APPENDIX 3

DISCHARGE TO ASSESS (D2A)

Supporting Operation Home First for Moray

A report of findings from the D2A Project to date

Dawn Duncan (NHS Grampian)
dawn.duncan@nhs.scot
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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.

Discharge to Assess – Home First for Moray

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.
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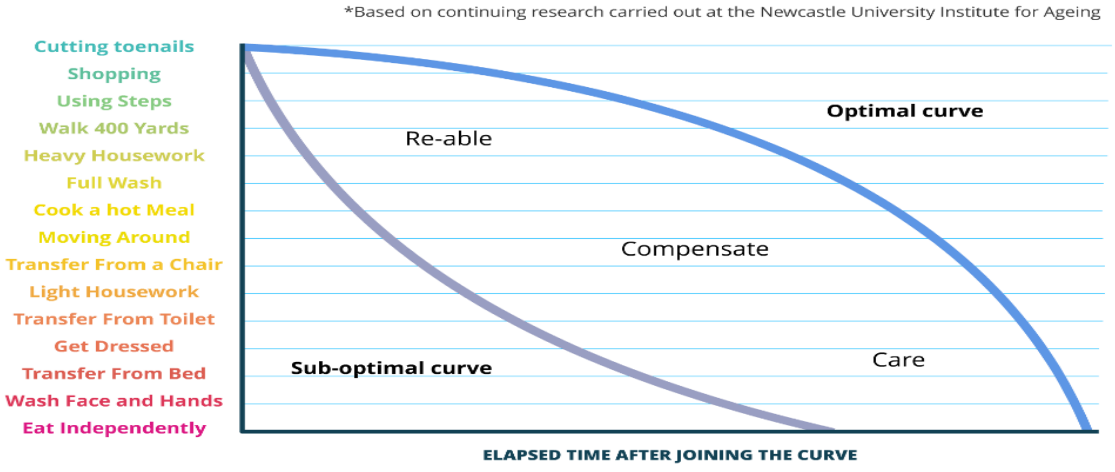
D2A and the Lifecurve™

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.



Discharge to Assess – Home First for Moray

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.

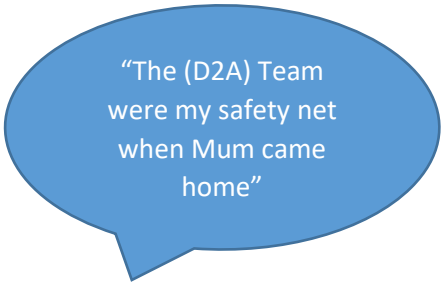
All bar two of the patients were referred from Dr Grays Hospital with the majority (17 or 35%) referred from Ward 7 under the specialism of geriatric medicine.

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.

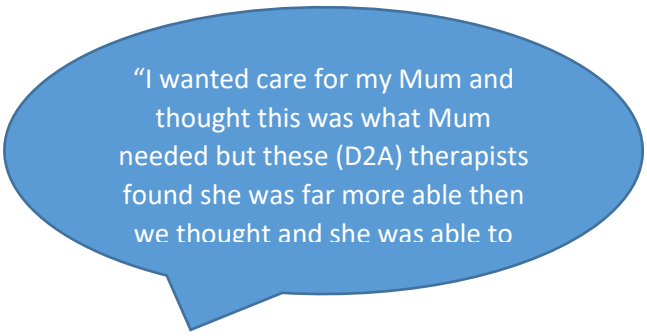
"I'd give them a medal, a very hard job [dealing with people like me]. I don't even like old people!"

Discharge to Assess – Home First for Moray

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.

Discharge to Assess – Home First for Moray

"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

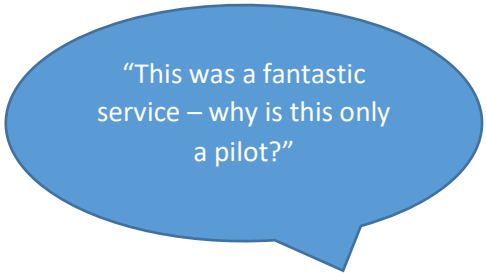
Patient and carer feedback has been pivotal to providing a person-centred D2A service. Semi-structured telephone interviews have been completed by Public Health colleagues to ensure objectivity and quotes from these interviews are included throughout this report. Evaluation is ongoing.

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.



Discharge to Assess – Home First for Moray

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.**

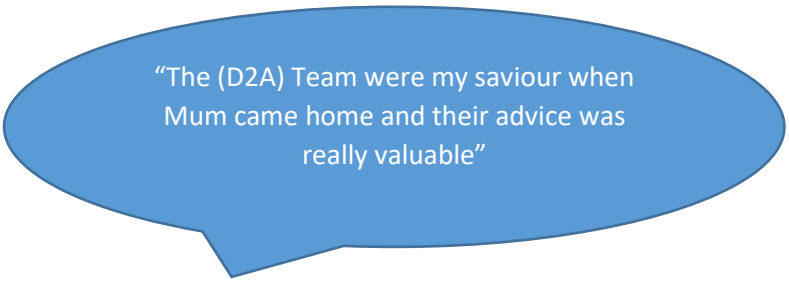
All of the patients assessed by D2A have had their anticipated journeys mapped (in the absence of D2A).

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.

Discharge to Assess – Home First for Moray

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:

Discharge to Assess – Home First for Moray

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

Discharge to Assess – Home First for Moray

Case Study 1 - Person and context

Lives alone

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**

Discharge to Assess – Home First for Moray

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