Appendix 1

Integrated Care Fund Plan Template

PARTNERSHIP DETAILS

Partnership name:	Midlothian Partnership
Contact name(s): See note 1	Eibhlin McHugh
Contact telephone	0131
Email:	eibhlin.mchugh@midlothian.gov.uk
Date of Completion:	1 December 2014

The plan meets the six principles described on pages 2 and 3 (Please tick √):

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

The Midlothian Partnership has made significant progress in reshaping care for older people and will seek to build upon this in delivering improved outcomes for adults across health and social care. In considering the work achieved to date, we are very much aware that the impact of unscheduled care and the acute hospitals capacity to deliver high quality, targeted and timeous services depends upon community services avoiding inappropriate or avoidable admissions and ensuring the fastest possible discharge.

Likewise the effectiveness of community services depends upon good quality and timeous information from hospital staff. Any impediment to smooth working of the hospital has a direct impact on people from Midlothian who require acute hospital care.

Midlothian Partnership has a shared interest with the acute sector in maximising the efficiency of the hospital systems. In particular, we recognise that delayed discharge, even for a day, is in no-one's interests and that while we have consistently met our discharge target in recent years, we should all be working towards the complete elimination of delays in hospital. Furthermore, in looking upstream in the patient pathway, we are also keen to ensure there are a range of interventions which avoid unplanned admissions and A&E attendances.

There are three main strands to the work being delivered within Midlothian:

- Admission Prevention
- Facilitating Early Discharge
- Intermediate Care

We recognise that there is no silver bullet to solving the challenge of reducing unscheduled care but rather a range of evidenced based interventions which have an accumulative effect of ensuring people can be cared for in their own home or community setting.

In recent years we have been paying increasing attention to addressing social isolation of older people. The impact of isolation on physical and mental wellbeing and the consequent increased risk of admission to both hospital and care homes has been well demonstrated. The Change Fund has enabled the development of community services to increase social opportunities thereby reducing the risk of ill- health as well as supporting recovery following a period of hospitalisation. We are in no doubt that for long term sustainability of health and care services combating social isolation must be a key component of our strategy.

Balance of Care Initiatives

There are a range of actions going on locally to support the broader shift in the balance of care through increased capacity in primary and community care services.

- Telehealth Strategy and Mobile Technology

Telecare already supports 1,900 people in Midlothian providing the mechanism for early warning of problems and enabling early intervention.

- Direct Support to Care Homes

Through Change Fund monies a dedicated nursing advisor post has provided support and advice to independent care homes, in part to reduce the need for hospital admissions

- Enhanced Rapid Response Service

The enhanced service is being combined with the extension of working hours in the evenings and weekends when a higher proportion of hospital admissions take place

- Falls Prevention and Support

This service now provides an immediate response to 90 falls per month thereby reducing admissions to hospital

- Midlothian Community Hospital

Initial exploration for opportunities to shift care from Liberton to MCH and increased outpatient clinics to improve local access for key specialties

- Hospital In-Reach

Through the Change Fund a small team, including a Carers' Support Worker, has been in place for the past two years helping to pull people out of hospital.

- Intermediate care beds at Highbank

Five beds were made available in Highbank Care Home over the winter period to enable early discharge form hospital where a return home was not immediately possible

- Support for people with dementia

Development of a specialist dementia service involving senior staff across health and social care

- Social isolation

Local Area Co-ordination and Buddy Schemes in partnership with the Red Cross and VOCAL is supporting work around social isolation and also enabling easier discharge from hospital for those requiring low-level support.

- Care at Home Capacity

The care at home service is subject to a retendering process and budgetary allowances have been made to ensure the new providers give priority to staff retention.

- Complex Care

The Council has recently approved capital funding of £3million for the provision of purpose-built accommodation for adults with complex needs and learning disabilities. This will increase our overall capacity to reduce the incidence of delayed discharge for complex coded patients.

Integrated Care Fund

In building on the work noted above, and following rigorous review and evaluation of Change Fund investments, we have identified a range of activities, interventions and service developments that will support the delivery of integrated health and wellbeing outcomes for adult health and social care. Whilst the focus of the ICF is on all adults, we also need to be aware that those over-65 still require dedicated support and services to enable them to live as independently as possible. There are clear links to the wider work designed to tackle health inequalities within Community Planning Partnerships, with a strong emphasis on preventing illness, disability and injury and staying healthy as well as supporting self-management. These build on the existing priorities of prevention, capacity building and localised access as set out in the Joint Health Improvement Plan.

The direction of work within the ICF is firmly embedded in the pathway work that is being taken forward by NHS Lothian, with clear alignment to both 'Hannah' and 'Scott', which recognises the need to take a person-centred approach to the delivery of care. In Midlothian, we are keen to further explore the House of Care model, using a whole-system approach to improve outcomes, with particular focus on enabling engaged, informed patients/service users to support personalised care planning.

The following sets out the context and direction for the Integrated Care Fund investment and highlights where the funding is being directed:

Supporting Self-Management and Lifestyle Management

A recurring theme from the community engagement work was help for supporting people to manage their own conditions better. Whilst we recognise this as an important issue, we also need to recognise that this requires people to have the capacity, resilience and skills in order to do this effectively. In using an assets-based approach, there will be further work done through an increased focus on lifestyle management, using the model developed by the Thistle Foundation and currently being delivered by Occupational Therapists in Midlothian through 'Living Life to the Full'. A further 2 Occupational Therapists will be employed to take forward this programme on a locality basis, aimed at those aged under 65 years with a long-term condition in order to support their self-management. This work will place the person at the centre, working with them to draw upon their own assets, including themselves, family & carers and the wider community.

We also know from the evidence that case management and care co-ordination have a key role to play in reducing unplanned admissions and the recent GP access survey results suggest that care co-ordination in Midlothian could be improved. In response, 2 Public Health Practitioner posts will be created to take on the co-ordination of care across all sectors as well as undertaking a case management role. To achieve greatest impact, these posts will be focused on areas of multiple deprivation in Midlothian, where we know there is most need. This will ensure closer working with primary care and local pharmacists to explore ways of working more effectively with those with co-morbidity. A key initial focus will be on COPD, given the high incidence of this within Midlothian. We will build on a previous small pilot by Newbattle Medical Practice, who contacted all those aged between 55 and 75 to come for COPD screening. This approach identified an increased number of patients with COPD but also managed to signpost them in the direction for help, including increasing access to smoking cessation. This will be rolled out across all GP Practices in Midlothian during 2015/16.

Investments:
COPD Screening Primary Care - £15,000
Public Health Practitioner posts - £80,000
Care Co-ordination Resources - £11,500
Lifestyle Management – OT posts - £70,000

Addressing social isolation
In discussion with health and social care professionals and third sector partners, social isolation remains a key issue and not just for older people. It is clear that people with mental health issues and/or substance misuse can feel isolated from their community, with limited or no peer support networks available. It is proposed to build on success of the Local Area Co-ordination model already in place in Midlothian to expand the services to include those under 65 with multi-morbidity. There is already a well-established LAC provision for people with a learning and/or physical disability as part of core investment, which will connect to wider LAC network. This work will be taken forward in partnership with British Red Cross, Volunteer Centre and Midlothian Voluntary Action. A key emphasis will be on developing peer networks and small grants will be made available to local groups to support some of this work as well as investment in full-time members of staff from the third sector to act as a catalysts and connector across localities.

The role of carers has consistently been at the forefront of work in Midlothian, with established partnerships with VOCAL and Alzheimer Scotland. This will continue through the ICF and we would seek to build on the local work undertaken across Midlothian through day centres and with ongoing emphasis on carers who are supporting someone with dementia. The model of care we aspire is to support those with dementia in their own home or community setting, which will require increased support for carers and families. This work will link closely to the Dementia Demonstrator Project in Midlothian and the developments we are taking forward as part of the 8 Pillars Work in partnership with Alzheimer Scotland.

