3. Act Now – getting people "Home First"



"Behind every Delayed Transfer of Care there is a person, in the wrong place at the wrong time."

Better Care Fund and Newton Europe 2018

As health and social care staff we should support individuals to return home. We should implement a Discharge to Assess model, where going home is the first option.



Act Now:

- ☐ From arrival at hospital, obtain as much information as possible about an individual's housing and home circumstances and keep this updated throughout their stay;
- ☐ Ensure assessment includes clinical criteria for discharge and an expected discharge date. Start planning for discharge at this point;
- ☐ Involve Occupational Therapy at an early stage to assess physical function and housing suitability, liaising with Social Care and care providers;
- ☐ Liaise with the individual's family, carers and key health and care professionals to ensure a seamless discharge process;
- ☐ Facilitate individuals to administer their own medicines when safe to do so:
- ☐ Include information about on-going care needs in the care plan and discharge process;
- ☐ If someone is going into hospital for elective treatment, start planning for hospital discharge before admission and take into account their anticipated ongoing needs after discharge;
- ☐ Ensure there is access to care and support if it is required on the day of discharge;
- ☐ Identify whether the individual is receiving homecare and maintain contact with their homecare provider, giving early notice of expected discharge date and likely requirements.



Additional resources:

- https://www.nhs.uk/NHSEngland/keoghreview/Documents/quick-guides/Quick-Guide-better-use-of-careat-home.pdf
- https://www.cqc.org.uk/publications/themed-work/beyondbarriers-how-older-people-move-between-health-care-england
- https://www.england.nhs.uk/leadingchange/staffleadership/framework-to-support-winter-pressures-2017-18/
- http://www.housinglin.org.uk/Topics/browse/HealthandHousing/H
 ospitalCarePathways/

What else can I do to get patients "Home First"?

- ☐ Adopt a "Home First" or "Discharge to Assess" way of working;
- ☐ Transfer hospital treatment and care closer to or at the individuals' home, when appropriate;
- ☐ Make decisions on long term care needs after allowing individuals a period of recovery and rehabilitation:
- □ Develop an awareness of services available at home: care at home might include 24 hour homecare, extra care or supported living, adaptations to the home and telecare. The UKHCA, a provider association, offer more information (www.ukhca.co.uk):
- ☐ Seek out and act on opportunities to involve voluntary and community sector organisations in the care package.

Wherever possible, people should be supported to return home. This guide should be read in conjunction with "Act Now – plan for discharge early"

Act Now – getting people "Home First"

Case study example of Home First in practice:

Medway CCG, Medway Council and Medway Community HealthCare established a Home First Initiative to provide support for individuals medically fit for discharge, but who will still require ongoing home support.

The initiative in Kent includes:

- A full assessment in their own home, within two hours of leaving the hospital;
- An occupational therapist will discuss with the individual what social and / or health care is needed to aid their recovery;
- A jointly agreed care plan which may include equipment needs and what support is required to get back to their daily routine;

The health and care teams in Medway are helping individuals get home through a successful partnership between health and care services.



Take a closer look:

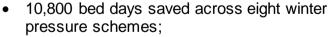
The Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), NHS England and the Department of Health co-developed the high impact change model for managing transfers of care which offers a practical approach to managing patient flow and hospital discharge: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

Read more here:

www.newtoneurope.com/content/sectors/NEW0164 DTOC Brochure Online Spreads 1.0 1.pdf

Case study: A collaborative partnership between Royal Bournemouth and Christchurch Hospital NHS Foundation Trust, Local Authority, CCG and AginCare has demonstrated both short- and long-term sustainable success in Home First projects by transforming traditional sector models to offer a highly flexible staffing model that is reactive to the

local needs:



 Flexible and agile workforce capacity - bridging, enhanced domiciliary and 24-hour models;

"Without the Discharge to Assess pathway it is very likely that patient X would have entered permanent

residential care, possibly with NHS

4 times a day." Staff from South

NHS England Quick guide).

Continuing Healthcare funded package

of care. Instead the patient went home

with a care package consisting of visits

Warwickshire, (Discharge to Assess,

 Improved outcomes, system breathing space, reduced readmission, Delayed Transfers of Care and 25% reduction in stranded patients 21 days+.



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