

Trust Board

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Paper Title:	Service Overview & Patient Story	
Section:	Public	
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The Airedale Wharfedale Craven Complex Care Team

The Airedale Wharfedale Craven Complex care team were commissioned to provide a new service model commencing on the 1st April 2016, initially for a 12 month, proof of concept period.

The overarching objective of the service is to improve the quality of care and outcomes for individuals with complex care needs by ensuring that the different, and traditionally distinct parts of the care system, work in a more joined up way to deliver care that is personalised to the needs of the individual.

The model is founded on the underlying principle of supporting individuals to have the confidence and knowledge to manage their own care.

It builds on existing local partnerships and promotes further joined up working between health, social care and voluntary and community services.

The team is multidisciplinary, multiagency and transcends traditional ways of working to ensure outcomes are achieved for its users.

The success of the team in achieving financial objectives whilst improving the lives of services users and carers has resulted in the service being commissioned for a further two years.

Service Profile

The AWC Complex Care Team is based within the digital care hub at Airedale Hospital.

It consists of a partnership between Bradford District Care Trust, YorDales General Practice Federation, Age UK, Carers Resource, North Yorkshire County Council and Bradford District Council.

The team consists of the following roles:

- Personal Support Navigators
- Carer Support Navigator
- Hospital Consultant
- General Practitioners
- Advanced Nurse Practitioner
- Team Leader
- Team Administrator
- Physiotherapist
- Occupational Therapist
- Physical Therapy Assistant
- Community Psychiatric Nurse
- Dietician
- Digital Care Hub Nurses
- Psychologist
- Psychology Assistant
- Information Analyst

Key Service Objectives

The service embodies the key service objectives as outlined below.

1. People who receive care and their carers have a good experience of care as evidenced by patient and carer feedback and case studies.
2. No one is in hospital unless their care can't be delivered safely in the community, they receive care that is coordinated, proactive and planned so that people are less reliant on intensive high cost services including long term care as evidenced by reduction in admissions, A&E attendances and readmissions.
3. Carers and families are supported to provide high quality support, can balance their caring roles and maintain their desired quality of life as evidenced by the carer survey and case studies.
4. People experience a timely, comprehensive, and holistic assessment of their physical psychological and social needs. They are supported in setting their own goals and receive care that is personalised to their needs. The personal outcomes tool demonstrates the achievement of personal goals.
5. Professionals actively promote participation in health and wellbeing of the individual. Staff contribute to a culture of joined-up working,