HOME FIRST ACTION PLAN DECEMBER 2020 **APPENDIX 1**

PROJECT 1	**Discharge to Assess (D2A) – whole system approach to discharge**		
Period covered:	Jan - March 2021	**Current Date:**	20/01/2021
Project lead(s)	Dawn Duncan	**RAG Status:**	Amber
Project Manager:			

SUMMARY OF PROGRESS:

Summary	• This is a 6 month pilot project which commenced in October 2020. The aim of the project is to support people with complex needs to be discharged quickly from hospital for their rehabilitation needs to be assessed in their own home.
Challenges:	• D2A is currently being provided as a 6-month project with seconded staff and staff working additional hours on a voluntary temporary basis. The capacity to provide this service across Moray over 7 days a week is limited by our staffing capacity and is potentially at risk should staff decide they no longer wish to participate in the project.
Achievements:	• This project has successfully completed a test of change, providing the system with enough assurance to allow it to progress to pilot phase and allocate funding accordingly. • Staff Q&A session December 2020 • Programme now has 2 days/week physiotherapy support • Data as at 18/01/2021 showing positive outcomes for patients

Target Date:	**Description:**	**Status:**
31/01/2021	• Report of Pilot Evaluation to SMT	Amber
31/03/2020	• Full implementation of programme with appropriate staffing/resources	

Activities over next Period:	• Data collection via MS forms to evidence of effectiveness of interventions and semi-structured interviews with patients/staff to provide qualitative data • On-going identification of patients who fit criteria and whose longer term rehabilitation needs are assessed at home • Patient videos required editing • Ongoing work with staff across the system to remind them of the pilot and how they can refer

PROJECT 2	**Health improvement approach to respiratory conditions**		
Period covered:	Jan - March 2021	**Current Date:**	20/01/2021
Project lead(s)	Iain McDonald	**RAG Status:**	Green
Project Manager:			

SUMMARY OF PROGRESS:

Summary	• **The purpose of this programme is to improve the health and wellbeing of those individuals with long term conditions through the promotion of self-management strategies and tools.** The working group has met every 2 weeks over the past 3 months. As well as reporting directly to the Home First Delivery Group the work stream is also represented at the Grampian Respiratory Cell. The Cell now meets every two weeks and promotes sharing of good practice between the three Grampian Partnerships.
Challenges:	• The challenge is to develop capacity and resources at a locality level to support patients with respiratory conditions. The work over the next three months will be to identify, with all stakeholders including community groups and external provides a sustainable model for health improvement.

Achievements:	The initial work of the work stream focused on interviews with a sample of 17 patients from Forres and Buckie localities. Patients with COPD were interviewed by Healthpoint staff to establish baseline data regarding their: • Knowledge and access to information on respiratory conditions • Ability to access this information digitally • Who they contacted for information • Which supports proved effect Some initial tests of change were then actioned with the patient sample. Follow up interviews were held mid-December 2020. The information gathered from the patient sample linked with discussions within the Work stream and at the Grampian Respiratory Cell helped to identify the priorities for the Work stream moving forwards. HSCM submitted a bid to the Grampian Respiratory Cell and were successful with funding for two projects: Pulmonary Rehab Virtual Activity and Physical Activity Virtual Programmes. Learning from the Forres and Buckie tests of change helped inform the structure for these programmes.

Target Date:	Description:	Status:
Jan – March 2021	• The Pulmonary Rehab Virtual Activity programme is an adaptation of the Core Pulmonary Rehabilitation Programme for individuals with an MRC score of 4 or 5. The Physical Activity Virtual Programme is for individuals with an MRC score of 1 or 3. Two blocks of programmes are planned where individuals can participate in one or two activity classes per week for a six week period. The first block begins 25 Jan 2021 and the second block begins March 2021. A key aspect of the programme is developing staff capacity and community resources to enable the programme to be sustainable.	Green

Activities over next Period:	• The work stream is working closely with the Grampian Commission for Evaluation of Home First to ensure a clear structure of evaluation is in place and outcomes are evidenced. A Grampian wide approach is being taken to ensure learning is maximised. Three key areas for evaluation are: the individual, staff and the system. • This will include self-assessment, qualitative feedback, case studies, measurement of uptake etc
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PROJECT 3	**Delayed Discharge – whole system approach to discharge**		
Period covered:	Jan – March 2021	**Current Date:**	20/01/2021
Project lead(s)	Lesley Attridge	**RAG Status:**	Amber
Project Manager:			

SUMMARY OF PROGRESS:

Summary	There are four components to this work stream: Admission avoidance**,** Discharge planning process**,** Community hospital transfers **and** Provision of care in the community A delayed discharge focus group has been meeting twice weekly since the beginning of October, identifying and implementing changes to the discharge process. The is a complex piece of work involving teams across the system and the aim is to ensure there is sustainable processes in place to support early discharge back home and reduce delayed discharge bed days.
Challenges:	• Scope, plan and deliver a whole system approach for discharge in Moray that is safe, properly resourced and is sustainable. • Ensure communication and engagement with members of the public and local communities is robust and key messaging is being embraced and understood.
Achievements:	The system has shown a sustained reduction in the number of delayed discharges since October 2020. The following identifies key areas of improvement which have contributed to this reduction: • Communication

	Weekly meetings are in place to review patients on Community Hospital waiting list Locality Managers attend weekly meetings with commissioning and providers Home Care Managers and providers attend 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 pathway circulated to Emergency Department. Contracts with x2 new external providers in place Discharge Coordinator appointment Implementation of Social Work screening tool

Target Date:	Description:	Status:
31/01/2021	• Appointment of Care at Home assessor	Red
31/01/2021	• Traffic light system for Planned date of discharge – implementation to be reviewed	Green
31/01/2021	• MDT model – Ward and 5 and 7 processes under review	
	• Work required with patients/carers/staff to ensure focus remains on discharge goals – meetings taking place with ward staff	
31/01/2021	• Embed daily dynamic discharge process in existing huddles	
14/02/2021	• Intermediate care options – identified and information shared with MDTs. Requires ongoing education	
14/02/2021	• Internal care providers – issues with appointing staff	
31/01/2021	• Review of Marie Curie OOHs and community nursing service	
March 2021	• Intermediate care options –review current provider provision and ensure adequate long term provision is in place. Planning meetings taking place.	
	• Core discharge document review – interim measure in place to allow scripts to be completed in timely manner	

Activities over next Period:	• The Delayed Discharge Action Group will continue to meet regularly to review progress

PROJECT 4	**Hospital at Home**		
Period covered:	Jan – March 2021	**Current Date:**	20/01/2021
Project lead(s)	Sam Thomas	**RAG Status:**	Green
Project Manager:			

SUMMARY OF PROGRESS:

Summary	**The provision of a hospital at home service in Moray is at scoping stage. A steering group has been established and there is early agreement the model will encompass unscheduled care, front door and home first components of service provision.**
Challenges:	• Rurality • Small health and social care partnership with limited specialist staffing resource • Recruitment of staff • Infrastructure - equipment
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

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Target Date:	Description:	Status:
April 2021	• The current Geriatrician model for Moray is a 6 month continuity plan supported through the Dept of Elderly Medicine in Aberdeen (end point of April 30 2021). As a **Key Risk** It is vital that a sustainable service continues thereafter, ideally with Moray embedded within a wider Grampian model to ensure continued provision of local Geriatricians. Urgent discussions are currently underway. •	Amber
To be identified	• Over time as the model grows there will be requirements for additional professionals such as Elderly trained ANP and AHP's. •	
To be identified	• Equipment for Point of Care Testing and Diagnostics will be required as the Hospital at Home part of the model develops.	
	• Remote consultation via telephone and Near Me could change how Senior Decision Makers support on the ground health professionals from a distance. This could potentially allow for a Grampian wide model of support thus more effectively utilising resources.	

Activities over next Period:	• Progress on health improvement work /planning with Health Improvement Scotland
	• Agree plan for sustainable geriatric service provision in Moray