# Discharge to Assess – Home First Hospital Discharge Care

Market Engagement
7 August 2019

west sussex county council

THE WEST SUSSEX WAY

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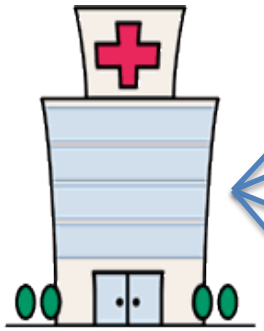
## Step Up Step Down Programme

- A 3 phased approach towards integrated hospital discharge and admission avoidance
- Step Up Services – admission avoidance to acute hospital services
- Step Down Services – support discharge from acute hospital
- Impact of delayed discharge
- Discharge to Assess Principles & Aims
  - Supporting people to go home should be the default pathway, with alternative pathways for people who cannot go straight home.
  - Person centred care – people and their families should be at the centre of decisions.
  - Support timely discharge from hospital.
  - Maintain independence where possible.
  - Reduce requirements for long term care packages. Ensure people don't have to make decisions about long term residential or nursing care while they are in crisis.
  - Assessment for care and therapy needs at home, not in hospital.

# Discharge to Assess



Patient no longer has care needs that can only be met in acute hospital

**Pathway 1 : Simple restart of a package**

Patients who enter hospital and leave with no change in support requirement (includes re-starting existing care package)

**Pathway 2 : Home First**

Discharging a patient home when medically fit for discharge with health and social care assessments completed and support delivered at home

**Pathway 3 : Bed Based**

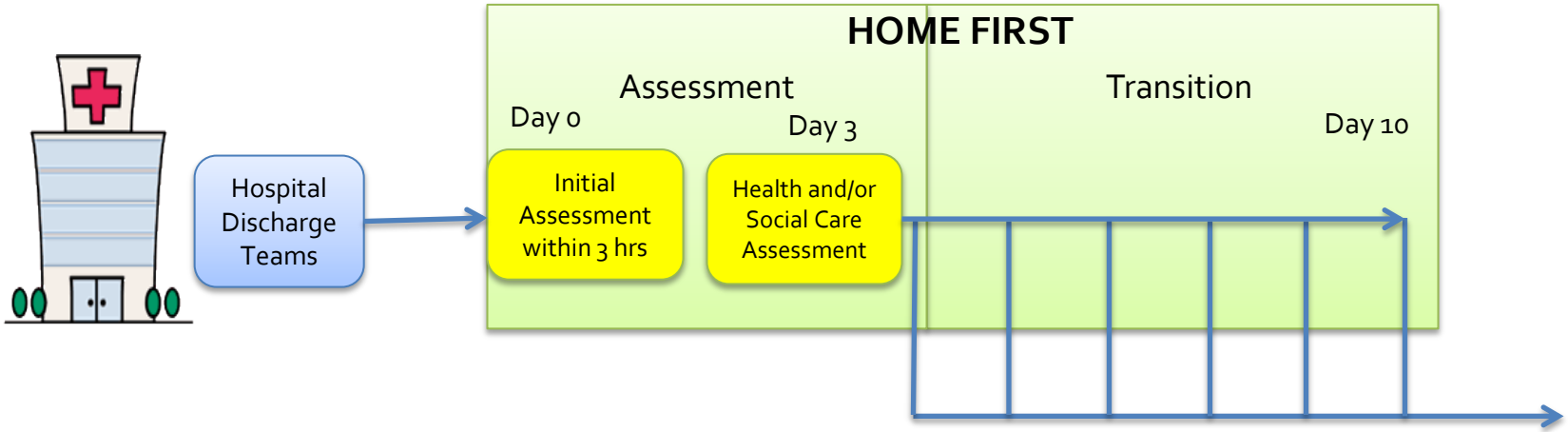
When a patient is not yet ready to be discharged home and requires a shorter stay in a reabling and supportive bedded environment (e.g. D2A Bed).

