Scrutiny Committee
Home First
27th November 2018

History of service:

The Home First service commenced in November 2017 which was an alignment of two services – Rapid Response which was a delivered by an internal Herefordshire Council team and an external commissioned reablement provision. The services were aligned to enable more capacity and to provide a streamlined service.

The primary objective of the Home First service is to deliver a strength based model, which is built upon an enabling ethos, to support people to regain skills and enable independence. The aim is to assist people on their journey to independence, allowing them to remain independent and to prevent the need for long term care.

Currently funded through BCF and iBCF and is integrated service with WVT.

Service objectives:

The overall aims of the Home First service are to achieve:

- greater independence and improved levels of confidence for people, enabling people to remain in their home environment;
- reduction in number of people requiring on-going formal care services;
- a reduction in the number of people being admitted to hospital;
- a reduction in permanent admissions to residential and nursing care;
- a reduction in delayed transfers of care; and
- a reduction in non-elective admissions

Service aims and principles

Up to a 6 week support with clear goals to be achieved

Makes full use of available resource to provide equitable services that are appropriate and proportionate to meet individual need

Provide a responsive service which can be rapidly mobilised when needed

Integrated service with the inclusion of therapeutic input

Meets whole system outcomes

One point of entry to the service managed as part of wider system pathway control

Build on trusted assessor/referrer model

Aligns to mobile working strategy

Promote choice and improve wellbeing

Effective service planning to ensure minimal carbon footprint

Cost effective service provision with robust performance management

Strength based assessment and enabling ethos to be incorporated throughout service

Present position:

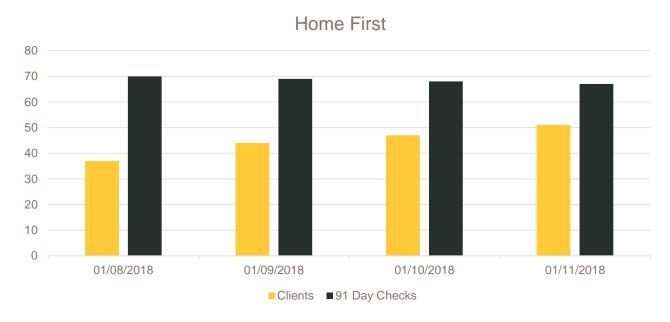
1st October 2018

- Implementation of the new Structure
- Rota changes to increase round capacity 07.00 15.00 and 14.00 22.00
- Recruitment 27 in post with offers issued
- Round Capacity 9 rounds in the morning 5 in the evening
- Staffing Numbers Recruit to 52
- Hours being delivered 55 hours per day
- Clients receiving a service between 46 and 56
- DTOC trending downwards
- Flow Front Door and Back Door managed to move clients through our service
- Registered Good rating with CQC

Problems and Solutions

Concerns Identified	Solutions
Leadership and Management	Management of change process completed with deputy managers in place and permanent RM in place with experience of service improvement
Workforce and Recruitment	Currently 27 in post with 52 needed - new recruitment campaign commenced with 16 potential applicant received
Maximising resources	New IT system in place to manage rota's. New rota's now in place following the management of change process which has increased capacity and support demand with 7 day working.
Data Collection	New IT system in place to capture the data information, still being developed and will improve.

Performance Averages



- Management of Winter Pressures ?
- Clear communication to service users?
- Performance of the service ?
- Able to manage handbacks, difficult to place cases?
- Looking at viable charging options to create sustainability for the service ?

The Future:

- Continue to increase capacity
- Increased staffing by recruiting drivers and non drivers
- Care experience and non care experience
- Work on Induction and Training Package
- Implement Care Certificate for non care trained staff
- Work on providing a bike round within the city
- Work with stakeholders and colleagues in a more integrated way
- Single point of Access
- Improved integrated ways of working

Herefordshire's Discharge to Assess pathway

MDT ward decision to refer for next step/hospital discharge



Integrated Hospital Discharge Team

A multi-disciplinary discharge team to embed a coordinated discharge planning system. This function will aim to ensure that fully integrated discharge to assess arrangements are in place for all cases.

Direct referral and admissions to Pathway 2 and 3



Pathway 1

Community non-bed based support

Decision making huddle with integrated community services to determine support at home.

> Homefirst, Hospital@Home, Community matrons, Therapists



Pathway 2

Community Hospitals

Patients who require short term 24/7 bed based rehabilitation support.



Pathway 3

Ledbury Shaw 14 beds

Patients who could potentially return home after a period of additional rehabilitation or patients who are likely to need ongoing care in residential or nursing setting.







Independence / reduced package of care to remain independent / long term care in place

Integrated Working

- Integrated Discharge Lead for both health and social care
- Alignment of Hospital Liaison Team (LA) and Complex Discharge Team (CDT)
- Further alignment of Home First and Hospital @ Home
- Delivery of Discharge to Assess (D2A)

Questions???