Inverclyde council

AGENDA ITEM NO: 6

NHS Greater Glasgow and Clyde

Report To:	**Community Health and Care Partnership Sub Committee**	**Date: 28 April 2010**
Report By:	**Robert Murphy Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/27/2011/BM**
Contact Officer:	**Brian Moore Head Of Health and Community Care CHCP**	**Contact No: 01475 715365**
Subject:	**Reshaping Care for Older People Local Change Plan**	

1.0 PURPOSE

1.1 To update the CHCP on the progress of the development of a local change plan which will drive forward the Reshaping Care for Older People directive under the auspices of the Change Fund as reported to the last meeting of the CHCP Sub-Committee.

2.0 SUMMARY

2.1 As reported to the Sub-Committee, the Reshaping Care for Older People programme recognised the increasing proportion of older people in the population and while a range of services had been developed, the status quo could not be preserved in the longer term. The Scottish Government has therefore identified £70 million across Scotland to fund a change programme aimed to meet the challenges faced. It is anticipated that this will be funding which will recur over the next four years though the imminent election may impact upon this planned investment.

2.2 From the National Fund an amount of £1.228 million for this financial year has been identified and allocated for use across Inverclyde on a partnership basis.

2.3 The principal policy goal of the Reshaping Care for Older people programme is to optimise independence and wellbeing for older people at home or in a homely setting. This is expected also to reduce the use of hospital care and Residential and Nursing care for individuals.

2.4 The local delivery plan for Inverclyde (Appendix 1) has been submitted to the Ministerial Strategic Group as part of a process of ensuring that a coherent national picture is achieved. Feedback from the process has indicated a favourable view of the local plan and agreement that we should now move forward to secure a formal process for implementation. Appendix 1

3.0 RECOMMENDATION

3.1 That the Community Health and Care Partnership approve the outline action plan for implementation and that a further report be provided to the next Sub-Committee meeting demonstrating the development of services to meet the targets presented in the plan.

Robert Murphy
Corporate Director
Inverclyde Community Health & Care
Partnership

4.0 BACKGROUND

4.1 The attached plan was developed through a multi disciplinary steering group who took account of the services provided at present and the challenges faced.

4.2 The Group identified the need for a "whole systems approach" to the provision of care for older people and set out a vision for local partners to re-cast their services to deliver this approach.

4.3 The plan was also informed through consultation with a variety of providers and also by taking account of the views of older people through the Older People's Forum and the Older People's Champions.

4.4 A new philosophy of care puts greater emphasis on preventative and anticipatory care with a focus on recovery, rehabilitation and re-ablement, leading to greater independence and wellbeing for older people. This new philosophy not only reflects what older people have been requesting for many years, but also starts to address the implications of the current financial situation and demographic changes in the longer term

4.5 Developments undertaken using the Change Fund will build on an already established range of work across Scotland including:

- Community care outcomes framework
- Integrated resource framework
- Long term conditions action plan
- Rehabilitation framework
- Self-directed support
- Dementia strategy
- Carers strategy
- Local housing strategies
- Shifting the balance of care
- Telecare and telehealthcare

4.6 The fund will be distributed subject to submission of appropriate partnership plans.

4.7 The initial change plans should be seen as interim or starter plans capturing the best information and ideas available and providing capacity for these ideas and changes to be implemented.

5.0 PROPOSALS

5.1 The proposal as outlined in the action plan should afford us the opportunity of tackling some of the significant challenges faced by services in respect of older people's care and allow us to facilitate service redesign to better meet the needs identified

5.2 It will now be important to build the service requirements around the action plan and to implement the strategy as quickly as possible in order to secure the full benefit of this first year allocation.

5.3 As indicated previously the service will challenge the target areas identified below:

- High levels of people aged over 75 years with multiple emergency hospital admissions
- A high number of bed days used by people aged over 75 years with 2+ emergency admissions
- A high number of bed days used by people awaiting discharge from hospital

- A high percentage proportion of people aged 65+ being supported in care homes
- A high percentage proportion of people aged 65+ receiving intensive homecare support
- A low percentage of people getting overnight homecare

5.4 The key areas of development have been identified as follows:

- Establishment of a single point of access for assessment and service delivery
- Development of a re-ablement service and change in culture
- Increased early interventions to preventative services
- Changes to the shape of long term care from inpatient services to care home provision, including use of housing with care
- Improving end of life care
- Development of capacity within the community to support independent living

5.6 The key measures will be:

- Reduction in unplanned acute bed days in the over 75 population
- Reduction in bed days lost to delayed discharge
- Remodelling care home use
- Increase in proportion of older people living at home
- Improved support for unpaid carers
- Increased personalisation/Self Directed Support
- Increase in housing related support
- Increased community capacity building

6.0 IMPLICATIONS

6.1 Legal: N/A

6.2 Finance:

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments
	1,228,000				

6.3 Personnel: NA

6.4 Equalities: An Equality impact assessment will be carried out on the Action Plan.

7.0 CONSULTATION

7.1 Your Voice, Inverclyde Community Care Forum will be the overarching consultation vehicle for older people within Inverclyde and the third sector will have representation from CVS and through the Providers Network.

8.0 LIST OF BACKGROUND PAPERS

Report to CHCP Sub-Committee 3 March, 2011

Change Plan template

1. Name of partnership

Inverclyde Community Health and Social Care Partnership

2. Partner organisations

Inverclyde CHCP - Inverclyde Council NHS Greater Glasgow and Clyde Your voice, Inverclyde Community Care Forum Scottish Care

Finance – use of Change Fund and additional resources (see Note 3)

From	Amount £
Initial central allocation	1,228,000
Added by NHS Board	
Added by local authority	
Other – delayed discharge & telecare	133,000
TOTAL	1,361,000

Summary of current partnership budget for older people

See below appendix 1 for detail

Local Authority Expenditure	£23,562,209
NHS Community Expenditure	£29,858,449
NHS Hospital based Expenditure	£ 6,628,000
Total budgets for older people	**£60,048,658**

It is recognised that there are elements of information not included such as use of Big Lottery funding and other non statutory funding. The mapping of these resources will form the base line for community capacity building and increased independence identification of these funding sources will proceed over the coming year.

Summary of key outcomes/outputs achieved through current resources

- Establishment of Community Health and Social Care Partnership
- Identified high impact changes as one of the lead areas in the National Shifting the balance of Care "agreeing priorities and delivering outcomes" programme. See appendix 2.
- Outputs as a demonstrator area for the National Demonstrator for Older People's Housing, Support, Health and Care programme
- Building on the COPD development with telehealth in Inverclyde
- Maintaining low and zero delayed discharges over six weeks sustained over a number of years

- Development of streamlined processes to ensure delays for AWI patients are kept at a minimum
- Reduction in NHS continuing care beds for frail older people
- Development of an Early Bird Nursing service
- Partnership working and support for external provision of care home services
- Jointly managed and resourced commissioning plan for delayed discharges including full range of services including:
  - Fast Track Geriatric Assessment
  - Gerontology nurse specialist
  - Interface pharmacy
  - Prevention and Support Nursing
  - Care home allocation
  - Home from Hospital service
  - EMI care management
- Quality monitoring for admissions to and from hospital through the Joint Inverclyde Quality and Advice Group (JIQAAG)
- Development of Housing with Care in partnership with Trust Housing Association
- Telecare developments and telecare strategy

Key changes to achieve over the next 5 years

- Establishment of a single point of access for assessment and service delivery
- Development of a re-ablement service and change in culture
- Increased early interventions to preventative services
- Changes to the shape of long term care from inpatient services to care at home provision, including use of housing with care
- Improving end of life care
- Development of capacity within the community to support independent living
- Reduction in EMI continuing care NHS beds
- Reductions in delayed discharges

Use of Change Fund and outcomes anticipated

See below appendix 3. This section should be read in conjunction with appendix 3.

There are six areas of development and redesign that have been identified through a number of pieces of work undertaken in Inverclyde over the past 18 months.

Each of the key areas are interlinked and co-dependent, and a level of progression across the continuum is expected, with early return on the first three areas, but recognising the impact and need to change the second three areas over a longer period of time.

The key areas of change identified by the Inverclyde Partnership are:
  a) Single Point of access
Developing a single point of access for services will allow for a number of initiatives and developments to combine to speed up access to service in times of crisis, reduce duplication in services and lack of clarity for service users and also streamline several processes thereby making optimum use of a range of resources.

The key measures of success will be around reduction in unplanned admissions,

reduction in bed days lost to delayed discharge and also improve support to carers.

The work will develop in the initial stages at a local level but it is envisaged that the work will widen out to include work in partnership with the ambulance service and NHS 24.

b) Re-ablement

A range of services will be redesigned and developed to work together to ensure a shift in the way in which people are supported, moving from a model of dependency to one of rehabilitation and enablement.

The key services involved will be assessment and care management, care at home, the frail elderly team and EMI services. It is recognised that these key services will require support from other services as the agenda develops.

A range of step up and step down options will be developed across a number of facilities including day services, sheltered housing and care homes, and these will increase the opportunities for re-ablement.

A redesign of day services will also introduce the reablement philosophy, using service as a stepping stone and support to returning to activities within the wider community.

The key measures of success will be a reduction in unplanned admissions for both people aged over 75 and EMI patients, a reduction in bed days lost to delayed discharge, an increase in older people living at home, and an increase in people accessing self directed support.

c) Early intervention

The use of SPARRA data has previously been used to identify patients for telehealth development. Further use of this information will assist in identification of older people with Long Term conditions and those who are at risk of admission.

Development of a range of service developments and process reviews will ensure that proactive actions can be taken including pharmacy reviews, better coordinated falls prevention services, specialist fast track assessment for EMI and frail older people with training and awareness raising for GPs in these areas, promotion of self management of care and support and advice to carers.

The key measures of success will be reduction in unplanned admissions for older people and EMI, reduction in bed days lost to delayed discharge, increase in older people living at home, an increase in self management of care and increased carer support.

d) Changes in the balance of care and long term care

The balance of care has changed over the past year due to changes in inpatient NHS services and also the increasing dependency of older people who have no informal care supports locally.
Work is underway to reduce further the number of EMI NHS continuing care beds.

A reduction in the balance of care from care home to care at home will be achieved through change in use of some care home beds with a move away from the traditional long term support to one of a rehabilitation and reablement focus and also good quality end of life care. This will be achieved through partnership working with independent sector care home providers.
Further development of the housing with care model will be progressed, giving older

people a real alternative to care home admission, and also develop a community hub within sheltered housing.

Care at home services will also increase their capacity and ability to provide planned service 24/7 and this development will link to telecare and night nursing services.

The key measures of success will be a reduction in unplanned admissions to care homes, an increase in older people living at home, reduction in permanent care home placements and reduction in delayed discharges.

e) End of life care

Working across the agencies and in partnership with voluntary organisations, clear pathways of care and funding streams will be established to provide expertise, choice and rapid access to services for end of life care.
A joint assessment and care management process and improved benefits advice will also provide improved support to carers.

The key measure of success will be a reduction in unplanned admissions, increased support to carers, increased self directed support.
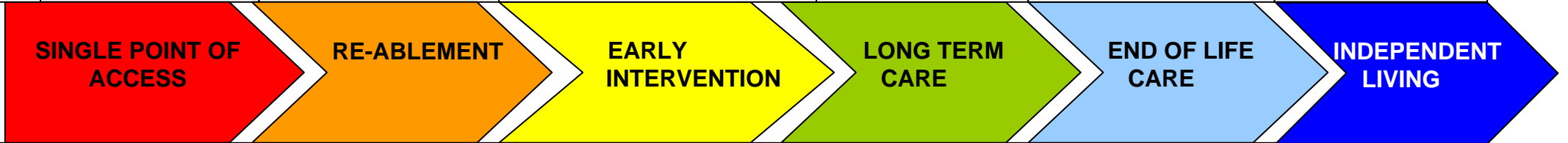
f) Independent living

Local consultation with older people through Your Voice, the Inverclyde Community Care Forum has identified clearly that older people would choose to remain at home longer and take part in mainstream leisure activities where possible. Application has been made to Big Lottery funding for community capacity building development with a view to providing buddying and befriending support to older people by older people.

Inverclyde has particular topography challenges and adaptations to property are often not possible. The allocation of sheltered housing is an essential part of making best use of available housing in Inverclyde. The future use of sheltered housing as part of a wider community hub will also be considered with RSLs.

Telecare provision and the dedicated response service will continue to expand and develop to provide a range of equipment and security to older people.

The key measures of success will be an increase in housing related support, an increase in older people living at home.

	SINGLE POINT OF ACCESS	RE-ABLEMENT	EARLY INTERVENTION	LONG TERM CARE	END OF LIFE CARE	INDEPENDENT LIVING
SERVICES	GPs Ambulance SERVICE NHS 24 A&E AHPs Community Nursing Inpatient staff Assessment & care management staff Homecare/healthcare staff Joint Store Telecare EMI services	Inpatient staff Occupational therapists – NHS & LA Care Managers Community Nursing Pharmacy Homecare Day services Telehealth Housing Care homes Joint store Fast track assessment Frail elderly team	Use of SPARRA GPs Community Nursing Homecare Assessment and care management Specialist nurses Pharmacy EMI services incl CPNs Telehealth A&E Day hospital Fast Track Assessment Falls services Respite bureau	Inpatient services Community Nursing Care Homes Home care Assessment and Care management staff Pharmacy Care Homes Housing EMI services Local Enhanced services - diabetes	GPs Community Nurses Specialist nurses Voluntary sector Joint Store Care Homes Inpatient services Homecare Telecare EMI services Assessment and care management staff	Voluntary sector Leisure services Day services Housing Joint store Adaptations Sheltered Housing Telecare Falls prevention Health improvement Befriending services
TO DO	Set up SPA – core staff and wider links Staff training Building confidence in community services Target unplanned admissions Research into what gaps are in service re unplanned admissions Define and develop 24/7 services Develop service links and access protocols 24/7 Work with ambulance service and NHS 24 to develop robust response services Information sharing and specialist notes	Review of homecare services and development of reablement service Develop reablement service for all new homecare referrals Agree dependency tools Develop review processes Staff training and cultural change facilitation Link telecare, falls prevention and re-ablement MH liaison service development linked to wider service redesign Link inpatient reablement to discharge process Redesign of day services	Polypharmacy reviews Pharmacy training for homecare staff Falls prevention Fast track assessment service for EMI and post diagnosis support Geriatric/GP specialist support with GPs Assessment processes for discharge and access to services Use of SPARRA data to develop support and use of telehealth Promotion of self management of care Staff training and awareness training Increased the range of respite opportunities for carers Carer assessment, information and advice promotion at all stages Early identification of carers through all services	Establish Balance of care Clear care pathway through services Develop 24/7 services Use of dependency tool for assessment and care home admission Clear criteria for all long term facilities Redesign palliative care pathways using LEAN approach Change of use for care homes Rehabilitation within care home settings Development of planned overnight services e.g. toileting , turning etc Further development of housing with care	Establish clear joint working protocols and care pathways Agree on funding streams Develop community services and capacity Better support to carers Joint assessment process across agencies Improved benefits advice	Promotion of telecare Post diagnosis support for dementia Use of sheltered housing as part of community hub Befriending and buddying Build of input from tea dance Build on proposals from providers forum Promotion of re-ablement and change of culture Use of leisure facilities by older people Redesign of day services Suitable adaptations and better knowledge of use of equipment. Allocation process for sheltered housing.
MEASURES	Reduction in unplanned admissions. Rapid discharge Carer crisis Improved support for unpaid carers	Reduction in unplanned admissions and bed days Rapid discharge Increase in older people living at home Increased personalisation	Link to LTC Reduction in unplanned admissions. Rapid discharge Increase in older people living at home Increased carer support	Balance of care – agree Increase in older people living at home Reduction in unplanned admissions Reduction in care home placements	Reduction in unplanned admissions Support to carers Remodelling care home use Increased personalisation	Increased community capacity building Increase in housing related support Increase in proportion of older people living at home Increased carer support

		Hospital discharge protocols and assessment processes, looking at identification of need, paperwork, timescales, and access to services

OVERARCHING PROCESS | **ISSUES**

Hospital discharge protocols and assessment processes, looking at identification of need, paperwork, timescales, and access to services

Specialist geriatric and psycho-geriatric support and training to support GPs

Staff awareness raising and training on:

- re-ablement
- monitoring and administration of medication for homecare staff and carers
- use of dependency tools
- single point of access
- early interventions
- dementia
- carers needs
- carer training as part of the care plan

Develop clear criteria for a range of services

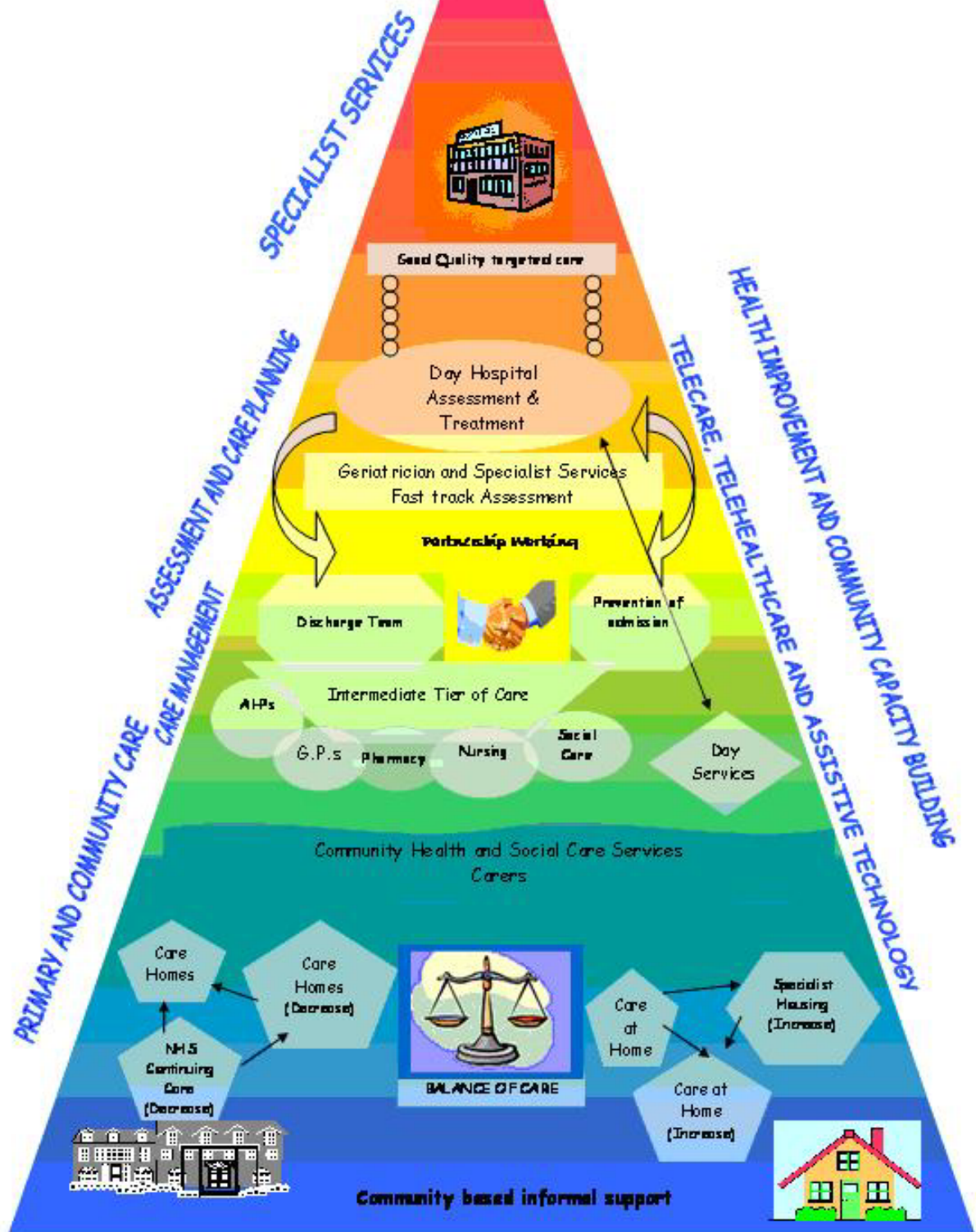Agree and train on use of dependency tools

Use of LEAN approach to process mapping and service redesign:

- palliative care pathways
- admission to care home
- development of re-ablement as part of the hospital discharge process

Introduction of a single review process across the services

Develop a comprehensive directory of respite options and funding to be managed through the respite Bureau

INVERCLYDE
OLDER PERSON'S SERVICE REDESIGN

SPECIALIST SERVICES

ASSESSMENT AND CARE PLANNING

CARE MANAGEMENT

PRIMARY AND COMMUNITY CARE

HEALTH IMPROVEMENT AND COMMUNITY CAPACITY BUILDING

TELECARE, TELEHEALTHCARE AND ASSISTIVE TECHNOLOGY

Good Quality targeted care

Day Hospital Assessment & Treatment

Geriatrician and Specialist Services Fast track Assessment

Partnership Working

Discharge Team

Prevention of admission

Intermediate Tier of Care

AHPs

G.P.s   Pharmacy   Nursing   Social Care

Day Services

Community Health and Social Care Services
Carers

Care Homes

Care Homes (Decrease)

NHS Continuing Care (Decrease)

BALANCE OF CARE

Care at Home

Specialist Housing (Increase)

Care at Home (Increase)

Community based informal support

## Key performance measures to assess progress

Inverclyde has particular issues in relation to the changing demographic composition and in the topography of the area. This combined with aspects of poverty and poor health and lower life expectancy make comparisons with all other areas across Scotland difficult.
The partnership have therefore chosen some activity information from ISD and also from NHS Greater Glasgow and Clyde as baseline information on which to build this plan.

Information gathered and considered by Inverclyde Partnership includes the following:
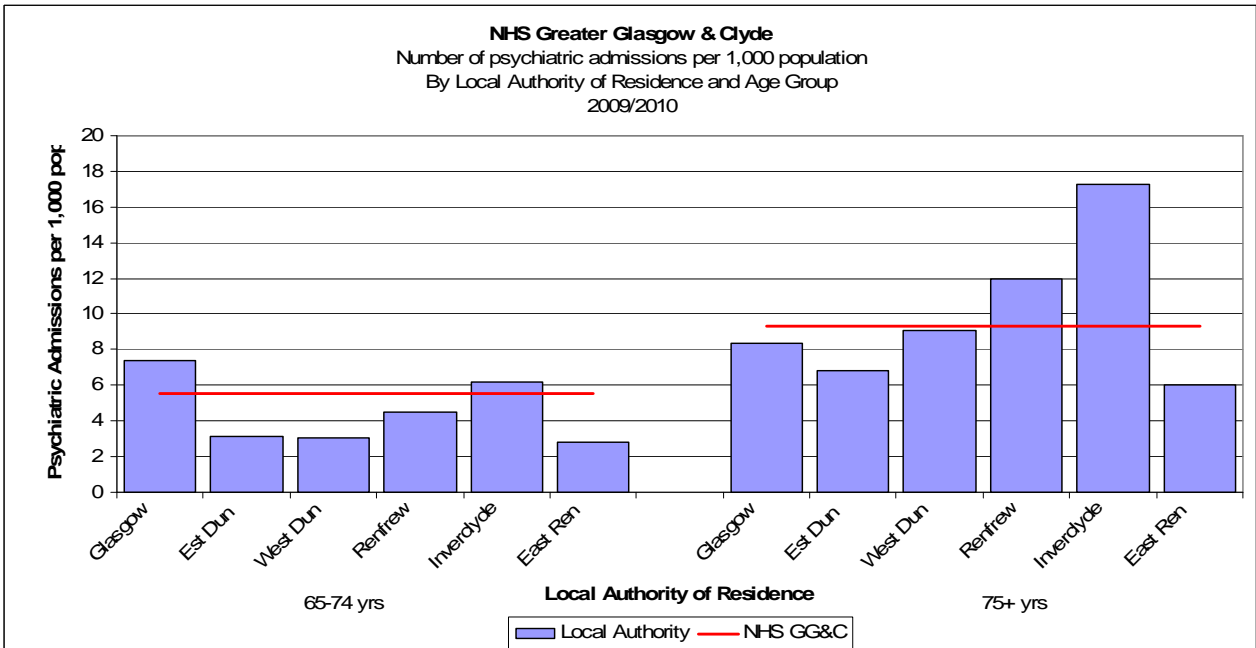
– **High levels of people aged over 75 years with multiple emergency hospital admissions**
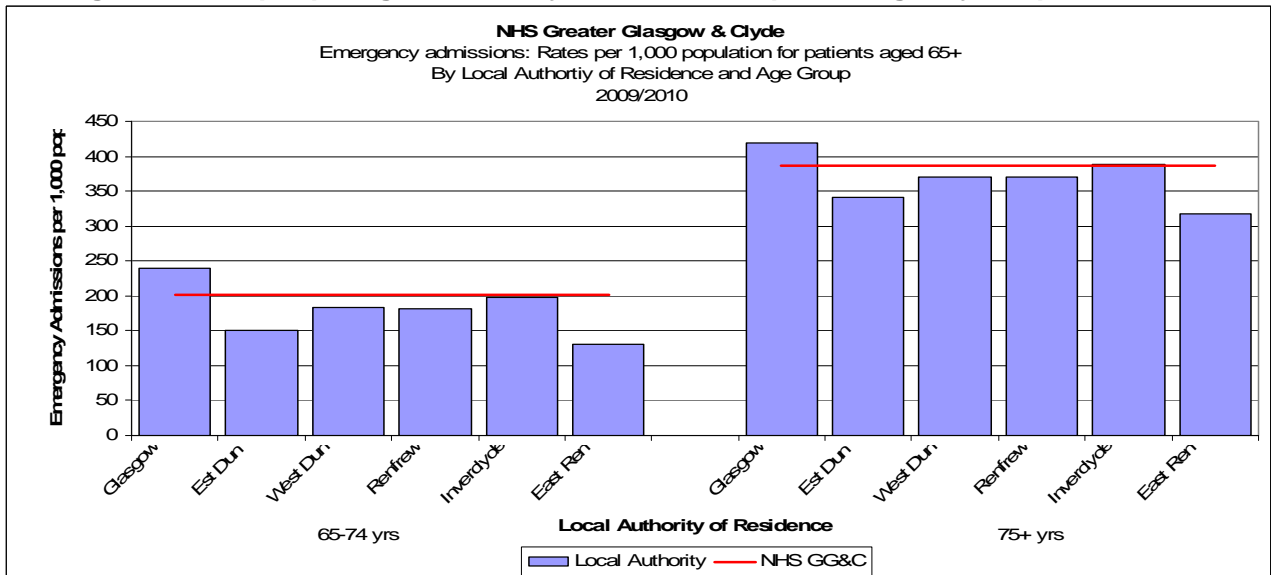

– **A high number of bed days used by people aged over 75 years with 2+ emergency admissions**
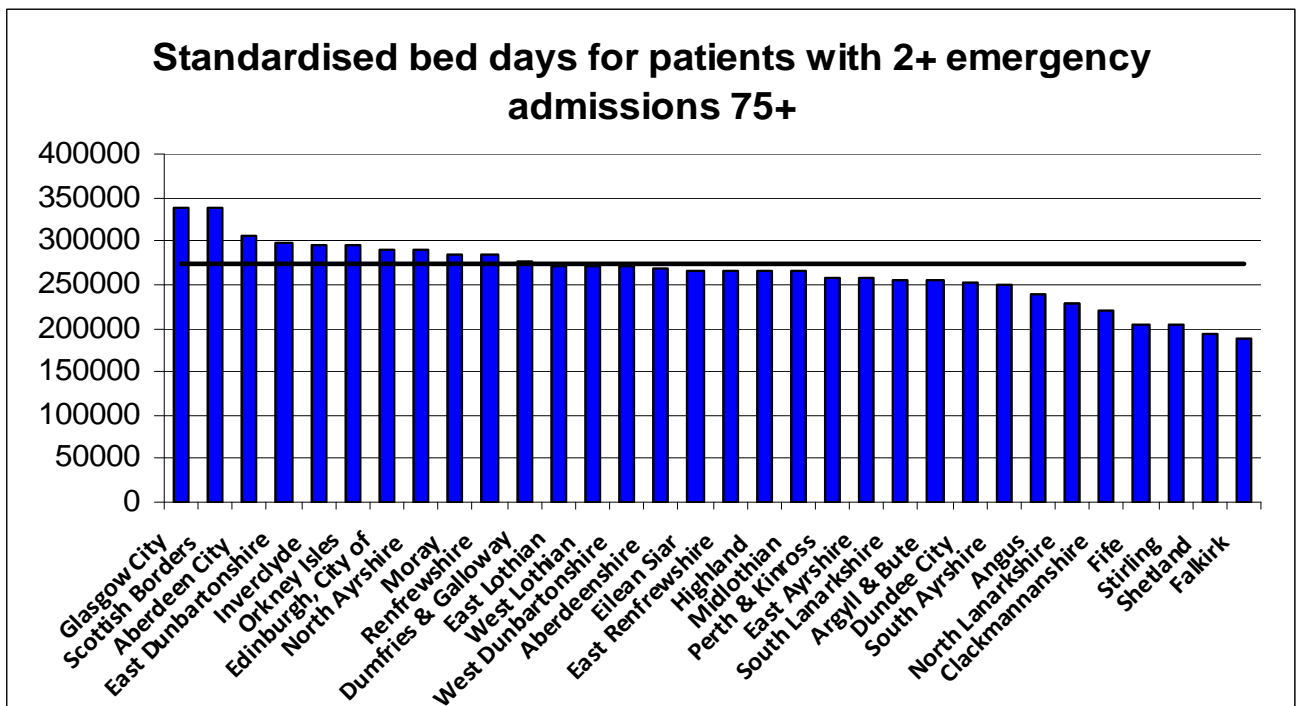
– **A high number of older people with mental illness being admitted to hospital on an unplanned basis**

NHS Greater Glasgow & Clyde
Number of psychiatric admissions per 1,000 population
By Local Authority of Residence and Age Group
2009/2010

– **A high number of delayed discharges per 1000 population**

NHS Greater Glasgow & Clyde
Number of Delayed Discharges per 1,000 population
By Local Authortiy of Residence and Age Group
2009/2010
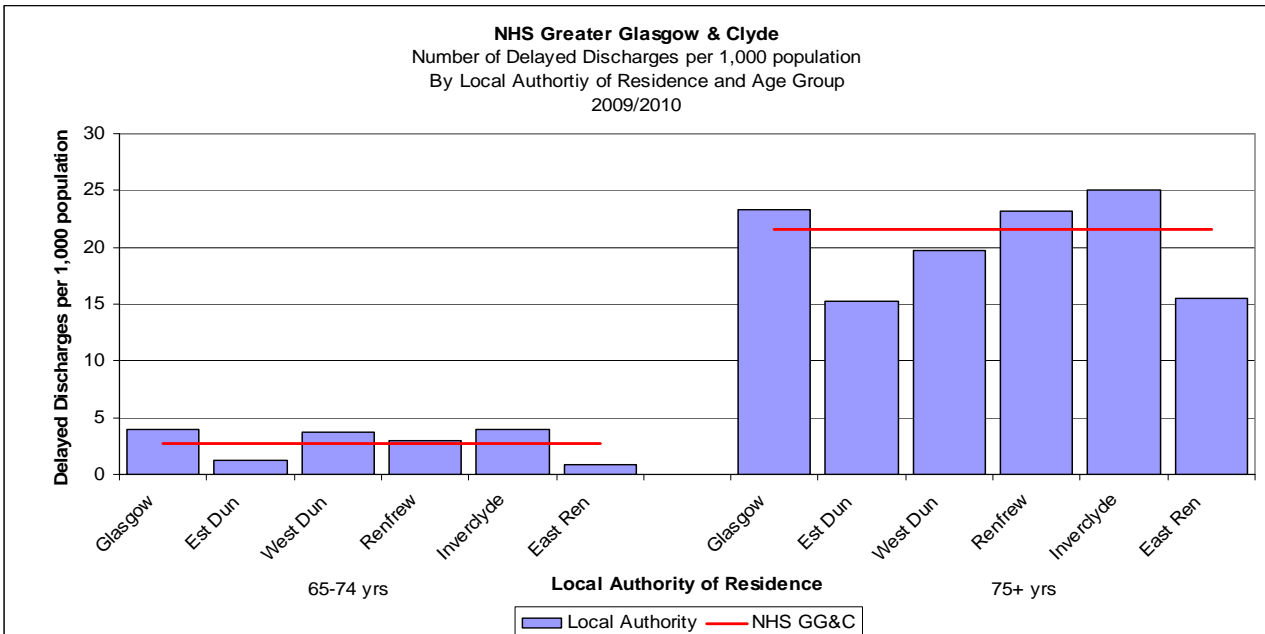
Inverclyde residents waiting for hospital discharge currently consume 6595 bed days we will reduce this by 35% by the end of First year with subsequent reductions of 15% therafter. This takes account of the whole system change required and the time to secure the desired outcomes.
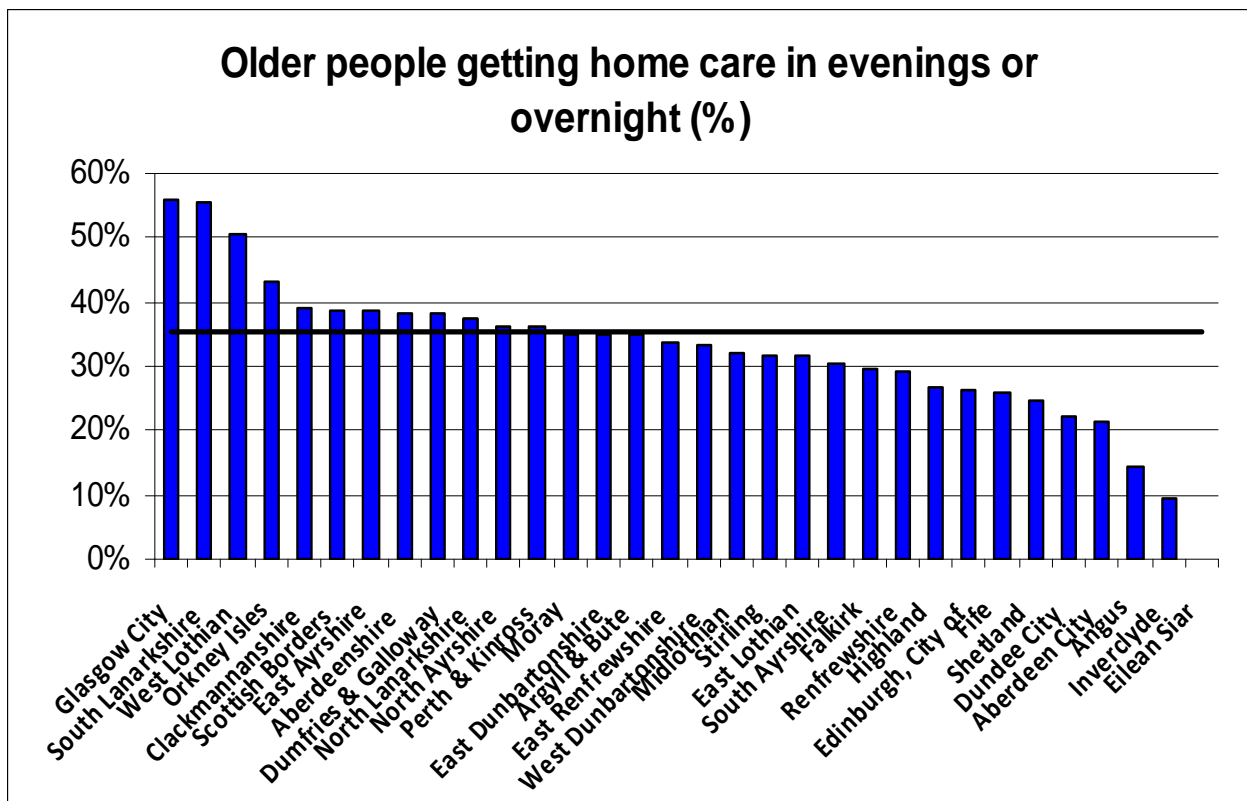
– **A high percentage proportion of people aged 65+ being supported in care homes**
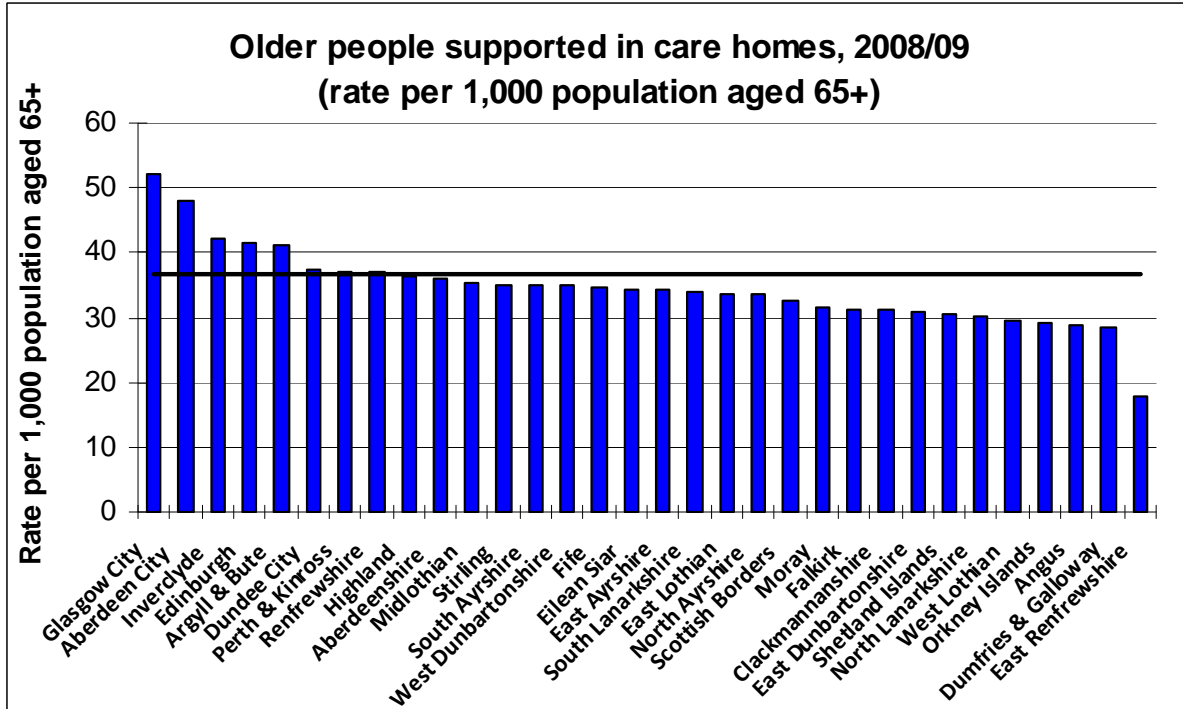
**Older people supported in care homes, 2008/09
(rate per 1,000 population aged 65+)**

– **A high percentage proportion of people aged 65+ receiving intensive homecare support**

**Older people receiving intensive home care (10+ hours per week), 2008/09
(rate per 1,000 population aged 65+)**
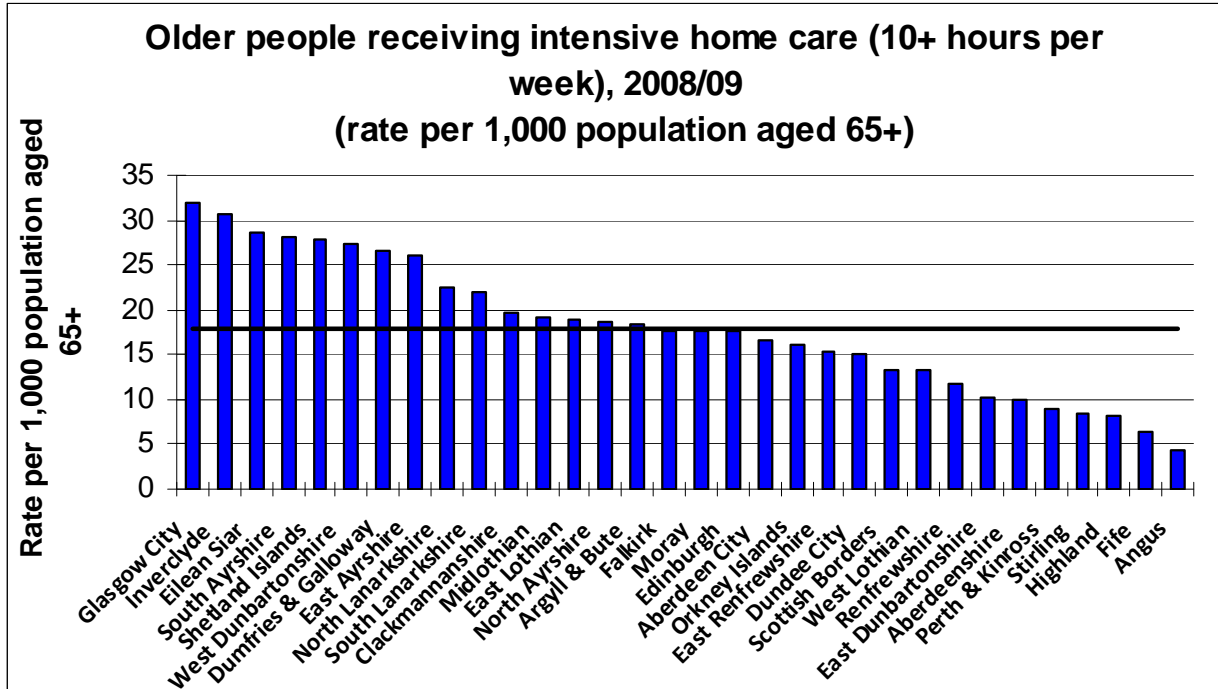
− **A low percentage of people receiving overnight homecare**

