Reshaping Care for Older People

Change Fund

Progress Report

November 2013
Setting the Context: Reshaping Care in Scotland

In 2010/11, approximately £4.4 billion of public funding was spent in Scotland on health and social care for people over 65 years. Well over half of this was spent on care in hospitals and care homes, often towards the end of life. Yet 89.5% of older people use universal services and are ‘outside’ the formal care system. Just a marginal shift in this percentage has a huge impact on demand and finances. Helping older people to remain active and independent is good for older people and for the public purse, and is at the heart of our approach to Reshaping Care.

Reshaping Care for Older People: A Programme for Change 2011 – 2021 (RCOP) describes our shared vision of care and support and how this will be delivered. Co-produced with political, organisational and community interests, the aim is an ambitious shift towards care at home and in community settings supported by greater investment in preventative and coordinated care and support and the use of technology to empower greater choice and control.

At just over 2 years into the programme we are already seeing progress:

- We know that the Manifesto Commitment of at least 20% of the Change Fund being used to provide both direct and indirect support for carers is either being met or exceeded across the country. This includes provision of carer’s assessments, opportunities for short breaks, information and advice, training, income maximisation and advocacy;
- 80% of people receiving support at home now benefit from telecare;
- Bed days in hospital for people aged 75+ following an emergency admission are down by 10.7% from 2009/10 to 2012/13;
- The number of beds used on average by people aged 65+ is around 1000 less than the ‘expected’ number had the age related rate at 2008/09 continued in line with the ageing profile of Scotland’s population;
- In 2011 there were around 6,500 fewer residents in care homes than projected based on demographic trends;
- Delays in discharge from hospital are at an all-time low.

This progress report presents examples of local impact and our analysis of the 2013/14 mid year reports submitted by all 32 partnerships. While we know we need to go further and faster, we are encouraged by these tangible shifts and by the evidence of local innovation with plans for spread. We are also pleased to see Scotland’s progress acknowledged by the European Commission’s Innovation Partnership on Active and Healthy Ageing and by The Kings Fund in their recent publication on Integrated Care:

“The impact of policies pursued in Scotland is evident in changes outlined...on emergency bed day use and delayed transfers, increased use of home care, and lower than projected use of care homes. The extent to which these changes can be attributed to initiatives related to integrated care remains uncertain but they do indicate that benefits are being realised.”

1 Integrated care in Northern Ireland, Scotland and Wales: Lessons for England, Professor Chris Ham, Chief Executive, The Kings Fund July 2013
Section 1: Setting the Context

**The Change Fund: Driving Delivery**

RCOP is a ten year programme that seeks not only to shift the location of care (from institution to community) but also to transform the culture and philosophy of care from reactive services provided to people towards preventative, anticipatory and coordinated care and support at home delivered with people.

The Reshaping Care Change Fund provides additional resources and capacity to support local partnerships to make progress on the policy goals and outcomes: to enable older people to remain independent and able to live at home or in a community setting, and amounts to 60% of the Scottish Government’s preventative spend funding (£300 million of the £500 million preventative spend budget).

With £70 million allocated in 2011/12 and a further £80 million per annum allocated in 2012/13 and in 2013/14, the Change Fund investment totals £230 million to date.

However the Change Fund should not be seen as an end in itself. It is a catalyst to enable partnerships to accelerate local progress and to develop plans to drive sustainable improvement in the national outcomes that relate to care of older people.

**The change fund has allowed innovative projects to be developed to address potential gaps and requests from our citizens in developing and shaping services for the future.**

Midlothian partnership

**The provision of “un-badged” funds is immensely useful to allow redesign and testing of innovations.**

Highland Partnership

RCOP and the Change Fund have helped to refocus and invigorate partnership working, including the contribution of the housing, third and independent Sectors in working with statutory services to redesign and transform care and support – an important step in the critical path towards health and social care integration.

**The Change Fund is the best thing that has happened with regard to the Third Sector and partnership working. We are now seen as a major player with regard to service delivery and also form an integral part of co-production.**

*I have also seen how the change fund has strengthened the partnership between the local authority and health board and paved the way for the health and social care integration agenda.*

Marie Oliver
CEO, Voluntary Action South Ayrshire

Sustainable change requires the longer term transformation and integrated working that will be enabled by Joint Strategic Commissioning, integrated resourcing and through continued improvement support for the integration of health and social care.
Supporting innovation and improvement

The JIT operates primarily at the middle step of the 3-step Improvement Framework for Scotland’s public services: working with partnerships to create the conditions for implementing national strategies and to deliver and sustain improved outcomes from health, social care and housing services.

This is achieved by the JIT having a clear line of sight from national policy and strategy to local delivery and improvement activity through a JIT Lead affiliated with each of the 32 health, social care and housing partnerships.

The Improvement and Support Group (ISG) is a collaboration led by the JIT with a wide range of national partners to ensure best value from our collective improvement capacity and capability (Annex 1). The group includes service delivery partners from all sectors and aims to ensure a coordinated and collaborative approach to leadership, innovation and improvement support for Reshaping Care and Integration.

The ISG reports to the Health and Community Care Delivery Group and to the recently established Joint Improvement Partnership Board which comprises senior executive representatives of Scottish Government, COSLA and NHSScotland, and executive representatives from the Independent Sector, the Third Sector and the housing sector. These robust cross sector governance arrangements support and challenge maximum impact from the Change Fund.

IMPROVEMENT NETWORK

The ISG provides oversight of the Reshaping Care and Integration Improvement Network. This Network facilitates cross-sector collaborative learning through themed learning sessions, benchmarking of data and use of the full range of improvement tools that are required to support and challenge adaptive change in a complex system. The Network, along with direct support from JIT leads, helps local Partnerships test and spread interventions, approaches or actions which collectively improve outcomes for older people.

These are set out as four ‘bundles’ aligned to the four pillars of the RCOP pathway and the related enablers (Annex 2).

The RCOP pathway was co-produced by the JIT and the Long Term Conditions Collaborative in 2009/10, working with NHS Boards and their partners. It was informed by the international evidence base for the Chronic Care model and by the High Impact Changes and actions in Scotland’s National Action Plan for Long Term Conditions. The interventions are highly interdependent reflecting the reality of complex whole system improvement. Thus partnerships need to make progress in all elements of the four ‘bundles’ to realise benefits across the whole system, rather than focussing on one ‘bundle’ alone.

2 For more info, see: http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/reshaping-care-improvement-network/
INTRODUCTION: REFLECTING ON PROGRESS

In this third year of the Change Fund, the focus has shifted from creating the conditions and testing and evaluating local improvements towards understanding and spreading what works and planning for sustainable change. The JIT had previously developed, and tested with some partnerships, a self-assessment tool to reflect on the extent to which specific improvements have been spread.

At the midpoint of the Reshaping Care Change Fund, the ISG agreed it would be useful to ask all partnerships to complete a self assessment as a prompt to consider where, and when, further gains may be anticipated. This would also contribute to the local analysis that partnerships are undertaking as part of their Joint Strategic Commissioning development programme.

The JIT, acting on behalf of the national partners, invited all partnerships to submit a summary of local progress by the end of September 2013. The main purpose was 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. Thus each partnership was asked to describe the learning from at least one initiative that they had taken forward under each pillar of the RCOP pathway and to describe the achieved or anticipated outcomes.

As the Change Fund has been an opportunity to explore innovations that are ‘Proof of Concept’ or ‘Tests of Change’, partnerships were invited to describe any learning from initiatives where barriers to progress had been encountered or where it had been agreed to discontinue funding.

It is essential that the national partners have clear, up-to-date, information on local Partnerships’ use of the Change Fund and its contribution towards the long term goals and outcomes of Reshaping Care. Therefore partnerships were once again asked to confirm their Change Fund investment against the four pillars of the RCOP pathway to track the progressive shift in focus and investment towards preventative and anticipatory care in the community.

Using an agreed template, Partnerships provided:

- Up to 5 examples of advances made locally, including an example of impact on carers;
- Self assessment of spread of key interventions and approaches
- Learning on use of data for option appraisal and investment decisions;
- A financial summary of investment by Reshaping Care Pathway
- Areas for future improvement support

This report presents an analysis of the 2013/14 mid-year reports submitted by all 32 Partnerships. This is presented as an improvement resource for use by all partners.

We will use this additional insight to understand what is working well, to share learning about successful innovations that require further support for spread, and to inform continuing national improvement support for Reshaping Care and integration.
EXAMPLES OF LOCAL IMPACT

Partnerships were asked to describe the learning from at least one initiative that they have taken forward under each pillar of the RCOP pathway. At least one of the case studies was expected to highlight either a direct or an indirect impact on carers.

Two hundred and thirty four examples were submitted and some partnerships provided additional publications which describe work which has been initiated through the Reshaping Care Programme and supported by the Change Fund.

Many examples are initiatives which have been tested, found to provide benefits and are now embedded in practice. Others describe recent initiatives that are yet to be fully evaluated but are already starting to show benefits.

Annex 3 illustrates examples of local improvement across the RCOP pathway.

These provide valuable insight into how local partnerships have deployed their Change Fund to make a difference to the lives of older people and their carers across Scotland.

Themes from the Examples of Local Impact

Preventative approaches are reflected across many of the pillars of the RCOP pathway and are not confined to the preventative and anticipatory care pillar.

There is a broad range of examples across the RCOP pathway and within each of its pillars, with many innovative solutions built from identifying local needs using local assets. There are also a significant number of examples which describe local implementation of national strategies, frameworks and approaches such as Scotland’s National Dementia Strategy, reablement and anticipatory care approaches, coproduction, ‘Up and About: a whole system pathway for the prevention and management of falls and fractures’ and polypharmacy reviews.

Partnerships are beginning to ‘join up’ interventions within a locality to amplify their impact.

The Angus Medicine for the Elderly Model (MFE) combines local solutions such as the Angus MFE led Acute Medical Unit liaison and the Angus Ortho geriatric pathway with national initiatives such as GP based Polypharmacy review clinics and a Care Home Support service to support creation of Anticipatory Care Plans.

Local Change Fund investment has built capacity within the Third and Independent sectors to support them to engage in Reshaping Care and deliver support.

Many examples describe the Third sector contribution across the spectrum of working with local communities to identify needs and solutions to being a partner in provision of service solutions. Other examples describe local investment in training and support for Independent Sector staff around reablement approaches, medicines management and to improve care for people with dementia.
West Lothian describes investing in a dedicated independent sector engagement role to support RCOP developments which has led to greater engagement with the independent sector in 2013.

In Dundee City, the Third Sector Interface have been funded to deploy 3 Community Engagement workers to extend co-production by working with local people to identify needs and to create new community activities aimed at keeping older people safe and well in their own homes. Such an activity is ‘Mind yer Heid’ mental health awareness training where community members and local service providers will be trained to deliver mental health awareness training.

Examples which describe benefits for carers were evident across all pillars of the pathway and as enablers to the RCOP Programme.

Some examples have a specific focus such as older carers and those becoming carers for the first time, and many described raising awareness of support for carers and putting in place integrated approaches to providing information and signposting to support for carers.

In Highland, Connecting Carers have helped the Scottish Centre for Enabling Technology develop and test apps for iTunes and android which act as an emergency planning tool for carers and a jargon buster. They have followed this up with a programme of IT training for carers.

Another example is the Inverclyde Carers Hospital Discharge project. Through the Change Fund, a carers' centre worker was seconded to work with the hospital discharge team at Inverclyde Royal Hospital raising awareness amongst staff of support for carers and providing support directly to carers. The funding has been extended for a second year and increased to roll out wider within the Hospital.

A number of Partnerships provided examples of enhancing housing and housing options to support people in their homes. These included housing with care, expansion of amenity housing, targeting housing adaptations, and including sheltered housing staff in training in falls prevention and supporting people with dementia.

In Borders work has been ongoing with Registered Social Landlords to develop models of on-site care and support such as Extra Care Housing and Housing with Care as alternatives to Care Homes.

Preventative and Anticipatory Care

The largest proportion of examples submitted relates to this pillar and many described creating opportunities for social interaction to reduce and prevent social isolation and maintain independence.

Examples include intergenerational befriending, locality networking, signposting to information, providing activities such as an Information Technology Skills Group, Lunch Clubs, Home & Garden Buddies and using volunteers to connect people.
Section 3: Examples of Local Impact

---

**Twoz Company Befriending run by VASA in South Ayrshire** was established by VASA with Change Fund resources, to support isolated older people. Referral can be from primary care, social work, third sector and self-referral. People are matched with trained local volunteer befrienders who offer support and friendship.

Other examples included:

- Supporting early diagnosis for people with dementia and providing post diagnostic support;
- Providing opportunities for exercise and activity;
- Implementing Anticipatory Care Plans;
- Providing support for self-management;
- Implementing ‘Up and About: a whole system pathway for the prevention and management of falls and fractures’;
- Providing foot care, occupational therapy and nutritional support services.

The Golden Games in Aberdeen City won the 2013 UK Award for Health & Wellbeing at the Association of Public Service Excellence. Over 350 booking were made for 23 events held over 3 days in 7 venues. Participants included teams from care homes and carers. More older people are now regularly taking part in Active Ageing opportunities, such as Table Tennis or Ten Pin Bowling and these are financially self-sustaining.

The Falls Subgroup in Renfrewshire, which is representative of all Health and SW partner agencies including SAS and Care Home Sector, is benchmarking the local position against the ‘Up & About’ good practice document and, with Scottish partners in the European Smartcare Initiative, developing an improved, evidence based and consistent care pathway for people with dementia and risk of falls.

The contribution of the Third Sector is most evident in the examples provided under this pillar of the pathway.

In Argyll and Bute a focus group with older people was conducted with Argyll Voluntary Action and the falls prevention workstream to modify a falls prevention ‘lunchbox’ resource for local use. The ‘third sector box’ is delivered by Argyll Voluntary Action and volunteers will be trained to deliver it to their peers to raise awareness of modifiable falls risks across Argyll and Bute. The interactive resource contains key messages and is designed to engage older people. Printed resources are being developed and will be available by Dec 2013.

---

**Proactive Care and Support at Home**

A number of examples described service redesign to provide support and care at home which had not been previously available, and improving the way services respond to prevent avoidable admission to hospital or care home. **Improvements in service response** include:

- Creating 24/7 community nursing services;
Section 3: Examples of Local Impact

- Rapid Response services;
- Providing a home care overnight service
- Establishing short breaks bureaux

During the period May 2012 to June 2013 only 78 of the 380+ referrals into the Perth & Kinross Rapid Response Service were admitted to hospital or a care home. The service provides support at home in an emergency as an alternative to admission. It works through a Single Point of Contact; Eight Rapid Response Social Care Officers based within the Community Alarm Team who are available 24/7 and spot purchased Step Up beds in Care Homes.

Examples of redesigning services include:

- Using telecare to support people to remain at home;
- Targeting housing adaptations;
- Creating a single point of access to housing adaptations;
- Developing a joint equipment store;
- Creating integrated community teams;
- Enhancing access to community rehabilitation and dietetic services.

In Moray investment to fund an equipment cleaner, a technician and a vehicle has enabled the development of a joint equipment store. Hospital beds for community clients were added to the stock which has allowed 73 patients to come home from hospital. Recycling of equipment has improved response times for equipment requests. Also an increase in delivery rates and a reduction in delivery times have been noted.

The Renfrewshire Change Fund is supporting the delivery of platinum telecare services, additional capacity for the housing aids and adaptations programme, housing advice for older people, a care and repair service, access to social activities and the Food Train shopping service.

Effective Care at Times of Transition

There were many examples of implementing a reablement approach at home, in day services, in intermediate care and Crisis Care, and in assessment and provision of community equipment.

