CLACKMANNANSHIRE COUNCIL

THIS PAPER RELATES TO ITEM 10

ON THE AGENDA

Report to: Housing, Health & Care Committee

Date of Meeting: 2 April 2015

Subject: **Reshaping Older People's Care Change Fund Update and Report on Progress of the 2015/16 Integrated Care Fund Plan.**

Report by: Assistant Head of Social Services

1. Purpose

1.1 This report informs the Housing, Health and Care Committee that the Reshaping Care for Older People (RCOP) Change Fund ends on the 31st March 2015. The RCOP Change Fund was introduced by the Scottish Government in April 2011 to support the redesign of health and social care services. A report outlining how the Change Fund has been utilised by Clackmannanshire and Stirling Partnership during the period April 2011 to March 2015 is appended to this report.

1.2 The report also informs Committee of the Scottish Government's intention to replace the RCOP Change Fund with the new Integrated Care Fund (ICF). The Integration Care Fund has been allocated to Partnerships for one year (2015/16) and will support the development of Joint Commissioning Plans. Governance will be through the Clackmannanshire & Stirling Transitional Board.

2. Recommendations

2.1 It is recommended that Committee notes:

- that the Reshaping Care for Older People's Change Fund (RCOP) ends on the 31st March 2015. The final programme review of the RCOP Change fund for Clackmannanshire and Stirling is appended to this report, (Appendix 1).
- the Scottish Government has created a successor to the RCOP Change Fund namely the Integrated Care Fund. This fund will commence on 1st April 2015 and is intended to support the rollout of Health and Social Care Integration .
- the Health and Social Care Partnership (Clackmannanshire Council, Stirling Council and NHS Forth Valley) has been allocated £0.96M for Clackmannanshire and £1.52million for Stirling to support the

implementation of the Integrated Care Fund Plan. A copy of the Integrated Care Plan is appended to this report (Appendix 1).

- the requirement by Integration Joint Boards to submit a progress report of local ICF plans to Scottish Government on a 6 monthly basis.
- An update on the ICF plan will be brought to Committee on a six monthly basis.

3.0 Considerations

3.1 The RCOP Change Fund was introduced by the Scottish Government in April 2011. To date the oversight and Governance of the RCOP Change Fund programme has been managed by the Clackmannanshire and Stirling RCOP steering group. The steering group reported directly to the Alliance in Clackmannanshire and the Community Planning Partnership in Stirling.

3.2 A summary of the change fund activity and spend for the Clackmannanshire and Stirling Partnership during the period April 2011 to March 2015 is set out in Appendix 2. This review will assist the Integration Joint Board in measuring the impact and performance of the Change Fund and inform the implementation and rollout of the Integrated Care Fund for 2015/16.

3.3 At a national level support and oversight of the RCOP Change Fund has been provided by the Joint Improvement Team (JIT). In addition annual and mid year reports have been submitted to the JIT by the Clackmannanshire and Stirling Partnerships during the lifetime of the RCOP Change Fund.

3.4 In July 2014, the Scottish Government wrote to Health and Social Care Partnerships to announce the allocation of additional resources for 2015/16 to support the delivery of the National Health and Wellbeing outcomes for Health and Social Care integration. In December 2014 the Clackmannanshire and Stirling Partnership submitted its Integrated Change Fund Plan to Scottish Government. The Integrated Care Fund (ICF) will support investment in integrated services for all adults. The 2015/16 allocation for the Clackmannanshire & Stirling Partnership area is confirmed as £2.48million. (Clackmannanshire £0.96m and Stirling £1.52million).

3.5 The ICF Scottish Government guidance sets out a number of key messages that reinforces and builds on the successes of the RCOP change fund programme. It is recognised that the full ambitions of the RCOP 10 year programme have yet to be fulfilled and that partnerships require to continue to make progress within the context of the new integrated arrangements for adult Services from 1st April 2015. This work will led by the Integration Joint Board and supported by development of Joint Commissioning Strategies by April 2016.

3.6 In line with Scottish Government Guidance, the Integrated Care Plan (ICP) for Stirling and Clackmannanshire will focus on the following priorities :

- reducing health inequalities
- tackling the challenges associated with multiple and chronic illnesses for adults and older people

- focus on multi-morbidity and the correlation with mental health physical health problems and deprivation
- transformational activity focused on prevention and preventative spend to redesign and redirect activity from complex and high cost service models
- working with the third sector and the independent sector as key partners in the delivery of care
- ensuring that personal outcomes for individuals and carers are at the centre of the plan

3.7 The introduction of the ICF also builds on the achievements of the Reshaping Care for Older Peoples' programme for Clackmannanshire and Stirling these include;

- the implementation of a Joint Commissioning plan for older people
- the redesign and roll out of intermediate care and enablement services to support hospital discharge and prevention of admission.
- the implementation of winter planning arrangements including, telecare & additional support for delayed discharge.
- the redesign of Health and Social Care pathways to ensure they are consistent with transformation programmes namely Clackmannanshire Councils Making Clackmannanshire Better (MCB) Stirling Council Priority Based Budgeting (PBB) and NHS Forth Valley Clinical Service Review.

4.0 Sustainability Implications

4.1 None.

5.0 Resource Implications

The Integrated Care Fund (ICF) will support investment in integrated services for all adults and in 2015/16 the allocation for the Clackmannanshire & Stirling Partnership area will be £2.48million. (Clackmannanshire £0.96m and Stirling £1.52million). The areas of spend are detailed within the Integrated Care Fund Plan

5.1 The full financial implications of the recommendations are set out in the report. This includes a reference to full life cycle costs where appropriate. Yes ☑

5.2 Finance have been consulted and have agreed the financial implications as set out in the report. Yes ☑

5.3 *Staffing* - There are no staffing implications associated with this report.

6.0 Exempt Reports

6.1 Is this report exempt? Yes ☐ (please detail the reasons for exemption below) No X

7.0 Declarations

The recommendations contained within this report support or implement our Corporate Priorities and Council Policies.

(1) **Our Priorities** (Please double click on the check box ☑)

The area has a positive image and attracts people and businesses	☐
Our communities are more cohesive and inclusive	☐
People are better skilled, trained and ready for learning and employment	☐
Our communities are safer	☐
Vulnerable people and families are supported	☐
Substance misuse and its effects are reduced	☐
Health is improving and health inequalities are reducing	X
The environment is protected and enhanced for all	☐
The Council is effective, efficient and recognised for excellence	☐

(2) **Council Policies** (Please detail)

N/A

8.0 Equalities Impact

8.1 Have you undertaken the required equalities impact assessment to ensure that no groups are adversely affected by the recommendations?

Yes ☐ No ☑

9.0 Legality

9.1 It has been confirmed that in adopting the recommendations contained in this report, the Council is acting within its legal powers. Yes X

10.0 Appendices

10.1 Please list any appendices attached to this report. If there are no appendices, please state "none".

Appendix 1 – Clackmannanshire & Stirling Integrated Care Fund Plan

Appendix 2 – Clackmannanshire & Stirling RCOP Change Fund Report to the JIT

11.0 Background Papers

11.1 Have you used other documents to compile your report? (All documents must be kept available by the author for public inspection for four years from the date of meeting at which the report is considered)

Yes ☐ (please list the documents below) No X

Author(s)

NAME	DESIGNATION	TEL NO / EXTENSION
David Niven	Programme Coordinator (Change Fund)	01786 233 904

Approved by

NAME	DESIGNATION	SIGNATURE
Phillip Gillespie	Assistant Head of Social Services	
Val de Souza	Head of Social Services	
Elaine McPherson	Chief Executive	

Integrated Care Fund Plan Template

PARTNERSHIP DETAILS

Partnership name:	Clackmannanshire & Stirling Partnership
Contact name(s): See note 1	Kathy O'Neill / Val de Souza
Contact telephone	01786454631 /
Email:	k.oneill@nhs.net / VdeSouza@Clacks.Gov.uk
Date of Completion:	12th December 2014

The plan meets the six principles described on pages 2 and 3 (Please tick √):

Co-production	√	Leverage	√
Sustainability	√	Involvement	√
Locality	√	Outcomes	√

Please describe how the plan will deliver the key points outlined in paragraph 18:

In line with Scottish Government Guidance, the Integrated Care Plan (ICP) for Stirling and Clackmannanshire is:

- Squarely focussed on alleviation of health inequalities
- Focussed on tackling the challenges associated with multiple and chronic illnesses for adults and older people
- Focussed on multimorbidity that is intimately tied to recognising the greater mix of mental and physical health problems seen as deprivation increases
- Enabling a move to more targeted transformational redesign focused on prevention and preventative spend to redesign and redirect activity from complex and high cost service models
- Enabling the third sector to play a crucial role
- Ensuring Personal Outcomes for Individuals and Carers are at the centre of the plan

Reshaping Adult Care in Clackmannanshire and Stirling:

There is a significant opportunity to build on the achievements made through Reshaping Care for Older Peoples' programme and joint commissioning plans in Clackmannanshire and Stirling. In addition, the ICP draws on further work done over the last two years including

- Single Outcome Agreements and work done on tackling poverty and inequalities
- Local Adult Care Pathway Review - Joint Commissioning priorities have not only been progressed,

but care priorities, pathways and services have also been reviewed and aligned, through the development of an “Adult Care Pathway”.

- Priority based ouputs from Primary Care led Locality Engagement Groups.
- Short term service transformation plans currently funded with short term funding e.g. LUCAP, winter planning, telecare and delayed discharge programmes.
- Ongoing organisational reviews including Stirling Council Priority Based Budgeting and NHS Forth Valley Clinical Service Review

The integrated Care plan will focus on priorities yet to be fully fulfilled. The leverage that the Integrated Care Fund offers will enable a focussed progression of an integrated adult care pathway with renewed focus on the core agendas of prevention, early intervention and care and support for people with complex and multiple conditions and their carers. Transformation of complex and high cost service models, in particular reduce the demand for emergency hospital activity requires to be a key objective.

There is a firm foundation of transformational change and very strong partnership working and governance process already in place on which to build. E.g. the partnership approach, and transparent programme review and appraisal process, established during the life of the Change Fund for Reshaping Older People’s Care.

The 2015/16 ICF will not be open to bids as the Change Fund previously was. Partners will be worked with closely over the next few months to specify and commission services and to design-in sustainability and evaluation and reporting. This work and experience will feed into wider Integrated Joint Strategic Planning work for 2016.

Please see the attached Integrated Care Plan for more details.

The content of this template has been agreed as accurate by:

……………………………

(name) for the Shadow Joint Board, or for a lead agency,

……………………………… or ………………………………

(name) for the NHS Board (name) for the Council

……………………………… ………………………………

(Alasdair Tollemache) SVE, for the third sector

(Robert Walters) CTSi, for the third sector

………………………………

(Robin Sidebottom) Mears Group, for the independent sector

When completed and signed, please return to:

Kelly Martin

2ER, St Andrew's House

Regent Road

EDINBURGH

EH1 3DG

Kelly.Martin@Scotland.gsi.gov.uk Templates should be returned by **12th December 14.**

Clackmannanshire and Stirling Integrated Care Plan

On the 7th July '14, the Scottish Government wrote to announce the provision of additional resources for 2015/16 to support delivery of improved outcomes from health and social care integration. The Integrated Care Fund (ICF) will support investment in integrated services for all adults and in 2015/16 the allocation for the Clackmannanshire & Stirling Partnership area will be £2.48million. (Clackmannanshire £0.96m and Stirling £1.52million).

Within the guidance there are key messages that highlight the need to build on the successes of the change fund and RCOP programme. It is recognised that the full ambitions of the RCOP 10 year programme have yet to be fulfilled and that partnerships require to continue to make progress within the context of integrated arrangements for adult services.

In line with Scottish Government Guidance, the Integrated Care Plan (ICP) for Stirling and Clackmannanshire is:

- Squarely focussed on alleviation of health inequalities
- Focussed on tackling the challenges associated with multiple and chronic illnesses for adults and older people
- Focussed on multimorbidity that is intimately tied to recognising the greater mix of mental and physical health problems seen as deprivation increases
- Enabling a move to more targeted transformational redesign focused on prevention and preventative spend to redesign and redirect activity from complex and high cost service models
- Enabling the third sector to play a crucial role
- Ensuring Personal Outcomes for Individuals and Carers are at the centre of the plan

Reshaping Adult Care in Clackmannanshire and Stirling:

There is a significant opportunity to build on the achievements made through Reshaping Care for Older Peoples' programme and joint commissioning plans in Clackmannanshire and Stirling. In addition, the ICP draws on further work done over the last two years including

- Single Outcome Agreements for Clackmannanshire and Stirling, including the work already done on tackling poverty and inequalities.
- Local Adult Care Pathway Review - Joint Commissioning priorities have not only been progressed, but care priorities, pathways and services have also been reviewed and aligned, through the development of an "Adult Care Pathway".
- Priority based ouputs from Primary Care led Locality Engagement Groups.
- Short term service transformation plans currently funded with short term funding e.g. LUCAP, winter planning, telecare & delayed discharge programmes.
- Organisational reviews including Stirling Council Priority Based Budgeting and NHS Forth Valley Clinical Service Review

The integrated Care plan will focus on priorities yet to be fully fulfilled. The leverage that the Integrated Care Fund offers will enable a focussed progression of an integrated adult care pathway with renewed focus on the core agendas of prevention, early intervention and care and support for people with complex and multiple conditions and their carers. Transformation of complex and high cost service models, in particular reduce the demand for emergency hospital activity requires to be a key objective.

There is a firm foundation of transformational change and very strong partnership working and governance process already in place on which to build.

Inequalities

It should be acknowledged that sustainably addressing inequalities throughout society is a long term and substantial challenge. That said, the links between inequalities and the success of Health and Social Care Integration mean that addressing inequalities should be included within plans for the use of the Integrated Care Fund in 2015/16. Health and Social Care Integration and all other efforts to improve the health and wellbeing of local citizens will be better served in the long term by ensuring that impact is initiated and exerted on inequalities in the short term.

Ensuring that reshaped adult health, care and support services resourced through the Integrated Care Fund in 2015/16 are focused on addressing inequalities has been informed by the work carried out by the Community Planning Partnerships in both Clackmannanshire and Stirling as part of developing their respective Single Outcome Agreements (SOA) in 2013. Both Clackmannanshire and Stirling SOAs identify poverty as the dominant inequality experienced by people living in their areas and recommend that a focus on addressing poverty is prioritised.

For the purpose of making recommendations about the allocation of the Integrated Care Fund (1% of total H&SC spend) over one financial year and recognising the need to focus plans with the aim of being able to demonstrate impact over that period. Efforts to factor inequalities into the allocation of Integrated Care Fund resources will consider poverty as the only proxy for inequality at this stage.

When focussing on inequalities two components will be considered:

- The geographical areas where greater densities of people experiencing inequalities are recorded.
- The extent to which planned efforts contribute to:
    - Prevention (including Early Intervention and Undoing) of inequalities
    - Mitigation of inequalities

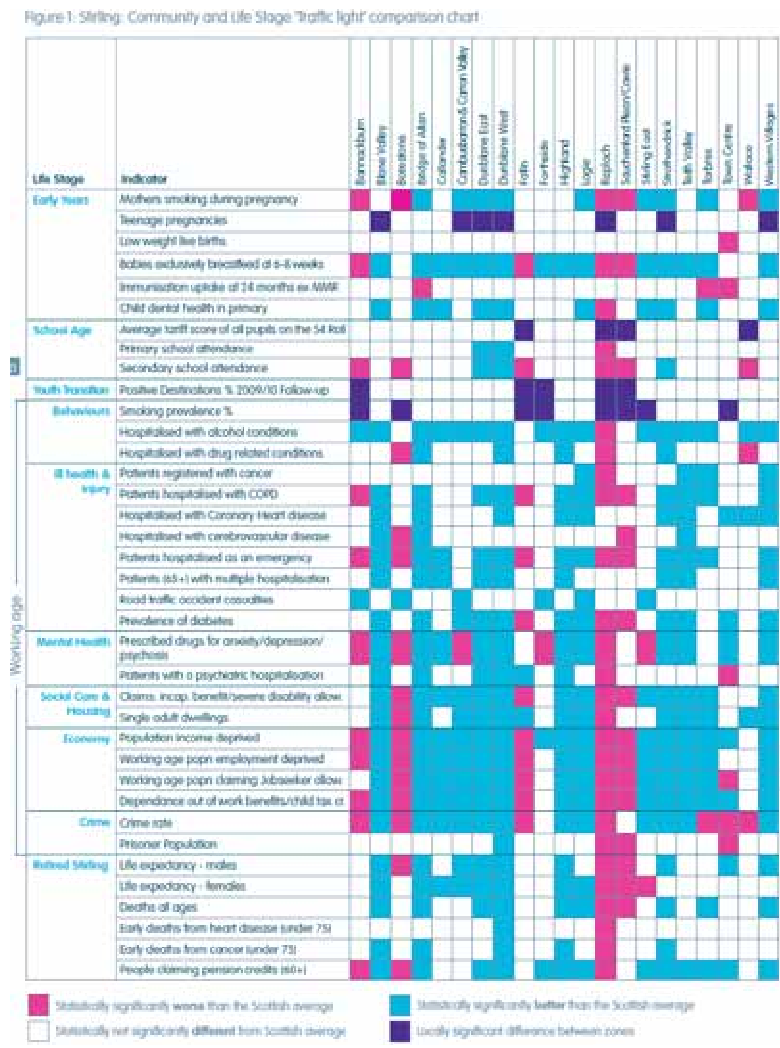
Prevention, Early Intervention and Mitigation of Inequalities.

The most prevalent method of addressing inequalities within mainstream health and social services is that of mitigation, where the aim is to improve the wellbeing of individuals over the short term by providing additional services without necessarily addressing the underlying causes. Prevention of inequalities is likely to cover a variety of wider ranging and complex approaches such as Community Led Local Regeneration, Housing, Education, Training or Employability programmes which require a longer term commitment from partners and funders.

It is unlikely that ICF investment of any scale will impact on Prevention over the one year period. In the short term, methods of support such as advocacy, micro grants, partnering, letters of support to funders etc. with the aim of supporting communities to achieve long term outcomes should be progressed.

Local Information on Inequalities.

Stirling Geographical info:



The Stirling geographies to focus on when planning services that target those experiencing poverty are:

The Hillpark area of Bannockburn

Culten Hove area of Borestone

Fallin

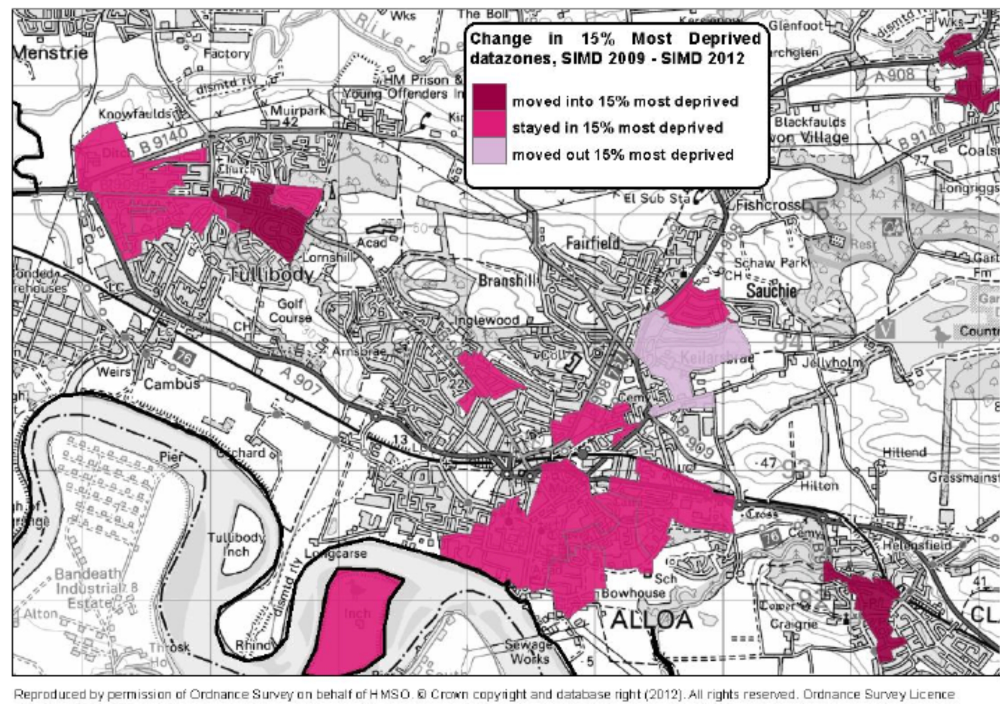
Raploch

Sauchenford Plean/Cowie (The Eastern Villages)

Data above taken from the Stirling Single Outcome Agreement 2013-23 document (page 10) accessed 17th Nov '14.
http://www.stirling.gov.uk/__documents/temporary-uploads/employment,-community-_and_-youth/communityengagement_final-soa13.pdf

Clackmannanshire Geographical info:

The map below illustrates change in the 15% most deprived datazones in Clackmannanshire between the two most recent SIMDs: 2009 and 2012.



Reproduced by permission of Ordnance Survey on behalf of HMSO. © Crown copyright and database right (2012). All rights reserved. Ordnance Survey Licence number 100024655.

Figure 1 Change in the 15% most deprived areas in Clackmannanshire, 2009 - 2012

Datazone	Intermediate geography
S01000835	*Clackmannan, Kennet and Forestmill*
S01000836	*Alloa South and East*
S01000837	*Alloa South and East*
S01000840	*Alloa South and East*
S01000841	*Alloa South and East*
S01000846	*Alloa South and East*
S01000850	*Alloa North*
S01000860	*Sauchie*
S01000866	*Tullibody North and Glenochil*
S01000867	*Tullibody South*
S01000868	*Tullibody South*
S01000869	*Tullibody North and Glenochil*
S01000870	*Tullibody North and Glenochil*
S01000874	*Fishcross, Devon Village and Coalsnaughton*

Figure 5 Datazones and corresponding intermediate geographies

Data above taken from a Clackmannanshire Council paper detailing Analysis of Clackmannanshire's datazones in the Scottish Index of Multiple Deprivation 2012. Accessed on the Clacks Council website 17th Nov '14. http://www.clacksweb.org.uk/document/3932.pdf N.B. The data above shows the datazones within Clackmannanshire that lie within the 15% most deprived datazones across Scotland not the 15% most deprived datazones in Clackmannanshire.

Multimorbidity

The impact and relationship between multimorbidity, mental health and social deprivation is clear. National data below shows the links between experiencing multiple conditions, age, socioeconomic status, mental health and affluence/deprivation.

The ICP will utilise local data and draw from the multimorbidity action plan to inform the detail of the Integrated Care Plan

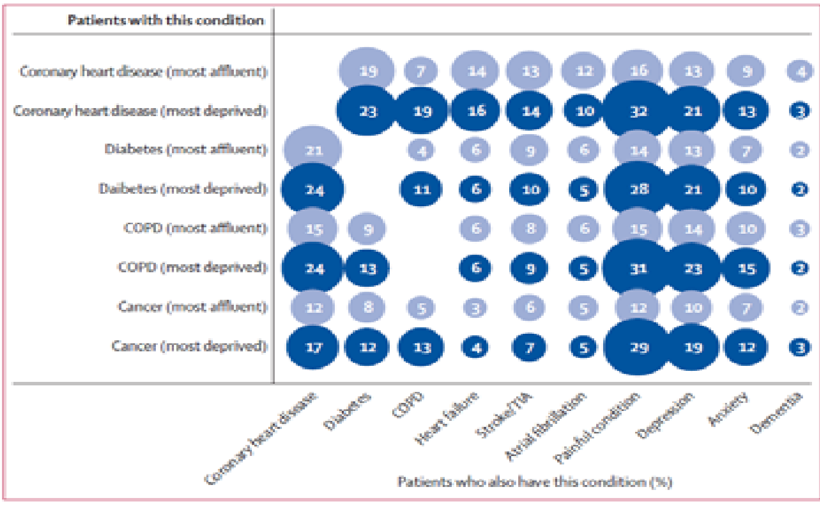


Figure 4: Selected comorbidities in people with four common, important disorders in the most affluent and most deprived deciles
COPD=chronic obstructive pulmonary disease. TIA=transient ischaemic attack.

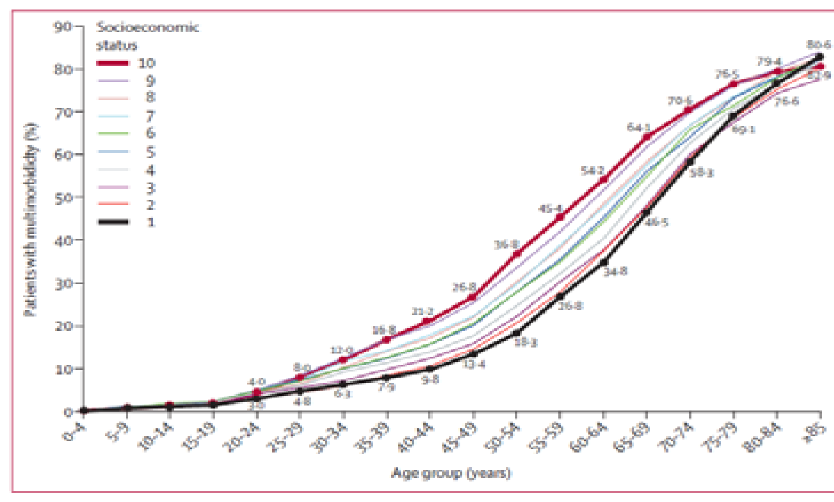


Figure 2: Prevalence of multimorbidity by age and socioeconomic status
On socioeconomic status scale, 1=most affluent and 10=most deprived.

Charts taken from "Epidemiology of multimorbidity and implications for healthcare, research, and medical education: a cross-sectional study" by *Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie (2012*

Key Investment Areas for the Integrated Care Fund 2015/16

The summary table on Pages 13 and 14 proposes an outline of ICP priority work streams and relative funding, the detail of which requires to be carried out in respect to the detail outlined above in the coming period. These priority streams cover 3 key areas.

1 – Redesigning/Redirecting activity on complex and high cost service pathways

The reshaping care programme has successfully embedded reablement and short stay intermediate care services across the area, with some evidence from strengthening models of a sustained impact on long term care home and home care pathways. The Integrated Care Plan will deliver sustainable change which must reduce demand for emergency admissions and hospital activity.

This will be achieved through key high impact changes which must evidence sustainable change.

- Implementation of an enhanced 24/7 integrated support model for Community Living.
    - Including a Single Point of Contact for statutory sector care response services
    - Enhanced overnight and weekend AHP, Nursing and social care response services
- Embedding person centred planning approach across all community services whilst focussing specialist ACP resource to areas of poverty and high multimorbidity with more awareness of the under 65yrs population and those with mental health problems.(East Stirling, Clackmannanshire)
- Final shifts to scale of Intermediate Care services with development across the adult care pathway including
    - Developing intermediate care model for dementia care.
    - Supporting Intermediate care models for adults with physical disabilities, Learning Disabilities and Mental Health.
- Strengthened partnership involvement and co-production approaches to deliver alternative supports which enhance outcomes for individuals
- Technology support services development

These models will be underpinned by service user and carer centred approaches delivered in partnership, with a clear and key role for non-statutory partners.

2- Prevention and Community/Locality Supports

Enabling a shift to support the assets of individuals, communities, and third and commercial sector businesses, through co-production and locality working.

- **The role of localities (and the service users, carers, citizens and professionals that live and work within them) to exercise their influence on developing Integrated Care commissioning plans**
    - Ensuring that any consensus outputs from partnership locality events are fed into integrated care plans.
    - The need to understand our populations in terms of multimorbidity and inequalities and support the direction of Integrated Care Funding to areas of greater need within our localities
- **Channel Shift – Shifting to support the assets of individuals, communities and third and commercial sector businesses.** [Channel Shift should be understood as a way of enabling public

sector bodies to focus on the higher tariff and more involved services that only they can reasonably deliver. By commissioning services and supports which can be more easily provided by independent or third sector providers (including bodies that are operated solely by volunteers), public sector bodies will free up time and resource to focus on more involved prevention and early intervention work. All shifts should be predicated upon the assumption that people using services and their carers are experts in their own conditions and should be recognised as assets when planning for future outcomes and care.]

- Extending Community Supports in Clackmannanshire and Stirling
- Extending Community and Post Diagnostic Support for adults with Dementia
- Extending the RSCOP Carers support model for anticipatory and preventative approaches to appropriate adult populations to support further implementation of the Carers Strategy.
- Telehealth/care development incl. DALLAS Telecare programme
- Further small scale local 3rd Sector volunteer operated Community Supports e.g. establish a small community "prevention" grant fund - potentially via Stirling Council Communities Team + Equivalent in Clackmannanshire
- Integrated Care Planning – supporting an interagency primary care based model of care co-ordination – linking to signposting, information, self-management
- "Community Navigation" – specific resource model to simplify access to local community supports. This will include linking primary and community care with third sector and Social Services in particular. For example Local Area Coordination and the work being developed by Social Service Planning & Commissioning in relation to SDS and establishing a website to profile the spectrum of commissioned services and supports. A further solution will be required to make available information about services across the whole market that are not currently commissioned including those delivered by local volunteers.
- Targeted resource to support lifestyle change and social prescribing for individuals with multimorbidity / those in poverty.
- Shift care and support by building on community assets, independence and resilience

3 – Infrastructure & Transformational Change

- Business Transformation - Information and E-health programme social care integration
- Business transformation - Workforce Development & Support and OD
- Business Transformation – Business Development Support

Models and process prioritising and allocating ICF spend:

In the first instance planning has drawn on the wealth of information gathered via RCOP engagement and joint commissioning process for older people's services as well as the experience of integration process from mental health and learning disability services. Ongoing, however, the principles and priorities for the ICF and process of allocating funds must be developed and agreed. The guidance indicates that plans should be informed by input from stakeholders, including third sector and service users and carers in line with joint commissioning approaches.

- The preferred method of allocation would be on a commissioned Intervention basis. Partners will work closely over the next few months to specify and commission services which will design-in sustainability and evaluation. This work and experience will feed into wider Integrated Joint Strategic Planning work for 2016
- It is recommended that investment priorities are allocated notional proportions of budget. This will focus plans on enabling appropriate scale and capacity to deliver sustainable outcomes. These should be reviewed and amended as details are agreed.
- Public Social Partnership (PSP) principles could be applied to commissioning change and may be particularly effective in engaging third sector partners.
- It is not proposed that the ICF will be allocated through an open application process although an element of small community grants may be considered for very small scale, short term funding for community initiatives.
- The ICF must focus on change and transformation of existing services, over and above delivering new services.

To support the development and confirmation of the ICP it is proposed that:

- the Joint Management Team to carry review proposed priorities (complete JMT 26th Nov)
- leads will be identified for each work stream (complete JMT 26th Nov)
- Leads will initiate detailed work to be undertaken in Dec-January 15.
- Proposal to Partnership Board in February 15 on proposed detailed spend, once approved, projects will go ahead. This will include aligning Commissioning with the required procurement measures for each service; ensuring that work streams are designed with sustainability and performance evaluation built-in; and that risk is clearly assessed, documented and processes are established to manage it throughout 2015/16
- The Reshaping Care Strategy Group, with additional membership as appropriate, will acts as the stakeholder engagement group for the ICP.

To ensure the principles of co-production; sustainability; locality; leverage; involvement and outcomes are embedded within projects, the integrated care fund support proposed will include a reporting and impact measurement system. All projects will be asked to set out:

- The impact measures they will use to demonstrate improved health and wellbeing outcomes for adult health and social care and their contribution to tackling health inequalities within community planning partnerships
- The extent to which their project will deliver improved outcomes in year and lay the foundations for future work to be driven through strategic commissioning.

- How relationships with localities will be built, including how input from the third sector, people using services, and carers will be achieved
- How projects/services (if successful) will be mainstreamed, e.g. where disinvestment elsewhere will support continuation of work
- How resources will be focussed on greatest area of need
- How the principles of co-production will be embedded in the design and delivery

Lesley White, Lesley Middlemiss, David Niven. Dec 14

Summary Overview of Integrated Care Plan	Value / Fit with 2015/16 Integrated Care Funding	Anticipated Value of 2015/16 Integrated Care Funding	Notes
1. Redesigning high Cost Service Models through Preventative spend -			
1.1 Test and Deliver actions to ensure a responsive 24/7 Health and social care model	High impact changes which sustain, unlock and improve resource utility. Actions which are driven by Involvement & Locality work identified as priorities which will improve outcomes for individuals	£600,000	Enhanced Response / prevention service in evenings and Weekends (DN/AHP/SW) Provision of Overnight social care Support
1.2 Develop and Extend intermediate care model to all adults – particularly implement a dementia intermediate care pathway.		£500,000	Shift Clacks integrated reablement to full scale Transitional integration towards care village Shift dementia activity from hospital bed model to integrated short stay assessment Restructure psychiatry Day Care model
1.3 Multimorbidity / Targeted Anticipatory & Preventative Care		£250,000	Embed work so far into mainstream community services and target specific resource for "my good life" model to areas of higher poverty and multimorbidity Increase opportunity through KIS. Also extend capacity to wider adult care groups for alternative models of anticipatory and preventative approaches
	Sub Tot	£1,350,000	
2.Prevention and community / Locality Supports (including scaling RSCOP projects to wider adult support and locality priorities Oct 2014)			
	Locality models tested through change fund which evidence better outcomes for individuals and carers. Strong partnership foundations	£350,000	
2.1 Extending Community Supports Stirling/Clacks			Work with to support inequalities programme /Multimorbidity action plan
2.2 Extending Community and post diagnostic supports for adults with Dementia			As per business cases submitted post change fund with support to focus more on inequalities /multimorbidity action plan
2.3 Extending RSCOP Carers support model for anticipatory and preventative approach to Supporting more and broader range of Carers			As per business cases submitted post change fund with support to focus more on areas of inequality/ multimorbidity action plan
2.4 Telehealthcare development incl. DALLAS		£75,000	Re: Multimorbidity action plan

Telecare programme			
2.5 Further 3rd Sector led Community Supports e.g. establish a small community "prevention" grant fund - potentially via Stirling Council Communities Team + Equivalent in Clacks	Work streams with strong locality focus. Identified through partnership engagement and to be delivered as such. Lower / long term leverage agents. Strong focus on personal outcomes	**£225,000**	Locality Priorities which also largely align with Joint Commissioning Plan and Adult Care pathway.
2.6 Integrated Care Planning – supporting a interagency primary care based model of care co-ordination			
2.7 "community Navigation" – specific resource model to simplify access to local community supports			
2.8 Targeted resource to support lifestyle change and social prescribing for individuals with multimorbidity / those in poverty.			
		£650,000	
3. Infrastructure and Transformational Change			
3.1 Business Transformation - Information and E-health programme social care integration			Linked Data Programme Shared Information Data and Performance e- System Integration Needs Assessment Mobile Working Single Point of Access Single shared assessment / KIS
3.2 Business transformation - Workforce Development & Support & OD		**£480,000**	Integrated team development, care village transformation, OT integration. Organisational Development, HR, governance. This will include embedding Outcomes Based Practice and efforts to enhance leadership capacity across all levels within partner organisations to empower staff to make decisions as close to the cared for as possible.
3.3 Business Transformation – Business Development Support			Business support – service review, service development, finance, project management, enabling and developing third sector support and Supporting Commissioning and Market Shaping and communications
	Total	**£2,480,000**	

Summary Overview of Integrated Care Plan	**JMT Lead(s)**	**Actions by End of January**
1. Redesigning high Cost Service Models		**Leads should engage with relevant stakeholders to develop detail of the work stream of the ICP. This should outline a shortlist of costed priority options which are proposed to be funded and delivered through the ICP. These options should demonstrate** • **Clear Alignment with the ICP criteria** • **Clear alignment with transformation of existing services rather than proposing new services** • **Context within existing service/ commissioning plans or strategies** **Demonstrate a clear rationale for prioritisation including** • **Evidence of need / scope for benefit realisation** • **Value in terms of impact on H&SC Outcomes** • **Extent to which the proposal will deliver improved outcomes in year and lay foundations for future strategic commissioning.** • **Value in terms of the investing as a lever to disinvestment** • **Predicted reach (scale, outputs, targeted coverage) of the proposed change** It is proposed that the range of options proposed should be honed to the final "short list" perhaps through a form of consensus/ values based appraisal.
1.1 Test and Deliver actions to ensure a responsive 24/7 Health and social care model	Bette Locke	
1.2 Develop and Extend intermediate care model to all adults – particularly implement a dementia intermediate care pathway.	Maureen Dryden	
1.3 Multimorbidity / Targeted Anticipatory & Preventative Care	Scott Williams / Bette Locke	
2.Prevention and community / Locality Supports		
2.1 Extending Community Supports Stirling/Clacks	Alasdair Tollemache Robert Walters (current change funded workstream)	
2.2 Extending Community and post diagnostic supports for adults with Dementia		
2.3 Carers support and further implementation of strategy		
2.4 Telehealthcare development incl. DALLAS programme	Linda Melville, Bette Locke	
2.5 Further 3rd Sector led Community Supports e.g. establish a small community "prevention" grant fund - potentially via Stirling Council Communities Team + Equivalent in Clacks	? Johny Keenan/ Alasdair / Robert?	
2.6 Integrated Care Planning – supporting a interagency primary care based model of care communication and co-ordination	Scott Williams Maureen Dryden	
2.7 "community Navigation" – specific resource model to simplify access to local community supports	Chris Sutton, Robert Walters, Alasdair Tollemache	
2.8 Targeted resource to support lifestyle change and social prescribing for individuals with multimorbidity /inequality	Johny Keenan	
3. Infrastructure and Transformational Change		
3.1 Business Transformation - Information and E-health	Ewan Murray	
3.2 Business transformation - Workforce Development & Support & OD	Divya Prakash	
3.3 Business Transformation – Business Development	Lesley White /Lesley M	

MULTIMORBIDITY	**High Impact Changes**	**Actions for Boards and Partnerships**
Care planning and consultations help	***Outcome based assessments:***	• Adopt *House of Care* consultation model in GP practices and

people to have control over their conditions, care and support and to achieve their personal outcomes	• Staff ask people about the priorities, goals and outcomes that matter to them • Consultations routinely include time for reflection, to 'think ahead' and to 'check out' ***Holistic care planning*** • Assessments, care planning and reviews support people to develop a personal care plan • People prescribed multiple drugs receive support to understand and manage their medicines	spread personal outcomes approaches in community teams • Design holistic GP practice and outpatient appointments for people with multiple conditions • Scale up Anticipatory Care Planning in primary care and use of Key Information Summaries in unscheduled care • Roll out Pharmaceutical Care Planning and reviews
Integrated care and support builds on community assets and promotes independence, wellbeing and resilience	***Self Management information, advice and support to help people stay well, active and at work*** • Peer support and volunteers are an integral part of local practices, integrated teams and services • Patients and carers use day to day technology and social media to manage their conditions ***Build enablement and generalist skills in the workforce*** • All education and CPD programmes deliver units of learning on multimorbidity, enablement, health behaviour change and working health	• Introduce practice attached support workers / community navigators and simplify access to local community support • Scale up use of digital information, guided self help, remote monitoring and consultation • Extend health coaching and health promoting interventions to all care settings • Develop roles, job shadowing and action learning to enhance generalist skills in specialist care and specialist expertise in community workforce
System wide pathways designed around people with multimorbidity and to reduce health inequalities	***Coordinated, Integrated technology enabled care*** • MCNs, care pathways, protocols and guidelines are attuned to people with common multimorbid syndromes and concurrent physical and mental health problems • Proactive care coordinated by a lead professional or care manager	• Support MCNs to develop single point of access, screening prompts and technology enabled decision support for people with multiple morbidity at key points in local pathways • Systematically identify people with multimorbidity and deliver stepped care using peer, Third sector, technology and professional support tailored to needs and complexity
Visible adaptive leadership and a coherent research, innovation and improvement infrastructure to drive excellence in Integrated Care for Multimorbidity	***Leadership, research and innovation*** Integration authorities and their Third and independent sector partners have the capacity and capability for improvement and innovation in integrated care and multimorbidity Scotland's digital and social innovation align to develop an ambitious programme of collaborative research, innovation, and knowledge exchange with global experts on integrated care and multimorbidity	• Map & build local capacity for integrated improvement for above • Enhance risk prediction tools, disease register templates and data on common combinations of long term conditions • Include prompts to consider multimorbidity at key points in guidelines and pathways for all common conditions • Develop units of learning on Multimorbidity • Establish a Knowledge Innovation Community and 'collaboratory' on Integrated Care and Multimorbidity

25 March 2015

Dr Margaret Whoriskey
Director, Joint Improvement Team
2E.03, St Andrews House
Regent Road
Edinburgh
EH1 3DG

Email:
Tel: 0131 244 3365

Dear Reshaping Care Lead,

Learning from Reshaping Care and the Older People Change Fund

On behalf of our national partners, and to build on the learning from our Change Fund report published in November 2013, I'm writing to invite you to complete the enclosed template detailing how your partnership invested the Older People Change Fund and the progress that has been made over the life of the fund to 2015.

To enable analysis and an overview report to be completed by the end of April 2015, I would be grateful if you would submit the completed template Annex A by 28th February 2015 to It is expected that the submission that you make will have been signed off by all of the partners.

The purpose of completing the template is first and foremost to share examples of how local partnerships have deployed their Older People Change Fund to make a difference to the lives of older people and their carers across Scotland.

Kathleen Bessos, Deputy Director for Integration and Reshaping Care, wrote on 10 April with a reminder that partners should be preparing to mainstream their approach to reshaping care and support for older people through Strategic Plans that take an outcome-based approach to planning, delivery and performance improvement.

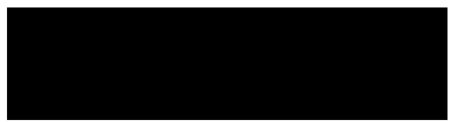
We recognise that integration authorities will want to understand the impact made by the Change Fund and use the learning from Reshaping Care for Older People to make best use of the new £100m Integrated Care Fund for 2015/16. Local partners will want to build on the learning and momentum from the previous investment and spread and scale the right approaches and solutions to shift the balance of care for older people in their localities.

The Guidance on the Integrated Care Fund highlights the role of the Joint Improvement Team in coordinating support from national partners and improvement organisations to improve the outcomes delivered through integrated care and support. The JIT will use the insight from the survey to share learning about improvements and innovations and to shape support offered to partnerships. This will include the Improvement Network for integrated care and support - a cross sector collaboration - to share learning across Scotland and to provide or broker assistance for partnerships to make local improvements.

An overview report on Reshaping Care and the Older People Change Fund will also be prepared for the Health and Community Care Delivery Group and the Ministerial Strategic Group.

If you have any questions regarding this request please don't hesitate to contact either your JIT partnership lead or myself.

Yours sincerely



Dr Margaret Whoriskey

Director, Joint Improvement Team

CC: Reshaping Care Operational Leads, Reshaping Care Third sector and Independent sector Leads

Annex A

Older People Change Fund Review

Partnership	Clackmannanshire & Stirling
Contact Name(s) & Job Title(s)	David Niven Programme Coordinator (Change Fund) Clackmannanshire & Stirling Councils Social Services
Email Address	nivend@stirling.gov.uk
Telephone	01786 233904
Date of Completion	26th February 2015

1. Examples of impact

Please submit, for each of the Reshaping Care Pathway workstreams below, a case study of at least one achievement from using the Change Fund to improve :

- ***Preventative and Anticipatory Care;*** *ACP Nursing*
- ***Proactive Care and Support at Home;*** *Rural Carers*
- ***Effective Care at Times of Transition;*** *Clacks Reablement*
- ***Hospital and Care Home(s);*** *Frailty*
- ***Enablers;*** *Intermediate Care Event*

Each case study should include the information in Annex B. At least one of the five case studies should highlight an impact on carers. Submitted case studies will be published on the JIT website.

2. Learning from what hasn't worked well

Through development of an outcomes focussed "benefits" appraisal tool (see below) we have been able to review project progress with a consensus based appraisal of project success which has enabled us to confidently identify projects which were not delivering effective change.

The appraisal tool has had two distinct impacts. Firstly, it has provided an open and transparent process through which disinvestment priorities are identified and agreed through our partnership process and Secondly, the existence of the tool has encouraged service providers to take requests for additional information seriously because the process has been shown to successfully lead to disinvestment in appropriate circumstances.

Another area that hasn't worked as well as it might have has been a lack of development support for new integrated services such as reablement & rehabilitation integration. A lack of project methodology and confusing / unclear service management arrangements has led to an implementation model driven forward well by clinical and care staff on the ground but made difficult and more complicated by a lack of clear structure and consequent evaluation of impact.

3. Option Appraisal

Please describe any option appraisal approaches used to consider sustainability and decide local investment priorities

All the Change Funded Services have now gone through two annual cycles of a rigorous qualitative and financial review conducted upon them to inform the Stirling and Clackmannanshire Partnership of progress and to inform ongoing funding.
Reports and Business Cases for ongoing funding are reviewed against a suite of outcomes based upon the Draft Outcomes for Health and Social Care Integration and the Reshaping Older People's Care Outcomes. Change Fund Partnership Support Team members complemented by a Carers Centre Manager carried out the consensus scoring review process. (0 no evidence– 5 very strong evidence)

Non Financial Benefits Appraisal

Outcomes	Weighting	Project A		Project B	
		Reach	Impact	Reach	Impact
Independent Living	2	4	4	4	4
Healthier Living	2	4	4	4	3
Carers are Supported	2	4	4	2	1
Positive Experience /Personal Outcomes	2	4	3	4	3
Partnership Approach	1	3	4	3	3
Engaged Workforce	1	3		2	
Impact on Inequality		2		1	
Continuous Improvement	1	3		3	
Weighted Total		42.5		34	
Ranked					

Subsequently, and separate from qualitative (non financial) benefits the support team reviewed current finances and projected costs for each service.

The Partnership Steering Group then considered the Support Team recommendations, and the full reports and business cases for the 5 services identified as performing least well, when making their own recommendations to the Decision Group. Organisations leading and hosting Change Funded Services have been kept informed of progress during this process, including the proposed reductions in funding for some.

4. Supporting improved outcomes through integrated care

Please provide details of any ongoing support you would welcome.

The Clackmannanshire & Stirling partnership would still welcome the sharing of examples from other areas, including details about how they work, of successful disinvestment, or examples where disinvestment has been committed to, to shift the balance of care.
The Clackmannanshire & Stirling partnership would also welcome the sharing of examples from other areas, including details about how they work, of sharing increasing levels of power with the third and community sector to enable genuine co-production.

5. Older People Change Fund spend

Please insert details of your Change Fund budget and the proportion of spend aligned to each of these 5 workstreams:

	2011/12	2012/13	2013/14	2014/15
SG Allocation	As previously reported	As previously reported	As previously reported	£1.749m
Carry Forward	N/A	As previously reported	As previously reported	£0.110m
Total In Year Allocation	As previously reported	As previously reported	As previously reported	£1.859m
Year-end Spend	As previously reported	As previously reported	As previously reported	£1.859m (anticipated)

		2012/13	2013/14	2014/15
Spend on carers (year-end spend)		As previously reported	£0.560m	£0.405m (anticipated)
			£	£ (anticipated)
Third Sector spend		£0.090m	£0.442m	£0.522m (anticipated)

Note: The partnership has an agreed methodology for calculating spent on support to carers therefore total carer spend is included rather than an direct/indirect split.

	Preventative and Anticipatory Care	**Proactive Care and Support at Home**	**Effective Care at Times of Transition**	**Hospital and Care Home(s)**	**Enablers**	**Total** *(should equal 100%)*
2011/12 (year-end spend)	As previously reported %	As previously reported	As previously reported	As previously reported	As previously reported	As previously reported
2012/13 (year-end spend)	As previously reported %	As previously reported	As previously reported	As previously reported	As previously reported	As previously reported
2013/14 (year	18%	9%	22%	38%	14%	100%

end spend)						
2014/15 (anticipated year end spend)	27%	11%	19%	29%	14%	100%

All money from the Older People Change Fund is expected to be spent – any underspend will **not** be available for carry forward to 2015 -16. There is also the potential, as indicated in a letter from John Connaghan, Director for Health Workforce and Performance, to give each Integration Authority the "best start possible" in 2015/16.
Additional local investment could be achieved now through the use of Change Fund slippage/flexibility and/or a review of the existing Change Fund plans for 2014-15 and/or accelerating planned spend from the Integrated Care Fund for 2015-16.

6. Assessment of Spread

The Reshaping Care Pathway represent the approaches and actions, and the enabling supports, which collectively improve outcomes for older people. Please complete the self-assessment at Annex B to reflect the extent to which new models of care and support have been spread and where future gains need to be made through Strategic Commissioning.

7. Key achievements

Please tell us what you consider the key achievements from the use of the change fund in your area to be.

1. The development of Intermediate care services, particularly reablement and short stay social care assessment beds. These services are now embedded across Stirling and Clackmannanshire, demonstrating positive outcomes, although in places still require some development of scale.
2. Partnership approach and engagement. The change fund has promoted and galvanised relationships between health, social care and the third sector. It has enabled an increased understanding of RCOP principles across partners which has productively fed into planning around health and social care integration.
3. Third Sector engagement and development of high quality outcomes focussed services for older people. (in fields of carers support, dementia services and exercise referral in particular)

8. Third Sector

Please give an example of what has been achieved through Third Sector use of the change fund.

Stirling and Clackmannanshire Carers Centres have both demonstrated how change fund has enabled their services to reshape. The service changes they have made have been accomplished through the establishment of infrastructure that uses co-production with all stakeholders. This has enabled a new anticipatory and preventative model of service delivery to support older carers and carers of older people and has ensured that positive personal outcomes are achieved by all.

9. Any additional comments?

no

Annex B Case Study 1

Partnership	Clackmannanshire and Stirling
Name of Initiative	ACP - Planning "What Makes a Good Life for You?"
Primary Contact	Irene Warnock, Community Nurse Manager
Email	Irene.warnock@nhs.net
Telephone	07768707641

Pathway Workstream :	Preventative and Anticipatory Care

1. Summary

Development of a Community Model for Anticipatory Care Planning Assessment - "What makes a Good Life for You?"

2. What was the issue you were addressing or working on?

- Increased identification and support of older people at risk of admission
- An increase in both the number and quality of anticipatory care plans and Key Information Summaries completed for older people
- An improved understanding amongst primary care and district nursing teams of the value of ACP and supported self management plans as valuable tools in improving the quality of life choices for older people.
- Increased confidence amongst primary care and community services in using ACP as a helpful and valid approach in providing appropriate person centred care for older people, gradually embedding the approach in mainstream practice.
- A reduction in inappropriate admissions to hospital for older people.
- Improvements in quality of life and increased involvement of older people in developing and influencing their own care, with increased links to local communities.
- Improved outcomes for carers

3. What did you do?

- Phase 1 (April to September 2013) Model and tool tested with 5 patients. Feedback from patients and staff used to adjust and amend tool and add further risk assessments.
- Phase 2 (September –December 2013) ACP nurses recruited. Training needs analysis and induction training completed. Linkage with community resources, for example carer support, Keep Well etc. Phase 2 saw 40 patients identified and visited with ACP and KIS completed.
- Phase 3 (to June 2014) At end June 2014 we had linked with 9 GP practices and seen 120 patients and are about to gather our information into qualitative and quantitative data
- Phase 4(to date) The project has now formed links with 9 GP practices and over 150 patients. There is significant linkage with the primary care Key Information Summary programme, carer support and Keep Well. Phase 5 – spread to mainstream community services

4. What were the outcomes / benefits ?

- Feedback from service users has been overwhelmingly positive with patients welcoming both the physical check and the opportunity to influence their own care in a real way.
- Carers also have demonstrated real benefits from the project intervention with an increase in both health checks and take up of support.
- Third sector organisations have been enthusiastic to support older people at home creatively.
- Many individual success stories improved personal outcomes including avoiding unnecessary hospitalisation.
- Medical staff within the Hospital Unit have found increased information helpful
- Joint visits with Social Services have been highly successful in meeting needs whilst reducing referral for ongoing service input.

Annex B   Case Study 2

Partnership	**Clackmannanshire and Stirling**
Name of Initiative	**Adult Rural Carers' Support Officer**
Primary Contact	**May Kirkwood**
Email	
Telephone	

Pathway Workstream :	**Proactive Care and Support at Home**

1. Summary

Please summarise the case study in one paragraph of no more than 100 words.

The Adult Rural Carer Support Service offers older carers and carers of older people an individualised, flexible support service, in line with provision available in urban based areas. Home visits, rural group support & events form an important part of the carer support provision to meet the difficulties that arise due to geographical location, social isolation, and travel & transport issues. The Adult Rural Carer Support Service works in close partnership with GP Practices, Health & Social Care teams and other Third Sector agencies.

2. What was the issue you were addressing or working on?

Older carers and carers of older people living in the rural areas of Stirlingshire can be unidentified, 'hidden', or 'hard to reach due to: isolation in the caring role; geographical location; lack of social opportunity; poor transport & travel links; financial difficulties; full time commitment to the caring role; lack of knowledge or confidence to request support & assistance from statutory or third sector agencies; inadvertent disengagement from advancements in new technologies; and a lack of accessibility to community resources and amenities in comparison to urban areas.

3. What did you do?

Mechanisms to support carers include: appropriate early intervention and partnership working to provide support prior to and following life affecting situations; 1:1 & group support; completion of Carers Assessments; internal co-working with Anticipatory Carer Support and Enhanced Discharge Support colleagues; referrals and joint working with external statutory agencies including, GP Practices, Health, Social Work Services & third sector agencies; and access to needs led training. The views, opinions and experiences of older carers and carers of older people are at the centre of all support and are used as the baseline for assessment, respecting their right as 'equal partners in Care' & support planning and its provision.

4. What were the outcomes / benefits ?

During the most recent reporting period (10 months from 1st Nov '13 to 31st July '14):

- 55 newly identified rural carers
- 49 contacts with rural GP practices and 19 awareness raising visits to GP practices
- 634 enquiries to support rural carers
- 77 one to one appointments carried out to support rural carers
- 9 Rural Carers Support Groups facilitated in rural area
- 2 My Time, informal respite groups facilitated for rural carers
- 3 rural carer training sessions co-facilitated with partner Carers Centre
- 52 income maximisation / form filling benefits appointments carried out equating to £172,049.26 in released benefits
- An extensive body of qualitative feedback can be demonstrated for this service via a user friendly database. Reports are comprehensive and strikes the balance well between reporting information relating to outcomes and harder edged data relating to outputs.

Annex B   Case Study 3

Partnership	Clackmannanshire and Stirling
Name of Initiative	Integrated Reablement in Clackmannanshire
Primary Contact	Linda Melville
Email	
Telephone	

Pathway Workstream :	Effective Care at Times of Transition

1. Summary

The Clackmannanshire Reablement Service was expanded on 1st October 2011 following successful funding through the Change Fund. This funding was put in place to expand the existing, limited Rehab at Home service. This aimed to increase by 300% the availability of the service to more users and include service users already on existing packages of care requiring additional homecare input.

2. What was the issue you were addressing or working on?

The central aim of the Clackmannanshire Reablement Service is to maximise service users independence and provide high level quality care which supports individuals to remain living at home.

The plan is to demonstrate good outcomes in relation to independence for service users and test service cost effectiveness by reducing care package costs in the longer term paid for by Clackmannanshire Council.

3. What did you do?

Through doubling resource the integrated reablement team increased service capacity by over 300%. (from 15 to 45 service users). The Reablement service delivers an integrated health and social care approach to delivering the former Rehabilitation at Home model with Homecare Reablement and provides up to 6 week of reablement and assessment by an Occupational Therapist, Physiotherapist and reablement Support Workers who are all trained in Rehabilitation/Reablement. The service user can receive up to x4 calls per day by the Support Worker. The service aims to ensure the service user receives the correct level of support to remain at home and maximise their potential for independent living.

4. What were the outcomes / benefits ?

- The service capacity has increased from 12 to between 45 and 50 reablement clients per day.
- Following Reablement Service input **53.1%** of service users required no or no additional homecare package from Clackmannanshire Council.
- The average care package post reablement is 7 hours per week less than that initially required pre reablement (from 132 completed episodes, Nov 13-July14).
- At three month follow up **86%** of clients who had completed reablement were continuing on the same level of care.

The Reablement pathway has extended with links to other supports including third sector services.

- All clients are offered fire checks by the local Fire and Rescue service
- Carers are offered support from PRTC Carers support service (aligned change fund service)
- Close working with the falls co-ordinator and local Active Living services such as OTAGO groups.

Annex B Case Study 4

Partnership	**Clackmannanshire and Stirling**
Name of Initiative	**NHS Forth Valley Rapid Access Frailty Service**
Primary Contact	**Jann Gardner**
Email	
Telephone	

Pathway Workstream :	**Hospital and Care Home(s)**

1. Summary

The aim of this project is to improve outcomes for frail elderly patients by reducing avoidable hospitalisation and supporting patients to be cared for in their own home/communities with the following key objectives:

- Provision of timely comprehensive Geriatric
- Reduce avoidable admissions through rapid access clinic assessment and treatment
- Timely discharge from Inpatient pathway asap when Acute Care no longer adds value
- Reduce avoidable disability/harm –risk ofloss of independence
- Optimise partnership approach between health – patients/ carers/ GP/ Social Care/ community service/ Mental Health/ other specialities
- Improve patient and carer experience

2. What was the issue you were addressing or working on?

An increasing number of frail elderly people presenting for Acute Care in Forth Valley Royal Hospital with conditions that tend to deteriorate as a result of admission. We recognised that there were patients for whom admission could be avoided if rapid access to specialist was possible.

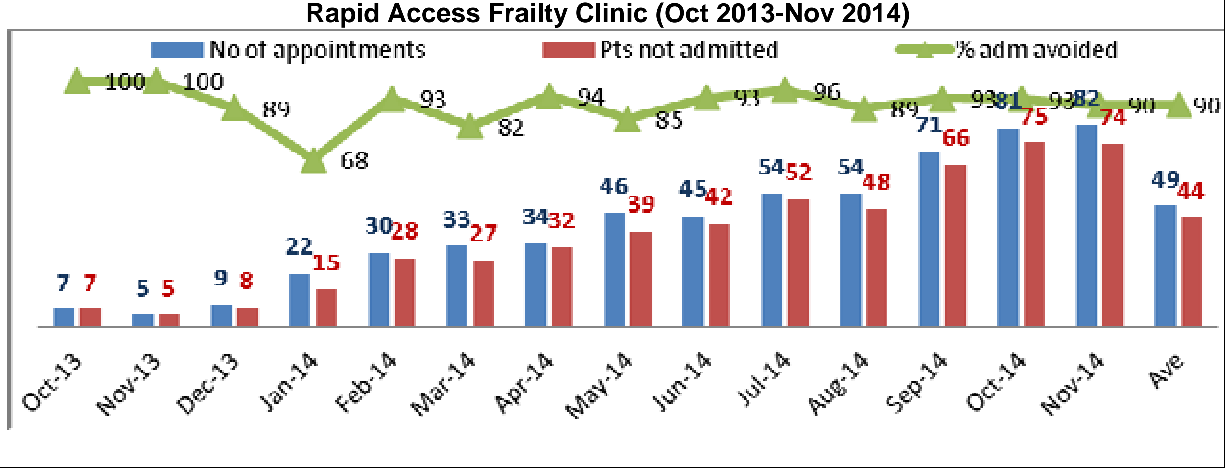
3. What did you do?

Established an Ambulatory Rapid Access Frailty Clinic & Rapid Access Frailty Inpatient Unit. Patients can be referred GP, community nursing/AHP. Clinics currently provided 5 days per week. Appointments for patients and family/carer with review by an experienced nurse, consultant geriatrician and AHP where required. After diagnostics a medical plan is defined and onward referral to social services, community AHP or nursing is arranged when required. If necessary the patients may be brought back to the clinic for follow up before formally discharging back to their GP.

4. What were the outcomes / benefits ?

As seen below, in total 445 patients have been seen at the Rapid Access Clinic. 87% of these patients have avoided admission. Patient, Carer and GP qualitative feedback has been excellent and there has been an estimated reduction of 15 beds worth of admissions per day from this service. Patients and families report that they feel more confident about next steps and it appears to help with resilience at home as the admission rates following clinic attendance are extremely low.

Rapid Access Frailty Clinic (Oct 2013-Nov 2014)



Annex B Case Study 5

Partnership	**Clackmannanshire and Stirling**
Name of Initiative	**West Rural Stirling Intermediate Care Event**
Primary Contact	**David Niven, Change Fund Support Team**
Email	
Telephone	

Pathway Workstream :	**Enablers**

1. Summary

Please summarise the case study in one paragraph of no more than 100 words.

An information sharing and networking event was held in Killearn in May'14 to support the introduction of Change Funded improvements to Intermediate Care services in West Rural Stirling. The event led to higher levels of awareness and understanding of the changes being made and promoted links with services that already existed in the area. Participants at the event identified the need for, and gave their support to, the establishment of a local Optimising Intermediate Care Working Group. The working group has a broad membership including Health, Social Care and Third Sector practitioners and GP locality representation.

2. What was the issue you were addressing or working on?

During 2013/14 Change Fund investment was approved in West Rural Stirling to bring Reablement, Rehab at Home, and Crisis Care services up to the same level as those already provided in North Rural Stirling and Stirling Town. The investment was focussed on the recruitment of more Social Services Reablement Carers to be based at Balfron and creating a care provision hub in Balfron to match the existing hub in Callander that serves North Rural Stirling. Alongside this, it was recognised that to ensure optimal impact of the increased capacity being established, efforts should be made to link into existing public and third sector services in the area as a first step.

3. What did you do?

An event was held in Killearn in May '14 called Optimising Care & Support in West Rural Stirling. The event included introductions to the Reshaping Care for Older People agenda followed by five, twenty-five minute long workshops each led by two local practitioners in the fields of Unpaid Carers; Community Based Rehab; Anticipatory Care; Community Supports; and Community Transport.
At the event the presenters moved from table to table and by the end of the afternoon each group of participants at each table had built up a rich picture of what colleagues around the table and the presenters were contributing to Optimising Care & Support in West Rural Stirling.

4. What were the outcomes / benefits ?

45 workshop participants were updated on the range of new Intermediate Care and existing support services that currently operate in West Rural Stirling across the public and third sectors.
A reference document containing notes of the key points shared and identified at each of the sessions within the workshop was circulated to all participants shortly after the event. The document also contained links and contact details for all of the services presented.
The West Rural Stirling Integrated Care Working Group was voted into existence at the workshop and subsequently established to maintain links across the services represented at the event in May and to identify further areas of attention to optimise Care & Support. The working group is currently conducting one to one surveys during home visits with people in receipt of a variety of forms of care at home including Reablement, Rehab at Home, Crisis Care, District Nurse and Carers Centre staff visits to identify gaps in services and further areas for improvement.

5. Additional contacts (to find out more)

(People, organisations, link(s) to further information, if available)

Alison Keir, Team Lead Reach Rural Team / Occupational Therapist / OT Professional Adviser, Based at Callander Medical Centre. Tel:

Annex C Self-assessment of Spread

Please assign a position statement 0-5 to each RCOP Pathway approach or intervention

Spread Value	Self-Assessment Position Statement
0	No agreed plan to implement the approach / intervention / improvement action
1	Agreed plan to take forward the approach / intervention / improvement action but not yet began to implement
2	Testing / implementing the approach / intervention / improvement action in a minority of localities / sites / teams / older people / carers
3	The approach / intervention / improvement action has spread to most localities / sites / teams / older people / carers
4	The approach / intervention / improvement action has spread to all localities / sites / teams / older people / carers but is not yet fully embedded in routine practice
5	The approach / intervention / improvement action is fully embedded in all localities / sites / teams / older people / carers and there is an agreed plan to sustain this

Preventative and Anticipatory Care		**Value (0-5) 14/15**
Build social networks and opportunities for participation	We are mobilising community support through volunteering, building community capacity, collaborations and social enterprises that promote participation and meaningful activity for older people living at home and in care homes.	2
Early diagnosis of dementia	We continue to work to increase the number of people with dementia who have a diagnosis as this improves access to support and services for the family.	4
Prevention of Falls and Fractures	The Partnership is implementing the recommendations of *Up and About*: a whole system pathway for the prevention and management of falls and fragility fractures.	4
Information & Support for Self-Management & Self-Directed Support	Practitioners and services signpost older people towards community and third sector resources that help them to stay well, to manage their conditions and provide useful and accessible information and advice on the choices they have about their future care, support and housing. This includes post diagnostic support for people affected by dementia and information and support required to adopt personal budgets.	3
Prediction of risk of recurrent admissions	Community health and social care teams routinely use a risk prediction tool (e.g. SPARRA) and local health and social care data and intelligence to identify older people who are frail and at greatest risk of emergency admission to hospital or care home.	3

Preventative and Anticipatory Care		Value (0-5) 14/15
Anticipatory Care Planning	Care providers support frail older people and their carers to develop Anticipatory Care Plans (ACPs): a summary or shared record of the preferred actions, interventions and responses in the event of an anticipated deterioration in the health of the person or their carer.	4
Support for carers	Our health and care staff routinely identify carers and are able to signpost them to information, advice and support from social work, carers centres and other agencies to help them to stay well and be supported to continue in their role.	4
Suitable and varied housing and housing support	We are investing in handyperson services, housing support, making better use of our existing stock of sheltered housing and developing new specialist provision to help older people maintain their independence and reduce the risk of accidents at home.	2

Proactive Care and Support at Home		Value (0-5)
Responsive flexible, self-directed home care	All providers of care and support at home adopt a "doing with" approach and formulate packages of care and support around the individual's personal goals. This includes the opportunity to adopt personal budgets for care and support.	4
Integrated Case/Care Management	Multi-disciplinary community health and social care teams adopt an integrated case / care management approach to monitor and proactively support frail older people with complex and changing needs at greatest risk of emergency admission to hospital or care home.	3
Carer Support and Respite	We provide opportunities for short breaks to help carers continue to provide care, helping reduce isolation, providing a better quality of life and maintaining carers' health and wellbeing.	3
Rapid access to equipment	There is effective and timely access to health and social care equipment and adaptations and this is an integral part of mainstream community care assessment and service provision.	3
Timely adaptations, including housing adaptations	We have streamlined access to adaptations and alterations which help older people to maintain their independence at home.	2
Telehealthcare	The partnership provides remote monitoring and assistive technology for older people with complex care and support needs who require this technology to remain supported in their own home.	3

Effective Care at Times of Transition		Value (0-5)
Reablement & Rehabilitation	Health and care practitioners adopt an enabling approach and all providers have a focus on maintaining independence, recovery, rehabilitation and re-ablement.	4
Specialist clinical advice for community teams	Primary and community health and care staff, including voluntary and independent sector partners, are supported by access to a range of specialist practitioners for advice on common important conditions in older people such as dementia, continence, nutrition and tissue viability.	4
NHS24, SAS and Out of Hours access ACPs	Community teams share essential information from ACPs (e.g. electronic Key Information Summary) with local emergency and out of hours services and with SAS and NHS24.	4
Range of Intermediate Care alternatives to emergency admission	Working alongside NHS24, SAS and Out of Hours services we provide rapid access to a range of enabling assessment and treatment services at home, in minor injuries units, day hospitals, community hospitals and care homes as safe and effective alternatives to acute hospital admissions and to support timely discharge.	4
Responsive and flexible palliative care	We provide timely access to community based support for palliative and end of life care to increase the proportion of older people who are able to die at home or in their preferred place of care.	4
Support for carers	We promote shared decision making and make sure that carers are informed and supported to help them continue in their role when the health of the person they care for deteriorates or they move to another care setting.	3
Medicines Management	Joint working between GPs, community pharmacists, mental health teams and geriatricians reduces polypharmacy for older people through mindful prescribing, review and reconciliation of medicines and use of pharmaceutical care plans. We support older people and their carers to administer and take medication safely.	3
Access to range of housing options	The range of intermediate care services provided includes timely accessible housing options for people whose functional ability has acutely declined.	2

Hospital and Care Home(s)		Value (0-5)
Urgent triage to identify frail older people	Pathways through A&E and admissions wards are configured to identify frail older people with physical, functional and cognitive impairments who will benefit from coordinated comprehensive geriatric assessment.	4
Early assessment and rehab in appropriate specialist unit	Frail older people with physical, functional and cognitive impairments and those who have fallen are 'pulled' to access multi-professional Comprehensive Geriatric Assessment within 24 hours of emergency admission to hospital.	4
Prevention and treatment of delirium	Pathways through acute hospitals minimise boarding for frail older people and care staff are trained to prevent, detect and effectively manage delirium.	3
Effective and timely discharge home or to intermediate care	All partners work together and with Scottish Ambulance Service to optimise use of estimated date of discharge, improve discharge planning and eradicate delayed discharges, including delays in short stay specialty beds and for Adults with Incapacity.	3
Medicine reconciliation and reviews	Medicine reconciliation is routinely undertaken for older people on admission and at discharge from hospital and care homes, and antipsychotic prescribing is minimised.	4
Carers as equal partners	We identify the carer at an early stage when the person is admitted to hospital and ensure that the carer is involved in the care, rehabilitation and discharge planning.	3
Specialist clinical support for care homes	We provide specialist clinical support to enable care homes to have a greater role in intermediate care and to support staff to care for older people with dementia and palliative / end of life care needs.	3

Enablers		Value (0-5)
Outcomes-focussed assessment	Our providers of care and support deliver personalised care through assessments which focus on personal outcomes and goals agreed with the older person (and their unpaid carer).	3
Co-production	Services are planned and delivered in an equal and reciprocal relationship between professionals, people using services, their families and the community.	2
Technology/ eHealth/ Data Sharing	We routinely share information across professionals and teams in line with agreed data sharing protocols and using the capability of emerging technology.	2
Development of Skill Mix / Integrated Workforce	We are developing a multi-professional workforce that is integrated, capable and fit for the future with core generic skills and appropriate specialist competencies.	3
Organisational Development and Improvement Support	We engage and communicate effectively with all partners, with our workforce and the public, and collaborate across professions and sectors to strengthen strategic leadership for change and to build improvement capacity and capability.	2
Information and Evaluation	We routinely use measurement for improvement and feedback performance measures to our staff and to the public to lever and assure quality.	2
Commissioning and Integrated Resource Framework	Statutory, community, third and independent sectors, users, carers, providers and commissioners of care come together to agree long term service development and investment proposals including where and how resources should shift from current services and care models to new arrangements. We are using the Integrated Resource Framework to lever a shift in the totality of the partnership spend on service and support for older people.	2