

Falkirk Partnership Change Plan

1. NAME OF PARTNERSHIP

Falkirk

2. PARTNER ORGANISATIONS

This Change Plan has been prepared on behalf of the Falkirk Partnership Board, which is the overarching governance group for the Falkirk Community Health Partnership and which is responsible for agreeing priorities and ensuring implementation of these priorities for health and social care services in the Falkirk area.

All partners are committed to continually enhancing care for older people in response to the changing needs and expectations of older people living in the Falkirk area. We aim to provide services capable of maintaining peoples' independence by helping older people stay active, live independently in the community for as long as possible and improving their choices. In developing this plan we have built on the commitments made in the Forth Valley Joint Commissioning Framework: Older People and the Change Plan enables a number of the priorities identified in this framework to be progressed.

The Change Plan takes account of national guidance issued on 23 December 2010. We have not yet had access to the National Delivery Plan, which is referred to in the guidance and so we will update our Change Plan, if necessary, when this is implemented.

The status of the Change Plan is that it is a draft awaiting formal approval through the partnership's respective governance bodies.

The partnership has consulted widely within our constituent organisations on the content of the plan. CVS Falkirk and District have been directly involved in it's development and consultation has taken place with Scottish Care.

In addition, the following planning groups have also been engaged in the development of the Change Plan:

- Forth Valley Joint Adult Strategic Planning Group
- Forth Valley Delayed Discharge Steering Group
- Older People's Implementation Group, which includes representation from statutory and voluntary organisations and carers
- Community Care and Health Forum Members, which includes approximately 40 voluntary organisations, such as the PRT Carers Centre (Falkirk and Clackmannanshire), Age Concern, Crossroads Scotland, Red Cross, Samaritans.

Further work will take place over the coming weeks to finalise the plan, which will include more work with the independent sector through established local provider groups.

An event was held with third sector partners on 11 February 2011 to specifically inform the strategic planning partners on the valuable contribution they can make to reshaping care and services to older people. Further approaches to ongoing engagement were agreed and will be taken forward through the Community Care and Health Forum.

There is ongoing reporting on issues related to older people that are reported to the Falkirk CHP Community Planning and Health Group and respective Committee and Boards.

3. FINANCE – USE OF CHANGE FUND AND ADDITIONAL RESOURCES

The respective funding arrangements are detailed as follows:

From	Amount £
Initial central allocation	£1.885
Added by NHS Board	
Added by local authority	
Other	
TOTAL	£1.885

4. SUMMARY OF CURRENT PARTNERSHIP BUDGET FOR OLDER PEOPLE

The current expenditure on older people's services presently remain within separate budgets held by the statutory partners, which in part is allocated to support services provided by both the Third and independent sectors.

The partnership intends that the Change Fund for 2011/12 will be used as transitional finance to support local activity focused on reshaping care for older people.

The partnership will use this experience to:

- build our understanding of how financial efficiencies can be released
- achieve agreement on how efficiencies will be reinvested
- identify opportunities to align budgets across the partnership
- agree arrangements for budget and resource risk allocation
- refine our estimates of the potential savings generated by proposals that can be robustly evidenced
- develop a clear focus on return to investment for change activity that is directly linked to outcomes
- agree robust monitoring and evaluation arrangements for projects including exit strategies where progress is limited.

Within the proposals the partners have committed existing resources as outlined above. There will be ongoing discussions within the partnership to determine the scope and extent of further resource allocation to augment the Change Plan as anticipated efficiencies are evidenced and released.

(See Appendix 1 for an overview of resources applied to Older People's Care in the Falkirk Partnership)

5. SUMMARY OF KEY OUTCOMES/OUTPUTS ACHIEVED THROUGH CURRENT RESOURCES

The partnership remains committed to ensuring the delivery of effective and efficient services and older people and their carers that support the shift in the balance of care to meet current and anticipated future needs and demands on services. This section summarises the context for service delivery that the partners are working within.

Planning

Falkirk Council and Community Planning partners Single Outcome Agreement (SOA) sets out the improvements that we want to achieve in our area. Our collective commitment to ensuring that we provide the best quality services at an affordable cost to our communities and citizens is not new and has always been at the very heart of our approach. Implicit in our vision is the need for our citizens and communities to be safe and healthy.

The Falkirk Strategic Community Plan sets out how all public agencies and community partners will work together to achieve our shared vision for our area. The plan demonstrates the commitment to working together to deliver more co-ordinated, high quality public services. Key themes of particular reference to health and community care services include:

- improving health and well-being
- enabling our citizens to live safely.

The Falkirk Community Health Partnership (CHP) is an important cornerstone of community planning. The CHP Community Planning and Health group co-ordinates a number of shared agendas including community care services, health services and health improvement and has representation from a range of community planning partners. The strategic priorities for the group, with specific relevance to this Change Plan include:

- co-ordinate health and social care services
- ensure equity of access to health care services to all individuals living within area including GP services, dental services, pharmacy and acute care services
- improve the health of all our communities but prioritising those who have the poorest health
- further develop the links between the CHP and the health theme group to ensure effective delivery of quality services.

The Forth Valley Joint Commissioning Framework: Older People describes at a strategic level what services for older people will look like in the future and thus identifies the areas where changes are required. The framework was prepared recognising the complex network of relationships which exists between all the partners and indeed between the partners and other agencies. The framework will provide the basis for a commissioning strategy which will set out in more detail how the strategic commissioning objectives laid out in the framework will be achieved.

The service delivery changes that have been made over the recent years have resulted in different models across the Forth Valley area. Whilst it is important to note that the rationale for these differences has been based on identified local need, there is merit in reviewing and learning from these different approaches. This will ensure the best approach is taken forward in the Falkirk partnership area. More recent work through the Forth Valley Carers Information Strategy monies has demonstrated the benefits of partnership working to maximise resources. This has supported the development of a Forth Valley wide approach to the development of key services to identify and support carers to address concerns about equitable service provision. The partnership will continue to review opportunities to work collaboratively in a number of areas including advocacy services.

Finance

The partnership are actively working together to develop full partnership financial management information for all areas of joint working, including relevant financial monitoring data for partnership arrangements. Since October 2008, community care financial data has been submitted to the Community Health Partnership, which considers detailed financial information on both health and community care services. A more integrated financial picture will continue to inform the development of a joint financial framework for the partnership, which will include investment in the third and independent sectors.

Workforce

We have 3 key challenges in relation to our workforce. Firstly we require to modernise working practices in order to both generate efficiencies and improve effectiveness. Secondly we require to change the culture of our organisations away from one where assumptions may be made that community care and health services will always be required towards one which promotes a reablement approach. These require extensive employee development and training and will be supported by a Change Plan proposal to specifically support this activity will all sector workforces. Thirdly we have an ageing workforce and need to explore ways of encouraging young people to become involved in community care and health provision both as paid employees and volunteers. This work will be broadened to include third and independent sector involvement.

As part of the commitment to continuous improvement, AHP services in NHS Forth Valley will engage in the Productive Community Services Programme. This will involve the systematic engagement of front line teams in order to improve quality and productivity. It is intended that the practical application of lean based techniques within the Productive Community programme will increase both capacity and

capability, in particular it is anticipated that it will increase patient contact time, reduce inefficient work practices, improve the quality and safety of care, and put staff at the forefront of redesigning their services.

Releasing Time to Care was identified as a model within NHS Forth Valley to modernise community nursing in the community. The approach that was used to achieve this work identified current processes, ways of improving this, identifying the waste in the system and engaging with staff to focus on an overall system of improvement. The key areas of improvement are as follows:

- scheduling workload
- caseload management
- equity
- resourcing
- productivity
- standardising best practice
- Administration burden

NHS Forth Valley is using a MiDIS system in early implementer sites to enable us to further improve nursing in the community. All the work carried out within NHS Forth Valley links with the national agenda *Modernising Nursing in the Community* that recognises we need to have a workforce fit for purpose. To enable this work to be carried out we will work more closely with all our partners to complement the activities set out in the Change Plan.

Falkirk Council Social Work services have completed a review of community care and integrated teams, in order to plan how we can best deliver our assessment and care management services, now and in the future. This work will ensure the most effective use of our resources in the delivery of community care services.

The key outcomes for service users, carers and partners anticipated from this work include:

- clear processes for requesting support
- improved service delivery
- faster and easier access to services
- avoid duplication
- improved partnership working.

Performance

There is ongoing scrutiny of performance and a review of current activity is underway to identify the scope for further and consistent change across Forth Valley. This work includes for example looking at admissions, readmission, homecare, and the Community Care Outcomes Framework.

In reviewing local indicators, the partnership has a mixed picture of performance. There has been progress made in the following areas:

- the average bed rates per 100,000 population of all emergency admissions for patients aged 65+ and 75 + are showing positive downwards trends and our performance is below the national average
- chart 3 readmissions – below the national average
- shifting the balance of care is moving towards an increase in community provision. The balance of care target for Scotland is 30%, but in Falkirk CHP the % of people with intensive care needs receiving care at home was 32.1% at 31 March 2010.
- SWIA follow-up inspection reported improved performance in offering and completing carers assessments. In 2009-10 there 2,193 carers' assessments carried out. This represents a rate per 1000 18+ population of 18.2. The proportion of these that were exclusive assessments of carers' needs, rather than being incorporated in the client's assessment rose from 21% in 2008-09 to 24% in 2009-10.

The following performance indicators have identified challenges for the partnership that will be addressed through the Change Fund and these include:

- respite
- delayed discharge targets. Until recently the partnership has consistently achieved the delayed discharge target, however this has become more challenging and this remains a high priority for the partnership

Following some detailed analysis of SPARRA data, a review of people known to have three or more long-term conditions in one GP practice in Clackmannanshire was undertaken in 2010. It is anticipated that the Falkirk Partnership will review these results and use them to inform future developments. There is significant indication that improved case management could improve the quality of care provided for patients and reduce unplanned admissions.

The partnership will aim to include third and independent sector performance over the coming year and beyond to ensure balanced performance of all activity is reported.

Demographics

The population of the Falkirk Council area has already increased by around 2% since 2008 and is projected to increase by a further 3% by 2013, which is slightly more than the increase of 2% in Scotland as a whole. By 2016 there will be a 15% increase in the number of people aged 65 and over. Across the Council there are variations in the proportions of the population in different age groups. Falkirk and Grangemouth have the largest proportion of older people rising to 19.3% of the total in Grangemouth, compared to only 13.9% of the population of the Braes and 14% in the Larbert/Stenhousemuir area.

Deprivation is not evenly spread across the Council area. Almost one third of the population of Falkirk and nearly a quarter of people in Grangemouth live in one of the Council's priority areas compared to under 5% of the population of the Denny/Bonnybridge and Larbert/Stenhousemuir areas.

Service Delivery

Reablement

Rehabilitation within a community setting has been well documented as being effective for the care and support of service users. Older people and people with long term conditions should be supported to live in their local communities with the appropriate integrated rehabilitation/enablement services. These services should be underpinned by enablement and self management support in community settings as well as appropriate training and staff development.

The ReACH (rehabilitation at home) service is a partnership between NHS Forth Valley and Falkirk Council Care at Home services. The current service offers intensive rehabilitation for up to 4 weeks to individuals, over the age of 65 years following their hospital discharge home to live in the community. The service is provided by a multidisciplinary team of therapists and rehabilitation carers.

The aims of the service are to:

- enable the safe and effective early discharge of patients from the acute hospitals (FDRI and SRI) to their own homes
- prevent hospital admission by offering the service to selected patients
- facilitate ongoing, intensive rehabilitation at home provided by rehabilitation carers (Falkirk council employees) and ReACH Falkirk therapists (NHS)
- assist in preventing long term use of Falkirk Council Care at Home services
- encourage and support patients to return to an optimum level of independence.

Our Rapid Response Service was provided to 882 people in 2009-10. In around 60% of these cases hospital admissions was prevented and around 40% of people achieved early discharge from hospital.

Community Hospital Model

The Community Hospital will act as a bridge between primary and secondary care, smoothing the patient's journey of care by introducing new ways of working and providing a key link in "joined up" services with no discernible divide between the different elements of health and social care.

The services provided from the community hospital will focus on maintaining and restoring independence and on rehabilitation, supporting people within their own homes, through to more specialised hospital care. The overall aim is to maintain and support people within their own homes for as long as possible and thus prevent the need to access hospital services. Future work opportunities will be explored with the independent sector around revisiting Community Hospital Model of Care There are three main components to the model for community hospital services:

a. *Community Services*

The community hospital will deliver a range of community based services but will

also be a base for staff providing outreach services delivered in people's homes, care homes, local health centres and other community locations. for example community rehabilitation service (ReACH)

b. Base for Community Outreach Services

The community hospital will provide multi-disciplinary assessment, care, and treatment services for people aged 65 years and over who have mental health needs, living in the Falkirk Council area. Specifically the Community Hospital will provide a base for community teams, outpatient and outreach services. The community teams include Community Mental Health Teams, Care Home Psychiatric Liaison Team and the Dementia Link Nurse Team. It is envisaged that these services will be integrated with a wider range of services located in the Falkirk area provided by health, social and independent sectors.

c. In-patients

In-patient services will be designed to allow a more flexible use to support provision for patients with complex needs, including palliative care, for patients undergoing rehabilitation, but medically stable, and for those requiring other intermediate care following an acute episode. The key issues in the model for community hospital in-patient services are:

- flexibility in the use of inpatient resources with no age barrier to accessing services, although normally people will be over the age of 65 years;
- ability to support a range of uses including continuing care for older people with complex needs, intermediate rehabilitation and palliative care; and
- the service will be multi-disciplinary team led. This is dependent on patients being medically stable, which is seen to be the primary function of the service.

Supporting Carers

There is strong commitment in the partnership to supporting carers as key partners in care. There are positive working relationships in place within the partnership with a shared vision to improve outcomes for carers.

Through investment from the statutory partners, the Carers Information Strategy (CIS) funding, concordat respite funding and other funding streams there is a wide range of support and information for carers including respite/short breaks, learning and training, support groups and welfare benefits advice. Carer support agencies, including PRT Carers Centre, Falkirk District Association for Mental Health and Alzheimer's Scotland provide a range of services including support groups, one to one support, welfare benefits advice and newsletters.

The CIS funding has facilitated the funding of a Carer Health Liaison Hospital Worker, Carer Health Liaison Community Workers and Carers Training and Development Co-ordinator, based and managed by the Carers Centre.

Further discussions will take place within the Forth Valley Carers Information Strategy group on 2011/12 investment to continue to support the needs of carers.

Falkirk Council Short Breaks Bureau (SSB) continues to develop innovative, flexible and supportive short breaks from caring and breaks with the cared for person. There will be further consideration given to developing the role of the SBB to enhance carer support.

Telehealthcare

There is local recognition that telecare/telehealthcare is an essential element in the process of re-ablement and shifting the balance of care. Falkirk and FVHB Telecare partnership will work to ensure greater integration of the telehealthcare model, building on the pioneering work that has been already been underway over the last four years in particular. This will include working with the third and independent sectors.

The Telecare Programme in Falkirk is integrated into mainstream services and is aligned to the Community Alarm Service and the Mobile Emergency Responder Service (MECS), for most forms of equipment. The REACH Team in NHS Forth Valley provide environmental control equipment, Ablelink and similar technologies for those with cognitive impairment, in partnership with Falkirk Council. The telecare service is available to any user group in Falkirk, where the telecare eligibility criteria is met, and includes:

- *Enhanced telecare* – Currently about 5,800 people have a Community Alarm System across the Falkirk Area. There has been a 10% increase in service provision since the Telecare Development Programme started. Falkirk provides a range of telecare equipment, including standalone systems and passive alarms according to individual assessed need. By March 2010, 231 people had been provided with an enhanced telecare package.
- *Lifestyle Monitoring* – We are currently trying out the use of Just Checking and other similar systems. Stimulating interest from Social Work and Health colleagues in use as an assessment tool is on-going and improving following the round of awareness raising events in 2010. Further events are planned for 2011.
- *Telehealth* – Negotiations have started around the use of Telehealth, aimed at users with COPD. We also have a medication initiative in the pilot stage.
- *Other* - Use of PDA, a handheld computer, and Ablelink for users with cognitive impairment has been trialled.

Falls Prevention

Forth Valley in partnership with other agencies developed the Forth Valley Falls Prevention and Bone Health Strategy 2008-2013. Given 30% of the population over 65 years who are community dwellers will fall per year, in Forth Valley this equates to around 14,000 falls with 7000 of those being recurrent fallers. The strategy recognises that the most effective interventions address multiple factors simultaneously and on a multi-agency basis, and sub-groups have been established to take forward the implementation plan. Further discussions will take place with voluntary and independent sector partners to extend opportunities.

The key aspects of the Falls Prevention strategy include:

- identification via initial screening and assessment
- care pathway development
- evidence based interventions
- evaluation of effectiveness
- community based strategies to prevent falls and promote self care.

Falkirk has a well established falls management service which is currently the subject of further development. With JIT funding the Falkirk Falls Management Project has appointed a Mobile Operations Co-ordinator for one year from July 2010 to undertake specific work with people referred to MECS in relation to falls they have been experiencing.

In Falkirk the collaborative work between MECS and ReACH services have allowed the development of a pathway for MECS to access ReACH services for older people who have fallen twice in 6 months. The Falkirk work clearly demonstrates reduced falls rates amongst its service users.

A further piece of partnership working with SAS is underway to develop a pathway which allows SAS access through MECS to services which would allow the uninjured faller to remain at home. This allows onward referral to appropriate AHP services. This will be piloted in Falkirk Council area initially and evaluated prior to roll-out to the other council areas.

The OTAGO strength and balance programme is an evidence based programme which reduces falls significantly. Training for staff across Forth Valley was funded by the 3 CHP's and OTAGO is now delivered in day therapy, residential care, Housing with Care and day care across all 3 council areas. Further training of physical fitness instructors is anticipated in spring 2011, which will allow patients to "graduate" from day therapy units to community based programmes.

Anticipatory Care

Increasing the use of an Anticipatory Care Planning (ACP) approach is a national priority. In Forth Valley we use ACPs for patients in Care Homes and with Palliative Care needs and have also used them for patients with long term conditions who are at high risk of hospital admission. Currently over 2000 patients in Forth Valley across these three main care groups have an anticipatory care plan (ACP). Reshaping Care for Older People Programme with its principle aim of optimising wellbeing and independence for older people recognises the need to shift care approaches towards those that are preventative and anticipatory. A key action will therefore continue to focus on the need to further develop and implement anticipatory care planning approach especially for those people who are most vulnerable and at greatest risk of hospital admission.

Working in Partnership with the Third Sector

Falkirk Community Planning Partnership's Strategic Community Plan places a significant emphasis on the role of the Third Sector and communities in tackling some of the issues being faced by public services. The partnership recognises that almost all Third Sector organisations contribute directly to the health and/or wellbeing of local citizens, particularly older and vulnerable people. In the Falkirk partnership area there are over 700 voluntary organisations and charities and over 30,000 active volunteers. The Change Fund will assist the partnership to explore with community groups and the voluntary sector alternative methods of delivery and earlier interventions. The partnership will continue to work alongside the Third Sector to build capacity of the sector and volunteering to make a clear and measurable contribution to achieve our common and shared outcomes.

Work in Partnership with the Independent Sector

The partnership currently involves the independent sector in the delivery of health and social care in all areas of our work. At front line officer level there is contact and discussion looking at immediate service delivery arrangements and issues. At an operational level we have contact between middle management officers looking at wider service delivery issues and operational efficiencies.

Social Work services have a dedicated contracts and commissioning team with officers linked to each contract type - e.g. Older People's Care Homes. This ensures that the partnership is able to respond to wider strategic and longer term issues through the commissioning cycle. This is where we take feedback from the first two levels of contact and analyse findings and develop commissioning strategies.

The commissioning team meet individually with providers and also in larger forum meetings, especially in the planning and reviewing sections of the commissioning cycle.

Housing

A Community Care Housing Needs Assessment has been carried out for the Falkirk Council area to identify the housing requirements of specific household groups and identify housing support needs and other relevant issues to be taken forward in the Local Housing Strategy. Some key findings in relation to older people include:

- An audit of sheltered housing indicated potential issues with this type of accommodation e.g. a large number of bedsits and some developments which did not have a lift to the upper floor (Falkirk Council 2010 Community Care Housing Needs Assessment).
- People 60+ made up between 12-18% of Council allocations (2000-9) and were predominantly let smaller and specialist properties -Housing with Care, lower flats, multi-storeys, bungalows (Falkirk Council 2009/10 housing management system).

Sensory Impairment Services

The Forth Valley Sensory Centre is run by Forth Valley Sensory Centre, a Company limited by guarantee with charitable status. It is a partnership with Falkirk Council, RNIB Scotland, NHS Forth Valley, Stirling Council, RNID, Guide Dogs, and Clackmannanshire Council. The Centre provides a range of services for people with a sensory impairment, their carers and related service providers, and has been recognised as a centre of excellence through MAISOP and SWIA inspections.

The centre provides a one-stop approach for service users by integrating health, social care and voluntary sector providers and volunteers to provide a seamless care pathway. The partnership has recognised that this model of service delivery meets the needs of service users and their carers and will provide a useful model to reshape services for older people reflected in the Change Plan.

Dementia and Old Age Psychiatry

Inpatient Care

Within Old Age Psychiatry Services a review and redesign of In-patient, Day Hospital and Community Mental Health services is being undertaken. With respect to In-patient services two Admission /Assessment Wards at have been recently commissioned at the new Forth Valley Royal Hospital. There is a pilot of an Integrated Care Ward for older people admitted to Acute Hospital with con-current medical and mental health needs. Staffed by Mental Health and Adult Nurses. Medical Input is being provided from both a Psychiatrist and Geriatrician. Also there is re-configuration of Psychiatrist Posts with one consultant now covering In-patient, Integrated Care and Liaison Psychiatry.

Day Hospital Services

There is a move away from a hospital/medical model to a nurse led service providing outreach clinics, joint working and Health Maintenance.

Community Mental Health Teams

In conjunction with Partners now developing new models for CMHS by using *Lean Methodology* processes aiming to look at improving patient contact time, reducing inefficiencies and improving quality.

Work Underway and Priorities

- A scoping exercise for dementia registers was undertaken and processes were improved for making and recording early diagnosis of Dementia with GP Partners.
- Improving post diagnostic support, early referral, assessment, diagnosis and treatment for dementia. Early referral to dementia link nurses.
- A Post Diagnostic Support group and 2 On-going Support groups have been set up jointly with NHS Staff and Alzheimers Scotland project worker.
- Care Home Liaison – optimising the mental health of older people in Care Homes. .
- Managing BPSD (Behavioral and Psychological Symptoms of Dementia) as effectively as possible without hospital admission, including crisis intervention and supporting early discharge (dementia)

- Managing and resolving Acute and Severe functional disorder.
- Increase access to and provision of Psychological Therapies
- Increasing the range of alternatives to admission.
- Increasing Self Care and self management skills.
- Improve support to Primary Care and Third Sector

Palliative Care

Partners across Forth Valley have established an Action Plan for the implementation of Living and Dying Well, the national policy driver for palliative and end of life care.

Key to its success is a person centred approach to care and care planning and the importance of communication, collaboration and continuity of care across all sectors and at all stages of the individuals journey. It is anticipated that further work on anticipatory care plans which are already being introduced in independent sector will assist in this person centred approach.

The priorities for action are as follows:

- early identification of [patients who may need palliative care
- advance / anticipatory care planning (ACP)
- palliative and end of life care in all Partnership sectors
- Electronic Palliative Care Summary (EPCS)
- do not attempt cardiopulmonary resuscitation (DNACPR)

Such priorities will embrace the policy of Shifting the Balance of Care and includes all agencies to work together to provide a 24/7 service.

Locally work is being undertaken in reviewing actions from Shaping Bereavement Care and developing a specific implementation plan. Also the Palliative Care in Care Homes Steering Group is shortly to distribute a number of recommendations which will require further action.

Community Equipment Services

It has been recognised by Forth Valley partners that the provision of community equipment is essential and without an effective provision the independence of many service users would be compromised. Furthermore the provision of equipment can be essential to prevent unnecessary hospital admission, support carers in their caring role and promote/maintain service users independence. This in turn can reduce the need for further service interventions.

The Forth Valley Joint Adult Strategic Planning Group (JASPG) recently approved a whole systems review of community equipment provision in conjunction with the Joint Improvement Team (JIT). The partnership's aim as highlighted through the review work is to deliver an efficient, integrated Community Equipment Service which contributes to a healthier, safer, more independent community. The partnership will achieve this by providing a range of quality services including assessment, advice and appropriate equipment provision, helping people to maximise their independence and well-being, and supporting carers in their caring role. It is

anticipated the equipment service will be underpinned by an enablement and self management approach in a community setting. This will include local agreement with the independent sector in relation to the ongoing national discussions about equipment provision and the national care home contract.

Medicines Management for Older People

Medicines are a significant and increasing area of expenditure and need to be managed both safely and cost effectively. As well as being prescribed a growing number of medicines for their multiple conditions, older people are more at risk of medication related adverse events with an increasing number of people being admitted to hospital as a result of these adverse events. In addition, older people often find it difficult to manage their medicines as prescribed requiring the support of family, friends, social care service providers or other health care professionals.

Good Practice Statements for Medication Management have been developed and provide a basis to implement a consistent, integrated health and social care service for medication management for older people e.g. through training carers, Telecare and community based healthcare professionals.

New ways of responding to these challenges will be required to support older people to live as independently as possible and enable them to manage their medicines safely and effectively e.g. greater involvement of family members or voluntary carers to help with medication management issues. The involvement of community pharmacists is of paramount importance and agreed pathways need to be promoted.

Falkirk Council Home Care Service secured match funding through JIT Telecare monies in 2010 for Medication Management. The service created a reviewing manager to specifically target service users where there are identified home care calls to support medication management, in particular medication prompts. The telehealth care proposal will continue to support the development work already underway with an additional assessor to carry out assessments to identify the most appropriate piece of equipment available and arrange installation and maintenance. It is envisioned this pilot work would be extended to include independent sector providers.

Modernising Technology

Falkirk Council Care and Support services recently completed a Performance Improvement Model self-evaluation across all service areas, excluding housing with care services. One of the key improvement areas identified was the need to modernise and streamline current paper-based processes that would release both employee capacity and cash efficiencies which can then be used to purchase or provide care to meet anticipated rising demand.

Transport

In January 2010, Scottish Ambulance Service (SAS) published “Working Together for Better Patient Care” a five year strategic framework to:

- improve patient access and referral to the most appropriate care
- deliver the best services for patients
- engage with all partners and communities to deliver improved health care.

Specifically the SAS is considering its potential contribution around improving care for older people in the following areas:

- avoiding hospital attendance/admission
- Contributing to Anticipatory Care Plans and Complex Case Management
- Building Community Resilience/Encouraging Co-Production.

We anticipate working together with the SAS as a key partner over the coming months to detail how we will work smarter together in improving care.

6. KEY CHANGES TO ACHIEVE OVER THE NEXT 5 YEARS

The Change Plan builds on the Forth Valley Partnership's shared vision for older people set out in the Forth Valley Joint Commissioning Framework: Older People. The shared vision is namely:

- older people are able to live in their own homes and local communities for as long as they wish, whilst enjoying a lifestyle that gives them what they want out of life
- universal public services are the principle means for supporting the wellbeing and healthy living options of older people and should enable many to live without recourse to formal health and social care services
- when an older person does need care and support their views and aspirations both as citizens and service recipients, as well as those of their carers, directly inform and influence the results that health and social care services strive to achieve
- older people receive a personalised response to their particular individual needs and are increasingly able to make as many of their own decisions as possible including when, how and by whom their service is provided
- services actively anticipate or prevent growing illness or infirmity and thereby support older people to remain active and healthy for as long as possible with the minimum necessary recourse to more intensive or intrusive care and support
- older people are kept safe by high standards of practice in the services they receive
- the outcomes achieved for older people across Forth Valley are not dependent on where they live.

Linking this vision to the strategic objectives of the Reshaping Care for Older Peoples' programme, this Change Plan seeks to deliver improved outcomes to older people and their carers that:

- maintain people, where appropriate, in their place of residence

- prevent acute admission/attendance by early intervention and planning for people with long term conditions
- ensure a consistent and sustainable approach to shifting the balance of care across the partnership
- support carers as key partners in care
- improve the focus and measurement on the quality of outcomes, minimising variation
- build on the track record of local partnership working
- change culture at an individual, community and services level
- mobilise communities and build resilience that empowers individuals and communities.

7. USE OF CHANGE FUND AND OUTCOMES ANTICIPATED

- improve outcomes for service users and their carers
- provide a comprehensive education programme with a focus on outcome-based interventions and reablement for all staff groups working with older people to achieve a cultural shift
- work in partnership with service users, acknowledging them as full partners in improving their health and independence and as experts in managing their own conditions and circumstances
- greater focus on reablement as a core principle and developing further approaches
- deliver a community based, multi-agency approach to the delivery of integrated care and rehabilitation at home or in a care setting provided by rehabilitation carers and AHP's, including the independent sector
- work proactively with the third and independent sector to progress alternative ways of working to promote reablement across all sectors. These will be developed in Partnership and will form the basis for the detailed Plans due by June
- assist in preventing inappropriate long term use of health and social care services
- prevent inappropriate or avoidable admission to long term care
- further develop approaches to intermediate care within the full partnership
- promote positive images of old age
- develop predictive tools to better anticipate service users and carer needs that will enable an appropriate response at the right time
- use technology to modernise services and support service delivery with timely and accurate performance management information.

The following summarises the Change Fund proposals (a- h) the partnership will take forward over 2011/12 and form the basis of future plans for the following 3 – 4 years.

a. Reablement in a Care Home Setting

We are aware that older people want to remain at home but to avoid admission to hospital in a crisis situation the person can sometimes require a range of different support systems to be confident and safe in their own home. In addition carers often require additional support and education to give them the confidence and ability to continue in their role.

A therapeutic environment within a care home could help to avoid admission to hospital particularly with older people who are having problems with mobility or living with a long term condition. It could support discharge from hospital in situations where the person no longer requires medical treatment but due to high levels of assessed risk has not yet reached the stage where they can return home. Evidence shows that there is an increase of people being admitted to hospital unable to cope without skills and knowledge in enablement

The proposal is to remodel 4/5 beds within a unit in a care home and provide a model of care which focuses on anticipatory and preventative approaches to care thus avoiding admission to hospital. Staff would work closely with the integrated rehabilitation/reablement service who would supplement helping the person regain their skills and help support them to remain in their own home. It is anticipated that each person would stay between 4 – 6 weeks with a discharge plan from admission.

The unit would provide 4/5 short term residential places for service users who are aged 65+ years who require more intensive rehabilitation than could be provided in their own home or who may have experienced a crisis at home which has severely impaired their ability to remain independent for a period. The unit could provide a service to approximately 36 people each year and result in fewer admissions to hospital or expedite a faster discharge from hospital.

The unit would be equipped with telecare to help introduce the person and their carer to its use to place a greater emphasis on self care and support for carers.

In addition a range of services would be offered to support reablement such as:

- falls prevention
- introduction to and support with telecare/health
- intensive rehab
- income maximisation.
- advice and support regarding telecare/health.
- signposting to other services in health, SW, independent with Third Sector carer support through education and networking.

We will work with independent providers for the future provision to be more flexible and community based, especially through care home and housing with care options.

b. Reablement at Home

The proposal is to extend the scope of the current enablement approach to work with service users who are aged 65+ years with long-term conditions and/or are frequent fallers who sustain an injury that does not require hospital admission. In addition, it is recognised that education and training professionals, service users, carers and providers will be crucial to ensure the culture shift required to implement reablement approaches.

c. Telehealthcare Service

The Falkirk partnership proposal will build on the progress made to date to further improve the integration of the telehealth care model into local service delivery in health and social care. The proposal would be to continue the Falkirk Council telecare and NHS Forth Valley (Falkirk CHP) telehealth leads for a further 18 months.

The outcomes anticipated include:

- Increase the number of staff and third party agencies who are trained in both telecare awareness and the telecare assessment process by providing more training sessions and developing and embedding telehealthcare training within mainstream health and social work training sections.
- Increased number of service users benefiting from telehealthcare equipment such as medication prompting devices, environmental controls, 'Just Checking' equipment etc.
- Establish a small starter budget for telehealthcare equipment for such items as medication devices, more environmental control equipment etc. until funds can be identified as savings for such and until these savings can be transferred over as a mainstream budget to enable long term sustainability of the telehealthcare programme.

d. Carer Support

Recognising the importance of supporting unpaid carers and the benefits that they derive from short breaks, we are committed to developing approaches that are innovative and flexible. Building on the achievements of Falkirk Council's Short Break Bureau, this proposal seeks to develop a new *Falkirk Shared Lives Service*.

Shared Lives is an 'adult placement', service model that involves recruiting, training and supporting families to become Shared Lives Carers, who use their own home to offer support to older people. This model builds on local community and family networks, is personalised and flexible to meet individual need. It can promote co-production, enhance health and well-being and promote citizenship.

Shared Lives can deliver short breaks, day support, rehabilitation and intermediate care. It provides a quality experience for the cared-for person, whilst giving their unpaid carer peace of mind and an opportunity for a short break.

A Falkirk Shared Lives Service would draw on the expertise of the Scottish Development Officer from NAAPS and would engage with the independent and third sector to determine the most effective method of delivering the service.

The costs for this proposal would be used to recruit and employ a member of staff, to then recruit, train and support Shared Lives carers, and to fund the additional respite care that this service would offer. This pilot service would highlight the opportunities for further development and for extending the service offered to other client groups, to the benefit of their carers, including older carers.

e. Workforce Development

As described in the previous section under Workforce, we recognise the only way that we are going to ensure a redesign of services and service delivery is through supporting our partnership workforce during this major change in culture.

The partnership anticipates that we will develop a detailed Organisational Development plan to cover the years of this Change Fund. It is anticipated that delivering the required level of training and development for our workforce will require to be carried out across the partnership. We also recognise that some partners will have limited or no resources within Organisational Development. Within NHS and Falkirk Council, there are departments which have worked together on specific projects and we anticipate that this will continue. The scale of managing the change agenda is such that there will be a requirement for external support with internal teams assisting in the operational delivery. We are keen to see any organisational development sessions being carried out in a multi-agency and multi-disciplinary manner, whilst ensuring all partners have equal access to this resource.

f. Planning and Commissioning Capacity

The Falkirk Partnership recognises the potential benefits that the Change Fund can bring in sustaining better outcomes for older people. As widely acknowledged this will require significant shifts in anticipatory and preventative approaches. This has been reflected in the various projects highlighted which have been linked to local agreed priorities. Nevertheless the successes of these projects are dependent on a number of factors. In delivering the necessary shift in the balance of care and ultimately influencing future decisions around the totality of the Partnership spend on older people's care will require investment in their implementation. However, equally important is consideration to their planning, continual evaluation, development and integration. There is a need to ensure dedicated capacity within the local Partnership to establish

- Jointly agreed processes and procedures that are both managed and coordinated.
- The engagement and active involvement of all key stakeholders across all sectors.
- Robust planning processes and monitoring of timescales to support and direct future planning activity.
- Supporting strategies for example, effective communications are in place throughout the planning and evaluating processes.
- Clear and systematic Service Level Agreements where appropriate.
- Evidence collection and analysis around future need base at a local Partnership level.
- A clear understanding of the benefits and any potential short comings of the projects by means of effective monitoring linking to available evidence base research.

However, increasing demand and expectations create significant challenges. These are combined with considerable budgetary constraints, competing pressures from other areas and a decreasing workforce. This has led to limited availability of existing planning and commissioning resources across the Partnership. In an effort to address this limitation Falkirk Partnership would intend to utilise additional resources

from the Change Fund. This would enhance the planning and commissioning capacity across the partnership to support the on-going success of the Change Fund including the production of a joint commissioning strategy 2012 – 20.

g. Real Time Monitoring System

The proposal is to purchase a real time monitoring system for the Care at Home service. This would be a one-off cost to purchase the system and employees to ensure successful implementation. It is anticipated that any further running costs (eg licences, maintenance) would be met through the efficiencies achieved by the implementation of the system. Further work will then take place to explore opportunities in following years to expand this into health and independent sectors.

A number of benefits and efficiencies have been identified from the introduction of electronic methods of recording, monitoring and managing the delivery of home care services (both in-house and those commissioned) to service users. The systems have the ability to provide commissioner's accurate data on actual care hours delivered to each service user therefore ensuring accurate charges are made.

Electronic monitoring systems can lead not only to improved quality of service, but also to streamlined processing and administration – especially where these processes currently rely on manual, resource-intensive systems. Electronic monitoring also facilitates payment on the basis of service delivered rather than service ordered, eliminating error (and fraud), supporting fair charging, reducing waste and service queries, and demonstrating value for money. Plus-points for providers include improved cash flow and faster dispute resolution.

The funding for this aspect of the plan would be non-recurring and the partnership would seek to reallocate this funding in year 2 of the Change Plan to other priority areas.

h. Partnership Innovation Fund

The core proposal is for the establishment of a Partnership Innovation Fund (PIF) to fund innovative bids. The PIF will support the development of smaller, innovative projects that meet clearly defined criteria and can be expected to contribute to the achievement of relevant outcomes in reshaping care for older people, as outlined in section 5. The key theme for the PIF will be to build community capacity.

The partnership will establish a panel to determine the criteria and outcomes based on local knowledge of needs, drawing from existing partnership strategies and plans but also clearly linked and complementary to the activity being undertaken within other strands of our Change Plan.

Bids of up to £50k will be sought from agencies across the public, independent and third sectors with bids to be led by third sector organisations. We do not seek to be overly prescriptive in determining the nature of the projects for fear of stifling the very innovation we seek and need although we will be very clear about the outcomes we are seeking. We know from engagement with the third sector that there are potential

projects around themes like befriending, advocacy, income maximisation, approaches to service planning and evaluation, repair and maintenance services, information provision, carer support and others. In many ways, this fund will support the principles of a Public Social Partnership (PSP) approach, something which already is being developed in partnership locally.

The PIF will be open to bids where there is demonstrated partnership activity across sectors. This recognises the significant contribution each sector makes to the achievement of outcomes for our older people and reflects the flexibility, creativity and commitment to our service users.

The intention of the PIF s to maximise the impact of the resource over a range of projects, to learn what works well locally and find ways of sustaining key activities to achieve our agreed outcomes. This Fund maximises opportunities, supports innovation and will be aimed at building community capacity as a way of achieving outcomes.

8. KEY PERFORMANCE MEASURES TO ASSESS PROGRESS

Further work to develop relevant performance measure will be required as initiatives develop but the partnership understands that key performance indicators will be critical to monitoring impact and outcomes for individuals and service efficiencies. There will be challenges within this in joint monitoring of pathways of care with varying care providers.

The key performance measures will include:

- Delayed discharge
- reduced rates of 75+ emergency admissions and bed days
- fewer avoidable A&E attendances and hospital admission/readmission
- more time spent in the community in the last 6 months of life
- increase the provision of reablement services, to reduce dependency in long-term care at home services
- reduced rates of new long term institutional care
- service user and carer satisfaction
- number of carers assessments completed.

9. SUMMARY OF HOW CHANGE FUND WILL ENABLE SHIFTS IN CORE BUDGETS AND IMPACT ON THE TOTALITY OF SPEND BY THE PARTNERSHIP OVER THE NEXT 5 YEARS

Following the MAISOP inspection outcomes, and through the development of the Joint Commissioning Strategy, partners acknowledge that continuing to provide the same services in the same way is not sufficient or sustainable.

Demographic change and financial pressures indicate that the gap would continue to widen between spend required and resources available. The development and modelling around re-ablement and intermediate care shows how these services could shift spend from more expensive care home and intensive care at home to more appropriate and cost effective support as and when required. Evidence also

suggests that effective use of electronic monitoring systems will realise savings of 5-8% in home care budgets whilst enabling a more responsive service for service users.

The partnership will develop data and financial modelling, using the Integrated Resource Framework. This will forecast the impact of planned changes on resource consumption and use which will inform decision-making on how resources can be shifted from acute provision to community based services that will continue to support the delivery of Shifting the Balance of Care and Change Fund programmes.

In addition, in delivering improved efficiencies across community health and social care services, this will assist the partnership to ensure the effectiveness and sustainability of services that will meet the current and future anticipated needs of older people and their carers.

10. THE FINANCIAL MECHANISM AND GOVERNANCE FRAMEWORK

Ensuring sustainability and best value will be integral to the Change Plan and the partnership will consider mechanisms such as formally pooled budgets to enable resource shifts across organisational boundaries.

With respect to financial governance arrangements financial control will be undertaken monthly by local Finance Officers in liaison with relevant Change Fund Managers.

Reporting of financial performance, operational matters and monitoring of outcome realisation will be to local management, a proposed Change Fund Steering Group, and then to the Joint Management Group and the Community Planning Leader Group for overall strategic review. In recognition of the priority to ensure the equitable delivery of services across Forth Valley and to ensure the sharing of good practice, Forth Valley wide governance arrangements will be arranged through the Partnership Boards, which will be supported by the Forth Valley Joint Adult Strategic Planning Group.

The Community Care and Health Forum will have the Change Plan as a standing agenda item, and is already attended by NHS and Council partners. The Third Sector has representation on the Older Peoples' Implementation Group, the CHP Health Partnership Management Group, the CHP Committee and numerous other multi-agency partnerships. Through these established relationships the Third Sector will be directly able to support the delivery of the Change Plan.

11. SUPPORT REQUIREMENTS TO ASSIST DELIVERY

The Forth Valley partners have recognised there will be a range of support requirements to create capacity across all sectors that will ensure the successful implementation of the Change Plan priorities.

It is proposed that planning, performance and commissioning capacity is build into respective Change Plans that will focus on the partner's priority areas, in particular realising joint commissioning strategy priorities.

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

Signed

APPENDIX 1

FAKIRK PARTNERSHIP - SPEND ON HEALTH AND CARE SERVICES FOR OLDER PEOPLE (2009/10)

FALKIRK PARTNERSHIP - SPEND ON HEALTH AND CARE SERVICES FOR OLDER PEOPLE			
	2009/10		
	LA	NHS	TOTAL
	£000	£000	£000
HOSPITAL BASED			
- Emergency Admissions		26,641	26,641
- Elective admissions and day cases		17,933	17,933
- Outpatients		11,706	11,706
- A&E		2,795	2,795
- Day Patients		1,653	1,653
- Direct Access			0
COMMUNITY BASED			
- GP Services		4,876	4,876
- GP Prescribing		14,786	14,786
- District Nursing		1,211	1,211
- Community AHP's		770	770
- Community Mental Health Services		1,660	1,660
- Care Homes	14,275	81	14,356
- Care at Home	15,737	431	16,168
- Other Care Services	6,515	6,046	12,561
- Other Community Services	546	5,712	6,258
Other Expenditure			
- Housing Support			0
- Care and Repair			0
- Transport			0
- Third Sector		476	476
- Other		8,038	8,038
TOTAL	37,073	104,814	141,887
Plus Capital Resources Totalling	76		76
Note:			
Health Expenditure has been allocated using best available local patient activity information and assumed proportions of expenditure relating to over 65's using bases calculated by the national IRF team.			
These figures should be considered as indicative at the moment and will be further refined upon completion of IRF mapping exercise.			

APPENDIX 2

INDICATIVE COSTING FOR FALKIRK PARTNERSHIP CHANGE PLAN

	Area for Change	£000's	Intention
a.	Reablement in a care home setting	300	Providing a step-up/step-down service for 4/5 older people at any one time.
b.	Reablement at home	386	Provide a reablement service to those older people at risk of admission to hospital
c.	Telehealthcare service	276	Further integration across all sectors of telehealthcare services
d.	Carers Support	100	Supporting carers and development of a Shared Lives model
e.	Modernising Technology	280	Real-time monitoring system (one-off spend)
f.	Partnership Innovation fund	300	The PIF will support the development of smaller, innovative projects across sectors.
g.	Organisational development	100	Provide a comprehensive education programme with a focus on outcome-based interventions and reablement for all staff groups working with older people to achieve cultural shift.
h.	Planning and Commissioning Capacity	100	Provide planning and commissioning capacity to progress previously agreed priorities, including the production of a joint commissioning strategy 2012 – 20.
i.	National Delivery Plan	43	To be determined by the publication of the National Delivery Plan. If this is not required the partnership will reallocate funding to accelerate the roll-out of reablement and to meet other agreed priority areas.
	Total	1885	

Note

A number of the proposals are in the early stages of development and further work will be completed to finalise the costings.

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