Reducing demand for Care Services and decreasing non-elective admissions

Sue Reay (Transformation Team)

Katie Dixon (MDS Manager)

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catalyst Stockton-on-Tees

Tees, Esk and Wear Valleys NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Health and Wellbeing

Agenda

- Stockton-on-Tees – a bit about us
- Our Co-creation approach
- The MDS and how it works
- A couple of case studies
- Measured outcomes and benefits
- What next for our wider model of integration between Health and Social Care

Stockton-on-Tees

- Unitary Council in North East with a population of 194,119
- Unique social mix:
  - 28% live in top 20% least deprived
  - 28% live in top 20% most deprived
- 5 main town areas all with their own identities
- One CCG (covers 2 LA's)
- One Acute Trust
- One Mental Health Trust (much wider geography)
- Strong local services
- Strong public sector ethos

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BCF – Our Partners

- Our plans and solutions have been co-created with the involvement of all partners – including our 3P event (production – preparation – process)

Commissioning Partners	Delivery Partners
Stockton Borough Council	Stockton Borough Council
Hartlepool and Stockton-on-Tees CCG	Tees, Esk and Wear Valleys FT
	North Tees and Hartlepool FT
	VCSE - Catalyst

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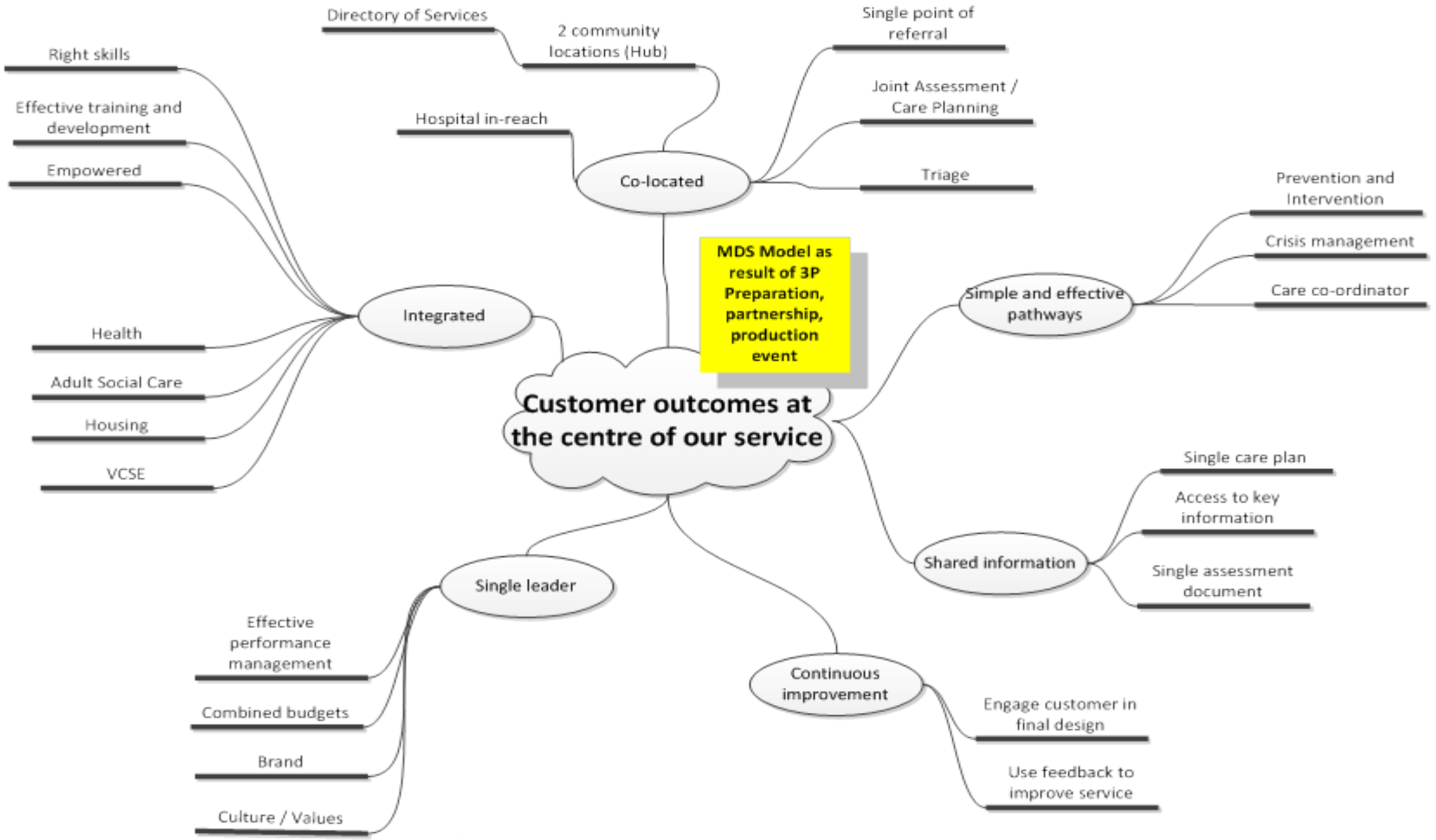
Working together to make it work



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NHS Foundation Trust

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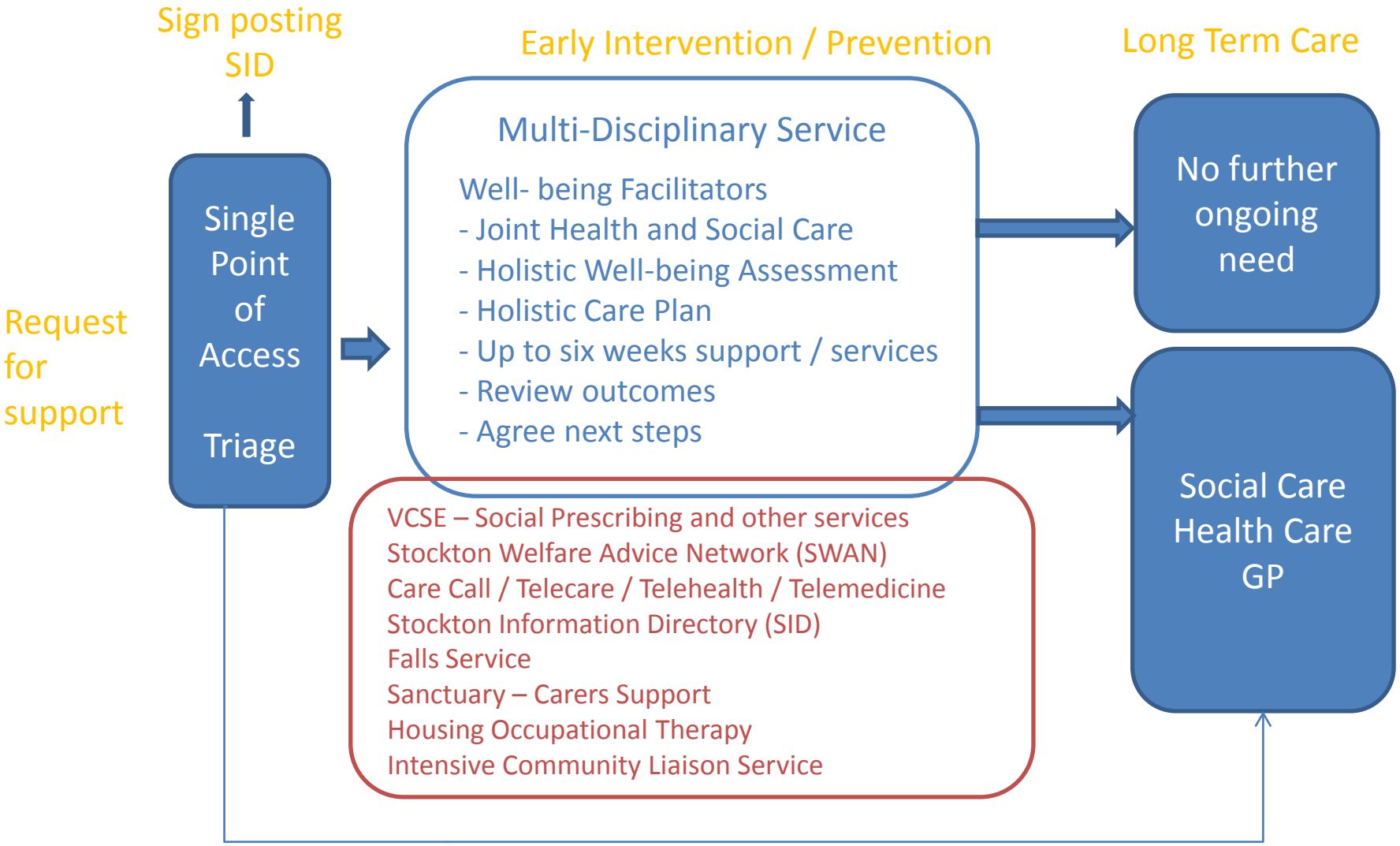
Health and Wellbeing

Multi-Disciplinary Service

- Aim
  - Multi-disciplinary service which will undertake:
    - targeted early interventions and preventative approaches
    - initially for people aged 65 and over (not known to Social Care)
- The Well-being team (completely new service)
  - MDS Manager
  - 6 Well Being Facilitators (health and social care)
  - Plus support (co-located) from the Stockton Welfare Advice Network
- Now includes:
  - Housing Occupational Therapy
  - Falls Service (early intervention and education)
  - Co-located: Intensive Community Liaison Service

