Bridgend County Care & Repair

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Hospital to Home Service

Meinir Woodgates, Health Caseworker (Hospital to Home, Princess of Wales Hospital)
Rena Sweeney, Chief Officer (Bridgend County Care & Repair)
Zoe Wallace, (Abertawe Bro Morgannwg University Health Board)

Welsh Audit Office : ‘I’m a patient get me out of here…….’

Enablers

- Long established multi sector partnership approach
- Willingness to define and develop new approaches
- Flexibility
- Trust
- Supportive Environment
- No preconceptions
- Positive approach to risk

Getting Started

- Engaged on a formal basis with Senior Management and formally sought permission (via the Executive Board of the Princess of Wales Hospital) for a Caseworker to be based in the hospital for 3 hours a week

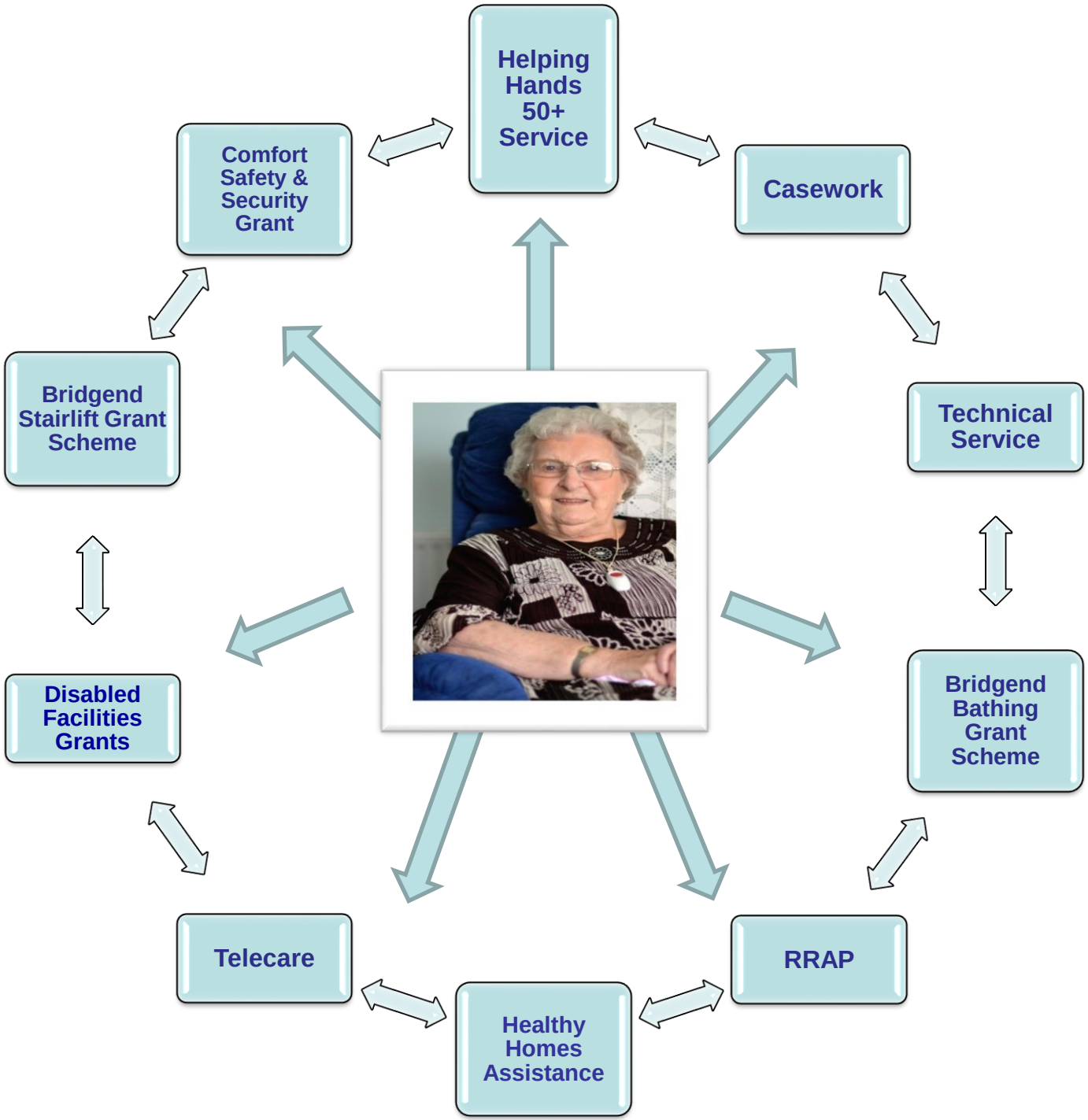
- No Funding……and yet right staff were relocated

- Reconfiguration required a cultural assimilation, good joint working and a real understanding of what the common sense of outcomes are

Why Hospital to Home?

