

Home First – discharge to assess...

When a patient is medically fit/clinically optimised and no longer requires an acute bed:

- Further rehabilitation/enablement takes place in their usual home environment or in a short-term interim setting, rather than on a hospital ward.
- At home we achieve a more accurate assessment of a persons abilities and care needs
- Better patient experience and supports earlier discharge from hospital

HOW?

Patient no longer has needs that can only be met in an acute hospital and may need further support

Pathway 1

Patient's needs can safely be met at home

Avg < 3 weeks

Pathway 2

Patient requires a short-term interim rehabilitation placement to enable a safe return home

Avg < 3 weeks

Pathway 3

Patient unable to return home initially, has more complex needs which may require permanent on-going care

Avg < 4 weeks

System Funded

- All pathways have additional therapy support provided by acute hospitals, Sompar & SCC
- All pathways have retrained reablement staff
- All pathways are the responsibility of discharging hospital pathway manager, including escalations. Pathway providers have a contact in the hospital
- All pathways monitored by daily MDT meeting

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Pathway 1- Support at home

- 3 Reablement providers working in partnership across Somerset exclusively for hospital discharge
 - Somerset Care, Brunelcare, Care South
- Supported by RHSS (Somerset Partnership)
- Supported by therapy resource
- Trained by hospital therapists
- Overseen by Pathway manager and discharge team via daily updates on progress from the community provision
- Payment by results – aim to reduce ongoing care and chance of readmission
- Help people live the life at home that they want!
- Target 8-14 days support

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Pathway 2- Interim bed to achieve reablement

- 3 bedded settings across Somerset exclusively for hospital discharge
- Bridgwater & West Mendip Community Hospitals, Cooksons Court
- Supported by additional therapy resource (Somerset Partnership, acute trusts and SCC)
- Trained by hospital therapists
- Overseen by Pathway manager and discharge team via daily updates on progress from the community provision
- “Hands off” support – supporting people to do things themselves not be done to
- Help people return home quickly
- Target 8-10 days maximum stay

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Pathway 3- Complex reablement bed

- 2 bedded settings across Somerset exclusively for hospital discharge
- Slower stream reablement e.g. to settle dementia confusion and give people best chance to go home
 - Sherborne House and Hamilton Park Nursing Home
- Supported by additional therapy resource (MPH, YDH and SCC)
- Trained by hospital therapists – partnership working
- Overseen by Pathway manager and discharge team via daily updates on progress from the community provision
- Help people to return home or the most appropriate setting for their needs
- Target 12-16 days maximum stay

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Total YTD (22/01/18)

Pathway	MPH	YDH
1	173	134
2	154	157
3	24	30

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Measuring Success

- Increase in independence score
- Reduction in DTOC to 2.5% April 2018

DTOC's in March 2017 :

T&S – 9.75% **1583 lost bed days**

YDH – 6.47% **656 lost bed days**

SOMPar – 6.99% **886 lost bed days**

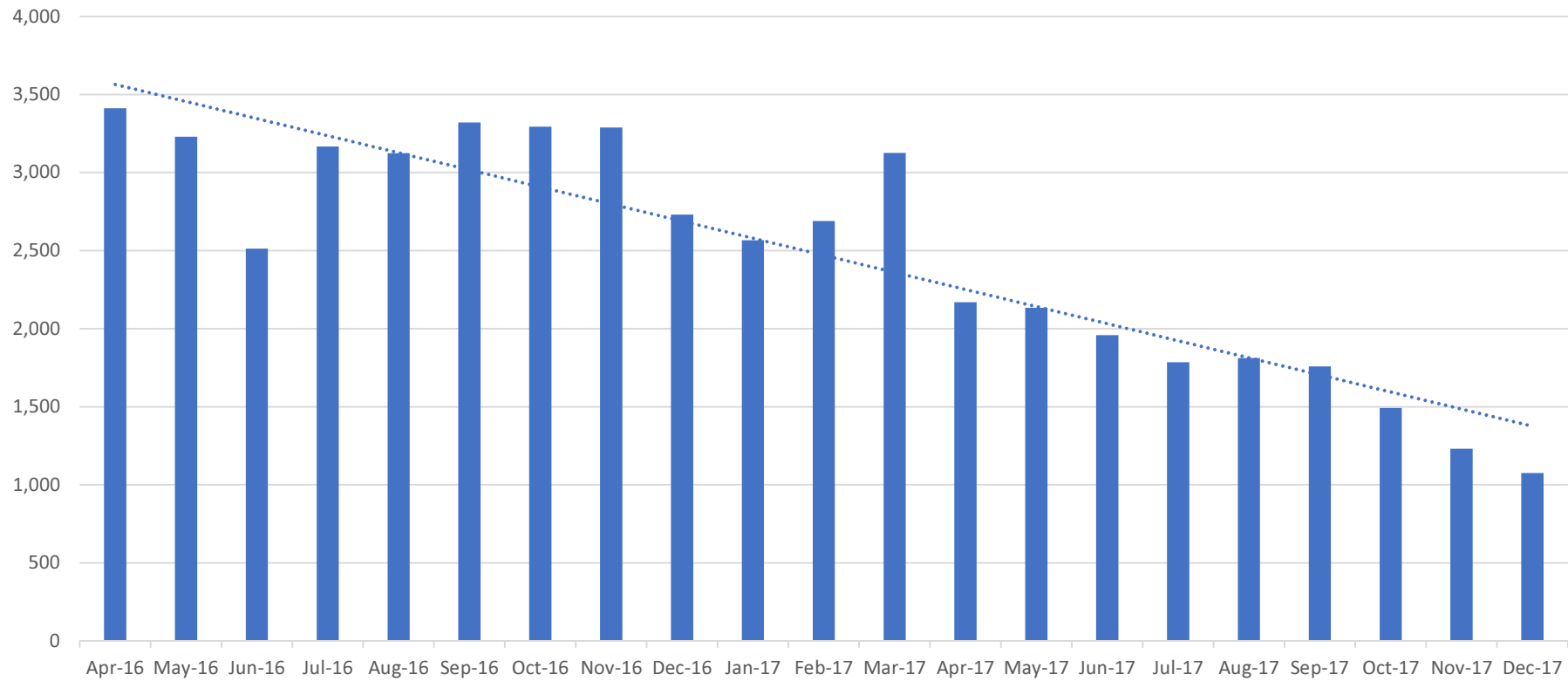
- Reduction in LOS >7 days
- Maintain/reduce long term Social Care expenditure
- Reduction in permanent care placements
- Reduction in acute readmission within 90 days

