Annual Update on Older People's Strategic Delivery Plan

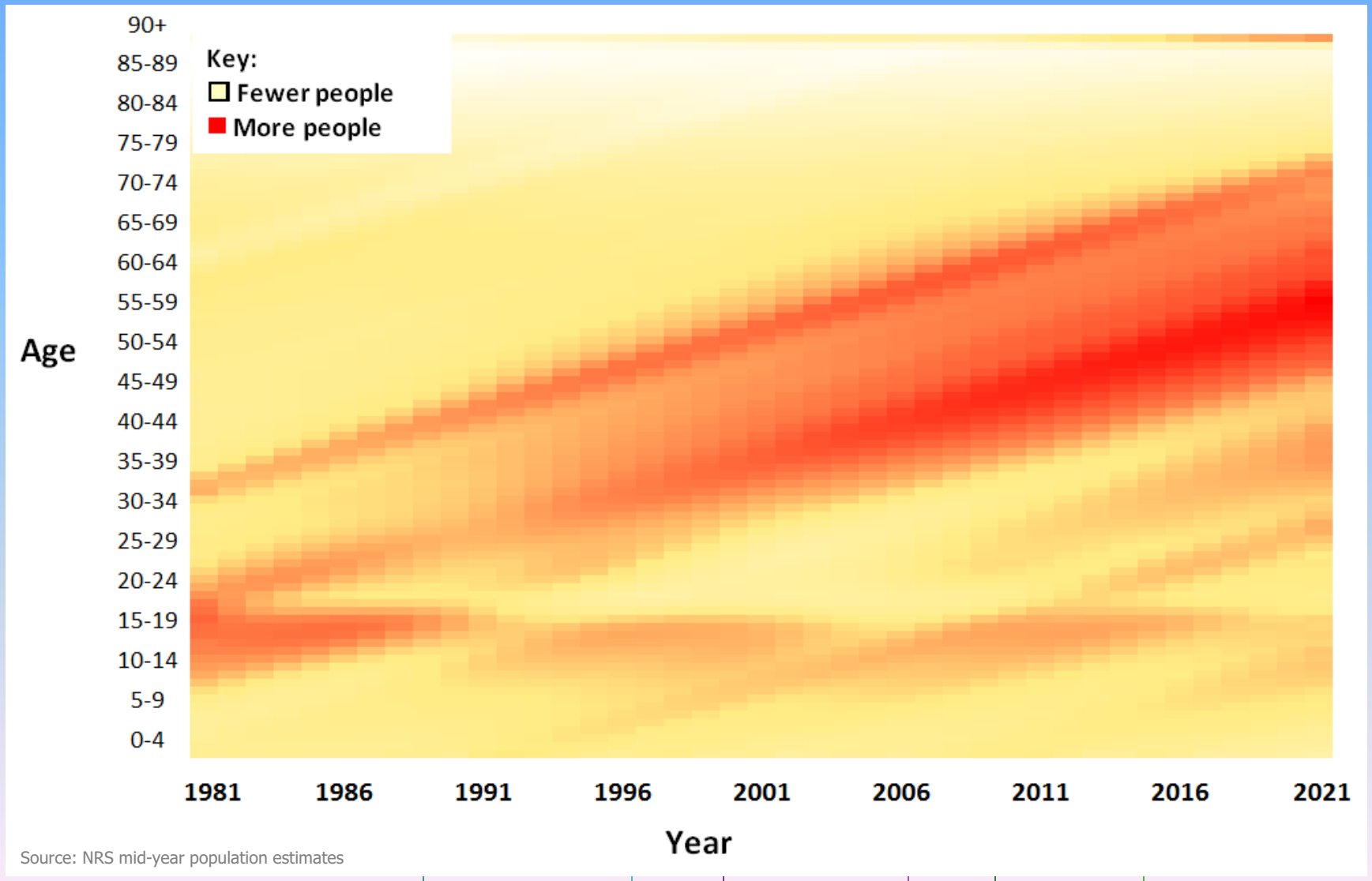
Evelyn Devine
Head of Health

Amanda Taylor
Senior Service Manager

Recommendations

- **Note progress to date against the programme of work outlined and funded under the Older People's Strategic Delivery Plan 2022 – 2025;**
- **Request an update in twelve months' time;**
- **Endorses the intention to evaluate the impact of the IJB investment in the Older People's Strategic Delivery Plan, and for the outcomes to be fed into the budget setting processes for 2024 – 2027.**

Key Challenges: population transformation



Source: NRS mid-year population estimates

Key Challenges

- **Increasing population of older people;**
- **Increasing complexity and frailty;**
- **Workforce recruitment and retention.**

What have we achieved: early intervention

- **Continued collaboration with key stakeholders;**
- **Continuing success of Going for Gold;**
- **Increasing participation in Live Active exercise programmes;**
- **Increasing volunteering activities in communities / community circles;**
- **Further funded and working with Support Circles to enhance their existing work and a brokerage model of delivery;**
- **Ongoing work and investment in rural communities to ensure equitable service provision;**
- **Activity workers embedded in PRI, Murray Royal and St Margaret's;**
- **Enhanced support for care homes.**

Go 4 Gold 2023

Paths for All BCH

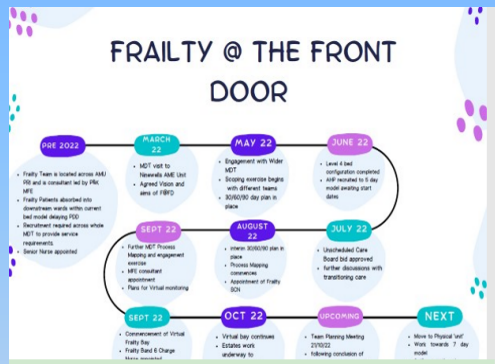
What have we achieved: shifting the balance of care

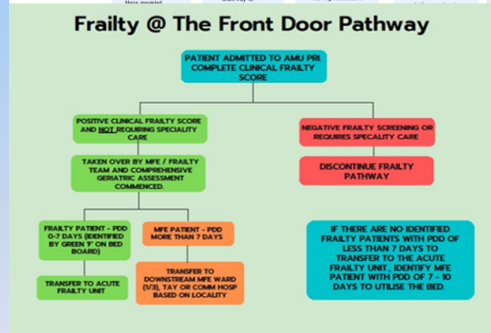
- **Continue to develop Locality Integrated Teams and development of locality integrated bases;**
- **Supporting culture change: What Matters To You links to P & K Offer;**
- **Launch of Hospital @ Home model of care (August 2023) supported by HIS;**
- **Development of urgent care pathways;**
- **Implementation of clinical standards across P&K, and integration across professions and teams (including the HIS frailty project).**

