HEALTH AND WELLBEING
NOTABLE PRACTICE FROM PEER CHALLENGES

Erewash – Integrated Care Framework with a Single Point of Access

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The benefits of a Single Point of Access

Population projections for NHS Erewash CCG show an ageing population, such that by 2033 27.5% of the population will be over 54, 14.6% over 75 and 5.7% over 85. This ageing population will increase the demands upon both health and social care. National evidence shows that joint working between health and social care improves outcomes for patients and service users, bringing care closer to the home and providing improved efficiencies.

Describe briefly the issue/challenge/opportunity that has been tackled.
Within Erewash it was acknowledged many services were available. What was evident after scoping with stakeholders was that the services had many different access methods, different criteria, no rapid response function available for community health services and none or limited integration. This was resulting in duplicated referrals to different organisations, duplication of work and admission to hospital being a preferred option, as it was the "path of least resistance". Patient experience, high quality care and an efficient service across all stakeholders became an urgent priority.

What solution was applied?
An Integrated Care Programme with a Framework and Model was designed to provide better care closer to home by providing continuity of care within an equitable needs based service.

Within the Framework, a key aspect was to create a **Single Point of Access** (SPA) to provide seamless urgent/short term care and give referrers an alternative to hospital admission where appropriate. Referrers from the different stakeholders, can refer a patient to SPA. Details are taken by clinical navigators who are able to advise what services are available and coordinate a rapid response within two to four hours. Pathways and protocols have been identified for services from different organisations. The SPA also has local bed and resource intelligence to facilitate referrals to relevant services/teams

In addition, and to support the SPA, other integrated solutions included:

- Six new integrated Community Delivery Teams (CDTs), inc. GPs, community matrons, social care and other health workers.
- Assigning a new role of Care Coordinator to each team
- Case management by the CDT: Integrated teams are a significant factor in improving care for people with Long term conditions: 'Singh D. Transforming Chronic Care: Evidence about.

Birmingham University (2005) meta-analysis'.

What organisations were involved?

- GP Practices
- CCG
- Community and Mental Health NHS Trusts
- Secondary Care providers
- Derbyshire LINk (Healthwatch),
- Erewash CVS
- Adult Care

What tangible outcomes/changes have been achieved? e.g. resource maximisation; innovative partnerships; how linked to other initiatives like integration;

The implication is improved patient experience whereby they now receive timely, appropriate care, delivered seamlessly. For those at risk of admission, they receive a rapid assessment and intervention and the teams have several options available to them. The GPs are able to make one referral through SPA and know numerous services may be triggered thereby reducing their time spent making onward referrals and appropriate services are deployed.

A case study of an 88 year old lady who had fallen demonstrates the benefit of the new model:

- "couldn't have wished for better" all from one phone call made by the GP.
- Housing Association visited and replaced the gas fire with electric fire.
- Social services have started re-ablement service.
- On going rehab by PT and OT. Now walking safely with the WZF and getting up safely at night.
- Medication now provided in blister packs, repeat prescriptions and delivery to be managed by pharmacy.
- Temporary key safe in situ, provided by Social care

Other outcomes of the SPA and Integrated Services include:

- Reduced duplication of referrals
- Evidence of reduced unplanned admissions
- Each service within the new Framework has defined pathways, standards and outcomes.
- Patients receive a rapid response service by health and social care
- Care coordinators are identifying patients who are at high risk and require case management
- More patients are case managed with a clear criteria for responsibility whether Social care or Health.
- Weekly or fortnightly integrated team meetings are held within each GP practice to discuss patients
- Patients are risk stratified within each practice using various information sources including the RISC tool and proactively managed
- Toolkit for referrers written to increase knowledge and awareness of services available.

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