AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date: 28 January 2020**
Report By:	**Louise Long, Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership**	**Report No: IJB/11/2020/AS**
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Subject:	**LIVING WELL**	

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on the emergent thinking around maximising service user/patient independence in Inverclyde, with a particular focus on helping citizens of Inverclyde to live well for longer.

2.0 SUMMARY

2.1 Inverclyde HSCP is facing the same pressures as whole HSCP system around increasing the need for social care in a climate of challenging financial demands. This paper outlines emergent thinking around multi-agency investment in earlier intervention and opportunities for self-management and independence which in many cases will delay the requirement for ongoing support from services.

2.2 This model will require further analysis around technology, points of access to the service and wide scale health promotion opportunities, as well as the requirement for a culture shift campaign around the responsibility of the citizen to keep well.

2.3 The paper outlines the need to shift some HSCP resources upstream into prevention to support changes required, as tightening the criteria to substantial and critical provision does not align with the prevention and maximising independence strategy. For this to be successful will require partnership approaches across multiple agencies.

3.0 RECOMMENDATIONS

3.1 That the Integration Joint Board supports further consideration of the emergent model which supports maximum levels for self-management and independence.

3.2 That the Integration Joint Board notes that a future paper will be submitted with proposals and potential resources required to take this proposal forward for consideration following engagement with South Clyde HSCPs with a view to working together jointly in taking the aspirations of the paper forward.

Louise Long, Corporate Director
(Chief Officer), Inverclyde HSCP

4.0 BACKGROUND

4.1 Background

Inverclyde HSCP has been sector leading with regard to implementing a joint joined up integrated model to delivering our Home First approach. There are many examples of successful proactive transformational change such as Home 1st, Reablement, falls prevention, technology enabled care, long term condition management, step up at home, one handed care, hospital discharge planning with an in reach element etc.

Along with other HSCPs, Inverclyde is facing the same pressures around growing demand for health and social care services in a climate of challenging financial restrictions and is beginning to experience the same difficulties as other areas around the level of provision of independent and in house care at home services to meet the current demand.

4.2 Local and National Direction

The proposals within this paper align well with both national and local policies in particular:

- National Health and Well Being Outcomes 1,2,3,4,6,7,9
- Scotland's Public Health priorities
- Mental Health Strategy 2017-27 A 10 year vision
- Active and Independent Living Programme (AILIP)
- Health and Social Care delivery plan
- NHS Integrated workforce plan
- HSCP Strategic Plan outcomes 1,4,6
- Inverclyde HSCP OT AHP review

4.3 Current models

When allocating staff assessment and provision resources, the focus in the main has been around support critical and substantial needs. Services are evidencing a shift in demand to urgent critical work which is having an impact on the lower level preventative rehabilitation and support.

4.4 Current Good Practice Supporting Independence

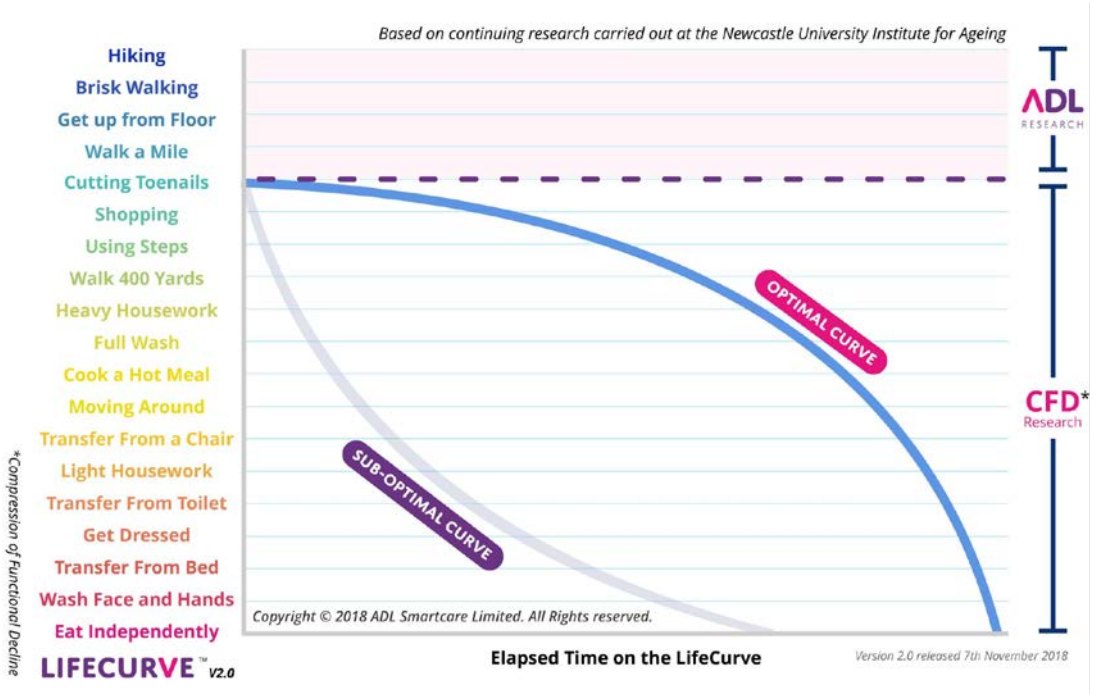
Over the last 8 years, we have made in roads to integrated working improvements in integration, nursing, Social work, AHPs, care at home services, Reablement and primary and acute clinical staff. All of these developments have advocated and shifted focus from delivering support and care to a reablement and self-management model. The work has put emphasis on independence with a move away from risk adverse practice to enabling proportionate risk.

The point of involvement within Adults and Older people's services however remains in the main at the critical and substantial level of need within the eligibility criteria resulting in missed opportunities at an earlier stage to optimise independence and self-management to delay the requirement for support and care.

To create healthier, more active citizens who live well for longer, we need to radically consider how we provide services and when.

4.5 **Life Curve**

There is a lot of national interest in research on ageing carried out at Newcastle University. The LifeCurve™ has been developed from this work. The evidence shows that people lose their ability to do daily tasks in a predictable order. This knowledge allows for a focus to be placed on areas of prevention, reablement and equipment services where they are most effective.



The graph above shows an optimal curve for care delivery delaying the requirements for care and support by ensuring at there is investment when people begin to have difficulty with daily living tasks to regain function. Our current model is a compensatory one where we utilise equipment, adaptations, support at this early stage in the process. While these are important solutions to independent living we are missing opportunities at this stage to ensure people regain skills and actively work together to support health promotion with all our partners.

4.6 **Integrated Work Force Health and Social Care Delivery Plan**

The Scottish Government has set out aspirations around high quality services that focus on prevention, anticipation and to support self-management. The focus for delivery will be in the main at home for within the community and around prevention of readmission to hospital, planning is underway around workforce planning to deliver this.

4.7 **Area of Good Practice**

North Lanarkshire utilises a model around technology for self-management, it invested in an electronic self-assessment system which has background algorithms that highlight the need for face to face assessment. The area's Digital Inclusion strategy ensures that the system is embedded in all community touch points where people meet or seek support. The technology brings exciting new opportunities around what is possible, however requires long term investment and buy in across all services.

The system has been developed in partnership with specialist services and hosts long term conditions and self-management advice that is open to members of the public or

officers across multi-agencies.

Early intervention is managed in partnership with the Third Sector, businesses, religious organisations, hospices, primary care, housing and through the digital platform's multiple points of access.

The system is also utilised as a single point of access to the service, automated signposting reducing demand and is purpose built by each area of the service for self-assessment and in built flagging where face to face assessments are required.

Another area of good practice is within GGC Children's services. We have seen the roll out of Request for Assistance models which significantly reduce the demand on services and free up professional time to see the most complex cases. This model requires further investigation around whether the utilisation of this transfers well into adult services and brings opportunities to the roll out of Access 1st.

One Vanguard area in Wigan has developed a social contract with the community they serve which is a radical cultural change around citizens' responsibilities to take responsibility to stay as healthy as possible in return for best utilisation of the services available without increasing council tax costs. Early indications show that this model is being adopted by the population.

4.8 **Opportunities Missed**

Prior to Care at Home requirements there are many opportunities where Inverclyde residents approach services for information and support e.g. GPs, housing, benefits, blue badges, equipment and adaptations, rehabilitation. Often easy solutions are sought with a focus on purely the issue at hand which limit the impact and opportunities to look at underlying causes of loss of function rather than investing earlier in the pathway in health promotion and interventions to regaining function which may delay the requirement longer term to requiring care as highlighted above in 4.5 and 4.6.

North Lanarkshire has looked at a model where, rather than using compensatory approaches with simple solutions, an approach is taken to look at what the underlying issue is. So a request for rails and grab rails may be an issue around balance, a precursor to experiencing falls, rather than only providing rails, opportunities could be taken to work on regaining strength and balance.

This organisation was an early adopter of the Life Curve work and is the most advanced in Scotland in utilising technology for self-management, health promotion and self-access to support.

Not only does this service utilise social prescription, its access system looks at highlighting activities and exercise opportunities in the area that they live in, which are open for practitioners to refer to.

The system is used to support long term condition management and change of culture to ensure maximising self-management.

4.9 **Housing and Communities**

There are further opportunities to work together with housing partners to help people to plan ahead to avoid decisions about moving being made at points of life crisis. This would ensure that the public resources are best utilised and support family accommodation crisis. The Scottish Government IHUB has developed a model of Housing Solutions which has aspirations where all housing staff and HSCP staff are trained in having simple housing solutions at an early point to discuss optimal housing in the future with older people to ensure that moves are planned for the future.

This model supports best use of adaptations budgets and also incentivises free up of

much needed family accommodation which is currently under occupied. A couple of Occupational Therapy staff along with two housing officers from River Clyde Homes undertook the train the trainers course for this work however there are competing demands that have not allowed for the roll out of this work.

Optimally there could be more invested in this training that would support the training of all staff across housing and care who have contact with service users to confidently and competently not only to have housing conversations but also to be advocates for a new model that shifts responsibility of managing health to the individual service user. This model could be tested within the temporary Housing Support post within Sheltered Housing which has a focus on building the community and tenants' assets to ensure more of a self-management and inclusive community which supports people with conditions such as dementia to be supported by their community to live well.

4.10 **Frailty**

Across GGC as part of the role out of the Frailty Implementation Plan partnerships have implemented the Rockwood Frailty Scale (Appendix 1) this tool is an easy to score method across health and social care to stratify older people's levels of frailty. The scale 1-9 (1-Very fit, 9-Terminally ill) allows for assessment staff to quickly score and record service users against the tool. Initial work has shown that HSCP involvement shows that the bulk of activity is around 5-6 (Mildly Frail/Moderately Frail). This tool could bring wider opportunities; we could take a multi-agency proactive approach to focussing around levels 3-4 Managing Well and Vulnerable to delay the move to requirement of support where possible.

This would require an upskilling of staff to ensure that they work at the top of their licence and move away from silo work to investing in a core skill set across the HSCP and partners to be skilled in Health promotion approaches and the skills to engage people in this remit.

The Frailty tool also gives opportunities to allow a criterion around responses and opportunities at triage or through electronic systems to ensure people on lower scores are signposted to activities that improve and protect independence abilities.

The present model which has pressures at the most urgent and most complex work without the ability to free up capacity to work in prevention will result in no change in the levels of increasing demand that the HSCP is facing.

4.11 **Campaign and Further Opportunities in Localities**

Despite our significant progress to date we are beginning to struggle to keep pace with the pressures of demand, in order to rebalance this Inverclyde requires a whole scale sustainable campaign around prevention and maximising independence opportunities however this cannot be done by the HSCP alone and requires active engagement and work with individuals of all ages, families, community organisations, third and independent sectors and housing partners to ensure that there is a change in approach which delivers prevention and early intervention with the clear message that the responsibility to keep well lies with the individual. (Similar to the work in Wigan).

4.12 **Next Steps - Recommendations**

Consider engagement with South Clyde HSCPs with a view to working together jointly in taking the aspirations of the paper forward. Look at the need for a dedicated resource to support this work.

Identification and targeting of falls risk, frailty, social isolation, dementia and co-morbidities as well as carer strain, poor self-esteem/challenging behaviour are all high risk indicators of requirement of demand for services.

Further work is required to identify the contact points prior to requiring care at home support around developing a partnership pathway which supports early intervention and self-management.

When investing in Access First it is important to look at different models such as ADL Smartcare (North Lanarkshire) self-assessment and digital solutions and to give consideration and take learning from successful models such as the Request for Assistance models.

The Frailty tool could potentially offer a way of focussing support in a more proactive way around prevention and keeping well in partnership with many stakeholders.

Focussing on strength and balance to reduce risks of falls and allow for maintenance of abilities should be scoped around where this approach is best placed and who is best to deliver this.

A comprehensive Active Living strategy and campaign are required to support he culture shift recommended.

Further scoping of the requirements of the changes is recommended along with a Quality Improvement approach to measure success and change will be required.

5.0 IMPLICATIONS

FINANCE

5.1 Further scoping of requirements to be outlined in future reports.

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments

LEGAL

5.2 There are no legal implication within this report.

HUMAN RESOURCES

5.3 There are no specific human resources implications arising from this report.

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

	YES

X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

5.4.2 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	Positive impact for people with physical disability/older people
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	Positive impact for people with physical disability/older people
People with protected characteristics feel safe within their communities.	Positive impact on
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications arising from this report. The approach recommended is robust to ensure that staff are trained appropriately based on their skill set to implement the recommendations of the report, further analysis around professional roles will be required for next steps to ensure that there are no Clinical or Care Governance risks.

NATIONAL WELLBEING OUTCOMES

5.6 How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	This report highlights the need to intervene early to improve living skills to maximise independence
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	This report covers our future direction of travel to support a range of older people to live at home.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	This report highlights the need to intervene early and improve people experience of health and social care support.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	This report acknowledges the need to improve the quality of life for people who require support.

Health and social care services contribute to reducing health inequalities.	The reports confirms the HSCP position in relation to tackling health inequalities.
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	The HSCP will continue to work closely with our partners to improve support provided to unpaid carers.
People using health and social care services are safe from harm.	The HSCP are committed to keeping people from harm by a range of interventions.
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Our workforce is committed to improve the lives of people in Inverclyde as per our strategic plan.
Resources are used effectively in the provision of health and social care services.	The HSCP have outlined our priorities in our strategic plan which makes best use of our resources.

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	X

7.0 CONSULTATION

7.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 None.

APPENDIX 1.

Active and Independent Living Programme (AILP)

The vision for AILP is that health professionals will work in partnership with the people of Scotland to enable them to live healthy, active and independent lives by supporting personal outcomes for health and wellbeing

	AILP ambition statements	Outcomes	What people can expect
AILP ambitions	To meet the health, care and wellbeing needs of the population now and in the future:	By 2020, working with local partners, the programme aims to:	What people can expect:
Health and wellbeing	AHPs need to prioritise health promotion, prevention and early intervention strategies across all services, underpinned by personal-outcomes approaches and inclusive information	prioritise prevention and early intervention as a key focus of AHP service delivery, whether through direct preventative approaches or partnership-working with other agencies	• availability of evidence-based, inclusive self-management information provided by AHPs • access to AHP interventions at the earliest time for maximum benefit • brief interventions from AHPs to promote health and wellbeing discussions with an AHP regarding their health and wellbeing will be routine, as and when appropriate
Access	people need easily accessible routes to AHP services and information when required	offer timely access to AHP services to people who need assistance or advice to live independently	• easy access and self-referral to all AHP services • simple re-routing from AHP services to other services if required use of web-based technology to access services/information/advice
Awareness	the public and other stakeholders need to be aware of AHP services in their	ensure that the general public, third sector organisations and health and social care staff have a better understanding of the	• AHP services embedded within the 'Know Who To Turn To' directory of services

	local communities	contribution AHPs make to promoting healthy and independent living	• AHPs who are aware of the health and wellbeing resources and amenities available in the communities in which they work to signpost people to the most appropriate services
Partnership-working	AHPs need to think about different ways of working with people who use AHP services	have developed AHP pathways that are multi-agency where appropriate, and partnership approaches that improve people's health and wellbeing	• pathways across agencies that set out the AHP contribution to supporting health and wellbeing • people's goals inform AHP actions • less duplication of assessment
Research and innovation	AHPs need to deliver excellence through improvement, innovation and research	ensure that research and innovation will be key to any service redesign	• technology supporting interventions, if required • evidence-based interventions • AHPs at the forefront of research into prevention and early intervention, and rehabilitation
Workforce	AHPs will comprise a competent, skilled and knowledgeable workforce that is flexible and responsive to the needs of the population	have an AHP workforce that will be delivering the right care in the right place	• appropriately trained and informed AHPs • an appropriate number and skill mix of AHPs providing local services • information about the recommended skill mix and number of AHPs working in their local area

Stage 1 of the recent Occupational Therapy Review mirrors the aspiration of the ALIP programme in that it identified that the bulk of the OT resources in dealing with crisis intervention and by taking a compensatory approach using equipment without the investment time of rehabilitation reduces the opportunities upstream to make an impact on delaying the requirement for care services.

Although AHP’s are integral to delivering this approach there are many more service contact points prior to requiring care could also take this approach to ensure that no opportunity to optimise people’s health and independence are missed.