ITEM No …8……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 31 OCTOBER 2017**

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

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB38-2017**

1.0 PURPOSE OF REPORT

1.1 This report is to update the Integration Joint Board in relation to the work of the Reshaping Non-Acute Care Programme in Dundee and to seek approval to proceed to the next phase of the programme. It describes a future outline operational plan for non-acute care in Dundee, ideally in partnership with other localities. It also outlines the future impact on property in relation to the wider transformation of the property portfolio across Dundee and Tayside.

1.2 The outline operational plan described in this paper fully supports relevant national and local strategies, specifically Dundee IJB's Strategic and Commissioning Plan, the emerging NHS Tayside Transformation Board's Integrated Clinical Strategy and its Property Strategy.

2.0 RECOMMENDATIONS

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

2.1 agrees the proposed future model of non-acute care for Dundee in principle as described in paragraphs 4.2 – 4.6;

2.2 instructs the Chief Officer to prepare a fully costed business case and present this to a future IJB meeting;

2.3 notes the level of engagement and consultation undertaken to date as set out in section 4.7 of this report and commits to a continuation of this approach over the next phases of the proposed development.

3.0 FINANCIAL IMPLICATIONS

3.1 Primary and Community Care projects which exceed £10 million build cost require to use the hub initiative Design, Build, Finance, Maintain (DBFM) procurement route, which is a revenue funded solution. The capital requirement for such projects is limited to enablement works, moveable (Groups 2, 3 and 4) equipment and subordinate debt. The Scottish Government Health and Social Care Department will provide capital funding for moveable equipment associated with the revenue financed hub projects.

3.2 The Tayside Community Care (Kingsway 2) project, of which this proposal is a key component, is expected to be delivered by the above route. In November 2014 a ministerial announcement was made supporting finance for the Kingsway project, quoting notional capital equivalent estimate of £20 million. Dundee Health and Social Care Partnership seeks to utilise this funding opportunity in the event a new facility is required.

3.3 It is intended that this would be the initial component of a phased programme of works that will see a transformation of all community facilities and the creation of locality hubs across the city.

4.0 MAIN TEXT

4.1 Background

4.1.1 The Reshaping Non-Acute Care in Dundee 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 and medicine for the elderly (POA and MFE)
- developing new models of care for neurological rehabilitation services, including the service previously known and 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 special palliative care service in Dundee
- identifying opportunities for integrated models of care for the above with Angus
- reviewing the impact on the existing facilities with a view to specifying a new portfolio of properties that will better meet the future demands of flexibility, safety, efficiency and sustainability.

4.1.2 Each of these areas have been working with the support of healthcare planners from Capita on mapping the future state of services, with a focus on new models of community and integrated care. The statistical analysis was undertaken to provide robust data to provide evidence to support these new models.

4.1.3 As Older People's Services face the combined challenges of increased demand for care, an ageing population and pressures on funding, they are progressing improvement work to modernise pathways of care in partnership with other care providers to integrate care, breaking down the boundaries experienced between hospital and non-hospital care and moving care into communities.

4.1.4 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.

4.1.5 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, Chronic Obstructive Pulmonary Disease (COPD), delirium, who have fallen, and those who are elderly and are deteriorating. These people can be particularly vulnerable to risks associated with admission.

4.1.6 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.

4.1.7 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.

4.1.8 A number of work streams already support this remodelling. There are work streams 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 and the development of integrated community mental health teams.

4.1.9 This also includes polypharmacy work, the 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.

4.1.10 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.

4.1.11 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.

4.1.12 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.

4.1.13 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 Dundee Enhanced Community Support Acute (DECSA) will further support people to be cared for in their own home.

4.2 Frailty Services

4.2.1 The reshaping of care for people who have multiple and complex needs resulting in frailty is a Scottish Government initiative aimed at improving services by shifting towards anticipatory care and prevention. Previously, the “Reshaping Care for Older People : A Programme for Change 2011-2021” set out the Scottish Government vision that 'Older people are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting'.

4.2.2 The health and social care workforce in Dundee currently operates in a relationship of co-production with patients, service users and community localities, something that was explicitly stated in the Christie Report (2011): "the workforce must be able to provide effective services and support that are designed with and for people and communities and not delivered top down for administrative convenience."

4.2.3 The model of care for frail people is evolving – the transition from care focused on the inpatient setting towards an approach of integrated care between health and social care i.e. the Dundee Enhanced Care Services (DECS), third sector and voluntary bodies for people in their own homes or communities. The continued development, growth and eventual roll-out of the DECS model has a direct and positive impact on inpatient numbers and results in a reduction in overall demand for inpatient beds.

4.2.4 This shift is both beneficial in terms of the patient’s experiences and outcomes as well as a reduced demand on health and social care resources and assets but is also vital in meeting the expanding demands for care that the population demographics and the diminishing levels of such resources force upon us.

4.2.5 The community inpatient components of the frailty services in Dundee currently operate from bed bases in Royal Victoria Hospital and the Kingsway Care Centre.

4.2.6 It is acknowledged that the current age and fabric of the Royal Victoria Hospital site does not

provide an environment which is sustainable for future requirements. This has been a contributory factor in the reduction of wards across the Royal Victoria Hospital site. In addition, Kingsway Care Centre is currently based in a leased building which is not purpose built. There is therefore, a requirement to review the options for alternative sites for both services based on the Royal Victoria Hospital site and the Kingsway Care Centre site.

4.2.7 In line with the principles of the IJB's Strategic and Commissioning Plan, this creates the opportunity to design an integrated, contemporary model of care with co-located services in an improved environment that will support the desired model of Medicine for the Elderly (MFE) with Psychiatry of Old Age (POA) while creating new models for Neurological Rehabilitation and Stroke services on a single site.

4.2.8 While this may reduce the number of bed spaces in a new facility, this is only part of the configuration of resources needed to provide this new community and patient focused model of care delivery. There is a direct correlation between the breadth and depth of community services and the bed numbers required.

4.2.9 Work is ongoing to develop robust community enhanced support including an acute pathway. Further work is also continuing to provide support for people with mental health difficulties, including dementia, in the community. In particular by developing post-diagnostic support, community mental health teams and an integrated care home team.

4.2.10 Improvements continue in joint working with MFE and POA including a locality model for psychiatry of old age services. From September 2017 the Acute Frailty Service, currently based in Ninewells to ensure frail elderly people are identified, is provided seven days per week. This ensures frail people receive a comprehensive geriatric assessment and are supported through their recovery journey in the most appropriate manner. Ideally this may be best delivered from an Acute Frailty Unit in the future. Other live initiatives supporting robust community models include the following:

- polypharmacy review
- enhanced Community Rehab services
- joint working with Out of Hours service
- development of rapid response social care
- further development of the falls pathway
- anticipatory care planning and work to promote power of attorney
- development of step-down and step-up models of care.

4.3 Specialist Neurological Rehabilitation

4.3.1 The Neurological Rehabilitation Services Initial Agreement document agreed by NHS Tayside in June 2017 outlines a proposal to develop a comprehensive new specialist neurological care pathway, including for trauma patients.

4.3.2 The development supports the achievement of three key objectives of Dundee IJB:

Improving Health
The holistic enablement and rehabilitative service provided by the multidisciplinary team will enable and support patients to live more independently, to participate more fully in family and community life, and will assist patients to live healthier lives.

Improving Patient Experience (Person Centred Care)
Patients requiring neuro-rehabilitation will experience a patient-centred approach to their rehabilitation, and more positive experiences and outcomes as they work in partnership with the multidisciplinary team to establish their personal goals, and will be treated in purpose-designed facilities that meet their needs.

Cost Efficiency (Making Best Use of Resources)
The service redesign will enable resources to be used more efficiently and effectively to support the rehabilitation needs of patients and their families. The potential new model of neuro-rehabilitative care will require reinvestment in the services provided by NHS Tayside

and the Local Authorities to enhance the local support provided to patients in a community setting and to supplement the work of the inpatient unit.

4.3.3 The Tayside Neurological Rehabilitation Redesign also looks to support the attainment of the following NHS Tayside Corporate Objectives:

- Agencies (public and voluntary sectors) will work together, and with communities to improve services and health outcomes
- Optimise the health and quality of lives of people living in Tayside and reduce health inequalities
- Improve quality of care in all health settings
- Improve patient experience of our services
- Provide care in a safe, clean environment
- Build capacity and capability to achieve sustainable change
- Deliver on the priority areas in our Clinical Strategy including achieving HEAT targets and standards
- Make the best use of resources and achieve financial balance.

4.3.4 The project also looks to contribute to the attainment of the strategic aims set out in the IJB's Strategic and Commissioning Plan.

4.3.5 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.

4.4 Stroke Services

4.4.1 The need for specialist rehab stroke services was outlined in report DIJB6-2017 (Medicine for the Elderly Services) which was submitted to the Integration Joint Board in February 2017. An interim unit has been created on the RVH site and will become fully operational toward the end of 2017. Whilst this is an improvement on the scale of services available previously further development of stroke services is required.

4.5 Palliative Care

4.5.1 Initial discussions have taken place to begin to scope out the design of future palliative care services. This process will be a joint initiative with the Angus Partnership. Whilst at such an early stage in the process it would be difficult to describe a future model, planning for the wider review of non-acute services should not exclude palliative care.

4.6 Psychiatry of Old Age (POA)

4.6.1 POA services were transferred to the Kingsway Care Centre in 2013 as an interim move. Since then the development of community based services has allowed significant reductions in bed numbers. The intention is to move to a three ward model however, due to building design and configuration issues, this cannot be accommodated on the Kingsway site.

4.6.2 It is further recognised that the needs of the population are significantly complex and the current population do not have either a mental or physical health problem, but have both. Co-location with MFE services would result in a more efficient and better quality service.

4.6.3 The re-modelling of services within Psychiatry of Old Age has enabled a review of staffing establishments as part of the wider workforce plan. Again, it is not possible to achieve this staffing model on the current site and with the current resources available.

4.6.4 The proposed phased approach contained within the Re-shaping POA Service programme has been designed to support an increase in the various community teams' capacity to support the reduction in in-patient bed numbers. The proposed workforce establishments will result in more efficient and effective use of staff resources.

4.7 Engagement

4.7.1 Engagement with staff has been done in partnership with staff side and a transition group has been set up at RVH. This group includes representation from all the major unions, key staffing groups, service managers and Human Resources.

4.7.2 Staff briefings and 1:1 staff sessions have also taken place at RVH and staff side communications and the engagement officer have been active participants in all of the planning sessions. This has allowed the identification and planned resolution of issues raised.

4.7.3 Information has been provided to both patients and their relatives at RVH. This was in the form of individual conversations with staff members. More general engagement has taken place with the Celebrate Age Network and the Pensioners Forum. Information has also been published in a range of places including the Partnership Newsletter. Reports have also been in the local press several times over the last few months.

4.7.4 A wide range of stakeholders have been involved in the development of the wider proposals. They include:

- Primary Care
- Social Work
- Allied Health Professionals (AHPs)
- Pharmacy
- Community Nursing
- NHS Transformation Team
- NHS and Dundee City Council Property Teams

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 as described in report number DIJB37-2017 (Proposed Model of Care for Older People – Business Case) presented to this meeting.

6.0 RISK ASSESSMENT

6.1 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 in their Strategic and Commissioning Plan. The report was presented to the Senior Management Team and amended following comments received to improve the clinical model. 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
    - Pensioners Forum
    - Celebrate Age Network
- Clinical Fora including:
    - Older Peoples Clinical Board
    - LMC Cluster Lead Meeting

8.0 BACKGROUND PAPERS

None.

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DATE: 27 September 2017

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