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: