Surrey Downs Health and Care

SDHC is a partnership between local health and care organisations to deliver a new care model for the people within Surrey Downs

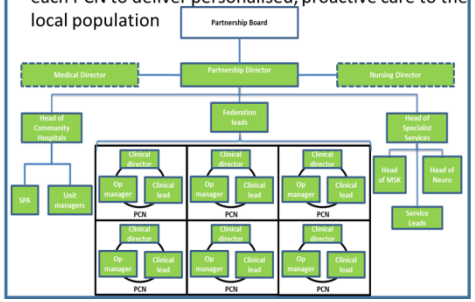
- ✓ Breaking down organisational barriers
- ✓ Providing care that is wrapped around the patient
- ✓ A partnership board representing all partners
- ✓ Consensus decision making

SDHC Governance

- Six partner members with voting rights – *one vote per partner* – unanimous decision-making
- Decision-making is delegated from parent boards
- Bound together by a legally binding agreement and risk sharing arrangements

Org. structure puts PCNs as the heart of our model

- 6 PCNs have been established each led by triumvirate consisting of a Clinical Director, Op Manager and Clinical Lead.
- Community and therapy services are wrapped around each PCN to deliver personalised, proactive care to the local population



The Way we Work

SDHC is not just about bringing services together, it's about holding shared values and changing the way we work to improve the care we provide

- A 'One-Team' ethos underpins our way of working to ensure we deliver care wrapped around the patient – not the organisation
- We believe staff and service users are best placed to advise how care should be delivered and are therefore heavily involved in co-designing pathways and models of care
- We are developing a staff council to continue to shaping the organisations culture ,ways of working and our values

What we've done: The @home Service

Over the last three years, the programme has developed the @home service- integrating care services for local residents 65+

- 'One-Team' principles have brought together GPs, reablement, Community Matrons, nurses, therapists and social workers spanning the acute and community supporting patients live as independently as possible
- The **enhanced@home** arm of the service provide support to patients in their home as an alternative to an inpatient stay. Where admissions are unavoidable the team support patients home early from the hospital ward in the acute.
- The **hub@home** arm provides proactive care planning and coordination and further support for up to 12 weeks.

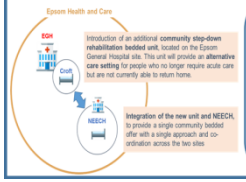
Integrated Stroke Service & Croft Community

New services have been developed built on the core principles of integration.

Integrated Centre For Stroke

The Epsom Health and Care: Centre for Stroke bring together existing services into a single integrated service supported by Surrey County Council Adult Social Services.

- The hyper-acute stroke unit, the acute stroke unit and the TIA Service that were previously provided by Epsom and St Helier University NHS Trust
- The in-patient stroke rehabilitation service previously provided by CSH Surrey
- The Community Neuro Rehabilitation Team including the Early Supported Discharge Service

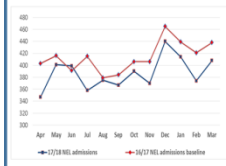


Integrated Bedded Provision

- Introduction of a **community step-down rehabilitation bedded** unit on the Epsom Hospital site.
- **Align with NEECH** providing a single community bedded offer with a single approach and co-ordination across the two sites

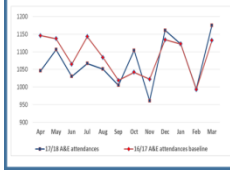
What we've achieved: @Home

The @home are supporting more people in the community, delivering a 6% reduction in overnight admissions and supporting 1 ward of patients in home.



People are receiving care in the right setting...

- **Over 6% reduction in overnight NEL admission for the last 3 years**
- Set against a backdrop of year on year NEL increase



More people have been receiving better care, at home...

- On average 3 patients remain at home and 2 brought home sooner each day
- Equivalent to 1 **ward** of patient being actively looked after at home
- Over **3000 patients** have been cared for in the community by the integrated team

What we've achieved: Integrated Stroke

The integrated Stroke service has improved the quality of care provided to Surrey gaining a SSNAP score of A and reducing LoS by over a day.

For Further Information please contact - Markku Slattery Deputy Director Integrated Care - Markku.Slattery@nhs.net