

Integration and Better Care Fund

Refresh 2018-19

Impact of system improvements and BCF investment

The cases below illustrate the importance of partners across the health and social care system working together to ensure that discharge plans are in place for individuals as soon as possible. During 2018/19 the Better Care Fund will be investing in a number of key schemes which will improve the urgent care experience for adults throughout Herefordshire. These include the introduction of an integrated discharge team, Trusted Assessor, Discharge to Assess, Community Capacity and Improving quality of Care in Care homes.

Case Study 1

Mr J was admitted to hospital with confusion. Nine days later Adult Social Care received a referral and following assessment it was identified that a residential placement would be required for discharge. 11 weeks following admission and this individual remained in hospital. His discharge had been delayed for 41 days as a residential home had not been secured. Homes either did not have vacancies or those that assessed Mr J had declined to accept him due to his challenging behaviour. Fortunately a home has very recently assessed and has accepted, however is not able to admit for a further 10 days.

The introduction of the Trusted Assessor model in Herefordshire will ensure that other individuals in similar situations to Mr J will be not be assessed multiple times by multiple residential homes. Instead the Trusted Assessor will complete a single assessment of the individual and then work with Care Home Providers to source and secure the most appropriate placement. This model will streamline the process and improve the experience for the individual, and their families.

The investment in improving the quality of care in homes throughout Herefordshire will also assist in ensuring that care homes are better equipped and trained to fulfil the needs of clients, such as Mr J, who are displaying challenging behaviour. In the case of Mr J this improvement may have resulted in a placement being secured more rapidly, therefore reducing his hospital stay.

Case Study 2

Mrs C recently had a Stroke and is currently on a ward in Hereford County Hospital. The individual's discharge has been delayed. A referral to Adult Social Care requested a 2:1 package of care to be delivered in the individual's home. This was initially sent to the Home First service, however due to limited capacity the council's brokerage team is currently sourcing care with a domiciliary agency. Unfortunately no providers are available to provide the support and a residential respite opportunity was offered to Mrs C, to facilitate discharge, however this was declined by both Mrs C and her family. During the delayed days in hospital Mrs C has become more mobile, her needs have decreased and she now requires 1:1 care, rather than the

previous request of 2:1. Due to this change the Home First service is currently sourcing calls and aim to discharge Mrs C to her own home shortly.

The introduction of an integrated hospital discharge team will ensure that professionals collaboratively work closer together to ensure the safe and timely discharge of patients. For individuals, such as Mrs C, this will result in improvements in discharge planning and improved communication.

A key improvement for individuals, like Mrs C, is the development of an integrated community capacity (ICC) function. The integrated/aligned teams will provide daily community capacity information to partners of the availability of health and social care services in the community. In the case of Mrs C above, this function would potentially reduce the delay and enable Mrs C to return to her home sooner.

Further details on all of these schemes can be found within the Integration and Better Care Fund Refresh 2018-19.