Providing the right care, in the right place, at the right time, every time

Hertfordshire has ambitious plans to transform the health and care system to enable people to live longer, be healthier and enjoy a better quality of life. A range of partners from commissioners to providers across the local health and social care systems are working together to make this happen.

The Integrated Care Programme Board is a partnership between providers and commissioners. [East and North Hertfordshire CCG](#) and [Hertfordshire County Council](#) (HCC) are working alongside [Hertfordshire Community NHS Trust](#), (HCT), [Hertfordshire Partnership University NHS Foundation Trust](#) (HPFT) and other partner organisations including the voluntary sector, with the aim of providing seamless care, helping to keep more people healthier in the community and out of hospital.

Over the past year, a number of initiatives have been put in place to break down organisational barriers and help improve services. We thought it would be useful to provide a quick recap on what some of these linked programmes are all about and how they fit into delivering integrated care. This issue will focus on the progress being made with HomeFirst and the integrated rapid response service in East and North Hertfordshire.

In this issue:
- HomeFirst rollout
- Plans for Stort Valley
- Psychology in HomeFirst
- Integrated Rapid Response team
- Referral criteria and contact information
- The impact so far
- Patient stories

**Better Care Fund**

This is a national scheme to realign budgets between the NHS and local government to create a more streamlined, efficient and connected health and social care service across the country.

In East and North Hertfordshire, £120m of health and social care money was pooled in a joint fund in March 2015.

This arrangement is leading to more 'joined up' services being offered to residents, with GPs, social workers, nurses, therapists and voluntary agencies working closer together to support individuals to live healthy and independent lives wherever possible.
**HomeFirst**

It’s about providing the right care, in the right place, at the right time, every time

HomeFirst is a joint project between East and North Hertfordshire Clinical Commissioning Group, Hertfordshire County Council, Hertfordshire Community NHS Trust and Hertfordshire Partnership University NHS Foundation Trust.

HomeFirst has three functions:

- Rapid response: responding to people in crisis within 60 minutes
- Case management: identifying people who are at risk of hospital admission
- Supported discharge: helping people regain independence following hospital admission

HomeFirst is fully operational in Lower Lea Valley and in North Hertfordshire and over the past year the rapid response element has been successfully rolled out in Welwyn Hatfield, Stevenage, Stort Valley and Upper Lea Valley. The integrated teams are demonstrating effective response times (98% of patients seen in their homes within 60 minutes) keeping people at home wherever possible (83% of those referred to the service stay at home) and there is evidence of reduced admissions for people with dementia.

It is intended that case management and supported discharge elements will be extended to Welwyn Hatfield and Stevenage by the end of 2016.

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**Stort Valley and Villages**

The ambition in Stort Valley and Villages is to bring all health and social care resources together at Herts and Essex Hospital to deliver an integrated response to the needs of the people living in Stort Valley and Villages. Services will be aligned to ensure they deliver both planned and unplanned care, whilst supporting the overall priorities of the locality.

The existing Integrated Community Team delivering nursing, therapy and matron support will be joined by mental health and social care staff to provide an integrated approach for the local community. There will be a single point of access for the integrated team and all referrals will be triaged and sent to the most appropriate member of the team.

The team will work with the GPs to risk stratify patients to ensure those identified will get the support they require. Using a case management approach the most appropriate professional will coordinate the care of the individual, working in a multi-disciplinary way to ensure all their needs are addressed.

Along with the rapid response service the ambition is to fund a dedicated GP within the team to support the holistic assessment of those who would otherwise be admitted to hospital.
In May 2016, HomeFirst in Lower Lea Valley welcomed clinical psychology staff to the team. HomeFirst supports service users with long term conditions to remain in their home and clinical psychology aims to provide enhanced input for patients with more complex needs.

Since joining the service, Dr Charles Heinson, Clinical Psychologist and Elif Huseyin, Assistant Psychologist have been involved in a broad range of work including helping patients self-manage their physical health problems as well as working alongside more complex patients that are not adequately accounted for by their physical health condition.

Referrals come from a range of sources including handovers, formal requests, informal discussions and GP meetings. In most cases, Charles or Elif arrange to visit patients in their homes to ‘have a look’ with other health care professionals involved in the case. The benefit of this approach is that staff members are exposed to alternative psychological views on the impact of physical health on quality of life, thus enabling a more ‘whole person’ approach to service delivery.

Charles and Elif work very closely with the multi-disciplinary team to increase awareness of the link between physical health and emotional wellbeing. The aim is to meet the needs of the local population by providing an holistic approach to patient care.

Joe’s story

Jas Hanson, Community Mental Health Nurse, tells us about Joe, a man in his early 30s, who was referred to the service.

“Joe was referred to the service following a diagnosis of cancer and extensive surgery to remove a tumour. His girlfriend stopped working to care for him.

“Joe was assessed by the occupational therapist and district nurses visited daily. He became increasingly anxious, depressed, upset and angry and following a discussion at the MDT meeting, he was referred to me.

“Joe was not keen to try anti-depressants but found it helpful to ventilate his feelings. He had difficulty coming to terms with his illness. He had problems attending hospital appointments as he was terrified of receiving bad news so I gave him coping strategies which enabled him to sit in the waiting room without panicking.

“We discussed his frustrations about the speed of his recovery and he started to write down his progress and achievements. He found it useful to see how far he had come.

“Joe was worried about finances so I helped him complete paperwork and arranged for an assessor to visit him at home. He was awarded payment which had a positive effect on his mental state. His girlfriend was given emotional support, coping strategies and help applying for a carer’s allowance.

“The district nurses reduced their visits as I monitored Joe’s blood pressure during my visits. His progress was discussed at the weekly MDT meeting.

“Joe has said he feels he has had a gold star service.”

Sarah’s story

Sarah, a lady in her mid-70s, was referred to psychology as she had not left her house for several months. She suffered from severe anxiety following a diagnosis of terminal cancer.

Following an holistic assessment of physical, psychological and social needs, it was established that Sarah’s anxiety was in part linked to her husband who was also unwell. She was very self-reliant and did not want to burden her husband with her problems as she was concerned about making his condition worse.

In a brief intervention lasting three sessions, Charles worked with Sarah and her husband to help enhance communication and to think of a way forward. This work, along with some practical anxiety management and support from the broader HomeFirst team, helped the couple develop confidence and resilience which resulted in a significant improvement in quality of life.

At the end of our involvement Sarah had embraced some of her previous interests and was getting out of the house several times a week!
Integrated Rapid Response

Our integrated rapid response team will respond to people in crisis within 60 minutes

The service provides a rapid response to people in crisis to support the delivery of acute care closer to patients’ homes and takes referrals from primary care. It provides integrated health and social care within a patient’s home for up to seven days – enabling people to remain at home where appropriate. The team provides nursing, therapy, social care, homecare and mental health support.

Referrals to the service are taken from all professionals including GPs, Acute In-Hours Visiting Service (AIHVS) and Herts Urgent Care (HUC), ambulance, acute services and care homes. The service is delivered between 8am and 8pm seven days a week. Referrals are taken between 10am and 6.30pm.

Following assessment, the professional will determine if it is suitable for the patient to be managed on the rapid response caseload and draw up an individual care plan to meet the needs. The care plan will address all physical and mental health and social care needs and the team will support patients on the rapid response caseload for up to seven days. The case will be discussed at the weekly MDT meeting and the patient’s GP will be kept informed. The team works collaboratively with other agencies to achieve the best outcomes for patients.

If the patient is deemed unsuitable to be managed by the service the team will arrange the appropriate onward referral.

The Integrated Rapid Response team

Primary Care

Medical responsibility for patients will be retained by the patient’s own GP. Close working relationships with GP practices are essential for this to work effectively.

Matron and Band 6 Case Management nurses

The nursing team coordinates and manages the cohort of patients within the Integrated Rapid Response team, providing clinical expertise in the management of patients. They are responsible for the team’s assessment, planning, implementation and evaluation of nursing care to patients.

Community Mental Health Nurses

The community mental health nurses are responsible for the team’s assessment, planning, implementation and evaluation of mental health care to patients living in the community.

Therapists

The therapist is responsible for the team’s assessment, planning, implementation and evaluation of therapy care to patients. This includes assessing and providing appropriate equipment to keep the patient at home safely.

Social Care

The social worker will carry out an assessment to establish social care needs, outcomes and eligibility under the national criteria set out in The Care and Support Regulations 2014.

Homecare

Specialist care at Home provides support within 4 hours of referral to ensure a patient can stay at home safely.

The teams are supported by Hertfordshire Community NHS Trust teams which include nursing and therapy staff, technical instructors and health care assistants.
If you have a patient you think we may be able to support please call the Clinician of the Day for your area:

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<tr>
<th>Area</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Stevenage</td>
<td>07789 864861</td>
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<tr>
<td>Welwyn and Hatfield</td>
<td>07342 078835</td>
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<tr>
<td>Stort Valley and Villages</td>
<td>07786 250617</td>
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<tr>
<td>Upper Lea Valley</td>
<td>07342 077898</td>
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<tr>
<td>Lower Lea Valley</td>
<td>01992 818025</td>
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<tr>
<td>North Hertfordshire</td>
<td>01462 426730</td>
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The service is delivered from 8am to 8pm seven days a week. Referrals to the service are taken from 10am to 6.30pm daily.
Maurilyn Wild, Advanced Social Work Practitioner talks about her experiences of working as part of an integrated rapid response team.

“The majority of patients referred to the rapid response service have long-term health and social care problems and encounter daily difficulties navigating through the health and social care system.

“Being in an integrated team has reduced the need for patients having to repeat their stories, through effective information sharing and involving the patients perspective in discussions about their care and planning.

“We have been able to prevent not only hospital admissions but reduce the need of respite and enabling people to die in their own homes; all delivered more cost effectively.

“One example of the how our rapid response team has worked together to demonstrate integrated care and service delivery can be seen in this case of a 76 year old gentleman who was referred to the service by his GP following a fall. “

Peter’s story

Peter, 76 year old gentleman, was referred by his GP following a fall which led to a deterioration in his mobility and muscle wastage as a result of diabetes and neuropathy. He was struggling at home and relying on a neighbour to help him with daily living activities.

The community matron and physiotherapist visited Peter within an hour of referral being received. An initial assessment was made and the physiotherapist advised him how to improve his movement and prevent injury. The correct walking stick was provided as his current one was short, compelling him to lean right. He was advised not to rush during walking, as he tended to lose his balance, he was also advised to practice his balance.

Peter talked about his reduced mobility and admitted that he was struggling with taking his insulin. He agreed to have carers to assist with personal care and prompting with medication.

The team discussed Peter’s case and it was agreed that a social worker would review short term care and support and the community mental health nurse would assess mood and memory problems. The social worker assessed his eligibility for care, and he decided that whilst his mobility was poor a few days of care would be enough. He wanted to regain his independence as quickly as possible.

The community mental health nurse assessed Peter’s memory problems. They discussed strategies to stimulate memory, keep the brain active and enable him make safe decisions.

One week after Peter’s referral his condition had improved as a result of the short term care and input from the occupational therapist and physiotherapist. He was back to his baseline of independence and able to be discharged. The community matron maintained good communication with his GP throughout the delivery of care. Peter remains on both the community mental health and occupational therapy caseload.

