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

SUBJECT: **HOME FIRST – DISCHARGE TO ASSESS**

BY: **HEAD OF SERVICE**

1. REASON FOR REPORT

1.1. To update the Board on the impact of Discharge to Assess (D2A) on system flow and capacity across the Moray Health and Social Care portfolio.

2. RECOMMENDATION

2.1. It is recommended that the Moray Integration Joint Board:

i) considers and notes the performance evaluation of the D2A Service with an emphasis on impact across system flow and capacity; and

ii) notes the actions identified in section 4 as an update on progress as requested by the Board on 26 May 2022

3. BACKGROUND

3.1. Health and Social Care Moray, remains under immense and sustained pressure from the COVID-19 pandemic since early 2020. The impact of COVID-19 can be seen across the entire health and social care portfolio and key performance indicators such as acute admission rates and delayed discharges remain high.

3.2. D2A is one of a number of initiatives developed within the Operation Home First Programme. The programme aims are:

- To maintain people safely at home
- To avoid unnecessary hospital attendance or admission
- To support early discharge back home after essential specialist care

3.3 D2A is an intermediate support approach which aims to secure early discharge of hospital in-patients who are clinically stable and do not require acute hospital care but may still require rehabilitation or short-term support to improve their function. D2A was one of the original initiatives through Operation Home First.

3.4 After two trial periods, MIJB agreed permanent funding of £497K for D2A on 26 March 2021 for:

- Band 7 Occupational Therapy Team Lead 1.5 WTE
- Band 7 Advanced Practitioner Nurse 1 WTE
- Band 6 Occupational Therapist 1 WTE
- Band 6 Physiotherapist 1 WTE
- Band 6 Registered Nurse 0.6 WTE
- Band 3 Generic Support Workers 6 WTE
- Band 3 Admin 1 WTE

3.5 Since going live on 3 August 2021, D2A has faced a number of challenges related to staffing. It is yet to operate at full staffing capacity and most recently has a vacant Band 7 Advanced Practitioner Nurse post. D2A has also experienced staff absence due to COVID-19, longer term sickness absence (7%) and maternity absence (13%). As such, it should be noted that D2A has not been operating at optimal staffing and all absence is managed according to the relevant policies.

3.6 D2A intervention comprises up to 2 weeks of intensive assessment and rehabilitation over 7 days a week in the patient's home from Occupational Therapy, Physiotherapy and an Advanced Nurse Practitioner with day to day support from Generic Therapy Support Workers working upon patient chosen goals.

3.7 The average length of D2A intervention remains 11 days and the cost per day of D2A services per patient remains £169 compared with £570 for a Dr Gray's Hospital (DGH) bed day or £262 for a Moray Community Hospital bed day.

3.8 D2A continues to provide a blended model of support where possible to patients with other teams such as START (Short Term Assessment and Reablement Team) and FNCT (Forres Neighbourhood Care Team) and any other appropriate agencies to support the frail elderly of Moray and provide timely discharge.

3.9 D2A has been operational from August 2021 and to date has assessed and treated just under 300 patients:

- 73% of referrals from DGH
- 17% from Moray Community Hospitals
- 10% from Aberdeen Royal Infirmary(ARI), Woodend Hospital or Raigmore Hospital

Patient Outcomes

3.10 Patient functional outcomes are measured using a suite of standardised tools:

- Barthel Functional Index (therapy-rated outcome)
- Canadian Occupational Performance Measure (patient-rated outcome)
- Tinetti (therapy-rated outcome)
- Elderly Mobility Scale (therapy-rated outcome)

3.11 Using these standardised measures:

- 95% of patients showed an increase in their functional performance in activities of daily living (ADL)

- 90% of patients rated an improvement in their own ADL
- 84% of patients rated an improvement in their own satisfaction with their ADL performance
- 94% of patients showed an improvement in their functional mobility and gait, therefore reducing the risk of falls and improving their overall ability to maintain ADLs
- 85% of patients showed improved scores regarding balance, gait and mobility

This reinforces the aim of D2A to support early discharge and maintain people at home.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The D2A report in May 2022 recommended that more information would be provided to the IJB regarding the system impact of D2A on the following:
- Avoiding unnecessary admission
- Reducing length of hospital stay (LOS) – DGH and Community Hospitals
- Lowering readmission rates
- Reducing the requirements for care

4.2. A retrospective audit was completed of all new patients (55) who were admitted to D2A for a 3-month period of May, June and July 2022. Data was collected and all actual patient journeys were mapped (as per the pilot of 2020) and consensus sought with the multidisciplinary team (MDT) on the journey, dependencies and outcomes patients would have experienced had D2A not been operational.

4.3. Findings for this period:
- 75% of patients were discharged to D2A from DGH (41)
- 16% of patients were discharged to D2A from ARI (7), Woodend Hospital (1) and Raigmore (1)
- 9% of patients were discharged to D2A from Moray Community Hospitals (5)

Avoiding Unnecessary Admissions

4.4. For the 3 month audit period, 8 patients were discharged directly from the DGH Emergency Department (7) and the Acute Medical Assessment Unit (1) – this patient stayed overnight for diagnostics. These patients would have been admitted to hospital in the absence of D2A provision and would have remained in DGH for an average length of stay of 7 days. This equates to a bed day saving of 56 days at a cost of £32K (£570 per day) minus £8K for D2A costs (11 days at £169 per person) with an overall cost saving of £24K.

Reducing the Length of Stay

DGH

4.5. For the 3 month audit period, 41 DGH in-patients discharged to D2A had their hospital stay shortened by one day. (Average DGH stay of 7 days against D2A 6 days). This amounts to a bed day saving of £23K minus D2A costs of £7K and an overall saving of £16K.

Community Hospitals

4.6. For the 3-month audit period, 2 patients from Seafield Hospital had their length of stay reduced by D2A by 24 days. The average length of stay for Seafield

Hospital for this period was 46 days (costing £262 per day). D2A intervention equates to a bed day saving of £6K for a Community Hospital stay minus D2A costs over a total of 20 days of intervention for these 2 patients of £3K and an overall saving of £3K.

4.7. For the same period, 3 patients from Turner Hospital had their length of stay reduced by D2A by 17 days. The average length of stay for Turner Hospital for this period was 55 days. D2A intervention equates to a bed day saving at a cost of £4K minus D2A costs of £4K for 26 days of intervention. Although there is no monetary cost saving in this instance, flow and capacity were created by D2A by providing intervention at home and not in a hospital bed for those 17 days.

Patients from Hospital Outwith Moray

4.8. Seven patients came directly to D2A from ARI. Had D2A not been operational, these patients would have been transferred to a Moray Community Hospital. These patients already had an average length of stay of 39 days before discharge to D2A. From individual data of each patient's length of stay, D2A intervention saved 102 bed days in Community Hospitals at the cost of £27K minus D2A costs of £5K and an overall cost aversion saving of £22K.

4.9. One patient came directly to D2A from Woodend Hospital and again, this patient would historically gone to a Community Hospital. D2A saved this patient a minimum of 46 days (this is the lowest average LOS for a Moray Community Hospital for this period) at the cost of £12K minus the cost of D2A intervention of £1K for under a week of rehabilitation at home and an overall cost aversion saving of £11K.

4.10. One patient came directly to D2A from Raigmore Hospital with the same cost saving of under a week of home-based rehabilitation with D2A and the same cost aversion saving of £11K.

Lowering Readmission Rates

4.11. On data analysis, patients who receive D2A intervention remain 50% less likely to be readmitted within 7 and 28 days as per previous findings.

Reducing the Requirement for Care

4.12. During the audit period, one patient from 55 was referred for care by D2A. The dependency level of all 55 patients referred to D2A on discharge from hospital during this audit period was mapped and consensus of the MDT reached to ascertain the level of support and dependency each patient would have required at point of discharge for these patients had D2A not been operational.

4.13. For the audit period, 7 patients from DGH would have required twice daily input from care agencies at the cost of £52K (the average length of a care package is 6-months at £20 per hour). Seven patients would have required care input 3 times daily at the cost of £77K. D2A intervention for these patients cost £26K and results in a cost aversion saving of £103K.

4.14. In Moray's Community Hospitals, 2 patients would have required twice daily input from care in the absence of D2A at the cost of £15K and 2 patients would have required 3 times daily input at the cost of £22K. D2A intervention for these patients cost £7K and results in a cost aversion saving of £30K.

4.15. The MDT agreed that 14 patients would have had a longer stay in DGH to await care in the absence of D2A. This would have increased these patients' LOS and bed days minus the cost of D2A intervention for these patients and a cost aversion saving of £62K.

4.16. It was concluded by the MDT, 5 patients would have required a longer stay in a Community Hospital to await care in the absence of D2A. D2A created a cost aversion saving of £5K.

4.17. Eighteen patients discharged to D2A from DGH or ARI/Woodend Hospital/Raigmore Hospital were mapped by the MDT as previously requiring to be transferred to a Community Hospital for rehabilitation in the absence of D2A.

4.18. The cost of a Community Hospital stay for these patients minus D2A costs equals a cost aversion saving of £184K.

D2A Delayed Discharges to Care

4.19. Throughout the last year, 6 patients over 335 days have had to remain with D2A whilst they have awaited either START (120 days) or mainstream care (215 days). This cost the organisation £57K and resulted in reduced D2A capacity.

Delays in Discharges from Hospitals to D2A

4.20. From May to July 2022, there were 31 days of delays identified in patients physically being discharged to D2A due to hospital-based issues such as transport, medication and coordination of discharge. These delays also alter length of stay for patients. Twenty-five days of delays were from DGH costing £14K and 6 days of delays from Community Hospitals costing £2K. D2A costs for the same period were £4K. Therefore the cost to the organisation of these delays was £12K.

4.21. **Cost Analysis**

Activity May, June, July 2022	
D2A Costs including non-pay	(£75K)
Avoiding unnecessary admission	£24K
Reduced length of stay – DGH	£16K
Reduced length of stay – Community Hospitals	£3K
Cost of additional bed days to await care from DGH in the absence of D2A	£62K
Cost of additional bed days to await care from Community Hospitals in the absence of D2A	£5K
Cost of patients transferring to a Community Hospital for rehabilitation in the absence of D2A	£184K
Reducing care requirements from DGH	£103K
Reducing care requirements from Community Hospitals	£30K

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 pan and in particular to the Home First Theme

(b) Policy and Legal
None directly associated with this report

(c) Financial implications
No direct financial implications but can demonstrate efficiency and cost aversion as detailed in paragraph 4.21.

(d) Risk Implications and Mitigation
In terms of patient outcomes, D2A continues to demonstrate high rehabilitation outcomes. D2A can also demonstrate reduced length of stay, lower readmission rates and reduced requirement for care. There is excellent qualitative data evaluation through the various outcome therapy led evaluators and this report demonstrates evidence of key quantitative performance indicators as requested from the last MIJB report.
This rehabilitation service provides assessment over 7 days predominantly in hours. Whilst there is a risk frail adult admissions may be missed for referral to D2A, capacity of the team is such that they are covering peak activity for discharges.
D2A continues to require highly specialist practitioners in order to mitigate the risk of increasingly higher medical acuity patients being discharged from all hospitals.

(e) Staffing Implications
D2A demands a workforce of highly specialist practitioners in order to achieve evidenced rehabilitation goals with patients and also mitigate and carry the risks of early discharge of frail elderly individuals. Recruitment for all Allied Health Professionals is challenging across the whole of the country and there is a national shortage of AHPs. Continual review of the staffing configuration has been required throughout with the maternity and sickness absence of staff, vacancies and a balance against to meeting the aims and objectives of the service. D2A is providing a blended model of care where appropriate.

(f) Property
D2A are to be permanently accommodated with DGH in the near future.

(g) Equalities/Socio Economic Impact
All patients who require D2A and are able to engage in rehabilitation receive D2A. As a rehabilitation service, it does not run 24/7 therefore some patients who attend ED out of hours may be missed.

(h) Climate Change and Biodiversity Impacts
There are no climate change and biodiversity impacts in this report.

(i) Directions

None arising directly from this report.

(j) Consultations

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

6. CONCLUSION

6.1 D2A has continued to meet the criteria as set out in its initial business case. This is an effective service that demonstrates excellent outcomes for patients in terms of functional ability after D2A intervention. The key actions highlighted in the report of May 2022 have been explored and evidenced within this report.

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Background Papers:

Ref: