Communities explained

We understand that the healthcare needs of people vary across northern Derbyshire and so we have divided the area into eight 'communities' so that each area can decide what things will work best for their specific area.

6 Work stream 6 Reactive integrated care services

Purpose

The purpose of this work stream is to implement what we call a multidisciplinary and multi-agency Integrated Care Service (ICS) within each 'community' (see box above for more information about 'communities') to provide intensive support in both urgent and non-urgent situations, to avoid unnecessary admissions to hospital or facilitate a supported discharge from a hospital or bed based setting. That's a lot to take in, so let us explain what we mean by 'integrated care' and 'multidisciplinary and multi-agency'.

What is integrated care?

In a nutshell, integrated care is about seamlessly co-ordinating health and social care services around an individual's needs in a comprehensive way. For the patient this reduces confusion, repetition and delay and the risk of getting 'lost' in the system. Sometimes integrated care is also referred to as 'person-centred' or 'coordinated care'.

What do we mean by multidisciplinary and multi-agency?

A multidisciplinary and multi-agency team is composed of members from different healthcare professions with specialised skills and expertise. The members collaborate together to make treatment recommendations that facilitate quality patient care.

Progress

To help achieve the aim of this work stream we have developed a set of 'discharge to assess and manage' (D2AM) principles that have grown out of the work of the acute frailty services work stream.

Earlier we mentioned that one in four people over the age of 75 currently in acute hospitals up and down the country have no medical reason to be there. One of the reasons for this is because the clinician that is responsible for an individual's care has to be sure that they will be ok at home once they are discharged. To help with this decision, patients undergo a range of assessments before they are considered fit to go home; assessments 21c feel could be better performed in the familiar environment of a patient's own home.

D2AM aims to reduce unnecessarily long stays in acute hospitals by ensuring that discharge is considered as soon as a person is admitted and that essential assessments for those patients requiring integrated and intensive support on discharge are completed in the person's own home.

To get this right requires a more joined-up way of working between health and social care and in both acute and community settings in order to build trust and a better understanding of each other's roles. That's where those multidisciplinary and multi-agency teams we talked about earlier - the Integrated Care Service - come in.

7 Work stream 7 - Community hubs

Purpose

In the section above on work stream 6 - reactive integrated care services – we talked about how we have divided northern Derbyshire into eight 'communities' to support the ambition to deliver health and care that is tailored to an area's specific needs. The purpose of the community hubs work stream is to establish the infrastructure in these communities that will enable patients to receive the right care, delivered by the right person, in the right place and to remain independent and in their own homes for as long as possible.

Progress

Establishing the right infrastructure is not an easy process as it involves many aspects of health, social care and voluntary provision. The three main areas of provision we have been focussing on are:

- Bedded care provided by community hospitals;
- Access to urgent care and;
- Care for older people with mental ill health.

We have looked at other parts of the country to see how they are providing care; have considered national strategies and service standards and have analysed local activity, demographic predictions, and financial modelling. We have involved a range of stakeholders including members of the public, professionals, clinicians, volunteers, care staff and voluntary groups and worked with them to develop possible models for each of these main areas of care. The aim underpinning each model is to transform care from being mainly hospital orientated to being person centred; to deliver quality provision in people's own homes as well as still offering quality care for those who need it in a hospital setting.

Throughout the last three months of 2015 we shall subject all the models that have been proposed to detailed scrutiny; and, having regard to practicality, financial value and avoiding overlap will be determining which of the proposed options we prefer.

The next stage then will be asking people living and working in northern Derbyshire what they think of the four proposed preferred options. People will be able to comment on these in a number of different ways and the outcome is expected to be shared in autumn 2016.

8 Work stream 8 Learning disabilities

Purpose

In line with the programme's aims, the team at 21c wants to make sure that where possible people with learning disabilities can live independently in the community, in a place they call home even if they have high levels of need.

Progress

By working together, the organisations that buy or provide learning disability services will make sure care is joined up - so people get the right care and support, in the right place and at the right time.

They will help people to:

- Have things to do and places to go in the day time - such as community groups, voluntary work or meeting with friends.
- Access education, stay healthy and use services such as libraries.
- Have choice and control over their lives, care and support.
- Share information and experiences with other people with a learning disability.

Joint working like this will not only improve care and services, it has the potential to use money more wisely. The NHS in North Derbyshire spends £13.4 million on services for people with learning disabilities. Derbyshire County Council's Adult Care services spend £64.6 million across the county of Derbyshire. By pooling these budgets care could be provided in different ways - perhaps with a personal health budget used to plan for individual needs, and with the person and their carers involved in making decisions about what's best for them.

The group is working closely with people with learning disabilities to find out what they think.

