Operation Home First
Portfolio Evaluation Report
June 2021

This report was prepared by the Operation Home First Evaluation Working Group:-

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Contents

Key Points

- The primary aim of this evaluation was to demonstrate the impact of the Operation Home First (OHF) priorities against the OHF aims. However, this evaluation aimed to address as far as reasonably possible, further questions that have been posed to the Evaluation Working Group at recent committees (for example impact on costs and health inequalities).
- Evaluating a complex portfolio such as this, comprised of multiple interconnections and interdependencies, will result in complex answers being generated.
- This evaluation occurred during and soon after the winter planning period (October 2020 – March 2021) and within this time, variability was evident regarding the degree and scale of implementation across OHF Priorities.
- Several initiatives have been comparatively small scale and have demonstrated positive impact for a small cohort of people. Such initiatives require scale-up to recognise marked impact at a population level.
- Implementing such a cross-system Portfolio with a variety of interdependent initiatives will likely result in prioritisation (and subsequent acceleration / deceleration) having to occur to account for challenges in capacity in resources.
- Having external evaluation support in the design and delivery of initiatives at project and programme level appears to be perceived valuable by Priority Leads.
- We understand that there is a strategic appetite for the ethos of “Home First” to become more embedded in Business as Usual for integrated health and care services across Grampian. To help it become so, we would recommend that project and programme evaluation is maintained as an integral part of the Strategic Commissioning Cycle, complementary to other key steps in that cyclical “Plan, Do, Study, Act” (PDSA) process.

Introduction / Context

This report aims to evidence the impact of the Operation Home First (OHF) Portfolio. It follows on from an interim evaluation report published in February 2021 that should be read prior to this report for further context. The interim report, available as Appendix A, provided an overview of OHF; the evaluation methodology implemented across the Portfolio; and an update on progress across each of the OHF Priorities. This report views the evaluation of the Portfolio through a strategic lens, with greater emphasis placed on the cumulative impact of individual Priorities and key learning / considerations that may be valuable to adopt in the future.

The Aims of Operation Home First

This portfolio has three main aims:

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

The Operation Home First Portfolio

The below figure illustrates the constituent parts of the OHF Portfolio that were included within the scope of this evaluation. As such, it does not contain the entirety of the activity that is undertaken across the three North-East Health & Social Care Partnerships (HSCPs) + Acute sector. The initiatives deemed as Priorities within this time period were selected and agreed by the OHF Steering Group.

It should be noted that some Priorities are standalone projects, whereas others are programmes of work (i.e. a group of projects). In other instances, particular initiatives span across more than one Priority area (for example, Hospital @ Home in Aberdeen City is aligned to the Frailty Pathway; the Stepped Care Approach; and the Respiratory pathway). These are depicted in Figure 1.

Figure 1. List of the OHF Priorities and their constituent parts (where applicable)

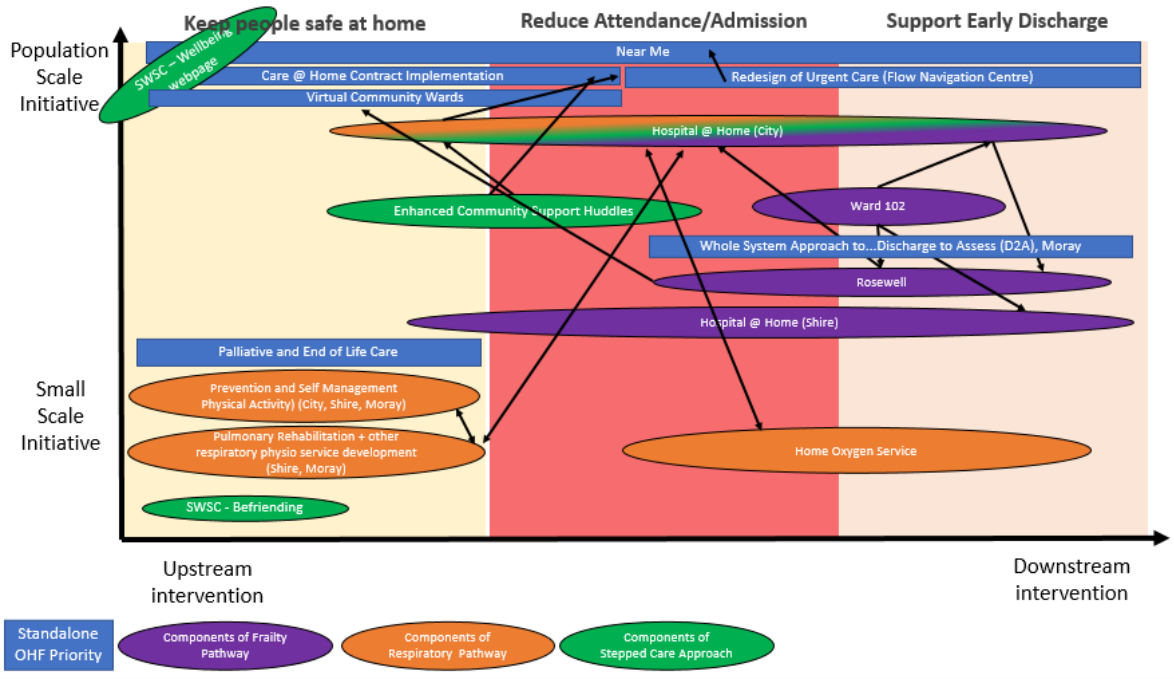
- Care @ Home Contract Implementation (Aberdeen City)
- Frailty pathway (pan-Grampian)
  - Hospital @ Home expansion (Aberdeen City)
  - Hospital @ Home development (Aberdeenshire)
  - Rosewell Intermediate Care Facility (Aberdeen City and Aberdeenshire)
  - Ward 102 (pan-Grampian)
- Near Me (pan-Grampian)
- Palliative & End of Life Care (pan-Grampian)
  - The Oaks Virtual Programme (Moray)
- Redesign of Urgent Care (Flow Navigation Centre) (pan-Grampian)
- Respiratory Pathway (pan-Grampian)
  - Home Oxygen Service (pan-Grampian)
  - Hospital @Home expansion: Respiratory Team (Aberdeen City)
  - Prevention & Self Management (Physical Activity) (3 similar projects in Aberdeen City, Aberdeenshire, Moray)
  - Pulmonary Rehabilitation: addition of 1-to-1 / Home support (Aberdeenshire)
  - Extension to Pulmonary Rehab/Respiratory Physio and associated publicity/education campaign (Moray)
- Stepped Care Approach (Aberdeen City)
  - Enhanced Community Support Huddles (Aberdeen City)
  - Stay Well Stay Connected workstream (variety of initiatives) (Aberdeen City)
  - Hospital @ Home (Aberdeen City)
- Virtual Community Ward (Aberdeenshire)
- Whole System Approach to Discharge (Moray)
  - Discharge to Assess (Moray)

Whilst Figure 1 provides a 'neat list' of the OHF Priorities, it falls short of conveying the true complexity of the Portfolio. Examples of such complexities include but are not limited to:

- *Priority composition* – Whether the Priority is a standalone project or a programme (i.e. a group of projects)
- *Priority scale* – Whether initiatives within the Portfolio are either being conducted at a small scale or a population level
- *Impact on OHF aims* – Not all OHF Priorities impact on all OHF aims
- *Priority emphasis* – Some priorities have a focus on upstream, preventative work, whereas others have a downstream, acute-based focus
- *Interdependencies* – Most OHF Priorities do not operate within a silo. They interact with other parts of the system (for example, Ward 102 will refer into the Aberdeenshire Hospital @ Home service when this becomes operational, meaning that performance on one part of the system can often be directly impacted by another part of the system).

Figure 2 is one such attempt to show these multiple complexities within one visual. It is intentionally convoluted to recognise that evaluation occurring within a complex system will always generate complex answers. It is important to note that this is illustrative only and designed to be a notional presentation of how the entire Portfolio interlinks with each other within the evaluation period defined above (i.e. not a direct comparison as to whether Priority 'x' or Priority 'y' is larger).

Figure 2: Complexity visual of OHF priorities and projects



NB – 'Hospital @ Home (City)' is multi-coloured to represent its presence under several OHF Priority areas.

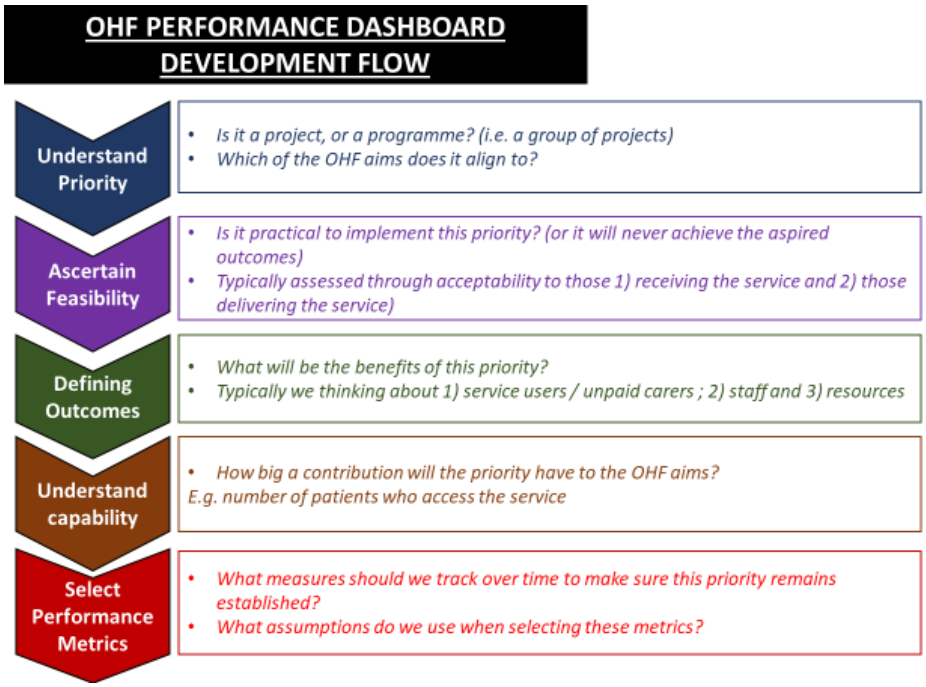
Evaluation Scope and Approach

The principal ask of the original commission was two-fold:

1) Evaluate the impact of the OHF Priorities against the OHF Aims
2) Develop a performance dashboard for ongoing monitoring of Priorities at a strategic level.

The Evaluation Working Group developed and applied a consistent methodology across Priorities, that is visually depicted and described below:

Figure 3. OHF Performance Dashboard Development Flow



Understanding the Priorities individually – Some of the OHF 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 OHF 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 OHF. 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 as rationale as to why that metric was selected.

The above would culminate in bespoke evaluation frameworks being developed across Priorities. This typically followed a standard template for monitoring purposes, illustrated below.

Figure 4. OHF Evaluation Framework Template

Ref	Measures	Aim alignment	Measurement tool / source	Measure frequency	Owner	RAG	Update / comments
1. Service User / Unpaid Carer outcomes							
1.1							
2. Staff outcomes							
2.1							
3. Resource / Service outcomes							
3.1							
4. Process / descriptive measures							
4.1							

NB – Template may / may not include multiple lines under each header. These were co-created and agreed with Priority Leads

All initiatives require a period of embedding before sufficient evaluation can be undertaken. Evaluation has to consider the inputs and processes required to deliver a project, as without these the subsequent outputs cannot be achieved and as such, the impact of the project cannot be realised. This notion is delineated in a simplified manner in the below example logic model.

Figure 5. Simplified Logic Model

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 A&E attendances and hospital admissions in the longer term; improved population health in the longer term.

NB – Content within logic model above aims to provide a balance of commonly applicable elements whilst not trying to exhaustively represent all the individual priorities within OHF Portfolio.

EXAMPLE CASE STUDY

CARE @ HOME CONTRACT IMPLEMENTATION (ABERDEEN CITY)

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.

At the time of evaluation, the new Care @ Home Contract had been implemented (i.e. the Inputs), however changes had not been made to care packages (i.e. the Outputs). Due to this, the perceived benefits of the project (i.e. the Outcomes and Impact) are not currently quantifiable.

This is a good example of an initiative that has the foundations successfully implemented, though requires more time to elapse before a judgement can be made as to whether it has made the desired impact.

The awareness and interest in the OHF Portfolio has grown over the winter period. Due to this, a variety of additional questions, beyond the original commission, have been posed to the Evaluation Working Group as potential areas of interest to explore over the course of its implementation. Given the range of these requests, coupled with the complexities and breadth of the Portfolio itself, a pragmatic approach has been taken within this evaluation. Whilst this report aims to provide a blend of relevant evidence and reflections, it is not a silver bullet and is not possible to be an exhaustive judgement across all facets described below given the timescales in which it was conducted. However, it is hoped that the information gathered and presented here will be beneficial for senior leaders and decision makers in aiding and shaping future service innovation and delivery.

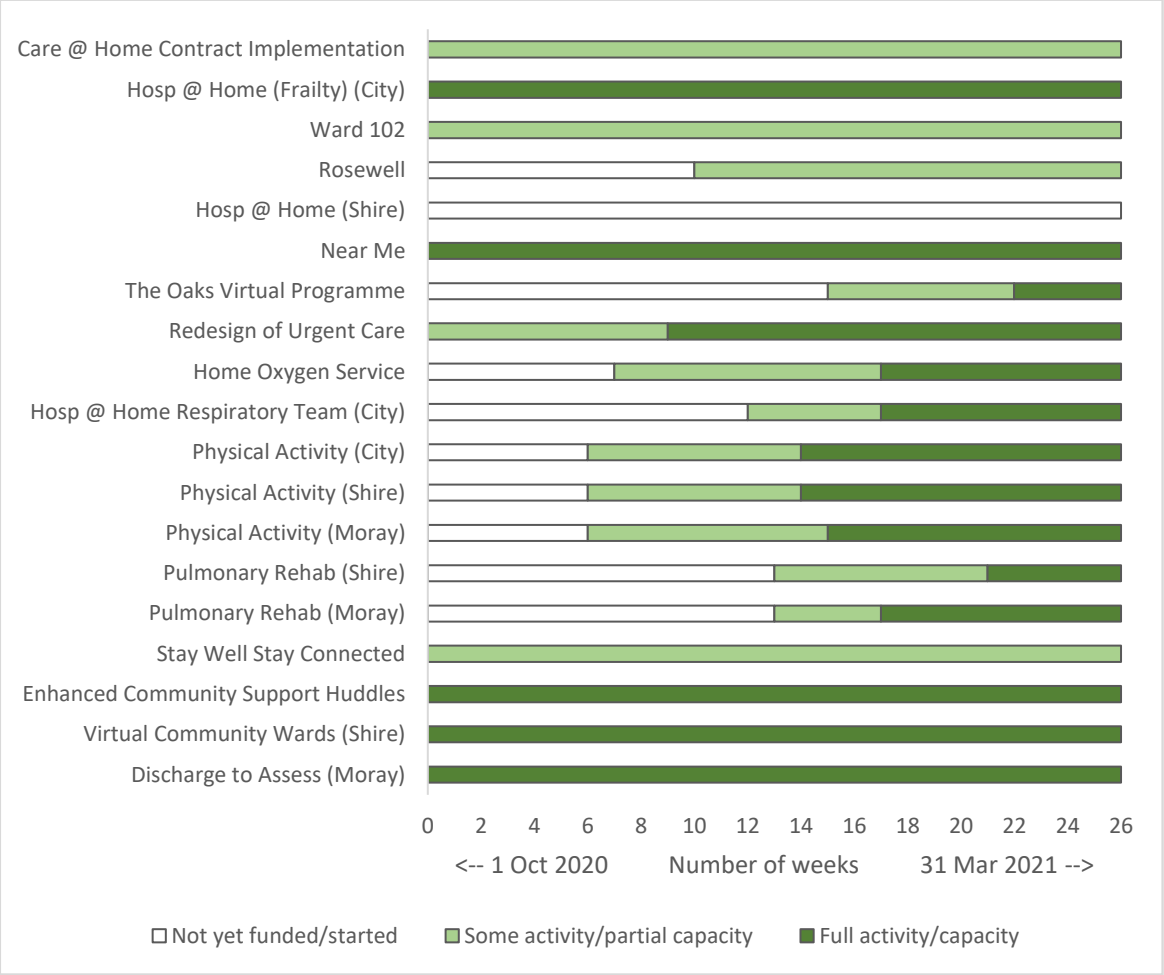
Evaluation Findings

Priority / Project Durations

The below visual aims to depict the degree of activity across different initiatives during the winter planning period. The purpose of this is not to provide a judgement on individual initiatives, instead it is to emphasise that different initiatives have been implemented to various degrees during this period and as such, will have different demonstrable impact.

This emphasises the different degrees of implementation across OHF Priorities. For example, NearMe has been implemented at scale during the winter period, whilst the Hospital @ Home service in Aberdeenshire is still in development. This means that both these initiatives cannot generate the same amount of data and impact within this time period.

Figure 6. Simplified Gantt Chart of OHF Priority Implementation



NB – The time ranges provided within this chart are indicative and subject to the interpretation of the Evaluation Working Group. It is designed to be illustrative for the purposes of demonstrating the differing degrees of implementation across Priorities.

EXAMPLE CASE STUDY

PALLIATIVE CARE CELL (PAN-GRAMPIAN)

The Palliative Care COVID-19 Cell was set up to focus on the issues pertaining to the pandemic and lots of work was progressed very quickly in response to COVID. It became apparent that finalisation of the Palliative and End of Life Strategic Framework, which had been almost ready to launch prior to the COVID outbreak, was a priority, ensuring that the final document reflected any lessons learned during the pandemic.

The main outcomes of the strategic framework are; to ensure people are supported at home at end of life (should that be their choice), reduce inappropriate admissions to acute hospitals and to allow the individual to fulfil their choices at end of life; these ambitions chiming with the ethos of OHF. Unlike the OHF Respiratory Priority which retained the wider Respiratory Cell working group and continued to meet on a weekly basis to progress programmes of work, the Palliative Care COVID-19 Cell was disbanded in September 2020 and responsibility for developing workstreams handed back to the Palliative and End of Life MCN Strategic Advisory Group.

The MCN group met in October (where the Chair announced his imminent retirement) and again in November, however subsequent meetings were cancelled, and the group has not met again during the period this report relates to. The framework has been finalised and is going through the approval process for launch Summer 2021.

The framework was always intended to be devolved to the three HSCPs and Acute sector to implement at a local level. A project that the OHF Evaluation Group has supported is the evaluation of The Oaks Virtual Programme. This was the translation of the palliative day service previously held at The Oaks, Elgin, into a four-week block of hosted virtual classes. Unfortunately, due to staff sickness, the project only ran for three weeks out of the planned four during the OHF evaluation period, with seven people attending. Feedback from patients and staff was generally positive towards this concept:

"Your service brought people in similar situations together. The chat was fun. I feel you are trying to cater for a variety of interests." [Participant]
"The Virtual Programme enabled the patients to form a bond, support network which helped them to arrive happy and comfortable for my online sessions." [Staff]

Roxburghe House, which provides palliative and end of life care for residents across Grampian as well as linking with the Western Isles, Orkney and Shetland, have successfully transitioned their model of day care into a virtual programme and have groups running concurrently.

Priority / Project Reach

As individual initiatives begin, we can start to capture early feedback from people receiving a service, and people providing it (see Appendix A for examples of this from across the Portfolio). Data on the acceptability (or otherwise) of services to patients and staff is an important part of the evidence base for further service development/expansion. Furthermore, for many initiatives in the OHF Portfolio, even in a period of a few months, it has been possible to demonstrate positive impacts on the people directly supported – such as improved clinical measurements and/or improved confidence in their ability to help manage their own condition(s) (again, see Appendix A for examples).

Beyond the immediate (short term) impacts on service users and staff, there has been a desire to evaluate (where possible) the impact (actual/potential) on usage of the health and social care system, and the potential to impact upon the wider population. In this report's section on the Impact on Operation Home First (Table 4), we have collated data on some of the main impacts at system level that it has been possible to source in this comparatively short time frame (from existing IT systems or new data collections developed specifically for OHF evaluation purposes). However, it is also important to be mindful that many of the OHF priorities have been tests of change or have for other reasons operated at relatively small scale. The number of people supported by an initiative may be somewhat smaller than the cohort of people who might be potentially eligible to benefit from it. Thus, whilst initiatives can have positive impact on the relatively small numbers of people they can help, they would need to be sustained/scaled up if they are to reach more of those within the potentially eligible cohort(s). Figure 7 below shows a conceptual example of a project providing support to some of the potentially eligible population, who in turn, are a subset of the whole population. In Table 4, we have collated data on the numbers of people supported by each of the OHF projects during winter 2020/21 (or the part thereof for which they were operational) – the yellow (top) part of this triangle. On the following pages, we provide further statistics, for broad context, on the green (middle) and blue (bottom) parts of this triangle.

Figure 7. Conceptual example of project reach.

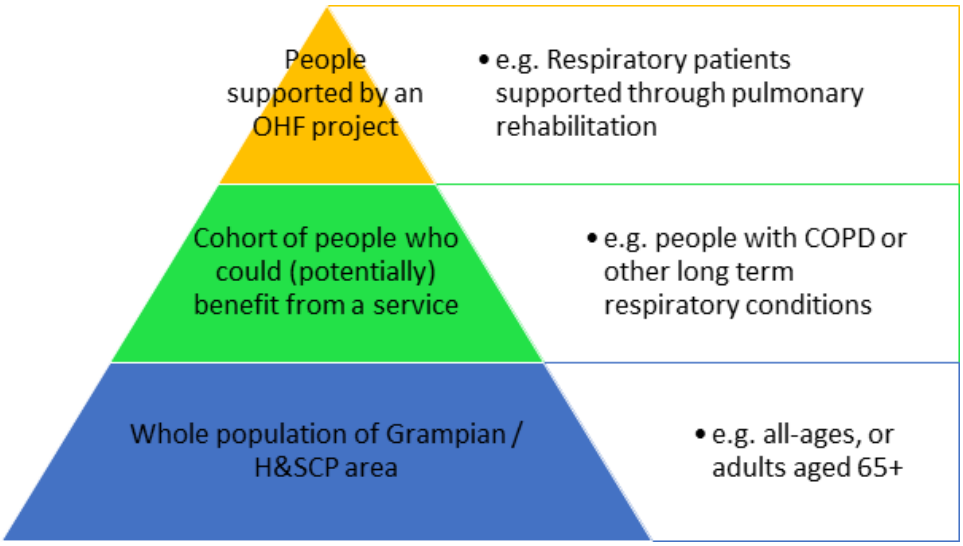


Table 1. Cohorts of people who could (potentially) benefit from a service pathway

Urgent Care

- Anyone of any age may find that they require urgent care, therefore our potentially eligible cohort is our entire population.
- In financial 2019/20 there was an average of nearly 7,400 ED attendances per month at ARI and Dr Gray's Hospital, of which c.4,400 attendances per month were from self-presenters, with a reduced self-presenting footfall during the pandemic, between April and November 2020, of c.2,600 attendances per month.
- Average attendances per month at Minor Injury Units were c.2,700 in financial 2019/20 and c.1,300 in financial 2020/21 up to the soft launch of the Flow Navigation Centre in December 2020.

Respiratory Pathway

- Chronic Obstructive Pulmonary Disease (COPD) is a cause of morbidity and mortality in Scotland, and (along with Asthma) is one of the main long-term respiratory conditions for which population prevalence estimates are available.
- The Scottish Burden of Disease Study estimates that around 11,000 people in Grampian are living with COPD. Numbers by Partnership area are shown in the table below.
- Generally speaking, just over half those with a COPD diagnosis are aged 65+, and just under half are younger adults.

HSCP/Area	Estimated number of people living with COPD (rounded to nearest 100)
Grampian	11,200
Aberdeen City	4,000
Aberdeenshire	5,000
Moray	2,200

Source: Scottish Burden of Disease Study

- Whilst preventable and increasingly treatable, the airflow obstruction seen in COPD is usually progressive. It is thus (amongst other respiratory conditions), an example of where supports can be put in place relatively upstream (e.g. physical activity classes) and otherwise in community settings (e.g. pulmonary rehabilitation) to delay or avoid hospital admissions in the months or years ahead.

Frailty Pathway

Healthcare Improvement Scotland have estimated that "*there are approximately 560,000 people living with frailty in Scotland - just over 10% of the population. Of this, 355,000 people are living with mild frailty, 151,000 with moderate frailty, and 50,000 with severe frailty. Growing numbers of older people are being admitted to hospital in an emergency and some of those admitted will deteriorate further or experience a delay in returning home due to being frail. Evidence shows that delivering early and effective Comprehensive Geriatric Assessment (CGA) for people living with frailty has potential to improve their outcomes and experience of care*."
Source: The Frailty at the Front Door Collaborative Impact report December 2019

If we apply these estimated numbers to the Grampian population – assuming that levels of frailty are similar to elsewhere in Scotland - this would translate as

- Roughly 60,000 people living in Grampian with some degree of frailty, of whom
- Roughly 5,000 may be living with severe frailty.

Palliative and End of Life Care

Research published in 2020 projects that across Scotland, by 2040, the number of people requiring palliative care will increase by at least 14%; and by 20% if multi-morbidity is factored in. https://bmjopen.bmj.com/content/11/2/e041317.

Whole population of Grampian and our three Health and Social Care Partnership areas.

The estimated Grampian population (all ages) is 585,700. The totals by Health and Social Care Partnership are: 261,210 in Aberdeenshire, 228,670 in Aberdeen City, and 95,820 in Moray.

Approximately 1 in 5 people in our population are aged 65 and over (although this varies between 15.8% for Aberdeen City and 21.6% for Moray). Projected population change in Grampian over the 10 years from 2018 to 2028 is expected to reflect increases in the numbers of people aged 65+ (up by 20%), and decreases in the numbers of younger adults, and children.

Table 2. Grampian population by age group, 2019.

	Under 15	15-24	25-44	45-64	65+	% aged 65+
Grampian	94,839	64,733	159,549	158,633	107,946	18.4%
Aberdeen City	33,642	28,745	75,359	54,767	36,157	15.8%
Aberdeenshire	46,107	25,661	62,120	76,249	51,073	19.6%
Moray	15,090	10,327	22,070	27,617	20,716	21.6%

Source: National Records of Scotland mid-year population estimates

Impact on Operation Home First Aims

Overview of priorities mapped versus OHF aims

The below table maps each of the OHF Priorities against each of the aims. To iterate, the aims of home first are:

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

Whilst this mapping demonstrates the intended impact against each of the aims, it does not mean that at the time of writing, Priorities are delivering on this. As stated above, Priorities that are still in development or operating at a small scale will only have minimal impact, with more time warranted before these aspirations can be fully achieved. Priorities that do not deliver against particular aims should not be perceived as inferior, as it was never the intention of all Priorities to directly impact on all aims.

Table 3. OHF Priorities Mapped Against OHF Aims

Priority Name	**OHF Aim 1**	**OHF Aim 2**	**OHF Aim 3**
Stepped Care Approach (Stay Well Stay Connected Workstream)	✓		
Stepped Care Approach / Frailty Pathway / Respiratory (Hospital @ Home Aberdeen City)	✓	✓	✓
Stepped Care Approach (Enhanced Community Support Huddles)	✓	✓	✓
Stepped Care Approach / Respiratory Pathway (Hospital @ Home expansion: Respiratory Team)	✓	✓	✓
Frailty Pathway (Ward 102)	✓	✓	✓
Frailty Pathway (Rosewell)		✓	✓
Frailty Pathway (Hospital @ Home Aberdeenshire)	✓	✓	✓
Care @ Home Contract Implementation	✓	✓	✓
Redesign of Urgent Care (Flow Navigation Centre)	✓	✓	
NearMe	✓	✓	
Respiratory Pathway (Home Oxygen Service)		✓	✓
Respiratory Pathway (Physical Activity Classes)	✓		
Respiratory Pathway (Pulmonary Rehabilitation)	✓		
Respiratory Pathway (Extension to Pulmonary Rehab / Respiratory Physio)	✓		
Palliative & End of Life Care (The Oaks Virtual Programme)	✓		
Whole system approach to discharge (Discharge 2 Assess)		✓	✓
Virtual Community Wards	✓	✓	

NB –Boxes in dark shade with tick mark denote association between Priorities and Aims. Less / no association is denoted by light shading. Mapping was done in collaboration between Evaluation Working Group Members and associated Priority leads.

Impact of Priority vs OHF Aims

The below table expands on the above mapping exercise by providing illustrative examples of how Priorities have impacted upon different aims. Its purpose is to provide information whereby the strongest correlations between Priorities and the OHF aims are present and quantifiable.

Table 4. OHF Priorities Mapped Against OHF Aims

Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
Stepped Care Approach	'Wellbeing Matters Webpage' (part of Stay Well Stay Connected workstream) received more than 1100 visits over a 12 month period, providing a number of helpful resources of keeping and staying well (though it is not possible to quantify whether this directly resulted in keeping people safe at home).	330 patients brought to the Enhanced Community Support Huddles since June 2020 whom would be at risk of hospital admission if interventions had not been implemented.	Hospital @ Home in Aberdeen City have cared for 184 patients through the Supported Discharge route in the last 12 months, helping get people out of hospital in a timely manner.
Frailty Pathway	General Practitioners have direct access to senior clinicians in Ward 102, meaning admissions have been avoided (and people kept safely at home when appropriate to do so) through discussing presentations and reviewing care options.	Hospital @ Home in Aberdeen City have cared for 321 patients through the 'Alternative to Admission' route in the last 12 months. Rosewell accepted one step-up admission into the facility that otherwise would have been a hospital admission.	Rosewell accepted 85 step-down admissions in the first two months of operation, thus reducing the pressure on secondary care services.
Care @ Home Contract Implementation	As of May 2021, Granite Care Consortium are supporting 1063 individuals.	Impact not yet reviewed as changes to type of care provision were not implemented at the time of writing.	Impact not yet reviewed as changes to type of care provision were not implemented at the time of writing.
Redesign of Urgent Care	Nearly 5,500 referrals have been made from NHS 24, with over 1,000 directed to the Flow Navigation Centre (FNC) and nearly 4,500 to the Minors Decision Queue, at an average of c.200 clinical referrals per week allowing people to stay safe at home and only attend hospital when absolutely necessary following a virtual consultation.	Only 58% of patients referred to the FNC and the Minors Decision Queue (FNC: 45%; Minors: 60%) have required a face-to-face appointment minimising the need for patients to attend ED or a minor injury unit, with 42% given self-care advice or re-directed to primary care following a virtual consultation.	Not applicable as Priority not adjudged to be aligned to aim.

Operation Home First Portfolio Evaluation

Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
NearMe	Service deals with over 3500 remote consultations per week as of February 2021, allowing people to stay safe at home.	44% of patients referred to the FNC and Minors Decision Queue did not need to attend a face-to-face appointment following a Near Me consultation.	Not applicable as Priority not adjudged to be aligned to aim.
Palliative & End of Life Care	**The Oaks Virtual Programme:** During the month of March 2021, 7 palliative patients were able to attend a 4-week programme of hosted virtual sessions from the comfort of their own homes.	Not applicable as Priority not adjudged to be aligned to aim.	Not applicable as Priority not adjudged to be aligned to aim.
Respiratory Pathway	**Hospital @ Home (H@H)**: During the 11 weeks to end March, 11 respiratory patients were admitted; between them this came to 60 H@H bed days.	**H@H:** Of the 11 patients admitted during this short period, 4 were 'Alternative to Admission' to Aberdeen Royal Infirmary.	**H@H:** Of the 11 patients admitted during this short period, 7 were 'Active Recovery / Supported Discharge'.
	Not applicable as Priority not adjudged to be aligned to aim.	**Home Oxygen Service:** In the last weeks of the financial year, the Team developed a rapid assessment service for immediate/ urgent referrals for oxygen to prevent admission. Seven referrals were received and assessed the same day and oxygen supplied in four cases, with an average installation time of 128 minutes.	**Home Oxygen Service:** Over the course of 9 weeks the Team were able to directly assess 36 inpatients for home oxygen. 28 patients were discharged within 2 days of assessment. A case review estimated average savings of 4.8 bed days per patient.
	Pulmonary Rehabilitation (PR) (Shire): In 10 weeks late Jan-end March, 51 patients had initial assessments. 27 started 1 to 1 (Home) PR block, of which 23 completed. 11 patients declined or unsuitable to continue.	**PR (Shire):** Unknown due to short timescale of project. Had capacity and follow-up time allowed, we would have looked at admissions up to 6/12 months pre- and post-intervention.	**PR (Shire):** Not impacted during this short project life span, but there is potential for it to do so in future.

Priority Name	Impact vs OHF Aim 1 (Keep people safe at home)	Impact vs OHF Aim 2 (Reduce unnecessary hospital attendance / admission)	Impact vs Aim 3 (Support early discharge)
	Extension to Pulmonary Rehab (PR) / Respiratory Physio – Moray: In 12 weeks early Jan-end March, 54 patients assessed (43 for PR + 11 for other respiratory physio), of which 17 started virtual PR and 7 completed block of virtual classes. And a further 8 started and completed Home PR.	**PR / Respiratory Physio (Moray):** Unknown due to short timescale of project.	**PR / Respiratory Physio (Moray):** Not captured during this short project life span, but there is potential for it to do so in future.
	Leisure Projects / Physical Activity Classes (Grampian): Between January and March 2021, 64 people with chronic respiratory conditions participated in 6-week blocks of instructor-lead, online physical activity classes.	Not applicable as Priority not adjudged to be aligned to aim.	Not applicable as Priority not adjudged to be aligned to aim.
Whole system approach to discharge	Not applicable as Priority not adjudged to be aligned to aim.	**Discharge 2 Assess (D2A):** Over the 25 weeks of the Discharge 2 Assess project 9 patients were redirected from Dr Gray's Emergency Department, saving an estimated 81 bed days.	**D2A:** Between October 2020 and March 2021 48 in were discharged via D2A. This reduced average length of stay by 1 day saving 48 bed days.
Virtual Community Wards (VCW)	For FY2020/21 quarter 3, 213 VCW admissions were reported by 17 GP practices who submitted returns (out of the 25 GP practices signed up to the VCW SLA) .* * In 2019/20 average of over 330 VCW admissions per quarter. It was not mandatory for GP practices to submit VCV quarterly returns in FY2020/21 however they were asked to submit data where available., It is planned that formal reporting on a quarterly basis, to monitor and understand the impact of VCW, will resume for 2021/22 for all practices signed up to the VCW SLA.	A previous audit found that the VCW model was able to manage 66.3% of all admissions at home, subsequently reducing unnecessary hospital admissions. This percentage was 38.3% greater than the presumed patient outcome as predicted by clinicians.	Not applicable as Priority not adjudged to be aligned to aim.

NB – The above data is not exhaustive, nor is it all collected over the same time frames (given the data provided previously regarding when Priorities went live and the scale at which they operate)

Performance Monitoring / Dashboard Development

One key output of the original commission was to develop a performance dashboard for the ongoing monitoring of priorities at a strategic level. This performance dashboard has been developed as part of an iterative process and consists of a minimal set of key performance metrics, aligned to the three OHF aims, that have been identified following the five-step development process set out in Figure 3. This performance dashboard has been designed to provide the OHF Steering Group with an indicative impact of the Portfolio at a high-level.

One key enabler in the development of such a performance dashboard is the need for it to be supported by a robust data and intelligence infrastructure. To achieve this goal we have adopted a tiered approach to performance monitoring, building on existing reporting and working to capture better data and address any data gaps, to get the right information to the right people at the right time and help facilitate data-driven decision-making across the OHF Portfolio of programmes and projects. As just like a house, strong foundations and pillars are required to support the roof (i.e. the performance dashboard).

Our tiered approach to performance monitoring and dashboard development, from the operational level up to the OHF Steering Group, consists of relevant and timely metrics structured across three tiers.

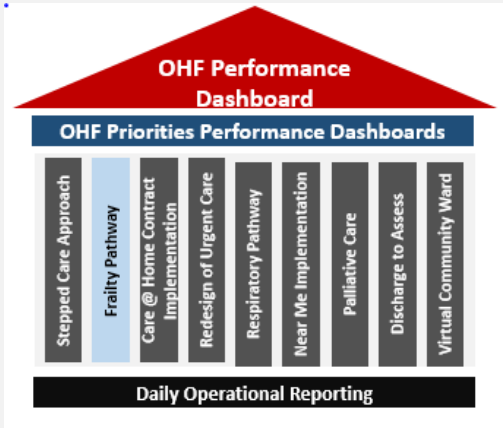
- Tier One (i.e. the roof) comprises of the performance dashboard for the OHF Steering Group. The performance dashboard contains a minimal set of outcome-based key metrics that most directly align with OHF aims and can be used to understand the overall impact of the portfolio at a high-level. Updated monthly, this performance dashboard consists of an overall summary that can be filtered by metric, aim alignment, priority alignment and sector, and supplemented by a high-level dashboard for each individual priority area that allows further drill-down of the respective key performance metrics within.
- Tier Two (i.e. the pillars) comprise of a suite of dashboards covering a wider set of metrics. We have currently developed tier two dashboards for the larger scale initiatives within the OHF portfolio. These dashboards, developed based on the respective needs of the Frailty Pathway Delivery Group and Redesign or Urgent Care Governance Group, help explain the causes of variation in Tier One performance for these Priority areas and why performance is improving or declining. Within the Tier Two dashboards the end-user can make a variety of selections, including specifying date range, the filters to apply for drill-down and choose the view (e.g. snapshot, trend or date table). These dashboards are updated weekly.
- Tier Three (i.e. the foundations) builds on the existing routine reporting in place. The metrics within these dashboards align with detailed daily operations that drive performance and ultimately provides the foundation for the first and second tiers. These dashboards are updated daily and drives the development of daily operational plans for achieving the desired outcomes and for monitoring progress.

This suite of dashboards will help provide a sustainable solution for measuring and reporting of performance from the operational level up, for projects both within the OHF Portfolio and as they transition to ‘business as usual.

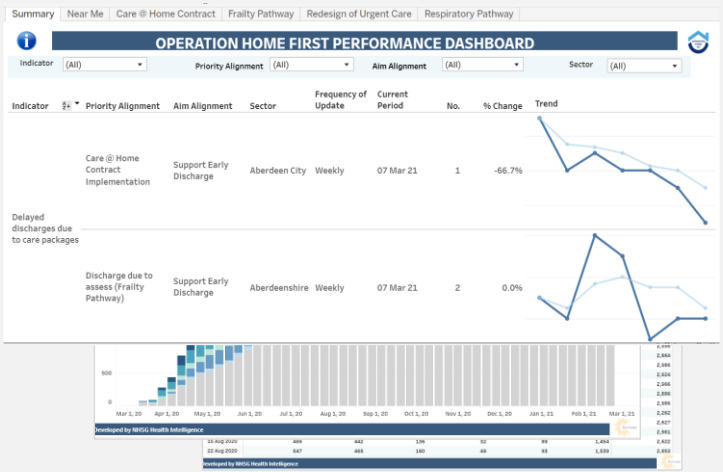
Figure 8 below provides an example of the tiered approach to performance monitoring we have implemented for the frailty pathway.

Figure 8. Example of Tiered Approach to Performance Monitoring Related to the Frailty Pathway

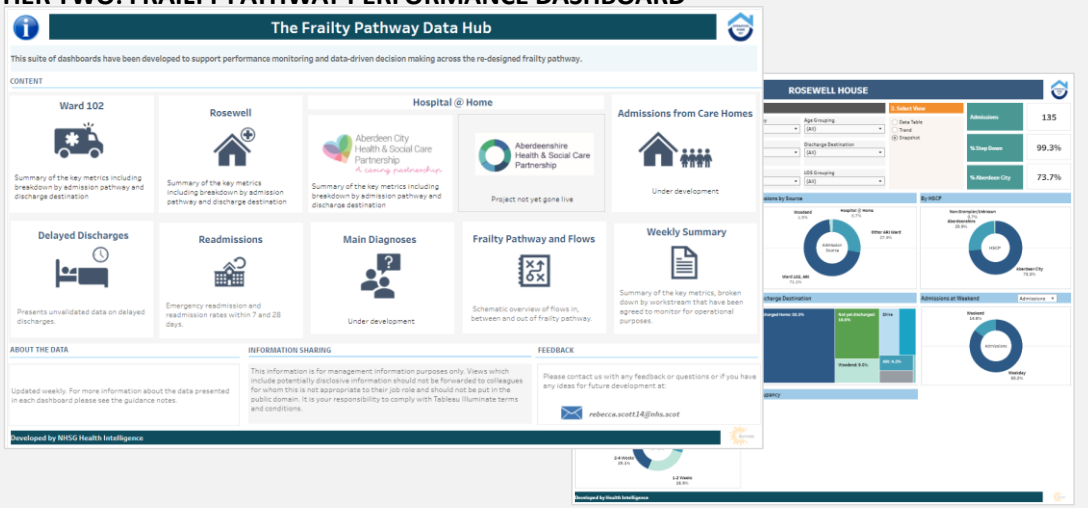
THE 'HOME FIRST' HOUSE OF METRICS



TIER ONE: OHF PERFORMANCE DASHBOARD



TIER TWO: FRAILTY PATHWAY PERFORMANCE DASHBOARD



TIER THREE: ABERDEEN CITY DAILY SURGE & FLOW OVERVIEW DASHBOARD

Additional reflections

Notes on Cost Dimensions

This report is not the product of a cost-effectiveness exercise. The primary drivers behind OHF were about keeping people safe at home during a global pandemic and avoiding / reducing hospital usage, where possible, in what was expected to be an even more challenging winter planning period than usual.

The OHF Portfolio consists of numerous initiatives targeting one or more of its aims (see Table 3: OHF Priorities Mapped Against OHF Aims on page 14). A multitude of factors influenced the development of individual projects: aligned priority, governance, perceived short-term vs. longer term benefit, scale, requirement for initial funding, resource, etc. Some tests of change were essentially ready to go at the time the Evaluation Working Group was formally commissioned, others developed during the evaluation reporting period and for some, the benefits of a change are yet to be recognised (Figure 6. Simplified Gantt Chart of OHF Priority Implementation). With these points in mind, an attempt to validate the full OHF Portfolio on economic grounds would meet with little success. However, economic-specific data collection practices have been utilised in some initiatives within this Portfolio to better understand this dimension and, in some instances, provide a basis for securing sustained investment. Discharge 2 Assess in Moray is one such example (see Figure 9. D2A Case Study Infographic for details).

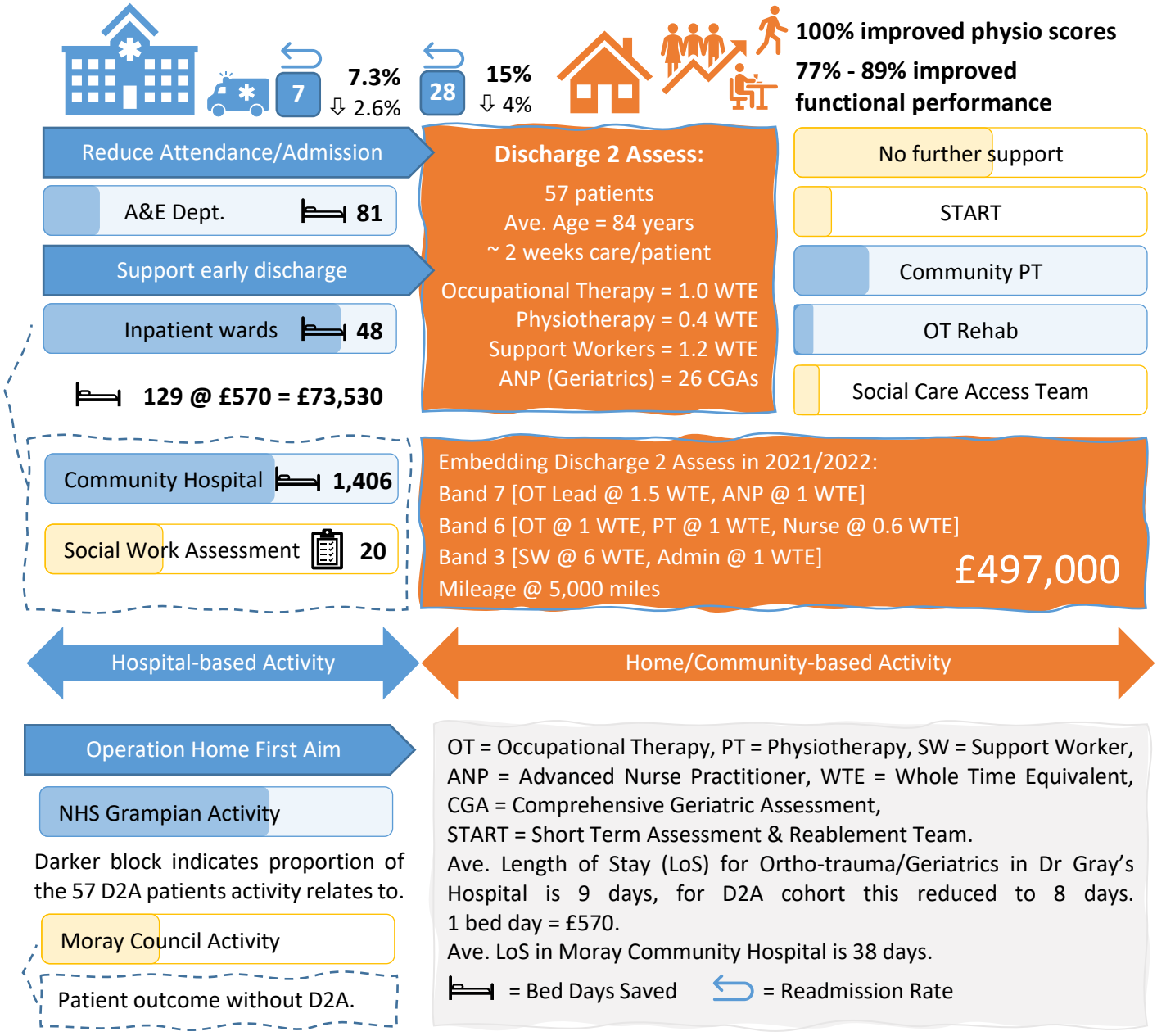
The Discharge 2 Assess (D2A) project introduced an established model of intermediate care, utilised in other parts of the country, to Moray. Its focus is those patients who are clinically stable and do not require acute hospital care but who may still require rehabilitation and care support in the short term. Assessment in the patient's home helps prevent admissions from A&E and reduces length of stay in acute wards. Length of stay, measured in bed days, is a standard NHS metric. By comparing the length of stay for the patients seen by the D2A team with the average for the specialties or wards most benefitting from D2A involvement, it is possible to calculate a bed days saved figure. In turn this can be converted to a cost or cost saving using figures obtained from national publications such as the NHS Costs Book.

Table 5. Bed Day Calculation used in Discharge 2 Assess

Item	Bed Days
Average Length of Stay in Dr. Gray's Hospital (Ortho-trauma & Geriatric Specialties)	*9*
Average Length of Stay in Dr. Grays Hospital for inpatients seen by D2A	*8*
Number of inpatients seen by D2A	*48*
Number of inpatient bed days saved through D2A [(9 – 8) x 48]	*48*
Number of patients attending A&E Department discharged to D2A	*9*
Number of bed days saved through admission avoidance [9 x 9]	*81*
Total number of bed days saved [48 + 81]	*129*

The NHS Costs Book puts a figure of £570 per bed day for the named specialties in Dr. Grays so simply multiplying the number of bed days saved by this gives an indication of potential savings: 129 x £570 = £73,530

Figure 9. D2A Case Study Infographic



D2A limits the transfer patients to Moray's community hospitals to those with more complex rehabilitation or discharge needs; it is estimated that two thirds of the patients seen by D2A team would otherwise have been placed in a community hospital. The average length of stay in Moray's Community Hospitals is 38 days so the so the saving in bed days is great (37 x 38 = 1,406).

Traditionally, social care assessments are carried out prior to discharge and this can result in delayed stays in hospital and packages of care that are not required or are over-specified. Figures for the average cost of care package for patients who were assessed in the relevant wards in Dr Gray's Hospital could have been obtained from Health & Social Care Moray and compared with the average cost of ongoing social care packages for patients managed by D2A, however this was felt to be unnecessary in the face of strong NHS evidence.

