Falkirk Council

Appendix 1

RESHAPING CARE FOR OLDER PEOPLE IN FALKIRK

CHANGE FUND SUBMISSION 2012/13

FEBRUARY 2012 DRAFT 2

1 THE FALKIRK PARTNERSHIP

The Falkirk Partnership area covers approximately 297 square kilometres. This is spread across the towns of Falkirk, Grangemouth, Bo'ness, Denny, Bonnybridge and a number of many small villages in rural and semi-rural locations. Presently it has a population of 152,480 people and by 2014 this is expected to increase by 4.3% with a 19% increase in the older population. It is projected there will be an increase in the older population from 19% to 21% of the total population by 2024.

Falkirk is one of 3 local Partnerships situated within the wider NHS Forth Valley area and continues to work closely together with the adjacent Stirling and Clackmannanshire Partnerships on areas of mutual interest in progressing joint initiatives.

Building on the previous outcomes of the 2011/12 Falkirk Change Fund, the 2012/13 Plan continues to demonstrate partners' commitment to continually enhancing care for older people living in the Falkirk area.

2 PARTNER ORGANISATIONS

2.1 Partnership Representation

The 2012/13 Falkirk Change Plan has been prepared by the Falkirk Change Fund Steering Group on behalf of the local Partnership Board. A diverse membership has included representation from:

- Falkirk Council Social Work Services and Housing
- CVS Falkirk and District
- Falkirk Community Health Partnership
- Third Sector Community Health and Care Forum
- NHS Forth Valley (Primary and Secondary Care)
- Scottish Care

In addition, the following Planning Forums have also been engaged in the development of the Plan:

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

- Falkirk Public Partnership Forum (PPF)

The Steering Group gratefully acknowledge the on-going support of the Joint Improvement Team (JIT) in providing further direction and additional supporting evidence in the preparation of this Plan.

2.2 Professional Engagement

Throughout the development of the Falkirk 2012 /13 Change Plan there has been continued inter-agency commitment and multidisciplinary involvement in preparing, implementing and monitoring of the individual Change Fund Proposals.

All key local stakeholders involved in Older People's services from social and healthcare statutory agencies, third and independent sectors have been engaged both in the monthly Change Fund Steering Group meetings and also in number of local focus events which have been held over the proceeding year.

2.3 Public Engagement

Following on from the various local 2011 events which the Reshaping Care for Older People Programme was raised and subsequently discussed, it is planned to hold a follow up multi-agency public engagement event in March 2012 on the theme of living well. It is anticipated that this will include wider consultation on reshaping care for older people. Furthermore many voluntary agencies will be represented and given the opportunity to showcase their services to the wider public.

The Falkirk Public Partnership Forum (PPF) as a major player in providing meaningful information and engaging with the Falkirk community, continues to hold open events on a quarterly basis. Sessions have been held with a focus on how to utilising the Change Fund that will encourage agencies to work together to promote independence and well-being for Older People living in or in a homely setting.

3. FINANCE

3.1 Resources Available

From	Amount £	Difference from 11/12
Monies Carried Forward	£0.848M	£0.848M
Initial Central Allocation	£2.154M	£2.154M
Added by NHS Board		
Added by Local Authority		
Other		
Total	**£3.002M**	**£3.002M**

3.2 Rationale for Financial Carry Over

There have been a number of significant factors that have influenced the need to carry forward financial allocations from 2011/12 to 2012/13. The main reasons for this financial carry over were that additional time was required to:

- Embed a real clarity of purpose and continue to develop relationships across the range of stakeholders to agree partnership working practices.
- Remodel aspects of a number of original 2011/12 proposals in noting that the initial time line for submission was challenging.
- Consolidate analysis of the complexities and range of existing services being provided to Older People living in the Falkirk area.
- Seek greater clarity as to the process for agreeing and progressing both local and Forth Valley joint proposals.
- Develop and agree new ways of working around commissioning and contracting and the need to establish agreed governance arrangements not only internal to the Falkirk Partnership but also to the wider Forth Valley Partnership.

Finally, despite the welcome addition of increased financial resources there remain challenges in identifying additional capacity in terms of human resources (skills and experience) to take on the dedicated tasks of work required. This has been further compounded by delays and difficulties in recruitment process as there is the requirement to work through the various Partners' Human Resources and employment term and conditions.

3.3 Change Fund Allocation by Pathway: Summary

	Anticipatory & Preventative Care	Proactive Care and Support at Home	Effective Care at time of Transition	Hospital & Care Homes	Enablers
2011/12	£0.178m	£0.247m			£0.612m
2012/13- includes c/fwd spend	£0.407m	£1.347m	£0.212m	£0.068m	£0.719m
2013/14	TBC	TBC	TBC	TBC	TBC
2014/15	TBC	TBC	TBC	TBC	TBC

£0.250m of the available change fund resource for 2012/13 is still to be confirmed.

3.3.1 Initiatives 2012-13

	Anticipatory & Preventative Care	Proactive Care and Support at Home	Effective Care at time of Transition	Hospital & Care Homes	Enablers
2012/13	Reablement in a community	Reablement at home	Supporting patient flow through acute	Extended nurse liaison	Modernising technology

	Anticipatory & Preventative Care	Proactive Care and Support at Home	Effective Care at time of Transition	Hospital & Care Homes	Enablers
2012/13	setting. DALLAS Project Stakeholder engagement and participation event.	Telehealth/ telecare Carers' support MECS service redesign Homecare redesign Handyperson scheme	care Augmenting community nursing teams with palliative care Self medication proposals (2) IV training Community nursing equipment	service Rehabilitation resources and assessment (home to home pathway)	Organisational development Partnership Innovation Fund Planning and Commissioning Housing research project

3.4 Total Resource Allocation by Pathway: Detailed

NHS Forth Valley and partners are nearing completion of Integrated Resource Framework (IRF) baseline mapping and the table below will be updated once this is drawn together, analysed and quality assured with the local partnerships. This will also be used as the financial baseline for the developing Forth Valley Older People's Plan and Joint Commissioning Strategy.

Falkirk Partnership – Spend on Health and Care Services for Older People			
	2010/11		
	LA	**NHS**	**TOTAL**
	£000	**£000**	**£000**
HOSPITAL BASED			
- Emergency Admissions		19,508	19,508
- Elective admissions and day cases		15,291	15,291
- Outpatients		12,167	12,167
- A&E		2,897	2,897
- Day Patients		1,025	1,025
- Direct Access			0
COMMUNITY BASED			0
- GP Services		5,039	5,039
- GP Prescribing		15,123	15,123
- District Nursing		1,058	1,058
- Community AHP's		681	681
- Community Mental Health Services		1,410	1,410
- Care Homes	13,746	85	13,831
- Care at Home	15,538	512	16,050
- Other Care Services	6,221	5,578	11,799
- Other Community Services	653	4,636	5,289
Other Expenditure			0

Falkirk Partnership – Spend on Health and Care Services for Older People			
	2010/11		
	LA	NHS	TOTAL
	£000	£000	£000
- Housing Support			0
- Care and Repair			0
- Transport			0
- Third Sector		472	472
- Other		7,650	7,650
TOTAL	**36,158**	**93,132**	**129,290**

NOTES:
Figures used are based on 2010/11 LFRs and LA and on NHS Health and Joint Allocations 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.

4 PERFORMANCE

A local Joint Performance Management Group has been established with the key task of drawing up a draft suite of performance indicators relevant to support the on-going development of the Falkirk Change Fund Plan. This group remains in the initial stages of developing its outputs and it is anticipated that it will contribute to the wider Forth Valley performance review.

4.1 Nationally Available Outcome Measures and Indicators (A)

Code	Target	Performance / Status
A1	*Emergency inpatient bed day rates for people aged 75+*	Forth Valley is the second top performer nationally behind Shetland when comparing bed day rates per 1000 population of over 75's
A2 a	*Patients whose discharge from hospital is delayed*	Significant effort has been directed to reducing delayed discharges resulting in meeting the target of zero delays in January 2012
A2 b	*Accumulated bed-days for people delayed*	623 bed days lost (January 2012)
A3	*Prevalence rates for diagnosis of Dementia*	Rate per 1000 in Falkirk area is 0.70
A4	*Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting*	Information not currently available
A5	*Percentage of time in the last 6 months of life spent at home or in a community setting*	Falkirk shows 91.0% very slightly above the Scottish average of 90.7

Code	Target	Performance / Status
A6	*Experience measures and support for carers from the Com munity Care Outcomes Framework*	
A6 a (S2)	*% of carers satisfied with their involvement in the design of care package*	2010-11: 94%
A6 b (C1)	*% of carers who feel supported and capable to continue in their role as a carer (including with support)*	2010-11: 86%

4.2 Local Improvement Measures (B)

Anticipatory and Preventative Care

Code	Target	Performance / Status
B1	*Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared with Out-of-Hours staff*	Information not currently available
B2	*Waiting times between request for a housing adaptation, assessment of need, and delivery of any required adaptation*	Information not currently available
B3	*Proportion of people aged 75+ with a telecare package*	2010-11: 24.4 which is significantly higher than the Scottish average of 18.5%
Other	*Other National CC Outcomes Indicators*	
S1	*% of community care service users feeling safe*	2010-11: 87%
S2	*% of service users and satisfied with their involvement in the design of care package:*	2010-11: 98%
S3	*% of service users satisfied with opportunities for social interaction*	2010-11: 93%
BC2	*Balance of Care Measure 15: (No of people receiving 10+ hrs of home care / No of people receiving 10+ hrs of home care + No of long stay people aged 65+ in care homes + Nos of people in geriatric longstay beds)*	2010-11: 34.0%

Responsive Flexible Homecare and Carers

Code	Target	Performance / Status
B4	*Reduction in hours of support required after re-ablement service being provided*	Information not currently available
B5	*Respite care for older people per 1000*	2010-11: 68.4 per 1000

Demand for Acute Care

Code	Target	Performance / Status
B6	*Rates of 65+ conveyed to Accident & Emergency with principal diagnosis of a fall*	Due to the establishment of our falls Service, the latest data for Winter 2010-11 shows 92.6 in Falkirk, compared to Sc. Average of 118.0

Effective Flow in Acute Care

Code	Target	Performance / Status
B7	Proportion of frail emergency admissions who access comprehensive geriatric assessment within 24 hours	Acute consultants state that all patients aged 65+ are referred and seen by a geriatrician within 24 hours

Use of Long Term Residential Care

Code	Target	Performance / Status
B8	Rate and proportion of new entrants admitted from home; acute hospital specialty; following intermediate care; graduate from emergency respite	Data to demonstrate where individuals are admitted from is not currently available

4.3 Partnership Resource Use (C)

Anticipatory and Preventative Care

Code	Target	Performance / Status
C1	Per capita weighted cost of accumulated bed days lost to delayed discharge	To be developed
C2	Cost of emergency inpatient bed days for people over 75 per 1000 population over 75.	To be developed
C3	A measure of the balance of care (e.g. split between spend on institutional and community-based care).	To be developed

Note that work continues across the Partnership in developing the Integrated Resource Framework (IRF) which will assist in giving greater clarity as to the current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for Older People's service

4.4 Successes

The success of the Falkirk Partnership cannot be measured merely in terms of the pace progress of individual submissions but acknowledgement must be given to the achievements around the shifting culture of those providing and those receiving care services. It would appear within the Falkirk locality there is a much greater sense of optimism around service integration both at a strategic and operational level across all sectors. There appears a genuine enthusiasm to work together actively to:

- 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
- promote a 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 initiatives the Falkirk Partnership has taken forward over 2011/12 which will form the basis of Falkirk's future intentions for the next 3 to 4 years. Monitoring of individual initiatives was undertaken by utilising a "traffic light" monitoring report format. (See Appendix 2). These reports are regularly submitted to the Falkirk Change Fund Steering Group.

4.4.1 Partnership Innovation Fund

A Partnership Innovation Fund (PIF) has been established to provide funding for innovative partnership projects, led by Third Sector organisations, which contribute to the Falkirk Change Plan outcomes. The Project will manage a budget and manage the funding process by assessing, monitoring and reviewing projects.

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. The intention of the PIF is 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 Falkirk's agreed outcomes. This Fund maximises opportunities, supports innovation and will be aimed at building community capacity as a way of achieving outcomes.

Progress to-date:

- Project officer established.
- Criteria and evaluation process for Third Sector bids agreed.
- Initial bids are being screened.

4.4.2. Reablement at Home

This projects aims to extend the current reablement approach for people who are 65+ years with long term conditions and / or are frequent fallers in the community who sustain an injury that does not require hospital admission. By offering a reablement service it is anticipated that this will reduce needs for long term support by helping people to (re)learn daily living skills and will assist in preventing inappropriate long term use of both health and social care services. The service will incorporate UDSET principals in identifying these outcomes for service users. Tracking savings which are made specifically in bed days saved as a result of preventing hospital admission along with information which will indicate a reduction in long term care needs should be identified and benchmarked against the more traditional model of care supplied.

Progress to-date:

- Training in place for extended home carers.
- Additional home carers have been recruited.
- Allied health professionals (AHPs) have been recruited.

4.4.3 Telehealthcare/Telecare

By promoting the development of telehealthcare responses it is anticipated that older people will be supported more safely and independently at home or in a care environment, while supporting unpaid carers and diverting demands that might otherwise be made on health, particularly acute health and social care services. Over the duration of this project (12 months), an increased take up of telehealthcare solutions, leading to a reduction in the need for staff input in individual care packages, generating savings elsewhere, while supporting unpaid carers by maintaining older people at home and reducing or delaying the need for them to move into a care setting or into hospital. 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.

This 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.

Progress to-date:

- Telecare and telehealth leads have been in post for 12 months.
- Equipment purchased.

4.4.4 Carers Support

Building on the achievements of Falkirk Council's Short Break Bureau, this proposal is developing a new *Falkirk Shared Lives Service*. 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. Shared Lives 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 and will:

- Improve outcomes for service users and their carers
- Support carers as key partners in care
- Assist in preventing inappropriate long term use of health and social care services
- Prevent inappropriate or avoidable admission to long term care

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.

Progress to-date:

- Models being developed in conjunction with Third Sector.

4.4.5 Reablement in a Care Home Setting (now termed Reablement in a Community Setting)

By working with independent providers to provide a flexible and community based, therapeutic environment possibly care home or housing with care could help 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.

The proposal is to 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 resource 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 rehabilitation
- income maximisation.
- advice and support regarding telecare/health.
- signposting to other services in health, social work, independent with Third Sector carer support through education and networking.

Progress to-date:

- Following initial proprietary work in developing a Care Home Model a more effective option was identified i.e. the potential of the use of supported accommodation. This proposal is now being worked up fully and is now referred to as Reablement in a Community Setting.
- The resource has been identified to provide initially 3 short term places.

4.4.6 Real Time Monitoring System

This is a time limited proposal around the 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, 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.

Progress to-date:

- A service specification has been established.
- Work is ongoing in developing an implementation plan with an implementation officer to support this process. .

4.4.7 Workforce Development

The Falkirk Partnership recognises the only way to ensure a redesign of services and service delivery is through actively supporting the Partnership workforce during this major change in culture. Work continues to finalise 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. It is also recognised 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 it is 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. The local Partnership is 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.

Progress to-date:

- In partnership, an organisational development workplan has been developed and implemented across the partnership.
- Training is ongoing with dedicated lead in post.

4.4.8 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 have created 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 intends 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 2012–14.

Progress to-date:

- Utilising existing skills and with existing staff seconded to support this process until the recruitment process has been finalised.

4.5 Lessons Learnt

Falkirk Partnership's response to progressing the Change Fund is continually evolving in response to the particular needs of the locality and how it reacts to the ongoing challenges of Partnership working. This has been further compounded by the need to ensure some uniformity from NHS partners who are striving for greater consistency of approach across a NHS Forth Valley wide area.

The requirement for such responsiveness means that the developing of the Plan has often appeared to be both complex and dynamic.

This at times has led to differing levels of understanding among the various stakeholders involved depending upon their viewpoint as to their involvement and responsibilities. For the future, the partnership has to be clearer as to individual's roles and responsibilities.

It was acknowledged early on in the development of the Plan that maintaining the status quo was no longer an option. Indeed in an effort to deliver better and sustainable outcomes it was therefore critical that the agreed funding proposals contained within Plan should challenge the existing mindset on how services are configured and thus move towards more anticipatory and preventative approaches.

As progress is being made, it is recognised that further clarity as to both the involvement and the joint governance processes of partners will be required. As a partnership we recognise the need to improve Third Sector engagement and are committed to doing so.

Furthermore there was an urgent requirement to highlight future intentions around an explicit vision and by what means the Partnership is intending to deliver this vision. The local vision was agreed by building upon the experience derived in developing the existing 2011/12 local Change Fund proposals and the work around the establishment of the local *Joint Commissioning Framework: Services for Older People (2012).*

To optimise independence and wellbeing of older people in the Falkirk area underpinned by effective partnership working across both statutory and non statutory sectors.

This vision sets out a number of desired outcomes, namely:

- Older people are able to live in their own homes and local communities, 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 will directly inform and influence the outcomes 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.

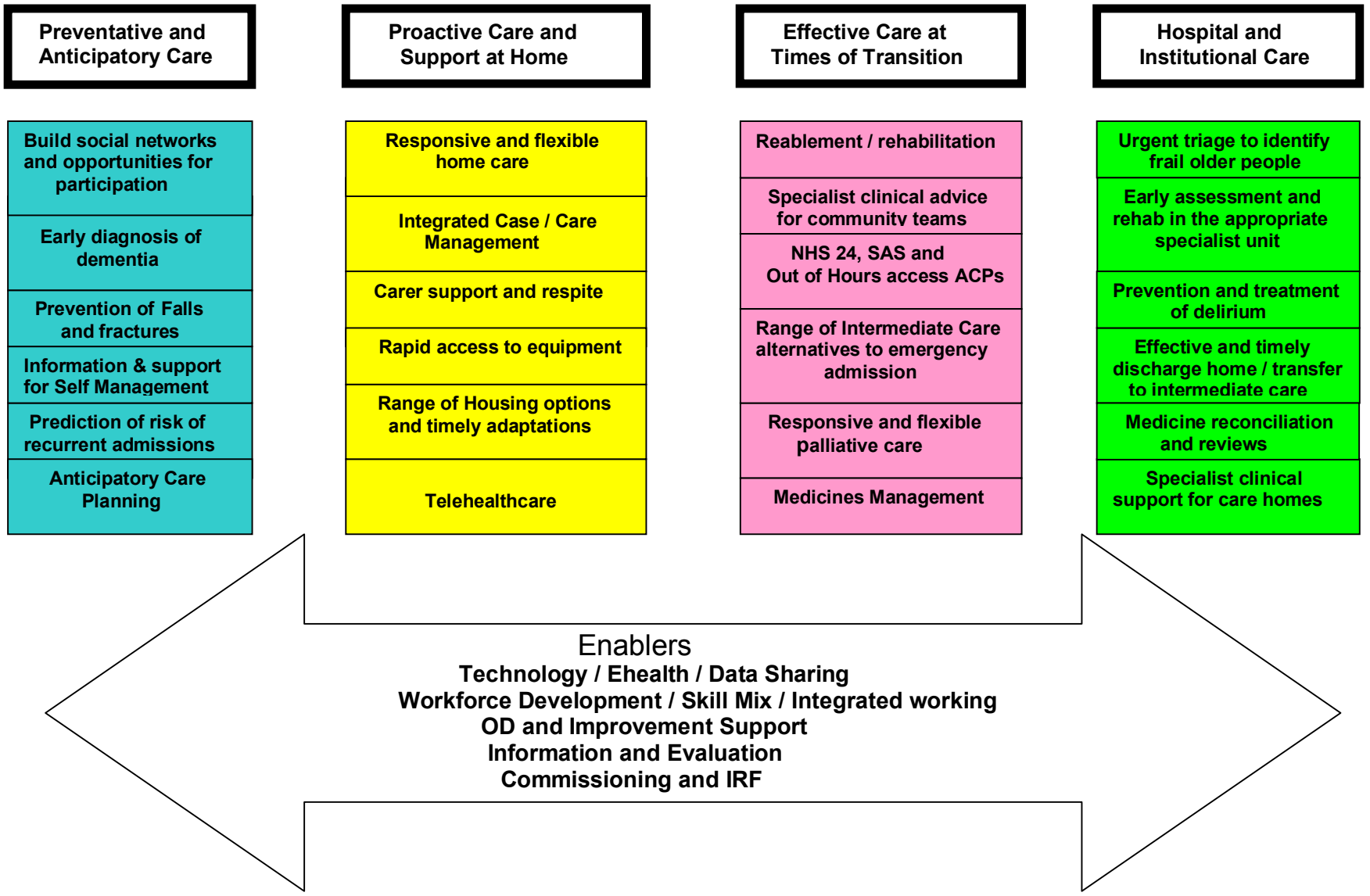
- Services actively anticipate or prevent growing illness or infirmity and thereby support older people to remain active and healthy for as long as possible with the minimum necessary recourse to more intensive or intrusive care and support.

- Older people are kept safe by high standards of practice in the services they receive

By providing a regular local focus for partnership working in terms of the Falkirk Partnership Steering Group, social care providers, third and independent sectors, primary, and secondary specialist healthcare services can come together to build good working relationship and by sharing knowledge and experience ensure that services for Older People are placed at the centre of both service planning and delivery.

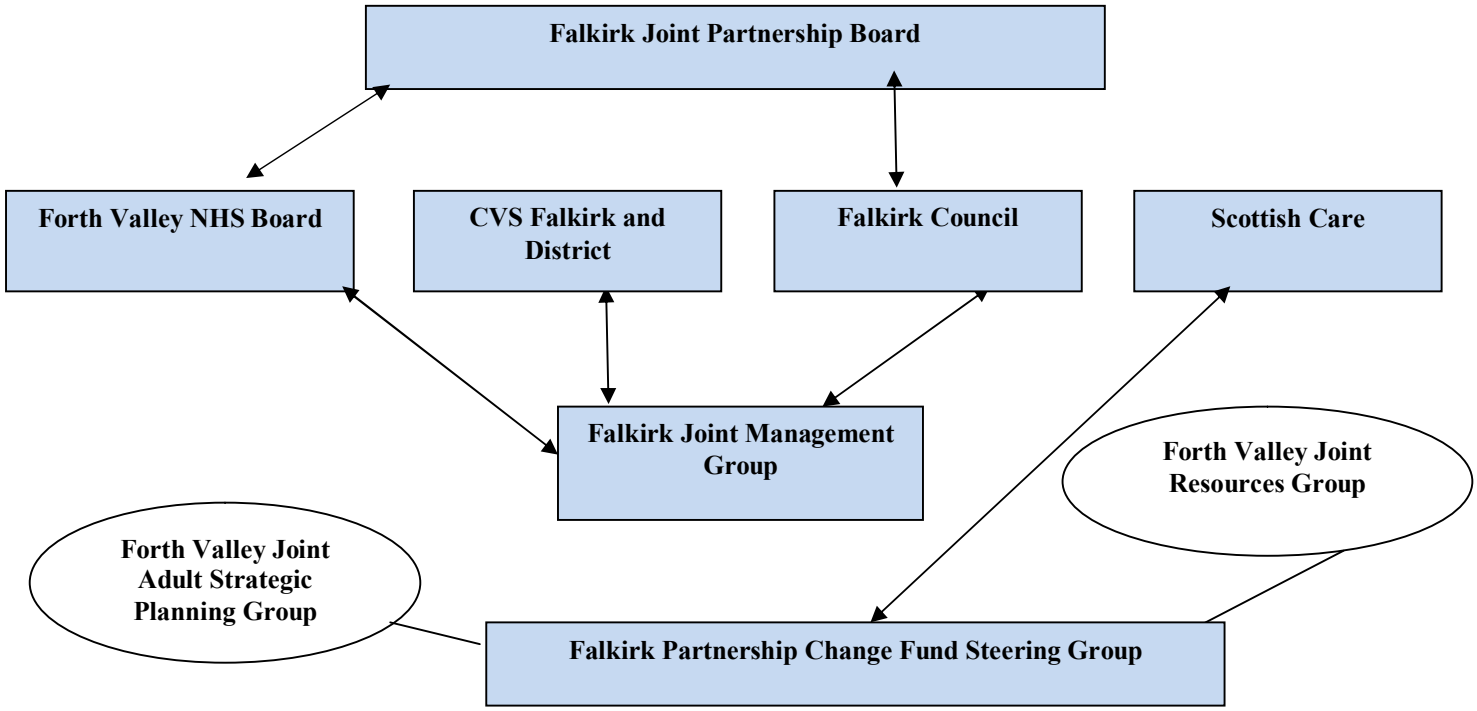
Furthermore in an effort to direct attention consistently towards the key areas and to assist in providing both an equitable and fair share of the available resource it was agreed that all funding proposals were grouped under the 5 themes (*Reshaping Care for Older People Change Fund Guidance for Local Partnerships: 2012/13)* and initially apportioning approximately 20% of the available funding allocation to each of these 5 themes below, namely:

Reshaping Care Pathway



5 GOVERNANCE

The present governance arrangements for delivery of the Falkirk 2012/13 Change Fund submission are demonstrated as below. Following completion of Change Fund Plan by the Falkirk Partnership Change Fund Steering Group it will then be considered by the Falkirk Joint Management Board prior to final sign off by Chief Executives of Falkirk Council, CVS, NHS Forth Valley and Scottish Care. Reporting and accountability links between the current joint Forth Valley Joint Adult Strategic Planning Group around Forth Valley wide proposals contained within the plan are still developing.



6 CARERS

It is recognised that the role of carers is seen as being fundamentally important in allowing older people to continue to live in their own homes and communities. As part of the Scottish Government's ongoing commitment to support carers from 2012-13 onwards. At least 20% of the Change Fund is recommended to be spent on supporting carers to continue to care. Falkirk Partnership therefore must ensure that this is additional to existing carer support funding streams.

For Falkirk to deliver this commitment it is necessary to set out what constitutes support to carers thus enabling the partnership to clearly ensure and demonstrate that at least 20% of the Change Fund allocation is spent in this way. The evidence base demonstrates that direct support to carers benefits people who are cared-for by reducing admissions to acute facilities and supporting planned discharges.

It is clear that if carers are not adequately supported there is a greater likelihood of the cared-for being admitted to hospital and carers' own health being compromised.

Services aimed at older people with carers also improve the welfare of both the carers and the cared-for. This allows people who are cared-for to remain within their communities for as long as is possible and appropriate.

The Forth Valley Integrated Carers Strategy (2011) clearly highlights that the optimum way of supporting carers is likely to be through a planned combination of direct carer support and support for the cared for. As demonstrated by the existing initiatives and future proposals the Falkirk Partnership is committed to:-

- Direct support to carers such as short breaks/respite especially where the carer and the cared-for person both benefit, carer training, the provision of information and advice and support to improve carers' health and well-being;
- Community capacity building to ensure a network of community-based support demonstrating how carers will benefit from this approach;
- Direct support to older people, including people with dementia, demonstrating how carers will benefit.
- The provision of telecare to people who have carers, demonstrating how the telecare will support the carers;
- Re-ablement services to enable older people with carers to become more independent.

It is recognised that support for carers is a cross cutting theme across all initiatives. Nevertheless Falkirk Partnership recognises the need to support and work with carers, in addition to these direct carers supports being put in place.

7 SUPPORT MECHANISMS

7.1 Additional Assistance Provided

The Falkirk Partnership acknowledges the regular attendance at the Steering Group meetings by members of the Joint Improvement Team and is grateful for their on-going support and advice. Furthermore steering Groups member reported back positively as to National Events and Web Ex sessions. Furthermore there was universal support for the accessible and informative JIT Web site and the resources contained within. The proforma for the Change Fund Plan itself is a useful initiative.

7.2 Potential Support to Other Partnerships

Falkirk Partnership has many enthusiastic individuals who would be willing to share their experiences in developing specific reshaping care for older people proposals.

8 JOINT COMMISSIONING STRATEGY FOR OLDER PEOPLE

A Forth Valley wide Joint Commissioning Framework for Older People was approved early in 2009 which set out the principles and overall approach for developing services for older people. Following the publication of Reshaping Care for Older People and launch of the Change Fund the Joint Adult Strategic Planning Group (JASPG) undertook a review in 2011 to identify how to deliver this strategic agenda locally.

Two work streams were established to develop the strategic approach for Older People in Forth Valley:

- Review of Forth Valley Joint Commissioning Framework.
- Development of a Forth Valley Strategy for Older People

In conjunction with this review process the JASPG identified the following area wide initiatives to co-ordinate the approach:

- The establishment of a Forth Valley wide Performance Management Group for Older People.
- Development of the Integrated Resource Framework.

The outcomes from the Review of the Joint Commissioning Framework were considered at the JASPG meeting in January in 2012 and agencies endorsed an agreed vision.

The following additional workstreams were seen as being integral in taking the strategic agenda forward in Forth Valley:

- Development of a Strategic Plan for Older People which incorporates the revised Joint Strategic Commissioning Framework/Plan.
- Review current arrangements for engagement with stakeholders users and carers and ensure principles of Co-production and Building Community Capacity are incorporated at all levels

    - Forth Valley wide
    - Falkirk
    - Stirling/Clackmannanshire

The partner agencies also agreed to develop this joint commissioning approach for all services.

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

Signed on behalf of Falkirk Council

MARGARET ANDERSON

Signed on behalf of CVS Falkirk and District

KENNY MURPHY

Signed on behalf of Forth Valley NHS Board

FIONA RAMSAY

Signed on behalf of Scottish Care

IAN S MACMASTER

Appendix 1

Re-shaping Care for Older People in Falkirk Partnership Group 2011 - 2015

Falkirk Change Plan Development Initiatives
Detailed Proposal Form

Proposal Title		
Key Theme (s)		**Tick**
Reducing Admission (anticipatory care and preventative care)		
Managing Effective Flow in Acute Care		
Facilitating Proactive Care and Support at Home		
Remodelling Care and Transitions		
Supporting End of Life Care		
Enhancing Carer Support		
Submitted to		
Submitted by		
Date		

Summary of the Proposal
Background

What are the proposed outcomes and how will this directly support the delivery of the Falkirk Partnership Change Plan?

Proposal

Give details of your proposal:

1. *What you will do*

2. *How you will do it*

3. *How you will manage the work*

4. *How you will use the resources available – money and people's skills and time – to complete the work*

5. *How you have considered how this might impact on people in terms of Equality and Human Rights.*

6. *Who will be the key people/organisations involved.*

7. *What is the anticipated timescale between funding award and start of project?*

Costs and Resources

*Identify the cost of the proposal at 2 levels – the **minimum** required to deliver useful change and improved outcomes and the **optimum** to maximise the pace and delivered benefits of the proposal. Provide a break down of the expected costs, which should include all on-costs for employee related proposals.*

What are the Staffing proposals? i.e. Category (Social Worker , OT etc) Grade, WTE

What other resources are you able to commit to it e.g. facilities, equipment?

Is this a Forth Valley-wide proposal? If so detail total costs and apportionment requested from Falkirk Change Fund

Timescale

How long will it take to achieve results?

When will the project/activity be completed?

Sustainability

Please detail how the project will be sustained financially after the period of the funding allocation

Identify area of mainstream service change which will release monies

Detail the amount saved and re-invested in mainstream reshaping care for older people budget

Please note that you may be asked to provide additional information in support of your proposal.

Appendix 2

Traffic light report

FALKIRK CHANGE FUND STEERING GROUP HIGHLIGHT REPORT

PROJECT:

DATE		AUTHOR/(S)		PERIOD COVERED	
What is the objective of this project (in a nutshell)?					
What will be the most important measures to show the impact of this work on care for older people (with estimated impact and timings if known)?					
What are the key milestones on the way to achieving your objective?				TIMESCALE	PROGRESS* (TRAFFIC LIGHT)

	On track to complete		Slight delay or concern but manageable		Significant delay or cause for concern		Completed

What were the main outcomes achieved in this reporting period?
Describe delays against milestones and/or other issues
1 PROPOSED RESOLUTION OF ISSUES
What significant risks are associated with the changes you are making?
Interfaces/cross cutting issues requiring input from other projects/delivery groups?
Are there any issues you wish to raise at the next Falkirk Change Fund Steering Group meeting?