

# 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/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 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](http://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.

“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).

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/3-medway-D2A-model.docx](http://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](http://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+.



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