Appendix 1

West Dunbartonshire
Community Health & Care Partnership

West Dunbartonshire Community Health and Care Partnership

Reshaping Care for Older People

Change Fund Plan

2012/13

Introduction

Our updated plan reflects the outcome of our review of change plan activity so far and proposes continued or increased investment for subsequent years, a refinement of planned activity and continuity to ensure that we have tested our year 1 proposals fully.

The plan reflects delays in establishing some key parts of the plan and shows additional non-recurrent investment from a carry forward (£80k) and additional non recurring funding from West Dunbartonshire Council (£360k). The Councils additional funding is provided to develop local 3rd sector services, continue to reduce our waiting times for OT assessment and Aids and Adaptations. It will also provide funding to continue our work with Alzheimer Scotland and to increase our respite provision.

The plan has been reconfigured to reflect the Reshaping Care Pathway model.
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.

We work closely with Carers of West Dunbartonshire and are committed to carers and their right to recognition and support

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.

Core elements of the Plan for 2012/13 include proposals that accelerate the expected reductions in the total number of delayed bed days and position us to achieve the new (interim) national target of a maximum wait of four weeks by 1 April 2013.

Reshaping Care Pathway

1. Preventative and Anticipatory Care

1.1 Anticipatory Care

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. Clear plans provide support and clarity for service users, carers and Health and Social Care staff. Carer's of West Dunbartonshire will realign the anticipated Carer's Strategy funding for 2012/13 to support elements of the Change Fund.

We intend to use two forms of anticipatory care planning

- threshold modelling
- predictive modelling tool.

Long Term Conditions

We propose continued development of such services linked to General Practice and to mainstream this model of care. From our initial work it has become clear that we need to make additional investment in Anticipatory Care for patients in all care settings.

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
- Improve coordination and ensure that information is updated and shared.
- Develop a Local Enhanced Service with General Practice to case find
- Place anticipatory care plans and social care information on e-KIS which will be available to our integrated nursing and social care teams.
- Introduce ACP Nursing team, linked to Out of Hours services.

Change Fund Investment

	2011/2012	2012/13	2013/14	2014/15
Additional Investment £000	50	154	154	154

1.2 Developing Services with the Independent Sector

We have agreed with Scottish Care to fund part time Development Officer to work with independent sector colleagues to develop services and models of care which will meet the needs of our population and fit with our commissioning strategy. In particular we will work with providers to develop their respite, challenging behaviour

and rehabilitation services and continue to provide support to develop staff and service quality.

Expected Outcomes

- Improved liaison with independent sector providers
- Development of capacity in line with changing demand
- Introduce additional respite and rehabilitation options

Change Fund Investment

Change Fund Investment	2011/12	2012/13	2013/14	2014/15
Liaison Officer	-	21	21	21

1.3 Developing Community Capacity

We will develop networked services with WD CVS to build on community capacity in particular befriending services, care and repair, support to carers and increasing awareness. We will invest in developing community directories and in publicising independent and 3rd sector services and groups, in partnership with Carers of West Dunbartonshire. We will seek to develop work in partnership with Alzheimer Scotland. We will measure the impact of this proposal on wider system objectives in collaboration with Carers of West Dunbartonshire and WD CVS.

Expected Outcomes

- Develop a LinkUp service to streamline referrals from and between the 3rd and Independent sectors
- Develop a dedicated helpline number manned by volunteers
- Develop a shared assessment process between key 3rd sector delivery partners
- Develop a shared staff development and training programme
- Develop new social enterprise models based on year 1 research
- Increase referrals to energy schemes by 5%
- Increase benefit applications by 5%
- 20 new older volunteers recruited
- 50 LinkUp contacts per quarter in 2012/13
- Support carers through Carers of West Dunbartonshire and do this in partnership with West Dunbartonshire CVS
- Identify and support more carers

Change Fund Investment

	2011/12	2012/13	2013/14	2014/15
CVS Proposal		114 (WDC)	-	-

2. Proactive Care and Support at Home

2.1 Housing

The new National Housing Strategy seeks to ensure clear strategic leadership about housing priorities for older people. It aims to ensure appropriate information and advice to make informed choices and that older people are assisted to remain in and make best use of existing housing stock. It seeks to invest in new housing which meets the needs of older people and to provide low level preventative support.

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 and nursing 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 and nursing care provision in West Dunbartonshire and 195 registered places in Council-run provision. The Council currently provides residential and nursing 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. We also provide 252 sheltered housing places in addition to 204 tenancies in a range of 3rd and independent sector specialist provision. 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

- Reduce waits for OT assessment and aids and adaptations
- Procure 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 2 with additional monies provided by WDC

Change Fund Investment

		2011/12	2012/13	2013/14	2014/15
Additional Investment £000	Social Enterprise Seed Funding	50	See Section 4	-	-
	Waiting List Initiative OT and Aids and Adaptations	200	160(WDC)	-	-

2.2 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. 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 initiatives.

We intend to establish a bureau model for older peoples respite services. This will enable direct access, improved 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. 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 and link to our Primary Care Dementia Service, our Community Older Peoples Team, Out of Hours Services and independent sector providers.

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. We will increase our investment to provide additional respite availability. In 2012/13 we will also make additional respite available with non recurrent funding made available by WDC.

Expected Outcomes

- Reduce "failure" rate and costs.
- Increase the number of respite weeks provided by 20% and to maintain that level
- Increase the level of self directed support for respite by 10%
- Improve access to out of hours and short break respite
- Improve access and support for carers

Change Fund Investment

Additional Investment	2011/12	2012/13	2013/14	2014/15
(£ £000	30	70	70	70
		60(WDC)		
Total	30	130	70	70

2.3 Primary Care Dementia Service

Currently 7.2% of people over 65 within West Dunbartonshire 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 2). 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.

In support of the HEAT Target to improve early diagnosis of dementia we have worked with Alzheimer Scotland (AS) to recruit a local dementia adviser. In year 1 we match funded their contribution to provide support to patients, their carers and to health and social care staff across all care settings. The post supports early diagnosis of dementia and diagnosis in primary care and provides education and training to staff. We will continue this investment and use the additional funding to develop our partnership with AS and WDCVS to develop social supports for patients with Dementia and their carers.

Expected Outcomes

- Reduce the numbers of patients with delayed discharge by 20% year on year by 2014.
- Reduce the average length of stay to 96 days.
- Link to supported discharge team to ensure successful transition
- Support additional carers in collaboration with Carers of West Dunbartonshire

Table 2 Target for Reduction in EMI Delayed Discharge and Average Length of Stay

	EMI DD Bed Days Lost	Target	Target for Average LOS
2009/10	1140		
2010/11	730		
2011/12		570	96
2012/13		570	96

Change Fund Investment

Additional Investment	2011/12	2012/13	2013/14	2014/15
£000s	50	110	110	108
Partnership with Alzheimer Scotland	25	50 (WDC)		
Total	75	110 (50)	110	108

2.4 Care at Home Provision

We will provide funding for additional complex home care packages to enable older people to remain at home and provide support to carers for longer and this will complement our current investment in telecare.

In years 3 and 4 we will expect to see a shift of resources from the reablement team into Care at Home and to use reablement as part of mainstream service provision

Expected Outcomes

- Support additional numbers of elderly clients to live as independently as possible
- Mainstream services to those reabled
- Support more carers in West Dunbartonshire in collaboration with Carers of West Dunbartonshire

Change Fund Investment

Additional Investment £000	2011/12	2012/13	2013/14	2014/15
	(250)	125	125	125
Released from Reablement		0	173	101
Total		125	298	326

3. Effective Care at time of Transition

3.1 Out of Hours Care

We are moving to 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 (see 1.1 Anticipatory Care).

Our experience in year 1 has evidenced a need to increase our Out of Hours provision to increase the level of support available to Primary Care and Social Work partners. We will therefore increase our commitment to support the roll out of our Anticipatory planning approach.

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	2011/12	2012/13	2013/14	2014/15
£000s	10	80	80	80

3.2 Rapid Geriatric Assessment

There is clear evidence that early geriatric assessment impacts positively on subsequent care. We have developed formal links with the Department of Medicine for the Elderly (DME), Community Older Peoples Teams and access to rapid geriatric assessment and consultant support and advice. Integrated community older peoples teams will provide rapid assessment of rehabilitation potential, deliver rehabilitation intervention and provide support to maintain at people at home or in a homely setting and avoid unnecessary admission to hospital.

Expected Outcomes

- Rapid multi disciplinary assessment
- Early intervention by multi disciplinary teams
- Access to rapid home based rehabilitation and equipment
- additional sessions of community consultant time
- Rapid access to augmented home care provision.

Change Fund Investment

Additional Investment	2011/12	2012/13	2013/14	2014/15
£000s	12	24	24	24

3.3 Reablement

We have established 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 with complex needs.

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 have recruited pharmacy technicians managed from our prescribing service to provide compliance support and to liaise with community pharmacy.

We will continue to use Change Fund to pump prime a shift from low intervention clients to high needs clients to meet the changing demographic picture. The projected spend in year 3 reflects an expectation that we will shift resource to care at home.

Expected Outcomes

- 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
- 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
- Carers will be supported and referred to other sources of help such as Carers of West Dunbartonshire

Change Fund Investment

Additional Investment	2011/12	2012/13	2013/14	2014/15
£000s	168	283	100	268
Pharmacy	20	40	40	40
Total	188	313	140	140

3.4 End of Life Care

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 available to all care settings.

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 (2009) recommends the introduction of a consistent model of care specifically within Care Home Settings. We have introduced a Community Specialist Palliative Care Nurse Service.

Expected Outcomes

- Each patient with Palliative Care needs is held on Palliative Care Register
- Using the Liverpool Care Pathway and the Gold Standards Framework reduce the proportion of people within West Dunbartonshire dying in hospital.
- 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
- Achieve a 20% decrease in the number of palliative care patients dying in hospital (see table 3)
- Carers will be supported throughout the whole process and referred to appropriate sources of help

Table 3
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	Cance r	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	2011/12	2012/13	2013/14	2014/15
£000s	30	80	80	80

4. Hospital and Care Homes

4.1 Facilitating Discharge

We intend to complete the development of our supported discharge activity by introducing additional capacity to work the discharge process. We are currently reorganising into 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. It will offer additional physical rehabilitation, liaison with families/carers and link directly to the Reablement Service and to the Primary Care Dementia Service and Carers of West Dunbartonshire for ongoing case management where necessary.

It will increase supported discharge capacity to include EMI with the appointment of MHOs with a prime responsibly for assessment, preparation of reports specifically relating to older people within a hospital setting and who are without capacity. It will include medication review to increase knowledge and adherence in patients and carers. Medication review is effective in reducing hospital admission.

We will fund four 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

- 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 will reduce the average length of time they are delayed to 35 days as we move to ensuring that maximum waits do not exceed four weeks by 1 April 2013.
- Reduction in bed days because of readmission/admission
- Carers will be involved and supported

Table 4
Target for Reduction in Days Lost to Delayed Discharge and for AWI

	DD Bed Days Lost	Target	AWI Bed Days Lost	Target	AWI DD Average Days Lost	Target
2009/10	7638		931			
2010/11	8644		3160			
2011/12		3819		466		35
2012/13		3819		466		35

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Change Fund Investment

	2011/12	2012/13	2013/14	2014/15
Additional Investment £000	120	240	240	137

4.2 Care Packages

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 five additional packages of residential or nursing care year on year to 2014
- Contribute to the reduction of Delayed Discharges by 20% year on year to 2014

Change Fund Investment

Additional Investment	2011/12	2012/13	2013/14	2014/15
£000s	250 (Included complex home care packages)	118	108	108

5. Enablers

Co-Production - 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 all 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	2011/12	2012/13	2013/14	204/15
Training and Education	20	7	7	7
Supported Self Care	20	0	-	-
LTC and CIS	40	40	40	40
Total	**80**	**47**	**47**	**47**