LIVING
WELL
TOGETHER

HEALTH & WELLBEING THEMATIC SUMMIT

Multi Disciplinary Teams and Community Partnership

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County Down Rural Community Network

FFP Down CIC

South Eastern Health and Social Care Trust

#MDT #DeliveringTogether

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MDT PROGRAMME AIMS

- Better meeting existing demand for primary care services
- Providing a platform for service reform, supporting the shift of care into primary and community settings
- Boosting capability and capacity for early intervention, prevention and focus on wellbeing

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WORKING TOGETHER

Innovative and sustainable health and wellbeing approaches

Primary Care Multi-Disciplinary Teams will see GP practices focus not only on managing ill-health, but also on the physical, mental and social wellbeing of communities.

- Down area – implementation commenced January 2019
- Over 50 MDT staff recruited covering population of 78K
- Rolled out to all GP practices
- Strong partnership between primary & secondary care and Community & Voluntary sector
- Early implementer site – learning applied across NI with regular region wide 'Share the Learning' events

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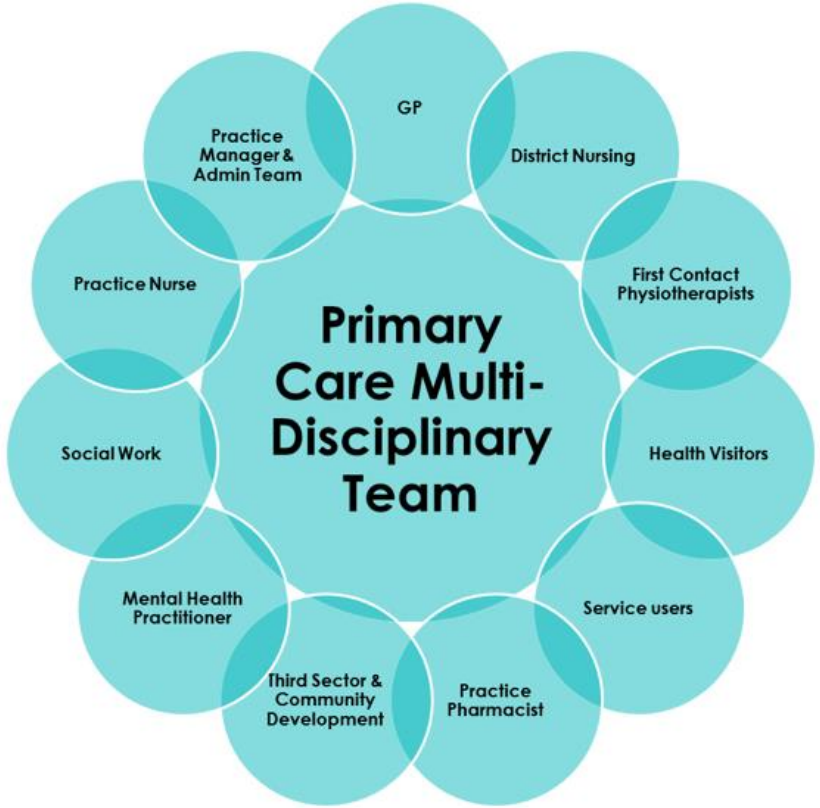
WHO ARE MULTI-DISCIPLINARY TEAMS IN PRIMARY CARE?



- Based in GP Practices providing local access to services
- Fully implemented in the Down area. Partial roll out in North Down and Ards.
- Focus on early intervention and prevention
- For a successful rollout true partnership working must take place

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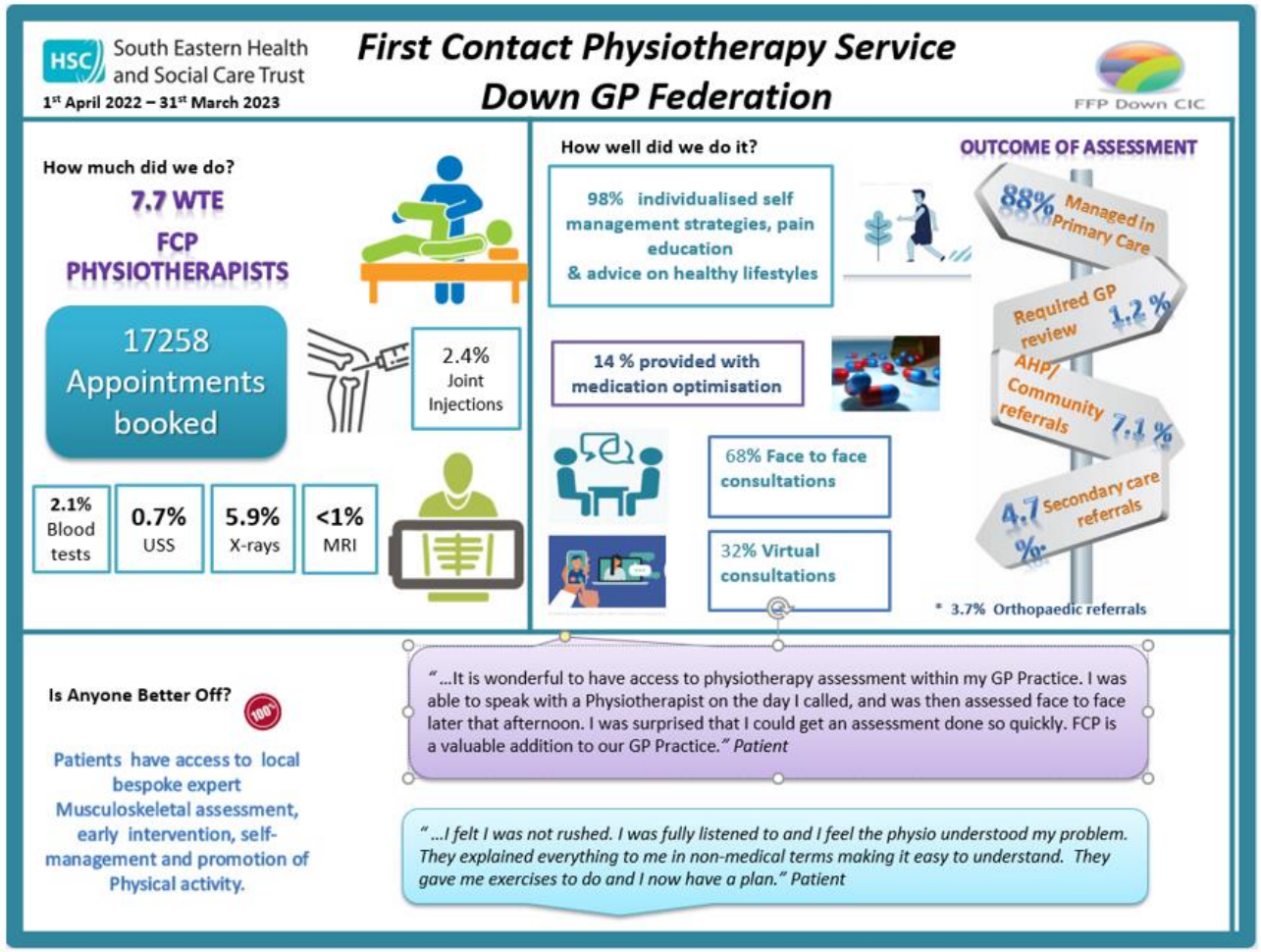
FIRST CONTACT PHYSIO



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41% reduction in physio referrals & 21% reduction in Orthopaedic referrals from Down GP Practices compared with 2018/19 (pre MDT)

