ITEM No …6……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017**

REPORT ON: **MEDICINE FOR THE ELDERLY SERVICES**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB6-2017**

1.0 PURPOSE OF REPORT

The purpose of the report is to update the Integration Joint Board (IJB) on the progress of work to reshape inpatient, outpatient and community Medicine for the Elderly Services in Dundee to respond to the changing needs and demographics of the population and in line with the strategic direction for older people clinical services of Dundee Health and Social Care Partnership. The current and proposed remodelling described within the report puts in place a range of service improvements which will enhance the quality of care afforded to older people and support older people to receive both health and social care closer to home.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Notes the progress made and future planned developments in:

- The creation of a specialist stroke rehabilitation unit in Dundee;
- The remodelling or rehabilitation and assessment wards in Royal Victoria Hospital (RVH);
- The developments in step down assessment and rehabilitation resources in the community;
- The development of multidisciplinary team working (Enhanced Community Support) in the community; and
- The improved liaison between community services and Ninewells.

2.2 Endorses the principle that any resources released as a result of the proposed changes outlined in this report are reinvested in community based services;

3.0 FINANCIAL IMPLICATIONS

The financial plan associated with the proposed changes is currently being developed and identified resources released as a result of the changes outlined in this report will support a shift in the balance of care through the reinvestment in community based services.

4.0 MAIN TEXT

4.1 Background

4.1.1 The Dundee Health and Social Care Strategic and Commissioning Plan 2016-21 outlines the intention of the partnership to redesign the way in which services are provided to Older People to meet the health and wellbeing outcomes of that population. People will have services provided closer to where they stay which will enable them to stay in their own home for as long as possible. Where they do require hospital treatment they will be able to return to a homelike setting as soon as possible.

4.1.2 A number of different work streams are in progress to achieve this redesign under the project Reshaping Care for Older People in Dundee. One of these work streams supports the redesign of Medicine for the Elderly Services. This report will update the IJB regarding progress of this work stream and the planned future developments. The remodelling is

summarised in the table below. In addition an update is provided in relation to other work which supports these developments.

4.1.3 The current bed model within RVH supports:

- 22 transitional beds for those who are deemed medically fit for discharge and for whom arrangements are being made and/or those who are not medically stable enough to be discharged

Within the community there are currently:

- 30 step down intermediate care places within a care home. These are supported by a multidisciplinary team including Social Work, Community Rehab Team and the Peripatetic Nursing Team;
- 2 housing with care step down places for people whose own accommodation does not meet their needs.

The following table provides the current bed base modelling for RVH and sets out the step changes across two phases to reach the desired bed modelling. This modelling describes an increase in community resources which supports step down from hospital.

Bed Base at RVH/Accommodation with Support

	Ward 3	Ward 6	Ward 4	Ward 5	Ward 7	Ward 8	Community	total
Current	8 transitional	14 transitional	14 Rehabilitation and Assessment	15 Rehabilitation and Assessment	22 Rehabilitation and Assessment	21 Rehabilitation and Assessment	32 30 care home 2 housing	126
Phase one	Non operational	14 transitional	16 14 stroke 2 swing	23 Rehabilitation and Assessment	22 Rehabilitation and Assessment	21 Rehabilitation and Assessment	36 32 care home 4 housing	132
Phase 2	Non operational	Non operational	16 14stroke 2 swing	23 Rehabilitation and Assessment	22 Rehabilitation and Assessment	21 Rehabilitation and Assessment	44 32 care home 4 housing 8 intensive care at home	126

4.2 Stroke Rehabilitation In-patient Services

4.2.1 Stroke is the third commonest cause of death and the most frequent cause of severe adult disability in Scotland. Evidence from a systematic review of a wide range of trials or organised stroke unit care indicates that stroke patients have a range of better outcomes in terms of survival, returning home and independence if they are managed in a stroke unit rather than admitted to a general ward. A Cochrane review of the benefits of a stroke unit found that there was:

- an 18% relative reduction in death
- a 20% relative reduction in death or institutional care
- 22% relative reduction in death or dependency

4.2.2 While acute stroke inpatient service for Dundee and Angus patients is located in Ninewells Hospital, there are currently 14 stroke rehabilitation older patients at any one time in RVH for patients from Dundee. Work is underway to redesign the way in which stroke rehabilitation services are provided to people in Dundee. The intention is to create a new specialist mixed sex unit in Ward 4 RVH. Currently this is provided in the four rehabilitation and assessment wards. The stroke rehabilitation unit will be a mixed sex unit and with 14 beds and 2 swing beds that will comply with NHS Tayside Single Sex Accommodation Policy ("*single sex accommodation for this policy is defined as when a room or bay is specifically for one sex with washing facilities also available solely for this one sex*"). The swing beds will be used more flexibly according to need. The service will include the development of a multidisciplinary team, and the identified wards will require some environmental improvements. It is anticipated this project will be complete by May 2017.

4.3 Rehabilitation and Assessment

4.3.1 Work is underway to improve the way in which more general rehabilitation and assessment is provided to older people in Dundee. Currently RVH has six wards. There are four rehabilitation and assessment wards and two transitional care wards. Transitional wards accommodate people who are not medically stable enough to be discharged and those who are fit for discharge and for whom arrangements are being made. In future models the needs of these patients will be met within the rehabilitation and assessment wards. The improvements contained within this report have resulted in less demand for transitional beds.

4.3.2 The needs of older people who do require to be in hospital have become increasingly complex and as a result the environments are no longer fit for purpose. In addition staffing levels will need to be adapted to support the changing complexity. There is a need to remodel to meet the needs of the population.

4.3.3 Following the described remodelling, provision for rehabilitation and assessment will be in three wards within RVH which can accommodate up to 66 people. These wards will have more appropriate environments and a higher staffing ratio. Staff will be redeployed between the stroke rehabilitation unit and these wards from the non-operational ward. Initially there will be a minimal overall reduction in bed numbers with a temporary reduction of one bed.

4.3.4 This work will take place in two stages as community models continue to be developed through shifting resources from in-patient to community services. This will include an increase in community capacity with the development of step down rehabilitation in care homes and dedicated housing with care. As a result of this increase in community options, stage one will see the retraction of one transitional ward and phase two will see the retraction of another transitional ward with redistribution of beds across both the in-patient and community setting. Bed usage over the past year confirms this can be achieved. The anticipated timescale for these changes is April 2017 for phase one and November 2017 for phase two as community services discussed below develop.

4.3.5 There have been a number of developments of community based assessment and rehabilitation resources which have supported the remodelling of inpatient resources. It is recognised that hospital is not the best environment for people who are medically fit for discharge and it is also not a good environment in which to conduct an assessment of the person's need for ongoing support. As a result there has been significant developments of resources to support people at home or if that is not possible a homelike environment.

4.3.6 These developments are supported and underpinned by a range of improvements in the way services are delivered. These include developments in the intermediate care, acute frailty team, community rehabilitation services, Enhanced Community Support (ECS) which is community based multidisciplinary working including the need for an additional Rapid Response arm, support to care homes, poly-pharmacy review and social care. Links between Ninewells and the community have been improved as have those between Acute Frailty and other departments in Ninewells.

4.3.7 The capacity of the intermediate care unit, contracted in a local Nursing Home, has been increased from 23 to 28 and there are a further two beds made available in step down care and two in a housing environment. Medicine for the Elderly team will transfer some of the workforce to support the team in Intermediate Care. This is predicted to increase patient throughput by a minimum of 15% and create additional capacity. Availability will be increased further over the next six months to include two further care home spaces, two housing with care spaces and on average eight people being supported at home by a specialist intensive social care team.

4.4 Acute Frailty Team

4.4.1 Developments in the Acute Frailty Team have significantly reduced the pressure on Ninewells Acute Medical Unit and Medicine Directorate, with 3-fold reduction in the length of time frail people spend in the Medical Assessment Unit and an increase in the numbers of frail patients being discharged from Ninewells front-door to home and community facilities. A current limitation is that this model is a five day service. In addition the Orthogeriatric and surgical

liaison service has had a significant impact on the length of stay for frail older people in surgical wards. It is proposed to build on this development to create a designated seven day Acute Frailty service as recommended by the National Clinical Strategy 2016.

4.5 Community Services

4.5.1 Dundee has made significant progress in relation to community multidisciplinary working. There are four GP cluster arrangements which are aligned to Medicine for the Elderly Consultant teams, Social Work Teams, Community Nursing Teams and the Community Rehabilitation Team. The day hospital is a key part of this and work will be undertaken to develop the services provided. Three further work streams are in place to develop this model and include: how the Psychiatry of Old Age Community Mental Health teams interface with these teams, how services are provided out of hours and how support is provided for people with a range of complex needs at home.

4.5.2 It is also evident that rapid response and triage by specialist Medicine for the Elderly teams in the community is required to bolster Enhanced Community Support model in order to avoid unnecessary hospital admissions in times of quick patient decompensation. Clinicians feel that there is a need to shift a rapid Comprehensive Geriatric Assessment from the acute hospital to the community. Discussions around this model are currently taking place and further details will be presented in due course. A model is aimed to be in-situ by November 2017 to improve community capability and capacity to care for more frail patients at home. Clinicians believe that in addition to numerous benefits to Dundee people that a reduction on the reliance of hospital beds can be realised, maybe in nature of 10%. This project in conjunction with others in paper will support Phase 2 of RVH bed model redesign.

4.5.3 A number of supports to care homes have been developed as many people were coming into hospital from these environments. These include a peripatetic team, a psychiatric care home liaison team, an Older People's review team and the support of an Advance nurse practitioner. Further development is underway to review the medical model of support and to move towards more integrated ways of working. The role of the advanced nurse practitioner is further being developed. Following successful pilot work pharmacy are working to implement a medicine review for people moving into care homes, supported by locality Medicine for the Elderly Consultants. This is a key priority as we look to reduce medication induced harm as well as look to address Primary Care medication spend.

4.5.4 Social care is a key component of the support needed by frail older people and a number of developments have happened. These include introducing a Contract Framework, commissioning a specialist palliative care service, introducing electronic scheduling and a new rota for home care staff to increase capacity. Community Social Work teams have been remodelled to promote assessment in the community and enablement support workers have been employed to ensure the flow through the enablement service works effectively for rapid services.

4.5.5 Effective communication is vital to improving services and a number of practice developments have been introduced to improve working relationships between the community and Ninewells. These include development of Ninewells Discharge Hub that houses both Dundee Discharge Team and hospital based care managers and the discharge process for frail people being centred around multidisciplinary team setting of Planned Dates for Discharge (PDD).This process involves real time communication with social work and allows patients to access necessary care packages to facilitate discharge at the point they are medically fit. This has already halved delays since winter 2015. New guidance for staff regarding people who may need Guardianship and transfer documentation will also reduce hospital delays.

4.6 Conclusion

4.6.1 In conclusion, there is the need to remodel non-acute inpatient services to meet the complex needs of the population. The Partnership is in the process of creating a dedicated stroke unit and rehabilitation and assessment ward in an appropriate environment with appropriate levels of staffing. There have been a number of developments across community based assessment and rehabilitation resources which have supported the remodelling of inpatient services. It is recognised that hospital is not the best environment for people who are medically fit for discharge and is also not a good environment in which to conduct an assessment of the

person's need for ongoing support. Both the current and planned developments will support older people to only be admitted to hospital where required, minimise delays to discharge and meet their health and social care needs in the community for as long as possible.

4.6.2 It is anticipated that this model of care delivery for frail older people in Dundee will achieve the Dundee Health and Social Care Partnership's commitments in relation to the recently published national Health and Social Care Delivery Plan.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATIONS

The Chief Finance Officer, Associate Medical Director (Older People), Clinical Lead Consultant (Medicine for the Elderly) and the Clerk were consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 7 February 2017