Joined Up Care
Derbyshire

Team Up Derbyshire

DERBYSHIRE County Council

NHS

Derby City Council

Team Up
Derbyshire

The plan

- Create one team across health and social care who see **all housebound patients** in a neighbourhood
- **One team to do it all** - urgent, planned or anticipatory. If someone is housebound and needs a service, this team will deliver it
- It is not new or ‘add on’ but a **teaming up** of existing services

Team Up
Derbyshire

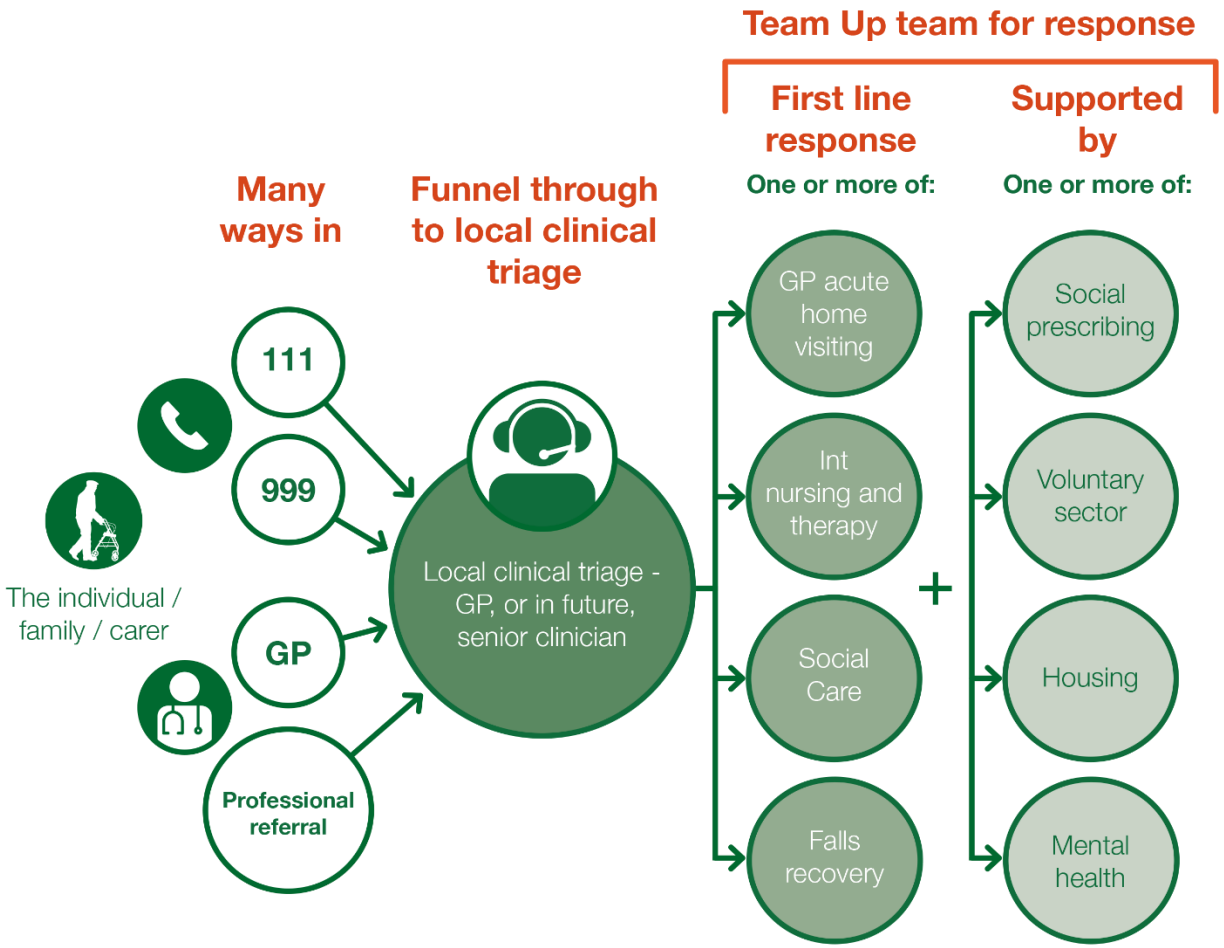
Who is in the Team Up team?

What would they do?

