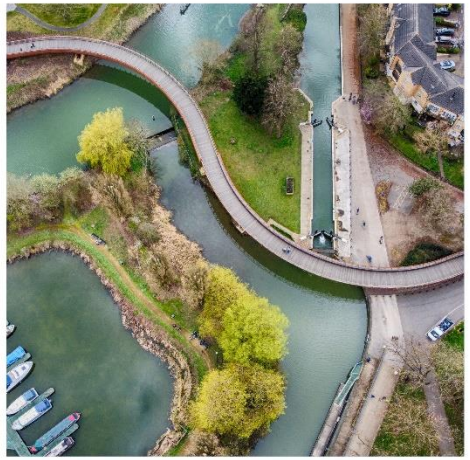
Integrated Care
Northamptonshire

Northamptonshire Urgent & Emergency Care Strategy



Six Stages of our Northamptonshire UEC Model

Integrated Care Northamptonshire

Right Care, Right Time, Right Place
An Integrated Multi Partner Approach to Mitigating and Responding to Urgent and Emergency Care Demand

Empowered Self Care & Active Prevention

Identified as at risk of escalation

- Holistic Care Plan inc crisis plan
- Keyworker support
- Remote Monitoring
- Ltc groups
- Lifeline response
- Advanced Care Plan for those at end of life
- Domiciliary Care
- Enhanced Healthcare in Care Homes

Rapid access to Primary and Community Care

Immediate Need not life threatening

- Same Day Primary Care
  - In hours & Out of Hours
- Community Pharmacy
- Minor Injury Access inc some local diagnostics
- Planned service at home
- MIND Cafes
- 111 Advice

Rapid and coordinated urgent care & crisis response

Escalation requiring intensive support to resolve out of hospital

- EMAS
- Single Point of Access for Clinical Triage
- 2hr Urgent Community Response 9 Domains inc Falls Response
- Step up Bed
- Urgent Respite Care
- Local diagnostics
- Respiratory Hubs
- UCAT
- Triage Vehicles

Sub Acute

Escalation which cannot initially be managed in community or requires specific treatment intervention

- SDEC / Frailty Assessment Area
- MIAMI
- Urgent Treatment Centre
- Diagnostics

Emergency and acute care

Life Threatening Emergency

- Emergency Department
  - Blue Light
  - Major injury
  - Acute Hospital Care
    - Safe Occupancy Levels
    - Medical Assessment

Recovering Independence

Discharge

- Home without additional support (P0)
- Home with intensive rehabilitation / reablement (P1)
- Short term 24 hr bed based recovery (P2)
- Longer Term Care (P3)
- End of Life Fast Track (P3)

Our Six Urgent Care Commitments

Integrated Care Northamptonshire

We will ensure all those living with **multiple long term conditions** are supported to **live well** and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks**

We will ensure those with a non-emergency need but requiring same day support can access the most appropriate professional through delivering **primary care services at scale** at locations around the county.

We will expand and embed a **single point of access** to respond to escalating needs to safely avoid a conveyance or admission to hospital, enabling the person to complete their recovery in their place of usual residence. Including **24/7 Urgent Community Response**; **management of certain EMAS calls; alignment with mental health response and primary care**

Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **SPOA support**

When time critical **acute or mental health** responses are required within a **hospital setting**, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams**

To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

STAGE 1

Integrated Care Northamptonshire

Empowered Self Care & Active Prevention

Our Commitment : We will ensure all those living with **multiple long term conditions** are supported to **live well** and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks**

Our Progress :

- Consistent use of care plans using Ardens Templates
- 100 patients per month receiving an extended GP led review
- Northamptonshire Shared Care Record created
- Peer support groups for COPD, Diabetes, Heart Failure, Dementia
- 161 persons in their own home and 296 care home residents set up for remote monitoring

Our Intent :
We will expand our capacity so that by 2028

1. 10,000 persons with multiple long-term conditions have a care plan using consistent care plan format
2. 5,000 persons benefit from remote monitoring
3. Every Local Area Partnership will have a minimum of one peer support group per month for each of the four long term conditions prioritised for support
4. We will extend the annual health check for all persons over the age of 50 to include full blood test and an extended review with a lead clinician
5. All partner organisations involved in the support for the named person will have access to the care plan and take part in Multi Disciplinary Teams reviews

STAGE 1

Integrated Care Northamptonshire

Empowered Self Care & Active Prevention

Our Commitment : We will ensure all those living with **multiple long term conditions** are supported to **live well** and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks**

How We Will Achieve This (1)

1. Expand and enhance the range of Long Term Condition support groups around the county, supporting patients to live healthier lives in the community and thus reduce readmission rates as proven via cardiac and respiratory services already in-place
2. Ensure that all unplanned hospital admissions for persons with two or more long term conditions are followed up by local place team with full clinician review where required within 72 hours
3. Create capacity across the Local Area Partnership / Primary Care Network footprints for 600 persons to be assigned a named keyworker with persons being in any one of three categories at any given time
    1. Receiving active support
    2. Receiving intermittent support and advice / guidance when needed
    3. Watchful waiting after period of support with direct access back to team should needs change
4. Scale capacity of nursing and specialist clinical response in our Remote Monitoring Hub to support safe growth in number or persons being supported
5. Identify those persons through local team reviews who would benefit from assistive technology and / or home monitoring with onboarding plan at rate of 100 new persons per month
6. Further strengthen the use of Ardens Templates with Northamptonshire Organisations and ensure this is core part of induction for all new staff and ensure key information travels between records and is visible within the Northamptonshire Shared Record

STAGE 1

Integrated Care Northamptonshire

Empowered Self Care & Active Prevention

Our Commitment : We will ensure all those living with **multiple long term conditions** are supported to **live well** and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks**

How We Will Achieve This (2)

1. Increase the range and breath of services at Local Area Partnership level to support patients with Long Term Conditions, identified by primary care and supported via initiatives such as Breathing Space, Pumped-Up (cardiac) and diabetes groups.
2. Increase the team of specialist clinicians able to lead peer support groups by allocating place-based areas to Acute Consultants and factoring in one group per fortnight as PA Session in Consultant job plans for the four long term conditions prioritised for support
3. We will extend the annual health check for all persons over the age of 50 to include full blood test and an extended review with a lead clinician
4. All partner organisations involved in the support for the named person will have access to the care plan and take part in Multi Disciplinary Team reviews
5. Swift access to additional support via the Single Point of Access in the event of an exacerbation

STAGE 2

Integrated Care Northamptonshire

Rapid access to Primary and Community Care

Our Commitment : We will ensure those with a non-emergency need but requiring same day support can access the most appropriate professional through delivering **primary care services at scale** at locations around the county.

Our Progress :

- At-scale delivery of same day primary care through Federation delivered Extended Access model
- Surge solutions for Paediatric and Respiratory Hubs
- Established model of 'walk in' for MIND Cafes, Children and Young Person Cafes

Our Intent :
We will expand our capacity so that by 2028

1. We will have modelled the same day demand expected from our population
2. Embedded NHS 111, linked to the Single Point of Access as the intended first port of call
3. We will have delivered an at scale a community integrated urgent care model across local area partnership footprints.
4. 'Same Day Access hubs' which will be a key feature of our model and will be established around the county, linked to diagnostic centres.
5. Integrated with pharmacy, dental and optometrist providers where possible to provide an unscheduled care service that builds on current arrangements
6. Our models will be designed in a way that we reduce the over reliance on acute urgent care services

STAGE 2

Integrated Care Northamptonshire

Rapid access to Primary and Community Care

Our Commitment : We will ensure those with a non-emergency need but requiring same day support can access the most appropriate professional through delivering **primary care services at scale** at locations around the county.

How we will achieve this

1. We will co-produce with the primary care sector and other key stakeholders a new community urgent care model. This will be delivered as part of the Primary Care Strategy which will be published in 2024.
2. We will identify all community urgent care capacity at a local area partnership level, empowering local teams to design and implement new enhanced ways of working.
3. We will set out a plan on how we will deliver our same day access hubs across the county. Where feasible we will look for opportunities to build on existing enhanced access / respiratory hubs. But we will also look for early implementers to test out our new model of care.
4. We will review how we commission GP Out of Hours services and align to our Same Day Access Hubs.
5. We will design a community based urgent care model that seamlessly integrates with sub- acute / acute care and diagnostics and reduces the number of patients utilising our A&E services.
6. We will develop a workforce plan that supports the delivery of our new model of care.
7. We will look for innovative estate solutions to accommodate our Same Day Access Hubs.

STAGE 3

Integrated Care Northamptonshire

Rapid and coordinated urgent care & crisis response

Our Commitment : We will expand and embed a **single point of access** to respond to escalating needs to safely avoid a conveyance or admission to hospital, enabling the person to complete their recovery in their place of usual residence. Including **24/7 Urgent Community Response**; **management of certain EMAS calls; alignment with mental health response and primary care**

Our Progress :

- A well established SPOA / Clinician to Clinician Live Handover / 2hr Urgent Community Response model responding to circa 30 escalations per day with direct access for known patients / carers
- Ability to take referrals electronically from EMAS and 111 as well as phone
- Nationally promoted Mental Health Crisis Pathway included Home Based Urgent Response, walk in access through Mind Café's, Police and Ambulance Triage Vehicles and access to Crisis House and Section 136 Suites

Our Intent : By 2028 we will

1. Develop a fully integrated 24 hour service able to provide two hour Urgent Community Response where this would achieve our commitment and the same outcome cannot be achieved through core service provision
2. Meet national target of 80% achievement of red referrals successfully responded to by face to face clinical contact within two hours
3. Ensure that persons who can be supported by 2hr Urgent Community Response are transferred to service from EMAS dispatch desk releasing crew capacity for attends
4. Ensure that all nine domains in the 2hr Urgent Community Response model are fully delivered locally strengthening our current capacity and pathway for escalations of persons at End of Life and in situations of carer / care package breakdown
5. Further improve patient experience and outcome by expanding the point of care testing capabilities of our Urgent Community Response services
6. Avoid long waits following a fall where there is either no injury or is a clear minor injury

STAGE 3

Integrated Care Northamptonshire

Rapid and coordinated urgent care & crisis response

Our Commitment : We will expand and embed a **single point of access** to respond to escalating needs to safely avoid a conveyance or admission to hospital, enabling the person to complete their recovery in their place of usual residence. Including **24/7 Urgent Community Response**; **management of certain EMAS calls; alignment with mental health response and primary care**

How We Will Achieve This

1. Undertake test and learn period to :
   - Provide Specialist Palliative Nurse as part of the Single Point of Access
   - Provide Voluntary Sector Coordinator as part of the Single Point of Access
   - Increase direct access to GP to support Multi-Disciplinary Team / Clinical Decision making within the 2hr Urgent Care Response model
2. Train additional partner community staff in the use of Raizer Chairs and supporting clinical decision making App to increase the pool of persons able to respond to non-injurious falls. Linked to further deployment of Raizer chairs and creation of an interactive map to show tracked location of devices available.
3. Create a new service specification which can meet needs of escalating patients between 10pm and 8am where this can be met by Urgent Community Response and would not be safe to delay until core service hour provision is available
4. Ensure that we have correctly forecasted and commissioned the volume of Urgent Community Response interventions needed to mitigate urgent care demand and attendances to inappropriate settings eg A&E
5. Align our physical and mental health urgent community response provision to ensure best patient outcomes are achieved and that persons with mental health and physical exacerbations receive a seamless integrated intervention

STAGE 4

Integrated Care Northamptonshire

Sub Acute

Our Commitment : Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **Single Point of Access support**

Our Progress :

- Same Day Emergency Care (SDEC) units at NGH and KGH
- KGH have dedicated Frailty Assessment Area staffed to support same day turn around of patients at point of escalation
- Primary Care have piloted Point of Care (POC) testing with home visiting Paramedic Service
- Agreement on two sites at Corby and Kings Heath in Northampton as Community Diagnostic Hubs

Our Intent : We will strengthen our provision and approaches to :

Establish the two Community Diagnostic Centres delivering specialist diagnostic services in two new localities, expanding the range and volume of diagnostic tests which can be undertaken outside of traditional acute settings increasing local provision and access for populations

Deliver multiple Same Day Access centres around the county linked to the primary care strategy

Implement solutions which enable a directing clinician to book see and treat slots within Urgent Care Centre and Same Day Emergency Care facilities supporting demand and flow management

Maximise the use of technology and point of care testing to reduce waiting periods for patients

Increase the range of remote monitoring solution so patients be observed at home whilst tests are performed

STAGE 4

Integrated Care Northamptonshire

Sub Acute

Our Commitment : Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **SPOA support**

How We Will Achieve This

1. Working with Primary Care on same day delivery model agree the presenting patient conditions which cannot be managed at a neighbourhood level but do not require an Emergency Department attend
2. Ensure direct referral and access to Same Day Emergency Care and Specialist Frailty Units with real time visibility of capacity and ability to direct book patients to attend for timed appointment slots
3. Extend our Same Day Emergency Care operating models to provide a 24-hr solution for ambulatory care conditions
4. Ensure that existing on-site provision at NGH and KGH is fully integrated to provide a blueprint for on-site redesign to combine the current services (Minor Injury, Same Day Emergency Care)
5. Provide estates solutions which deliver seamless patient flow ensuring our ambition of right care, right time, right place is achieved

STAGE 4

Integrated Care Northamptonshire

Sub Acute

Our Commitment : Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **Single Point of Access support**

How We Will Achieve This

1. Deliver the first two Community Diagnostic Hubs and review learning and outcomes to inform further planning of additional capacity for 2025/2026 and identify opportunities for wider 'one stop' shop approach within communities based on solutions implemented in Humberside and in Havering
2. Work with technology partners through framework procurement agreements to ensure that we are maximising the latest in remote diagnostic capabilities and point of care testing
3. Develop SOPs which enable clinicians working in UTC or Community Diagnostic Hubs or Extended Primary Care Same Day models to have access to local overnight bed solution to support a 24 hour monitoring period where required and unable to be delivered in patients own place of usual residence

STAGE 5

Integrated Care Northamptonshire

Emergency and acute care

Our Commitment : When time critical **acute or mental health** responses are required within a **hospital** setting, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams**

Our Progress :

- Established Same Day Emergency Care services in each hospital
- Established mental health triage car service
- Reprocured the Urgent Care Centre provider at Corby
- Outline case written to expand majors cubicles and minors capacity at NGH

Our Intent : We will strengthen our provision and approaches to :

1. Ensure our Emergency Departments are right-sized to manage demand
2. Reduce the number of patients who are fit to leave hospital – enabling bed capacity to be appropriate utilised
3. Deliver ambulance response times and ensure handovers occur without delay
4. Provide the equipment and environments which ensure timely transfer of patients arriving by ambulance – adults and children
5. Increase our workforce so that decision making is consistent across every day of the week both in receiving medical teams and specialist medical treatment staff
6. Give clinicians access to timely diagnostic results, minimising the need to refer to hospital
7. Enable receiving clinical teams to access the full patient record
8. Step patients into Virtual Ward provision

STAGE 5

Integrated Care Northamptonshire

Emergency and acute care

Our Commitment : When time critical **acute or mental health** responses are required within a **hospital** setting, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams**

How We Will Achieve This

1. Support University Hospitals of Northamptonshire to remodel the NGH emergency department
2. Deliver the proposals listed in Stage 6 to reduce bed occupancy
3. Expand the range of point of case testing at the acute front door and reduce the time taken for test results during hospital admissions
4. Develop staffing models across Unified Acute Group which maximises the available staff skills and resources across both sites
5. Ensure our Paediatric A&E are of correct size to meet the demand from the growing population expected within this cohort

STAGE 5

Integrated Care Northamptonshire

Emergency and acute care

Our Commitment : When time critical **acute or mental health** responses are required within a **hospital** setting, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams**

Northampton General Hospital Emergency Department redesign

- A single “front door” for walk-in patients seeking emergency care
- Subsequent separation of adult and paediatric patient flows
- Rapid assessment and triage of walk in patients
- An integrated Urgent Care Centre comprising (Adult) Minor Illness and Minor Injury (MIAMI) plus Same Day Emergency Care
- Dedicated paediatric urgent treatment facilities immediately adjacent to the Paediatric Emergency Department
- An additional 8 majors cubicles
- Remodelled (previous) ED minors waiting area to improve initial assessment and treatment
- Improved ambulance handover facilities

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 0 Discharges**

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

Our Progress :

- Expanded remote and virtual monitoring services
- Voluntary sector partners to make follow up welfare call checks on discharged patients
- Where family or carer are not able to support we ensure the home is ready to receive the returning person eg warm, essential food in place, any equipment needed has been delivered
- Patients on discharge have emergency contact numbers for first 24 hours

Our Intent : We will strengthen our provision and approaches to :

1. Discharge notes are immediately visible in the patient record through the Northamptonshire Shared Care Record
2. Each GP practice will receive a same day electronic advice to state patient discharge completed
3. The needs of patients identified for P0 discharge are identified early in the stay enabling the Voluntary Sector to schedule pre return visits to the home and post return home calls
4. Maximise the number of discharges completed by midday by ensuring transport solutions are in place and take home medication is with the ward or discharge lounge before 11
5. We will ensure that all discharged patients are contacted within 72 hours of leaving hospital to ensure planned actions have happened and have direct access to either the Hospital Team or their GP if they have concerns immediately following return home.

