Homeward – how Virgin Care is to helping hospital patients get home quicker and stay home

Introduction

Enabling patients to go home safely once they no longer need to be in hospital has been a priority for the National Health Service for many years.

Discharging patients who are ready to leave the hospital is essential since a prolonged stay in a hospital bed can lead to poor health outcomes for that patient, especially for older people.

Reducing the length of stay is an essential operational priority across NHS hospitals. As well as the associated costs to the hospital (and care system), the issue of delayed discharges, commonly known as bed blocking, has been a severe problem for hospitals who badly need free beds, especially during the busy winter months. This has been dramatically illustrated during the COVID-19 pandemic when lack of available hospital beds had led to significant delays for ambulances handing over patients to the hospital.

Acute hospitals need to be able to discharge patients once they no longer need acute care, and community hospitals need to discharge patients to make way for others who need a community hospital bed.

However, while medically fit, many patients need support to be discharged safely and to avoid the risk of readmission. While some patients can go straight home with a package of care, others need a period of reablement in a community hospital before returning home. Finding a way for people to be able to return home more quickly, but also to be fit and well enough to remain there safely, must be a key priority.

To find solutions to some of these problems, Virgin Care took part in the #ActNowHomeFirst Collaborative, led by NHS England and Improvement. Wards providing rehabilitation and reablement are not new, but the 'Homeward' project run by the Virgin Care team at St Martin's Hospital in Bath, was developed to offer a unique approach by creating a hybrid community hospital model that increases the flow of patients and prepares patients for safe discharge.

The challenge

The NHS long-term plan focuses on discharging patients safely and quickly to free up beds in acute and community hospitals. Providers from all health service areas, including Virgin Care, have been encouraged to find ways to make this happen.

A national shortage of reablement, therapy, social care staff, and appropriate care home places has slowed down patient flow through the system. It has also led to high agency costs.

Therefore, the challenge was to shift the focus to more intensive rehabilitation that promotes independence and confidence and to find ways of getting patients mobile and confident enough to manage at home, once they were well enough to be discharged.

The project looked to develop a service which could:

- Ensure patients had the support, resources and skills to recover as best they possibly could in the most appropriate place for them.
- Explore multi-disciplinary solutions to improving holistic patient care
- Address recruitment and retention challenges (locally) and improve job satisfaction
- Share the learning throughout the organisation and the collaborative

The solution

A six-bed therapy-led ward approach called "Homeward", was trialled by a Virgin Care team at St Martin's hospital in Bath and North East Somerset.

The project was led by a senior Occupational Therapist. Core to the project's success was the development of Reablement Therapy Workers (RTWs), trained in a range of therapeutic and clinical skills, who can better support patients with a more holistic care plan, supporting both medical and therapeutic care needs. The new RTWs were better able to promote patients' independence in the wards while ensuring patient safety.

Along with therapy staff, RTWs were allotted together with nursing staff to the e-roster to support integrated workforce planning, supporting a whole ward approach.

The ward was fitted with a "Tasks of Daily Living Area" which comprised a kitchenette, a bathroom, a sofa and TV area so the patients could practice (and be assessed in) daily living activities such as cooking meals, using appliances, getting up off the sofa and standing from a wheelchair. The enhanced therapy approach allowed patients to practice daily living tasks as part of their daily ward routine

The key to the success of the project was the "Rehab Therapy Worker" (RTW) role which offered:

- A cohesive position cementing joint working approaches to patient care
- A role that could support both nursing and therapeutic capacity
- Locally, an exciting and autonomous role which appealed to a broader potential workforce population, thus broadening the recruitment pool

The difference

The results of the project were very positive:

- The new holistic approach resulted in a reduction in average length of stay by two days, and improved patient flow.
- It allowed us to reduce the number of trained nurses required on each morning shift by one, seven days a week, helping to alleviate shortages in the nursing workforce
- For those patients discharged home with reablement, the patient required fewer community teams visits (15 less a week). Capacity could then be focussed on the more complex patients across the patch.

- There was a high level of patient satisfaction; patients even became protective of their "rehab" status!
- It supported recruitment and retention, with the new way of working delivering job satisfaction and a development opportunity for staff in the role.

An excellent example of the therapy-led ward's effectiveness is a lady admitted to the ward with a high dependency score. The lady in question needed two people to help her to her wheeled frame, needed help washing and support during the night to use a commode. She was unable to mobilise and required her medication to be administered by nursing staff.

After spending time on Homeward, her dependency score reduced dramatically. Upon discharge, she was able to mobilise, make her food and snacks, and take them to a table using a wheeled frame and, with the help of a profiling bed, use a commode herself - all tasks both she and community teams were happy she could manage herself in her own home.

The next steps are to:

- Establish the holistic model as 'business as usual' making it an integral part of the system flow in Bath and North East Sommerst
- Share the learning within Virgin Care as a national model for the delivery of services within Commnity Hospitals
- Explore the role of assistive technologies with the introduction of Miicare, an AI-powered virtual health coach for seniors and their loved ones.

A congratulation to the team from the Virgin Care Project Liaison:

It has been a long road since the first days of the pilot, and there is still a way to go. The team encountered many challenges, with COVID-19 being only one of many. However, challenges led to learning, and now we have a new approach supporting both patients and staff.

The model was celebrated and shared nationally through the #ANHF Collaborative forum, from which our work sparked further interest. The team were later asked to present the model at the Virtual NSHE&I South West Regional Discharge conference. The team tempered their virtual jitters and with pride, shared the solution to a suddenly much broader audience. The team truly deserved all the positive feedback they recieved. Hopefully, their work will inform and inspire others to create small changes, that make a big difference.