## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCOP and Change Fund by numbers</td>
<td>3</td>
</tr>
<tr>
<td>Reshaping Care in Scotland</td>
<td>4</td>
</tr>
<tr>
<td>The Change Fund in context</td>
<td>5</td>
</tr>
<tr>
<td>Supporting Innovation and Improvement</td>
<td>7</td>
</tr>
<tr>
<td>Change Fund investment</td>
<td>11</td>
</tr>
<tr>
<td>Trends in national outcomes</td>
<td>14</td>
</tr>
<tr>
<td>Sharing the learning</td>
<td>22</td>
</tr>
<tr>
<td>Key local achievements</td>
<td>26</td>
</tr>
<tr>
<td>Investment in the Third Sector</td>
<td>32</td>
</tr>
<tr>
<td>Prioritising investment</td>
<td>37</td>
</tr>
<tr>
<td>Self Assessment of Spread</td>
<td>41</td>
</tr>
<tr>
<td>Learning from what’s not worked</td>
<td>44</td>
</tr>
<tr>
<td><strong>Annex 1</strong></td>
<td></td>
</tr>
<tr>
<td>Improvement and Support Group</td>
<td>48</td>
</tr>
<tr>
<td><strong>Annex 2</strong></td>
<td></td>
</tr>
<tr>
<td>Reshaping Care Pathway</td>
<td>50</td>
</tr>
<tr>
<td><strong>Annex 3</strong></td>
<td></td>
</tr>
<tr>
<td>Examples of Impact</td>
<td>51</td>
</tr>
</tbody>
</table>
Reshaping Care for Older People & Change Fund by numbers

39% CHANGE FUND SPEND 2014/15 SUPPORTED CARERS

2 Million MORE DAYS IN OWN HOME THAN ‘EXPECTED’

17% FEWER OLDER PEOPLE CONVEYED to HOSPITAL after a fall (non-injured)

10% REDUCTION IN RATE OF 75+ EMERGENCY BEDDAYS OVER 4 YEARS

1300 PER DAY FEWER PEOPLE AGED 65+ IN HOSPITAL BEDS THAN ‘EXPECTED’

IN RECEIPT OF FORMAL CARE AT HOME HAVE TELECARE

4000 PER DAY FEWER PEOPLE IN CARE HOMES THAN ‘EXPECTED’

19% FEWER PEOPLE DELAYED IN HOSPITAL OVER 2 WEEKS
Reshaping Care in Scotland

Reshaping Care for Older People: A Programme for Change 2011 – 2021 sets out our shared vision of care and support for older people in Scotland and describes how this will be delivered in the future. Co-produced with political, organisational and community interests, the aim is aligned with our 2020 vision for health and social care in Scotland - an ambitious shift towards more care at home and in community settings supported by greater investment in preventative support and the use of technology to empower greater choice and control. The Reshaping Care programme (RCOP) also seeks to transform the philosophy of care from reactive services provided to people towards preventative, anticipatory and coordinated care and support at home delivered with people.

This report describes the progress made over the first four years of the ten year RCOP programme. It builds on the Reflecting on Progress report published by the Joint Improvement Team (JIT) in November 2013. Both reports describe how partnerships have used their Change Fund to make a difference to the lives of older people and their carers across Scotland.

Entering year five of the RCOP programme, Scotland has much to be proud of:

- **39% of the Change Fund provided support for carers** including provision of carer’s assessments, opportunities for short breaks, information and advice, training, income maximisation and advocacy.
- **Bed days in hospital for people aged 75+** following an emergency admission are down by 10% from 2009/10 to 2013/14
- **Reduction of 17%** in Scottish Ambulance Service rate for conveyance to A&E of older people who have fallen and are not injured
- **19% reduction in** delays over 2 weeks at April 2015 compared to April 2011.
- The **number of emergency hospital beds used by people aged 65+ in 2013/14 was around 1300 less than ‘expected’** had the age related rate at 2008/09 continued in line with the ageing profile of Scotland’s population.
- In 2014, there were **around 4,000 fewer older people living permanently in a care home than projected** based on the 2009 rate and demographic trends.
- Taking together the above reductions in use of care homes and hospital beds, **older people spent nearly 2 million more days at home in 2013/14** than might have been expected had the 2008/09 rates continued.

But we all know that we need to do even more. The integration of health and social care offers a once in a generation opportunity for a radical shift in the pace and scale of transformational change. The new integration authorities must use the learning from Reshaping Care for Older People to make best use of their Integrated Care Fund investment and to scale up and mainstream new models of care and support for all adults.

The insights from this report, and the links to many examples of good practice, will support integration authorities as they develop their Strategic Plans throughout 2015 and establish locality integrated care for all adults.
The change fund in context

The Older People Change Fund provided additional resources to help partnerships make progress on key policy goals and outcomes: to enable older people to remain independent and able to live at home or in a community setting.

The Fund was 60% of the Scottish Government’s preventative spend funding (£300 million of the £500 million preventative spend budget to 2015). Assessment of the impact of the Fund must be viewed in the context of the timescale and proportionality of the investment.

The Change Fund has been a catalyst for system and service change. It has had significant impact although this has to be seen against the rising tide of demand. Whilst the Change Fund resource as a proportion of the total older people’s health and care budget is very modest (about 1.5%) it has been a positive catalyst for change, allowed new service models to be nurtured and developed and to begin to change our approach to supporting people in line with the national and local Reshaping Care vision. **South Ayrshire**

RCOP and the Change Fund helped to reinvigorate partnership working, including the contribution of the housing, Third and independent Sectors in working with statutory services to redesign and transform care and support. The relationships forged and the behaviours nurtured through the RCOP journey has been a key success factor in the critical path towards health and social care integration. RCOP provides a strong platform as Integration Joint Boards develop capability for Strategic Commissioning, integrated resourcing and using the national outcomes framework to lever performance improvement.

The relationship between the Health, Social, Independent and Third Sector organisations has gone from strength to strength over the lifetime of the programme and has resulted in a mature, at times challenging, collaborative planning, allocation and decision making collective. The programme of change will continue as we integrate health and social care services in Argyll and Bute; it has enabled us to develop very strong foundations of integrated approaches to care which will be built on and developed over the coming years. **Argyll and Bute**

The key achievement has been the development of truly integrated strategic commissioning practice through the development of the Adult Services Commissioning Group concerned with the totality of Adult Care investment (circa £0.5bn), rather than purely the Change Fund (circa £4m). In the early days, a “traditional” approach was taken, where statutory partners dominated decision making. Major progress has been made in adopting a very different methodology and culture through establishing a partnership based, decision making body which accounts to a Board Committee. The body aims to achieve equitable representation across all sectors and to ensure that a commissioning approach is followed which recognises community assets and sector capability and capacity. **Highland**
The co-productive partnership approach enabled a ‘whole systems approach’ to developing tests of change. This meant we were able to work on developing new models and pathways of care for people that were a combination of partnership working involving health, social care, communities, Independent and Third sectors. This approach takes an investment of time and resource but the results of this work have been hugely positive and have provided a solid platform upon which integrated/partnership approaches to the planning and delivery of services can grow.

**Dumfries and Galloway**

However partnerships highlighted the continuing challenges from demographic and economic pressures – and not just those associated with older people.

**While the additional Change Fund allocation has been very welcome the demographic pressures will continue to present significant challenge for all partners within mainstream resources, even with the advent of the Integrated Care Fund and the additional funding for delayed discharges. East Dunbartonshire**

The Change Fund has enabled some release of pressures within the systems including hospitals, and some absorption of unscheduled care demands. However, the tensions between being able to developing longer term preventative models of care and responding to short term emergency demands remain evident, presenting a barrier to significant mainstream disinvestment in existing health and social care systems. The demographic profile and patterns of co-morbidity contribute to this complexity and the scale of this challenge within the city.

**Glasgow**

Making the transition to the Integrated Care Fund is also a challenge.

**There is an expectation from stakeholders that the Integrated Care Fund is ‘new money’. The challenge of securing release of funds to enable mainstreaming of successful projects is compounded by the lead in time required before some preventative projects can demonstrate success and meaningful outcomes. Edinburgh**

Disinvestment in existing service models to enable mainstreaming of new models of care remains an elusive goal for most partnerships. However some have been able to go further towards sustainable change in the balance of care.

**There has been a strong emphasis on developing upstream services and reducing reliance on institutional care through the development of community based alternatives. £1.8m has been released and a further £2m is planned for 2016/17 from a review of the bed model in the partnership. The focus is now to ensure continuation of the successful components, whilst expanding the methodology to cover the whole adult population in line with the integration agenda. North Lanarkshire**

Partnerships highlighted the scale of the challenges ahead as they develop their integration authorities and strategic plans throughout 2015. The JIT and the emerging integrated improvement resource will use the insights from this report to shape the future support offered to integration authorities.
Supporting Innovation and Improvement

**IMPROVEMENT COLLABORATION**

The JIT convened an Improvement and Support Group (ISG) to ensure best value from our collective improvement capacity and capability (**Annex 1**).

The group brings together national partners with service delivery partners from all sectors to ensure a coordinated and collaborative approach to leadership, innovation and improvement support for Reshaping Care.

As a subgroup of the Health and Community Care Delivery Group, the ISG reports to the Ministerial Strategic Group and to the Joint Improvement Partnership Board - senior executive representatives of Scottish Government, COSLA and NHSScotland, and executive representatives from the Independent Sector, the Third Sector and the housing sector. This robust cross sector governance arrangement has assured strategic and operational support from all national partners to drive maximum impact from the Change Fund.

The ISG has now evolved to support the integration of health and social care for all adults as well as Reshaping care for older people.

**IMPROVEMENT NETWORK**

The ISG provides oversight of the Improvement Network for Integrated Care and Support\(^1\). This Network facilitates cross sector collaborative learning through:

- Webex and themed learning sessions
- benchmarking of data
- practical improvement support for adaptive change in a complex system.

The Improvement Network, along with direct support from JIT partnership leads, helped partnerships to test and spread interventions, approaches or actions which collectively improve outcomes for older people. These are set out as four ‘bundles’ of interventions aligned to the four pillars of the RCOP pathway and the related enablers (**Annex 2**).

The RCOP pathway was informed by the international evidence base for the Chronic Care model and by the High Impact Changes and actions in Scotland’s National Action Plan for Long Term Conditions. The interventions are highly interdependent reflecting the reality of complex whole system improvement.

Partnerships require to make progress in all elements of the four ‘bundles’ to realise benefits across the whole system.

---

\(^1\) For more info, see: [http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/reshaping-care-improvement-network/](http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/reshaping-care-improvement-network/)
Partnerships were invited to provide details of the supports they would welcome in future to help improve outcomes through integrated care. Although not specifically asked to comment on this, many partnerships affirmed the improvement support that had been provided to date.

*The support of our nominated JIT leads has been of major assistance to the Partnership. It is hoped that this formal linking can continue. The programme of Learning and Sharing coordinated by JIT throughout the life of the Fund has allowed invaluable peer contact, ideas interchange and informal benchmarking.*

**E Dunbartonshire**

*Signposting to areas of best practice and areas which may have implemented similar projects to promote learning. Support to share Fife projects.*

**Fife**

*Support around RCOP - third sector, discharge planning and the intermediate care team from the JIT - enabled us to achieve the outcomes we required.*

**Moray**

*We would welcome continued support from our JIT Associate during development of our Strategic Plan and its subsequent implementation.*

**South Lanarkshire**

*The Renfrewshire partnership values the ongoing input from JIT as “friendly challenger” locally and its support to local partnership development work. The Partnership also values the national learning and benchmarking events which produce examples of good practice at a national level. The additional input from the Institute of Public Care (Oxford Brookes University) enhanced the input from the JIT.*

**Aberdeen**

*The support of the Joint Improvement Team has been helpful in the Change Fund/Integration process to date. This has included individual contact, informal discussion and advice with aligned JIT Associates and the development of regional networking opportunities.*

**Shetland**

*We would welcome a JIT approach to the use of the Integrated Care Fund where initiatives and ideas are shared across partnerships.*

**Edinburgh**

*How the principles of collaboration and partnership working developed through the Change Fund can be developed further as part of integration.*

**Falkirk**

*Support for data linkage (ISD) – Improvements to local real-time data - and continued directional support from JIT.*

**W Isles**

*There is a need to develop staff across all areas for joint commissioning. Leadership is needed to further the use of data for improvement.*
The requests for future support will shape the 2015/16 workplan for JIT and for the Improvement Network. Requests span a number of thematic areas:

- Networking and sharing learning, innovation and good practice
- Strategic commissioning and developing locality arrangements
- Sharing health and social care data and analysis of performance
- Evaluation of impact – particularly the contribution of Third sector in prevention and to understand connections / inter dependencies
- Local JIT lead support and challenge
- Adopting personal outcomes and co-production approaches

The skills, expertise, capacity and capability to provide the support requested requires collaboration across a number of national partners and improvement organisations.

Other specific support requested includes

- national social marketing campaign about the need to change the way we do things and the preventative approach - public acceptance and buy in remains at the heart of what we are trying to achieve
- Practitioners’ forums at Team Leader level to share developments and to develop skills and enthusiasm for managing change at local level.
- Additional TSI and local TSOs time and the capacity to participate meaningfully and effectively in the numerous service design /redesign exercises that are beginning to develop under the Integration agenda, many of which are happening simultaneously on a large scale, many at a ‘hyper-local’ level around specific ‘natural communities’.
- Support with utilising collaborative service improvement methodology for the Integrated Care Fund.
- Assistance in regard to developing strategic and operational approaches to personal outcomes.
- Information sharing and support in relation to the development and evaluation of intermediate care models.
- Assistance and practical tips on the Joint Strategic Commissioning process including how best to maximise the benefits from existing information systems and sources.
Many partnerships highlighted the scope and scale of the challenges ahead and stressed the need for continued local support and challenge as they develop their integration authorities and strategic plans.

There are several significant system-wide service reviews that require to be undertaken during the course of the first 18 months of the integrated Health and Social Care Partnerships within NHS Ayrshire and Arran. A number of these will be led by East Ayrshire Health and Social Care Partnership and ongoing Joint Improvement Team support to these in a facilitative and ‘critical friend’ capacity would be welcome.

Regular Joint Improvement Team contact and liaison is valued by the Partnership. Ongoing sharing of promising practice, collaborative networks and innovative ways of sharing learning through Webex and other methods, e.g. ‘House of Care’ session.

East Ayrshire

The support we have received from JIT throughout the lifetime of our change programme has been useful and valued. These supports have included
- The delivery of training (joint commissioning)
- Supporting events at a local level
- Information events/conferences nationally/ Webex sessions
- Providing advice and information (guidance, newsletters, etc)
- Sharing examples from elsewhere; disseminating ideas and good practice

All of the above have been helpful and would continue to be welcomed and valued going forward. We would also welcome ongoing support from JIT to the Strategic Planning Group and working with the group overseeing the review of Home care and care home provision in D&G. Also ongoing support to assist with the locality focus.

Dumfries and Galloway

We look forward to support becoming available through an integrated health and social care dataset which will enable sophisticated analysis of the performance of the health and social care system particularly in relation to care of older people. We may need additional support in the interpretation of data in the context of our local systems.

Aberdeenshire

The evaluating of a wide range of programmes and projects has tested the partnership and support to develop a comprehensive model of evaluation would be welcomed. This would also support the evaluation of the projects funded through the Integrated Care Fund.

Dundee

More sophisticated analysis across ‘whole system’ programmes in relation to the interventions producing the most impact including health economics. Better methodologies to enable the measurement and evidencing of third sector programme.

South Ayrshire

We have had very good support from the Joint Improvement Team throughout the Older Peoples Change Fund. The relationships that have been built have carried into other initiatives such as the current PSP for housing support. We would welcome continuation of this general support to the partnership.

West Lothian
CHANGE FUND INVESTMENT

In the four years of the Change Fund from 2011-2015, a total of £300 million was allocated to partnerships - £70m in the first year followed by £80m, £80m and £70m respectively over the following three years.

Partnerships were invited to supplement this national funding with additional local funding to increase the amount available for their Change Fund initiatives. They were asked to report expenditure for each year.

The chart below shows the actual amount of Change Fund monies spent during each year expressed as a percentage of the Change Fund allocated in that year.

In the first year, partnerships spent about 70% of the allocation available. The difference between available and actual expenditure in that year was caused by the time required to agree and establish priority initiatives and then recruit to associated posts. Partnerships were able to agree carry forward of spend into year two.

By the second year, Change Fund spend had achieved balance with the available annual investment. Once again, the unspent funds were carried forward into the next year.

Figure 1 shows that expenditure in 2013/14 and 2014/15 was somewhat higher than the amount allocated for the year in question as partnerships fully deployed the Change Fund that had been carried forward from years one and two, and invested additional funding drawn from other local sources.

Fig 1

Expenditure in-year expressed as percentage of Change Fund allocation

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>69%</td>
</tr>
<tr>
<td>2012/13</td>
<td>98%</td>
</tr>
<tr>
<td>2013/14</td>
<td>116%</td>
</tr>
<tr>
<td>2014/15</td>
<td>144%</td>
</tr>
</tbody>
</table>
Tracking investment across the RCOP pathway

Partnerships have tracked their annual Change Fund spend across the five RCOP pathway workstreams. This annual expenditure is illustrated in Figure 2 below.

The proportion deployed on initiatives in hospitals or in care homes has fallen year-on-year from about 25% in year one to around 10% in 2014/15.

The proportion invested in Proactive Care and Support has remained level. Continuing investment in enablers reflects ongoing evaluation, workforce development and building readiness for strategic commissioning.

The annual Change Fund spending on Effective Care at Times of Transition rose from 21% to 27%, mirrored by an increase from 19% to 26% for spend on Preventative and Anticipatory Care workstream.

Preventative approaches enhance wellbeing and independence, reduce or delay dependency, and prevent negative outcomes right across the RCOP pathway.

- Preventative and anticipatory care that supports best use of the assets of older people, their families and local communities in improving physical, psychological and emotional health, wellbeing and inclusion
- Proactive and integrated care that enables older people to maintain their independence and to remain safe and supported at home.
- Effective and enabling assessment and care at home, or closer to home, to help older people to regain their capability and confidence after an illness or change in their circumstances.
- Early intervention in hospital / care homes to prevent escalating dependency, reduce delays in returning home and premature admission to long term care

Fig 2

Change Fund review
Expenditure by Workstream; by year
Change fund spend on Carer support

From year two of the Change Fund, partnerships were asked to ensure that a significant proportion of their investment was targeted towards improving support for carers. The national commitment was to invest at least 20% of the Change Fund for this purpose.

Partnerships identified and reported on Change Fund direct spend on support for carers or for carer organisations; and on indirect spend where a Change Fund initiative would benefit the carer as well as the older person.

Over the three years during which this investment in support for carers was tracked, around 9% of the Change Fund was invested in direct support for carers and a further 29% deployed on indirect supports.

This illustrates a commitment to prevention through support for carers’ health and wellbeing.

Figure 3 summarises the total investment in support for carers 2012-2015. This represents 39% of the Change Fund.

Fig 3

<table>
<thead>
<tr>
<th>CARER support</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of total spend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct spend</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Indirect spend</td>
<td>27%</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>Overall spend</td>
<td>36%</td>
<td>39%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Investment in the Third Sector

A distinctive feature of the Change Fund was the involvement of the Third Sector as a full partner from the outset - both in developing and agreeing plans for the use of the Fund and in the design and delivery of support and care.

The Third sector made a significant contribution to the additional support for carers.

Many examples of impact from investment in the Third sector are described in a specific section of this report.
At a national level, progress in Reshaping Care for Older People is primarily evidenced by trends in the suite of published national outcomes that relate to the care of older people. These are primarily:

- the rate of emergency hospital bed days for people over 75 years;
- indicators of the Balance of Care for people over 65 years;
- delays in discharge from hospital.

It is useful to look at trends in this national data over the period of the Change Fund.

**Rate of emergency bed days for older people**

Each NHS Board and their partners agreed a trajectory that would exceed the anticipated demographic changes in the population aged 75+ to reduce reliance on emergency admission beds in order to sustain continuing investment in primary and community support and services for the growing numbers of older people and their carers. The latest available published data for 75+ emergency bed days is presented in Fig 4. **From 2009/10 to 2013/14 the rate has fallen by 10.2%**. The target reduction is 12% by 2015.

The most recent published figures show 107,051 fewer emergency bed days for over 75s in 2013/14 compared to 2009/10.

**In 2013/14, each day nearly 300 fewer people over 75 years occupied a bed in hospital as a result of an emergency admission than in 2009/10.**
The average number of emergency beds occupied by people aged 65+ had been gradually rising until 2008/09, in line with the changing demographics. The chart shows what would have been ‘projected’ had the rate observed in 2008/09 continued through to 2013/14. From 2008/09 through to 2013/14 the number of hospital beds occupied by older people following an emergency admission has reduced year on year. This is in contrast to the ‘projected’ number of occupied beds had the age related rate at 2008/09 continued to be observed as the population continued to age. Fig 5

**Emergency beds Scotland: 65+; Comparison of actual vs projected** (2008/09 base)

In summary, in 2013/14 each day around 1300 fewer older people than projected occupied a hospital bed following emergency admission.

Emergency admissions (as distinct from occupied beds) have shown a different pattern in recent years. Fig 6 shows the separate trends for 65+ emergency admissions and bed days indexed to 2008/09. This highlights that whilst bed days have fallen in the 65+ age group, admissions increased by about 9% between 2009/10 and 2012/13. Encouragingly in 2013/14 there was a small reduction. Fig 6
Contributing to this improvement is the significant progress in implementing alternative emergency pathways for older people who have fallen but are not injured. **Scottish Ambulance data in Fig 7 shows around 17% reduction in conveyance in the period between 2012 and 2015.**

**Fig 7**

![Elderly Conveyance Scotland from 2012](image)

The trend in emergency admissions over the longer term is shown in Fig 8. The line indicates a projected trend based on the rate at 2002/03. It confirms that emergency admissions have until recently increased at a faster amount than would be accounted for by the ageing of the population alone.

**Fig 8**

![Number of emergency admissions: aged 65+ ; actual vs. projected](image)
Previous analyses have highlighted the important contribution to the trend made by people who have short lengths of stay – these short stay admissions had increased disproportionately.

Contributory factors may include changes in referral patterns or decision making by practitioners, changing public behaviours and expectations, and impact of protocol driven pathways for common emergency presentations such as chest pain and breathlessness. Local systems still need to enhance access to urgent ambulatory and intermediate care alternatives to admission, particularly for those who are frail.

Whilst the number of individual people of all ages who experienced at least one emergency admission during 2013/14 compared with 2008/09 has grown by only 2%, there has been a significant rise in the number of people admitted more than once in a year. This is particularly the case for the over 85s. Perhaps this increase is not surprising if older people are living longer and more are staying for longer periods at home – see figures 10 - 13.

An illustration of the rise in multiple admissions is shown in Fig 9, which shows the percentage increase from 2008/09 to 2013/14 for people admitted three or more times within a year.

**Fig 9**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Percentage increase 2008/09 to 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-49</td>
<td>5%</td>
</tr>
<tr>
<td>50-64</td>
<td>12%</td>
</tr>
<tr>
<td>65-84</td>
<td>11%</td>
</tr>
<tr>
<td>85+</td>
<td>25%</td>
</tr>
</tbody>
</table>

ISD will help integration authorities to identify people at risk of experiencing recurrent emergency admissions so that local integrated teams can enhance anticipatory care and coordinated case management so that more people can be supported to remain at home.
Balance of Care

Figure 10 shows data published by the Scottish Government on the balance of care for people aged 65+ in 2014. The home care figures refer to people receiving ‘intensive’ home care (10 hours or more per week). The CC Census figures refer to people receiving NHS Continuing Care.

Fig 10

Benchmarking is influenced by application of eligibility thresholds, reablement practice, Self Directed Support and telecare across Scotland. Following the Act implemented in 2014, Self-directed Support (SDS) is an essential aspect of social care. One aspect of SDS is the option for people who are eligible to choose a direct payment. As is seen in Figure 11 there has been a steady increase since 2008/09.

Fig 11

Number of people aged 65 and over who received Direct Payments in Scotland
An example of the use of technology for support and care is evident in the chart below (Fig 12). It shows that with increased adoption of telecare by 2014, **83% of people who receive social care support at home are provided with telecare.**

**Fig 12**

Telecare in Scotland 2014: use with/without home care

- 56% Telecare (no home care)
- 27% Both telecare and home care
- 17% home care only

The Technology Enabled Care Programme and improvement support will build on the models of care established through RCOP and the Change Fund to help partnerships to increase the pace of adoption of telehealth and telecare.

The chart below shows the trends for long term residents in care homes in Scotland compared to a 2009 baseline. Despite an ageing population, fewer older people now live permanently in a care home. The chart below shows what would have been ‘projected’ or ‘expected’ had the rate of long term care home residency observed in 2009 continued to 2014.

**Fig 13**

**Long term care home residents Scotland: older people; Comparison of actual vs projected (2009 base)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual</th>
<th>Addnl projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>31,226</td>
<td>32,686</td>
</tr>
<tr>
<td>2010</td>
<td>32,245</td>
<td>32,245</td>
</tr>
<tr>
<td>2011</td>
<td>32,585</td>
<td>32,585</td>
</tr>
<tr>
<td>2012</td>
<td>32,615</td>
<td>32,615</td>
</tr>
<tr>
<td>2013</td>
<td>31,762</td>
<td>31,762</td>
</tr>
<tr>
<td>2014</td>
<td>31,843</td>
<td>4,018</td>
</tr>
</tbody>
</table>

**In 2014, around 4000 fewer older people lived permanently in a care home than would have been expected had the rate continued at the 2009 level.**
Taken together with the difference in hospital bed use shown in Fig 5, this implies that on average about 5300 fewer older people per day were in a hospital or care home. In other words, older people spent almost 2 million more days and nights at home in 2013/14 than would have been expected had the 2008/09 rates for institutional care continued.

Delayed Discharge

Fig 14 shows published data for Delayed Discharges; Scotland; April 2011 to April 2015 (excluding code 9s - for whom the standard maximum delay is not applicable; and delays of 3 days or less - gathered only from May 2012 onwards).

The report of the April 2015 census shows 357 people delayed in hospital for more than two weeks. This compares with 441 delays over two weeks at April 2011 (19% reduction in delays over two weeks). The principal reasons for delay at the census point were:

- Waiting place availability in a care home – 151 patients (42%).
- Waiting care to go home – 111 patients (31%).
- Awaiting community care assessment – 59 patients (17%).
- Funding/ healthcare arrangements/ disagreements - 36 patients (10%).

This has to be considered in the context of greater demand for care at home, and acknowledging that partnerships have supported older people in Scotland to spend around two million more days at home in 2013/14 than had been projected. For example, Aberdeen, City of Edinburgh and NHS Highland continue to experience significant local challenges around homecare capacity and access to care homes.
Increased elective activity may be another factor - total hip replacements increased by 10% and elective knee replacements increased by 12% 2008/09 to 2012/13, with consequences for access to equipment, adaptations, rehabilitation and packages of support for discharge. This requires close collaboration with leads for planned care.

Almost 75% of all delayed discharge bed days are occupied by people aged 75 and over. Figure 15 shows variation across Scotland at April 2015 census report.

Fig 15

The chart below shows that, at the April 2015 census, 258 (34%) of delays were in an acute hospital location, compared to 475 people delayed in a community location.

Fig 16

During 2014 additional funding was released to support partnerships to further enhance care and support at home and to drive down the bed days lost to delayed discharge.
WHAT WORKED: SHARING THE LEARNING

Over the four years of the Change Fund, support evolved from creating the conditions and testing and evaluating local improvements towards understanding and spreading what works and planning to commission for sustainable change.

Partnerships undertook a self assessment exercise at the mid-point of the Change Fund to reflect on the extent to which specific improvements had been spread and where, and when, further gains may be anticipated. The JIT invited partnerships to repeat this self assessment in February 2015, to describe their key achievements, and share learning from at least one initiative from each pillar of the RCOP pathway. At least one of the case studies was expected to highlight the impact for carers.

As the Change Fund has been an opportunity to explore innovations that are ‘Proof of Concept’ or ‘Tests of Change’, partnerships were asked to describe any learning from initiatives where barriers to progress had been encountered or where it had been agreed to discontinue funding.

Using an agreed template, partnerships provided information about:

- Local examples of impact, including for carers and from investment in the Third Sector
- Key achievements
- Financial investment and option appraisal for decision making
- Learning from what didn’t go well
- Self assessment of spread of key interventions and approaches
- Areas for future improvement support

This report presents an overview analysis of the submissions from all Partnerships. It is presented as an improvement resource for use by all national partners and local partnerships.

LOCAL EXAMPLES OF IMPACT

190 examples were submitted. A few were updates on examples provided for the 2013 Change Fund Review and all of these described progress made since then. Some partnerships provided additional publications which describe work initiated through the Reshaping Care Programme and supported by the Change Fund.

Annex 3 has links to examples of local improvement. These have been collated as ten thematic summaries, drawn from RCOP workstreams.

Many examples provide contact details and are supported by more detailed resources or case studies on the JIT website. The examples include some personal narratives that offer valuable insight into how local partnerships deployed their Change Fund to make a difference to the lives of older people and their carers across Scotland.
Themes from the local examples of impact

Preventative approaches are reflected across the RCOP pathway

Access to information and support for carers and to enable older people to remain well at home - eg contact centres, befriending, timebanking, advice lines

SROI assessment of the Coupar Angus Timebank project indicated a social return of £6.29 was achieved for every £1 invested.

In 2014, 189 people accessed the Positive Choices programme in Perth & Kinross, a self management programme designed to support people with long term conditions to better manage their own health. Participants reported many benefits including potentially averting a health crisis and families observed positive changes too.

“What makes a Good Life for You?” is the question being asked in Clackmannanshire and Stirling where Anticipatory Care Planning has received overwhelmingly positive feedback from patients, their carers and health and care professionals in all sectors. There are many individual stories of improved personal outcomes and avoiding unnecessary hospitalisation.

Change Fund investment has built community capacity in localities

Work to reduce social isolation, build locality resilience and engage communities in wider ‘planning’ activities as well as in specific preventative and transport initiatives.

The Older People’s Resource Centre in Haddington, E Lothian is run by the RVS and opened in 2013, is a “One Stop Shop” for information on services and activities. It also runs “Fancy a Coffee?” networking coffee mornings with Age Scotland and has developed Dementia Support Resources including RVS trained volunteers

East Ayrshire Vibrant Communities supports preventative services such as the Zone - Garden Buddies and Home Buddies and Centrestage (community engagement through the arts), Musical Generations, socialisation and activity programmes in supported accommodation, such as Invigor8 and Motiv8 falls management programmes

The Scottish Borders ‘Getting You There’ service is a collaboration between the Bridge and Red Cross that invested in an online booking service, a shared transport administrator and has a single point of access. It has reduced the number of missed GP/hospital appointments, increased social interaction opportunities, facilitated patient discharge and enables users to book their own transport.

Aberdeen has been asked to submit its social transport collaborative solutions project to the Scottish Parliament’s Equal Opportunities Commission on Social Isolation. Based on local research the pilot uses a Third sector partnership between Co-wheels Car Club to source vehicles, and highly trained drivers through Buchan Dial A Bus, which are both social enterprises.
Enhanced support from technology and housing options

Housing with care, expansion of amenity housing, advocacy, care and repair and expanding and mainstreaming community alarms and remote monitoring modalities

Fife’s telecare has expanded to 2769 users with 95% user satisfaction. Between 1st April and 2nd Sep 2014, it helped prevent 19 delayed discharges, 82 unplanned hospital admissions and 28 care home admissions, saving 6500 bed days.

Smart Supports in East Ayrshire links telehealth, telecare, self-directed support and anticipatory care. By targeting uptake through pilots related to falls and Chronic obstructive Pulmonary Disease, now over 3,000 use telecare.

The Change Fund in Orkney funded revenue costs of a house provided by Red Cross to use as step up/ step down facility where returning home from hospital to the outer isles is not practical or awaiting required home adaptation. The rehabilitation team visit several times a day if required. Red Cross provide volunteer support for daily activities such as shopping and attending appointments. The house has a community care alarm to call for urgent aid should it be required. The development demonstrates co-production across health, social care and the third sector.

Focus on support for mental health and wellbeing

Focus on dementia across the pathway from Dementia Friendly Communities, liaison services, early diagnosis and post diagnostic support.

Dumfries & Galloway’s award winning IDEAS team has delivered training for over 600 care home staff in understanding and managing stress and distress behaviours in dementia and achieving reductions in inappropriate prescribing, admissions to acute care, and presentations to A&E from care homes.

Dementia Friendly Edinburgh is a partnership between the NHS, Local Authority, Alzheimer Scotland and other voluntary and independent sector organisations, engaging with businesses and communities to progress initiatives in several parts of the city, such as training for local shops and businesses.

Adopting a reablement approach to increase independence

The number of clients completing the reablement programme in Glasgow increased by 75% in 2013/14 with 42% requiring no further homecare. The service achieved a 43% reduction in ongoing homecare hours provision and ensures timely provision of supports to enable and sustain discharge. User satisfaction has been positive.

Since 2012 outcomes of reablement in Inverclyde have remained consistent with around 30% of service users becoming independent, around 54% transferring to long term care at home, and around 32% reduction in on-going care requirements.

South Lanarkshire increased capacity of Supporting Your Independence homecarers to support older people in their own homes.
Joining up local interventions to amplify their impact

Implementing new models of care across whole system pathways that align anticipatory care planning by multi-professional and integrated teams with access to enhanced community support and equipment, Hospital at Home and Rapid Response services for people with complex or palliative care needs

The Rapid Assessment Link Service in East Dunbartonshire is attached to the Community Health Partnership Rehabilitation Team. Through a single point of access it provides alternatives to hospital admission through crises intervention and enhanced interface between acute assessment units and community services.

The Fast Track Palliative Care Discharge service in Glasgow is co-ordinated by Marie Cure Discharge Liaison Nurses who support a discharge at end of life or prevent the unnecessary admission of palliative care patients to hospital or hospice. The service has cared for over 1200 patients and their families over the last 3 years.

The Rapid Response Team in Perth & Kinross responded to 822 requests last year through a single point of access with only 8% resulting in a hospital admission.

In Dumfries and Galloway most equipment is delivered, fitted and demonstrated by the Integrated Community Equipment Services Driver/Fitter in a ‘next working day’ service with a reduction in waiting times for occupational therapy assessment.

Investment in Workforce development

Integrated workforce planning, My Home Life development programme, independent sector development posts, specialist nurses, training on dementia, nutrition, foot care and palliative care, e-learning modules

Approximately 3000 patients have utilised the Older Adult Liaison Nurse Service (Mental Health) since it was introduced in 2012/13 in West Dunbartonshire. The Nurse works with partners including social work Alzheimer Scotland, Richmond Fellowship and the Vale of Leven Hospital assessing the mental health needs of clients referred from Care Homes. The Nurse also provides training to staff and carer education. Positive outcomes have been shown in reductions in admissions to hospital from Care Homes, in polypharmacy and in the volume of calls received by the social work duty system.

An e-learning deaf awareness training resource has been developed which focuses on the needs of older people with an acquired hearing loss living in the Borders. The module draws on the experiences of people living with hearing loss and has established Deaf Awareness training. It includes videos of local people explaining their experiences and is hosted on an existing learning system.

A mentoring scheme for Care Home managers and activity staff in Aberdeenshire includes network meetings, one to one support, training courses and two Quality in Practice Development Days all with the aim of sharing practice ideas and resources.
KEY LOCAL ACHIEVEMENTS

Improving system and personal outcomes

Aberdeenshire
- More diagnostic and treatment services provided in the Community
- Reduction in bed days for people 75+ against the increase in demographics
- Increase in home care clients supported at weekends/evenings/overnight
- Reduction in rate of multiple emergency admissions for over 65s
- Increase in use of anticipatory care plans
- Increase in identification of over 65s at risk of a fall
- Increase in proportion of people spending last 6 months of life at home
- Increase in short breaks

The downward trend in percentage of the 65+ population who become unplanned admissions compares with an upward trend across all age health and social care activities. This demonstrates that our investments to support alternative options to admission such as development of a rapid response services, introduction of step up to care homes, additional capacity for Marie Curie Palliative Care Service, Advance Nurse Practitioner and additional community nursing support are having a positive effect on stemming the inward flow.  **Perth & Kinross**

Community nurse in reach and flexible 24/7 working in the Rehabilitation and Enablement Service and Care at Home Teams, has increased levels of complex care delivered in the community, supported with technology where appropriate. This has enabled people to be discharged from hospital when medically fit, and achieved a sustained reduction in bed days lost due to delayed discharge.  **Renfrewshire**

Edinburgh’s Balance of Care delivered at home improved from 29% - 35% over the period of the Change Fund. The Change Fund provided additional investment for preventative approaches-from preventing admission to hospital or long stay care home place and preventing repeat contacts due to social isolation or depression. The six monthly evaluation reports demonstrated the difference that Change Fund investments made to people’s lives. For example:

"The team really helped me get used to being back at home and I went from being frightened of doing things to being happy to give things ago. My confidence is so much better now and I think I just needed time. I think people forget that older people need more time."  **Intermediate Care**

“I had a triple bypass in February so I feel the cold a lot more and depend on the heat. I need heating in the winter and now have a better understanding of how to use it.”  **Changeworks – Heat Heroes**

“When I came out of hospital I felt lost, for someone to start supporting me to move on in life was helpful – you’re not finished if you still can’t do something”.  **ECSS**

“Ellen did not move out of her home due to having behavioural issues which were initially reported as extremely disruptive to care staff.”  **EBSS**

“I’m building my energy levels back up and I’m going home next week with the therapists to see how I get on. It will be a big thing going home but I’m more confident now.”  **Step Down**

“If CAS had not been put in place David would be in a care home and not looking forward to a new sense of freedom”  **Telecare**
Midlothian’s work with Evaluation Support Scotland described activities and costs against agreed outcomes for the people in receipt of services. For example:

a) ‘older person/carer has little or reduced stress and able to cope,
b) older person stays independent for longer at home,
c) improved financial wellbeing,
d) have stronger connections in the community and
e) older people and carers are involved in shaping services.

Enabling independence and reducing demand

Homecare re-ablement was introduced through significant investment during year 2 of the Change Fund. The re-ablement approach has now reduced the demand for care and only a small level of additional funding is now required. **Orkney**

Intermediate care services, particularly reablement and short stay assessment beds. are now embedded across **Stirling and Clackmannanshire**, demonstrating positive outcomes, although in places still require some development of scale.

Moving to a reablement focus for the increasing number of care at home clients enabled a focus on maintaining independence. After reablement, 22% had a reduction in need for service, and 42% required no service. **West Dunbartonshire**

**Thinking Differently**

Acknowledging, identifying and accepting that different cultures exist within each sector (and the mini-cultures that exist in large organisations) helped develop our understanding of each other and to respect each other’s values and beliefs. Much of what has been achieved has been as a result of everyone acknowledging and embracing their own unique leadership role within their particular areas of expertise and interest. This effective leadership at all levels contributed significantly to a combined top down and bottom up approach to developing tests of change. **Angus**

CPP partners have a shared strategic vision and a focus on prevention, community capacity, assets and addressing inequality and co-production with residents, service users and partners has been a central feature. The vision at a local level recognises that reshaping is not only concerned with a shift in the location of care but also in changing ways of working linked to the approach set out in Christie – eg ‘Thinking Differently’ approach to technology enabled care, self-directed support and anticipatory care planning. **East Ayrshire**

**Moray**

- Moving away from service interests to working together towards a shared aim.
- Collaborative working, Multi-disciplinary and multi-agency approaches
- Drawing on community assets and building on volunteering capacity.
- Having the willingness and resources to test approaches and learn from them.

Significant developments have taken place in Care@Home (Tariff, Living Wage, “Pop up” SDS Care arrangements) that are a product of the change fund process, albeit not funded by it. **Highland**
Building capacity and capability in localities

Using an adaptive leadership approach, solutions have emerged to frequently wicked problems through active listening, 1-2-1s, focus groups, personal outcomes events and Action Learning Sets. This included interviews with every GP Practice in North Lanarkshire. Some GPs have also taken part in Locality Action Learning Sets. This has supported the evolving Integrated Locality Mode that includes development of a Hospital at Home service and Intermediate beds in Care Homes, along with increased community capacity in Nursing, Social Work, Home Care and OT. See Locality Response video at: http://youtu.be/rnIZA4iLSJI  

Empowering Communities and co-production projects are building resilience and self reliance in communities, increasing participation in volunteering, growing community support networks and developing sustained and meaningful engagement with communities. They are evidencing positive outcomes for our local communities and are vital to the development of an asset based community led approach which seeks to embed service users and communities as key partners in public services. This has supported our shift to more preventative, anticipatory care and proactive community involvement.  

Perth and Kinross

Initiatives based around GP ‘clusters’ is the basis for locality planning in integration: an Action Learning Set approach brought together GPs, health and social care practitioners, housing, the independent sector, Scottish Ambulance, Police, and community groups to tackle locally identified priorities. Integrated working is being supported by Organisational Development Facilitators.  

Aberdeen

Enhanced support for Carers

‘Wee Breaks Midlothian’ funds innovative ways for carers to have a break from their caring role. This included the development of a website working in partnership with Red Cross community coordinators, the Ageing Well Initiative, local tourism providers and Highbank Intermediate Care facility to collect information for the searchable directory and bed booking calendars. Close working with the Council finance department enabled a simple system to administer the fund and create guides to frequently asked questions such as charging.  

Midlothian

Renfrewshire involved carers in designing a user-friendly leaflet and a “re-launch” of the home-based respite service for carers of older people. This resulted in increasing demand and overwhelming levels of satisfaction with the service.  

“The service is very good they never let me down, it allows me to go to bingo and community events which I have not been able to do for three years. My husband just sleeps when it is him and I but when the carer comes in he will have a blether, watch sports on TV. One of the male workers watches snooker with him and he loves it. I feel as if I have gone from having no life to having a life again”.

“Mum is very sociable, she really enjoys company and having a laugh, the service stops me feeling guilty if I can’t visit, knowing she has respite at home visitor for a couple of hours, someone who will chat, play cards or look at old photos instead of mum going to bed out of boredom.”
Joining up initiatives to increase impact across the pathway

Achievements are from a number of improvement projects blended together. For example, the reduction in admissions of older people in Carnoustie and Monifieth due to the development of multi-disciplinary teams, increased use of ACP’s and KIS, improvements in polypharmacy and the enhanced community support model has built on top of the success already delivered in this locality from the medicine for the elderly model. This work is developing our vision for local integrated locality model that will be shared across all Angus localities. 

Angus Change Fund enabled incremental development of a fully integrated service across Council, NHS and Third Sector services. In the current financial climate we would not otherwise have been able to so effectively manage the transition to integrate these services with associated changes in practice and service delivery models to

- Reduce duplication of effort and delays in accessing services for the individual.
- Reduce the number of and length of stay of frail elderly people whose discharge from hospital is delayed, and specifically, to meet the new standard.
- Reduce unnecessary unscheduled admissions and re-admissions to acute care

ELSIE (East Lothian Services for the Integrated Care of the Elderly)

Aberdeen’s Falls Pathway will train 15,000 people in falls awareness; medication reviews and improved medication management with training for paid and unpaid carers. It is supported by telecare, with a 526% increase in installations in 2 years and over 2360 people supported; and easier access to aids and equipment, including on-line, staff-facilitated self assessment and direction to safe, suitable solutions. A redesign of sheltered housing is increasing the options for accommodation and support, with telecare upgrades to 340 properties. A Scottish Ambulance See and Treat service prevents inappropriate conveyance to A&E, Anticipatory Care Plans lead to better decisions on options for care, and AHP assessment at A&E supports earlier return home. A pilot of enablement at home is reducing demand for care and increasing independence. Intermediate care beds at Clashieknowe avoids admission and supports discharge

West Lothian’s Frail Elderly Programme has four main projects: 2 hospital based, 2 community based. One of the community based projects will review current arrangements and performance in respect of supporting people at home with a view to balancing supply with demand, particularly in respect of discharge from hospital. Although not scheduled to complete until December 2015, the indications are that the project will ensure that the Reablement, REACT, and OPACT services will form part of mainstream services of the integrated health and care partnership within an overall sustainable model.

Falkirk is linking an Integrated Discharge Hub with dedicated admin support, growing awareness and capacity for adopting a reablement ethos in intermediate care, a Red Cross Reablement Project and rapid access frailty clinic. Complementary programmes evidenced impact on the number of unplanned admissions (Early Intervention/ Enhance Community Support Model); supported timely discharge from hospital (Enablement services) and supported more older people with complex needs to live in the community (Housing with Care). Dundee
Developing the capability of the care workforce

**Western Isles** mapped and developed local career pathways against national frameworks. In 2015 the NPA in Health and Social Care: Promoting Reablement SCQF: level 5 was introduced as an addition to senior school course options.

A multi-agency Workforce partnership has been tackling recruitment and retention problems in social care. A Care Centre of Excellence established in 2014 brought 220 new people into social care, trained them, arranged employment with providers, with 88% still employed after three months. DWP invested staff time and funding and a collaboration between Third and independent sectors and SSSC to improve care standards developed new training courses and opportunities for SCQF accredited learning. The Chamber of Commerce is undertaking a survey across providers. **Aberdeen**

An **East Lothian** Change Fund workforce project developed a ‘care passport’ and elearning portal which will evidence that a high standard of basic training has been achieved by all care workers in participating organisations across sectors. This aims to raise standards and reduce the movement of staff between organisations. The e-learning portal is available to third sector organisations and to family carers.

The Innovation and Improvement programme has supported the independent sector to take innovative approaches to help achieve the RCOP vision and outcomes. This has supported a range of projects from gardening to digital inclusion. Ten Care Home managers are due to complete My Home Life training which promotes quality of life for those living, dying, visiting and working in Care Homes. 8 managers have already completed the training and cascaded this to a further 22 care and ancillary staff within their Homes. **North Lanarkshire**

**Aberdeen’s** Change Fund has supported many initiatives led by community groups and social enterprises, such as the Lunch Club Network, C-fine Community food outlets, Silver Darlings fish cooking project, the Shared Roots garden project and Allotment Market Stall, the Helping Hands Centre for Afro-Caribbean elders, and expansion of the innovative work of the Council’s small Wellbeing team working with Robert Gordon University, the Sports Village, Sport Aberdeen, Aberdeen F.C. Communities Trust, Cornhill Hospital, Scottish Care, care home providers, and the Council’s Environmental service. Achievements include the Golden Games, Technogym, chair-based exercise and Otago training, support for carers and people with dementia, the Great Outdoors Project. The collaborative work has been recognised with local and national awards.

**Renfrewshire**

The Change Fund provided match funding and a “change management” context for the European SmartCare and United4Health initiatives around falls prevention, action on multi-morbidity and the management of long term conditions. This includes a programme of training for community-based volunteers following the falls prevention training model developed in Ayrshire and Arran.
Engaging the public

Partnerships stressed the importance of public messaging about RCOP including a clear statement that health and social care cannot on their own provide sufficient support and services to maintain frail older people to live in their own home.

Families, friends and the community need to become involved and provide support too. **Aberdeenshire**

**North and South Lanarkshire partnerships** both invested in developing capacity to support public messaging about RCOP and to facilitate behaviour change. The resulting Communication Strategy has been the basis for the North and South Lanarkshire Integration Communication strategy, described as good practice in The Scottish Government’s Integration Communication Toolkit.

A proactive media strategy achieved prominent, consistent and regular coverage of RCOP events, activities and projects in local media and significant national coverage of North Lanarkshire-based RCOP projects in a range of national newspapers and news programmes. One RCOP release gleaned viral international coverage.

Implementation involved regular contact with local elected members, MPs and MSPs to proactively promote the work of the RCOP partnerships. 15 Parliamentary Motions have since been upheld in recognising the exemplary RCOP work in Lanarkshire. The Scottish Government commissioned a film to demonstrate one example of this good practice. See Matt’s story. [http://vimeo.com/108130294](http://vimeo.com/108130294)

A RCOP web page has been created to centralise information See: [www.rcop.org.uk](http://www.rcop.org.uk)

An information film, involving staff, partners and public, has been produced to deliver key messages to a broad audience. See [http://bit.ly/1pLVcVk](http://bit.ly/1pLVcVk). 86% of respondents said the film was either a useful or very useful way of conveying what the partnership was seeking to achieve. 89% said the film offered positive reassurance.

**South Ayrshire’s** Strictly Seniors magazine has annual circulation of 7000 readers. At last year’s Strictly Senior’s event 250 people participated in taster activities, learned about services and resources and debated issues relating to older people.

**Glasgow City** partnership led ten weeks of city wide engagement with older people, carers and other key stakeholders to hear views on the draft commissioning plan. They used written consultation materials and partner website information for feedback. There was a city wide launch, three local sector based events and another 13 sessions for interest groups such as carers, third sector providers and older people themselves. The latter were organised by GCVS and Glasgow Disability Alliance. GCVS also organised an online survey of third sector stakeholders.

Another strand of work in Glasgow is the Power of Attorney media campaign that encouraged people to appoint an Attorney whilst they have capacity to do so. This successful campaign is now being adopted by other partnerships with national support.
BENEFITS FROM INVESTMENT IN THIRD SECTOR

Strengthening Third sector leadership and strategic link

The Change Fund has enabled our Third Sector Interface (VASA) to work more strategically as an equal and valued partner within key work areas. VASA has itself grown in its ability to provide strategic leadership to the local third sector and to provide substantial input in relation to strategic and service planning (and in future, to Locality Planning). The Change Fund related work programmes and the relationships that have been nurtured have put engagement with this sector in a healthy position within the context of the new Health and Social Care Partnership. South Ayrshire

Growing learning and development across sectors.

Voluntary Action Angus has secured SQA status which provides enormous potential to build accredited learning across the third sector in partnership with others. This may enable accreditation for young or unemployed volunteer, carers, befrienders and volunteer drivers to begin their journeys in a career of care work. The expansion and collaborative approach taken on developing an all Angus befriending and volunteer transport movement is proving to be a critical contributor to prevention and discharge whilst providing an additional layer of capacity as we move toward health and social care integration. Angus

Building local trusting relationships

The Change Fund has strengthened professional relationships between the third sector and other partners which has led to greater collaboration not only in Reshaping Care for Older People but in other arenas. The shared governance arrangements has allowed the development of a shared understanding of why things happen and what might happen differently. The TSI Reshaping Care for Older People Capacity-Building Programme has raised the profile of the third sector within the field of older people’s services in Dundee and built strong foundations to meet the needs of the Health and Social Care Integration agenda. Dundee

Responding to need through innovative service models

Feet 1st, a nail cutting service managed by the local CVO, promotes self-management through client led appointments, client held notes and equipment. Delivered by a coordinator and a team of volunteers appropriately trained by NHS Podiatrists, the service operates from 11 clinic locations across the authority to ensure geographic spread and parity of access. Anyone who has difficulty in cutting their own toenails can make an appointment for the service for a small charge. After answering some basic health questions, an appointment will be made at the most suitable clinic. Home visits can be arranged where required. East Ayrshire

FootcAyr project where local volunteers co-ordinated through VASA provide Toe Nail cutting service to 1000 local people. South Ayrshire
Unlocking value from existing local assets

The Older Peoples Access Line has created an effective partnership within the voluntary sector leading to more connectivity between groups providing the service, more effective delivery of voluntary sector services through one single point of access and through the support provided by the capacity building funded within the project. The project supported improvement in quality of service, and the ability to work more effectively with public sector partners and particularly GPs.

E Dunbartonshire

Community Empowerment and Participatory Budgeting

EVOC’s Canny wi’ Cash Participatory Budgeting project was all about direct democracy – reaching out to Older People across the city, giving them the power to make spending decisions on a small-grants programme to fund work with, by and for Older People. Paid facilitators went to where Older People gathered. The team received 101 project bids, valued altogether at £106,000. Over a ‘voting fortnight’ 312 Older People across agreed to fund 56 of these projects to the tune of £56,000. Projects and Participants engaged enthusiastically; as one keen voter put it: “Our Voice is Being Heard at Last.” Edinburgh

Nurturing Social Enterprise

A local social enterprise Growbiz, worked with IRISS to offer support for micro-businesses, self-employed individuals and social enterprises in the social care sector, through the Creative Care and Support. The aim of this change funded project was to develop a network of micro-provider small businesses to offer local and responsive community services in preparation for self-directed support. 13 people were supported to become self-employed and to launch a small business and 4 existing businesses given support to develop and diversify to meet the needs of the care and support market. Perth and Kinross

West Dunbartonshire’s successful Link-up Project is meeting the needs identified by local older people for more information about services and is sustainable as part of the wider infrastructure supporting volunteers. The consortium that developed link-up is currently seeking lottery funding to develop and expand the service.

Supporting carers

Change Fund built capacity in Voluntary Action Shetland to deliver the Carer’s service and provide community support for carers groups in areas where there was no support previously. Shetland now has a Carer’s centre, website and facebook page that offers online 1:1 or group support, carer forums, e-training, information, local carers groups in the outlying islands, carer’s Assessments, a Young Carer’s group and siblings group. Shetland

Commissioned local research informed the ‘One Stop Shop’ model of Short Breaks in Dundee. The full report is available ‘Short Break (Respite Care) Provision in Dundee – now and in the future www.dundeecarerscentre.org.uk
Staying Connected and Reducing Social Isolation

We can confidently state that in excess of 2,100 older people are in receipt of support through third sector interventions largely as a result of RCOP. 27,000 hours and rising of volunteer input are directly supporting older people. A further 11,000 hours support, for example, carers or specific groups of older people with long term conditions. Maintaining independence, wellbeing, both emotional and physical, and social connections to combat isolation and loneliness are well documented and we have measured and tracked progress robustly. Argyll and Bute

An innovative partnership between East Lothian and the Royal Voluntary Service has created a combined community transport and support scheme for older people. Transport is provided by Royal Voluntary Service Volunteers who use their own vehicles and mileage costs are funded from the Change Fund. Over two years, 40 Volunteers delivered over 2,000 hours of support to 591 older people through:
- transport, shopping, collecting prescriptions
- signposting to other local services
- voicing apparent concerns around living environment and lifestyle.
- respite for carers

In Midlothian approximately 462 people have benefited to date from Connect Online to reduce feelings of social isolation, maintain independence and improve digital skills and confidence in older people and isolated individuals by free one-to-one IT tuition within their own homes or in a group setting.

Red Cross Community Co-ordinators and Neighbourhood Links have supported 732 people to access services and activities which have improved the persons quality of life. Thsi includes short term support for hospital discharge or who may be at risk of re-admission if practical support is not provided. In the last year a Volunteer Coordinator has recruited and trained 33 Community Links volunteers. 88 clients have been successfully engaged in a match with a befriender and 20 are in the process of being matched. Midlothian

Aberdeen’s Befriending project used a collaborative advantage model with five partners of diverse size and remit. They worked to support the client base and each other delivering a very successful befriending service for the city.

The GATE (Good at the End) project is now recognised by major Scottish charities as an excellent vehicle to support families to deal with end of life wishes of older people and work with an enjoyable process to build memories and ensure satisfaction with the path to end of life. Aberdeen

Investing in infrastructure – eg 2 additional community transport minibuses; equipment, IT and improved access for key community facilities and Sheltered Housing Common Rooms; Ayr ‘One Stop Shop’- Book and Bun South Ayrshire

Implementation of a referral pathway with Scottish Fire and Rescue Service to identify and share information about adults who are vulnerable and in respect of whom earlier interventions may prevent negative outcomes. West Lothian
Strategic investment in Third Sector

North Lanarkshire partnership resourced their Third Sector to lead a strategic Community Capacity Building programme around ten thematic strands (based on a needs analysis) and six locality partnerships (hosted by a local organisation known to the respective communities). The programme had a strong governance and evaluation framework employing ‘Talking Points’ personal outcomes principles. Outcomes for 2013/14 were:

- Reduced isolation and loneliness 1606
- Increased participation 1867
- Improved information advice and education 2196
- Improved well-being 1378
- Reduced isolation carer 246
- Increased ability to cope or manage caring role 270
- Improved well-being carer 218
- Direct link to carer support 242

New activities has given me peace of mind and helped with my depression as I gradually didn’t need to put up a front, I had other people to talk to and activities to look forward to and all of this brightened up my mood. (Senior Sizzlers, Craigneuk)

My understanding of my father’s condition has been deepened and I will pass this on. My mind-set has been changed when dealing with aggression. I need to think frustration not aggression and why he acts this way. MM (61)

175 programmes have funded through a co-production model that gives local people and professionals the responsibility to co-commission a £15,000 per year budget to micro-fund key projects. Locator, an electronic database of community resources, had 115,550 hits and 34,269 visits. Third sector organisations have generated additional funding of around £1million to deliver home visiting and befriending and the expansion of a local men’s group funded by the Robertson Trust.

The Voice of Experience Community Liaison Officer has linked with the local Food Co-operative to supply basic groceries for those fit for discharge. Contact is made with the ‘Supported Transport from A&E’ initiative who drive the older person home with simple provisions such as bread and milk. The supported transport worker or Community Liaison Officer phones the next morning to check that everything is ok.

In South Lanarkshire, four locality officers identified and mapped over 800 groups for older people. They carried out interviews which highlighted priority concerns: isolation; befriending; transport; information. Projects were established to quantify the need and look at possible remedies. These included an early morning call service, telephone befriending service, community transport scheme, Strength and Balance training and a walking challenge to improve wellbeing. Information was displayed using a computer data base called ‘Locator’ which shows local groups and activities that older people can benefit from in their local area. The database has received over 400,000 hits in less than two years, and is available direct from VASLan’s website. The database is used by all the Partners of RCOP.
In Fife, nine voluntary sector partners were funded via The Community Interventions Fund (CIF), overseen by Fife Voluntary Action. Each unique project illustrated the wide range of services and interventions offered in Fife by the third sector. The nine projects spanned a diverse range of activities from a Men’s Tool shed to provision of advice and support in planning Housing solutions. This programme approach has meant that delivery partner organisations have learnt about each other’s services, referred participants to one another, hosted activities carried out by other delivery partners or, in some cases, altered their own plans to avoid duplication and optimise use of resources. Support activities have been highly valued, very effective and added value to the projects being managed as one integrated programme.

An outcome focussed approach was taken to evaluation at both programme and project levels and using Charities Evaluation Services (CES) Planning Triangles and associated monitoring frameworks. The evaluation strategy reflects Talking Points guidance on outcomes. The external evaluator’s interim [18 month] report records clear evidence of positive outcomes achieved for older people in all of the projects. There is also evidence of positive outcomes for carers, volunteers, staff, delivery partner organisations and other stakeholders amongst the nine original projects.

Fife partnership and Alzheimer Scotland created a network of volunteers to work with people with dementia and their carers with the specific aims of reducing isolation, improving mental health and wellbeing, increasing community capacity, increasing social capital, increasing personalised care and resilience, increasing flexibility in support provision, intergenerational work, increased carer resilience.

26 volunteers recruited to support five new groups. 679 places established providing support for 53 people with dementia and their carers; 60 sessions held to date for around 1300 people.

Inverclyde Change Fund supported an older people’s officer to help support and develop the sector. Funding supported a range of projects; face to face and telephone befriending, increased advocacy including regular drop in sessions in care homes and increased access to home maintenance services especially rapid response with the ability to respond in support of hospital discharges. Reporting and client evaluation shows that there are improved outcomes for older people which include increased confidence and the confidence to stay in their own homes.

One of the main developments was the redesign of day care services with an explicit co-production approach. Much has been learned in the process and it is anticipated that the deliverables will be achieved within the time scale of the Integrated Care Fund Plan. A more recent co-productive exercise is still at a very early stage; this is the Public Social Partnership (PSP) which has been set up to redesign the service interventions that will support people who were previously supported through housing support in Sheltered Housing developments. Registered Social Landlords have indicated that they are withdrawing from this business and the PSP is exploring options to both fill the gap and also establish more effective supports to the wider community. It is proposed to use an element of the Integrated Care Fund to pilot activity in advance of the main transition to the redesigned services. It is expected that the activity will span traditional housing support, carers support, and befriending. West Lothian
PRIORITISING INVESTMENT

Partnerships were invited to describe any option appraisal approaches used to consider their Change Fund initiatives and to decide on local investment priorities.

Most partnerships used structured assessment criteria that linked proposed initiatives to the RCOP goals and outcomes, including personal outcomes.

**Falkirk** issued monitoring forms, seeking performance information, including robust evidence of sustainability. Project leads were asked to outline what approach is being taken to generate or secure on-going resources (if required) and where their service could compliment or create alternative services to those currently offered.

**In Stirling and Clackmannanshire** all Change Fund services have gone through two annual cycles of rigorous qualitative and financial review to inform on progress and ongoing funding.

**Angus** used a range of approaches such as cost benefit analysis, multi-criteria analysis and social return on investment, but are committed to using LEAN, developing six sigma and organisational development approaches to deliver on transformational change rather than transactional change.

**Scottish Borders** used a score card considering strategic fit, outcomes, financial benefits, expected impact on carers and against an ambitious return on investment of 3:1. All partners scored each initiative, combined scores were ranked against the allocation and similar projects were compared or sometimes combined. This process was repeated throughout the Change Fund to ensure projects remained in scope.

Some partnerships attempted more ambitious analysis of return on investment.

**In conjunction with NHSGGC Public Health Directorate, Glasgow City** appointed a senior researcher who has undertaken an evaluation of the Change Fund programme, focusing upon the role and contribution of the statutory partners. Additional input was also commissioned from the Yunus Centre for Social Business and Health based at Glasgow Caledonian University, which concentrated upon the assessment of the impact of the housing and third sector projects.

**West Dunbartonshire** commissioned ISD to undertake an independent evaluation of their Anticipatory Care Planning approach, reviewing the impact on unplanned inpatient care, prescribing and social care activity.

Most partnerships devolved prioritisation of community capacity building and preventative investments to a wider group of stakeholders. This is welcome and in the spirit of community empowerment and co-production.

**Argyll & Bute** used an option appraisal to inform allocation of £120,000 of the Change Fund to their four localities. The framework requires involvement by all sectors and people who use services and their carers.
**Edinburgh Canny wi’ Cash – Older People deciding on grants for Older People**

An allocation of £35k was made for a small grants fund (up to £1,500) for very small community groups for older people across the city. Participatory budgeting was used involving older people who voted and decided which applications should be funded. EVOC led this work and a team of trained facilitators went out to visit groups of older people eg lunch clubs, day centres etc - and gathered their views over a ‘voting fortnight’ in November 2013. See the full report on the EVOC website.

Partnerships are now using their learning from RCOP to inform their Integrated Care Fund plans and to develop Strategic Plans to mainstream effective initiatives.

**East Ayrshire** undertook option appraisal during 2014/15 to consider sustainability in light of the reduced Change Fund allocation for that year and in preparation for the transition to the Integrated Care Fund. A prioritisation exercise assessed initiatives on a five-point risk scale to inform investment decisions, mainstreaming or cessation of programmes. Initiatives mainstreamed and put on a sustainable footing following re-design or resource release from shifting the balance of care include community geriatrician, primary care support to community hospital, community physiotherapy capacity, dementia liaison nursing, social work support in primary care settings, third sector coordination, community transport.

The **Renfrewshire Partnership**, used the national improvement programme for commissioning with the JIT and the Institute of Public Care (Oxford Brookes University) to complete a joint strategic needs analysis and plan for Older People’s Services. Proposals were assessed against Change priorities:

- reducing levels of delayed discharge
- avoiding unnecessary admission to hospital
- capacity building
- support for independent living
- direct support for carers
- community capacity building

**E Dunbartonshire** took forward a prospective evaluation against performance indicators for East Dunbartonshire SOA Outcome 5 and evidence of benefit from service users/carers and other stakeholders. In **Year 3 a deeper dive audit** of 55 vulnerable service users was undertaken to inform investments in Years 3 and 4 through a redesign workshop. A detailed evaluation focused on 15 projects using a contribution/attribution/framework for short and medium term outcomes. In year 4 the workstreams were scored against the integration fund guidance and principles

- Impact
- Cost
- Co-production
- Sustainability
- Leverage
- Involvement
- Outcome
- Rationale for Integration Funding (double weighting)
E Lothian used tools from the Strategic Commissioning Programme. Each project was placed on the following grid according to assessment of the project report as part of the 6 monthly review process.

**Low Risk/ Good alignment with Priorities & needs**

<table>
<thead>
<tr>
<th>Poor quality/</th>
<th>Good quality/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value for money</td>
<td>Value for money</td>
</tr>
<tr>
<td>Decommission</td>
<td>Remodel</td>
</tr>
<tr>
<td>Renegotiate/end contract</td>
<td>Maintain</td>
</tr>
</tbody>
</table>

**High Risk/ Poor Alignment with Needs**

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>DESCRIPTION</th>
<th>SCORING Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIC FIT (SF)</td>
<td>Does the project fit with the aims, objectives and values of the RCOP agenda and the Change Fund objectives. Reshaping Care Pathway/ Core Measures/OPS Priorities/</td>
<td>YES / NO</td>
</tr>
<tr>
<td>DELIVERY (D)</td>
<td>Is the project delivering according to expectations and targets set for activity? If not, are there reasons for this that are being addressed?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>SUSTAINABLE (SUS)</td>
<td>Is the project financial plan on target and is the project within budget? If not are there clear reasons for this? Is there a plan for how the work of the project can be sustained in the longer term.</td>
<td>YES / NO</td>
</tr>
<tr>
<td>RISK (R)</td>
<td>Are risks being identified and managed effectively?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>RETURN ON INVESTMENT (ROI)</td>
<td>Has the project been able to evidence clear added value and a proportionate return on investment for the indicated outcomes?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>OPERATIONAL FIT (OF)</td>
<td>Is there evidence that other local services/processes and related change targets are being positively impacted by the project? Can the project demonstrate an ability to reduce unscheduled admissions/delayed discharges?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>DUPLICATION (DUP)</td>
<td>Is the project as being delivered able to demonstrate its unique selling point, i.e. it is not duplicating other project or other current activity/practice?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>PARTNERSHIP/ COLLABORATION (P/C)</td>
<td>Have appropriate links to other services/organisations and opportunities for partnership working/collaboration been maximised?</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

All Highland Change Fund activity has been agreed through discussion at the multiagency Adult Services Commissioning Group, ensuring that Carers; Service Users Third and Independent Sectors, consider investment options alongside other pressures. This group is concerned with commissioning decisions across the whole Adult Care agenda (circa £0.5bn rather than purely the Change Fund (circa £4m)... Both operational areas have piloted use of Programme Budgeting Marginal Analysis (PBMA) to support specific areas of development.
North Lanarkshire and South Lanarkshire partnerships both agreed a Contribution Analysis approach to evaluating RCOP projects. All key stakeholders agreed a theory of change which was then mapped as a logic model. The aim of this approach was to analyse to what extent observed changes to outcomes were as a result of individual projects or services.

Performance management and evaluation data-gathering arrangements were developed. Quarterly meetings provided a forum to discuss data and evidence of contribution to the short and medium term outcomes. Where there was limited or no evidence, the project was reviewed and decisions taken on whether it should continue, either in a modified form or to discontinue funding.

This approach has provided regular, robust evidence to the partnerships and has influenced investment decisions. Each initiative was reviewed to ensure best value for money.

Dumfries & Galloway

The Putting You First programme scored all tests of change to identify potential to impact significantly on reshaping care /shifting the balance of care and sustainability. Tests were assessed using set criteria:

- Assessment of activity, performance and financial data
- Discussions with project leads
- Feedback from individuals who have used the test
- Exit strategy information
- Financial Data
- Discussions with relevant staff across the partnership

A matrix gives the programme board an at-a-glance view of those tests of change which potentially reshaped care, could be sustainable with minimal additional funding and scaled up across Dumfries & Galloway

- Probability of the test reshaping care assessed out of 5 to be 1=rare, 2=unlikely,3=possible,4=likely,5=almost certain and
- Impact that this could have on the system assessed as 1=negligible, 2=minor, 3=moderate, 4=major, 5=extreme
SELF ASSESSMENT OF SPREAD

Partnerships must be clear about the extent to which they have tested and spread new approaches and improvements so that they can understand where and when future gains can be anticipated. This is an important aspect of Commissioning through which the integration authority can plan to scale up and mainstream successful initiatives within their Strategic Plan.

Partnerships were invited to complete a position statement which assessed how far they had achieved spread on each of the approaches and interventions identified within the four pillars of the RCOP pathway and the associated enablers.

They were asked to self-report using an ordinal scale with values 0 to 5, which had definitions given as shown in Table 3.

Table 3

<table>
<thead>
<tr>
<th>Spread Value</th>
<th>Self Assessment Position Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No agreed plan to implement the approach / intervention / improvement action</td>
</tr>
<tr>
<td>1</td>
<td>Agreed plan to take forward the approach / intervention / improvement action but not yet began to implement</td>
</tr>
<tr>
<td>2</td>
<td>Testing / implementing the approach / intervention / improvement action in a minority of localities / sites / teams / older people / carers</td>
</tr>
<tr>
<td>3</td>
<td>The approach / intervention / improvement action has spread to most localities / sites / teams / older people / carers</td>
</tr>
<tr>
<td>4</td>
<td>The approach / intervention / improvement action has spread to all localities / sites / teams / older people / carers but is not yet fully embedded in routine practice</td>
</tr>
<tr>
<td>5</td>
<td>The approach / intervention / improvement action is fully embedded in all localities / sites / teams / older people / carers and there is an agreed plan to sustain this</td>
</tr>
</tbody>
</table>

Thirty of the thirty one partnerships completed the updated self assessment.

Table 4 summarises the self-reported assessments provided

The JIT will use the insights from the self assessment to work with national partners and other improvement organisations to target our collective improvement support towards the interventions and enablers that require additional effort to scale up.

The aim will be to draw on the experience of those partnerships which are further ahead in implementing these interventions in order to help those who are making slower progress in spread and adoption.
<table>
<thead>
<tr>
<th>Enablers</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals and Care Homes</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Early assessment and rehab in specialist unit</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>9</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Prevention and treatment of delirium</td>
<td>2</td>
<td>6</td>
<td>13</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective and timely discharge home or to intermediate care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine reconciliation and reviews</td>
<td>6</td>
<td>14</td>
<td>9</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers as equal partners</td>
<td>4</td>
<td>14</td>
<td>11</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist clinical support for care homes</td>
<td>1</td>
<td>14</td>
<td>13</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Effective Care at Transitions                                          | 3   | 3   | 18  | 6   |     |     |
| Reablement & Rehabilitation                                            | 8   | 16  | 6   |     |     |     |
| Specialist clinical advice for community teams                         | 6   | 13  | 10  | 1   |     |     |
| Range of Intermediate Care alternatives to emergency admission         | 6   | 13  | 10  | 1   |     |     |
| Responsive and flexible palliative care                                | 1   | 10  | 14  | 5   |     |     |
| Support for carers                                                     | 11  | 15  | 4   |     |     |     |
| Medicines Management                                                   | 4   | 10  | 13  | 3   |     |     |
| Access to range of housing options                                     | 1   | 9   | 14  | 4   | 2   |     |

| Proactive Care and Support at Home                                     | 1   | 2   | 13  | 14  |     |     |
| Responsive flexible, self-directed home care                           | 3   | 14  | 11  | 2   |     |     |
| Integrated Case/Care Management                                       | 2   | 6   | 15  | 7   |     |     |
| Rapid access to equipment                                             | 5   | 14  | 11  |     |     |     |
| Timely adaptations, including housing adaptations                      | 1   | 2   | 7   | 16  | 4   |     |
| Telehealthcare                                                         |     |     |     |     |     |     |

| Prevention and Anticipatory Care                                       | 5   | 13  | 12  |     |     |     |
| Build social networks and opportunities for participation             | 2   | 7   | 17  | 4   |     |     |
| Early diagnosis of dementia                                           | 3   | 12  | 14  | 1   |     |     |
| Prevention of Falls and Fractures                                     | 4   | 13  | 12  | 1   |     |     |
| Information & Support for Self-Management & Self-Directed Support     |     |     |     |     |     |     |
| Prediction of risk of recurrent admissions                            |     |     |     |     |     |     |
| Anticipatory Care Planning                                            | 6   | 13  | 9   | 2   |     |     |
| Support for carers                                                     | 8   | 19  | 3   |     |     |     |
| Suitable housing and housing support                                  |     |     |     |     |     |     |

| Information & Support for Self-Management & Self-Directed Care        |     |     |     |     |     |     |
| Prediction of risk of recurrent admissions                            |     |     |     |     |     |     |
| Anticipatory Care Planning                                            | 6   | 13  | 9   | 2   |     |     |
| Support for carers                                                     | 8   | 19  | 3   |     |     |     |
| Suitable housing and housing support                                  |     |     |     |     |     |     |

| Hospitals and Care Homes                                               | 2   | 1   | 2   | 10  | 12  | 3   |
| Early assessment and rehab in specialist unit                          | 3   | 1   | 4   | 9   | 9   | 4   |
| Prevention and treatment of delirium                                    | 2   | 6   | 13  | 9   |     |     |
| Effective and timely discharge home or to intermediate care            |     |     |     |     |     |     |
| Medicine reconciliation and reviews                                    | 6   | 14  | 9   | 1   |     |     |
| Carers as equal partners                                               | 4   | 14  | 11  | 1   |     |     |
| Specialist clinical support for care homes                             | 1   | 14  | 13  | 2   |     |     |

| Information and Evaluation                                            | 8   | 10  | 11  | 1   |     |     |
| Commissioning & Integrated Resources                                   | 7   | 14  | 7   | 2   |     |     |
At least 50% of partnerships reported **spread to all localities** (score 4 or more) for:

- Early diagnosis of dementia
- Prevention of falls and fractures
- Support for carers and respite
- Suitable and varied housing and housing support
- Rapid access to equipment and adaptations
- Access to Telehealth and telecare
- Reablement and rehabilitation
- Specialist advice and support for community teams
- Responsive and flexible palliative care
- Medicines management in the community
- Triage to identify frail older people in hospital
- Timely discharge home or to intermediate care
- Specialist clinical support for care homes
- Outcomes focused assessment
- Organisational development and improvement capacity

This represents significant progress compared to the 2013 self assessment.

The other approaches and interventions have **spread to most localities** (score 3 or more) in 80% of partnerships.

Interventions that require further spread include **adoption and use of Anticipatory Care Planning and Key Information Summaries**, **flexible and responsive homecare**, **case / care management of people with complex support needs**, and **medicines reconciliation**.

*These are priorities in the Multiple Conditions action plan, the six key actions for Unscheduled Care and in the guidance for use of the Integrated Care Fund.*

Around 25% of partnerships reported a **systematic approach to risk prediction and sharing of information** in only a minority of localities (score 2 or less).

*The refreshed national advisory group on risk prediction and the Health and Social Care Data Integration and Intelligence Project will help address this gap.*

A similar number of partnerships reported limited **early assessment for frail older people and detection and treatment of delirium in acute care**.

*A whole system Frailty improvement programme will commence from June 2015.*

Most partnerships recognise significant further work is required to develop their workforce and skill mix and to fully adopt commissioning approaches that analyse local data and use integrated resourcing to design local services. This will be supported through the Strategic Commissioning Development programme and work with ISD to help integration authorities use their needs assessment, performance data and Integrated Resource Framework to plan and invest in sustainable care and support that delivers value and positive outcomes for older people and their carers.
LEARNING FROM WHAT’S NOT WORKED

The Change Fund has been a lever for improvement and an opportunity for Partnerships to explore innovations that are ‘Proof of Concept’ or ‘Tests of Change’.

The Plan – Do - Study - Act model for improvement refines incremental tests of change before reaching a definitive model for spread and wider adoption. This is an important step for strategic commissioning of sustainable support and services.

Undertake Plan - Do – Study – Act cycles to test and spread initiatives

Adopt an Analyse - Plan – Deliver – Review approach to commissioning

Learning from what’s not worked is an essential component of any improvement programme. Organisational learning about what works and what gets in the way drives innovation and redesign.

We asked partnerships to describe any learning gained where a decision not to continue an initiative was made – e.g. where barriers to progress were encountered, the initiative was not found to be effective, or where learning has led to disinvestment. The examples below illustrate how partnerships are reviewing and adapting local initiatives to make best use of existing capacity and resources.

Continuous Evaluation and Review

Many initiatives were adapted as local circumstances changed or if the proposed approach was overtaken by other developments and initiatives.

Six monthly evaluation has taken place throughout the Change Fund and any work streams that were not found to be effective were modified and barriers addressed on an ongoing basis. Edinburgh City

We have learned through evaluation and monitoring of our change fund initiatives where and when an alteration is required to meet our agreed outcomes for older people. As our decisions were based on an analysis of need and service mapping, it was a case of doing things differently rather than deciding not to continue. Moray

Recruitment issues

Small projects and fixed term tests of change face challenges around recruitment and retention of staff. Success or otherwise is often person dependent. This is a symptom of wider issues in recruitment to the care sector in some areas.

Aberdeen City faced service staff shortages and recruitment problems that have slowed or impeded progress.

Dundee experienced difficulty in recruiting to professional posts and this has, on occasion, led to a delay in taking forward projects. Often this is exasperated by the short term nature of the funding.
Dundee could not recruit a Moving and Handling Assessor/Trainer to work with carers. The resource was redesigned as a spot purchase fund which has provided carers with a choice of supports which can be tailored to their needs.

Western Isles “Help in the Home” project aimed to reduce inappropriate social admissions to hospital but due to the vast distances between clients the existing team could not support the delivery without recruiting additional volunteers.

Timing and readiness for the intervention

Many initiatives were time critical, dependent on cultural readiness or on other local or national developments to create the necessary conditions and context. There is a need to understand and address human factors that may stifle adoption and spread.

Argyll and Bute discontinued a post established to improve capacity to deliver a wider range of pharmaceutical interventions to people at home, including use of subcutaneous and intravenous treatments. Further work is required first to develop the policies and procedures. The partnership also agreed that a Releasing Time to Care Facilitator post would be more useful when teams are integrated from 2015.

Shetland abandoned plans to introduce a community nursing IT system due to a national decision to pilot this in one geographical area, prior to roll out to other areas.

Glasgow City’s Assessment at Home initiative faced a lack of systemic and cultural preparedness for change across partners and across the pathway. Experience has informed development and implementation of the ‘Step Down Assessment’ model being rolled out across the city to enable patients to be discharged within 72 hours of being Fit for Discharge. Where required, patients are discharged to step down units in care homes. An OD Plan has also been developed in order to address the cultural, behavioural and team development issues and ensure this new model of care is understood, supported, and effectively implemented across the city.

Introduction of Occupational Therapists (OT’s) within independent care at home providers in East Dunbartonshire did not deliver the desired outcomes as clients and their families feared their care package was going to be taken from them. Learning directed the partnership to support providers to undertake reablement reviews themselves where trust has been gained from their clients.

The opportunity to tender to provide additional flexible support at home did not sit with the core business of the existing third sector in Orkney. The partnership learned that community developments need collaboration with any potential partners from the outset and formally commissioned third sector projects during years 3 and 4.

Low Referrals or Insufficient Impact

It is a challenge to ensure all staff and public are fully engaged informed and advised of developments. Despite extensive involvement of key partners, partnerships often experienced difficulty in identifying appropriate referrals to new services and to secure buy in to new models of care.
**East Lothian** ceased funding their mental wellbeing project due to consistently low levels of take-up. Whilst the course appeared to be successful if completed, take-up was so low that it did not represent a good return on investment or address the local need. A more individualised approach may be required.

**Inverclyde** disinvested from the carers befriending project to expand the carers support for hospital discharge which was reporting better outcomes.

**Dumfries & Galloway’s** Putting You First (PYF) programme tested a change where an independent care at home provider offered overnight home visits for older people who have a short term non-life threatening ailment. Only 2 people were referred by their GP in 3 months. Learning for future proposals
- Robust communication is essential from the outset
- Referral process must be simple or the easier option is admit to hospital
- Social Work, District Nurses, Out of Hours and A&E should be able to refer
- Extend the criteria to include older people who do not have care packages.

In **North Lanarkshire**, five Sheltered Housing flats offered Carer respite. Despite being promoted through Locality Planning Groups and Carers organisations, the demand remained low. A revised model of ‘Community Resource Flats’ are now in place as a temporary solution for people delayed in hospital awaiting a housing adaptation and to provide a place of safety during investigation of Adult Protection.

**Better outcomes from aligning / integrating resources**

**Angus** Multi-disciplinary teams (including care managers based around GP practices) are delivering early intervention and anticipatory care on which the enhanced community support model builds to prevent admissions which were not achieved through the previous single agency virtual ward model. Integration of occupational therapy services and the development of a First contact service for all social work referrals has reduced waiting times for equipment and adaptations and further reduced demand for supported accommodation. The development of the voluntary sector single point of contact approach identified more community volunteers, volunteering approaches and community activity which was previously unknown. This information is supporting the local development of the ALISS system.

**Midlothian** developed too many innovation funded projects targeting social isolation causing duplication of services while gaps remained in social isolation provision. The learning from this has directed us to develop a comprehensive Local Area Co-ordination Service (Red Cross Community Co-ordinators).

**South Ayrshire** Intermediate Care and Enablement Service (ICES) 7 day working was not judged to be effective with the existing service model. The move towards 7 day ICES working needs to be linked with access to other services through longer term re-design work and within our Supporting Discharge programme.

**Aberdeenshire** disbanded their specialist Rehabilitation and Enablement Teams as it proved difficult to fill posts for limited hours and the service was very expensive. Staff working in the community are now being trained in enablement and the approach is being embedded into mainstream provision.
Annex 1

HEALTH, HOUSING AND SOCIAL CARE PARTNERSHIPS IMPROVEMENT AND SUPPORT GROUP

Purpose

The Improvement and Support Group is a collaboration of improvement organisations and national partners collectively maximising support for Health and Social Care innovation, implementation and improvement. It reduces duplication, harnesses collective energies and expertise and provides consistent messaging on improvement and support for delivery of the national health and wellbeing outcomes.

Remit

- To promote a coordinated and coherent approach to implementation and improvement support for integrated care and support
- To help all Integration Authorities, Partnerships and their localities build capacity and capability for improvement and integration.
- To provide oversight, leadership and identification of improvement and support priorities for the Improvement Network.
- To review the Improvement Network’s progress and outcomes, ensuring that it maximises the collective contribution and resources of national partners.
- To support the use and feedback of measurement and evidence of the impact of integrated care and support
- To review and monitor the impact of improvement and support on delivery of national priorities, targets and cross sector outcomes in relation to integrated care and support

Function

The Group will meet every 2 months to provide oversight and challenge for improvement and support activities and to review progress and outcomes. Each group member will be aware of and represent the views of their constituents.

Reporting

The Group reports to the Health and Community Care Delivery Group and Joint Improvement Partnership Board.
## Membership

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair - Director JIT</td>
<td>Margaret Whoriskey</td>
</tr>
<tr>
<td>Acute Sector</td>
<td>Tba</td>
</tr>
<tr>
<td>ALACHO</td>
<td>Jim Hayton</td>
</tr>
<tr>
<td>Care Inspectorate</td>
<td>Robert Peat</td>
</tr>
<tr>
<td>CCPS / Housing Coordinating group</td>
<td>Yvette Burgess</td>
</tr>
<tr>
<td>Chief Officers Group</td>
<td>Iona Colvin</td>
</tr>
<tr>
<td></td>
<td>Eibhlin McHugh</td>
</tr>
<tr>
<td></td>
<td>Susan Manion</td>
</tr>
<tr>
<td>Clinical Lead</td>
<td>Anne Hendry</td>
</tr>
<tr>
<td>COSLA</td>
<td>Ron Culley</td>
</tr>
<tr>
<td>Health Scotland</td>
<td>Pauline Craig</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland and QI Hub</td>
<td>June Wylie</td>
</tr>
<tr>
<td>Improvement Service</td>
<td>Colin Mair</td>
</tr>
<tr>
<td>Institute for Research &amp; Innovation in Social Services (IRISS)</td>
<td>Alison Petch</td>
</tr>
<tr>
<td>Leading Improvement Team (LIT)</td>
<td>Fiona Montgomery</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>Stuart Cable</td>
</tr>
<tr>
<td>Quality and Efficiency Support Team (QuEST)</td>
<td>Susan Bishop</td>
</tr>
<tr>
<td>Scottish Care</td>
<td>Margaret McKeith</td>
</tr>
<tr>
<td>SCVO</td>
<td>Lucy McTernan</td>
</tr>
<tr>
<td>Scottish Social Services Council</td>
<td>Mairi-Anne McDonald</td>
</tr>
<tr>
<td>Social Work Scotland</td>
<td>Elaine Torrance</td>
</tr>
<tr>
<td>Voluntary Action Scotland</td>
<td>Helen Macneil</td>
</tr>
</tbody>
</table>

## In attendance as required

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Network Lead</td>
<td>Mandy Andrew</td>
</tr>
<tr>
<td>Integration and Service Development Division</td>
<td>Alison Taylor</td>
</tr>
<tr>
<td></td>
<td>Jo Maclennan</td>
</tr>
<tr>
<td>Older People / Dementia Team</td>
<td>David Berry</td>
</tr>
<tr>
<td>Planning and Quality Division</td>
<td>Mairi McPherson</td>
</tr>
<tr>
<td>Primary Care Division</td>
<td>John Nugent</td>
</tr>
<tr>
<td>Secretariat</td>
<td>JIT</td>
</tr>
</tbody>
</table>
**Annex 2  Reshaping Care Pathway**

**Preventative and Anticipatory Care**
- Build social networks and opportunities for participation.
- Early diagnosis of dementia.
- Prevention of Falls and Fractures.
- Information & Support for Self Management & Self Directed Support.
- Prediction of risk of recurrent admissions.
- Anticipatory Care Planning.
- Support for carers.
- Suitable, and varied, housing, build support and housing support.

**Proactive Care and Support at Home**
- Responsive and flexible home care.
- Integrated Case/Care Management.
- Carer Support and Respite.
- Rapid access to equipment.
- Timely adaptations, including housing adaptations, and equipment.
- Telehealthcare.

**Effective Care at Times of Transition**
- Reablement & Rehabilitation.
- Specialist clinical advice for community teams.
- NHS24, SAS and Out of Hours access ACPs.
- Range of Intermediate Care alternatives to emergency admission.
- Responsive and flexible palliative care.
- Support for carers.
- Medicines Management.
- Access to range of housing options.

**Hospital and Care Home(s)**
- Urgent triage to identify frail older people.
- Early assessment and rehab in the appropriate specialist unit.
- Prevention and treatment of delirium.
- Effective and timely discharge home or transfer to intermediate care.
- Medicine reconciliation and reviews.
- Carers as equal partners.
- Specialist clinical support for care homes.

Outcomes-focussed assessment
Co-production
Technology/eHealth/Data Sharing
Workforce Development/Skill Mix/Integrated Working
OD and Improvement Support
Information and Evaluation
Commissioning and Integrated Resource Framework
<table>
<thead>
<tr>
<th>Annex 3</th>
<th>Examples of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticipatory and Coordinated Care and Medicines Management</strong></td>
<td>![EoIs Anticipatory, Coordinated Care anx](EoIs Anticipatory, Coordinated Care anx)</td>
</tr>
<tr>
<td><strong>Carers Support</strong></td>
<td>![EoIs Carers support.docx](EoIs Carers support.docx)</td>
</tr>
<tr>
<td><strong>Coproduction &amp; Community Capacity Building</strong></td>
<td>![EoIs CoProduction and CCB.docx](EoIs CoProduction and CCB.docx)</td>
</tr>
<tr>
<td><strong>Care Homes and Independent sector</strong></td>
<td>![EoIs Care Homes and Independent Sec](EoIs Care Homes and Independent Sec)</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td>![EoIs Dementia.docx](EoIs Dementia.docx)</td>
</tr>
<tr>
<td>Falls and Physical Activity</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td></td>
</tr>
<tr>
<td>Housing, Equipment and Adaptations</td>
<td></td>
</tr>
<tr>
<td>Intermediate Care and Improving Discharge</td>
<td></td>
</tr>
<tr>
<td>Reablement</td>
<td></td>
</tr>
<tr>
<td>Technology Enabled Care</td>
<td></td>
</tr>
</tbody>
</table>

EoI Falls and Physical activity.docx
EoI Housing, Equipment and adapt
ead.docx
EoIs Intermediate Care and Discharge.docx
EoIs Reablement.docx
EoIs Technology Enabled Care.docx