Not in Hospital Strategy

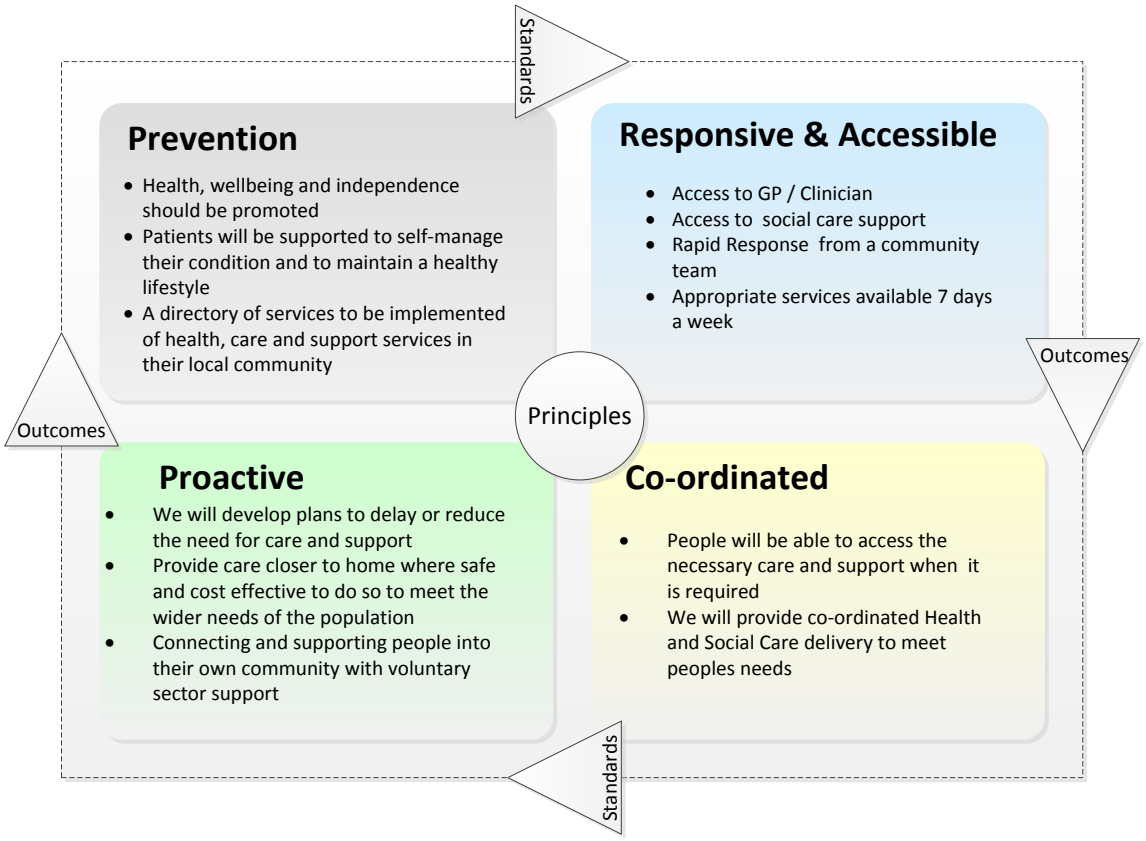
Joined up community health and care enabling people to live longer, healthier lives.

The Not in Hospital programme aims to develop and implement models of care which ensure the sustainability of primary and community care now and in the future. To deliver high quality care which is person centred, irrespective of organisational boundaries. People will receive continuity of care that is effectively co-ordinated and delivered where possible close to home.

