DUNDEE CITY COUNCIL

REPORT TO: **POLICY AND RESOURCES COMMITTEE – 9TH FEBRUARY 2015**

REPORT ON: **INTEGRATED CARE FUND**

REPORT BY: **CHIEF EXECUTIVE**

REPORT NO: **42-2015**

1.0 PURPOSE OF REPORT

To advise the Policy and Resources Committee of the Integrated Care Fund and how this will be used within Dundee to support the implementation of the Integration of Health and Social Care and to improve the health and wellbeing outcomes for adults.

2.0 RECOMMENDATIONS

It is recommended that the Committee:

- Note the Integrated Care Fund Plan.

3.0 FINANCIAL IMPLICATIONS

The Integrated Care Fund will be allocated to Health Boards for use by the partnership. The allocations to Health Boards will use a composite of the following two distributions on a 1:1 ratio:

- The NHS National Resource Allocation Committee (NRAC) distributions for adults in the Acute, Care of the Elderly, Mental Health and Learning Difficulties, and Community Care Programmes;
- Local Authority Grant Aided Expenditure (GAE) distributions for People aged 16+ derived using a population weighted composite indicator based on a number of factors.

The Tayside allocation is £7.86 million of which the Dundee Partnership's share is £3.1 million. The full resource is to be used within the financial year April 2015 – March 2016. At this stage the fund is to be considered a single year resource only.

4.0 MAIN TEXT

4.1 Integrated Care Fund

4.1.1 In the budget statement of 11th September 2013, the Cabinet Secretary for Finance and Sustainable Growth announced that £100m would be made available via Health Boards to support the delivery of improved outcomes from health and social care integration. This fund builds on the Reshaping Care for Older People Change Fund which ceases in April 2015. As with the Reshaping Care Change Fund, the Integrated Care Fund will support partnerships to focus on prevention, early intervention and care and support for people with complex and multiple conditions, particularly in those areas where co-morbidity/multi-morbidity is common in adults under 65, as well as older people. There is an expectation that the funds will strengthen the focus on inequalities.

4.1.2 The Integrated Care Fund will be used to test innovative and preventative approaches which reduce future demands. Plans for the use of the fund include actions to address the inverse care law; reduce demand for emergency hospital activity and emergency admissions and improve health and wellbeing. Partnerships were asked to build on the

learning from the use of the Reshaping Care for Older People Change Fund and take cognisance of the priorities detailed in the National Action Plan for Multi-morbidity.

4.1.3 In the guidance provided, the Scottish Government identified six key principles that should underpin the development and use of the fund:

- **Co-production** – the use of the Fund must be developed in partnership, primarily between health, social care, housing, third sector, independent sector, people who use support and services and unpaid carers. It should take an inclusive and collaborative local approach that seeks out and **fully supports the participation of the full range of stakeholders, particularly the third sector,** in the assessment of priorities and delivery of innovative ways to deliver better outcomes.
- **Sustainability** – the Fund needs to lead to change that can be evidenced as making a difference that is **sustainable and can be embedded through mainstream integrated funding sources** in the future.
- **Locality** – the locality aspects must include input from professionals, staff, users and carers and the public. Partnerships should develop **plans with the people who best know the needs and wishes of the local population**. Such a bottom up approach should maximise the contribution of local assets including the third sector, volunteers and existing community networks. Partners will be expected to weight the use of their funding to areas of greatest need.
- **Leverage** – the funding represents around 1% of the total spend on adult health and social care so must be able to support, unlock and improve the use of the total resource envelope. Our approach to strategic commissioning will be key to this, so it is important that plans for the use of this resource are embedded in the strategic commissioning process.
- **Involvement** – Partnerships should take a co-production, co-operative, participatory approach, ensuring that the **rights of people who use support and services and unpaid carers are central to the design and delivery of new ways of working** – delivering support and services based on an equal and reciprocal person centred relationship between providers, users, families and communities. These relationships should be evidenced within each partnership's plans.
- **Outcomes** – partnerships will be expected to **link the use of the funds to the delivery of integrated health and wellbeing outcomes for adult health and social care** which will be the responsibility of the new Integration Joint Boards or lead agencies following enactment of the legislation for integration.

4.1.4 The Integrated Fund will be available to the partnerships for a single year. As a result, partnerships were asked to ensure that the Integrated Care Fund Plan demonstrated that proposed actions are built into and can be sustained through longer term strategic commissioning approaches. How the plans were to be developed was left to local partnership agreement, however the guidance highlighted that partnerships were asked to deliver Plans which describe:

- The activities that will support the delivery of integrated health and wellbeing outcomes for adult health and social care – and the contribution to wider work designed to tackle health inequalities within Community Planning Partnerships;
- The extent to which activity will deliver improved outcomes in-year and lay the foundations for future work to be driven through Strategic Commissioning;
- Relationships with localities, including how input from the third sector, users and carers will be achieved. Such a bottom up approach should maximise the contribution of local assets including volunteers and existing community networks;
- The long term sustainability of investments and the extent to which the use of the fund will be focused on the areas of greatest need;
- How the principles of co-production will be embedded in the design and delivery of new ways of working;
- Progress in implementing priority actions for partnerships as described in the forthcoming National Action Plan for Multi–morbidity;
- How it will enable the partnership to produce a progress report based on the above for local publication in autumn 2016.

4.1.5 There is an expectation that two progress reports will be submitted to the Ministerial Strategic Group on Health and Community Care during the period of implementation. These progress reports will be structured to show progress made against the bullet list above. Partnerships were asked to submit the detailed plans for the use of the resources to the Scottish Government by the 23rd January 2015. And the fund submission must be signed off by representatives of NHS Tayside; Dundee City Council; the Third Sector and the Independent Sector.

4.2 Developing a Dundee Integrated Care Fund Plan

4.2.1 To deliver these planned actions within a tight timescale, two engagement events were held on the 3rd October 2014 and the 7th November 2014. These events were large participative events which included representatives from Health, Social Care, Housing, the Third Sector, the Independent Sector, services users and unpaid carers. The first event focused on agreeing the principles and priorities for Dundee, demonstrated how the national drivers and priorities should be accounted for within the plan and set out a process for developing the local Dundee plan. The second event considered and prioritised the key actions to be included in the Dundee Integrated Care Fund Plan for Dundee. Both events included in excess of 120 attendees. The process built on the work undertaken to develop the Older People's Change Fund Plan and enabled number of key stakeholders to utilise and extend existing networks to meet the requirements for developing the Integrated Care Plan.

4.3 Development of the Integrated Care Plan Submission

4.3.1 A strategic approach was taken to develop the Integrated Care Fund Plan which built on three current developments: the progression of the Reshaping Care for Older People Change Plan; the Care Group Strategic Commissioning Statements; and the current Community Plan. The priorities identified through these developments will in turn form the basis of the Integration Strategic and Commissioning Plan for Dundee.

4.3.2 Through integrated health and social care services, the overall aims for Dundee citizens can be defined as follows:

- To have a population which is healthy and well and which experiences less health inequalities.
- To have a city where individuals can achieve positive outcomes including access to education, employment and meaningful engagement.
- To have fewer people delayed in hospital and to provide health care as close to home as possible.
- To have more people cared for at home.
- To have more direct support for carers.
- To have a wider range of alternatives to statutory services which meet the needs of both individuals and communities.
- To work with communities in localities or neighbourhoods to build community resilience.

4.3.3 Through the events key priorities were identified and agreement reached as to how these priority areas would be progressed. Seven key areas for development were identified:

- Supporting carers.
- Reducing health inequalities.
- Building capacity and resilience.
- Developing integrated pathways which shift the balance of care.
- Developing new models of integrated care and support.
- Developing relationships with localities.
- Achieving integrated health and wellbeing outcomes for adults.

4.3.4 Each of these development areas will form a programme of work within the Integrated Care Fund Plan.

4.3.5 Proposals were then sought based on these themes and these were considered by a representative panel made up of all the stakeholders (Health, Social Work, Voluntary Sector; Independent Sector; and Carers) and a proposed list of future projects agreed.

4.3.6 In developing the Integrated Care Fund Plan both the short term and long term priorities were considered and two work streams developed. Work Stream 1 will take a long term approach. It will continue to build community capacity through the development of a community infrastructure that tackles health inequalities; develops the relationships with communities; builds community capacity and resilience and improves outcomes for individuals and carers. The approach will not only be preventative and support programmes of health improvement and self care for the general public, but will also target those most vulnerable in our communities and least likely to make use of current health and social care supports.

4.3.7 Work Stream 2 will put in place changes which will review the current models of service delivery and support change and redesign. It will reduce the reliance on acute hospital care by providing a timely and proactive multidisciplinary response to the identification of need and will remodel current services to support the delivery of health and social care support closer to home. In line with the principles of self directed support; there will be an investment in supports which provide a more flexible response for individuals. A copy of the Dundee Integrated Care Fund submission is attached at Appendix 1.

4.4 Implementation and Ongoing Monitoring

4.4.1 Partnership approval and sign off was required prior to submitting the Dundee Integrated Care Fund Plan to the Scottish Government. The final plan will be widely circulated following presentation to the relevant committees.

4.4.2 There will be robust governance arrangements for the management, monitoring and delivery of the Integrated Care Fund Plan. This will incorporate and build on the processes currently in place for the management of the Change Fund and will include regular reporting and financial governance arrangements. Lead officers will be allocated to each programme within the work streams to monitor and provide feedback on implementation progress. In addition, clear guidance for the governance and evaluation of the resource will be issued to organisations taking forward the individual projects. It is hoped that project leads will be able to beginning planning for the new projects as soon as confirmation of the resource is received and to allow a start date of the 1st April 2015.

4.4.3 The Scottish Government has requested 6 monthly progress reports detailing the implementation and outcomes achieved from the use of the Integrated Care Fund. It is recommended that these six monthly reports be provided to the Shadow Board and its successor for information and action as required. The governance and monitoring arrangements proposed will support the production of any future national and local progress reports

4.5 Conclusion

4.5.1 The Dundee Integrated Care Fund Plan was developed following a programme of consultation and engagement with a wide number of stakeholders and key partners. The proposed plan takes into account key aims for the city, current strategic plans and sets out a series of work streams, programmes and projects to test out a range of change proposals. It is anticipated that during the shadow year for the new integration arrangements, that the Integrated Change Fund Plan will support and feed into the development of the Integration Strategic Commissioning Plan for Dundee.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Sustainability, Strategic Environmental Assessment, Anti-Poverty, Equality Impact Assessment and Risk Management. There are no major issues.

