Shaping health and care in Mid-Nottinghamshire

A renewed joint vision for our PRISM teams – delivering local integrated care

1. **Purpose of the teams**
   The overarching purpose of the integrated care team is to provide the most appropriate form of holistic and coordinated proactive care for the residents who have the most complex set of needs within the local area. By working closely together with the person and any family or carers, health (physical and mental health) and social care staff will be able to develop personalised, flexible and multi-skilled responses to people's needs quickly, so that their independence and well-being can be sustained. The need for hospital admission will be reduced significantly and the need for residential care will be delayed or prevented altogether. The outcomes that the team will deliver against are defined in the Better Together Outcomes Framework.

2. **Who will the team support ?**
   A risk stratification tool (he Devon Tool) will help the teams to collaborate with individual GP practices to identify those priority people who need focused support within the catchment area, to maintain the person in their home for as long as possible, prevent unnecessary hospital admission and facilitate speedy and successful discharge from hospital. As well as using a formal risk stratification process, the GPs and teams will use local knowledge to highlight people who need additional support. These people are likely to be frail and elderly, at risk of losing their independence and with deteriorating health. In addition, there will be younger adults who have a combination of long-term health conditions and who require frequent support to maintain their well-being.

   The defined catchment for each team relates to a clear group of GP practices and their registered populations. There are 5 teams across Mansfield and Ashfield (Rosewood, Hardwick, JAKS, Vantage and Ashwood); these teams are aligned with the Federation Commissioning Group structure There are three teams in Newark and Sherwood (North, West and Newark & Trent); these teams are geographically aligned.

3. **Which staff will work in the teams ?**
   There will be one multi-disciplinary team for each local area, consisting of: :
   - Team Leader
   - Nursing staff - Community Matrons, District Nurses, Specialist Nurses (Respiratory, Diabetes, Heart Failure)
   - Social Worker / social care staff

- Therapists - Occupational Therapist, Physiotherapist
- Mental Health Worker
- Healthcare Assistants
- Self Care Advisors (Self Help Nottingham)
- Ward/Team Coordinator

Other services will be linked into the core team (eg. housing workers, police, specialist health and social care teams, social care providers including reablement and home care, dentists, pharmacists, leisure service staff, benefits advisors).

4. What will the team do ?

4.1 INFORMATION, ADVICE AND EARLY INTERVENTION

a. Direct people towards resources that will enable them to learn about their conditions and take as much responsibility as possible for their own health and well-being.

4.2 PREVENTION

a. Help people make connections with their peers for support and friendship, to overcome loneliness and share expertise. Work with the voluntary sector locally to encourage befriending schemes.

b. Build links with the local leisure service to promote fitness and recovery activities that are age-appropriate and welcoming to everyone

c. Promote AssistiveTechnology and other equipment to keep people at home and support their independence for as long as possible.

d. Assess carers needs and provide ongoing support to eligible carers, to enable them to carry on caring

e. Build links with local care homes to support their staff to use best practice in relation to continence care, falls, medication management, pressure care, use of aids and Assistive Technology.

4.3 SHORT TERM SUPPORT (re-ablement)

a. Provide short-term therapy, treatment and reablement to enable people to stay at home safely.

b. Track local patients who are admitted to hospital so that appropriate reablement and other support arrangements can be put in place to support the person at home (as

the default position) as soon as he/she is medically fit for discharge. Alternatively, maintain contact with the patient if discharged to a temporary intermediate care bed, to ensure a return to home as quickly as possible.

4.4 ASSESSMENT AND CARE MANAGEMENT

a. After reablement interventions have been tried, assess people for eligibility to longer-term social care provision; if people are not eligible, then signpost people to appropriate services that they could fund themselves. If people are eligible, then provide a Personal Budget (see section 4.5).

b. Refer people to other specialist resources if necessary, including Community Learning Disability Teams, additional Community Mental Healthsupport, Deprivation of Liberty Services, Approved Mental Health Practitioners, Multi-Agency Safeguarding Hub for safeguarding concerns.

4.5 PERSONAL BUDGETS

a. Provide a personal budget to the people who are eligible for social care support, to fund appropriate services to meet outcomes. Review the Support Plan at least annually to assess whether the level of personal budget can be reduced to support greater independence.

b. Provide a Personal Health Budget to people with on-going health needs, where this is requested.

5. How will the team work ?

5.1 Professional identity

a. Staff will have a clear sense of purpose and team identity; they will understand why the sum is greater than the individual parts.
b. Staff will have trust and confidence in each other's opinions and skills, as well as acceptance of the risks that each profession deems appropriate to the situation
c. Each member of the team will have a very clear understanding of what other colleagues in the team do and what resources they can tap into.
d. There will be dedicated professional development time.
e. Professional supervision will be provided by managers from the same profession as the worker.
f. Day to day management and leadership is provided by each Team Leader

5.2 Work base

a. Co-location and hot-desking will encourage good communication and working relationships.
b. Staff will be able to spend time working within the local GP practices and will feel welcome there. A protected clinical decision-making forum (Multi- Disciplinary Team – MDT – meeting) will take place each month within the GP practice.

5.3 Use of data and ICT

a. There will be mobile working (eg. use of tablets).
b. Staff will have shared access to the health and social care records for each person.
c. "Dashboard" style information to help staff understand how well they are doing against the agreed outcomes and areas for improvement.
d. Feedback processes will be in place so that the team can track progress made by people at 3 month and 6 month intervals after receiving support from the team, in order to learn lessons and ensure ongoing development of the model.

5.4 Working practices

a. Staff will use a single assessment format and the "Trusted Assessor" model will be established so that health and social care staff can carry out assessments that commit resources or make referrals on behalf of both organisations.
b. There will be regular multi-disciplinary team meetings both within each operational team and with the wider practice team to discuss new referrals of people in significant need and on-going work with priority people.
c. Some staff will be trained in features of another discipline so that they are multi-skilled, to minimise different people having to work with the same client.
d. Day-to-day line-management could be retained by the original employing organisations or transferred to a single-line manager. Matrix management is likely to be appropriate.
e. Staff cover will span 7 days and beyond normal office hours.

Written by Wendy Lippmann (Transformation Manager, NCC) and developed with comments from Karen Sandy and the members of the Urgent and Proactive Care Steering Group (Better Together).