NHS
Torbay and South Devon
NHS Foundation Trust

HEALTH AND CARE INSIGHTS

Issue 4 - October 2017

Beginning our third year as an integrated care organisation

In our first two years as an integrated care organisation we have achieved a lot towards our vision of supporting more people to be able to live independently at home. This newsletter updates you on some of the current developments as well as some of our achievements to date.

Our investment in community services is really making a difference with our community intermediate care teams are now caring for 40% more people at home or closer to home. We also have Wellbeing Coordinators in every area who have already supported 2,000 people on what matters to them. These are some of the additional services that have helped more people to be able to receive treatment and care in their own home or community and therefore have not needed to come into hospital. But when people do medically need a hospital bed they are able to access one quickly and with the support of services in the community they are able return home sooner. The average stay in one of our hospital beds has reduced to one of the lowest in the south of England. Our record on delays in transfers of care, often referred to as bed blocking, is consistently one of the lowest in the country.

The Medical Admissions Avoidance Team (MAAT)

Our MAAT nursing team is now providing specialist care to people where they live or in their community. This can include treatments such as intravenous fluids or antibiotics, management anticoagulation for pulmonary embolus, deep vein thrombosis, atrial fibulation and pre-operative care. Previously patients would have been admitted to hospital for the duration of their treatment - which could have been anything from days to weeks. Such treatments require frequent monitoring and specialist nursing skills to deliver. This also means that if someone does need follow up specialist care following a hospital stay they can be discharged home with the MAAT team providing the care.

The MAAT team works closely with our hospital and community teams; providing regular in-reach to our hospital wards and Emergency Department, helping to identify people who they could care for at home. They also work with our microbiologists to identify where patients could receive different kinds of antibiotics, which could be delivered away from hospital. Referrals to the MAAT team can be made by GPs, community teams and hospital teams. Below is Grace's story:

'Grace is an elderly lady who developed an infected complex leg ulcer, which was resistant to oral antibiotics. She therefore required intravenous antibiotics, which is usually done in a hospital. Grace did not want to go into hospital and because of her disability getting her into hospital would have been difficult and uncomfortable. The MAAT and vascular teams worked together with a vascular nurse setting up the IV midline in Grace's home and the MAAT team nurses administering the IV antibiotics. Grace was very pleased that she never had to attend or be admitted to hospital.'

HEALTH AND CARE INSIGHTS

Rapid Assessment and Discharge Service (RADs)

Our new RADs team are now supporting the Emergency Department to make sure elderly people attending get the best possible support. When an elderly person comes into the Emergency Department a doctor assesses them and if they don't need to be admitted into hospital but have complex needs they are seen by our new Rapid Assessment and Discharge (RADs) team. This nurse-led team works with therapists and other professionals, to assess the person's physical, mental and social needs. The team also work with the person and their family or carers to understand what might help them to recover and stay well. The team link in with other services; such as intermediate care teams and care homes so that the person's immediate care needs are met and identify other issues which may arise; putting things in place to prevent them. This enables the person to avoid an admission to hospital, and usually return home the same day with the right care and support in place.

Help to Overcome Problems Effectively (HOPE) Programme

HOPE, a self-management/health coaching/peer support programme is being launched across our area. This group programme for people who are living with long term health conditions and their carers, will be delivered by health and social care professionals alongside trained lay volunteers. The training for these volunteers is currently taking place and the first courses will begin in January.

HOPE has been developed locally, to specifically support people to develop knowledge skills and confidence to selfcare/self-manage their health condition/s. The health and lifestyle coaching programme uses cognitive behavioural principles and techniques underpinned by a number of well researched theories. The six week programme will be available to anyone over 18 who is feeling overwhelmed with their health issues or who are disengaged in their selfcare/self- management.

Plans submitted for a new wellbeing centre for Dartmouth

A planning application for a purpose-designed Health and Wellbeing Centre at Riverview in Dartmouth has been submitted to Dartmouth Town Council and it is hoped that there will be a decision on the proposals within six to eight weeks. If planning permission is granted, the next step is to secure a partner to deliver the care home provision. The plans include a 36-bedded care home, GP practice, pharmacy, retail area (possibly a coffee shop) co-located with the Voluntary sector and Dartmouth Caring, Trust outpatient clinic rooms and a base for the local Health and Wellbeing team.

We hope you find this update useful and that you can see we are making real progress towards our aim of supporting more people to be well and independent. If you would like to be receive future issues by email contact tsdft.communications@nhs.net