healthwatch North Lincolnshire

WELCOME HOME PILOT EVALUATION

DATE: March 2022

Contents

1 Introduction

1.1 What is Healthwatch North Lincolnshire?

We are the independent champion for people who use health and social care services. We exist to make sure that people are at the heart of care. We listen to what people like about services and what could be improved. We share their views with those with the power to make change happen. We also help people find the information they need about services in their area.

We have the power to make sure that people's voices are heard by the government and those running services. As well as seeking the public's views ourselves, we also encourage services to involve people in decisions that affect them. Our sole purpose is to help make care better for people.

In summary Healthwatch is here to:

- Help people find out about local care
- Listen to what people think of services
- Help improve the quality of services by letting those running services and the government know what people want from care
- Encourage people running services to involve people in changes to care

1.2 Why this Subject?

During the Coronavirus pandemic the voluntary sector began working to provide low level intervention and support to local people, in an attempt to alleviate pressure on statutory services. One part of this support was the introduction of the Welcome Home Service, which aimed to help people resettle at home after a stay in hospital and help them to re-establish connections in their local community, if necessary. It was hoped that in doing this, people would be less likely to return to hospital soon after returning home and would develop local connections to aid with any isolation or loneliness which they may be feeling. In turn these things would enrich the lives of local people and promote wellbeing. Healthwatch North Lincolnshire is part of the Voluntary and Community Sector Alliance in North Lincolnshire and through this was asked to complete an independent evaluation of the service to establish its impact on the lives of those who received it and the potential impact on other services. It would also be an opportunity to provide any learning which could be used to develop the service in the future.

2 Background

2.1 Methodology

Due to uncertainty around the numbers expected through the service and the short initial timeframe, it was agreed that all clients would be asked whether they were happy to be contacted by Healthwatch North Lincolnshire to participate in the evaluation process.

Welcome Home responders passed on a leaflet introducing the evaluation process at their initial visit to clients after their discharge from Hospital. The responder then asked for consent from the client to pass on their contact details to Healthwatch North Lincolnshire. We then arranged for a volunteer to contact them for an initial informal telephone conversation where the volunteer would introduce themselves and conduct the initial structured interview, or arrange another suitable time to call to do this. A follow up telephone call was then arranged for around 3 weeks later, to enable us to gather information about how the service has impacted their lives over the weeks since discharge. The follow up calls also looked for any difference between this experience and previous experiences, as well as any benefits or gaps with the current provision.

Using a semi-structured interview, including topic prompts, to gather information through conversation with patients, gives the most useful and informative view of the patient journey through the discharge process. This type of rich qualitative data is most useful to create case studies of patient experience, which is a good way to establish how the service is being received by clients.

The target cohort for this work would be those who have recently been discharged from an inpatient hospital stay, demographic information could have been collected to look for deeper trends and themes. However, due to uncertainty of the number of clients expected and the short time frame, it was decided to focus on the overall patient journey without separating into smaller demographic trends and themes, as with such a small sample this would not have given any true representation.

Consideration was also made that these individuals had recently been in a state of ill health, which may have continued after their discharge, as such they may be vulnerable due to recovery. We reflected that this could mean initial contacts may need to be brief with a plan to follow up at a time when they are feeling more at ease.

The overall time frame set out for the evaluation was initially 6 weeks, however due to low initial uptake this was extended by a further 4 weeks, covering the end of August through to the start of October.

2.2 Local Services/Pathway

Locally, the discharge process should begin during, or where relevant prior to, admission to hospital and be well communicated with the patient and any relevant family, carers or others involved in the individuals care. Hospital staff should be regularly communicating this process with the patient and documenting as they go. This should ensure patients are routinely and suitably involved in the process and decisions made. The discharge process aims to achieve the following objectives:

- Unnecessary hospital admissions are avoided
- Medical and Surgical Ambulatory care should be utilised for all appropriate patients to avoid unnecessary use of inpatient capacity and avoid crowding in the Emergency Department
- Hospital at Home should be utilised as an alternative to admission and also to support early discharge from inpatient capacity
- Planning for hospital discharge is part of an ongoing process and should start prior to admission for planned admissions and at the earliest opportunity for other admissions
- The principles of SAFER and Red2Green should be applied throughout the patient journey – further information on SAFER and Red2Green are available in the Patient Flow, Escalation and Surge Policy
- The engagement and active participation of individuals and their family/carers is central to the delivery of care and in the planning of a successful discharge
- Staff should work within a framework of integrated multi-disciplinary and multi-agency team working to manage all aspects of the discharge process
- The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services and their rights, and receive advice and information to enable them to make informed decisions about their future care. This should include information about their right to appeal against decisions reached
- Effective and timely discharge requires the availability of alternative, and appropriate, care options including intermediate care services or individualised home care support to ensure that any rehabilitation, recuperation, reablement and continuing health and social care needs are identified and met
- Patients who have been assessed as multi-disciplinary fit/stable to transfer from acute care should not remain in an acute bed to wait for either assessment or service availability as set out in the Care Act and Multi-Agency Policy to Support Patient Choice, avoiding Long Hospital Stays

(Northern Lincolnshire and Goole NHS Foundation Trust[1])

As part of the discharge process, in line with discharge to assess model[2] patients are assigned to a particular pathway which indicates the level of support a person is likely to require upon discharge. The four pathways are:

Pathway 0
Likely to be minimum of 50% of people discharged:

- simple discharge home
- no new or additional support is required to get the person home or such support constitutes only:
    - informal input from support agencies
    - a continuation of an existing health or social care support package that remained active while the person was in hospital

Pathway 1
Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.

Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.

Pathway 2
Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home

Pathway 3
For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0).

[1] Northern Lincolnshire and Goole NHS Foundation Trust
[2] Department of Health and Social Care

3 Findings

3.1 Case Studies

Client A

Client A was discharged from Ward 16 following a six day stay in hospital. Of their time in hospital they said that the ward seemed to be short staffed and that they saw a lot of different consultants. They described the nurses as very caring and felt they were treated well. However, on the last day in hospital they were not sure what was going on. They returned home and were visited by the Welcome Home team the next day. The client commented about how the Welcome Home responder helped them settle back in at home by thinking about the little things such as checking the smoke alarm was working. The client was a smoker and the responder noticed there were visible burn marks on the carpet. Upon checking the smoke alarm they found that this was not working and needed a new battery, this was changed and the smoke alarm was then left in working order. The responder also helped the client to check and bag up a large amount of unused medication which was no longer required and helped to arrange for this to be collected by the pharmacy when they delivered their next prescription. The responder checked that the client had arrangements for support and the client advised they pay someone to do their shopping for them as they struggle with their mobility. The client was very impressed with the level of service provided by the Welcome Home responders and stated it had been ‘very useful and better than similar services received in the past’.

During our second contact with the client, we discussed how life had been before going into hospital and how life had been different since they came out. The client described how life had been a struggle for a while and they had been adjusting to limited mobility and reduced socialisation after leaving work. Whilst they have found their mobility is improving a little since leaving hospital, they have been feeling very isolated and lonely. The Welcome Home responders have addressed this by helping the client to access a new group on a Monday, when we spoke with the client they were due to attend the first session the following week, but were grateful the responders had helped arrange this. When asked about how their most recent experience of leaving hospital differed from previous the client stated that it had been about the same but praised the help they had from the Welcome Home responder. General comments made about their experience in hospital included seeing a range of different consultants due to multiple health concerns and also that due to pandemic restrictions they had needed to remain beside their bed and now walk around anywhere which they found frustrating.

Client B

Client B was discharged from Ward 16 after a six day stay in hospital. When asked about their last day in hospital, they stated that they did not see any other services during the discharge process and that no one spoke to them about going home until they were discharged. They were transported home via ambulance after a two hour wait. Upon returning home the client had a friend who helped them to settle in and they described returning home as 'peaceful'. The Welcome Home responder visited the client two days after their discharge and said they had been very good and helped to sort a few jobs. The client did not go into detail about what the jobs the responder assisted with but on the notes provided by the Welcome Home team they have indicated they assisted with checking the smoke alarm and requesting for handrails and a possible ramp be fitted for easier access to the property for the client. We were unable to contact the client by phone after they agreed to be contacted a few weeks later, therefore the follow up session was not completed.

