Joined Up Care
Derbyshire

Team Up
Derbyshire

DERBYSHIRE County Council

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What is Team Up?

Team Up Derbyshire is an ambitious programme in Derby and Derbyshire that aims to create one team across health and social care who see **all housebound patients** in a neighbourhood.

A housebound patient is someone unable to leave their home due to physical or mental illness. It includes people living in their own home or a care home. **These patients tend to have complex health and social care needs**. Being housebound can be a permanent or temporary situation.

This team will provide **planned care and urgent care**. If someone is housebound and needs a service, this team will deliver it.

This team is not a new or 'add on' service – it is a ***teaming up*** **of existing services** – with general practice, community, mental healthcare, adult social care and the voluntary and community sector all working together.

The overall aim is **to keep people safe at home and provide the best, most seamless care**, keeping people out of hospital wherever possible.

Team Up Derbyshire aims to ensure that person-centred care services are provided at the **right time, in the right place, by the right person**. As a result, people should be able to live well, for longer.

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Investing in better care

There are approximately **30,000 people** in Derbyshire (0.3% of the population) who are living with moderate or severe frailty

Each year it costs the NHS in Derbyshire at least **£100 million** (about 10% of budget) to look after people who are living with moderate or severe frailty

People who are living with moderate or severe frailty required **96,605 hospital bed days** (in 2019-20) – the equivalent of about 10 wards. This figure is only predicted to increase in the future

Team Up Derbyshire/Ageing Well aims to **invest up to £3 million in 2021-22** in the development of these integrated community teams. This sum is due to increase significantly over the next few years

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What are Team Up's objectives?

- Promote a **team approach** made up of different professionals across the NHS and social care working with their communities in an integrated way, to provide tailored support that helps people live well and independently at home for longer
- Ensure that **the care and support people receive is based on their wishes, preferences and aspirations**, particularly towards the end of their lives
- Offer **more support for people who look after family members, partners or friends** because of their illness, frailty or disability
- Develop more **rapid community response teams**, to support older people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home
- Offer **more NHS support in care homes**

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Acute home visiting service

An acute home visiting service is a responsive and effective home visiting service for patients, providing person-centred care, timely assessment and support for vulnerable patients. As well as being designed to help prevent hospital admissions, the acute home visiting service is set to improve the patient experience and lead to a better use of resources. Visits will be provided by a range of different professionals, such as nurses, therapists, paramedics or social care practitioners, according to patient need. Responsibility for providing the service will be across a larger footprint than a single GP practice. New approaches are now being explored in areas such as Erewash, Derby and Chesterfield.

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Urgent community response

The urgent community response service aims to support people with complex needs to live safely in their communities, through co-ordinated and responsive care, reducing the need for unnecessary admissions to hospital and long-term care.

The urgent community response service is set to provide crisis response care within two hours of referral and reablement care within two days of referral.

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Enhanced health in care homes

People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, the voluntary and community sector and care home partners.

The NHS Long Term Plan contained a commitment to roll out enhanced health in care homes across England by 2024. This reflects an ambition to strengthen support for the people who live and work in and around care homes, including how urgent community response is accessible to people living in a care home.

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Anticipatory care

Older people living with frailty are the highest users of services across health and social care and have the highest levels of emergency admissions to hospital. Anticipatory care can help prevent people's health deteriorating and support people to live well and independently for longer.

For anticipatory care to succeed, we need to understand the housebound population better and use those insights to provide more personalised approaches.

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Step up and discharge pathways

Step up care describes a pathway for people who are tipping into or have tipped into a care crisis and who have a care need that cannot be managed within their own home or they cannot be left safely at home. At this time they may benefit from being stepped up into care such as a community reablement bed or a care home bed.

Discharge pathways mirror ‘step up’ but sees services put in place in the community to receive patients from hospital. Patients who are clinically stable and do not require an acute hospital bed, but may still require care services, are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting.

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https://bit.ly/3vHzXRt