WEST DUNBARTONSHIRE COUNCIL

Report by the Director of the Community Health and Care Partnership

CHCP Committee: 21 May 2014

Subject: Review of West Dunbartonshire Community Planning Partnership Reshaping Care for Older People (Change Fund) Programme 2013-14

1. Purpose

1.1 To report on the progress and outcomes of the Reshaping Care for Older People (Change Fund) Programme for 2013-14.

2. Recommendations

Committee is asked to:

2.1 Note the workstreams taken forward in 2013-14.

2.2 Note the impact of change in the delivery of services to Older People.

3. Background

3.1 Partnerships across Scotland have been funded (Change Fund) since 2010-11 to develop programmes which support a Shift in the Balance of Care and to embark on a Reshaping Care for the Elderly strategy.

3.2 A multiagency, multidisciplinary group which also has representation from service users, carers and the 3rd and Independent Sectors oversees the Reshaping Care agenda and the Change Fund programme.

3.3 The finance available in 2013-14 was £1.38m.

4. Main Issues

4.1 The programme is designed to develop and lever changes in the way Older People and their carers are supported and where and how care is delivered. The programme is delivered under 5 key workstreams.

4.2 These are:

- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Effective Care at Time of Transition

- Hospital and Care at Home
- Enablers

4.3 Preventative and Anticipatory Care

4.3.1 We have developed an Anticipatory Care Programme (ACP) which allows the identification of older people at risk, undertakes a full assessment and puts in place a wide range of supports and plans particularly at times of crisis. 1190 clients/patients have been identified.

4.3.2 The fund has supported the development of the Linkup Project with West Dunbartonshire CVS which has seen a 54% increase in inter-service referrals and is now developing a "social prescribing" model with GPs in the area.

4.4 Proactive Care and Support at Home.

4.4.1 This workstream is designed to ensure that service users and carers are enabled to remain at home for as long as possible.

4.4.2 Investment in this workstream has included the development of a respite booking bureau which enables service users to plan and book their own scheduled respite. We have also increased the amount of respite provided and improved uptake rates.

4.4.3 Further investment has included additional support to Dementia sufferers in care homes and after diagnosis and has funded additional partnership working with Alzheimer Scotland.

4.4.4 The Care at Home service has expanded its ability to offer planned and unplanned respite at home.

4.5 Effective Care at Time of Transition

4.5.1 This workstream improves links between care sectors including more integrated services.

4.5.2 Additional linkages between Out of Hours services have been developed, particularly between Care at Home services, Out of Hours GPs and District Nurses.

4.5.3 The Care at Home service has developed a Reablement Team which focuses on improving confidence and the ability to undertake personal care and life skills. Of the clients who have received the service 33% need no further service; 33% need less service, with a final 33% needing the same or more service. The number of service users has decreased allowing the delivery of higher level care packages to service users with complex needs.

4.5.4 Linked to the Reablement Team is the Care at Home Pharmacy Service which undertakes a review of medication and provides advice and compliance

support. Both of the services were initially targeted at patients discharged from hospital and following success with this group is expanding to cover a wider group in receipt of services living at home.

4.5.5 Finally in this workstream a Palliative Care Nursing service is in place supporting primary care staff, care home patients and families at the end of life.

4.6 Hospital and Care at Home

4.6.1 This workstream supports the move from hospital to home or care home.

4.6.2 The Hospital Discharge Team is a multidisciplinary, multiagency team which includes social workers, occupational therapists, nurses, physiotherapists and additional MHO resource. Complex discharges whether to home or care setting are managed by the team and is available along with Care at Home services to hospital staff using a singe point of access. This allows for services to be deployed quickly and reduce time delayed in hospital. There has been a 21% reduction in bed days lost to delayed discharge in the year 2013-14.

4.7 West Dunbartonshire Reshaping Care for Older People workstream is delivering a change agenda. Whilst there is improvement across all key performance indicators (appendix 1) there remain considerable challenges to lever the changes we require to deliver services to a growing ageing population with complex health and social needs.

5. People Implications

There are no people implications.

6. Financial Implications

6.1 The workstream returned a balanced budget for 2013-14. An analysis of the impact of the Change Fund on levering changes to service delivery for both the NHS and WDC will be provided when the full years figures are available.

7. Risk Analysis

7.1 There is no risk identified.

8. Equalities Impact Assessment (EIA)

8.1 There is no equalities impact.

9. Consultation

9.1 The 2013-14 report has been developed with a full range of stakeholders.

10. Strategic Assessment

10.1 The plan meets the Council's objectives to:

- Improve care for and promote independence for older people and
- Improve the wellbeing of communities and protect the wellbeing of vulnerable people.

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Appendices:	CHCP Change Fund KPIs NHS GGC - March 2014.
Background Papers:	None
Wards Affected:	All