Item 5.5

Report

Review of Integrated Care Fund Projects

Edinburgh Integration Joint Board

24 March 2017

Executive Summary

1. This report informs the Integration Joint Board of the evaluation and review of a number of initiatives currently funded from the Integrated Care Fund; and seeks approval for the allocation of ongoing funding for these projects from the Social Care Fund, based upon recommendations from the Strategic Planning Group.

Recommendations

2. The Integration Joint Board is asked to:
3. note the contribution made to the delivery of better outcomes for citizens through the work carried out by the eight projects reviewed by the Strategic Planning Group;
4. agree to the recommendations for further funding of the eight projects from the Social Care Fund as set out in the table in paragraph 14; and
5. agree to delegate authority to the Chief Officer and Vice Chair of the Integration Join Board in respect of recommendations to be made by the Strategic Planning Group on 31 March 2017 regarding the Step Forward Project.

Background

6. The Integrated Care Fund (ICF) was established in 2015/16 by the Scottish Government replacing the Reshaping Care of Older People Change Fund. The purpose of the Fund is to support the delivery of improved outcomes for health and social care, with a focus on tackling the challenges associated with multiple and chronic illnesses for both adults under 65 and older people. The allocation for Edinburgh was £8.2 million per year for three years. However, it has now been confirmed as recurrent funding and forms part of NHS Board baselines for planning purposes. Boards and Integration Authorities should assume that this funding will continue.

7. During 2016 the Scottish Government wrote to the Chief Officers of Integration Joint Boards, advising them that it would no longer be necessary to produce separate plans and performance reports in respect of the

Integrated Care Fund. Instead the proposed use of the monies should be set out within strategic commissioning and financial plans and the impact included in annual performance reports.

8. Allocation of the Integrated Care Fund monies in Edinburgh has been overseen by the Integrated Care Fund Core Group, membership of which included representatives from the Council, NHS Lothian, third and independent sectors. However, recognising the change in the expectations of the Scottish Government set out in 7 above, the Integrated Care Fund Core Group has been disbanded and all proposals relating to the use of Integrated Care Fund monies will be referred to the Strategic Planning Group for recommendation to the Integration Joint Board.

9. On 10 March 2017 the Strategic Planning Group considered evaluations of eight initiatives currently funded through the Integrated Care Fund and has made recommendations regarding future funding. These recommendations are the subject of this report.

Main report

10. At the final meeting of the Integrated Care Fund Core Group in December 2016 the projects and initiatives supported by the Fund were split into three groups:

- those that should be considered part of core services and rolled into base budgets;
- a set of initiatives to be reviewed and evaluated by 31 March 2017; and
- a set of initiatives to be reviewed and evaluated by 31 March 2018.

11. The Chief Finance Officer has recommended that in order to create a fund to pump prime innovation using Integrated Care Fund monies, any ongoing financial commitment in respect of the last two sets of initiatives should be met through the Social Care Fund. Provision is made for this in the Draft Financial Plan being presented to the Board today. The Financial Planning Update presented to the Integration Joint Board in January by the Chief Finance Officer recommended that proposed Social Care Fund investments should be referred to the Strategic Planning Group for prioritisation (paragraph 2d).

12. When it met on 10 March 2017 the Strategic Planning Group reviewed evaluation forms completed in respect of eight projects due for evaluation and review by 31 March 2017. A further three projects had decided not to request additional funding. The table on the following page provides a high level summary of the initiatives seeking further funding and the recommendations of the Strategic Planning Group. A more detailed summary of the projects and the recommendations made by the Strategic Planning Group is attached as Appendix 1.

Table 1 Recommendations of the Strategic Planning Group

Project	Description	Recommendations from the Strategic Planning Group
Night Support Service	The pilot was set up to help tackle the current levels of reliance on costly sleepovers in individual home settings by providing provides a night time digital video calling solution along with a responder service; and at the same time, develop a sustainable response to projected increases in demand for night time support. The project can demonstrate savings against the cost of a sleepover service and evidence reduced hospital admissions and the potential to support timely discharge from hospital.	£144,350 for 2017/18 with provision for ongoing funding Work to take place with providers to develop exit strategy and ensure sustainability of the service.
Edinburgh Dementia Training Partnership	The project takes a multi agency approach to delivering Promoting Excellence in Dementia Care training to staff from all sectors. The project has been instrumental in increasing awareness of dementia and ensuring that staff have the skills to meet current and future demand. Membership of the Dementia Ambassadors Network has grown to 200+.	£26,500 for 2017/18 only.
Behaviour Support Service	The project provides a behavioural support service, focusing on distressed behaviour for individuals with dementia, and aims to reduce demand for admissions as well as facilitating the discharge of older adults from the Royal Edinburgh Hospital to Care Homes. 96.4% (target set at 95%) of referrals have remained in the same placement and not admitted to the REH or another escalated care	£222,378 on a recurring basis to establish the project as a mainstream service.

Project	Description	Recommendations from the Strategic Planning Group
	unit and this has been sustained over time.	
LOOPs Hospital Discharge Service	Pilot project to establish a collaborative team of Third Sector Liaison Workers drawn from 4 organisations as part of an integrated function within the new locality Hubs and acute hospital settings. This will provide a formal pathway to the Third Sector, with the aim of ensuring that all older people who are involved with community and hospital based health and social care services are given support to attend local community based social and preventative health services. As it develops the project will seek to avoid hospital admissions and speed up discharge from hospital by providing a fast link to appropriate services run by the third sector. The project has received 177 referrals since it began in October 2016, during which time referrals have doubled from 31 to 62 per month. During 2017/18 it will also progress the Peer Support within hospital and Hospital to Home elements of the project.	£313,240 for 2017/18 Work to take place to promote the project to staff and investigate other opportunities for development.
Carers Support Hospital Discharge Service	The service has one worker based at the Western General Hospital and the other at the Royal Infirmary of Edinburgh who provide carers with emotional support, information and advice; undertake carer assessment and support plans; make referrals to other carer support services; and support carers in the first days at home as this can be vital if patients are to successfully manage at home. Since September 2016 the service has supported 167 carers and completed 24 separate carer assessments and support plans,	Allocate £74,000 on a recurring basis for carer support but award to this project for 2017/18 only pending further review.

Project	Description	Recommendations from the Strategic Planning Group
	ensuring that these were carried out in a timely manner and reducing pressure on both carers and social work colleagues.	
COPD Integration Service	The project has redesigned COPD patient care by integrating existing teams from primary care, secondary care, out-of-hours and emergency services and introducing new dedicated services. A community based respiratory hub has also been created with a focus on multi-disciplinary working. The project has demonstrated an overall reduction in occupied bed days, prevention of admissions and a reduction in hospital attendances.	£154,517 on a recurring basis to establish the project as a mainstream service. Ensure the project takes account of impending national announcements around Anticipatory Care Planning.
Anticipatory Care Planning	To support locality hubs to deliver more streamlined multidisciplinary case review and improved anticipatory care planning (ACP) processes for “high risk” patients with complex conditions and multimorbidity in North East and North West localities. Whilst the project has had limited success to date it has identified the reasons for this and will refocus efforts in 2017/18 to improve ACPs in care homes and support GPs to create electronic Key Information Summaries.	£77,910 for 2017/18 only.
Step Forward Project	The project is a partnership between two voluntary organisations in North East Edinburgh that aims to;	The Strategic Planning Group has requested further information before making a

Project	Description	Recommendations from the Strategic Planning Group
	• help people access the type of support they need by focusing on what matters most to them and providing access at a place and time and in a way that best suits their life circumstances; • builds the capacity of people and communities to be 'enabled, supported, engaged and informed' in order to improve outcomes for people with long term conditions; and • provides health and well being link workers to 5 GP Practices within the North East Edinburgh locality. The project has received 234 referrals and can evidence reduced anxiety and increased confidence and sense of coping. Local GPs are very supportive of the project and have reported a reduction in patient appointments from some of those engaged with the project.	recommendation in respect of this project.

13. In respect of the Step Forward Project, it is recommended that the additional information required by the Strategic Planning Group is requested from the project and considered at the Strategic Planning Group meeting on 31 March 2017. If the Group subsequently recommends funding this project for 2017/18, it is recommended that the Integration Joint Board delegate the decision to the Chief Officer and Vice Chair of the Board to allow the project to be notified by 31 March 2017.

14. The table below summarises the recommendations for funding from the Social Care Fund made by the Strategic Planning Group:

Project	Funding for 2017/18 only £	Recurring funding £
Night Support Service	0	144,350*
Edinburgh Dementia Training Partnership	26,500	0
Behaviour Support Service	0	222,378
LOOPs Hospital Discharge Service	313,240	
Carers Support Hospital Discharge Service	0	74,000*
COPD Integrated Service	0	154,517
Anticipatory Care Planning	77,910	0
Total	**417,650**	**595,245**

*Recurring funding recommended to support work in this area but not necessarily delivered by this specific project after 31/3/18.

15. The commitment from the Social Care Fund in respect of the projects that the Strategic Planning Group has recommended should be funded is £1,012,895 for 2017/18 with an ongoing commitment of £595,245. The commitment for 2017/18 will rise to £1,092,895 if the Strategic Planning Group recommends funding of the Step Forward Project once the additional information requested has been considered.

16. If the Integration Joint Board agrees to the recommendations of the Strategic Planning Group a member of the Health and Social Care Partnership Executive has been identified to act as a link with each project to monitor progress and act as a point of escalation for any barriers to delivery.

Key risks

17. There is a risk that if the projects detailed in this report do not receive ongoing funding the benefits delivered to date will be lost. As a number of these projects are working to reduce unnecessary hospital admissions and support timely discharge from hospital, there may be a negative impact in terms of increased hospital admissions and delayed discharges.

18. There is a small risk that the projects may not achieve the outcomes and performance targets agreed with them. However, regular monitoring and the identification of a named person within the Executive Team as a link with each project will mitigate against this.

Financial implications

19. The proposals within this report will create commitments against the Social Care Fund of £417,650 in 2017/18 and £595,245 on a recurring basis. Provision has been made for these commitments within the Draft Financial Plan being presented to the Integration Joint Board at this meeting.

Involving people

20. The recommendations within this report have been put forward by the Strategic Planning Group membership of which includes citizens of Edinburgh and representatives of health and social care professionals, the third and independent sectors, social housing providers and localities.

Impact on plans of other parties

21. The proposals and recommendations within this report have no impact on the plans of other parties.

Background reading/references

Financial Planning Update report to the Integration Joint Board in January 2017

Rob McCulloch-Graham

Chief Officer, Edinburgh Health and Social Care Partnership

Report author

Contact: Wendy Dale, Strategic Planning Manager,

E-mail: wendy.dale@edinburgh.gov.uk

Tel: 0131 553 8322

Links to priorities in the strategic plan

The recommendations contained within this report will contribute to the achievement of all six priorities within the strategic plan:

- Tackling inequalities
- Prevention and early intervention
- Person centred care
- Right care, right place, right time
- Making best use of capacity across the whole system
- Efficient use of resources

Appendix 1
Review of Integrated Care Fund Projects

Strategic Planning Group agreed as a principle that carry forward of any underspend in respect of these projects would not be agreed.

Project Title: Night Support Service

Project outline:

The pilot was set up to help tackle the current levels of reliance on costly sleepovers in individual home settings by providing an alternative night time contact point; and at the same time, develop a sustainable response to projected increases in demand for night time support.

The project provides a night time digital video calling solution along with a responder service where that is needed. The pilot aims to test this solution for up to 35 customers.

What difference has the project made:

Savings by replacing sleepover night time support

Projected savings to end March 17 for 10 people - £87,048 pa

Projected savings over 2 years with no increase in customers - £200,250 pa

Projected savings over 2 years with increase to 35 customers – c£617,000 pa

Reduced hospital admissions– evidenced by case studies

Early discharge – case studies evidence avoidance of need to find new accommodation to allow sleepovers

Increased independence and privacy – people can access support when they need it without having to have someone staying in their home.

Strategic Fit (Links to Strategic Plan):	Challenges and barriers:
Priorities: Supports all 6 priorities in the strategic plan **Actions:** Action 38 – Increased use of Technology Enabled Care	• Difficulty in getting referrals • Changes in key contact personnel within the Council • EHSCP staff do not have time to attend familiarisation session • Lack of criteria

Funding received to date:	Funding requested going forward:
2016/17 - £144,350 Staffing, operating costs, equipment	2016/17 - £144,350 + carry forward of any underspend – one year only Salary, operating costs, equipment

Next steps if successful:	Risks if funding ceases:
• Continue to run pilot • Increase referrals by working with partners	• Loss of service • Sleepovers would need to be reinstated • Loss of benefits – efficiency savings, reduced hospital admissions and increase in delays, loss of independence for individuals supported

Recommendations:
• Support request for funding to 31 March 2018 • Identify key contact to work with providers • Work with providers to develop exit strategy to ensure sustainability of service • Support providers to develop increase referrals • Exec Team link – Strategic Planning and Quality Manager for Older People • Further clarity on CleverCogs running costs to be requested

Project Title: Edinburgh Dementia Training Partnership

Project outline:

The project takes a multi agency approach to delivering Promoting Excellence in Dementia Care Informed and Skilled Practice level training and provides:

- Facilitator's training, prioritising day services
- Practitioner's training, prioritising day services
- Cognitive Stimulation Therapy training for day services and other services which run activity groups
- Autonomous practitioner training for those who direct and manage care services, to support the Psychological Needs and Wellbeing of People with Dementia

What difference has the project made:

Attendance at events met the targets set. Feedback received was positive and demonstrates training achieved the intended outcomes.

Dementia Ambassadors network has been increased significantly in last 3 years from 4 – 200+

Strategic Fit (Links to Strategic Plan):	Challenges and barriers:
Priorities: Supports all 6 priorities in the strategic plan **Actions:** Action 23 - Improving support for people with dementia	• Unable to complete all of programme due to delay in confirmation of funding. Outstanding work will be undertaken in May and June 2017.

Funding received to date:	Funding requested going forward:
£34,514 for 2016/17	Request to carry-over the unspent element from 2016/17 to 2017/18 (approx £26,500)

Next steps if successful:	Risks if funding ceases:
To provide existing planned ,further sessions of Promoting Excellence Improving Practice (Skilled Practice Level) events within localities and follow-up work. In addition consideration would be given to the provision of palliative and end of life care training	Programmed, further training and follow-up work will not be completed. Associated benefits of training ,which help enable delivery of better care for people living with dementia, will not be realised.

Recommendations:
• Support request to carry-over unspent funding or allocate equivalent amount from 2017/18 budget • Exec Team link – Strategic Planning and Quality Manager for Older People • Further information on work plan to be requested

Project Title: Behaviour Support Service

Project outline:

The project provides a behavioural support service, focusing on distressed behaviour for individuals with dementia, and aims to reduce demand for admissions as well as facilitating the discharge of older adults from the Royal Edinburgh Hospital to Care Homes. Activities include:

•Provision of direct clinical service to all Edinburgh Care Homes;
•Direct Psychology support and supervision to two REH inpatient wards (Ward 14 & Pentland)
•Provision of staff training in priority group of Care Homes
•Establish ongoing co-working with Edinburgh Council supported by the TEC fund to enable use of tele-conferencing within care

What difference has the project made:

•38.5% of people referred to the EBSS have been in jeopardy of having their placement break down or of an admission to hospital.
•96.4% (target set at 95%) of referrals have remained in the same placement and not admitted to the REH or another escalated care unit and this has been sustained over time.

•For the NPI frequency and severity of behavioural symptoms has reduced by 34% following intervention. The occupational disruption caused by the behaviour has decreased by 27% following intervention.
• For the CMAI the frequency of distressed behaviours has reduced by 20% following intervention. The carer distress caused by the behaviour has decreased by 46%.

Strategic Fit (Links to Strategic Plan):	Challenges and barriers:
Priorities: Supports all 6 priorities in the strategic plan **Actions:** Action 19 – New models to better meet the needs of frail elderly people at home and in care homes Action 23 - Improving support for people with dementia	•Difficulty in recruiting to and retaining Occupational Therapy staffing •Service demand to date has exceeded capacity. •Priority given to Care Homes resulting in difficulties extending training to other staff groups (such as CMHT, RRT, wards, social care) without reducing direct clinical input.

Funding received to date:	Funding requested going forward:
Funding allocated for 2016/17 £231,142. Salaries, travel and training support	£222,378 on a recurring basis as mainstream provision Salaries, travel and training support

Next steps if successful:	Risks if funding ceases:
Retain specialist staff currently employed. Ongoing work to integrate the service pathway for individuals presenting in emergency/crisis referrals to the CMHT and Rapid Response Team.	• Project will end with loss of service • Significant risk of hospitalisation or placement breakdown for clients, an increase in crisis referrals to CMHT, reduced confidence in the community on the Older People's Mental Health Service and loss of other benefits realised to date

Recommendations:
• Support request for recurring funding • Support integration of service with Rapid Response Teams and CMHTs • Exec Team link – Strategic Planning and Quality Manager for Older People

Project Title: LOOPS Hospital Discharge Service

Project outline:

The LOOPs Hospital Discharge Service is a pilot project to establish a collaborative team of Third Sector Liaison Workers drawn from 4 organisations as part of an integrated function within the new locality Hubs and acute hospital settings. This will provide a formal pathway to the Third Sector, with the aim of ensuring that all older people who are involved with community and hospital based health and social care services are given support to attend local community based social and preventative health services.

The project has 3 elements: core service - light touch case management and supported referral to third sector; peer support within the hospital environment; hospital to home.

What difference has the project made:

The core service has only been operating since October 2016 during which time referrals have doubled from 31 in November to 62 in January. In total 177 referrals were received for older people within scope of the project, 16 from Royal Edinburgh Hospital.

- 91 older people immediately accepted the support of the project while a further 30 are awaiting assessment. 46 carers have also been supported
- 56 people declining the service, 38 of whom have been provided a signposting service.
- of 71 active referrals to third-party providers, the team has successfully referred to 67 services.

The Peer Support Service have run 15 groups attended by 36 individuals a number of whom have been signposted to a range of third sector service

Significant learning about complexity of system and what does and does not work well. Involvement in the development of the MATTS.

Development of case management systems and progress on data sharing agreements
Work with ISD to formally evaluate contribution and increase management info on third sector contribution

Strategic Fit (Links to Strategic Plan):	Challenges and barriers:
Priorities: Supports all 6 priorities of the Strategic Plan **Actions:** 1 Establish local collaborative working arrangements across partners 13 Approach to prevention	• Delay in establishing Locality Hubs and frequency of MATTs • Data-sharing processes have been cumbersome and lengthy • Culture and Practice – working across sectors – difficulties of integrating third sector practice into the statutory sector •Hospital to Home not delivered to date due to complexity involved in delivering a volunteer-supported transportations service

Funding received to date:	Funding requested going forward:
2016/17 - £313,240 Funding for Peer Support and Hospital at home £22,200 not utilised	2017/18 - £313,240 + carry forward of slippage of £22,200

Next steps if successful:	Risks if funding ceases:
• Continue to deliver and progress the 3 services • Undertake evaluation with ISD • Explore additional opportunities , e.g. support for community assessments, support those in Interim Care facilities to reconnect with communities	• Loss of existing services and other opportunities • Intended outcomes would not be achieved

Recommendations:
• Support request for funding to 31 March 2017/18 • Promote the project within the Hubs and hospitals • Work with the project to investigate additional opportunities • Following completion of the evaluation work with the project to develop an exit strategy • Exec Team link – Locality Manager North West • Expedite laptops being made available to the project

Project Title: Carers Support Hospital Discharge

Project outline:

The Carer Support Hospital Discharge (CSHD) service works alongside unpaid carers of adults, in pre hospital discharge planning to provide information, inform care package decisions and support better outcomes to carers. It follows the Carers (Scotland) Act 2016 Section 28: Carer involvement in hospital discharge of cared-for person and the Edinburgh Joint Carers' Strategy outcomes which feed into the overall Integrated Care Fund outcomes.

The service has one worker based at the Western General Hospital and the other at the Royal Infirmary of Edinburgh who provide carers with emotional support, information and advice; undertake carer assessment and support plans; make referrals to other carer support services; and support carers in the first days at home as this can be vital if patients are to successfully manage at home.

What difference has the project made:

Since September 2016 the service has supported 167 carers and completed 24 separate carer assessments and support plans, ensuring that these were carried out in a timely manner and reducing pressure on both carers and social work colleagues.

The service uses a baseline evaluation followed up by a review to measure impact. To date 30 baseline evaluations have been completed and 16 reviews. Of these 16 carers: 43% were positive about the impact of the information and advice received; 25% reported improved confidence in their caring role; 6% felt their health had improved; 25% reported an improvement in their social life; 26% felt that services met their needs.

Strategic Fit (Links to Strategic Plan):	Challenges and barriers:
Priorities: Supports all 6 priorities **Actions:** Action 14 – Support for unpaid carers	Promoting and embedding a new service in the acute hospital setting as a part of a multi disciplinary team is challenging and takes time and resilience.

Funding received to date:	Funding requested going forward:
2016/17 - £74,000 (underspend of £27,058 due to delay in recruitment) Staffing and operating costs	2017/18 onwards recurring funding of £74,000 per annum Salaries and operating costs

Next steps if successful:	Risks if funding ceases:
• Expansion of exiting service • Support the development of the locality Hubs	• Breakdown in informal caring arrangements as carers feel unsupported going through the hospital process and at point of discharge • Delays in carers assessments • Negative message to carers

Recommendations:

- Support allocation of £74,000 recurring funding for supporting carers around hospital discharge
- Support the funding of this initiative until 31 March 2018 and review in the light of the operation of the locality Hubs and increased evidence base from operation over a longer period
- Support the development of links with the Hubs and within acute hospitals
- Exec Team link – Locality Manager North West
- Refer to the Carers Strategy Group for advice re generating uptake and evaluation methodology

Project Title: COPD Integrated Service

Project outline:

The overall aim of the project is to use a single system approach to improve the quality of care patients with COPD by focusing on their physical and mental health, treating acute exacerbations of COPD in the community and preventing admissions and readmissions to hospital. COPD patient care has been redesigned by integrating existing teams from primary care, secondary care, out-of-hours and emergency services and introducing new dedicated services. A community based respiratory hub has also been created with a focus on multi-disciplinary working.

What difference has the project made:

- Overall reduction of 2954 occupied bed days resulting in a productive gain of £942,131
- Admissions prevented for 37% of patients assessed with acute exacerbations by the Community Respiratory Team
- 255 patients triaged at hospital door and referred to the respiratory hub for ongoing care
- Reduction in hospital attendances
- Psychologically informed care has led to reduction in anxiety and depression and improved quality of life
- Patients are better able to cope and manage their condition

Strategic Fit (Links to Strategic Plan):	Challenges and barriers:
Priorities: Supports all 6 priorities **Actions:** • Action 30 – Integrated model for COPD • Action 32 – Increased use of Anticipatory Care Plans	None identified

Funding received to date:	Funding requested going forward:
2016/17 - £147,000 Staffing including 0.2 WTE post in third sector and operating costs (Actual spend £152,550, shortfall met from Long Term Conditions Programme)	2017/18 onwards recurring funding of £154,517 to establish the COPD integrated care model as a core service.

Next steps if successful:	Risks if funding ceases:
• continue to develop the COPD integrated care model to target patients most at risk of hospital admission/readmission, to extend the reduction in hospital bed days • use transferable learning in development of services for complex patients with multimorbidity in locality based hubs	• Project will end • Potential increase in hospital admissions and loss of other benefits realised to date

Recommendations:
• Support request for recurring funding • Exec Team link – Locality Manager North East

Project Title: Step Forward Project

Project outline:

Step Forward is a partnership between two third sector providers covering North East Edinburgh that:

- aims to help people access the type of support they need by focusing on what matters most to them and providing access at a place and time and in a way that best suits their life circumstances.
- builds the capacity of people and communities to be 'enabled, supported, engaged and informed' in order to improve outcomes for people with long term conditions
- provides health and well being link workers to 5 GP Practices within the NE Edinburgh locality.

What difference has the project made:

234 referrals received; 67% women, 60% from SIMD 1 and 2 populations, majority of those referred are aged between 35 and 49 reflecting the demographic of the North East Locality

Evidence of reduced anxiety and increased confidence and sense of coping

GPs have indicated that the service is valued and reported a reduction in patient appointments from some of those engaged with the project

Strategic Fit (Links to Strategic Plan):	Challenges and barriers:
Priorities: Supports all 6 priorities **Actions:** Action 9 – encourage take up of social prescribing Action 11 – partnership working to tackle inequalities Action 13 – Approach to prevention Action 29 – Development of a long term conditions strategy	Time intensive model, health and well being worker capacity has been limited to 5 GP practices during this project

Funding received to date:	Funding requested going forward:
2016/17 - £50,000 Staffing and lifestyle management course costs	2017/18 - £70,000 Staffing?

Next steps if successful:	Risks if funding ceases:
Provide an expanded service based on a hub model operating in the 2 GP clusters within the North East locality to support more people with multimorbidities. Gather quantifiable data to evidence the impact of the project.	• Project will come to an end • Loss of service that is valued by both GPs and their patients

Recommendations:

- Support request for funding to 31 March 2018 dependent upon further evidence of impact and clarification to address issues raised by representative of the Professional Advisory Group
- Ensure coherence with other initiatives being developed around link workers
- Exec Team link – Locality Manager North East

Project Title: Anticipatory Care Planning

Project outline:

To support locality hubs to deliver more streamlined multidisciplinary case review and improved anticipatory care planning (ACP) processes for “high risk” patients with complex conditions and multimorbidity in North East and North West localities.

The evaluation has led to a proposed change in focus for this project to anticipatory care planning in care homes, ACP training across all services, collation of information from community based ACPs and Pan Lothian Admission Avoidance Network.

What difference has the project made:

Objective to increase the number of Key Information Summaries for people with high SPARRA scores has not been realised

Significant opportunities for improvement in anticipatory care planning in care homes identified

Better understanding of what is required to improve anticipatory care planning processes

Strategic Fit (Links to Strategic Plan):	Challenges and barriers:
Priorities: Supports the following priorities: tackling inequalities; prevention and early intervention; person-centred care; right care, right place, right time **Actions:** Actions 5 & 32 – Increased use of Anticipatory Care Planning Action 29 – Development of a long term conditions strategy	• Delay in implementation of locality Hubs • Challenges in engaging practice staff • GP frustrations around the limitations of the KIS software • Time constraints in practices do not allow for 'good conversations with patients and creation of ACPs

Funding received to date:	Funding requested going forward:
2016/17 - £61,963 (underspend forecast of £5,445) Staffing	2017/18 - £103,590 Staffing

Next steps if successful:	Risks if funding ceases:
• Roll out ACP in Care Homes element of the project from 4 to 10 care homes • Develop and deliver a planned approach to training across all services including the creation of a "toolkit", tailored to individual care settings • Support the delivery of the Pan Lothian Admission Avoidance Network	• Capacity to deliver Actions 5 and 32(increased use of ACPs would be significantly reduced and may have an adverse impact on the strategic aim to reduce hospital admissions

Recommendations:
• Recommend funding of £77,910 to 31 March 2018 • Exec Team link – Locality Manager North East • Ensure fit with impending national announcement in respect of ACPs