HomeFirst Programme – AHAL Scrutiny Board Progress Update – August 2024

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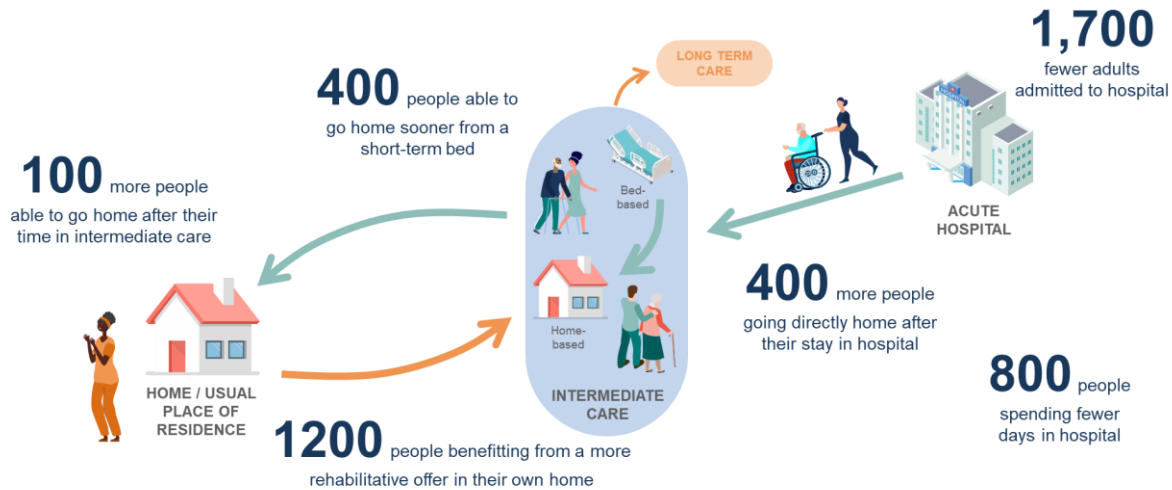
Overall Progress Update

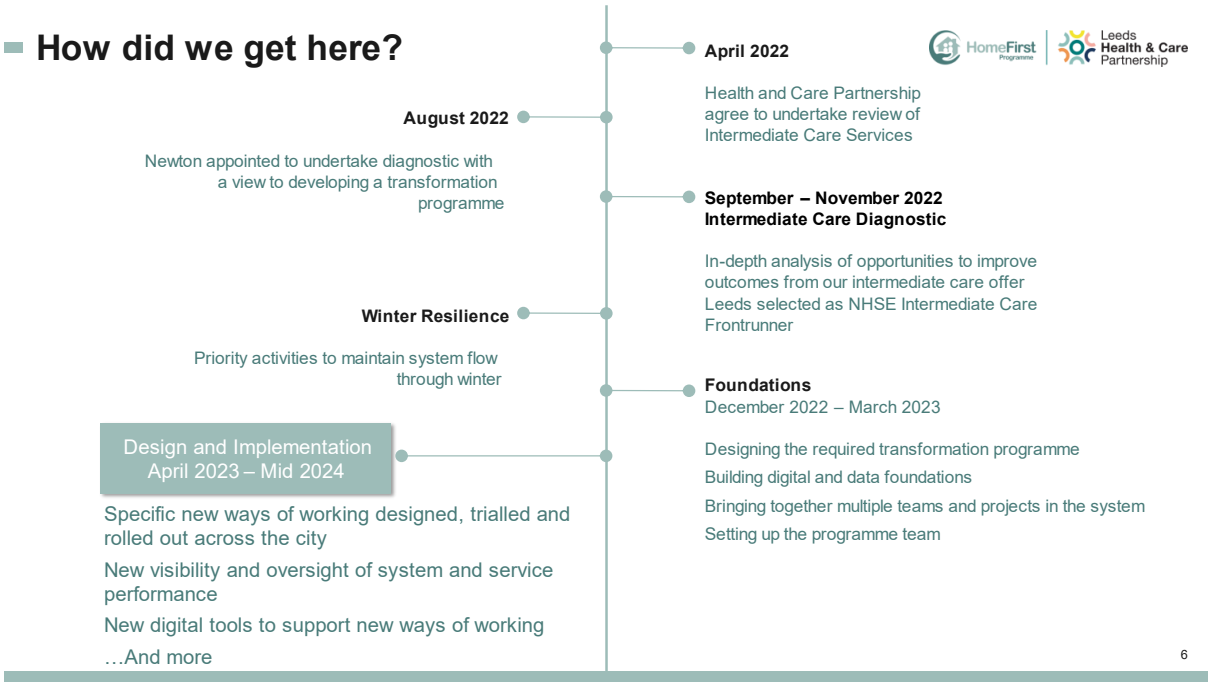
The HomeFirst programme brings together health and care partners with support from an external partner Newton Europe and has been set up to achieve the following vision and outcomes:

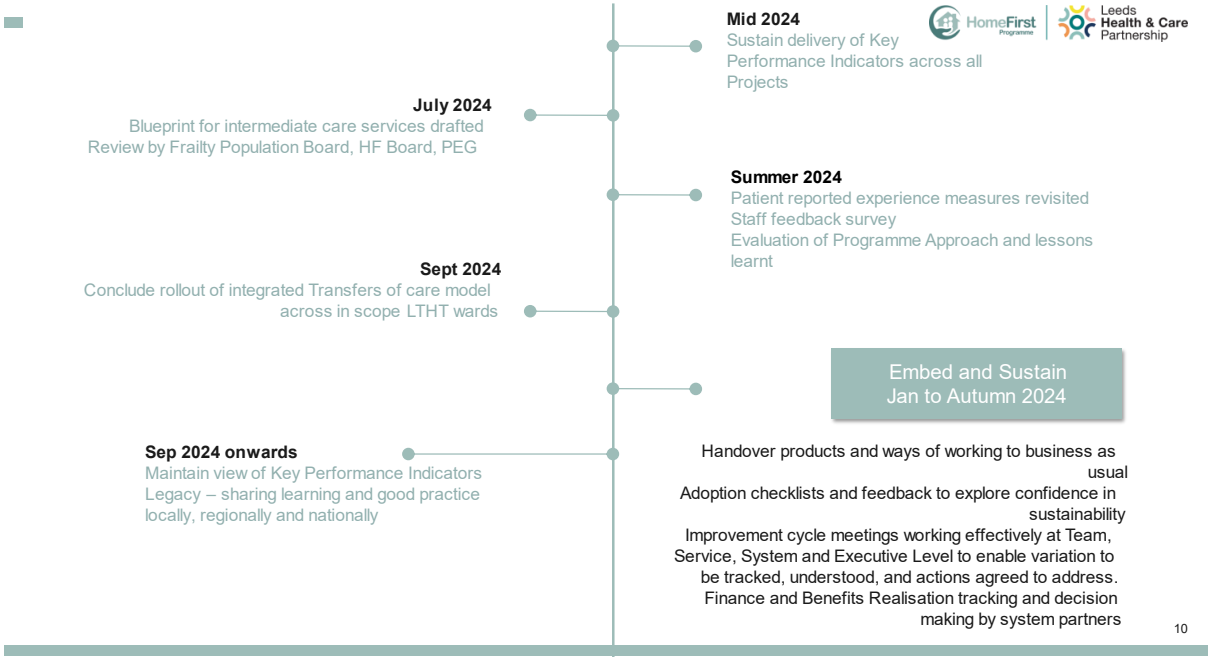
A sustainable, person-centred, home-first model of intermediate care across Leeds that is joined up and promotes independence



This culminates in an ambition to improve outcomes for over 3000 Leeds residents each year, resulting in an annualised financial saving of £17.3m to £23.1m.

The Programme is now in the embed and sustain phase, following phases over the last 2 years where we have diagnosed, laid foundations, designed, piloted, evaluated, and rolled out changes across our 5 projects.



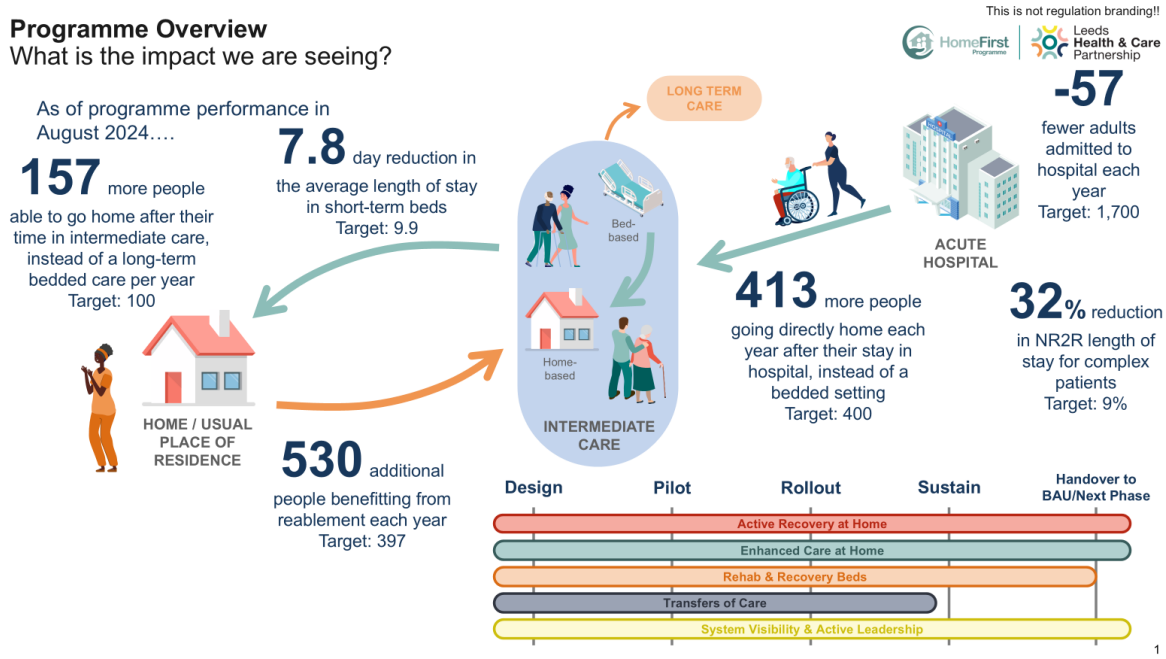


Overall Programme Impacts

Figure 1 below shows the delivery against target for our key performance indicators as at August 2024. It should be noted that these indicators are tracked monthly and will change as performance moves. Overall Programme delivery is ahead of target. Most indicators are ahead/significantly ahead of target. short term beds length of stay is slightly below target. The team are working to understand how a potential shift in acuity may have impacted on the target value.

The number of avoided hospital admissions is currently tracking below baseline, resulting in a negative value. The August position on this indicator is out of kilter with the performance in previous months tracking which has on average been equivalent of 971 avoided admissions per year. This may be the result of seasonal variations in demand but there may be other factors impacting. The Programme Team are working with partners to understand the contributing factors to this and actions needed to address.

Figure 1 – HomeFirst Programme Impact August 2024



Delivering effective intermediate care services involves collaboration between the person and their family/carers and a wide range of staff working in partner organisations across health and care. A significant focus in the Programme has been on bring people together with a shared focus on how to build a better offer focussed on a home first ethos and with the person at the centre. Building and sustaining relationships to work through tricky issues, enabling timely access to trusted data, and creating a sense of common purpose have been core activities alongside more technical project management approaches.