The reablement service in Glasgow City is a partnership between Social Work Services, Cordia and NHS Greater Glasgow and Clyde with the support of Social Care Direct (CBS). It provides tailored homecare support to people in their own home for up to six weeks. The two key objectives of the service are to promote independence and ensure ongoing care is tailored to individual needs, reducing dependency where relevant.

A project in the Western Isles is ensuring the continuation and expansion of Reablement in partnership with Care at Home Services, and strengthening the integrated Community Equipment Service. A comprehensive multidisciplinary falls screen tool has been developed, tested, and rolled out to the wider OT and
Physiotherapy service and the referral pathway from A&E and the SAS to the Rehab team has been redesigned. In last 18 months over 360 people seen by the service. The project has now been expanded to include the development of the Community Equipment Service.

Many partnerships are developing different models of care as alternatives to admission to hospitals and care homes. In many cases these utilise the assets of all partners and provide an integrated response:

- ‘See and Treat’ provided by the Scottish Ambulance Service, linking to other community supports to prevent admission to hospital;
- Intermediate Care provided on a multi-agency basis;
- Enhanced and integrated response services;
- Short term Care Home beds;
- Rapid Response resettlement service;
- Palliative Care at Home;
- Amenity housing and housing with care.

Highbank Intermediate Care in Midlothian provides short term support for older people that provides the opportunity for intensive rehabilitation or short term increased carer support, following an illness. It is provided in a dedicated residential unit with access to occupational, physiotherapists and physiotherapy equipment for people who do not need to be in hospital but cannot remain independently at home. In 2012 there were 56 admissions to intermediate care at Highbank which may have avoided a hospital admission or provided early hospital discharge.

A number of partnerships described initiatives to help people to manage their medicines at home and provide medication reviews and pharmaceutical care.

The Borders Pharmaceutical Care Project aims to prevent avoidable medication related hospital admissions (e.g. falls, adverse drug reactions), optimise medicines use, and support others to identify patients at high risk of medication related adverse events. A Polypharmacy Patient Review programme has been implemented and has a target of 2216 by end of 2013. Data from a sample of 50 patients indicate that there is also potential for financial benefits to be achieved.

In West Dunbartonshire the Pharmacy Support Team has been aligned with the Care at Home Reablement Team to offer support to older people and their families around medication management. The Team has identified that 79% of older people are better able to manage their medication, Care at Home staff routinely ask for advice re medication and Community pharmacists report increased knowledge of conditions affecting older people e.g. Dementia, continence issues.

Hospital and Care Home(s)

Many examples describe support to Care Homes, through specific investment funds, training and specialist input. Examples include:

- ‘My Home Life’ Leadership and Community Development Programme
Section 3: Examples of Local Impact

- Medicines Management;
- Training in Palliative Care, long term conditions and Dementia;
- Care Home peripatetic team;
- Referrals to dietetic services from care Homes;
- Liaison psychiatry service;

As part of the implementation of ‘Living and Dying Well’ in Aberdeenshire, Palliative Care training has been extended to primary care, social care, voluntary and independent care settings. Teaching packages for carers looking after residents with end stage dementia have been developed with CPNs, and support provided in Community Hospitals. The support provided allowed more people to die in their own home if they wished this and supported their carer/family members to enable this. It also prevented unnecessary hospital admissions and reduced the length of stay.

Examples of improving hospital discharge focus on streamlining processes, integrating services and preventing future emergency admissions.

In East Renfrewshire a senior social work practitioner based in a hospital ward as a hospital discharge liaison worker supports a beneficial transition for an older person back into their home in a safe, timely way. This provides real-time intelligence as to the East Renfrewshire residents in hospital and good partnership working as the discharge liaison worker participates in the hospital multi disciplinary team meetings and liaises with colleagues in the community.

A number of examples described early comprehensive assessment of older people across the pathway and early provision of specialist services to meet the needs identified:

- Elderly care assessment nurses;
- Access to comprehensive geriatric assessment in the community;
- Medicine for the Elderly model which links across the RCOP pathway;
- Integrated AHP service in acute receiving wards;
- Psychiatric nurse liaison in acute care;
- Dementia friendly ward in an acute setting;

In Glasgow experienced Elderly Care Assessment Nurses have been appointed at each of the four acute receiving sites in Glasgow to identify and signpost frail older people with physical, functional and cognitive impairments who will benefit from coordinated comprehensive geriatric assessment, and

In Falkirk the extension of the older people’s psychiatric liaison team by 2 RMNs has allowed a 7 day a week, proactive service to be offered to patient aged 65+ and over admitted to Forth Valley Royal Hospital who have or may develop psychiatric disorders associated with their acute physical problems. Early assessment and diagnosis, advice/implementation of treatment can be carried out, liaison with carers and support for discharge by referral to other services. The service has been highlighted in the recent OPAC report as an area of best practice.
Section 3: Examples of Local Impact

Enablers

The majority of examples in this area describe investment in workforce development.

'My Home Life' the Leadership and Community Development Programme is described by several partnerships, and although in its early stages of implementation, the feedback so far from participants have been positive.

Glasgow City reports that the ‘My Home Life’ programme is running well and participants have already begun to form a community of practice, sharing learning with each other.

In East Ayrshire the Change Fund is supporting 17 Care Home Managers through this 14 months programme which ends with a Validation Day on 4th July 2014

The development of Action Learning Sets and providing Promoting Excellence in Dementia Training are also described by many partnerships. There are also some Examples of cross sector workforce planning.

“The ALS programme has been invaluable and has challenged me personally and professionally. It is useful to have an honest open attitude and to be able to take constructive criticism in this supportive environment. I have welcomed the opportunity to develop my skills in dealing with change management and look forward to supporting others to do the same”, participant Perth & Kinross

In Argyll and Bute a Workforce Development Passport has been agreed across all sectors which have identified training sessions agreed as priorities by the partners. It outlines who these sessions are targeted at and what organisational and service outcomes are being addressed by each session.

In the Western Isles a project is identifying the future workforce needs of care at home services and ways to meet them. These include developing a draft career pathway framework with the Recruit and Retain project and undertaking preliminary work to develop the generic support worker role with RRHEAL and the work undertaken within the Orkney Health & Social Care Partnership.

There are also examples of projects to develop the evidence base and to engage with the public about Reshaping Care and the Change Fund.

Making it CLEAR (Community Living, Enablement and Resilience) is a partnership between City of Edinburgh and Queen Margaret University. The project aims to enable older people to live well within their communities by better understanding what supports them to remain resilient.

Clackmannanshire and Stirling held a one-day Stakeholder and Speed Networking Event for all sectors and community planning partners. There were Information Tables to advertise services, short presentations from current Change Fund recipients, and two one-hour long speed networking sessions. Each attendee was challenged to make contact with someone from the event within 1 month.
Section 3: Examples of Local Impact

Support Team also produced a comprehensive information document of all the Change Fund recipients and their services; this was issued to each attendee for future reference.

Highland partnership has invested in training, especially for team development and shared learning across sectors. People are clearly thinking differently which is resulting in more person centred planning. It is reported that Multi Disciplinary Team (MDT) meetings are much more productive, with genuine risk sharing and better supported of professionals by each other. The teams that have been able to co-locate report the best outcomes. The communication has greatly improved, informal meetings reap rewards in that advice is available quickly and the need to make formal referrals has reduced. In one District, coordinated visits to the Health Centre can be arranged so that the individual can come once to see a range of professionals.

Demonstrating Local Impact

The JIT, along with research and analytical colleagues in the Scottish Government, the Quality and Efficiency Support Team (QuEST), NHS Information Services Division (ISD) and the Scottish Community Care Benchmarking Network (SCCBN) hosted a series of Demonstrating Impact learning events between February and June 2013. The presentations from these events are available on the JIT website.

The impact of the Change Fund has to be seen within the context of shifting population demands and a general shift in innovation and redesign that makes direct attribution of impact difficult. The assessment of impact of the Fund is not simply a case of resource saved and released, but also one of keeping pace with a demographic demand. The benefit of the Change Fund therefore requires to be seen not in terms of how much resource we were able to remove from institutional care and place in community services, but in terms of the fact that we have contained the increase in population demand within the existing resource. Simply put, the question is not “How much did we get out?”, but rather “How much did we not put in?”

Highland Partnership

Bringing partners together has highlighted the different perspectives on what ‘impact’ means – e.g. the impact on high level system measures such as emergency admissions to hospital and the impact on the quality of life for older people.

Edinburgh City Partnership

The JIT will continue to support partnerships to demonstrate the impact of local initiatives through the use of local improvement measures that include process and intermediate outcomes as well as qualitative assessments of experience and personalised outcomes. This work is informing the developing indicators which will track progress towards the outcomes that integrated health and care should deliver.

Proposed indicators for integrated health and care are also a balance of local improvement indicators, personal outcomes and higher level system outcomes.
**TRENDS IN NATIONAL OUTCOMES AND TARGETS**

At a national level, progress in Reshaping Care for Older People is primarily evidenced by trends in the suite of published national outcomes that relate to the care of older people. These include:

- the rate of emergency hospital bed days for people over 75 years;
- delays in discharge from hospital;
- indicators of the Balance of Care for people over 65 years.

It is useful to look at trends in this national data at the mid point of the Change Fund.

**Rate of emergency bed days for people aged over 75 years**

Each NHS Board and their partners agreed a trajectory that exceeds the anticipated demographic changes, so that the system will be able to reduce the reliance on the existing cohort of hospital beds for emergency admissions in order to sustain continuing investment in primary and community services to support the growing numbers of older people. Published data for 75+ emergency bed days to March 2013 is presented in Fig 1. This shows a reduction of 10.7% in the rate compared to 2009/10 and against a target to achieve a 12% reduction by 2015.

![Fig 1](image)

The recent ISD publication reports 131,075 fewer emergency bed days for over 75s in 2012/13 compared to 2009/2010. That is equivalent to 359 fewer people over 75 years each day occupying a bed in hospital as a result of an emergency.

Encouraging as these figures certainly are, the chart below shows the trends up to 2011/12 for emergency admissions in the 65+ and the 75+ population. In addition to the actual values, the chart shows what would have been 'expected' had the rate which applied in 2007/08 continued through to 2011/12.
Section 4: Trends in National Outcomes and Targets

Fig 2 shows the year on year rise in the number of emergency admissions is at a rate slightly higher than that expected by the demographic changes.

![Fig 2](Image)

Emergency Admissions in Scotland

However Fig 3 shows that much of this rise is attributable to people admitted for shorter lengths of stay which have increased at a faster rate than would be expected.

![Fig 3](Image)

Factors that may be contributing to this rise include changes in referral patterns or decision making by practitioners, changing public behaviours and expectations, and the impact of increasingly protocol driven assessments for common emergency presentations such as acute chest pain and breathlessness. This challenges local systems to develop urgent ambulatory care and community alternatives to inpatient assessment and treatment, particularly for those who are frail.

The number of beds occupied on average by people aged 65+ had been gradually rising until 2008/09. From 2009/10 until 2012/13 (prov) the number has fallen year
on year. This contrasts with an ‘expected’ number of occupied beds had the age related rate at 2008/09 continued in line with the ageing population. The difference between the expected and the actual is around 1000 beds in 2012/13.

**Fig 4**

**Comparison of average daily beds used by emergency admissions aged 65+:**

*Actual versus Expected (based on 2008/09 rate)*

**Delayed Discharge**

The substantial reduction in delayed discharges since the beginning of the last decade has been a notable success story for partnership working. More recently the trend in the current standard - that no patient should be delayed for more than four weeks - has shown year on year improvement since 2011, the year the Change Fund began, albeit that there is fluctuation quarter by quarter.

**Fig 5**

**Number of people waiting more than 4 weeks for discharge to an appropriate setting, Scotland: by quarterly census**

In Scotland, at the October 2013 census, there were 156 patients delayed for longer than the current standard.
Although delays over 4 weeks reduced by 62% between April 2012 and April 2013, performance varies across Scotland and further progress is required to drive down the bed days lost to delayed discharge.

Ministers have announced an ambitious new target to have no delays over 2 weeks by April 2015. Figure 6 shows the scale of this challenge with 312 patients delayed for longer than 2 weeks.

Figure 6

It had been anticipated that bed days lost would reduce as partnerships improve their performance in managing discharge. However, Table 1 shows that quarterly totals for bed days lost remain steady.

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-Jun 2012</td>
<td>119,272</td>
</tr>
<tr>
<td>Jul-Sep 2012</td>
<td>121,948</td>
</tr>
<tr>
<td>Oct-Dec 2012</td>
<td>125,091</td>
</tr>
<tr>
<td>Jan-Mar 2013</td>
<td>125,410</td>
</tr>
<tr>
<td>Apr-Jun 2013</td>
<td>122,911</td>
</tr>
</tbody>
</table>

The relatively static figure for bed days lost each quarter has to be considered in the context of a year on year rise in the number of emergency admission episodes as well as the impact of the Treatment Time Guarantee and increasing elective activity.

For example there were around 8,434 elective total hip replacements performed as a main procedure in 2012/13 – an increase of 10.4% from 7,642 in 2008/09 – and a corresponding rise of 11.7% in elective knee replacements from 6,840 in 2008/09 to 7,637 in 2012/13. This rise in elective activity will have consequences for access to equipment, adaptations, rehabilitation and packages of support for discharge and suggests a need for greater collaboration with leads for planned care.

**Balance of Care**

Change is evident in the way that we care for older people. Fig 7 shows the trend in the actual number of long stay residents in care home homes in Scotland and the trend which might have been anticipated had care home use increased in line with the ageing of Scotland’s population since 2003. By 2012 the difference between the actual number and the projected number is nearly 6500 people.
Section 4: Trends in National Outcomes and Targets

**Fig 7**

*Number of long stay residents in care homes: people aged 65+; Actual vs Projected (using base 2003 rate)*

The chart below shows the most recent figures (2012) of the balance of care for people with more complex needs i.e. people who are either living as a resident of a care home, in a continuing care facility in hospital or are receiving at least 10 hours of home care. It shows the amount of variation which exists across Scotland in this particular balance of care measure.

**Fig 8**

the proportion aged 65 plus who are receiving intensive support at home compared to in a care home or a continuing care facility.

Benchmarking for this national indicator is a challenge as this balance of care measure will be influenced by the application of reablement practice and eligibility thresholds. There remains considerable variation across Scotland.
Section 5: Using Data and Information

**USING DATA AND INFORMATION**

Partnerships were invited to describe their local progress, and any barriers, in the effective use of data and information.

Despite the complexity of demonstrating impact in complex whole system change, all partnerships are continually improving and using local information to drive performance improvement and to inform their Joint Commissioning investment and disinvestment decisions. They are applying local RCOP improvement indicators to track their progress towards the high level national indicators and targets.

The Aberdeenshire partnership reports data quarterly as part of their Joint Performance Framework. This includes national core measures and local measures to measure progress in reshaping care and shifting the balance, using the Change Fund.

Several partnerships have used logic modelling to identify indicators of short term, intermediate and long term outcomes and now provide regular reports of progress against this set of indicators. This approach has been further developed by NHS Health Scotland and set out as a logic model for the health and wellbeing of older people.

The Partnerships in North and South Lanarkshire have together established a joint performance framework and electronic dashboard for RCOP and Integration. This uses an application that can be easily accessed, viewed and interrogated across agencies. Their approach includes an evaluation process based on a RCOP logic model. All projects have been mapped to clearly identify which outcomes within the logic model they are contributing to and are now providing evidence to allow contribution analysis to be carried out.

Partnerships are developing ways to simplify and streamline reporting to the various health, local authority and community planning partnership groups that currently oversee performance.

Staff from all partners in Ayrshire have received training and access the Covalent system remotely via web links. The Covalent system allows for single input of performance information and can generate reports for CHP structures, Council and Community Planning Partners as required including the Single Outcome Agreement.

**Analytical Capacity**

There is an urgent need for dedicated local analytical capacity and capability to support needs assessment, analysis and investment decisions for Joint Commissioning and Integrated Resourcing. However there are many other competing information demands that challenge local information services staff.

Partnership require to give greater priority to the RCOP and Integration work and ensure their local information systems are able to adapt to changing models of integrated service delivery.
Another constraint to optimal use of information is the timing of management data which may be up to six months out of date when received. This can be a barrier to real time decision making and effectively managing changing activity and demand.

The Clackmannanshire & Stirling Partnership in collaboration with the Falkirk Partnership recently recruited a full-time Senior Data Analyst to bring together and provide regular local real time data on core performance measures and to work with ISD on a linked data information sharing and analysis project which includes CHI seeding. The Data analyst will work alongside the Change Fund Support Officer and SCCBN to benchmark practice using the SCCBN Data Query Tool.

Even with excellent analytical support, the ever-increasing workload of operational managers and their teams can be a barrier to the collection and critical interrogation of robust data prior to investment and prioritisation decisions being made.

Availability of accurate costing information or lack of confidence in its use are both perceived barriers to measuring the financial impact of changes.

The Challenges of Attribution

Where acute sector services span a number of partnerships within a NHS Board area there may be challenges in extracting and analysing the impact on local residents of initiatives and investments that are primarily targeted at hospitals.

Even more challenging is evidencing attribution and contribution to the RCOP measures from preventative supports and services. This may place the Third Sector at particular risk of disinvestment due to a perceived lack of evidence of contribution to short term priorities.

Measuring and evidencing ‘impact’ of preventative initiatives in the lifetime of a one-year project is unrealistic and counter-productive for changes and improvements that can only be reliably measured in the longer term, if at all.

The Stitch in Time evidence based performance framework, when complete, will be immensely helpful given the emphasis on prevention, community capacity building and volunteering. However partnerships are concerned that this framework will not be finalised before the final year of the Change Fund.
Sharing Information

Separate ‘IT’ systems and ‘Data Protection’ legislation continue to impede the effective sharing of information between partners and result in significant loss of productive staff time. Most partnerships are developing local solutions to enable exchange of information and to allay both staff and public concerns.

In Argyll and Bute MiDIS is being implemented across all NHS community services including community hospitals. This will work alongside the Carefirst system used in social work to provide joint data on key performance measures.

In Dumfries and Galloway data linkage and electronic sharing of social work and health data is being progressed as a test of change through the Dumfries Hub project.

Western Isles has some good examples of data sharing including the Releasing Time to Care Pilots which are supporting practical steps towards integrated working.

Shetland’s assessment tool (With You For You) is used by all agencies and relevant professionals within the NHS and Voluntary sector have been given access to the Social Work System (SWIFT) to enable this joint working. The level of access various depending on the role the professional plays within a person’s support.

In Edinburgh Multi-Disciplinary Team Meetings of the COMPASS team highlighted the challenges that multiple systems present for practitioners trying to deliver more integrated care using at least four systems: social care - SWIFT, NHS – TRAK (hospital and community), mental health - PIMS and GP systems). A successful pilot used portal technology to allow practitioners to access relevant information from different systems. This approach is now being rolled out further.

Partnerships see the lack of established information sharing protocols across health and social care and with third and independent sector organisations as a barrier to fully joining up information. The roll out of Self Directed Support and a more personal outcomes focussed approach will be a catalyst for organisations and sectors to put in place information sharing protocols.

West Dunbartonshire produced a ‘Privacy Impact Statement’ which is now on their CHCP internet website. This will inform service users that the integrated single
Section 5: Using Data and Information

service will be using the same systems to record information about the service user. Consent is requested if using other sector organisations as service providers.

The JIT and national partners will continue to work with ehealth and information leads to highlight these barriers and help to spread learning about practical solutions as the National Information and Intelligence framework is further developed.
A sustainable shift to prevention embeds preventative approaches across the whole system and at all stages in care and support pathways. Therefore preventative approaches apply across the RCOP pathway to enhance wellbeing and independence, reduce or delay dependency, and prevent negative outcomes:

- Preventative and anticipatory care that supports best use of the assets of older people, their families and local communities in improving physical, psychological and emotional health, wellbeing and inclusion;
- Proactive and integrated care that enables older people to maintain their independence and to remain safe and supported at home;
- Effective and enabling assessment and care at home, or closer to home, to help older people to regain their capability and confidence after an illness or change in their circumstances;
- Early intervention in hospital / care homes to prevent escalating dependency, reduce delays in returning home and premature admission to long term care.

Partnerships were asked to disaggregate their investments against the Reshaping Care Pathway from their year-end spend in 2011/12 and 2012/13 (which is a more accurate reflection than previously published), along with their projected year-end spend for 2013/14. This consistent approach to reporting Change Fund spend allows JIT, on behalf of the national partners, to both track and challenge a balanced investment across the whole pathway.

Table 2 below shows the self-reported Change Fund investments against the 4 pillars of the Pathway and the set of Enablers.

<table>
<thead>
<tr>
<th>SCOTLAND</th>
<th>Preventative and Anticipatory Care</th>
<th>Proactive Care and Support at Home</th>
<th>Effective Care at Times of Transition</th>
<th>Hospitals and Long Stay Care Homes</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/2012 Actual Year-End Spend</td>
<td>21%</td>
<td>33%</td>
<td>19%</td>
<td>18%</td>
<td>9%</td>
</tr>
<tr>
<td>2012/2013 Actual Year-End Spend</td>
<td>26%</td>
<td>28%</td>
<td>21%</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>2013/14 Projected Year-End Spend</td>
<td>26%</td>
<td>26%</td>
<td>23%</td>
<td>12%</td>
<td>10%</td>
</tr>
</tbody>
</table>

NB Due to rounding, figures will not necessarily add up to 100%

The increasing investment in enablers reflects the work on evaluation, workforce development and readiness for joint commissioning.

Due to the previously reported delay in getting activity underway in year one, funding has been carried forward – over £28 million into year three, compared to around £22 million carried forward into year two. With this carry forward and additional resources added by 13 partnerships to the central allocation of £80 million, the total Change Fund resource available for 2013/14 is at least £119.5 million. Partnerships
are projecting to spend around £96.7 million of this by the end of 2013/14. Sixteen partnerships anticipate some carry forward into the final year of the Change Fund.

**PRIORITISING INVESTMENT**

**Support for Carers**

As with last year, there was a requirement for partnerships’ to allocate *at least 20%* of their central Change Fund allocation to supporting carers. As reported by the partnerships, by the end of 2013/14 it is anticipated that £8.7 million (10.8%) will be spent on *direct* support to carers, and an additional £26.8 million (33.6%) on *indirect* support to carers.

This represents a total anticipated investment for 2013/14 of £35.6 million, or almost 45% of the Scottish Government’s allocation to partnerships.

However, similar to last year recent discussions with some partnerships have highlighted continued difficulty in determining what constitutes direct and indirect carer support, therefore an element of caution should be applied to these figures as it does not necessarily reflect the total spend on carers support through the Change Fund. Following engagement at the start of 2013, identified partnerships have been given support and this will continue.

The important aim is to achieve positive outcomes in terms of sustaining carers to continue to care and to have a life alongside their caring role. This is important also in helping to promote older people’s independence and to shift the balance of care.

Further guidance on Joint Strategic Commissioning will be produced early next year and this will include guidance on direct and indirect carer support, building on what Carers Branch has already provided to partnerships by way of information and advice about direct and indirect spend.

**Options Appraisal**

Partnerships were invited to describe any option appraisal approaches they had used to agree local priorities for their Change Fund investment. The responses stressed the need to balance an agile, inclusive approach that has minimal bureaucracy with the need to ensure transparent decision making through agreed processes and criteria for all funding proposals.

Although few partnerships applied a rigorous formal option appraisal process all had developed structured assessment criteria that linked proposed initiatives to the RCOP goals and outcomes.

---

*Aberdeenshire’s OPSOG consider and debate all proposed projects, ensure these are in line with Reshaping Care objectives, are realistic in scale and achievability, and neither duplicate existing activities nor replace core functions. Decisions on innovative co-production proposals are devolved to a wider group of stakeholders and practitioners in the co-production steering group.*
Section 6: Tracking and Prioritising Investment

Most partnerships devolved prioritisation of community capacity building and preventative investments to a wider group of stakeholders. This is welcome and in the spirit of community empowerment and co-production.

Canny wi’ Cash – Older People deciding on grants for Older People in Edinburgh. An allocation of £35k has been made for a small grants fund (up to £1,500) for very small community groups for older people across the city. Participatory budgeting will be used so that older people vote and decide which applications should be funded. EVOC are leading this work and a team of trained facilitators will go out to where older people are – lunch clubs, day centres etc. – to gather their views over a ‘voting fortnight’ in October. Using this creative approach, we hope we can reach out to 1,000 voices of older people across Edinburgh.

Falkirk’s ‘Dementia Summit’ had a focus on reviewing, debating and prioritising proposals that had significant potential to support and improve on the current good practice in the delivery of care, support and interventions to and with people with a diagnosis of Dementia. The summit reflected on existing services, pathways, carers support and matched project proposals to gaps, service priorities, Scotland’s Dementia Strategy and to the Life Changes Trust.

A minority of partnerships have attempted rather more ambitious analysis of return on investment from their Change Fund.

Scottish Borders option appraisal approach used a scoring matrix and weighting system across key areas to be considered; strategic fit, carer support, outcomes, financial benefits and outputs. The financial benefits are considered against a target of a 3:1 return on investment and all four partners are involved in the process.

All partnerships are now using the intelligence from their Change Fund investments to inform their developing Joint Commissioning Plans and consider these as the route to sustain and mainstream effective initiatives.

In E Dunbartonshire a comprehensive scoring system was agreed and used by partners to prioritise investment in Years 1 and 2. For Year 3, we evaluated all of the Change Fund workstreams, undertook an audit of 55 vulnerable service users to inform investments in Years 3 and 4 and established a Service Redesign workstream to make use of the intelligence gathered, inform the development of East Dunbartonshire’s Older People’s Transformational Change Programme and identify how the remaining Change Fund can most effectively be invested to March 2015.

The JIT is coordinating the National Improvement Programme for Joint Commissioning in partnership with the Institute of Public Care, based in Oxford Brookes University. This offers partnerships the opportunity to develop additional skills, capacity and capability including analysis of costs data, and tools to support option appraisal for joint investment and disinvestment e.g. Needs Vs Quality and Risk Vs. Value for Money.
East Lothian placed each of its Change Fund projects on a risk and value grid according to assessment of the project report provided at the 6 monthly review. This led to substantial disinvestments and investment in a new cross sector Intermediate Care project to directly address priorities.

The Supporting the Third Sector programme hosted by the ALLIANCE in collaboration with JIT is offering development and peer support to Third Sector interface to fully engage in option appraisal and Joint Commissioning as equal partners.

In Dundee City a similarly rigorous process has been instigated when reviewing projects funded through the Reshaping Care - Capacity Building Fund administered through the Voluntary Gateway (Voluntary Sector Interface) in Dundee. The bids made to this fund are considered by a multidisciplinary panel from Dundee Voluntary Action, Dundee Volunteers Centre, Dundee Social Enterprise, Dundee CHP, the Social Work Department and Older People representatives. Evaluations are required once the initial funding period is complete and project outcomes scrutinised.
LEARNING FROM WHAT HASN’T WORKED

The Change Fund is essentially a lever for improvement and an opportunity for Partnerships to explore innovations that are ‘Proof of Concept’ or ‘Tests of Change’. Testing change using the model for improvement is an important preparatory step towards joint commissioning of sustainable support and services.

- **Apply:** Plan-Do-Study-Act cycles to test and spread individual initiatives
- **Adopt:** An Analyse-Plan-Deliver-Review approach to Joint commissioning

We asked partnerships to describe any learning gained from initiatives where barriers to progress have been encountered, where an initiative was not found to be as effective as anticipated or was discontinued.

*We have learned through the evaluation and monitoring of our change fund initiatives where and when any alteration is required to meet our agreed outcomes for older people. As our decisions were based on analysis of need and service mapping, it was more a case of doing things differently than deciding not to continue.*

---

**Moray Partnership**

Partnerships reported that some initiatives had to be adapted as local context or circumstances changed or if the proposed approach was overtaken by other developments. There is a clear sense that partnerships are learning from and adapting to these challenges. This is consistent with the Plan-Do-Study-Act model of improvement where multiple cycles of tests of change are refined before reaching a definitive model for spread and wider adoption.
Learning from what’s not worked is an essential component of any quality improvement programme. Organisational learning drives innovation and redesign.

The examples below illustrate how partnerships are reviewing and adapting local initiatives to make best use of existing capacity and resources.

**Moray’s intermediate care team was effective in supporting older people at home however monitoring proved that existing community teams could support the delivery without a separate team. The JIT supported us in clarifying our outcomes for older people and supported us to adjust our initial proposal.**

**The Glasgow Assessment at Home pilot learned that the conservative approach evident was in part due to a lack of systemic and cultural preparedness for change across the partners. There has been a re-evaluation of the risk assessment process which is expected to lead to a less conservative approach and investment in creating change agents with dedicated time to lead culture change in shifting the balance of care across all services. Lessons are being learned and the initiative is soon to be re-launched as ‘Step Down Assessment’, retaining the same strategic objectives. The Assessment at Home initiative has, therefore, informed and strongly influenced the ongoing development of the Intermediate Care approach in Glasgow.**

**Perth and Kinross partnership tested Stepdown to 3 identified Care Homes but found the majority of patients experienced a potential increase in length of stay and often did not benefit from rehabilitation / reablement given the constraints of the environment of the care home to which the majority of discharges were transferred. The partnership are recommending discontinuation of this service and that all discharges be trialled at home with appropriate community services in place.**

**Enhanced Supported Discharge in Edinburgh – A twelve week test of change involved the supported discharge of selected Medicine of the Elderly, Acute Stroke & Respiratory patients at the Royal Infirmary of Edinburgh. The predominant interventions required to support the discharge of patients were not of a secondary care nature, but were from the support of Allied Health Professionals, assessment, therapeutic and social care teams. The findings from this work have shaped further work of the Change Fund, including the development of the COMPASS model and ongoing communications and engagement activity to build understanding and confidence between hospital and community based teams.**

**Midlothian developed too many innovation funded projects targeting social isolation causing duplication of services while gaps remained in social isolation provision. The learning from this has directed us to develop a Midlothian wide co-ordinated outcomes approach to reducing social isolation through a comprehensive Local Area Co-ordination Service.**

**At the mid-term review of the Glasgow City Transformation Fund, it was clear that most of those organisations with established roots in Glasgow were further ahead than those that were moving into the area for the first time. It was also evident that larger charities which lacked existing inks to local communities had not fully anticipated and had not planned for the amount of time it would take to establish their projects and develop relationships at locality levels. In the second round of the**
Section 7: Learning from What Hasn’t Worked

Transformation fund additional steps were taken to ensure proposed projects evidenced need, referral pathways were in place and successful projects were well communicated to key staff teams and groups. In the main, these actions have overcome the difficulties experienced in round 1.

Recruitment

Small projects are particularly vulnerable to challenges in terms of recruitment and retention of staff and the success or otherwise often relies on the individuals recruited. These issues have caused challenges across all sectors for projects that have required to start with a short lead in time and to quickly demonstrate impact. Where projects have experienced some or all staff moving on for a range of reasons, often out-with the control of the organisation, this has often delayed full implementation of the projects and subsequent ability to demonstrate their full potential.

Recruitment is a significant challenge in West Lothian which has led to implementation delays in some projects but also more generally difficulties in generating enough capacity to support shifting the balance of care. A radically different approach for recruitment to a specialised team was successful but very labour intensive. Consideration needs to be given to how to attract a workforce which can support change fund aims. We are in early stages of developing a new approach in partnership with West Lothian College.

This challenge is not confined to Change Fund initiatives but a symptom of wider issues in recruitment to the care sector in some areas. There is also a challenge in recruitment to posts which are advertised on a fixed term basis.

In West Dunbartonshire each initiative has faced challenges in implementation including staffing issues such as recruitment delays and staff turnover. These staffing issues are often related to anxiety around sustainability of the funding. This lack of certainty can also inhibit risk based innovation.

Delays in start up of some projects prompted some partnerships to develop alternative proposals and to capitalise on emerging innovations and evidence.

An inability to recruit Consultant Geriatricians in Forth Valley delayed the planned Hospital at Home project. However, the time provided by the unsuccessful attempts to recruit created the space to develop the Acute Frailty model that is now being tested at Forth Valley Royal Hospital, informed by new learning through the Older People in Acute Care improvement programme.

Managing local expectations

The expectations and timeframes have been unrealistic in relation to community capacity building. Taking a true co-production approach using concept build modelling is more time consuming if done properly than a standard procurement process. For example, partnership set out an ambitious programme to have dementia cafes available in each multi-member ward. The dementia cafes had to be
grown from local communities and the partnership came under significant local criticism for this not happening fast enough.

The independent providers were very supportive of placement of Occupational Therapists (OT’s) to develop reablement and review long standing large packages of care within care at home services. However, clients and their families did not engage well with the OT’s fearing their care package was going to be taken away from them. Learning from this has directed us to support providers to undertake reablement reviews themselves where trust has been gained from their clients.

West Lothian Partnership

Low Referrals

It is a challenge to ensure all staff and public are fully engaged informed and advised of developments. Despite extensive involvement of key partners, partnerships often experienced difficulty in identifying appropriate referrals to new services and to secure buy in to new models of care. There is a need to address the human dimensions of change and tackle the human factors that may stifle adoption and spread.

Telehealthcare remains a core element to developments, however further roll out of the ‘Telehealth’ element i.e. vital signs monitoring and the proposed triage service has been put on hold. The learning from this project was that ‘clinical buy in’ should have been achieved before project commencement. A Telehealth strategy has been developed in NHS Borders in consultation with partners. Final sign off and development of an implementation plan is in progress. The Telecare element has been successfully mainstreamed into existing alarm monitoring and fitting services.

Scottish Borders Partnership

Requirement to develop the wider workforce

Change Fund initiatives don’t exist in a vacuum. They are implemented within the wider system and delivered by staff that are part of a wider workforce. Some initiatives, for example implementation of a personal outcomes approach, may need to be spread and adopted by the wider workforce before their impact is evident.

We intended that using the personal outcomes star approach would complement and pave the way for the roll out of self-directed support and associated outcomes focussed assessment. This has been the case, with professionals across the sectors having a greater awareness of and skills development in relation to an outcome focussed approach. The development of a Carer Star, alongside the Older Person’s Star use has led to a greater emphasis on and awareness of the needs of carers and the importance for carer wellbeing of using a personal outcomes approach to assessing their needs.

East Lothian Partnership
SELF ASSESSMENT OF SPREAD

Partnerships must be clear about the extent to which they have tested and spread new approaches and improvements so that they can understand where and when future gains can be anticipated. This is an important aspect of the preparatory work for Joint Commissioning which will be the principal mechanism to fully spread and mainstream initiatives as part of the landscape of future support and services.

Within Ayrshire and Arran the focus, as we move towards the final 18 months of Change fund monies, has been to develop and embed the spread of the work underway. Partners have agreed that the Change Fund is seen as a key part of the broader Reshaping Care Programme, and that initiatives funded by Change fund monies are developed to become embedded within the mainstream programme.

Year four change fund priorities will be agreed by the joint commissioning group post evaluation of our change fund initiatives which reflect the vision and strategic priorities of our JCS for older people and the outcomes gained. This will be in conjunction with our self-assessment against the pillars of the RCOP pathway.

Anticipatory Care investment assisted the partnership to build a practice infrastructure and this is now being mainstreamed in District Nursing.

East Renfrewshire Partnership

Partnerships were invited to complete a position statement which assessed how far they had achieved spread on each of the approaches and interventions identified within the four pillars pathway for Re-shaping Care and the enablers. They were asked to self-report using an ordinal scale with values 0 to 5, which had definitions given as shown in Table 3.

<table>
<thead>
<tr>
<th>Spread Value</th>
<th>Self-Assessment Position Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No agreed plan to implement the approach / intervention / improvement action</td>
</tr>
<tr>
<td>1</td>
<td>Agreed plan to take forward the approach / intervention / improvement action but not yet begun to implement</td>
</tr>
<tr>
<td>2</td>
<td>Testing / implementing the approach / intervention / improvement action in a minority of localities / sites / teams / older people / carers</td>
</tr>
<tr>
<td>3</td>
<td>The approach / intervention / improvement action has spread to most localities / sites / teams / older people / carers</td>
</tr>
<tr>
<td>4</td>
<td>The approach / intervention / improvement action has spread to all localities / sites / teams / older people / carers but is not yet fully embedded in routine practice</td>
</tr>
<tr>
<td>5</td>
<td>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</td>
</tr>
</tbody>
</table>
Section 8: Self-Assessment of Spread

Table 4 summarises the self-reported assessments of spread provided by all partnerships (Stirling and Clackmannanshire provided a combined response).

### Table 4

<table>
<thead>
<tr>
<th>ASSESSMENT OF SPREAD</th>
<th>Count of partnerships reporting spread value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>spread value 1 2 3 4 5</td>
</tr>
<tr>
<td><strong>PREVENTATIVE AND ANTICIPATORY CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Build social networks and opportunities for participation</td>
<td>1 7 17 6 0</td>
</tr>
<tr>
<td>Early diagnosis of dementia</td>
<td>0 7 7 13 4</td>
</tr>
<tr>
<td>Prevention of Falls and Fractures</td>
<td>1 6 10 13 1</td>
</tr>
<tr>
<td>Information &amp; Support for Self-Management &amp; Self-Directed Support</td>
<td>0 12 16 3 0</td>
</tr>
<tr>
<td>Prediction of risk of recurrent admissions</td>
<td>1 13 10 4 3</td>
</tr>
<tr>
<td>Anticipatory Care Planning</td>
<td>5 11 9 3 3</td>
</tr>
<tr>
<td>Support for carers</td>
<td>0 2 9 18 2</td>
</tr>
<tr>
<td>Suitable and varied housing and housing support</td>
<td>0 3 11 15 2</td>
</tr>
<tr>
<td><strong>PROACTIVE CARE AND SUPPORT AT HOME</strong></td>
<td></td>
</tr>
<tr>
<td>Responsive flexible, self-directed home care</td>
<td>1 6 15 9 0</td>
</tr>
<tr>
<td>Integrated Case/Care Management</td>
<td>0 11 13 7 0</td>
</tr>
<tr>
<td>Carer Support and Respite</td>
<td>0 1 8 17 5</td>
</tr>
<tr>
<td>Rapid access to equipment</td>
<td>0 1 11 9 10</td>
</tr>
<tr>
<td>Timely adaptations, including housing adaptations</td>
<td>0 4 11 13 3</td>
</tr>
<tr>
<td>Telehealthcare</td>
<td>1 3 15 7 5</td>
</tr>
<tr>
<td><strong>EFFECTIVE CARE IN TIMES OF TRANSITION</strong></td>
<td></td>
</tr>
<tr>
<td>Reablement &amp; Rehabilitation</td>
<td>1 3 9 13 5</td>
</tr>
<tr>
<td>Specialist clinical advice for community teams</td>
<td>0 2 9 14 6</td>
</tr>
<tr>
<td>NHS24, SAS and Out of Hours access ACPs</td>
<td>3 13 8 5 1</td>
</tr>
<tr>
<td>Range of Intermediate Care alternatives to emergency admission</td>
<td>2 9 12 8 0</td>
</tr>
<tr>
<td>Responsive and flexible palliative care</td>
<td>0 0 11 13 7</td>
</tr>
<tr>
<td>Support for carers</td>
<td>0 1 13 16 1</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>0 7 10 12 2</td>
</tr>
<tr>
<td>Access to range of housing options</td>
<td>4 9 13 4 1</td>
</tr>
<tr>
<td><strong>HOSPITAL AND CARE HOME(S)</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent triage to identify frail older people</td>
<td>1 4 13 10 2</td>
</tr>
<tr>
<td>Early assessment and rehab in appropriate specialist unit</td>
<td>2 4 16 5 2</td>
</tr>
<tr>
<td>Prevention and treatment of delirium</td>
<td>0 8 14 7 0</td>
</tr>
<tr>
<td>Effective and timely discharge home or to intermediate care</td>
<td>0 4 16 8 3</td>
</tr>
<tr>
<td>Medicine reconciliation and reviews</td>
<td>1 6 14 8 2</td>
</tr>
<tr>
<td>Carers as equal partners</td>
<td>0 5 17 7 2</td>
</tr>
<tr>
<td>Specialist clinical support for care homes</td>
<td>1 2 11 13 3</td>
</tr>
<tr>
<td><strong>ENABLERS</strong></td>
<td></td>
</tr>
<tr>
<td>Outcomes-focussed assessment</td>
<td>1 6 15 7 2</td>
</tr>
<tr>
<td>Co-production</td>
<td>1 10 14 4 2</td>
</tr>
<tr>
<td>Technology/eHealth/Data Sharing</td>
<td>2 13 10 5 1</td>
</tr>
<tr>
<td>Workforce Development/Skill Mix/Integrated Working</td>
<td>5 6 14 5 1</td>
</tr>
<tr>
<td>Organisational Development and Improvement Support</td>
<td>1 6 14 8 2</td>
</tr>
<tr>
<td>Information and Evaluation</td>
<td>1 6 16 7 1</td>
</tr>
<tr>
<td>Commissioning and Integrated Resource Framework</td>
<td>1 12 11 6 1</td>
</tr>
</tbody>
</table>

At least half of the partnerships reported they had spread to all localities (spread value of ‘4’ or more) the following interventions:
Section 8: Self-Assessment of Spread

- Early diagnosis of dementia
- Respite and support for carers
- Suitable and varied housing and housing support
- Rapid access to equipment
- Timely adaptations
- Reablement and rehabilitation
- Specialist support for community teams
- Responsive and flexible palliative care
- Specialist clinical support for care homes

The remaining interventions have generally spread to most localities (value ‘3’).

Over one third of partnerships reported they are still testing specific interventions or have implemented them in only a minority of localities (value ‘2’ or less).

- Self-Management and Self-Directed Support;
- Risk prediction and Anticipatory Care Planning;
- Sharing of information (e.g. ACPs)

Similarly, over a third reported limited adoption of:

- co-production approaches;
- use of enabling technology;
- joint commissioning and integrated resourcing.

The intention is that this self-assessment of spread can help partnerships to develop local plans for spread and sustainability as they progress their work on joint commissioning and integrated resourcing.

The JIT will also use the insights gained to work with national partners and other improvement organisations to target collective improvement support towards the interventions and enablers that require additional effort to increase spread and adoption. One aim for improvement effort for example will be to draw on the experience of those partnerships which are further ahead in implementing specific interventions in order to help those who are making slower progress in spread and adoption.

The JIT will use these insights to work with national partners and other improvement organisations to target our collective improvement support towards the interventions and enablers that require additional effort to increase spread and adoption.

Through the Joint Strategic Commissioning National Development Programme in 2014/15, the JIT will support partnerships to finalise Joint Commissioning Strategies for older people and all adults: to include spread and sustainability plans for new initiatives and to embed agreed models of care into mainstream support and services.
**IMPROVEMENT SUPPORT**

Partnerships were invited to identify specific support that they would welcome. Although not specifically asked to comment on this, many partnerships affirmed the improvement support that had been provided to date.

- **The Aberdeen Partnership** has found the support of the Joint Improvement Team helpful in the *Change Fund process* to date.

- **Continued support from our JIT Lead** in our Joint Strategic Commissioning Plan and its subsequent delivery / implementation plan.

- **The support to date around conferences and shared learning links** has been useful.

- **Support at present to assist with the development of our Joint Commissioning Strategy** is very valuable to us and we hope this will continue.

- **We have welcomed analytical reports**, in particular, the ‘Rear View Mirror’ report provided by Pete Knight from the JIT, and the ‘Stitch in Time’ initiative being facilitated by Evaluation Scotland.

- **The Partnership values the on-going input from JIT as “friendly challenger” locally and its support to local partnership development work.** The Partnership also values the *national learning and benchmarking events* which produce examples of good practice at a national level.

Suggestions have been themed around common issues that will shape the 2014/15 work plan for both JIT and the Improvement Network.

**Joint Commissioning**

- Sharing of examples of successful disinvestment to shift the balance of care and of genuine co-production;
- Support for decisions on disinvestment / sustainability;
- Further development of tools that support whole system evaluation and option appraisal i.e. methodologies and approaches for establishing the benefits of a preventative activity as opposed to a clinical intervention.

**Integration**

Future support may be required around the integration agenda to forge the links with reshaping care for older people as we progress joint commissioning strategies.
Section 9: Improvement Support

Analysis

- Support to assist in high level joint data analysis to help us understand the costs of our models of care. Marginal analysis would assist us in future decision-making;
- On-going support in relation to effective data analysis through the Improvement Network;
- More support is required to objectively analyse and evaluate the benefit and impact of projects to provide evidence and support shifting the balance of care;
- Examples of ways that other areas are approaching the challenge of data collection and aggregation of individual case data to measure the impact of services.

Data Sharing

- Support on how we overcome the barriers to electronic systems and data sharing.

Integrated Resourcing and performance improvement

- Support nationally to agree a notional cost for a hospital bed day and development of a whole system performance framework;
- Further support around basic project management, improvement techniques and measuring the impact of change would be welcome;
- More frequent national reporting on data sets to inform improved local decision making;
- Further support to maximise use of Integrated Resource Framework.

Learning events and resources

- Webex sessions with focus on self directed support, reablement, self management, anticipatory care, telehealthcare, community development;
- Learning from other partnerships success in mainstreaming successful projects and initiatives;
- The sharing of learning, good practice and case examples are positive enablers of improving practice.

Engagement

- Ongoing support to ensure continued involvement for older people;
- National social marketing campaign about RCOP. Public acceptance and buy in is at the heart of what we are trying to achieve and so it would be good to see some national work on this.
Involvement of Secondary Care

- Whist the service models have changed in respect of community and social care provision there is no significant change in secondary care with clinical behaviour and practice continuing in traditional model. There needs to be greater emphasis on whole system approaches to maximise benefit.

Recruitment and retention of care workers

- Any national support in this context, such as the positive promotion of care work and/or Aberdeen as a great place to develop a career would be very welcome.

Personal Outcomes and SDS

- To continue with Talking Points training in gathering and using Data;
- It would also be useful when major changes such as Self Directed Support are introduced, that national resources and support is provided to the partnership;
- Examples of how other partnerships are embedding personal outcomes and practical support and suggestions for how this is done locally.

Peer Support

- Virtual link up with the RCOP Managers on a regular basis might also help with the sharing of improvement stories and promote a collaborative approach and sharing across Scotland.
RESHAPING CARE and INTEGRATION
IMPROVEMENT AND SUPPORT COLLABORATION

ROLE AND REMIT

- Promote a coordinated and coherent approach to implementation and improvement support for Reshaping Care, Dementia and for Health and Social Care Integration
- Agree priorities for improvement and support and maximise the collective contribution and resources of national partners
- Help all 32 partnerships build local capacity and capability for improvement and integration.
- Provide oversight of the Improvement Network for Reshaping Care and Integration
- Support the use and feedback of measurement and evidence of the impact of Reshaping Care, Change Fund and Integration
- Review and monitor the impact of improvement and support on delivery of national priorities and targets in relation to Reshaping Care, Dementia and Integration
- Monitor and report on progress to the Health and Community Care Delivery Group and to the Quality Alliance Board

Function
The Group will meet every two months to provide oversight and challenge for improvement and support activities and outcomes.

<table>
<thead>
<tr>
<th>Chair</th>
<th>Margaret Whoriskey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Sector</td>
<td>Margaret Duffy</td>
</tr>
<tr>
<td>ADSW</td>
<td>Elaine Torrance</td>
</tr>
<tr>
<td>ALACHO</td>
<td>Jim Hayton</td>
</tr>
<tr>
<td>Care Inspectorate</td>
<td>Susan Castle</td>
</tr>
<tr>
<td>CHP Association</td>
<td>Susan Manion</td>
</tr>
<tr>
<td>Clinical Lead</td>
<td>Anne Hendry</td>
</tr>
<tr>
<td>COSLA</td>
<td>Ron Culley</td>
</tr>
<tr>
<td>Health Scotland</td>
<td>Pauline Craig</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland and QI Hub</td>
<td>June Wylie</td>
</tr>
<tr>
<td>Improvement Service</td>
<td>Colin Mair</td>
</tr>
<tr>
<td>Institute for Research &amp; Innovation in Social Services (IRISS)</td>
<td>Alison Petch</td>
</tr>
<tr>
<td>Leading Improvement Team (LIT)</td>
<td>Fiona Montgomery</td>
</tr>
<tr>
<td>Quality and Efficiency Support Team (QuEST)</td>
<td>Susan Bishop</td>
</tr>
<tr>
<td>Scottish Care</td>
<td>David Manion</td>
</tr>
<tr>
<td>SCVO</td>
<td>Lucy McTernan</td>
</tr>
<tr>
<td>VAS</td>
<td>Helen Macneil</td>
</tr>
</tbody>
</table>

In attendance

| Older People’s Unit | Richard Lyall   |
| Integration and Service Development Division | Alison Taylor |
| Mental Health Division | David Berry |
| Primary Care Division | Jess McPherson |
| Improvement Network Lead | Margot White |
| Secretariat          | JIT             |
ANNEX 2

Reshaping Care Pathway

Preventative and Anticipatory Care
- Build social networks and opportunities for participation.
- Early diagnosis of dementia.
- Prevention of Falls and Fractures.
- Information & Support for Self Management & Self Directed Support.
- Prediction of risk of recurrent admissions.
- Anticipatory Care Planning.
- Support for carers.
- Suitable, and varied, housing, build support and housing support.

Proactive Care and Support at Home
- Responsive and flexible home care.
- Integrated Case/Care Management.
- Carer Support and Respite.
- Rapid access to equipment.
- Timely adaptations, including housing adaptations, and equipment.
- Telehealthcare.

Effective Care at Times of Transition
- Reablement & Rehabilitation.
- Specialist clinical advice for community teams.
- NHS24, SAS and Out of Hours access ACPs.
- Range of Intermediate Care alternatives to emergency admission.
- Responsive and flexible palliative care.
- Support for carers.
- Medicines Management.
- Access to range of housing options.

Hospital and Care Home(s)
- Urgent triage to identify frail older people.
- Early assessment and rehab in the appropriate specialist unit.
- Prevention and treatment of delirium.
- Effective and timely discharge home or transfer to intermediate care.
- Medicine reconciliation and reviews.
- Carers as equal partners.
- Specialist clinical support for care homes.

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

37
## Annex 3: Examples of local improvement

### Benefits for Carers

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>PILLAR</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highland</td>
<td>Preventative and Anticipatory Care</td>
<td>Connecting Carers</td>
<td>Connecting Carers is a third sector organisation that provides information, advice, support and training to unpaid Carers across the Highland region. The Scottish Centre for Enabling Technology based at the University of the West of Scotland have helped to develop a free app for iTunes and Android which is a jargon buster and an emergency planning tool for carers with the aim of replacing the emergency action card for carers. The project involved the complete coding design, development and testing of a native app in the area of telehealthcare. Connecting Carers produced tried and tested out the 2 apps with carers and followed this up with a programme of IT training for carers to enable more carers to be aware of the use of technology as part of their caring role.</td>
</tr>
<tr>
<td></td>
<td>Preventative and Anticipatory Care</td>
<td>Dementia Specific Carer Support</td>
<td>“Dementia Specific Carer Support” provides tailored person-centred support, information and advice to older people caring for a family member or friend with dementia throughout their caring journey - from initial diagnosis and through the progressive stages of the illness.</td>
</tr>
<tr>
<td></td>
<td>Preventative and Anticipatory Care</td>
<td>Supporting Older People into Caring</td>
<td>“Supporting Older People into Caring” provides tailored person-centred support, information and advice to older people (50)+ as they become new carers, carers in crisis situations resulting in a major change in their caring situation, and to carers in employment forced into retirement or forced to re-evaluate their employment position due to sudden or crisis transition into caring.</td>
</tr>
<tr>
<td>Moray</td>
<td>Preventative and Anticipatory Care</td>
<td>Health and wellbeing for the older person</td>
<td>Quarriers Carer Support Service (Moray) in partnership with the local NHS Health Improvement Team and using external providers developed and delivered 2 x 6 week health and wellbeing courses for unpaid Carers aged over 65 years or caring for others aged over 65yrs resident in the Elgin and Buckie area. Post course feedback suggested that all 22 participants found the course to be informative, practical and of long term use. A follow up health check is being undertaken in September to identify any changes along with a 3 month post course evaluation to identify longer term lifestyle and caring impact and further support needed.</td>
</tr>
</tbody>
</table>
### ANNEX 3: Examples of Local Improvement

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>PILAR</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Lanarkshire</td>
<td>Preventative and Anticipatory Care</td>
<td>Welfare Rights Officers to Support Carers</td>
<td>South Lanarkshire Carers Network records information about issues and concerns raised by Carers. Quarterly summaries are provided to help inform service planning and development. An increase in the number of Carers looking for information about benefits and/or money advice was identified. As part of the reshaping care agenda, in partnership with South Lanarkshire Carers Network, four welfare rights officers were recruited by Money Matters to provide a welfare rights service to Carers across South Lanarkshire. Since the project started 14 months ago the service has supported over 1,000 people to attain annual benefits of over £4m.</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>Preventative and Anticipatory Care</td>
<td>Older Peoples Carers Support Worker</td>
<td>Full time Support Worker funded to work with Carers over the age of 65. The aims being earlier Carer identification and intervention. The Carers Centre has provided information, support and advice in many different forms (e.g. support groups, drop in sessions, alternative therapies, counselling, 1:1 support, training. The support groups have been slow to pick up and we will be changing the day to try to accommodate more people. The craft and reminiscence group have been a tremendous success. Drop in sessions have varied and we are constantly trailing different areas. Carer Talk has been slow to pick up but we continue to make Carers aware of the service. Carers training sessions continue, the uptake has been varied but the feedback from Carers who have attended has been positive. 1:1 Support, counselling, benefits etc. have positive results. Alternative therapy appointments are always popular.</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>Proactive Care and Support at Home</td>
<td>Direct support for older carers and carers of older people,</td>
<td>Extra Carer Support and Development workers were appointed across Aberdeenshire in April/May 2013 to specifically identify and support older carers. Information sessions and guidance/training specific to the needs of older carers is provided as well as facilitating peer support to enable carers to share common experiences, issues and concerns. The workers link with REACH teams to raise awareness of the enablement approach that is adopted and will work with older carers and carers of older people to highlight the availability of the Time to Live Fund. They will also raise awareness of the Carers Support Service amongst health staff.</td>
</tr>
<tr>
<td>Dundee city</td>
<td>Proactive Care and Support at Home</td>
<td>Time 4 U</td>
<td>Time 4 U vouchers are a simple and flexible way of supporting carers to arrange a break from their caring responsibilities. An alternative to the direct provision of services by the local authority or through Direct Payments, the vouchers provided can be viewed in the overall context of Self Directed Support (SDS). The aim of the service is to; Provide the family with easy access to short periods of support without having to approach the Local Authority Offer more flexibility to the family by giving greater control over the type, length and frequency of the short break used 55 families have received vouchers on the scheme. 23 have completed reviews – all have maintained or improved their health and wellbeing and ability to cope in their caring role.</td>
</tr>
<tr>
<td>PARTNERSHIP</td>
<td>PILLAR</td>
<td>EXAMPLE</td>
<td>SUMMARY</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>Proactive Care and Support at Home</td>
<td>North Argyll Carers Centre – Outreach Service</td>
<td>The Change fund has enabled us to have a designated worker supporting rural carers and is enabling us to start new peer support groups in remote and islands areas. Carer A living in rural area who had to move to another rural area due to progressive long term condition of their partner. Carer A felt isolated and despondent about the future. Concerned about the viability of living in area and also had to give up work. Through engagement with the Outreach Support Worker and wider team carer A is now accessing therapies, training, a condition specific carer support group and will access a rural support group in October. Carer A has recently offered to volunteer in the centre. “If it wasn’t for you guys I would be stuck in the house, not seeing anyone”</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>Proactive Care and Support at Home</td>
<td>A Survey of Sleep Quality in People with Dementia and Their Relatives</td>
<td>The project was aiming to find out information about the sleep quality of patients with dementia and their carers. The project conducted a survey on the sleep quality of patients with dementia and their carers in the East Renfrewshire area. Overall, 99 people participated in this survey: 46 people with dementia and 53 carers. Within the patient group, overall 42.5% were identified as having a degree of insomnia. Within the carer group 66.6% were identified as having some degree of insomnia. As a result, a staff training package has been developed which aims to increase knowledge and skills in sleep assessment and non-pharmacological intervention.</td>
</tr>
<tr>
<td>Falkirk</td>
<td>Effective Care at Times of Transition</td>
<td>Falkirk Enhanced Hospital Discharge</td>
<td>Funding from the Change Fund was awarded to appoint a Carer Support Worker to work in partnership with professionals from health and community care to identify carers at the point of hospital discharge, and to provide information and support to the carers of older people in Falkirk at this vital time at the start of their caring journey or when their caring role was changing. In response to referrals made to date, the CSW has provided information and support to 40 individual carers around the point of hospital discharge through 71 one to one contacts</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>Effective Care at Times of Transition</td>
<td>Carer Aware Training</td>
<td>Carer Aware Training has been developed and is being provided across the partnership. The training has three levels aimed at different staff groupings along with an online module with a basic awareness of Carers and their issues. This work is linked to the Joint Carers Strategy. This has been in operation from May 2013. Feedback to date has been positive, with staff reporting a greater understanding of carers issues particularly at times of transition</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>Effective Care at Times of Transition</td>
<td>Palliative Care Information Sessions for informal carers</td>
<td>In collaboration with the palliative care team it was decided to develop a series of workshops covering a number of topics relating to palliative care and invite informal carers to participate. An initial pilot series of four workshops was delivered. The evidence shows that carers clearly require this information therefore there is an agreement to continue to provide these workshops on alternate months and in alternate locations to widen the opportunity for carers to attend.</td>
</tr>
</tbody>
</table>
## ANNEX 3: Examples of Local Improvement

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>PILLAR</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perth &amp; Kinross</td>
<td>Effective Care at Times of Transition</td>
<td>Carers Link Worker</td>
<td>The role of the Hospital Link Worker is to provide support to hospital staff and the Hospital Discharge Team within Perth Royal Infirmary by supporting carers. The service provided by the Hospital Link Worker has been highly successful, receiving positive feedback from the Carers who have received the service, and the professionals from Health, Social Work and other Voluntary Organisations who have been involved in the partnership working. The demand for the service has also been much greater than anticipated, and has a huge potential for further development. The Hospital Link Worker attends a variety of meetings with Health and Social Work. These include, weekly Multi-disciplinary Team meetings on the Tay Ward and Stroke Unit, daily Board Rounds on Wards 3 and 6, and the Delayed Discharge Meetings twice a week. A referral is now made to the Hospital Link Worker, at the same time a referral is made to the Hospital Discharge Team for the patient/cared for. To date 74 Carers have created a Carers Support Plan with the Hospital Link Worker. Only 2 of these had been previously identified as carers.</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>Effective Care at Times of Transition</td>
<td>Carers Hospital Discharge Project</td>
<td>To improve the experience of carers of older people through the journey of hospital discharge from beginning to end. Change fund secondment of carers centre worker to be located within hospital setting at Inverclyde Royal. 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. 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.</td>
</tr>
</tbody>
</table>
| Angus | Hospital and Care Home(s) | Carers Support Service – Locality Workers | We have developed a preventative carers' assessment and support service targeted at carers and cared for people over the age of 60 years. We have improved support to carers by co-locating Carer Support Workers within local GP practices. We work in partnership with local GP practices, particularity with practice nurses, to ensure that carers registers are up to date and that all carers had been offered a carers health check. Some of the benefits:  
- Carer Support Workers are now part of a range of local groups e.g. multi-disciplinary groups and palliative care groups where the needs of the cared for and the carers role are identified as part of patient care planning.  
- Better support for carers has contributed to a reduction in hospital admissions e.g. One cared for person was able to remain living at home as a bespoke care package was put in place for the carers.  
There is an increase in locality based training programmes available to carers to assist them in undertaking their caring role, e.g. new to caring course, stress management. |
## Enhancing Housing

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>PILLAR</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moray</td>
<td>Preventative and Anticipatory Care</td>
<td>Falls Pathway</td>
<td>Working with the National Falls lead, a trigger screening tool was introduced into the A&amp;E department initially. Once this model was established in A&amp;E it was replicated at other identified sites including sheltered and very sheltered housing complexes, Scottish Ambulance service, day care, community alarm. The benefits have been measured using personal outcomes measures. Final report available on request</td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>Preventative and Anticipatory Care</td>
<td>‘Moving, for independence’</td>
<td>Wrap around support provided by timebank volunteers to enable a safe move from one accommodation to a better suited, safer home; retaining independent living and enabling the older person to control and choose the actual move itself. Maintaining that independence, enabling a move at nil cost, enabling the pace to be suited overcame the anxieties and fears which were overshadowing need to move house and made settling in supported by volunteers a comfortable and safe process. It also removed the need to move into a care home as the easiest option and family preference.</td>
</tr>
<tr>
<td>Borders</td>
<td>Proactive Care and Support at Home</td>
<td>Alternative Housing Models &amp; Intermediate Care, Sept 2013</td>
<td>We are working with Registered Social Landlords to develop models of on-site care and support, including Housing Support and Personal Care. Over the last two years the Change Fund has supported the development of alternatives to long stay institutional care; Extra Care Housing, Housing with Care and Intermediate Care. Capacity in non-institutional alternatives has risen from 46 in September 2011 to 141 in August 2013. We have seen packages of care reduced as older people have moved from their own home to a more supportive and suitable environment of Housing with Care. Since project initiation 20 older people have moved into Housing with Care developments via the joint allocation protocol. In total we have agreed a minimum of 174 properties will be available for Housing With Care in 13 different developments across the Borders. The Dovecot extra care housing development offers 37 units; each could potentially house 2 people and was developed as part of the Transforming Older Peoples Services programme, with the Change Fund providing transitional and social support on site. Tenants have been actively involved in taking part in community activities and groups with 95% satisfied with the opportunities for social interaction.</td>
</tr>
<tr>
<td>Angus</td>
<td>Proactive Care and Support at Home</td>
<td>Timely adaptations including housing adaptations</td>
<td>Access to adaptations and alterations which help older people to maintain their independence at home has been streamlined. The centralising of the enquiries and referral point within community care First Contact service has been particularly successful in releasing OT staff time in locality teams to carry out assessment and arrange provision. Following these tests of change it has been agreed that OT and OT assistant posts will become a substantive part of First Contact.</td>
</tr>
</tbody>
</table>
## South Lanarkshire
**Effective Care at times of transition**

**Housing**

The project to increase the supply of housing suitable for older people began in December 2011. Amenity housing is specially designed or adapted to meet the needs of older people and includes features such as external and internal handrails, non-slip bathroom flooring and repositioned electrical and lighting sockets. The project involves:

- upgrading 278 properties to meet the full amenity standard
- converting over 600 general needs properties to amenity standard; and
- supporting the development of 30 units new-build amenity housing

“We hadn’t actually realised this sort of housing existed, but we are so glad we were told about it. We had applied for sheltered housing but the lady from the Council asked if we had thought about amenity housing, which was great as it suits us perfectly.”

## Dundee City
**Effective Care at times of transition**

**Housing with Care**

This case study describes the development of 2 Housing with Care services in partnership with Caledonia Housing and Bield housing. The model delivered 200 hours of care and support for up to 10 people in each site. Both sites have mixed tenures providing an environment where the assets of other are drawn on to provide a lively and active community.

The service supports both people with deteriorating health and those who have dementia. There is overnight care available.

## East Renfrewshire
**Enabler**

**Independent Sector Engagement – My Home Life**

Support training and development needs in particular development of leadership and management skills for 9 care home managers and also 3 managers of extra care housing through the My Home Life programme. The programme commenced Aug 13 and will run for 14 months.

## Preventative and Anticipatory Care

### East Lothian
**STRIVE Intergenerational Befriending**

Sept 2013 3rd sector

This Project trains young people between the age of 15 and 20 as befrienders visiting local Care Homes or Hospitals in a small group accompanied by an experienced volunteer. The small groups take part in activities and conversations with older residents. 62 older people involved in group activities from 56 sessions run across 4 care homes. An average of 36 older people participating during each week with 29 active young volunteers. 9 new young people trained as volunteers, supported by 4 active adult supervisors. 2 new adults trained as supervisors with a total of 251 hours of befriending provided. residents said: ‘You get a good laugh!’; ‘I enjoy it, I look forward to it.; ‘and It's brilliant! I’m delighted to have volunteers in. They bring different things in. Staff have reported that ‘Interestingly, some residents who wouldn’t normally join in activities have attended and participated in a variety of activities. In addition, three young people represented the project through a 10 minute presentation when it won the MWC award for ‘Care & Support of People with Dementia. Feedback from one of the schools was very positive: ‘Both the volunteering and the opportunity to present their work, has been a fantastic experience for these girls and has really boosted their self-esteem.’
## PARTNERSHIP | EXAMPLE | SUMMARY
--- | --- | ---
East Dunbartonshire | Older Peoples Access Line (OPAL) | OPAL combines key information, advice and advocacy support through Citizens Advice Bureau, CEARTAS and Carers Link and capacity building support through East Dunbartonshire Voluntary Action. The groups work to ensure that older people can access advice, information and other support required to assist in keeping them out of hospital and to reduce isolation in the community. The project operates a case management process whereby the voluntary sector officer taking the call will deal with the issues and follow up on behalf of the customer. In the period since the Access Line opened in June 2012, there have been 420 advice referrals from various sources including Health (with GPs being one of the major sources of referral), Social Work, voluntary organisations and self-referrals. In addition, capacity building work focussed on improvement planning has been carried out with over twenty local older people service organisations.

Borders | Anticipatory Care | This project developed and utilises the Stow Anticipatory Care Community Assessment Tool (STACCATO) to improve care for people living at home who have problems with their health, are dependent on a carer or where the main carer is stressed. The assessment is about what a person is able to do on their own and what help they currently receive. The assessment is then used to plan what care needs to be put in place should they become unwell or their regular carer be unavailable for a period of time. There have been 4 Anticipatory Care Plans (ACPs) activated and in each case it was possible to maintain the person at home rather than admitting them to a care home and, in one case, prevented what would have been an onward admission to hospital resulting in a saving of £6,744. Analysis for 68 of the STACCATO patients showed:
- a reduction of 45 bed days for the 11 people who had admission both in the year pre, and post STACCATO
- There were another 10 clients who had admissions totalling 85 bed days pre STACCATO who had no admissions post STACCATO. Assuming an average cost per bed day this equates to a saving of £31,450

South Ayrshire | Twoz Company Befriending run by VASA in South Ayrshire | Twoz Company was established by VASA with Change Fund resources, to support isolated older people. Referral can be from primary care, social work, third sector and self-referral. People are matched with trained local volunteer befrienders who offer support and friendship.

Clackmannanshire & Stirling | “Active Living for Life” – an Exercise Referral, Brief Intervention Project for older people | Active Living for Life is an exercise referral brief intervention project encouraging physical activity in managing age and obesity related conditions. The philosophy behind Active Living for Life is to get new people active in a preventative 12 week brief intervention programme and create a best practise health promotion service which supports individuals to sustain an active lifestyle. This project commenced in December 2012. Although at an early stage, significant progress has been made in setting up and establishing specialist classes for older people. We are well on way to reaching an anticipated 300, new annual referrals including anticipatory care referrals from Keep Well Stirling and long term conditions referrals from the REACH teams. The crucial follow on rate for people continuing their physical activity is now being established with the initial referrals that are now completing their brief intervention period.
**ANNEX 3: Examples of Local Improvement**

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perth &amp; Kinross</td>
<td>Men’s Sheds</td>
<td>The development of a “Men’s Shed” is an approach that is being implemented across the world in an attempt to engage men of all ages. Predominately in the first instance retired older men in our communities that have time and minimal interests to keep them busy and active. Men’s Sheds provide men, who might otherwise become isolated from important work, family and community networks, and a place to gather, to participate in a variety of activities whilst supporting each other. Staying connected is recognised as important for good health. Social isolation is associated with higher morbidity and mortality rates, for men especially. “Men’s Sheds provides a great way to find support and friendship, and are open to people from all walks of life.”</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>Aberdeen Golden Games</td>
<td>In 2013 23 separate events were held over 3 days and seven venues. Over 350 bookings were made for these events. The Golden Games won the 2013 UK Award for Health &amp; Wellbeing at the Association of Public Service Excellence. Participants included teams from nursing homes and carers. In the last 2 years, approximately £6000 p.a. from the Change Fund has been used to support costs. More older people are now regularly taking part in Active Ageing opportunities, such as Table Tennis or Ten Pin Bowling and these are financially self-sustaining.</td>
</tr>
</tbody>
</table>
| East Renfrewshire | “Your Wee Red Bus”                 | “Your Wee Red Bus” aims to make a difference to people’s lives by providing transport for afternoon teas and assisted shopping services to enable people to interact socially within the community. The service offers:  
  - Trips to medical appointments  
  - Assisted shopping trips  
  - Trips to afternoon teas  
  A recent survey showed 85% of new people using the service to feeling isolated and wanting to get out more to meet people. Over 90% of existing users of the service reported personal benefits including having things to do and people to see. Surveys showed the difference in 6-9 months and how the individual was less isolated from what they were at the start. 25 new user surveys and 36 existing user surveys were carried out. The responses showed the afternoon teas were the most popular activity as mostly everyone rating the afternoon teas as 5/5 or excellent. |
| Argyll and Bute    | Third sector promoting self-     | A focus group with older people was conducted with Argyll Voluntary Action and the falls prevention workstream to modify the language and messages in a falls prevention ‘lunchbox’ resource developed and presented at a JIT workshop by Dr Heather Hall for use by Sheltered Housing wardens. The ‘third sector box’ is delivered by Argyll Voluntary Action at present but the plan is to train volunteers to deliver it to their peers to raise awareness of modifiable falls risks across Argyll and Bute. The interactive resource contains key messages and is designed to engage older people. The box contains examples of a good shoe, a crunchie and aero (to demonstrate the differences between osteoporotic and normal bone) and wipes to clean glasses. Printed resources are being developed and will be available by Dec 2013. |
|                   | management in falls prevention    |                                                                                                                                       |
### ANNEX 3: Examples of Local Improvement

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
</table>
| **Angus**   | South Angus Locality Medicine for the Elderly Model (MFE) | Tested in one locality (south Angus) then spread to two others. Each project is delivered by locality teams, led by locality geriatrician so there is continuity of care for patients linking all of the pathways and projects culminating in a whole Angus locality approach.  
- Angus MFE led AMU liaison (supported by discharge coordinators) reviewed all frail patients from Angus within 24 hours of admission. This led to more than 85% discharged directly from AMU to home, with responsive services, or to a local community hospital. A surgical model has just commenced.  
- Angus Ortho geriatric pathway. All Angus patients admitted to Orthopaedic wards are reviewed by Angus MFE within 48 hours and discharge planning is supported by “perfect orthopaedic pathway” to home.  
- A Care Home Support service was started where the locality MFE team supported local GP’s to deliver annual medication reviews, support creation of Anticipatory Care Plans, give timely telephone advice at time of crisis and ensure all new admissions to care homes have anticipatory care plans including Do Not Attempt CPR status.  
- Practice based Polypharmacy review clinics. Every Angus patient on 12 or more medications and over age 75 years has undergone a collaborative medication review with their own GP, practice pharmacist and local MFE Consultant.  
- Practice based multidisciplinary team meetings (MDT) with Angus carers, therapists, social work, district nurses, MFE and GP discuss “at risk” patients at weekly meeting aimed at crisis prevention.  
- Angus in-reach Therapy project. Angus occupational therapists support Ortho geriatric and AMU models with ability to discharge patients home with same day review of function.  

**Outcomes:**  
- 60% reduction in unscheduled admissions to hospital from care homes.  
- Reduction in new care home admissions by 40%.  
- Reduction in length of stay in orthopaedics by 8 days and in medicine by 5.5 days per patient.  
- New locality based model has led to more efficient and effective service delivery and a significant reduction in bed reliance in South locality 25 beds are used per night compared to 43 beds 3 years ago.  
- Mean patient length of stay in South locality is 6.8 days as opposed to 9.2 days in North locality where spread is 12-48 months behind |
| **East Ayrshire** | Early intervention of Nutritional Care for Older People’s Services | The Nutrition and Dietetics department within NHS Ayrshire and Arran has worked in partnership with care providers to develop a practical training programme aimed at improving the quality of nutritional care for those at home. Since November 2011, a total of approximately 1000 care at home staff have been trained. On-going evaluation of the education programmes has highlighted at least an 80% increase in knowledge, skills and confidence in implementing nutritional care and first line advice |
ANNEX 3: Examples of Local Improvement

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow City</td>
<td>Dementia Post Diagnosis Support</td>
<td>A model of Dementia Post Diagnosis Support (PDS) was developed in partnership across health, social work and the voluntary sector to deliver the requirements of the Dementia HEAT target for post diagnosis support. Over 300 people in the past year have received a new diagnosis of Dementia in South Glasgow and have had access to a named Link Worker who has worked with them and their relatives/carers to develop a Personal Plan based around Alzheimer Scotland’s 5 Pillars approach. As we approached the end of the first year, we reached capacity with our available staffing resources (current NHS staffing plus the addition of the Alzheimer Scotland Link Workers) to deliver PDS and have recruited to enable rollout across the city. This will be informed by the lessons learned from the initial phase of the project, such as the processes used for allocation of cases. In addition, we have developed recording systems (both electronic and patient-held), which will also be rolled out. We are likely to trial different models of PDS in other areas, in order to evaluate what appears to be the most efficient and effective. In evaluation currently.</td>
</tr>
</tbody>
</table>

| Shetland    | Neurological Exercise Project    | The project was set up with the primary aim of ensuring that all patients with neurological conditions had access to appropriate exercise opportunities in the community and were supported to access these. Initial start-up funding was provided through the Neurological services improvement programme, which provided for a neuro physiotherapist for a year. The change fund has lengthened the programme by 9 months to allow it to be mainstreamed. In the exercise group with impairments associated with MS 90% of the group made a clinically significant improvement in one or more objective measures. In the exercise group with impairments associated with Parkinson’s 40% of the group made a clinically significant improvement in one or more objective measures. The improvement in the Ms group exceeded expectation ands and we plan to continue this group unchanged. The Parkinson’s disease programme and results will be reviewed and regards expected outcomes and programme efficacy. |

**Proactive Care and Support at Home**

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angus</td>
<td>Timely adaptations including housing adaptations</td>
<td>Streamlined access to adaptations and alterations which help older people to maintain their independence at home. The centralising of the enquiries and referral point within community care First Contact service has been particularly successful in releasing OT staff time in locality teams to carry out assessment and arrange provision. Following these tests of change it has been agreed that OT and OT assistant posts will become a substantive part of First Contact.</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>Assistive Technology Assistants</td>
<td>Project is to raise staff awareness of the Telecare options that are available to clients and/or their carers to help more people remain at home. Service had 525 referrals in 2012. Over 60% of these referrals resulted in a better solution being advised than what was originally proposed by referrer.</td>
</tr>
</tbody>
</table>
## ANNEX 3: Examples of Local Improvement

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perth &amp; Kinross</td>
<td>Rapid Response</td>
<td>The aim of the Rapid Response Service is to provide community based alternatives to unplanned admissions to hospital and crisis admissions to Care Homes for people in Perth and Kinross over 65 years old. Perth &amp; Kinross developed a rapid response service which commenced January 2012 and had 3 elements: 1. Single Point of Contact (SPOC) 2. Eight Rapid Response Social Care Officers (RRSCOs) available 24/7 in the Community Alarm Team 3. Step Up beds in Care Homes (spot purchased) During the period May 2012 to June 2013 there were over 380 referrals into the service for support at home in an emergency. Of these only 65 were finally admitted to hospital and 13 being admitted to a care home. The majority of those who were admitted to hospital or care home were supported in their own homes for longer than they would have been without the service.</td>
</tr>
<tr>
<td>N Ayrshire</td>
<td>Telehealth</td>
<td>NHS Ayrshire and Arran in partnership with the 3 Local Authorities and initial funding for equipment from the Integrated Resource Framework began Telehealthcare projects as follows  • South Ayrshire – 2 GP Practices in Girvan identified 20 people with COPD who would benefit from Telehealthcare, monitoring is carried out by Community Nursing Teams in conjunction with Respiratory Specialist Nurses. This began in August 2011 and is on-going.  • North Ayrshire – Heart Failure Specialist Nurse identified 20 people from his case load who would benefit from Telehealthcare, this began in November 2011 and is on-going  • East Ayrshire – Dalmellington Medical Practice identified 20 people from their COPD register who would benefit from Telehealth. The GP and Practice Nurse monitor the results from this and now have 24 monitoring. This began in December 2011 and is on-going. The three separate projects were evaluated and evaluation reports are available. All three pathways show  • 80% reduction in Emergency Admissions  • 27% reduction in GP appointments  • 90% reduction in Community Nurse home visits  • 40% reduction in Out of Hours contacts  • 100% reduction in Respiratory out patient</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>Integrated Community Support Teams</td>
<td>Integrated Community Support Teams (East Kilbride &amp; Strathaven pilot) started on 14th May 2013. The teams provide inter agency support for frail older adults requiring coordinated care in their homes. Nursing and Home care has now been made available 24 hrs/ 7 days per week with other elements currently working weekdays. The 24 hour nursing service was an immediate success with older people, their families, carers and staff. The Community Nursing, Allied Health Professionals and support staff are now operationally managed together. Although slow to establish fully, this has transformed the access to services for older people in particular. An added benefit has been the effect on care delivery to all age groups within the locality.</td>
</tr>
<tr>
<td>PARTNERSHIP</td>
<td>EXAMPLE</td>
<td>SUMMARY</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Glasgow city</td>
<td>Reablement</td>
<td>Reablement provides tailored homecare support to people in their own home for up to six weeks. It builds confidence by helping people to regain skills to do what they can and want to do for themselves at home. The 2 key objectives of the service are to promote independence and ensure on-going care is tailored to individual needs, reducing dependency where relevant. The Reablement Service is a partnership between Social Work Services, Cordia and NHS Greater Glasgow &amp; Clyde with the support of Social Care Direct (CBS).</td>
</tr>
<tr>
<td>City of Edinburgh</td>
<td>Home Care Overnight Service</td>
<td>The Home Care Overnight Service provides support to older people aged 65+ in their own homes between 2200 and 0730. Each of the six teams consists of two workers on duty at any time, working in pairs. Each team makes around 20 visits per night throughout the city which prevent people with high care needs from being admitted to care homes or hospital. There was a view that referrals to the service were not being made due to its limited capacity and when the service was expanded the additional capacity would be quickly taken up – which it was. This implies that more people were able to be supported at home than would previously have been the case and potentially prevented from hospital or care home admission.</td>
</tr>
<tr>
<td>Borders</td>
<td>Pharmaceutical Care</td>
<td>The overall aim of the project was to prevent avoidable medication related hospital admissions (e.g. falls, adverse drug reactions); to optimise medicines use and reduce the number of potentially inappropriate medicines prescribed and to enhance integrated working between Health and Social Care to enable safe medicine administration and to support others to identify patients at high risk of medication related adverse events. A Polypharmacy Patient Review was implemented and rolled out to optimise drug therapy in patients identified as at increased risk of re-admission and receiving treatment with drugs from more than 10 therapeutic groups. Based on data from other areas and an assessment of the recommended changes in a sample of 50 patients, these reviews will reduce medicines spend by an estimated £200k per annum. There has been significant progress with polypharmacy reviews with a target of 2216 by end of 2013. If all the recommendations made by pharmacists were implemented by GPs and extrapolated to the NHS Borders population eligible for polypharmacy review then potentially £416,000 could be realised.</td>
</tr>
<tr>
<td>Moray</td>
<td>Joint Equipment Store</td>
<td>Investment to make improvements in the community equipment store to ensure systems are in place to provide outcome focused assessment and the provision of an effective equipment service. The Change Fund provides funding for an equipment cleaner, a technician and a vehicle. The employment of an equipment cleaner at the store has enabled the development of a joint equipment store and not just an OT store. Hospital beds for community clients were added to the stock which has allowed 73 patients to come home from hospital. Recycling of equipment has improved response times for equipment requests. We have noted an increase in delivery rates, a reduction in delivery times and an increase in equipment recycling. Measures are drawn from HEAT Targets and data drawn from the GREAS system.</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>Carers Innovative Personalised Short Breaks Sept 2013</td>
<td>East Renfrewshire Carers Centre provides older carers with an opportunity for a short personalised break to help them in the long-term in their caring role. The initiative has been in operation since June 2012. All 69 carers who have received a short break have reported a variety of positive personal outcomes. This investment therefore directly benefits the carer and the cared-for, and is personalised to meet the needs of the carer.</td>
</tr>
</tbody>
</table>
### ANNEX 3: Examples of Local Improvement

**PARTNERSHIP** | **EXAMPLE** | **SUMMARY**
---|---|---
Orkney | Home Care Reablement | Home care is all provided by the Orkney Islands Council and reablement approach has been adopted with all referrals to the home care team being considered for their potential. An Occupational Therapist has been appointed through change fund to support this approach.

#### Effective Care at Times of Transition

**PARTNERSHIP** | **EXAMPLE** | **SUMMARY**
---|---|---
West Lothian | Reablement and Crisis Care | West Lothian Council embarked on an expansion of our re-ablement service and the creation of a Crisis Care (intermediary) Service. Since April 2012, 314 residents in West Lothian have benefited from a Reablement Service. Of those
- 126 reached full independence
- 77 became more independent and needed less formal care
This resulted in an efficiency of approximately 1,000 care hours per week which would have been an annual resource equivalent of £780,000.
For the Crisis Care Service during the period 1st May – 31st March 2013 the service responded to:
- 474 Falls with an average response time of 35 minutes
- 541 Personal care calls with an average response time of 45 minutes
- 395 HSS equipment calls with an average response time of 40 minutes
- 176 General assistance calls with an average response time of 45 minutes

Glasgow city | Rapid Response & Resettlement Service | In partnership with the British Red Cross (BRC), this is a transport and resettlement service supporting the 4 A&E sites in Glasgow. Between 2pm – 2am, 7 days per week, BRC collect older people (over 60) who are fit for discharge home and resettle them in their own home. This involves a quick response to A & E, providing transport and initial support to the older person at home, to ensure they are safe and comfortable. The following day, contact is also made with the individual to see if they require any other immediate form of low level support. To date 369 patients have been transported home and settled. Approximately 60% of these have been considered by A&E staff to be avoidable admissions i.e. if this service was not available, it is likely the person would be admitted to hospital. So far, most patients are being collected from A&E within 45mins of the request for service being made. Patient feedback has also been extremely positive, particularly around the swiftness and person-centred approach of the service.

South Lanarkshire | Supporting Your Independence | Mrs B is a 93 year old lady who suffered a broken collar bone after falling at home in June 2013. Prior to injury, Mrs B was fully independent and went out daily. On referral from GP, Mrs B was assessed by a South Lanarkshire Council, Supporting Your Independence, Occupational Therapist who identified a need for appropriate equipment and home care support with personal care and meal preparation in the morning and evening. The home care service was delivered using the Supporting Your Independence approach.
<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Dunbartonshire</td>
<td>Care at Home Pharmacy Team</td>
<td>Aligning the Pharmacy Support Team with the Care at Home Reablement Team to offer support to older people and their families around medication management. Post Hospital Discharge a ‘transition’ time for many older people was originally targeted with the service now mainstreamed to cover all Care at Home clients. The Reablement Team have identified that 79% of older people are better able to manage their medication. Care at Home staff routinely ask for advice re medication e.g. inhaler administration. Community pharmacists report increased knowledge of conditions affecting older people e.g. Dementia, continence issues.</td>
</tr>
<tr>
<td>Dundee City</td>
<td>Housing with Care</td>
<td>This case study describes the development of 2 Housing with Care services in partnership with Caledonia Housing and Bield housing. The model delivered 200 hours of care and support for up to 10 people in each site. It is a flexible model which can be extended to meet increasing need. Both sites have mixed tenures providing an environment where the assets of other are drawn on to provide a lively and active community. The service supports both people with deteriorating health and those who have dementia. There is overnight care available. Of the service users who have moved to the new service, care managers’ report that they believe that they would have moved into a care home had they not accessed the support.</td>
</tr>
<tr>
<td>Western Isles</td>
<td>Reablement/Community Equipment Service</td>
<td>This project ensures the continued provision of the Reablement pilot (phase 1) and strengthening of the integrated Community Equipment Service to ensure responsive and integrated delivery of timely interventions whilst developing phase 2 of Reablement in partnership with Care at Home Services in the Western Isles. In last 18 months over 360 people seen by the service. The Rehab team developed a comprehensive multi-disciplinary falls screening tool, which has been embedded in clinical practice since June 2012 and has been rolled out to the wider OT and Physiotherapy service. The referral pathway from A&amp;E and Ambulance service has been formalised. When someone is admitted to A&amp;E with a fall a rehabilitation referral is e-mailed to the Rehab Team. The Ambulance service notifies the Rehab team of people in the community who required their support following a fall and any identified concerns. In September 2013 the project has expanded to include the development of the Community Equipment Service.</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>‘See &amp; Treat’</td>
<td>SAS staff were trained to “see and treat” a fall and link an older person into other community supports. In 1 year one of the project, 35% of people who fell, were supported to continue to remain at home</td>
</tr>
<tr>
<td>Midlothian</td>
<td>Highbank Intermediate Care</td>
<td>The service is primarily older people over the age of 65yrs to provide short term support that may be used to avoid hospital admission or facilitate discharge. The service provides the opportunity for intensive rehabilitation or short term increased carer support, following an illness. This is provided in a dedicated residential unit which can facilitate access to occupational, physiotherapists and physiotherapy equipment for people who do not need to be in hospital but cannot remain independently at home. In 2012 there was 56 admissions to intermediate care at Highbank which may have resulted in a hospital admission or provided early hospital discharge</td>
</tr>
</tbody>
</table>
### ANNEX 3: Examples of Local Improvement

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Lanarkshire</td>
<td>Palliative Care @ Home</td>
<td>The Care @ Home Palliative Care Project provides therapeutic, emotional and psychosocial support to people over 65yrs, their carers and family members affected by Cancer, Motor Neurone Disease, Multiple Sclerosis and Parkinson’s Disease. It is a partnership involving The Haven, St. Andrew’s Hospice and Kilbryde Hospice. A patient and carer survey was carried out earlier this year (2013) and all respondents indicated that the nurse information &amp; support and complementary therapies were of benefit. People reported that they now felt more confident and able to cope with their condition due to the supports they had received.</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>IC&amp;ES Intermediate Care and Enablement Services</td>
<td>The new service brought together health and social care resources previously managed separately in local authority and hospital sectors. The integrated budget for the new service includes contributions from health board, local authority and national funding to support the transition of services to a community setting. A single point of contact for referrals reduces admissions and readmissions to hospital, maximise older people’s ability to self-manage at home and maintain their independence and at the same time reduce reliance on services.</td>
</tr>
</tbody>
</table>
| N Ayrshire        | Pharmacy Hub/IC&ES Service       | Provide specialist clinical pharmacist resource within the community setting to enhance pharmaceutical care and reduce avoidable hospital admissions due to medicines and support successful discharge. Develop a pharmacy service to the Hub and IC&ES team as well as support the LOT’s  
  - Develop the role of the clinical pharmacist within the Hub and IC&ES team  
  - Collect data on issues and interventions  
  Outcomes  
  - Improved provision of pharmaceutical care to intermediate care patients within Ayrshire and Arran  
  - Promote multidisciplinary working between pharmacy and other healthcare professionals within the community setting  
  - Improved communication and development of joint working with GP’s  
  - Improved communication and development of joint working between health and social care  
  Improved recording of data collection on issues and interventions allowing more detailed and efficient analysis of information to direct future resources and workload patterns and thus maximise efficiency of service |
ANNEX 3: Examples of Local Improvement

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fife</td>
<td>Intermediate/Re-ablement Care Beds</td>
<td>Piloted an intermediate care/re-ablement bed model within a local authority care home. Utilising the existing staff group working alongside colleagues from NHS, Fife Council and the voluntary sector to provide care, support and reablement for older people at risk of going into hospital or long term care etc. We saw 80% of those who went through the model returning to live within their own homes. In a number of cases the benefits were seen quickly, often within a few days; individuals had begun regaining their confidence and were beginning manage some of their own personal care needs. Within a few weeks, they were often able to undertake most domestic and personal care needs with minimal support. Additionally, it was noted that most were far more positive about the future and were keen to return home to live independently. Consequently, those individuals who returned to live at home, generally did so with a relatively small home care package (particularly given they had been at risk of moving into a long term care facility). Through the links with the Local area Co-ordinators, service users were encouraged to access local community resources as an ongoing support following discharge from the facility. Individual case study provided.</td>
</tr>
</tbody>
</table>

**Hospital and Care Home(s)**

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>Medication Management for Frail Older People</td>
<td>To create a simple yet robust assessment tool &amp; system that would allow safe self-administration of medicines, where appropriate. To highlight &amp; resolve medication management issues before returning home from hospital / residential care.</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>Palliative Care Training in Care Homes and the Community (including community hospitals),</td>
<td>A dedicated Project Manager was appointed to facilitate implementation of Living &amp; Dying Well in Aberdeenshire. Previous work had focused on Aberdeenshire Care Homes and there was a need to extend this approach to other primary care, social care, voluntary and independent care settings. The Project Manager is working with Dieticians, DN team managers, MacMillan and Marie Curie nurses, senior charge nurses, care managers and liaison nurses in secondary care. Teaching packages for carers looking after residents with end stage dementia have been developed with CPNs, and support provided in Community Hospitals to introduce the ICP and data gathering. The support provided allowed more people to remain at home, prevented unnecessary hospital admissions and reduced the length of stay. It allowed more people to die in their own home if they wished this and supported their carers/family members to enable this.</td>
</tr>
<tr>
<td>Dundee city</td>
<td>Liaison Psychiatry for Older People</td>
<td>Liaison posts for Psychiatry (Older People) were introduced in Dundee to bridge the gap between hospital and community care and promote greater understanding of the management of older people with mental health issues. The posts are sited within the Community Mental Health Team for older people in Dundee which is a joint venture between Dundee City Council SWD and Dundee CHP. They provide an in-reach service and can follow the patient through to the community.</td>
</tr>
<tr>
<td>PARTNERSHIP</td>
<td>EXAMPLE</td>
<td>SUMMARY</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Dundee city | Care Home Peripatetic Liaison Team           | A Care Home Peripatetic Liaison Team was developed to support the independent sector in the care and management of frail older people with complex care needs. The Team identify gaps in the current systems of care and in care home staff skills and knowledge and address these by working alongside staff. While this case study relates to the use of sub-cutaneous fluids, the overarching aims of the Team are to:  
  - Improve the care and treatment being delivered within Care home settings.  
  - Reduce the need for hospital admission for the service user  
  - Improve communication and joint working  
  As a result of this particular intervention, Care Home staff are now trained, knowledgeable and confident when delivering fluids via this method. There is an established budget for supply of S/C equipment which all Care Homes can access if they have service users requiring S/C Fluids. |
| Glasgow city| Elderly Care Assessment Nurses               | Experienced Elderly Care Assessment Nurses (ECANs) appointed at each of the four acute receiving sites in Glasgow to identify and signpost frail older people with physical, functional and cognitive impairments who will benefit from coordinated comprehensive geriatric assessment.  
  Significantly improved identification of appropriate patients for geriatrician review resulting in earlier intervention and shortened length of stay |
<p>| Moray       | Access to Comprehensive Geriatric Assessment in the Community, | In Moray we monitor daily the number of patients that are over 65yrs, who attend A&amp;E and are subsequently discharged. We used the Change Fund to second a senior nurse practitioner to work alongside a Consultant Geriatrician to follow up the patients who were discharged. The Nurse Practitioner makes contact with all patients who are 65yrs who presented to A&amp;E and were subsequently discharged to ascertain if the commencement of a Comprehensive Geriatric Assessment would be appropriate. If appropriate the Nurse Practitioner visits the patient in their home and begins the assessment. If the patient has complex issues then the patient is booked into the Consultant Geriatrician clinic at the nearest Community Hospital or in the acute outpatient department. If the patient is unable to attend an appointment the Consultant will carry out a house call. Moray’s admission rates, bed days and readmission rates are dropping. Case studies from the Nurse Practitioner suggest that early intervention of this type has prevented further deterioration or planned interventions removing the unpredictability of an unscheduled admission. The project is in its ninth month of twelve and has now branched out to take referrals from GP’s (particularly supporting medicines reconciliation) and District Nurses (complex long term conditions). The Nurse Practitioner is also taking referrals from the Acute Medical Assessment Unit and the acute medical ward if patients are discharged but would benefit from a Comprehensive Geriatric Assessment. |
| East Renfrewshire | Hospital Discharge Liaison               | This case example highlights how a senior social work practitioner based in a hospital ward as a hospital discharge liaison worker supported a beneficial transition for an older person back into their home in a safe, timely way. This has not only provided real-time intelligence as to the East Renfrewshire residents in hospital but also good partnership working where the discharge liaison worker participates in the hospital multi-disciplinary team meetings and liaises with colleagues in the community with the common goal of enabling safe and timely discharge for the individual |</p>
<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falkirk</td>
<td>Extended Psychiatric Nurse Liaison Team for older people in acute care</td>
<td>Extension of the Older people’s psychiatric liaison team by two full time band 6 RMNs has allowed us to offer a seven day a week, proactive service to patient’s aged 65 and over admitted to Forth Valley Royal Hospital who have or may develop psychiatric disorders associated with their acute physical problems. We can highlight to acute teams pre-existing psychiatric disorders, provide early assessment and diagnosis of cognitive impairment, advise/implement treatment, liaise with carers and support discharge by onward referral to CMHTs, Alzheimer’s Scotland and Princess Royal carer’s Trust thereby improving patient outcomes and reducing lengths of stay. We have improved the management of people with dementia and identified around 98 new cases over the past six months who otherwise may have gone unrecognised. This has allowed appropriate feedback from trained staff to patients and carers, ensured that they are given education and information about the condition and that they have the right treatments and referrals made for on-going support. The lengths of stay are less for patients involved with OALP service and fewer end up in institutional care. The service has been highlighted in the recent OPAC report as an area of best practice.</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>Integrated AHP Service in Acute Medical Receiving Wards</td>
<td>Provision of an integrated Occupational Therapy and Physiotherapy Service commencing in Medical Receiving and continuing along the patient journey to facilitate a reduction in hospital stay. Earlier AHP assessment/intervention on all sites has resulted in a reduction in referral to treatment times with 85% of referrals assessed within 24hrs Monday to Friday. Creation of integrated OT/PT workforce has reduced duplication in the assessment process and expedited commencement of therapy interventions. Introduction of Band 4 Assistant Practitioners has successfully released time for registered staff to be involved in more complex cases and directing clinical decisions.</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>Integrated Discharge Hub at Hairmyres Hospital</td>
<td>It was agreed that establishing an Integrated Discharge Hub would support the radical redesign of the assessment and discharge processes within the hospital environment with a view to integrating the discharge process within the re-ablement and rehabilitation continuum to ensure safe, effective and timely discharge once clinically ready. Ward staff refer any older person who requires health and social care support to the Discharge Hub. The Hub Team then review the referral and contact the older person to discuss their needs on discharge. The Hub Team put in place the supports required to facilitate discharge. This approach has streamlined the discharge process for older people with complex discharge needs and has reduced the number of people who are delayed in hospital.</td>
</tr>
</tbody>
</table>
| East Ayrshire       | Referrals to Dietetic Service from Care Homes                            | The following have been developed:  
* Nutrition Care Pathway for Care Homes  
* Dietetic Referral Guidance and referral form in care homes allowing directly refer patients rather than having to ask GP to refer  

The new referral paperwork has been piloted in a number of Care Homes with positive feedback and will be rolled out to all care homes from October 2013. The referral pathway will be audited at 6 months post implementation. |
<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
</table>
| Argyll and Bute  | Reducing Emergency Admissions to Hospital                               | Multi-disciplinary group established in each area to meet on weekly basis to review each person who has been admitted to hospital as emergency in preceding 7 days. With engagement of hospital and community nurses, social work and AHP staff (as well as consultant/GPs) and local managers the group use set of prepared questions to interrogate the reasons for admission and to identify what work could have been done a) further upstream to prevent the crisis and b) at time of crisis to prevent admission.  
  - Reduction in number of emergency hospital admissions across 5 sites  
  - Improved, more joined up approach across care pathways  
  - Better understanding by professionals in all settings of services available in local areas  
  - Identification of gaps and local solutions  
  - Implementation of Virtual Ward to support management of those at higher risk of hospital readmission  
  - We need to aggregate the information from each hospital to identify further areas for development |
| Glasgow City     | Specialist ward for patients with behavioural and psychological symptoms (BPSD) of dementia and delirium | A ward in the Mansionhouse Unit in Glasgow was developed to meet the needs of patients with the most challenging behaviours associated with cognitive impairments. The ward was upgraded to be a ‘dementia friendly’ environment and staff underwent training in all aspects of dementia care. Routine input from a Consultant Psychiatrist of Old Age was agreed and has been integrated into a full multi-disciplinary team approach to patient care. Change fund monies were secured and staff training began in October 2011. The ward refurbishment completed on 24th January 2013.  
  Data has been collected six monthly since the project commenced. The main findings include:  
  - Patients with the greatest levels of challenging behaviours are being managed in this ward.  
  - Medical assessment of cognition and capacity, use of Adults with incapacity legislation, and diagnosis rates of dementia or delirium has improved considerably.  
  - Use of antipsychotic drugs is now more appropriate, planned and monitored.  
  - More patients are maintaining or increasing their weight.  
  Relative and patient satisfaction is improving |
| N Lanarkshire    | Psychological Interventions in response to stress and distress in Dementia | This training initiative was originally aimed to increase knowledge and skills of NHS and local authority staff in how to prevent, assess and respond to distress in dementia for individuals with dementia, their families and carers – this approach is now being rolled out to independent sector care home staff. To date a 2-day training model developed by NHS Education for Scotland (NES) has been delivered locally to 186 staff working at enhanced/expertise levels. In conjunction with GP training & medication reviews, positive outcomes have been evidenced including a reduction in antipsychotic prescribing, improved person-centred care, reduced multiple placement changes and readmission to hospital. |
### Enablers

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeenshire</td>
<td>Action Learning Sets, August 2011</td>
<td>A health and care network was established for GPs, local team managers and practitioners to come together to constructively challenge and improve practice, behaviours and pathways of care for older people, towards a shared outcome of shifting the balance of care. ALS were created in 11 areas in Aberdeenshire and meetings scheduled on a 6 weekly cycle. Locums were funded to enable GPs to participate. 172 people regularly attended the meetings. (Phase I August 2011 – March 2012), Phase II (April 2012 – March 2013) introduced an improvement methodology (DMAIC – Define, Measure, Analyse, Improve, Control). Significant progress has been made with improved communication and positive relationships within and between health and social care staff. Areas focussed on included understanding factors contributing to multiple admissions and understanding local data regarding ‘length of stay’, which provided clarity of where to focus efforts that would reduce length of stay.</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>Joint Strategic Commissioning Officers x 2</td>
<td>Additional capacity was obtained to deliver the requirement for a Joint Commissioning Strategy, (JCS) in the timescales expected (Feb 2013). This enabled the Aberdeen Partnership to listen firstly to the views of all stakeholders and secondly produce a Joint Strategy based on Needs and Strategic priorities. JCS was published in May 2013.</td>
</tr>
<tr>
<td>City of Edinburgh</td>
<td>My Home Life</td>
<td>A Change Fund bid for 30 care home managers pan City of Edinburgh to participate in the My Home Life leadership support and community development was successful. M.H.L. course will last for fourteen months and Talking Points personal outcomes are being threaded through the programme. The programme commenced 15th May 2013 and will run for 14 months. Very positive evaluations by all participants Excellent attendance People are already making changes in their practice particularly in the way they engage with staff, families and residents People are becoming more mindful of language</td>
</tr>
<tr>
<td>PARTNERSHIP</td>
<td>EXAMPLE</td>
<td>SUMMARY</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>West Lothian</td>
<td>Independent Sector Engagement</td>
<td>Investing in a dedicated independent sector engagement role to support RCOP developments has led to greater engagement with the independent sector in 2013. A full time project lead for IRISS was appointed on 19th August 2013. This project is still at a very early stage with the final report not due until September 2014.</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>My Home Life</td>
<td>Through Change Fund East Ayrshire are supporting this programme for 17 Care Home Managers. This 14 month programme involves a package of community and practice development, leadership support and training to help improve quality of life in care homes. My Home Life is a UK wide charitable initiative promoting quality of life for older people living and dying in care homes and for those visiting and working with them, through relationship centred and evidence based practice. MHL Scotland is a movement for quality of life in Care Homes and will help deliver some of the key policy drivers being developed by Government. This programme will continue to June 2014 and end with Validation Day on 4th July 2014.</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>Action learning sets</td>
<td>Offering a mixture of health and social care staff the opportunity to work on ‘wicked problems’ for their area which relate to Health and social care integration. ALS already carried out in Highland Perthshire – Northwest Perthshire and Strathmore Completed : ALS in North West Perthshire Ten team leaders and senior practitioners (from Health/Social care in NW Perthshire) were nominated and took part in the Highland Perthshire Action Learning programme. The ALS was evaluated after the six sessions/three full days A further set of half day sessions were requested by the group Planned: ALS – Strathearn : Sept 2013- Feb 2014 Example of Participant feedback: The ALS programme has been invaluable and has challenged me personally and professionally. It is useful to have an honest open attitude and to be able to take constructive criticism in this supportive environment. I have welcomed the opportunity to develop my skills in dealing with change management and look forward to supporting others to do the same.</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>Promoting Excellence in Dementia Training</td>
<td>The Change Fund funded three Dementia Training posts to deliver the Promoting Excellence in Dementia Care at informed and skilled practice level to Health, Local Authority and Independent Sector staff. The three Dementia Trainers deliver Promoting Excellence at Informed and Skilled Practice Level in Dementia: Informed Level - The total number of staff who have attended the Informed Practice Level is: East 114, Across the “3 Ayrshire’s” - Scottish Fire Service 133 The delegates who attended are from Home Care, Care Homes, Local Authority and NHS. The Scottish Fire Service received a hybrid model of the Informed Practice Level Training. Skilled Level - The total number of staff who have attended the Skilled Practice Level is: East 421. The trainers are funded until 31st March 2014</td>
</tr>
</tbody>
</table>
# PARTNERSHIP | EXAMPLE | SUMMARY
--- | --- | ---
Argyll and Bute | Workforce Development Passport | Having identified 108 sessions that were available for staff across the partnership to attend teams and managers were struggling to understand what was ‘must dos’. To address these concerns a Cross Sectoral Workforce Development Group was set up to review all development activity for the partnership.
Three priorities were agreed as below –
1. Core requirement to ensure implementation of the Model of Care – essential to all groups identified
2. Will support the embedding of the Model of Care and/or CPD opportunity – essential to all teams but can be address individual eventually
3. Enhance community resilience and/or CPD opportunity or clarity required – excellent for team but generally personal development

The group populated new lists for each of these priorities with a total of 21 sessions being agreed from the original 108. A workforce development passport was developed around these that outlined who these sessions were targeted at and what the organisational and service outcomes were being addressed by each session. This passport has now been agreed and circulated across the partnership to be used in conjunction with the usual partnership frameworks/policies for development.

Aberdeen City | Joint Commissioning Strategy Officers x 2 | Additional capacity was obtained to deliver the requirement for a Joint Commissioning Strategy, (JCS) in the timescales expected (Feb 2013). This enabled the Aberdeen Partnership to listen firstly to the views of all stakeholders and secondly produce a Joint Strategy based on Needs and Strategic priorities. JCS was published in May 2013.

Glasgow City | Independent Sector Engagement | Investment in a dedicated independent sector Development Officer role, has enabled increased communication and engagement with this sector in relation to the Change Fund and Reshaping Care agendas. This Officer has also co-ordinated the introduction of the ‘My Home Life’ workforce development programme for care home managers. They have also represented the independent sector within Glasgow’s Reshaping Care Partnership, and contributed to the work of the Partnership in a variety of ways. During the consultation on Glasgow’s Joint Strategic Commissioning Plan, care home managers were given literature on the Plan to utilise in their care homes. Some held residents, relatives and/or staff meetings, explaining what the Plan was about, and seeking feedback upon it. In addition to written responses, some managers also attended the engagement events on the Plan, allowing them to provide feedback directly. The ‘My Home Life’ programme is running well and participants have already begun to form a community of practice, sharing learning with each other. No qualitative data is yet available.

City of Edinburgh | Making It clear | Making it CLEAR (Community Living, Enablement and Resilience) is a partnership with Queen Margaret University. The project aims to enable older people to live well within their communities by better understanding what supports them to remain resilient. Deliverables to date include an integrative literature review which has informed the development of a tool to measure resilience. The tool is being robustly tested through working with older people in Edinburgh and will enable us, for the first time, to objectively measure the concept of resilience. Analysis of the data will now direct the next stages of the project.
<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clackmannanshire</td>
<td>Stakeholder &amp; Speed Networking Event</td>
<td>Partnership members felt that they would like the opportunity to improve relationships with other organisations, extend community connections and as most organisations are extremely busy they would like to try and achieve this all in one go. So we had to look at how this could be encapsulated within a one-day Stakeholder Event on the 20th August 2013. Invitations were extended to all sectors and community planning partners. All the organisations were given the opportunity to provide an Information Table to further advertise their services to all the attendees. Some of the current Change Fund recipients were allocated timeslots to deliver a presentation enabling them to give further insight on how their services are making changes to the lives of our older citizens. Also, there were two one-hour long speed networking sessions, which were organised in a way that gave consideration to the area of work and the location each attendee came from. This enhanced the sharing of information. Each attendee was challenged to make contact with someone from the event within 1 month. The Support Team also produced a comprehensive information document of all the Change Fund recipients and their services; this was issued to each attendee for future reference. From feedback the day has improved understanding of the co-production ethos, given a better understanding of the Change Plan for Older People and the services that are being provided. There has been further development of partnership working and relationship building, additional Links and contacts made. Partners have been able to establish where there are gaps in the current provision. Finally, there has been continual follow up activities through the support team.</td>
</tr>
<tr>
<td>Dundee City</td>
<td>Reshaping Care Third Sector Capacity Building: Community Engagement</td>
<td>The Third Sector Interface have been funded to deploy 3 Community Engagement workers to extend co-production by working with local people to identify needs and to create new community activities aimed at keeping older people safe and well in their own homes. They mapped local services and held Community Events in the 8 political wards to get older people’s opinions about their area. They identified 5 priority areas and set up Steering Groups to work together with local people and workers to create new community activities. It is early days but already there are new initiatives being delivered in coproduction such as the Look After Your Neighbour Project, Older People’s Drama Project and Mind yer Heid Training. The workers have access to a small grants programme. Other TSI staff engage with the city wide third sector. New community activities were developed which included the Look After Your Neighbour project, Older People’s Drama Project and Mind yer Heid Training - e.g. Mind yer Heid is mental health awareness training where community members and local service providers will be trained to deliver mental health awareness training to local service providers and the community.</td>
</tr>
</tbody>
</table>
The project will identify the changes required with the Comhairle’s community support services service to deliver support that enables people to live and remain in their own home and develop an overall implementation change plan.

- Provide a workforce capable of meeting the demands of increased anticipatory care activity within homes or homely settings by addressing the key priorities of the workforce development agenda.
- A draft career pathway framework has been developed with the Recruit and Retain project.
- Preliminary work to develop the generic support worker role working with RRHEAL and the work undertaken within the Orkney Health & Social Care Partnership.
- Development of a Pre Scholarship for Adult Social Care and Support – building on the excellent work with the Pre Nursing Scholarship.
- Collection and collation of data with regards to the current profile, future demands and anticipated demand focused on geographical localities. Attempting to do this across health and social care data.
- Recruitment packs being developed for job/career events.

<table>
<thead>
<tr>
<th>PARTNERSHIP</th>
<th>EXAMPLE</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Isles</td>
<td>Future of Caring at Home Career</td>
<td>The project will identify the changes required with the Comhairle’s community support services service to deliver support that enables people to live and remain in their own home and develop an overall implementation change plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provide a workforce capable of meeting the demands of increased anticipatory care activity within homes or homely settings by addressing the key priorities of the workforce development agenda.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A draft career pathway framework has been developed with the Recruit and Retain project.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Preliminary work to develop the generic support worker role working with RRHEAL and the work undertaken within the Orkney Health &amp; Social Care Partnership.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Development of a Pre Scholarship for Adult Social Care and Support – building on the excellent work with the Pre Nursing Scholarship.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Collection and collation of data with regards to the current profile, future demands and anticipated demand focused on geographical localities. Attempting to do this across health and social care data.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Recruitment packs being developed for job/career events.</td>
</tr>
</tbody>
</table>