In this edition, find out more about the work we are doing as part of our vision for integrated care in County Durham.

There’s news on how we are bringing together health, social care and voluntary organisations to achieve improved health and wellbeing for the people of County Durham through an Accountable Care Network.

An Accountable Care Network brings together a number of providers who collaborate to meet the needs of the population they serve, by taking responsibility for the cost and quality of care for a defined population with an agreed budget.

The Accountable Care Network in County Durham represents a new way of working, to provide better healthcare and a better experience for patients, service users and carers. We will work together to avoid unnecessary duplication of services, so that people receive the right care, at the right time, in the right place.

This is a long-term project, which will see the integration of services developed over a number of years using a planned, step-by-step approach involving many partners,

In this bulletin, we provide information on how we are improving ways of working with GP practices in the county, so that local people get access to better joined-up services.

Lesley Jeavons, Director of Integration for County Durham
Our vision for Integrated Care

To bring together health, social care and voluntary organisations to achieve improved health and wellbeing for the people of County Durham

What is Integrated Care?

There is no single, agreed definition of integrated care. Integration can take place at a number of levels: team, service, locality or organisation and can apply to a small number of specialist services or to the full range of health and social care services.

Integration can mean that services are jointly funded, delivered by multi-disciplinary teams in which team members are employed by more than one organisation, or delivered by multi-disciplinary teams in which members are employed by the same organisation.

An integrated approach to planning and service delivery should result in service users being able to access effective, efficient and well-coordinated care services from a range of providers.

By seeking to overcome fragmentation and minimise organisational barriers, this should result in improved outcomes and experiences for people, with less duplication.
Why do we need integrated care?

One of the greatest challenges facing the health service and providers of adult social care is how to respond to an increasingly older population and its changing needs. There is a clear consensus that reorganising services around people with increasingly complex health and social care needs will improve outcomes for people.

An integrated whole system approach is also expected to facilitate a move away from episodic ill health and care towards a greater emphasis on early intervention, prevention and promoting independence.

This requires integrated care and support by a number of different disciplines and services which are fundamental to a person’s good health and wellbeing, with the GP as the expert medical generalist at the centre of the process.

Integration of care is about placing patients at the centre of the design and delivery of care. It leads to better outcomes for patients, safer services, improved patient experience and can also result in more cost-effective care.

Teams Around Patients (TAPs)

The first stage in our development of integrated care in County Durham is to establish Teams Around Patients, (TAPs) which will offer a range of coordinated services centred around groupings of GP practices.

There will be 13 Teams Around patients (TAPs) across the county:

- Five in the North Durham Clinical Commissioning Group area
- Eight in the Durham Dales, Easington and Sedgefield Clinical Commissioning Group area.

To date eight TAPs across County Durham have expressed an interest in becoming ‘early adopters’. Initial development sessions have been held with Sedgefield and Durham Dales TAP’s to gain an understanding of what was already in place with regard to collaborative working across Practices, risk stratification, MDTs, care planning and estates; which could be utilised or further developed in the new TAP delivery model. Sedgefield and Durham Dales TAPs are scheduled for implementation by May/June 2017.

We are in the process of setting up initial meetings with Derwentside and Chester le Street TAPs who have recently signalled their interest in moving forward as ‘early adopters’.

Work undertaken in development sessions will run parallel to work carried out in the Integration Workstreams, which should help to progress the TAP delivery model.

Which services will be included in the TAPs?

This will vary across the TAPs depending on the needs of the local population. Services which may be included are: Community nursing, Continence services, Dietetics, Falls Prevention, Intermediate Care, Occupational Therapy, Palliative Care, Podiatry, Physiotherapy and Musculoskeletal Services, Short and Long Term Services, Specialist Nursing, Stroke Services, Urgent Care, Voluntary and Community Services, Vulnerable Adult Services, Wellbeing for Life.
What does this mean for healthcare professionals?

The TAPs will be founded on strong multi-disciplinary working, drawing on both generalist and specialist skills. In particular, this means pioneering new ways of joint working between GPs and consultants and strengthening primary care teams and the links between general practice, community health services and social care.

For integrated care to be successful, it will need to be assessed on its more cost-effective user of resources. This will result in greater satisfaction for clinicians and other care staff, as:

- They will waste less time in duplication of information and chasing referrals
- They will have better communication with colleagues in other areas, so that there are shared goals rather than a silo mentality
- There will be greater opportunities for shared learning and development

There are many examples of successful integrated care projects and initiatives across the country, both on a small and a large scale.

Case studies undertaken in 2016 by the Royal College of General Practitioners show how it is possible to take advantage of the opportunities available and work within existing frameworks to create a service which provides the long-term collaborative care patients need.

Click on the following link for further information: The Future of GP Collaborative Working

Who are we talking to?

We are working closely with the voluntary and community sector in the development of the TAPs in County Durham – and we will provide further information on this in the next bulletin.

In the meantime, we are meeting with members of the public through patient reference groups and patient and public forums to provide updates and share information about what is happening on integration.

The latest from CDDFT

County Durham and Darlington NHS Foundation Trust have concluded consultation on their restructure proposals.

Presentations have taken place between 24 and 28 April 2017 where localities were informed of the allocation of community nurses to the TAPs, with an implementation date of 1 May 2017.
Who is involved in the project?

The TAPs model needs involvement from a number of organisations working across County Durham. The following play an important role in the project:

- Durham County Council
- North Durham NHS Clinical Commissioning Group
- Durham Dales, Easington and Sedgefield NHS Clinical Commissioning Group
- County Durham and Darlington NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- NHS North of England Commissioning Support Unit
- County Durham and Darlington Fire and Rescue Service
- Durham Community Action
- Voluntary Organisations’ Network North East
- Durham County Carers Support
- Derwentside Healthcare Limited
- Chester-le-Street Health Limited
- Central Durham GP Providers Limited
- Durham Dales Health Federation
- Intrahealth Limited
- South Durham Health Community Interest Company
- County Durham Healthwatch