**REPORT TO:** **MORAY INTEGRATION JOINT BOARD ON 28 JANUARY 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 overview 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) 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) requests 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 & 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 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

3.3 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**.

3.4 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.

3.5 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.

3.6 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 MATTERS RELEVANT TO RECOMMENDATION

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 action plan (**see Appendix 1**).

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

4.2 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:

- 37 patients have received D2A intervention in Moray
- Average age is 85 - ranging from 69 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**
- 23 patients have had the Canadian Occupational performance measure administered, **17 rated an increase in their performance** of activities of daily living and 6 stayed the same. Of the 23, **19 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 3 of the 37 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.

Health improvement approach to respiratory conditions

4.3 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.

4.4 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 action plan (**Appendix 1**). 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.

4.5 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.

4.6 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.

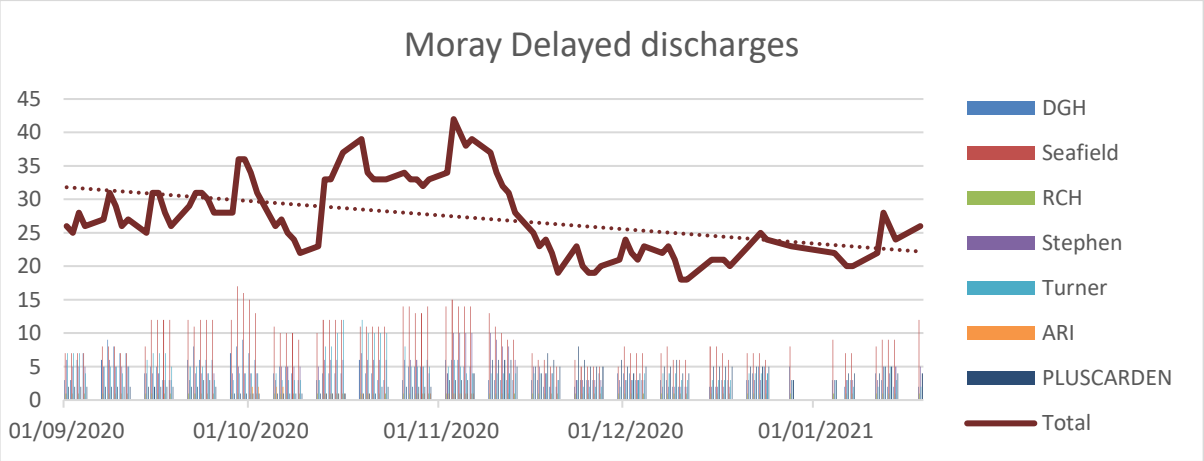
Whole system approach to discharge – Delayed Discharge

4.7 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 workstream 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 – see Section 4.2.

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 action log in the attached framework (**see Appendix 2**) describes progress to date. 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.

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.

Grampian Commission for Evaluation of Home First

4.20 A cross-system working group is collaborating with colleagues from each of the priority areas across Grampian to ensure the right information is capture 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. 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.

## 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 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**

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.

**(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.

**(e) Staffing Implications**

As the modelling for change in service delivery progresses the staffing implications will be identified and taken forward following the appropriate policies.

Short term funding has been allocated to the transformation programmes to allow them to move to pilot phase. This has facilitated some additional staff resource to be identified and attached to the programmes.

**(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) Consultations**

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

## 6 CONCLUSION

**6.1 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.**

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

**6.3 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:
Ref: