

#### Integrated, personal and sustainable



# **Community Services**

# Building on strengths

- ✓ Clinical, professional and care staff commitment
- **✓ Extensive community support**
- ✓ Work of leagues of friends and volunteers
- ✓ Progression to integration of health and social care
- ✓ New and innovative projects already in place



#### A view to the future

Six priorities built from engagement

Integrate care
Personalise support
Co-ordinate pathways
Think carer, think family
Home as the first choice

I want healthcare that does not stop at the boundaries

See me as a person not a condition

Carers are vital

# Context for change

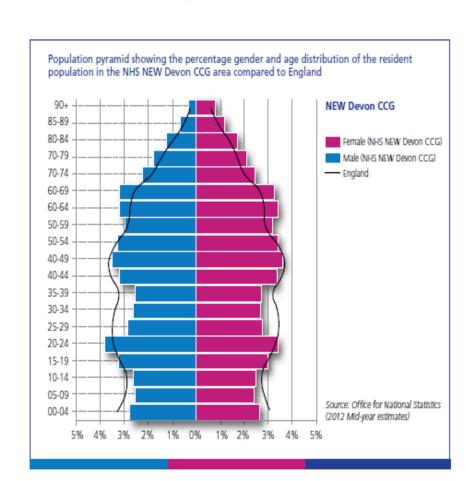
Population is getting older

**Greater complexity of needs** 

Out of hospital care is achievable

**Sustainable services important** 

People and policy signal change



#### Preventive and personalised support

**Hubs for health and wellbeing** 

Personalised care planning

Personal health budgets

Pro-active care for high level needs/risk

**Technology and communities** 



'We need pathways that start and finish with wellness'

### Pathways for complex needs

Out of hospital model of care

Clinically –led multidisciplinary pathway teams

Enhance small number of community hospitals

Co-ordination, consistency and links to wider expertise



'See me as a person – not a condition'

## Urgent care in the community

Clear, simple, easy to use urgent care

Uses early support when possible e.g. 111

Urgent care centres replacing current MIU model

Links to primary care services and wider networks



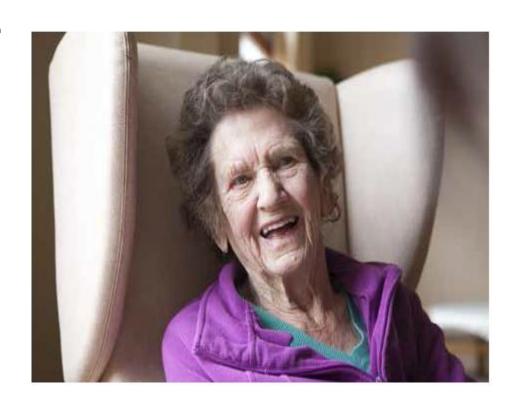
'I want healthcare that does not stop at the boundaries'

# Community specialty services

Co –production to get future design right

Model for low volume and specialty community provision

**Emphasis on health and wellbeing** 



# **Underpinned by Integration Principles**

#### In a safe and warm home

I can expect my services to be based on the best available evidence to achieve the best outcomes for me

l experience joined up and seemiess care - across organisational and team boundaries

I receive high quality services that meet my needs, fit around my circumstances and keep me safe

> I know what resources are available for my care and support, and I can determine how they are used

In a safe and supportive community

I will take responsibility to stay well and independent as long as possible in my community



I tell my story once and I always know who is co-ordinating my care

I can plan my own care with people who work together to understand me and my family

> The team supporting me allow me control and bring services together for outcomes important to me

I can get help at an early stage to avoid a crisis at a later time

With access to education and employment

I have the information and the help I need to use it to make decisions about my care and support

# Next steps

- Views gathered until 8<sup>th</sup> July 2014
- Governing Body discuss on 16<sup>th</sup> July 2014
- Further more detailed engagement in period until Sept 2014