Stockton Well-being Model of Care



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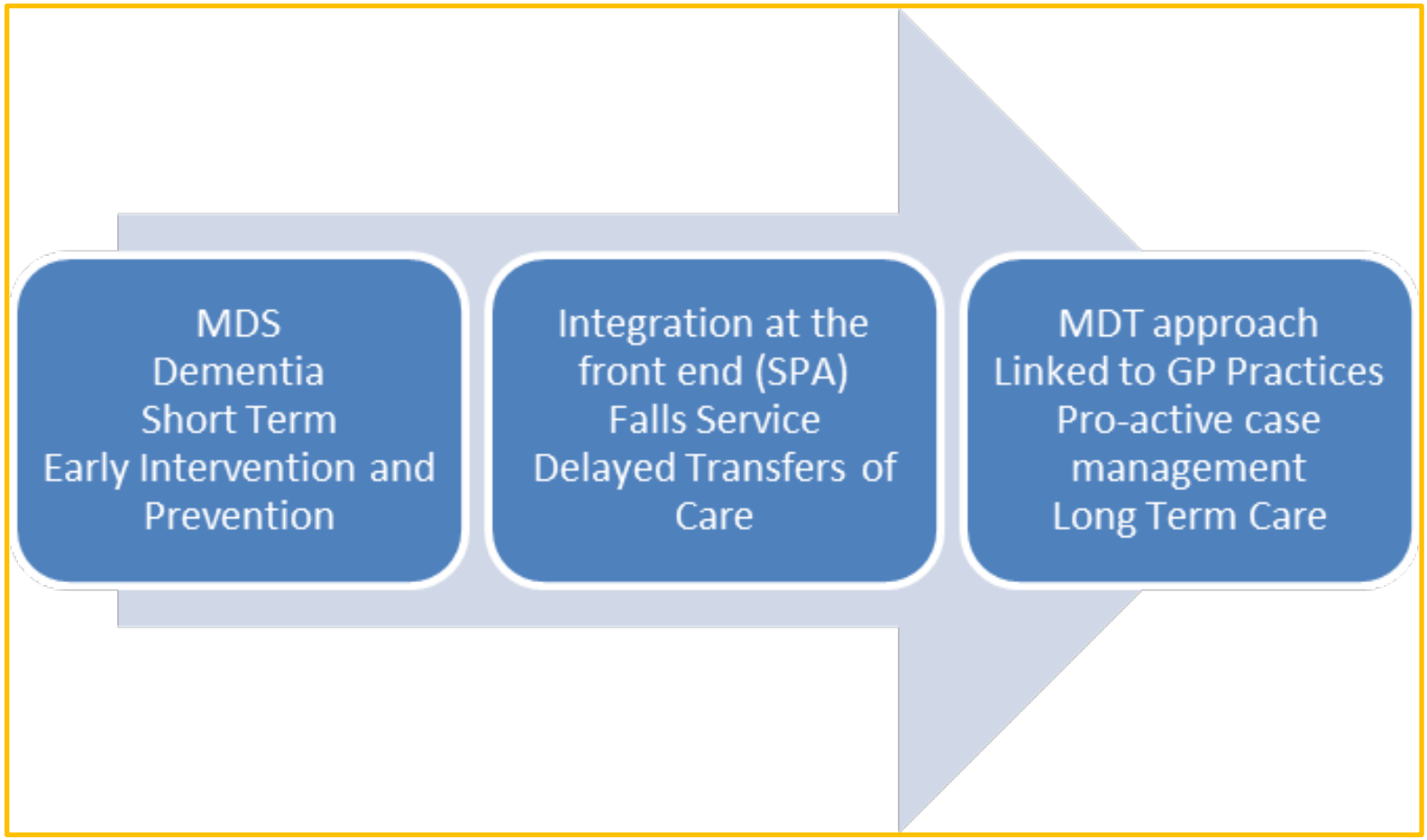
Case Studies

- Case Study 1 – MDS
  - 85 year old gentleman, recently widowed and not coping at home.
  - Referred by his daughters for residential care / long term package of care.
- Case Study 2 – SWAN
  - 84 year old married lady
  - Owner occupier
  - Referred for benefit and energy check

Benefits and Outcomes

- 100% client satisfaction
  - 80% rated the service excellent
- 439 referrals since October – only 17 were referred to long term social care following intervention
- Case management risk assessment
  - Average improved score 4
- SWAN – 287 referrals & £454k additional income (October – May)
- Small reduction in Non-elective admissions 0.1%
- GP's on board and can see benefits

Direction of Travel



Short Term Care | Crisis Urgent Routine | Up to 6 weeks

ongoing | Top 2% Frailty Recurring demand Multi-cond. | Long Term Care

Multi-Disciplinary Service:

- Well-being Team
- Housing O/T
- Falls Service
- ICLS
- Community Matrons
- Rapid Response
- CIAT
- Intermediate Care / Reablement
- SWAN
- VCSE / SSNP
- Care Call

Care Co-ordination:

- TAPS
- District Nursing
- Community Matron
- Social Workers
- VCSE
- O/Ts
- ICLS
- GP
- Prescribing services

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