HOME FIRST – Programme update - October 2022

Home First is our approach for delivering the right health and social care in the right place and at the right time. A three- year transformation programme across local systems that allows residents to receive the highest quality care in the most independent environment and wherever possible, this should be the person's home. ICB ; RBG ; LGT ; Oxleas and others are the delivery partners.

Research has shown that for most people home is the best place to be cared for, so we have invested in a wide range of health and care services in the community to enable most people to be cared for at home or in a community bed to prevent people having to go into hospital. The advantage is it increases the opportunities for residents to receive targeted support to help them recover form periods of ill-health and maintain independence whilst reducing unnecessary admissions or lengthy stays in hospital.

Our vision is that our Home First services will enable system partners to provide flexible, holistic and rapid interventions which provide a real alternative to hospital care

Home first has 3 aims:

- Identify people at risk of a hospital admission and provide care that prevents their condition from worsening;
- Allow people to be given a high level of care in their own homes instead of being admitted unnecessarily to hospital and;
- Allow for advanced discharge from hospital so that patients can recuperate in the comfort of their home while receiving high quality care.

Home First services bring together a range of support in the patient's own home to prevent unnecessary admission, or help patients return home sooner. This is different to traditional home based community services provided by district nurses and carers because it is designed to offer more intensive medical support for a shorter period of time (usually two to seven days). Home first encompasses a range of services which include:

- urgent clinical assessment at home for very unwell patients
- close patient monitoring, with short-term intervention in a serious episode of ill health
- initial treatment and on-going monitoring of a patient
- care 365 days of the year, with access to overnight help
- daily visits to patients, up to four times a day when necessary
- home visits by a consultant or GP when required
- intensive physiotherapy and/or occupational therapy support, to help patients be as mobile as possible
- Support to families/carers to strengthen resilience

The clinical benefits include:

- effective and efficient integrated partnerships,
- a reduction in emergency department attendances,
- a reduction in length of hospital stays and associated costs,
- reduced conveyance times allowing the ambulance service to go to the next emergency call and
- a reduction in inappropriate hospital admissions, reduced risk of hospital acquired infections and reduced delirium and confusion.

From the patient perspective, the benefits include:

- improved health outcomes,
- a preference for being treated at home rather than in hospital,
- reduced pain and anxiety and the psychological and social benefits of being treated in their own home.

Progress

Care Home Multi Disciplinary teams (MDT) are in place which focus on developing services that support early identification of those at risk of deterioration and promote self management. They mainly focus on frailty and falls with National Institute of Care Excellence (NICE) compliant Greenwich falls service and Frailty MDT service.

Joint Emergency Team: consistently achieving 2 hour response assessment target for over 90% of calls. Through close working with the Emergency Duty team therapists complete assessments at the point of attendance, through working alongside the multidisciplinary team they have limited unnecessary admissions:

- o Involved in upwards of 150 patients each month, 47% are not admitted. The main reason for attendance is falls.
- o Increasing referrals into alternative pathways eg JET team, Age UK, Community services, Packages of care.
- o Where admissions take place the therapy review has already been completed.

Enhanced reablement

Greenwich has put in place an outcomes-based model of homecare which has a focus on further reablement and promoting independence for residents who still need a package after the initial reablement period. The borough has increased capacity from 500 to 800 people per year through

more effective processes, enabling a broader complexity of person to be managed in their own home.

For residents who go through our reablement service with a view to maximise their independence we are delivering good outcomes, with a package of care being on average of 9.2 hours smaller per person per week than if they had not received this service. The number of referrals into this service so far this year is lower, with 49 residents on average being referred each week compared to 57 last year.

The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services has improved compared with the previous year. From 65% in 20/21 to 71% in 21/22

92% of patients in hospital were discharged to their usual place of residence in Q4 2021/22.

The Home first programme has been reviewed and priorities for the second year agreed including dementia and delirium, virtual wards and discharge to assess (D2A) offered. In addition a Home First Dashboard will be developed looking at effective ways of measuring success and outcomes to help us understand the impact on people.