HomeFirst Programme – AHAL Scrutiny Board Progress Update

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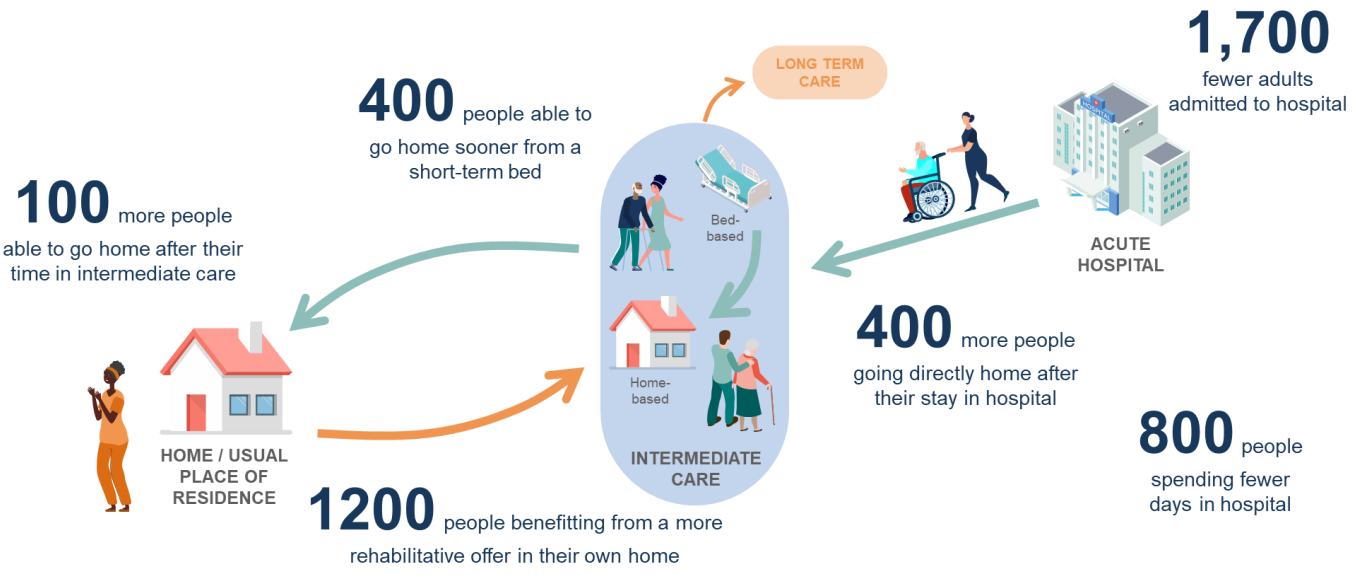
Overall Progress Update

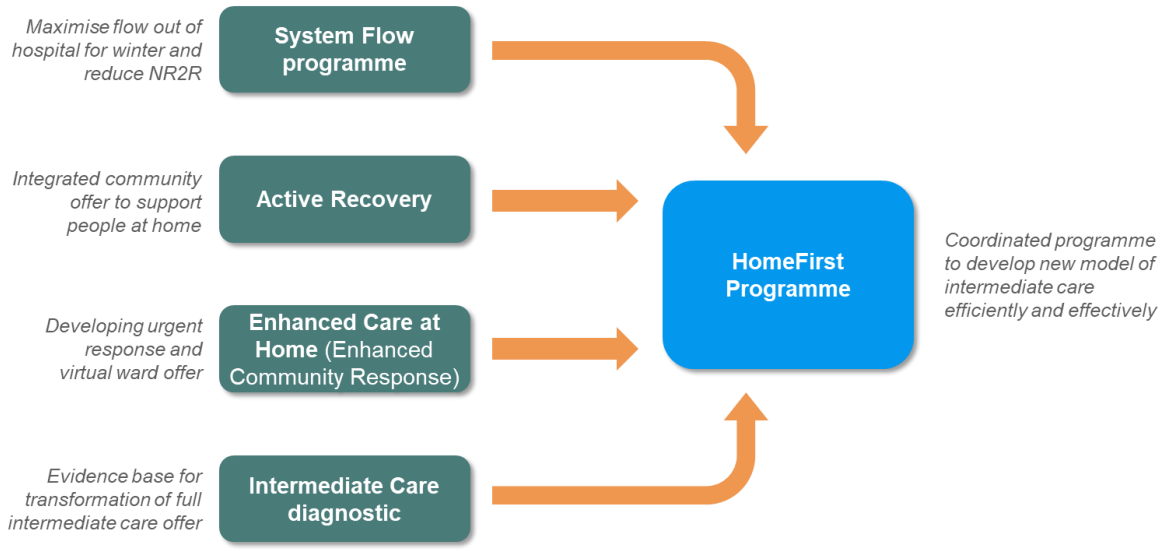
The HomeFirst programme has been set out to achieve the following outcomes for the Leeds Intermediate Care System:

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

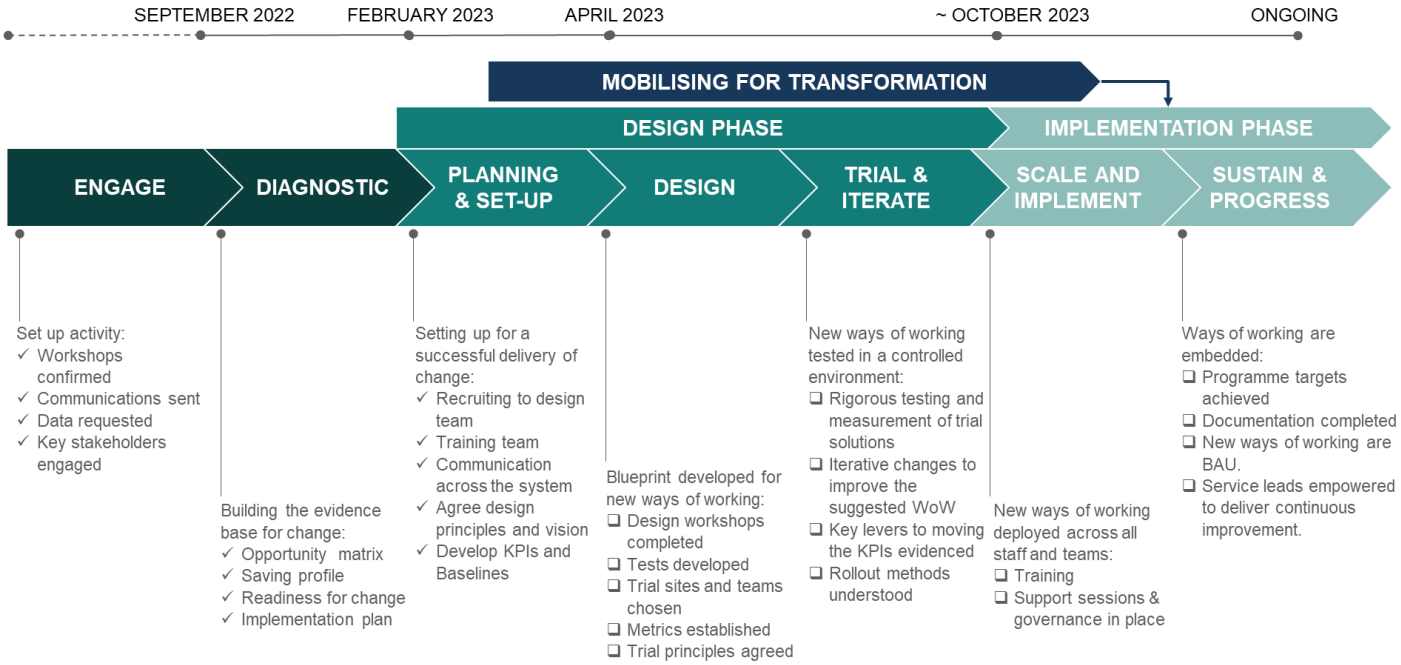


This culminates in an ambition to improve outcomes for over 3000 Leeds residents each year, resulting in an annualised financial saving of £17.3m to £23.1m.

The programme was pulled together following the intermediate care diagnostic in autumn 2022 and brings together a number of pre-existing transformation initiatives across the system:

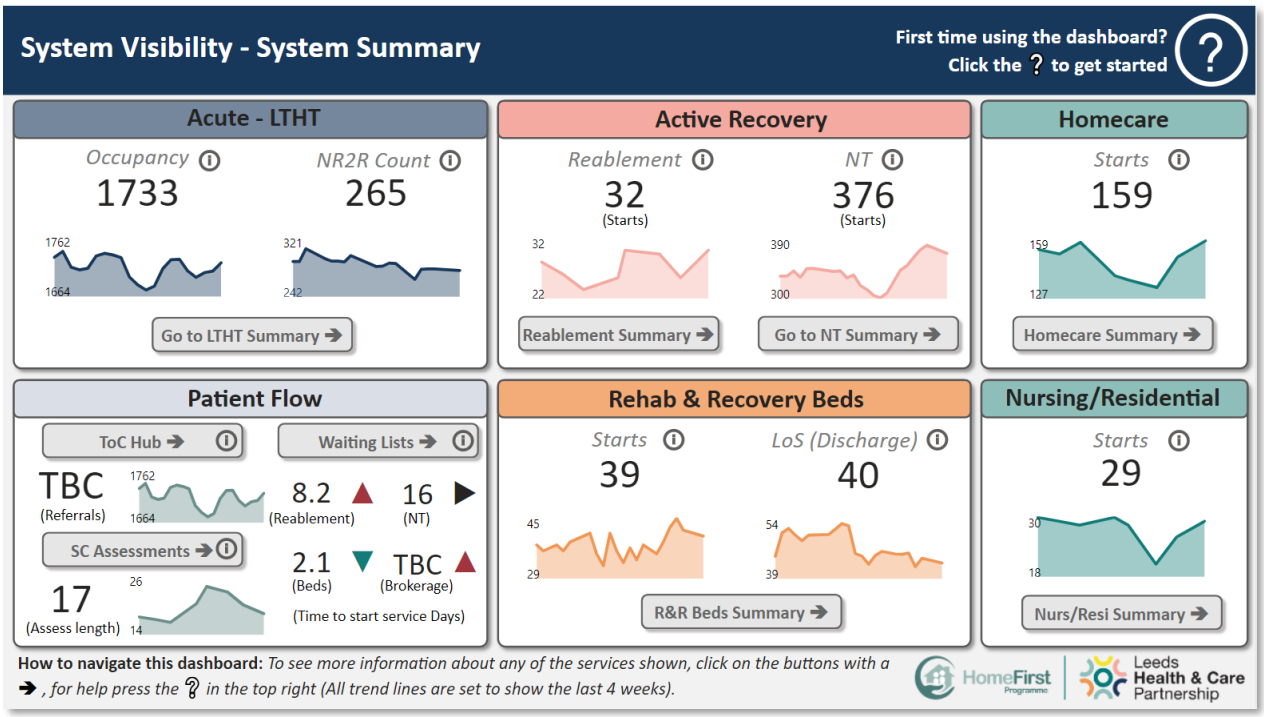


Across the programme we are currently in a period of piloting and testing the changes to ways of working, processes, workforce and culture that have been carefully designed with experts from across services and organisations. The changes are being iterated based on the measurable impact they are having on the programme KPIs, as well as feedback from staff and patients/service users. Once we have the confidence and evidence in each of these changes, we will transition into the rollout phase, scaling up the new models of care and support across the system and services.



