APPENDIX 2

INTEGRATED CARE FUND – EILDON COMMUNITY WARD PROGRESS REPORT

Aim

1.1 This report aims be give a clear understanding of the Projects that make up the Eildon Community Ward.

Background

2.1 The Scottish Borders has four community hospitals. There is no such facility within the Eildon area as Ward 14 in the BGH used to provide this function but this was decommissioned in 2008. In order to flex capacity and increase patient flow, patients can be placed out of area in a community hospital where they have a transitional care need which prevents them from being discharged home. There is a complex model of medical support within the Community Hospitals through the local GP practices. The GPs feel that the service is inequitable, not patient centred nor is this sustainable.

2.2 Consideration was given to test a community ward model in the Eildon area to assess whether this would improve the care given to the community within the borders. It was agreed to seek ICF funding to support this model.

2.3 It was noted by the Strategic Planning Board on 23rd November 2015 that there were links between three ICF project proposals; the Eildon Community Ward, Health Improvement LTC's and Health and Social Care Coordination.

2.4 The Strategic Planning Board approved the recruitment of a Project Manager and Project Support Officer to develop a joined up business case and project brief for these projects under one banner of "The Eildon Community ward".

Summary

3.1 The Eildon Community Ward is a key project within the portfolio of Integrated Care Fund projects. It is one of three key projects that contribute to a new model of care, initially in central Borders, which will provide a bridge across primary and secondary care as well as with Social Work and other partner agencies, as is aligned to the principles of the House Of Care approach.

3.2 Progress to date has been limited. The recruitment of the Project Manager on a 6 month basis was unsuccessful; agreement has been given to re-advertise on the basis that this post will be 18 months in duration. The recruitment of the Project Support Officer was successful.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report.

Policy/Strategy Implications	The implementation described in the report will ensure local delivery of national policy and strategy.

Consultation	
Risk Assessment	The time taken for projects to be approved and feedback from the different levels of governance. Governance structure to be reviewed.
Compliance with requirements on Equality and Diversity	The use of funding in way described will promote inclusion.
Resource/Staffing Implications	See section

Approved by

Name	Designation	Name	Designation
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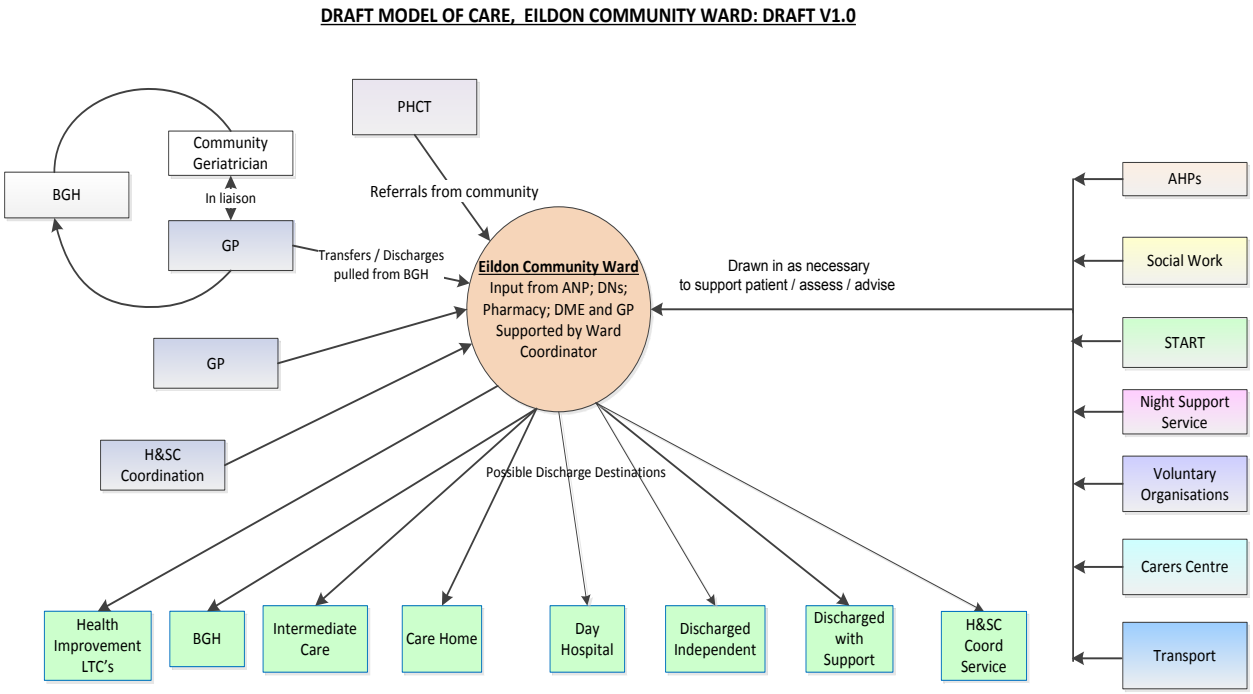
4. Eildon Community Ward Model

4.1 The transfer of patients to facilities away from their own community can impact adversely on patient experience, is not person-centred and potentially compromises patient safety - elderly patients can become very disoriented and confused when they are moved to somewhere unfamiliar.

4.2 It is proposed to develop a model of care, initially in central Borders, which will provide a clinical bridge across primary and secondary care as well as with Social Work and other partner agencies. It will focus on supporting patients in their local community, preventing admission where appropriate and enabling rapid-return from acute care to the patient's own home or community. It will aim to improve patient experience and safety and will be person-centred, utilising anticipatory care planning and care continuity.

4.3 It was agreed to focus on those patients requiring community hospital level care i.e. sub-acute care but the co-dependency with the Health & Social Care Coordination Project and the Health Improvement Project was recognised. Accordingly, it has been agreed that these projects will be brought together under one banner, which would allow testing of the transfer processes to and from sub-acute care and enable appropriate rationalisation of resources.

4.4 The diagram below shows how these projects would link together.



5. Overarching Objective

5.1 To develop a model of care, initially in central Borders, which will provide clinical consistency across primary and secondary care as well as with Social Work and other partner agencies. It will focus on supporting patients in their local community, preventing admission where appropriate and enabling rapid-return from acute care to the patient's own home or community. It will aim to improve patient experience and safety and will be person-centred, utilising personalised care planning, anticipatory care planning and care continuity delivered by a multidisciplinary team approach.

6. Combination of Projects

6.1 Three projects will work together to produce this model of care.

6.2 Eildon Community Ward -The objective of the Eildon Community Ward is to develop community ward capacity outwith BGH that supports Central Borders patients who are unable to access local community hospital services to receive the care they need at home or within the local community setting.

6.3 Specifically contracted GP input (i.e. separate from existing GP practices) will be responsible for the clinical management of patients identified as no longer requiring acute services but who still require a level of care equivalent to that normally provided in a community hospital. The GPs will work as part of a multi-disciplinary and multi-agency team. While delivering care in patient's own homes or in the local community setting, the team will also provide an in-reach service to help "pull" patients from BGH. In doing so, they will work in close consultation with acute clinicians as well as with social work and voluntary organisations to ensure the right outcomes for individual patients.

6.4 Eildon Community Ward will be patient-focussed and will be flexible enough to provide care and support wherever is most appropriate for the patient.

6.5 The model will provide:

- A step-down/step-up 7 day service which links with BGH specialties and works closely with ED and BECS as well as Social Work.
- Appropriate eligibility/admission criteria.
- Resilient anticipatory care planning processes and care escalation policies.
- In-reach to BGH to "pull" patients from acute care – with the potential to consider direct care by the Eildon Community Ward GPs/AHPs.
- Multi-disciplinary assessment within 48 hours of admission to the Ward.
- The capability to manage IV therapy in the Ward.
- A level of flexible training and education potential through rotations/placements to support the development of a pool of staff with consistent skill sets across the system.

6.6 Health and Social Care Coordination including Reablement - This project aims to introduce a Health and Social Care Co-ordination approach through integrating teams within one locality in the Borders. We will test the model of reablement in regard to the utilisation of Reablement Support Workers.

6.7 Phase 1 of the integrated team approach will be to introduce the Health and Social Care Co-ordinator (Duty Coordinator) role, based on the Torbay model, to create a single point of access, will be created to facilitate liaison between the team and main point of contact for GPs, patients and carers. The role will be able support screening provision to enable small packages of care to prevent crisis.

6.8 Phase 2 of the integration would result in the delivery of the following functions:

- Rapid assessment and prevention of admission
- Crisis response
- Discharge management
- Rehabilitation and reablement (please note this will link with the reablement project)

6.9 The Reablement Programme of activities within Social Care is now in Phase 2. It now needs to deliver the following objectives:-

- Develop the Reablement Support Worker role across locality teams that can follow the person across traditional organisational boundaries to deliver reablement plans *
- Develop a matching unit that identifies and manages external home care provision across the localities to ensure flexible and responsive use of resources, and frees up practitioner time in trying to resource provision
- Enable self-assessment through technology to support people to self-manage their conditions thus preventing inappropriate referrals to social work, and enable rapid response to other solutions e.g. Smartcare solution; tablet technology at point of access in hospital. This is being managed through another project
- Implementation of sustainable reablement training programme

** the role of Generic Support Worker, comparable to the role of the Reablement Health Care Support Worker, was developed under the reablement programme 2009. This did not come to fruition at that time due to NHS Health & Safety policies. The purpose of this role was to work across traditional boundaries following the person not the service. It is anticipated that by establishing this role now within community services that this will morph with the pending integration of community locality teams. This role has been the key role in delivering the reablement plans within the traditional IC beds since 2007.*

6.10 Health Improvement LTCs - Health Improvement LTC's focuses on strengthening the capacity to support shared management of LTCs which is critical in addressing the changing health needs of the Borders population, and in developing integrated care models. This project builds on a current project designed to improve shared management of LTCs amongst older people. This new project extends the basic concept to include all adults with LTCs, including those with multiple conditions, so learning from experience and maximising the use of short-term funding.

6.11 There are two key components to this project:

- LTC shared-management project (older people): An extension of 12 months to the existing LTC Shared Care project operating in the Coldstream and Ellwyn

(Galashiels) practices and focusing on older adults. This would be to ensure a longer term evaluation, including the continued involvement of service users and carers, and embedding of developments within the practices to support sustainability and provide a platform for the future roll out of this approach in the Borders

- LTC locality project: The development of a locality-based model that supports all adults with LTCs within a specific locality across the tiers of intervention

  - Tier 1 - targeted work within local communities via existing networks such as Healthy Living Networks;
  - Tier 2 - front-line primary and community health & social care services;
  - Tiers 3 and 4 - e.g. specialist community-based/acute/residential services.

6.12 This is an extension of a Change Fund project. Initially 6 months funding was granted for component 1 of this project. Years 2 and 3 would involve developing, testing, then scaling up and implementing new ways of working that support health improvement across the care system with a wider application that can be sustained.

6.13 As with the existing LTC project, this project is based on the House of Care approach (Kings Fund 2013). House of Care is designed to empower patients and carers to be actively involved in their own care, and focuses on having 'good conversations' with professionals to create individualised care and support plans.

6.14 Four key components of the House of Care model are:

- Service users and carers are engaged, informed and supported: Service user outcomes include more meaningful involvement in own care, improved compliance with treatment plans, healthier lifestyle choices, greater stability of symptoms, improved management of LTCs, improved health and well-being.

- Services have systems, tools, structures and processes in place that support shared-management: Service level outcomes include having a consistent, equitable, evidence-based quality service that addresses service users' needs, and a reduced demand in inappropriate contact resulting from improved access to information, advice and tailored support.

- Professionals (health, social care and third sector) are committed to partnership working. Service provider/professional outcomes include improved knowledge, understanding and competencies around supporting shared-management and the application of these competencies in practice.

- Planning and funding partnerships ensure the responsive allocation of resources: Partnership outcomes would include synergy across and between funded projects that collectively contribute to achievement of agreed goals; continued service improvement that demonstrates impact of investment in resources; local commissioning informed by evidence of what is needed and what works within a locality context.

6.15 The LTC Locality Project would apply the House of Care model at various tiers across community settings, social care, primary and secondary specialist care, and acute/residential settings/intermediate care unit beds. The project would work

across the NHS, social care, and third sector and with housing providers, actively engaging local communities.

6.16 The LTC Locality Project includes a partnership with the Borders Sport & Leisure Trust to develop accessible health programmes which aim to get more people with LTCs physically active.

7. Outcomes

7.1 The combined project will deliver against all four of the Scottish Government's priority areas and ICF principles and have identified the following key outcomes -

Project	Locality	Outcomes	National Outcome
ECW (including Health Improvement LTC's and H&SC Coordination)	Eildon	Reduced admissions	2,
		Reduced readmissions	7, 9
		Reduced number of GP home visits	2,
		Reduced Length of Stay	
		Reduced number of out of locality placements	
		Reduced number of delayed discharges	2
		Improved wellbeing	1
		Reduced dependency on services	1
	Wider Community	Reduced LOS in other community hospitals	
		Improved patient satisfaction	3
		Improved staff satisfaction	
	Coldstream and Ellwyn – Year 2 locality to be confirmed	Improved self-management of LTCs	1,2
		Improved knowledge and understanding of LTC	1
		Healthier lifestyles	1
		Improved ability for carers to look after their own health	6
		Greater capacity for, and use of, peer support	6
		Greater stability of symptoms	1
	Wider Outcomes	Service delivery outcomes	3
		Professional Outcomes	8
		Organisational Outcomes	8,9

8. Review of Progress

8.1 To date, each project has produced a project brief. The Eildon Community Ward and the Health and Care Coordination project have worked together to produce a combined project brief.

8.2 The Strategic Planning Board has approved ICF funding to recruit a Project Manager and a Project Support Officer to develop the combined Eildon Community Ward business case and associated project Documentation. The Project Support Officer post has been filled; the Project Manager post has been re-advertised and is expected to be in post by May 2016.

9. Implications

9.1 Financial – Indicative costs are detailed below -

Project	Year 1	Year 2	Year 3	Total
ECW	£1,090,186	£1,228,186	£173,000	£2,491,372

9.2 Please note that these costing's will be refined by the ECW Project Manager when the business case for the ECW is developed. Year 3 costs are just for the Health Improvement LTC's project.

9.3 Risks - The following risks have been identified –

Risks	Control measure	Owner
Model may not work.	Ongoing Monitoring and Evaluation to measure performance.	Project Manager and Sponsors
Overlap with the Transitional Care Facility.	Ensure that the projects work together to form the business case and brief.	Project Manager and Sponsors
There is a potential need for more specialist home care	This will be monitored throughout the project.	Project Manager and Sponsors

10. Implementation Plan