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 0 Discharges**

Our Commitment : Whilst most people will leave hospital and return directly home without ongoing intensive interventions we recognise that within this cohort there may be anxiety and requirement for planned follow up actions eg a wound dressing. We will ensure that all discharged patients are contacted within 72 hours of leaving hospital to ensure planned actions have happened and have direct access to either the Hospital Team or their GP if they have concerns immediately following return home.

How We Will Achieve This

1. Build a digital solution which is triggered to primary care when patient leaves the ward / discharge lounge
2. Contract with the voluntary sector to include transportation for those who require getting home support
3. Ensure the Single Point of Access and EMAS are aware of all patients discharged each day to be aware of potential re-escalation
4. Ensure Patients / Carers have access to advice / guidance in the 72 hours immediately following discharge
5. Set clear Expected Date of Discharge for patients to ensue families can prepare for return home

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 1 Discharges**

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

Our Progress :

- Dedicated staff within Community Health and Council Reablement Services currently supporting 10 patients home each day 5 of which will be jointly delivered
- Changes made to Frameworks operated by Local Authorities to bring Domiciliary Care Providers into place based planning and delivery
- Commissioned provider by NNC to provide additional P1 recovery capacity
- Introduced improved tracking and monitoring of demand, capacity, delays and outcomes through shared dashboards

Our Intent : We will strengthen our provision and approaches to :

1. Ensure that patients do not wait for more than 48 hours in hospital from being ready for discharge to being at home
2. Provide longer term therapy where required through local community therapy services
3. Ensure any equipment or minor home adaptations required to support maximum independence of person are identified early in the patient journey and implemented to avoid delays
4. Utilise short term alternative (non 24 hr staffed) accommodation for persons to commence their out of hospital recovery if their own home is not yet available for them to return to
5. Maximise the use of Virtual Ward to enable the patient to return home for further recovery where they would otherwise have occupied a hospital bed where they are supported through outreach monitoring

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 1 Discharges**

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

How We Will Achieve This

1. Utilising our future Single Point of Access to ensure we have resource to support and track seven day discharges increasing the number of supported weekend discharges by 50% and smoothing current mid / late week peaks
2. Recruit to the staffing establishments required to meet forecast demand
3. Review our existing contractual arrangements to maximise the use of available resource by creating an outcome based approach for identified presenting patient need including those who need intensive health input beyond seven days including collarcare, non weight bearing and short term specialist feeding support
4. Develop a partnership approach with domiciliary care sector organisations to skill up workforce able to deliver reablement interventions
5. Establish agreements with Housing partners for access to suitable short term use accommodation
6. Review our capacity within community therapy and identify solutions to remove current waits so that there are no gaps in continuity of care
7. Maximise the use of Disability Living Grant provision for home adaptations and modifications, working with partner building companies to reducing delays in assessment, decision making and implementation

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 2 Discharges**

Our Commitment : Those persons who require a period of intensive rehabilitation or recovery before being able to return home or transition safely to next care setting and require a bedded solution to achieve this will transfer to an appropriate facility within five days of becoming medically fit following an Acute managed escalation

Our Progress :

- Analysed use of and demand for current pathway
- Introduced additional board round approach to improve discharge planning
- Reduced days lost in P2 facilities for persons who no longer have reason to reside
- Created a new Recovering Independence Bedded Unit (RIBU) model of one facilities jointly operated by health, social care and primary care.
- Prepared high level model plan showing how we will deliver a 230 bed model to meet local demand whilst retaining small elements of surge capacity

