DUNDEE CITY COUNCIL

REPORT TO: **POLICY AND RESOURCES COMMITTEE - 27TH JUNE 2011**

REPORT ON: **RESHAPING CARE FOR OLDER PEOPLE - CHANGE FUND**

REPORT BY: **DIRECTOR OF SOCIAL WORK**

REPORT NO: **237-2011**

1.0 PURPOSE OF REPORT

The purpose of this report is to advise Committee of the progress that has been made by the Dundee Partnership in accessing the Change Fund which has been introduced by the Scottish Government to support the implementation of the Reshaping Care for Older People Programme.

2.0 RECOMMENDATIONS

It is recommended that the Policy and Resources Committee

2.1 Note the change fund submission;

2.2 Endorse the development of a more detailed project plan to advance the proposals contained within the change fund submission; and

2.3 Approve the governance arrangements outlined in paragraph 4.6 of this report.

3.0 FINANCIAL IMPLICATIONS

Acceptance of a final change fund application by the Ministerial Group will provide the Dundee partnership with access to its share of the £70 million change fund estimated to be £2.23 million per annum for Dundee for the next three years.

4.0 MAIN TEXT

4.1 The introduction of the Change Fund to support the Reshaping Care for Older People Programme was announced through the Government's 2011/12 budget.

4.2 On 23 December 2010 the Ministerial Strategic Group (MSG) for Health and Community Care agreed, and issued guidance to Health Local Authorities and others in the voluntary and private sector on the preparation of change plans which were to be submitted to the Scottish Government by 28 February 2011. These plans, if acceptable were to secure access to the Change Fund.

4.3 The purpose of the change fund is to provide bridging finance to shift the balance of care from institutional to primary and community settings. This is consistent with the principal policy goal of the Reshaping Care for Older People Programme which is to optimise independence and wellbeing of older people at home or in a homely setting. The change plans were to be prepared using local community partnership planning mechanisms, and were also to be undertaken in co-operation with the independent sector. This required approach builds upon the underpinning philosophy of care of the Reshaping Care Programme, which is predicated upon the principles of co-production.

4.4 The Change Fund application in Dundee has been developed in line with these expectations. Local partners involved in strategic planning and operational service delivery for older people and people with dementia organised into a small project group and arranged a consultative event to assemble the change plans that would form the basis of the application for Dundee. It was prepared and submitted for 28 February deadline and is attached as Appendix 1 of this report. The proposals contained within the submission are consistent with and draw explicitly upon the Older People and Dementia Strategies already approved by Dundee City Council and Dundee CHP.

4.5 The Ministerial Group approved all submissions in March and partnerships now await confirmation of the resource allocation and distribution mechanism. It is anticipated that a full project plan will be required by the end of May 2011. A further partnership focus group has been organised to complete this second stage of the process.

4.6 The proposed approach to the governance of the Change Funds is that a Partnership Monitoring Group will be established that will report to the existing Health and Local Authority Joint Management Team that oversees the joint commissioning of community health and social care and support service and has formalised links with the Community Planning Partnership. The chair of the monitoring group will also report to the Chief Executive of the Council. The governance framework is explained in Section 10 of the Change Fund application attached.

4.7 **Conclusion**

The Change Fund provides a significant opportunity and financial incentive to advance the development of support and care for older people whilst bringing about a meaningful shift in the balance of that care.

5.0 POLICY IMPLICATIONS

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

5.2 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, Depute Chief Executive (Support Services) and Director of Finance. Representatives of the voluntary and private sector have been involved in constructing the application and a stakeholder event was organised to support the process and provide endorsement to the proposals.

7.0 BACKGROUND PAPERS

Equality Impact Assessment

Alan G Baird DATE: 25th May 2011
Director of Social Work

Change Plan Submission 2011 - 2012

1. Name of Partnership

Dundee City Partnership

2. Partner Organisations

Third Sector Interface representing Dundee Voluntary Action, Dundee Social Enterprise Network, Dundee Volunteer Centre.
NHS Tayside
Dundee City Council
Independent Sector - Scottish Care

It is the intention of the Dundee Partnership to work collaboratively with all partners in the development, implementation, evaluation and monitoring of the Change Fund.

3. Finance – Use of Change Fund and Additional Resources

Table 1: Dundee Partnership Funding

PARTNERSHIP: DUNDEE

FINANCE - SUMMARY OF RESOURCES

Source	2011/12 Funding (£000)
Initial Central Change Fund Allocation	2,232
NHST - Hospital Based	77,501
NHST - Community Based	30,045
Local Authority	42,661
Total	152,440

Notes
Based on total resources for Older People.
Excludes Leisure, independent sector, voluntary sector (except where funded by NHST/LA).

4. Summary of Current Partnership Budget for Older People

Table 2: Dundee Partnership Funding Detail

	LOCAL AUTHORITY	NHS	TOTAL
	£000	£000	£000
HOSPITAL BASED			
ELECTIVE INPATIENTS		10,160	10,160
NON-ELECTIVE INPATIENTS		45,011	45,011
TRANSFERS		439	439
DAY CASES		1,678	1,678
OUTPATIENTS		5,233	5,233
PSYCHIATRY		7,814	7,814

GERIATRIC LONG STAY		3,820	3,820
ACCIDENT AND EMERGENCY		1,744	1,744
DIRECT ACCESS		1,602	1,602
TOTAL	0	77,501	77,501
COMMUNITY BASED			
GP SERVICES		5,721	5,721
GP PRESCRIBING		16,846	16,846
COMMUNITY NURSING (ADULT)		4,633	4,633
COMMUNITY AHPs		754	754
COMMUNITY MENTAL HEALTH TEAMS FOR OLDER PEOPLE	337	874	1,211
COMMUNITY EQUIPMENT	685	279	964
DAY HOSPITALS AND DAY CARE	908	938	1,846
ASSESSMENT & MANAGEMENT OF CARE	3,150	0	3,150
CARE AT HOME SERVICES	14,536	0	14,536
CARE HOMES	19,158	0	19,158
RESPITE CARE	351	0	351
OTHER		0	0
TOTAL	39,126	30,045	69,170
OTHER (EXCLUDES NHST, SOCIAL WORK)			
HOUSING SUPPORT SERVICES	3,536	0	3,536
TRANSPORT	0	0	0
LEISURE	0	0	0
INDEPENDENT SECTOR	0	0	0
TOTAL	3,536	0	3,536
GRAND TOTAL	42,661	107,546	150,208

Notes
(Generic)

1. "Transfers" includes patients recorded via SMR01 as being transferred within NHST.
2. Day Cases excludes Day Hospitals.
3. Inpatients include Acute Hospitals and Community Hospitals.
4. Out patients refers to consultant led Out patients work.
5. Psychiatry refers to activity recorded on SMR04 forms.
6. Direct Access refers to Laboratory and Radiology activity only.
7. Costs of prescribing based on 65+ activity as recorded via SMRs etc.
8. Resource Transfer funding captured within Council figures (including Voluntary Sector payments).
9. Community costs exclude all overheads, hospital costs include all overheads (i.e. site and corporate)
10. Community costs are based on 2010/11 budgets and hospital costs are based on 2009/10 costs.
11. Community costs include a HIGH level of assumption.

5. Summary of Key Outcomes/Outputs Achieved Through Current Resources

In this section, performance and activity data is structured around the Community Care Outcome Framework (CCOF) themes and also the Single Outcome Agreement (SOA) priorities to demonstrate links with outcomes. The analysis of the data will take a uniform format for each area of activity.

- What is the data telling us?
- What is our current position?
- What will we do in the future?

Further analysis around performance and outcomes measurement will address variation across our processes and models of service delivery.

Section 5.1 SOA Priorities: Healthy, Safe Communities AND Quality of Life and Social Inclusion
Community Care Outcome Theme: Identifying Those at Risk

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

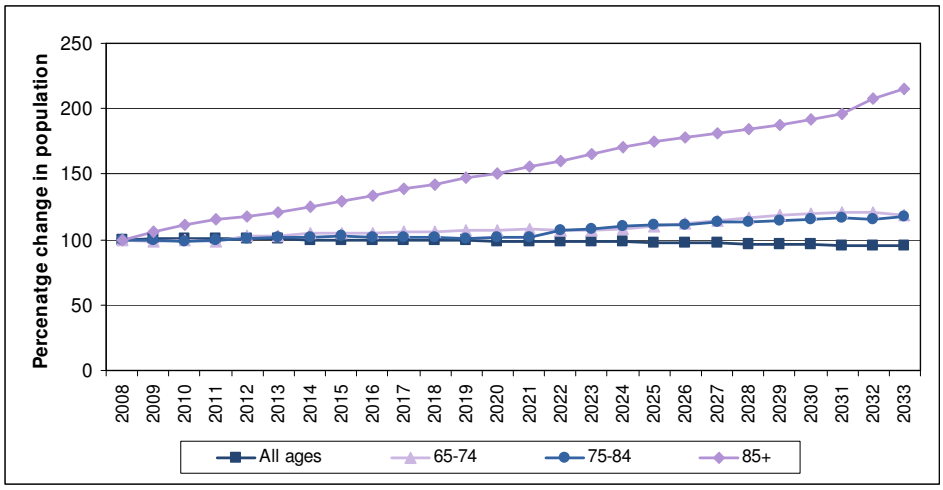


Table 3: Prevalence of Selected Long Term Conditions from GP Quality Outcome Framework (QOF) Register, Dundee City.

Conditions	Patients on Register	Prevalence per 100 patients	
		Dundee City	Scotland
Obesity	15,141	9.0	7.0
Hypothyroidism	2,666	4.9	3.5
COPD (Chronic Obstructive Pulmonary Disease)	4,573	2.7	1.9
CKD (Chronic Kidney Disease)	6,144	3.6	3.2
Hypertension	23,271	13.8	13.4
Mental Health	1,803	1.1	0.8
Diabetes	7,307	4.3	4.1
Stroke & Transient Ischaemic Attack (TIA)	3,852	2.3	2.1
Heart Failure	1,627	1.0	0.8
LVD (Left Ventricular Dysfunction)	1,214	0.7	0.6
CHD (Coronary Heart Disease)	7,619	4.5	4.4
Epilepsy	1,399	0.8	0.7
Atrial Fibrillation	2,355	1.4	1.4
Dementia	1,060	0.6	0.6
Asthma	9,865	5.8	5.9
Cancer	2,290	1.4	1.5
Depression 2 (of 2): new diagnosis of depression	10,838	6.4	8.6

Prevalence = number of patients on the specified QOF register, divided by list size, multiplied by 100.
Source : ISD General Practice - Quality & Outcomes Framework

What is the data telling us?

- Dundee has an increasing ageing population with associated morbidity, particularly around dementia prevalence.
- Dundee's overall population is decreasing and the proportion of older people is increasing. The 85+ population is expected to rise by 93% by 2033.
- The ageing population in Dundee means that people will continue to be increasingly dependent on community health, care and support services and resources.

What is our current position?

- Our current model of service delivery will not allow delivery against the increased demand that will arise as a result of this demographic shift.

What will we do in the future?

- Dundee's Integrated Care Model for Older People shows how we aim to shift this balance of care (**Appendix 1**).

Section 5.2 Community Care Outcome Theme: Quality of Assessment and Care Planning

What is the data telling us?

- Currently, community care assessments for those admitted to hospital are completed in hospital.

What is our current position?

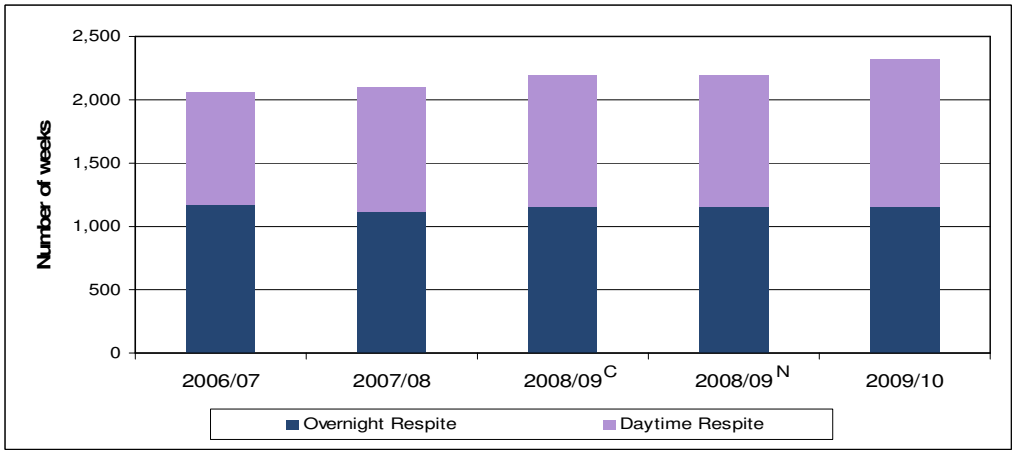
- It is recognised that this is not the most appropriate setting for the assessment as amongst other reasons, it can increase the rate of referrals directly to residential care.

What will we do in the future?

- Final community care assessments in hospital need to be minimised and alternative service responses increased. Slow stream rehabilitation and enhanced enablement at home needs to be developed. We would expect this to reduce the length of stay in hospital and readmission rates.

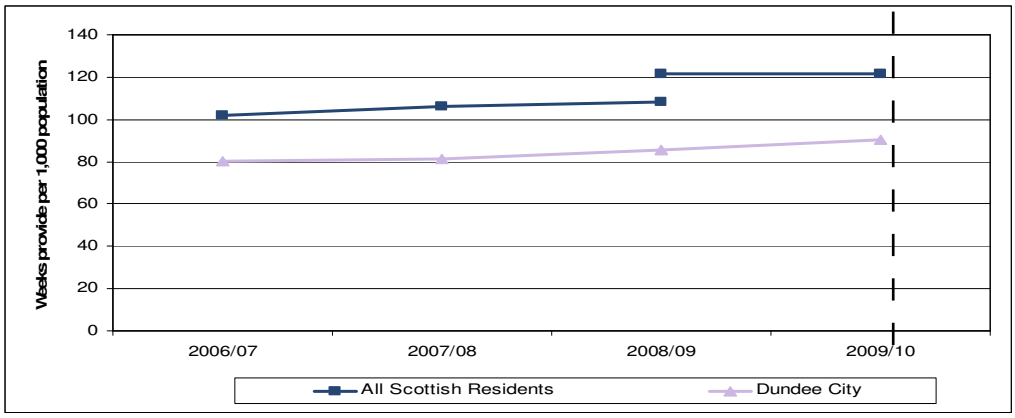
Section 5.3 Community Care Outcome Theme: Support for Carers

Chart 2 : Provision of Respite Weeks in Dundee City, 2006/07 to 2009/10



Sources : Scottish Government Respite publication, Carers
C - Same methodology used as in 2007/08 making the figure comparable to 2007/08
N - New methodology used making the figure incomparable to 2007/08 but comparable with 2009/10

Chart 3 : Rate of Respite Provision per 1,000 Population in Dundee City, 2006/07 to 2009/10



Sources : Scottish Government Respite publication, Carers
[1] seven respite nights equal one respite week and 52.5 hours equal one respite week

What is the data telling us?

- The Scottish Government Concordat on Respite Care set a target to increase provision across Scotland by 10,000 weeks.
- Although no local targets were set, Dundee's proportional share equates to 300 weeks, based in the population.
- Charts 2 and 3 illustrate that Dundee has already greatly exceeded this amount.
- Despite the fact that we have exceeded National expectations, respite provision per 1,000 of the population remains below the National rate.

What is our current position?

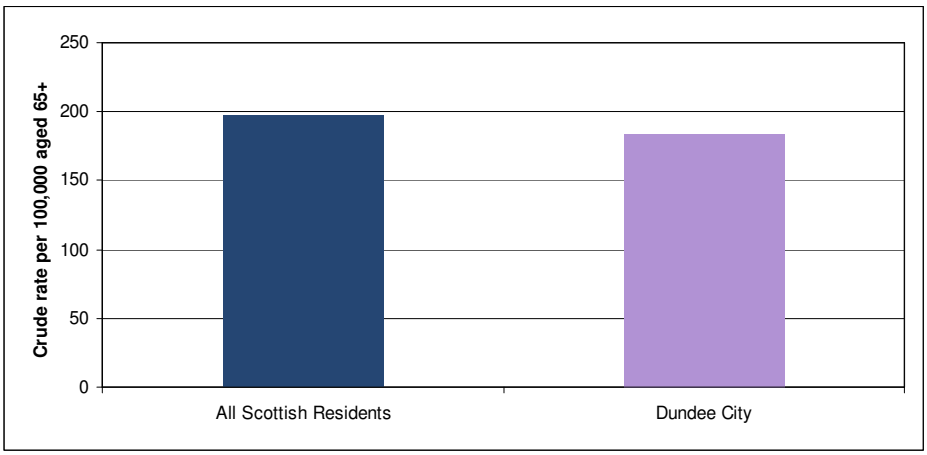
- It has been identified that respite provision should be used more proactively to assist carers, rather than reactively in response to crisis situations.

What will we do in the future?

- Models of respite will be reshaped, particularly in dementia services and care at home and we will increase the provision of carer's assessment which will assist the allocation of respite to those in greatest need.

Section 5.4 Community Care Outcome Theme: Moving services closer to service users / patients

Chart 4 : NHS Continuing Care Census September 2010, Cat A Patients.



Source : ISD Continuing Care Census

What is the data telling us?

- The rate in Dundee is lower than the National rate.

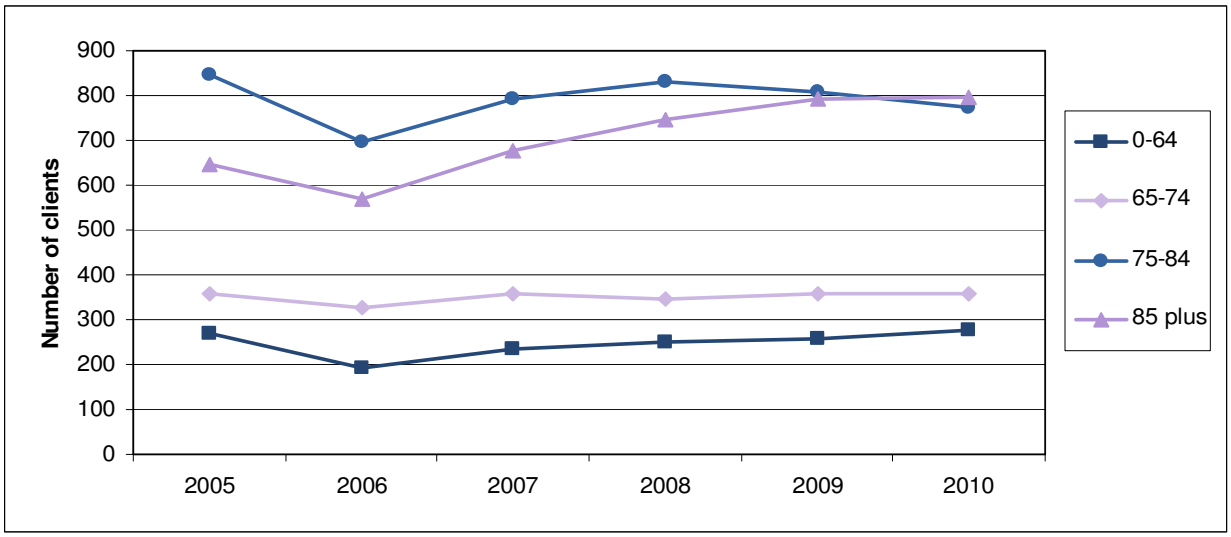
What is our current position?

- The model of continuing care in Dundee is under review and alternatives to geriatric long stay are currently going through the procurement process.

What will we do in the future?

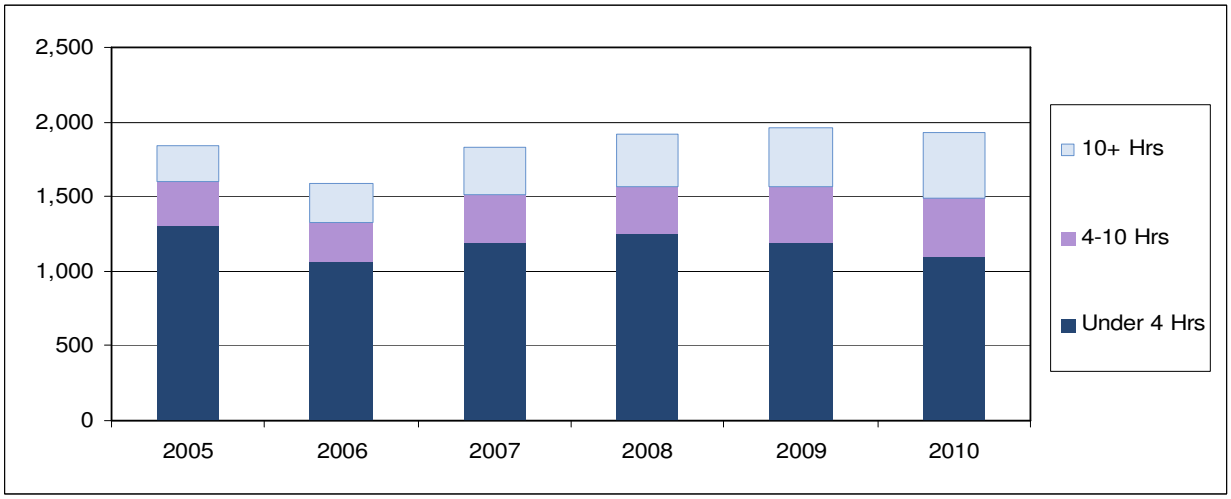
- There will be a remodelling and improvement of the current service response for those with continuing care needs.

Chart 5 : Home Care Clients Age Groups.



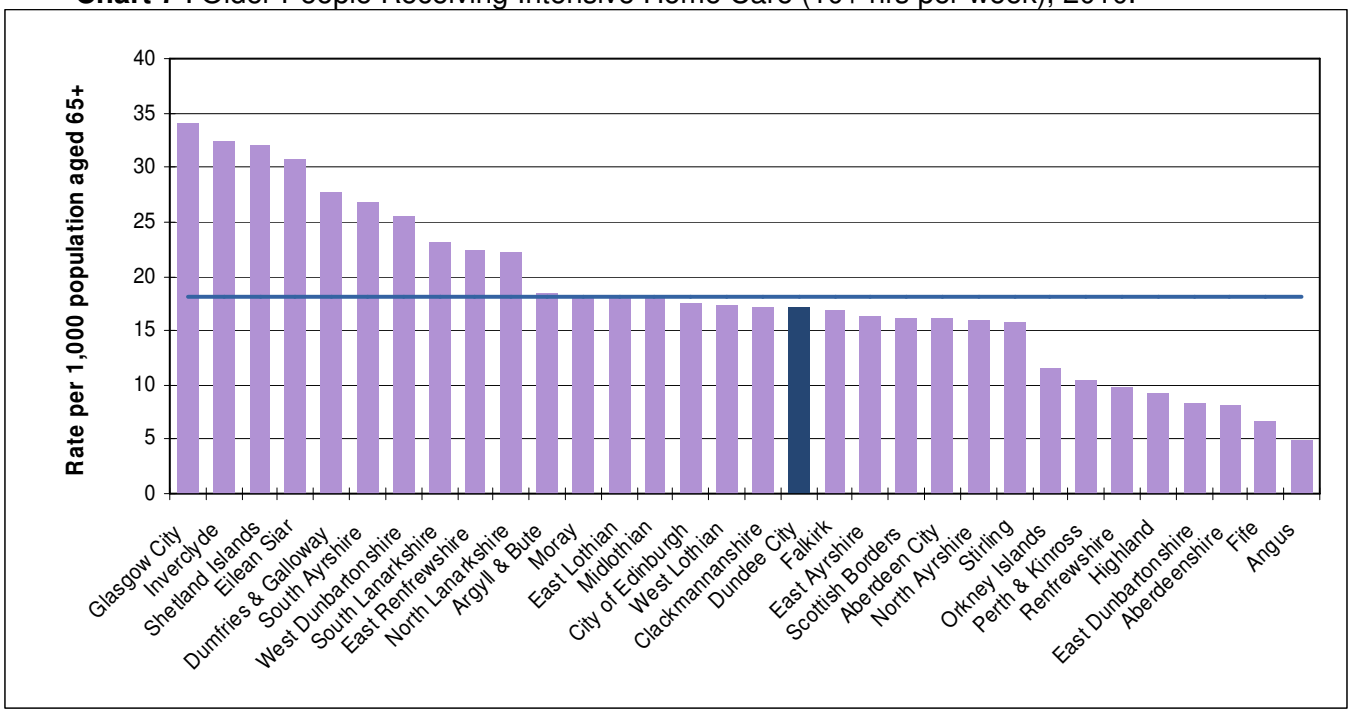
Figures collected during week last week in March
Source : Scottish Government Health and Community Care - Datasets

Chart 6 : Proportion of Clients Aged 65+ Receiving Home Care Hours, 2005 to 2010.



Figures collected during week last week in March
Source : Scottish Government Health and Community Care - Datasets

Chart 7 : Older People Receiving Intensive Home Care (10+ hrs per week), 2010.



Figures collected during week last week in March
Source : Scottish Government [Health and Community Care - Datasets]

What is the data telling us?

- Chart 5 shows that, to date, the rise in home care clients is directly proportional to the ageing population in Dundee.
- The rate per 1,000 population aged 65+ for people receiving 10 or more hours of home care per week in Dundee has increased considerably since 2007.
- Chart 6 shows a comparison between the number and proportion of home care hours provided between 2005 and 2010. Although there has been a levelling off of the number of people receiving homecare, these people are receiving larger packages of care and more intensive homecare. This reflects the increased morbidity of the population.

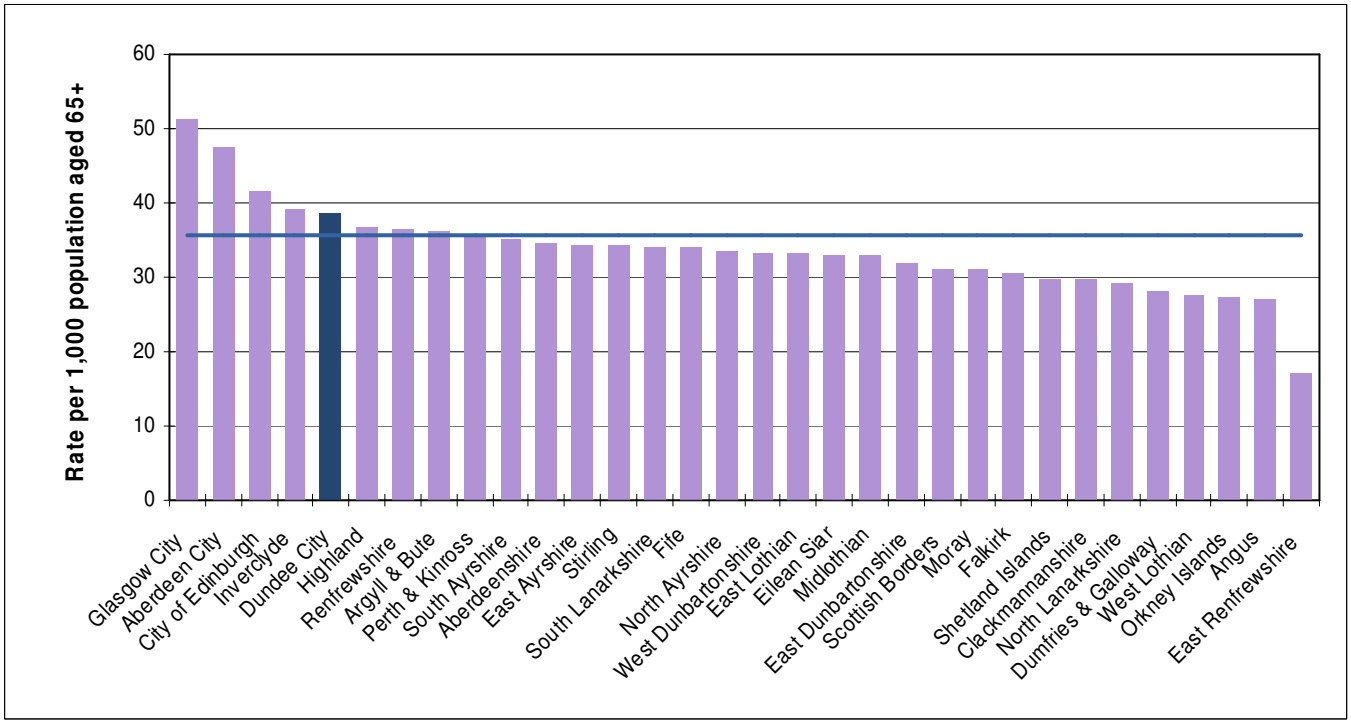
What is our current position?

- The ageing population and the high prevalence of long term conditions means that people will be increasingly dependent on community health, care, support and assistive technologies services to assist them to stay in their own homes for longer.
- It has been identified that current service provision cannot be enhanced to meet the needs of the increasingly dependent population.

What will we do in the future?

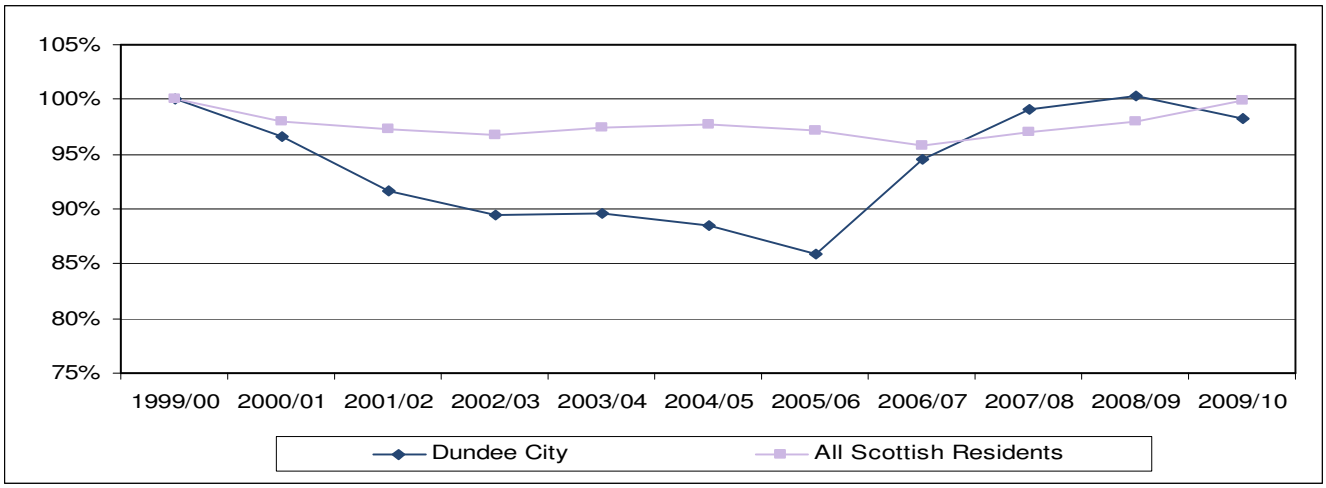
- Revised models of care will place more emphasis on rehabilitation and self help.
- Efficiency will be increased by concentrating in-house resources on those with complex health and care needs and externalising stable, longer term packages.
- To further support self help, more emphasis will be placed on telehealth and telecare as service responses. In addition, we recognise that individual and community resilience is required to improve self help, health and wellbeing approaches. More emphasis will be placed on co-productive approaches which will contribute to improved health and wellbeing.

Chart 8 : Older People (Aged 65+) Supported in Care Homes, 2009/10.



