Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Pathway 0- an innovative approach to support hospital discharges in BNSSG

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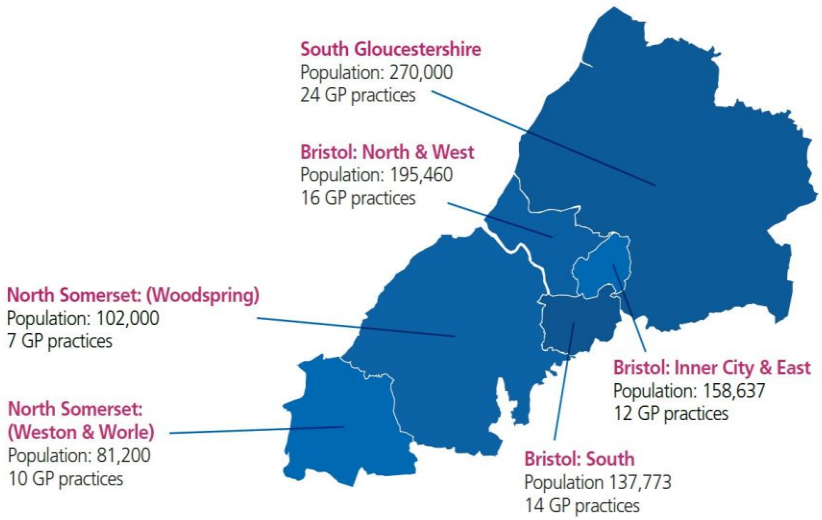
We have a shared ambition in BNSSG to build thriving and dynamic integrated partnerships at Locality level…



Our Integrated Care System will:

- Deliver preventive, proactive, personalised and integrated care
- Focused on local population health
- Building on the asset base of individuals and communities
- Embedding the voluntary sector and working with community and faith groups
- To make the community the default setting of care

The Collaborative Approach in BNSSG

- BNSSG system has worked as one to deliver a number of innovative programmes both pre-COVID and during the Pandemic
- A collective voice
- Responsive and Innovative
- True co-operative partnership working
- Working across traditional boundaries
- Driving and embracing the Integrated Care System approach

Pathway 0

People on '**Pathway 0'** have been identified in the **Hospital Discharge Service: Policy and Operating Model** (August 2020) as **50%** of those who following discharge from hospital will have no formal input from health or social care services once at home.

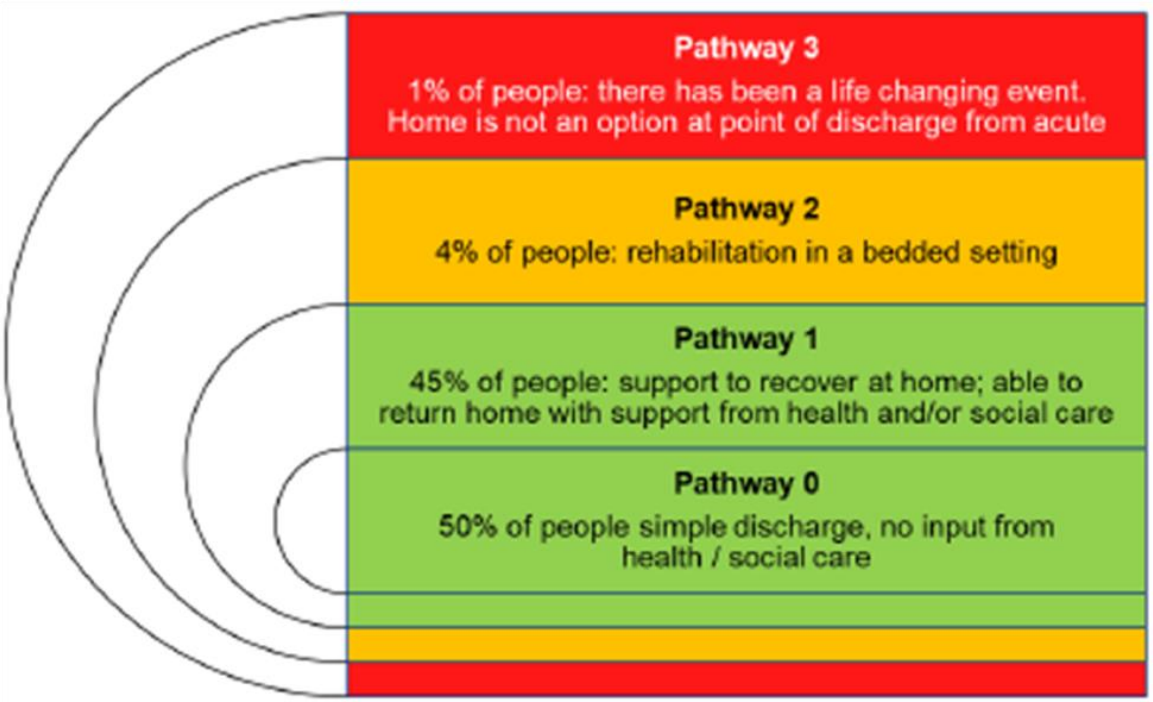


Figure 1: Discharge to Assess model

Pathway 0 – A Vision & Our approach

Based on learning from Manchester

- Pathway 0 ‘owned’ by 1 VCS organisation connected to other commissioned VCS services supporting hospital discharge
- Proactive follow-up calls carried out 48hrs post-discharge to prevent re-admission or ED Attendance
- For anyone over the age of 65 resident in Bristol, North Somerset and South Gloucestershire discharged from the Emergency Department or a Medical Ward
- Ensure person is safe, well & support if there are immediate needs
- Pathway 0 connects to longer term sources of community support more local to the individual; Social Prescribing, etc.

Pathway 0 – Outcomes

- Reduction in unnecessary hospital re-admission, ED or GP attendance
- Improved experience of hospital discharge
- Improved community connections and preventative support
- Better co-ordination of services which are already commissioned and better utilization of VCS capacity

Pathway 0 – Support Provided

- Service started in November 2020
- Between November 2020 – April 2021
  - **13,629** Patient details received
  - **9,488** Calls successfully answered
  - **1,874** Signposts & onward referrals

We signpost as appropriate to help meet the individuals needs, some of the common needs centre around;

Mental well being, crisis support, home adaptions, financial support , mobility aids, meal deliveries and shopping, home help, loneliness & isolation

Pathway 0 – Common Concerns

- Common concerns highlighted include;
  - No catheter bags provided or feeling insecure about night time usage
  - Discharge summary missing or lack of clarity
  - New medication; what to do with old medication and how to collect new prescription
  - Returning home with no provisions
  - Waiting for nurses or package of care
  - Equipment needs

Pathway 0 – Case Studies

Case Study 1:

Patient's wife was carer, self funded package of care. Recent fall left wife with poor mobility.

Patient's wife was waiting for an extension to the package of care. She felt unable to cope and was unaware if any further support was available as patient's care needs had increased.

Signposted to Independent Age and Age UK for information on types of care available. Further signposting to We Care Home Improvements and for and financial advice.

Case Study 2:

During a call the patient became out of breath and started to panic they started to shout for help.

The caller was able to ring 999 from another phone whilst reassuring the patient and stayed on the line until the ambulance arrived.

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Thank you
Any questions ?