Stockton-on-Tees Better Care Fund

Suggested presenters

Yvonne Cheung SBC

Kathryn Warnock ICB

Angela Grady/Lynne Calder NTH NHS Trust

Jordan Cummings TEWV NHS Trust

Better Care Fund

BCF is a programme that supports local systems to successfully deliver the integration of NHS and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

Vision of BCF

Enable everyone to live at home longer, be healthier and get the right support where required, whether this be provided by NHS, social care and/or VCSE

- Integrated NHS and Social Care
- Primary prevention
- Early diagnosis and intervention
- Supported self-management
- Closing health and wellbeing gap
- Reduce inequalities
- Transformation to close care and quality gap

Metrics

- Avoidable admission
- Falls related hospital admission
- Discharge to usual place of residence
- Residential admission
- Reablement

Case study 1 – Hospital discharge

- A 76 years old gentleman was transferred to Rosedale for rehabilitation following admission to North Tees Hospital due to a fall at home and long lie.
- He had urine infection which caused delirium which was resolved while in hospital. He was previously independent and lives at home alone.
- He was assessed by the therapy team in Rosedale, He required assistance of 1 with a wheeled zimmer frame and for all transfers.
- After 5 days he was independent with transfers and walked approx. 30 metres with a 4 wheeled walker. He continued with step practice. He completed kitchen practice and made his own cup of tea.
- He required support with washing and dressing lower body initially. Support workers continued washing and dressing practice and he became independent after a few days.
- After 12 days, he was discharged home with Reablement support.

Interventions

Rosedale

Community Matron visited the gentleman on the ward for initial review.

District Nurse referral on admission to Rosedale to change dressings due to pressure sore.

Rosedale Therapy involved to provide rehabilitation to improve mobility:

- Mobility practice with parallel bars and throwing bean bags onto coloured mats, standing balance exercises, chair and bed transfers.
- Step practice with 5 inch and 7 inch wooden step (gentleman lives in a bungalow).
- Kitchen practice
- Home visit identified equipment required (high backed chair and bed lever).

Reablement

Reablement team visited once a day, each morning.

- To observe and monitor progression at home with daily tasks.
- Due to two falls after returning home, support remained in place to continue to monitor and provide necessary support. A fall assessment was carried, risks of fall were modified through assistive equipment and education on home safety.
- He was encouraged to wear pendant alarm as a means of summoning help to prevent long lie in an event of a fall.

Outcomes

- Supported timely hospital discharge.
- Continued with rehabilitation in a 24 hours care setting before being discharged home with support to maximise safety and independence.
- Continued progression once at home, increased confidence in independent completion of tasks.
- Increased awareness and compliance with home safety equipment.
- Risks of fall were modified.
- Time spent with the support in place allowed this person to remain at home independently without the need of further service intervention.
- Service ended within three weeks
- Positive feedback received from the individual **who stated that the girls are a credit to the service, feeling valued and stating all support was delivered with dignity and respect.**

Case study 2 – Support in the Community

- An urgent referral for received via NEAS Bleep into Community Integrated Assessment Team (CIAT).
- A gentleman fell when trying to walk to the toilet at home with no obvious injuries. He lives with his wife and was independent prior to the fall.
- CIAT arrived within 30 minutes. He was laid on the bathroom floor. A full body screening and clinical observations were taken. He presented with acute confusion. Staff used a slide sheet to move him to the corridor so he could be safely raised from the floor using a Raiser.
- Assessment identified that he required assistance of one with a wheeled zimmer frame for mobility and his wife was unable to provide support for personal care.
- Referred to Virtual Frailty Ward for further clinical assessments, treatment and observation
- Referred to Reablement Service for further support

Interventions

Therapy assessment – CIAT

- Transfers and mobility assessment
- Provision of a wheeled zimmer frame, commode and toileting aids
- Ongoing therapy to return to previous level

Medical Assessment – Clinical Community Practitioners, Virtual Frailty Ward

- Medical assessment queried Urinary infection
- Prescribed antibiotics
- Closely monitored by the VFW
- Clinical observation by Home First Team for 48 hours to prevent deterioration

Social care – Reablement Service

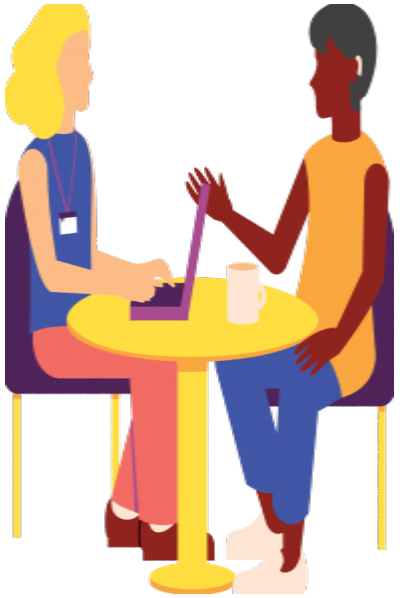
- Implemented short term care package twice daily for personal care

Outcomes

- Prevented avoidable hospital admission.
- He was remained at home with wife and additional support while recovering from the urinary infection.
- Reablement support reduced from two calls a day to once a day after one week.
- Discharged from CIAT after 2 weeks.
- He regained his independence and was discharged from Reablement in week 3.

Case study 3 – Mental Health Support

- An 89 years old man with multiple co-morbidities was referred to the Virtual Frailty Ward by his GP.
- He had delirium attributed to a urinary infection.
- His increased confusion with delusion brought attention to the Integrated Community Liaison Service during the Multidisciplinary meeting.
- He lives alone with family support. He has bypassing catheter, Urinary Infection, abnormal blood results.



Interventions

Medication review - ISPA Pharmacist

- De-prescribing medications no longer appropriate
- Prescribing antibiotics
- PRN for distress
- Insulin for newly identified diabetes

Physical Health - Clinical Care Practitioners, Home First Team, CIAT

- Bloods obtained, reviewed and actioned
- NEWS daily
- Assessment of mobility – equipment provided

Social care - ISPA Social Work Team

- Implemented short term care package to support family
- Carer support advice given

Mental health - ISPA Mental Health Practitioner

- Face to face assessment inclusive of the PINCHME
- 4AT assessment tool for delirium
- Onward referral to appropriate community mental health team

Outcomes

- Prevented avoidable hospital admission.
- The person recovered and remained in his own home to promote independence.
- Care package to reduce carer strain.
- Reviewed of mental health and onward referral to community mental health team for support.
- Education and advice for family on delirium, and pre-existing mental health concerns and how these should be managed.
- An emergency healthcare plan was discussed and co-produced with the person and family members to manage the physical and mental health conditions.
- The person was discharged from the Virtual Frailty Ward.
- Details of the support and intervention was sent to the person's GP.


Any Questions?