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	Pathway 2	Pathway 3
Patient's needs can safely be met at home	Patient requires a short-term interim rehabilitation placement to enable a safe return home	Patient unable to return home initially, has more complex needs which may require permanent on-going care
Avg < 3 weeks	Avg < 3 weeks	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

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

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

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

Total YTD (22/01/18)

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

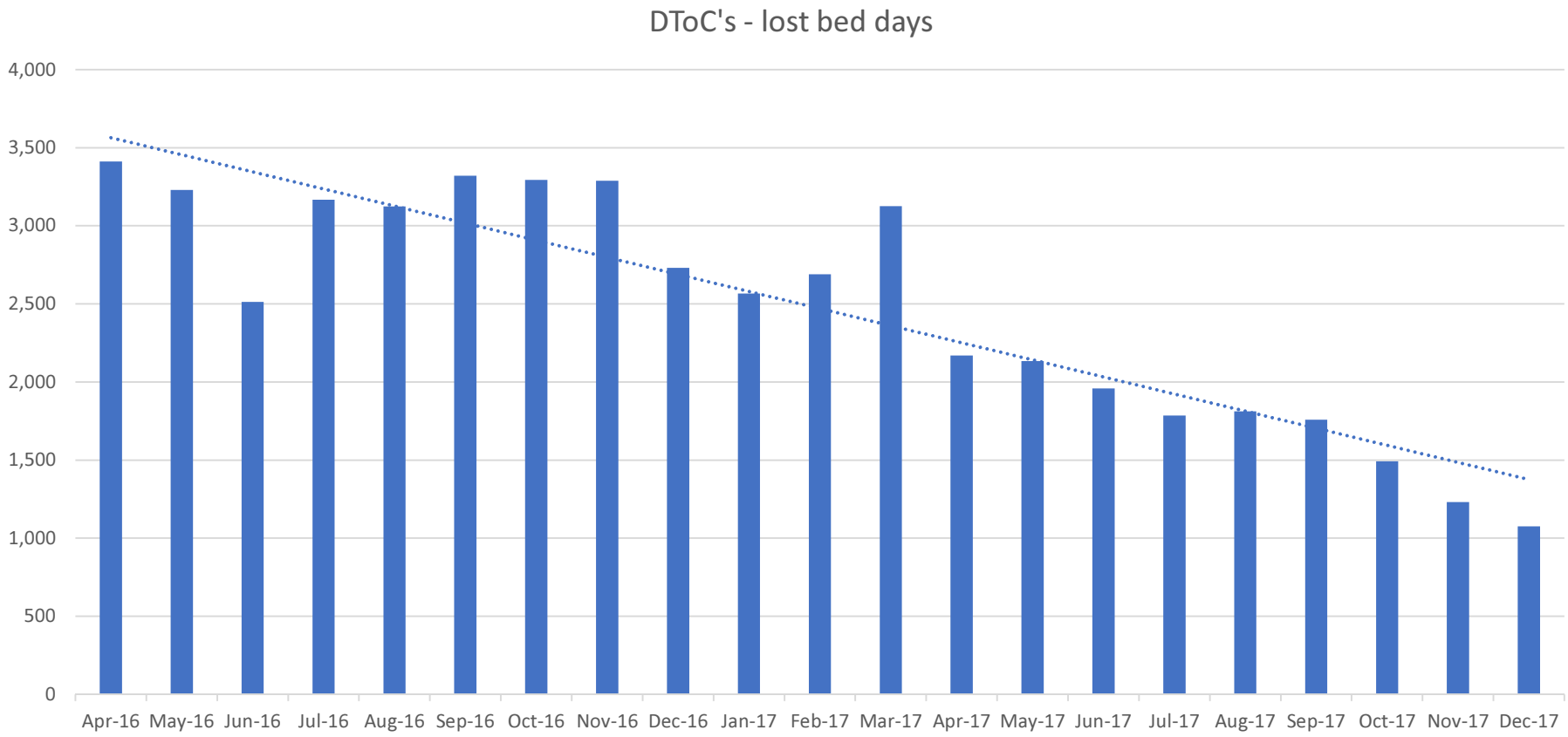
Measuring Success

- 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

Long term trajectory



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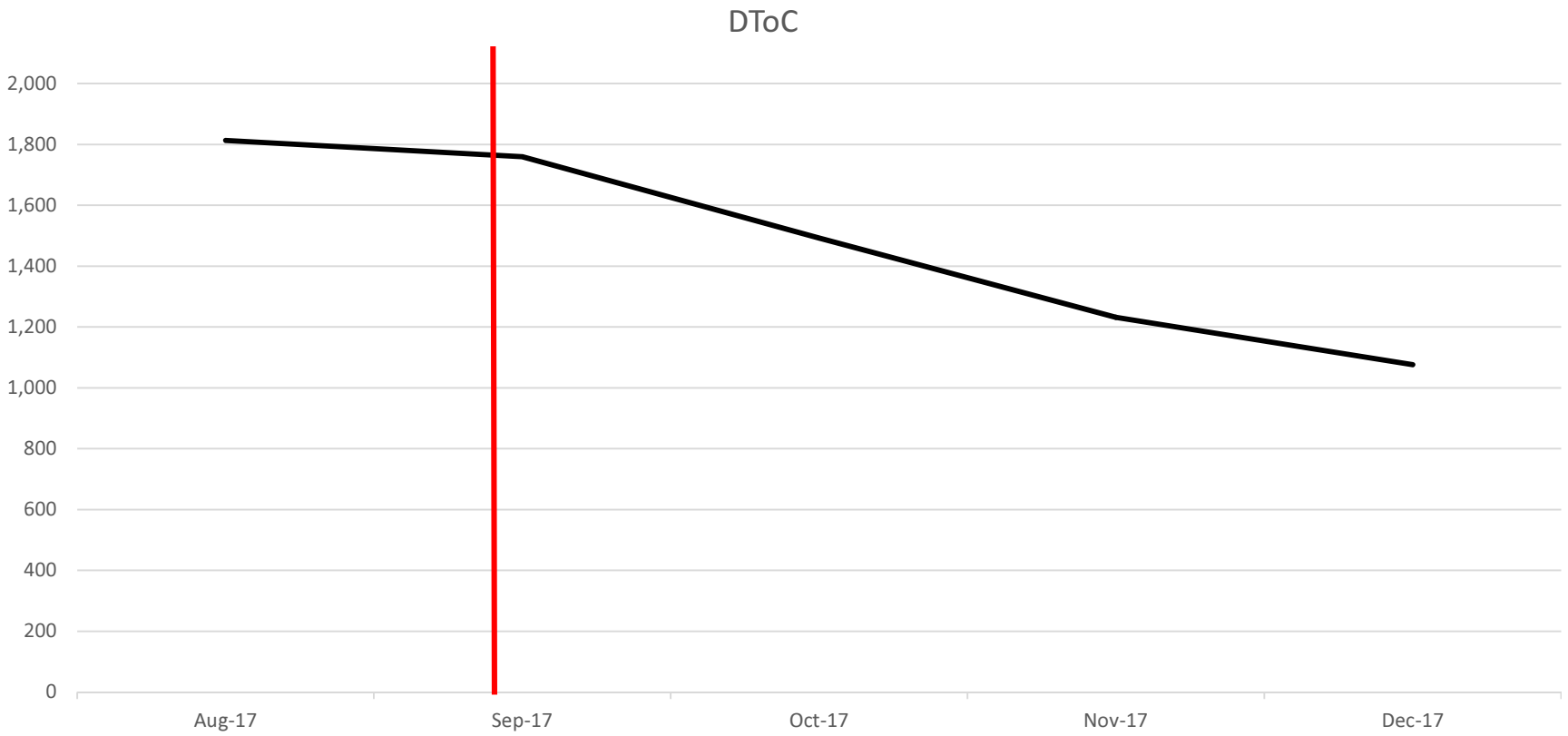
Since Home First launch



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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

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

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