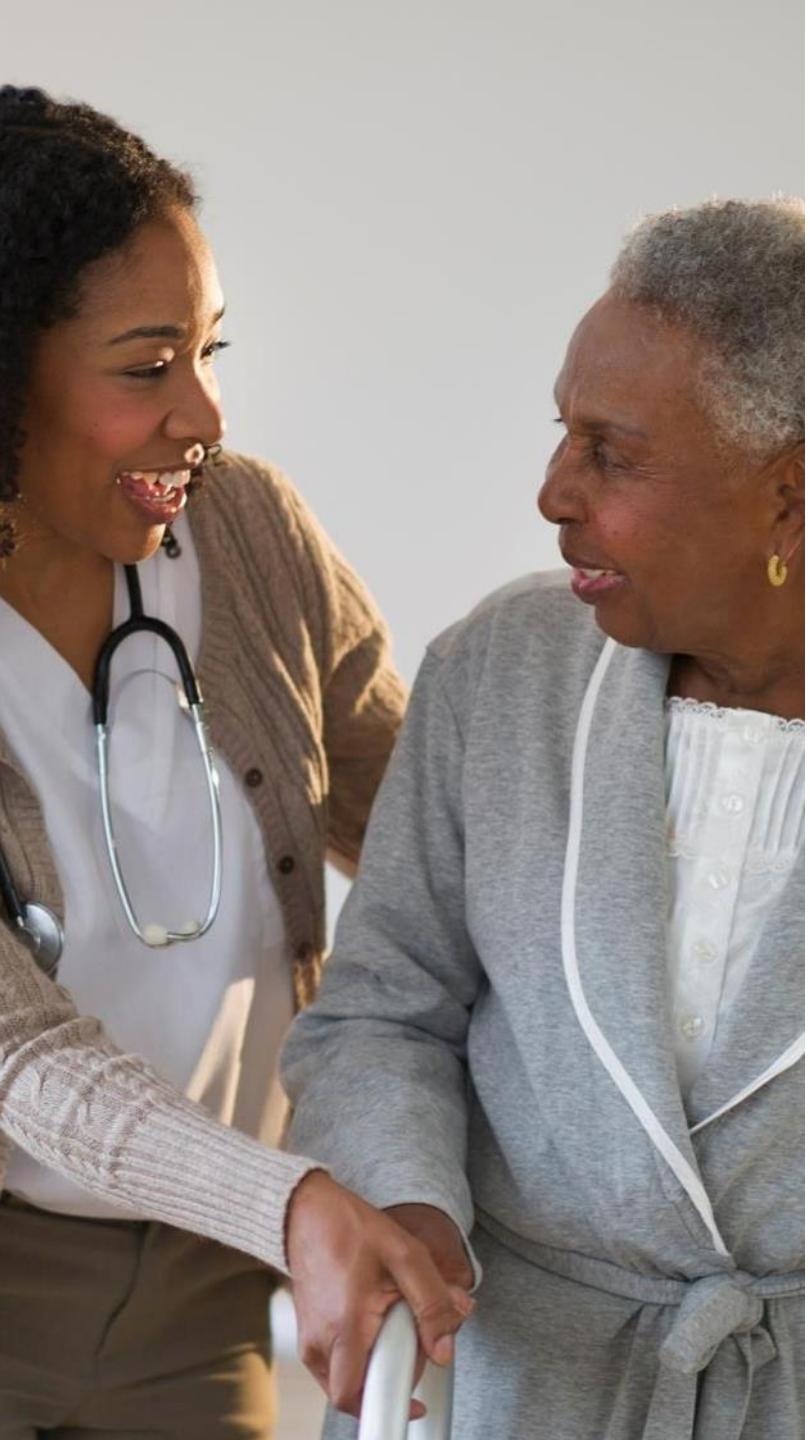
Leeds HomeFirst Programme

Transforming intermediate care through integration, partnership working and system visibility

HomeFirst Programme | Leeds Health & Care Partnership



Why redesign intermediate care?

- Too many people spend more time in hospital than they need to
- Our short-term care in the community is provided across many different services
- Outcomes for people can vary depending on where, when and how they are supported
- We have a high use of bed-based care
- Many older people could reduce or avoid the deconditioning that has an impact on their independence and long-term care needs

What does the evidence say?

- **400+ more people** every year could be supported to recover at home
- People spend up to **twice as long** as they need to in a community bed
- **1,700 more people** could avoid admission to hospital
- **100 long-term residential placements** could be avoided each year with effective, consistent intermediate care

How did we get here?

April 2022

Health and Care Partnership agree to undertake review of Intermediate Care Services

August 2022

Newton appointed to undertake diagnostic with a view to developing a transformation programme

September – November 2022
Intermediate Care Diagnostic

In-depth analysis of opportunities to improve outcomes from our intermediate care offer

November – December 2022

Feedback of diagnostic findings

Winter Resilience

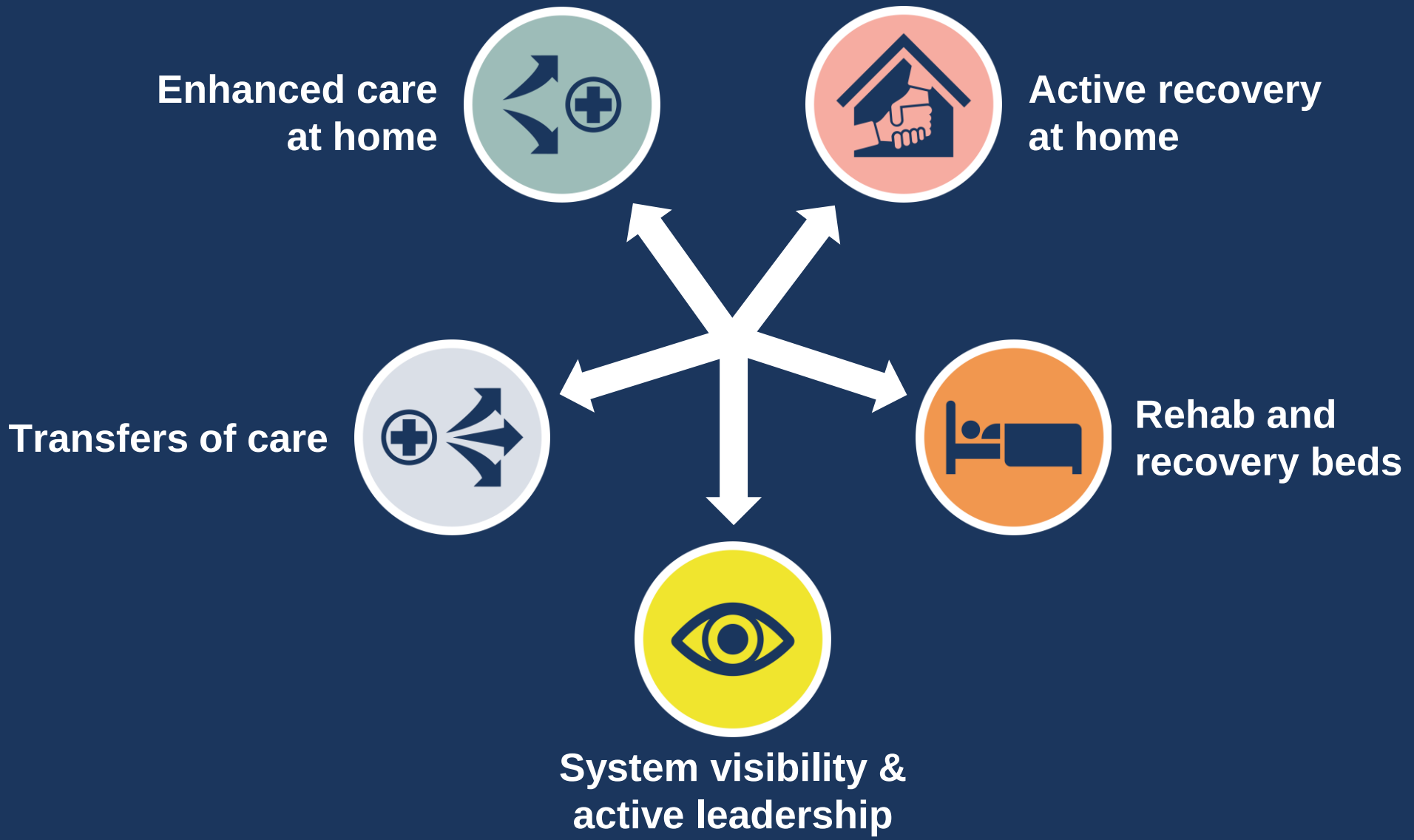
Priority activities to maintain system flow through winter

December 2022 – March 2023
Foundations

Designing the required transformation programme
Building digital and data foundations
Bringing together multiple teams and projects in the system
Setting up the programme team

April 2023 – Mid 2024
Design & Implementation

Five interdependent projects



System visibility shows everything from system trends to the next steps for residents

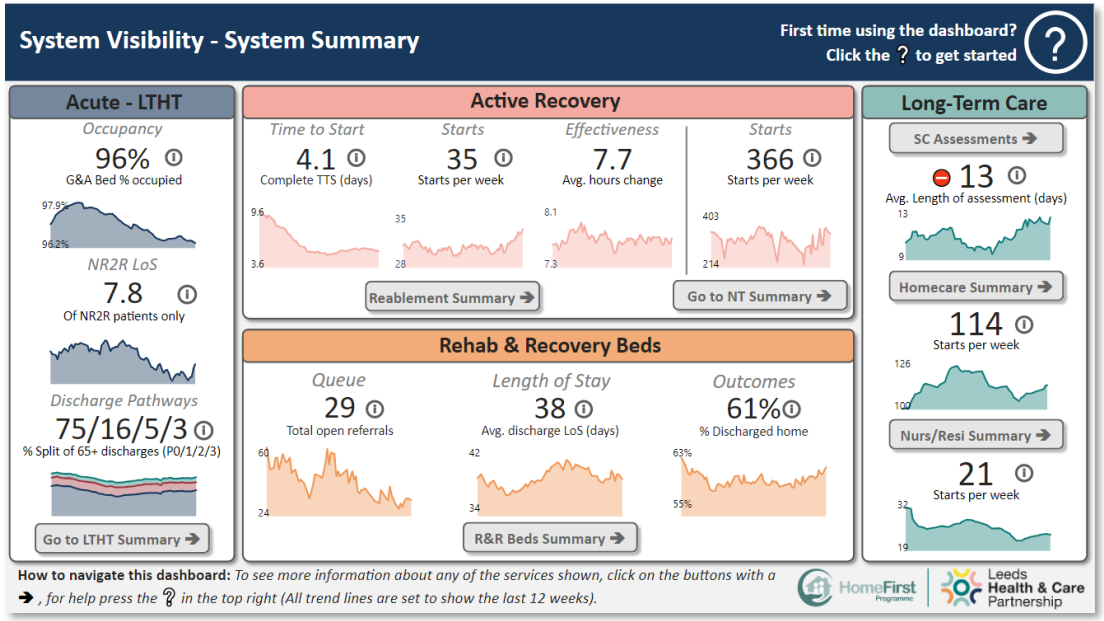
SYSTEM REPORT

- An overall **summary of system performance** and **pressures**
- To be used for **tactical weekly decision making** about how to **immediately support these pressures** and **monitor impacts over time**

SERVICE SPECIFIC REPORTS

- A **detailed** view of **service operations** down to a **caseload view**
- To be used as a **single joined-up view of caseload and performance** to allow for **service themes to be actioned** and individual patient **actions and next steps to be monitored**

EXAMPLE REPORT VISIBILITY



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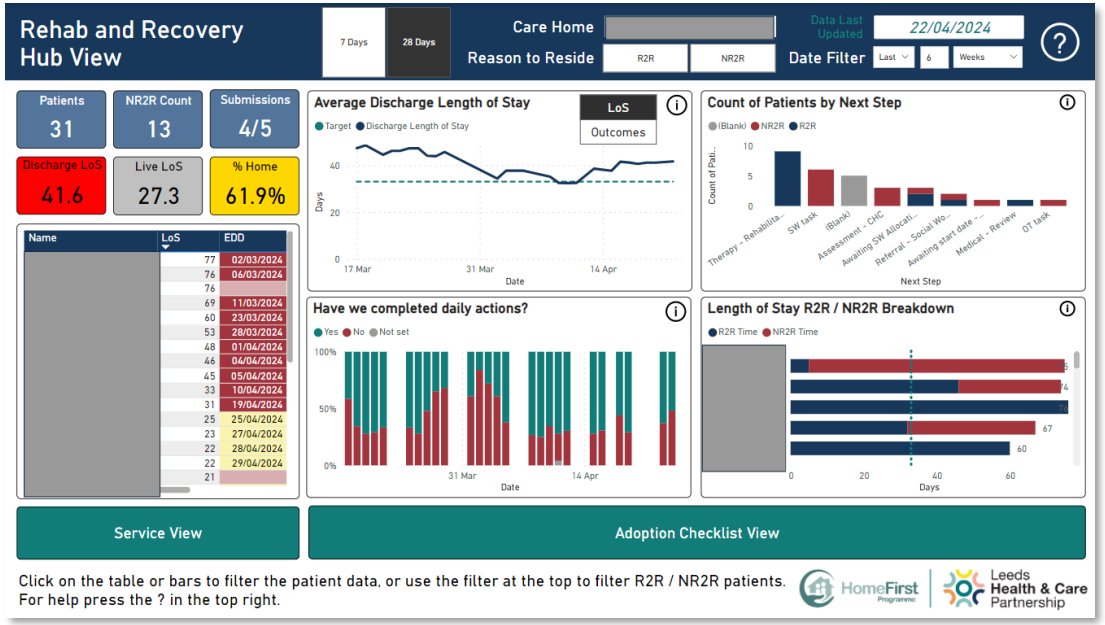
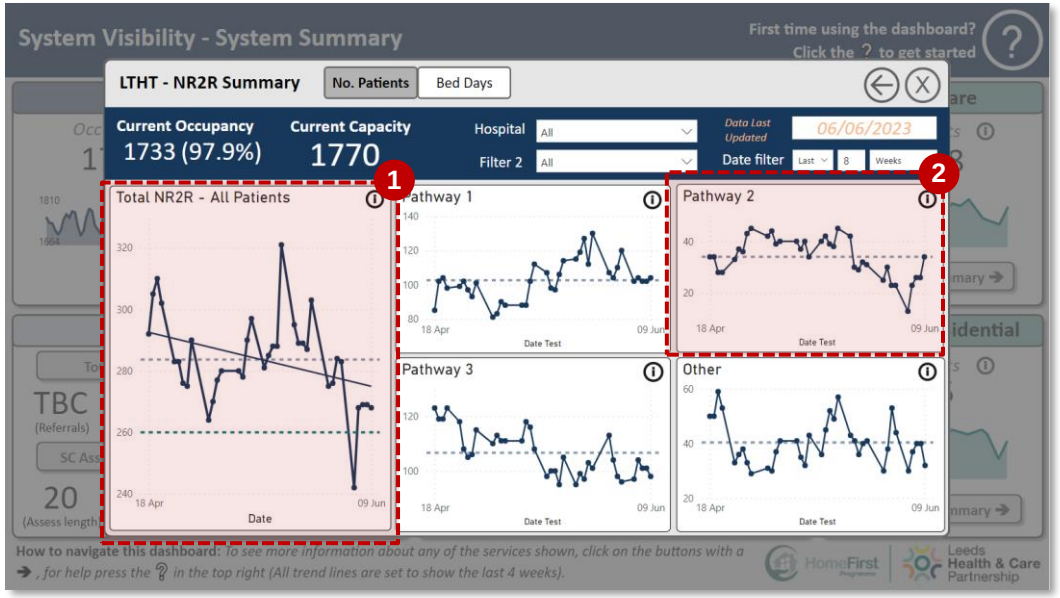
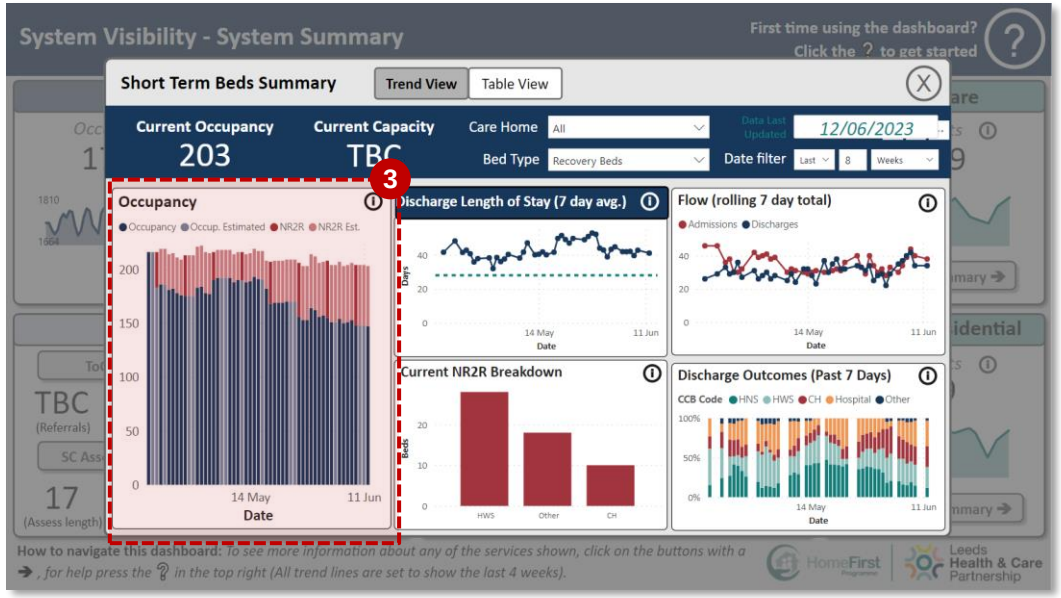
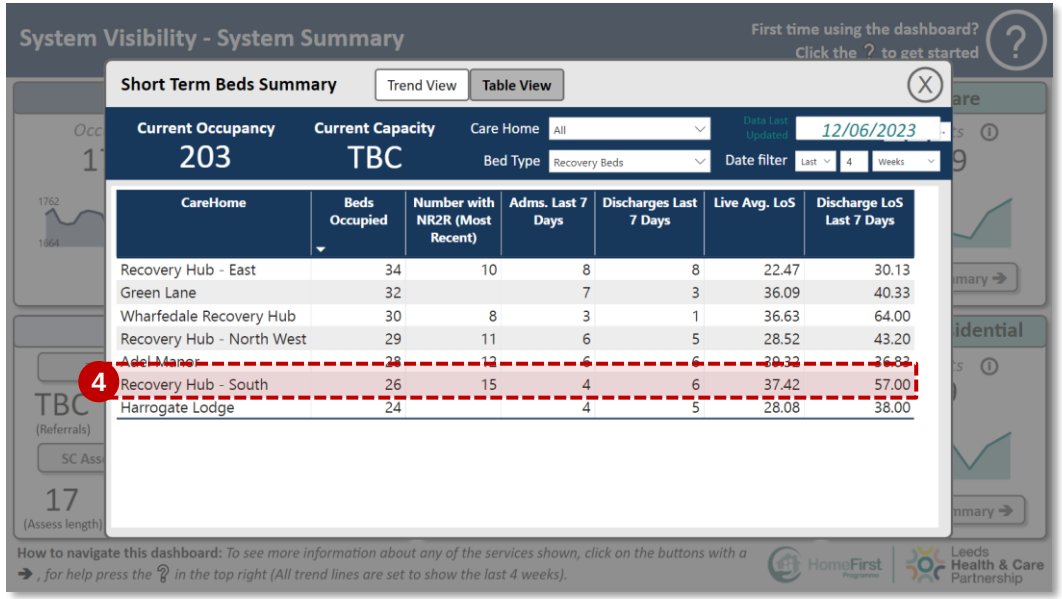


Case study short-term beds: Spotting delays early and taking targeting action







1. We can see our **current acute delays to discharge**, and how this has been **trending over the last four weeks**

2. By looking at the breakdown of delays we can see that there has been an uptick in the **pathway 2 queue size**

3. To understand how we support this we can view **our short-term bed performance** which shows **an increase in delays** there.

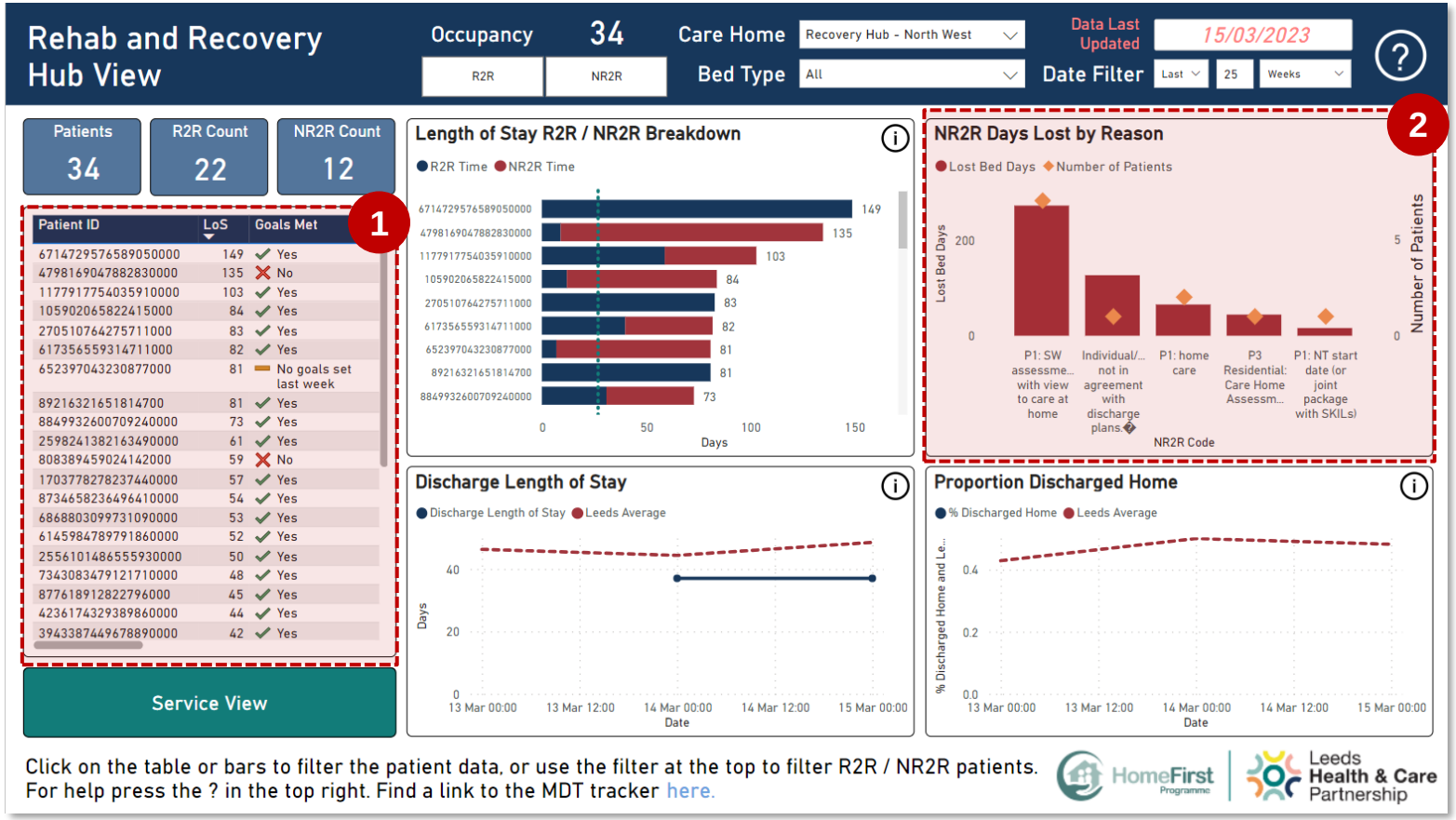
4. We can then view delays across our different sites to understand if there is a **specific site which requires further support**

Case study short-term beds: Spotting delays early and taking targeting action

To further understand what is driving the service pressure, frontline staff access the service report which goes down to patient level visibility.

The example shown is the service report for our community beds

1. **Individual patient goal progression & next steps**
2. **Common reasons for delay**

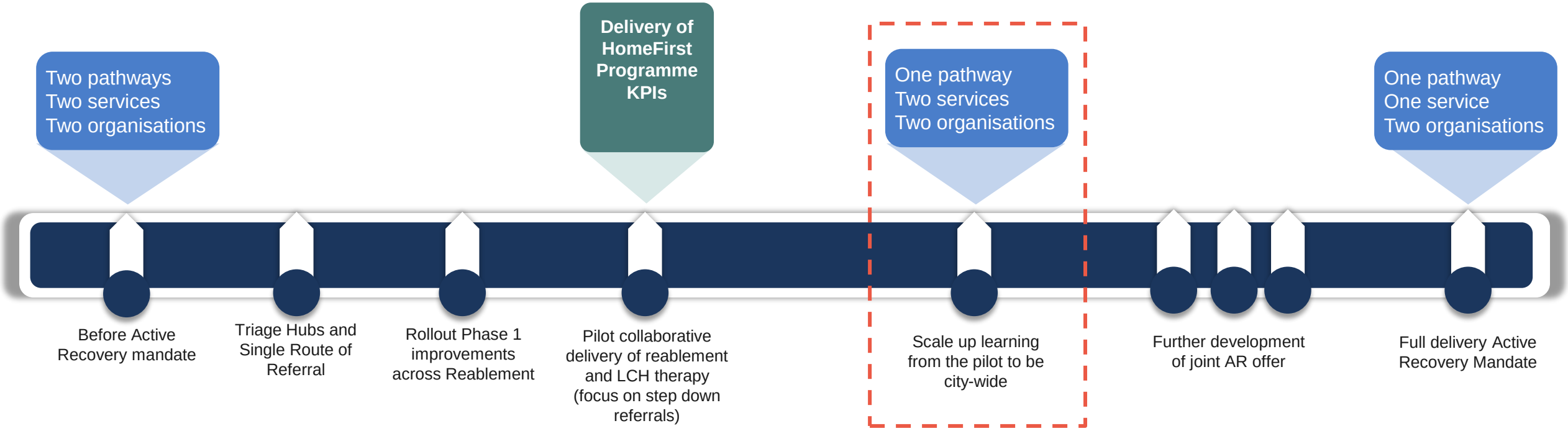


DUMMY DATA VERSION OF SERVICE LEVEL BEDS REPORTING

Active recovery – the journey so far…

Project aims

The Active Recovery project aims to develop a **single short-term home-based rehabilitation and recovery** offer with the required **capacity** and approach to support more people at home and to support people to achieve more **independent outcomes.**



Supporting more people to more independent outcomes

SMART Goal-Based Care supported by a progression tracker

Streamlined communication of a person's progress towards person-centric independence goals to allow timely step downs and interventions, and a more personal care journey.

MDT meetings supported by an MDT tracker

Weekly caseload reviews with multiple healthcare professions to ensure the individual has the right support to achieve the best outcome in a timely manner. Capturing actions with named accountability and target completion timeframes.

Daily huddles supported by a scheduling tool

Daily handovers to maximise staff resource assigned for assessments and exits, and to drive accountability in actions agreed to progress individuals towards independence.

Active Leadership and Improvement Groups supported by a dashboard

Simple data visualisation and structured meetings to help leadership understand the biggest blockers to capacity and outcomes, and where to direct their support.

Balancing of teams supported by a support worker distribution model

Simple, accessible data to support targeted actions to balance rotas and match staffing capacity to demand.

Active recovery at home

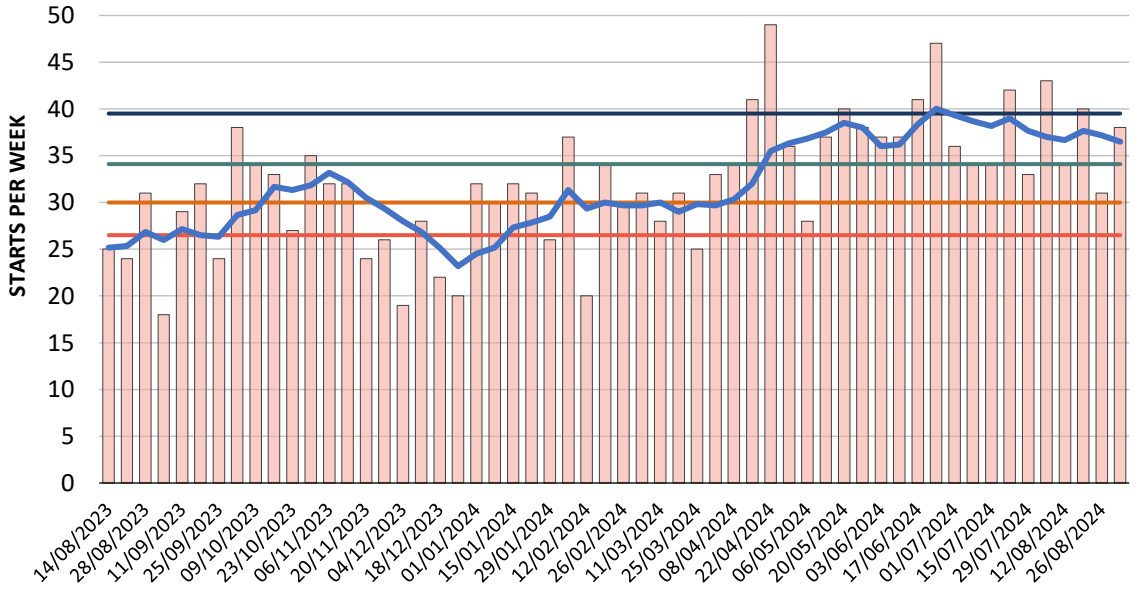
Starts definition: total number of starts per week across the reablement service. Current performance is defined as the **six-week moving average.**

Effectiveness definition: average reduction in ongoing homecare need (in hours per week) achieved through the reablement intervention. Current performance is defined as the **eight-week moving average.**

