DUNDEE CITY COUNCIL

REPORT TO: **SOCIAL WORK AND HEALTH COMMITTEE – 25 FEBRUARY 2013**

REPORT ON: **DUNDEE JOINT STRATEGIC AND COMMISSIONING STATEMENT FOR OLDER PEOPLE**

REPORT BY: **DIRECTOR OF SOCIAL WORK**

REPORT NO: **88-2013**

1.0 PURPOSE OF REPORT

To seek approval for the Dundee Joint Strategic and Commissioning Statement for Older People. (The Statement).

The Statement is attached as Appendix 1 to this report.

2.0 RECOMMENDATIONS

2.1 It is recommended that the Social Work and Health Committee endorse the Dundee Joint Strategic and Commissioning Statement for Older People appended to the report.

3.0 FINANCIAL IMPLICATIONS

3.1 The commissioning intentions outlined in the Joint Strategic and Commissioning Statement for Older People will be funded from the combined resources available to the Dundee Social Work and Health Partnership, consisting of Social Work, Health and Change Fund Resources. The outcomes will be delivered through a combination of service redesign, resource release and through commissioning additional services.

3.2 The shift in resources from institutional and hospital based care to anticipatory and preventative services over the period is reflected in the statement.

4.0 MAIN TEXT

4.1 Background

The Dundee Joint Strategic and Commissioning Statement for Older People reflects the current policy directions established through the Reshaping Care for Older People Framework. The framework emphasises a requirement to invest in anticipatory and preventative approaches that will help manage demand for formal care; work closer with the third sector; develop community capacity and support carers.

4.2 As noted at Social Work and Health Committee on 27 February 2012 (Report 84-2012), the Dundee Social Work and Health Partnership received additional resources to implement the Dundee Change Plan and 2 work streams were developed with 11 associated project areas. The development of the Change Plan has facilitated an opportunity to test and review a number of changes. It is anticipated that through the life time of both the Change Plan and the Dundee Joint Strategic and Commissioning Statement for Older People, that these changes will lead to a redesign of service delivery through disinvestment in current models of service and re-investment into new models of service. Overall it is anticipated that this will result in a shift in the balance of care from institutional and hospital based care, to care in the community with both social care and health care delivered at home or close to home.
The detailed Change Plan submissions were the subject of Committee Reports: Reshaping Care for Older People – Change Fund (84-2012) and Reshaping Care for Older People – Change Fund (237-2012).

4.3 The Dundee Joint Strategic and Commissioning Statement for Older People spans a five year period (2013-2018) which will allow both the strategic changes and the Change Plan developments to be tested and evaluated. It identifies the progress made in achieving the strategic outcomes and defines the actions to be taken over the period of the Statement. Two reviews will be undertaken during the period of the Statement.

4.4 **Developing the Strategic and Commissioning Statement**

The Scottish Government issued guidance to Local Authorities regarding the development of strategic and commissioning plans for older people, and asked local partnerships to self assess their progress. In preparation for the development of the Strategic and Commissioning Statement, a Strategic Needs Assessment of Older People in Dundee was developed. The information from the Strategic Needs Assessment of Older People is currently being collated and will be able for future reference. In addition to mapping trends and prevalence, the Needs Assessment identified that:

- the number of older people aged over 65 is expected to rise by approximately 30% by 2035 (6.700 people),
- the number of people aged over 75 will increase by 40% and those over 85 will increase by 93%,
- prevalence has increased in Dundee in 10 of the 17 Long Term Conditions, particularly in relation to dementia,
- the cost of caring for older people can be as much as 5.5 times more than those without dementia, and
- using the Scottish Index of Multiple Deprivation, that in 2011, 34.2% of the 65+ aged population in Dundee City were living in the most deprived quintile of Dundee, compared with 19.2% living in the least deprived quintile.

4.5 As a result, older adults in Dundee will be more acutely unwell at an earlier age and experience a greater level of dependency. As previously described, the Dundee Joint Strategic and Commissioning Statement for Older People will build on the work aligned to the Change Plan. The financial resources aligned to the Change Plan will primarily support the period of change, with resources released for further remodelling. Despite this bridging fund, matching the level of demand with the pace of change will prove a challenge for the Dundee Partnership and may place additional financial pressure on both Local Authority and Health services. This will be monitored and reported as required. The Statement lists both the commissioning intentions and the redesign proposals and states whether or not the resources for these changes are currently secured.

4.6 Previously we have set out the Strategic Plans for Older people by describing a range of strategic promises. In developing this Statement, we commissioned the Celebrate Age Network to undertake public engagement. The engagement was developed by exploring older adults' views in relation to personal outcomes. The Celebrate Age Network met with approximately 200 older adults through a series of one to one interviews, focus groups and an engagement event. The information gathered through this engagement exercise is reflected throughout the Statement and can be defined in summary as follows:

- Most people were happy with service they receive.
- The lack of flexible and affordable transport was a common theme throughout.
- The cost of living caused on-going problems.
- There was desire for basic supports such as housing and gardening.
- People reported feeling isolated, particularly at night.
- Many people had not undergone a welfare benefits check and were concerned about the level of charges for services.
- There were perceived difficulties with health services such as access to GP's, the responsiveness of out of hour's service and the quality of hospital care.
- Older carers reported a decrease in their health and ability to access activities which might keep them well.

4.7 To maintain an outcome approach the Statement has adopted the use of outcomes to describe the strategic overview. The Older Peoples Strategic Planning Group held a development day where the following personal outcomes were identified as those most relevant to older adults within Dundee and these are used within the Statement:

- Having choice and control of my life.
- Keeping in touch and maintaining meaningful relationships.
- Being part of the world that I live in.
- Staying as well as I can.
- Maximising my potential.
- Being safe and feeling safe.

4.8 Our vision, therefore is that Older Adults will be supported to live a fulfilled life, as part of the community of their choice with the supports that assist them to achieve this. In recognition of the changes required to meet this vision, we have summarised our aims as:

- To have more people cared for at home;
- To have more direct support for carers;
- To have fewer people delayed in hospital;
- To have fewer people in care homes; and
- To have a wider range of alternatives to statutory services for individuals and communities.

4.9 In describing the vision, aims and personal outcomes, the Dundee Joint Strategic and Commissioning Statement for Older People strongly reflects the views of older adults within Dundee. The actions contained within the Statement will be delivered through the Dundee Partnership, which includes the Local Authority, health, the Voluntary Gateway, the Third Sector, the Celebrate Age Network, the Dundee Carers Centre and older people. It builds on the Change Plan developments and recognises the future demands.

4.10 A copy of the approved Dundee Joint Strategic and Commissioning Statement for Older People will be circulated to the wider stakeholders involved in the development of the Statement for their information and to seek their confirmation of the content of the Statement.

5.0 POLICY IMPLICATIONS

This Report has been screened for any policy implications in respect of Sustainability, Strategic Environmental Assessment, Anti-Poverty and Equality Impact Assessment. There are no major issues.

An Equality Impact Assessment has been carried out and will be made available on the Council website http://www.dundeecity.gov.uk/equanddiv/equimpact/

6.0 CONSULTATIONS

The Chief Executive, Director of Corporate Services and Head of Democratic and Legal Services have been consulted in preparation of this report.

The Dundee Joint Strategic and Commissioning Statement for Older People was developed following a comprehensive engagement process. This process included public research commissioned by the Older People's Strategic Planning Group and undertaken by the Celebrate Age Network. The engagement process is detailed in the Statement.

7.0 BACKGROUND PAPERS

None.

ALAN G BAIRD, DIRECTOR OF SOCIAL WORK **DATE: 5 FEBRUARY 2013**

DUNDEE JOINT STRATEGIC AND COMMISSIONING STATEMENT FOR OLDER PEOPLE

JANUARY 2013

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1.0 OUR VISION FOR DUNDEE

It is **our vision** that older adults in Dundee are supported to live a fulfilled life, as part of the community of their choice with the supports that assist them to achieve this.

To do this we intend to develop better links within local communities and to make local resources known and more accessible. We aim to support the development of a range of activities and opportunities for networking and socialisation.

We understand that to assist you to remain at home we must expand the level of support provided, give greater choice and make this more flexible. We have developed partnerships between the Local Authority, Dundee Community Health Partnership, the Voluntary sector and the Independent sector to progress new models of support and care. In addition we are progressing the use of social enterprise models and looking at volunteer led supports.

Many older adults are carers of others or are cared for. We recognise the role of carers and aim to provide a range of respite and therapeutic options to support you in this role. We want you to have confidence in the services we provide for the person you care for and will introduce new quality assurance measures to monitor services.

We want take a preventative approach to your health care needs and assist you to manage your heath as independently as possible. Where you do have to go into hospital you should be assisted to return home as soon as you are medically fit to do so.

Where additional help is required we want this to be delivered in your own home or close to your home. If you are no longer able to remain in your current accommodation then we will develop a range of housing choices to meet your changing needs. If you are no longer able to stay at home, we will plan with you to make arrangements for your future care. While we will always respond to emergency or crisis situations, we would want to support your decision to move into a care home setting and for this to be a planned positive choice for you. We will work with our care home providers to make sure that the care provided is of a high quality.

Taking this into account, **our aims** can be summarised as:

- **to have more people cared for at home;**
- **to have more direct support for carers;**
- **to have fewer people delayed in hospital;**
- **to have fewer people in care homes; and**
- **to have a wider range of alternatives to statutory services for individuals and communities.**

During the development of the Strategic and Commissioning Statement the Dundee Joint Strategic Planning Group for Older People and Older People with Dementia further developed these aims to reflect the experience of being an older adult in Dundee. At a Strategic Planning Development Day the following **personal outcomes** were considered to be those most relevant for older adults:

1. **Having choice and control of my life.**
2. **Keeping in touch and maintaining meaningful relationships.**
3. **Being part of the world that I live in.**
4. **Staying as well as I can.**
5. **Maximising my potential.**
6. **Being safe and feeling safe.**

To ensure we maintain our focus on the outcomes we want to achieve, the actions linked to the Strategic and Commissioning Statement has been aligned to these outcomes.

2.0 STRATEGIC DIRECTION

2.1 Scope of the Strategic and Commissioning Statement

The Dundee Strategic and Commissioning Statement (the Statement) represents the views and planning efforts of the Dundee Partnership (the Partnership). The Partnership includes NHS Tayside, Dundee CHP, Dundee City Council Social Work Department and Housing Department, Dundee Voluntary Gateway and associated organisations, independent providers, Celebrate Age Network, older people and their carers.

Building on the strategic direction set out in the Dundee Older Peoples Joint Strategy and Commissioning Framework 2008 – 2011, the Dundee Joint Strategy and Commissioning Framework for People with Dementia 2009 - 2012 and the Dundee Partnership Change Plans spanning 2011 – 2015 (the Change Plans), the Statement defines the broad strategic direction for older people living in Dundee.

The Statement spans a 5 year period and allows the current Change Plan developments to be evaluated and mainstreamed. We have shown the financial framework over a five year period to demonstrate the full period of redesign, remodelling, investment and disinvestment as identified through the Change Plans

In developing the Statement the Partnership followed the guidance produced by the Joint Improvement Team as defined in Figure 1, analysing the information known about the needs of older adults in Dundee, planning the service and support requirements in line with the demands and needs identified, and defining the commissioning and redesign intentions.

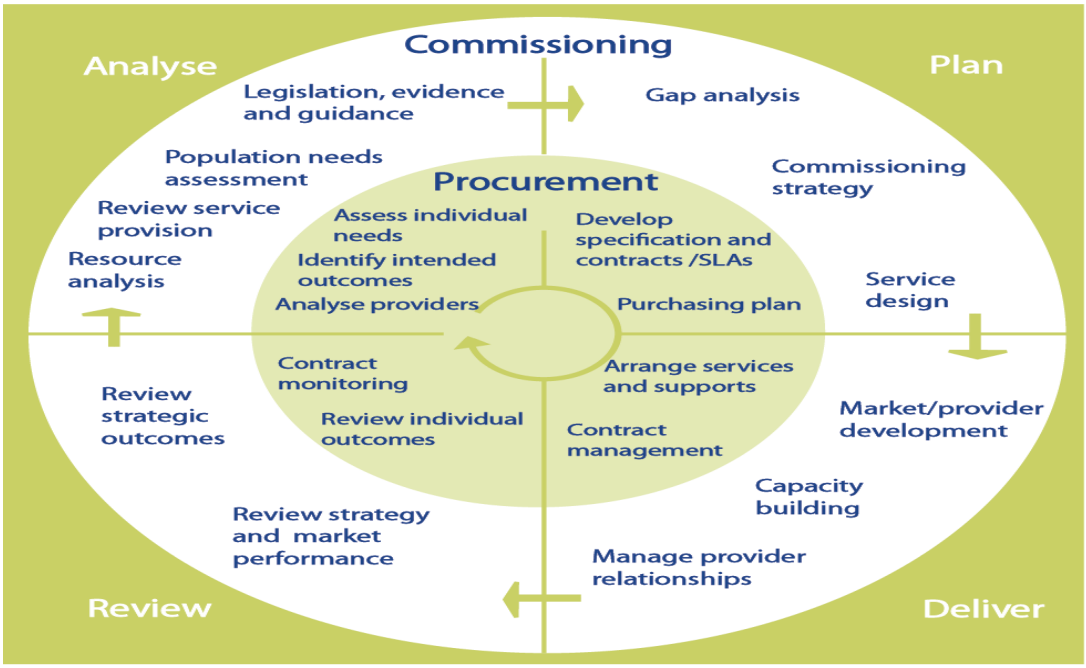


Figure 1

The development of the Change Plans has facilitated an opportunity to review and test a number of changes and while many of the projects are still in the implementation phase, we

are able to make some predictions about further service commissioning and remodelling. This process of review and revaluation will be a recurrent feature during the implementation of the Statement.

2.2 Policy context

The Statement reflects the current policy direction established through the Reshaping Care Framework. Taking account of the growing number of older people and the changing demographics in Scotland, the framework identified that demographic and fiscal pressures make the current models of personal and health support services unsustainable and that the anticipated shifts in the balance of care, from institutional care to care at home, have not progressed quickly enough.

To make the proposed shifts requires a change in a policy and the proposed approached highlighted that:

- older people should be viewed as assets,
- individuals should take more personal responsibility for their health and care,
- coproduction should be at the heart of service redesign and development,
- carers should be recognised and supported, and
- there should be a range of support options including peer supports and community supports.

To accelerate the changes, Partnerships were awarded a Change Fund to bridge the gap between the current models of service and the planned redesigns. During the period of the Change Plan, partnership will release resources by reducing or discontinuing expenditure on current models of support and investing in new models. The framework for developing these changes focused on four key priority areas:

- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Effective Care at Times of Transition
- Hospital and Care Homes

The Dundee Partnership submitted detailed Change Plans in 2011 and 2012 setting out the local actions for Dundee.

Promoting Self Directed Support is part of the Scottish Government's wider programme to increase individuals' choice and control over their community care and support arrangements, by providing a personalised budget and/or range of options for procuring and determining the support package to be provided. To meet this change, a wider range of service options will be required and there may be a need to remodel statutory services and align budgets to change the ways in which support and care services are provided.

The Adult Support and Protection (Scotland) Act 2007 placed a responsibility on Local Authorities to assess where an adult concern was raised and to take appropriate actions to safe guard individuals if required. The introduction of this Act provided a framework for the support and protection of adults at risk. For older adults there has been an increase in the level of referrals received, which has resulted in a corresponding increase in workload for Council Officers. We are more aware of the risks experienced by older people and the actions required to minimise these risks.

The Scottish Government continues to assure the public that no one will be delayed in hospital once they are fit to return home and national standards have been set for partnerships. By meeting these standards, reducing the number of bed days lost through delays and implementing the local Change Plan; local partnerships will be in a position to

review the totality of hospital based provision and remodel to further develop community supports.

3.0 ENGAGEMENT PROCESS

The Statement has been defined through a range of engagement events over the last two years which have involved older people, carers, independent and voluntary providers of services, representatives of the Dundee Voluntary Gateway, local authority staff and health staff. In developing the Dundee Partnership Change Plan, we have examined collectively the information known about our older population, the predicted demands from demographic changes and the potential impacts of maintaining our current models of service delivery. Through development days we have articulated our strategic direction and agreed how we will implement the required changes.

To add to our understanding of our local needs, the Dundee Strategic Planning Group for Older People and People with Dementia, commissioned the Dundee Celebrate Age Network Forum (CAN) to undertake a consultation exercise in preparation for the development of the Statement. The engagement undertaken consisted of two key elements:

- gathering the views of current service users of services; and
- a community conference asking older people and carers to identify their priorities.

Using the Older Peoples Outcome Star as a framework for discussion, CAN spoke with 82 service users/carers and held an engagement event for 100 older people. In general the following views were determined:

- Most people were happy with service they receive.
- The lack of flexible and affordable transport was a common theme throughout.
- The cost of living caused on-going problems.
- There was desire for basic supports such as housing and gardening.
- People reported feeling isolated, particularly at night.
- Many people had not undergone a welfare benefits check and were concerned about the level of charges for services.
- There were perceived difficulties with health services such as access to GP's, the responsiveness of out of hour's service and the quality of hospital care.
- Older carers reported a decrease in their health and ability to access activities which might keep them well.

The views collated through the engagement process are recorded throughout the report.

Finally, prior to the development of the Strategic and Commissioning Statement, a development event was held to determine and agree the outcomes which were important to older people within Dundee.

4.0 INFORMATION ANALYSIS

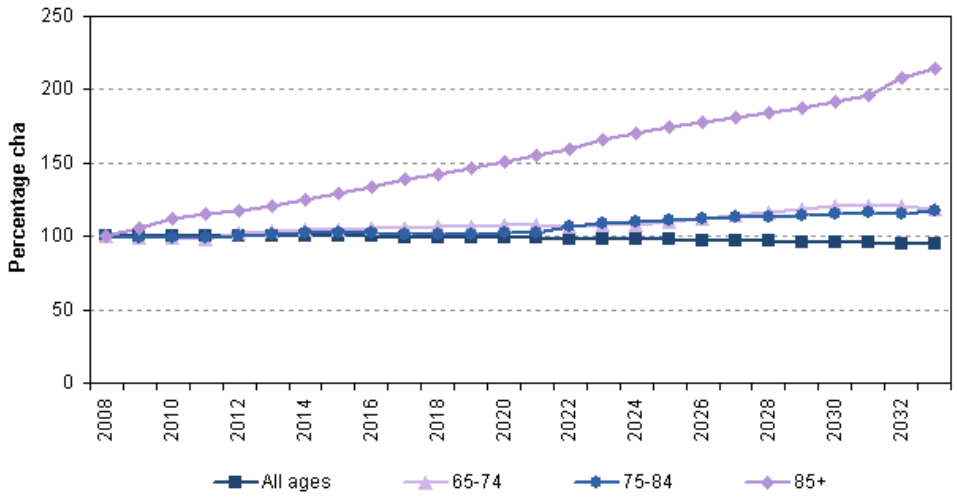
To forward plan for the city a Joint Strategic Needs Assessment was undertaken. This analysis gives us a clear understanding of the needs of older people within Dundee and the demands these will place on future service provision.

We participated in the Information and Resource Framework (IRF) analysis alongside partners from health and local authorities in the Tayside area. This work aimed to map resource allocation against population at a locality level and will provide a detailed cost analysis against this. While this work is still be concluded we were able to utilise the analysis to inform our understanding.

Dundee has an increasing ageing population with associated morbidity (Chart 1). While our overall population size is broadly remaining stable, the proportion Dundee people who are older is rising and this will impact on our future work force and capacity to deliver support to those who need this. Demographically we expect to see a:

- 30% increase in number of people over 65 by 2033.
- 40% increase in number of people over 75 by 2033.
- 93% increase in number of people over 85 by 2033.

Chart 1: Projected Population Change of the Dundee City: 2008-2033



Given the significant rise in the number of people aged over 75, we can also expect an increase in the number of older people with dementia. Using information provided by Alzheimer's Scotland, we can predict that the prevalence rates of dementia for Dundee, by gender and as based on predicted levels of population, will be as detailed below in Table 1.

Table 1 Predicted Numbers of Older People with Dementia 2013 – 2016 (Dundee City)

Males	**55 - 65**	**65 - 75**	**75 - 85**	**85 +**	**Totals**
Dundee 2013	16	154	387	320	877
Dundee 2014	16	156	390	336	898
Dundee 2015	16	154	396	356	922
Dundee 2016	16	155	394	371	936
Females	**55 - 65**	**65 - 75**	**75 - 85**	**85 +**	**Totals**
Dundee 2013	38	175	639	896	1748
Dundee 2014	38	173	638	921	1770
Dundee 2015	38	175	631	946	1788
Dundee 2016	38	175	627	978	1818

Using this information we can therefor predict that in 2013 we will have 2,625 people with dementia, in 2014 we will have 2,668 people with dementia, in 2015 we will 2,710 people with dementia and in 2016 we will have 2,754 people with dementia. We know that a large number of people with dementia are undiagnosed and that the prevalence rate for dementia within care homes is very high (although again diagnosis is not always formally recorded). In addition, the outcome for people entering hospital is poorer than that for people without dementia and they are more likely to have lengthy stays in hospital and be admitted directly to care home from hospital.

Dundee people experience a high level of poverty and the city has:

- the third largest percentage of its population (28.8%) living in the 15% most deprived areas of local authority areas in Scotland
- the fourth largest percentage of its population (21.0%) classed as income deprived of local authority areas in Scotland
- a greater percentage of households (44.3%) in the lower income categories (£0-20k) than the Scottish average (36.9%) (2009) and
- had the highest percentage of households in relative poverty (26% to 24%) across Scotland between 2002 and 2008

As a result our people demonstrate age related conditions at an earlier age. In addition to the increasing levels of dementia, the prevalence of long-term conditions within Dundee is higher than the national averages as detailed in Table 2.

Table 2 - Prevalence of Selected Long Term Conditions from GP Quality Outcome Framework (QOF) Register, Dundee City (2011)

Conditions	Patients on QOF register	NHS Tayside	Dundee CHP
Hypertension	61,136	14.6	13.8
Obesity	40,207	9.6	9.6
Asthma	23,857	5.7	5.8
Hypothyroidism	21,449	5.1	5.0
CHD (Coronary Heart Disease)	18,928	4.5	4.4
Diabetes	18,950	4.5	4.6
CKD (Chronic Kidney Disease)	15,693	3.7	3.7
Depression 2 (of 2): new diagnosis of depression	22,753	5.4	6.9
Stroke & Transient Ischaemic Attack (TIA)	10,134	2.4	2.3
COPD (Chronic Obstructive Pulmonary Disease)	9,397	2.2	2.7
Atrial Fibrillation	6,937	1.7	1.4
Cancer	6,694	1.6	1.5
Dementia	3,417	0.8	0.7
Heart Failure	4,074	1.0	1.0
Mental Health	3,926	0.9	1.1
Epilepsy	3,182	0.8	0.8
LVD (Left Ventricular Dysfunction)	2,919	0.7	0.7

Our older people are more acutely unwell. This increase in acuity and dependency impacts on the demand for acute hospital services (Ninewells Hospital), Medicine for the Elderly services (Royal Victoria Hospital) and community services. We are closely monitoring our occupied bed days for 75+ data and as shown below in Chart 2, bed days lost has increased.

Chart 2 - Occupied Days Lost to Delayed Discharges

We are also aware that the number of people aged 65+ with multiple emergency admissions and the rate of multiple emergency admissions per 100,000 populations has increased, as detailed in the charts below.

Chart 4

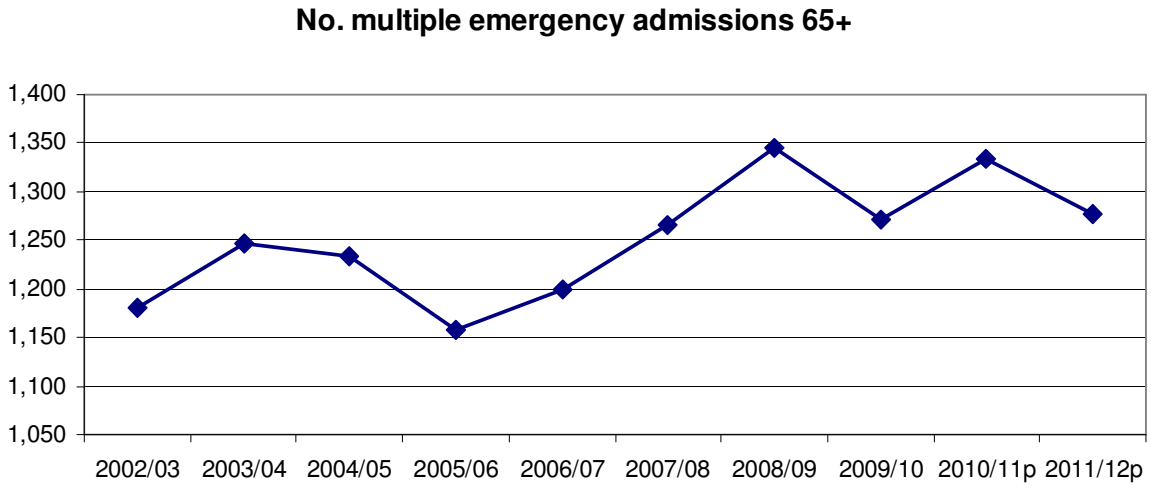
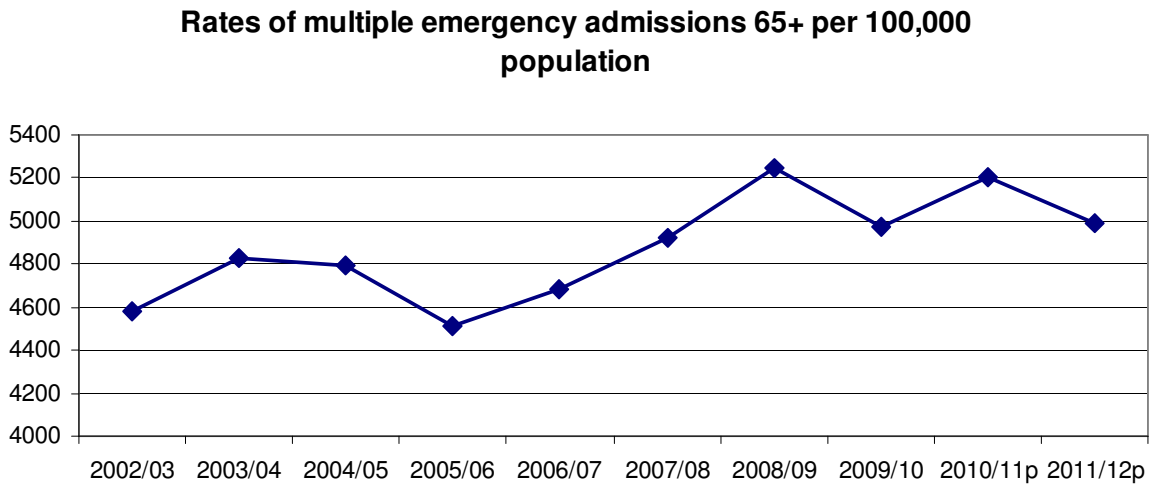


