"I can’t praise them enough to be honest"

"I felt I was looked after at home much better than I would have been in hospital where I feel they wouldn’t have had time for me"

"Most importantly, we patients prefer and hope to be at home not in hospital, so I think this service is the way of the future."

HomeFirst
HomeFirst

- HomeFirst is a rapid response service which helps people stay well and independent and which now operates in our Lower Lea Valley and North Hertfordshire areas.
- The service supports older people and others with long term or complex conditions to remain at home rather than going into hospital or residential care.
- Many people prefer to be supported in their own homes, close to friends or family carers, where it is easier to get back into familiar routines and an independent lifestyle once their medical crisis has eased.
HomeFirst brings together health and social care services to deliver:

- Improved access to rapid support with care from the right professional
- Better communication between people using services and health and social care professionals working as part of the same team
- Reduced accident and emergency attendance and unplanned hospital admission or residential care
- Rapid discharge from acute hospital
- The scheme has been planned and paid for by Hertfordshire County Council and East and North Hertfordshire Clinical Commissioning Group. HomeFirst teams are made up of a partnership of health professionals from Hertfordshire Community NHS Trust and county council social care workers
HomeFirst

The service in north Hertfordshire started at the end of July 2014 and builds on a successful pilot scheme which was run in the Lower Lea Valley area since November 2012 with excellent feedback from staff, GPs and people using the service. HomeFirst’s operation has also coincided with significant savings locally on emergency hospital services against the forecast spending levels

– Patient case study:

An 80 year-old patient was admitted to HomeFirst team following his wife’s call to their GP. The patient had had a fall and had become progressively more immobile and bedbound. The patient’s wife also had some mobility issues and was housebound

HomeFirst were at the patient’s house within 14 minutes of taking the referral call from the GP. From the first day the patient received occupational therapy, physiotherapy and homecare services, which enabled him to stay at home and not be taken into hospital. The patient was back to normal and discharged from HomeFirst after 10 days
A GP point of view:

Dr Pauline Taylor, a GP at Cuffley and Goffs Oak Medical Practice has a patient with a long term condition, who lives on her own with a few friends that come by and act as her carers. The patient developed a urinary tract infection and because of her underlying problems, her mobility became affected.

“HomeFirst means we can get support in to our patients very quickly rather than admitting them to hospital. The HomeFirst team are usually at the patient’s home within an hour. The HomeFirst nurses have helped to treat and clear up the infection and the physiotherapists have done some wonderful work to get the muscle strength back in the patient’s legs. She’s getting more social care support too, which takes some of the weight off her friends who were acting as carers – it means they feel supported and cared for too.”
New in 2016

Rapid Response teams have now been established in the following localities in E&N Herts:
- Welwyn & Hatfield, Stevenage, Bishops Stortford & Stort Valley, Upper Lea Valley

- The Rapid Response service provides a rapid response to support the delivery of acute care closer to home. It provides integrated health and social care within a patient’s home for up to seven days - to enable people to remain at home rather than be admitted to hospital. The team provides nursing, therapy, social care / homecare and mental health support for people with the following six identified key priority conditions:

<table>
<thead>
<tr>
<th>Priority conditions</th>
<th>What the team can offer...</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTI's and blocked urinary catheters</td>
<td>Nurses who can support male and female catheterisation, blocked and by-passing catheters. Urethral, supra-pubic and intermittent.</td>
</tr>
<tr>
<td>Intravenous antibiotics</td>
<td>Skilled nurses who can site peripheral cannulas and administer doses of up to TDS IV Therapy. Peripheral, via a PICC line, Hickman line or Portocath.</td>
</tr>
<tr>
<td>Falls</td>
<td>Therapists who can assess and provide equipment</td>
</tr>
<tr>
<td>Dehydration</td>
<td>We will work with homecare agencies to monitor fluid intake</td>
</tr>
<tr>
<td>Respiratory Conditions</td>
<td>We can manage exacerbations of COPD and will liaise with the wider pulmonary rehab service and respiratory specialists</td>
</tr>
<tr>
<td>Dementia</td>
<td>Where condition, associated behaviours and/or co-morbid presentation within home or care home setting requires additional intervention to prevent admission to an escalated level of care or where carer breakdown is anticipated.</td>
</tr>
</tbody>
</table>
Rapid Response

