HEALTH AND SOCIAL CARE SCOTLAND

Embedded and emerging good practice in health and social care

Aligned to the *Framework for Community Health and Social Care Integrated Services*

Health and Social Care Partnership: Orkney				
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Name of good practice: Home First Approach				
Select (x) all areas that apply to your good practice (select more than one if applicable)				
CLIENT GROUP	Children and young people		Older adults	x
	Younger adults	x		
SETTING	City		Remote & rural (incl islands)	x
	Corporate		Urban	
SERVICE AREA	Addictions		Management team	
	Admission avoidance		Mental health	
	Community care services incl care at home/care homes	x	Physical disabilities	
	Day services		Physical health	
	Housing incl Homelessness		Primary care	
	Intermediate Care incl Hospital at Home	x	Rehabilitation	
	Justice services		Social care services	x
	Learning disabilities		Supported discharge	x
	Other – please specify			
ELEMENTS of FRAMEWORK	Anticipatory care planning		Live independently at home or in a homely setting	x
	Assets based approach		Manage own care	
	Connect with communities		Reablement	x
	First point of contact		Seamless working with acute	
	Enhanced care in care homes / supported accom		Short term targeted interv to meet more complex needs	
	Fully integrated community teams	x	Teams aligned with general practice	
	Other – please specify			
ENABLERS	Agile working		Information sharing	x
	Aligned plans		Infrastructure	
	Clarity of vision		Management information	
	Clinical and care governance		Shared accountability	x
	Collaborative leadership	x	Strong team ethos	x
	Culture and values	x	Technology	x
	Fit for purpose premises		Well-developed lead professional roles	
	Improvement capacity		Well-developed relationships	x
	Other – please specify			

Orkney HSCP

Home First approach

SITUATION	Prior to implementation of the Home First Service pilot, patients admitted to hospital were assessed and discharged with home care; packages were determined by the hospital staff who assessed on needs displayed whilst in ward. 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.
ACTIONS TAKEN	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. 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 at the point of discharge. 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. 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. No specific criteria to receive home first 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. 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. 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. The Home First Team comprises the following: • Occupational therapist, full time, 35 hours per week • Social worker, 28 hours per week (split between adult social work duties and Home First) • Care at home, 141.25 hours split across 5 posts • Physiotherapy (as required) • Pharmacy (as required)

OUTCOME / IMPACT	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. 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 people improving quicker and more effectively if those individuals are assessed at home. 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. 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. 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. 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.
MEASURES/ INDICATORS OF SUCCESS	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. 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. On average Home First currently supports two new patient hospital discharges per week, with overall capacity to support between 7–9 people at any given time. 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 people who returned to hospital were re-admitted within 1-2 weeks of discharge from hospital. These same people 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. 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. 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, it is

	too soon to say if any reduction is as a consequence of any increased capacity realised overall by the home first pilot. 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. 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.

Even better if …
(enablers to further the principles of integration and result in even better outcomes if …)

There continue to be ongoing challenges related to information systems. The Home First Service, like many other new integrated ways of working, could be even more effective if there was an integrated system for recording. At present, we continue to seek work-arounds for ensuring access to information for all the professionals involved in an individual's care.

NATIONAL HEALTH AND WELLBEING OUTCOMES	
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	x
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	x
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	x
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	x
5. Health and social care services contribute to reducing health inequalities.	
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	
7. People who use health and social care services are safe from harm.	x
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	x
9. Resources are used effectively and efficiently in the provision of health and social care services.	x
Health and Social Care Scotland's 5 Essential Elements (click link to listen to statement of intent)	
1. Transforming the approach to improving health, wellbeing and independence	x
2. Building stronger community care systems and primary care services	
3. Establishing a new focus on mental health	
4. Securing a sustainable acute hospital service and specialist care service	
5. Strengthening future partnerships to ensure a modern sustainable workforce	x

Links to any published reviews/evaluations	

Before submitting this example of good practice please ensure approval and sign-off by your head of service / chief officer.

Approved for online publication *(signature and position)*	Stephen Brown, Chief Officer

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