Client C

Client C was discharged home on pathway 0 after an overnight stay in hospital. The discharge process was lengthy and the client was upset by arrangements which meant their family was left waiting outside for two and a half hours but other services, like the Welcome Home service, were allowed to come onto the ward. The client was also unhappy about the lack of COVID testing before leaving hospital and they were concerned they would pass something on to their family. The client's family are very supportive and collected them from hospital to help them return home. Once back at home the client described everything as ok, and that they did not see the Welcome Home team as useful to them, as they have a supportive family, however they could see the benefit to people who were on their own without family support.

During the follow-up contact the client again expressed their dissatisfaction around family being unable to visit on the ward but other people, such as the responders, being able to. The client was informed that this feedback had been passed on to the Welcome Home service and the patient experience team at the hospital trust. The client stated that they had been fine before attending hospital and had been generally well cared for whilst there. Since leaving hospital they described that things were going better but they were concerned about going out, due to the coronavirus pandemic and many people now choosing not to wear masks. When asked how their most recent experience of leaving hospital compared to any previous experiences, the client stated the most recent time was more professional.

Client D

Client D was discharged from hospital on pathway 0 after twenty-six days in hospital, they were then visited by the Welcome Home team just over a day later. The client stated they had found the stay in hospital tedious but that staff had been supportive and helpful. To return home patient transport was arranged for the client as they have difficulty walking, there was some waiting around for transport but other than this the client said the arrangements were fine. Once home the client stated they had found it difficult to adjust. They have mobility issues and feel they may need practical help with shopping in the future and would like to consider getting a walking aid or mobility scooter in the future. The client had seen the Welcome Home team twice and found them useful, however they also described how they have found returning home from hospital difficult as they find it difficult to ask for help. The client has family who live away and a daughter but they describe that she has a lot to deal with in her own life.

During the follow up call the client described how their mobility had been better before going into hospital. Whilst in hospital everything was ok but they were ready to leave by the end of their stay. The client also expressed they were having more difficulty getting about and that they are unable to walk very far without having to stop and sit down. The client has been referred for help with their mobility by the Welcome Home service and they are happy with the support they have received so far. When asked about their most recent experience of returning home after hospital compared to previous experiences they stated that is was better in some ways, mainly due to receiving support from the responder. They said they have been treated very well.

Client E

Client E was discharged from hospital after a single day in hospital. They state, they felt well supported whilst in hospital and the transport home, which was arranged by the hospital, went very smoothly. The client stated they have adjusted to living back at home but can become lonely and would like someone to speak with. Whilst back at home the client has been visited by the Welcome Home service and described the responders as 'friendly and supportive'.

The client said everything had been ok before going into hospital and during their stay there. They reported that the nursing staff had been sorry to see them return home, as their sense of humour had helped to keep morale up. The client admitted to finding asking for help difficult and stated that all had been ok since leaving hospital.

Client F

Client was visited by Welcome Home after a brief stay in hospital. Client stated they had been well since leaving hospital but often feels anxious and this can be a reason they call for an ambulance. They report having a good network of friends and support locally but would appreciate someone visiting regularly, on a weekly basis to ensure they are doing ok. The client has some support from services for mobility currently, such as physiotherapy for their arthritis and has walking aids already in place.

Before their last admission to hospital the client reported having episodes of sleeplessness and anxiety. Since they have been home from hospital they have been prescribed some medication by their GP and are seeing some beneficial effects of this already. Client said they had been happy with the visits and calls from the Welcome Home service and would like to have regular visits from a service to check they were doing ok.

Client G

Client G was discharge from hospital after just over two days and seen by the Welcome Home team shortly after they returned home. Client had spoken with hospital staff about finding things difficult at home and the hospital therefore introduced them to the Welcome Home team. The client has family who work in care and is in touch with adult social care about arranging support. Upon discharge the client was given a leaflet about Welcome Home and informed that someone would visit, they had hospital transport arranged for their journey home, which they felt went ok. When the client got home, family was available to help them settle back in and ensure everything was ok. Whilst the client has a supportive family who helped them to settle back in at home, they found the Welcome Home service very useful in directing them towards other services which are available. The client enjoyed the visits and calls from the Welcome Home team.

