The Leeds Teaching Hospitals NHS Trust

HomeFirst Progress Update
Public Board
28th March 2024

Presented for:	Information
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Previous Committees:	NONE

Our Annual Commitments for 2023/24 are:	
Effectively develop and deploy new assets (buildings, equipment, IT)	
Reduce healthcare associated infections	
Improve staff retention	
Deliver the financial plan	ü
Reduce average length of stay by 0.5 days per patient	ü
Achieve the Access Targets for Patients	ü
Support a culture of research	

Risk Appetite Framework				
Level 1 Risk	(ü)	**Level 2 Risks**	**(Risk Appetite Scale)**	**Impact**
Workforce Risk		Choose an item.	Choose an item	Choose an item.
Operational Risk	ü	Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Minimal	Moving Towards
Clinical Risk		Choose an item.	Choose an item	Choose an item.
Financial Risk	ü	Change Risk - We will deliver change aligned to the Trust's strategy on time and to budget with benefits achieved and no significant adverse impacts, focussing on the delivery of large-scale capital developments and waste reduction programmes.	Minimal	Moving Towards
External Risk	ü	Partnership Working Risk - We will maintain well-established stakeholder partnerships which will mitigate the threats to the achievement of the organisation's strategic goals.	Minimal	Moving Towards

Key points	
1. This report provides a six-monthly progress update on the Leeds Health and Care Partnership HomeFirst Programme. 2. LTHT is a core partner in the HomeFirst Programme which is improving the Leeds intermediate care offer	For Information

Summary

This paper provides a six-monthly update for the Board on the progress and delivery of the Intermediate Care (HomeFirst) Programme.

These updates had originally been requested to be presented to LTHT Board following discussions at the Partnership Executive Group (PEG) and Executive Team Meetings to provide an updated position of the Home First Programme which LTHT are a lead provider. The last update was previously presented at September 2023 Trust Board. Professor Phil Wood, CEO is the Senior Responsible Officer (SRO) for this programme. Updates have been provided to PEG and the city Health and Wellbeing Board and are also provided to other provider Boards across the city.

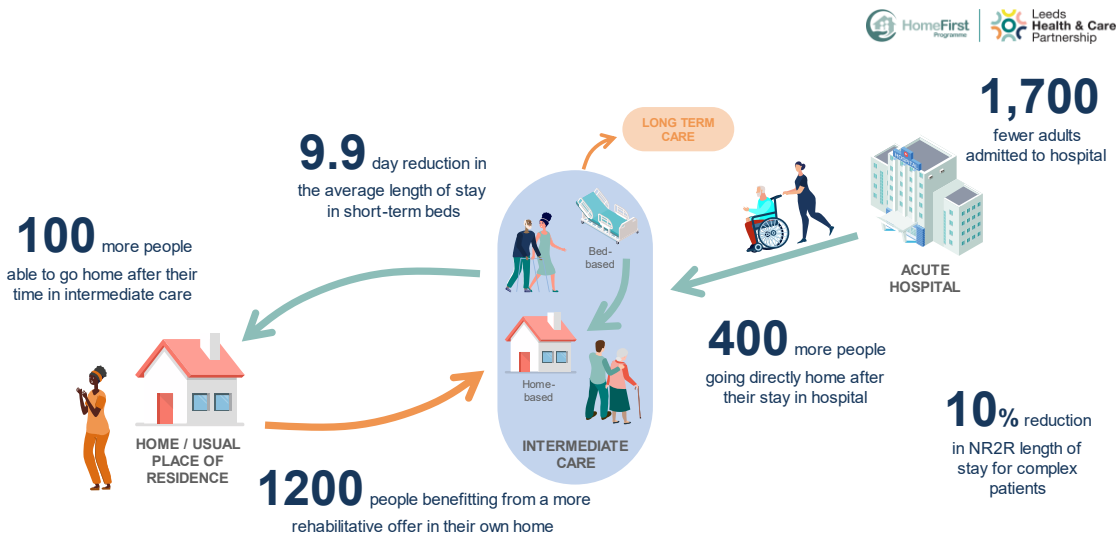
Background and Overall Progress Update

Leeds Health and Care partners agreed to contract Newton Europe to support delivery of the programme for an 18 month period (until March 2025), with funding distributed between Leeds City Council, Leeds Community Healthcare Trust and LTHT. This work follows on from the intermediate care diagnostic carried out in Autumn 2022 by Newton Europe, with the programme aiming to address the opportunities identified. The HomeFirst Programme aligns several existing transformation initiatives (including Active Recovery, the System Flow Programme, and Enhanced Care at Home).

The HomeFirst Programme continues to develop and implement a new model of intermediate care services to achieve more independent and safe outcomes, helping more people to stay at home, whilst improving the experience for people, carers, and staff. The vision is to achieve a sustainable, person-centred, HomeFirst model of intermediate care across Leeds that is joined up and promotes independence.

The HomeFirst Programme commenced in August 2022 to transform the model of intermediate care for the city and in doing so significantly improve the efficiency and effectiveness of services. It is being delivered by a joint team of staff from across the Health and Care provider organisations in the city, the West Yorkshire Integrated Care Board and is supported by our transformation partner Newton.

The HomeFirst Programme has been set out to achieve the following outcomes for the Leeds Intermediate Care System by the end of the Programme, which is currently anticipated to be mid-2024.



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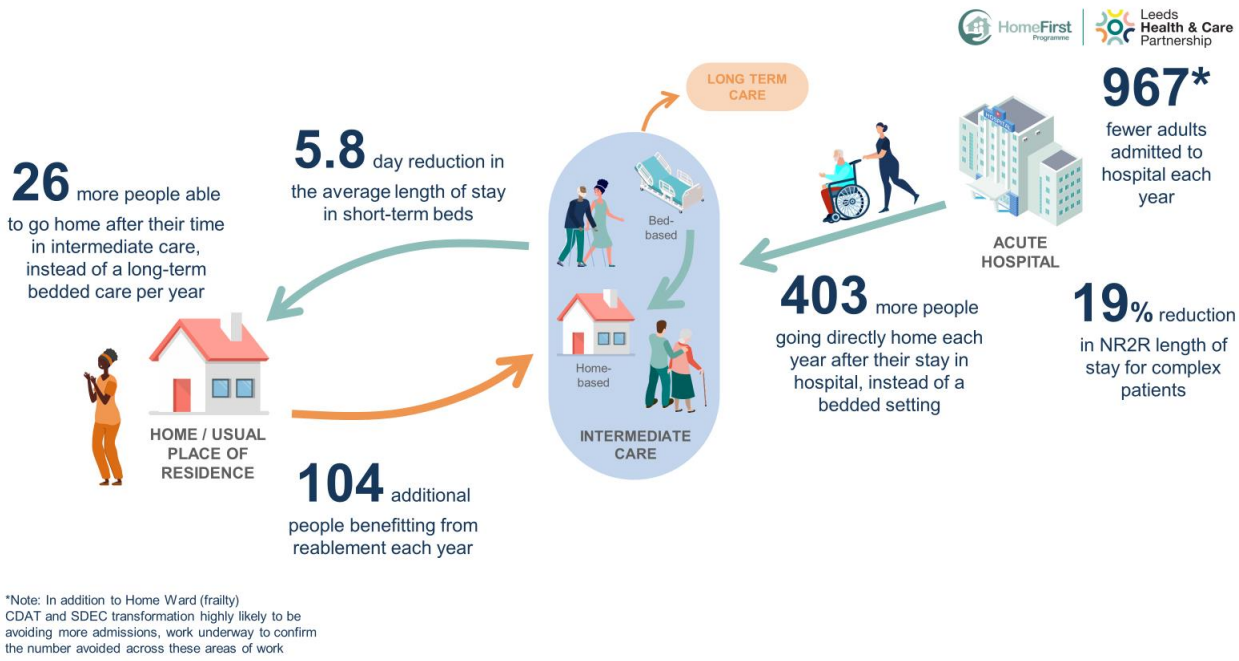
Progress is measured through agreed Programme Key Performance Indicators:

Project	KPI	Definition	Units
Active Recovery at Home	Reablement Throughput	Total number of starts per week across the reablement service.	Starts per Week
	Reablement Effectiveness	Average reduction in ongoing homecare need achieved through the reablement intervention.	Hours per Week
Rehab & Recovery Beds	Length of Stay	Length of stay at discharge for all patients leaving short-term beds.	Days
	Outcomes	Proportion of successful discharges (excluding readmissions) that are discharged home instead of a long-term bedded setting.	-
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
	Discharge Outcomes – P3	Proportion of 65+ discharges, discharged down Pathway 3.	-
	Discharge Outcomes – P2	Proportion of 65+ discharges, discharged down Pathway 2.	-
	Discharge Outcomes – P1	Proportion of 65+ discharges, discharged down Pathway 1.	-
	Discharge Outcomes – P0	Proportion of 65+ discharges, discharged down Pathway 0.	-
Enhanced Care at Home	Admission Avoidance	Admissions avoided through additional referrals to preventive services from the acute front door.	Admissions per Week

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

Across the programme, we have developed ways of working, processes, workforce, and culture that have been carefully designed with experts from across services and organisations. The changes have then been tested, piloted, and iterated based on the measurable impact they have on the programme KPIs, as well as feedback from staff and patients/service users. Following this, we have now shifted focus to scaling up the new models of care and support across the system and services. In some projects, these changes have been fully rolled out and the project teams are focussing ensuring the improvements seen are sustained as Business as Usual. In other projects, there is still significant work left to do to rollout the new ways of working.

As of March 2024, this is how the system is performing against these targets as shown below. The February financial run rate for programme is currently the equivalent of £13.8m. This is 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).



At March delivery against overall Programme targets is tracking above the low case target, largely driven by improvements in hospital no reason to reside length of stay. Some areas of the Programme are behind trajectory for delivering sustainable improvements in performance. There are several reasons for this, for example requirement for additional support from the Programme Team for local leadership teams to ensure sustainability of culture change in reducing rehab and recovery bed length of stay, challenges in staff availability in key roles e.g. Case Officer capacity in our Reablement service, requirement to ensure collaborative agreement to deliver joint transfer of care model. Action plans are in place to bring performance back on track with additional assurance requested by the HomeFirst Programme Board to increase confidence in pace and robustness of delivery.

Project areas

The HomeFirst Programme is delivered through five interdependent projects:

1. **Active Recovery at Home**

This project is developing 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.

The project has implemented a series of improvements initially developed in one part of the city and then rolled out citywide from January 2024. The team have also designed and tested a joint delivery offer bringing together a multidisciplinary approach, with the new model ready for citywide rollout later in the year.

2. **Rehab & Recovery Beds**

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. The project is reducing the length of time people spend in community bed settings and increasing the number of people able to be supported home.

The new ways of working are now live and having an impact across the six intermediate bed base. Length of stay has reduced by over a week, and we have also hit the low-case target for percentage of people being discharged home. Following a successful trial, Adult Social Care (ASC) have agreed

to formally move to the dedicated social worker model with ASC delays reducing significantly and this will help ensure we continue to hit the programme KPIs now and in the future.

We are now moving into the sustainability phase, offering light-touch support to each bed base as we transition to the ownership and monitoring of the KPIs to the local management team at each site. The Programme Team are inputting into a draft specification to support commissioning of short-term intermediate care beds, with the new model in place from April 2025.

3. Transfers of Care

This project is reviewing, improving, and redesigning transfers of care so that it is timely, safe, reduces delays and maximises independence for people. This work is initially focussed on involving the teams and services that coordinate people's journey out of hospital, ensuring full patient and carer involvement.

These new ways of working have been piloted in several wards in the Gledhow Wing and rolled out across the Beckett Wing. The results seen to date in this pilot have been hugely positive, with great feedback from the frontline staff involved. Across December and January, two summit events have been held to bring together senior leaders across the system to finalise this future model and agree the role of each organisation required to deliver. An interim leadership Team, consisting of colleagues from LTHT, Leeds Community Healthcare NHS Trust (LCH) and Leeds City Council (LCC), has now been identified to take forward the implementation of this model. The team are now focussed on scaling up across all wards in the Speciality and Integrated Medicine Clinical Services Unit (CSU) by the end of May.

4. Enhanced Care at Home

This project is developing fast and effective care outside a hospital setting to safely reduce unnecessary admissions and help people to return home more quickly after receiving care in hospital. The project is increasing the number of people accessing alternatives to acute attendance and admission by improving referral pathways from key intervention points.

The number of people accessing the Home Ward (frailty) service continues to increase, with a record week seen at the end of January when 60 people started on the Home Ward (frailty). New ways of working and visibility have been introduced to the Community Discharge Assessment Team (CDAT) at St James's Hospital with the aim of increasing the amount of people who can benefit from CDAT support, ultimately reducing the number of people who are admitted to hospital. The team is also working closely with the LTHT Same Day Emergency Care (SDEC) team in context of recent changes to this model to understand how service elements fit together to best impact on people's outcomes. Once this work is complete (anticipated to be by mid-April 2024), we will be able to report more fully on the impact and value of these changes in totality.

5. System Visibility & Active System Leadership

System Visibility is both an enabler to the HomeFirst 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 has developed both the reporting suites and the governance structures to enable reviews and continuous improvement from system leadership to daily patient reviews.

The system level dashboard is now complete and in the process of being handed over to Leeds colleagues for BAU ownership. The Integrated Care Board's Leeds Office of Data Analytics will host the dashboard with data flows from partner organisations, including LTHT.

Blueprint for Intermediate Care

From its inception, the HomeFirst Programme has sought to design test and deploy a sustainable model of intermediate care for Leeds that delivers against the following ambition: *A sustainable, person-centred, home-first model of intermediate care across Leeds that is joined up and promotes independence.*

It was recognised that delivering this ambition would be achieved over several years, with the initial phase of work focus on achieving improvements in outcomes, experience, and flow in the short term.

The requirement and desire to transform intermediate care in the city was understood against a backdrop of rising demand, constrained capacity and backlogs being experienced by people in our system over the preceding 3-5 years. In addition, demographic changes likely to play out over the course of the next decade will significantly increase these demand pressures.

Work is being led by the HomeFirst programme with representatives from each provider and the Integrated Commissioning Board to produce the Blueprint that could be the roadmap for how the system can respond to the challenges it will face to deliver its ambition for intermediate care services over the next five -10 years.

Proposal

The Board are asked to receive and note the paper for information.

Financial Implications

There are no new financial implications associated with the contents of this paper.

LTHT contributed £650,000 to the first year of the work provided by Newton Europe. The HomeFirst programme vision has been set out: A sustainable, person-centered, Home First model of intermediate care across Leeds that is joined up and promotes independence.

This culminates in an ambition in the current Programme to improve outcomes for over 3000 Leeds residents each year, resulting in an annualised financial saving between £17.3M to £23.1M. In order to understand the financial benefit associated with each operational improvement, a Finance and 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 track delivery of each financial benefit and to connect with organisation and system plans for realising those benefits where additional decisions and actions are required.

Risk

There are no new risks identified related to the contents of this paper.

The Board Committee provides assurance oversight of the Trust's most significant risks, which cover the Level 1 risk categories (see summary on front sheet). Following discussion at the Board Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories and the Trust continues to operate within the risk appetite for the Level 1 risk categories set by the Board.

All risks identified have been marked with a minimal risk appetite, with an impact of moving towards. This is to highlight the importance of our progress in this programme and to highlight the positive impacts it creates for our system, staff and patients.

Communication and Involvement

The HomeFirst Programme has developed communication and involvement plans collaboratively, with people from our health and care system, including third sector and citizen volunteer support.

There is consistent use of 'I Statements' created from existing insight to place what people want from services at the centre of the programme's plans. Focus groups have been formed including interviews with staff, service users and carers to understand what matters to them.

Publication Under Freedom of Information Act

This paper is exempt from publication under Section 36 of the Freedom of Information Act 2000, as it contains information which are in early stages of strategic thinking and contain discussions about future public consultations.

Recommendation

The Board are asked to receive and note the paper for information.

Megan Rowlands, Programme Director, Leeds Health and Care Partnership
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March 2024