Clinical and Care Governance Committee

Thursday, 27 May 2021

To be held remotely in various locations

NOTICE IS HEREBY GIVEN that a Meeting of the **Clinical and Care Governance Committee** is to be held at **To be held remotely in various locations**, on **Thursday, 27 May 2021** at **09:30** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

MEMBERSHIP

Professor Nicholas Fluck (Chair)

Councillor Frank Brown (Vice-Chair)
Jane Ewen (Member)

Mr Ivan Augustus (Non-Voting Member)
Ms Karen Donaldson (Non-Voting Member)
Ms Jane Mackie (Non-Voting Member)
Dr Malcolm Metcalfe (Non-Voting Member)
Mrs Val Thatcher (Non-Voting Member)
Dr Ann Hodges (Non-Voting Member)

Clerk Name:	
Clerk Telephone:	01343 563016
Clerk Email:	committee.services@moray.gov.uk

MINUTE OF MEETING OF THE INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 25 February 2021

remote locations via video conference

PRESENT

Mr Sandy Riddell, Cllr Frank Brown, Mr Ivan Augustus, Mr Simon Bokor-Ingram, Mrs Jane Mackie, Dr Malcolm Metcalfe, Mr Sean Coady, Mrs Jeanette Netherwood and Ms Sam Thomas

APOLOGIES

Ms Pauline Merchant and Mrs Jane Ewan

IN ATTENDANCE

Also in attendance at the above meeting was Mrs Isla Whyte, Interim Support Manager, as clerk to the Board.

1. Chair of Meeting

The meeting was chaired by Mr Riddell.

2. Welcome and Apologies

The Chair welcomed everyone to the meeting and apologies were noted.

3. Declaration of Member's Interests

There were no declarations of Members' Interest in respect of any item on the agenda.

4. Minute of Board Meeting dated 29 October 2020

The Minute of the meeting dated 29 October 2020 was submitted for approval.

The Board agreed to approve the minute as submitted.

5. Action Log of Board Meeting dated 29 October 2020

The Action Log of the meeting dated 29 October 2020 was discussed and updated accordingly at the meeting.

6. Clinical Governance Group Escalation Report

A report by Sean Coady, Head of Service, informs the Committee of progress and exceptions reported to the Clinical and Care Governance Group during quarter 3 of 2020/21 (1 October up to 31 December 2020).

The Clinical Governance Group became the Clinical and Care Governance Group (CCG Group). The group is co-chaired by Ms Sam Thomas, Chief Nurse – Moray, and Mrs Jane Mackie, Head of Service/ CSWO.

An overview of papers that went through CCG Group during quarter 3 are set out in the report, as are areas of achievement. There has been some delay in progressing some actions due to the ongoing response to the pandemic and focus on the COVID-19 Vaccination Programme.

Mr Coady assured the Committee that the Clinical Risk Management (CRM) Group continues to meet every two weeks to discuss adverse events, complaints and risks. The group comprises of senior management, clinical leads, chief nurse and relevant service managers/ consultants.

It was noted complaints relating to COVID-19 vaccination programme are being managed centrally. Moray specific information can be incorporated into the report for the next committee.

There has been one Level 1 review required during quarter 3. Although the report states it will be complete by the end of February 2021, Mr Coady confirmed it is now complete. As previously stated all Level 1 and 2 reviews are discussed and monitored at the fortnightly CRM meeting.

Dr Metcalfe, chair of the corporate CRM, is progressing work with colleagues for those complaints that transcend services i.e. primary and secondary care.

The group discussed complaints and assurance was given by Mr Coady that all complaints are monitored by CRM to ensure they are progressing accordingly. Complaints received into Datix are often multi-faceted and include more than one service, which can impact on response times due to the level of investigation and coordination required.

From the data presented regarding adverse events, it shows a steady increase in ‘near misses’ by quarter. Ms Thomas advised this rise may be as a result of recent work with staff in relation to Datix reporting and encouraging the reporting of any near misses. She also advised that at the next meeting with Charge Nurses they will start a ‘deep dive’ process to focus on how, what and why something requires to be reported, and that work, as it moves forward, will identify any trends.

The Chair thanked Mr Coady for the report, which gives assurance that progress is being made despite the current situation and there is the appropriate governance and safeguards in place.

The Committee noted the contents of the report.

7. Progress Update on Clinical and Care Governance Report

A report by the Chief Officer provides an update to the Committee of the governance arrangements in place during the COVID-19 lockdown December 2020 to date, and progress in relation to the review of clinical and care governance arrangements and assurance framework following the workshop in January 2020.

Mrs Jeanette Netherwood presented the report and advised the associated action plan is in place and will be driven forward by the Clinical and Care Governance Group.

The Chair recalled the workshop held in January 2020 and the offer of support from Nick Fluck and Caroline Hiscox. The Chair is keen to take up that offer and build on what is in place and suggests a workshop in 2022 to take stock. The Chief Officer suggested a joint workshop with clinical and care governance committees across Grampian.

Mrs Mackie concluded discussions stating a learning point from responding to COVID-19 is the ability to provide assurance and governance in a supportive and helpful way. This is has been demonstrated through governance procedures put in place to support Care Homes, Direct Payment Carers and Care at Home Providers. Real benefits have been realised with positive relationships established.

The Committee noted the governance arrangements during the continuing response to COVID-19 and the update on progress with output from the Clinical and Care Governance Workshop held in January 2020.

The committee welcomes a further progress update in August 2021.

The meeting closed at 13:29

MEETING OF MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 25 FEBRUARY 2021
ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Review of Clinical and Care Governance – Output from Workshop	Further progress update will be provided to Clinical and Care Governance Committee in August 2021.	August 2021	Jeanette Netherwood
2.	Mental Health in Moray	Paper explaining the risks and contingencies in place in relation to Mental Health Officers and out of hours service – briefing was issued to members on 11.01.21. An update report will be presented in May to CCG Cttee. Update on Mental Health will be presented to March MIJB.	May 2021	Jane Mackie
4.	Health and Social Care Moray Complaints	Further development of complaints performance information to be progressed in liaison with Council Complaints Officer.	May 2021	Pauline Merchant

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 MAY 2021**

SUBJECT: **HEALTH & SOCIAL CARE MORAY (HSCM) CLINICAL AND CARE GOVERNANCE GROUP ESCALATION REPORT FOR QUARTER 4 (JANUARY TO MARCH 2021)**

BY: **HEAD OF SERVICE**

1. REASON FOR REPORT

1.1. To inform the Clinical and Care Governance Committee of progress and exceptions reported to the Clinical and Care Governance Group during quarter 4 of 2020/21 (1 January up to 31 March).

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee consider and note the contents of the report.

3. BACKGROUND

3.1. The Health and Social Care Moray (HSCM) Clinical Governance Group was established as described in a report to this committee on 28 February 2019 (para 7 of the minute refers).

3.2. The assurance framework for clinical governance was further developed with the establishment of the Clinical Risk Management Group (CRM) as described in a report to this committee on 30 May 2019 (para 3.2 of the minute refers).

3.3. As reported to the Committee on 29 October 2020 (para 5 of the minute refers) Social Care representatives now attend the Clinical Governance Group. As such the group was renamed HSCM Clinical and Care Governance Group. With Ms Samantha Thomas, Chief Nurse - Moray, and Mrs Jane Mackie, Head of Service / CSWO, as co-chairs.

3.4. The agenda for the Clinical and Care Governance Group has been updated and now follows a 2 monthly pattern with alternating agendas to allow for appropriate scrutiny of agenda items and reports. A reporting schedule for Quality Assurance Reports from Clinical Service Groups / departments is in place (attached as **Appendix 1**). This report contains information from these reports and further information relating to complaints and incidents / adverse events reported via Datix; and areas of concern / risk and good practice shared

during the reporting period. Exception reporting is utilised as required. Since April 2020, the 3 minute brief template has been used for services to share their updates; this has been met with positive feedback.

3.5. Due to the huge volume of work and staff resources required to establish and implement the COVID-19 vaccination programme in December 2020 and the set up and opening of the Fiona Elcock Vaccination Centre in January 2021, the January Clinical and Care Governance Group was cancelled. The March 2021 meeting was not quorate therefore the Clinical and Care Governance Group have only met once during this reporting period.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit, Guidelines, Reviews and Reports

4.1 Relevant Audits, Guidelines Reviews and Reports are tabled and discussed. These include local and national information that is relevant to HSCM, for example, recommendations from Health Improvement Scotland (HIS) reports from other areas which require to be discussed and assurance given that services in Moray are aware of these and have process in place to meet/ mitigate these recommendations. Overview from quarter 4 2020/21 is listed below:

- Suicide Prevention Guidelines
- Policy & Procedure following a Death in Care Services
- Adverse Events Policy
- Risk Control Notices
- Risk Register.
- Adverse Events.
- Feedback and Complaints.

Areas of achievement / Good Practice

4.2 The Community Response Team (CRT) have been exemplary in adjusting to the many time sensitive and competing demands during the COVID-19 pandemic. The CRT in Moray provides support to the Covid Hub in providing care and support throughout the pandemic whilst retaining primary role and remit. The team became the sole responders to uninjured falls within the community decreasing the pressures on Scottish Ambulance Service (SAS) attendance to uninjured fallers. This is significant on top of their current role and remit.

4.3 VCreate Pilot – NHS Grampian is one of only two Speech & Language Services in Scotland to be piloting the use of VCreate to enable families to share video footage securely with therapists, reducing the need for face to face contact and enabling communication and flexibility of access to the service.

4.4 Monthly educational sessions are held for the Grampian Medical Emergency Department (GMED) to learn from adverse events and build sustainable connections between GMED clinicians and between the service and wider system. These sessions receive positive feedback and are well attended.

Clinical Risk Management (CRM)

4.5 The Clinical Risk Management (CRM) group meet every 2 weeks to discuss issues highlighted on the HSCM Datix dashboard. This includes Level 1 and Level 2 investigations, complaints, Duty of Candour and risks.

4.6 The group is attended by members of the senior management team, clinical leads, chief nurse and relevant service managers / consultants. An action log is produced following each meeting and is administered and monitored. Individual services can be invited to attend to offer further scrutiny and assurance.

4.7 There will be a focus on lessons learned which will be reported quarterly to the HSCM Clinical and Care Governance Group. A process for recording lessons learned will be developed to support easier recognition of trends and sharing of information. Due to the ongoing COVID-19 response and the focus on the COVID Vaccination Programme this piece of work is on hold.

Complaints and Feedback

4.8 Within HSCM, complaints received by NHS Grampian and Moray Council are recorded on 2 separate systems, in accordance with the appropriate policy and procedure of these organisations.

4.9 A report to the Committee meeting on 29 October 2020 (para 7 of the minute refers) provided members with detail on the procedures for NHS and Local Authority complaint handling to demonstrate the similarities and differences.

4.10 Overall, a total of **15** complaints were received during quarter 4.

	Total Received in last quarter	**Total Closed in last quarter**
Local Authority	6	8
NHS	9	5

4.11 A total of 18 complaints were received during quarter 3. A total of 15 complaints were closed within the same time period.

4.12 A total of 21 complaints were received during quarter 2. A total of 25 complaints were closed within the same time period.

4.13 These figures do not include complaints raised regarding the vaccination appointments or processes as these are being dealt with through a dedicated team covering the Grampian area.

4.14 Please see **Appendix 2** for details of complaints closed during quarter 4 of 2020/21 (1 January up to 31 March).

4.15 Complaints received into Datix are often multi-faceted and include more than one service which can impact on response times due to the level of investigation and coordination required.

4.16 Action taken as a result of complaints received by NHS Grampian and Moray Council during quarter 4 include:

- Monthly multi-disciplinary meetings set up
- Communication improvements
- Education / training of staff
- Access Improvements: system changes

Complaints Handling Procedures

4.17 Since 2012 the Scottish Public Services Ombudsman's (SPSO) Complaints Standards Authority has worked closely with a range of partners and stakeholders to develop and implement Model Complaints Handling Procedures (MCHPs) for each public service sector. In 2018-19 the SPSO conducted a review of MCHP to establish effectiveness and usability. Following consultation the MCHPs were revised, updated and published under section 16B(5) of the Scottish Public Services Ombudsman Act 2002 on 31 January 2020 to give public sector organisations time to implement any changes by April 2021**.**

4.18 The NHS was the last public sector to adopt the MCHP on 1 April 2017. Therefore, the NHS MCHP has not yet been revised since it was first published.

4.19 The revised Local Authority MCHP, published 2020, applies to social work complaints, whether they are handled by local authority or health and social care partnership staff.

4.20 For complaints relating to the actions and processes of the Integration Joint Board itself, IJBs are asked to adopt the MCHP for the Scottish Government, Scottish Parliament and Associated Public Authorities.

Adverse Events

4.21 Adverse Events by Category and Level of Review* Reported on Datix (Quarter 4, 2020/21)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Level 1 - significant adverse event analysis and review	No value	Total
Abusive, violent, disruptive or self-harming behaviour	108	1		0	109
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	17	0		1	18
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Radiation, Needlesticks or other hazards)	96	2		0	98
Clinical Assessment (Investigations, Images and Lab Tests)	5	0		0	5
Consent, Confidentiality or Communication	6	1		0	7
Diagnosis, failed or delayed	3	1		0	4
Financial loss	1	0		0	1
Fire	6	0		0	6
Implementation of care or ongoing monitoring/review (inc. pressure ulcers)	7	3		1	11
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	7	0		0	7
Medical device/equipment	1	0		0	1
Medication	18	0		3	21
Other - please specify in description	19	0		5	24
Patient Information (Records, Documents, Test Results, Scans)	10	0		1	11
Security (no longer contains fire)	1	0		0	1
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	3	0		0	3
No value	0	1		0	1
Total	308	9	0	11	**328**

* Not all adverse events allocated a level of review at time of reporting.

4.22 In quarter 3, 64 adverse events were allocated a Level 3 Review and categorised under abusive, violent, disruptive or self-harming behaviour. For quarter 4 there are 108 Level 3 reviews under the same category. Further analysis shows the increase in events is attributed to a small number of very challenging patients both in adult and older adult mental health inpatient areas.

4.23 Adverse Events by Harm Reported on Datix (Quarter 4, 2020/21)

	2020/21 Quarter 1	2020/21 Quarter 2	2020/21 Quarter 3	**2020/21 Quarter 4**
Occurrence with no injury, harm or ill-health	169	204	170	**222**
Occurrence resulting in injury, harm or ill-health	51	77	73	**72**
Near Miss (occurrence prevented)	16	26	35	**34**
Property damage or loss	2	5	2	**0**
Death	0	0	0	**0**
Total	238	312	280	**328**

4.24 Adverse Events by Severity Reported on Datix (Quarter 4, 2020/21)

		2020/21 Quarter 3	**2020/21 Quarter 4**
Negligible	No injury or illness, negligible/no disruption to service / no financial loss	215	**262**
Minor	Minor injury or illness, short term disruption to service, minor financial loss	60	**58**
Moderate	Significant injury, externally reportable e.g. RIDDOR, some disruption to service, significant financial loss	4	**7**
Major	Major Injury, sustained loss of services, major financial loss	1	**1**
Total		280	**328**

Findings and Lessons Learned from incidents and reviews

4.25 A level 1 review consists of a full review team who have been commissioned to carry out a significant event analysis and review, reporting findings and learning via the division/ service governance structures.

4.26 There are no level 1 reviews in progress (at the time of reporting).

4.27 As reported to the Clinical and Care Governance Committee in February 2021 (para 6 of the minute refers) there was 1 level one review underway. This review is now complete. Minor system of care/service issues were identified and itemised recommendations have been set out for consideration within NHS Grampian.

HSCM Risk Register

4.28 New risks identified on Datix are discussed at each Clinical and Care Governance Group and CRM. There has been **0** new risk identified as "High" during this reporting period.

4.29 Each Clinical Service Group/Department will highlight risks associated with their service, which are discussed during a reporting session to the HSCM Clinical and Care Governance Group. The risk register has been reviewed with leads given guidance and support to update. An overview of the Risk Register is shown in **Appendix 3**.

4.30 There are no "Very High" risks currently on the register.

Duty of Candour

4.31 Three events are currently being considered for Duty of Candour.

Items for escalation to the Clinical and Care Governance Committee

4.32 Adult Support and Protection – multi-disciplinary joint inspection of adult protection activity in Grampian is expected in 2021. A self-assessment return for NHS employed staff was completed and submitted to NHS Grampian Adult Protection Group, on 5 March 2021, as part of a wider programme of work to prepare NHS Grampian for the upcoming joint inspection. An action plan will be issued to areas in due course, it is anticipated adult support and protection training for health colleagues will be a priority.

4.33 Adult Support and Protection in Moray – the Adult Support and Protection Improvement Plan has been paused pending resolution of capacity and resource within social care. Moray Access Teams' currently do not have capacity to make Initial Referral Discussions (IRDs) operational. This is a 'red risk' on the Social Care Practice Governance Board Risk Register. Approval was given by HSCM Senior Management Team (SMT) at their meeting on 13 May 2021 for the recruitment of a further 3.5 full time equivalent (FTE) temporary social workers for the Access Team. The MIJB are to receive an update report on Adult Support and Protection at the meeting of 27 May 2021.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

As set out within Annex C of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Clinical and Care Governance Framework.

(b) Policy and Legal

Clinical and Care Governance requirements are set out within the Moray Health and Social Care Integration Scheme. Appropriate arrangements must be in place to ensure and evidence good governance in meeting duties under the Public Bodies (Joint Working) (Scotland) Act 2014.

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

There are systems and processes in place across service areas to support clinical governance, providing assurance to the HSCM Senior Leadership Team and to the Clinical and Care Governance Committee. There are platforms within Health and Social Care to discuss and share good practice, learning and challenges.

Moray Integration Joint Board (MIJB), Moray Council and NHS Grampian could find themselves exposed to significant risks if good governance is not in place. The purpose of this report is to oversee the processes to ensure that appropriate action is taken in response to adverse events, scrutiny reports/action plans, safety action notices, feedback, complaints and litigation, and those examples of good practice and lessons learned are disseminated widely.

Adverse events and complaints provide significant information on trends relating to risk and an encouraging opportunity for learning across the system. Regular monitoring of this is critical to ensure continuous improvement and the ambition of achieving excellence in our delivery of high quality care and treatment.

The local Clinical Risk Management (CRM) group reviews all events logged on Datix, ensuring risk is identified and managed.

(e) Staffing Implications

This activity is core to all practitioners in the front line both in terms of their professional competence and assurances in care delivery.

(f) Property

None directly arising from this report.

(g) Equalities/Socio Economic Impact

There is no requirement for an equality impact assessment because there is no change to policy required as a result of this report.

(h) Consultations

Consultations have been undertaken with the following staff who are in agreement with the content of this report where it relates to their area of responsibility:

- Jane Mackie, Head of Service / Joint Clinical and Care Governance Group Chair
- Sam Thomas, Chief Nurse Moray / Joint Clinical and Care Governance Group Chair
- Jeanette Netherwood, Corporate Manager
- Tracey Sutherland, Committee Services Officer, Moray Council

6. CONCLUSION

6.1 The HSCM Clinical and Care Governance Group are assured that issues and risks identified from complaints, clinical risk management, internal and external reporting, are identified and escalated appropriately. The group continues to develop lines of communication to support the dissemination of information for sharing and action throughout the whole clinical system in Moray. This report aims to provide assurance to the Moray Integration Joint Board Clinical and Care Governance Committee that there are effective systems in place to reassure, challenge and share learning.

Author of Report: Isla Whyte, Interim Support Manager, HSCM
Background Papers: with author (data extracted 20.04.21)
Ref:

2021	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Jan	Feb	Mar	Apr	6 May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
AHP												
Adult Support and Protection (added)												
Children and Families Health Services (Qtr)												
Dental												
GMED (Qtr)												
Mental Health												
Substance Misuse Service												
Pharmacy (Qtr)												
Moray GP/ Primary Care Contracts Team												
Locality (Claire)												
Locality (Iain)												
Locality (Cheryl)												
Locality (Lesley)												
Learning Disability (Health)												
Optometry												
Public Health												
Adverse Events and DoC * (learning)												
Morbidity & Mortality*												
Feedback Reports* (HIS visits etc)												
Risk Management*												
Exception Reporting												
External Reports												
Internal Reports												

- Locality reports will incorporate updates for complaints, duty of candour etc
- Community Hospitals - covered weekly/fortnightly in other meetings
- District Nursing - covered at other meetings, any escalations can be forwarded. CRM, or picked up via complaints etc

- Adverse Events, DoC, Feedback, M&M and Risk Management will have a deep dive each quarter with exception reporting at each HSCM Clinical Governance Group meeting.
- Morbidity & Mortality* (deaths and inequalities re morbid health, information from Public Health (year old data) – diabetes, poverty figures etc – Govt performance report
- Feedback Reports* (HIS visits etc)

3 minute brief – people should read papers before. – good practices, challenges (mitigations) and does anything need escalation – since last reporting period

Practice Governance – separate item on agenda and will provide any exception reporting to C&CG. Minutes of Practice Governance to be circulated with papers for CCG Group

Clinical Care and Governance Committee dates:-

Item for Committee	**Date of CCG Group**	**Papers due**	**Date of CCG Committee**
Quarter 4	6 May	7 May 2021	27 May 2021
Quarter 1	5 Aug	26 July 2021	26 August 2021
Quarter 2	7 Oct	4 October 2021	28 October 2021
Quarter 3	January 2022	31 January 2022	24 February 2022

HSCM Closed Complaints Overview (quarter 4, 2020/21) **APPENDIX 2**

	Total Received in last quarter	Total Closed in last quarter
Local Authority	6	**8**
NHS	9	**5**

Local Authority

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Community Care Finance	0	0	2	2
Head of Service	0	2	3	5
Care at Home	0	1	0	1

Stage	Upheld	Partially Upheld	Not Upheld	Total	%	Average Time Working
Frontline	0	1	5	6	75	21.67
Investigative	0	2	0	2	25	54.00
Escalated Investigative	0	0	0	0	0.0	

Stage	Complaints within timescale	%
Frontline	0	100
Investigation	0	100

NHS

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Community Nursing	0	0	1	1
GMED	3	0	0	3
Adult Mental Health	0	0	1	1

Stage	Upheld	Partially Upheld	Not upheld	Total
Early Resolution	0	0	1	1
Investigation	3	0	1	4
Ombudsman	0	0	0	0

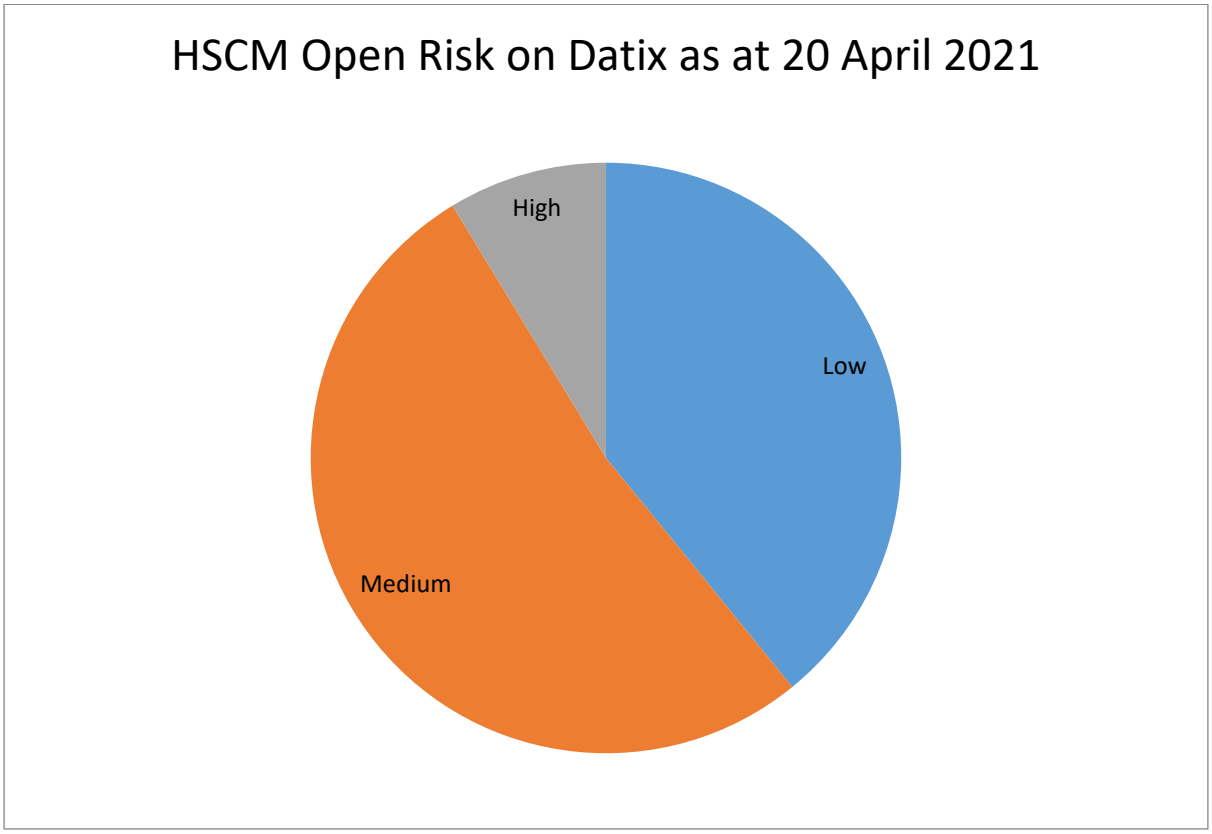
Stage	Complaints within timescale	%
Early Resolution	1	100
Investigation	2	40

Overview of action taken / learning outcome from closed complaints during quarter 4 (2020/21)

- Monthly multi-disciplinary meetings set up
- Communication improvements
- Education / training of staff
- Access Improvements: system changes

Appendix 3

Datix Risk Register Overview



	Number of Risks	%age
Low	9	39
Medium	12	52
High	2	9
Very High	0	0

By service	Number of Risks
Sector Level Risk	2
Allied Health Professionals	3
Community Hospital Nursing	10
GMED	5
Mental Health	2
Community Nursing	1

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 MAY 2021**

SUBJECT: **ADULT SUPPORT AND PROTECTION IMPROVEMENT PLAN**

BY: **CHIEF SOCIAL WORK OFFICER**

1. REASON FOR REPORT

1.1. To inform the Committee of the Adult Support and Protection (ASP) improvement journey

2. RECOMMENDATION

2.1. It is recommended that the Committee consider and note the continued work on the delivery of the ASP improvement plan in anticipation of a Care Inspectorate ASP inspection.

3. BACKGROUND

3.1 The delivery of Adult Support and Protection (Scotland) Act 2007 gives greater protection to adults at risk or harm or neglect. The Act places a duty on Councils to make inquiries about individuals' wellbeing, property, or financial affairs where the Council knows or believes that the person is an adult at risk and that they may need to intervene to protect them from being harmed. The Council has a duty to consider providing appropriate services, including independent advocacy, to support adults where an intervention under the Act is necessary. To make inquiries, the Act authorised Council officers to carry out visits, conduct interviews or require health, financial or other records to be produced in respect of an adult at risk.

3.2 During 2019, preparations began for the anticipated Care Inspectorate ASP thematic inspection. A self-evaluation exercise was undertaken with members of the Moray Adult Protection Committee and representatives of the Moray ASP partner agencies. The self-evaluation exercise was based on exploring the 3 sets of quality indicators, grouped as Outcomes, Key Processes and Leadership which have been developed by the Care Inspectorate as part of their inspection regime. The findings of the self-evaluation exercise along with findings from the case file audit and the social work questionnaire provided a strong evidence base for the development of an Improvement Action Plan.

3.3 The Self-Evaluation Report identified the following 7 workstreams that form the basis of the Improvement Action Plan:

1. Policy, Process and Procedures
2. Training and Development
3. Audit and Lived Experience
4. Performance Management
5. Service Redesign and Review
6. ICT and Recording
7. Professional Practice

3.4 The improvement plan involves Health and Social Care Moray (HSCM) working with NHS Grampian, Police Scotland, and Scottish Ambulance Service (SAS). Due to competing priorities and the global pandemic, a delay occurred in developing and implementing the improvement plan. Consequently, for the plan to be achievable in line with competing priorities, the focus was agreed to prioritise improvements in policy, processes, and procedures. Phase 1 of the plan focused on the review of the core ASP process with the aim of ensuring that it adequately reflects multi-agency input and covers the whole ASP process including monitoring and review. Phase 1 also covers NHS Grampian requirements to produce and facilitate a pan Grampian approach for Initial Referral Discussions (IRDs). The outcome is to offer a consistent response across Grampian. This is fully supported by the NHS Grampian Public Protection Officer. The full improvement plan with timelines can be found in **Appendix 1**.

3.5 To date the improvement plan has achieved the milestones of creating a robust screening tool, mapped and developed processes and procedures for ASP across a whole systems approach whilst working in partnership with NHS Grampian to develop a pan Grampian IRD process for Health. These improvements require testing and further reviewing through staff consultation prior to being adopted as business as usual.

3.6 Risk and issues are reviewed by the working group and transferred to the Adult Protection Committee if unresolved. The most recent issue identified as a Major, highlighted the lack of capacity for social work to screen referrals and drive forward the improvements required by the processes in the Access Team. This issue has incurred a 3-month delay to the project. The issue has been resolved by directing Covid finances to recruit 3.5 full time equivalent (FTE) social work staff for a 9-month period to support the improvement plan.

3.6 HSCM anticipates a Care Inspectorate ASP inspection later this year or early 2022, further information is expected from the Care Inspectorate late May.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Based on current self-evaluation activity (both by lead agency and more recently NHS Grampian), it is clear that ASP activity in Moray is currently not fully compliant or congruent with the scrutiny bodies Quality Indicator Framework. Improvement activity has been initiated across both the lead agency and multiagency partners. However, given that the scrutiny bodies will be reviewing evidence retroactively, it must be accepted that it is highly likely they will identify some deficiencies in policy, procedure, and practice. This is reflected within the improvement plan.

4.2 A multiagency delivery group continue to work on consecutive workstreams with an aim to improving the multiagency response to referrals of adult protection concerns in a timely and effective manner through prioritising the redesign of processes and procedures. The improvement journey will continue through multiple phases, guided by the self-evaluation outcomes and the feedback from the inspection report in the near future.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"
This report supports the Moray Strategic Plan in relation to Partners in Care, making choices and taking control over decisions affecting our care and supporting the outcome that people are safe.

(b) Policy and Legal
The Adult Support and Protection (Scotland) Act 2007 is the main legal reference points for this project which the MIJB are legally responsible for.

(c) Financial implications
Covid funds have been allocated to support this project with the recruitment of 3.5FTE temporary social work staff for 9 months.

(d) Risk Implications and Mitigation
There are existing systems and processes in place across service areas to support ASP referrals, IRDs and investigations. Currently they are person dependant, which is a significant risk to HSCM. The improvement plan will implement robust systems and processes to ensure appropriate action is taken in response to ASP referrals with a multiagency approach. Regular monitoring and reviewing of new processes are critical to ensure continuous improvement and the ambition of achieving a very good Care Inspectorate inspection. Whilst the additional resource is welcomed it is currently time limited which will impact on the essential improvements being embedded longer term.

(e) Staffing Implications
The improvement plan has been allocated an additional 3.5FTE social workers for 9 months to support the Access Team to build capacity into the system to drive forward the ASP improvement plan. A dedicated ASP Advanced Practitioner post has been created for 12 months to lead on the change management requirements in to embed the ASP processes. Whilst this is supportive of the improvement plan currently it is short-term and will not embed long-term changes which are required and identified.

(f) Property
No property issues identified at this point.

(g) Equalities/Socio Economic Impact
Not required as there are no changes to policy.

(h) Consultations

Chief Social Work Officer, ASP Consultant Practitioner, Corporate Manager, HSCM and Tracey Sutherland, Committee Services officer, Moray Council, have been consulted and comments incorporated.

6. CONCLUSION

6.1. This report aims to provide assurance to this Committee that there is an effective project team in place to drive forward improvements for adult support and protection in Moray.

Author of Report: Carmen Gillies Senior Project Officer HSCM
Background Papers: With Author
Ref:

Teams	Who	When	Why
Core Group	**ZS**=Zandra Smith, **IM**=Iain McGregor, **JM**=Jane Mackie, **SC**=Sean Coady, **EM**=Emma Gormley **CG=**Carmen Gillies, **MN=**Marie Noble **BS=** Bridget Stone	Virtual Meetings 3 week (if required) 1/2/21	To be accountable and consult
Operational Working Group	CORE GROUP PLUS, **CM**=Charles McKerron, **LM=** Lesley McLean (Police Scotland) or **FT**=Fiona Topping (Police Scotland), **CP**=Claire Powers, **CSH=**Cheryl St Hilaire, **IMD**=Iain MacDonald, **BS**=Brendan Stephens, **LA**=Lesley Attridge **SG**=Suzy Gentle, **VL**=Vicky Logan, **MS**=Michelle Stephen **, AA**=Ashleigh Alan (NHSG) **KOB** = Kenny O'Brien(NHSG)	Virtual meetings every 6 weeks as invited 05/11/20 11/1/21 22/2/21 15/04/21**.** 17/05/21. 28/06/21. 09/08/21. 20/09/21. 01/11/21. 13/12/21	To be accountable and consult
Operational Working Group +	**BW**=Bruce Woodward, **GM**=Garry MacDonald, **EM**=Eilidh MacKetchnie, **TW**=Tracie Wills, **TA**=Tracey Abdy, **YW**=Yvonne Wright, **NM** – Neil McGlinchey (legal)	Receive updates via email	To be kept informed
Committees	**ASPC**=Adult Support & Protection Committee,	Receive updates via email	To be kept informed

The plan is divided into 2 phases. Phase 1 will focus on developing and agreeing the core process. Phase 2 workstreams will be prioritised after the completion of phase 1.

Phase 1.0 - Policy, Process & Procedure			
	Work stream	**Description**	**Timeline**
1.1	**Develop Core Process – ASP processes 1-4** *This will involve creating and embedding a robust screening tool into procedures, created with multi-agency input*	Create small team to finalise process Support Access Team to improve the use of the screening tool OWG endorse process **Screening Tool LIVE Aug 21**	~~Mar 21~~ now Aug 21
1.2	**Training & Data** *To support the project though identifying which training can be offered in Phase 1 to assist with improving the core process*	Identify and share with OWG what existing training is on offer (Jackie Macintosh – Grampian trainer) Identify what data we need to collect Through monitoring data, identify any patterns where re education and training may be required across all environments.	~~Jan- Mar 2021~~ now Aug 21
1.3	**Develop Core Process - IRD** *To create a robust IRD process created with multiagency input*	NHSG Public Protection lead to support on the creation of a skeleton IRD process pan Grampian. Aim March for draft IRD to be endorsed. Moray IRD process to be developed incorporating Pan Grampian approach **IRD LIVE Dec 21**	Mar - Jun 21 Aug – Dec 21

1.4	**Documentation and ICT** *To ensure all forms are reviewed to ensure that they support information sharing between partners and are consistent with the revised Moray policy and procedures*	Systematically identify forms which need created/amended as the project progresses Support process through modifications to Care First	Mar ~~– May 21~~ now Nov 21
Phase 2.0			
	Work stream	**Description**	**Timeline**
2.1	**Multi Agency - Training and Development** *Support staff by offering training and information sessions*	Develop a package of training materials and information sessions to support the delivery of change management	May – Dec 21
2.2	**Communication and Engagement** Inform all stakeholders of the change process and explain the rationale	Develop a communication plan to explain the change process and the reasons why this change has taken place	ongoing
2.3	**Continuous Professional Development** *Support change management through coaching, mentoring and supervision***.**	Deliver an on-going programme of materials to re-enforce new way of working	May – Dec 21
2.4	**Performance Management** *Create a performance report which is clear, concise and timely to produce*	Develop performance measures to support statutory requirements and continuous improvements. Sample test IRDs like Care Inspectorate 1-6 scale for CI. Sample internal processes – ASP 1-4 Begin with Screening tool – sample Asp referral form	Sep -Dec 21

Summary of Meeting 17/5/21	Action	Who
1.1 Develop Core Process **1.1.1 ASP Process 1 - Screening Tool:** Interim process prior to IRDs in place for Access Team and ASPs has been created. As well as exceptions of practitioners when they identify ASP risks with people they already assigned to. Mapping of pathways have been created and written guidance from Zandra to be finalised before Screening tools goes live at the Access team. Screening tool will be in use when IRDs are being developed, then pathways will be further refined to incorporate IRD process. Access to start using screening tool as 2 APs are screening but no evidence of improvement. So using the tool will aid this. **Access team have funding for 3.5FTE Social Workers for 12months, with a review in Dec 21.** Issue/Snagging log was created by VL for access team to offer data to refine screening tool **MILESTONE:** Screening tool will be functioning and used on Care first by **end Aug 21** Deadline for Phase 1: End of March 21- **Now Beginning of Aug 21**	**ACTION:** Screening tool date to go live to be agreed with ZS and EG. **ACTION:** Zandra to support access team to embed change management **ACTION:** Zandra to create guidance notes for screening tool **ACTION:** Emma to add issue Log to teams share drive – Margaret to direct team to issue log and capture as they go once screening tool goes live	ZS with EG ZS ZS EG
1.1.2 Further Development of Core Process: **ASP process 2 – Process for Practitioners** (when they identify their own service user as potentially being at risk of harm under ASP legislation) **ASP Process 3- ASP Team Process** (when screening tool is forwarded from Access team -T*his is an interim process whilst the IRD process is being developed)* – Go Live same time as Screening tool Process **ASP Process 4 - ASP Investigation Meeting** (including when 3pt test is met and no longer required)	**ACTION:** Zandra to create guidance notes	ALL VL

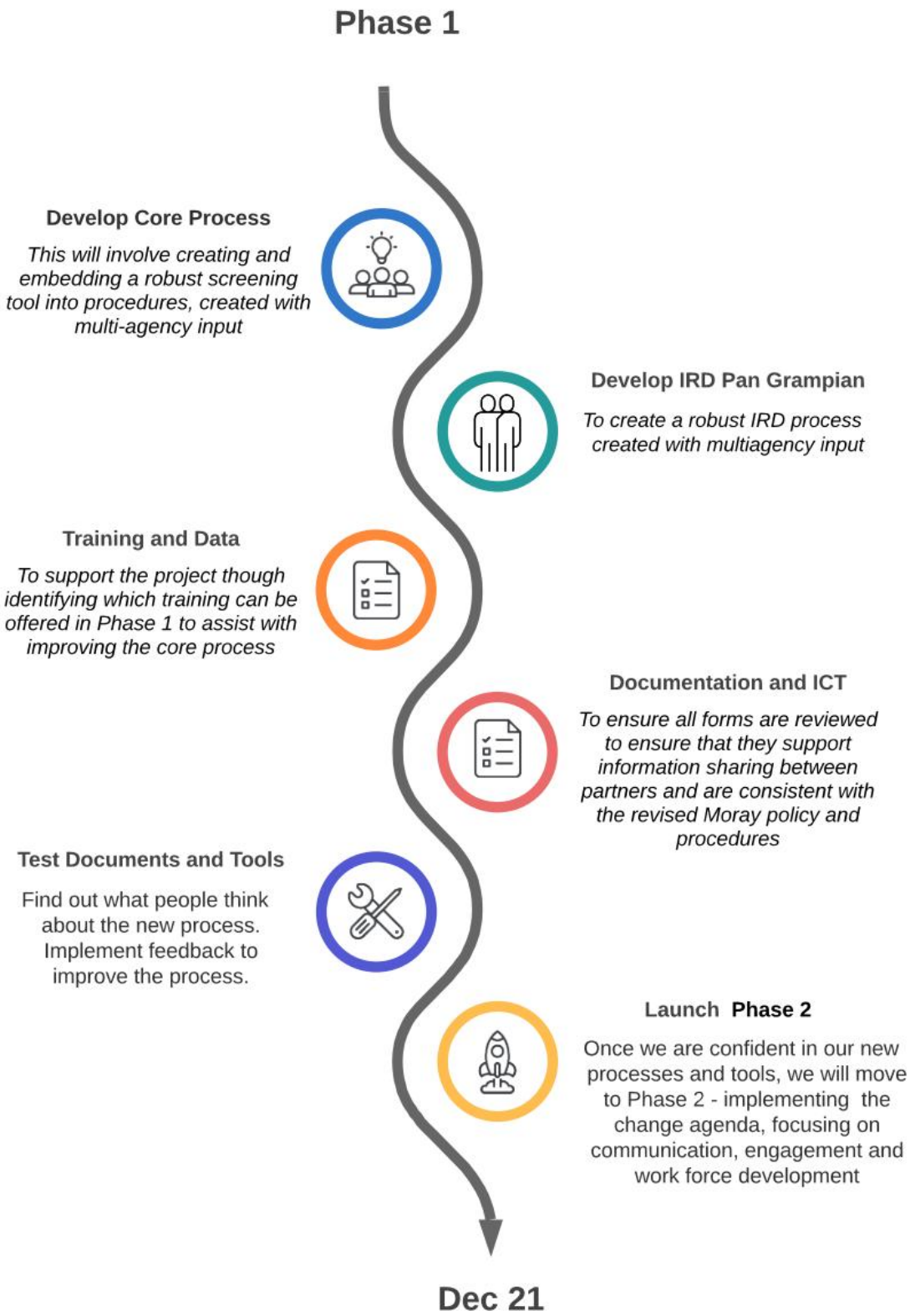
MILESTONE: ASP Processes 2-4 will be embedded between March through to June until IRDs are developed and core processes are further adapted and refined. Deadline for Phase 1: **End of Aug 21**	for ASP all other processes. Focus on ASP Process 3 – ASP Team process. **ACTION:** Date to be decided for ASP 2 and 4 **ACTION:** Under ASP Process 4 : When a person meets the 3pt test a new event is required to be added called ASP Monitoring alongside ASP screening and ASP investigations. Vicky to add this into care first **ACTION:** FCAs required an additional drop down on ASP referral form. EG emailed VL for this to be actioned. **ACTION:** Under IRD need a minute of the meetings added to CF	VL VL
1.2 Training & Data		

Training: ASP module 1 and 2 training has been delivered to staff over TEAMS for MC employees and outside agencies. Module 3 / 4 harder to deliver online. Risk – training online is not as valuable as F2F. Reluctancy to discuss online. **ZS** – Council Officer Refresher training to be rolled out **NHSG Training:** – Training offer for Adult Protection for all NHS staff. Also offering level 3 training for GPs via CPD connect. Request from internal adult protection to provider training to nursing and AHP, level 2 is over subscribed. Liz Tait will see first draft of NHS Public Protection framework. Co-define who goes on what courses and training. **Quality Assurance: for Phase 2** – sample 5 IRDs – look at the quality of the screening tool and grade 1-6 like Care Inspectorate. Look for areas of improvement. Deadline for Phase 1: **End of Aug 21**	**ACTION:** SG run Council Officer Training	
1.3 Develop care Process **Background:** **IRD Process:** Involvement from Public Protection Officer is essential to streamline the process across Grampian. Draft process to be shared end Jan for consultation and finalised by end Mar. A short life working group has been created to offer a consistent response across Grampian. Grampian IRD process will offer strategic guidance (Skeleton structure) which will need to be implemented into local IRD processes. Likely to have a phased approach to IRDs during June/July across Grampian. NHS requires a single point of contact between each HSCP. This person would not be the person to take forward the IRDs, they would need to access the clinical systems then identify the right person to nominate for take forward the IRD. KOB is consulting with GPs. Change management and culture change is required to support Adv Prac to chair IRDs, formally record on care first. **Latest Update May 21:** Grampian group have created an IRD process, just required sign off and implementation. Update will be given regarding single point of contact for NHSG.		

IRD training will be created through online presentations. First 6 slides will be IRD and the remaining will be specific to Moray. **MILESTONE:** Grampian IRD developed and in test phase for a period of review. Deadline for Phase 1: **End of March 21 – COMPLETED** **MILESTONE:** Develop Moray IRD pathway incorporating Grampian framework Deadline for Phase 1: **March – July 21 – Delayed Dec 21**	**ACTION:** ASP Team to work with KOB to add Morays IRD info to training package	KOB / ASP Team
1.4 Documentation and ICT VL has made great progress with updating Care first. Drop down options have been created, Also Police Concern Form is now Live in Care first and being used by Access Team. Stats regarding how many forms being created and the outcome are going to Emma Gormley. Need to discuss what is required to be audited and can we use care first to do this? Self-evaluation for heath board required – legal duties sit with health board and local authority. Base lining where NHS and staff are. Deadline for Phase 1: **End of Dec 21**	EG and VL to work on data and share with OWG at next meeting. Gap analysis required	EG/VL
AOCB **Police:** Meeting with Fiona Topping Detective Inspector in charge of Aberdeen Hub met on 17 March 2021. LA – Is there any changes required form the police concerns report? **ASP Adv Prac** – new role to job advert and interviews planned middle May 21.	**ACTION:** Lesley to liaise with Fiona re police concern reports. Any changes required by Police?	Lesley McLean

Risks discussed for Risk Log in meeting: • Resource / Capacity of Access Team and prioritisation of workload. Radical review and implement changes in ASP processes in Moray. Rolling review. ASP process needs to be fulling resourced tomatine the ASP processes. Specifically access team resources. Screening is time consuming and needs to be resourced. Regularly review the process will identify a resource issue. **– COMPLETED 3.5 FTE staff allocated to Access Team** • Access Team capacity reduce from Major to Significant risk due to funding for 3.5FTE • Legal to be invited to APC	**ACTION:** Emma and Zandra to progress with recruitment	ZS/EG
Outcomes/ So what Data. What are the outcomes for those individuals? Measure the outcomes of the individuals who were involved in an IRD. Adult at risk and actively reviewing these people until the are no longer, or limited risk mitigation. Escalate to corporate risk register. National level have had problems with service user feedback from a person coming through AP processes. Looking to involve advocacy. City and Shire discussion to see if they have changed their ways. SG proposal. SU to engage is a difficulty. Outcomes of the process/meetings/IRDS can be tracked and monitored. However, capturing outcomes for the service users on their journey needs to be recorded on CF, this may need more refining of the forms. Often advice and info can be passed via emails, phones, so need to be better able at record this as supporting outcomes.	**ACTION:** ZS to check was city/shire are doing with Service User feedback after they went through AP process. **ACTION:** CG Create an Outcome focused workstream after processes are embedded. June 21	
TASKS FROM THE CRITICAL PATH WILL BE SENT OUT TO INDIVIDUALS. NEXT MEETING: **28 June 1500 TEAMS**		

Adult Support & Protection: Moray Improvement Action Plan 19/05/21 APPENDIX 1


Phase 1
Develop Core Process
This will involve creating and embedding a robust screening tool into procedures, created with multi-agency input
Develop IRD Pan Grampian
To create a robust IRD process created with multiagency input
Training and Data
To support the project though identifying which training can be offered in Phase 1 to assist with improving the core process
Documentation and ICT
To ensure all forms are reviewed to ensure that they support information sharing between partners and are consistent with the revised Moray policy and procedures
Test Documents and Tools
Find out what people think about the new process. Implement feedback to improve the process.
Launch Phase 2
Once we are confident in our new processes and tools, we will move to Phase 2 - implementing the change agenda, focusing on communication, engagement and work force development
Dec 21

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 MAY 2021**

SUBJECT: **MENTAL HEALTH OFFICER SERVICE IN MORAY**

BY: **CHIEF SOCIAL WORK OFFICER**

1. REASON FOR REPORT

1.1. To inform Committee of the current situation in the Mental Health Officer Service in Moray.

2. RECOMMENDATION

2.1. It is recommended that the Clinical and Care Governance Committee consider and note the current situation within the Mental Health Officer (MHO) service in Moray and the actions being taken by the MHO Governance Group to mitigate.

3. BACKGROUND

3.1. Mental Health Officers (MHOs) assess individuals experiencing mental disorder who may need compulsory measures of care and treatment. The role carries considerable autonomy and responsibility, and involves working alongside medical and legal professionals in order to safeguard the health, safety, wellbeing and rights of people. MHOs must be a social worker and hold additional qualification. The training is at master's degree level (SCQF level 12) and requires significant commitment from the individual and the local authority to support their learning.

3.2. In Moray all MHOs have a substantive post and there are no dedicated MHOs in Moray. Therefore it is an additional duty to their normal responsibilities as a social worker or advanced practitioner or team manager. There are 9.1 full time equivalent (FTE) MHOs who are normally on the Mental Health Act rota during office hours. Managers do not participate on the rota but do undertake guardianship reports.

3.3. The MHO Forum meets every 3 months to allow time for mutual support, continuous personal development (CPD) and updating on local and national practice developments.

MHO Governance

3.4. The MHO Governance Group is chaired by the Chief Social Work Officer and members include the Consultant Practitioner Mental Health (MH), Manager of the MH Social Work Team, Integrated Service Manager MH and Out of Hours Social Work Manager. It meets quarterly and monitors capacity of the service and provides a strategic overview.

Pressures on the MHO service MH Act

3.5 During the COVID-19 pandemic there were 3.5 FTE officers unable to carry out Mental Health Act work due to change of role or shielding, which left Moray working with 62% of the MHO workforce who would normally be available. This extra work was largely absorbed by the mental health team and there was little guardianship work progressed.

3.6. The current situation is that all MHOs are undertaking MHO roles. There remains a significant challenge with ability to cover the daytime rota especially during periods of annual leave. This challenge is felt across other teams where managers are required to release an MHO for rota duty, because their own teams are stretched.

3.7. Mental Health Act activity and comparative data is provided in **APPENDIX 1**.

Pressures on the MHO Service Guardianship Reports

3.8. Only day time MHOs undertake guardianship reports. There are currently 13.1 FTE MHOs undertaking guardianship reports including team managers. For the year 1/04/20 to 31/03/21 there were 60 referrals for guardianship reports and considering that there were fewer MHOs on the rota during the spring and summer of 2020 due to shielding or alternative duties that means that some MHOs have completed 6 reports in the year.

3.9. Whilst every effort is being made to eliminate the waiting list there are currently11 people outstanding, with the longest person waiting since December 2020. Although many other local authority areas have waiting lists for MHO reports for private guardianships it is the first time Moray has had to deviate from normal policy of allocating to an MHO directly on receipt of the request. A system of prioritising means that urgent applications are placed at the front of the list (e.g. adults at risk and delayed discharge).

3.10. Efforts to reduce the waiting list include MHO working additional hours and plans to employ a relief MHO using funds allocated by Scottish Government to deal with the effects of Covid-19.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Out of Hours MHO cover

4.1. In 2018 two MHOs retired and it proved difficult to recruit MHOs with experience of child protection. The service is operating with two social workers in the OOHs social work team that are not MHO qualified.

4.2. A workforce analysis was completed in 2018 and it was agreed that 2 candidates would be put forward to the Mental Health Officer training programme run by the Robert Gordon University to replace MHOs leaving, retiring or being promoted.

4.3. The most recently recruited out of hours social worker is being prepared for the 2021/22 course intake. The Scottish Government is offering a grant to help build MHO capacity nationally. In order to maximise chances of qualification a grant application for backfill was made and was successful. Interviews take place on 7 May 2021 for entry into the MHO programme.

4.4. The Mental Health Care and Treatment Act makes it clear that the principal route to admission to hospital for someone experiencing mental ill health is through a short-term detention certificate (STDC). It requires a S22 doctor (a doctor who has undergone specific training) and MHO consent. Treatment can start immediately and the person has a right of appeal.

4.5. Should someone be assessed by a GP for example, or there is a S22 doctor available but no MHO consent then a person may be admitted to hospital under an Emergency Detention Certificate (EDC). It lasts for 72 hours and should be converted to an STDC as soon as feasibly possible (if appropriate). There is no right of appeal and treatment cannot start until converted to an STDC.

4.6. The Mental Welfare Commission has highlighted an increase in EDCs nationally and NHS Grampian as a whole is well below the national average for detention under EDC.

Actions to mitigate risk out of hours MHO Cover

4.7. In November 2020 the Governance Group for MHOs compared Moray's situation with those of neighbouring authorities. In Highland all out of hours staff are qualified MHOs but there is no MHO cover for the rural locations out of hours. In Aberdeenshire the out of hours MHO rota is covered by daytime staff (in their contract on qualification as an MHO which attracts additional salary). Aberdeenshire train 4-5 MHOs every year which reduces the burden of covering out of hours. There is no MHO cover after 11pm.

4.8. Given low numbers of out of hours detentions in Moray (where there is no MHO on duty outside office hours **(SEE APPENDIX 1))** it does not merit daytime MHOs covering shifts on standby, because it would place an additional strain on the daytime duty rota which would potentially move the problem. Actions were agreed as below. It was agreed to stay with the current model of out of hours social workers being qualified MHOs:

- Collation of data where a S36 is required on Friday night or Saturday (i.e. assessment for a STDC does not take place next day). Further review if the rate of these detentions under EDC increase by more than 20%
- Preparation with the new OOHs worker included spending time with an MHO and in the Mental Health Team.
- Release of out of hours social worker for half his post using the grant for backfill to maximise the learning experience.

- Recruitment of OOHs in future will require an agreement to either hold MHO qualification or an agreement to train as an MHO. To determine if they would be capable of being successful in applying for the course, recruitment will include a written exercise if the candidate is not an MHO. Future recruitment panels will include either the Consultant Practitioner or MHT manager
- Exploration of recruitment of an MHO to be on standby on a casual basis out of hours
- The Governance Group will meet again in May 2021 but another meeting and further review will be triggered if OOHs detentions increase by over 20%.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019
This links to Outcome 7 of the Strategic Commissioning Plan "Partners in Care" – People using health and social care services are safe from harm.

(b) Policy and Legal
The Mental Health Care and Treatment Act

(c) Financial implications
None specified at present.

(d) Risk Implications and Mitigation
A number have been identified within the body of the report along with the actions planned to mitigate the risks.

(e) Staffing Implications
There are no staffing implications arising as a result of this report.

(f) Property
There are no property implications.

(g) Equalities/Socio Economic Impact
An Equality Impact Assessment is not needed because there are no changes to policy as a result of this report.

(h) Consultations
Consultations have taken place with the MHO Governance Group who are in agreement with the content of this report.

6. CONCLUSION

6.1. The MHO Governance Group is chaired by the CSWO and members include the Consultant Practitioner MH, Manager of the Mental Health Social Work Team, Integrated Service Manager MH and Out of Hours Social work Manager. It meets quarterly and monitors capacity of the service and provides a strategic overview. This group has identified some

pressures and mitigations on MHO service and agreed a set of actions as per 4.8 above.

Author of Report: Bridget Stone, Consultant Practitioner
Background Papers:
Ref:

APPENDIX 1

Table 1 below shows Mental Health activity for 2020/21 and compares to previous year. The numbers of EDCs in brackets show the occasions where an MHO was not available out of hours. It suggests that the numbers for EDCs are stable and that the second retirement has not increased the use of EDC. Reason for this is unclear.
In addition to the activity detailed below there are currently 30 people on a CTO or CO that require ongoing MHO input/involvement and mandatory review.

Comparative Data 2019/2020 to 2020/2021

Table 1

2019	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan 2020**	**Feb**	**Mar**	**total**
EDC	0	4	1	5	2	3	3(2)	3(2)	4(3)	0	**0**	**0**	**25**
STDC	7	7	5	8	8	7	6	8	9	2	**3**	**3**	**72**
CTO	1	1	0	1	0	0	1	1	3	1	**1**	**7**	**17**
CTO6	0	0	0	0	1	1	1	1	0	0	**0**	**0**	**4**
CO	0	1	0	0	0	0	0	0	0	1	**0**	**0**	**2**
2020	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan 2021**	**Feb**	**Mar**	
EDC	4(1)	1(1)	0	3(2)	2(1)	0	2(1)	0	2(2)	0	**3**	**0**	**17(8)**
STDC	9	9	3	9	6	4	6	5	3	5	**1**	**5**	**65**
CTO	0	4	0	0	2	2	1	2	2	2	**1**	**1**	**17**
CTO6	0	0	0	0	1	0	0	1	1	0	**1**	**0**	**3**
CO	0	2	0	0	0	0	0	0	0	0	**0**	**0**	**2**

Key: EDC=Emergency Detention Certificate. STDC =Short Term Detention Certificate. CTO=Compulsory Treatment Order. CO=Compulsory Order. CTO6 = CTO extension.

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 MAY 2021**

SUBJECT: **OUT OF HOURS MENTAL HEALTH SERVICE PROVISION FOR 16-18 YEAR OLDS**

BY: **SERVICE MANAGER, CHILD AND ADULT MENTAL HEALTH SERVICES**

1. REASON FOR REPORT

1.1. To inform the Committee of the current gap in out-of-hours mental health service provision for young people aged 16-18 years in Moray and actions that are being taken to address this.

2. RECOMMENDATION

2.1. It is recommended that the Committee:

i) note the contents of this initial report; and

ii) agree to receive a fuller report with update on progress made at the next meeting on 26 August 2021.

3. BACKGROUND

3.1. The specialist Child and Adolescent Mental Health Service (CAMHS) in Grampian is a Tier 3 and Tier 4 outpatient service for children and young people aged 0-18 years. The service operates from two sites – the CAMHS Rowan Centre, adjoined to the Glassgreen Centre in Elgin, and the CAMHS Links Unit on the City Hospital site in Aberdeen. Core operating hours for the service are 9am till 5pm, Monday to Friday, excluding public holidays.

3.2. CAMHS, along with operational responsibity and the associated budget for Grampian-wide inpatient and specialist Mental Health and Learning Disability Services, are delegated to the Aberdeen City Integration Joint Board. Ward 4 Dr Gray's Hospital and Muirton Ward, Buckie remain delegated to Moray Integration Joint Board. However, the remit of the service remains pan-Grampian and CAMHS can accept referrals from a range of professionals across health, social care and education, including GPs, Paediatricians, Liaison Psychiatry, School Nurses, Health Visitors, Social Workers, Guidance Teachers and Educational Psychologists.

3.3. There is not specific out-of-hours CAMHS provision in Grampian and this is the case for most CAMH services across Scotland. Due to the ongoing challenges with capacity and demand and requirement to meet the national 18-week referral-to-treatment target (which will shortly change to 4 weeks) in an already overstretched service, CAMHS has been unable to redirect in-hours/scheduled care resource to out-of-hours provision.

3.4. The out-of-hours mental health provision for children and young people accessing Aberdeen services (i.e. patients from Aberdeen City and Aberdeenshire) is different to the provision available for children and young people in Moray. The structure of out-of-hours mental health service provision in Moray is different from Aberdeen, which is a bigger site.

3.5. It would appear that a change of practice with regards to out-of-hours provision for 16 and 17 year olds with mental health problems in Moray has occurred since the onset of the COVID-19 pandemic. This largely went unnoticed for a period due to low frequency of events but has become more apparent due to the increase in need for an out-of-hours response to mental health presentations from young people in Moray, and demand for inpatient crisis admissions.

3.6. As part of the COVID-19 contingency plan, the short stay paediatric assessment unit (Ward 2) at Dr Gray's Hospital agreed to take 16 and 17 year olds presenting with mental health issues to ease pressure on the Emergency Department. There had been an assumption that these patients would be able to be seen by the Nurse Practitioners on the generic Mental Health rota for Health and Social Care Moray, to assess for fitness for discharge out-of-hours. However, this has not been the case.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Whilst there is an existing out-of-hours pathway for children and young people under 16 years with mental health problems in Moray, there is no out-of-hours service at present for 16-17 year olds. As such, there is a gap in service provision for this age group, and inequity in comparison with their peers from Aberdeenshire and Aberdeen City.

4.2. Young people aged 16-17 years who present following overdose or with suicidality are declined an out-of-hours assessment by the Consultant Psychiatrist on the generic Mental Health rota for Health and Social Care Moray. Nurse Practitioners at Dr Gray's Hospital are willing to undertake mental health assessments for these young people, as long as Consultant Psychiatrists are able to supervise them.

4.3. Some Consultant Psychiatrists in Moray have advised that they do not want to provide input to under 18's because they are not child mental health specialists and they have concerns about support from the organisation, should something go wrong. Some defence unions are stating that members should not see young people under 18 years.

4.4. The Mental Health (Care and Treatment) (Scotland) Act 2003 (updated in 2015) states that children in Scotland are defined as those young people being under 16 years of age. Where required for young people aged 14 years and over

from Aberdeen City and Aberdeenshire, an out-of-hours assessment is provided via the generic Mental Health and Learning Disabilities rota (Royal Cornhill Hospital).

4.5. As a result, necessary clinical conversations are not taking place out-of-hours with regards to these young people in Moray, and there is increasing frequency of 16 and 17 year olds with mental health presentations staying on Ward 2 at Dr Gray's Hospital, beyond 24 hours. This is creating additional pressures on paediatric staff and paediatric medical beds.

4.6. For Ward 4, the Adult Mental Health ward at Dr Gray's Hospital, the acuity has changed over time and more acutely mentally ill adults in crisis are having to be admitted. The historical staff profile has also changed. Staff who would have had experience of assessing young people under 18 in Moray have moved on. Health and Social Care Moray have developed adult community based services and they are providing more community based care to adults at home.

4.7. Presently, there is a lack of a multi-disciplinary system for these young people when they are in crisis and a short-life working group has recently been convened with key stakeholders from across our system in Moray to work collaboratively to develop options for when young people in Moray simply need a "safe space" out-of-hours rather than a hospital bed.

4.8. A full report with update on any progress made by the Short-Life Working Group to address this gap in service provision will be submitted for consideration by this Committee on 26 August 2021.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"
This reports links to delivery of Outcome 7 of the Strategic Plan to ensure People using health and social care services are safe from harm.

(b) Policy and Legal
The content of this report relates to services provided in relation to The Mental Health (Care and Treatment) (Scotland) Act 2003 (updated in 2015)

(c) Financial implications
There are no financial implications associated with this report.

(d) Risk Implications and Mitigation
This report outlines the risks that currently exist and the measures that are in place to mitigate them in the short term, and outlines the plan for developing a sustainable service for the longer term.

(e) Staffing Implications
None arising directly from this report

(f) Property
There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment is not required as there is no change to policy and procedures resulting from this report.

(h) Consultations

Consultation on this report has taken place with the Chief Officer, Chief Social Work Officer, Head of Service, Corporate Manager, HSCM and Tracey Sutherland, Committee Services Officer, Moray Council; who are in agreement with the content of this report as regards their respective responsibilities.

6. CONCLUSION

6.1. This reports sets out the current position in relation to the service provided for 16 and 17 year olds in Moray, the mitigation in place and the steps that are being taken to establish a longer term provision.

6.2. It is proposed that a future report be submitted to this committee setting out the plan for the future.

Author of Report: Alex Pirrie, Service Manager, CAMHS
Background Papers:
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 MAY 2021**

SUBJECT: **HOME FIRST IN MORAY – PATHWAY ASSURANCE**

BY: **HEAD OF SERVICE**

1. REASON FOR REPORT

1.1. To provide the Committee with assurance in relation to the pathway for a patient under the remit of Discharge to Assess. Home First.

2. RECOMMENDATION

2.1. It is recommended that the Clinical and Care Governance (CCG) Committee consider and note;

i) the example pathway described in the report for Discharge to Assess; and

ii) further reports will be submitted to this committee in relation to developments in pathways arising from the Home First project.

3. BACKGROUND

3.1. Operation Home First was launched in June 2020 as part of the Grampian wide health & social care response to the 'living with COVID' phase of the pandemic. All three Health & Social Care Partnerships (HSCPs) are working together with the acute services sector of NHS Grampian to break down barriers between primary and secondary care and to deliver more services in people's homes or close to people's homes. We know that outcomes for people who are cared for closer to home are better and we believe that expanding the range of services available to people at home will be of immense benefit to individuals, their families and the wider community.

3.2. The ambition of Operation Home First is to maintain people safely at home, avoiding unnecessary hospital attendance or admission, and to support early discharge back home after essential specialist care.

Whole System Approach to Discharge – Discharge to Assess (D2A)

3.3. Discharge to assess is an intermediate care approach for hospital in-patients who are medically stable and do not require acute hospital care but may still require rehabilitation. They are discharged home with short-term support to be fully assessed for longer-term needs in their own home. The programme began operating as a 6 month pilot from October 2020 to March 2021 and a full report was submitted to MIJB on 25 March 2021 when the MIJB approved permanent funding (para 10 of the draft minute refers). Recruitment of permanent team members is in progress.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. An element of the Discharge to Assess project was to review the pathway to enable early identification of people for whom discharge to assess would be appropriate so that admission could be avoided and people could return home with appropriate support.

4.2. There has been engagement with the clinicians directly involved in this pathway to ensure that all aspects have been considered to provide assurance that it is safe and there are no unintended consequences. In addition there has been wider consulation through the Home First Project Group that has representation from services across the system, third sector and carers.

4.3. An example of a patient journey is set out below:

- Patient is assessed and agreed for Discharge to Assess (D2A) by the inpatient multidisciplinary team at ward level
- Patient consents to D2A involvement and pathway
- Patient is triaged by an Occupational Therapist, Physiotherapist or Advanced Nurse Practitioner from D2A Team
- Liaison takes place between the D2A team and the patient's carers/relatives to ensure understanding
- It is established by the medics and documented in the D2A notes for that patient that they are medically fit for discharge
- ECCi letter will be sent to GP re D2A involvement
- Input from D2A is agreed and starts on day of discharge
- Patient is fully assessed at home by the D2A team - an Occupational Therapist, Physiotherapist and/or an Advanced Nurse Practitioner (ANP)
- All professions within the D2A are professionally supervised by their own profession and operationally supervised by the Team Leads or Dawn Duncan, D2A lead.
- Liaison takes place with any Primary Care or Third Sector agencies previously involved with the patient as to the patient's discharge
- Where Comprehensive Geriatric Assessment is indicated, this is completed jointly with 2 or more professionals from the D2A team
- Medical outcomes are reported to the GP by the ANP and/or liaison with Consultant Geriatrician
- Care requirements identified: referral via Short Term Assessment and Reablement Team (START) - this may change with the change in care provision in Moray & may have to go direct to Access

- Carer assessment needs: referral is made directly to Quarriers or to Access for Social Work involvement if the Hospital Discharge Team Social Workers have not been involved
- Ongoing therapy requirements are referred to the Glassgreen Community Therapy Team
- Major home adaptations are referred to Community Occupational Therapy
- Depending on the patients' assessed needs and personal goals social prescribing takes place or referral may be made to Third Sector organisations as appropriate
- ECCi discharge letter sent to GP re D2A involvement

4.4. Discharge to Assess is the first of the Home First projects to have progressed to implementation phase. There are other strands of work underway in Health and Social Care Moray (HSCM) including Health Improvement approach to respiratory conditions, whole system approach to addressing Delayed Discharges and Hospital at Home. These aspects align to work that is being progressed through the Moray Transformation Board and further detail is provided in **APPENDICES 1-3**.

4.5. As these themes progress and pathways are refined, further updates will be provided to this Committee.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

The aims of Discharge to Assess have significant alignment to the objectives of the MIJB strategic plan and in particular to the Home First theme.

(b) Policy and Legal

None directly associated with this report

(c) Financial implications

Funding has been made available on a permanent basis to enable progression of the programmes of transformation.

(d) Risk Implications and Mitigation

The risks around being unable to successfully embed a Discharge to Assess approach in our culture and system will be identified on a patient case by case basis and mitigations identified accordingly at every stage of the pathway.

(e) Staffing Implications

As the modelling for change in service delivery progressed, the staffing implications were identified and taken forward following the appropriate policies.

(f) Property

There are no property implications to this report.

(g) Equalities/Socio Economic Impact

An Equalities Impact assessment is not required as there are no changes to policy as a result of this report.

(h) Consultations

Consultations have taken place with the Home First Delivery Group, Chief Officer, Clinical Lead, Head of Service and Corporate Manager, HSCM and Tracey Sutherland, Committee Services Officer and comments incorporated.

6. CONCLUSION

6.1. Discharge to Assess was a clinically successful pilot and the pathway for the individual patient has been agreed in consultation with the relevant clinical parties. An individual's pathway would also have input and liaison with the family and carers.

6.2. Further information on Home First and Discharge to Assess can be found in the appendices listed below.

Author of Report: Dawn Duncan, Moray Occupational Therapy Lead
Background Papers: Appendix One: Paper to Moray Transformation Board
Appendix Two: Home First Workstreams
Appendix Three: Discharge to Assess paper

Ref:

REPORT TO: **MORAY TRANSFORMATION BOARD 21 APRIL 2021**

SUBJECT: **HOME FIRST IN MORAY**

BY: **SEAN COADY, HEAD OF SERVICE**

1. REASON FOR REPORT

1.1. The purpose of this report is to provide an update to the Moray Transformation Board (MTB) on the current status and priorities for Home First in Moray.

2. BACKGROUND

Operation Home First was launched in June 2020 as part of the Grampian wide health & social care response to the 'living with COVID' phase of the pandemic. All three Health & Social Care Partnerships (HSCPs) are working together with the Acute services sector of NHS Grampian to break down barriers between primary and secondary care and to deliver more services in people's homes or close to people's homes. We know that outcomes for people who are cared for closer to home are better and we believe that expanding the range of services available to people at home will be of immense benefit to individuals, their families and the wider community.

3.1 The three partnerships and acute services set out a series of principles to help them deliver on these ambitious plans, and they are:

- We will adopt a principle of 'home first' for all care
- We are working within the agreed strategic direction set out by the IJBs and NHS Grampian
- We will focus on outcomes for people.
- We will ensure whole system working and improving primary/secondary care joint working
- We will maintain agile thinking and decision making
- We will support system flow and retain flexibility to respond to system surge (covid/winter)
- We will work within the constraints of segregation/shielding/physical distancing measures and a reduced hospital bed base
- We will maximise digital solutions

3.2 The ambition of Operation Home First is to **maintain people safely at home, avoiding unnecessary hospital attendance or admission, and to support early discharge back home after essential specialist care**.

3.3 At the start of the programme, there was a whole system review to identify services and programmes of transformation that could support a Home First approach.

3.4 A tabletop exercise with senior clinicians and service leads in Moray was held towards the end of May 2020. The purpose of the tabletop exercise was to identify the key areas in the system that would support a whole system approach to the strategic implementation of Home First. Following this exercise a **Home First Delivery Group** was established. It has broad representation from across the services in Health and Social Care Moray (HSCM) and has met weekly since the beginning of July. The group quickly identified key work steams, leads and working groups.

3.5 Adopting quality improvement methodology the working groups have identified key actions, developed driver diagrams, reported on progress through 3 minute briefs and strategic briefings. The work has been supported by cross system work streams of information support, evaluation, communication and engagement and workforce.

4. KEY AREAS OF DEVELOPMENT

4.1 Following a further review at the start of the December 2020, these are now the key areas of focus for transformation work. More detail on all these programmes is contained in the attached PowerPoint (**see Appendix A**).

4.2 A replacement 1.0WTE project manager post has been advertised.

Whole System approach to discharge – Discharge to Assess (D2A)

4.3 Discharge to assess is an intermediate care approach for hospital in-patients who are medically stable and do not require acute hospital care but may still require rehabilitation. They are discharged home with short-term support to be fully assessed for longer-term needs in their own home. The programme is now operating as a 6 month pilot from October 2020 to March 2021. Key outcomes to date:

- 48 patients have received D2A intervention in Moray
- Average age is 84 - ranging from 64 years to 96 years
- Patients all assessed at home from all over Moray - most patients were from Elgin followed by Forres then Buckie and Lossiemouth.
- **30 of 33** patients have seen **increased scores in the functional activities**
- 32 patients have had the Canadian Occupational performance measure administered, **26 rated an increase in their performance** of activities of daily living and 6 stayed the same. Of the 32, **28 patients rated an increase satisfaction** with their performance of activities of daily living

- Of those patients where physio administered Tinetti (balance and gait measure) there has seen **an increase in scores with all those patients and for the Elderly Mobility Scale** (EMS)
- Only 5 of the 48 patients have been referred to START for care of which one patient was re-enabled and no longer requires care
- Patient satisfaction is high according to early feedback from the evaluation work.
- An advanced nurse practitioner (ANP) is supporting the programme. The ANP is completing a comprehensive geriatric assessment (CAG) in the patient's home. They are also undertaking a medication review and assessing the patient's risk of falling.
- D2A now has £500,000 funding approved by IJB and is now in the recruitment process.

Health improvement approach to respiratory conditions

4.4 The aim of this programme is to provide the opportunity for individuals to self-monitor their health and wellbeing within their home and local communities, enable professionals to access information and training so they can best support individuals within their own home and local community and promote and develop community support and resilience to support individuals within their local communities.

4.5 The two initial tests of change with the patients cohorts from Forres and Buckie have been completed and where appropriate those patients have been given further information on how to self manage their condition and have been referred on to one of the respiratory pathways outlined in the attached slide (**Appendix A**). Health and Social Care Moray in partnership with Moray Council Sport and Leisure Service have started a new Respiratory Programme dedicated to those living with or at risk of respiratory disease.

4.6 Based on physical activity and behavioural change, healthcare professionals can refer patients to either the core Pulmonary Rehabilitation Programme or to a new Physical Activity Programme by completing the appropriate referral form. Patients also have the option to self-refer to either programme.

4.7 The Workstream is working closely with Grampian Commission for Evaluation to ensure a clear structure of evaluation is in place and outcomes are evidenced. The key Home First theme is people remain within their own homes. Three key areas for evaluation are: the individual, staff and the system. The third cohort is about to commence. This workstream is now at the maintenance phase.

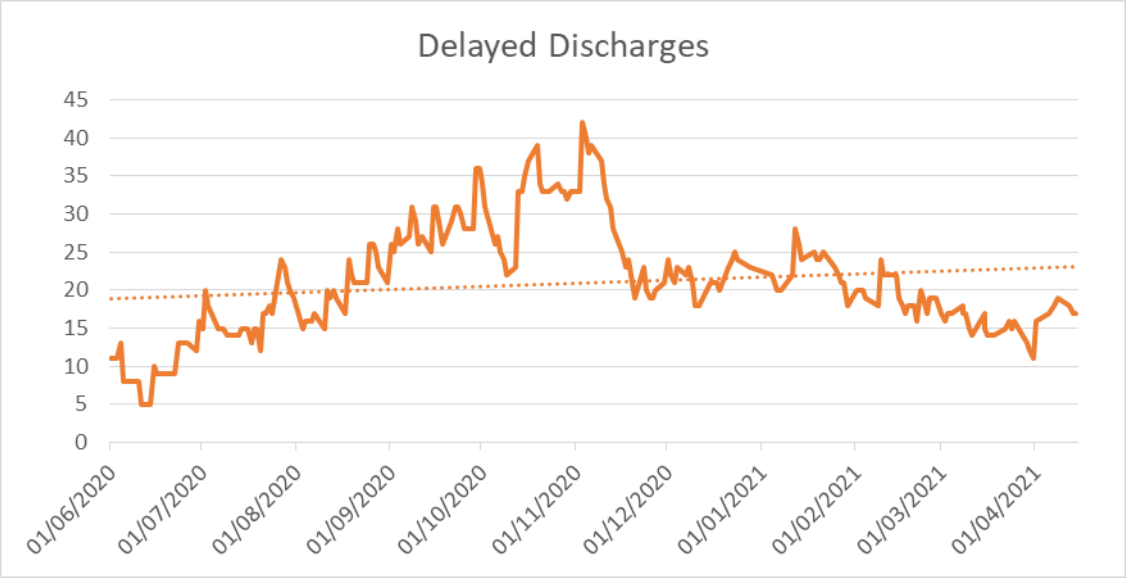
Whole system approach to discharge – Delayed Discharge

4.8 The delayed discharge transformation programme has required a whole system approach as discharge is a complex process. It involves many different members of staff and the components of the discharge process cover a number of different services. The focus of this work is on the following four parts of the system:

a) admission avoidance
b) discharge planning/process
c) community hospital transfers

d) provision of care in the community

4.8 A Delayed Discharge Focus Group has been meeting regularly to address these issues – identifying and progressing actions. Since the action group began meeting at the beginning of October 2020 there has been a sustained reduction in the number of delayed discharges in Moray. More details on the workstreams are available in Appendix 1.



Hospital at Home

4.9 Hospital at home is a short-term targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital. This programme in Moray is at scoping stage and meetings are taking place with clinicians and service managers to agree and identify components of a hospital at home model that takes in to account the remote and rural aspects of service delivery in Moray.

4.10 The components of the proposed service are:

4.10.1 Upstream Assessment.

Identifying people for clinical assessment, treatment and functional improvement at a point well before their trajectory reaches crisis point and potential admission is a key preventative measure that needs adequate resourcing. Early intervention by a member of a multi-disciplinary team can prevent a crisis in the first place and will significantly reduce the utilisation of downstream resources.
Regular tabletop meetings with each Moray General Practice are key to making this strand work well.

4.10.2 Alternatives to Admission

A patient with a decompensating frailty syndrome may present in a crisis either at home or at the Front Door of Dr Gray's Hospital (DGH). Such presentations can be assessed by a multi-disciplinary team and if clinically stable but with functional decline may be able to return home with support. This is currently happening from the Front Door of DGH with the D2A Model.

4.10.3 Safer/Earlier Discharge.

Some patients will of course still require hospital admission to stabilise and treat their clinical condition. With an Older People's Assessment and Liaison Team (OPAL) such patients can have a rapid CGA (clinical geriatric assessment) and as soon as their clinical condition and circumstances permit, can be allowed an early supported discharge under D2A. Such assessments and supports provide for a reduced length of hospital stay, a safer earlier discharge and a potential reduction in 7 and 28 day re-admission rates.

4.11 HSCM has been approved to take part in an Improvement Programme with Health Improvement Scotland to help develop and implement the Hospital at Home model.

Home First Communications and Engagement Framework

4.12 This framework sets out the approach to communicating the Home First programme across Moray and engaging in an open and honest manner with patients, service users, staff and stakeholders to inform its implementation.

4.13 The attached appendix one slides show up to date progress at a glance. Regular staff briefings have been sent to all members of HSCM staff and 2 staff engagement sessions were held in December 2020. There are staffside representatives on the Home First Delivery Group who are actively engaging with staff on all aspects of the programme. Information on Home First is also shared through the Chief Officer's briefings and on the HSCM website.

Third Sector Action Group

4.14 A Third Sector Action Group was recently established to support the implementation of Home First in Moray. This group is represented on the Home First Delivery Group and will ensure there are key linkages between the community groups and the programmes of transformation, identifying areas for action and supporting communication of key messages, to facilitate the transformation programmes.

Home First and Carers

4.15 Under the National health and wellbeing outcomes framework, people who provide unpaid care should be supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being. They should be:

- identified, consulted and actively involved in hospital discharge planning processes at an early stage
- respected and have their expertise valued as equal partners in the provision of care through positive and meaningful relationships / interactions with practitioners
- referred / signposted to Quarriers as the local carer support service in order to access a range of support and advice
- able to exercise their right to an Adult Carer Support Plan and if eligible for support can access a personal budget

4.16 A representative of Quarriers, the commissioned carers support service, is a member of the Home First Delivery Group and is also a member of the Third Sector Action Group. This early engagement with carers now needs to be developed with a structured approach to ensure the action points identified above are taken forward and embedded in our Home First approach. A further meeting with carers is being held in April to discuss concerns/ issues and expectations.

4.17 Feedback from carers is part of the evaluation framework being implemented for Home First.

Home First and Primary Care

4.18 The current programme for Home First in Moray is supporting a model of patient care whereby the patient does not have an ongoing acute medical condition but has a significant functional decline making living at home precarious and thus requiring some form of re-enablement. It is important that as the Home First model develops within the community that we are mindful of workload on an already stretched primary care service by incorporating adequate provision of support .

4.19 As mentioned in Section 3.2.4 (Hospital at Home) the aspects of service development covering upstream assessment, alternatives to admission and safer/enhanced discharge must be adequately resourced. It is anticipated the requirement will be an enhanced multidisciplinary team operating in the community, the resources for which will be identified through both re-design of current workforce and re-direction and redistribution of workload across the hospital and community interface.

4.20 Mental Health

Mental Health pathways (along with palliative and geriatric) run across the entirety of Home First. Key aims are to provide safe, equitable mental health services for the Moray population. Further details are available in Appendix one. An IJB session for Mental Health services is scheduled on 29 April.

Grampian Commission for Evaluation of Home First

4.21 A cross-system working group is collaborating with colleagues from each of the priority areas across Grampian to ensure the right information is captured to evidence the positive changes being made. The working group is headed by a Research & Evaluation Lead to oversee the implementation of this piece of work. The Moray Information Support Team are working closely with the Grampian Commission on key pieces of work to ensure transformational change is supported by robust evidence to allow for delivery of sustainable change going forward.

Appendix Two
Key Ambitions of Operation Home First

To maintain people safely at home

To avoid unnecessary hospital admission or attendance

To support early discharge back home after essential specialist care

HSCM HOME FIRST-DISCHARGE TO ASSESS

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF1 **Project Lead**: Dawn Duncan **SRO:** Sean Coady

Key Aims

- Intermediate, early supported discharge approach
- Where hospital in-patients who are clinically stable and do not require acute hospital care but may still require rehabilitation or care services provided with short term support
- Discharged to their own home where assessment for longer term requirements is then undertaken in the most appropriate setting i.e. the person's own home and at the right time, by a trusted assessor

Primary Objectives

- Essential criteria
- Patient focussed care
- Easy and rapid access to services
- Effective assessment
- Easy information flow
- Networks of blended care
- Blurred boundaries
- Continuous evaluation & feedback

Scope

- #endpjparalysis/Care in Between
- Delayed Discharges/Hospital @ Home
- Care of the Elderly/Living Longer Living Better in Moray
- Moray Partners in Care/6 Essential Actions for Unscheduled Care
- Active & Independent Living Programme Ambitions for AHPs.

Achievements

- This project has successfully completed a test of change (July/Aug 2020), providing the system with enough assurance to allow it to progress to pilot phase and allocate funding accordingly – 5Oct to 31 March 2021.
- Staff Q&A session December 2020
- Forensic mapping of 12 patient journeys
- Report presented to SMT and then to IJB development session was favourably received and then approved funding on 25 March 2021 for full implementation.

Programme Workstreams Progress

Activities in current period

26/3/21	**Permanent funding establishes- approved by MIJB.**	
1/4/21	Recruitment of new staff – in progress (Hiatus now between end of pilot and establishing new staff)	
	.	

Future Actions/Milestones

Action	Timescale	RAG
Recruitment of adequate staff resource to ensure operability.	June 2021	
Preparation of Staffing arrangements for new team, including equipment	June 2021	
Establishment of performance measures to monitor progress and identify further opportunities	June 2021	
Progress update on service delivery to Home First then SMT	November 2021	

Key Risks/Issues

- Failure to establish permanent staff
- failure to embed pathway in the systems.

Dependencies

- Recruitment pending

Finance

- £500,000 funding secured for 2021/22

Performance

- Measurements for success needed and criteria established.
- Real time measurements as well as potential future aims.
- Established trends noticed.

HSCM HOME FIRST-DELAYED DISCHARGES

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF2 **Project Lead**: Lesley Attridge **SRO:** Sean Coady

Key Aims

Whole system approach to discharge

Primary Objectives

There are four components to this work stream: Admission Avoidance, Discharge Planning Process, Community Hospital Transfers and Provision of Care in the Community

Scope

To identify and implement changes to the discharge process. This a complex piece of work involving all teams across the system.
The aim is to ensure there is sustainable processes in place to support early discharge home and reduce delayed discharge bed days.
Scope, plan and deliver a whole system approach for discharge in Moray that is safe, properly resourced and is sustainable.

Achievements

The system has shown a reduction in the number of delayed discharges since October 2020. The key areas of improvement that have contributed to this reduction are:
Communication - weekly meetings to review patients on Community Hospital waiting list; weekly meetings to review operational issues/concerns; Locality Managers attend weekly meetings with commissioning and providers; Weekly/daily Multidisciplinary team meetings; Mental Health staff attend senior charge nurse meetings; key information summary available to members of the multidisciplinary team; Out of hours Social Work contact details given to Emergency Department.
Improvements in pathway work - Community Response Team (CRT) pathway circulated; Contracts with new external providers in place; Discharge Coordinator in position; Implementation of Social Work screening tool and Implementation of traffic light system across both acute & community hospitals.

Programme Workstreams Progress

Activities in current period

31.01.2021	Appointment of Care at Home assessors – ongoing	
31.01.2021	MDT model – Ward 5 and 7 processes under review	
31.03.2021	Intermediate care options being reviewed including current provider provision and long term provision. (Jubilee cottages in place whilst Loxa court is pilot project, ended March 2021 and an evaluation to be undertaken.	

Future Actions/Milestones

Action	Timescale	RAG
Review of OOHS provision of 24/7 community nursing model	TBC	
Overview of Surge and Flow Discharge work (to have a consistent process across NHSG), links with process mapping, all being led by Acute improvement team	TBC	

Key Risks/Issues

- Delays in the recruitment process and appointment of Care at Home assessors is impacting on progress. This is progressing and one person takes up post on 26 April and the second has a date pending.

Dependencies

Communications
Recruitment
Funding

Finance

Funding for extra posts

Performance

Measurements criteria established.
Real time measurements as well as potential future aims.
Established trends noticed.

HSCM HOME FIRST-HOSPITAL AT HOME

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF3 **Project Lead**: Sam Thomas **SRO:** Sean Coady

Key Aims

- Older people with frailty are at particular risk of being affected by institutionalisation and delirium. Some 30 to 56% have been shown to experience a reduction in their functional ability between admission to hospital and discharge.
- Hospital at Home is a short-term, targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital.
- Hospital at Home works best when it is part of an integrated acute and community-based service model to meet local population need.
- Creating the environment to support Integration Authorities, NHS Boards and Local Authorities to effect transformation and introduce services such as hospital at home will require close collaboration and robust strategic planning and commissioning across sectors.
- Timescales are driven by SG

Primary Objectives

- A short-term, targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital.
- It differs from other community services by enabling the management of more severe conditions, such as sepsis and pulmonary embolism.
- It provides urgent access to hospital-level diagnostics, such as endoscopy, radiology and cardiology, and access to interventions such as intravenous fluids and oxygen.
- Care is delivered by multi-disciplinary teams of healthcare professionals and is Consultant led, complying with current acute standards of care.

Scope

Programme Workstreams Progress

Activities in current period

	•Various meetings have been held that encompass a multi-disciplinary approach including acute, geriatrician, AHP and GP support.	
	•This has been supported by national webinars and meetings that have offered a national generic model.	
	D2A set up as a key foundation plank	

Future Actions/Milestones

Action	Timescale	RAG
process map and draw together appropriate team, incorporating governance and clinician buy in. A small cohort of patients will be trialled in the first instance. Grampian wide model.		
Staffing training , measurement and equipment Remote consultation via telephone and Near Me effectively utilising resources.		
Process will then go to SMT/IJB for appropriate timeline.		

Key Risks/Issues

- Failure to establish permanent staff/ failure to embed pathway in the systems/ SG criteria may not fit with Moray picture/ whole system approach/ rurality, limited HSCM model, recruitment issues in general and equipment infrastructure are ongoing issues. Geriatric pathway is ongoing concern Continued inappropriate admissions· Loss of independence
- · Increased morbidity/mortality through unnecessary hospital admissions· Increase in Delayed Discharges and decreased availability of medical beds for acute unstable admissions
- · Continued "silo management" and failure of integrated working

Achievements

- HSCM has been approved to take part in an Improvement Programme with Health Improvement Scotland to help develop and implement the Hospital @ Home model

Dependencies

- Funding
- Staffing

Finance

- funding

Performance

- Specific Targets/Measures need to be further elucidated/ identified through QI methodologies applied to
- multi-professional SLWG's in line with current modern clinical practice
- · It is important that both patients, relatives, carers and "staff at the coal face" are involved in the co-
- production of targets and measures in line with Realistic Medicine

HSCM HOME FIRST-Prevention& Self Management/ Respiratory Conditions

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF4 **Project Lead**: Iain MacDonald **SRO:** Sean Coady

Key Aims

To improve the health and wellbeing of those individuals with respiratory conditions, through the promotion of self -management strategies and tools. The three primary drivers to achieve this are:

- Provide the opportunity for individuals to self-monitor their health and wellbeing within their home and local communities.
- Enable professionals access to information and training to ensure they can best support individuals within their own homes and local communities.
- Promote and develop community support and resilience opportunities to support individuals within their local communities.

Primary Objectives

- Improving individuals digital connectivity
- Improving access to information
- Improving peer and community supports
- Increasing access to Weather Alerts
- Increasing access to My COPD App
- Increasing access and attendance at exercise programmes
- Increasing attendance at pulmonary rehabilitation programmes

Achievements

- Test of change completed with COPD patient cohort Oct to Dec 2020
- COPD Information for individuals/patient updated
- Community resources identified and actioned to support individuals becoming digitally connected.
- Virtual Pulmonary Rehab Programme provided for two patient cohorts Jan to March 2021.
- Virtual Exercise Programme provided for two respiratory conditions patient cohorts Jan to March 2021.
- Training Programmes for staff to upscale programmes Jan to April 2021.
- Funding identified and26 ICT devices purchased to enable individuals/patients to access information/virtual classes
- Sustainability of programme linked to Moray Council Sport and Leisure Business Plan

Programme Workstreams Progress

Activities in current period

12/04/2021	Third Cohort of Exercise Programme	
12/04/2021	Training of Exercise Instructors to Level 3 Qualification	

Future Actions/Milestones

Action	Timescale	RAG
Broaden out Programme to encompass all Long Term Conditions. Completion of training for exercise instructors	April 2021 onwards	
Further develop promotion material for individuals/patient, GPs and HCPs. Reintroduction of face to face classes whilst maintaining virtual programmes	May 2021 onwards	
Promote a locality perspective to developing Prevention and Self Management incorporating local 3rd sector & volunteer organisations. Introduction on MYCOP and Health Care Apps	June 2021 Onwards	

Key Risks/Issues

- Sustainability of funding to maintain and develop programmes.

Dependencies

- Staffing and Resources

Finance

- Further funding investment to maintain provision of programmes

Performance

- Work completed at a Grampian level to ensure robust evaluation of programmes provision. Evaluation on going.

Data collected and evaluated includes:

- Before and after questionnaires for participants and staff
- Measurement of EQ 5D improvement in wellbeing scores
- Participant case studies
- Quantitative data

Participant Feedback:

"Prior to the programme I felt that I had no energy & lethargic and quite depressed. I was missing social interaction with people due to COVID-19 and having to shield."

Participant Feedback: *"I think the programme has helped my physical health because my strength in my arms and legs has improved and my stamina has also improved."*

HSCM HOME FIRST-Mental Health

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF10 **Project Lead**: Pamela Cremin **SRO:** Sean Coady

Key Aims

- Safe, equitable secondary care mental health services for Moray population; Access
- Recovery focussed secondary care Moray mental health services
- Community based mental health services
- Reducing Drug and Alcohol related harms
- A move away from traditional service age boundaries at transitions – services for young people up to age of 25 more integrated across CAMHS and Adult Mental Health Services
- Suicide Prevention
- Improving people's experience of care
- Peer and Carer involvement

Scope

- Delivery of Good Mental Health for All Moray Strategy 2016-26; and NHS Scotland Mental Health Strategy 2017-2027
- Unscheduled Care
- Distress Brief Interventions
- Forthcoming Mental Health Transition and Renewal Plan and funding
- Strategic Commissioning
- Trauma Informed Workforce
- Primary Care Mental Health: service and workforce development

Achievements

- Mental health Services fully remobilised and responsive
- Technology enabled service and practitioner uptake of Near Me
- Referral Criteria for secondary care updated
- Improved Adult Psychology waiting times – achieved 18RTT standard in November 2020 and sustained as of April 2021
- Evaluation of Urgent Care Team which was in place during pandemic – now disbanded as service is fully remobilised
- Liaison with GP practices and their MDTs established as a regular part of mental health service delivery in Moray
- NHS Grampian Psychological Therapy Hub (Access); Moray staff supporting Hub delivery
- Moray Primary Care Psychological Therapies redesign

Programme Workstreams Progress

Activities in current period

	Redesign of Moray secondary care Psychological Therapies and re-establishing Groups	
	New Primary Care Psychological Therapies Service commenced on 1st April 2021	

Future Actions/Milestones

Action	Timescale	RAG
Develop Mental Health First Response in GP Practices to replace GP Link Worker Service	As soon as possible – current service gap	Specific to Primary Care
Trauma Informed Workforce – training and development for all H&SC Moray and commissioned service workforce	In progress	
IJB development session for mental health services to be held on 29 April 2021	29 April 2021	

Key Risks/Issues

- Bed spacing and reduced admission capacity across NHS Grampian for mental health in patient care
- 3rd Sector remobilisation in terms of supporting and working with people in their own homes to manage their mental health
- Workforce availability – some mental health posts difficult to recruit to. Medical Locum insitu for Older Adult Mental Health
- IT Platform for group therapy requires expansion to meet NHS G demand
- On going high risk drug and alcohol related harms; and deaths

Dependencies

- Multi agency working and collective risk and case management

Finance

- Mental Health Budget has no budget pressures. Core budget uplift announced by Scottish Government for 2021/22
- Increased funding for Moray Drug and Alcohol Service (MIDAS) from Moray Alcohol and Drugs Partnership (MADP)
- Significant new and future financial investment by Scottish Government mental health and substance misuse services for all ages

Performance

- Ongoing service performance and measurement of KPIs
- Performance monitoring of third sector commissioned contracts for mental health and substance misuse

DISCHARGE TO ASSESS (D2A)

Supporting Operation Home First for Moray

A report of findings from the D2A Project to date

Dawn Duncan (NHS Grampian)
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February 2021

Discharge to Assess – Home First for Moray

Executive Summary

- 48 patients seen by D2A Team – 40 inpatients and 8 redirected from Emergency Department
- Saved an estimated 112 acute bed days through supported early discharge and admission avoidance
- 32 patients directed away from community hospital resulting in an estimated saving of 1,216 bed days
- Just 5 patients required onward referral to START, one of whom was discharged from START following reablement, demonstrating a reduction in the requirement for care following a D2A intervention
- 81% - 91% of patients saw improvement in Occupational Therapy standard assessment scores (Barthel and COPM)
- All patients saw improvement in standard Physiotherapy standard assessment scores (Tinetti and EMS)
- Patients and carers provided very positive feedback for their experience of D2A
- Fully supported by Senior Management & Clinicians in Dr Gray's Hospital
- High degree of interest in Moray D2A from across Grampian and Scotland

Discharge to Assess – Home First for Moray

Background

Operation Home First is a phase of the Grampian-wide health and social care response to "living with COVID-19" phase of the pandemic. The Moray Home First Delivery Group met for the first time at the end of June 2020. The 3 key ambitions of Operation Home First for Moray are:

1. To maintain people safely at home
2. To avoid unnecessary hospital attendance or admission
3. To support early discharge back home after essential specialist care.

The agreed principles for Home First are:

- "Home First" for all interventions
- Agreed strategic direction set out by the Integrated Joint Boards (IJBs) and NHS Grampian
- Focus on outcomes for people
- Whole system working and improving primary/secondary care joint working
- Maintain agile thinking and decision making
- Retain flexibility to respond to surge (COVID/winter)
- Work without constraints of segregation
- Maximise digital solutions

Discharge to Assess (D2A) Work Stream

Prior to the COVID-19 pandemic, D2A was identified through the 6 Essential Actions Programme for Unscheduled Care (6EA) as a vehicle for patients to be discharged from Dr Grays Hospital (DGH) in a safe and timely way and for their functional needs to be assessed in the most appropriate setting. It was recognised that extra or alternative resource would be required for this.

The Moray D2A work stream was activated through the formation of a multidisciplinary, multiagency working group comprising key stakeholders from acute and health and social care which has met virtually via Microsoft teams and formed smaller working groups for specific tasks.

Occupational Therapy had explored established D2A Team models across the UK through the 6EA framework and provided a definition and key principles of D2A as well as the requirement to establish a therapy–led model with senior medical decision making at point of discharge.

Definition of D2A

D2A is an intermediate, early supported discharge approach where hospital in-patients who are clinically stable and do not require acute hospital care but may still require rehabilitation or care services provided with short term support, are discharged to their own home where assessment for longer term requirements is then undertaken in the most appropriate setting i.e. the person's own home and at the right time by a trusted assessor.

Principles of D2A

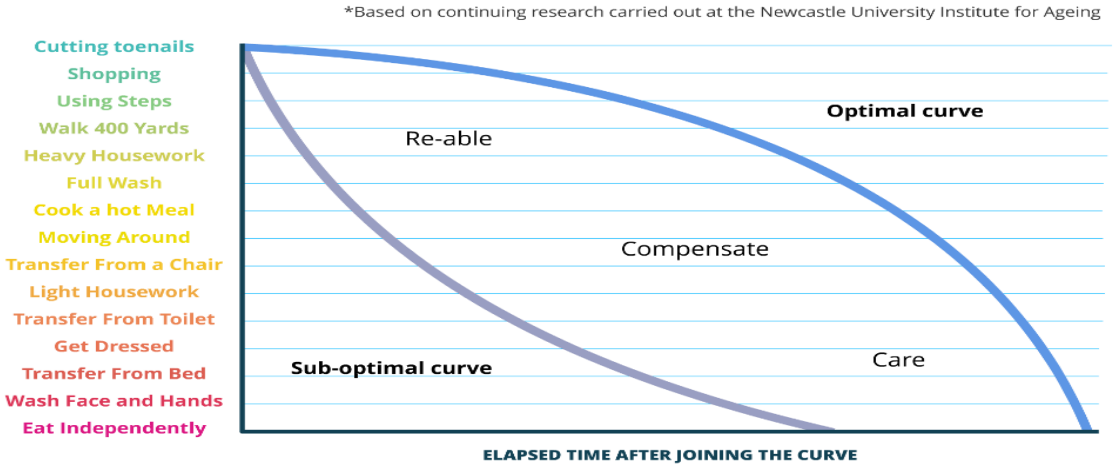
- Essential criteria
- Patient focused care
- Easy & rapid access to services
- Effective assessment
- Easy information flow
- Networks of blended care
- Blurred boundaries
- Continuous evaluation & feedback

Moray Model for D2A

- Moray lacked intermediate care options and an appetite for positive risk taking for patients – patients were placed on a journey for care as there were no other options available to robustly support discharge. This meant that patients often waited in hospital longer than was necessary.
- D2A Moray is for in-patients who have not, cannot or should not be fully functionally assessed by Allied Health Professional (AHPs) in the hospital environment but can be supported to be assessed at home in a risk-assessed timely way.
- D2A is led by AHPs in the community once the person is deemed medically stable for discharge.
- D2A is reliant upon quick and easy access to AHPs and rehabilitation Support Workers with Occupational Therapy and Physiotherapy competencies.
- D2A in Moray also offers the input of an Advanced Nurse Practitioner (ANP) for Geriatrics to complete Comprehensive Geriatric Assessment.
-

D2A and the Lifecurve™

Newcastle University in partnership with ADL Smartcare Research developed a model of compressed functional decline named the Lifecurve™ which is based on evidence in literature proving there is a hierarchical order to the loss of functional ability. In short, we lose our ability to carry out everyday activities of daily living in a set order.



The Lifecurve™ model means that if we know which activity a person cannot currently perform independently we have advanced knowledge of what their next challenge will be and allows us to target rehabilitative interventions earlier in the individual's Lifecurve™. This assists patients in self-managing their condition and associated functional difficulties more effectively and reduce their dependency upon care services in the longer term. If we provide care too early in a patient's Lifecurve™ they become more dependent quicker on that care and less functionally able.

In 2017, all Allied Health professional (AHPs) across Scotland completed the Lifecurve™ Survey with their patients for a set period as part of the Active and Independent Living Programme (AILP).
The aim of the survey was to establish where people were on their Lifecurve™ when receiving AHP services and the results showed that AHPs require to intervene higher or quicker in a patient's Lifecurve™ in order to influence their trajectory. We also need to understand the cost of the consequence of intervening "late" in the trajectory.
The recommendations of the survey were the promotion of discussion around prevention of functional decline and supporting innovation for delivery of earlier intervention and the subsequent improvements in health and wellbeing as a result.
It was hypothesised that a D2A therapy-led approach would offer an opportunity to maintain patients on their Lifecurve™ and prevent care requirements sooner than necessary.

Drivers for D2A

Primary strategic drivers for D2A in Moray are the Moray Partners in Care Strategic Plan 2019-2029, Living Longer Living Better in Moray Plan 2013-2023, the Active and Independent Living Programme for AHPs and the 6EA programme, as well as the Operation Home First agenda.

- Research shows attendances at Emergency Departments (ED) by the elderly are often an indication of increasing frailty and a decline in function in the 6 months preceding a crisis which culminates in ED attendance.
- Research has also shown that prolonged unnecessary hospital admissions cause harm to individuals resulting in deconditioning, harm from exposure to hospital acquired infections, falls, confusion and many people never returning home.
- The health outcomes of people improve quicker and more effectively if those individuals are assessed and managed at home.
- It is for these reasons the D2A Working Group consider multidisciplinary Comprehensive Geriatric Assessment (CGA) to be an important element of the identification and management of frailty factors in this population as part of the Moray model.

D2A Mapping – July 2020

- The working group identified 12 in-patients whom they considered would have benefitted from a D2A approach.
- These patients' journeys were mapped in detail and common characteristics were identified which led to the formulation of criteria for Moray D2A – **See Appendix One**.

- It was agreed by the working group that short term support would be up to 2 working weeks with flexibility to increase this period should patient need deem it necessary.
- It was agreed by the working group that with analysis of D2A teams across Scotland, the mapping of these 12 patient journeys and the Lifecurve™ Survey that rehabilitation as opposed to care was what was required and would therefore be the primary focus of the D2A Team in Moray.
- On full analysis of the data for these 12 patients, the group were also able to formulate the process of how and where people could enter the D2A model and key professionals required at each of these stages – **see Appendix Two**

D2A Pilot – July/August 2020

A D2A pilot was then carried out with 6 patients – 2 of which attended the Emergency Department at Dr Grays Hospital and 4 were in-patients. The purpose of this pilot was to test criteria, process and measurements.

Measurements considered:

- Personal functional outcomes based on AHP assessment at hospital attendance or admission and at the end of D2A intervention
- Qualitative patient evaluation and feedback of their D2A journey
- To consider anticipated patient journeys (Delayed discharges)
- Transfers to Community Hospitals
- Admission prevention from ED into DGH
- Length of stay for those patients who experience D2A compared with what their projected journeys may have been
- Readmission rate to DGH for those patients who experience D2A

This pilot highlighted the following:

- **Staffing** – it was clear Occupational Therapy was central to all referrals for D2A. Physiotherapy input was not required for all patients. Senior medical review was necessary to confirm and document each patient medically stable for discharge. The intervention of a Consultant Geriatrician sped up the process of identifying appropriate patients for D2A intervention. Follow up for some individuals by an Advanced Nurse Practitioner (ANP) for Geriatrics provided Comprehensive Geriatric Assessment within the person's own home which addressed decompensating frailty syndrome, added to the quality of the discharge process for that individual and established links with Primary Care.
  It was clear a 7 day D2A service was required.

- **Measurement** – the Canadian Occupational Performance Measure (COPM) is a person-centred and person-rated individualised tool for establishing a person's functional goals and outcomes. COPM requires the person to prioritise their functional goals and occupations and rate their performance and satisfaction with

their performance at the start and end of therapy intervention. COPM and the Barthel Index were piloted with the 6 people in the test of change. Physiotherapy used the Tinetti Assessment Tool and the Elderly Mobility Scale as outcome measures for those people who were appropriate although functional mobility was usually also measured via COPM. The test group were also issued with a satisfaction form to complete by mail.

- **Process** – the pilot clarified the D2A process of referral, assessment, review and also referral onto other agencies. The criteria was proven to be appropriate and through a D2A process patients were less likely to require care.

- **Outcomes** – feedback from our 6 people showed that they benefited and appreciated the input of D2A – individuals perceived an improvement with their performance in functional tasks and also an improvement in their satisfaction with that performance of functional tasks, their anxiety on discharge was dissipated, their individual needs were identified and dealt with through a Making Every Opportunity Count (MEoC) approach and they felt listened to and supported.

  An SBAR report detailed the success and opportunities D2A, if resourced, could play in the achievement of the key ambitions of Operation Home First for Moray but in particular the key ambition of early supported discharge back home after essential specialist care. Estimated costings for a permanent service were provided for staffing, travel and equipment costs.

As a result of the success of the pilot for D2A funds were allocated to run a 6-month project from 5th Oct 2020 to 31st March 2021.

D2A Project – 5th Oct to 31st March 2021

- **Funding** – was identified from 5th Oct 2020 to 31st March 2021 to run a 6-month project to fully test D2A.
- **Staffing –** the timeframe meant that recruitment was not an option. It was clear that full-time leadership was required therefore secondments were offered to Occupational Therapy staff to provide operational management of the project as well as clinical input and also a development opportunity for those staff members. One WTE Occupational Therapist (2 staff members) were seconded with backfill for their substantive posts.
  The Physiotherapy Service was carrying a number of vacancies at the beginning of the project and could offer 4 extra hours to support D2A. However, as recruitment has taken place, 2 days per week for Physiotherapy have been allocated since mid-Dec.
  Generic Occupational Therapy/Physiotherapy Support Workers on the Moray Bank were offered the opportunity for extra hours to support D2A and there was a healthy response. Two Support Workers from The Oaks were offered secondments for the duration of the project to D2A. This was advantageous to both parties in that D2A had Support Worker input of minimum 43.5 hours per week and also an opportunity

for those staff members to expand their competencies for their return to their substantive roles.
The Consultant Geriatrician left at the end of Oct 2020 and a temporary seconded Consultant Geriatrician is in post for 6 months. The ANP for Geriatrics was to continue to provide input to D2A where possible and when required.
Measurement and monitoring support from Quality Improvement, Public Health and Health Intelligence was also made available.

- **Equipment –** laptops and SMART phones were purchased and have been pivotal to the real-time gathering and recording of data and communication.
Diagnostic and monitoring equipment has been purchased – a bladder scanner, thermometers, a blood pressure monitor and an ECG machine is on order.

D2A Project – The Story So Far

From 5th Oct 2020 to 17th Feb (19 weeks) **48 patients** have been assessed by the D2A Team. **29** (60%) were female and **19** (40%) male.

The average age of people referred was **84 years** with the eldest being 96 years and the youngest being 64 years.

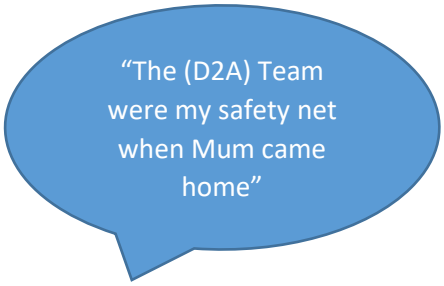
All bar two of the patients were referred from Dr Grays Hospital with the majority (17 or 35%) referred from Ward 7 under the specialism of geriatric medicine.

8 (22%) of the 48 patients were referred from the Emergency Department at Dr Grays Hospital, preventing unnecessary admission. One of these patients was referred out of hours and assessed the following day at home.

Each individual has been assessed in their own home. The geographical spread of patients is all over Moray from Forres in the West to Cullen in the East, Dufftown in the South and Lossiemouth in the North.

12 (29%) of the 41 people assessed were from Elgin, 9 (23%) from Forres and 4 (10%) from Buckie and Lossiemouth respectively.

Please refer to appendices for Case Studies



Outcomes

Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) is a person-centred and person-rated individualised tool administered by Occupational Therapists for establishing a person's functional goals and outcomes. COPM requires the person to prioritise their functional goals and occupations and rate their performance and satisfaction with their performance out of 10 at the start and end of therapy intervention. COPM is used with patients with multiple and complex goals.

- **26** (81%) of the 32 patients using COPM rated their performance in activities of daily living (ADL) as **improved**
- **6** rated their performance in ADL had been **maintained**
- **28** (88%) of the 32 patients rated their satisfaction with their performance in ADL had **improved**
- **4** rated their satisfaction with their performance in ADL had been **maintained**
- Evidence of functional improvement and/or maintenance of ADL as perceived by our patients

81% of patients rated their performance in activities of daily living as improved
88% of patients rated their satisfaction with their performance in activities of daily living as improved

The Barthel Index

The Barthel Index is one of earliest standardised functional assessments and is an ordinal scale used to measure performance in activities of daily living (ADL) in the domains of personal care and mobility in patients with chronic, disabling conditions especially in rehabilitation settings.
Domains assessed include toileting, transfers, bathing eating, dressing, continence and mobility. Patients receive numerical scores based on whether they require physical assistance to perform the task or can complete it independently.

Functional tasks are assessed and scored at first and last assessment and scored out of a total of 100. Scores are weighted according to the functional assessment and professional judgement of the therapist. A score of 0 would represent a patient dependent in all assessed activities of daily living, whereas a score of 100 would reflect independence in these activities,

91% of patients have shown an **increase in their scoring**.
The average patient score at first assessment was **79** and the average patient score at final assessment was **94**. This shows an increase in independence in activities of daily living in those patients assessed using the Barthel Index.

"The (D2A) girls were great – they motivated Dad and showed him he was able to do more and it took the pressure off me"

Tinetti Assessment Tool

The Tinetti Assessment Tool is a simple, easily administered test used by Physiotherapists to measure a person's gait and balance. The test is scored on a person's ability to perform specific tasks and can give an indication of that person's risk of falls.

Where the Tinetti Assessment Tool was administered with D2A patients – all patients had an increase in their scores indicating an improvement in their gait and balance and a reduction in their risk of falls.

Elderly Mobility Scale

The Elderly Mobility Scale (EMS) is a 20-point validated assessment tool for the assessment of frail elderly individuals. The EMS is measured on an ordinal scale.

Where Physiotherapists used the EMS as an outcome measure, all D2A patients showed an improvement in their mobility.

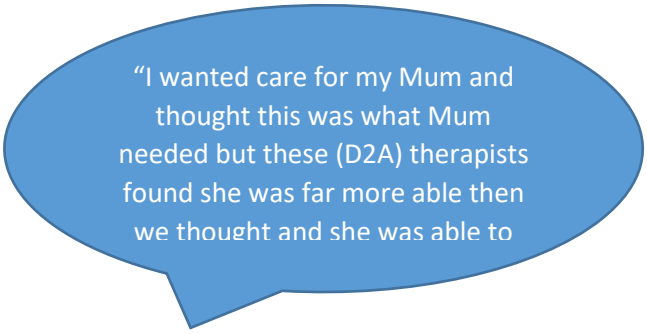
Please note patients' functional mobility was also measured using the Barthel Index and COPM.

"I'd give them a medal, a very hard job [dealing with people like me]. I don't even like old people!"

Patient Outcomes – Onward Referrals

The primary aim of the D2A project was to provide effective intermediate support for early supported discharge based upon therapy input. We know that patients wait longer in hospital if they are awaiting care.

Of those 48 patients assessed thus far, 5 patients have required referral for ongoing care from START (Short Term Assessment Reablement Team) and one of these patients was discharged from START within 2 weeks. This shows that the premise of D2A as a functional therapy-led assessment programme for early supported discharge works.



Of those 48 patients assessed thus far, 4 have required referral to the Access Team – 3 of which were referred to Community Occupational Therapy for adaptations to their bathrooms (bath to shower or level access showers) and one to Social Work for a carers assessment where the patient's son required support himself.

Ten patients have been referred on to the Community Physiotherapy service (Glassgreen Therapy Team) for ongoing mobility, outdoor mobility, gait, strength and balance issues. One patient was referred on to the Glassgreen Therapy Team for ongoing Occupational Therapy rehabilitation.

The majority of patients were issued with the Moray Occupational Therapy Falls Bundle which details how individuals can prevent falls through a self-administered assessment and the provision of self-management information and supported by practical activities.

The D2A Team used a Making Every Opportunity Count (MEOC) approach with all patients and this included signposting to local community and national resources to assist those patients to live as full and independent a life as possible at home.

D2A has proven that therapy-led services, when they can intervene early on a patient's Lifecurve™ after a decline in function which necessitates a hospital admission/attendance, can maintain and improve patient's functional abilities rather than compensate for their functional problems with care.

"This (D2A) team is a great idea – when Dad had been discharged previously we were just left to get on with it"

Advanced Nurse Practitioner Role and Input to D2A

Eleven D2A patients have been reviewed by the Advanced Nurse practitioner (ANP).

Actions and benefits identified by the ANP as a result of those reviews were:

- Comprehensive Geriatric Assessment of frail elderly individuals in their own home.
- Patients perform better in their own familiar environment with improved longer term outcomes.
- Prevented unnecessary lengthy hospital admissions which lead to deconditioning in the elderly – patients were deemed medically stable for discharge but medically optimised at home.
- Actions for GPs including referrals to other specialities
- Medication reviews which identified poor compliance in patients with medication at home as a result of problems with physical dexterity accessing medication and cognitive issues. The prescribing of appropriate medication regimes reduces the risk of harm to the patient through reducing the falls risk and if the medication is of no clinical benefit. Waste is reduced.
- Examinations, monitoring and diagnostics leading clinical decision making – this was expedited through access to equipment (bladder scanner, thermometers, blood pressure monitors etc.) and support workers to carry this out
- Patient ownership and more control of their health at home under a patient centred model rather than a medical model.

"Lovely [K] showed me how to boil potatoes without lifting the pan. It was practical but really useful ways of doing things"

Blended Approach

The D2A Team were able to work with some patients alongside input from the Community Response Team (CRT) for individuals particularly living in rural areas (Speyside & Forres) where there was a presence of the CRT members and they were able to supplement the D2A input.
There has also been a blended approach with Forres patients with the Forres Neighbourhood Care Team (FNCT) particularly at a weekend when D2A resource was stretched across Moray geographically.
A blended approach when working alongside families has also been of great importance and the support of families for the ethos of D2A is vital.

All of these examples of joint working have concerned all parties working with the patient to the same clearly documented rehabilitation goals identified by a trusted assessor from the D2A Team

Patient/Carer/Family Feedback

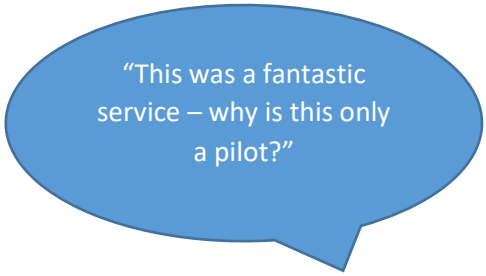
Patient and carer feedback has been pivotal to providing a person-centred D2A service. Semi-structured telephone interviews have been completed by Public Health colleagues to ensure objectivity and quotes from these interviews are included throughout this report. Evaluation is ongoing.

All patients and their carers interviewed have been **highly satisfied** with the intervention of the D2A Team on their discharge from hospital and their discharge from the D2A Team.

Patients recognised a **reduction in their anxieties** around discharge from hospital following a period of illness and their carers supported this view in their feedback.

Both patients and carers recognised and reported on an **improvement in the patient's ability to engage in activities of daily living** as a result of targeted therapy intervention.

Carers commented on **perceptions of the requirement for care being dispelled** as a result of targeted therapy interventions and person centred functional assessment. Evidence of **positive risk taking** as a result of robust functional assessment has emerged.



Impact of D2A on Flow & Capacity

Prevention of Inappropriate Admission to Hospital

Eight of the 48 patients were referred and assessed at home directly from attendance at the Emergency Department at Dr Grays Hospital thus preventing unnecessary admission to hospital.

The Occupational Therapist in the Emergency Department at Dr Grays Hospital is able to swiftly identify those patients appropriate for D2A and ensure these patients are then assessed at home by a trusted assessor. The D2A Team and ANP are actively screening patients over 85 years of age attending the Emergency Department at Dr Grays Hospital.

The average general medical & orthopaedic trauma hospital admission for Dr Grays Hospital is 9 days therefore we can extrapolate that by discharging these 8 patients directly from the front door, D2A prevented an unnecessary patient admission and saved 72 bed days in the system with the associated costs of £41,040.

Reducing Length of Hospital Stay

The advantages of reducing hospital unnecessary length of stay have already been explored and we know this is beneficial to the patient in a number of ways.

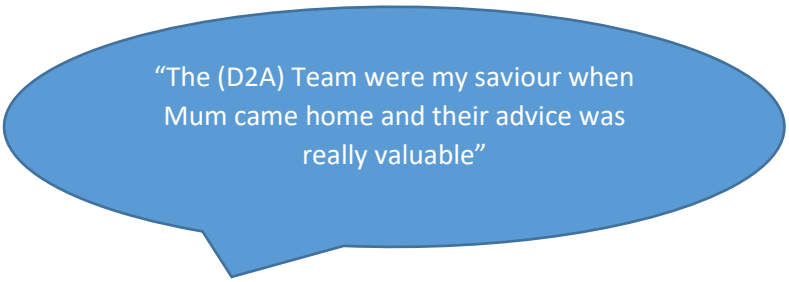
The average length of stay for a patient admitted to Dr Grays Hospital under the specialism of geriatric medicine or orthopaedic trauma from 2019 to 2020 was 9 days.
The average length of stay for a D2A patient was **8 days**.
A cost saving of one bed day per each in-patient seen for D2A amounts to 40 beds day at a saving of **£18,810**.
We know with greater capacity in the D2A Team this number would increase.
Within the 19 weeks of this pilot thus far, it is estimated a total of **112 acute beds days were saved.**

All of the patients assessed by D2A have had their anticipated journeys mapped (in the absence of D2A).

32 (2/3) of the patients assessed by D2A would have been transferred to a Moray Community Hospital for slower stream rehabilitation and/or for assessment for care. The average length of stay in Moray Community Hospital for 2019/20 was **38 days**. Estimated D2A **1,216** bed days.
1/3 of patients would have been directly referred for assessment for care from Dr Grays Hospital.

In providing early supported discharge through D2A there has been a **decrease in the number of patients transferred to a Moray Community Hospital.** There has seen an improvement in efficacy in the team decision making regarding the transferring of patients to a Moray Community Hospital and a contribution to flow mechanisms in the system.

Readmission rate for D2A patients was lower at both 7 days and 28 days – **7.3 %** at 7days compared with average rate of 9.91% and **15%** at 28 days compared with 19% for medical patients



Reducing the Requirement for Care Packages

Only five of 48 patients assessed by D2A required onward referral to START and one of these patients was discharged from START after a short period of further enablement.

D2A reduces risk adversity in the system by providing an intermediate support service with agility to discharge patients early with person-centred targeted interventions identified with the patient by a trusted assessor. In mapping all D2A patients' anticipated journeys it is projected that almost all of these patients would have either experienced longer stays in hospital or would have been referred for assessment for care and potentially START either whilst in Dr Grays Hospital or most certainly whilst in a Community Hospital.

The D2A Team with ANP are also screening patients over 85 who attend the Emergency Department to ensure we are capturing any frailty issues in those patients, anticipating patient need and attempting to prevent unnecessary referrals for care.

Key Stakeholder Feedback

The staff groups were canvassed for their feedback on the D2A project. Key themes emerging were:

Benefits to the patient

- "Rapid comprehensive assessment of patients at home"
- "Home is the best environment to assess patients"
- Improved patient outcomes – feedback post D2A input to inpatient teams has shown a positive difference in patients at home in comparison with perceived abilities on discharge
- Reduced length of stay and therefore reduced deconditioning of patients – described as discharge when patients are "medically stable"
- Patients not having to wait unnecessarily for care because this was the only option for follow up at home
- Facilitating positive risk taking
- Joint working of the MDT

- A “safety net” of trusting your colleagues to pick up patients quickly and comprehensively at home
- Reducing patient and carer anxiety about discharge – a “seamless transition from hospital to home”
- An increased understanding of the role of the D2A as the project has gone on leading to earlier appropriate referral

Benefits to the MDT & the System

- Improving and development of skills and knowledge in the D2A Team
- Early supported discharge and subsequent reduced length of stay
- Improved flow and capacity in the system
- Reduction in unnecessary admissions
- Increased staff competencies
- Wider and more effective discharge planning and communication within the MDT
- Support Worker have reported they have felt well-supported, valued and listened to by both qualified staff in the D2A team and by the patients and their families
- Support Workers have reported that in working more generically they have felt of greater value to D2A patients at home as their work was function not task based

Challenges Identified as a result of the D2A Project & Future Considerations

- Staff education and understanding of the principles of Home First and D2A
- Risk adversity in a number of professionals
- Organising the logistics of morning discharges to support early assessment by D2A that afternoon
- D2A Team capacity – this is a project and capacity of the team has limited capacity of the amount of patients who can be accepted onto the caseload
- Input from Occupational Therapy and Physiotherapy into D2A has been dependent upon their being capacity within the existing teams in Moray and Bank staff. At the beginning of the project the Physiotherapy service was carrying a number of vacancies and therefore able to provide limited input to the project. From mid-December 2 days of Physiotherapy has been released for D2A.
- Rurality of patients spread across Moray made capacity and rota planning difficult when having to be in two spaces for example, for self-care in the early morning at opposite ends of Moray.
- The rurality of the pan-Moray caseload has seen mileage costs attached to the D2A project. The Occupational Therapy pool cars based at Dr Grays Hospital have been used for the majority of visits but visits have also been planned logistically to fit where staff live to enable staff to visit patients at the beginning and end of the day where realistic to reduce unnecessary travel and mileage costs
- There has been a risk to the project as a result of staffing as Generic Support Workers have been offered extra hours on a voluntary basis to provide shifts for D2A. If these staff had felt unable to provide this input and had withdrawn capacity would

have dwindled for the team to be able to safely provide early supported discharge in a timely way.
- Lone working as with many community based services. Every staff member was issued with a mobile phone, Smart phone or laptop and a "Buddy System" is in operation.

Feedback from the Moray Community Hospitals Stakeholders

- More appropriate patients are being transferred to Community Hospitals i.e. those patients with complex rehabilitation and discharge arrangements.
- Less inappropriate patients coming to a Community Hospital to await smaller packages of care – these are being discharged from Dr Grays Hospital with D2A.
- Keen for D2A to be in place post-COVID when Moray Community Hospitals can admit directly from the community as these patients would be appropriate for D2A and be able to be turned around quicker.

"Thank you for sharing the preliminary results of your Discharge to Assess project at the Moray Community Hospital Directors meeting today. We are aware that you have been preventing admissions at Dr Grays or pulling them from the wards and preventing transfer to community hospital.
We all see the sense of this and would unanimously agree that it as a project as part of Home First which is producing results and is taking significant pressure off the wards as well as care system, and as such would strongly support that this work is continued to be funded and becomes mainstream." Ewen Riddick, Community Hospital Director, Seafield Hospital.

D2A – Spreading the Word

There has been a high degree of interest across NHS Grampian in Moray's D2A project. The work stream lead has presented to Aberdeenshire Health & Social Care Partnership and has provided information to Acute and City colleagues regarding the Moray model.

A video has been produced with NHSG Corporate Communications which is currently being edited.

The D2A Team have presented to a number of forums in Dr Grays Hospital including the Clinical Forum, Senior Staff Committee and Senior Charge Nurses forum.

We have also presented to the IJB and provided a virtual staff engagement session in December 2020.

We have also produced a patient, carer and staff booklet which explains the ethos and process of D2A

Summary & Recommendations

- Feedback from patients and their carers supports that a D2A approach has been successful for them in reducing anxieties, supporting positive risk taking and in meeting their functional goals.
- D2A evidences early supported discharge from hospital, prevention of admission to hospital & reduced readmission rates in Moray and therefore has an impact on the whole health & social care system and is cost effective.
- D2A evidences targeted therapy input improves patient functional outcomes and there is reduced requirement for care for those patients.
- D2A evidences by intervening early in a patient's LifecurveTM with a targeted functional approach, patients can improve or maintain independence after a hospital admission/attendance.
- D2A requires Occupational Therapy leadership over 7 days – all 48 patients' required Occupational Therapy assessment as a result of patient's chosen goals for activities of daily living. With a 7 day service senior decision making can maintain effective flow and early supported discharge over 7 days from Dr Grays Hospital.
- D2A requires Physiotherapy input – just less than half of the patients assessed so far have required Physiotherapy.
- D2A requires Generic Occupational Therapy and Physiotherapy with Support Workers with generic competencies at a Band 3 level.
- D2A requires ANP input for Comprehensive Geriatric Assessment and also succession planning in the form of additional nursing hours.
- D2A requires its own administration support

D2A requires to be permanently funded in its entirety in order to continue to support patients and to continue to contribute to capacity and flow within the health and social care system in Moray.

The following is a breakdown of the costs required to establish D2A in Moray permanently:

Band	FYR Costing Top	Number Required	Total Cost
Band 7 Occupational Therapists – Team Leads & Governance	£60,987	1.5	£91,481
Band 7 ANP	£60,987	1	£60,987
Band 6 Occupational Therapist	£51,744	1	£51,744
Band 6 Physiotherapist	£51,744	1	£51,744
Band 6 Nurse	£51,744	0.6	£31,046
Band 3 - Generic Support Workers (OT & PT competencies)	£29,334	6	£176,004
Band 3 – Administration Support	£29,334	1	£29,334
Mileage Costings based on projections from project			£5,000
Total yearly costs			**£497,340**

Appendix One

D2A Criteria

- Person informed consent
- Resident of Moray
- 18 years and over
- Medically stable
- Rapid diagnostics completed e.g. Bloods, ECG, Chest X-Ray /Plain Film X-Rays, CT Head if deemed required
- Initial combined AHP assessment completed at Emergency Department front door/early on admission
- Independently mobile with/without aids
- Anticipated short term assessment period ≤ 2/52
- Continence can be managed – independent with equipment/pads or support including overnight
- Admission to hospital likely to be detrimental to cognitive status
- Person's family in agreement

Discharge to Assess – Home First for Moray

Appendix Two

Referral Sources:

Discharge to Assess Process -

Acute Medical Assessment Unit (AMAU)

Seen 8am ward round + stable

Emergency Department (ED)

Identified by ED team

Case finding people ≥ 80 years of age

Falls

Trauma & Orthopaedics

Stable fractures

Criteria*

Discharge2Assess

Single combined Assessment

Or

Several interventions & follow up

Essential Team Kit

- *ECG machine*
- *BP meters x 2*
- *Bladder scan*
- *Access to essential ADL equipment*
- *Access to pool cars*
- *Smart phones & laptops*

Essential Education

- *ED staff*
- *AMAU staff*
- *Scottish Ambulance Service (SAS)*
- *Social care/enabling services*
- *Primary Care*

Home with D2A Team input within 24 hours

Blended approach to diagnostics and functional assessment

Occupational Therapist/Physiotherapists

Geriatrician/GP with Special Interest – 3 sessions per week

Geriatric ANP

Access to Support Workers

Access to Social Work/Care to move patients on

Discharge

Rapid onward referral

Case Study 1 - Person and context

Family locally, fall at home, fractured clavicle, admitted to hospital

- Occupational Therapy assessment - able to transfer from chair and bed independently; mobilising with a quad stick
- Washing and dressing difficult due to collar and cuff in situ
- Patient and family concerns - meal preparation and transfer; convinced longer term care was required to enable safe discharge at home
- Discharge to assess criteria met and seen by the Discharge to Assess Team (D2AT) on ward prior to discharge
- Afternoon discharge from hospital

Outcomes

- Visited at home and assessed by the D2AT on day of discharge
- Goals identified for two week intervention period with lady
- Health Care Assistant 3 x daily visits initially and reduced over time
- Initial progress limited due to collar and cuff
- Two week intervention period extended slightly due to readmission (medical reasons)*
- Successful use of kitchen trolley for meal preparation and transportation
- Marked improvement in function across all areas, lady expressed increase in confidence with own functional abilities, no further interventions required, discharged
- No longer an identified need for formal care
- Making Every Opportunity Count (MEOC) signposted to McLintock Eye service (provide home visits) – lady took up this opportunity

Lessons Learned

- **Reassessing following readmission* and Investing additional Discharge to Assess team time beyond 2 weeks ensured there was no need for any formal input from care services**
- **Essential to ensure information is fedback clearly to individuals and family members to confirm understanding and clarity throughout service provision**
- **Discharge from hospital early in the day is essential to avoid delays in the discharge process and ensure patients can be followed up the same day at home by the Discharge to Assess Team**

Anticipated outcome without D2A – would have required formal care potentially resulting in lengthy hospital stay

Case Study 2 - Person and context

Limited outside social support, admitted to hospital with sciatic hip pain

- Occupational Therapy assessment - able to transfer from chair and bed independently; needed assistance of a leg lifter and small stool; mobilising with a zimmer frame
- Effortful lower body dressing and time consuming impacting on energy reserves and activity
- Attends to meal preparation at home
- Occupational Therapy and Physiotherapy rehabilitation goals identified
- Discharge to assess criteria met and seen by the D2ATeam on ward prior to discharge
- Morning discharge from hospital (Friday am)

Outcomes

- Friday afternoon, visited at home by the D2AT, assessed, goals identified with lady
- Health Care Support Worker 2 x daily visits over the weekend to work on rehabilitation goals with lady – practice personal care and mobility with kitchen trolley
- Marked improvement in function across all areas, no further Occupational Therapy input required, discharged from Discharge to Assess Service
- Physiotherapist reviewed lady at home on Monday and further telephone review the following week then referred to Advanced Nurse Practitioner (ANP)
- Visit arranged by ANP to optimise medications and pain management
- Making Every Opportunity Count - provided with list of private domestic help

Lessons Learned

- **Morning discharge from hospital enabled the Discharge to Assess Team to assess that day and prior to the weekend, allowing input to commence over the weekend**
- **Had the discharge been later in the day assessment would have taken place on the Monday**
- **Early in the admission process lady was identified as meeting the Discharge to Assess criteria enabling timely discharge and assessment in own home**
- **Input over the weekend enabled notable functional improvement by the Monday, clearly demonstrating benefits of input over the weekend and 7 day working**

- **As part of the Discharge to Assess process having multidisciplinary interventions available in a timely manner clearly benefited the lady**

Anticipated outcome without D2A input – would not have had tailored support, therefore would not have achieved rehabilitation goals so soon after discharge

Case Study 3 - Person and context

Admitted to hospital following a fall

- Occupational Therapy assessment - able to transfer from chair, toilet and bed independently
- Reduced vision, anxiety and unfamiliar ward environment impacting on functional ability
- High importance placed on housework and meal preparations at home
- Occupational Therapy rehabilitation goals identified
- Discharge to assess criteria met and seen by the Discharge to Assess Team (D2AT) on ward prior to discharge
- Family fully informed of the role of the D2AT and provided with information leaflets
- Morning discharge from hospital (Tuesday)

Outcomes

- Visited at lunchtime on day of discharge by the Occupational Therapist from the D2AT, assessed, rehabilitation goals identified with lady
- Health Care Support Worker initially 3 x daily visits to work on rehabilitation goals with lady – reassurance, encouragement to build confidence with personal care and meal preparations, support was very quickly reduced
- Within 4 days (by Friday), visits were reduced to 1 x daily as noted improvement in all abilities
- Reviewed by Occupational Therapy (Saturday), rehabilitation goals met, showed significant improvement in function, therefore discharged from services

Lessons Learned

- **Early Tuesday morning discharge from hospital enabled the Discharge to Assess Team to assess at lunchtime that day and input to commence straight away**
- **The Occupational Therapist from the Discharge to Assess Team was able to meet with the patient and the family, all were fully aware of the role of the D2A Team and the plan for input. This facilitated a more streamlined discharge from**

the ward and maintained open communication with all parties' e.g. patient, Ward staff, D2A Team.

- **Had the discharge been later that day, assessment would have taken place the following day, which would have impacted on the patient and the family's confidence with discharge**
- **The Health Care Support Worker input 3 x daily enabled reduction to 1 x daily by the 4th day, review by the Occupational Therapist on 5th day confirmed all rehabilitation goals had been met. This demonstrated maximised utilisation of all resources and enabled all rehabilitation goals to be achieved in a short time frame**
- **Timely intervention following discharge clearly indicate the benefits and outcomes achieve through seven day working**

Anticipated outcome without D2A input – likely to have resulted in a longer stay in hospital/peripheral hospital for further assessment and care

Case Study 4 - Person and context

Admitted to hospital following a fall, sustained back injury

- Occupational Therapy assessment - able to transfer from chair and toilet independently, bed transfer using bed lever, mobilising with a walking stick
- Struggling with personal care, washing and dressing
- Occupational Therapy and Physiotherapy rehabilitation goals identified
- Discharge to assess criteria met
- Patient and family member fully informed of the role of the Discharge to Assess Team (D2AT) and provided with information leaflets
- Afternoon discharge from hospital to care of family member

Outcomes

- Visited next morning and assessed by the Occupational Therapist from the D2A Team
- Rehabilitation goals agreed – to wash and dress independently and increase confidence in mobility
- Falls prevention advice given to person/family member and discussion on community alarm
- Health Care Support Worker (HCSW) input 1 x daily supported personal care
- Visited by Physiotherapist and HSCW, exercises demonstrated and completed daily supported by HCSW and family member

- Reviewed a week later by Physiotherapist referred to Community Rehabilitation Physiotherapy to support ongoing rehabilitation goals
- Visited by the Advanced Nurse Practitioner, medication review, blood pressure assessed and bladder scan carried out. GP add in
- Blended approach with the family member identified constraints they were experiencing in their caring role - referred to Social Work for assessment and to explore additional carer support/other resources e.g. Key Safe

Lessons Learned

- **Family support is very beneficial to support Discharge to Assess planning**
- **As an inpatient having discussion with family to ascertain the baseline (in hospital) and the family capacity to support is crucial to the D2A planning**
- **Evidence of the benefits from Multidisciplinary input – Physiotherapy, Advanced Nurse Practitioner, Social Work, Dementia and Frailty Nurse provision**
- **Opportunity to formalise referral pathway with the Short Term Assessment Reablement Team (START)**

Anticipated outcome without D2A input – discharge directly home to care of family member who was unsupported, likely to have been unsustainable; potential lengthy stay in a peripheral hospital awaiting care

Case Study 5 - Person and context

Admitted to hospital following a fall, reduced mobility and urinary retention

- Occupational Therapy assessment – independent with transfers and basic personal care; supervision required due to confusion, not at baseline function; household tasks shared with wife. Mobilising with a zimmer frame in hospital (normally independently without mobility aids)
- Discharge to assess criteria met, patient and family fully informed of the role of the Discharge to Assess Team (D2AT) and provided with information leaflets
- Equipment provided for use at home on discharge
- Late afternoon discharge from hospital (Friday), family happy to support

Outcomes

- Occupational Therapist from the D2A Team contacted, visit agreed 4 days after discharge due to risk assessment and patient/family choice

- No immediate rehabilitation goals identified as mobilising well around the house without mobility aids and managing personal care
- Telephone review agreed in one week including Physiotherapy input if required
- Following week admitted to hospital again for medical reasons
- D2A input again following discharge, functional abilities improving; input from Physiotherapy and Health Care Support Work 2 x weekly to support exercise programme and practice; Advanced Nurse Practitioner and Occupational Therapist reviewed cognition and functional abilities, both improving, no further input required

Lessons Learned

- **Family support is hugely beneficial to support Discharge to Assess planning. This discharge would have been delayed if family support not available and due to current D2A capacity particularly for weekend discharges**
- **Prompt D2A reconnection with person and family following 2nd medical admission to hospital enabled continued rehabilitation support on discharge**
- **Having Multidisciplinary Team members a part of the D2A Team clearly benefits the person particularly through joint assessment process, maximisation of MDT skills and communication to identify most appropriate support required for the person**

Anticipated outcome without D2A input – may have placed further stress on family member particularly due to change in cognition and function