As a result, many of the changes from the programme are still to be implemented, however, early improvements have been seen as we have balanced the priority of impact this year for our residents, with the need for long-term test and redesign. There are three key areas in particular where we have seen significant early improvement:

A core component to these improvements has been the implementation of a System Reporting suite that allows leaders to understand where the pressure is in the system, what is contributing to it, and what outcomes we are achieving with a live view. Managers and team leaders can now view down to patient level to understand capacity, flow, delays, next steps, and outcomes. This is beginning to embed a culture of data-driven decision making in the system, and the programme will continue to embed this across all teams.



While a lot of the benefits of the programme will be delivered and take full effect in 2024, as the programme hasn't been designed around preparing for winter this year, through the impact seen thus far (and the benefits of work done outside the programme) the system is heading into winter in a much better position that we were in this time last year.
Key highlights from each of the projects:

- The first **Active Recovery** pilot team is now live, with Neighbourhood Teams therapists and SkILs reablement staff coming together to form the pilot team.
- Rollout has started within **Rehab & Recovery Beds**, with training workshops completed and new ways of working, data capture, and processes now live in the first two bed bases.
- The **Enhanced Care at Home** design group has kicked off focussing on better understanding the opportunities to avoid admissions at the acute front door through a series of studies due to take place across LGI and SJUH.
- In **Transfers of care**, the first of two ward-based pilots is now live, bringing changes to improve outcomes through a better discharge decision-making environment, and reduce delays to discharge through a simpler process and closer grip of patients as their discharge is arranged.
- Within **System Visibility**, the focus continues to be the handover of the existing reports to BAU owners within the system. Development has started of the long-term roadmap for future developments to expand the scope and value of the existing product.

Project Updates

The remainder of this update covers the progress in each of the five HomeFirst projects that are delivering the outcomes outlined, as well as an update on the ongoing work to value and realise the financial impact delivered by the programme.

Active Recovery at Home

Project Overview

This project will develop a health and social care short term community rehabilitation and reablement service for Leeds, and in doing so will increase the number of people able to be supported at home both before and after their stay in acute hospital as well as improve their long-term outcomes. It will also ensure all relevant parts of the system have the awareness of, and easy access to, intermediate care services to 'step-up' care for people in the community and avoid attending hospital.

Progress Update

Within Active Recovery the project team are focussed on the following areas at present:

Active Recovery Pilot
Iterating and evidencing the impact of new ways of working to support more people home to more independent outcomes

Single Care Plan and Safe Delegation
Designing the next iteration of ways of working to achieve a more co-ordinated short-term health and social care offer at home

Designing the Scaled-Up Model
Using learnings and evidence from the pilot, design the model and plan to scale up across Leeds

Reablement Rollout
Supporting the adoption of some components tested in the Pilot across Reablement teams to mitigate current and future pressures.

Systems
Implementing a joint Rostering and Case Management IT system across Active Recovery

The first Active Recovery pilot team, bringing together LCC reablement staff and LCH therapists to work in a single integrated team, has been live now for three weeks. This team is developing and iterating exciting new ways of working that will help us work towards a single integrated home-based offer for intermediate care in Leeds. The following summarises the initial changes the team are focussed on developing:

Sequencing of changes

Integrated MDT meetings & Daily huddles
To discuss scheduling and updates around individual's progress towards goals

Shared MS Teams Channel
To enable more collaborative working and easy communication and referrals

Pilot improvement group
For pilot leads and managers to analyse pilot performance and action improvement areas

Progress towards goals visibility
To give live insight into how individuals are progressing during every call to prompt step-downs and therapy input
(starting September)

Streamlined discharge process
The design of a trusted assessor service to minimise delays to ongoing care
(testing September)

While the pilot team has only been live for a couple of weeks, we're seeing a great deal of initial positive impact on capacity and outcomes within the team, as well as great feedback from the staff working in the team.

Key KPIs

7 Reablement starts last week
Target = 6

TBC Effectiveness last 28 days
Target = 8 hrs/wk

4 Of these were joint visits

+4 Internal referrals from reablement to therapists

Real benefits of closer working for individuals

During the daily huddle and using the shared MS Teams channel, a joint assessment was organised for a referral that came in. The case-officer and OT worked together during their assessments and did identify physiotherapy requirements and that the person was at risk of falls. Now the therapists and reablement staff can continually communicate and feedback to each other to ensure that the person's support is appropriate and safe.

Previously, a joint assessment wouldn't have taken place with very limited communication between reablement and therapy.

