Paper no: MSGHCC/128/2020
Meeting date: 22 January 2020
Agenda item: 6

Purpose: For action / note

Title:	**Overview of 2018/19 IJB Annual Performance Reports**

Key Issues:	This paper provides an overview of the 2018/19 Annual Performance Reports prepared by Integration Authorities. The overview covers elements including: • Progress being made; • Compliance with the content of performance report regulations; • Illustrative examples of local initiatives put in place.

Action Required:	In conjunction with the progress update on the integration review (and in particular proposals 5.1 and 5.2) the MSG is invited to note this overview. Members are also asked to agree that officials take up with Integration Authorities instances where there is a lack of required detail (such as the steps to be taken in relation to financial reporting, as noted in paragraph 25).

Author: Integration Division **Date: January 2020**	

Overview of 2018/19 IJB Annual Performance Reports

Introduction

1. The Public Bodies (Joint Working)(Scotland) Act 2014 established the legislative framework for the integration of health and social care services in Scotland. To ensure accountability, the Act obliges Integration Authorities to publish an annual performance report to cover the performance over the previous reporting year. The report should be published no later than four months after the end of the reporting year (i.e., the end of July) and should set out an assessment of performance in planning and carrying out the integration functions for which it is responsible. For most Integration Authorities, this will be the third annual performance report.

Background

2. The required content of the performance reports is set out in the Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. In summary, each report must include an assessment of performance in the context of the Integration Authority's strategic commissioning plan and financial statement and how the expenditure allocated in the financial statement has contributed to achieving the national health and wellbeing outcomes. Specific guidance was published in 2016 on what should be included in annual performance reports as well as additional guidance on financial statements.

Layout of reports

3. An annual performance report effectively fills two functions. Firstly, a statutory one, to report on performance against strategic planning priorities, national wellbeing outcomes and national (and local) indicators. Secondly, in being made publicly available, it needs to communicate these in an accessible, plain English format, ideally not too long and making good use of graphics and case studies that bring performance to life. The best reports marry these two statutory and public facing functions together well.

4. In reporting performance for 2018/19, all 31 Integration Authorities have prepared their annual performance reports, although some remain in draft form and/or difficult to find on their web pages. Taken together, the reports comprise over 1,900 pages and vary in length from 24 pages, in Orkney and Western Isles, to 116 in Glasgow City, which may not be surprising given these are respectively the smallest and largest partnerships. The typical length of report (50-80 pages) allows for factual reporting of performance and to be a vehicle to highlight some of the factors that have influenced reporting.

5. There has been general improvement in terms of clarity and accessibility of reports, with most improving on last year's report or maintaining previous good standards.

6. In line with previous years, Integration Authorities have taken different approaches to how they have reported progress on delivering the national health and wellbeing outcomes. Some have reported activity over the reporting year split by each of the outcomes, while others have reported activity by service user type and highlighted progress on the national outcomes throughout the report. The best reports mix national and local quantitative data with qualitative information and narrative. Embedding the statistical information in to the narrative works well to link activity and achievements with the relative health and wellbeing outcomes.

7. While it is important that each report meets the statutory requirements (and some do not) it is through the narrative that performance comes to life, explaining what services are and how they actively help people. The weakest reports do not do this, making them rather dull and lifeless to the wider readership.

Content of reports

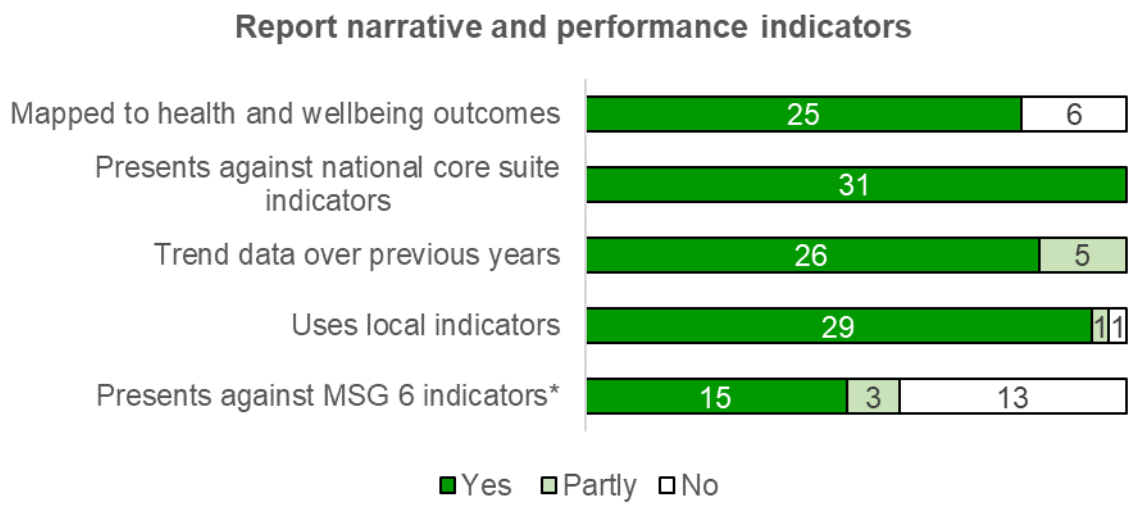
8. A key requirement is for the reports to assess performance in relation to the national health and wellbeing outcomes. Most of the reports included sections that were explicitly structured around the health and wellbeing outcomes, either directly, or indirectly by being structured around local strategic objectives, with these then mapped to the outcomes. Where this approach had been taken, it was generally easier to see how service provision contributed to the delivery of the national outcomes, although the range and depth of information provided was variable.

9. For the few reports where the report sections were not explicitly mapped to the outcomes, it was often more difficult to tell how well the work described contributed to delivery of the outcomes, although the narrative itself was usually clear and accessible with some good examples of progress, successes and challenges.

10. Progress described in the narrative of most reports includes some key legislative and strategic drivers over the year, including implementing Primary Care Improvement Plans in relation to the new GMS contract; implementing to requirements of the Carers (Scotland) Act 2016, which came into effect on April 2018; implementing the actions outlined in the national Mental Health Strategy 2017-27, particularly with regard to action 15 (workforce); and rolling out the use of technology following TEC pilots. In addition, around two thirds of the reports report on achievements against the six performance themes monitored by the MSG.

11. The reports also highlight the challenges the partnerships faced in 2018/19 and that they continue to tackle. These include financial pressures, with many Integration Authorities going in to reserves in order to balance their budgets; demographic changes, with a rise in older populations and a reduction in people of working age; workforce challenges with difficulties in recruiting and retaining GPs, other specialist clinical staff and care staff; and rising levels of A&E attendances, hospital admissions and delayed discharges. However, the reports (and strategic plans) include a number of examples of work to mitigate these factors.

12. Integration Authorities are required to report performance against the national core suite of integration indicators for the reporting year, and for the preceding years up to at least five years. All reports highlighted progress against the Core Suite of Integration Indicators in some way. All but five reports include trend information from at least 2016/17.



13. *Although not a mandatory requirement, two thirds of the reports present progress against the 6 MSG indicators. We would also expect to see local performance measures and other data to illustrate progress and nearly all of the reports do so.

Core Suite of Integration Indicators (Outcomes*): National Performance

Indicator	Title	2015/16	2017/18	Direction
NI - 1	Percentage of adults able to look after their health very well or quite well	95%	93%	↓
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	83%	81%	↓
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	79%	76%	↓
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	75%	74%	↓
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	81%	80%	↓
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	85%	83%	↓
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	80%	↓
NI - 8	Total combined % carers who feel supported to continue in their caring role	40%	37%	↓
NI - 9	Percentage of adults supported at home who agreed they felt safe	83%	83%	⇔

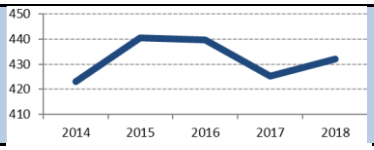
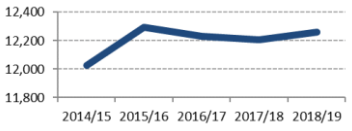
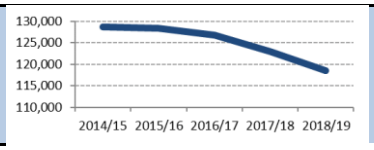
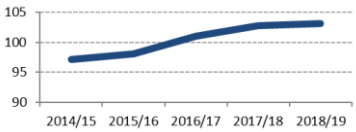
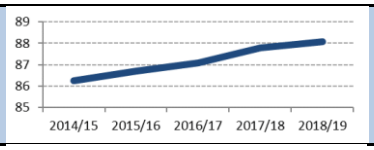
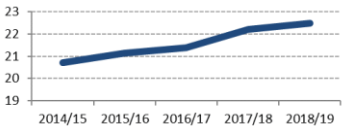
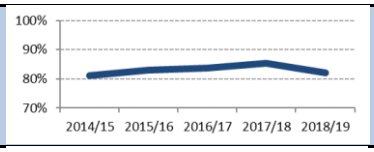
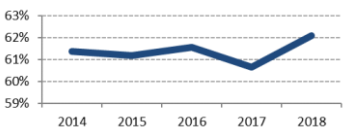
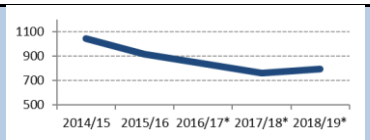
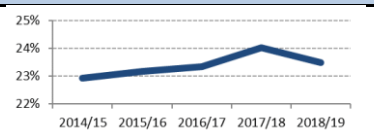
Source: Health and Care Experience Survey (Biennial), Scottish Government.

*Note: Indicator NI-10 - Percentage of staff who say they would recommend their workplace as a good place to work – is not reportable nationally. However, some Integration Authorities have included in their Annual Performance Reports the results for this or equivalent questions from their iMatter and/or other local staff surveys.

14. Generally, the feedback from these surveys is positive although there have been small percentage drops between 2015/16 and 2017/18. Next year's reports will include more up to date survey results (from the 2019/20 survey, results of which are due to be published in May 2020) and provide a better indication of progress since integration. In particular, we would look to see improvement in the level of carers who feel supported to continue in their caring role, as Integration Authorities fully implement the requirements of the Carers (Scotland) Act 2016, which took effect from April 2018.

15. For the other measures we would want to see improved performance again, reflective of ongoing developments in services and other supports overseen by Integration Authorities, and (in relation to experience of care provided by GP practices) in relation to Primary Care Improvement Plans/implementation of the new General Medical Services (GMS) contract.

Core Suite of Integration Indicators (Data Indicators*): National Performance

Indicator	Title	Trend over 5 years	2018/19*
NI - 11	Premature mortality rate per 100,000 persons		432
NI - 12	Emergency admission rate (per 100,000 population)		12,259
NI - 13	Emergency bed day rate (per 100,000 population)		118,462
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)		103
NI - 15	Proportion of last 6 months of life spent at home or in a community setting		88.1%
NI - 16	Falls rate (admissions to hospital) per 1,000 population aged 65+		22.5
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections		82%
NI - 18	Percentage of adults with intensive care needs receiving care at home		62%
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) *Note: data not directly comparable before and after July 2016.*		793
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency		23.5%

*For indicators 11 and 18 the data are for calendar year 2018.

Source: Core Suite Indicator workbooks, ISD, December 2019. These figures are based on more complete data than was available to Integration Authorities in summer 2018, when they had to finalise their 2018/19 Annual Performance Reports.

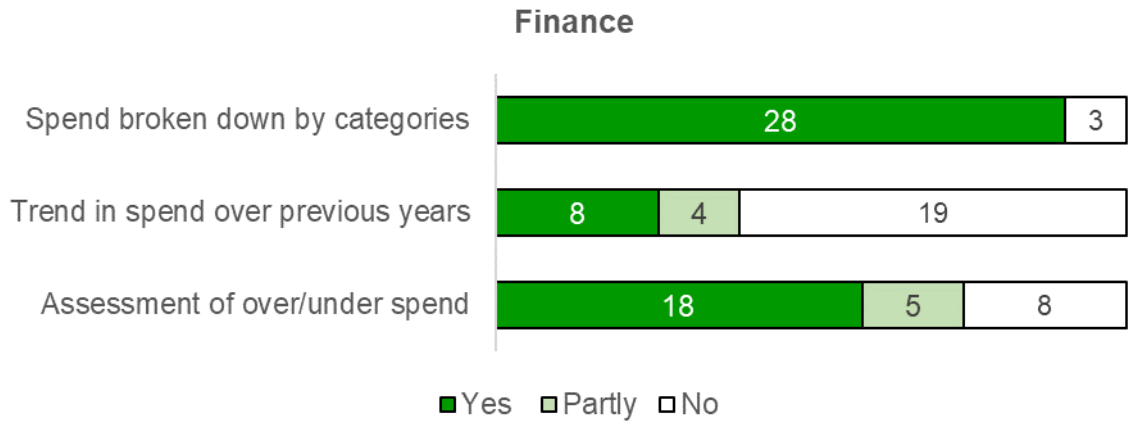
Financial performance and best value

16. The regulations require reports to include the total amount and proportion of spend by reporting year broken down by service and by key care groups. The service types, as a minimum should include:

- Hospital inpatients;
- Primary and community health care services;
- Care home and home care services;
- Social care services provided to support unpaid carers;
- Delegated social care services not mentioned above.

17. The information presented should include comparator figures for previous years (up to 5 years).

18. The report should also identify any over/underspend against planned spending and an assessment of why this has occurred. As well as an assessment of best value, the report must also set out the amount paid to, or set aside for use by, each locality.



19. There is some ambiguity over whether the regulations *(a description of the extent to which the arrangements set out in the strategic plan and the expenditure allocated in the financial statement have achieved, or contributed to achieving, the national health and wellbeing outcomes)* requires actual expenditure to be mapped to outcomes. SG guidance recognises that it will take time for Integration Authorities to develop analyses sufficient to support the full extent of reporting required by the regulations.

20. There is a great deal of variability across the reports and it is evident that they are some way from meeting the requirements set out in the regulations. That said, it is important to concentrate on the spirit of the policy intention rather than the strict letter of the regulations. In that respect, the reporting by service type is sufficient and the most important gaps are those for localities, carers, care groups and outcomes. This isn't surprising as reporting by service type fits the traditional NHS Board and local government reporting formats whilst the others require substantial additional analysis.

21. Localities and care groups are effective means of reporting expenditure in terms of the integrated pound and also resonate with the public more meaningfully than those in organisational and service specific terms.

22. The absence of expenditure on unpaid carers is more difficult to understand.

23. None of the reports include analysis of expenditure by outcomes, which underlines the ambiguity noted above. The regulations for strategic planning are clearer on the need for outcome based budgeting but it remains a gap in strategic plans and Chief Finance Officers are of the view that it is a challenging task. Its inclusion as a requirement in the regulations was aspirational and acknowledged by the Scottish Government that it was likely to be a long term reporting objective. Since then very few public sector organisations have developed outcome based finance reports and it may be that a more practical proposition would be for Integration Authorities to use an alternative approach based on outcome indicators and care programmes. However the Health and Sport Committee have taken an interest and questioned its absence and so this requires resolution one way or another.

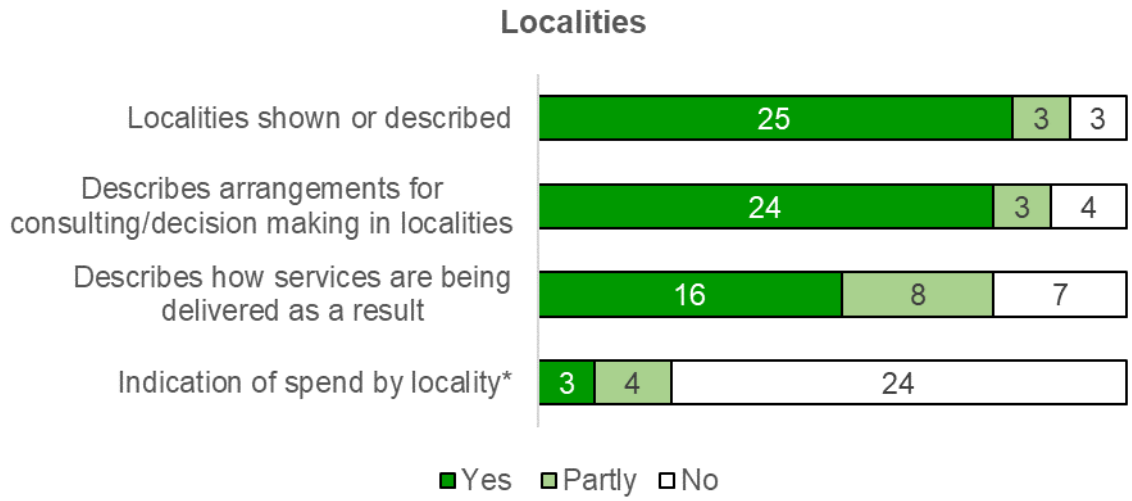
24. A further concern is the variability of the best value reporting, which is missing in some reports and hard to identify from the narrative in others.

25. The Scottish Government will provide feedback to the CFO network and develop a joint plan to improve the finance sections in the 2019/20 reports and to address the issue of outcome based reporting.

Reporting on localities

26. For localities, each report should include a description of the arrangements made in relation to consulting and involving localities and an assessment of how these arrangements have contributed to the provision of services, and the proportion of the Integration Authority's total budget that was spent in relation to each locality.

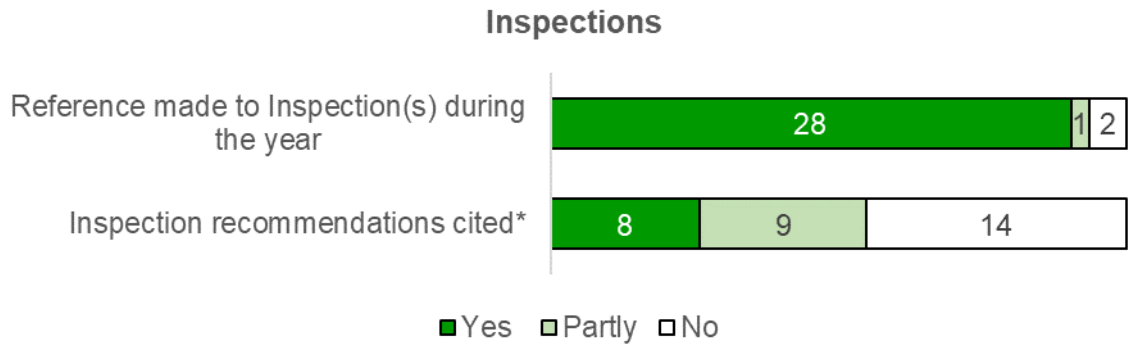
27. Generally, most reports made clear what their localities are and described the arrangements for consulting with and involving them, although in a few cases the description is very brief. In some cases the localities or arrangements have been reviewed and are changing (for example, to better align with existing Community Planning Partnership arrangements). However, information on how the arrangements have contributed to the provision of services is less comprehensive.



28. *Many areas are finding it challenging to report spend by locality, which in some cases is a reflection on how some services are provided on a pan-partnership or pan-NHS Board basis, but where this is not provided the reports often make reference to the work underway to be able to do this in the future.

Inspection of services

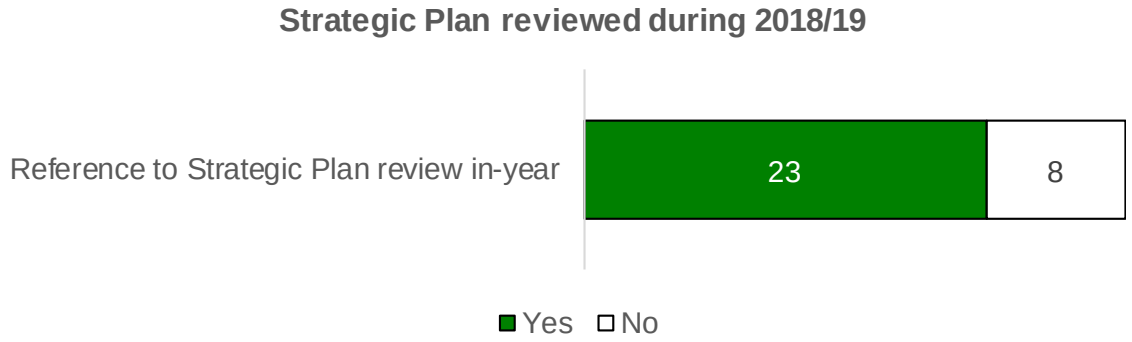
29. The Performance Reporting Regulations also require the report to include details of any inspections carried out relating to the functions delegated to the Integration Authority. This must include any recommendation which the body has made alongside the actions taken to implement the recommendation. Inspections of services are referenced in nearly all the reports, although two do not. Many reports provide extensive tabulations or other details of all services inspected with grades received, and/or link to the Care Inspectorate reports. There is more variability as to whether requirements or recommendations are cited (in full or outline). Most do this to some extent, but a third do not at all.



30. *One Integration Authority still had an inspection report pending at the time their annual performance report had to be finalised, thus it could not provide details of any recommendations that may have been identified.

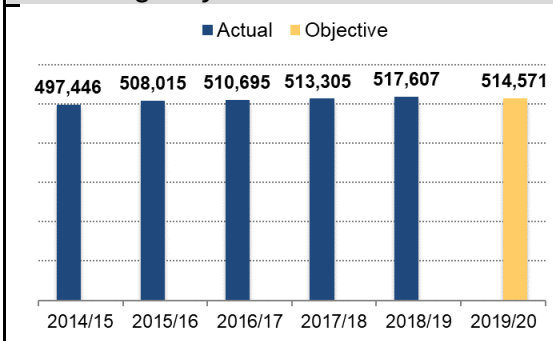
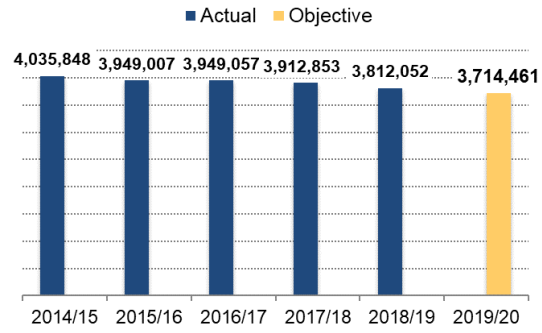
Review of Strategic Commissioning Plans

31. Where applicable the performance report must include a statement as to why the review was carried out, whether this resulted in any changes to the plan, and if changes were made, a description of what these were. Many Integration Authorities did review and update their strategic plans during the year and the reports made reference to this.



MSG Integration Indicators: Summary of performance

32. The following charts show national performance against the six MSG indicators for which Integration Authorities were asked to share improvement aims. These figures are based on data available at December 2019.

<table>
<tr><th colspan="2">1. Emergency admissions, H&SCP area residents age 18+</th></tr>
<tr><td> 
</td><td>There has been an upward trend in numbers of emergency admissions, to 517,607 in 2018/19. This is partly reflective of an increasing number of older adults in the population. This is illustrated by the admission rate per 100,000 population (Core Suite Indicator 12) decreasing slightly in the three years to 2017/18 although there was a slight rise again in 2018/19. Collectively, Integration Authorities are working to achieve a total by the 2019/20 year end that would be an absolute reduction on 2018/19.</td></tr>
<tr><td colspan="2">At a local level, 12 Integration Authorities have reported a reducing number of admissions, with 17 showing an increase. Two have remained relatively static.</td></tr>
<tr><th colspan="2">2a. Acute unplanned bed days, H&SCP area residents age 18+</th></tr>
<tr><td> 
</td><td>There has been a downward (improving) trend, to 3,812,052 in 2018/19. This reduction is partly driven by reductions in length of stay. Collectively, Integration Authorities are working to achieve further reductions in 2019/20.

2018/19 total is provisional and subject to revision as data become more complete.</td></tr>
<tr><td colspan="2">Although around half of Integration Authorities have seen increasing admissions, 21 had a reducing level of unplanned bed days, with 10 showing an increase.</td></tr>
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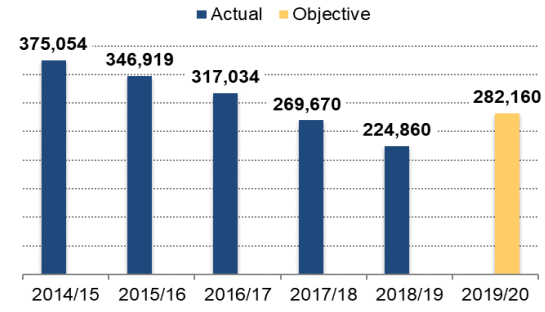
2b. Geriatric Long Stay unplanned bed days, H&SCP area residents age 18+

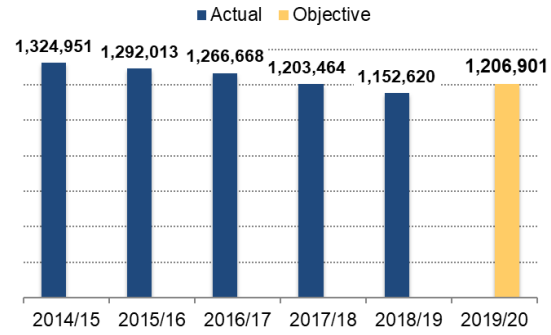


2018/19 total is incomplete and will be revised upwards as data become more complete.

There has been a downward (improving) trend. Although figures for 2018/19 are incomplete, they are strongly suggestive of a further reduction relative to 2017/18. Not all Integration Authorities use beds coded to this specialty. Amongst those that do, several have already surpassed their aims to substantially reduce GLS bed days. Thus, the collective "objective" number for 2019/20 looks higher than the reductions that have in fact already been achieved. Where they continue to use GLS beds, we expect Integration Authorities will wish to revisit their objectives accordingly.

10 Integration Authorities do not, or no longer use GLS beds. Of the 20 that do, bed days have been reducing in 17 and increasing in 3.

2c. Mental Health unplanned bed days, H&SCP area residents age 18+



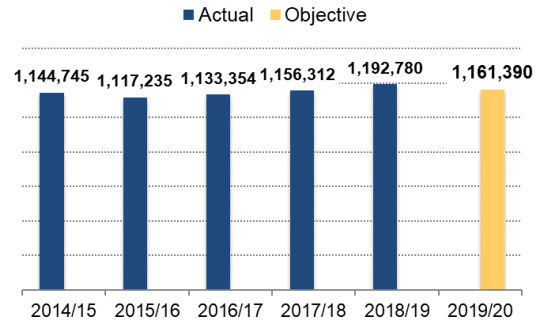
2018/19 total is incomplete and will be revised upwards as data become more complete.

There has been a downward (improving) trend. Although figures for 2018/19 are incomplete, it is likely that there will be a further small reduction relative to 2017/18.

Similarly to Geriatric Long Stay beds, several Integration Authorities have already surpassed their aims to substantially reduce MH bed days. Thus, the collective "objective" number for 2019/20 looks higher than the reductions that have in fact already been achieved. In view of this, we expect Integration Authorities will wish to revisit their objectives accordingly.

In 21 Integration Authorities areas, MH bed days have been reducing, whilst 10 have seen increases.

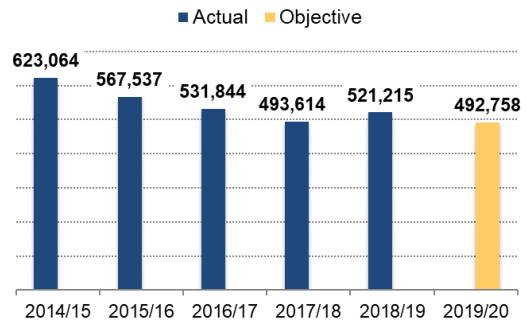
3. A&E Attendances, H&SCP area residents age 18+



Numbers increased annually in the four years to 2018/19. Taken collectively, Integration Authorities are aiming to reduce attendances in 2019/20.

Almost all (27) Integration Authorities have seen increasing levels of attendances at A&E, with 3 showing reductions and one relatively static.

4. Delayed Discharge Bed Days, H&SCP area residents age 18+

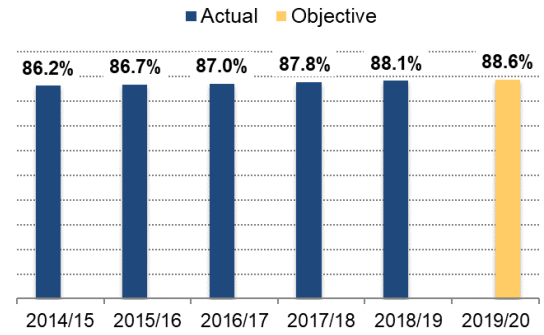


An improving trend to 2017/18 was followed by an increase in 2018/19. Taken collectively, Health and Social Care Partnership objectives for 2019/20 equate to reversing the increase in 2018/19 and achieve a further reduction on the numbers seen in 2017/18.

Please note: Data up to June 2016 are not directly comparable with data from July 2016 onwards. This is due to definitional changes made to the recording of delayed discharge information from 1 July 2016 onwards.

11 Integration Authorities did see a reduction in delayed discharge bed days, but 20 showed an increase.

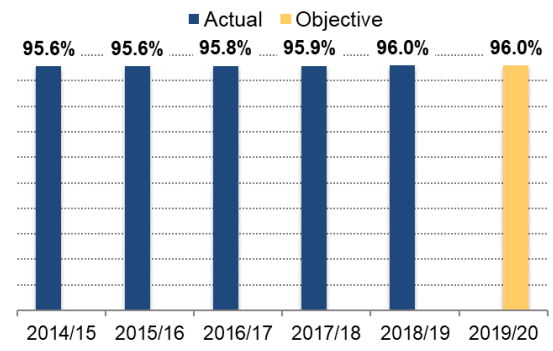
5. Percentage of last 6 months of life spent in the community, all ages



There has been a progressive improvement in this measure and a corresponding progressive reduction in the percentage of time people spent in a hospital setting. Collectively, Integration Authorities are working to achieve further improvements, particularly through developments in Palliative and End of Life Care.

21 Integration Authorities showed improvement with an increase in percentage of last 6 months of life spent in the community. 9 showed a worsening position with 1 remaining static.

6. Percentage of population living at home supported or unsupported, age 65+



There has been a progressive increase in the % of people living at home. Although the absolute changes appear small, between 2015/16 and 2018/19 the change relates to approximately 45,000 more people aged 65+ living at home.

All but one have shown improvement (1 was relatively static).

Annex 1: Overview of local progress

Progress is being made in shifting the balance of care. More people are being supported to live at home with fewer people spending the end of their lives in hospital. However, the reports highlight the challenges partnerships are facing with ageing populations and the increases that are being seen in A&E attendances and hospital admissions. This in turn has led to a struggle in many Integration Authority areas to make the desired reductions in delayed discharges.

Drawing on illustrative examples of local practice, incorporating case studies and comments, we highlight some of the actions and initiatives that integration has allowed.

Reducing hospital use

The Scottish Government is working with Healthcare Improvement Scotland to develop a blueprint for **'hospital at home'**. Many areas, such as Fife and Lanarkshire, have well established hospital at home services. Annual Performance Reports also make mention of further developments. In Aberdeen City, the Acute Care at Home Service had a total of 84 admissions to the service, most of which were from the Geriatric Assessment Unit and consisted of older adults with frailty requiring support following hospital discharge. In comparison to an acute hospital admission, 2.5% more patients were living at home 90 days following a period of acute care at home, with 6.8% lower mortality rates reported.

Aberdeenshire's Virtual Community Ward (VCW) works by bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention, with the aim of avoiding unnecessary hospital admissions. The VCW has now been adopted by 28 of 31 GP practices in Aberdeenshire and helps identify individuals who will need health and social care services at an earlier stage, improving outcomes and experience. It is estimated that 1,640 hospital admissions have been avoided over the three year period 2016-17 to 2018-19. Teams cite the positive impact the VCW model has had on building relationships within multi-disciplinary teams.

Case Study: Mrs S Aberdeenshire

Mrs S is an 87 year old lady living alone at home with care twice daily for assistance with personal care and medication prompts each morning and evening. The home carers noticed a change in Mrs S's behaviour, she had become confused and this was raised at the Virtual Community Ward (VCW). It was agreed a carer should return to obtain a sample of urine and it was found that Mrs S had an infection. The GP prescribed antibiotics. Visits were increased to three times daily to ensure the antibiotics were given at prescribed times and to encourage Mrs S to drink plenty of fluids. The Homecare Responder Service was made aware of a change in Mrs S's needs, should they be called out of hours. Mrs S was able to remain in her own home with additional visits to monitor her health and wellbeing. She remained in the VCW for 5 days until her condition improved. Support was then reviewed and returned to having twice daily visits.

The development of virtual wards has allowed **Argyll & Bute** to monitor both individuals in Glasgow hospitals and those being supported at home, to prevent unnecessary in-patient stays. In **Highland**, a virtual ward model is being developed in Inverness to support an integrated approach to admission prevention for those identified as being most at risk of repeated hospital admission. This links in with the social work duty system and the "step up" beds in residential homes, which can be used to prevent emergency hospital admission where there is no acute medical need.

These build on more established intermediate care models of care. **Stirling** Health and Care Village opened in autumn 2018. This includes the Bellfield Centre, comprising 32 nurse led health rooms and 84 intermediate care rooms. There are now clearly defined routes from Frailty at the Front Door, the Discharge Hub, as well as Forth Valley Royal Hospital wards. There are improving levels of awareness within community and primary care teams of the opportunities that exist to 'step up' into the Bellfield Centre for short term rehabilitation/reablement and assessment which avoid admission to acute services, minimise lengths of stay, and maximise independence to support successful return to the community.

Bonnyton House, in **East Renfrewshire** is being developed using six beds as an intensive rehabilitation resource to prevent hospital admission and ensure a safe return home for people discharged from hospital. A further six beds will be used for people who need end of life care, who can't be supported to die at home.

Falkirk Hospice at Home Service, provided by Strathcarron Hospice, has operated over the last 5 years, supported mainly through Big Lottery funding. It supports people in their own home who are in the last weeks of life through practical, emotional and personal care. A core element of the service is flexible support to family carers as death approaches. An external evaluation (working with ISD) has evidenced this intervention enabled more people to die at home, has high user satisfaction, and achieved an excellent rating from Care Inspectorate.

In the **Scottish Borders**, Waverley Care Home in Galashiels provides 16 transitional care beds, in addition to 10 long-stay residential care beds. The transitional beds deliver short-term rehabilitation for up to 6-weeks for individuals who no longer need to be in hospital, but require some additional support to regain their independence before ideally returning home. The average age of individual's admitted to transitional care is 83. Over the duration of transitional care service, the average length of stay has been 34 days and over 80% of individuals have returned to their own homes. A Discharge to Assess Unit, based at Garden View in Tweedbank, closely aligned to the Waverley Transitional unit, provides capacity outwith Borders General Hospital to assess patients prior to them moving home or to supported accommodation. Over the period December 2017 to July 2019, 243 patients were accommodated at Garden View, with an average stay of 20 days and over 4,500 bed days being made available at BGH.

> Garden View and Waverley are fantastic examples of successful partnership working. Both facilities are improving the flow of patients through the hospital and is delivering improved outcomes for patients and their families.
>
> SB Cares Operations Director

Dundee's integrated approach to reducing delayed discharges has demonstrated clearly that long term challenges can be successfully overcome with the necessary focused response and investment. They have continued to develop an assessment at home model in partnership with British Red Cross as a means of enabling people to step down from a hospital setting and continue the assessment of their care needs in their own homes. A similar approach is taken in **East Ayrshire** where the Red Cross Home from Hospital Service supported around 1,800 people in 2018/19. The service is delivered from University Hospitals Crosshouse and Ayr and supports people to be discharged as early as possible, reducing their length of stay and re-settling them in their home. Once home, the service helps to prevent falls and reduce social isolation, supporting people to regain their confidence, skills for living independently and organises telecare to support families to continue to care. A total of 2,856 bed days have been saved in East Ayrshire, equivalent to cost avoidance of £494,088.

Case Study:
Donald where's your troosers, Argyll & Bute and Highland

The 'Get Up, Get Dressed, Get Moving' Campaign in Highland and Argyll & Bute builds on the good work undertaken in hospitals so that people who need to go in to their hospitals, and their families, are aware that they encourage people to bring in their day clothes and foot wear, to get out of bed, to get dressed and to move around the ward as much as possible.

Even short periods of being inactive lead to muscle loss, increased risk of falls, increased confusion, reduced independence, delays in getting home and increased risk of needing help when leaving hospital. The key message of the campaign is to 'Get Up, Get Dressed, Get Moving'. If we increase physical activity we can enhance recovery and help people to get back to their home/homely setting sooner to live as independently as possible.

Inverclyde is at the forefront of the **Home First** approach. The Home First Reablement Service is a time limited, multi-disciplinary service which carries out an assessment at home and develops a personal plan to meet individual's health and social care needs and outcomes. "Compassionate Inverclyde" has moved from being a good idea, to a good initiative and is now described as a "social movement". The ethos drives most of what the health and social care partnership does. In addition to the 'back home box', the partnership has introduced a "no one dies alone" scheme using volunteers to support people in their final hours.

Case Study: Inverclyde Back Home Boxes

Representing community acts of kindness to support people who live alone as they return home from hospital. The boxes are gifted by a local business and are filled with community donations of essential food items, hand crafted kindness tokens, a get well card made by local school children and a small knitted blanket made by local people and community groups. Volunteers organise collecting contents from local community and distributing the Back Home Boxes within local hospital.

I wanted to send you a quick email to express my gratitude for the Back Home Box and the kindness of it. I will explain how much it meant. My brother was recently in Inverclyde Royal Hospital, very unexpectedly – he had collapsed which is frightening enough for anybody but even more so for him. He has had lifelong severe mental health problems and has had struggles with that over the years. He wasn't in that long but got a box given to him on discharge. I can't tell you how much it meant to him, if you had seen and heard his reaction to it you would have been so moved and would have known that what you are doing is amazing.

He leads a very isolated life and has very little contact with anybody, when I went round to visit him he had a beautiful homemade card in pride of place on his unit, what a fabulous idea and also for the children who make them to give too and understand about giving. He was so chuffed with it and he told me he'd even got jam and milk too and listed out the box items. It felt like a Christmas hamper! It's not even totally what is in the box but the very idea that somebody can be so kind to a stranger means the world and in a time of need such a tonic as well as being so useful as he hadn't been able to get the shops.

I will be donating items into the collection boxes you have and hope that it means as much to whoever gets them as it did to both my brother and me. I confess I even felt a bit tearful about it, in a good way! He gave me the heart to hang on my twig tree! So a huge thank you to you and everybody involved and the little girl from a school in Largs who made a beautiful get well card. You are all stars".

In **Edinburgh**, the principle of **Home First** aims to shift the balance of care from acute hospital services to home or a homely setting within the community. It will be delivered through prevention of admission or early supported discharge and will inform the way the health and social care partnership works across a person's care journey. Home First promotes rehabilitation and recovery through a risk enabled, multi-disciplinary approach, which has the potential to prevent life changing decisions being made in a period of crisis, which too often result in long-term institutional care outcomes. Home First improves outcomes for those citizens who are able to return home and generates more capacity in acute hospitals to care for those who have acute needs that cannot be met elsewhere.

MERRIT (Midlothian Emergency Rapid Response Intervention Team) includes services such as 'Hospital at Home', 'Rapid Response Service' and the 'Discharge to Assess' Team. In the last year, this has provided over 2700 'virtual ward' bed days and almost 1400 emergency falls call outs. The newly formed Discharge to Assess Team helps reduce length of hospital stays and early results are very positive. All of these services offer community based alternative care and support, to what not so long ago would have resulted in a hospital admission.

North and South Lanarkshire, in conjunction with the Acute Services division of NHS Lanarkshire introduced Discharge to Assess last year, as a means of expediting patients' discharge from hospital. Discharge to Assess co-ordinators, based in each of the acute hospitals, identify individual who could benefit from the pathway. Significant progress has been achieved in the short life of the pathway with over 100 people supported through the discharge to assess process.

The **East Lothian Discharge to Assess team** is an Allied Health Professional (AHP) led, 7 days a week service that provides assessment at home on the day or day after someone is discharged from hospital. Also in this health and social care partnership, the Short Term Assessment & Rehabilitation Team (START) works with older people in the Tranent, Prestopans and Port Seton area. Set up in April 2018, it focuses on helping people to become more active and independent after illness. The partnership feels it works so well because of its relationships with wider community services including GP practices, District Nurses, Social Work, Hospital at Home, Day Centres and the third sector. Key to this success is the working relationship between the occupational therapists, physiotherapists, community care workers and physiotherapy assistants with STRiVE, East Lothian's third-sector interface organisation. STRiVE has been instrumental in recruiting, training and supporting local people and their families and offering the opportunity to help older people in their local community.

Case Study: Janice, East Ayrshire

Janice is 76 years old and lives in sheltered housing. She was admitted to hospital in having fallen and fractured her hip. The hospital Social Work team was contacted three weeks into her stay as ward staff were concerned her ability to return home and live independently and safely- they felt that she would benefit from a care home placement. Janice moved to the care home of her choice the following month, on a Discharge to Assess (D2A) basis. During the ongoing assessment, she expressed her wish to return home with an increased package of care. Though her family had concerns about the risks involved, Janice's decision was respected and she returned to her own home to live independently later that month. A review of Janice's discharge supports took place shortly thereafter, identifying that a wet floor shower would be beneficial, which was then installed.

To date Janice remains living at home independently with care at home assisting with personal care, meal preparation and medication. She has had input from a physiotherapist from the Integrated Care Team, a dietician and has a community psychiatric nurse to assist with her mental health. Janice has a very supportive daughter who attends to all practical tasks for her including attending hospital appointments, ordering and monitoring of medication supplies and housework.

West Dunbartonshire's Focussed Intervention Team delivers a reactive, rapid response service to people in their own homes or in a care home setting. The service supports people who have frailty or complex needs whose wellbeing is deteriorating and where attendance or admission to hospital is becoming a possibility. The team also manage a suite of intermediate care beds, providing alternatives to admission and faster discharge. This will take the form of intensive multi-professional support, for a period of up to 4 weeks, before care is passed onto the most appropriate community team or the GP. The development also includes further funding of the third sector to provide a range of opportunities for individuals to move on to, from strength and balance work in their own homes, to physical activity in community settings, with the potential to become volunteers themselves.

Dumfries & Galloway is extending its successful STARS team.

"This service is second to none - exceptional. The keynote is unobtrusive support provided with patience and kindness to enable independent living. Gentle encouragement to do what one can do for one's self helps to make progress towards recovery. Practitioners are scrupulous in ensuring dignity is maintained while providing support. No praise is high enough for the exceptional people who provide this service - I am truly grateful".

North Ayrshire's Intermediate Care and Rehabilitation Hubs provide a single point of access, with screening and clinical triage, ensuring the person is seen by the right service, first time and includes 7-day support. The model supports people at different stages of their recovery journey and builds on existing intermediate care and rehabilitation services, reducing duplication and fragmentation of services across Ayrshire.

Case Study: Shetland Intermediate Care

The Intermediate Care Team in Shetland considered how to provide an equitable service across Shetland and that 'equitable' does not necessarily mean the same service. A client in Unst had fallen and fractured her hip while visiting London. The Intermediate Care Team initially worked with this client in a care home in Lerwick, where her reablement journey started. The client then transferred to Nordalea Care Home in Unst where the Intermediate Care Team continued to oversee her reablement plan. However, as it was not possible for the Rehabilitation Support Workers to provide multiple daily support visits in Unst, these were carried out by local staff, such as the care centre staff, the community Occupational Therapist and community nurses. After further reablement, the client was able to return home with a care support package. Intermediate Care provision is no longer dependent on home location and all clients who meet the referral criteria are considered regardless of their home address.

Falkirk are investing in the prevention of admissions to hospital and supporting discharge. Initiatives include their Enhanced Community Team, which is a team of Advanced Nurse Practitioners, senior staff nurses, Health Care Support Workers, Allied Health Professionals and GPs, operates over 7 days and aims to provide an immediate response, normally within 2 hours. In addition, through a Rapid Access Frailty Clinic, people have access to a Consultant Geriatrician and a full range of diagnostic tests.

Integration Authorities are generally trying to move to a preventative approach. In **West Lothian Anticipatory Care Planning** involves health and care practitioners working with people to have conversations to help them understand their condition and talk about the type of care they wish to receive. People have the opportunity to highlight what's important to them and set out their wishes.

Inverclyde's Care at Home service provides care and support to those who require assistance to remain independent at home for as long as possible. Investing in this preventative support helps reduce unnecessary admission to hospital and is a key intervention in achieving their aim of "people, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community".

Case Study: South Ayrshire Invigor8

Invigor8 is an evidence based falls prevention programme for the over 60's in South Ayrshire. More people are admitted to hospital for falls related incidents than any other condition. Having a fall can affect people in many ways ranging from soft tissue damage, fractures or even death. People also lose confidence and can become isolated by having a fall or being fearful of having a fall.

Invigor8 classes work on balance, strength, flexibility, endurance, how to get down onto the floor and back up, floor work, tai chi and confidence building as well as socialisation. The programme delivers excellence through the operation of Invigor8 classes throughout Ayrshire; maintaining people's independence, improving or maintaining functional ability to do everyday tasks, socialising to improve mental health and reduce loneliness. In 2018/19 there were 271 new referral clients and 8393 attendances at classes.

"I only go out once a week so the class gets me out, helps me meet people and improves my balance through the exercises. As time has gone on I get better and better, even my family mentioned that I look better and I'm much more confident"

Glasgow's prevention and early intervention actions to prevent admission and better support people in the community have included implementing anticipatory care plans within specific patient groups such as COPD and residential care home clients; introducing a frailty screening tool to better manage frailty within the community; working with care homes to reduce hospital admissions including rolling out the red bag scheme; working with the Scottish Ambulance Services to reduce the number of falls conveyed to hospital as part of a wider falls prevention strategy; and extending the community respiratory service to provide a service over weekends.

Case Study: Glasgow's Red Bag Scheme

The Red Bag Scheme involves the provision of a transportable red bag to care homes which is used to store information, medication and property for care home residents who require unplanned acute attendance and/or admission. If the resident is admitted, the Red Bag follows the resident through their journey into acute and back to the care home. Staff in each sector use it to provide key information on transfer, which speeds up processes and supports decision making. The Glasgow City health and social care partnership has led the implementation of the scheme across the Health Board, covering 70 care homes in Glasgow and a further 200 homes across the Board area. This process began with a pilot in July 2018 and has been fully implemented from December 2018. The partnership has worked with partners including acute and the Scottish Ambulance Service to raise awareness and ensure this bag is clearly identifiable to all staff, patients and carers alike. Initial board-wide performance suggests reduced attendances and admission from care homes, with further gains anticipated as the Red Bag scheme becomes more fully established.

Chronic Obstructive Pulmonary Disease (COPD) is one of the most common reasons people go to A&E. **Edinburgh** have developed a multi-agency Community Respiratory Hub to support people with COPD who are at high risk of hospital admission. The hub aims to improve how people experience care when they are unwell by increasing the number of people who can confidently self-manage their condition, supporting people with their physical, mental health and the wider issues that matter to people. Between April 2018 and March 2019, 574 people who were at immediate high risk of hospital admission were assessed by the Community Respiratory Team within the hub. 91% (520) of these people were able to be safely cared for at home, avoiding hospital admission. There has been a 17% reduction in the number of days people who are unwell with COPD spend in hospital.

Midlothian's Community Respiratory Team helps people manage their COPD, and last year expanded to include physiotherapists, nurses and psychology expertise. They took direct referrals from 2 GP practices, focusing on patients who had been admitted to hospital frequently. There was a drop of over 40% of patients from these practices admitted to hospital for COPD.

In addition, over 2,000 people were seen by a District Nurse in Midlothian, with over 500 visits each month. These highly skilled nurses assess, plan and deliver care and use their prescribing and clinical decision making skills to offer a high quality service 24 hours a day. Over 6,000 home visits took place as well as over 49,000 patient contacts, giving people choice and the option of receiving care and treatments in their own home.

It is not just older people or adults that Integration Authorities are working with to reduce hospital use.

Case Study: East Dunbartonshire's Pre-5 Immunisation Programme

East Dunbartonshire's Children and Families Team transferred the delivery of the Pre 5 Immunisation programme to a geographical clinic model during 2018-19. The feedback from the new service delivery model has been very positive from both parents and staff. Initial non-attendance rates were high, especially in families with complex needs and a history of non-engagement. The situation was reviewed and the team agreed to receive direct appointment requests from the Health Visitors, for families identified as requiring additional support. The appointments can be arranged at very short notice. Families are informed of the appointment by the Health Visitor, either at a home visit or via a telephone call. This has significantly reduced the non-attendance rates, which is reflected in the most recent immunisation figures of 97% across the HSCP, 3% above national average. This level of flexibility would not have been possible in the previous model of delivery.

While services are increasingly planned and delivered at a locality level, some Integration Authorities are dealing with more complex hospital discharges by moving to a 'hub' model. **Glasgow** have developed a single hospital discharge function, which aims to streamline improve delayed discharge performance and enable the smoother transition of patients from acute hospital care to intermediate care and other community based care settings.

West Lothian undertook a redesign of the whole system to reduce emergency admissions, readmissions and improve performance on delayed discharge. An Integrated Discharge Hub established at St John's Hospital and investment in test of change to look at the systems and processes in place for matching packages of care.

Similarly, in **Perth & Kinross** a Discharge Hub, Liaison Service and Home Assessment and Recovery Team has been implemented and works as part of an integrated model. In developing the model they learned from managing winter pressures and from other partnerships, to ensure the approach is efficient and effective not only during the winter months, but throughout the year.

In the **Scottish Borders,** Community Led Support is a community hub model for accessing Social Work services and signposting clients to community solutions. In the Borders these are called 'What Matters Hubs'. The hubs use a conversational approach to ask an individual what matters to them, rather than what is the matter with them. The Community Led Support approach encourages individuals to use community-based solutions, where possible, to address their needs. By September 2018, there were 527 signposts made to community solutions, thus diverting people away from what may be considered traditional Social Work Services to alternative community services, more appropriate for the individual's specific situation.

South Ayrshire Case Study: Jacqueline

Jacqueline was diagnosed with multiple sclerosis when she was 19 years old. She lived at home with her mother and was able to manage the symptoms of her condition with minimal input every morning from a local care company and daily family support.
When she was 24 years old her mother passed away and combined with a notable deterioration in her condition, Jacqueline was struggling to maintain her independence. A review of her care and support needs was carried out by social work and it became evident that additional support was now required to maintain Jacqueline in her own home and enable her to be part of her community.

Having been made aware of the SDS options, Jacqueline considered that Option 1 a Direct Payment could provide her with both the consistency and flexibility she required from her care and support. With support from Ayrshire Independent Living Network (AILN) she placed an advert in the local job centre and recruited a personal assistant for 30 hours per week. This allowed Jacqueline to be supported by the same person every day and to have choice over when and how her care and support would be delivered.

Changing ways of working

Also key to keeping people safely in their own homes is the provision of **equipment and adaptations** and the use of **Technology Enabled Care**.

There is evidence in the annual reports that the Scottish Government funded Technology Enabled Care (TEC) programme has a key role to play in the modernisation of health and social care in many health and social care partnerships, offering a range of possibilities to help people to live independently for longer. TEC can also prevent hospital admissions and earlier than necessary moves to residential care. It is clear that the development of technology (including Telecare) within each partnership needs to be sustained.

In **Aberdeenshire**, the developments in technology have included the use of an app to enable patients with Chronic Obstructive Pulmonary Disease (COPD) to self-manage their symptoms and the provision of IT kit to all GP practices so that they can offer video consultation appointments to their patients moving forward. The health and social care partnership also looked to reshape their care approach in 2018 with Home and Mobile Health Monitoring; Video Consultation; and Telecare. In **Moray**, the "Florence" assistive technology for self-care of blood pressure monitoring is being placed in all GP practices.

Case Study: Independent Living Angus

Funding from the TEC Fund enabled the introduction of ADL Smartcare in Angus – renamed Independent Living Angus (ILA) for local use. Of 2,183 people who accessed ILA, 44% are finding help through the self-assessment and LifeCurve section and people are also using the equipment catalogue and the local information section, finding help from local services and organisations embedded within the site.

In **East Lothian**, they have an extensive range of assistive and enabled care technologies available including telecare; identifying someone's location to support people with dementia (GPS); monitoring blood pressure at home and texting readings to GP practice; voice activated devices (Amazon Echo) and tablets and video consultation between professionals and people in their own home. By ensuring that technology is considered during all stages of their engagement with people, they can support people to make informed choices to find the best possible solutions. East Lothian TEC team currently has over 2,200 clients with analogue connected alarms and 4,301 connected telecare products.

At the end of last year all GP practices in **East Renfrewshire** had agreed to use Home and Mobile Health Monitoring (HMHM) for hypertension management. So far all but two practices have recruited patients to the service. Just over 640 patients have benefitted from the service with an estimation of over 1800 face-to-face appointments saved.

Case Study: West Lothian Florence

'Flo' is a text messaging system that sends patients reminders and health tips tailored to their individual needs. Flo has had a huge impact on people's lives, revolutionising the way patients manage their own health. Since 2010 it has been used by more than 30,000 people in over 70 health and social care organisations in the UK. In West Lothian, Flo is being used in a range of GP practices as well as with a number of individual service users. The technology behind Flo is fairly straightforward: doctors or other care professionals can adjust Flo for each patient, defining when messages should be sent, what information they are asking for and how the system should respond. Flo then sends regular text messages to patients helping them to monitor their health and share information with the person managing their care.

In a rural area like **Dumfries and Galloway**, internet connectivity can be challenging. MORSE is an IT system for health professionals working in the community that enables them to download up to date information about the people that they are working with. Once the information is securely downloaded, no wifi signal is required. This means that staff can work offline and make changes or complete paperwork while they are with the person. When staff return to a secure internet connection, they are then able to upload their saved work. The application reduces the amount of time that professionals spend completing paperwork, enabling them to spend more time with people. MORSE is currently being developed for teams across NHS Dumfries and Galloway. Health visitors and school nurses have been involved in the early testing of a this new IT system.

Case Study: Kim, Dumfries & Galloway

Kim was diagnosed with cancer. She found that using NHS Attend Anywhere to keep in touch with her oncologist helped to reduce the stress of travelling for appointments: "I first came to hear about Attend Anywhere when I went to Dumfries for an appointment to see my oncologist. She had problems in the morning so she was unable to travel from Edinburgh to Dumfries. So when I arrived they asked if I would be ok to do the video conferencing with my oncologist. I was taken into a room along with my husband and there was also one of the nurses in the room alongside us. She was there just in case there was anything was required, if bloods were required, or a weight or height measurement but also to help if something technical went wrong. We discussed everything that we would have discussed at the appointment anyway, which was only going to be a 5 to 10 minute appointment. Because that worked so well, they actually scheduled, there and then, the appointments that I was supposed to have, 3 months later in Edinburgh, to do exactly the same thing." "Doing video link absolutely makes so much sense. Once you've been diagnosed with cancer you've got scans, you've got x-rays you've got appointments. Within a week you can maybe have 5 different appointments in 5 different places. I know myself that I did. I come from a small village just outside Newton Stewart. It's probably another 15-20 mins from Newton Stewart so travelling is big thing for myself. Going to Edinburgh to meet up with an oncologist to say this is what we're going to do at your next visit, a 5 minute appointment, for a 7 hour round trip for myself."

The **Aberdeenshire Joint Equipment Service** plays a crucial role in supporting people at home by providing an integrated and responsive community equipment service. Located in Inverurie, the service has grown at a huge pace since opening in 2010 and now provides a range of occupational therapy, nursing and physiotherapy equipment as well as community alarms, telecare, communication aids, housing adaptations and bariatric equipment. During 2018, a second store was secured nearby and children's equipment, both social work and education, is now being moved to this store to ensure maintenance, repair and best value is achieved.

'The new ordering system enables me to see the availability of equipment in real time. So as a therapist I can see what is available at the precise moment I need to order something, which has a number of benefits for both staff and clients. For example, I had a client who required a specialist chair to meet her complex postural needs. I was able to check the online system to see what was available and then arrange to have some adaptations made to a chair they already had in stock. Normally it can take up to six weeks to order specialist equipment, so not only did this save time but it also saved money by recycling what was available. Most importantly it meant I could meet this client's needs very quickly. Another positive development has been around the use of technology. Staff can now Skype into the store to have a look at specific pieces of equipment. Using Skype, the JES can let staff view equipment that they have seen online but might have queries about. This saves money and time as staff don't have to travel to the JES to check equipment in person, and we can then get equipment to our clients more quickly than we could before.'

Kerry Adam, occupational therapy team manager

As an illustration of the volume of work undertaken by the service, in 2018-19 approximately 1,800 items were delivered each month. Around 40 community profiling beds are installed in residents' homes each month alone. Approximately 150 people per month were enabled to return home to Aberdeenshire soon after undergoing hip replacement at Aberdeen Royal Infirmary, Dr Gray's, and Woodend Hospital through provision of adaptive equipment.

During 2018, the Aberdeenshire Joint Equipment Service because the first in Scotland to install an online ordering system. The online ordering system now allows for more complex reporting and real time activity accessible through handheld devices.

Case Study: Living Well in Falkirk

In partnership with ADL Smartcare and the University of Newcastle, Falkirk has implemented Living Well Falkirk. This is an online tool for people who live in the Falkirk area and who want information, support or help with everyday living. The tool gives people choice and control by sharing a wide range of information about local and national health and social care services.

Living Well Falkirk allows people to connect in to local groups and services and so helps them to live independently and do the things that they want to do. There is information about local fitness classes, local charities supporting aa range of physical and mental health conditions, as well as how to access equipment privately or through the Joint Loan Equipment Store. People can also use it on behalf of someone they live with or who they help care for. If assistance is needed in using the tool, staff at local libraries are able to help.

Integration Authorities are obliged to work closely with housing services combining suitable accommodation with the modern technological solutions TEC can bring. **East Lothian** recently opened Wellwynd Hub as a resource to assess people with functional difficulties to look at solutions to help gain independence and improve activity. The Health and Social Care Partnership, working with East Lothian Council's Housing Service, has converted a sheltered housing warden's flat into a 'dementia friendly' homely setting with smart technology to assist people requiring help with daily tasks such as reminders or turning on lights by voice command. Home to the Active and Independent Living Clinic, it allows people the chance to try adaptations and equipment such as wet rooms, adapted showers, specialist wash/dry toilets, adjustable beds and a wheelchair accessible kitchen. People can also find out more about and try out Technology Enabled Care (TEC) and Telecare solutions such as motion sensors, bed sensors and community alarms. Some of the most innovative approaches involve the use of readily available products that people may already have in their homes such as voice activated devices, smart TVs and lighting, and apps that control heating.

Case Study: Glasgow Housing First

A 37 year old male service user lived with a friend for a year until the relationship broke down. He had no family supports or networks in Glasgow and has Organic Personality Disorder with a history of self-harming. He disclosed binge drinking and daily cannabis use and had been medically retired from his job. After a traffic accident he suffered inverse skull fracture and was also diagnosed as bi-polar. He was not always compliant with medication which results in paranoia and his emotional expressions being loud and unpredictable. He does not always look after himself especially when drinking and his accommodation quickly falls into a poor state. Following a referral to Housing First via a commissioned service, he moved into his own tenancy in August 18 with a range of services and support provided by the HSCP and partners and has managed this successfully.

Due to his mental state, he regularly discusses the difficult conditions he used to live in and compares this to the higher standards he now enjoys. He recently chaired his own Housing First Review in his flat and articulated very well, conveying his own personal history of mental health, hopes, fears and aspirations, in a very positive manner. He has a forte in performance arts has attended baking classes and wrote a poem for St Andrew's night. He has also enrolled in a short 12 week course at Glasgow University and travelled to spend Christmas with his family.

South Ayrshire is working in partnership with the Strategic Housing Team in the Council to develop supported accommodation for people with Learning Disabilities. People will be offered their own tenancy within a cluster of 11 flats and will be individually supported by a staff team located at the cluster. Support will be flexible, responsive and designed to empower and enable people to live as independently as they can, to improve their health and wellbeing, reduce inequalities and social isolation, together with creating real opportunities to further engage with a range of supports and services within the community. The use of technology will be a key feature of the development.

Case Study: John, Falkirk

John has a learning disability, and behaviour that challenges. Over the years, John had numerous admissions to Loch View due to his increasingly difficult behaviours. He often issued verbal and physical threats of aggression to staff and threatened to harm himself. For a time he had a placement in the community however his behaviours became more challenging and he was admitted to hospital and then moved to Loch View. John enjoyed living there but always wanted to move to his own place. When John was ready for discharge, his family, advocacy worker, social worker, Loch View staff were all involved with John, working together to plan how best he could be supported in the community.

John's support had to be individualised and bespoke to meet his needs. A one bedroom flat and a support provider were identified. A transition plan was agreed by all, and a speech and language therapist was involved so that John could understand the plan. This had a visual time line of what John could expect from a move from Loch View to his new home. John visited his new flat a number of times with his new support staff and he really liked it. John began spending more of his time with his support staff, planning the décor of his new flat and purchasing items. He was also supported to decorate the flat himself. John was included every step of the way and when his tenancy was ready, an easy read tenancy agreement was produced that he could sign without legal intervention.

Today John is very much in control of his support plan and discusses this with support staff every week. John's staff are vigilant and ensure he has a good balance of emotional and physical support. He has a responder system in place in his flat that he can activate if he wishes to speak to staff or requires assistance. John can still be frustrated at times but staff training and their understanding of him have meant the frequency and intensity of any behaviour deemed as challenging has reduced. John has a full life since he moved from Loch View that is community based. He recently participated in the kilt walk and raised money for charity. He hopes to do more charity work in the future.

The **Carers (Scotland) Act 2016** looks to extend and enhance the rights of these carers in Scotland to help improve their health and wellbeing, so that they can continue to care, if they so wish, and have a life alongside caring.

Dundee Carers Centre is commissioned to provide a Short Breaks Brokerage Service for Carers in Dundee. Demand for the service continues with 372 people awarded and benefitting from a short break during 2018/19. They co-hosted a Shared Care (Scotland) Lead Officer Event in late March 2018 where Dundee's work, in particular Short Breaks Brokerage, was highlighted as good practice model to Short Breaks Lead Officers across Scotland.

Case Study: John, East Renfrewshire

Through working with the Carers Centre, I have a better understanding of who carers are and that many people who are carers and would be entitled to support, financial or otherwise, do not consider themselves to be carers. Examples of this would be couples and under 16s. Knowing this has helped me identify hidden carers. Now that I have a better understanding of who would be classed as a carer I am more confident to ask relevant questions. This helps me determine the correct signposting. However, I always let the person know about the Carers Centre in my signposting."

The Scottish Government's strategy for tackling social isolation and loneliness has seen the introduction of Community Link Workers and other 'community connectors'. Community Link Workers are now rolled out to all GP practices in East Renfrewshire and have provided support to 800 people. Link Workers in Renfrewshire help people change their behaviour. There is now a Link Worker in every GP surgery in Renfrewshire who can help provide information and support to connect people into the right services in their community.

The Community Connector team of 8 Connectors and 3 Community Support Assistants continue to work across East Ayrshire, aligned to GP Practices and their developing multidisciplinary teams, to support people who may live in complex and challenging circumstances, in a personal way, based on their needs views and goals. In the reporting period there were 427 referrals to the Community Connectors, giving a total of 2,868 to date. The main reasons people give for their involvement with Community Connectors are isolation, social activities and financial hardship in relation to welfare benefits. 21% of people involved with the Community Connectors are aged between 46 and 55 years old, continuing to illustrate the potential scale of the loneliness-related problems for local future generations of older people.

Fife have shown how wider community engagement can help people with **dementia**. The Dementia Friendly Glenrothes Project, aims to deliver a dementia-friendly community that will make it easier for people living with dementia to be understood, valued and continue to be able to contribute to their community. The project supports businesses and services in Glenrothes including shops, banks, leisure and cultural services, such as swimming pools, theatres, and libraries, and transport providers to understand what they can do to assist their customers living with dementia. It has created safe, public open spaces for people with dementia so that they can enjoy walking and other active leisure pursuits. Physical activity and access to safe open space is key to maintaining the health, wellbeing and social inclusion of people with dementia.

Case Study: Dementia Friendly Fife
To date 150 businesses or services have achieved Dementia Friendly status and there are 4,500 registered Dementia Friends. The Project is now in the process of working with people in Burntisland, Lochgelly, Ballingry, St Andrews, Cupar and Newburgh to take the same approach forward in these areas. It is anticipated that by the end of the project all these villages, and hopefully many more, will have achieved Dementia Friendly status and be delivering dementia friendly activities. Through the engagement of local people who are taking ownership of this agenda in their local communities we hope to have rolled out Dementia Friendly Communities across Fife by October 2020.

Transforming Primary Care

In addition to the introduction of Community Link Workers, 2018/19 saw the implementation of the new GMS Contract, supporting a refocusing of the GP role and building on the core strengths and values of General Practice enabling GPs focus their skills on patients who most require their expertise. To allow this to happen, some tasks traditionally carried out by GPs will be carried out instead by additional members of a wider primary care multi-disciplinary team (MDT) where it is deemed safe, appropriate and improves patient care. The introduction of MDT working is complex and the scale of change required across professions presents us with a unique opportunity to progress a longer-term strategy of transformational change to deliver the vision for Primary Care.

As a result of innovative recruitment campaigns, **East Ayrshire** has been able to successfully recruit a large number of additional health professionals to help further embed multi-disciplinary team working in GP Practices. These included Midwives to deliver vaccinations, Primary Care Nurses, GP Clinical Pharmacists, Pharmacy Technicians, Advanced MSK Physiotherapists, Community Link Workers and Mental Health Workers. This new Primary Care workforce has been placed in GP Practices across Ayrshire and Arran and all Practices now have access to Pharmacotherapy Support. The availability of new Primary Care funding has had a positive impact upon some of the challenges that **Aberdeenshire** had previously experienced by enabling them to recruit to a range of new posts linked to the Primary Care

Improvement Plan, including pharmacists, nurse practitioners, allied health professionals (AHPs) and mental health officers. Argyll & Bute introduced three Advanced Nurse Practitioners (ANP) based in a local GP Practice in Helensburgh, who work across five local GP Practices to ensure alternative care pathways.

Case Study: East Renfrewshire Advanced Practice Physios

East Renfrewshire have put in place Advanced Practice Physiotherapists as the first point of contact. There is evidence that this approach has resulted in a direct release of GP time and streamlining of the patient journey. During March and April 2019, 465 appointments were made available with 92% uptake.

Argyll & Bute and **Dundee** have introduced a **'First Contact Practitioner'**, where first appointments are issued at local GP surgeries with Specialist Physiotherapists for people reporting musculoskeletal problems, which should reduce treatment times for people. In Aberdeen, a pilot scheme is helping GP practices deliver an afternoon home-visiting service where an Advanced Nurse Practitioner does the visit.

Action 15 of the Mental Health Strategy aims to increase the workforce to give access to dedicated mental health professional to all A&Es, all GP practices, every police custody suite, and prisons, with funding over five years for 800 additional mental health workers in those key settings. In **Edinburgh** Mental Health Nurses are working as part of 20 primary care teams and improving the support available through local services. **Falkirk** introduced Mental Health Nurses in 19 practices. Following a successful pilot in **Dumfries & Galloway**, mental health professionals are now set to become a regular feature in GP practices, delivering support, early help and intervention.

Also in **Dumfries & Galloway**, clinical pharmacists are having a more developed role within GP practice as they meet people and provide expert consultation on medication. In September 2018, the Quality, Safety and Efficiency in Prescribing programme was launched in **Perth & Kinross** to deliver safe, effective and person-centred prescribing. Funding was provided, allowing active support to GP practices to further engage with quality prescribing initiatives, with one of the practices reducing their year-on-year prescribing expenditure by 15%.

East Lothian have developed Collaborative Working for Immediate Care, an innovative service developed to accommodate 'same day demand' for health care differently. CWIC absorbs this aspect of care from GP colleagues, facilitating their management of more chronic and complex health conditions. Patients who do not require to attend a GP are directed to another, appropriate health care professional. This ensures rapid access to the right care, delivered by the right professional at the right time to receive assessment signposting and/or treatment.

Case Study: GP Prescribing in Angus

In Angus, a GP prescribing lead was appointed to support involvement of GP practices in understanding and addressing the prescribing differences. Practice-specific prescribing reports were produced, allowing practices to identify their own projects in order to address both patient safety and financial issues through the interpretation of their own data. Communications about the work were produced by GPs and pharmacists, for GPs and pharmacists. Specific projects to improve prescribing approaches were tailored to individual practice needs. GP's were supportive of conversations in localities with the public and information shared through social media to highlight the importance of regular medication reviews; the importance of good self-management of long term conditions and the support available; the difference in performance and cost of some medications where alternatives existed; and the level of medication waste. This approach has led to a reduction in prescribing costs of more than £1.5 million in Angus

The new Community Care and Treatment Services (CCTS) Team in **Dundee** will deliver treatment room care at sites across the city to support the shift in the balance of care from GP surgeries to locality based services. Pathways of care are being developed in 4 key areas; Leg Ulcer Care, Wound Care, Ear Care and Phlebotomy.

In **Glasgow**, actions being taken forward jointly with acute to better manage patients in the most appropriate setting, reviewing acute assessment unit referrals discharged on the same day, to explore scope for managing this activity as part of planned care; reviewing repeat A&E attenders to explore scope for an early intervention approach to reduce attendances; introducing condition specific re-direction policy at Glasgow Royal Infirmary; and introducing a test of change involving consultant geriatricians and GPs to better manage care home patients. Similarly, **Inverclyde** is looking to support progression of the GP role as expert medical generalist ensuring a refocus of activity is applied within practices, as workload shifts; to support the re-design of services and embedding of multi-disciplinary primary care teams to create a more manageable GP workload and release GP capacity to improve care for those patients with more complex needs; and to educate and inform the population of alternative services/professionals to attending a GP through their 'Choose the Right Service' campaign.

Annex 2: Service areas delegated to each Integration Authority

Integration Joint Board	Children's Health Services	Children's Social Care Services	Criminal Justice Social Work	All Acute Services
East Ayrshire	Delegated	Delegated	Delegated	Not delegated
North Ayrshire	Delegated	Delegated	Delegated	Not delegated
South Ayrshire	Delegated	Delegated	Delegated	Not delegated
Scottish Borders	Not delegated	Not delegated	Not delegated	Not delegated
Dumfries & Galloway	Delegated	Not delegated	Not delegated	Delegated
Fife	Delegated	Not delegated	Not delegated	Not delegated
Clackmannanshire & Stirling	Not delegated	Not delegated	Not delegated	Not delegated
Falkirk	Not delegated	Not delegated	Not delegated	Not delegated
Aberdeen City	Not delegated	Not delegated	Delegated	Not delegated
Aberdeenshire	Not delegated	Not delegated	Delegated	Not delegated
Moray	Not delegated	Not delegated	Not delegated	Not delegated
West Dunbartonshire	Delegated	Delegated	Delegated	Not delegated
East Dunbartonshire	Delegated	Delegated	Delegated	Not delegated
East Renfrewshire	Delegated	Delegated	Delegated	Not delegated
Glasgow City	Delegated	Delegated	Delegated	Not delegated
Inverclyde	Delegated	Delegated	Delegated	Not delegated
Renfrewshire	Delegated	Not delegated	Not delegated	Not delegated
Argyll & Bute	Delegated	Delegated	Delegated	Delegated
North Lanarkshire	Delegated	Not delegated	Not delegated	Not delegated
South Lanarkshire	Delegated	Not delegated	Not delegated	Not delegated
East Lothian	Delegated	Not delegated	Delegated	Not delegated
Edinburgh	Not delegated	Not delegated	Not delegated	Not delegated
Midlothian	Delegated	Not delegated	Not delegated	Not delegated
West Lothian	Not delegated	Not delegated	Not delegated	Not delegated
Orkney	Delegated	Delegated	Delegated	Not delegated
Shetland	Delegated	Not delegated	Delegated	Not delegated
Angus	Not delegated	Not delegated	Not delegated	Not delegated
Dundee City	Not delegated	Not delegated	Not delegated	Not delegated
Perth and Kinross	Not delegated	Not delegated	Not delegated	Not delegated
Eilean Siar	Delegated	Not Delegated	Delegated	Not delegated

Lead Agency	Adult Health and Social Care	Children's Health and Social Care
Highland Health and Social Care	NHS Highland	Highland Council