Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS

Implementing the Home First Discharge Policy

What you can do now and in the next six months to improve patient flow, care and support after discharge and reduce unnecessary admissions

November 2021 Updated Version

Integration and Better Care Fund

Please note, these slides reflect ideas for quick wins over winter rather than must dos

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS

What you can do now in time for this winter…

1. Provide enhanced health support to domiciliary care providers especially in the evenings and weekends as part of an admission avoidance scheme.

2. Set a firm expected discharge date at the first consultant review and ensure everyone works to that – family, individual, ward staff, transport, pharmacy and transfer of care hub staff. Ensure clinicians “describe not prescribe” at ward rounds.

3. Revise local communication documents for individuals and families – post Covid and based on new discharge policy. Create scripts for staff in acute and community settings to use to help them explain the new policy.

4. Create a multidisciplinary triage process at the front door of the transfer of care hub – no separate routes in to or out of the hub. After discussion with the individual, the hub decides the pathway, destination and level of care.

5. Create alternatives to domiciliary care directly from the hospital or reablement service – such as live-in care, personal assistants, voluntary sector, informal carer support, or 72hr /24hr wrap around care provision.

6. Have a joint recruitment programme to create a bank of care and healthcare assistant staff and students who can be deployed according to local need, wherever that may be in the community. Jointly fund the bank of staff. Deploy according to the postcode where care is hard to source.

Integration and Better Care Fund

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS

What you can do now in time for this winter…

7. Review all care at home to maximise the use of the scarce domiciliary care resources. Taking a person-centred approach, ensure that the levels of care enhance independence utilising digital technology; this includes asking the individual what they would like to be supported to go home.

8. Invite care provider, housing and voluntary sector colleagues to join escalation meetings. Encourage joint meetings with providers so everyone understands each other's challenges and pressures – what makes a safe and timely discharge and what prevents one.

9. Establish weekly data and intelligence sharing across the system. Use the dashboard to establish the trends and challenges and develop solutions – coordinate and drive via the system's single coordinator.

10. Use private hospital and hospice resources and capacity to supplement community hospital capacity – not just for end of life care or elective care but also as step-down beds.

11. Ensure NHS acute providers routinely adopt processes to follow the NEWS2 admission decision flow chart tool to prevent unnecessary hospital admissions.

12. Senior clinical and organisational leaders should create a culture of trust and respect in their leadership of the system through winter – modelling behaviour across and within organisations – however tough the winter pressure becomes.

Integration and Better Care Fund

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS

What can you start working on for the future…

1. Create a narrative and ambition for admission avoidance, flow and safe and timely discharge which the whole system owns, and which is understood and owned by the wider community so it starts to influence behaviour.

2. Ensure the Discharge Policy is fully implemented from the point of admission through to the point of the person returning home to live.

3. Address the challenges of risk-averse practice, and put in place the organisational development and professional support and advice to enable professionals to practise differently and embrace positive risk-taking.

4. Create a long-term joint approach to the health and social care workforce – maximising the opportunities across geographical and organisational boundaries.

5. Establish collaborative commissioning at place, and align budgets to get the best from care providers.

6. Develop ways of managing people's care within the hospital that avoids multiple moves across in-patient wards, which creates greater dependency, longer lengths of stay and likely delay to discharge.

Integration and Better Care Fund

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS

What can you start working on for the future…

7. Use the Reducing Preventable Admissions High Impact Change Model to identify the gaps in the current system and put a programme in place to address the gaps (free facilitated support is available, email integration@local.gov.uk).

8. Undertake a cost benefit analysis of the Discharge Policy and the use of reablement as an alternative to bed-based care ensuring that the most efficient and effective model is used to make sure the whole system funds the resources needed in the community.

9. Create an organisational development plan for system senior and middle managers to understand and appreciate each other's roles and challenges – walk in each other's shoes in order to save valuable time and energy discussing issues repeatedly and not finding solutions to challenges.

10. Create regular forums with care providers to engage and support them in discharge solutions and wider challenges, broadening discussions beyond contracts and immediate capacity issues.

11. Ensure the individual's and family's voice are heard in a way that informs the future system response.

12. Create a system ambition and vision which focuses on place-based integrated community services to shift the emphasis away from the acute hospital to investing in a health and social care system which supports population health management and people living independent, healthy lives.

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS

What has worked in other systems…

1. Weekly / fortnightly pause and reflect sessions building trust and respect to enable leaders to have honest, challenging and supportive conversations about the system performance and challenges. External facilitation can support honest conversations.

2. Developing a shared data set and dashboard to jointly look at current performance – creating one version of the truth locally, and for regional and national enquiry.

3. Ensuring every system has a discharge policy single coordinator who works across the whole system accountable to the senior executive leaders as a group and able to act on their behalf – managing up and down and delivering the programme of work needed.

4. Ensuring equality of relationships across the system and with other partners – care providers, primary care, voluntary sector and wider local government.

5. Understanding of the funding flows and challenges in the system – creating aligned joint funding where it is needed but being clear about legislative boundaries, and local and national accountabilities.

6. Joint working between finance, HR and programme management teams across the system, sharing resources and workloads, developing common understanding and purpose in using resources efficiently.

Integration and Better Care Fund

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS

What has worked in other systems…

7. Staff seconded to the transfer of care hub from a care provider to assist with triage decisions, and trusted assessment, thus ensuring that discharge planning starts as soon as possible and not once the criteria to reside decision has been made.

8. Joint therapy teams being established across acute, community and social care – sharing the assessment burden but being clear about their therapeutic specialities. Particularly strong therapy input at the front door or in the frailty service running across evenings and weekends.

9. Being clear about the best use of community beds – health and social care – and not letting short-term bed placements become long term, and so avoiding creating greater dependency.

10. Creating multidisciplinary team / virtual ward rounds in the community, bringing together community health, social care, primary care, mental health, and ambulance for those most at risk of admission.

11. Introduce personal health budgets on discharge – use the draft standard operating procedure and pilot report on the Future NHS collaboration platform to design your local approach.

12. Developing a scheme to collect, recycle and redistribute community equipment no longer required to build equipment stores and reduce delays due to awaiting new equipment given current supply problems.