Workshop: Working together for admission avoidance and discharge

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Rotherham

Integration and
Better Care Fund

Rotherham Place Plan
Urgent and Community Work Stream

Working Together for Admission Avoidance and Discharge

'Trusted Assessor' Pilot

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CONNECT HEALTHCARE ROTHERHAM CIC

Rotherham Doncaster and South Humber NHS NHS Foundation Trust

The Rotherham NHS NHS Foundation Trust

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

VoluntaryAction Rotherham

Why Change?

The Rotherham Place Plan

* Challenges of aging population, increased demand, funding gap
* Care Act: Prevent, Reduce, Delay agenda
* 6 interdependent priorities to deliver integrated health and social care working by 2020
* Joined together through Home First golden thread

The Patient View

* Most people don't want to be in hospital
* Increased risks: infection, muscle loss, reduced mobility, institutionalisation.

Place Plan vision:

to support 'people and families to live independently in the community, with prevention and self-management at the heart of our delivery'.

The Trusted Assessor Pilot

Aim

To provide community led interventions in ED, AMU and with the Frailty Team to enable adults to be discharged & supported at home as an alternative to admission

Work streams

* 6 month Trusted Assessor pilot, June 2018 (front door)
* Integrated Discharge Project October 2017 (back door)
* Anticipated benefits
  * Reduced admissions
  * Reduced Length of Stay
  * Reduced DTOCs

Defining a Trusted Assessor

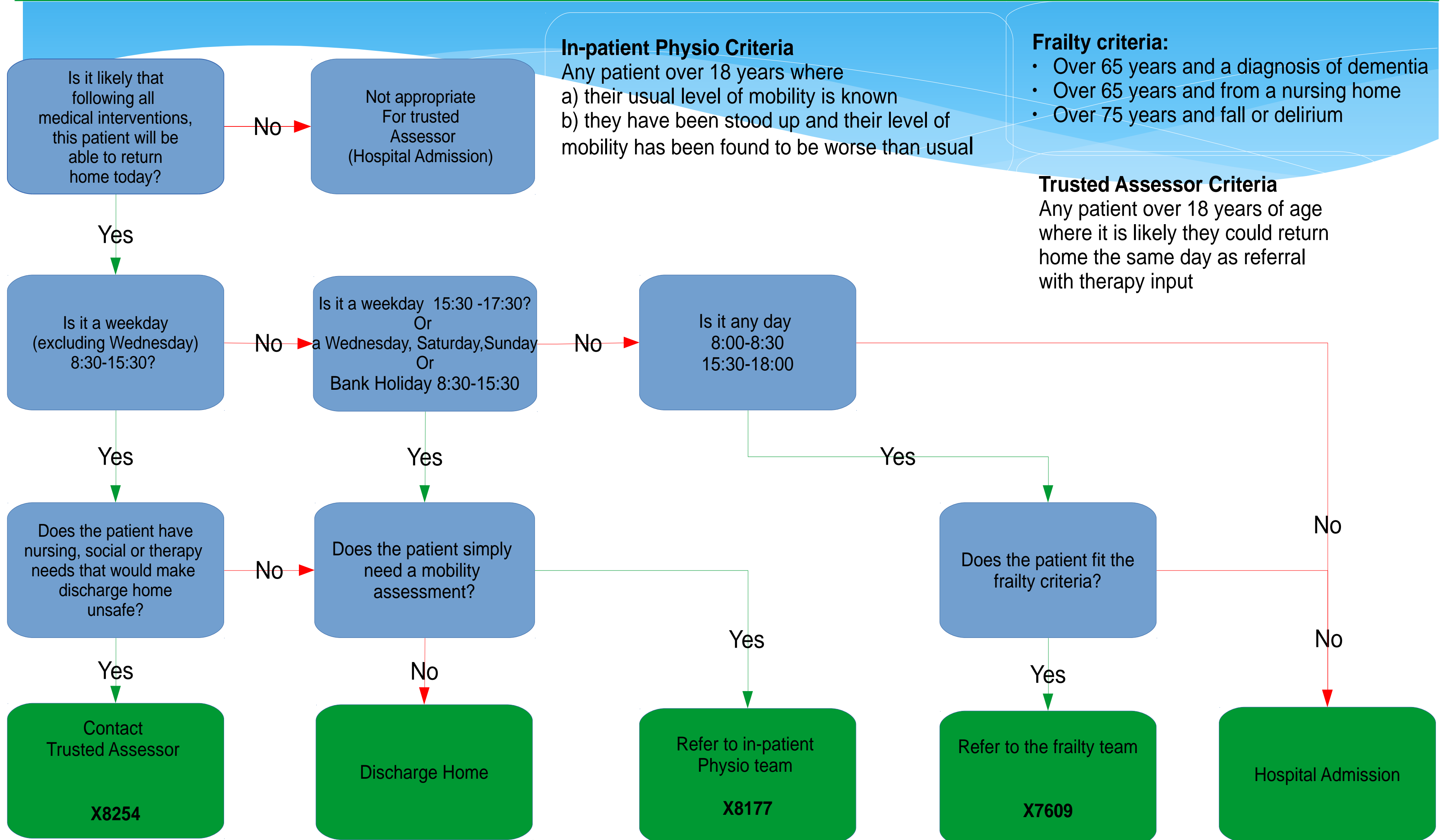
* Someone who helps patients *"move from hospital back home or another setting speedily, effectively and safely"* (NHS England, 2018 - "Trusted Assessor scheme)
* A health professional "trusted" to carry out a *generic assessment* to decide whether a patient may be able to *return home the same day*
* Carried out in consultation with other professionals involved in the patient's care
* Considers *social issues as well as therapy issues*
* Based on a *"Home First" model*

