

***Community Hospitals Association Improving Practice***

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| **Innovation and Best Practice Award 2018 Summary** |
| **Title:** |
| Hospital to Home Clinic |
| **Background:** |
| In May 2016 NHS England along with NHS England, Health Education England, The National Institute for Health and Care Excellence, Public Health England and the Care Quality Commission predicted rising costs for providing NHS services which could be as high as £30 billion by 2020.  This information together with concerns regarding readmissions to hospital reinforced a need to try to improve the transition from hospital to home, increase support to patients and empower and enable them to remain independent at home. Voluntary community services could play an important role in supporting patients who are discharged from hospital and they could become a more familiar sight on the wards if used effectively. |
| **Description:** |
| In March 2017 Horizon Unit invited community NHS services and community organisations to a meeting to discuss the current discharge process and inviting them to come up with ideas to improve the transition from hospital to home and increase support without increasing costs to the NHS.  The meeting resulted in a very positive response from the 25 – 30 people who attended and demonstrated that many people had similar concerns.  The “Hospital to Home” clinic was birthed and set up within 2 months of this meeting.  This social interactive hub was held every 2 weeks in the ward dining room. It was coordinated by an occupational therapist and a therapy assistant and was attended by patients, relatives and carers along with Age UK, Carers Support, Apetito, British Red Cross and the Carers Health Team. A central table was available with additional information about frozen ready meal companies, mobility aids, catalogues, Carers guide and other voluntary and telephone services.  Patients admitted to the unit had a Welcome Meeting with a trained member of the MDT and relatives or carers. This provided valuable information and was a good time to begin a discussion about the clinic. Patients set goals for discharge and started their rehabilitation. Patients were sent a written invitation to the clinic providing a personal touch which also served as a reminder to relatives and carers and patients with cognitive impairment.  The time frame of fortnightly clinics was to match availability of services to attend and to allow for assessment time on the unit. Patients attend with relatives and carers to sit and chat with a cup of tea. Being able to put a face to a service opens the doors to possibilities previously difficult to engage patients with. Those who attended were encouraged to fill out feedback forms which contributed to a service evaluation. |
| **Outcome and Impact:** |
| One of the positive impacts was that information patients received was current, something that previously was difficult to keep track of.  We have experienced one carer coming back to the clinic post discharge of their relative because they knew they would be able to access the right support and information.  Feedback has been positive and other sites did consider if something similar could work for them.  Negative feedback was largely in relation to services that were not able which was overcome by passing information on to that service.  There was feedback that the room could be quite noisy at times, so additional quiet space was been made available.  Feedback from the community services that attend found their some of client uptake has increased by 30%.  A volunteer coordinator with health care experience was found to take over the clinic with a technician.  In October 2017 this work was presented to the Trust Patient Participation group. |
| **Supporting Information:** |
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| **Organisation:** |
| Sussex Community NHS Foundation Trust – Horizon Unit, Horsham Hospital |
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| **CHA Judges Comments:** |
| *The Hospital to Home Clinic was developed as a response to identified need to support patients on discharge home and reduce readmissions. The clinic was well researched, involved multi-disciplinary and multi-agency working and the evaluation was excellent with the next step being to review the data to see if there has been a reduction in readmissions.* |