Chart 5

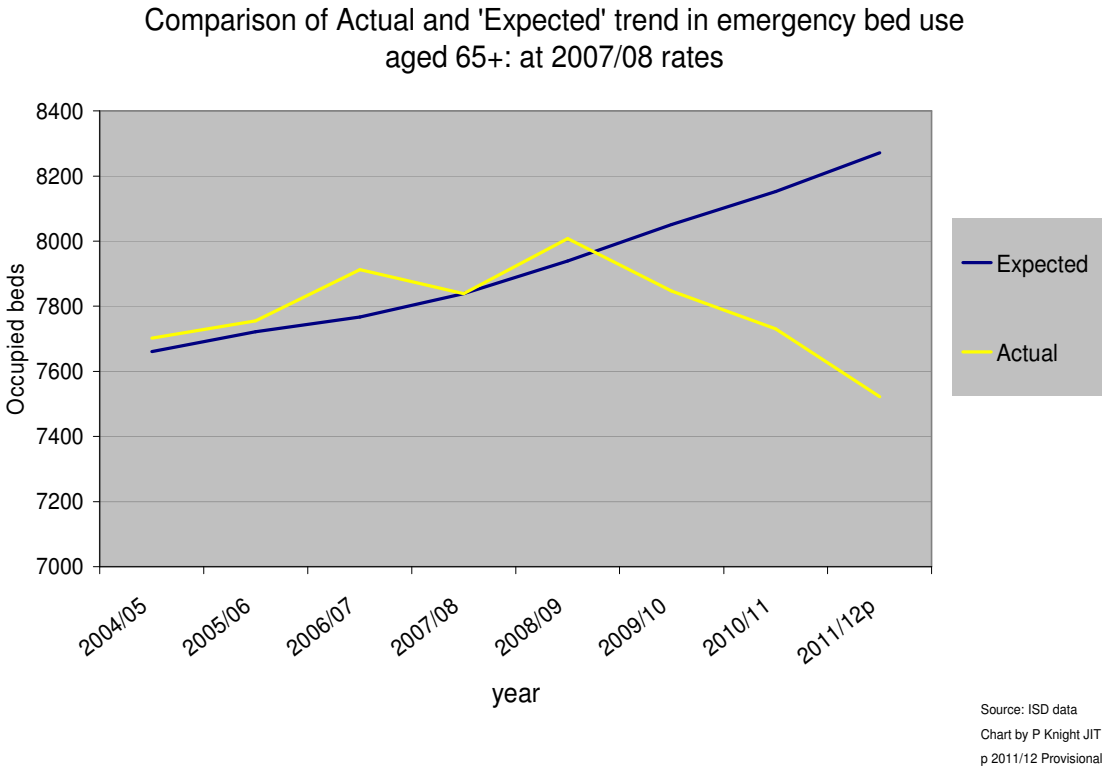


Despite this change we know that the following have **not** increased at the same rate as the occupied bed days for people aged 75+:

- Number of people aged 75+ with an emergency admission
- Average bed days per emergency admission for people aged 75+

This reflects the national trend where the prediction in the expected trend in emergency bed use has not been realised as shown in Chart 6 below.

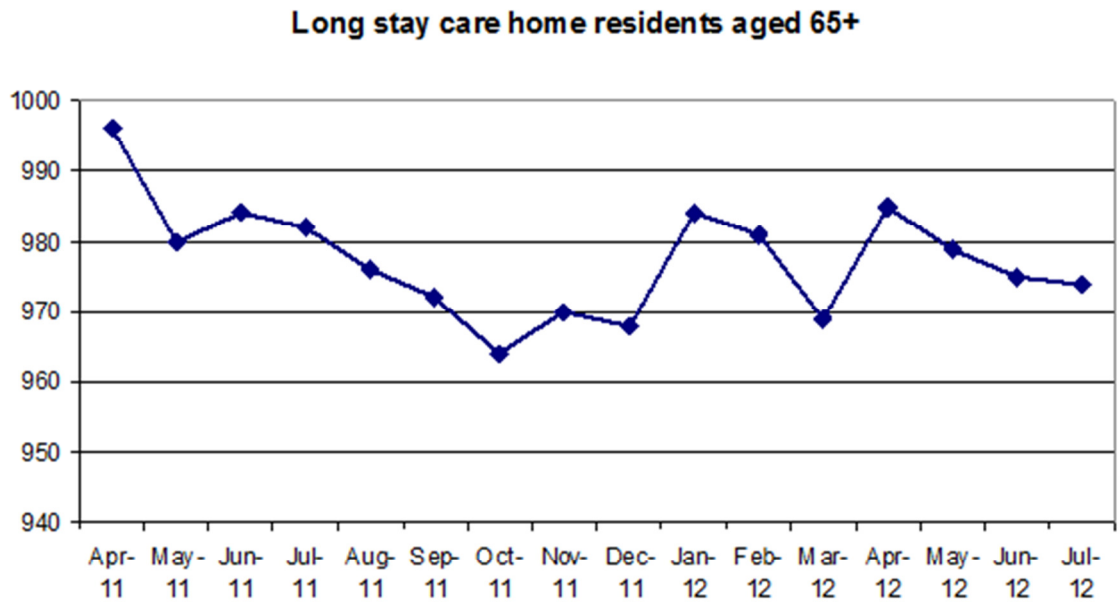
Chart 6



Given the above information our conclusion is that the reason for the increase in occupied bed days for people aged 75+ is that we are admitting older people who are increasingly frail and have multiple co-morbidities which contribute to their length of stay in hospital; their onward social needs are inevitably resource intensive and we are observing a rise in the number of very dependant older people with high packages of care.

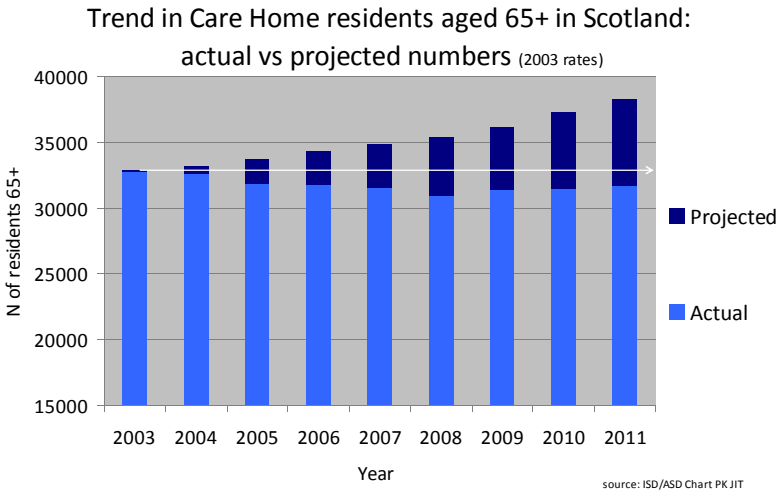
Despite this rise in demand we had continued to exceed the balance of care target of 30%. Over an 18 month period we demonstrated a reduction in the number of older people living within care home settings, reducing from 998 people in April 2011 to 946 people in September 2012.

Chart 7



This reflects the national trend as detailed in Chart 8.

Chart 8



Despite these significant improvements, we are aware that not only are the older people entering hospital more frail but the level of dependency among older people in the community is also increasing. This has resulted in an increase in the number of emergency admissions to care homes when the risk to individuals suddenly increases as a result of health changes or carer's changes and the older person cannot be maintained at home.

To improve our opportunities to maintain older people at home for longer, inroads must be made to provide both early interventions and rehabilitative supports. We have redesigned services and introduced an enablement approach to maximise people's skills, offering more rehabilitation and concentrating our resources on the frailest people who are most in need. We have redesigned our services to offer more support at over night. Examination of our current service provision identified that:

- 23% of the 75+ population in Dundee receive Tele-care support. This is greater than the Scotland average of 19%.
- In a snap shot evaluation, on average 80 – 85% of people completing enablement required no homecare hours or reduced homecare hours.
- The enablement service is currently supporting individuals to return home that would have previously been assessed as requiring residential care.

We continue to assess for and provide low level supports such as housework, shopping and meal delivery and recognise that these are preventative services which support older people to maintain their independence. As the number of older people increase, we will be required to target our resources at those most in need and we are working with our partners in the voluntary and independent services to explore options for additional models of support.

The work undertaken to date has impacted significantly on our service delivery and we believe that without these changes we would not have achieved or maintained our current level of performance. We are aware that the demand for support and services, both in hospital and in the community, is continuing to rise rapidly. While we will continue to review our models of service delivery and explore options to disinvest in current models and reinvest in alternative models, this will become a challenge in the future for our partnership.

The impact of socio-economic circumstances of individuals in Dundee is evident in the complexity of health and care needs presented by both older people and their carers. This is reflected in the dependency of people living at home and in care home settings; the acuity of people in hospitals and the rate of unplanned admission and readmissions into hospital.

This Strategic and Commissioning Statement takes a whole systems approach, from the development of early interventions and peer supports to the improvement in the quality and provision of care and end of life supports. We recognise that the changes required are long term changes and it may take some time to see the benefits, however without these fundamental changes we will be unlikely to meet the presenting need of older people in Dundee in the future.

5 OUTCOME COMMITMENTS

5.1 *Outcome 1 Having choice and control of my life*

Maintaining a sense of independence is often directly linked to the ability to make personal choices and exercise control over our lives. To achieve this, you want your views, both individual and collective, to be listened to and acted on, and to influence the way in which future services are delivered.

As we grow older we experience life changes that impact on our ability to exercise choice and control and you may need help may to navigate through these changes. Changes can occur as a result of retirement, health, financial matters or bereavement. Understanding your

entitlements to support, accessing financial assistance and receiving an assessment of your needs will support you to maintain your independence.

There may come a time where additional supports and services are needed to maintain health and wellbeing. At this time it is essential you are assisted to make choices about day to day actions and to have control over your future plans, particularly where there may be a difficulty in communicating your views. You should have access to the information and advice you need to make these decisions. This information should be provided in a range of settings and be available when you need it.

One means of maintaining control is through the use of Self Directed Supports. To access this, an assessment to determine the levels of support you require will be undertaken and you will be allocated a personal budget with which to plan and purchase your support package. Older adults are historically low users of this model of support and we will continue to review our systems to ensure this model is flexible and accessible should you wish to use this option.

Through our consultations we asked your views and you told us that:

- Service providers and health professionals should listen more to service users and carers and involve them in decision making.
- There should be more information and advice to help make informed choices.
- You did not always feel confident raising your concerns and worries with professionals and worried about being a 'bother'.
- There are still many older adults who have not had a benefits check.
- Many people did not know about the range of services available despite already being in receipt of a support or health service.

How have we started to achieve this outcome?

Through the use of the Change Fund and service redesign we have:

- Established the Dundee Information and Advocacy Helpline for Older People (DIAL OP) as developed by the Celebrate Age Network and Dundee Independent Advocacy Support.
- Funded training for older adults with a hearing loss to provide the skills to participate in both collective and individual engagement and decision making.
- Carried out an audit of organisations, services and activities for older adults in Dundee as part of the development of a directory of services.
- Piloted a Housing Options Programme for all individuals seeking housing in the City.

How will we further develop to achieve this outcome?

To progress our work towards this outcome we will:

- Develop an engagement and communication strategy for older adults that informs and guides our current and future work and act on any issues identified.
- Hold an annual engagement event.
- Involve older adults and their representatives in the prioritisation of local resources and service redesign and be clear about any resource restrictions.
- Review and expand our models of information to take into account the diverse needs of older adults and their carers and tailor these to match the periods of transition and change.
- Publish the Discover Age Directory on the Celebrate Age Network website.
- Develop models of self referral and self assessment and publish our service criteria.
- Develop and implement the Self Directed Support Framework for Dundee and raise awareness of this to older adults and their carers at the time of assessment or re-assessment.

- Increase the number of older adults utilising the Self Directed Support Scheme to manage their care and support needs.
- Further develop and implement our Tele-care and Tele-health strategy and use technologies to promote independence and minimise external interventions.
- Work with Third Sector organisations to develop a Coproduction approach to service development and design.
- Provide assistance to older adults who are subject to benefit changes and ensure all new service users have their income maximised.
- Further promote self management of Long Term Conditions with patients and carers through the development of education packs and other supports.
- Utilise the 'This is Me' booklet for older adults with dementia.
- Introduce a city-wide Housing Options programme for all individuals seeking housing in the City by December 2013.
- Develop a Social Rented Common Register by 2016

For carers we will:

- Develop and implement a new Carers Strategy for Dundee.
- Develop Carers Ambassadors to ensure professionals and services can recognise carers and can understand their particular needs.

5.2 *Outcome 2 Keeping in touch and maintaining meaningful relationships*

There are well known health benefits to maintaining relationships and having on-going contact with others and it is important to keep these links strong as you grow older. The ability to maintain meaningful relationships reduces with the loss of friends and health changes may impact on your ability to attend activities previously enjoyed. Loneliness can be a problem for some, particularly following the loss of a life long partner. Making new friends and taking up new activities can be difficult.

A close relationship may change if you become a carer or someone close to you becomes your carer. While this can be a rewarding and natural part of your relationship, if not recognised, it can lead to stresses and difficulties. To be able to maintain your own interests and relationships, as a carer you should have confidence in the services which support the person you care for. It is also important that you have an opportunity to socialise as a couple, maintain joint activities and meet up with people who have an understanding of your role and empathy towards the needs of the person they care for.

There are many ways in which you can expand your opportunity to maintain contact with others. There are social activities through organisations such as community centres, libraries, colleges and churches. The number of older adults using computers to maintain contact by going online is increasing. This is not for everyone and the cost of equipment and learning opportunities to increase your IT skills can be a barrier. For others, support through befriending schemes or demand responsive transport may be required when visiting friends and families. You may need a more structured support with input from statutory or commissioned services such as a day centres, lunch club or outreach service, where activities and supports are tailored to your individual needs. For some a more targeted support such as a specialist dementia service can be provided.

Through our consultations we asked your views and you told us that:

- Activities at lunch clubs, sheltered housing and day care were an important element of people getting out and about and socialising.
- It is not always easy to maintain activities and funding is hard to come by for tutor fees and resources.
- A significant number of people said they felt lonely in the evenings.
- It was difficult to know about events.
- We should not assume that everyone has access to a computer.

- Anxiety can be a barrier to making contact with people.
- Some people felt very isolated and had no family or had lost their friends.

How have we started to achieve this outcome?

Through the use of the Change Fund and service redesign we have:

- Piloted a Community Transport service, using Volunteer car drivers, to provide older adults with affordable, flexible transport.
- Funded the appointment of an Activities Co-ordinator for Caledonia Housing Association to develop activities for tenants and local people.
- Developed a DVD which promotes the health and wellbeing benefits of volunteering as older adults.
- Reviewed our criteria for the OPEN funding to ensure the maximum number of groups can benefit from this resource.
- Piloted a dementia café for older adults with dementia and their carers in partnership with Bield housing association.
- Piloted a voucher scheme for older carers and carers of older adults which can be exchanged for respite care at home whenever the carer requires this.

How will we further develop to achieve this outcome?

To progress our work towards this outcome we will:

- Develop a range of local community based opportunities which provide opportunities for socialisation.
- Develop and implement a Transport Plan which addresses the transport needs of older adults.
- Evaluate and review the Community Transport pilot and act on the approved recommendations.
- Develop a day opportunities framework, review current services and remodel to meet future needs.
- Further develop dementia care services to provide a range of activities for both individuals and individuals and their carers.
- Provide more local community day opportunities for older people by investing the use of lunch clubs and sheltered housing communal areas.
- Evaluate the CANFICs project and identify ways to develop the project to ensure continuity and reach more isolated people.
- Test a co-production model to design and commission projects to address issues amongst older people, involving all stakeholders.

For carers we will:

- Develop and introduce a new carer's assessment and increase the number of assessments undertaken.
- Evaluate the use of the Time for You Voucher scheme and expand as required.

5.3 *Outcome 3 Being part of the world I live in*

Being part of the world that you live in, means having the opportunity to contribute as well as receive help. Older adults are citizens with a contribution to make to the communities in which you live and this interdependence is a key factor in maintaining a level of well being.

Older adults are assets to our communities. They are often important members of their networks of family, neighbours and friends, providing mutual support. They are the carers of others and the volunteers for many activities. Despite this you have told us that you do not feel valued or respected for the roles that you play.

Ageism is still experienced in our society, particularly where you also have a physical disability, difficulties with your mental health or have dementia. We must contest the negative stereotypes of ageism and work towards environments which are open and accessible for all older adults. Change is challenging and meeting the aspirations of older adults will require a collective approach which respects the diversity of older people both in culture and need.

Getting involved provides opportunities for broadening your mind, making friends, strengthening skills, adopting strategies, having fun, combating isolation and learning. The ability to be involved improves confidence, moral and can lead to a more fulfilled life.

One way you can continue use your skills and help others, is by volunteering. Volunteering opportunities are wide ranging and can be tailored to your area of interest. A local Time Banking scheme allows local people to put forward their skills, such as decorating, joinery, sewing or babysitting, in exchange for the use of others skills.

The opportunity to participate in local events and activities or to maintain chosen interests will provide the sense of belonging to a wider community. Where these important links are lost or are yet to be developed, support to access new opportunities is sometimes necessary. There are currently services such as the Community Links service which can provide you with this support. We recognise that this is an area where a wider range of supports are required.

Through our consultations we asked your views and you told us that:

- Once you retire you can be lost, volunteering is a good way of taking things forward.
- There are already ways of being involved and maintaining contact, for example through churches, courses, tenants associations and the community centre.
- Anxiety can be a barrier to joining groups.

How have we started to achieve this outcome?

Through the use of the Change Fund and service redesign we have:

- Developed and implemented a Community Links service which assists older adults to access community based resources and maintain their chosen activities and life styles.
- Funded Alzheimer's Scotland (Dundee Centre) to develop a Dementia Choir.
- Developed an Early Outreach Service for people with Dementia that supports older adults with a dementia and provides access to a range of activities and groups.
- Appointed three Community Engagement Workers to further engage communities in the Reshaping Care agenda, develop community initiatives and support small community projects.

How will we further develop to achieve this outcome?

To progress our work towards this outcome we will:

- Review and further develop the Community Links services to improve access to local community resources and build up confidence.
- Develop a volunteer service which supports older adults to maintain hobbies and access new activities by providing 1 – 1 support.
- Develop a range of local community based opportunities which provide meaningful activities.
- Develop a city wide model of 'Time banking' which allows older adults to use their skills and interests to benefit others and in turn to make use of others skills and interests.
- Promote and increase the number of older adults volunteering.
- Become a Dementia Friendly City.
- With the Celebrate Age Network, develop a web based directory of services.
- With the Celebrate Age Network, develop a local campaign which promotes a positive message of aging.

5.4 *Outcome 4 Staying as well as I can*

Ageing is a natural part of life. The way in which we grow old and experience this process can impact on our ability to age well. Most older adults will describe their own health as good and even when they do have an illness, this does not impact significantly on their day to day lives. A number of things can support your ability to stay well and these include a good diet, regular exercise, contact with others, routine check ups, including hearing and dental check ups, and a consistent sleep pattern.

We know that prevention, early intervention and personalised health improvement approaches can produce the best outcomes for older adults. Keeping well involves looking after yourself and even at the oldest ages individual choices about a healthy and active life can influence good outcomes. By understanding your own health needs, both physical health and mental well being, you can take a greater control in managing the impact and symptoms of illness. Where you are not able to manage your health independently, health interventions should be delivered locally and preferable near your own home. When hospital admissions are required there should be no delays in returning you home when you are well enough to do so.

If you have a long term condition or a disability, we understand that future planning is important. Being able to explain your wishes and having these recorded ensures that the care and support provided will meet your needs. Multiple health conditions often result in multiple medications and there can be problems arising from the interactions between medications or the mismanagement of medications. Regular medication reviews can help avoid this.

Over the last 2 years, the needs of older adults living at home and in care home settings have increased significantly. Most residents in care homes have complex, health needs, and many are suffering from dementia. This most vulnerable group of people require support from skilled staff with clear leadership and we will work closely with providers to maintain this. If you have dementia we will look to provide you with a more streamlined service with a clearly defined pathway and range of supports which start at the point of your diagnosis and assessment.

Through our consultations we asked your views and you told us that:

- Maintaining a healthy lifestyle was expensive and you were not always able to afford this.
- During times of change such as those arising from health deterioration or bereavement there were insufficient supports and information available.
- Accessing health and social services was not always easy.
- Access to health services was made more difficult if transport was not available, affordable or flexible.
- If you relied on medication for your illness you wanted support to manage this.
- You wanted professionals to listen, know about your health needs and offer appropriate advice
- You were not always happy with the services received out of hours.
- Loneliness and isolation affected your mental wellbeing.
- Looking after others often affected your health and wellbeing.
- A number of older adults and carers had at some time felt depressed.

How have we started to achieve this outcome?

Through the use of the Change Fund and service redesign we have:

- Developed a peripatetic health team to work with the staff in Care Homes for Older People to increase their health care skills.
- Introduced dementia liaison staff to care homes
- Introduced a dementia nurse specialist to acute services to develop and support staff in acute settings dealing with patients suffering from dementia.
- Funded Dementia Facilitators training for staff working in Care Home settings.

- Piloted an Integrated Community Service model of health assessment and support which takes a multidisciplinary approach to the health care of older adults. This model involves GP Practices, Geriatricians, Community Health services and Social Works services.
- Increased our enablement teams to facilitate quicker discharge from hospital.
- Targeted OPEN funding to expand the number of organisations who participate in exercise programmes.
- Introduced peripatetic general health support in the form of a registered general nurse in to Psychiatry of Old age services.
- Funded a Tissue Viability Nurse to work with the staff in Care Homes for Older People to increase their knowledge and skills in wound care/skin care.
- Introduced a single point of referral to Community Nursing.
- Trained all Health Care Assistants in Medication Administration.
- Introduced a Medication Concordance Assessment Tool to support patients to manage their medication safely.

How will we further develop to achieve this outcome?

To progress our work towards this outcome we will:

- Encourage a culture of peer support and brief interventions to bring about health improvements at an individual and community level.
- Develop community programmes which help maintain skills' relevant self help and care and increase social interactions.
- Appoint a pharmacy technician and provide all new service users with an opportunity to have a review of their medication when accessing enablement services.
- Implement a community medication administration policy and introduce models of assisting with medication in the community.
- Develop community treatment centres which allow local access to health care support.
- Develop an integrated model of social and health community support, Social Care and Community Nursing.
- Develop a discharge management and improvement plan that ensures older adults are not delayed in hospital once they are fit to return home, takes into account season demands and meets the standards for delayed discharge set by the Government.
- Resource and pilot new models of discharge in line with the Discharge Management and Improvement Plan
- Roll out the Integrated Community Services model and reduce the proportion of people aged 65 years and over admitted as an emergency in-patient 2 or more times in a single year by implementing a model of predictive health support.
- Explore the options for intermediate care to and from hospital by testing out new models.
- Pilot a model of Housing with Care which provides opportunities for slow stream rehab and intermediate care.
- Review and publish service information.
- Increase the number of older adults with an Anticipatory Care Plan.
- Provide Dementia Facilitators training for home care providers.
- Redesign our rehabilitative services to provide more support at home.
- Provide services for people with a diagnosis of functional mental health or dementia from a single site.
- Confirm a Dundee Dementia pathway.
- Develop training for frontline staff in social prescribing skills.

For carers we will:

- Introduce moving and handling training for carers.
- Evaluate and extend the range and availability of the On the Spot therapies.
- Introduce carer's health checks.

5.5 *Outcome 5 Maximising my potential*

Most older adults live out their lives with no or little intervention from statutory agencies. For most people this would be the preferred option. Where supports are required you want to be able to maximise your potential to continue to live as independently as possible. To do this we have introduced an enablement approach to our services and we will work with you and your carers to maintain or increase the skills that you have.

We recognise that the right support at the right time can allow you to continue to live as normal a life as possible and to do this requires a range of support services. These supports include assistance with food provision and eating, household tasks, personal care and health care. We want to provide you with options and choices which are flexible and affordable. This can be difficult when there are increasing demands for current services and when these demands are made at peak times. We will continue to monitor and evaluate our services against this demand and seek to increase these through procurement or remodelling where this is required. In addition we will work with other providers to look at different models of support and with communities to provide you with peer supports.

Dundee is a culturally diverse city and like many cities in Scotland the range of communities of culture or interest is growing. To ensure our services are fit for purpose we will review the means in which services are provided to you to further take into account your cultural or religious needs.

Your home is important to you and research has shown that older adults want to remain in their own home for as long as possible. Being in a community which is active and supportive is important and we are working to develop a range of suitable community housing in different areas of the City.

Through our consultations we asked your views and you told us that:

- You did not always know about the available services and supports.
- You had concerns about the charges for or costs of some services.
- You were unhappy about the timing of services.
- You were generally reluctant to access services.
- You were generally very pleased with the services and support you did receive.
- You wanted more help with housework.
- There are not enough housing options in different parts of the city.

How have we started to achieve this outcome?

Through the use of the Change Fund and service redesign we have:

- Increased the level of Tele-care and Tele-health supports.
- Funded a local Housing Association to scope out the level and range of household maintenance services for older adults.
- Established the Food Train Service in Dundee which provides an affordable shopping service for older adults.
- Increased the level of Enablement Services to ensure older adults can maintain their skills.
- Supported a local housing association to expand their domiciliary service outwith their housing base.
- Planned the development and commissioning of new Housing with Care units

How will we further develop to achieve this outcome?

To progress our work towards this outcome we will:

- Review our models of practical supports which takes into account models of social enterprise and community based options.

- Develop a cross agency healthy home checker initiative.
- Review the provision of and criteria for social care and home care services and remodel to meet increasing demand.
- Re-commission social care services for a three year period.
- Roll out the enablement approach to all areas of service and support.
- For older adults with dementia, develop a specialist model of service provision which helps to maintain current skills.
- Review and develop the ways in which home care and other services meet the cultural needs of older adults in Dundee
- Reduce the number of older adults cared for in institutional environments by developing a wide range of accommodation with care options and by further developing community based services.
- Review the Council Sheltered Housing Service.
- Introduce amenity housing for older adults within the Council providers.
- Fully complete the development of two new Housing with Care services in the Kirkton and Menzieshill areas of Dundee.
- Scope out options to further develop Housing with Care to reach a target of 100 Housing with Care units in Dundee.
- Develop an option appraisal for the current Housing with Care settings to address the increasing needs and demand for the service (overnight care).
- Review the Supporting People element of Sheltered Housing (Housing Associations)
- Review the Supporting People model for older adults extend the model to include support to older adults in other rented accommodation and owner occupied housing.
- Complete the review of home maintenance services and develop models of support which take into account social enterprise models and community based options.

5.6 *Outcome 6 Being safe and feeling safe*

Taking risks is part of everyday life and most people know and understand how to keep themselves safe. As our abilities change in line with our age the ease at which you feel safe can reduce. The reasons for this change will be unique to you as will the range of concerns which lead to this unease. There were, however, some common themes reported through the consultations sessions. We are looking at ways to counteract these concerns and will work with other agencies such as housing and the police.

Research has shown that older adults are particularly at risk of falls, from both environmental and health factors. At home, lighting, flooring and poor footwear can lead to slips and trips, as can ill health, poor mobility or complications arising from your medication management. For older adults who fall, many never report this or seek advise, a fall can also lead to a significant physical injury. The results of a fall are often not just physical but also emotional. We know that after a fall you can feel shaken and lose confidence and this in turn can lead to changes in your normal routines activities. You may be reluctance to go out and this can result in increased isolation and reducing independence. Taking action to reduce falls is therefore very important.

The Adult Support and Protection Act introduced a formal framework for the protection of adults who may be at risk from abuse. In Dundee we know from our work that you can be most at risk of financial abuse when living at home and that there have been instances of neglect for those living in longer term care settings. As the framework has developed locally, we are now much more aware of the risks faced by you and have taken steps to address these.

Where you are no longer able to make you own decisions, you want to be reassured that others will make safe decisions on your behalf and that these decisions are in line with your wishes and preferences. Where we are involved in this process, we will do this in a way which is the least restrictive to you and support those making decisions on your behalf to do so safely ensuring your prior wishes are respected.

At the end of your life you will receive Specialist Palliative Care Services if you have palliative care needs, irrespective of your diagnosis. Current services include MacMillan Day Care which offers a range of services to patients in the community; Pulmonary Rehabilitation for patient with advanced COPD; self management classes in Fatigue, Anxiety and Breathlessness; Relaxation and Complementary Therapies.

Through our consultations we asked your views and you told us that:

- While you felt safe going out during the day, none felt safe going out at night.
- There are issues with nuisance calls and cold callers at your door.
- The conditions of pavements is a concern and has resulted in falls, there was also a concern about the number of cars parked on the pavement making it difficult to walk safely.
- Good community police officers are important.
- Security lights and alarms help you feel safer
- You have concerns that Self Directed Support may be abused by families who will misuse the personal budget.
- You were anxious about the care in Care Homes, particularly following the more negative stories in the press.
- You were anxious about some of the young people you encountered.
- You had difficulties with neighbours and some had experienced bullying.
- You were concerned about who would make decisions for you if you were unable to do this yourself.

How have we started to achieve this outcome?

Through the use of the Change Fund and service redesign we have:

- Appointed Social Care Co-ordinators who will review the needs of older adults receiving lower level of care and take action to ensure care and support is provided in line with changing needs.
- Provided additional Mental Health Officer time to undertake the relevant assessments to support older adults in need of a Welfare and/or Financial Guardian.
- Held our first summit specifically looking at the Adult Support and Protection concerns of older adults.
- Examined the causes and outcomes for older adults who are sent to Accident and Emergency services as a result of a fall.
- Introduced falls assessment by a Falls Co-ordinator for patients attending Accident and Emergency following a fall
- Referred patients onto a Falls Clinic following attendance at accident and emergency after a fall.
- Established the Palliative Care Home project which provides specialist supports and education enabling older adults to remain in their care home at the end of their life.

How will we further develop to achieve this outcome?

To progress our work towards this outcome we will:

- Introduce quality assurance systems which ensure that you are receiving the level and quality of support and care you are assessed as requiring and that this is meeting the outcomes you identified.
- Procure a system of electronic monitoring which will be used by service providers to monitor the level and quality of services provided.
- Review our procedures for Adult Support and Protection and develop an action plan and on the concerns identified through the Older People's Adult Support and Protection Summit.
- Review the current advocacy services for older adults in line with demand and increase the number of people going through Adult support and Protection Procedures who have an advocate.

- Introduce the development of Anticipatory Care Plans for all patients attending the Falls Clinic.
- Develop a Dundee Falls Strategy which will minimise the risks of a fall and develop models of assessment and support which address the causes and outcomes of a fall.
- Commission a Falls Support Service with a third sector provider.
- Develop an exercise strategy for older adults which includes signposting to local community based activities, assessment, individual and community programmes.
- Train our staff to consider the requirement for Fire Safety Assessments and organise fire lectures that are community focussed.
- Ensure our staff have a working knowledge of available aids utilising tele-care to improve patients/service user safety.
- Introduce the Sloppy Slippers Scheme which encourages older adults to wear appropriate and safe footwear.
- Develop a programme of individual and community support to encourage and enable older adults to maintain healthy lifestyle choices such as stopping smoking and reducing alcohol intake.
- Roll out the Celebrate Age Network Forum's See Off Scam's Initiative and repeat on an annual basis.
- Explore options for intergenerational work.
- Develop and implement a community care risk assessment framework.
- Continue to raise awareness and train Health and Local Authority staff in Adult Support and Protection Procedures.
- Pilot the Here 4 U project (Palliative Community Care Volunteer Service) a neighbourhood network of volunteers.

For carers we will:

- Support you with your formal roles such as an appointee and or where a guardianship order is in place.

6.0 PLANNING FOR CHANGE AND MONITORING OUR PROGRESS

Earlier we summarised our aims as:

- to have more people cared for at home;
- to have more direct support for carers;
- to have fewer people delayed in hospital;
- to have fewer people in care homes; and
- to have a wider range of alternatives to statutory services for individuals and communities.

Along with other partnerships, Dundee was awarded a Change Fund to bridge the changes while developing more sustainable models of support for older people. The Dundee Partnership expressed the proposed changes in the Dundee Change Plan. When developing our Change Plan and this Strategic and Commissioning Statement, we recognised that to effect change would require both short term and long term change. To implement our Change Plan we developed two work streams.

Work stream one aimed to reduce the reliance on hospital based provision and care home placements to meet the needs of older people with complex needs. This work stream sought to develop Housing with Care, models of support for people who were at risk as a result of complex or changing health needs in both the community and care home settings and set out the foundations for developing a closer more integrated approach to service delivery.

Work stream two focused on the development of a community infrastructure which would sustain the shift in the balance of care from long stay care setting and inpatient resources, to community services. This approach would effect change over the medium to long term. It included the development of specialist services and supports for people with dementia, and carer's supports which included new models of respite. Fundamental to this work stream is the development of a coproduction, and increase in community capacity including peer or volunteer support and the development of social enterprise models, and access to information. The work plans for this Strategic and Commissioning Statement will be aligned with these work streams and the associated projects.

To implement the changes we are working as a partnership and in addition to health and social work services, we have tasked lead organisations with the development and implementation of the actions. This Dundee Carer's Centre will lead on the development of carer's supports, the Dundee Voluntary Gateway and the Reshaping Care Team will lead on the development of community capacity and coproduction and the Celebrate Age Network and partners will support the research of the needs of Dundee older people and lead on the development of accessible information.

We will seek to implement changes through Change Fund investments and through resource released as a result of further service redesign. This is intended to facilitate the move from existing service delivery models to future models of care. This is further developed in our commissioning intentions (Section 7) and our redesign proposals (Section 8).

We have a detailed monitoring framework in place and will report on our progression on a bi-annual basis.

7.0 COMMISSIONING INTENTIONS

The outcomes will be achieved through a combination of service redesign and remodelling and by commissioning additional services.

The following commissioning intentions are currently costed for within our Change Fund financial plans for the next three years:

- Purchase additional tele-care and tele-health equipment.
- Commission a model of intermediate care and slow stream rehab within Housing with care.
- Commission Stirling University to provide Dementia Facilitators Training for Care at Home Service Providers.
- Commission a home from hospital service from a third sector provider.
- Commission a falls support service from a third sector provider.
- Complete the commissioning of 16 – 20 additional Housing with Care units by October 2013.
- In partnership with the Dundee Voluntary Gateway, commission a range of coproduction models, increase community capacity and test out new models of working.
- Procure an electronic model of monitoring care at home services.

We will seek to address the following commissioning intentions through resources released following the change fund investments and further redesign.

- Procure additional social care services.
- Commission additional Housing with care facilities (to reach a target of 100 Housing with Care units within Dundee)

- Bridge the changes through additional Care Home placements to meet seasonal peeks of need and in line with the increasing acuity of hospital patients. Reduce this in line with the development of community services.
- Commission additional models of intermediate care through the procurement of care home beds as a base for out of hospital assessment and rehabilitation.
- Review and commission a range of models of practical and low level supports which include the development of social enterprise models.
- Complete the investment to deliver psychiatry of Old Age In Patient, Day Hospital and Community Mental Health Services from one site for a three year period.
- In partnership with the Dundee Carers Centre, increase the level of respite support and commission new models of short breaks and respite provision.

8.0 SERVICE REDESIGN AND REMODELLING

In addition to the commissioning intentions, the Statement will be supported by service redesign and remodelling. We will:

- Implement an outcome model of assessment.
- Develop and implement the Self Directed Support framework, realign budgets and service models to meet the demands as required.
- Review current social care contracts and commission service provision for the period 2013 – 2016.
- Develop a coproduction model of service redesign and development.
- Review models of day support and further develop models which support older people to access local, community day opportunities.
- Develop a transport plan.
- Develop volunteering opportunities including time banking.
- Further develop services for people with dementia.
- Reduce the number of people living in care home placements in line with the development of community supports and the increase in the number of Housing with Care units.
- Implement a community medication policy.
- Develop community treatment services.
- Develop an integrated model of social care and community nursing.
- Redesign discharge services to meet discharge targets.
- Roll out the Integrated Community Services Model.
- Review the criteria for social carer services and remodel to meet demand.
- Explore extending the current contractual models with General Practices or groups of General Practices with the intention to standardise Anticipatory Care of older people registered with practices. Such anticipatory care will include identification of those at most risk and planned, multidisciplinary approaches to mitigate risk where possible.

9.0 FINANCIAL FRAMEWORK

We will seek to deliver the commissioning intentions outlined in the preceding statement will be funded from the total resources available to the Dundee Partnership over the period of the plan. This will be through a combination of Change fund investments, existing resources and resources released as a result of further system redesign.

Additional funding has been directed to Older People's services in Dundee to reflect the growing demographic demand and this will be invested in services which will facilitate the shift towards more anticipatory and preventative services as described in the commissioning statement.

The current level of direct investment in Older Peoples Services is noted below:

	2013/14 Budgeted Resource £000
Change Plan*	3,282
NHS Board**	53,647
Local Authority	44,017
TOTAL	100,946

*Includes carry forward of resources from 2012/13

**Includes resources directly attributable to Older People services only (excludes organisational and property overheads)

The pattern of Change Fund investment is outlined in the table below which reflects the proportionate projected expenditure against each of the pathways as outlined in the Change Plan. This is consistent with the commissioning intentions outlined in this statement.

Dundee Partnership – Change Fund – Investment Plan

The table below shows the Partnerships Change Fund investment plan for period 2011/12 to 2015/16 by work stream, programme, and pathway.

DUNDEE PARTNERSHIP - CHANGE FUND FINANCIAL PLAN		2011/12	2012/13			2013/14			2014/15			2015/16			2016/17		
Work stream	Programme	Actual	Plan (Recurring)	Plan (Non-recurring)	Plan Total	Plan (Recurring)	Plan (Non-recurring)	Plan Total	Plan (Recurring)	Plan (Non-recurring)	Plan Total	Plan (Recurring)	Plan (Non-recurring)	Plan Total	Plan (Recurring)	Plan (Non-recurring)	Plan Total
		£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K
1	Housing With Care	0	185	226	411	370	142	512	370	129	499	370	105	475	370	0	370
1	Moving Assessment for Care Home Admission from Group Settings	423	430	108	538	456	99	555	456	40	496	456	0	456	456	0	456
1	Additional Support in Care Homes	59	92	0	92	88	0	88	88	0	88	88	0	88	88	0	88
1	Telehealth/Equipment	0	10	30	40	60	0	60	60	0	60	60	0	60	60	0	60
1	At Risk Assessment & Support	209	254	60	314	456	138	594	491	57	548	461	0	461	461	0	461
1	Integration	1	0	2	2	10	145	155	10	0	10	10	0	10	10	0	10
2	Support for People with Dementia	128	336	60	396	336	0	336	336	0	336	336	0	336	336	0	336
2	Integrated OT Service & Equipment Service	13	16	0	16	32	0	32	32	0	32	32	0	32	32	0	32
2	Carer Support	9	64	12	76	154	41	195	154	0	154	154	0	154	154	0	154
2	Community Capacity Building and Co-production	46	401	53	454	551	99	650	500	47	547	429	0	429	329	0	329
2	Improved Models of Public Information	5	18	3	21	18	0	18	18	0	18	16	0	16	16	0	16
2	Emergency Care Home Capacity	0	0	36	36	0	0	0	0	0	0	0	0	0	0	0	0
Other	Provisional Commitments	0	0	25	25	0	13	13	0	0	0	0	0	0	0	0	0
Other	Contingency	0	0	0	0	0	33	33	0	67	67	0	102	102	0	137	137
Total	Total	893	1806	614	2420	2531	751	3282	2515	341	2856	2412	207	2619	2312	-26	2286

Allocations by Pathway (Scot Govt definition)

	%	£K	%	£K	%	£K	%	£K	%	£K	%	£K
Unallocated	0.0%	0	0.0%	0	2.3%	74	2.4%	67	3.9%	102	-1.1%	-26
Preventative and Anticipatory Care	25.5%	227	27.7%	671	32.3%	1059	34.5%	986	33.6%	881	33.5%	765
Proactive Care and Support at Home	16.2%	145	17.0%	412	19.3%	633	16.5%	470	15.2%	399	16.8%	384
Effective Care at Times of Transition	48.9%	437	30.0%	727	26.4%	866	27.7%	790	28.4%	745	30.3%	692
Hospital and Care Home(s)	8.6%	77	17.6%	426	11.7%	383	12.2%	348	13.0%	340	14.0%	319
Enablers	0.8%	7	7.6%	183	8.1%	267	6.8%	194	5.8%	152	6.7%	152
Total	100.0%	893	100.0%	2420	100.0%	3282	100.0%	2856	100.0%	2619	100.0%	2286

It is anticipated that the intentions outlined in the commissioning statement will effect the following shift in the allocation of the total partnership resource across the pathways over the course of the plan period:

	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
2012/13	11,559	30,705	12,518	44,594	183	99,559
2013/14	11,983	30,950	12,942	44,804	267	100,946
2014/15	11,903	30,787	12,866	44,770	194	100,520
2015/16	11,833	30,950	12,938	44,411	152	100,284

It is important to note from this illustration that fluctuations of investment within the pathways over the period reflect the pattern of expenditure within the change plan in particular given the higher levels of resources available within 2013/14 and 2014/15. This is due to the carry forward of resources in previous years as noted in the previous table. The expenditure across the pathways from 2012/13 to 2015/16 highlights the shift in expenditure as a result of the partnership's commissioning intentions.

Dundee Partnership – Existing Local Resources

Dundee Partnership - Existing Local Resources 2013/14

		Preventative and Anticipatory Care	Proactive Care and Support at Home	Effective Care at Times of Transition	Hospital and Care Home(s)	Enablers	Funding (£k)
		£k	£k	£k	£k	£k	£k
NHS Tayside	Continuing Care	0	169	0	2,243	0	2,412
	Psychiatry of Old Age (In Patients)	0	0	0	4,236	0	4,236
	Psychiatry of Old Age (Community)	0	1,705	0	0	0	1,705
	Psychiatry of Old Age (Medical)	0	170	68	441	0	678
	Day Hospital & Supported Discharge	0	0	393	0	0	393
	Intermediate Care	0	0	0	1,049	0	1,049
	Community Nursing Services	0	4,426	0	0	0	4,426
	AHP Services	0	2,099	0	2,099	0	4,198
	Palliative care	0	1,728	0	1,728	0	3,456
	Total	0	10,297	460	11,796	0	22,553
	General Medical Services	2,513	2,513	1,257	0	0	6,283
	GP Prescribing	3,968	3,968	1,984	0	0	9,919
	Acute Services - Occupied Beds	0	0	0	14,892	0	14,892
	Grand Total	6,481	16,778	3,701	26,688	0	53,647
Social Work	Community Mental Health Teams for Older People	207	207	0	0	0	414
	Community Equipment	0	739	0	0	0	739
	Day Care	474	474	0	0	0	948
	Assessment & Management of Care	0	2,328	0	0	0	2,328
	Care at Home Services	0	9,607	6,404	0	0	16,011
	Care Homes	0	0	1,970	17,735	0	19,705
	Respite Care	184	184	0	0	0	368
	Housing Support Services	3,504	0	0	0	0	3,504
	Grand Total	4,369	13,539	8,374	17,735	0	44,017
Partnership Total		10,850	30,317	12,075	44,423	0	97,664

Notes
1. Figures for GP Prescribing and General Medical Services are apportionments to over 65 age group of overall CHP resources.
2. Figures for Acute Service are a notional representation of direct costs.
3. Figures for other services are direct costs associated with service provision and include full costs of some services that largely, but not exclusively, deliver services to Older People.