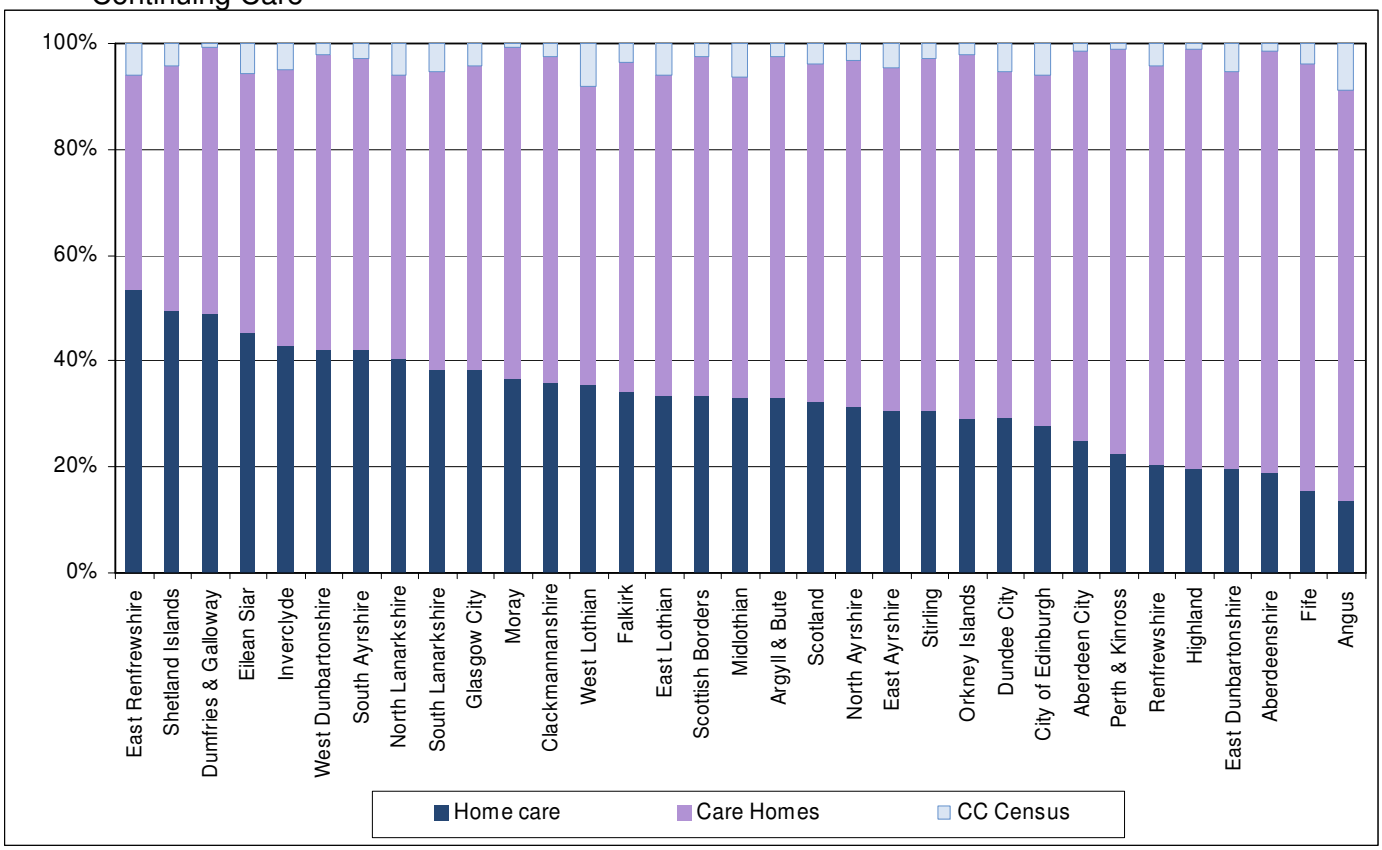
Figures from quarterly monitoring return
Source : Scottish Government Health and Community Care - Datasets

Chart 9 : Trend in Care Home Places for Older People, Dundee City & Scotland



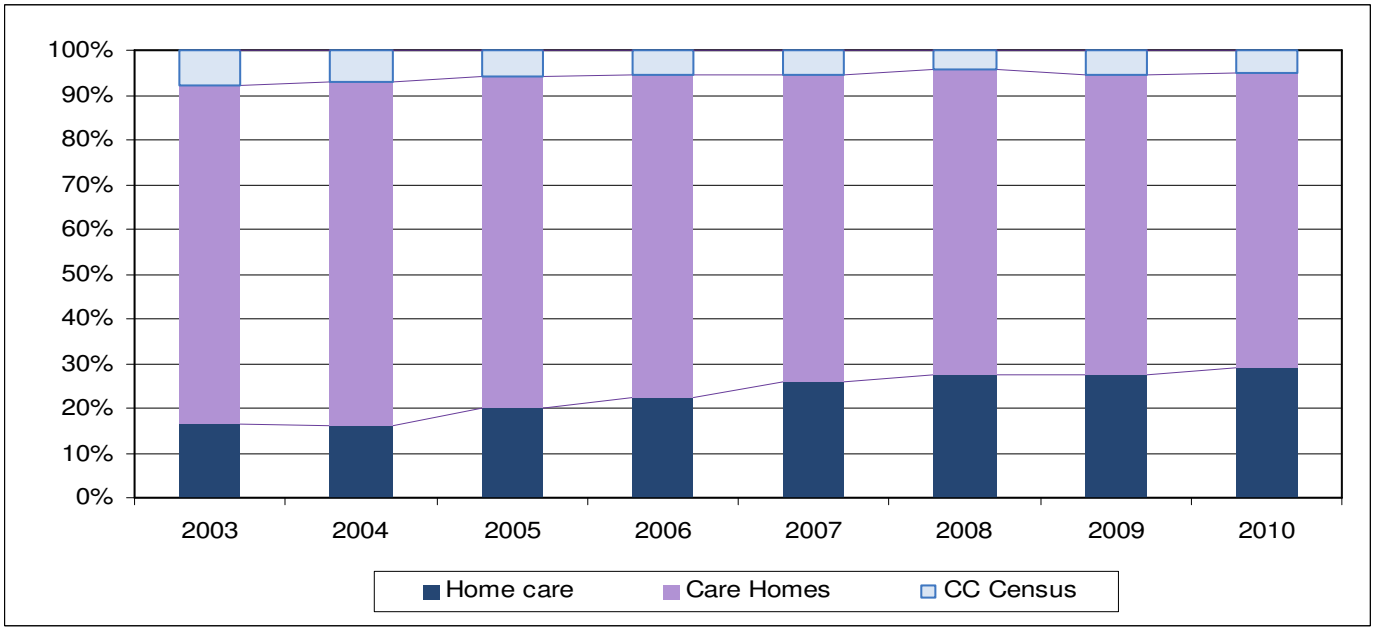
Base year 1999/00 = 100%
Source : Scottish Government & ISD, Scottish Care homes census Care Homes Census

Chart 10: Balance of Care : Supported in Care Homes, Intensive Home Care and NHS Continuing Care



Sources : Scottish Government Quarterly Monitoring, Home Care census & ISD, Continuing Care Census.

Chart 11 : Balance of Care for Dundee City, 2003 to 2010.



Sources : Scottish Government Quarterly Monitoring, Home Care census & ISD, Continuing Care Census.

What is the data telling us?

- There has been an increasing trend in the number of care home placements since 2005/06, however over the last 10 months this trend has slightly reversed.

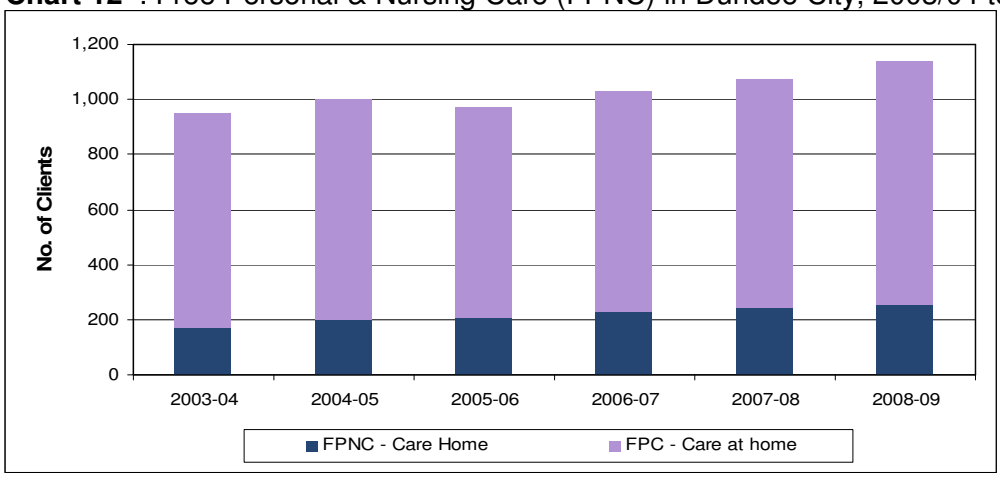
What is our current position?

- Performance against the 30% 'Whole Systems' target continues to be monitored locally. Chart 11 shows that Dundee is almost hitting this target, however it is believed that there are still insufficient resources in the community relative to other forms of intensive care, such as continuing care and care homes.

What will we do in the future?

- Moving assessments from the hospital and introducing more rehabilitative services such as slow stream enablement and improving anticipatory aspects of respite for carers will assist people to be supported in their own homes for longer.
- In order to shift the balance of care we need to:
  - reduce the amount of assessments provided in hospital and acute settings;
  - increase the range and the alternatives to residential care by extending our intermediate care to include slow stream rehabilitation and more intensive enablement.;
  - provide more direct, proactive support to carers; and
  - provide more supports in individuals own home to promote independence.

Chart 12 : Free Personal & Nursing Care (FPNC) in Dundee City, 2003/04 to 2008/09.



Source : Scottish Government Self-Directed support publication Free Personal and Nursing Care, Scotland, 2008-09

What is the data telling us?

- The number of people receiving FPNC continues to increase, however the number of hours of care is increasing at an accelerated pace. Over 8000 hours were provided during 2010, which is almost double that provided during 2006.

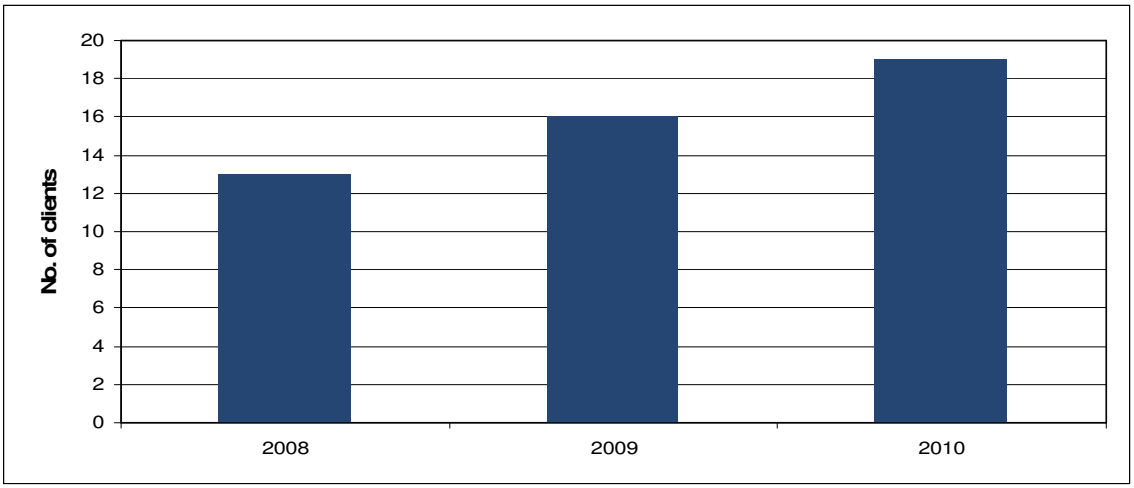
What is our current position?

- Local analysis as part of the Integrated Resource Framework (IRF) has illustrated the enormous variation in need across the city.

What will we do in the future?

- As part if the IRF we will further examine variation in service provision.

Chart 13 : Direct Payment to Clients aged 65+ in Dundee City, 2008 to 2010.



Source : Scottish Government Self-Directed support publication Self-directed Support (Direct Payments), Scotland, 2010.

What is the data telling us?

- The number of people receiving direct payments has increased since 2008.

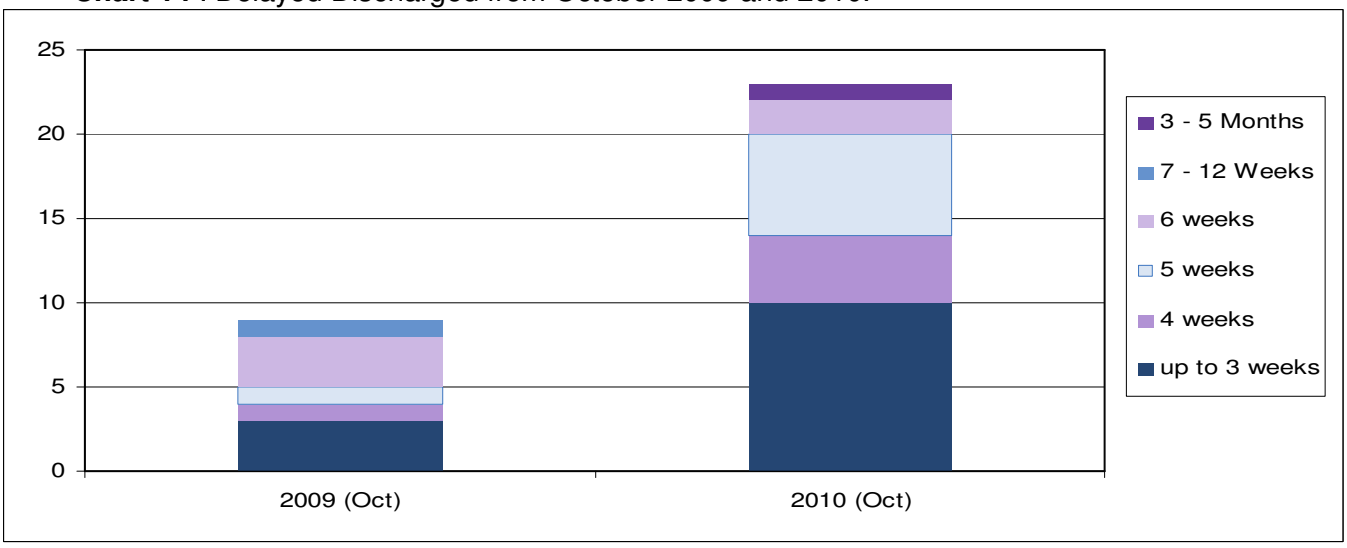
What is our current position?

- Practice has been improved to introduce more individualised approaches to the delivery of services with, for example the piloting and rolling out of Talking Points.

What will we do in the future?

- A more detailed business plan is currently being developed to change provision of Self Directed Support, which will be aligned to the anticipated national approach.

Chart 14 : Delayed Discharged from October 2009 and 2010.



Source : ISD Delayed Discharges

What is the data telling us?

- Chart 14 shows a slight upward trend in the number of people delayed between 2009 and 2010. However, local data shows an overall reduction within the last the last 5 years.
- There has also been a reduction in waiting times for care at home services.
- Bed days lost as a result of delayed discharges has increased over the past 12 months and the average loss is 43 bed days per delay.

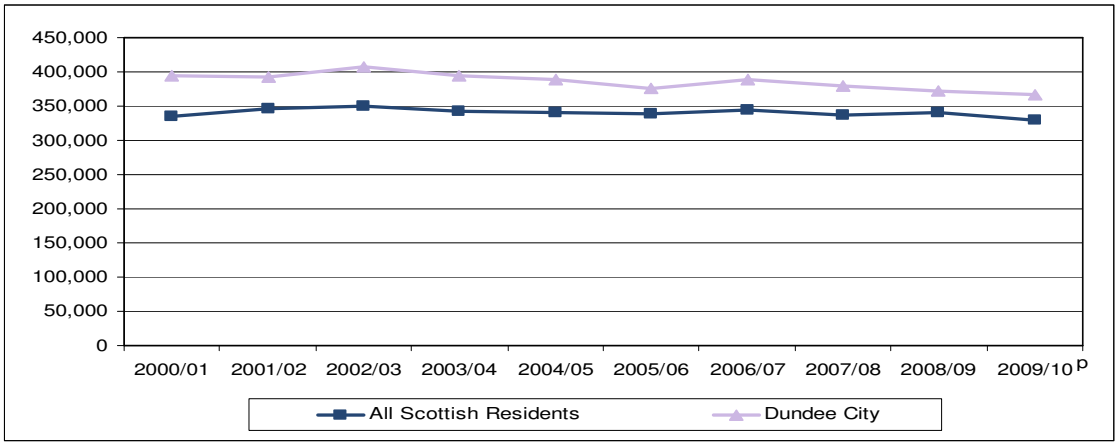
What is our current position?

- It has been identified that there is a gap in provision for people who are expected to take a longer time to rehabilitate. Slower stream rehabilitation will assist these people in their recovery with the ultimate goal to return to their own homes on a permanent basis.

What will we do in the future?

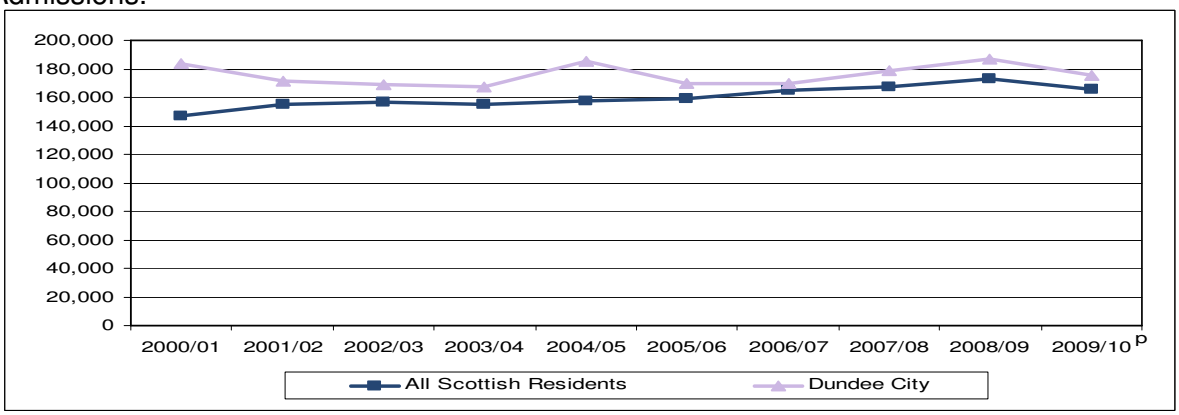
- We would like to significantly reduce the bed days lost as a consequence of people being delayed beyond their date of discharge. The following programmes will contribute to reduced delays, as well as reduce unplanned and repeat admissions:
  - anticipatory care;
  - virtual wards;
  - enablement;
  - telehealth / telecare; and
  - self help.

Chart 15: Bed Day Rates per 100,000 Population of All Emergency Admissions for Patients Aged 65+.



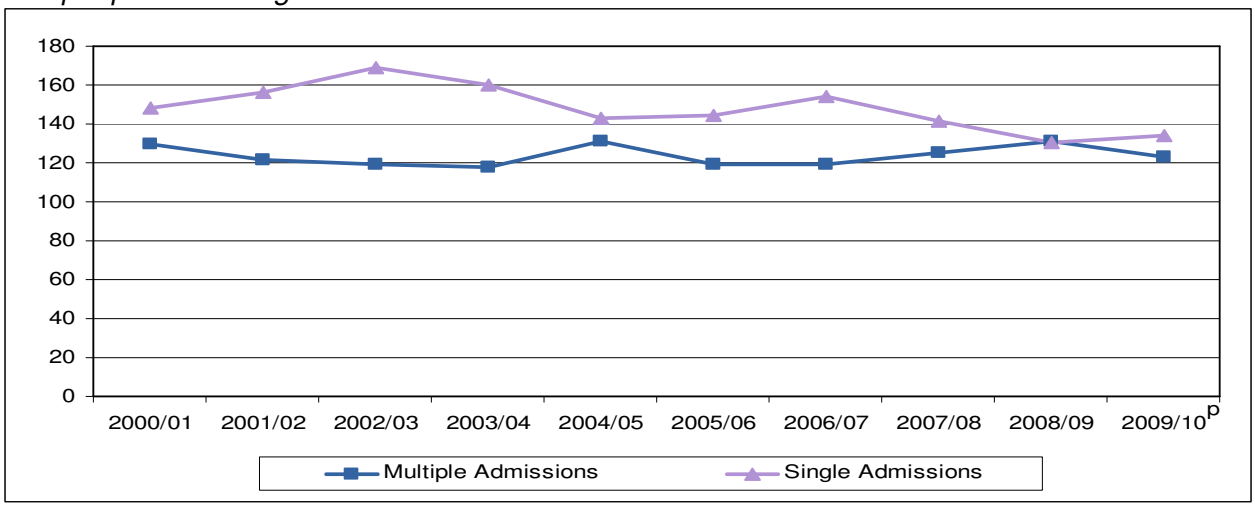
p = provisional figures
Source : ISD Inpatient, Day Case and Outpatient Activity

Chart 16 : Bed Day Rates per 100,000 Population for Patients Aged 65+ with 2+ Emergency Admissions.



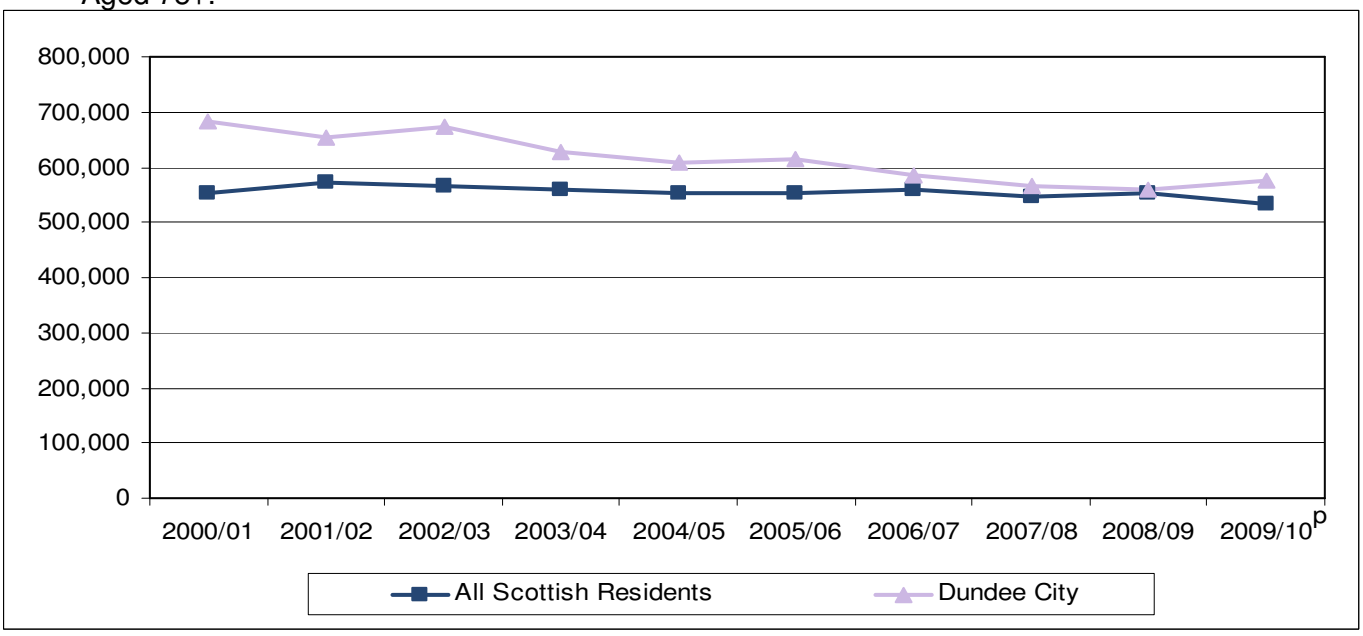
p = provisional figures
Source : ISD Inpatient, Day Case and Outpatient Activity

Chart 17 : Average Beds Occupied by Emergency Admissions for Patients Aged 65+.
p = provisional figures



Source : ISD Inpatient, Day Case and Outpatient Activity

Chart 18 : Bed Day Rates per 100,000 Population of All Emergency Admissions for Patients Aged 75+.



p = provisional figures
Source : ISD Inpatient, Day Case and Outpatient Activity
Note - Beds days have been specifically allocated to the year in which they took place. For example, if a patient was admitted on 1 March 2008 and discharged on 1 May 2009 a total of 31 days have been assigned to the year ending 31st March 2008, 365 days have been allocated to the year ending 31st March 2009 and 30 days have been allocated to the year ending 31st March 2010. (Previously all 426 days would have been assigned to the year ending 31st March 2010).

What is the data telling us?

- Charts 15 - 18 show modest and consistent improvement in the bed days rate.

What is our current position?

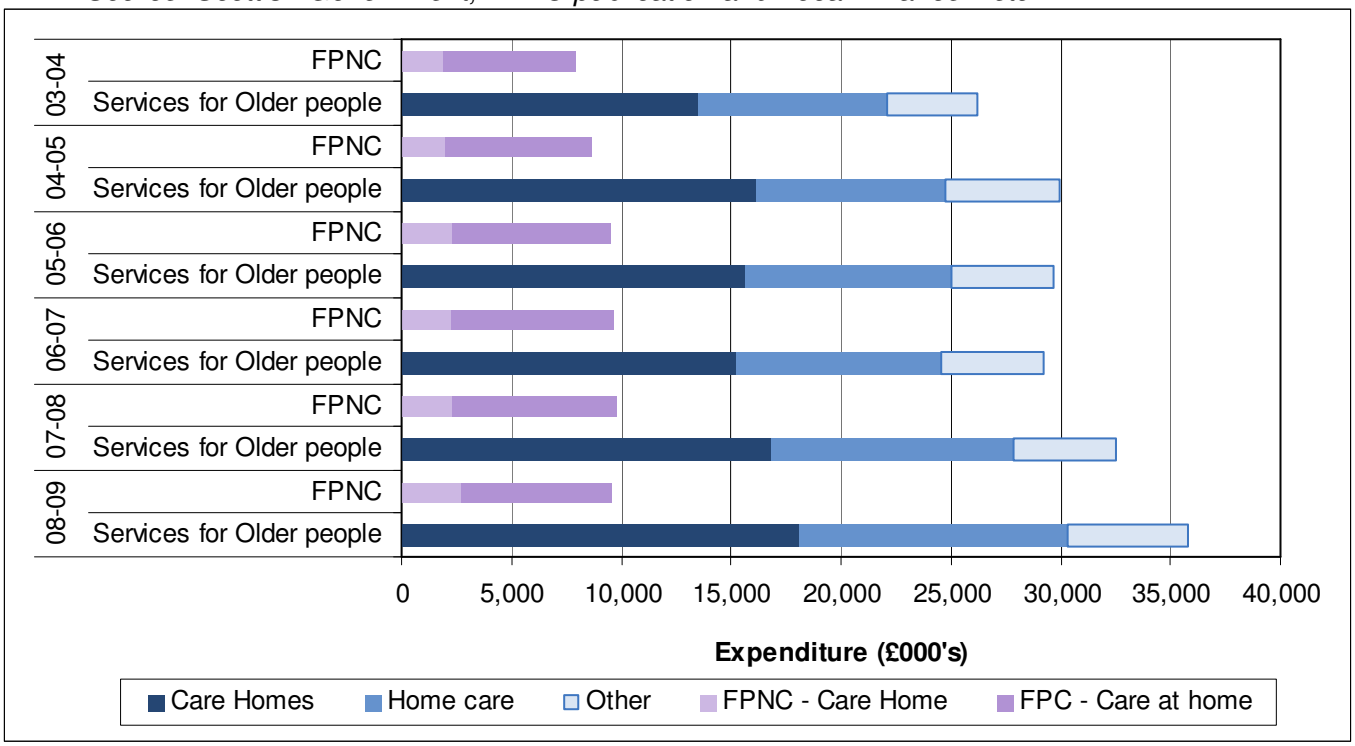
- To assist with this thus far we have piloted Virtual Wards, introduced intermediate care and developed and rolled out re-enablement however, the rate of improvement is insufficient to meet strategic objectives.

What will we do in the future?

- The roll out of holistic assessments in Medicine for the Elderly services will contribute to continued reduced readmissions.
- This following programmes will contribute to reduced bed days:
  - anticipatory care;
  - virtual Wards;
  - enablement;
  - telehealth / telecare; and
  - self help.

Section 5.5 SOA Priority: Corporate change and improvement

Chart 19: Expenditure on Older People Services in Dundee City, 2003/04 to 2008/09.
Source: Scottish Government, FPNC publication and Local Finance Return



It is estimated that by 2033 the 65+ population will increase by 30% and that if the approach to service delivery is not revised, then expenditure on services for this age group will continue to rise in line with this statistic.

This, supported by the performance and activity information outlined above confirms; the requirement to achieve an overall shift in the balance of care; the importance of ensuring services are delivered efficiently with all waste removed from our systems and variation minimised; and that we receive optimal value from our investments.

6. Key Changes to Achieve Over the Next 5 Years

We have an agreed **Integrated Care Model for Older People in Dundee**. A diagrammatic description of the model is attached as **Appendix 1**. This model shows our direction of travel and our intention is to use the change fund to help scale up and accelerate the pace of change represented by the integrated model.

In summary our aims are:

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

The actions to achieve the above aims follow:

1 Reduce unplanned admissions to hospital and other congregate settings by:
- extending the pilot of virtual wards; and
- supporting care homes to avoid unnecessary admission to hospital.

2 Reduce the number of people entering care homes from hospital or emergency respite care by:
- ceasing to assess for care homes in the hospital setting;
- developing slow stream rehabilitation; and
- reviewing models of assessment.

3 Remodel dementia care by:
- improving quality and re-commissioning models of residential care;
- managing risk more effectively in the community by providing rapid response teams;
- improving access to care at home services for people with dementia; and
- improving end of life care.

4 Move resources from hospital/care homes to the community and increase the choice of home based services by:
- increasing the number of housing with care units;
- increasing enablement services;
- increasing telecare/telehealth support;
- further developing carer's supports and providing proactive carers assessment; and
- further integrating OT and equipment services.

5 Develop a Co-Production/Asset Approach which will build community capacity/resilience by:
- testing models of co-production;
- encouraging and supporting local enterprise to develop low level support services;
- providing a more informed base for individual decision making; and
- increasing choice and promoting independence (e.g. transport, care and repair).

6 Realign current roles and responsibilities to provide a more efficient and seamless service to service users and their carers.

The Change Fund will be used to bridge the resource release from the shift in the balance of care. We anticipate that resource will be released for reinvestment through the:

- reduction in acute and other hospital beds;
- reduction in care home placements;
- more efficient delivery and procurement of care at homes services;
- further development of co-production; and
- integration of service delivery both strategically and operationally.

7. Use of Change Fund and Outcomes Anticipated

In considering the use of the Change Fund to effect both short term and long term change within the city we have developed two work streams. Indicative costs are provided across the respective work streams for the purpose of the application. The Dundee Partnership will give further consideration to the alignment of resources as the detailed proposals are developed.

Work stream 1 will put in place changes which will reduce the reliance on acute hospital and care home places to meet the needs of older people with complex care needs. By changing the models of service we will release resources from the acute and care home sector for reinvestment in community resources. The Change Fund will bridge this change and 62% of the overall allocation will be targeted at these changes.

Table 4 : Work Stream 1 - Allocation of Change Fund Resources

Prog. No.	**Description**	**Value £000**	**Change Fund %**
1	Housing with Care	223	10%
2	Moving assessment for care home admission from congruent settings	446	20%
3	Supporting older people with changing health needs to be cared for in care home settings	112	5%
4	Telecare / Telehealth	112	5%
5	At risk assessment and support	491	22%
6	Integration	2	0
Total - Work Stream 1		**1,386**	62%

Work stream 2 will begin the development of the community infrastructure to sustain the shift in the balance of care through the medium and longer term. This work stream includes the remodelling of dementia care services. The Change Fund will bridge this change and 38% of the overall allocation will be targeted at these changes. We anticipate that in years 2 to 4 of the Change Fund, that the balance of funding between work streams 1 and 2 will change, with the greater proportion of funding being allocated to work stream 2. Our intention will be to further invest in the development of social enterprise and capacity building.

Table 5 : Work Stream 2 - Allocation of Change Fund Resources

Prog. No.	Description	Value £000	Change Fund %
7	Resources and support for people with dementia	335	15%
8	Integrated OT service and equipment service	30	1.5%
9	Carers support	156	7%
10	Building capacity	304	13.5%
11	Public information	22	1%
Total - Work Stream 2		**846**	**38%**
Grand Total (Work Streams 1 +2)		**2,232**	**100%**

The anticipated resource release which the Change Fund will bridge is outlined below. In defining the level of resource release consideration has been given to the stepped approach that would be required to achieve bed closures in acute/hospital settings. An upper and lower limit has been included because the extent of resource release is dependant upon the scale of bed closures that could be achieved through the period of change.

Table 6 : Resource Release

Change Fund Year	Change Fund Allocation £000	Resource Release - £000			
		Year 1	Year 2	Year 3	Year 4
2011/2012 Lower limit	2,232	770	2,634	3,425	4,215
2011/2012 Upper limit	2,232	770	3,744	4,534	5,325

WORK STREAM 1 - REMODELLING TO RELEASE RESOURCES

Programme 1 - Housing with Care - Alternative to Care Home Admission

Aim is to reduce number of care home admissions by develop an additional 100 Housing with Care Units, providing integrated care and health support which includes the potential for overnight care.

1. Identify potential accommodation:
   - agree model - type of housing, new build/conversion, number of units per build, communal facilities;
   - review current provision for desirability/model of service;
   - incorporate of telecare/telehealth; and
   - identify providers.

2. Scope social/health support required:
   - cost SCO/Health input;
   - cost overnight care/support; and
   - identify providers.

3. Financially bridge change.

Outcome / Output
- maintain more people at home
- avoid social admission/re-admission/delayed discharge
- improved quality of life for service users and carers
- improved service user and carers health
- reduction in care home admissions
- reduction in emergency respite placements
- reduction in hospital admission
- reduced bed days
- reduction in acute beds

Release resources through the reduction of acute beds and care home placements
- manage flow
- agree disinvestment level from care home placement budget
- agree the level of acute bed closure

Programme 2 - Moving Assessment for Care Home Admission from Congruent Settings (Hospital/Respite)

Aim is to stop assessment for care home admission in hospital/respite and reduce potential inappropriate admissions.

1. Change current culture of assessment/decision making at an early stage:
   - policy statement to change practice

2. Identify alternative resources to facilitate assessment:
   - slow stream rehab; and
   - enhanced enablement at home.

3. Scope resources for return to home and financially bridge changes:
   - additional community resources;
   - additional health resources;
   - overnight service;
   - telecare/telehealth; and
   - carer support.

Release resources through the reduction of acute beds and care home placements:
- manage flow;
- agree disinvestment level from care home placement budget; and
- agree the level of acute bed closures.

Outcome / Output
- maintain more people at home
- reduction in acute beds
- reduction in care home placements
- reduced bed days

Release resources through the reduction of acute beds and care home placements
- manage flow
- agree disinvestment level from care home placement budget
- agree the level of acute bed closures

Programme 3 - Support Older People with Changing Health Needs to Continue to be Cared for in a Care Home Setting

Aim to prevent older people where ever possible from being admitted from Care Home to acute setting (can be widened to other congruent settings)

1 Remove traditional boundaries of where health and social care are delivered.

2 Identify resource to provide Nurse Liaison Service to care homes.

3 Increase health input to care homes to support current GP LES – nurse led model of dedicated support to care homes.

4 Provide Community Medicine for the Elderly consultant support to care homes.

Outcome / Output
- avoid social admission/re-admission/delayed discharge
- improved quality of life for service users
- improved service health
- reduction in emergency respite placements
- reduction in hospital admission
- reduced bed days
- reduction in acute beds

Release resources through the reduction of acute beds and the reduction of readmissions
- agree the level of acute bed closures

Programme 4 - Telecare / Telehealth

Aim to enhance independence and reduce reliance on statutory care.

1. Integrate into assessment:
   - build into every initial assessment; and
   - build in staff competency/training.

2. Scope telehealth/telecare implementation:
   - identify telehealth opportunities (e.g. e-triage (virtual wards) - trial CA/Community Nursing/NHS 24);
   - progress medication (polypharmacy) support; and
   - reduction in slips, trips, falls project.

3. Scope out telecare/resources:
   - invest in purchase of equipment on year by year basis.

Outcome / Output
- maintain more people at home
- avoid social admission/re-admission/delayed discharge
- improved quality of life for service users and carers
- improved service user and carers health
- reduction in care home admissions
- reduction in emergency respite placements
- reduction in hospital admission
- reduced bed days
- reduction in acute beds

Release resources for investment in social care supports by reducing the high cost of care packages through the use of supportive technology.

Programme 5 - At Risk Assessment and Support

Aim is to redefine the pathways for older people who are at risk from the impact of escalating health and social needs. This includes the assessment of need, the promotion of self help and personalisation and an integrated model of support.

1. Review models of assessment:
   - evaluate current Single Shared Assessment tools and means of electronic sharing;
   - implement outcome approach and use of Talking Point model; and
   - develop integrated personalisation culture across assessing agencies.

2. Revised current initial assessment teams:
   - better integrated hospital assessment service with reviewed skill mix;
   - integrate health staff into the First Contact Team; and
   - develop' CISCO' approach and link to Virtual Ward initial assessments.

3. Further develop enablement service:
   - extending to other areas to provide an open referral service;
   - extend to provide an intervention service at times of changing need;
   - develop a lower level enablement service - meals/practical support; and
   - support discharge from hospital to facilitate long term care assessments.

4 Further develop Virtual Wards :
   - city wide implementation;
   - use Risk Stratification Tool to identify people at risk of admission in the coming year
   - determine Virtual Wards Co-ordination role;
   - develop sessional input to Virtual Ward from a range of agencies/personnel developing core competencies;
   - further develop links to rapid assessment by Medicine for the Elderly at Day Hospital; and
   - strengthen GP /Clinical decision making on care pathways.

5 Develop Slow Stream Rehabilitation/Enablement:
   - develop a model and function;
   - review current models; and
   - procure service.

Outcome / Output
   - maintain more people at home
   - avoid social admission/re-admission/delayed discharge
   - improved quality of life for service users and carers
   - improved service users and carers health
   - reduction in care home admissions
   - reduction in emergency respite placements
   - reduction in hospital admission
   - reduced bed days
   - reduction in acute beds
   - maintain more people at home

Release resources through the reduction of acute beds and care home placements

- manage flow
- agree disinvestment level from care home placement budget
- agree the level of acute bed closures

Programme 6 - Integration

Aim is to consider how changes to the management of our assets (staff, building, systems and budgets) might be better aligned to provide a more efficient and seamless service to individuals and their carers. This is a critical support to the development of our strategic approach to integration in Dundee, as expressed through the Dundee Integrated Care Model for Older People (**Appendix 1**).

1 Review Current Roles/Posts across the Statutory and Third Sectors

The following posts were identified as potential areas for consideration where either similar tasks are carried out by others and/or services are restricted in volume. This will take into account the terms and conditions of the workforce affected.

- Out of Hours services including Community Nursing/Interval Night Care
- Health Care Assistant/ Social Care Worker (Complex Care Support)
- Enablement/Rehabilitation Workers
- Case Worker/Case Manager (Role of the Social Worker/CPN/Community Nurse)
- Mental Health Support Workers (CPN Support Worker/SW Support Worker/Social Care Workers)
- Occupational Therapy Services (OT/OT Support Workers)

2 Review the Use of Building Assets:

- building assets are currently subject to joint review..

3 As service integration develops, we will review systems, management and support arrangements.

Outcome / Output

- improved efficiency
- sustainable joint workforce with right skills mix
- harmonised terms and conditions
- reduction in building costs
- integrated assessment framework

Resources will be released by more efficient use of our physical and human resources and by streamlining systems.

WORK STREAM 2 - BUILDING A SUSTAINABLE COMMUNITY INFRASTRUCTURE

Programme 7 - Improve Resources and Support for People with Dementia

Aim to provide an integrated and responsive service for people with dementia which addresses the demographic changes, quality standards and public expectations.

1. Improve and develop early detection and support services:
   - review current models;
   - invest in redesign; and
   - commission support services.

2. Revised modelled care home for people with dementia:
   - review current provision against future requirements;
   - agree model of service;
   - commission new services/remodel existing provision; and
   - strategic procurement placements against an agreed spectrum of care.

3. Agreed model of end of life care for people with dementia:
   - build on current work undertaken by palliative working groups.

4. Review community care models to support people with dementia at home:
   - enhance and develop community OT services to address dementia specific environment adaptations;
   - develop a health/social care crisis response including out of hours that is delivered within the home environment;
   - review overnight support;
   - develop telecare responses; and
   - review support worker (health/social work)/social care worker role in community mental health teams.

5 Review support of people with dementia who require hospital admissions:
   - enhance current hospital liaison services.

6 Promote self directed support for people with dementia.

Outcome / Output
- maintain more people at home
- avoid social admission/re-admission/delayed discharge
- improved quality of life for service users and carers
- improved service users and carers health
- reduction in care home admissions
- reduction in emergency respite placements
- reduction in hospital admission
- reduced bed days
- reduction in acute/psychiatric beds

Programme 8 - Further Develop an Integrated OT Service and Equipment Service

Aim is to provide a more integrated and efficient OT and equipment service which better meets the diverse needs of individuals within a constrained budget.

1. Develop an integrated equipment service:
   - agree shared assessment tool and process;
   - shared system development;
   - develop joint training;
   - develop joint guidance; and
   - develop a policy for Bariatric equipment.

2. Develop the use of equipment and adaptation response to behavioural issues:
   - develop joint training;
   - develop joint guidance and policies;
   - invest in appropriate equipment; and
   - build robust links through telecare/community alarm.

3. Build a broader assessment/prescribing base for equipment.

4. Integrate Community OT/AHP Services:
   - staff development/training;
   - terms and conditions; and
   - remodelling.

5 Integrate Moving & Handling services for service providers:
   - integrated protocols;
   - single training/assessment service; and
   - develop agreed processes.

Outcome / Output
   - maintain more people at home
   - avoid social admission/re-admission/delayed discharge
   - improved quality of life for service users and carers
   - improved service users and carers health
   - reduction in care home admissions
   - reduction in emergency respite placements
   - reduction in hospital admission
   - reduced bed days
   - reduction in acute beds

Programme 9 - Carer Support

Aim is to enable carers to continue to support people they care for at home.

1. Carers assessment:
   - provide responsive carers assessment; and
   - offer/review carers assessment at key stages (service users review/change in need).

2. Increase respite options and resources:
   - reshape model of respite;
   - develop respite for people with dementia;

- further invest in care at home;
- consider implementing the home from home respite model; and
- procure respite based on carer's needs.

3. Increase support options and resources and ensure carers are aware of their options:
   - develop peer support groups;
   - promote self directed supports;
   - develop individualised carer's budget; and
   - provide telecare/telehealth to support caring role (for example medication administration).

4 Support carer's to keep well:
   - develop carer's training in areas such as equipment, moving and handling and telecare.

Outcome / Output
- maintain more people at home
- avoid social admission/re-admission/delayed discharge
- improved quality of life for carers
- improved carers health
- reduction in care home admissions
- reduction in emergency respite placements
- reduction in hospital admission
- reduced bed days
- reduction in acute beds

Programme 10 - Capacity Building and Co-production

Aim is to build the capacity of communities to deliver services which maintain people in their own home in response to identified community need. This will include the development and promotion of co-production models, volunteering and commissioned services through social enterprise and will address the community needs of both local communities and/or communities of interests.

1 Determine the support requirements to develop, support and sustain co production and capacity building models:
   - identify the administrative and development requirements;
   - confirm the priorities for early development;
   - agree allocation of funding for development; and
   - agree processes and criteria for funding allocation.

2.. Test models of co-production in contrasting communities:
   - identify natural communities; and
   - scope and test new models.

3. Build on/implement/extend current models of capacity building, including volunteering:
   - review models such as time banking;
   - develop outreach services which support older people to access community opportunities (both statutory and non-statutory); and
   - investigate the role of local communities in providing support to older people in their own home e.g. lend a hand schemes.

4 Identify opportunities for the development of social enterprise approaches which address the following:
- enable older home owners to improve their housing conditions, safety, security and comfort;
- provide cost effective low level supports (moving home, handy person. practical support, shopping, laundry); and
- explore options for promoting Care and Repair and share good practice from Home Improvement Agencies in England..

Outcome / Output
- maintain more people at home
- build community resilience
- manage resources to meet growing demand
- develop social enterprise
- increased choice
- improved service users and carers health and wellbeing
- extended co-production
- further integration across sectors

Programme 11 - Improved Models of Public Information

Aim to enable the public to make informed choices about support which maximises public independence and minimises the need for statutory intervention.

1 Develop integrated and comprehensive models of information:
- scope out and agree information;
- build on current good practice (CAN website);
- develop and support web base resources;
- agree non web based means of sharing information; and
- explore use of the Television Community Channel.

2 Improve support to access information:
- review initial contact services to include volunteer led information points;
- support individuals in the use of information technology;
- utilise the Talking Points approach to identify and meet individualised information needs; and
- review the scope and promotion of DILCEC as a means of developing choice.

Outcome / Output
- maintain more people at home
- avoid inappropriate social/health interventions
- increased independence and control
- informed public
- improved quality of life for service users and carers
- improved service users and carers health

8. Key Performance Measures to Assess Progress

The following are strategic performance measures that are drawn from the National Performance and Outcome Measures Framework and the Dundee Health and Local Authority Partnership performance measurement framework. The strategic outcome measures are reported and monitored regularly while the individual outcomes measures are

under development. As the more detailed Change Fund work streams and programmes are progressed, local measures for improvement will be developed.

Strategic Outcomes

- To support shifting the balance of care, NHS boards will achieve agreed reductions in the rates of attendance at A+E.
- By 2010/11, NHS Boards will reduce the emergency inpatient days for people aged 65+ by 10%, compared with 2004/05.
- Number of people admitted twice or more to acute specialties per 1,000 population.
- To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD from 2006/07 to 2010/11.
- Number of people who were delayed more than 6 weeks to be discharged into an appropriate setting.
- % of people aged 65+ who have been admitted twice and who have not had a shared assessment of their health and social care needs.
- Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.
- Increase the level of older people with complex care needs receiving care at home.
- % of people 65+ receiving personal care at home.
- % of people assessed as being in the critical or substantial eligibility categories and who did not receive free personal care within 6 weeks from the completion of their community care assessment.

Individual Outcomes

- % of carers who feel supported and capable to continue in their role as a carer.
- % of users and carers satisfied with their involvement in the design of care package.
- % of community care service users feeling safe.
- % of users satisfied with opportunities for social interaction.

9. Summary of How Change Fund will Enable Shifts in Core Budgets and Impact on the Totality of Spend by the Partnership Over the Next 5 Years

The anticipated growth in expenditure based on demand is outlined in Table 7 below. It was calculated by estimating the age related assessed demand for care and support in congregate and community settings.

Table 7 : Projected Growth in Expenditure Required to Support Community Response

	2011	2012	2013	2014	2015
Age Band	£000	£000	£000	£000	£000
65-74	23	23	23	23	23
75-84	125	125	125	125	125
85+	895	895	895	895	895
Total	1,043	1,043	1,043	1,043	1,043
Cumulative Projected Growth in Expenditure	1,043	2,086	3,129	4,171	5,214

Resource release is based upon a proposed planned reduction in the use of residential care; a reduction in the average number of days lost by people delayed in hospital beyond their

medically fit date of discharge and an assumed increase in efficiency in the delivery and procurement of care and support at home.

Table 8 : Assumed Reduction in Care Home Placements

	2011	2012	2013	2014	2015
Reduction in No of Care Home Beds (no of placements)	150	37	37	38	38
Saving - Care Home Beds		770	770	790	790

Table 9 : Assumed Reduction in Bed Days Saved

	2011	2012	2013	2014	2015
Reduction in No of Acute Sector Bed Days (average 43 days delayed to 21 days)	7,300 bed days		7,300	7,300	7,300

An upper and lower level of resource release is included because, in defining the level of resource release, consideration has been given to the stepped approach that would be required to achieve bed closures in acute/hospital settings.

Table 10 : Estimated Resource Release - Lower Limit

	2011 £000	2012 £000	2013 £000	2014 £000	2015 £000
Cumulative Saving - Care Home Beds (£20,800 average annual unit cost per placement)		770	1,539	2,330	3,120
Saving - Acute Sector Bed Days - reduce from 43 to 21 (£150 average daily cost per bed)			1,095	1,095	1,095
Total Potential Resource Release		770	2,634	3,425	4,215
Net Resource (Release) / Additional Spend Required	1,043	1,316	494	747	999
Change Fund Investment	2,232	2,232	2,232	2,232	2,232

Table 11 : Estimated Resource Release - Upper Limit

	2011 £000	2012 £000	2013 £000	2014 £000	2015 £000
Cumulative Saving - Care Home Beds (£20,800 average annual unit cost per placement)		770	1,539	2,330	3,120
Saving - Acute Sector Bed Days - reduce from 43 to 21 (£302 average daily cost per bed)			2,205	2,205	2,205
Total Potential Resource Release		770	3,744	4,534	5,325
Net Resource (Release) / Additional Spend Required	1,043	1,316	(615)	(363)	(110)
Change Fund Investment	2,232	2,232	2,232	2,232	2,232

In Section 7 above, two work streams were identified with associated programmes of development. Work stream 1 will put in place changes which will reduce reliance on acute hospital beds and care home places. Work stream 2 will begin the development of the community infrastructure to shift the balance of care through the medium to longer term.

10. Indicate the Financial Mechanism and Governance Framework

Change Fund monies will be accessed using the Resource Transfer mechanism. The Tayside Resource Transfer Agreement was recently reviewed and the schemes of delegation confirmed.

We have a joint commissioning structure in place (Dundee Health and Local Authority Management Group) which has delegated responsibility for our integrated financial services for adult care. This Management Group reports to the CHP and to the Dundee Social Work and Health Committee and is supported by a range of strategic planning groups for adults care.

There are established strategic planning groups for Older People and People with Dementia, which will take forward the work streams.

The Change Fund will be governed through the Dundee Partnership's delivery of the Single Outcome Agreement for the city. This includes:

- reporting to the public, partners and the Scottish Government through the SOA annual report;
- an annual report to the Dundee Partnership Management Group by the chair of the Partnership's Health & Wellbeing strategic theme group (currently the General Manager of Dundee CHP and the chair of the Alcohol and Drug Partnership); and
- quarterly reporting on progress through the Partnership's online performance monitoring database.

In addition, the Chief Executives Group will hold an overview of the Taysidewide implementation of the change.

11. Support Requirements to Assist Delivery

Current resources include:

- Established joint strategic planning groups for older people and for people with dementia and associated workgroups which are linked into the local partnership governance framework.
- A joint steering group to progress and support the implementation of our telecare strategy.
- A Dundee project team that consists of staff from Health and Social Work and which will be expanded to include other key stakeholders.
- We have organisational development in place and have identified support and training for front line staff and change leaders as a key priority.
- We have workforce development plans within both agencies and recognise that we need to integrate and support this further.
- A key objective will be to agree with our partners a model of community engagement and to resource this.
- Strong history of user involvement in both older people strategic groups and work streams.
- We have a joint project team responsible for the development of personalisation.
- We have an agreed procurement process and an established contracts team.

Our delivery would be enhanced by:

- Dedicated project management to ensure the preparation of a detailed implementation plan and an adherence to time scales.
- Technical support from the Joint Improvement Team to assist in the further development of our integrated resource framework to better identify variation.
- Technical support to identify and manage the market shifts that will be required to effect transition and change.
- Dedicated OD support drawn from across both agencies – working together to ensure a consistent approach to change management.
- Dedicated HR support across all agencies to effect change in staff terms, conditions, and roles, while working closely with staff side from all agencies.
- Support re community engagement work building on existing expertise i.e. via Communities Officers/Public Involvement Manager/Public Partnership Groups/ Local Community Planning Partnerships/ Celebrate Age Network /Healthy Living Initiative.

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

David K. Dorward

David K. Dorward
Dundee City Council

25th February 2011
Date

David W. Lynch
NHS Tayside

25/2/11
Date

Morna Wilson

Morna Wilson
Dundee Third Sector Interface

25/2/11
Date

Ewan Findlay
Scottish Care

25th feb' 2011
Date

Dundee Integrated Care Model for Older People

User & Satisfaction

Faster Access

Support for Carers

Quality of Assessment & Care Planning

Identifying Those at Risk

Moving Services Closer to Users/Patient

"AS IS"

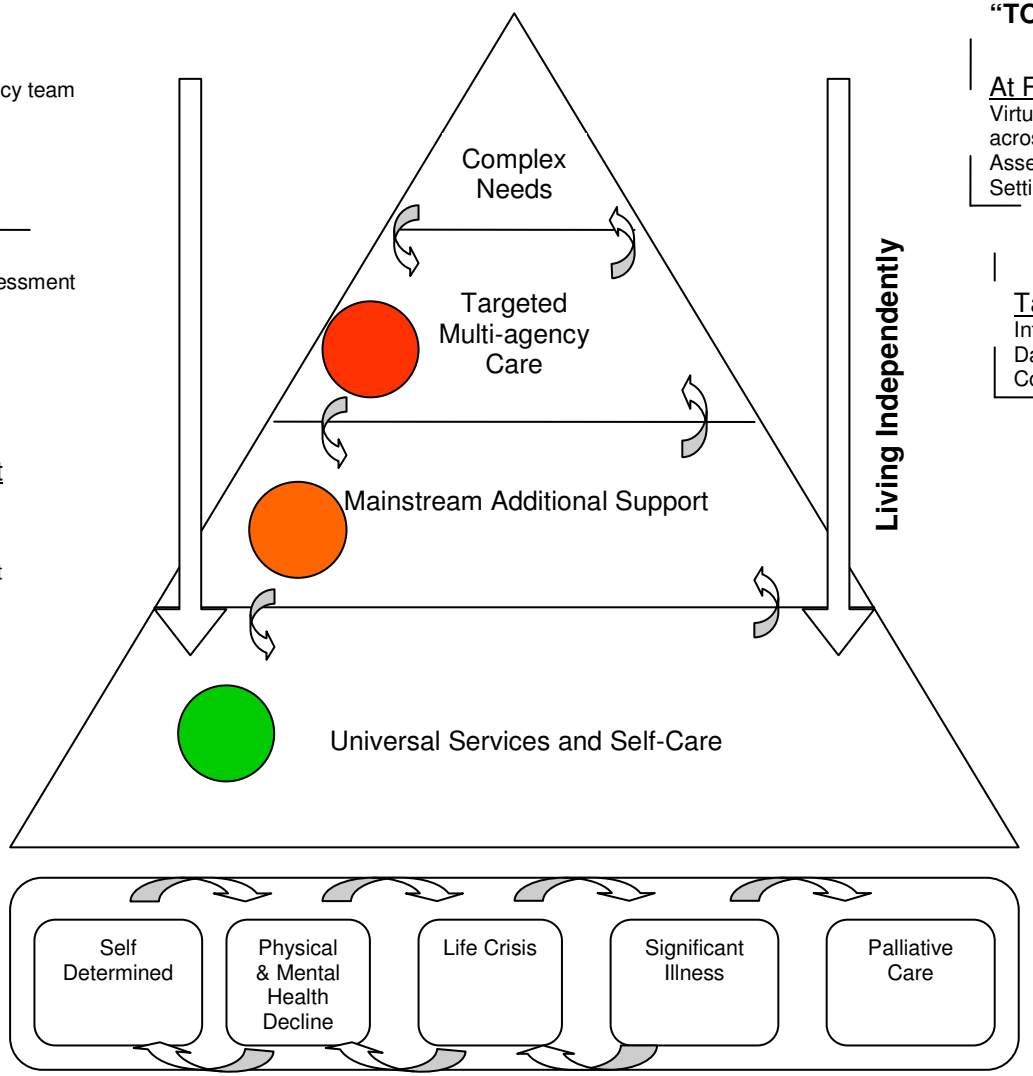
At Risk Support
Virtual Ward - multi agency team approach.
Care Management
Case Management
Care Homes
Hospital Care

Targeted Extra Support
Comprehensive Geriatric Assessment
Day Services
Day Hospital
Intermediate Care
Intensive Home Care
Very Sheltered Housing

Mainstream Extra Support
Social Work Services
Community Rehabilitation
Enablement
Independent Living & Equipment Centre
Sheltered Housing

Universal Services
Health
Leisure & Communities
Housing
Voluntary Sector
Private Sector

Pipeline Approach
The main statutory agencies will assess every older person at key milestones with the aim of enabling the person to regain/retain as independent a lifestyle as possible. Service providers will then have a clear outcome to achieve.



Integrated Assessment Framework
Single Shared Assessment
Integrated Care Record
End of Life Pathway

"TO BE"

At Risk Support
Virtual Ward approach across city.
Assessment in Appropriate Setting

Targeted Extra Support
Intermediate Care - step-up
Day Hospital
Community Geriatric Care

Mainstream Extra Support
Enablement Approach for All
Rehabilitation at Home
Telehealth
Telecare

Self Care/Self Management
Direct Access
Anticipatory Care
Healthy Communities