West Dunbartonshire

Community Health and Care Partnership

Reshaping Care for Older People

Older People's Change Fund

Delivery Plan of Action

Year Three: 2013/2014

Introduction

West Dunbartonshire Community Health and Care Partnership has worked with local community planning partners to build on the progress made over the previous two years of its local Older People's Change Fund Plan and prepare this comprehensive year three Delivery Plan of Action. This delivery 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 previous actions fully tested. The routine and in-year implementation of this delivery plan of action will continue to be driven and monitored through the local Community Planning Partnership Older People's Change Plan Implementation Group (whose membership includes statutory, voluntary and private providers as well as community and carer representatives).

This delivery plan is the vehicle for co-ordinating action across community planning partners in relation to supporting independence and improving care for older people, and its content has been developed to support the third year refresh of our local Community Planning Partnership's (CPP) current Single Outcome Agreement (as required by Scottish Government). As in previous years, this delivery plan supports the long-term commitments within the CHCP's long-term and iterative Commissioning Strategy for Older People's Services (which itself has been subject to further refinement through 2012/13). Consequently then, it is important to note that this important programme of work is a consistent element of the much larger range of older people's services (and investment) provided locally by and with the CHCP, and indeed other community planning partners.

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. 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 include proposals that maintain the expected reductions in the total number of delayed bed days and achieve the national target of a maximum wait of four weeks for inclusive codes from 1 April 2013 and towards the target of 2 weeks by 1 April 2014. We have implemented a single point of access for our Hospital Discharge and Older Peoples Teams.

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 CHCP 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.

Long Term Conditions

We propose continued development of such services linked to General Practice and to mainstream this model of care. In 2013/14 we will make additional investment in Anticipatory Care for patients in all care settings and align this work with the new QOF contract for General Practice.

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.
- 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

	2012/13 £000	2013/14 £000	2014/15 £000
Additional Investment £000	154	154	145

1.2 Developing Services with the Independent Sector

We will continue our partnership with Scottish Care to fund a 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.

We will invest in a joint development programme (My Home) which will deliver improved coordination and service quality across Council and Independent Sector care homes across West Dunbartonshire.

Expected Outcomes

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

Change Fund Investment

Change Fund Investment	2012/13	2013/14	2014/15
Liaison Officer	21	21*	21
My Home Programme		40*	

1.3 Developing Community Capacity

We have developed networked services with WD CVS to build on community capacity in particular befriending services, care and repair, support to carers and increasing awareness. We have invested in developing community directories and in publicising independent and 3rd sector services and groups, in partnership with Carers of West Dunbartonshire. We have developed work in partnership with Alzheimer Scotland. We have introduced systems to measure the impact of developments on wider system objectives in collaboration with Carers of West Dunbartonshire and WD CVS. A review of the programme shows it has met its year 1 targets. In 2013/14 we will continue this work and support the next stage of its development.

Expected Outcomes

- Further develop the LinkUp service to streamline referrals from and between the 3rd and Independent sectors
- Maintain a dedicated helpline number manned by volunteers
- Further develop a shared assessment process between key 3rd sector delivery partners
- Support a shared staff development and training programme
- Develop new social enterprise models based on year 1 research
- Increase referrals to energy schemes by a further 5%
- Increase benefit applications by a further 5%
- A further 20 new older volunteers recruited
- An additional 50 LinkUp contacts per quarter in 2013/14
- Support carers through Carers of West Dunbartonshire and do this in partnership with West Dunbartonshire CVS
- Identify and support more carers

Change Fund Investment

	2012/13	2013/14	2014/15
CVS Proposal	114 (WDC)	68*	-

2. Proactive Care and Support at Home

2.1 Housing

Our 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 alternatives which maximise the independence of older people 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
- Ensure rapid access to assessment, and provision of aids and adaptations.

Expected Outcomes

- Reduced waits for OT assessment and aids and adaptations to 4 weeks
- We are developing new models of care at home such as extra care housing
- We are working with 3rd Sector and Local Housing Associations to develop housing with care options.

Change Fund Investment

	2012/13	2013/14	2014/15
OT Waiting Times	160(WDC)	90*	-

2.2 Respite

We have established a bureau model for older peoples respite services. This enables direct access, improved coordination and take up of existing respite and step up/ step down opportunities and is more flexible and responsive to peoples' needs. It provides 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 links to our Primary Care Dementia Service, our Community Older Peoples Team, Out of Hours Services and independent sector providers.

In 2012/13 we made additional respite available with non recurrent funding from WDC. We will continue the increased additional respite availability.

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
- Provide respite at home

Change Fund Investment

	2012/13	2013/14	2014/15
Respite Bureau	70	70	70
Additional Respite	60(WDC)	60*	
	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. In 2012/13 we have reduced the number of patients delayed at discharge by 50 %.

Expected Outcomes

- Reduce the numbers of patients with delayed discharge from EMI beds 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
- Avoid Admission to EMI beds particularly from care homes

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	596 (provisional)	570	96
2013/14		530	96

Change Fund Investment

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

2.4 Care at Home Provision

We have provided funding for additional complex home care packages to enable older people to remain at home and provide support to carers for longer and this complements 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
- Increase the support available Out of Hours (see 3.1 below)

Change Fund Investment

Additional Investment £000	2012/13	2013/14	2014/15
	125	125	125
Released from Reablement	0	158	101
Total	125	283	226

3. Effective Care at time of Transition

3.1 Out of Hours Care

We are now managing Out of Hours Nursing, Home Care, Sheltered Housing, Care Homes, and Mobile Attendants as a coherent network, based around neighbourhood teams.

We are now able to 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).

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	2012/13	2013/14	2014/15
£000s	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	2012/13	2013/14	2014/15
£000s	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.

Our evaluation of our reablement service outcomes shows that one third of clients require additional input, one third the same level of service but that the final third require no further service. The number of clients in receipt of service has fallen but the average hours per client has risen. This indicates that we are targeting our services appropriately, maintaining clients with complex needs at home and provides capacity to meet the demand of this growing demographic.

We anticipate that because fewer clients need care 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.

A single point of access allows close links 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. Outcomes from this service has shown improved compliance and early detection of prescribing issues.

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	2012/13	2013/14	2014/15
£000s	283	100	100
Pharmacy	40	78	78
Total	313	178	178

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.

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

We have met our 2014 targets in 2012/13 and have revised them to seek further improvement

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		Hospital	
2009/10		2012/13	
Cancer	Non Cancer	Cancer	Non Cancer
52.2%	60.1%	38.1%	31.2%
Initial Target 2014		Revised Target 2014	
40%	48%	30%	30%

Change Fund Investment

Additional Investment	2012/13	2013/14	2014/15
£000s	80	80	80

4. Hospital and Care Homes

4.1 Facilitating Discharge

We have introduced an integrated multi-disciplinary Community Hospital Discharge Team. The team integrates 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 which has recruited a carer support worker to work with families. 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, will have a maximum stay of four weeks and be used to deliver reablement and rehabilitation (see 4.2 below).

Expected Outcomes

- Reduce the number of bed days consumed by patients ready for discharge to target.

- Where patients are delayed we will reduce the average length of time they are delayed to 35 days.
- Reduction in bed days because of readmission/admission
- Carers will be involved and supported

We have seen a considerable increase in the rate of hospital discharges referred to CHCP social work services which has significantly supported the hospital sector to maintain business flow at the same time as improving our performance for average length of delay. We have seen a 6% increase in referrals for complex home care packages and a 50% increase in referrals for long term care – overall a 34% increase in discharge referrals. We are currently undertaking work with ISD to measure the rate, average delays and readmissions for all West Dunbartonshire patients since 2010.

We have made progress in reducing bed days lost but have not achieved target in 2012/13. However for non AWI clients the average delay is much reduced. We have targeted reduction in the numbers of AWI delays and the length of delay which if achieved will deliver the target volume in 2013/14. We have improved our performance against a backdrop of a 34% increase in discharge referrals.

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	8611	3819	1798	466		35
2012/13	NA	3819	NA	466	NA	35
2013/14		3819		466		35

Change Fund Investment

	2012/13	2013/14	2014/15
Additional Investment £000	240	258	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 provide additional support to clients transferred to Sheltered Housing, Extra Care housing with high packages of care or to care home or intermediate care settings. 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 additional short term packages of intensive care at home, care home or intermediate care

- Contribute to the reduction of Delayed Discharges

Change Fund Investment

Additional Investment £000s	2012/13	2013/14	2014/15
	118	98	98

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**

* Indicates funded from carry forward