

Team Up Derbyshire

July 2023 bulletin of Team Up Derbyshire



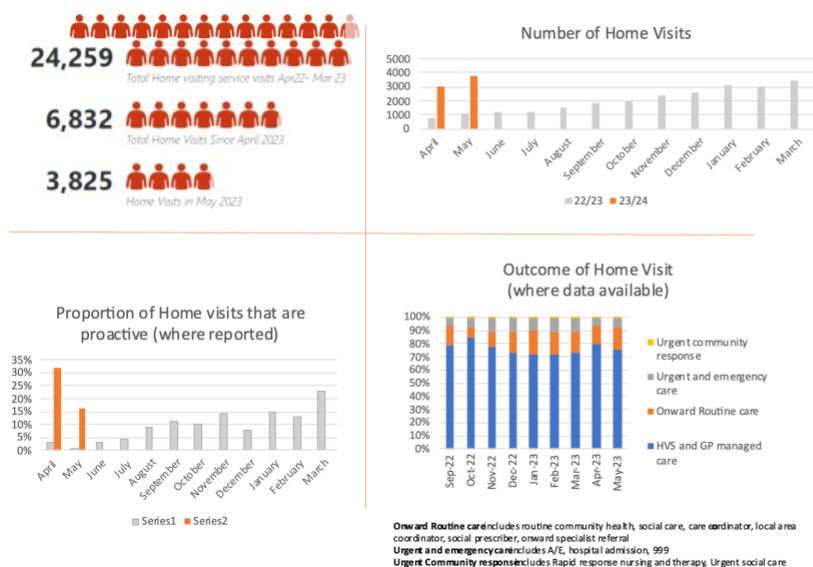
This latest bulletin from Team Up Derbyshire brings together news from the programme and updates from the Team Up Steering Group. Team Up Derbyshire is an ambitious programme in Derby and Derbyshire that is creating one team across health and social care who see all the people in a neighbourhood who are currently unable to leave home without support. For more information, visit the [Joined Up Care Derbyshire website](#).

Home visiting in South Hardwick gets the green light

Funding has been allocated to South Hardwick Primary Care Network (PCN) to go ahead with its Team Up home visiting service plan. Home visiting is carried out by members of a multi-disciplinary team and aims to enable individuals to be cared for at home and reduce inappropriate hospital admissions. The plan has been approved by both the Team Up Steering Group and the Team Up Learning in Practice (TULiP) group. Group members reviewing the plan have made minor changes to proposals regarding communications and engagement, finances and the handover of patient care back to routine services.

The diagram below shows how home visiting services across Derby and Derbyshire PCNs continues to grow month-by-month.

Home Visiting Service-May 2023



Target
100% costed plans reviewed by 1.6.22 Revised local target date - TBC
Target achievement
Plans to be signed off: NE Derbyshire South Hardwick South Dales
Target
100% PCNs delivering: Revised local target: 5 day per week 8am -6:30pm by 31 st March 2023 7 days a week 8am -8pm by 1 st April 2024
Progress towards target achievement
8am-6:30pm 5 days a week - PCNs working 5 days per week - 92% (11*) PCNs working 8 am -6:30pm-83% (*10)
6.30pm -8pm 5 days a week no PCNs working until 8pm
Weekend working - no PCN working weekends
100% Geographical coverage (of population) - HVS in action

*Derby City is counted as 1, although is 5 PCNs working together
Note: Glossop not yet included.

Survey shows support for community geriatrician

A community geriatrics service pilot running in the Alfreton, Ripley, Crich and Heanor (ARCH) area has seen many initial early benefits for professionals and patients. The pilot was set up within ARCH PCN in December 2022 with the aim of looking at how an integrated geriatrician can improve care for the housebound population. The service has seen a community geriatrician support primary and community-based teams in providing high quality care to older people living with frailty.

