“Home First”
Risk share/ benefit share arrangement to support more people going home faster

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**Background and context**

**Situation analysis:**
Lewisham & Greenwich Trust failing to deliver on A&E standards

**Needs**
Whole system identification, ownership & acceptance of drivers

**One Version of the Truth**
(OVT1 & 2)
2015 & Jan 2016

Whole System analysis of the problems for Lewisham & Greenwich Trust and Partners

**Business Case 1**
Whole System

**Lean Processes 2016**
(for complex discharge patients)

**Business Case 2**
Home First Team Bexley
(improving complex discharge patient pathways including avoiding further admissions)

**Response & Flow is the issue e.g.:**
1. Specialty response to ED
2. Discharges pre 13:00 (lack of) inc. simple
3. Complex discharges – patients and bed days consumed
4. Ambulatory care and admission avoidance
5. ED process including CDUs and also RATing

**Following a decline in August, the number of patients on RfD has increased**

Jan '15 to Jan '16 – Queen Elizabeth Woolwich site only – patients on RfD averages 63 patients Jan 16 (20% of bed capacity)

All CCGs
Lean Processes Business Case

Business Case 1
Whole System

Lean Processes 2016
(for complex discharge patients)

Showing the problem & the opportunities

Detailed analysis of the Ready for Discharge (RfDs) – and clinical analysis of a group of patient pathways which showed:

6 Patient Case Studies Opportunities to Reduce Care Days through Lean Processes

<table>
<thead>
<tr>
<th>Patient</th>
<th>Primary admission condition</th>
<th>Number of days on RfD Actual</th>
<th>Number of days on Lean RfD</th>
<th>Saving in bed/care days to discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Agnes</td>
<td>Infection</td>
<td>126</td>
<td>23</td>
<td>103</td>
</tr>
<tr>
<td>Patient Bert</td>
<td>Trachy malfunction</td>
<td>163</td>
<td>5</td>
<td>158</td>
</tr>
<tr>
<td>Patient Cathy</td>
<td>Unspecified anaemia</td>
<td>119</td>
<td>7</td>
<td>112</td>
</tr>
<tr>
<td>Patient Doris</td>
<td>Fracture Neck of Femur</td>
<td>67</td>
<td>3</td>
<td>64</td>
</tr>
<tr>
<td>Patient Edward</td>
<td>Acute infection</td>
<td>49</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>Patient Frank</td>
<td>Urinary Tract Infection</td>
<td>24</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td><strong>Sub total Care Days post medically fit</strong></td>
<td></td>
<td><strong>548</strong></td>
<td><strong>60</strong></td>
<td><strong>488</strong></td>
</tr>
<tr>
<td>Cost for care days using ExBD</td>
<td></td>
<td>£132k</td>
<td>£15k</td>
<td>-£117k</td>
</tr>
</tbody>
</table>
Issues identified:
1. EDD/ NOAs and NODs – not being completed (lack of Care Act compliance all orgs)
2. Lack of parallel processes & join up
3. Time taken overall (& wasted resources)
4. Data on patients is inaccurate & a lack of live information between agencies
5. Poor patient pathway (leading to reduced rehabilitation potential and disproportionately high residential care)
6. Collective change at pace

Agreed Initiatives for the Whole System

1. Develop One (electronic) List, daily, accurate, shared & updated
2. Introduce the identification of Estimated Discharge Date (EDD) within 24 hours of admission (Trust) & ensure Assessment Notification in line with Care Act 2014
3. Reduce Trust paperwork processing to a maximum of 3 days
4. Social Care: Instigate and maintain agreed timescales between paper work, panels and packages of care
5. Introduce Discharge to Assess (D2A) & other services
Home First Team Bexley

Pilot of a range of services around QEH site:
1. Increased packages of care via London Borough of Bexley including Discharge to Assess
2. CHC interim placement beds and also EOLC additional fast track beds
3. Senior clinical flow manager
4. Additional winter beds as required and reducing LOS on existing SUSD beds
5. Increased admissions to be avoided
6. Integrating teams virtually using Home First Team brand

Social Care Investment for
- Social care additional staffing
- Care packages (basic level, enhanced levels, and emergency respite services)
- Above delivers Discharge to Assess (D2A) services, plus increased discharges

Improve productivity in existing contracts:
- Increasing admissions avoided -£217,000 per annum
- Reducing ALOS on intermediate care beds 3 days per bed

Plus winter resilience funded services:
- CHC step down and Fast track EOLC beds
- Additional SUSD beds for main winter
RfD list at Queen Elizabeth Hospital

Key facets:

1. Whole system change (shared ownership & incentives)
2. Multiple solutions to address patient pathways
3. Determination & conviction “driving change”
4. Personal director level leadership, commitment and involvement (Super 6) individual patients
5. Pre-planning with the ability to change rapidly (responding to a situation)
6. Shared learning
7. Joint multi agency working