STARTS — Whole Service Performance — EFFECTIVENESS

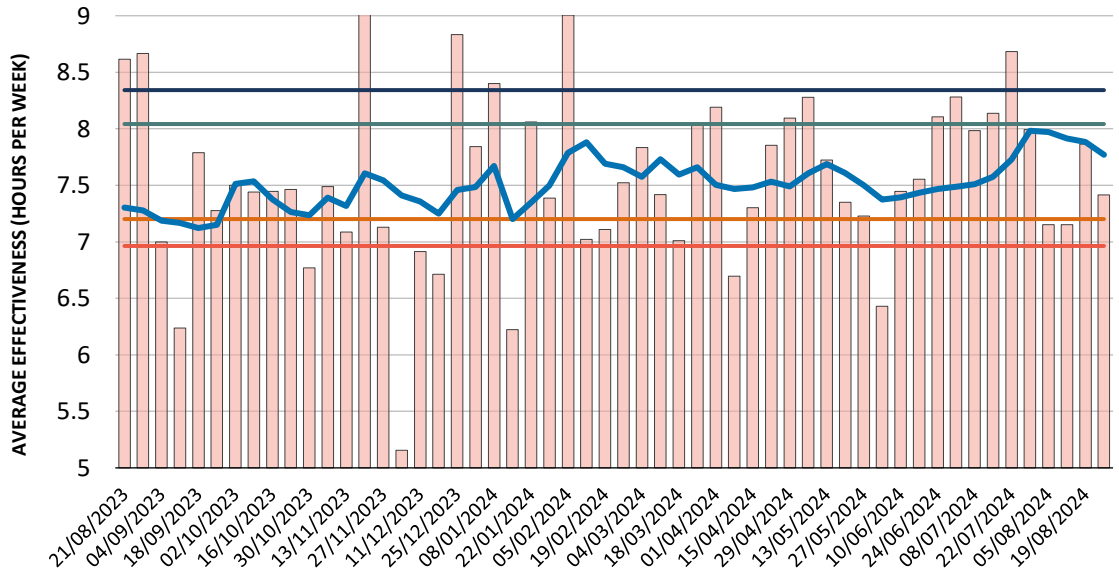
STARTS

Baseline Value	Current Value	Target Values	
26.5	36.5	30.0	Low Case
Starts per Week	Starts per Week	34.1	Mid Case
		39.5	High Case
		Starts per Week	



EFFECTIVENESS

Baseline Value	Current Value	Target Values	
6.96	7.77	7.20	Low Case
Hours per Week	Hours per Week	8.04	Mid Case
		8.34	High Case
		Hours per Week	



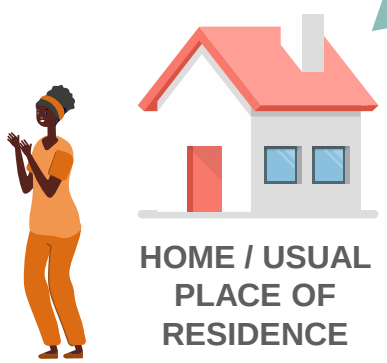
Key: Current Baseline Low Case Mid Case High Case

Programme Overview
What is the impact we are seeing?

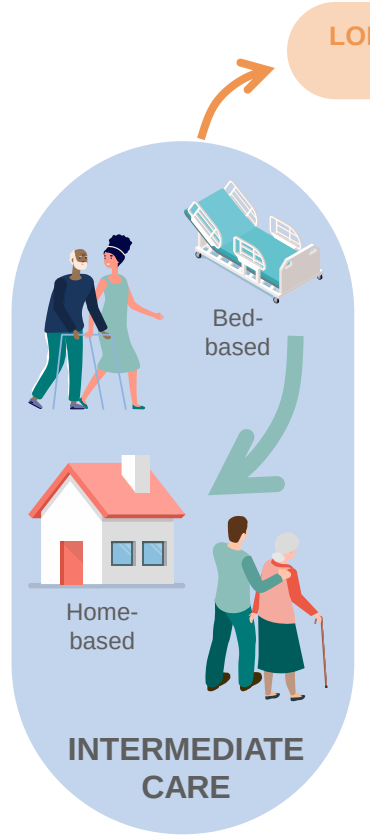
As of programme performance in September 2024.

169 more people able to go home after their time in intermediate care, instead of a long-term bedded care per year

8.2 day reduction in the average length of stay in short-term beds



HOME / USUAL PLACE OF RESIDENCE



ACUTE HOSPITAL

786 fewer adults admitted to hospital each year

421 more people going directly home each year after their stay in hospital, instead of a bedded setting

31% reduction in NR2R length of stay for patients requiring support on discharge

522 additional people benefitting from reablement each year

This performance translates to **£23.7m** per annum of financial benefit to the system. These benefits are spread across system partners and are a combination of cost-out, future cost avoidance, or investment in quality.

Q&A

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