directors of adass
adult social services

Local Government Association

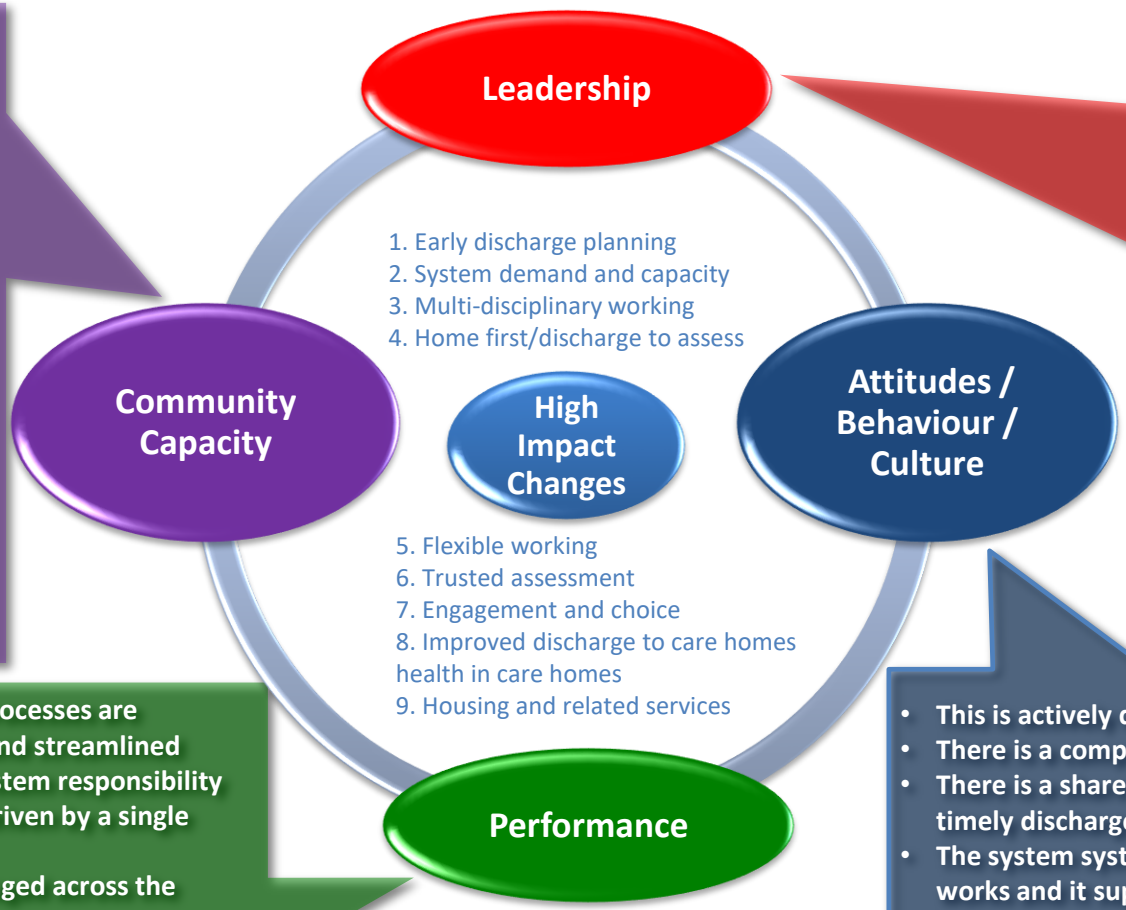
Implementing a Home First Approach to Discharge from Hospital




What Good Looks Like

Outcomes for People

- People get treatment, care and support that is co-ordinated, person centred and outcomes focused
- No-one has to make (or has made for them) lifetime decisions in hospital
- No-one is persuaded into short term care that is effectively long term



- System capacity is aligned to population need
- Role of the third sector maximised to improve community resilience
- Reliance on bed-based solutions reduced, enabling Home First models to succeed
- Future market strategy and flexible employment opportunities co-produced
- Pooled budgets and risk shares are underpinned by evidence

- Desire to make things better for local people underpins leadership and action
- Time is given to build relationships and trust
- There is a collective ambition and vision
- Lines of decision making and accountability are clear and understood
- Plans are clear, simplified and prioritised
- Clear use of distributed leadership

- Services, pathways and processes are simplified, standardised and streamlined
- There is agreed shared system responsibility
- System improvement is driven by a single agreed dataset
- Flow and capacity is managed across the whole system
- The nine High Impact Changes are systematically and sustainably implemented

- This is actively driven by system leaders
- There is a compelling shared narrative
- There is a shared understanding of safe, timely discharge
- The system systematically learns about how it works and it supports staff to be involved in continuous improvement
- Successes are celebrated

Top Tips for Implementing Home First

Leadership

- Do leaders focus on outcomes for people by promoting safe and ethical discharge, Home First, effective reablement and not using services that are ineffective?
- Is the escalation system delegated to the right staff to enable them to focus on same-day discharge? Is the data used in escalation calls current, accurate, reliable and accepted by all?

- Do you review issues causing delay weekly, including raising them regionally or nationally?

Pathways

- All: Are informal and unpaid carers identified and connected to information and support?

- Pathway 0: Are ward staff fully empowered to implement discharge? Are they connected to their councils? Do they have access to the care market and the voluntary sector?

- Pathway 1 and 2: Are social care and community health staff aware of and able to plan early enough for people needing reablement? Is access to it same day, seven days a week? Do people get follow-up healthcare? Do discharge teams know what happens after they leave?
- Pathway 3: Are people waiting for a bed in the community when they could be going home with enhanced support? Are people ending up on Pathway 3 because of poor early discharge planning? Have options been discussed?

Top Tips for Implementing Home First

Commissioning

- Is the system reviewing data and discharges to ensure the care market is supported to take discharges seven days a week with primary and community health support?

- Are you doing all you can to maximise capacity to support people at home? Consider payment on plan, off-frame capacity, COVID funding streams, and enabling providers to rapidly adjust care packages within agreed limits.

- Are you considering the use of direct payments, short-term reablement, care hotels, housing-based options, Shared Lives, and live-in or intensive domiciliary care?

Workforce

- Has the council reviewed the hospital social work team to enable it to carry out Care Act assessments in the community while maintaining a presence in the acute trust to manage complex and safeguarding cases?

- Has the acute and community trust(s) reviewed the therapy services to enable them to carry out assessments after discharge in the community?

- Is there resilience support available to staff, and a joint approach to managing gaps in staffing?

Top Tips for Implementing Home First

Finance

- Are you using COVID funding for packages to avoid unnecessary admission?
- Have you engaged and funded the voluntary and community sector to provide home-from-hospital services? Are you investing in wraparound care, 24/7 for 72+ hours to enable care at home either through expanded reablement or live-in or Shared Lives' carer support? Are you investing in AI/smart home technology?
- Are NHS commissioners investing in sufficient primary and community health, and have identified with their council(s) the resource implications for adult social care?

Data

- Is the whole system sighted on the daily data return on Criteria to Reside, Pathways 1-3 and Patient Destination? Do you use that to understand why people's discharge is delayed or not going Home First?
- Does the data show both the internal and external reasons for delay enabling long length of stay to be addressed? Are you linking to end of life care support?
- Is the date of discharge set at admission and driving discharge plans?

How We Can Help You

- Facilitated leadership sessions using a range of tools including gap analysis tool, peer review and ‘pause and reflect’ methodologies, delivered jointly as appropriate with ECIST (Emergency Care Improvement Support Team) and Better Care Fund Team

- Data analysis support
- Peer support, mentoring and critical friend challenge
- Putting systems in touch with other systems who have tackled specific issues or have good practice to share

- Support around health and social care system risk assessments
- Support to develop and implement lead/joint commissioning models and support to create creative capacity now and plan for the post-COVID demand

- Hospital social work team redesign workshops
- Therapy teams redesign workshops (collaboratively with ECIST)