integrated working

JIGSAW

PIECING TOGETHER PATIENT CARE • ISSUE 2 • December 2013

Welcome to JIGSAW

This is the second instalment of Jigsaw. We want to show you, the staff working hard in hospitals, community and mental health settings, that there is much going on to bring health and social care together.

COMMUNITY INTERVENTION SERVICES (CIS)

By David Jarrold,
Suffolk Community Healthcare

Community Intervention Services (CIS) hold a key role in delivering the vision for West Suffolk's health and social care systems. It sees a number of teams, each with their own discrete function, all working together to deliver the same goal.

It means that the people of West Suffolk:

- will not have to navigate a complex system to find the right service that meets their need
- have their health or care need identified early before a crisis occurs
- have access to a range of local services that focus on self-care and supporting primary prevention
- have their care coordinated across clinical and service areas.

The core teams in the CIS are the admission prevention service, the early intervention service, the COPD service and the pulmonary rehabilitation service. We also work closely with the Dementia Intensive Support Service provided by Norfolk and Suffolk Foundation Trust.

The development of these teams and the delivery of services is driven by collaboration and partnerships between health and social care providers

and third sector providers, such as Crossroads Care and Age UK. Together the teams bring specialist nursing and therapy to those in urgent need. The CIS aims to deliver response times inside 4 hours
to prevent unnecessary admission and where possible provide care closer to home.

Delivering CIS is a huge challenge to all involved. All of the partnership organisations are working closely together to bring this about and the vision is beginning to fall into focus.

LOOKING TO MENTAL HEALTH

By Ros Tandy, GP Lead for Mental Health at West Suffolk CCG

People who are in great mental distress are common in A&E and in the hospital - but often they wait for far longer for admission or treatment.

Norfolk and Suffolk Foundation Trust and West Suffolk Hospital have developed a new service for people aged 18 and above to address this, which was launched this month.

The Psychiatric Liaison Service is a high profile mental health team at the hospital front door. It provides a range of mental health specialities within one multidisciplinary team of mental health liaison practitioners specialising in general psychiatry, deliberate self-harm, substance misuse and old age psychiatry. It means patients can be assessed, treated, signposted or referred appropriately. Working closely with hospital clinicians and managers, the professionals ensure that the mental and physical health needs of people are considered and treated together.

The service will work as an integral part of the pathway of care for people from the community, into the hospital and back to support care in the community.

A NEW WAY OF WORKING IN ADULT CARE

By Saraid Cann, Professional Advisor, Adult and Community Services, Suffolk County Council

Suffolk County Council has a new way of working to keep adults living independently for longer - and to keep them connected to what's happening locally.

It's called Supporting Lives, Connecting Communities (SLCC) and the council has been testing how it works in Bury St Edmunds and the west of Suffolk over the summer. It will be rolled out across the county in 2014.

The way SLCC works is that when someone calls into the local social work team they speak to one person who will be their contact all the way through.

The conversation may be about:

- what help someone needs to help themselves
- short-term help and support after a crisis, like a fall
- ongoing support, and in these cases it's about talking about what will work for them and how to make it happen.

Staff have been working in new teams and thinking outside traditional approaches to achieve these outcomes.

The relationship with partners is crucial and health professionals and local GPs are a key player.

Any GP referrals social care in the west of the county should continue to be directed to Customer First GP referral line on (08456066167, Option 2). For an urgent response referrals - see Admission Prevention Pathway article. Where a GP knows that their patient already has an allocated social worker, they can ring that team. There will be more information on how this is working in the next update.

SIMPLIFYING ACCESS TO THE ADMISSION PREVENTION PATHWAY

FOR PEOPLE WITH BOTH URGENT HEALTH AND SOCIAL CARE NEEDS

By Mark Crawley, Commissioning Manager, Adult and Community Services, Suffolk County Council

A social worker now sits in the Care Coordination Centre for urgent health and social care response - in conjunction with the CIS.

The service, which is currently on trial, is available from: Monday to Friday 9.00am - 5pm. Telephone Number - 0300 123 2425. Outside these times referral arrangements for urgent social care response that cannot wait until the next working day still need to be made to Customer First -
Professionals line - 0845 6066167, Option 2
Referrals from others - 0808 800 4005

Please note that non-urgent referrals should go through Customer First.

To support improved response to social care services out of hours, Adult and Community Services (ACS) has recently commissioned an out of hours crisis service from Suffolk Careline. This is also a trial to test levels of demand, effectiveness and the value for money of such an approach.

Access to this out of hours service is through the Customer First numbers set out above, which will divert to the ACS Emergency Duty Service (EDS.) Please note that EDS is able to deploy Home First and to access other networks of support in addition to Suffolk Careline, as appropriate.

PLANNING FOR THE END OF LIFE

By Dawn Barrick-Cook, Transformation Lead, West Suffolk Clinical Commissioning Group

Giving people the chance to die a dignified death in a place of their choosing is very important. It is what people want.

All those who are within a year of their deaths and living in care homes are now given the opportunity to plan for it. Called a Yellow Folder, it contains core information and supports the involvement of patients and carers in the decision-making process and signposting to supportive patient/carer information leaflets. It holds key documents such as the Advance Care Plan and DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) form.

Patients have welcomed an opportunity to think about, talk about and write down their preferences and priorities for their future care, including how they want to receive their care towards the end of their life.

There is currently a £50 payment for West Suffolk surgeries each time they issue a Yellow Folder to a patient. This is in place to encourage issue and to embed into everyday clinical practice. Since the project's inception in April 2012 over 2000 folders have been issued to patients; all 25 of our local GP practices are now fully engaged and participative, culminating in an overall year-on-year increase in distribution of Yellow Folders of over 51%. This in turn has contributed to an increase in patients dying in their preferred place of death.

GET INVOLVED

If you have any news or views on any of these projects, please contact the partners through this email address: getinvolved@westsuffolkccg.nhs.uk