REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD
3rd February 2020

Operation Homefirst (Aberdeenshire) Update

1 Recommendation

It is recommended that the Integration Joint Board (IJB):

1.1 Consider the update on developments within Operation Homefirst, specifically the development of the Aberdeenshire component of the Frailty Pathway and identified performance measures; and

1.2 Agree to receive a performance report on Operation Homefirst (Aberdeenshire) in 6 months.

2 Directions

2.1 No direction requires to be issued to Aberdeenshire Council or NHS Grampian as a result of this report.

3 Risk

3.1 IJB Risk 8 – Risk of failure to deliver standards of care expected by the people of Aberdeenshire in the right place at the right time. We will work closely cross-system to improve care for the people of Aberdeenshire and support the development of services closer to home by working collaboratively with secondary care colleagues in shifting the balance of care.

3.2 IJB Risk 9 – Service and business transformation. We will deliver transformational change in how services are planned, managed, and delivered to ensure our model of care is fit for the future.

3.3 IJB Risk 6 – Working effectively with Partner organisations. Constructive joint working is needed to achieve significant change across all sectors, working towards the same objective.

4 Background

4.1 In July 2020 the Integration Joint Board received an initial report outlining the aims of Operation Home First and the intended ongoing developments. Operation Home First is an integrated approach taken by all 3 local Health and Social Care Partnerships (Aberdeenshire, Aberdeen City, and Moray) and NHS Grampian in response to areas of change and improvement brought about by the first phase of the COVID-19 pandemic. It is overseen by the Chief Officer's steering group.

4.2 The aims of Operation Homefirst (as they apply to the Grampian area) are as follows:

- To maintain people safely at home ("home" being where a person normally lives or would choose to live and may include a care home).
- To avoid unnecessary hospital attendance or admission.
- To support early discharge back home after essential specialist care.

4.3 The Principles of Operation Home First are the mechanisms by which we can achieve the Aims by working collaboratively. These are as follows:

- We will adopt a principle of 'home first' for all care.
- We will have a greater focus on better, evidence based, outcomes for our patients.
- We will remain flexible and agile so that, should there be a surge in demand we are ready to respond.
- We will maximise digital solutions wherever we can.
- We will look at the whole person, their circumstances and supports when deciding on whether admission to hospital is required.
- We will deliver on the strategic aims of the three Integration Joint Boards (IJBs) and the NHS Grampian Board.
- We will work within the constraints of physical distancing and the needs of our 'shielded' population.

4.4 Over the course of the pandemic, Health and Social Care Teams across Aberdeenshire have been working steadfastly to further embed the aims and principles of Operation Homefirst into their everyday practice, with a specific focus on keeping people in their home environment, avoiding unnecessary admissions, and minimising delayed discharges. This is in line with national messaging on staying at home and minimising the risk of contracting COVID-19.

4.5 A development of note has been a significant increase in the use of and access to 'near me' digital consulting software across all services. This has been an integral resource to ensure clinicians and Health and Social Care practitioners can have direct contact with those they support within their home environment (be that in a community or Care Home setting) as well as enabling patients within our Community Hospitals to link in with clinicians in other settings to coordinate their effective treatment. Whilst there continues to be room to expand further considerable progress has been made.

5 Operation Homefirst approach to 2nd Wave of COVID-19 pandemic

5.1 It is important to recognise that we continue to experience significant challenges as a result of the COVID-19 pandemic across health and social care which impacts on our capacity across the community.

5.2 Operation Homefirst principles are essential to managing these pressures particularly when we are experiencing further local outbreaks of COVID-19 leading to temporary ward closures and the resulting further reduction in bed-base availability.

5.3 Section 6 outlines key progress in developing our Frailty Pathway for Aberdeenshire. This development has also been impacted by COVID-19 pressures with additional demands placed on senior management and the wider workforce impacting on their capacity to focus on development work.

6 Aberdeenshire Frailty Pathway and Hospital at Home development

6.1 Overview

6.1.1 A key focus of the Grampian Operation Homefirst group has been the redesign of the Frailty Pathway for Older Adults from Aberdeen Royal Infirmary (ARI) which is a service hosted by Aberdeen City HSCP. A reduction in Care of the Elderly beds to 25 provided a need for, and an opportunity for, and the 3 partnerships were asked to consider alternative provision for these patients, allowing the development of community-based provision. An agreement was in place that proportional resource (either staffing or financial) would follow any redesigned service delivery.

Who would be admitted to the Frailty Pathway?

Older people (usually over 75) presenting with a typical frailty syndrome including;

- Falls
- Confusion
- Rapid functional decline
- Advanced Frailty.

6.1.2 An Aberdeenshire Frailty Pathway Delivery Group was established to consider this redesign. A number of workshops and targeted focus groups took place with key stakeholders within health and social Care to consider what model would work best within an Aberdeenshire context. Consideration was made of whether our existing Community Hospital resource would be able to absorb the additional patients which would need to be cared for by alternative means. This has not been deemed feasible due to existing pressures on our community resources. It was also deemed preferable to look at a home-based model in line with our aspirational approach to Operation Homefirst.

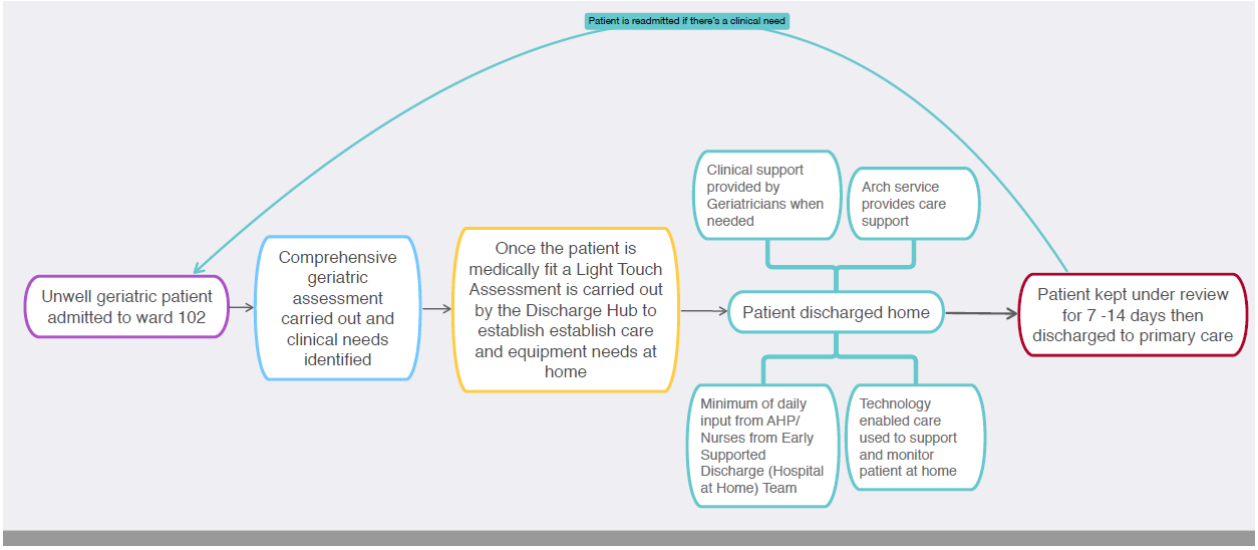
6.1.3 As outlined in the July 2020 report Aberdeenshire HSCP aspire to develop a Hospital at Home model.1 This internationally recognised model delivers a range of ordinarily hospital-based interventions, including diagnostics, within people's own homes with additional support provided leading admission avoidance and improved outcomes for patients. Aberdeen City HSCP had already established a model prior to the COVID-19 pandemic which has been well received by patients in Aberdeen.

6.1.4 Significant resource and ongoing evaluation is required to develop a full Hospital at Home service. An interim model is therefore being progressed by the Aberdeenshire the Frailty Pathway Group with a focus on Early supported discharge. This will create capacity within the system whilst also allowing for ongoing learning and evaluation to determine what a full Hospital at Home service could look like for Aberdeenshire. This new pathway is called the 'Early Supported Discharge (Hospital at Home) Pathway.

6.1.5 The Pathway will be made up of a number of key provisions;

- Increased Aberdeenshire Allied Health professional (AHP) and Care Management presence within the Discharge Hub in ARI to facilitate speedy flow from acute.
- Increased capacity within the Aberdeenshire Responders for Care at Home (ARCH) service to provide care to those on the pathway at home.
- Teams of Nursing and AHP staff based in Aberdeenshire (overseen by Geriatricians within ARI under hosting arrangements with Aberdeen City HSCP).

6.1.6 The following diagram indicates what this pathway would look like for the patient;



6.1.7 In addition to the above it has been agreed that Aberdeenshire patients can access the newly established Aberdeen City HSCP Frailty beds within Rosewell House during winter 20/21 to increase capacity for patients during the development of the Aberdeenshire model.

6.1.8 Resource for the new pathway will be transferred from the existing pathway to follow the development of the new model.

6.1.9 The remote and rural geography of Aberdeenshire poses specific challenges in delivery of a community-based model. In the model under development the new AHP /Nursing Teams will be based within Central and

North Aberdeenshire with enhanced provision in Deeside and the most southernly area of Kincardine and Mearns. This should allow capability to reach most areas within 30 minutes. Whilst patients are on the Pathway the Teams will provide frequent at home support and assessment based on the individual needs of the patient. Additionally, the ARCH service has a much wider scope and will be essential in responding to the care needs of those on the pathway timeously.

6.1.10 In order to ensure a safe and supportive return home we will also invest further in technology enabled care with the ability to monitor the activities of daily life of those on the pathway. This can alert the teams to additional support needs and provide assurance to patients and families that these needs are manageable within a home environment.

6.2 Healthcare Improvement Scotland (HIS) / Scottish Government – Hospital at Home Funding

6.2.1 In December 2020 we were pleased to have been awarded £175000 of Scottish Government funding towards the development of our Hospital at Home Pathway for Aberdeenshire. We will also have access to support from an Associate Improvement Advisor within HIS which will be of great benefit to the AHSCP.

6.2.2 The funding is time limited for 2021/22 and could not be used to pay for ongoing staff. The bid therefore includes;

- Technology Enabled Care 'Just Checking system' (as described in point 6.1.9).
- Equipment for new Nursing and AHP Staff to work remotely and flexibly within Aberdeenshire.
- iPad for use with patients to link into support from Secondary Care.
- A one-year project support role at NHS Band 5 to support, monitor and evaluate the service model.
- Funding for training to upskill workforce to take on leadership roles within the team.

7 Performance Monitoring

7.1 At an NHS Grampian level, performance metrics are in the process of development to support monitoring and evaluation of the Operation HomeFirst initiative on a Grampian-wide basis.

7.2 Specific to Aberdeenshire, the Frailty Pathway work as described above also continues to be in the development phase therefore we are not able to report on performance at this time. The Aberdeenshire Frailty Pathway Group has however developed a number of performance measures which we will use to monitor the implementation of the new pathway.

7.3 In line with the new approach to performance reporting agreed by the IJB, a benefits mapping workshop was undertaken with members of the

Aberdeenshire Frailty Pathway Group through which the following methodology was followed to develop its performance reporting framework:

1 Agreeing the priority aims of the frailty pathway and identifying the outcomes (benefits) that would deliver this.
2 Identifying what action could be taken to deliver those outcomes (the drivers of improvement).
3 Identifying the performance indicators that will assure us of the impact of the frailty pathway and that improvement is taking place.

From this process, the key performance measures identified and the associated rationale for reporting such measures are summarised in Appendix 1.

This approach aims to provide the balance of quantitative and qualitative data required to ensure we can test and measure the expected impacts on the system from the frailty pathway whilst also furthering our understanding of the actual impact on outcomes for patients following the new pathway. This is an initial suite of performance measures which may be subject to further development as project implementation proceeds. Targets for improvement will be considered once indicators have been assured to provide reliable and valid information.

8 Summary

8.1 Operation Homefirst continues to develop at pace in Aberdeenshire and pan-Grampian with our partners in Aberdeen City HSCP, Moray HSCP and NHS Grampian.

8.2 Whilst we continue to experience the challenges of the COVID-19 pandemic it has still been possible to continue with important developments within the Frailty pathway and looking towards a Hospital at Home model. This will continue to be guided by the overall aims and strategic direction of Operation Homefirst.

8.3 The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officers within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

9 Equalities, Staffing and Financial Implications

9.1 An equality impact assessment has not been completed because this has already been undertaken for development and approval of the Strategic Plan, which is in alignment with the proposals as set out in this paper. A specific EIA for the Aberdeenshire Frailty Pathway model is being drafted as part of the development of the new model.

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Report prepared by Amy Richert, Strategic Development Officer, 11/01/2021

[1]Healthcare Improvement Scotland, 'Hospital at Home; Guiding Principles for Service Development' January 2020 https://ihub.scot/media/6928/2020205-hospital-at-home-guiding-principles.pdf

Appendix 1

Aberdeenshire HSCP Operation Home First – Frailty Pathway
Proposed performance monitoring framework

	Measure	Rationale
Qualitative	Patient satisfaction survey	Post-intervention survey to capture patient perspective and experience (subject to consent) and ensure we have an understanding of service user outcomes in addition to process and input/output measures. Potential to include unpaid carers.
	Staff satisfaction survey	Systematic survey to capture staff perspective and experience. Research indicates close link between staff experience and patient satisfaction. Feedback and learning can also be used to drive further improvement within the frailty pathway model.
Quantitative	Readmission rates at 7 days	To monitor re-admission rates (where reason for admission is the same as original admission) providing an indicative measure of effectiveness of the discharge home/frailty pathway (proxy measure for 'doing less harm').
	Patient location at 90 days	To measure the number of patients who remain at home 90 days following discharge (standard outcome measure in Geriatric services and for people using reablement services).
	Medically fit date of discharge versus actual date of discharge	Clinical tool through which the whole multi-disciplinary team (MDT) is aligned to achieving specific objectives for every patient – improved patient flow and enhanced community resource/ response should reduce constraints or waits and thereby reduce or eradicate length of time between these two dates.
	Mortality rates	To be confirmed – potential for comparative mortality rate study between patients in hospital and patients in Hospital at Home/Frailty pathway but recognising different levels of acuity.

	IoRN (Indicator of Relative Need)	An existing standard tool (questionnaire) utilised by rehab and enablement staff in Aberdeenshire HSCP to assess a person's functional needs and/or their degree of dependence/independence, and which can be used to evidence the outcome of interventions.

Appendix 2 – Reference

[1]Healthcare Improvement Scotland, 'Hospital at Home; Guiding Principles for Service Development' January 2020 https://ihub.scot/media/6928/2020205-hospital-at-home-guiding-principles.pdf