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यह दस्तावेज़ अनुरोध किए जाने पर अन्य भाषाओं और प्रारूपों में उपलब्ध है।

ਇਹ ਦਸਤਾਵੇਜ਼ ਬੇਨਤੀ ਕੀਤੇ ਜਾਣ ਤੇ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਅਤੇ ਰੂਪਾਂ ਵਿੱਚ ਉਪਲਬਧ ਹੈ।

در صورت در خواست این سند به زبانها و شکلهای مختلف در اختیار شما قرار می گیرد.

یہ دستاویز دیگر زبانوں اور مطلوبہ شکلوں (فارمیٹ) میں بھی دستیاب ہے

ذه الوثيقة متاحة بلغات اخرى وباشكال غير الكتابة المقروءة وذلك عند الطلب

Team Name
Address

NH586

www.nottinghamshirehealthcare.nhs.uk

May 2015

better+together
Shaping health and care in Mid-Nottinghamshire

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Mansfield and Ashfield Integrated Care Teams
County Health Partnerships

Patient information leaflet

Better Health Starts Here!

We provide care to:

- People age 18 and over
- Who are registered with a GP across Mansfield & Ashfield
- Who have a long term condition *
- Who are frail or elderly and housebound
- Who are at risk of a hospital admission
- Who are at risk of deterioration

*A long term condition is a health condition that cannot be cured but can be managed with therapy and/or medication.

positive
about integrated healthcare

Introduction

Mansfield and Ashfield Adult Community Services have changed the way they deliver care locally through the introduction of five integrated care teams across the area.

Vantage
Rosewood
Hardwick
Ashwood
JAKS

Each team brings together physical and mental health, social care and the voluntary sector making better use of the skills and resources across Mansfield and Ashfield, and working together to support people's needs.

The teams provide high quality clinical care which supports recovery, eases pain, limits deterioration and encourages self management.

Integrated care teams and what this means for you?

As an integrated care team we will work closely with your GP to give you coordinated care and support which is tailored to your individual needs.

We have brought together services previously provided by district nursing, community matrons, community therapy, community nursing and mental health and social care professionals. Each team is supported by a number of services from Mansfield and Ashfield that provide specialist knowledge or clinic based services.

This integrated approach to patient care also works in partnership with the voluntary sector to meet the extended needs of the people of Mansfield and Ashfield.

Concerns, Comments, Compliments or Complaints

We are constantly reviewing are services to ensure we offer the highest quality of care to our patients. Your feedback is very important to us and will enable us to develop, shape and improve our services to patients' needs. If you have any comments you would like to share regarding your experiences and care please complete your patient feedback card or leave a patient story online at www.patient.opinion.org.uk. You can also leave a comment on the Trust's feedback website www.feedback.nottinghamshirehealthcare.nhs.uk.

Alternatively please contact 01623 673849.

Notes

How can I get in touch with the service if I need help or advice between visits or out of hours?

If you have any worries or concerns you can call our single point of access telephone number below.

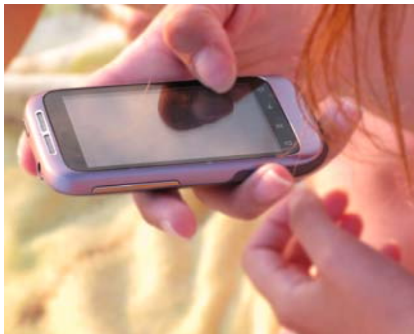
Single Point of Access (SPA): 0300 456 4951

Please talk to any member of the team if you would like any more information about our service and how we care for you.

How technology is developing to improve your care

The internet and mobile phone technology are increasingly playing an important role across the NHS and social care. This will help people with complex conditions to interact with health professionals so they can confidently manage their own symptoms using text messages and online communications.

Florence (Flo) Simple Telehealth service



Flo is a simple telehealth free text messaging service that helps you take a more active role in your health care. Flo can give personalised health tips, provide valuable advice to help you stay on track and send medication reminders. It is quick to set up and easy to use. For more information on this service please speak to your health professional.

The Team

Working with your GP each team of healthcare professionals delivers personalised care for *You*.

Key Worker; you will be assigned a key worker who will have the skills relevant to your personal health needs. The key worker will spend time with you and your carer and/or family to plan your care.

Your key worker will support you if you are at risk of an admission to hospital and will coordinate your care, helping you to remain in your home. If you do need to go to hospital, they will also work with the ward team to help you home as soon as your discharge date has been agreed.

District Nurse; if you have just been discharged from hospital you may be supported by a district nurse. The district nurse will also lead your care if you have complex needs, require support to manage a long term condition, have a disability, are frail, or at the end of life.

Practice Nurse; if you are able to access your GP practice, your practice nurse will support you following a hospital stay or help you manage a long term condition.

Community Matrons and Specialist Nurses will help you to live well with a long term condition. They will work with you to identify and manage triggers that make you feel unwell. They will also help you to plan your personal health goals so that you can build confidence and independence as you live with your condition.

Community Nursing, Healthcare Assistants, Intermediate and Falls Care will support all members of the team to provide timely care including ongoing assessment and physical examinations.

A Physiotherapist or **Occupational Therapist** will provide assessment, advice and physical management to help you to remain as independent as possible.

Clinical Nurse Specialist in end of life care/palliative care will provide specialist care if you have been diagnosed with a progressive advanced disease.

A **Social Worker** will assist if you experience issues that effect your independence and will provide solutions to help you to remain within your community.

A Mental Health Worker will provide opportunities to receive brief interventions and self help advice to manage common mental health issues.

Self Care Advisors create a link into the voluntary sector and can help you identify resources from local agencies and organisations that may help you remain independent and active within your local community.

How can you access the integrated care team?

If your GP thinks you would benefit from additional health or social care support, he or she will contact the relevant team and we will then arrange to visit you at home.

Important information

What if I need support from other healthcare services?

Your integrated team works with a wide range of other Mansfield and Ashfield community based services and the Consultants, Doctors and Nurses at King's Mill Hospital, Newark Hospital and Lincoln Hospital. If we think you need further specialist care we will refer you.

Mansfield and Ashfield residents also have access to a wide range of additional specialist services such as; podiatry, stroke/ neurology rehabilitation, specialist continence and wound care and diabetes expertise.

What are my responsibilities as a service user?

- Please ensure that the nurse can gain safe entry into your home. Health Partnerships operates a zero tolerance towards both physically and verbally aggressive behaviour by a patient or carer/relative. As a consequence of such behaviour your treatment may be discontinued.
- Please ensure that any pets are secured in a different room to ensure safe care delivery.
- A non-smoking environment is expected whilst a member of the team is visiting your home.

Please note that the professional does not carry any medical or dressing supplies. It is your responsibility to arrange collection and delivery of any items that may be required for your treatment. It is your choice which pharmacy you wish to use. If you are struggling to find a pharmacy out of hours, please telephone 0300 456 4951. If you are discharged from the hospital the appropriate treatment items should be sent with you on discharge.