Aims of Today

- Update the SPRG on the development of the revised plan and timeline
- Summarise the finding so far from our completed activities
- Inform the SPRG of the headlines from our annual performance report
- Inform the SPRG of current testing of options
- Work together to agree our strategic outcomes
Series of Workshops

- April 17 “Reviewing the strategic plan”
- Sept 17 “Reshaping Care for Older People”
- Nov 17 “Promoting Community Wellbeing”
- Feb 18 “Development day IJB scoping the plan”
- May 18 “Vision/Principles”
- June 18 “Community Assets mapping “
- July 18 “Understanding our demand and supply”
- Oct 18 “Developing our strategic Outcomes “
Activities completed to date

- Established SPG and SPRG
- Scoping of the strategic plan
- Agreed the project plan for revision of the strategy
- Review of national / local direction
- Joint Strategic Needs Assessment
- Identification of service pressures
- Draft Annual Performance Report
- Series of workshops completed
Findings/Feedback
Scoping the strategic plan

- All adults 18+ only as Moray Children’s Services Plan 2017-27 covers children
- Includes health and social care services which are in scope and the integrated budget
- Moray geographical area
- Three year strategy
- Clear, concise, honest and inclusive
Reviewing our vision, principles and values

- Vision a bit lengthy – shorten without losing meaning
- Update the principles/values - in line with integration principles and new care standards principles
National/Local Policy Update

- Health and Social Care Delivery plan Dec2016
- The New Carers Act April 2018
- Strategic framework for action on Palliative and End of life care 2015
- Scotland’s National Dementia Strategy 2017-2020
- Health and Social Care standards – My support, my life 2018
- Mental Health Strategy 2017 – 2027
Joint Strategic Needs Assessment

- Inequalities in health (includes life expectancy, rates of disease, age of onset)
- Ageing (increasing frailty)
- Military (active service and veteran health)
- Distance to health services (within and outwith Moray)
- Person-centred care (amidst multi-morbidity)
- High Resource Individuals (emergency admissions for frailty; and during palliative care)
- Carers (perceived ability to continue)
Service Pressures

- Limitation of care staff and demand - particularly around LD
- Recruitment and retention – nursing, AHP’s
- Pharmacy – no control over drug costs
- Equity of access over 24hours - mental health
- Pace of hospital throughput - admissions, readmissions frail elderly
- Living at Home with challenging needs - needs quick responses, home care, equipment, commissioning – value
- Sustainability of GP practices
- Implementation of the GMS 2018 contract and the roles as described
- Sustainability of services for the future e.g. Community Hospitals
- Delivering on the new care standards
- Diminishing Budgets and available funding
Annual Performance Report 2017/18
National integration indicators

- Populated from national data sources and updated biannually or quarterly and issued nationally

RAG scoring based on the following criteria

- **G**: If Moray is performing better than the Scottish average.
- **A**: If Moray is performing worse than the Scottish average but within 5% tolerance.
- **R**: If Moray is performing worse than the Scottish average by more than 5%.

▲ − ▼ Indicating the direction of the current trend.
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Title</th>
<th>Previous score 2015/16</th>
<th>Current score 2017/18</th>
<th>Scotland 2017/18</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI - 1</td>
<td>Percentage of adults able to look after their health very well or quite well</td>
<td>96%</td>
<td>93%</td>
<td>93%</td>
<td>G ▼</td>
</tr>
<tr>
<td>NI - 2</td>
<td>Percentage of adults supported at home who agreed that they are supported to live as independently as possible</td>
<td>74%</td>
<td>83%</td>
<td>81%</td>
<td>G ▲</td>
</tr>
<tr>
<td>NI - 3</td>
<td>Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided</td>
<td>73%</td>
<td>75%</td>
<td>76%</td>
<td>A ▲</td>
</tr>
<tr>
<td>NI - 4</td>
<td>Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated</td>
<td>71%</td>
<td>73%</td>
<td>74%</td>
<td>A ▲</td>
</tr>
<tr>
<td>NI - 5</td>
<td>Total % of adults receiving any care or support who rated it as excellent or good</td>
<td>79%</td>
<td>80%</td>
<td>80%</td>
<td>G ▲</td>
</tr>
<tr>
<td>NI - 6</td>
<td>Percentage of people with positive experience of the care provided by their GP practice</td>
<td>86%</td>
<td>80%</td>
<td>83%</td>
<td>A ▼</td>
</tr>
<tr>
<td>NI - 7</td>
<td>Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life</td>
<td>83%</td>
<td>79%</td>
<td>80%</td>
<td>A ▼</td>
</tr>
<tr>
<td>NI - 8</td>
<td>Total combined % carers who feel supported to continue in their caring role</td>
<td>38%</td>
<td>39%</td>
<td>37%</td>
<td>G ▲</td>
</tr>
<tr>
<td>NI - 9</td>
<td>Percentage of adults supported at home who agreed they felt safe</td>
<td>79%</td>
<td>84%</td>
<td>83%</td>
<td>G ▲</td>
</tr>
<tr>
<td>NI - 10</td>
<td>Percentage of staff who say they would recommend their workplace as a good place to work</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Title</td>
<td>Previous score</td>
<td>Current score</td>
<td>Scotland</td>
<td>RAG</td>
</tr>
<tr>
<td>-----------</td>
<td>-------</td>
<td>----------------</td>
<td>---------------</td>
<td>-----------</td>
<td>-----</td>
</tr>
<tr>
<td>NI - 11</td>
<td>Premature mortality rate per 100,000 persons <em>(European age-standardised mortality rate per 100,000 for people aged under 75)</em></td>
<td>360 2016</td>
<td>372 2017</td>
<td>425</td>
<td>G ▲</td>
</tr>
<tr>
<td>NI - 12</td>
<td>Emergency admission rate (per 100,000 population)</td>
<td>8,739 2016/17</td>
<td>9,037 2017/18</td>
<td>11,959</td>
<td>G ▲</td>
</tr>
<tr>
<td>NI - 13</td>
<td>Emergency bed day rate (per 100,000 population)</td>
<td>94,327 2016/17</td>
<td>86,732 2017/18</td>
<td>115,518</td>
<td>G ▼</td>
</tr>
<tr>
<td>NI - 14</td>
<td>Readmission to hospital within 28 days (per 1,000 population)</td>
<td>74 2016/17</td>
<td>81 2017/18</td>
<td>97</td>
<td>G ▲</td>
</tr>
<tr>
<td>NI - 15</td>
<td>Proportion of last 6 months of life spent at home or in a community setting</td>
<td>90% 2016/17</td>
<td>90% 2017/18</td>
<td>88%</td>
<td>G −</td>
</tr>
<tr>
<td>NI - 16</td>
<td>Falls rate per 1,000 population aged 65+</td>
<td>16 2016/17</td>
<td>15 2017/18</td>
<td>22</td>
<td>G ▼</td>
</tr>
<tr>
<td>NI - 17</td>
<td>Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections</td>
<td>71% 2016/17</td>
<td>85% 2017/18</td>
<td>85%</td>
<td>G ▲</td>
</tr>
<tr>
<td>NI - 18</td>
<td>Percentage of adults with intensive care needs receiving care at home</td>
<td>67% 2015/16</td>
<td>65% 2016/17</td>
<td>61%</td>
<td>G ▼</td>
</tr>
<tr>
<td>NI - 19</td>
<td>Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)</td>
<td>1,095 2016/17</td>
<td>955 2017/18</td>
<td>772</td>
<td>R ▼</td>
</tr>
<tr>
<td>NI - 20</td>
<td>Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency</td>
<td>21% 2016/17</td>
<td>20% 2017/18</td>
<td>23%</td>
<td>G ▼</td>
</tr>
<tr>
<td>NI - 21</td>
<td>Percentage of people admitted to hospital from home during the year, who are discharged to a care home</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>NI - 22</td>
<td>Percentage of people who are discharged from hospital within 72 hours of being ready</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>NI - 23</td>
<td>Expenditure on end of life care, cost in last 6 months per death</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>
Key Areas of Focus 2017/18

- Transforming Primary Care and Out of Hours Care
- Transformation Programme in Learning Disabilities Services.
- Developing Acute Care for the elderly in the context of our wider older peoples pathways of care.
- Preparing for the implementation of the new Carers Act 2018.
- Continue to build on our housing based initiatives supporting people to live independently with a range of personal challenges or health and care needs.
Key Areas of Focus 2017/18

- Continued focus on Health Improvement and active communities.
- Implementing key aspects of our Good Mental Health for All strategy.
- Start to engage more proactively on the possibilities of Digital transformation and how Technology Enabled Care (TEC) solutions can further support independence.
- Continue to implement enabling approaches such as Self Directed Support (SDS) and Shared Lives.
https://hscmoray.co.uk/performance.html
Purpose

Up-date you on the impact of:-

• Woodview, Urquhart Place
• The Learning Disability Transformation Project
• Testing New Models of Care-Varis Court (FNCT & ACU’s)
Our Vision Statement

“To enable the people of Moray to lead independent, healthy and fulfilling lives in active and inclusive communities, where everyone is valued, respected and supported to achieve their own goals.”

The Moray Strategic Plan 2016-2019
Woodview, Urquhart Place

A New Housing Development for Adults with Autism and Communication Difficulties
Why?

The previous residential service for people with autism and challenging behaviour was a converted Victorian house in Forres (Maybank). This was an unsuitable physical environment has contributed to:-

• Increased challenging behaviour;
• An unacceptable high level of assaults on staff;
• Poor staff retention; and recruitment; and

These issues were also identified by a Care Inspectorate Inspection in 2013.
What?

- £2.5m Capital Build project;
- 10 purpose built bungalows including a communal area and staff office;
- Design co-produced with family members;
- A project management approach which involves the joint workforce and parents;
- Fully utilizing technology enabled care to support independent living;
When

• The construction phase was completed in July 2017;
• The 4 Maybank Service Users moved from Forres in 14 August 2017;
• Maybank was decommissioned for Health & Social Care use in August 2017;
• The remaining 4 tenants-including the out of area placement- moved in the Spring of 2018.
The Challenges

This is the first significant capital build project for Health & Social Care Moray...

• Creating new way of living for where the occupants will have a tenancy;
• Co-production with parents;
• Ensuring smooth transitions including for out of area placements;
• A partnership approach across professional and organisational boundaries.
What we hoped for

Health & Social Care Services Committee Report on 5 June 2013 to:-

“Provide the Maybank challenging behaviour unit in a purpose built, design specific unit located on a suitable local site.”

A change of environment that will mean:-

• Improved outcomes and a better quality of life;
• Fewer incidents of staff being assaulted; and
• A more satisfied workforce leading to better staff recruitment and retention.
Our Objectives

Business Objectives:-

• **Objective 1:** From September 2017 onwards, the staff retention rate at Urquhart Place will not drop below a monthly average of 80% of the WTE staff roll for this development; and

• **Objective 2:** From September 2017 onwards, there will be a 50% reduction in the number of incidents at Woodview compared to the historical monthly average at Maybank.
What we achieved

• In relation to **Objective 1:**

• Through the interview process, all 25 WTE support worker posts were filled. This had never previously been achieved at Maybank and the Manager was always engaged in a continuous process of recruitment; and

• With the exception of 1 member of staff going on maternity leave, there has only been one other member of staff who has left by December 2017.
What we achieved

• In relation to **Objective 2**:–
  • A 75% reduction in medication based on a survey of the same period in 2016;
  • A 91% reduction in number of incidents per month from 12.6 to 3 since the same period in 2016;
  • The overall recorded incident severity is 90% less than the historic monthly average;
  • A 100% reduction in staff injuries from an average of 6.6 in the same period 2016 to nil; and
  • A 97.4% reduction in use of BSS (restraint techniques) and 100% reduction in use of supine since the same period in 2016.
The Process

One parent said:-

“This development has had from the first day we have been invited to participate had Michael as the very centre. There are design decisions throughout the development that individually some of us might not personally like but we have all viewed the development through Michael's eyes and built a house for him not us. Michael may not have language as many would understand but you can hear his voice shouting from every part of it. I'm proud to be part of the team that is building his house.”
What we achieved

• Also one parent stated:

“There is a big difference in Matthew, he is a lot happier and calmer now he’s at Woodview. He has an air of calmness.”
Next Steps

• Iona Colvin, Chief Social Work Advisor for Scotland has visited Urquhart Place and identified the development as an example of best practice worthy of future research;

• Financial Benefits- ‘spend to save’

• Independent academic interest will explore how the above benefits have been secured. One research strand currently being discussed is in relation to the reduce use of anti-psychotic medication through improving the physical environment.
The Learning Disability Transformation Project
The Context

In the context of an growing number of older people, including people with a learning disability, combined with the financial constraints faced by the public sector, the challenge is to:

“achieving better outcomes for people with a Learning Disability in Moray within a financially sustainable model.”
Underpinning Assumptions

• People will choose to be more independent than dependent
  – given a free choice, without undue influence

• The aim of intervention is to help people to make the most of their abilities and so realise their aspirations for independence

• People with a learning disability are able to learn but they learn at their own pace
‘Progression’ - a definition

(n.) ‘Progression’ is a person-centred developmental approach that seeks to help an individual achieve their aspirations for independence.
Progression focussed practice and planning of accommodation and support helps people achieve their aspirations, reduces needs (or constrains/delays increases) and reduces costs.

“Progression” focussed practice supports people to acquire/re-gain independent living skills or to delay/avoid loss of skills. Over time “Progression” can enable moves to preferred and more cost effective accommodation support combinations or help people avoid moves to less preferred or cost effective mixes.
EXAMPLE: The individual’s aspirations and long-term goals as recorded in their Person Centred Plan (PCP) are to (eventually) live alone or with one other person. The “progression” plan indicates residential placement (2-3 years) followed by supported group living (5-7 years) and then home with domiciliary care/ floating support (targeted support). Eventually this is withdrawn and the person uses universal services only.

For commissioning and planning purposes multiple individual service/ accommodation requirements can be estimated for each year and a long term planning model developed.
Aims of the “Progression” Pathway

Cost falls as independent living skills are gained and support diminishes

Population people with Learning Disability receiving support

On-going support enables increasing independence

Mid and later life work with individuals and families so service changes at “trigger points” are into the least intensive support model possible
Achieving Successful Independent Living – The Challenge

Motivation, confidence, suitable friendship group “good enough” independent living skills

Successful Independent Living

Commissioning

Suitable Accommodation

PCP

Right Support

Commissioning

Social Care

Health

Ready Individual

Motivation, confidence, suitable friendship group “good enough” independent living skills

Practice

Case work, skills and personal development programmes, family support at home

Housing

Housing Related Support

PCP

Commissioning
LD Transformation Project Scope

CLDT
- Professional and practice development
- Integrated pathway operating framework development
- Process & tools development
- ART move here

Commissioning
- Market shaping (inc. accommodation and support planning, redesign and decommission contracts)
- Commissioning for outcomes
- Contract monitoring
- CFC tool development
- Contracting arrangements

‘In House Services’
- Business model & service model development
- ‘Trusted provider’ review service development
- Specialist assessment service development
LD Transformation Journey (to-date)

The Norm

- Setting up the project & Introductory Training
- Developing new ways of working
- Getting ready to use new ways of working including training
- Go-live. Starting to use new ways of working
- Reflecting & refining and benefits realisation

The New Norm

<table>
<thead>
<tr>
<th>March &amp; April 2017</th>
<th>May &amp; June 2017</th>
<th>July &amp; Sept 2017</th>
<th>October 2017</th>
<th>November onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take part in training</td>
<td>Take part in workshops and discussions</td>
<td>Go on training and trying new practices</td>
<td>Go Live with the new operating model</td>
<td>Refine model and benefits realisation</td>
</tr>
</tbody>
</table>
Intended Benefits

The overall benefit for people who access CLDT services that this project seeks to achieve is:

- To help adults with learning disabilities achieve their aspirations for independence;

This can be further broken down to achieving:

- real choice and control;
- greater independence;
- a better place to live;
- meaningful occupation, employment or purposeful activities;
- better health and wellbeing; and
- keeping safe.
Evaluation
A Balanced Scorecard Approach...

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Type of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Customer (Service User)</td>
<td>Personal Outcomes</td>
</tr>
<tr>
<td>2. Financial</td>
<td>Service Outcomes</td>
</tr>
<tr>
<td>3. Internal Process</td>
<td>Service Outcomes</td>
</tr>
<tr>
<td>4. Workforce Learning</td>
<td>Service Outcomes</td>
</tr>
</tbody>
</table>
Customer (Service User)

• 32 People have had a change in their living circumstances (e.g. residential care to supported living);
• Move from ‘block funding’ to ‘individual budgets’;
• In one village 6 people were living together and made the transition to having their own tenancies;
• Assessment showed their accommodation was not fit for purpose;
• With support, delivered on individuals choices and aspirations and allowed them to mainta links with the local community.
## Financial

<table>
<thead>
<tr>
<th>Customer Group</th>
<th>Number of Service Users</th>
<th>Projected Annual Surplus/(Deficit) (2018/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Residential Care/ supported accommodation to living in different accommodation with support</td>
<td>20</td>
<td>£488,366</td>
</tr>
<tr>
<td>2 Lived with Family to living in own tenancy with support</td>
<td>9</td>
<td>(£163,393)</td>
</tr>
<tr>
<td>3 Lived in a non-family setting (usually out of area) to living in own tenancy with support</td>
<td>3</td>
<td>(£491,930)</td>
</tr>
<tr>
<td>4 People who become 18 and live at home and are new to adult services</td>
<td>13</td>
<td>(£132,059)</td>
</tr>
<tr>
<td>5 Total</td>
<td>45</td>
<td>(£299,016)</td>
</tr>
</tbody>
</table>
Internal Process

• 85 new Care Support & Treatment Plans have been completed by the Integrated Learning Disability Team since the ‘go live’ for this project;

• 46 have been identified as having significant potential to benefit from a progression focused approach;

• Specialist Assessments have also been completed by Day Services;
Workforce Learning

• Staff Mentoring through supervision sessions is in place;
• Weekly Integrated Learning Disability Team Meetings;
• Staff Survey focusing on improving the efficiency of team meetings;
• Monthly Project Management Group Meetings;
• Workforce Learning Event will be held in November.
The Next Steps…

- Open Space Events. This follows events held earlier this summer and Autumn;
- Continued evaluation through a balanced scorecard approach;
- Following circulation of the Market Shaping Strategy, Conversations with the Provider Market in October;
- To test a new approach to sleepover support;
- To complete the tendering process for the Care Fund Calculator and further develop our approach to outcomes based contract monitoring.
Testing New Models of Care
Varis Court (FNCT & ACU’s)
A Partnership Project

- Hanover (Scotland) Housing Association
- Forres Health Centre
- NHS Grampian
- Moray Health and Social Care Partnership
- The Forres Locality
The Project

Specification

<table>
<thead>
<tr>
<th>Unit Type</th>
<th>Number of Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Bespoke</td>
<td>7</td>
</tr>
<tr>
<td>Sheltered/Extra Care Care Units</td>
<td>21</td>
</tr>
<tr>
<td>Augumented Care Units</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>
The Project

Objectives

• design and build affordable accommodation that meets the local demand for sheltered or extra care housing for older people with a range of complex health conditions and which includes the deployment of technology enabled care;

• provide bespoke flats for people with dementia which is based on guidance by the Stirling University Centre for Dementia Excellence; and

• pilot a new model of providing health care - in partnership with Forres Health Centre - which has the potential of being mainstreamed across Moray.
The Context

• The establishment of a test site a Varis Court to explore the delivery of new models of care;
• The establishment of the Forres Locality Professional Core Group to develop a Transformation Plan leading to the delivery of sustainable health and social care services in the Forres Locality Area;
• The nurse recruitment crisis at Leanchoil Community Hospital leading to the closure of the hospital in September;
• Workforce Culture-exploring the Buurtzorg model and establishing new ways of working.
The Intended Benefits

A sustainable health and social care system, characterised by:-

• Reduced number of hospital admissions/ reduced re-admission rates
• Reduction in length of stay and a faster recovery
• Less isolation and more social interaction
• Improved personal outcomes and better quality of life
• Improved carer experience
• A safer environment
• A more efficient case management system
• A more rewarding workplace for staff
The reasons for the referral

<table>
<thead>
<tr>
<th>Reason for referral</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative care</td>
<td>2</td>
<td>25.00%</td>
</tr>
<tr>
<td>Pain management</td>
<td>2</td>
<td>25.00%</td>
</tr>
<tr>
<td>UTI/ Respite</td>
<td>1</td>
<td>12.50%</td>
</tr>
<tr>
<td>UTI</td>
<td>1</td>
<td>12.50%</td>
</tr>
<tr>
<td>Respite</td>
<td>1</td>
<td>12.50%</td>
</tr>
<tr>
<td>Rehydration</td>
<td>1</td>
<td>12.50%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>8</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
The type of care provided

<table>
<thead>
<tr>
<th>Type of care (more than one option can be applied)</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venepuncture</td>
<td>4</td>
</tr>
<tr>
<td>Pain management</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Catheterisation</td>
<td>2</td>
</tr>
<tr>
<td>Personal Care</td>
<td>2</td>
</tr>
<tr>
<td>Respite</td>
<td>2</td>
</tr>
<tr>
<td>End of life</td>
<td>2</td>
</tr>
<tr>
<td>reable</td>
<td>2</td>
</tr>
<tr>
<td>IV Fluids</td>
<td>1</td>
</tr>
<tr>
<td>Signposting</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>
Total number of referrals received by FCNT

<table>
<thead>
<tr>
<th>Place of care</th>
<th>No OF REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home only</td>
<td>95</td>
</tr>
<tr>
<td>Varis only</td>
<td>10</td>
</tr>
<tr>
<td>Both</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>113</td>
</tr>
</tbody>
</table>
Support for Informal Carers

“Respite for her as unable to cope with own medical condition. Came in with husband who has dementia.”

and

“Cognitive impairment came in with wife for respite for her. Without FNCT support wife would have not been able to cope due to her own medical condition and both could have been admitted to hospital.”
“Inpatient in ACU 13/7 - 20/7/18. Her daughters and carers & other daughter who lives locally is struggling to cope. Patient admitted into ACU for one week...This is a new phase of her care as she have previously been reluctant to have carers to look after her at home, preferring her daughters to shower and look after her. She has had previous admissions to Dufftown for respite but much preferred being in Forres. She very much enjoyed going up the town in her wheelchair”
The Buurtzorg Model

“Change of management structure makes me feel empowered to do the 'right thing' for patients and their families. I feel that I have the freedom to choose how I fulfil my role in the best interest of service users. This could be sitting with a dying patient or doing a jigsaw. Very much outwith the traditional 'medical model.”

FNCT member
MDT Structure

Support - Service Manager/GP’s
USC/Geriatrician/Team Manager Community
Nursing/FNT Team Lead

Team - FNT/Community Nursing/OT/Physio/SW/Homecare/ANP

Resource - Community/ACU’s/Care Home

Patient

Abbreviations:
GP’s — General Practitioners
USC — Unscheduled Care
FNT — Forrest Neighbourhood Team
OT — Occupational Therapy
Physio — Physiotherapist
SW — Social Work
ANP — Advanced Nurse Practitioner
ACU — Augmented Care Unit
## Cost Comparison

<table>
<thead>
<tr>
<th>Service</th>
<th>‘As Is’ (based on 2018 estimates)</th>
<th>‘To be’ (Estimates based on this Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forres District Nurse Team</td>
<td>£297K (with applied efficiency saving)</td>
<td>Community Nursing Team with ACU’s £392K (includes £38K Phlebotomy plus £24K supplies) £541K (top point) plus £55K (rent) (funded from Social Care Fund recurring budget)</td>
</tr>
<tr>
<td>FNCT/ACU</td>
<td>£574K</td>
<td>(Costs incorporated above.)</td>
</tr>
<tr>
<td>Leanchoil Hospital</td>
<td>£631K</td>
<td>£0</td>
</tr>
<tr>
<td>Forres Health Centre</td>
<td>£331K (NHS Grampian Health Board funded at present)</td>
<td>£535K (funded through redesign of services within Forres for sustainability – Board funding no longer sustainable)</td>
</tr>
<tr>
<td>GP contract</td>
<td>£45K</td>
<td>£45K</td>
</tr>
<tr>
<td>Care Home Retention</td>
<td></td>
<td>£81K (based on max occupancy over 12 month period)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£1.878M</td>
<td><strong>£1.649M</strong></td>
</tr>
</tbody>
</table>
Next Steps

• Consultation on the Transformation Plan for the Redesign of Health & Social Care Services in the Forres Area is live (1 October to 1 November 2018);

• Ihub/HiS are undertaking an evaluation of the economic impact of the FNCT;

• Dundee University are presently conducting interviews in relation to the application Buurtzorg principles in relation to the FNCT;

• Transformation Plan and Evaluation Reports to be considered at the IJB Meeting on 30 November.
Purpose

Up-date you on the impact of:-

• Woodview, Urquhart Place

• The Learning Disability Transformation Project

• Testing New Models of Care-Varis Court (FNCT & ACU’s)
Our Vision Statement

“To enable the people of Moray to lead independent, healthy and fulfilling lives in active and inclusive communities, where everyone is valued, respected and supported to achieve their own goals.”

The Moray Strategic Plan 2016-2019
Purpose

Up-date you on the impact of:-

• Woodview, Urquhart Place
• The Learning Disability Transformation Project
• Testing New Models of Care-Varis Court (FNCT & ACU’s)