- Work with the person to identify clinical and social needs and support - and put it in place
- Ensure housing is appropriate
- Encourage and promote independence
- Respond to acute need to prevent hospital admission

Team Up Derbyshire

Urgent community response



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Derbyshire

Derbyshire's Population - 2020

807,183 people
(England = 56,550,138)

0.6%
4,490 increase since 2019
(England = 263,180, 0.5% increase)

Median age
46 years
(England = 40 years)

64%
increase in the very elderly population aged 90 years and over since 2001
(England = 63%)

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Derbyshire

Why focus on the housebound?

- Almost all have complex health and social care needs
- Healthcare provision is a challenge
- It is best done at a scale bigger than general practice
- Risk of health inequalities

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Derbyshire

What will change?

The **current state** of first line urgent response - at the point the patient phones for help:

- Largely ambulance or general practice
- Single clinician
- Time pressured
- Make safe

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Derbyshire

What is involved

The **new approach** will develop:

- Acute home visiting service
- Urgent community response (Ageing Well)
- Enhanced health in care homes (Ageing Well)
- Anticipatory care (Ageing Well)
- Step up
- Discharge pathways
- Falls recovery service

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Derbyshire

Enhanced health in care homes

- People living in care homes should expect the same level of support as if they were living in their own home
- Initiative stems from NHS England vanguard programme to strengthen support for the people who live and work in and around care homes
- GP practices aligned to care homes, multi-disciplinary approach, weekly home rounds to care homes and care plans in place

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Derbyshire

Home visiting service

- Visits to be undertaken by a range of professionals according to patient need
- Access to dedicated GP
- Responsibility for service with primary care networks
- GP service delivered at the same scale as other community services

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Derbyshire

Urgent community response

- Will support people with complex needs to live in their communities, avoiding admission to hospital or long-term care
- Crisis response within two hours of referral
- Reablement care within two days of referral
- Delivered by teams of professionals working together in the community
- Avoids reliance on hospital as ‘place of safety’

Team Up
Derbyshire

Thank you

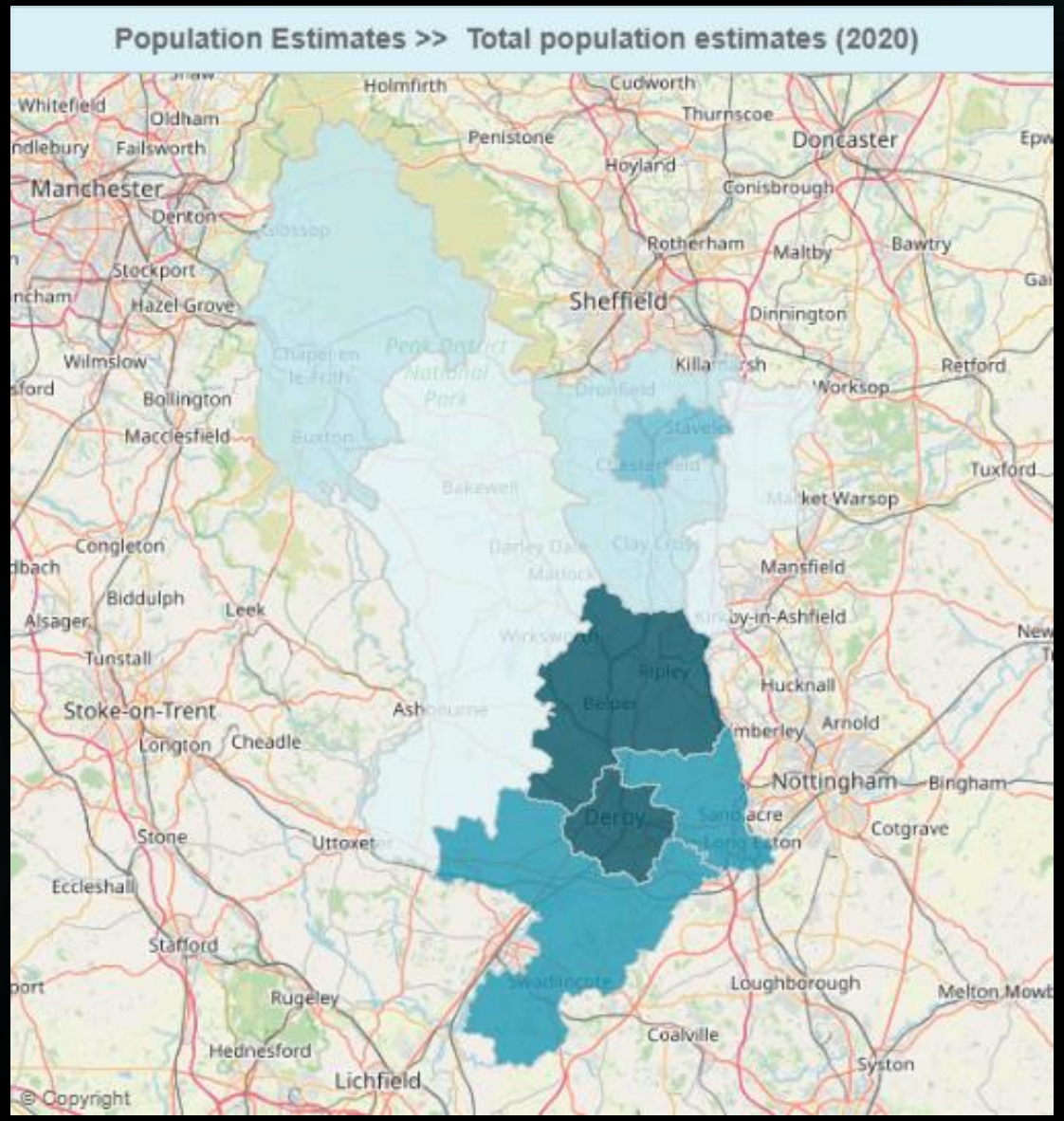
More information on the
joinedupcarederbyshire.co.uk website

