REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021**

SUBJECT: **DISCHARGE TO ASSESS**

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

1. REASON FOR REPORT

1.1. To inform the Board of the outcome of the Discharge to Assess (D2A) pilot project and to request D2A is embedded into the health and social care system in Moray.

2. RECOMMENDATION

2.1. It is recommended that the Moray Integration Joint Board (MIJB) agrees to scale up the D2A team and secure permanent funding in order to continue to support patients, flow and capacity within the health and social care system.

3. BACKGROUND

3.1. Operation Home First is a partnership between all three of Grampian's health and social care partnerships and Grampian's Acute Services. The shared ambition is to:

- Maintain people safely at home
- Avoid unnecessary hospital attendance or admission
- Support early discharge back home after essential specialist care

3.2. The Home First approach in Moray is being driven forward at pace. A delivery group was formed back in June 2020, Chaired by Sean Coady, Head of Service. Lead officers were identified under each of the Home First Workstreams to pull together colleagues and partners to establish and take forward improvement projects.

3.3. The workstreams are Discharge to Assess (D2A), Prevention and Self-management, Hospital at Home and Delayed Discharges.

3.4. 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.

3.5. D2A is an intermediate care approach for 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.

3.6. Patients are discharged 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.

3.7. 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. Please see **Appendix 1**. 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.

3.8. 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. 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.

3.9. A D2A pilot was then carried out with 6 patients. The purpose of this pilot was to test criteria, process and measurments.

3.10. As a result of the success of the pilot, temporary funding was identified and allocated to D2A through winter planning to support a 6-month test of change project from 5 October 2020 to 31 March 2021. The full report of this pilot is attached at **Appendix 2.**

4. KEY MATTERS RELEVANT TO RECOMMENDATION

D2A Pilot Project

4.1. From 5 October 2020 to 17 February 2021 (19 weeks) **48 patients** were assessed by the D2A Team.

- **29** (60%) were female and **19** (40%) male, with an average age **84 years** with the eldest being 96 years and the youngest being 64 years.
- **46** of 48 of patients were referred from Dr Grays Hospital with the majority (17 or 35%) referred from Ward 7 – almost all geriatric medicine.

Avoiding Unnecessary Admission and Early Supported Discharge

4.2. **Forty** in-patients were referred to D2A. For these patients and average length of stay was **8 days**. An average length of stay for a geriatric medicine and orthopaedic trauma admission and discharge from Dr Gray's Hospital is **9 days**. This is a saving of 40 bed days.

4.3. **8** (17%) of the 48 patients were referred from the Emergency Department at Dr Gray's Hospital and discharged straight home with D2A. Preventing admission of these patients saved 72 bed days at a cost of £41,040.

Whole System Flow & Capacity

4.4 As part of the pilot all anticipated 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.
- **2/3** of D2A patients would have been transferred to a Moray Community Hospital for longer rehabilitation or assessment for care.

4.5 Average length of stay for a community hospital in Moray for 2020 was 38 days. D2A has reduced the amount of patients transferred to a Moray Community Hospital by supporting a Home First approach. Lower readmission rates were also recorded.

Outcomes

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

- **81%** of patients rated their performance had improved with D2A input
- **88%** of patients rated their satisfaction with their functional performance had improved

4.7 The Barthel Functional Index scoring showed an increase in functional performance in **91%** of patients.

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

- **100%** 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.
- **100%** of D2A patients assessed using EMS saw an increase in their scores showing an improvement in their mobility.

Onward Referrals

4.9 D2A takes a blended approached with joint working across the health and social care partnership. 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.

4.10 There has also been a blended approach with Forres patients with the Forres Neighbourhood Care Team (FNCT) particularly at the weekend when D2A resource was stretched across Moray geographicaly.

- Just **5** of the 48 patients were referred to Short Term Assessment and Reablement Team (START). One of these patients was discharged from START after a short period of frther enablement.
- **10** of the 48 patients have required referral to Community Physiotherapy for ongoing mobility, outdoor mobility, gait and balance issues.
- **4** of the 48 patients have been referred to the Access Team – 3 for adaptations to their bathrooms and one for a carer assessment of his needs.

- **One** patient has been referred onto Community Rehabilitation Occupational Therapy.

Patient and Family Feedback

4.11 All patients and their carers who were interviewed as part of the pilot project stated they were 'highly satisfied'.

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

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

Summary

4.14 Targeted therapy input leads to improved patient functional outcomes and therefore reduced requirement for care for those patients.

4.15 Intevention 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.

4.16 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.

4.17 Additional and permanent funding will enable the recruitment of a robust team that will have the ability to expand the work significantly across Moray.

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"

Primary strategic drivers for D2A in Moray are set out in the 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.

(b) Policy and Legal

D2A is a work stream under Homefirst aligned to the Strategic direction in Moray within Partners in Care.

(c) Financial implications

The table below details the annual funding required to operate D2A on an ongoing basis. The 2021/22 Revenue Budget paper is also subject of a report on today's agenda. The costs associated with D2A for the 2021/22 financial year have been built into the budget as an area of pressure. The Chief Financial Officer has been clear that it will be necessary to identify areas of disinvestment and to engage in wider conversations around the set aside budget to enable D2A to be fully embedded beyond the 2021/22 financial year. Progress reports on transformational change are suggested.

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
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**

(d) Risk Implications and Mitigation

The project completes end of March. D2A underpins other transformations under Homefirst and has evidenced benefit to shift the balance of care out of hospitals and into the community. If we do not proceed to take D2A forward on a permanent basis into full implementation then we will not realise the change we need to make.

(e) Staffing Implications

Scaling up of the D2A team would require Occupational Therapy Leadership, Physiotherapy input, generic Occupational Therapy and Physiotherapy support workers. ANP input for comprehensive geriatric assessment is also required and administration support.

(f) Property

There are no property implications.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment is not required because there are no service, policy or organisational changes being proposed.

(h) Consultations

Consultation on this report has taken place with the HSCM Senior Management Team and Home First Delivery Group (Moray).

6. CONCLUSION

6.1. D2A requires to be permanently funded in its entirety in order to continue to support patients and to continue to contribute to flow and capacity within the health and social care system in Moray.

Author of Report: Dawn Duncan, Professional Lead for OT – Moray
Background Papers: **Appendix 2**
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