APPENDIX 1

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:	30/09/2021
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 permanent funding approved on 25 March 2021 for full implementation.

Programme Workstreams Progress

Activities in current period

July	One and half Band 7 starts Monday 14 June Band 6 OT and Occupational Therapist starts 28 June 7 HSCW (6 WTE) appointed and started 13 July	
August	Discharge to Assess goes live 2 August. Performance measures established.	

Future Actions/Milestones

Action	Timescale	RAG
Progress update on service delivery to Home First then SMT	January 2022	

Key Risks/Issues

- Failure to demonstrate value within D2A and establish long term sustainability
- Failure to embed pathway in the systems.
- Impact of relocation from Dr Grays at short notice to temporary accommodation results in lack of accommodation for new starts.

Dependencies

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:	30/09/2021
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

Ongoing areas of improvement 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.
Recruitment – Appointed 2x Care at Home Assessors

Programme Workstreams Progress

Activities in current period

August	Intermediate care options being reviewed including current provider provision and long term provision – includes both Loxa Court and Jubilee Cottages.	
September	Launch of new pilot to look at obligations put in place through the Carers Act. Will look at how unpaid carer can be involved in each stage of the discharge process.	

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	
Planned Date of Discharge – embed surge and flow process across Moray system, incorporating MDT and traffic light system. Define approach Implement and communicate	TBC	

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.

Key Risks/Issues

- Staffing issues:-
  - Delays in the recruitment process and appointment of Care at Home assessors is impacting on progress. Short of staffing in some areas – may be as a result of model but requires investigation;
  - Delays in recruitment process may temporarily result, in the loss of an Experienced Discharge Coordinator. Work is ongoing to avert this.
  - Seeking maternity cover for Social work post.
- Number of Acute patients in hospital has increased and has caused an impact on the Hospital discharge team. These patients are more poorly than previously experienced.
- SDS, 3 Conversation model, Adult Social Care review- impact of potential changes to approaches is not yet know.
- Lack of understanding of PDD across sector – communication being progressed for cascading to staff

HSCM HOME FIRST-HOSPITAL AT HOME

Report Date:	30/09/2021
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

		RAG
July	Bid approved from Scottish Government at £207k. Funding for 8A (or maybe 7) and 2 Band 6.	
August	Band 8A and band 6 Job descriptions are being drawn up for recruitment. It is expected to be a secondment opportunity.	
July	Attendance at a number of Scottish Government/Health Improvement Scotland meetings will be required to report on performance. First meeting 25 July.	

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.	TBC	
Staffing training , measurement and equipment Remote consultation via telephone and Near Me effectively utilising resources.	TBC	
Process will then go to SMT/IJB for appropriate timeline.	TBC	

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

Dependencies

- Funding
- Staffing

Finance

- Funding of £207,000 received from SG

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

Achievements to date

- HSCM has been approved to take part in an Improvement Programme with Health Improvement Scotland to help develop and implement the Hospital @ Home model
- D2A set up as a key foundation plank
- Meetings held encompassing multi-disciplinary approach including acute, geriatrician, AHP and GP support

HSCM HOME FIRST-Prevention& Self Management/ Respiratory Conditions

Report Date:	30/09/2021
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.
- Funding identified and26 ICT devices purchased to enable individuals/patients to access information/virtual classes
- Instructors now trained to Level 3 and available to facilitate virtual and face to face sessions.
- Partnership working between Physio staff and Exercise Instructors.

Programme Workstreams Progress

Activities in current period

July 2021	Fifth Cohort of Exercise Programme underway.	
July 2021	Health and Wellbeing Officer post approved at Moray Council. This post will lead on leisure pathway work in the future.	
July 2021	Programme now broadened to encompass all Long Term Conditions.	
July 2021	Pulmonary Rehab and Exercise pathways now established and in the process of being incorporated into mainstream provision.	
July 2021	Reintroduction of face to face classes whilst maintaining virtual programmes	

Future Actions/Milestones

Action	Timescale	RAG
Explore social prescribing. Including establishing group membership and priorities activities.	September 2021 onwards	
Promote a locality perspective to developing Prevention and Self Management incorporating local 3rd sector & volunteer organisations.	On-going	
Seek additional funding for Pulmonary Rehab activity programme	September 2021 onwards	
Introduction on MYCOPD app.	September 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."

"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-Green Shielded Hub / Moray Resource Centre

Report Date:	30/09/2021
RAG Status:	

Project Ref : HF5 **Project Lead:** Claire Power / Andrew McArdle **SRO:** Sean Coady

Key Aims

- Initial objective was to identify a 'green' location where the shielded population could receive treatment in a safe environment outwith GP practice.

Primary Objectives

- As the acute sector begin the remobilisation of services post covid there is an increasing workload from secondary care relocating to the community. GP practice are unable to support the additional workload.
- There is a requirement to identify a 'third space' that could be utilised for a variety of work including:
- Elective care
- Paediatric
- Community assessment centre
- Secondary care bloods
- Shielding population
- CTAC (Community Treatment and Care Centre)
- Flu and Immunisations

Priority shift to secondary care hub rather than green shielding.

Scope

- Establishment of a safe clinical treatment space for Shielded patients for:- essential blood testing, management of dressings, ECGs, administration of injectable treatments, other essential treatment room tasks.
- Cervical screening (funding provided)
- Longer term – relocate clinics where patients currently attend acute hospital setting that could be carried out in community ie secondary care bloods, catheter care, haematology services, CTAC services etc

Achievements

- Moray Resource centre identified and funding approved (£42k)

Programme Workstreams Progress

Activities in current period

July	Voice Comms installed ICT Procurement underway Furniture and peripherals identified ordering to be done	
August	Working to resolve capacity issues as MSK Physio staff still placed at MRC. May be there until end of 2021.	

Future Actions/Milestones

Action	Timescale	RAG
Relocation/ dual location of previous assets/ services at MRC for NHSG clinics	TBC	
Progress communications/engagement with users of MRC (past and future)	TBC	

Key Risks/Issues

- Long term plans for services recommencing is not yet known
- Availability of budget for upfront one off revenue costs
- No budget for ongoing revenue costs
- No staffing budget e.g. Domestic staff
- Change in use agreement with MC
- Reciprocal arrangements and potential outcomes with MC (TBC)

Dependencies

- Joint working - Flexibility in approach to shared use of building from Day Services and Clinical services.

Finance

- Capital funding secured for clinical treatment rooms from NHSG £42k and £2.5k for IT
- Majority equipment required to be transferred from existing premises
- Funding for cervical screening

Performance

Will look at patients numbers treated, patient experiences, what services moved from acute (patient footfall transferred) etc

HSCM HOME FIRST-Ambulatory Care/community hospitals

Report Date:	30/09/2021
RAG Status:	On hold

Project Ref : HF6 **Project Lead:** Cheryl St Hilaire **SRO:** Sean Coady

Key Aims

Ambulatory Care – Venesections
Provide this service out with Dr Grays Hospital (DGH)

Primary Objectives

- Improve Service
- Reduce waiting times
- Make service more accessible to patients
- Improve patient experience

Scope

To cover whole of Moray
Potential to use Community Hospitals and Hubs in the East, with potential use of Moray Resource Centre for the West.

Achievements

Haematology in ARI are now supporting this service and all patients will be registered with them to enable remote monitoring and appointments being made only as needed. This has reduced waiting lists and patients only attending appointments when needed instead of being issued "just in case" appointments.

Appointments re currently held on a Friday and DGH and facilitated by ANP's

Programme Workstreams Progress

Activities in current period

	On hold	

Future Actions/Milestones

Action	Timescale	RAG
Identification of suitable premises in East and West of Moray – Moray Resource Centre check??		
Identify and train staff to deliver the service across the community		

Key Risks/Issues

Dependencies

Staff availability from DGH to enable service delivery in the Community

Finance

None identified at this point

Performance

Number of venesections being delivered in the Community

Patient satisfaction

HSCM HOME FIRST- Palliative Care

Report Date:	30/09/2021
RAG Status:	

Project Ref : HF7 **Project Lead**: Lesley Attridge **SRO:** Sean Coady

Key Aims

Provide support to those people in Moray with palliative diagnosis through a person centred approach.

Primary Objectives

- To remobilise palliative care services at the Oaks
- To develop a model for sustainable service, covering a wide variety of disciplines, to provide support to those with a palliative diagnosis
- To coordinate the in reach and out reach services in the model to ensure appropriate and equitable access to all those with a need.

Scope

To provide support to anyone with palliative support needs within Moray through maximising the services that can be offered through a co-ordinated approach.

Achievements

"Virtual Day" sessions – 6 individuals supported at a time – one full programme completed. Evaluation now under way.

Provision of Occupational Therapy and Physio service for rehabilitation for palliative care patients across Moray in place via phone, video call or home visiting as required.

Confirmation that the McGill QOL to be used for evaluation of the programme at the Oaks

Programme Workstreams Progress

Activities in current period

Sept 2021	Band 6 post has now been advertised as a secondment and interviews happening soon.	

Future Actions/Milestones

Action	Timescale	RAG
Face to face session (6 per session)	When Govt Guidelines allow	
Development of Model of in reach and outreach support	September 2021	
Meeting of Oaks group – expand membership	TBC	
Consultant led sessions recommence	TBC	

Key Risks/Issues

- Lack of staff resource:-
  - Recruitment of Band 6 nurse, held up in recruitment process out with HSCM control, is progressing now but delay is impacting in progress.
  - Long term sick of Band 5 post
- Health Care support worker – held up in recruitment

Need these posts to provide the clinical support to the delivery of the model.

Dependencies

Oaks Volunteer co-ordination – Angela Stewart
Clinical support – Flora Watson

Grampian wide strategic framework to be ratified.

Finance

No additional request to the existing budget

Performance

Feedback from participants (in development)

Participant numbers

HSCM HOME FIRST- Third Sector Action Group

Report Date:	30/09/21
RAG Status:	

Project Ref : HF8 **Project Lead:** Cheryl St Hilaire **SRO:** Sean Coady

Key Aims

To facilitate engagement and identify opportunities for greater reach for third sector involvement in supporting the objectives of Home First

Primary Objectives

- Form a short life working group with key members of the third sector in Moray.
- Explore where and how the third sector (community groups and charities) could align with Home First work streams.
- Produce information for the Home First Group on findings of where and how the third Sector does and could align with Home First work streams.
- Make recommendations based on findings as to what Home First need to have, consider and/or implement to enable third sector involvement in Home First.

Scope

Involvement across the whole of Moray

Identifying ways and means of complimenting the full circle of a patient's journey and preventative intervention through the third sector who can provide support out with health and social cares remit

Achievements

A paper was produced and presented to the Home First Group identifying the 'Golden Thread' – where and how the third sector can, is and could support Home First, along with a brief which gave recommendations.

Programme Workstreams Progress

Activities in current period

August 2021	TSI funding application from Endowment fund was successful and a Community Support Co-ordinator has now been employed on a 2 year contract	

Future Actions/Milestones

Action	Timescale	RAG
Scope opportunities and identify gaps – produced the Golden Thread	October 2021	
Design plan to communicate and engage	October 2021	
Implementation of plan to increase volunteers supporting delivery of home first projects	October 2021	

Key Risks/Issues

- Potential lack of capacity of Third sector and volunteers to be able to engage with meetings
- An uncoordinated approach to involving the third sector and damaging relations and potential collaborative working opportunities.
- Home First Work streams being not able to refer appropriately and sign post into third sector without a dedicated resource to support and monitor.
- Third sector being unable to meet all the needs of Home First (our own volunteers would counteract this).

Dependencies

Finance

Volunteer infrastructure fit for the future TBC

Resource in HSCP Moray to manage referrals/signposting TBC

Performance

Increase in numbers of people volunteering

Feedback from individuals receiving support

HSCM HOME FIRST-Mental Health

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

Report Date:	30/09/2021
RAG Status:	

Key Aims

Primary Objectives

- Safe, equitable secondary care mental health services; 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; upstream intervention and prevention. Improved transitions – mental health and well being services for young people up to age of 25
- 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 - Action 15
- Unscheduled Care and Distress Brief Interventions
- Strategic Commissioning
- Trauma Informed Workforce
- Primary Care Mental Health: service and workforce development
- Forthcoming Mental Health Transition and Renewal Plan and funding

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

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. Alternative Tier 1& 2 pathway in place to support
Trauma Informed Workforce – training and development for all H&SC Moray and partner agency workforce	In progress	
Strategic Commissioning: • Wellness Service • Direct Access for Drug and Alcohol	In progress	

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. Band 5 nurses; Psychologists; Medical Locum insitu for Older Adult Mental Health; Mental Health Officers
- IT Platform for group therapy requires expansion to meet NHS G demand
- On going high risk drug and alcohol related harms; and deaths – plans in place to risk manage and mitigate against these,

Dependencies

- Integrated and multi agency working and collective risk and case management.
- Care and treatment pathway access and service delivery across Tier models
- Closer working between adult mental health and children and young people; drug and alcohol services and community justice services.

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 for mental health care and treatment and for drug and alcohol services – across all population age range

Performance

- Ongoing service performance and measurement of KPIs
- Performance monitoring of third sector commissioned contracts for mental health and drug and alcohol services