To date, 82 patients have been seen by the service and a comprehensive geriatric assessment undertaken. Evaluation has found that 70 medications have been stopped or reduced, eight patients have been started on bone protection and 12 unwanted hospital admissions have potentially been avoided. 100% of clinicians surveyed felt the service added value to the patients' care.

Feedback from family members has included:

- *“Both my wife and I were reassured by the visit which helped us to secure the future path of my wife’s care.”*
- *“The doctor rang me (daughter) after the consultation as requested. I felt much more informed as a result, had a much better understanding of dad’s situation and felt the consultation was very valuable.”*

The Team Up Steering Group has been reviewing how best to develop this pilot and produce a full business case.

Support role for care homes

Deborah O'Connor, who provides programme support for the Enhancing Health in Care Homes (EHCH) team, is due to step down from her role in September with a planned retirement. We would like to thank Deborah for all her fantastic work and wish her the very best in her future plans. The team is seeking funding from the Ageing Well programme for the recruitment of a 12-month role to replace Deborah. Duties would include supporting all elements of the EHCH programme, with a particular focus on developing our communications and engagement with care homes, helping run the care home falls project and supporting care homes and local Integrated Neighbourhood teams to work effectively together.

Progressing falls prevention

The Team Up Steering Group has reviewed outline proposals that would see a systematic falls prevention offer embedded within Integrated Neighbourhood Teams (INTs) following a fall or awareness of a fall. Falls represent a significant and preventable issue in Derbyshire and will be a key component of our winter planning in 2023-24. There are opportunities for improved evidence-based interventions across organisations, including the NHS and the voluntary and community sector.

In terms of risk factors in helping the prevention approach, we know that the biggest risk factor for falling is having had a previous fall. The ambition is to put in place a basic offer so that every person who presents to health and care following a fall is offered an effective falls prevention intervention within the local INT. This would include a rapid risk assessment followed by the appropriate interventions being put in place. Developing the next steps to



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achieve the ambition will be overseen by a system-wide programme group, with capacity and co-ordination planned with local Places and INTs, building on and connecting existing provision.

Understanding our clinical roles

The local GP Taskforce has devised profiles for a number of roles under the Additional Roles Reimbursement Scheme (ARRS) to aid understanding and support recruitment plans. Role profiles for musculoskeletal first contact practitioner, physician associate, social prescriber, clinical pharmacist, paramedic, pharmacy technician and health and wellbeing coach have now been devised and cascaded. The profiles outline benefits, duties and qualification requirements for each role, and associated useful links for wider understanding. A number of lunchtime drop-in question and answer sessions covering these roles took place in June.

Team Up featured as national best practice case study

Team Up Derbyshire has been picked out by the NHS nationally in showcasing the best in integrated care programmes. Team Up's work is being highlighted as a case study of good practice on the [NHS England website](#). You can also read the case study on the [Team Up blog](#).

The case study picks out how the integrated neighbourhood team approach in Derby and Derbyshire has reduced unnecessary ambulance call-outs and hospital stays. It highlights how team visiting services under Team Up carried out 24,000 visits last year, which contributed to a reduction of 2,300 'category three' ambulance call-outs and reduced hospital stays by 1,400.

Perhaps the best illustration of the impact that Team Up is having is shown in the patient quotes included in the case study:

- *"I'm convinced that the attention and care provided by the team has meant my Uncle B has recovered."*
- *"I just want to congratulate you on an excellent department within the NHS. My father is 96, and requires quite a lot of care now still living alone in his own home (where he wants to be)."*
- *"Thank you for making my mum so comfortable last week. The last days of her 98 years were filled with compassion and respect. She and I couldn't of asked for more."*

Further information

For further information about the programme management of Team Up Derbyshire and Ageing Well, please contact:

- Helen Baxter, Deputy Ageing Well Programme Manager, helen.baxter@nhs.net
- Team Up Derbyshire [website](#) and Team Up Derbyshire [blog](#)

For clinical advice/referral enquiries, please contact your GP Practice who will be able to put you into contact with the team in your area.



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