REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 27 JANUARY 2022**

SUBJECT: **HOME FIRST IN MORAY: DISCHARGE TO ASSESS UPDATE REPORT**

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

1. REASON FOR REPORT

1.1. To update the Board of the performance of Discharge to Assess (D2A) for the period August to December 2021.

1.2. To introduce the Hospital Without Walls Programme as the natural progression for the Home First work streams.

1.3. To update the Board of the progress to date on the Home First work streams.

2. RECOMMENDATION

2.1. **It is recommended that the Moray Integration Joint Board (MIJB) considers and notes:**

i) the performance evaluation of the Discharge to Assess programme from August to December 2021;

ii) the introduction of the Hospital without Walls programme as a mechanism to coordinate the various Home First work streams; and

iii) the progress made on the Home First work streams to date.

3. BACKGROUND

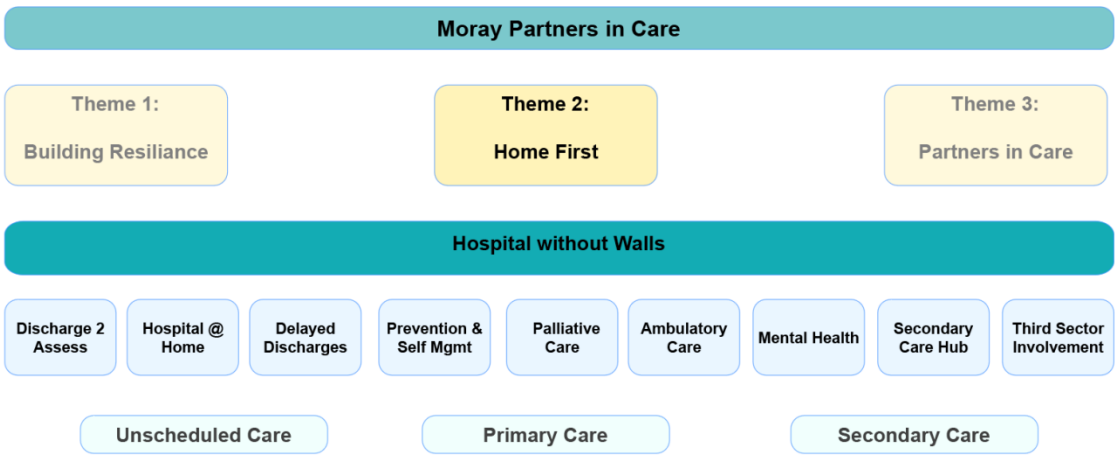
3.1 Moray Partners in Care (2019 – 2029) – The Strategic Plan for Health and Social Care in Moray over a 10 year period, highlights Home First as one of three key themes. It defines Home First as 'being supported at home or in a homely setting as far as possible'.

3.2 Operation Home First was then 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 & 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. A suite of work streams have been developed under the Home First Delivery Group (Moray).

4. HOSPITAL WITHOUT WALLS

4.1. The Home First programme continues to progress and the delivery group have identified the need to pull together the individual work streams whilst also considering the overall patient pathway and have done so under the new umbrella of 'Hospital without Walls. This creates a new model involving all aspects of Home First alongside unscheduled care, primary/secondary care and acute services. The key objective of the Hospital without Walls programme is to establish a suite of responsive, seamless, co-ordinated, multi-disciplinary care supporting older people with frailty and multi-morbidity.



4.2. The model is still emerging and moving at pace, however effort is being concentrated on developing a Home First Frailty Team - who will be primarily focused at the 'front door' of Dr Gray's Hospital but will also offer support within the community. The multi-disciplinary team (MDT) will include physiotherapy, occupational therapy, pharmacy, advanced nurse practitioners, discharge co-ordinator, care assessor and potentially a career start GP. The team will be supported by the geriatric consultant as well as mental health. For clarity, the MDT will be made up of existing teams with an emphasis on streamlining the pathway and taking a coordinated approach. In particular, elements from both the D2A and Hospital @ Home teams will be representing the Home First work streams of the model. The objective of the team would be to offer rapid geriatric assessments and allow a quick turnaround of those presenting at the front door.

4.3. The team is to be funded from the recently announced Scottish Government winter funding monies if approved by the MIJB today (Additional Investment and Winter Funding Report will be taken as a confidential paper) in addition to the previously secured Hospital @ Home and Emergency Department 4 Hour funding. Further updates will be provided to the board as the model progresses.

4.4. Existing employees will form part of the team, with the remaining roles to be recruited once funding has been approved. Two advanced nurse practitioners

have recently been appointed under the Hospital @ Home project and this will operate as a blended model with the already established D2A and geriatric service.

4.5. A further team of 17 Health Care Support Workers (HSCW's), of which three will support the front door, are also being recruited utilising recently announced Scottish Government funding with the aim of recruiting an additional 1,000 HCSW's across Scotland. The use of bank staff for these posts has been authorised in the interim to ensure the model can progress at pace.

5. D2A

5.1. D2A is an intermediate support 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.

5.2. MIJB agreed to scaling up, permanent funding and the embedding of a D2A team into the Moray health and social care system on 25 March 2021 (para 10 refers).

5.3. The Home First ambitions of D2A are 2-fold:

- Support early discharge back home after essential specialist care
- Maintain people safely at home

5.4. It was hypothesised from the pilot project which ran from October 2020 to March 2021 that a scaled-up D2A team could provide support for up to 20 new individuals per month.

5.5. Intervention by D2A comprises up to 2 weeks of intensive assessment and rehabilitation from Occupational Therapy, Physiotherapy and an Advanced Nurse Practitioner with day to day support from Generic Support Workers working upon patient chosen goals.

5.6. Moray is developing a new model incorporating all aspects of Home First, unscheduled care, primary/secondary care and acute care brought together under the umbrella of "Hospital without Walls". D2A as an intermediate support team is pivotal to this model.

5.7. Recruitment took place from March to September 2021 for the following posts:

- 1.5 WTE Band 7 Team Lead Occupational Therapists (June)
- 1 WTE Band 7 Advanced Nurse Practitioner (September)
- 1 WTE Band 6 Physiotherapist (June)
- 1 WTE Band 6 WTE Occupational Therapist (June)
- 5.7 WTE Band 3 Generic Support Workers (July)

5.8. Induction of qualified staff took place from in June/July 2021 in preparation for the intensive training and induction of the Generic Support Workers over 3 weeks in July 2021. The training framework included all statutory and mandatory training as well as Occupational Therapy and Physiotherapy competencies.

5.9. D2A went live to referrals on 3 August 2021.

5.10. The team have presented to 4 staff engagement sessions which have been well attended across the health and social care partnership and have made several informal presentations to staff groups across Moray.

6. DISCHARGE TO ASSESS – PERFORMANCE EVALUATION

6.1. From 3 August 2021 to 20 December 2021 (20 weeks) 103 patients were assessed and treated by the D2A Team.

- 59 (57%) were female and 44 (43%) male, with a mean age 79 years and the median age being 73.5 years.
- In the first month of operation, there were an even proportion of referrals from Moray's Community Hospitals (45%) and Dr Gray's Hospital (45%) to D2A. With the remaining 10% of referrals from Aberdeen Royal Infirmary (ARI) and Woodend Hospital.
- This signified patients awaiting intermediate care in Moray's Community Hospitals in the absence of D2A from the end of the project in March to D2A becoming operational in August.
- Since then there has been a steady shift to 70% of referrals originating from DGH, 21% from Community Hospitals and 9% from ARI or Raigmore.
- On average each patient is receiving 12 days of D2A intervention over 7 days per week.
- D2A are seeing patients of a higher acuity than during the project – this reflects the ongoing pandemic and the consequences of lockdowns.

Avoiding Unnecessary Admission and Early Supported Discharge

6.2. 11 of the 103 patients were referred from the Emergency Department at Dr Gray's Hospital and discharged straight home with D2A thus preventing unnecessary admission of these patients.

6.3. 92 in-patients were referred to D2A.

Whole System Flow and Capacity

6.4. All anticipated patient journeys, based upon functional abilities (in the absence of D2A) were mapped.

- 1/3 of D2A patients would have been referred for assessment for care directly from DGH as they required assistance with at least 3 functional tasks per day – this would have necessitated a longer in-patient stay
- 2/3 of D2A patients would have been transferred to a Moray Community Hospital for longer rehabilitation or assessment for care – this would have necessitated a longer in-patient stay.

6.5. Average length of stay for a patient in a Moray Community Hospital is 50 days. D2A has reduced the amount of patients transferred to a Moray Community Hospital by supporting a Home First approach.

6.6. Lower readmission rates were recorded for patients receiving D2A intervention for both 28 day (7 patients) and 7 day (3 of the 7 patients) readmissions. The readmission rate for within 7 days for medical patients is 9.9% (D2A is 3%) and for 28 days it is 19% (D2A is 7%).

Outcomes

6.7. The Canadian Occupational Performance Measure was used by Occupational Therapist with patients for patients to self-rate their own functional status

- 88% of patients rated their performance had improved with D2A input
- 82% of patients rated their satisfaction with their functional performance had improved

6.8. The Barthel Functional Index scoring showed an increase in functional performance in 95% of patients.

6.9. The Tinetti Assessment Tool and Elderly Mobility Scale (EMS) are used by physiotherapists to show outcomes of treatment with mobility, gait and balance.

- 95% of D2A patients assessed using Tinetti saw an increase in their scores showing an improvement in their gait, balance and mobility and reducing their risk of falls.
- 83% of D2A patients assessed using EMS saw an increase in their scores showing an improvement in their mobility.

6.10. The inclusion of a fulltime Advanced Nurse Practitioner (ANP) with a Geriatric specialism has been of great benefit to patients through the contribution to Comprehensive Geriatric Assessment and by providing specific actions for GPs, medication reviews, examinations, monitoring and diagnostics at point of discharge.

6.11. Communication with GPs for those patients returning home under D2A has enhanced with the embedding of the ANP within the team. GPs describe:

"Brilliant interface with D2A following patient discharge"
"Timely information regarding medication review"
"Good communication on assessment post discharge"

Onward Referrals

6.12. D2A takes a blended approached with joint working across the health and social care partnership. The D2A Team work with some patients alongside input from other statutory and voluntary organisations across Moray as well as close partnerships with carers and relatives. D2A are actively working with START (Short Term Assessment and Re-ablement Team) to ensure patients' needs are met through a more blended approach to support

6.13. Of those patients referred onwards following D2A intervention:

- 3 patients have been referred to START for further re-ablement – one of these patients is still awaiting START input due to the pressures for providing care in the community and remains with D2A.
- 2 patients have been referred for Social Work assessment for mainstream care – one patient remains with D2A and the second patient has been safe to be discharged to await assessment.
- 16 patients have required referral to Community Physiotherapy for ongoing mobility, outdoor mobility, gait and balance issues.
- 8 patients have been referred to Community Rehabilitation Occupational Therapy for ongoing rehabilitation.

6.14. The D2A team operate a Making Every Opportunity Count (MEOC) approach working in partnership with patients to identify their wider longer term needs. Patients have been referred onto a variety of services including Quarriers, the Handy Person Service, Shop Mobility, Men's Shed and the Fire Service and signposted for a range of issues including private domestic assistance, toenail cutting, fire safety checks, gym referral for maintaining activity, walking groups, grief counselling and smoking cessation.

Feedback

- Consenting patients and their carers have received telephone interviews from Public Health Analysts and have provided feedback based upon their experience of D2A and any suggestions for how this experience could be improved
- Feedback has been exceptionally positive with no comments from patients on how the service could be improved
- Key themes are:
  - The practical functional nature of the service
  - Building confidence and reassurance
  - Quality of the exercises patients require to engage in themselves
  - Communication

6.15. Recognition was given to a reduction in their anxieties around discharge from hospital and recognition of an improvement in the patient's ability to engage in activities of daily living as a result of targeted therapy intervention.

6.16. Carers commented on perceptions of the requirement for care being dispelled as a result of targeted therapy interventions and person centred functional assessment.

Challenges

6.17. Occupational Therapy and Physiotherapy services at Dr Gray's Hospital (DGH) required to vacate their departments for water treatment works and the refurbishment of Ward 7 above these departments. As a result, D2A were temporarily based at Moray College until 22 December 2021 when temporary accommodation was found on the DGH site. This accommodation is only available until the main departments reopen within the DGH building, planned for 14 February 2022. As a critical component of patient flow and supporting discharge, D2A accommodation will require to be sought from 14 February 2022 with a preference to be located on the DGH site. This is being considered alongside other service requirements.

6.18. In the absence of permanent accommodation and restrictions regarding COVID-19 room occupancy levels, 1 WTE Band 3 Administration post and 0.6 WTE Band 6 post have not been advertised resulting in an underspend. Occupational Therapy administration have provided support to D2A in the interim.

6.19. Underspend from maternity leave will be used to advertise for 1 WTE Band 6 to provide temporary Occupational Therapy maternity cover.

6.20. D2A provides a service to patients across Moray 7 days per week and team staffing capacity (currently 9.7 WTE) influences decision making around capacity to safely accept referrals.

Summary

6.21. Moray is developing a new model incorporating all aspects of Home First, unscheduled care, primary/secondary care and acute services brought together under the umbrella of "Hospital without Walls". D2A as an intermediate support team will be pivotal to this model.

6.22. Targeted therapy input leads to improved patient functional outcomes and therefore reduced requirement for care for those patients. D2A focuses on patient functional outcomes and patients self-rate their improvement and their satisfaction with their improvement.

6.23. Intervention early in a patient's journey with a targeted functional approach results in patients remaining independent after a hospital admission / attendance supporting their health and wellbeing.

6.24. D2A evidences whole system working.

6.25. D2A evidences early supported discharge from hospital & reduced readmission rates and therefore has an impact on the whole health & social care system and is cost effective.

7. HOME FIRST UPDATE

Delayed Discharges

7.1. Work is ongoing to address delayed discharges and a 4-month plan has been established to look at demand across the portfolio and how it can be better managed to reduce numbers. The plan has identified three key areas for development; admission prevention, in hospital and discharges.

7.2. Targets were set at the Moray Portfolio Performance update in December 2021 with the goal of achieving delayed discharges of 25 by the end of December 2021 and less than 20 by the end of January 2022. Delayed Discharges were reported at 47 by the end of 2021 and at the time of this report are sitting above 35.

Hospital @ Home

7.3. Hospital @ Home (H@H) was initially designed to be a standalone work stream which offered short term targeted intervention that provided a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital. The project is funded for 12 months and is being supported by Healthcare Improvement Scotland (HiS).

7.4. Given the need for a whole system approach it was identified that H@H could contribute to the Hospital without Walls programme and rapid geriatric assessments. This would allow H@H to be consultant-led which was unlikely to be the case if the project was standalone. HiS have been consulted and are satisfied that the larger model will still meet the intended objectives of the project.

7.5. To date two advanced nurse practitioners have recently been appointed and are expected to be in post by mid-January and mid-March 2022 respectively. Funding has also been used to provide specialist physio-therapy support with recruitment still underway. HiS have also offered the assistance of a Health Economist and are due to undertake a pathway documentation exercise and economic evaluation in March and July 2022 respectively. This will allow for an evaluation report to be submitted to the Board around Q3 of 2022/23.

Prevention and Self-Management (Respiratory Conditions)

7.6. Work continues to progress on a social prescribing model for respiratory conditions. Focussing on early intervention the purpose of the model is to make people accountable for their own health and provide them with the support needed to be able to do so. Continuing from the earlier work of the group which included an exercise referral programme the group are incorporating all referrals / social prescribing / health walks etc in to one comprehensive pathway. A driver diagram is currently being drafted with three drivers being identified; impact on individuals, health professionals and community. A recent GP Cluster Group meeting on 15 December 2021 identified three GPs who are keen to be involved.

Palliative Care

7.7. A piece of work has just been completed to review the acute pathway for end of life patients returning home. Key stakeholders have been engaged with and the pathways will soon be approved. Further training will be provided to those directly involved and the pathways will be communicated to all relevant parties.

7.8. The Oaks was fully remobilised from Tuesday 23 November 2021. It offers 6 places at present in line with Covid guidance, as well as offering a range of complimentary therapies which already being fully utilised. Driver volunteers are also returning on a phased basis. The Oaks is being supported by an interim manager and newly appointed Band 6 nurse along with the other core staff that are essential to being able to remobilise.

Ambulatory Care

7.9. Work has been focusing on blood transfusions and venesections. A short life working group has been formed to document the pathway and available resources. Services at present are limited due to staffing and premises reasons.

Mental Health

7.10 The Moray Primary Care Psychological Therapy Service is now fully mobilised. Recruitment for Mental Health and Well Being practitioners has been unsuccessful to date and has gone to another round of advertisement. The Trauma Informed Workforce training programme (which looks to prevent further harm or re-traumatisation for those who have experienced psychological trauma or adversity ad any stage in their lives) has been presented to the Senior Leadership Group and will soon be rolled out across the other HSCM team in the coming months.

Secondary Care Hub – Moray Resource Centre

7.11 Progress continues to stall on the Moray Resource Centre whilst the space is being utilised by MSK Physiotherapy team who have been displaced from Dr

Grays. It is expected the earliest the space may be available is March 2022. There have been concerns raised that the lease for the space is only for two years to which 12 months have already passed. It should be noted that whilst the space is unavailable, the services it will be used for are still ongoing albeit in various other locations.

Third Sector Involvement

7.12 Work is ongoing with NHSG to establish a suite of protocols for volunteers under the current Covid guidance. Plans are underway to trial volunteers across the ED to perform non clinical tasks in an effort to reduce the demands on clinical staff. Discussions are also underway on the possibility of recruiting a volunteer co-ordinator.

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. The Hospital without Walls programme offers a natural progression linking up the Home First work streams at a more strategic level.

b) Policy and Legal

None directly associated with this report

c) Financial implications

There are various elements of funding associated with the Home First programme of transformation which have been subject to MIJB papers and approved formally. A separate, confidential, paper on today's agenda covers the funding aspect in more detail.

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

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

The lack of available space across the Moray Portfolio is having an impact on both the Discharge to Assess and Secondary Care Hub work streams.

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, Chief Officer, Chief Financial Officer, Clinical Lead, Head of Service, Corporate Manager, Moray Council and comments incorporated regarding their respective areas of responsibility.

9. CONCLUSION

9.1 Hospital without Walls is the natural progression of the existing Home First work streams bridging the gap between unscheduled, primary and secondary care with a focus on the whole patient journey. The key objective of the Hospital without Walls programme is to establish a suite of responsive, seamless, co-ordinated, multi-disciplinary care supporting older people with frailty and multi-morbidity.

9.2 D2A continues to support patients to achieve the best functional outcomes and contributes to flow and capacity within the health and social care system in Moray and will be pivotal to the success of the Hospital without Walls model.

9.3 The Home First work streams continue to progress with some reaching maturity. Early development of the Hospital without Walls model is utilising a number of these work streams as well as elements of the locality planning work that is also being done.

Author of Report: Jamie Fraser, Project Manager, HSCM
Dawn Duncan, Professional lead, Occupational Therapy
Background Papers:
Ref: