they would have to arrange an IC+ nurse to attend over the holidays.

DDHF Health Care Coordinator agreed to visit daily over the weekend and through the family's holiday, checking and recording basic observations daily. As the DDHF Health Care Coordinator has a good relationship and knowledge of Mrs M and her usual status she felt she would be better placed to recognise any changes. GP in complete agreement.

Outcome: No further 999 calls and Mrs M remained at home and continues to do so, fully supported by the DDHF Health Care Coordinator.

DDHF STAFF DEVELOPMENT

DDHF analyse patient data to align our staff development programme with the needs of our local population. Where a gap in our service provision is identified DDHF encourage staff to develop new skills to continuously improve our service capability.

As a result of this continuous improvement methodology DDHF have developed some of the most highly skilled clinical staff in County Durham. Personal development is encouraged and promoted within DDHF.

Examples of recent training activity; 4 members of staff have completed their non-medical prescribing and 5 members of staff have completed clinical examination skills.