Referrals to the service will be taken from GPs, Practice Nurses, Community Nurses and HUC only between 10am – 6.30pm 7 days a week via the Clinician of the Day (COD) can be contacted on: Tel: 07342 078835

Rapid Response service referral criteria:

- Adults 18 years and over and registered with a GP (including patients referred from A&E in neighbouring boroughs)
- The patient must have been assessed by a GP/ A&E/ HUC / AIHVS within the last 24 hours; this could be a telephone assessment
- Or referred by a community matron/district nurse with the agreement of the patient’s GP
- The patient is not requiring 24 hour medical support, and is deemed as being safe to stay in their normal place of residence overnight.
- The patient is experiencing an acute event /deterioration/breakdown of care with an increased risk of a hospital admission.
Exclusion Criteria:

- Undiagnosed collapse
- Patients who are medically unstable and require on-going medical supervision of their care
- Patients needing specialist mental health care who are in crisis and require an acute intervention
- Serious physical injury sustained through trauma
- Patients requiring a pulmonary rehab programme
- Patients who can access (with transport) other community services
### Integrated care models in Hertfordshire

<table>
<thead>
<tr>
<th>Model</th>
<th>HomeFirst</th>
<th>HomeFirst</th>
<th>Rapid Response &amp; Timely Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Launch Date</strong></td>
<td>January 13</td>
<td>November 12</td>
<td>January 14</td>
</tr>
<tr>
<td><strong>Hours</strong></td>
<td>08:00-22:00</td>
<td>08:00-18:30</td>
<td>08:00 – 20:00</td>
</tr>
<tr>
<td><strong>Services offered</strong></td>
<td>Rapid response Virtual Ward</td>
<td>Rapid Response Virtual Ward</td>
<td>Rapid Response Timely Discharge</td>
</tr>
<tr>
<td><strong>Risk Stratification</strong></td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Medical Cover</strong></td>
<td>HomeFirst GP + Registered GP</td>
<td>IHVS* + Registered GP</td>
<td>Registered GP</td>
</tr>
<tr>
<td><strong>Homecare</strong></td>
<td>Dedicated</td>
<td>Dedicated</td>
<td>Mainstream</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>NO</td>
<td>YES (new addition)</td>
<td>Limited</td>
</tr>
</tbody>
</table>

* In Hours Visiting Service – available not dedicated to HomeFirst
### Rapid Response: Activity

<table>
<thead>
<tr>
<th>Jan to Oct-13</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage seen within 60 minutes (TARGET 80%)</td>
<td>89</td>
<td>82</td>
<td>84</td>
<td>72</td>
<td>86</td>
<td>100</td>
<td>81</td>
<td>85</td>
<td>88</td>
<td>100</td>
<td>96</td>
<td>100</td>
<td>90</td>
</tr>
</tbody>
</table>
## Rapid Response Activity

<table>
<thead>
<tr>
<th>Rapid Response</th>
<th>Jan to Oct-13</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupied Bed Days</td>
<td>6373</td>
<td>729</td>
<td>923</td>
<td>797</td>
<td>579</td>
<td>704</td>
<td>740</td>
<td>711</td>
<td>644</td>
<td>533</td>
<td>777</td>
<td>719</td>
<td>899</td>
<td>15128</td>
</tr>
<tr>
<td>Admissions</td>
<td>420</td>
<td>39</td>
<td>51</td>
<td>56</td>
<td>43</td>
<td>36</td>
<td>50</td>
<td>44</td>
<td>48</td>
<td>52</td>
<td>61</td>
<td>56</td>
<td>59</td>
<td>1015</td>
</tr>
<tr>
<td>Discharges</td>
<td>401</td>
<td>28</td>
<td>57</td>
<td>53</td>
<td>48</td>
<td>37</td>
<td>45</td>
<td>52</td>
<td>49</td>
<td>49</td>
<td>60</td>
<td>50</td>
<td>71</td>
<td>1000</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>15.0</td>
<td>18.8</td>
<td>19.3</td>
<td>15.0</td>
<td>14.1</td>
<td>17.5</td>
<td>14.6</td>
<td>18.0</td>
<td>11.7</td>
<td>11.4</td>
<td>12.5</td>
<td>11.9</td>
<td>16.8</td>
<td>15.0</td>
</tr>
</tbody>
</table>

