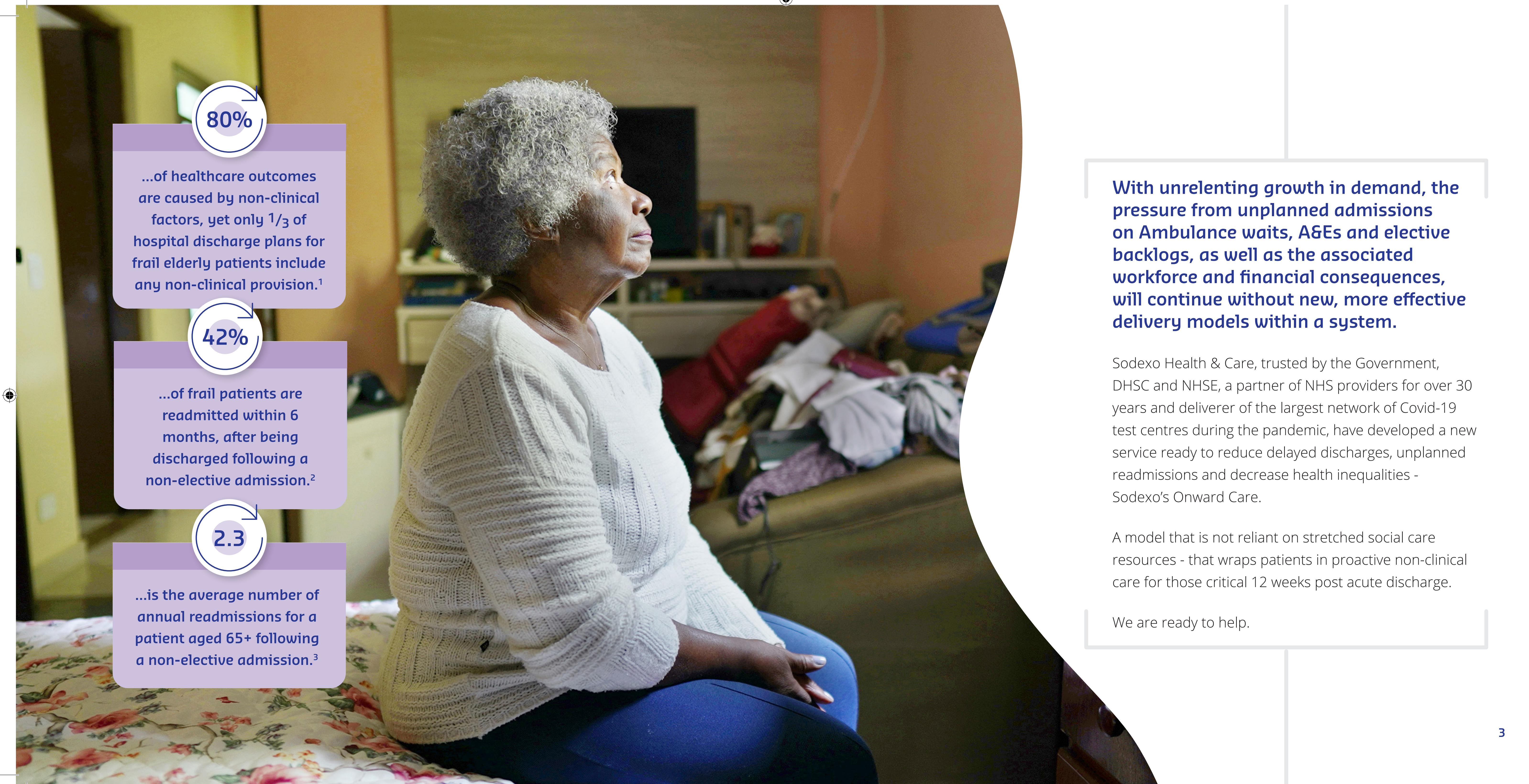
Please get in touch with
Sodexo's Onward Care Managing Director
to start a conversation today.

onwardcare@sodexo.com

Targeted non-clinical care that helps get patients home, and keeps them safe and well following discharge – reducing unplanned readmissions by 77%, decreasing health inequalities, and freeing up beds.

15437 Continuum of Care Brochure_07.indd 16-1

29/11/2023 19:10



With unrelenting growth in demand, the pressure from unplanned admissions on Ambulance waits, A&Es and elective backlogs, as well as the associated workforce and financial consequences, will continue without new, more effective delivery models within a system.

Sodexo Health & Care, trusted by the Government, DHSC and NHSE, a partner of NHS providers for over 30 years and deliverer of the largest network of Covid-19 test centres during the pandemic, have developed a new service ready to reduce delayed discharges, unplanned readmissions and decrease health inequalities - Sodexo's Onward Care.

A model that is not reliant on stretched social care resources - that wraps patients in proactive non-clinical care for those critical 12 weeks post acute discharge.

We are ready to help.

15437 Continuum of Care Brochure_07.indd 2-3 29/11/2023 19:10

The current gap

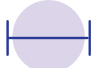
None | High

No care provided

Onward Care fills the gap through proactive non-clinical telephone, face-to-face and lifestyle support

Supported by social care and other traditional services

Onward Care supports patients whose needs fall outside 'traditional' clinical and social care, but who do need more than nothing for ongoing recovery and wellbeing.



It fills this gap by coordinating and delivering a broad range of non-clinical support that will help patients stay safe and well after being discharged from hospital.

Wrapping these patients in non-clinical support not only reduces their risk of readmission, it also reduces demand for traditional domiciliary care services.

The Impact of Onward Care

Sodexo will deliver these ambitions at the same time as improving patient outcomes by delivering preventative care outside expensive clinical settings.

Supporting people who have **2x level of social deprivation,** addressing Health Inequalities.

77% reduction in acute hospital bed days for Onward Care patients.

91% of patients would recommend the service to friends and family.

Our Managed Service

12 weeks support from our fully trained and experienced care teams.

Care includes home visits, phone calls.

Non-clinical remote monitoring by our team, with alert protocols for activity outside agreed thresholds.

One off food packages and home cleans to support earlier discharge.

Escalating and signposting to local clinical and health and voluntary sector resources as required.

Act as an integrator within the system, signposting to the right resources.

15437 Continuum of Care Brochure_07.indd 4-5 29/11/2023 19:10

First things first - pinpointing patients for greatest benefit

Using local data, we identify and target those patients most likely to benefit from Onward Care.

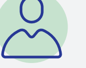
We analyse primary and secondary care patient-level data to identify the mix of factors that increase the likeliness of readmission.

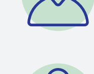
We use hundreds of markers, including age, frailty score, deprivation decile, existence of long-term condition (mental and physical), and whether they live alone.

This analysis enables us to pinpoint where to focus Onward Care for greatest benefit to both patients and your trust's care delivery.

58%
of discharged patients have no unplanned hospital admissions within 6 months

42%
of patients are readmitted within 6 months





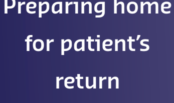
We identify those most likely to be readmitted and most likely to benefit from Onward Care

Fully managed by our care experts

Onward Care is a fully managed and coordinated service. Using Sodexo's vast range of tried and tested expertise, it eases the current care-planning burden on your workforce, freeing staff resource to improve your acute patient flow.

Because we use our own pool of existing expertise, we complement current clinical and social care resources without draining or duplicating them.

Typical services include:



15437 Continuum of Care Brochure_07.indd 6-7
29/11/2023 19:10

Here is an example of our wraparound Onward Care managed service for Ken...

...a 76-year-old widower with COPD, asthma and diabetes. He's just been discharged after being in hospital following a fall.

Reassuring your clinical teams

Being able to put plans in place while patients are still in your care, helps give your clinical teams greater confidence that patients can be safely discharged, improving patient flow and freeing beds.

Onward Care relieves acute discharge teams of the dilemma of having to delay discharge while waiting for social care packages for patients who don't require ongoing support with daily living, but would benefit from proactive checking, passive remote monitoring and target mobilisation of local community and voluntary sector resources. This brings forward the moment when your clinical staff can feel confident their patients can be safely discharged, easing the pressure on hospital staff and beds.

15437 Continuum of Care Brochure_07.indd 8-9 29/11/2023 19:10

A WEEK BY WEEK INDICATIVE GUIDE TO ONWARD CARE ENGAGEMENT

1 month prior to service start	Pre Discharge	Day 1 & 2	Days 3-7	Weeks 2-4	Week 5-12
Using hospital and wider health system data, our analysts identify the markers for patients with greater propensity for readmission and that are most likely to benefit from Onward Care services.	Work with your discharge teams to identify patients who will benefit from Onward Care.	Call or meet with the patient and their family at the patient's home.	Call patient to check up. Follow up if necessary.	Weekly check-up calls.	Review progress against patient's objectives.
	Ask target patients for their consent to join the Onward Care programme.	Share system support network information.	Review patient's progress.	Weekly home visit if needed.	Weekly check-in calls and home visits as needed.
	Meet with your MDT discharge team to agree the Onward Care plan for each patient.	Confirm patient defined objectives for the next 12 weeks.		Daily remote monitoring with actions if behavioural changes occur.	Daily remote monitoring.
	Meet with patients and their families to understand their goals and lifestyle aspirations over their first 12 weeks post discharge.	Set up remote monitoring technology, such as smart watch and movement monitors.			Agree full plan following discharge from Onward Care, including wider care system support where needed.
	Arrange discharge food package and home cleaning - where that will reduce future risk of readmission.				Provide close off report to hospital and discharge co-ordinator.

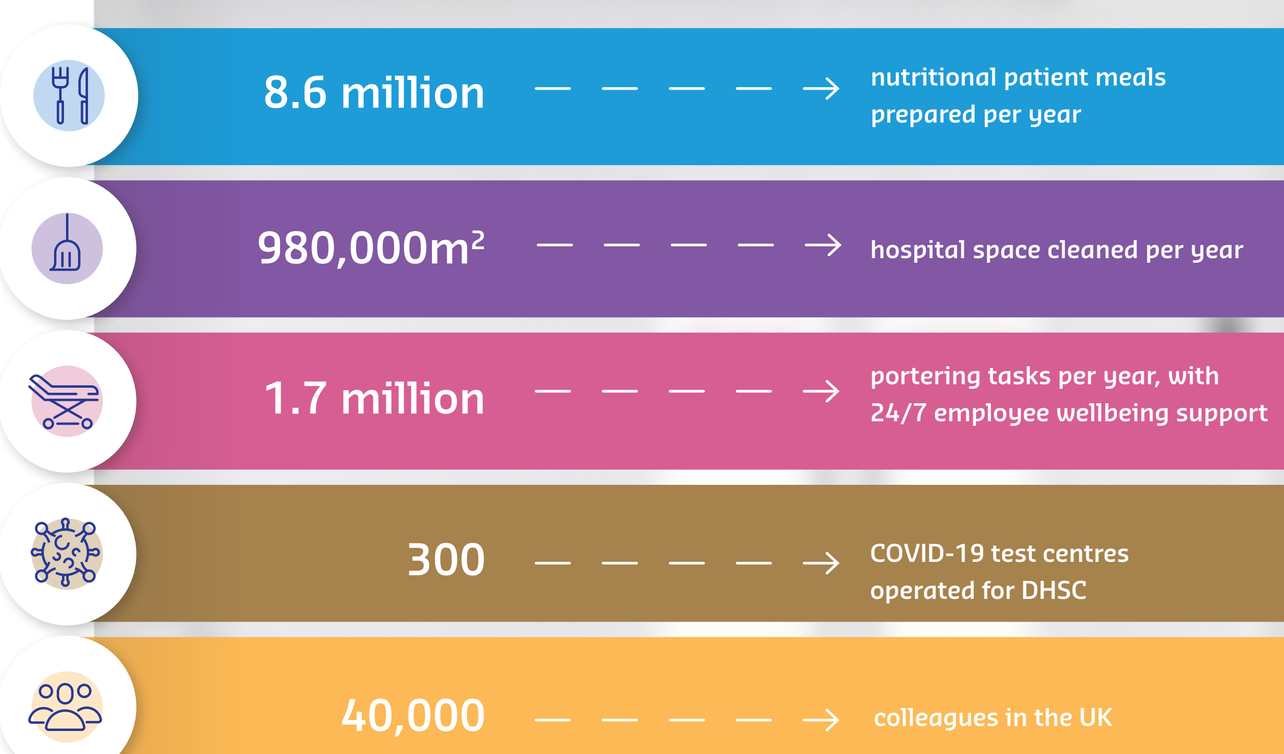
Doubling a Patient Activation Score can reduce use of clinical resources by 25%.[4]

Expert care services delivered by a single trusted partner

Sodexo has deep experience of providing acute and home care over the past 30 years.

We already partner with many major NHS trusts and successfully set up and ran the UK's largest network of COVID-19 test centres for the Department of Health and Social Care, rapidly training an additional 10,000 staff.

With a regular team of over 13,000 colleagues working right across public and private health and care, our understanding of the system along with our data and health analytics expertise ideally places us to support your discharged patients.



1. https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm
2. Feedback from mid-ranking trust based on National HES Data – trust nonelective readmissions (2020).
3. Sodexo commissioned survey (Aug 2021) of over 65s following discharge from a non elective admission. (n= 494)
4. NHS England Population Health Management Development Programme statistic, Feb 2020 - Jul 2022.
5. Readmission data analysis from large US Healthcare provider.

Please email
Sodexo's Onward Care
Managing Director
Adrian McCourt for a
further exploratory
discussion on **07740 398 202** or
onwardcare@sodexo.com

15437 Continuum of Care Brochure_07.indd 14-15 29/11/2023 19:10