Appendix 2 Better Care Fund Lambeth. SLIC Older Peoples Programme Project List

Project	Description	MoC Stage
Better proactive identification of need and intervention		
HHA's	A proactive and holistic assessment of need, for over 65s, undertaken by someone's GP Practice.	Implementation
Care Management	Additional named support for care co-ordination / navigation or wider action planning, following a HHA, for more vulnerable or complex older people.	Implementation
CMDT Meetings	A community multi-disciplinary team of hospital, community and social care staff who will support care managers and GPs with challenging care management or system blockages.	Implementation
Care Homes	Acute – care home Interface- A proposal has been developed to test an interface role to work between the Kings' and local care homes to improve transfers of care and support advance care planning in the home.	Testing
An alternative acute response		
Consultant Hotline and hot clinic	A direct access specialist hospital phone line and rapid access clinics for community staff and GPs to support immediate action planning and admission avoidance.	Implementation
Enhanced Rapid Response	ERR provide enhanced therapy, nursing and social work support to support people to stay in their own home and prevent an admission to hospital, or to support them to be discharged from hospital earlier in their stay.	Implementation
@home	**@home** provides acute clinical care (where there is a medical need) at home by a multidisciplinary team and which otherwise would be carried out in hospital. Interventions, treatment and monitoring are delivered in the usual place of residence in order to provide the best possible patient experience and outcomes, and enable the patient to benefit from holistic integrated care.	Implementation
Maximising independence before long-term care is finalised		
Simplified Discharge	Using learning from previous tests involving extended ERR service and an enhanced social worker service on the older peoples wards. This project group is designing options for a unified point of access for community and social care services at the point of discharge and new models to improve the discharge process for patients returning home or to a care home.	Design and testing
Improved Clinical Pathways		
Falls	New strength and balance classes are being offered to older people who have had a fall or are worried about falling to improve their strength and balance and reduce the risk of falling. The test is focussing on how to identify at risk clients and provide a	Testing

	triage service using a Ban 4 physio assistant.	
Infection	Catheter passport – the passport is a patient document that goes with them as they move through care settings to improve information sharing and empower the patient to better self-manage their catheter. The aim of this is to reduce the instances of catheter related UTI that result in avoidable A&E admissions. Cellulitis and UTI check lists are professional checklists designed to support healthcare professionals identify and treat these infections, particularly recurrence, to avoid avoidable A&E admissions.	Testing
Nutrition	A team of community based dieticians are being recruited for a 12 month test of two dietetic models, direct care and education / facilitation models, to determine which has the greatest impact in addressing instances of malnutrition.	Testing
Dementia	Digital Directory – a digital directory of local dementia services has been developed and validated to support health and social care professional as well as citizens and carers access local information on services for them. Mental health support to care homes – a specialist mental health team is to be recruited for a 12 month period to test their impact upon supporting care home residents with dementia but who also exhibit challenging behaviour. This will test the impact of the team on the experience and outcomes of residents, as well the impact upon admissions. MH Acute to community – this test is to examine the impact of mental health in the acutes, as well as on the links into community services to support the integrated on health and mental health, as well as transfers of care. Better discharge pack to care homes – this is a small test to improve the flow of information for dementia patients (and others) who are discharged to care homes with a specific discharge pack.	Design & Testing