**Introduction**

The Council of the Isles of Scilly and NHS KERNOW are responsible for ensuring that the Islands’ Health and Social Care economy is designed to respond to the needs of the island population. To meet the challenges of an ageing population and increasing demand for services we need to be developing integrated partnerships that put the needs of the service user first and make best use of the islands’ multi-disciplinary team.

Our future service model is based on the following themes:

* We want to support people to stay safe, well and independent in their own homes.
* We want individuals to have access to good quality information and advice.
* We want people to be able to choose how they want to live their lives.
* We want people to be connected to their community.
* We want there to be swift and effective support when it is needed.
* We want Reablement and recovery to be a feature of all services
* We want good quality support to be available thereafter.

Moving forward we are committed to a set of underpinning principles that ensure that future health and social care services are either provided, commissioned or encouraged to develop on the islands that:

* Reduce crises which put pressure on resources
* Focus on delivering agreed outcomes.
* Promote models that deliver savings.
* Where appropriate, support people to use alternatives to residential care and hospital-based care.
* Support the prevention and deferred onset or deterioration of long term conditions.
* Support the community and Carers to support each other.

**Funding**

The project detailed in this document is funded through the islands Better Care Fund strategy. The Better Care Fund provides financial support for councils and NHS organisations to drive the transformation of local services to ensure that people receive better and more integrated care and support.

This is a 2 year fixed term contract with the Council of the Isles of Scilly, using non recurrent funding from the Better Care Fund. £60-80,000 has been allocated to employ the delivery partner who will support the development, management and delivery of the three key elements of the plan detailed below. While the delivery partner is essential to the success of the project, he/she will need to work closely and collaboratively with current health and social care staff, and the third sector.

The cost of operational delivery of the proposed pathways is included in the allocation. Existing services will continue to be required to contribute to the delivery of the care to the islands’ residents. Recharging mechanisms may need to be established to support this.

The funding allocated to the project is broadly expected to be split into:

1. The recruitment to post of an appropriately skilled delivery partner who will have a high level presence within the Integrated Care Team.
2. Operational delivery of the pathways. This may include working with the Council and other partners to agree a recharge mechanism for the existing workforce.

**Project Requirements**

Outcomes and recommendations resulting from this project will be reported to the IOS Health and Well Being Board.

This project is intended to design and pilot the following three key elements under the Better Care Fund plan, namely:

1. Early intervention service

2. Rapid response

3. Reablement pathway design.

The Council of the Isles of Scilly is seeking a delivery partner to co-design and pilot the three key elements mentioned above, ensuring that the individual is at the heart of the support they receive. The delivery partner will demonstrate that they have an excellent understanding of the current service structures in place on Scilly and be able to engage other partners in changing how the existing staff resource is used. The delivery partner will play an active role in the newly evolving Isles of Scilly Integrated Care Team and will use their expert knowledge of early intervention and community based rehabilitation services to improve outcomes for the islands’ residents.

They will be required to join the developing integrated care team and provide leadership and active case management. They will proactively identify service users who would benefit from a rehabilitative support plan and work with services in planning, delivering and reviewing outcomes.

The delivery partner is not expected to themselves deliver all operational aspects of the service, but rather to work with colleagues/professionals and volunteers in the Integrated Care Team.

1. Early intervention service.

The recipients of this service will be older adults at risk of functional decline. This pathway is intended to reduce and delay demand for acute health and statutory services for these people. The delivery partner will be an essential player in developing this pathway to enable service users to access early support to maintain independence and wellbeing. Services not currently within the Integrated Care Team arrangements will also be able to refer people onto this pathway. This will include housing and all emergency services. Similarly, current preventative groups and activities will need to remain in place and evolve further in order to maximize the health and social care outcomes for this service user group.

2. Rapid response.

This will be a new pathway to prevent immediate risk of admission to Residential Care or Hospital. It will be delivered by increasing access to rehabilitation services before, during, and after hospital admission. The existing Rehabilitation provision will be supported through the Integrated Care Team in order to provide a more responsive multi-agency service to acute illness or functional decline.

3. Reablement Pathway redesign.

The existing Reablement pathway is solely managed by the Adult Social Care team. It is recognized that the current service lacks sufficient health expertise input to assess, create and review appropriate goals. With reference to current research and best practice, the delivery partner will be an essential player in redesigning the existing Reablement pathway to provide a multi-disciplinary, therapist led programme that supports a rapid return to independent living and a reduced demand for long term services. The development of a training plan to enhance the skills of the current care work force will be required to ensure the workforce are skilled and those skills are maintained to deliver this essential service.

The 3 services will share the following characteristics:

* Be designed around the needs of the service user.
* Have clear multi-agency referral process.
* Enhance the development of the Integrated Care team.
* Maximize the use of equipment, aids to daily living and assistive technology.
* Reduce duplication of paperwork.
* Targeted use of the limited staff resource available.
* Ensure service user consent and application of the Mental Capacity Act when necessary.
* Apply existing Information sharing protocols.

**Outcomes:**

* Pathway maps that will be suitable for inclusion in future integrated commissioning arrangements. The maps will include/reflect all existing operational processes of the Cornwall and the Isles of Scilly Safeguarding Adults board, and the Mental Capacity Act.
* Recruitment of an appropriately skilled practitioner.
* Practitioner participation in existing clinical forums (that include service user and carer representation) to contribute to the development of the project.
* Existing rehabilitation groups are enhanced. (Groups include ‘staying steady’ and ‘falls prevention’).
* A reduction in the need for medical travel to the mainland due to improved service availability and access on the IOS.
* Practitioner input to development/refinement of operational guides for health and social care staff.
* Review of the current, and development of new, data reporting processes to measure impact of service. For the Reablement pathway this will include the Adult Social Care statutory reporting requirements SALT and ASC-FR.
* Provision of finance and activity reports that feed into the reporting structures of

the Better Care Fund.

* Development and delivery of Reablement training to improve competency of the Integrated Care Team.
* A risk log for project implementation that will be maintained and shared with the commissioners when required.