Older people getting home care in evenings or overnight (%)

−

The partnership therefore plans to target the following areas as priority:
− Reduction in unplanned acute bed days in the over 75 population
− Reduction in delayed discharges per 1000 population
− Reduction in unplanned EMI admissions
− Remodelling care home use and reduction in percentage of permanent care home places within the balance of care
− Increase in proportion of older people living at home through development of re-ablement and reduction in number of people requiring long term high input care packages
− Improved support for unpaid carers
− Increased personalisation/Self Directed Support
− Increase in housing related support
− Increased community capacity building

Work is underway to establish baseline information – see APPENDIX 4

Information gathered from the Older Person's Tea Dance (copy of report attached APPENDIX 5) and from the Providers' Forum (copy of agenda and attendance list attached APPENDIX 6a&b) have also informed the shape of this plan and form the basis of partnership working with older people, service users, carers, third sector and independent sector providers. This dialogue and communication will continue to develop as an ongoing process throughout the development of the plan and service redesign.

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 Change Fund will be used in the initial stage to improve and influence processes, systems and culture.

The work will cross all agency boundaries, ensuring clear pathways and will identify changes in activity within each service as developments progress.

These elements will reduce unplanned hospital admissions, improve hospital discharge processes and reduce re-admissions.

The three areas for service redesign are identified as:
– Single point of access
– Re-ablement
– Early intervention

and with both training, awareness raising and service redesign, the balance of care will transfer from inpatient beds to community services. The longer term work will focus on long term care, end of life care and independent living, recognising that across the continuum as one service redesigns there will be impact on other areas.

In taking forward the work streams there will be redefinition of roles across the disciplines and service areas, changing the emphasis from dependency to rehabilitation and independence.

Indicative allocations of funding have been identified initially as following on the understanding that as services change, mainstream budgets will be examined and options for reallocation of funding will be agreed through the governance arrangements above:

CHANGE FUND APPLICATION OF RESOURCES

Training, awareness raising, cultural shift	£200,000
Extended hours, AHPs, change in remits	£500,000
Tools, equipment, IT, telecare	£200,000
Pharmacy	£100,000
GP support and EMI Fast Track assessment	£130,000
Respite and carer support	£100,000
Community development	£50,000
Project management	£80,000
	£1,360,000

Indicate the financial mechanism and governance framework

The Change Plan steering group has been established with membership from Local Authority, NHS acute services and community services, Mental Health services and voluntary sector.

This membership will ensure that all service redesign will be shared with relevant stakeholders, gaining feedback from community, service users and carers, service providers as part of the process. Quality impact assessments will also be undertaken.

The funding will be monitored as a pooled budget through this steering group. The pooled budget will be managed through the CHCP and will replicate the processes that have been in place for a number of years to manage the pooled budget for delayed discharges.

The governance for the Change Fund for the Inverclyde Partnership will be through the Inverclyde Community Health and Social Care Partnership, with a reporting link to the Alliance Board and NHS Greater Glasgow and Clyde.

Support requirements to assist delivery

The Partnership requires support to develop the IRF within the locality to ensure best use of the totality of resources.
The Partnership would also be interested in linking national Intermediate Care developments to learn from lessons elsewhere.
Information on managing quality and financial monitoring for Self Directed Support would also be helpful.

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

Summary of current partnership budget for older people

RESOURCES CONTRIBUTING TO CARE FOR OLDER PEOPLE - INVERCLYDE
NHS Estimated Costs for over 65's

DENTAL CONTRACT	£2,911,159.00
OPTOMETRISTS	£883,331.00
PHARMACY CONTRACT	£1,991,439.00
GMS	£6,261,929.00
Prescribing	£9,704,972.00
Community AHPS	£367,501.00
District Nursing	£1,366,583.00
Elderly Inpatients	£3,409,109.00
Other HCC	£1,316,043.00
Eld Community MH	£479,752.00
Accommodation/Admin & Others	£1,112,163.00
Ambulance service - delayed discharge	£54,468.00
Hospital Based NHS services	£6,628,000.00
Total NHS expenditure	**£36,486,449.00**

RESOURCES CONTRIBUTING TO CARE FOR OLDER PEOPLE - INVERCLYDE
Local Authority Community Care expenditure

Home Care	£7,473,275.00
Day Services	£1,116,153.00
Community Alarms	£538,020.00
Meals on Wheels	£147,240.00
Other services	£903,001.00
Assessment and Care Management	£1,334,340.00
Care Homes	£9,936,170.00
Residential respite	£141,960.00
Housing support	£689,850.00
Direct payments	£180,200.00
Adaptations	£950,000.00
WOOPI (lottery funding)	£152,000.00
Total Local Authority Expenditure	**£23,562,209.00**

NB The above figures include expenditure from Resource Transfer
and a pooled budget for delayed discharge