During the follow-up call the client stated they had not been living in the area for long and therefore did not have many friends locally, however they have some family who live in the area. Client has been referred to the Lindsey Lodge Wellbeing service and is looking forward to socialising with other people in a similar situation. Whilst in hospital the client expressed they had found it difficult waiting in A & E for a prolonged time (nine hours) before they were admitted to a ward. Staff had appeared busy but the client had been very happy with the treatment they recieved and had found everyone to be very helpful and polite. After leaving hospital the client had received two visits and some telephone calls from the Welcome Home service and found them to be a great help, they even helped them to find a gardener. The client stated they lost the Welcome Home paperwork and were therefore unsure whether they would contact them again. Client had commented that they were looking forward to attending the Lindsey Lodge Hospice but was unsure about transport as they were no longer using volunteer drivers due to the pandemic. The Healthwatch volunteer who completed the follow up call provided the client with the telephone contact details for two local services for the client to contact if they wished.

Client H

Client H was discharged home after a three week stay in hospital, they live alone and have very little support locally. The client was transported home by a friend or relative and said the process was ok. The client reported that they desperately wanted some support to feel less alone.

During the follow up call the client reported that everything went well in hospital. They had seen the Welcome Home responder on their return from hospital and found them very useful. They felt that they were beginning to get life sorted out again and had no current concerns. When asked about how their most recent experience of leaving hospital compare to previous experiences the stated it seemed better and they had been able to get some good support from the hospital and the responders.

3.2 Evaluation

Impact on the individual

Loneliness - One of the most common impacts seen, in relation to individuals, was that many of those who saw the service as a benefit were living alone or described feeling lonely. People valued the service on helping them feel heard, that someone would listen to them and could arrange or provide support if needed. This theme suggests that the service is beneficial for helping those who have smaller support networks.

Communication - Many of the service users we spoke to describe a lack of communication about either their discharge or the involvement of the Welcome Home service. People value being kept informed about their care and pathway.

Support - where some people described finding it difficult to ask for help and support, it appeared that with regular contact from the Welcome Home service some clients were able to speak about their unmet care needs and have either some information shared about options or things put in place to support them. This strengthens to need for effective communication and relationship building between services and their users.

Impact on other services

It was quite difficult to ascertain the impact the Welcome Home service could have on other services, as it is difficult to show that the involvement of one service has meant another service has not been required. However, even in the follow up calls, clients did not report many additional services becoming involved which could indicate a positive impact by the involvement of the Welcome Home service. The following was considered from the information we collected.

Transport - As many of the clients we spoke to were living alone or with limited support, many relied on hospital transport to return home. Most comments about transport were positive and people were pleased with the service, however some experienced lengthy waits to return home because of needing hospital transport. This service seems invaluable to those who need it, but may benefit from better planning or communication so that; patients are kept informed of plans for their return home and, to avoid long periods of waiting. This will also ensure that any support being implemented once a patient has returned home, such as being met at home, can be suitably organised.

Wider services - From the comments and information we collected it was clear that the Welcome Home service was not solely focused on the immediate health and care needs of the individuals but also the wider picture. Responders checked smoke alarms which resulted in a number being found to need attention, such as new batteries. Whilst this does not have a direct impact on other services, it does reduce the risk of serious injury or death from fire related incidents which in turn reduces the impact on additional services. Responders also checked clients surrounding for hazards such as steps, hand rails and trip hazards, again whilst this does not have a direct impact, it likely reduced risk of further incident which again alleviates pressures on services.

Quality of Welcome Home

Assistance - Most comments collected expressed positive sentiment towards the Welcome Home responders, they were praised for thinking of the things that often slipped a person's mind and not just checking things but helping to arrange get them sorted.

Support - Clients valued the regular contact with the service, it increased feelings of support for those with limited support networks. Clients were supported to access additional support when required and given information and options to make informed choices.

Safety - Some clients also described how the actions of the Welcome Home team gave them a better sense of safety. This sense of safety not only directly impacts the individuals but strengthens the value of the Welcome Home service for those who are feeling they have few people to turn to.

4 Conclusion

Looking at all the information gathered, it is clear that individuals have seen value in the service provided by the Welcome Home service. It has given support and security for vulnerable people at a time when they have needed it most. Readjusting to life at home after a stay in hospital can be difficult and people can struggle to find the right support, the Welcome Home service has gone some way in bridging this gap and has signposted people to places of support when needed. The service has also given, those with limited support networks, a helping hand with the practicalities of returning home, such as checking for and minimising risks of recurring or new issues such as trip hazards and fire safety. By doing these small practical tasks it is certainly hoped, if not apparent from the information we have gathered, that people will successfully return home from hospital and should reduce the risk of readmission for at least some individuals. The service may also, if desired and needed, give individuals the opportunity to reach out to other services in the community, for longer term support or increased connectivity which will not only reduce feelings of isolation but could tackle feelings of loneliness.

Overall, the Welcome Home service has been well received by those who have used it. There have been lessons learned along the way about ensuring the right people are referred to the service. Where one client had a good support network, they saw the value for someone who did not much support but for them it had not been particularly useful. This highlights a need to ensure the service reaches those most in need and avoid potentially wasting resources. There was also possible room for improvements seen in ensuring all parties have the right amount of accurate information to ensure effective delivery. Such as ensuring hospital staff are aware of what the service offers and have a clear criteria of who to refer. As well as, ensuring clients have information to manage their expectations of the service, such as knowing when they will be contacted. One client admitted to not knowing whether they welcome home responders would be in contact again, however they did state they had misplaced the paperwork they had been given and it could have been on that. With these things said, it would certainly seem that people are receptive to the service and see it as a real asset to our area.

5 Recommendations

Going forward we would recommend that The Welcome Home Service:

1. Ensure there is a robust criteria for referral to the service to ensure it targets the right people. This should include patients who are being discharged on Pathway 0 who are found to have little or no support network already in place. For example patients who have no local family connections and few links to the local community. This robust criteria should then be disseminated to relevant hospital staff to ensure suitability of referrals.

2. Continue to develop relationships with hospital staff to ensure smooth transition for those referred to the service. Where patients are being discharged into the Welcome Home service, hospital staff should be provided with a contact at the Welcome Home service to liaise with and in case of any problems arising during the process to ease the transition from hospital to home for the patient.

3. Ensure information is provided to clients at the time of referral to make clear the service aims and objectives as well as they process and pathway from discharge into Welcome Home. This could be in the form of a printed leaflet which could be handed over during the discharge process to ensure patients understand what to expect from the service and should include details of who they should contact if they have any queries in relation to it.

4. Develop a structure to review operational learning to inform the service further. This was seen in relation to the checklist used by responders in their initial and follow up visits, relating to updates around checking fire safety. Such reviews help to ensure consistency and relevance of checks completed and support provided.

5. Since this evaluation was completed over such a short pilot, and now the service has extended funding, we would recommend the service undertake a further review and check longer term impact of the service, possibly by tracking individuals over a period of weeks or months to check for any wider service impacts.

Going forward we would recommend that Northern Lincolnshire and Goole NHS Trust:

1. Ensure that patients are fully informed during the process for returning home, particularly when using Hospital Transport. This should include an estimated time of departure, regularly updated as necessary, to ensure patients are fully aware of possible wait times and can plan their return effectively.

6 Acknowledgements

We would like to thank:

The clients who provided their experiences to enable us to complete this evaluation.

Our volunteers who made phone calls to clients to gather and record their experiences.

The Welcome Home team for their support in gathering the experiences of their service users.

7 References

1 Northern Lincolnshire and Goole NHS Foundation Trust – Discharge Policy dated 16.09.19 amended 03.03.2020

2 Department of Health and Social Care https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model

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Rural Action

14th April 2022

Dear Ms Allen

Re: Formal report with recommendations submission under the Local Government and Public Involvement in Health Act 2007 (part 14) as amended by the Health and Social Care Act 2012 (Part 5)

I acknowledge receipt and thank you for the report for the evaluation of the Welcome Home Pilot dated November 2021 and received on 30th March 2022.

It is very pleasing to read that the service has received such positive comments as to the service being provided when a person is discharged from hospital. In addition to this, the positive impact on such as loneliness and on the wider picture than health and care needs for the individuals demonstrates the need for such a service.

With regards to the recommendations given, please find below are comments and acknowledgements to these.

