Inverclyde council

AGENDA ITEM NO: 7

NHS Greater Glasgow and Clyde

Report To:	**Community Health & Care Partnership Sub Committee**	**Date:**	**26th February 2015**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No:**	**CHCP/26/2015/DP**
Contact Officer:	**Derrick Pearce, Service Manager Quality and Development**	**Contact No:**	**01475 715375**
Subject:	**Inverclyde Integrated Care Plan 2014/15**		

1.0 PURPOSE

1.1 The purpose of this report is to notify CHCP Sub Committee members of the submission to the Scottish Government of the Inverclyde Integrated Care Plan, and anticipated allocated funding to the Inverclyde Partnership of £1.7 million in 2014/15.

2.0 SUMMARY

2.1 Partnerships were asked by the Scottish Government to develop plans which incorporate the benefits of Integration, whilst working concurrently alongside national strategies for health and social care. The plans were to be tailored to local needs under the auspices of the six core principles of the Integrated Care Programme:

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

It was for local partnerships to decide how best to develop their Plan for the use of their share of the £100m announced for allocation nationally. The Plan was required to clearly outline the role of the non-statutory partners and to describe the level of support to carers. The Plan is primarily intended to drive service innovation, development, and improvement, and to communicate priorities. Partnerships are required to monitor their own performance and are expected to submit two progress reports at six monthly intervals to the Ministerial Strategic Group on Health and Community Care.

2.2 Our aims in the Integrated Care programme are:

- To reshape care for everyone
- To work in a truly integrated, participative way
- To ensure equality for partners in the planning, commissioning, delivery, and scrutiny of care.

Our aims are consistent with those expressed in our Integration Scheme and will inform the first Inverclyde Health and Social Care Partnership Strategic Plan.

2.3 We intend to achieve these aims through the following:

- Use the integrated care programme as a vehicle by which to consolidate existing streams of work
- Reform how we deliver health and social care services and supports in the community
- Enable personal ownership amongst our communities
- Recalibrate the system around health and social care supports and services
- Continue our good progress in shifting the balance of care
- Build on the successful legacy and outcomes of RCOP
- Maximise our intelligence around:

    - service use and demand
    - costs and resourcing
    - critical operational challenges such as delayed discharge and readmission to secondary care

3.0 RECOMMENDATIONS

3.1 It is recommended that CHCP Sub Committee members endorse the attached Inverclyde Integrated Care Plan.

3.2 It is recommended that CHCP Sub Committee members endorse the submission of the attached Plan to the Scottish Government.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 Essentially the Integrated Care Fund builds upon the legacy of the Reshaping Care for Older People (RCOP) programme, and the subsequent Change Fund that accompanied it. In determining how to utilise the Integrated Care Fund, consideration was given to the following:

- developing proposals that can make a significant impact within a year
- safeguarding services and interventions which have been shown to be effective, supported by short term investment
- agreeing investments that re-calibrate the care system and, in doing so, deliver system-wide cost efficiencies
- embedding transformational change to achieve the required shift in the balance of care

4.2 In developing the Inverclyde Integrated Care Plan, the partners have aimed to achieve a balanced approach in terms of:

- improving performance in the prevention of emergency admissions
- continuity in the effective management of delayed discharges
- recognising adults with Long Term Conditions including older people
- balancing care and treatment with preventative measures
- establishing an investment profile that recognises the contribution from all the partners
- analysing performance information to inform decisions

5.0 Our Intentions

5.1 Our intended areas of action set out in the Inverclyde Integrated Care Plan are as follows:

Co-Production and Involvement
- Stroke
- Housing
- Technology to assist self-management
- Strategic Needs Analysis

Sustainability
- Strategic Needs Analysis
- Delayed Discharges

Locality
- Nurturing Local Capacity
- Self Directed Support
- Nurturing Carers
- Developing Commissioning

Leverage
- Intermediate Care and Support
- Reablement

Outcomes
- Supported Self Care
- Falls
- Transitions

5.2 The Integrated Care Fund (ICF) is being introduced at a time of significant financial challenge facing the public sector. As a result, many mainstream services will be subject to searching examination and likely change from 2015-16. Our priority programme should take account of this. It is appreciated that payback on ICF investment has to be achieved either within the year, through the service becoming self funding, or by absorption into the Joint Strategic Commissioning process.

Therefore all spending identified in our Integrated Care Plan is on the explicit understanding that it is non-recurring. Any recurrent spending beyond April 2016 would have to be met from the mainstream budgets of the new health and social care partnership and, where appropriate, of other partners. In terms of the Change Fund, the current projects, totalling investment of £1.7m across CHCP, acute services, housing, carers, third and independent sectors, have been evaluated for impact and best value. Those projects which evaluated positively have then been assessed against agreed ICF criteria and priority programmes.

6.0 IMPLICATIONS

Finance

6.1 Inverclyde CHCP's anticipated share of total funding is expected to be in the region of £1.7 million for 2015/16. Final spending on projects will be per confirmed allocations.

Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
Various	Various	2015/16	1,700		External funding

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

Legal

6.2 There are no legal implications of this report.

Human Resources

6.3 There are no direct human resources implications of this report.

Equalities

6.4 None at this time, although recognition will be given to the wider and associate equalities agenda.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	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.

Repopulation

6.5 The Inverclyde Integrated Care Strategy supports the aspirations to encourage repopulation and population sustainment for the local area.

7.0 CONSULTATIONS

7.1 The CHCP hosted a meeting on 7th November 2014, at which representatives from all sectors and non-statutory bodies were invited to attend. At this meeting the cross cutting strategic themes of the RCOP programme and the Integrated Care Fund were discussed, and all stakeholders were invited to contribute to discussion around the criteria for the Integrated Care Plan. Small group discussion accompanied a wider round-the–table exchange of opinions. Following this discussion, the CHCP produced a first draft of the Integrated Care Plan, which was circulated for comment prior to a final meeting before sign off on Friday 16th January 2015, which saw the consolidation of the RCOP Executive Group with its replacement by the ICF Executive Group. At this meeting all final comments / issues with the draft plan were put on the table, and following on from this feedback, a final draft was produced on 23rd January 2015 and submitted to the Scottish Government thereafter.

8.0 BACKGROUND PAPERS

8.1 Nil

INVERCLYDE INTEGRATED CARE PLAN

JANUARY 2015

PARTNERSHIP DETAILS

Partnership name:	INVERCLYDE
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Date of Completion:	23rd January 2015

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 of the guidance:

1. Introduction

1.1 Inverclyde Community Health & Care Partnership (CHCP) is an integrated partnership between Inverclyde Council and NHS Greater Glasgow and Clyde, bringing together community and primary healthcare, and social work / social care services. The CHCP's status as an established collaboration between Inverclyde Council and NHSGG&C provides a strong basis for integration and joint working in our communities.

1.2 Since April 2014, Inverclyde CHCP has been preparing for full integration under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. During this consolidation, the CHCP has taken the opportunity to evaluate the lessons learned thus far from its existing partnerships. Building on our successes since 2010, we have sought to realise the opportunities for improvement that the legislation provides. We have therefore spent significant time considering what integration, under the CHCP umbrella, has delivered for individuals and our communities, and how best to take this forward and improve on our existing model in the new HSCP.

1.3 Building on the experience, outcomes and learning from our Reshaping Care for Older People programme, this Integrated Care Plan has been developed to inform integrated services for all adults. It has been co-produced with local stakeholders, and explicitly shapes the new Inverclyde HSCP plan for its first year of operation, underpinned by the new health and wellbeing outcomes for adult health and social care.

2. Key Factors

2.1 In determining how to utilise the Integrated Care Fund, consideration has been given to the following:

- developing proposals that can make a significant impact within a year
- safeguarding services and interventions which have been shown to be effective, supported by short term investment
- agreeing investments that re-calibrate the care system and, in doing so, deliver system-wide cost efficiencies
- embedding transformational change to achieve the required shift in the balance of care.

3. Our Approach

3.1 In developing the Inverclyde Integrated Care Plan, the partners have aimed to achieve a balanced approach in terms of:

- Improving performance in the prevention of emergency admissions
- Continuity in the effective management of delayed discharges
- recognising adults with Long Term Conditions including older people
- balancing care and treatment with preventative measures
- establishing an investment profile that recognises the contribution from all the

partners
- analysing performance information to inform decisions.

3.2 The Inverclyde Partnership is committed to the continued development of integrated multi-agency and multi-professional working across a wide spectrum of partners. We are moving into a new era of health and social care. We aspire to be at the vanguard of this by building on our successes as a fully Integrated Community Health and Care Partnership since 2010, and in the Reshaping Care for Older People programme.

3.3 We recognise the need for radical change and we are enthusiastic about delivering on that agenda. Inverclyde CHCP is recognised as a successful partnership in addressing the deep rooted health, social and economic inequalities which pervade in our area through co-ordinated joint working across the system.

3.4 Our communities are resilient in the face of high levels of complex ill-health, poverty and inequality, and we recognise the unique context in which we operate. Consequently, we intend to use the Integrated Care Programme to learn as much as we can about how to most effectively support people to tackle the negative or challenging aspects of their lives. This will be through the use of their own personal and community assets, and by having access to high quality, well integrated and seamless services and supports

3.5 Our aims in the Integrated Care programme are:

- To reshape care for everyone
- To work in a truly integrated, participative way
- To ensure equality for partners in the planning, commissioning, delivery, and scrutiny of care.

3.6 Our Plan is underpinned by consolidation and reflection; we want to ensure we collectively know our business and are focussed in our approach. Our first principle is that people should be *"**Home First**"*, and that if people have been able to do something they enjoy in the past they should enjoy it once more; ***"I've done it before and I'll do it again"***.

3.7 How we will do this:

- Use the integrated care programme as a vehicle by which to consolidate existing streams of work
- Reform how we deliver health and social care services and supports in the community
- Enable personal ownership amongst our communities
- Recalibrate the system around health and social care supports and services
- Continue our good progress in shifting the balance of care
- Build on the successful legacy and outcomes of RCOP
- Maximise our intelligence around:
    - service use and demand
    - costs and resourcing

- critical operational challenges such as delayed discharge and readmission to secondary care.

3.8 We must ensure we are as effective as possible in the use of the resources we have at our disposal, and target these where they will have maximum benefit.

This will be through:

- Effective nurturing of preventative and anticipatory interventions
- Seeking to promote opportunities for Recovery
- Reablement opportunities for all that will benefit from them
- Removal of boundaries within and between services
- Mature service integration to avoid perceived “service saturation”
- Maximised use of community and personal assets
- Tailored supports augmented by formal service intervention.

4. Our vision

4.1 The Inverclyde Partnership vision for integrated care is consistent with the Scottish Government 2020 vision for health and social care that;

*“**everyone is able to live longer healthier lives at home, or in a homely setting.** We will have a care system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.”*

4.2 Our Integrated Care Plan is closely linked to our strategy for local implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 and the integration planning principles, which are;

(a) that the main purpose of services which are provided in pursuance of integration *functions is to improve the wellbeing of service-users,*
(b) that, in so far as is consistent with the main purpose, those services should be provided in a way which, so far as possible—

> *(i) is integrated from the point of view of service-users,*
> *(ii) takes account of the particular needs of different service-users,*
> *(iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided,*
> *(iv) takes account of the particular characteristics and circumstances of different service-users,*
> *(v) respects the rights of service-users,*
> *(vi) takes account of the dignity of service-users,*
> *(vii) takes account of the participation by service-users in the community in which service-users live,*
> *(viii) protects and improves the safety of service-users,*
> *(ix) improves the quality of the service,*
> *(x) is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),*
> *(xi) best anticipates needs and prevents them arising, and*
> *(xii) makes the best use of the available facilities, people and other resources.*