The collaborative working on this particular case not only demonstrates how we work together to prevent hospital admissions, but also how it helps to achieve better and quicker outcomes for patients. Without this service Peter may have waited up to four weeks to receive a care and support needs assessment and care package (dependent on capacity), a few days or weeks for an occupational therapy assessment and equipment and several weeks to months for a memory and mental health assessment. Without the quick responses from the professionals it may have led to a carer breakdown and/or deterioration of his physical and mental health.

Maurilyn Wild
Advanced Social Work Practitioner
A Team Manager’s perspective

“The knowledge, skills and training between the different disciplines is immense and the weekly MDT is an opportunity to share ideas, challenge thinking and agree actions for person-centered care.

“The added value of having professionals who are experienced for example in applying the Mental Capacity Act and Safeguarding Vulnerable Adults procedures in practice is very useful and has helped to develop greater discussions around risk.

“We have devised a monthly teaching session to share knowledge (and language) across the team.

“Sessions include dementia, medication, behaviours and support; Powers of Attorney and the Office of the Public Guardian; Mental Capacity Act in practice; anxiety management; palliative care and pressure ulcer prevention.

“Collaborative working has enabled the team develop relationships with the voluntary and charitable sector including Age UK and the Red Cross who we regard as members of our team.

“Probably the greatest challenge is the lack of home care which is an issue in our part of the county. To prevent admission to hospital we have taken a pragmatic approach and use HCA input until social care can be sourced.”

Roz Kearney is Team Manager of the Integrated Rapid Response team in Stort Valley and Villages.

“From a Team Manager’s perspective I find integrated working and collaborative care planning extremely rewarding.

Patient feedback

“I write in praise of your HomeFirst team and to say how very impressed we have been since our excellent GP contacted you in August. I would like to express our thanks to your excellent telephone team who contacted us and were prepared to visit my husband - even on a Sunday or Bank Holiday, the counsellors who came to visit us and helped to lift his spirits, all the nurses who have been absolutely wonderful and have (along with others in your team) made him feel officially supported.

“Parkinson’s Disease along with thyroid cancer can isolate any patient and put them at further risk; however I feel he has a fighting chance due to the extra help he has received to date. I would be grateful if you would be kind enough to pass on my thanks to all those involved now and in the future.”
Key Contacts

Julie Hoare, Director of Service Development and Partnerships
Hertfordshire Community NHS Trust
Julie is the Executive Lead for the workstream leading the rollout of Integrated Rapid Response and HomeFirst. Prior to her current role Julie held the position of Director of Operations for four years. She is a registered nurse and health visitor. Julie is particularly interested in service transformation and staff development.

Arnold Sami, Head of Service, Health and Community Services
Hertfordshire County Council
Arnold is a registered social worker with many years' experience as a practitioner, manager and senior manager working across community and hospital services. "Working together towards a better service for people in need."

Linda Patrick, Deputy General Manager
Hertfordshire Community NHS Trust
Linda is a registered nurse and community nurse, with extensive experience of working in both primary and secondary care settings in clinical and managerial roles, including working in an integrated health and social care organisation. “We will always work better when we work together.”

Keith Mupita, Service Line Lead, Community Specialist Mental Health Services
Hertfordshire Partnership University Foundation Trust
Keith is a mental health professional with many years' experience as a clinician and senior manager working across specialist mental health services in Hertfordshire. He always focuses on quality and is committed to “great care and achieving great outcomes for our service users.”

Liz West
Programme Manager, HomeFirst
Email: Liz.West@hpft.nhs.uk
Starting off her working life as a residential social worker, Liz has worked in learning and development and project management. She led on integrating mental health into HomeFirst and the roll out of Rapid Response in Stort Valley and Villages.

Sabina Tai
Programme Manager, HomeFirst
Email: Sabina.Tai@hct.nhs.uk
Sabina is an occupational therapist with extensive experience as a clinician and a senior manager working across community and hospital services. Sabina is leading on the roll out of Rapid Response and HomeFirst in Stevenage and Welwyn and Hatfield.