Home First

Helen Martin
Director Adult Community Services
Medway Community Healthcare

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Medway Council
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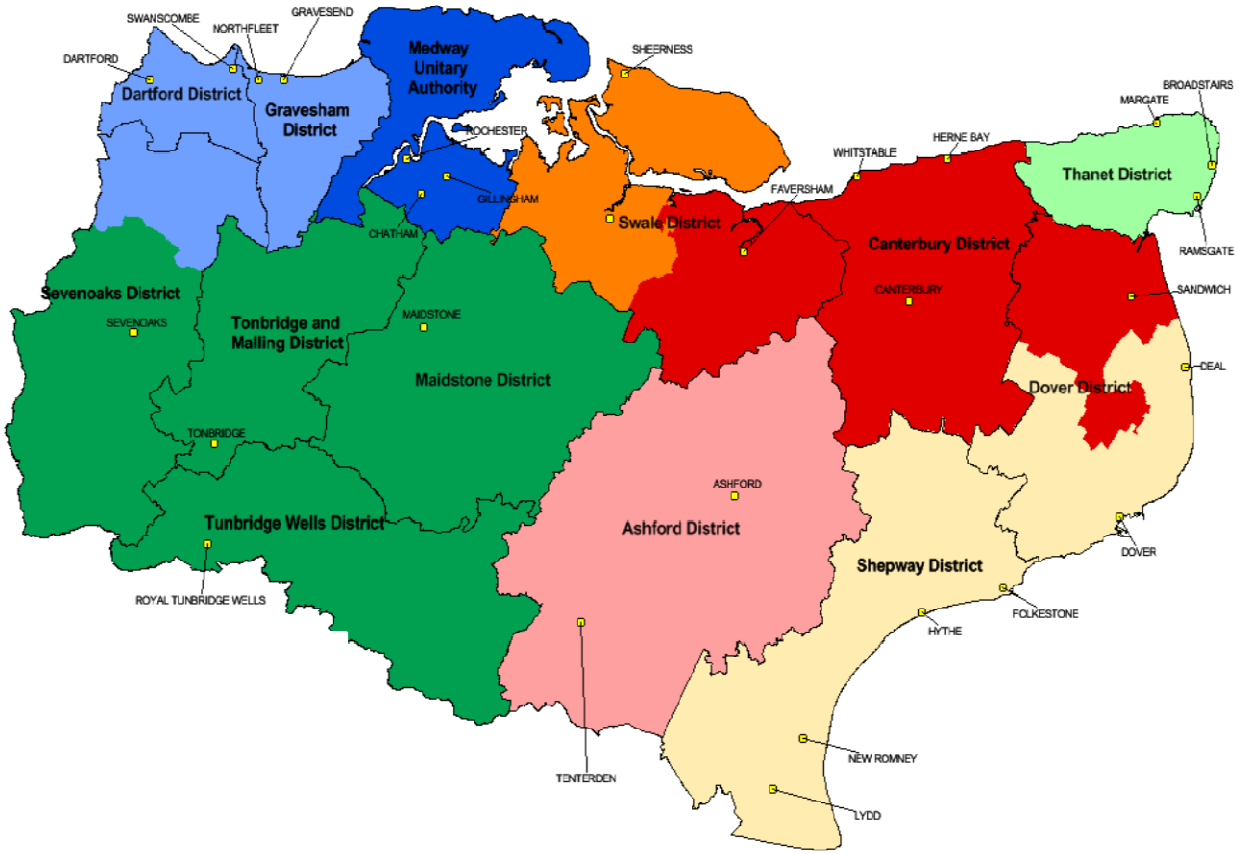
NHS Foundation Trust



…we are caring and compassionate …we deliver quality and value …we work in partnership

The Medway System

- One acute hospital
- One community provider
- One CCG
- Unitary Authority
- Partnership Commissioning

So what's the problem?

Medway Health and Social Care Partner's pledge is to:-			
Minimise patient's acute hospital length of stay			
Maximize independence through enablement			
Support care at home or closer to home			
Make no decision about long term care in an acute setting			
Support timely discharge from hospital, avoiding delays and supporting people to leave earlier	Maintain maximum independence where possible and enable people to help themsleves	Reduce the level of long term care packages and premature admission to a residential care setting	Improve outcomes for patients and carers

Our community challenge
Develop and implement in 8 weeks

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What pathway is your patient on?

Pathway 0

- The patient no longer has any care needs that require additional support
- Patient identified as medically fit and no further support require
- Coordinate discharge and restart any previous care packages

Pathway 1

- The patient has additional care needs that can be safely met at home
- Patient identified as medically fit but further support required
- Patient deemed safe between visits at home
- Call **01634 891 900** to refer (including equipment, therapy, and enablement)

Pathway 2

- The patient is unable to return home for a short period of time as they require further rehabilitation
- Patient identified as medically fit but requires further rehabilitation, and is unsafe to be left between visits.
- Requires further support but no longer required to be delivered in an inpatient setting
- Refer to the Integrated Discharge Team (IDT)

Pathway 3

- The patient has complex needs and is unable to return home
- Patient unable to live independently at home and requires long term social support / placement; or the patient is end of life / is rapidly deteriorating / in the terminal phase of illness
- Refer to the Integrated Discharge Team (IDT)

Home First

Home First is a multi-agency partnership working across the whole health and social care system to reduce unnecessarily prolonged lengths of stay in an acute hospital.

Home First initiative facilitates more timely and effective hospital discharges, achieved by the community providing holistic assessment, equipment and on-going enablement and support in the patient's own home or intermediate care facility.

Home First facilitates up to 35 discharges per week, including weekends

Pathway One

The Ward contact community single point of contact

Triage completed over the telephone:

- If transport is required a slot will be booked
- Any previous community support & enablement will be reinstated
- A timed visit will be made for an OT to assess
- Any onward health service referrals will be made
- The patient will be visited within two hours of arriving home

The OT will:-

- Perform a holistic assessment of needs
- Establish personal enablement goals
- Instigate an independence program (inc therapy & personal care up to 6 weeks)
- Order / provide equipment within next two hours
- Decide upon anticipatory pathway including onward referrals

Achievements so far…

- The Pilot worked
- The service is now contracted
- To date 3696 referrals accepted and assessed
- Reduction in DTOC numbers – currently under 3%
- Change in culture – Integrated partnership working
- Reduction in long term care reliance
- Improved patient flow
- Recognition
- Great working relationships & sustainability
- A model to build upon

Home First

The Facts and Figures

- Average **32 referrals per week** under Home First
- Maximum number of patients seen **in one day was 14**
- Almost **9% of discharges** referred for **telecare support** once home
- Approx **50% of those discharged** from hospital **required enablement** support
- **77.5% successfully enabled** and **discharged within 6 weeks**
- In total **79.3%** of discharges **did not require a longer term care package**
- **100% service users** discharged **rate service 'good or excellent'**
- **Low numbers** of discharges seen on **Mondays and B. Holidays**
- **High numbers** of discharges seen on **Fridays**

From left: Julie Aiken, Associate Practitioner and Home First patient Barbara Littlewood

Celebrating our 1,000th 'Home First' patient

A service designed to help Medway residents stay well and independent in their own homes after leaving hospital has helped its 1,000th patient, less than a year after it was launched.

Home First

Home First, an initiative developed through the partnership of Medway Foundation Trust Hospital, Medway Clinical Commissioning Group (CCG), Medway Council and Medway Community Healthcare, provides support for patients medically fit to be discharged, but who still require additional home support.

Barbara Littlewood, aged 87 from Allhallows, was the 1,000th Medway resident to be supported by Home First, after she was discharged following surgery on her knee. Commenting on the Home First service, Barbara Littlewood said: "I've been so impressed by how efficient the staff were in getting me home.

> I've been so impressed by how efficient the staff were in getting me home. I was healthy and ready to get back to my daily routine, and they made sure I had all I needed to get around my home independently.
>
> **Barbara Littlewood, Home First patient**

"After my surgery and rest I was healthy and ready to get back to my daily routine, and they made sure I had all I needed to get around my home safely and independently. They also provided me with my lovely carer who has been giving me physiotherapy twice a week. For the first time today I was confident enough to take a walk with my son and he was so pleased to see me doing so well after everything that's happened."

Every Home First patient has a face to face assessment in their own home by an occupational therapist to discuss what social and/or health care is needed to help their recovery. A care plan is then jointly agreed with the patient, which can include equipment to restore patients back to their daily routine of getting around the home and preparing meals to receiving regular home visits from a healthcare professional.

Amanda Gibson, Lead Matron for Discharge at Medway Foundation Trust Hospital, said: "Our absolute priority since starting Home First with our community partners has been to ensure that every patient who is discharged goes home with the right support in place in order for them to regain their health, independence and confidence."

The Home First scheme is funded through the Better Care Fund which allows local authorities and CCGs to spend jointly on social services and community services.

Caroline Selkirk, Accountable Officer for Medway CCG, said: "We know that many people prefer to be supported in their own homes, close to friends or family carers. By having the Home First team in place it is easier for patients to get back into familiar routines and an independent lifestyle once a medical crisis has eased. Home First brings together health and social care services to deliver more joined-up personal services with staff providing care and working as part of the same team."

Find out more about the Home First scheme
www.medway.nhs.uk/for-patients/home-first

> Our absolute priority since starting Home First has been to ensure that every patient goes home with the right support in place in order for them to regain their health, independence and confidence.
>
> **Amanda Gibson, Lead Matron for Discharge**

" Mum felt very uneasy about letting strangers wash her, let alone into her home. These ladies were, to put it mildly, very reassuring to mum and befriended her.

They gained her trust and respect and she still talks about them.

I cannot thank them enough for giving mum time, support, reassurance and most of all, the courage and space to allow her to find the enthusiasm to gain her self-respect and get back on her own two feet.

Our journey ‘Home’ continues

- Daily challenge continues through multi-agency acute and community DToC conference calls, Ward rounds, MADE
- Integrated discharge team review
- Home first ‘plus’
- Urgent community response pilots
- Local care models including TICC (Buurtzorg Nursing)

Critical success factors

- One vision
- Champion ‘Home First’
- Trust your staff and partners
- Bend the rules
- Find local solutions
- Communicate
- Keep it simple…….

Thank you for your time

Any questions ?

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Contact me

Helen Martin
Director Adult Community Services
Medway Community Healthcare
t: 01634 334624
e: helen.martin6@nhs.net
www.medwaycommunityhealthcare.nhs.uk

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