ITEM No …8……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

REPORT ON: **RESHAPING NON-ACUTE CARE IN DUNDEE UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB31-2018**

1.0 PURPOSE OF REPORT

This report is to update the Integration Joint Board in relation to the work of the Reshaping Non-Acute Care Programme in Dundee and outline progress towards the plans for non-acute care and residential care in Dundee described in report DIJB38-2017 (Reshaping Non-Acute Care presented to the Integration Board held on 31 October 2017).

2.0 RECOMMENDATIONS

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

2.1 Notes the contents of this report;

2.2 Instructs the Chief Officer to bring back to the IJB the initial business case at its meeting on 28 August 2018.

3.0 FINANCIAL IMPLICATIONS

3.1 The cost of developing the project will be outlined in the initial business case for onward submission to the Scottish Government for consideration of funding.

3.2 The proposed integrated model of care will provide opportunities for a more efficient use of resources, including shifting the balance of care which will be set out in the initial business case.

4.0 MAIN TEXT

4.1 Background

4.1.1 As described in the Reshaping Non-Acute Care in Dundee report (report number DIJB38-2017) a programme of work was initiated in 2014 as part of the Steps to Better Healthcare initiative. A review of the scope and deliverables of the programme was carried out in early 2016, with a new programme leadership, scope and deliverables and team emerging in mid-2016 focussing on the following:

- developing new models of care around frailty services in Dundee, including the services previously known and psychiatry of old age (POA) and medicine for the elderly (MFE);
- developing new models of care for neurological rehabilitation services, including the service previously known as the Centre for Brain Injury Rehabilitation in Dundee;
- developing a new model of care for stroke services in Dundee;
- developing a new model of care for specialist palliative care services in Dundee;
- identifying opportunities for integrated models of care for the above with Angus.

4.1.2 The proposed model of care for much of this work has been outlined in Proposed Model of Care for Older People - Business Case (report number DIJB37-2017 presented to the IJB on

31 October 2017) and Remodelling Care for Older People (report number DIJB21-2017 presented to the IJB on 27 June 2017).

4.1.3 Since these reports were submitted to the IJB, work is underway to develop an initial business case for the Scottish Government which seeks to secure project development investment. The initial discussions have identified that there may be opportunities to include the re-provisioning of Craigie House and the delivery of both the Menzieshill and Coldside Local Care Centres as key components of an integrated strategic programme. This will support the development of a whole system approach with a robust community model to allow the necessary shifts in the balance of care.

4.1.4 This whole system approach will strongly be considered by the Scottish Government in relation to the provision of project funding. This approach supports the transformational service changes outlined in the Primary Care Improvement Plan and NHS Tayside Transformation Programme. It will allow for a range of services to be delivered in localities, support more people to remain at home and enable the restructuring of patient services to meet the needs of the population. As part of this work a long list of site options has been drawn up, an engagement strategy drafted and design workshops are being planned to coproduce the design statement. This initial business case is intended to be ready to bring back to the IJB in autumn for submission to the Scottish Government in October.

4.1.5 In the meantime we have further developed the range of models described previously that promote a rapid assessment in the community with direct access to a range of resources which can prevent people deteriorating, prevent unnecessary admission and facilitate a timely discharge with a range of supports. This, along with the management of people with more complex needs in care homes with the support of an integrated care home team has meant a reduction in the numbers of people in hospital wards. As a result it has been possible to achieve the interim model in Royal Victoria Hospital (RVH). There are currently a dedicated stroke ward for older people and three assessment and rehabilitation wards. As the success has exceeded expectations there is an opportunity to look at improvements in other pathways of care such as the development of an Orthogeriatric model for people who have experienced trauma such as fractures but have underlying frailty issues. This will allow better outcomes by caring for people in a multidisciplinary team with geriatric specialists as well as orthopaedic surgeons. In addition this will seek to meet the needs of people who are chronologically younger but have complex needs.

4.1.6 The current layout in Kingsway does not support a move to the model outlined in the Reshaping Non Acute Care report and this will not be achieved until alternative provision is identified. As described in the previous report there are gaps in the current provision which include younger people with dementia and those with more complex challenging needs. Work is underway to support the proposal that care homes managed by the Partnership develop as a specialist resource for these people. There is now an integrated care home team and this has meant that care homes have been able to support more people with complex needs.

4.1.7 As outlined in the previous report the neuro rehabilitation redesign will enable resources to be used more efficiently and effectively to support the rehabilitation needs of patients and their families. The redevelopment of the facilities and redesign of the service will markedly improve the quality of the service that is provided and much improve the environment for both patients and staff. It will also allow the service to reduce the likelihood of delayed discharge and to cope with predicted future demands on the service.

4.1.8 Initial discussions have now taken place around the future of provision of Specialist Palliative Care Services with a range of stakeholders and this will now be taken forward as part of the Reshaping Non Acute Care work.

4.1.9 In addition, options to work more collaboratively with Angus Health and Social Care Partnership continue to be explored as part of this programme of work.

4.2 Engagement

4.2.1 A wide range of stakeholders have been involved in the development of the wider service proposals and will continue to be involved in the coproduction of the initial agreement. Engagement with staff has been done in partnership with staff side representatives and a

transition group was set up at RVH to manage the change process. Wider discussion has taken place through Strategic Planning Groups, Local Medical Committee (LMC) Cluster Lead meetings, team meetings and other fora. In order to ensure a comprehensive approach a draft engagement strategy has been produced.

5.0 POLICY IMPLICATIONS

5.1 The objectives of the project support the strategic aims of person centred, community based care in keeping with the principles of the IJB's Strategic and Commissioning Plan. The objective is also to ensure that this is delivered as safely and efficiently as possible in line with the emerging NHS Tayside Integrated Clinical Services Strategy for Older People, produced by the Older People Clinical Board.

5.2 The proposals within the report are in line with the NHS Tayside Property Strategy. The obtainment of additional Scottish Government resources will provide the development of a centre for excellence and support the remodelling of care.

5.3 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

No specific risks have yet been identified however, as part of the wider programme of work, a risk workshop will be conducted and all the risks identified. A risk log will be created highlighting risk owner and mitigation strategy. This risk log will be maintained and monitored at the regular programme review meetings.

7.0 CONSULTATIONS

7.1 Dundee IJB cited the project as a key development in their Strategic and Commissioning Plan. Detailed components of this summary document have been submitted to the following gateway committees:

- Integrated Strategic Planning Group
- The Older Peoples Board
- Strategic Planning Groups
- Clinical Fora including:
    - Older Peoples Clinical Board
    - LMC Cluster Lead Meeting.

7.2 The Chief Finance Officer and the Clerk were also consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 24 May 2018

Jenny Hill
Locality Manager