FINANCE COMMITTEE

DRAFT BUDGET 2014-15

SUBMISSION FROM GLASGOW CITY COUNCIL

1.0 Purpose of Report

1.1 This report provides an outline of the Reshaping Care for Older People Change Fund initiatives undertaken by Glasgow City Council Social Work Services. The information provided includes brief background to each initiative, level of spend and evidenced impact.

2.0 Background

2.1 The Reshaping Care for Older People: A Programme for Change 2011 – 2021 has been supported by additional resources identified via the 'Change Fund'. In Glasgow the following allocation has been identified for activities coordinated by Social Work Services:

- 2012/13 £4,309,685
- 2013/14 £3,071,756

2.2 This funding has been utilised to support 8 key initiatives.

3.0 Change Fund Initiatives

3.1 **Purchased Care Home Placements – 2011/12 £3.2m reducing to £800k in 2014/15**

Intention
To purchase additional Care Home placements in order to support hospital discharge within defined timescales.

Impact
An additional 26 Care Home places were purchased each month during 2012/13 to support discharge from hospital within defined timescales.

Bed days lost provides a more relevant measure of performance across time. Between May 2011-September 2013 the monthly bed days lost in Glasgow City reduced by around 52%.

In terms of delayed discharges there has been steady progress made during the lifetime of the Change Fund; that is, a reduction in 18 delays over 6 weeks in April 2010 had reduced to 8 delays over 4 weeks in August 2013. Some of these delays related not to older people, but to younger adults with complex physical disabilities for whom specialist services need to be commissioned on a case-by-case basis, increasing the risk of delayed discharge.

3.2 **Reablement – 2011/13 £1.3m**

Intention
To establish a service that provides tailored support to people in their own home for up to six weeks. Initially aimed at people coming out of hospital, it builds confidence by helping people to regain skills to do what they can and want to do for themselves rather than rely on others to perform these tasks. This approach identifies and responds early to barriers to community living.

The phased roll out this service across Glasgow city was completed on 31st March 2013.

Impact
A target of 3000 service users completing reablement per annum within a fully operational service was set.

122 new referrals received pr week against a target of 87.

Sample of 200 service users, 83% reported that they were able to resume their usual activities, and 77% reported being able to do more for themselves.

The average reduction in home care hours required at end of reablement period was more than 50%.

3.3 **Assessment at Home (Step Down Assessment) - 2012/14 £1.3m**

Intention
To develop an intermediate care solution that aims to support discharge when the patient is medically fit, reducing bed days lost, and reducing the numbers being admitted to long term care. The target group is individuals over 65 who are at risk of being delayed in hospital for 2 weeks or over.

Early aspirations were that the majority of individuals would be discharged home for assessment and that remainder would be admitted to a care home for up to 21 days assessment. The evidence to date has established that the majority of individuals have been admitted to a care home for assessment with only a small proportion of individuals being assessed at home.

In 2012/13, 10 care home places were commissioned in care homes for step down assessment.

The pathway will be extended to a second hospital in November 2013. The step down care home places will increase to 20 in the south of the city. Following this, the pathway will be rolled out to other hospitals in the north and east of the city. An additional 24 step down places will be commissioned in the north and east of the city to support this roll out.

Impact
Based on current experience 20% of those admitted to the care home will return home and 80% will be admitted to long term care.

145 cases have been considered for Assessment at Home (Step Down Care). 36 were discontinued (e.g. required Palliative Care, Continuing Health Care), 31 have been completed (7 remain in own home, 16 in residential care, 8 nursing care). The remaining 78 cases are ongoing.

Early indications are that the “Step Down Care” pathway approach is having a positive impact re-directing admissions away from nursing to residential care. It has also contributed to the reduction in bed days lost referenced above.

3.4 **Adults with Incapacity – 2012/14 £120k**

Intention
To fund additional admin staff to support the work required to ensure that Guardianship applications are progressed as quickly as possible as a means of reducing bed days lost to AWI delays.

Impact
AWI bed days lost has decreased by 64.6% between Jan 2012- Jan 2013.

3.5 **Power of Attorney Public Awareness Campaign – 201/14 £47k**

Intention
This funding has been awarded to develop and commission a public awareness campaign to promote awareness of and increase uptake of POA.

The key elements of the campaign will be a TV advert with the strapline “Start the Conversation". A TV company have been commissioned to who will produce 3 TV adverts which will be shown on STV first week in December 2013 with 20 day time slots and 5 peak time slots.

In addition, work is ongoing with solicitors in the city and the Office of the Public Guardian (OPG) to explore how POA can be pursued by families as effortlessly and cost effectively as possible.

Impact
It is anticipated that this campaign will increase the number of advanced powers registered with the OPG. Thus further reducing the number of people detained in hospital due to incapacity.

3.6 **Anticipatory Care – 2012/14 £200k**

Intention
To work within 9 GP practices in the South of the City with a view to reducing hospital bed days used by anticipating those older people most likely to be admitted to hospital in an emergency using SPARRA data.

The SW element of funding employs 2 Social Workers who complete Single Shared Assessments with older people admitted to hospital within 2 days to ensure rapid return home where possible. Social Work staff also work closely

with health staff and GPs to identify those older people most at risk of hospital admission and agree joint anticipatory care plans.

Impact
A target of 200 Single Shared Assessments has been agreed for 2013/14 and performance in 1St quarter was 25 due to low referrals rates. It has been agreed that quicker throughput from practices will improve performance in subsequent quarters.

3.7 **A&E Rapid Response – 2012/14 £90k**

Intention
The SW element to this funding has been to employ a Social worker to work within A&E with health colleagues to ensure that older people presenting at A&E do not end up being admitted to hospital if this could be prevented by relevant interventions. Additionally the project seeks to reduce potential admissions for unplanned care in the over 65 population. The SW role has been accepting referrals for community carer assessments and/or reviewing current packages of home care.

Impact
An average of 25.3 people per month have avoided admission to hospital.

3.8 **Supporting Older Carers – 2012/13 £330k**

Intention
Older Carer Development Workers have been recruited to build capacity within carer services to provide increased support to older carers and carers of older people. This has been done in partnership with primary and acute services and the voluntary sector.

Impact
Over 230 carers have been identified through Social Work Older People's Services and through Discharge Planning. Based on current levels of activity c600 carers assessments will be undertaken each year.

All carers have undergone outcomes focussed assessments and have had access to a range of services including income maximisation, training to support the caring role, short breaks and emotional support. All carers were offered health checks in recognition that carers often neglect their own health and well being.

Examples of positive outcomes to date:

c2,400 hours of short breaks provided.

C60 carers have received health reviews.

14 carers have received training in moving and handling.