OPERATION HOME FIRST

Evaluation Progress Report

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Executive Summary

This report provides an update on the evaluation of Operation Home First . Operation Home First is the collective priorities of the three North-East Health & Social Care Partnerships in collaboration with the Acute sector of NHS Grampian. The information contained within relates to those Operation Home First projects and programmes that have relevance to Aberdeen City. The information contained within is predominantly for the purposes of providing assurances that a robust process has been implemented to evidence the impact of these priorities.

In general, positive progress is reported on most of the priorities. This includes: 1) an approximate 40-fold increase in the average number of NearMe consultations per week in the last 12 months; 2) the opening of 30 NHS beds in Rosewell as an interim care facility; 3) the implementation of a new Care @ Home contract, moving away from a time and task model to an outcomes-based approach. Of priorities that have been operational for an adequate period, evidence of acceptability to both service users and service providers is a critical first step towards ensuring that these initiatives are feasible to implement and subsequently, may deliver positive outcomes.

The full impact of the Operation Home First portfolio cannot yet be fully quantified. This is for several reasons, for example: 1) several initiatives have only been operational for a limited period (such as the interim service model in Rosewell going live on 18.01.21), meaning more time must be given in these circumstances to generate enough data to robustly determine their function and 2) other priorities have moved at a slower pace given the recent Civil Contingency status that Grampian has been placed under since January 2021 (such as the sign-off and implementation of recommendations made in the Grampian-wide Strategic Framework for Palliative and End of Life Care). However, with reference to Operation Home First priorities with a more acute focus, strong causation can be drawn of their direct impact against the aims of Operation Home First. For example, every admission to Hospital @ Home that is identified as an ‘alternative to admission’ means that the person is not admitted unnecessarily to Aberdeen Royal Infirmary wards, but instead is supported safely at home. Furthermore, this helps to lessen pressures that can otherwise lead to patients being “boarded” in Aberdeen Royal Infirmary beds out with the specialty whose care they are under.

A further report will be published towards the end of Spring 2021, with greater detail on the collective impact of the Operation Home First portfolio. This time allows for additional data to be collected and further analysis to be conducted. This, in turn, will ensure more meaningful conclusions and future recommendations can be derived.

Introduction

Operation Home First is the collective priorities of the three North-East Health & Social Care Partnerships in collaboration with the Acute sector of NHS Grampian. It is a portfolio that has emerged through positive, cross-system working during the COVID19 pandemic and emphasises the importance of shifting the balance of care, when safe and appropriate to do so, from acute settings to community settings. There are three aims to Operation Home First:

1) To maintain people safely at home
2) To avoid unnecessary hospital attendance or admission
3) To support early discharge back home after essential specialist care

More background information about Operation Home First, including its underlying principles, can be viewed here.

In October 2020, The Operation Home First Steering Group commissioned an evaluation working group to evidence the impact of the Operation Home First portfolio. The remit of the working group was two-fold:

1) Understand the impact of each Operation Home First priority, and how they contribute towards achieving the aims of Operation Home First
2) Develop a high-level, performance dashboard of meaningful metrics to monitor overtime to understand the performance of the portfolio.

This report outlines the progress made against the above as of February 2021. In particular, it is designed to provide assurances that a robust process has been designed and implemented to evidence the impact of this portfolio. Of interest to Aberdeen City, the following Operation Home First priorities are considered in scope:

- Care @ Home Contract Implementation
- Stepped Care Approach
- Frailty Pathway
- Redesign of Urgent Care
- Respiratory Pathway
- Palliative Care
- Implementation of Near Me

A further report will be published towards the end of Spring 2021, with greater detail on the collective impact of the Operation Home First portfolio. This additional time allows for additional data to be collected and further analysis to be conducted. This, in turn, will ensure more meaningful conclusions and future recommendations can be derived.

Methods

Evaluation process

To develop a meaningful, performance dashboard of high-level metrics that may be positively influenced should a complex portfolio of this nature be implemented as theoretically planned, an understanding must first be sought of each individual priority. The figure below describes, at a strategic level, the approach that the evaluation working group took across priority areas. These are elaborated upon below:

OHF PERFORMANCE DASHBOARD DEVELOPMENT FLOW

Stage	Questions
Understand Priority	• *Is it a project, or a programme? (i.e. a group of projects)* • *Which of the OHF aims does it align to?*
Ascertain Feasibility	• *Is it practical to implement this priority? (or it will never achieve the aspired outcomes)* • *Typically assessed through acceptability to those 1) receiving the service and 2) those delivering the service)*
Defining Outcomes	• *What will be the benefits of this priority?* • *Typically we thinking about 1) service users / unpaid carers ; 2) staff and 3) resources*
Understand capability	• *How big a contribution will the priority have to the OHF aims?* *E.g. number of patients who access the service*
Select Performance Metrics	• *What measures should we track over time to make sure this priority remains established?* • *What assumptions do we use when selecting these metrics?*

Understanding the Priorities individually – Some of the Operation Home First priorities are individual projects (such as Implementation of Near Me). Others are programmes (i.e., a group of projects, such as the Stepped Care Approach). In the latter scenario, the full impact of the programme cannot be understood until individual projects are understood. During this stage, priorities were mapped against the Operation Home First aims, which helps inform the data collection process.

Ascertaining feasibility – Service changes / developments cannot realise benefits if they are not practical to implement. As such, a critical component to new initiatives is determining whether they are acceptable to those delivering the service (i.e., staff) and to those receiving the service (i.e., service users and unpaid carers).

Defining outcomes - If initiatives pass the feasibility test, consideration can be given as to what benefits these will have. These benefits can usually be categorised by 1) benefits to service users / unpaid carers; 2) benefits to staff; 3) benefits to resources / services.

Understanding capability – This helps answer the question as to the impact individual priorities have against the aims of Operation Home First. For example, a small-scale test of change will not have a substantial impact on reducing hospital attendances but is helpful to prove a new concept or to determine how it may make a positive contribution should it be scaled up.

Selecting performance metrics - The goal here is to distil each priority down to a minimal number of measures that can provide an indicative overview as to how that priority is functioning. Key to this is developing assumptions that provide a rationale as to why that metric was selected.

