Short Term Care at Home

- Delivering an end to end service (combined crisis/reablement)
- Short Term homebased support
- 5 Geographical boundaries
- Block contracted hours
- Service commenced 3 April

Short Term Care at Home (BLOCK CONTRACTS)

The Service will focus on the needs of the individual at that point in time, providing support in the following situations:

- **Urgent support** - Where an individual requires urgent care and support at home where normal living arrangements (including unpaid/informal care) have broken down unexpectedly or another crisis situation has led to a need for urgent care and support without which could lead to hospital or care home admission. In exceptional circumstances, this could be used to support hospitals.

- **Planned support** - The service will support all planned discharges from acute and community hospitals and bed-based care settings currently working through a Discharge to Assess (D2A) or rehabilitation model. The Service will also receive referrals for individuals living in the community which will focus on prevention, recuperation and rehabilitation.

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Key Aims

- Deliver continuity of care for the person as they will be in receipt of care and support from the same provider throughout their intermediate care journey.
- A single case co-ordinator that would be the point of contact throughout, monitor progress, support with provision in change of needs and prevent the multiple handoffs currently experienced.
- Single Point of Access.
- Greater oversight and management of information.

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Outcomes

- Support people to regain life skills that have been temporarily lost, or where there has been a gradual deterioration or a risk of loss of ability, and to help people to retain or regain their independence
- Prevent people from requiring more intensive forms of care (for example, hospital or care home) and to help them return home after a stay in hospital or in a short-term care home setting.
- Support people in their own home who may not otherwise be able to stay safe and well at home.
- Help people avoid unnecessary admissions into residential homes, hospital or other formal care settings through working with the individual and their support networks.
- Support people at home with high quality interventions and to be connected within their local communities where they feel safe and supported with personalised care that promotes choice and control in all aspects of daily life.
- Support people to achieve their goals through a strengths-based approach which allows people to learn new ways of undertaking personal and home-based activities, with the support of equipment and/or technology to help them remain independent.

STSS - Delivery Team

- Provide case management by having an allocated worker.
- The allocated worker will be the point of contact for the person, their family and internal and external partners.
- Within 5 days the allocated worker will establish a support plan based on the person's needs, this could be to continue to recover/recuperate or to set SMART goals.
- The allocated worker will continually review the level of need and adapt the care provision to suit as things change.
- Provide advice on other internal and external services and make appropriate onward connections/referrals to support the person as required.
- Support for up to 6 weeks, or longer if the person has the potential to re-establish/regain an appropriate level of independence.
- If long term support identified and a POC is put in place, review around 2 weeks from start date.

Model approach

Supported by….
'A Case Co-Ordinator' for every person
(A point of contact for families and services to navigate through the whole intermediate care journey providing information, support, brokerage and reducing handoffs)

Accessed via….

-Home
-Bed Base
(Residential Care or Acute)

Through a Single Intermediate Care Front Door (LCC)

With clear information around circumstances and immediate medical issues have been addressed such as medication.

'Intermediate Care' Core Team
(Home Based & Bed Based – Dependent on identified need)

Single Assessment To Identify Needs, Type of Intermediate Care Approach and Anticipated Outcomes

Reablement Approach

Rehabilitation Approach

Recuperation Approach

Outcomes for People Using The Service ….

-More people independently living at home
-Easy access to support for people and families
- Single point of access and clarity around support for families
- Less handoffs and reduced assessments between services
- Tailored support to people's needs rather than one size fits all

Enhanced by….
Prompt access to specialist provision, information and advice when needed via a framework as a bolt on to the core offer rather than a referral onwards. For example, Telecare, Adaptations, Memory Support Services, Stroke provision or Housing