REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 26 MAY 2022**

SUBJECT: **HOME FIRST - DISCHARGE TO ASSESS AND THE IMPACT ON SYSTEM FLOW ACROSS MORAY**

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

1. REASON FOR REPORT

1.1. To update the Board on the impact that Discharge to Assess (D2A) has made on system flow 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 Discharge to Assess Service with an emphasis on impact across system flow and capacity;

ii) notes the actions identified in section 4 and that an update on progress will be submitted to the Board within the next six months.

3. BACKGROUND

3.1. Health and Social Care Moray, like most other partnerships, have been under immense and sustained pressure from the COVID-19 pandemic since early 2020. Now entering its third year 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. Discharge to Assess (D2A) is one of a number of initiatives that has been 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

Discharge to Assess

3.3 D2A is an intermediate care approach that aims to secure the early discharge of 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. D2A was one of the original initiatives through Operation Home First. Intervention by D2A comprises up to 2 weeks of intensive assessment and rehabilitation in the patient's home from Occupational Therapy, Physiotherapy and an Advanced Nurse Practitioner with day to day support from Generic Support Workers working upon patient chosen goals.

3.4. The following criteria provides guidance to referring practitioners :

- Patient 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 required
- Initial combined AHP assessment completed in Emergency Department or early on in admission
- Independently mobile, with/without aids
- Anticipated short term assessment period of 2 weeks plus
- Continence can be managed – independent with equipment/pads or support including overnight
- Admission to hospital likely to be detrimental to cognitive status
- Patient's family in agreement

3.5. D2A aims to have system impact on the following :

- Avoiding unnecessary admission
- Reducing length of hospital stay – DGH and Community
- Lowering re-admission rates
- Reducing the requirement for care packages

3.6. After two trial periods, D2A went live on 3 August 2021. At the MIJB meeting on 25 March 2021 (para 10 refers) permanent funding of 497K was secured for:-

- Band 7 OT Lead 1.5WTE
- Band 7 Advanced Nurse Practitioner 1WTE
- Band 6 OT 1 WTE
- Band 6 Physiotherapist 1WTE
- Band 6 Registered Nurse 0.6WTE
- Band 3 HCSW 6WTE
- Band 3 Admin 1WTE

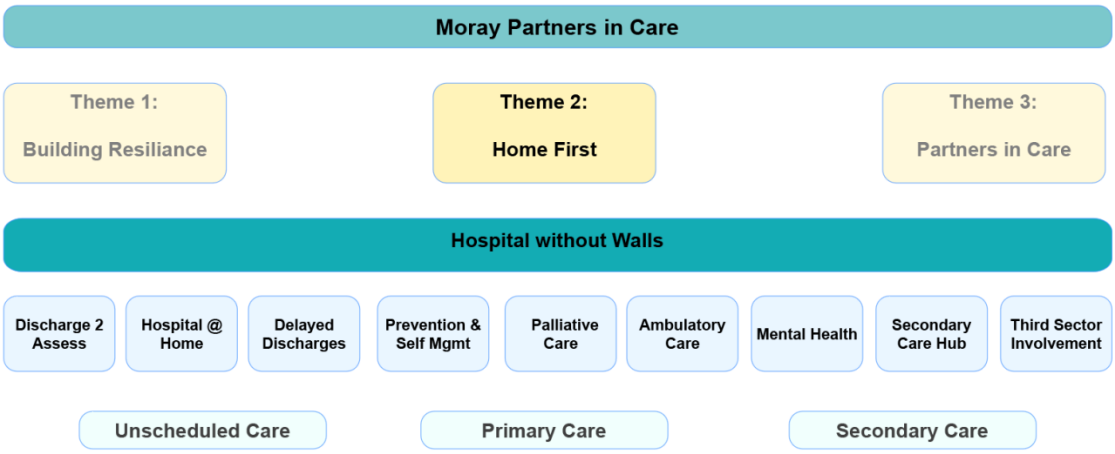
3.7. D2A was awarded a budget of £497K per annum. For the period of 3 August 2021 to 31 March 2022 D2A spend was £299k against a prorated budget of £331k. Whilst the service operated under budget it recognises that if a full staffing compliment was in place there would be overspend. For the same period maternity absence accounted for 13% of staffing and long term sickness absence 7%. Travel costs have come in higher than original estimate.

3.8. The average length of treatment once discharged home with support from the D2A team was 11 days, making the cost per day of the D2A service per patient £169 compared with £570 for a DGH bed day and £262 for a Community Hospital bed day.

3.9. Since going live 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 6 physiotherapist post. D2A has also experienced staff absence due to COVID-19, longer term absence and maternity leave. As such, it should be noted that D2A has not been operating at optimal staffing.

3.10. D2A is part of a wider programme exploring the entire patient pathway – particularly for those with frailty and multimorbidity. Hospital without Walls was introduced at the meeting of the Board on 27 January 2022 (para 11 of the minute refers). 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. Hospital without Walls pulls together the individual work streams under Home First whilst also considering unscheduled care, primary/secondary care and acute services.

The diagram below provides an illustration of Hospital without Walls.



4. KEY MATTERS RELEVANT TO RECOMMENDATION

Avoiding Unnecessary Admissions

4.1. For the 8 month period August 2021 to March 2022, a total of 161 patients were assessed by D2A. 11% of those (18) were referred to D2A by Dr Gray's Hospital (DGH) Emergency Department (ED) and discharged home directly. Assuming that these patients would have been admitted and would have remained in DGH for the average length of stay of 7 days this equates to a bed day saving of 126 days at a cost of £72K minus £33.5K for the cost of D2A (11 days at £169 per day per patient) so an overall cost saving of £38.5K. A review of the ED attendance will be done in conjunction with the Home First Frailty team to ascertain if more patients could be referred to D2A earlier in their journey to prevent unnecessary hospital admission.

Reducing Length of Stay

4.2. For the 8 month period August 2021 to March 2022, for 118 DGH in-patients assessed by D2A had their hospital stay was shorted by one day. (DGH 7 days against D2A 6 days). This amounts to a bed day saving of £67K. Review of

inpatient discharge arrangements to D2A in collaboration with the Home First Frailty Team is planned and further review will be done to establish if length of stay could be further reduced.

4.3. In month one (August), 45% of patients were discharged from DGH to D2A, 45% of patients were discharged from a Community Hospital to D2A and the remaining 10% directly from ARI or hospitals out with Moray. Currently 73% of patients are discharged from DGH to D2A and 19% from a Community Hospital. This demonstrates a shift to early supported discharge from DGH and D2A's contribution to capacity and flow as well as reduced length of stay. Work will be undertaken to establish the extent of this benefit as lengthy Community Hospital stays impact on patient outcomes and severely hamper flow.

4.4. D2A is providing a blended model of care where appropriate with START (short Term Reablement and Assessment Team) to ensure timely discharge which supports all the needs of the patient. D2A will also provide input to Hospital Without Walls as well as links to Primary Care AHPs and the Home First Frailty Team and any other appropriate agencies thereby introducing a seamless service that supports the frail elderly of Moray.

Lowering Readmission Rates

4.5. The readmission rate for DGH period August 2021 to March 2022 (1539 admissions) is 3.84% at 7 days and 8.28% at 28 days. The readmission rate for D2A (161 patients) is 1.86% at 7 days and 3.73% at 28 days. Standardising these rates demonstrates that for 7 days DGH has a 1 in 26 risk of readmission and D2A has a 1 in 53 risk of readmission. For 28 days, DGH has a 1 in 12 risk of readmission, and 1 in 26 risk readmission within the D2A service. This demonstrates that patients who are supported by the D2A service are over 50% less likely to be readmitted.

