

## Aberdeen City Partnership

### 1. Partner organisations

The Aberdeen City Partnership consists of:

- Aberdeen City Council (Social Care and Wellbeing, Housing)
- NHS Grampian
- Aberdeen City Community Health Partnership (including Department of Medicine for the Elderly)
- NHS Grampian Acute Division
- NHS Grampian Old Age Psychiatry
- Aberdeen Council of Voluntary Organisations
- Scottish Care (involved in workshops – will identify local representative to join CHP Committee in taking this forward)
- GP Cluster Leads

Approved by:

- Aberdeen City Community Health Partnership Committee
- Aberdeen City Community Planning Partnership (The Aberdeen City Alliance)

Public Engagement and Involvement:

- Aberdeen Older People Consultation and Monitoring Group

**The Aberdeen City Partnership will continue to actively involve all of the above stakeholders in the implementation of this plan.**

### 2. Finance

From	Amount
Initial central allocation	£2,738,000
Added by NHS Board	Joint Senior Operational Management Post (to be established by June 2011).
Added by Local Authority	Leadership capacity for integration of Rapid Response Services (to enable a single team to be operational by October 2011).
Resource Transfer (Older People and Dementia)	£5,600,000
Delayed Discharge	£1,028,000
Other (Third Sector)	In kind
<b>TOTAL</b>	<b>£9,466,000</b>

**3. Current Partnership Budget for Older People (2008/2009) (2009/10 budget not available until 14<sup>th</sup> March due to time pressures)**

	Notes	ABERDEEN CITY			
		LA	NHS	Total	spend per weighted head (£)
		(£000's)	(£000's)	(£000's)	
<b>HOSPITAL BASED</b>					
Emergency admissions			49,927	<b>49,927</b>	<b>1,429</b>
Mental Health IP & Cross Boundary Flow			7,561	<b>7,561</b>	<b>216</b>
Elective admissions and day cases			11,977	<b>11,977</b>	<b>343</b>
Outpatients			10,539	<b>10,539</b>	<b>302</b>
A&E			824	<b>824</b>	<b>24</b>
Day patients	ACUTE		709	<b>709</b>	<b>20</b>
Direct access	ACUTE		1,420	<b>1,420</b>	<b>41</b>
<b>COMMUNITY BASED</b>					
GP Services	GMS		9,896	<b>9,896</b>	<b>283</b>
GP Prescribing	Prescribing		14,096	<b>14,096</b>	<b>403</b>
District Nursing	Community		2,090	<b>2,090</b>	<b>60</b>
Community AHPs	Community		1,194	<b>1,194</b>	<b>34</b>
Community Mental Health Services	MILD		2,220	<b>2,220</b>	<b>64</b>
LA Older Care Home	COE	25,611		<b>25,611</b>	<b>733</b>
LA Older Home Care	COE	13,816		<b>13,816</b>	<b>395</b>
LA Older Other	COE	5,368		<b>5,368</b>	<b>154</b>
Other Community Services	Community		5,178	<b>5,178</b>	<b>148</b>
<b>TOTALS</b>		<b>44,795</b>	<b>117,631</b>	<b>162,426</b>	

In the time available the following information was unavailable and will be included in proposals for next years Change Plan as part of the intended Joint Commissioning Strategy (2012-2020):

- Third and Independent Sector Resources
- Housing Support

**4. Key Outcomes/Outputs Achieved Through Current Resources**

Present performance key:

















Good and improving



Below national average – or (where no national average available) considerable room for further growth

Service Area	Performance Measure
Reducing Delayed Discharge	<ul style="list-style-type: none"> <li>• 0 patients waiting more than 6 weeks in both 2009 and 2010 Census.</li> <li>• Majority of patients discharge by 3 weeks</li> </ul>

Bed Day Rates per 100,000 Population for Patients Aged 65+ with 2+ Emergency Admissions		Aberdeen level is above Scottish Average, however the gap has narrowed. This is an area for additional improvement.
Beds occupied by Emergency Admissions for patients aged 65+.		<ul style="list-style-type: none"> <li>17% decrease in bed days for over 65s and over 75s in the last 15 months – particularly due to redesign of inpatient activity.</li> <li>Aberdeen now at Scottish average which leaves further room for improvement.</li> </ul>
NHS Continuing Care		<ul style="list-style-type: none"> <li>Less than half the Scottish average rate.</li> </ul>
People (aged 65+) supported in care homes, 2009/10		<ul style="list-style-type: none"> <li>Second highest rate in Scotland but similar to the other large cities.</li> <li>10% reduction in care home places in Aberdeen since 2003.</li> <li>Average length of stay in Aberdeen has reduced from 33 to 11 months since 2007</li> </ul>
Older People Receiving Intensive Homecare		<ul style="list-style-type: none"> <li>Aberdeen rate below average for Scotland.</li> <li>30.3% of over 65s with intensive needs receiving care at home (522 clients) compared to 30% national standard.</li> <li>Housing with care model established in 7 locations. Facilities such as Coronation Court have increased opportunities for independent living.</li> <li>Home care alignment to sheltered housing complexes introduced in 2007 Efficient model of providing intensive home care.</li> </ul>
Increasing Respite		<ul style="list-style-type: none"> <li>Respite voucher scheme established by Aberdeen City Council to increase equity and flexibility of provision.</li> <li>36,825 daytime hours of respite provided to older people during 2009/2010 an increase of 4,004 hours from the previous year.</li> <li>20 respite places in Rosewell House opened by Aberdeen City Council 2009.</li> </ul>
Improving Wellbeing		<ul style="list-style-type: none"> <li>Older People Wellbeing Events</li> <li>Older People Exercise Classes</li> <li>4 locality development officers to support social inclusion</li> </ul>
Integrated Health and Social Care Teams		<ul style="list-style-type: none"> <li>All GP practices have an attached integrated community teams including District Nursing, Care Management, Occupational Therapy and Health Visiting. Established 2004.</li> <li>Specialist integrated teams eg rapid response also exist</li> </ul>
Integration of Out of Hours Services		<ul style="list-style-type: none"> <li>Joint rapid improvement event planned to achieve integrated service.</li> </ul>
Expanding Use of Equipment		<ul style="list-style-type: none"> <li>Joint equipment service being established and an action plan developed to implement 2009 guidance and recent guidance on recycling.</li> </ul>

Improved Palliative Care	<ul style="list-style-type: none"> <li>• New palliative care pathways introduced.</li> </ul>
Introducing Reablement and Increasing Rehabilitation	 <ul style="list-style-type: none"> <li>• Investing in development of services reablement.</li> <li>• Increased OT capacity.</li> <li>• Rehabilitation capacity being increased at Rosewell House.</li> </ul>
Expanding Telecare	 <ul style="list-style-type: none"> <li>• 1708 people supported by Community Alarm (Feb 2011).</li> <li>• 92 people supported by enhanced technology.</li> </ul>
Redesign of Woodend Hospital	 <ul style="list-style-type: none"> <li>• 11.3% reduction in number of patients in 2010 compared to 2009.</li> <li>• 14.7% of patients seen by Triage Unit and sent home or to community services.</li> <li>• Bed occupancy rate rose by 5.16% to 96.62% in 2010.</li> <li>• Average length of stay was 10.5 days in 2010 compared to 21.5 days in 2009.</li> </ul>
General Practice	 <ul style="list-style-type: none"> <li>• Primary Care Redesign programme has successfully engaged General Medical Practice in developing new ways of working.</li> <li>• Four 'clusters' of practices formed (with between 52,000 – 66,500 population) to enable joint working between practices and with practices.</li> <li>• All Care Homes in the City are aligned to a GP practice.</li> <li>• All GP practices have a link Community Geriatrician to enable structured community based clinical review of cases and joint working.</li> <li>• Joint medication reviews introduced in early adopter practices. Workshop arranged for 17<sup>th</sup> March to roll out across City.</li> </ul>
Supporting People with Dementia	 <ul style="list-style-type: none"> <li>• Community Old Age Psychiatry Teams in place and aligned to General Practice.</li> <li>• Old Age Psychiatry liaison service established with acute hospitals.</li> <li>• The Eurodem prevalence figure for Aberdeen City is 2625 and the 61% target to be achieved is 1601. Aberdeen has 1715 patients registered (65%)</li> <li>• Established 'Singing for the Brain' to increase carer support and improve quality of life</li> </ul>
Older People's Consultation and Monitoring Group	<ul style="list-style-type: none"> <li>• Long standing mechanism for the meaningful involvement of older people in service provision, planning and redesign.</li> </ul>
User and Carer Surveys	<ul style="list-style-type: none"> <li>• 800 older people were surveyed on a range of issues in 2009.</li> <li>• Sheltered Housing surveys (high satisfaction levels)</li> <li>• 500 carers were surveyed in 2010. 89% of respondents wanted to continue their caring role and most were satisfied with the support they received.</li> </ul>

## 5. Key Changes to Achieve Over the Next 5 Years

The partnership recognises that the majority of older people in Aberdeen do not require or receive services. However there are situations where individual circumstances change and in these circumstances the system should be flexible enough to allow adjustments to be focused on enabling the service user to regain control of their own care and lives as quickly as possible.

### **Cross Cutting Themes**

The Aberdeen City Partnership intends to take an inclusive approach to future services for Older People. As such we recognise that some older people have dementia or other forms of mental illness and also that many older people are dependent on the support of family or friend carers to support them in their daily living. All projects, initiatives and redesign will include the needs of all older people (including those with dementia) and their carers.

**The Change Fund will be used in Aberdeen** to facilitate the work towards the following outcomes (as specified in our Partnership Agreement):

- Optimising independence, supported independence, active ageing and wellbeing. Working with Older People and the Third Sector build on the already substantive capacity for older people to be self caring, and caring for other older people within their family/community.
- Improve outcomes for older people by prioritising anticipatory care, and through this reduce the levels of unscheduled and/or emergency care.
- Ensuring that older people receive the best possible timely hospital care when necessary, but are not admitted to hospital when this is not in their best interest and reduce in-patient bed numbers as a result.
- If admitted to hospital, ensure an appropriate discharge at the right time with regards to their treatment requirements. Aiming to return to home based living as soon as is possible.
- Shifting the focus of services towards reablement and reduce the number of residential continuing care places.
- Maximising choice and opportunities for self directed care and support for older people and their carers.

### **Model of Treatment, Care and Wellbeing**

The City will have four clusters of GP practices (7 or 8 practices in each). Each cluster will have a GP Clinical Lead, and management support for social care and wellbeing, community health and health improvement services. Working on an integrated basis (and towards joint budgeting), with their aligned community geriatric and community old age psychiatry teams this core leadership team will work to further enhance clinical services to meet the needs of their combined populations (75+ population:- 3,150 – 4,350 per cluster). Specialist opinion and structured clinical reviews will be delivered in community based settings wherever safe and appropriate; increased access to diagnostic tests shall be available on a near patient basis and via the Health Village (post 2013).

From a treatment & care perspective we aim to increase access to anticipatory care planning, personal budgets, rapid specialist assessment in the community, rehabilitation, reablement, respite, housing adaptations, rehousing, medication reviews, telecare and telehealth. We shall continue to ensure appropriate access to in-patient NHS care and

continuing care in residential settings, but with increased use of alternatives when this is safe and desirable.

We intend to work closely with the Care Sector to ensure more flexible & innovative use of bedded capacity (respite, GP beds, intermediate care) across all sectors to meet the needs of older people and a growth in home based care capacity.

We shall work with the Third Sector via the Interface and other members of the Community Planning Partnership to maximise opportunities for older people to remain healthy, socially active and contributing to their communities. We also intend to stimulate social enterprise growth to offer choice for older people in relation to meeting their health & care needs. The provision of accurate, current information for older people and carers in easy to access formats and locations shall be further enhanced.

Joint working between housing, social care and health services seek to find more innovative ways to improve the ability of people to remain as active in their community as possible.

All the action plans that are developed from this proposal will be expected to include provision for joint training/learning, education and organisational development.

To highlight the area where each use of Change Fund money will have the most direct impact they have been targeted at the outcomes described in the following Reshaping Care Logic Model.

## **6. Use of the Change Fund and Outcomes Anticipated**

The change fund will be allocated to accelerate implementation of the following local and national strategies:-

- Aberdeen Partnership Agreement for Reshaping Care for Older People
- Single Outcome Agreement
- The Healthcare Quality Strategy
- Carers Strategy
- Shifting the Balance of Care Agenda
- National Older Peoples Strategy
- National Dementia Strategy
- Self care/Long Term Conditions Strategy
- Better Care Without Delay
- Living and Dying Well

The following outcomes have indicative spend allocations. These are proposed for the first year of the Change Fund and relate to areas where work has already commenced and improvement can be made rapidly and will release resource and capacity for future investment. Subject to continued Parliamentary approval and continuation of the fund, proportions will be altered to be more aspirational and transformational particularly with regards to the balance of care between the older person, carer, community and the traditional providers of care.

Detailed implementation plans and performance measures for 2012 – 2020 will be included in the Joint Commissioning Strategy which shall be developed throughout 2011.

## 6. Use of the Change Fund and Outcomes Anticipated (continued) – Logic Model

Community Infrastructure	Effective intervention	Personal Outcomes	Quality, Value & System Outcomes
<b>Change Fund Allocation One (30%)</b> Increased use of anticipatory care plans with targeted treatment to promote safe independent and supported independent living Continue to improve patient and carer choice in relation to end of life care.			
Aligned Multiagency community teams with within Primary Care 'Clusters'	Rapid Access to alternatives to admission eg a joint responder service	No needless delays for assessment, care and support equipment or diagnostic tests	Sustainable joint workforce with the right skill mix
Specialist Community Services (outreach moving to 'inreach')	Rapid access to geriatric assessment in all settings via Community Geriatric Teams aligned to clusters	Greater Support and Confidence to Live Well and Self Manage Long Term Conditions	Fewer avoidable A&E attendances and hospital admissions
Supporting people before their needs are traditionally met by services	Effective prescribing and review for people on multiple medicines. Also Falls and Fractures Prevention	People experience fewer adverse drug events <i>and are enabled to manage their own medication as much as possible</i>	More effective and efficient drug prescribing <i>and full implementation of agreed medication guidance.</i>
Integrated Out-of-hours service	Access to generalist and specialist palliative care	Improved experience and continuity of care	More time spent in community in last 6 months of life
<b>Change Fund Allocation Two (15%)</b> Maximising carer support			
More flexible carer respite.	Increased choice of respite and opportunities for self directed support.	Unpaid carers feel supported.	More carers feel able to continue their caring role.
Leadership to increase cultural change working in partnership with carers.	Increased focus of staff on supporting carers, via joint pilots for "Releasing Time to Care"	Carers are a valued part of the team with access to training, advice, information and support.	Further development of the carer support network.

<b>Change Fund Allocation Three (25%)</b>			
Accelerated hospital discharge and reduction in failed discharges/transitions.			
Specialist community outreach – moving to ‘inreach’ (including community geriatricians).	Continual development and acceleration of integrated, intermediate care services	Improved Patient/Carer experience and continuity of care	Reduced rates of 75+ emergency admission and bed days
Commissioned community residential places for rehabilitation	Integration of out of hours service – Care at Home & Community Nursing. Investigate alternative provision of support including third and independent sector provision.	Care and support closer to home and in more homely setting	Enhanced capacity of community and voluntary sectors
<b>Change Fund Allocation Four (20%)</b>			
Enabling people with long term conditions to maximise their independence and quality of life			
Health Improvement, community and voluntary sector capacity	Rapid access to equipment and adaptations	Greater support and confidence to live well and self manage long term conditions	Improve long term condition management
Enhanced technology to assist independent living	Telehealthcare Support	Enhanced independence, participation and wellbeing	Improved efficiency of response
Joint information and improvement support	Tailored and accessible advice to help older people make informed choices/decisions	Greater Control and choice	
<b>Change Fund Allocation Five (10%)</b>			
Active Ageing & Wellbeing			
Community development and social enterprises.	Older people remain socially active and engaged in their communities	Enhanced independence, participation and wellbeing	Enhanced capacity of community and voluntary sector
Maximising the use of community services (sports and libraries).	Finance and support development of a wider support structure for existing third sector and volunteer activity	People feel valued and safe.	Healthier and more socially interactive older population.

## 7. Key Performance Measures to Assess Progress

<b>1. Reduction in Unplanned Acute Bed-Days in the Over 75 Population</b>
Current Performance 5702 bed days per 1,000 population (April 2010)
Target: - to be confirmed A 10% reduction would save 11,000 bed days per year. A 10% reduction would also divert 174 people from multiple admissions.
Example Initiatives <ul style="list-style-type: none"><li>• To continue to roll out SPARRA across integrated teams with an increasing focus on long term condition management and the suitability of social care packages.</li><li>• Further integration of intermediate care services.</li><li>• Work with the Scottish Ambulance Service to develop a culture of 'treat and see' to prevent hospital admission.</li><li>• Improved triage at Accident and Emergency through closer working with Geriatricians</li></ul>
<b>2. Reduction in Bed Days Lost to Delayed Discharge</b>
Current Performance 277 patients and families affected 4071 bed days lost (2008/09) Approximate cost of £1,286,654
Target:- To be confirmed A 10% reduction would save 407 bed days and approximately £127,000 per annum
Example Initiatives <ul style="list-style-type: none"><li>• Expansion of Old Age Psychiatry liaison service to cover all of Aberdeen Royal Infirmary (ARI)</li><li>• Expansion of Early Supported Discharge Service to cover all beds at ARI, Woodend and Links Unit</li><li>• Patient to return to home with support (or to short term place in care home) pending assessment and decision regarding long term care. This recognises that hospital can be disabling and give a false impression of a persons ability to live in the community.</li><li>• Actively promote 'Power of Attorney' to older people in community settings.</li></ul>
<b>3. Remodelled Care Home Use</b>
Current Performance TBC
Target to be confirmed Percentage shift from long term care to short term care to be confirmed.
Example Initiatives <ul style="list-style-type: none"><li>• Development of 'community facing' sheltered housing</li><li>• Direct GP access to care home beds in emergency situations</li><li>• Joint commissioning of rehabilitation services and intermediate care</li></ul>

<b>4. Increase in proportion of Older People Living at Home</b>
Current Performance TBC
Target: Percentage shifts in spend to be confirmed. % of Older People receiving intensive home care to rise from current level of 30.3% to 35% (need to impact assess increased use of personal budgets)
Example Initiatives <ul style="list-style-type: none"> <li>• Development of responder service</li> <li>• Improve Support for Family/Friend Carers</li> <li>• Increase proportion of people with personal budgets</li> <li>• Implementation of releasing time to care to release time to support carers</li> <li>• Investment in telecare including community alarm</li> </ul>

The Aberdeen Partnership established a Joint Balance of Care Programme in 2010 to accelerate shifts in the balance of care. A Joint Programme Board was established and seven key workstreams identified, with joint lead officers.

In order to monitor performance and demonstrate that the Change Fund is making a direct impact, a Balance of Care (Community Care Outcomes) Progress Report has now been established. This will be supplemented by the use of the Shifting the Balance of Care 'High Impact' Matrix. All of the Balance of Care Programme workstreams have been mapped against this template locally.

The Aberdeen City CHP Committee at it's November 2010 meeting agreed that the Executive Group would provide governance and assurance to the Full Committee through a set of performance reports that would report on financial performance, activity levels, workforce changes. The CHP Committee has a workplan and the change fund will be an integral part to the workplan. Reports for the CHP Executive Group will be provided by the Integrated Strategic Management Team (responsible for joint delivery of adult services).

**8. 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**

In recent years the Partnership has used the simulation software (Simul8) to create models of demand for spending on services for older people. This has provided figures relating to demographic changes and the associated financial implications. As an example the growth in the over 85 population in Aberdeen is predicted to increase by 120% by 2033. It is therefore acknowledged that total spend on older people is unlikely to decline over the next five years. However the implementation of this proposal will aid the partnership in constraining growth in spend over the same period, whilst increasing service capacity and this in itself should be seen as a success. There will be a reduction in spend on in-patient NHS care, and the transfer of consultant staff and their specialist teams to community settings will enable needs to be met out-with hospitals. There will be less reliance on 'prescribed' or pre-determined public sector provided services, with an increase in personal budgets and greater involvement of the third and independent sector in meeting care and wellbeing requirements flexibly.

## Population Projections

	2008	2023	2033
65+	16,566	21,981	24,443
75+	15,629	19,962	26,021

The Aberdeen City Joint Commissioning Plan will be developed throughout 2011. This plan will give greater clarity on the following:-

- The extent to which NHS inpatient beds and average length of stay will be **reduced**.
- The level of **reduction** in continuing care home beds and the ways in which this released capacity will be used.
- **Increased** flexibility of respite offered.
- The required **increase** in spend on telecare/telehealth equipment.
- The impact of the emergency care centre opening in 2012

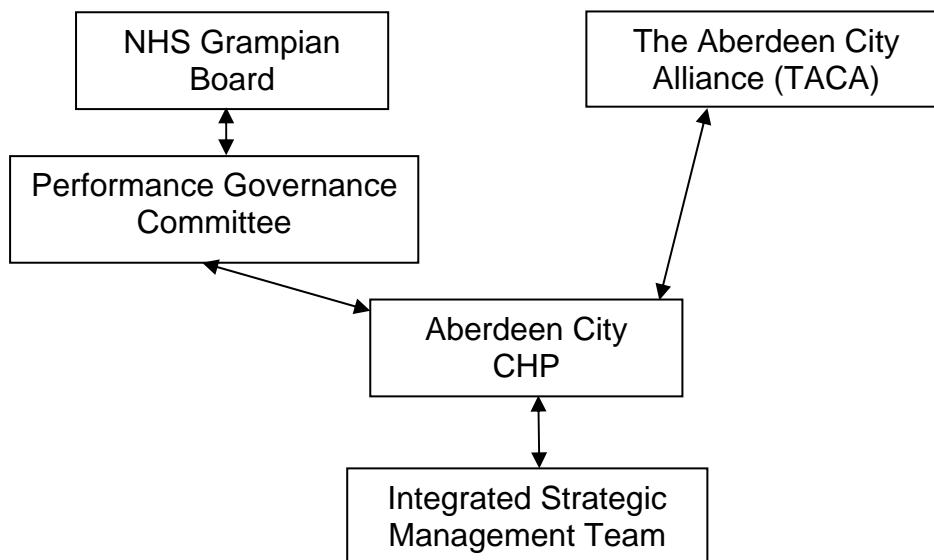
## 9. Indicate the Financial Mechanism and Governance Framework

The Aberdeen Partnership Agreement for Reshaping Care for Older People provides the overarching context. NHS Grampian and Aberdeen City Council are signatories to an existing Joint Governance and Accountability Framework. In addition a Joint Staffing Framework enables staff to work across both organisations.

### Finance Mechanism

Subject to final agreement the Partnership Budget shall be delegated to the Aberdeen City CHP Committee. The Committee shall 'commission' services from all partners to this agreement in line with the plan. (Discussions are currently taking place regarding the potential for this Committee to have responsibility for all health and social care expenditure for joint projects and services and for a change of name to Aberdeen City Health and Social Care CHP.) ***Each initiative at time of implementation shall have a clear target for cash releasing efficiency to ensure 'bridging nature' of fund is upheld.***

### Governance Arrangements



Aberdeen City CHP is both a Sub-Committee of NHS Grampian Board, and a full challenge forum of the community planning partnership TACA and as such is in an excellent position to drive forward all aspects of Reshaping Care for Older People including those aspects relating to building community capacity, community led initiatives, business responses and influencing the provision of varied housing models. The CHP Committee is accountable to TACA for the delivery of National Outcome 6 "We live longer and healthier lives". The actions contained in this Change Plan are included within this.

Aberdeen City CHP is also a Sub-Committee of NHS Grampian and provides an exception report to the Performance Governance Committee of the Board, in addition to all minutes of the Committee being included on Board agendas.

The work of this plan will be undertaken by the Integrated Strategic Management Team (Chaired by Director of Social Care & Wellbeing) and appropriate working groups such as the Joint Balance of Care Group.

## 10. Support Requirements to Assist Delivery

Continued support from Scottish Care would be welcomed.

NHS Grampian shall work with Aberdeen City Council to take forward the CHP Committee Action Plan for Improved Joint Working. The plan (developed in November 2011) aims to increase the level of delegated authority and responsibility from both NHS Grampian and Aberdeen City Council to ensure all joint services and projects are accountable to the CHP Committee. Support from the Joint Improvement Team may be useful in concluding this work.

NHS Grampian intends to work with all three partnerships to develop robust Commissioning Strategies that when combined give maximum opportunity for the NHS to modernise services for older people. Again support from the Joint Improvement Team to assist this may be requested.

NHS Grampian Public Health Team and Health Intelligence Team have agreed to provide support to assist with longer term needs assessment and forecasting.

Aberdeen City Council and NHS Grampian have both invested in skills development to underpin rapid improvement and service transformation, however, given the scale of redesign anticipated there may be benefit from additional skills training for staff and managers.

This plan has been prepared and agreed by NHS Grampian, Aberdeen City Council, Third Sector and Scottish Care.

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