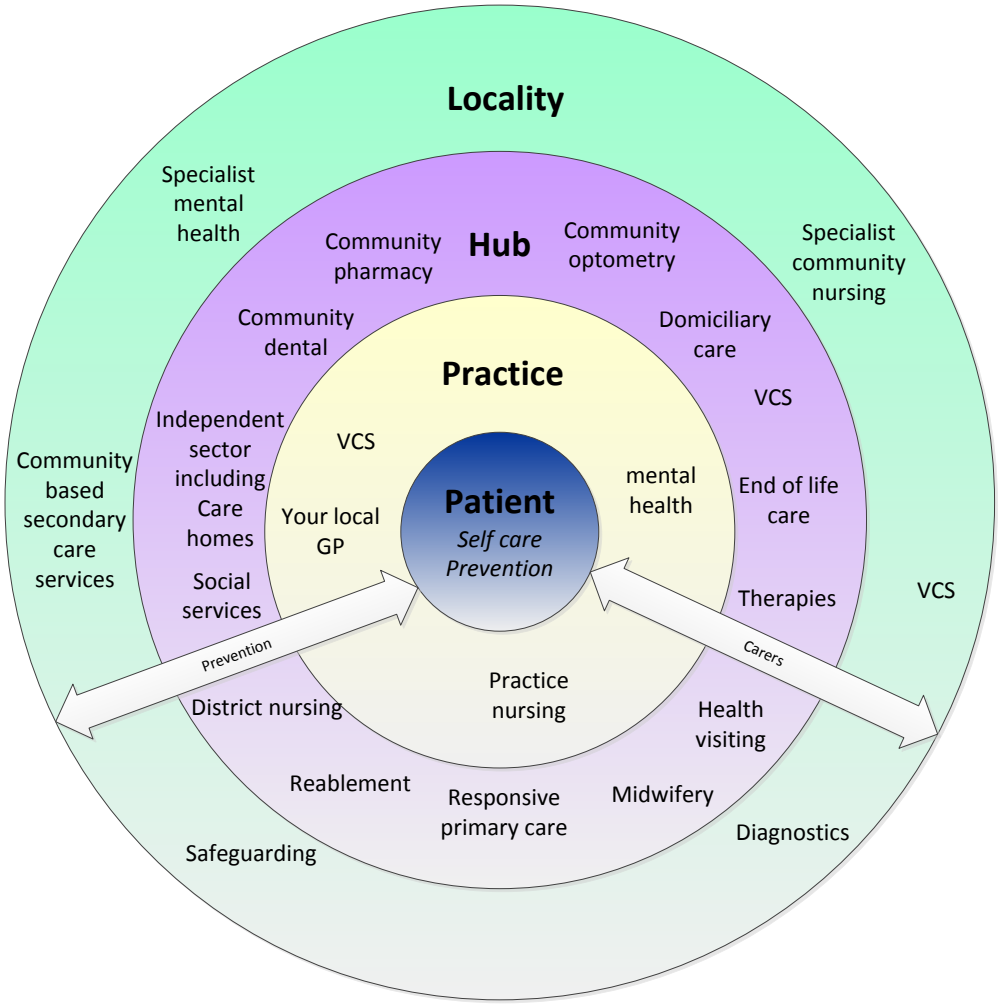
Stakeholders across the Better Health geography have developed a set of quality standards which set out the ambition of the Not in Hospital workstream to deliver person-centred outcomes based on four key principles;

- Prevention
- Proactive care
- Responsive and accessible care
- Co-ordinated approach

Not in Hospital Principles



Not in Hospital Model of Care



VCS – Voluntary Community Sector

Enablers

Integration will enable the delivery of the not in hospital model and will feature as an overarching principle of the work programme. The following are the key issues which need to be delivered in an integrated way;

<u>Workforce</u>

- To deliver the NiH model of care we need a workforce which has an enhanced set of skills, delivered in a different environment and that promotes a different philosophy and culture

<u>Estates and Informatics</u>

- Information sharing and access to support person centred care

- Make best use of shared estates to support the Not in Hospital model of care

Interface

- The Not in Hospital workstream needs to ensure alignment with the models of care within the 'in-hospital' programme and across the system

Outcomes

The Not in Hospital programme has developed a range of outcomes which can be categorised into two elements; person centred and system outcomes.

Person centred outcomes focus on:

- I will get quick access to my primary and community care team
- I will feel well informed about how to lead a healthy lifestyle and feel supported to manage my own condition
- I will have the information and support I need to be as independent as possible with someone available to navigate my care
- If I need to go to hospital I will be supported to be discharged as soon as possible and receive the appropriate support in the community
- I know that I will only need to tell my story once and people will have access to this information
- I will only be admitted into hospital or a care setting when it's absolutely necessary

System outcomes include:

- Improved range of Not in Hospital Services, that provide earlier intervention, better coordinated care, improved community services and hospital stays.
- Supporting patients at home to have improved patient outcomes, satisfaction and provide better value for the public pound.
- Reduced variation in access to care and the quality of care.
- Reduced bed usage across all acute hospital sites within Durham, Darlington and Tees Valley
- Appropriate length of stay in all care settings.
- Timely and well supported discharge across the system.
- Increased number of people supported to live at home longer.
- Resilient and sustainable health and care services.
- Improved support available to family and carers providing Care Closer to Home.