West Dunbartonshire
Health & Social Care Partnership

INTEGRATED CARE FUND – END YEAR REPORT 2015/16

Integrated Care Fund (ICF) 2015/16: End-Year Financial Summary

	ALLOCATION FOR 2015/16	TOTAL YEAR SPEND	OVER/UNDERSPENDS
Preventative and Anticipatory Care	521	521	0
Proactive Care and Support at Home	570	570	0
Care at Times of Transition	340	340	0
Unscheduled Care	474	474	0
Performance Management	85	85	0
TOTAL ICF SPEND - 2015/16	**£1,990,000**	**£1,990,000**	**0**

Integrated Care Fund (ICF) 2015/16: Achievement of ICF Outcomes

ICF Themes: Service Re-design; Prevention; Early Intervention; Care & Support

WORK STREAM ACTIVITY OR PROJECT	ACHIEVEMENT OF OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE	THEME(S)	FUNDING BREAKDOWN (£000)
Preventative & Anticipatory Care	We have developed and reviewed anticipatory care plans for over 1,800 patients in West Dunbartonshire. By introducing additional community based nursing to support General Practice we have been able to support the avoidance of unnecessary hospital admissions. As shown below, there has been a 78% increase in the numbers of patients with anticipatory care plans between 2013/14 and 2015/16. We continued to target services towards those with high level needs, in order to maintain or improve their independence; and prevent their circumstances deteriorating. People with high level needs often require visits where two or more carers provide support: during 2015/16 we provided 8,924 of carer hours to people aged 65 and over (566.9 hours as a rate per 1,000 population). Key self care programmes with enhanced interventions (including targeted health improvement activities) are in place. Work is ongoing with independent sector organisations (e.g. Link Up scheme with WDCVS). Work has commenced on developing model of care for COPD patients and Frailty.	Internal monitoring in place, including: • Numbers of patients identified. • Numbers of ACPs undertaken. • Numbers of interventions delivered. • Number of A& E attendances. • Unscheduled care activity.	N/A	Service Re-design. Prevention. Early Intervention. Care & Support	521

WORK STREAM ACTIVITY OR PROJECT	ACHIEVEMENT OF OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE	THEME(S)	FUNDING BREAKDOWN (£000)
Proactive Care & Support at Home	We have successfully created an integrated out of hours provision of District Nursing and Care at Home services and have been able to more timeously and effectively identify and respond to risk and avoid unnecessary admissions to hospital. This community service links directly to out of hours GP services and all our local authority and private sector care homes. During 2015/16., here were 5,089 visits; and 43% of these were unscheduled, highlighting the responsive nature of the service. Our Community Nursing team has introduced Patient Status at a Glance Boards that are updated following the team's daily meetings to identify vulnerable patients and those at risk of admission. Our Home Care Re-ablement service has ensured that the focus of Care at Home service is to achieve better outcomes for clients by maximising clients' long term independence and quality of life and appropriately minimising structured supports. During 2015/16, 61.5% of people who received a reablement package reached their agreed personal outcomes and re-learned the skills necessary for daily living and improved their levels of independence. We continue to work in partnership with Carers of West Dunbartonshire, and in 2015/16 the number of carers of people aged	Internal monitoring in place, including: • Number of patients in programmes. • Number of out of hours visits • Number of clients re-abled. • Number of carers identified and to whom support offered.	N/A	Service Re-design. Prevention. Early Intervention. Care & Support	570

WORK STREAM ACTIVITY OR PROJECT	ACHIEVEMENT OF OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE	THEME(S)	FUNDING BREAKDOWN (£000)
	over 65 years identified and offered support increased from 1,348 to 1366 at December 2015.				
Care at Times of Transition	We provided Care at Home to 36% of people aged 65 and over with intensive needs allowing them to live at home within their community. During 2015/16, 8,637 hours of home care (548.7 hours as a rate per 1,000 population) were provided per week to people aged 65 and over, with 90.3% receiving personal care as part of their service. Our Prescribing Team has been identified as sector leading in its work with the local Care at Home services to support "medicines prompting" and improved medicines management. We have developed Hospital Discharge Liaison Workers to provide early assessment and practical support in the ward setting. The wider Hospital Discharge Team can then involve patients and carers sooner; develop and deliver integrated care and support packages; ensure the most appropriate care and opportunities at the point of discharge; and monitor and review care package for four weeks. Home care services are managed alongside district nursing services and home based pharmacy support to ensure such continuity of care post-discharge.	Internal monitoring in place, including: • Number of patients receiving support. • Number of hours of home care provided.	N/A	Service Re-design. Prevention. Early Intervention. Care & Support	340

WORK STREAM ACTIVITY OR PROJECT	ACHIEVEMENT OF OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE	THEME(S)	FUNDING BREAKDOWN (£000)
Unscheduled Care	By focusing on timely and appropriate hospital discharge, including the creation and embedding of our community/acute service early assessor processes, we have achieved the Scottish Government's target of 0 patients delayed for more than 14 days in all but one month (March 2016) during 2015/16. We continue to see a significant decline in the number of bed days lost as a result of the redesign of services and the focus on community support. The bed days lost to delayed discharge significantly declined by 61% since 2011/12. There has also been a 12% reduction in emergency admissions for people aged 65 and over for same period. We have created a Respite Booking Bureau to provide choice and to help co-ordinate respite for carers to find suitable and appropriate respite provision. Our award winning integrated Palliative Care service has trained and supported health and social care staff from the HSCP and wider partners in the community as well as public and private sector care homes, with 62% of patients being supported to die at home or in a homely setting.	Internal monitoring in place, including: • Numbers of delayed discharges. • Number of bed days lost. • Number of emergency admissions. • Number of people being supported to die at home or in a homely setting.	Work continuing to maintain performance in relation to delayed discharge in with approach articulated within the ICF.	Service Re-design. Prevention. Early Intervention. Care & Support	474
Performance Management	ICF performance management aligned with systems for HSCP Strategic Plan, with ICF year end performance integrated within HSCP Annual Performance Report 2015/16.	N/A	N/A	N/A	85

Integrated Care Fund (ICF) 2015/16: Indicators of progress

QUESTION	COMMENT
How has ICF funding allowed links to be established with wider Community Planning activity?	The outcomes of the ICF support the delivery of key Single Outcome Agreement priorities for the local Community Planning Partnership. Our Integrated Care Fund Reference Group is one of the local Community Planning Partnership's Delivery and Implementation Group (DIG). The HSCP convenes and chairs this group on behalf of the local Community Planning Partnership Management Group, with the group having representation from the third and independent sectors, carers' representatives and service user representatives. Progress on delivering the ICF is reported to the local Community Planning Partnership Management Group.
What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly?	The outcomes of the ICF support the delivery of key commitments within the HSCP Strategic Plan. ICF year end performance is integrated within the HSCP Annual Performance Report 2015/16; and reported to the West Dunbartonshire Health & Social Care Partnership Board (the local Integration Joint Board). The work of the ICF Reference Group has been supported by engagement with stakeholders within with the two localities confirmed within the HSCP Strategic Plan: Alexandria & Dumbarton; and Clydebank – most notably in relation to developing workstreams on COPD and Frailty. The has been developed further to create a Market Facilitation Consortium model of commissioning across all of our health and social care services from across the statutory, independent and third sector to make the best use of the significant resources invested across our communities. The approach provides third and independent sector partners (alongside procurement specialists) access to the same information and data used within statutory services. This thus provides opportunities for collaborative service delivery where there is an agreed and identifiable need for services based on demographic and neighbourhood analysis. Partners across sectors are thus working in an innovative and collaborative approach; and one that is responsive, flexible and accountable locally. This approach ensures that the HSCP and the Community Planning Partnership more broadly effectively has been able to effectively deploy the ICF alongside other funding streams available.
How has ICF funding strengthened localities including input from Third Sector, Carers and Service Users?	The work of the ICF Reference Group has been supported by engagement with stakeholders within with the two localities confirmed within the HSCP Strategic Plan: Alexandria & Dumbarton; and Clydebank – most notably in relation to developing workstreams on COPD and Frailty. The has been developed further to create a Market Facilitation Consortium model of commissioning across all of our health and social care services from across the statutory, independent and third sector to make the best use of the significant resources invested across our communities. The approach provides third and independent sector partners

	(alongside procurement specialists) access to the same information and data used within statutory services. This thus provides opportunities for collaborative service delivery where there is an agreed and identifiable need for services based on demographic and neighbourhood analysis. Partners across sectors are thus working in an innovative and collaborative approach; and one that is responsive, flexible and accountable locally. This approach ensures that the HSCP and the Community Planning Partnership more broadly effectively has been able to effectively deploy the ICF alongside other funding streams available.
What evidence (if any) is available to the partnership that ICF investments are sustainable?	As with the predecessor Older People's Change Fund and in keeping with the strategic approach of the HSCP as a whole, our partnership to deliver upon the outcomes of the ICF is based on investment for change within services rather than project based workstreams, so as to ensure that practice changes are sustainable and future proof as far as possible. However with an increasingly challenging financial envelope across the public sector there we are committed to a continual process of reviewing the best value achieved by and relative merits of investments across all partners - mapped to an analysis of spend and linked to outcomes for patients and clients - as part of our overall strategic commissioning process.
Where applicable - what progress has been made in implementing the National Action Plan for Multi-Morbidity?	We have a well-established Long Term Conditions Working Group, which includes local GPs, pharmacists, nurses and social care professionals. The work of this group is informed by analysis of health and social care demographic data as well as prevalence data, alongside more innovative models of delivery – e.g. as social prescribing with the third sector; medicines prompting with care at home; and volunteer foot care services with podiatry services. As community health and social care teams have been integrated within West Dunbartonshire since 2010, shared assessment practice and the delivery of integrated care are already embedded across community health and care adult and older people's teams. This includes our integrated out of hours provision of District Nursing and Care at Home services, which links directly to out of hours GP services and all our local authority and private sector care homes.
Please provide a brief narrative around how the ICF has been used in year one towards achieving the overall outcomes set out in the strategic plan.	The outcomes of the ICF support the delivery of key commitments within the HSCP Strategic Plan that the Health & Social Care Partnership Board approved at its first meeting in July 2015. The ICF year end performance is integrated within the Health & Social Care Partnership Board's first Annual Performance Report (2015/16). These documents are available at http://www.wdhscp.org.uk/about-us/health-and-social-partnership-board/