Health & Social Care Moray

Delivering Home First for Moray

Working together to stay well at home

Staff update 7 – 16.10.20

Transformation focuses on rapid design of services

Moray Partners in Care - the Strategic Plan of the Moray Integration Joint Board – seeks to deliver health and social care services in ways that support people to be safe and well at home, and in their community, for as long as possible.

The Home First approach is one of our core strategic priorities designed to shift the balance of care from acute hospital services towards delivering more integrated community-based health and care services either in people's own homes or close to where they live.

A transformation programme has been initiated in Moray which is focused on the rapid redesign of a range of services. Led by Health & Social Care Moray teams working collaboratively with colleagues in the Acute, Third and Independent Care Sectors, Home First will be delivered through a focus on prevention of admission and hospital attendance and early supported discharge.

There are many predicted benefits of the programme which include:

- reduction in length of stay
- reduction in occupied bed days
- reduction in delayed discharges
- reduction in unscheduled admissions and readmissions
- improved experience for the individual
- improved staff experience.

Delivery Group

The Moray programme is to be strengthened by the recruitment of a Third Sector liaisor/representative to the Delivery Group and the formation of short life Third Sector planning and action group focused on operational development in support of the Home First agenda.

Moray's Third Sector is made up of professional and volunteers who work with and support a wide range of people in Moray - including unpaid carers - who have a clear stake in the successful implementation of Home First and the sector is vital to the successful system-change required.

Programme updates

Discharge to Assess – The service based at Dr Gray's is now live and delivering on a six month test of change.

Delayed Discharge – The group has been meeting three times a week to implement system change improvements to reduce delayed discharges from acute and community hospitals, and the number of unscheduled admissions through the provision of alternative methods of care at home.

A dashboard of daily data is being captured along with work to map the journey of care of a cohort of patients.

Care of the elderly – A review of services to support individuals with Parkinson's has been completed and pan-Grampian provision agreed. Consultant Geriatrician resource has been secured for an initial six months following the departure from Dr Gary's of the current Consultant at the end of October.

Prevention and self-management – Working to improve the health and wellbeing of individuals with chronic obstructive pulmonary disease (COPD), baseline interviews have been conducted with a group of 10 patients in Forres and will be carried out with the same number in Buckie. The test of change seeks to empower patients to more effectively self-manage their condition through self-monitoring, community support and resilience opportunities.

Palliative care – Support is gathering for a prehabilitation project to support newly diagnosed patients to engage in improving their physical and emotional health and wellbeing. A group is overseeing the remobilisation of the Oaks in Elgin, with a scoping exercise ongoing to review service provision pre-COVID and the way forward.

Children and families – The quality improvement methodology and practice has been adopted to support the Working Leadership Collaborative, with direct input and support via the Children and Young People Improvement Collaborative regional advisor. Activity being taken forward centres on the development of pathways for practitioners to provide clarity on actions to be taken in respect of child poverty and child neglect; development of a knowledge and skills framework for staff; and assessment tools for different levels of practitioners.

Mental health – The Urgent Care team established as part of the response to COVID has been made permanent. Work is underway with Primary Care and Third Sector partners to explore the provision of an appropriate service to people who no longer receive a secondary care mental health service.