Scottish Borders Health and Social Care Partnership
Integrated Joint Board

20 September 2023

Hospital at Home

Report by:
Cathy Wilson – General Manager for Primary Care and Community Services

1. PURPOSE AND SUMMARY

1.1. To seek approval to extend the current 6-month Test of Change (TOC) for the Hospital at Home (HaH) service in the Scottish Borders, so that a full Business Case can be presented at the February 2024 Integration Joint Board (IJB) meeting to decide the future continuation of the service. Existing funding from previous IJB Direction is available due to the secured Scottish Government (SG) bid fund in October 2022. An additional funding bid will be submitted to SG prior to September 2023, which may help support further development of the TOC during the extension period from 27 October 2023 to 29 March 2024.

1.2. This paper provides an update on the progress of the HaH current TOC, which has gained national recognition for its exemplary collaboration, methodology, governance, data collection and rapid implementation. The success of this project was showcased at a national conference in June 2023, leading to an invitation to mentor a neighbouring Health Board in establishing their own HaH service, and for Scottish Borders Health & Social Care Partnership (HSCP) to apply for further SG funding.

1.3. The TOC is closely governed by the HaH Programme Board whose members, such as senior management and key stakeholders across Scottish Borders Health and Social Partnership, are ultimately accountable for ensuring the TOC is delivered successfully. In tandem with the HaH Programme Board, a Reporting and Finance subgroup regularly meets to ensure accurate data is being collected as well as making sure financial controls are adhered to.

1.4. It is important to note the HaH programme has two active workstreams currently in a pilot/test of change phase - Hospital at Home and Virtual Respiratory Ward. Both workstreams focus on creating more virtual capacity with NHS Borders. The Virtual Respiratory Ward workstream commissioned their test of change in 2023 with the aim of establishing a Respiratory Hospital at Home/virtual ward service based primarily on remote patient monitoring. The virtual ward supports seven respiratory pathways, with each having pre-defined clinical physiological alarm parameters, based on an international evidence base. The virtual respiratory ward supports personalised care for patients with a range of Respiratory conditions who are stable, or improving, but require acute care and would usually require a hospital bed. This offers a safe alternative pathway to hospital admission and/or an early supported discharge pathway for patients who require ongoing monitoring.

2. RECOMMENDATIONS

2.1. **The Integration Joint Board is asked to:**

a) Note progress made between April 2023 until August 2023;
b) Extend the current TOC, scheduled to end 27 October 2023, to run until 31 March 2024; and
c) Note HaH team's intention to apply for further funding by September 2023.

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers	Improving our effectiveness and thinking differently to meet need with less	Reducing poverty and inequalities
X	X	X	X	X	X

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
X	X	X	X	X	X

4. INTEGRATION JOINT BOARD DIRECTION

4.1. Direction has already been provided so it is not required at this stage.

5. BACKGROUND

5.1. In recent years, healthcare professionals have been considering new ways to respond to the acute care needs of older people with frailty and other long-term conditions. Urgent care is needed but hospitals bring risks for older people as well as benefits, and community-based alternatives are increasingly being explored. This has resulted in a shift in focus within the NHS and internationally towards providing hospital-level care in a person's home environment.

5.2. Across Scotland, Health Boards have developed this service to provide care in this form. The care is recognised to be safe, cost effective and popular with patients and staff. It can provide an alternative to admission for selected patients, can relieve some pressure on acute services (once scaled up) and in some areas it has been shown to facilitate closure of inpatient beds. SG are supportive of this care model and NHS Borders have approached SG for funding to develop this method of care.

5.3. The HaH service has direct clinical oversight from two Community Geriatricians, with operational oversight being provided by Cathy Wilson, General Manager for Primary and Community Services. Wider leadership and governance are provided by Dr Tim Young, Primary Care and Community Services Associate Medical Director. It is however recognised by all project group members that developing a HaH service cannot be done in isolation. As such, key stakeholder engagement and cooperation is required across HSCP services.

6. TEST OF CHANGE UPDATE

Launch

6.1. Project scope and planning began in January 2023 with a target of admitting a first patient by early Spring. The commitment to rapid implementation has been pivotal to the successful launch. Through effective project management and clear and effective communication, the service was implemented within a relatively short timescale.

6.2. The HaH TOC was successfully launched in April 2023. A small project and clinical team were secured to develop and tailor nationally approved processes and procedures. They were also tasked to trial whether these could be applied as a functioning clinical model in the Borders.

6.3. It was recommended to commence the HaH TOC on a smaller scale initially, prioritising patient safety a primary concern. This approach allowed for careful monitoring and evaluation of the service's effectiveness before considering further expansion.

6.4. Until early August, the HaH service offered a five-day schedule, operating from Monday to Friday, between 8am and 6pm. This timing was chosen to align with the availability of healthcare professionals and resources, ensuring comprehensive coverage during weekdays. The decision to begin with this limited schedule was also to enable streamlined processes, assessment of outcomes, and prompt resolution of any challenges that may arise. This measured approach ensures that patient safety remains the top priority as the team continues to build a strong foundation.

6.5. Following recent staff appointments, the HaH service now offers a seven-day service which is ensuring the HaH team can look after more patients in a homely setting.

6.6. As insights are gained and data is collected, there is an intention to gradually expand the availability of the service based on patient demand, resource allocation, and clinical feasibility. A challenge encountered during the HaH TOC is limited workforce availability. Due to the nature of this innovative project, offering the necessary staff to support the service has proven to be difficult. As part of the TOC initiative, only secondments were possible to address this issue.

Challenges

6.7. While striving for a virtual capacity of up to 20 beds, it is vital to carefully consider the balance between capacity, acuity, and dependency. Factors such as patient complexity, required treatments, nurses needed per visit, travel distances, and other variables directly influence the number of patients that can be safely accommodated at any given time.

6.8. Understanding these complexities has proven challenging for external services. To address this, a Red-Amber-Green (RAG) status will be developed to reflect the variations in the service's capacity and its ability to accept to accept patients. This visual indicator will provide clear visibility of the current capacity and capability of the HaH service, considering the aforementioned factors.

6.9. Implementing the RAG status will enable better decision-making regarding patient admissions, manage whole-systems expectations, and prioritise patient safety throughout the TOC.

6.10. Continued monitoring of these factors will be essential to ensure a safe and effective HaH service. Striking a balance between meeting patient care demands and delivering it safely and efficiently, within available resources, remains a key focus for the team.

Service delivered

6.11. To date, the service has treated 60 patients (39 admissions from BGH, 21 admissions from community/outpatient settings). A service specification document is continually being updated to reflect the practices and processes of the HaH service in Borders.

6.12. The service initially targeted 'step down' patients from Borders General Hospital (BGH) but have commenced with targeting patients from community services such as Primary Care, Adult Social Care and Home First.

6.13. It is important to highlight that the HaH service is not a step-down service from acute hospital because it aims to provide acute-level care at home rather than in a hospital setting. The primary purpose of the HaH service is to deliver safe and effective hospital-level care to patients in the comfort of their own homes, bypassing the need for hospital admissions.

6.14. Unlike step-down services, which are typically used to transition patients from acute hospital care to a lower level of care (e.g. Home First), HaH actively prevents hospital admissions by providing comprehensive medical treatment, monitoring, and support in the patient's home. This can be particularly beneficial for patients with acute illnesses or exacerbations of chronic conditions who can be safely managed at home. This therefore reduces the length of stay by two days as discharge, following acute illness episode, is timely and not limited by starting or restarting community support.

6.15. The HaH TOC has received widespread recognition within the local healthcare community. The collaborative effort of a multidisciplinary team, consisting of health care professionals, administrators, and technology specialists, have been instrumental in the project's progress. The ability to effectively work together, problem solve, and harness diverse experience and expertise has set this project apart as a national exemplar.

6.16. The HaH service typically involves a multi-disciplinary team comprised of healthcare professionals who provide a range of services, including physician visits, in-home nursing care, medical management, and possible rehabilitation. HaH aims to reduce the risk of complications, improve patient outcomes, enhance patient satisfaction, and lower healthcare costs by reducing unnecessary hospital admissions and promoting a patient-centred care model.

