Item 8a

South Tyneside Partnership

Health and Wellbeing Board
Date: 22 July 2026

Guiding You Home Programme Update – July 26

Report of Vicki Pattinson

Why Has this Report Come to the Health and Wellbeing Board?

1. Programme Update for assurance

2. The Health and Wellbeing Board is asked to note the content of the paper and update on progress

Which Outcome is this Linked to Within the Health and Wellbeing Strategy and How?

3. Fair Delivery of Service – giving every person who uses our services across Health & Social Care, the opportunity to return home to the most independent setting for them, which is safe and using a 'Home Frist' approach.

How Does This Report Contribute to the Cross Cutting Theme(s)?

4. The work is contributing to the cross cutting themes of supporting people to live heathier lives, promoting independence and connection to support.

The Guiding You Home Programme commenced on 14 July 2025, with a 6-week design sprint. This followed an intense onboarding week between Newton and the SRO teams to ensure the has 3 workstreams supported by Newton

- **Acute discharge**: Improving the outcomes of people being discharged from hospital.
- **Reablement at Home**: Ensuring that as many people as possible can return home following a hospital stay and subsequently live as independently as possible.
- **Return-to-Independence Beds**: Ensuring that those who can't yet go home, are given the most potential to get there through effective use of our Returning-to-Independence beds.

There are two other workstreams that are not supported by Newton, but which were felt to be critical to support the ambition and were included within the Programme for consistency

- **Admission avoidance**: Ensuring only those who's need are best met in a hospital setting are admitted.
- **Hospital flow**: Supporting those admitted to hospital, to spend only the time necessary within the acute hospital setting.

The programme has used a pilot and then roll out approach, testing new ways of working, measuring the impact and ensuring that they work before rolling these out across the system. Following the launch event in November, all new ways of working have been rolled out across the system and across all workstreams. In addition to this, data-drive continuous improvement cycle meetings have been established for all workstreams to ensure that this work is embedded into practice and becomes 'Business As Usual'.

Financial rebaselining and calculation of financial opportunities are complete with tracking now in place. This is being reviewed monthly by the Programme

Hospital Discharge

The aim of this workstream is to improve the independence and outcomes of people being discharged from hospital, by promoting 'home first' as the priority and identifying people who would be better supported through our at-home support services or our 'Returning-to-Independence' beds. Always asking the questions 'Why not home? Why not today?' The key metric for the programme has been to reduce the number of people who leave hospital and go directly into a nursing or residential placement in 24-hour care, both permanently and on a temporary basis.

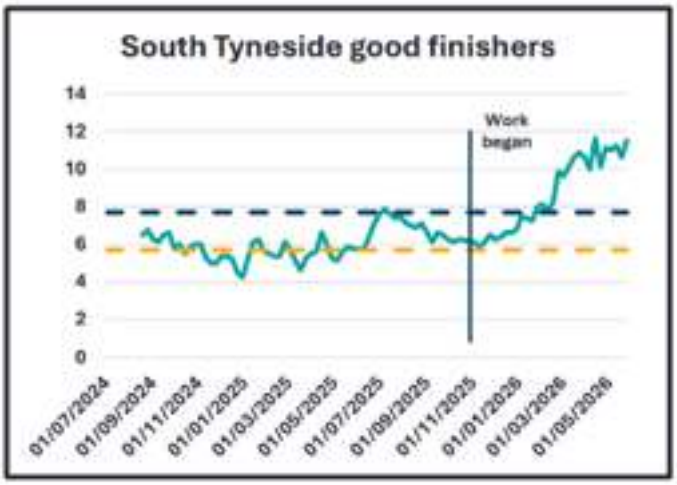
On the ward, where it is suspected that a person may need 24 hour care, a Collaborative Independence Discussion (CID) takes place with the whole multidisciplinary team and incorporating the persons wishes, to collectively explore whether we are able to put measures in place to facilitate a more independent pathway out of hospital. These CIDS happen twice weekly in South Tyneside, with virtual CIDs in place for patients who need escalating early for a discussion. Data from the workstream demonstrates a reduction

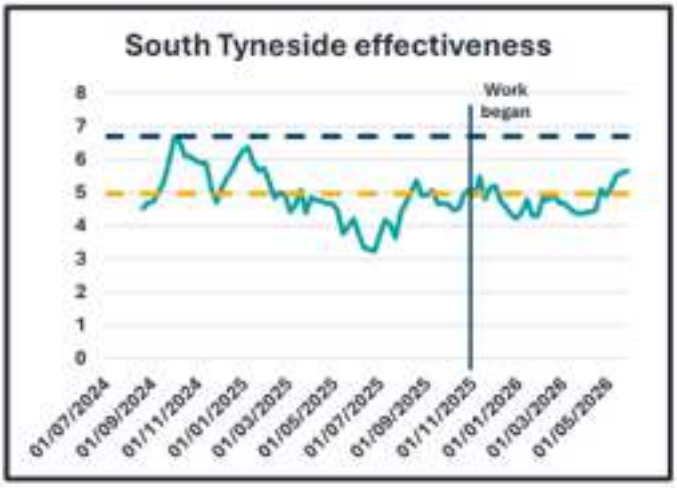
overall in the number of people leaving hospital and going into 24-hour care. There are a number of people who remain temporarily placed due to not being able to go directly home, but require some recovery that can not be currently met in the community beds. This issue forms part of the current actions within the work programme, to promote less restrictive criteria within our Return to Independence beds (RIBs), to allow some recovery before commencing reablement, and to support the person home. Enhanced staffing will be required, to allow the RIBs to support people with moderate cognitive impairment and enhanced observational needs. Once this is in place, we will expect to see a further reduction in numbers of people going into permanent care.

Reablement At Home

The aim of this workstream is ensuring that as many people as possible have the opportunity to increase their independence in their own home following a stay in hospital. Maximising the independence of all those accessing reablement. Measured as the difference between start and end package size, aiming for a reduction in ongoing care needs, as well as an increase in the number of people successfully completing their reablement plan (good finishers).

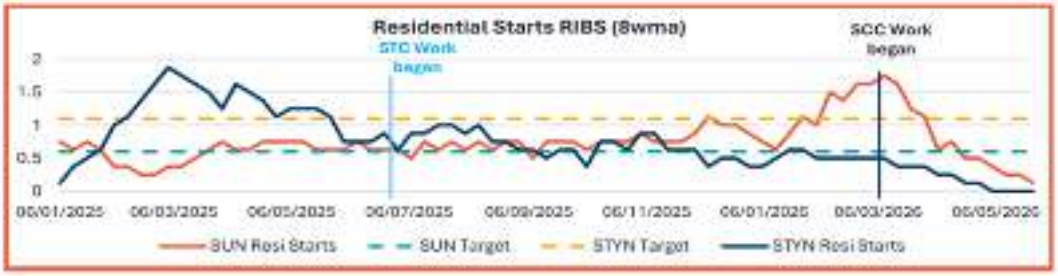
Data monitoring demonstrates a steady increase in capacity within the reablement services. For South Tyneside, this now represents a return to the level of capacity available before the issues with one of the care providers. However, the time to access the reablement package is significantly longer than before the issues and the team are actively working to reduce the time to access the package of reablement, supporting people to leave hospital in a more timely way. Effectiveness currently sits between baseline and target and good finishers are above target in South Tyneside. Key to this success is the flexibility and willingness from teams to change ways of working, early Estimated Date of Discharge from the service, clear patient centered goals and timely review of progress.





Return to Independence Beds (RIBs)

The aim of this workstream is to support the 'Home First' philosophy increasing the opportunities for people who use our services, to return home, by spending a period of reablement in the community in a bedded setting, to increase the likelihood of them being able to go home. In addition, our aim is also to reduce the number of people going into residential care from this reablement service.



Working with the Providers (Borrowdale House and Haven Court), person centered, strength based goals are set early in the stay and communicated widely, along with an estimated date of discharge. Residents are discussed in collaborative independence discussions at least twice per week by the multi-disciplinary team, to assess progress and put measures in place for timely supported discharge. Reductions in the length of stay in the RIBs has been observed in the services, which has supported efficiency and increased flow through the beds. Some issues with the sourcing of packages of care for those leaving the service has been observed and has at times, impacted on the length of stay. This has been driven by both provider issues (which are now resolving) as well as the complexity of this cohort of people which are now generally older and more frail but would have ordinarily gone into long term care. As a result of this improved efficiency, we have found that there is excess capacity within the RIB bedstock and are therefore exploring how we can use the beds differently to support flow out of hospital giving more people the opportunity to get home, as well as part of admission avoidance and delivering care closer to home, aligned to the neighbourhood models of care. At the end of June, the excellent work of Borrowdale and Haven, saw no people leaving their service and going into residential care, all leavers went home.

Admission and Attendance Avoidance

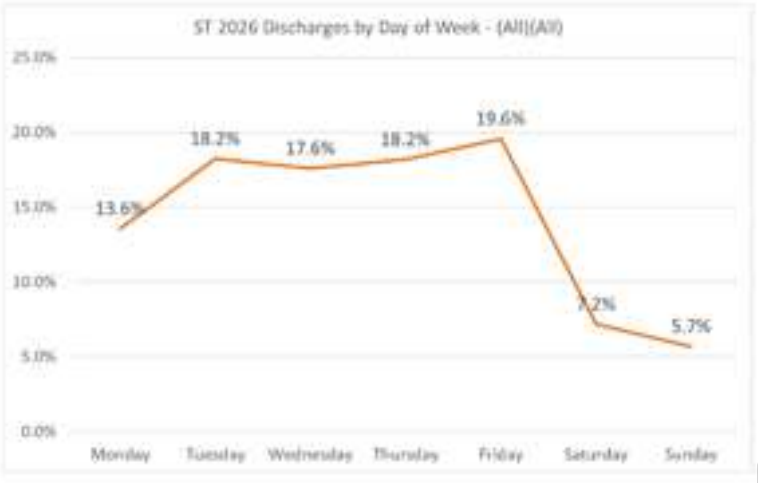
The aim of this workstream is to develop new pathways to incorporate triage from Care Coordination Hub with community services as first point of access. Reduce ED visits by decreasing the number ambulance conveyances from care homes to the emergency Department. Increasing staff awareness of available community services and the care coordination hub. Commencing in December 2025, work with the North East Ambulance Service (NEAS) saw the implementation of ‘Call Before Convey’ for Care Homes, into the Care Co-ordination Hub (CCH). This meant that ambulance crews on scene in care homes and the person did not have a life, sight or limb threatening problem, were able to discuss with the community teams (which include nursing, GP, therapy, pharmacy and Consultant staff). the patients needs and where possible, agree a plan for the person to remain in the care home to receive their treatment rather than conveyed to hospital. As a result of this people are able to receive care in familiar surroundings by skilled staff, ambulance crews are able to be released back onto the road and respond timely to the next call and the Emergency Department is decompressed by less attendances. The success of this work has seen a reduction in care home conveyances from an average of 17 per day to less than 10 per day. The development of new pathways (head injury and falls with a long lie) in response to weekly improvement cycles, has seen a further reduction in conveyances. The workstream is now in the process of rolling Call Before Convey out to all people across Sunderland and South Tyneside and not just those in care homes. This is likely to have a further impact on reducing conveyances to hospital and an increase in providing care in the persons home. This new way of working has been supported by the Frailty Hospital at Home service, where people need enhanced care including the support of a Geriatrician, they can be stepped up onto the virtual ward until they are well enough to return to the care of the community nursing teams.

In-hospital Flow

The aim of this workstream is to reduce the number of patients with lengths of stay exceeding 7, 14, and 21 days by promoting flow and challenging delays including the amount of time spent 'waiting' for something to happen. This includes working to increase the number of people discharged home on a weekend and revieing our ways of working in the discharge process and its linear nature. We are aiming to increase the number of people who are discharged on their Discharge Ready Date. The use of the Red2Green flow tool is important in this process; a patient is on a red day if they are waiting but there is a delay and a green day if they are waiting and all actions are progressing in line with professional standards.

From a weekend discharge perspective, we don't do this very well so working with health and social care colleagues to explore 'What would need to be true, to support more people to leave hospital on a weekend?'

Current performance



Initial findings include offering 7-day services/working, access to equipment, ability to accept people into services over a weekend, transport issues – the group are working through what we can do to improve this process including earlier intervention and action.

Financial Opportunities

Values presented are the target annual values at full run rate for each workstream split by organisation. The admission avoidance and flow workstreams are part of Guiding You Home but not with direct Newton support, so will have targets agreed subsequently.

Workstream	Area	KPI Definition	STSFT	STC	SUN	ICB	Target	Stretch
Admission Avoidance	Admission Rate	[illegible]	TBD					
	UCR Volume	[illegible]						
							£0m*	£0m*
Flow	Community Rehab LoS	[illegible]	TBD					
							£0m*	£0m*
Acute Discharge	P2 Discharges	[illegible]		£1.7m	£3m	£1.5m		
	P2 Discharges	[illegible]						
	No Community Rehab LoS	[illegible]	£1.5m					
							£8m	[illegible]
Intermediate Care: Return to Independence levels	Average length of LoS	[illegible]		[illegible]	[illegible]	[illegible]		
	[illegible]	[illegible]						
							[illegible]	[illegible]
Intermediate Care (Reablement)	Volumes	[illegible]		[illegible]	[illegible]	[illegible]		
	[illegible]	[illegible]						
							[illegible]	[illegible]
			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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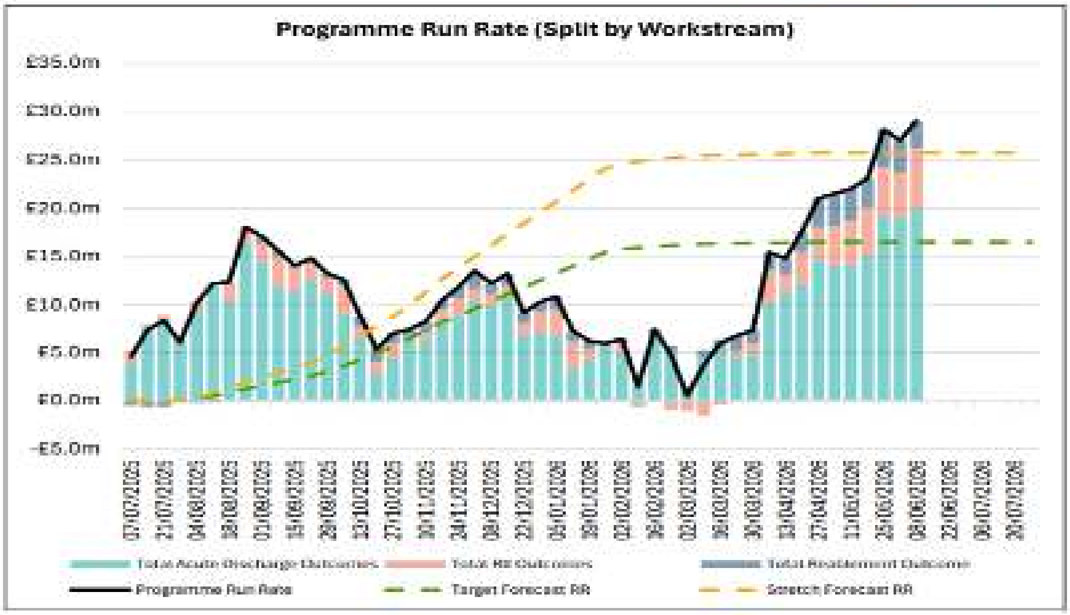
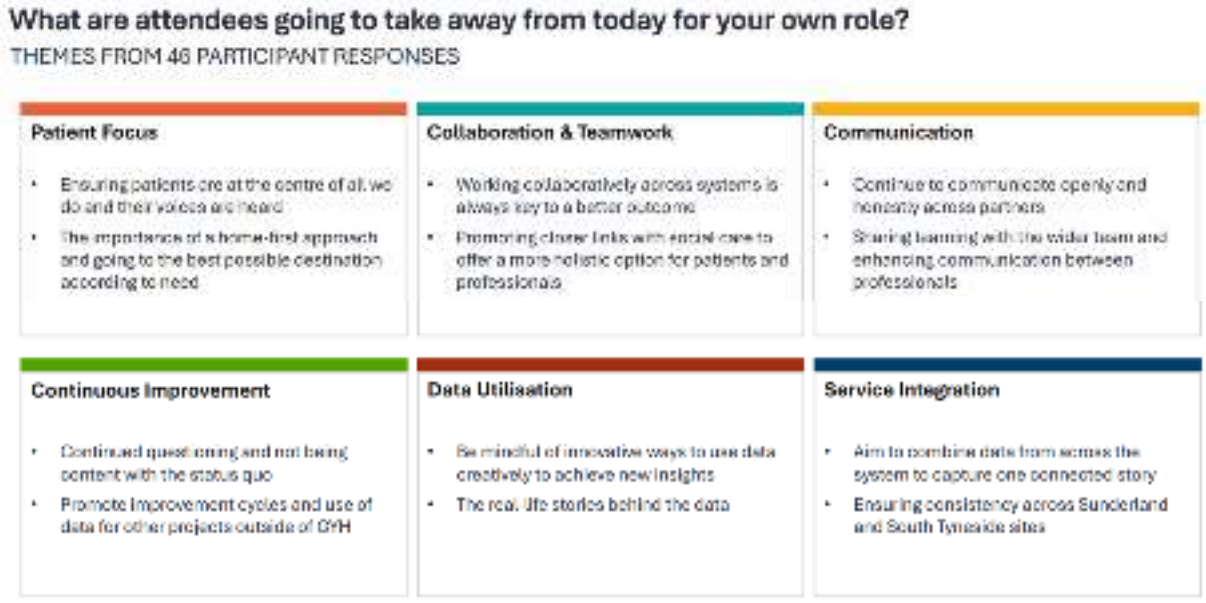


Current performance against the financial opportunities is positive. It should be noted that some financial opportunities require a strategic decision within organisations (eg. Opportunities from length of stay reduction in hospital), others will flow based on changes to practice (eg. Less people going into permanent care means less LA spending on care home placements). Financial opportunities are closely tracked with the finance teams from each organisation.

Celebrating Success

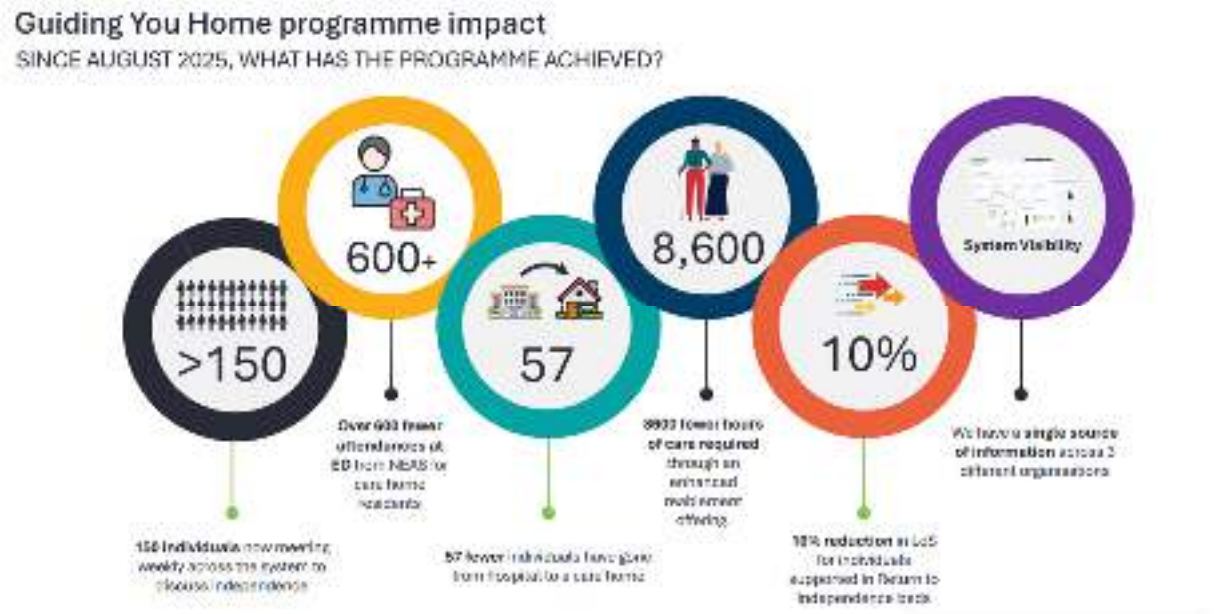
The success of Guiding You Home has been through the effort of the teams on the ground, their willingness to do things different, their flexibility of approach and the shared

goal of getting people home on the most independent pathway possible. This has been enabled through the support from the programme executives, in giving staff the freedom to be creative, test things out and change and adapt. Our staff have embraced the whole programme, for the benefit of people who use our services across health and social care. We held a celebration event at the beginning of June, where teams shred their GYH journey, things they found difficult as well as celebrating their successes. It was a very uplifting day and the teams were outstanding and so passionate. We asked them what they felt the next steps were for the programme as well as their take away from the day and below is a summary of their responses.



Summary and recommendations

So far the Programme has delivered:



Health & Wellbeing Board are asked to note the content of this paper and be assured of the progress and delivery of the Guiding You Home Programme.

Anna Hargrave
Programme Director
July 2026