**South Ayrshire Integrated Care Fund outline plan (Full)**

**Introduction**

In July 2014, Health and Social Care Partnerships a letter was issued to Health and Social Care Partnerships regarding a new Integrated Care Fund (ICF) together with guidance material.

Subsequently, the Joint Improvement Team also issued an advice note to support the development of planning associated with the ICF.

The ICF is put in place for 2015/16 to support partnership work on ‘multimorbidity’ – a program to support those living with more than one long-term condition.

South Ayrshire has been allocated £2.34 million for 2014/15.

The Guidance sets out 6 underlying principles for the Integrated Care Fund.

**Principles of Integrated Care Fund**

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

Paragraph 13 of the guidance mentions:

- Test and deliver a matrix of supports and interventions to improve health and well-being outcomes through, for example:
  - Deepening our focus on improving personal outcomes
  - Supporting health literacy
  - Adopting a co-production approach
  - Using technology to enable greater choice and control
  - Adopting an asset based societal model to improve population health and wellbeing

In the national JIT advice note on multi-morbidity outlines **10 local actions for NHS Boards and Partnerships**

- **Outcome based assessments and holistic care planning**
  - (1) Adopt House of Care in GP practice
  - (2) Holistic GP practice and outpatient appointments
  - (3) Scale up Anticipatory Care Planning
  - (4) Pharmaceutical Care planning and reviews

- **Self-management information, advice and support to help people stay well, active and at work**
  - (5) Introduce practice based support workers/community navigators, simplify access to community support
  - (6) Scale up use of digital information, guided self-help, remote monitoring and consultation
(7) Extend health coaching and health promotion interventions to all care settings

- **Build enablement and generalist skills in workforce**
  - (8) Develop roles, job shadowing and action learning
    - Enhance generalist skills in specialist care
    - Enhance specialist expertise in community workforce

- **Co-ordinated, integrated technology enabled care**
  - (9) Support MCNs to develop single point of access, screening prompts and technology enabled decision support
  - (10) Systematically identify people with multi-morbidity and deliver stepped care using peer, 3rd sector, technology and professional support tailored to needs and complexity

Subsequent to the ICF guidance material, an additional fund – the Technology Enabled Care (TEC) utilising £10million of top-sliced monies, has been set aside to support programs using technological approaches to support the roader outcomes.

The Guidance sets out expectations regarding the content of the Integrated Care Fund plans:

**Partnerships are asked to develop Plans which describe:**

- the activities that will support the delivery of integrated health and wellbeing outcomes for adult health and social care – and the contribution to wider work designed to tackle health inequalities within Community Planning Partnerships;
- the extent to which activity will deliver improved outcomes in-year and lay the foundations for future work to be driven through Strategic Commissioning;
- relationships with localities, including how input from the third sector, users and carers will be achieved. Such a bottom-up approach should maximise the contribution of local assets including volunteers and existing community networks.
- the long term sustainability of investments and the extent to which the use of the fund will leverage resources from elsewhere.
- how resources will be focused on the areas of greatest need.
- how the principles of co-production will be embedded in the design and delivery of new ways of working.
- progress in implementing priority actions for partnerships as described in the forthcoming National Action Plan for Multi-morbidity.
- how it will enable the partnership to produce a progress report based on the above for local publication in autumn 2016.

**Development approach in South Ayrshire**

In order to identify the priorities for investment in South Ayrshire of the £2.34 million 2015/16 allocation the following process has been carried out:

Following the process set out in a previous SIB report, the Change Fund Advisory Group held a review session in order to identify existing Change Fund projects that had a strong ‘fit’ with the guidance on the ICF and where there was strong evidence of impact.
From this session, 3 Change Fund projects are being recommended for ‘mainstream’ funding utilising £251k of Resource Transfer monies (Our Intermediate Care and Enablement Service, a Falls Technical Instructor post and Out of Hours Nursing service).

Sustaining productive Change Fund projects was also supported and round £950k of the ICF will be set aside for the continuation of these projects.

Stakeholder and Partnership engagement:

- A broad engagement staff session took place on 29th September with input from Dr Ann Hendry – Clinical Lead for JIT
  - Around 50 staff in attendance from broad range of clinical, social work, third and independent sector backgrounds
  - The workshop generated a significant number of potential areas for investment

- A GP Engagement session – also held on evening of 29th September – also identified a range of areas where there is potential for the ICF to be used to strengthen the ability of GPs to contribute to the programme outcomes

- A third sector engagement session took place on Monday 6th October jointly with VASA in order to identify areas where the 3rd sector could play an important role

- These stakeholder sessions allowed for the identification of key priorities for the use of the Integrated Care Fund

- More substantive proposals were then developed over October and November (using template appended) with key ‘leads’

- Alongside the development of our ICF planning was the process to submit and Ayrshire-wide proposal for the Technology Enabled Care funding and where necessary, ICF resource was linked to this overarching programme

- Dialogue has also been developed with colleagues in North and East Ayrshire to consider Ayrshire-wide proposals

- Proposals were prioritised according to their ability to demonstrate:
  - How well they addressed the ICF Guidance requirements
  - How well they contributed to the priorities set out in the Multi-morbidity Advice Note
  - How well they were thought to contribute to reducing unscheduled emergency hospital admissions
  - Their ‘fit’ with the draft Partnership Strategic Plan Strategic Objectives* and priorities
  - Their ‘deliverability’ in 2015/16
  - Their linkage to the Technology Enabled Care submission for Ayrshire

- A small group from NHS, council, third and independent sectors considered the proposals and made recommendations to the Officer Locality Group which then provided a report to the Shadow Integration Board
The outline investment plan for South Ayrshire Health and Social Care Partnership was approved at the December 11th 2014 Shadow Integration Board.

**Addressing the demands of the Guidance**

The core questions relating to the Guidance (para 18) to be addressed:

1. **The activities that will support the delivery of integrated health and wellbeing outcomes for adult health and social care – and the contribution to wider work designed to tackle health inequalities within Community Planning Partnerships;**

   The programme for the Integrated Care Fund includes the following work strands:
   
   i. Community linking and community capacity work
   ii. Care Planning
   iii. Self Management and links to Managed Clinical Networks
   iv. Community based Rehabilitation
   v. Workforce Development and Supporting Service Integration
   vi. Telehealthcare/Technology Enabled Care
   vii. Locality Planning
   viii. Programme Management and Enablers

2. **The extent to which activity will deliver improved outcomes in-year and lay the foundations for future work to be driven through Strategic Commissioning;**

   The outline programme (appended) has been assessed in relation to deliverability in 2015/16 together with its congruence with the Strategic Objectives and key priorities set out in the draft Strategic Plan 2015-18 for the Partnership

3. **Relationships with localities, including how input from the third sector, users and carers will be achieved. Such a bottom-up approach should maximise the contribution of local assets including volunteers and existing community networks.**

   a. One of the work strands will have an explicit focus on the development of 6 Locality Planning groups linked to ‘neighbourhood’ planning
   b. It has now been agreed that this will become the ‘locality’ construct for wider Community Planning

4. **The long term sustainability of investments and the extent to which the use of the fund will leverage resources from elsewhere.**

   a. Long Term sustainability
   i. Change processes will be linked to existing improvement methodologies such as Releasing Time to Care which has successfully supported our Occupational Therapy integration work
   ii. The ICF work will also contribute towards much longer term strategic work that is being developed with colleagues in the Acute sector (most explicitly University Hospital Ayr) and in particular work on reducing
hospital admissions and reducing discharge times (as well as the Local Unscheduled Care Plan)

iii. Interventions individually and as part of larger programmes (and at system level) will seek to minimise failure demand, increase pathway efficiency and, ultimately allow the re-profiling of where resources are deployed across the whole system

iv. A significant priority consequently, will be much better and more productive utilisation of data within Primary Care, social Work and Hospital systems.

b. Leverage

i. The linked Technology Enabled Care funding, if successful, and including its linked European funding will be a substantial additional resource

ii. Linking to Community Planning and broader Community Support programmes such as Asset Based Communities pilot work

iii. Linking to Self Directed Support resources

iv. Linking to other broader work strands such as Addiction (and resources of ADP)

v. Linking to a broader partnership approach to support Community Capacity Building and Co-production involving significantly more volunteer led supports

vi. Linking to other broader work strands such as Addiction (and resources of ADP)

5. How resources will be focused on the areas of greatest need.

a. Targeting of services

i. Our Integrated Care Fund programme will address people living with multiple long-term conditions according to the Guidance. Many of these, particularly within the adult age population, live within the more deprived areas within South Ayrshire so this should create a skewing of resource towards these areas

ii. Our GP Practice Link worker programme will also concentrate most strongly on areas with high levels of deprivation

iii. Our Strategic Plan also highlights the need to address the ‘Inverse Care Law’ and this will be considered within the broader context of the deployment of all our resources

6. How the principles of co-production will be embedded in the design and delivery of new ways of working.

a. The development processes that will support most of the interventions will allow wide stakeholder involvement including service users and carers. This is already a characteristic of existing programmes linked to Self Management, Managed Clinical Networks and Community Capacity building

b. Explicit community capacity and community development work will be integral to the plan particularly to the development of locality and neighbourhood planning

a. The Integrated Care fund Plan addresses the key priority areas set out in the Multi-morbidity Advice Note including:

- Adopt House of Care in GP practice
  - There will be pilot work in 3 GP Practices utilising House of Care methodology in particular linking it to Self-Management approaches
- Holistic GP practice and outpatient appointments
  - GP practices will be supported through a range of the ICF (and other) related work as key contexts for better support in the broadest context
  - This will include greater service user and carer input into planning, Organisational Development support at a range of levels, widened professional support to GP practices from key clinical and social care services, more accessible access points to services and greater connection of Primary Care to wider community supports
- Scale up Anticipatory Care Planning
  - Anticipatory Care Planning will be a priority work strand including:
    - Further support for Community Ward and Girvan Community hospital work
    - Further capacity building at GP Practice level re ACPs
    - Development of longer term tiered approach to ACP
    - Incorporating broader screening programmes into our ACP tiered approach
- Pharmaceutical Care planning and reviews
  - There will be focused work in relation to developing additional medicines management within:
    - Girvan Hub- to provide clinical pharmacy input from local community pharmacists to the MDTs
    - Care Homes- to resource a “level 2” enhanced service from community pharmacists who have signed up to a service specification that will result in a more robust medication review and management service provision to the patients resident in the care home.
    - Care at Home Pharmacy Service- pharmacy technician resource
- Introduce practice based support workers/community navigators, simplify access to community support
  - We will develop pilot ‘Link workers’/Community Connectors in a number of GP Practices
- Scale up use of digital information, guided self-help, remote monitoring and consultation
  - As part of our wider Technology Enabled Care work strand we will be continuing to support Telecare and Telehealth, in particular, the Smartcare and United4 Health European programmes
- Extend health coaching and health promotion interventions to all care settings
  - This is already a priority within our existing Reshaping Care programme for example in relation to the Health Promoting Residential Establishment work and the My Home Life programme
- Develop roles, job shadowing and action learning
  - Enhance generalist skills in specialist care
    - Our work streams that link to key pathways (such as Intermediate Care, Falls, Telehealthcare and anticipatory Care) will provide contexts for the widening of understanding within a range of clinical specialties in relation to community based activity
  - Enhance specialist expertise in community workforce
    - The Self Management and MCN related work strand has a particular emphasis on skills development for example in Respiratory skills within the Primary Care workforce
    - The improvement methodologies deployed (such as RTTC) will also allow for opportunities for sharing skills and expertise

- Support Managed Clinical Networks to develop single point of access, screening prompts and technology enabled decision support
  - As mentioned above our Technology Enabled Care work strand will include aspects of this work

- Systematically identify people with multi-morbidity and deliver stepped care using peer, 3rd sector, technology and professional support tailored to needs and complexity
  - We will build up work utilising our Primary Care based information at Practice and Locality level to identify particular sub-groups with 2 or more LTCs and in particular, targeting support for existing high users of emergency care services

- **how it will enable the partnership** to produce a progress report based on the above for local publication in autumn 2016.
  - All ICF funded projects will follow the model developed in relation to the Change Fund in having associated outcome models and with a linked (Covalent) performance Reporting system
  - Individual and more discrete ICF interventions will be the subject of evaluation
  - The Partnership will produce an annual report explicitly linked to the Partnership Strategic Plan which will contain as an integral part, reporting on activity, outcomes and impact analysis in relation to Integrated Care Fund programme (although within the context of the broader Partnership work)
Proposed component parts of the South Ayrshire Integrated Care Fund plan

The following content sets out the current proposed approach to the utilisation of the ICF together with notional allocations for these work strands:

**Programme strand A  Community linking and community capacity work  £476k**

- Continuation of VASA Community Capacity programme
- Further extension of Carers Support programme
- Good Morning continuation at maintenance level
- **Linking** the clinical and care world to the local supports available
  - GP Link workers based in practice including ‘accompaniment’ to activities
- Building up **local activity** base particularly at neighbourhood levels
  - Potential for use of ‘small grant scheme’ at locality level (under Locality costing)
- Supporting ADP peer support and recovery
- Bidding process for 3rd sector re:
  - Addressing **social isolation** and loneliness*
  - Providing more access to lower level **physical activity***
  - Addressing **rurality access** issues*

**Programme strand B  Care Planning  £549k**

Care Planning Supporting General Practice based interventions
- GP Leadership change support
- GP Support for MDT work

Care Planning – Care Homes Support

Care Planning – more coherent approach to Anticipatory Care Planning

Care Planning – Extended Pharmacy and Medicines management
- Continuation of existing CF provision
- Clinical Pharmacy input into Girvan MDT
- Care Homes Clinical Pharmacy input
- Care at Home pharmacy service

Care Planning - Community Ward

Care Planning – Girvan Community Hospital Hub sustaining work programme

Care Planning – Discharge support (Red Cross)

**Programme strand C Self Management and Managed Clinical Networks  £113k**

Supporting Self Management Network

A new model for integrated, person-centred, community based health and social care: Testing in Respiratory Services
House of Care – developing Self Management skills and confidence in staff

Talking about Diabetes (Diabetes MCN)

Speech and Language Therapy Talking Mats

Programme strand D  Community based Rehabilitation  £241k

Access to Falls Prevention Exercise based prevention programmes (invigor8)

Weight to Go

Development of sustainable ‘tiered’ Rehabilitation programme

Programme strand E  Workforce development and supporting service integration  £191k

Talking Points Training

Workforce development

OT Integration

Programme strand F  Telehealthcare*  £364k

Telecare Programme

Utilisation of Telehealthcare
  ● Roll out of Telehealthcare work on COPD, Heart Failure and Diabetes
  *Note – match funding for application to Technology Enabled Care funding

Programme strand G  Locality Planning  £150k

Establishing Locality Planning arrangements (£120k)

Small grants fund

Programme strand H  Programme support and ‘enablers’  £170k

Enablers and programme management and support
  o  Programme Management
  o  Performance Management
  o  Analysis and evaluation
  o  Health Economics
  o  Leadership (Scottish Care)
  o  Stakeholder engagement
  o  Communication

TOTAL £2.254k (leaving £76k as yet unallocated)
In relation to the Community Capacity programme, the proposal is to invite submissions from Third sector organisations seeking to support Multi-morbidity work in particular focused on:

- Tackling social isolation
- Developing low level (Tier 1) physical activity programmes
- Addressing rural access and transport issues

£125k will be assigned to this development
## Appendix a

### Timetable for development of Integrated Care Fund investments

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
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<tbody>
<tr>
<td>Change Fund Advisory Group develop outline approach</td>
<td>5/8/14</td>
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<tr>
<td>OLG Adults considers approach</td>
<td>18/8/14</td>
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<tr>
<td>SIB agrees approach set out in paper</td>
<td>26/8/14</td>
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<tr>
<td>Change Fund Advisory Group considers existing Change Fund programme re impact and ICF fit</td>
<td>23/9/14</td>
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<tr>
<td>Integrated Care Fund Stakeholder event – development of key outline components of plan</td>
<td>29/9/14</td>
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<tr>
<td>GP session on Integrated Care fund</td>
<td>29/9/14</td>
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<tr>
<td>Third sector event on Integrated Care Fund</td>
<td>6/10/14</td>
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<tr>
<td>Discussion on technology and ICF</td>
<td>13/10/14</td>
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<tr>
<td>Sharing of outline plans with North and East partnerships + Acute</td>
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<tr>
<td>OLG Adult considers outline of investment programme</td>
<td>14/10/14</td>
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<tr>
<td>More intensive work with ‘leads’ and PW to develop more comprehensive programme (at least in outline) using outline template (appended)</td>
<td>From 29/9/14 – 14/11/14</td>
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<tr>
<td>Opportunity for Strategic Planning Group to consider outline plan</td>
<td>23/10/14</td>
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<tr>
<td>Change Fund Advisory Group meet</td>
<td>3/11/14</td>
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<tr>
<td>Adult and OP Sub Group meet and consider outline investment plan</td>
<td>10/11/14</td>
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<tr>
<td>OLG Adult agrees ICF outline/investment plan</td>
<td>24/11/14</td>
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<tr>
<td>Letters of comfort issued to existing ‘continuing’ CF projects with indicative allocations</td>
<td>28/11/14</td>
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<tr>
<td>Strategic Planning Group meets and considers outline plan</td>
<td>3/12/14</td>
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<tr>
<td>Shadow Integration Board agrees ICF Plan</td>
<td>11/12/14</td>
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<tr>
<td>Submission to Scottish Government</td>
<td>12/12/14</td>
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Appendix b

Template for Outline proposals

(Ideally – all new initiatives will be underpinned with an outcome model that will set out the elements to be reported on through Covalent)

Name of initiative:

Lead person and contact info:

Linkage to Integrated Care fund Guidance and/or Advice Note on Multi-morbidity:
(How does the initiative support the overall approach outlined in the guidance)

Can you comment on how the initiative is underpinned by the following ICF ‘principles’:

- Co-Production; ...fully supports the participation of the full range of stakeholders, particularly the third sector
- Sustainability; ..sustainable and can be embedded through mainstream integrated funding sources
- Locality; .. Partnerships should develop plans with the people who best know the needs and wishes of the local population
- Leverage; ..must be able to support, unlock and improve the use of the total resource envelope
- Involvement; ...ensuring the rights of people who use support and services and unpaid carers are central to the design and delivery of new ways of working

Brief description of initiative including:

- Key outcomes and outputs to be achieved over 2015/16
- Core activity
- Methods for monitoring and evaluation
- Numbers of patients or service users
- Dimensions of change
- Staffing implications
- Timetable
- Funding required
- Any notable implications beyond March 2016?
- If funding had been available on longer term basis, would this have been requested?
Appendix c

South Ayrshire Health and Social Care Partnership – draft Strategic Objectives from draft Strategic Plan 2015-18

The Strategic Objectives for the plan period designed to deliver the National Outcomes for Adults, Older People and Children are:

(A) We will work to reduce the inequality gradient and in particular address health inequality.
(B) We will protect children and vulnerable adults from harm.
(C) We will ensure children have the best possible start in life.
(D) We will support people to live independently and healthily in local communities.
(E) We will prioritise preventative, anticipatory and early intervention approaches.
(F) We will proactively integrate health and social care services and resources for adults and children.
(G) We will develop local responses to local needs.
(H) We will ensure robust and comprehensive partnership arrangements are in place.
(I) We will support and develop our staff and local people.
(J) We will operate sound strategic and operational management systems and processes.
(K) We will communicate in a clear, open and transparent way.

Key priorities identified in the Strategic Plan are:

- reduce the number of avoidable emergency admissions to hospital;
- minimise the time that people are delayed in hospital;
- reduced adverse events in children and young people and provide the best start in life for them;
- institute a transformational change programme across the functions delegated to the Partnership;
- integrate services and staff supported by the development of integrated strategy, systems and procedures; and
- efficiently and effectively manage all resources to deliver Best Value.