Team Up-UCR High Peak

RUTH DAWES INTEGRATED COMMUNITY MANAGER DCHS IN THE HIGH PEAK

INTEGRATED CARE: DELIVERING THE LONG TERM PLAN

11.10.22


Population Estimates >> Total population estimates (2020)
Holmfirth
Cudworth
Whitefield
Oldham
Thurnscoe
Penistone
Doncaster
Failsworth
Hoyland
Manchester
Conisbrough
Denton
Rotherham
Maltby
Bawtry
Stockport
Sheffield
Hazel Grove
Dinnington
Wilmslow
Retford
Worksop
Bollington
Macclesfield
Tuxford
Congleton
Mansfield
Biddulph
Leek
Alsager
Tunstall
Hucknall
Stoke-on-Trent
Arnold
Longton
Cheadle
Nottingham
Bingham
Derby
Cotgrave
Stone
Uttoxet
Eccleshall
Stafford
Loughborough
Rugeley
Melton Mowb
Coalville
Hednesford
Syston
Lichfield
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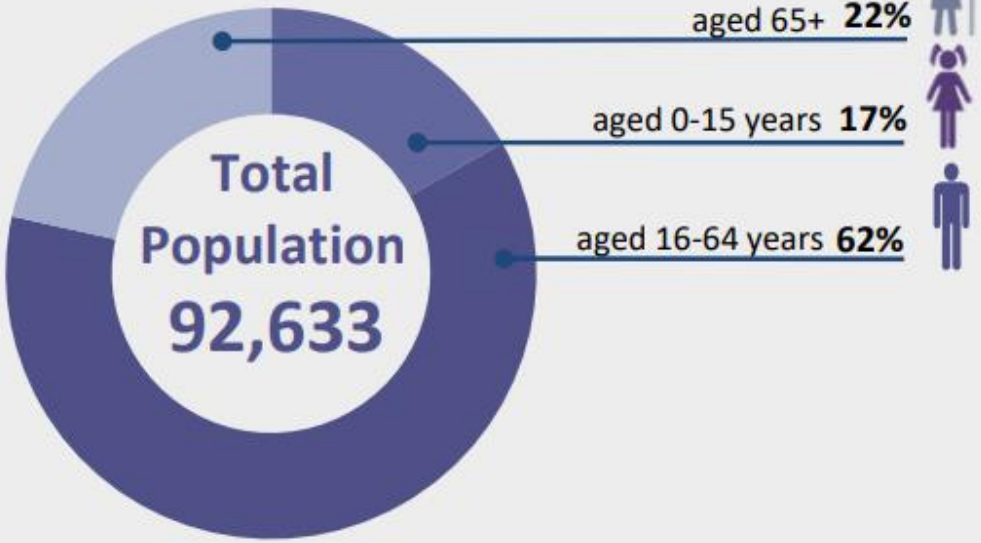
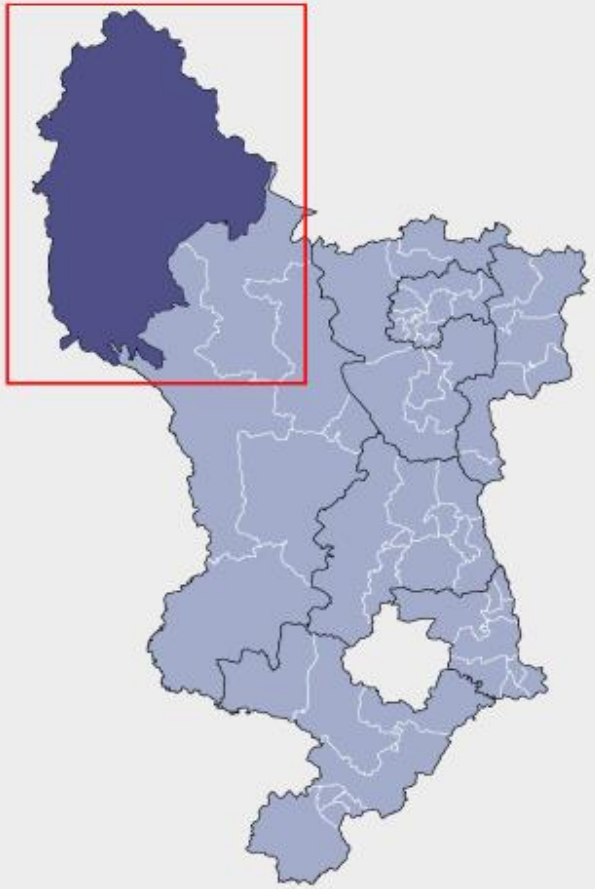
2021 Area Summary Profile
High Peak District

