MCH
medway community healthcare

Medway Council
Serving You

Home First

…we are caring and compassionate

…we deliver quality and value

…we work in partnership

Setting the scene..

- Acute trust in special measures
- Focus on three areas of improvement
- Discharge to Assess pilot - September 2015
- Other models explored

8 WEEKS

Quotes that made an impact

Home First Principle (Ian Sturgess)

No patient should ever enter hospital and never return to see their home ever again (Liz Sergeant)

Understand and successfully operate the existing business – Alignment (Ian Sturgess)

Need to remove barriers and perverse incentives created by contracts and organisational boundaries via planning and working collaboratively (Ian Sturgess)

OUR AIM

Our aim was to speed up hospital discharge times and improve patient outcomes

We pledged that we would support patients who might need assistance at home by providing assessment of needs in the patients own home; setting goals and providing any necessary support; promoting independence and reducing the need for ongoing long term care in the future

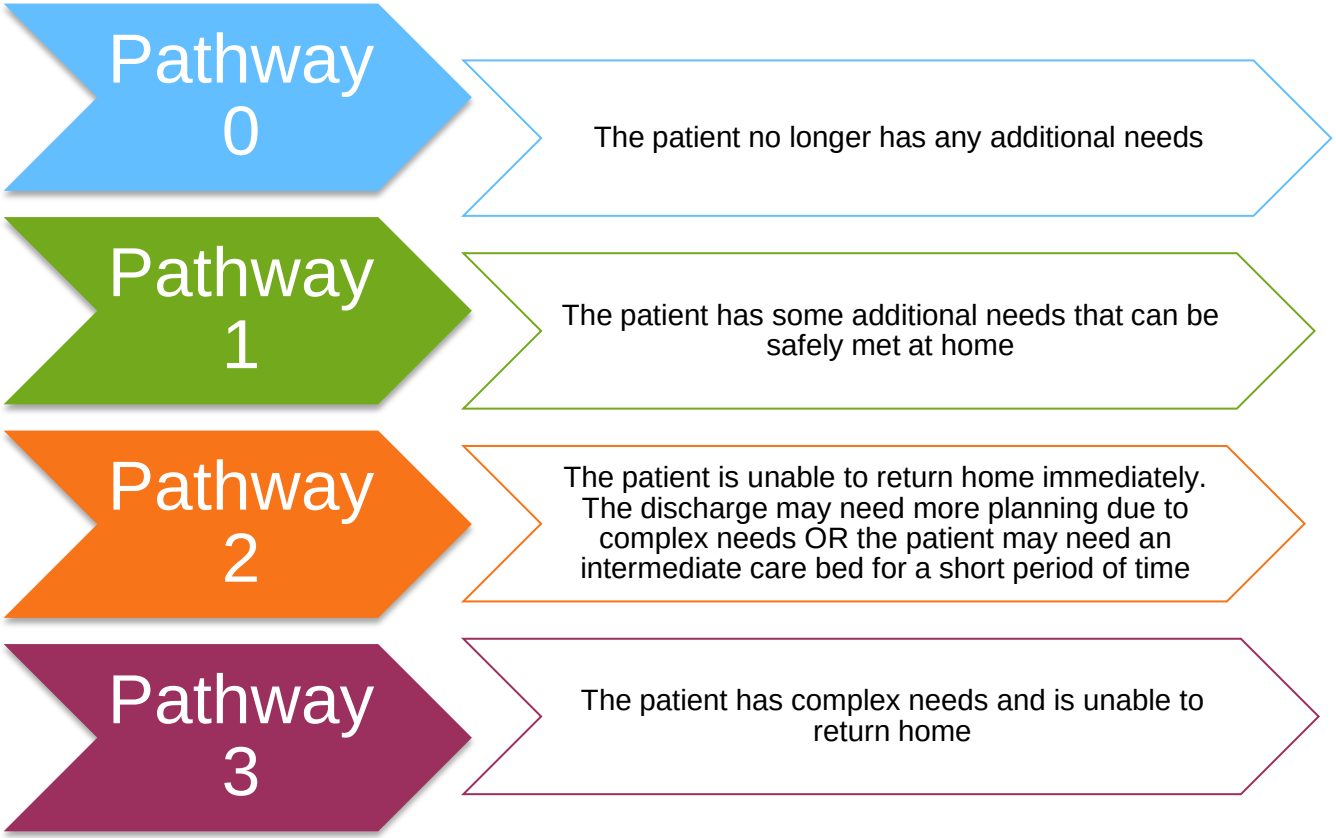
A multi-agency partnership initiative working across the whole health and social care system to reduce unnecessarily prolonged lengths of stay in an acute hospital.

Facilitating more timely and effective hospital discharges, achieved by the community providing holistic assessment, equipment and on-going enablement and support in the patient's own home or intermediate care facility instead of in the hospital.

Facilitating up to 35 discharges onto Pathway One per week, including weekends.

- Designated Lead
- Pathways

- Pathways – The Medway model designed four pathways to get people out of the hospital quicker:



Pathway One

The Ward contact community single point of contact

Triage completed over the telephone:

- If transport is required a slot will be booked
- Any previous community support & enablement will be reinstated
- A timed visit will be made for an OT to assess
- Any health service referrals will be made
- In the community the patient will be visited by an OT within two hours of arriving home.

The OT will:-

- Perform a holistic assessment of needs

- Establish enablement goals
- Instigate an independence program (inc therapy & personal care for *up to* 6 weeks)
- Order / provide equipment within next two hours

- **Designate a lead** – supported by a core group
- **Pathways** – keep it simple
- **Single Point of Access (SPA)** – one call does it all
- **Staffing** – flex resource across the whole system
- **Enablement agency support** – free care for all
- **Board rounds** – trusting decisions
- **Equipment provision** – quick access
- **Transport** - reliable
- **Wrap around support** – substitute for care visits
- **Comms** – spread the message and the vision
- **Contingency and escalation plans** – it may not be perfect but it can be good enough
- **Branding**

Themes & Issues

- No EDN's
- Wards not calling to inform us the patient had left the ward
- Patients not ready to leave by 3pm
- Backlogs & 'roll overs'
- Numbers and trends
- Bypassing of the systems in place
- Some complex needs required more planning before discharge
- Creation of new/alternative pathways

What has been achieved so far..

- Time…Started in April 2016
- Discharges under Home First…over 2000
- Reduction in DTOC numbers
- Change in culture
- Reduction in long term care reliance
- Improved patient flow
- Recognition and awards
- Great working relationships & sustainability

MEDWAY

Home First