

**Report To:** Community Health & Care  
Partnership Sub Committee

**Date:** 13 February 2012

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Care Partnership

**Report No:** CHCP-18-2012-BM

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**Subject:** Reshaping Care for Older People – Inverclyde Local Change  
Plan

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## 1.0 PURPOSE

- 1.1 To provide an update on the development and progress of the local Change Plan currently driving The Scottish Government Directive, Reshaping Care for Older People as previously reported upon.

To seek approval, to submit to Scottish Government Ministers the prepared submission for continued allocation of Change Funds for 2012/13 to progress the Change Plan to the next stage.

## 2.0 SUMMARY

- 2.1 As previously reported the Government has initiated a directive to transform the existing model of care and support for older people. The 10 year strategy 2011 -2021 A Programme of Change, sets out the Scottish Government vision for improving care quality and outcomes for older people in our communities, and presents unique challenges with regard to rapidly changing demographic trends, expectations and economic drivers.
- 2.2 This report provides an update for the Community Health and Care Partnership Sub-Committee on the progress of Inverclyde's CHCP local plans for Reshaping Care for Older People, and also presents the planned submission to the Scottish government for 21012 /13 Change Plan Funding.
- 2.3 Performance to date in respect of the Implementation Phase is considered to have progressed, has recently gained momentum in some aspects and is viewed as positive regarding some key measures achieved during 2011.
- 2.4 The partnership has demonstrated noteworthy progress taking account that for many of the workstreams, there has been substantial lead in factors influencing implementation including the setting up of governance arrangements, developing performance measurements, negotiating with partners, recruitment and selection processes and internal considerations.
- 2.5 A Project Manager has been recruited to assist in the development and progress of the Change Plan.

### **3.0 RECOMMENDATION**

3.1 The Community Health and Care Partnership Sub-Committee members are requested to:

(a) Note the progress made with regard to implementing the Local Change Plan and the Scottish Government agenda on Reshaping Care for Older People 2011/12.

(b) Endorse the prepared submission for funding allocation to the Change Fund 2012/13.

**Robert Murphy**  
**Corporate Director**  
**Inverclyde Community Health & Care**  
**Partnership**

## **4.0 BACKGROUND**

- 4.1 Reference is made to previously submitted Sub- Committee Reports outlining the Scottish Government's strategy on Reshaping Care for Older People. The vision set out by Government is that "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting".
- 4.2 The directive to transform existing care and support models is central to the Government's endeavours to realise this vision and optimise both wellbeing and independence for older people.
- 4.3 The key elements of the Government strategy are therefore, the requirement for further integration of care pathways and service delivery, community capacity building, with a clear focus on reducing unnecessary hospital admissions, lost bed days and the use of care homes. Reflecting aspiration to determine vital change at every level, it is notable that current Government guidelines stipulate as prerequisite for future funding consideration, that a plan for Joint Commissioning processes be indicated in the funding submission for 2012/13.
- 4.4 As demographic trends change, older populations are rapidly increasing, and at a time of financial constraint, there are acknowledged inherent challenges in providing expected better outcomes for older people and carers. The provision of a continuing Change Fund is therefore pivotal to accelerating this transformation process.
- 4.5 The Sub-Committee will recall that in February 2011 Inverclyde CHCP was allocated a £1.28 share of the £70m million budget from the Scottish Government Change Fund for 2011/12.
- 4.6 To further support the Reshaping Care Programme, the Government subsequently announced a continuation of funding for a further three year period and invited submissions for change fund monies (increased nationally from £70m to £80m) for 2012/13, to be submitted by 17 February 2012.
- 4.7 The Change Fund is being used to support and improve care for older people and their carers in Inverclyde CHCP through the delivery of key objectives initially set out in local change plan and submitted to the Ministerial Strategic Group in 2011.

## **5.0 PROPOSAL**

- 5.1 Inverclyde CHCP proposes to continue its work with a wide range of partners and stakeholders to ensure Change Fund investment together with other local resources accomplishes the objectives set out in the local Change Plans with regard to the Government agenda, of Reshaping Care for Older People.

## **6.0 PROGRESS OVERVIEW**

- 6.1 Commitments outlined in the CHCP's Change Plan are advancing. Although modest change is evident in specific areas of current workstreams, other changes taking place cannot be specifically related to the Change Fund at this time.
- 6.2 As can be seen from the summary reports provided below, workstreams are progressing, some are at early operational stage, others well underway with defined work programmes, and some are at implementation stage.
- 6.3 There is evidence of a cultural shift in professional and community settings borne out by the evaluation of engagement events. Within the professions and local communities there is growing recognition that historic models of care and support for older people are fundamentally both undesirable and unsustainable.

- 6.4 There is considerable positivity with regard to the redesign of services and associated benefits are acknowledged with regard to outcomes for older people, carers and services overall.
- 6.5 Whilst challenged by changing expectations, shifting demographic patterns and available resources the workforce have benefitted from training provision and are confident and competent in role.
- 6.6 Ensuring robust performance measurement is a challenging area of work. Currently we are reviewing the way local data is collated to ensure best fit to effectively demonstrate change and associated outcomes.
- 6.7 **A number of initiatives and developments detailed below have contributed to modest improvements and will continue to deliver agreed targets and objectives.**

6.7.1 SINGLE POINT OF ACCESS

Development continues on the partnership's Single Point of Access element of work designed to provide a single entry point for rapid access for older people to the rehabilitation and re-enablement services.

6.7.2. HOSPITAL DISCHARGE PROCESS

(a) Assessment - The partnership has reviewed Social Work capacity within the hospital setting; consequently processes are streamlined to facilitate early discharge. Social Workers are aligned to specific wards; briefing sessions have been held and changes are viewed in a positive light.

(b) Specialist Multi-Disciplinary Assessment Tool (SMAT) - Training has been delivered to ward staff and the above assessment tool was formally introduced to hospital wards within the IRH campus in December 2011.

(c) Reablement Development - All new cases are assessed for reablement potential. The service is provided for approximately 6 weeks before being passed to mainstream homecare, reducing or withdrawing services. A total of 58 people have been assessed between October and December 2011.

(d) Adults with Incapacity - Briefings have ensured that priorities are identified at early stage where capacity is an issue, and processes have been streamlined in respect of relevant applications.

6.7.3. SPARRA

SPARRA data is being reviewed to try and identify factors contributing to increased probability of hospital admission. A pilot in relation to patient's age > 65 with high risk of falls with a risk score over 65 is underway, and a small cohort of patients will be reviewed to explore the benefits of introducing additional interventions.

6.7.4. SOCIAL WORK TEAMS - The feasibility of realigning existing Social Work Teams to cohorts of GP practices is being explored to identify potential benefits. It is intended to enhance links with District Nursing staff/ Care Homes within the locality and highlight at an early stage those clients who would benefit from additional and/or different services.

6.7.5. UNPLANNED ADMISSIONS AUDIT - An audit of unplanned/emergency admissions across a 12 week period has been conducted. Information collated from this, together with data from the Scottish Ambulance Service will shape future additional capacity and enhance the range of services required to support people at home rather than being admitted to hospital.

6.7.6 INTERMEDIATE CARE - A range of intermediate care developments will be taken forward as an element of the reablement process. Consideration will be given to alternative usage of resources provided within NHS facilities, including the

possibility of using care home beds for these plans.

6.7.7 **DEMENTIA STRATEGY** - Inverclyde CHCP is implementing the Modernising Mental Health Services Strategy. Work being undertaken relates to the redesign of Older People's Mental Health Services, including specifically the dementia care pathway. The provision of funding from the Change Fund for 2012 -2013 will enable focus on workstreams and a Lead Officer will support this work in key areas identified in the Change Plan submission.

6.8 **CARERS** - Inverclyde has been cited in the National Carers Strategy for examples of best practice. The Government target of ensuring a 20% allocation of funding for carers is met. The partner organisations involved in the local response to the needs of carers are as follows:-

- **Inverclyde Carers Council**
- **Your Voice - Inverclyde Community Care Forum**
- **Inverclyde Carers Centre**
- **Inverclyde Community Health and Care Partnership (CHCP)**
- **Community Capacity Building**

Big Lottery funding of approx £600,000 has been allocated to three local groups and will inform the future prioritisation of Change Fund investment. Nine projects have been funded through the Change Plan Community Capacity workstream and will provide a range of resources to address the needs of Inverclyde's carers.

6.9 **GOVERNANCE** - The Partnership has amended its governance arrangements putting in place structures that enhance transparency, accountability, and flexibility and ensure the required leadership.

6.10 **FINANCE** - The document attached to this report highlights relevant areas of funding and expenditure across each of the pathways.

The full allocation of funding has not been utilised in 2011/12; this is due to the length of time required to initiate projects, including advertising and recruitment of relevant staff. The carry forward balance, approved by Government, relates to 9 project areas and will be applied across the 5 pathways in 2012/13. Additional slippage of £232K has been transferred to Greater Glasgow and Clyde Health to manage new pressures within related to the changes being made.

As detailed in the Change Plan submission, the allocation for 2013/14 and 2014/15, is anticipated to be in the region of £1.4 and £1.2 million respectively. The prioritisation and allocation of resources across pathways will be determined by the outcomes from 2012/13 and impacts of the commissioning strategy and integrated resource framework.

It is acknowledged that the total allocation of £1.433 million in 2012/13 is £0.03 million in excess of allocation. This will be contained through monitoring and prioritisation of projects.

A significant "Big Lottery award has been secured in Inverclyde

6.11 **SELF ASSESSMENT AGAINST 2011/12 PERFORMANCE** - On the basis of performance to date, and taking into account Government allowances made for the first six months of the Change Plan Programme for all partnerships, it is concluded likely that we will meet the 35% set reduction targets for delayed hospital discharges for 2011/12 and 15% in 2012/13.

6.12 **IMPACT ASSESSMENT** – To date no impact assessments have been carried out. These will be undertaken in the course of 2012 and full impact assessment will be required for Joint Commissioning as this is progressed.

## 7.0 PROPOSALS

Inverclyde CHCP proposes to continue its work with a wide range of partners and stakeholders to ensure Change Fund investment together with other local resources accomplishes the objectives set out in the local Change Plans with regard to the Government agenda, of Reshaping Care for Older People.

## 8.0 IMPLICATIONS

8.1 Legal: Non identified at this time

8.2 Finance: N/a

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

8.3 Personnel: None

8.4 Equalities: None

## 9.0 CONSULTATION

There has been extensive consultation through the partnership forums, staff briefing events and provider's forums concerning the progress and development of the Change Plan.

## 10.0 LIST OF BACKGROUND PAPERS

- (1) Change Plan Submission
- (2) Change Fund Data Report
- (3) Change Plan Development Reporting/Monitoring System: Independent Living
- (4) Change Plan Development Reporting/Monitoring System: Carers

## Appendix 1

### Change Plan Template

#### 1. Name of Partnership

Inverclyde Community Health & Care Partnership

#### 2. Partner Organisations

##### 2.1 Partners signed up to the Change Plan

Partners are as before, with Inverclyde CVS as an additional signatory to the Change Plan for 2012/13.

##### 2.2 Professional Engagement in the development of Plans

Progress reports on 11/12 workstreams have been delivered through the mechanisms of the established Inverclyde Providers Forum and also Staff Briefing Events. These have provided a useful platform for providers and a wide range of professional groups to participate with regard to sharing relevant information and enabling contribution to the ongoing Change Plans. The positive feedback from participants concerning the value of these events is acknowledged and will inform future developments with regard to the ongoing engagement of multi-disciplinary professionals. The Partnership whilst recognising the evaluated success of these events will address the limitations of singleton or annual briefing sessions; consequently the partnership will develop staff forums for each of the key workstreams. This will facilitate the sharing of information regarding implementation progress and any issues arising on a more regular routine basis.

Following each quarterly Project Board meeting a planned, electronic newsletter providing relevant Change Plan updates and appropriate contributions from professionals engaged in service delivery will be distributed to all CHCP staff and other stakeholders. Bi-monthly multi-disciplinary lunchtime network meetings will also be held at Inverclyde Royal Hospital thereby widening opportunities for staff to be proactively involved. The purpose of these sessions will be to provide opportunity for continuous review of practice, processes and performance, and to ensure specific focus on admission and discharge activity.

These arrangements will be augment existing professional forums within Inverclyde, i.e. PEG and Social Work Practitioners Forum, Clinical Governance Groups and the Joint Inverclyde Quality, Advice and Assurance Group.

The Joint Inverclyde Quality, Advice and Assurance Group (JIQAAG) was

established in Inverclyde to explore ways of improving service quality. Learning from experiences, both positive and negative, informs the quality improvement agenda including necessary effective communication links with formal complaints processes.

The group membership is multi-disciplinary, crosscutting and represents acute services, GPs, Primary Care, Mental Health and Community Care services.

The group ensures that necessary links between NHS and private care homes are established and robust. Where issues of poor quality are identified around discharge and admissions to hospital from care homes, these are highlighted and relevant resources are effectively mobilised to ensure positive change with regard to improvement and sustaining quality.

A key focus of the group remit is to explore and analyse relevant trends and issues, ensuring lessons are learned and mechanisms are in place to ensure continued and sustained quality improvement overall. The group also considers new requirements for service delivery and helps identify processes required to be developed locally to support implementation and, critically, facilitates links across services. Group members also have a responsibility to ensure that information is shared appropriately and disseminated to relevant staff groups.

The Partnership recognises the requirement for an effective and more proactive approach concerning the engagement of General Practitioners in the coming year. The GP Forum and other communication mediums, including local GP/consultant forum provide appropriate structures for ensuring this agenda is rigorously pursued. Similar engagement with other relevant independent contractors, for example, pharmacists will also be progressed to achieve maximum impact in this area of work.

Ensuring GPs are fully engaged in 2012/13 is crucial to delivering new sustainable approaches to caring for older people; consequently previous work conducted in Inverclyde, concerning the alignment of GPs to the Care Homes Estate, will be revisited in 2012/13. Whilst dialogue concerning existing arrangements will take cognisance of the work already undertaken by Greater Glasgow and Clyde, the Partnership will progress the current debate with due regard to Inverclyde's rapidly changing population and overall care estate. Links to the Ageing Population Planning and Review Group will ensure that the experience of other partnerships together with evidence based research will inform this process.

Developing this aspect of work will help determine whether an alternative model can contribute to preventing admissions to care homes, hospital and lost bed days; develop further support for long term condition management; maximise potential for achieving the set targets of the Change Plan; and overall provide improved sustainable outcomes for people.

In cognisance of the National Housing report recently published, dialogue has begun with housing/accommodation providers to ensure service delivery will



meet changing needs in local communities as the Change Plan continues to have impact on the care and support of older people. Engagement with this sector will be progressed further in 2012/13 and with reference to the planned joint commissioning strategy.

Reporting mechanisms for development and activity concerning professional engagement will be through the Change Plan Project Board. ICHCP Organisational Development and Staff Training will progress the evolving agenda and ensure ongoing professional engagement regarding the Reshaping Care for Older People Programme.

The above will ensure that the engagement process with the professions will be ongoing, targeted and meaningful, enabling a multi-disciplinary root and branch approach to developing the evolving Change Plans.

### 2.3 Public engagement in the development of Plans

The Partnership acknowledges the need to engage with the wider public, the future beneficiaries of the Reshaping Care Programme, and has established a communications sub group to progress this strategy. Local newspapers, internal newsletters and our Solus Screens will be used to facilitate engagement and will routinely communicate short and long term objectives of the Reshaping Care for Older People Programme. The use of technology to enhance communication and engage with communities will also be explored to ensure that modern media can enhance what we do in this important aspect of work.

Regular updates on the Change Plan are currently provided by the chair of the CHCP sub committee, Councillor Joe McIlwee, and the community representative, Mrs Nell McFadden MBE, in their role as Older Peoples Champions. They are supported by 'Your Voice' to engage regularly with local older people and circulate quarterly newsletters to over 1,000 local older people.

Currently there is in place an Older People's Sub Group as a component of our CHCP Advisory Group structures (which encompass our PPF). This sub group will operate as a reference point for the views of older people in our community.

We make use of regular older people's tea dances, facilitated by Your Voice (our engagement partners) to establish the views of current and future generations of older people. We are also enhancing our range of mechanisms for gathering the views of current users of our older people's services.

Two people from the older peoples sub group are members and in their capacity as members have contributed to the remit of the Community Capacity Working Group; they will continue to contribute their expertise and experience to inform future Change Plan activity.

Local people from Inverclyde's diverse community have also been involved in the End of Life Care workstream through our 'Compassionate Inverclyde' programme, and carers are acknowledged and central to our Supporting Carers workstream.

The above approaches, as outlined in 2.2 and 2.3, represent a significant culture change within Inverclyde's partnership and local communities with regard to caring for older people. A shift in focus to a more robust outcomes approach together with service redesign and an emphasis on wider engagement, will determine evidence based improvement and by implication realise required and sustainable cultural change.

### 3. Finance

#### 3.1 Resources available to Partnerships

From	Amount £ £'000	Difference from 2011/12 £'000
Monies carried forward from 2011/12 allocation	288	N/A
Initial central allocation	1,721	493
Added by NHS Board	0	0
Added by local authority	277	144
Other	0	0
<b>TOTAL</b>	<b>1,710</b>	<b>637</b>

#### 3.2 Reasons for financial 'carry forward'

The full allocation of funding has not been utilised in 2011/12; this is due to the length of time required to initiate projects, including advertising and recruitment of relevant staff. The carry forward balance relates to 9 project areas and will be applied across the 5 pathways in 2012/13 as follows:

Pathway	£'000
Preventative & Anticipatory Care	52
Proactive Care & Support at Home	82
Effective Care at Time of Transition	42
Hospital & Care Homes	101
Enablers	10
<b>Total</b>	<b>288</b>

### 3.3 Change Fund allocation by pathway

	Preventative & Anticipatory Care £'000	Proactive Care & Support at Home £'000	Effective Care at Time of Transition £'000	Hospital & Care Homes £'000	Enablers £'000	Total £'000
2011/12	181	284	146	581	36	1,228
2012/13	195	387	211	425	216	1,433
2012/13	9%	27%	12%	35%	17%	
2013/14	Please see note 1 below					
2014/15	Please see note 1 below					

#### Note 1:

The allocation for 2013/14 and 2014/15 is anticipated at £1.4 and £1.2 million respectively. The prioritisation and allocation of resources across pathways will be determined by the outcomes from 2012/13 and impacts of the commissioning strategy and integrated resource framework.

#### Note 2:

It is acknowledged that the total allocation of £1.433 million in 2012/13 is £0.03 million in excess of allocation. This will be contained through monitoring and prioritisation of projects.

### 3.4 Total resource allocation by pathway

See Note 6

	Preventative & Anticipatory Care £'000	Proactive Care & Support at Home £'000	Effective Care at Time of Transition £'000	Hospital & Care Homes £'000	Enablers £'000	Total £'000
2011/12	191	299	153	599	38	1,279
2012/13	235	462	252	509	252	1,710
2013/14	Please see note 1 at 3.3. above					
2014/15	Please see note 1 at 3.3. above					

#### 4. Self Assessment Against 2011/12 Performance

On the basis of performance to date, and taking into account Government allowances made for the first six months of the Change Plan Programme for all partnerships, we believe it likely that we will meet the 2012 targets. In parallel the partnership is focussed on ensuring the delivery of the new targets set for further prevention of delayed discharges and reducing lost bed days for 2013.

##### 4.1 Nationally available outcome measures and indicators

The availability of data in relation to the National Core Improvement Measures, suggested Local measures and Partnership resource use has been variable.

In relation to the JIT core improvement measures we can report the following for section A, at this stage:

<b>A: Nationally available outcome measures and indicators</b>	
A1. Emergency inpatient bed day rates for people aged (75+)	Baseline: 2009/10 = 6,401 (per 1,000 population) Actual: Nov 2011 = 3071 (per 1000 population)
A2 (a). Patients whose discharge from hospital is delayed	Provided (ISD) Baseline: April 2011 >6wks = 0 <6wks = 7 Actual: Jan 2012 >6wks = 0 <6wks = 3
A2 (b). Accumulated bed days for people delayed	Provided (ISD) Baseline: 2009/10 = 6,724 Actual: Nov 2011 = 283
A3. Prevalence rates for diagnosis of dementia	Provided (NHS QOF) Baseline: as at 30/04/11 - 735 Actual: as at 31/10/11 - 729
A4. Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting	Provided (ISD) Baseline: Info not provided Actual: Info not provided
A5. Percentage of time in the last 6 months of life spent at home or in a community setting	Provided (ISD) Baseline: 2009/10 = 88.0% of all deaths Actual: Info not provided
A6. Experience measures and support for carers from the	Provided (SCCBN) Baseline: Info not yet available Actual: Info not yet available

Community Care Outcomes Framework	
<p>In relation to Section B of the core improvement measures we can report the following at this stage:</p>	
<p><b>B. Local Improvement Measures</b></p>	
<p><i>Anticipatory and Preventative Care</i></p>	
<p>B1. Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared</p>	<p>Baseline: Info not yet available Actual: Info not yet available</p> <p><i>Local work has begun in relation to Anticipatory Care Planning and we anticipate being able to present data in relation to ACPs in year 2 of the programme.</i></p>
<p>B2. Waiting times between request for a housing adaptation, assessment of need, and delivery of any required adaptation</p>	<p>Baseline: Info not yet available Actual: Info not yet available</p> <p><i>We are identifying the relevant local data source and will be able to report this in year 2 of the programme</i></p>
<p>B3. Proportion of people aged 75+ with a telecare package</p>	<p>Baseline: Jan-Mar 2011 Over 65 - 116 Actual: Jul-Sept 2011 Over 65 = 53 Over 75 = 37</p> <p><i>There was a gap in information provision due to the long term absence of a key member of staff, thus our latest reportable figures are for the quarter to end Sept 2011.</i></p>
<p><i>Responsive / flexible home care and carers</i></p>	
<p>B4. Reduction in hours of support required after reablement service provided</p>	<p>Baseline: Information not yet available Actual: Information not yet available</p> <p><i>Our reablement service has been put in place relatively recently. Data capture arrangements are being put in place and this data will be reported in year 2 of the programme. See section 4.4 for an update on progress re re-ablement.</i></p>
<p>B5. Respite care for older people per 1000 population</p>	<p>Reported as <b>weeks</b> of respite Baseline: 10/11 8870 weeks (People aged 65+) Actual: 11/12 will be available Sept 2012</p> <p><i>We report weeks of respite as per the national PI rather than respite by number of</i></p>

	<i>people in receipt. We are currently reviewing our local intelligence in relation to respite and short breaks.</i>
<i>Demand for acute care</i>	
B6. Rates of 65+ conveyed to Accident & Emergency with principal diagnosis of a fall (Data from Scottish Ambulance Service)	Provided (SAS) Baseline: Information not provided Actual: Information not provided
<i>Effective flow in acute care</i>	
B7. proportion of frail emergency admissions who access specialty unit within 24 hours	Local Acute Baseline: Information not provided Actual: Information not provided  <i>The implementation of Track Care in our acute sector has meant that information availability has been limited. When the Track Care implementation is complete we are confident we will be able to report this measure in year 2.</i>
<i>Use of long term residential care</i>	
B8. Rate and proportion of new entrants admitted from home; acute hospital specialty; following intermediate care; graduate from emergency respite	Baseline: Information not yet available Actual: December 2011 Hospital = 8 Community = 3  <i>As of December 2011 we are routinely recording the source of referral to care home</i>
In relation to section C of the Core Improvement Measures (Partnership Resources use) we are unable to report any information as confirmed IRF data has not yet been released to the partnership.	

#### 4.2 Local improvement measures

We have a range of key local indicators in place across NHS GG&C in order to demonstrate improvement/change in the context of the health board. The embedded document below contains trends information on these key performance indicators. Also included in the embedded document is a brief summary statement in respect of our performance against these indicators in relation to the key performance expectations we set ourselves at the outset of our Reshaping Care for Older People Programme, which were:

- 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 the proportion of older people living at home through development of re-ablement and reducing 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

In addition to the Board-level indicators, we are continually developing a suite of local indicators specific to our agreed work streams which again link to our core deliverables agreed in year 1 of our Change Plan.

Key indicators will be agreed which help reference spend in relation to change activity, as per agreed workstreams in the following key priority areas:

- 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**
- Increased support for **carers**

We have devised a Specific Measures proforma as a means of collating and routinely analysing information regarding the development and progress of each workstream. Linked to both activity and key deliverables and in relation to the allocated spend from our overall change fund, workstream leads will return this information monthly to reflect agreed indicators, on the following basis:

<b>Workstreams Specific Measures – being developed (as per Monthly Monitoring Forms)</b>						
	<b>Indicator</b>	<b>Baseline (as close to April 2011 as possible)</b>	<b>Target (for year or quarter)</b>	<b>Outcome for Period (this month)</b>	<b>Outcome Since start (cumulative)</b>	<b>Source of data</b>
Single Point of Access						
Re-ablement						
Early Intervention						
Long Term Care						
Independent Living/						

Comm Capacity						
End of Life Care						
Supporting Carers						

An example of our workstream monitoring forms is included in section 6 below, in relation to our supporting carers workstream.

#### 4.3 Partnership resources

See Note 7  
As previous; please see above section 4.

#### 4.4 Successes and lessons learnt

Ensuring robust performance measurement has been a time consuming and challenging area of work for the partnership and we share the stated JIT view that it will be difficult to measure the impact of year 1 Change Fund on key performance measures alone. Some of the difficulties are related to National data being unavailable at this time. We are also currently reviewing the way local data is collated to ensure best fit for required performance measurement that can effectively demonstrate change and associated outcomes.

Although it is evident that some changes are taking place which cannot be specifically related to the Change Fund at this time, we will continue to explore ways to capture information which will enable us to assess the hypothesis that there is a positive correlation.

A number of initiatives and developments detailed below have contributed to modest improvements and will continue to deliver agreed targets and objectives. These activities focus on delivering key strategic objectives of reducing bed days lost to delayed discharges, prevention of avoidable admissions or readmissions to inpatient settings and reducing emergency admissions.

It is our intention in year 2 to utilise the JIT self-assessment toolkit in relation to Reshaping Care. This will assist in identifying areas of strength that can contribute to sustainable improvement; provide enhanced focus on delivering required outcomes; and will ensure reliable information is available to inform future decision making.

The partnership is committed to continually assessing and prioritising its approach to enable us to factor in future developments and reflect on progress to date. In doing so the partnership acknowledges renewed



emphasis on preventative measures is required in the next stage of the Reshaping Care agenda. Ensuring prevention that encompasses self management principles is fully embedded in all workstreams elements will reduce potential for compromising objectives achieved across other interventions longer term.

### **SINGLE POINT OF ACCESS**

Development continues on the partnership's Single Point of Access element of work. Designed to provide a single entry point for rapid access for older people to the rehabilitation and re-enablement services, this process supports the prevention of avoidable hospital admissions and will facilitate a rapid and coordinated process for hospital admission and readmission in certain cases when fully implemented. The SPOA builds on the multidisciplinary and multiagency approach of our community rehabilitation teams augmenting the developments of the Change Plan with NHS GG & C's redesign of rehabilitation services from acute to community.

The SPOA also develops clear and concise pathways for each patient, signposting them to the most appropriate service, improving the journey and decreasing duplication of referrals. Integration of health and social care teams has given an opportunity to further develop electronic links between services via SWIFT to aid in the referral process, increase efficiency and decrease duplication and this will be further explored. This development will continue in 2012/13 through a two phased approach to service inclusion in the SPOA.

### **HOSPITAL DISCHARGE PROCESS**

#### **1. Assessment**

Given the emphasis on reducing beds days lost as a result of delayed discharge and the introduction of the new targets post 1<sup>st</sup> April 2013, the partnership made a conscious decision to review Social Work capacity within the Hospital and consequently streamlined SW processes to facilitate early discharge to the most appropriate setting.

Following review of referral and allocation data Social Workers have subsequently been aligned to wards within the Larkfield Unit and key Medical wards in the IRH tower block.

Prior to the introduction of the new arrangements briefing sessions were held with Clinical and Nursing Leads in the respective Directorates to provide opportunity for consultation and highlight the planned changed processes. The changes were viewed in a positive light. Subsequently ward staff have been able to identify positive benefits from linking with a designated worker, resulting in an improved multi-disciplinary approach, continuity and significantly the identification of complex cases on admission. Aligned SWs now attend and participate in all multi-disciplinary ward social rounds which contribute to the early identification of complex hospital

discharges and the co-ordination of complex care needs which are now taking place at an earlier stage.

## **2. Specialist Multi-Disciplinary Assessment Tool (SMAT)**

The above assessment tool was formally introduced to wards within the IRH campus in December 2011.

Prior to its introduction training was delivered to ward staff during November and we have received positive feedback on the sharing of standardised information.

## **3. Change Plan Update - Reablement Development 2011**

As part of a wider review of homecare services, all new cases coming to homecare will be assessed for reablement potential. The service will be provided to people for a period of approximately 6 weeks before either being passed to mainstream homecare, reducing or withdrawing services.

136 homecare staff have been provided with appropriate training so that the inherent philosophy continues after the reablement service is withdrawn.

An initial team of 17 staff have been identified to provide a reablement service. This will increase to three teams over the coming months. Briefing sessions have also been provided to a wide range of staff including social workers, geriatricians, housing staff, inpatient staff and AHPs.

A total of 58 people were assessed through the service between October and December 2011, with 39 of this number being hospital discharges and 19 being community referrals. 19% transferred to mainstream homecare service with no reduction in hours, 41% of people became independent and service was withdrawn and 10% had a partial reduction. The remainder either were readmitted to hospital or did not meet the criteria for service.

It is acknowledged as important to ensure that the services provided are both efficient and achieve desired outcomes of reshaping care for older people. We, therefore, intend to conduct follow-up activity regarding people's experience and views of their re-ablement journey to establish sustainable changes achieved as a result of the interventions within the Change Plan Programme. It is anticipated that a local organisation will be utilised to obtain service user feedback on their views of re-ablement and inform this area of work.

## **4. AWIA**

We have reviewed and streamlined processes in respect of AWIA applications. As part of this exercise we have clarified roles, responsibilities and timescales. AWIA is a key aspect of discharge planning and briefings have ensured that priorities are identified at the earliest possible stage where capacity is an issue. In addition we have highlighted the need, where appropriate, for consideration of alternatives to intervention under the relevant

Act, including the use of 13ZA.

### **SPARRA**

We are currently reviewing SPARRA data to explore the factors which contribute to those patients who present with an increased probability of hospital admission.

A pilot is currently being conducted in relation to patient's age > 65 with high risk of falls with a risk score over 65.

A small cohort of patients has been identified. We intend to review individual cases to ascertain if they are known to social work, including home care, together with the level of support currently being provided. Each case will be re-assessed with a view to exploring the possibility of introducing additional interventions therefore maximising the potential to prevent future hospital admissions

### **SOCIAL WORK TEAMS**

Given the recent review of Homecare services and the decision to establish of 3 geographical teams across Inverclyde as detailed below, we are actively exploring the feasibility of realignment of existing Social Work Teams to cohorts of GP practices. Options are at an early stage of development and we hope to progress proposals over the course of this calendar year. We see clear benefits from this approach in terms of improved multi disciplinary working, ability to promote reablement, early intervention, capacity, proactive Care Management, incorporating Telehealthcare support and prevention of admission into hospital from care managed cases in the community setting.

As a component of this review it is also our intention to enhance links with District Nursing staff/ Care Homes within the locality to promote multi-disciplinary working and highlight at an early stage those clients who would benefit from additional and/or different services which would continue to support ongoing care in the community

### **UNPLANNED ADMISSIONS AUDIT**

An audit of approximately 300 unplanned/emergency admissions took place across a 12 week period; information was screened by a Gerontology Nurse Specialist and a Pharmacist. Approximately 75 patients were subsequently followed up by a District Nursing visit to look at any possible information around what actions could have been taken to prevent the admission. Any obvious issues relating to medication were examined by the pharmacist. Admissions ranged from 0 to 13 in any one day. Analysis of the information is currently underway and should be available to the partnership by March 2012. This work will link into the early intervention developments, providing key information about some prevention supports that require to be established.

Information from the above-mentioned audit, together with data being

gathered through the Scottish Ambulance Service in relation to falls and hospital admissions will be collated to shape future additional capacity and enhance the range of services required to support people at home, as opposed to being automatically admitted to hospital over the coming year.

### **INTERMEDIATE CARE**

To facilitate the strategy and reduce the number of bed days used by people whose discharge is delayed, and also to support people as an alternative to hospital admission, a range of intermediate care developments will be taken forward over the coming year as an element of the re-ablement process.

Consideration will be given to alternative uses and supports provided within NHS facilities where traditionally the beds were classified as acute beds and, where due to a reduction in need, these could possibly be included in the continuum of care across the inpatient/intermediate care spectrum. Discussions will therefore commence across acute services and community services to ensure best use is made of all available resources over the next 2 years. We will also explore the possible alternative of using a small number of care home beds in the private sector as an element of these plans. Detailed discussions still require to take place and an initial draft paper on intermediate care will be discussed by the partnership in March 2012 to begin to develop the necessary workstreams.

### **DEMENTIA STRATEGY**

Currently Inverclyde CHCP is engaged in implementing the Modernising Mental Health Services Strategy. Currently work being undertaken includes the redesign of Older Peoples Mental Health Services and is based on the development of care pathways, including specifically the dementia care pathway. The work in this area includes addressing the interface with wider community care services, older people's services and the acute sector. This is a current priority of the partnership.

One strand to this work has included updating of the existing Dementia Care Pathway action plan, to reflect Scotland's National Dementia Strategy 2010, and incorporating Standards of Care for Dementia in Scotland 2011;

The provision of funding from the Change Fund for 2012 -2013 is aimed at focusing on the interface with wider available services for older people and enabling all services to meet the needs of people with Dementia and their carers. A Lead Officer will support this work.

Relevant work in this area for the future will be informed by Inverclyde's emerging Dementia Strategy. The key areas of work for 2012-2013 are identified below:-

- Anti Stigma and Awareness programme
- Post Diagnosis Support

- Community Services
- Liaison service: Development into Acute and Care Home settings
- Standards of Care: End of Life Care

## **. 5. Governance**

5.1 Describe your Partnership governance framework and financial framework to enable Partnership decisions if they have changed since 2011/12

Over the past 9 months the Partnership has amended its governance arrangements putting in place structures that provide necessary transparency, accountability, flexibility and to ensure the required leadership to deliver the transformation programme required over the next 3 years.

The Partnership benefits from the active involvement of third sector representatives, independent sector and acute colleagues in administering current governance arrangements.

The Change Plan Project Board will meet quarterly to provide strategic direction and determine future commissioning intentions.

The Executive Implementation Group will meet bi-monthly. The group will continue to apply existing scrutiny arrangements for current and future developments and evaluate performance against targets and objectives. Performance management will be core activity of the group. Decisions regarding disinvestment and reprioritisation of projects/initiatives will also be made by this group and reported to the Project Board. The group will also have responsibility for detailed financial monitoring and tracking the allocation and movement of activity across to reshaping care pathways.

Terms of reference will be drawn up for both groups.

## **6. Carers**

6.1 Describe the range of services that improve outcomes for carers

The partners are committed to enabling carers to continue with their caring role with as little impact on their own health and wellbeing as possible, whilst supporting them to have a life outside of caring.

Addressing the needs of carers is a priority across all the Change Plan workstreams, as well as having a dedicated workstream in its own right. The partners are involved to a great extent in supporting carers by working together across a range of issues. Continuing to respond to needs identified by carers, as evidenced over the life of our past 2 local carers' strategies, and

within the financial constraints that we face is a key priority.

Inverclyde has been cited in the National Carers Strategy for examples of best practice, namely the funding of a range of different types of breaks for carers by the Carers Centre, and the Timeout training programme organised by staff within the CHCP.

We recognise that more is required to improve outcomes for carers and that we are facing new challenges with the introduction of self directed support and the reablement agenda, the changing demographics and increase in the older population over the next 10-15 years.

The partner organisations and range of activities involved in the local response to the needs of carers are as follows:-

- **Inverclyde Carers Council**

Inverclyde Carers Council is a voluntary organisation of carers who promote the interests of carers locally and lobby on their behalf. The Carers Council was instrumental in establishing the Carers Centre in Inverclyde along with the Carers Council, who are the leading partner in the promotion of the Carers Charter for all carers.

- **Your Voice - Inverclyde Community Care Forum**

Your Voice facilitates the involvement of a large number of community care stakeholders throughout Inverclyde. In addition to their partnership role with the CHCP Your Voice is commissioned to undertake pieces of consultation and engagement on behalf of the CHCP.

- **Inverclyde Carers Centre**

Inverclyde Carers Centre is a limited company run by carers and former carers for the benefits of carers living throughout Inverclyde. The centre employs 5 staff and provides a range of support to carers including information and advice; support groups; stress management; short breaks. The centre plays a key role in the identification and support of carers both at the Centre and through its outreach work.

- **Inverclyde Community Health and Care Partnership (CHCP)**

Inverclyde CHCP is a partnership of NHS Greater Glasgow & Clyde and Inverclyde Council. The CHCP delivers community health and social care services to the people of Inverclyde and employs over 1000 staff. The CHCP was established with the coming together under one management structure of Inverclyde Community Health Partnership (CHP) and Inverclyde Council Social Work Services in October 2010. The CHCP leads on the review and continual development of the Inverclyde Carers Strategy through the Carers Development Group, and will oversee the work in relation to supporting carers linked to the Change Plan.

- **Community Capacity Building**

Carers support will also be enhanced by developments to expand community based support through the community capacity workstream. The community capacity sub group with representation from CHCP, Your Voice, CVS and older people representatives completed a scoping exercise to identify gaps in the existing network of community supports. Following a collaborative evaluation exercise £91,000 was allocated to 7 local voluntary organisations to provide a range of programmes, as evidenced in the document embedded below.

The group also identified future areas of work and areas of unmet need which will inform longer term commissioning intentions.

The partnership area has also benefited from Big Lottery funding of approx £600,000 to three local groups. The successful bids will also support carers through a range of initiatives. This positive development will inform the future prioritisation of Change Fund investment in community capacity activities.

The Partnership also recognises areas where forms and levels of carers support can be improved, out of hours support, use of telecare and the availability of alternative short breaks. These issues will be progressed through on-going service re design and future commissioning plans based on requirements of the personalisation agenda.

6.2 Indicate the total amount of Partnership resource allocated to support carers to enable them to continue to care

Total resources allocated from **dedicated funds** to support carers (CHCP):

<b>Funding</b>	<b>Project/ Activity</b>	<b>Sum (2011/12)</b>
<u>Carers Information Strategy Funding</u>	Carers Strategy	£10,000
	Carers Network	£1,500
	Carers Carnival	£946
	Carers Health Improvement	£2,736
	Carers Training Co-ordinator*	
	Carers Centre Printer*	
	Carers Emotional Support*	*£46,550
	Young Carers (allocated commitment)	£10,000

<u>CHCP Core</u>	Carers Centre Core Costs Carers Council Core Costs Carers Centre Sitting Service Carers Centre Group Holidays	£97,820 £6,430 £14,850 £4,950
<u>Short Breaks (Administration Funding)</u>	Short Breaks Bureau Core Costs Short Breaks Fund	£64,100 £68,640
<u>Specific Funding from Change Fund (Allocation to Carers Centre)</u>	Production of Carers Information Packs Carer Befriending Emergency Planning Supporting hospital discharge	£2000 £5000 £7000 £7000
<p>The form below demonstrates the resource being committed to supporting carers from our year 1 and 2 allocations of the Change Fund, and gives a description of the work involved and measures we have set ourselves (which are being refined). It must be noted that an element of 'mainstream' funding in core services is used to support carers, in addition to the dedicated funding streams noted above.</p>		

## 7. Support Mechanisms

### 7.1 What support has helped you so far? What didn't?

The partnership considers the J.I.T. web site and newsletter to be a valuable asset for bench marking purposes and sourcing evidence based/best practice material.

Feedback from J.I.T. network sessions is variable dependent on themes.

It would be helpful if consideration could be given to providing more advance notice for the network events programme provided by JIT. This would assist forward planning, the partnership could take better advantage of the experiences from these events that can be extrapolated to upcoming workstreams, and also it would help avoid the problem of nominating appropriate representatives at short notice.

Greater use could be made of web exs.

Link arrangements with partnerships requires further clarity regarding role and purpose as the arrangements have shifted from a formal approach to one based on an advisory buddying role.

Linkages with future Care Inspectorate multi-agency thematic inspections for OP by the Care Inspectorate will also require clarification.



Discussion regarding evaluation/assessment framework for initial Joint Commissioning Plan would be beneficial as the Change Fund allocations for 13/14 will be determined by that process?

IRF framework requires to be developed to ensure performance management improvement for next year.

With regard to the Change Plan submission template further and clearer directions between the template structure and guidance would be helpful.

## 7.2 What support, if any, could you offer other Partnerships?

The partnership would be willing to provide input to others in relation to our Community Capacity Building and Supporting Carers workstreams.

Establishing links with neighbouring partnerships may suggest future benefits, including a mutual role with regard to peer evaluation.

## 8. Joint Commissioning Strategy for Older People

In terms of your Joint Commissioning Strategy:

- what Partners will be involved in the preparation of the Strategy;
- what are the estimated total resources for the Strategy;
- what governance arrangements are you planning on implementing;
- what is the timeline involved;
- how will your Joint Commissioning Strategy link in with your Change Fund application?

Inverclyde CHCP is developing an overarching commissioning strategy to ensure a consistent and coherent approach across diverse care groups with regard to delivering outcome based service delivery. Engagement with people who use services and our strategic partners will be a key element and a guiding principle of the partnership's commissioning approach.

The National Guidance on Social Care Procurement which emphasises the involvement of individuals, families and carers in the development of commissioning strategies together with The National Care Home Contract and the Care Standards of The Care Inspectorate will inform the commissioning process.

Existing Change Plan partners will contribute to the preparation of the Joint commissioning Strategy and the adopted approach will be reported through the previously described governance arrangements.

For specific commissioning proposals other partners i.e. RSL's SAS will be involved.

The estimated total resources available for the strategy will be identified by revisiting Health and Social Care expenditure collated and 11/12 Change Plan

submission and augmenting with arranging IRF data and information co-ordinated by GG&C.

A Public Social Partnership approach will be taken with regard to procurement where appropriate, enabling recipients of services and voluntary and independent sector organisations to be involved in work including the design of specifications and trialling of different methods of working.

The initial focus will be on specific areas of the local system and project teams will be established to progress the associated workstreams.

The following areas are anticipated to be the focus of joint commissioning activity:

- Intermediate care
- Sector wide out of hours response initiatives
- Housing with support
- Sector wide (voluntary and independent sector, local authority and Health) Day care provision
- Support at Home
- Short breaks/respite provision including emergency respite

Discussions are ongoing with Scottish Care and others regarding funding of a part time development post to facilitate Intermediate Care developments.

The aim of the above workstreams will be to utilise resources across the partnership area to deliver better outcomes and efficiencies. The approach will require a radical rethink of existing service delivery arrangements and the use of further innovative approaches to using aggregated resources.

The partnership recognises the inherent challenge of developing a joint commissioning strategy covering the period 2012 to 2020, however also acknowledged the potential requirements to decommission initiatives and developments referred to in this Change Plan prior to the end of the 4 year funding period should the targeted changes in the wider system not be achieved.

**This Change Fund Plan has been prepared and agreed by the NHS, Local Authority, Third Sector and Independent Sector interests.**

**Signed**

## **NOTES**

**Note 1.** This should be based on the Local Authority area – however it is open, by agreement with all parties, for the purposes of the Change Fund, to vary the Partnership boundaries (e.g. if neighbouring councils wish to combine along with their NHS and voluntary/independent sector Partners).

**Note 2.** Change Plans must be agreed by NHS Boards, Local Authorities and Third Sector and Independent Sector Partners. Partnerships should specify the names of organisations directly engaged in preparing the Change Plans. Partnerships should highlight differences if any in the organisations from 2011/12 and the reasons for change.

Plans should indicate how older people themselves and carers will be engaged to support both the preparation of the Change Plan and the development of longer term Strategic Plans or Commissioning Strategies, and how they will help directly shape the form of new services and supports to ensure the principles of co-production are achieved in practice.

**Note 3:** Describe how multidisciplinary clinical teams (from both primary and secondary care), social work teams, third and independent sector representatives and the management that support them have been engaged in the process of developing Change Plans. Please include details of how this engagement will be assured on a continuing basis via the Primary & Secondary Care clinical and social work leaders who help to shape engagement through the professions. Please also include an outline of how the local public are being, and will be engaged.

**Note 4:** This section should record the total size of the Change Fund allocation, any monies carried forward from the Partnership allocation from 2011/12 and any supplementary funding from other sources. This might include Resource Transfer, delayed discharge, housing support, Lottery funding or other funding not specifically committed (e.g. community care commissioning budgets). In some cases, Partnerships might want to state the totality of the resource available for older people and pool the entire budgets.

It is for Partnerships to agree locally how to deal with underspend /slippage as long as this meets the objectives of your Change Plan. Any request for NHS Boards to carry forward underspends should be agreed with Scottish Government Health Finance colleagues.

**Note 5:** This section should record the reasons why Partnerships have been unable to spend their allocation from 2011/12. It should include detail about how this resource will be utilised within the 2012/13 period.

**Note 6:** Partnerships are asked to provide an indicative summary of how the Change Fund and total resource have respectively been divided between the stages of the reshaping care pathway. Where initiatives support more than one stage, resources should be divided proportionally. This information is for illustrative purposes and indicative figures should be used. Annex C describes the reshaping care pathway in more detail.

**Note 7:** This section should include the key measures and outcomes that the Partnership was focussed on delivering in 2011/12. It should indicate the progress made against the three levels outlined within the Core Improvement Measures paper (Annex B); nationally available outcome measures and indicators; local improvement measures and Partnership resource use. The data presented should, as far as possible, be clearly attributable to the joint resource and the Change Fund monies, not wider system performance.

**Note 8:** This section should outline the main successes and lessons learnt in delivering planned outcomes. It should also account for any targets that have been missed and detail what actions have been put in place to ensure continuous improvement through 2012/13.

**Note 9:** This Section should outline the governance arrangements that are in place to ensure accountability for outcomes and financial spend for Partners. It should note the links to the Community Planning Partnerships and Single Outcome Agreements, and where applicable Community Health Partnerships and HEAT targets.

**Note 10:** Partnerships should summarise the services they have put in place to support carers and the cared-for with regard to the 20% of total resource commitment.

**Note 11:** Partnerships should provide detail of the total proportion of Change Fund resources allocated to support carers and the cared-for.

**Note 12:** Partnerships should describe what support has been beneficial and what has not added value through the Change Fund process.

**Note 13:** This section should indicate where Partnerships feel they would be able to support other Partnerships to improve outcomes and deliver the aims of the Change Fund. This can include the organisational arrangements put in place to progress Partnership working, specific service developments, and the development of a Joint Commissioning Strategy or any area the Partnership feels it has made particularly good progress.

**Note 14:** This section should note the Partners involved in developing and agreeing the Joint Commissioning Strategy.

**Note 15:** This section should outline the total resource that the Joint Commissioning Strategy covers.

**Note 16:** This section should highlight the governance arrangements for the delivery of the outcomes noted within the Joint Commissioning Strategy. It should demonstrate the links made to Single Outcome Agreements and HEAT targets.

**Note 17:** This section should outline the process that will be undertaken to develop the Joint Commissioning Strategy and the timescale for doing so.

## **Annex B**

### **Reshaping Care for Older People: Core Improvement Measures**

#### **A: Nationally Available Outcome Measures and Indicators**

A1. Emergency inpatient bed day rates for people aged 75+ (NHS HEAT 2011/12)

A2. a. Patients whose discharge from hospital is delayed and

b. Accumulated bed-days for people delayed (NB further detailed guidance on b. will be issued soon).

A3. Prevalence rates for diagnosis of Dementia (NHS QOF)

A4. Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting (ISD)

A5. Percentage of time in the last 6 months of life spent at home or in a community setting.

We also recommend that Partnerships continue to develop their use of:

A6. Experience measures and support for carers from the Community Care Outcomes Framework (Community Care Benchmarking Network)

#### **B: Local Improvement Measures**

##### **Anticipatory and preventative care**

B1. Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared with Out-of-Hours staff

B2. Waiting times between request for a housing adaptation, assessment of need, and delivery of any required adaptation

B3. Proportion of people aged 75+ with a telecare package

##### **Responsive / flexible home care and carers**

B4. Reduction in hours of support required after reablement service provided

B5. Respite care for older people per 1000 population

##### **Demand for acute care**

B6. Rates of 65+ conveyed to Accident & Emergency with principal diagnosis of a fall (Data from Scottish Ambulance Service)

##### **Effective flow in acute care**

B7. Proportion of frail emergency admissions who access comprehensive geriatric assessment with 24 hours

##### **Use of long term residential care**

B8. Rate and proportion of new entrants admitted from home; acute hospital specialty; following intermediate care; graduate from emergency respite

#### **C: Partnership Resource Use**

C1. Per capita weighted cost of accumulated bed days lost to delayed discharge

C2. Cost of emergency inpatient bed days for people over 75 per 1000 population over 75

C3. A measure of the balance of care (e.g. split between spend on institutional and community-based care).

IRF data will support use of these C measures in particular.

### **OUTCOMES FRAMEWORK FOR COMMUNITY CARE**

The Community Care Outcomes Framework helps Partnerships to understand their performance at a strategic level in improving outcomes for people and their carers

who use community care services or support. The Framework also allows Partnerships to share information with each other and compare performance directly on the basis of consistent, clear information.

### National Outcomes

- Improved health
- Improved well-being
- Improved social inclusion
- Improved independence and responsibility

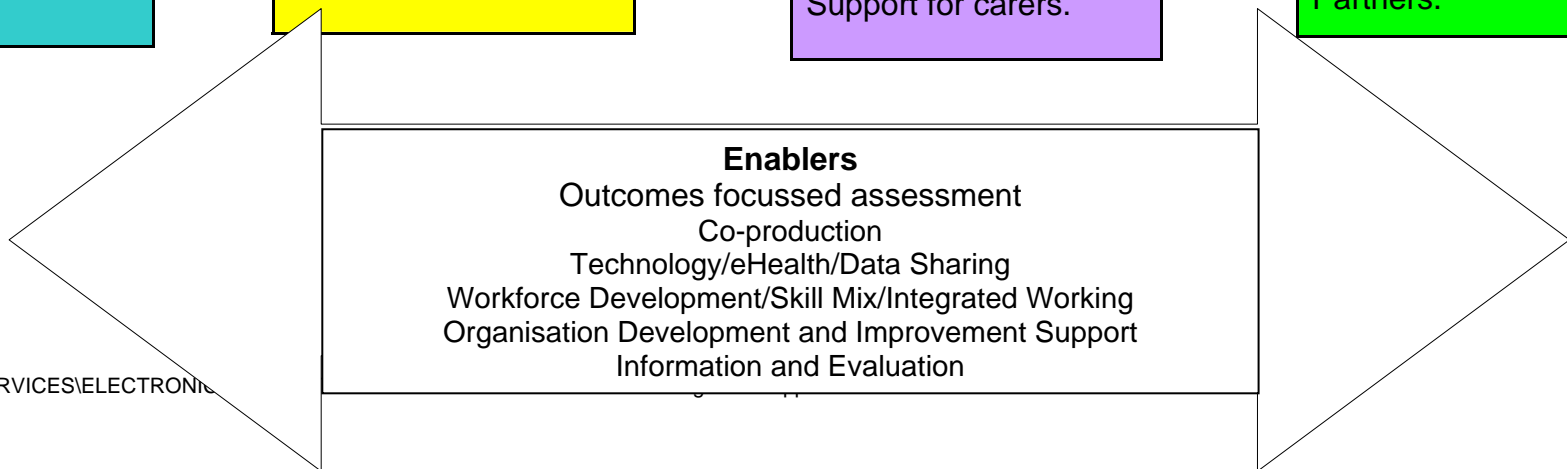
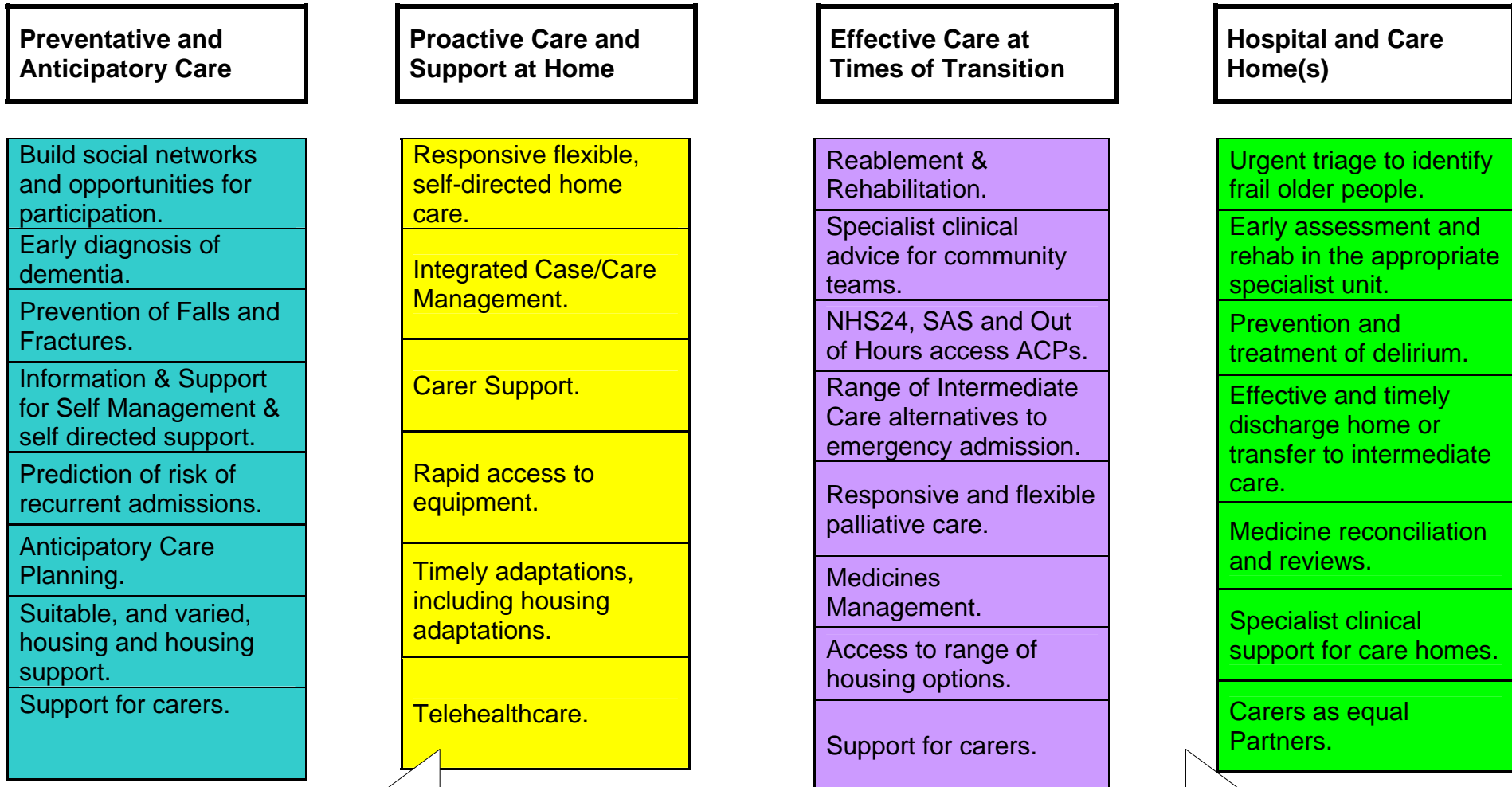
### Performance measures and targets – user and carer experience

Themes	Code	Measure <sup>1</sup>	Type	Data Source / Status
<b>Satisfaction / Experience</b>	S1	% of community care service users feeling safe.	Outcome	Data drawn from NMIS*
	S2	% of users and carers satisfied with their involvement in the design of care package.	Outcome	Data drawn from NMIS*
	S3	% of users satisfied with opportunities for social interaction.	Outcome	Data drawn from NMIS*
<b>Support for carers</b>	C1	% of carers who feel supported and capable to continue in their role as a carer.	Outcome	Data drawn from NMIS*

\*NMIS is the National Minimum Standards for assessment, shared care and support plans and review (July 2008)

<sup>1</sup> The full Community Care Outcomes Framework, and the definition for each measure, can be found at: <http://www.scotland.gov.uk/Topics/Health/care/JointFuture/CommunityCareOutcomesF/Definitions>.

# RESHAPING CARE PATHWAY



## Appendix 2

### Inverclyde CHCP – Change Fund Data Report January 2012

#### 2012/13 Targets based on Monthly Average Trajectory

	Indicator	Baseline 2009/12	Monthly avg 11/12 Apr - Nov 2011	Target 2011/12	Projected outturn 2011/12 based on performance so far	Average based trajectory 2012/13*	Trajectory based outturn target 2012/13
1	Number of acute bed days lost to delayed discharges	6,724	472	4280	5665	429	<b>5150**</b>
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	300	34	0	0	N/A	<b>0</b>
4	Unplanned acute bed days (65 +)	56,840	4030	N/A	32691	2724	<b>32691</b>
5	Unplanned acute bed days (75 +)	41,741	2966	N/A	35593	2966	<b>35593</b>
6	Number of emergency admissions 65+	4,045	1390	N/A	2897	241	<b>2897</b>
8	Reduction in unplanned admissions for people aged over 75	2,562	913	N/A	1862	155	<b>1862</b>
9	Reduction in unplanned admissions for EMI patients	121	4	N/A	54	4	<b>54</b>

\* Based on monthly average performance in 2011/12

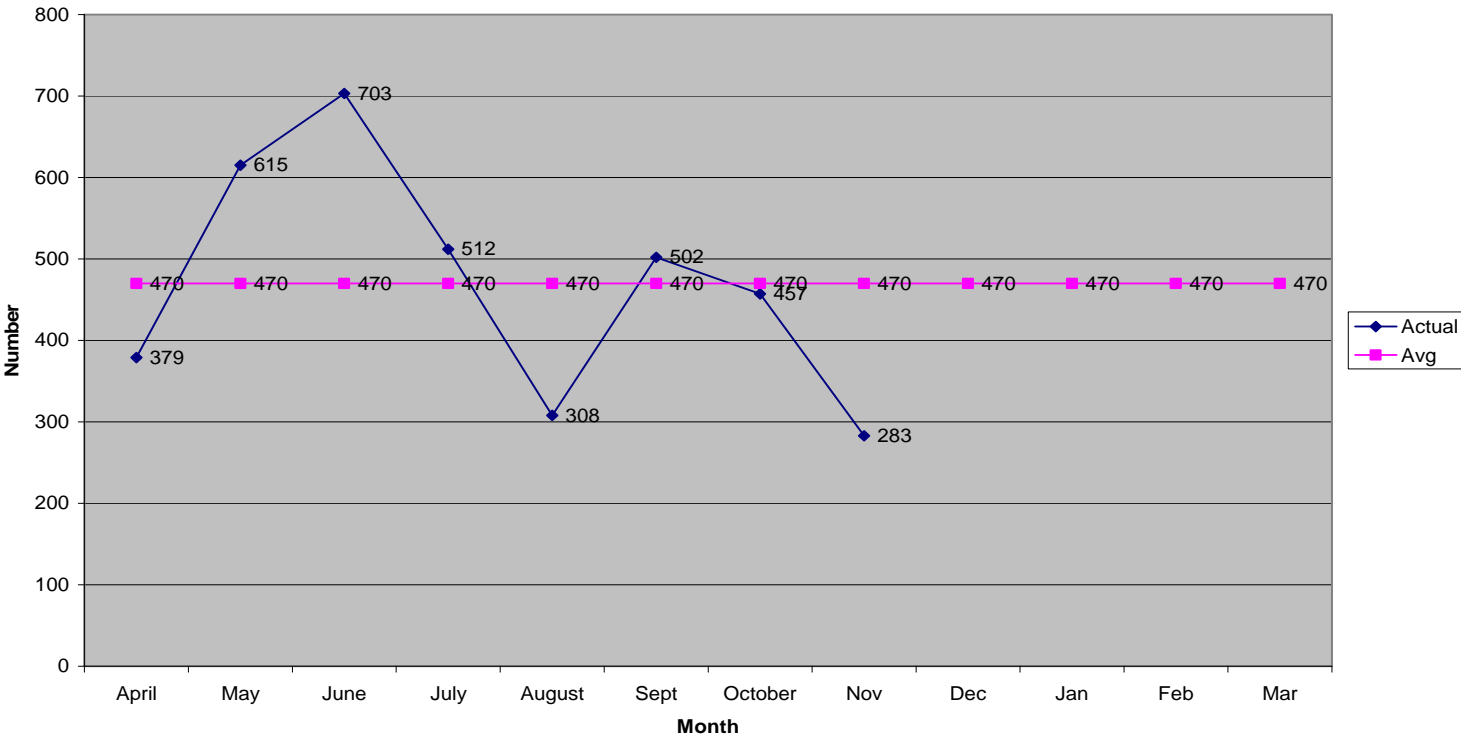
\*\* This figure is based on a move towards the new target of 4 weeks



**Comments:**

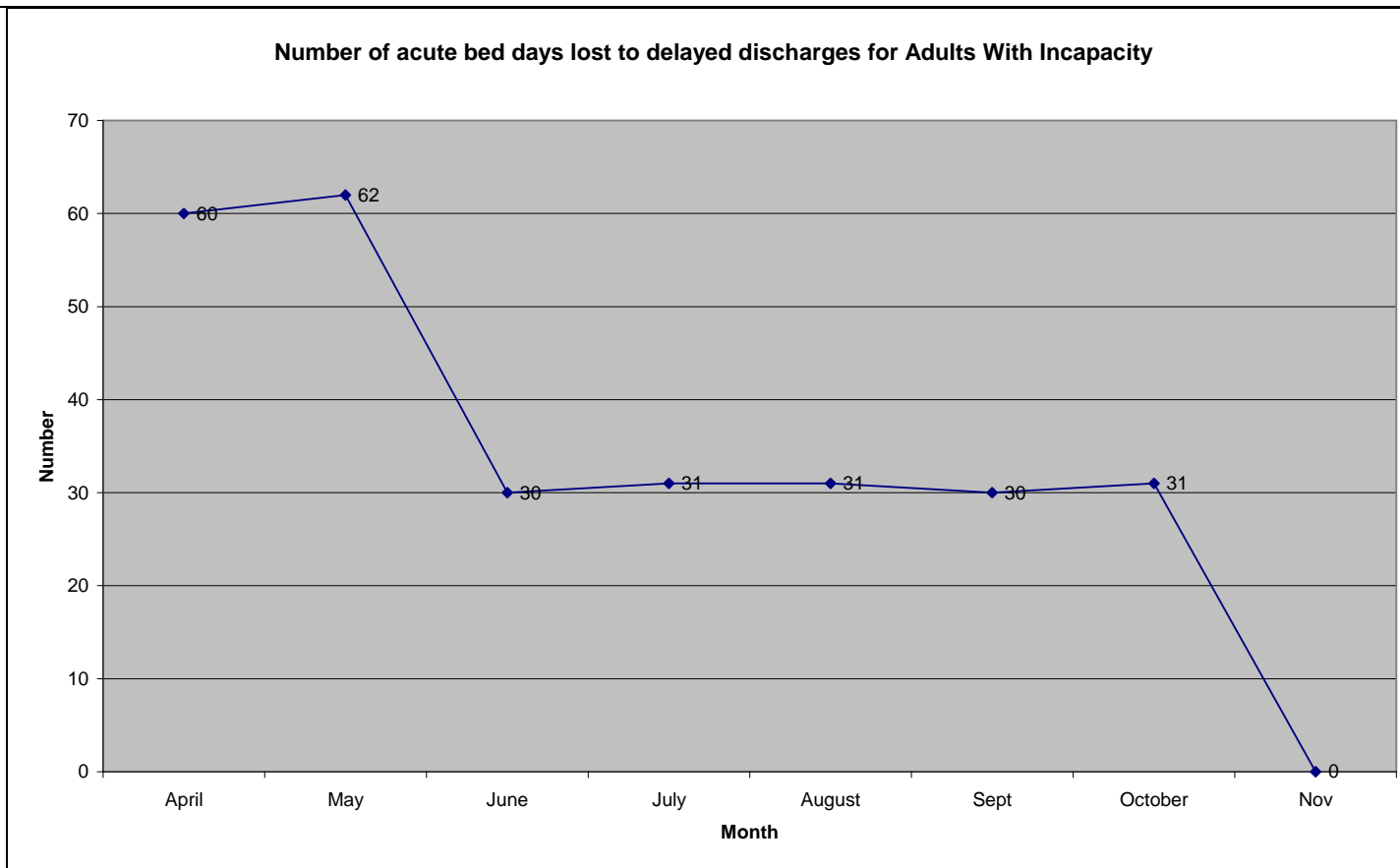
We have established average-based trajectories for 2012/13. Performance targets for the above indicators have been established by adding the cumulative performance to date (Nov 2011) to the sum of 4 months of average performance (i.e. monthly average from April 2011 – Nov 2011 multiplied by 4 for the 4 remaining months of 2011/12). This calculation has given us a projected outturn for 2011/12 and a target based on current performance for 2012/13. We anticipate being able to exceed these targets in 2012/13 given that we have based these on average and not best performance in 2011/12

Number of Acute bed days lost to delayed discharge



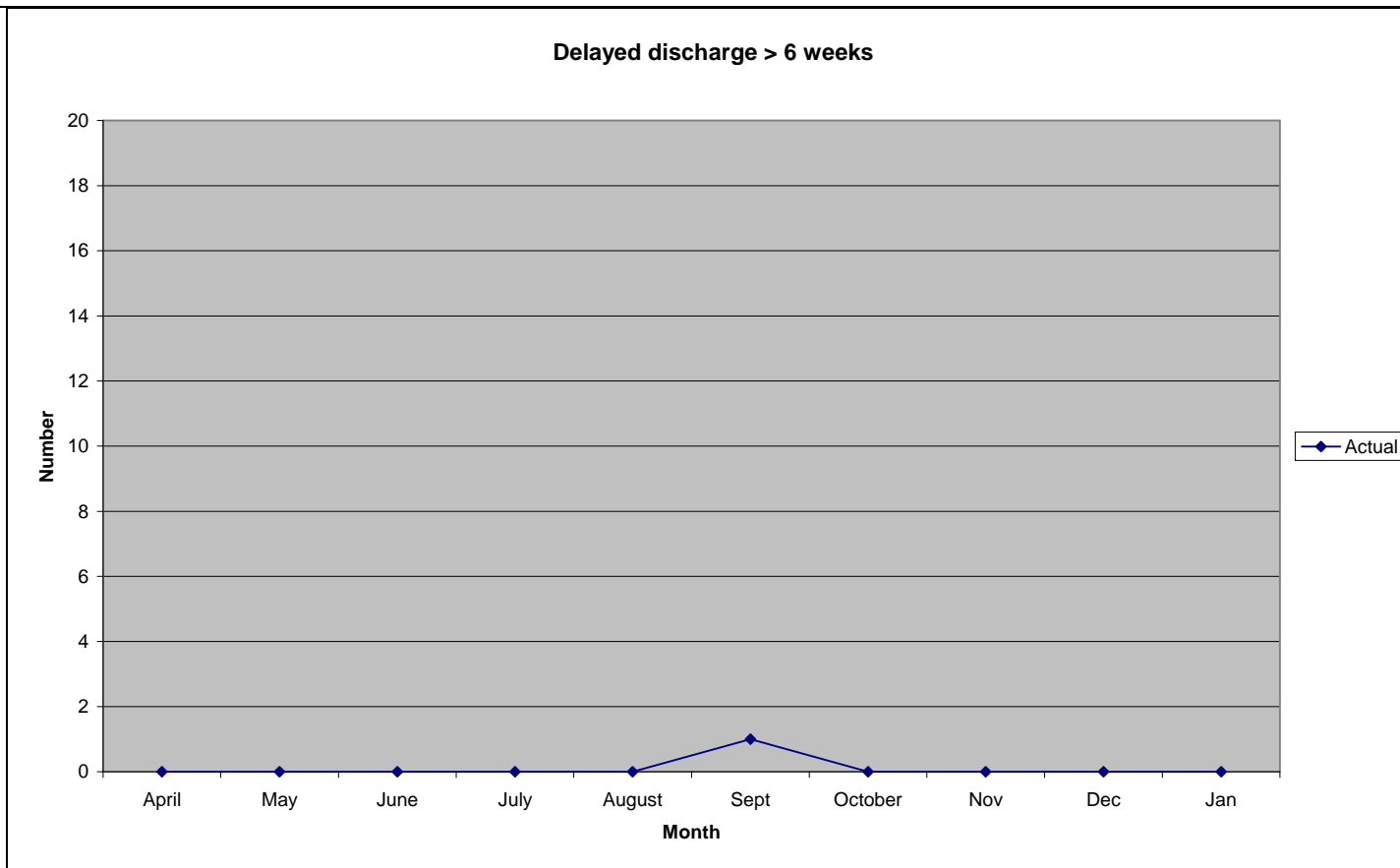
**Comments:**

There have been fluctuations in performance in 2011/12 in the Acute bed days lost to delayed discharges indicator. Monthly average performance has been 472 bed days lost per month. At November 2011, our most recent reportable performance point, we have reduced below this average to 283 bed days lost. We anticipate exceeding our 2011/12 target of 4280 based on average performance. (Anticipated outturn of 5665).



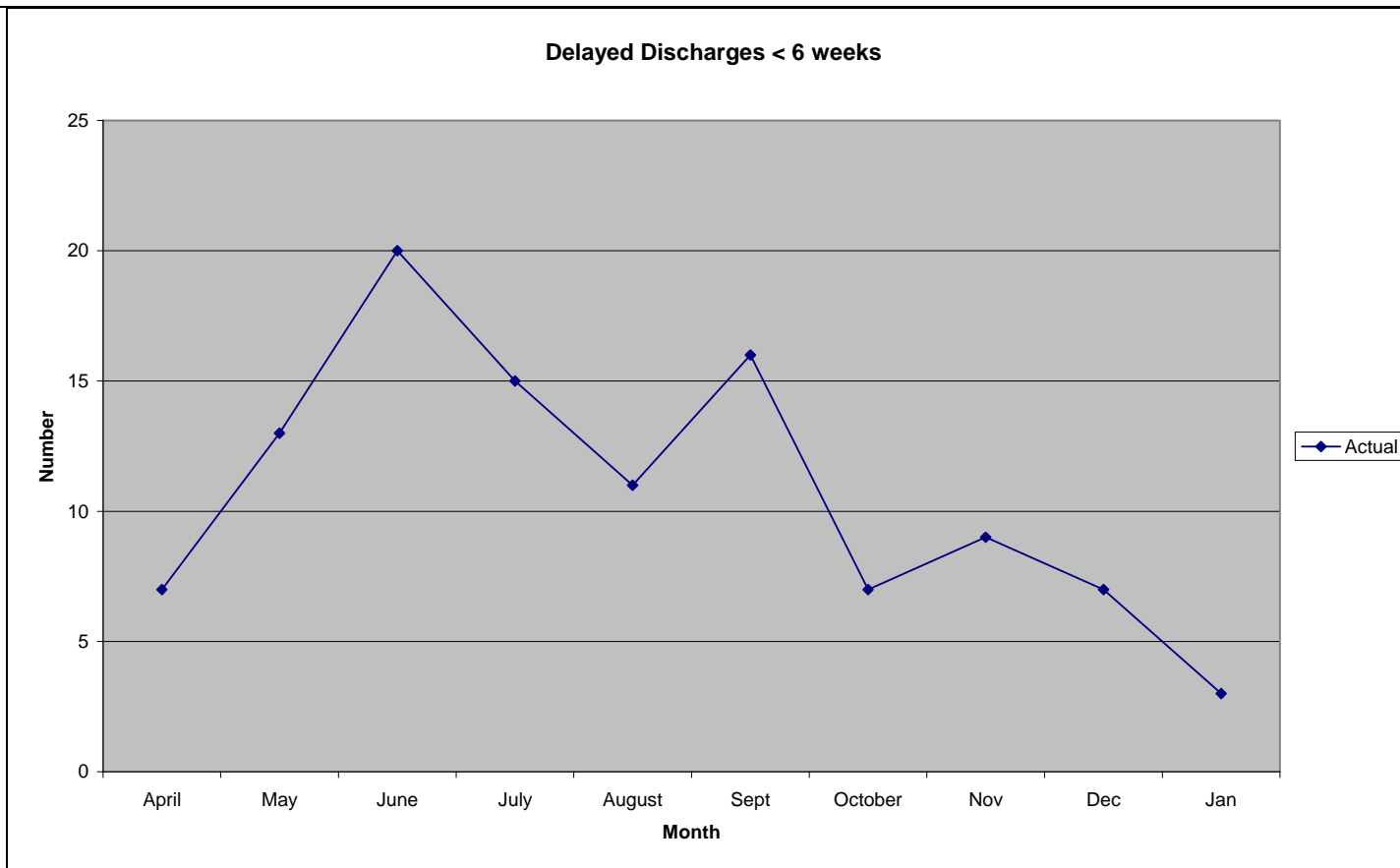
**Comments:**

One individual who had accounted for our bed days lost to delayed discharges in the AWI category has been moved to alternative accommodation, thus at November 2011 we have 0 bed days lost to delayed discharges (AWI) It is our aspiration to maintain the number of bed days lost to delayed discharged (AWI) at 0 for the remainder of this year.



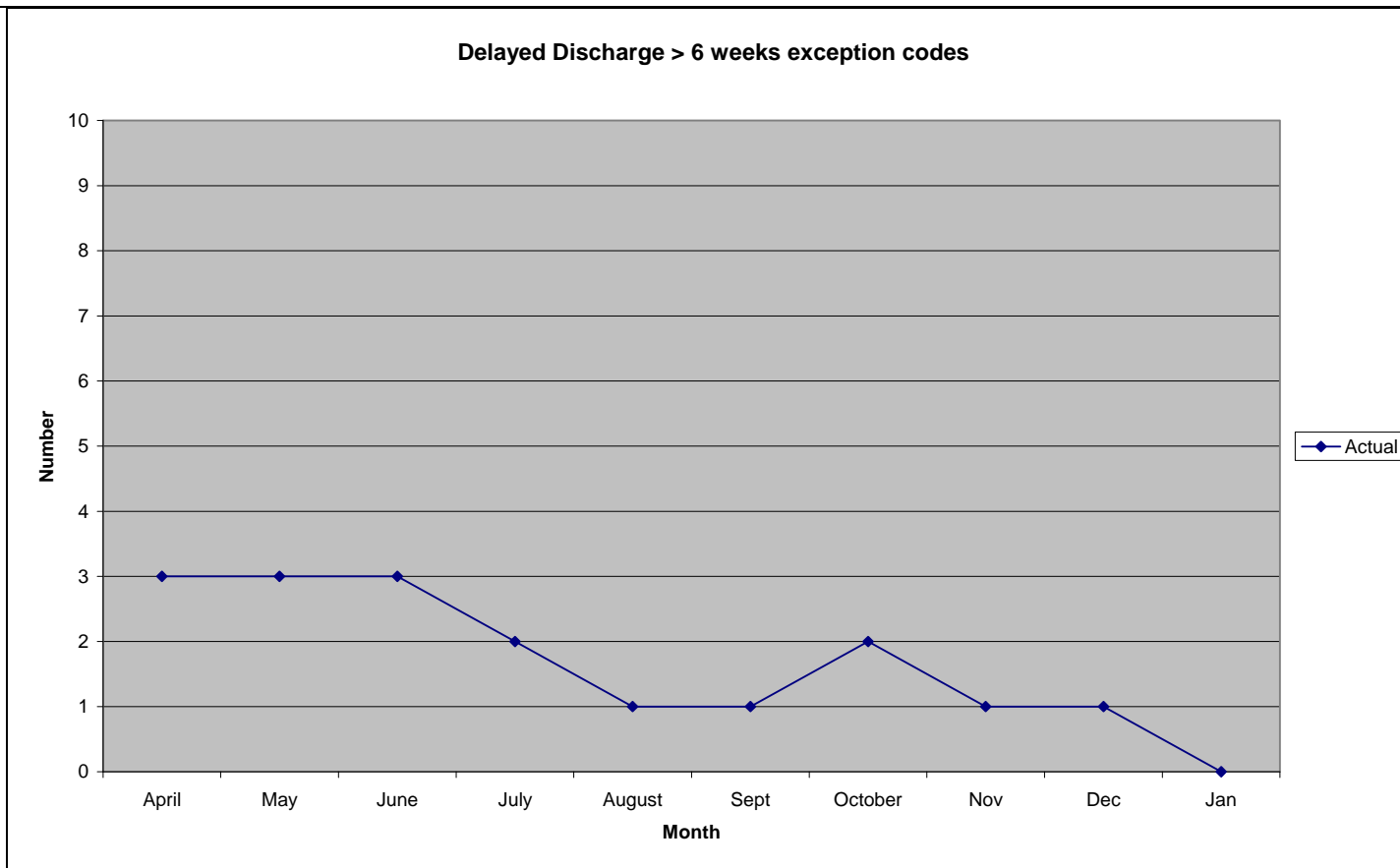
**Comments**

Despite a blip in performance in September 2011 where 1 person was delayed over 6 weeks, we have almost completely maintained the 0 standard. We anticipate maintaining the 0 standard for the remainder of 2011, and are working towards achievement of the 4 week standard from April 2012.



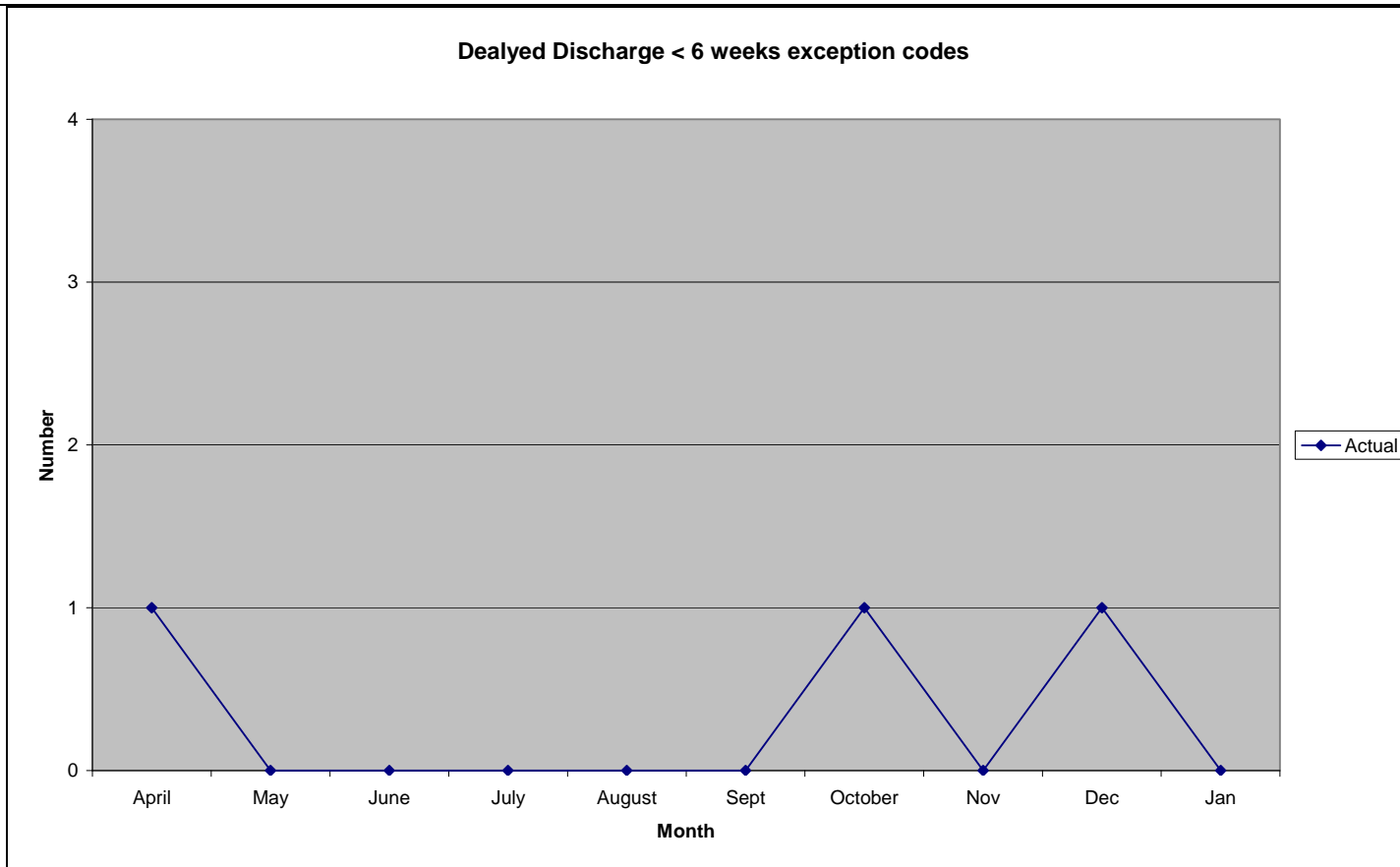
**Comments**

At 15<sup>th</sup> January 2012 we have 3 people delayed in discharge beyond 6 weeks. This is the lowest number we have achieved in 2011/12. We have in place a range of local measures, including local use of the new EDISON system, as well as increased staffing resources in our hospital social work team as a result of the Change Fund, to continue to maintain this low level of delayed discharges (under 6 weeks) for the remainder of 2011/12.



**Comments**

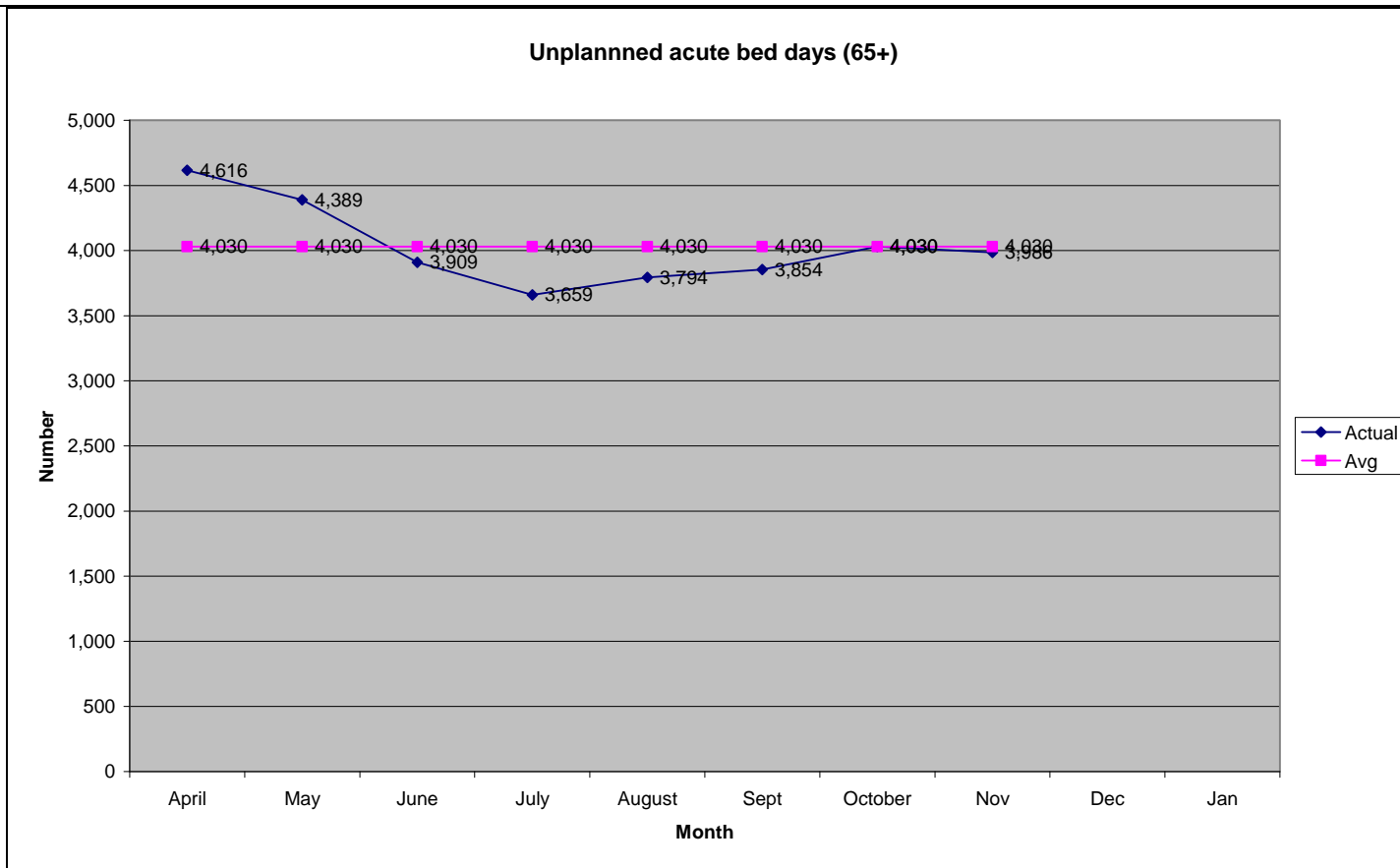
As reported above, the one individual who accounted for our delayed discharges (AWI) has been moved to alternative accommodation. As at 15<sup>th</sup> Jan 2012 we have 0 delayed discharged over 6 weeks.



**Comments**

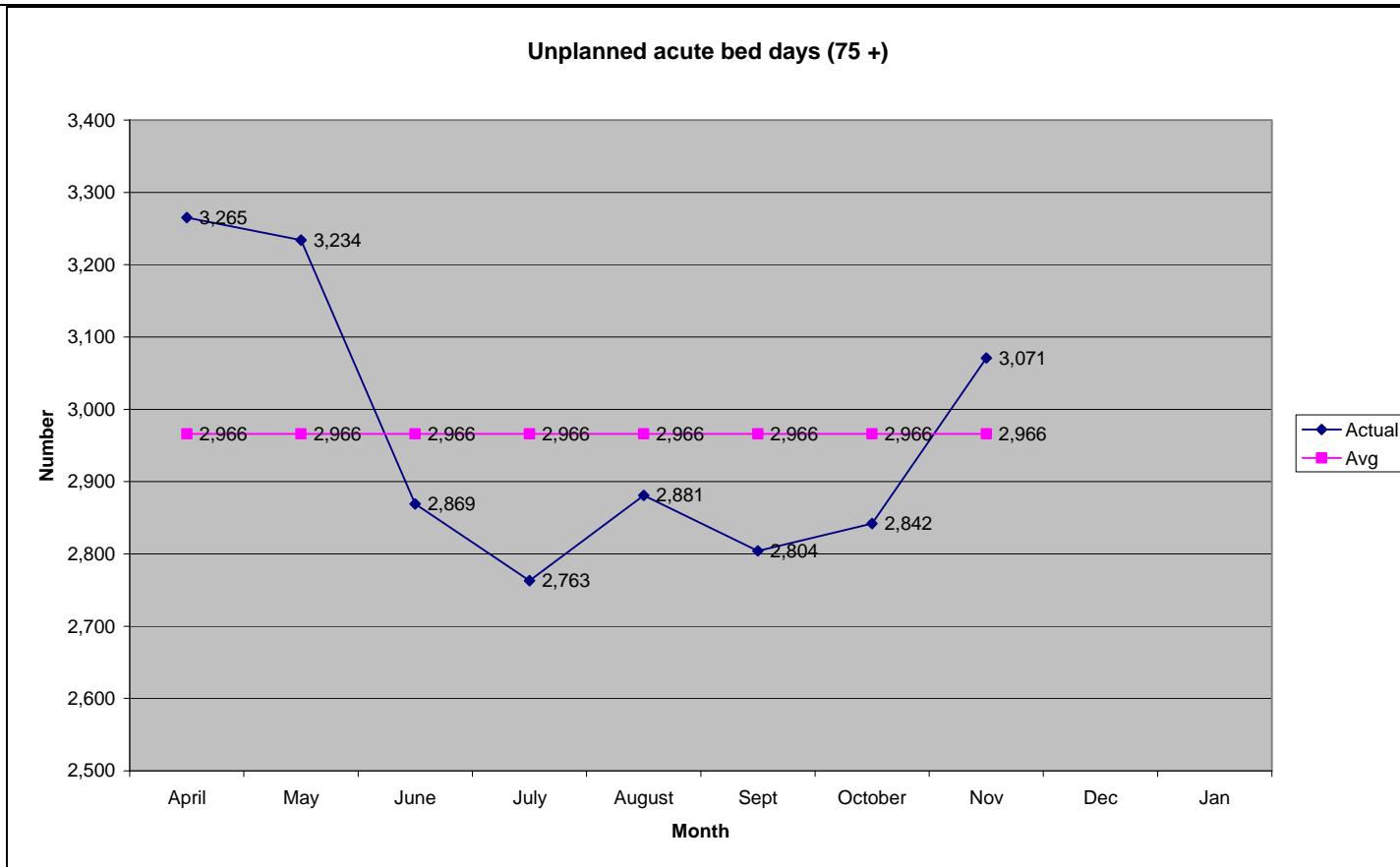
Our delayed discharges under 6 weeks for AWI has also reduced to 0 as at 15<sup>th</sup> January 2012.





**Comments**

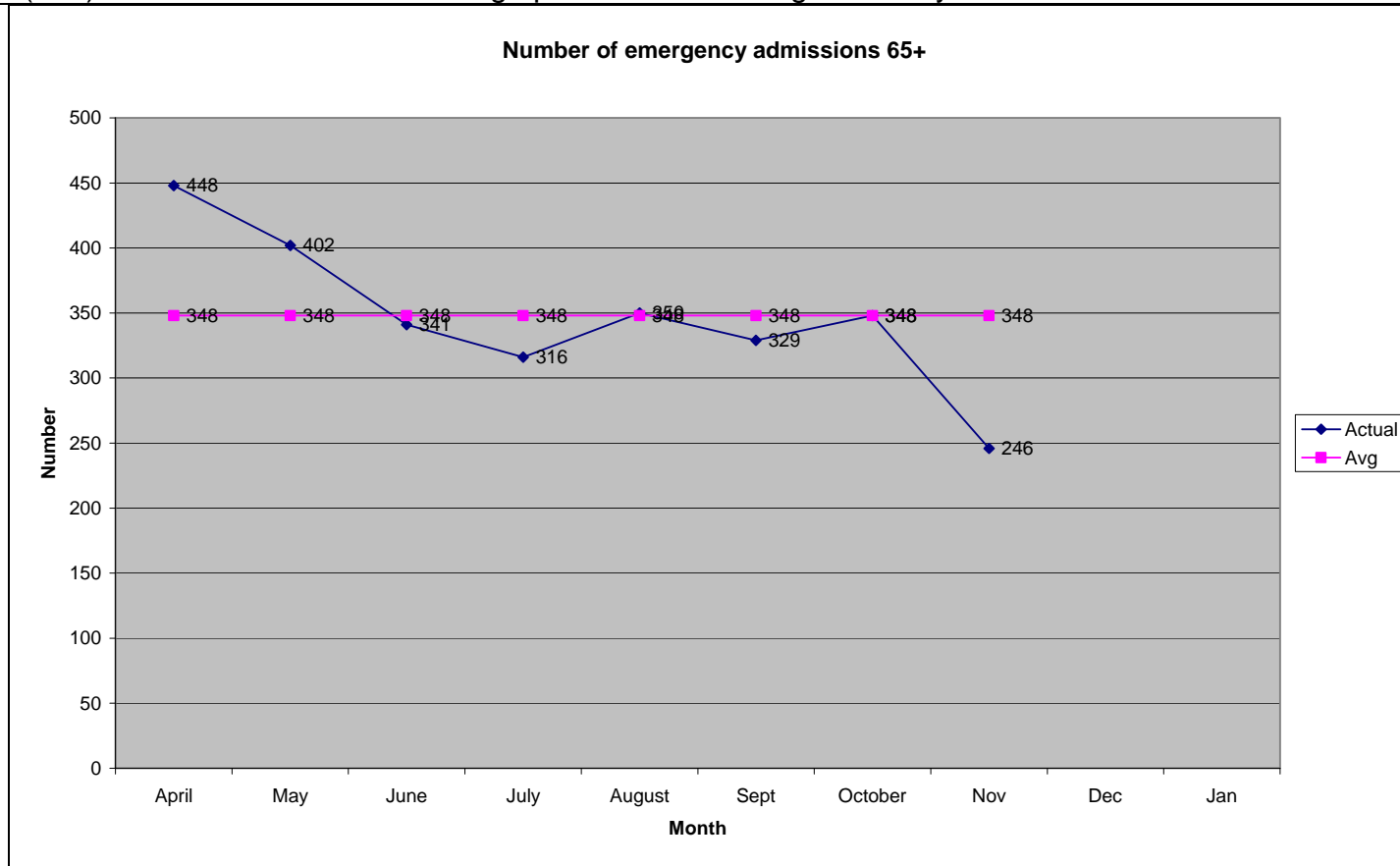
At the start of 1011/12 performance was on a positive downward trend (3659 in July 2011), in July 2011 this started to rise and although our latest figures show performance not to have gone above the monthly average of 4030 we have not yet returned to our lowest level of unplanned bed days for people aged 65+. We anticipate, however, that with the range of supports out in place as described elsewhere in this paper, and local knowledge of under occupancy in the acute sector in December 2011 that more up to date information may reflect a more positive trend. We continue to monitor this indicator closely.



**Comments**

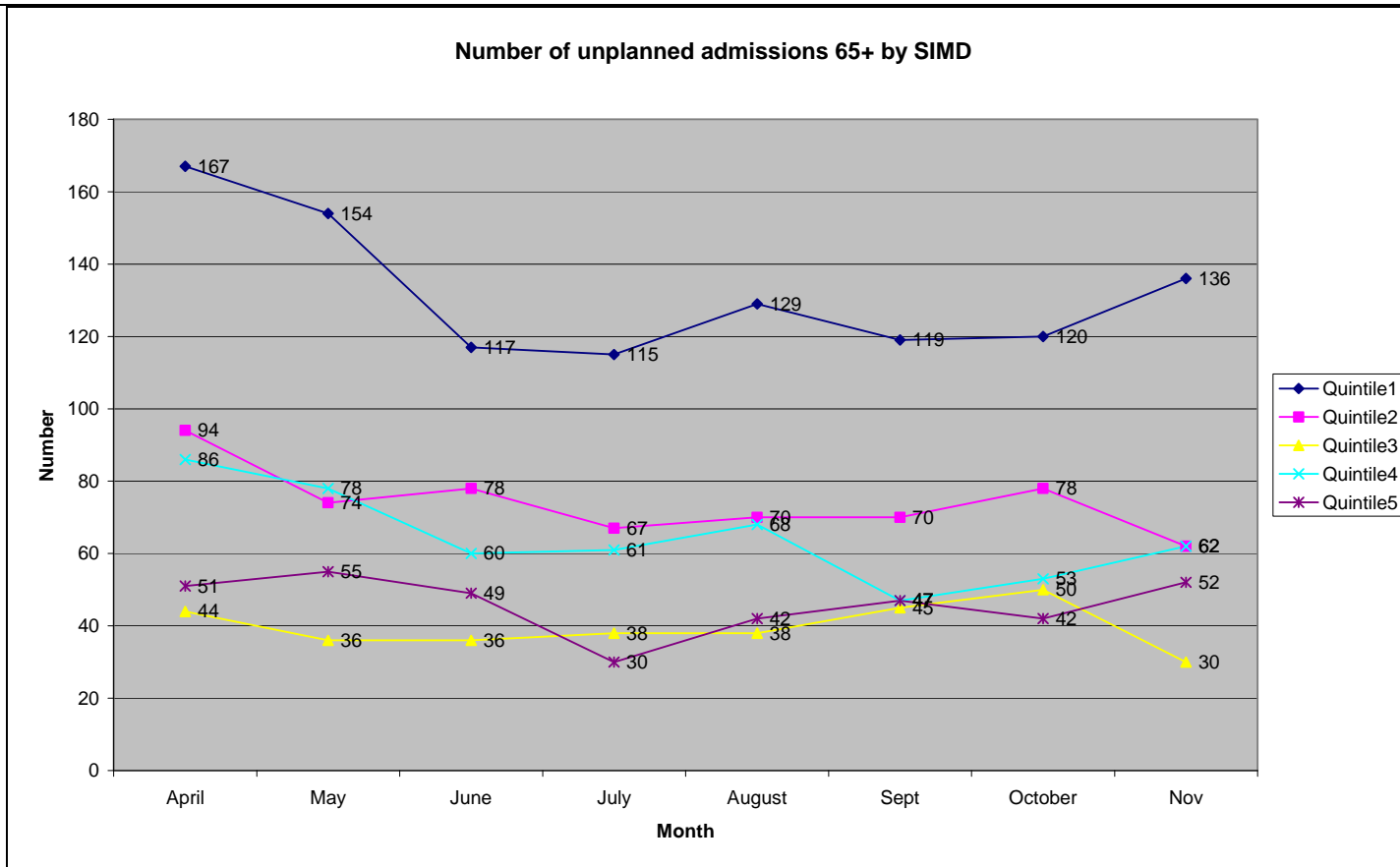
Performance in relation to this indicator has fluctuated through 2011/12. As with unplanned acute bed days over 65 there was a sharp improvement in performance at the start of 2011/12. In recent months to November 2011 performance has declined and as

at our latest figure has breached the monthly average of 2966, although it has not reached previously high levels such as 3265 (April 2011). We anticipate that with the supports which have been put in place as described elsewhere in this paper, performance will once again improve as new figures come through. We anticipate an outturn performance figure of around 35,000 unplanned acute bed days (75+) for 2011/12 based on average performance throughout this year.



**Comments**

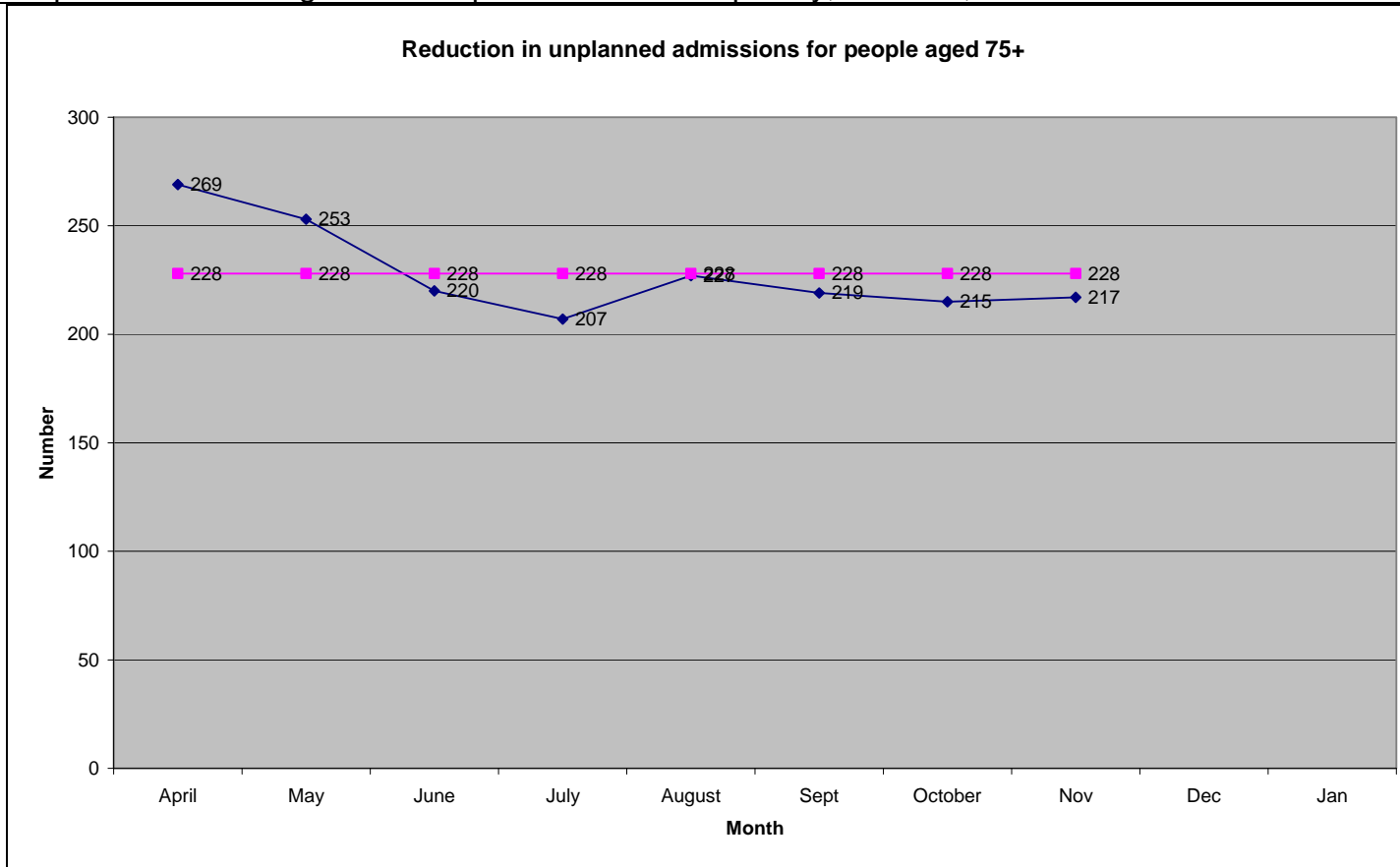
The number of people over 65 admitted to secondary care as an emergency in 2011/12 has fallen. We have achieved average performance of 348 admissions per month so far this year. Based on an average based trajectory of the performance so far we anticipate a reduction on the numbers of emergency admissions over 65 for 2011/12 compared to our baseline (2009/10)



#### Comments

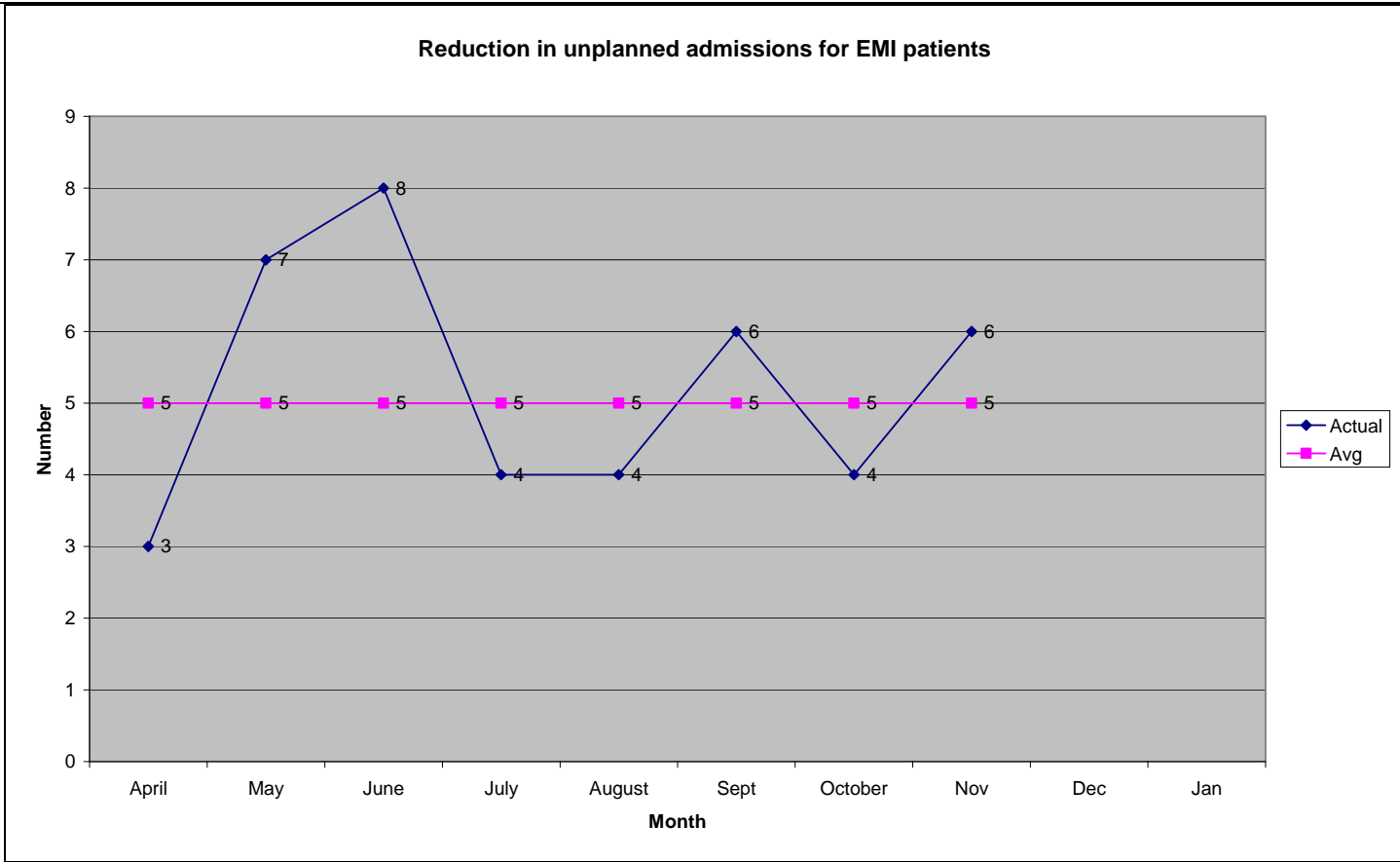
Performance in respect of unplanned admissions 65+ by SIMD is as one would expect for Inverclyde with high numbers of people

being from the more deprived areas. We have seen reductions in unplanned admissions in 3 of the SIMD quintile categories and an increase in 2, including our most deprived area, and our least deprived. Patterns of admission do not appear to be correlated to higher levels of deprivation. Tackling health inequalities remains a priority, however, and we will monitor this indicator closely.



**Comments**

The number of people over 75 admitted to secondary care as an emergency in 2011/12 has fallen. We have achieved average performance of 228 admissions per month so far this year. Based on an average based trajectory of the performance so far we anticipate a reduction on the numbers of emergency admissions over 75 for 2011/12 compared to our baseline (2009/10)

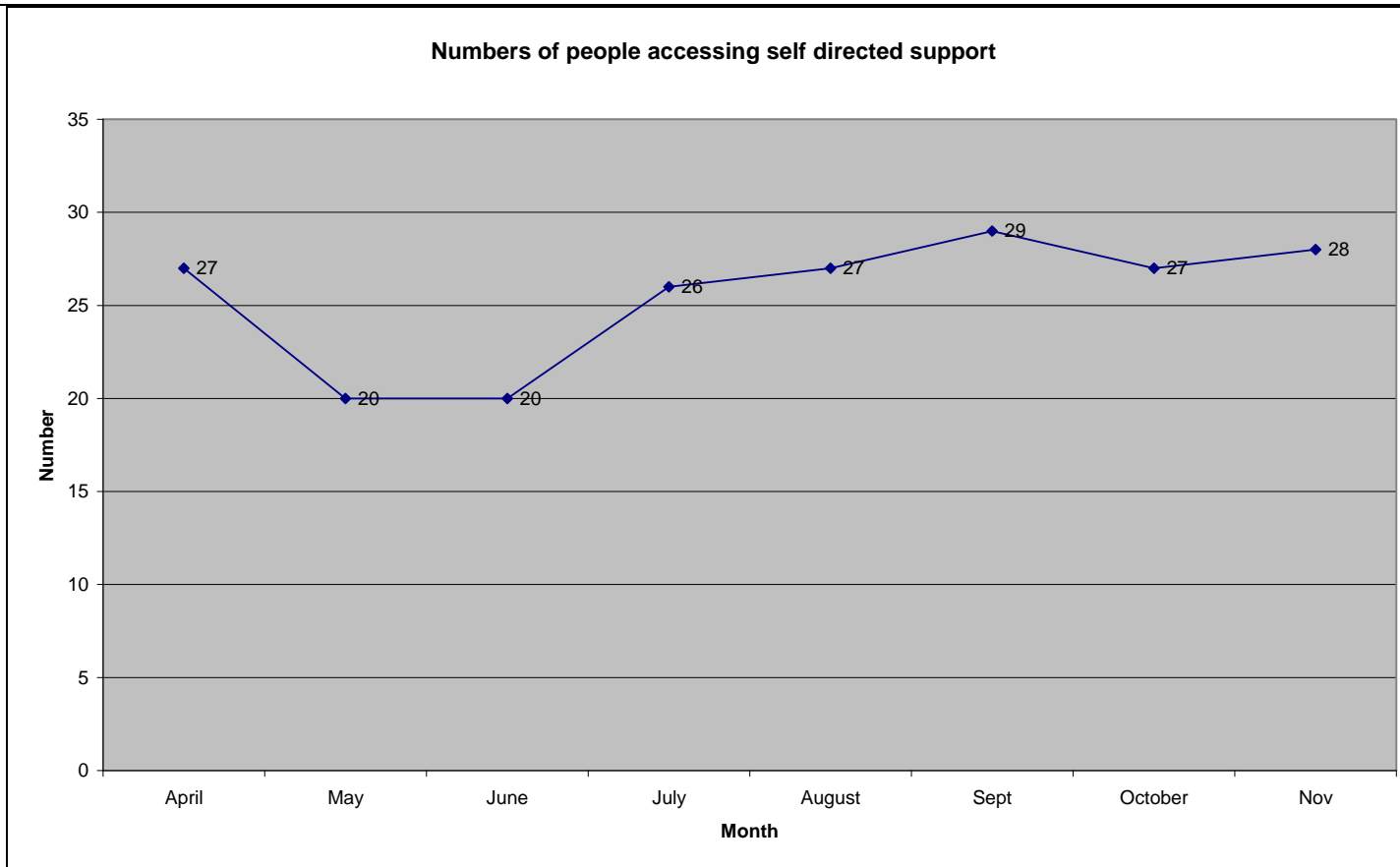


**Comments**

There has been significant fluctuation in performance in relation to this indicator. Our most recent reported performance (Nov



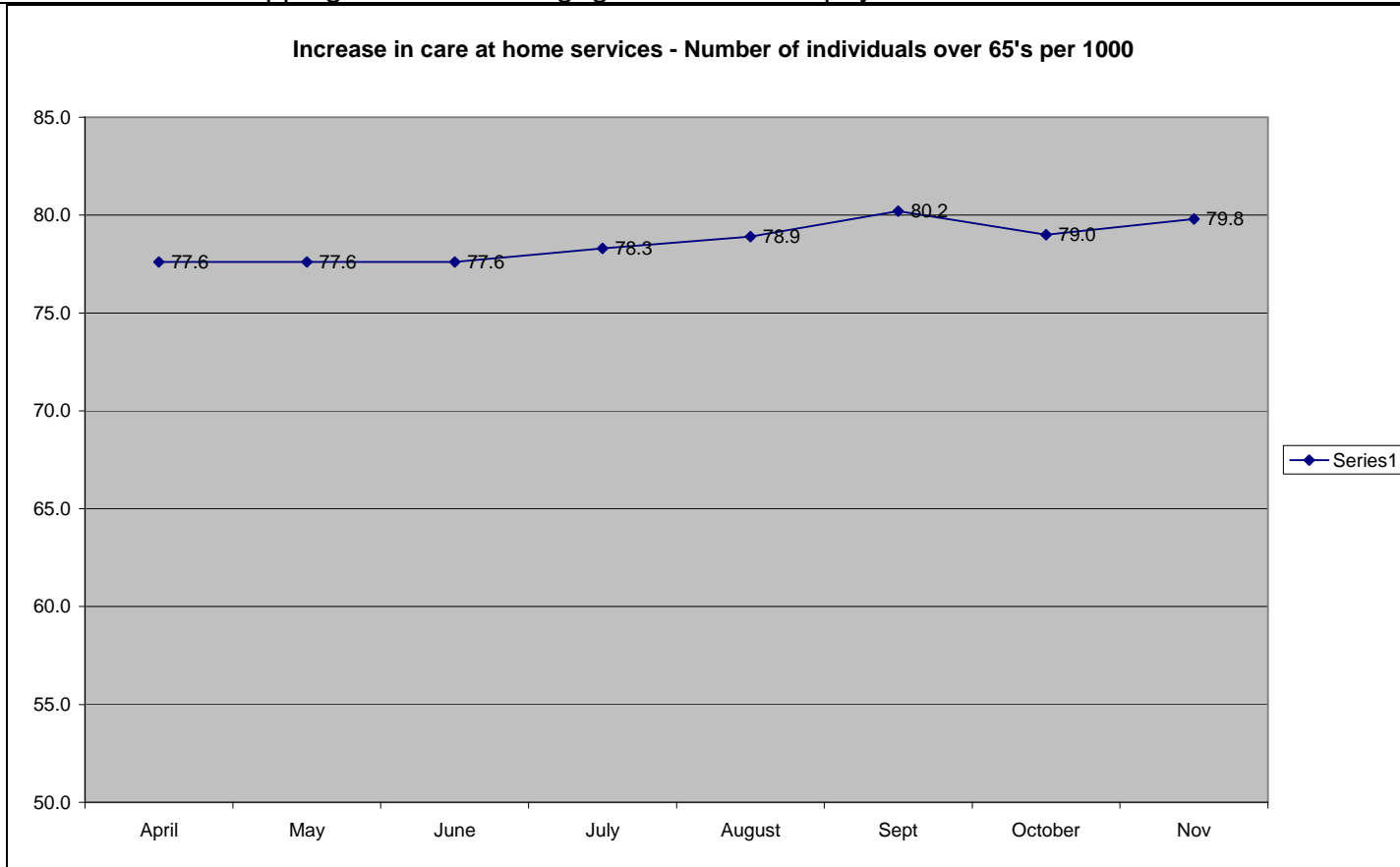
2011) shows we have breached our monthly average of 5, by 1. Based on our average monthly performance we anticipate that the end of year performance will result in around 60 unplanned admissions for EMI patients. This represents an improvement on our baseline figures of 121.



**Comments**

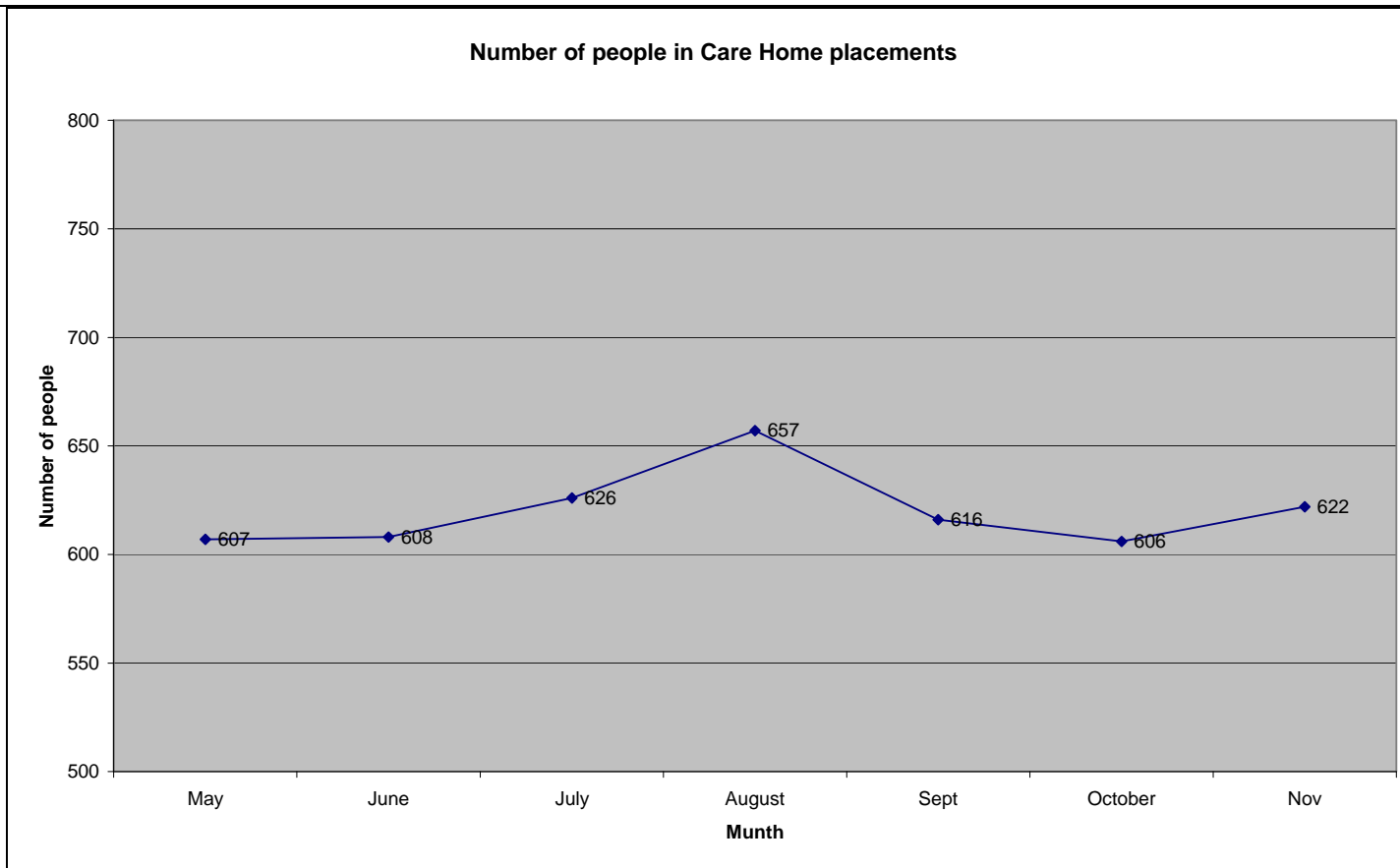
The numbers of people over 65 accessing self directed support is currently 28 (Nov 2011). We have begun a process of

information giving in services around Self Directed Support and hope to see increased in uptake as a result of this by year end. In addition we have a number of people over 65 participating in the Independent Living Scheme. The scheme represents indirect self directed support and can be a stepping stone to full engagement in direct payments.



**Comments**

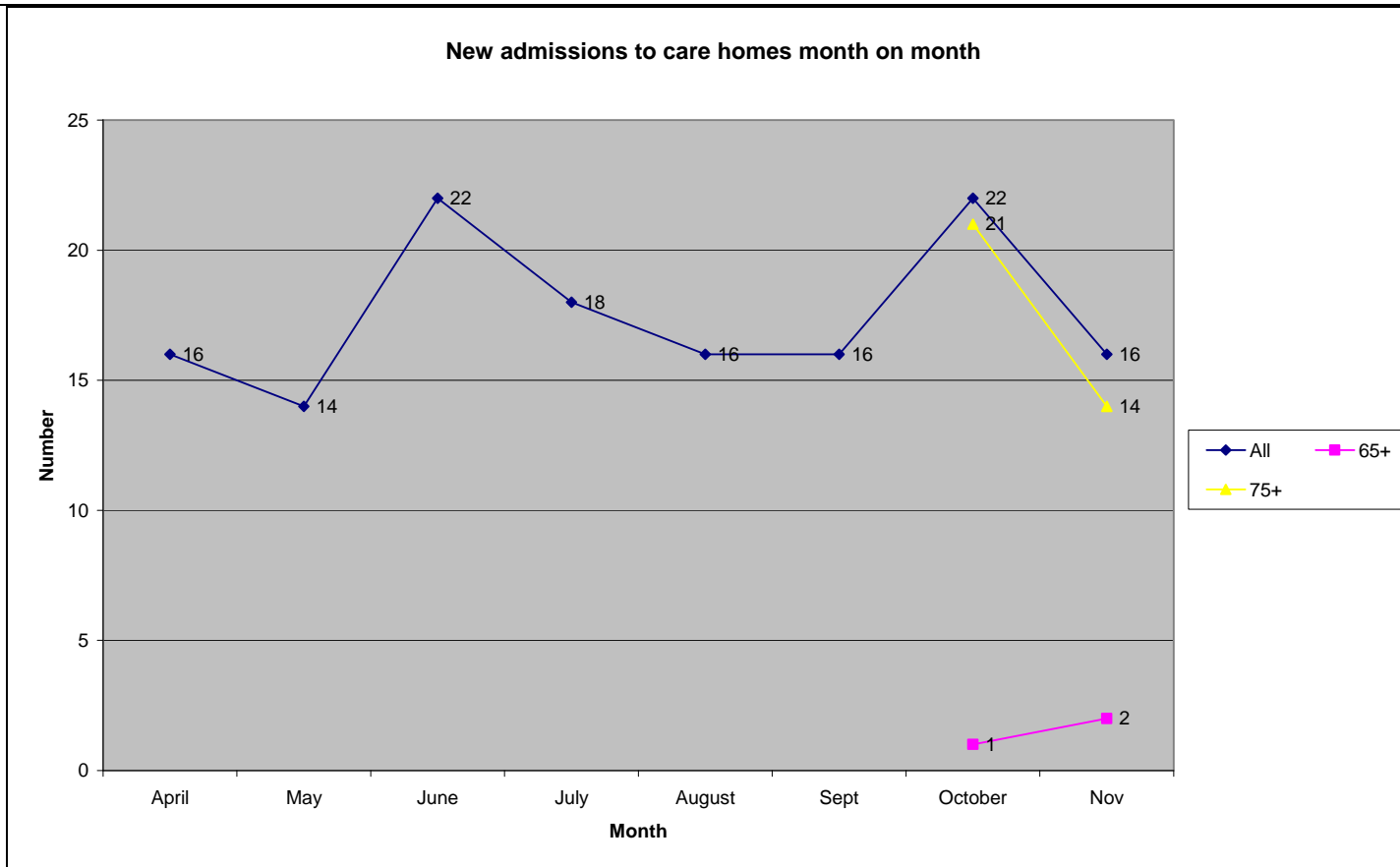
The number of people over 65 per 1000 population in receipt of home care has increased since April 2011.



#### Comments

The number of people in care home placements was 622 as at November 2011. We are working locally to identify factors and

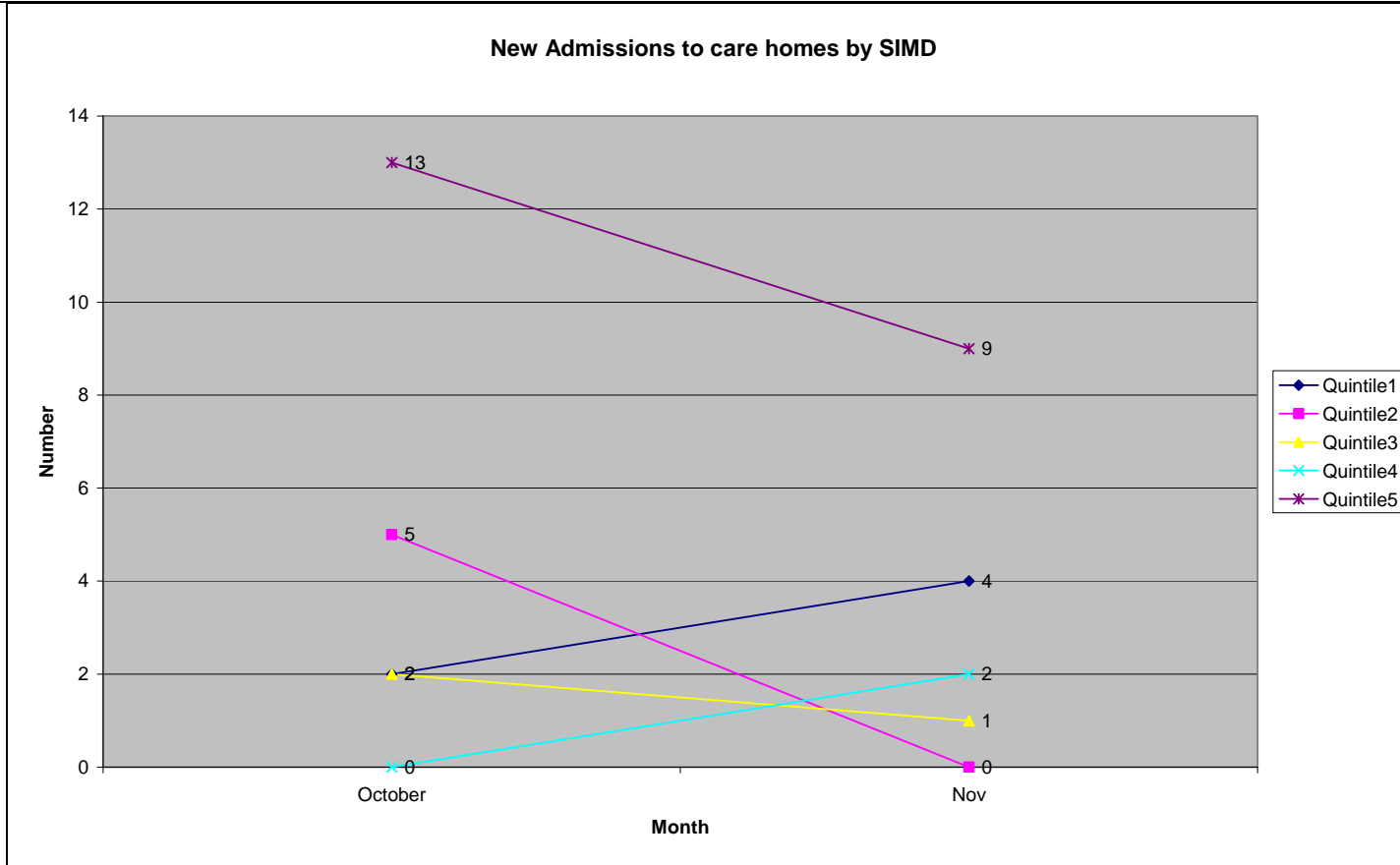
patters in relation to admission decision in respect of care homes, with a core vision to maintain people at home as long as possible and reduce our use of the care home estate.



**Comments**

The average number of admissions to care homes per month from April to November has been 17. Since October 2011 we have

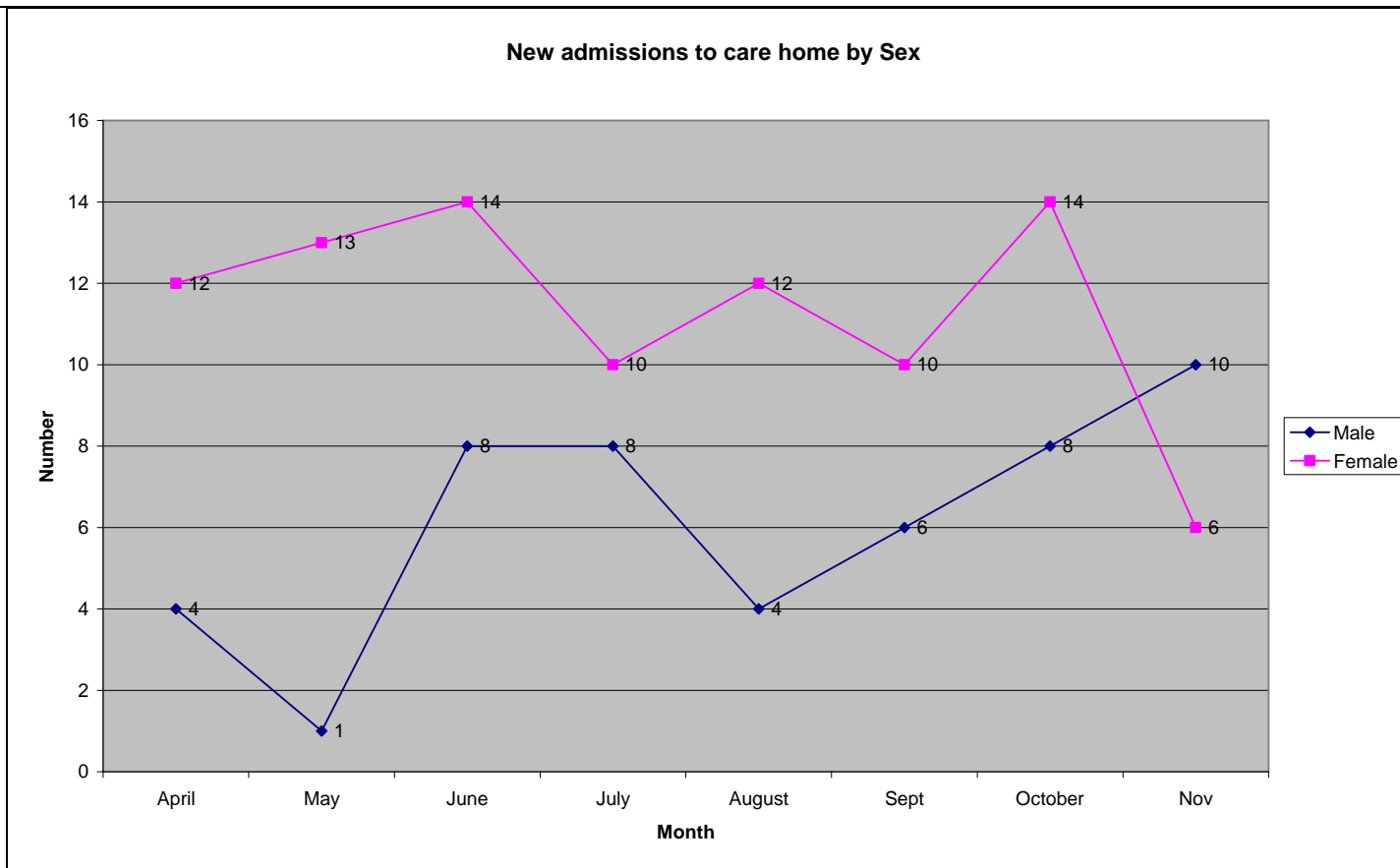
been monitoring new admissions per month against a range of types – including age split. We can see that more new admissions have been for people aged 75 and over. We aspire to ensure that fewer people under 76 are admitted to care homes as a proportion of all admissions, as a proxy for people being maintained at home for longer. Reducing the number of new admissions to care homes each month is a core aim for us.





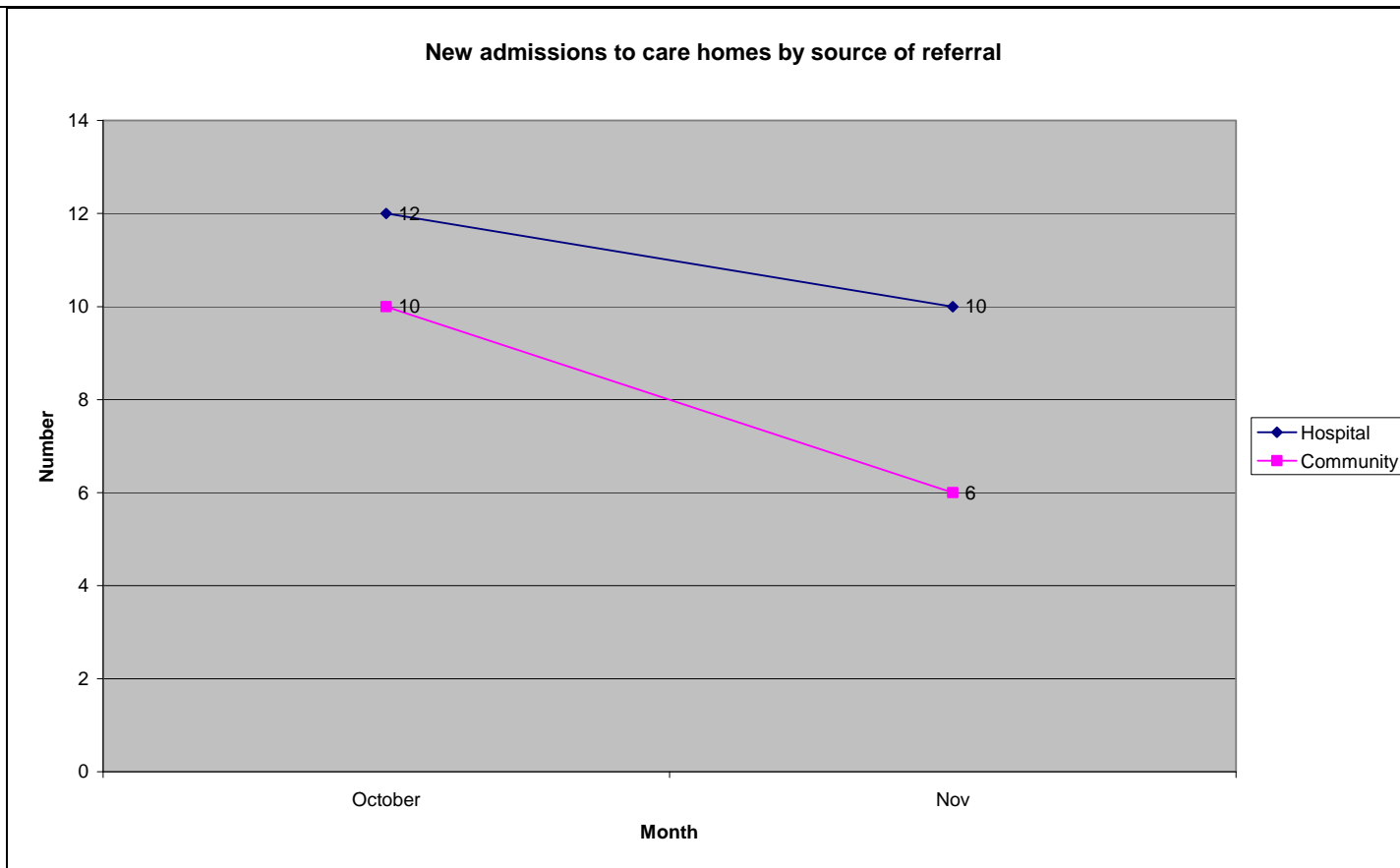
**Comments**

As above we will monitor the circumstances of people being admitted to care homes to better understand factors relating to care home admissions – deprivation is one such category.



**Comments**

As above we will monitor the circumstances of people being admitted to care homes to better understand factors relating to care home admissions – sex is one such category. On average more females than males are admitted to care homes in our area.



**Comments**

Since October 2011 we routinely monitor the source of referral to care home, linked to other indicators such as admissions and delayed discharges.

Appendix 3

**CHANGE PLAN DEVELOPMENT REPORTING/MONITORING SYSTEM**

**Workstream: Independent Living**

**Lead: Andrina Hunter**

1. Description of development	2. Start date	3. Funding agreed	4. Overarching Theme from plan	5. Key change areas	6. Baseline information e.g. activity currently being reported or that can be measured	7. Link to local data and person responsible for reporting	8. Link to National Improvement Measures
<b>1. Provision of range of Capacity Building activities which will be piloted for 1 year</b>	January 2012	£100,000-(2011/12)  £100,000-(2012/13)	Independent living	Development of capacity within the community to support independent living An increase in older people living at home	7 programmes of work currently funded as outlined below  Participation in programmes by older people	Andrina Hunter	A4
Comments Funding allocated 7 local organisations in Jan to deliver in year totally approx £91,000 as outlined below							
<b>1.1 Contact the Elderly Sunday groups</b>	January 2012	£5000	Independent Living	Development of capacity within the community to support independent living	We will establish baseline at project commencement re numbers of groups established, older	Andrina Hunter	A4

				Alleviate loneliness and isolation	people attending and volunteers involved		
<p>Comments</p> <p>Contact the Elderly is a new initiative being brought to Inverclyde. Alleviate loneliness and isolation by providing Sunday afternoon groups for the older person who is socially isolated and in many cases housebound. Funding is for a part time development officer and volunteer training.</p>							
<b>1.2 Cloch Housing Falls prevention and Home safety scheme- (supply of equipment)</b>	January 2012	£5000	Independent Living	Development of capacity within the community to support independent living  Assist older people to remain independent and safe at home	Amount of equipment utilised and installed by Cloch Small repairs service	Andrina Hunter	A4
<p>Comments</p> <p>Cloch Housing currently operates a small repairs scheme and have officers who currently support older people who are owner/occupiers with small repairs. This funding will provide equipment e.g Yale Locks, door chains, electrical equipment which will enable an older person to</p>							

feel safe and rectify any potential tripping hazards.

<p><b>1.3 WRVS Good neighbours and social transport</b></p>	<p>January 2012</p>	<p>£25,000</p>	<p>Independent Living</p>	<p>Development of capacity within the community to support independent living</p> <p>Alleviate loneliness and isolation</p> <p>An increase in older people living at home</p>	<p>Provides services to 135 service users. Recruit 80 volunteering opportunities Signpost to 29 organisations Provide 380 interventions</p>	<p>Andrina Hunter</p>	<p>A4</p>
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**Comments**

This WRVS bid provides an innovative approach to meeting the needs and desires of older people with low-level preventative support service, via our integrated structure. This structure brings together all WRVS services within Inverclyde providing the platform for an integrated approach to identification and delivery of services built around our core services in the Community and in the Hospital.

It will provide:

- Social transport via Volunteers cars to access any local service, leisure centre, library group or organisation, including existing Lunch or Social clubs. Also provide access and escort to shops, as well as assistance with prescription collection, pension collection and banking and Social Outings. Links will improve confidence and help people feel connected to communities
- Good Neighbours / Befriending- volunteers visit in a person's home or bedside, and provide companionship. Volunteers assist older people with socialising, i.e. assisted trips to pub, club, bingo etc. Letter writing, dealing with tradesmen, going for a walk, simple

household tasks.

Funding is for a service co-ordinator and admin support

<p><b>1.4Muirshiel Centre-Home Maintenance</b></p>	<p>January 2012</p>	<p>£16995.52</p>	<p>Independent Living</p>	<p>Development of capacity within the community to support independent living</p> <p>An increase in older people living at home</p> <p>Assist older people to remain independent and safe at home</p>	<p>We will establish baseline at project commencement re numbers of older people supported</p>	<p>Andrina Hunter</p>	<p>A4</p>
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**Comments**

This service currently exists and provides 2 part time handypersons who support older people with gardening services, decorating services and general works.

This funding will allow the additional recruitment of a 3<sup>rd</sup> handyperson which will provide a quicker and more efficient response

<b>1.5 Inverclyde advocacy Service</b>	January 2012	£15,114	Independent Living	Development of capacity within the community to support independent living  Assist older people to remain independent	To assist 120 older people either wishing to return home, access services or change services.	Andrina Hunter	A4
<b>Comments</b> Funding will provide for 20 hours /week advocacy worker who will support people in hospital, care homes, day services and own homes							
<b>1.6 Financial Fitness</b>	January 2012	£14088	Independent Living	Development of capacity within the community to support independent living  Assist older people to remain independent	250 older people discharged from hospital will receive a full income and financial circumstances check	Andrina Hunter	A4



Comments

Funding will provide for part time money advice worker who will support people in their own homes once discharged from hospital

**1.7 Stepwell –  
cookschoools  
3 month pilot**

January  
2012

£10,000

Independent  
Living

Development  
of capacity  
within the  
community  
to support  
independent  
living

Alleviate  
loneliness  
and isolation

20 cook schools  
will be provided  
40 older people  
will be supported  
to attend

Andrina Hunter

A4

Comments

Cook schools will provides opportunities to learn how to cook for one, reduce budgets and waste and, in addition, share time with other older people in similar circumstances.

1. Description of development	2. Start date	3. Funding agreed	4. Overarching Theme from plan	5. Key change areas	6. Baseline information e.g. activity currently being reported or that can be measured	7. Link to local data and person responsible for reporting	8. Link to National Improvement Measures
<b>2. Identification of gaps in social transport system for older people and commissioning of a consortium bid for future funding 2012/13</b>	January 2012	£5000-(2011/12)	Independent living	Development of capacity within the community to support independent living An increase in older people living at home	Consortium bid developed and funding agreed	Andrina Hunter	A4

Comments

A short scoping exercise undertaken by the Community capacity sub group highlighted the lack of social transport systems for older people who wish to access a range of activities. CVS has been commissioned to develop a consortium bid for 2012/13 change fund to develop a more flexible and robust service

1. Description of development	2. Start date	3. Funding agreed	4. Overarching Theme from plan	5. Key change areas	6. Baseline information e.g. activity currently being reported or that can be measured	7. Link to local data and person responsible for reporting	8. Link to National Improvement Measures
<b>3. Establishment of Community capacity sub group and proposed work plan</b>	January 2012	Funding available 2012/13- £100,000	Independent living	Development of capacity within the community to support independent living  An increase in older people living at home	Current pilot projects which are effective will be continued and new funding allocated to identified gaps.	Andrina Hunter	A4
The sub group will meet on 16 <sup>th</sup> January and involve representatives from the CHCP, Voluntary sector and older people representatives from the CHCP advisory structure. A Workplan will be developed							

## Appendix 4

### CHANGE PLAN DEVELOPMENT REPORTING/MONITORING SYSTEM

Workstream: Carers

Lead: Derrick Pearce

1. Description of development	2. Start date	3. Funding agreed	4. Overarching Theme from plan	5. Key change areas	6. Baseline information e.g. activity currently being reported or that can be measured	7. Link to local data and person responsible for reporting	8. Link to National Improvement Measures
4. Production of Carers Information Packs	January 2012	£500 (£2000 in year two)	Support to carers	<p>Increased information for carers</p> <p>Aids independent living</p> <p>(can link to all change areas)</p>	<p>Intend to deliver 1000 carers information packs over two years</p>	<p>Increased carer involvement in care planning</p> <p>Increase respite provision for cares</p> <p>Increase number of carers accessing income maximisation advise</p> <p>Increased early identification of carers</p> <p>Proportion of older people cared for at home compared to proportion cared for in hospital/ care homes (enabling OP to stay at home)</p>	<p>B5 (respite)</p> <p>(proxy link to others)</p>

<p>Comments</p> <p>Funding allocated to Carers Centre in Jan to deliver in year 1 (proposed allocation of £2000 for year two agreed in principle)</p> <p>Carers centre will employ sessional staff to compile packs for distribution at key points of carer engagement (e.g. hospital discharge, initial registration with Carers Centre at via outreach)</p>							
1. Description of development	2. Start date	3. Funding agreed	4. Overarching Theme from plan	5. Key change areas	6. Baseline information e.g. activity currently being reported or that can be measured	7. Link to local data and person responsible for reporting	8. Link to National Improvement Measures
5. Carer Befriending	January 2012	£5000 (proposed allocation of £25k in yr 2)	Support to carers	<p>Aids independent living</p> <p>Alleviate carer isolation</p> <p>(can link to all change areas)</p>	<p>We will establish baseline at project commencement re numbers of carer befrienders trained, and befriending matches</p>	<p>Proportion of older people cared for at home compared to proportion cared for in hospital/ care homes (proxy for increased support for carers to enable OP to stay at home)</p>	<p>Proxy via most measures</p>
<p>Comments</p> <p>Was planned to be coupled with a longer term project re Shared Care – this has been postponed in year 1 and will be revisited in year 2</p> <p>Carers Centre will employ a Carer Support Worker (28 hours per week) to recruit, train and support former carers to provide informal peer support to unpaid carers. Focus will be on carers aged 65 plus and carers of people aged 65 plus. Volunteers will undertake training and be matched to carers with similar interests and experiences.</p>							

1. Description of development	2. Start date	3. Funding agreed	4. Overarching Theme from plan	5. Key change areas	6. Baseline information e.g. activity currently being reported or that can be measured	7. Link to local data and person responsible for reporting	8. Link to National Improvement Measures
6. Emergency Planning	January 2012	£7000 (proposed £40K in year 2)	Support to Carers	Prevent carer breakdown  Prevent avoidable hospital admissions  Prevent care plan failure  Increase support to carers	We will establish at commencement of the project measurement of number of carer enquiries in relation to emergency planning, and number of carers who an Emergency Plan in place	Reduction in unplanned admissions (65/75 plus)  Reduction in repeat admissions (65 plus)  Increased carers involvement in care planning  Increase respite provision for carers (uptake)  Reduction in direct care home admissions from hospital  Increase in carer assessments  Proportion of older people cared for at	Proxy via most measures

						home compared to proportion cared for in hospital/ care homes (proxy for increased support for carers to enable OP to stay at home)	
<p>Increased use of anticipatory care planning (ACP)</p>							
<p>Comments</p> <p>Carers Centre will employ a Carer Support Worker (35 hours per week) to engage with unpaid carers and Assessment/Care Management Staff to facilitate the development of emergency care plans. This work is designed to help plan for the future and prevent avoidable admissions (e.g in the event of carer crisis or breakdown). Work will be focussed on carers of people aged over 65 and carers aged 65 plus. Initial focus (year 1) will be around identifying best practice via research of other areas etc.</p>							
<b>1. Description of development</b>	<b>2. Start date</b>	<b>3. Funding agreed</b>	<b>4. Overarching Theme from plan</b>	<b>5. Key change areas</b>	<b>6. Baseline information e.g. activity currently being reported or that can be measured</b>	<b>7. Link to local data and person responsible for reporting</b>	<b>8. Link to National Improvement Measures</b>
7. Supporting hospital discharge	January 2012	£7000 (proposed allocation of £30k in year 2)	Support to carers	Prevent delayed discharge/ failed discharge  Prevent carer breakdown	Intend to provide information around hospital discharge to 250 carers per year	Reduction in repeat admissions over 65  Reduction in length of stay/ bed days  Reduction in direct care home	A1  A2 (a) and (b)  A5

				<p>Prevent avoidable hospital readmissions</p> <p>Prevent care plan failure</p> <p>Increase support to carers</p>	<p>Delayed discharge data (? Where carer availability/ readiness is the issue)</p>	<p>admissions from hospital</p> <p>Increased early identification of carers</p> <p>Increase in carer assessments</p> <p>Proportion of older people cared for at home compared to proportion cared for in hospital/ care homes (proxy for increased support for carers to enable OP to stay at home)</p>	
<p>Comments</p> <p>The Carers Centre will employ Carers Support Worker (28 hours per week) to provide support, advice and information to unpaid carers from the initial hospital admission of the person being cared for through to discharge – including facilitation of carer inclusion in discharge planning. Focus will be in carers of people aged 65 plus, and carers who are aged 65 plus. Methods will include; raising awareness of carer services with secondary care staff, implementing a clear referral process to carer support services and engaging directly with carers in support of secondary care staff (e.g. following admission and at time of discharge planning).</p>							