Lincolnshire Home First Model

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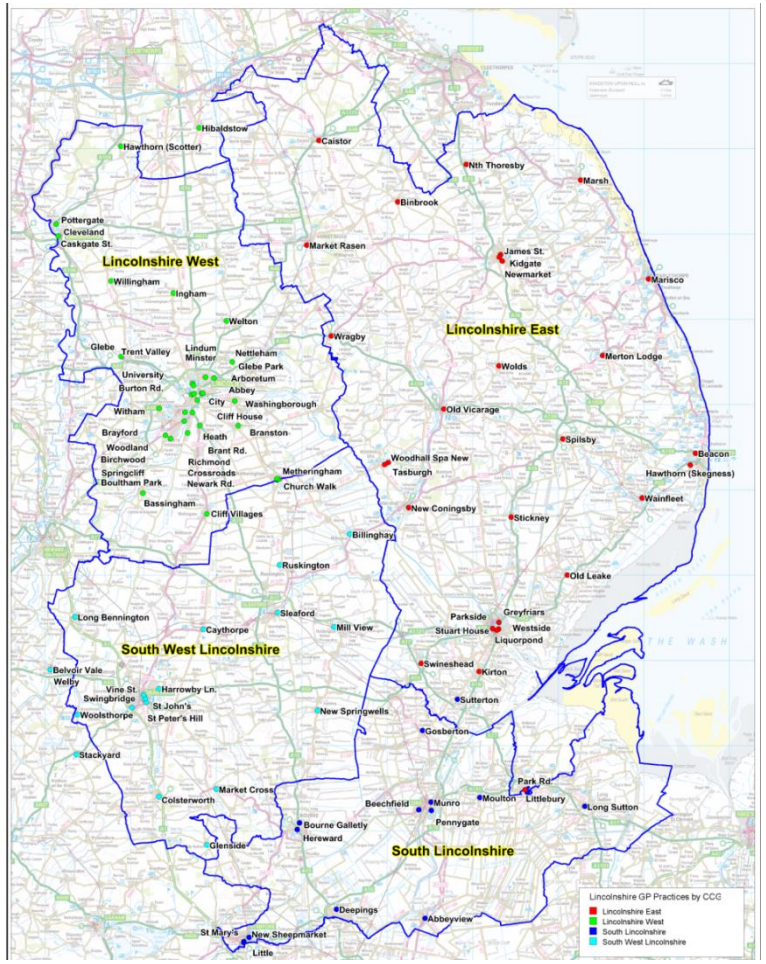
Lincolnshire



- 2,350 Square Miles
- 751,200 Population
- 23% over 65 in Lincs compared to 19% in East Midlands
- 22 miles of dual carriage way
- The worst broadband coverage in England.

Single County Wide Reablement contract awarded to Allied Healthcare

- Eligibility kept wide
- One County wide Provider
- 7 day service for support and referrals
- Focused on delivering excellent reablement Outcomes
- 40% increase in capacity in year one
- 60% people reabled to no ongoing AC support

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Wellbeing Service

Countywide Monitoring Service

- TeleCare monitoring, response triggering, proactive wellbeing phone calls

Wellbeing Support and Response Service

- Trusted Assessment, Generic Support, Minor Adaptations, Equipment, TeleCare, Wellbeing Response – Stay Safe & Home Safe, Resettlement

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HART (Hospital Avoidance Response Service)

Reduction in delayed discharges and support admission avoidance by;

- Facilitating a supported discharge and providing up to 72 hours of care and support to resettle a person at home
- Offer a ‘bridging the gap service’ for a 72 hr period to give other domiciliary providers or the reablement service the opportunity to commence later in the pathway
- Support the Clinical Assessment Service (CAS) to avoid hospital admission and/or attendance at A&E
- Offer a telecare unit as part of the service, enabling person to have access to the responders 24/ 7 – assurance of support through the night should it be required
- offers the person a Wellbeing Service assessment and will refer them on appropriately if accepted

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Impact of HART

The impact and outcomes HART has had for people accessing the service during April 2017 – March 2018 include;

- Providing 72 hours of care and support to 1157 people within Lincolnshire
- Supporting 941 people to be discharged from hospital with a package of care and support
- Supporting 216 people supported at home, preventing them unnecessarily from accessing hospital services

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Savings resulting from HART

The service has achieved the following savings for the NHS within Lincolnshire in 2017/2018;

- £515,500 bed savings made from Hospital Discharge into further care provision (bridging the gap)
- £450,000 Hospital bed savings due to Admission Avoidance (avoiding hospital admission)
- £56,400 potential additional savings made through people accessing an independent pathway

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CHTA (Care Home Trusted Assessor) Scheme

- Support for busy Care Home Managers
- An independent, experienced individual who is there to support the Care Home Manager to facilitate timely discharge
- Ask the questions and gather the information needed
- Based on Site
- Support for the Discharge Team
- Able to respond as soon as a placement is agreed
- Liaison between hospital and care home on an equal footing

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Statistics from first full year

439 referrals

340 Assessments Completed

304 discharges

Total days saved 735

Total Savings £400K (Net)

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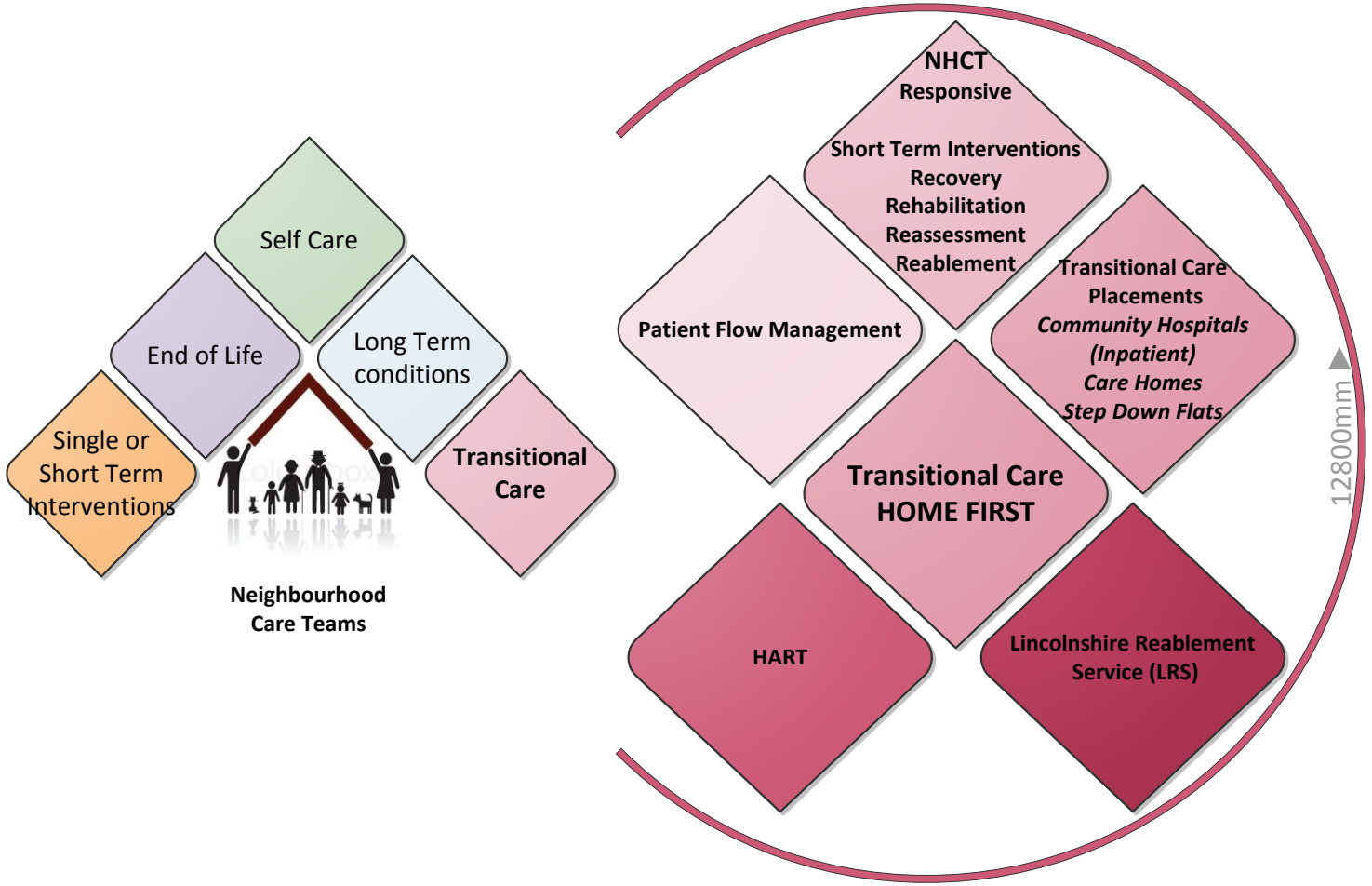
The functions of Transitional Care



Transitional Care – Home First Principles

Home

We will support people to remain in their own homes wherever possible and if they are not at home we will strive to ensure they return home as swiftly as possible

Outcomes

We will work with people to understand what is important to them and support them to achieve the outcomes they identify

Empower

We will recognise that people are individuals, not patients or conditions. Our role is to support people to be stronger, more confident and in control of their own lives

Innovative

We will not match people to services, but will build on the permission we have to develop and utilise new ways of supporting people to meet their goals

Risk

We will be positive in our identification of risks and support people to make their own choices about how and where they wish to live their lives

Strengths

We will recognise that everyone we work with has strengths and assets. We will support people to identify these assets and work with them to utilise them in the best possible way

Challenges of Home First Principles

1. Capacity in the community to meet demand
2. Risk aversion
3. Not having the required level of care needed to meet health needs in the community.

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Multi Disciplinary Discharge planning meetings

- Daily hub meetings 9am to discuss all patients medically fit for discharge.
- Agencies attending meetings: ULHT discharge team, Lincolnshire County Council, Lincolnshire community health service, Reablement facilitators.
- HART facilitators, Mental health liaison officers, Wellbeing in reach, housing in reach, carers first, palliative service all based on site and easily accessible
- Integrated spreadsheet detailing patient's plan with timescales shared across services several times daily.
- Escalation calls to enable blockages/issues to be resolved as required.

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Challenges of Integrated working

1. Time commitment to daily meetings
2. Tendency to become distracted and conversations not meaningful
3. Initially a blame culture and Health V Social Care environment

The Future Vision

- Joint commissioning across Health & Care
- Greater integration between neighbourhood teams and the acute setting
- Discharge to Assess
- MFFD Sop roll out
- Transfer of Care policy roll out

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