Strategy Delivery Plan

Older People & Unscheduled Care

Perth & Kinross Health & Social Care Partnership

2019-2022

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INTRODUCTION

OLDER PEOPLE & UNSCHEDULED CARE

As part of the refresh of the Strategic Commissioning Plan, the Perth & Kinross Health & Social Care Partnership reorganised its Strategic Planning Framework into four programmes of care. Older People & Unscheduled Care is one of the four Programmes of Care created in September 2018. The Boards have been established to provide a co-ordinated approach to achieving the objectives of the Partnership's Strategic Commissioning Plan and enabling a more effective and focussed approach for the planning of service delivery.

The Programme is overseen by the Older People & Unscheduled Care Board which meets bi monthly. The membership of the Board has strong clinical support from Associate Medical Directors, a General Practitioner as well as representation from the Health & Social Care Partnership and Independent and Third Sectors. The OPUSC Board ensures that there are strong links with the wider transformation being taken forward by NHS Tayside for Older People & Unscheduled Care and Perth and Kinross Council's Housing Service. The Board reports to the Partnership's Strategic Planning and Commissioning Board.

DELIVERY PLAN DEVELOPMENT

The Strategic Delivery Plan was developed with the members of the Older People & Unscheduled Care Board Three workshops were held in Autumn 2018 to agree the vision and key strategic priorities for Older People & Unscheduled Care. National and local strategic guidance and direction, feedback from public consultation, and demographic and performance information were used to inform the development of the plan.

The plan was developed in accordance with the Health & Social Care Standards, NHS Tayside's' Clinical Strategy for Older People and the six themes of the Partnership's Strategic Plan:

- Early Intervention and prevention
- Personalisation and person centred care

- Working with communities
- Reducing inequalities
- Making best use of resources
- Keeping people safe

The Strategy Delivery Plan describes the delivery of an integrated care system for health and social care services for Older People & Unscheduled Care which has the intention to improve and enhance what is currently being delivered.

By taking this approach the Partnership will be able to move further towards shifting the balance of care to communities in order to proactively anticipate the need for care at an earlier stage, change the emphasis from services focused on acute conditions towards systematic and personalised support for long term conditions, and develops continuous integrated care rather than disconnected episodic care.

The vision is to:

"*Support people to remain in a homely setting for as long as possible, providing access to personalised and sustainable integrated rehabilitation and reablement models of care and in partnership with communities promote healthy ageing.*"

The Board agreed the following strategic aims:

1. Develop and promote thriving, resilient communities through volunteering, social prescribing and neighbourhood initiatives (Priority 1: Thriving Resilient Communities)
2. Shifting the balance of care from traditional bed based models to early intervention/prevention integrated community models (Priority 2: Shifting the Balance of Care)
3. Improving the admission and discharge pathways (Priority 3: Improving Patient Flow and Pathways)

PHYSICAL DISABILITIES

Strategic development for adults with physical disabilities is part of the responsibility of the Older People and Unscheduled Care Board. Further work is required to detail specific actions relating to people with physical disabilities under 65 years of age. This will be taken forward as a sub group of the Older People and Unscheduled Care Board.

PRIORITY 1: THRIVING RESILIENT COMMUNITIES

BACKGROUND

The majority of older people in Perth and Kinross live healthy and active lives. The majority of older people do not receive 'formal' care as many do not need any assistance, while for others assistance is provided by family and friends, or organised and purchased privately.

We will build on this positive position by increasing the access for older people to leisure, sport and community activity. Our vision is for Perth and Kinross to be a place where older people contribute and are supported by thriving, resilient communities. Older people will be supported to be safe and healthy, independent and maximise their potential to make a positive contribution within their community.

Older people also play a critical role in supporting other older people to live independently at home. Supporting, sustaining and increasing this capacity, as well as that of family, friends and neighbours, is essential to achieve better outcomes for older people.

Our offer is to facilitate local communities to have the capacity to provide care and support with and for older people. This will reduce isolation and loneliness, enable participation, improve independence and wellbeing and delay escalation of dependency, and need for more complex care and support. The Partnership will work closely with Third Sector providers to ensure that their expertise and knowledge of communities is supported. The Partnership will review current Third provision for older people to ensure that we have equity of access of provision.

KEY ACTIONS

1. Paths for All - Develop dementia friendly walking initiative to embed physical activity into care homes
2. Embed community link workers and social prescribing in communities
3. In partnership with Third Sector provide an Active Communities project specifically for older people
4. Reduce social isolation by developing a neighbourhood initiatives programme to create networks of supports for older people
5. Further implement Care About Physical Activity Programme into care at home services
6. Review Third Sector provision for older people to ensure in line with Market Facilitation priorities and equity of access

PRIORITY 2: SHIFTING THE BALANCE OF CARE

BACKGROUND

Shifting the balance of care is central to the Partnerships vision for a new model of care for older people and unscheduled care in Perth and Kinross. This is a model of care that shifts health and care support firmly into the local communities where people live. Shifting the balance of care is a strategic objective of the Scottish Government, NHS and Local Authorities. Demographic pressures (particularly the rise in older people); workforce issues; the need to improve health and social care outcomes and the increasing cost of 'formal' care means that current models of care delivery are not sustainable.

By shifting the balance of care the Partnership aims to improve the health and wellbeing of the people of Perth & Kinross by increasing our emphasis on health improvement and anticipatory care, providing more continuous care and more support closer to home. The Partnership is also committed to providing equal access to serves for older people in all localities.

KEY ACTIONS

1. Creation of an enhanced community support approach within each integrated care team aligned to GP Clusters
2. Development of a specialist community based respiratory support team
3. Embed technology enabled care and home health monitoring
4. Develop digital health pilots to enable people to access health supporting
5. Review the use of inpatient rehabilitation beds and care home placements, including equality of access
6. In Partnership with NHS Tayside review Psychiatry of Old Age Services
7. Support the Primary Care Improvement Programme to develop the Advanced Nurse Practitioner role and Community Care & Treatment Services
8. Continue to work in collaboration with acute and partnership clinicians to move support for patients from acute hospital wards to support in the community.
9. Review care at home provision to ensure capacity to enable more older people to be supported at home for longer

10. Enable housing and accommodation solutions to support older people longer in their communities
11. Review integration of OT to ensure model fits into deliver of enhanced community support

PRIORITY 3: IMPROVING PATIENT FLOW AND PATHWAYS

BACKGROUND

The Partnership is committed to improving the experience of patients receiving care and treatment in hospital. Key to this is the patient receiving the right treatment at the right time and by returning home as soon as they are fit to do so. In most cases, the faster patients return home, the faster they will experience rehabilitation. Improving unscheduled care across Scotland is a key ministerial priority for the Scottish Government. Through the National Unscheduled Care – 6 essential actions improvement programme, the government aim to improve the timeliness and quality of patient care from arrival to discharge from the hospital and back into the community.

The term 'patient flow' refers to the ability of the care systems to manage people effectively and with minimal delays as they move through stages of care. Discharge delays and increased demand contribute to poor flow. The Partnership is committed to building on improvements already achieved locally to deliver patient outcomes that match the best performing areas in Scotland.

KEY ACTIONS

1. Redesign the patient's pathway for scheduled and unscheduled care across Tayside in collaboration with NHS Tayside.
2. Develop an integrated discharge service.
3. Deliver a discharge to assess service as part of an Enhanced Community Support approach
4. Develop a single approach to discharge across Tayside.
5. Explore creation of intermediate care beds.

FINANCE

In order to deliver on the Partnerships new model of care we need to move resources to where they are required and move them away from where they are no longer required. This investment and disinvestment over the lifetime of the Strategy is set out below.