<u>Pragmatic considerations</u>

Evaluation of a portfolio of this scale is a complex undertaking. There are multiple reasons for this, including but not limited to:

- *Degree of implementation*: The priorities within the Operation Home First portfolio did not all begin at the same time, with the same capacity and resources to deliver them. As such, by October 2020 (and at the time of writing) priorities were ranging from being delivered at scale to still being in a planning phase. In some cases, therefore, data collection is required to be retrospective, in others it can be planned before initiatives commence.
- *Pace of implementation*: Some initiatives have stricter deadlines than others, for example due to time-limited funding. Given this and other extraneous factors, such as Grampian being placed within Civil Contingencies level 4 in January 2021, this means some priorities were accelerated with their implementation, whilst others have moved at a slower speed.
- *Downstream vs Upstream Activity* – Given the pressures that COVID19 has had on secondary care provision, evaluation activity has been prioritised on those initiatives that are closer to this part of the system.

Priority Updates

The following section provides an update of each of the priorities linked to service provision in Aberdeen City. These are in the form of one-page flash reports that are designed to provide an overview of progress to date. Where possible, links are also provided to relevant metrics that will be integrated into the Operation Home First performance dashboard that will be used to monitor priorities over time.

Operation Home First Priority
Stepped Care Approach

Priority Workstream (if applicable)
Stay Well Stay Connected

RAG Status

Operation Home First Aims this aligns to
Keep people safe at home

Brief description of priority
The Stay Well Stay Connected workstream is the bottom level of the Stepped Care Approach. The core aim is improving self-management and reablement within the community.

Update as of February 2021
A review of the workstream is being undertaken to understand progress to date and highlight areas of focus moving forward. Three working groups have been developed, each with a different focus: 1) *Respite* [overnight and/or residential]; 2) *Buildings Based Day Activities* [to be established]; 3) *Prevention* [restructuring to align to strategic aims]

Impact to date
Community / Staff Engagement: 93 people responded to the 'Fit Like' Survey, that aimed to understand and identify key issues to address to improve health and wellbeing in communities. For this, eight problem statements were identified, for example: 1) 40% of respondents did not have a device or internet and 2) over 50% of responders report they don't or would like to get out and about and described having low mood.

The result of this has been the implementation of a variety of initiatives across communities. For example: 1) *"Wellbeing Matters Webpage":* that provides a number of helpful resources on keeping and staying well (and received more than 1100 visits in the last 12 months); 2) *Physical Activity packs for people at home*: collaboration with physiotherapy students including exercise instructions, walking routes and information on government guidelines; 3) Boogie in the Bar: currently holding virtual boogies for older adults during COVID via Facebook, YouTube and twice weekly on Station House Media Unit radio.

Aligned performance indicator
To be developed aligned to the Prevention workstream review currently being undertaken.

Case Study / Testimonials
The Student Befriending Pilot was a collaboration working between Robert Gordon University and Aberdeen City Health & Social Care Partnership. In this pilot, 12 students (six Occupational Therapists and six Physiotherapists) were paired with six older adults over a period of 6-8 weeks with the aim to provide befriending and identify links to enhance wellbeing.

John and Vera (pseudonyms) were one elderly couple who engaged in the pilot. Versa newly lost sight in both her eyes, whilst John had a recent stroke, leaving weakness down one side and with no speech.

The outcomes they wanted to achieve through the pilot were to shop online, keep in touch with family and take advantage of health care appointments.

At the end of the pilot, John and Vera had created their first email account and received their first online shopping delivery much to their excitement They have been referred into Occupational Therapy for further input.

"The pilot was a very positive experience for me, I enjoyed it very much. Building the relationship both with the befriendee and my physio partner was a highlight of my placement"

(Occupational Therapy Student).

Additional comments
Analysis of current and predicted demand across our client groups is underway to inform future commissioning requirements regarding planned respite. To ensure a comprehensive approach is taken, an overview of all commissioning beds for interim, surge and respite is being summarised to ensure a balance across the system which responds to the needs of our population.

Operation Home First Priority Stepped Care Approach / Frailty Pathway	**Priority Workstream (if applicable)** Hospital @ Home (H@H)	RAG Status	

Operation Home First Aims this aligns to *Keep people safe at home; Reduce unscheduled attendances / admissions; Supporting early discharge.*

Brief description of priority

Hospital @ Home provides acute care for geriatric patients in their own home via a multi-disciplinary team. There are two admissions routes: 1) alternative to admission (whereby otherwise the individual would be admitted to hospital) and 2) supporting discharge (referrals from hospital to return home sooner and receive the final part of their care at home). The service has been operational since June 2018 and has had 957 admissions during this period (up to February 2021).

Update as of February 2021 Detailed information about the development of the respiratory component of H@H is visible in the associated flash report.

Impact to date

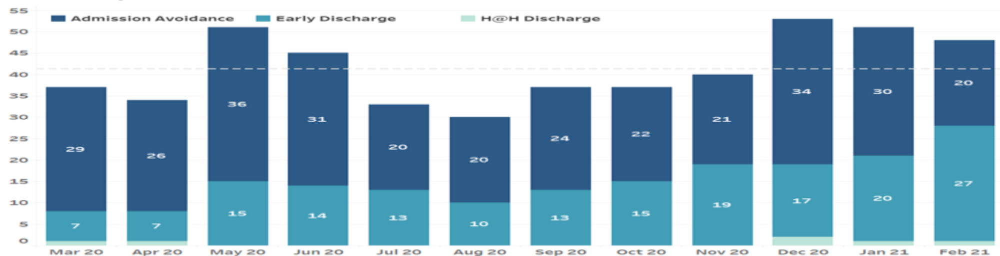
Service metrics: 476 referrals in the last 12 months (Admission Avoidance=308; Early Discharge=168). Both Hospital @ Home (71%) and Geriatric Assessment Unit (72%) show similar proportion of patients at home / in a community setting 90 days post discharge.

Service User / Unpaid Carer Acceptability: Previous feedback from 16 patients demonstrated high satisfaction in the service (mean score = 4.1/5) and confidence in the team (mean score = 4/5). One said: "*I was amazed at the amount of help I received. Each person knew exactly what they were going to do and did it all so cheerfully and willingly. Thank you all*" (Responder x).

A sample of unpaid carers (n=16) rated the Hospital @ Home team strongly on providing them encouragement and support (mean score = 4.8/5) and providing them with extra knowledge or skills to look after their cared for person (mean score = 4.6/5). One stated: "*This home team is a great service, more info was passed on and explained than during the hospital stay. The nurses were able to spend time with my relative, listen to him, watch him and make a true assessment of his needs. The help put in place will allow him to stay at home and have as good a quality of life as possible. This service has also given us as a family peace of mind*" (Responder x).

Staff outcomes: A previous staff satisfaction survey found a mean satisfaction score of 73%, which is 5% higher than the average NHS employee. A sample of services who regularly work with Hospital @ Home, including General Practice and District Nursing, had high agreement of how easy the referral process was into Hospital @ Home (mean agreement = 84%).

Aligned performance indicator



Hospital@Home Admissions by Month

Case Study / Testimonials

"Mrs B fell when she was walking to her local shop. She was taken to Geriatric Assessment Unit where she was x-rayed and no fractures were found. Mrs B had sustained a superficial injury to her foot. She was referred to Hospital @ Home from Emergency Department, avoiding a hospital admission.

During Mrs B's initial visit from the Hospital @ Home team, the Physio Therapist & Advanced Nurse Practitioner suspected she had delirium. The Health Care Support Worker took routine observations such as blood pressure, temperature, respirations, oxygen saturations and pulse. On next visit, Mrs B was hallucinating and a urine sample test con-firmed a urinary tract infection. Mrs B's mood was low on several occasions, stating she felt a burden as well as a nuisance towards her family and Home @ Home staff.

The Hospital @ Home team recommended Mrs B should have carers 3 x daily care to support with personal hygiene, diet and medication prompt. Mrs B required regular reminders not to go out walking alone, due to high fall risk. Family members were sign posted to relevant services which may benefit Mrs B's ability to remain at home safely (e.g., community alarm, key safe, city home helpers). The family decided to install a key safe following this advice. The Team Lead completed a care management care plan. Due to care package not being in place and husband still in hospital, Hospital @ Home decided not to discharge Mrs B.

Emergency Department informed Hospital @ Home that Mrs B had fallen overnight and was in the department with a head injury receiving treatment. Hospital @ Home was informed Mrs B was to be admitted to Geriatric Assessment Unit, however after discussion it was decided that Hospital @ Home would take over care, preventing hospital admission.

Hospital @ Home staff continued to provide 3 x daily care while awaiting Mrs B care package. The Pharmacy Technician liaised with care providers regarding medication. Mrs B was then discharged from Hospital @ Home and her care was handed over to the District Nurse regarding Mrs B's ongoing care of foot dressing as well as the staple removal from head injury". (Advanced Practitioner, Hospital @ Home).

Additional comments

This performance indicator assumes 1) all admission avoidance referrals directly result in one less admission to Ward 102 in Aberdeen Royal Infirmary 2) each 'early discharge' referral directly reduces pressure on secondary care and 3) increasing referrals to Hospital @ Home mean more people are being cared for in a more appropriate setting.

Operation Home First Priority Frailty Pathway	**Priority Workstream (if applicable)** Ward 102	RAG Status

Operation Home First Aims this aligns to

Support early discharge; Reduce unnecessary hospital attendances and admissions

Brief description of priority

Safe, effective patient flow in and out the Geriatric Assessment Unit within Aberdeen Royal Infirmary, ensuring the right patients (i.e., those with decompensated frailty) are managed appropriately within the right area of the health and social care system in a timely manner.

Update as of February 2021

Five workstreams have recently been developed to support the progression of this priority: 1) Admission and Flow Group; 2) Discharge; 3) HAME and Front Door Frailty Identification; 4) Establish 102 Workforce; 5) Operational principles and escalation practices.

Impact to date

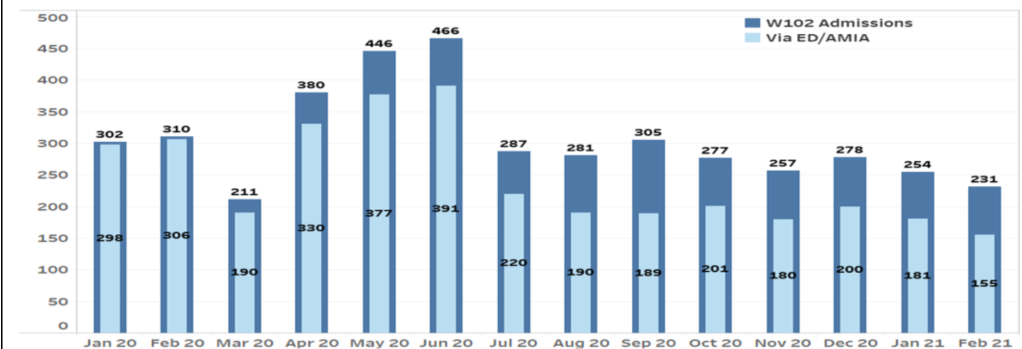
Direct access – General Practitioners can contact a clinician within Ward 102, for example when the first signs of delirium are present in their patients. This allows them to have timely access to specialist advice, resulting in care being provided in the most appropriate setting (whether that is at home, in hospital or other).

Implementation of Rockwood scoring within Emergency Department – patients are now scored using Rockwood Frailty Scale at point of admission. This allows for early identification of frailty and subsequent implementation of a frailty bundle that outlines the appropriate early interventions required. This has been used with 65 patients to date. The next phase will be exploring its implementation with Scottish Ambulance Service.

Escalation plan developed – required in response to managing flow (i.e., managing beds). Outlines each members of staff roles within the plan to ensure efficiency of service delivery.

Development of criteria-led discharge – leading to a more timely and efficient discharge, with the goals being person-centred as opposed to medically-led.

Aligned performance indicator



Ward 102 referrals from Emergency Department / AMIA by month for the last 12 months

Case Study / Testimonials

"General Practitioner access to a senior clinical decision maker available in Ward 102 has been facilitative of timely intervention and admission to hospital only when agreed as essential and unavoidable.

Admissions have been avoided when General Practitioners contact the ward direct to discuss patients' presentations and to explore with the Geriatrician / Registrar management options. The exclusion of delirium alongside other management considerations when frailty significantly impacts patient's recovery, wellbeing and activities of living.

Discussions between General Practitioner and Geriatrician ensure medication review, minimise unnecessary polypharmacy and optimise medications." (Staff member, Ward 102)

Additional comments

Operation Home First Priority Stepped Care Approach	**Priority Workstream (if applicable)** Enhanced Community Support Huddles	RAG Status	

Operation Home First Aims this aligns to

Keep people safe at home; Support early discharge; Reduce unnecessary hospital attendances and admissions

<u>Brief description of priority</u>

Huddles have been established to support unscheduled care in the community for discussion for those individuals who are at risk of admission or re-admission, for those that are potentially stepping down from acute services, and to provide rapid wraparound support using a virtual multi-disciplinary team approach. Huddles function within each of the 3 localities and there are two levels (1 daily triage huddle, rapid conversation with unscheduled individual, take action that day) and 2 (weekly multi-disciplinary teammeeting [wrap around support for individuals who are stable but with room for improvements regarding functioning etc]).

<u>Update as of February 2021</u>

The Enhanced Community Support huddles have been functioning since April 2020 and have used an iterative improvement methodology approach that has been staff led that pragmatically works well. Exploring how we can increase attendances at huddles to ensure equitable access for all services across the city, for example services within Primary Care.

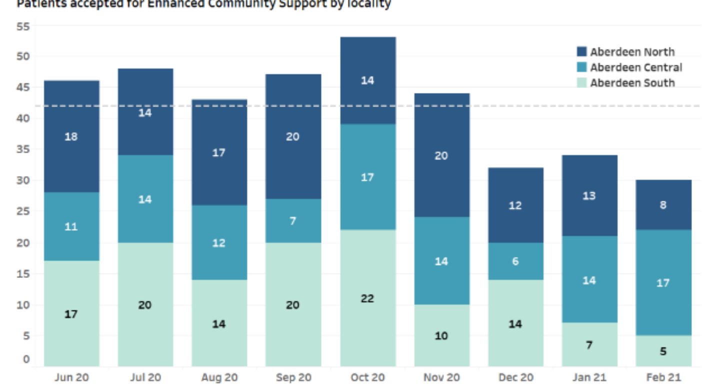
<u>Impact to date</u>

Performance metrics: Nearly 380 requests (relating to over 330 patients) have been brought to Enhanced Community Support since June, an average of 42 cases per month. Overall spread of patients with Enhanced Community Support input across each locality has been similar, although has fluctuated month on month, with 36% of cases brought by Aberdeen North and 30% and 34% by Aberdeen Central and Aberdeen South respectively.

Staff acceptability: 48 attendees of the Huddle provided feedback on its function. Overall responses were positive – Huddles received a mean score of 7.6/10. Components strongest rated included improved patient care (91.3% agreement) and improved multi-disciplinary working (89.4% agreement). It was also suggested that this approach saved staff time (63.8% agreement).

Service outcomes:

<u>Aligned performance indicator</u>



<u>Case Study / Testimonials</u>

"The Enhanced Community Support Huddles provide a platform for front line health and social care staff to discuss individuals who would benefit from an increase in care or therapy due to a change in their circumstances. It is designed to 'pick up' individuals who have an unscheduled event and need a more urgent care and or therapy intervention to enable them to remain at home. The huddle also enables staff working within the Acute Sector to provide information to the community teams on any individuals being discharged that may be 'fragile' and need additional support at the point of discharge.

Benefits include

- *Right service at the right time delivered by the right person in the right place*
- *<u>Daily</u> forum for any member of the Multidisciplinary team (in its widest sense) to discuss any individual that is giving them concern – making it a timely response*
- *Weekly follow-on huddle per locality for more in-depth discussion/learning opportunities*
- *Locality and multidisciplinary team approach to assessment, and interventions*
- *Shared learning/understanding of the roles of the multidisciplinary team*
- *Building relationships within the localities*
- *Joint ownership – self managing multidisciplinary team*
- *Supported by senior members of the locality leadership huddle*
- *Quality improvement approach to development" (Occupational Therapist feedback)*

<u>Additional comments</u>

The more cases that are brought to the huddles, the less likely that those at risk of admission / re-admission manifest. This, in turn, helps to keep people safe at home. Note – data does not include patients presented but not accepted / not appropriate for Enhanced Community Support

Operation Home First Priority Care @ Home Contract Implementation	**Priority Workstream (if applicable)** Not applicable	RAG Status	

Operation Home First Aims this aligns to

Keep people safe at home; Support early discharge; Reduce unnecessary hospital attendances and admissions

Brief description of priority

Under the new model, the provision of care will move away from the current schedule of tasks which are timed. Instead, teams will work together with people receiving care, their families, and other practitioners within each locality to provide care tailored to individual needs. Local assets will also be used to connect people back into their community. The incoming Granite Care Consortium is made up of 10 care providers who have worked closely with colleagues to problem solve and coproduce solutions in an agile and innovative delivery model.

Update as of February 2021

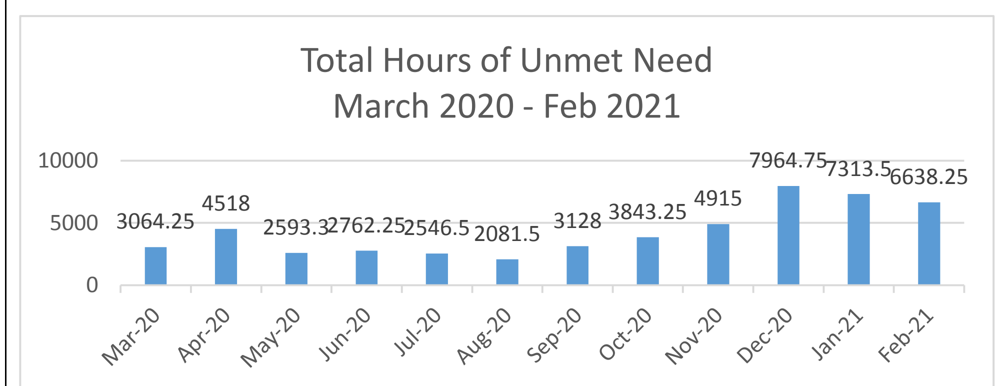
A multidisciplinary group is now meeting weekly to review care packages within the Granite Care Consortium unmet needs list. The aim being that this approach will be widened in the future to provide a consistent holistic approach to the whole of the unmet need population. A working group has also been set up to progress risk assessed care, this will help to plan and find sustainable solutions for increased demand on our systems in the future, we will look at where correctly assessed equipment can be used to enhance and support the care delivered while first and foremost keeping people safe.

Impact to date

Staff perceptions – A baseline survey was distributed to Grampian Care Consortium staff in December 20 that 62 people responded to. Overall, staff felt very supported by their colleagues (mean score 8.5/10) and those who deliver care to service users felt satisfied in their caring role (mean score 7.4/10). Perceived advantages included being more reactive to people's needs: "*The flexibility will be good for our clients who have varying presentation and needs, as their illness worsens or improves*" (Care Provider).

Market stability – Baseline metrics were collected to understand the workforce of the Grampian Care Consortium (total of 637 as of December 20) and the total number of eligible clients within Aberdeen City (N=1484). This will be reviewed in Summer 21 to understand how these metrics are impacted.

Aligned performance indicator



Case Study / Testimonials

"Granite Care Consortium was established in March 2020, as a concept to achieve market stability and improved outcomes for service users in the provision of care at home across the City of Aberdeen.

Granite Care Consortium is at the centre of improvements to adult social care support in the City of Aberdeen and Scotland. It is a pathfinder model and to our knowledge, the first of its kind from an operational and commissioning context, primarily in terms of the outcomes it looks to achieve for and with people who use our services.

The journey for Granite Care Consortium over the next 3 years is summarised as:

1. Shift the cultural paradigm on how we step up, step down and enable those receiving care at home.

2. Strengthen the foundations of care at home in Aberdeen, through market stability, the development of our workforce and their employment stability.

3. Redesign the system, bringing together those cared for, social care managers and social care staff in assessment and delivery, shifting the cultural and operational paradigm.

Granite Care Consortium will challenge some of the historic narratives about social care and care at home support. Granite Care Consortium will deliver effective social care support based on positive outcomes for everyone who receives care at home from Granite Care Consortium in the City of Aberdeen.

A foundation to Granite Care Consortium is our social care and care at home workforce. For us to achieve the improvements and developments we seek to achieve in partnership with the Aberdeen City Health & Social Care Partnership, our goal is to establish and build a workforce that feels engaged, valued, and rewarded for the very important work that they do.

Granite Care Consortium will develop an approach that builds trusting relationships between its social care providers, rather than competition. We will foster partnerships, not marketplaces and we will encourage the voice of lived experience at every level in our service delivery. We will co-produce our new model of delivery with the people who it is designed to support, both individually and collectively." (Executive, *Granite Care Consortium*)

Operation Home First Priority Redesign of Urgent Care (Flow Navigation Centre) (Pan-Grampian)	**Priority Workstream (if applicable):** Not applicable	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions* ✓	

Brief description of priority

This work is part of a Scotland-wide programme to build on opportunities to support people to access the Right Care in the Right Place at the Right Time, and as part of this, to reduce attendances at Emergency Department/Minor Injuries Units if there are more appropriate sources of help and support. The public are asked to call NHS 24 – 111 - day or night when they think they need Emergency Department but it is not life-threatening. NHS 24 will offer telephone advice on what care is required and where is the best place to access this. If necessary, they will refer on to NHS Grampian urgent care staff. Each local health board has established a Flow Navigation Centre (hub) that will directly receive clinical referrals from NHS 24. The Flow Navigation Centre offers rapid access to a senior clinical decision maker within the multidisciplinary team, optimising digital health through a telephone or video consultation where possible. Through this consultation they may again signpost or refer to other services available to best meet health care concerns raised. If the senior clinical decision maker determines the patient needs to go to Emergency Department or a Minor Injuries Unit, they will be offered an appointment to attend in person.

Update as of February 2021

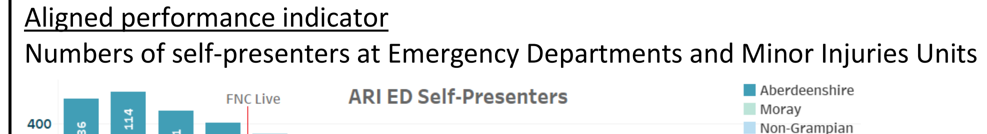
This new service went live in Grampian and across Scotland on 01 December. Phase 2 underway will build on the work already achieved by the Redesign of Urgent Care Programme, to establish a single access route which delivers efficient, safe and effective person-centred care.

Impact to date

Over 2,600 patients have been referred from NHS 24, to the Flow Navigation Centre and Minors Decision Queue, an average of 200 clinical referrals per week (Flow NavigationCentre: 38 per week; Minors: 162 per week). Only 59% of patients have required a face-to-face appointment minimising the need for patients to attend Emergency Department or a minor injury unit, with 36% given self-care advice and 5% re-directed to primary care following a virtual consultation. Since the soft launch of the Flow Navigation Centre, the self-presenting patient footfall at Aberdeen Royal Infirmary Emergency Department has significantly reduced and is currently over 40% down, with a reduction of 32% seen in the number of Aberdeen City patients self-presenting at Aberdeen Royal Infirmary Emergency Department. However, with many variables including lockdown it is too early to estimate the true impact of the redesign.

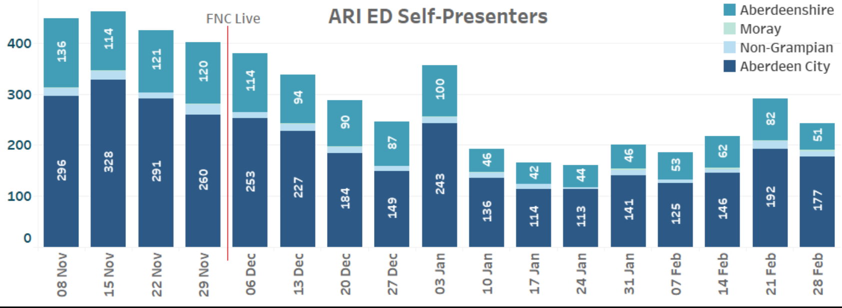
Case Study / Testimonials

- A survey has been developed to gather patient feedback on experience and views and is expected to launch in March.
- Questions in Grampian's Redesign of Urgent Care survey overlap with those to support local and national evaluation of Near Me video consultations and as such are expected to provide information of mutual benefit to multiple workstreams.



Aligned performance indicator

Numbers of self-presenters at Emergency Departments and Minor Injuries Units



Operation Home First Priority NearMe	**Priority Workstream (if applicable)** Not applicable	RAG Status	

Operation Home First Aims this aligns to

Keep people safe at home

Brief description of priority

NearMe is a video consulting service, allowing people to attend health and social care appointments from wherever is convenient for them. The service has been operational across Grampian since 2019, being used in both Primary Care and Secondary Care settings.

Update as of February 2021

Near Me is now embedded within service models for many services. Focus is now shifting to sustaining the change and supporting new models of care, e.g.; how NearMe can help to deliver multi-disciplinary clinics or shared decision making across primary and secondary care.

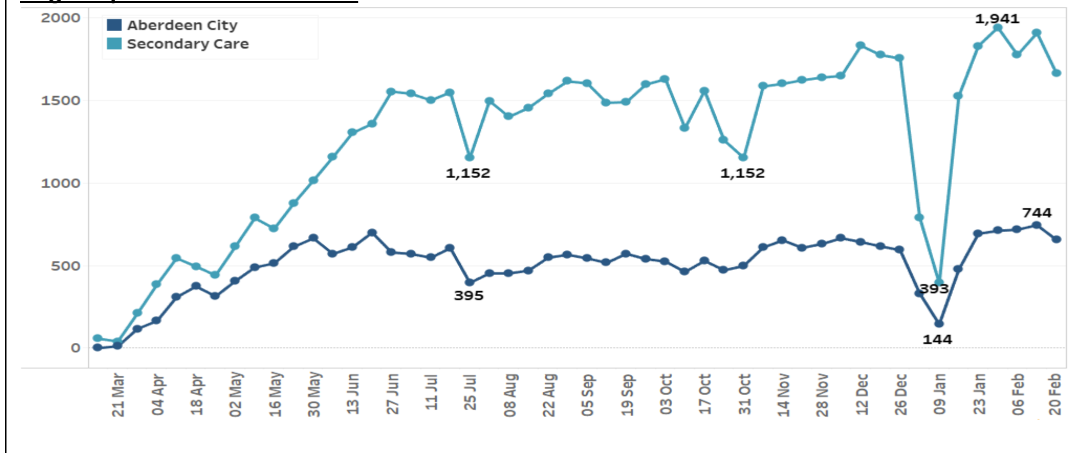
Impact to date

Patient satisfaction: 93% (N=2012) of patients self-reported their NearMe experience as 'very good' or 'good'. 97% rated the quality of care provided as either 'very good' or 'good'

Staff outcomes: 38% (N = 755) of clinicians self-reported saving travel as a result of using the NearMe platform. One-fifth felt it took less time than regular consultations.

Service performance: In Feb 20, we were conducting ~80 video appointments per week; in Feb 21 that number is >3500 per week. In the same time period, the number of active NearMe service waiting areas has increased from 16 to ~200, and the number of laptops issued to facilitate the service provision has risen from 2800 to ~5500.

Aligned performance indicator



NearMe Consultations by month

Case Study / Testimonials

"I elected to have my initial pain management clinic appointment via video.

I received all the information, did the test call and today accessed the appointment with a lovely Female Registrar … I had a good, focused, no noise, no waiting or travelling (being in pain or knowing you can have a bad day without warning knowing I wouldn't have to travel made things easier), appointment, I was able to listen to the questions, answer them, have time to explain, definitely a more focused appointment, I know not for everyone but I certainly felt more comfortable especially as my husband didn't have to take time off work to take me etc.

The Registrar was brilliant, put me at ease, explained and reflected back. Yes I will need a face to face but the medical history, my concerns and expectations etc have all been done"

(Near Me Service User).

Additional comments

This performance indicator assumes that 1) digital is the preferable mode of delivering consultations when it is safe and appropriate to do so, and 2) may be a more efficient mode of delivery for both staff and patients.

Operation Home First Priority Respiratory Pathway + Stepped Care Approach	**Priority Workstream** Hospital @ Home expansion: Respiratory Physiotherapy	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions ✓*	*Support early discharge ✓*

Brief description of workstream

This expansion to the Hospital @ Home service is helping to avoid unnecessary respiratory admissions and readmissions. It includes a focus on supported discharge so that people – often with substantial anxiety around their condition – are not readmitted. Funding was approved to second/recruit respiratory physiotherapy staff (2.0 Whole Time Equivalent) to join the existing Hospital @ Home team.

Update as of February 2021

1.0 Whole Ttime Equivalent Band 7 (comprised of 2 x 0.5 Whole Time Equivalent) have been seconded into Hospital @ Home as of mid-December 2020. 1.0 Whole Ttime Equivalent Band 6 has been recruited and is only just in post – since 1st February. Band 7s have been taking referrals and starting to provide support from 7th January, on part capacity until the Band 6 in post. We will be providing 7-day cover over the month of March.

Impact to date

Whilst clinicians have reported seeing less in the way of exacerbations of Chronic Obstructive Pulmonary Disease than would normally be the case in winter, because many people are shielding due to the COVID pandemic, we have still seen demand for our services:-

- 13 patients have been referred to us since 7/1/21, of which 9 have been admitted to Hospital @ Home (4 alternative to hospital admission and 5 active recovery/supported discharge). We have since discharged 8 of them.
- In this short space of time we have provided 49 Hospital @ Home bed days, of which 36 were for patients we have discharged, and 13 is the running total (at 28/02/21) for the 1 patient we are currently supporting.
- For context, across the patients we have supported so far, in the 12 months prior to us starting to give them respiratory physio support, there were 28 admissions for respiratory conditions, totalling 193 bed days (163 acute bed days and 30 Hospital @ Home bed days).

To illustrate the comparative costs:-

- Average cost per case of our Hospital @ Home respiratory physio intervention to date is £254.73. So, across our 4 alternative to hospital admission patients this comes to £254.73 x 4 = c.£1.019.
- Average direct cost per inpatient case in Aberdeen Royal Respiratory Medicine = £3,615. So, if these 4 patients had been admitted to Aberdeen Royal Infirmary this could have cost £3,615 x 4 = £14,460.
- Average cost per Respiratory inpatient bed day in Aberdeen Royal Infirmary = £583, so had our 49 bed days been delivered in Aberdeen Royal Infirmary, this would have equated to £583 x 49 = £28,567.
- As the Hospital @ Home service continues to expand and develop in scope, we expect that further work will be required to assess the impacts that this has on average bed day costs in Hospital @ Home

Source for ARI costings: NHS Costs Book 2019/20 R040 tables. Direct Costs per inpatient case (staff, theatre, laboratory). This was then divided by specialty average length of stay to estimate average cost per inpatient bed day.

Case Study / Testimonial

"The patient was able to remain at home and improved after his exacerbation. He has also been referred to Pulmonary Rehab for appropriate follow up."

"During the short time the service has been available, the expansion of the H@H team to support respiratory patients has already had a huge impact on patient care and service delivery. The service has been shown to be a cost-effective intervention, supporting all three of the OHF aims."

Additional Comments

- We have promoted the Hospital @ Home Respiratory service to referring clinicians by email: respiratory consultants and all General Practitioners via their primary care bulletin.

Aligned performance indicators

- Numbers of people supported by Hospital @ Home
- Numbers of respiratory admissions (note: Operation Home First are working on a broader measurement from several respiratory projects combined).

Operation Home First Priority Respiratory Pathway	**Priority Workstream (if applicable)** Home Oxygen Service	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions*	*Support early discharge* ✓

Brief description of priority

Changes to way that consultants in non-respiratory specialties engage with Home Oxygen Team and efficiencies brought about by move to Office 365 suite of applications have enabled Home Oxygen team to directly assess inpatients at Aberdeen Royal Infirmary and those needing support in the community far quicker than previously was the case.

Update as of 01 March 2021 – Current status:

Over three-week period since implementation Home Oxygen Teams have conducted 21 inpatient assessments – 17 the same day as referral received and 4 the following day.
Unable to recruit the 1xBand 4 Whole Time Equivalent that funding from Operation Home First Respiratory Cell was secured for, so having to utilise additional hours from existing Band 7 and Band 3 staff.
Inpatient service due to finish at end of March 2021.

Impact to date

Discharged same day as assessment	6
Discharged day after assessment	6
Discharge 2 days after assessment	5

- Feedback received from 13 individuals regarding 11 patients all of whom felt that the patient was discharged earlier as a result of the intervention and that it saved their time. It was estimated that an **average of 4.8 bed days were saved per patient**
- 7 patients from in or around Aberdeen were referred for urgent/immediate oxygen to prevent admission. All patients were seen the same day and 4 were supplied with oxygen after assessment – the oxygen installation was completed on average 128 minutes after time of referral

Case Study / Testimonials

Staff: 'It enabled Discharge far quicker than I had thought possible'

'Gives the patient confidence and reassurance on Discharge'

'Oxygen teams input in organising the oxygen for this patient was very helpful, as he would likely have stayed in hospital far longer'

'Patient absolutely delighted to be getting home, felt he would be able to do more at home and recover quicker'

Patient: 'Overall, the Oxygen team allowed me to overcome this difficult time with much more confidence, providing the means to allow me returning home, comfortable with the fact that I would not be breathless during my recovery.'

Aligned performance indicator

Bed days saved; Number of admissions avoided

Additional comments

Lack of ongoing funding may mean both projects cease at the end of March 2021, or shortly thereafter.

Operation Home First Priority Respiratory Pathway	**Priority Workstream (if applicable)** Prevention & Self-management (Physical Activity)	RAG status	

Operation Home First Aims this aligns to

Keep people safe at home ✓	*Reduced unscheduled attendances / admissions*	*Support early discharge*

<u>Brief description of priority</u>

Multiple projects within the Respiratory Pathway priority focus on health improvement for patients with Chronic Obstructive Pulmonary Disease and other respiratory conditions providing: 1) Physical Activity classes; 2) Pulmonary Rehabilitation and 3) Respiratory Physiotherapy support within Hospital @ Home. These projects are linked in that patients referred to one may subsequently be redirected to another depending on their current level of health. The Physical Activity classes are a natural progression for patients who have been on the Pulmonary Rehabilitation programme. Whilst there may be local differences in implementation, leads for the projects in each of Grampian's three Health and Social Care Partnership areas are working together to ensure consistency, where appropriate, in their approach to reporting and evaluation. In Aberdeen the physical activity project is being delivered by Sport Aberdeen, whose instructors have developed the online delivery of classes using the Zoom video-conferencing app. *[Note: In Aberdeen pulmonary rehabilitation is being delivered on a business-as-usual basis and is not one of the Operation Home First-funded projects].*

<u>Update as of 01 March 2021 – Current status:</u>

-Programme is operating on a rolling 6-session basis with participants joining as Sport Aberdeen triage them into the programme.

-The first couple of participants reached their 6th session at the end of February and a few more will do so during the first week of March.

-There is plenty capacity within the virtual classes, so participants who have completed their initial 6-week block can stay so they're able to continue exercising, however a more challenging class is being introduced from week beginning 8th March for those who are ready to move into something new.

<u>Impact to date</u>

There have been 63 referrals received to the programme (6 from Health Professionals and 57 Self-Referrals). Of these Sport Aberdeen have: 17 attending virtual exercise classes; 4 receiving 1-to-1 phone call support as they don't have access to online classes; 18 were signposted to the Pulmonary Rehabilitation Physio Team because they didn't meet inclusion criteria for Sport Aberdeen programme . Of the others there are a mix of people who haven't been able to participate due to other health conditions/injuries and some who were referred into Live Life Aberdeenshire or Moray programmes due to their addresses.

<u>Case Study / Testimonials</u>

A YouTube video has a further testimonial in the form of an interview with participant Peter Hall, see: Winter Pulmonary Rehabilitation Programme Case Study

<u>Aligned performance indicator</u>

Number of participants completing the block

<u>Additional comments</u>

Patient and instructor feedback surveys are planned to be implemented from week commencing 1st March. These will contribute a more quantitative element to the evaluation of the Physical Activity workstream.

Operation Home First Priority Palliative & End of Life Care		**Priority Workstream (if applicable)** Virtual Programme	RAG status	
Operation Home First Aims this aligns to				
Keep people safe at home ✓	*Reduced unscheduled attendances / admissions*	*Support early discharge*		
Brief description of priority The focus within this Priority has been on the draft Grampian-Wide Strategic Framework for Palliative and End of Life Care, which sets out the vision for the next three years. Workstreams within this Priority have not been developed to the same stage as other Priority areas.				
Update as of February 2021 Staff at both The Oaks in Elgin and Roxburghe House in Aberdeen are modifying their palliative care offering to patients so that these can be delivered remotely. Evaluation and measurement frameworks are under development and these will look to capture feedback from patients and their carers/family and from staff delivering these services. Working with the project leads, the Operation Home First Evaluation team will help to foster a rounded understanding of the costs and benefits of delivering Palliative End of Life Care support to patients via online platforms and the consequences (intended or otherwise) to all palliative services and the wider connected system.				
Impact to date Not available at this time		Case Study / Testimonials Not available at this time		
Aligned performance indicator For the virtual palliative classes this may be Number of participants completing the block. This would align with other Workstreams in aiming to Keep people safe at home.		Additional comments		

Operation Home First Priority Frailty Pathway	**Priority Workstream (if applicable)** Rosewell	RAG Status	

Operation Home First Aims this aligns to
Keep people safe at home; Reduce unscheduled attendances / admissions; Supporting early discharge.

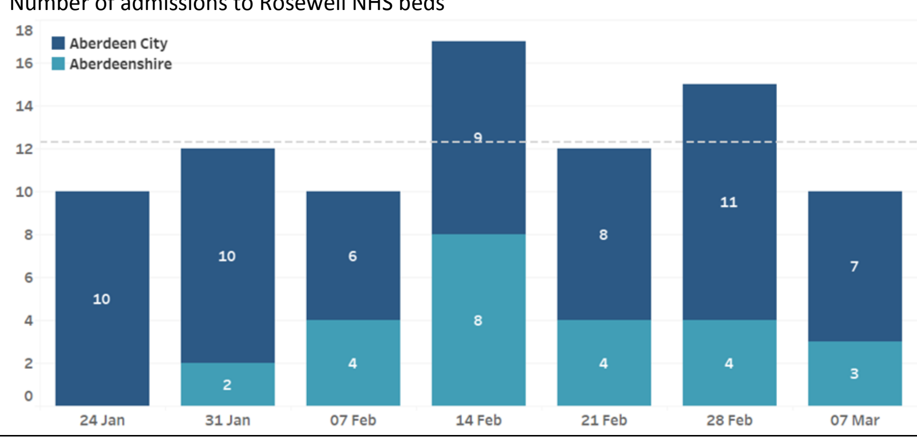
Brief description of priority
Rosewell House is being developed as an enhanced pathway and service model. This would see an integrated service providing intermediate care for both step down from hospital and step up from community. The model will increase capacity in the system as well as meeting our aim of delivering the right services, in the right place at the right time whilst also reducing the need for unscheduled admissions and enabling the safe discharge of patients from hospital who require further care prior to returning home.

Update as of February 2021
To facilitate an urgent response to surge and flow during the latest Covid19 wave, Rosewell House was opened as an interim NHS Grampian facility on 18.01.21. This involved 20 beds remaining under Bon Accord Care's registration, with the remaining 40 beds transferring to NHS Grampian on a temporary 16-week basis. As of 22.02.21, 30 out of 40 of these NHS beds are open and accepting admissions. Work continues to develop the longer-term model ahead of the end of the period for interim arrangements (10.05.21).

Impact to date
Transfer of staff: The current nursing workforce for the NHS beds is 20 Whole Time Equivalent (21 headcount), supported by 26.8 Whole Time Equivalent Health Care Support Workers (30 headcount) and a headcount of 25 Bon Accord Care support workers. This staffing has been supported by the movement of workforce from two wards in Woodend Hospital that have now been closed, meaning that more people can be cared for closer to home when safe and appropriate to do so.

Service metrics: Since January 18th there have been 86 admissions to NHS Rosewell beds (61 patients from Aberdeen; 25 from Aberdeenshire). All except one from Hospital @ Home have been step-down admissions from hospital. 51 patients have subsequently been discharged/transferred from Rosewell (34 patients discharged home, nine transferred to a Shire community hospital, three to Woodend Hospital, one re-admitted to Aberdeen Royal Infirmary, one stepped-down to Hospital @ Home and three who died). The average length of stay for patients who have been discharged/transferred has been 12.4 days with a maximum length of stay of 36 days.

Aligned performance indicator
Number of admissions to Rosewell NHS beds



Case Study / Testimonials
"In January 2021, as a result of significant pressures on hospital services in Aberdeen, under civil contingencies, it was agreed to allow NHS Grampian to operate 40 beds within the 60 bedded Rosewell Care home (with the remaining beds remaining as care home rehabilitation beds.) Since that time, 30 beds have been used by NHSG teams supported by Bon Accord Care staff.

This arrangement, although put in place as an emergency measure, have provided a unique opportunity for us to learn from a different model at Rosewell. Including: how staff from different organisations can work effectively together as integrated teams; a better understanding of the nature of the care demands that may present at a peak period, and latterly a more usual level; and how flow between hospital, intermediate care, rehabilitation care and community care can be made more efficient.

It is intended that the learning from this model, which was established due to necessity, will enable the longer-term model that is developed to be fit for purpose in a system of varying demand over time."

Additional comments
An evaluation of the interim model was commenced 22.02.21 and will be completed 26.03.21 to inform its future direction.

Comments / Observations

To date, all priorities that have been operational for an adequate period have demonstrated sufficient feasibility (i.e., they are broadly acceptable to both service users and service providers). For some priorities within this context, it is too early to determine fully the benefits they will deliver at current scale, and potentially if scaled up. The simplified model for service change and evaluation, below, illustrates that in order to achieve the desired outcomes and impacts, the right inputs must be in place, relevant activities performed, and the required outputs delivered. However, our evaluation to date provides an important basis in ensuring that any changes in service provision can be sustained longer-term. Previously in-depth evaluations conducted by Aberdeen City Health & Social Care Partnership have typically taken place after six months of implementation (see the 'West Visiting Service' evaluation here and the 'Hospital @ Home' evaluation here) which provides a useful barometer of the balance that is required to be struck between evolving initiatives at pace whilst ensuring enough data is generated to inform future service provision.

Simplified Logic Model for theory of change / service evaluation

Inputs	→	Activities	→	Outputs	→	Outcomes and Impact (short-, medium- and long-term)
e.g., funding; staffing		e.g., training; process development		e.g., virtual classes; supported discharges		e.g., increased awareness and ability of person to manage their condition(s); admission avoidance in short versus longer term; reductions in Emergency Department attendances and hospital admissions in the longer term; improved population health in the longer term.

One key enabler that is important to emphasise within the context of reporting progress is the access to and development of an intelligent data infrastructure. For example, the 'patient location at 90 days' outcome articulated within the Stepped Care Approach / Frailty Pathway Hospital @ Home flash report above exists due to the creation of a virtual ward within the TrakCare system and then a further automated code that runs daily to determine whether patients who have received care in that service are back in hospital (or another setting). In other initiatives, such as the Enhanced Community Support huddles, the performance data was manually pulled off electronic systems by one member of staff who is no longer working for Aberdeen City Health & Social Care Partnership.

One aspect that might temper the potential success of the Operation Home First programme was the use of Winter Planning funds to develop several projects under the Respiratory Priority. These monies allowed purchase of kit and staff training for the Physical Activity Classes for participants with Chronic Obstructive Pulmonary Disease, however without establishing a revenue model for this preventative approach to health care Sport Aberdeen may not be able to support the programme beyond the 2020/21 financial year. The same is true of the Home Oxygen Team, for which funding enabled additional temporary staffing resource allowing them to explore projects aimed at supporting early discharge and avoiding unnecessary hospital admissions. In these examples, whilst initial data looks very positive, the funding came late in the day and as such none of the above projects have been established long enough to fully evaluate their impact on the Operation Home First top line.

Such a wide-ranging portfolio as Operation Home First is unlikely to ever have a neat end point. This is because it is cross-system by design and naturally evolves over time based on evidence and key learning. For example, the Stay Well Stay Connected workstream within the Stepped Care Approach have identified social isolation as a key area of required focus moving forward in response to physical distancing that has emerged from the COVID19 pandemic. This means that, rather than evaluation being viewed as an activity that is undertaken at the 'end' of a project, it could be perceived as a tool that does not just determine the benefits of a particular initiative but is also used as a basis to guide future activities based on evidence. We would recommend that thought is given to maintaining a rolling programme of evaluation, underpinning the cyclical process of strategic planning and commissioning.

Next Steps

A more formal evaluation report on the progress of Operation Home First will be produced towards the end of Spring 2021, including the collective impact of this portfolio and recommendations on the future direction.

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