PERTH AND KINROSS COUNCIL

Housing and Health Committee

27 May 2015

Reshaping Care for Older People

Report by Executive Director (Housing & Community Care)

PURPOSE OF REPORT

This report advises Committee on the evaluation of successful Reshaping Older People's Services Change Fund activity and measures to ensure their sustainability. It is the successor paper to 14/108 presented to Committee on 12 March 2014.

1. BACKGROUND / MAIN ISSUES

1.1 In 2010, the Government launched its 'Reshaping Older People's Care' agenda with a strong emphasis on developing robust community alternatives to residential and hospital care. The 'Change Fund for Older People' was subsequently established in 2011 by top slicing funds from NHS Scotland and distributing these to Health Boards and their partner Local Authorities in order to support the shift of resources as described above. This Fund came to an end in March 2015. Government's expectation of Change Fund Partnerships was that they would introduce new ways of working which saw fewer older people being admitted to hospital and those who were admitted being discharged faster. In addition, it was expected that the new Change Fund partnerships would develop new relationships with communities which saw more older people being supported, with a range of statutory and voluntary input, in their own homes and communities.

1.2 It is the performance of the various Change Fund projects against these outcomes which are reflected in this paper. These approaches we now intend to consolidate and build upon as a key pillar of our Reshaping Older People's Strategy henceforward. In some instances it is difficult to distinguish the contribution of a single initiative. It may have built upon existing good practice (such as Reablement) or connect directly to other important initiatives funded by the Change Fund. Where a marginal or relative contribution analysis has been possible, this has been undertaken. Where this has not proved possible, key areas of impact have been attributed to one or more initiatives which in the view of the Change Fund Board, have contributed directly to a shared outcome. The Change Fund created 4 key workstreams (1.1 – 1.4) supported by a planning and support workstream (1.6). A further test of change of the Enhanced Care model has recently been appended as a sixth workstream (1.5). The workstreams are as follows:

1.3 **Initiatives Designed to Reduce Unplanned Admissions**

Unless an initiative is marked as '1 Year only', all costs should be read as 'Recurring costs'. Where employment or other costs (e.g.Step Up Care Beds) are set against this Council, this is indicated by (Council). Where costs are attributable to NHS Tayside or to a voluntary organisation, this is similarly noted.

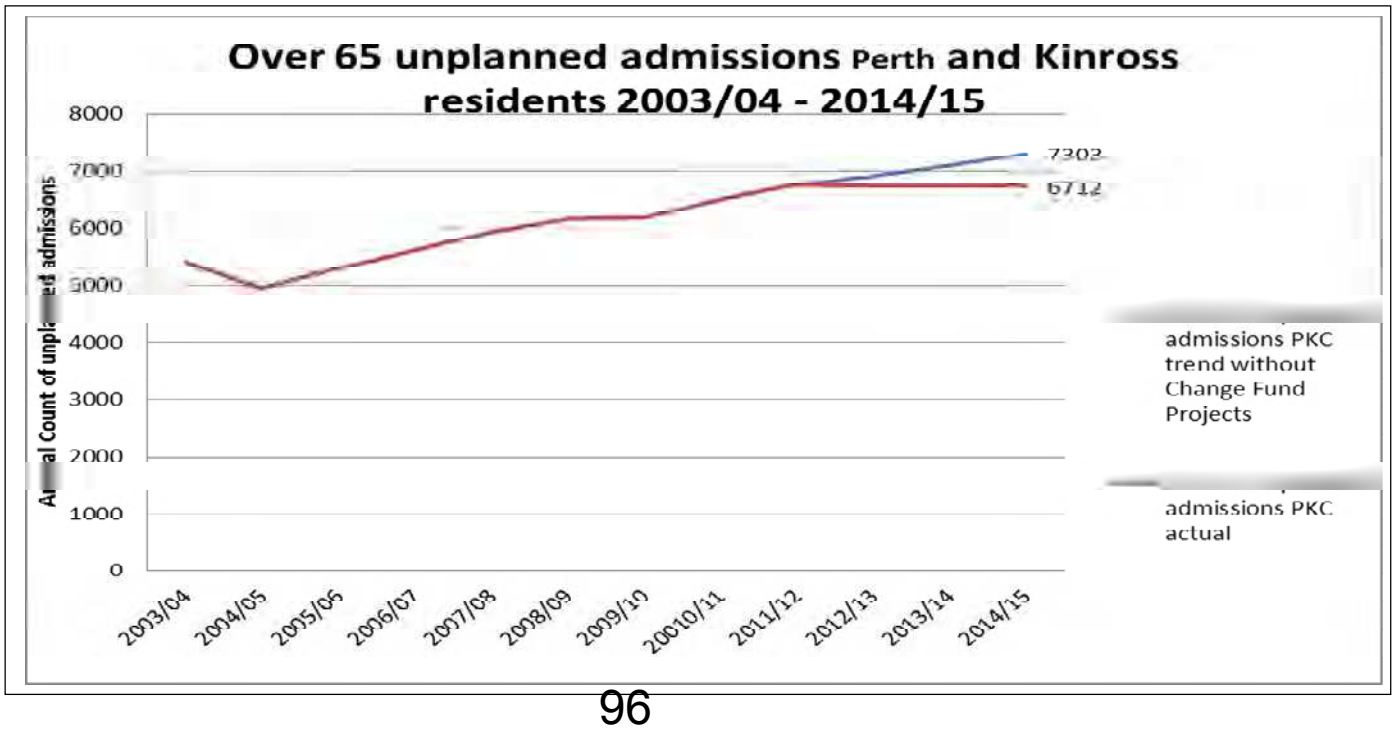
The key Change Fund initiatives assessed as having greatest impact upon unplanned admissions were as follows:

- The core Rapid Response Team comprising 8 x Social Care Officers - (Council) and 1 Nurse Co-ordinator - (Health)
- 'Step Up to Care Homes' - (Council)
- Marie Curie Health Support Workers x 3 - (Health)
- Chronic Obstructive Pulmonary Disease (COPD) Nurse - (Health – **1 year only**)

1.4 The Rapid Response Team focus on preventing avoidable admissions to hospital by delivering a same day 'Homecare' service linked to Nursing Advice, while also providing an access point to 'Step Up' residential care as a direct alternative to hospital care. The three Health & Personal Care Assistants employed through the Marie Curie Service support patients in the last 3 months of life, enabling them to remain in their own home and supporting their unpaid carers in their caring role. The feedback from carers and families has been very positive.

Cumulatively, these are serving to stem the tide of unplanned admissions of people aged over 65. As Figure 1 beneath demonstrates, the percentage of those aged over 65 in Perth and Kinross who became an unplanned hospital admission began to level off in 2010/11 and has flattened out during 2013-14 – suggesting that these projects are beginning to exert a collective brake on the inexorable rise in unplanned admissions.

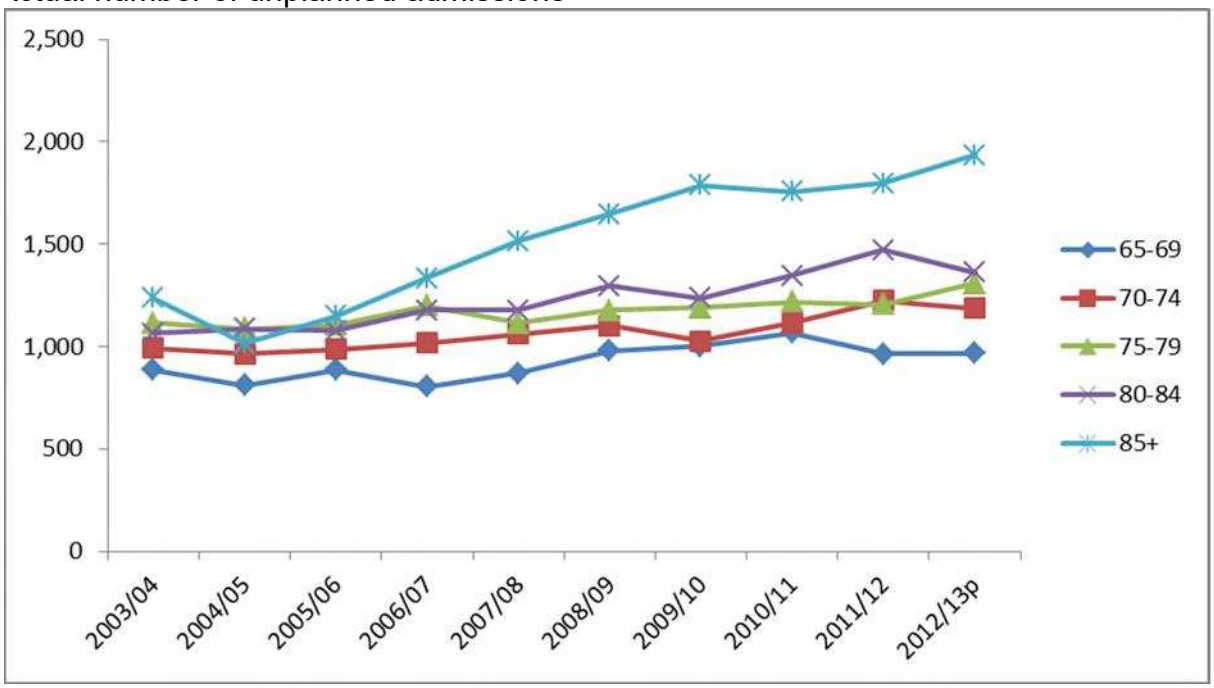
Figure 1



While the introduction of Change Fund initiatives have served to stabilise admissions to hospital of older people, however, the actual numbers of those admitted has declined very little, if at all, as illustrated by Figure 2 beneath.

Figure 2

Actual number of unplanned admissions



1.5 While reductions in admissions to 2012/13 can be seen in the 70-74 and 80-84 age groups – these are offset by increases in the 75-79 and, above all, in the 85+ age groups. The total number of unplanned admissions to hospital has increased, but the rate of increase has slowed significantly compared to that in the 12 month period before the Change Fund began.

