Appendix 3 (B)

Reconfiguration of Community Teams Briefing

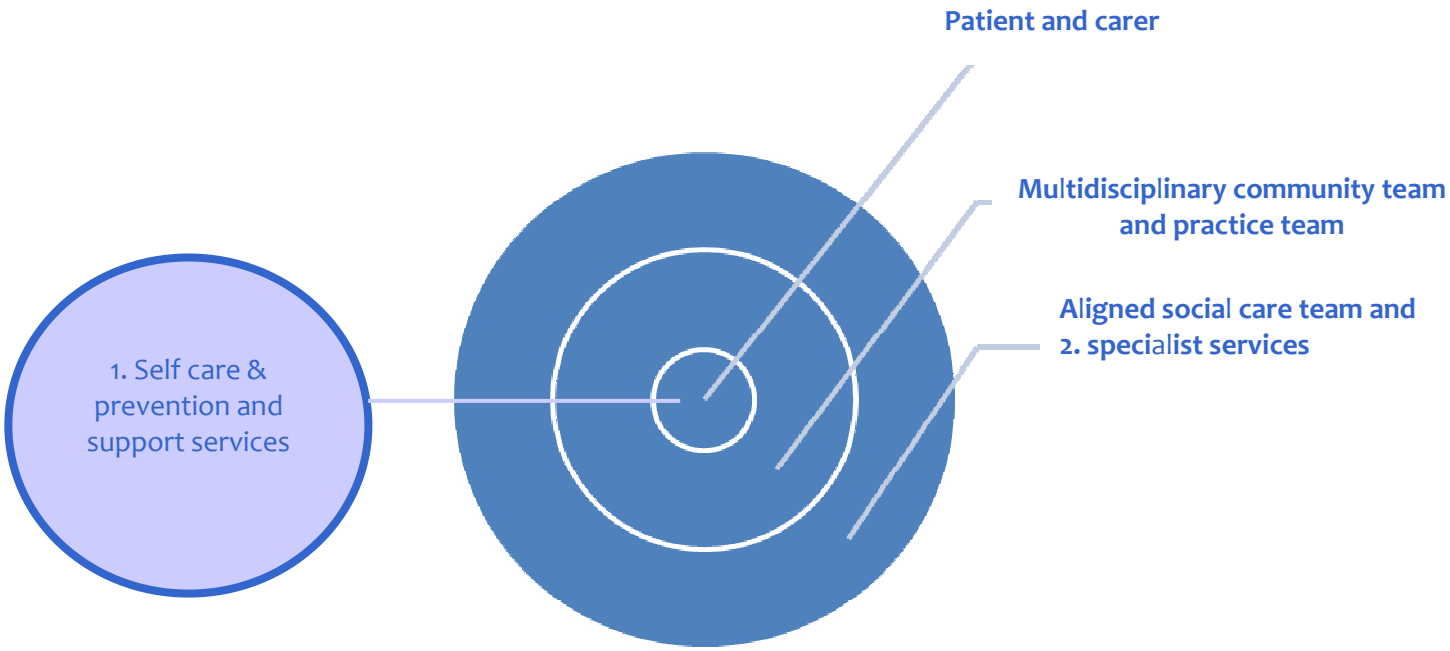
Background

NHS Sussex (Brighton and Hove) and Sussex Community Trust have reconfigured a number of community teams that support patients with a range of needs; such as long term conditions and frail, older people.

Previously these teams worked separately to support people within the community and often in isolation from primary care. This meant that some people within the community received multiple visits from different community teams, whilst others received few visits - notably those who are housebound or in care homes, leading to a service which is fragmented, inequitable and inefficient.

Long term conditions teams have been brought together with General Practice teams to form new multidisciplinary teams. These teams, termed Integrated Primary Care Teams, link with between two and five practices, to better support patients with a range of needs within the community. The practice remains the centre of care; with the practice population becoming the overall team caseload - enabling equitable support for all patients.

Model



1 Health trainers, information prescriptions, community and voluntary sector support services
2 Hospital care services, specialist teams (diabetes etc), end of life support

Which community teams are involved?

The community teams include the following

- District nurses
- Community matrons
- Care home support team
- Medical review pharmacy
- Community physiotherapy
- Community phlebotomy (second phase of the development)

As well as the compliment of staff above, teams will, from April 2012, have the resource to support carers, and over time be better aligned with social services to improve coordination across health and social care.

Timeframe for full implementation?

The new service model began to be implemented from January 2012. 2012-13 is a transitional year for the full implementation of the service with a final service specification from April 2013 onwards.

What does it mean for patients?

- Improved support to manage a range of needs within the community – where appropriate a dedicated care coordinator
- A jointly developed care plan to maximise patient outcomes
- An equitable service based on patient need, not ability to attend the practice
- Improved coordination between health and social care – less duplication
- Support for patients and carers to manage their own condition/s
- Prevention of avoidable hospital admissions and support with timely discharge

What does it mean for community teams?

- Less isolated working, greater team working
- The opportunity to develop new skills
- Improved patient care and experience
- Access to dedicated resource to support carers
- Greater coordination, communication and stronger relationships with primary care colleagues
- Improved links to specialist services and support

What does it mean for primary care?

- Dedicated support from known community teams to better-manage patients with a range of needs within the community
- Opportunity to have stronger relationships and regular communication with community teams and with social care
- A range of support tools to improve care planning and coordination; including dedicated resource to develop relationships with the community teams and the Clinical Dashboard to support better patient care
- Equitable service which includes housebound patients and those in care homes

What does it mean for specialist services?

- Improved pathways into and out of specialist services
- Clear risk and referral thresholds
- Use of specialist skills and experience more appropriately
- Improved links with community teams and better care coordination