Ensure there is a robust criteria for referral to the service to ensure it targets the right people. This should include patients who are being discharged on Pathway 0 who are found to have little or no support network already in place. For example, patients who have no local family connections and few links to the local community. This robust criteria should then be disseminated to relevant hospital staff to ensure suitability of referrals.

A criteria has been developed for the service and portrayed to the hospital discharge service. It seems from the report that the hospital discharge service is still unclear as and when to use Welcome Home service. The Welcome Home service are trying to have more access to the hospital to ensure that all those responsible for discharge on each ward are not only clear of the service criteria but know of the Welcome Home service. Due to the limited access to hospitals over the last two years, this is something that is being worked on and developed. Although information has been provided to the hospitals, they will need to be dispersing the information through their own internal infrastructure to ensure wider coverage of the help and support that can be given. Following the pilot service, we are revising the information that we wish to be used to make it clearer to others.

Continue to develop relationships with hospital staff to ensure smooth transition for those referred to the service. Where patients are being discharged into the Welcome Home service, hospital staff should be provided with a contact at the Welcome Home service to liaise with and in case of any problems arising during the process to ease the transition from hospital to home for the patient.

When the pilot commenced, clear material was given to the hospital to enable them to provide both staff and service users with contact details and information about the Welcome Home service. Welcome Home continue to liaise with the hospital discharge team and are considering ways to have more of a presence on site. Discussions have already taken place with senior nursing staff with regards to the hospital promoting the service through team meetings and to have discussions on a regular basis with the discharge team.

Ensure information is provided to clients at the time of referral to make clear the service aims and objectives as well as the process and pathway from discharge into Welcome Home. This could be in the form of a printed leaflet which could be handed over during the discharge process to ensure patients understand what to expect from the service and should include details of who they should contact if they have any queries in relation to it.

At the time of referral to the Welcome Home service, the clients are under the care of the hospital discharge team. This team has been allocated with the appropriate information with regards to the Welcome Home service along with explanatory leaflets about what the service provides and helps with. Within this information are the details to give to each client to ensure they can contact the service and understand its aims. To encourage the hospital discharge service to give such information out to perspective clients, Welcome Home will review its literature with the possibility of a card being made available with clearly defined contact details and service description. This approach would enable people to recognise the type of provision available and ensure that the key point of the literature is visible. It must be noted, however, that there is still a reliance on the discharge team giving the appropriate information to the clients.

Develop a structure to review operational learning to inform the service further. This was seen in relation to the checklist used by responders in their initial and follow up visits, relating to updates around checking fire safety. Such reviews help to ensure consistency and relevance of checks completed and support provided.

Although virtual meetings have taken place during the pandemic, there is more opportunity now to build upon what the pilot produced and to arrange regular meetings with the responders. There is a monitoring process already taking place and such information helps in the development of the service. Through the gathering of this information, the Welcome Home team meetings will be a source to discuss areas or situations that have not gone so well and the appropriate place for the sharing of good practice.

Since this evaluation was completed over such a short pilot, and now the service has extended funding, we would recommend the service undertake a further review and check longer term impact of the service, possibly by tracking individuals over a period of weeks or months to check for any wider service impact.

The service currently monitors the impact on the client over the period that we are supporting them. From this, it can be established whether further help and support is required. The service can help by contacting relevant support that is available and introducing the client to such. This monitoring will continue and feedback given to the team. A follow up call is made to ensure that the clients are left in a position where they have appropriate contacts and support. This element is significant to the prevention of further concerns developing for the client that could have a detrimental effect on their health and wellbeing.

I hope the above responses demonstrate the commitment the Welcome Home service has in ensuring its success in supporting the safe and timely discharge of Pathway 0 clients into the community from hospital.

Welcome Home is a North Lincolnshire Voluntary Community and Social Enterprise (VCSE) Alliance service provided through Humber and Wolds Rural Action (HWRA) and delivered by Welcome Home Responders under the guidance of the Welcome Home Coordinator. It is working in partnership with North Lincolnshire Council Home First Service, Northern Lincolnshire and Goole NHS Foundation Trust and North Lincolnshire Primary Care Networks.

If you require any further information with regards to this service, please do not hesitate to contact me at the above office.

Yours sincerely

Howard Westoby

Delivery & Development Manager

Strengthening Communities In East Yorkshire & northern Lincolnshire

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