- Significant pressures at POW for delayed discharge
- Levels or readmission were evident
- Arms length referral was essentially ‘after the fact’
- Low take-up of Caseworker service following completed works…..face-to-face engagement more difficult
- Telephone surveys indicated that older frail people, particularly 85+ needed further co-ordinated support for benefits advice, adaptations and housing maintenance
- Many with complex housing needs, chronic ill health, history of falls posed a risk of readmission
- Concerns that Agency was only “scratching the surface” in terms of meeting longer-term their housing needs

Good Partnerships



Proven Track Record

The Service

- Co-location to improve awareness, speed up service and enable problem-solving
- The Caseworker attends “board round meetings” and MDTs
- Works closely with patient, relatives and health professionals to secure access and early intervention
- Linked to the home & community and post discharge assistance
- Based at frontline in the Discharge Lounge with regular interface between clinicians, nursing staff, rehab,

  patients-family/carers
- Clinical Doctor and Property Doctor

Performance Achievements

- Since 2014, **4,500** patients helped (**1,272** in 2016-17)…**80%** with a safe & timely discharge
- **1,434** jobs completed at a value of **£510,000** targeting home interventions/adaptations
- **144** patients had their benefits increased at a combined **£341,557** annual sum
- **401 (32%)** had a Healthy Home Assessment following discharge
- **98%** of patients with chronic conditions and average speed of service **1.5 days**
- **918** were known fallers and high risk for readmission

Benefits

- Enables a smooth transition from hospital to home reducing the length of stay in hospital (**10 day average to 2-3 day average**)
- Possibly prevent or reduce the number of readmissions
- Enhances communication between professionals and patients to streamline the discharge process to ensure a patient-led approach…..positive patient experience
- Improved clinical planning through quicker bed vacancies

for NHS but also assists Care & Repair to target resources to a priority group and streamline process to enable quick, easy access outcomes

“We are so thankful. The stairlift has been such a support. My husband no longer worries about falling and hasn’t been readmitted to hospital..

“I don't feel like I'm going to fall down stairs any more”

“The walk in shower has really helped me. I no longer struggle to get in and out of the bath”.

“The support I received in hospital and after I came home was fantastic. My income has been increased I no longer worry about the bills. My heating has been upgraded and I have had a stairlift installed. , I feel much safer now.

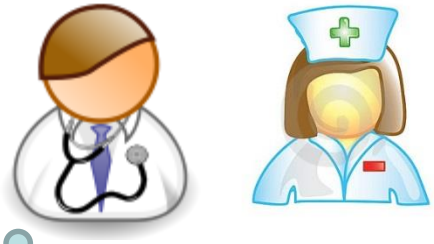
“Without the hospital caseworker I would not have known about the services available.”

“Care and Repair are wonderful. They’ve even given me aids”

"The Hospital to Home Service is essential to our intervention. The service plays an integral role in enabling us to discharge people home from hospital efficiently and safely"

"Our partnership with Care and Repair means that our assessments and our treatment plan can make a real difference to people's lives. It enables me to look after my patients in a more holistic way"

"The comprehensive service that Care and Repair provides enables smooth transition from hospital to home, reducing their length of stay in hospital and preventing readmissions"



"Having a designated caseworker within the hospital environment has also speeded up the response to queries, which is essential when working with a fast paced caseload with patients with life limiting conditions"

"The quality of service that I am able to provide within my specialist area would be considerably impacted without the Hospital to Home Scheme".

"The caseworker is extremely efficient at informing myself of when work is scheduled, this enables the planning of timely discharges"

Conclusion

- Recognise the local need from all stakeholders viewpoints including patients
- Understand your common objectives first
- Start small be realistic!
- Create flexibility and recognise the contribution of all partners to the project allow the service to be shaped to meet need.

This service supports all the local health board priorities in relation safe discharge of patients from hospital to home as well as linking to ABMU's Unscheduled Care and Patient Flow Programme to expedite discharge and avoid readmission where appropriate, reduces inpatient stays and enhances patient experience

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Thank you for listening