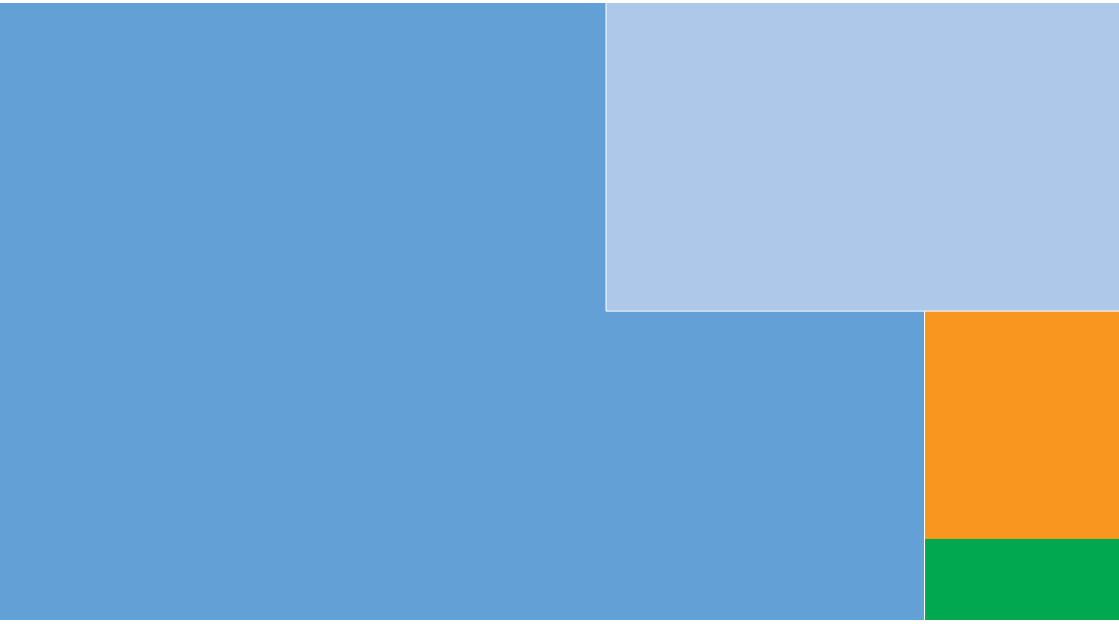
Your local health and social care services are changing – tell us what you think



Herefordshire Council

NHS Herefordshire

Hereford Hospitals NHS
NHS Trust

Introduction

In November 2009, we asked for your views as NHS Herefordshire started to look at how health and social care services in the county were currently provided. The objective of this was to look at how we could improve services with the aim of providing high quality care through a more joined up and seamless approach.

After listening to your feedback and completing this work we now have more detailed proposals for you to consider. We want to continue to involve you at every step of the planning process that will change the way services are provided to you, your family, friends and carers.

Over the coming months, we will be holding a number of engagement events, giving you the opportunity to learn about, discuss and contribute to the more detailed proposals that have arisen so far. Your views are vital in building the service of the future and in deciding how it is to be delivered.

There is an opportunity to create a new integrated care organisation (subject to formal approval processes) that would take on responsibility for the vast range of services currently provided by teams from across community care, hospital care and social care. The proposed changes do not include mental health services.

However, we will work closely with the provider of mental health services to ensure that they are fully involved in these proposals and that any new structure and services are fully compatible.

Why are we engaging now?

Maintaining our services to a small population of around 179,000 people in a large rural area presents challenges in Herefordshire. We are striving to:

- Make sure everyone receives the same high quality of care;
- Provide care closer to people's homes;
- Provide cost effective care.

The age profile in Herefordshire is already higher than elsewhere in England, and older people tend to have a much greater need for social and health services than the young. We estimate that by 2012, our population aged 65 or over will have increased by nearly 15% from 2008, almost a third more than the rest of England.

The care we currently provide relies heavily on a significant number of hospital beds in institutions such as Hereford County Hospital and the community hospitals. By contrast, the NHS as a whole is keen to provide care closer to or in people's homes. For the future we are looking to deliver more care in this way.

Public services nationally face a difficult future. The economic downturn means that constraints on public spending are going to be severe in the coming years. We therefore have a duty to ensure that the services we provide for everybody in the county are safe, sustainable and the best value for money.

Recent reviews of services in Herefordshire have highlighted significant potential for improvements in quality and efficiency through closer integration of services. As a result, we have completed work to model how care might be provided differently in Herefordshire, at the same time as delivering a better service to users. Our findings are summarised in this document.

Aims

Our ambition for health and social care in Herefordshire is summarised as follows:

'We will provide integrated, high quality and safe care to support personal health, well-being and independence within a sustainable Herefordshire health and social care community.'

We will continue to provide existing services for residents of Powys and other neighbouring counties.

We will:

- Work with you to achieve maximum well-being and independence;

- Ensure that you receive care that is appropriate to your needs and circumstances;
- Be clear with you what care you will receive, who will provide it and where it will be provided from.

Our ambitions for health and social care services are:

- A quality of care that we would want for ourselves, families and friends;
- Care delivered within your local neighbourhood;
- Efficient and excellent value for money;
- Help you to remain independent by providing support to look after yourself.

Service Principles

We have developed a new integrated model of care based on a number of key principles:

- Deliver services through improved pathways of care;
- Focus on predicting and preventing crises in the people that are most at risk of becoming unwell;
- Deliver health and social care through local neighbourhood teams where possible;
- Provide improved services for dealing with crises when they do happen.

Proposals

When we engaged you earlier in this process, you told us that you wanted services that enabled you to remain independent and stay at home for longer, with fast access to a specialist when necessary.

The changes we are proposing are based around four integrated care themes as set out in the diagram opposite:

Predict and Prevent

This element recognises the importance of health promotion, screening and self care as a way of improving health outcomes for people. Active management and early intervention reduces the need for crisis management and in some cases a hospital admission. At the earliest stages of a problem, people can be supported to manage their own conditions and circumstances with the right amount of support from health and social care services. Early detection of difficulties can help people to make informed choices about how their condition can be managed and reducing the chance of the situation worsening.

Neighbourhood Health and Social Care Teams

Neighbourhood teams would be at the heart of the new model of health and social care delivery in Herefordshire, providing co-ordinated care and support to people and

Care Pathways	• Five new care pathways that aim to ensure that care is continuously improved wherever you receive it; • Standards of care based on best practice guidance; • Care delivered in the right place, at the right time.
Predict & Prevent	• Screening for those at risk of illness ensuring that those identified are given opportunities to reduce that risk; • Using information in GP practices to identify those frail older people who are most at risk; • Signposting people to community based services that will support choice and maximise independence.
Neighbourhood Teams	• Rapid response services to support frail older people and avoid unnecessary hospital admission; • Intensive rehabilitation in the community (often in people's own homes) to promote independence and support the individual over a short-term illness; • Supporting people with the management of their longer-term health and/or social care needs and conditions.
Crisis Care	• Urgent Care situated at the County Hospital with an integrated health centre, community care base and A&E department; • Hospital care for those that need it; • New systems to help people return home as soon as they are able.

their carers. Neighbourhood teams would include adult health and social care services working in close partnership with GPs and voluntary services. The teams will:

- Promote independence and recovery;
- Reduce the need for hospital admissions when care could be provided in another setting;
- Reduce the length of stay for hospital patients;
- Work with other county-wide specialist services to ensure a co-ordinated approach.

Each neighbourhood team will work across a number of GP practices. The teams would include nurses, social workers, occupational therapists, physiotherapists and support workers. It is estimated that a neighbourhood team would serve a population of around 15,000 people.

Neighbourhood teams are key to the implementation of a new model of integrated working through their ability to:

- Provide care that is designed around the needs of the local population;
- Be accountable for the quality of care provided in their neighbourhood;
- Work together in teams to ensure that people who use our services receive treatment at the right time and in the best location for them.

Crisis Care

There will be times that people need increased support and help when their circumstances change. For example, this could be due to changes in their illness or a change in their social situation. To deliver the new model of care, we have reviewed how our "crisis care" services operate. Where possible, people will continue to be supported in their own home through increased support and treatment. Good crisis care will ensure that:

- People are able to access the services that they require;
- Individual's needs are rapidly assessed;
- High quality care is delivered in the right place.

For those people that need hospital admission, services will be developed to ensure that once treatment is completed; support and help will be put into place to enable people to continue to recover in their own home.

Care Pathways

The new approach to providing services is based on improving the care that we provide. To help achieve this we want to deliver services in a more joined up way and ensure that people receive their care in the right place, by the right people and at the right time.

A care pathway looks at the whole of the person's journey through the health and social care system from first contact through to follow-up care and discharge.

We have looked at how we currently provide services and have initially developed 5 new care pathways for people who have:

- Problems because they are frail and older;
- Had a stroke, or are at risk of having one;
- Chronic Obstructive Pulmonary Disease;
- Diabetes;
- Lower back pain.

The new pathways aim to set out standards and expectations that ensure high quality care is consistently provided. The care pathways also aim to identify those people most at risk, promote self-care and management, deliver care closer to home, reduce the need for hospital admission and provide services that meet national best practice guidance. Key to the success of the new pathways is the focus on support at the very early stages of a person needing care.

How will it be different in practise?

Mrs Collins' story

Mrs Collins is not a real person, but she is typical of people that access our services daily. She is 85 years old, having retired at 65 and lives alone in a bungalow in Leominster. Her husband died four years ago and her daughter lives in Warwick.

She has been a diabetic for ten years, has mild heart failure and leg ulcers.

The existing model of care

- Practice nurse dresses her leg ulcers, monitors her diabetes and heart failure;
- When she had a dizzy spell in March and fell at home, she was admitted to the County Hospital and stayed for two weeks;
- Mrs Collins' confidence was shaken by being in hospital and was transferred to Leominster Community Hospital and stayed in for a further four weeks;
- After a total of six weeks away from home she was discharged and a district nurse visited a further three times to check she was managing her Diabetes. Her leg ulcers had healed.

Future/proposed model of care

- Mrs Collins is known by the GP and Neighbourhood Team as a person who has complex health needs and therefore at risk of hospital admission;
- She is clear that if she becomes unwell she would like if possible, not to go into hospital as she says it took a long time for her to get back to normal after her previous hospital stay;
- She has support from a neighbour who takes her shopping and a local friend who calls in every day. She has a community alarm in her home which she can use in times of crisis;
- She has a clear personal plan for all her health conditions;
- Her health is also monitored by a Telehealth device. This technology monitors Mrs. Collins diabetes and sends information electronically to the Neighbourhood Team on her health and blood sugar levels;
- If she becomes unwell she can telephone her dedicated Neighbourhood Team, who will visit her. The Neighbourhood Team are able to quickly set up increased packages of support (24/7) that will help Mrs Collins stay in her own home. The Team would identify a Care Coordinator who will be

responsible for ensuring that Mrs Collins' needs are continuously reviewed and that an individualised care plan is put into place. The Neighbourhood Team are able to arrange an appointment with Mrs Collins' consultant who looks after her diabetes and heart problems;

- Mrs Collins and her Neighbourhood Team have a greater opportunity to provide better care and support without the need of going into hospital.

Differences between now and the future

- High quality of care provided through an integrated health and social care Neighbourhood Team which:
  - Reflected what Mrs Collins wanted ie. Care in her home;
  - Enabled her to return to normal health more quickly;
  - Continued the use of her existing support network.

- Enabled more efficient use of the local NHS & social care resources as Mrs Collins was not admitted to hospital when she could have care at home;
- Single team approach meant that her care was not complicated by organisational boundaries.

Mr Walker's story

Mr Walker is not a real person, but he is an example of someone who could access our services.

Mr Walker lives with his wife having retired to Hereford 20 years previously to be near their daughter. Mr Walker leads an active life and enjoys walking their dog and evenings dancing with friends. On Saturday Mr Walker celebrated his 80th birthday with an evening out in the company of his wife, his daughter and friends. On Sunday afternoon Mr Walker developed disturbed speech and a weakness in his left arm.

The existing model of care

- Mrs Walker telephones the out of hours service who arrange for an ambulance to bring Mr Walker to hospital;
- Mr Walker is assessed and receives acute stroke treatment and rehabilitation;
- Mr Walker receives further rehabilitation at a community hospital.

Future/proposed model of care

- Mrs Walker telephones a single Herefordshire health number where she speaks to a triage nurse. The triage nurse collates information about Mr Walker's condition. Given the description of his symptoms which would suggest he may have had a stroke, the nurse arranges for an ambulance to bring Mr Walker immediately to hospital. The nurse provides initial advice and reassurance to Mrs Walker;
- Mr Walker arrives at A&E accompanied by his wife. Within 15 minutes, an initial clinical assessment has been made by the A&E team. An action plan is put into place, the initial actions include:
  - Immediate arrangement of a CT scan;
  - Immediate assessment for treatment;
  - Transfer to the Specialist Acute Stroke unit at the County Hospital.
- Once he is transferred to the unit, Mr Walker has a more detailed assessment and treatment is started;
- Over the next 48 hours Mr Walker receives acute treatment for his stroke;
- Mrs Walker is given advice and support by the acute stroke team, including assessment of her needs as a carer;

- Once acute treatment is completed, Mr Walker is transferred to a local specialist stroke rehabilitation unit which will support both Mr and Mrs Walker through the recovery process;
- The rehabilitation team makes early contact with Mr Walker's GP and Neighbourhood Team;
- A Neighbourhood Team care coordinator is assigned, who begins to work with the Walker family to plan discharge and ongoing treatment at home.

