Appendix Two
Key Ambitions of Operation Home First

To maintain people safely at home

To avoid unnecessary hospital admission or attendance

To support early discharge back home after essential specialist care

HSCM HOME FIRST-DISCHARGE TO ASSESS

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF1 **Project Lead**: Dawn Duncan **SRO:** Sean Coady

Key Aims

- Intermediate, early supported discharge approach
- Where hospital in-patients who are clinically stable and do not require acute hospital care but may still require rehabilitation or care services provided with short term support
- Discharged to their own home where assessment for longer term requirements is then undertaken in the most appropriate setting i.e. the person's own home and at the right time, by a trusted assessor

Primary Objectives

- Essential criteria
- Patient focussed care
- Easy and rapid access to services
- Effective assessment
- Easy information flow
- Networks of blended care
- Blurred boundaries
- Continuous evaluation & feedback

Scope

- #endpjparalysis/Care in Between
- Delayed Discharges/Hospital @ Home
- Care of the Elderly/Living Longer Living Better in Moray
- Moray Partners in Care/6 Essential Actions for Unscheduled Care
- Active & Independent Living Programme Ambitions for AHPs.

Achievements

- This project has successfully completed a test of change (July/Aug 2020), providing the system with enough assurance to allow it to progress to pilot phase and allocate funding accordingly – 5Oct to 31 March 2021.
- Staff Q&A session December 2020
- Forensic mapping of 12 patient journeys
- Report presented to SMT and then to IJB development session was favourably received and then approved funding on 25 March 2021 for full implementation.

Programme Workstreams Progress

Activities in current period

26/3/21	**Permanent funding establishes- approved by MIJB.**	
1/4/21	Recruitment of new staff – in progress (Hiatus now between end of pilot and establishing new staff)	
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Future Actions/Milestones

Action	Timescale	RAG
Recruitment of adequate staff resource to ensure operability.	June 2021	
Preparation of Staffing arrangements for new team, including equipment	June 2021	
Establishment of performance measures to monitor progress and identify further opportunities	June 2021	
Progress update on service delivery to Home First then SMT	November 2021	

Key Risks/Issues

- Failure to establish permanent staff
- failure to embed pathway in the systems.

Dependencies

- Recruitment pending

Finance

- £500,000 funding secured for 2021/22

Performance

- Measurements for success needed and criteria established.
- Real time measurements as well as potential future aims.
- Established trends noticed.

HSCM HOME FIRST-DELAYED DISCHARGES

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF2 **Project Lead**: Lesley Attridge **SRO:** Sean Coady

Key Aims

Whole system approach to discharge

Primary Objectives

There are four components to this work stream: Admission Avoidance, Discharge Planning Process, Community Hospital Transfers and Provision of Care in the Community

Scope

To identify and implement changes to the discharge process. This a complex piece of work involving all teams across the system.
The aim is to ensure there is sustainable processes in place to support early discharge home and reduce delayed discharge bed days.
Scope, plan and deliver a whole system approach for discharge in Moray that is safe, properly resourced and is sustainable.

Achievements

The system has shown a reduction in the number of delayed discharges since October 2020. The key areas of improvement that have contributed to this reduction are:
Communication - weekly meetings to review patients on Community Hospital waiting list; weekly meetings to review operational issues/concerns; Locality Managers attend weekly meetings with commissioning and providers; Weekly/daily Multidisciplinary team meetings; Mental Health staff attend senior charge nurse meetings; key information summary available to members of the multidisciplinary team; Out of hours Social Work contact details given to Emergency Department.
Improvements in pathway work - Community Response Team (CRT) pathway circulated; Contracts with new external providers in place; Discharge Coordinator in position; Implementation of Social Work screening tool and Implementation of traffic light system across both acute & community hospitals.

Programme Workstreams Progress

Activities in current period

31.01.2021	Appointment of Care at Home assessors – ongoing	
31.01.2021	MDT model – Ward 5 and 7 processes under review	
31.03.2021	Intermediate care options being reviewed including current provider provision and long term provision. (Jubilee cottages in place whilst Loxa court is pilot project, ended March 2021 and an evaluation to be undertaken.	

Future Actions/Milestones

Action	Timescale	RAG
Review of OOHS provision of 24/7 community nursing model	TBC	
Overview of Surge and Flow Discharge work (to have a consistent process across NHSG), links with process mapping, all being led by Acute improvement team	TBC	

Key Risks/Issues

- Delays in the recruitment process and appointment of Care at Home assessors is impacting on progress. This is progressing and one person takes up post on 26 April and the second has a date pending.

