Inverclyde has a history of whole system working, including: the promotion of joint planning and commissioning for reduction in delayed discharges, co-location of joint teams through hospital reprovision programmes and pooled budgets to ensure best use of collective resources to achieve jointly agreed targets.

A number of initiatives are underway that feed into, and offer opportunities to further develop joint working and to work towards an agreed joint balance of care.

**Attached in Appendix 1**, the local approach is outlined and this mirrors very closely the SBC Improvement Framework recently published nationally.

There is however a recognition that at this point in time certain challenges are facing the partnership in their quest to achieve a speedy shift in the balance of care that will reflect the required outcomes for a range of individuals in the community, and its ability to maintain targets already achieved e.g. zero target for delays over 6 weeks.

The partnership is proud of the work to date, but incorporating national initiatives including implementation of the NHS Continuing Care criteria, and the National Framework for Eligibility Criteria for adult social care services and standard waiting times for Free Personal and Nursing Care along side financial constraints that face all the organisations within the partnership as well as concluding a hospital closure programme, has resulted in a need to consolidate the ongoing work and re-consider realistic joint priorities.

The partnership has steadily shifted the balance of care from hospital settings to community settings. This has however sometimes been on an ad-hoc basis, taking an opportunity as it arises as opposed to a truly joined up vision across all services. The SBC Improvement Framework would provide a format that would enable the partnership to prioritise and redesign services in a systematic and sustainable way to meet the changing demography of the area in the longer term.

The range of initiatives along with a coterminous CHP and Local Authority area offer a real opportunity for establishment of an achievable joint SBC change programme. This, coupled with some examples of good and innovative practice to share across Scotland would identify the Inverclyde Partnership as an ideal participant in the integrated change programme.
The compact nature and size of the partnership would also offer an ideal setting for analysis and study of the processes, targets and outcomes that can, and sometime cannot be achieved.

The Inverclyde team identified to take this work forward have a wide range of experience of joint working, joint planning and service change. This includes leadership and involvement in:

- Developing, managing and monitoring the delayed discharge commissioning plan with an attached pooled budget of over £2m.
- NHS ward closure and service redesign
- Developing, managing and monitoring the Demonstrator for Older People’s Housing, Support, Health and Care
- Development and implementation of the local telecare and telehealth programme
- Leading and participating in the joint quality assurance and advice process
- Management of a range of community services
- Clinical experience and leadership

Planning: Helen Watson
Finance: Jonny Bryden
Social Care Expert: Gillian McCready
Acute Clinician: Paul Lawson
Epidemiologist: to be agreed
Community Clinician: Dr Mike Mutch
Resource Use: Margaret McConnachie
Housing Expertise: Ronny Lee
Balance of Care

Inverclyde Partnership

Outline of Approach and Work Underway

________________________________________________________________________

Approach

1.0 Balance of Care and Outcomes

Central to the Balance of Care work across the partnership is a focus on improved outcomes for service users. These outcomes are in line with the key national outcomes to:

- Improved health
- Improved wellbeing
- Improved social inclusion
- Improved independence and responsibility

Within the context of the Balance of Care achieving these outcomes includes a focus on the impact of needs and eligibility and services delivered across health, social care and housing services, including models of service delivery.

The Community Care Outcomes Framework Joint Performance agreed themes:

1. User Satisfaction
2. Faster Access to services
3. Support for Carers
4. Quality of Assessment and Care Planning
5. Identifying those at risk
6. Moving Services Closer to service users/patients

provide a structure through which balance of care outcomes will be directed across the partnership.

2.0 Key Focus for Inverclyde Shifting Balance of Care (SBC)

The emphasis for Shifting the Balance of Care within Inverclyde has a focus (in line with national direction) to implement changes at different levels across health and social care to support improvements in health and wellbeing and better service outcomes and use of resources.
Three broad “Balance of Care” priorities for Inverclyde Partnership are:

1. **Shifting the Location of Care**

Including:
- Supporting people to live in their own home whenever possible
- Better access to health and social care services in the community

2. **Shifting the Focus of Care**

Recognition of the enhanced role for a service focus on:
- Health improvement
- By enhancing anticipatory care;
- Continuous, integrated care rather than, episodic care
- Supporting self-care and, where appropriate, enabling people to take greater control of their conditions and their lives.

3. **Shifting our Ways of Working**

Including supporting change in service delivery through:
- Community-based, multi-agency approaches to the delivery of integrated care.
- Extended primary and community care teams that make better use of generalist and specialist expertise across community and hospital services.

3.0 **Monitoring and Evaluation**

Monitoring and Evaluation will include outcome, output and process change towards balance of care objectives.

**Improvement Framework**

The partnership will make use of the Scottish Government (NHS Scotland) Improvement Framework for Shifting the Balance of Care as a mechanism for monitoring progress towards balance of care objectives.

- Maximise flexible & responsive care at home with support for carers
- Integrate health and social care and support for people in need and at risk
- Integrate health and social care and support for people in need and at risk
- Reduce avoidable unscheduled attendance and admissions to acute hospitals
- Improve scheduled and flow management for scheduled care
- Extend scope of services provided by non medical practitioners outside acute hospital
- Improve access to care for remote and rural populations
- Improve palliative and end of life care
- Improve Joint use of resources

The improvement framework will be used in tandem with local balance of care targets. (Appendix 1 outlines the draft framework measures recognising the need for additional local indicators, includes Inverclyde CHP Balance of Care improvement initiatives. 2009/10).

**National and Local Performance Management Structures**

Monitoring and evaluation of Balance of care progress will also be carried out in conjunction with wider National and Local Performance Management Structures including HEAT, Single Outcome Agreement and Community Care Outcomes Framework

**4.0 Balance of Care Modelling**

Our approach includes developing models which reflect demand and supply pressures influencing the models of care we provide. This approach will take account of demographics, prevalence, policy direction, legislation and resources. Models will require accounting for the specific needs of each community care client group. Initial work has provided a focus on older people’s services lessons from which will be applied to other client groupings.

Learning disability services are already scoping the use of the Scottish Governments Improvement Framework for shifting the balance of care.

**Key Components:**

1. Establish Key Demand Factors influencing change:
   - Demographic change
   - Prevalence across care groups and needs
   - Carers

2. Establish current baseline of services including costs
   - Service mix
   - Volume of use
   - Establish data collection methods which facilitate modelling
   - Specialist services reflecting particular needs (e.g. Dementia services)
3. Establish models within options appraisal within context of:
   - Models of Care
   - Service Redesign
   - Targets National and Local Targets
   - Resource Implications

4. Financial Framework

5. Workforce planning issues

6. Commissioning Strategy
   - Balance of care recommendation will support future commissioning strategy decisions.

Modeling will take account of national guidance including JIT workbook and Guidance for commissioning strategies.

5.0 Current Work Streams

There are currently a wide range of work streams which are working the towards the partnerships Balance of Care broad objectives. These include:

- Hospital re-provisioning programme (Ravenscraig closure)
- Integration of Addictions services
- Implementation of Rehabilitation Framework
- Eligibility Criteria
- Rehabilitation Models
- Care and support at Home Review
- Service Redesign-Hospital Closure Programme
- Telecare Development/Tele-health Development
- Sheltered Housing Review
- Housing Allocation Policy
- Housing with Care Models
- SPARRA
- SCRUGS analysis
- Intermediate Care
- Care Pathways
- Development of Respite Care services

More details can be provided on the developments listed if required.