## VW

<table>
<thead>
<tr>
<th>VW</th>
<th>Jan to Oct-13</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupied Bed Days</td>
<td>22361</td>
<td>5419</td>
<td>5882</td>
<td>5795</td>
<td>5235</td>
<td>5168</td>
<td>4723</td>
<td>4998</td>
<td>4399</td>
<td>3190</td>
<td>2261</td>
<td>1770</td>
<td>1792</td>
<td>72993</td>
</tr>
<tr>
<td>Admissions</td>
<td>351</td>
<td>32</td>
<td>35</td>
<td>36</td>
<td>27</td>
<td>19</td>
<td>49</td>
<td>29</td>
<td>26</td>
<td>22</td>
<td>22</td>
<td>21</td>
<td>16</td>
<td>685</td>
</tr>
<tr>
<td>Discharges</td>
<td>161</td>
<td>33</td>
<td>32</td>
<td>46</td>
<td>30</td>
<td>36</td>
<td>41</td>
<td>45</td>
<td>54</td>
<td>64</td>
<td>44</td>
<td>22</td>
<td>17</td>
<td>625</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>58</td>
<td>76</td>
<td>93</td>
<td>98</td>
<td>113</td>
<td>129</td>
<td>95</td>
<td>117</td>
<td>125</td>
<td>150</td>
<td>141</td>
<td>95</td>
<td>125</td>
<td>101</td>
</tr>
</tbody>
</table>
Secondary Care Admissions: LLV
Social Care: Impact

LLV data- CareTrak allows for more detailed analysis and is not available for Hertsmere.
## Evaluation Criteria

### Experience
- How likely is it that you would recommend this service to friends and family? (net promoter)
- Numbers of complaints
- Complaints managed at service level
- Carer’s net promoter
- GP Questionnaire:
  - Net promoter
  - How easy do you feel it is to refer patients into Home First?
  - Do you feel that Home First responds in a timely manner?
  - Do you feel that due to HomeFirst, you are now doing more multi-professional joint working?
  - Could you say that HomeFirst has affected your workload?
- Staff Survey

### Outcome
- Patients in ‘crisis’ will commence an assessment within 60 minutes of receipt of referral being received into HomeFirst

### Safety
- NHS Patient Safety Thermometer
- Number of patient related health & social incidents in month and top three categories
- Number of serious patient incidents in month against NHS Hertfordshire SI Policy
- Number of patient related incidents that resulted in severe harm or death
- Number of medicines incidents reported.
- Number of HES incidents which impacted upon patient outcome.

### Cost – Health
- Number of A&E attendances that arrived by ambulance
- Number of A&E attendances
- Number of non-elective admissions for ambulatory care sensitive conditions
- Cost of non-elective admissions for ambulatory care sensitive conditions
- Out of hours telephone contacts

### Cost – Social Care
- Total social care spend
- Total social care spend as a result of service user receiving input from Home First team
- Residential care placements
- Overall referral rate to HomeFirst via IPA
- Clients receiving enablement care
Impact: Patients and referrers

- 86%+ of all patients referred to the service are safely managed in the community
- 96% of patients would highly recommend service to friends and family
- ‘It’s been an excellent scheme, really valuable. It is wonderful to be out in the community on a home visit and not wonder about admission/ how a patient will cope/ who can observe them in the community (apart from us). And HomeFirst has been the answer’ – GP
- ‘This is truly the future of health and social services. I was truly impressed by how they all knew what needed to be done and then did it professionally – HomeFirst Patient’
Key Learning

– Health and social care makes a difference - staff experience and pride in what they can offer
– GP engagement and system leadership are key components
– Bigger impact on secondary care admissions where there is both risk stratification/ virtual ward and rapid response
– Regular communication (con calls or face to face makes a difference) - co – location
– Specialist dementia care capacity in Rapid Response is the gap about to be filled
The Future

- Co-ordination of care across different providers within a locality - integrating care for the client
- Extended primary health care team around primary care - includes existing core services (planned and unplanned)
- Rapid response to prevent admissions to hospital
- Targeted virtual ward case management approach to better manage Long Term Conditions, prevention and earlier intervention
- Hybrid role development / shared skills
- New roles e.g. Emergency Care Practitioner
- Links to community navigators and voluntary sector