West Lothian Council

NHS Lothian

Date: 19 January 2017
Agenda Item: 7

WEST LOTHIAN STRATEGIC PLANNING GROUP

WEST LOTHIAN FRAIL ELDERLY PROGRAMME UPDATE

REPORT BY PROGRAMME MANAGER

A PURPOSE OF REPORT

A description of the West Lothian Frail Elderly Programme, outlining the four projects in the programme and the programme structure, was provided to the Strategic Planning Group in November.

This report is intended to update the Strategic Planning Group on progress since then.

B RECOMMENDATION

To invite comments on the Programme and its progress.

C TERMS OF REPORT

The diagram at appendix 1 sets out the health and social care system for the frail elderly population in West Lothian, with each of the projects in the programme shown. Current baseline data for each major service has been collected, against which we can measure change.

Recommendations from each project were discussed at an extended Programme Board meeting in December and further work is being carried out in January and February to develop detailed business cases. The Older People's Mental Health project will submit its recommendations in February and the other three projects will be brought together into a programme business case to be submitted to the March Programme Board meeting, highlighting the interdependencies between projects and the changes to the whole system being recommended.

Progress in each project is as follows:

Frailty Hub and Rapid Access Clinic

The aim of this project is to create an integrated community-based Hub and Rapid Access Clinic (RAC) which will provide patients, their families and GPs with one point of contact to refer frail elderly patients for managing an episode of acute deterioration by providing combined assessment, access to care and treatment as appropriate under the REACT banner:

R rapid
E elderly
A assessment
C care
T team

There are already two services currently in operation under the REACT banner – hospital@home and rehab@home. This project aims to introduce a third element – the Rapid Access Centre, which will act as an early intervention with frail elderly residents to prevent unnecessary hospital admissions. Combining the three elements Rapid Access Centre, hospital at home and rehab at home will create the REACT Hub.

A key element of the Hub is the provision of a Comprehensive Geriatric Assessment (CGA), an evidence based form of multidisciplinary care. The benefits associated with the GCA have been widely researched and reported[1]:

- Patients are more likely to be alive and in their own homes after an emergency admission to hospital
- Patients are less likely to be living in residential care
- Patients are less likely to die or experience deterioration
- Potential cost reduction compared with general medical care

Many other areas are developing a similar model of a single point of contact for frail elderly referrals. The Integrated Care Hub and crisis response team in the Isle of Wight helped prevent over 1,000 patients over the age of 65 going into hospital in a 14 month period. The hub also provided better access to social care for older people and helped pick up undiagnosed dementia cases.

In December, the programme board agreed that this project was an important development and asked the project team to develop operational arrangements and a fully costed business case to be brought back to the March 2017 programme board meeting. Consultation with GPs and Care Providers is also taking place.

[1] Ellis et al 2011, Cochrane Library

In-Patient Re-design Project

The following high level principles were agreed by the Programme Board:

We will move away from the language of 'medically fit for discharge' to one where frail elderly patients are 'safe for transfer' based on a Comprehensive Geriatric Assessment (CGA) setting out safe discharge criteria and plans for ongoing assessment and follow up in the community. This recognises that their acute episode of illness has been treated.

We will agree criteria for 'safe discharge' as the minimum that can be done in hospital. This will build on the approach of REACT and ROTAS and set out how this will change the risks we have to manage.

We need to manage the expectations of patients, family and acute care staff that ongoing care needs of elderly patients can often be met more effectively in the patient's own environment.

We need to integrate the activities and communication through the hospital and into the community to minimise duplication.

Smaller working groups are now setting out:

1. Criteria for those patients who are 'safe for transfer' including the level of support needed in hospital and the community and the impact of making the change on the length of the in-patient stay and on community services.

2. How to embed the CGA into the hospital and how to make the journey through hospital as seamless as possible, plus the impact of those changes.

A separate pilot is also starting to test out a multi-disciplinary approach in the Medical Assessment Unit to facilitate early discharge from this unit.

Intermediate Care Project

This project aims to explore the contribution that intermediate care provision can make to whole system review and redesign.

Intermediate care can be provided in:

- Individuals' own homes, sheltered and very sheltered housing complexes
- Designated beds in community hospitals
- Designated beds in local authority or independent provider care homes

The following recommendations were agreed by the Programme Board in December:

1. To increase Care Home capacity by exploring the options for securing additional care home beds.

2. To revise our current policy on care home placements to give priority to delayed discharge on a short term basis.

3. To review, and revise if appropriate, our current policy on direct discharge from acute hospital to a care home.

4. To review our current respite care provision.

5. To review the commissioned provision at St. Michaels and Tippethill. At present the units are considered to have 3 functions: patients with continuing complex medical needs (HBCCC), end of life care, boarders. Clearly the latter of these is undesirable but needs either alternative provision or improvement in flow through the system to eliminate the need. The first two functions remain as commissioning requirements though not necessarily within the current units

6. Consideration should be given to commissioning an enhanced service for dementia support.

Older People's Mental Health Project

This project covers three main areas:

1. To propose a more sustainable model for the core Older People's Assessment and Care Team (OPACT)

2. To recommend how best to deliver the 1 year post-diagnostic support requirement for those diagnosed with dementia (PDS)

3. To recommend how best to provide a Behavioural Support Service (BSS) for care home residents

The funding for OPACT has been agreed and a paper is going to the Workforce Planning Group at the end of January for approval.

A proposal for the future configuration of the PDS service will come to the February Frail Elderly Programme Board meeting

Although the initiative was viewed positively, the BSS recommendation for funding was not approved at the December Programme Board meeting as savings had not been identified elsewhere to fund the development of the service. It has been decided that this should be included within the wider review of mental health services where savings generated in the Mental Health Re-design Programme could be used to fund the BSS development.

D CONSULTATION

Project teams involve a mix of health and social care staff, as well as GP and third sector representatives. As proposals are being developed, stakeholder groups are being consulted. A communications plan is also being prepared for wider consultation on changes once they have been approved.

E REFERENCES/BACKGROUND

Strategic Planning Group 17 November 2016

F APPENDICES

1. Diagram of health and social care system with projects highlighted

G SUMMARY OF IMPLICATIONS

Equality/Health	In developing its Strategic Plan, the IJB took account of the requirements for mainstreaming equality by aligning its strategic outcomes with the equality outcomes. The plan was subject to an integrated equalities impact assessment and this programme is covered by that assessment.
National Health and Wellbeing Outcomes	The programme is intended to implement the relevant National Health and Wellbeing Outcomes in accordance with the IJB Strategic Plan.
Strategic Plan Outcomes	The programme is aligned to relevant Strategic Plan Outcomes and will incorporate detailed performance indicators.
Single Outcome Agreement	The Strategic Plan outcomes are aligned to the Single Outcome Agreement outcomes related to health and social care.

Impact on other Lothian IJBs	None at present, though some future programme recommendations are likely to have an impact on other Lothian IJBs.

Resource/finance

Policy/Legal

Risk

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