Reshaping Care Improvement Network

Report of Practice Exchange

Friday October 28th

Objectives:

- **To engage a wide range of primary, community and secondary care practitioners in Reshaping Care for Older People**
- **To exchange models of collaborative interdisciplinary practice with a particular focus on delivering integrated and co-ordinated clinical care to support frail older people to remain at home**
- **To share experience in managing transitions including out of hours care**
- **To promote closer working between extended primary care teams, community hospitals, secondary care specialists and mental health services**
- **To explore key enablers to improve quality, efficiency and integration**

Practice Exchange

NHS Boards and their partners nominated up to 10 practitioners to attend a Practice Exchange organised by JIT in collaboration with a number of national professional organisations. Participants were drawn from primary care, community teams, community hospitals, geriatric medicine, palliative care, pharmacy and mental health services for older people.

To maximise exchange of practice across adjacent Partnerships, CHPs collaborated to field a multi-professional group drawn from across their NHS Board area. The event engaged the experience and ideas of practitioners who primarily work with older people. Throughout the day participants considered the key interventions, approaches and enablers that contribute to the Reshaping Care Pathway.

Quality and Integration

The morning session positioned Reshaping Care as a key driver to improve Quality and Outcomes for older people and a focus for the emerging policy on health and social care Integration.

Sir Lewis Ritchie outlined Delivering Quality in Primary Care's commitment to Reshaping Care and the progress in improving:

- out of hours care and access
- patient safety in primary care
- referral and emergency pathways
- redesign of services – eg eye care integration.

He described the challenge of *sharing and making routine what is good between different parts of the country and between the different contractors* and urged professionals to use data to constructively tackle variation.

Graeme Dickson, Director for Health and Social Care Integration, reminded participants of the economic and demographic challenges that lie ahead:

- **21% rise in 65+ from 2006 – 2016 and 62% rise by 2031**
- **38% rise in 85+ by 2016 and 144% rise by 2031**
- **1 in 3 people aged 75+ have two or more Long Term Conditions**

He outlined how the Reshaping Care Change Fund (£300 million between 2011 and 2015) is now being used by Partnerships as a catalyst to lever a shift in the balance of care and to inform their longer term joint commissioning. Graeme highlighted the current variation in care for older people across Scotland and the Scottish Government's proposal to tackle this through greater integration and improvement across health and social care, including use of integrated budgets. He described the overall aim of Integration to ensure that:

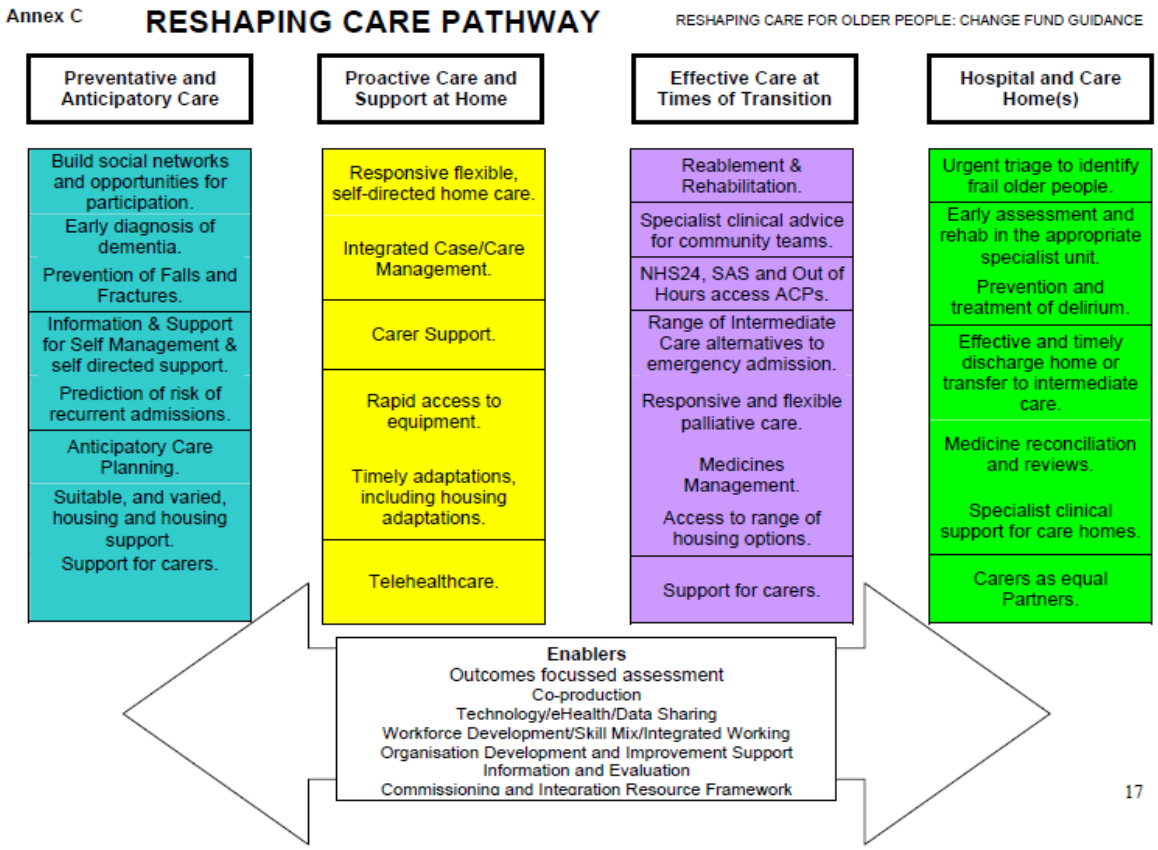
- **older people are supported to live well at home or in the community for as much time as they can**
- **they have a positive experience of health and social care when they need it.**

Proposed Framework for Integration

- Consistency of approach across Scotland
- Applies in every council and health board area
- Statutory underpinning
- Integrated budget to deliver some acute, community and social care services
- Someone clearly accountable for delivering agreed outcomes
- Professionally led by clinicians and social workers
- Simplifies rather than complicates existing bodies and structures and
- Wherever possible, it should be achieved with minimal disruption to staff and services.

Practice Exchange

Each delegate participated in two round table discussions to explore aspects of the Reshaping Care Pathway. This Pathway is a framework for the evidence based interventions and enablers that contribute to better outcomes. The Pathway is outlined in Annex C of the 2012/13 Change Fund guidance.



Participants shared experience and learning across a wide range of table topics.

- Using SPARRA to identify older people for case / care management
- Developing and sharing Anticipatory Care Plans
- Community multidisciplinary assessment / Hospital at Home
- Triage and assessment at A&E / emergency admissions unit
- PreHospital Pathway for older people who fall
- Polypharmacy and medicine reconciliation
- Preventing falls and fractures
- Post diagnostic support for people affected by dementia
- Effective use of community hospitals
- Managing discharge from hospital
- Recognising and planning for expected decline
- Comprehensive out of hours care

Case studies, supporting materials and contacts will be available on the Reshaping Care section of the JIT website.

A sample of related case studies is included in this report.

TOPIC: Using SPARRA to identify older people for case / care management

The Issue – Predicting risk of recurrent admissions using SPARRA Version 3
Scottish Patients at Risk of Readmission and Admission (SPARRA) is a tool developed by Information Services Division to predict a patient's risk of being admitted to an acute hospital as an emergency inpatient in a particular year.
Recent development work has focussed on extending the SPARRA cohort to include more than the current 750,000 patients with a recent hospital emergency admission. The aim is to develop an algorithm which uses a number of datasets to significantly increase the number of patients for whom the risk of emergency hospital admission can be estimated. Knowing which patients are at risk will help the service effectively target appropriate interventions to meet each patient's individual needs.

The Action
National hospitalisation, prescribing, outpatient, A&E and psychiatric admission datasets were linked using CHI number to build a cohort of 3.5m patients for analysis. A combination of statistical techniques and clinical input informed identification of key risk factors to be included within an enhanced algorithm.

The Deliverable / Outcome
An enhanced SPARRA algorithm was developed for a much larger cohort of patients, employing risk factors from a range of data sources. Following piloting, it is planned to make the new tool available to all Boards/CHPs in January 2012.

Contacts *ISD* SPARRA Team nss.isdLTC@nhs.net
www.isdscotland.org/sparra

TOPIC: Falls and fracture prevention

Issue
Establishing a multifactoral falls prevention programme for people aged 65 years. The programme assists older people who have fallen by identifying and modifying falls risks to prevent further falls and injuries.

Action
The Community Falls Prevention Programme (CFPP) was established by the formation of a multidisciplinary, community based team. The service operates an open, direct referral system, taking referrals from health and social care professionals as well as self referrals. Older people who have fallen are triaged to exclude immediate medical needs. A falls risk assessment is carried out in their own home, with onward referral to a range of services including geriatric falls clinic, falls pharmacist and a 12 week strength and balance exercise programme. The CFPP is integrated with the rehabilitation and fracture liaison services and links with Glasgow City Council Sport and Leisure exercise class facilities.

Deliverable / Outcome
The service has undergone an external evaluation which showed that in the first 10 years of this integrated service approach that NHS Greater Glasgow has brought about a 3.6 per cent decrease in emergency hip repair surgery. This compares with

the rest of Scotland and England where hip surgery has increased by 5.1 and 16.2 per cent respectively.

What would we do differently? Better access to more efficient IT systems and improve pathways with A&E departments, Scottish Ambulance Services and NHS 24 for older people who present with a fall.

Contacts
Margaret Anderson (Lead for Falls Acute and Community) 0141 427 8311
Margaret.anderson@ggc.scot.nhs.uk

TOPIC: Improving the Pre-hospital Pathway for Falls and Frail Older People

Issue
Frail older people commonly present to the Scottish Ambulance Service for unscheduled care, particularly after a fall. Currently SAS attends around 106 65+ incidents per day conveying almost 8 in every 10 to hospital.

Action
A Task & Finish group has considered factors which influence a decision to convey to hospital and developed an initial assessment triage/tool, options for practitioner decision support and links to pathways that refer to Single Point of Access and falls services

Deliverable / Outcome
Anticipated benefits for partnerships implementing the above include:

- ✓ A reduction in rate of falls conveyed to hospital and in repeat calls to SAS
- ✓ An increase in SAS referrals to Falls Services and Intermediate Care Services
- ✓ Understanding of how voluntary organisations can support local falls pathways.

Contacts
Drew Wemyss (Scottish Ambulance Service Head of Strategy Implementation)
Mobile no: 0780 179 2433 e-mail: a.wemyss@nhs.net

Ann Murray (National Falls Programme Manager Framework for Adult Rehabilitation)
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TOPIC: Anticipatory Care Planning

Issue
People with long term conditions and complex needs are at high risk of emergency admissions and longer stay in hospital at high cost and often poor experience and outcomes. The aim was to improve planned, co-ordinated and proactive care of these individuals.

Actions
Through an anticipatory care Local Enhanced Service (LES) practices across Highland are asked to complete anticipatory care patient alerts (ACPAs) for all care home residents and the top 1% of their population at greatest risk of unscheduled admission (using SPARRA risk prediction data). An ACPA form is completed in Primary care and involving the patient and their family. Key Information recorded on Anticipatory Care Alert Form includes:

- Contact numbers for Relatives/ Carers and for community nursing team
- List of main active diagnoses and current drugs
- Prompts to discuss Power of Attorney and CPR (where appropriate)
- Brief outline of baseline functional status
- Preferred direction of travel in case of illness
    - Community Hospital / acute hospital / Care Home
    - Plan in case of deterioration
- Consent to share information with Out of Hours service

Deliverable / Outcomes
- 5,329 ACPAs were developed by 31 March 2011
- 29% reduction in emergency new admissions and 47% reduction in occupied bed days for patients who have an ACPA in place.
- Patients with a SPARRA score of ≥ 50% but no ACPA in place showed an increase in both emergency new admissions (+59%) and occupied bed days (+63%).

Contacts
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TOPIC: Implementation of Liverpool Care Pathway (LCP)

Issue
Availability and standard of palliative care is variable across settings and diagnoses. The LCP is an evidence based tool that is adaptable to different patient groups and areas.

Actions
Funding was secured to employ a team of 6 facilitators for three years. Each facilitator was responsible for a specific clinical area, utilising their experience and expertise to provide education, conduct audit to inform reflective practice, provide feedback and ongoing support.

Deliverable/ Outcomes
The LCP is now being used in all clinical areas, including acute hospital, general practice and care homes with most areas having embedded it into their everyday

clinical practice. Staff are more skilled and confident when caring for dying people and their families. A robust and extensive final evaluation is planned. .

Contacts
Julie Graham, LCP Team Leader, NHS Lanarkshire
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www.mcpcil.org.uk/liverpool-care-pathway

TOPIC: Hospital at Home

Issue
Developing safe, effective and person centred Intermediate Care alternatives to emergency admission for frail, older people

Actions
Hospital in the Home Test of Change

GP referrals for the over 75s were diverted to a team who responded to assess the patients within the hour in their own home environment. The team included nurses trained in medical assessment, OT, PT, Social Work and a Geriatrician. Homecare was available immediately with a re-ablement emphasis. Treatment was planned including basic investigations, rehabilitation and onward referral or discharge.

The test ran for one week in a single locality (circa 3000 over 75s) in order to:
a) road test the experience for patients,
b) inform the planning of the next phase and
c) problem solve the logistics required to set up the service.

Patients, carers, staff and where possible primary care colleagues were asked for feedback.

Deliverables/ Outcomes
85% of definite expected admissions were successfully managed at home with input from the Hospital at Home team. Many patients and carers expressed high satisfaction (as did the team!).

This proof of concept test of change is informing the next step – establishing a substantive Hospital at Home service in a locality.

Contacts
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TOPIC: Information sharing to support Proactive Team based Care

Issue
Being able to use and share the GP record with colleagues in the Out of Hours service, nurses and GP's. This includes the Docman correspondence and includes Single Shared Assessment if this is scanned in.

Action
Ensure staff signed up to Roles and Responsibilities of using the GP record. Ensure patient consent and co-operation from eHealth department

Deliverable/ Outcomes
A&E, District nurse team, Physiotherapy, Inpatient in community hospital, all have access to information that benefits patient care.

Reduction in medication / allergy errors, more comprehensive view of patient in the Unscheduled care situation.

Contacts
Dr Adrian Baker (Nairn Town and County Hospital, Nairn, IV12 5EE)
adrian.baker@nhs.net

TOPIC: Triage and assessment at A&E/emergency admissions unit

Issue
To improve patient flow through triage, early assessment, treatment and rehabilitation, where possible, in a community setting

Actions
Created a Triage Unit to ensure the early assessment, treatment and timely discharge of all unscheduled referrals to the Department of Medicine for the Elderly at Woodend Hospital

Created a Supported Discharge Service for people following a stroke or orthopaedic trauma

Created Community sessions in consultants' job plans; aligned geriatricians with general practices and aligned practices with care homes, using a local enhanced service contract.

Funding to increase geriatrician and multi-professional team capacity, and local enhanced service contract to ensure GPs, consultants and multi-disciplinary colleagues work jointly to

- Review patients in care homes/sheltered housing.
- Participate in planned review of complex patients and anticipatory care planning.
- Work with the aligned community old age psychiatry team around patients
- Review more urgent 'at risk' patients at the request of the community teams

Deliverables/ Outcomes
Average length of stay reduced from 23 days to 14 days. Improved service which is less dependent on beds (reduction of 123 beds since 2005) and increasingly focussed towards community based multiprofessional working to support older people to remain well and as independent as possible in their own home or supported care setting.

