Bringing Healthcare Home

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Focus of Talk

• The current state
• Current patient experience
• Making Discharge to Assess the default pathway
• Enablers
Current State

Population growth 2011-2022

ED Admissions: 1000 population by age

Patrick’s Story (video not available in presentation)
Why Change our System?

- Current model is not working
- Causing harm
- Need to enable patient choice
- Need to increase patient trust and satisfaction
- Need to provide safe and timely discharge of patients with complex needs, with no increase in readmissions
- Need to reduce cost
- Need to improve flow and reduce LOS
- Need to improve employee satisfaction

7 day re-admission Rate

Reduction in 7 day re-admissions of 29.4%

No of re-admissions ≥years by Day 7
Jan to June 2015 to 2018

7 day emergency re-admissions ≥ 75 years

<table>
<thead>
<tr>
<th>Days</th>
<th># Discharges</th>
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<tbody>
<tr>
<td>2016</td>
<td>85</td>
</tr>
<tr>
<td>2017</td>
<td>82</td>
</tr>
<tr>
<td>2018</td>
<td>60</td>
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What Smart Hospitals Do

- Focus on the admission pathway (early assess and short stay)
- Maximise emergency day care (ambulatory emergency care)
- Assertively manage frailty and tackle deconditioning
- Focus on down-stream flow
- Have processes to reduce delays
- Focus on simple discharges ... case manage and not over assess in hospital
- Work as a system – as a team of teams

Flipping Discharge Assessment
Discharge to Assess Model: Redesign of the Care Process

Where patient are clinically optimised and do not require an acute hospital bed, but may still require funded care services, in the short-term, to be discharged to their own homes or other community settings.

Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

Discharge to Assess Principles

• Home is default pathway – *home first* ethos

• Prompt assessment and rapid access to care

• Time limited support service

• A service that tries to say yes
The Team......

Access to:
- OT
- PT
- Nurse
- Multi-task Assistant
- SLT
- Dietitian
- MSW
- Doctor
- Pharmacist

Discharge to Assess Outcomes

Sheffield Headline Outcome:
37% increase in patients discharged on day of admission/following day

South Warwickshire Headline Outcome:
0.5m net long-term costs averted in year 1 by reducing conversion to LTC

Medway Headline Outcome:
Delayed transfer of care rates down 25% in 3 mths, discharging 32 patients per week
Highlights of D2A Test
Beaumont Hospital 2016/7

53 people in their own beds
70 – 101 years

96% improved or maintained their FIM pre/post intervention
TUG – 49% Improvement
81% safely maintained at home > 30 days

>€740,000 savings for cost of 1WTE OT for 5 months

50% of patients did not have any formal HCP in situ
44% cognitively impaired

What Our Patients are Saying

I had lost my faith in myself, having a fall knocks your confidence, you’ve given it back to me, I'd recommend you to all my friends. (Patient)

I went back to my art class, I was nervous, but I knew I was alright to go, sure I’m probably fitter then I was in year. (Patient)

Normally when you leave hospital they forget about you, but this service has been brilliant, you’ve given me my mother back. (Daughter of patient)

She’s a new woman, I was so worried. Now she is back to herself. (Daughter of patient)

This is the best help we've had leaving the hospital, you've given him a huge boost to his confidence. (Wife of patient)
Therapist experience

1. Difficult challenging the status quo
2. Time & perseverance required in building trust & openness for effective team work

1. Empowering to design a service which is right for patients
2. Proud to work in partnership on what matters to them
3. Grateful for the opportunity to develop leadership skills

Discharge to Assess – Top Tips

- Whole system approach
- Senior decision-making
- Own your competence
- Inter-disciplinary working
- Shared documentation
- Trusted assessor model
- Multi-agency meetings
- Shared governance
- Shared funding
Measuring Performance, Driving Improvement

- Re-admission rate – 7, 30, 60, 90 days
- % pts, with services in situ, within 48 hrs of DC
- % pts awaiting an agreed service in any week
- % pts delayed DC who are fit for DC from Medical/HSCP perspectives
- Proportion pts DC to LTC without opportunity for short-term recovery
- Proportion of pts who return home from transitional care (should be 75%)
- Proportion of pts requiring LTC after short-term home-based rehab (should be 25%)
- Proportion of pts DC who have no formal supports at 2 wks and 6 wks (should be 40%/66%)

(https://ipc.brookes.ac.uk/publications.html )

Embracing Risk and Enabling Choice

#endPiliparalysis
#homefirst
#last1000days
#redtogreen
Myron's Maxims

- People own what they create
- Real change takes place in real work
- The people that do the work do the change
- Start anywhere but follow it everywhere
- Keep connecting the system to itself
- The process we use to get to the future determines the future we get