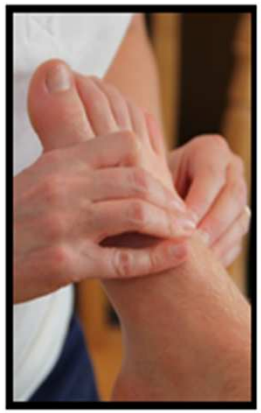
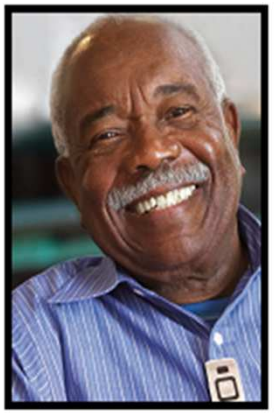
TRAFFORD COUNCIL

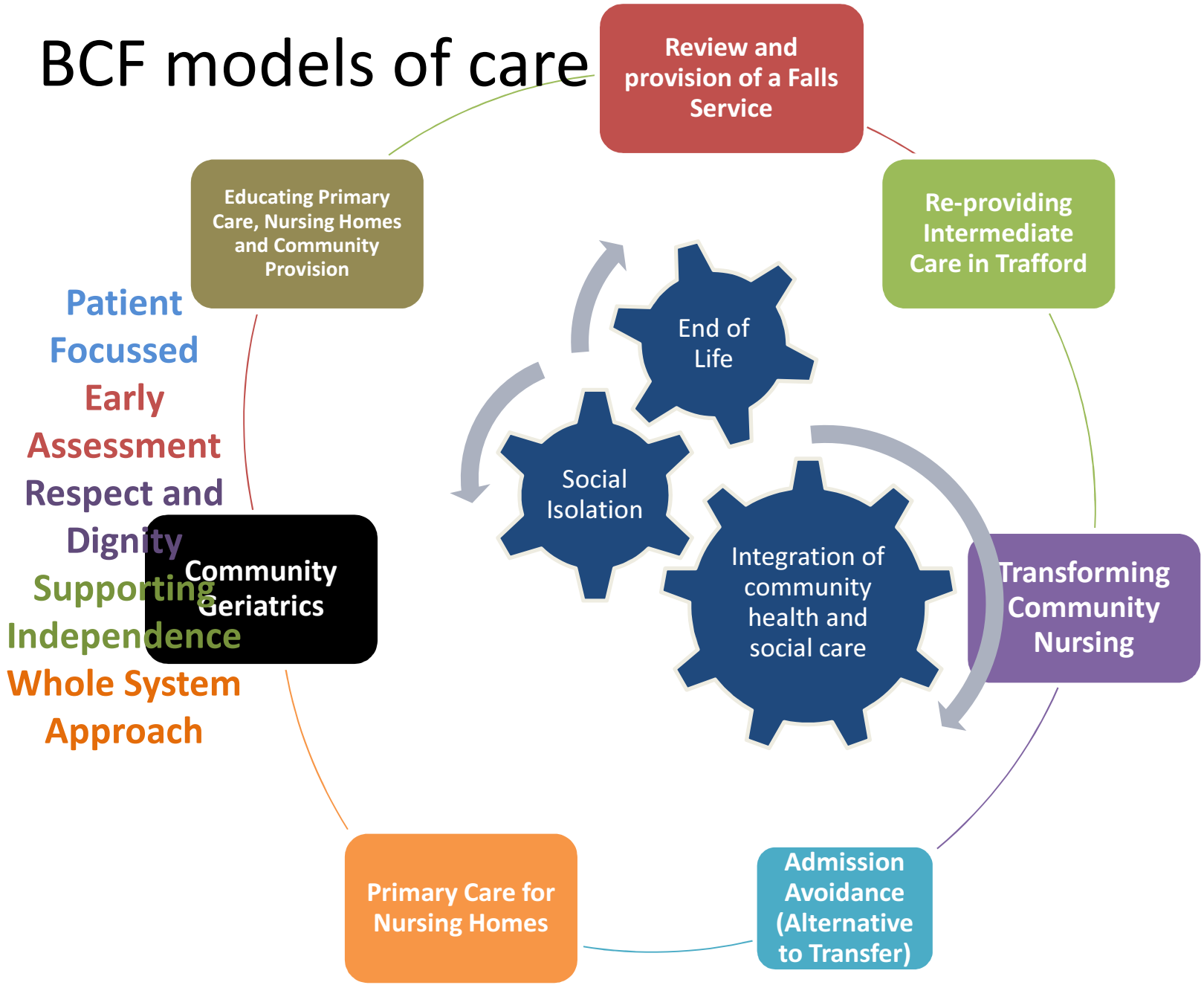
Health Scrutiny
Adult Health and Social care Integration

16TH December 2015

BCF models of care



Primary care

4 Neighbourhood model

- Primary care working with the integrated teams
- Access 7 days a week (primary care and community services)
- Working differently – federation
- Service to support residential and nursing home residents

Primary care

New estate

- Modern buildings / technology
- All services located together
- Improved patient experience
- Supported by Trafford Care Co-ordination centre - out reach of TCCC

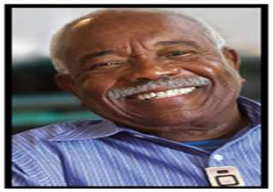
Alternative to transfer

Reactive to patients needs

- For all patients
- For residents of nursing and residential homes







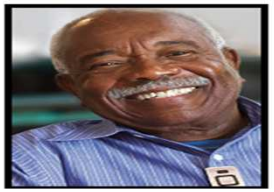
Community nursing review

New Service model

- Health and social care
- Reduce duplication
- Prevention – flu etc.
- Assessment, signposting , treat
- Work with TCCC
- Phase 1 community nursing, specialist , enhanced community service







Integrated care(adults)update

- Locality teams in place for support for adults
- Joint Heads of service and operational leads
- New models of care
  - Intermediate care
  - Reablement
  - Home from hospital
  - Proactive care plans to prevent admission
  - Links to TCCC development

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Pennine Care NHS
NHS Foundation Trust

Trafford division neighbourhood teams

Neighbourhood Team North

Head of Service Gaynor Burton
Operations Managers:
Tina Beaumont (social) and Alison Collins (health)

Core team*
Ear Care team
Discharge team (Manchester Royal Infirmary)

Neighbourhood Team South

Head of Service: Debbie Walsh
Operations Managers:
Sue Read (social) and Carol Harratt (health)

Core team*
Out of hours nursing service
Community Enhanced Care (CEC) service
Bladder and bowel service
Discharge team (University Hospital South Manchester)

Core Access Service

Head of Service: Chris Warner
Operations Managers:
Chris O'Grady (social) and Hayley Jones (health)

Phlebotomy
Safeguarding (health & social care)
Infection control
Health Single Point of Access (including clinical triage)
One Stop Resource Centre
Equipment team
Screening Team
Early discharge team
Macmillan Centre
Mobility Officers Sensory/equipment
Reablement (responsible officer)
Ascot house – Intermediate Care beds
Direct payment service management
Welfare benefits
Supported living
Day services

Neighbourhood Team West

Head of Service: Fiona O'Shea
Operations Managers:
Chris Lomas (social) and Debra Maloney (health)

Core team*
Community Neuro Rehab/Parkinson's disease/Stroke teams
Specialist Weight Management Service
Dietetics team
Speech and Language Therapy
Pulmonary Rehabilitation
Out Patients Rehabilitation
Discharge team (Trafford General Hospital & Salford Royal)

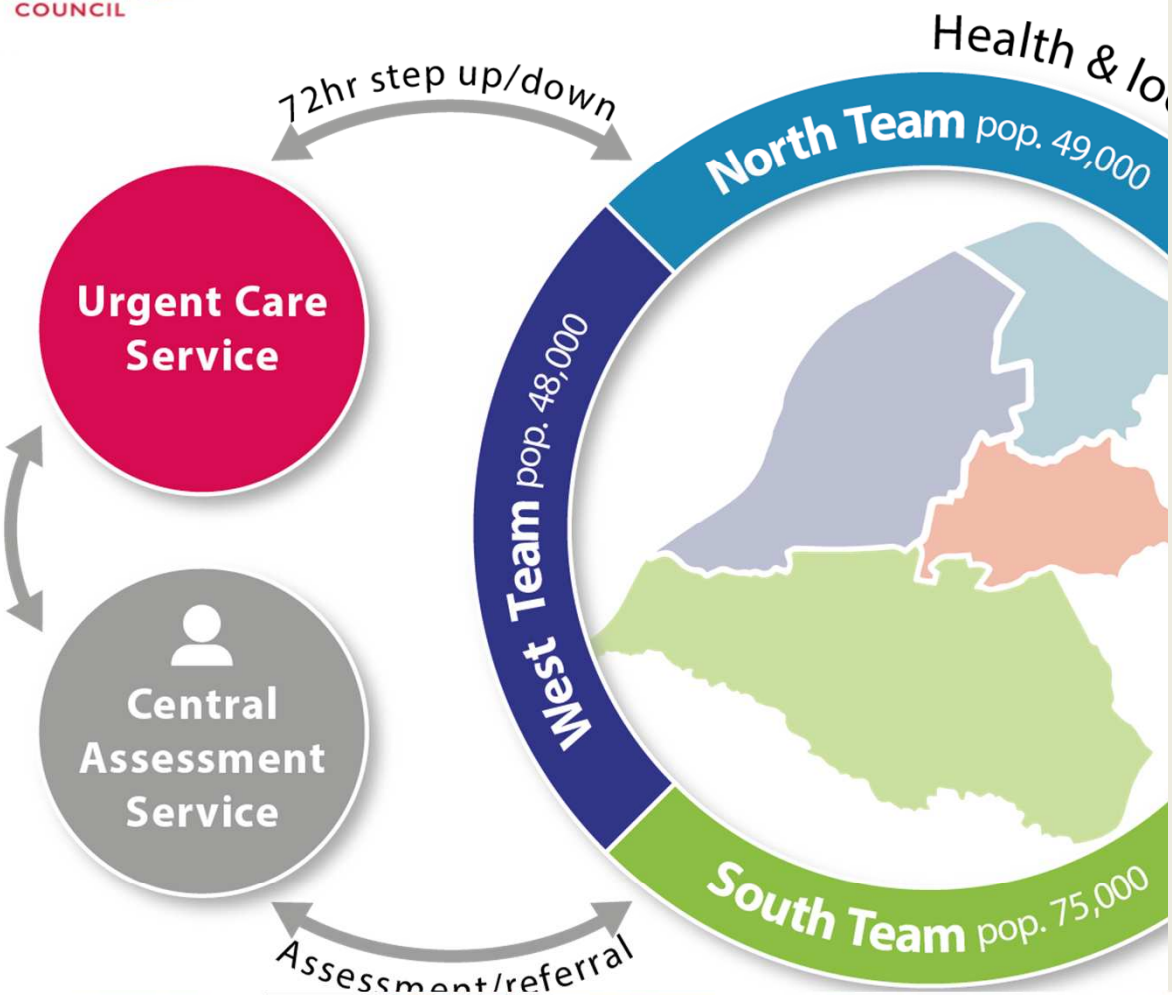
Neighbourhood Team Central

Head of Service: Allan Tronconi
Operations Managers:
Nick Edwards - interim (social) and Jennifer Sigley (health)

Core team*
Leg ulcer clinics
Musculoskeletal service
Women's Health Physiotherapy Service
Podiatry service
Treatment room
Tissue Viability team

*CORE TEAM – in each neighbourhood, there will be staff from the following service teams: District Nursing, Specialist Palliative Care, Occupational Therapy/Physiotherapy, Senior Practitioner, Support Workers, Social Care Assessor, Reviewing Officers, Direct Payment Brokers, Social Workers, Reablement

Adult IHSC model-

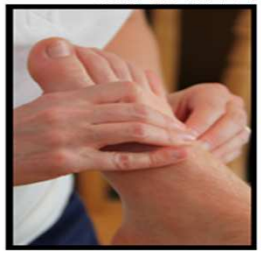


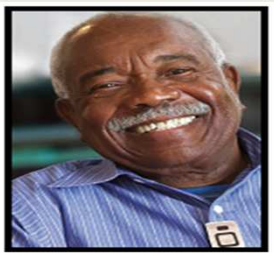
Neighbourhood Teams:

- GPs
- Matrons
- District Nurses
- Reablement
- Social workers
- Commissioning of care packages
- Review /reassessment functions
- OT/Physio
- Social care assessors
- Hospital teams

Central Assessment Service:

- Rapid response
- EDT
- Urgent Care
- Single Point of Access

Assessment pathways

Refocusing the offer in Trafford

•*We will provide a more effective and appropriate reablement service by…*

- Developing a stabilise and make safe service (first three weeks)
- Streamlining care pathways ,systems and processes
- Implementing a new model for people with the greatest need utilising Trafford council reablement service
- Developing the home care market to enable people throughout their period of home care support be enabled further .
- Developed an intermediate care model at Ascot house
- Revising pathways of assessment and support for people leaving hospital
- Introducing a triage process in the hospital teams
- Educating the ward staff about social care and community health services

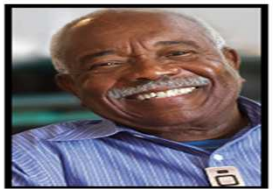
Stabilise & Make Safe

•*We will look to incentivise the market in different ways with a shared risk/reward approach by…*

- Establishing a clear plan at the outset of each intervention and the outcomes expected
- A new payment method for achieving the plan as the person starts to lead their independent life.
- Ensuring that the provider market responds to the additional care package requirements is incentivised to promote independence in the initial period of contact as people gain confidence .
- Support is intensive for 2 or 3 weeks.
- Two providers procured covering half the Borough each

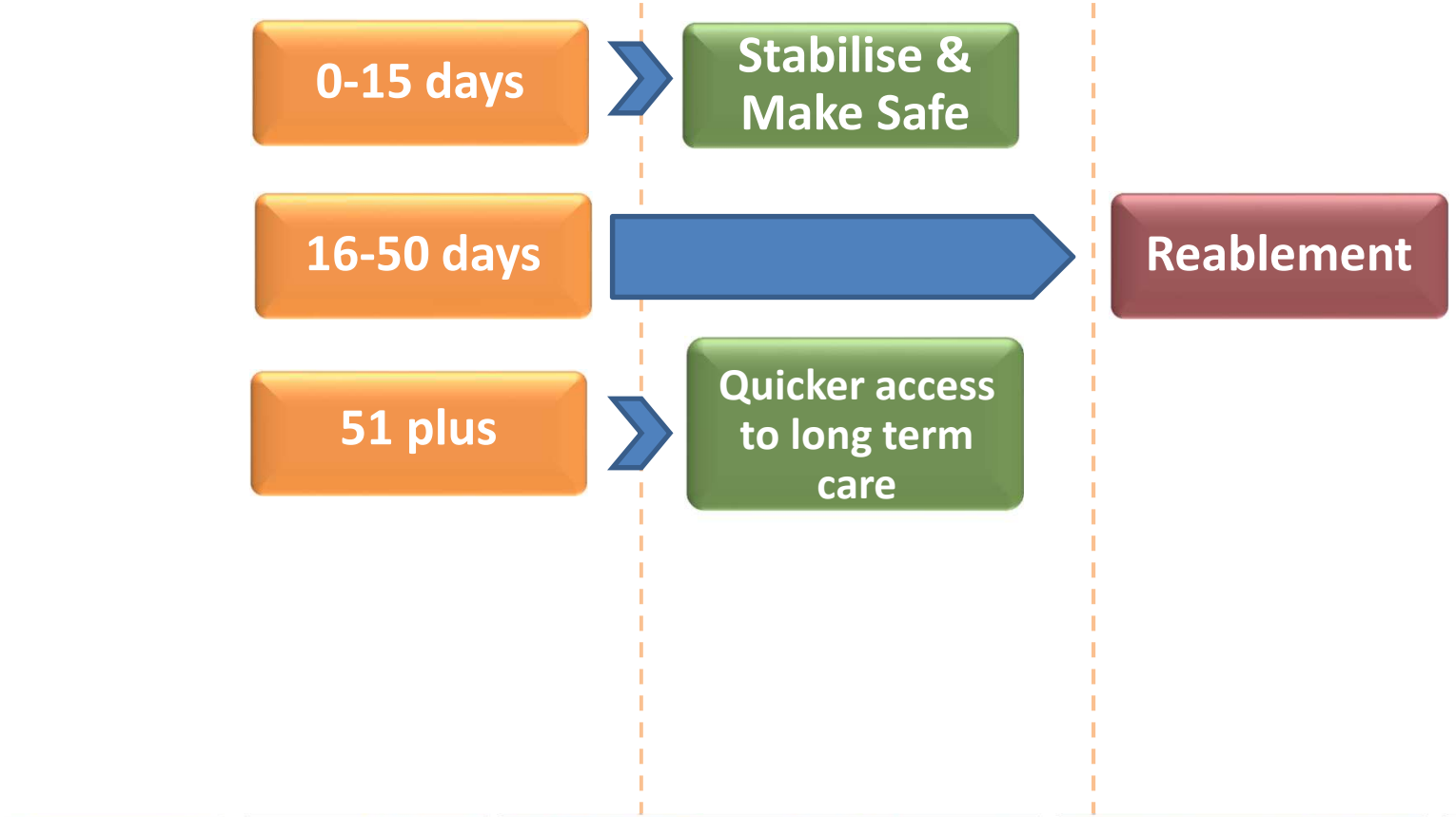






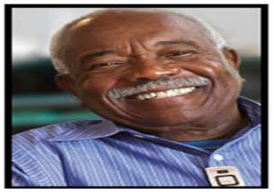
Reablement and ‘Stabilise & Make Safe’

Identify those who are likely to be in service for…









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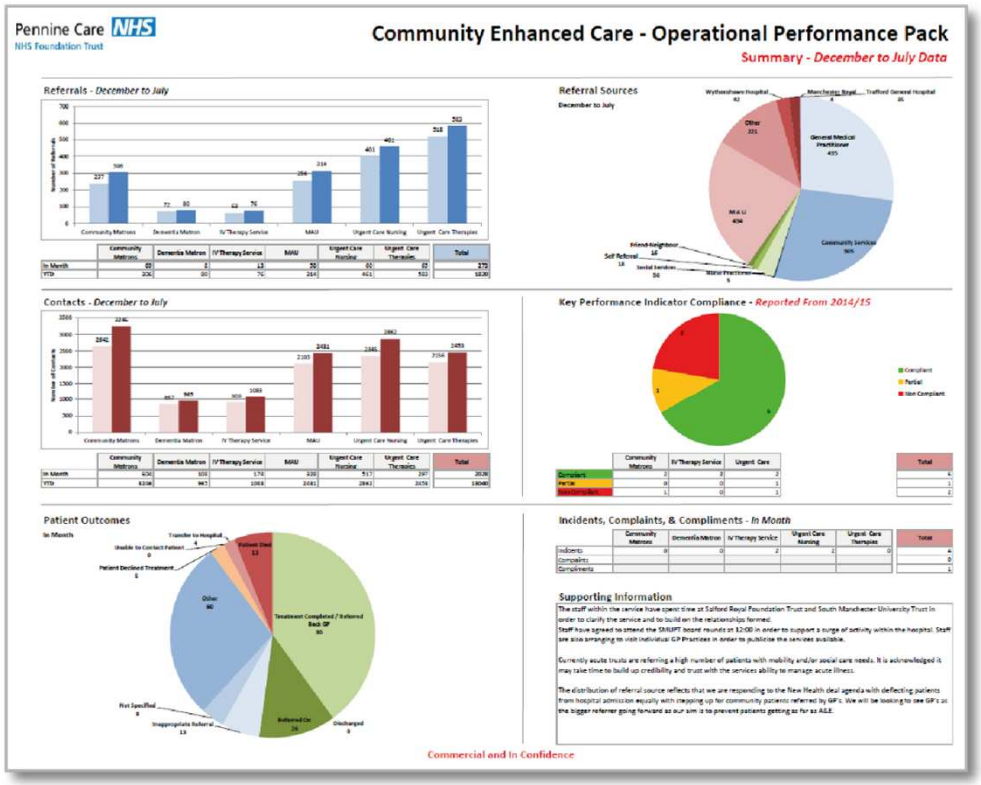
Community Enhanced Care



- Launched November 2013, designed to prevent unnecessary admissions to acute
- Critical to our integrated care offer
- Collaboration with commissioners for market insight
- Underpinned by shared data, designed around a seamless pathway
- It takes time and effort to achieve change – but we are beginning to see the results





Community Enhanced Nursing

Trafford Community Enhanced Care (CEC) aims to prevent avoidable hospital attendance or admission by providing an alternative for patients who are experiencing medical, health or social care crises.

There are two parts to the service:

- **Neighbourhood teams** to provide on-going management for patients with a long term condition, conditions associated with ageing, or patients with complex needs requiring holistic assessment.

- There are four neighbourhood teams that work the hours: 8am – 5pm, Monday – Friday and are based at –

South area - Broomfield Lane Clinic, Hale

Central area - Conway Road Medical Centre

North area - The Delamere Centre, Stretford

West area - Partington Health Centre

all provide on-going management for these patients

- **Urgent response team** for patients at risk of hospital admission without intervention based at Ascot House, Sale. This service runs 7 days per week, hours: 8am – midnight, on-call from midnight – 8am

Patients with long term conditions, acute Infections, conditions associated with ageing or patients with complex needs requiring holistic assessment

Community Enhanced Nursing

About the CEC service -

- The CEC service includes Matrons who are both Advanced Practitioners and non medical prescribers. They -
- Triage
- Assess
- Make a differential diagnosis
- Initiate investigations
- Commence a treatment plan, including prescribing where appropriate
- Provide a nursing care plan
- Evaluate the outcome of care and modify treatment as required

There is a range of nursing and therapy staff working across the CEC urgent response and neighbourhood teams, including those from:

- Rapid response
- Community Matrons
- I.V therapy
- Heart Failure Specialist
- Dementia Specialist Nursing
- Occupational and Physiotherapy (including chest physio)
- Medicines management
- Social care support for personal care, light meals and drinks