Investment and Disinvestment	2019/20	2020/21	2021/22	Total
	£000	£000	£000	£000
Investment				
Enhanced Community Support	441	441		882
Rehabilitation/Intermediate Care Beds	165	165		330
Respiratory Community Model	91	91		182
	697	697	0	1,394
Disinvestment				
Redesign of Rehabilitation Beds	487	740		1,227
Shifting the balance Acute to Community Older People			500	500
Review of POA		200		200
Review of Care Home Placements		450	450	900
	487	1,390	950	2,827
Net Direct Savings	210	-693	-950	-1,433
Other Inter-dependant Savings - Review Care at Home	222	203	213	638

STRATEGIC DELIVERY PLAN

THRIVING COMMUNITIES

Outcomes	*Actions*	*Lead Person*	*Key Partners Involved*	*Performance Indicator*	*Timeframe*	*Governance*	*Priority*
✓ ***Improve the lives of older people in care homes through increased opportunities to be active everyday***	1. Develop dementia friendly walking initiative	C Wilson	• P&K HSCP • Care Inspectorate • Scottish Government • Independent Sector • Spirit of 2012 • Sports Scotland • Live Active Leisure	➢ CAPA performance indicators	1 April 2019 – 31 March 2021	Older People Steering Group	Medium
✓ ***Improved wellbeing for those accessing social prescriber support, through access to non clinical or statutory supports, using services and activities already available within the community***	2. Embed community link workers and social prescribing in communities	K Ogilvy	• P&K HSCP • GP Practices • Third Sector • Communities	➢ Social workers and others are aware of other non statutory supports ➢ Reduced demand for statutory services ➢ New community providers identified ➢ Satisfaction / Experience of users	Aug 2018-Aug 2020	Older People Improvement Group	Medium
✓ ***Older people are supported to live***	3. Provide an active communities project	P Henderson	• P&K HSCP • Live Active	➢ Project performance	1 April 2019-1 April 2021	Older People Improvement	High

active healthy lives	specifically for older people			outcomes to be agreed		Group	
• ***Older people are supported to live active healthy lives***	***4.*** Reduce social isolation by developing a neighbourhood initiative programme	P Henderson	• Live Active • Other third sector groups	➢ Project performance outcomes to be agreed	1 April 2020	Older People Improvement Group	Medium
• ***Older people are supported to live active healthy lives***	5. Further implement CAPA into Care at Home Services	C Wilson	• P&K HSCP • Care Inspectorate • Independent Sector	➢ CAPA performance outcomes ➢	1 September 2019- 1 April 2020	Older People Improvement Group	Medium
• ***Older people are supported to live active healthy lives***	6. Support unpaid Carers to enable older people to remain at home	K Sharp	• P&K HSCP • PKAVS	➢ Reduced length of stay in care home provision ➢ Carers census	1 April 2019-1 April 2022	Carers Board	Medium
• ***Older people are supported to live active healthy lives***	7. Review Third Sector provision for older people to ensure in line with Market Facilitation priorities and equity of access	E McMullan	• P&K HSCP	• Reduced demand for statutory services	1 September 2019-1 September 2020	Older People Improvement Group	Low

SHIFTING THE BALANCE OF CARE

Outcomes	*Actions*	*Lead Person*	*Key Partners Involved*	*Performance Indicator*	*Timeframe*	*Governance*	*Priority*
✓ ***Prevent older people at risk of an unplanned admission being admitted*** ✓ ***Facilitate patient's discharge from hospital to home***	1. Further develop enhanced community support approach within Integrated Care Teams	A Taylor L Baillie C Lamont	• P&K HSCP • GP Clusters • Third Sector • Independent Sector	➢ No of emergency admissions ➢ No of delayed discharges ➢ eFrailty tool pilot ➢ Number of Anticipatory Care Plans ➢ Experience / Satisfaction of service	1 April 2019 – 31 March 2020	Older People Steering Group	High
✓ ***Improve quality of life and outcomes for people living with COPD and Asthma***	2. Develop a specialist community respiratory team	H Dougall	• P&K HSCP • NHS Tayside	➢ To be developed	1 April 2019 – 31 March 2020	Older People Steering Group	High
✓ ***Support people to stay living well and safely at home***	4. Embed technology enabled care and home health monitoring	P Henderson	• P&K HSCP	➢ The numbers of older people supported at home using TEC	1 April 2020-2022	Older People Improvement Group	Medium
✓ ***Provide equity of access and make best use of resources***	***8.*** Review inpatient rehabilitation and care home beds, including equality of access	H Dougall P Henderson	9. P&K HSCP 10. NHS Tayside 11. GP Practices 12. Independent Sector	➢ Lenght of stay in care homes is reduced	1 April 2019 – 31 March 2022	Older People Steering Group	High
✓ ***Older people are supported to live in their own homes and***	13. Review Psychiatry of Old Age Services	C Charlton	P&K HSCP NHS Tayside	➢ To be developed	To be agreed	OPUSC Steering Group	Medium

	communities for longer							
✓	***Being developed***	14. Develop the Advanced Nurse Practitioner role and Community Care and Treatment Services	C Jolly	P&K HSCP GP Practices NHS Tayside	➢ Being developed	1 April 2019 - 2021	Primary Care Improvement Board	High
✓	***Provide care closer to home by the right person, in the right place at the right time***	15. Collaborate with Acute and Partnership Clinicians to move support for patients from acute hospital wards to community	H Dougall E Devine	P&K HSCP NHS Tayside	➢ To be developed	To be agreed	Integrated Clinical Forum	High
✓	***Older people are supported to live in their own homes and communities for longer***	16. Review care at home provision	P Henderson	P&K HSCP Independent Sector	➢ Reduce average hours of support per person	April 2019 – 1 April 2022	OPUSC Commissioning Group	High
✓	***Enable housing and accommodation solutions to support older people longer in their communities***	17. Improve housing and accommodation options for older people	P Henderson	Perth and Kinross Council	➢ Numbers of older people in supported accommodation ➢ Length of stay in care homes	1 September 2020	Supported Living Improvement Board	Medium
✓	***Prevent older people at risk of an unplanned admission being***	18. Review integration of OT to ensure model fits into deliver of	P Henderson	P & K HSCP	➢ Integrated OT model delivered in localities	1 April 2020-2022		Medium

admitted ✓ ***Facilitate patient's discharge from hospital to home*** ✓ ***Embed rehabilitative approach across all localities***	enhanced community support			➢ No of emergency admissions ➢ No of delayed discharges ➢ eFrailty tool pilot ➢ Number of Anticipatory Care Plans ➢ Experience / Satisfaction of service			

IMPROVING PATIENT FLOW & PATHWAYS

Outcomes	*Actions*	*Lead Person*	*Key Partners Involved*	*Performance Indicator*	*Timeframe*	*Governance*	*Priority*
✓ ***Improved patient care and treatment***	1. Redesign the patient's pathway for scheduled & unscheduled care across Tayside	S Muir	NHS Tayside 3 x HSCP	➢ Bed days lost due to delayed discharge	1 April 2020	NHS Tayside USC Board	Medium
✓ ***Timelier discharge from hospital***	2. Develop an integrated discharge service	C Caitlin P Henderson	P&K HSCP	➢ Bed days lost due to delays	1 September 2019 – Dec 2019	OPUSC Steering Group	High
✓ ***Timelier discharge from hospital***	3. Deliver a discharge to assess service	C Caitlin P Henderson	P&K HSCP	➢ No of people discharged via D2A ➢ Delayed discharges ➢ Length of stay ➢ Readmissions	1 April 2020	OPUSC Steering Group	High
✓ ***Seamless, co-ordinate discharge care and improved communication***	4. Develop a single approach to discharge across Tayside	C Caitlin P Henderson	P&K HSCP Angus HSCP Dundee HSCP NHS Tayside	➢ Bed days lost due to delays	1 September 2019	OPUSC Steering Group	Medium
✓ ***Timelier discharge from hospital and improved rehabilitation of patients***	5. Explore creation of intermediate care beds	P Henderson	P&K HSCP Independent Sector	➢ No of people admitted to intermediate care bed ➢ Delayed Discharge ➢ Readmission ➢ Satisfaction / Experience	1 October 2019 – 31 March 20202	OPUSC Steering Group	Medium