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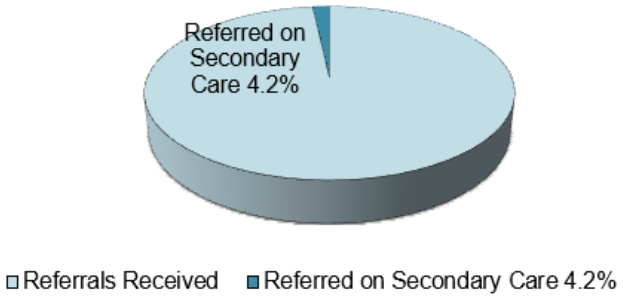
MENTAL HEALTH

- 2022/2023 in Down and NDA there were total consultations of 15.349k (11.7 WTE)
- Patients have access to comprehensive MH assessment and psychological interventions
- Key interventions included CBT focused interventions; medication review/advice; anxiety/stress management and psychoeducation.
- Number of SMHPs completed EMDR training – delivering trauma focused early intervention, in line with stepped care model.
- Sustained low percentage of onward referrals to Secondary MH services.

"MHP works very hard to explain what's happening and why…. which is helpful"

"Primary Care for me has proved to be the best safe guard against mental deterioration and its aftermath"

In Down 2022 -2023 - Out of **6548** referrals received – only **4.2%** were referred onto Secondary care



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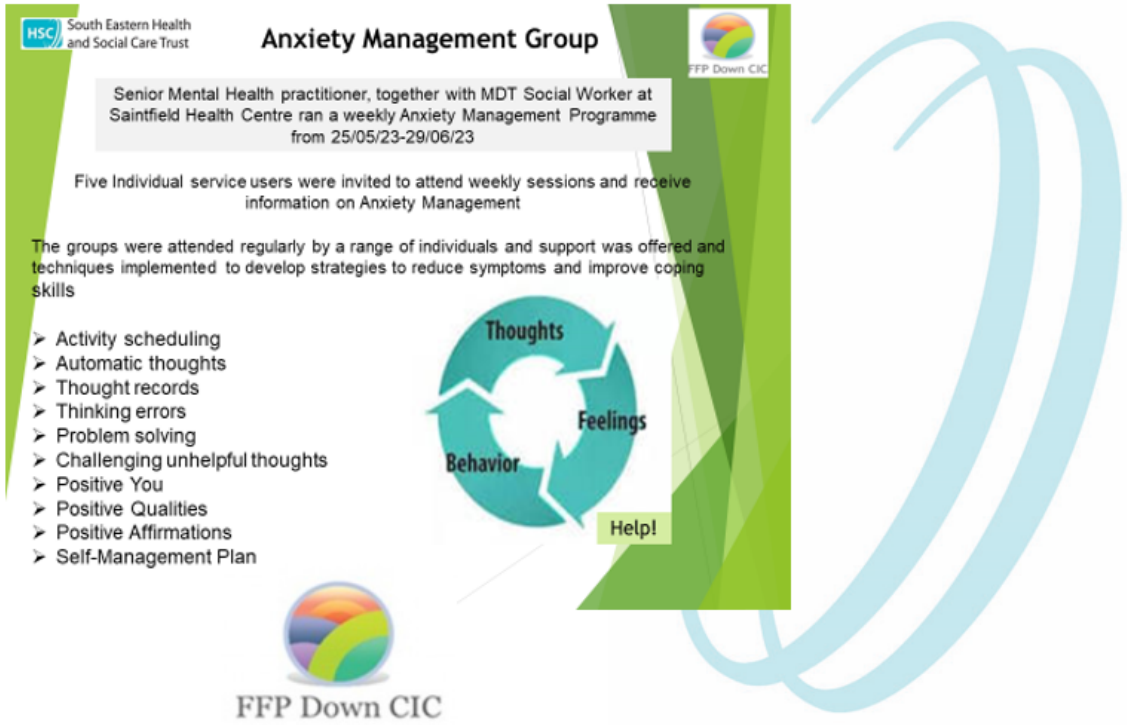

