Berkshire West 10 Highlight Report

PROGRAMME	Hospital at Home Pathway model	PROGRAMME & PROJECT MANAGERS	**Fiona Slevin-Brown, Provider SRO** **Katie Summers, CCG SRO**	OVERALL RAG STATUS	
REPORTING PERIOD	01-31 Jan 15	REPORT ISSUE DATE	**6th Feb 2015**	STATUS	Amber

HOSPITAL AT HOME PATHWAY

The Hospital at Home project is a high profile cross partnership project which is also included within the 3 Better Care Fund plans. It was expected to achieve significant reductions in NEL and savings for the CCGs in 2014/15 however these have not been achieved as the project did not go–live in year.
Following a proof of concept exercise completed in October 2014 it was agreed that there would be benefits to the system in refocusing the Hospital at Home business case and pathway to include early supported discharge of patients deemed medically stable as well as including some admission avoidance activity with the opportunity for improving both patient experience and health outcomes as well as achieving efficiency gains through reductions in length of stay.

PROJECTS/ SCHEMES STATUS		
The Hospital @ Home model development process has demonstrated strong integrated working and whilst the Proof of Concept (POC) was unable to identify the predicted numbers of patients for admission avoidance, the data gathered does show that there are real opportunities for reframing the original scope of the project to include other opportunities such as early supported discharge, enhanced support for care homes and addressing frequent re-attenders. The Providers developed a reframed business case for Hospital at Home which was presented to QIPP and Finance in December 2014 and was approved formally in January 2015. This re-framed Provider led business case has been developed and shared with key stakeholders from both Health and Social Care. It was agreed that project implementation would commence as soon as possible pending appointment of a new Project Manager. The PM started on the 29th January 2015.	⇐	**Project Status**
	⇓	**Finance Status**
	⇐	**Activity Status**
	⇐	**Milestone Status**

KEY ACHIEVEMENTS	
	• Implementation Project Manager appointed to commence 29th January 2015. • Implementation Group reconvened twice monthly, first meeting took place 3rd Feb 2015. • Implementation work stream and leads agreed 5th February 2015.

NEXT STEPS / PLANNED ACTIVITIES	
	• Task and finish groups planned for implementation of clinical and pharmacy pathways • Recruitment and training of new personnel to commence pending formal letter of intent to fund from CCGs to BHFT • BHFT to develop a formal training plan of its community teams including a review of specialist community nursing, IV therapy and integrated discharge partnership in RBFT and aligned to the locality work being undertaken as part of the Integration projects and BCF schemes • Procurement of Tele Health equipment

NEW ISSUES RAISED THIS PERIOD
Ongoing funding of interdependent schemes or posts which have been funded to date through Operational resilience funding, e.g. weekend therapists in the RBH

NEW RISKS IDENTIFIED THIS PERIOD
No new issues have been raised at this stage

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PLANNED BENEFITS

	Benefit	Timescale/date to be realised	Responsibility	Achieved Yes/No	Comment
	Improving patient flow across the whole health and care system and achieve a reduction in the numbers of delayed transfers of care through co-ordinated discharge planning, and a pull from a community led integrated discharge team. Delivering a reduction in: • *readmission rates – supporting targets in the BCF* • *average length of stay across both acute and community in-patient unit. This is expected to be by at least 4 days in the RBFT and should enable over time an equivalent reduction in in-patient beds of 21.* • *avoidable NELs by 546*	March 2016 fye	Provider transformation Lead	No	Service full go-live from July 2015 with soft launch in May 2015.
	Improve patient's experience through: • *the provision of short-term intensive high acuity care in their normal place of residence through multi-disciplinary case management* • *engagement of patients and carers in individualized planning*	March 2016	Provider Transformation Lead	No	Full evaluation will need to include patient experience surveys
	Create a platform for Integration of Social and Health Services and assist in improving the productivity & responsiveness of community services through: • *building on the services already provided in the community and the plans being developed through local Better Care Fund Schemes* • *the development of the community workforce, providing opportunities for upskilling and career progression* • *the integration of the discharge/service navigation team at the RBH with staff from the community to develop a pro-active and Community led function* • *moving away from isolated specialist care groupings which do not in themselves meet the needs of growing numbers of patients with multiple co-morbidities to generic teams with specialist skills embedded within them*	From April 2015	Provider transformation lead	No	Details to be set out in the implementation plan. First draft due early March 2015.
	To reduce the inconsistency of care and ensure care is safe and equitable through the use of shared documentation, enhanced information sharing and a reduction in handoffs and maximising the effectiveness of the interface between secondary and community care	From April 2015	Provider Transformation lead	No	

RISK LOG

Risk	*Owner*	*Mitigating Action*	*Impact (1-5)*	*Likelihood (1-5)*	*Rating (R/A/G)*
Inability to recruit and failure to upskill community staff to be able to safely manage higher levels of acuity in the community may impact on the success of the pathway	*BHFT*	*Early notification to BHFT to commence recruitment.* *Inclusion of ANP posts in the model should be attractive to potential applicants* *Training programme to be developed as part of the*	*4*	*2*	*8*

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		implementation plan *Q2 commencement of the pathway*			
Interdependency upon other BCF, QIPP and partnership schemes will have an impact on the ability to deliver the revised pathway model	*BHFT/Providers*	*Robust project leadership of the implementation phase, and regular assessment and escalations of risks and issue via the local Integration steering groups*	*3*	*2*	*6*
Refreshed model is not approved by the HWB	*CCGs*	*CCG SRO to provide updated communications to Health and Wellbeing Boards on refreshed model, highlighting benefits.* *.*	*3*	*2*	*6*
Patients may consent not to access the service	*CCGs/Providers*	*Updated communications out to the general public on the model, including the CCG website. Patients to be provided with leaflets about the pathway and their options discussed with the discharge team*	*4*	*2*	*8*
There is a risk that the providers will not agree the revised payment and contracting terms for this pathway	*CCG and Provider DoFs*	*Both Provider finance teams have been involved in and agreement has been sought as part of the business case on the local tariffs and funding in the business case.* *development of a local incentive scheme on potential gain share*	*4*	*3*	*12*
Insufficient leadership capacity and capability to successfully lead the implementation phase of the pathway	*BHFT/RBFT*	*Business case includes funding for ongoing project management support from the Providers. An individual has been identified and can start once funding has been approved*	*3*	*2*	*6*
The pathway is dependent upon the redesign and development of a community led integrated discharge team, and the agreement of providers to positively engage in this work	*BHFT/RBFT*	*Commissioning intentions from the CCGs already include this requirement.* *To be included in the contracting discussions with both RBFT and BHFT* *Transformation lead will oversee and co-ordinate this work*	*3*	*3*	*9*
Clinicians and professionals are culturally slow to change their behaviours and are risk averse, failing to engage in both the development and use of the new pathway	*RBFT/BHFT/LAs*	*Transformation lead will be responsible for ensuring that the individual organisation leads are leading internal work streams which support the success of the pathway.* *Reporting will be through the Provider Steering group*	*3*	*3*	*9*
Access to timely Patient transport and to equipment including monitoring devices will be critical for some patients	*BHFT/BCES/CCG CCIO*	*Equipment funding included in the business case. Any delays will be monitored through a pathway performance framework and actioned with BCES* *Tele-monitoring devices will need to be procured in line with the Connected Care work stream*	*4*	*2*	*8*
A&E attendances may continue to rise if the level of complexity of patients prevents them from accessing the service in sufficient numbers to impact on admissions.	*CCGs*	*NEL activity and A&E attendances will be monitored monthly to evaluate the impact of all the QIPP schemes and the increasing demand pressures both in secondary and primary care*	*4*	*4*	*16*