4.3 To ensure that local people can participate in the integrated care programme and in the health and social care agenda generally, we will continue to facilitate and build the capacity of the CHCP Advisory Network to help guide local people through the new structures and plans. We collectively endorse, and adhere to, the National Standards for Community Engagement, the principles of co-production and the Community Empowerment Bill 2013: Equality, Diversity, Accessibility & Reciprocity, and are compliant with the 8th (and aware of the 9th) Protected Characteristics of people who use services.

5. Financial Context

5.1 The Integrated Care Fund (ICF) is being introduced at a time of significant financial challenge facing the public sector. As a result, many mainstream services will be subject to searching examination and likely change from 2015-16. Our priority programme should take account of this. It is appreciated that payback on ICF investment has to be achieved either within the year, through the service becoming self funding, or by absorption into the Joint Strategic Commissioning process. Therefore all spending identified in our Integrated Care Plan is on the explicit understanding that it is non-recurring. Any recurrent spending beyond April 2016 would have to be met from the mainstream budgets of the new health and social care partnership and, where appropriate, of other partners. In terms of the Change Fund, the current projects, totalling investment of £1.4m across CHCP, acute services, housing, carers, third and independent sectors, have been evaluated for impact and best value. Those projects which evaluated positively have then been assessed against agreed ICF criteria and priority programmes.

6. Our Intentions

6.1 The following section sets out how we intend to deliver on the criteria of the Integrated Care Programme and use the anticipated allocation of £1.7 million non-recurring funding in 2015/16.

6.2 We have allocated the key criteria descriptions to the 6 themes of the programme, and have merged Co-production and Involvement because, for us, they are interlinked.

7. Areas of Action

7.1 Co-production and Involvement: *how the principles of co-production will be embedded in the design and delivery of new ways of working.*

7.1.a Stroke

Building upon the ongoing work to improve stroke pathways, both within health services and beyond, we will revisit the roles and responsibilities relating to the immediate and extended support for stroke patients. Utilising the capacity of a new member of the medical staff, we will review existing, and develop new, approaches to care. We will work with the Stroke Association to pilot an online platform for goal setting and peer support. We will consolidate the approach of the Stroke Matters Peer Support Group and review how to use similar approaches to support other long term conditions groups.

7.1b Housing

As 'business as usual' will not be an option moving forward, Inverclyde Council is working with local social landlords to explore how to respond to demographic and policy challenges, and ensure many more older people can be supported to live in their own homes as they age. The Inverclyde Partnership is committed to

understanding all aspects of the physical housing environment and wider environmental issues impacting on health and social outcomes. Whilst the majority of our activities in relation to housing, linked to health and social care, focus on older peoples issues, we will seek to engage with the communities in and around areas of social deprivation given that 73% of Inverclyde social housing stock is in these areas. We recognise that this is a characteristic unique to Inverclyde, further exemplifying our need to embed approaches which seek to tackle inequalities.

To guide these policy discussions, we will:

- Work in partnership with Strategic Housing Team and local Registered Social Landlords Forum
- Build an intelligence base around housing requirements for people with health and social care needs
- Maximise opportunities for housing investment in this area
- Ensure there is sufficient housing stock
- Ensure robust process for timely availability to people who require adapted, or specially designed, accommodation
- Synthesise available evidence on the current and future anticipated housing related needs of older people in Inverclyde
- Map the geographical spread, consumer cost and physical design of specialist housing provision (sheltered, very sheltered housing etc)
- Provide a clear picture of allocation arrangements and associated demand issues for specialist housing
- Identify strengths and weaknesses in the current housing provision for older people within Inverclyde, taking account of the structure of the local housing markets
- Drawing on good practice in other local authorities, we will outline some policy options in relation to addressing the future requirements for housing and care for older people across Inverclyde. This will be consistent with Scottish Government policies as well as local ambitions.

7.1c Technology to assist self-management

There is good local evidence that current telehealthcare for individuals with COPD has reduced hospital admissions. We will use this evidence to expand existing programmes around telehealth and telecare in a more integrated and co-productive way. This will allow people with long term conditions to use technology to manage their own conditions in partnership with healthcare professionals, thus supporting our anticipatory approach to care and crisis prevention.

A key partner in this will be the CHCP Advisory Group including the Carers, Learning Disabilities, Older People & Long Term Conditions sub groups, who will be central to promoting the positive impact assistive technologies and communication tools can have on independence and self- management.

7.2 Sustainability: *the long term sustainability of investments and the extent to which the use of the fund will leverage resources from elsewhere.*

7.2a Strategic Needs Analysis

We will continue our successful work around the primary and secondary care health interface to better understand need, demand and delivery in relation to health and social care, remodelling to utilise resources more effectively when required.

We will make maximum use of the Integrated Resource Framework data via an in-depth study of the 1600 people in Inverclyde who account for 50% of resource use, mapped against a sample of similar people who account for the lowest resource use.

Our intention is to learn what circumstances, supports (or lack thereof) and characteristics determine an individual's likelihood to access services in high volume. Inversely, we are looking to establish the factors that can allow someone to require very low levels of formal support.

Our aspiration is to identify the optimal level of support, and access to services, which, if in place, should mitigate this group from requiring very high resource use unnecessarily. This, in turn, will enable us to target our services where possible and desirable.

We intend to make use of the House of Care model and the Morbidity Assessment Risk Score (MARS) data to shift the balance of care towards prevention and early intervention for people with Long Term Conditions.

We anticipate that many people with LTCs account for a large proportion of the 1600 high resource individuals mentioned above. Working closely with local GP's, particularly those who are in the 17c category of practices, we hope to identify these people. This increased clarity will enable us to build the case for resource shift from one area of the system to another in a more robust way. And, by working in an integrated fashion through our primary/secondary care Interface programme of work, we will be able to jointly agree a more sustainable model for the future based on people accessing the right support, at the right time, in the right environment, with Home First as our guiding principle.

We intend to learn from work done elsewhere for example in Borders and more locally in Paisley regarding 'Day of Care' audits, in order to carry out a similar exercise at Inverclyde Royal Hospital. This will establish if there are inpatients who could be better cared for outside the acute environment, and assist us to either improve pathways to those alternative places of care, or to commission these, should they be appropriate. This will also inform our work on intermediate care beds.

7.2b Delayed Discharges

For a number of years, and more recently through the Reshaping Care for Older People mechanisms, Inverclyde as a partnership has demonstrated clear commitment to addressing the challenge of Delayed Discharge. Starting from a relatively strong level of performance, we have sustained and improved upon this throughout the period of the Change Fund. We have clearly demonstrated reduced delays, with a corresponding reduction in bed days lost to Delayed Discharges. In common with other partnerships, there continues to be an increasing number of emergency admissions for over 65s. However, for Inverclyde, the reduction of bed days reflects that older people are being admitted more frequently for a shorter period of time. In a nutshell, this illustrates the dichotomy of Shifting the Balance of Care: by supporting older, frailer people at home they require to be admitted to hospital more frequently when their condition exacerbates but then, as a result of effective community services, can be discharged and supported more quickly in the community.

The local joint action plan to achieve the 14 day Delayed Discharge target will continue to be implemented to improve the key areas identified, and we will continue to respond to individual issues as they arise. We know that there are often small numbers of individuals who account for high numbers of lost bed days, and that there are complex factors contributing to this for example; capacity issues, family dynamics and specialist housing needs. There will be ongoing exploration of the data to better understand, predict and respond to these.

The challenge of providing high levels of complex care and intensive rehabilitation to enable safe discharge home should not be underestimated, and we will continue to look at ways to integrate our existing workforce to maintain and further develop our 'intermediate care' response.

As a partnership, analysis of our activity demonstrates that, on the whole, discharge is not our key issue. Rather, we need to make similar progress to ensure we avoid admissions in the first place. We will complete an option appraisal on the benefits to be gained through utilisation of Step Up - and to a lesser extent Step Down - Intermediate Care Beds, working with Homecare, Care Homes and Housing Providers to agree how best to improve upon not only current performance, but to improve outcomes for local people.

7.3 Locality: *how relationships with localities will be consolidated, including maximising input from the third sector, independent sector, users and carers. Such a bottom up approach will increase the contribution of local assets including volunteers and existing community networks and address how resources will be maximised on the greatest need.*

The Partnership utilises an assets based approach and will continue to engage with, and build the capacity of, local people. We will focus on individual and community assets to steer the planning and provision of local services to better suit them and enhance their quality of life. Integral to this approach, will be a focus on exploring options for the inclusion of volunteering as a means of enhancing the provision of health and social care services.

7.3a Nurturing locality capacity

The challenges of integrating health and social care cannot be met by the NHS and Local Authority alone; the partnership intends to invest in nurturing the local relationships between the statutory and third / independent sector to ensure there is a broader contribution to the achievement of outcomes from the wider partnership.

As is the case nationwide, Strategic Commissioning and Integration will require ever closer collaboration across the wider partnership. This will see provider organisations being involved at the heart of service planning and design to help us move away from statutory services designing the model, and the third / independent sector being invited on board later in the process to tender for delivery.

We recognise the need for the third / independent sector to have the capacity to engage in the wider integration of the health and social care agenda as a key partner. We intend to use our Integrated Care Fund allocation to bring about increased capacity in the third and independent sector to support strategic commissioning via market development, provider engagement and development, availability and efficacy of community capacity, to respond to need on an assets based model.

We aim to focus on helping to develop locality based supports and services which augment what the statutory sector can provide to those assessed as having need for a formal health and/or social care service, to help reduce reliance on formal condition-specific intervention.

We will also use the Integrated Care Fund allocation to improve community capacity in an agreed priority area. We aim to focus on developing supports that are volunteer involving, and locally based, and services which improve the general health and wellbeing of that community; while also augmenting statutory provision to those assessed as having need for a formal health and/or social care service - helping increase people self-reliance and reducing the need for formal condition-specific intervention.

7.3b Self Directed support

There will be strong links to the continued implementation of Self Directed Support in this area and that a robust tool, for people to find out what is available for them to access, will be in place and routinely updated. The Inverclyde Life information portal (www.inverclydelife.com) will be an important facet of this part of our programme. This will be linked to the modernisation of support planning and review, in order to ensure everyone who is eligible has awareness of their options for accessing care and support, and is supported to look afresh at these on a regular basis.

It is the Partnerships intention to link integrated care programme developments and the national strategy for SDS. We aim particularly to utilise anticipated SDS funding to stimulate dialogue on the relationship between SDS and person centred health.

The partnership will assist recipients of care and support to:

- explore the idea of / become part of an SDS network in their local area
- enable individual and community / collective capacity
- provision of up to date and appropriate information
- establish key messages to inform the future of the self-directed support
- create safe, friendly, educational environments to bring together a broad range of stakeholders
- facilitate a range of peer support groups to assist in the education and promotion of SDS.
- evaluate the views of people using SDS to improve processes and outcomes

7.3c Nurturing Carers

Inverclyde benefits from a very healthy approach to supporting cares, with high levels of carer awareness and carer participation. Our local Carers Strategy, co-produced and edited by carers, is our guiding strategic document in respect of what carers say they need, and what services have committed to delivery. We had success via RCOP in relation to carer support for hospital discharge and Long Term/Emergency Planning. The partnership recognises the need to continue to invest in carers, and it is intended that the allocation of funds from the Integrated Care Fund will be used at the disposal of the local Carers Development Group. This will fund further innovation in relation to supports for carers, which can be mainstreamed in statutory and other services in the longer term, having proved their value. Our role as an EPiC pilot site has given us further opportunity to ensure staff in the statutory sector ‘think carer’, and the integrated care programme locally will be a vehicle by which we can continue to nurture the partnership between carers, carer organisations, the local community and statutory services.

7.3d Developing commissioning

The challenges of integrating health and social care cannot be met by the NHS and Local Authority alone; and our partnership intends to invest in building upon the local relationships to deliver a broader contribution to the achievement of outcomes from non-statutory agencies. The Reshaping Care for Older People programme has significantly enhanced the relationship between the statutory and third / independent sectors; opening up exciting new opportunities. As is the case nation-wide, Strategic Commissioning and Integration will require ever closer collaboration between commissioners, delivery agencies and community. This will see provider organisations and relevant community groups being involved at the heart of planning and design of all services. Testing of Public Social Partnership approaches is proving valuable in improving commissioning, and we aim to continue this type of approach.

We recognise the need for the third / independent sector to have the capacity to engage in this, and the wider integration of health and social care agenda, as a key partner. We intend to use some of our Integrated Care Fund allocation to bring about increased capacity in the third and independent sector to support strategic commissioning via market development, provider engagement and development; as well as further development of community capacity and asset-based approaches.

7.4 Leverage: *the extent to which activity will deliver improved outcomes in-year and lay the foundations for future work to be driven through Strategic Commissioning.*

7.4a Intermediate Care and Support

In Inverclyde, intermediate care is provided in people's own homes with support from a range of CHCP services. We have carefully considered learning from elsewhere and have commenced an options appraisal which will inform our approach to bed based intermediate care. We will work closely with local providers and Scottish Care to consider the best use of residential and nursing facilities to support intermediate care in line with the Task Force Review of Residential Care in Scotland which recommends:

"an evolution and expansion of the extra-care housing sector; a growth in the residential sector focused on rehabilitation and prevention (step-up / step-down care); and a smaller, more specialised residential sector focused on delivering high quality 24-hour care for people with substantial care needs."

Our agreed partnership vision will be implemented through the joint strategic commissioning process.

7.4b Reablement

We continue to learn valuable lessons from implementing Reablement in our care and support at home services, predominantly benefiting older people. We aim to work across boundaries and expand the model of Reablement to other service areas. We will link with community supports for people to access following successful Reablement, this includes signposting individuals to peers support opportunities and supported community activities. We are keen to see Reablement for adults with learning disabilities and people with mental health issues linked to the Recovery movement. Reablement underpins our aim that people should be afforded the opportunity to participate in their community for as long as possible and have maximum rehabilitation to achieve optimum independence.

By using a Reablement model with older people we have seen a reduced level of interventions than was the case before using our Reablement approach. In the long term this benefits the individual, because their independence and sense of personal control has been maximised. Additionally resources can be freed up for others who may require them. We can use Reablement to maximise resources, linking with the community capacity and the assets each individual has at their disposal.

7.5 Outcomes: *the activities that will support the delivery of integrated health and wellbeing outcomes for adult health and social care – and the contribution to wider work designed to tackle health inequalities with Community Planning Partnerships. Progress in implementing priority actions for partnerships as described in the forthcoming National Action Plan for Multi-Morbidity*.

7.5a Supported Self Care

Inverclyde's Supported Self Care Network aims to improve access to education and information in order to enable individuals to better understand and manage their long term condition(s). The network sees partners from the CHCP, third / independent sector, housing, acute services and others, come together in an integrated way to drive forward improvements.

Over the coming year, the network will continue to develop work already underway and to find ways to better disseminate this. We will also carefully consider the recommendations of the Keep Well evaluation and ensure clear and robust mechanisms for assessing impact and outcomes in our population.

Our main priority is to ensure that those diagnosed with LTCs are equipped with the skills and empowered to manage their own conditions in the community for as long as possible. Our aspiration is that all partners, and especially the third / independent sector, are equipped with the knowledge and confidence to engage in conversations, utilise motivational interviewing techniques and to offer appropriate support to individuals with long term conditions. This will include improving health literacy, ensuring information is available, in appropriate formats, and is tailored to individual and community needs. The network has successfully developed a local COPD information booklet and this will inform development of a range of disease specific information.

We are mindful of local intelligence and available data showing that many individuals locally do not attend health services with symptoms of long term conditions until a crisis occurs. Identifying such individuals at an earlier stage will allow us to engage and diagnose sooner, and offer advice and education to improve condition management. We are keen to focus on health improvement focussing on social and environmental interventions; seeking to fully embed the principles of health improvement in operational service delivery in a meaningful and pragmatic way.

Anticipatory Care Planning (ACP) has been steadily developed in Inverclyde. This has been achieved by utilising SPARRA data to inform our approach by District Nurses, alongside plans developed by GPs as part of the GMS contract, and a care home specific pilot in Inverclyde. Emergency/ anticipatory/ Individual Long Term planning has also been undertaken by Inverclyde Carers Centre and supported by the Change Fund. We are currently evaluating our approach and will continue to develop this with the evidence gathered. It is our intention that anyone discharged from hospital with complex or palliative care needs will have an ACP contributed to by the Multi-Disciplinary Team where appropriate and that the use of SPAR within care homes will be further embedded.

7.5b Falls

Following on from the publication of the new framework for action for Scotland - "The prevention and management of falls in the community" from the Scottish Government - Inverclyde CHCP will develop and implement a local integrated falls pathway. An initial draft falls pathway for Inverclyde CHCP has been developed. One of the main issues identified by our partnership falls group is that very few services within our area collect any falls data. The need for a falls register has been highlighted in order to proactively work more intensively, and in an integrated way, with those identified as being prone to falling. This would make maximum use of all resources such as the Scottish Fire and Rescue Service home safety checks.

Inverclyde CHCP's work involving our District Nurses and Community Alarm Service has been highlighted as an area of good practice. This pathway was developed following RCOP work to develop a local falls pathway for fallers known to the community alarm service. Our Community Alarm Service now has direct access to our District Nursing service, where they identify when there has been a change in someone's abilities and a nursing assessment is then carried out with onward referrals to other services as indicated. We seek to further develop this integrated working via the integrated care programme, and to expand the model working with the Scottish Ambulance Service and out of hours services. We will scope the viability and necessity for local falls prevention exercise classes in the community. This would be delivered in an integrated model, to maximise transport efficiency and outcomes of people, such as having social interaction as well as practical support and advice re falls prevention (e.g. in a joint day service/ day hospital/ community group environment).

7.5c Transitions

In order for people who have multiple and complex conditions to do well in their lives, a successful transition from children’s services to adult services is essential. Local people tell us that often the challenges of living with multiple and complex health and social care needs are exacerbated unnecessarily for the individual and their carers by service boundaries. The partnership recognises the need to try and explore further where improvement can be made at the transition stage for young people who are leaving one branch of the system and entering another, which is much wider and more complex. We will invest in scoping work to map the transition process for young people with long term conditions and multi-morbidity to better understand how to plan for a more seamless transition as part of the wider recalibration of our current models of service delivery.

6. Summary of spend

Theme	Item	Allocation
Co-production and Involvement	Stroke	£70,000
	Housing	£25,000
	Telecare/ Telehealth for LTCs	£75,000
Sustainability	Strategic Needs Analysis	£130,000
Locality	Carers	£150,000
	3rd sector and community capacity	£200,000
Leverage	Intermediate Care	£250,000
	Reablement	£700,000
Outcomes	Supported Self Care/ Falls prevention	£50,000
	Transitions	£50,000
TOTAL		£1,700,000

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

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Brian Moore for the Shadow Joint Board,

…………………………….. and ……………………………….

Robert Calderwood
for the NHS Board

John Mundell for the Council

…………………………………….

……………………………….

Ian Bruce for the third sector

Charles Young
for the independent sector