9 Work stream 9 End of life care

Purpose

End of life care is support for people who are in the last months or years of their life. End of life care should help those that need it to live as well as possible until they die, to die where they want to and to die with dignity. This work stream has three main objectives for end of life care:

- To improve the quality of care
- To improve equity of access to community services such as home-based nursing
- To develop and improve the culture around end of life care in all settings

Progress

This work stream is still in its infancy but work has already been done to understand better how it links in with the other work streams. Also, analyses of hospital admissions for end of life patients are near completion and the group has linked with the care planning group to see how plans for a shared electronic palliative care plan fit with the roll out of the Health and Social Care summary we spoke about earlier in this newsletter.

We hope this newsletter has been helpful and that as we continue on our #JoinedUpCare journey you'll be interested and involved in what's happening. Keep following our story at www.joinedupcare.org.uk and on Twitter @21cNorthDerbys.

Contact us

If you want to let us know your thoughts on 21c #JoinedUpCare you can get in touch with us in a number of ways.

By post: JoinedUpCare, Freepost Licence Number RTBE-UYBK-YRBR, c/o Communications Department, Chesterfield Royal Hospital, Calow, Chesterfield, S44 5BR

By email: crhft.JoinedUpCare@nhs.net

By Twitter: @21CNorthDerbys #JoinedUpCare

Web: www.joinedupcare.org.uk

The principles of 21c #JoinedUpCare

We'll treat you with dignity and respect

Our services will be person-centred

We'll be flexible and adaptable to meet your needs

We'll challenge what we do now and find better ways of working

We'll work with you to plan and deliver services

We'll promote healthy lifestyles and support you to make a change

October 2015 - **Issue 3**

Health and social care in northern Derbyshire is changing

An update on 21C #JoinedUpCare

OUR JOURNEY SO FAR

Hello and thanks for picking up the latest edition of our newsletter. In this edition we will look at some of the progress that has been made so far and for those of you that perhaps haven't heard of 21c #JoinedUpCare we'll recap what it's all about.

What is 21c #JoinedUpCare?

21c #JoinedUpCare (or '21c' for short) has been developed by the health and social care organisations in northern Derbyshire that buy or provide services for its 390,000 people. The aim of 21c is to find smarter and new ways of working together that improve services for our citizens and use public money in the best possible way. Overall we want to make sure our patients receive not just high-quality clinical care, but well-organised care that enables a good patient experience.

21c #JoinedUpCare partners

NHS North Derbyshire Clinical Commissioning Group, NHS Hardwick Clinical Commissioning Group, Chesterfield Royal Hospital NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, Derbyshire Health United, Derbyshire Community Health Services NHS Foundation Trust, East Midlands Ambulance Service, North Derbyshire Voluntary Action and Derbyshire County Council

What's happened so far?

Sharing the challenge

In February and March we held eight public events and visited towns and villages across northern Derbyshire. We shared the challenges that health and social care face, but more importantly, we listened to local views and experiences – with people telling us what they think about health and care and how it could be improved for them. This input has been excellent and it continues to help us shape our thinking, as we look to develop new models of care across our eight northern Derbyshire communities.

Thousands of NHS staff, such as GPs, nurses, community matrons, pharmacists, commissioners and more are also an integral part of 21c. We've involved them in our discussions and given them the opportunity to have their say about how services ought to work in future.

Accountability

It's equally important that everyone has confidence in 21c and is able to hold us to account. To support this, during the summer, a Members Action Group was set up. This group is made up on Non-Executive Directors, Lay Representatives (members of the public appointed to act as a critical friend) and Governors from each organisation collaborating on 21c. They represent the patients and public we serve to make sure we are doing the right things for our communities.

Improving access to care

In each of the eight communities across northern Derbyshire (we'll explain more about what we mean by 'communities' later), members of the public, clinicians, professionals, voluntary organisations, Local Authorities and NHS managers have been looking at the services and facilities we have now and how they are used. They have considered feedback from the public and have worked out a number of possible options to improve access to care. An analysis of these options - including travel times, quality, equality and cost - is almost complete and will be used to support the proposals that will be put out for public consultation in 2016.

Work streams
making the big, small

Because the scope of 21c #JoinedUpCare is so large it has been divided into nine 'work streams'. By dividing it in this way it helps to make it more manageable. In this part of the newsletter we introduce you to each work stream, explain its purpose, and let you know what's been going on recently.

1 Work stream 1 Social capital

Purpose

The purpose of the social capital work stream is to foster a collaborative approach between all the organisations and individuals involved in providing health and care in northern Derbyshire to achieve better health outcomes.

Progress

To support this work stream social capital plays a vital part in the five year plans of North Derbyshire Clinical Commissioning Group and Hardwick Clinical Commissioning Group (the two organisations that fund health and care in northern Derbyshire), Derbyshire County Council's adult care reforms, and is also a key component of the Derbyshire Better Care Fund (BCF). The BCF brings the NHS and local government closer together and part of this has seen the creation of a local pooled health and care budget.

