Supporting the flow of patient care from hospital to home

HomeLink Healthcare (HLHC) has been providing clinical care in the home to release in-patient bed capacity and improve patient choice with Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHT) since January 2019. The two organisations have co-created the service, NNUH at Home and successfully utilised the SBS Patient Discharge Framework when the contract was renewed in 2020. The service creates additional capacity and promotes improvements in patient flow from hospital to home. A key feature of NNUH at Home is that it compliments and integrates with existing services, rather than replicating those already in place. During this time over 9,000 bed days have been saved with 80% of all patients being discharged on or before their expected discharge date.

This has also resulted in outstanding patient satisfaction with 100% of patients saying they would recommend NNUH at Home to their friends and family.

The situation

Delayed transfers of care (DTOC) are a widespread problem for the NHS and can cause considerable distress and unnecessarily long stays in hospital for patients. In addition, there is an increased risk of infection, low mood and reduced motivation, ultimately affecting their recovery and chances of hospital readmission.

Delayed transfers and high bed occupancy rates have a wider impact on the health system, causing delays in A&E and elective care cancellations, as a reduced number of beds will be available for other patients.

Finding the solution

NNUHT was committed to reducing DTOC and the need for escalation beds, promoting effective and efficient patient flow, minimising delays and maximising utilisation of hospital beds.

Analysis of hospital data during winter pressures planning in summer 2018 indicated there were opportunities at NNUHT to improve patient flow and relieve pressure on beds. In a bid to realise efficiencies, in September 2018 NNUHT established a partnership with HomeLink Healthcare, a CQC registered company experienced in home-based clinical care, to deliver and evaluate Early Supported Discharge and virtual ward services. This service became known as ‘NNUH at Home’. NNUH at Home service initially focused on two patient pathways:

- Early supported discharge (ESD), which provides bridging packages of care, so patients who are medically fit can be discharged from hospital. The NNUH at Home team provides care until longer term community services are available.
- The virtual ward, provides clinical care at home for patients who are medically stable and can finish treatment at home, while remaining under the care of the hospital consultant. For example, Intravenous Therapy, Blood Monitoring, Physiotherapy, Rehabilitation or Wound Care.

Collaboratively Developing NNUH at Home

Collaboration was key for successful implementation of NNUH at Home. Teams across the trust, HLHC, community services and commissioners worked alongside one another to agree the service design prior to service delivery. Overseen by the NNUH at Home project board, the governance and safety protocols, referral, escalation and discharge processes, were jointly agreed during the service mobilisation phase.

Working cohesively with NNUHT's current process was fundamental to avoid any unnecessary duplication of services and safe, effective and efficient utilisation of the capacity provided by the NNUH at Home pathways. The NNUH at Home clinicians became part of the trust team, fully embedding by attending multidisciplinary team and bed meetings.

A service designed with patients in mind

NNUH at Home patients are safe in the knowledge that if there are complications while at home, there is a nurse on the end of a phone available to triage clinical concerns. Patients appreciate the support NNUH at Home provides, valuing its punctuality, efficiency and knowledgeable and caring staff. Family members are grateful for having their loved ones at home, not to mention avoiding countless journeys to hospital.

"I am very appreciative of the care, support and advice I received by experienced staff, which in turn gave me confidence to deal with my health issues. Having support in the community did not feel at all obtrusive", said one NNUH at Home patient.

These sentiments were echoed in the Family and Friends test with 100% of patients stating they would definitely recommend the service to others.

Jon Green, then the Director of Transformation at NNUHT, said: *"Thank you to the team at HomeLink who have supported us through the implementation phase of NNUH at Home, providing us with expert advice so the service has seamlessly integrated with the trust. Collaborating with clinical, operational and community teams was essential to the success of the programme and HomeLink were fundamental in enabling this to happen.*

Proving the success

A review of the first two years showed that NNUH at Home provides safe, efficient and cost-effective capacity, as well as an excellent patient experience. Strong cross organisation working relationships, the skill mix of the community based, and an on-site team were instrumental in achieving these results.

NHS England data shows that during the first six-months of operation of NNUHT there was an 18% reduction in delayed bed days compared to 2018.

NNUH at Home has contributed to the COVID-19 pandemic response at NNUH by freeing up inpatient beds and reducing the need for patients to visit the hospital.