Health & Social Care Moray

Delivering Home First for Moray

Working together to stay well at home

Staff update 8 – 30.10.20

Hospital at Home – how to start a service

Moray colleagues joined the Scottish Hospital at Home (H@H) virtual learning event hosted by Healthcare Improvement Scotland (HiS) last week for the opportunity to learn from services up and running across Scotland, reflect on success and challenges, and to collectively consider future steps.

H@H has the potential to be a key plank in Moray's Home First approach to effective integrated system-wide health and community care services which meet the local population needs. It is one of a range of intermediate care services that can provide alternatives to an acute admission and support timely discharge home.

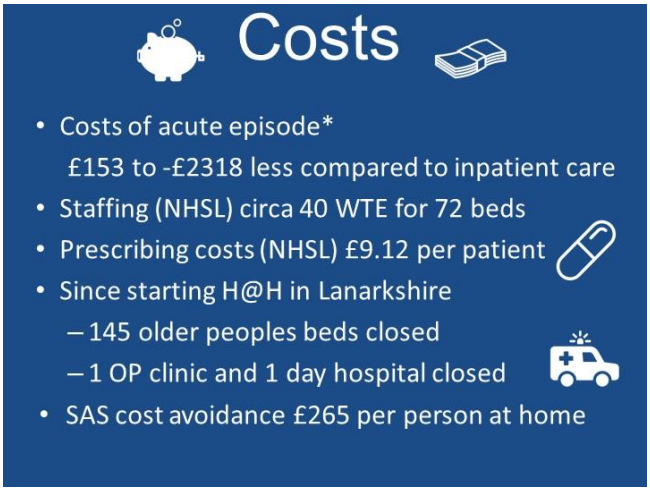
The national learning event heard from Professor Graham Ellis, National Clinical Advisor at NHS Scotland, and Claire Ritchie, Site Director, Ayr Hospital. They talked through how H@H was set up in Lanarkshire as an acute, hospital-level care service delivered by healthcare professionals for conditions that would otherwise require acute hospital inpatient care.

It receives 3,000 referrals a year and 80% are managed entirely at home. (Some patients are appropriate for admission to hospital). Average length of stay is approximately 4-6 days. Through work with the Scottish Ambulance Service they are now able to take referrals directly and average 2 referrals per week to the service.

The Lanarkshire team reinforced that Hospital at Home is not about doing the work of GPs rather the management of acute unwell older people delivered by the right professionals all working as if the bed in the home was part of a ward.

The key people elements include:

- Trans-disciplinary working
- Clinical decision making and risk taking
- Team working dynamics and leadership
- Clinical skills and competency framework and career progression
- Specialist supervision
- Governance
- Recruitment and retention



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The Fife experience of supporting very early discharge and preventing admission to acute was outlined by Dr Angie Wilkinson, Consultant Geriatrician, and Anne McAlpine, Clinical Service Manager.

Funding was identified from the Reshaping Care for Older People Change Fund to supporting the developing model where strategic and operation groups combined and were supported by senior managers and clinicians from the outset.

Since implementation in 2012 the staffing complement has flexed and changed. It is now: Consultant Geriatrician; Clinical Fellows; Advanced Nurse Practitioners; Nurse Practitioners; Staff Nurses; Healthcare Support Workers; Pharmacy; Admin support; with rapid access to AHPs.

Current service parameters to which the three H@H teams work are:

- Age > All adults, but must be frail
- GP must see the patient
- Refer to Single Point of Access
- Step down from Acute 7 days
- Tested out evening and weekend admissions during Covid for all admissions
- Access 9 am – 5 pm, Mon – Fri for GP admissions
- 7 days / week service delivery

Fife has estimated that if H@H were not there, an additional two acute wards would be needed.

The 12 November HiS Hospital at Home virtual learning event is on Leadership – engaging and building will.

Moray programme updates

The Discharge 2 Assess six month test of change got underway at the start of October and following an initial awareness raising phase, has worked with eight patients – two have been discharged and the team continues to work with the other six, while a further four potential patients have been identified in Dr Gray's.

Staff are very engaged and the test continues to evolve as issues are addressed and performance data gathered. Colleagues in Aberdeenshire have already expressed interest in learning from Moray's experiences.

The discharge hub at Dr Gray's is fully operational with social workers having been able to return to the hub room. An increase in resource has been agreed and short-term secondment opportunities are being advertised internally to NHS and Local Authority staff (see the advert at the end of this newsletter).

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The delayed discharge focus group continues to implement the action plan which has highlighted priority areas for redesign.

Consultant Dr Graham Hoyle has begun a six month secondment as part of the Dr Gray's continuity plan and will support the care of the elderly workstream. The recruitment of consultants at DGH continues to be a major challenge.

Two cohorts of patients – from Forres and Buckie – with COPD have been recruited for a prevention and self-management test of change promoting peer, community and digital support. Future projects following the plan-do-study-act cycle are expected to be applied to falls and diabetes.

The ambulatory care workstream is working with the haematology service at ARI to reduce appointment waiting times and journey times for Moray venesection patients.

The palliative workstream recognises the significant potential of partnership working and is collaborating with Third Sector partners including CLAN Cancer Support.

A scoping exercise is ongoing as part of the remobilisation of the Oaks to assess services delivered from the building prior to COVID and to identify how/if/when services will resume. OT and physio clinics resume next week.

The children and families workstream will be broadening its work to engage further with secondary care colleagues and consider Home First approaches to support children with chronic and enduring conditions and gypsy/ traveller children and their families.

GPs have been brought up to speed with the mobilising of mental health services and new ways of working, in particular new referral criteria, being taken forward by the mental health workstream, including the Third Sector support people with lower level needs can already assess in their communities.

Secondment opportunities