Reducing the Requirement for Care

4.6. Prior to D2A the only response to patients requiring support with activities of daily living was a referral to Social Care. By introducing D2A, 161 patients have swapped a potentially lengthy wait for a social care package with short term intensive targeted rehabilitation and avoided the risk of becoming a delayed discharge. Since launching, only 4% of D2A patients required assessment for care. More work will be done to analyse this benefit and cost saving.

Patient Outcomes

4.7. 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)

4.8. Using these standardised outcome measures:

- 95% of D2A patients showed an increase in their functional performance in Activities of Daily Living (ADL)
- 90% of patients rated an improvement in their own ADL performance

- 94% of patients improved their functional mobility and gait, therefore reducing the risk of falls and improving their overall ability to maintain ADL's
- 85% of patients were rated with improved scores around balance, gait and mobility
- The Advanced Nurse Practitioner (ANP) for D2A carries out a review of medication management for patients discharged to reduced poly pharmacy and ensure interface between secondary and primary care

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

4.9 **Cost Analysis**

Activity August 2021 to March 2022	**£**
D2A costs (including non-staff)	(299K)
Avoiding unnecessary admission	72K
Reducing length of stay – DGH	67K
Reducing length of stay – Community Hospitals	-
Reducing care requirements	-
Total	**(160K)**

4.10 Potential savings from reduced transfer to Community Hospitals and therefore reduced length of stay for patients and reduced social care packages require to be costed. Work will be done to better evaluate these elements it is anticipated the value created by D2A will be better illustrated. It should be noted that cost savings are for DGH and not the wider MIJB at this stage.

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 plan and in particular to the Home First theme.

(b) Policy and Legal

None directly associated with this report

(c) Financial implications

There are financial risks with D2A budget being overspent if left to continue. To mitigate this, continuous budget monitoring is ongoing including the review of staffing and banding. Additionally, cost savings relate to DGH and not the wider MIJB at this stage.

(d) Risk Implications and Mitigation

There are financial risks with D2A. As above.

In terms of patient outcomes, the 161 patients supported by the service saw high rehabilitation outcomes, reduced length of stay for DGH and a lower readmission rate.

Although there is excellent qualitative data evaluation through the various outcome therapy led evaluators there is a lower reliance on key quantitative performance indicators. To mitigate this, quantitative metrics will be identified and evaluated and should link to high level national, regional and local strategic indicators.

This rehabilitation service provides assessment over 7 days predominantly in hours. There is a risk that the well documented peak activity periods for admissions of frail adults is missed for referral for D2A. A review of ED attendance is planned with the Home First Frailty Team to ascertain if more patients could be referred to D2A earlier in their journey.

(e) Staffing Implications

D2A demands a workforce of highly specialist practitioners in order to achieve evidenced rehabilitation goals with patients. Recruitment for all Allied Health Professionals is challenging across the whole of the country and there is a national shortage of AHPs.

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 with START (short Term Reablement and Assessment Team) and also will provide input to Hospital Without Walls as well as links to Primary Care AHPs and Home First Frailty team thereby introducing a seamless service that supports the frail elderly of Moray.

(f) Property

As previously reported, the D2A team have had issues with accommodation, often being displaced outside of DGH.

(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. Work is ongoing to review this.

(h) Climate Change and Biodiversity Impacts

There are no climate change and biodiversity impacts in this report.

(i) Directions

NHS to be directed to provide this service through Scottish Government Winter Funding announced 4 November 2021. The specific direction will be included in the Financial Investment report to come to this committee 30 June 2022.

(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. A number of key actions have been highlighted in the report and will be further explored.

6.2 D2A is a single part of the overall frailty service and with refinement under the Hospital without Walls model opportunities for better utilisation will be explored.

6.3 A report will be brought before the board in 6 months.

Author of Report: Alison Smart, Home First Clinical Lead
Background Papers:
Ref: