REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 24 NOVEMBER 2022**

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 Integration Joint Board (MIJB) on the current status and priorities for Home First in Moray.

2. RECOMMENDATION

2.1 It is recommended that the MIJB:

i) considers and notes the progress towards delivering the identified aims for Home First in Moray and confirms that this programme should remain a priority activity to meet the objectives of the Strategic Plan; and

ii) agrees that further reports will be brought to the MIJB as specific decisions are required.

3. BACKGROUND

3.1. Operation Home First was launched in June 2020 as part of the Grampian wide health and social care response to the 'living with COVID' phase of the pandemic. All three Health and Social Care Partnerships (HSCPs) in Grampian 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.

3.2. Operation Home First aims to maintain people safely at home, avoid unnecessary hospital attendance or admission, and to support early discharge back home after essential specialist care.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Following a previous update in September 2022, a number of Home First work streams have seen progress.

Discharge to Assess (D2A)

4.2 D2A aims to provide early supported discharge and short-term intensive assessment and rehabilitation in a person's own home.

4.3 Between August 2021 and August 2022, the service has seen 245 new patients, 89% of patients showed an improvement in their function abilities following intervention.

4.4 An audit completed in May, June and July 2022 will be included in the November IJB report.

4.5 The service has reduced the length of stay in DGH from 7 days to 6 and reduced the length of stay in Moray Community Hospitals from an average of 43 days to 17. Patients are also 50% less likely to be readmitted following a D2A intervention and only 3% of the D2A patients required care upon completion of their D2A intervention.

Hospital at Home (H@H)/Hospital without Walls

4.6 A review of planning assumptions around H@H is being undertaken. Funding will come to an end over the next 6 to 8 months, whereupon sustainable funding will need to be sought. While that exercise is undertaken, work is ongoing to establish a flexible model of H@H that includes core services such as GP's and DN's who have historically provided H@H interventions. These teams already hold the key to the knowledge of the frail elderly in localities, including them and D2A and CRT into the H@H portfolio creates a Multi-disciplinary approach to meeting the aims of this workstream.

Prevention and Self-Management – Respiratory Conditions

4.7 This programme aims to develop a Social Prescribing model for the Moray population that supports prevention and self-care activities. The programme also offers support to enable health professionals to have easy access to information on non-clinical services and activities within their locality and to have a process in place to refer individuals.

4.8 This is a well-established work stream group with good representation from across services. Recently a Test of Change was undertaken in Forres and further tests are planned for Lossiemouth and Buckie.

Palliative Care

4.9 This programme aims to provide quality Palliative Care Services to the Moray Population. Key objectives have been developed in line with the Strategic Palliative Care Framework. The programme has a newly appointed Clinical Lead and the moray Strategic Palliative Care Group will reconvene following the approval of the Grampian framework.

4.10 The End of Life pathway is in operation within DGH, with the main focus on barrier free support to get people back home/or to a homely setting as close to their community as possible.

4.11 Two end of life beds have been procured for the North East of Moray.

Delayed Discharges

4.12 The Moray Delayed Discharge Plan takes a two phased approach. Phase 1 was to return delayed discharges to March 2022 numbers (average 45) which

has been achieved. Phase 2 aims to make systematic changes to sustainably reduce delays to 10 or less.

4.13 Phase 1 actions included the extension of contractual arrangements to increase Option 3 providers, (creating more Care @ Home capacity), the prioritisation of Care @ Home resource to Delayed Discharges, end of life patients, those in crisis in the community and prevention, the use of D2A and the Community Response Team flexible to improve capacity, the redesign of the Monday Delayed Discharge Operational Huddle and the implementation of a daily meeting to operationalise system pressures and available resource.

4.14 Phase 2 actions include the scaling up of Hospital @ Home, a HandSC Moray self-assessment of processes, systems and services, a focus on Care @ Home review, criteria led discharge, an assessment of Moray's risk appetite and a review effectiveness of current projects and services.

Care at Home

4.15 Care at Home was added to the Home First programme recently. Priorities for this workstream are to explore key areas in relation to the prioritisation of care resource (Delayed Discharges, End of Life, Crisis in the Community and Prevention) and to have oversight of resource that would support the Home First Objectives.

4.16 Operational stakeholder workshops are held monthly, outputs from the workshops so far include, the creation of a set of prioritisation criteria to help with the allocation of resource, a daily resource allocation collaborative, where resource that would support the Home First objectives is discussed and allocated and operational knowledge of system wide pressures promoting a shared approach to the solutions

Involving Carers in Hospital Discharge

4.17 This workstream was added to the Home First programme recently. Priorities for this workstream are to improve unpaid carer involvement in the planning and completion of hospital discharge and the health and wellbeing of both carer and cared for are considered.

4.18 Initial awareness activity has taken place in Community Hospitals and DGH. Staff have been encouraged to undertake training and carer-specific promotional materials have been created and circulated.

4.19 Working relationships between the designated Family Wellbeing Worker (FWW) and ward staff has led to easy referral of carers. FWW's are included in ward meetings and huddles. Health Care Support Workers from Community Hospitals are volunteering to become Unpaid Carer Champions.

Mental Health – Care Home Liaison

4.20 This is a new addition to the Home First Programme. The Key aim is to provide a proactive, anticipatory service to Moray's care homes from the Older Adult Mental Health service (OAMH); to reduce admissions from care homes, to the Muirton Dementia Unit, reduce the length of stay for patients who are admitted and to improve care home staff experience in relation to support from the OAMH service.

Mental Health – Multidisciplinary Team (MDT)

4.21 This is a new addition to the Home First Programme. The key aim is to develop MDT working, resulting in outcome focused admissions to the Muirton Dementia Unit, to reduce the length of stay and improve patient/carer and staff experience in relation to MDT working.

5. CHALLENGES

Recruitment and retention

5.1 Recruitment and retention across the NHS continues to be a challenge. Core Services are depleted and compete with projects and new services for staff. The self-assessment (Delayed Discharge workstream) will examine this issue in depth and while this exercise is undertaken, Moray will not bid for projects that require professional staff from core services on a temporary basis. Home First workstreams with unfunded posts will look creatively for ways to continue developments with existing funding. The Programme Team will encourage robust workforce planning to understand if the workforce within projects can be adjusted.

6. EVALUATION

6.1. The Home First Programme Team meet regularly with stream leads to assess progress against the Home First aims and to review key performance indicators. Home First now has a Dashboard of key performance data which supports the evaluation of works streams and allows the Programme Team to support and guide stream leads to meet objectives

7. GOING FORWARD

Core Teams

7.1 The contribution of Core Teams (DN's, GP's etc) will be included in the Home First programme going forward. Early review indicates gaps in service provision, particularly for the very frail elderly. Although much work has been undertaken, very little resource is available to this group, a crisis here often leads to an acute admission or an untenable risk lying with Social Work Teams. Work going forward will focus on this group. This will include early identification of risk (Anticipatory Care Planning) and the reinvigoration of Multi-disciplinary teams in localities to manage those risks. Home First will be brought together with Core Teams to create a workforce that provides a seamless service for the most vulnerable in our care.

8. 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 Home First have significant alignment to the themes 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

There are no direct financial implications from this report. Short term funding has been made available on a short-term basis to enable progression of the programmes of transformation. This is being kept under review, accepting that any long term implications are required to be met within existing budget where relevant, financial implications have been highlighted in this report.

d) Risk Implications and Mitigation

The risks around being unable to successfully embed a Home First approach in our culture and system will be identified on a project by project basis and mitigations identified accordingly.

There is a risk of projects not being able to proceed within desired timescales due to the lack of suitably qualified and experienced staff being available due to the ongoing impact of the Covid pandemic on recruitment and retention.

e) Staffing Implications

Staffing absence remains a high risk to the delivery of all programmes of care in Moray. Cognisance of the balance between a depleting workforce and new innovations is required in order to successfully achieve the Home First Programme aims and objectives. A clear directive is that innovation must be system wide and not siloed for a group of the population, workforce planning will form a large part of planning moving forward through the programme.

f) Property

There are no property implications to this report.

g) Equalities/Socio Economic Impact

There are no changes to policy as a result of this report.

h) Climate Change and Biodiversity Impacts

None arising directly from this report.

i) Directions

None arising directly from this report.

j) Consultations

Consultations have taken place with the Home First Delivery Group, Chief Officer, Chief Financial Officer, Clinical Lead, Head of Service, Corporate Manager, and Tracey Sutherland, committee officer, Moray Council and comments incorporated regarding their respective areas of responsibility.

9. CONCLUSION

9.1 Home First is the right approach to driving forward sustainable change to provide the maximum benefit to the health and wellbeing of the population in Moray.

9.2 By taking a whole system approach we can plan our services to deliver the maximum benefits to residents.

9.3 Home First will drive the changes needed to continue the shift of health and social care systems to offer more person-centred alternatives to hospital.

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Background Papers:
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