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Agenda Item: 17

Integration Joint Board

Date of Meeting: 30 June 2021.

Subject: Progress of Home First Service Pilot.

1. Summary

1.1. This report seeks to update the Integration Joint Board (IJB) in relation to the development and progress of a discharge to assess model known as the Home First Service Pilot.

2. Purpose

2.1. To update the IJB and report on the findings of an initial three-month review of the Home First Service Pilot.

3. Recommendations

The Integration Joint Board is invited to note:

3.1. That, prior to implementation of the Home First Service Pilot, patients admitted to hospital were assessed and discharged with home care if support needs were identified.

3.2. That, due to capacity issues within health and the Care at Home service, this pathway was resulting in prolonged hospital stays waiting for assessment and packages of care to be in place.

3.3. That, for the purposes of the Home First pilot, it was agreed that the focus would be on individuals currently in hospital who required a new or an increased Care at Home package on mainland Orkney only. Referrals have been accepted across the whole of the mainland, which is a challenge for a small team.

3.4. That, unlike other Home First pilots running in Scotland, the pilot does not use specific eligibility criteria but accepts all individuals who would be deemed to need a Care at Home (Home Care) package. This decision was taken to avoid ‘cherry picking’ individuals to achieve a better pilot service performance outcome overall by accepting only those individuals where clear reablement potential is likely.

3.5. That the improvement in discharge arrangements for those accepted onto the Home First pilot means that individuals can be discharged directly home at the point of their expected date of discharge, assuming Home First has capacity. This avoids any delay whilst Care at Home services are identified.

3.6. The impact on the waiting list for those service users requiring a Care at Home package, in that the waiting list now captures those people in the community awaiting a care package or who require a package to support palliative needs.

It is recommended:

3.7. That approval be given to continue with the Home First Pilot service until 31 March 2022 enabling the pilot to operate for one year including one full winter.

3.8. That the remainder of funding received as Winter Planning funding be used to sustain the pilot.

3.9. That, following evaluation of the pilot, a further report is brought to the Board meeting to be held in April 2022, which will have more comprehensive outcome data and a recommendation based on the results of the pilot.

4. Background

4.1. The Home First initiative was identified as part of the 2020/21 winter bed planning and commenced on 16 February 2021.

4.2. On 9 December 2020, it was noted in the report to the IJB on the proposed new Kirkwall care facility, that the Home First Service was underway utilising winter planning funding. The winter planning funding ceased on 31 March 2021.

4.3. At a meeting on 22 March 2021 with NHS Orkney's Executive Management Team (EMT), it was identified that the Pilot Service required further scope to move more fully to a discharge to assess model and to provide more robust evaluation data over an extended 9 month period.

4.4. To extend the pilot, further funding was needed for 0.6 WTE = 21 hours of a Band 6 Occupational Therapist to add to an existing 0.4 WTE = 14 hours to create a full time 35 hour post. Whilst it was highlighted that Orkney Health and Care (OHAC) was currently seeking to identify this funding, if this could not be found, EMT was asked to consider enabling the project to continue. OHAC has subsequently identified funding utilising the Winter Planning Funding to sustain the pilot until 31 March 2022.

4.5. Prior to its implementation, patients admitted to hospital were assessed and discharged with Care at Home (Home Care) if support needs were identified. Due to capacity issues within health and the Care at Home Service, this pathway was resulting in prolonged hospital stays waiting for assessment and packages of care to be in place.

5. Home First Service

5.1. The Home First Service offers six weeks of reablement support to enable timely discharge from the hospital and the opportunity to assess patients in their own environment. Early evaluation results are encouraging with statistically significant improvement noted in functional outcomes and positive patient feedback.

5.2. No specific criteria to receive Home First (see section 3.3) is applied for the service accepting individuals who require a new or increased care package on the mainland of Orkney to enable discharge from hospital to go home. Where required, the Social Worker will complete the Outcome Focussed Single Shared Assessment to assess social needs and to determine that individuals meet the eligibility criteria of substantial or critical to access services.

5.3. Patients who have already received a period of assessment in the community and have had their care needs established would not be considered and would be referred directly to Care at Home.

5.4. Palliative patients may be referred to Care at Home, not Home First to ensure continuity of end of life care. If a patient is discharged home prior to Home First arrangements in place, they will no longer be eligible for Home First service.

5.5. The Home First Team comprises the following:

- Occupational Therapist G10 – full time 35 hours per week.
- Social Worker – part time 28 hours per week (split between Adult Social Work duties and Home First).
- Care at Home Hours – 141.25 split across 5 posts.
- Physiotherapy – as required.

5.6. Discharging people to the Home First service to support an assessment of their care and support needs in their own home can assist in reducing the strain on acute services as well as mitigate the recognised risk of deterioration to an individual's functional abilities caused by delayed discharge.

5.7. Research has also shown that prolonged unnecessary hospital admissions cause harm to patients resulting in deconditioning, harm from exposure to hospital acquired infections, falls, confusion and many patients never returning home compared with the health outcomes of patients improving quicker and more effectively if those individuals are assessed at home.

5.8. Evidence shows that 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.

5.9. The Home First model provides an evidenced based approach to maintaining 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.

6. Analysis

6.1. At the commencement of the Home First service there were four in-patients who were delayed discharges as a consequence of awaiting a Care at Home package. Their average discharge delay time was 19.5 days.

6.2. The lengthiest delay of this group was 31 days at a cost to the NHS of approximately £26,319 if patient stay calculated at £849.00 per night.

6.3. The evaluation of the service in early June 2021 has identified that Home First has supported 24 patient discharges with an average delay time in hospital awaiting a care package of 2.9 days. This demonstrates an 85% reduction in the waiting time for a care package overall realising a reduction of bed days equating to a financial cost of £59,090.

6.3.1. For nine weeks within the first three-month period there have been zero patients delayed as a consequence of awaiting a Care at Home package.

6.4. On average Home First currently supports two new patient hospital discharges per week with overall capacity to support between 7 and 9 people at any given time.

6.5. Overall there has been a 58% decrease in the request for required Care at Home hours. This is calculated from initial ward assessment requests until the point of discharge from Home First. This reduction creates valuable capacity within the Care at Home service.

6.5.1. Re-admission rates have been examined and out of the 24 hospital discharges there have been six Home First patient re-admissions e.g. Falls, medical deterioration.

6.5.2. The majority of patients who returned to hospital were re-admitted within 1-2 weeks of discharge from hospital. These same patients were discharged back into the community within an average of four days of re-admission. Further analysis of the data is being explored against national benchmarks.

6.6. Members will recall that, in relation to the discussions on the bed capacity for the proposed new Kirkwall care facility, new and expanded models of community services are required in order to reduce the pressure on the use of residential beds. The Home First Service pilot is demonstrating that such a model can facilitate both a timely discharge reducing pressure on acute beds as well as reducing the need and demand on the Care at Home service.

6.7. Over the first three months of the Home First pilot there is evidence of a reduction in the delayed discharges for people waiting for a Care at Home package which is encouraging.

6.8. Between 15 February and 17 May 2021 there were an average of 28 people awaiting a Care at Home package across Mainland Orkney with 35 people awaiting a package at the start and 29 people waiting by 17 May 2021. Home First referrals are not reflected in these figures as individuals transfer from Home First to Care at Home with any short delay being supported by Home First.

6.9. The numbers on the waiting list now reflect people waiting in the community and not those people who would otherwise have been delayed as a consequence of waiting for a Care at Home package to support their discharge from hospital.

6.10. The impact of the Home First Service on numbers of people waiting for a Care at Home package is difficult to quantify at this time. Whilst the number of people waiting for a package has reduced over the period of the pilot evaluation, whilst it may be likely, it is too soon to say if any reduction is as a consequence of any increased capacity realised overall by the Home First pilot.

6.11. Over the period of the pilot service further analysis of the overall waiting time data and any longer-term positive effects for the Care at Home Service can be considered.

6.12. Evaluation at the six-month period will provide more robust data on the Home First service pilot performance outcomes achieved, and additionally the impact of the Home First Service on Care at Home capacity and community referrals.

7. Contribution to quality

Please indicate which of the Orkney Community Plan 2019 to 2022 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.	No.
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.

8. Resource implications and identified source of funding

8.1. There is Adult Social Care Winter funding of £83,949 within the IJB reserves that has been unutilised to date which would fund the additional cost (staffing resource) required.

8.2. The additional costs in relation to this pilot relate to an additional 0.6 WTE (whole time equivalent) post of Occupational Therapist (G10). A full year's cost of this G10 post is £31,860 which can be accommodated within the funding identified.

9. Risk and Equality assessment

9.1. An Equality Impact Assessment is attached as Appendix 1 to this report.

10. Direction Required

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

NHS Orkney.	Yes.
Orkney Islands Council.	No.
Both NHS Orkney and Orkney Islands Council.	No.

11. Escalation Required

Please indicate if this report requires escalated to:

NHS Orkney.	No.
Orkney Islands Council.	No.
Both NHS Orkney and Orkney Islands Council.	No.

12. Authors

12.1. Stephen Brown (Chief Officer), Integration Joint Board.

12.2. Lynda Bradford, Head of Health and Community Care, Orkney Health and Care.

12.3. Su Dutton, Acting Service Manager, Health and Community Care, Orkney Health and Care.

13. Contact details

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14. Supporting documents

14.1. Appendix 1: Equality Impact Assessment.

14.2. Appendix 2: Draft Direction.

Equality Impact Assessment

The purpose of an Equality Impact Assessment (EqIA) is to improve the work of the Integration Joint Board (Orkney Health and Care) by making sure it promotes equality and does not discriminate. This assessment records the likely impact of any changes to a function, policy or plan by anticipating the consequences, and making sure that any negative impacts are eliminated or minimised and positive impacts are maximised.

1. Identification of Function, Policy or Plan	
Name of function / policy / plan to be assessed.	Home First Service Pilot.
Service / service area responsible.	Community Occupational Therapy / Care at Home / Adult Social Work.
Name of person carrying out the assessment and contact details.	Su Dutton.
Date of assessment.	8 June 2021.
Is the function / policy / plan new or existing? (Please indicate also if the service is to be deleted, reduced or changed significantly).	New service; however, using existing functions, as above.

2. Initial Screening	
What are the intended outcomes of the function / policy / plan?	To discharge people from an acute hospital bed to Home First, to assess needs.
State who is, or may be affected by this function / policy / plan, and how.	All people 18 + who are in an acute hospital setting, awaiting discharge, and who have reablement potential.
Is the function / policy / plan strategically important?	(Strategic plans include major investment plans, new strategic frameworks or plans such as annual budgets, commissioning services or corporate plans). Home First is included within the Strategic Commissioning Implementation Plan, taking account of community service development in relation to the New Kirkwall Care Facility, Winter Planning.

How have stakeholders been involved in the development of this function / policy / plan?	All key stakeholders in Orkney Health and Care / NHS Orkney / Orkney Islands Coucnil have been involved in the development of the service development and service function.
Is there any existing data and / or research relating to equalities issues in this policy area? Please summarise. E.g. consultations, national surveys, performance data, complaints, service user feedback, academic / consultants' reports, benchmarking (see equalities resources on OIC information portal).	Existing research and data have supported the need for the pilot development. Locally, performance monitoring and data capture are providing evidence of the service outcomes, and being benchmarked against national data for the initial three months of the pilot. Further analysis will take place at 6, 9 and 12 months.
Is there any existing evidence relating to socio-economic disadvantage and inequalities of outcome in this policy area? Please summarise. E.g. For people living in poverty or for people of low income. See The Fairer Scotland Duty Interim Guidance for Public Bodies for further information.	Please complete this section for proposals relating to strategic decisions). The Strategic Commissioning Implementation Plan identified this service development. It is recognised that the pilot service needs to address disadvantage to support individuals living in the Isles. It is acknowledged that as the service is predominantly supporting older people, there is a likelihood that socio-economic factors such as the impact on health and wellbeing, housing and low income, particularly income in older women, will need to be supported. The Home First service pilot is supported by Social Work support, so any socio-economic factors should be supported through the OFSSA process. A Financial Assessment is undertaken ensuring affordability of any ongoing service provided.
Could the function / policy have a differential impact on any of the following equality strands?	(Please provide any evidence – positive impacts / benefits, negative impacts and reasons). Positive impact is that people are enabled to return to their own home, and have the experience of participating in an evidenced-based assessment process.

1. Race: this includes ethnic or national groups, colour and nationality.	There is no negative impact for this group.
2. Sex: a man or a woman.	There is no negative impact for this group.
3. Sexual Orientation: whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	There is no negative impact for this group.
4. Gender Reassignment: the process of transitioning from one gender to another.	There is no negative impact for this group.
5. Pregnancy and maternity.	There is no negative impact for this group.
6. Age: people of different ages.	There is no negative impact for this group. A significant proportion of service users will be older people. Returning people to their own home, as soon as possible, is expected to provide significant wellbeing benefits.
7. Religion or beliefs or none (atheists).	There is no negative impact for this group.
8. Caring responsibilities.	There is no negative impact for this group Where a service user is a carer, a Carers Assessment and an OFSSA will identify the outcomes/needs, and any package of support would include support to the primary service user of the Home First Service, and support will be provided for the cared for person.
9. Care experienced.	There is no negative impact for this group.
10. Marriage and Civil Partnerships.	There is no negative impact for this group.
11. Disability: people with disabilities (whether registered or not).	There is no negative impact for this group.
12. Socio-economic disadvantage.	There is no negative impact for this group. If there are socio-economic needs an OFSSA would be completed and a care plan devised identifying support needs to achieve outcomes. It is the primary intention that everyone returns to their home, unless housing is inappropriate or the assessment concludes the person is physically unable to manage.
13. Isles-Proofing	The pilot is currently focussed on Mainland Orkney. Solutions are being sought to enable Isles residents to access this service should approval be given to mainstream this service. The likelihood is that e.g. Red Cross House will be utilised with the Home

	First service providing the required support, pending discharge home to the isles with the appropriate level of support being put into place as needed.

3. Impact Assessment	
Does the analysis above identify any differential impacts which need to be addressed?	No.
How could you minimise or remove any potential negative impacts?	Yes, See 13.
Do you have enough information to make a judgement? If no, what information do you require?	Yes.

4. Conclusions and Planned Action	
Is further work required?	No.
What action is to be taken?	
Who will undertake it?	
When will it be done?	
How will it be monitored? (e.g. through service plans).	Service Performance Reviews, IJB Updates.

Signature: [redacted]

Name: Su Dutton Date: 8.6.21

Integration Joint Board Direction.

Reference	2021.02 – Home First Approach.
Date direction issued	30.06.21.
Date direction in effect from	Date to be determined by Integration Joint Board.
Direction issued to	NHS Orkney.
Does this direction supersede, amend or cancel a previous direction – If yes, include reference number(s)	No.
Service area covered by direction	Health and Community Care – Adult Social Work; Care at Home and Occupational Therapy.
Detail of Direction	That, the Home First Pilot service be extended to be in operation for one year including one full winter, until 31 March 2022. That, the remainder of funding received as Winter Planning funding be used to sustain the pilot. That a further report is brought back once following evaluation of the pilot to the April 2022 IJB meeting as this will have more comprehensive outcome data and a recommendation based on the results of the pilot.
Budget allocated for this direction	There is Adult Social Care Winter funding of £83,949 within the IJB reserves that have been unutilised to date which would fund the additional staffing resource required.

	The additional costs in relation to this pilot is the cost of an additional 0.6 WTE G10 Occupational Therapist. A full years cost of this G10 post will be £31,860 which can be accommodated within the funding identified.
Outcome(s) to be achieved, including link to Strategic Plan	Prior to its implementation, patients admitted to hospital were assessed and discharged with Care at Home (Home Care) if support needs were identified. Due to capacity issues within health and the Care at Home Service, this pathway was resulting in prolonged hospital stays waiting for assessment and packages of care to be in place. The evaluation of the service in early June 2021 has identified that Home First has supported 24 patient discharges with an average delay time in hospital awaiting a care package of 2.9 days. This demonstrates an 85% reduction in the waiting time for a care package overall realising a reduction of bed days equating to a financial cost of £59,090. Overall, there has been a 58% decrease in the request for required Care at Home hours. This is calculated from initial ward assessment requests until the point of discharge from Home First. This reduction creates valuable capacity within the Care at Home service. Re-admission rates have been examined and out of the 24 hospital discharges there have been six Home First patient re-admissions e.g. Falls, medical deterioration. The majority of patients who returned to hospital were re-admitted within 1-2 weeks of discharge from hospital. These same patients were discharged back into the community within an average of four days of re-admission. Further analysis of the data is being explored against national benchmarks. The Home First Approach pilot falls under the Strategic Priority: Promoting Self-Management within the Strategic Plan 2019-22.
How will this be measured	A further evaluation will be presented to the IJB in April 2022.
Date of direction review	Annual, unless required otherwise.