Bath & North East Somerset Council

NHS
Bath and North East Somerset
Clinical Commissioning Group

Home First Service Development

Caroline Holmes & Ryan Doherty

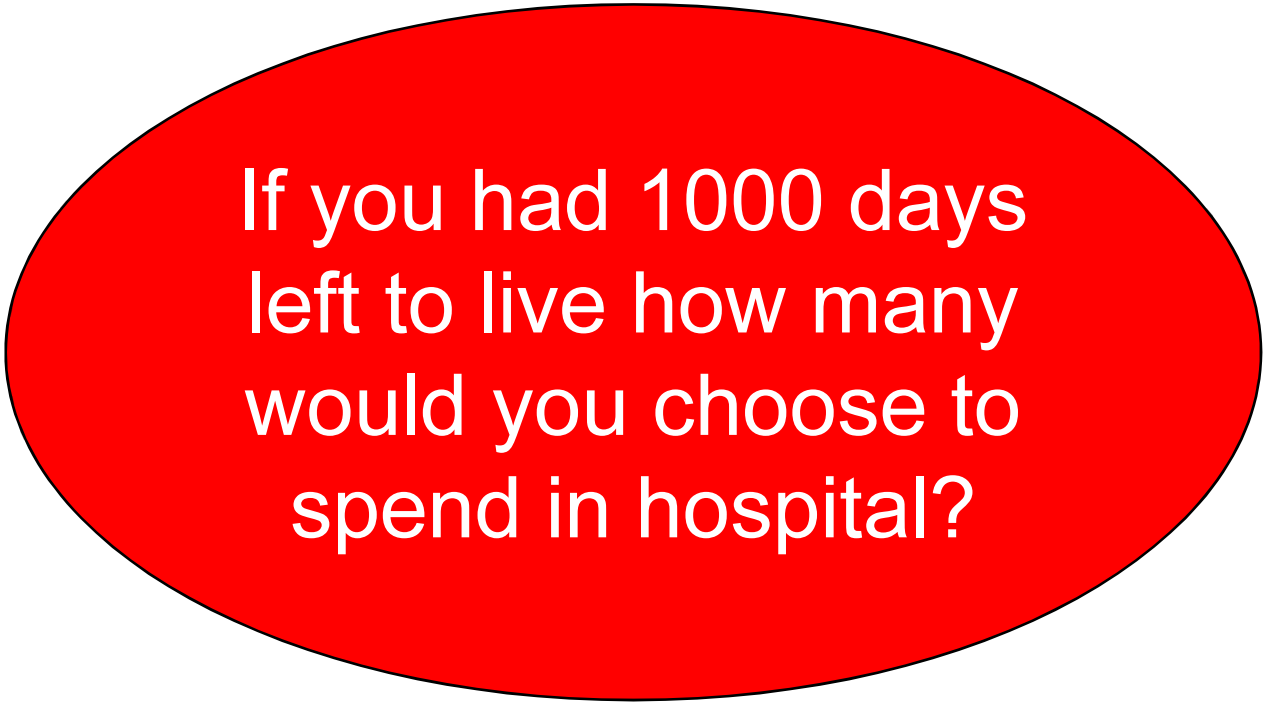
Senior Commissioning Manager and Commissioning Project Manager

Time Is The Currency

Health and Social Care is measured in time:-

- **Waiting Times**
- **A&E Performance Times**
- **Delayed Transfer of Care Times**
- **Length of Care Visits**
- **Time = an important currency for people.**
- **The average hospital patient is in their last 1000 days.**

Time Is The Currency



The Last 1000 days – Molly Case

Home First

- Home First supports the last 1000 days ethos.
- Home is the default pathway for all people.
- People do not spend anymore time than they need in hospital.
- People receive rehabilitation and reablement to increase independence.
- Nobody makes a decision about their long term care whilst they are in crisis.

Home First Benefits

- Reduces the risks of long hospital stays.
- Increases independence & functioning.
- Improves the flow and movement of patients through hospital.
- Overall, it's the right thing to do for the health and care system and patients.
- Collaborative system working to deliver Home First. It helps us all.

What Does Home First Look Like

- **Significant work undertaken to review the pathways to support Home First principles.**

Essential Criteria

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**
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

Home First Pathway 1

- Delivered by the Integrated Reablement Team in Virgin Care.
- 20 discharges per week Mon-Fri.
- Care, rehab and assessment over 7 days, for up to 6 weeks.
- 24 hour turnaround from referral to discharge.
- Met at home within 2 hours of discharge.
- Care and equipment provision sourced.
- Ongoing rehabilitation, reablement and assessment.

Pathway 1 Performance & Plan

- Since May 17– 126 patients discharged.
- An average of 14 per week.
- Plan to increase this to 20 per week in place.
- Includes a single point of access for wards, triage questions & performance dashboard.
- Plan to expand service to 7 day discharges (offering 24 slots per week).

Home First Pathway 1 Patient Story

• Mrs A

- 87 years and lived alone
- Previously had domestic support once weekly
- Admitted to RUH following a fall and community acquired pneumonia
- Home First Referral: 20/06/2017
- Discharged home: 22/06/2017
- Left ward around 12pm first visit at 2pm
- Mobile safe and independently
- Assessed and able to safely make hot drink
- Very anxious around changes to medications
- Morning visits to establish routine and support with medications.
- How is she now?

Home First Pathway 2 & 3

- Pathway 2 relates to those who are unable to go home and some support day and night.
- Currently provided by Community Hospitals.
- However plans to diversify bed base to include 5 rehabilitation and assessment beds.
- This ensures the person is in the most appropriate environment for reablement & assessment.

Home First Pathway 2 & 3

- Pathway 3 relates to patients who are likely to be entering long term care.
- Understand the support for homes to best meet patients needs in a timely manner.
- Pathway 3 allows people to have their long term care needs assessed away from a busy hospital when they have been ill.
- Additionally pathway 2 & 3 developments are to be discussed at a system wide event on the 24th July

Conclusion

- Home First makes the most of people's time.
- Home is the default pathway.
- Where people are unable to return home pathways exist to support them.
- Ensures people reach their potential for living independently and no decisions about long term care are made in crisis.

Any Questions?