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Agenda Item: 7.

Integration Joint Board

Date of Meeting: 20 April 2022.

Subject: Home First Evaluation.

1. Purpose

1.1. This report provides Members with the findings of the 12 month Home First pilot "discharge to assess" model.

2. Recommendations

The Integration Joint Board is invited to note:

2.1. That all individuals referred to Care at Home are offered the Home First model to maximise their independence and reduce future demand on Care at Home.

2.2. That the Home First, Intermediate Community Therapy and the Mobile Responder Green Team will form an intermediate care hub with a single point of access to request, as detailed in the diagrams attached as Appendix 2.

2.3. That, on 22 March 2022, when considering proposals for additional health and social care funding received from the Scottish Government, the Board agreed to commission various services, including the permanent establishment of the Home First team.

3. Background

3.1. The Home First initiative was identified as part of the 2020/21 winter bed planning and commenced on 16 February 2021. Funding was secured utilising winter planning funding to support the pilot until 31 March 2022. The pilot costs were 0.6 WTE equivalent Occupational Therapist hours with other elements being provided through re-utilisation of some social care resource.

3.2. The staffing required to operate the service across 7 days was:

- 1 WTE Occupational Therapist.
- 120 hours care at home workers.
- 21 hours Social Work support.

- 15 hours rapid access physiotherapy support.

3.3. Prior to its implementation, a standard model of delivery based on a traditional assess to discharge model resulted in prolonged hospital stays waiting for assessment and packages of care to be in place. In addition, due to the difficulties of predicting actual need whilst service users were inpatients, this resulted in packages requiring an almost immediate increase or decrease in care hours required.

4. Home First Service

4.1. The Home First Service is a discharge to assess model offering up to six weeks of reablement support to enable timely discharge from the hospital and the opportunity to assess patients in their own home.

4.2. The reablement approach supports people to do things for themselves. It is a 'doing with' model, in contrast to traditional care at home which tends to be a 'doing for' model. Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness.

4.3. An open approach to accepting individuals into the pilot was taken with all new referrals for care at home packages and requests for increases included.

4.4. Evidence indicates that even a delay of one day in discharge results in avoidable harm to patient such as deconditioning, increased exposure to hospital acquired infections, and risk of falls.

4.5. More accurate assessment and better outcomes can be achieved when people are in their own homes. The person sets achievable goals with the team Occupational Therapist and care and support is delivered by a dedicated care at home team.

4.6. Occupational Therapists are trained in the science of occupational performance and can work together with individuals to re-establish independence after illness or injury. Furthermore, they help to co-design adjustments to daily living where full recovery is not possible. Physiotherapists are trained in the specialist assessment of physical function for example strength, balance, gait and condition.

4.7. The Home First model provides an evidenced based approach to maintaining an individual’s independence at home and increases the confidence of the individual and their family members and reduces the expectation and reliance on a long term Care at Home package being required to enable the person to remain at home for longer.

5. Analysis

5.1. The results of the 12 month pilot are summarised below. More detailed evaluation data can be found in Appendix 1.

5.2. Health intelligence data shows that from February 2020 – February 2021, 21 people were delayed in hospital awaiting care at home packages. The average delay was 14 days (399 avoidable bed days lost). The average waiting time for Home First commencement was 4 days. This equates to 530 bed days avoided with an

estimated value of £499,970. However, it must be recognised that, due to the size of the Balfour Hospital, there is no opportunity to reduce beds to release any funding.

5.3. Home First has supported 53 patients over the 12 month pilot. Of these, 85% were severely frail. People with this level of frailty will have significant issues with moving about; managing everyday tasks and they will have a number of other diagnoses – for example dementia, loss of sight and hearing, osteoporosis, multiple long term conditions.

5.4. The pilot was impacted by the shortages experienced by Care at Home, generally in the months from late October to December 2021, when no new Home First packages could commence (with waiting times for commencement peaking at 28 days in December) and this has impacted on numbers through the pilot.

5.5. People who received the services saw an 89% improvement in their occupational performance using validated outcome measures (Barthel Index, Derby outcome measure and Morriston Occupational Therapy outcome measures).

5.6. There was a reduction in the number of hours of support required by individuals upon discharge from Home First to Care at Home of 26.4%. Furthermore, a number of individuals required no ongoing care support following their period of reablement.

5.7. As confidence grew amongst referring professionals, the complexity of individuals referred to service increased. We do anticipate that if we could offer a reablement approach to all care at home referrals we have the potential to reduce dependency levels further.

5.8. On review, there is evidence that reduction in ongoing support requirement is being maintained after discharge from the service, with some individuals continuing to make progress and care packages continuing to reduce. Given the demographic predications for the Orkney population, with a consequent likely increase in frailty levels, it is important that we maximise independence and maintain this for as long as possible. A reablement model supports this.

5.9. In the calendar year 2021, Care at Home received 234 referrals, 74 new service users had packages of care commenced. Care at Home is currently supporting 155 service users and the average package size is 10.4 hours per week.

5.10. Extending the reablement model to all referrals into Care at Home has the potential to release capacity back into Care at Home equating to 418.5 hours per week and 21,762 hours per year. To put this into context, the total required predicted hours on the waiting list for Care at Home is 333 hours per week.

5.11. For individuals who have completed the reablement period and who have transferred over to Care at Home, there was a reduction of 172 individual care visits. Again, if reablement was applied to the entire Care at Home caseload there is the potential for 852.5 visits less per week (44,330 visits less per annum) There will be associated travel time savings in addition.

5.12. Home First has prevented 4 individuals from having to leave their home to go into residential care.

5.13. The implementation of video consulting technology, Attend Anywhere, has provided opportunity to extend the initial pilot to include people living in the ferry linked isles. Reablement training was delivered by an Occupational Therapist to Care at Home teams.

5.14. Patient feedback has been sought throughout through the use of a patient reported experience measure (PREM). Initial communication issues were resolved quickly and a relaxation in COVID-19 infection control rules enabled the Occupational Therapist to conduct more hospital in-reach which had a positive impact. Some quotations from patients, their families and the Care at Home teams supporting them can be found in the evaluation data in Appendix 1.

5.15. There has been collaborative working between Home First and the Intermediate Community Therapy (ICT) team. This has proved very beneficial in achieving outcomes for individuals and it is a model we believe would benefit from strengthening.

5.16. This enhanced way of working offers resilience across the two teams which currently have lone therapy practitioners and would form the basis of a single point of contact for intermediate care services. Integration with the Green Team would provide 18 hours of potential support each day increasing the scope of individuals that intermediate care services could support. A single point of access was strongly supported by referrers into the services when we undertook a survey in December 2021. A description of the proposed integrated model is contained within Appendix 2.

5.17. To conclude, Home First has challenged the assumptions of the professionals involved in this pilot. It has really demonstrated the power of person centred, outcome based care and shown that even the frailest people in our community can meet their personal goals, improve their independence and live safe and fulfilling lives in their own homes.

5.18. Members will recall on 22 March 2022, when considering proposals for additional health and social care funding received from the Scottish Government, the Board agreed to commission various services, including the permanent establishment of the Home First team.

6. Contribution to quality

Please indicate which of the Orkney Community Plan 2021 to 2023 visions are supported in this report adding Yes or No to the relevant area(s):

Resilience: To support and promote our strong communities.	Yes.
Enterprise: To tackle crosscutting issues such as digital connectivity, transport, housing and fuel poverty.	No.
Equality: To encourage services to provide equal opportunities for everyone.	Yes.
Fairness: To make sure socio-economic and social factors are balanced.	Yes.

Innovation: To overcome issues more effectively through partnership working.	Yes.
Leadership: To involve partners such as community councils, community groups, voluntary groups and individuals in the process.	No.
Sustainability: To make sure economic and environmental factors are balanced.	No.

7. Resource and financial implications

7.1. Although there are no resources that can be taken from saved bed days, the Home First approach enables people to leave hospital earlier and therefore reduces demand within the Care at Home team thereby enabling the commencement of new packages for people waiting in the community.

8. Risk and equality implications

8.1. There are no risk or equality implications arising from this report.

9. Direction required

Please indicate if this report requires a direction to be passed to:

NHS Orkney.	No.
Orkney Islands Council.	No.

10. Escalation required

Please indicate if this report requires escalated to:

NHS Orkney.	No.
Orkney Islands Council.	No.

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12. Supporting documents

12.1. Appendix 1: Home First Evaluation Report.

12.2. Appendix 2: Proposed Intermediate Care Model.

12.2. Appendix 3: Flash Report – Home First Evaluation.

Data Analysis – Home First Pilot

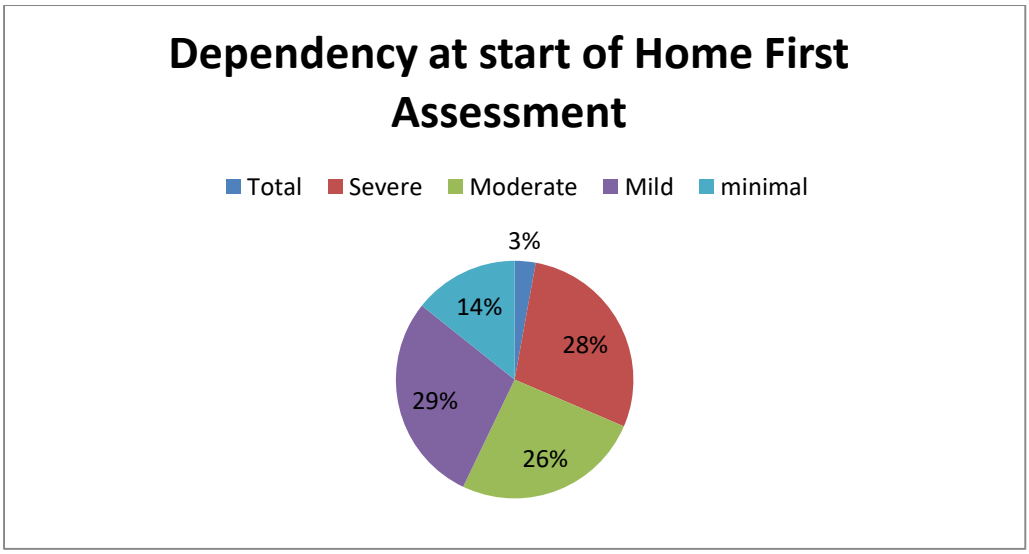
12 month review

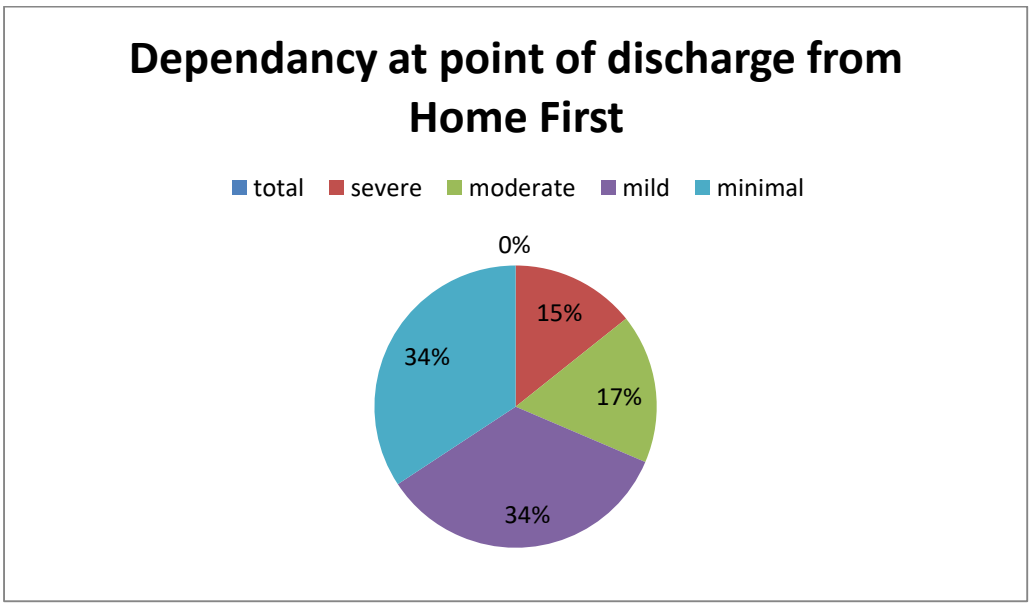
Outcomes for Service Users

For this pilot we chose to use the same basket of outcome measures which had been used in the NHS England National Audit of Intermediate Care. These were:

The Barthel Index:

The Barthel Index is used to assess and monitor changes in disability over time (Ferrucci et al. 2007) and is one of the most widely used outcome measures within Europe (Chun-Chan 2022). There is extensive literature on the Barthel index and its validity. It can be utilised in a variety of health and social care settings but has been found particularly beneficial when measuring outcomes with older people (Sainsbury et al. 2005, Lam et al. 2014). It is simple to administer and has been recognised as more robust than any other ADL scales within health and social care settings (Carroll 2011 Shan and Cooper 1993).





Derby Outcome measure

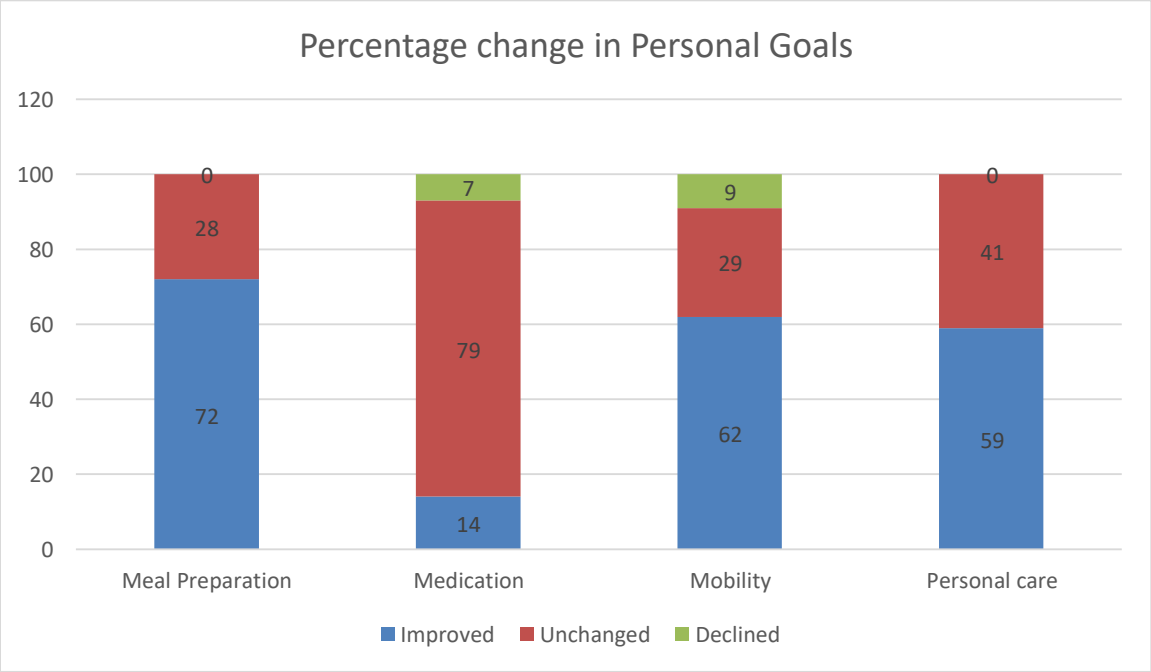
The Derby Outcome measure (2009, NHS Derby City) considers the domains of cognition, personal care, transfers and mobility, food preparation, continence, medication and the amount of support required from professionals

89% of patients demonstrated an improvement in occupational performance scores, whilst **8%** of patients remained unchanged. One patient had a decline in derby outcome score. However, it must be noted that this patient had declined surgical intervention for hip surgery, therefore we focused on pain management. The patient recognised that their mobility and function was expected to decline over time due to their hip stability.

The Morriston Occupational Therapy Outcome Measure

The Morriston Occupational Therapy Outcome Measure is a patient-centred outcome measure that allows the service user to set their own goals and rate their performance before and after occupational therapy intervention. It is seen as client centred as the service user is in control of choosing the activities that they need or want to be measured and involved in the rating process (Corr; 2004).

Changes in rating scores for the domains included are shown in the graph below



Feedback from Service Users and Others

A patient reported experience measure was utilised to gather feedback from participants. Below is a summary of the some of the feedback provided during evaluation

What did Service Users say:

"I am so happy to be living in my own house. I want to stay here as long as possible. I didn't think I would be able to come home a few times when I was in the hospital. I am glad I am home."

"My biggest achievement is getting to and from the toilet myself. When I left hospital I had just had a catheter removed and I was now in a wheelchair. I am pleased to say I am toileting independently"

"I am back to getting out and about to see my family, this is what matters most to me"

"I think it is a good service. I feel more independent at home; I can do more for myself since leaving hospital. Who would have thought I would be sitting here peeling my own tatties!"

"When I look back at how I felt in hospital, I thought I would never manage at home, but look at me now...I have achieved so much"

"People were excellent and service was very good in supporting me. "

"Generally speaking they were very good, no complaints against the Home First team in any way, they were always kind and respectful. "-

What did family and carers say:

"*Very, very pleased with everything. In particular support from OT with weekly visits. The service has made a real difference in supporting my wife at home. " - Husband*

"I thought it was excellent service, it made a real difference to my mum. It also made a big difference to my daughter and families lives. We would be happy to provide feedback any time or endorsements to see this project continue – it really has been an excellent service. " son

"All very good, all excellent. He is walking a lot better and doing really well. He is helping wash and dries the dishes, sets the table and does most of his care himself. Homecare re-started his morning visit and they were amazed at how well his is doing, one carer said it "made her day". – wife

"Invaluable service – if she hadn't had this we don't know what would have happened. I can't think of anything the Home First service could have done differently. " - daughter

What did the Care at Home staff supporting the service users say:

"I didn't realise how important it was to try and encourage people to do things for themselves until I saw the benefits first hand."

"I personally enjoy home first, it's rewarding watching service users progress really good once they are home, and with the goals they want to meet it encourages them more to be determined. Working closely with OT we get resources quickly "

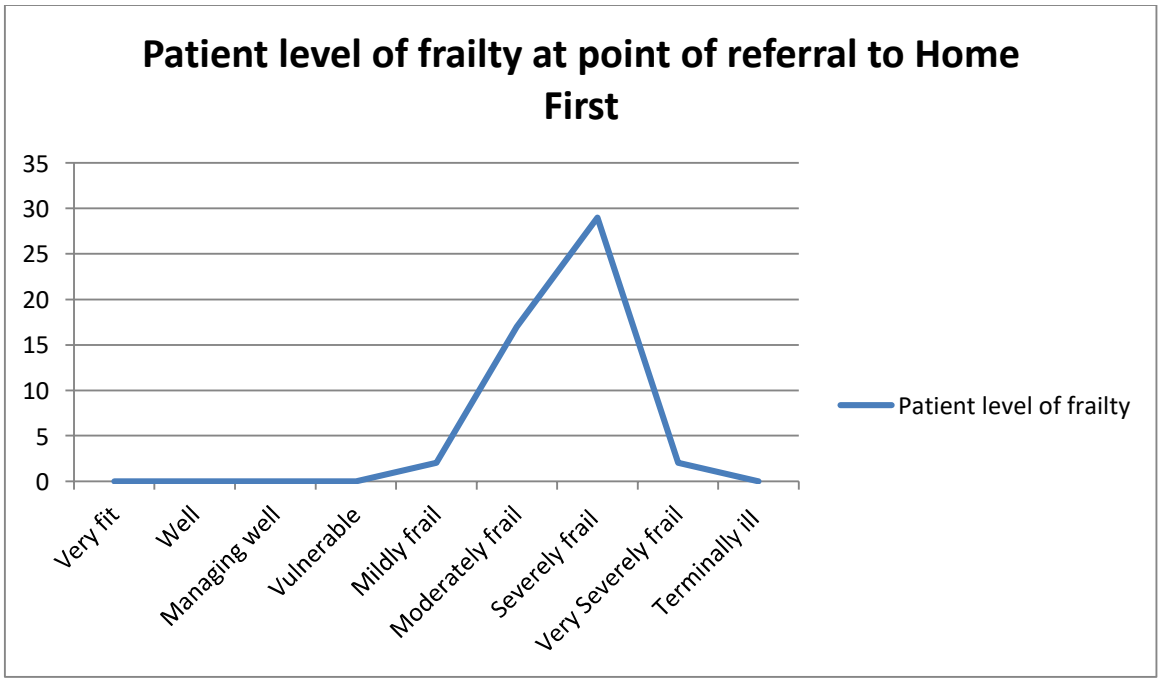
What did other members of the Multi-Professional team say:

"It is particularly pivotal in demonstrating the 'game changing' nature of what you are doing, by showing that the service is not only having the immediate and obvious impact of 'freeing up' hospital beds, but also easing the longer-term pressures on the system as a whole through the enabling approach reducing longer term care needs. This is such a powerful argument and shows the benefits to both 'the patients and the systems' of what you are doing. A win win! "– GP/Medical Director

"I think your team have helped enormously with her care." - GP

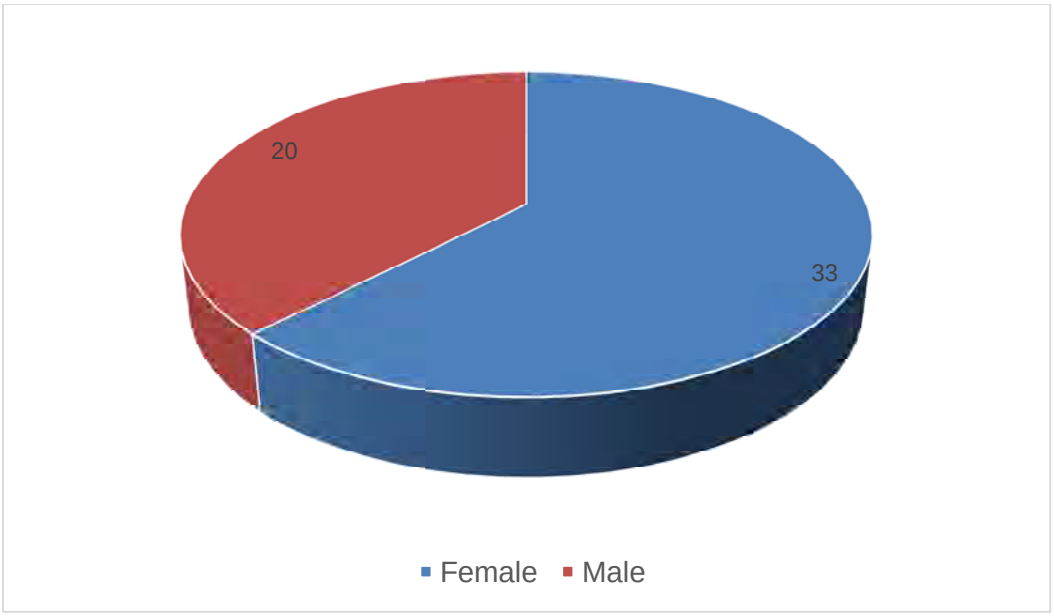
Demographic Information Regarding Service Users

Patient level of frailty when referred to Home First

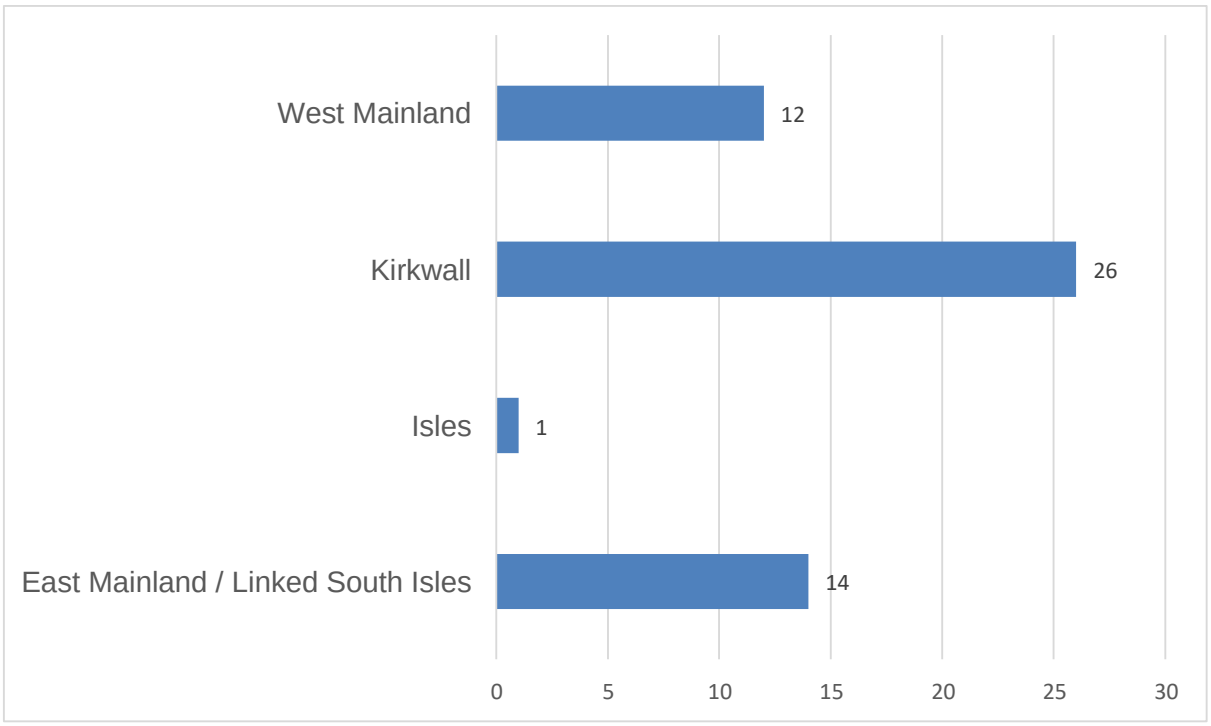


As at 8 February 2022, 53 appropriate referrals have been received by the homefirst team.

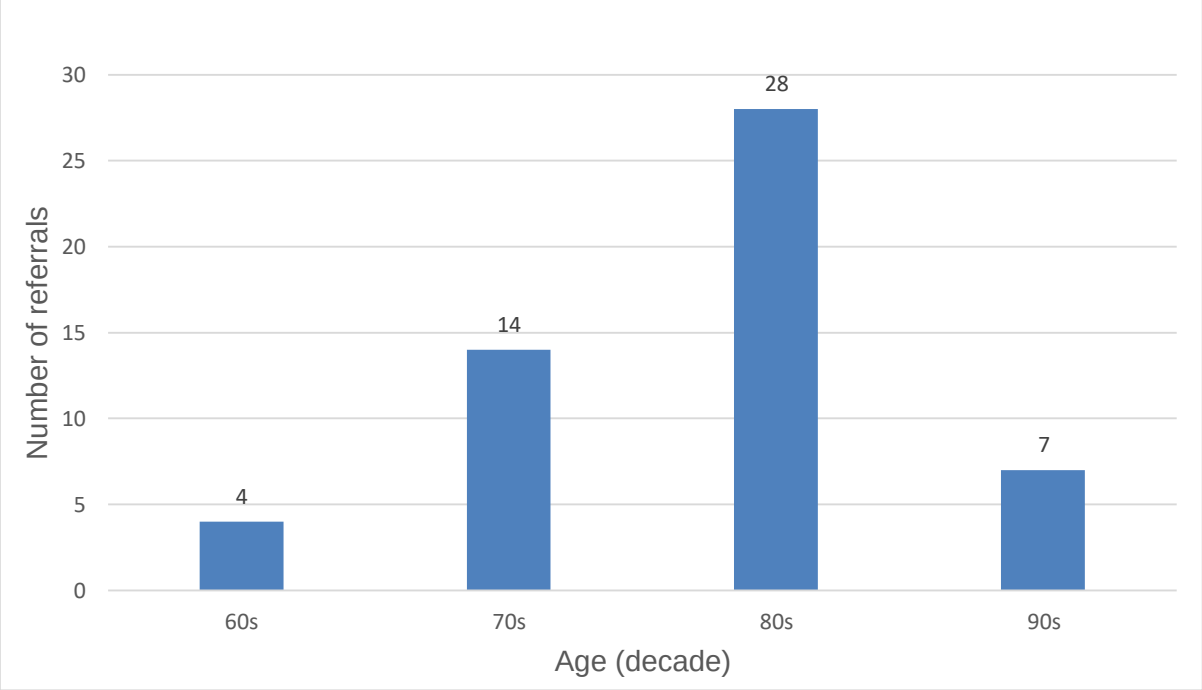
Referrals by gender



Referrals by geographical area:



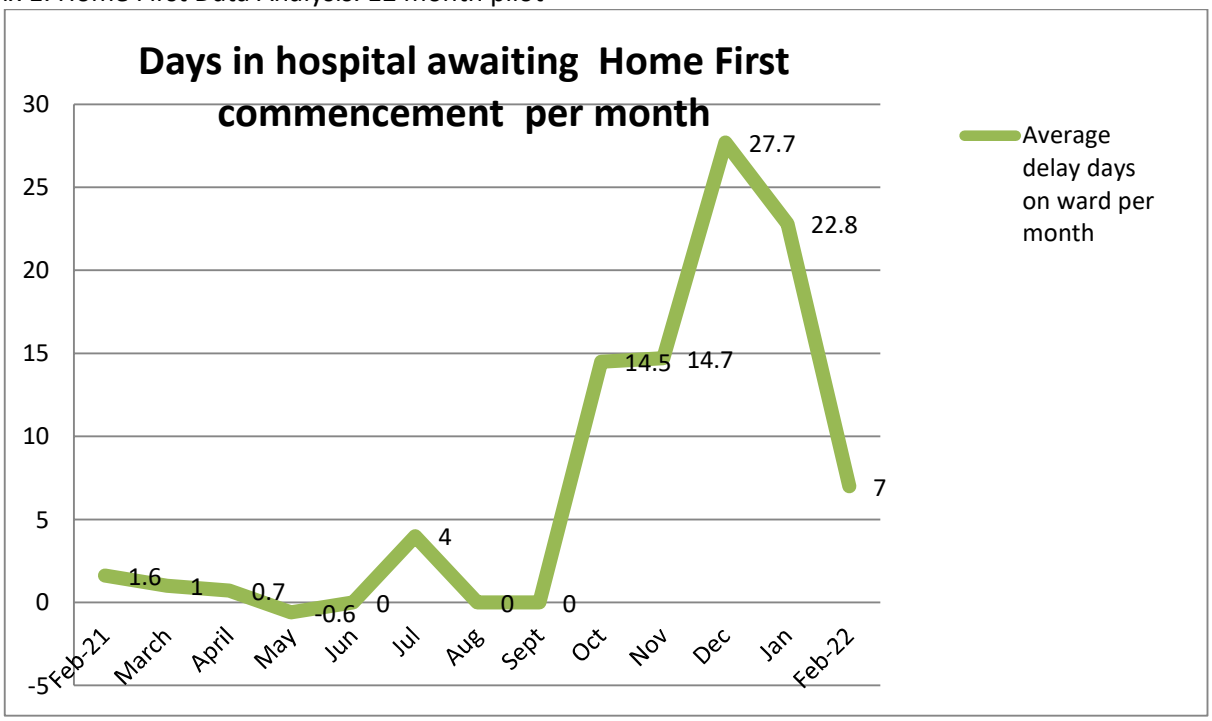
Age at the time of referral:



Acute services data

- At the start of Home First there were 4 in-patients who were delayed discharges as they were awaiting homecare. Their average discharge delay time was **19.5 days.**
- Most lengthy delay was 31 days.
- Between February 2020-February 2021 the average length of delay awaiting a care at home package was 14 days.
- As of 8th Feb 2022, average delay time across the pilot was for Home First was 4 days.
- The shortest delay time was 0.6 days.
- As of 8th Feb 2022 – 71% decrease in delayed discharges for Care at Home.
- Bed days avoided – 530 which is a total saving of £499,970.
- Care at Home capacity was reduced during the months of November and December in particular and this is reflected in waiting time data for home first as carers had to be redeployed to support existing Care at Home packages.

Appendix 1. Home First Data Analysis. 12 month pilot



Re-admissions

4 individuals were re-admitted within 7 days of hospital discharge, turnaround time – 3 days. One patient went into residential care.

Patient stories (Readmissions):

Patient one

Patient was deemed as severely frail at point of discharge from hospital and had a cognitive impairment. She returned home with an additional morning visit from Home First to accompany 3 other visits from her current care at home team. On day 4 of her return home she was readmitted to hospital due to back pain that had resulted in her inability to get in and out of bed over night. This had led to incontinence and family stress in dealing with this overnight. This hospital readmission happened over the weekend and it is felt by Home First team that if it had happened during the week, this issue could have been resolved with equipment and additional support from Green team. Family held POA and she went into a residential care home.

Patient two

Following 24 hours at home this patient was readmitted following a fall at home. He was in his 60's, moderately frail and had been in hospital following hip surgery. At point of discharge, he declined commode, community care alarm and did not want any more than one carer visit per day. He required supervision for mobilising. He fell through the night trying to get up to the toilet. Home First were then able to provide equipment, telecare and additional care to support him back home. Following a period of reablement with Home First, he is independent and receives no formal care at home support.

Patient three

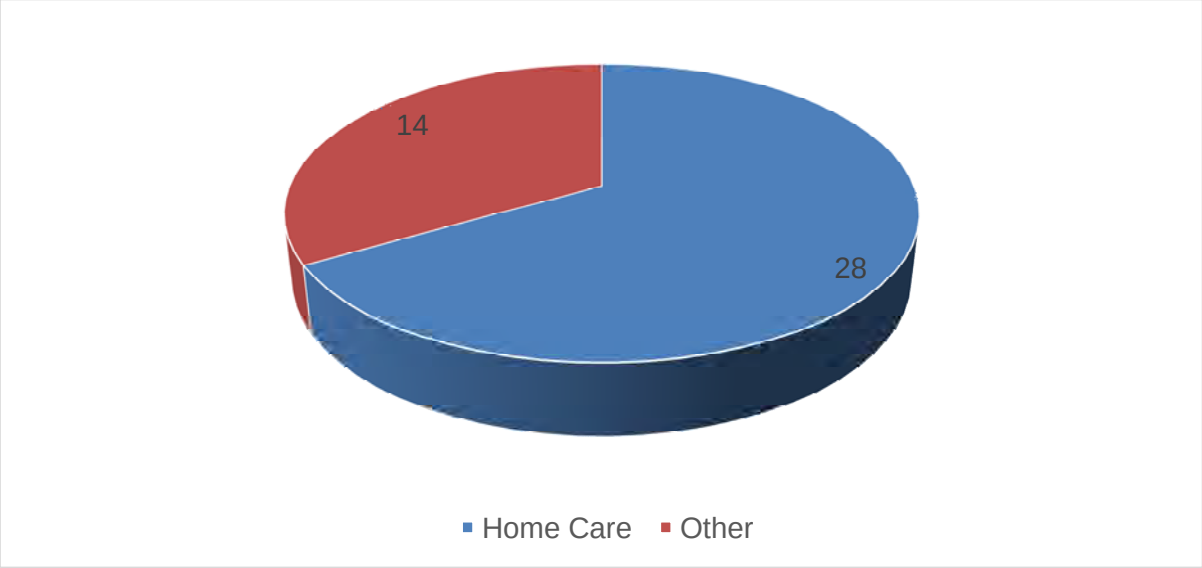
Following 5 days at home this severely frail man returned to hospital due for medical interventions following intense stomach pain and constipation. He was high risk medically for further complications and has a cognitive impairment. He returned home within 2 days of his re-admission with his Home First care package. He remains at home with a care at home package and wife support.

Patient four

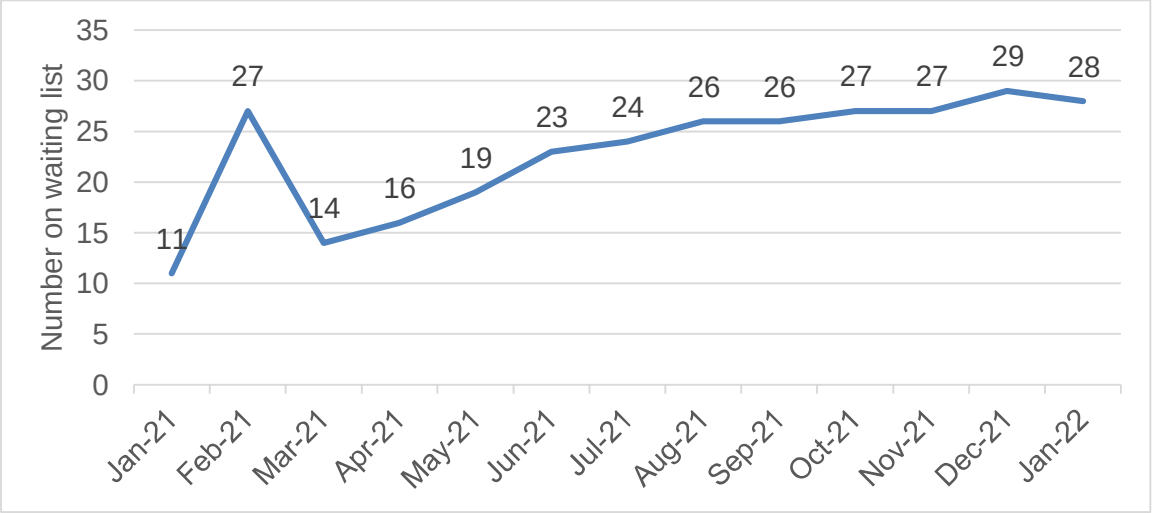
This severely frail lady had long standing COPD and was re-admitted following two days at home due to exacerbation of this. She returned home within 24 hours with her current Home First care package and advice/education was given to carers around energy conservation and anxiety management to try and prevent further admissions.

Community Services Data

At 8 February, 42 service users have been discharged from the service. The following chart shows the proportion moving on to a regular Care at Home service:

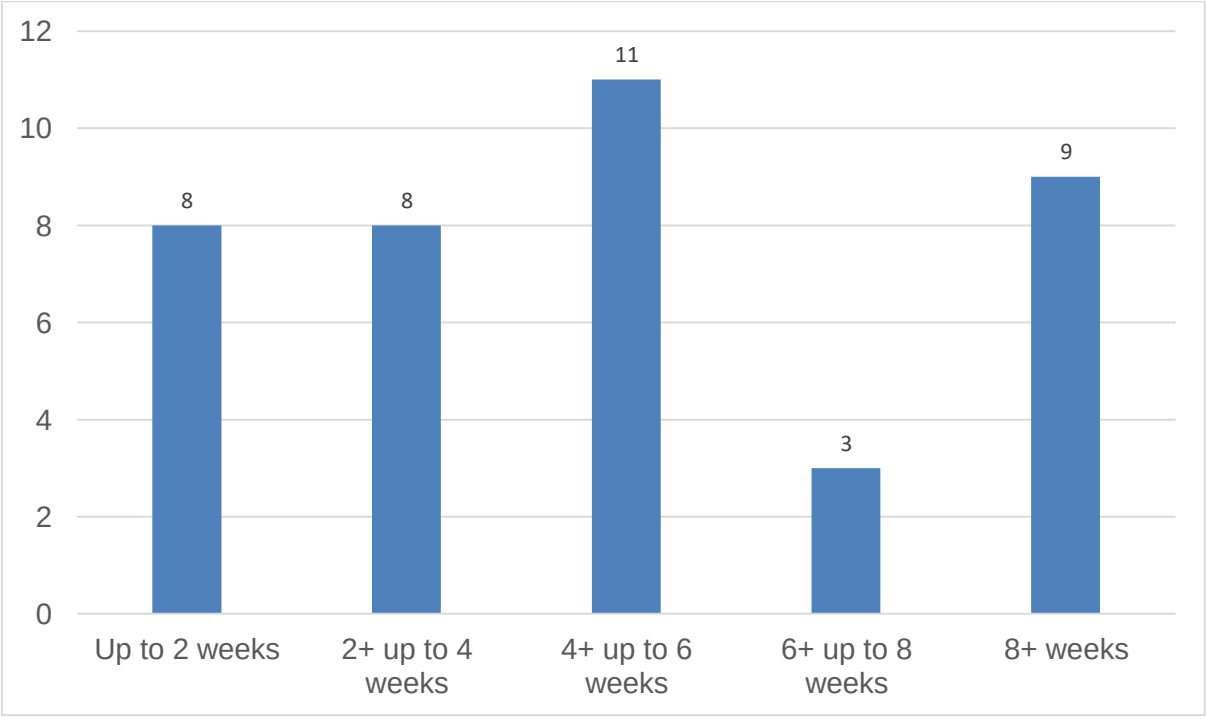


The following shows the number of people on the waiting list for a Care at Home service (including Home First) at the end of each month:

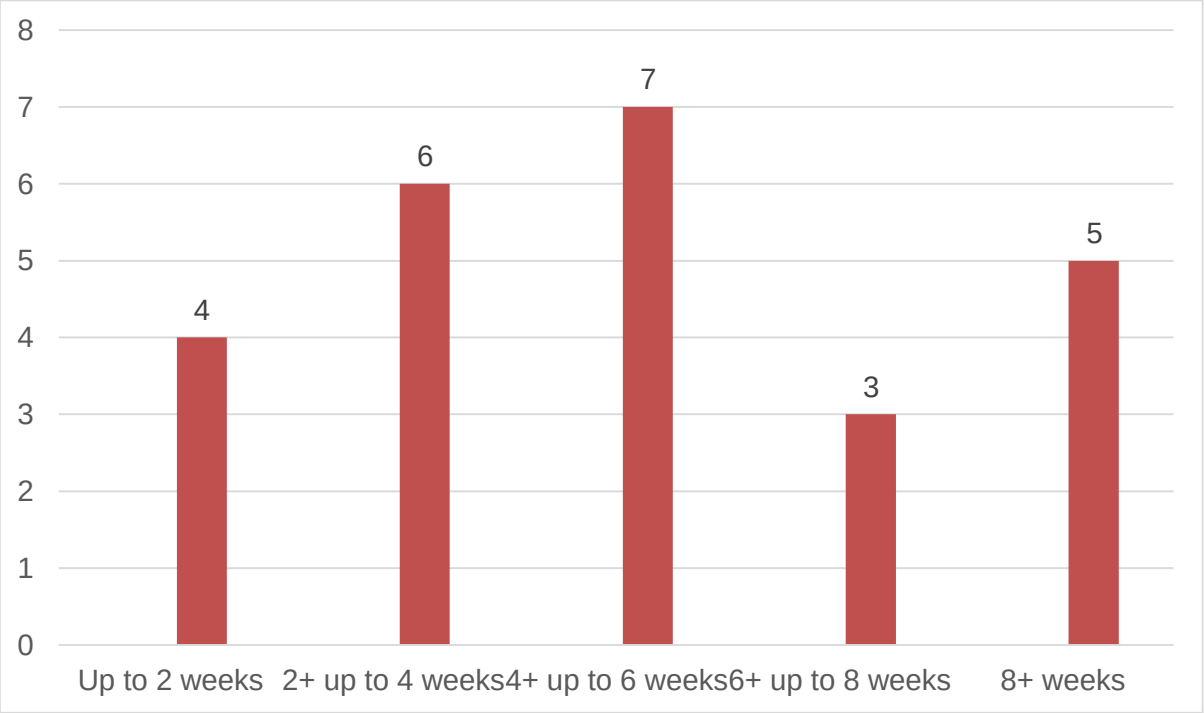


How long did service users receive the Home First service?

Of the 39 service users discharged from the service thus far, the longest reablement package was just over 22 weeks; the shortest 1 day with the median a little under 5 weeks

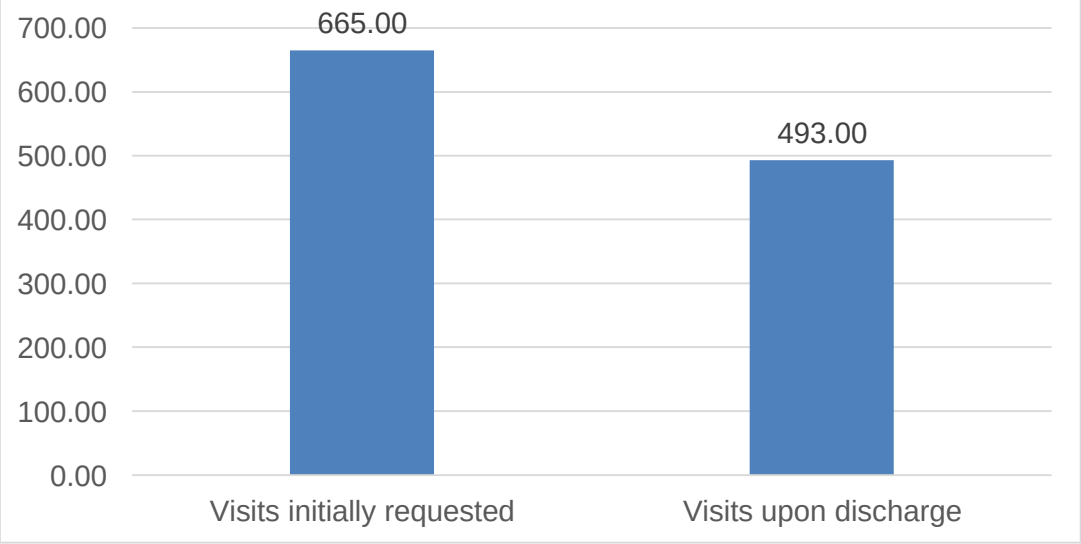


How long did service users have to wait to be discharged to the Care at Home service once goals had been achieved?



Ongoing Support required

Many service users saw a reduction in visit numbers between the start and end of their Home First service. The following chart contrasts the number of visits per week originally requested vs the number of visits received upon discharge from Home First. This represents a reduction of 5.5 visits per week per service user.



In addition to the reduction in the number of individual visits each week, there was also a reduction in the hours of support required following reablement

This represents a weekly reduction of 3.2 hours per week for each service user.

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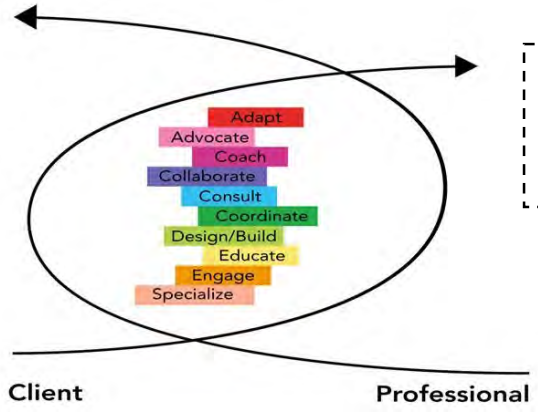
Appendix 2



Client and professional enablement model adopted throughout patient journey.

Hospital at home/community medical support available throughout

In-patient

In-reach option available from ICT/Home First

Intermediate community therapy team support required to offer **rapid response**, daily team rehab input and multidisiplinary approach

(*Staffing - OT/PT + 2 x RSW per shift)*

Green team support

Step up/step down approach between ICT and Home First during assessment stage.

Reablement support and assessment by Home First

(*Staffing - OT, SW, 2 x HF carer per shift*)

Single point of referral used to direct referrals to appropriate community therapy services.

Maintained in community with no or some support from community services (*i.e. Ageing well service, neurotherapy, community OT/PT, Age Scotland, Home care, direct payment, residential placement*)

Reablement OT able to assist with re-assessment/reviews of home care packages/respite/residential placements

Appendix 2

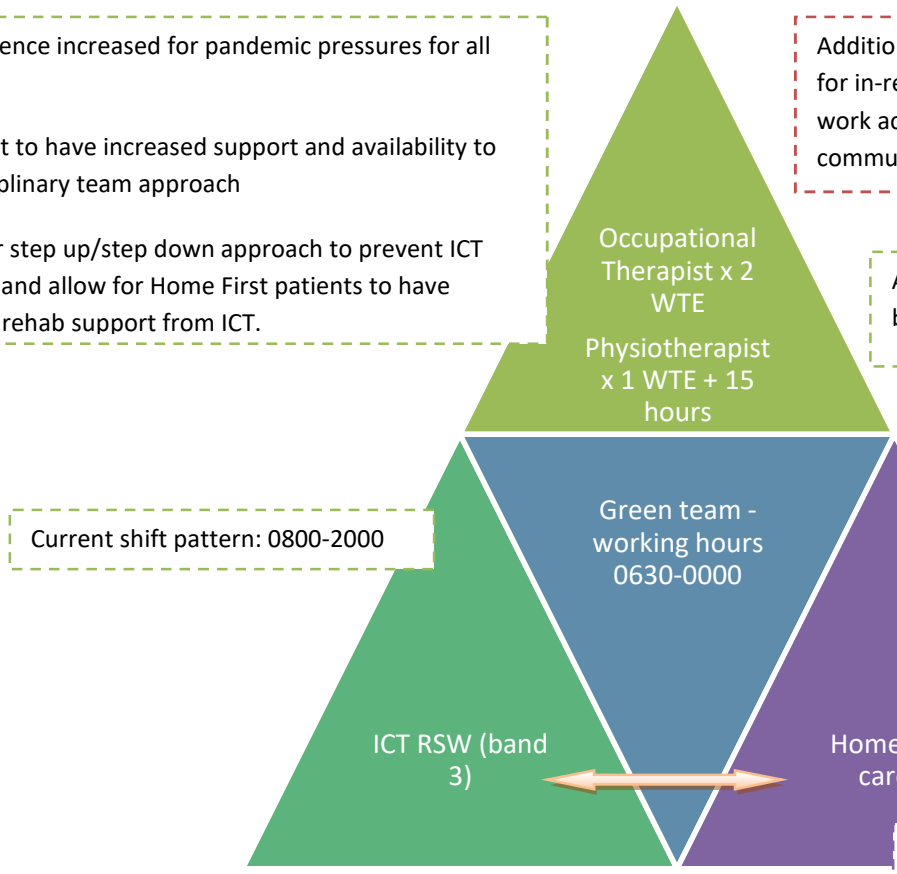
Joint working approach between ICT, Home First and Green team model

Staff resilience increased for pandemic pressures for all teams

Home First to have increased support and availability to multidisciplinary team approach

Option for step up/step down approach to prevent ICT 'blocking' and allow for Home First patients to have increased rehab support from ICT.

Additional therapist cover to increase capacity for in-reach, ICT and Home First cover - can work across both teams and assist with community pending list



AHP working hours – between 0800-1630

Current shift pattern: 0800-2000

Current shift pattern: 0830-1400, 1600-1800, 1930-2200

Home First team needs to be kept separate from home care to avoid staff being pulled to cover home care service and to ensure capacity to take on new service users.

Taking a Home First approach to Patient care within Orkney Health and Care

Evaluation flash report – February 16th 2021 – February 8th 2022

Summary: The Home First pilot has demonstrated through a reablement approach we are able to avoid hospital bed days and release social service capacity whilst improving patient's occupational performance within their own home.

Acute Service Outcomes

Hospital discharges

71 % **Reduction** in days delayed in hospital awaiting home care in 12 months

Bed days avoided

530

Estimated savings of

£499,970

Service Delivery

Inclusive - for **mainland** and **isles** patients.

Early intervention and in-reach

assessment available and patients are supported home from hospital by OT. On average patients are seen by Home First for **5 weeks.**

Simplistic criteria –

unlike other Home First models

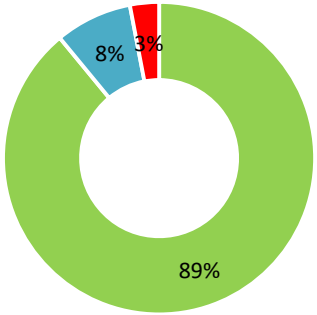
Patient Outcomes

59 People referred to Home First, 53 deemed appropriate. **85%** of people in **severely frail** category

"When I look back at how I felt in hospital, I thought I would never manage at home, but look at me now… I have achieved so much…"

"I think it is a good service. I feel more independent at home; I can do more myself since leaving hospital. Who would have thought I would be sitting here peeling my own tatties!"

Occupational Performance Outcomes

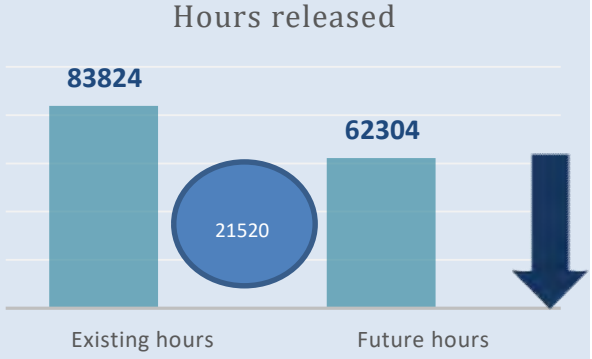


Community Service Outcomes

28 People were referred to home care following Home First assessment.

At point of referral to home care, the visit hours required had **reduced by** **27%**

Potential Service Capacity Released



44,430

visits released