Inverclyde council

AGENDA ITEM NO: 12

NHS Greater Glasgow and Clyde

Report To:	**Community Health and Care Partnership Sub Committee**	**Date: 25 August 2011**
Report By:	**Robert Murphy Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/33/2011/GMcC/AM**
Contact Officer:	**Gillian McCready Service Manager Older People's Services**	**Contact No: 01475 715377**
Subject:	**Reshaping Care for Older People Inverclyde Change Plan**	

1.0 PURPOSE

1.1 To inform members of the detail of the Inverclyde Change Plan.

1.2 To seek approval and support in the implementation of the plan.

2.0 SUMMARY

2.1 A report was presented to the CHCP sub-committee in February 2011 outlining the requirements for development of a local change plan as part of the wider Reshaping Care for Older People's Programme.

2.2 As part of the process for accessing the £1.228m allocation of funding for the Inverclyde partnership, change plans had to be submitted to the Scottish Government by 28th February 2011 using a template provided for the purpose.

2.3 The template included requests for information on:

- Finance
- Total budget for Older People's services
- Summary of key outcomes achieved through current resources
- Key changes to be achieved
- Detail of the use of the Change Fund
- Key performance measures
- Summary of how the change plan will shift the balance of care
- Financial and governance framework
- Support requirements to assist delivery

2.4 The plan required to be prepared and agreed by the NHS, Council, Third Sector and Independent Sector.

2.5 A copy of the Change Plan is attached for detailed information. See appendix 1 — Appendix 1

3.0 RECOMMENDATION

3.1 That the sub-committee approve the detail of the Change Plan and support its implementation.

Robert Murphy
Corporate Director Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 The Change Fund was developed to act as bridging finance to support the shift in the balance of care for older people, moving from institutional care to primary and community settings, and to influence decisions taken with respect to the totality of Partnership spend on older people's care.

4.2 The framework for the change plan sits alongside other strategies for particular groups including the Dementia Strategy, Carers Strategy, Self Directed Support Strategy and Living and Dying Well. Together these build a cohesive and comprehensive approach to meeting the care and support needs of older people.

4.3 A new philosophy of care puts the emphasis on preventative and anticipatory care with a focus on recovery, rehabilitation and reablement, leading to greater independence and wellbeing for older people.

4.4 This move 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 Success in delivering the programme will have as much to do with shifting attitudes and expectations as it will about shifting resources and redesigning of services.

4.6 There is a need to move away from measuring success by how much service is provided to how many people to that of how many older people can be enabled to stay independent and well at home without the need for care and support.

4.7 Services will have to change to provide personalised care and support designed to optimise independence and wellbeing through an enabling approach.

4.7 It also has to be recognised that this approach is not just a health and social work responsibility, but includes providers of services like housing, transport, leisure, community safety, education and arts as well as commercial enterprises. The approach must be a whole system.

4.8 The Change Plan was developed in Inverclyde following consultation with older people and service providers as well as health and social work services.

4.9 Information relating to activity within the health and social care system was examined, and a high number of unplanned admissions to hospital and a high number of bed days used by older people were key areas of concern.

4.10 It was recognised that a number of key outcomes had been achieved recently across the partnership and these outcomes would be used both as a learning platform and also a base on which to take forward service changes in the future.

4.11 The partnership Change Plan was submitted to the Scottish Government on 28th February 2011.

5.0 PROPOSALS

5.1 The Inverclyde Change Plan identified six key themes:

- Single point of access
- Early intervention
- Reablement
- Long Term care
- End of life care
- Independent living

5.2 Each of the key areas are interlinked and co-dependent. There will be a level of progression across the key themes, with an early return expected on the first three, while recognising the impact and need to change the second three areas over a longer period of time.

5.3 Challenging targets have been set to ensure a shift in the balance of care away from inpatient settings to improved independence and community integration.

5.4 The targets include a reduction in the number of bed days used by older people admitted on an unplanned basis, reduction in the number of older people admitted on an unplanned basis, an increase in the number of people who manage their own care through self directed support.

5.5 A range of service redesign programmes will take place, with homecare establishing a reablement focus for all new referrals; remodelling the use of care homes to include step up and step down opportunities and the redesign of day services to link into community capacity building to ensure older people have the opportunity to remain active within their own communities.

5.6 Indicative allocation of funding from the change fund was identified initially on the understanding that as services change, mainstream budgets would be examined and options for reallocation of funding would be agreed though agreed governance arrangements.

5.7 The application of resources included the following:

- Training and awareness raising
- Extended hours of working, change n remits
- Tools, equipment, IT and telecare
- Pharmacy
- GP support and EMI Fast Track assessment
- Respite and carer support
- Community development
- Project management

5.8 The implementation of the Change Plan will be supported through the Joint Improvement Team with identified link people attached to each partnership.

5.9 A steering group has been established to monitor and advise on the implementation of the change plan, with representation from NHS primary care and acute services, Social Work services, strategic housing, independent sector providers, third sector and staff partnerships.

6.0 FEEDBACK ON THE CHANGE PLAN

6.1 A feedback session was held with members of the Joint Improvement Team and the steering group, highlighting positive issues and gaps in the plan for future discussion and inclusion.

6.2 The breadth of the Inverclyde proposal was acknowledged, recognising the investment across the whole system, with the keys areas for Reshaping Care being integrated with an overall service redesign ethos which was well illustrated in the continuum of care.

6.3 The identification of particular groups including dementia, carers and palliative care and end of life was welcomed.

6.4 Limited work has been progressed across the partnership in relation to the Integrated Resource Framework programme that has been rolled out across Scotland and this needs to be followed up.

6.5 Significant investment in culture change, training and Organisational Development was identified as being helpful.

6.6 Third sector involvement would be taken forward through Your Voice, with a sub group being developed to include a wider range of third sector partners.

