HARROGATE AND RURAL ALLIANCE

Health & Social care working together with you across all of our communities

Developing Our Service Together

Collaborate △ Partner △ Empower

Twitter: #HARA
wifi: log on via your browser (no code needed)

7 November 2019

Harrogate and Rural District Clinical Commissioning Group

North Yorkshire County Council

Yorkshire Health Network

Harrogate and District NHS Foundation Trust
Tees, Esk and Wear Valley NHS Foundation Trust

Welcome

- Welcome
- Housekeeping
- Our goal for today

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North Yorkshire County Council
Yorkshire Health Network
NHS Harrogate and District NHS Foundation Trust
Tees, Esk and Wear Valley NHS Foundation Trust

Programme for today

- **Welcome**
- **Presentations**
  - Introduction to HARA – Richard Webb
  - Delivering HARA – Charly Gill & Anne Mann
  - Perspective from County Durham – Lesley Jeavons
- **Panel Questions and Answers**
- **World Café – table conversations**
  - What matters to you?
  - What should matter to us?
  - How can we do this together?
  - 5 minute reflection
- **Next steps and close**
- **Lunch**

How we aim to work today

- We are all equal partners in the room
- Everyone's voice is important
- We will speak one at a time so that everyone can be heard
- We will use the microphones available so that everyone can hear clearly
- We will speak at a normal speed to support the BSL interpreters in their role
- If anyone is speaking too softly or too quickly please say so

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Richard Webb
Corporate Director Health and Adult Services
North Yorkshire County Council

Who are HARA?

- GPs and Primary Care (Yorkshire Health Network and Primary Care Networks)
- Health commissioners (Harrogate and Rural District Clinical Commissioning Group)
- Harrogate District Hospital NHS Foundation Trust Community Health Services
- North Yorkshire County Council Adult Social Care
- Mental health services (Tees, Esk and Wear Valleys NHS Foundation Trust)

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Our aspiration

- Provide a service that is **owned by the community and all our colleagues, that** delivers **good outcomes** and **value for money**
- Place the **person and community at the centre** of everything we do, using a **strength-based approach**

What will be different?

- One of the first places in England to integrate all health & social care adult community services
- General Practice, community health and social care professionals **working together as one team**
- This is about the **whole caseload**, rather than part of it
- This will be a **genuine alliance** – with people who use services, carers and wider partner organisations – co-produced by people who use the services
- **Owned by colleagues** who work in the service
- Commissioners and providers are **working together** as an alliance

1 Service
2 Localities
4 Teams

Building on what we have heard from you

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We want to build HARA with you

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Charly Gill
Service Manager
Knaresborough and Boroughbridge

Anne Mann
Service Manager
Harrogate South

Localities

- 2 areas – Ripon and Rural and Harrogate – Divided into 4 teams
- Each team organised around a group of GP practices
- Integrated teams with health and social care staff within them
- Co-location at 4 bases
- Agile working / use of technology
- Improved access via referral line

Huddles

- Health and social care staff in each team meet daily for 30 mins at their base
- Review any people who require a joint approach, who are at risk of admission or where concerns have been raised
- Discuss capacity and demand across the whole team
- Look for joint opportunities and solutions
- Allow roles to be assigned to the most appropriate person

Example of a Huddle and actions taken

Case Study

- 71 year old male living alone housebound – lonely
- Insulin dependant diabetic – poor diet as unable to prepare balanced meals, increase in community nurse visits as poor wound healing and diabetic control
- Non healing leg ulcers
- Poor state of property hygiene
- Not managing own personal hygiene needs

Actions Taken as an immediate result of Huddle on Day 1

- Previously known to Social Care, case reopened with consent
- Joint visit arranged – District Nurse and Social Worker
- Carers implemented –improve personal hygiene and help with loneliness
- Voluntary shopping service commenced – better diet to improve diabetic control and wound healing

Multi-Disciplinary Teams (MDTs)

- Future plans to hold weekly MDTs in each team
- Held at GP practices where possible
- Bring together GPs, community health and social care teams, specialist teams, mental health and voluntary sector
- Discussion of complex cases
- Focus on prevention
- Coordinate care around a person
- Share best practice and learn

Future

- Focus on frailty
- Prevention
- Self care and empowering people
- Local population health
- Build communities around the 4 teams
- Listen to our communities
- Work closely with all partners
- New roles and opportunities

County Durham Integrated community care partnership

Integration in County Durham

Lesley Jeavons – Director of Integrated Community Services

Harrogate and Rural Alliance Event

7 November 2019

Why?

- Compelling case for change:
  - Increasing elderly population
  - Increasing long-term conditions
  - Teams provide better outcomes
  - Funding not keeping pace with demand
  - Status quo not an option

Role of Primary Care

- Wrapping services around primary care
- GPs uniquely skilled to lead the response to the challenges of caring for this group
- General practice consider whole person and context of patients position in community
- Already take responsibility for care across many disease episodes and over time co-ordinate care across organisations
- New service development taking place in isolation, services not working together

What will be different for our populations

- Improving experience of care and support
- Care closer to home
- Care centred on the patient
- Less duplication and visits from multiple professionals
- Improved access to services
- Emphasis on preventative, less reaction based care and promoting independence
- Supporting reduction in acute and long-stay admissions

Who?

- 13 Teams Around Patients (TAPs) across County Durham will focus on these people.
- Initially top 2% of the most frail older people in our communities.
- Usually age 75+ with more than one long-term condition and at risk of admission to hospital.
- As teams develop our target group will shift to others at risk of losing independence and deteriorating health and wellbeing.

What are community services?

- Community services are made up by teams of nurses and therapists who coordinate care, working with other professions including GPs and social care.
- Teams provide a wide range of care, from supporting patients to manage long-term conditions (such as diabetes), helping patients to recover from a period of illness or injury (such as through physiotherapy) to treating those who are seriously ill with complex conditions.

Examples of community services

- GP practices
- Social Care
- Community nursing (inc. District Nurses)
- Vulnerable adults service
- Specialist nursing services including respiratory, cardiology
- Falls prevention services
- End of life care
- Continence services
- Intermediate care and intermediate care +
- Stroke services
- Dietetics
- Physiotherapy
- Speech and language therapy
- Occupational therapy
- Podiatry/foot care
- ‘Wellbeing for Life’ services
- Voluntary Sector
- Community Pharmacy
- Social Work

Mrs Annie Smith

- 89 years old, husband died 8 years ago.
- 2 children who live in London.
- Lives in her 3 bedroom family home which she does not want to leave.
- Independent until the last 6 months.
- Developed heart failure diagnosed by her GP who she really trusts and put on a frailty register.

Annie Smith Cont'd

- Unable to get out now as much, Annie feels guilty about bothering people so she doesn't.
- Lonely.
- Takes a taxi once a week to the shops.
- Hates taking her tablets and being "unwell" so sometimes she doesn't bother taking her treatment.
- Annual review by her cardiologist "I'm only in 5 minutes".
- Contacts her GP only when she is really unwell.
- Struggling at home, not really managing but she struggles on.
- Lonely, so her mood isn't as good as it was.
- **Annie's care could be different if the team respond early enough.**

Lets think….

- With specific consideration to people over 65 think of a situation where you or a relative have experienced a care episode similar to Annie. Had TAPs been in place:

- What would have been different?
- Is there any additional service you would like to see provided by the TAPs?

What Next?

- Initial focus community services
- Integrated commissioning 2019/20
- Shift of resources and services; acute to community
- Transformation and new opportunities
- Digital development

Primary Care Networks

- New service models
- Durham – head start
- Increasing resilience and sustainability
- Managing demand
- Influencing local service offers
- Driving investment opportunities

Feedback from community services staff and service users

“My mother had been unwell for a long time and was unable to cope at home. I rang social services and within hours staff went out to see her and carers were put in place. “It all went so smoothly, it was obvious that all the different teams were talking to each other, knew each other well and it was clear they were identifying the best ways of dealing with things. This made such a difference. This made a difficult time much less stressful. It’s brilliant!” **Patient’s relative**

“It has achieved a lot, starting with understanding what we could each contribute, what our roles are and how to work better as a team (especially not passing work off). We all seem to be a lot closer. “The main benefit is practices coming together and talking, what we do and sharing new ideas. They agree on best ways forward and then try things out We are all talking to each other better such as more open, honest discussions with District Nurses and Social workers and we discuss patients who need lots of teams involved (to support/treat them).” **Primary Care Network lead**

Feedback from community services staff and service users

“Since the implementation of the Virtual Ward the team has noted a marked improvement in the way we deliver and co-ordinate nursing care to the frail population. It enables effective communication for the patient between hospital and home and increases effective discharge planning, with the team promoting and signposting acute staff to the vast range of services available within the community, including equipment delivery, enabling the patient to return home much sooner.” **Community Sister, TAPS**

“I love my job - working in a truly integrated team, across health and social care which benefits patients and staff, easy communication, no barriers between teams and excellent working relationships across all parties – including primary care. I’m part of a highly dedicated, responsive and flexible team, who feel respected and valued. The range of different systems can be problematic, but generally overcome by co-location and good working relationships.” **District Nurse.**

Feedback from community services staff and service users

“We’re all working together and we all know who each is and that accounts for a lot as we all understand what each other’s role is in the jigsaw which we probably didn’t know before, and we meet together regularly. In the Primary Care Network meetings we discuss how we can improve processes and in the practice meetings we discuss how we can help patients, so there’s a very big bunch of people who are keen to make a difference and change things for the better.” **GP**

“I was TUPEd across from North Tees and Hartlepool Trust in the Easington area under the new community contract. It’s been great - pretty much what I used to do before but I feel like I’m part of a team now because before I was more isolated and worked on my own. I even get a lunch break now!” **Podiatrist**

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Thank you for listening.

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Panel
Questions and Answers

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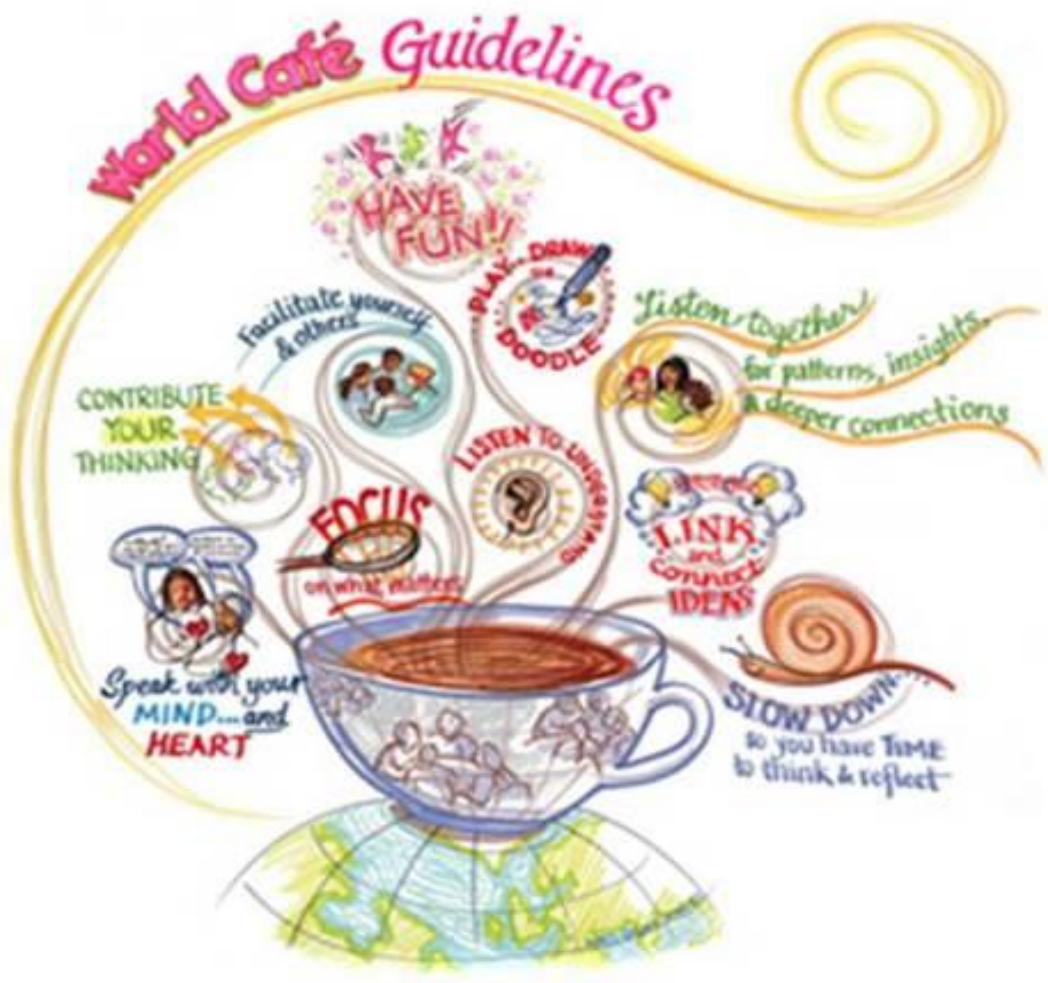
World Café
table conversations

World café



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conversation 1

What matters to you?

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Refreshment break

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conversation 2

Based on what you have heard and discussed already today what do you think our priorities should be?

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conversation 3

How do you think we should work with our community to develop the service and are there any examples of good practice you think we can learn from?

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5 minute reflection

What is one of the most important things you would like us to take away from the conversations today?

Next steps and close

- This is the beginning of a conversation – thank you for coming with us
- There will be another event for community members early in the new year – please make sure you have registered your interest in being kept up to date to receive an invite to that event
- You can learn more about HARA and submit questions to us any time on our website at www.harrogatealliance.co.uk
- Any final questions?
- Lunch and marketplace (until 2.00)

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