OLDER PEOPLE'S PLANNING FRAMEWORK 2013-16

1. NATIONAL CONTEXT AND TARGETS

1.1 Reshaping Care for Older People is a major national priority for the NHS and partner agencies. The key national drivers to this programme are:

- **Reshaping Care for Older People: A Programme For Change 2011 – 2021;**
- Allocation of the **Change Fund;**
- Consultation on **integration of adult health and social care services**, the outcome of which should be known later this year**.**

1.2 This framework requires to deliver the following HEAT targets:

- Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15. (**NHSGGC target 5,630 by March 2015**);
- No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015. (**NHSGGC target 0 by April 2013**)

2. NHSGGC CONTEXT

2.1 A review of progress against previous planning framework outcomes indicates that the following require further action over the course of this planning cycle:

- development of effective approaches to early intervention and anticipatory care including with other partners to ensure older people who need support have their needs identified as early as possible and that appropriate multi speciality and agency arrangements are in place;
- further development of community capacity and support to carers, clearly linked to delivery of outcomes;
- a shift in the balance of care so that people are cared for in settings appropriate to their needs;
- actions to meet targets for discharging patients from hospital as soon as they are clinically ready;
- implementation of the national dementia strategy; and,
- further development of effective end of life care.

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OUTCOMES AND ACTIONS

Preventing Ill-Health and Early Intervention

Preventing ill health and early intervention are vital if we are to reshape older people's services and support more people to live independent lives in community settings, including those with dementia. Prevention and early intervention are also crucial in improving the health of older people, tackling inequalities and reducing demand. A key focus for us over the next three year planning cycle will be to put in place programmes to support active ageing and older people staying healthy, more anticipatory care plans.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
1) Effective joint plans with other partners, including housing and the third sector to prevent ill health amongst older people.	- Develop local programmes to support active ageing, with a focus on preventing depression, anxiety, social isolation, and promoting positive physical and mental health and well being, including actions on smoking, alcohol and obesity as well as health impacts of poverty and welfare reform. - Take forward actions from the Community Food, Fluids and Nutritional Care group to implement nutritional screening and intervention. - Review local falls prevention programme in light of national recommendations.	- Number of older people participating in active ageing programmes, including carers - Completion of MUST and related care pathways within community settings - Levels of participation in physical activity/falls prevention programmes - Rates of 65+ conveyed to A&E with principal diagnosis of a fall (SAS data)
2) Promote early intervention by improving identification of, and response, to vulnerable older people, particularly those at risk of admission to hospital.	- Maximise use of SPARRA amongst GP practices to support early intervention approaches and assist in managing demand - Introduce GP practice based registers of	- Reduced rate of emergency inpatient bed days for over 75s - Number of people with anticipatory care plans. - Evidence of carers needs included in

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
	vulnerable older people utilising QOF/QP data on COPD, falls and SPARRA. - Ensure anticipatory care plans are in place for those at risk of admission to hospital. - Introduce anticipatory prescribing to enhance patient care and aid the prevention of unnecessary crises and unscheduled hospital admissions. - Ensure carers needs and support are an integral part of anticipatory care planning. - Investigate ways to secure more integrated working between GP practices, community health services, social work services and third sector organisations	anticipatory care plans

Shifting The Balance of Care

We need to shift the balance of care if we are to support more people to live in community settings, and to respond to the demographic changes. Progress will be needed over the course of this three year planning cycle to change key pathways of care, and deliver services closer to where people live, if we are to make a significant shift in the balance of care by 2016.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
3) Ensure patients, including people with dementia, are cared for in appropriate settings, and able to stay in their own homes, including care homes, as long as possible.	- Implement local provision of specialist medical assessment where appropriate. - Deliver Board-wide specification on support to care homes. - Take action with Acute and Social Work to improve and maintain the efficient management of discharge planning. - Take action via locality unscheduled care groups to analyse patterns of admission and design appropriate effective interventions. - Assess need for intermediate care to inform commissioning plans and identify issues requiring consistent Board-wide approach. - Reach agreement with SAS and GEMS on actions to improve OOH response including District Nursing. - Implement actions from polypharmacy strategy and associated guidelines.	- Reduction in number of acute bed days lost to delayed discharge (inc AWIs) – 65+ - Emergency admissions 75+ Rate /1,000 pop - Delayed Discharges: zero delays longer than 4 weeks by April 2013 and zero delays longer than 2 weeks by April 2015
4) More carers are supported to continue in their caring role.	- Put in place arrangements with GPs to identify and support carers in primary care	- Number of carers recorded on GP registers

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
	settings - Assess the implications and unpaid care requirements of reshaping care for older people plans - Assess how carers will be identified and supported - Align Change Fund carers support with Carers Information Strategy implementation plans	
5) Increase the number of people dying in the place of their choosing.	- Implement recognised tools or triggers for palliative and end of life care needs. - Implement processes for assessment and review of patients with palliative care and end of life care needs using recognised tools. - Ensure that timely, holistic and effective care planning takes place at appropriate stages of the patient journey.	- % of time in last 6 months of life spent at home or in community setting (national guidance to be issued) - Number of advanced care plans.

Reshaping Care for Older People

Reshaping care is a key strategic priority for NHS GG&C and our partners, and a national priority. Reshaping the way we delivery care for older people is important if we are the meet the demographic and resource challenges set out in the Corporate Plan. Over the course of this three year planning cycle fundamental changes are planned that will be taken forward in partnership to radically change how we respond to the needs of older people, including those with dementia. These will be articulated in Joint Strategic Commissioning Plans that set out a ten year strategy to change the way we support older people.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
6) Clearly defined models of care and patient pathways that meet the needs of people with dementia, including increased levels of post diagnosis support.	- Establish specialist liaison services with adult mental health and OPMH - Improve liaison arrangements between GPs, psychiatrists, nurses, community pharmacy, care homes, and community services in prescribing and medicines management. - Encourage GPs to identify dementia at an early stage in the disease process. - Implement protocols for post diagnosis support in conjunction with social work services and the voluntary sector - Prepare local action plan to implement new HEAT target by March 2014.	- Reduction in average length of hospital stay - Number of people diagnosed with dementia on QoF - Number of people with post diagnostic support packages
7) Improved partnership working to redesign and enhance support to older people to remain at home.	- Develop joint strategic commissioning with partner agencies, including users and cares, that reduce delays and emergency admissions, shifts the balance of care towards early intervention and prevention, including arrangements for integrated	- One year action plan, three year plan and ten year strategies in place by March 2013 - Shared joint financial framework that shifts balance of care. - Shared performance framework.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
	multi-agency approach to care. - Use Integrated Resource Framework to inform agreed joint financial and workforce plans to shift balance of care. - Establish effective shared performance management framework that informs service plans.	

Improving Quality, Efficiency and Effectiveness

The NHS Board has a programme in place to improve the quality of care for older people in all care settings. It is a key priority to improve patient's experience of the NHS and the quality and effectiveness of the care we provide. At a time of considerable change in older people people's services it is vital that service quality is maintained and patient's experience of care in NHSGG&C continues to improve.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
8) Improved experience of care for older people in all care settings.	- Implement single point of contact model. - Take forward the Board's quality improvement programme for older people to improve patients' experience of NHS care - Establish engagement with older people and their carers and use feedback to improve service redesign and delivery - Take forward actions and recommendations arising from National Hospital Inspection reports	- Number of people accessing services via single point of contact model - Evidence of improved patient experience reported annually - regular feedback mechanisms in place and evidence of follow up - Agreed action plans in place following each inspection visit.
9) Modernise District Nursing services to provide a safe, effective and patient centred service.	- Implement actions from the District Nursing service review, including specific actions on agile working, Releasing Time to Care, leading better care, local workforce plans, and DN Out of Hours service.	- improved clinical quality indicators - improved prevention of pressure ulcers - Increased patient facing time - Increased patient activity - Improved staff satisfaction rates - Improved patient experience - Improved efficiencies in stock control and staff travel costs.

10) People with dementia and their carers receive the treatment, care and support that enable them to live as well as possible regardless of setting.	- Raise awareness and understanding of dementia and promote early identification and improved response. - Improve the recognition and management of dementia across all staff groups in acute care settings. - Review standards of service delivery for people with dementia with the aim of improving quality of care. - Review dementia training for staff, ensuring there is appropriate access to training as per the recommendations in Promoting Excellence (Scottish Government 2011).	- Achievement of Dementia Standard. - Number of patients receiving an annual review.

Tackling Inequalities

The challenge to meet inequalities among our older population and protect people from the adverse effects of early ageing and deprivation in particular were outlined in the Director of Public Health's report. Partnerships in developing local plans need to ensure that measures are put in place to mitigate against the potential for widening the health gap among older people, as well as responding to equalities legislation.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
11) Plans in place that respond to older people's wider social circumstances.	- EQIA change fund plans and joint commissioning strategies. - Impact of welfare reforms assessed as part of proposals for local service change, including Change Fund plans.	- EQIAs complete - Equalities plans in place - Evidence of plans taking into account impact of welfare reform and deprivation and other factors.

3. FINANCE AND WORKFORCE

Workforce

3.1 Partnership Change Fund plans include a significant number of new NHS posts appointed to support implementation of a range of projects/initiatives across CHP/CHCPs and Acute Services. Workforce plans will need to be in place to manage these changes when Change Fund funding ceases in March 2015, together with other planned changes such as those arising out of the District Nursing review.

Finance

3.2 The estimate of current NHS spend on older people's services in NHS Greater Glasgow and Clyde is approximately £650m. The financial challenge relating to older people's services comprises:

- Achieving year on year efficiency savings.
- Meeting the anticipated growth in demand for primary care, community services in particular District Nursing services, and acute hospital services due to increases in the number of people aged over 75...
- Managing the impact of Change Fund ceasing in March 2015.

3.3 During this three year planning cycle we will make a shift in resources from hospital/institutional care to support community based anticipatory care/early intervention, meet the demographic challenge and enable older people to remain within their own homes or other community settings. The projected reduction in acute hospital bed days lost due to delays in discharges will support Partnerships in implementing this shift in the balance of care. Partnership's joint strategic commissioning plans for reshaping care for older people, to be developed towards the end of 2012, will need to be robust enough to ensure this requirement is capable of being met.