Home First

...we are caring and compassionate

...we deliver quality and value

...we work in partnership
Setting the scene..

- Acute trust in special measures
- Focus on three areas of improvement
- Discharge to Assess pilot - September 2015
- Other models explored

8 WEEKS
Task One

OUR AIM

...we are caring and compassionate...we deliver quality and value...we work in partnership
Our aim is to speed up hospital discharge times and improve patient outcomes

We will support patients who might need assistance at home by arranging an independence program

Our offer will provide assessment of needs, setting of goals and provision of support at home; promoting independence and reducing the need for ongoing long term care in the future
Quotes that made an impact

Home First Principle (Ian Sturgess)

No patient should ever enter hospital and never return to see their home ever again (Liz Sergeant)

Understand and successfully operate the existing business – Alignment (Ian Sturgess)

Need to remove barriers and perverse incentives created by contracts and organisational boundaries via planning and working collaboratively (Ian Sturgess)
Our Shared Pledge:

**Medway Health and Social Care Partner's pledge is to:**

- Minimise patient's acute hospital length of stay
- Maximise independence through enablement
- Support care at home or closer to home
- Make no decision about long term care in an acute setting

| Support timely discharge from hospital, avoiding delays and supporting people to leave earlier | Maintain maximum independence where possible and enable people to help themselves | Reduce the level of long term care packages and premature admission to a residential care setting | Improve outcomes for patients and carers |
A multi-agency partnership initiative working across the whole health and social care system to reduce unnecessarily prolonged lengths of stay in an acute hospital.

Facilitating more timely and effective hospital discharges, achieved by the community providing holistic assessment, equipment and on-going enablement and support in the patient’s own home or intermediate care facility.

Facilitating up to 35 discharges onto Pathway One per week, including weekends.
What our Home First model will deliver:

• Assessment for reablement and improving independence within an environment familiar to the patient.

• Removal of steps, processes and delays in the discharge process which consume valuable resources and do not add value for the patient.

• A reduction in length of stay.

• A reduction in the risk associated with vulnerable patients remaining in a hospital environment and deconditioning.

• Increased discharge rates on the wards.

• Freeing up of hospital beds.

• Increased patient flow through the hospital.
Task Two

DESIGN & PLANNING
• Designated Lead
• Pathways
• Single Point of Access (SPA)
• Staffing
• Enablement agency support
• Board rounds
• Equipment provision
• Transport
• Wrap around support
• Comms
• Contingency and escalation plans
• Branding
We know that you would rather recover at home than in hospital.

That's why we are working together to make getting you home our priority with Home First.

We will make sure you feel confident, independent and supported by us every step of the way.
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Pathway Zero
Pathway One
Pathway Two
Pathway Three
What pathway is your patient on?

Pathway 0
- The patient no longer has any care needs that require additional support
- Patient identified as medically fit and no further support required
- Coordinate discharge and restart any previous care packages

Pathway 1
- The patient has additional care needs that can be safely met at home
- Patient identified as medically fit but further support required
- Patient deemed safe between visits at home
- Call 01634 891 900 to refer (including equipment, therapy, and enablement)

Pathway 2
- The patient is unable to return home for a short period of time as they require further rehabilitation
- Patient identified as medically fit but requires further rehabilitation, and is unsafe to be left between visits.
- Requires further support but no longer required to be delivered in an inpatient setting
- Refer to the Integrated Discharge Team (IDT)

Pathway 3
- The patient has complex needs and is unable to return home
- Patient unable to live independently at home and requires long term social support / placement; or the patient is end of life / is rapidly deteriorating / in the terminal phase of illness
- Refer to the Integrated Discharge Team (IDT)
Home First

Enablement
- Existing package of care - no additional support required: 0
- New or additional support required: 1
- Medway Council tax payer:
  - Yes: 1
  - No: 2
- Continuing healthcare: 3

Equipment
- None: 0
- Mobility / toileting / transfers: 1
- Profiling beds / hoists: 2
- Adaptations required: 2

Safety
- Confused and lives with a carer: 1
- Confused and lives alone: 2
- Keysafe required to access property: 2
- The patient is a carer for another person: 2

Clinical
- OT / physio input: 1
- Community nursing: 1
- Dynamic mattress required: 2
- Fast-track: 3

Key things to remember:
- Must have EDN
- Post-op instructions

Specific pathways:
- Stroke
- Palliative
- Fast-track

Transport:
- Home First can arrange before 1pm

Contacts:
- Home First - 01634 891900
- IDT - 01634 833901

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Pathway One

The Ward contact community single point of contact

Triage completed over the telephone:

- If transport is required a slot will be booked
- Any previous community support & enablement will be reinstated
- A timed visit will be made for an OT to assess
- Any health service referrals will be made
- In the community the patient will be visited by an OT within two hours of arriving home.

The OT will:

- Perform a holistic assessment of needs
- Establish enablement goals
- Instigate an independence program (inc therapy & personal care for up to 6 weeks)
- Order / provide equipment within next two hours
Themes & Issues

- No EDN’s
- Wards not calling to inform us the patient had left the ward
- Patients not ready to leave by 3pm
- Backlogs & ‘roll overs’
- Numbers and trends
- Bypassing of the systems in place
- Some complex needs required more planning before discharge
- Creation of new/alternative pathways
What have we achieved so far..

• Time…
• Discharges under Home First…
• Reduction in DTOC numbers…
• Change in culture…
• Reduction in long term care reliance…
• Improved patient flow…
• Recognition…
• Great working relationships…
• DoH – Patient Access & Flow Team
• NHS Improvement Organisation – Flow & Capacity Booklet
• NHS England – Discharge to Assess Guide
• NHS England Showcase Days
• The Academy of Fabulous Stuff Penguin Award
• BBC News
• National Award Nominations