Our Intent : We will reprofile to ensure that by 2025

1. Any person requiring general rehabilitation / reablement in a bedded unit will be able to access this provision within ten miles of their home
2. We will have a single specialist facility giving correct provision of specialist stroke recovery beds to meet demand and ensure patients do not remain in Acute bed for longer than benefits their recovery plan
3. For persons who require a bedded pathway to manage unresolved delirium or challenges from behaviour related to dementia before they can progress to next part of their recovery journey we will provide beds within one of our units with additional on site, in and out-reach staff to support successful outcomes
4. We have achieved full approval for our plans from stakeholders including HOSC North and West
5. We have maximised the use of our best estate and reduced future estate liability costs
6. No more than 5% of recovery beds are occupied on any given day by a person who no longer has reason to reside

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 2 Discharges**

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

How We Will Achieve This

1. Continue to test and learn from the RIBU approaches at Turn Furlong and Thackley Green to inform future model
2. Develop individual business cases for each of the steps towards delivering our overall vision with the first element being an affordable solution for the re-use of Spinneyfield facility in Rushden, East Northants.
3. Increase our current stroke bedded rehab capacity by further four beds to reduce waits in transfers from NGH
4. Work with the Community Stroke Team to ensure a consistent and cohesive recovery pathway after stroke decreasing the length of stay required in bedded element of the pathway and maximising those who can return home including consideration of respite and step up within the bedded unit
5. Develop primary care led medical models which enhance continuity and ensure patient is supported by their PCN Neighbourhood team throughout their recovery journey
6. Invest in our estate to ensure that the environments support recovery as applicable to each patient cohort to include use of technology to mitigate falls risks and coproduced and designed day spaces (internally and externally) which support engagement activities and provide safe wandering and sensory experiences
7. Ensure that we have correctly forecasted and commissioned the volume of packages of care for the next stages of the patient journey

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 3 Discharges**

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

Our Progress :

- Established Discharge Hubs in both NGH and KGH and Discharge Coordinators in Community Bedded Units
- Daily reporting processes and dashboards showing pathways assigned
- Established an Integrated Brokerage Team to source places on behalf of ASC and ICB CHC
- Thematic analysis of the challenges and causes of current delays and backlog

Our Intent : We will strengthen our provision and approaches to :

1. Fully implement trusted assessor model across statutory and commissioned providers
2. Provide appropriate bridging care environments for persons whose onward package of care is not immediately available to free beds to support safe patient flow
3. Have a robust market of providers working to a partnership model who are able to accept and meet the needs of an increasingly frail patient cohort
4. Ensure appropriate community wrap around support for our long term care providers
5. Meet patient and family choice whilst ensuring that additional harm does not occur from extended hospital stays
6. Implement recommendations of the End of Life workstream to increase the number of persons able to die with privacy, dignity and respect in the place of their choice
7. Implement solutions which are able to resolve escalations through commissioning of bespoke care packages where these fall between business as usual provision

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 3 Discharges**

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

How We Will Achieve This

1. Utilising our future Single Point of Access to ensure we have resource to support and track seven day discharges increasing the number of supported weekend discharges and smoothing current mid / late week peaks
2. Design and commission capacity for complex Dementia Care Packages having taken steps to mitigate demand through our P2 improved Dementia and Delirium recovery provision
3. Refine our daily reporting to ensure visibility of total demand, current Medically For Discharge and time waiting for packages to commence
4. Strengthen our escalation and resolution process empowering decision makers with the resources to create and implement bespoke packages when required. To note in time escalation will be through our Single Point of Access / Oversight.
5. Engage with our market providers to identify support required to meet P3 demand in timely manner building on our ambition that our Domiciliary Care Providers and Care Home Providers become key partners in our local integrated place based teams
6. Maximise the use of provided technology for persons receiving long term care to reduce frequency of escalations and to ensure timely support to clinical advice and guidance from those providing the ongoing care
7. Ensure that we have correctly forecasted and commissioned the volume of packages of care for the next stages of the patient journey

Listening to our patients….

Integrated Care Northamptonshire

Challenges identified through previous engagement

Integrated Care Northamptonshire

healthwatch Northamptonshire

Northamptonshire Health and Care Partnership

Public views and experiences to inform the NHS Long Term Plan in Northamptonshire

Healthwatch Northamptonshire

what would you do?

It's your NHS. Have your say.