Contacts

Jackie Bremner; Aberdeen City CHP jackie.bremner@nhs.net 01224 558548

TOPIC: Family Group Conferencing as Post-Dignostic Support for Dementia

Issue

Midlothian Partnership is one of 3 Dementia Demonstrator Sites in Scotland and is carrying out a feasibility study into applying the Family Group Conference model used in Childcare to Older Adults with a diagnosis of dementia. The principles of FGC are to re-empower the individual and their family to identify and plan the care required to support the individual at home (including anticipatory care planning) using family and natural network supports – in essence, family solutions to family problems.

Action

Visited to "Daybreak" project in Hampshire which uses FGC for Older Adults for whom there are Adult Protection issues, liaising with Alzheimer Scotland and Kalm Solutions on options

Deliverable / Outcome

Improved sense of control and decision making and complete involvement in identifying and setting up a care plan which belongs to the individual and is not prescribed by professionals

Contacts

Jane Fairnie (Midlothian DDS Project Manager) Jane.Fairnie@midothian.gov.uk
0131 271 3642 or
Peter Haughey (FGC lead) Peter.Haughey@midlothian.gov.uk 0131 271 3929

Workshops

Afternoon workshops signposted delegates to resources, improvement support and emerging technology that will enable Quality, Efficiency and Integration.

Productive General Practice and Releasing Time to Care

Janet Harris, Service Improvement Manager, Quality and Efficiency Support Team (QuEST) Janet.harris@scotland.gsi.gov.uk

Pam Gowans, Releasing Time to Care Manager, NHS Grampian Pamgowans@nhs.net

Productive General Practice and Releasing Time to Care shows practices, wards or teams how they can improve the way in which they work by making them more streamlined to deliver:

- Increased patient facing time
- Improved quality and efficiency
- Improved patient experience
- Valued high performance teams.
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Both programmes adopt a team based approach and develop capacity and capability using tried and tested improvement tools and LEAN methodology. Removing non value added steps will reduce waste and release time for direct patient care.

For the latest information visit: www.institute.nhs.uk/productivegeneralpractice

Institute for Innovation and Improvement. Releasing Time to Care Community Services. (2010)

http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_community_services.html

Relationship Based Care – Building Resilience

Fiona Mackenzie – Local Clinical Manager, Kirkcaldy and Levenmouth Community Health Partnership fiona.mackenzie3@nhs.net **01592 226541**

Reshaping Care for Older People and the Quality Strategy both highlight the need to change how we work in order to meet service demands. The ambitions of mutually beneficial partnerships, co production, spiritual care, compassion and integrated models feature strongly in many key strategic documents. There is an acceptance that radical change will be needed – but how this will be achieved is less clear. If more of the same will not do – then what will?

One organisation in Alaska is felt to have pioneered a way of working and philosophy that can deliver the changes we seek. This model places the importance of relationship firmly at the centre of health improvement as well as efficiency and productivity.
This workshop shared the experience of a team from Fife who visited Southcentral Foundation in Alaska earlier this year, shared key themes and emerging actions and provided an opportunity to discuss and debate what this model may offer our Scottish system in the future.

For the full report of the Southcentral Foundation team's visit to Scotland / Fife in June 2010:

http://www.playfieldinstitute.co.uk/research/alaska_visit/alaska_home.php

Google – Southcentral foundation to find other resources including video clips that illustrate the philosophy and work of this organisation.

EKIS and emerging e health opportunities

Libby Morris, Alan Lawrie, Chris Mackintosh

The management and sharing of information is an essential element of care yet fraught with difficulties often seen as barriers to integration. The workshop discussed lessons and insights from the LTC ehealth projects and how Lanarkshire partnerships are applying new solutions. The complexities of information sharing are becoming more manageable but embedding solutions in practice remains a challenge.

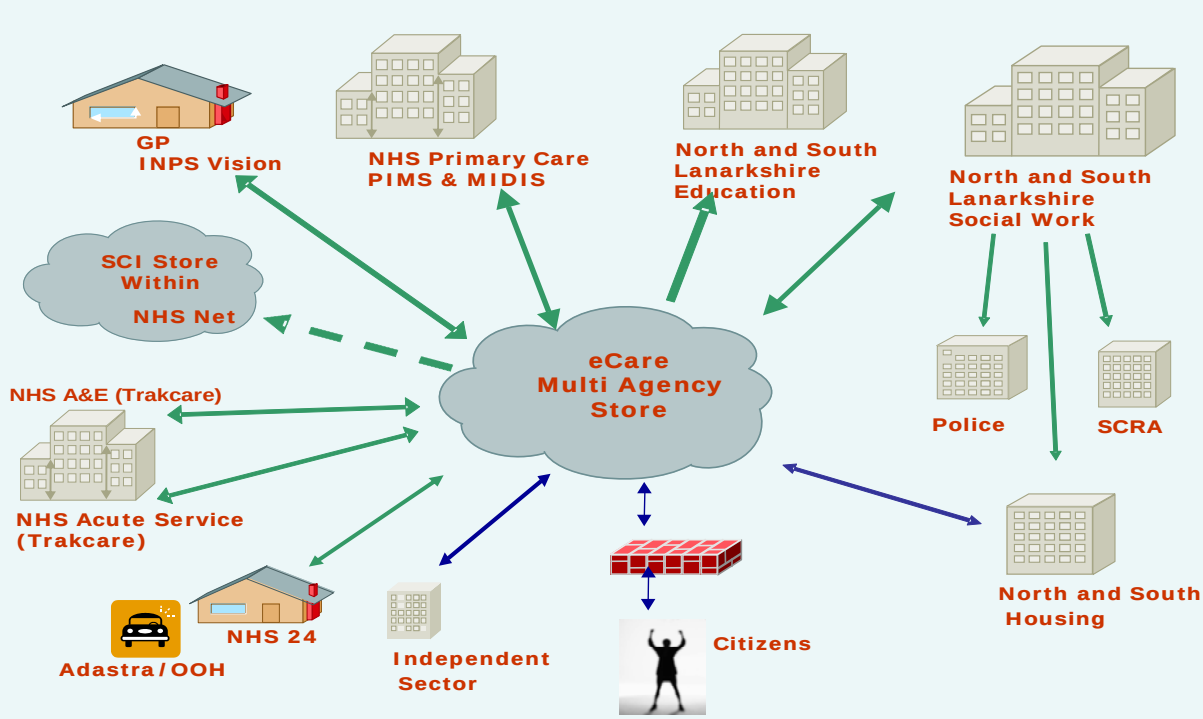
The Emergency Care Summary (ECS) is now established in Scotland, with all GP practices connected to the system and 200,000 accesses to patient records every month.

The core ECS consists of medication and adverse reaction data from Primary Care systems and is available to any clinician working in Acute Receiving Units or A&E.

The Key Information Summary (KIS) will be created in Primary Care systems in collaboration with the patient and carer for anyone who needs one. It will include important information from the ACP such as past medical history, carer details, patient wishes and DNACPR decisions if appropriate. KIS will be available to all users who can access ECS.

As each KIS will be tailored for an individual patient, this will improve efficiency, safety and timeliness, all central tenets of the Quality Strategy. Patients will be involved in the creation of their own KIS, ensuring that the process will be firmly person centred and also improve equity of service for those who are most vulnerable. Finally, the availability of Key Information for patients at the interfaces of care will improve effectiveness and promote team working.

Patient leaflets, training materials and information for clinicians will all be developed for the KIS pilots early in 2012. Further information is available on the ECS website www.ecs.scot.nhs.uk/kis (N3 users only) and updates will be published on the SNUG and SCIMP websites as the project progresses.



Using the Integrated Resource Framework for Redesign

Paul Leak: paul.leak@scotland.gsi.gov.uk **Alastair Noble:** Anoble30@aol.com

Older people deserve the best care possible and all the evidence supports the view that for most of them, for most of the time, that should be care at home or in their local community. If we deliver a high standard of community care then those who need consultant led hospital care will receive it more appropriately and be able to return to the community more

quickly. To ensure that all older people receive the right care and support in the community requires integrated care in each locality. In turn this requires a shift in resources currently deployed in acute settings. If we can make a shift from 93% of the over 65 population being at home to 97% being well looked after at home then we would be redistributing hundreds of millions of pounds.

The workshop described the Integrated Resource Framework as the underpinning financial mechanism to shift resources in a fair way that rewards good practice and encourages improvement by challenging variation.

Find out more about the Integrated Resource Framework (IRF)

Education and Workforce Development

Gill Walker – NHS Education for Scotland (NES) gill.walker@nes.scot.nhs.uk
0131 313 8099 / 07827 858783

Laura Gillies – Scottish Social Services Council laura.gillies@sssc.uk.com
01382 346491 / 01456 459083

Frances Smith – Scottish Association of Community Hospitals

The workshop explored the skills, knowledge and values required by the workforce to embed and sustain outcomes focussed care for frail older people living at home or who are in transition

- Overview of the workforce workstream in the Reshaping Care for Older People programme
- Process and results from the NES/ SACH Learning Needs Analysis of Community Hospital Staff.
- Discussion of resources developed through working with a range of health and social care education and professional groups to support workforce development and access to education and learning.

NHS Education for Scotland, in partnership with the Scottish Social Services Council, have developed a website to provide a 'one stop shop' for finding and sharing knowledge - including evidence, learning resources, legislation, standards and guidelines, publications on topics such as nutrition, stroke, dementia, medicines management and much more.

Visit: www.knowledge.scot.nhs.uk/olderpeople or www.ssks.org.uk/olderpeople

Visit the SACH website: www.scotcommhosp.org.uk

Collaborative coordinated community care

Delegates participated in round table discussions to compare and contrast emerging models of collaborative practice and co-ordinated integrated care for older people. Four Partnership examples are attached to illustrate work in progress to develop integrated and intermediate care tailored to local needs and circumstances.

The table discussions explored:

- The core disciplines and functions of an integrated team
- How to make best use of community hospitals
- Engaging effectively with general practitioners
- Involving specialist services for older people.

Participants returned to their Board groups to consider how these models could improve outcomes and experience for a scenario at the heart of Reshaping Care.

Scenario

Miss A, lives alone but with an attentive niece a few doors away and good neighbours. She is approaching 90th birthday, and has recently "felt her age". She has a long standing but well managed cardiac problem, joint pain that restricts her mobility in the morning and a recent fall in the garden. She has home care once per day Monday-Friday, family support at weekends. Family feel she has "not been right" for a couple of weeks.

Today (Friday at 4pm), a neighbour called to find her confused, unsteady on her feet and appeared very agitated. The neighbour called the GP and her niece who both attended by 4.30pm to assess situation and discuss options.

90 day challenge

Delegates were asked to identify practical actions for their Partnership to take over the next 90 Days as they develop their Change Plans for 2012/13. These actions should build local capacity and capability to reliably respond to this typical scenario.

Who? should be involved.
What? should they do
How? should they respond.
When? should things be put in place

Conclusions

Frank Strang, Deputy Director, Scottish Government Primary Care Division, reflected on a constructive day of valuable collaboration on Reshaping Care and Integration across professions and between primary and secondary care colleagues. Margaret Whoriskey, Joint Improvement Team Director, thanked participants and speakers and invited concluding reflections from the different professional groups represented. All gave a clear commitment to continue to engage and energise their colleagues to participate in the local Reshaping Care programme and in the commissioning and redesign of sustainable services that improve quality and outcomes for older people.

Integrated Community Teams in South Lanarkshire

South Lanarkshire is developing Integrated Community Support Teams (ICSTs) initially in the East Kilbride area. The ICSTs will be made up of health and social care staff who will be collocated to enable integrated working. Each ICST will cover a geographical area and be aligned to specific GP Practices. The service model for the ICSTs is made up of a three tired approach.

Tier 1
There is a strong focus on supported independence. Services at this level are universal and often accessed by the individual. Focus on self assessment, self management. Some examples of service elements would be GPs, dentists, local pharmacies, support groups, voluntary organisations.

Tier 2
Care management, monitoring and review. Individuals are identified via comprehensive assessment as requiring a minimum level of care management. The focus again is on providing the necessary services to support an individual's independence and may be provided by individual team professions or uni-disciplinary teams managed as part of the integrated team. Some elements of the service may include homecare, district nursing, physiotherapy, podiatry, packages up to a defined level, overnight care, and palliative care.

Tier 3
Intensive support / care management triggered by a specialist assessment managed through a dedicated care manager. Examples of some service elements would be emergency crisis care, specialist complex care packages, intensive rehabilitation services, specialist medical services, specialist nursing support.

Aim

The overall aim of the ICSTs is to support older people to be able to live in their own home for as long as possible. ICSTs aim to avoid hospital admission where possible however if an older person is admitted to hospital the ICSTs will enable earlier, quicker and more streamlined discharge back to community supported care.

Access to the service

People will access Tier 1 of the ICST model in the same way as currently as in this tier the services are universal services with well recognised and efficient access routes.

For Tier 2 support i.e. support requiring coordination and involving more than one agency and Tier 3 support i.e. coordinated intensive support involving medical input access will be via a new Single Point of Access

Anticipated Gains, Experience and Outcomes:

Projected Activity

Detailed Demand, Capacity and Activity work is underway currently to identify the demand for ICSTs to ensure that each team has the capacity to be responsive to changing needs of the population it covers. Data is being sourced at present for each proposed area covered by the ICSTs based on:

1. GP Populations
2. admissions to hospital by volume, age and type
3. attendances at A&E
4. SPARRA (inc new version)
5. Existing LTC Community Nurses caseload complexity analysis

Anticipated impact on Reshaping Care Core Measures

It is anticipated that ICSTs will have a positive impact on emergency bed days, delayed discharge and community care outcomes.

Core Features

The Core Team of the ICST will be made up of:

- Care Manager
- Community Nurses
- Homecare staff
- Social Workers
- Social Work Assistants
- Physiotherapists
- Occupational Therapists
- Clerical and admin staff.

The Core Team will have access to a virtual team of specialists including:

- Geriatricians
- Community Psychiatric Nurses
- Speech & Language Therapists
- Dieticians
- Specialist Nurses

Components currently in place

The elements of the service model and the infrastructure to support ICSTs are currently being developed.
Long Term Condition Community Nursing Teams and Homecare staff currently work in a similar way with geographical zones aligned to GP Practices.
An implementation group is established to oversee this work.

Planned developments in next 6-12 months

Over the next 6 months it is planned to test the service model by developing 2 ICSTs in the East Kilbride area. Following evaluation the model will be extended to other areas within South Lanarkshire over the next 12 months.

Integrated Community Teams in Aberdeenshire

Multidisciplinary Team Working in All Community Hospitals across Aberdeenshire

Aims

a. Introduce a method of cross sector working that is sustainable and owned by the HMDT.
b. Develop local capacity within GP Acute Beds to appropriately admit and care for more patients locally and consequently relieve pressure on acute hospital beds.
c. Reduce patients Length of Stay to an average of 12 days in GP Acute Beds; to an average of 25 days in GP Rehabilitation beds; to an average of 42 days in Psychogeriatric Assessment beds and the Fraserburgh Stroke Care beds; through effective planning, communication and leadership through the Senior Charge Nurse and Hospital Medical Director, across the local health and social care system.
d. Proactively support the shift in the balance of care and allow the NHSG and wider social Care System (Aberdeenshire, Aberdeen City and Moray), to free resource/capacity through joint action around the Health and Care Framework and ARI Blueprint (ECS etc.)
e. Reduce/remove inappropriate delay in the discharge process.

Access to the service

Admission to a community hospital as either a direct admission or transfer from the acute sector

Projected Activity

In addition to the 30 beds worth of activity for over 65s already removed from the acute sector, the CHP will create additional capacity for 1,700 admissions directly to Community Hospital Beds.

Anticipated impact on Reshaping Care Core Measures

a. Number of GP Acute patients who have an EDD and agreed Treatment Plan within two days of admission. (Target 100%)
b. Achieving and maintaining a 15% reduction in the average Length of Stay based on 08/09 Community Hospital Report figures or achieving a 12 day length of stay for GP Acute Beds, and reducing monthly variance.
c. Achieving and maintaining a 10% increase in the number of appropriate admissions to GP Acute Beds in Community Hospitals.
d. Within an overall reduction in the use of emergency bed days for over 65's, reduce dependency on acute sector beds. (Target 50%)

In addition to these specific measures the HMDT will contribute to delivery of the wider system (Health and Social Care) goals outlined in the Change Fund Plan, especially in the areas of Rehabilitation and Enablement and Improving Long-Term Care.

Core Features

a. Demonstrable leadership from the Hospital Medical Director and Senior Charge Nurse, both within the HMDT meeting and between meetings, ensuring that agreed plans are followed.
b. Consistent presentation of patients to the HMDT (appendix 5), and regular administrative support to the meeting, ensuring that an Action Note from the meeting (appendix 6), is circulated within 24 hours, to all members of the HMDT.
c. Regular support from Locality Managers and Clinical Leads.
d. Clear communication via secure e-mail to confirm referral to Home Care and Care Management by Community Hospitals.
e. An Aberdeenshire Council Care Management & Home Care Request for Assessment form must be completed for all referrals from a Community Hospital to Home Care or Care Management and forwarded to the appropriate person as soon as it is decided that the patient has needs that require assessment.

Components currently in place

The new model of working within the HMDT will only be sustained through the partnership between the Hospital Medical Director and Senior Charge Nurse demonstrating the required behaviours.

Action Learning Sets have been established based around the wider Health and Community Care Teams aligned to community hospitals, to provide a safe environment for promoting understanding, sharing best practice, undertaking joint problem solving and monitoring performance. Members of the HMDT will be important contributors to Action Learning Sets, shaping the role/use of local inpatient beds within the community.

Locality Managers and Clinical Leads will have a key role in providing operational support to the HMDT working with them to develop and agree local targets, monitoring performance and providing feedback on performance against target through local variance management processes. Imperative to achieving this is robust and timely coding of all admissions to community hospitals.

Integrated Community Teams in Renfrewshire

Description of the model and area covered

Rehabilitation and Enablement service implemented in May 2011, organised in two geographical teams covering the whole of Renfrewshire.

Renfrewshire has a GP practice population of approximately 176,000.

Aim

The aim of the Rehabilitation and Enablement service within Renfrewshire is to provide an integrated service to support people at home and provide rehabilitation and enablement which will lead to more people being able to live within an appropriate community setting. Services will be targeted at complex and intensive care needs and will link with main stream services to ensure appropriate services are in place to meet the needs of individuals.

Access to the service

Access to the service is through Single Point of Access (SPOA). Initially established as a health only system, this is now a joint service with ASeRT (Adult Service Request Team) within Social Work Services.

Anticipated Gains, Experience and Outcomes

Projected Activity
Key indicators in service delivery are reduced bed days, early intervention to prevent hospital admission and supported early discharge, resulting in people being supported in the community.

Core Features

The RES service is an integrated service and referrals are triaged according to need and signposted to the appropriate professional staff within the service. There are close working relationships with:

- Renfrewshire care at home services
- Acute hospital services such as A & E
- Supported discharge form acute services
- Re-ablement services within Social work
- Renfrewshire 24 – responsive 24 hour care at home team
- Day hospital for older people
- Community Nursing
- Main stream AHP services.

Other core features within the service include:
Triage to identify priority of need and signpost to the most appropriate professional
Responsive to urgent referrals
Single Point of Access
Care management
Standardised Single Shared Assessment
SWIFT (electronic) recording system across the entire service
Multi disciplinary working

Components currently in place

- Community Psychiatric Nursing
- Social work
- Occupational therapy
- Domiciliary Physiotherapy
- Physiotherapy assistant role
- Technical Instructors
- Support staff
- Specialist Nursing (Respiratory, Gerontology, Intensive Care Manager)
- Dieticians
- Speech and language therapists
- Psychology
- Administration
- Interface pharmacy.

Planned developments in next 6 months

- General nursing in reach to acute service
- EMI nursing
- Physiotherapy
- Dietetics
- Psychology
- Supported discharge
- Palliative care and anticipatory care planning.

Integrated Community Teams in Fife

Description of the model and area covered

Fully Integrated Community Assessment and Support Service (ICASS), organised in three local areas providing the same range of services.

NHS Fife / Fife Council area: Pop 365,000:

1. Dunfermline and West Fife
2. Kirkcaldy and Levenmouth
3. Glenrothes and NE Fife

Aim

The aim of the enhanced and redesigned ICASS is to provide a fully integrated range of services that are able to respond to the needs of adults in the community. The service will support effective home based acute care, anticipatory care, the earliest possible discharge from hospital, avoiding inappropriate admission to hospital and improve the patient and carer experience through better communication between services, and best clinical care.

Access to the service

Through Local access points (3) providing triage, assessment, admission to service, response and co-ordination functions (telephone or electronic access)

Admin function fully integrated within the service

Anticipated Gains, Experience and Outcomes

Projected Activity

Anticipated impact on Reshaping Care Core Measures - eg Emergency Bed Days; Care Home Admissions; Delayed Discharge; Community Care Outcomes

Core Features

Services fully integrated and provided according to need. Includes close links with community nursing, GP and mental health services:

- Hospital @Home acute assessment and treatment
- Care Management and coordination
- Integrated MDT response
- Re-ablement Home Care
- Integrated Voluntary Organisation Provision
- Access to Community Hospital Beds
- Intermediate Care housing

Core Features (continued)

- Key services Co located
- Access through one point
- Patient need / priority level is identified
- Patient allocated Key worker / responder
- Assessment carried out according to acuity.
- Multi-disciplinary treatment plan developed
- Elements of IC put in place
- Treatment plan implemented
- Monitoring and review
- Follow-up support identified
- Other agencies contacted
- Anticipatory Care function
- Patient discharged to return to independent living or support from other agencies

Components currently in place

- Nursing
- Home Care managers
- Physiotherapy
- Occupational Therapy
- Support staff – rehab care assistants
- Administration and information Team
- Collocation of SW staff (hot desk)

Planned developments in next 6-12 months

- I C Manager – joint post
- Medical Cover (from Consultant and GPs)
- Specialist Nursing
- Care Manager – Dementia and Frailty (KL only at this time)
- Dietetics
- Pharmacy
- Psychology – Dementia and frailty
- Mental Health Liaison
- Collocation of Rapid assessment and Discharge Team from A&E (OT and PT)

Programme

9.00 – 9.30 **Registration**

9.30 – 9.40 **Welcome**
Professor Sir Lewis Ritchie, Chair, Delivering Quality in Primary Care
Dr Anne Hendry, National Clinical Lead for Quality

9.40 - 10.00 **Reshaping Care – the journey so far**
Graeme Dickson, Director for Health & Social Care Integration

10.00- 11.00 **Practice Exchange 1** *Choice of table discussions*

11.00- 11.30 **Collect coffee / tea and move to next table discussion**

11.30- 12.30 **Practice Exchange 2** *Choice of table discussions*

12.30- 13.15 **Lunch, networking and posters**

13.15- 14.05 **Quality, Efficiency and Integration Workshops**
Choice of Workshops - sign up sheets at Registration Desk

Bruce	Releasing Time to Care in the Community and Productive General Practice *Pam Gowans (Grampian) and Janet Harris (QuEST)*
Patio	Relationship Based Care – Building Resilience *Fiona Mackenzie (Fife)*
Menteith	Education and Workforce Development *Gill Walker (NES), Laura Gillies (SSSC), Frances Smith (SACH)*
Kinneil	eKIS and emerging eHealth opportunities *Alan Lawrie and Chris Mackintosh (Lanarkshire), Libby Morris (ehealth)*
Earl	Using the Integrated Resource Framework for redesign *Paul Leak and Alastair Noble (Highland)*

14.05 *Collect coffee / tea and visit World Café tables*

14.05 – 14.45 **Collaborative coordinated community care**
Round table discussions of models of collaborative practice and co-ordinated integrated care for older people

14.45 – 15.45 **C4 Action Plans**
Using a scenario, delegates identify the local changes required to reduce avoidable emergency admissions, including those in the out of hours period? What local improvements and tests of change can practitioners scope and test in the next 90 days to help Partnerships support more older people to remain at home.

15.45 – 16.00 **Close**
Margaret Whoriskey, Director, Joint Improvement Team
Frank Strang, Deputy Director, Primary Care Division
Reflections from representatives of different professional groups

Event Evaluation

Structure and timings of event
Excellent / Very Good 81%

Suitability of the venue (including location and facilities)
Excellent / Very Good 81%

Quality of lunch and refreshments
Excellent / Very Good 75%

How did you rate the event overall
Excellent / Very Good 86%

Most useful:

- Networking, making links with other professionals and other authorities
- Time to explore with professionals across health and social care, locally and nationally, the options for change and existing good practice.
- Sharing of good practice/information/ideas for change
- Intermediate care/increased care discussions with colleagues
- Finding out what was happening across Scotland – good practice
- Very inspiring to listen to other good practice examples
- Table discussions to hear and participate in improvement of delivery of care
- Finding out that my partnership is on the right track
- Initial scene-setting presentations with statistics
- Developing understanding, concern and focus on the need to change what is and isn't delivered to Scotland's older citizens
- Thought provoking concepts for delivering primary care
- Workshops
- The dementia 'table talk' regarding family conferencing
- Workshop on Integrated Resource Framework
- The IT presentation
- Releasing time to care talk
- Resilience workshop very informative and thought-provoking.

Least useful:

- Introductions
- Jargon
- IRF workshop.
- RTCC workshop– thought it would be more in depth
- Not enough representation from 3rd sector, user groups or social work sector
- Distance travelled
- Last two sessions –difficult to get consistency across different areas in Board
- Scenario – RCOP work already planning for these scenarios
- Late PM format a bit clunky
- Workforce planning session tried to cram too much in
- Perhaps put too much into the whole day.