# 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 always support individuals to return home, wherever possible. 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 the local authority and care providers;
- ☐ Liaise with the individual's family, carers and key health and care professionals, including care providers, 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 home care and maintain contact with their home care provider, giving early notice of expected discharge date and likely requirements.

### Additional resources:

- https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-better-use-of-care-at-home.pdf
- https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england
- https://www.england.nhs.uk/leadingchange/staff-leadership/framework-to-support-winter-pressures-2017-18/
- http://www.housinglin.org.uk/Topics/browse/HealthandHousing/HospitalCarePathways/

### 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 individuals have had a period of recovery and rehabilitation;
- ☐ Develop an awareness of services available at home: care at home might include 24-hour home care, extra care or supported living, adaptations to the home and telecare. The UKHCA, a provider association, offer more information about homecare (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"

"Without the Discharge to Assess pathway it is very likely that patient X would have entered permanent residential care, possibly with NHS Continuing Healthcare funded package of care. Instead the patient went home with a care package consisting of visits 4 times a day." **Staff from South Warwickshire, (Discharge to Assess, NHS England Quick guide).**

**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.

www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/3-medway-D2A-model.docx

**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:

- 10,800 bed days saved across eight winter pressure schemes;
- Flexible and agile workforce capacity - bridging, enhanced domiciliary and 24-hour models;
- Improved outcomes, system breathing space, reduced readmission, Delayed Transfers of Care and 25% reduction in stranded patients 21 days+.

Provided in partnership with:

For more information, please contact: ENGLAND.leading-change@nhs.net