scie social care institute for excellence

in collaboration with Integration and Better Care Fund

Better Care Fund resources

Working together for admission avoidance and discharge – trusted assessor pilot

Scheme

Who?

Connect Health Care

Rotherham, Doncaster and South Humber NHS Foundation Trust

The Rotherham NHS Foundation Trust
Rotherham Metropolitan Borough Council

Rotherham Clinical Commissioning Group

Voluntary Action Rotherham

What

The aim is to provide community-led interventions in emergency departments (EDs) and acute medical units (AMUs) and with the frailty team to enable adults to be discharged and supported at home as an alternative to admission.

Why?

Reasons for setting up the scheme include:

- increased demand for hospital places because of the ageing population and resulting funding pressures
- support for the aims of the Home First scheme.
- legislation and policy drivers: Care Act 'prevent, reduce, delay' agenda

There are also important advantages from the person's point of view

- avoiding a stay in hospital – most people would prefer to be at home
- avoiding the increased risks of infection, muscle loss, reduced mobility and institutionalisation from a hospital stay.

When?

After a successful nine-month pilot, the scheme has been extended until June 2020 and more staff have been employed.

How?

The trusted assessor's role is to carry out clinical work and to develop and evaluate the service. It includes community physiotherapy and occupational therapy in-reaching.

The role works into the ED and AMU

and with the frailty team. Responsibilities include:

- mobility and transfer assessment
- liaising with all relevant individuals, professionals and family/carers to ensure personal and domestic activities of daily living (ADLs) can be managed.
- following up with the wider community-based therapy team for further home assessment to determine equipment and treatment needs and onward referrals.

It is a seven-day service aiming to assess at home the same day or within 24 hours.

Any adult over 18 whose medical condition can be managed in the community but who has other complex needs which may be a barrier to discharge home may be referred for assessment.

Challenges

There were a number of challenges to setting up the scheme:

- limited resources – only one Band 7 therapist (job share) was employed and the role includes service development, resulting in clinical hours being part-time
- other established teams were initially unaware of the new role
- many different pilots were undertaken simultaneously, causing confusion for other care teams
- other services and teams had limited capacity to support both acute and community services
- funding for further timely service development and progression was delayed.

Impact

There has been positive feedback from people who use services, families and professionals. Outcomes include:

- majority home same day
- greater understanding of risk acceptance.
- despite the limited resources of the trial, a significant impact on hospital admission avoidance
- contributed to change of culture in acute setting – focus now on Home First
- closer working between acute and community therapists

Case study

Lucy, aged 82, was admitted to ED with a suspected cerebrovascular accident (CVA). She was having trouble standing and was leaning to one side.

Lucy's son explained while attending

her medical assessment that her symptoms, although perhaps a bit worse, were the result of a previous CVA. The assessment team found no new symptoms and Lucy was declared medically fit for discharge.

The trusted assessor was called to assess Lucy. She decided that Lucy's care needs had increased and she now needed two people to help her stand up and two people for some care tasks. (She had previously only needed one person for her support needs.) Lucy also needed a rollator frame because she was at risk of losing her balance when walking. The trusted assessor provided a rollator frame and contacted Lucy's care agency to let them know she would need support from two care workers, but the care manager said they would need a social worker to change Lucy's care package. The trusted assessor contacted the hospital social worker who was able to change the package straight away. She also arranged with the urgent therapy team that they would visit Lucy at home the next day (Saturday) to assess her for additional equipment needs. Without the work of the trusted assessor, Lucy would have had to stay in hospital over the weekend.

View all practice examples link 1

link 1 | https://www.scie.org.uk/integrated-care/better-care/practice-examples