The borough of High Peak is rural in nature and largely comprises the Peak District National Park. There are five market towns including Glossop, New Mills, Whaley Bridge, Chapel-en-le-Frith and Buxton. High Peak has the fifth highest number of households of all Derbyshire districts at just under 39,000.





Development of the High Peak Team Up group

- CLOSE WORKING RELATIONS THROUGH PLACE ALLIANCE GROUP (PAG) – F2F MONTHLY MEETINGS.
- PAG MEETINGS INCREASED DURING COVID- WE WENT TO MS TEAMS AND THE MEETINGS WERE RENAMED AS HIGH PEAK WEEKLY COMMUNITY RESILIENCE CALL
- IN 2021 THE CHAIR OF PAG (LOCAL GP) STARTED THE HUB/TEAM UP/PCN WORKING GROUP WHICH DEVELOPED INTO LOCAL ACCESS POINT (WORKING) GROUP.
- SHARED VISION WITH ALL PARTNERS

NEEDED TO TURN INTO SOMETHING TANGIBLE.

NEEDS LEADERSHIP/STAFF/INFRASTRUCTURE

Leadership

- ALREADY IN SITU- PCN CLINICAL DIRECTOR, PCN ADMINISTRATOR, DERBYSHIRE COMMUNITY HEALTH SERVICES MANAGER, DERBYSHIRE COUNTY COUNCIL MANAGERS, VOLUNTARY SERVICES MANAGER, EMAS MANAGERS
- KEY APPOINTMENT IS THE OPERATIONAL MANAGER
- THE TEAM UP OPERATIONAL MANAGER APPOINTED BY PCN ENACTS THAT VISION/DIRECTION
- THE OPERATIONAL MANAGER WILL BE RESPONSIBLE FOR ENSURING DAY TO DAY RUNNING OF THE SERVICE EVEN THOUGH STAFF COME FROM DIFFERENT EMPLOYERS
- OPERATIONAL MANAGER AND CLINICAL DIRECTOR ARE LEADING ON CLINICAL GOVERNANCE

Staff!