**Pathway 4 : Complex pathway**

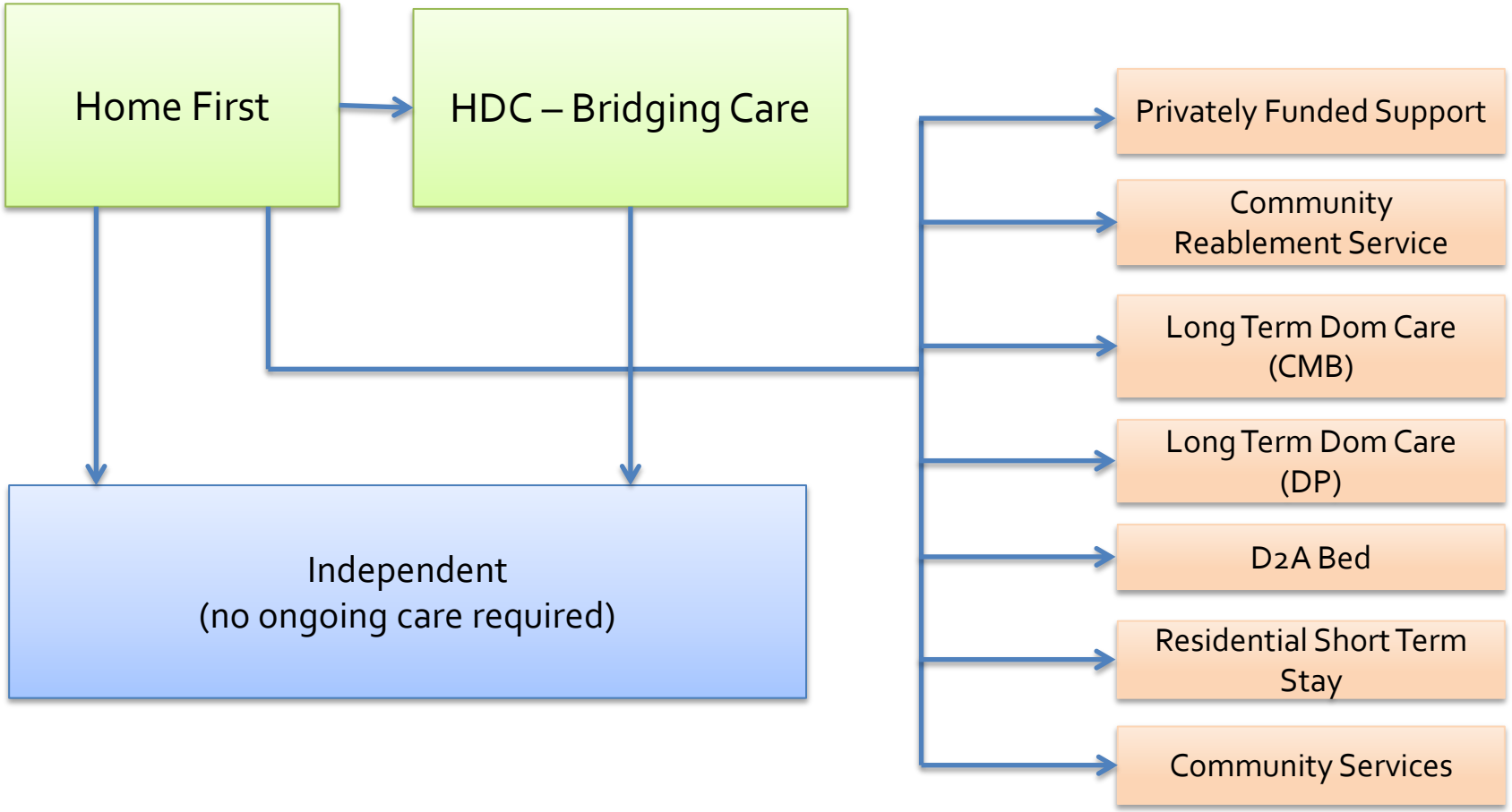
Patients have multiple complexities and require more intensive support in an environment such as a nursing home.

# Home First Pathway

- Principles
  - Individuals who are medically fit for discharge, clinically optimised and no longer require an acute hospital bed but may still require health and/or social care services
  - Not for individuals who require 24 hour care at discharge
  - Non-condition specific
  - Assessment for longer term care and support needs is undertaken in the home and at the right time for the individual
  - 7 days a week service including new referrals
- Multi-Agency
  - Acute hospitals
  - SCFT Responsive Services (Therapists, OTs Health Care Assistants)
  - WSCC
  - Commissioned providers



## Home First Pathway



## Hospital Discharge Care Service (1)

- Commissioned care provider – block and buffer contract
- Two functions -

1. Home First Care Function
   - Care delivery from discharge up to day 10
   - Part of multi-agency and multi-disciplinary pathway

2. Bridging Care Function
   - Continuing support for individuals requiring social care support where on-going service hasn't commenced within Home First service duration (Day 10+)

- Quick & responsive service
- Reabling approach
- Geographical coverage
- Support & maximise independence and support transition to other services
- Strategic partner in health & social care system

## Hospital Discharge Care Service (2)

### Geographical Areas

## Hospital Discharge Care Service (3)

### Potential Projected Service Volumes

- Maximum delivered hours per week
- Mixture of Block and Buffer
- Pathway roll-out and growth
- Flexibility – respond to demand

| HDC Function | Northern | Southern | Western |
|---|---|---|---|
| Home First Care | 180 | 150 | 90 |
| Bridging Care | 240 | 110 | 30 |
| **Total** | **420** | **260** | **120** |

## Service Outcomes

1. Reduction in the amount of time people **remain in hospital** and amount of **functional decline and deconditioning** when fit for discharge.
2. More people receiving a health and/or social care **assessment at home**.
3. Increase in effectiveness of assessing the most **appropriate level of support** for people**,** including those not requiring long term support.
4. **Realignment of WSCC commissioned services** to support hospital discharges. Dedicated responsive service to support people direct from hospital.
5. Reduced number of **Delayed Transfers of Care.**

## Procurement Timeline

| Action | Date |
|---|---|
| WSCC Key Decision | August/September 2019 |
| Tender published | October 2019 |
| Closing date for tender | November 2019 |
| Tender evaluation and moderation | December 2019 |
| Bidders notified of outcome | January 2020 |
| Mobilisation period | January – March 2020 |
| Contract start date | 6 April 2020 |

# Questions

# and

# Comments

**Further questions or comments to adultscommissioning@westsussex.gov.uk**