Dependencies

Communications
Recruitment
Funding

Finance

Funding for extra posts

Performance

Measurements criteria established.
Real time measurements as well as potential future aims.
Established trends noticed.

HSCM HOME FIRST-HOSPITAL AT HOME

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF3 **Project Lead**: Sam Thomas **SRO:** Sean Coady

Key Aims

- Older people with frailty are at particular risk of being affected by institutionalisation and delirium. Some 30 to 56% have been shown to experience a reduction in their functional ability between admission to hospital and discharge.
- Hospital at Home is a short-term, targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital.
- Hospital at Home works best when it is part of an integrated acute and community-based service model to meet local population need.
- Creating the environment to support Integration Authorities, NHS Boards and Local Authorities to effect transformation and introduce services such as hospital at home will require close collaboration and robust strategic planning and commissioning across sectors.
- Timescales are driven by SG

Primary Objectives

- A short-term, targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital.
- It differs from other community services by enabling the management of more severe conditions, such as sepsis and pulmonary embolism.
- It provides urgent access to hospital-level diagnostics, such as endoscopy, radiology and cardiology, and access to interventions such as intravenous fluids and oxygen.
- Care is delivered by multi-disciplinary teams of healthcare professionals and is Consultant led, complying with current acute standards of care.

Scope

Programme Workstreams Progress

Activities in current period

	•Various meetings have been held that encompass a multi-disciplinary approach including acute, geriatrician, AHP and GP support.	
	•This has been supported by national webinars and meetings that have offered a national generic model.	
	D2A set up as a key foundation plank	

Future Actions/Milestones

Action	Timescale	RAG
process map and draw together appropriate team, incorporating governance and clinician buy in. A small cohort of patients will be trialled in the first instance. Grampian wide model.		
Staffing training , measurement and equipment Remote consultation via telephone and Near Me effectively utilising resources.		
Process will then go to SMT/IJB for appropriate timeline.		

Key Risks/Issues

- Failure to establish permanent staff/ failure to embed pathway in the systems/ SG criteria may not fit with Moray picture/ whole system approach/ rurality, limited HSCM model, recruitment issues in general and equipment infrastructure are ongoing issues. Geriatric pathway is ongoing concern Continued inappropriate admissions· Loss of independence
- · Increased morbidity/mortality through unnecessary hospital admissions· Increase in Delayed Discharges and decreased availability of medical beds for acute unstable admissions
- · Continued "silo management" and failure of integrated working

Achievements

- HSCM has been approved to take part in an Improvement Programme with Health Improvement Scotland to help develop and implement the Hospital @ Home model

Dependencies

- Funding
- Staffing

Finance

- funding

Performance

- Specific Targets/Measures need to be further elucidated/ identified through QI methodologies applied to
- multi-professional SLWG's in line with current modern clinical practice
- · It is important that both patients, relatives, carers and "staff at the coal face" are involved in the co-
- production of targets and measures in line with Realistic Medicine

HSCM HOME FIRST-Prevention& Self Management/ Respiratory Conditions

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF4 **Project Lead**: Iain MacDonald **SRO:** Sean Coady

Key Aims

To improve the health and wellbeing of those individuals with respiratory conditions, through the promotion of self -management strategies and tools. The three primary drivers to achieve this are:

- Provide the opportunity for individuals to self-monitor their health and wellbeing within their home and local communities.
- Enable professionals access to information and training to ensure they can best support individuals within their own homes and local communities.
- Promote and develop community support and resilience opportunities to support individuals within their local communities.

Primary Objectives

- Improving individuals digital connectivity
- Improving access to information
- Improving peer and community supports
- Increasing access to Weather Alerts
- Increasing access to My COPD App
- Increasing access and attendance at exercise programmes
- Increasing attendance at pulmonary rehabilitation programmes

Achievements

- Test of change completed with COPD patient cohort Oct to Dec 2020
- COPD Information for individuals/patient updated
- Community resources identified and actioned to support individuals becoming digitally connected.
- Virtual Pulmonary Rehab Programme provided for two patient cohorts Jan to March 2021.
- Virtual Exercise Programme provided for two respiratory conditions patient cohorts Jan to March 2021.
- Training Programmes for staff to upscale programmes Jan to April 2021.
- Funding identified and26 ICT devices purchased to enable individuals/patients to access information/virtual classes
- Sustainability of programme linked to Moray Council Sport and Leisure Business Plan

Programme Workstreams Progress

Activities in current period

12/04/2021	Third Cohort of Exercise Programme	
12/04/2021	Training of Exercise Instructors to Level 3 Qualification	

Future Actions/Milestones

Action	Timescale	RAG
Broaden out Programme to encompass all Long Term Conditions. Completion of training for exercise instructors	April 2021 onwards	
Further develop promotion material for individuals/patient, GPs and HCPs. Reintroduction of face to face classes whilst maintaining virtual programmes	May 2021 onwards	
Promote a locality perspective to developing Prevention and Self Management incorporating local 3rd sector & volunteer organisations. Introduction on MYCOP and Health Care Apps	June 2021 Onwards	

Key Risks/Issues

- Sustainability of funding to maintain and develop programmes.

Dependencies

- Staffing and Resources

Finance

- Further funding investment to maintain provision of programmes

Performance

- Work completed at a Grampian level to ensure robust evaluation of programmes provision. Evaluation on going.

Data collected and evaluated includes:

- Before and after questionnaires for participants and staff
- Measurement of EQ 5D improvement in wellbeing scores
- Participant case studies
- Quantitative data

Participant Feedback:
"Prior to the programme I felt that I had no energy & lethargic and quite depressed. I was missing social interaction with people due to COVID-19 and having to shield."

Participant Feedback: *"I think the programme has helped my physical health because my strength in my arms and legs has improved and my stamina has also improved."*

HSCM HOME FIRST-Mental Health

Report Date:	14/04/2021
RAG Status:	

Project Ref : HF10 **Project Lead**: Pamela Cremin **SRO:** Sean Coady

Key Aims

- Safe, equitable secondary care mental health services for Moray population; Access
- Recovery focussed secondary care Moray mental health services
- Community based mental health services
- Reducing Drug and Alcohol related harms
- A move away from traditional service age boundaries at transitions – services for young people up to age of 25 more integrated across CAMHS and Adult Mental Health Services
- Suicide Prevention
- Improving people's experience of care
- Peer and Carer involvement

Scope

- Delivery of Good Mental Health for All Moray Strategy 2016-26; and NHS Scotland Mental Health Strategy 2017-2027
- Unscheduled Care
- Distress Brief Interventions
- Forthcoming Mental Health Transition and Renewal Plan and funding
- Strategic Commissioning
- Trauma Informed Workforce
- Primary Care Mental Health: service and workforce development

Achievements

- Mental health Services fully remobilised and responsive
- Technology enabled service and practitioner uptake of Near Me
- Referral Criteria for secondary care updated
- Improved Adult Psychology waiting times – achieved 18RTT standard in November 2020 and sustained as of April 2021
- Evaluation of Urgent Care Team which was in place during pandemic – now disbanded as service is fully remobilised
- Liaison with GP practices and their MDTs established as a regular part of mental health service delivery in Moray
- NHS Grampian Psychological Therapy Hub (Access); Moray staff supporting Hub delivery
- Moray Primary Care Psychological Therapies redesign

Programme Workstreams Progress

Activities in current period

	Redesign of Moray secondary care Psychological Therapies and re-establishing Groups	
	New Primary Care Psychological Therapies Service commenced on 1st April 2021	

Future Actions/Milestones

Action	Timescale	RAG
Develop Mental Health First Response in GP Practices to replace GP Link Worker Service	As soon as possible – current service gap	Specific to Primary Care
Trauma Informed Workforce – training and development for all H&SC Moray and commissioned service workforce	In progress	
IJB development session for mental health services to be held on 29 April 2021	29 April 2021	

Key Risks/Issues

- Bed spacing and reduced admission capacity across NHS Grampian for mental health in patient care
- 3rd Sector remobilisation in terms of supporting and working with people in their own homes to manage their mental health
- Workforce availability – some mental health posts difficult to recruit to. Medical Locum insitu for Older Adult Mental Health
- IT Platform for group therapy requires expansion to meet NHS G demand
- On going high risk drug and alcohol related harms; and deaths

Dependencies

- Multi agency working and collective risk and case management

Finance

- Mental Health Budget has no budget pressures. Core budget uplift announced by Scottish Government for 2021/22
- Increased funding for Moray Drug and Alcohol Service (MIDAS) from Moray Alcohol and Drugs Partnership (MADP)
- Significant new and future financial investment by Scottish Government mental health and substance misuse services for all ages

Performance

- Ongoing service performance and measurement of KPIs
- Performance monitoring of third sector commissioned contracts for mental health and substance misuse