Better Care Fund

Integration - Engaging the Voluntary Sector

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Context

- AUKEL works with over 8,000 older people and carers a year in hospitals, in their homes and in the community across East London. We are regulated and have an overall Outstanding CQC rating
- Our main boroughs are Tower Hamlets, Hackney and Newham which have the highest levels of income deprivation for older people in the country and above average levels of older people living on their own.
- We support the Better Care Fund ambitions of integrating health and social care to promote independence and improve quality of life. We understand the value of putting people in charge of their wellbeing and support the most vulnerable older people to know their choices and their rights.

Transformation

- Transformation is evolving differently in each of our boroughs although they are all part of one STP. Different governance structures.
- Building relationships is key to all models
- Different languages spoken by different stakeholders. Not only Health, and Social Care but also the Voluntary sector. Invitation to contribute.
- At a senior leadership level we are contributing to the vision of integration and emerging neighbourhood models both as VCS reps and as service providers.

Better Care Fund objectives

At a service level we have also developed an integrated discharge service which aligns with the following BCF objectives:

- Reductions in non-elective admissions
- Reduced admissions to residential and care homes
- Increase effectiveness of reablement
- Reduce Delayed Transfers of Care
- Patient / service user experience

The hub model

- Visible hub –2 coordinators (on ward and in hub), 3 home support workers
- Open 7 days a week
- Up to 6 weeks home support post discharge
- Wrap around service for patients, carers and relatives at any point in their hospital journey
- Fast track to our own and other Voluntary and Community services. Befriending, Advice and Information, Handyperson, Advocacy, LYOL etc.

What we unblock

- Accessing homes (35% during stay)
- Homes not fit for purpose – handyperson (OTs)
- Financial issues/poverty – benefits, food
- Patient lives out of borough - partners
- Challenging patients/relatives –Advice and Advocacy
- Lack of suitable care home – patient choice
- Increasing complexity of need – frailty, confidence
- Fear (speed of discharge, losing home etc.)

Outputs and outcomes

Started in 2014 in one hospital now in 5 with an advanced hub model in The Royal London, Barts NHS Trust

- 1800 older people supported each year (75-90 largest cohort)
- 79% live alone
- 3.4% readmission rate at 30 days
- 65% improved wellbeing
- 95% maintained or improved Independence
- Nominated for GSK/Kings Fund IMPACT award 2018

Why it works

Supporting system change with an agile and flexible service (D2A, IIT, AA)

- Person centred care
- Speed – responsive, intervening early – planning discharge at point of admission
- Re-direction and support for those older people presenting at hospital whose needs would be better met in the community
- Effective communication – teamwork and branding
- Choice (information and support to patients and carers/relatives)
- Safeguarding – sharing risk
- Not ‘business as usual’ – proactive (service and dashboard)

Continual Improvement
Looking to the future

Thank you

East London ageUK