EAST AYRSHIRE SHADOW INTEGRATION BOARD
TUESDAY 23RD SEPTEMBER, 2014
EAST AYRSHIRE RESHAPING CARE FOR OLDER PEOPLE
REPORT BY: DIRECTOR HEALTH AND SOCIAL CARE

PURPOSE OF THE REPORT
1. The purpose of report is to provide the Shadow Integration Board with an update in relation to the progress in respect of the Reshaping Care for Older People Programme and the associated Change Fund.

BACKGROUND
2. As the SIB are aware, the demography of East Ayrshire will change significantly over the next 25 years. This will see an increase of 11% in the number of people over 75 from 2010 to 2015. Looking further ahead the number of people in this age group will have increased by 81% by 2035 with a particular spike between 2020 and 2025 where there will be a 25% increase within this period alone.

Projected population, by age group, in East Ayrshire, 2010-2035

<table>
<thead>
<tr>
<th>Age group</th>
<th>Base year 2010</th>
<th>Projected years 2015-2035</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>21,134</td>
<td>21,177 21,580 21,538 21,026 20,221</td>
</tr>
<tr>
<td>16-29</td>
<td>20,657</td>
<td>20,755 18,989 17,721 17,876 18,281</td>
</tr>
<tr>
<td>30-49</td>
<td>32,803</td>
<td>30,095 28,615 28,800 29,001 28,492</td>
</tr>
<tr>
<td>50-64</td>
<td>24,489</td>
<td>25,239 26,827 25,927 22,868 20,429</td>
</tr>
<tr>
<td>65-74</td>
<td>11,775</td>
<td>13,594 14,116 14,127 15,752 16,664</td>
</tr>
<tr>
<td>75+</td>
<td>9,382</td>
<td>10,404 11,751 14,095 15,412 16,992</td>
</tr>
<tr>
<td>75+ % Inc</td>
<td></td>
<td>11% 25% 50% 64% 81%</td>
</tr>
<tr>
<td>All ages</td>
<td>120,240</td>
<td>121,264 121,878 122,208 121,935 121,079</td>
</tr>
</tbody>
</table>

3. In recognition of the importance placed on inclusion of older people as active citizens in our communities and the inevitability of increased resource demands from all ageing population, the East Ayrshire Partnership is progressing in the development of the Reshaping Care for Older People Programme and associated Change Fund agenda. This work will be supported by the development of a 10 year joint commissioning plan for older people as required by Scottish Government, which includes plans for the reshaping of mainstream services and use of Integrated Care Fund to demonstrate long term, strategic and sustainable change.
4. The Reshaping Care for Older People Programme has agreed a Ten Year Vision for Joint Services - Reshaping Care for Older People.

5. *Older people in Ayrshire enjoy full and positive lives within their own communities.*

6. This vision fully supports how we work together, as partners, to deliver services to improve outcomes for older people.

7. Both the Third Sector Interface and the Independent Sector are fully integrated within partnership structures in order to ensure full engagement in the reshaping care programme as it develops.

8. The East Ayrshire Partnership has been shifting resource as part of a re-alignment of our wider systems, particularly in relation to telecare, care and repair services and delivery of home care. In 2012/13 the East Ayrshire Partnership also received £147,000 of resource transfer monies from the closure of NHS long stay elderly mental health beds and these monies have been used to mainstream our mobile alarm teams in the South of the authority. Further recurring partnership resources of approximately £300,000 will become available in 2015/16 to support the sustainability of this work within the partnership.

9. The Change Fund was established in 2011 as ‘bridging finance’ to support the development of the Reshaping Care Programme. The four years of the Change Fund has allowed partners from NHS, Council, Third and Independent Sectors to work together with this additional investment to allow new approaches and services to be established and to support longer change processes to take place, with a focus on shifting to prevention and anticipatory care approaches.

10. The Change Fund represents 1 per cent of the overall annual spend on older people, and has provided the following resources over the last 4 years, to allow the testing of new service models, working across wider partnerships with our Third and Independent Sector Colleagues to improve outcomes for older people:

- Year 1 2011/12 - £1.64 million
- Year 2 2012/13 - £1.88 million
- Year 3 2013/14 - £1.88 million
- Year 4 2014/15 - £1.64 million

11. Locally the Reshaping Care for Older People Programme was split into the following work streams to describe the ambition to move resource across the total spend for Older Peoples Services towards a more preventative approach:

- Promotion of Community Wellbeing
- Sustaining Independence/Self Management
- Integrated Rehabilitation/Enablement Services
- Intensive Supports

12. Partners have also contributed directly to support Reshaping Care for Older People priorities, with East Ayrshire Council providing an additional £470,000 and the NHS contributing £60,000 to further support Carers Information Services on an annual basis.
CHANGE FUND COMMISSIONING STRATEGY FOR INVESTMENT PRIORITIES

WORKSTREAM ONE - PROMOTION OF COMMUNITY WELLBEING, INCLUDING UNIVERSAL SERVICES

13. This approach is founded upon community development and asset based principles in recognition that the majority of older people do not receive or require direct health or social care services. This work has largely been undertaken by third sector partners. The types of projects and initiatives that have received funding have included:

- Basic sector leadership and community development capacity
- Activities including buddying supports
- Training activity such as Falls Prevention
- Skills development – through developing seniors groups
- Befriending projects
- Advocacy
- Carers support
- Wider volunteering projects – eg gardening support
- Small grants schemes
- Community transport schemes
- Feet First project
- Inter-generational work
- Information and sign-posting activity
- Community directories
- and representative support
- Community events
- Care and repair
- Sheltered Housing support programmes

14. This funding has been a catalyst to support much more profound partnership arrangements with third sector organisations. The third sector is now well-established and valued contributors within strategic and operational planning contexts. This has been supported through the funding of a post working with third sector organisations to support project development. This workstream includes working with community planning partners to participate in an inclusive, preventative approach across the partnership.

15. As part of the council transformation strategy, integrated transport solutions have been developed, alongside models for community transport. This will support the preventative care agenda, is provided through the third sector.

16. This work has been prioritised by the partnership to continue to receive funding and will be important to develop this approach to all adult care groups through our Integrated Care Fund.
WORKSTREAM TWO - SUSTAINING INDEPENDENCE AND PROMOTING SELF MANAGEMENT (IN HOMELY SETTINGS)

17. When older people require support we are developing our services to make this available through models which are personalised to promote independence and are planned and delivered respecting the views of and with full participation of individuals. This includes:
   - Community based clinical pharmacy support, and training for unpaid carers
   - Additional telehealthcare capacity, including equipment and home-based monitoring
   - Dementia Strategy Training Officer to work across all partners
   - Ayrshire wide Falls lead post to develop integrated prevention and management services, with support for multi-agency training and referral pathways
   - Community Capacity Training & Equipment (links with Falls and dementia)
   - Additional social work support for GP practices
   - Development of out of hours district nursing support
   - Allied Health Professionals redesign work

18. This work has been particularly beneficial in the areas below:
   - The introduction of the national Chronic Medicine Service by our local pharmacists will also support the sustainability of support to paid and unpaid carers in the longer term
   - In 2014/15 our Allied Health professionals and the ICES team are continuing to assess the changes required to disinvest in traditional models to deliver greater community capacity, which can be sustained through an integrated Single Point of Contact.
   - Supporting the development of an integrated falls prevention and management pathway, through our Invigor8 programme, and integrated falls assessments provided through our integrated ICES team
   - Over 800 staff across the partnership have been trained in Promoting Excellence in dementia. This has supported sustainable best practice in relation to dementia services throughout the partnership.
   - Development of our Out of Hours District Nursing service which works directly with ADOC, Out of Hours Social Work, community alarm response services and Accident and Emergency to prevent admission and support discharge.

19. The areas highlighted above will remain a priority for the partnership as we continue to establish our approaches to support individuals to self manage their own health. This will include further work around anticipatory care planning and technology enabled care, particularly in the areas of:
   - expansion of home health monitoring;
   - supporting people with dementia to remain at home;
   - extending the use of NHS video conferencing facilities to other partners,
   - continuing to grow the numbers of people receiving telecare packages;
   - to shift from analogue to digital platforms, to enable direct access to information, advice and assistance.
20. The East Ayrshire Partnership is well advanced in this area, with work being undertaken in Dalmellington, supporting individuals with Chronic Obstructive Pulmonary Disease to use telehealth equipment to self manage their condition. This work has been acclaimed nationally as best practice.

WORKSTREAM THREE – INTEGRATED REHABILITATION AND ENABLEMENT SERVICES

21. The partnership has established a multi-agency hub at Kirklandside, which supports the co-location of a wide range of community health and social care staff and encourages a single, co-ordinated approach to service delivery. In addition there is a smaller hub established within East Ayrshire Community hospital.

22. The hub at Kirklandside includes:

- Out of hours mobile home care services,
- Reablement service for older people
- Income maximisation
- Integrated Care and Enablement Services
- Community District Nursing
- Social Work and home care staff
- Allied Health Professionals
- Dementia Liaison Nurses to support care homes
- Community pharmacy support for hubs, including medication reviews
- Falls Management Technician
- Community ward with dedicated clinical team

23. Using the opportunities presented by co-location of staff, the partnership continues to develop:

- Close working relationships with individual GP practices to support integrated case/care management approaches, anticipatory care planning and multi-disciplinary team working through additional staff supports, particularly with social work
- Improved integration and effective working between day time and out of hours health and social care services
- Clear links between out of hours services and ambulance services
- The ability to provide our care homes to with specialist support in terms of dealing with more complex individuals with dementia, preventing hospital admission.

24. There have been changes in the spend profile in East Ayrshire Partnership over the last 3 years with the transfer of Rapid Response services from the acute services to community based approaches, integrating with East Ayrshire Council Home From Hospital team, in the development of a new Intermediate Care and Enablement Service (ICES). This has been further supported through the co-location of district nursing services, mobile alarm teams, and community ward.

25. This work will continue to be a priority for the partnership as we develop locality based service hubs, which include integrated Single Point of Access to Intermediate Care services across our adult population groups.
WORKSTREAM FOUR – INTENSIVE SUPPORTS

26. 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 Care and Health professionals. To support this we are developing arrangements that will link specifically with the Hubs, and provide the shift of specialist secondary care services to communities. This includes:

- Multi-agency team approach to work with care homes to develop and continue good working practice. This includes social workers, district nurses, AHPs, and pharmacists.
- Provision of specialty services in the community (e.g. COPD), through consultant support to GP practice multi-disciplinary teams
- Review and further development of specialist pathways into and out of secondary care settings
- Providing 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 officer post providing liaison with independent sector and the partnership

27. The provision of specialist consultant support to GP practice multi-disciplinary teams has supported a reduction in the number of emergency admissions and it is hoped that this work can be considered within consultant contracts in the longer terms to sustain this model.

28. The support officer post provided through Scottish care to support partnership working works directly with Care homes to support project development, including the development of My Home Life programme which has provided training to staff working within care homes across East Ayrshire.

29. This area of work will continue to be a priority for the partnership as we continue to develop relationships with secondary care and review alternatives to hospital admission and the challenge of future delayed discharge targets.

NEXT STEPS

30. As outlined above, the opportunity created through the additional change fund investment has supported the partnership to build and develop approaches which require to be sustained and extended to include our adult population groups, as we develop our partnership services across East Ayrshire.

31. This approach supports and is evident within the recommendations outlined in the guidance relating to the integrated care fund:

- Care planning and consultations that help people to have control over their conditions, care and support and to achieve their personal outcomes
- Integrated care and support that builds on community assets and promotes independence, wellbeing and resilience
- Whole system pathways that are designed around people with multiple conditions and aim to reduce health inequalities
- Visible adaptive leadership and a coherent research, innovation and improvement infrastructure that drives excellence in Integrated Care for Multimorbidity
32. This approach also supports the national and local performance frameworks which highlight priority areas for the partnership around the prevention of avoidable hospital admissions and the prevention of delayed discharges.

33. Through these approaches, the partnership will focus on personal outcomes; supporting health literacy; adopting a co-production approach; using technology to enable greater choice and control; and adopting an assets-based societal model to improve population health and wellbeing. The third sector has a crucial role to play in supporting this approach and in promoting self management and self directed support.

34. The Reshaping Care Executive group are continuing discussions with key leads across partnership services in relation to the next steps.

35. As a result, partnership leads have agreed to focus on the development of a whole systems approach to this work, which will include the key steps outlined below:
   - the legacy of the change fund approaches and models
   - the rapid needs assessments provided by public health
   - the development and use of the integration fund
   - the opportunity for service review and redesign as integration develops
   - locality based needs assessments and planning
   - joint strategic commissioning

36. A contractual review is currently underway across the NHS/LA in relation to staff employed through the Change Fund. This work is ongoing with both organisations finance and HR officers.

37. From April 2015, the additional investment available to the partnership to continue new approaches to be established and to support longer term change processes to be developed is:

<table>
<thead>
<tr>
<th>Partnership Resource (recurring)</th>
<th>£770,0000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care Fund 2015/16 (non - recurring)</td>
<td>£2,470,000</td>
</tr>
<tr>
<td></td>
<td>£3,240,000</td>
</tr>
</tbody>
</table>

38. A report will be brought to the SIB in November, which will include the draft submission for the use of the Integrated Care Fund.

39. It is proposed that this report will describe the approach outlined above, the developed financial position in relation to the use of the additional resource, and will describe the models developed through change fund which will be further developed to support and sustain whole system change.

RECOMMENDATIONS

40. Members of the Shadow Integration Board are requested to:
   (i) note the progress in relation to the Reshaping Care Programme and the associated Change Fund
   (ii) agree the approach laid out at paragraph 35
   (iii) note the additional investment available in April 2015, paragraph 37
   (iv) agree to receive a further report and draft Integrated Care Fund Plan at the November SIB meeting
Eddie Fraser  
Director of Health and Social Care  
18 September 2014

For background information please contact:

Shiona Johnston  
Partnership Facilitator  
01563 575404