6.7 There is an expectation that each partnership will develop a joint commissioning strategy by 2012. The Joint Improvement Team will develop guidance and a framework to support partnerships in taking forward a joint commissioning strategy.

7.0 IMPLEMENTATION

7.1 The Joint Improvement Team is promoting shared learning and good practice across all partnerships through a Reshaping Care Improvement Network using a range of communication processes including newsletters, WebEx discussions and national events.

7.2 A number of posts including a Project Manager to drive forward the implementation have been developed and are awaiting final approval, with recruitment processes to be agreed across the agencies.

7.3 The steering group has been established and has been meeting on a monthly basis to monitor and drive the process forward. A key focus of this group has been to ensure communication into all the relevant parts of the system and also to identify and agree performance measures for the plan.

7.4 A number of sub groups will take forward the implementation process and develop detailed plans for service redesign. The Palliative Care development group has been operational for a number of years and agreement has been reached for this multi agency group to be the forum for taking forward the palliative care and end of life work.

7.5 An independent living group is being established to make links with wider third sector developments and incorporating representation from CVS and Your Voice to ensure inclusion and consultation across the community.

7.6 The review of homecare services in Inverclyde has just been completed, with the key focus being on the development of reablement. A roll out of reablement services is taking place across Scotland. It is based on an approach which aims to help people do things for themselves and as such is a change in culture for many service providers and carers.

7.7 There will be an expectation that the model of care will include support from occupational therapists with reablement being provided for an average of 6 weeks for all new referrals and hospital discharges.

7.8 Key elements of reablement include:

- Integration of services across health and social care
- Changes to the assessment and care management process
- User identified outcomes being central to the reablement process

7.9 An action plan has been developed as part of this work, with a copy attached for information. See appendix 2.

Appendix 2

8.0 PERFORMANCE MONITORING

8.1 Three levels of performance monitoring for the Change Plans are being developed, each one being a sub set of the other. Attempts are being made to ensure that the performance monitoring process is robust, but that it uses information already being collated and reported.

8.2 The Joint Improvement Team are developing a suite of Reshaping Care core measures with a mixture of hard information and some more qualitative measures. This work is linking into the National Benchmarking Group in which Inverclyde participates.

8.3 NHS Greater Glasgow and Clyde have developed summary indicators, gathering information from each partnership plan and identifying baseline information.

8.4 The Inverclyde Partnership have identified possible local information that could be used to inform the effectiveness of service redesign, and further work is underway to refine this information. The reablement sub group is considering the information requirements

8.5 A Mid-year Progress return with Implementation of Change Fund has been requested with a response date of the 26th August 2011. See attached appendix 3.The detail of the request and response will be discussed at the Steering Group on 9th August 2011. Appendix 3

9.0 IMPLICATIONS

9.1 Legal:

Finance. Monitoring of expenditure of £1.228m will be managed through Inverclyde CHCP with a separate budget being established.

Personnel: New posts will be established for a 12 month period. A process will be established to take forward appointments across the agencies.

10.0 CONSULTATION

10.1 Consultation sessions with service providers and staff has taken place as part of the development of the Change Plan. Ongoing consultation will take place with service providers, service users, carers and the wider community as part of the development of the range of service redesign proposals.

10.2 Your Voice, ICCF will play a key role in consulting with older people, both in detail of service redesign, but also to ascertain the views and wishes around the shape of care for older people in the future.

10.3 The Providers Forum will continue to be the main platform to ensure that service providers are able to contribute, and be aware of the full range of redesign proposals.

11.0 LIST OF BACKGROUND PAPERS

11.1 Appendix 1 – Change Plan

11.2 Appendix 2 – Reablement action plan

11.3 Appendix 3 – Mid Year Progress with Implementation of the Change Plan letter and template

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

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:

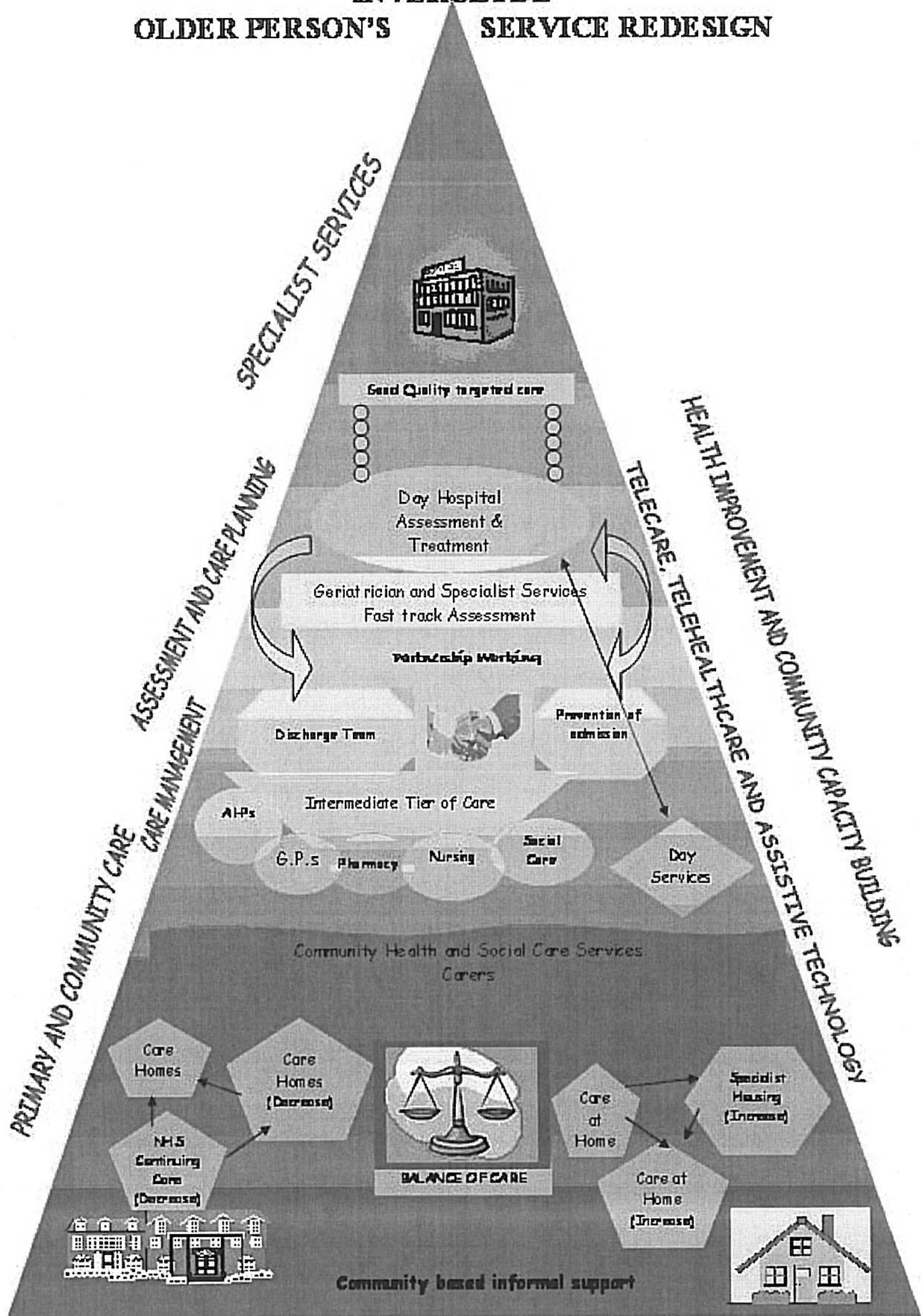
- re-ablement
- monitoring and administration of medication for homecare staff and carers
- use of dependency tools
- single point of access
- early interventions
- dementia
- carers needs
- carer training as part of the care plan

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

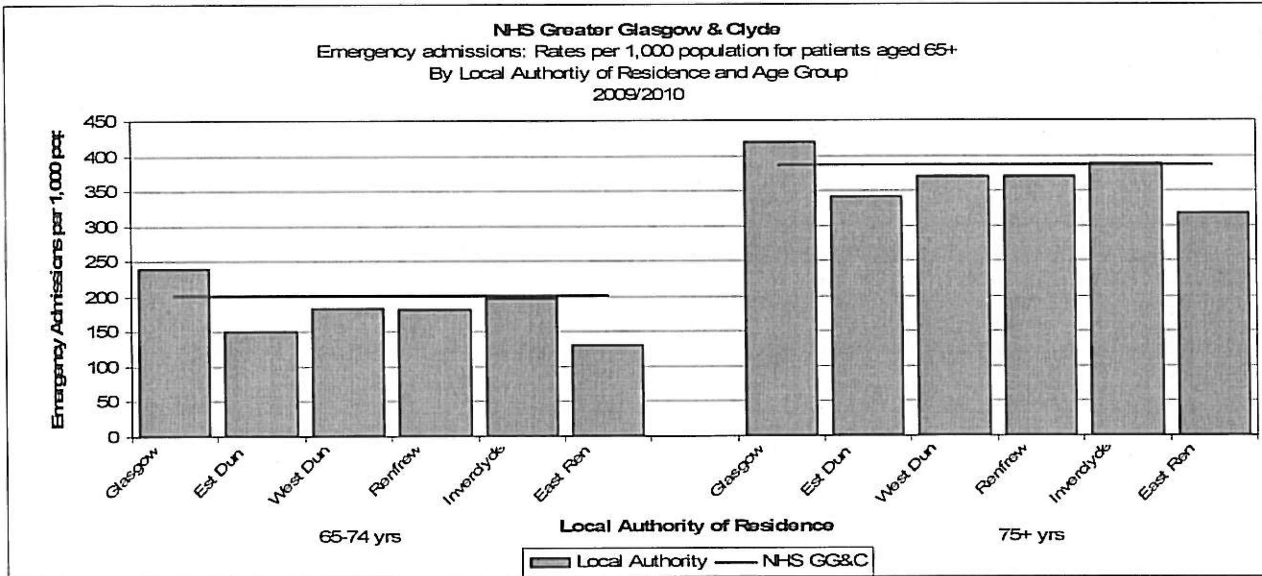


Key performance measures to assess progress

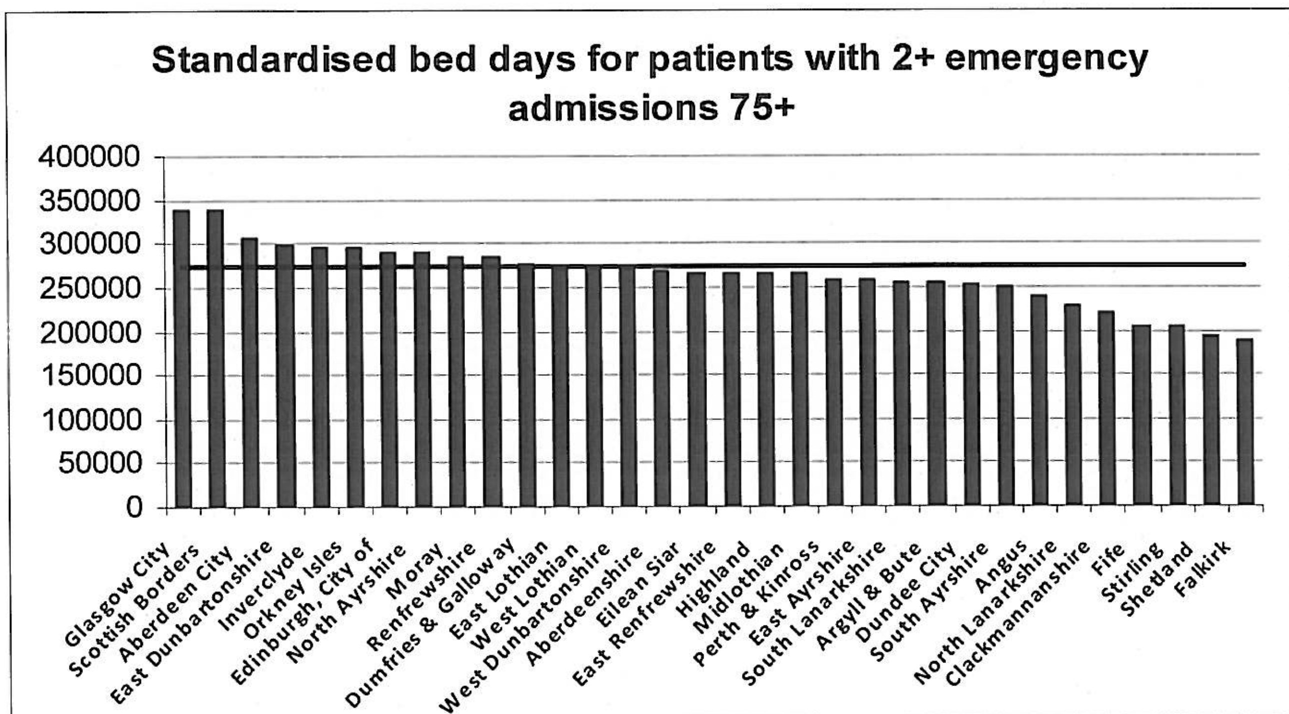
Inverclyde has particular issues in relation to the changing demographic composition and in the topography of the area. This combined with aspects of poverty and poor health and lower life expectancy make comparisons with all other areas across Scotland difficult.
The partnership have therefore chosen 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:

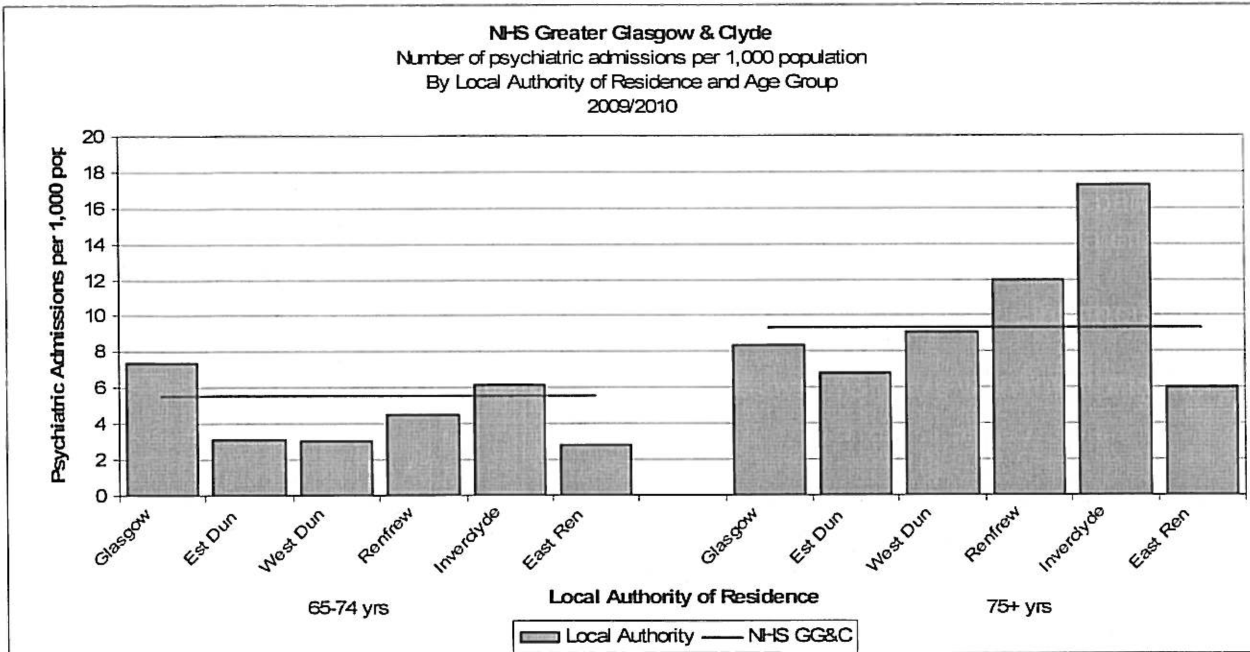
- **High levels of people aged over 75 years with multiple emergency hospital admissions**



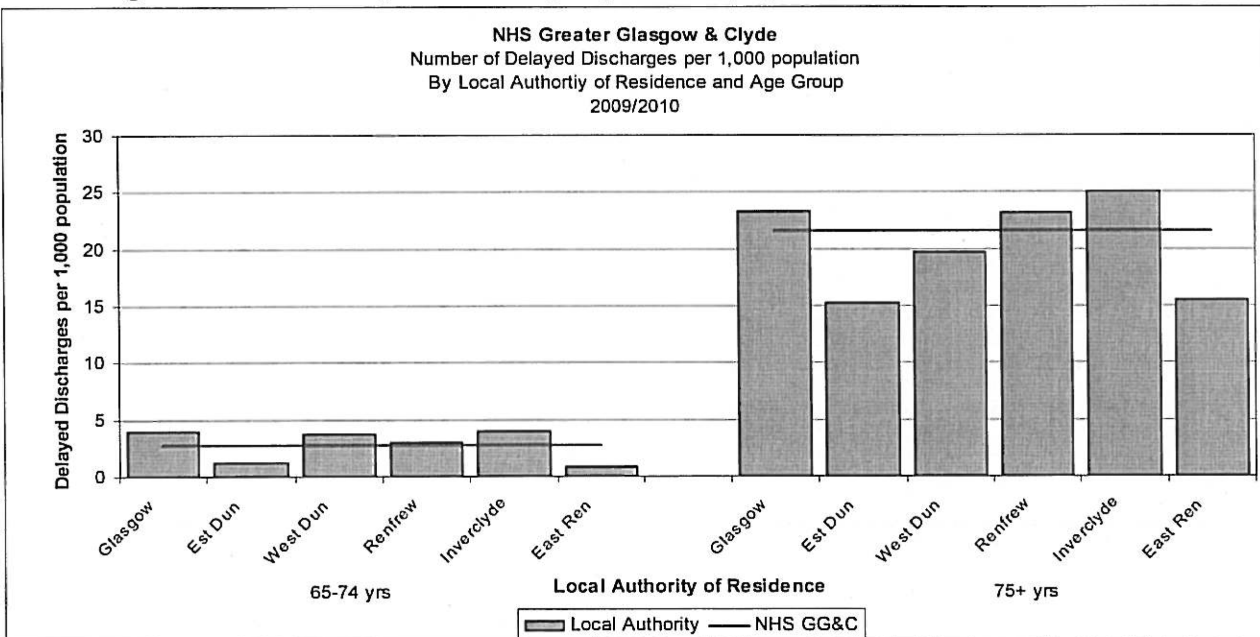
- **A high number of bed days used by people aged over 75 years with 2+ emergency admissions**



- **A high number of older people with mental illness being admitted to hospital on an unplanned basis**

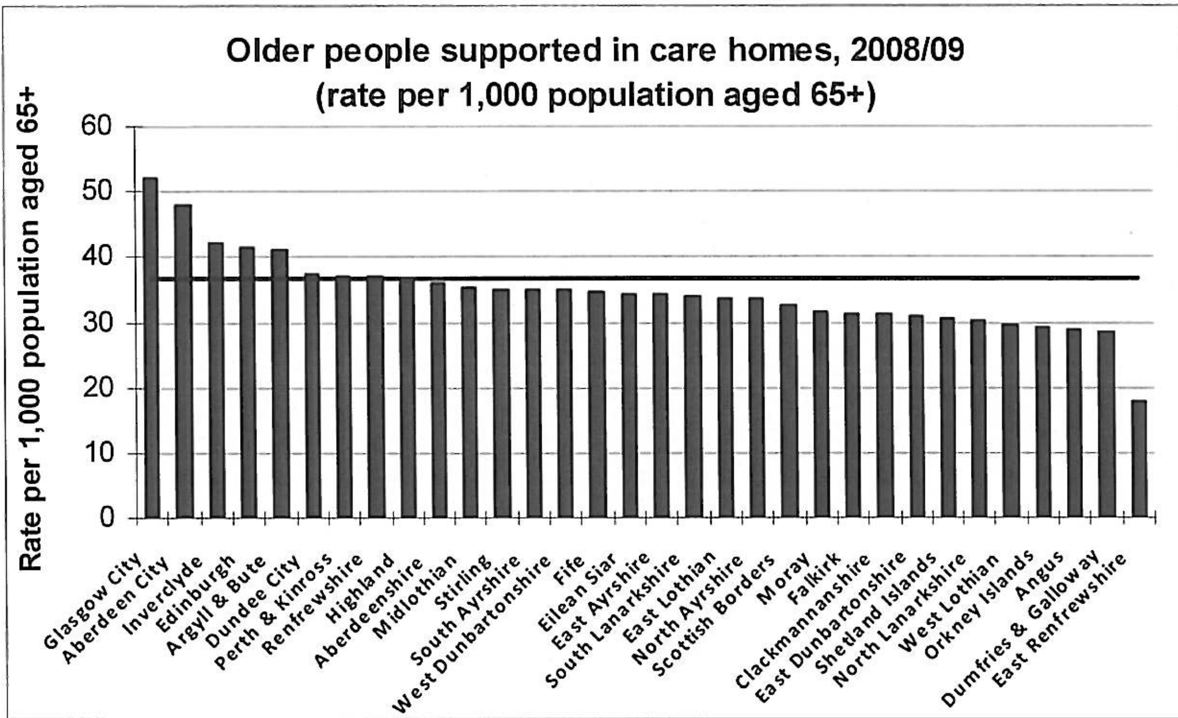


– **A high number of delayed discharges per 1000 population**

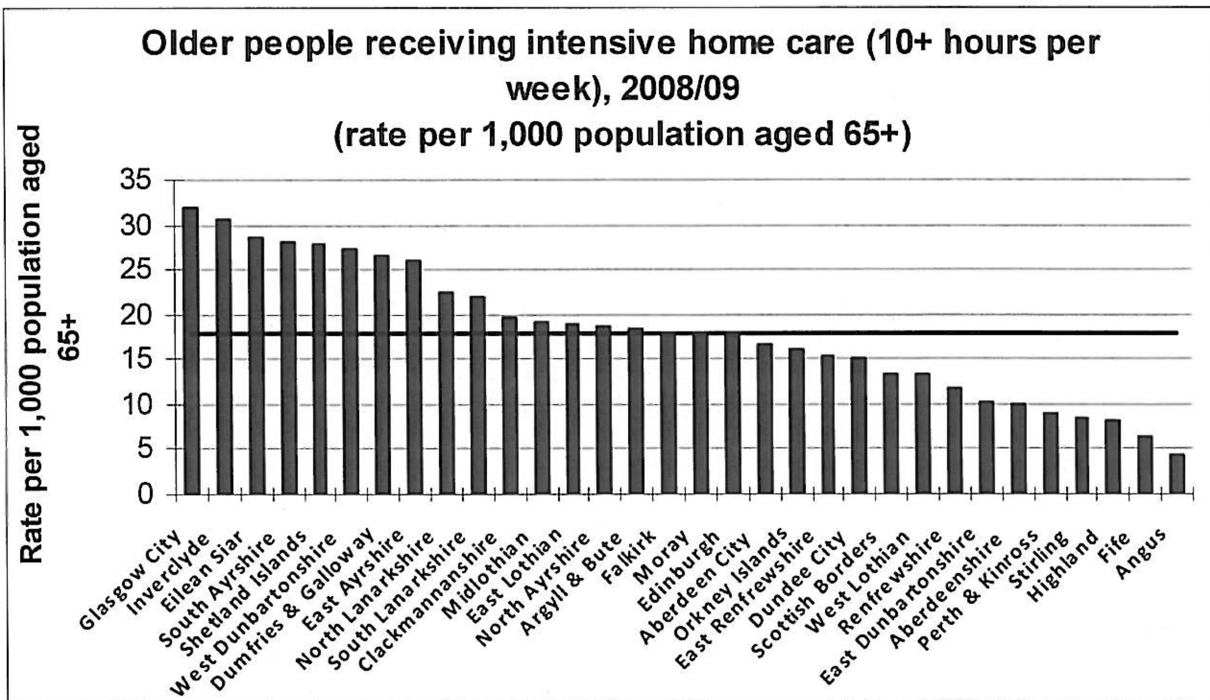


Inverclyde residents waiting for hospital discharge currently consume 6595 bed days we will reduce this by 35% by the end of First year with subsequent reductions of 15% thereafter. This takes account of the whole system change required and the time to secure the desired outcomes.

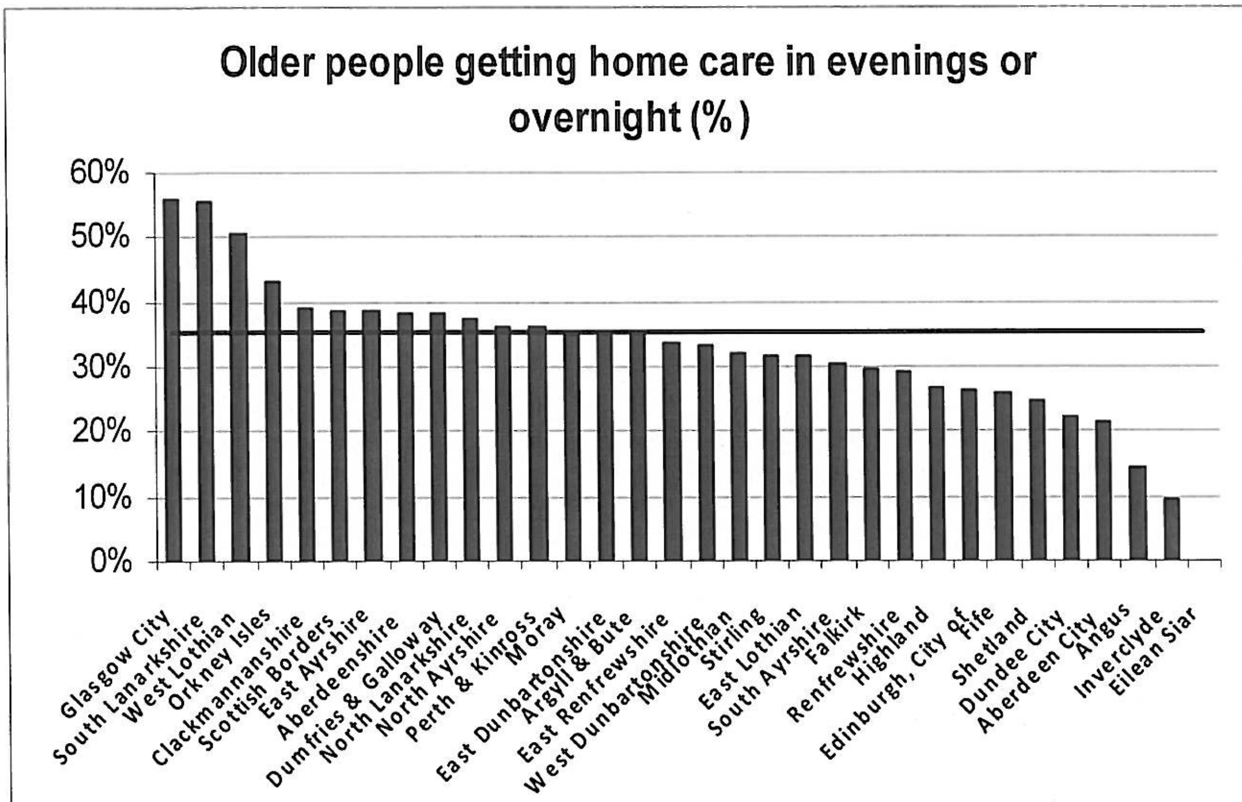
– **A high percentage proportion of people aged 65+ being supported in care homes**



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



– **A low percentage of people receiving overnight homecare**



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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.

Signed

Chief Executive
NHS Greater Glasgow
And Clyde

Chief Executive
Inverclyde Council

Corporate Director
Inverclyde community Health
& Care Partnership

Your Voice, Inverclyde Community Care Forum

Scottish Care

APPENDIX 1

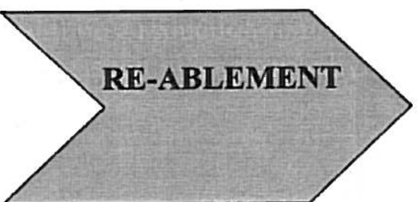
Summary of current partnership budget for older people

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

Appendix 2



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 re-ablement 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.

Services involved

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

Tasks to do

Review of homecare services and development of reablement service. Change Home from Hospital service and Rapid Response services to re-ablement services. Target all hospital discharges through the re-ablement service to ensure any rehabilitation possibilities are explored and goals for improvement set between clients and services.
Employment of OT staff to support the assessment process and develop re-ablement programmes. Link to Frail Elderly Team redesign.
Awareness training for staff around the change in philosophy from dependency to independence especially around inpatient services and assessment and care management staff.
Link inpatient reablement to discharge process
Public awareness raising.
Agree and roll out use of dependency tools so that realistic service requests are made that match the needs of the clients/patients.
Develop robust review processes to ensure goals are being met and that care provision is changing to meet the changing client needs.
Work with care homes to ensure that a re-ablement philosophy is developed for all new admissions to ensure residents reach their optimum independence and also have an opportunity to return home if they wish to.
Link telecare, falls prevention and re-ablement
MH liaison service development linked to wider service redesign
Redesign of day services

Measures

Reduction in unplanned admissions and bed days
Rapid discharge
Increase in older people living at home
Increased personalisation

Appendix 2

REABLEMENT ACTION PLAN

Action	Issues/links	Lead person	Timescale	
	Link to homecare review work Develop re-ablement with Home from Hospital and Rapid Response. Identify Home Support Managers to manage re-ablement.			
Staff briefing to widest staffing groups re reablement		Change Fund Steering Group	May	
Service user consultation and development of public information	As part of the wider Change Plan	Derrick Pearce Joyce Allan	August	
Make decisions regarding charging policy in relation to re-ablement and quantify any cost implications for loss of income		CMT	June	
Quantify additional capacity required to establish re-ablement		Team Leaders Homecare	June	
Advertise Reablement Development Lead post	Change Fund	Gillian McCready	July	
Develop training programme for re-ablement and identify staff to lead this. Develop rolling programme of training over the year, arrange venues etc	Cost backfilling requirements for training	Team Leaders Homecare and Head Occupational Therapist	July onwards	
Identify additional staffing	Internally recruited or externally recruited	Joyce Allan	July	
Advertise OT post	Identify district nursing links	Gillian McCready	August	
Identify referral process for new cases and change in circumstances	Link to SPA work	Team Leaders Homecare	August	

Appendix 2

Action	Issues/links	Lead person	Timescale	
Identify dependency tool		Reablement Development Lead	August	
Agree transfer process out of re-ablement and links to care management		Alan Buckley	September	
Roll out training programme		Jacquie MacIntyre, Reablement Development Lead Joyce Allan	September onwards	
Identify information requirements and how that will be captured and reported.	Link to Change Plan	Derrick Pearce	July	
Establish client satisfaction process	Talking points			
Establish evaluation process for reablement	Link to Change Plan and information requirements	Reablement Development Lead	September onwards	
Evaluation of reablement service	Link to change plan outcomes	Gillian McCready	April 2012	

Notes on completion of JIT mid-year Change Fund Review

The form has been designed to be as easy to complete as possible. Please let us know if you have any difficulties. An example is given on the form for reference. Different partnerships have broken down their fund into very different levels of detail. 12 columns are offered here, which should be filled in as necessary. if you have more investment headings, please just copy along further columns.

Field	Notes
Brief Description/Title of Investment area	Free text - very brief description. Group into themes as desired.
Progress to Date - select which stage this aspect of the plan has reached	Drop down options to select best fit - **Planning; Implementation; Delivery; Review;**
Original Change Plan submission proposed spending	From Change Plan. If the change plan spend was not broken down to the detail it now is, this section will be blank - please make this clear at Comments below
Actual Allocation 2011/12	Full year allocation 2011/12
Spend to 30 September 2011	6 month projected spend based on July/August position
Projected spend 2011/12	Projected end of year actual spend
Comments on forecast position/planned slippage? *Please also note here any funding itemised under projected spend 2011/12 which has been added by the partnership to the Scottish Government Change Fund allocation*	Any comments on problems with spend to date, reasons for any delay/planned phasing. Please also include here any elements of spend above which have been added by the partnership - i.e. not from Change Fund Allocation
What metrics are you using to identify impact in this area?	Please use one row for each metric/data item - add further rows if necessary
Metrics Continued (if required)	
Metrics Continued (if required)	
Metrics Continued (if required)	
Metrics Continued (if required)	
Comment/Issues	Free text - any comments regarding any elements of this investment or the overall plan

Partnership Name:		Date of Completion:	dd/mm/yyyy			
Contact Name: Tel. No. E Mail:						
	Example	Change Fund Investment/Proposal 1	Change Fund Investment/Proposal 2	Change Fund Investment/Proposal 3	Change Fund Investment/Proposal 4	Change Fund Investment/Proposal 5
Brief Description/Title of Investment area	Community Capacity Building . Encourage voluntary sector providers, faith group and community network involvement in the provision of low level and preventative inputs. Includes community transport supporting access to alternative day opportunities and other opportunities					
Progress to Date - select which stage this aspect of the plan has reached	Implementation					
Original Change Plan submission proposed spending (if itemised - see notes)	£100,000					
Actual Allocation 2011/12	£70,000					
Projected Spend to 30 September 2011	£15,000					
Projected spend 2011/12	£50,000					
Comments on forecast position/planned slippage? *Please also note here any funding itemised under projected spend 2011/12 which has been added by the partnership to the Scottish Government Change Fund allocation*	Recruitment timescales in one element of the project have delayed full implementation. Expecting to use some non recurrent underspend to fund handperson services to deliver increased preventative support in current year. Would seek some small carry over to continue commitment for a full three years to the elements of the investment with staffing implications prior to cash release elsewhere as per local implementation plan					
What metrics are you using to identify impact in this area?	Reduce unplanned acute bed-days for people aged 75 and over					
Metrics Continued (if required)	Increase in proportion of older people living at home					
Metrics Continued (if required)	Improved support for unpaid carers					
Metrics Continued (if required)	Improvement on 'Talking Points/Personal Outcome Approach' measures of outcomes fully met (safety, seeing people, things to do, living where want to live, respected)					
Metrics Continued (if required)						
Comment/Issues						

Partnership Name:						
Contact Name: Tel. No. E Mail:						
	Example	Change Fund Investment/Proposal 6	Change Fund Investment/Proposal 7	Change Fund Investment/Proposal 8	Change Fund Investment/Proposal 9	Change Fund Investment/Proposal 10
Brief Description/Title of Investment area	Community Capacity Building . Encourage voluntary sector providers, faith group and community network involvement in the provision of low level and preventative inputs. Includes community transport supporting access to alternative day opportunities and other opportunities					
Progress to Date - select which stage this aspect of the plan has reached	Implementation					
Original Change Plan submission proposed spending (if itemised - see notes)	£100,000					
Actual Allocation 2011/12	£70,000					
Projected Spend to 30 September 2011	£15,000					
Projected spend 2011/12	£50,000					
Comments on forecast position/planned slippage? *Please also note here any funding itemised under projected spend 2011/12 which has been added by the partnership to the Scottish Government Change Fund allocation*	Recruitment timescales in one element of the project have delayed full implementation. Expecting to use some non recurrent underspend to fund handyperson services to deliver increased preventative support in current year. Would seek some small carry over to continue commitment for a full three years to the elements of the investment with staffing implications prior to cash release elswhere as per local implementation plan					
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Metrics Continued (if required)	Increase in proportion of older people living at home					
Metrics Continued (if required)	Improved support for unpaid carers					
Metrics Continued (if required)	Improvement on 'Talking Points/Personal Outcome Approach' measures of outcomes fully met (safety, seeing people, things to do, living where want to live, respected)					
Metrics Continued (if required)						
Comment/Issues						

Partnership Name:			
Contact Name: Tel. No. E Mail:			
	Example	Change Fund Investment/Proposal 11	Change Fund Investment/Proposal 12
Brief Description/Title of Investment area	Community Capacity Building . Encourage voluntary sector providers, faith group and community network involvement in the provision of low level and preventative inputs. Includes community transport supporting access to alternative day opportunities and other opportunities		
Progress to Date - select which stage this aspect of the plan has reached	Implementation		
Original Change Plan submission proposed spending (if itemised - see notes)	£100,000		
Actual Allocation 2011/12	£70,000		
Projected Spend to 30 September 2011	£15,000		
Projected spend 2011/12	£50,000		
Comments on forecast position/planned slippage? *Please also note here any funding itemised under projected spend 2011/12 which has been added by the partnership to the Scottish Government Change Fund allocation*	Recruitment timescales in one element of the project have delayed full implementation. Expecting to use some non recurrent underspend to fund handyperson services to deliver increased preventative support in current year. Would seek some small carry over to continue commitment for a full three years to the elements of the investment with staffing implications prior to cash release elswhere as per local implementation plan		
What metrics are you using to identify impact in this area?	Reduce unplanned acute bed-days for people aged 75 and over		
Metrics Continued (if required)	Increase in proportion of older people living at home		
Metrics Continued (if required)	Improved support for unpaid carers		
Metrics Continued (if required)	Improvement on 'Talking Points/Personal Outcome Approach' measures of outcomes fully met (safety, seeing people, things to do, living where want to live, respected)		
Metrics Continued (if required)			
Comment/Issues			

jit joint improvement team

Date : 21st July 2011

For enquiries:

0131 244 3365
Margaret.whoriskey@scotland.gsi.gov.uk

Reshaping Care Strategic Leads
Reshaping Care Operational Leads

Dear Colleague

Mid-year Progress with Implementation of Change Fund

We are aware that your Partnership is moving forward in developing and implementing the range of proposals set out in your Change Plan and progressing the work around the development of your strategic approach to Reshaping Care and the Change Plan for 2012 – 2015. We anticipate that guidance on this will be issued in the Autumn, following the Spending Review.

As I am sure you will appreciate, it is important to be able to evidence and understand the impact being made by the Change Plans in local areas and the effective use of the Change Fund. It is also important to ensure that we maximise opportunities for shared learning in this regard and we hope that the Improvement Network arrangements will assist with this. A letter has recently been issued setting out the Reshaping Care Core Improvement Measures, following consultation with local Partnerships and stakeholders, which will inform progress over time.

To assist in the development of local Change Plans, we circulated Service Profiles for each Partnership at the end of last year and this data is available on the link below:
http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/change-fund-library-of-resources/national-data-and-evidence/

We plan to update the data in these reports in line with any new published statistics.

We are conscious that, in many areas, much of the activity in the first three months has been in refining proposals, reviewing governance arrangements to ensure inclusion of third and independent sector representatives, and implementing project management arrangements. We would however like to be in a position to present a more detailed progress update to the next meeting of the Health and Community Care Delivery Group in early September and the subsequent meeting of the Ministerial Strategic Group.

We are looking for your assistance in providing a brief summary on the position in your partnership and progress with your developments . This should include the level of agreement regarding change plan developments, the commitments you have made regarding allocation of change funds to end of September 2011 and year-end financial projections. A Proforma is attached to assist you with this. It will also be helpful to have this information updated for the end of December 2011.

This information will clearly be important in the discussions during the autumn regarding the anticipated 2012-2015 spending review allocation regarding the Change Fund commitment.

It is important that this year's allocation is fully committed, against your strategic plan, to achieve maximum impact in providing a solid foundation for a shift in the balance of care and related resources. Many partnerships are already looking at appropriate and targeted non- recurring investments that will contribute to this, including building third sector capacity, organisational development, equipment and telehealthcare. I would encourage all partnerships to do the same. JIT will run some web ex sessions in September with Partnership representatives to discuss this further and to consider good practice examples with regard to areas such as equipment and adaptations and Telecare/Telehealthcare.

I hope the above is helpful. In the meantime, could you please send me the relevant monitoring information regarding your change plans and change funds activities, including specific monitoring information regarding the use of the change fund and year end projections by **26th August 2011,** by e mail to patrick.hogan@scotland.gsi.gov.uk

If you would like to discuss this request further please don't hesitate to contact me. The JIT lead for your Partnership is available to discuss this also and work with you to complete the Proforma.

Thank you for your consideration in this matter and look forward to hearing from you.

Sincerely,

Dr Margaret Whoriskey
Director
Joint Improvement Team