

Hospital discharge and admission avoidance: Sussex Partnership NHS Foundation Trust – Home First Service, mental health inpatient wards

Context

Sussex Partnership NHS Foundation Trust provides mental health services across East Sussex, West Sussex and Brighton and Hove. The trust operates inpatient older people's acute wards from which the Home First service now runs, providing OT-led support to bridge the gap between inpatient admission and settled life at home.

The Home First service was first piloted in 2019 to 2020, initially using short-term winter monies funding. Prior to this, a model equivalent to the Home First approaches already operating in acute physical hospitals did not exist in mental health settings. What began as a small, time-limited pilot has since grown into a substantively funded service operating across all older people's inpatient wards within the trust. Each ward now has a dedicated Band 6 occupational therapist and Band 3 OT support worker. Although the team members are attached to inpatient wards, they operate very much as a community service, working alongside neighbourhood mental health teams and community OT colleagues to provide continuity across the transition home.

The challenge

The period when a person leaves a mental health hospital and returns home is a particularly vulnerable time. Before the Home First service was established, several gaps in provision made this transition harder than it needed to be.

Crisis teams not addressing occupational needs: Crisis teams were predominantly nursing-orientated and focused on managing risky behaviours or other factors that might extend a hospital stay. There was little focus on occupational and functional needs, which meant the distinct skills of the OT and AHP workforce were not being used effectively.

No equivalent to acute hospital models: Home First or discharge-to-assess type teams were already active in acute physical hospitals, but mental health settings had no comparable offer. People leaving mental health inpatient care were not receiving the same level of structured, occupation-focused support.

Reactive rather than preventative: Without proactive support during the transition period, people were at greater risk of losing confidence and daily living skills during their stay, struggling to reintegrate into their communities, and being readmitted. Discharge planning focused on getting people home safely but did not adequately address how they would rebuild their lives once there.

Fragmented pathways: The way OT resource was commissioned across the system had created silos, with acute OTs, mental health OTs and community teams each working to a defined scope. This made it harder for anyone to take a genuinely holistic view of what a person needed to live well at home, rather than simply to survive the transition.

The role

The Home First OTs begin their involvement while people are still on the inpatient ward, identifying individuals who would benefit, seeking consent, and building a picture of what obstacles exist to a timely and sustainable discharge. Environmental assessments are completed for everyone referred, covering both practical barriers and the broader occupational and social factors that will shape how well someone can manage at home. Care package needs are reviewed and the OT works closely with providers to ensure the right support is in place from the outset.

A significant part of the role involves addressing confidence and lost skills. After a period of inpatient admission, many people are uncertain whether they can manage independently. Rather than immediately tackling the idea of going home, an OT might first support someone to visit a favourite place in town, building confidence through familiar, meaningful activity. This recognises that for many people, the psychological impact of the admission is as significant a barrier as any practical one.

The team's flexibility is central to its effectiveness. OTs are supported to respond to whatever each individual needs: helping someone source essential items for their home, supporting someone through a hoarding situation, resolving a problem with keys, or accompanying someone to a local community group to begin rebuilding social connections. The service has supported people to return to activities they had given up entirely, including fishing. All Home First OTs have PIN number access to the community equipment store, enabling direct provision of minor equipment without referral delays. Where ongoing input is needed from another service, the OT invests in building that relationship alongside the person, so that handovers are meaningful rather than simply administrative.

Benefits to the system

- Readmission rates halved for people who received Home First support compared with those who did not
- Earlier discharge achieved through proactive occupational support, contributing to improved patient flow
- Financial return on investment demonstrated through bed day savings and reduced readmission data, supporting the case for substantive funding
- OT skills deployed where they add most value, reducing fragmentation across acute, mental health and community teams
- Strong staff retention, with one OT remaining in post for six years and progressing from Band 6 to Band 7
- Consistent quarterly reporting has embedded the service across the trust, with non-OT colleagues now recommending it to one another

Benefits to individuals and families

- People describe getting their life back, reconnecting with meaningful activities and rebuilding the routines and social connections that give daily life structure
- Loss of confidence addressed through a gradual, person-centred approach that meets people where they are
- Practical barriers, however small, resolved promptly so they do not become obstacles to a sustainable return home
- Carers report a meaningful difference both to the person they support and to their own experience of the transition
- Consistently positive feedback from patients, carers and ward staff

Developing the role: a practical guide

Getting started

- Start with whatever funding is available, even if it is short-term and modest. The Home First service began with a small amount of winter monies for three months, with no certainty it would continue. The priority is to get the service running and generating evidence.
- Establish an evidence base before launching. Before the pilot, the team undertook a thorough literature review to support the proposal, which built credibility with decision-makers from the outset.
- Build relationships early: with inpatient ward teams, community mental health colleagues, and reablement services. Existing OT connections in neighbourhood mental health teams provided a trusted entry point into the community system.

Building the service model

- Define eligibility criteria, but build in flexibility. The person-centred nature of the service depends on OTs being able to respond to individual need rather than applying a rigid checklist.
- Ensure OTs have direct access to equipment provision. PIN numbers for the community equipment store allow the team to respond quickly to practical barriers without referral delays.
- Allow OTs to work across the boundary between inpatient and community settings. This flexibility is fundamental to the model.
- Do not be rigid about what the OT's role covers. The interventions that prevent readmission are often small, practical and creative. The service works because OTs are trusted to exercise professional judgement.

Demonstrating impact from the outset

- Collect data consistently from day one, even if the measures are refined over time. The discipline of continuous data gathering has been essential to the service's sustainability.
- Use validated clinical outcome measures alongside service-level data. The team uses CORC and ReQoL to measure clinical outcomes, complemented by bed day and readmission data.
- Compare readmission rates for people who received the service with those who did not. This comparison has provided some of the team's most compelling evidence.
- Present quarterly using a consistent format, so that the message is reinforced each time and the service remains visible across the organisation.
- Capture patient and carer quotes to support the numerical evidence and communicate the human impact of the work.

Sustaining and growing the service

- Be proactive about sharing what the service does. The team has sought out opportunities at patient flow meetings, inpatient transformation workstreams and the housing workstream, rather than waiting to be invited.
- Move between organisational workstreams as funding and priorities shift. This flexibility has extended the team's reach and connected them with different decision-makers over time.
- Use external platforms, including conferences and professional publications, to raise the profile of the service. The team has presented at the OT Show, contributed to OT News and received a positive practice award.
- When you encounter resistance, keep going. One ward initially declined to participate, on the grounds that OTs were already in post. A trial was eventually agreed, and the service was subsequently adopted and supported in that area.

Measuring impact

- Readmission rates halved for people receiving Home First support compared with those who did not
- Bed days saved through earlier discharge, contributing to improved patient flow
- Positive clinical outcomes measured using CORC and ReQoL
- Positive feedback from patients, carers and ward staff captured as part of quarterly reporting
- One OT remained in post for six years with progression from Band 6 to Band 7
- Service now substantively funded across all older people's inpatient wards following five years of evidence building
- Service extending to adult wards through an independent pilot led by a senior member of the Home First team

Top tips for managers

- Start with whatever funding is available and use it to generate evidence. A small, time-limited pilot with rigorous data collection is more persuasive than a larger proposal without it.
- Articulate what is distinctive about OT in this context: the occupational focus, the emphasis on meaningful activity and community reintegration, and the holistic view of what it takes to live well at home.
- Give OTs the tools and permissions they need to do the full job, including direct access to equipment provision, flexibility about where they work, and time for community and reintegration work.
- Capture data consistently and present it regularly, using a format that speaks to different audiences: clinical outcomes for clinical colleagues, bed days and readmission rates for those focused on patient flow and finance, and human stories for everyone.
- Do not wait to be invited. Seek out the meetings and decision-making forums where your evidence will land, and keep sharing it.
- Be prepared for some resistance and be willing to propose a trial. Results tend to be persuasive.
- Think about job satisfaction as part of your workforce strategy. A role that enables OTs to practise in a genuinely occupational way is a strong recruitment and retention offer.

"It's quite rare to find an OT job that is so pure OT as this one."

"It's the best job ever. I've done it for six years and I'm still enjoying it as if I just started."