Data Collection

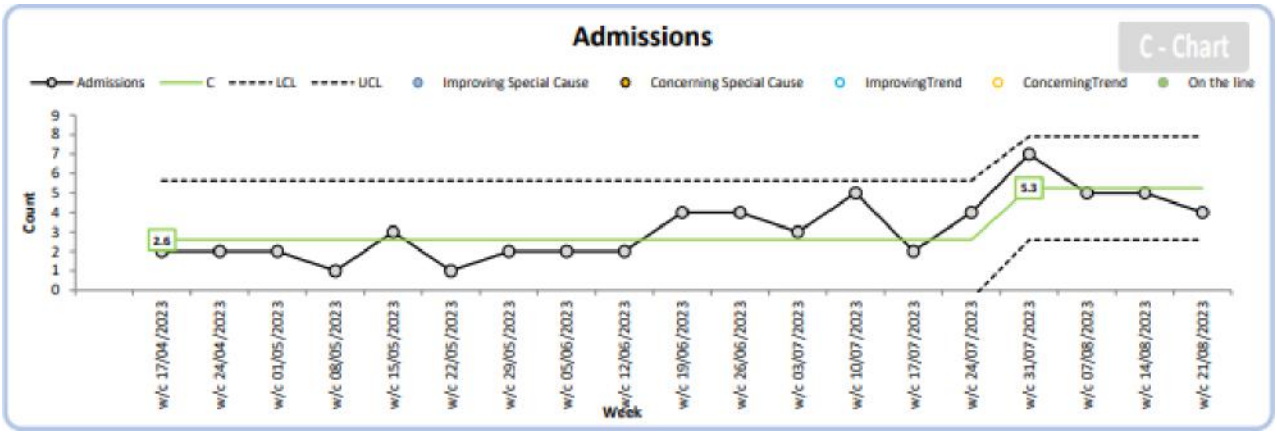
6.17. To meet the success criteria, it was agreed by Healthcare Improvement Scotland and the Borders Business Intelligence team, that NHS Borders should collect and report the following quantitative data:

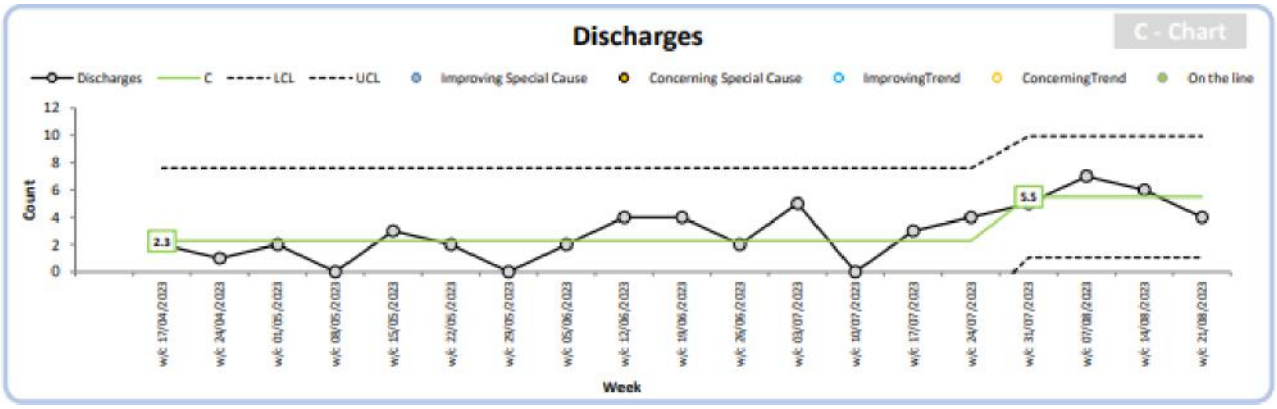
- Admissions
- Discharges
- Average Length of Stay
- Occupied bed days
- Total number of patients seen by the HaH team

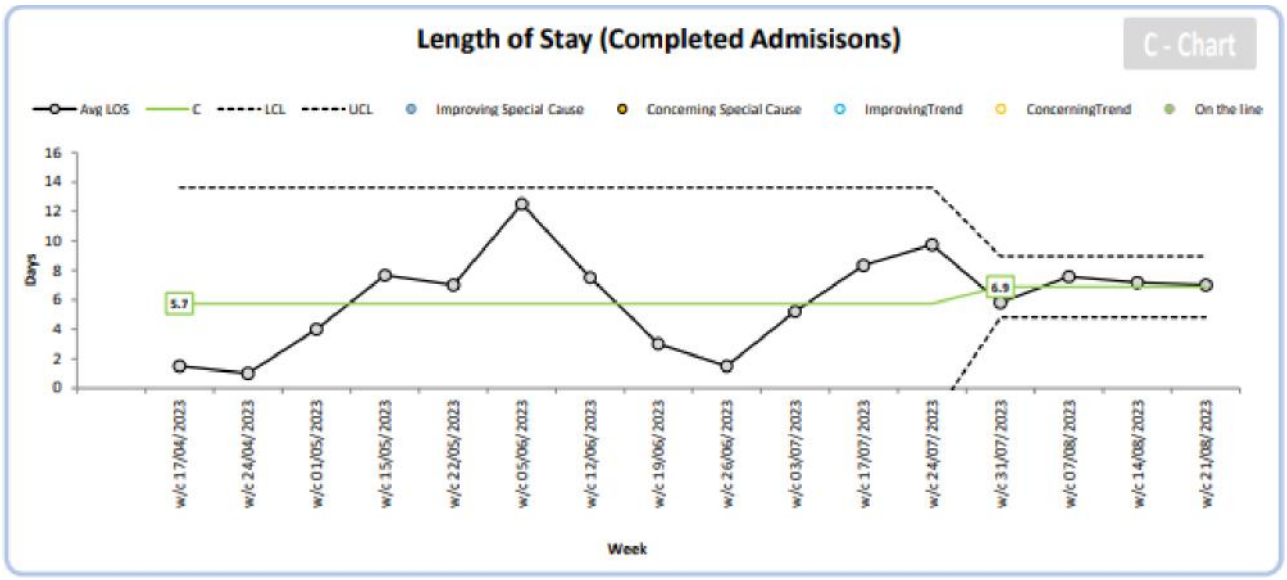
- Readmission rates

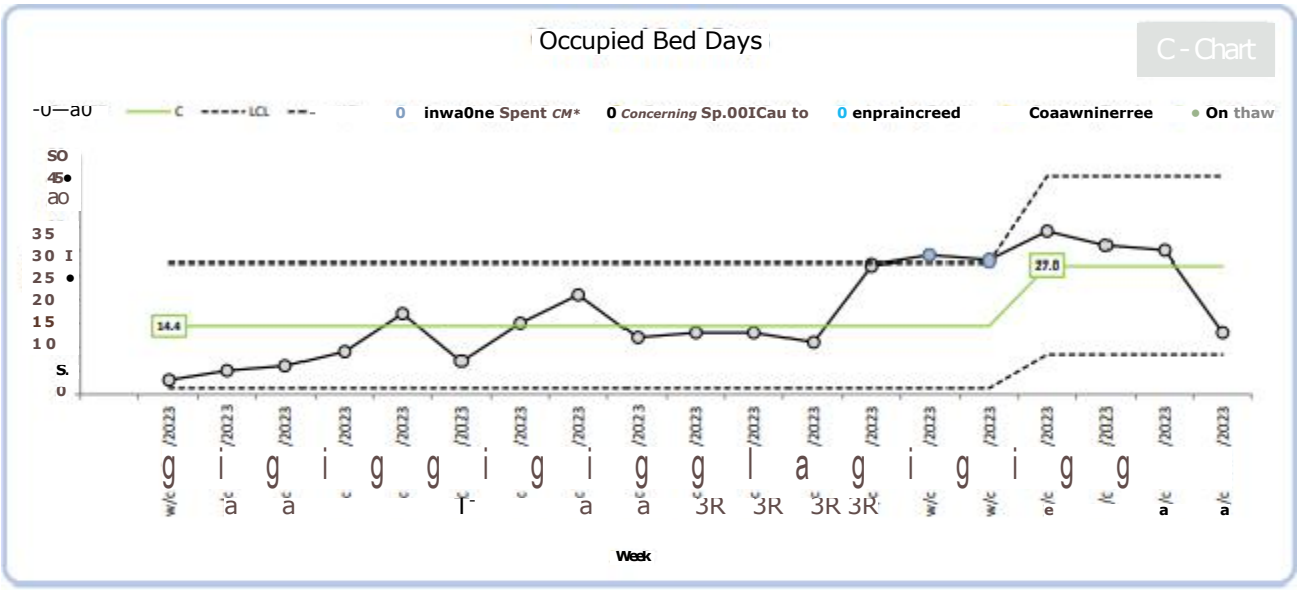
6.18. See below reported data from WC 17/04/2023 to WC 28/08/2023

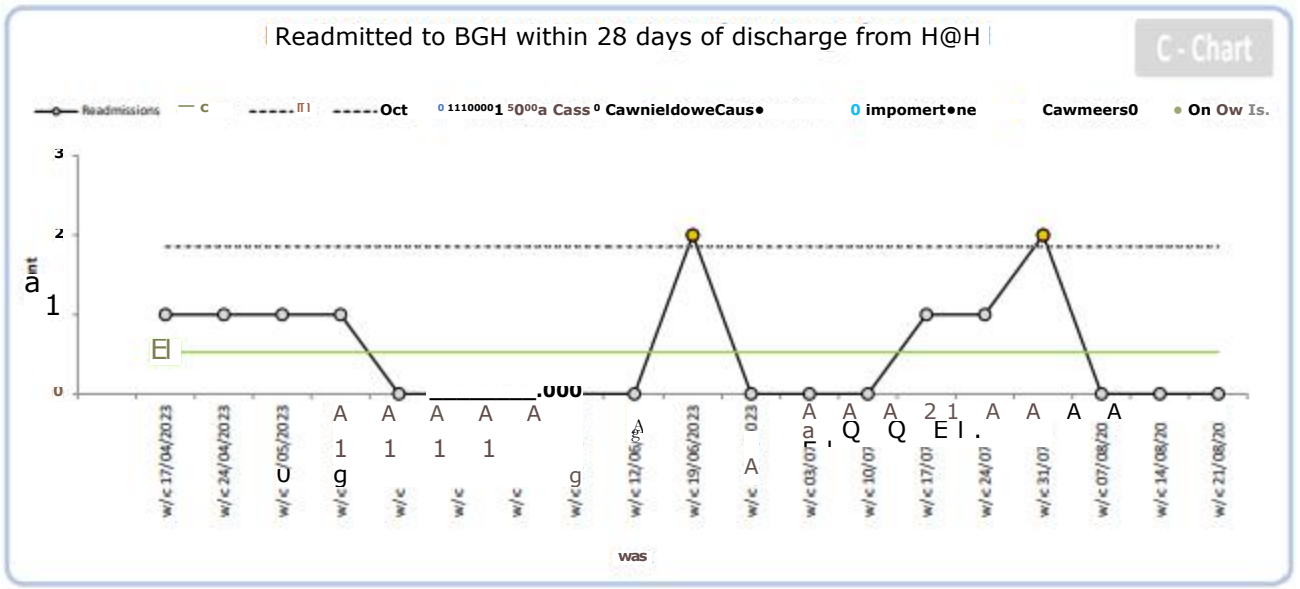
Total Admissions	60
Admissions from BGH	39
Admissions from Community/outpatient settings	21








Occupied Bed Days
C - Chart
Week


Readmitted to BGH within 28 days of discharge from H@H
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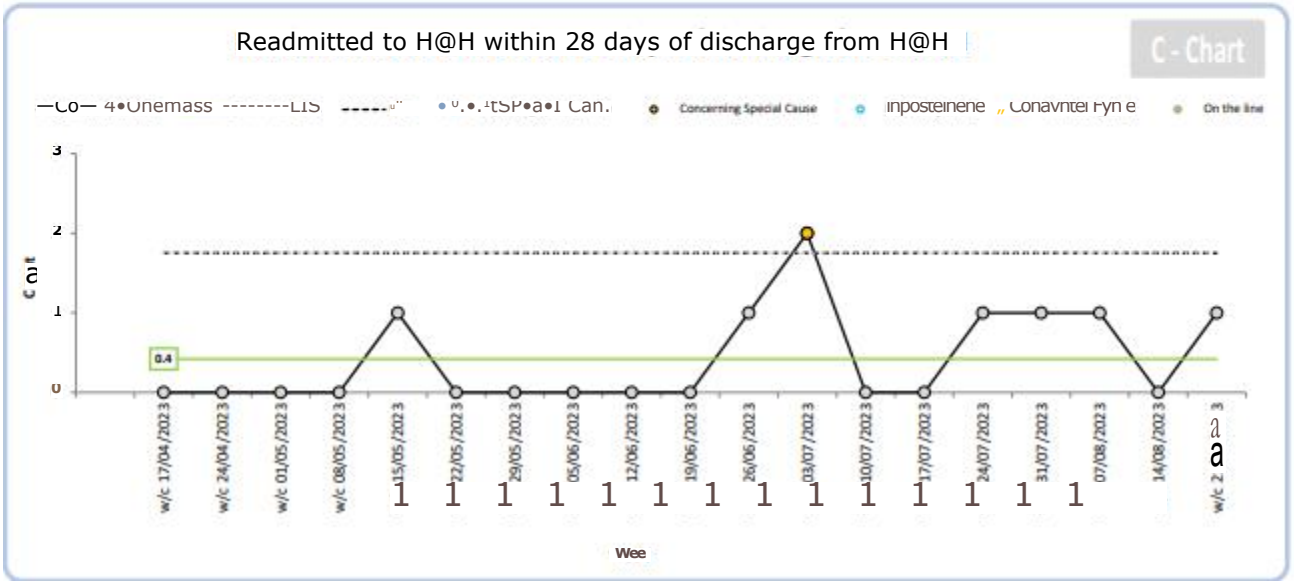

Readmitted to H@H within 28 days of discharge from H@H
C - Chart
Wee

Advice on other sources of information to collect was:

- **A summary of feedback from patients who have used the HaH service:**

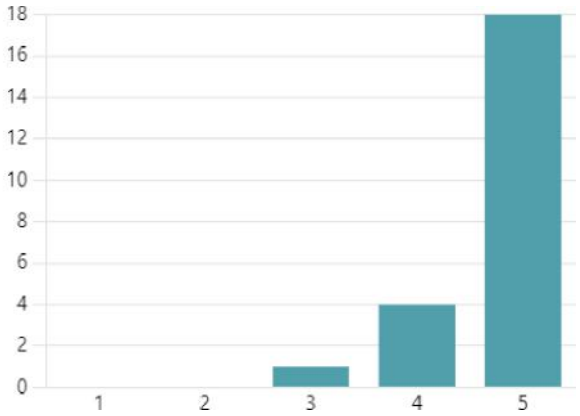
3. How much would you agree/disagree with the following statements?

More Details

4. How would you rate your care overall? (1: lowest score - 5: highest score)

More Details Insights

4.74
Average Rating



5. If you have any additional comments, please add these below:

14 Responses

ID T	Name	Responses
1	anonymous	This fantastic service meant mum could get back 'home' to Grange Hall much sooner. The hospital was very busy, noisy and made mum even more anxious which exacerbated her breathlessness. As soon as she got back to GH, she immediately relaxed. Hopefully this service will continue, as I am sure it will be much appreciated by many more families and free up much needed beds at the BGH.
2	anonymous	The nurses who came to see me were very efficient, supportive and empathetic. I could not rate them more highly.
3	anonymous	Excellent service. Most helpful and cheerful.
4	anonymous	Could have lasted longer
5	anonymous	Best service ever. Nurses and doctors were very friendly, and answered all questions honestly. Wonderful service, please keep it going. The nurses - Delia, Gail and Victoria, Dr Cantley and Dr Jenny Inglis, excellent devoted sincere people.
6	anonymous	Helped me greatly being treated at home. Thank you
7	anonymous	Once referred, the service and care was excellent. Very reassuring being able to contact the consultant and nurse on phone. Disappointed to be discharged the day after the first iron infusion but understand the short term nature of referral.
8	anonymous	Good service to keep going. Good at what treatment was needed.
9	anonymous	Service very professional and much appreciated, could not have asked for better. Home is much better than being in hospital. Long may this service continue.
10	anonymous	Tele Call First Always on Time Very Good Care
11	anonymous	5+. Outstanding care, would highly recommend this service
12	anonymous	After a decision to admit patient to BGH for further test and drove patient to ae at around 17:30 and was asked Hospital at home would pass on details to ae and they would have all info details when we arrived. This was not done ae wanted all the information from me as to why he was there. we had to wait until 9pm before he was eventually seen. ae did admit as one patient that they were aware of his admission but we would still have to wait.
13	anonymous	Written information on who is responsible for what and who to contact would be very helpful. MOT meetings would be beneficial. all staff were very friendly
14	anonymous	The nurses who attended myself were very professional and helpful. they made my hospital to home an easier transition. well done. excellent service.

- A summary of feedback from engagement sessions the HAH Team had with stakeholders is below:

Audience	Feedback	Outcome(s)
NHSB Formal Area Staffside	The idea of the HaH service was met with positivity and the only take away was to ensure the HaH service is in communication with, and involving, AHPs and the Out of Hours service.	To promote communication and involvement with AHP and OOH services, meetings with the AHP Professional Leads and the BGH Emergency Department have been organised.
NHSB Allied Health Professional Leads	The AHP Professional Leads were very welcoming of the HaH service, and only asked that similar services be considered to assist with reducing hospital admission.	AHP Lead, and member of the HaH Programme Board, is taking forward work to ensure synergies are in place with the Home First service and work done by the RAD team. AHP Lead is also considering when and where appropriate for AHPs to refer to the HaH service.
NHSB Central GP Cluster	Positive and offer of further feedback at meetings encouraged.	To keep attending future meetings to provide updates of how the service is progressing. Also, following this meeting GP Communications were drafted and approved, date for circulation TBC.
NHS Lothian (Midlothian)	Met with the Midlothian HaH team to be shown the service, the roles/responsibilities of the administrator, and the data/information that is collected.	Reassurance that NHS Borders are collecting appropriate/relevant data and information. Teams channel/network for NHS Lothian administrators being created which HaH team administrator will be invited to join.
NHSB Out of Hours Emergency Department	Met with Borders Urgent Care Service Leads, feedback was positive and future collaboration encouraged.	Meeting helped to promote positive engagement moving forward.
NHSB Scottish Ambulance Service	The SAS leads were very welcoming of the HaH service and offered their support throughout the Test of Change.	Offer of partnership working to create a referral pathway for SAS to HaH. Explained that once Test of Change is ready for this, the team will be in touch.
NHS Western Isles	Positive feedback received from NHS Western Isles Team, encouraged that a similar sized board is now on their own journey.	Sharing best practice i.e. datasets, job descriptions.
NHSB Heart Failure Spec Nurse	Provided learning on Heart Failure care and provided positive feedback on the HaH service.	Outcome was that Spec Nurse offered to provide more learning sessions if required.
NHS Highland	Positive feedback received and another HaH service in Scotland very much welcomed.	Sharing best practice i.e. datasets, job descriptions. Further meetings to be set up once ANP comes back from annual leave.
NHSB BGH – Ward 7 & Ward 9	HaH team provide overview of service and answered questions from colleagues.	HaH team have made themselves available to all staff in Ward 7 and 9 when they have questions. Referrals are now being made from there to HaH team.

NHS Dumfries & Galloway	Meeting was more about Borders HaH team educating D&G on how the services has been going as well as answering many questions D&G had.	Both agreed to share best practice when required and agreed to keep in touch to provide support and advice.
NHSB Acute Clinical Nurse Managers and Associate Nursing Director	HaH team provide overview of service and answered questions from colleagues. Positive feedback received and they will promote the services HaH can provide when looking to discharge patients.	HaH added to the acute safety brief which takes place 8.30am every day so team can provide capacity updates. HaH also added to the integrated huddle to provide capacity updates.
NHSB Junior Doctors	HaH team met with new intake of FY1's and FY2s to introduce service	Positive feedback provided and discussed referral pathways into the HAH Service
NHSB Medical Registrars	HaH team with new intake of junior doctors, to introduce service, specifically to those taking Med Reg calls from primary care	Positive feedback provided and discussed referral pathways into the HAH Service
NHSB Public Health	HaH met the team during a CPD session to discuss service and answer any questions	Meeting helped to promote positive engagement and discussions around Oral Health and Smoking Cessations pathways

Highlights

6.19. So far, the HaH service has successfully achieved the following:

- Incremental increase in treating patients since service started 17 April 2023
- HAH Team building on existing skills with funding secured to upskills 2 members to Advanced Nurse Practitioner level
- HAH Team provide capacity and service updates at the Acute Safety Brief
- HAH Team provide capacity and service updates to primary and community services
- Multiple successful engagements to gather public and professional opinion on how the HAH service is going
- Current HAH Team staffing capacity allowing the service to onboard approx. 8 patients
- HAH Team now able to pilot 7-day service
- Agreement in principle from the IJB Strategic Planning group to extend pilot to 12 months
- NHS Borders Hospital at Home Service Specification document developed
- Agreement on the HaH service workforce model
- Development of numerous referral pathways such as the Prescribing pathway, Oxygen Therapy pathway, and Primary Care referral Pathway,
- Treatment of patients with IVs
- Sourced all required equipment to provide a comprehensive HaH service
- Development and implementation of a discharge letter specific to the HaH service
- Co-ordinating care with the District Nursing team to reduce footfall in patient's homes
- Uptake of a student placement, with more students identified to participate
- Creation of sub-group tasked in identifying and assessing impacts of HaH service
- Working with business partners from both Acute and Primary & Community Services in monitoring data and financial scrutiny, supported by the IJB Chief Finance Officer.

- Collaborating with the Respiratory Virtual Ward service team to ensure best practice is aligned and that both services are providing the best care for patients being treated in the community.

7. NEXT STEPS

7.1. In terms of growth – the original Business Case had hypostasised the below model which aimed to cover a 7.5-hour day, seven-day week service, with a total virtual capacity of up to 20 beds.

	WTE
Specialist Consultant*	0.2
Consultant Geriatrician*	0.5
Nursing Band 6	3.26
Nursing Band 7/ANP	1.6
Nursing Band 8a	0.3
HCSW Band 3	3.26
Admin Band 4	1
IM&T Band 6	1

7.2. On review against Midlothian (practice population of 95,000 over a smaller geographical area), a similar sized Health Board model, the findings were:

Max. 22 patients on caseload
Seven-Day Service – 8am to 8pm

- Consultant physicians – shared cover between 2 consultants (Mon-Fri)
- Specialty doctors – 9 sessions per week
- GP Trainee 1 WTE
- Band 8 Lead pharmacist – (1 WTE shared with CH ward)
- Band 7 ANP – 1.6 WTE
- Band 7 Trainee ANP – 2.7 WTE
- Band 6 Nurse Practitioners – 4 WTE
- Band 5 Staff Nurse – 1 WTE
- Band 3 HCSW – 2.7 WTE
- Band 5 Admin – 1 WTE
- Band 2/3 Admin – 1 WTE

7.3. The Borders HaH service can currently manage 6-8[1] patients across seven days. The service requires further staffing to cover 20 open beds, working 7 days a week from 8am to 6pm. Specific staffing required would be:

	Shift pattern	WTE	Gap	Comment
Consultant		0.9	0.2	inclusive of SPA
Junior Doctor (FY2 or GP Trainee)		1	1	inclusive of SPA
Speciality Doctor		1	1	inclusive of SPA
Nursing Band 6	7 days a week 8am to 6pm	4	2	

[1] It is important to note that Hospital at Home is aiming to take patients with a higher dependency level than those people normally kept at home. Capacity is a combination of staff availability and skill plus patient dependency and acuity. Further work is being done to understand daily capacity. (see 6.8)

Nursing Band 7/ANP	7 days a week 8am to 6pm	3	1	
HCSW Band 3	5 days a week 9am to 3pm	2	2	inclusive of admin cover
Admin Band 4	5 days a week 8am to 4pm	1	0	

7.4. By recognising the workforce challenges in the NHS, there is a collaborative effort with Health Improvement Scotland[2] to explore alternative models for HaH service in the Borders – acknowledging our geographical and financial limitations. One potential option being considered is the incorporation of Advanced Nurse Practitioner (ANP) input, which would leverage their advanced clinical skills to enhance the service's capabilities.

7.5. The exploration also includes more innovative solutions, such as fostering a symbiotic relationship with District Nursing (DN) service. This approach would involve working closely with DNs to tap into their resources and expertise, ensuring a coordinated and comprehensive approach to patient care.

7.6. By considering these alternative models and embracing innovation as part of the TOC's expansion, the aim is to overcome the workforce challenges and strengthen the current HaH service. This approach acknowledges the importance of seeking novel strategies to optimise patient care and achieve sustainable healthcare delivery within the constraints of the workforce.

Scottish Government Funding

7.7. In June 2023, HaH team was invited to attend a National Hospital at Home conference in Edinburgh. The conference included workshops that focused on analysing existing data and exploring ways for current HaH teams to expand their capacity. This involved considering skills mix, reviewing functions and roles, and implementing capacity management processes.

7.8. During the conference, it was announced that a national funding of £3.6M would be made available to support Hospital at Home Services across Scotland. However, access to this fund was restricted to partly assist in establishing new services or expanding existing ones.

7.9. Despite being in the middle of a TOC, Health Improvement Scotland believed that the Borders HaH was sufficiently established to submit a bid for funding to support their expansion efforts. Up to this point, the team has been collaborating with Health Improvement Scotland in preparing a bid that aligns with the expansion criteria, with the aim to submit it by September. The bid will be reviewed by NHS Borders Executive Team prior to submission.

IJB Funding

7.10. The IJB had earmarked £319k funding for the service as part of November 2022 Direction, should the HaH business case be successful. Although it had not agreed to anything beyond project costs under the discretion of the IJB Chief Financial Officer, the project was able to conduct its test of change with SG funding. As this funding has been fully utilised, the ask is to now pull down on the £319k earmarked funds on a non-recurrent basis in order to continue the current pilot for an additional 6 months.

8. IMPACTS

Community Health and Wellbeing Outcomes

[2]In collaboration with Health Improving Scotland as part of funding bid work.

8.1. **Outcome 1 - People can look after and improve their own health and wellbeing and live in good health for longer.**

HaH provides an avenue for people to receive necessary medical care and support in the comfort and familiarity of their own homes. This environment encourages individuals to actively participate in their own care and make informed decisions about their health.

By shifting care from traditional hospital settings to home-based settings, HaH promotes self-management and personal responsibility for health. Patients are provided with tools and resources needed to effectively manage their conditions, including access to education and personalised care plans. This approach empowers individuals to understand and monitor their health status, make lifestyle modifications, and engage in preventative measures.

HaH has also shown to improve patient outcomes by reducing the risk of hospital-acquired infections and complications associated with hospital stays. Patients often experience better physical and mental wellbeing when surrounded by familiar surroundings, family support, and reduced disruptions to daily routines.

Additionally, HaH contributes to better long-term health outcomes by facilitating early intervention, ongoing monitoring and coordinated care allow HSCP health providers to identify changes in health status promptly and intervene/adjust as needed. This proactive approach can prevent the progression of diseases, reduce the need for hospital re-admissions and ultimately lead to improved overall health.

8.2. **Outcome 2 - People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**

HaH prioritises the provision of care and support services that promote a person-centred approach, ensuring individuals can maintain their autonomy and quality of life.

HaH is designed to deliver comprehensive and coordinated care, allowing individuals to receive necessary medical treatment and support services in the comfort and familiarity of their own homes – eliminating the need for prolonged hospital stays and enable individuals to remain in their preferred environment.

For people with disabilities, long-term conditions, or frailty, HaH offers several benefits. Patients can maintain their independence by living in familiar surroundings, where they have established support networks and access to community resources. This helps to preserve their sense of identify and autonomy while receiving the necessary care and assistance tailored to their specific needs.

HaH promotes the development of personalised care plans that acknowledge the unique requirements and preferences of everyone. This ensures that the care provided aligns with their personal goals and fosters an environment that supports their wellbeing. HaH often involves multi-disciplinary teams that include healthcare professionals, AHPs, social workers, and community support workers who collaborate to address the diverse needs of individuals, including physical, emotional, and social aspects.

By enabling individuals to remain in their homes or community settings, HaH helps minimise the disruption and negative impact associated with institutional care. This can lead to improved mental wellbeing, reduced stress, and enhanced social connections, as individuals are able to maintain their social interactions and engagement within their communities.

8.3. **Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected.**

HaH prioritises the delivery of person-centred care in a respectful manner. By providing care into a patient's home or community setting, HaH creates a more comfortable and familiar environment, which can contribute to a more positive overall experience. Patients are often more at ease in familiar surroundings, surrounded by their loved ones and with fewer disruptions to their daily routines.

HaH aims to provide coordinated and holistic care that considers individuals' unique needs, preferences, and values. A multi-disciplinary team approach ensures that the care provided is tailored to meet the physical, emotional, and social aspects of a patient's wellbeing.

By fostering a person-centred approach, HaH places a high emphasis on respecting a patient's dignity – involving them in the decision-making process, providing clear and timely communication about their care and actively involving them in the management of their health conditions. Patients are seen as partners in their care rather than passive recipients, promoting a sense of autonomy and maintaining their self-worth.

HaH staff are trained to have cultural competence, compassion, and sensitivity, ensuring that care is provided in a respectful and non-discriminatory manner. This helps foster trust and a positive relationship between the patient and their care providers.

8.4. **Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

HaH prioritises a holistic approach to care that goes beyond simply addressing medical conditions. It recognises the importance of addressing the broader social, emotional, and functional needs of individuals, in addition to their healthcare needs. By focussing on the overall wellbeing and quality of life, HaH aims to enhance the individual's overall experience and outcomes.

For patients, they receive care in the comfort and familiarity of their own homes or community settings. This promotes a sense of independence, control, and dignity, which can significantly contribute to improving their quality of life. Being able to stay in a familiar environment with support of loved ones can positively impact mental wellbeing, reduce stress, and enhance social connections.

Additionally, the HaH service involves personalised care plans that are tailored to meet the specific needs, preferences, and goals of the individuals. Using a multi-disciplinary team approach, HSCP professionals work collaboratively to develop comprehensive care plans that not only consider medical treatments, but also address social determinants of health, emotional support as needed. This comprehensive approach aims to improve the individual's overall quality of life by targeting factors that may affect their wellbeing beyond the physical aspect.

Moreover, HaH prioritises continuity of care and support. By ensuring seamless transitions between hospital and home setting or the continuation of existing package of care, patients receive consistent and coordinated care, reducing the disruptions in their daily lives, and maintaining a sense of stability. This can contribute to better management of chronic conditions, improved functional abilities, and enhanced overall quality of life.

By focussing on a patient's ability to live independently and actively engage in their communities, HaH promotes social inclusion and reduce reliance on long-term institutional care, leading to a more sustainable and person-centred health and social care system.

Peter's Story

Peter is a retired window cleaner who lives with his wife and their dog. He has had a lot of medical problems over the years, including heart failure, diabetes and a previous below knee amputation. He is usually able to manage at home with the help of his wife but has had multiple previous hospital admissions for his various problems.

The specialist Heart Failure nurse saw him at home for review and found Peter to be increasingly breathless and unwell. His leg was swollen, and his abdomen distended. She felt that he required an inpatient admission for intensive diuretic treatment, however he was very reluctant to agree to this – not least because he and his wife had a wedding anniversary coming up within the next few days.

The nurse contacted the Hospital at Home team, and we visited Peter the same afternoon. He was distressed and unwell. He told us that he felt he was drowning each night when he lay down in bed. We let his GP know that he had been admitted to our care and we commenced him on high dose diuretic treatment. Daily adjustments to his regime and regular blood monitoring were required over the next few days, but he made good progress and was able to be discharged back to the care of his GP and the heart failure nurse just over a fortnight after admission.

Peter and his wife found the service hugely reassuring and told us in our feedback that "the whole team should be given a medal". It meant a great deal to them that he had been at home for their anniversary, as they know how ill he is. On asking them whether I could share his story, his wife told me "Please do! You should be shouting it from the rooftops!"

Every new patient brings new learning for the team. In this case we also worked closely with the District Nurses so that we weren't duplicating visits, and we're currently still liaising with the GP and Pharmacy teams on how best to make changes to medication as we gear the patient up for discharge back to Primary Care. Best of all is that all the changes made to Peter's tablets were discussed at each stage with him, so we were confident that his new regime would continue after he was discharged.

8.5. **Outcome 5 - Health and social care services contribute to reducing health inequalities.**

A good example of how HaH reduces health inequalities is that because the HaH service 'takes' care to patients while in their homes, this removes the disadvantage some patients and carers may have when it comes to accessing acute care services, specifically Borders General Hospital. This is especially important to those patients who live in a geographic location that has no community hospital (e.g. Eildon) or other acute care services available.

8.6. **Outcome 6 - People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.**

A key area for consideration in the development of any HaH service is the recognition of unpaid carers as equal partners in the planning and delivery of care and support. It is important that members of the HaH team identify the needs of the carers also as this ultimately leads, not only to the benefit of carers, but also the people they are caring for. The HaH service provides

supporting materials, which importantly contains a contact phone number, for use by the patient and their carer.

Another benefit of having the HaH service in place allows unpaid carers to remain in their home alongside the patient rather than travelling to and from a hospital. This means the carer is far less likely to be at a financial disadvantage due to travel and helps the carer to maintain their own links in their community.

8.7. **Outcome 7 - People who use health and social care services are safe from harm.**

HaH services have shown to reduce a range of complications associated with hospital stays such as hospital-acquired infections and pressure sores as well as older people with frailty being at more risk of institutionalisation and delirium. Since the HaH service provides a more person-centred care experience for individuals in their own home, this helps the patient to avoid the need for hospital admission, therefore keeping the patient safe from the risks of unnecessary loss of independence and functionality, which can result in the requirement for care at home services or a long-term care home admission to hospital.

8.8. **Outcome 8 - People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

Involvement and engagement, led by the HaH team, has been key to the development of the service. By involving many other services such as Social Care, 3rd Sector, acute and community pharmacy, project management, business intelligence, and quality improvement, the HaH team have produced the following specific processes and procedures:

- Developing a Borders HaH Service Specification
- Improving the process of populating NHS Borders Immediate Discharge Letters specific to HaH
- Developing and testing several patient referral and discharge pathways
- Developing and circulating a HaH patient and carer information leaflet

The HaH team have welcomed the continued support from all the health and social care services that have been involved so far and are actively seeking further involvement to ensure a robust HaH service is available to Borders.

Gail Turner – Nurse Team Lead, Hospital at Home

"I feel I have been an active participant in all aspects of the development of HaH since I started in post. I am extremely passionate about the service and the values it represents. I feel supported by our HaH team, the wider HaH community and our health and social care colleagues, to continuously strive to develop a gold standard service, to provide the population of NHS Borders with the right care at the right time."

8.9. **Outcome 9 - Resources are used effectively and efficiently in the provision of health and social care services.**

Since the implementation of the TOC, the HaH team regularly monitors the use of resources to ensure these are being used effectively and efficiently throughout. This information is regularly recorded and will be used when evaluating the TOC, specifically looking at what impact the

resources had on the process of managing a patient at home rather than in BGH or other acute services.

8.10. In additional to the information above, it is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	How it will be measured	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Admissions with no onward referral to inpatient services.	Increase
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Admissions with no onward referral to inpatient services.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Through patient feedback surveys that Hospital at Home staff provide during visits.	Increase
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Through patient feedback surveys that Hospital at Home staff provide during visits.	Increase
5	Health and social care services contribute to reducing health inequalities.	Information from Admissions to HaH service. Average length of stay – can help to reduce the amount of travel family/carers would do to hospital.	Increase
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.	This could be captured via a Social Care questionnaire.	Increase
7	People who use health and social care services are safe from harm.	Admissions with no onward referral to inpatient services.	Increase
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Through discussions at the weekly Hospital at Home Delivery Group meetings and their daily huddles.	Increase

9	Resources are used effectively and efficiently in the provision of health and social care services.	Through discussions at the weekly Hospital at Home Delivery Group meetings and their daily huddles.	Increase

Financial impacts

8.11. In order to extend the current model, the pilot will require further investment as the SG money has been utilised. Therefore, it is recommended that the IJB release the MDT allocation component that has been earmarked for HaH on a non-recurring basis.

Equality, Human Rights and Fairer Scotland Duty

8.12. Stage 1, Stage 2 and Stage 3 of Equality, Human Rights and Fairer Scotland are attached as separate documents.

Legislative considerations

8.13. Currently there are no relevant legislative considerations that impact the work on Hospital at Home.

Climate Change and Sustainability

8.14. HaH models can contribute to supporting climate change mitigation and adaption by reducing the carbon footprint associated with traditional hospital care. HaH could require less energy-intensive infrastructure compared to traditional hospitals. This includes lower energy requirements for heating, lighting, and other operational needs, resulting in reduced carbon emissions associated with energy consumption.

8.15. HaH models aim to provide care in a patient's own residence, reducing the need for resource-intensive hospital equipment/utilities. This includes the efficient use of electricity, medical supplies, and other resources such as laundry facilities.

8.16. HaH can help minimise indoor air pollution by providing care in a patient's home, where air quality can be more easily controlled and maintained compared to traditional hospital where expensively run ventilation and filtration systems.

Risk and Mitigations

8.17. **There is a risk that operational scalability may be limited due to local workforce challenges leading to partial outcome realisation and inconclusive model options.**
HaH programme is flexible and adaptable to changing circumstances. With access to the Health Improvement Scotland's Hospital at Home Portal and respective national mentors, as workforce challenges arise, the programme has been open to revising existing strategies and adjusting plans accordingly. The programme continuously evaluates the scalability of the service under a Scottish Borders context and will adjust staffing levels or allocation as needed to minimise any negative impacts to the integrity of the TOC.

9. CONSULTATION

Communities consulted

9.1. As early adopters of the Health and Social Care Partnership's Equality, Human Rights and Fairer Scotland Duty Impact Assessment process, HaH proactively identified several groups through our dedicated Impact Assessment Working Group, paying specific attention to any gaps there may be.

9.2. The group is chaired by the P&CS General Manager and members include patient representatives and NHS Borders Public Involvement Officer. They meet regularly to review any emerging service development and they can directly influence meaningful changes to safeguard or enhance people's access and interactions with the service. The group has used the HSCP Impact Assessment template to guide considerations and will actively pursue the views of those that may be impacted by the service.

9.3. There are 3 stages to the Impact Assessment with Stage 1 'Proportionality and Relevance' having been completed. Results from Stage 2 'Empowering People – Capturing their Views' are displayed in the table under section 9.4, with further consultation with identified groups planned. The last stage, Stage 3 'Analysis of Findings and Recommendations' will be discussed at the next Impact Assessment meeting in August 2023 and then all required actions will be taken forward. It is important to note that Stage 2 and Stage 3 of the Impact Assessment are ongoing stages, therefore these will not be completed until the end of the TOC. The Stage 1 and Stage 2 documents will be attached as separate documents.

9.4. Services / Teams that have been to date been contacted/ consulted:

Audience	Feedback	Outcome(s)
HaH Programme Board	Patient representatives suggested change to patient leaflet.	Suggested changes made to leaflet and updated leaflet being provided to patients treated by the HaH service.
Physical Disability Strategy Group	The Physical disability Strategy Group asked for feedback on the following 3 questions: 1. What if I need additional equipment? 2. What if a patient has complex needs? 3. What happens if I need a hoist?	All 3 questions, with answers, were added to the Information Pack's Q&A section and circulated to the group for information.
Strategic Ukrainian Settler Group	How will HaH overcome language barriers?	The HaH will follow the same procedure as in hospital – using Language Line to assist with language issues with refugees Apps such as "Say Hi" and Google Translate are tools that can also help if language barriers are unexpected.
Drug and Alcohol Partnership	Only feedback received was of a positive nature and that the HaH service is seen as an excellent addition.	Positive feedback recorded.

Poverty	Question raised re how district nurses respond to patients living in abject poverty and if the HaH service will refer patients to community larders/ foodbanks.	HaH service explained if these scenarios arise, building and continuing relationships with the patient to provide support is very important. Conversations will also take place with the GP, Adult Protection Services and Social Work if required.
Ethnic Minority Group	Only feedback received was of a positive nature and that the HaH service is seen as an excellent addition.	Positive feedback recorded.
LGBTQ+/ Gender Reassignment	Ongoing	Request sent to meet to discuss the HaH service.
Child Carers	Ongoing	Request sent to meet to discuss the HaH service.

Integration Joint Board Officers consulted

9.5. The IJB Chief Officer is a core member of the Reporting and Finance subgroup and the IJB Chief Officer is involved via the Urgent and Unscheduled Care Programme Board. Both Officers have provided feedback and contributed to the development of the project.

9.6. The IJB Equalities, Human Rights and Diversity Lead will be involved, by reviewing and by providing feedback at the Integrated Joint Board meeting taking place 20 September 2023.

9.7. In addition, consultation has occurred with our statutory operational partners at the:

- HSCP Joint Executive
- SPG Meeting – 02 August 2023
- Hospital at Home Programme Board

Approved by:

Cathy Wilson – General Manager for Primary and Community Services

Author(s)

Cathy Wilson – General Manager, Primary and Community Services
Debbie Raftery – Project Manager, Urgent and Unscheduled Care Programme, Hospital at Home

Background Papers: Stage 1, Stage 2 and Stage 3 of the Equality, Human Rights and Fairer Scotland documents will be attached as separate documents.

Previous Minute Reference: none

For more information on this report, contact us at Cathy Wilson, cathy.wilson@borders.scot.nhs.uk

DIRECTION FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Direction issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-200923-1
Direction title	Hospital at Home Pathfinder
Direction to	NHS Borders
IJB Approval date	TBC – to be considered at Health and Social Care Integration Joint Board on 20 September 2023
Does this Direction supersede, revise or revoke a previous Direction?	Yes (Reference number: SBIJB-210922-01) Supersedes X Revises Revokes
Services/functions covered by this Direction	General Medicine, Medicine of the Elderly Services, Respiratory Medicine, Community Health services
Full text of the Direction	NHS Borders is asked to undertake a 6 month test of change for the Hospital at Home service as a transformation programme, so that a full Business Case can be presented to the February 2024 Integration Joint Board meeting to decide on whether the service is sustainable using existing resource, and should be continued. As part of this test of change, the Health and Social Care Integration Joint Board would be supportive of a separate bid being made to the Scottish Government / Healthcare Improvement Scotland for further funding, should this be endorsed by the NHS Borders Board Executive Team.
Timeframes	To start by: With immediate effect To conclude by: 31 March 2024, with a paper to be considered by the IJB in February 2024.
Links to relevant SBIJB report(s)	20 September 2023 Integration Joint Board: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6537&Ver=4 Item 4a 21 September 2022 Integration Joint Board: https://scottishborders.moderngov.co.uk/ieListDocuments.aspx?CId=218&MId=6386&Ver=4
Budget / finances allocated to carry out the detail	The Integration Joint Board has agreed to allocate £319k of the MDT funding allocation on a non-recurrent basis to the end of 2023/24 to enable the test of change. It is expected that a financially sustainable business case will be presented to the Integration Joint Board to determine the ongoing funding of this service past the timeframes outlined in this Direction.
Outcomes / Performance Measures	Opportunity cost information on the staffing and financial model compared to the status quo is expected from the business case. In addition, the IIA, staffing model, use of technology enabled care, transformation project plan, proposed service specification and expected capacity should be included. The following improvements in the National Health and Wellbeing outcomes are sought from the business case: • The percentage of adults with intensive care needs at home • Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated • Percentage of adults supported at home who agreed that they are supported to live as independently as possible; • Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their

	quality of life; • Percentage of adults supported at home who agreed they felt safe; and • The percentage of carers supported to continue in their caring role Should the business case be supported then capture of the following minimum performance dataset is required: • Service user surveys against the National Health and Wellbeing outcomes listed above • Number of patients referred per month • Proportion admitted of total referrals • Number of patients managed at home • Length of stay • Anticipated hospital bed days saved • Mortality during admission • 30 day outcomes (death, readmissions) • Onward referrals to other statutory and partner health and social care services (broken down and grouped by service)
Date Direction will be reviewed	As the business case will be reviewed in the February 2024 Integration Joint Board, there is not an expectation that this Direction is reviewed at the IJB Audit Committee.

Scottish Borders Health and Social Care Partnership

Equality, Human Rights and Fairer Scotland Duty Impact Assessment – Stage 1 Proportionality and Relevance

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What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

Development of Hospital at Home Service in the Scottish Borders

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (employees, clients, customers, people using services) indicate all that apply

Age	Disability Learning Disability, Learning Difficulty, Mental Health, Physical Neurodiversity	Gender	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation
□	□	□	□			□	□	□

Equality and Human Rights Measurement Framework – Reference those identified in Stage 1 (remove those that do not apply)

Education	Work	Living Standards	Health	Justice and Personal Security	Participation
Higher education Lifelong learning	Employment Earnings	Poverty Housing Social Care	Social Care Health outcomes Access to health care Mental health Reproductive and sexual health*	Hate crime, homicides and sexual/domestic abuse	Access to services Social and community cohesion* Family Life*

*Supplementary indicators

Main Impacts	Are these impacts positive or negative or a combination of both	Are the impacts significant or insignificant?
People will be cared for, as far as reasonably practicable, independently in their own home.	Positive	Significant
Improved patient satisfaction and health outcomes.	Positive	Significant
Prioritises the delivery of person-centered care in a respectful and dignified manner.	Positive	Significant

Is the proposal considered strategic under the Fairer Scotland Duty?	Yes
E&HRIA to be undertaken and submitted with the report – Yes **If no – please attach this form to the report being presented for sign off**	**Proportionality & Relevance Assessment undertaken by:** **Cathy Wilson – General Manager of P&CS** **Date: 10/05/23**

Equality Human Rights and Fairer Scotland Duty Impact Assessment

Stage 2 Empowering People - Capturing their Views

Hospital at Home

The pilot will implement a Hospital at Home in NHS Border to understand how to gain the maximum benefits for the patients, how to assist with hospital pressures and how to implement the service so that it is operationally efficient- processes, procedures, sustainability.

Equality Human Rights and Fairer Scotland Impact Assessment Team

Role	Name	Job title	Date of IA Training
E&HR Service Specialist	TBD		
HSCP Joint Executive Team	Dr Lynn McCallum Chris Myers	Medical Director Chief Officer of Health and Social Care Partnership	
Responsible Officer	Cathy Wilson	General Manager – Primary and Community Services	
Main Stakeholder (NHS Borders)	Urgent and Unscheduled Programme Board		
Mains Stakeholder (SBC)	Urgent and Unscheduled Programme Board		
Third/Independent Sector Rep			
Service User	Margaret	Patient Representative	

	Carol Anderson	Patient Representative

Evidence Gathering (will also influence and support consultation/engagement/community empowerment events)

Evidence Type	Source	What does the evidence tell you about the protected characteristics affected?
What equalities information is routinely collected from people currently using the service or affected by the policy?	Not currently gathered	New service equality data to be embedded, captured and reported against as part of TOC and will include the following Patient Management data systems – TRAK, EMIS, BadgerNet
Data on populations in need	Healthcare Improvement Scotland/Cochrane Review	Older people with frailty are the single biggest users of hospital beds and the fastest growing demographic. Across the UK the population of over-85s is predicted to double between 2018 and 2043. Evidence and experience points to various drivers for developing a Hospital at Home service for older people. Safe and effective alternatives to hospital bed-based acute care are needed to manage demographic pressures and provide a better experience for individuals.
Data on relevant protected characteristic	Not currently gathered	New service equality data to be embedded, captured and reported against as part of TOC and will include the following Patient Management data systems – TRAK, EMIS, BadgerNet
Data on service uptake/access	To be gathered via Hospital at Home Dashboard	New service equality data to be embedded, captured and reported against as part of TOC. This will include: Age Sex Race
Data on socio economic disadvantage	Not currently gathered locally. Healthcare Improvement Scotland	GP referral will be recorded to identify correlation between areas of multiple deprivation and access/uptake to the service. Nationally, areas of deprivation may have higher referral rates to Hospital at Home services. COVID-19 has seen a shift towards patients requesting an alternative to hospital admission and may increase referral rates. Patients living in rural areas where it could be difficult to access medical care could see Hospital at Home as a favourable option.

Research/literature evidence	Healthcare Improvement Scotland/Cochrane Review	Evidence points to various drivers for developing a Hospital at Home service for older people as it reduces the disruption to a person's existing formal and informal care and support arrangements through the addition of acute-level care in their home. The drive to provide a more person-centred care experience for individuals, avoiding the risks of healthcare acquired infection, and/or institutionalisation.
Existing experiences of service information	Not available - new service to Scottish Borders	Not available - new service to Scottish Borders
Evidence of unmet need	NHSB delayed discharge data	Scottish Borders has the largest percentage of people going from hospital to residential care as unable to meet their needs within the community.
Good practice guidelines	Hospital at Home – Healthcare Improvement Scotland	Evidence points to various drivers for developing a Hospital at Home service for older people as it reduces the disruption to a person's existing formal and informal care and support arrangements through the addition of acute-level care in their home. The drive to provide a more person-centred care experience for individuals, avoiding the risks of healthcare acquired infection, and/or institutionalisation.
Other – please specify		
Risks Identified		Not identified yet as still to find out what the inequalities are
Additional evidence required		

Consultation/Engagement/Community Empowerment Events

Event 1: Patient Representative Discussion

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
28/02/2023 - onward	Teams	2	Age, Poverty, Disability, Unpaid careers

***Attendance by category – including but not limited to: People using the service, people not using the service - currently, unpaid carers, paid carers, key stakeholders (organisation and job title)**

Views Expressed	Officer Response
Patient representatives asked for alternative forms of gathering patient feedback once the service has been implemented. An example given would be exploring the potential for volunteers to gather feedback from patients either online or on paper. Under Living Standards, should people living alone, with no family member close by, be included?	Patient feedback forms to be co-designed with patient representatives. Living alone does not exclude anyone from being eligible for Hospital at Home – everyone irrespective of if they live alone or with someone will be assessed against the eligibility criteria.

Event 2: Strategic Ukrainian Settler Group

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
18/04/2023	Teams	Not documented	Age, Race, Religion/Belief, Refugees

Views Expressed	Officer Response
Language Barriers Question raised from Ukrainian Settler Group on how HAH will overcome language barriers when treating patients.	Establish at initial assessment how person would like to be communicated with. This will enable HAH team to follow the same procedure as in hospital. They will utilise services such as Language Line, Say Hi, Google Translate. Protocols around the use of language apps etc to be developed to reduce any possibility of data breach or misinformation. Patient feedback forms will look to capture satisfaction of the process.

Event 3: Physical Disability Strategy Group

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
13/04/2023	Teams	Not documented	Disability

Views Expressed	Officer Response
What if I need additional equipment? What happens if I need a hoist? What if a patient has complex needs?	This was taken into discussion with the Physical Disability Strategy Group and resulted in the co-production of a contribution to the Hospital at Home Information Pack which addresses all of the questions asked

Event 4: Alcohol and Drug Partnership

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
24/04/2023	Teams	Not documented	Substance/ alcohol misuse

Views Expressed	Officer Response
No view expressed at this involvement event.	Link between Hospital at Home Programme Board and the Alcohol and Drug Partnership to enable ongoing dialogue during the TOC to ensure the needs of those with the relevant lived experience are taken into account.

Event 5: NHSB Ethnic Minority Group **

Date	Venue	Number of People in attendance by category*	Protected Characteristics Represented
26/04/2023	Teams	Not Recorded	Race

Views Expressed	Officer Response
A positive development that enables individuals to meet their own cultural needs eg food preparation	

Equality, Human Rights and Fairer Scotland Duty Impact Assessment

Stage 3

Analysis of findings and recommendations

Hospital at Home

Please detail a summary of the purpose of the proposal being developed or reviewed including the aims, objectives and intended outcomes

In recent years, healthcare professionals have been considering new ways to respond to the acute care needs of older people with frailty and other long-term conditions. Urgent care is needed but hospitals bring risks for older people as well as benefits, and community-based alternatives are increasingly being explored. This has resulted in a shift in focus within the NHS and internationally towards providing hospital-level care in a person's home environment. This service is generally referred to as "Hospital at Home" and is a short-term intervention providing acute care of a level comparable with that provided in a conventional hospital. It is not the same as case management of chronic conditions but can work with this type of service to assist in the management of exacerbations of those conditions.

Across Scotland, Health Boards have developed this service to provide care in this form. The care is recognised to be safe and cost effective, and popular with patients and staff. It can provide an alternative to admission for selected patients and (once scaled up) can relieve some pressure on acute services, though only in some areas has it been shown to facilitate closure of inpatient beds.

The pilot will implement a Hospital at Home in NHS Border to understand how to gain the maximum benefits for the patients, how to assist with hospital pressures and how to implement the service so that it is operationally efficient- processes, procedures, sustainability.

Section 1: Equality Act 2010 – Relevant Protected Characteristics as identified in Stage 1 or during Stage 2

Protected Characteristic	Equality Duty	What impact and or difference will the proposal have	Measures to evaluate/mitigating actions
Age	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home is uniquely designed and planned with a person-centred approach. Hospital at Home assessments takes into account individual preferences, capabilities, and independence. Therefore ensuring that people are treated with dignity and respect.	Hospital at Home reporting dashboard monitors admission by age.
	Advancing equality of opportunity	Hospital at Home assessments criteria will ensure that the care package is designed to meet the unique requirements of each individual, enabling older people to live in their own home with their loved ones.	Hospital at Home reporting dashboard monitors admission by age. Analysis of patient feedback forms.
	Fostering good relations by reducing prejudice and promoting understanding	Hospital at Home associated communication leaflets have been designed to promote that this service is designed to meet needs and not explicitly for people over the age 65+.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases.
Disability	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home is an inclusive service, that results in a more tailored service for patients because of reasonable adjustments and taking an agile/flexible approach to patient care.	Ensure our Patient Management System is up to date with knowledge about patient communication needs and capacities. It is not possible with the current data set to clearly capture and report on individuals with disabilities, however case notes and be reviewed retrospectively and daily huddles discussions include the review of

		For people with disabilities, long-term conditions, or frailty, Hospital at Home offers several benefits. Patients can maintain their independence by living in familiar surroundings, where they have established support networks and access to community resources. This helps to preserve their sense of identify and autonomy while receiving the necessary care and assistance tailored to their specific needs.	individual care – recognise each patient care and/or enhanced care needs
	Advancing equality of opportunity	Allowing individuals to be treated in the comfort of their own home environment which may be a more appropriate and familiar setting, Hospital at Home complements the person-centred approach. The Hospital at Home model of care provides the time to go over key information to help people with learning disabilities to make informed decisions.	We will engage with learning disability groups within the local community to ensure that people with learning disabilities are aware of what the Hospital at Home service is.
	Fostering good relations by reducing prejudice and promoting understanding	Hospital at Home associated communication leaflets have been designed to promote that this service is designed to meet needs including those of disabled people.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases.
Gender Reassignment	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	By supporting people at home, the service can be beneficial to those who feel any perceived risks as a result of gender	We will link with Gender Reassignment groups to understand what adjustments

		reassignment by providing the flexibility to schedule appointments or access healthcare.	may be required and we will train our staff to be aware of these. Investigating if our Patient Management System can support gender identification and use of pronouns
	Advancing equality of opportunity	Being in a familiar environment can reduce stress and contribute to a sense of safety	We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the needs of people undergoing gender reassignment recognising that they may require service adjustments sensitive to these.
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this time	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases. Staff and caregivers will be trained on appropriate use of pronouns and questions through training.
Marriage and Civil Partnership	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	None identified at this stage

	Advancing equality of opportunity	None identified at this stage	None identified at this stage
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	None identified at this stage
Pregnancy and Maternity	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	None identified at this stage
	Advancing equality of opportunity	None identified at this stage	None identified at this stage
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	None identified at this stage
Race	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Hospital at Home care delivery will be designed to meet the specific medication and care needs of individuals.	Ensuring communication and information is available in different languages.
	Advancing equality of opportunity		Staff will be made aware of the sensitivities relating to explaining some health issues, for example, mental health issues or sexual health issues.
	Fostering good relations by reducing prejudice and promoting understanding		We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the individual needs of people recognising that some Races have a higher incidence of certain diseases.
Religion & Belief including non- belief	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	Individuals will co-produce a care plan that meets their religious requirements e.g. times of worship, religious-based dietary requirements, cultural awareness and sensitives e.g., providing hygienic shoe covers to enable entry to house	Staff awareness programme

	Advancing equality of opportunity	**Hospital at Home enables individuals to continue practice more fully their religious beliefs.**	**None identified**
	Fostering good relations by reducing prejudice and promoting understanding	**We will listen to our community representatives and the voices of those with lived experience to ensure our services meet the needs of people regardless of religion and belief.**	**Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice.** **This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases.** **We will link with representatives of the relevant religious and faith communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.** **Hospital at Home staff are trained to have cultural competence, compassion, and sensitivity, ensuring that care is provided in a respectful and non-discriminatory manner. This helps foster trust and a positive relationship between the patient and their care providers.**
Gender (Sex)	**Eliminating discrimination, harassment, victimisation, or any other prohibited conduct**	**Hospital at Home enables the individual to present in their preferred gender and not to conform with hospital admission criteria.**	**Investigating if our Patient Management System can support gender identification and use of pronouns**
	Advancing equality of opportunity	**Hospital at Home enables the individual to present in their preferred gender and not to conform with hospital admission criteria.**	**Staff will be made aware of the sensitivities surrounding gender**

			Analysis of patient feedback forms.
	Fostering good relations by reducing prejudice and promoting understanding	Individuals will co-produce a care plan that recognises their gender preferences and document sensitives around care giving.	Feedback mechanisms will be analysed as a way of identifying any unintended discriminatory practice. This will allow for prompt action and resolution, fostering an environment of inclusivity and eliminating any harmful practices or biases
Sexual Orientation	Eliminating discrimination, harassment, victimisation, or any other prohibited conduct	None identified at this stage	We are still to meet with representatives of the LGBTQ-i- communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.
	Advancing equality of opportunity	None identified at this stage	We are still to meet with representatives of the LGBTQ-i- communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.
	Fostering good relations by reducing prejudice and promoting understanding	None identified at this stage	We are still to meet with representatives of the LGBTQ-i- communities in Scottish Borders to educate and gather feedback to help inform our thinking in this respect.

Section 2: Equality and Human Rights Measurement Framework Human– Reference those identified in Stage 1 (remove those that do not apply)

Domain	Indicator	Enhancing or Infringing	Impact and or difference will the proposal have	Measures to evaluate/mitigating actions
Education	Higher education and lifelong learning	Enhancing	The proposal will allow those to continue attendance of education without unnecessary interruption. It allows them to receive necessary medical care while still being able to attend classes or study from home. Enables individuals with disabilities or chronic illnesses to actively participate in higher education or lifelong learning. They would not be restricted to the physical limitations of hospital settings, promoting inclusion and equal opportunities for education. Patients can engage in educational activities at their own pace and convenience, preserving their dignity and autonomy throughout the treatment process. Overall, the flexibility of the service empowers patients to balance their educational commitments and medical treatment effectively.	Feedback from patients will focus on accessibility, inclusivity, autonomy, and flexibility that the service has offered.
Work	Employment Earnings	Enhancing	The proposal will allow people who work from receive necessary medical care while still being able to work. This empowers patients to balance work/life commitments and medical treatment effectively.	Feedback from patients will focus on accessibility, inclusivity, autonomy, and flexibility that the service has offered.

		Infringing	An unpaid carer in paid employment may be negatively affected if they are required to support the patient at home while treatment is provided.	Part of the assessment for Hospital at Home eligibility is a conversation with the individual, family and/or non-paid carer. It is important prior to admission to fully understand the impacts treatment in a home may have.
Living Standards	Poverty Housing Social Care	Enhancing	Enables people to stay at home to. The service will also be able to signpost and refer people they are caring for to community based services.	We will ensure safeguarding is in place such as researching into how food is provided to patients who need it prior to referring a patient to the Hospital at Home service. We will work with other community services such as social work to ensure patients are able to access the Hospital at Home service. We will utilise the Integrated Joint Board needs assessment to understand the needs of patient. We will tap into poverty related third sector to support patients access care in their homes. We will aim to deliver person-centred service in response to need.

				Hospital at Home is aware of possible fluid accommodation arrangements so the Hospital at Home service will develop a way of being flexible to meet the needs of potential patients, especially as patients may be in non-residential setting eg hotels
Health	Social Care Health outcomes Access to health care Mental health	Enhancing Infringing	By enabling individuals to remain in their homes or community settings, Hospital at Home helps minimise the disruption and negative impact associated with institutional care. This can lead to improved mental wellbeing, reduced stress, and enhanced social connections, as individuals are able to maintain their social interactions and engagement within their communities. The majority of unpaid carers are women and by using Hospital at Home will enable women to continue in their care-giving role Non-paid carers that may benefit from temporary respite from an acute hospital stay, may be negatively impacted by having to look after their loved ones at home.	Staff who are treating patients in their home will be able to signpost to appropriate community support services provided by third sector. Admission with no onward referral to inpatient services Through patient feedback surveys that Hospital at Home staff provide during visits.
Justice and Personal Security	Hate crime, homicides and sexual/domestic abuse	Enhancing	Hospital at Home may provide a service in a setting that has domestic abuse which may endanger the patients themselves or the non-paid carer in their home. Quality and ability of the service may also be impacted. As nurses are trained to recognize signs of domestic	We will ensure safeguards are in place for patients/ respond quickly if any gender-based violence occurs.

			abuse in the home, they will be able to raise concerns via the adult protection process.	Safer community documents are shared from community groups.
Participation	Access to services Social and community cohesion* Family Life*	Enhancing	By enabling individuals to remain in their homes or community settings, Hospital at Home helps minimise the disruption and negative impact associated with institutional care. This can lead to improved mental wellbeing, reduced stress, and enhanced social connections, as individuals are able to maintain their social interactions and engagement within their communities.	Through patient feedback surveys that Hospital at Home staff provide during visits.

Section 3: Fairer Scotland Duty

Identify changes to the strategic programme/proposal/decision to be made to reduce negative impacts on equality of outcome and or improving health inequalities	Updating Information Pack's Q&A with additional details around accessing equipment Recognising the cultural and religious sensitivity aspects of treating a patient in their home through training As the proposal is in a test to change cycle for an additional 6 months the team will be constantly reviewing and assessing changes that can be made to reduce impact and improve health inequalities.
Identify the opportunities the strategic programme/proposal/decision provides to reduce or further reduce inequalities of outcome and or improving health inequalities	Hospital at Home can enhance access to health care for patients who may face barriers such as transportation difficulties, socioeconomic challenges, or living in remote areas. By bring the necessary care directly to patients' homes, Hospital at Home can bridge the gap an ensure equitable access for all individuals, reducing inequalities in outcomes. Hospital at Home enables clinicians/ health care professionals to intervene promptly when patients' conditions require medical attention. This timely intervention can prevent exacerbation of illnesses and reduce the likelihood of complications, improving health outcomes and narrowing health inequalities caused by delayed or inadequate treatment.

Care is tailored to individual needs. This approach can address health inequalities by acknowledging and accommodating patients' specific circumstances, cultural backgrounds, and preferences. Carers don't have to travel to hospital and care packages will remain the same for patients.

Hospital at Home service facilitate better continuity of care by enhancing communication and coordination between health and social care providers, leading to more streamlined and holistic care – this is particularly important for those with complex medical conditions or multiple health care needs, reducing health inequalities.

By providing patients with information, resources, and support to manage their conditions effectively, the services can empower individuals to take control of their health, reducing health inequalities associated with knowledge gaps or limited literacy.

Section 4: Are there any negative impacts with no identified mitigating actions? If yes, please detail these below:

Not Applicable

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Section 5: Equality, Human Rights & Fairer Scotland Duty Impact Assessment Recommendations

What recommendations were identified during the impact assessment process:

Recommendation	Recommendation owned by:	Date recommendation will be implemented by	Review Date
	(Name and job title)		
Analysing feedback forms to gather relevant information under Fairly Scotland Duty	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC
Review easy read material – adapted from learning from Hospital at Home pilot	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC
Staff training on cultural and social sensitivities	Hospital at Home Clinical Team Lead	31/01/2024	TBD after evaluation of TOC
Establish list of community services for signposting	Hospital at Home Administrator	31/01/2024	TBD after evaluation of TOC
Codesign patient leaflet	Hospital at Home Clinical Team Lead	31/01/2024	TBD after evaluation of TOC
Investigation Patient Management system for recording of additional characteristics	Hospital at Home Administrator	31/01/2024	TBD after evaluation of TOC
Continuing active engagement with representatives of LGBTQA+; religious and faith, Race and people undergoing gender reassignment	Cathy Wilson, GM	31/01/2024	TBD after evaluation of TOC

Section 6: Monitoring Impact – Internal Verification of Outcomes

How will you monitor the impact this proposal affects different groups, including people with protected characteristics?

Monthly Hospital at Home Reporting Sub-Group
Analysis of data to see if there are any variances between the protected characteristics
Through patient feedback surveys that Hospital at Home staff provide during visits
Continuous engagement with community representatives to gather feedback to help inform our thinking and develop our service

Section 7: Procured, Tendered or Commissioned Services (SSPSED)

Is any par/t of this policy/service to be carried out wholly or partly by contactors and if so, how will equality, human rights including children's rights and the Fairer Scotland duties be addressed?

N o

Section 8: Communication Plan (SSPSED)

Please provide a summary of the communication plan which details how the information about this policy/service to young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language will be communicated.

Our Public Health team has recently joined us for collaborative working to ensure that any communication plans are communicated in a way that supports young people, those with a visual or hearing sensory impairment, difficulty with reading or numbers, learning difficulties or English as a second language.

Easy read material will be provided for those who request it and communication awareness with staff to understand the challenges.

Signed Off By:

Cathy Wilson, General Manager of Primary and Community Services

Date: 13/09/23

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