HomeFirst

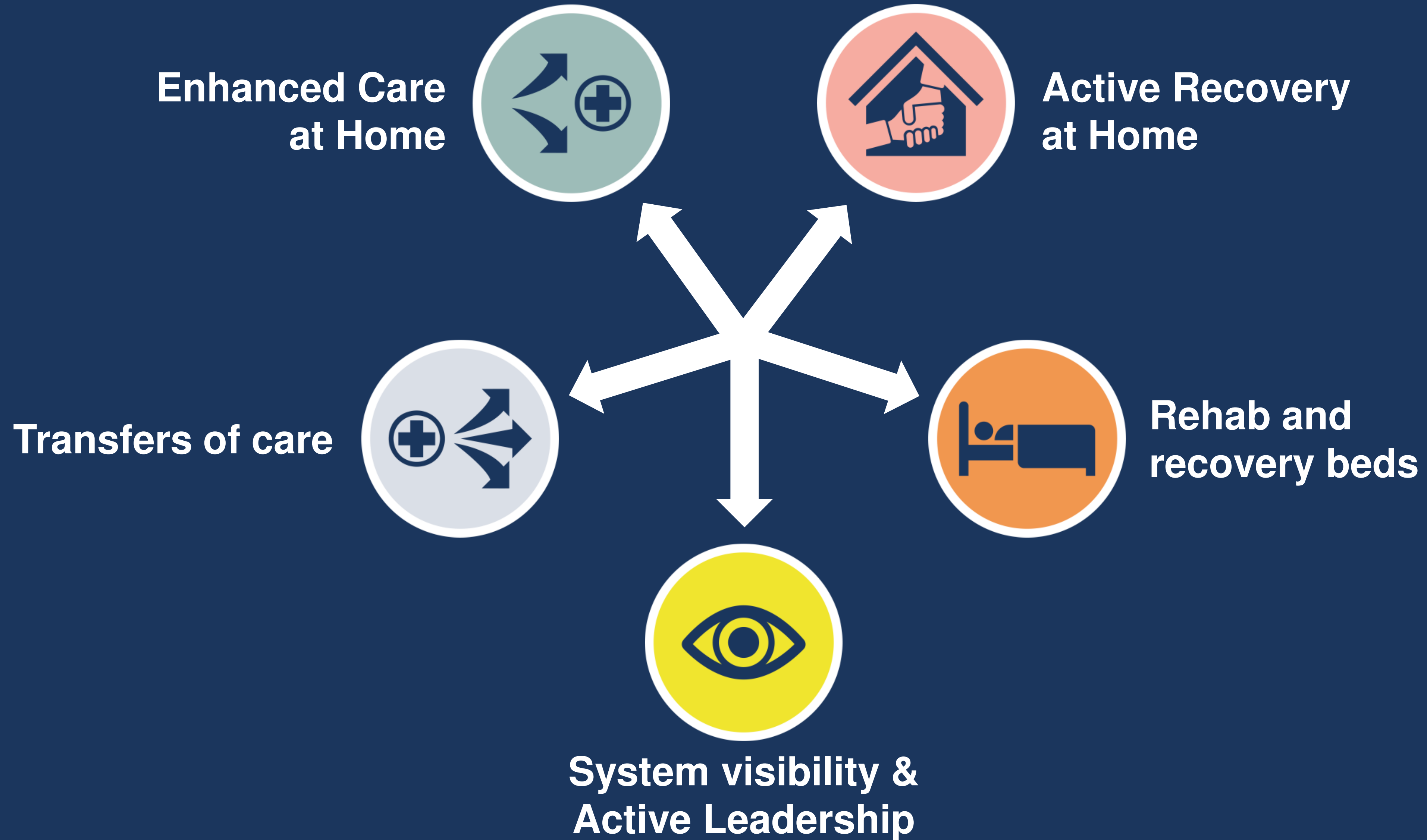
Why redesign intermediate care?

- Too many people spend more time in hospital than they need to
- There are too many people in LTHT that are not receiving acute care (NR2R)
- As a city we do not maximise a Home First approach
- As a city have a high use of bed-based care which can impact on patient outcomes
- Many people living with frailty could reduce or avoid the deconditioning that has an impact on their independence and long term care needs

What does the evidence/diagnostic (Sept 22) 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 at home or in short term beds

5 Interdependent Projects



Transfers of Care

There is an opportunity for improving the discharge service in Leeds

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8.4 days

The average NR2R Length of Stay for patients who needed supported discharge

This has led to 300+ NR2R patients waiting in hospital

1 in 10 patients

Are not going home upon discharge.

This is twice the national guidance.

How we measure success

Success for Patients:

- Reduced NR2R length of stay
- More patients going home (P0/P1)
- Patient feedback survey

Success for Staff:

- Collaborative working , reduction in time spent chasing
- Team Leeds
- Staff feedback survey

We supported the new process by focussing on five areas

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IMPROVING TRANSFERS OF CARE OUT OF HOSPITAL

More continuity and clarity for patients, fewer delays and clear accountability for staff.

Consistent quality and grip around decision making and progress for all complex discharges.

Case Management Function, Process and Team Governance

- Consistent case management function and work process with clear accountability and support for discharge coordinators
- Working with the patient, family and receiving services, taking initiative and working through challenges
- Mixed-model with different expertise delivering the function and the team governance that creates opportunities to learn from, and develop, each other

Decision MDT

- Decision about someone's discharge outcome is taken with a full MDT (including ASC and therapy) with opportunity to challenge and problem solve
- A Decision is taken once, with full information, and followed through by case manager

Patient Tracking and Caseload Reviews

- Tracking of everyone’s status and next steps to ensure we do not lose days of progression through lack of grip
- All next steps have owners and due dates and are reviewed regularly to check that every patient has a plan
- Regular prioritised reviews of the caseload to escalate challenges and spot any areas for additional support

Simple Referral Pathways

- Reduced need for referrals passing through multiple people and risking information loss
- Improved communication with receiving services with an open dialogue to work through challenges and rejections

Improvement Cycles and Visibility

- All patients tracked in a consistent fashion to give complete visibility of caseloads and flow
- Visibility of queues, aggregated delay reasons and the steps in the process contributing to the longest waits
- Regular retrospective review of aggregated data to target thematic improvement to the most impactful areas

Patients are being discharged faster and to more independent outcomes in our pilots

SIM

NR2R Length of Stay

7.4 days

*Baseline: **10.7***

% of Discharges Home

83.3%

*Baseline: **80.1%***

Whole Service

NR2R Length of Stay

6.0 days

*Baseline: **8.4***

% of Discharges Home

91.8%

*Baseline: **90.8%***

Residential and Nursing starts per week

3.2

*Baseline: **4.5***

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

A patient was desperate to get home and had been MOFD 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 MDT to provide some innovative problem solving, they **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 was sent 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.

Staff Feedback

Case Manager

"I enjoy getting to spend more time with patients and feel like I can make a real impact on improving someone's life"

"I can see the merits within the whole system; the concept works and the benefits are present"

Discharge Coordinator

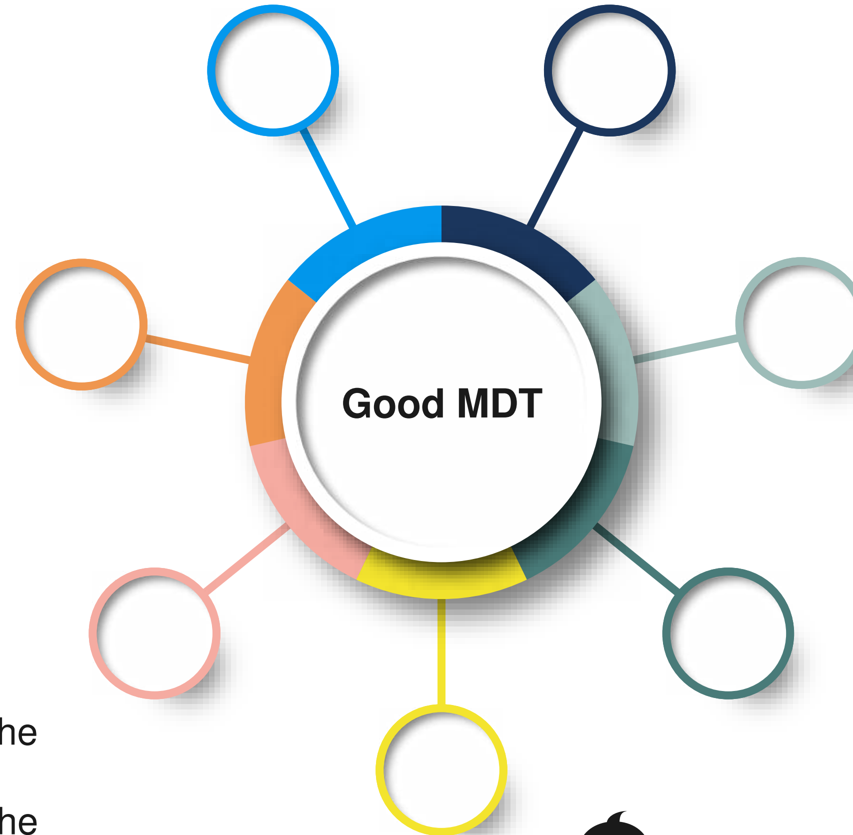
Enabling workstreams

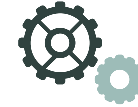
What makes a good MDT?

Consistency
Regular time, place, and structure (agenda) to the meeting, so that everyone knows what's going on

Attendance
All of the ward team, including OT and PT, plus the social worker

Culture
Bringing everyone in and encouraging discharge plans to be constructively challenged:
Why not home?
Why not today?

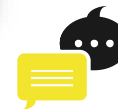




Grip
Who is the case owner?
What is the next step?
Who will do it and when?
Who records it on PPM?

Goals
What does the patient want?
Is it realistic?
Has this been discussed with the patient?
Has this been discussed with the family?

Holistic
See the whole person: covering medical issues, devices, functional ability, social skills, capacity



Communication
Who will communicate with the friends/family?
Who will communicate with the patient?

Recovery Plan First Version – Supporting the case management process – Enabler 2

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WHAT IS IT FOR?

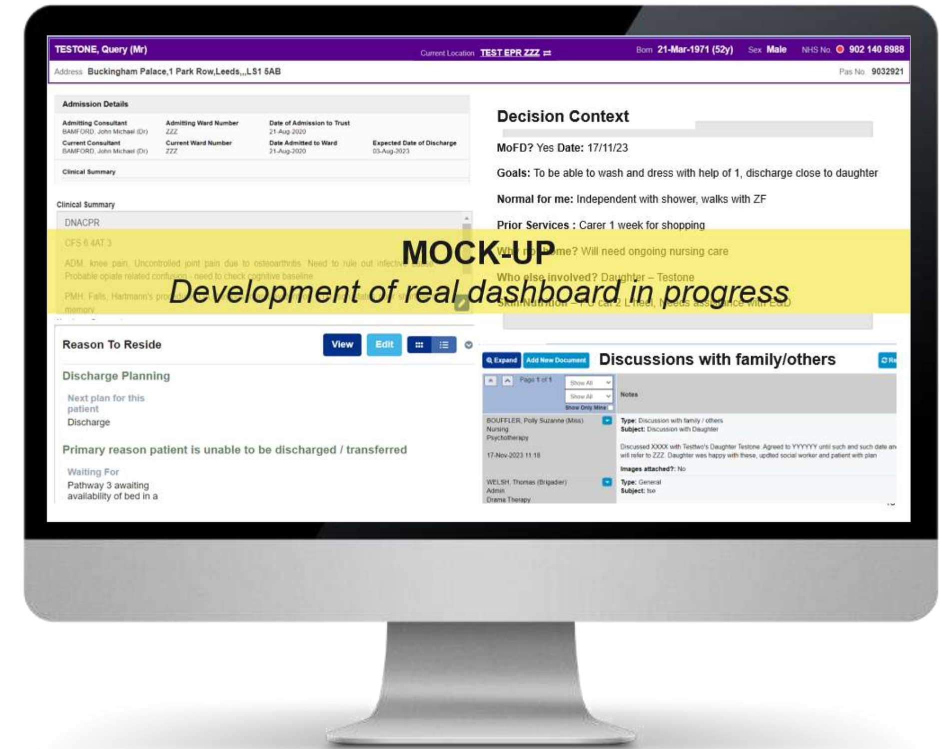
- Creating a shared, live, document that staff involved in a patient's discharge can read from and write onto.
- Starting with Pilot Wards Available to staff in the case management function from LCC, LTHT and LCH.

WHAT ARE THE BENEFITS?

- Improving patient experience by reducing the need for different staff to ask the patient the same questions.
- Putting an understanding of what is 'normal' for the patient and what their goals are at the centre of discharge decisions.
- Providing richer, and more structured data that is easy to understand 'at a glance' so that everyone is sighted on the plan for discharge
- Improved reporting and service improvement with more reliable and integrated data capture

WHAT WILL IT REPLACE?

- Replacing the Discharge Plan and Tracker.
- Removing duplication from information that is already stored in PPM+ by other colleagues by pulling existing information together



TESTONE, Query (Mr) Current Location TEST EPR ZZZ Born 21-Mar-1971 (52y) Sex Male NHS No. 902 140 8988

Address Buckingham Palace,1 Park Row,Leeds,,,LS1 5AB Pas No. 9032921

Admission Details

Admitting Consultant	Admitting Ward Number	Date of Admission to Trust	
BAMFORD, John Michael (Dr)	ZZZ	21-Aug-2020	
Current Consultant	**Current Ward Number**	**Date Admitted to Ward**	**Expected Date of Discharge**
BAMFORD, John Michael (Dr)	ZZZ	21-Aug-2020	03-Aug-2023

Clinical Summary

Clinical Summary

DNACPR

CFS 6 4AT 3

ADM: knee pain, Uncontrolled joint pain due to osteoarthritis. Need to rule out infective cause. Probable opiate related confusion - need to check cognitive baseline.

PMH: Falls, Hartmann's procedure, Previous harm event on ... states poor short-term memory

MOCK-UP

Development of real dashboard in progress

Decision Context

MoFD? Yes Date: 17/11/23

Goals: To be able to wash and dress with help of 1, discharge close to daughter

Normal for me: Independent with shower, walks with ZF

Prior Services : Carer 1 week for shopping

Why not home? Will need ongoing nursing care

Who else involved? Daughter – Testone

Skin/Nutrition – PU cat 2 L heel, Needs assistance with E&D

Reason To Reside

View Edit

Discharge Planning

Next plan for this patient

Discharge

Primary reason patient is unable to be discharged / transferred

Waiting For

Pathway 3 awaiting availability of bed in a

Discussions with family/others

Expand | Add New Document | Re

Page 1 of 1 | Show All | Show All | Show Only Mine

	Notes
BOUFFLER, Polly Suzanne (Miss) Nursing Psychotherapy 17-Nov-2023 11:18	**Type:** Discussion with family / others **Subject:** Discussion with Daughter Discussed XXXX with Testtwo's Daughter Testone. Agreed to YYYYYY until such and such date and will refer to ZZZ. Daughter was happy with these, updted social worker and patient with plan **Images attached?:** No
WELSH, Thomas (Brigadier) Admin Drama Therapy	**Type:** General **Subject:** tse

Transfers of Care Rollout Plan

Team Managers | Operational Layer | Interim Leadership Team | Other

	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Design with ILT and Operating Layer	Phase 3 Plan Agreed Agree rollout resourcing (CSU and TOC release)	SIM evaluation Solidifying SOP	Consultation			Full evaluation			
Embedding joint management	Embed Governance and Improvement through TMs/OL					*Transition to BAU Continuous Improvement*			
SIM	SIM Rollout	Light Support	**49% of Complex *Demand* Covered**						
Unit 2 (Resp + UC)		Preparation, Staff engagement & Training	Rollout **15% of Complex *Demand* Covered** *(total now 64%)*						
Unit 3 - LGI (TRS, Neuro, H&N, Cardio)			Comms and co-design (with CSU Leadership)	Trial (as reqd.)	Engagement / training	Rollout **22% of Complex *Demand* Covered** *(total now 86%)*			
Unit 5 - CAH (Chapel Allerton)									
Unit 4 (AMS) (ONC TBC)				Comms and co-design (with CSU Leadership)	Trial (as reqd.) Engagement / training	Rollout	**14% of Complex *Demand* Covered** *(total now 100%)*		