TRAFFORD COUNCIL

Integrated Care in Trafford

Deborah Brownlee, Corporate Director
Joanne Willmott, Director of Operations
Children, Families and Wellbeing
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Introduction

- Case for change
- Greater Manchester picture
- Trafford overview
- Integrated care – benefits
- Customer stories
- Trafford Health and Social Care Service

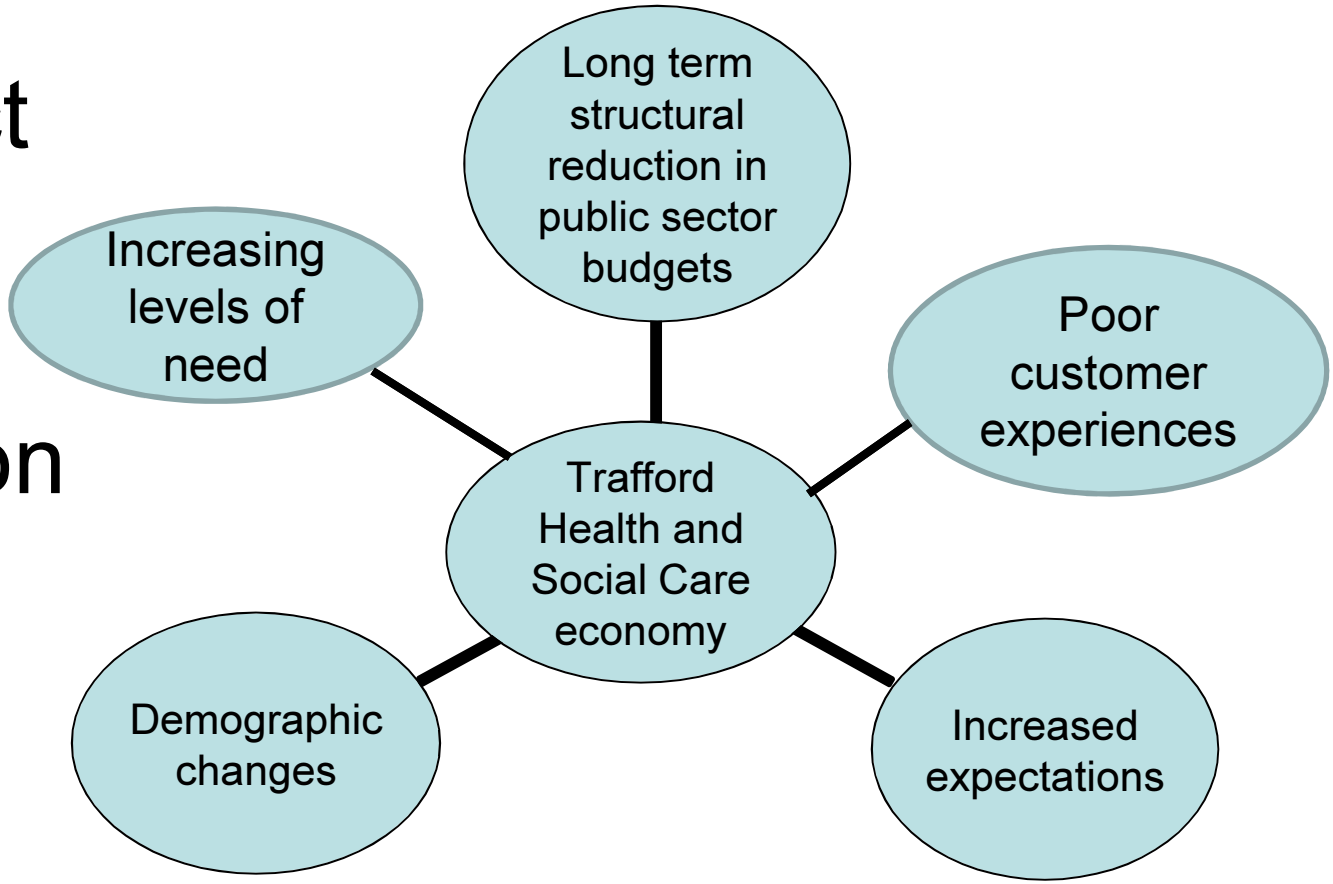
The Case for Change

"People don't want health care or social care, they just want the best care. Integration is a vital step in creating a truly joined-up system that puts people first. Unless we change the way we work, the NHS and care system is heading for a crisis".

Minister of State for Care Services, Norman Lamb

The Case for Change

"The Perfect Storm" Increasing Pressures on Decreasing Budgets



Greater Manchester Picture

- AGMA and Association of Clinical Commissioning Groups leading Integrated Care Programme. 10 local models within overarching Greater Manchester vision
- Aligned to Public Services Reform agenda
- Aligned to developing Healthier Together Programme

Trafford Health and Social Care Economy

- Worked closely with Trafford Clinical Commissioning Group to develop a joint integrated care vision and action plan
- Operational integration between Adult Social Care and Pennine Care, based on integrated neighbourhood teams and enhanced reablement
- Creation of Trafford Health and Social Care service through deployment of Adult Social Care staff into Pennine Care – mirror image of Children and Young People Service

What Integrated Care Means:

- Right care, in right place by right people
- Support for self care and independence
- Accessible and responsive services
- Quick community based response to urgent care needs
- Appropriate hospital care when required
- Services working together to deliver seamless and compassionate care through effective collaboration

What Integrated Care delivers

- Better health and social care outcomes for customers
- Better customer experience – telling story once, treated as an individual and supported in a holistic way
- Efficiencies across the health and social care system, building resilience and management of ever increasing demand

Integrated Care for Mrs Trafford

Mrs Trafford lives by herself in Gorse Hill, she is 84, has COPD and poor mobility

Enhanced reablement work with Mrs T to develop her daily living skills and reconnect her with her local community

North integrated team provide care co ordination , ensuring any changes in Mrs T's needs are responded to quickly

When Mrs T is acutely ill, for example has a severe chest infection, the urgent care team provide 72 hours of nursing and social care support at home

Following a fall Mrs T receives integrated health and social care rehabilitation at Ascot House to support her to return home

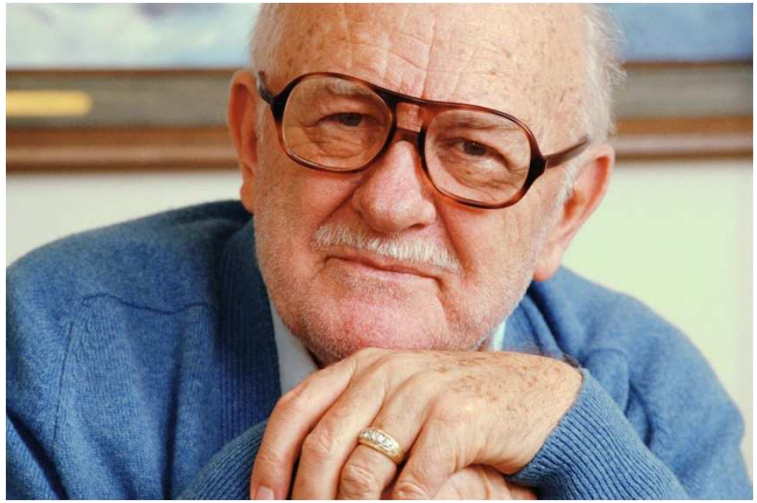
Ascot House

Right CARE
Right TIME
Right PLACE

- Integrated health and social care assessment unit
- Opened an additional 8 dedicated health beds for intermediate care in addition to 20 social care beds
- Weekly Geriatrician consultant on site clinics, improved Community Matron and District Nurse support and extensive therapy interventions for all residents.
- A wide range of Pennine Care Services have office space within Ascot, improving partnership working and offsetting Council costs.

Mr Timperley

Right CARE
Right TIME
Right PLACE



- Mr Timperley is 80
- Mr Timperley admitted to Ascot House for 6 week assessment, requiring maximum support in all areas of daily living.
- Mr Timperley was determined to return home and worked with a range of health and social care staff, including Physiotherapists, Occupational Therapists and reablement workers to improve his mobility.
- The social care assessor arranged a package of care and Telecare equipment including falls detector, bed sensor, pendent alarm and key safe.

Mr Timperley

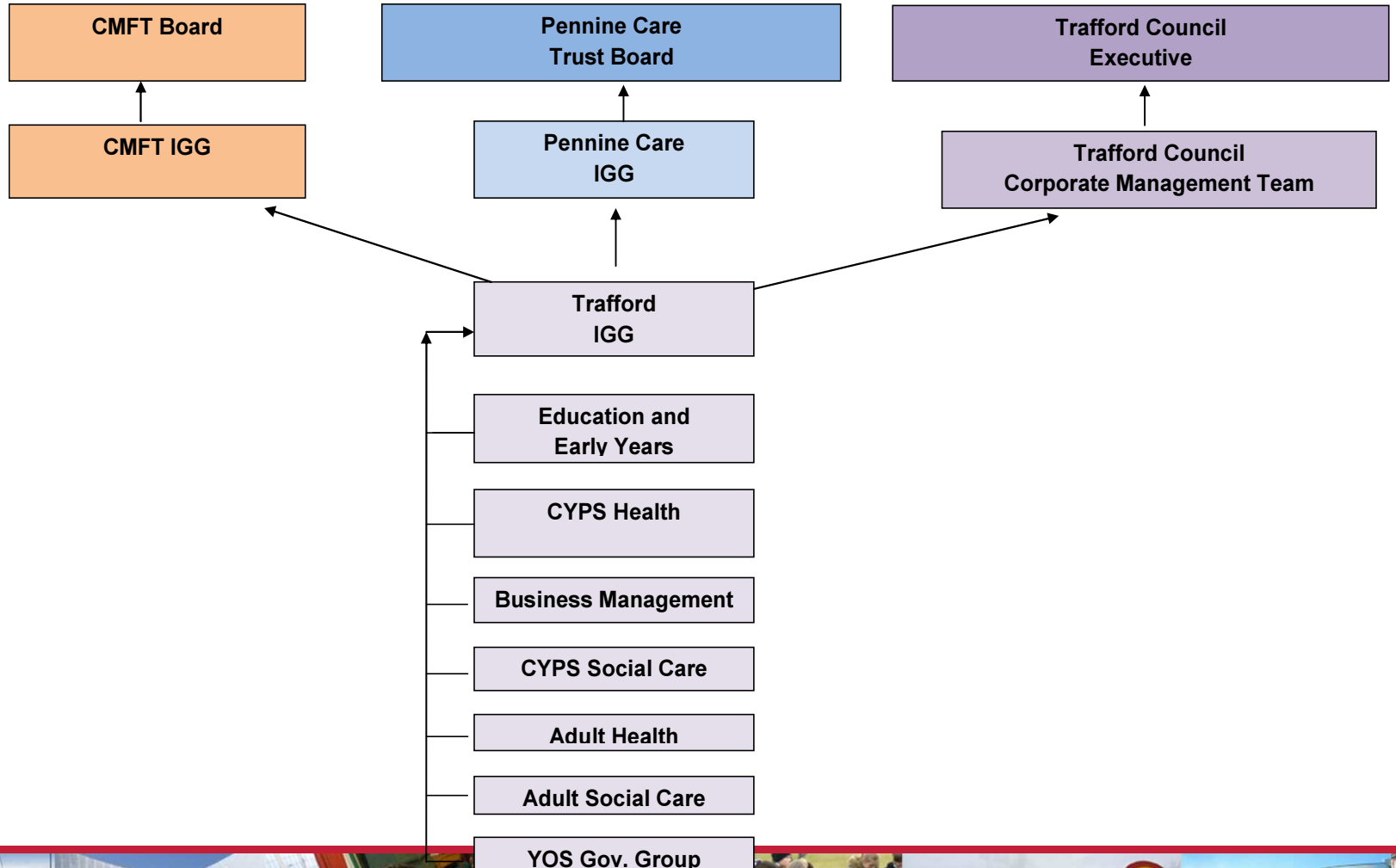
Right CARE
Right TIME
Right PLACE

- Due to the progress he made and the improvement in his confidence and mobility Mr Timperley was able to return home after four weeks.

Trafford Progress Update

- Building on integrated CYPS, Mental health and Learning Disability Services
- Signed Partnership Agreement with Pennine Care
- Integrated health and social care reablement and assessment at Ascot House
- Major Adaptations integrated into One Stop Resource Centre
- Urgent Care Team recruited and based at Ascot House, clear pathways in relation to social care

Governance Model



Integrated Management Structure

Corporate Director CFW

Director of Operations Pennine Care

- Deputy Director - Service Development, Adult and Community services
- Director of Service Development, Children, Family and Education
- Director of Public Health
- Joint Director Children, Families and Social Care
- Joint Director Children, Families and Health
- Joint Director Adults' social care
- Joint Director Adults' Community Health

Commissioners

Providers

Employed by Pennine Care

Trafford Model for Integrated Adult Service

Single Point of Access
Easy access for customers, delivering simple and straightforward customer journey

Ambulatory and Borough Wide Care
Clinics - keep people healthy and well in the community. Services like healthy hearts exercise classes and family planning clinics
Specialist Support such as learning disability supported network

Neighbourhood teams
Support people in the community, teams understand their local area, know local people and keep them healthy and well

- Central
- South
- North
- West

Include people like:
District Nurses
Brokers
Community Social Workers
Reablement workers
Occupational therapists
Physiotherapists

Admission Avoidance
Keep people out of hospital, help people to leave hospital as soon as they are well
People like
Hospital Social workers
Urgent care Team
(nurse people at home)

Next Steps

- Finalising structure
- Development of integrated neighbourhood teams
- Shared learning and development
- Development of detailed processes and systems
- Work with CCG re risk stratification and GP alignment