DUNDEE CITY COUNCIL

REPORT TO: **SOCIAL WORK AND HEALTH COMMITTEE - 27TH FEBRUARY 2012**

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

REPORT BY: **DIRECTOR OF SOCIAL WORK**

REPORT NO: **84 - 2012**

1.0 PURPOSE OF REPORT

The purpose of this report is to advise the Committee of how it is proposed the actions put forward in the Change Fund application of 2011/2012 will be consolidated using the 2012/13 Change Fund.

2.0 RECOMMENDATIONS

It is recommended that the Social Work and Health Committee:

2.1 Note the Change Fund Submission for 2012/13 attached as Appendix 1 to this report and;

2.2 Note that funds will be available for partnerships annually until the end of 2014/15 and it is anticipated they will bridge a change in the way the total resource on health and social care is spent.

3.0 FINANCIAL IMPLICATIONS

The annual Change Fund allocations for Dundee are £2.550m in 2012/13, £2.550m in 2013/14 and £2.230m in 2014/15. The overall resource available will be enhanced by the flexibility afforded through the carry forward of unspent Change Fund resource in 2011/12 and future years and the planned release of resources from residential styles of care. As a result total expenditure on Change Fund projects is estimated to total £3.1m in 2012/13. The total resource release expected per annum by the end of the Change Fund period is approximately £2.3m.

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. Following the 2012 Spending Review, Ministers announced that an £80 million Health and Social Care Change Fund will be available for partnerships in 2012/13, with £80 million committed for 2013/14 and £70 million for 2014/15.

4.2 The purpose of the Change Fund is to provide bridging finance to shift the balance of care from institutional to primary and community settings. In this respect, it is anticipated that partnerships will have a clear strategy for investing 'upstream in anticipatory and preventative approaches that will help to both manage demand for formal care, and support carers when more older people are at home'.

4.3 The 2011/12 Change Plan was prepared using community planning partnership mechanisms and also undertaken in co-operation with the independent sector. This engagement was extended during 2011/12 with further engagement events and the

establishment of a partnership monitoring group to check progress on the development of the programme and monitor the progress against agreed outcomes.

4.4 With respect to outcomes, Section Four of the 2012/13 Change Plan contains a self assessment of the performance of the Dundee Partnership to date. This is done with reference to both the national and local outcome framework. In addition, the Dundee Partnership has set its own outcomes and targets for the workstreams that are delivering the programme of change.

4.5 In broad terms the self assessment tells us that we are making progress towards our agreed outcomes. However, the scope and scale of change is not likely to be evident until the latter years of the programme.

4.6 Proposed future developments maintain the current direction of travel which drew explicitly upon the Older People and Dementia Strategies approved by Dundee City Council and Dundee CHP. A revised full commissioning strategy for Older People and Dementia to cover the 10-year period from 2012/13 on is under preparation using the same partnership mechanisms outlined above.

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 have been consulted in preparation of this report. 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
Director of Social Work

DATE: 15th February 2012

Change Plan Submission

1. Name of Partnership

Dundee City Partnership

2.1 Partner Organisations

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

Dundee Partnership works collaboratively with all partners in the development, implementation, evaluation and monitoring of the Change Plan. Information about the engagement of older people and carers follows in section 2.2 below.

2.2 Professional Engagement in the Development of Plans

The Change Plan in Dundee has been developed by building on and strengthening the pre-existing partnership approach. To ensure continuing professional and public engagement, our principle has been to embed the process of change through the whole system and across all partnership arrangements rather than through a separate process, as follows:

- we have standing groups, such as the Older People's Strategic Planning Group and the Dementia Implementation Group, which have multidisciplinary professional involvement from primary and secondary sectors; voluntary and independent sectors involvement and service user and carer involvement. The standing groups set and maintain an overview of the direction of travel and scrutinise performance against outcomes. The Change Plan submitted is consistent therefore with the strategic direction set by the Older Peoples Strategic Planning Group and the Dementia Implementation Group. The Strategic Planning Groups are responsible for the development of the longer term Older People Commissioning Strategies;
- we have Change Plan co-ordinating groups, such as the Change Plan Monitoring Group and the Change Plan Implementation Group, which include representation from the voluntary sector, independent sector; carers and the primary, secondary and social care sector. The groups build collective ownership for the current and future programme of change and provide collective scrutiny of the progress towards agreed targets;
- we have themed consultation and involvement groups at both service provider and service user levels such as the Voluntary Sector Network, Celebrate Age Network, Carers Forum and the Care Home and Resource Providers Forums. They are supported by the Partnership and focused on quality improvement, service redesign and strategic development. Many of the proposed changes arose from these fora. They test the sensitivity of current changes and will originate and contribute to the development of further change;
- we have representative Change Plan specific groups which are responsible for taking forward the work streams described in the Change Plan submission of 2011/12. These groups have multidisciplinary, professional and representative involvement in accordance with the focus of the work. They are driving a process and programme of

continuous improvement which is consistent with the work of the fora described immediately above; and
- we have held two further stakeholder events to confirm the proposed high level objectives, strengthen communication and ensure that everyone involved is able to maintain an overview and an understanding of the entire process of change.

2.3 Public Engagement in the Development of Plans

Our approach to public engagement has been determined by our understanding that:

- demographic and fiscal pressures make the status quo in terms of service design unsustainable. The associated proposed shift in the balance of care coincides with public preferences;
- the public, both directly and through their collective advocates, should be involved in the process of shaping the strategic direction of travel;
- members of the public who have experienced services and have expectations of using them in the future have much to contribute to service design and redesign;
- people want to have more influence and control over the response to their individual care and health needs; and
- individuals have personal responsibilities for their health and care and value good information to help them make informed decisions.

Against this understanding the public are being and will be engaged in the following ways:

- through the process of development of the longer term commissioning strategy for older people which will involve their direct engagement and will make explicit reference to their preferences. Preferences were expressed in the form of promises in the last round of strategic plans for older people and will be described as outcomes in the forthcoming strategic commissioning plan;
- NHS Tayside Board have prepared a policy on co-production and on public engagement. This underpins the role of the local Community Planning Partnership in the development of public participation and the role of frontline staff in the same. This is supported by a programme of organisational development;
- it is recognised that sustained development and support is required to maintain public engagement. This process is led by the Celebrate Age Network in Dundee which provides leadership in to the Partnership in this respect. The Network has developed a range of initiatives that sustain public engagement. These include a well established forum led by older people with associated themed work streams; a directory of services and supports; and CANFICS an outreach project which directs older people towards a range of social supports and provide more accessible information;
- any re-design of existing services is done with the involvement of service users and carers. In addition, the Change Fund has been used to help build community capacity in ways which maintain people in their own homes in response to identified community needs. The developments have concentrated on volunteering and social enterprise to date; and
- we continue to develop more personalised approaches to service delivery with the redesign of the assessment process to be more outcome based as trialled through, for example, Talking Points and the continuing role out of a five years strategy for the development of personalisation in Dundee.

3. Finance

3.1 Resources available to Partnerships

Table 1 - Partnership resources

From	Amount £000	Difference from 2011/12 £000
Monies carried forward from 2011/12 allocation	1,033	N/A
Initial central allocation	2,550	318
Added by NHS Board	107,551	0
Added by local authority	43,456	795
Other	0	0
TOTAL	154,590	1,113

3.2 Reasons for financial 'carry forward'

The Partnership developed a structure for evaluating proposals and allocating funding to the work streams as described in the Change Plan submission 2011/12. In addition to the resources allocated to projects managed through the statutory agencies, monies were allocated directly to both the Carer's Centre and the Voluntary Gateway for administration and allocation. The Voluntary Gateway developed an application process and criteria for the evaluation of bids. Bids were submitted at the end of 2011 and funds allocated January 2012 with a likely commencement date for projects being March to May 2012.

There were difficulties in recruiting new staff to specific posts (AHP, Nursing, CPN's) which resulted in staff slippage across the work streams.

A lead in time was required for the Housing with Care developments, with funds allocated to start up costs such as recruitment, registration and building works. These projects will commence in October 2012.

3.3 Change Fund allocation by pathway

Table 2 - Allocation by Pathway

	Preventative & Anticipatory Care £000	Proactive Care & Support at Home £000	Effective Care at Time of Transition £000	Hospital & Care Homes £000	Enablers £000	Total £000
2011/12	319	219	513	95	53	1,200
2012/13	1,188	618	768	271	252	3,098
2013/14	1,239	517	692	252	160	2,861
2014/15	1,239	467	626	252	160	2,745

3.4 Total resource allocation by pathway

Table 3 - Total Resource Allocation by Pathway

	Preventative & Anticipatory Care £000	Proactive Care & Support at Home £000	Effective Care at Time of Transition £000	Hospital & Care Homes £000	Enablers £000	Total £000
2011/12	4,669	43,159	8,390	95,140	53	15,141 2
2012/13	5,559	44,184	8,859	95,252	252	15,410 6
2013/14	5,609	44,083	8,783	95,233	160	15,386 8
2014/15	5,609	44,033	8,717	95,233	160	15,375 2

4. Self Assessment against 2011/12 performance

In our Change Plan submission 2010/11 we described our process of change in terms of two work streams. Each work stream contained a range of programmes. Processes have been developed to monitor programmes against national, strategic, service and personal outcomes. In this section performance is firstly assessed against national outcomes, and secondly against our local outcomes. This work plan has been updated into a revised Change Plan.

We have assessed out progress against the national outcomes in the following way:

- What is the data telling us?
- What are our current challenges?
- How will this impact on our Change Plan work streams and programmes?

For the purpose of comparison it has been agreed that the performance baseline should be Quarter 3 2011/12.

We have used the revised Change Plan to further assess our progress against our local objectives and targets and this is reported in sections 4.2 and 4.4.

4.1 Nationally available outcome measures and indicators

Overview

The principal policy goal of the Reshaping Care for Older People programme is to optimise independence and wellbeing for older people at home or in a homely setting. The implications of the current financial situation and demographic changes make this a challenging task, as an increasing number of people will require improved services, care and support.

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

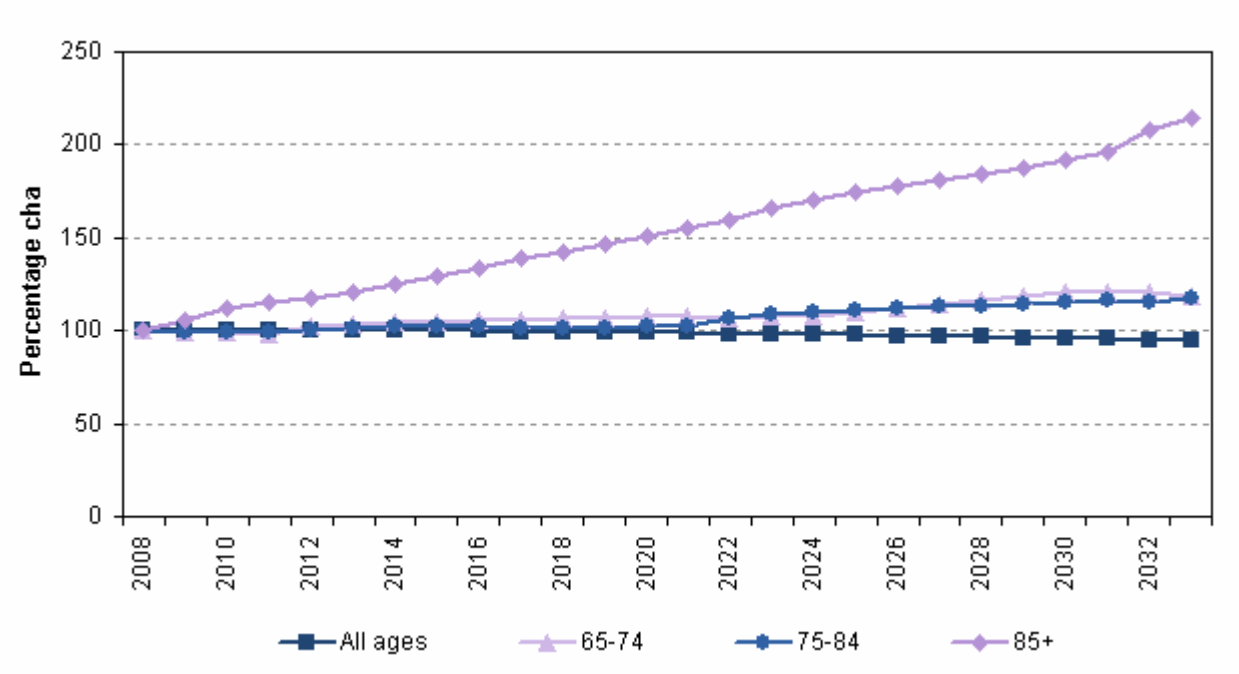


Table 4 - Prevalence of Selected Long Term Conditions from GP Quality Outcome Framework (QOF) Register, Dundee City (2011)

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

Prevalence = number of patients on the specified QOF register, divided by list size, multiplied by 100. Source: ISD

What is the data telling us?

- Dundee has an increasing ageing population with associated morbidity, particularly around dementia prevalence.
- Dundee's overall population is remaining broadly stable but 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.
- Dundee has higher levels of deprivation and harder to reach communities than other areas of Tayside.

What are our current challenges?

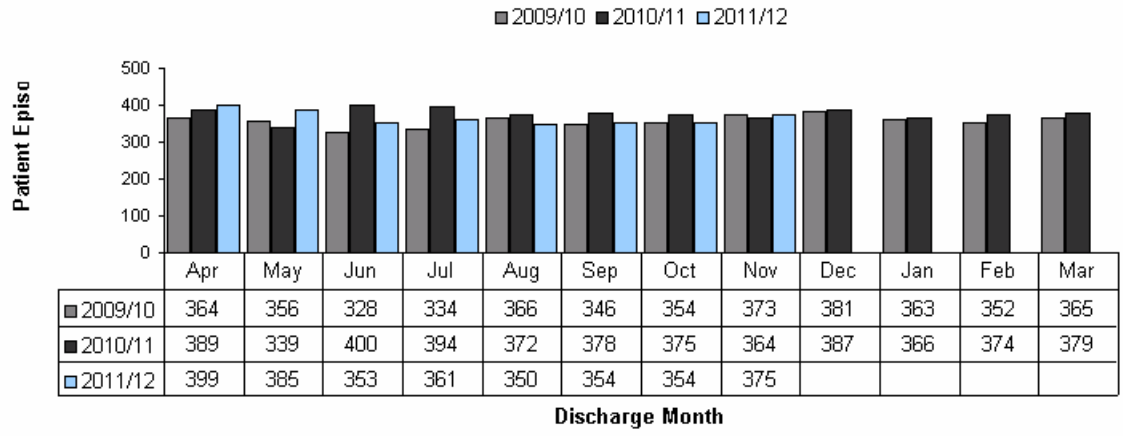
- The balance between the proportion of retirement age and working age populations will impact on workforce and capacity issues.
- There is an increasing demand on acute services and primary care services as a result of co-morbidity.
- There is a greater demand on community care services as a result of demographic change.
- Public perceptions of the changes required to meet demand are not yet in step with proposed policy changes.
- Our unpaid carer population is ageing.

How will this impact on our Change Plan work streams and programmes?

- Our current model of service delivery is not sustainable against the increased demand that will arise as a result of the projected demographic shift.
- We will change our approach to service delivery in line with the Dundee Integrated Care Model for Older People.
- A revised commissioning strategy will be prepared which shows how services will be improved and redesigned over the next 10 years.
- We will monitor our Change Plan against national and local outcome measures.

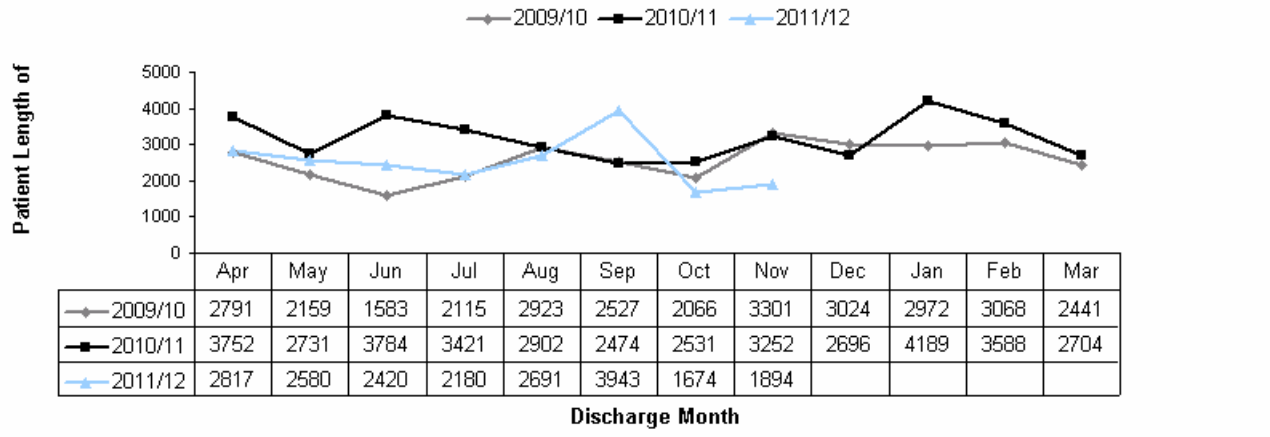
A1. Emergency inpatient bed day rates for people aged 75+

Chart 2 - Emergency adult episodes 75+ - Patients with Dundee GP



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	364	356	328	334	366	346	354	373	381	363	352	365
2010/11	389	339	400	394	372	378	375	364	387	366	374	379
2011/12	399	385	353	361	350	354	354	375				

Chart 3 - Emergency Adult Occupied Bed Days 75+ - Patients with Dundee GP



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	2791	2159	1583	2115	2923	2527	2066	3301	3024	2972	3068	2441
2010/11	3752	2731	3784	3421	2902	2474	2531	3252	2696	4189	3588	2704
2011/12	2817	2580	2420	2180	2691	3943	1674	1894				

What is the data telling us?

- Charts 2 and 3 illustrate that the number of episodes have increased slightly; however, this is offset by length of stay in hospital (LoS) being shorter - more people are being seen with less bed days. This would suggest we are either improving patients' pathways in hospital, or improving discharge arrangements, or both.

What are our current challenges?

- There is an increasing demand on acute services and primary care services as a result of co-morbidity which means that people are being admitted to hospital with more complex needs, resulting in longer treatment periods. This will impact on the flow through hospital.
- Ensuring assessments are completed in the most appropriate place to allow people to return home as quickly and safely as possible.
- Bridging the change between reducing care home placements and increasing the number of people returning from hospital to the community whilst managing hospital flow pressures.
- Demonstrating the links between community based changes and improved performance within the acute hospital.
- Managing public / carer concerns regarding earlier discharge.

How will this impact on our Change Plan work streams and programmes?

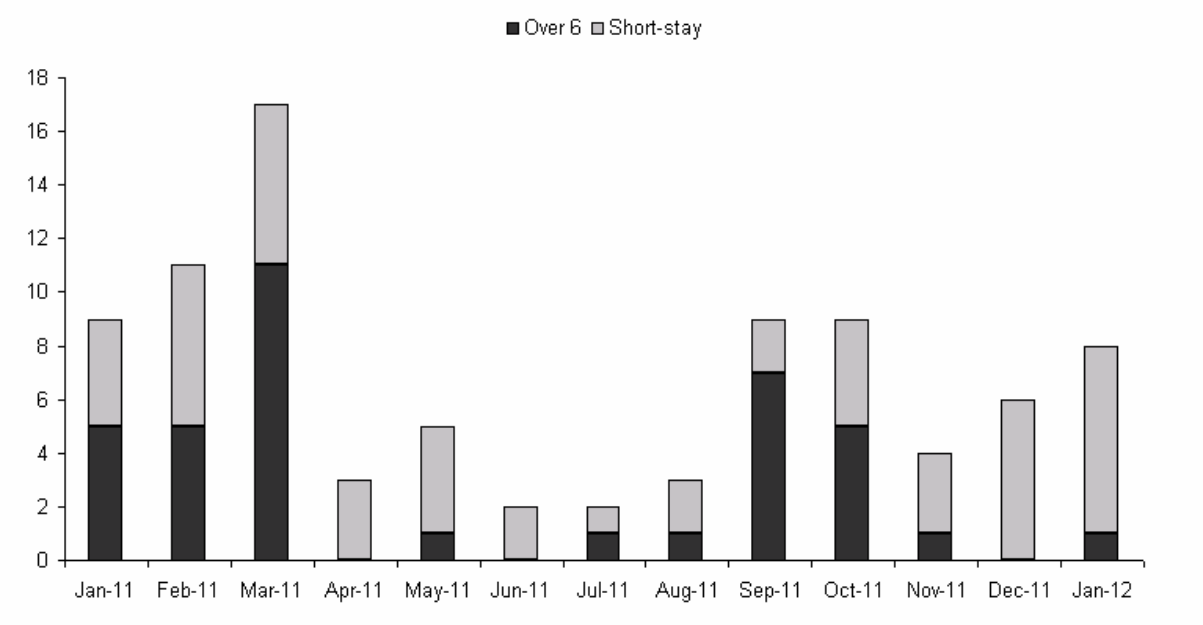
- We are changing our model of assessment to ensure more older people complete assessment at home rather than in hospital.
- We are testing a model of Virtual Wards under a Local Enhanced Service (LES) which uses a risk stratification tool to select people most at risk of admission in the coming year.
- We have worked with Medicine for the Elderly to redesign the service towards a community based model with rapid access to GPs for diagnosis and assessment in the day hospital facilitates.
- Enablement teams help us to discharge patients when medically safe to do so.
- We will progress the development of a Early Intervention Service to work with GPs and the multidisciplinary team (which will include anticipatory care and good

medicines management) to identify those most at risk and offer them appropriate assessment and services in a coordinated way.

- We will progress alternatives to admission and support discharge through sitting services, working within the voluntary sector to increase community capacity and resilience.
- We will progress the option of same day assessment for GPs with our Medicine for the Elderly consultant in the rapid access clinic as an alternative to Ward 15.
- We will test 'step up' and 'step down' as an option through the Intermediate Care Unit.

A2. a. Patients whose discharge from hospital is delayed

Chart 4 - Number of people delayed over 6 weeks or in short stay settings at 15th of each month (Source: Edisson, January 2012)



A2b. Accumulated bed-days for people delayed (NB further detailed guidance on A2b. will be issued soon, once the Delayed Discharge Expert Group has reported)

At 15 December 2011 there were 437 accumulated bed days (baseline).

What is the data telling us?

- The number of delayed discharges has reduced over the last 3 years and the occupied bed days lost improved over 2010 and 2011.

What are our current challenges?

- There is an increasing demand on acute services and primary care services as a result of co-morbidity which means that people are being admitted to hospital with more complex needs, resulting in longer treatment periods. This will impact on the flow through hospital.
- Ensuring assessments are completed in the most appropriate place to allow people to return home as quickly and safely as possible.

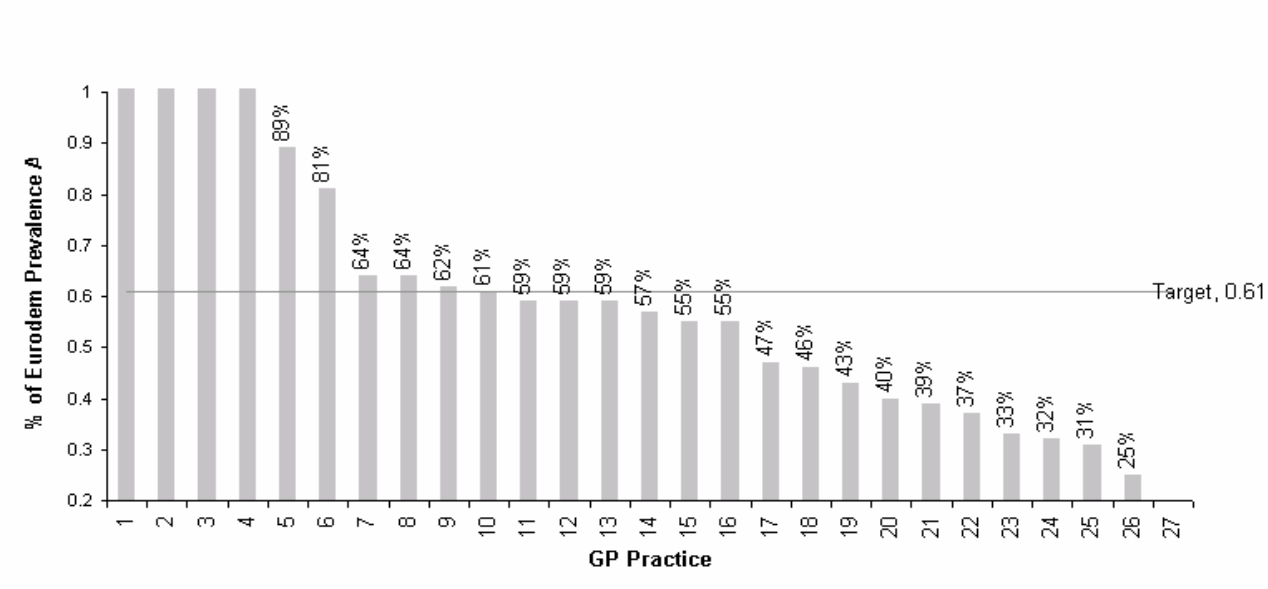
- Bridging the change between reducing care home placements and increasing the number of people returning from hospital to the community whilst managing hospital flow pressures.
- Demonstrating the links between community based changes and improved performance within the acute hospital.
- Managing public / carer concerns regarding earlier discharge.

How will this impact on our Change Plan work streams and programmes?

- Remodelling of the Medicine for the Elderly patient pathway with ward closures on the acute hospital site (October 2010) and on the Medicine for the Elderly Rehabilitation site (June 2010) will improve the flow within the hospital system.
- The enablement service will continue to provide the support people need to return home safely.
- Increasing capacity within the Hospital Care and Assessment Team by moving assessments into the community will ensure resources are focused on improving care pathways for those admitted to hospital. This will have the affect of reducing the length of stay and ensuring assessments lead to optimal care packages being developed which will reduce readmissions.
- We will maintain a focus on redesign through the work of the Discharge Management Group.

A3. Prevalence rates for diagnosis of Dementia

Chart 5 QOF Register Size Expressed as % of Anticipated Practice Prevalence (Eurodem) - Dundee CHP - December 2011



Notes: Data extracted 10th Jan 2012 from Quality Outcome Framework (QOF) calculator**.** Data not available for practices ref 10, 22 and 26 - last successful data submission reported in these instances. Practice 27 closed in 2011.

What is the data telling us?

- There are 3,417 people with a diagnosis of dementia recorded on QOF registers. This equates to 0.7 people per 100 patients registered with a GP.
- There is variation in prevalence rates across practices.

- Dundee has met the HEAT target of 61%.
- Based on the prevalence rates of dementia predicted across care homes, this would indicate an under recording of dementia across this sector.

What are our current challenges?

- Improving information systems to ensure accurate information is recorded and maintained (including the recording on Community Care client databases as well as GP QOF registers).
- Strengthening the links between GPs, primary care and secondary care to meet the needs of an increasing prevalence of dementia.
- Managing both the risk to individuals living in the community with dementia and the public's perception of this risk.
- Increasing the range of specialist services in the community which meet the needs of older people with advanced dementia.
- Responding to the increasing numbers of people with dementia admitted into care homes from the community for emergency respite, as a result of carer's stress.
- The increasing number of people entering care homes with an advanced stage of dementia and the inability of the current model of care homes to meet their needs.

How will this impact on our Change Plan work streams and programmes?

- We have appointed dementia liaison nurses and adopted the butterfly scheme to support the care of older with dementia in the acute hospital setting.
- Dundee CHP will continue to work with GP practices to recognise and promote the diagnosis and recording of people with dementia.
- We will remodel our early diagnostic services commencing with the redesign of the community mental health teams. This will better provide for those with dementia and their carers, promote self management of their conditions, avoid crises and provide the appropriate community or clinical support.
- We will provide further support for those with dementia and their carers through the development of community based projects and by expanding the Alzheimer's early support service.
- We will remodel care home provision and provide clinical support and training through our dementia liaison services.

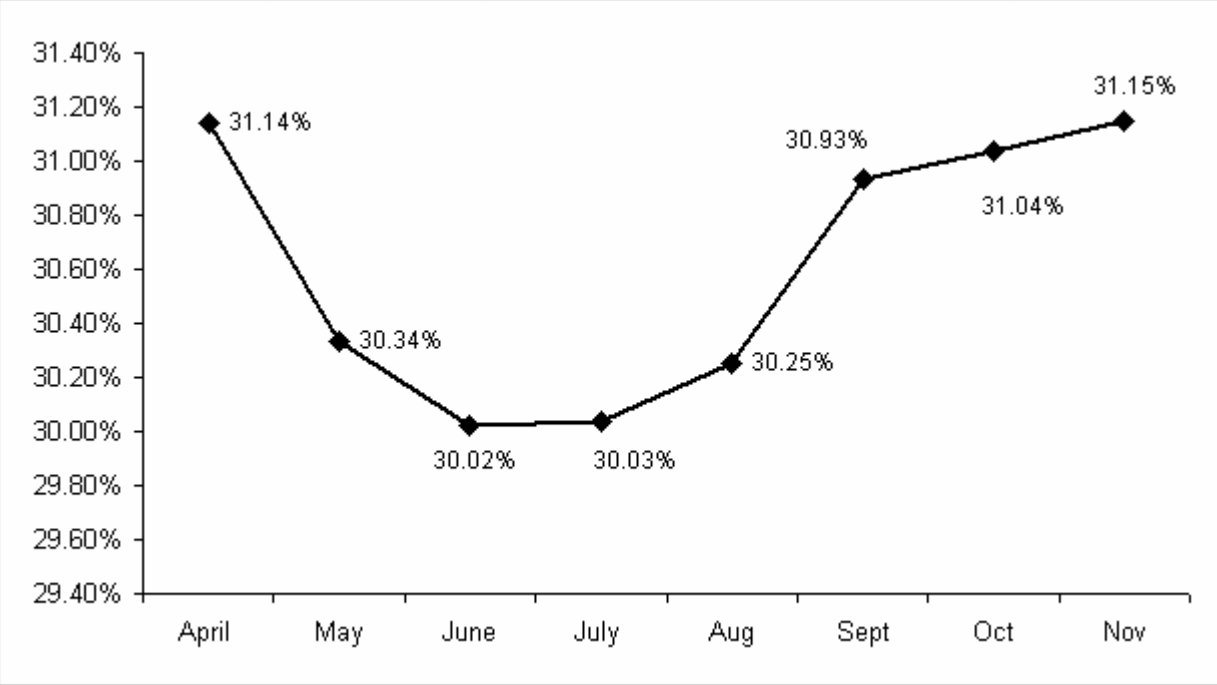
A4. Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting

Table 5 - Number of people receiving long stay care 2011

People aged 65+	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**
Continuing Care Beds	39	35	37	36	36	35	35	38
Supported in care homes*	996	980	984	982	976	972	976	970
Intensive home care	468	442	438	437	439	451	455	456
TOTAL	**1503**	**1457**	**1459**	**1455**	**1451**	**1458**	**1466**	**1464**
Intensive home care as a % of all long	**31.14%**	**30.34%**	**30.02%**	**30.03%**	**30.25%**	**30.93%**	**31.04%**	**31.15%**

stay care								

Chart 6 Number of people receiving intensive homecare as a % of all long stay care



What is the data telling us?

- Dundee continues to make good progress towards this measure. The local target of 30% has been achieved as a result of the reduction in geriatric long stay bed, the reduction in the number of people in care homes and an increase in the number of people receiving intensive homecare.
- Performance towards this target is improved compared with 2010/11, for instance performance during April 2010 was 28.19, compared with 31.14 during April 2011.

What are our current challenges?

- In order to improve performance to this measure only slightly would require a considerable increase in the number of homecare hours provided each week.
- Increasing the alternatives to residential care in order to reduce care home placements.
- Demographics - people are living longer with greater demand on services with the potential for unmet need.
- Public perceptions remain that those with most complex needs should be admitted into a long term care environment (hospital, continuing care or care home).
- Our unpaid carer population is ageing.

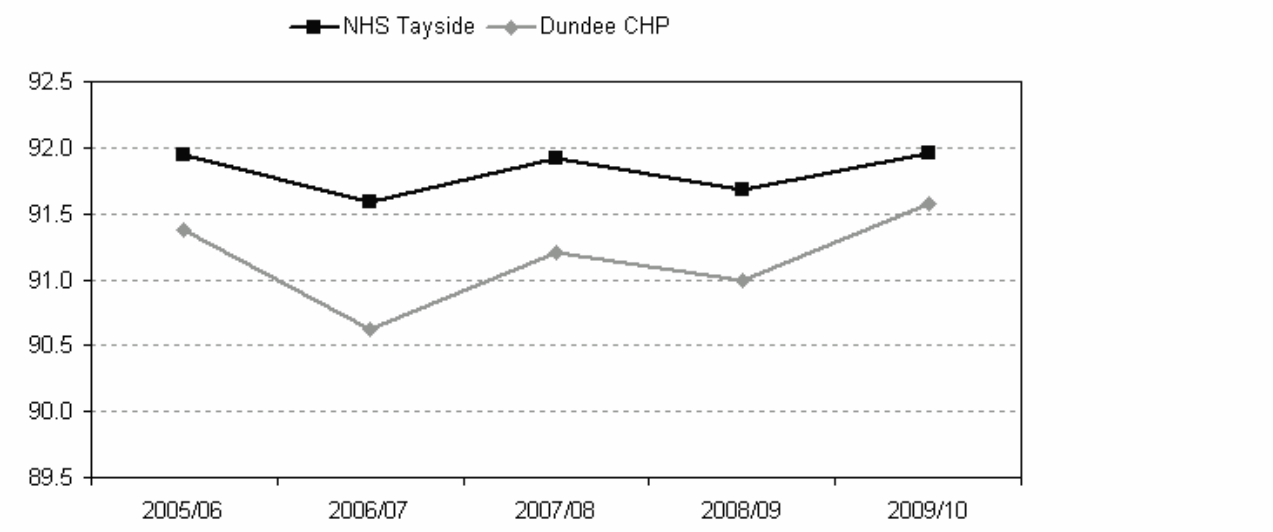
How will this impact on our Change Plan work streams and programmes?

- Moving assessment for care home admissions, the increase in telecare / health provision, redefining pathways for older people who are at risk from the impact of escalating health and social needs, increased support for people with dementia, and improved support for carers are just some of the work streams which contribute to this measure.

- We will continue to increase the range of models available to people with higher needs, e.g. Housing with Care and Integrated Community Service with a further 16-20 new Care at Home units by October 2012, in partnership with housing associations.

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

Chart 7 - Percentage of last 6 months of life spent at home or in a community setting



What is the data telling us?

- The % of people who spent the last 6 months at home or in a community setting has increased since 2005/06. Performance in Dundee is marginally less than the Tayside performance. This can be attributed to the correlation between hospital admissions and proximity to acute facilities.
- Local analysis indicates a positive impact as a result of the introduction of the GP Nursing Home Local Enhanced Service (LES), reducing the number of people entering hospital at end of life stages.

What are our current challenges?

- Ensuring that where a person spends the last 6 months of their life is where they wish to be.
- Ensuring assessments are completed in the most appropriate place to allow people to return home as quickly and safely as possible.
- Developing the skills of care home staff to meet the palliative care needs of service users without admission to hospital.
- Strengthening the links between GPs, primary care, secondary care, out of hours services, care homes and the community to meet the palliative needs of individuals.
- Demographics - people living longer and greater demand on services.
- Our unpaid carer population is ageing.

How will this impact on our Change Plan work streams and programmes?

- We will increase the number of housing with care units and introduce enhanced social care services to maintain people with long term conditions at home.
- We will increase the number of people with an Anticipatory Care Plan.

- We will continue to develop the role and function of the Care Home Peripatetic Team to provide the best possible health care to older people and to prevent their unnecessary admission to hospital.
- We will seek to facilitate ways to influence a LES light contract with GP's which captures residents not covered by the full Nursing Home LES.

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

- A Carers Impact Assessment has been developed. This will help to integrate improvements for carers into all other programmes. This will ensure carers are recognised as partners and offered the support they require to fulfil their roles.
- Dundee Carers Centre is leading the Change Plan's Carer's Programme and they have developed 3 services in partnership with Dundee City Council and Dundee CHP. These are Time 4 U (respite voucher scheme), On the Spot (access to therapies and supports) and Virtual Ward (identification of carers).
- As these services operate the experience and outcomes of people who use them will be monitored.

Carers were surveyed during 2010/11 and the following % of carers showed improved outcomes.

- Increased confidence – 96%
- Improved mental health/wellbeing – 75%
- Improvement in coping financially – 92%
- Reduced isolation – 88%
- Feel able to continue caring – 98%

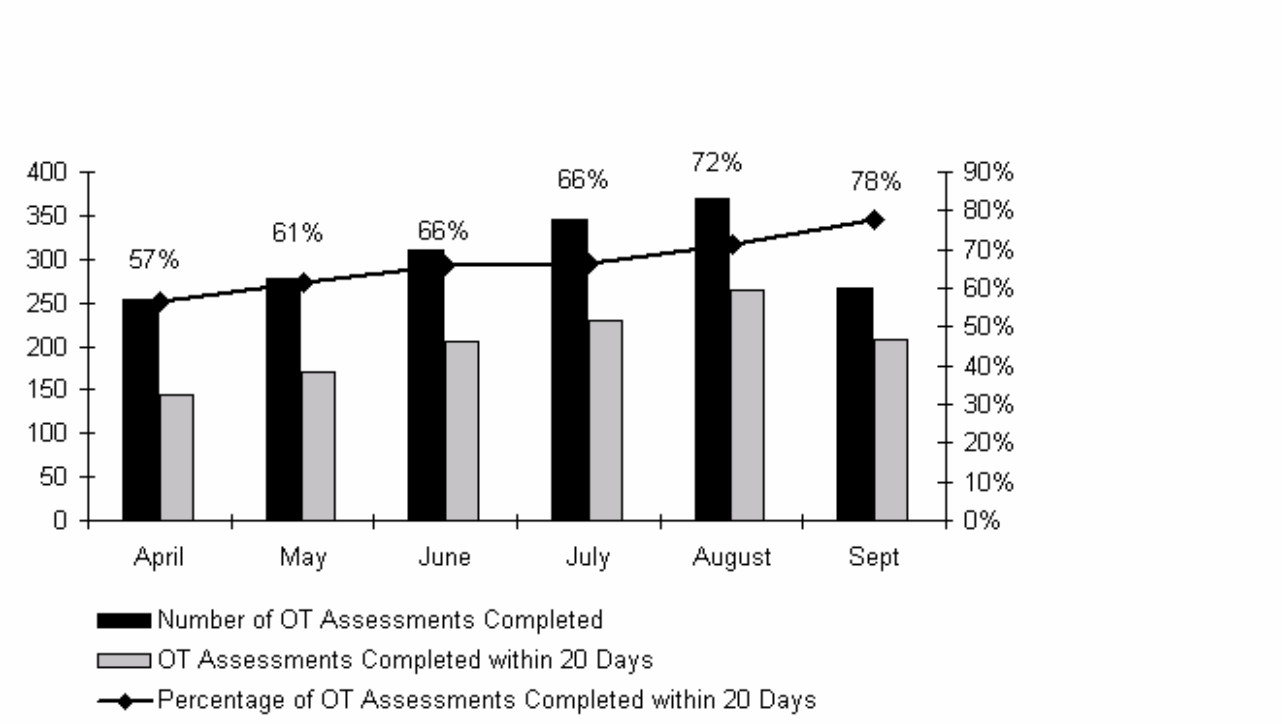
B1. Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared

Performance towards this measure is currently in progress. It has been agreed to start with the Nursing Homes LES and scale up, learning from successful tests of change. As of the 31st December 2011 there were 1,127 Tayside residents included within the LES.

Information systems will be developed to monitor the number and % of these people who have an Anticipatory Care Plan in place.

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

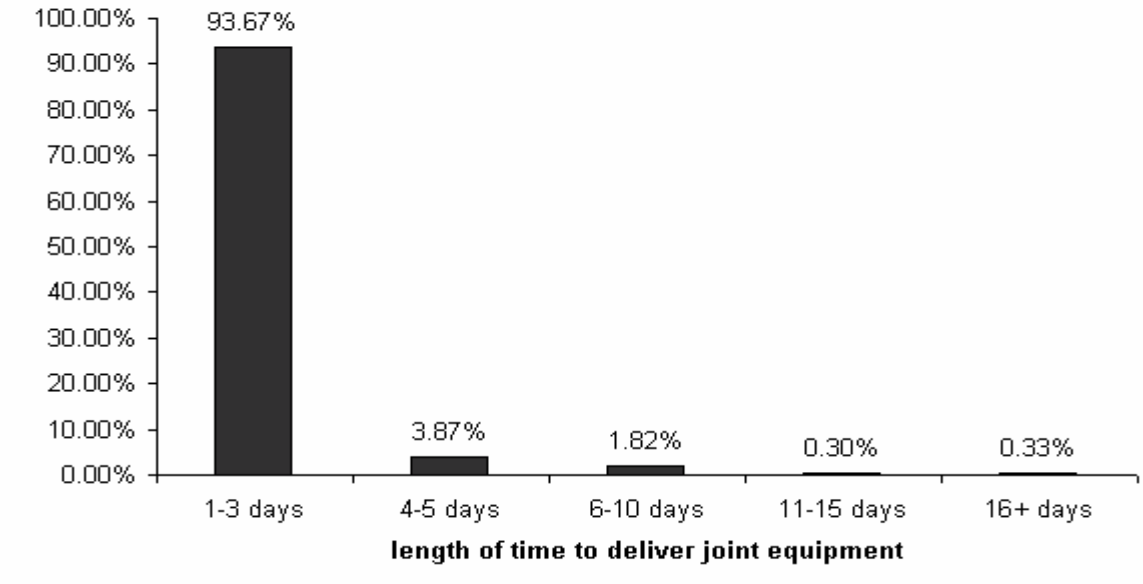
Chart 8 - Number of Community Care Occupational Therapy and % of these completed within 20 days



Delivery of joint equipment Q2 2011/12

6,918 pieces of joint equipment were issued at a value of £373,134

Chart 9 length of time to deliver joint equipment



What is the data telling us?

- The data indicates an overall increase in the volume of OT assessments completed and a proportionate increase in the number that are completed outwith 20 days. These assessments primarily relate to non-urgent referrals and/or delays in completing discharge due to changing health status prior to hospital.
- Urgent and high priority referrals are completed within 24 hours, facilitating discharge from hospital.
- Our changes to the service have resulted in a more responsive service with 94% of deliveries of equipment completed within 3 days of request.

What are our current challenges?

- Managing increased activity in the community.
- Working with varying priorities for housing adaptations across different housing providers and the multiple funding streams.
- The requirement for specialist equipment within care homes and agreeing a criteria and funding stream to meet this demand.
- Managing expectations both politically and publicly regarding the criteria for adaptations.
- Lack of suitably adapted housing or stock currently occupied by older people which can be readily adapted.

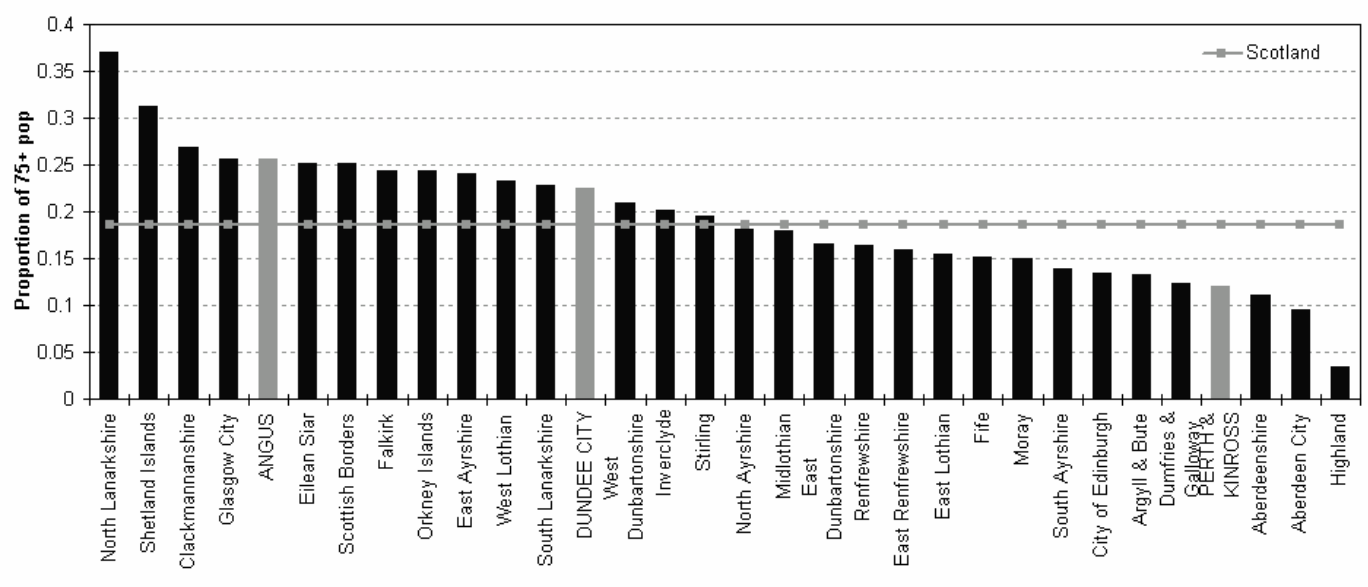
How will this impact on our Change Plan work streams and programmes?

- We will map both current and future equipment requirements in care homes, including specialist equipment and develop a protocol which clarifies the responsibility for equipment provision.
- We will continue to review the provision of equipment.
- We will remodel our assessment pathways, broaden access to equipment and increase range of equipment which can be self assessed for.
- We are reviewing our model of community rehabilitation.

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

Breakdown of Home Care Clients in receipt of a community alarm or other telecare service by Local Authority, 2010.

Chart 10 - Proportion of 75+ population with a telecare package, 2011



What is the data telling us?

- 23% of the 75+ population in Dundee receive telecare support. This is greater than the Scotland figure of 19%.

What are our current challenges?

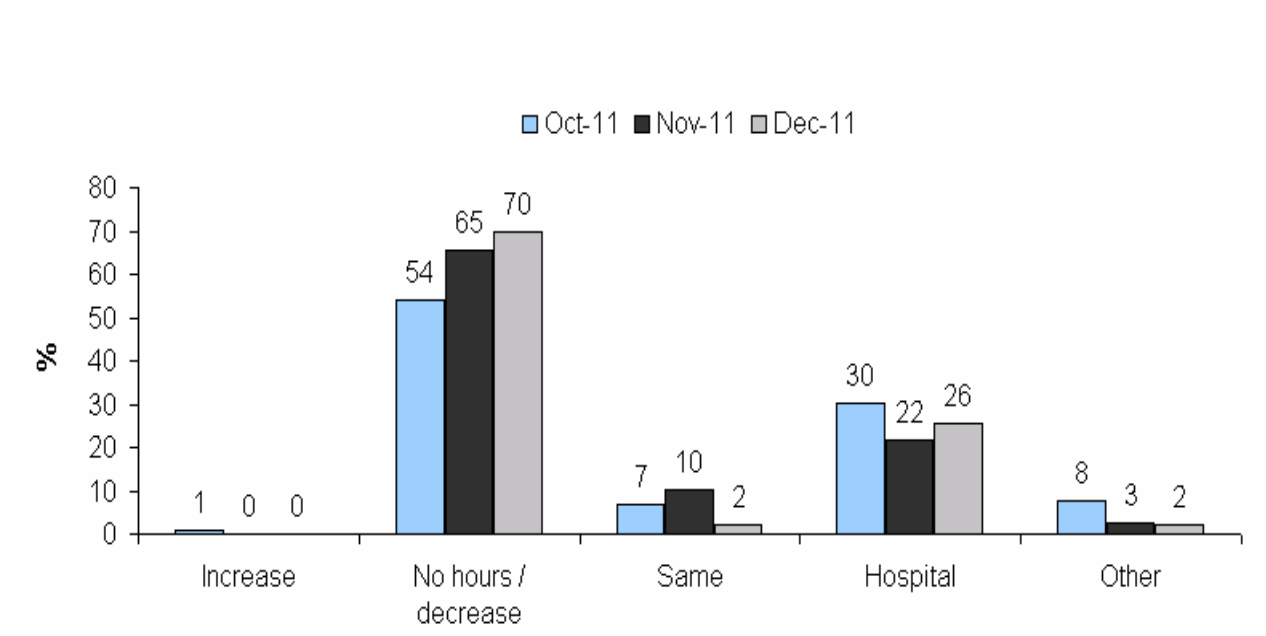
- Skilling the workforce to recognise the need for and application of, telecare equipment during the assessment process.
- Widening the awareness of telecare and telehealth across all partner agencies.
- The need for more primary care dialogue with GPs.
- The increased demand for equipment as more people with complex needs are maintained safely in their homes.
- Developing a range of telehealth and telecare equipment to support carers.
- Developing a range of telehealth and telecare equipment to support people with dementia.

How will this impact on our Change Plan work streams and programmes?

- We are finalising our Tele-care / Tele-health Strategy and have an established Project Board directing our approach.
- We are developing contractor awareness of smart technology.
- We continue to expand the range of telecare equipment available.
- We will continue to train staff in the assessment for and provision of telecare equipment.
- We will encourage earlier introduction of self-management telecare to prevent crisis admissions.
- We will develop the smart flat for assessment and rehabilitation.
- We will integrate the use of telehealth and telecare into the Falls Strategy.

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

Chart 11 - Change in hours required following enablement



What is the data telling us?

- The agreed baseline for Change Plan performance is Quarter 3 2011/12. Chart 11 splits Quarter 3 up into months. Although Chart 11 shows variation over the 3 months, on average 61% of people completing enablement during Quarter 3 required no homecare hours or reduced homecare hours following enablement.
- The successful introduction of the enablement approach to the delivery of homecare in Dundee as a result of collaboration between the Council and Dundee CHP Allied Health Profession staff is displaying two long term effects, a reduction in the number of people requiring intensive homecare and a reduction in care home admissions.
- The service re-design enables individuals to be discharged from hospital without delay, thus reducing delayed discharges.
- The service is currently supporting individuals at home, who previously were assessed as requiring residential care. The success rate of this is being monitored, and although not suitable for all individuals, the early indications are that this is successful in preventing admissions to residential care.
- Local surveys demonstrated high levels of customer satisfaction with 74% of people feeling that enablement had benefited them and 87% rating the service to be either excellent (62%) or very good (25%).

What are our current challenges?

- Ensuring assessments are completed in the most appropriate place to allow people to return home from hospital as quickly and safely as possible.
- We still need to further reduce the number of people admitted to care homes.
- We need to redesign our services to integrate crisis response in the community.
- We need to skill social care staff in meet more complex needs.
- Applying the enablement approach when working with people with dementia.
- Demonstrating the links between community based changes and improved performance within the acute hospital.

How will this impact on our Change Plan work streams and programmes?

- We need to remodel the enablement approach to meet the needs of people with dementia.
- We will develop an enhanced enablement model to meet more complex needs.
- We will adopt the enablement approach across all services.
- We will monitor readmission rates to hospital as part of our continuous improvement.

B5. Respite care for older people per 1000 population

Chart 12 - Provision of respite weeks in Dundee City, 2006/07 to 2010/11

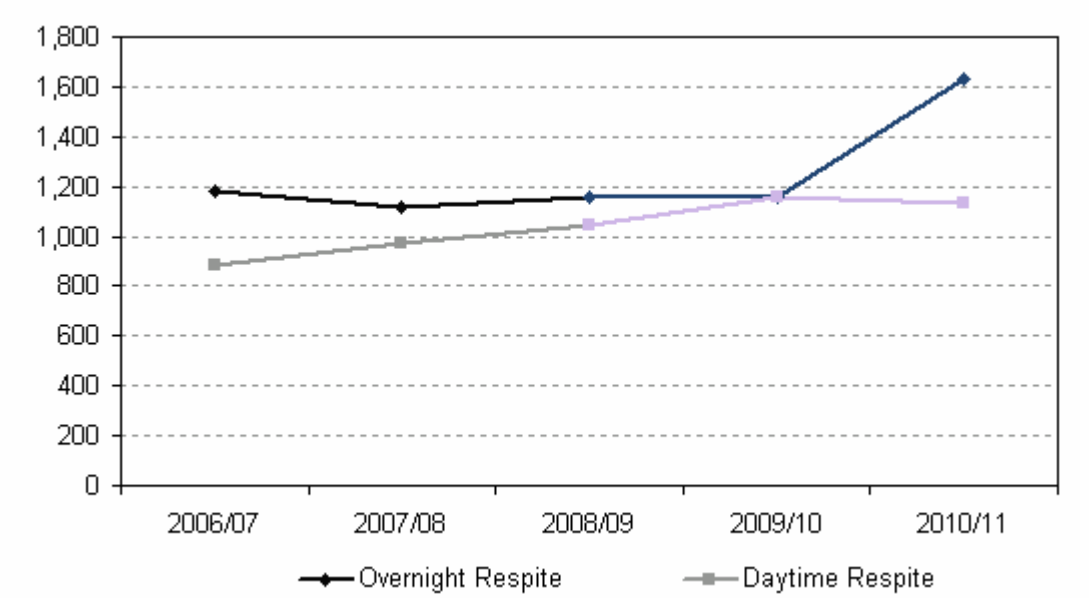
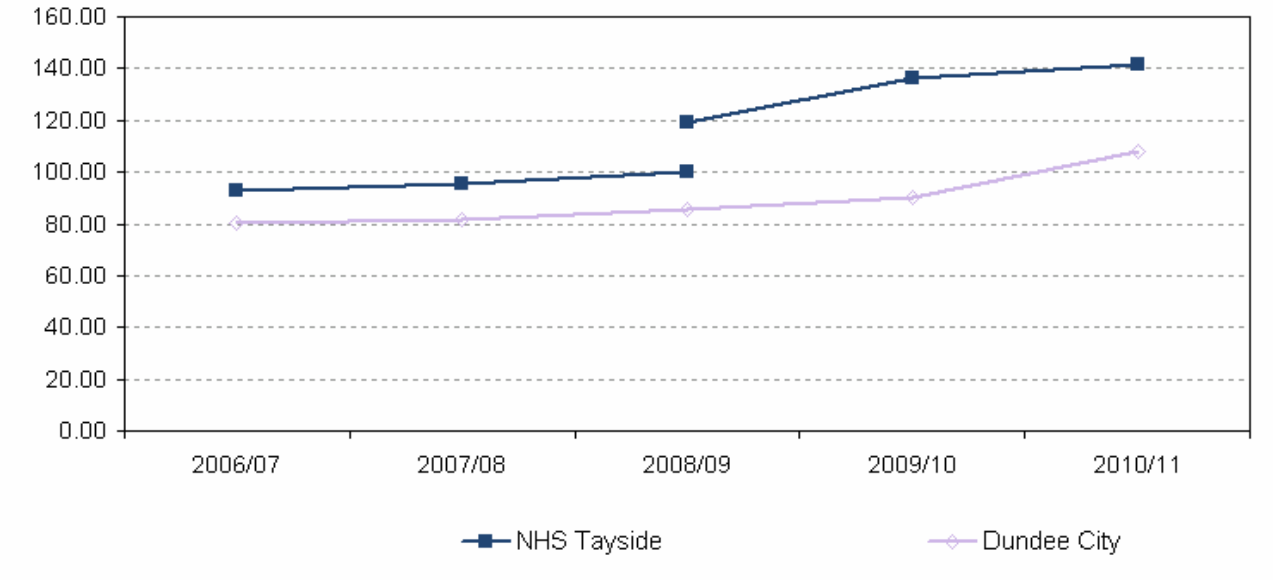


Chart 13 - Rate of respite provision per 1,000 population, 2006/07 to 2010/11



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 12 and 13 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.
- Performance has improved since 2010/11 reporting.

What are our current challenges?

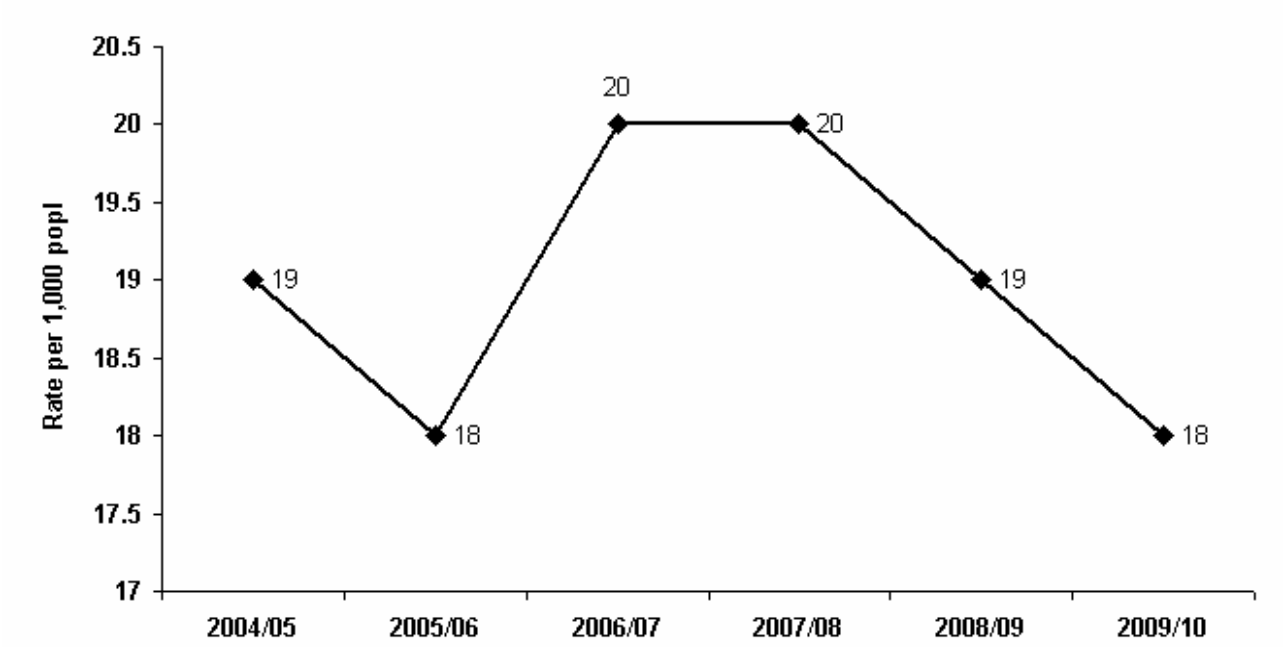
- Ensuring respite is not always reactive to emergency situations.
- We recognise that the current range of short break services available does not offer sufficient choice.
- Responding to the increasing numbers of people with dementia admitted into care homes from the community for emergency respite, as a result of carer's stress.
- We have a low uptake of carers assessments by carers.
- Demographics - people are living longer with greater demand on services.
- We need to raise carers' awareness regarding short breaks and respite options.
- Our unpaid carer population is ageing.

How will this impact on our Change Plan work streams and programmes?

- It has been identified that respite provision should be used more proactively to assist carers, rather than reactively in response to crisis situations.
- We will undertake an options appraisal to determine the future model of short breaks in the city.
- Models of respite will be reshaped, particularly in dementia services and care at home.
- We will increase the provision of carer's assessment which will assist the allocation of respite to those in greatest need.
- The 'Time 4 U (Short Breaks)' project which will further support carers when they need it most is being piloted. We will evaluate this and expand it as required.

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

Chart 14 - Rates of 65+ conveyed to A&E with principal diagnosis of a fall per 1,000 population. Source: CCBN



What is the data telling us?

- The rates of 65+ being conveyed to A&E with a principle diagnosis of a fall have remained steady over the last 6-7 years. In 2009/10, Dundee had a lower rate than the Scottish average.

What are our current challenges?

- Identifying people who are at risk, in particular those people who have had a fall where no medical treatment is required.
- Reducing length of time between Occupational Therapy referral to assessment.
- Providing appropriate public information about falls prevention.
- Developing a simple falls pathway which has dedicated resources.
- Demonstrating the links between community based changes and improved performance within the acute hospital.
- Managing falls during out of hours.
- Meeting the demands on the current Social Care Response Service.
- Supporting individuals following a fall.
- A range of local community supports are available, but there are no connections between these supports and clinical assessment services.

How will this impact on our Change Plan work streams and programmes?

- An additional falls measure is being developed across NHS Tayside relating to the number of over 75s admitted to hospital with diagnosis of a fall.
- We are developing a falls pathway for the partnership which will include early intervention and screening services, a falls clinic and a range of supports, including community group exercise activities and 1 - 1 therapies led by volunteers.
- In partnership with a voluntary agency, we will develop a quick response sitter service for older people who have been affected by a fall.

- We will develop an information pack for people who have fallen or who are at risk of falling.
- We will provide a comprehensive health assessment, including medication reviews, for people who are at risk of falls.

B7. Proportion of frail emergency admissions that access specialty unit within 24 hours

- Further development required to allow reporting

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

- Further development required around definitions, to allow reporting

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

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

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

C1, C2 and C3 - we are awaiting further detailed guidance.

4.2 Local improvement measures

In our Change Plan 2010/11 we identified a number of improvement measures which were aligned against two work streams. The measures which coincide with the national outcomes are as follows:

- maintain more people at home
- improve quality of life for service users and carers
- improve service user and carers health and well being
- reduce care home placements
- avoid social admission/re-admission
- reduce emergency respite placements
- reduce hospital admission
- reduce bed days
- reduce acute hospital beds.

We have reported our progress against these measures in sections 4.1.

The local measures which relate to outcomes are as follows:

- improve efficiencies
- sustainable joint workforce with right skills mix
- harmonise terms and conditions
- reduce building costs

- integrated assessment framework
- further integration across sectors
- build community resilience
- manage resources to meet growing demand
- develop social enterprise
- increase choice
- extend co-production
- increase independence and control
- have an informed public

We have reported our progress against these measures within the work plan as detailed in section 4.4.

In addition, local performance, activity and outcome measures have been developed against each Change Plan programme. Diagrammatic representations of the measures set against Work Stream 1 and Work Stream 2 are included in Appendices 1 and 2. These measures were developed in partnership with the programme leads. We anticipate that future progress will be assessed against these local measures.

The position in Tayside will be monitored using the Tayside Change Fund Metrics which can be found in Appendix 3.

4.3 Partnership resources

The anticipated growth in Social Work expenditure for older people based on demand is outlined in Table 6 below. It has been calculated by estimating the age related assessed demand for care and support in congregate and community settings.

NHS Tayside estimates it will spend c£107m on services for Older People in 2011/12. The impact of a 29.2% growth in over 65s by 2033, and the very significant growth in over 85s within that age group, will put significant additional strain on NHS services. While it would be incorrect to say there will be a direct correlation between required increased spend on Older People and the growth of that population cohort, there will be some correlation. Even if the required increase in spend on over 65s only equated to half of the growth in population cohort size, then that 15% increase would still equate to additional cost increases of approximately £16m over this 20 year period. These figures have not been factored into the demographic pressures below but must be considered within the overall resource allocation process in future years.

Table 6 - Projected Growth in Expenditure Required to Support Social Work Community Response

Age Band	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £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

The forecast outcomes noted below are 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 7 - Forecast Outcomes

	2012/13	2013/14	2014/15	2015/16	2016/17
Reduction in No of Care Home Beds (no of placements)	18	18	36	54	54
Reduction in No of Acute Sector Bed Days	n/a	n/a	n/a	tbc	tbc

Theoretically; it could be anticipated that a reduction in delayed discharge days or emergency admissions will reduce occupied days and bed numbers. However there is the possibility that Change Fund investment will not directly realise immediate operational savings in this area. This explains the projected delay in NHS resource release.

Table 8 - Estimated Resource Release

	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17
Cumulative Saving - Care Home Beds	390	390	780	1,170	1,170
Resource to be released via NHS Tayside and reflected in NHS Tayside's Strategic Financial Planning				558	1,116
Total Potential Resource Release	390	390	780	1,728	2,286
Net Additional Spend Required to Meet Demographic Pressures	1,696	2,738	3,391	3,486	n/a
Change Fund Investment	2,232	2,232	2,232	2,232	n/a

4.4 Successes and lessons learnt

We have reviewed our progress against the Dundee Partnership Change Plan 2011/12, recorded the successes and through the planned actions for 2012/13, addressed any lessons learned or missed targets. In the revised Dundee Partnership Change Plan 2012/13 we have matched the 11 programmes to the Reshaping Care Pathway. The updated Dundee Partnership Change Plan for 2012/13 is presented below.

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 developing 100 Housing with Care Units and providing integrated care and health support which includes the potential for overnight care.

Progress made against Change Plan 2011/12
During the first year of our Change Plan we were successful in completing the following actions. We have:

- continued to provide 44 existing Housing with Care units and have maintained this service;
- scoped out our future model of Housing with Care;
- completed a Partnership Agreement to develop 16 - 20 Housing with Care places with 2 Housing Associations; and
- agreed the bridging funding to modify existing sheltered accommodation into Housing with Care.

Outstanding Action from Change Plan 2011/12

- We will fully scope out proposals for additional Housing with Care accommodation to meet our proposed target of 100 Housing with Care units. This and any revision to this target will be included in the 10 year commissioning plan.

Proposed Actions Change Plan 2012/13
To progress our Change Plan, during 2012/13 we will:

- complete the commissioning of 16 - 20 Housing with Care units and make placements;
- expand our current provision of Housing with Care to increase provision by a further 6 places;
- remodel our current provision to include overnight responses and introduce a new staffing model thus meeting more complex needs;
- explore further opportunities for the commissioning of additional Housing with Care; and
- decrease our levels of care home placements in line with the increase in Housing with Care provision.

Outcome / Output

- maintain more people at home
- avoid social admission/re-admission/delayed discharge
- improve quality of life for service users and carers

- improve service user and carers health
- reduce care home admissions
- reduce emergency respite placements
- reduce hospital admission
- reduce bed days
- reduce acute beds

Links to Reshaping Care Pathway

- Preventative and Anticipatory Care
- Effective Care at Times of Transition

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

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

Progress made against Change Plan 2011/12

During the first year of our Change Plan we were successful in completing the following actions. We have:

- changed our culture of assessment with more people completing their assessment at home;
- additional enablement teams to facilitate discharge;
- re-established our Intermediate Care Unit and revised the criteria;
- remodelled our overnight services to make them more responsive;
- continued to roll out our telecare strategy; and
- progressed our range of carers' supports.

Outstanding Action from Change Plan 2011/12

- We will scope out a model of enhanced enablement to meet more complex needs in the community and include this in our 10 year commissioning strategy.

Proposed Actions Change Plan 2012/13

To progress our Change Plan, during 2012/13 we will:

- remodel our Care and Assessment services to meet the ongoing needs of older people with less complex needs and avoid unnecessary readmission to hospital;
- expand our current enablement services to develop an enhanced enablement service for older people with more complex needs;
- scope out different models of intermediate care and step up facilities;
- review our models of care and assessment in hospitals and remodel this in line with our changes to move assessment into the community;
- research the reasons for emergency respite admissions and scope out a range of responsive and crisis support services;
- purchase additional hours for Mental Health Officer assessment to facilitate timely discharge; and
- develop a hospital based Welfare Rights resource to facilitate timely discharge.

Outcome / Output

- maintain more people at home
- reduce acute beds
- reduce care home placements

- reduce bed days

Links to Reshaping Care Pathway

- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Effective Care at Times of Transition
- Hospital and Care Home(s)

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

Aim is to prevent older people where ever possible from being admitted from a Care Home to an acute setting.

Progress made against Change Plan 2011/12

During the first year of our Change Plan we were successful in completing the following actions. We have:

- recently established a Care Home Liaison Team which will provide clinical support, training and skill development for nursing homes;
- developed named Community Mental Health link workers for all care homes;
- recently appointed two Community Mental Health Liaison Nurses who will provide dementia care support, training and skill development and who will support the management of behaviours which challenge services;
- progressed our learning network events for care home providers and covered subjects such as - outcome assessment, dependency management, and quality indicators. Our event this month will look at falls management;
- dedicated hours from community nursing to provide tissue viability clinical advise, support and education in care homes and to build capacity to improve practice in tissue viability;
- purchased some specialist equipment to support people with dementia in care homes;
- maintained a Nursing Home LES, which contributed to the alignment of GP practices to nursing homes. This has made a significant positive impact on the number of admissions from care homes to hospital; and
- completed a palliative care project improving end of life care for older people in care homes.

Outstanding Action from Change Plan 2011/12

- We will align Medicine for the Elderly Consultant support to care homes through the roll out of our Integrated Services Model.

Proposed Actions Change Plan 2012/13

To progress our Change Plan, during 2012/13 we will:

- explore the development of a quality improvement framework in partnership with the Care Inspectorate, NHS Tayside, Dundee City Council and care home providers;
- evaluate the impact of the Care Home Liaison Team;
- evaluate the impact of the Community Mental Health Liaison Nurses;
- produce and disseminate a tissue viability resource pack to care homes and establish pathways to continuous advice and support;
- introduce a Nursing Home LES light which will offer a contract with GP's to capture those patients not covered by the full LES;

- facilitate two way contact with Care Inspectorate and GPs e.g. Protected Learning Event March 2012;
- look at the ways specialist equipment can be provided to support people to remain in care;
- provide advice and best practice when moving and handling;
- provide Best Practice in Dementia Care (Facilitators Training) for all care homes.

Outcome / Output

- avoid social admission/re-admission/delayed discharge
- improve quality of life for service users
- improve service user health
- reduce emergency respite placements
- reduce hospital admission
- reduce bed days
- reduce acute beds

Links to Reshaping Care Pathway

- Effective Care at Times of Transition
- Hospital and Care Home(s)
- Enablers

Programme 4 - Telecare / Telehealth

Aim is to enhance independence and reduce reliance on statutory care.

Progress made against Change Plan 2011/12

During the first year of our Change Plan we were successful in completing the following actions. We have:

- progressed the Telecare/Telehealth Strategy and will have this ready in February for consultation;
- held training for assessment staff and integrated the use of telecare/telehealth into the assessment process;
- identified 8 assessors who will be local telecare champions and who will help mainstream telecare into services;
- purchased a range of additional telecare supports, such as the Buddy system and the Just Checking system and are using these to assist assessment, plan adaptations, reassure carers and maintain people at home;
- developed a draft referral pathway; and
- increased our technical infrastructure as a base for our telecare progression.

Outstanding Actions from Change Plan 2011/12

- We have purchased a range of telecare equipment and will continue to scope out our requirements in line with the completed Telecare/Telehealth Strategy.
- We will continue to explore the use of medication support and how this might reduce the time spent by community nursing staff administrating medications.

Proposed Actions Change Plan 2012/13

To progress our Change Plan, during 2012/13 we will:

- finalise our Telecare/Telehealth Strategy;
- purchase 21 demonstrator kits to demonstrate supports available to service users and their carers;

- explore the application and impact of telehealth resources across Scotland and pilot approaches locally;
- complete the development of Earn Crescent (smart flat) which will enable hospital assessment to take place outwith the hospital setting;
- develop contractor awareness;
- provide further training for health and social care staff;
- progress medication support systems for older people with polypharmacy use;
- develop a telecare equipment pack in line with our Falls Strategy, for those at risk of falls or who have fallen; and
- continue to develop the options available to people as detailed below:
    - addition of smart technology cabling in new build homes,
    - smart technology in group accommodation,
    - telecare to offer safety/confidence e.g. bogus caller buttons,
    - fire prevention connected to Community Alarm,
    - exit sensor/GPS location technology solutions, and
    - develop a range of telecare supports for carers.

Outcome / Output

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

Links to Reshaping Care Pathway

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

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.

Progress made against Change Plan 2011/12

During the first year of our Change Plan we were successful in completing the following actions. We have:

- increased our enablement services facilitating discharge from hospital;
- reviewed our enablement referral pathways to include direct referral systems for Allied Health Professionals (AHP's) and discharge co-ordinators;
- increased the flow of older people leaving hospital to return home with either no delay or minimal delay;
- established the Food Train shopping service;
- supported a local housing organisation to improve their resources for a local home help service;
- re-established our intermediate care and reviewed the criteria for this unit;

- agreed our Integrated Care Services Model.
- commenced alignment of the Medicine for the Elderly Consultants with GP practices;
- implemented the use of the Risk Stratification Tool to identify people at risk of admission in the coming year;
- determined the Virtual Wards Co-ordination role;
- developed sessional input to the Virtual Ward model from a range of agencies/personnel and developed core competencies;
- further developed links to rapid assessment through Medicine for the Elderly Day Hospital;
- strengthened GP /Clinical decision making on care pathways;
- looked at ways to provide community based assessment for equipment;
- provided more streamlined access to equipment;
- piloted early intervention when people experience mobility difficulties through the physiotherapy clinic;
- established a Single Point of Access (SPA) arrangement within Community Nursing to improve access to the nursing service and ensure a timely response to assessing needs;
- evaluated the use of the Single Shared Assessment documentation; and
- developed the 'CISCO' approach and link to Virtual Ward initial assessments.

Outstanding Actions from Change Plan 2011/12

- We will commence the redesign of our assessment documentation to reflect our outcome/personalisation approach.
- We will continue to pursue electronic information sharing across the partners, including Anticipatory Care Plans.
- We work towards the rolling out the Virtual Ward model city wide as an early intervention approach.
- We will strengthen the links between the patient's own GP, Psychiatry of Old Age and / or Medicine for the Elderly.
- We will continue to develop a model for slow stream rehab.
- We will continue with our review of initial assessment teams to provide an integrated response.

Proposed Actions Change Plan 2012/13

To progress our Change Plan, during 2012/13 we will:

- develop a falls strategy and pathway which includes
  - a first response service and triage,
  - falls sitter service to reassure older people who have fallen,
  - a screening and assessment service,
  - falls information leaflet and information pack,
  - provide additional opportunities for exercise: both for 1 - 1 and groups,
  - telecare equipment for those at risk or who have fallen, and
  - aids and adaptations to minimise risk;
- develop an outcome focused assessment framework and associated assessment tools;
- roll out our Integrated Care Services Model (including Virtual Wards) city wide;
- pilot a treatment centre in one area to release Community Nursing capacity by moving the management of leg ulcers and complex dressings from home visiting and hospital settings.
- enhance the Community Nursing Service with 4 additional practitioners to implement an earlier intervention/case management approach to service users/patients admitted

to the Virtual Ward that is not exclusive to the household and builds on learning from our Virtual Wards;
- establish/embed pathways to access for social care; service users; carers; acute hospitals; General Practice and voluntary agencies;
- scope out opportunities for the integration of initial assessment services and overnight services;
- pilot a Health Care Assistant Medication Team for community service users;
- complete our Medication in the Community policy for social care services;
- upskill 4 locality pharmacists to support clusters of GPs by providing expert input to complex polypharmacy reviews; and
- complete our technical solution to provide a means for electronic sharing of information, including anticipatory care planning.

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

Links to Reshaping Care Pathway
- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Effective Care at Times of Transition
- Hospital and Care Home(s)

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.

Progress made against Change Plan 2011/12
During the first year of our Change Plan we were successful in completing the following actions. We have:
- undertaken a Creating Breakthrough training programme which will assist managers tackle the difficulties arising from change;
- reviewed and changed our joint management arrangements/forum;
- commenced our planning to move to a single collocated site;
- commenced a redesign of our Community Mental Health Teams which will look at structures, roles and approaches to service delivery;
- commenced a redesign of Occupational Therapy/Physiotherapy services across both the hospital and the community; and

- explored the use of electronic monitoring systems to map overlap between service providers, professions and to reduce duplication and waste in our services.

Outstanding Actions from Change Plan 2011/12

- We are still reviewing the current roles/posts across our services. Our intention would be to manage this review within the individual Change Plan work streams and report progresses as these arise.

Proposed Actions Change Plan 2012/13

To progress our Change Plan, during 2012/13 we will:

- produce a Dundee Partnership position statement on the plans for integration within Dundee;
- complete the redesign of the Older People Community Mental Health Teams; and
- complete the move into a collocated site.

Outcome / Output

- improve efficiency
- sustainable joint workforce with right skills mix
- harmonise terms and conditions
- reduce building costs
- integrate assessment framework

Links to Reshaping Care Pathway

- Enablers

WORK STREAM 2 - BUILDING A SUSTAINABLE COMMUNITY INFRASTRUCTURE

Programme 7 - Improve Resources and Support for People with Dementia

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

Progress made against Change Plan 2011/12

During the first year of our Change Plan we were successful in completing the following actions. We have:

- piloted an Early Detection Clinic within the Community Mental Health Teams for Older People and are providing a quicker diagnosis;
- commissioned an early detection support service from Alzheimer's Scotland to support older people and their carers and the point of diagnosis;
- set up a multi-agency working group, including care home providers, to develop a revised model of dementia care;
- increased our specialist Community Mental Health Social Care Team to support more older people;
- reviewed our overnight services to provide a more flexible response;
- recently appointed two Community Mental Health Liaison Workers who will provide support to care homes and carry out assessments within Ninewells Hospital;
- invested in the development of acute based allied health staff in undertaking Dementia Champion training;

- increased our range of telecare services to include the Buddy system, the Just Checking system, door sensors, etc which enable more people to remain safely at home and minimise risk;
- developed a specialist dementia nurse role in Ninewells Hospital that will assist with skills development and staff training; and
- commenced a full review of the Community Mental Health Teams which will also include the Memory Clinic.

Outstanding Actions from Change Plan 2011/12

- We will consider the use of specialist equipment for older people with dementia and their carers as part of our Occupational Therapy review.
- We will review the team roles within the Community Mental Health Teams as part of the Community Mental Health review and our plans for integration.

Proposed Actions Change Plan 2012/13

To progress our Change Plan, during 2012/13 we will:

- contribute to the review of respite/short breaks in Dundee to ensure that we meet the needs of carers who care for people with dementia;
- commission 2 respite care home beds to meet the needs of older people and their carers and evaluate this provision in line with the respite review outcomes;
- agree a model for dementia care and commission specialist dementia care in care homes;
- review the use of the local authority care homes and upgrade one home to provide specialist dementia care;
- purchase the Best Practice Dementia Facilitators training (Stirling University) and make places available for all Dundee older people's care homes;
- review the current hospital provision for people with end of life dementia/continuing care needs and procure more appropriate accommodation;
- review our models of support for people with end stage dementia;
- enhance and develop Occupational Therapy services to address dementia specific environmental adaptations;
- complete the redesign of community mental health services;
- promote self directed support for people with dementia; and
- develop a palliative care volunteer network to support older people with palliative care needs and their carers

Outcome / Output

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

Links to Reshaping Care Pathway

- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Effective Care at Times of Transition
- Hospital and Care Home(s)

Programme 8 - Further Develop an Integrated Occupational Therapy Service and Equipment Service

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

Progress made against Change Plan 2011/12
During the first year of our Change Plan we were successful in completing the following actions. We have:

- commenced a review of the Occupational Therapy services in Dundee;
- made better use of the equipment management services (ELMS);
- established a joint management group;
- consolidated our equipment guidance;
- built a broader assessment and prescribing base for equipment;
- enhanced the enablement services to provide a rehabilitative approach; and
- appointed a Moving and Handling Co-ordinator who will work across health and social work services.

Outstanding Actions from Change Plan 2011/12

- We will move towards a more integrated equipment service and Occupational Therapy and Physiotherapy service following our service reviews.

Proposed Actions Change Plan 2012/13
To progress our Change Plan, during 2012/13 we will:

- complete our review of the joint equipment service and move to an integrated equipment service;
- develop a policy for Bariatric equipment;
- develop the use of equipment and adaptation responses to behavioural issues;
- integrate Community Occupational Therapy/Allied Health Professions Services through staff development, training and remodelling; and
- integrate Moving & Handling services for service providers with integrated protocols; single training/assessment service; and develop agreed processes.

Outcome / Output

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

Links to Reshaping Care Pathway

- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Enablers

Programme 9 - Carer Support

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

This element of the Change Plan is managed by the Dundee Carers Centre, an organisation which represents the views of carers.

Progress made against Change Plan 2011/12
During the first year of our Change Plan we were successful in completing the following actions. We have:

- reviewed our carers' assessment and are piloting its use;
- developed a new model of respite care - Time 4 U - which provides a short break voucher scheme for carers' use;
- increased our enablement services;
- increased our specialist Community Mental Health Social Care Team;
- agreed a proposal to develop a community cafe in one sheltered housing complex for people with dementia and their carers;
- agreed a budget for carer support at time of crisis or stress (On the Spot) which provides therapeutic support, short term resources and individual counselling;
- appointed a link worker for carers aligned to the virtual ward remodelling; and
- developed a range of telecare supports such as the Buddy system, the Just Checking system, etc which reassures carers as to the safety of their cared for person.

Outstanding Actions from Change Plan 2011/12

- We will develop moving and handling/equipment training for carers as part of our approach to an integrated moving and handling service.
- We will promote self directed support for carers and individualised budgets as part of our personalisation strategy.

Proposed Actions Change Plan 2012/13
To progress our Change Plan, during 2012/13 we will:

- undertake a scoping exercise of current respite provision and develop an options appraisal scheme for moving forward;
- continue to promote the use of the Time 4 U voucher scheme, evaluate the usage and increase as required;
- continue to promote the On the Spot project, evaluate and increase as required;
- purchase two specialist dementia care respite beds in care homes to meet the need of carers of people with dementia for 1 year and review the future model of care in line with the outcome of the respite review;
- expand the range of respite facilities and pilot new ways of working;
- provide increased support for carers with training in moving and handling and the use of equipment;
- build capacity for carers by developing a peer befriending and mentoring network; and
- develop a palliative care volunteer network to support older people with palliative care needs and their carers.

Outcome / Output

- maintain more people at home
- avoid social admission/re-admission/delayed discharge

- improve quality of life for carers
- improve carers health
- reduce care home admissions
- reduce emergency respite placements
- reduce hospital admission
- reduce bed days
- reduce acute beds

Links to Reshaping Care Pathway

- Preventative and Anticipatory Care
- Proactive Care and Support at Home

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, volunteering, commissioned services and social enterprise and will address the community needs of both local communities and/or communities of interests.

This element of the Change Plan is managed by the Dundee Voluntary Gateway.

Progress made against Change Plan 2011/12

During the first year of our Change Plan we were successful in completing the following actions. We have:

- established an Older Peoples Voluntary Sector Network;
- established an infrastructure to support the development and sustainability of community capacity building models;
- established a year on year Community Capacity Fund managed by the Dundee Voluntary Gateway which supports tests of change within the community and allocates resources to community organisations;
- developed a criteria and process for the evaluation of bids and allocation of resources under the Community Capacity Fund;
- used the Community Capacity Fund to support organisations identify opportunities for the development of social enterprise approaches;
- recently appointed a Volunteer Development Worker who will support and enable volunteering services which benefit older people; and
- allocated resources to organisation to support community capacity building, including:
    - a community cafe in one sheltered housing complex for people with dementia and their carers;
    - training resources to facilitate the expansion of a voluntary sector home help service;
    - a network to support and train older people in sheltered housing to support peer run activities and opportunities for socialisation;
    - a home support service which will: scope out current care and repair services, handyman services and repair services; develop a directory of approved providers; create a one stop hub for home maintenance information and advice and provide small home repairs enabling older people; and
    - pilot a community transport service using volunteer drivers in one part of the city.

Outstanding Actions from Change Plan 2011/12

- Our newly appointed Reshaping Care Development Worker will work with communities to test models of co-production during 2012/13 and we have allocated a small resource to support tests of change.
- We will further develop and explore volunteering models such as Time Banking and Lend a Hand schemes.

Proposed Actions Change Plan 2012/13
To progress our Change Plan, during 2012/13 we will:

- build on the mapping, engagement and capacity building with the wider voluntary sector;
- maintain our Community Capacity Fund to support the development of community capacity building and social enterprise approaches;
- expand our engagement with local communities and work with them to access community assets;
- manage a small grants resource to support community development;
- recognise the personal, health and institutional barriers to volunteering for older people and provide a bridge which facilitates opportunities for older people to volunteer; and
- work with other work streams to develop the use of volunteers in areas such as palliative care, the falls strategy and carers.

Outcome / Output

- maintain more people at home
- build community resilience
- manage resources to meet growing demand
- develop social enterprise
- increase choice
- improve service users and carers health and wellbeing
- extend co-production
- further integration across sectors

Links to Reshaping Care Pathway

- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Enablers

Programme 11 - Improved Models of Public Information

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

This element of the Change Plan is managed by the Celebrate Age Network, an older people's organisation which represents the views of older people

Progress made against Change Plan 2011/12
During the first year of our Change Plan we were successful in completing the following actions. We have:

- scoped out our models of information for older people;
- reviewed the use of the Celebrate Age Network website and are in discussion with partnership agencies to develop this further;
- agreed a partnership arrangement between the Celebrate Age Network and Dundee Independent Advocacy Service to scope out and provide a local Older Peoples Helpline; and
- researched the views of older people in Dundee using the Older Peoples Outcome Star in both structured 1-1 interviews and group sessions which will inform the future shape of care and the 10 year commissioning strategy.

Outstanding Actions from Change Plan 2011/12

- We will introduce different models of information for older people, such as the use of the Television Community Channel over the next year and evaluate its use by older people.

Proposed Actions Change Plan 2012/13

To progress our Change Plan, during 2012/13 we will:

- expand the resources of the Celebrate Age Network to facilitate the engagement of older people in the development of the Reshaping Care changes;
- complete the development of an older people's website for Dundee citizens;
- establish our older people's helpline and evaluate its use;
- develop a wider range of information resources and link this with other work streams; and
- support individuals in the use of information technology.

Outcome / Output

- maintain more people at home
- avoid inappropriate social/health interventions
- increase independence and control
- have an informed public
- improve the quality of life for service users and carers
- improve service users and carers health

Links to Reshaping Care Pathway

- Preventative and Anticipatory Care
- Enablers

Summary - Self Assessment

In this summary we have taken our self assessment and analysed our progress against the Reshaping Care Pathway.

Preventative and Anticipatory Care

The 85+ population in Dundee is expected to double by 2033 and it is recognised that anticipatory and preventative support is essential to maintaining people safely at home for longer. Our overall objective is to strengthen our community, primary and social care infrastructure. Over the next financial year we will consolidate the work undertaken through the Virtual Ward pilot and the community capacity pilots and roll out our Integrated Care Services Model across the city.

Dementia prevalence is expected to increase and we must ensure that we know who the people affected by dementia are. We will continue to work with the GP practices and care homes, and through the Early Detection Clinic to ensure early diagnosis and appropriate support.

We will develop a Falls Strategy to focus on reducing falls and proactively trying to predict those at risk of falls so that the necessary measures can be implemented. This work will be monitored as part of the Change Plan monitoring arrangements.

Proactive Care and Support at Home

We have increased our telecare provision and technical infrastructure and will continue to develop the range of telecare and telehealth options available to people. We aim to present our telecare/telehealth strategy for consultation in the spring.

Through our review of the Occupational and Physiotherapy services, we are aiming to improve our approaches to older people requiring rehabilitation and equipment based supports and develop an Integrated Equipment Service. This, added to our extended enablement approach, is providing a proactive care and support service response for those identified as requiring community based assistance.

Effective Care at Times of Transition
The redesign of the enablement service in Dundee has been seen as a success. Maximising independence produces better outcomes for individuals and less reliance on care services. Local surveys demonstrated high levels of customer satisfaction with 74% of people feeling that enablement had benefited them and 87% rating the service to be excellent (62%) or very good (25%).

The service re-design enables individuals to be discharged from hospital without delay, thus reducing delayed discharges. This service complements the Intermediate Care Unit facility which supports the discharge of older people with more complex needs.

We are currently supporting individuals at home who previously were assessed as requiring residential care. The success rate of this is being monitored, and the early indications are that this is successful in preventing permanent admissions to residential care. In addition, we continue to monitor the levels of readmission to hospital and/or admission to emergency respite services following enablement to determine how we might further improve our service.

We have not increased the level of Housing with Care units during the first year of the plan, but will have developed an additional 16 - 20 places by October 2012.

Hospital and Care Home(s)
Increasing capacity within the Hospital Social Work Team by moving assessments into the community will ensure resources are focused on improving care pathways for those admitted to hospital. This will have the affect of reducing the length of stay and ensuring assessments lead to optimal care packages being developed which will reduce readmissions.

The number of older people supported in care homes is showing signs of decline, although not at the rate anticipated in 2010/11. The 2012 projected resource release was £770,000 which equates to 37 places at £21,000 per place. We would aim to reduce the placement rate further over the next year.

Occupied emergency bed days for people aged 75+, numbers of emergency admissions from care homes and emergency inpatient bed day rates for patients admitted from care homes have dropped considerably compared with 2009/10 and 2010/11. This can be attributed to improved patient pathways and improved discharge processes.

Data shows us that there is a reduction in the number of older people admitted from care homes to hospital. This change in practice relates directly to both the introduction of the Nursing Home LES and, for some care homes, the palliative care pilot which assisted staff to continue to care for older people at the end of life. The newly developed Care Home Liaison Team and the Dementia Liaison workers will further support this change.

5. Governance

Broadly our Governance arrangements remain as described in the 2011/2012 Change Plan submission. However, we have reviewed our joint management arrangements following a leadership development event. A revised description follows below.

Change Fund monies will be accessed using the resource transfer mechanism. A Tayside Resource Transfer Agreement is in place and schemes of delegation have been confirmed.

We have a Change Plan Monitoring Group with membership drawn from the signatory agencies and carers groups. It has responsibility for allocating the Change Fund monies and monitoring programme progress against agreed outcomes. In addition, we have a Change Plan Implementation Group comprising of the leads of the work stream programmes. This group will hold responsibility for progressing the redesign of services.

Our joint commissioning structure remains in that we have an integrated management group (Community Adult Services Management Team) which has delegated responsibility for our joint financial services for adult care. This management group reports to the CHP Committee and to the Dundee Social Work and Health Committee.

We also have a range of strategic planning groups for adults that have responsibility for developing commissioning frameworks. There is an established strategic planning group for Older People and People with Dementia, which is developing the 10 year joint commissioning strategy.

The Change Plan is 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
- a monitoring database.

In addition, the Chief Executives' Group holds an overview of the Tayside wide implementation of the Change Plan.

6. Carers

6.1 Describe the range of services that improve outcomes for carers

The carer work stream is led by the Dundee Carers Centre in collaboration with the Carers Group. The Centre manages the distribution of a specific carer funding allocation and provides monitoring information on the progress of the carer's projects. In 2011/12, 7.5% of the Change Fund monies were specifically allocated to the carers work stream. For 2012/13 we have assessed the impact on carers from the continuing and proposed programmes and have calculated that the overall allocation will rise to 25.5%.

In 2011/12 three carer's projects were established: the identification of carers through the Virtual Wards, On the Spot and Time 4 U.

<u>Virtual Wards</u>

Dundee Carer's Centre will work with the Virtual Ward pilots in Dundee to identify, assess and provide support for carers. The demographics of the Virtual Ward patients mean that the carers are likely to be older themselves and may have health needs which are not being met. Following assessment, carers will be referred or signposted to the Dundee Carers Centre and/or other support services to address the carers needs. Dundee Carers' Centre will undertake a training needs analysis and design and deliver training to a range of agencies, including to GP's, and provide induction training on the function of the Virtual Wards.

On the Spot

On the Spot supports carers to enable them identify their needs, access appropriate support and plan for the future. Many of the carers referred to Dundee Carers Centre are facing critical situations with immediate pressing issues requiring urgent responses to prevent the break-down of the caring relationships. The ability to buy in services to relieve immediate pressures can allow carers and Dundee Carers Centre to gain time to work out longer-term solutions.

Time 4 U

Time 4 U is a Short Break Voucher Scheme, a simple and flexible way of supporting carers and service users to arrange a break from their caring responsibilities. The Short Break Voucher Scheme gives the recipient a greater level of control without the level of budget management responsibility associated with a Direct Payment.

In addition to the above, the Building Community Capacity work stream allocated funding to Bield Housing Association to pilot a community cafe aimed at providing a drop-in support service for older people with dementia and their carers later this year. The service will work initially with tenants currently living within the sheltered housing scheme and will provide ongoing peer support and a period of respite.

Further projects have been provisionally agreed for 2012/13 and these are detailed below.

Moving and Handling Training for Carers

Carers are at increased risk of both physical and mental health difficulties as a result of their caring role. Moving and Handling support for carers is a key aspect and we will develop and deliver moving and handling support to carers in individuals and groups. The purpose of this project will be to:

- identify carers who are providing care that involves moving and handling and support them to reduce the number of injuries by providing advice and support;
- provide advice and support around the use of equipment and telecare; and
- identify and develop recourses which can support carers.

Short Breaks

We will commission an option appraisal of short breaks based on the views of carers and the people they care for and identify the future options for short breaks.

During the last year there was recognition that carers of older people with dementia do not currently make good use of the respite/short breaks available within the city. This has led to a pattern of emergency respite following crisis. There is a lack of confidence in the current care home provision and the 'spot' purchase approach to provision has led to an inconsistent quality of service. We will purchase 2 respite beds for people with dementia for 1 year, with a specified quality contract arrangement and evaluate this service in line with the mapping exercise described above.

Volunteering

A range of volunteering opportunities were identified which will build older carers' capacity in 2 main areas: firstly, to build a stronger befriending and mentoring network enabling carers to share more effectively their own strategies and tools for coping with the caring role; and secondly, to develop the idea of Carer Ambassadors, who will be trained and equipped to represent the Carers Centre and reach out to 'hidden carers' in local communities.

In addition we are seeking to develop Palliative Care Volunteers to work with older people in the palliative stage of their lives and their carers.

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

	Change Fund Allocation £000	**Allocation to Carers £000**	**Percentage Allocation**
2011/12	2230	153	7%
2012/13	2550	647	25.5%
2013/14	2550	595	23%
2014/15	2230	551	25%

7. Support Mechanisms

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

The National Seminars have been helpful, particularly where they have been well attended. We found the Co-production Seminar useful at this stage of our partnership development.

Individual inputs from JIT members have strengthened our technical approach and understanding of the local situation.

Support from ISD to our IRF work has allowed us to progress it and to connect our integration and change agendas.

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

We understand that our partnership approach with the voluntary sector and the Dundee Carers Centre has been well received by these sectors and would be happy to share our experience with others.

8. Joint Commissioning Strategy for Older People

The Joint Commissioning Strategy will be led by the Older People and People with Dementia Strategic Planning Group. As previously described in Section 2 of this application, the strategic planning group is multi-agency, with professional, clinical, carer and older people representation.

The financial resources available for the Joint Commissioning Strategy are as detailed in section 3.1 as a total resource and in section 3.4 by pathway. In addition, in section 4.3 the projected growth in expenditure against need and how we will financially bridge the change is described.

Our governance and partnership arrangements for the development of the10 year Strategic and Commissioning Plan will operate within the governance framework described in section 5 of this submission. The Older People Strategic Planning Group's responsibility for developing the 10 year commissioning strategy is undertaken on behalf of the Community Planning Partnership. As such, the Older People Strategic Planning Group will contribute to the development of the next Single Outcome Agreement and ensure that its outcomes are incorporated into the 10 year commissioning strategy for older people and people with dementia.

The strategic planning group has commissioned the Celebrate Age Network (CAN) to engage with both older people in receipt of services and the wider public. Using the Older Peoples Outcome Star as the basis of a discussion in both 1 to 1 sessions and group sessions, the CAN will determine older people's views on the future shape of care. This work will be completed by the end of March and will inform the strategic direction of the ten year plan. We anticipate that a full ten year Strategic and Commissioning Plan will be completed by December 2012.

This proposed Change Plan builds on the work undertaken by established themed engagement and operational working groups such as: the local provider's forums, the voluntary sector network, the carers group and the Celebrate Age Network. As a result there will be a strong correlation between the Change Plan, the current strategic plans for older people and people with dementia and the ten year Strategic and Commissioning Plan.

Statistical information has been collated and analysed, some of which forms the basis for this Change Plan submission. The financial framework is progressing and further work will project our current predictions for this four year Change Plan into a ten year Strategic and Commissioning Plan. A number of assumptions will be made when determining the future financial envelope and these include: a reduction in the number of care home placements; an increase in the number of people cared for at home, a reduction in the number of emergency admissions and a reduction in the bed days lost as a result of delayed discharges. The analysis of the demographic changes and the associated morbidity of the local population will be further costed and will underpin our financial information. This will be assisted by the IRF work which should help us to identify where further improvements and efficiencies could be made through a more integrated approach.

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

	_____	_____
	David K. Dorward **Dundee City Council**	**Date**
	_____	_____
	David W. Lynch **Dundee Community Health Partnership**	**Date**
	_____	_____
	Kathryn MacKenzie **Dundee Voluntary Gateway**	**Date**
	_____	_____
	Ian MacMasters **Scottish Care**	**Date**

A1. Emergency inpatient bed day rates for people aged 75+
A2. a. Patients whose discharge from hospital is delayed
A2. b. Accumulated bed-days for people delayed (NB further detailed guidance on b. will be issued soon, once the Delayed Discharge Expert Group has reported)
A3. Prevalence rates for diagnosis of Dementia
A4. Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting
A5. Percentage of time in the last 6 months of life spent at home or in a community setting (further detailed guidance on this will be issued soon as part of the Quality Measurement Framework and the Re-shaping Care Network will be consulted on the measure's methodology).
A6. Experience measures and support for carers from the Community Care Outcomes Framework (Community Care Benchmarking Network)
B1. Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared
B2. Waiting times between request for a housing adaptation, assessment of need, and delivery of any required adaptation
B3. Proportion of people aged 75+ with a telecare package
B4. Reduction in hours of support required after reablement service provided
B5. Respite care for older people per 1000 population
B6. Rates of 65+ conveyed to Accident & Emergency with principal diagnosis of a fall (Data from Scottish Ambulance Service)
B7. proportion of frail emergency admissions who access specialty unit within 24 hours
B8. Rate and proportion of new entrants admitted from home; acute hospital specialty; following intermediate care; graduate from emergency respite
C1 Per capita weighted cost of accumulated bed days lost to delayed discharge
C2 cost of emergency inpatient bed days for people over 75 per 1000 population over 75
C3 A measure of the balance of care (e.g. split between spend on institutional and community-based care)

Local Measures

- No. people supported in care homes
-No emergency respite places
-Lost bed days
- % acute bed closure
- Cost of supporting people in care homes.
- Cost of providing home care

Tayside Metrics

Work Stream 1

- No. people living in housing with care
- % of service users who's outcomes have improved since moving into HWC.
- Increase spend on Housing with Care
- No. new housing with care units by April 2014

Programme 1
Housing with Care

- No people receiving enablement
-% of service users receiving enablement whose outcomes have improved.
- Increase spend on enablement

Programme 2
Moving assessment for care home admission from congruent settings (hospital / respite)

- No. unplanned admissions from care homes to hospital
- No. care home residents diagnosed with dementia
- Void costs of care home placements during periods of acute care (SMR01)
- % of reviews during hospital admission completed within 6 weeks
- No. homes demonstrating improved outcomes for older people (Care Inspectorate grading)

Programme 3
Support Older people with changing health needs to continue to be cared for in a care home setting

- No. people receiving telehealth / telecare
- Cost of telecare / telehealth

Programme 4
Integration and implementation of telehealth / telecare

-Emergency in-patient bed day rates for patients admitted with COPD/Asthma
- Emergency in-patient bed day rates for patients admitted with diabetes/CHD
- LTC total occupied bed days
- The number of readmissions within 28 days (any hospital)
-The number of readmissions within 28 days to the same specialty
-The number of care home residents with an anticipatory care plan
-The number of people assessed for admission to virtual ward
-The number of people admitted to the virtual ward
- The number of people admitted to the virtual ward who have had medication reviewed
- The number of people admitted to the virtual ward who have an anticipatory care plan in place
- The % of people admitted to the virtual ward whose confidence has increased as a result of admission
- The % of people admitted to the virtual ward whose health/wellbeing has improved as a result of admission

Programme 5
Redefine pathways for older people who are at risk from the impact of escalating health and

Programme 6 - Integration escalating health and social needs

Maintain more people at home
Avoid social admission / readmission / delayed discharge
improved quality of life for service users and carers
improved service user and carer health
reduce care home admissions
reduce emergency respite placements
reduce hospital admissions
reduce bed days
improved quality of life for service users and carers

improved carer health
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

Improve Efficiency
Sustainable joint workforce with right skills mix
harmonised terms and conditions
reduction in building costs
integrated assessment framework
avoid inappropriate social/health interventions
increased independence and control
informed public
improved service users and carers health

A1. Emergency inpatient bed day rates for people aged 75+
A2. a. Patients whose discharge from hospital is delayed
A2. b. Accumulated bed-days for people delayed (NB further detailed guidance on b. will be issued soon, once the Delayed Discharge Expert Group has reported)
A3. Prevalence rates for diagnosis of Dementia
A4. Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting
A5. Percentage of time in the last 6 months of life spent at home or in a community setting (further detailed guidance on this will be issued soon as part of the Quality Measurement Framework and the Re-shaping Care Network will be consulted on the measure's methodology).
A6. Experience measures and support for carers from the Community Care Outcomes Framework (Community Care Benchmarking Network)
B1. Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared
B2. Waiting times between request for a housing adaptation, assessment of need, and delivery of any required adaptation
B3. Proportion of people aged 75+ with a telecare package
B4. Reduction in hours of support required after reablement service provided
B5. Respite care for older people per 1000 population
B6. Rates of 65+ conveyed to Accident & Emergency with principal diagnosis of a fall (Data from Scottish Ambulance Service)
B7. proportion of frail emergency admissions who access specialty unit within 24 hours
B8. Rate and proportion of new entrants admitted from home; acute hospital specialty; following intermediate care; graduate from emergency respite
C1 Per capita weighted cost of accumulated bed days lost to delayed discharge
C2 cost of emergency inpatient bed days for people over 75 per 1000 population over 75

Local Measures

- No. people supported in care homes
-No emergency respite places
-Lost bed days
- % acute bed closure

Work Stream 2

-Inc dementia registers
-% of community care service users with diagnosed dementia who's outcomes improved between assessment and review
- % of community care service users with diagnosed dementia who have Anticipatory and / or palliative care plan
- No. carers who's outcomes improved following interventions
- The number of people on CMHT case lists with diagnosis of dementia
- The number of people attending day hospital
- Improved carer satisfaction (*opportunity for cross programme work?)*
- Number of admissions to dementia assessment wards
- No of patients diagnosed with dementia who have anticipatory care plans/ "This is me" in place
- Number of continuing care beds
-Number of emergency admissions for people

Programme 7 Improve resources and support for people with dementia

-% of integrated OT assessments completed within target timescale (ie 20 days?)
- average cost of items of equipment issued

Programme 8 Further develop an integrated OT service and equipment service

-Number of statutory carer's centre assessments completed
-Number of carer's assessments offered
-Number of carers who's outcomes have improved following completing of an assessment
-Number of virtual ward patients with a carer
- Number of carers accessing therapies / activities / support budget
-Number of carers assessing therapies / activities / support budget who's health and wellbeing has improved.
-Number of carers benefiting from 'Time to Cope' service
-Number of carers benefiting from 'Time to Cope' service who's outcomes improved.
- Spend on services for carers
- Spend on respite services (LFR)

Programme 9 Carer Support

-Number of voluntary sector organisations developing projects
- Number of older people reporting an increase in their health and well being as a result of project engagement
-Number of volunteer hours achieved through working with projects
-Number of new volunteer opportunities developed
- Number of volunteers recruited, trained and placed
- Number of volunteer hours in added value
-Number of people accessing services

Programme 10
Building Community Capacity

-no of people accessing / calls to the information line
-no of queries successfully resolved
-no.users of the information line and follow up services who's personal outcomes have improved.

Programme 11
Improved Models of Public Information

Maintain more people at home
Avoid social admission / readmission / delayed discharge
improved quality of life for service users and carers
improved service user and carer health
reduce care home admissions
reduce emergency respite placements
reduce hospital admissions
reduce bed days

improved carer health
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

Improve Efficiency
Sustainable joint workforce with right skills mix
harmonised terms and conditions
reduction in building costs
integrated assessment framework
avoid inappropriate social/health interventions
increased independence and control
informed public
improved service users and carers health

Appendix 3

NHS Tayside Change Fund Metrics: Health Measures

Baseline data set Quarter 3 2011/12.
Information to be segmented in age bands for each of the CHP: Perth & Kinross, Dundee and Angus.
Age bands: 65 – 75 years, >75 (with exception of Delayed Discharge measure, this will include all ages)
All metrics to be consistent across the three CHP's and aligned to triple aim: Patient Experience, Quality & Finance.

Theme		Measure	Metric Definition	Data Source	Frequency	Improvement Trajectory		
						2012	2013	2014
Finance	F1a	Number of occupied Emergency inpatient bed days from care homes.	Number of occupied emergency inpatient bed days	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	F1b	Number of occupied Emergency inpatient bed days for: • COPD • Asthma • Diabetes • CHD	Number of occupied emergency inpatient bed days	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	F2	Patients whose discharge from hospital is delayed: ➢ Number of days lost in reporting period ➢ Mean and median length of delay for patients discharged in month and the number of patients discharged.	Number of bed days lost to delayed discharge (monthly) Mean / median length of delay for patients discharged in month and the number of patients discharged	EDISON	Monthly	↓ % reduction?	↓ % reduction	↓ % reduction

Finance	F3	Number of readmissions within 28 days.	Number of emergency admissions readmitted with 28 days to the same specialty *with same diagnosis*	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	F4a	Occupancy levels in acute and continuing care beds across acute setting (by Directorate, then speciality). David M to discuss hierarchy with Susan B	Number of Occupied Bed Days	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	F4a	Occupancy levels in acute and continuing care beds across non-acute setting (by Directorate, then speciality). David M to discuss hierarchy with Susan B.	Number of Occupied Bed Days	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
Quality	Q1	Prevalence rates for diagnosis of dementia. HEAT Target – Achieve 61% of patient population recorded on a disease register for dementia	Number of prevalent cases and register size as a proportion of EURODEM	QOF Calculator	Monthly	↑ % increase?	↑ % increase?	↑ % increase?
	Q2	Numbers of admissions and bed days for those with primary diagnosis of dementia (excluding POA beds). David M to discuss with Audrey Ryman (P&K)	Test Data to be provided	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	Q3a	Number of 65+ with diagnosis of a fall to: A&E & MIU's Susan B to confirm level of information available	No. falls >65 to A&E, MIU	TOPAS/ Symphony	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	Q3b	Number of 65+ with diagnosis of a fall to: Admission wards Susan B to confirm level of information available	No. falls >65 to admission wards	TOPAS/ Symphony	Monthly	↓ % reduction	↓ % reduction	↓ % reduction

Quality	Q4	Length of stay – orthopaedic rehabilitation over 65 age bands – RVH, PICU, Community Hospitals Measure to be broken down for each part of the journey. Definition of orthopaedic rehabilitation required to ensure data currently being recorded accurately (Karen Anderson to provide) Derek T to discuss with Karen Anderson to agree definition of rehabilitation and metric definition	Median / Range of LOS, with a focus on rehab and split between planned and unplanned	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	Q5	Number of people receiving rehabilitation at home. Derek T to discuss with Karen Anderson to agree definition of rehabilitation and metric definition	To be defined	To be defined	To be defined	↑ % improvement	↑ % improvement	↑ % improvement
	Q6	**LOS** Medicine for the elderly: Acute, Rehabilitation RVH, Community Hospitals Information currently available in KPI packs David to review whether breakdown required for >65 or not.	**>65 MFE acute wards (admissions)** **>65 outwith acute setting Ave & median & Total**	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	Q7	Number of people receiving NHS continuing care in an NHS setting. Continuing care defined as where 'there is a need for ongoing and regular specialist clinical supervision of the patient' as a result of: - the complexity, nature or intensity of the patients heath needs - the need for frequent, not easily predictable medical intervention - the need for routine use of specialist health care equipment or treatments - a rapidly degenerating or unstable condition requiring specialist medical or nursing supervision. David M to review and confirm. (discuss with G Collins).	Total number of patients receiving NHS continuing care in an NHS setting	TOPAS	Monthly	↓ % reduction	↓ % reduction	↓ % reduction

Quality	Q8	Number of people discharged direct to care homes from acute care per month. Information currently provided on a monthly basis. Susan and Kirsty to review information form Local Authority to determine what information could be matched	Number of patients discharged to care homes from acute setting	Currently manual data collection - TOPAS Potential to record new patients from Local Authority	Monthly	↓ % reduction	↓ % reduction	↓ % reduction
	Q9	Number of care home residents who have an anticipatory care plan Target - 100% Currently measured through QOF for those care homes with LES (approx 85%). Should monthly returns from Care homes be set up? JC to ask Alison Fannin to review and discuss information available with colleagues in P&K and Angus to agree source, provision of data and metric definition	Anticipatory care plans for care home residents.	Practice Submission LES/PCD	Quarterly	↑ % improvement	↑ % improvement	↑ % improvement
	Q10	Number of people with anticipatory care plans in the community. JC to discuss with Ann Robb (other contacts Ann Gourlay / Rhona Guild for contacts in Perth and Angus)	To be defined	To be defined		↑ % improvement	↑ % improvement	↑ % improvement
	Q11	Number of people with end of life care plans in the community. JC to discuss with Ann Robb (other contacts Ann Gourlay / Rhona Guild for contacts in Perth and Angus)	To be defined	To be defined Potential Source GP electronic Palliative Care Summary		↑ % improvement	↑ % improvement	↑ % improvement

Patient Experience	P1	Number of people dying in acute hospital setting linked to NHS Tayside Palliative Care Strategy. Test date to be provided: (1) Number of patients dying in acute hospital setting linked to NHS Tayside Palliative Care Strategy (2) Number of patients dying in community hospitals setting linked to NHS Tayside Palliative Care Strategy (3) Number of patients dying at home linked to NHS Tayside Palliative Care Strategy JC to discuss with Ann Robb (other contacts Ann Gourlay / Rhona Guild for contacts in Perth and Angus)	To be defined JC to work with Ann Robb to prepare metric definition	TOPAS – palliative care coding Potential Sources: NHS Central Register or General Register	TBC			
	P2	Percentage of time in the last six months of life spent at home or in a community setting. Joe D to discuss with Carol Angus and Susan Baird to pull test data	Distribution of the percentage of time in the last six months of life spent at home or in a community setting.	Potential Sources: NHS Central Register or General Register / TOPAS	To be defined	↑ % improvement	↑ % improvement	↑ % improvement

Theme	**Measure**	**Metric Definition**	**Data Source**	**Frequency**	**Improvement Trajectory**		
					2012	**2013**	**2014**
LA1	Rate and proportion of new admissions to residential care admitted from: Home, acute hospital speciality, following intermediate care i.e. all admissions *Method of data collection to be confirmed e.g. crisis admission from care home, step down etc.* *Definition of residential care home / or residential care. (Kirsty P&K to discuss with JIT)* **Contacts within Local Authority:** **Louise McLennan (Angus)** **Lynsey Webster (Dundee)** **Kirsty Jackson (P&K)**	TBC DMcL / KJ to prepare Metric Definition	SWIFT (P&K), K2 (Dundee) Angus to be confirmed	Monthly	↓ % reduction	↓ % reduction	↓ % reduction

Core Measures Letter - **Reshaping Care for Older People: Core Improvement Measures**
A: Nationally available outcome measures and indicators (to be cross matched against locally available measures)

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

A2. a. Patients whose discharge from hospital is delayed and
b. Accumulated bed-days for people delayed (NB further detailed guidance on b. will be issued soon, once the Delayed Discharge Expert Group has reported)

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

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

A5. Percentage of time in the last 6 months of life spent at home or in a community setting (further detailed guidance on this will be issued soon as part of the Quality Measurement Framework and the Re-shaping Care Network will be consulted on the measure's methodology).

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

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

B: Local Improvement Measures

Anticipatory and preventative care
B1. Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared
B2. Waiting times between request for a housing adaptation, assessment of need, and delivery of any required adaptation
B3. Proportion of people aged 75+ with a telecare package

Responsive / flexible home care and carers
B4. Reduction in hours of support required after reablement service provided
B5. Respite care for older people per 1000 population

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

Effective flow in acute care
B7. proportion of frail emergency admissions who access specialty unit within 24 hours

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

C: Partnership resource use
C1 Per capita weighted cost of accumulated bed days lost to delayed discharge
C2 Cost of emergency inpatient bed days for people over 75 per 1000 population over 75
C3 A measure of the balance of care (e.g. split between spend on institutional and community-based care)