Maintaining and caring for the whole person to ensure continuity within their long-term care and ensuring all have access to patient records through a 'patient passport' were also felt to be important

"A closer to home hospital or support system in my locality." (Age 35-44 carer)

don't want to be seen as a condition or a diagnosis; they want to be treated in a holistic way, with a focus on their overall wellbeing and with respect for individual choice

difficulties around discharge from hospital, where carers felt they were not fully involved in decisions and where family members were discharged from hospital without proper assessment of their needs or adequate notice to carers of the arrangements: "Professionals need to understand the family dynamics when the patient is considered vulnerable",

a lack of communication and coordination between services. Information about a person and their needs is not always transferred in a timely and accurate manner, particularly when treatment involves admission to hospital. Problems with the flow of information had contributed to delays in treatment, an inability to deal with people's multiple conditions and prescribing difficulties (including incorrect medication being prescribed and instructions being incorrect or misunderstood). Such problems can lead to a person's condition deteriorating and considerable distress for patients and their carers.

Throughout the development of this strategy, as well as previous service developments such as Ageing Well, we have engaged with service users and providers to seek their views on services within Northamptonshire.

Previous Engagement Comments

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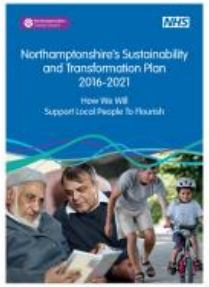

respondents mentioned needing sufficient care staff who are properly trained and funded and the need for continuity of healthcare professionals"

respondents said they want to be involved in decisions about their treatment, receive timely communications and have easier and quicker access to services.

difficulties with understanding clinical language and the process of diagnosis, treatment and care (not everyone understands the term 'pathway'), including what choices are available

There continues to be national issue needing resolution in terms of health and care support to overcome the issues arising from the current structure of separate heath and care services and geographical differences."

"I want an end to initiatives which promise all these things yet only do so on paper. Don't put them in place unless they are meaningful. Don't tell me I can see a healthcare professional when I need to, then not allow me to do so because of underfunding. Don't tell me I will get the treatment I need, then deny it me because you won't fund it. Don't keep passing all my problems back to me, my friends and family."

There are a number of consistent themes that have arisen in the course of our patient discussions which are summarised below; for every proposed service development we will ensure that this feedback is built-in to the design process to ensure that the views of those who experience and deliver our services are heard.

Listening to our patients….

Integrated Care Northamptonshire

Timely access to primary care – ensuring that patients can access their GP in the most appropriate clinical timescale. Our plan is to support this via the establishment of same day access hubs; meaning that more appointments are freed-up in mainstream General Practice.

Patient record visible to support good decision making and avoid retelling of story at each touch point. This is a common theme across the entire healthcare sector which will be addressed considerably by the Northamptonshire Care Record.

Being kept updated, patients tend to be more amenable to a wait in their journey if kept informed as to the reasons and how to access support in the meantime. We will do this via the Single Point of Access development

Better coordination for End of Life care especially at crisis points. This is another piece of consistent feedback, Many families will have experienced caring for a loved one at the end of their lives and when the person deteriorates it is a stressful and distressing time. Care needs to be provided swiftly and in the preferred place of a persons death. This will also be delivered via the Single Point of Access service.

Escalations don't all happen Monday to Friday between 9 and 5 – access to specialist knowledge and response support should be available as minimum 8am to 10pm every day which will be delivered via our proposed Same Day Access Hubs and co-ordinated by the Single Point of Access.

Simple communication, our service users ask for us to speak in lay persons terms and in clear language. Not using abbreviations or complicated medical terms. This is a task that all members of the health service should adopt whether working in Emergency Care or another sector.

Clear expectation of what needs to be achieved for safe discharge the vast majority of patients do not want to be in hospital and their relatives would rather they were in their usual place of residence. However, we don't always plan accordingly and involve patients and relatives appropriately. We don't explain what to expect, recovery expectations, how to use equipment or the types of care packages as well as we could. This will be delivered in our plans to redesign services for patients leaving hospital and who need extra support from health or social care.

Co-production & Engagement

Integrated Care Northamptonshire

As we implement this strategy we will engage and listen to members of our community at every step of the way.

Our UEC model has developed over several years reflecting best practice, locally, nationally and internationally and building on the success of innovation and transformation achieved within Northamptonshire.

Over the coming months we will continue to work with our patients, carers and staff to further evolve and refine our plans utilising existing forums eg Health and Wellbeing Boards, Primary Care Patient Participation Groups, Users of our LTC Condition Groups, Persons receiving Care Packages including Lifeline help, Governor and Elected Member meetings, Community Champion led events as well as facilitating on-line and in person bespoke events.