West Dunbartonshire Community Health & Care Partnership

West Dunbartonshire Community Health and Care Partnership

Reshaping Care for Older People

Change Plan

February 2011

Introduction

The development of these proposals has been a collaborative exercise within West Dunbartonshire Community Health and Care Partnership. This is an integrated partnership jointly managed on behalf of West Dunbartonshire Council Social Work Department and NHS Greater Glasgow and Clyde through its Community Health Partnership (CHP) in West Dumbarton. The CHCP has a co-terminus boundary with the Local Authority and services populations in Clydebank, Alexandria and Dumbarton.

The plan was developed with stakeholders including, Social Work, Health and Housing partners. The partnership also undertook an active engagement process with the NHS Acute Sector, 3rd Sector partners and Independent Sector providers. A list of partners involved in the development of the plan is listed at Annex A.

Developing Services to Prepare for Demographic Change

In West Dunbartonshire the demographic change in the number of older people shows an increase in the older population although not as stark as for the rest of Scotland. Table 1 shows the projected demographic change in the ageing population in West Dunbartonshire to 2018.

Table 1
Older people Population Data – % Change 2005-2008 and Projections 2008-2018

	% change 2005-08 (65-74)	% change 2005-08 (75-84)	% change 2005-08 (85+)	Projection 2008 - 18 (65-74)	Projection 2008 - 18 (75-84)	Projection 2008 - 18 (85+)
West Dunbartonshire	-2%	2%	5%	18%	2%	23%
Scotland	**1%**	**2%**	**11%**	**21%**	**18%**	**40%**

Our own analysis shows that there will be a significant change in the level of need in our population: Using IORNS data we have projected a significant increase in the number of people in high needs categories. We have set a target of supporting 70% of our clients at home or within a homely setting and table 2 below shows the impact of that and the demographic change in the numbers of older people in each group to 2030.

Table 2
Number of Additional Service Users (Demographic Change and Shift in the Balance of Care to 70% Cared for in their Own Homes or in a Homely Setting)

IORNS Grouping	2008 Base	2011	2014	2020	2025	2030
A	Base	17	56	119	198	282
B	Base	39	131	274	457	651
C	Base	13	42	89	148	211
D	Base	13	42	89	148	211
E	Base	6	21	44	74	106
F	Base	14	48	101	167	239
G	Base	3	11	22	37	53
H	Base	2	7	15	25	35
I	Base	10	34	71	118	168
Total Movement		116	392	824	1372	1956

As a CHCP West Dunbartonshire has embarked on a redesign of our services to develop integrated Older Peoples and Older Peoples Mental Health teams. This includes full integration of our Care Homes sector, Home Care, Social Work Assessment and Care Management as well as our Community Health Services.
Over the next 3-4 years West Dunbartonshire has a relatively static demographic picture. Our plans for the use of the Change Fund will enable us to make structural adjustments to our current pattern of provision and to prepare for the anticipated increase from 2014 onwards. This will include additional investment in rehabilitation, reablement and in developing new models for providing care at home. It will also provide the opportunity to refocus our expenditure to those with higher levels of need. It is our intention to complete a joint strategy for Older Peoples Services supported by the development opportunities the Change Fund brings and to bring a meaningful shift in the balance of care over the next 3 years. This shift will include a shift from acute hospital based care to community based health care as well as a shift from institutional care to care at home.
The Change Fund plan builds on joint work already underway and many of our partners have been involved in the development of strategies for older people over several years. The plan seeks to deliver change under the following themes;

1. **Facilitating Discharge**
2. **Avoiding Admission**
3. **Maintaining Older People at Home or in a Homely Setting.**
4. **End of Life Care**
5. **Co-production, Education and Training**

1. Name of partnership

West Dunbartonshire Community Health and Care Partnership

2. Partner organisations

NHS Greater Glasgow and Clyde, West Dunbartonshire Council, West Dunbartonshire Community Health and Care Partnership, Third Sector Partners – see annexe, Independent Sector Partners – see annexe

3. Finance – Use of Change Fund and additional resources

From	Amount £
Initial central allocation	1,209,000
Added by NHS Board	30,107,094
Added by local authority	32,059,000
Other	0
TOTAL	**63,375,094**

4. Summary of current partnership budget for older people (does not include acute costs)

Table

West Dunbartonshire CHCP - Gross Spend on Older Peoples Services - 2009/10

Local Authority	**£**
Residential Accommodation	13,775,000
Home Care	9,050,000
Day Care	1,480,000
Other	7,754,000
TOTAL - LOCAL AUTHORITY	**32,059,000**
Health	**£**
DENTAL CONTRACT	3,526,455
OPTOMETRISTS	851,648
PHARMACY CONTRACT	1,731,243
GMS	6,872,912
Prescribing	9,690,931
Community AHPS	1,084,282
COPT	474,767
District Nursing	1,557,449
Elderly Mental Health Inpatients	1,813,796
Other HCC	872,145
Elderly Community MH	833,658
Accommodation/Admin & Others	797,808
TOTAL - HEALTH	**30,107,094**
TOTAL - ALL	**62,166,094**

5. Summary of key outcomes/outputs achieved through current resources

West Dunbartonshire Community Health and Care Partnership is an integrated and devolved service which brings Community Health and Social Work together as a single organisation co-owned by its partners NHS Greater Glasgow and Clyde and West Dunbartonshire Council. The partnership formally began in October 2010 but was built on a history of joint planning, joint working and joint service development with internal stakeholders and the Acute Sector of the NHS and 3rd and Independent Sector partners.

1. Facilitating Discharge

Improved Delayed Discharge Performance
Reduced Length of Stay in acute hospital settings
Joint discharge planning process
Homecare Discharge Team
Step down provision

2. Avoiding Admission

Increase in telecare provision
Early development of "at risk" registers using predictive model as a prelude to the development of anticipatory care.
Step up provision
Long Term Conditions – integrated care packages with General Practice

3. Maintaining Older People at Home or in a Homely Setting

Augmented home Care
Increased respite capacity
Joint Care Management protocols established
Domiciliary Rehabilitation
Extra Care Housing

4. End of Life Care

Introduction of Liverpool Care Pathway
Training for Care Home staff on End of Life Care

5. Co-Production, Education and Training

Increase in Self Directed Support and Supported Self Care
Carers Information Strategy – a partnership with Carers of West Dunbartonshire, CSV, British Lung Foundation, Diabetes UK and McMillan
Local Authority-Wide consultation on Older Peoples Services agreed and in preparation
Work with housing colleagues on sustainable housing solutions.
Develop our Social Enterprise capability particularly in partnership with Local Older Peoples organisations and Local Housing Associations
Joint training with 3rd and Independent Sector Partners, Social Work and Health
Jointly fund dementia support with Alzheimers Scotland

6. Key changes to achieve over the next 5 years

1. Facilitating Discharge

Although West Dunbartonshire's performance in reducing Delayed Discharges has improved considerably there remains considerable scope for further work (see table 3 below). A key change will be to reduce bed days consumed for all older adults by improving our discharge processes and by reducing unnecessary admissions and re-admissions.

Table 3
West Dunbartonshire Delayed Discharge patients >65 to Acute Hospitals 2009/10

	65- 74 years	75+ years	85+ years
No of Delayed Discharges	26	134	160
DDs per 1000 pop	3.3	19.7	10.8
DD Bed Days consumed	1103	5380	6483
DD Ave Stay	42.4	40.1	40.5
DD Bed Day Rate/1000 pop	139	790	439
% patients delayed	2.1	6.1	4.6

In particular our performance in relation to Adults with Incapacity (Table 4) could be improved and the addition of Mental Health Officer capacity will support clients and families in this category. It will also contribute to early intervention in partnership with our Community Older Peoples teams to avoiding admission.

Table 4
West Dunbartonshire Delayed Discharge AWI > Acute Hospitals 2009/10

	65- 74 years	75+ years	85+ years
No of AWI DDs	1	6	7
AWI DDs/1000pop	0.1	0.9	0.5
AWI DD Bed Days consumed	134	429	563
AWI DD Ave Stay - Days	134	71.5	80.4
AWI DD Bed Day Rate/1000pop	16.9	63	38.1

Our key changes will be to reduce the number of bed days lost to delayed discharge particularly through application under AWI. Facilitate early safe discharge from hospital and avoid unnecessary hospital admissions/readmission through the provision of targeted rehabilitation programmes. Extend supported discharge provision in partnership with local General Practice. Improve patient/client pathways and continuity of care by embedding a care management culture and processes into joint health and social work practice. Implementation of targeted medication review e.g. for patients with long term conditions, dementia etc.

2. Avoiding Admission

Table 5 below shows the number of patients admitted as an emergency in 2009/10 and we will target a reduction in this number. Our key changes will include; an increase in our anticipatory care planning and introducing Multi Disciplinary Team (MDT) anticipatory care plans; identification of at risk patients and clients using a predictive model and local intelligence and providing alternatives to care for this group; Improving our management of Long Term Conditions particularly those which impact most on emergency admissions such as Diabetes and COPD; provide improved out of hours care by developing neighbourhood teams which bring together community based resources from housing health and social work and provide a single point of access; work with the Care Home Sector to provide alternatives to admission such as nurse led or step up beds. We will increase our support to carers.

Table 5
West Dunbartonshire patients >65 admitted as emergency admissions (2009/10)

	65 -74	75 plus	85 and over
No Emergency Admissions	**1460**	**2527**	**3987**
Admissions per 1000 pop	**184**	**371**	**270**
Bed days	**14492**	**38440**	**52932**
Ave Stay	**9.9**	**15.2**	**13.3**
Bed Day rate/1000 pop	**1824**	**5641**	**3586**

3. Maintaining Older people at Home or in a Homely Setting

Care Home Provision

The demographic picture for West Dunbartonshire shows a relatively flat trajectory in the numbers of older people to 2014 and in line with the rest of Scotland an increase in the elderly population thereafter (see table 1). In order to reduce the number of bed days lost to delayed discharges we will increase our placement activity by 20% in years 1, 2 and 3 in order that we can manage the increased demand which we expect from 2014. We anticipate that we will have increased the proportion of our population living in non institutional settings by 30% and that by then we will be able to maintain our current level of activity.

Reablement

We intend to invest in this model of care to maximise independence of clients, to provide minimum intervention to enable people to stay at home and reprovide this activity to those people with complex care needs living at home.

Integrated Community Older Peoples Service

We intend to enhance our capacity to assess, care manage and provide rehabilitation to older people living at home. We will build on our Community Older Peoples Teams to support more older people to live at home, provide rapid access to aids and equipment and ensure appropriate home supports. These teams will link closely with our Primary Care

Dementia Service, Supported Discharge Team and Reablement Team. They will link with our Out of Hours Neighbourhood Services to provide access to 24 hour support. These teams will be linked to Community Consultants in Older Peoples Medicine and Psychiatry. Key changes will be a greater number of older people supported in their own homes.

Respite

We will use respite care as an integral part of early intervention and anticipatory care and increase the respite options available.

Housing

We are working with Housing colleagues to ensure that the Local Housing Strategy takes account of the needs of older people and the demographic challenges facing the Council in the years ahead.

4. End of Life Care

Within West Dunbartonshire, an individual is more likely to die in hospital than at home, in a hospice or a care home. Evidence indicates this is as a result of unnecessary/inappropriate admissions, exacerbated by lack of local access to Palliative Care hospice beds and a lack of community based specialist support. We will increase the proportion of patients who die at home including in Care Homes. We intend to reduce hospital admissions from care homes.

Table 6
Proportion of Cancer Deaths and Non Cancer Occurring at Hospital, Care Home, Hospice and Own Home in West Dunbartonshire. (GG&C HNA Palliative Care 2009)

Hospital		Care Home		Hospice		Own Home	
Cancer	Non Cancer	Cancer	Non Cancer	Cancer	Non Cancer	Cancer	Non Cancer
52.2	60.1	3.7	12.5	16.8	1.8	26.9	25.3

5. Co-Production, Education and Training

Co-production is a philosophy of partnership and the practitioner or paid carer with the person cared for and those close to them (COSLA 2010). Our aim will be to ensure this partnership develops in our ways of working with individuals including an outcomes focussed and shared approach to assessment and care planning. We also want to use this philosophy to sponsor social enterprise work with our 3rd Sector partners to provide supports which can maintain people at home as independently as possible.
We have undertaken significant work with our Long Term Conditions collaborative partners and intend to increase our delivery of supported self care with our current partners such as the British Lung Foundation, Alzheimer's Scotland. Diabetes UK, Asthma UK.

7. Use of Change Fund and outcomes anticipated

1. Facilitating Discharge

i) Delayed Discharge

We intend to enhance our supported discharge activity by introducing additional capacity to work the discharge process.

We intend to reorganise into an integrated and multi-disciplinary Social Work and Health team providing a service to our partners in Acute Care and Mental Health.

- The team will integrate the hospital based service (devolved to the CHCP) with additional rehabilitation staff and additional Mental Health Officer capacity. The team will manage the transition from the hospital setting to community, ensure that we maximise the opportunity for independent living and enable transition to other care settings when necessary.

- It will offer additional physical rehabilitation, liaison with families and link directly to the Reablement Service(7.3.3) and to the Primary Care Dementia Service(7.3.1) for ongoing case management where necessary.

- It will increase supported discharge capacity to include EMI with the appointment of MHO's with a prime responsibly for assessment, preparation of reports specifically relating to older people within a hospital setting and who are without capacity.

- Include medication review to increase knowledge and adherence in patients and carers. Medication review is effective in reducing hospital admission (Ref 1 2 3 4). Problems with the ability of patients to independently manage their medication can be responsible for delayed discharges and emergency re-admission.

- Fund 4 additional Step Up, Step Down beds in partnership with the independent sector to provide an opportunity to maximise rehabilitation potential. These beds will be accessed by protocol by the Discharge Support Team, will have a maximum stay of four weeks and be used to deliver reablement and rehabilitation.

- The Discharge Support Service will operate seven days a week.

Expected Outcomes

We have a number of targets for delayed discharge, these are:-

- Reduce the number of bed days consumed by patients ready for discharge by 50% in the first full year of change fund spending.
- Where patients are delayed we want to will reduce the average length of time they are delayed to 35 days.
- Reduce failed discharges due to fragmented care, improve pathways and access to

rehabilitation to support discharge and we will introduce target milestones for AWI process and ensure we meet them.

- Reduction in bed days because of readmission/admission through increased independence of client/patient as a result rehabilitation programmes and supported discharge.

Table 7
West Dunbartonshire Delayed Discharge patients >65 in Acute Hospitals 2009/10 and target for reduction in 2011/12 and by 2014

	65- 74 years			75+ years			85+ years		
	09/10	11/12	2014	09/10	11/12	2014	09/10	11/12	2014
No of Delayed Discharges	26	15	14	134	76	66	160	92	80
DDs per 1000 pop	3.3			19.7			10.8		
DD Bed Days consumed	1103	550	490	5380	2690	2310	6483	3240	2800
DD Ave Stay	42.4	35	35	40.1	35	35	40.5	35	35
DD Bed Day Rate/1000 pop	139			790			439		
% patients delayed	2.1			6.1			4.6		

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Table 8
West Dunbartonshire Delayed Discharge AWI >65 in Acute Hospitals 2009/10 and target for reduction 2011/12 and by 2014

	65- 74 years			75+ years			85+ years		
	09/10	11/12	2014	09/10	11/12	2014	09/10	11/12	2014
No of AWI DDs	1	0	0	6	3	3	7	4	3
AWI DDs/1000pop	0.1			0.9			0.5		
AWI DD Bed Days consumed	134	0	0	429	215	86	563	280	226
AWI DD Ave Stay - Days	134			71.5			80.4		
AWI DD Bed Day Rate/1000pop	16.9			63			38.1		

Change Fund Investment

	Yr 1 PYE	Yr 2 FYE	Yr 3 FYE	Yr 4 FYE
Additional Investment £000 Staff/Costs	120	240	240	240

ii) Care Home and Home Care Provision

In order to meet our targets to shift the balance of care in the first years of the plan we will need to purchase additional care home places and additional support to clients transferred to Sheltered Housing, Extra Care housing and home with high packages of care. We anticipate that the trajectory of placements will peak in the first years of the Change Fund and level out thereafter as we maintain a steady rate.

Expected Outcomes

- Provide a minimum of 10 additional packages of care year on year to 2014
- Support the reduction of Delayed Discharges by 20% year on year to 2014

Change Fund Investment

Additional Investment £000s	Year 1 PYE	Year 2 FYE	Year 3 FYE	Year 4 FYE
	250	250	250	250

2. Avoiding Admission

i) Anticipatory Care

There are a number of ways to identify patients who may be at high risk of future emergency hospital admissions of failures of care packeages which lead to emergency admission to respite or care home. There is evidence that integrated disease management models can reduce emergency admissions and length of stay. There are significant benefits for chronic conditions such as COPD (Salford, Runcorn, Torbay). We intend to use 2 forms of anticipatory care planning

– threshold modelling which identifies those at high risk based on a defined set of criteria including factors such as being housebound, polypharmacy, cognitive impairment and living alone. We have used this as part of out winter planning model and it has been successful in ensuring that care mangers include forward planning with clients and carers. and
-we will also seek to use a predictive modelling tool.

Together these will populate an “at risk register” managed by our current Community Older Peoples team. We will deliver this in partnership with colleagues in General Practice. Identified patients/clients will have an anticipatory care plan which will include alternatives to admission. Out of Hours colleagues will have access to these plans. We intend to commission short term care home admission to nurse led beds and commission this capacity from independent sector partners.

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Long Term Conditions

We have developed services for patients with COPD and Diabetes (high risk for admission NHS GG&C). These include additional support such as Dietetics, Income Maximisation, linked programmes delivered by 3rd Sector, patient education to support self care, carers

support, care management and assessment. We propose continued development of such services linked to General Practice and to mainstream this model of care.

Expected Outcomes

- Identify a cohort of clients/patients at high risk of admission or failure of care package and develop alternatives to admission.
- Plan rapid response and alternative choices on behalf of at risk clients

The HEAT Target states

- Reduce the Need for Emergency Hospital Care - NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.

Using baseline information we will agree a target for

- Reduction in emergency admissions for patients with COPD and Diabetes.

- Percentage of people aged 65plus admitted twice or more as an emergency

- Number of older people admitted twice or more, as emergency, who have not had an assessment

Table 9
West Dunbartonshire patients >65 admitted as emergency admissions 2009/10 target for reduction by 2014

	65 -74		75 plus		85 and over	
	2009/10	2014	2009/10	2014	2009/10	2014
No Emergency Admissions	1460		2527		3987	
Admissions per 1000 pop	184		371		270	
Bed days	14492		38440		52932	
Ave Stay	9.9		15.2		13.3	
Bed Day rate/1000 pop	1824		5641		3586	

Change Fund Investment

	Yr 1 PYE	Yr 2 FYE	Yr 3 FYE	Yr 4 FYE
Additional Investment £000	50	104	104	104

ii) Out of Hours Care

Out of Hours services in West Dunbartonshire are currently fragmented and do not support alternatives to admission. The evidence (Kings Fund 2010) indicates that primary care provision is a factor in determining avoidable admissions. We will manage Out of Hours Nursing, Home Care, Sheltered Housing, Care Homes, and Mobile Attendants as a coherent network, based around neighbourhood teams. We will provide accessible options to General Practice and Social Work colleagues for clients who require rapid response, nursing and care at home provision by providing a single point of contact.

Expected Outcomes

- Provide alternatives to admission.
- Provide Rapid Response Out of Hours
- Develop Neighbourhood Services
- Integrate Social Work and Health Out of Hours provision

Change Fund Investment

Additional Investment £000s	Year 1 PYE	Year 2 FYE	Year 3 FYE	Year 4 FYE
	10	20	20	20

We will deliver this service within existing resources although we will require additional administrative support, to co-ordinate the service

iii) Rapid Geriatric Assessment

- We intend to develop formal link with DME by providing direct link between Community Older Peoples Teams and access to rapid geriatric assessment and consultant support and advice. There is clear evidence that early geriatric assessment impacts positively on subsequent care.
- agree partnership with DME for two additional sessions of community consultant time
- Integrated community older peoples teams will provide rapid assessment of rehabilitation potential. Deliver rehabilitation intervention and provide support to maintain at home and avoid unnecessary admission to hospital.
- Rapid access to augmented home care provision.

Expected Outcomes

- Rapid multi disciplinary assessment
- Early intervention by multi disciplinary teams
- Access to rapid home based rehabilitation and equipment

Change Fund Investment

Additional Investment £000s	Yr 1 PYE	Yr 2 FYE	Yr 3 FYE	Yr 4 FYE
	12	24	24	24

3. Maintaining Older People at Home or in Homely Setting

i) Primary Care Dementia Service

Currently 7.2% of people over 65 within West Dunbartonshire will have Dementia. As our population increases and ages this is projected to increase by 75% by 2031 (The Dementia Epidemic, 2011).

During 2010 60% of admissions to the Dementia assessment unit were from other care settings, primarily care homes or acute hospital beds and 65% of discharges during 2010 were to care homes. The average length of stay was 134 days. The number of available beds will reduce following the review of Older Peoples Mental Health Inpatient beds and therefore a target reduction in the numbers of patients is hard to predict. We will however aim to reduce the average length of stay to 96 days.(see table 10)
This model of provision aims to prevent unnecessary admissions,reduce the average length of stay facilitate earlier supported discharge in partnership with the Supported Discharge Team. which evidence shows that as the Dementia progresses fewer people need care homes and reported recently by the Department of Health “Carer support and counselling at diagnosis stage can reduce care home placements by 28%”. (Transferring the Quality of Dementia Care 2008).

The continued Case Management of people with Dementia and complex care needs within care home settings often inappropriately falls to the care home. With the prevalence of Dementia set to rise within care home settings and people being discharged from acute settings, the continued case management of people with Dementia who have more complex care needs would be best managed through an Integrated Primary Care Dementia service which can support care homes and patients with dementia living at home.

In support of the HEAT Target to improve early diagnosis of dementia we will also work with Alzheimer’s Scotland to recruit a local dementia adviser. In year 1 we will match fund their contribution to provide support to patients, their carers and to health and social care staff. The post will support early diagnosis of dementia and diagnosis in primary care and will provide education and training to staff.

Table 10
West Dunbartonshire Patients >65 in Psychiatric Beds 2009/10 and target for reduction in average stay in2011/12 and by 2014

	65-74 years			75+ years			85+ years		
	09/10	11/12	2014	09/10	11/12	2014	09/10	11/12	2014
Patients (No)	24			62			86		
Patients/1000 population	3			9.1			5.8		
Bed days consumed	3650			8667			12317		
Average stay (days)	152	130	96	140	130	96	143	130	96
Bed Day Rate/1000 Population	459			1272			834		

The team will move existing medical models of liaison towards partnership working, where the person with Dementia in a care home, in the community or acute hospital bed can receive timely assessments and ongoing care management which meets their health and

social care needs and to draw on the local community supports available for the person and their family/carers. The team will work closely with Discharge Support Service, Community Elderly Mental Health Teams, Care Homes and primary care to deliver a case management service for dementia clients and their carers and who are currently not managed by traditional mental health specialist services.
This model is supported by Reshaping Care Logic Model Annex E (2010) that reducing the need for emergency hospital care and reductions in emergency inpatient bed day rates for 75+ can be achieved by improvements in partnership working between acute/primary and Community care sectors and delayed discharge is an existing HEAT target where there is cevidence demonstrating that discharge planning is essential to facilitate earlier discharge.

Table 11
West Dunbartonshire Delayed Discharge patients in Psychiatric Beds 2009/10 and targets for reduction in 2011/12 and by 2014

	65-74years			75+ years			85+ years		
	09/10	11/12	2014	09/10	11/12	2014	09/10	11/12	2014
No of EMI DDs	3	3	1	11	9	6	14	10	7
EMI DD/1000 Population	0.4			1.6			0.9		
DD Bed Days Consumed	103		34	726	654	396	829	590	413
Average Stay (Days)	34	34		66			59		
Bed Day Rate/1000 Population	13			107			56		
% Patients Delayed	13			18			16		

Expected Outcomes

- Reduce the numbers of patients with delayed discharge by 20% year on year by 2014 (see table 11).
- Reduce bed days consumed to 843 from 1658.
- Reduce the average length of stay to 96 days.
- Support people for longer in their own homes, through earlier interventions. Reduce Bed Days by preventing admission.
- Introduce roving clinics within care homes to provide easy access to specialist help and advice for people with Dementia and support the care home with providing the appropriate type of care.
- Reduce the stress experienced by families, improve chronic disease management for the patient, improve health outcomes e.g. dietary needs
- Facilitate earlier discharge from hospital.
- Work with the Discharge Support Team to co-ordinate a discharge plan which will allow for an earlier discharge with the right supports in place.
- Support care homes to feel more confident to manage people with more complex care needs associated with an advancing Dementia.
- Provide on-going care management and regular reviews. Develop care plans.
- Staff in care homes will receive training and support.
- Case manage Older People with complex dementia.
- Increase length of stay at home
- Link to supported discharge team to ensure successful transition

Change Fund Investment

Additional Investment £000s	Yr 1 PYE	Yr2 FYE	Yr3 FYE	Yr4 FYE
	50	108	108	108
Match Funding (in Partnership with Alzheimers Scotland)	25	0	0	0
Total	75	108	108	108

ii) Respite

In 2009-10, the total number of respite weeks provided in West Dunbartonshire rose slightly to 3815, an increase of 321 weeks on the previous year. There was a 14.89% increase in the level of daytime respite and a 20.48% reduction in the level of overnight respite. This rise in respite provision is in excess of the target set by the Scottish Government in July 2008 with its additional monies for respite initiative. Following "**Caring Together"** the Carers Strategy for Scotland and in support of the West Dunbartonshire Carer's Improvement Plan and the National and Talking Points Outcomes for Carers we intend to make respite provision more accessible.

We intend to establish a bureau model (Falkirk) for older peoples respite services will enable direct access and the better coordination and take up of existing respite and step up/ step down opportunities as well as the development of new arrangements which can be more flexible and responsive to peoples' needs. In particular it will provide an out of hours service to support emergency access to respite and step up services where a client's or a carer's needs are urgent. The service will work closely with Out of Hours services. This service will build on the current partnership for provision which we already have for Learning Disability Servcies with Quarriers and a relatively low level of inverstment will have a significant impact

Expected Outcomes

- We will reduce "failure costs" by improving co-ordination and allocation of respite which will allow us to fund
- An increase in the number of respite weeks provided by 20%
- Increase the level of self directed support for respite by 10%
- Provide better access to out of hours and short break respite
- Link to our Primary Care Dementia Service, our Community Older Peoples Team and our Out of Hours Services.

We also intend to increase the percentage of carers who feel supported and able to continue their role as a carer and also increase the percentage of carers satisfied with their involvement in their health and social care package.

Change Fund Investment

Additional Investment £000s	Yr 1 PYE	Yr2 FYE	Yr3 FYE	Yr4 FYE
	30	70	70	70

iii) Reablement

Home care reablement provision in England and Scotland has accumulated compelling evidence indicating that the approach improves confidence, motivation, empowerment, choice and maximises independence for clients. Shifting the balance of care requires approaches that can maximise independence and enable people to develop skills to remain safely in their own home. We intend to establish a Home Care Reablement team which changes the culture of Home Care from task and time to better outcomes, maximises clients long term independence and quality of life and appropriately minimises support reducing the whole life cost of care. We anticipate that because clients need less care hours at the end of reablement than they would have received from a traditional home care service, the care hours available can be used to meet the demand for home care from an increasing number of older people. West Dunbartonshire has a relatively stable over 65 population until 2014. Thereafter we expect an exponential increase in older people and in those who are very elderly with a proportionate rise in those with very complex needs including those with Dementia. The reablement team will link closely with our Supported Discharge Team and our Community Older Peoples Team. In addition to the Home Care and Occupational Therapy staff we will recruit a pharmacy technician managed from our prescribing service to provide compliance support and to liaise with community pharmacy.

We will use Change Fund to pump prime a shift from low intervention clients to high needs clients to meet the changing demographic picture. Using the Edinburgh costing model we have reviewed our current expenditure and intend to match fund Change Fund investment with resources redirected from our current Home Care provision (see Annexe B) We do not believe that the level of reablement gain will match that of the Edinburgh experience but if 20% of clients can be reabled we anticipate releasing £300k for redirection to the increasing number of complex clients being cared for at home.

Expected Outcomes

- Work with assessment and care management/ community nursing/ allied health professionals to establish and outcomes approach using goal setting rather than time and task. The approach fits well with the Talking Points outcomes approach.
- Re-invest the savings benefits of reablement to meet the needs resulting from the growth in older people.(see Annex B)
- Continue to develop appropriate medication-related education and training for WDC Home Care staff.
- Reduction in bed days in relation to discharge
- Reduction in re-admissions
- Increased capacity and throughput
- Contribute to our Anticipatory care planning approach
- Increase appropriate use of Telecare and Step Up, Step Down provision
- Introduce Day Care Reablement and reablement in short term care home placements
- Provide a focus for volunteer input – eating with clients, Macmillan volunteers, Care & Repair

Change Fund Investment

Additional Investment £000s	Yr 1 PYE	Yr 2 FYE	Yr 3 FYE	Yr 4 FYE
	168	268	268	268
Pharmacy	20	40	40	40
Total	188	308	308	308

iv) Housing

A key priority for us is to develop alternative settings in which to house older people which maximises their independence and their ability to live at home for as long as possible.

There are currently 609 registered residential care places provided within the West Dunbartonshire Council area. The balance of care between Council-run and purchased places shows that there are 414 registered places in private and voluntary sector residential care provision in West Dunbartonshire and 195 registered places in Council-run provision.
The Council currently provides residential care for around 599 older people in both Council -run care homes and through the purchase of residential care from the private and voluntary sectors. Our Best Value Review proposes that new extra care housing provision should be developed.

Our Local Housing strategy will

- Develop plans for new and refurbished Housing
- Develop Services at Points of Transition
- Provide preventative interventions and supports

Expected Outcomes

- Undertake waiting list initiative in Year 1 to reduce waits for OT assessment and aids and adaptations
- Commission new models of care at home such as extra care housing
- Work with 3rd Sector and Local Housing Associations to develop Social Enterprise models which provide services to older people by older people provide investment in year 1

Change Fund Investment

		Yr 1 PYE	Yr 2 FYE	Yr 3 FYE	Yr 4 FYE
Additional Investment £000	Social Enterprise Seed Funding	50	-	-	-
	Waiting List Initiative OT and Aids and Adaptations	200	-	-	-

4. End of Life Care

i) Palliative Care

In West Dunbartonshire you are more likely to die in hospital than at home, including Care Homes (see table 12 NHS GG&C Health Needs Assessment 2009). The evidence indicates this is a result of unnecessary/inappropriate admissions. In partnership with Acute Sector partners we will improve palliative care provision by increasing the available palliative care beds and by providing additional Community Palliative Specialist Nurse resource. The use of a Palliative CARE Register within GP practices and the rollout of the LCP have improved the ACP of Palliative Care Management.The Health Needs Assessment recommends the introduction of a consistent model of care specifically within Care Home Setting.

- Introduce a Community Specialist Palliative Care Nurse Service
- The key to providing appropriate palliative and end of life care is first of all to identify those likely to benefit from it.
- Ensure each patient with Palliative Care needs is held on Palliative Care Register within each GP Practice.
- Using the Liverpool Care Pathway and the Gold Standards Framework reduce the proportion of people within West Dunbartonshire dying in hospital.
- Provide home based care
- Introduce Supportive and Palliative Action Register (SPAR) to provide a tool to aid the identification of cancer and non-cancer patients entering a palliative phase
- Enhance training for care home and home care staff
- Increase the level of carer support plans and support (see 6 i)

Expected Outcomes

- Improved care for residents within care homes.
- Provide education and training available to all staff within the care home.
- Co-ordinate support for residents with complex needs including access to specialist palliative care nursing,
- Improved the patient pathway at the point of diagnosis and approaching end of life care
- Improve support for carers
- Achieve a 20% decrease in the number of palliative care patients dying in hospital (see table 12)

Table 12
Target Reduction in the Proportion of Cancer Deaths and Non Cancer Deaths Occurring in Hospital in West Dunbartonshire. (GG&C HNA Palliative Care)

Hospital		Care Home		Hospice		Own Home	
2009/10		2009/10		2009/10		2009/10	
Cancer	Non Cancer	Cancer	Non Cancer	Cancer	Non Cancer	Cancer	Non Cancer
52.2%	60.1%	3.7%	12.5%	16.8%	1.8%	26.9%	25.3%
2014		2014		2014		2014	
40%	48%	-	-	-	-	-	-

Change Fund Investment

Additional Investment £000s	Yr 1 PYE	Yr 2 FYE	Yr 3 FYE	Yr 4 FYE
	30	78	78	78

5. Co-Production

i) Carers Development

We will align the development of supported self and carer's support by sponsoring a collaborative project bringing together our investment from the Carers Information Strategy, Long Term Conditions Funding and the Change Fund.

Expected Outcomes

- Raise awareness of staff employed across West Dunbartonshire CHCP of carers needs, the role carers play in supporting self care particularly in areas of Diabetes, COPD, Stroke, and Dementia.
- Develop and support the current workforce in a multi disciplinary approach to targeted health care improvement
- Increase our provision of self directed care
- Continue to work with McMillan, Carers of West Dunbartonshire to deliver training and education for patients and carers with long term conditions.

Change Fund Investment

Additional Investment £000s	Yr 1 PYE	Yr 2 FYE	Yr 3 FYE	Yr 4 FYE
Training and education	20	7	7	7
Supported self care	20	-	-	-
LTC and CIS	40	40	40	40
Total	80	47	47	47

8. Key performance measures to assess progress

1. Facilitating Discharge

Frail Elderly (Table 7) AWI (Table 8)	• Reduce the number of bed days consumed by patients ready for discharge by 50% in the first full year of change fund spending. Where patients are delayed we want to will reduce the average length of time they are delayed to 35 days.
EMI (Table 11	Reduce the number of patients subject to Delayed Discharge in OPMH inpatient settings by 20% year on year to 2014 Reduce Bed Days consumed by DD by 50% by 2014
Care Packages	Increase Packages or Placements by an additional 10 and reinvest decrement to fund additional packages

2. Avoiding Admission

Develop at Risk Register – target n50 in 11/12 and additional 50 year on year to 2014
At Risk Clients with MDT anticipatory care plan 100% by 2014
Reduce emergency admissions out of hours to 25% of all admissions from 35%
Reduce emergency admission of older patients with COPD and Diabetes
Integrate OOH services by 2012
Reduce waiting times for allocation and assessment

3. Maintaining People at home or in a Homely Setting

Provide Dementia care support to all West Dunbartonshire Care Homes
Reduce average length of stay in EMI beds to 96 days by 2014
Reduce the percentage of admissions and re-admissions from local care home settings for people with Dementia
Provide reablement to all clients discharged home
All new clients with <10 hours of home care will be in receipt of a reablement programme
Increase *available* respite weeks by 20%
Increase the level of self directed support for respite by 10%
Develop Extra Care Housing as part of Local Housing Strategy

4. End of Life Care

Reduce the numbers of palliative care patients dying in hospital by 20%

5. Co-production

Increase the number of clients in receipt of supported self care packages by 20% by 2014.
Increase in self directed care by 20% by 2014.

9. Summary of how Change Fund will enable shifts in core budgets and impact on the totality of spend by the partnership over the next 5 years

The fund will further support primary and community health and care services to deliver integrated solutions to support service users to live as independently as possible. We intend to increase the proportion of care provided by the independent sector within our mainstream budgets subject to our current competitiveness reviews and Council approval in addition to the figures applied to the Change Fund Plan.

We plan to deliver a reduction in bed days lost to delayed discharge, by shifting activity to community settings. We have used 2009/10 outturn figures to set our targets but we will review this when the full year figures are available for 2011/12 and we will deliver our targets proportionately.

Within community settings we intend to maximise the number of clients supported to manage their health and live as independently as possible. We will do this by improving our capacity to assess, care manage, rehabilitate, educate and reable service users. We will provide additional support to manage change or crisis by enhancing our Out of Hours and Rapid Response provision. We will use Change Fund investment to realign our expenditure to meet the needs of a growing and complex cohort of service users by reinvesting from redesign in Home Care.

We will work with 3rd Sector and Independent Sector partners to develop new models of care. We will develop housing strategies which meet the changing needs of our population.

We are currently reviewing with our partners and as part of our consultation on Older Peoples Services how we contribute to the development of Social Enterprise models.

Total Change Fund Investment

	2011/12	2012/13	2013/14	2014/15
Proposal	£000	£000	£000	£000
Delayed Discharge	100	240	240	240
Increased Care Package Provision	250	250	250	250
Aids and Adaptations	200	-	-	-
Anticipatory Care	75	104	104	104
Early Geriatric Assessment	12	24	24	24
Out of Hours	10	20	20	20
Primary Care Dementia Service	100 (25)	108	108	108
Respite*	30	70	70	70
Reablement	200	308	308	308
End of Life Care	42	78	78	78
Co-production and Supported Self Care	20	-	-	-
Social Enterprise	50	-	-	-
Training and Education	20	7	7	7
Total	1209	1209	1209	1209

Full year effect – expenditure by sector

Change Fund	Community Health	Community Care	Independent Sector	3rd Sector	Housing and Social Enterprise

£1,209,000	£441,000	£571,000	£100,000	£97,000*	TBA

We anticipate a significant lead time in year 1 before new services are recruited to and we intend to use change funding to pump prime service change and development such as developing social enterprise model for community supports, aligning with other strategies such as Carer's Information strategy and Long Term Conditions strategy. We will also invest in one off expenditure such as waiting lists to ensure that we can maximise the benefit of the fund.

Part Year effect – expenditure by sector Year 1

Change Fund	Community Health	Community Care	Independent Sector	3rd Sector	Housing and Social Enterprise
£1,209,000	£272,000	£735,000	£75,000	£77,000*	£50

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10. Indicate the financial mechanism and governance framework

A Change Fund Implementation Group will report to the Older Peoples Strategy Group and to the CHCP Committee which is a sub-committee of both West Dunbartonshire Council and Greater Glasgow and Clyde NHS Board. The Older Peoples Strategy Group includes professional stakeholders and service users and carers.
The Fund will be managed by West Dunbartonshire Community Health and Care Partnership

11.Support requirements to assist delivery

The partnership will welcome continuing support from the Joint improvement Team.

This plan has been prepared and agreed by the NHS, Council, Third Sector and Independent Sector interests.

Signed

Annexe A

3rd Sector	Selena Ross Drena O'Malley Colin Williams Jan Johnson John Spiers Fiona Sandford Kathleen Donnelly Kim McNab Maddy Halliday	Manager WD CVS Resources Manager, Deafblind Scotland Chair, Carers of West Dunbartonshire Area Manager, Alzheimers Scotland Deaf Connections Visibility Capability Scotland Carers of West Dunbartonshire Stroke Association
Private Sector	Anna Houston Charles Young Helen Turnbull Martine Clark John Kennedy Moraig Kennedy Gloria McLachlan Dennis McGlennor Ann Don Kenny Valentine Linda McElroy	Managing Director, Scottish Care & Carewatch Scottish Care Strathleven Home Edinbarnet Nursing Home Assured Care (Scotland) Ltd Assured Care (Scotland) Ltd Scottish Care Carers Direct Carers Direct BUPA Sunningdale Care Home
Carers		West Dunbartonshire Carers Strategy Group West Dunbartonshire Older Peoples Strategy Group

Reablement Costings

4 weeks at 10 hours per client, 11 new clients per week

Number of FTEs required	21.8	Equals	805.75	Hours

				PAY			DIRECT COSTS OVERHEAD BUILD-UP		INDIRECT COSTS - OVERHEAD BUILD-U			
	Hours	Hourly rate	Weekly Total	Salary	Superannation and National Insurance	Over time	Training, Supplies, & Travel	Assest Rental Cars	SW Management Costs	Central Support Allocation	Insurance	Total
Number of hours at Grade 4	805.75	£9.95	£8,017.22	£416,895.43	£59,490.98		£18,016.59	£1,675.96	£10,055.77	£12,569.71	£3,770.91	£522,475.35
Minus Home Carer Hours funded from existing resources at Grade 3 ***SW***	**-530**	**£8.96**	**-£4,748.80**	**-£246,937.60**	**-£35,238.00**		**-£11,850.80**	**-£1,102.40**	**-£6,614.40**	**-£8,268.00**	**-£2,480.40**	**-£312,491.60**
Difference				**£169,957.83**	**£24,252.98**	**£0.00**	**£6,165.79**	**£573.56**	**£3,441.37**	**£4,301.71**	**£1,290.51**	**£209,983.76**

	Hours	Hourly rate	Weekly Total	Salary	Superannation and National Insurance	Travel	Total
Occupational Therapists X 2	70	£15.56	£1,089.20	£56,638.40	£9,872.07	£2,831.92	£69,342.39
Minus 1 Occupational Therapist post funded from current resources (Community, RAD?) ***SW or NHS***	**-35**	**£15.56**	**-£544.60**	**-£28,319.20**	**-£4,936.04**	**-£1,415.96**	**-£34,671.20**
Admin X 2	70	£8.96	£627.20	£32,614.40	£5,684.69	£0.00	£38,299.09
Minus Admin funded from existing resources at Grade 3 ***SW***	**-27**	**£8.96**	**-£241.92**	**-£12,579.84**	**-£2,192.67**	**£0.00**	**-£14,772.51**
Home Help Organiser X 2	70	£14.01	£980.70	£50,996.40	£8,888.67	£2,549.82	£62,434.89
Minus 2 X Home Help Organiser posts funded from existing resources at Grade 6 ***SW***	**-70**	**£14.01**	**-£980.70**	**-£50,996.40**	**-£8,888.67**	**-£2,549.82**	**-£62,434.89**
Difference				**£48,353.76**	**£8,428.06**	**£1,415.96**	**£58,197.78**

Summary		
Cost of Service	Existing Resources	Change Fund Contribution
£522,475.35		
	-£312,491.60	**£209,983.76**
£69,342.39		
	-£34,671.20	**£34,671.20**
£38,299.09		
	-£14,772.51	**£23,526.58**
£62,434.89		
	-£62,434.89	
£692,551.73	**-£424,370.19**	**£268,181.54**

Cost	£692,551.73
Minus existing resources	**-£424,370.19**
Total	**£268,181.54**