ITEM No …13……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2017**

REPORT ON: **REMODELLING CARE FOR OLDER PEOPLE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB21-2017**

1.0 PURPOSE OF REPORT

The purpose of this report is to outline the future provision of care to meet the future needs of older people which supports care in their own home or a homelike setting.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the contents of this report.

2.2 Notes and approves the future direction of delivery of health and care for older people.

2.3 Instructs the Chief Officer to conduct a full business case options appraisal in partnership with practitioners to determine the most effective and efficient mix of service models which will meet the care needs of older people within Dundee and to present this to a future IJB meeting for approval.

3.0 FINANCIAL IMPLICATIONS

The financial implications of remodelling care for older people will be fully set out within the business case to ensure that best value is achieved in the use of resources.

4.0 MAIN TEXT

4.1 Background

4.1.1 Dundee, along with the rest of Scotland, faces significant challenges related to an ageing population and significant numbers of people with dementia. To meet these challenges requires a preventative approach which supports older people to remain healthier longer, and shifts the balance of care to allow older people to remain in their own home or in a homelike setting rather than in hospital. The strategic approach to these challenges is outlined nationally in the Reshaping Care for Older People policy, the 20/20 vision and Scotland's National Dementia Strategy.

4.1.2 The Dundee Health and Social Care Partnership has set its strategic direction in the Health and Social Care Strategic and Commissioning Plan 2016-2021 by identifying eight strategic priorities. These are health inequalities, early intervention/prevention, person centred care, carers, building community capacity, engagement with localities, models of support/pathways of care and making best use of our resources.

4.1.3 The Dundee Joint Older People's Strategic and Commissioning Statement and Scotland's National Dementia Strategy set out the following objectives:

- support, protect and improve the health of older people;
- shift the balance of care across the whole system of health and social care;

- provide older people with access to a wide range of care and support;
- prevent inappropriate admissions to hospital;
- facilitate timely discharge from hospital;
- enable people to keep control over their own lives; and
- Enable people with dementia to access high quality care services.

4.1.4 We know that there are advantages of older people remaining in their own home rather than being admitted into hospital. In addition to the demographic pressures facing hospital services there are risks associated with hospital admission such as hospital acquired infection, institutionalisation and a greater likelihood the person will not be able return home. Many older people are very reluctant to come into hospital and prefer to be at home and this can allow them to carry on with their usual routine.

4.1.5 Previously the model of service provision promoted people being assessed at Ninewells and accessing other resources from there. Predominately this involved a transfer to either Kingsway Care Centre or Royal Victoria Hospital. Recent years have seen the development of a range of models that promote a rapid assessment in the community with direct access to a range of resources which can prevent people deteriorating, prevent unnecessary admission or facilitate a timely discharge with a range of supports.

4.1.6 While there will always need to be acute care for medical emergencies the people who benefit from these new models include those who have infections, heart failure, COPD, delirium, who have fallen, and those who are elderly and are deteriorating. These people can be particularly vulnerable to risks associated with admission.

4.1.7 Work has been undertaken through the Older People Strategic Planning Group and wider engagement with a range of stakeholders to develop models which will support the strategic direction. These models have the support of Practitioners from a range of disciplines and will provide better outcomes for people.

4.1.8 The proposed future model is that by using an asset based approach people will be supported to be healthier and independent for longer in their own community. Involvement of the Third Sector is vital to the success of this model and this will need increased investment. The development of locality work will continue to identify people at an early stage of their journey where things do go wrong and provide early intervention and anticipatory care. Where people do start to deteriorate a range of services will be provided to allow them to maximise their recovery and be independent in their own home. Where this is not possible there will be intermediate care services within the local area. Where people do need to go to hospital this will only be for the length of time they need to be in hospital and they will be able to step down using the same range of supports and resources. Both community and inpatient services will be redesigned to ensure they meet the needs of people who have both cognitive impairment and physical health problems.

4.1.9 A number of workstreams already support this remodelling. These are workstreams to develop Enhanced Community Supports including those designed for people with a more Acute need, the development of Community Rehabilitation Teams, the development of the Post Diagnostic Team for people newly diagnosed with dementia, the development of integrated Community Teams, the development of a care home support team, the development of integrated community mental health teams, polypharmacy work, development of the acute frailty team, rapid response social care, work to co-ordinate out of hours services, development of an integrated discharge hub and a range of intermediate care resources. Collectively the intention of these resources and teams is to ensure continuity of care, prevent admission where possible and if not to ensure a timeous return home to be assessed.

4.2 Developing Locality Working

4.2.1 There has been significant investment in the Third Sector recently through the use of Change Funds as set out within the IJB's Transformation Programme. This has helped to support older people to remain socially connected in their communities and prevented the need for statutory intervention. There has also been significant investment in services which support carers.

4.2.2 In addition, in order to develop locality models Dundee has created four virtual GP clusters with alignment to the Medicine for the Elderly (MfE) Consultants to support a community model. All

four clusters are aligned to Social Work Teams, the Community Rehabilitation Team, Community Nursing and Psychiatry of Old Age. This model allows more preventative work and greater continuity of care as it allows for involvement before during and after an admission. Work will continue to integrate these services on a locality model. This model is most embedded in one of the four clusters and has shown the greatest impact on bed day use and unscheduled care episodes here.

4.2.3 In terms of supporting people with Dementia there has been the development of integrated Community Mental Health Teams and the Post Diagnostic Support Team which works with people in the first year following diagnosis. Work will continue to ensure that people achieve an early diagnosis as this means that people can put things in place for when their health deteriorates.

4.2.4 People who live in care homes are particularly vulnerable and a number of teams have been put in place to support them. These include the development of a peripatetic nursing team, a care home liaison team and a social work review team.

4.2.5 The impact of these developments has been a significant reduction in demand for non -acute inpatient services particularly in Royal Victoria Hospital and improved outcomes for Older People. It has also been possible to decrease the bed base in Kingsway Care Centre. There are no longer any continuing care patients in Royal Victoria Hospital and two of the continuing care wards have been closed with the closure of the third ward planned later in the year. This is a total bed reduction of 36 beds in Royal Victoria Hospital and 15 in Kingsway Care Centre. Currently 24 beds have closed in Royal Victoria and nine in Kingsway Care Centre.

4.2.6 In the cluster of GPs where the model has been most developed there has been an additional significant reduction in unscheduled care episodes. The aim in order to build on the work to date is to replicate this across the other three clusters, develop hospital at home services and to develop resources which can support people with complex needs relating to dementia many of whom can be in hospital for long periods.

4.2.7 The work undertaken to date will allow a resource release from Royal Victoria Hospital which can support the work streams which are in progress to further develop robust community services which can work at home with people with a range of complex needs. It is proposed that this is used to support the roll out of Enhanced Community Support including a hospital at home service. In Kingsway Care Centre the work will allow the recommended staffing levels to be achieved reducing the current cost pressure.

4.2.8 It will not always be possible or appropriate for the person to be at home and a number of options need to be available to prevent unnecessary admission into acute hospital settings. These will include acute hospital, Day Hospital, Kingsway Care and Royal Victoria Hospital. There may also be occasions where the person does not need to be in hospital but would benefit from rehabilitation or assessment in an intermediate care setting. Where possible this should also be provided in a locality setting to keep continuity of care.

4.3 Development of Intermediate Care

4.3.1 Intermediate Care is a package of intensive, time limited interventions provided at home or in a community setting to help avoid unnecessary admission to hospital or help facilitate a safe discharge home after a hospital stay.

4.3.2 Maximising Recovery Promoting Independence: An intermediate Care Framework for Scotland describes intermediate care as a continuum of integrated community services for assessment, treatment, rehabilitation and support at times of transition. It describes how it reduces demand and improves outcomes by providing an alternative to emergency admission, enabling timely discharge, reabling people and enabling them to return to independence and reducing premature admission to care homes.

4.3.3 There are three key types of intermediate care which have been developed in Scotland. These are intermediate care at home, bed based intermediate care and hospital at home. Work is underway to develop models in all three areas in Dundee, with Enhanced Community Support, Enhanced Community Support Acute and the development of bed based intermediate care. In Dundee the intention is to continue to develop these resources with a locality focus. This will

mean that rather than people experiencing handovers in their care provision they will have continuity of care.

4.3.4 A number of options have already been developed including rapid response social care, temporary housing and intermediate care in a care home. Work is underway to develop intermediate care in housing with care.

4.3.5 While, where possible, it is desirable to support an older person in their own home this is not always possible or safe and it is recognised there will need to be some bed based provision. This has been commissioned in Dundee in a 28 bed facility. This is not provided on a locality basis and it is not possible to offer the continuity of care that a locality model would provide. It is also more difficult to maintain a connection with the local community as a result.

4.3.6 In 2014 the Scottish Government published the Future of Residential Care for Older People in Scotland. This report seeks to examine the purpose of residential care to meet the aspirations and needs of future generations in terms of the strategic direction outlined above. This sets out three key objectives which are to continue to develop Housing with Care, Intermediate Care and smaller specialist care homes. Developing intermediate care, as detailed above, can ensure there is a continuum of integrated community services for assessment, treatment, rehabilitation and support for older people who do not or no longer require to be in hospital. Flexible responsive models are required which will allow them to best meet the needs of the local population and maximise the movement of individuals through the hospital system.

4.4 Speciality Residential Care

4.4.1 A recent review of residential provision in Dundee concluded that Health and Social Care Partnership Care Home provision is particularly suited environmentally, geographically and in terms of staff skills and training to focus on intermediate care and specialist residential dementia care. There are gaps in provision particularly for younger people with dementia and those who are stressed or distressed. Many of these people end up in hospital for prolonged periods of time. These areas are gaps which have not been filled by the private and voluntary sector.

4.4.2 The environment provided in one of the Partnership homes has been designed to be dementia friendly. Currently people with very complex needs are able to be looked after in this resource. By further expanding this provision and working closely with the Care Home liaison team people may be prevented from being admitted and discharged more timeously from Kingsway Care Centre. The intention will also be to develop intermediate care for this group of people. For people with cognitive impairment transitions are very challenging and so getting this right is of great importance.

4.5 Current Provision of Accommodation Based Care

4.5.1 Current hospital provision consists of 81 beds at Royal Victoria Hospital and 55 beds at Kingsway Care Centre. There are over of 1000 care home places provided in Dundee in a mixed economy of private, voluntary and statutory sectors. The Dundee Health and Social Care Partnership operates four residential care homes for older people in the city, which provide 108 permanent and four step down places. There has also been and continues to be an expansion of Housing with Care which can offer an alternative flexible support to older people preventing the need to move into a care home.

4.5.2 In addition a 28 bed intermediate care facility has been commissioned in the private sector in the Bluebell Unit. This unit is supported by a range of professionals including the Community Rehab team and Medicine for the Elderly service. Further step down options are available in sheltered housing and housing with care.

4.6 Proposed Future Provision

4.6.1 Work is underway to redevelop inpatient services for Older People. These will be co-located as the presenting population have both physical and cognitive issues. In the meantime an intermediate model will provide 74 beds in Royal Victoria Hospital and 49 in Kingsway Care Centre.

4.6.2 The intention is to develop locality based intermediate care in Dundee Health and Social Care Partnership operated homes. This will be for people with Cognitive and Physical issues. The location of these homes will support this work to be delivered in more of a locality manner.

4.6.3 There are currently gaps for people with complex needs who can no longer live at home. These include younger people with dementia and those with more complex challenging needs. The proposal is that care homes managed by the Partnership develop as a specialist resource for these people. This will lead to a reduction in people who are in Kingsway Care Centre for prolonged periods.

4.6.4 The proposed roll out of Enhanced Community Support in the other three clusters is likely to lead to similar gains to that of Cluster 2 and the development of hospital at home will further support people to be cared for in their own home.

4.6.5 In order to ensure the most effective use of resources, it is proposed that the Chief Officer conducts a full business case options appraisal on the range and scale of service models and presents recommendations to a future IJB meeting.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. An EQIA is attached.

6.0 CONSULTATIONS

The Chief Finance Officer, Executive Director of Corporate Services - Dundee City Council and the Clerk were consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

Date: 1 June 2017

EQUALITY IMPACT ASSESSMENT TOOL

Part 1: Description/Consultation

Is this a Rapid Equality Impact Assessment (RIAT)?		Yes ☒	No ☐
Is this a Full Equality Impact Assessment (EQIA)?		Yes ☐	No ☒
Date of Assessment:	07/06/2017	**Committee Report Number:**	DIJB21-2017
Title of document being assessed:		Remodelling Care for Older People	
1. This is a new policy, procedure, strategy or practice being assessed (If yes please check box) ☐		**This is an existing policy, procedure, strategy or practice being assessed?** (If yes please check box) ☒	
2. Please give a brief description of the policy, procedure, strategy or practice being assessed.		This is a report to update the IJB as to proposed models of Intermediate Care and Care at Home	
3. What is the intended outcome of this policy, procedure, strategy or practice?		Seek approval to develop a full business case	
4. Please list any existing documents which have been used to inform this Equality and Diversity Impact Assessment.		None	
5. Has any consultation, involvement or research with protected characteristic communities informed this assessment? If yes please give details.		None but stakeholders have been involved in developing the strategy through the Strategic Planning Group.	
6. Please give details of council officer involvement in this assessment. (e.g. names of officers consulted, dates of meetings etc)		None	
7. Is there a need to collect further evidence or to involve or consult protected characteristics communities on the impact of the proposed policy? (Example: if the impact on a community is not known what will you do to gather the information needed and when will you do this?)		No	

Part 2: Protected Characteristics

Which protected characteristics communities will be positively or negatively affected by this policy, procedure or strategy?

NB Please place an X in the box which best describes the "overall" impact. It is possible for an assessment to identify that a positive policy can have some negative impacts and visa versa. When this is the case please identify both positive and negative impacts in Part 3 of this form.

If the impact on a protected characteristic communities are not known please state how you will gather evidence of any potential negative impacts in box Part 1 section 7 above.

	Positively	Negatively	No Impact	Not Known
Ethnic Minority Communities including Gypsies and Travellers	☐	☐	☒	☐
Gender	☐	☐	☒	☐
Gender Reassignment	☐	☐	☒	☐
Religion or Belief	☐	☐	☒	☐
People with a disability	☒	☐	☐	☐
Age	☒	☐	☐	☐
Lesbian, Gay and Bisexual	☐	☐	☒	☐
Socio-economic	☐	☐	☒	☐
Pregnancy & Maternity	☐	☐	☒	☐
Other (please state)	☐	☐	☒	☐

Part 3: Impacts/Monitoring

1. Have any positive impacts been identified? (We must ensure at this stage that we are not achieving equality for one strand of equality at the expense of another)	This will help to ensure a smooth transition for people leaving care homes.
2. Have any negative impacts been identified? (Based on direct knowledge, published research, community involvement, customer feedback etc. If unsure seek advice from your departmental Equality Champion.)	No
3. What action is proposed to overcome any negative impacts? (e.g. involving community groups in the development or delivery of the policy or practice, providing information in community languages etc. See Good Practice on DCC equalities web page)	N/A
4. Is there a justification for continuing with this policy even if it cannot be amended or changed to end or reduce inequality without compromising its intended outcome? (If the policy that shows actual or potential unlawful discrimination you must stop and seek legal advice)	N/A
5. Has a 'Full' Equality Impact Assessment been recommended? (If the policy is a major one or is likely to have a major impact on protected characteristics communities a Full Equality Impact Assessment may be required. Seek advice from your departmental Equality lead.)	No
6. How will the policy be monitored? (How will you know it is doing what it is intended to do? e.g. data collection, customer survey etc.)	The impact of this will be monitored through service user reviews.

Part 4: Contact Information

Name of Department or Partnership	Health & Social Care Partnership

Type of Document	
Human Resource Policy	☐
General Policy	☐
Strategy/Service	☐
Change Papers/Local Procedure	☒
Guidelines and Protocols	☐
Other	☐

Manager Responsible	**Author Responsible**
Name: Diane McCulloch	**Name:** Jenny Hill
Designation: Head of Service	**Designation:** Locality Manager
Base: Claverhouse Office	**Base:** Claverhouse office
Telephone: 438302	**Telephone:** 438307
Email: diane.mcculloch@dundeecity.gov.uk	**Email:** jenny.hill@dundeecity.gov.uk

Signature of author of the policy:	Jenny Hill	**Date:**	07/06/17
Signature of Director/Head of Service:	Diane McCulloch	**Date:**	07/06/17
Name of Director/Head of Service:	Diane McCulloch		
Date of Next Policy Review:	Click here to enter text.		