Bracknell Forest Place Discharge and Flow Plan 23/24

Action / Scheme	Rationale	Detail	Expected Impact	Lead
D2A Social Worker	To support with complex pathway 3 / D2A discharges within the Adult Community Team Previous scheme run shows the resource is better allocated towards complex D2A instead of facilitating discharge from A&E. Additional staff needed to support community teams undertaking assessment and arranging ongoing care.	1 x social worker (locum)	Our current hospital discharge team are still supporting D2A (following patient discharge) which can take between 6 weeks to 6 months depending on the complexity. Therefore, by having a dedicated resource to focus on these assessments, the hospital discharge team will be able to maintain their focus on the timely allocation and flow of discharges.	Anna McCafferty, ACT Team Manager
Care Home Physiotherapy Pilot	To provide physiotherapy and reablement to people returning to a care home placement following hospital discharge. To support activity leads in the care homes with appropriate exercise Proposal to extend for 9 months, reviewing the pilot and then seeking recurrent funding through the BCF	1 x Physio 1 x Multi-therapy assistant	27 people were supported between Dec-Mar. The majority were supported on the same day or within a day of referral. Support falls prevention, preventative therapy, and rehabilitation. Supporting people back to care homes in a timely way with rapid access to physiotherapy. Enabling care homes to feel confident to accept residents back after hospitalisation	Claire Collins EHCH lead
CHMTOA Pathway 3 Social Workers	To provide complex pathway 3 and D2A assessments for people in the Mental Health Older Age team	2 x practitioners (locum)	19 individuals were supported between Dec 22 - Mar 23 with a minimum of 3 assessments each. Dedicated resource focused on the hospital discharge process supports system flow, integrated working through improved relationships with the ICB, continuity of the assessments and good quality communication with the families. Additional staff needed to support community teams undertaking assessment and arranging ongoing care.	Mari Longworth, Team manager for the Community Mental Health Team, Older Adults

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Assistive Technology Grab Bags	To provide people with monitoring equipment at the point of hospital discharge Improve patients' confidence on discharge from hospital. Supports with Bracknell Forest Council's pursuit for an improved technology first approach.	Access to a range of assistive technology equipment	9 people were supported with grab bags or pendants Jan – Mar 23 Frimley x3 grab bags Heathlands x2 to support discharge ASC x4 residents supported with tech/care for hospital prevention 60 pendants sent to the three acutes to be readily available to the patient at the point of hospital discharge. Confidence to families and patients at the point of discharge when leaving the acute to return home	Marney Ahmed, Forest Care
Complex Home Care	To provide complex packages of homecare to ensure and support hospital discharge Supports swifter discharges from the acutes with a quick step up of complex packages of home care. POCs have been sourced and started within 24hrs which helps to speed up discharge as they are not having to wait for a residential or nursing home assessment.	Homecare Framework	Supported with 2755 hours of care between Dec-Mar. Supported SU's on discharge with 2x12hr support. These either then get reduced over time or shows the need for 24hr care within a placement. Facilitates swifter discharge through immediate access to funding of complex packages.	Sue Halligan, AtR Manager
Temporary Accommodation and Home Preparation	To provide temporary accommodation for a person who is medically fit for discharge, whilst their home is prepared for safe habitation. Prevent unnecessary admission into residential care. Enable early intervention, promote, and encourage independence with a focus on what the person can do.	Accessible Guest suites facilitated by Silva Homes Rapid access to cleaners	The temporary accommodation scheme supported 3 people during the winter period and was successful in reducing bed days lost whilst home preparations were made The home preparation scheme supported 6 people between Dec-Mar.	Anna McCafferty, ACT Team Manager

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	Prevent delays to discharge while waiting for the home to be in a suitable condition.			
ICS Discharge Assessor	To support discharge from bed-based intermediate care with reablement. Supported the care home physiotherapy scheme to help people back to care homes	1 x locum trusted assessor / discharge coordinator	Coordinated discharge will increase flow through the community beds	Bethan Spickett, Heathlands ICS Manager
Home First Social Worker	Dedicated social care to support people to achieve independence following discharge. Track wrap around care provided to support an enhanced home service Facilitate assessment for ongoing care to be undertaken outside of hospital supporting Enhanced Home First approach	1 x locum social worker	Prevent Discharge delay due to risk averse and concerned families and discrepancies between acute/ community assessments	Anna McCafferty, ACT Team Manager
Support Coordinator	Based in FPH enhancing communications between Iris, wards and hospital discharge team – supporting the home-first narrative and liaising with families to provide assurance and information	1 x support coordinator (5 months)	Prevent Discharge delay due to risk averse and concerned families and discrepancies between acute/ community assessments	Anna McCafferty, ACT Team Manager