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HEALTH VISITING

- HV caseloads have been reduced by up to 27% for 0-4s giving health visitors more time to spend with clients/offer more support. Increase in child health assistant resource- quicker response to client needs. Full implementation of HCHF Programme
- All HCHF contacts completed in clients home
- All clients offered an Ante natal contact – establish professional relationships earlier
- Improved communication between HVs and GPs/ practice staff
- Identification of needs in community- Group work has increased with the introduction of Minor Illness and first Aid sessions along with walking groups, weaning groups, breastfeeding support groups and new parent support groups.
- Implementation of a referral pathway to the HV service
- Introduction of Infant Health Hub in Downpatrick

I was grateful the health visitor had time and I felt I was able to build a good relationship with her. She'll never know how much I really appreciated the visits and felt they really helped my mental health and build confidence in my own parenting skills.' - Mum

'I love that MDT allows me to conduct more visits outside of core to families that need more support and I am not rushing the visits, I have time to listen and complete necessary referrals on time'- HV

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Accredited as Baby Friendly Gold unicef UNITED KINGDOM

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COMMUNITY NURSING

- Alignment with GP and other MDT colleagues allows nurse to quickly and easily communicate patient needs and develop excellent working relationships with other professionals.

Working 8am -8pm along with the integration of the evening /night team has enabled a seamless district nursing service 24/7, which facilitates continuity of care for patients. District Nurses especially appreciate the opportunity to visit their palliative and end of life patients at the beginning and end of the day to ensure that patients are comfortable and have all their needs met. Feedback from the daughter of a patient who received end of life care from District Nursing at home praised the excellent communication and collaboration between the GP, Social Worker and District Nurse, ensuring that a care package, equipment and all anticipatory medications were in place to ensure her Mum's timely, efficient and person-centred care.

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"My mum was well cared for, her wish to die at home was facilitated and she was treated with dignity and respect. She received world class care 24rs a day in her own home. The gold standard nursing care delivered was enhanced by the new ways of working and the new model of district nursing."

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SOCIAL WORK

- **6438** patients referred to MDT SW service in 2022/23 with a total of **20,223** contacts.
- **4625** Therapeutic and emotional sessions in 2022/23
- **69** Community based groups and events facilitated in 2022/23
- **1429** patients supported in partnership with GP and MDT colleagues in 2022/23.

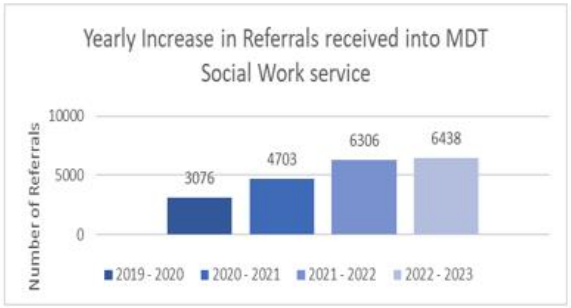
Dementia Groups

Momenta Groups

Prescribed Art

Crafty ladies Group

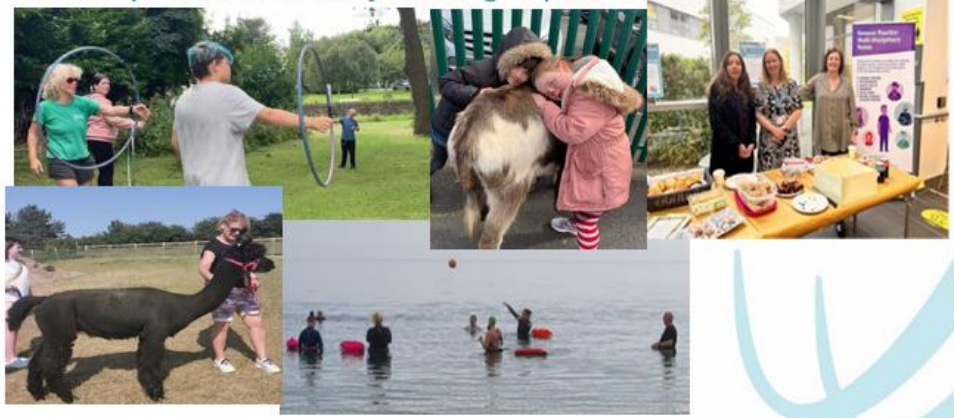
Walking Groups



"I didn't know all this help was available and I am so glad that it is. I know there are difficult times ahead but I feel more confident that I'll be able to cope" Service User Feedback

Community based groups have increased by 383% from 18 in 2019/2020 to 69 in 2022/2023

Examples of Community based group work



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Benefits of working together and partnership working - examples

HEAT & EAT EVENT NEWCASTLE

The event was attended by approximately 70 people and they were offered the opportunity to make their way around the range of statutory and voluntary sector services and organisations in order to gain information and advice on making much needed savings and cost effective tips.

A range of community and voluntary sector partners attended to offer advice and support at this difficult time.

Unit T Community Kitchen, Eden Project,
Dolmens Climate Change Group,
Newry, Mourne & Down Community Advice,
CDRCN,
Make the Call,
SE Trust Dietitian Services,
DEA Coordinator,
MYMY,
CAP Debt support,
Surestart,
Pantry Foodbank

Attendees also had the opportunity to meet the MDT Social Work Teams in their local area and find out more about the role and supports available.

"This is a great idea for the community to get to talk over some problems they have".

Very well organised information afternoon. Thank you

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In Newcastle, MDT SW is actively involved in the Community Stakeholder Group working with a range of the organisations including YMCA, YMCA Greenhill, Council, HomeStart, SureStart, EA, Volunteer Now, Mears, CDRCN, Community Policing and SERC to support the Internationally Protected Families residing in the Donard Hotel.

The MDT SW has provided regular drop in sessions to Donard Hotel providing advice and guidance for the residents and is actively involved in trying to address a number of health inequalities alongside partner organisations.

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Benefits of working together and partnership working - examples

Ghanaian Seafarers

Core skills of facilitation, active listening, and empathy were vital for establishing respectful working relationships with the seafarers, parish priest, harbour master, GAA Club, and other professionals in the multi-disciplinary team. Trust was built through the provision of food parcels during the pandemic and making links to the GAA Club for exercise

Feedback from one of the Ghanaian fishermen, he welcomed the role of the social worker and social work assistant in helping him access health care, medication, and food, and social exercise and laundry facilities through the local GAA Club. Feeling a warm welcome from the Ardglass community, he was delighted at the opportunities given to the men by local GAA coach to learn a new type of football.

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Teddy Bear's Picnic

Aim - promote awareness of the role of Primary Care MDT in the locality and of other community services available in the area.

In partnership with:

District Nursing- providing health checks
Social Work (MDT)
Health Visiting Team (MDT)
Physiotherapy team (MDT)
Community Advice NMD
Fountain Food Bank
NI Fire Service
NI Housing Executive
SureStart
Home start
NI Library – rhythm and rhyme session
Council Home Safety
Community Dental
Henry Programme
ABC PIP's
School Nursing Team
County Down Rural Community Network
Ollie and His Superpower
Mini First Aid
Face painting
Bouncy Castle
Ice cream Van
Balloon making
NMD Council provided gazebos and
NI Housing Executive supported staff and attendees with parking facilities.

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INVESTMENT & GROWTH (DOWN FEDERATION)

13
GP Practices currently have an element of the MDT model

79,000
Patients with direct access to MDTs

42,700
Patient contacts

68% patients with no onward referral

Onward Referrals:

6.1% Primary Care
4.4% C&V sector
5.9% AHP
7.1% Other
8.7% Secondary

WTE Staff in Post:

Mental Health	8.2
Physiotherapy	7.7
Social Work	23.1
Health Visiting	7.22
District Nursing	11.0

Community Engagement

69 Community Projects

1917 MDT Patients

9,154 patient contacts

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INVESTMENT & GROWTH (NEWRY & DISTRICT FEDERATION)

23
GP Practices currently have an element of the MDT model

133,000
Patients with direct access to MDTs

32,000
Patient contacts

66% patients with no onward referral

Onward Referrals:

9.9% Primary Care
5.2% C&V sector
4.3% AHP
6.3% Other
8.0% Secondary

WTE Staff in Post:

Mental Health	11.4
Physiotherapy	7.7.
Social Work	19.7
Health Visiting	8.9
District Nursing	8.5

Community Engagement

20 Community Projects

438 MDT Patients

5,188 patient contacts

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INVESTMENT & GROWTH (REGIONAL)

114
GP Practices currently have an element of the MDT model

730,000
Patients with direct access to MDTs

285,000
Patient contacts

65% patients with no onward referral

Onward Referrals:
7.7% Primary Care
5.6% C&V sector
6.7% AHP
7.7% Other
7.6% Secondary

WTE Staff in Post:

Mental Health	67
Physiotherapy	59
Social Work	118
Health Visiting	46
District Nursing	65

Community Engagement

214 Community Projects

7051 MDT Patients

43,307 patient contacts

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MDT/CDRCN:
Benefits of working together and partnership working

County Down Rural Community Network

- CDRCN have been on the whole journey – from application to implementation
- Increased partnership working between MDT's/CVS helps get a holistic picture/ assessment of clients and their needs in the Down area.
- CDRCN's position as an established and key part of the community infrastructure in the local area, has aided in identifying community needs

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PARTNERSHIP AND INVOLVEMENT WORKING

- People's views are sought, listened to and acted upon -snapshot

Newcastle Spring into Wellness Event

Crossgar Wellbeing Day

Saintfield Community Information event –

Feedback from a service user:
"Today was a great opportunity to see all the services in my local area. I had no idea that there was so much available and this event was great to get out to and meet other people as I had been so lonely since COVID."

Aim

- To provide information on Primary Care MDT.
- To bring together a wide range of local services from both the community and voluntary sector and also Trust services.
- Feedback gathered on what people would like to see in their community and from the MDT team.
- Health checks completed.
- Provided the opportunity to have a cup of tea and chat with each other and also MDT Staff.

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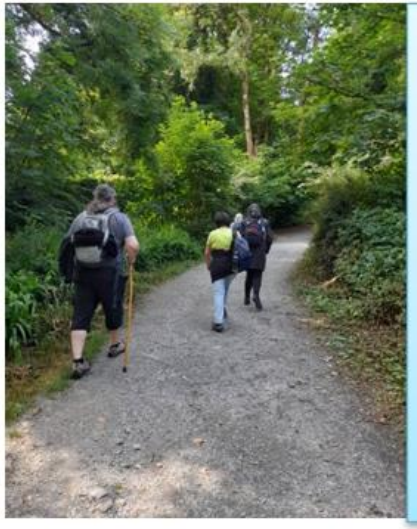
MDT/CDRCN:
Benefits of working together and partnership working

- Men's Group was set up in 2021 held on Tuesday afternoons in The Wellbeing Hub, Newcastle. A group that is run to provide a social outlet for men and help them support each other. The men have completed sessions in mindful art, glass painting and mindfulness.



"The men's group has been a lifeline for me, as a result of being involved in the activities. I have been off alcohol for a year. My life has been turned around."

- Cancer Support Group was set up in 2022, held on Tuesday mornings in The Wellbeing Hub, Newcastle. Provides support and friendship to those who have had cancer and those currently experiencing cancer/cancer treatment. Funded activities have included a number of art sessions - felting, painting, silk scarf painting, copper rubbing.

"I don't know what I would do without the group after being recently diagnosed with skin cancer. The support and friendship has been so positive and valuable to me"

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NURTURING AN IMPROVED CULTURE OF HEALTH AND WELLBEING

Reducing health inequalities:

- Improved Patient Access to services
- Improved Patient Outcomes and capacity to self care
- Greater understanding of Population Health needs
- A focus on early intervention and prevention
- Reduced demand in secondary care
- Partnership working with Community and Voluntary Sector to address health inequalities and improve the long term health and wellbeing of the local population

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