A joined up health and care community

Caroline Taylor-Director of Adult Social Services
Provide a Single Point of Access and Coordination

Encourage Self care, healthy lifestyles & maintain independence

Reactive care coordination of people with deteriorating complex health issues

Proactive care coordination of people with complex needs and frail elderly

Integrated medical management of people with complex co-morbidities

Discharge support from hospital to home

Falls prevention

Palliative care
Integrated Care Organisation—part of a health and care system

- Acute services
- Community services
- Social services
- £375m pool—risk share between 2 commissioners and ICO as integrated provider
- ICO can move resource quickly and dynamically to achieve outcomes
- Low lengths of stay, low DTOC, plus
Low residential care placements
Enablement and Management

**Dependent**
- **Urgent** e.g. A&E, EDS, CRT, Safeguarding

**Moderate dependence**
- e.g. planned care, in a safe place (e.g. wards or bed based)
- **SKILLED CARE AT HOME**
  - MDT, ABI, Intermediate Care

**Minimal dependence**
- e.g. Managed conditions / stable, e.g. PEER MENTORING – CONDITION AND IMPROVEMENT RECORDING/REPORTING
  - LTC AND CLINICAL CARE PLAN FULFILMENT

**Independent**
- **COMMUNITY NETWORKS**
- SELF MANAGEMENT & BEING A PEER SUPPORT AND EXPERT BY EXPERIENCE
- **RECIPIENTS & CONTRIBUTORS**
- RELEASE OF RESOURCE, ill-health prevention and wellness, housing, education

**Living Well@Home**
- INVESTMENT
- SKILLS, SYSTEMS & £££
**Cultural shift**

- From reactive to proactive
- From paternalistic model to focus on self management and well being
- From condition-specific to holistic
- From specialty/condition specific approach to a multi-skilled, cross-professional approach

**Result**

- Earlier identification and improved conditions management
- Patient is empowered to find own solutions
- Identify full range of patient needs and detect underlying issues
- Use workforce more flexibly and achieve pt outcomes in non-traditional ways, eg, guided conversations

**Outcomes/behaviour change**

- Reducing acuity/crisis
- Reducing demand on traditional health and social care services
- Reducing dependency upon statutory services
- Improving opportunity to return to ‘normal’ life following ill health
- Increasing management of complexity/acuity in the community
LMATS-Care Act- strengths based

• **Principles of Implementation**

• We have developed the following principles for the implementation of strengths based approaches:
  • We will empower staff to use their skills and experience
  • We will let go of care management approaches
  • We will focus on community involvement
  • We will concentrate on the assets and strengths of the people who use our services, our staff and our partners
LMATS (Local Multi Agency Teams)

- GPs as ‘holder’ of patient care with LMATs
- 5 day email advice from specialists-reduced ftf referrals by 30%
- Specialists outward facing and ‘upskilling’
- System benefit-cost and workforce benefit
- Patient benefit 5 day wait not 8 weeks
LTC (Long Term Conditions)

- Broad skills supported by specialist and coordinator
- Also diabetes 10% drop in referrals when demand is increasing
- Pre-assessment of Medical and social model
- Day surgery higher (increasing over in-bed acute stays)
- LTC reduced ftf referrals by 10%
A person with multiple long term conditions
Mr A is 72 and lives in Teignmouth
He has 4 LTCs – Atrial Fibrillation, Congestive Cardiac Failure, Chronic Kidney Disease and Type 2 Diabetes.

2014/15
Attended 3 separate consultant LTC clinics and saw 2 specialist nurses and 2 different dietitians
Total of 25 hospital appointments
Another 12 appointments at his GP’s surgery
Admitted twice to Torbay hospital for heart failure
He takes 14 medications
Lonely as he lives alone
Confused and doesn’t know what to do for the best.

Now
Attends new service in Teignmouth.
Has a ‘Well-being coordinator’ who has put him in touch with local voluntary services. Happier.
Sees one team - a doctor, nurse and a dietitian for all his problems. 6 appointments per year.
Better coordination - only 3 GP appointments needed.
Support from the heart failure team at home rather than admission
Understands his treatment now and has reduced to 9 medications.
Living Well@Home
(workforce...new solutions)

Royal College of Nursing – June 2014

47% drop in district nurses since 2003
35% of district nurses are over 50 years of age
37% amount of time spent on patient care

Do we need more nurses or more nursing activity? Physiotherapists or physiotherapy?
## LW@H – Partnership Solution

<table>
<thead>
<tr>
<th>Will provide -</th>
<th>Which means that -</th>
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<tbody>
<tr>
<td>Careers, £, care profile</td>
<td>Capacity - new cohort of care staff</td>
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<tr>
<td>Community development</td>
<td>Resource and contingency</td>
</tr>
<tr>
<td>Coordination</td>
<td>Efficiency and contingency</td>
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<tr>
<td>Recording and reporting</td>
<td>Value, cost reduction, early intervention</td>
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<tr>
<td>Safeguarding</td>
<td>Training, consistency, management, correlation,</td>
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<tr>
<td>Outcomes Based</td>
<td>Personalised, Wellbeing</td>
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<tr>
<td>Investment</td>
<td>Fund the changes, system investment, risk share</td>
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Aging better-prevention

• Combating social isolation
• Brokerage-SPACE and my support broker
For more information

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