Better Care in Hull

Conference 2016

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Hull City Council

NHS
Hull Clinical Commissioning Group

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Rehabilitation: Transfer to Assess

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Background

- The **Transfer to Assess** service commenced on 4th July 2016 supporting people who are being discharged from the Acute Trust (Hospital) and Intermediate Care Facilities to their home address.

- Staff work with people to facilitate discharge from these facilities and the outcome of this support could either be See and Solve or Transfer to Assess

- The ethos of supporting people to **regain their independence** is **one of the most important** things we do

- By increasing a person's independence **we decrease ongoing package costs**, which will help us become financially sustainable and able to offer support and care to those who need it most

ACTIVE RECOVERY

- Builds on the idea of reablement and will replace the term ‘reablement’ which was previously used
- Underlines the importance of active input – from us and from people
- Underlines the importance of recovering as much independence as possible
- Underlines the importance of working towards clear personal goals
- Is something that happens *throughout* the person’s journey with us, from assessment, through short term intensive input and into longer term support
- This concept will mean more and be more understandable to people than reablement

Clear **goals** help in Active Recovery

Having clear goals…

- provides the person and the practitioner with something to aim for,
- helps build confidence through reflection on achievement,
- provides an objective measure of achievement,
- is innately therapeutic by providing a form of reflection,
- gives a sense of purpose and;
- provides a focus for tasks and future work.

Supported **Discharge**… *Transfer to Assess*

- When a person is deemed medically fit a Social Care Advisor or Support Organiser or Social Worker will see the person on the ward/Intermediate Care facility
- They will undertake the See and Solve ethos using the solution focussed approach
- If support is required to facilitate discharge they will create a basic support plan agreeing achievable goals for Active Recovery and discharge will take place
- Social Worker with then undertake the Assessment within the person's home

Transfer to Assess

57

People

Have been **discharged**

with **Transfer to Assess**

Since July 2016

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Transfer to Assess

21

People

Have become **fully independent**

of **services**

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Transfer to Assess

3

People

Have been moved onto **Long Term Support**

but had a

reduced *hospital stay*

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Transfer to Assess

33

People
are **still receiving**
active
recovery

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New team name for homecare reablement

To reflect the new ethos of Active Recovery, the Reablement Homecare team has changed to become the

Supporting Independence Team

Home Care Assistants became

Support Assistants

Home Care Organisers became

Support Organisers

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Reaffirming role and purpose of the Supporting Independence Team

Supporting Independence is there to:

- actively help people to regain or maintain independence,
- support people to meet clear goals related to carrying out activities of daily living themselves,
- provide short term care with the explicit aim of getting people 'back on their feet' and;
- encourage people and help them regain confidence in doing what they can for themselves .

The team is there to provide a specialist short term intervention aimed at maximising independence

Supporting Independence is not for:

- 'stop gap' care e.g. while waiting for private providers to pick up care packages,
- 'emergency' or 'rapid response' care – e.g. in the cases of safeguarding or sudden carer breakdown,
- care for 'high risk' individuals where there are no Active Recovery needs e.g. when what is really desired is a 'trusted pair of hands' or;
- care for people that private providers are not able or willing to support e.g. with complex or challenging behaviour but no clear Active Recovery needs

The team should be working to meet care needs only (except for in exceptional circumstances)

Explaining the role of the team to clients

An A5 flyer all social work staff to use and give out to clients. This will both help social work staff understand and explain the role of the Supporting Independence Team, and will also put the person in the right frame of mind to work towards independence

Supporting Independence Team

The Supporting Independence Team provide a specialist service that can help you achieve your full potential for independence and rebuild your confidence in doing day-to-day tasks. Rather than doing things for you we provide hands on support to help you do practical activities like washing, dressing and meal preparation for yourself.

We can also help with creative problem solving (sometimes with the help of OTs), assessing risk at home and giving confidence using new equipment.

The Supporting Independence process:

Supporting Independence Team

Agreeing initial achievements to aim for

Your social worker may use questions like these to discuss how Supporting Independence can help you recover as much independence as possible:

- "What would you like to be able to achieve?
- "Is there someone else who will help you get there? Do we need to talk about this with them?
- "Could you aim for more?" / "Is that something you can do in a reasonable amount of time?"

Case study

Mrs H was referred to the Supporting Independence Team following a fall but had been living independently at home before.

Though Mrs H had lost some confidence and found hospital a bit confusing, she was keen that this fall end her independence. Her social worker suggested referral to the Supporting Independence Team who could help her get back on her feet.

When she got home Mrs H had three visits a day to tasks like personal care and getting ready for bed. At the beginning the Support Assistants from the team did most things for her, but every day Mrs H was encouraged to do more for herself. The service continued for 4 weeks, and in the end Mrs H was back to living independently as she was before her fall.

Next Steps

- **Promote Active Recovery and Transfer to Assess** with our partners and people
- Evaluate the **effectiveness of Active Recovery**
- Ensure staff have the **skills to work in a goal orientated and solution focused way**
- Work towards **achieving the BCF target of *92%* of people still at home 91 days** following hospital discharge
- Work towards **assessing more people at home**, rather than a hospital or ICT environment