Bath & North East Somerset Council		
MEETING	**Health and Wellbeing Select Committee**	
MEETING DATE:	**19 July 2017**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**An Introduction to the Home First Service**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Not Applicable		

1 THE ISSUE

1.1 This paper aims to provide the Health and Wellbeing Select Committee with an outline overview of the Home First service model, which was implemented within Bath and North East Somerset (B&NES) in March 2017. The paper additionally aims to highlight the progress made within the B&NES Home First service to date and outline any planned developments.

2 RECOMMENDATION

2.1 The Committee is asked to note the briefing on the Home First service model.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 The Home First service is currently provided within the Virgin Care Integrated Reablement Service using existing staffing and funded largely through the Better Care Fund. It is also supported with additional funding from the Clinical Commissioning Group. Part of the Improved Better Care Fund Adult Social Care grant monies awarded to the Council for 3 years from 2017-2020[1] will also be used to support a 7 day service, offer earlier transport home and to commission 5 beds within a nursing home which are explained more at sections 5.3 and 5.4.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Home First has been set out as a requirement for Clinical Commissioning Groups and Councils to develop. It is set out within the Better Care Fund

[1] Three year adult social care grant funding known as the Improved Better Care Fund (I-BCF) announced in the Spring Budget and totalling £6.5m for B&NES. It must be used to support the delivery of social care and local social care providers such as care homes, and also help ensure that hospital discharges are not held up where possible.

guidance for 2017-19 which expects that local health and care systems will invest in services which support people to be discharged from hospital as soon as they are ready and also in NHS England's Next Steps for the NHS Five Year Forward View published in March 2017.

5 THE REPORT

5.1 Home First (also known as Discharge to Assess) has been identified as a key priority locally to support patients to leave hospital and help them to have their needs assessed at home or in a more homely environment wherever possible. Being delayed in hospital can have many repercussions for people themselves but also for acute hospitals and people needing care and treatment elsewhere in the health system such as the front door of hospitals (the Emergency Department), as people cannot move through the hospital system. The service model for Home First is specifically referenced in this year's guidance for the Better Care Fund, the Government's strategic approach to health and social care integration and also the Improved Better Care Fund which is three year adult social care grant funding announced in the Spring Budget 2017. As noted above, Home First has also been identified as a priority in NHS England's Next Steps on the Five Year Forward View, published on 31st March 2017.

Home First is based upon the principle that it is aimed, where safe, for all individuals to be discharged home as soon as they no longer require care that can only be provided in an acute hospital bed. Here any further health and social care assessments can be undertaken at the right time and in the most appropriate environment for the individual to fully assess their long term care and support needs. If individuals are unable to safely return home then temporary options need to exist to allow assessments to be undertaken in an environment which will best meet their needs. before Home First, often assessments for care at home and long term care home beds were carried out in hospital, in an unfamiliar environment and also when people were still recovering from an acute illness. This meant that permanent decisions about care needs were often made at a time when people's needs could still change, leading to early admissions to care homes and also over-provision of care in the community at a time when this is a scarce resource.

5.2 The local and national focus on Home First stems from the fact that not only does it help deliver improvements against national measures, such as people delayed in hospital waiting to be discharged (Delayed Transfers of Care, also known as DTOC), but also from the recognition that an acute hospital bed is not the best place for individuals who no longer need to be there. For older people in particular, it is recognised that prolonged hospital stays can lead to worse health outcomes and can increase their long-term care needs. By allowing time for recuperation, rehabilitation and reablement in a more appropriate environment, it will increase an individual's independence and ability to undertake day to day activities such as washing, dressing and meal preparation. Additionally it ensures that nobody is making a decision about their long term care needs whilst they are in crisis. In summary, Home First is not only the right thing to do for the system; it is the right thing to do for individuals.

However, whilst the rationale for Home First is clear, pathways need to be developed to support the Home First model. The pathways for Home First in

B&NES have been the subject of significant work across the health and care system and four pathways have been agreed as follows:

	Pathway 0 **No additional support**	**Home First - Pathway 1** **Additional support needed, but can go home**	**Pathway 2** **Additional support needed, but can't go home**	**Pathway 3** **Straight to long term care/ specialist care**
Essential Criteria	RUH ward manged discharge	RUH ward identify patients, referral process?	RUH ward refer to IDS & MDT discussion	RUH ward refer to IDS & MDT discussion
	1. Medically able, with no additional post discharge support required	1.Medically able but additional post-inpatient support required	1.Medically able but additional post-inpatient support required	1.Medically able but additional long term support required
	2. Safe to be discharged to home (includes no safeguarding concern)	2. Safe to be left between visits (including no safeguarding concerns present)	2. Not safe to be left between visits (includes safeguarding concern)	2.Known and settled long term complex needs which prevent returning home
	3. Has access to a normal place of residence (this includes nursing and residential home settings)	3. Has access to a normal place of residence (includes residential care homes but not nursing homes)	AND/OR 3. Doesn't have access to a normal place of residence (includes existing care /nursing home)	OR 3.Known and settled long term complex needs which can be managed at home through a bespoke, planned discharge package
				OR 4. Additional support needs could be met in existing care /nursing home subject to assessment/ planning of discharge

(Figure 1)

5.3 Home First Pathway One has been recognised both nationally and locally as the pathway that is likely to deliver the biggest improvements against national measures, such as DTOCs, and individual outcomes, such as increased independence, and therefore has been the subject of significant work.

Within B&NES, this work is led by a Home First Operational Group made up of health and social care organisations in B&NES, Wiltshire and Somerset. For B&NES, representatives from the third sector (our Age UK Home from Hospital service) and domiciliary care agencies attend as well as our main providers such as Virgin Care and the RUH. The RUH provide the day to day leadership to develop this model.

Within B&NES the Home First Service (Pathway One) is delivered by the Integrated Reablement Team based with Virgin Care and three strategic domiciliary care agencies. The team are currently commissioned to provide Home First discharge slots for 20 individuals per week between Mon and Fri. Additionally they provide care, support and assessment to all people receiving Home First on their caseload across 7 days, for a maximum of 6 weeks.

It was agreed that this service should consist of the following:-

- A 24 hour turnaround from ward referral to discharge.

- An initial assessment by a Registered Physiotherapist or Occupational Therapist within 2 hours of discharge to identify immediate care and equipment needs.

- Care support of up to 4 visits per day, delivered by the Reablement Team or Reablement Strategic Domiciliary Care Partners.

- Equipment provision to support the individuals' care and mobility needs.

- On-going rehabilitation and reablement to increase to help people regain independence and strength – for example to climb stairs, make meals an get dressed themselves.

- On-going assessment to fully assess long term care needs.

- Onward referral to appropriate services once long term needs are apparent.

Since May 2017, 126 individuals have been discharged into the B&NES Home First Service, an average of 14 per week.

The service is continuing to develop and as outlined in the Better Care Fund Briefing provided to the Health and Wellbeing Board on 17th May 2017, an investment proposal has been agreed in principle to expand the service to support referral and discharge across 7 days. Temporary funding has also been provided to the RUH to help fund a discharge vehicle to enable people return home earlier in the day.

5.4 Pathway Two supports people who are still aiming to go home but will need some support over a 24 hour period and are unable to go home immediately. This is currently provided in B&NES only by the two community hospitals at St Martins and Paulton. Other communities may provide a wider range of options for people including rehabilitation, reablement and assessment beds within residential and nursing homes.

As outlined in the Better Care Fund report to the Health and Wellbeing Board on 17th May 2017 an investment proposal has been agreed in principle, to procure 5 beds within a single nursing home provider which will deliver bed based rehabilitation, reablement and assessments for up to 6 weeks. The rationale behind this is whilst community hospitals are able to deliver effective and evidence based rehabilitation, this is done so in a clinical environment and there are many people who need 24 hour support immediately on discharge from hospital, but do not need the medical input provided by a community hospital.

5.5 The investment above will also support people whose needs are likely to be met in a nursing or residential care environment, yet could be offered a further period of reablement to stabilise their needs and avoid making long term decisions about care needs in a hospital setting. This is Pathway Three in the table at figure 1.

5.6 Strategic development of these pathways will continue at a system-wide discharge workshop on the 24th July and metrics are currently being developed for this service.

In conclusion this briefing aims to outline the ethos behind the Home First Service model within B&NES. Generally it is about ensuring that home is the default pathway option for all individuals who no longer require care that can only be provided in an acute hospital bed. If the individual is unable to return home, then temporary options exist to support such individuals. These options ensure that, where possible, no decisions are made about individuals' long term care needs in a hospital environment and they offer additional opportunities to return home and to increase independence wherever possible. The development of the Home First service so far in B&NES has been led by colleagues across health, social care and the voluntary sector in a collaborative and positive way. The service is being evaluated and will shortly be able to demonstrate the positive impact that assessing a person's needs in their own home environment, or allowing them the time to recover from an acute illness before making a decision about their long term care needs can have on people themselves and on each part of the health and care system as capacity is directed to those who most need it. The outcomes for people themselves are positive, as are the outcomes for our health and care services which must ensure that they make the most of the resources available to them.

6 RATIONALE

6.1 Not Applicable. Paper for reference only.

7 OTHER OPTIONS CONSIDERED

7.1 Not Applicable. Paper for reference only.

8 CONSULTATION

8.1 B&NES CCG Commissioners, B&NES Council Adult Social Care Commissioners, Virgin Care and The Royal United Hospitals Bath NHS Foundation Trust.

9 RISK MANAGEMENT

9.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance. However as this report is for reference only, no risks have been identified.

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Background papers	*Not Applicable*
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