Health and Wellbeing Board

22 June 2017

Integration Update

Report of Lesley Jeavons, Director of Integration, North Durham Clinical Commissioning Group, Durham Dales Easington and Sedgefield Clinical Commissioning Group, Durham County Council

Purpose of the Report

1 To provide the Health and Wellbeing Board with an update on progress relating to health and social care integration in County Durham.

Background

2 A report was presented to the Health and Wellbeing Board on 16 March 2017 providing information on the County Durham Accountable Care Network and the Teams Around Patients (TAP) model to be implemented across the county.

3 It was agreed that a follow-up report would be provided to the Health and Wellbeing Board in three months' time, at its meeting in June 2017.

County Durham Accountable Care Network

4 A Memorandum of Understanding (MoU) for the County Durham Accountable Care Network has been agreed by the Integration Board. Whilst not a legally binding document, the Memorandum of Understanding provides a clear statement of intent for the direction of travel and agreement on the desired outcomes of collaborative working. The MoU is currently progressing through partner organisations' Governing Bodies.

5 A 'brand' has been created for the Accountable Care Network, which can be applied to communications made on behalf of the network with regard to the integrated care agenda (for example, presentation slides, document templates, etc.). The logo is shown in Figure 1 below.

Figure 1 - Accountable Care Network logo

6 An Accountable Care Network Bulletin was circulated to stakeholders in May 2017. This is being shared with frontline practitioners and the voluntary and community sector through representatives on the Integration Steering Group.

There is an intention for this bulletin to be issued bi-monthly for the foreseeable future.

Primary Care Home

7 Primary Care Home (PCH) is a joint programme launched in 2015 by the National Association of Primary Care and the NHS Confederation. The model aims to re-shape the way primary care services are delivered, based on local population needs.

8 The PCH model aligns clinical and financial drivers with appropriate shared risks and rewards and improvement of care by focusing on healthcare teams working together from all disciplines and encouraging partnerships across primary, secondary and social care.

9 The key benefit for patients is a multi-disciplinary team (MDT) approach which provides comprehensive and personalised care to individuals – everyone within the team knows everyone else and the patient has a more consistent experience of care.

10 This is a similar model to TAP but focuses on ***all*** activity, both elective and non-elective, across primary care. DDES CCG has re-modelled its clinical leadership in line with PCH and an induction for primary care clinical leads in the Durham Dales, Easington and Sedgefield Clinical Commissioning Group area has been completed and a Primary Care Home launch event took place on 25 May 2017. To confirm therefore: PCH incorporates Teams Around Patients.

11 In support of the PCH TAP approach, an MDT approach is being applied across three levels:

- GP practice-based MDT (micro)
- TAP level MDT (intermediate)
- Primary Care Home meeting (macro)

Appendix 2 outlines the structure and purpose of the three MDT levels.

12 Work is currently underway to develop this model of clinical leadership in the North Durham Clinical Commissioning Group, as it enhances clinical engagement across primary care.

Teams Around Patients

13 Development work has continued with the ‘early adopter’ Teams Around Patients (TAPs) in the Dales and Sedgefield areas, who are now mobilising teams.

14 Locality briefing meetings have been held in Derwentside and Chester-le-Street and engagement with key stakeholders in these TAP areas is ongoing.

15 Frequently Asked Questions and operating principles for the TAPs have been developed, including a statement of purpose, and an induction for primary care clinical leads is being implemented.

16 Primary care leads have become involved in the Integration Steering Group's work streams and are helping to turn the vision into practical reality through discussing and resolving issues related to workforce development, engagement with staff, referral pathways etc.

17 Community nursing workforce allocations for the TAPs has been confirmed and the roles and responsibilities for Band 7 lead nurses are under development.

18 Representation from adult social care on an alliance basis has been agreed.

19 To complement the Primary Care Home model, terms of reference for the intermediate level (TAPs) MDTs have been completed.

20 In order to ensure that the voluntary and community sector (VCS) is engaged in the development of the TAPs, a VCS Delivery Plan is being implemented. Priorities include supporting the VCS in influencing commissioning decisions on a locality basis and identifying commissioning issues for consideration by TAPs, with a specific focus on frail elderly people and those with long term conditions.

21 A performance outcomes dashboard for the TAPs has been agreed and further work is to take place on social care metrics and Wellbeing for Life outcomes data, which can be obtained at a GP Practice level.

Recommendations and reasons

22 The Health and Wellbeing Board is recommended to:

- Receive this report for information.
- Support the direction of travel and note progress made.
- Encourage further engagement of the VCS and request that Durham Community Action present to the County Durham Partnership a summary of its engagement to date and plans to enhance VCS involvement in primary care in the future.
- Agree to receive a further update report at the Health and Wellbeing Board meeting in September 2017.

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Appendix 1: Implications

Finance
Existing and future financial challenges facing the NHS, local government and public health, as well as increased demand for health and social care and the rising costs of delivering services, will make integrating health and social care services increasingly difficult. The Better Health Programme framework of care will have to be implemented within current financial resources.

Staffing
A critical element of delivering an integrated model of care will depend on a suitably trained and skilled workforce.

Risk
Failure to transform and integrate services will result in reputational damage for the council and its partners. If transformation and system-wide reconfiguration is not achieved, this will result in services aimed at improving results for patients, life expectancy and quality of life not being delivered efficiently and effectively.

Equality and Diversity / Public Sector Equality Duty
Equality Impact Assessments are carried out as part of the work being undertaken through the Accountable Care Network and within the remit of the Director of Integration for County Durham.

Accommodation
No direct implications.

Crime and Disorder
No direct implications.

Human Rights
No direct implications.

Consultation
Proposals for integration would be the subject of consultation with stakeholders.

Procurement
No direct implications.

Disability Issues
No implications at this stage.

Legal Implications
There are a number of key legislative and policy developments / initiatives which have led the way and contributed to adult care transformation and further integration with health and social care services. All changes must be compliant with legal requirements.

Appendix 2 – Primary Care Home levels of multi-disciplinary teams (MDT)

Level	What	Where	Why	Who
Micro	MDT	Practice	• MDT approach • Individual practices identifying opportunities for elective and non-elective pathways • Using risk stratification as a tool for identifying top 2%	• GPs in practice • District nurse • Vulnerable Adults Wrap Around Services (VAWAS) nurse
Intermediate	Primary Care Home	TAPs	• Collective of practices working together to share learning and skills and identify areas of learning across the TAPs • Identify patient flow and support concerns • Use adult social care and VCS to address patient flow and support for most vulnerable • Meetings are at the discretion of group	• Lead GP for each practice • Primary Care Home Lead only meets with district nurse and adult social care worker from the TAPs
Macro	Primary Care Home	Locality	• Each PCH group meets to identify locality-wide issues, including influencing health and social care commissioning	• Lead GP from each practice and / or Practice Manager • General Manager • Community nursing • Adult social care team manager