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Long term trajectory

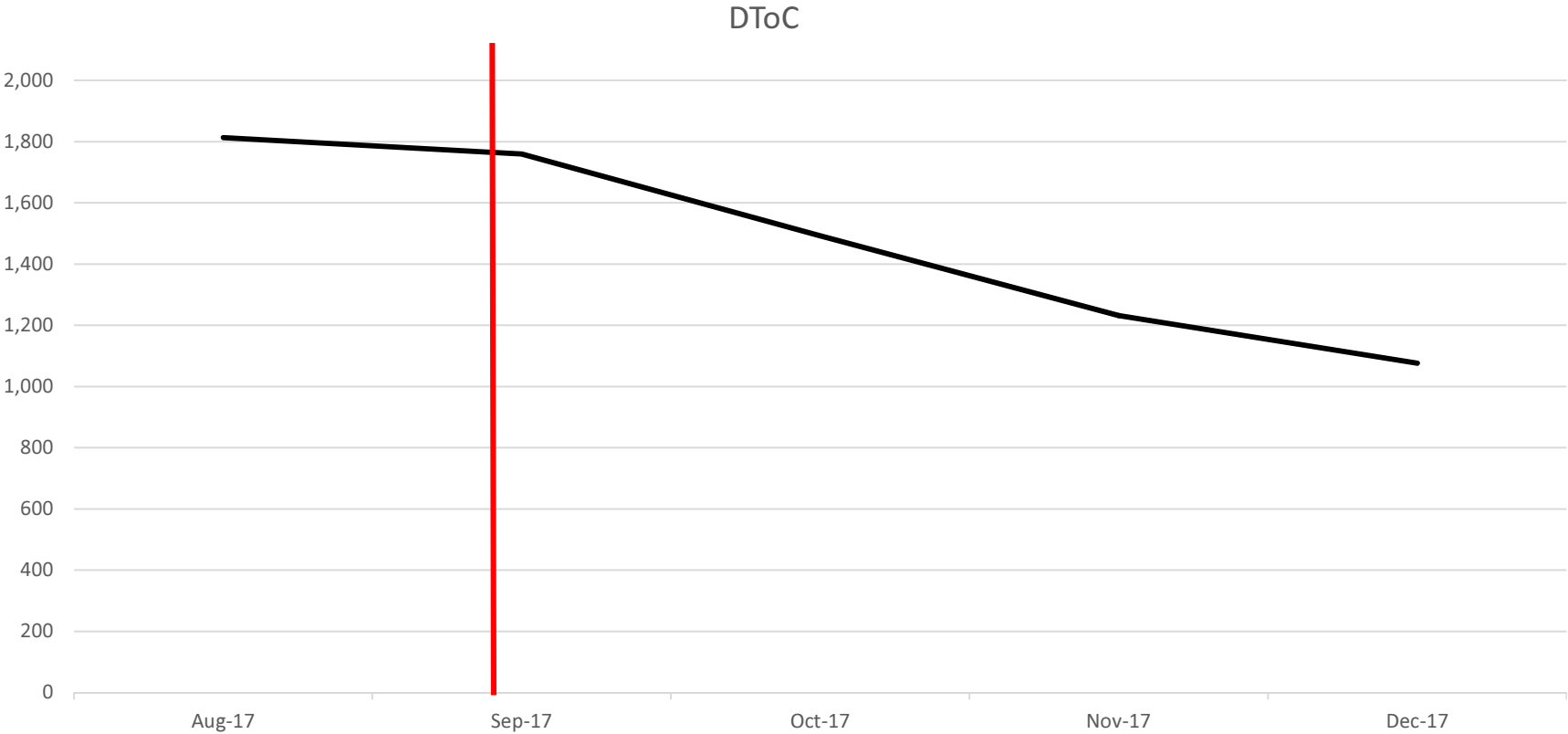
DToC's - lost bed days



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Since Home First launch



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BCF Targets

	Delay(Bed Days)	BCF Target
July	1,786	1,835
August	1,813	1,725
Sept	1,759	1,571
Oct	1,492	1,513
Nov	1,232	1,415
Dec	1,076	1,411
Jan		1,369
Feb		1,208

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Learning so far...

- Still a reliance on bed based care models
- Therapy capacity in the community a challenge
- Ave bed days saved 5+ per person
- Variable decision making
- GP engagement?
- Challenge/too early to evidence overall outcomes on long term care and system
- No increase in readmittance
- Partnership working can be done, at pace and without complicating it
- Closer links to acute hospitals benefit the hospital AND social care
- DToC's are everybody's business not one organisations fault or problem

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Further work

- Cost benefit analysis and funding decision 18/19
- Increase % of Pathway 1 and no pathway needed
- Link to LoS in Community Hospitals
- Impact on long term care
- Practice – peer forums and learning
- Roll out to reablement plus model to all not just hospital discharges
- Re-align all care at home options
- Look at admission avoidance using similar modelling/cooperation
- Bigger role for 3rd sector/Community connect

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