5. WEST LOTHIAN ELDERLY PROGRAMME UPDATE

The Strategic Planning Group considered a report (copies of which had been circulated) by the Programme Manager which provided an update on progress made with the West Lothian Frail Elderly Programme.

Attached to the report at Appendix 1 was a diagram that set out the health and social care system for the frail elderly population in West Lothian and included details of each of the programmes being developed; these being Frailty Hub & Rapid Access Clinic, In-Patient Re-design Project, Immediate Care Project and Older People's Mental Health Project.

Recommendations for each project were discussed at an extended Programme Board meeting in December 2016 and further work would be carried out in January and February 2017 to develop detailed business cases. The Older People's Mental Health project was intending to submit its recommendations in February 2017 and the other three projects would be brought together in a programme business case to be submitted to the March 2017 Programme Board meeting.

The report then provided a narrative on each of the projects and were summarised as follows :-

Frailty Hub & Rapid Access Clinic

The aim of this project was to create an integrated community-based Hub and Rapid Access Clinic (RAC) which would provide patients, their families and GP's with one point of contact to refer elderly patients for managing an episode of acute deterioration by providing combined assessment, access to care and treatment as appropriate under the REACT (Rapid Elderly Assessment Care Team) banner.

In-Patient Re-design Project

This project involved the move away from the language of "medically fit for discharge" to one where frail elderly patients were "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 would include the managing of the expectations of patients, family and acute care staff that ongoing care needs of elderly patients could often be met in the patient's own environment.

Intermediate Care Project

This project aimed to explore the contribution that intermediate care provision could make to the whole system review and redesign including care 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

Older People's Mental Health Project

This project would cover three main areas which were as follows :-

- ❖ To propose a more sustainable model for the core Older People's Assessment and Care Team (OPACT)
- ❖ To recommend how best to deliver the 1 year post-diagnostic support requirement for those diagnosed with dementia (PDS)
- ❖ To recommend how best to provide a Behavioural Support Service (BSS) for care at home residents.

Decision

1. To note the content of the report; and
2. To look forward to the plan being implemented at the earliest opportunity.