County Durham Integrated care partnership

Bulletin Edition 1

May/June 2018

Welcome to the first edition of the County Durham Integrated Care Partnership bulletin designed to keep you up to date with integrated care in County Durham.

In this edition:

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Clinical Commissioning Groups (CCG's) across County Durham alongside County Durham and Darlington NHS Foundation Trust , Tees Esk and Wear Valley NHS Foundation Trust and Durham County Council have a clear vision and strategy to deliver their functions in line with the NHS Five Year Forward View. This partnership recognised the importance of further developing integrated models of care and as a consequence, they appointed Lesley Jeavons as Director of Integration, to lead the partnership across health and social care.

The County Durham Accountable Care Network was born out of this vision and the partners wider obligations to develop effective integrated services with all of the key stakeholders in County Durham to improve patient outcomes. This led to the development of the Teams Around Patients (TAP) model of care which became the 'out of hospital' model with delegated accountability and budgets. Significant achievements have been made over the last 12 months with aligned clinical leadership confirmed in the Autumn of 2017. NHS provider staff are now aligned to TAPs, priorities have been established and TAPs meetings have been taking place.

During the time we were developing the County Durham model, in some areas partnerships across the NHS were evolving and integrated care systems were being established. These were mainly a collaboration of NHS provider trusts, primary care provision and CCGs. Whilst this approach was a positive one, it was our view that greater synergy was possible if local government were involved in an attempt to develop 'system wide' solutions to increasing demand and finite

resources. We have therefore described our aspiration for system collaboration within a 'County Durham Health and Care Plan' which in reality involves the NHS provider Trusts who operate across County Durham, the local council which includes both adult and children's services and the CCGs, working in an integrated partnership. We expect that these organisations, including Primary Care, will take collective responsibility for managing resources, delivering NHS and Local Government targets, and ultimately improve the health and wellbeing of the population that they serve.

It has been clearly articulated that the aim of the TAPS model is to promote much closer working across all disciplines so ensuring an effective approach that encourages relationships which work to support people who are at risk of losing their independence through ageing and/or frailty and disability. In recognition of this a new community service specification has been developed and the procurement process has now ended. A Mobilisation Board is in place to oversee the development and implementation of the new service model. The model will deliver an integrated approach with the health provider working alongside adult social care in a single management structure, with activity being overseen by a new dedicated role of Chief Officer. A key activity in the early part of the implementation of the new model being to deliver a comprehensive Organisational Development programme which is focussed upon changing culture and managing change, the emphasis of which is to empower frontline staff to influence how services are delivered pertinent to their local population. The model encourages local teams to be in control of service development and operational activity relevant to their own localities to provide better and more joined up care for people.

As the NHS works alongside Durham County council, and draws on the expertise of others such as local charities, the voluntary sector and community groups, we can expect people to live healthier lives for longer, and to stay out of hospital when they do not need to be there. This approach will be oversee by a refreshed Integration Board and partners will collaborate in a formal arrangement known as **County Durham's Integrated Care Partnership**.

Lesley Jeavons,
Director of Integration for County Durham

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Benefits/Advantages of Teams Around Patients (TAPs) approach

- Primary Care focussed
- The TAP follows the patient and focusses it's caseload on high users and those likely to use emergency admission routes into hospital
- A single named Care Co-ordinator who is the primary contact for the patient
- The TAP will operationally take a neighbourhood approach to ways of working
- Greater opportunities for increased multi-agency approaches to multi-disciplinary working at Primary Care level.
- The TAP's approach is pivotal in addressing those patients with multiple conditions and complex needs
- The TAP's will provide a supportive environment for collective knowledge sharing and decision making
- Communication, collaboration and co-operation is at the heart of the TAP's approach
- Improved understanding of each partner organisations objectives, ethos and legal framework and constraints
- Involvement of the VCS locally adds a further dimension to mainstream health and social care services
- The TAP's is a model of horizontal integration which involves the co-ordination of care across the whole range of an individual's health including primary and secondary care and beyond this to social care
- The whole person approach to dealing with multi-morbidity should lend itself to improved patient experiences and better health outcomes

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Clinical Commissioning Groups announce appointed provider of New Community Services

In the last bulletin we explained that the existing contracts for community services was due to expire and we were working with potential providers to procure new community services.

Following a comprehensive tender and evaluation process, the three CCGs would like to announce that they have chosen County Durham and Darlington Foundation Trust (CDDFT) as the preferred provider of new community services which will start in October 2018 as per the agreed timeline.

We want to grow and improve local community services across County Durham and Darlington and have a legal duty to carry out re-procurement exercises for contracts for healthcare in the community to ensure that provision constantly meets expected levels of quality and that it continues to represent best value.

This approach is in line with our vision of developing an Integrated Community Service as part of our Five Year Forward View plans to improve access, continuity and coordination of community based health and care services for the local population.

We are very much looking forward to building on the strong foundations that are already in place with CDDFT. We will be looking at what is working well and strengthening that so that our team of healthcare professionals are focused around providing excellent care for everyone in the community.

We will be working in a new way with CDDFT to develop the existing community services, to prevent unnecessary acute hospital attendance and support people to stay well in their own homes. This new way of working will include bringing health and social care organisations closer together and moving from reactive care to prevention models that look at early intervention. We want to improve the quality of services for local people by supporting multidisciplinary teams for those with complex needs and ensuring all services in place are financially sustainable in the long term.

Sue Jacques, Chief Executive of CDDFT said: “We are absolutely delighted to have been awarded the contract for community services. We truly believe this is a great opportunity to work differently with our health and social care partners across County Durham and Darlington which will bring real improvements to both patient care and also the overall health and wellbeing of our local communities.

“Our experience of providing community services over previous years gives us a fantastic foundation on which to build and we know we have a dedicated and highly skilled workforce ready to take on this new challenge.

“We will be working closely with GPs, local authority and voluntary sector colleagues as well as our patients and local communities to deliver services fit for the future.”

So what will be different?

Patients don't need to do anything differently, but we hope that they will notice an improvement in coordination with one provider overseeing care and joint working between professionals responsible for their care. We want to avoid duplication and improve services by helping clinical staff in different organisations to work even more closely together to support patients to achieve outcomes which matter to them. We want to see care being delivered closer to home as that's what patients have told us that they want.

We will be involving local partners to support various joint projects to ensure local quality and safe treatment and care continues to be delivered for patients.

Existing patients will receive information about the new community service ahead of its launch in October 2018 outlining any changes and improvements.

Commissioning community health services in a partnership approach is key to ensuring we achieve a robust, safe, value for money services for communities across Durham and Darlington.

Visit the CCG's websites for more information about the community services re-procurement, including a list of frequently asked questions and previous briefings.

www.darlingtonccg.nhs.uk/new-community-services/
www.durhamdaleseasingtonsedgefieldccg.nhs.uk/about-us/community-services/
www.northdurhamccg.nhs.uk/about-our-ccg/new-community-services/

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C3 Care Co-ordination Centre 'The Front Door to CDDFT Community Services'

C3 is working hard to reduce call waiting times with ongoing recruitment and the addition of a generic email inbox which is monitored during our opening hours 8am – 8pm, 7 days a week, 365 days a year.

Non-urgent referrals must be emailed using a referral form to cdda-tr.ContactCentreCCTH@nhs.net

Urgent visits required the same day *or* within 24hrs must be telephoned to C3 on 0191 333 2 666

What we are

- ✓ Based at The Whitehouse in Peterlee
- ✓ Staffed by 14 Administration Staff
- ✓ Supported by 5 qualified nurses
- ✓ One Clinical Lead
- ✓ Working a variety of shift patterns covering 8am till 8pm, 7 days a week, 365 days a year
- ✓ Front door for new referrals into community services for – District Nursing, Continence Services, Weekend Frail and Elderly Booking and Intermediate Care – Others will be added in due course
- ✓ We will accept queries/referrals from the public
- ✓ We use 18 separate units within SystmOne also HDS continence systems and SIDD (social care system)
- ✓ Staff use duel screens in order to process referrals as quickly as possible
- ✓ Staff are in the process of being multi-trained on all systems and services currently covered by C3
- ✓ Urgent patient referrals which require a visit the **same day or within 24hrs MUST** be telephoned to us promptly
- ✓ Emails are processed 8am till 8pm 7 days a week, 365 days a year and are ***continuously monitored***
- ✓ C3 is managed by a qualified nurse

What we are not

Do you have doctors, social workers and therapists on site? No – we can pass messages to the relevant teams via the computer system but we are unable to speak to them in person

Will the person answering the phone be a nurse? No - You will not always speak to a nurse unless Triage is required or further support is needed or requested

Are all the staff qualified practitioners? No - The staff who answer the telephone are not all qualified clinicians. They are administration staff.

Are you just another call centre? No - Our aim is to process all new community referrals via a single access point in order to ensure consistency of information and accuracy for the patients' destination. We have administration work such as Emails for all services as well as answering the telephones

Do you see patients? No

Do I have to ring in every referral?

No we would encourage you to ONLY call us if the referral is urgent and needs processing the same day or within 24hrs.

An elderly chap called C3 in quite a distraught state, he had a problem with his sink and understood we supplied TAPS so could we help !!

The C3 call handler actually did help him as he was in such a state – a plumbers contact details were found and given to him and he left the call calmer and happier.

GP Surgery Engagement in North Durham

Pictured above: Staff at The Haven Surgery, Burnhope

From the establishment of the Wellbeing for Life service in 2014, the teams across North Durham have worked tirelessly to engage with GP Surgeries in partnership to achieve shared objectives. With this in mind we have utilised their Quality Outcomes Framework (QOF) data to identify patients registered as pre-diabetic (HbA1c 42 -47). On behalf of Wellbeing for life the surgeries will then either call, text or write to these patients inviting them in to the surgeries for a 1:1 appointment with a Health Trainer running the clinic directly on site. This approach has been very well received by the surgeries who have wanted to host the Health Trainers. The majority of the surgeries have also set up clinics on their booking systems (often SystemOne or equivalent) meaning that GPs, Practice Nurses, Secretaries etc can all book patients in directly. We are delivering clinics at Tanfield View Surgery, Stanley, The Louisa Surgery, Stanley, The Haven Surgery, Burnhope, Browney House Surgery, Langley Park and Sacriston Surgery, Sacriston.

Patients are invited in for their initial assessment with a Health Trainer whereby they have the opportunity to discuss the service, ask any questions they may have as well as the Health Trainer being able to highlight how the service can be of benefit to the patients engaged to reduce their risk of developing Type 2 Diabetes. All patients are set a Personal Health Plan including reviewing food diaries and setting Specific Measureable Achievable Realistic and Timely (SMART) goals. They are signposted to other services that may also be of benefit to them.

In addition to our work with pre-diabetic patients, a weekly Stop Smoking Clinic is also hosted by the Wellbeing For Life Health Trainers at Browney House Surgery which continues to grow and excel including being recognised at the solutions4health annual celebration event where we were awarded with the 'Outstanding Achievement' award for our ongoing investment in to this service including an average of 67% 'quit rate' well above the 40% minimum required.

Between 1st April 2017 and 28th February 2018 a total of **179** patients across the surgeries engaged with have taken up the 1:1 support of a Health Trainer and the results have been staggering.

This is what people are saying about us…

*"I feel so much better in myself. I am eating better, sleeping better, I feel more full of energy, just everything really! Even when walking around Newcastle shopping I used to always stop and have a rest, I don't need that now and I just keep going!"- **Client***

*"The partnership we have developed with the Health Trainers has been beneficial to both parties. I am well aware Martin and his team of staff have been able to recruit more Patients but it also enhances our service here in the Surgery. We are able to utilise the Health Trainers to refer in our pre-diabetes risk Patients for 1-2-1 support which eases off time in other appointments for the GPs and the other surgery staff. The progress we have seen for many Patients including weight loss and improvements in their blood sugars has been fantastic."- **Kim Beedham, Practice Manager, The Haven Surgery***

VCS Engagement: An Update from Durham Community Action

The VCS in County Durham works together across several key networks, which bring large and small groups and organisations together. These networks, which are organised by and for the VCS, also have membership from health and social care professionals. They include networks for community building management groups, another for Volunteer Coordinators and, perhaps the key network for those involved with TAPs, the Advice in County Durham Partnership.

We have been spending time with the TAPs as they are developing and listening to ideas which come through the meetings. Some of the ideas are focused on projects which provide support for patients in the community. We are looking at options for developing new initiatives where there may be gaps at local level, and we are also working closely with local Area Action Partnerships (AAP's) to discuss opportunities for funding local projects.

We are also picking up on providing support for the network of Crees (local "Mens' Sheds" initiatives in County Durham) which provide a wide range of informal support networks for people (there are Crees which cater for Men, Women and young people) …..Their work, together with the new Wellbeing for Life programme will provide further resources and access to hand holding support for more vulnerable patients. Development work is starting so we will provide more information in a later bulletin.

Finally, the work to recruit and train Care Navigators is continuing, alongside the appointment of Link workers in the County. Care Navigators will be providing sign posting from surgeries and Link workers will be actively supporting individual patients to find the most appropriate kind of support when a little bit of extra help is needed. Our role will be to offer training, and support for link workers to get better access into local VCS led services, also to help them become familiar and properly connected into the full range of VCS networks which meet in the County.