All CCGs in Derbyshire are looking at ways of harnessing community support and personal resilience, diverting people away from formal services wherever possible through sustainable, flexible individual and community solutions. This will allow people to take control in managing their own care, to stay well longer and ultimately increase their health and wellbeing.

A report, 'Social Capital in Derbyshire' will be presented at the Health & Wellbeing Board in November. It explores ways of measuring social capital and makes a number of recommendations for creating more social capital. The recommendations are grouped under six themes: connectivity, sharing assets, building trust, social value, community action and measuring social capital.

2 Work stream 2 Care plans

Purpose

The purpose of this work stream is to establish a single, shared care and contingency plan for people with ongoing care needs which is used by them, their carers and health and social care.

Progress

To help achieve the ambition of bringing all care management plans under one umbrella, those involved in this work stream have been busy putting things in place to enable practices to create a 'Health and Social Care Summary' (H&SC).

The H&SC will contain information that will help patients and the people involved in their care to better support their health and social care needs. It will be especially beneficial for patients with long term conditions and complex healthcare needs.

To date, 34 practices across northern Derbyshire have received training on how to use the H&SC and one practice is working with Derbyshire Health United as the pilot to iron out any problems before it is rolled out further.

If you have a Rightcare Plan then this will now form part of the H&SC. The Rightcare number has now also changed to NHS111 to provide consistency of access and quality for patients.

3 Work stream 3 Proactive management of care

Purpose

This work stream focuses on ensuring that people can stay as well as possible by helping them to manage their own health and wellbeing proactively. Another aim of this work stream is to identify those people who are at risk of admission to hospital or to residential care and to intervene effectively so that they are able to live at home independently for as long as possible.

Progress

In this work stream staff in the community mental health team and one GP practice have been piloting 'wellness plans'. The purpose of the wellness plan is to support people to consider their own health and wellbeing, to identify key issues and to agree three things that they can do which will help them to stay as healthy as possible. People also make their own plan to identify any signs of potential future deterioration and plan for the actions that they need to take to prevent this. Both pilots have reported that they resulted in 'rich' discussions, sometimes resulting in surprising and useful insights.

The mental health team concluded that wellness plans were particularly useful with functional mental health issues such as depression but not suitable for someone with organic mental health problems, which include conditions such as advanced dementia.

Looking ahead, there are plans to trial wellness plans in more areas and this may prove a useful tool to help people to identify their own needs.

4 Work stream 4 Urgent access to care

Purpose

The purpose of this work stream is to see if the ways we access the services we need when we want to see a health professional urgently are the best they can be.

Progress

Earlier in this newsletter we told you that a number of people have been looking at the services and facilities we have now and how they are used to see if there are ways we can improve urgent access to care; this work stream is the driving force behind that work.

The work stream has been looking at things like opening hours of facilities, the services people access, and how far people have to travel to get the service they need.

New national standards for urgent and emergency care services are being announced during this autumn by NHS England and this work stream will have to consider those standards when looking at our current services and facilities.

Another exciting development in this work stream is that Chesterfield Royal Hospital, one of the partners of 21c, is working up plans for an urgent care village to help to reduce the number of emergency admissions and to make sure that when people need urgent care it's the right care, at the right time in the right place.

5 Work stream 5 Acute frailty services

Purpose

The purpose of this work stream is to establish the best things we can do to look after our most frail citizens.

Progress

The first project to come out of the acute frailty services work stream was an 'acute frailty unit' (AFU) at Chesterfield Royal Hospital which opened in April 2014. The purpose of the AFU is to get suitable people home as quickly as possible.

The reason for this lies in the statistic that one in four people over the age of 75 currently in acute hospitals have no medical reason to be there. Worse still, these patients are likely to lose 10% of their aerobic capacity and 14% of their muscle strength for every 10 days they spend in a hospital bed. That is why discharging them as soon as possible is so important, so long as it is safe to do so.

The focus of the AFU is to support and rehabilitate the patient in order to get them home as quickly as possible whilst working alongside a network of partners to ensure they have the right care and support in place once they are home. Patients in the AFU are not expected to stay more than three days.

This work stream is now also looking at a number of other elements to help support the frail across northern Derbyshire:

- The frailty pathway is being scrutinised to see what scope there is for improvement. The team is also looking at what services and support are in place in the community to help prevent our frail citizens from being admitted to hospital in the first place.
- Training the pubic and health and social care professionals to recognise the signs and symptoms of frailty and to promote self-management.
- The team is also looking at better management of delirium as this often affects frail and elderly people.

Pathways explained

A pathway (short for "patient pathway") is the route that a patient will take from their first contact with an NHS member of staff - usually their GP - through referral, to the completion of their treatment.

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