At completion in autumn 2024 we anticipate that the Programme will have achieved the following impacts:

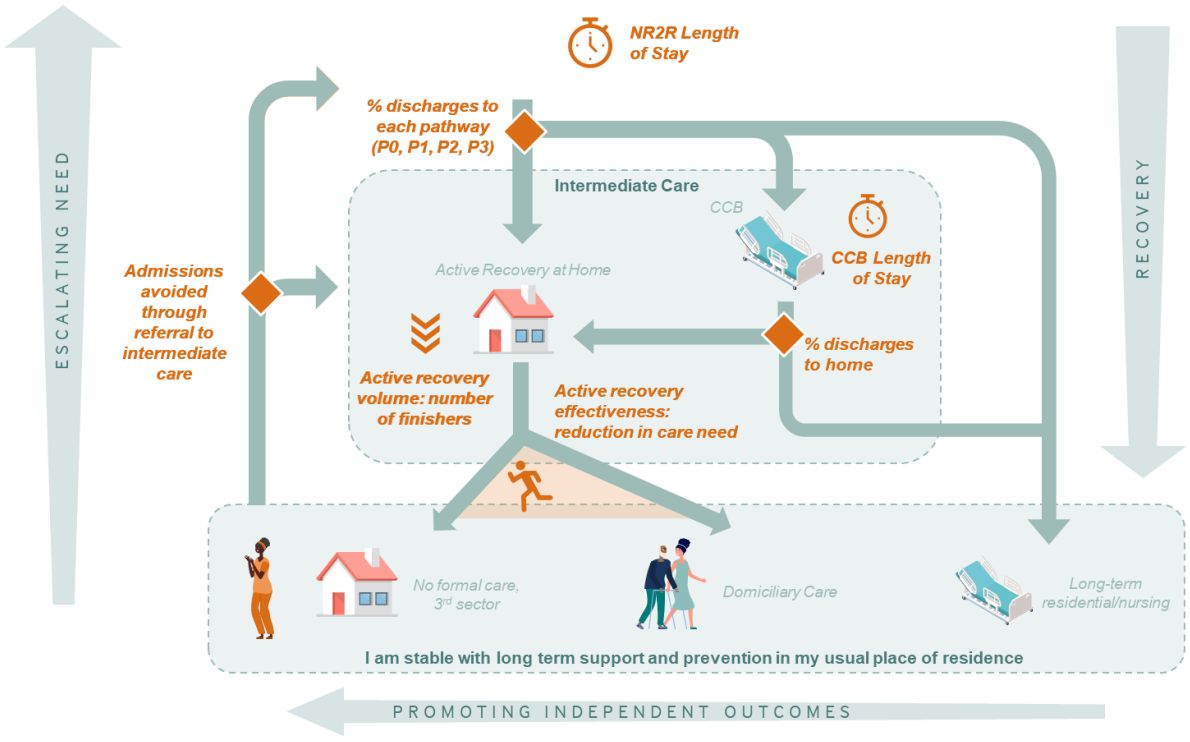
- Benefits for people, measured through the key performance indicators above, with:
    - reduced hospital admissions
    - reduced length of stay in hospital and community beds
    - more people supported with an improved offer at home
    - reduced requirement for long term care at home or in residential settings.

- A new model for rehabilitation and recovery beds, which is being commissioned for implementation from April 2025
- Improvements in the short-term home-based rehabilitation and reablement offer delivered by Active Recovery.
- Piloted a joint delivery offer for Active Recovery which is ready for citywide rollout
- Improved the multidisciplinary and multiagency offer to reduce hospital attendance and admission and support people home in a timely way following a hospital admission
- Implemented a System Visibility and Active Leadership framework that will enable system partners to work together on an ongoing basis to understand performance trends and consider actions needed to enable improvement
- Improved involvement for people and families/carers in goal setting and planning, with more sill to come
- Improved staff experience within intermediate care services, with more still to come
- Ensure staff and teams are equipped with tools and training to enable continuous quality improvement within this model
- Begun the culture change across system partners to enable a home first approach where services and professionals collaborate with the person and their family/carers to wrap support around what matters to them, promote positive risk taking and community-based care.

Finance & Benefits

Progress Update

Measuring the impact of the programme on each of the key operational measures it is aiming to move will be a core focus for each of the five projects. These measures are summarised in the following diagram:



To understand the financial benefit associated with each operational improvement, the Programme Finance & Benefits Realisation group, consisting of finance leads from each organisation, has held responsibility of ensuring that throughout the programme we are able to understand how much of

each financial benefit has been delivered. The table below translates the Programme performance into financial opportunities based on a run rate as at August 2024. Most opportunities are at or above target, but the Enhanced Care at Home performance in August means that this is below target value.

Programme Financial KPIs

Baseline Values: these are the KPI values prior to impact of the programme (as a default this is the average performance for the year prior to the programme start).
Target Values: these are the low, mid and high case targets for the end of this phase of the programme.
Current Values: these values (are the average performance from the last six, eight or twelve weeks, as specified on the individual KPI update slides.

The following table summarises the current programme performance against each financial KPI:

Project	KPI	Definition	Units	Baseline	Target Values			Current Value	Current Period
					Low Case	Mid Case	High Case		
Active Recovery at Home	Reablement Throughput	Total number of starts per week across the reablement service.	Starts per Week	26.5	30.0	34.1	39.5	36.7 ↓	6 Weeks
	Reablement Effectiveness	Average reduction in ongoing homecare need achieved through the reablement intervention.	Hours per Week	6.96	7.20	8.04	8.34	8.03 ↑	8 Weeks
Rehab & Recovery Beds	Length of Stay	Length of stay at discharge for all patients leaving short-term beds.	Days	44.8	39.3	34.9	31.8	37.0 ↓	6 Weeks
	Residential Home Placements	Number of new Residential Home Placements per week for patients leaving short-term beds *(12-week lag in tracking).*	Starts per Week	1.33	1.13	0.92	0.72	1.08 -	12 Weeks
	Nursing Home Placements	Number of new Nursing Home Placements per week for patients leaving short-term beds *(12-week lag in tracking).*	Starts per Week	0.94	0.72	0.50	0.28	0.67 ↑	
Transfers of Care	Hospital NR2R Length of Stay	Average no-reason-to-reside length of stay at discharge for complex discharges ("for "in scope" wards only).	Days	8.40	8.00	7.64	7.30	5.69 ↓	6 Weeks
	Pathway 2 Reduction	Number of short-term bed starts per week for all patients leaving hospital.	Starts per week	40.1	38.2	36.2	34.3	29.6 ↓	12 Weeks
	Residential Home Placements	Number of new Residential Home Placements per week for patients leaving hospital *(12-week lag in tracking).*	Starts per Week	2.54	2.15	1.75	1.36	2.25 ↑	
	Nursing Home Placements	Number of new Nursing Home Placements per week for patients leaving hospital *(12-week lag to tracking).*	Starts per Week	2.00	1.75	1.50	1.25	1.17 ↑	
Enhanced Care at Home	Avoided Admissions – HW(F)	Average increase in admission avoidance starts in Home Ward Frailty (step up, excluding transfer to hospital after admission).	Admissions Avoided per Week	29.1	37.4	42.8	48.1	27.3 ↓	6 Weeks
	Avoided Admissions - CDAT	Average admissions avoided by CDAT team (borderline admissions who are discharged).		15.0	18.0	23.0	28.0	15.7 -	

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Programme Financial Opportunities

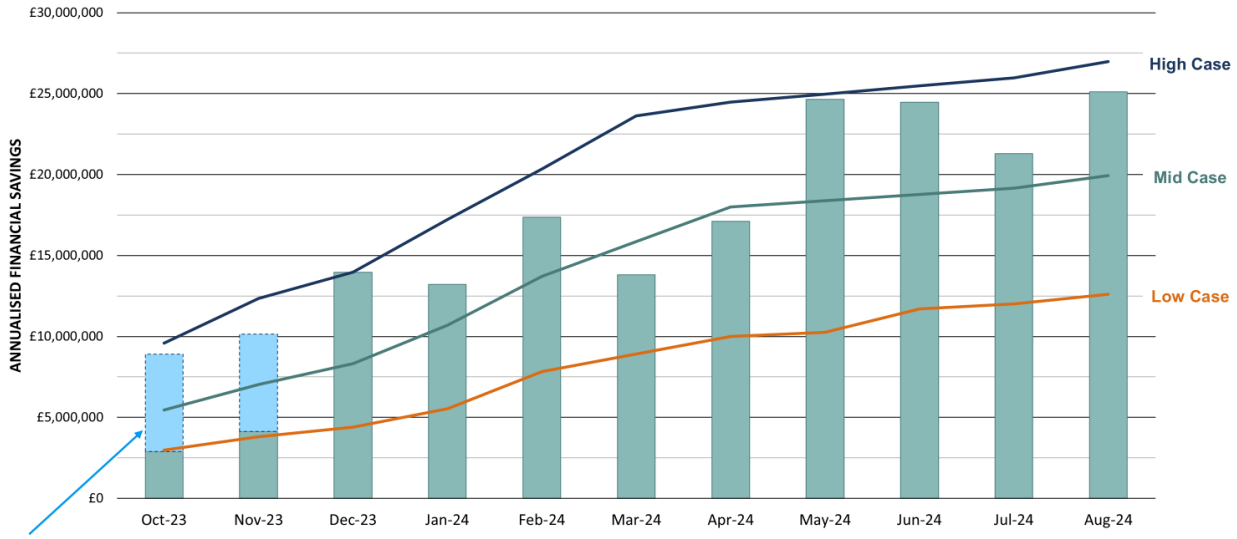
The following table summarises the financial performance of the HomeFirst programme:

Project	Opportunity	Opportunity Description	Diagnostic Target Value*	Diagnostic Stretch Target Value*	Current Programme Performance
Active Recovery at Home	Reablement Throughput	Increasing the number of people that benefit from reablement before entering long -term homecare (if required).	£ 3.30m	£ 5.10m	£ 2.64m
	Reablement Effectiveness	Improving the effectiveness of reablement interventions, reducing ongoing care requirements.			£ 1.05m
	Reablement Overlap	Additional benefit due to the overlap of the two benefits above (improved outcomes for additional cohort).			£ 0.40m
		Project Total:	£ 3.30m	£ 5.10m	£ 4.09m
Rehab & Recovery Beds	Length of Stay	Releasing capacity in short -term beds through a reduction in length of stay.	£ 3.60m	£ 4.30m	£ 3.64m
	Outcomes (Nursing and Residential Placement Avoidance)	Reduction in ongoing care costs due to a decreased proportion of discharges to LT bed -based care.			£ 0.69m
		Project Total:	£ 3.60m	£ 4.30m	£ 4.33m
Transfers of Care	Hospital NR2R LoS	Releasing acute bed capacity through a reduction in discharge delays.	£ 7.20m	£ 9.50m	£ 9.09m
	Discharge Outcomes (Nursing and Residential Placement Avoidance)	Reduction in ongoing care costs due to an increased proportion of discharges directly home following hospital.			£ 1.70m
	Pathway 2 Reduction	Releasing capacity in short -term beds through a reduction in the proportion of Pathway 2 discharges.			£ 5.99m
		Project Total:	£ 7.20m	£ 9.50m	£ 16.79m
Enhanced Care at Home	Acute Admission Avoidance - Home Ward Frailty	Releasing acute bed capacity through admissions avoided through use of Home Ward Frailty.	£ 3.20m	£ 4.20m	-£ 0.17m
	Acute Admission Avoidance – CDAT	Releasing acute bed capacity through increased admissions avoided by CDAT.			£ 0.07m
		Project Total:	£ 3.20m	£ 4.20m	-£ 0.11m
		Programme Total	£ 17.30m	£ 23.10m	£ 25.10m

Important note: all financial figures shown are the **annualised values to the system if we remain in steady state** (i.e. if the performance of each KPI is sustained at its current value on an ongoing basis). This is often referred to as the programme financial run rat e.

Programme Financial Performance

The following graph shows the programme financial run rate compared to the expected trajectories for each target case. This shows the recurring year-on-year saving to the system (based on sustaining the improved performance seen to date) in steady state.



Note: Accurate tracking of benefit from Transfers of Care was not available due to data issues. Estimated benefit of **£5-7m** from reduction in **pathway 2 beds (c. 75 beds)** and NR2R length of stay (over **20% reduction**). Average of this range shown.

Embedding and sustaining change, ensuring involvement of people and staff

The HomeFirst Programme team has worked with partner services to ensure that all changes are fully embedded and sustained, with ongoing monitoring of benefits realisation as set out above and involvement from people and staff.

An example – Transfers of care project

The Transfers of care project focusses on how we improve services to enable smooth and timely transfer for people who need additional support following a hospital admission. The project started by developing an understanding of the current position through the diagnostic: what worked well and what could be better.

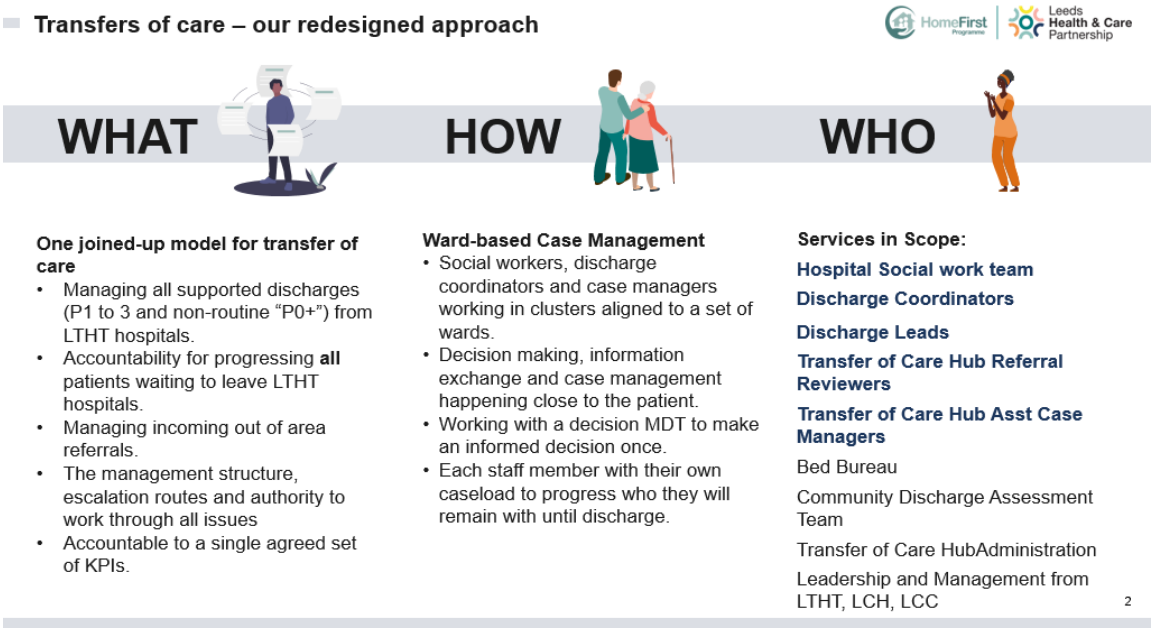
The 2022 Healthwatch report identified key recommendations based on people's experience:

- Improve involvement of people in conversations about their discharge at all stages of their hospital journey.
- Improve identification of family carers and refer to Carers Leeds for information and support as required.
- Ensure that everyone leaving the hospital is given appropriate follow-up contact details for further support and advice.

The Healthwatch report findings, diagnostic outputs, and engagement with staff involved in this area of work resulted in designing a new model of care delivery wrapped around the person on the ward and their family/carers, as shown in Figure 2 below. This brings the multi-agency (LCH, LTHT, LCC), multidisciplinary team closer to the person with a shared focus on how to support the person to get home wherever possible, and reduces the number of

decision points, referrals and handoffs that were delaying people moving on when they were ready to leave hospital.

Figure 2: Transfers of care – new approach



The new model was initially trialled in the Specialty and Integrated Medicine Clinical Service Unit at St James's Hospital (which accounts for the highest proportion of people who need support following their hospital admission). The results of this trial, and including feedback from people and staff, shown in Figures 3 and 4 below, informed rollout across all in-scope wards across St James's Hospital, Leeds General Infirmary and Chapel Allerton Hospital, which is due for completion by end September 2024.

Figure 3 – Summary evaluation results from Specialty and Integrated Medicine – June 2024

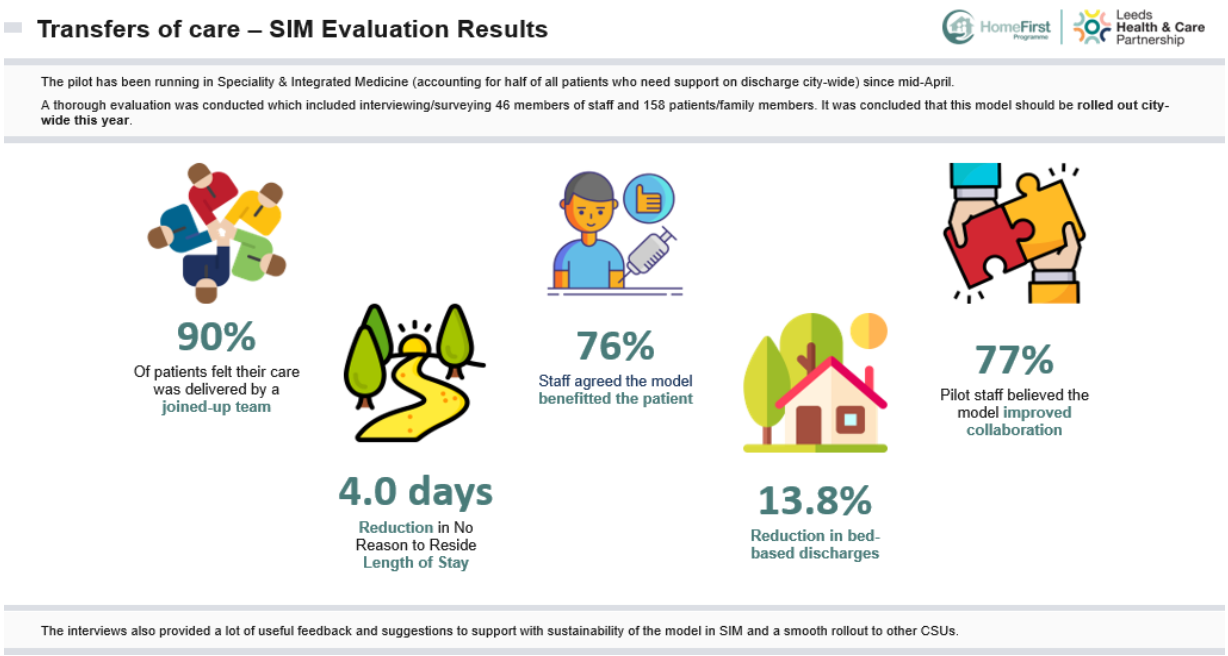
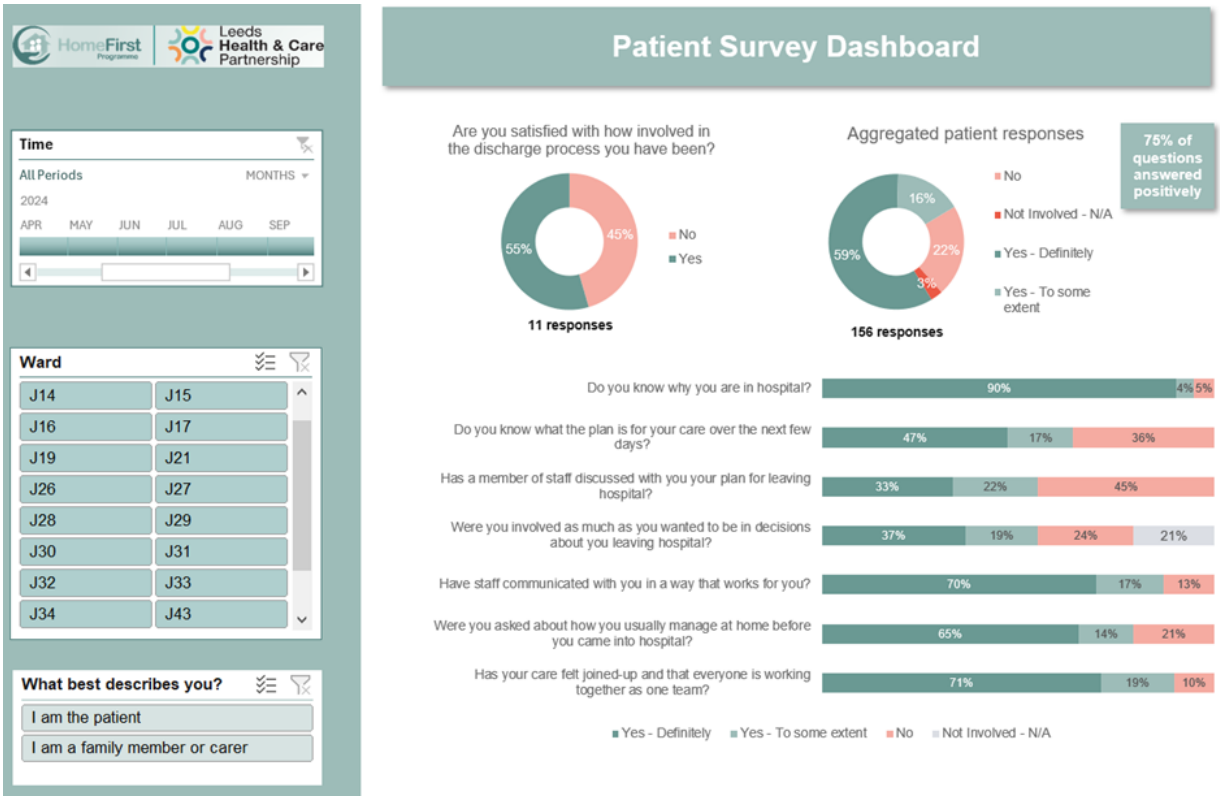


Figure 4– Patient survey results selected LTHT wards May 2024



In the survey 158 patients were interviewed within the pilot wards across SIM. The results demonstrated some areas of great work especially pertaining to joined up working. The feedback relating to the person being involved in their discharge plan and someone discussing the plan with them does require some focus and improvement which the team are working on. We will continue to survey people as we rollout to wider wards to understand trends and impact of our work. The volunteer service at LTHT has been invaluable in supporting this work.

In parallel to this work, a refreshed approach to identifying and involving carers has been developed across the West Yorkshire partnership and is being implemented in LTHT alongside the Transfers of care Project.

How the new approach works in practice

People who require support after their hospital stay can have a wide range of needs including health needs, social care needs, housing needs, equipment needs, and informal support needs requiring a combined response from system partners. Some people have particularly complex needs requiring coordination with the person and family/carers and a range of partners, whilst other people need a relatively short term support plan involving one partner. The approach that we have implemented builds on existing work and has focussed on supporting better coordination and reducing process delays.

For example, for someone with complex housing and support needs, the new approach prompts early identification of the housing need on the ward and connection with existing dedicated housing workers in our transfer of care team to work with the person and link with housing agencies to identify solutions. Alongside support from family and friends, and existing third sector input, the person might

also require support from home based intermediate care services through Active Recovery and provision of equipment. The person will be allocated a case manager who works with the person to 'hold the ring' on the post-hospital support plan, ensuring connections between the partner agencies so that the elements can be delivered in a coordinated way. The Recovery Plan enables these plans to be updated in a single plan so that all staff who are supporting the person on the ward can understand the situation and next steps and can share clear information with the person and family/carers.

Whilst the new approach supports timely identification, coordination and communication, on its own the approach does not resolve the issues of housing supply to meet everyone's needs in a timely way. System partners including health, social care and housing are working together on this issue including temporary housing options to enable ongoing recovery in a community setting, in situations where the person has completed their hospital intervention but a long term housing solution is not yet available.

The Case Study below provides a further example:

Collaboration on the ward allowed a patient to go home earlier than predicted

A patient was desperate to get home and had been medically ready to leave hospital for 7 days when the case manager got involved. It is estimated by the staff that the patient could be waiting for **another month** for their package to be arranged.

Making use of the collaborative multidisciplinary team to provide some innovative problem solving, the case manager **worked with the patient, family and social worker** to avoid this delay.

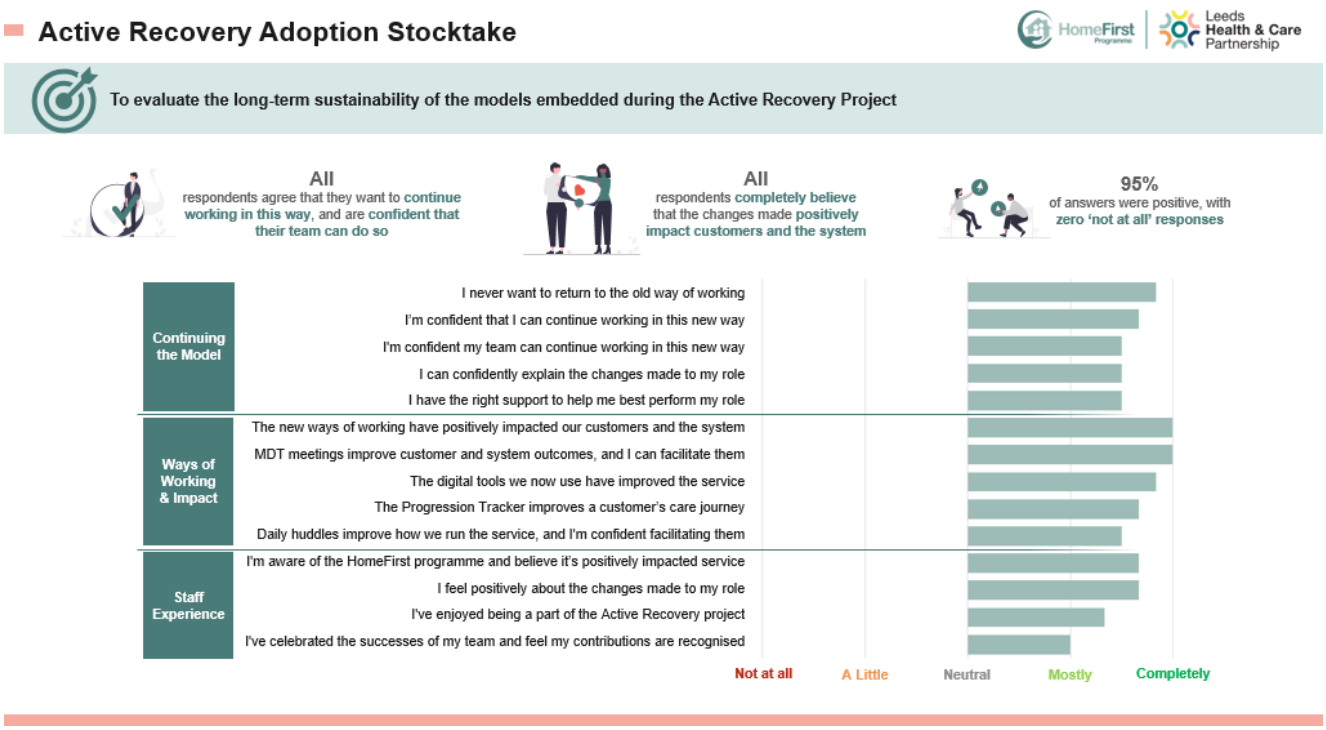
As a result, their social worker completed an assessment on the first day of them being allocated. Their family acted proactively to support the patient home before their package was ready and bridge the gap themselves.

As a result, the patient went home - and will stay home - within two days of the case manager getting involved and avoided a predicted 4-week delay.

Months later, in a chance encounter, the patient's daughter recognised the case manager and shared just how big of an impact being sent home had on her mother and how pleased she was with the outcome.

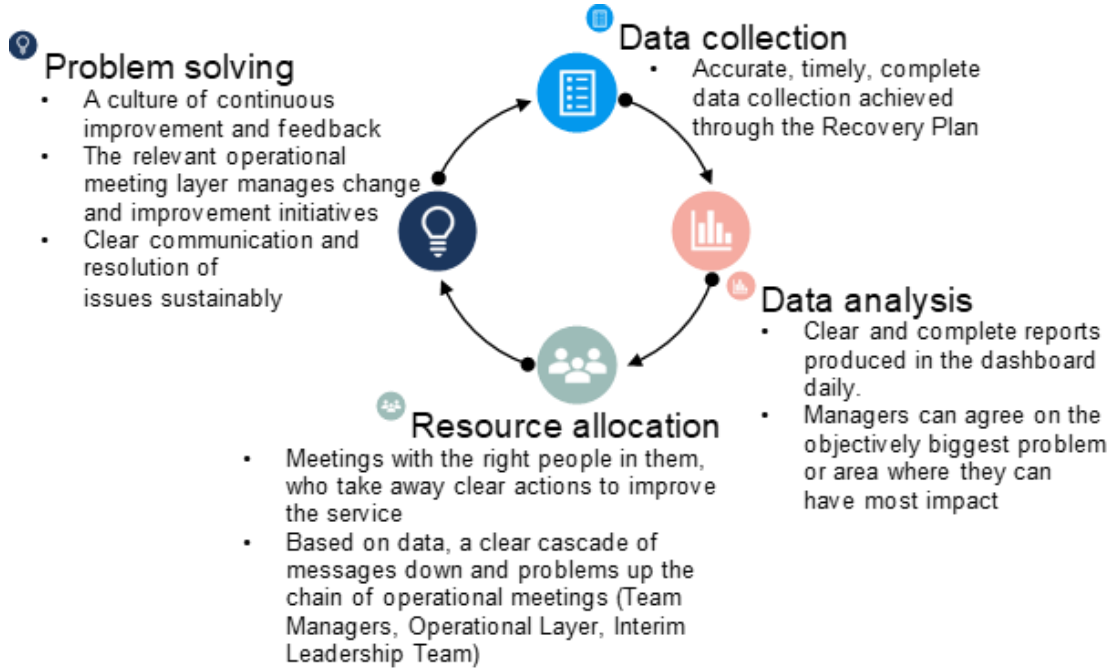
Once the changes are rolled out and embedded, we will need to ensure that staff and leaders in relevant services feel confident and competent to sustain the changes. We be undertaking an Adoption Stocktake similar to the approach already taken in Active Recovery, where changes are fully implemented, and illustrated in Figure 5 below. The approach involves staff and service managers reviewing a series of statements relating to the sustainability of the model and to rate the extent to which they agreed with them. Responses are anonymous. The Adoption Stocktake results inform areas for further attention and enable ongoing improvement.

Figure 5 – Results - Active Recovery Adoption Stocktake – June 2024



Another route to sustainability is the Active Leadership and System Visibility infrastructure which uses a consistent Improvement Cycle methodology. Improvement Cycles drive incremental improvement in a system, allowing partners to continue responding to ever-changing demands and support continuous quality improvement at team, service, and system wide, with escalation routes to senior executives to enable system oversight and unblocking of challenges when required. Figure 6 below shows the Improvement Cycle for Transfers of care.

Figure 6 – Transfers of care Improvement Cycle



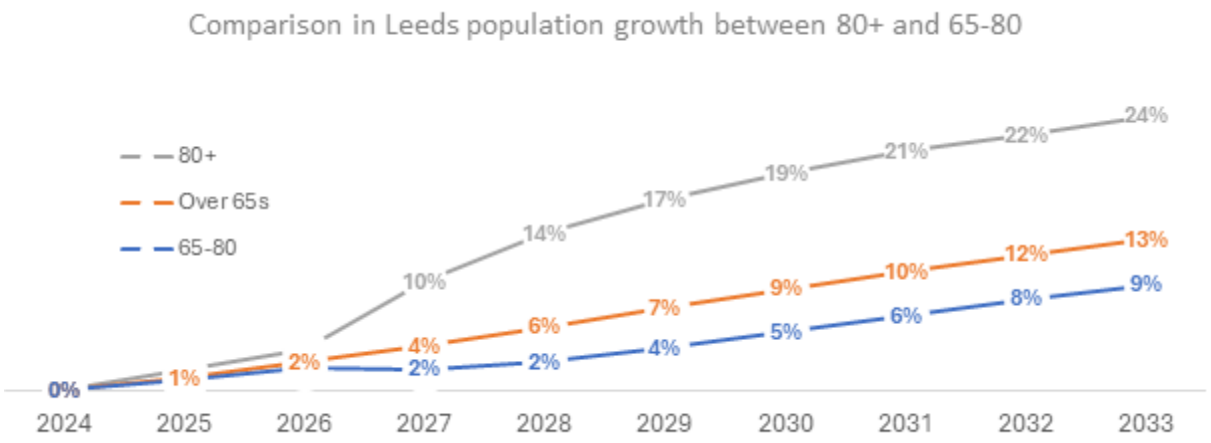
Next steps

Blueprint for Intermediate Care Services

By its conclusion in autumn 2024 the HomeFirst Programme will have delivered tangible improvements for people in Leeds, enabling better staff experience and better use of our shared resources. However, we will not have fully realised our ambitions for our intermediate care service offer, and we need to consider the changing needs of our population.

We know that the population of older people in Leeds and particularly those over 80, who make up the majority of users of intermediate care services, will increase substantially in the next 10 years changing the demand profile for intermediate care services, and eroding the benefits delivered through the HomeFirst programme as shown in Figure 7 below.

Figure 7 – Changes in Leeds population 2024-2033



The HomeFirst Programme team, with support from a multiagency working group, has developed a draft Blueprint for Intermediate Care Services in Leeds, which sets out a proposed work plan covering the near term (2024-2025), medium term (5 years), longer term (10 years). The HomeFirst Programme Board is considering these proposals during August 2024 with a view to agreeing next steps to ensure we are delivering the best possible health and care offer.

Sharing learning and celebrating impact

As this phase of work concludes, a system wide event will be held in early October to reflect on progress made since the start of the Programme, the changes in culture and partnership working and our next steps. This even will coincide with formal evaluation of the Programme's impact and opportunities to share our learning regionally and nationally as we progress to the next phase of work.