Differences between now and the future

- Mrs Walker was able to get advice through a single point of access. Mr Walker's situation was assessed by a health professional and immediate action taken;
- On arrival to hospital, the A&E team were quickly able to further assess Mr Walker's health and commence treatment as described in the national stroke strategy;
- The care team were able to follow a clear and explicit patient pathway which ensures that all service users receive a high quality service that is consistently provided regardless of time, day or where someone lives;
- Following the acute phase of treatment, Mr Walker was transferred to a specialist intensive rehabilitation facility;
- The Neighbourhood Team were involved at the earliest opportunity; a care

coordinator was assigned who would begin to work with the family and the rehabilitation team in planning for discharge;

- The discharge planning would include a full assessment of the Walker family's health and social care needs. Ongoing care and support would be put into place that will help Mr Walker's medical recovery alongside access to local community supports that would assist both Mr and Mrs Walker.

GLOSSARY

Crisis Care Services – Emergency Care services mainly delivered from the County Hospital including A&E and the medical admissions unit. Sometimes known as the unscheduled care system.

CT scan – Special x-ray used to establish causes of some illness such as stroke. Sometimes known as a brain scan or CAT scan.

Integrated Care Organisation (ICO) – proposed new body incorporating the Acute Trust (Hereford County Hospital), Community Services (PCT Provider) and Adult Social Care.

Neighbourhood Team – Integrated team of health and social care staff – eg. Nurses, Occupational Therapists, Physiotherapists, Social Workers and Support Workers will provide health and social

care in local communities grouped across GP surgeries.

NHS Herefordshire – NHS body responsible for commissioning health care services for the Herefordshire population (often known as the PCT).

Thrombolysis – drug treatment that breaks down blood clots.

Triage – a system for assessing someone's needs, prioritising the problems and arranging appropriate response or treatment.

What happens next?

We are seeking your views on these proposals now. The responses that you provide will be recorded and any changes made as a result will be clearly shown.

In January 2011 we will present your feedback and our proposals to the Boards of Hereford Hospitals NHS Trust (HHT), NHS Herefordshire, PCT Provider Services and Herefordshire Council's Health Scrutiny Committee (HSC) for consideration.

We will make this document widely available by mail or e-mail to a range of individuals and groups, including:

- Carers groups
- General public
- Herefordshire Council/Parish and Town Councils
- Herefordshire LINk
- HHT members
- Service user and patient representative groups (e.g. Age Concern etc.)
- Partner agencies
- Service users
- Staff and staff groups
- Voluntary organisations and community groups

We are aware that many of the people that use our services live outside of Herefordshire, particularly those in Powys. We will therefore ensure that groups representing these areas are included in this exercise.

We will also hold meetings to give individuals, groups and organisations the opportunity to contribute to the discussion. An up-to-date schedule of meetings will be available on the programme website and will be widely publicised.

How you can help

Your views on the proposals set out in this document are required. We will also be pleased to attend meetings of local groups to explain our proposals in more detail and answer questions. We will include information on our website about the meetings we are organising or attending.

Our web address is:
www.herefordshire.nhs.uk/serviceintegrationprogramme

You can contact us by e-mail to: psipconsult@hhtr.nhs.uk

Send your responses by post to:

Herefordshire Services Integration Programme
Trust HQ
County Hospital
Union Walk
Hereford
HR1 2ER

Or by telephone:
01432 372928

We will keep a full account of all responses received during this engagement exercise. All contributions will be acknowledged and comments responded to, so please include full contact details. Representative groups will be asked to provide a summary of the people and organisations they represent when responding. The analysis of the responses will be made available to all respondents and made available on the website. Individual responses will be made available to anyone who requests one.

This information leaflet is also available in Large Print (it is also available in Braille, other languages and on audio tape on request).