## Introduction

The Integrated Care Transformation Programme (Better Together) was created to develop an integrated care solution for health and social care.

This proposal sets out a joined up approach to health and social care for **proactive and urgent care**. It will improve the quality of care received by residents within mid Nottinghamshire and provide financial benefits to the health and social care economy.

This has been written with information developed by care design groups made up of clinical staff and service users. They looked at our current services to see how they can be improved. We also considered the case for change which is set out below. A communications and engagement programme involving patients, public and stakeholders was also included.

## Why we need to change

**Across England w**e have an ageing population. Increased demand and people's changing expectations about the time and type of care they receive are increasing pressure on the NHS.

The 2013 National Urgent and Emergency Care Review identified five key actions which would support improved delivery of an effective and sustainable service for patients receiving emergency care.

1. Better support for people to care for themselves.

2. Help people with urgent care needs to get the right advice in the right place, first time.

3. Provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E.

4. People with more serious or life threatening emergency care needs should receive treatment to maximise chances of survival and a good recovery.

5. Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

In our communications and engagement programme, patients, the public and stakeholders told us:

- There is a lack of easy access to General Practice in normal working hours
- There is poor communication between the NHS teams who provided their care leading to delays in care
- Health and social care are working in isolation
- There is confusion around what services are available and how to access them
- There are frustrating and lengthy referral times / waits
- There is limited access to reduced out of hours cover – sometimes the only option is to call 999

There were however many examples of good practice and positive feedback.

Organisations and their staff showed a strong commitment to deliver high quality, improved care to patients.

## How will the proposals for proactive and urgent care work?

Proposals:

1) Self Care and Care Planning:

**A Self Care Hub** will be developed which will support patients to learn more about their conditions. Patients will benefit from being able to become more involved in making decisions about and planning their own care.

The hub will support the delivery of education programmes for patients with Long Term Conditions. The hub will work closely with the teams who provide a community based service using a multi-disciplinary team. This is just like a hospital ward, using the same staffing, systems and daily routines, except that the people being cared for stay in their own homes throughout.

2) We will be looking at how people use services in their doctor's surgeries and are aiming to make primary care more accessible making it easier for people to see their GP when they need to.

3) Better Community Services:

**Proactive care**. Proactive care is currently being successfully delivered in Newark and Sherwood, known as PRISM. These teams focus primarily on people who are at high risk of future admission to hospital and then work with them to put in place care and support which reduces that risk and avoids the need for an unnecessary admission. This business case extends the PRISM model across Mansfield and Ashfield so that all of our citizens can benefit from this approach.

**Enhanced Intermediate Care**. Intermediate care can help support people experiencing a period of ill health or difficulty to remain at home rather than having to go into hospital. It can also help people to regain independence following a hospital stay. Our new intermediate care model will focus on increasing the number of people receiving care and support at home rather than in a hospital or care home bed. People receiving the most intense level of care can expect to receive up to four visits per day from a joint health and social care team and if needed, have access to night sitting and tele-health services.

4) Care and Crisis Services:

Often healthcare professionals do not know which services are available for them to offer help to patients and so we will develop a new service called the Care Navigator. This will be used specifically for Health and Social Care professionals to contact services when they need to arrange support for their patients who need help.

This will be available seven days a week and will help identify and arrange alternatives to hospital admission or support a discharge from hospital or care home. GPs will be encouraged to use the service for all unplanned hospital admissions with the exception of patients with clear life threatening conditions and children. This means that patients will be signposted to and supported by the most appropriate service in the most appropriate care setting in a timely and coordinated way.

**Crisis Response Team**. A community based crisis response service will operate 24/7 and provide intense and focused health and social care support (including personal care) to assist people experiencing difficulties and support them to remain living in their own home and maintain independent living skills rather than having to go into hospital. The crisis response staff will be unqualified but trained staff who will respond to a request for support within 2 hours and will work closely with community teams who will provide clinical support.

5) Integrating Acute and Community Services:

We propose that **Specialist Intermediate Care Teams** (SICT) will provide health and social care and support to bridge the gap between acute and community services. Linking these services together will help avoid unnecessary admissions, reduce delays in discharge and enable more effective patient flows through the system.

**Single Front Door.** At King's Mill Hospital there are separate doors for A&E and Primary Care 24 (PC24). We propose that this will be changed so that all patients enter through a single front door and book in at one front desk. This will remove patient confusion. Nurses, Emergency Nurse Practitioners and Advanced Nurse Practitioners supported by a GP will identify the level of patient need and a 'see and treat' model will be in place so immediate patient needs can be met. At Newark Hospital General Practitioners will work within the Minor Injuries Unit. Hospital based staff will work closely with their community based

counterparts to help identify and arrange alternative support in the community or in the patients home should a hospital admission not be necessary.

**Discharge Function.**

Our new discharge service will ensure that people don't need to stay in hospital any longer than necessary and that they can be discharged with all of the support they need to the most appropriate care setting. The aim will always be to support patients to return to their own home

The team will start this planning process very early on in the hospital stay and they will work closely with their colleagues in the community to ensure that all of the support needed is in place ready for when the patient is medically fit for discharge.

6) Communicating Changes with the Public:

We will educate and support the public on how to choose the health service best suited to their health needs. We will work with sectors of the population to understand their current use of urgent care services and remove barriers to access.

## Working together

It is essential that there is a programme of organisational development so that all organisations understand the changes needed, their role in delivering them and what they need to do to support and develop their own workforce accordingly. This is a system wide model of care which requires all organisations to work closely together, develop new ways of working and break down traditional organisational boundaries

## What will be the impact upon patients?

People will receive the right care at the right time in a place closer to home wherever possible. The new model will mean that people will only need to go into hospital when they need specialist help and will be able to remain living in their familiar surroundings at home with the support they need to do so.

They will have a named person responsible for coordinating their care and all of the people involved in that care will have the information they need about the person and will work closely with each other to ensure that the care being delivered is seamless.

People will have more information about their own condition and support to help both themselves and their carers to become more involved in decisions about how their care is planned and delivered.

## What will be the impact upon the system?

**The link to the proposals, which give much more detail can be accessed by visiting:** http://www.bettertogethermidnotts.org.uk

We have calculated that the number of people who will attend A&E will fall and the number of people who require a hospital admission will fall.

We have also calculated that bed days will fall.

The change will also be enabled by changes and investment in workforce, estates and IM&T(Information Management & Technology). These areas have been given careful consideration and are referenced within the overarching business case.

## Timetable

Some new ways of working in the joined up teams will happen very soon, but the aim is to provide the large scale improvements by April 2015.

---

The Better Together partners are Nottinghamshire County Council, Sherwood Forest NHS Foundation Trust, Mansfield and Ashfield CCG, Newark and Sherwood CCG, East Midlands Ambulance Service, Nottingham University Hospitals and Nottinghamshire Healthcare Trust.

February 2014