> "This closer working is brilliant, I'm now able to instantly receive therapy support for people on my caseload meaning that I'm reassured they're safe and able to progress towards their independence goals"
>
> ***Case-officer***

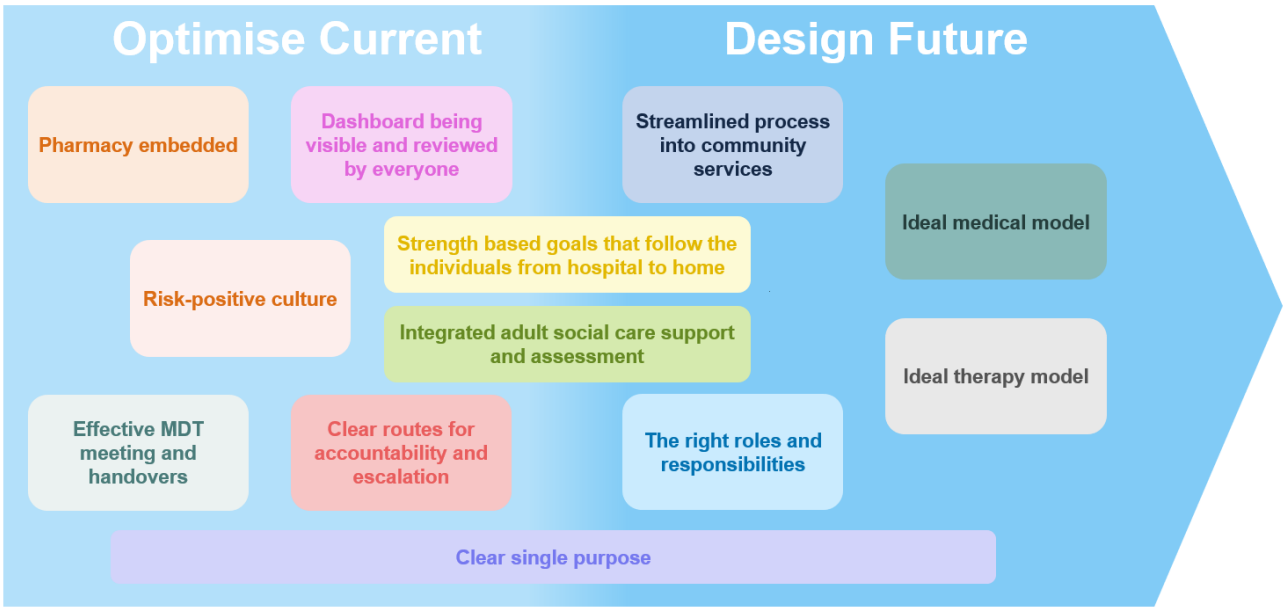
Rehab & Recovery Beds

Project Overview

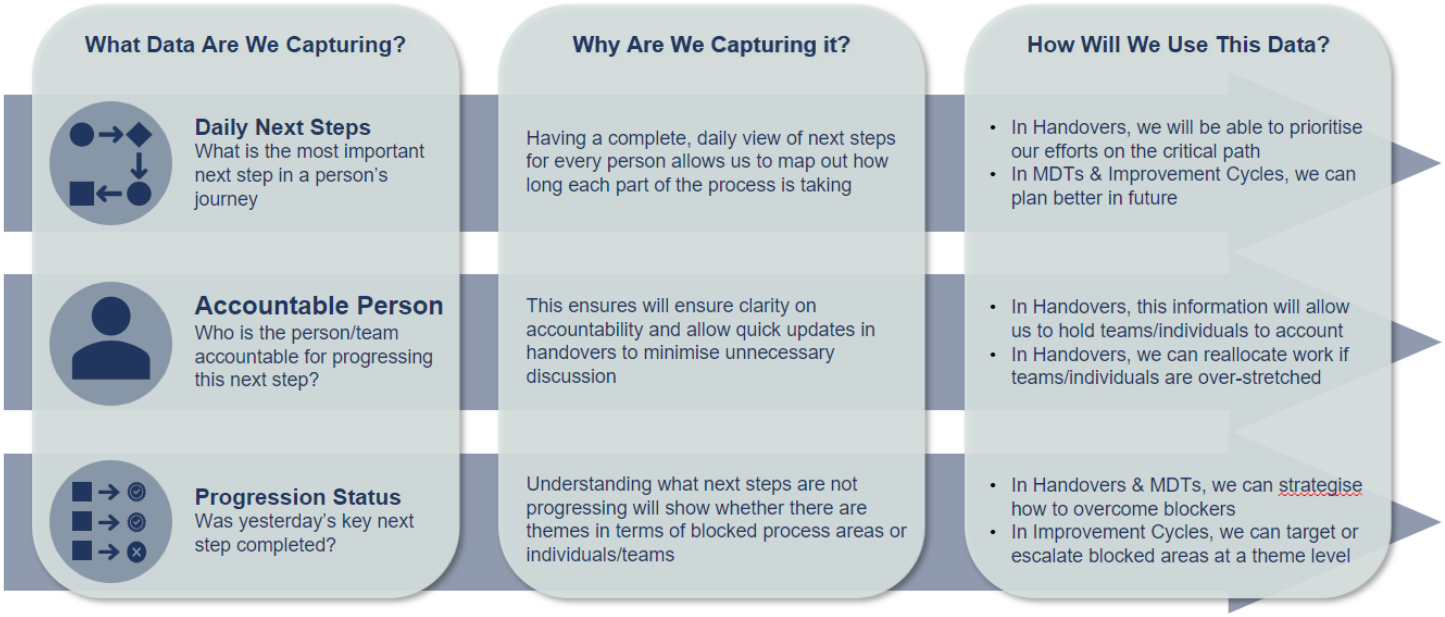
To support a Home First model in Leeds, the system needs the right bed-based care in the community for those who are not safe to be at home, and to support their recovery and journey back home. This project will review all types of non-acute short-term community beds (CCBs/step-down/short-term residential) and design the capacity, workforce, and ways of working required to give everyone in any bed the same chance of recovery. The project aims to reduce the length of time people spend in community bed settings and increase the number of people able to be supported home.

Progress Update

This project can be divided into two clear phases, optimise the current model for 2024 and designing a new, optimal model from 2025 onwards. The work for both is happening concurrently but the tasks can be clearly divided into one of the two phases.



Five new primary ways of working have been designed to optimise the current intermediate beds performance: MDT meetings, goal-based care, daily handovers, staff training and a suite of new meetings revolving around new dashboard which provide us with enhanced visibility of performance. Whilst some of these may seem like processes which were already happening, new structure has been applied to them and they will be rolled out consistently across all of the sites, regardless of the provider who manages that site. These new ways of working (some detail below) have been rolled out across two of the bed-bases, with the other five following in October.



Transfers of Care

Project Overview

The aim of the project is to review, improve and where necessary redesign transfer of care so that it is timely, safe, reduces delays and maximises independence for the patient. This work will involve the teams and services which coordinate people's journey out of hospital, ensuring full patient involvement, aiming to:

- Improve patient level tracking and visibility of discharge timelines and outcomes from acute and community settings.
- Review and reduce the number of triage points, assessments, and handovers in the discharge processes from acute and community settings.
- Standardise and redesign where necessary required discharge information and forms to minimise duplication and manual recording of information.

Progress Update

The project now has two concurrent ward-based pilots live, developing and iterating the following changes:

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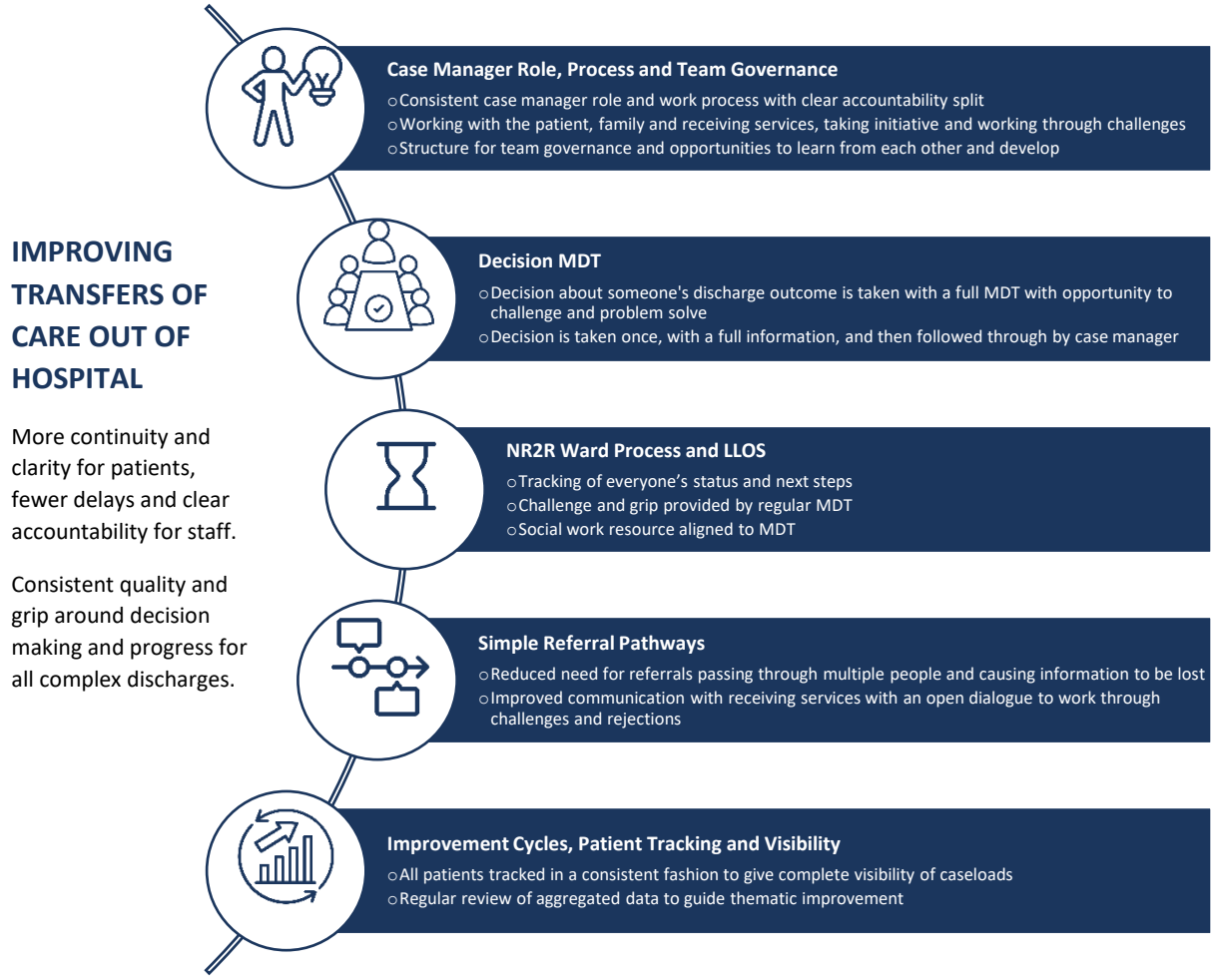
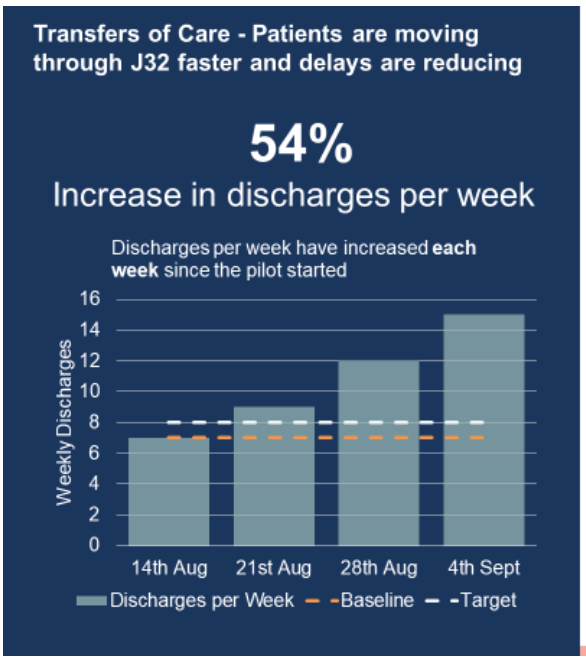
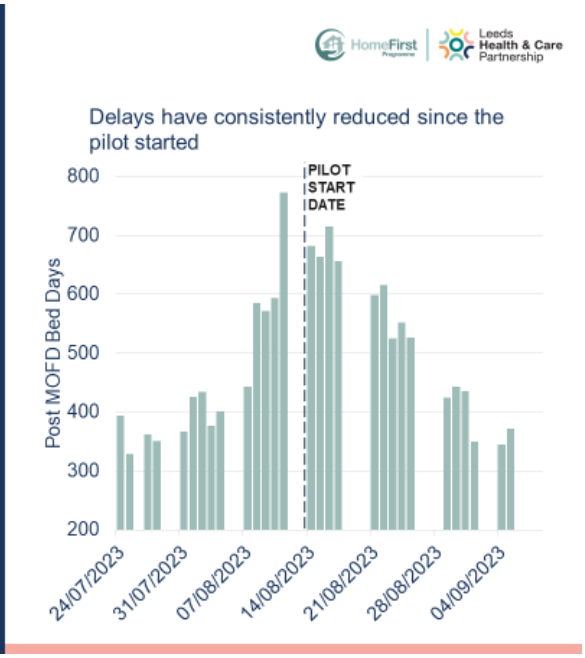
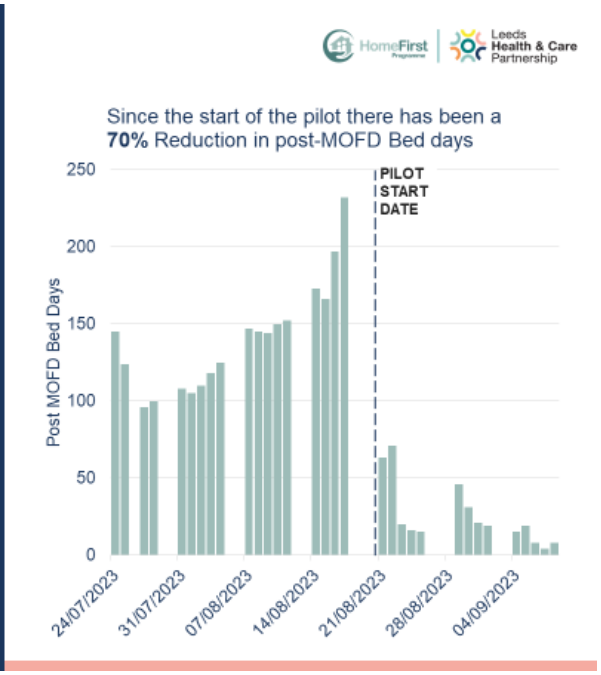


The first of these pilots is taking place in an NR2R ward (J32) and builds on prior work focussed on ward-based MDT working. This pilot is particularly focussed on minimising discharge delays. In the first few weeks of the pilot going live, we're seeing a really positive impact on discharges per week from the ward, as well as a positive impact on outcomes through MDT discussions.





The second pilot has just launched in J16, with a focus on discharge decision making and outcomes, as well as early discharge planning with the same aim of minimising delays. The following case study outlines some of the early impact we are seeing:



Enhanced Care at Home

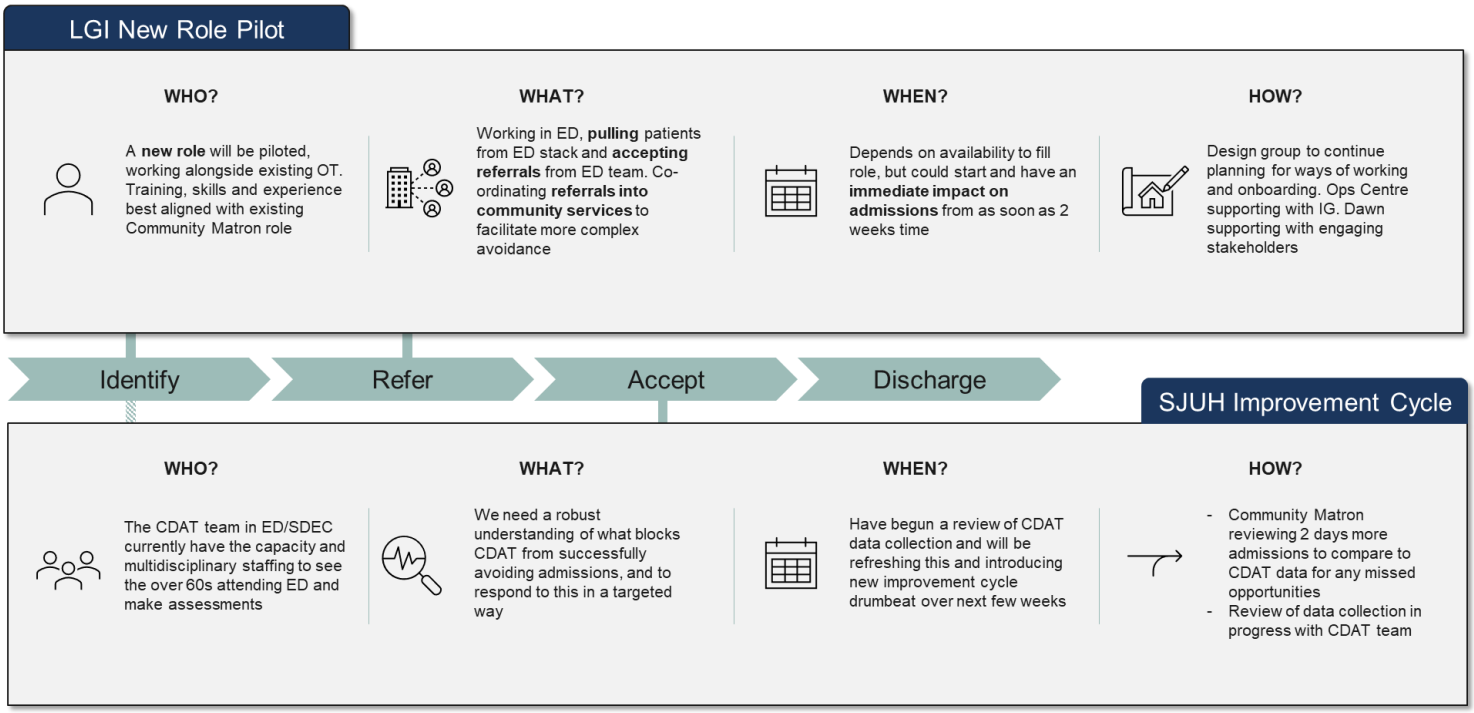
Project Overview

This project aims to develop fast and effective care outside of a hospital setting to safely reduce unnecessary admissions and help people to return home more quickly after receiving care in hospital. Enhanced Care at Home will increase the number of people accessing alternatives to acute attendance and admission by improving referral pathways from key intervention points.

Progress Update

A particular recent focus for the project team has been a series of studies to better understand the opportunities that exist to avoid admissions for patients (aged 60+) across both acute sites. Following these, the team have worked close with their design group to identify next steps that will allow us to better understand how we tackle these opportunities, with a pilot due to take place in LGI and improvement work to kick-off with CDAT and SDEC teams in SJUH.

Pilot Scope



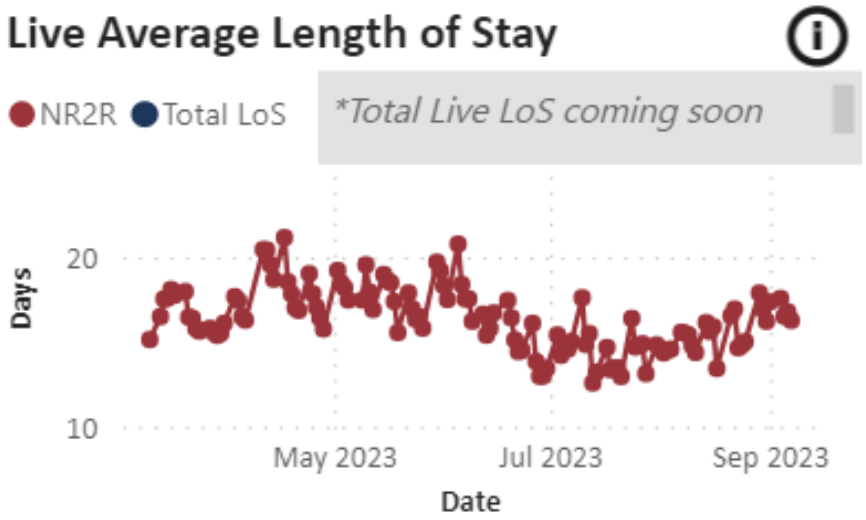
System Visibility & Active System Leadership

Project Overview

System Visibility is both an enabler to the Home First programme as well as a key product towards landing a sustained cultural change across Leeds. The system will move to using a single source of truth when it comes to reviewing the performance of services. This project will develop both the reporting suites and the governance structures to enable reviews and continuous improvement from system leadership to daily patient reviews.

Progress Highlights

The system level dashboard is now complete and in the process of being handed over to Leeds colleagues for BAU ownership. A weekly meeting looking at high level trends has been established and is at least partially responsible for seeing excellent progress in the NR2R queue and LoS

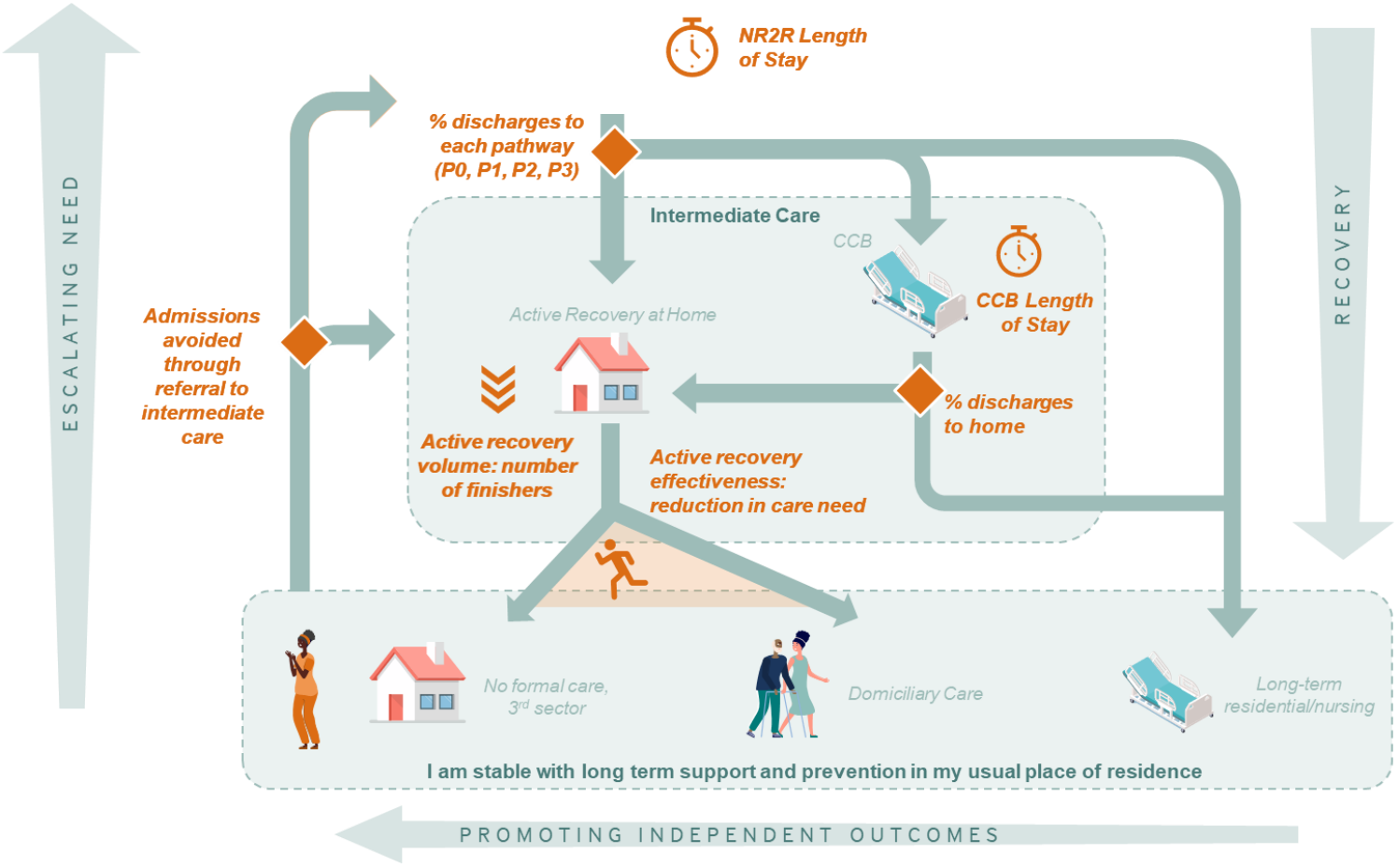


Service level dashboards have been created, allowing for a patient level view of what is happening in different services across the system e.g. Pathway 2 beds, reablement etc. Verbal agreement has been reached for how the Information Governance for this patient level data. Once formal agreement has been reached / papers have been signed, the patient level dashboards will be published. This will create an end-to-end suite of dashboards which will show high level trends and specific progress/issues with individual residents in the system. The final step will be to ensure that the right people are using these dashboards at the right frequency and that these various meetings have continuity between them, ensuring that there is a clear understanding of how individual patient decisions can impact high-level trends and vice versa.

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:



In order to understand the financial benefit associated with each operational improvement, the Finance & Benefits Realisation group has been formed, consisting of finance leads from each organisation. This group have the responsibility of ensuring that throughout the programme we are able to understand how much of each financial benefit has been delivered.

Project	Opportunity	Opportunity Description	Diagnostic Target Value	Stretch Target Value	Current Delivered
Active Recovery at Home	Reablement Throughput	Increasing the number of people that benefit from reablement before entering LT care.	£ 6.40m	£ 8.30m	-
	Reablement Effectiveness	Improving the effectiveness of reablement interventions, reducing ongoing care requirements.			-
	Reablement Overlap	Additional benefit due to the overlap of the two benefits above (improved outcomes for additional cohort).			-
		Project Total:	£ 6.40m	£ 8.30m	-
Rehab & Recovery Beds	Length of Stay	Releasing capacity in short-term beds through a reduction in length of stay.	£ 3.60m	£ 4.30m	-
	Outcomes	Reduction in ongoing care costs due to a decreased proportion of discharges to LT bed-based care.			-
		Project Total:	£ 3.60m	£ 4.30m	-
Transfers of Care	Hospital NR2R LoS	Releasing acute bed capacity through a reduction in discharge delays.	£ 4.10m	£ 6.30m	-
	Discharge Outcomes	Reduction in ongoing care costs due to an increased proportion of discharges directly home following hospital.			-
	Pathway 2 Reduction	Releasing capacity in short-term beds through a reduction in the proportion of Pathway 2 discharges.			-
		Project Total:	£ 4.10m	£ 6.30m	-
Enhanced Care at Home	Admission Avoidance	Releasing acute bed capacity through admissions avoided through use of intermediate care services.	£ 3.20m	£ 4.20m	-
	Hospital R2R LoS	Releasing acute bed capacity through step-downs from acute wards to intermediate care services.			-
		Project Total:	£ 3.20m	£ 4.20m	-
		Programme Total	£ 17.30m	£ 23.10m	-

For specific benefits (those that relate to releasing acute or short-term bed capacity), the group will also ensure that the system has the right plans in place to realise the financial benefit delivered. We are working towards having the financial tracking in place for each opportunity as outlined by the following roadmap: