Paper 5

East Ayrshire CHP Committee

3rd October, 2011

RESHAPING CARE PROGRAMME

EAST AYRSHIRE COMMUNITY HEALTH PARTNERSHIP TRANSFORMATIONAL PLAN 2011/2012

OUR VISION: WHAT WE WANT OUR SERVICES TO LOOK LIKE

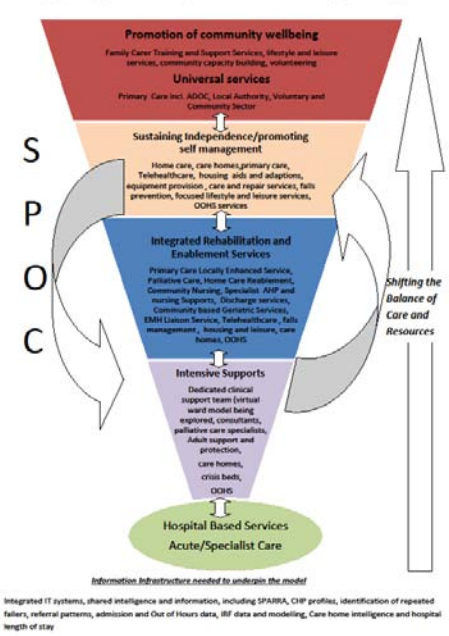
Reshaping Care for Older People Programme Model

Workstream 1

Workstream 2

Workstream 3

Workstream 4



The Change Fund is utilised within this model as a mechanism for bridging finance to support transformational service change rather than being the service change in its own right. It will be used to drive service re-design and enable shifts in core budgets.

WHAT WILL WE DO (through the associated change fund)

WORKSTREAM ONE - Promotion of Community Wellbeing, including Universal Services

This approach will be founded upon community development and asset based principles in recognition that the majority of older people do not receive or require direct social care services. We will seek to build community capacity that will include:

- Increased support to carers
- Development of Leisure/Lifestyle/capacity building services
- Support to voluntary org/social enterprises to build future capacity
- Development of Well-connected & Befriending Project, with the Voluntary Sector
- PQASSO training for voluntary organisations
- Public health capacity building – preventative work through public health improvement.

This workstream will include working with community planning partners to participate in an inclusive, preventative approach across the partnership.

WORKSTREAM TWO - Sustaining Independence and Promoting Self Management (in homely settings)

When older people require support we will further develop our services to make this available through models that are personalised to promote independence and are planned and delivered respecting the views of and with full participation of individuals. This will include: -

- Community Pharmacy medicine management for home carers
- Additional telehealthcare capacity, including equipment and technician
- Partnership Telecare project for older people, working with Scottish Fire Service
- Ayrshire wide equipment post, commissioning with Cordia to develop an integrated service
- Dementia Strategy Training Officer to work across partners
- Advocacy Services, including additional investment from Local Authority
- Ayrshire wide Falls lead post to develop integrated prevention and management services
- Care and Repair – to provide minor adaptations to support housing needs of older people
- E-health Solutions for Stroke Pts (SLT) - Ayrshire wide
- Nutritional Education in Care Homes - Ayrshire wide
- Positive Steps Resources (Falls) – for use in Day Centres and Sheltered Housing
- Community Capacity Training & Equipment (links with Falls and dementia)
- Reflexology for Carers and Care Homes
- Alzheimer's Scotland – post diagnostic self-management course

WORKSTREAM THREE – Integrated Rehabilitation and Enablement Services

In order to deliver on the key policy goal of Reshaping Care to "optimise independence and wellbeing for older people at home or in a homely setting" it is essential that services work together in a co-ordinated way.

Specifically this will see two locality Single Point of Contact Hubs (SPOC) established to ease access to services which will serve the communities to the North and South of East Ayrshire.

The Hub will include :-

- out of hours mobile home care services,
- the new community reablement service for older people agreed by Council in the 2011/2012 budget.
- Income maximisation

- Integrated Care and Enablement Services
- Primary care services
- Community District Nursing
- Social Work and home care staff
- Allied Health Professionals
- Community based Geriatrics service
- Community based Elderly mental health liaison services, particularly to support care homes
- Community pharmacy support for hubs, including medication reviews
- Falls Management Pathway Development
- Review of Out of Hours Services, including Nursing
- Increased AHP capacity
- Additional investment in Equipment

Hubs will focus on the provision of the use of all workstreams within the triangle model outlined above. In particular it will include: –

- Integrated targeted support and services linked to condition, age, geography, falls or risk prediction such as SPARRA (Scottish Patients At Risk of Readmission and Admission), and practice profiling data
- Close working relationships established with individual GP practices to support integrated case/care management approaches, anticipatory care planning and multi-disciplinary team working
- Close liaison with GP practices to support delivery of reduced emergency hospital admissions
- Improved integration between in hour and out of hours health and social care services
- Clear links between out of hours services and ambulance services (unscheduled care)

WORKSTREAM FOUR – Intensive Supports

In achieving positive outcomes for older people through effectively delivering on workstreams 1 to 3 we require to utilise the full resources, skills and knowledge of Social Work and Health professionals. To support this we will develop arrangements that will link specifically with the Hubs and will include;

- The development of a community ward approach with dedicated clinical team to contribute to targeted reductions in acute admissions and acute bed days, within the North of East Ayrshire
- Multi-agency team approach to work with care homes to develop and continue good working practice. This will include social worker, district nurses, and pharmacists.
- Provision of specialty services in the community (e.g. COPD), through Managed Clinical Networks
- Promote Adult support and protection
- Provide support at times of crisis in an appropriate setting, including working with Scottish Care to develop model for care home bed use.
- Additional geriatric sessions to develop community infrastructure

- Support winter pressures within East Ayrshire, to support early discharge and prevent admissions.

It is acknowledged that the Change Fund should be utilised as a lever for change, through the above initiatives to compliment the change agenda within partnership services.

HOW WILL WE KNOW WE HAVE SUCCEEDED

PERFORMANCE

East Ayrshire Community Health Partnership have agreed that the performance reporting tool to be utilised for this programme will be COVALENT. This will require the information gathered through the local authority CORVU system to be transferred to COVALENT. We are progressing with this through some key steps:

- Performance surgeries have been held with Project Leads, identifying and confirming outputs and outcomes for the projects outlines above.
- Performance officers have been trained in Covalent to support data inputting
- Baseline information gathering in relation to the high level outcomes is being gathered. This needs to reflect locality hub performance information as the service hubs develop, to measure progress.
- Focus on personal outcomes and enablement, through promotion of Talking Points

Jean Hendry
Eddie Fraser
Co-Chairs, Officer Locality Group(Adults)

26th September, 2011

N.B. FINANCE APPENDIX TO BE TABLED