AGENDA ITEM NO: 3

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 24th October 2013**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/53/2013/BC**
Contact Officer:	**Beth Culshaw Head of Health & Community Care**	**Contact No: 01475 715387**
Subject:	**RESHAPING CARE FOR OLDER PEOPLE**	

1.0 PURPOSE

1.1 To provide an update on the 2013/14 Mid Year Report of the local Change Plan currently driving the Scottish Government Directive, Reshaping Care for Older People.

2.0 SUMMARY

2.1 As previously reported, the Government has initiated a directive to transform the existing model of care and support for older people. The 10 year strategy 2011- 2021 A Programme of Change, sets out the Scottish Government vision for improving care quality and outcomes for older people in our communities, and presents unique challenges with regard to rapidly changing demographic trends, expectations and economic drivers.

2.2 The Government strategy refresh 'Getting On' published in September 2013 reports good progress nationally on achieving the outcomes of Reshaping Care for Older People whilst acknowledging there is still work to be done.

2.3 This report provides an update for the Community Health and Care Partnership Sub Committee on Inverclyde CHCP's progress as outlined in the 2013/14 mid year report submitted to Scottish Government on September 27th 2013.

3.0 RECOMMENDATION

3.1 The Community Health and Care Partnership Sub Committee members are requested to:
(a) Note the content of the mid year report and the progress made with regard to implementing the local Change Plan.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 Reference is made to previously submitted Sub Committee reports outlining the Scottish Government's strategy on Reshaping Care for Older people. The vision set out by Government is that "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting".

4.2 The Sub-Committee will recall that a national £70m change fund was introduced in 2011/12 to support the implementation of Reshaping Care for Older People. It was subsequently confirmed that funding would continue for a further 3 years and increase to £80m for 2012/13 and 2013/14. Inverclyde's share of resources is outlined at 7.2 below.

4.3 Reshaping Care for Older People requires investment across five pathways: Preventative and Anticipatory Care, Proactive Care and Support at Home, Effective Care at Times of Transition, Hospital and Care Homes and Enablers. Investment should show a progressive shift towards Preventative and Anticipatory Care and a commitment of at least 20% of the Change Fund must be dedicated to supporting carers to continue to care for older people.

4.4 The Scottish Government requested a mid- year review be submitted in September. The purpose of this review was to share examples of change fund investment by submitting a short case study for each of the five pathways and to undertake a self-assessment of the spread of local approaches.

4.5 Inverclyde CHCP undertook the self assessment and submitted five case studies; Closer Working with Housing, Carers Hospital Discharge Project, Reablement Care at Home, Early Facilitated Hospital Discharge/ Prevention of Care Home Admission, and Closer Working with the Independent Sector.

5.0 PROPOSALS

5.1 Inverclyde CHCP proposes to consolidate its work with a wide range of local partners and stakeholders and to continue to develop approaches which fully embed the required changes outlined in Reshaping Care for Older People across Inverclyde.

6.0 MID- YEAR 2013/14 PROGRESS OVERVIEW

6.1 At the mid-year point 2013/14 there is good progress in spreading and sustaining change across the pathways.

6.2.1 There are a number of areas where 'spread' is self-evaluated as 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".

- Rapid access to equipment
- Timely adaptations, including housing adaptations
- Specialist clinical advice for community teams
- Responsive and flexible palliative care
- Medicines Management

6.2.2 There are no areas assessed as 0 and only one area remains where spread has been self assessed as 1: "Agreed plan to take forward the approach/ intervention/ improvement action but not yet began to implement"

- Range of Intermediate Care alternatives to emergency admission

6..2.3 Whilst services aimed at avoiding unnecessary admissions to hospital exist within Inverclyde, the requirement to develop alternatives that are more responsive is noted. Work is underway to scope the potential use of care home beds and sheltered housing as step up/ down facilities.

6.3 The range of short case studies chosen show improved partnership working across housing, independent and third sectors. In particular progress towards:

- Improved communication and processes with housing providers
- Delivering a leadership programme for care home managers *'My Home Life'*
- Improved support for carers when the cared for person is in acute care or being discharged from acute care

6.4 Investment shift from Hospital and Care Homes across the pathways to Preventative and Anticipatory Care and Proactive care and Support at Home is evidenced in the change fund budget allocation at 7.2 below.

6.5 Evidence of our commitment to investing in support for carers is also shown with 19.6% direct and 22% indirect spend in 2013/14.

7.0 IMPLICATIONS

7.1 Legal:

7.2 Finance: Total Change Fund Resources over 3 years with carers allocation for 2012/13 and 2013/14

	2011/12 £000's	**2012/13 £000's**	**2013/14 £000's**
SG Allocation	1228	1400	1403
Additional Local Resources (if any)	0	0	0
Carry Forward	N/A	488	398
Total Allocation	1228	1888	1801
Year-end Spend	740	1491	1801
Anticipated Carry Forward to 2014/15			0
Direct spend on carers (year-end spend)	N/A	203	275
Indirect spend on carers (year-end spend)	N/A	244	309

Total allocation- five pathways showing shift in spend over 3 years

	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)	15%	23%	12%	47%	3%	100%
2012/13 (year-end spend)	18.99%	36.27%	15.98%	22.71%	6.05%	100%
2013/14 (anticipated year end spend)	21.00%	34.98%	15.75%	14.21%	14.06%	100%

7.3 Personnel:

7.4 Equalities:

7.5 Depopulation:

8.0 CONSULTATION

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9.0 LIST OF BACKGROUND PAPERS

9.1 Change Fund 2013/14 – Mid Year Review
Reshaping Care for Older People – Getting On. Sept 2013

Change Fund 2013/14 – Mid-Year Review

Dear colleagues

The main purpose of this year's mid-year Change Fund survey is to share examples of how local partnerships have deployed their Change Fund to make a difference to the lives of older people and their carers across Scotland. The JIT will use this additional insight to understand what is working well, to share learning about the impact of successful innovations, and to identify areas of work that may require further improvement support in order to make progress on joint strategic commissioning and integration. An overview report will be shared with the Health and Community Care Delivery Group and the Ministerial Strategic Group.

We ask you to describe the learning from at least one initiative that you have taken forward under each pillar of the RCOP pathway. We appreciate that full evidence of impact may not yet be availablefor some of these initiatives. Therefore your comments should describe achieved or anticipated outcomes and gains, along with your learning to date and any implications for future investment decisions.

As in previous years, we have asked you to report spend against the pillars of the RCOP pathway. This is to help track the progressive shift in focus and investment towards preventative and anticipatory care.

We realise that it will take time to fully realise this shift and to show measurable impact on outcomes at scale. Therefore, we invite you to complete a self-assessment proforma to reflect on the extent to which specific approaches and improvements have been spreadlocally and to understand where, and when,further gains can be anticipated through joint commissioning. This will also enable JIT to identify those initiatives that require further support for implementation.

Recognising the growing importance of accessing and using data and information to inform decision making, we have also included a specific question about this in the 2013/14 mid-year review.

Your responses will inform the on-going improvement support for Reshaping Care and Integration provided by JIT and our partner organisations.

Please send your response to Mohamed.Omar@scotland.gsi.gov.uk by **Friday 27th September**. Thank you for taking the time to complete this mid-year review.

DR MARGARET WHORISKEY
Director, Joint Improvement Team

Contact Details

To ensure our records are up-to-date, please complete for all four partners:

Strategic Lead

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Operational Lead

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Third Sector Lead

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Other Key Contacts (if any – e.g. overall Project Managers/Officers, Development Managers/Officers etc.)

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Name	**Debbie Maloney**
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Telephone #	**01475 504897**

Name	
Job Title	
Email Address	
Telephone #	

<u>Change Fund 2013/14 – Mid-Year Review</u>

Partnership	**Inverclyde CHCP**
Contact Name(s)& Job Title(s)	**Emma Cummings** **Project Manager RCOP**
Email Address	**Emma.cummings@ggc.scot.nhs.uk**
Telephone #	**01475 715395**
Date of Completion	**18.9.13**

1. Examples of impact

Please complete a case study template (Annex 1) describing<u>at least one</u> achievement that your partnership has made through use of the Change Fund <u>for each of the Reshaping Care Pathway workstreams</u> (i.e. we would like at least 5 in total to be submitted):

- ***Preventative and Anticipatory Care;Proactive Care and Support at Home;Effective Care at Times of Transition;Hospital and Care Home(s);Enablers.***

Each case study should be no more than one page long, with**at least one of the case studies highlighting either a director an indirect impact on carers**.Question 7 below contains short descriptors of interventions in the pathway.

2. Learning from what hasn't worked as well as anticipated

The Change Fund has been an opportunity for Partnerships to explore innovations that are 'Proof of Concept' or 'Tests of Change'. Please describe any shareable learning gained from initiatives **where a decision not to continue** has been taken – e.g. where barriers to progress were encountered or the initiative was not found to be effective.

We made a decision to disinvest in a project where the person in post was continually asked to carry out duties not relevant to the project. This appeared to be around lack of communication and understanding of the outcomes expected. It is therefore essential that frontline staff and line managers/ supervisors are fully aware of the aims of the change funded post/ initiative, what commitment and outcomes are expected and why. Robust reporting and monitoring processes are now in place to support this and to evidence delivery of outcomes.

3. Option Appraisal

Please describe any option appraisal approaches used to decide Change Fund investment priorities – e.g. whether applied to all / only selected initiatives and who was involved.

Whilst we have prioritised our approaches and improvement areas we have not yet undertaken any formal options appraisals. We have prioritised two for this year, these being around day care and care homes.

4. Use of Data and Information

Please describe your local progress and any barriers to effective use of data and information between partners (both within and out with the statutory sector).

We have recruited an impact analyst with change fund money who has prepared a suite of information and updates this regularly. Some issues surround the timing of data whereby this may already be 6 months out of date when received and it can be difficult to make real time decisions or respond effectively. We are beginning to collect more robust data on outcomes delivered by change fund projects both from statutory and third sector organisations which is informing our decision making processes and investment priorities.

We should now agree on how we share more detailed data with our partners eg on use of care home beds to evidence our strategic approaches and options appraisals.

5. Improvement support

Please provide details of any support you would welcome.

Support for decisions on disinvestment/ sustainability

6. Budget 2013/14

Please insert details of your 2013/14 Change Fund budget and the proportion of spend aligned to each of these 5 workstreams:

	2011/12 £000's	**2012/13 £000's**	**2013/14 £000's**
SG Allocation	1228	1400	1403
Additional Local Resources (if any)	0	0	0
Carry Forward	N/A	488	398
Total Allocation	1228	1888	1801
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Direct spend on carers (year-end spend)	N/A	203	275
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	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	15%	23%	12%	47%	3%	100%

(year-end spend)						
2012/13 (year-end spend)	18.99%	36.27%	15.98%	22.71%	6.05%	100%
2013/14 (anticipated year end spend)	21.00%	34.98%	15.75%	14.21%	14.06%	100%

7. Assessment of Spread

The Reshaping Care Pathway represents 4 'bundles' of interventions, approaches or actions and the related enablers which collectively improve outcomes for older people.As you take forward Joint Commissioning, it is important to understand the extent to which you have spread new approaches and improvements so that you can understand where and when future gains can be anticipated.

Therefore we invite Partnerships to complete a self-assessment of spread**as at September 2013** by assigning a position statement 0-5 to each approach or intervention in the pathway.

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)**
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.	3
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

Preventative and Anticipatory Care		Value (0-5)
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.	2
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.	2
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.	3

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.	2
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.	4
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.	5
Timely adaptations, including housing adaptations	We have streamlined access to adaptations and alterations which help older people to maintain their independence at home.	5

Proactive Care and Support at Home		Value (0-5)
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.	4

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.	5
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.	1
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.	5
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.	4
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.	5
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

Hospital and Care Home(s)		Value (0-5)
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.	2
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.	5
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).	2
Co-production	Services are planned and delivered in an equal and reciprocal relationship between professionals, people using services, their families and the community.	3
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.	3
Workforce Development/Skill Mix/Integrated Working	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.	4
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.	3

Enablers		Value (0-5)
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.	4

8. Any additional comments?

Thank you for taking the time to complete this mid-year review. Please return this template, along with at least 5 case studies using the pro-forma in Annex 1, to Mohamed.omar@scotland.gsi.gov.uk by **Friday 27 September 2013.**

Annex 1 – Examples of Impact

As per Question 1, please complete the following template for each example of achievement your partnership has made through use of the Change Fund for each of the Reshaping Care Pathway workstreams.We would like at least one example for each workstream, with at least one of the case studies highlighting either a **director an indirect impact on carers**.

*Note – This paper is designed to show highlights and not a full case study and **should be no more than one page long**, allowing readers to have access to further information, if helpful. Please remember to 'tag' the case study appropriately on the next page. Submitted case studies will be published on the JIT website.*

Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP**

Name of Initiative Highlighted	**Closer Working with Housing**
Date of Submission	27/9/13

Primary Contact	**Debbie Maloney**
Email	Debbie.maloney@inverclyde.gov.uk
Telephone	01475 504897

Pathway:	Enablers

1. Summary

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

Within Inverclyde there are six RSL's, three of which are national providers which operate specialist housing for disability and older people. There was a lack of a cohesive approach to implementing the local housing strategy across the CHCP therefore dedicated OT time was sought to develop closer working and appropriate processes.

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

Reviewing and refining processes across services and organisations. Influencing choice based letting to ensure that those who have difficulty engaging with the bidding processes were supported. Working with RSL's to influence housing allocations and adaptations, and to carry out site surveys to ensure appropriate allocations for those with complex housing needs. Strengthening the links to allow housing colleagues access to CHCP services. Signposting RSL's to link with 3rd sector organisations to provide social activities within sheltered housing complexes.

3. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

Dedicated time was afforded via the change fund through employment of a dedicated housing OT and the support of an exerienced OT who is also leading reablement. The approach started in January 2013 and will be ongoing initially for 2 years via

the change fund. A process of active engagement with all providers has taken place and has included for example, planned training with allocation staff at RSL's to raise awareness of disability/carer housing needs. The support of the CHCP director has been crucial to opening channels of communication.

4. What were the outcomes/benefits or otherwise?

(What happened and what was gained or lost from this? When were the benefits realised? Would you do anything differently? What is/was your timeline?)

Overall there is much improved communication with RSL's and we are beginning to develop much clearer transparent processes accross CHCP around housing allocation including:

- Chairing multi disciplinary housing allocations meeting to influence best use of extra care housing provision.
- Testing processes for allocation of adapted or specialist housing with one provider.
- Plan for OT to support 3 local one stop shops being developed by local RSL's.

5. Additional contacts (to find out more)

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

Robyn Garcha Housing OT Inverclyde CHCP Tel. 01475 714350

Once submitted, this case study will be published to the JIT website. To help users find case studies relevant to their area of interest, this case study should be tagged with the following search terms (e.g. Reshaping care, re-ablement, community capacity, third sector, preventing admissions, intermediate care)

In order to help us best sort the case studies please enter a Y into each and every box you think this applies to, being cognisant of the primary pathway chosen on the previous page:

Preventative and Anticipatory Care	Case Study	**Proactive Care and Support at Home**	Case Study	**Effective Care at Times of Transition**	Case Study	**Hospital and Care Home(s)**	Case Study
Build social networks and opportunities for participation		Responsive flexible, self-directed home care		Reablement & Rehabilitation		Urgent triage to identify frail older people	
Early diagnosis of dementia		Integrated Case/Care Management		Specialist clinical advice for community teams		Early assessment and rehab in appropriate specialist unit	
Prevention of Falls and Fractures		Carer Support and Respite		NHS24, SAS and Out of Hours access ACPs		Prevention and treatment of delirium	
Information & Support for		Rapid access to equipment	**Y**	Range of Intermediate		Effective and timely discharge	**Y**

Annex 1 – Examples of Impact

Self-Management & Self-Directed Support				Care alternatives to emergency admission		home or to intermediate care	
Prediction of risk of recurrent admissions		Timely adaptations, including housing adaptations	**Y**	Responsive and flexible palliative care		Medicine reconciliation and reviews	
Anticipatory Care Planning		Telehealthcare	**Y**	Support for carers		Carers as equal partners	
Support for carers				Medicines Management		Specialist clinical support for care homes	
Suitable and varied housing and housing support	**Y**			Access to range of housing options	**Y**		

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
Workforce Development/Skill Mix/Integrated Working	
OD and Improvement Support	
Information and Evaluation	
Commissioning and Integrated Resource Framework	

Annex 1 – Examples of Impact

Note – This paper is designed to show highlights and not a full case study and ***should be no more than one page long****, allowing readers to have access to further information, if helpful. Please remember to 'tag' the case study appropriately on the next page. Submitted case studies will be published on the JIT website.*

Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP**

Name of Initiative Highlighted	**Carers Hospital Discharge Project**
Date of Submission	27/9/13

Primary Contact	**Maureen Hamill**
Email	Maureen.hamill@invercyde.gov.uk
Telephone #	01475 715385

Pathway:	**Effective Care at Times of Transition**

6. Summary

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

To improve the experience of carers of older people through the journey of hospital discharge from beginning to end.

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

Carers expressed views that they felt excluded from the process of hospital discharge and needed to access relevant information and support.

8. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

Need identified through carers strategy 2012-15. Change fund secondment of carers centre worker to be located within hospital setting at Inverclyde Royal. Established steering group for all carers projects which included representative from acute and hospital social work team leader to design project. It was decided to focus on the Larkfield unit where care of older adults takes place. Worker focussed on staff awareness raising, established referral system, distributed carers information within hospital and has worked with individuals one to one. There are plans to enable carers to access more support within the hospital rather than needing to visit the carers centre

9. What were the outcomes/benefits or otherwise?

(What happened and what was gained or lost from this? When were the benefits realised? Would you do anything differently? What is/was your timeline?)

Worker has raised awareness amongst staff regarding information and support available to carers. Has offered direct support and information to carers and

signposted carers to relevant services. This has improved joint working between carers centre and social work staff in hospital. Feedback from individual carers is positive and there has been an increase in registration at the carers centre. This was initially funded for one year and has been extended into a second year. A decision has also been taken to increase investment in this project for the next 6 months to roll out wider within the hospital.
Our involvement in the Equal partners in Care (EpiC) pilot will underpin staff awareness across services to further embed our approach to supporting carers.

10. Additional contacts (to find out more)

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

Inverclyde Carers Centre Tel 01475 735180

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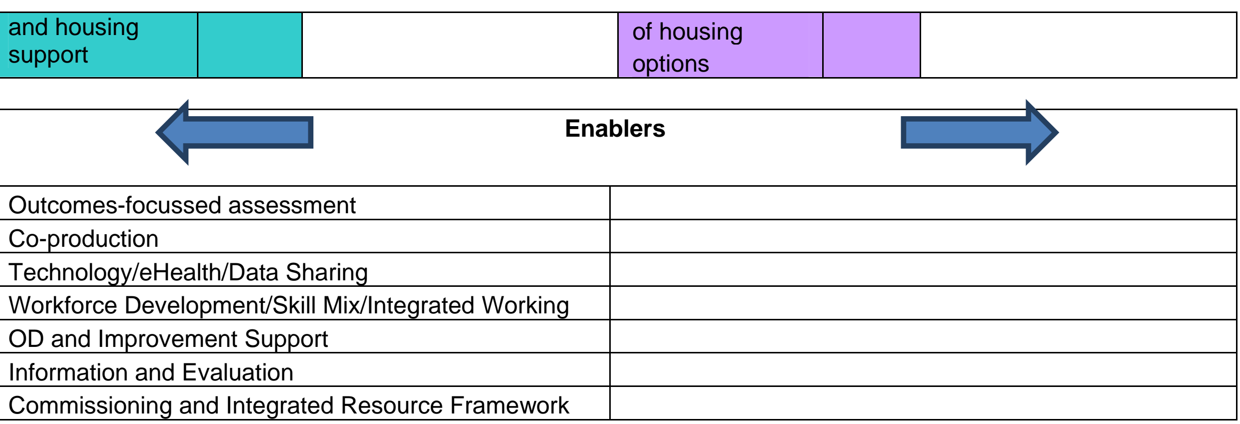
Preventative and Anticipatory Care	Case Study	**Proactive Care and Support at Home**	Case Study	**Effective Care at Times of Transition**	Case Study	**Hospital and Care Home(s)**	Case Study
Build social networks and opportunities for participation		Responsive flexible, self-directed home care		Reablement & Rehabilitation		Urgent triage to identify frail older people	
Early diagnosis of dementia		Integrated Case/Care Management		Specialist clinical advice for community teams		Early assessment and rehab in appropriate specialist unit	
Prevention of Falls and Fractures		Carer Support and Respite	Y	NHS24, SAS and Out of Hours access ACPs		Prevention and treatment of delirium	
Information & Support for Self-Management & Self-Directed Support		Rapid access to equipment		Range of Intermediate Care alternatives to emergency admission		Effective and timely discharge home or to intermediate care	Y
Prediction of risk of recurrent admissions		Timely adaptations, including housing adaptations		Responsive and flexible palliative care		Medicine reconciliation and reviews	
Anticipatory Care Planning	Y	Telehealthcare		Support for carers	Y	Carers as equal partners	Y
Support for carers	Y			Medicines Management		Specialist clinical support for care homes	
Suitable and varied housing				Access to range			

Annex 1 – Examples of Impact



and housing support			of housing options		

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
Workforce Development/Skill Mix/Integrated Working	
OD and Improvement Support	
Information and Evaluation	
Commissioning and Integrated Resource Framework	

Annex 1 – Examples of Impact

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Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP**

Name of Initiative Highlighted	**Reablement Care at Home**
Date of Submission	27/9/13

Primary Contact	**Debbie Maloney**
Email	Debbie.maloney@inverclyde.gov.uk
Telephone #	01475 504897

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

11. Summary

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

Reablement and mainstream care at home activity data for Inverclyde shows a positive impact on ability and independence of individuals both immediately post discharge and subsequently over time. Reablement has been delivered as part of a discrete service; however, there is a requirement to embed the ethos across all services and to ensure that any individual's improvements in abilities and confidence of individuals are sustained.

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

Within Inverclyde CHCP Reablement has been fully funded from change fund since early in 2012 and there is a need to identify and release the resource benefits to ensure the service remains viable and the approach is embedded. We see reablement as a crucial part of the assessment process for SDS.

13. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

There have been a number of approaches involving support from local finance and JIT. A review group has been monitoring data from care at home and reablement to understand shifts in demand and capacity and JIT support has framed some of these discussions. The reablement lead (change fund post) has driven the connections with mental health and dementia services in order to embed the approach and to develop joint processes.

14. What were the outcomes/benefits or otherwise?

Annex 1 – Examples of Impact

(What happened and what was gained or lost from this? When were the benefits realised? Would you do anything differently? What is/was your timeline?)

Despite showing successful outcomes for service users, it is only recently that we have started to identify and transfer resource and to be able to transfer posts from temporary change fund posts to permanent posts. We continue to identify areas where reablement has impacted on capacity such as the OT aids & adaptations waiting list and have begun to use this capacity more creatively, through joint working initiatives to support the reablement approach.

15. Additional contacts (to find out more)

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

Joyce Allan Service Manager- Care at Home joyce.allan@inverclyde.gov.uk

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Build social networks and opportunities for participation		Responsive flexible, self-directed home care	**Y**	Reablement & Rehabilitation	**Y**	Urgent triage to identify frail older people	
Early diagnosis of dementia		Integrated Case/Care Management		Specialist clinical advice for community teams		Early assessment and rehab in appropriate specialist unit	
Prevention of Falls and Fractures		Carer Support and Respite		NHS24, SAS and Out of Hours access ACPs		Prevention and treatment of delirium	
Information & Support for Self-Management & Self-Directed Support		Rapid access to equipment		Range of Intermediate Care alternatives to emergency admission		Effective and timely discharge home or to intermediate care	
Prediction of risk of recurrent admissions		Timely adaptations, including housing adaptations		Responsive and flexible palliative care		Medicine reconciliation and reviews	
Anticipatory Care Planning		Telehealthcare		Support for carers		Carers as equal partners	
Support for carers				Medicines Management		Specialist clinical support for care homes	
Suitable and varied housing and housing support				Access to range of housing options			

Annex 1 – Examples of Impact

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
Workforce Development/Skill Mix/Integrated Working	
OD and Improvement Support	
Information and Evaluation	
Commissioning and Integrated Resource Framework	

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Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP**

Name of Initiative Highlighted	**Early Facilitated Hospital Discharge / Prevention of Care Home Admission**
Date of Submission	24 09 13

Primary Contact	**C Hennan / T Bench**
Email	Chrsitine.hennan@ggc.scot.nhs.uk
Telephone	01475 506028

Pathway:	Preventative and Anticipatory Care

16. Summary

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

In order to support individuals to remain in her own home following discharge from acute care an integrated approach involving PHCT / Local Authority / Secondary Care and family members / informal carers is being used. Starting from the pre discharge case conference, joint planning and assessment is being used to co-ordinate the return home and support tailored care to avoid care home admission.

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

Systems & processes are not always conducive to good communication, anticipatory planning and integrated working. This is particularly evident for people with complex needs requiring a multi agency, multi disciplinary approach who may not able to advocate for themselves.

18. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

Examples from one case include:
Assessment & care management team met with senior nurse adult community nursing to scope potential for successful trial period at home.
Subsequent involvement of GP, district nursing both day & OOH teams, Homecare reablement team, Community Alarms service, GG&C Anticoagulant Service.
Initial home assessment over a number of weeks to assess patterns of need / behaviour to establish how best to support patient across 24 hours and minimise risk for example facilitating safe use of medicines.

Annex 1 – Examples of Impact

Reablement in Inverclyde is used as a conduit for problem solving in complex discharges and has been fully funded from change fund. Staff have been given autonomy to create processes and relationships which support joint working.

19. What were the outcomes/benefits or otherwise?

(What happened and what was gained or lost from this? When were the benefits realised? Would you do anything differently? What is/was your timeline?)

There have been some successful outcomes for patients who would in the past have been admitted to long term care and in the example above, the lady still maintains her tenancy within very sheltered housing complex (since Dec 2012). Patient and family pleased with integrated / joint approach to service provision. Some challenges remain in and around communication / collaboration with services not managed by the CHCP. A more collaborative approach to the administration of medicines in the home setting particularly potentially harmful medicines such as Warfarin and this will be explored via the change fund pharmacy technician post. The principles of joint planning and delivery of care will be built upon by the development of integrated frontline teams (including DNs, care managers, AHPs) across the coming months.

20. Additional contacts (to find out more)

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

Ava Hallac Team Leader Assessment & Care Management ava.hallac@inverclyde.gov.uk

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Prevention of Falls and		Carer Support and Respite		NHS24, SAS and Out of		Prevention and treatment of	

Annex 1 – Examples of Impact

Fractures				Hours access ACPs		delirium	
Information & Support for Self-Management & Self-Directed Support		Rapid access to equipment		Range of Intermediate Care alternatives to emergency admission		Effective and timely discharge home or to intermediate care	**Y**
Prediction of risk of recurrent admissions	**Y**	Timely adaptations, including housing adaptations		Responsive and flexible palliative care		Medicine reconciliation and reviews	**Y**
Anticipatory Care Planning	**Y**	Telehealthcare		Support for carers		Carers as equal partners	**Y**
Support for carers				Medicines Management	**Y**	Specialist clinical support for care homes	
Suitable and varied housing and housing support				Access to range of housing options			

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
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Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP RCOP Partnership**

Name of Initiative Highlighted	**Closer working with Independent Sector**
Date of Submission	27.9.13

Primary Contact	**Brian Polding-Clyde**
Email	brian.poldingclyde@scottishcare.org
Telephone	07780007914

Pathway:	Hospital and Care Homes/ Enabler

21. Summary

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

Since becoming an integrated body in 2010 Inverclyde CHCP has focused energy and resource on the development of Partnership working between the; Statutory, Third and Independent Sector.
We have funded a Development Officer to support our engagement with the Independent Sector; having them participate in the development of all RCOP Policy Development and decision-making processes.
One such activity was the promotion of the; 'My Home Life Inverclyde' Leadership and Community Development Programme

What was the issue you were addressing or working on?

Inverclyde CHCP recognised that we had to develop our partnership working with the Care Home Sector in order that they could deliver care in line with the emerging RCOP agenda, supporting change initiatives in areas such as; Anticipatory Care Planning, Dementia Care and End of Life Care.

22. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

The Change Fund was used to support the Development Officer promote the programme across all of Inverclyde's Care Homes and when sufficient interest was noted a formal bid for funding of the programme was submitted to the RCOP Executive Group for consideration. At this stage in the consultation Extra Care Housing Managers were also invited to participate in the My Home Life programme and they will be involved.

Annex 1 – Examples of Impact

23. What were the outcomes/benefits or otherwise?

(What happened and what was gained or lost from this? When were the benefits realised? Would you do anything differently? What is/was your timeline?)

The programme is set to Launch on 30th September with representation from all four partners. The design of the Launch Programme is such that it reflects Inverclyde CHCP's desire for all four partners to be fully involved in the development of how we reshape care in Inverclyde.

In funding My Home Life we aim to:

a) Promote the Leadership Skills of those managing Care of older people within Inverclyde and
b) Support older people living in institutional settings to become more integrated into their local community
c) Create a direct link from those providing care to the Change Fund Executive Group and thus promote healthy lines of communication.

Those participating in the programme will be supported to write up a report in order to review its impact and the programme will run until Nov 2014.

24. Additional contacts (to find out more)

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

Emma Cummings RCFOP Project Manager
emma.cummings@ggc.scot.nhs.uk

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Annex 1 – Examples of Impact

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Support for carers				Medicines Management		Specialist clinical support for care homes	Y
Suitable and varied housing and housing support				Access to range of housing options			

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