Salford Together
Transforming Health and Social Care
Our Challenges

- **6%**
  - The population is estimated to grow by 6% between 2014-2020, the most in Greater Manchester.

- **70%**
  - 70% of the population live in areas classed as highly deprived.

- **7000**
  - At any one time, there are 4,100 people with adult social care needs being supported to help them live as independently as possible.

- **40,000**
  - An estimated 40,000 adults in Salford have depression or an anxiety problem.

- **21%**
  - 21% of the population are living with a long term condition such as diabetes, high blood pressure, and heart disease.

- **2,000**
  - In 2016/2017 there were almost 2,000 emergency admissions at Salford Royal per month. 1 in 4 could have been dealt with in the community.

- **£65M**
  - By 2020/21 there will be an estimated financial shortfall of more than £65M across health and social care in Salford.
Our Aims

✓ Improved Health and Social Care outcomes for people
✓ Improved experience of health and social care
✓ Making better use of limited resources
Driven by design principles

- Co-creating
- Person Centred
- Doing with, not for
- Self Care
- Promoting Independence
- Just enough support when needed
Health and Social Care Working Together

Salford City Council

Salford Clinical Commissioning Group

Salford Royal NHS Foundation Trust

Greater Manchester Mental Health NHS Foundation Trust

NHS
FOUR PRIORITIES TO MAKE THIS HAPPEN
Our Priority Focus

• Develop our care model for NBH
• Create NBH operational leadership
• Develop and test enhanced care teams

Neighbourhood teams

• Work with SPCT to develop sustainable model for General practice and test new ways of working

Sustainable General Practice

• Redesign IMC and Domiciliary Home Care aligned with development of NBH
• Develop and test a Crisis Team to hold people safely at home for up to 72 hrs
• Develop centre of contact

Extended Care

• Develop care pathways for high-volume LTCs in line with Right Care benchmarks
• Falls
• MSK
• Cardio-respiratory

Pathway redesign
Redesign pathways of care

Co-creating
Person Centred
Doing with, not for

Self Care
Promoting Independence
Just enough support when needed

Extended care
Active recovery to stay well at home

Neighbour-hood teams
Transformed workforce

General Practice
Responsive & Accessible services
Digital enablement

Supporting population health improvement
What are we trying to achieve

- Reduce emergency activity & NEL
- Reduce permanent admissions to care homes
- Reduce planned care activity
- Improve quality of life for users and carers
- Increase the % of people supported to manage their own condition
- Increase satisfaction with care and support provided
- Increase Flu vaccination:
  - Increase the proportion of people who die in their usual place of residence
  - Dementia diagnosis rate and care plans
  - Medicines optimisation

What priority changes can we make that will result in improvement

- Develop model of care for risk stratified population including high risk groups
- Develop leadership teams and governance system
- Develop delivery team to meet neighborhood needs
- Work with community assets and voluntary sector

- Redesign IMC for Homefirst - Introduce crisis response to avoid admission and discharge to assess to help people get home faster
- Redesign domiciliary homecare to include neighborhood team support including and reablement
- Improve care in care homes
- Enhanced care navigation and sign posting via Centre of contact single point of access

- High volume conditions using RIGHT Care benchmarking – initial focus CVD/Respiratory /MSK / falls
  - Early and accurate diagnosis/ assessment in high risk groups
  - Optimal management – Behaviour change , self care and secondary prevention, medication,
  - Escalation and action planning – planned care advice and guidance
  - End of life

- On boarding of practices
- Virtual ward
- Pharmacists
- Extended access
- Paramedic home visiting

Key enablers

- NBH teams working with risk stratified population
- Extended care
- Redesigned pathways for high volume conditions
- Sustainable General Practice

Information technology, Digital and population health, Workforce redesign and staff and service user communications and engagement, Estates,
Eligible Population – 5 Salford Neighbourhoods

<table>
<thead>
<tr>
<th>Neighbourhood</th>
<th>Population</th>
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<tbody>
<tr>
<td>Swinton</td>
<td>36,405</td>
</tr>
<tr>
<td>Eccles and Irlam</td>
<td>57,205</td>
</tr>
<tr>
<td>Ordsall and Claremont</td>
<td>53,968</td>
</tr>
<tr>
<td>Little Hulton &amp; Walkden</td>
<td>30,803</td>
</tr>
<tr>
<td>Broughton</td>
<td>30,580</td>
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</tbody>
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Total Eligible Population: 208,961
What is the Neighbourhood Vision?

• Delivering care closer to home
• Proactive management of people with the most complex, long term health and social care needs
• Preventing those at risk of becoming dependent by proactive early intervention
• Improved care co-ordination, access to care pathways and optimising the skills and resources in Neighbourhoods
• Improving access to GP’s and community services
• Different offer of community and primary care services, through care navigation
• Support the transformation and sustainability of primary care
Neighbourhood Teams

JOINING UP CARE

USING DIFFERENT SKILLS

PERSON AT THE CENTRE

IN THE COMMUNITY
Neighbourhood Model of Care

Model of Care
- Risk Stratification - proactive identification and care optimisation
- Maintenance of health and wellbeing
- Response to deterioration

Core Structure
5 Neighbourhoods aligned to clusters of GP practices, includes social, MH and Community nursing teams
Neighbourhood leadership team accountable for performance, quality and safety
Defined workflows, pathways and links to city wide services eg: IMC
Proactive involvement of wider teams eg: health improvement and third sector

NBH Prevention and self care
Proactive self care and wellbeing signposting

NBH Core Care
Team based care that provides comprehensive and convenient care and improved LTC management

NBH Enhanced Care
Co-ordinated and integrated support for people who are high users of resources and require a period of intensive input to maintain / regain stability

Extended Care Services
to help you remain at home or recover during or after episodes of illness
Improving access to GP and community services

- **Quick and timely access to GPs** for people who need to see a doctor
- Sometimes the GP is not the right person to see so there will be a **wider range of professionals providing advice and support** through local practices
- **New care navigators** who will be professionals trained to direct and refer people, ensuring they get the service they need faster
- **GP practices working more closely together to meet people’s needs**
Extended Care Model

Salford Extended Care Model

**STEP UP**
Up to 72 hours crisis management
- Contact person within 2 hours of referral
- If not Crisis transfer to appropriate pathway
- Confirm onward health/care support plan and key worker

**SERVICE PATHWAY 1**
CRISIS TEAM/STEP UP
- Crisis team will triage new referrals on the telephone with the referrer
- Will accept initial triage referrals from NWAS
- Appropriate response dispatched within 2 hours
- Crisis team assessment at home within 2 hours of referral
- Overnight care arranged as appropriate
- Comprehensive assessment (including medical, ASC, MH and therapy) initiated
- Acute pathways available including telephone support to nurse in charge at ED and community geriatricians
- Diagnostic pathways available
- Equipment ordered where appropriate
- Person centred therapy plan commenced within 24 hours
- Reablement commenced as required
- Medical/Medication review within 72 hours
- Complete Social Care Assessment prior to discharge
- Arrange Social Care Package within 72 hours
- Complete Discharge summary and refer on to relevant services
- **STEP UP BEDS RINGFENCED FOR INDIVIDUALS WHO ARE NOT ABLE TO REMAIN AT HOME**

**SERVICE PATHWAY 2**
HOME via BEDDED UNIT
- ‘HomeSafe attend within 2 hours and assess individual
- ‘Bedded Unit’ decision made based on XYZ
- ‘Unit Ready’ arrangements agreed within (x) hours
- Transport booked within (x) hours
- Placement commenced within (x) hours
- Unit initial assessment complete within (x) hours
- CGA (including ASC, MH and therapy) reviewed within (x) days and updated within (x) days
- Rehab ‘goals’ set in Unit
- Intensive therapy/reablement commenced within (x) days of admission to bedded unit
- Medical/Medication review (virtual?) within (x) days
- HomeSafe@Home assessment made (daily MDT)
- HomeSafe@Home decision made
- HomeSafe@Home arrangements agreed within (x) hours of decision
- Transfer home to complete R&R via HomeSafe at home as soon as bed not needed

**SERVICE PATHWAY 3**
HOSPITAL TO HOME / STEP DOWN
- HomeSafe triage within 4 hours
- HomeSafe decision made
- Patient at home within (x) hours following decision
- HomeSafe package within (x) hours
- Service commence within (x) hours of home arrival
- Overnight care arranged as appropriate within (x) hours
- CGA (including ASC, MH and therapy) started within (x) days and completed within (x) days
- Rehab ‘goals’ set
- Intensive therapy/reablement commenced within 24 hrs if required
- Reablement commenced within 24 hrs if required
- Medical/Medication review (?virtual?) within (x) days
- Social Care Assessment decision (yes/no)
- Complete Social Care Assessment prior to discharge
- Arrange Social Care Package
- Discharge assessment and decision including review of rehab goals achieved and further rehab required

**TRANSFER FROM EXTENDED CARE via HOMESAFE to NEIGHBOURHOOD COORDINATOR (ENHANCED CARE/ MDG/ VIRTUAL WARD)**

**METRICS/OUTCOMES** – REDUCTION IN NEL’S & A & E ATTENDANCE, REDUCE LENGTH OF STAY, ENABLE MORE OPPORTUNITY TO CHOOSE PREFERRED PLACE OF DEATH, IMPROVED PATIENT/CARER EXPERIENCE, SHIFT ACTIVITY FROM THE ACUTE TO COMMUNITY, SINGLE ASSESSMENT, ENHANCED THERAPY MODEL
Better support **to help people** manage their physical, mental and social needs in the community

- Better access to diagnosis and treatment
- More coordinated care for people with long term conditions
- Personalised support to live at home
HELPING TO MAKE THIS HAPPEN
Sharing information between health and social care professionals

Records will be available to health and social care professionals providing your care when they see you.
Maximising Independence

• Support to help people and their carers to manage their conditions at home

• Encourage people to take greater responsibility for their own physical & mental health and live independently as part of their communities
FOR MORE INFORMATION

WWW.SALFORDTOGETHER.ORG.UK