To put this into context, the drop of 0.9%, during 2013-14 in the numbers of people aged 65+ who became an unplanned admission equates to 294 patients for that year. At approximately 5 patients per week, this amounts to an estimated saving on admission costs of approximately £2,000,000 per annum and a further saving of over £700,000 in relation to these same people not then being delayed in hospital awaiting discharge. (The average cost of an unplanned admission for those aged over 65 for financial year 2010-11 was £7,100).

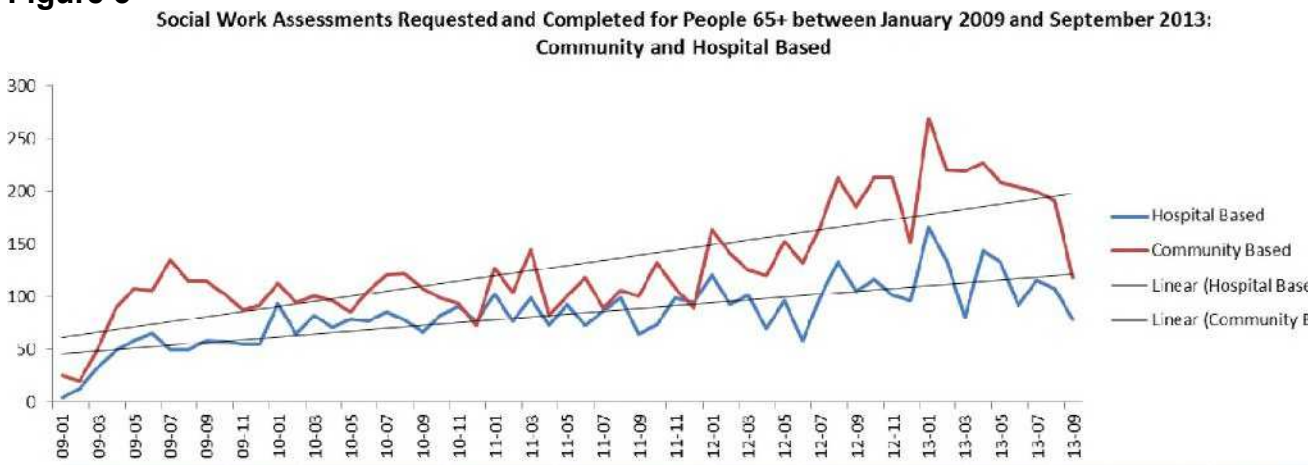
Over and above this figure, however, is the cost (both human and financial) of planned operations which would have been cancelled – had steps to reduce the number of unplanned admissions not been in place.

1.6 **Initiatives designed to reduce the number of bed days lost through delayed discharge from hospital**

The backdrop against which these initiatives should be considered is not that of the number of unplanned admissions of those aged over 65, but rather the proportion of those unplanned admissions who were subsequently referred for Social Work support. In practice, the vast majority of such referrals will require the services of Reablement, Home Care or a Residential Care placement in order for them to leave hospital.

As Figure 3 beneath, starkly illustrates, the number of patients referred to hospital Social Workers has risen by a factor of almost 200% between 2009- 10 and 2013-14. It is against this backdrop of an exponential rise in referrals for Social Work support that the success of those initiatives targeted at reducing the number of days lost to delayed discharge should be evaluated.

Figure 3



	2009	2010	2011	2012	2013 (Outturn)
Hospital	551	949	1037	1193	1404
Hospital Referrals per week		18	19	22	27
Community	1047	1214	1303	1977	2476
Community referrals per week		23	25	38	46

The key Change Fund investments assessed as having greatest impact in this area are as follows:

- 4 Social Worker posts dedicated to the assessment of older people in hospitals – to be commuted to 2 x Social Worker posts and 1 x Community Care Assistant - (Council)
- 15 part time Social Care Officers supported by a clerical worker, who deliver the Immediate Discharge Service (Council)
- 3 Rehabilitation Assistants and 1 Occupational Technical Instructor – (Health)

- Care Home Liaison band 5 nurse - part year funding only 15/16 (Health)

The total cost of this investment over the 3 year period of the Change Fund amounted to £1.5m and the Council's calculations would suggest that these investments will have saved an estimated 6,200 delayed days for the full 3 year period. This equates to a saving of £1,085,000 in bed days per year, based on a conservative cost per delayed bed day of £175.

As Figure 3 above indicates, however, the number of patients referred to hospital Social Workers for continuing Social Work support upon discharge from hospital rose from 949 to 1404 between 2010-2013. To achieve any reduction in the number of days lost to delayed discharge, when faced with such a sharp increase in demand, bears testimony to the impact of these initiatives. In their absence, an increase in the number of Delayed Discharge days of least 50% would have been in prospect.

1.7 **Initiatives focused on supporting dementia sufferers in the community and preventing avoidable stays in hospital**.

The initiatives under this workstream, whilst few in number, were significant and sought to build upon the ground-breaking work undertaken in the Strathmore Dementia Demonstrator site. This separate, but related development saw the transfer of staff from Blairgowrie Community Hospital into the community to support service users and their families and the provision of respite from within local Care Homes as an alternative to Psychiatric hospital. At the other end of the disease spectrum, intensive screening was also undertaken to identify the disease at an early stage, with advice and support to patients and their families as appropriate.
In terms of impact, the Dementia Demonstrator Pilot enabled the closure of a hospital ward and saw the number of dementia sufferers from the Strathmore area admitted to Murray Royal Hospital reduce from one of the highest in Perth and Kinross to the lowest, in under 3 years. Currently, admissions per month for Strathmore is between 12 1/2 - 25% less than admissions for any other area in Perth and Kinross.

1.8 The Change Fund provided an important adjunct to the demonstrator pilot through the appointment of Dementia Link workers employed by Alzheimers Scotland. These 3 workers, attached to the Older People's Community Mental Health Teams, now provide post-diagnostic support for a minimum of 1 year, supporting achievement of the Scottish Government's post diagnostic Heat Target. Evidence from Mental Health professionals, service users and their families, clearly indicates that they provide a much needed advice, information and self-management support service with most service users remaining independent/self-managing upon discharge from the service.

This Change Fund workstream also saw the appointment of a Dementia Liaison Nurse and Occupational Therapist within Perth Royal Infirmary tasked with preventing older people with dementia becoming 'stuck' in a medical ward because staff were not skilled or experienced in meeting their underlying

needs. Prior to the appointment of these staff, transfer of patients admitted to PRI for a physical reason straight to Murray Royal Hospital had been common place. Within 6 months of their introduction, this figure had reduced and remains at that level. The 5 Social Care Officers attached to this project work closely with the Occupational Therapist to support rehabilitation and prevent readmission to hospital. The average length of stay in hospital for older people affected by dementia or some other mental health need has fallen since the introduction of this enhanced team, by an average of two days per referral.

1.9 **Initiatives designed to engage more effectively with communities and encourage the development of greater community resilience.**

This workstream focused on the need to engage communities in determining their future health and social care needs and on working with them to develop greater resilience.

1.10 A Community Engagement approach has now been developed involving Change Fund workers from PKAVS, ECS Capacity Workers and members of the Healthy Community Collaborative in Highland Perthshire, Strathmore and Strathearn which has facilitated an extensive consultation exercise in Highland Perthshire regarding the shape of future Health and Social Care provision, the establishment of Development Groups in Highland and Strathearn, and Older People's fora in Pitlochry and Blairgowrie, with a wide range of community contacts at points in between.

While these developments are difficult to calculate in monetary terms, there is strong evidence that communities across Perthshire are now much more involved in informing and contributing to the shape of Health & Social Care Services in their areas.

1.11 In addition, we now have 5 Timebanks operating across Perthshire; a Carers Support Worker, based in PRI and employed by PKAVS; Mens Sheds in Invergowrie and Aberfeldy; and a network of support provided to people suffering from long term conditions provided through 'Positive Choices', a local voluntary organisation.

The total ongoing investment in Workstream 4 amounts to:

- 4 x Engagement Workers employed by PKAVS
- Timebanking Co-ordinator employed by PKAVS
- Carers Hospital Link Worker employed by PKAVS
- Support to those with long term conditions (Positive Choices)
- Healthy Community Collaborative worker (Health – **1 year only**)
- Support Officer for Scottish Care (Scottish Care)

1.12 As noted earlier, it is difficult to ascribe a value to much of the work taken forward within this Workstream. The estimated Return on Investment for Timebanks, however, is known to be £6 return for every £1 invested (Change Fund Mid-Year Review). On the basis of the hours committed through Timebanks during 2013 (in excess of 4,500 hours) the scheme has already

generated the equivalent of £27,000 of value. Since the project was last evaluated, new schemes have emerged in Blairgowrie, Rattray, Alyth and Pitlochry.

The Carers Support Worker, attached to the Hospital Discharge Team, identified 138 new carers during their first year in post and signposted them to services as appropriate. Given the new challenges facing local authorities and their partners in this area, the introduction of a post which identifies carers more effectively at the point of entry into this system is of considerable assistance – although difficult to quantify in monetary terms.

The work with patients/service users with long term conditions undertaken by Positive Choices is more readily quantifiable. A sample of 20 respondents provided strong evidence that they were now taking the correct dose and type of medication (100%); were unlikely to be admitted to hospital (85%); and were able to manage their conditions (85%).

1.13 **Enhanced Care Team**

Learning from the success of a Winter Pilot conducted in Dundee and Angus with a group of GP practices focused on avoiding unnecessary admissions and on early hospital discharges – funding has been committed for 1 year from the Change Fund to trial a similar approach in Perth and Kinross. 2 GP practices have been identified (one a rural practice and the other a Perth City practice) and targeted additional resources will be provided to facilitate early identification of ‘at risk patients’, coordinated support from health professionals and ‘pull-through’ the hospital system where possible. These ‘Enhanced Care Teams’ are intended to integrate health professionals more effectively around the needs of patients and will provide a platform on which to build inter-agency disciplinary teams in due course.

The key additional elements of Enhanced Care Teams entail backfill for certain health care posts and funding of additional GP sessions to enable key staff to commit to a level of communication and planning necessary to deliver earlier intervention.

Enhanced Care Teams will be evaluated at regular intervals as the pilot projects progress, but the evidence from Dundee/Angus pilot suggests the real possibility of reductions in both Unplanned Admissions and in days lost to Delayed Discharge. Funding from the Change Fund for this project is for 1 year only as a test of change. Longer term funding requirement to be confirmed.

1.14 **Planning and Support**

In addition to the foregoing areas of operational investment it has also proved necessary to invest in a number of administrative posts to support forward planning, communications, commissioning and integration. Some of these posts will come to an end naturally during financial year 2015-16 (Planning & Support Officer for Health and Lead Officer for Integration of Occupational Therapy Teams) while the need for others will continue (Communications Strategy Officer and Joint Commissioning Strategy Officer).

2. PROPOSALS

2.1 On the basis of our experience of Change Fund projects, we would now propose to incorporate the key lessons of the last 3 years into our Reshaping Older People's Care Strategy – as they relate to:

- Initiatives which have served to reduce unplanned admissions
- Initiatives which have served to stem the number of bed days lost through delayed discharge
- Initiatives focussing on support to dementia sufferers and their families
- Initiatives designed to engage with communities and to support the development of community resilience

Funding to support successful Change Fund projects has been identified from a combination of the balance of Change Fund monies remaining at the end of financial year 2014-15 and a successful bid into the Integrated Care Fund of £2,630,000. By 2016, both NHS Tayside and Perth and Kinross Council must have identified longer term funding sources if these successful Change Fund initiatives are to be safeguarded.

3. CONCLUSION AND RECOMMENDATIONS

The Change Fund for Older People's Services provided opportunities for developing new approaches to deliver more cost effective and sustainable services to older people. It is now clear which initiatives have contributed most towards these objectives and which may be incorporated into, and to inform our Reshaping Older People's Care Strategy. The key challenge now facing us is to secure the funding necessary to embed these successful projects as pillars of our Reshaping Older People's Care Agenda.

In light of this, it is now recommended that Housing and Health Committee:

(i) Instruct the Executive Director (Housing and Community Care) to continue to work with colleagues in NHS Tayside to identify medium term funding, beyond April 2016 to support successful Change Fund initiatives.

(ii) Instruct the Executive Director (Housing and Community Care) to bring forward a further report to Committee in six months time.

Author

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Approved

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ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	**Yes / None**
Community Plan / Single Outcome Agreement	**Yes**
Corporate Plan	**Yes**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Asset Management (land, property, IST)	**None**
Assessments	
Equality Impact Assessment	**Yes**
Strategic Environmental Assessment	**None**
Sustainability (community, economic, environmental)	**None**
Legal and Governance	**None**
Risk	**Yes**
Consultation	
Internal	**Yes**
External	**Yes**
Communication	
Communications Plan	**No**

1. Strategic Implications

Community Plan / Single Outcome Agreement

1.1 This report supports the following outcomes of the Community Plan / Single Outcomes Agreement in relation to the following priorities

(iv) Supporting people to lead independent, healthy and active lives
(v) Creating a safe and sustainable place for future generations

Corporate Plan

1.2 This report supports the following outcomes of the Community Plan / Single Outcomes Agreement in relation to the following priorities

(iv) Supporting people to lead independent, healthy and active lives; and
(v) Creating a safe and sustainable place for future generations.

2. Resource Implications

Financial

2.1 There are no immediate resource implications arising from this paper. As the funding to support the initiatives described therein has been identified for the current year.

The resource implications will arise from 2016 onwards. If negotiations with NHS Tayside and Scottish Government result in longer term funding being identified through the recurring of Change Fund monies, the Integrated Care Fund or some other avenue, the posts relating to the initiatives described in this paper will be protected. If such funding is not identified, decisions will be taken about which posts should be continued (if any) and which funding sources will be employed.

Workforce

2.2 The workforce described within this paper has already received induction and training. Opportunities to maximise the benefits from this workforce (and other staff within HCC) are continually explored. The principle workforce implication will arise only if a longer term funding source to support these posts cannot be identified.

Asset Management (land, property, IT)

2.3 n/a

3. Assessments

Equality Impact Assessment

3.1 Under the Equality Act 2010, the Council is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Carrying out Equality Impact Assessments for plans and policies allows the Council to demonstrate that it is meeting these duties.

The Equality Impact Assessment undertaken in relation to this report can be viewed by clicking www.pkc.gov.uk/olderpeople

The proposals have been considered under the Corporate Equalities Impact Assessment process (EqIA) with the following outcomes:

- The average length of Delayed Discharge of older people has been reduced
- Certain older people are being prevented from being admitted to hospital unnecessarily
- Initiatives are being developed within communities which contribute to the resilience of those communities and the options to support older people
- Options have also been developed which open up employability avenues and increase choice for older people

Strategic Environmental Assessment

3.2 The Environmental Assessment (Scotland) Act 2005 places a duty on the Council to identify and assess the environmental consequences of its proposals.

3.3 Under the provisions of the Local Government (Scotland) Act 2003 the Council must discharge its duties in a way which contributes to the achievement of sustainable development. Under the Climate Change (Scotland) Act 2009 the Council also has a duty relating to climate change and, in exercising its functions must act:

- In the way best calculated to delivery of the Act's emissions reduction targets;
- In the way best calculated to deliver any statutory adaptation programmes; and
- In a way that it considers most sustainable.

N/A

Legal and Governance

3.4 N/A

Risk

3.5 The key risks contained within this paper is that long term funding to support these projects cannot be identified. Given the continuing decline in funding available to the Council to support Older People's Services combined with the demographic challenges described within this paper, it would be extremely difficult for this Council to identify such long term funding – without significantly imperilling (or indeed ceasing) other aspects of Community Care provision.

The initiatives within this paper are focussed upon protecting our hospital system. If long term funding cannot be identified, it is this system which will be placed at greatest peril. For this reason, it is appropriate that we seek to identify a long term funding solution in discussion with our colleagues in NHS Tayside and the Scottish Government.

4. Consultation

Internal

4.1 This paper has been the subject of consultation with the Chief Social Work Officer, Head of Finance and Head of HR.

External

4.2 This paper has been the subject of consultation with the Acting General Manager of the CHP and the Director of Communities, NHS Tayside.

5. Communication

5.1 N/A

2. BACKGROUND PAPERS

None

3. APPENDICES

None