Culture change & quality improvement

What have we achieved: optimising capacity & flow

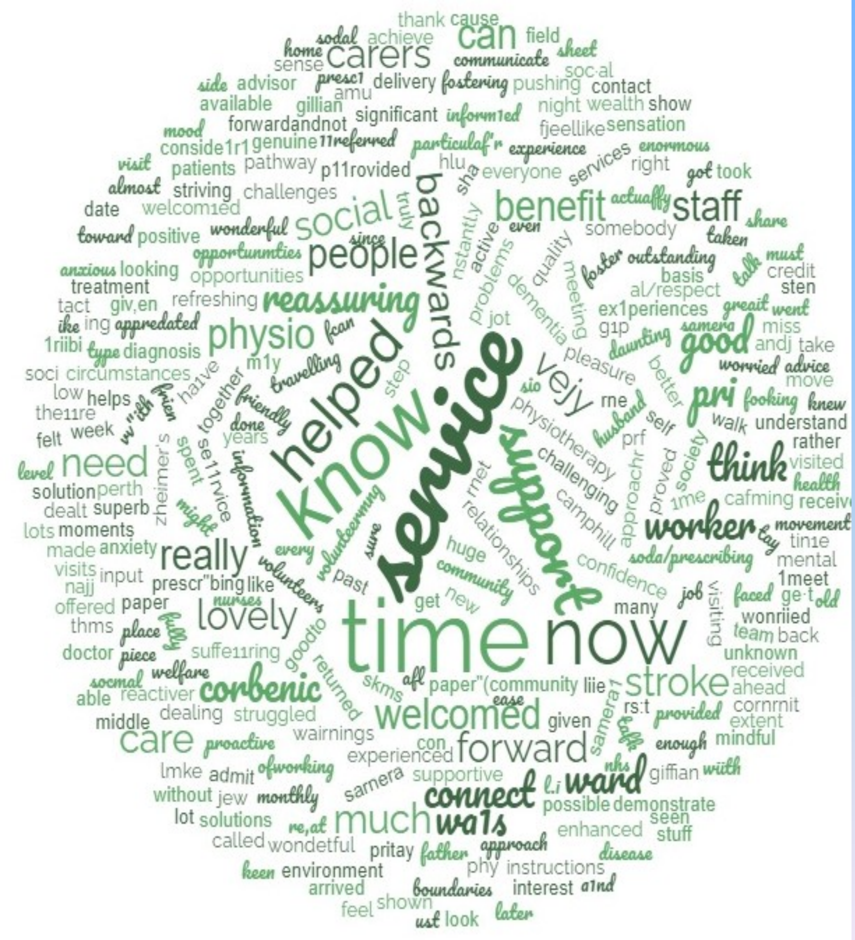
- **Implementation of strategic Discharge without Delay programme, including new pathways from hospital to home;**
- **Integrated team from PRI and localities implemented a quality improvement approach;**
- **Integrated frailty pathway from hospital to community, and opening Frailty Unit at PRI;**
- **Enhanced integration of PRI discharge hub and hospital discharge team.**





Frailty service

Service user feedback



"The input provided to date from the Enhanced Care Home Team has been very welcomed at Corbenic Camphill Community. Their active approach, with time taken to really get to know the service has been both refreshing and reassuring. The level of interest shown has helped foster a genuine sense of working together to move toward solutions for some of the challenges faced in the service delivery. The visits to Corbenic have helped us communicate and demonstrate the quality and type of service we are striving to achieve in a place that really has to be seen and experienced to fully understand it. The supportive approach and time spent visiting the service in particular, has been a significant step in fostering very positive relationships that are proactive rather than reactive, and have been much appreciated."

(Corbenic Camphill Community)

Social Prescribers

- "It's so good to have this service - I feel like I am looking forward and not backwards. I know if I need to connect to any social opportunities I can now contact Social Prescribing"
- "She helped me a lot with my confidence and social skills…"
- "I think it's having somebody to talk to that helps a lot. I don't think I could have done it without them"

Community AHPs

- "I have had physio in the past and just been given physio instructions before on a sheet of paper, but not to the same extent as I got from Gillian. This time having Gillian actually show me what to do which was much better than having a piece of paper" (Community Physiotherapy)
- "I can now share this with the carers as a solution to the problems I was having.. … she was lovely and knew her stuff" (Community OT)

Partnership inpatient care

- "He dealt with my father in challenging circumstances and he was very very good, even being available when I called him later in the middle of night. What an outstanding doctor." (PRI AMU)
- "I must admit to pushing the boundaries with the physio staff and did cause a few anxious moments…but all respect to them and the job they do" (PRI Stroke)
- "When I arrived at PRI I could not talk or walk and struggled with movement and sensation on my right side. With the treatment I received, I have almost returned back to my old self" (PRI Stroke)
- "All staff in Tay ward are a huge credit to our NHS" (PRI Tay Ward)
- "We cannot thank them enough, they truly are wonderful nurses, and the environment was so lovely and calming for all patients and a pleasure to visit" (Blairgowrie Community Hospital End of life care)

Focus on transformation

1. Optimising independence and quality of life for people living at home;

2. Enhancing capacity in dementia services;

3. Developing a person-centred approach to rehabilitation and reablement.

Next Steps

- Considerable progress in year 1 towards whole system integration with investment approved from IJB;
- Ongoing implementation of Integrated model of care across P&K and evaluation of individual projects;
- Consolidation of learning from year 1 and what are we taking forward into budget review;
- Developing training on the EFIA process to support staff to make equitable decisions when redesigning or transforming services;
- Focus on Transformation.

THANK YOU: ANY QUESTIONS?