"I wanted care for my Mum and thought this was what Mum needed but these (D2A) therapists found she was far more able then we thought and she was able to manage at home."

The results from the D2A project are positive, with only a few patients being referred for ongoing support, much of it temporary in nature e.g. modifications to their home to enable the patient's ongoing independent living. Indeed, whilst indicative costs in terms of Bed Days Saved were provided in the formal business case to Senior Leadership Team and Moray IJB, the mapping of actual outcomes against a non-D2A model and overwhelming support from key stakeholders, the patients and their carers, negated the need for an in-depth costings exercise.

D2A provides a good example of how easy to obtain and well understood hospital data can quickly add an economic dimension to the evaluation of a project. In theory then, with time allowing, OHF projects seeking to tackle Aim 2 (Preventing hospital attendance/admission) and Aim 3 (supporting early discharge) could follow suit should that be a primary driver of interest.

The Physiotherapy-lead, Pulmonary Rehabilitation project in Aberdeenshire added an economic dimension to the evaluation by combining hospital financial data with project specific costings. Evidence from published sources makes a strong case for pulmonary rehab effectively preventing future admissions to acute care. The spend-to-save model is shown in Table 6.

Table 6. Spend to save model used in Pulmonary Rehabilitation project

Item	Cost per client (£)
Average direct cost for Respiratory Admission at ARI (see Table 7: Estimated costs associated with hospital inpatient stays)	*3,615*
Pulmonary Rehab service average cost (inc. travel)	*267*
Average saving per patient	*3,348*

Table 7: Estimated costs associated with hospital inpatient stays

Hospital	Specialty	Sum of direct costs per case	Average length of stay (days)	Average cost per bed day
Aberdeen Royal Infirmary	General Medicine	£1,492	3.7	£403
Dr Gray's	General Medicine	£1,289	4.0	£322
Aberdeen Royal Infirmary	Geriatric Assessment	£3,412	5.2	£656
Dr Gray's	Geriatric Assessment	£2,902	6.6	£440
Aberdeen Royal Infirmary	Respiratory Medicine	£3,615	6.2	£583

Source: NHS Costs Book 2019/20 (R040 tables) https://beta.isdscotland.org/find-publications-and-data/healthcare-resources/finance/scottish-health-service-costs/

The more upstream / preventative the project, the less relevant published hospital data becomes and other financial models become necessary to express the economic benefits of funding these projects. For example, being physically active could prevent hospital admission for many years, so presenting the benefit of the virtual exercise classes by comparing costs of delivering the service with a hospital admission is not necessarily a strong correlation. Third sector organisations are used to using Social Return on Investment (SROI) approaches to attract funding, whilst health economists might argue the benefits of Cost-Benefit or Cost-Consequence models. Whilst recognising these approaches, they were out of scope for a Portfolio-level evaluation, and would require a separate methodology to be systematically implemented across all initiatives to understand more fully.

Health Inequalities Synthesis

By health inequalities we mean systematic, avoidable and unjust differences in health and wellbeing between different groups of people which arise because of the conditions in which they are born, grow, live, work and become older. Legislation exists to address health inequalities in the UK including the Health and Social Care Act 2012, which addresses inequalities in access to health services and outcomes of different groups of people[1].

Ensuring equitable access to services is a key priority to address issues of inequalities in health. In the below table, the Evaluation Working Group have provided an appraisal to each Priority through a health inequalities lens, specifically how initiatives actively address this, or whether closer monitoring is required as time progresses. It should be noted though that this evaluation is not (and was never designed to be) a rigorous Health Inequalities Impact Assessment. Such an assessment should be conducted as a separate commission if this is desirable, though the below appraises elements of such with particular reference to access of services.

[1] Reducing Health Inequalities – The Health and Social Care Act 2012. Available here

Table 8. OHF Priority Appraisal through a Health Inequalities Lens

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Stepped Care Approach (Stay Well Stay Connected - Wellbeing Matters Webpage) Aberdeen City	Whilst being an initiative of Aberdeen City Health & Social Care Partnership, the webpage is technically available to anyone with an internet connection. For the small cohort of individuals who do not have access to the internet, wellbeing manuals have also been developed in paper copies to provide information of wellbeing resources locally.
Stepped Care Approach (Stay Well Stay Connected - Student Befriending Pilot) Aberdeen City	Befriending pilot exists to support those who already may experience health inequalities, as reasons for referral included social isolation, bereavement or being geographically distant from family members. Initiative still at small scale to prove the concept, therefore mechanisms of identifying appropriate individuals should be considered as part of the scale-up plan to minimise the impact of potentially exacerbating health inequalities.
Stepped Care Approach (Enhanced Community Support Huddles) City	With a recent Audit of service provision demonstrated that patients brought to the Huddle from North, Central and South localities was 36%, 30% and 34% respectively, this suggests that the model is operating effectively with regard to geographical reach (though further analysis of patient deprivation not conducted within would reinforce these findings). Multi-disciplinary team input across a variety of professions mean that the reach across different population cohorts is large. This will be further improved as participation of Primary care services increases.
Stepped Care Approach / Respiratory Pathway (Hospital @Home expansion: Respiratory Team) Aberdeen City	Although a very small team, operating only in the latter weeks of the Winter 2020/21 period, the Hospital @ Home Respiratory service was about to support referrals via both the Alternative to Admission route and 168 via the Supported Discharge route, showing that both routes had access into this service. Service delivered in a person's home, reducing the need for them to travel to access services.
Respiratory Pathway (Home Oxygen Service) Pan-Grampian	Inpatient assessment for home oxygen to support discharge was made available to non-Respiratory consultants in ARI, with virtual support provided to consultants in DGH. In 9 weeks, the Home Oxygen team enabled the discharge of 28 patients, including 2 young palliative patients who were able to die at home surrounded by their families, which otherwise would not have been possible. The rapid home assessment service aimed at preventing hospital admission was only available to those living in or around Aberdeen City.

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Respiratory Pathway (Prevention & Self-Management (Physical Activity) Online Classes) Pan-Grampian	The delivery of online, instructor-led, physical activity classes for patients with chronic respiratory diseases was identified as a proactive approach to halt and reverse the decline in health due to lack of opportunities to partake in exercise. Successful bids for Winter Funding via the Respiratory Cell enabled the purchase of equipment to ensure those who may otherwise have been excluded from the classes, could fully participate. 1:1, telephone-based, instruction was also provided to a few patients, for whom the digital technology was not appropriate. Links with the Pulmonary Rehab projects ensured people were able to access the most suitable option for their condition. Feedback showed that participation in these classes provided confidence to use digital technology for other purposes.
Respiratory Pathway (Physiotherapy-led Pulmonary Rehabilitation addition of 1-to-1 / Home support) Aberdeenshire	Delivered home pulmonary rehabilitation to patients who were unable to access online classes. Additionally, to contribute to reducing health inequalities, the team supported those with no access to transport who, in normal circumstances, would struggle to attend classes due to the rurality and lack of infrastructure around public transport.
Respiratory Pathway (Extension to Pulmonary Rehabilitation/Respiratory Physiotherapy and associated publicity/education campaign) Moray	This project has been Moray-wide (access to virtual pulmonary rehabilitation is not dependent on where someone lives) whereas before it was locality-based (depended on sufficient people to be worth running the face-to-face class, otherwise they would be offered a class in a different locality). Digital access is now within the team's current establishment to increase sign posting to community digital services, and potential for loanable technology to help reduce digital access inequalities (they are awaiting arrival of ordered iPads). The Moray physiotherapy team are still doing home pulmonary rehab to help reach patients for whom support via Digital is not an option/not appropriate (previously coming into the class was the only option, the team did very little home PR).
Frailty Pathway (Hospital @Home) Aberdeen City	Service now operates at scale across Aberdeen City, with referrals accepted both from community-referring services (i.e. General Practices across the City) and secondary care service (i.e. Geriatric Assessment Unit in Aberdeen Royal Infirmary). Recent audit showed 308 referrals via the Alternative to Admission route and 168 via the Supported Discharge route, showing that both routes have access into the service. Service delivered in a person's home, reducing the need for them to travel to access services.

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Frailty Pathway (Hospital @Home) Aberdeenshire	Service is not currently live so a health inequalities appraisal is not yet appropriate. However, close collaboration with developers of the Hospital @ Home model in Aberdeen City will help produce insights of best practice of implementing such models to reduce the likelihood of health inequalities occurring.
Frailty Pathway (Ward 102) Pan-Grampian	Given reductions in the number of geriatric beds, this does result in Ward 102 frequently carrying a proportion of boarders in different wards (i.e. patients who should be cared for in the ward but instead are elsewhere in this hospital). Reducing this is directly dependent upon capacity being scale up elsewhere in the system to facilitate flow, for example scaling up the Hospital @ Home model, or increasing the bed base at Rosewell.
Frailty Pathway (Rosewell) Aberdeen City & Aberdeenshire	Whilst Rosewell appropriate received almost exclusively step-down admissions from secondary care settings during its initial period of implementation, the longer-term vision for the facility was that of a community-facing intermediate care setting. Given this, the proportion of Step-Up vs. Step-Down referrals should be monitored closely to ensure there is equitable service provision focussing not just on accelerated discharge from hospital, but also avoiding admission to hospital by accessing the service.
Care @ Home (Contract Implementation) Aberdeen City	The move away from timed tasks to providing care tailored to the need of individuals may mean that more person-centred care can be delivered. The development of Granite Care Consortium is hoped to enhance market stability, meaning that the total hours of unmet need reduce over time. Whilst changes have not been made at the time of evaluation, this should be monitored as implementation develops. Service delivered in a person's home, reducing the need for them to travel to access services.
NearMe Pan-Grampian	NearMe provides a digital solution, thus making services broadly more accessible, particularly to those living in geographically dispersed areas. However, telephone consultation can still be used between patients and clinicians and face to face consultations can still be had if physical examinations are necessary. As such, there are other means by which individuals can access services, should they not be digitally connected.

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Redesign of Urgent Care (Flow Navigation Centre)	All NHS Boards in Scotland have been required to establish Flow Navigation Centres as part of the Scottish Government's Redesign of Urgent Care national programme. An initial "Discovery Report" commissioned by the Scottish Government, noted: that "*A fundamental part of the unscheduled and urgent care redesign is that this does not further disadvantage or widen health inequalities*." *"Key Findings:* • *The level of understanding and comprehension of current and future systems was low.* • *More deprived individuals have low levels of access to telephony and to appropriate spaces to make telephone calls.* • *The emotional and practical needs of users must be met to provide a satisfactory experience.* • *Frustrations with primary care drive self-presentation at A&E.* *The service as it stands today does not build in additional measures to prevent a further widening of health inequalities. We would recommend Mitigation steps."* The Scottish Government are leading/commissioning further analysis and work on the service redesign, to further identify and plan further service changes to mitigate against widening inequalities. National evaluation of the redesign of urgent care is recommencing, and it would be desirable for Grampian's evaluation activities to link in with the national work, where possible.
Palliative & End of Life Care (The Oaks Virtual Programme) Moray	The restrictions in place to prevent the transmission of COVID-19 prohibited the reintroduction of a face-to-face service for this vulnerable patient group at the current time. The translation of the palliative day service previously held at The Oaks, Elgin, into a four-week block of hosted virtual classes ensures support to this cohort is maintained. Issues of access to technology is a potential barrier to participation, though can be addressed through partnering with agencies whose specific remit is to encourage uptake of digital access. This in turn, reduces another barrier to participation through physical travel across the area to attend a class in person.

Priority Name (Project name in brackets)	Appraisal through a Health Inequalities Lens
Whole system approach to discharge (Discharge 2 Assess (D2A), Moray	For most people, being cared for at home, rather than hospital, is preferable and produces better outcomes (i.e. reductions in functional decline). D2A directly addresses the needs often associated with (prolonged) stays in hospital, through a multi-disciplinary, patient-centred approach. By instilling the confidence to continue to live as independently as possible, the provision of support services are kept to a minimum, freeing up capacity in the health and social care system for those who require more sustained treatment.
Virtual Community Wards Aberdeenshire	Model is established and used through Aberdeenshire. Particularly beneficial given the geographical dispersion of the area that allows for people of interest to be monitored closely if required. Service delivered remotely, reducing the need for people to travel to access services.

Operation Home First Evaluation Working Group Priority Appraisal

Given the data provided above, with specific regard to Priority timescales; degree of implementation and evidencable impact, the below Table provides an appraisal, from the Evaluation Working Groups perspective, as to the delivery of each of the OHF Priorities.

Table 9. Evaluation Working Group Appraisal of OHF Priorities

Priority Name	Evaluation Working Group Appraisal
Stepped Care Approach (Stay Well Stay Connected Workstream)	Staff working on workstream were redeployed to support other system-wide priorities during time of evaluation, including COVID vaccinations and Surge & Flow, resulting in some work slowing. Priorities within workstream have now been refreshed to account for the new context and should be allowed sufficient time to be developed and implemented before concluding their effectiveness.
Stepped Care Approach / Frailty Pathway / Respiratory (Hospital @ Home Aberdeen City)	Hospital @ Home model has been subject to rigorous evaluation previously, demonstrating acceptability to service users; unpaid carers and staff. Model delivers strong benefits aligned to OHF through caring for people at home and subsequently reducing pressure on secondary care. Given the ambitions of OHF, scaling this service further would be valuable.
Stepped Care Approach (Enhanced Community Support Huddles)	The huddles directly support the reduction of potential admissions or re-admissions to hospital by providing wraparound support using a virtual multi-disciplinary team approach. The huddles care for similar numbers of patients across Aberdeen City's localities and demonstrate high levels of acceptability from staff who attend, the majority of whom agree that this model improves patient care. Further work to engage Primary Care services will enhance their function.
Frailty Pathway (Ward 102)	Priority has focused on enablers to ensure the system operates more optimally, for example the development of criteria-led discharge and implementation of Rockwood scoring within the Emergency Department. The 'performance' in Ward 102 is inextricably linked to Hospital @ Home / Rosewell Priorities, with capacity required out-with the hospital setting to facilitate flow. The scale-up of Hospital @ Home and ability to open the remaining 10 beds in Rosewell may both help reduce the number of boarders the Ward faces.
Frailty Pathway (Rosewell)	The intermediate care facility effectively reduced the pressure on secondary care during the winter period by allowing flow out of Aberdeen Royal Infirmary. Ongoing organisational development work is required to support the growth of a 'One Team' culture, and such an ethos will require patience to manifest. Increasing the proportion of Step-Up referrals will be critical to avoid preventable hospital admissions and should be regularly monitored to ensure this is achieved.
Frailty Pathway (Hospital @ Home Aberdeenshire)	The model was under development during the evaluation period, meaning there are no deliverable benefits yet. However, there is strong evidence from the Aberdeen City Hospital @ Home model, and other similar models implemented nationally, that this will be valuable to adopt. More time is required to allow this service to go live before reviewing its impact.

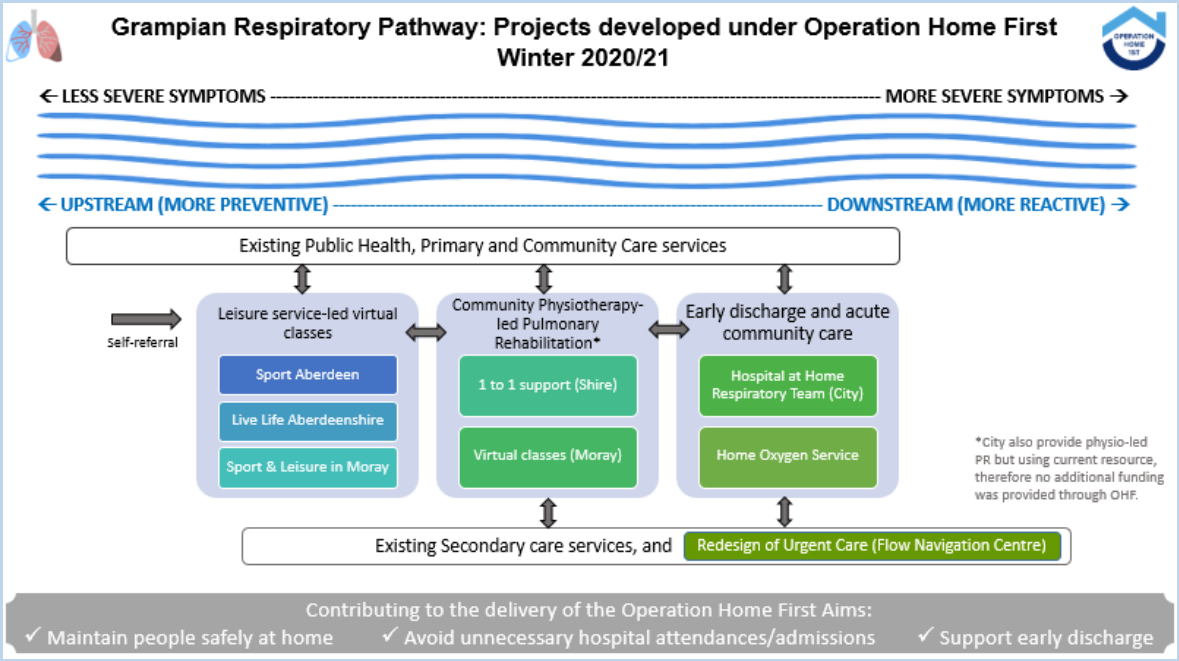
Priority Name	Evaluation Working Group Appraisal
Care @ Home Contract Implementation	During the evaluation period, the new Care @ Home contract had been implemented, however changes had not been made to the type of care that service users received. Therefore, more time is required to make a judgement on the impact of this new contract. However, Granite Care Consortium staff reported to be satisfied within their caring role and cited numerous perceived advantages to this way of working, including more flexibility as service users' wellbeing increases and decreases.
NearMe	Service has been scaled up since the COVID-19 pandemic and continues to support large numbers of people to be cared for across community and secondary care services virtually. It is highly acceptable to service users and staff. It is only used when safe and appropriate to do so, with telephone and face-to-face consultations still options if required. This is now an established model of delivery that will be valuable to continue in future.
Redesign of Urgent Care (Flow Navigation Centre)	This work is part of an ongoing, 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 A&E/Minor Injuries Units if there are more appropriate sources of help and support. The programme leads within Grampian, and nationally, will continue to develop the service further, and with it, monitoring of relevant data to support both service operation and evaluation.
Stepped Care Approach / Frailty Pathway / Respiratory Pathway (Hospital @ Home expansion: Respiratory Team)	Local and national evaluations have shown that the Hospital @ Home model is well received and delivers good outcomes. This expansion of Hospital @ Home capacity in Aberdeen City was only for a short period and at small scale but again delivered good results, with substantial opportunities for future development. This is reinforced in Policy Direction/further funding opportunities at Scotland level. We would therefore suggest that there is merit in restarting and extending the Hospital @ Home respiratory team. UK researchers are doing further work on the economic evaluation of Hospital @ Home.
Respiratory Pathway (Home Oxygen Service)	The potential for changes to the Home Oxygen Team's way of working was demonstrated but not fully realised due to the unsuccessful recruitment of an additional staff member. There was no promotion of changes due to concerns over inundating the delivery of the existing service. The inpatient assessment test of change, supported by winter funding, highlighted the fact that home oxygen is not solely for patients suffering pulmonary conditions; most assessments and facilitated early discharges were for non-Respiratory specialties. Professional and patient support for this project was very high. Continued engagement between the evaluation team and Home Oxygen lead is necessary to understand key learning points from these brief tests of change and identify ways that service could implement these.

Priority Name	Evaluation Working Group Appraisal
Respiratory Pathway (Pulmonary Rehabilitation - Aberdeenshire)	This project successfully delivered home-based, 1 to 1 Pulmonary Rehabilitation, to patients who could clinically benefit from it, but who were not able to access support via Digital means (or it was not suitable for them). Thus, even at its small scale, it played a part in helping to reduce inequalities. Additionally, as with other projects on the Respiratory pathway, the team communicated and cross-referred with other project teams, e.g. the Home Oxygen Service and Live Life Aberdeenshire (Physical Activity Classes). This was a good demonstration of integrated working. The Scottish Government's Respiratory care - action plan: 2021 to 2026 makes clear that "*A critical part of the respiratory care pathway is access to pulmonary rehabilitation*", and whilst the Shire physiotherapy team are continuing to provide group classes, consideration should be given again funding to further develop this service, e.g. to continue providing 1 to 1 support for those who are unable to access digital options, or for whom the group support is not appropriate (i.e. not to widen inequalities); to further develop links with the Home Oxygen Service / Acute.
Respiratory Pathway (Extension to Pulmonary Rehab / Respiratory Physiotherapy - Moray)	The team developed and delivered virtual Pulmonary Rehabilitation (PR) classes for the first time in Moray. They also undertook other small tests of change, including support for Home Oxygen reviews (saving staff and patient travel to/from hospital). This project used OHF funding to raise awareness of the existence (and benefits of) PR and respiratory physiotherapy, and associated referral pathways, amongst fellow health professionals in Moray. The team developed training and resources to increase capacity, within existing establishment, to take PR/Respiratory physiotherapy referrals – and saw an increase in such referrals during Jan-Mar 21 relative to Jan-Mar 2019. Even at small scale, this has been a very positive example of service development and (subject to ongoing resourcing) has the potential to continue to grow as part of an integrated respiratory pathway.
Respiratory Pathway (Physical Activity Classes)	Established with winter funding via the Respiratory Cell, the local sports providers (Sport Aberdeen, Live Life Aberdeenshire, Moray Council) developed programmes of instructor-led, physical exercise classes delivered virtually to patients whose respiratory illness had likely become compromised during the pandemic. A common evaluation framework was agreed to enable outcomes to be measured at both individual provider and collective Grampian levels. Whilst the late application for funding and time from award to implementation did mean that the number of weeks the classes could run was limited, feedback from those who participated (patients and the instructors) was very positive. The approach taken with this project shows great potential for expanding to include those with non-respiratory long-term conditions, making the service more viable. The benefits are wider than just improving physical health, with known links to improved mental wellbeing, peer-group support, reduced isolation, increasing digital literacy and so forth. A more robust evaluation framework over a longer period would surely yield benefits across the entire system.

Priority Name	Evaluation Working Group Appraisal
Palliative & End of Life Care (The Oaks Virtual Programme)	Despite only being able to deliver 3 of the 4 intended weeks for the first Virtual Programme, feedback from the patients who attended was very positive and showed that physical, group sessions are not the only acceptable format for supporting people's palliative care needs. The fact that Roxburghe House is continuing to develop their virtual offering further supports this view, although the experience of the team at Roxburghe House does show that frequent (weekly) 1:1 support will be essential for some patients. The design of a Grampian-wide Virtual Programme, complemented by individual support, when necessary, may help to promote equity of access, although there are significant resource implications requiring further consideration. Evaluation support for development of this programme will be essential to fully recognise the value of such an offering.
Whole system approach to discharge (Discharge 2 Assess)	Discharge 2 Assess is a great example of the adoption of a tried initiative that has been developed elsewhere in the country to fill a gap in local service provision. Whilst the figures from the D2A pilot are very encouraging at patient, staff and service levels, without a doubt the service lead's enthusiasm and tireless campaigning played a huge role in the successful implementation of the service. It is no coincidence that whilst D2A is currently "offline" for staff recruitment, Moray once again is struggling to manage its Delayed Discharge numbers. Funding for the service through 2021-2022, should be accompanied with evaluation support to maximise the service potential and cement the business case for permanent funding.
Virtual Community Wards	No significant changes to delivery during evaluation period whilst resources were diverted to developing Aberdeenshire's Hospital @ Home model. However, this Priority has been established as business as usual and its impact well evidenced.

Figure 10. Development of the Respiratory Pathway

EVALUATION APPRAISAL CASE STUDY: DEVELOPMENT OF THE RESPIRATORY PATHWAY



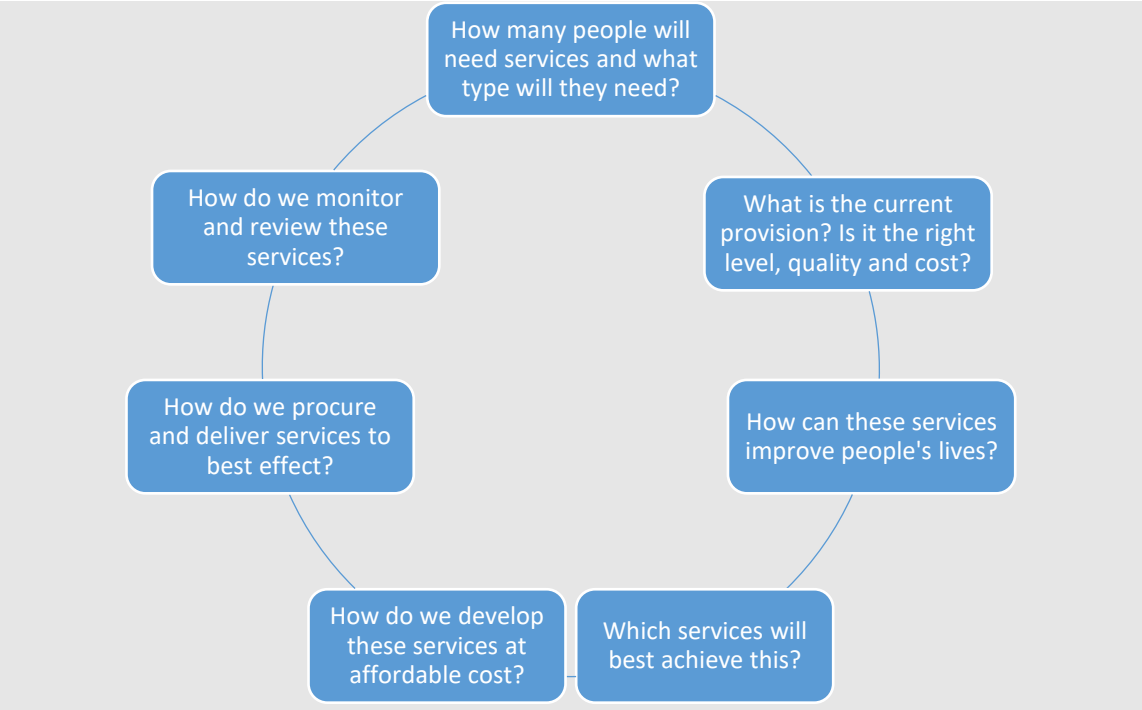
- The work of the GRAM Respiratory Cell in developing a series of inter-connected projects on the Respiratory Pathway, has been a good example of an OHF Priority area taken forward in an inclusive and actionable way.
- The Respiratory Cell is an extension to the pre-existing Managed Clinical Network (MCN), with enhanced Multi-disciplinary (clinical and non-clinical) working.
- The projects developed/extended with Winter 2020/21 monies have comprised a balanced mix of upstream and downstream supports, mindful of the often progressive nature of many respiratory conditions, and the opportunities to prevent people with relatively moderate illness from becoming more severely unwell.
- Project development has been nimble and flexible.
- The pathway's projects are inter-connected, and even at very small scale have demonstrated commitment to communicate with each other, inclusive of cross-referring patients as a function of the progression (or improvement in) their clinical condition.
- Many areas of potential to progress the work of the Cell have been identified, both at Strategic and Project level, subject to resourcing in the months ahead.

Strategic Context / Next Steps

The development of the OHF Portfolio was driven in large part by the combination of a requirement to remobilise services amidst ongoing COVID-19 restrictions, and to mitigate against expected pressures on acute services during the October 2020 – March 2021 winter period. The evaluation of OHF has taken place during a (COVID-19 necessitated) acceleration of service (re)development and (tests of) change. Many elements of work were reflective of existing Strategic Plans (and have good alignment with the aims of health and social care integration), but with additional, more reactive layers.

Taken as a whole, this is a complex portfolio, with many programme strands at different stages and paces of development. Over the course of various exchanges with staff over (and after) the life span of OHF, it appeared that awareness in the wider workforce of OHF as a concept may not have been high as a whole, sitting as it did in conjunction with the winter planning period, and between Grampian's two other "Operation" phases of Rainbow and Snowdrop. We understand, however, that there is a strategic appetite for the ethos of "Home First" to become more embedded in Business as Usual for integrated health and care services across Grampian. To help it become so, we would recommend that project and programme evaluation is maintained as an integral part of the Strategic Commissioning Cycle, complementary to other key steps in that cyclical "Plan, Do, Study, Act" (PDSA) process. The visual below, drawn from the Scottish Government's Strategic Commissioning Plans Guidance, illustrates that amongst the questions pertinent throughout the commissioning process, there is a natural place for a range of Evaluation activities, alongside other relevant work such as Needs Assessments and Performance Monitoring. Such evaluation may be in respect of the ongoing "Home First" Portfolio, and/or other areas of relevant service provision.

Figure 11. Questions pertinent throughout the Strategic Commissioning Process



Redrawn from: https://www.gov.scot/publications/strategic-commissioning-plans-guidance/

It is also relevant to consider again where the strands of the OHF Portfolio sit in relation to regional and national policy and strategy, inclusive of key documents that were published during the winter 2020/21 period or shortly thereafter. We have bulleted, and then tabulated, some of these below. It is not an exhaustive list, but we have included here as they are of relevance in informing strategic decision-making going forward.

- The Redesign of Urgent Care will continue to be a priority for the Scottish Government (SG), with further actions and evaluation anticipated.
- The SG, with support from Healthcare Improvement Scotland, are continuing to promote the development of Hospital @ Home services. A paper published earlier this year has added to the evidence base around the benefits of Hospital at Home.
- The SG have in recent weeks published their Respiratory care - action plan: 2021 to 2026. Amongst the recommendations in this is that Pulmonary Rehabilitation services be provided in all areas.
- The Independent Review of Adult Social Care in Scotland ("the Feeley Report") is of particular significance, and we can anticipate that this will have substantial implications going forward.
- Other portfolio-relevant themes such as Frailty, and Intermediate Care, remain on the national agenda for the continuation/continued development of services with a "Home First" focus.

Table 10. Some Relevant Key Strategic Literature Relevant to the OHF portfolio (with particular focus on those published during the winter 2020/21 period)

Redesign of Urgent Care (Flow Navigation Centre)
Healthcare standards: Urgent Care (Scottish Government) https://www.gov.scot/policies/healthcare-standards/unscheduled-care/ *"It is considered that approximately 20% of patients who self-present at A&E could be helped to access more appropriate services for their needs and often care that is closer to home. The need for new ways of delivering services during COVID-19 has demonstrated what can be achieved to keep people safe and that there are a range of alternative ways to access NHS services which are available, in addition to traditional face to face care. The Redesign of Urgent Care looks to build on these opportunities to support the public to access the Right Care in the Right Place at the Right Time."*
Hospital at Home
Shepperd et al (2021). Summary on Hospital at Home Society website: https://www.hospitalathome.org.uk/hah-study-rct, links to full paper at https://www.acpjournals.org/doi/10.7326/M20-5688 Results of a randomised trial of >1,000 H@H patients in the UK. • Providing healthcare at home to selected older people who experience a deterioration in health rather than in hospital could reduce pressure on hospital resources and be less disruptive to older people • In this study, outcomes for patients who received 'Hospital @ Home' care were just as good six months later, as for those who were admitted to hospital • There were higher levels of patient satisfaction with Hospital @ Home care. • It is not yet known whether Hospital @ Home care is cheaper than hospital-based care, but the research team are investigating this in an economic analysis.

Intermediate Care

Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland (Scottish Government, 2012) https://www.gov.scot/publications/maximising-recovery-promoting-independence-intermediate-care-framework-scotland/.
The framework encourages the development of a range of integrated services that can provide alternatives to hospital admission, and provide step-down care after a hospital admission.

The landscape for bed-based intermediate care in Scotland (Royal College of Nursing, 2017) https://www.rcn.org.uk/about-us/our-influencing-work/policy-briefings/sco-pol-the-landscape-for-bed-based-intermediate-care-in-scotland.
"There is a small but growing evidence base on how bed-based intermediate care supports improved system and individual outcomes." (…) *"Intermediate care beds are also seen as a mechanism to deliver more cost-effective care. However, a recent paper by Nuffield Trust looking at delayed transfers of care in England noted 'it cannot be assumed that alternatives to hospital will save large amounts of money unless far more radical changes to the system are made'. Looking at intermediate care beds specifically, there is mixed evidence on whether the use of intermediate care beds increases or reduces costs in comparison to hospital care."*

Respiratory pathway

Respiratory care - action plan: 2021 to 2026 (Scottish Government, 24 March 2021)
https://www.gov.scot/publications/respiratory-care-action-plan-scotland-2021-2026/
This plan "*identifies key priorities and commitments to improve outcomes for people living with respiratory conditions in Scotland. The plan encourages new and innovative approaches and intends to share best practice. It sets out our desire to see a whole system approach to respiratory care, across health and social care."* It notes that *"provision of high quality, joined-up respiratory care across Scotland must be the priority. New investment in well trained, multi-disciplinary healthcare teams is critical, right now."* Examples of Priorities as applicable to the Operation Home First Portfolio include (but are not limited to), the following:

Priority 2- Diagnosis, management and care.
"A critical part of the respiratory care pathway is access to pulmonary rehabilitation. [This offers] a structured exercise and education programme designed for people living with a respiratory condition." (…) *"Pulmonary Rehabilitation is one of the most effective forms of management for people living with respiratory conditions. 90% of people who complete the programme experience improved exercise capacity or increased quality of life. However, Chest Heart and Stroke Scotland (CHSS) estimates that only 2% to 21% of those who might benefit are being referred to pulmonary rehabilitation. Pulmonary rehabilitation is best established within treatment for COPD, however there is evidence of clear benefit in asthma, pulmonary fibrosis and bronchiectasis."*

Priority 3 – Supporting Self-Management
"Self-management (…) *requires a strong partnership with health professionals and access to a wide range of support networks."* (…) *"Self-management techniques are well established within long-term conditions and during the COVID-19 pandemic, they became more important than ever. With access to hospital and community services disrupted, people were forced to take a different approach to manage their condition."*

Priority 5. Workforce
"Allied Health Professionals (AHPs) play a significant role in the treatment and care of respiratory conditions in Scotland. The development of more advanced roles means we are seeing more AHP-led services."

"We recognise the importance of including wider sectors within workforce planning. There is vast support available within the third sector and we should consider opportunities of developing pathways and partnerships with organisations such as Chest Heart Stroke Scotland and Asthma UK and the British Lung Foundation."

Frailty

The Frailty at the Front Door Collaborative Impact report December 2019 (Healthcare Improvement Scotland iHub). https://ihub.scot/media/6870/201912-frailty-at-the-front-door-collaborative-impact-report-v10.pdf

"*There is compelling evidence to support the benefits of early and effective Comprehensive Geriatric Assessment (CGA), re-enablement and intermediate care for people living with frailty. The benefits for people and organisation include:*

- *improved care experience,*
- *a reduction in the need for hospital care by consideration of a range of care options,*
- *people who are more likely to be supported in their own home with the appropriate level of care, and*
- *shorter periods of time in hospital if admission is required*."

https://www.cochrane.org/CD006211/EPOC_comprehensive-geriatric-assessment-older-adults-admitted-hospital

Independent Review of Adult Social Care in Scotland, February 2021 ("the Feeley Report").

https://www.gov.scot/publications/independent-review-adult-social-care-scotland/.

There were 53 recommendations in this report, many of which reinforce messages inherent to the aims of Health and Social Care Integration, such as outcomes focussed commissioning, and preventive/upstream services. Below are some excerpts from those recommendations that have particular relevance to the OHF Portfolio (although this should not be taken to mean that the other recommendations do not). We can expect actions around the 53 recommendations to come to the fore as preparatory work for the establishment of a National Care Service gets more fully underway.

Models of care

"28. The Scottish Government should carefully consider its policies, for example on discharge arrangements for people leaving hospital, to ensure they support its long held aim of assisting people to stay in their own communities for as long as possible."

"31. Investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. Investment in, or continuance of, models of social care support that do not meet all of these criteria should be a prompt for very careful reflection both by a National Care Service and local agencies."

Finance

"50. Careful analysis by a National Care Service, with its partners in the National Health Service, Integration Joint Boards and beyond, of opportunities to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes such as those experienced by people who are delayed in hospital."

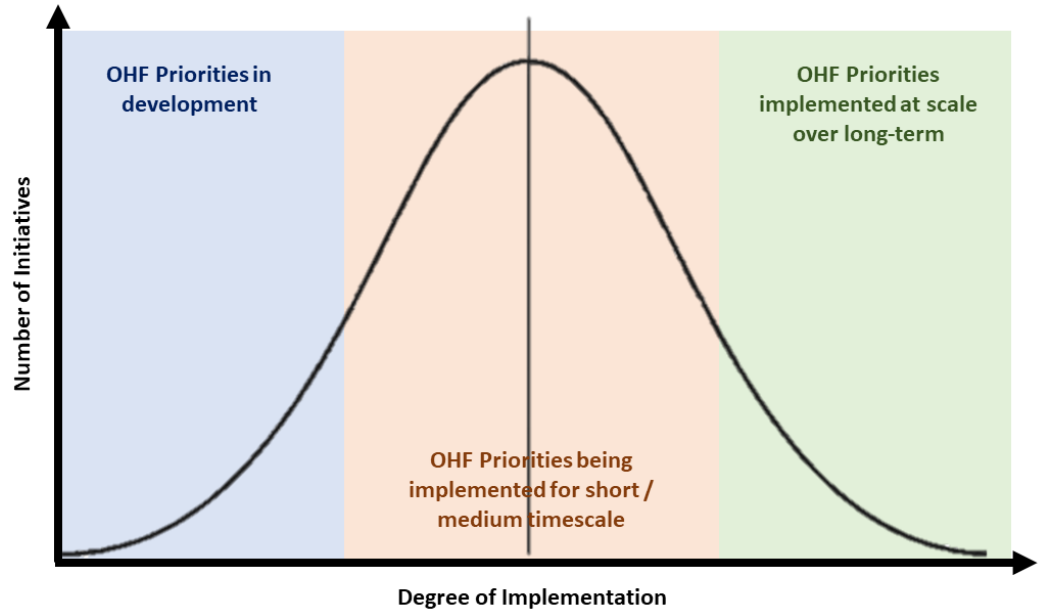
"51. Additional investment in order to:

- *expand access to support including for lower-level preventive community support"*

Summary / Discussion

The purpose of this report was to evidence the impact of the OHF Portfolio against its three aims of maintaining people safely at home, reducing unnecessary hospital attendances/admissions, and/or supporting early discharge. The report has also aimed to address a variety of additional queries that have been posed to the Evaluation Working Group over the course of its lifespan, including evidence of health inequalities; evidence related to cost; and the potential scalability / population-wide reach of different Priorities. Given the complexity of the Portfolio, the answers of its impact are complex, with different initiatives occurring at different scales over different time periods. Broadly speaking, Priorities in their infancy still demonstrate acceptability to service users and staff, whilst numerous Priorities have been evidenced to directly impact on the OHF aims. These are typically activities that strongly correlate to reducing pressure on secondary care, such as Hospital @ Home. Overall, the implementation of the OHF Portfolio can be illustrated using a bell curve to denote different initiatives sitting at different stages of development/implementation.

Figure 11. Bell curve illustrative of OHF priorities being implemented to varying extent.



Cumulative Impact

This evaluation intentionally stops short of providing grand totals, either for the cumulative impact on each of the OHF aims, or for other factors deemed of interest (such as financials). There are inter-related reasons for this:

1) The OHF portfolio is vast and heterogeneous, even within the deceptive simplicity of its three key aims. It has a mixture of upstream / downstream activity, Priorities occurring as small tests of change / at scale and Priorities impacting on one or more aims. Providing such grand totals would be a reductionist interpretation of the true value of the Portfolio.
2) Provided the context above, it is not possible to, with 100% accuracy, determine the totality of the Portfolio. Even with sweeping assumptions across the suite of activities within, it would likely underestimate the full impact.
3) Additionally, we are mindful that to attempt a detailed Economic Evaluation of the portfolio would require us to secure further resource, with the requisite skill base required to be

implemented concurrently with a separate, systematic methodology applied across all initiatives within the Portfolio, for that particular type of analysis.

This provides some key insight into how / what an evaluation of a complex Portfolio looks like. It is important to reiterate that this Portfolio emerged through a variety of complex social-economic / political factors (though primarily out of necessity given a global pandemic) and as such, required the implementation of an agile, multi-modal and pragmatic evaluation approach to concurrently run alongside.

Data Collection Considerations

Key to determining the impact of any initiative is the data that are available / able to be gathered. The more data that can be gathered, the more confident and robust conclusions can be. However, this requires more time and capacity to be invested in order to make this happen.

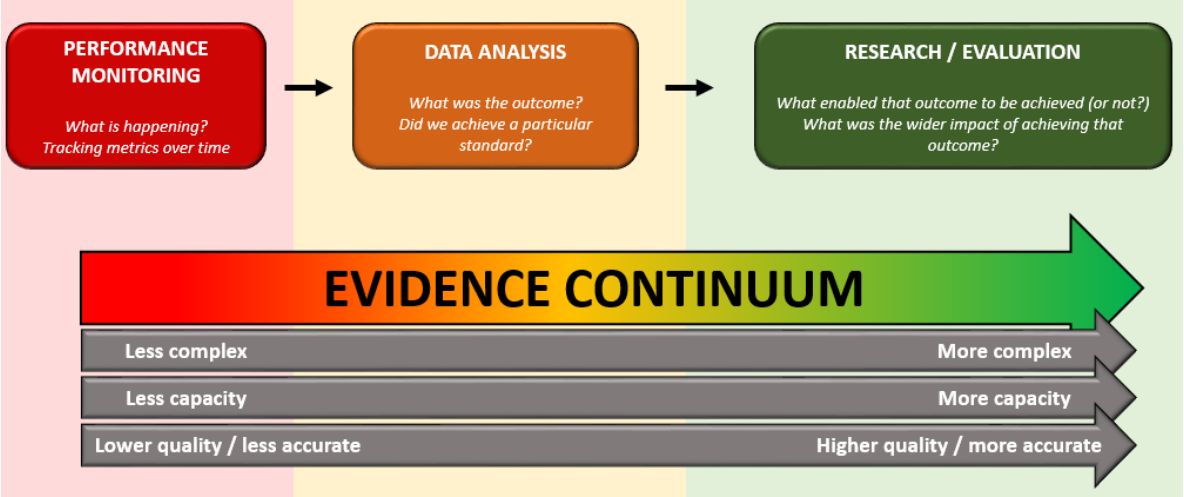


Figure 12. Evidence Continuum

For each initiative described within, the trade-off between time, capacity and evidence considerations had to be reviewed and judged at an individual level. Initiatives in their development phase during the evaluation period were able to closer align their data collection methods and requirements to that of the aims of the Portfolio. Other initiatives that were already implemented prior to this period have existing performance monitoring frameworks that are not necessarily feasible to adapt, particularly if they are long established. However, having an evaluation team with strategic oversight of such a Portfolio allow for connections / linkages to made across different initiatives to provide a clearer perspective on its cumulative impact. This also means that operational staff can focus more time on service delivery, a particularly pertinent point given the pressures the health and social care system have been under during the COVID-19 pandemic.

Resourcing

As aforementioned, not all OHF Priorities have been implemented to the same degree across the period of evaluation. One reason for this is challenges around resourcing and competing priorities. For example, a survey circulated to the OHF Priority leads (N=17) at the beginning of the evaluation period returned a mean score of 5/10 with regard to perceived confidence that the necessary resources (i.e. staffing) were available to deliver the change. In some instances, changes to particular Priorities were slowed to allow for acceleration in others (for example, the Palliative Care workstream decelerated activity as the relevant Occupational Therapists were assigned to Moray's Discharge 2 Assess project

instead). As highlighted in Figure 2, it is to be expected that implementing such a Portfolio with a variety of interdependencies would consequently result in prioritisation having to occur.

The long-term resourcing of Priorities within the OHF Portfolio is also variable. Some initiatives, such as the Respiratory Cell's Home Oxygen and Leisure projects were delivered using winter monies and, whilst demonstrating measurable benefits, are not subject to long-term investment. This is where the value of implementing a robust evaluation framework becomes apparent, as it provides senior leaders and decision makers with information to support decision making towards investing in initiatives that are thought to deliver tangible benefits. One such example is the Discharge 2 Assess project in Moray, which received the necessary ongoing funding from their Integration Joint Board to scale up and care for more people. It is recognised that in some instances, the long-term investment in one initiative may only be possible with the disinvestment in others, however a judgement on potential areas of disinvestment was out of scope for this report.

Equity of Evaluation Support

As mentioned above, initiatives competing for the same resources has meant that some projects have been prioritised over others. The same tension is evident within the capacity of the Evaluation Working Group to support all initiatives equitably. Given the pressure secondary care services were under during the winter period, initiatives that directly impact on this typically received greater emphasis of evidencing impact than upstream activities. One example of this was the rapid evaluation of the Rosewell Intermediate Care Facility, that was completed within a five-week period to inform the future direction of the service. It should also be recognised that the capacity of colleagues to engage with the evaluation process can be variable, particularly if service areas are under pressure. In these situations, the priority of the Evaluation Working Group is to minimise the additional burden of primary data collection and to review existing data infrastructure to draw as accurate conclusions as possible given the constraints.

Perceived Value of External Evaluation Support

The OHF Portfolio was novel, insofar as dedicated evaluation resource, comprised of a cross-system working group, was established to evidence this impact. Below, case studies were voluntarily written by Leads of some OHF Priorities to explain, from an implementation perspective, the value that this external support provided.

Reflections on Evaluation Support for the GRAM Respiratory Cell

"I think having you both [Evaluation Working Group Members] involved from the outset has allowed us to not only think about evaluation (in terms of looking back and seeing how something has worked or not worked) but to consider evaluation in advance and in the design stage. This has resulted in not only some new questions being asked or issues considered at the design stage but has helped sharpen focus and bring additional perspective to our projects."

"I think being able to use data / information / feedback for assessment is incredibly valuable, but I think being able to use that prospectively and having that be an integral part of project working on an ongoing and evolving basis is even more valuable. This helps underpin our work with a level of intelligence and assurance and allows us to have a much stronger basis for recommending things start, continue, adapt or stop and I think that has been to our considerable benefit."

"From my discussions with Kris [Cell Deputy chair] and Angie [Cell chair] I am confident that the above is reflective of their views also."

Robert O'Donnell, MCN Co-ordinator, NHS Grampian.

Reflections on Evaluation Support for Rosewell (Frailty Pathway)

"As we explore and try out new models of integrated working, it is critical that we can evidence the impact of the change that we are making. This information will let us see: how much progress we are making; whether that progress is in the intended direction; and at the pace we need.

The establishment of a new integrated model at Rosewell was achieved at pace, during the second wave of the pandemic and at a time of intense winter pressures. The model, while in line with the strategic intent for Rosewell as a key component of Operation Home First and the Frailty Pathway, was implemented in response to the civil contingencies crisis at that time.

A rapid evaluation within two months of implementation allowed the project team to be clear (supported by robust data), about the impact the new model was making - in terms of feasibility to staff and service users. This has allowed direct focus on specific areas as the interim model continues. This will allow for focussed modifications to be made during the extended test period, concurrently with other changes to the system as a result of remobilisation and changes in demand, allowing robust information to inform decisions on what will be best to put in place in the longer term.

There is no doubt, that without the initial capacity around the rapid evaluation, very early on in the change process, we would not be in such an informed position, which could have resulted in negative impacts, such as a longer required test period, and/or the project not meeting its desired outcomes."

Gail Woodcock, Interim Managing Director (Bon Accord Care)

Reflections on Evaluation Support for the GRAM Redesign of Urgent Care (RUC) Governance Group

"The evaluation team have brought a clear insight, direction, and drive. They have understood exactly what was asked of them to complement the governance of the RUC programme. I would argue that they are integral to the programme moving forward as we continue to evaluate in more depth the feedback from patients, but also staff as to the effectiveness or otherwise of the RUC programme."

John Thomson, Divisional Clinical Director, Division of Unscheduled Care, NHS Grampian

Limitations

This evaluation, whilst it has covered a lot of ground, is not a silver bullet. Given the breadth of the Portfolio, the variety of questions that were posed along the way and challenges with time and resources, it is not possible to provide an exhaustive oversight on all facets described within. Should this report result in outstanding questions of interest that remain unanswered, these can be reviewed in the future. Furthermore, it has been conducted over a relatively short timescale in the midst of a global pandemic, meaning that its conclusions must be viewed within that context. Understanding the longer-term impact of these Priorities would require a longer-term monitoring of their outputs.

Acknowledgements

The Evaluation Working Group would like to acknowledge the following groups / individuals in the production of this report:

- The OHF Steering Group for establishing and ongoing commitment to the evaluation process.
- The OHF Priority Leads (and other close colleagues) for their enthusiasm and engagement.
- All service users and unpaid carers who volunteered to engage with numerous initiatives described within.
- The three North-East Health & Social Care Partnerships (Aberdeen City; Aberdeenshire and Moray); NHS Grampian; and the three North-East Local Authorities (Aberdeen City Council; Aberdeenshire Council and Moray Council) for their support and investment into the evaluation process.
- To Public Health Scotland for providing human resources to support the Portfolio evaluation

Appendix A: Interim Evaluation (including project Flash Reports)

OPERATION HOME FIRST

Evaluation Progress Report

March 2021

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Executive Summary

This report provides an update on the evaluation of Operation Home First (OHF). OHF 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 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 OHF 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 OHF priorities with a more acute focus, strong causation can be drawn of their direct impact against the aims of OHF. For example, every admission to Hospital @ Home that is identified as an 'alternative to admission' means that the person is not admitted unnecessarily to the ARI wards, but instead is supported safely at home. Furthermore, this helps to lessen pressures that can otherwise lead to patients being "boarded" in ARI beds out with the specialty whose care they are under.

A further report is due to be published towards the end of Spring 2021, with greater detail on the impact of each individual priority against the aims of OHF. 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 (OHF) 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 OHF:

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 OHF, including its underlying principles, can be viewed here.

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

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

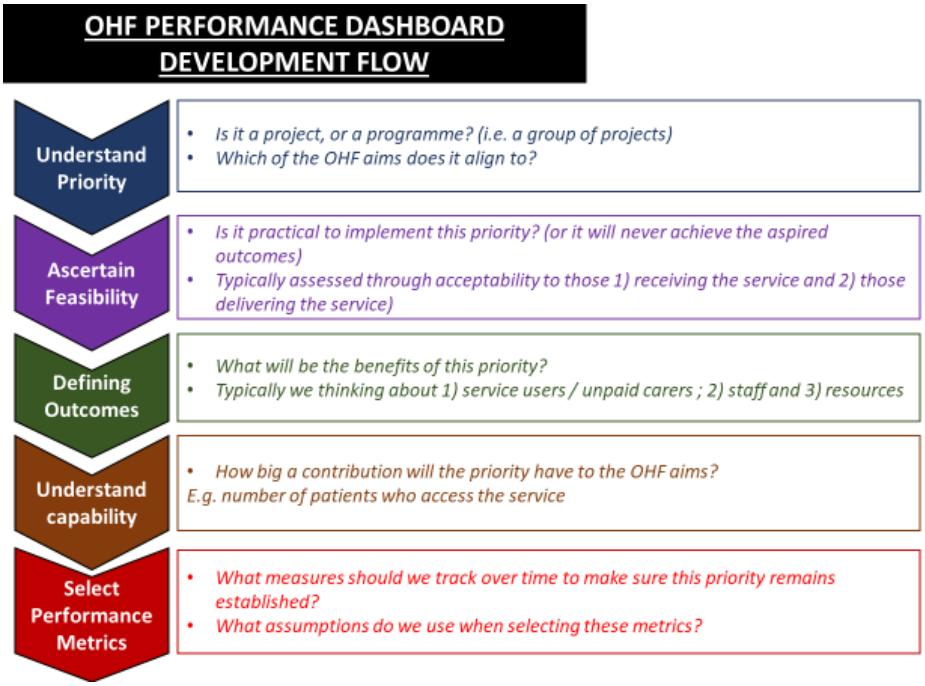
This report outlines the progress made against the above as of February 2021. In particular, it is designed to provide assurances that a robust process has been designed and implemented to evidence the impact of this portfolio.

A further report is due to be published towards the end of Spring 2021, with greater detail on the impact of each individual priority against the aims of OHF. 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:



Understanding the Priorities individually – Some of the OHF 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 OHF 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 OHF. 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 as rationale as to why that metric was selected.

Pragmatic considerations

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 OHF 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. 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 OHF 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 SHMU 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 (RGU) and Aberdeen City Health & Social Care Partnership. In this pilot, 12 students (six Occupational Therapists and six Physiotherapists) were paired 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

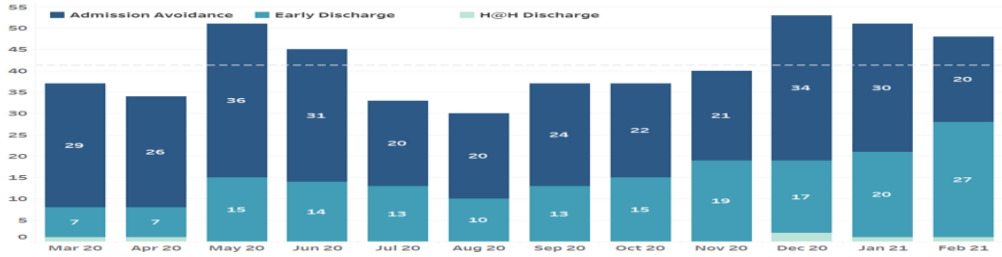
Service metrics: 476 referrals in the last 12 months (Admission Avoidance=308; Early Discharge=168). Both Hospital @ Home (71%) and GAU (72%) show similar proportion of patients at home / in a community setting 90 days post discharge.

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 H@H 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 H@H, including General Practice and District Nursing, had high agreement of how easy the referral process was into H@H (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 GAU where she was x-rayed and no fractures were found. Mrs B had sustained a superficial injury to her foot. She was referred to H@H from ED, avoiding a hospital admission.*

During Mrs B's initial visit from the H@H team, the PT & ANP suspected she had delirium. The HCSW 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 confirmed 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 AC@H staff.

The AC@H 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 TL completed a care management care plan. Due to care package not being in place and husband still in hospital, AC@H decided not to discharge Mrs B.

A&E informed AC@H that Mrs B fallen overnight and was in the department with a head injury receiving treatment. AC@H was informed Mrs B was to be admitted to GAU, however after discussion it was decided that AC@H would take over care, preventing hospital admission.

AC@H staff continued to provide 3 x daily care while awaiting Mrs B care package. The PTech liaised with care providers regarding medication. Mrs B was then discharged from AC@H and her care was handed over to the DN regarding Mrs B's ongoing care of foot dressing as well as the staple removal fro;m head injury". (Advanced Practitioner, H@H).

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)** 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 NHSG 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).

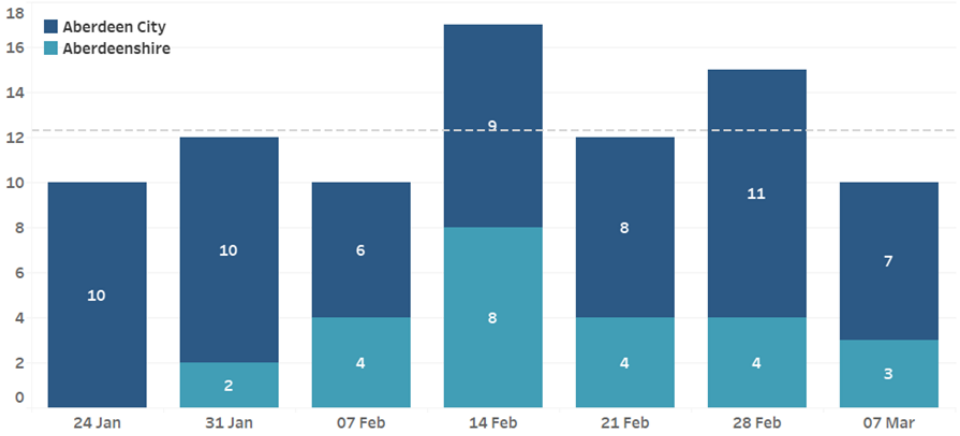
Impact to date

Transfer of staff: The current nursing workforce for the NHS beds is 20WTE (21 headcount), supported by 26.8WTE HCSW (30 headcount) and a headcount of 25 BAC 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 H@H 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 WGH, one re-admitted to ARI, one stepped-down to H@H 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 NHSG 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 utilised by NHSG teams supported by BAC 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.

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

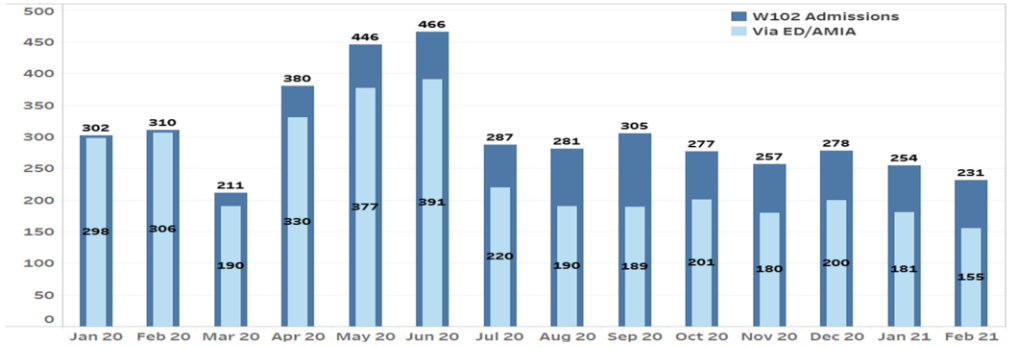
Direct access – General Practitioners can contact a clinician within Ward 102, for example when the first signs of delirium are present in their patients. This allows them to have timely access to specialist advice, resulting in care being provided in the most appropriate setting (whether that is at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

"GP 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 GPs 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 patients recovery, wellbeing and activities of living.

Discussions between GP 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

Brief description of priority

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 MDt meeting [wrap around support for individuals who are stable but with room for improvements regarding functioning etc]).

Update as of February 2021

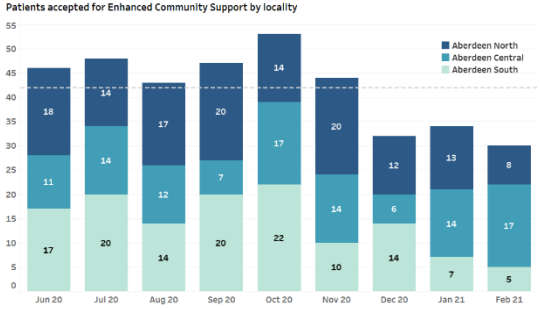
The ECS huddles have been functioning since April 2020 and have used an iterative improvement methodology approach that has been staff led that pragmatically works well. Exploring how we can increase attendances at huddles to ensure equitable access for all services across the city, for example services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

Impact to date

Performance metrics: Nearly 380 requests (relating to over 330 patients) have been brought to ECS since June, an average of 42 cases per month. Overall spread of patients with ECS 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:

Aligned performance indicator



Case Study / Testimonials

"The ECS 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*
- *Daily forum for any member of the MDT (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 MDT approach to assessment, and interventions*
- *Shared learning/understanding of the roles of the MDT team*
- *Building relationships within the localities*
- *Joint ownership – self managing MDT*
- *Supported by senior members of the locality leadership huddle*
- *Quality improvement approach to development" (Occupational Therapist feedback)*

Additional comments

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 ECS

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 (GCC) 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

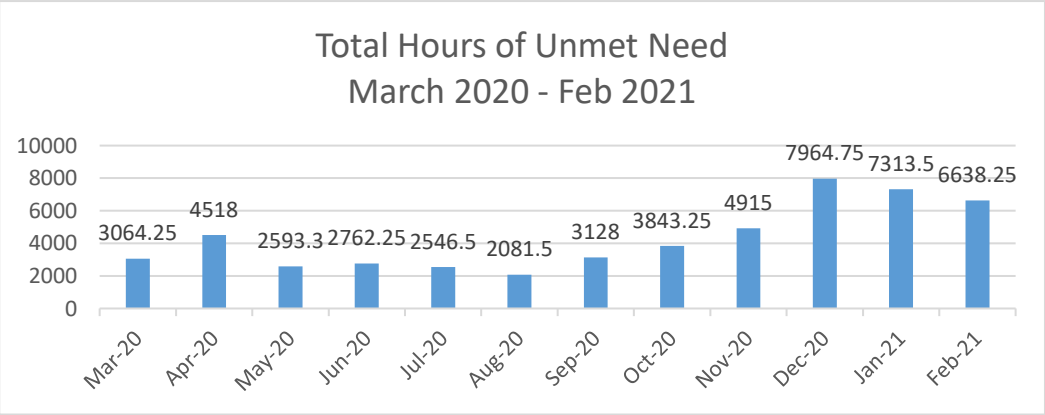
A multidisciplinary group is now meeting weekly to review care packages within the Granite Care Consortium (GCC) unmet needs list. The aim being that this approach will be widened in the future to provide a consistent holistic approach to the whole of the unmet need population. A working group has also 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 GCC staff in Dec 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 peoples 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 GCC (total of 637 as of Dec 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 (GCC) 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.

GCC 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 GCC 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.

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

A foundation to GCC 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 ACHSCP, our goal is to establish and build a workforce that feels engaged, valued, and rewarded for the very important work that they do.

GCC will develop an approach that builds trusting relationships between its social care providers, rather than competition. We will foster partnerships, not market-places 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, GCC)

Additional comments

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 A&E/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 A&E but it is not life-threatening. NHS 24 will offer 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 FNC 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 A&E 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

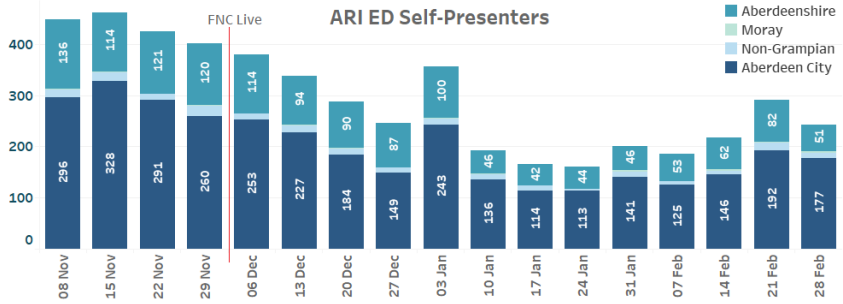
Over 2,600 patients have been referred from NHS 24, to the FNC and Minors Decision Queue, an average of 200 clinical referrals per week (FNC: 38 per week; Minors: 162 per week). Only 59% of patients have required a face-to-face appointment minimising the need for patients to attend ED or a minor injury unit, with 36% given self-care advice and 5% re-directed to primary care following a virtual consultation. Since the soft launch of the FNC, the self-presenting patient footfall at ARI ED 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 ARI ED. 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, eg; how NearMe can help to deliver multi-disciplinary clinics or shared decision making across primary and secondary care.

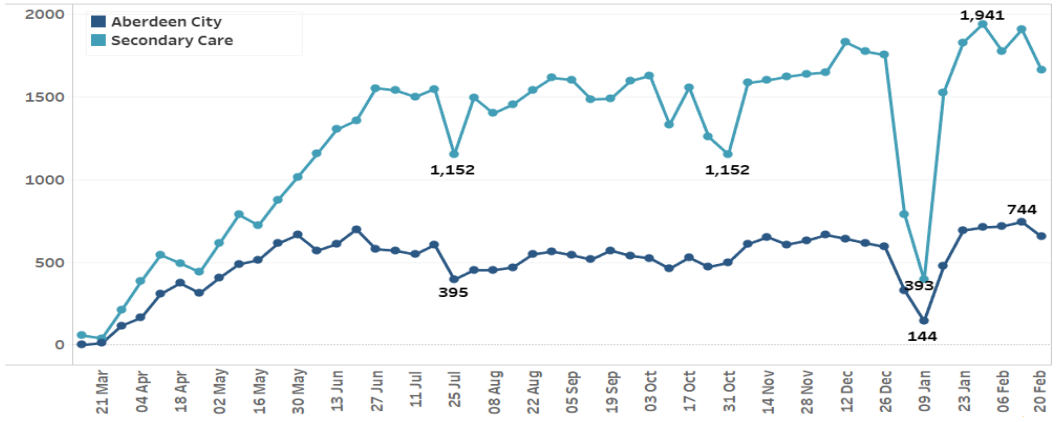
Impact to date

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 at 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 H@H 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 WTE) to join the existing H@H team.

Update as of February 2021

1.0 WTE B7 (comprised of 2 x 0.5 WTE) have been seconded into H@H as of mid-December 2020. 1.0 WTE B6 has been recruited and is only just in post – since 1st February. B7s have been taking referrals and starting to provide support from 7th January, on part capacity until the B6 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 COPD 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 H@H (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 H@H 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 H@H bed days).

To illustrate the comparative costs:-

- Average cost per case of our H@H 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 ARI this could have cost £3,615 x 4 = £14,460.
- Average cost per Respiratory inpatient bed day in ARI = £583, so had our 49 bed days been delivered in ARI, this would have equated to £583 x 49 = £28,567.
- As the H@H 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 H@H.

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 H@H Respiratory service to referring clinicians by email: respiratory consultants and all GPs via their primary care bulletin.

Aligned performance indicators

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

OPERATION HOME 1ST
Working together to stay well at home

NHS Grampian | Aberdeenshire Health & Social Care Partnership | Aberdeen City Health & Social Care Partnership | HEALTH & SOCIAL CARE MORAY

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 ARI 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 1xB4WTE that funding from OHF Respiratory Cell was secured for, so having to utilise additional hours from existing B7 and B3 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*

Brief description of priority

Multiple projects within the Respiratory Pathway priority focus on health improvement for patients with COPD and other respiratory conditions providing: 1) Physical Activity (PA) classes; 2) Pulmonary Rehabilitation (PR) and 3) Respiratory Physiotherapy support within Hospital at 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 PR 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 PA 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 PR is being delivered on a business-as-usual basis and is not one of the OHF-funded projects].*

Update as of 01 March 2021 – Current status:

- 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.

Impact to date

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.

Case Study / Testimonials

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

Aligned performance indicator

Number of participants completing the block

Additional comments

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 OHF Evaluation team will help to foster a rounded understanding of the costs and benefits of delivering PEOLC 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)** **Early Supported Discharge (H@H) - Aberdeenshire**	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

As part of the whole system redesign of the Frailty Pathway the Aberdeenshire Frailty Pathway workstream were tasked with developing an Aberdeenshire model. Having considered a range of options the planned model is an Early Supported Discharge model which aspires to being Hospital at Home. A service model has been developed which will include additional community capacity from our Aberdeenshire Responders for Care at Home (ARCH), 2 specific teams consisting of Nurses and AHPs and technology enabled care.

Update as of February 2021

At present we are awaiting a final decision on the workforce financial split to be agreed before we can move to formal organisational change.

Impact to date	Case Study / Testimonials
Virtual ward has been agreed, similar to the functionality that Hospital @ Home in Aberdeen City use on TrakCare, and is now in development. This will be used as a basis for collating performance data for the project, including caseload numbers; length of stay and discharge location. Evaluation framework has been agreed and established for the project. This includes a bespoke feedback survey have been populated to assess patient and unpaid carer acceptability, focusing on constructs of hospital discharge; home assessment; receipt of care and discharge from the pathway. Staff acceptability of the new model will also be assessed once the project has had adequate opportunity to be embedded into business practice.	None available at this time.
Aligned performance indicator	Additional comments
Performance indicators are not yet operational for this project as it has not gone live. However, metrics including patient location at 90 days; 7-day readmission rates; and medically fit date of discharge vs actual date of discharge will all be monitored.	We've been successful in receiving H.I.S. Hospital at Home funding which will support the use of technology enabled care and for improving Staff skill base. We also have funding for a specific post for Project Management/Development

Operation Home First Priority Aberdeenshire Virtual Community Ward	**Priority Workstream (if applicable)**	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 Virtual Community Ward (VCW) works by bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention, with the aim of avoiding unnecessary hospital admissions. The model is GP-led and operates upstream of acute services, with local health and social care teams working together within the boundaries of GP practice populations. The VCW is very effective at identifying individuals who need health and social care services at an earlier stage, which can significantly improve patient outcomes and experience. The approach involves a daily short huddle (typically 15 minutes) of the core team, where vulnerable / at risk individuals are discussed as well as the progress of those already within the VCW. Co-ordination of short term wrap-around care (personal and nursing care the most frequent requirements) is agreed, mobilised and monitored for those admitted to the VCW.

Update as of February 2021

The VCW model had already been embedded across Aberdeenshire prior to the Covid 19 pandemic. The model of working has continued to remain very important as part of the whole system response to Covid and as health and social care teams have required to adapt with flexible community nursing teams involving District Nursing, community hospital nurses, urgent care practitioners and others. VCWs moved to virtual meetings allowing more team members to participate.

Impact to date

Nearly all Aberdeenshire GP practices signed up to VCW in 2019/20 with an average of over 330 VCW admissions per quarter. For 2020/21, in-line with other enhanced services, it has not been mandatory for GP practices to submit VCV quarterly returns however they have been asked to submit data where available. Health Intelligence will analyse the 2020/21 submissions once the data for the final quarter is in.

It is planned that formal reporting on a quarterly basis, to monitor and understand the impact of VCW, will resume for 2021/22 for all practices signed up to the VCW SLA.

Case Study / Testimonials

Previous feedback from staff on the VCW model following initial implementation highlighted improved and more effective communication as a result of daily huddles, which was felt to have led to:

- Better use of resources and prioritisation of resources to individuals.
- Quicker access to interventions.
- Improved care pathways (better organisation, more integrated/seamless pathways).
- More holistic / person centred care.
- Reduction in hospital admissions.
- Better overall staff experience.

Aligned performance indicator

Existing dataset collated from GP Practices on a quarterly basis (not mandatory during Covid-19 pandemic) collates demographic information of patients admitted to VCW and in addition:

- Reason for VCW admission and length of stay
- Outcome of VCW admission and presumed outcome were VCW not available.

Additional comments

Given allocation of resource to other Home First priorities, the VCW has remained in a 'business as usual' context with no significant changes to service delivery.

Operation Home First Priority Whole system approach to discharge	**Priority Workstream (if applicable)** Discharge to Assess (D2A)	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

Sparked by a relatively high number of delayed discharges, Health & Social Care Moray senior management team recognised that far greater awareness of the upstream and downstream factors influencing discharges from hospital was required. The lack of intermediate care services to assist in the management of patient flow into and out of Dr Gray's Hospital was identified as a key gap in provision. An Occupational Therapy (OT) lead, Discharge to Assess (D2A) model was identified as a possible solution. In the Moray D2A model, OT and Physiotherapy staff would provide two weeks of intensive support to patients in their own home. As an intermediate care service, D2A will support early discharge for inpatients assessed as appropriate in Dr Gray's Hospital (DGH) and offer an alternative to admission for people attending the A&E department.

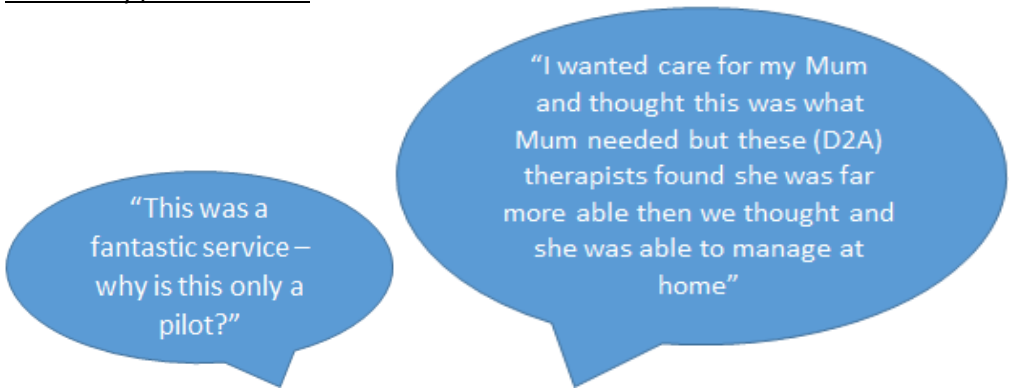
Update as of March 2021

Following a successful pilot and extended test of change, core funding for the Discharge to Assess service was confirmed by Moray IJB on the 25th March 2021. Funding will allow the seconded staff to return to their substantive posts and recruitment to commence for the permanent AHP and nursing staff required to run the service.

Impact to date [5th Oct 2020 to 17th Feb 2021 (19 weeks)]

- 48 patients seen by D2A Team – 40 inpatients and 8 redirected from A&E.
- Saved an estimated 112 acute bed days through supported early discharge and admission avoidance.
- 32 patients directed away from community hospital resulting in an estimated saving of 1,216 bed days.
- Readmission rates lower for D2A patient cohort at both 7 and 28 days.
- Just 5 patients required onward referral to START, demonstrating a reduction in the requirement for care following a D2A intervention.
- 81% - 91% of patients saw improvement in OT assessment scores with remainder maintaining their scores.
- All patients saw improvement in Physiotherapy assessment scores.
- Patients and carers provided very positive feedback on their experience of D2A.
- Fully supported by Senior Management & Clinicians in Dr Gray's Hospital.
- High degree of interest in Moray D2A from across Grampian.

Case Study / Testimonials



Aligned performance indicator

Hospital bed days saved.

[average length of stay (LOS) for key specialties of Geriatric Medicine and Ortho-trauma in DGH is 9 days; D2A average LOS is 8 days.]

Additional comments

Final figures for the test of change period which ended on the 31st March 2021 are currently being prepared.

Operation Home First Priority Respiratory Pathway	**Priority Workstream (if applicable)** Physiotherapy-led Pulmonary Rehabilitation: Aberdeenshire	RAG status	Amber: Uncertain future

Operation Home First Aims this aligns to

Keep people safe at home ✓		

Brief description of priority

This project's aim was to support patients with long term lung conditions to stay safe at home and reduce subsequent related unscheduled attendances/admissions. Increasing activity levels and provision of education to support self-management were core and were met through the delivery of a home based 1:1 Pulmonary Rehabilitation (PR) Programme (in addition to our existing PR service, which had already switched to virtual classes). Provision of an equitable service to those unable to access digital technology was paramount.

Update as of end March 2021

Significant time was required at the start of the project to focus on start-up i.e. staff secondment/recruitment, followed by fundamental corporate and in-house training. 1.0 WTE B6, 2 x 0.5 WTE B4s, then 2 further WTE B4's were established in post with caseload by the end of Jan and Feb 2021, respectively. We delivered home PR to patients who were unable to access online classes, or who would have been unsuitable for such classes (or indeed standard PR group programmes). Additionally, to contribute to reducing health inequalities, we supported those with no access to transport who, in normal circumstances, would struggle to attend classes due to the rurality and lack of infrastructure around public transport. We were also able to link with Acute colleagues in Oxygen Clinic to provide feedback regarding Oxygen (levels).

Impact to date

To date – 51 patients assessed, 27 currently undertaking PR programme, 4 completed, 6 on waiting list. 11 patients declined or unsuitable to continue.

Results – of those 4 patients completing the PR programme before the end of March:

- All reported that their condition was improved or much improved following PR.
- All reported that they achieved completion of at least one of their personal goals.
- All consented to onward referral to Live Life Aberdeenshire for further support.
- Clinical scores improved: COPD Assessment Test (CAT) scores improved in 4/4 (by 6 points on average); number of sit-to-stand in 1 minute improved in 4/4 (by 57.5% on average); and MRC breathlessness scale scores improved in 2/4 (50%).

Aligned performance indicators (to develop if project continues beyond March 2021)

- Number of referrals to the service, by quarter
- Number of people completing PR support block, by quarter

Additional comments

Lack of ongoing funding will mean the project will cease after the end of March 2021, and these patients may then deteriorate, potentially leading to unscheduled attendances/admissions. If we were to secure further funding in the future we would aim to extend to support more acute admission avoidance and early discharges.

Feedback / Testimonials

I was very surprised at the exercises I can do on my own at home

Please keep up the one to one programme. It's been so helpful and gives you a chance to ask more personal questions. Also helped me explain to my family about COPD

I feel much better in myself now I have been doing the exercise and can push myself knowing my limits. Walking further and have taken up golf again, starting to love gardening

We surveyed primary and secondary care staff involved in Respiratory care; all 18 responders agreed or strongly agreed for the need for a service to support PR by means of virtual classes (in addition to our face to face classes) and to support PR by means of 1:1 telephone/home support (for people who can't join classes).

[GP practice team member] *The provision of pulmonary rehab & physio is very limited in Aberdeenshire (…) residents getting to a venue can be difficult therefore missing out on a valuable, beneficial service for our Respiratory patients within our surgery*

Operation Home First Priority Respiratory Pathway	**Priority Workstream (if applicable)** Physiotherapy-led Pulmonary Rehabilitation: Moray	RAG status	Amber: Uncertain future

Operation Home First Aims this aligns to

Keep people safe at home ✓		

Brief description of priority

This project's aim was to support patients with long term lung conditions to stay safe at home and reduce subsequent related unscheduled attendances/admissions. Increasing activity levels and provision of education to support self-management were core and were met through the transition from face to face classes to Virtual Pulmonary Rehabilitation (PR), and expansion of our 1:1 PR for housebound/frailer patients. Provision of an equitable service to those unable to access digital technology was paramount.

Update as of end March 2021

Funding for this project was confirmed 03/12/20. 2 B7s and 2 x B3s were established in post by Feb - March 2021, respectively. In this short space of time, we redesigned our procedures and paperwork for transition of our PR service (including education and self-management material), and up skilled our whole physiotherapy team in new Virtual and home PR. As well as delivering PR to respiratory patients, we have scoped local respiratory requirements; completed training/education and liaised with a range of stakeholders in Dr Gray's Hospital, Oxygen Service Aberdeen, GP practices, community AHPs, and 3rd sector/leisure services, to help raise awareness and improve pathways between services.

Impact to date

To date – 56 referrals received, 32 patients assessed, 5 completed Virtual PR, 4 currently undertaking virtual PR, 8 undergoing Home PR, 7 declined PR (respiratory advice given).

Results – Amongst 6 virtual class participants for whom we have clinical scores pre- and post-support, we saw improvements: COPD Assessment Test (CAT) scores improved in 4/6 (66%); number of sit-to-stand in 1 minute improved in 5/6 (83%), and MRC breathlessness scale scores improved in 3/6 (50%).

- Amongst the 5 patients completing a block of 6 virtual classes by 31/3/21, 4 reported that their condition was improved or much improved following PR, and 3 reported that they achieved 100% completion of at least one of their personal goals.
- 10 patients (virtual and home PR) did not need complete block of support from us; 7 have subsequently engaged with long term exercises.

Demand - We have seen increased referrals for PR and a wider range of specialist respiratory physiotherapy in Jan-Mar 2021, compared with Jan-Mar 2019. Numbers indicate increased need/perception of need. For example, referrals for PR increased from 42 to 56; for specialist intervention increased from 3 to 15; for Oxygen service review/monitoring increased from 0 to 15.

Capacity – Within our current establishment to; support the increasing numbers of patients referred; to reduce digital access inequalities with loanable technology and increase sign posting to community digital services.

Feedback / Testimonials

I had to stop once crossing garden, my wife did all meals and all housework. After the class, this morning I have gone for a walk, painted the garden fence, did the hoovering and now I make breakfast for my wife every day.

I wanted to try anything to help, had tried all the medications which didn't help. Had been told in the past I would never improve due to my age. I like being able to go out and do things I enjoy, I am a much happier person.

Questionnaires from 9 stakeholder staff pre and post training/education/liaising showed an improved perception of PR and specialist physiotherapy intervention.

Aligned performance indicators (to develop if project continues beyond March 2021)

- Number of referrals to the service, by quarter
- Number of people completing PR support block, by quarter

Additional comments

Scoping has highlighted need for further funding to meet need of respiratory service in Moray. Identified capacity requirements to upscale current PR service to prepare for next winter – PR consists of 6 week cohorts so need to start now.

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 in 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. For example, previously in-depth evaluations conducted across the health and social care system have typically taken place after six months of implementation (see the 'West Visiting Service' evaluation here and the 'Acute Care @ 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 A&E 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 in the North East.

One aspect that might temper the potential success of the OHF 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 COPD, however without establishing a revenue model for this preventative approach to health care, the programme may not be able to be supported 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 OHF top-line.

Such a wide-ranging portfolio as OHF 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 OHF is due to be be produced towards the end of Spring 2021, including recommendations on the future direction of the portfolio.

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