Our Trusted Assessor Role

* Band 7 job share to carry out clinical work, develop and evaluate the service
* 9 month secondment
* Community Physio and OT in-reaching
* Generic working
* Working into ED, AMU and with the Frailty Team

How it Works in Practice

ED Referrals to Trusted Assessor, Frailty or In-patient Physiotherapy



Referral Criteria

* Any adult over 18 years whose medical condition can be managed in the community
* but who has other complex needs which may be a barrier to discharge home
* including therapy intervention, equipment provision, social, nursing, mental health, care or enabling input

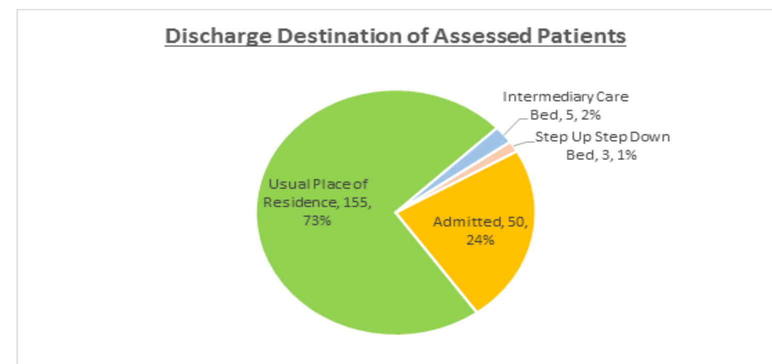
Assessment

* Generic Assessment includes:
* mobility and transfer assessment
* liaising with all relevant individuals, professional and family/carers to ensure personal & domestic ADLs can be managed.
* Followed up by our wider community based therapy team for further home assessment to determine equipment & treatment needs & onward referrals.
* 7 day service aiming to assess at home same day or within 24hours

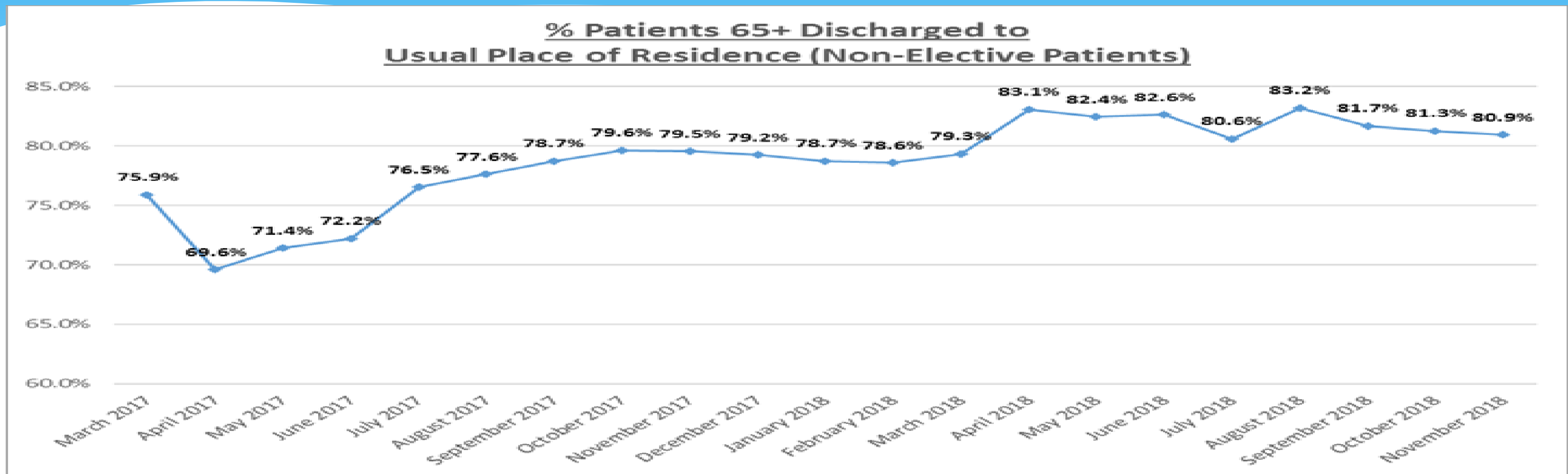
Benefits: Trusted Assessor

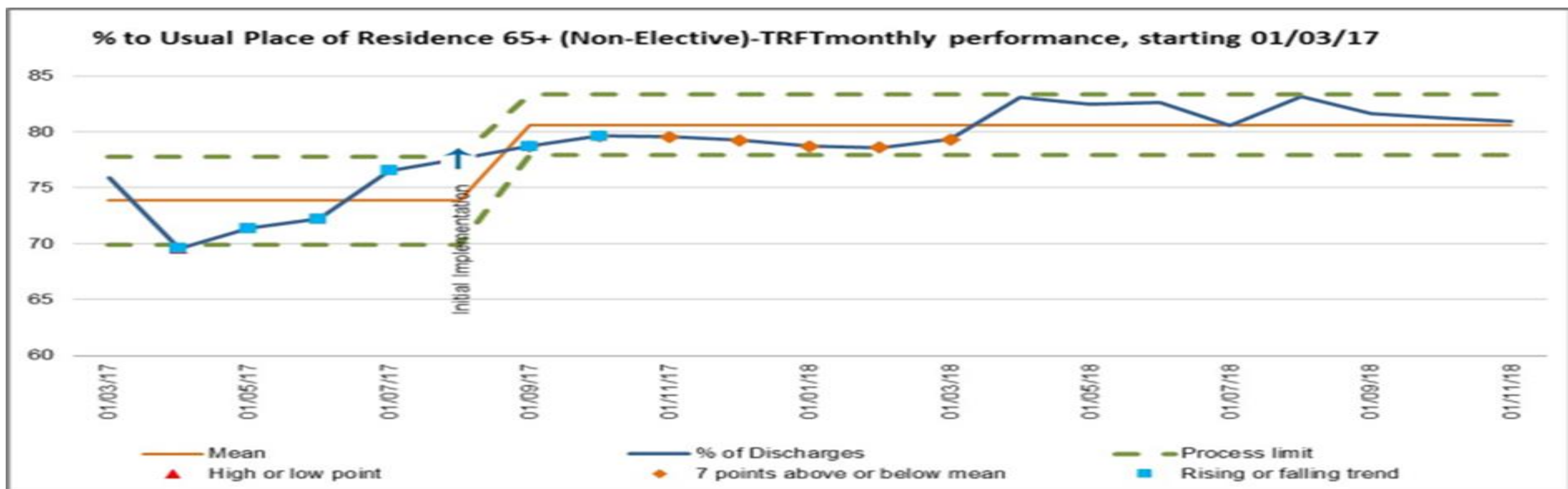
- Positive feedback from patients, families & professionals
- Majority home same day/ just with therapy resource
- Despite limited size of trial, 1 part time therapist, worked as a job share, has had significant impact on hospital admission avoidance as shown.
- Change of culture in acute setting re: Home First
- Closer working between acute and community therapists
  - Greater understanding of risk acceptance
  - Cover in ED/AMU

Destination	Number	%
Usual Place of Residence	155	73%
Admitted to the Acute	50	24%
Admitted to Intermediate Care	5	2%
Admitted to Alternative Step-Up Step-Down Facility	3	1%
Total	213	



Contribution to System-Wide Home First Outcomes





Challenges

* Limited resources – 1 band 7 therapist, job share, service development resulted in clinical hours being part time.
* Other established teams unaware of our presence or role.
* Many different pilots undertaken simultaneously and therefore confusion for teams.
* Capacity of other services & teams to support both acute & community.
* Funding being delayed for further timely service development and progression.

Next Steps

Investment of winter monies

* Community Hospital Admission Avoidance Team (CHAAT)
* 7 day cover 8 am – 6pm
* Trusted assessors/Therapists – further developing integration of community in-reaching service & community Urgent therapy team
* 3 Band 6 therapists & 2 band 3 support workers
* Further development of integrated working with both community nursing services, social services and care providers.

Intermediate Care and Reablement Review

* Development of Home First model
* Re-configuration of Community Beds

Contact Details

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