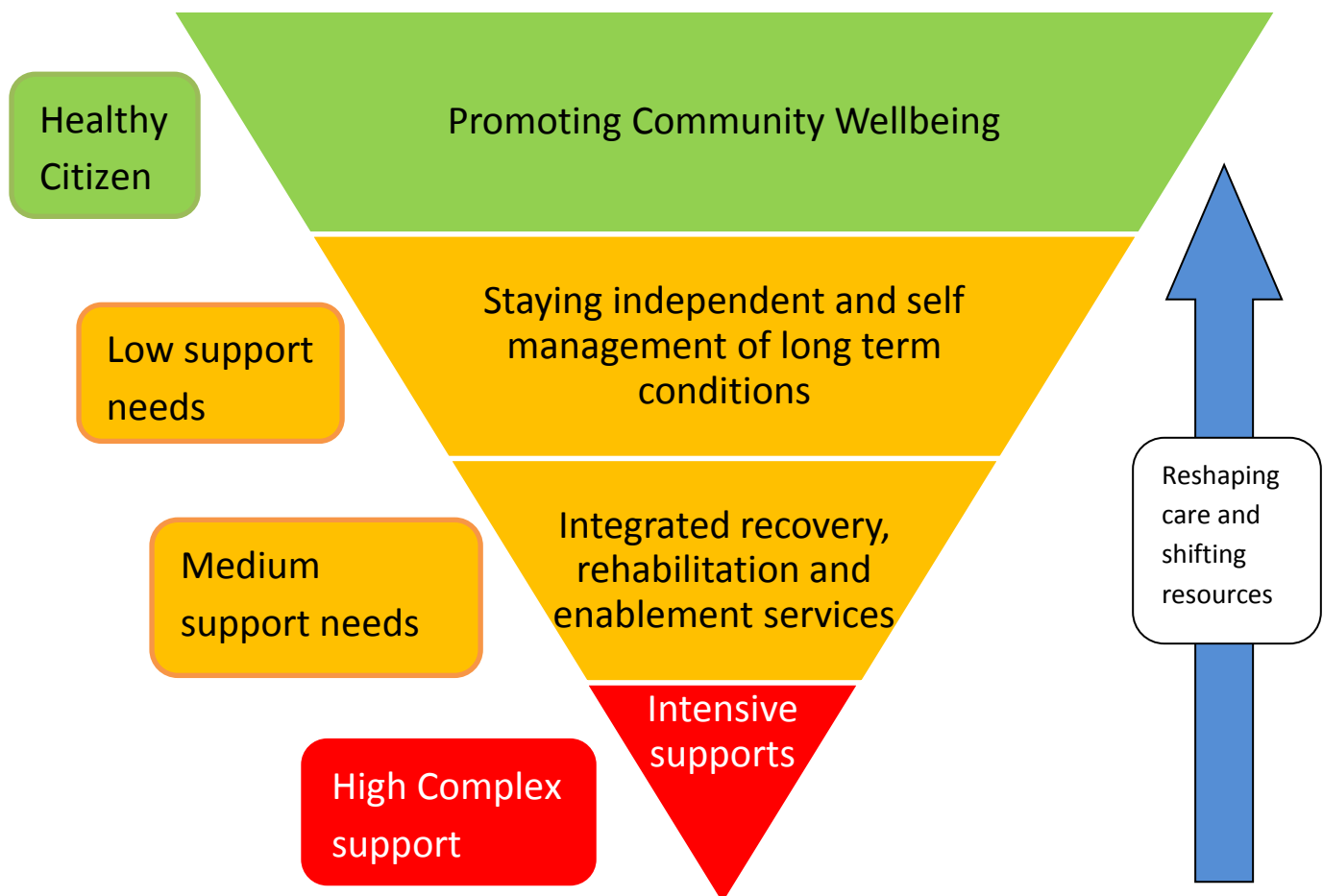


Moray Reshaping Care Model

The Reshaping Care model represents four bundles of interventions, approaches and the related enablers which collectively improve outcomes for all adults. The bundles are interdependent and a person's care needs may be met across the bundles. Reporting on spend against these interventions overtime will track the shift towards greater investment in preventative and anticipatory care to promote community wellbeing and proactive care and support at home to enable independence and self-management of long term conditions. A focus on recovery, rehabilitation and enablement delivered through integrated working in the community when care and support is required will reduce unplanned admissions to acute services. When needs are more complex and require intensive or ongoing support, accommodation based services shall meet the needs of the individual.

This Reshaping Care model will support achieving the national Health and wellbeing outcomes



Promoting Community Wellbeing - preventative and anticipatory care

- **People keeping well, Healthy Citizen**
- **Building Community Resilience**

Early Intervention, prevention, education: There is a wide range of universal and third sector agencies and services and protective services which impact upon the determinants of health and wellbeing: Community Planning, TSI community development, Community Care Access Team (TMC) Sports & Recreation, Library Services, debt advice, Jobcentre Plus, Citizens Advice, Health Point (Dr Grays), Volunteering, Choose Life (suicide prevention), Housing support, Schools, Healthy Working Lives, Peer Support groups.

This includes Public Health and awareness campaigns; lifestyle information and advice (being active, nutrition, alcohol, smoking); working with the media, information signposting; the natural environment (outdoors, parks, green spaces); social networks; volunteering; Community Groups (BALL(Be active life long) groups, Mens shed; Information services (MORINFO). National programmes i.e. Smoking, Alcohol, obesity key messages, National drives e.g. Stroke FAST programme, screening programmes (bowel, breast) ; Vaccination programmes(flu).

Staying independent and self-management of long term conditions – Proactive care and support

- **People with low support needs**

Approaches and interventions required will include:

- Varied housing and housing support
- Building social networks
- Anticipatory care planning
- Medicine management
- Integrated Case/Care management
- Care at home services, day services, dementia post diagnostic support
- Wellness Recovery Action Planning (WRAP)
- Peer support groups i.e. Moray Mental Health support group
- Falls prevention and assessment
- Access to Books on Prescription, Samaritans, Breathing Space, NHS 24, CRUSE, ARROWS (drugs/alcohol)Age Scotland, Alzheimer's Scotland

Integrated recovery, rehabilitation and enablement services –Care at points of transition

- **People with medium support needs**

Approaches and interventions required will include:

- Access to equipment and timely adaptations
- Range of housing options,
- Recovery after exacerbation of long term condition
- Focus on recovery, enablement, rehabilitation
- Timely access to diagnosis
- Clinical advice for community teams
- Home from hospital - enablement, recovery
- Outreach Teams - mental health, drug and alcohol
- Range of Intermediate care services as alternative to hospital admission
- Responsive, flexible palliative care

Intensive Support

- **People with high and complex support needs**

Approaches and interventions required will include:

- Support for people with long term conditions and multiple long term conditions
- Early assessment for frail elderly and access to comprehensive geriatric assessment
- Medicine reconciliation and reviews
- Timely discharge from hospital
- Treatment of delirium
- Specialist dementia unit/housing
- Supported accommodation which meets the needs of the person
- Clinical support for care homes
- Self-directed support
- Palliative and end of life care

Related Enablers which will support the above

Carers as Partners – unpaid carers/families will be treated as equals

Outcome focussed assessment – which focus on personalised outcomes and goals with agreed with the individual and carer

Integrated working and workforce development – Develop a multi skilled workforce that is integrated, capable and fit for the future

Co-production – services are planned and delivered in an equal and reciprocal relationship between professionals, service users, family and the community

Technology Enabled Care – share information and use the capability of emerging technology

Commissioning – services will be commissioned as appropriately using the IPC commissioning cycle.

Health Promotion – All contacts with service users should be considered a health promotion opportunity

People living with multiple conditions in Scotland say the following will be key to improving outcomes for them:

Communication, choice, control, continuity, co-ordination, community and collaboration