NHS
University Hospitals Tees

Matt Wynne, Care Group Director

Jill Foreman, Head of Community Services

Adult social care and health select committee
17th December 2024

Caring Better Together

NTHFT Current role working alongside Stockton Reablement Service

- Home First principles
- Integrated Single point of Access
- Integrated Discharge team – top performing ED in England
- Community Integrated Assessment Team (CIAT)– working in collaboration with Reablement (30 Clients on average per month 80 contacts)
- Trusted assessments – 7 days
- Change to delivery – Autumn 2024
- Realignment of therapy & challenge over prescribing
-

Caring
Better
Together

Case study 1 – Support in the Community

- An urgent referral for received via NEAS Bleep into Community Integrated Assessment Team (CIAT).
- A gentleman fell when trying to walk to the toilet at home with no obvious injuries. He lives with his wife and was independent prior to the fall.
- CIAT arrived within 30 minutes. He was laid on the bathroom floor. A full body screening and clinical observations were taken. He presented with acute confusion. Staff used a slide sheet to move him to the corridor so he could be safely raised from the floor using a Raiser.
- Assessment identified that he required assistance of one with a wheeled zimmer frame for mobility and his wife was unable to provide support for personal care.
- Referred to Virtual Frailty Ward for further clinical assessments, treatment and observation
- Referred to Reablement Service for further support
-

Caring
Better
Together

Emerging system frailty model

140,000 people aged over 65
15,500 moderate or severe frailty
5,500 of these in care homes

(22% projected increase in next 10 years)

Proactive Care

Tier 4

Tier 3

Tier 2

Tier 1

Emergency care

Hospital@ Home and UCR

Frailty at Place

Case management

SPA MDT
Health and social interventions - optimisation & rehabilitation

Identification of individuals – offer an assessment at home and complete a care plan. Focus on population groups with high unmet needs

Primary, community, social and voluntary care and support

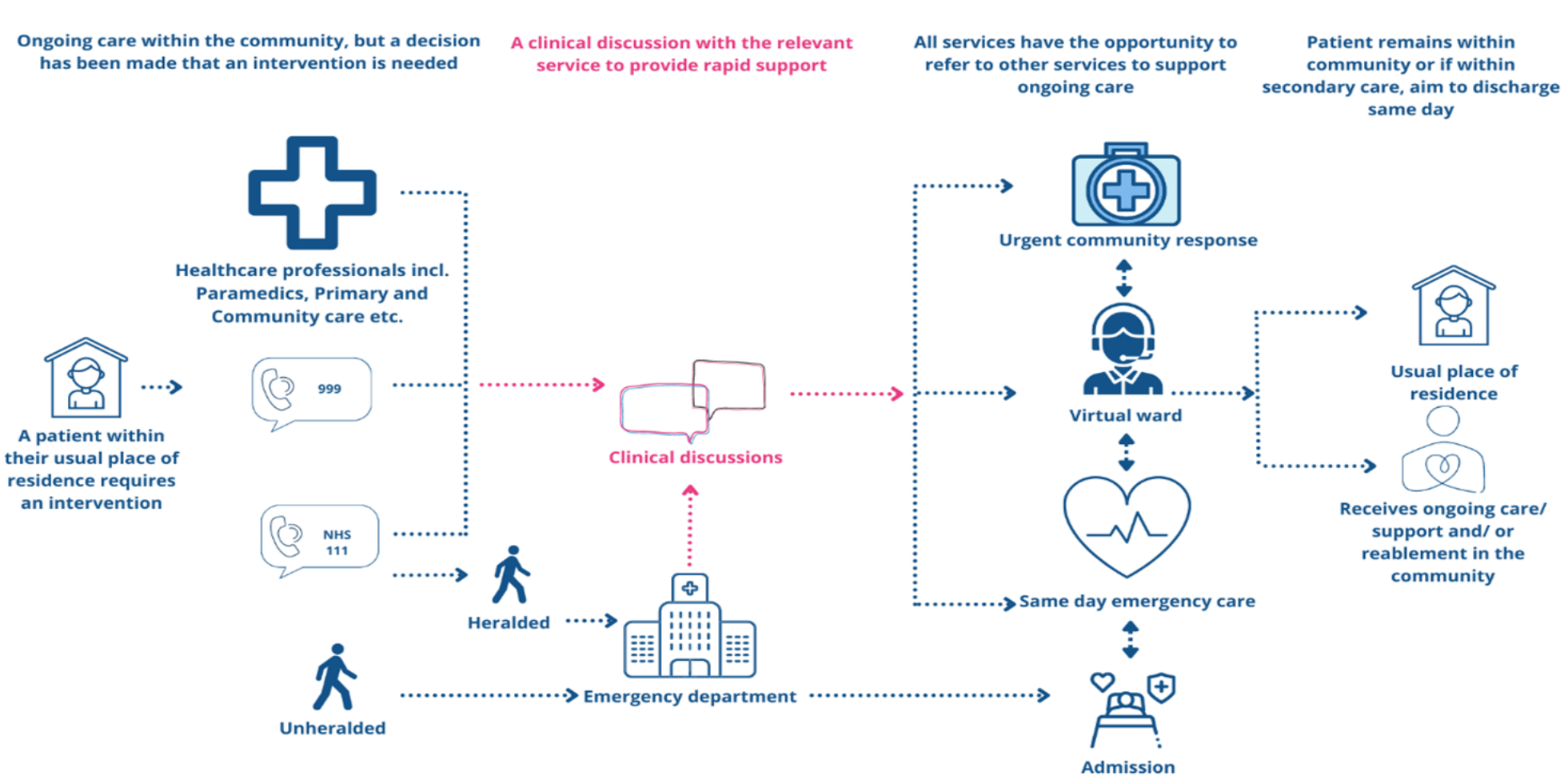
Self care inc. carer support

Remote monitoring (via Healthcall): questions to assess care need and/or vital signs monitoring and video consultation

Emerging outputs

Reduce admissions in >65 from 44,000/yr
Reduce Care Home admissions from 4620/yr
Reduce A&E attendances in >65 from 80,000/yr

NHSE Frailty strategy

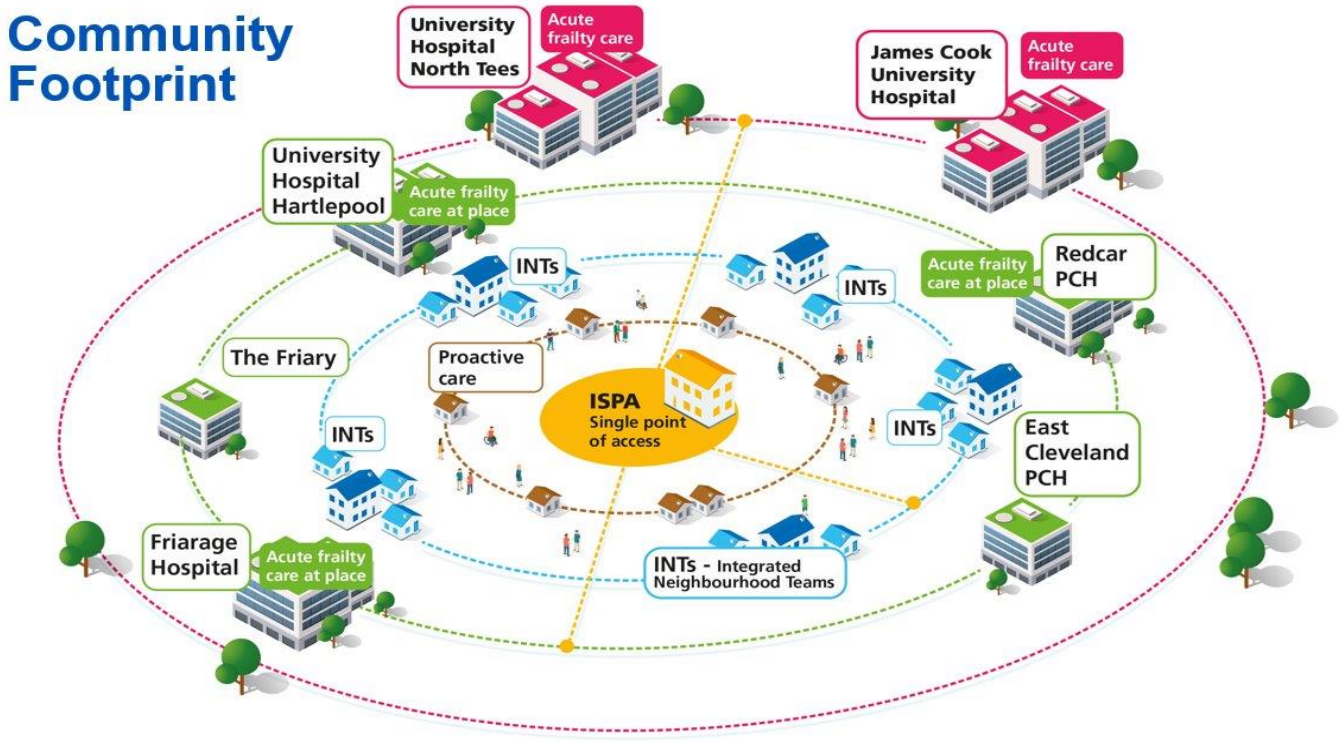


Caring Better Together

Future possibilities

- Hospital to Community
- Analogue to digital
- Prevention

- Integrated model
- 24/7 access
- Discharge to assess principles
- Complex case management
- Community OPTICA



Caring Better Together

Thank you