The overarching principle of Derbyshire Team Up is to have a team developed from existing organisations. Some existing staff and some new appointments – funded through PCN using drop down funds

- There are nurses and therapists from Derbyshire Community health services (DCHS)
- Social workers and their teams from Derbyshire County Council
- Falls recovery service
- GP (to be appointed) from the PCN
- Paramedics – either hosted by EMAS or practice employed
- Admin staff (DCHS + PCN)
- Care coordinators (?employer)
- ACPs (hosted by DCHS)
- Frailty liaison officer (?employer)

Employers

Adult Social Care
DCHS
DHU/111 EMAS
CVS
Falls Recovery Team
MH Team
PCN

Infrastructure
Location of the LAP (local access point)

- OUR HIGH PEAK VISION WAS FOR CO-LOCATION
  - THE MAIN BASE FOR THE SERVICE HAS BEEN SECURED AND WILL BE CO-LOCATED AND HOSTED BY DCHS INTEGRATED COMMUNITY TEAM AT THE HUB WITHIN THE CAVENDISH HOSPITAL AT BUXTON.
  - OPPORTUNITIES FOR INTEGRATION AND BUILDING ON THE STRONG FOUNDATION OF MULTI-DISCIPLINARY WORKING ARRANGEMENTS.
  - COLLEAGUES FROM HEALTH & SOCIAL CARE WILL WORK WITHIN THE BASE OR OUTREACH SATELLITE OFFICES FACILITATES COMMUNICATION FOR A TRULY HOLISTIC APPROACH TO ASSESSMENT FOR AND THE PROVISION OF SERVICES.

Local Access Point in practice (7.10.22)

Next stages/considerations

- Recruitment
- Referral Routes in agreed. Emails/phone/task
- IT (DSCR)
- Shared rotas
- Trusted assessor/shared assessments
- Agreed inter-team referrals vs conversations- how to document on different e-records (DSCR)
- Different employers/T+C/salaries
- Lanyards

Thank-you

Team Up – Erewash

Fee Buswell-Marsh
Integrated Community Manager - Erewash

Whistle stop tour of Erewash

- Erewash lies between Derby and Nottingham with a population of 115,400 Erewash naturally splits into 2 communities of Ilkeston in the north and Long Eaton in the south.
- Erewash contains 4 of the most deprived areas in Derbyshire
- About 17.2% children live-in low-income families.
- Life expectancy is 9.8 years lower for men and 4.3 years lower for women in the most deprived areas of Erewash.
- 19.9% of children are classified as obese.
- Breastfeeding and smoking in pregnancy are worse than the England average.
- The rate for alcohol-related harm hospital admissions is worse than the England average.

How Team Up is developing in Erewash

- Erewash was a previous vanguard site, so had some previous investment.
- However, these individual teams worked in isolation of one another, as delivered by different providers.
- We are currently working on teaming up together to have 'One Team, One Leadership, One Management and One Clinical Governance.'
- Co-location of existing teams for handovers and those invaluable casebased discussions
- Development opportunities for staff in existing teams to increase their knowledge and skills
- Local access point being developed with a consistent clinical triage for all referrals

Mary’s story

- **Pre team up**
- Lives with daughter who is main carer
- Poorly controlled Diabetes
- Frequently seen by the on day acute home visiting service for hyperglycaemia and falls
- Due to the time of day and reactive nature of her medical presentation, options often limited so was frequently taken to hospital as a place of safety and to obtain an assessment…
- 11 admissions to the acute trust in 6/12 period
- Not previously known to the Frailty Team or Community GP.

- **The Team up journey**
- Comprehensive triage by an ACP
- This lady did live with her daughter who was her main carer. Requests for acute home visiting service were always at a time where there was carer breakdown.
- Holistic assessment identified that Mary was not taking her medications as prescribed. It was also identified that this lady was being financially abused and neglected.
- Referred to Social worker for safeguarding and re-housing. Care package also provided.
- Full structured medication review and de-prescribing undertaken.
- Blister packs prescribed to support compliance
- Referred to community mental health team for low mood. This supported the start of re-building relationship with daughter
- Social Prescriber organised a befriender and connected Mary to an online community group
- Therapy for equipment to enable Mary to live safely in her new home
- The handy man service for the key safe to allow multiple professionals to access Mary as appropriate
- **In addition** there was an onward referral to Environmental Health regarding the previous property and concerns for other occupants of that residence.
- Referral made to RSPCA as daughter had left Marys two dogs locked in a room upstairs
- Dogs re-united with Mary and voluntary agencies provided dog walking facilities
- 1 admission to the acute trust in last 3 months
- Significantly reduced call outs for an urgent community response

Challenges and Opportunities

Challenges

- Organisational barriers
- Established teams with embedded processes in place
- Fear of change
- Anxieties re: own competence
- Concerns regarding work becoming reactive only

Opportunities

- Increased flexibility
- Consistency for patients
- Reduces duplication
- Reduce ED attendances and avoidable admissions through proactive work
- Better outcomes for patients