Investments:
Red Cross Buddy Scheme - £60,000
LAC Service – Red Cross Community - £60,000
Volunteer Co-ordinator – Volunteer Centre - £34,000
Peer Network Grants – MVA - £20,000
Day Centre Support - £61,000
Dementia Link Worker – Alzheimer Scotland - £36,000
Dementia LAC – Volunteer Centre - £26,000

Early Intervention and Prevention
In working with people to manage their own conditions, we also need to consider what more can be done to avoid or at least reduce the impact earlier in the patient pathway. To take this forward, the plan is to build on the Football Fans model used successfully with professional football teams and to work with local amateur teams in Midlothian, many of whom have strong connections to the local community but who also have fans of a similar health and age demographic as the professional. In using this model, we will seek to address the health behaviours whilst also training the coaches to ensure a legacy and sustainability to the approach. This will form part of wider work in looking at diet, diabetes and exercise, supported by additional investment in Midlothian Active Choices and Ageing Well, all of which have linked to the wider work around reducing Falls.

In taking a pathway approach with orthopaedic rehabilitation, through a piece of work undertaken as part of the AHP National Delivery Plan, we have identified an opportunity to test out a 'discharge to assess' model for patients within acute hospital requiring rehabilitation. It is proposed to pilot a model which would allow patients to be discharge directly from acute setting to home, where there orthopaedic rehabilitation would then be delivered. This will avoid a further move in the hospital and will allow patients to begin their recovery within familiar settings, further aiding their recovery – this earlier discharge will also reduce length of stay and may also reduce the level of ongoing care required.

Investments:
Dietetics weight management - £25,000
Midlothian Active Choices and Ageing Well - £51,000
Falls Prevention - £9,000
Discharge to Assess Model - £35,000

Technology Enabled Care
We have also taken the opportunity to connect our activities outlined in the ICF Plan to the recent application to the Technology Enabled Care fund, with an emphasis on self-management and greater use of technology to support localities and communities. This will build on the established telehealthcare arrangements in place within Midlothian, which would be continued through the ICF as it presents opportunities to look at a different client group who would benefit from telehealthcare.

Investments:
Telehealthcare Delivery team - £93,000
Teleheathcare Strategy Officer - £30,000

Supporting Early Discharge and Intermediate Care
Whilst many of the activities noted above are directly aimed at supporting those with long-term conditions and co-morbidity, we have also recognised the need to ensure that we continue to do work on admission prevention, supporting early discharge and having intermediate care in place to support rehabilitation and assessment. The current model of dedicated hospital in-reach staff has been very much welcomed by the acute hospitals and has been a key factor in the Midlothian Partnership achieving 0 delays over 2 weeks at Census over the previous 2 months.

This will be further augmented by establishing a single point of contact through which hospital discharges will be co-ordinated in Midlothian in order to further reduce occupied beds days. However, we also know we need to do more in terms of patients requiring guardianship and this will be a focus for the Partnership over the coming months. A further development will be to create an additional 7 beds within Highbank to allow for an increase in assessment and rehabilitation within a community setting and staffing associated for this will be funded through the ICF.

Investments:
Hospital in-reach service (Council & VOCAL) - £161,000
Intermediate Care Team Leader - £48,000
Assessment & Step-Down Beds - £275,000
Increased assessment and rehabilitation staff - £79,000
24 Hour Falls Response Service - £39,000

Working with the Independent Sector

The role of the independent sector is important for the Partnership in delivering its outcomes for our population. There is currently a process underway to retender the care at home contracts, with increased emphasis being placed on staff training, support and supervision to address issues of staff retention as we are very aware of the value of continuity of carer by those using the service. We have also embarked on an extensive programme of work with care homes, which has included funding video conferencing facilities to aid training and support as well as dedicated input from an experienced nurse to the care homes. There is still work to be done and through support of the independent care home providers, we will look to build on this over the coming year, with a focus on working with them to support residents with more challenging and complex behaviours. A further area of development has been with our extra care housing, working with the local housing associations to look at what more can be done to allow people to remain supported in their own tenancy.

Investments:
Care Home Nurse Advisor - £54,000
Extra Care Housing - £48,000
Medication Management - £19,500

Strategic Alignment in Midlothian

The main focus of the activity noted above will deliver improved outcomes in-year and lay the foundations for future work to be driven through Strategic Commissioning however there is also a need to be mindful of the change that can be delivered within a limited timeframe. In terms of the long term sustainability of investments, the ICF will allow us to adopt a test of change concept to look at effective ways of supporting those with multi-morbidity in order to reduce future demand on services at point of crisis or medical intervention. This approach will identify areas for future investment and will need to be driven by a shift in resource from secondary to community care to ensure sustainability going forward. There has been previous success in using external investment such as the Change Fund to leverage resources from elsewhere and this will be continued through the Integrated Care Fund. This will include alignment with possible funding from Transforming Care After Treatment, the House of Care pilot with Scottish Government and Thistle Foundation

The ICF has built on the locality model, recognising the important contribution of local assets including volunteers and existing community networks. The development of the Strategic Commissioning Plan has been supported by data and evidence from Public Health in NHS Lothian. This information has been used to direct and guide how resources will be focused through the ICF on the areas of greatest need in Midlothian. Whilst the areas of multiple deprivation are well known within Midlothian, we are also aware that given the relatively small population groups within the local towns, pockets of deprivation can be overlooked. The data tells us that compared to other parts of Lothian, Midlothian has the lowest number of people living in the least deprived SIMD quintiles as a proportion of local population. In terms of localities, the approach in Midlothian has been to split the area in to East and West for the purpose of forming clusters for primary and community care services and this will be further tested through the development of the Strategic Commissioning Plan and deliver of the Integrated Care Fund Plan.

The production of the Strategic Commissioning Plan and Integrated Care Fund Plan has built on the principles of co-production in the design and delivery of new ways of working, with consultation and engagement with communities, community groups, staff and third sector partners.

The key issues identified from engagement with the public were:

- Reducing isolation – peer support
- Being able to manage conditions better
- Knowing where to go for support
- Holistic, co-ordinated, person-centred care
- Local access to services
- Follow-up care for people with long-term conditions
- More support for neurological conditions

There was also strong emphasis amongst third sector partners on the value of supporting peer networks, reducing social isolation, building community capacity and recognising the benefit of having small amounts of funding available to support community action.

Performance Reporting

There is an already established reporting mechanism in place related to the Reshaping Care for Older People Change Fund and this will be used and developed to enable the Partnership to produce a progress report for local and national publication in mid-2016. In terms of governance, it is proposed that the emerging Strategic Commissioning Group will take on this role for overseeing the delivery of the Integrated Care Fund Plan, with clear reporting mechanisms to the Integrated Joint Board, Community Planning Partnership, NHS Lothian and Midlothian Council.

Whilst there will be emphasis placed on using agreed existing measures to demonstrate progress, such as reducing emergency and unplanned admissions, delayed discharge, occupied bed days, etc. we are also keen to explore more person-centred measures and self-reported measures of progress. This will be taken forward over the coming months to establish appropriate mechanisms for capturing this data and we are working with ISD Scotland on this development. Through this work, we will also seek to make more effective use of the Integrated Resource Framework to show investment and impact across health and social care. We are building on a fairly advanced model of using personal outcome approaches in Midlothian and have further developed CARE measures through our Occupational Therapy practitioners to better capture progress in terms of self-reported outcomes through self-management. These will form the basis of the performance reporting mechanisms for the Integrated Care Fund and will then be used to take forward the Strategic Commissioning Plan.

Future Direction

The activities and workstreams within the Midlothian ICF Plan will support delivery of the aim for 2020 that all adults with multiple conditions are supported to live well and experience seamless care from the right person when they need it and, where possible, where they want it. This builds on the future direction of care in Midlothian through the drive to redesign local services, such as Midlothian Community Hospital, to be more responsive to meet local needs through the provision of increased access to diagnostics, rapid access clinics and therapy services.

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

…….

(name) for the Shadow Joint Board, or for a lead agency,

…….. or …….

(name) for the NHS Board (name) for the Council

…… ……..

(name) for the third sector (name) for the independent sector

When completed and signed, please return to:

Kelly Martin
2ER, St Andrew's House
Regent Road
EDINBURGH
EH1 3DG

Kelly.Martin@Scotland.gsi.gov.uk

Templates should be returned by **12th December 2014**.