6.0 CONSULTATIONS

The Chief Executive, Director of Corporate Services and Head of Democratic and Legal Services were consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

7.1 Letter (Kathleen Bethos); Integrated Care Fund; 7th July 2014 (including Integrated Care Fund Guidance).

7.2 Multi-morbidity Advice Note July 2014; Joint Improvement Team.

David R Martin DATE: 16 January 2015
Chief Executive

APPENDIX 1

INTEGRATED CARE FUND PLAN – DUNDEE PARTNERSHIP

1 PARTNERSHIP DETAILS

Partnership Name:	Dundee Partnership
Contact Name:	Diane McCulloch, Head of Community Care
Contact Telephone:	01382 438306
Email:	diane.mcculloch@dundeecity.gov.uk
Date of Completion:	23.12.2014

2 INTEGRATED CARE PLAN PRINCIPLES

The plan meets the following six principles described on pages 2 and 3:

Co-production	√	Leverage	√
Sustainability	√	Involvement	√
Locality	√	Outcomes	√

Sustainability

The preparation of the proposals for the Integration Fund sits within the context of our strategic planning and commissioning and the development of our Scheme of Integration for the forthcoming Integration Authority. In developing these proposals, established strategic and commissioning approaches have been used which take into account the delegated financial resources, the current analysis of local need and future models of service delivery and support.

An analysis of the current Reshaping Care Change Fund programmes was undertaken at the beginning of this financial year. This process identified three key areas for further development and roll out across all adult services. These three areas are: the Enhanced Community Support/Early Intervention Model; Carer's respite models; and the Community Capacity Building Fund managed through the local Interface Group. These models support a shift in the balance of care, increase support for informal carers and support innovations in community capacity building and engagement.

In the process of developing previous change plans our partnership has been very clear about priorities and strategic direction. In the consideration of the Integration Fund, all proposals have been required to demonstrate that they are part of strategic thinking and link to current commissioning frameworks or that they are part of a current programme of change which is recognised and supported by the partners.

In conclusion our approach was predicated on the understanding that sustainability would have to underpin the proposals featured within the Integrated Care Fund Plan.

Leverage

When prioritising the proportion of spend across the Integration Care Fund, programmes which demonstrated the potential to shift the balance of care were prioritised. As a result a large proportion of the funding was allocated to the further development and roll out of the Enhanced Community Support/Early Intervention Models and the continuing support of models of care which tested or enhanced co-productive approaches and community engagement.

In addition through the assessment of individual bids, evidence of sustainability and redesign was sought.

Outcomes

The national health and wellbeing outcomes underpinned the process of development of the plans for the use of the Integration Care Fund and the assessment of individual bids.

Locality

We have an established policy position regarding localities and community approaches within Dundee. The approach recognises the individual; the home; the family and the place. When working with communities within neighbourhoods, we will build on established approaches which have been developed through existing community planning arrangements. We are working towards a locality based service delivery model that will further enhance relationships between services, people and professionals and which will optimise both the outcomes for individuals and the impact of resources on their circumstances.

In considering the proposals presented for funding, we considered the inequalities between localities and the targeting of resources and provided advice and guidance on the alignment of proposals around locality needs. We have further invested in organisational development to support leaders and service providers to make more fundamental shifts across statutory or commissioned services to meet locality service delivery needs.

Co-production

Two events were held to set out and agree the priorities for the use of the fund. These events were large, participative events which included representatives from Health, Social Care, Housing the Third Sector, the Independent Sector, services users and unpaid carers. In excess of 120 people attended each event. The events showcased good practice and innovative practice examples and demonstrated the models of change currently in place. The examples spanned all care groups. The first event identified the key priority areas for development. In the second event we discussed how these priority areas would be taken forward.

Involvement

Our approach to involvement has been to take a co-productive approach to the entire commissioning cycle and the planning for the Integrated Care Fund Plan. The events enabled a number of organisations and individuals to become more engaged in the planning process. This built on the existing strategic planning arrangements and other planning processes which already involve a range of stakeholders, unpaid carers and service users. The principles of this inclusive approach were applied to the assessment of the proposals for this change plan. So for example,

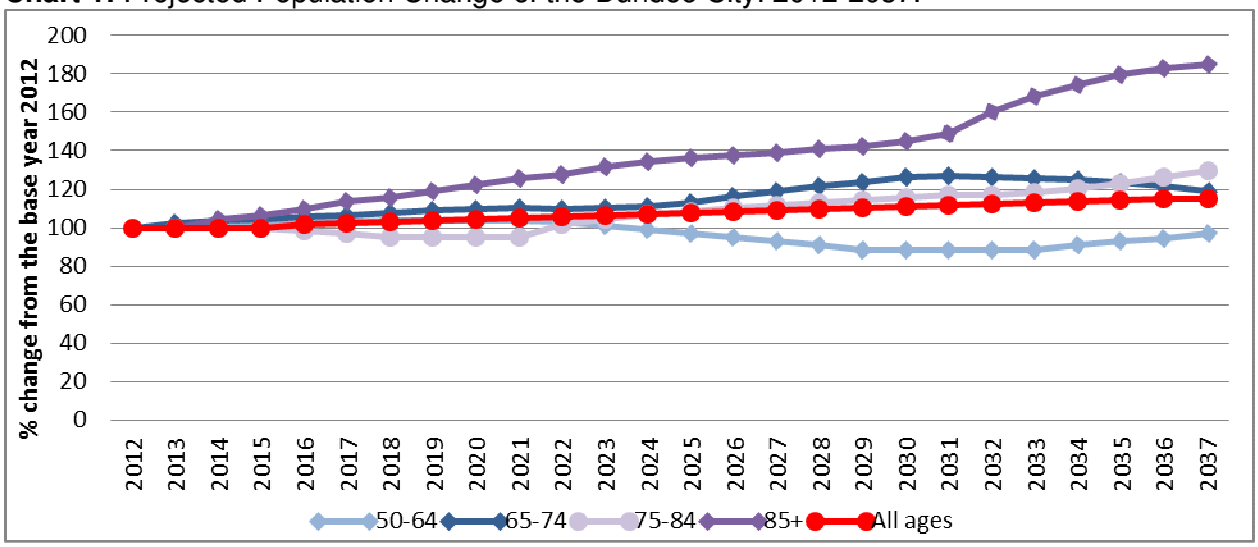
the local research that tested the principles of reciprocity in practice was used to shape the proposals for carers which came forward for the Integration Care Fund Plan.

3 PERFORMANCE AND ACTIVITY DATA

In this section, we describe the performance and activity data which sets the context for our future planning and how in anticipation of a full strategic plan we have prioritised the use of the Integration Care Fund.

Section One: Population

Chart 1: Projected Population Change of the Dundee City: 2012-2037.



Source : GROs mid year population estimates 2012

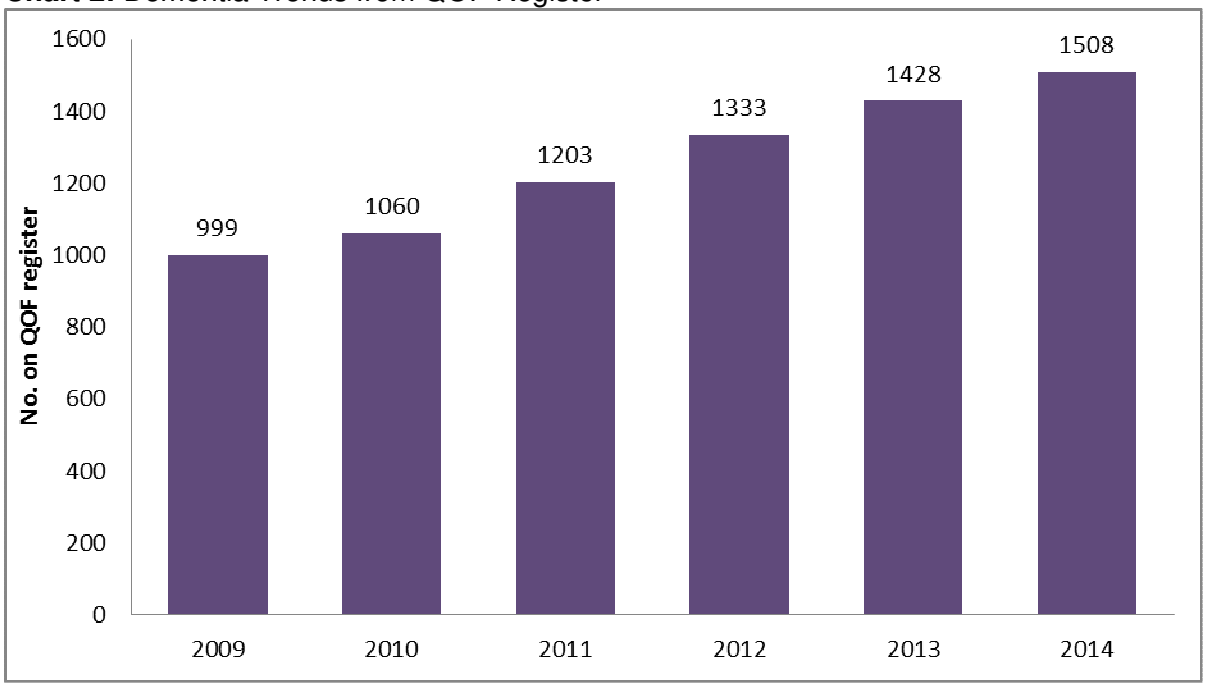
Table 1: Prevalence of Selected Long Term Conditions from GP Quality Outcome Framework (QOF) Register, Dundee City 2014

Conditions	Patients on Register	Prevalence per 100 patients	
		Dundee City	Scotland
Obesity	15,046	8.85	8.05
Hypothyroidism	9,045	5.32	3.8
COPD (Chronic Obstructive Pulmonary Disease)	4,935	2.9	2.18
CKD (Chronic Kidney Disease)	5,643	3.32	3.23
Hypertension	23,799	14.0	13.94
Mental Health	1,908	1.12	0.88
Diabetes	8,640	5.08	4.79
Stroke & Transient Ischaemic Attack (TIA)	3,955	2.33	2.16
Heart Failure	1,701	1.0	0.83
LVD (Left Ventricular Dysfunction)	933	0.55	0.27
CHD (Coronary Heart Disease)	7,073	4.16	4.26
Epilepsy	1,399	0.82	0.75
Atrial Fibrillation	2,659	1.56	1.59
Dementia	1,508	0.89	0.79
Asthma	10,473	6.16	6.10
Cancer	3,302	1.94	2.18

Depression: new diagnosis of depression	8,470	4.98	5.81

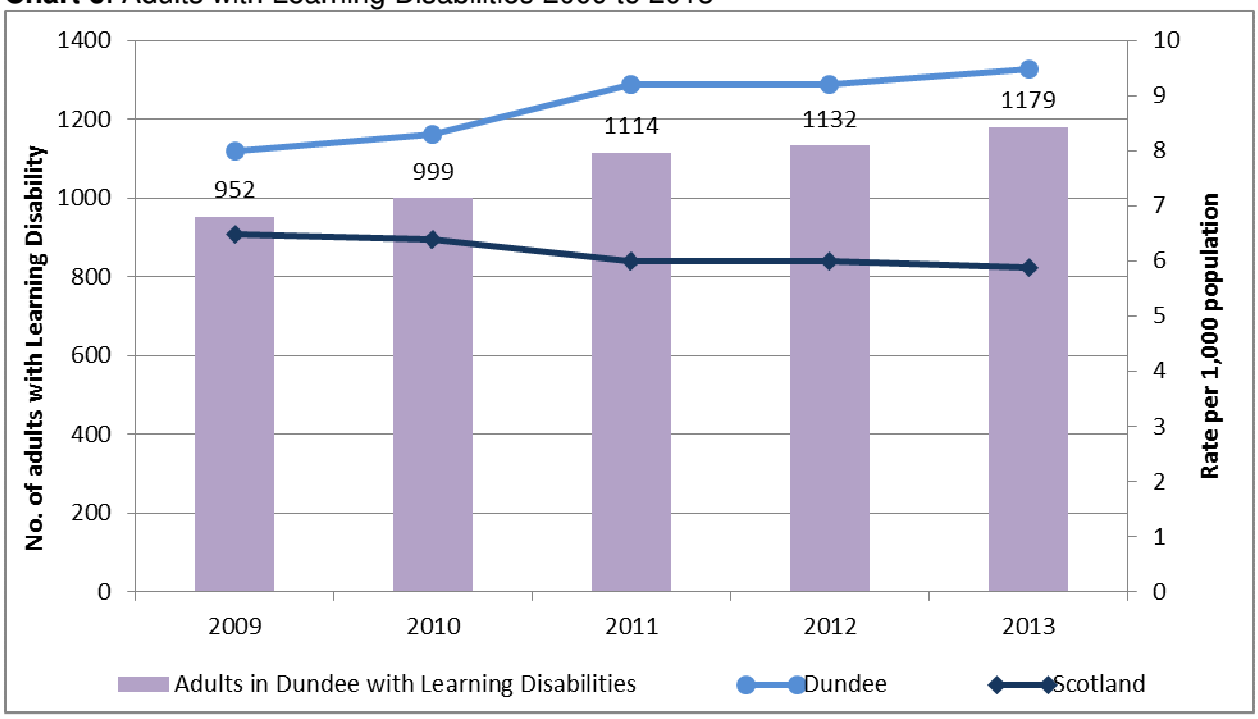
Prevalence = number of patients on the specified QOF register, divided by list size, multiplied by 100. Based on patients registered with GP practices.
Source : ISD General Practice - Quality & Outcomes Framework

Chart 2: Dementia Trends from QOF Register



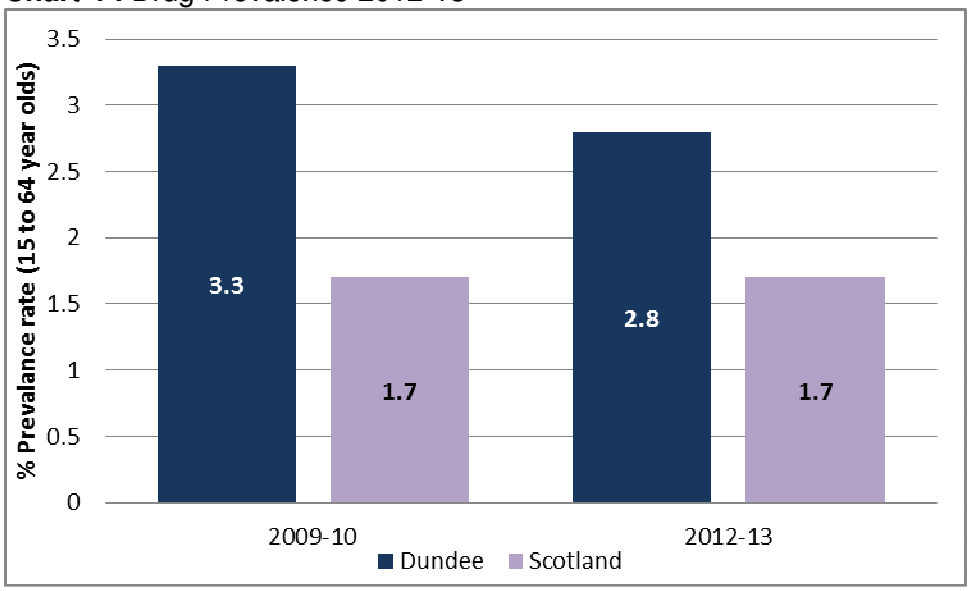
Source : ISD Scotland, QOF data 2014

Chart 3: Adults with Learning Disabilities 2009 to 2013



Source :Scotland Consortium for Learning Disabilities (SCLD), Learning Disabilities Statistics

Chart 4 : Drug Prevalence 2012-13



Source : Drug prevalence 2012-13, ISD Scotland

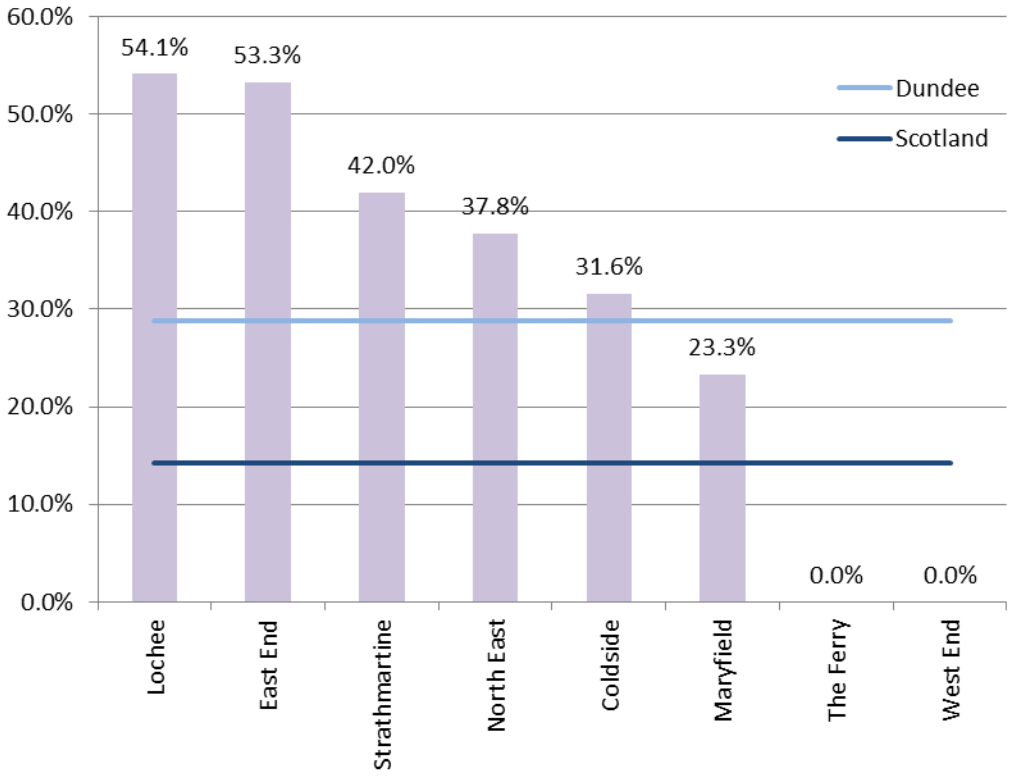
The above information is taken from the Drug Prevalence study conducted by ISD (Information Statistics Division). It is an estimate for drug prevalence. The data is gathered from the Scottish Drug Misuse database and treatment agencies, Hospital dischargers, Criminal Justice Social Work and the Police.

What is the data telling us?

- Dundee's overall population is increasing, with the proportion of older people increasing even faster. The 85+ population is expected to rise by 85% by 2037.
- People experience long term conditions associated with ageing at a younger age in Dundee resulting in an above average morbidity rate.
- The needs of the adult population in Dundee mean that people will require community health, care and support services and resources.
- We know that we will have particular needs which will lead to an increasing demand for support for example Chart 2 shows a year on year increase in dementia, Chart 3 demonstrates that Dundee has a higher prevalence of learning disability than other parts of Scotland and Chart 4 shows that we have a higher drug prevalence than other parts of Scotland

Section 2 Deprivation

Chart 5: % of population where the most deprived live

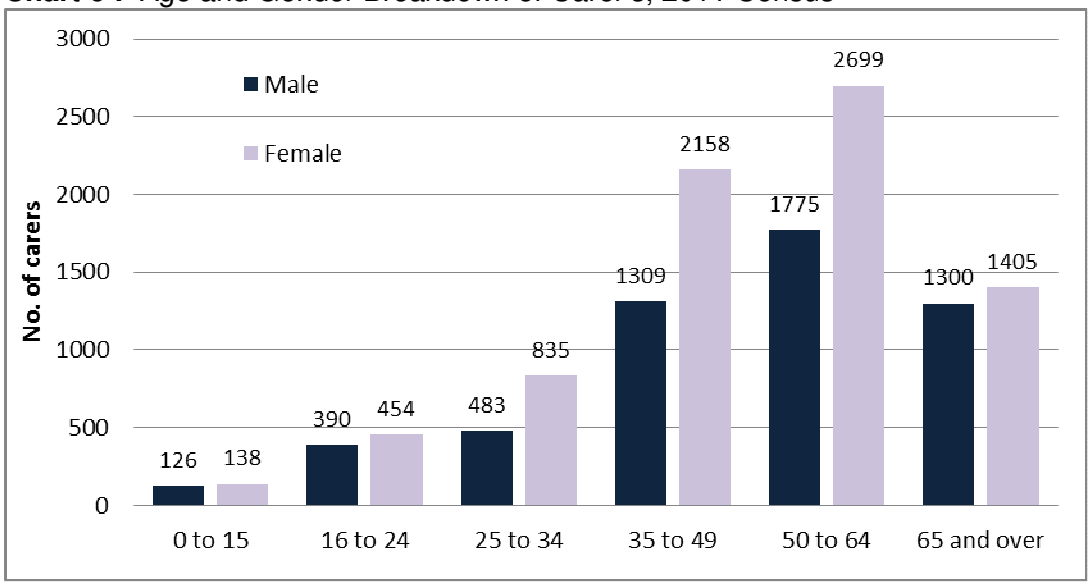


Source : SIMD 2012

- Deprivation in Dundee is high and just over 29% of the population live in 15% of the most deprived areas.
- Dundee has the third highest level of deprivation in Scotland with only Glasgow and Inverclyde higher.
- The SIMD is used to identify most deprived small areas and the graph above shows the percentage of people living within the 15% most deprived areas in Dundee.
- It also shows that six of eight Dundee locality areas are above the Scottish average of 14.2% and five are above Dundee's average of 28.8%.
- Deprivation is not evenly distributed across the city, over half of those living in Lochee and East End live in 15% of the most deprived areas. In contrast, none of the areas with The Ferry or the West End are registered as being in the most deprived areas.
- The impact of deprivation on our population contributes to the level of multi-morbidity.

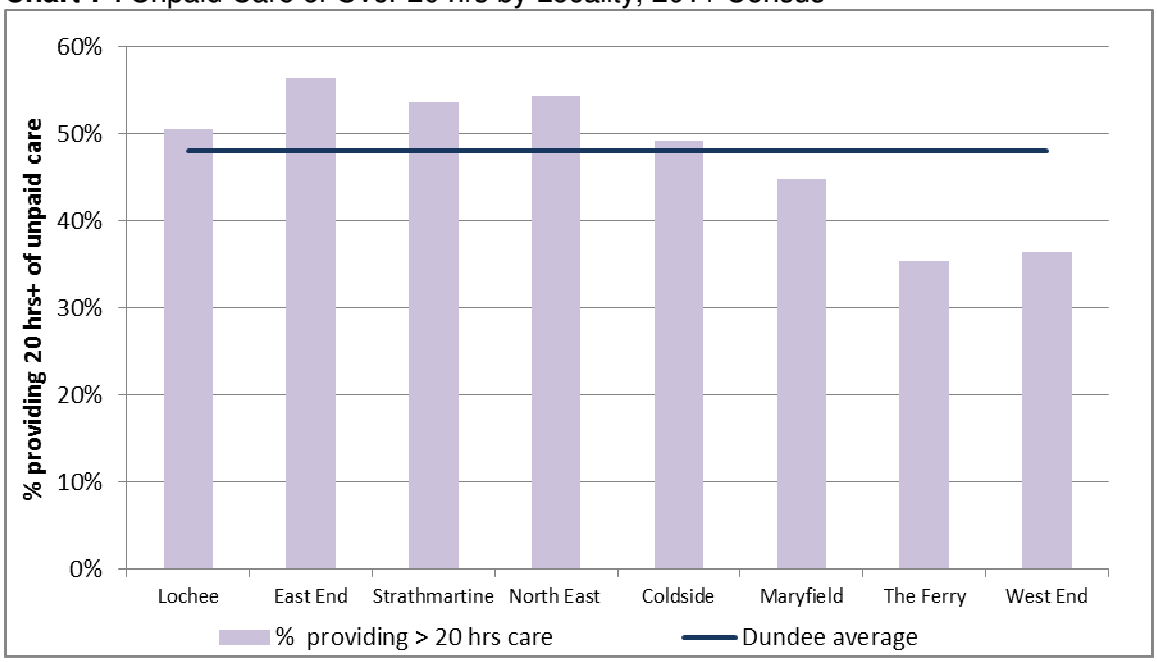
Section 3: Support for Carers

Chart 6 : Age and Gender Breakdown of Carer's, 2011 Census



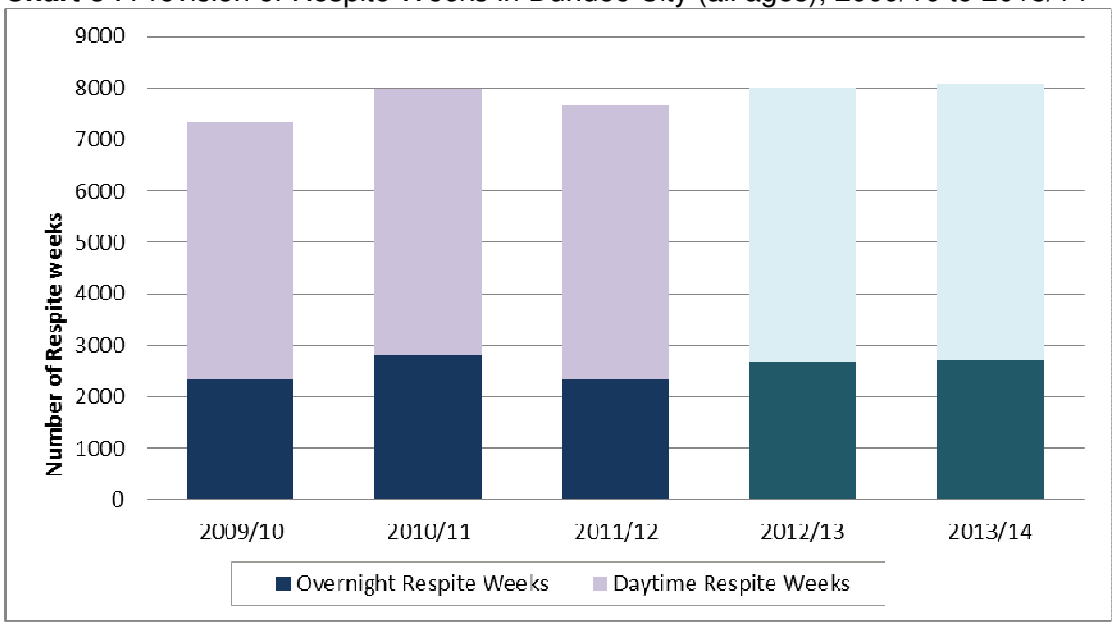
Source : Scotland Census 2011

Chart 7 : Unpaid Care of Over 20 hrs by Locality, 2011 Census



Source : 2011 Scotland Census

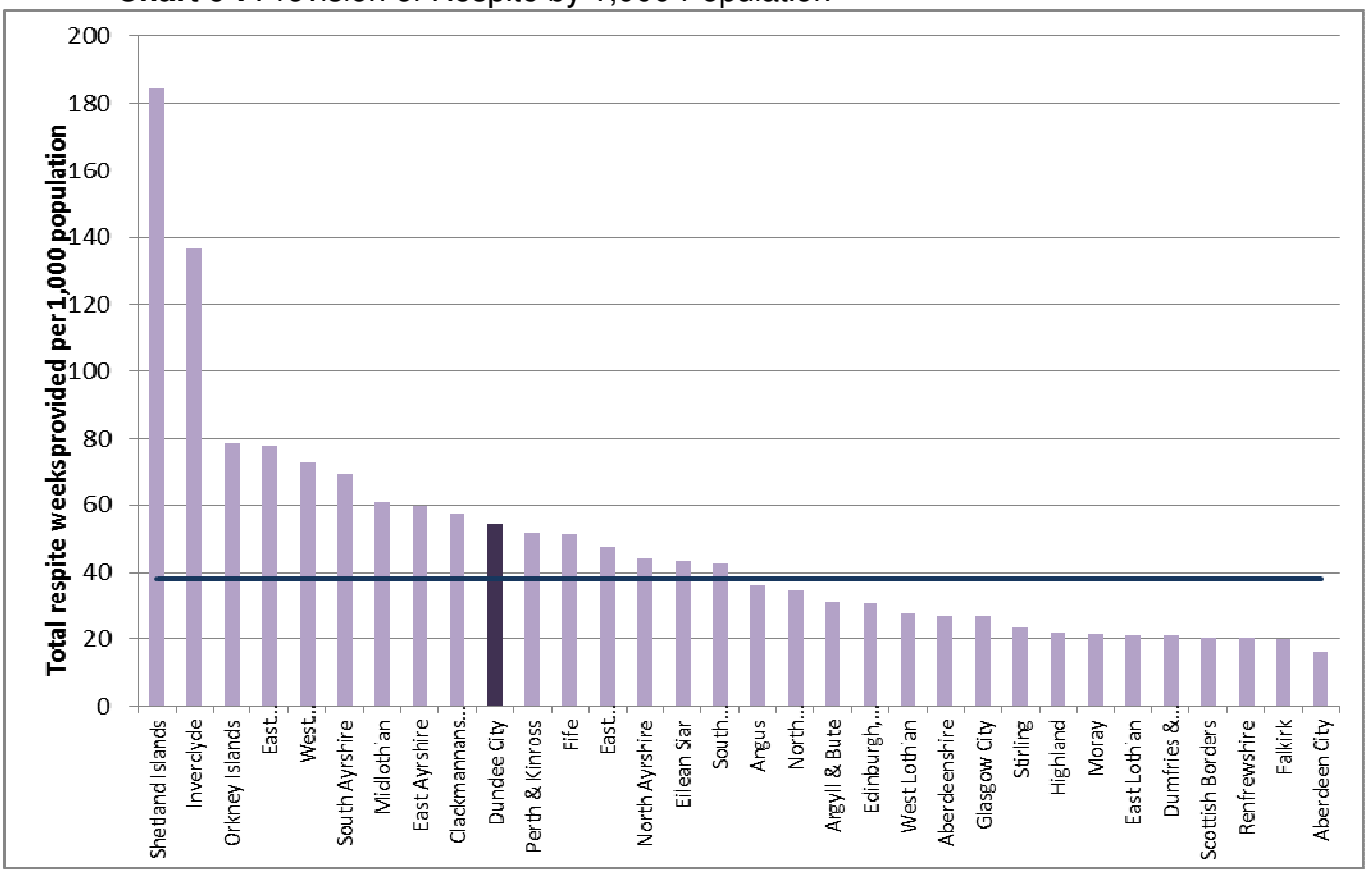
Chart 8 : Provision of Respite Weeks in Dundee City (all ages), 2009/10 to 2013/14



Source : Scottish Government, Respite provision

Note – extreme caution should be taken before comparing figures year on year. The counting methodology changed in 2012/13 and 2013/14 therefore these years are not comparable with previous years. Therefore presented in a different colour.

Chart 9 : Provision of Respite by 1,000 Population



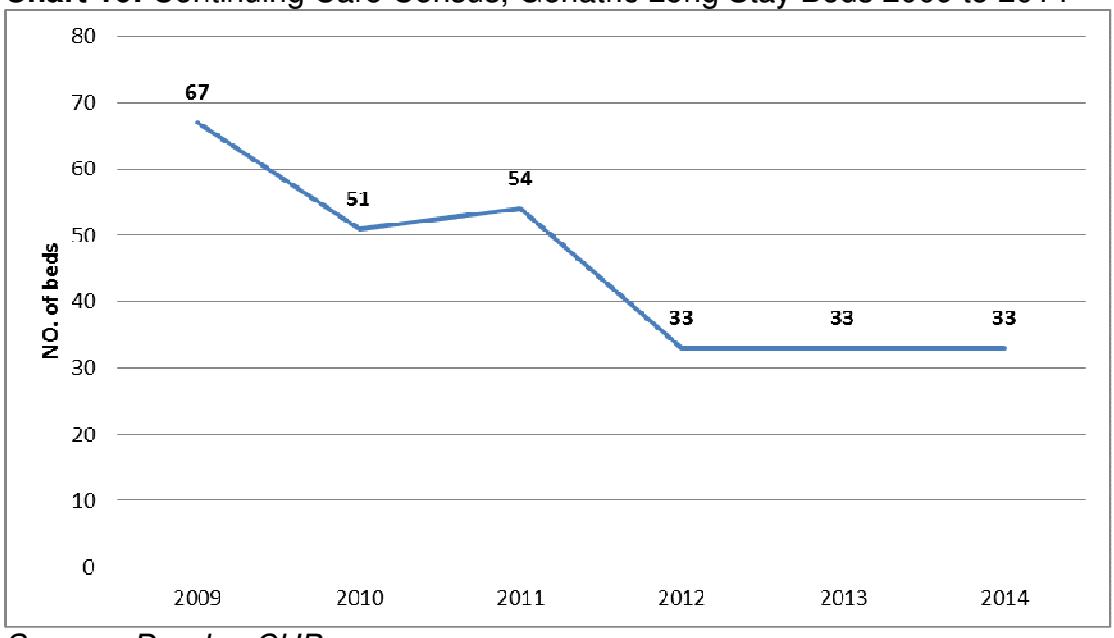
Source : Scottish Govt, Respite provision

What is the data telling us?

- Census data from 2011 suggests nine per cent of Dundee's population are carer's; this is the same proportion for Scotland. Dundee has approximately 13,000 carers. Given that some carers often do not recognise themselves as carers, these figures are likely to be underestimates. (Chart 5)
- Chart 6, shows that just over a third of all carer's are in the 35 to 49 age group. Nearly 60% are women. Approximately a fifth of the carer's are over 65.
- Chart 7 shows carer's that provide more than 20 hours of care are more likely to live in the more deprived areas of Dundee.
- Since 2011/12 Dundee has increased the provision of respite. The trend for Scotland has stayed about the same. (Chart 8)
- Dundee exceeds the Scottish average for respite care provision. (Chart 9)

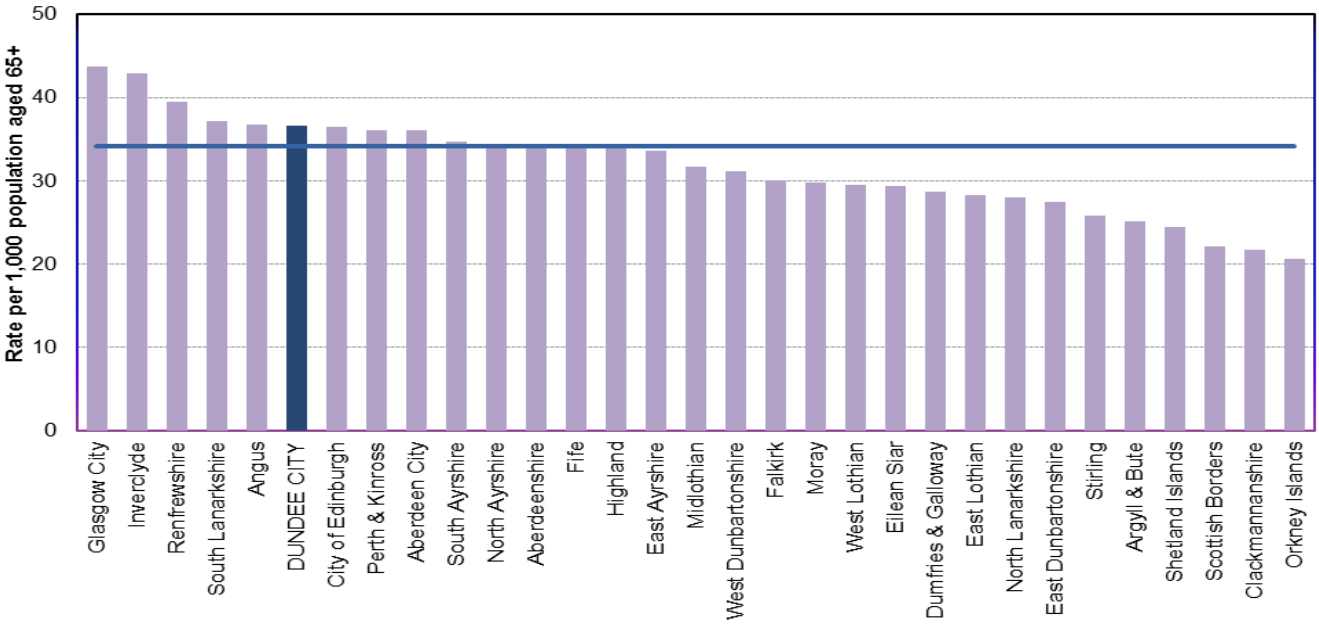
Section 4 Balance of Care

Chart 10: Continuing Care Census, Geriatric Long Stay Beds 2009 to 2014



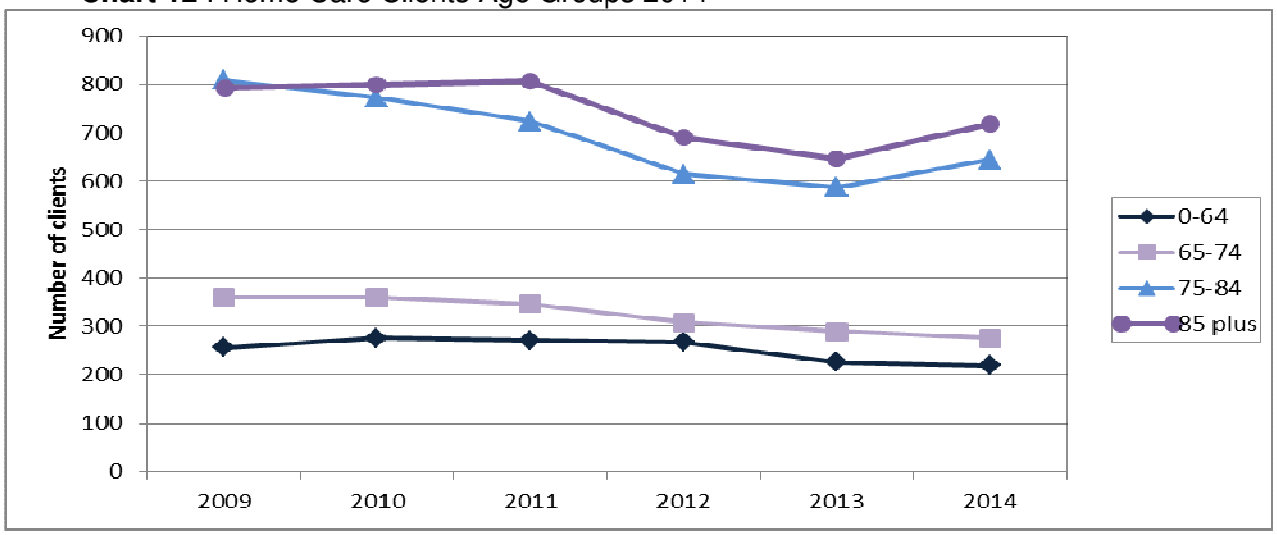
Source : Dundee CHP

Chart 11: Older People (Aged 65+) Supported in Care Homes March 2014.



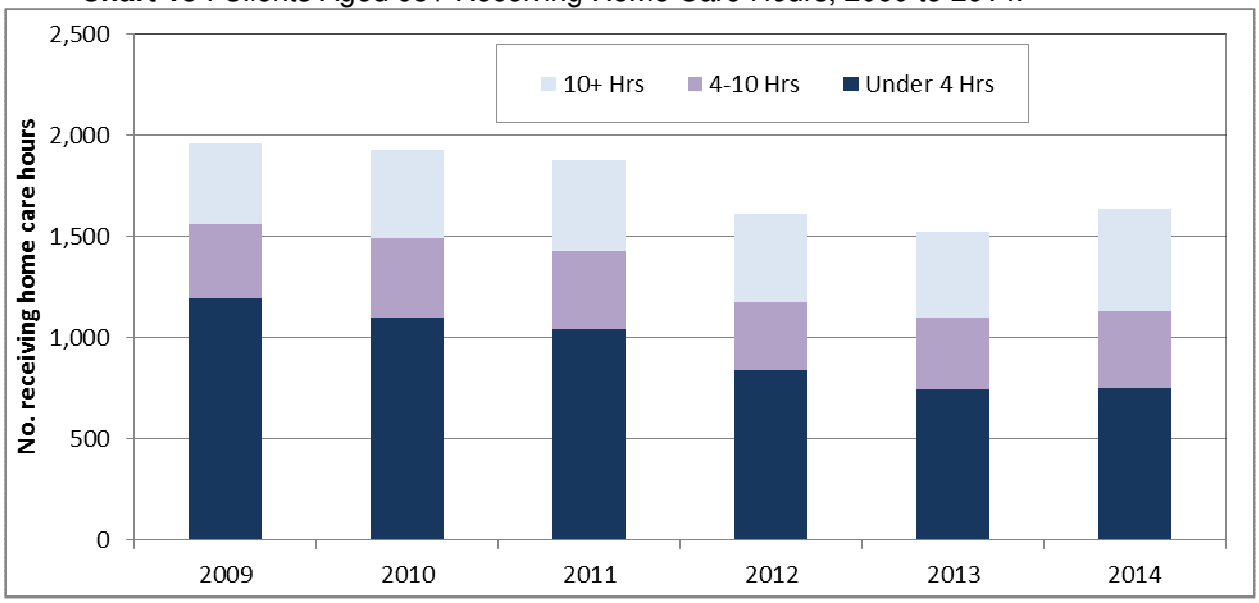
Source: Care Home Census

Chart 12 : Home Care Clients Age Groups 2014



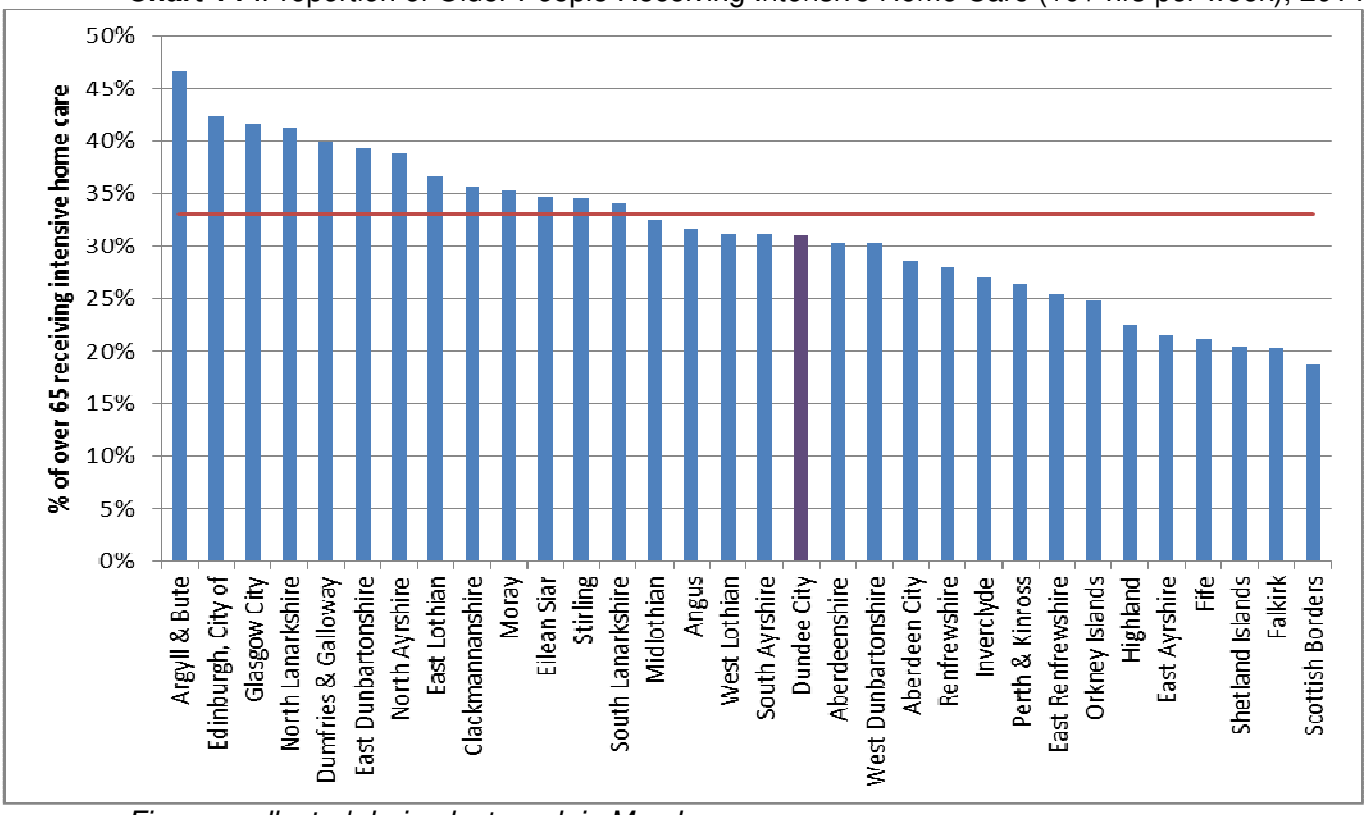
Figures collected during week last week in March
Source : Scottish Government Health and Community Care - Datasets

Chart 13 : Clients Aged 65+ Receiving Home Care Hours, 2009 to 2014.



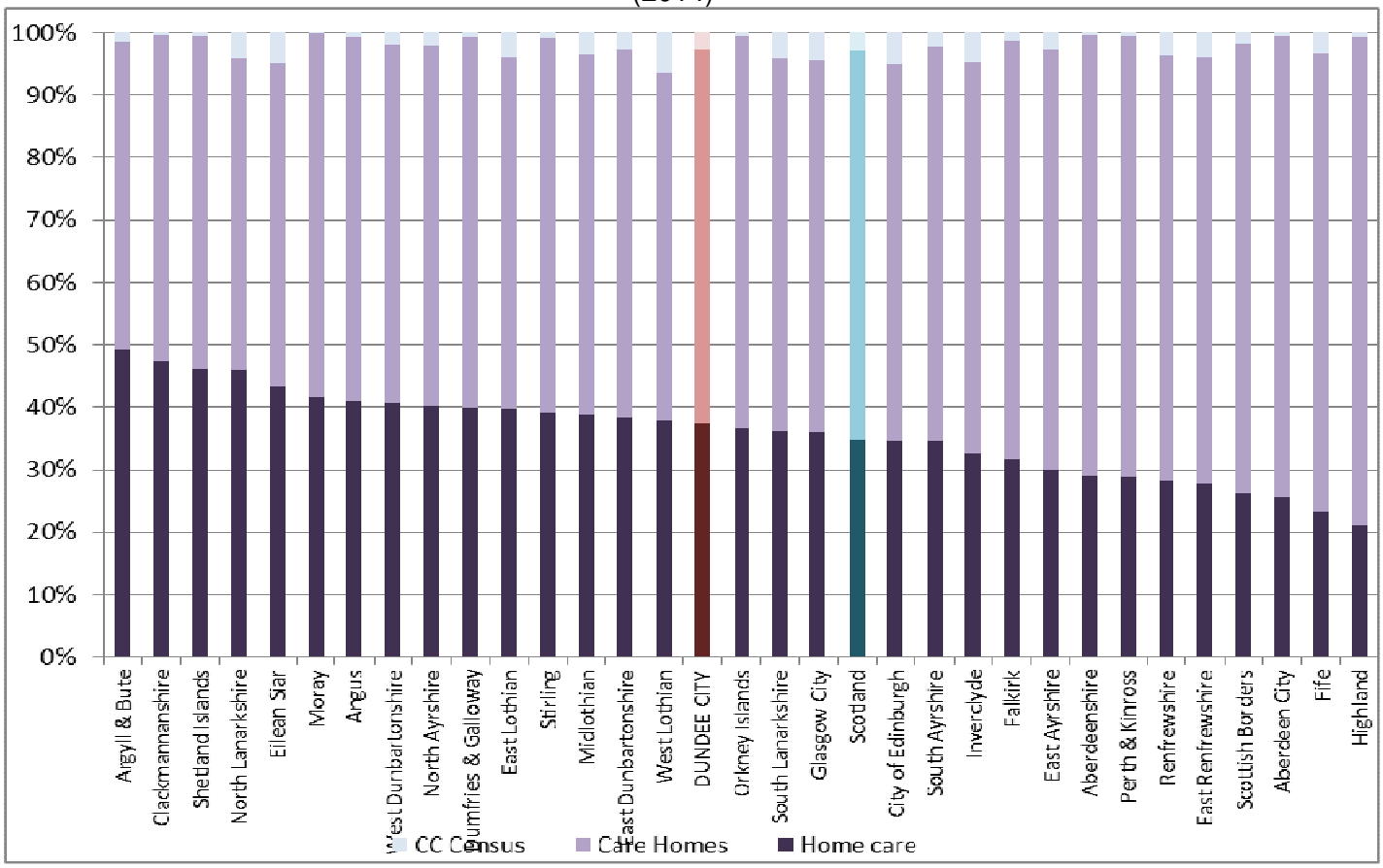
Figures collected during week last week in March
Source : Scottish Government [Health and Community Care - Datasets]

Chart 14 :Proportion of Older People Receiving Intensive Home Care (10+ hrs per week), 2014



Figures collected during last week in March
Source : Scottish Govt, Social Care Survey

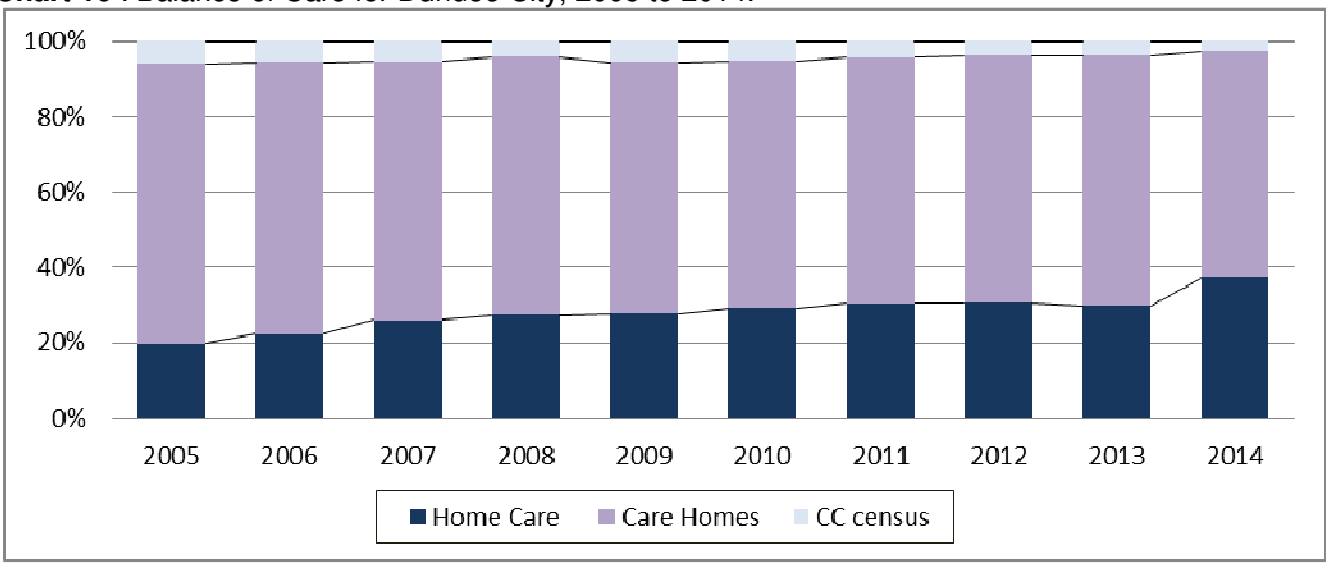
Chart 15: Balance of Care: Supported in Care Homes, Intensive Home Care and NHS Continuing Care (2014)



Sources : Scottish Government Quarterly Monitoring, Home Care census & ISD, Continuing Care Census.

Dundee has improved in 2014, 523 receiving intensive home care increase on 2013 of 438

Chart 16 : Balance of Care for Dundee City, 2005 to 2014.

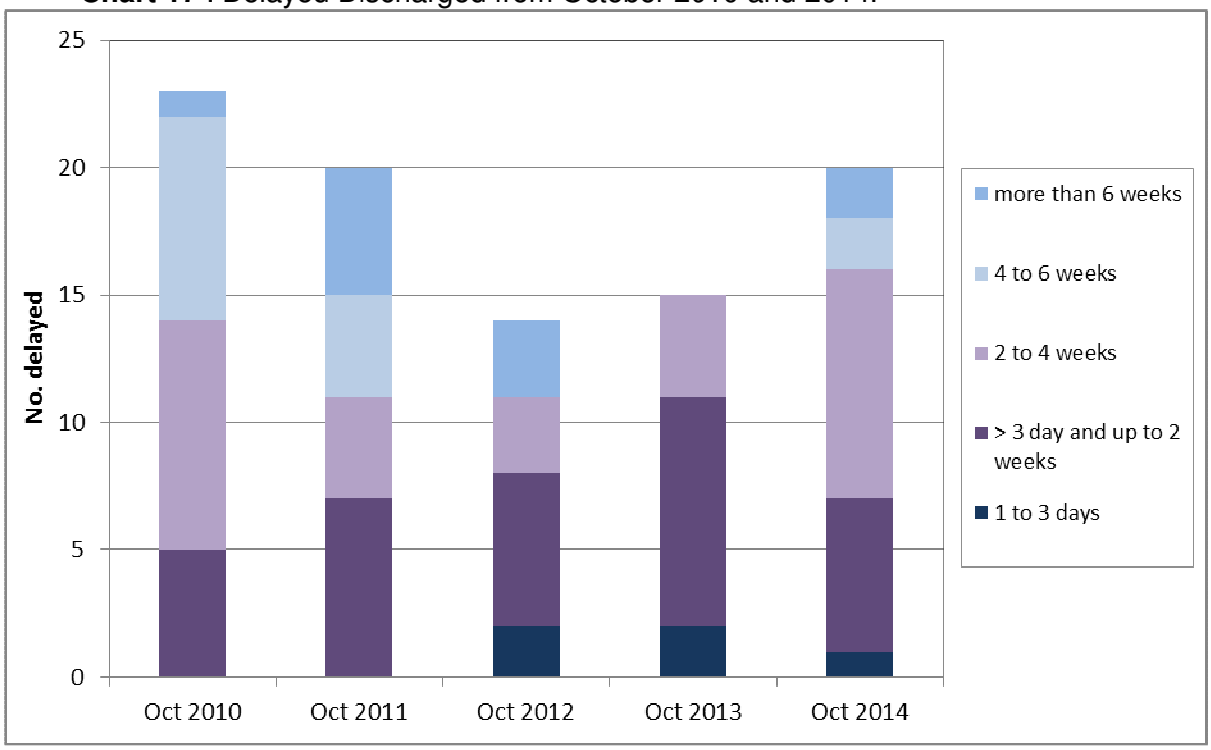


Sources : Scottish Government Quarterly Monitoring, Home Care census & ISD, Continuing Care Census.

What is the data telling us?

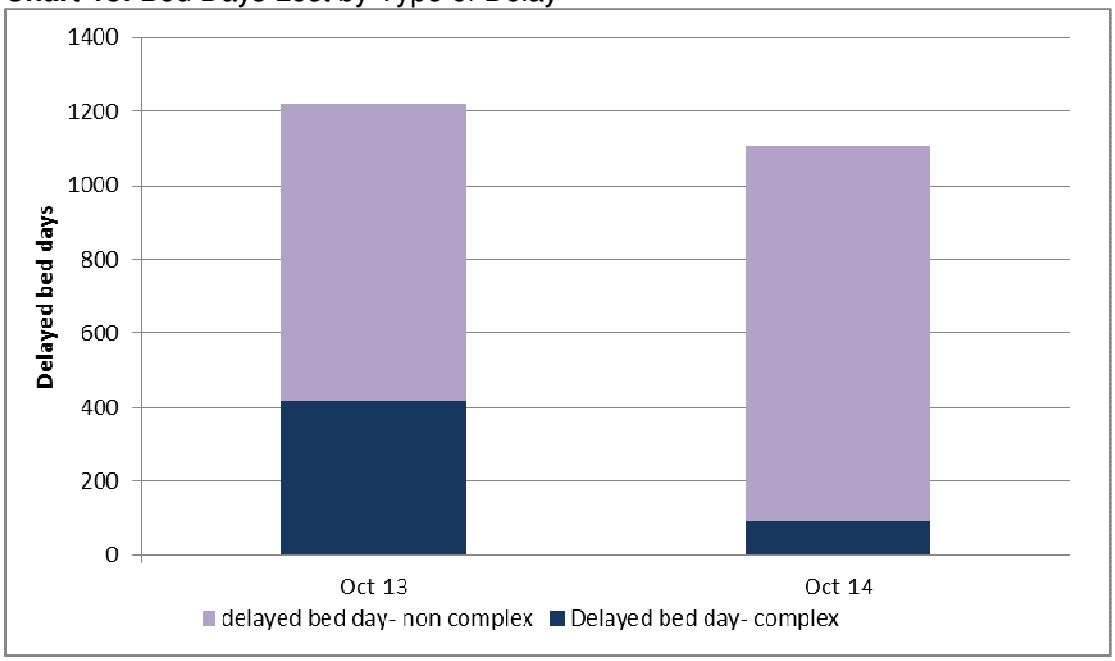
- The data shows that the number of registered continuing care beds for older people remain constant however, as a result of a redesign exercise, 24 beds are used as transition beds to support assessment and rehabilitation. (Chart 10)
- The rate of older people per 1000 of the population supported in care homes has improved marginally since 2009/10. (Chart 11)
- There the number of adults living in supported accommodation rather than in care home settings has continued to increase.
- The number of older people living in Housing with care has increased.
- There has been a drop in the number of people receiving less than 4 hours of home care. (Chart 13)
- Although there has been a drop in number of people receiving home care, the number receiving intensive home care (10 hours plus) continues to increase. (Chart 14)
- The overall balance of care has improved. (Chart 16)

Chart 17 : Delayed Discharged from October 2010 and 2014.



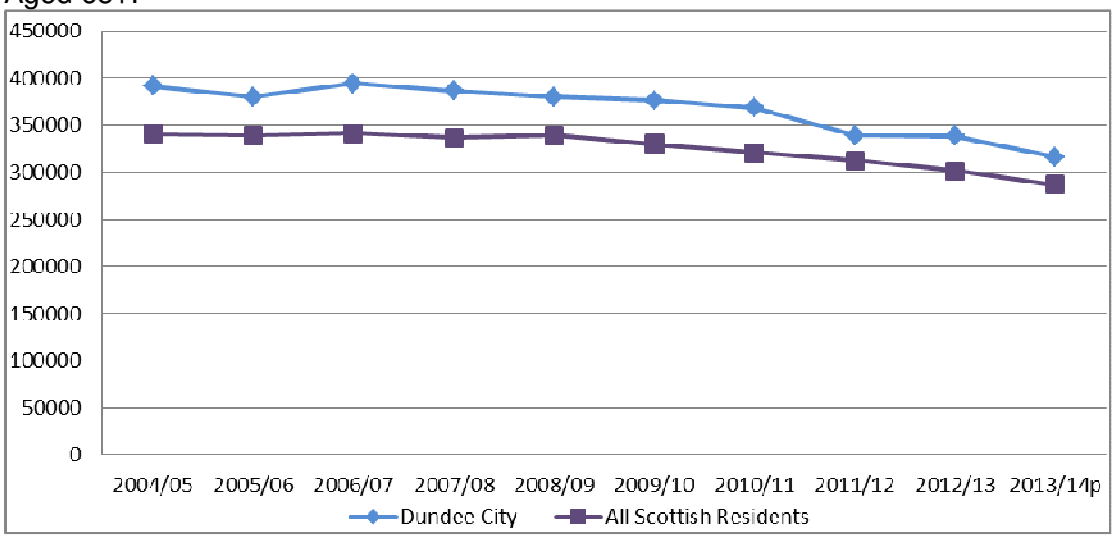
Source : ISD Delayed Discharges

Chart 18: Bed Days Lost by Type of Delay



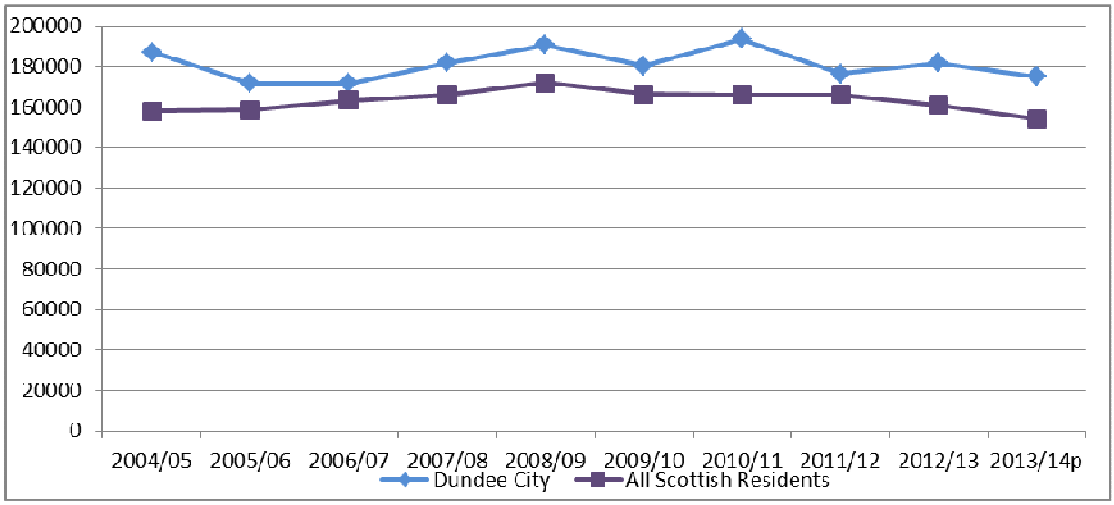
Source : NHS, Edison

Chart 19: Bed Day Rates per 100,000 Population of All Emergency Admissions for Patients Aged 65+.



p = provisional figures
Source : ISD, NHS emergency admissions and bed days

Chart 20 : Bed Day Rates per 100,000 Population for Patients Aged 65+ with 2+ Emergency Admissions.



p = provisional figures
Source : ISD, NHS emergency admissions and bed days

What is the data telling us?

- Chart 17 shows an increase of people delayed between 2012 and 2014. There had been a decrease between 2010 and 2012.
- Chart 18 shows that there has been a small decrease in the number of bed days lost.
- There is a downward trend for all emergency admissions for people aged 65's. (Chart 19)
- The 2 plus emergency admissions has a slight downward trend for the 65+ population. (Chart 20)

In summary, the data identifies that inequalities impact significantly on the health and wellbeing of our communities. This not only impacts on outcomes for people who need care and support but also on the informal carers who care for them.

To improve outcomes for people we will develop better relationships with communities, target our resources and build community capacity and resilience. In developing our relationship with communities we will: define and agree our localities; work with communities to coproduce models which will have the greatest impact on personal outcomes and inequalities; develop models of community engagement which seek locality based solutions; and support communities to be the solution to both individual and community problems.

To reduce health inequalities we recognise that we need to: embed tested models of prevention; continue to target resources towards early intervention; support approaches that are sensitive to local community needs and design responses which target those who are the most vulnerable to health inequalities.

We recognise that to provide seamless care that will meet the needs of our population as it emerges in different localities we need to test new models of integrated care and embed current ones. More specifically we will develop alternatives to hospital and emergency care, we will deliver health care closer to home and redesign current systems to produce integrated pathways which shift the balance of care.

The features of these new models which we will test will provide more proactive care and support at home, increase choice and flexibility in line with the principles set out within the self directed support policy.

Supporting carers will continue to be central to our approach and further development priorities have been identified for carers which will raise awareness support carers to care and involve carers in service design.

4 LINK TO KEY POINTS (As Described in Paragraph 18 – Integrated Care Fund: Guidance for Local Partnerships; Scottish Government; 07.07.14)

The Guidance for Local Partnerships sought reassurance that future Integrated Strategic Commissioning Plans describe the range of activities which will support the delivery of integrated health and wellbeing outcomes for adult health and social care (paragraph 18). In addition, should demonstrate that the approach taken through the use of the Integrated Care Fund will complement this approach.

As previously described, a strategic approach was taken to develop the Integrated Care Fund Plan. The plan will build on three current developments: the progression of the Reshaping Care for Older People Change Plan; the Care Group Strategic Commissioning Statements; and the current Community Plan. The priorities identified through these developments will in turn form the basis of the Integration Strategic and Commissioning Plan. We have described the particular health and socioeconomic difficulties faced by the city, and many of the proposed changes seek to address health and social inequalities in both a targeted and indirect way. The proposals include a scaling up of current pilots to further demonstrate the impact of new ways of working and the testing of a range of redesign approaches which introduce new models of service delivery. A number of these projects will strengthen and develop more integrated models of working.

There will be robust governance arrangements for the management, monitoring and delivery of the Integrated Care Fund Plan. This will incorporate and build on the processes currently in place for the management of the Change Fund and will include regular reporting and financial governance arrangements. This will support the production of any future national and local progress reports.

5 INTEGRATED CARE FUND PLAN

Through integrated health and social care services our overall aims for our citizens can be defined as follows:

- To have a population which is healthy and well and which experiences less health inequalities.
- To have city where individuals can achieve positive outcomes including access to education, employment and meaningful engagement.
- To have fewer people delayed in hospital and to provide health care as close to home as possible.
- To have more people cared for at home.
- To have more direct support for carers.

- To have a wider range of alternatives to statutory services which meet the needs of both individuals and communities.
- To work with communities in localities or neighbourhoods to build community resilience.

The key finding from the Performance and Activity Data as described in Section 3 was presented at the first multi agency development event held in October 2014. At this event, participants were asked to explore how change should be taken forward and focused on locality delivery, health inequalities and community capacity building. Information was gathered and fed back to participants at the second event. Seven key areas for development were identified:

- Supporting carers.
- Reducing health inequalities.
- Building capacity and resilience.
- Developing integrated pathways which shift the balance of care.
- Developing new models of integrated care and support.
- Developing relationships with localities.
- Achieving integrated health and wellbeing outcomes for adults.

Proposals were then sought based on these themes which were considered by a representative panel made up of all the stakeholders identified above which resulted in the proposals outlined in the Integrated Care Fund Plan

In developing the Integrated Care Fund, we considered both the short term and long term priorities to address these aims. To do this we have developed two work streams.

Work Stream 1 will take a long term approach. It will continue to build community capacity through the development of a community infrastructure that tackles health inequalities; develops the relationships with communities; builds community capacity and resilience and improves outcomes for individuals and carers. The approach will be not only be preventative and support programmes of health improvement and self care for the general public, but will also target those most vulnerable in our communities and least likely to make use of current health and social care supports.

Work Stream 2 will put in place changes which will review the current models of service delivery and support change and redesign. It will reduce the reliance on acute hospital care by providing a timely and proactive multidisciplinary response to the identification of need and will remodel current services to support the delivery of health and social care support closer to home. In line with the principles of self directed support; we will invest in supports which provide a more flexible response for individuals.

Each work stream will have associated programmes as listed below. While only brief descriptions are given or the programmes within this bid, there are defined aims and outcomes for each individual project, including the means for measurement of success or change. The work stream programmes and associated projects will be monitored through the Change Fund/Integrated Care Fund Monitoring Group, a multi agency working group which will measure both the financial management of the fund and the progress made on achieving the proposed outcomes.

WORK STREAM ONE – BUILDING A SUSTAINABLE COMMUNITY INFRASTRUCTURE

Programme 1 Achieving Integrated Health and Wellbeing Outcomes for Adults

Within this programme we will aim to improve the health and wellbeing outcomes for adults by introducing news ways of working which promote self help programmes, provide places of safety and improve our communication and means of sharing information.

1 Information Sharing/IT Development

Scope out and resource development to enable information sharing in line with the requirements for integration

2 The Same Page

Develop a series of digital modules for adults who are Learning Disabled which is accessible in a variety of formats, and which harnesses and shares existing knowledge and expertise.

3 Learning Disability Health Needs Assessment database and PARC (Pre-appointment Recording Chart) Development

Improve the supports and personal outcomes for individuals who are Learning Disabled

4 Prevention of Homelessness for young adults

Test of change project to reduce the number of young people who present as homeless

5 Safe Zone

Create a range of safe zones/resources for people in distress

6 Self Management/Life Style Programme for Stroke/TIA

In partnership with a range of partners, develop a self management life style programme for individuals to develop independence and long term self care

Programme 2 Developing relationships with communities

Within Dundee we have strong community planning arrangements which provide an established forum for community engagement, however the particular arrangements within Dundee for GP catchments areas makes further streamlining of locality working approaches and models more complex. We have a number of initiatives currently in place and through this programme we will explore synergies between models and develop partnership approaches. In addition we recognise that there are communities of interest which require further investment to ensure they are fully supported to participate in both care group planning and the wider integrated planning arrangements.

1 Organisation Development – Localities

Use a coproductive model to develop multidisciplinary team working modelled around locality delivered services and supports.

2 Organisational Development – Sensory Services

Develop and scope out the supports and services for sensory services and how these might be developed.

Programme 3 Building Community Capacities and Resilience

The aim of this programme will be to build the capacity of communities to deliver services which maintain people in their own homes and to respond to community need. This will include the development and promotion of co-production models, volunteering and commissioned services through social enterprise and will address the community needs of both local communities and/or communities of interests.

1 Small Grants Fund

Extend the reach and impact of the small grants community capacity building fund that is administered, managed and monitored through the Third Sector Interface.

2 Community Hubs for Older People

Test a model of service where by sheltered housing complexes (Housing Associations) are used as a base from which supports can be provided to a wider community.

3 Hospital Ward Volunteering

Co design and co deliver a model of hospital ward volunteering

4 Community Companionship

Build the capacity of existing organisations to create a new non dependant model of companionship

Programme 4 Reducing Health Inequalities

The aim of this programme will be to reduce health inequalities within the city by reviewing current models of tackling health inequalities, driving forward health inequality sensitive practice and developing services which take preventative approaches.

1 Reducing Health Inequalities

Review and consolidate existing models of health inequalities work and build the capacity of public and voluntary organisations to adopt health inequality sensitive practice.

2 Defining and improving prevention through health and social care

Define prevention, early intervention and recovery outcomes to assess the extent which current arrangements deliver prevention and early intervention approaches.

3 Welfare Rights in Primary Care

Test the efficiency of providing welfare rights in a primary care setting.

4 STEP (Shared Thinking Empowerment Project)

Develop the STEP model with in the third sector to support adults to develop personal capacity and improve personal outcomes through coproduction approaches.

5 Parish Nurse Project

Address the health inequalities within hard to reach groups by targeting resources and training and supporting volunteers.

6 Management of Malnutrition in the Community

To develop an innovative social model which improves the identification and management of malnutrition in the community

7 Alcohol and Older People

Increase awareness of the impact of alcohol on older people; improve interventions and support for older people and their families and increase the skills of the professionals working with those adults.

Programme 5 Supporting Carers

The aim of the programme is to raise awareness of carers needs, identify carers and, support carers in their carer's role. This programme will administer, managed and monitored by the Dundee Carers Centre.

1 Carers Engagement:

To develop a carers engagement strategy and identify the areas for future development and contribute to the development of the Carers Commissioning Strategy

2 Carers Media Campaign

To raise awareness and increase identification of carers within communities enabling better sign posting of supports for carers.

3 Develop a Short Breaks One Stop Shop

Build on the recent short breaks research to develop and test new models of respite across all adult groups and develop a model for a short breaks one stop shop.

WORK STREAM TWO – REMODELLING SERVICES

Programme 6 Developing integrated pathways which shift the balance of care

The aim of this programme is two fold, firstly to reduce potential inappropriate admissions to hospital or care homes. Secondly to redesign current pathways for people most at risk from the impact of escalating health and social care needs and who require support when in the community or to be discharged from a hospital setting into the community.

1 Enhanced Community Support

Expand the Enhanced Community Support model and Early Intervention model to adults with multi-morbidities and in different areas of Dundee.

2 Rehabilitation and Transitional Support in a Community Setting for Adults with an Acquired Brain Injury

Upskill staff and redesign the care pathway of change to support earlier discharge from hospital into a community rehabilitation setting

3 Discharge Support for people who have Chronic Obstructive Pulmonary Disease.

To offer additional support for the 14 days following discharge from hospital

4 Equipment and Adaptation Prescribing

Develop a competency framework to improve the consistency in the prescribing of equipment and adaptations and increase the range of people who can prescribe equipment and adaptations.

5 Community based catheter clinic

Develop a community clinic based approach to catheter change for non housebound patients.

6 Palliative Care Response Standards

Embed the integrated response standards and care plan for palliative care support into mainstream activity.

Programme 7 Developing New Models of Integrated Care and Support

Our aim in this programme is to develop a range of community based supports which test integrated models of working and new roles.

1 Care Providers Transition Support

Increase delivery options for service users and build capacity within the Small – Medium Enterprises and Social Enterprise community to respond to the changing market for care and self directed support.

2 Implementing Community Falls Prevention Exercise classes

Develop a community exercise programme which can be delivered in both the community and in care homes

3 Administration of Medications by the Social Care Workforce

Development and implementation of a training programme for the social care workforce which expands the number of social care staff who can administer medications.

4 Dundee Recovery Partnership Coordinator

Deliver accessible recovery focussed services for adults who use substances from a community pharmacy base.

5 New Opportunities- Scoping the Contribution of the Independent Sector

Enhance the contribution of the independent sector to support innovation and new models of service delivery

6 Upskilling the Workforce

Standardising and sharing training across service providers from the statutory sector, independent sector and the third sector

The allocation of resources across the two work streams and associated programmes are shown in the table below:

Work Stream 1 Programmes	**Value £k**
1 Achieving Integrated Health and Wellbeing Outcomes for Adults	292
2 Developing Relationships with Localities	71
3 Building Community Capacity and Resilience	255
4 Reducing Health Inequalities	503
5 Supporting Carers.	256
Total	1,377
Work Stream 2 Programmes	
6 Developing Integrated Pathways that Shift the Balance of Care	1,462
7 Developing New Models of Integrated Care and Support	261
Total	1.723
Overall Total	**3,100**

PARTNERSHIP SIGNATORIES

The content of this template has been agreed as accurate by:

pp. Lesley McLay, Chief Executive for the NHS Board	David Martin, Chief Executive for the Council
Morna Wilson, Chief Executive, Dundee Voluntary Action for the Third Sector	Julia White, Scottish Care for the Independent Sector
David Lynch, Interim Chief Officer	Laura Bannerman, Interim Chief Officer

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