HomeWard

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Looking after you locally
Overview

• Our story
• Developing our service
• How our service operates
• What have we achieved?
• What next?
• What have we learnt?
Norwich Health and Social Care system recognised the need to change and created “YourNorwich” to bring together Commissioners, GP, NHS Providers, Social Care Services and the Voluntary Sector to create and work towards a single vision.

A gap in intermediate care was identified – A service which offered intermediate care in the home to prevent unnecessary admission to acute care and to help people to return home sooner after periods of acute illness.

HomeWard was commissioned in October 2014 and started in December 2014 to increase community capacity and capabilities to fill the gap.
Developing our Service.

• We were given a very short period for implementation – 6 weeks;
• We had ideas on what the service needed to do but had to learn on the go;
• Collaboration and being inclusive was essential to developing the right service for our local requirements;
• There was a need to give things a go but also accept some things may not work;
• Constantly built on learning.

We created a dynamic service offering multiple resources to patients in Norwich irrespective of the bed they occupy.
How the service operates.

- 7 day service offering night sits;
- Admits from GP’s, Intermediate Care and Acute; priority given to “Step Up” referrals;
- Capacity based on “Visits”, not “Virtual beds”;
- The patient, Integrated Care Co-ordinators, HCA’s, Physiotherapists, Occupational Therapists, Registered Nurses, Social Worker and the patient’s own GP make up our MDT;
- Close links with Voluntary Sector (Red Cross, Befriending services and Age UK), Social Services, the Acute Hospital (especially the Urgent Care Centre, A&E based Community Early Intervention Team, Medical Assessment Unit and Ambulatory Emergency Care).
- EPR SystmOne used within the Team, by 100% of the Practices in Norwich and by Community Teams working in the NNUHFT (Urgent Care Centre & ED Early Intervention Team).
Referrals

Referrals to HomeWard
January 16 - January 17

- Accident And Emergency: 1.46%
- Acute Medical Unit: 0.27%
- Alder Ward: 0.33%
- Care at Home Team: 11.17%
- Care Home: 12.37%
- Caroline House: 2.13%
- Case Managers: 7.98%
- Community and Nursing Hub: 0.13%
- Community Hospital: 0.8%
- Community Liaison Team: 4.65%
- Community Provider Services - NCH&C: 0.53%
- Early Intervention Team: 9.44%
- GP: 0.13%
- HomeWard: 2.26%
- HomeWard IV Therapy: 0.13%
- NNUH: 16.62%
What have we achieved?

Activity: Since December 2014, 809 patients have been admitted to the HomeWard and seen an **85% increase** in monthly referrals over the last 12 months.

- **Since December 2014:**
  - 330 visits providing care to people who would otherwise been admitted to Acute Care (Validated by CCG);
  - 215 people have been discharged early from both Acute and Community Hospitals;
  - 583 people have regained independence following rehabilitation, many of whom would have previously required admission or readmission to hospital;
  - 36 people have received IV therapy in their own home who previously would have required to be treated in the Acute Hospital.

- **Since April 2016:**
  - 23 people have received co-ordinated and holistic end of life care to enable them to die within their preferred place of care and in accordance with their wishes (14 were listed for CHC fast track);
  - 19% reduction in number out of area community hospital admissions resulting in reduction in out of area OBD by 11%;
  - Overall community hospital admissions have reduced by 6%;
  - Total number of community hospital bed days have reduced by 9%;
  - NCCG reports it is 391 cases under plan for short stay unplanned admissions & 47 cases under plan for long stay admission. **Norwich CCG is the only CCG in our region demonstrating a reduction.**
HomeWard was nominated for an HSJ Award and has been selected as a finalist.
What's next?

- HomeWard +
- Working with the developing Multispecialty Community Provider (MCP) in Norwich – N.E.A.T (Norwich Escalation Avoidance Team)
- Work with partners to extend “Wrap Around” service and promote self care and increased independence.
What’s have we learnt?

• It’s all about people;
• Collaboration, not competition;
• Risk management, not risk avoidance;
• Accept things will go wrong and that learning adds value;
• Open and trusting relationship between Commissioner, NCH&C and other providers is key;
• It takes time to see benefits.
Case Studies

**Getting home earlier - IV Antibiotics**

Mr PG was admitted to HomeWard for a course of IV antibiotics following 1st stage hip revision/washout due to infection.

He received 6 weeks of intravenous antibiotics from us followed by 2 weeks of PICC line maintenance – flush to keep line patent.

Mr PG was safely discharged from service following his treatment awaiting date for 2nd stage surgery for new total hip replacement.

He was readmitted to IV service later that year following surgery and received 4 weeks prophylactic intravenous antibiotics after which he was discharged.

Prior to this service, Mr PG would have remained in the Acute Hospital for the length of his IV treatment (10-12 weeks).

“Its terrific as far as I am concerned – I can’t hope for anything better really ….I would be lost with them” PG

**Avoiding Admissions – Rehabilitation**

A 90 year old lady, Mrs BL was seen by her GP due to increasing joint pain in knee and reducing mobility over many months.

The GP referred to HomeWard for Admission Avoidance as she was stuck in her chair unable to transfer/mobilise or care for herself. She needed support from us to help her regain mobility.

She was seen by OT for initial assessment and goal setting. Due to her needs and presenting condition they discussed downstairs living and arranged for bed to be moved from upstairs. Pressure area equipment was supplied for her bed and chair. She was also provided with toileting equipment, transfers aids and mobility practice.

A Nurse visited and reviewed her medications and provided advice on ways to manage her medication. Referrals were made to Speech and Language Team and the Specialist Continence team. Mrs BL had wounds on legs which were dressed and Build Up drinks ordered to support her nutritional intake.

The Physiotherapy visit to assess transfers and mobility noted some Parkinson type symptoms. This was highlighted to the GP via an EPR S1 task.

A package to support Mrs BL was set up. HCA visits 4 x day to support with personal care, meal preparation, mobilisation, medication prompts and wound management

HomeWard continued with RN and HCA visits. HCAs carry out ongoing mobility and transfer practice.

Discharged from Homeward after 13 days to the Community Nursing team for simple wound management and to Norfolk First Support for re-ablement. This ongoing re-ablement ensured Mrs BL was able to remain independent and at home.

Before this service, Mrs BL would have most likely been admitted to the Acute Hospital to access the care and support she needed.

“fabulous service, I really did not want to go to hospital and they helped me to stay in my own home” BL
Thank you for listening

Any Questions?