THE ANGUS CARE MODEL

Let's keep the conversation going

Thank you for your interest in the development of the Angus Care Model.

During week beginning 16 October 2017 people from across Angus attended drop-in information sessions held in Forfar, Carnoustie, Montrose and Arbroath. These events gave locals the chance to talk to health and social care professionals. Our conversations focused on the challenges facing services, the opportunities for change and how we can together build a future Angus Care Model that provides the best possible care to the most people possible.

The majority of people (85%) who attended the meetings found them helpful and informative. Whilst a small number of people commented that they would have preferred a formal meeting, people (94%) overwhelmingly felt that they had been given an opportunity to comment and offer their opinion. When arranging future meetings we will take account of people's suggestions and improve the way we raise awareness about the meetings.

We were asked to share the information that was on display. In addition to talking to staff and have many of their questions answered, we also invited people to write down questions and leave comments. We have done our best to answer as many of the questions as possible.

Please take some time to consider the information contained below and get involved in the conversation by completing a short ***survey*** **https://www.surveymonkey.co.uk/r/WDFV53D** ***or by contacting us on*** ***hsciangus.tayside@nhs.uk***

We look forward to continuing our conversation with you in the very near future. Please look out for the dates of our next series of drop in sessions in December 2017.

Thank you.

Vicky Irons

Vicky Irons
Chief Officer

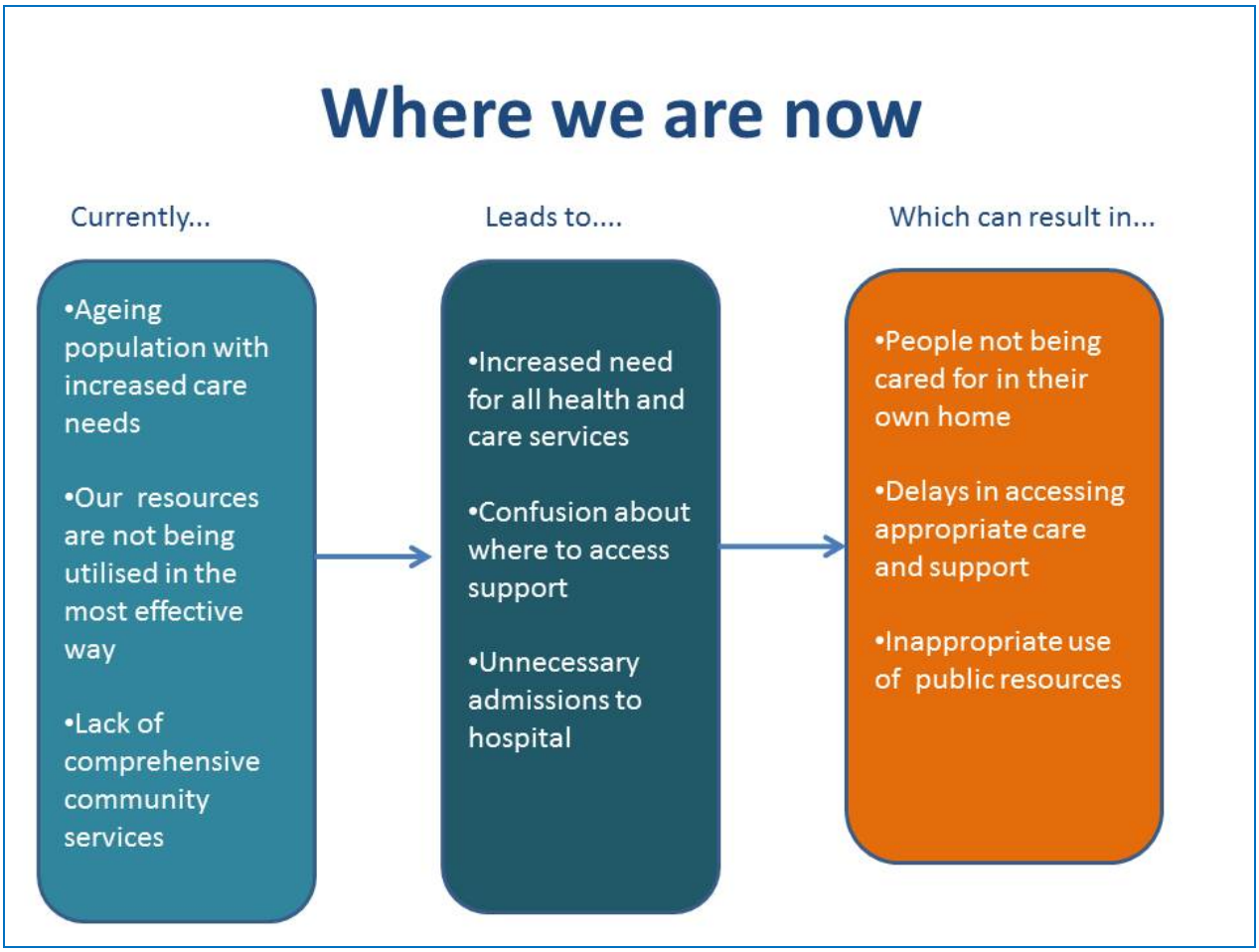
November 2017

1. Case for change

Background

Optimising and joining up health and social care services is critical to realising the ambitions of health and social care integration. A package of assessment, treatment, rehabilitation and support in the community, along with help for carers, can better serve the needs of people and help deliver more effective deployment of the resources available to the Integration Joint Board which oversees the Angus Health and Social Care Partnership. People must become central to decisions about their own needs, outcomes and support.

Angus Health and Social Care Partnership is focused on delivering an approach to integration that has a much greater emphasis on prevention, early intervention, self-management and supporting people in their own homes and communities with less unnecessary use of hospitals and care homes. Information to date suggests we are already doing well in with more than 90% of older people's care being delivered in the community but there is still more to do for the whole adult population.

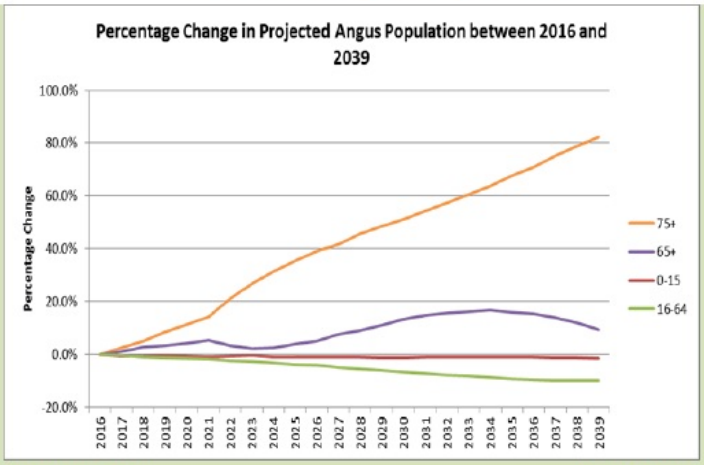


About the Angus Population

Today

Angus population is 116,240

- 1 in 5 people are over 65 years
- 1 in 10 people are over 75 years (11,279 people)
- Average life expectancy is 81.6 years and for males is 78.5.

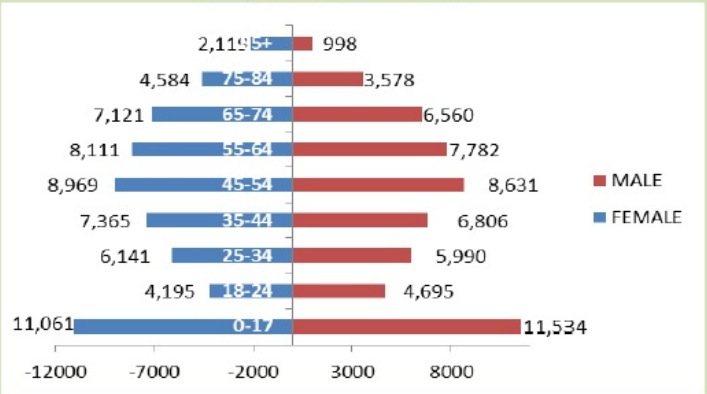


By 2037

The total population is expected to be 115,327

- 1 in 3 people will be over 65
- 1 in 5 people will be over 75 years (20,978 people)
- There will be 14% fewer people under 65 years
- Life expectancy will continue to improve

Angus Population Today



People have more complex needs

- 1 in 6 people have hypertension(high blood pressure)
- 1 in 12 people have asthma or chronic obstructive pulmonary disorder (COPD)
- 1 in 20 people have diabetes
- 1 in 14 people have heart problems
- 1 in 25 people over 65 are known to have dementia (figures suggest that this could be as high as 1 in 12 people)
- 1 in 4 people have 2 or more long term conditions
- 1 in 5 people have regular prescriptions for 5 or more items
- 1 in 75 people have regular prescriptions for 10 or more items
- 1 in 7 people over 65 have a community alarm
- 1 in 6 people over 65 have personal care support in their home
- Around 1 in 7 people over 75 years are living in a care home
- The number of people with long term conditions is increasing.
- The number of people using services is increasing

Our Resources

Our Money

NHS Tayside c£120million + Angus Council c£50million = Angus Health & Social Care Partnership c£170million

Angus Council need to save £38.4million over the next 3 years (report no. 274/17)

NHS Tayside have to find savings of around £200million over the next 5 years (Audit Scotland)

The Angus Health and Social Care Partnership budget is affected by the financial position of NHS Tayside and Angus Council

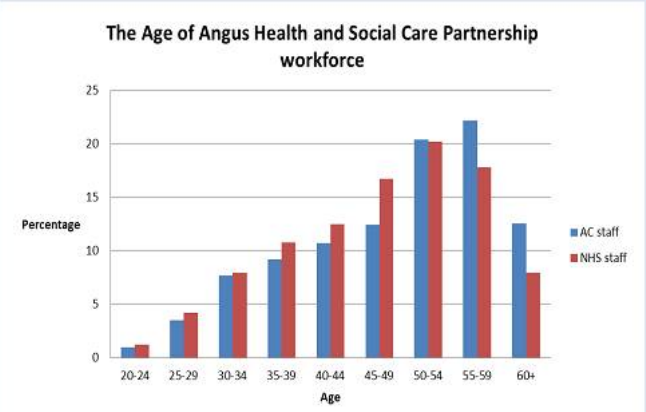
There is pressure on our finances. If we do nothing…..

In 5 years Angus Health and Social Care partnership is likely to have a £15million shortfall in our budget.
The Partnership budget is affected by:

- **The savings that both Angus Council and NHS Tayside have to make;**
- **New legislative duties such as the implementation of the Scottish Living wage for care workers and the new Carers Act to be implemented in April 2018. Additional resources made available by the Scottish Government may not fully fund these additional duties;**
- **Greater demand from an increasingly older population**
- **Inflation of around 1.5% per year.**

We will have to do more with less

Our People



Staff working for Angus Health and Social Care Partnership are employed by either Angus Council or NHS Tayside

The workforce is ageing; 55% of NHS Tayside staff and 45% of Angus Council staff are over the age of 50

Around 1 in 3 of the whole workforce could retire in the next 5 years

ANGUS
Health & Social Care Partnership

What you have told us

"I want to be cared for in my own home for as long as possible"

"I don't want to go to hospital unless I really have to"

"No decisions about me without me"

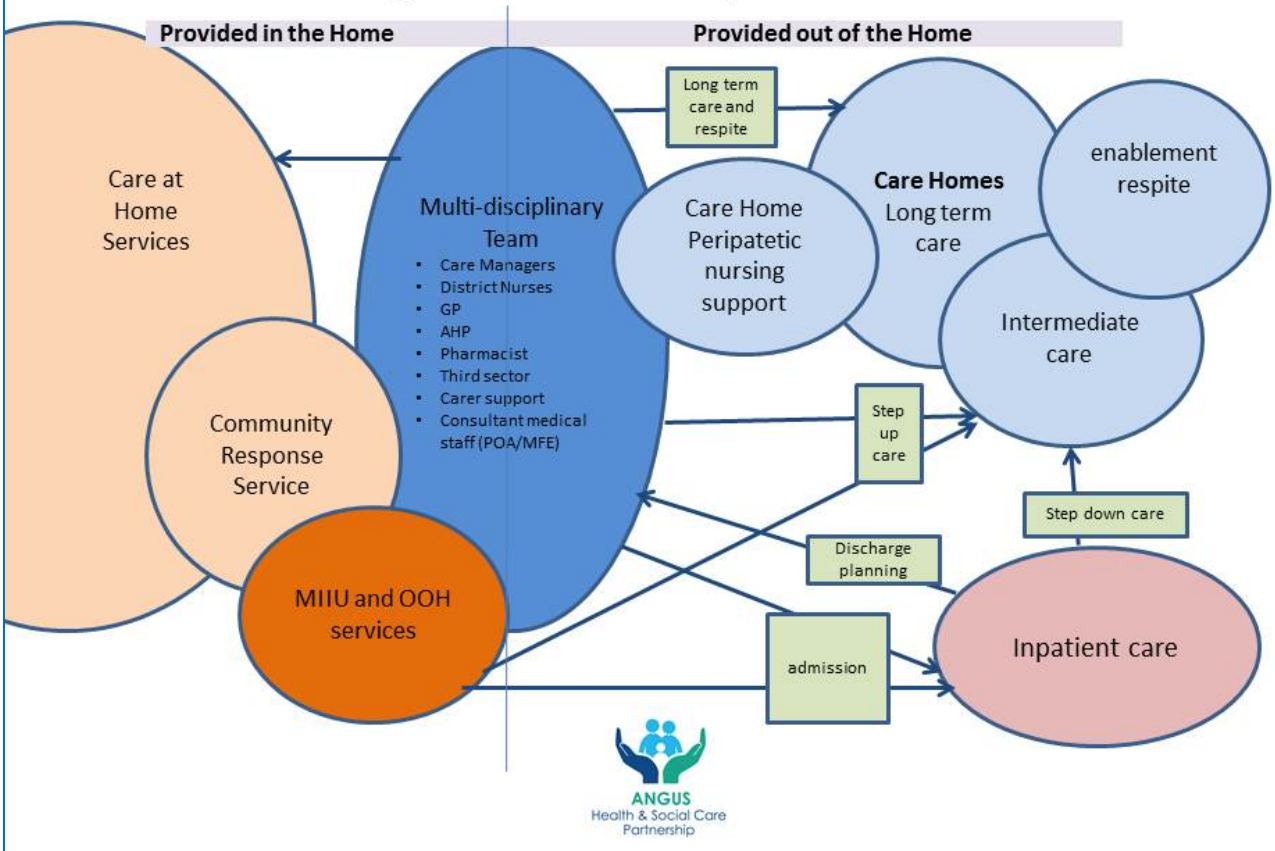
What do we need to do?

Provide the best possible care for the most people possible

How will we do this?

- **Rebalance** care, maximising support for people in their own homes
- **Reconfigure** access to services delivering a workable geographic distribution of care outside the home
- **Realise** a sustainable workforce delivering the right care in the right place
- **Respond** to early warning signs and risks in the delivery of care
- **Resource** care efficiently, making the best use of the resources available to us

The Angus Care Model built on a foundation of an Angus that Actively Cares



The Angus Care Model

- Multi-disciplinary team working at the heart of care pathways and support for individuals
- Supporting individuals with the right support at the right time
- Creating the opportunity to integrate care home and inpatient care to provide the most appropriate support with step up and step down approaches to preventable admissions.
- Establish the building blocks for mature partnership working

We believe this will make Angus an exciting place to work with fresh approaches and opportunity.

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Partnership

The story so far……..

- ✓ A multi-disciplinary team approach exists in Learning Disabilities, Adult Mental Health, Older People's Mental Health and Drug and Alcohol Services.
- ✓ Multidisciplinary team working has been embedded in General Practice for many years and is being expanded via Enhanced Community Support to become a multi-agency approach.
- ✓ The Acute Medicine Team and the Acute Medical Unit in Ninewells Hospital now work in a new way. Speciality In-reach Medical Model of care reducing assessment time for emergencies, preventing admissions, considering local options for step up, step down care and reducing hospital length of stay.
- ✓ Help to Live at Home has delivered an expansion of care at home within available resources.
- ✓ Voluntary Action Angus is supporting an Angus that actively cares by further developing the Third Sector and creating and supporting volunteering opportunities.
- ✓ Voluntary Action Angus and Angus Carers Centre staff work in the multi-disciplinary teams identifying social solutions to support people's needs and enabling greater independence.
- ✓ The ALISS (A Local Information Service for Scotland) system has been developed to ensure that information on the richness of the Angus Third Sector contribution to health and social care is accessible.
- ✓ Independent Living Angus website provides information to help you improve your life curve and self-assessment for equipment to support daily living.

What is Independent Living Angus?

•Online Self Assessment IT System (developed by ADL Smartcare)

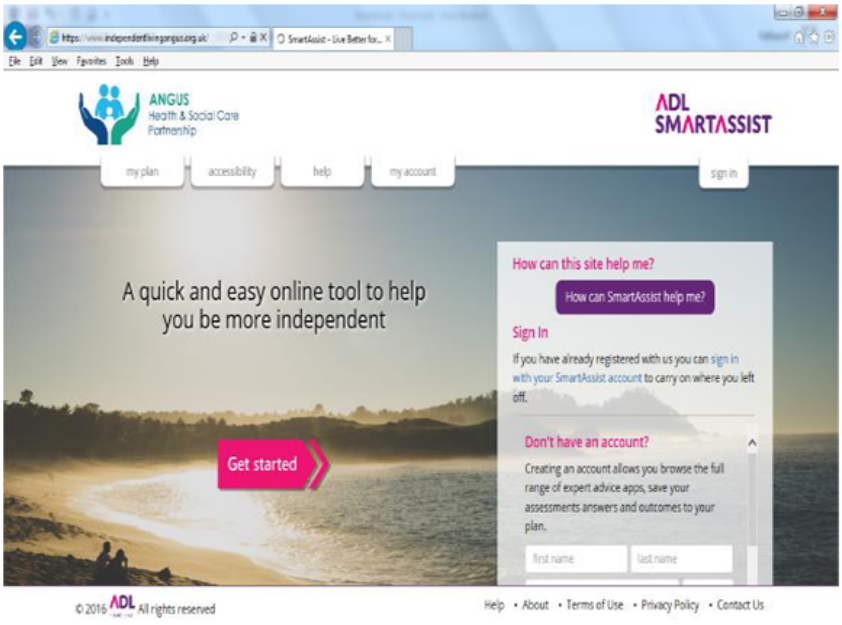
•Provides independent advice, signposting information 24 hours a day, 7 days a week

•Provides information on local and national groups and organisations

• Supported self assessment for particular problem areas such as bathing, toileting or falls

•Provides options for purchasing equipment solutions as well as safety advice

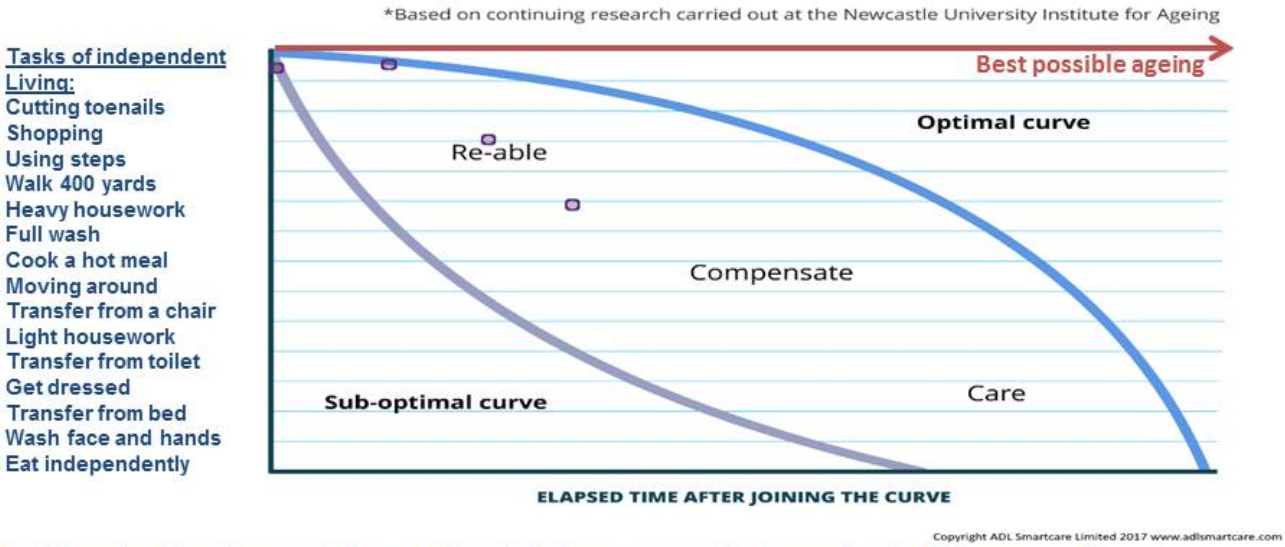
•Opportunity to deliver our services differently



2. Add life to your years – Life Curve/ Self Management

Life Curve

Did you know you can change how you age? Having a positive outlook on ageing and taking regular exercise can have a positive influence on keeping you independent. Estimate your fitness level by visiting:www.worldfitnesslevel.org
Ageing follows a predictable pattern following the loss the tasks listed below.



The blue 'optimal curve' shows that it is important that you look after yourself and stay as independent as possible.

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KNOW WHO TO TURN TO LEAFLET

Information was displayed to help people **KNOW WHO TO TURN TO** should they need advice about health and social care in Angus.

We asked if this type of information would be useful. We received very positive feedback and we are working on the suggestions as to how the leaflet can be further improved.

Self-management

Self-management is about people living with long term conditions being in 'the driving seat'. It supports people to live their lives better, on their terms.

A long term condition is a health condition that lasts a year or longer. It can impact on a person's life and may need ongoing care and support. These include mental health problems and a wide range of physical conditions such as diabetes, heart disease, dementia and chronic pain.

Self-management supports and encourages people living with long term conditions to access information and to develop skills to find out what's right for their condition and, most importantly, right for them. Life can be better with self-management. Being told you have a condition for which there may be no cure can be devastating. Individuals respond in individual ways. It can often have a profound impact on a person's well-being and self-esteem.

Together with health professionals and others who provide support, self-management can help people to make decisions that are right for their life.

Self-management can mean people being:

- better informed about their condition(s),
- better prepared for everyday challenges,
- better supported when they need it

More information available at:

My condition My terms My life
Living better with self management

www.myconditionmylife.org/

ALISS
A Local Information System for Scotland

www.aliss.org

MOODJUICE
Self help resources for mental wellbeing

www.moodjuice.scot.nhs.uk/

Get in the driving seat. Available support for self-management in Angus includes:

- Angus Long Term Conditions support groups in Montrose, Carnoustie and Forfar
- Forums and/or peer support groups for Arthritis; Diabetes; Pain; COPD; Heart Disease and Stroke providing ongoing access to education and support
- Access to free courses on managing fatigue; managing chronic pain
- Angus Activity Programme in conjunction with Angus Cardiac group and Angus Alive
- Access to more intensive courses to support people live with their conditions. This currently includes chronic pain, fatigue management, pulmonary and cardiac rehabilitation.
- A Long Term Conditions information event is held every two years, with the next event planned for April 2018.

Examples of support for self-management include:

Support for living with chronic pain

Approximately 18% of the population live with moderate to severe chronic pain. To support self-management Angus Health and Social Care Partnership offers:

- Monthly self- management groups run by Pain Association Scotland
- Intensive self-management programmes in each locality
- An online Pathways through Pain programme
- Chronic pain management resources in libraries across Angus (and in the mobile library)
- Physiotherapy services delivering the pain management plan

Pain Association Scotland
Intensive Self-Management Programme

Participants see improvements in:

Relaxation skills
Dealing with others
Dealing with difficult thoughts and feelings
Dealing with problems positively
Stress management
Goal setting
Pacing
Dealing with flare-ups
Understanding the effects of pain on life
Understanding what alters pain
Understanding the role of medication
Coping (overall)

Breathlessness not helplessness

Community respiratory services focus on self-management and empowerment of people with Chronic Obstructive Pulmonary Disease(COPD). There are around 2500 people in Angus with COPD.

The service supports:

- Diagnosis and management of COPD in primary care
- Annual review of housebound people with COPD
- Peer support groups
- Regular COPD education and awareness sessions
- Pulmonary rehabilitation
- Post hospital discharge review
- Long term oxygen therapy
- Palliative care

Community respiratory services have supported people effectively.
We have seen:

- Improvements in admission rates of people with COPD
- Reduced length of stay in hospital following an admission
- Effective collaboration with people who have COPD

People have told us.....

3. An Angus that Actively Cares – Third Sector

Voluntary Action Angus promotes an Angus that Actively Cares. 901 organisations offer a wide range of supports across the communities in Angus. This ranges from Arts to Life, befriending to gardening projects. Contact VAA if you want to find out more about what VAA does or about how to volunteer**. Please call 01241 875525/01307 466113 or visit our website http://www.voluntaryactionangus.org.uk**

4. Multi-disciplinary Team (MDT) working

Neighbourhood Care in South West Locality

We are developing plans to introduce a multi-disciplinary, co-located team composed of district nurses, care managers, AHP's, home care assessors, and GPs. Building upon enhanced community support, this model sets out to co-locate truly integrated multi-disciplinary teams. South West Angus locality will test this development

A team delivering strong emphasis on working practices which promote independence for service users, which encourage enablement and the self-management of conditions, and which incorporate the principles of "ageing well", - Neighbourhood Care

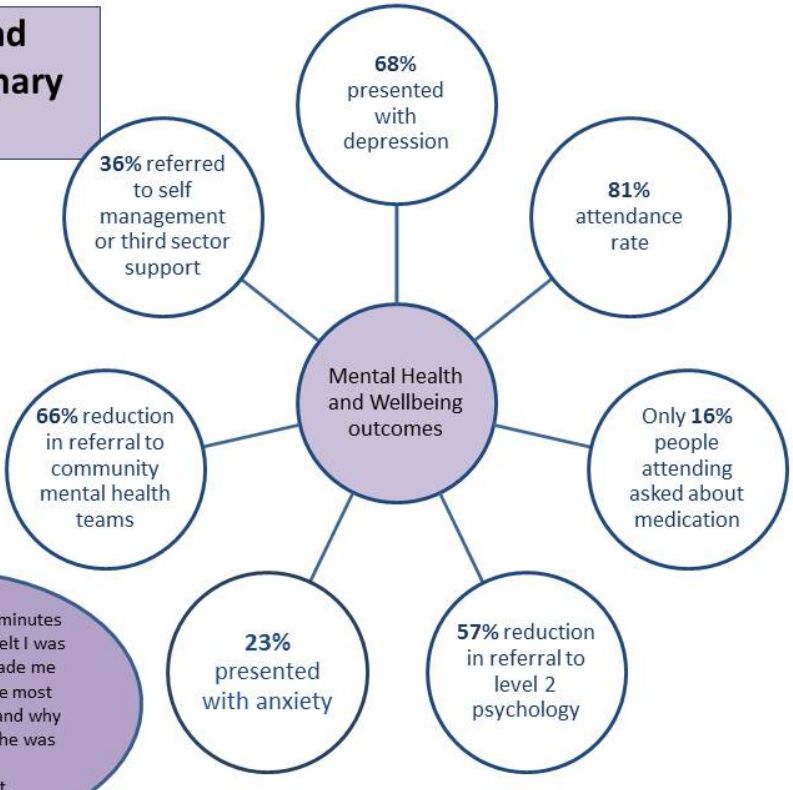
- ✓Better systems for the allocation of work through a multi-agency approach.
- ✓Improved assessment and care pathways though integrated support delivery
- ✓Addressing demand-capacity challenges through more efficient use of staff
- ✓Improved communications and information-sharing
- ✓Understanding each others professional role
- ✓shared functions and mutual learning; accommodating each other without losing professional identity.
- ✓Increased resilience due to shared responsibility for risk.
- ✓A whole system approach to assessment, information-sharing and decision-making
- ✓ Closer liaison with the third and private sectors at a locality level and the chance to develop resources to better reflect local need.
- ✓ Better outcomes for service users

Mental Health and Wellbeing in Primary Care

New ways of supporting people with mental health needs have been tested at Brechin GP practice by introducing a Mental Health and Wellbeing Nurse into the practice's multidisciplinary team.

People can be directed to the nurse without the need to see the GP first.

People who have used the service have rated it as excellent.



"Even in the first few minutes of the appointment I felt I was understood which made me feel at ease. I feel like most people don't understand why people get sad, but she was great."
Brechin Patient

Enhanced Community Support
Showing you how working together does make a difference …..

The following scenario is based on a real life event.
Only the names of the service user and her daughter have been changed.

My name is '**Mrs Mary Smith'**, I am 91 years old and until recently I have lived alone independently with support from my daughter 'Jennifer' and some carers who visit 3 days a week to help me have a shower.

My GP came to see me recently after I had a fall. I hurt my hip and I am still in pain and can't move about very well. To be honest I have had back pain for a while and was struggling a little bit but know I don't feel safe walking around and have just been staying in bed. I know that isn't good for me and the toilet is downstairs so that is a problem as well.

Dr Baldwin has passed my details on to the people at something called Enhanced Community Support who will hopefully help me get around more.

ENHANCED COMMUNITY SUPPORT

I'm **Arlene**, a social work assistant and following the multidisciplinary team meeting yesterday I arranged with Mary and Jennifer to visit them. We talked about the support and equipment Mary was getting from the other members of the team and both Mary and Jennifer said that they were happy with this support.

Jennifer was however concerned about her mother remembering to take her medication and that she may fall during the times she was on her own. I suggested they might like to think about having a community alarm installed to provide peace of mind about not being able to get help should Mary fall and they both agreed that this would be a good thing to do.

I also asked Mary if she would like to talk to her community pharmacist about having her tablets delivered in a dispenser that would let her see what she needed to take and when. Mary said that she was able to remember what to take and when but that as it would stop Jennifer worrying she agreed to talk to the pharmacist.

We then had a discussion about ongoing support and I gave Mary and Jennifer a leaflet that explained about self directed support, the assessment process, carers assessment and the options available to Mary if she needed ongoing support. We agreed that I should come back in a few weeks time to see how Mary was getting on.

I'm a district nurse in Angus - my name is **Emily**. Dr Baldwin shared Mary's details with us at the multidisciplinary team meeting today and requested support for her.

I was able to visit her the same day after our meeting. I was able to assess Mary's home environment as well as her health and social care needs. This let me make referrals for carer support four times a day from the prevention of admission to hospital scheme, physiotherapy, occupational therapy and a nurse practitioner for medicine for the elderly.

I'm **Sarah,** a Physiotherapist, and I visited Mary at home the same day that Emily made the referral. I was able to provide a wheeled walking frame and assess her mobility and levels of pain.

Mary and I discussed ways to build strength and improve confidence and agreed an exercise programme that would last for a period of weeks.

My name is **Karen,** I'm an Occupational Therapist and I was able to visit Mary the same day that Emily made the referral. I delivered a commode for use in the bedroom as there is no toilet upstairs and Mary is having difficulty with getting around at present. I was also able to provide equipment to help Mary get in and out of bed safely including an inflatable device that can lift her legs.

I was also able to assess Mary's ability to do things in her kitchen and give her advice on easier ways to do thing for example fill her kettle. I was also able to provide a caddy to be fitted to the wheeled walking frame. This will help her to transport meals independently once she has regained some of her strength.

I'm a nurse practitioner with the medicine for the elderly team and my name is **Kristy**.

I was able to visit Mary the same day as the initial referral was made. I carried out a comprehensive assessment to find out if Mary was safe and well enough to stay at home or if she really needed to be admitted to a community hospital.

I took some blood samples, tested her urine for infection and established the level of Mary's pain. In addition I reviewed her medication and referred Mary to the pharmacist and pharmacy technician for their support as already agreed with Mary's care manager. Jennifer, Mary's daughter, agreed to make sure her Mum took her tablets until the pharmacist was able to visit.

I discussed a treatment plan with the consultant geriatrician and Mary's GP and requested a prescription for pain killers. Following a discussion with Mary and Jennifer it was agreed that Mary should stay at home with a package of care to support her. This reflected her previous discussions with her GP and what was documented in her anticipatory care plan.

I then continued to monitor progress and receive feedback from other professionals involved in order to provide coordinated care and improve communication between the team.

I'm **Kay** the community pharmacist and I was able to have a discussion with Mary about her medication.

I completed a full review and after discussing the outcome with Mary's GP it was agreed that the medication that was no longer needed would be stopped. I also explained to her the different dispensers we could use for her medication. Mary decided that she wanted one that was broken down by day and time.

I'm a Pharmacy Technician and my name is **Alison.**

I visited Mary a week later to show Mary her dispenser and to check that she is able to use it.

She found it simple to use which supported her wish to remain independent and gave her daughter Jennifer confidence. I returned any medication that was no longer required to the chemist.

I'm **Tracey**, Senior Co-ordinator for the Prevention of Admission Team. I was asked to arrange for a social care officer (SCO) to visit Mary four times a day to help her with personal care, toileting and meal preparation. This support was to help Mary remain at home, which was what she wanted.

When they first visited Mary she needed quite a bit of support and encouragement having lost some of her confidence after her fall. The SCO established what she was able to do and what she had some difficulty with. We also encouraged Mary to move around during our visits to help increase her confidence. The SCOs worked with Mary in what is described as an enabling way. They built on what Mary could do and supported her to regain her ability in other areas and to be as independent as far as possible.

My name is **Debbie** and I support volunteers who want to become a befriender. Mary had said she was feeling lonely despite her daughter visiting regularly and had agreed to a referral being made to our befriending service.

I arranged to visit Mary to find out what her interests were and what she would like to do. She decided that she would like to be matched with a befriender who would spend time with her at home and also take her out in their car once she was able to move around more.

As Jennifer was the main carer for her Mum I told her about Vanessa at Angus Carers and the ways in which they could help support her as a carer. She is thinking about contacting them soon.

The outcome of working together was that...

- **Mary was assessed promptly by the primary care team and the efficient referral to the OT/ PT initiated a rapid response. This enabled her to safely stay in her own home with the equipment and support to facilitate this.**
- **Mary and her family decided it would be best to move her bed downstairs so she could live on one level without the need to risk using the stairs.**
- **She made great progress with physiotherapy and OT and managed to return back to her previous level of mobility. This meant she could walk to the kitchen to make her own meals and drinks and this meant that the social care officers were no longer needed at meal times.**
- **She is now able to administer her medications independently from the compliance aid.**
- **Mary's pain has improved and her painkillers have been reduced which has reduced the risk of side effects.**
- **She now doesn't have to rely on carers to get her in and out of bed which continues to promote her independence and has not needed to use her community alarm since the equipment was installed.**
- **Mary has met her befriender and is now enjoying a weekly visit or outing with her new friend. Jennifer is still thinking about contacting the Carers Centre.**

What do Mary and Jennifer think...

They are both very happy with the level of support provided and how responsive the service was. They felt listened to and valued during any conversations or decisions about planned treatment or care.

They also were both extremely grateful that Mary didn't have to go to hospital and could stay at home.

In addition Mary feels that having a befriender not only gives her a new interest and helps her to feel less isolated - it gives her daughter a break as well.

5. Help to Live at Home (HTLH)

Working with providers of long term care at home

Angus Council used to deliver 80% of all long term care at home. Now supported people have choice, control over their care. We work with 25 independent care providers who currently provide 80% of all care at home in Angus.

We are working with providers through collaboration to:

- Help with recruitment and retention
- Develop and Deliver a fair cost of care
- Develop and deliver specialist services
- Focus on quality

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Long term support for care at home

In 2016/17 336,000 hours of personal care in peoples homes

to 3507 different adults

People are receiving more personal care. In 2016/17 we provided

30% more personal care in the community than in 2015/16

Short term Care and responsive services

Current model – where do I go for support?

Early Supported Discharge

Community Alarm

Enablement

Personal Care

Vision

Angus Health and Social Care Partnership (AHSCP) provides "Help to Live at Home" services to support people to manage as independently as possible, and in times of urgent need or transition.

This is the **Enablement and Response Service**.

In addition, we provide assistance to arrange ongoing care and support services through a range of **good quality independent care providers.**

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New model

Short term support

Longer-term care

Enablement and Response Service

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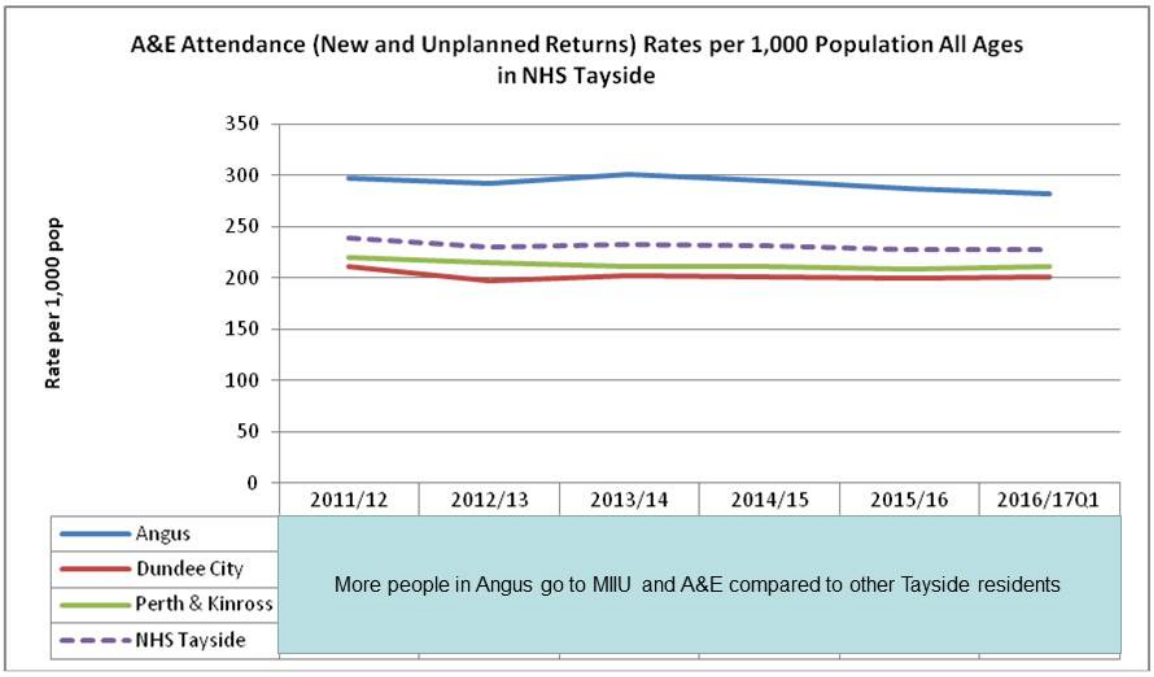
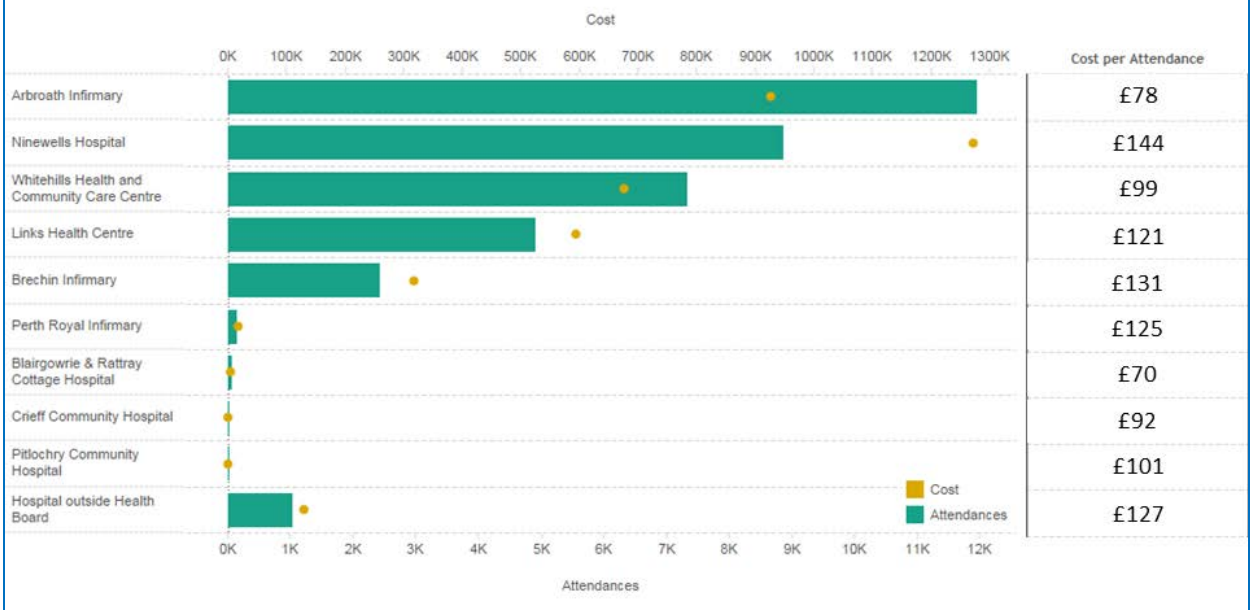
Independent Care providers

6. MIIU / Out of Hours

MIIU and A&E attendance rates per 1,000 population for all ages in Tayside Source: A&E datamart (ISD)

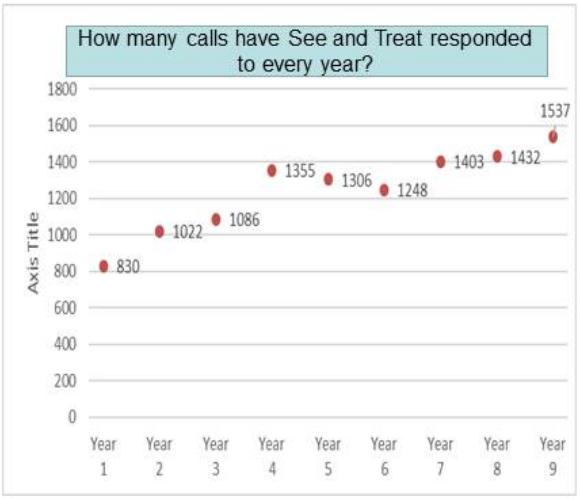


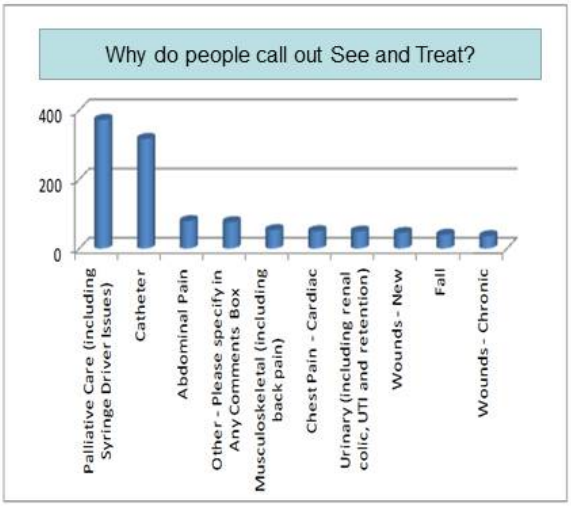
Which MIIU or A&E do Angus residents attend?



See and Treat

A paramedic and MIIU nurse operating 7 days a week (22.00 to 08.00) in an emergency response vehicle. The service has been operating for 9 years.





The average number of patients seen by See and Treat every night is 4.2

Challenges facing MIIU services in Angus

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- **More people in Angus use MIIU services than any other area of Tayside.**
- There is both professional and public confusion of the purpose of the units. **Many people attend inappropriately**. MIIU is used in hours for dressings and out of hours for wound care and minor illness.
- Typically 1 to 2 people attend each unit every hour. **Services are not efficient.**
- We are facing recruitment issues and an ageing staff group.
- We currently provide MIIU services from **some facilities which are not suitable** to support the delivery of modern, more flexible health and social care models.

People who use MIIU services say:

Confusion

Didn't see the point of going to Arbroath, waited ½ hour the xray wasn't open so then and ended up being sent to Ninewells waited 3 hours there, could have gone straight to Ninewells seems a waste of money

My friend's son had a rash, he was told at the Health Centre to go to MIIU. When she took him there, they told him they do not take care of this, and for him to go to the Health Centre. When she explained the Health Centre had sent her to them, they sent her to the chemist. This is not good practice!!

Where do I go?
What time can I go?
What can I go for?

Seen really quickly

Couldn't get a GP appointment so I came here, great service

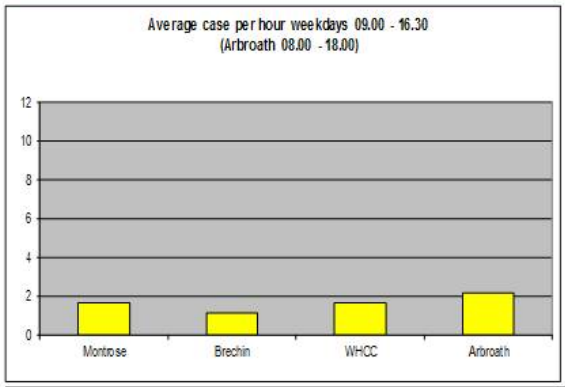
Its a casualty isn't it?

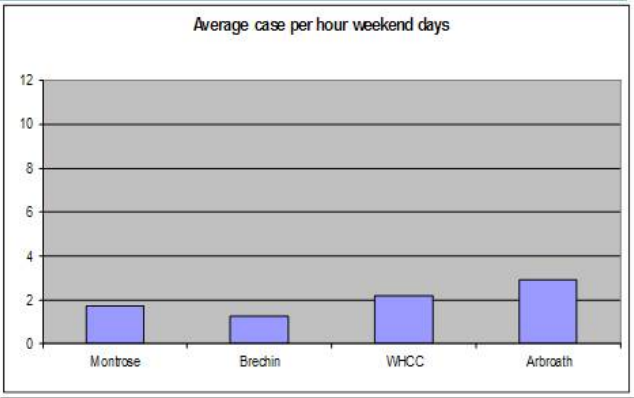
I was told by NHS 24 I would be seen by a Doctor there isn't one there

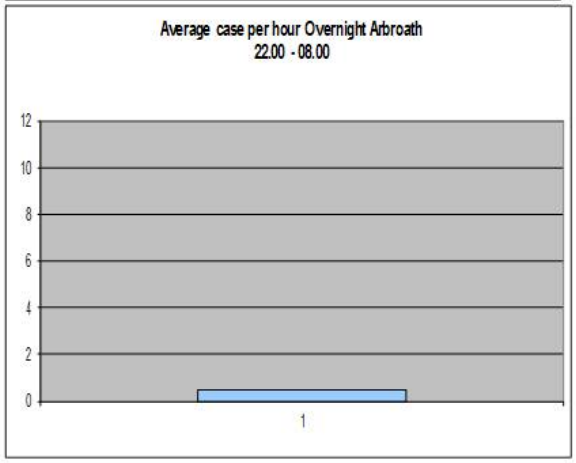
Great service

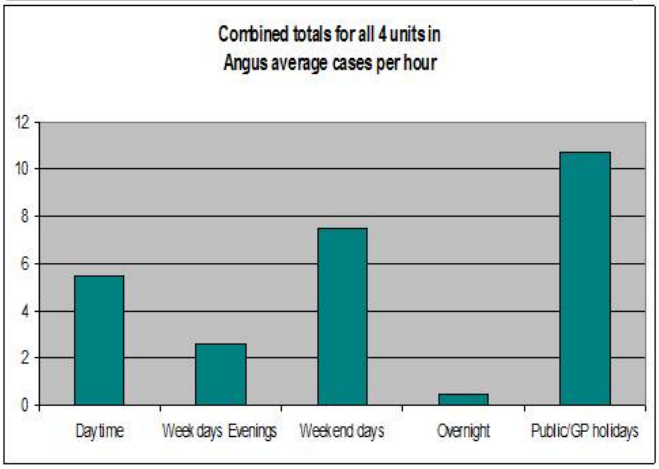
Complicated System

How many people attend MIIU in Angus and when do they attend?

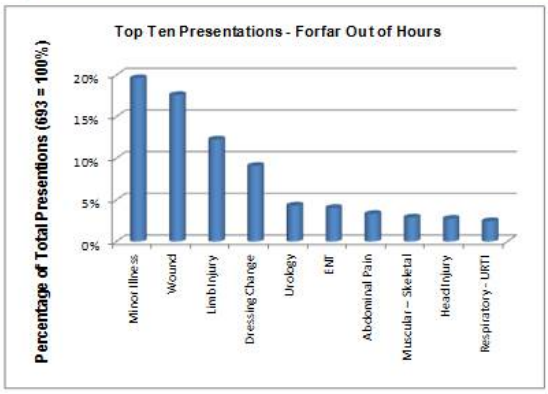


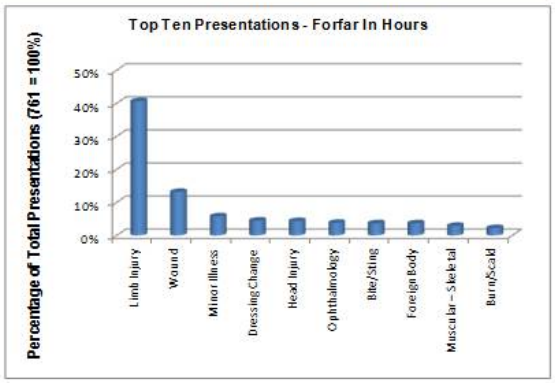


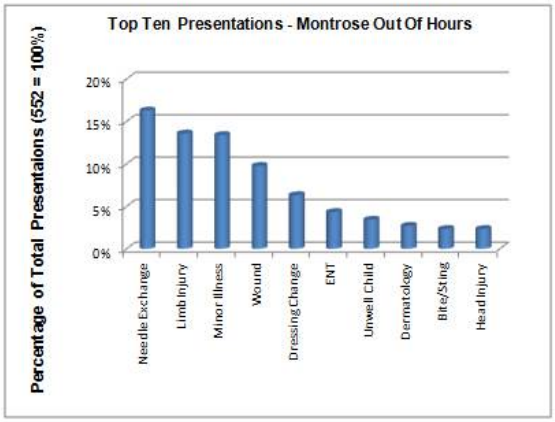


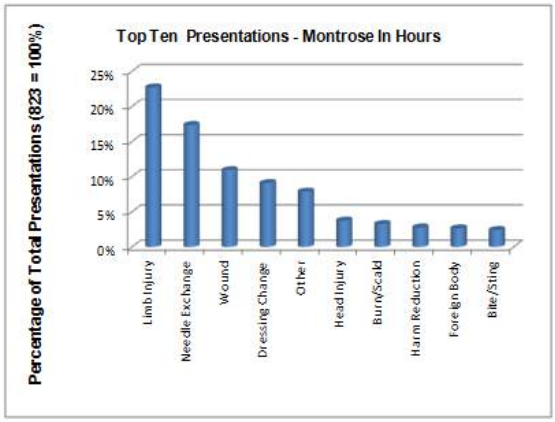


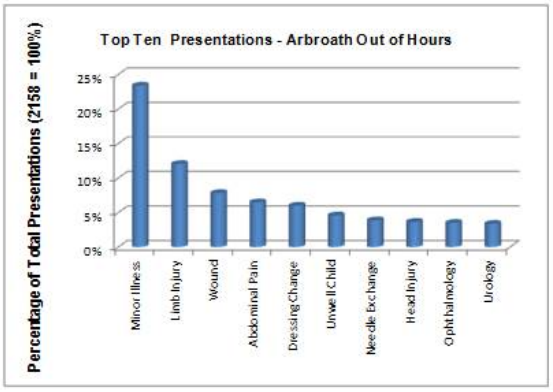
Why do people attend Angus MIIU?

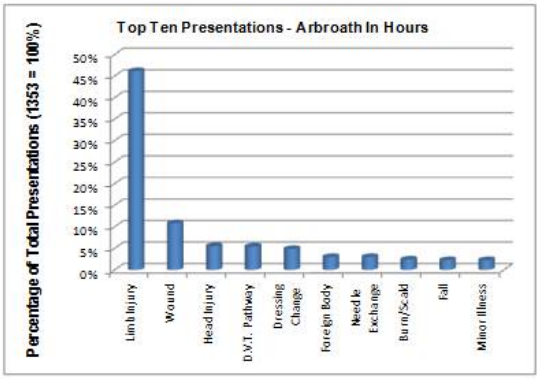


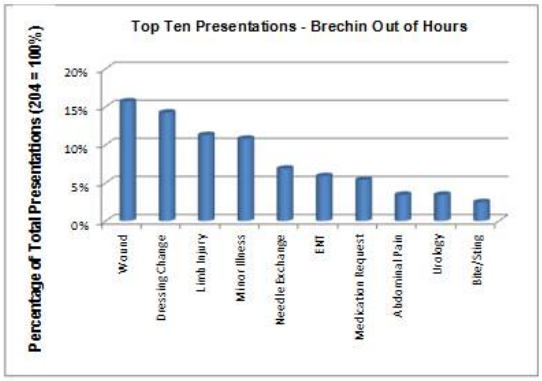


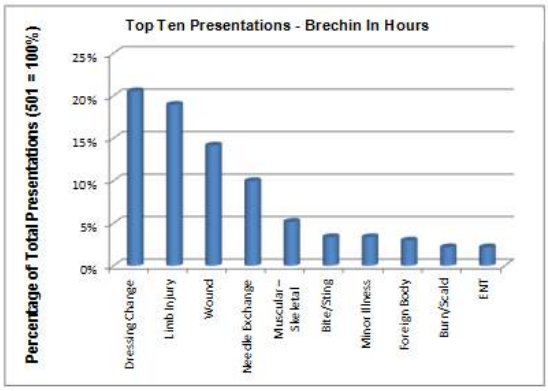












77% of people attending MIIU in Angus had <u>not</u> sought advice elsewhere (such as NHS24) before attending MIIU

Option A

Two Angus Care Hubs, a Priority Home care Team and the Dundee Urgent Care Hub

Dundee Hub Out of Hours
Service with
GPs
Nurses
HCSWs
Drivers

Angus Hub 08.00 to 22.00
Minor Injury through NHS 24
Minor illness through NHS 24
Nursing Team
GP 18.00 to 22.00 (across Angus)
Multi-disciplinary team eg Mental Health access
Physiotherapy 7 days 09.00 to 17.00
Spiritual care
Voluntary Support

Angus Hub 08.00 to 22.00
Minor Injury through NHS 24
Minor illness through NHS 24
Nursing Team
GP 18.00 to 22.00 (across Angus)
Multi-disciplinary team eg Mental Health access
Physiotherapy 7 days 09.00 to 17.00
Spiritual care
Voluntary Support

Angus Priority Home Care Team 22.00 to 08.00
GP; Advanced Nurse Practitioner, SCO/Driver (Community Enablement Response)

Pros:
- Open and closes before and after GP surgeries.
- Standardised opening hours across the service- less confusion
- Sustainable model
- Provides career progression, in turn supporting recruitment and retention.
- Provides opportunities for skills development for MIIU nurses- mandatory training and work shadow
- Opportunity to develop Advanced Nurse Practitioner Roles in line with Scottish Government recommendations
- Increases skill mix and support for new nurses.
- Opportunities for Multidisciplinary Teams working together
- eg: Physiotherapy; Mental health; Social prescribing Volunteers Utilise Spiritual care
- OOH GPs more effectively across Tayside with effective triage from NHS 24 and community alarm
- Support for Hospitals and Care homes

Cons:
No overnight MIIU/ PCEC.
Centre in 2 localities rather than 4
Does not address the need to provide scheduled care functions, e.g. complex dressings, catheter care, blood workup

Option B

Two Angus Care Hubs, a Priority Home care Team,the Dundee Urgent Care Hub and a faciltiy offering scheduled care such as dressing cahnge and catheter care, bloods, ECG

Dundee Hub Out of Hours with
GPs
Nurses
HCSWs
Drivers

1 scheduled Care facility

Angus Hub 08.00 to 22.00
Minor Injury through NHS 24
Minor illness through NHS 24
Nursing Team
GP 18.00 to 22.00 (across Angus)
Multi-disciplinary team eg Mental Health access
Physiotherapy 7 days 09.00 to 17.00
Spiritual care
Voluntary Support

Angus Hub 08.00 to 22.00
Minor Injury through NHS 24
Minor illness through NHS 24
Nursing Team
GP 18.00 to 22.00 (across Angus)
Multi-disciplinary team eg Mental Health access
Physiotherapy 7 days 09.00 to 17.00
Spiritual care
Voluntary Support

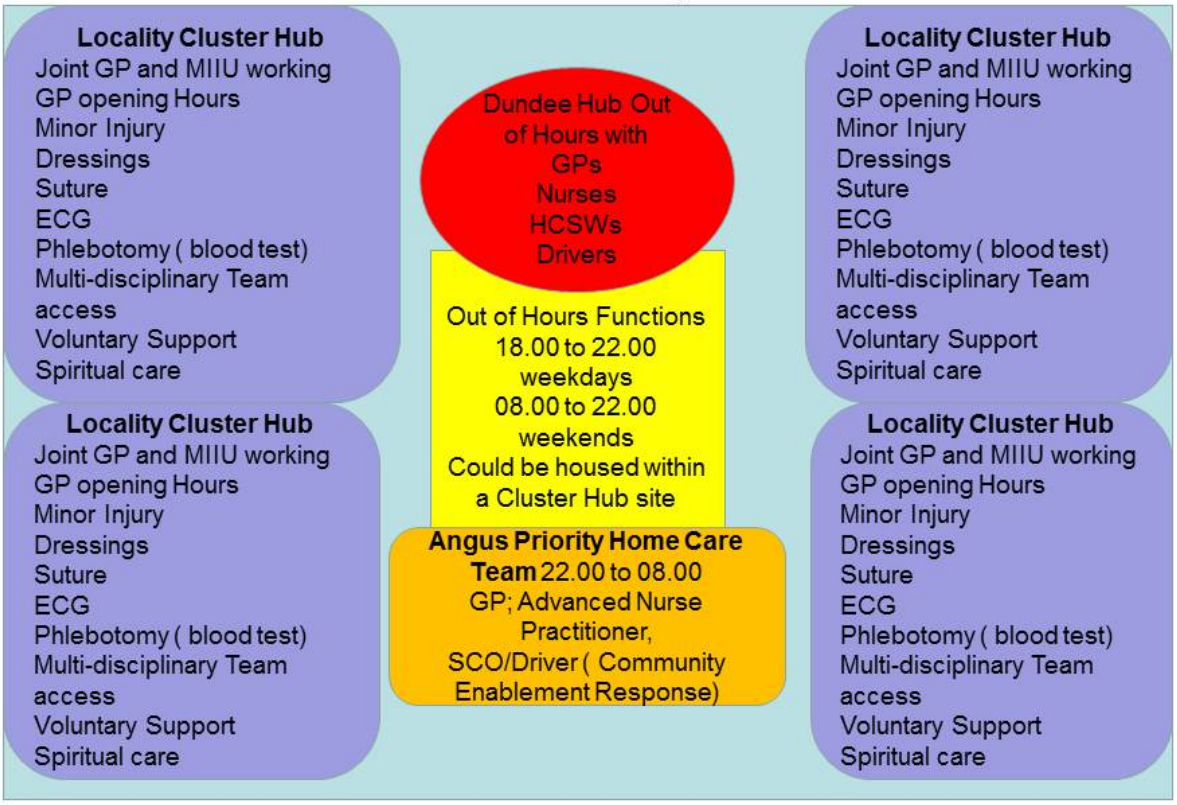
Angus Priority Home Care Team 22.00 to 08.00
GP; Advanced Nurse Practitioner,
SCO/Driver (Community Enablement Response)

Pros:
- Open and closes before and after GP surgeries.
- Standardised opening hours across the service - less confusion
- Sustainable model
- Opportunity to provide people with choice of time and location to attend therefore reduce their waiting time – (Patients will be given a choice of the time to attend)
- Provides career progression, in turn supporting recruitment and retention.
- Provides opportunities for skills development for MIIU nurses- mandatory training and work shadow.
- Increases skill mix and support for new nurses.
- Opportunities for Multidisciplinary Teams working together eg: Physiotherapy; Mental health; Social prescribing Volunteers; Spiritual care
- Utilise OOH GPs more effectively across Tayside with effective triage from NHS 24 and community alarm
- Opportunity to provide shared care with DN / inpatient services
- Opportunity to develop Advanced Nurse Practitioner Roles in line with Scottish Government recommendations

Cons:
No overnight MIIU/ PCEC
Centre in 3 localities rather than 4
Will need to co-ordinate planned care
Will need to clarify with all stakeholders how to use the system appropriately

Option C

Locality Cluster Hubs which integrate GP practice and MIIU services, priority Home care and Dundee Urgent care Hub



Option C

Pros:

Pools resources across Angus
Provision of services in each locality across Angus
Supports locality model/ integration.
Support locality improvement plans- meeting needs of local populations.
Support provision of local flexibility
Provide capacity to meet the emerging issues regarding planned care activity.
Provides opportunities for skills development and career progression, in turn supporting recruitment and retention.
Opportunities for multidisciplinary models of care
Better use of combined resources.
MIIU service 08.00 – 22.00pm in 2 locations
Opportunity to develop Advanced Nurse Practitioner Roles in line with Scottish Government recommendations

Cons:

Dependant on new GP contract expected in 2018
No overnight MIIU

7. Inpatient Care Review

Reasons for Review

- **Growing Demand for Care** – people are living longer with multiple and complex care needs that require more support from health and social care services
- **Workforce** – we anticipate further significant change over the next few years, particularly nursing and medical workforce which will make it increasingly challenging to recruit and retain staff in the numbers required to deliver the current model of care
- **Condition of our buildings** – no longer suitable to support the delivery of modern, flexible health and social care models
- **Resource Management –** growing requirement to manage resources in line with demand. The Angus HSCP Strategic Plan identifies a number of efficiencies and the shift required

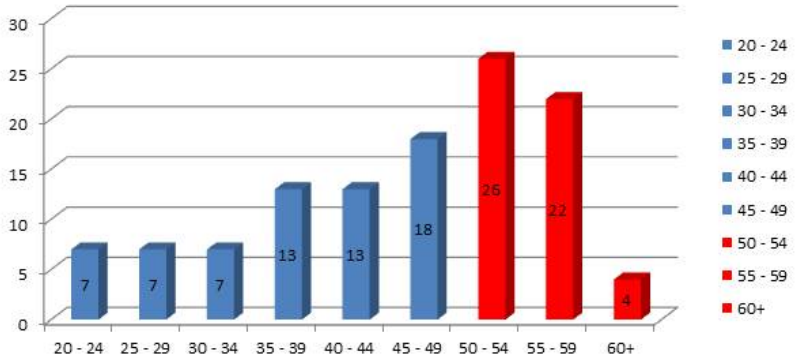
Which areas are included in the review?

Current inpatient services for community service areas delegated to the Angus HSCP i.e. Medicine for the Elderly (MFE), Psychiatry of Old Age (POA), Community Inpatient Care, Palliative Care and Stroke Rehabilitation carried out across the following sites:

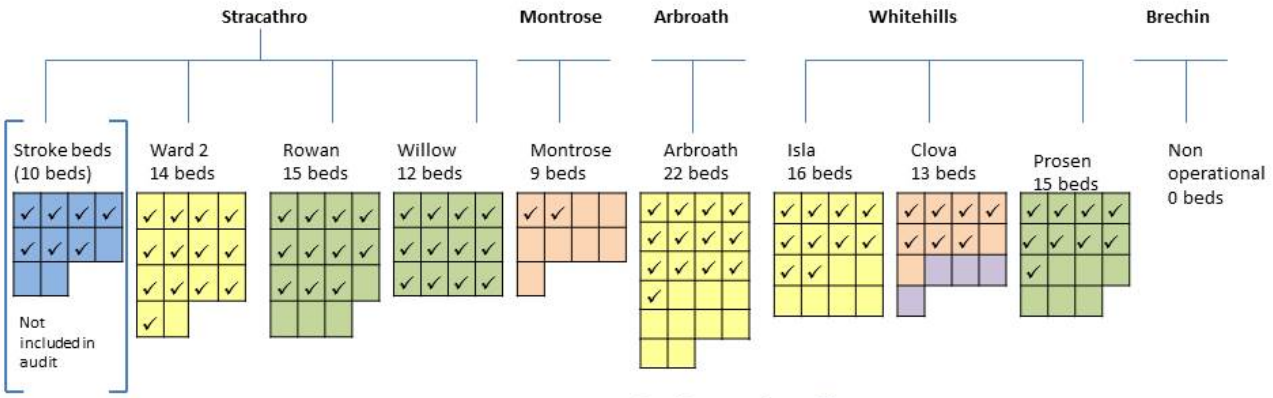
- Arbroath Infirmary
- Brechin Infirmary (non-operational since October 2015)
- Montrose Royal Infirmary (GP ward)
- Stracathro Hospital (Ward 2, Stroke Unit, Willow and Rowan)
- Whitehills Community Health and Care Centre (Isla, Clova and Prosen)

Combined nursing workforce age profile for all wards included in IPCR (MFE/GP/POA/Stroke)

Age profile at August 2017	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	TOTAL	Over 50
Band 5	7	7	7	11	11	12	23	18	3	99	44%
Band 6				2	1	4	2	2		11	36%
Band 7					1	2	1	2	1	7	57%
Nursing Bands 5 - 7	**7**	**7**	**7**	**13**	**13**	**18**	**26**	**22**	**4**	**117**	**44%**



On 7 September 2017 we carried out an audit to help us understand the needs of people who had been admitted to our inpatient areas. (Stroke beds were not included in the audit)



✓ = occupied bed

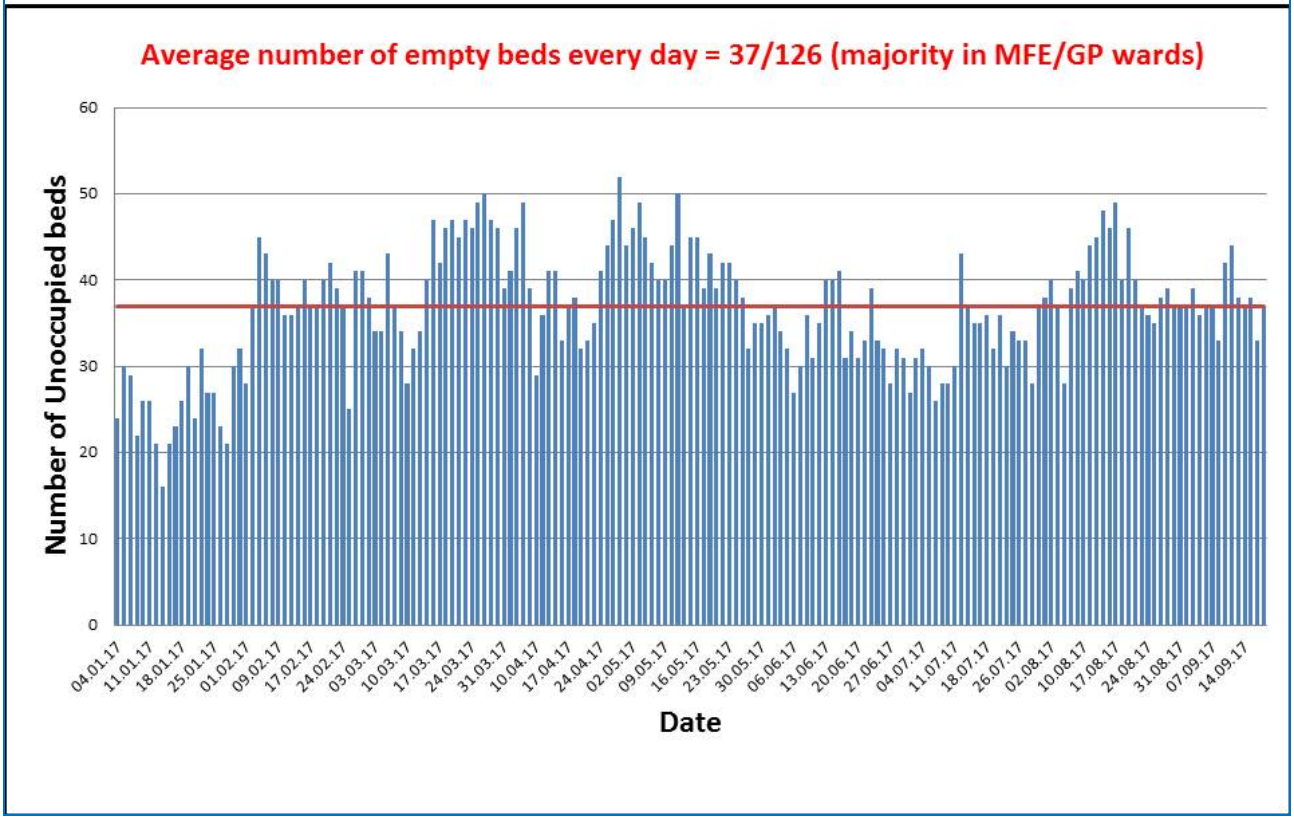
Description	Total Bed No.
Psychiatry of Old Age	42
Medicine for the Elderly	52
GP	18
Palliative care	4
TOTAL	**116**

Findings of audit:

- 77 beds were occupied (66)%
- 39 beds were empty (34%)
- 23 (30%) of people had been admitted to hospital as a result of a fall
- 49/77 (64%) people could have benefited from community intervention earlier in their journey, had appropriate services been available, which may have avoided the need for a hospital admission.

Number of empty beds in Angus January 2017 – September 2017

Wards included: Medicine for the Elderly (MFE), GP, Psychiatry of Old Age and Stroke



ANGUS
Health & Social Care Partnership

The future of inpatient care in Angus

What do you think we should do about having an average of 37 empty beds in our inpatient beds every day?

8. Care Home Review

Permanent Care Home Placements

There are 30 care homes providing 1030 care home beds in Angus. Occupancy is high with Angus care homes attracting residents from outwith Angus

Typically 710 Angus older people are living in a care home at any one time.
550 of them live in a care home in Angus.
Others move to care homes elsewhere to be near family or for other reasons

There are different types of care provided in care homes:

- Residential care
- Nursing care
- Care of the elderly mentally infirm
- High dependency social care

Most Angus care home provision is provided by independent sector providers (92%).
Some is provided in local authority care homes (8%)

Angus Health and Social care Partnership annual expenditure on care home placements is £21.5million.

£4.5 million of this is funded by care home residents

Permanent Care Home Placements

Care homes are not distributed equally across Angus. There are more beds in the South East locality, mostly in Arbroath itself.

The average age of someone living in a care home is 84.

There is little difference between care homes in the level of need and dependency of residents. All care homes provide for different level of need.
25% residents are low dependency
30% are medium dependency
45% residents are high dependency

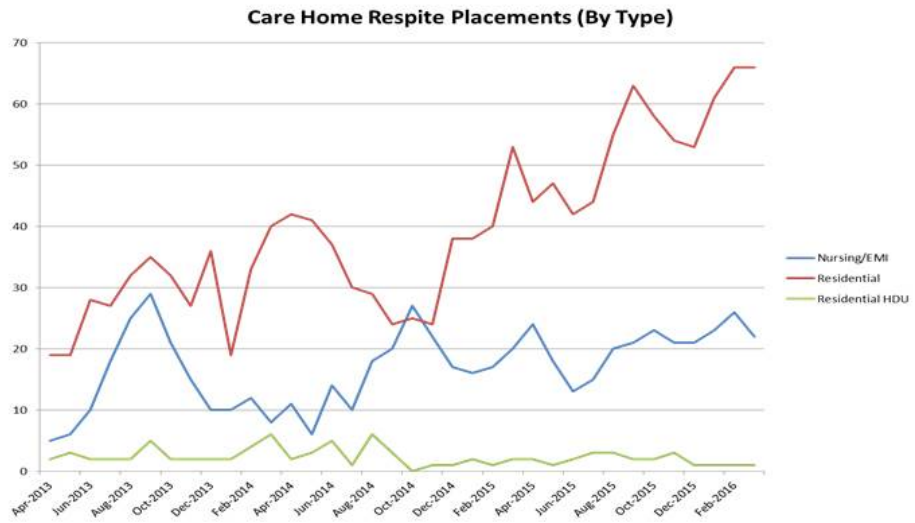
There is variation between localities and social work teams in the use of care home placements as a means of meeting the needs of older people. More people from the South East locality are placed in care homes

The net cost of a care home placement is higher than the average cost of an intensive care at home support plan. We ned to ensure people with low and medium dependency are supported at home.

Variation in our localities

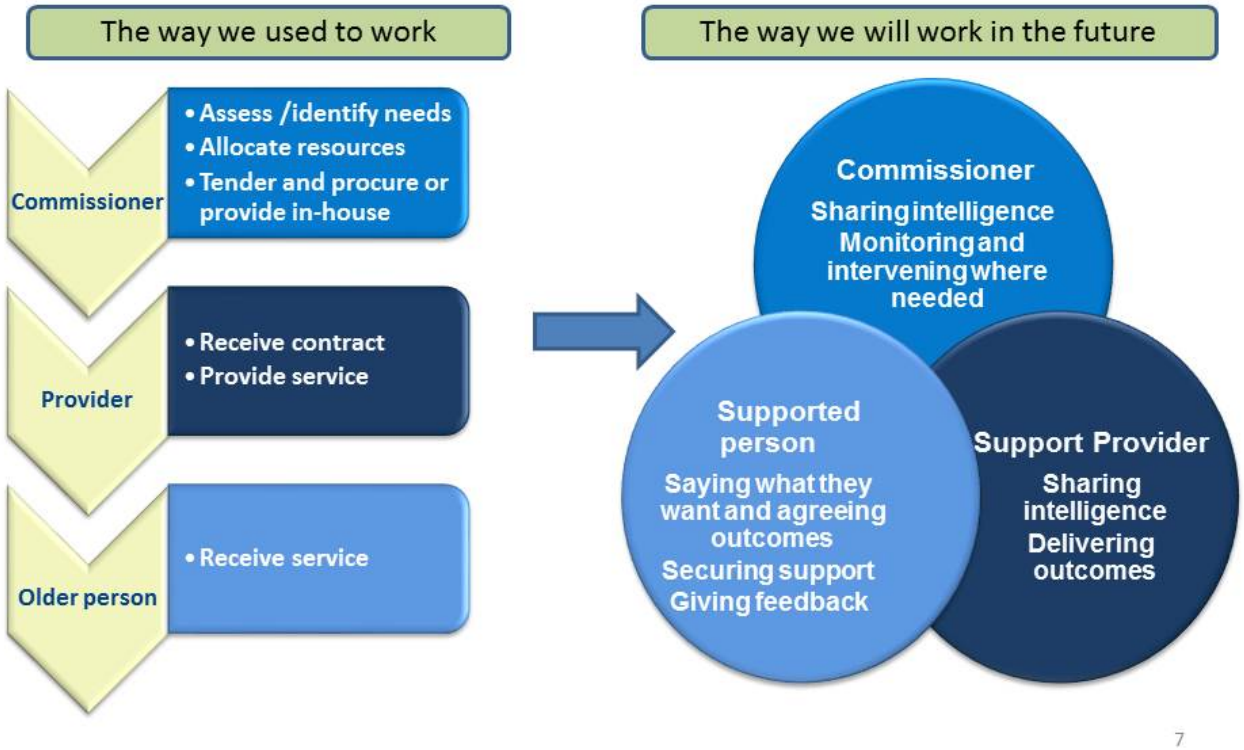
Locality	SW	SE	NE	NW
Total population	24,394	29,437	25,445	36,964
Population over 75	2,544	2,654	2,445	3,636
Percentage of population who are owner occupiers	80	57.8	59.4	65.3
Percentage over 65 population living alone	52	41	43	46
Available care home bed numbers	253	284	185	250
Available beds per 1000 over 75	99.4	107.0	75.66	68.7
Nursing home commissioning rate per 1,000 over 75 population	11.91	25.54	36.68	15.66
Residential home commissioning rate per 1,000 over 75 population	47.46	70.4	50.8	46.3

Care Home Respite



Demand for respite is increasing. We expect this increase in demand to continue as the new Cares Act is implemented in April 2018 and as more people are supported at home for longer.

Facilitating Change in Angus Care Homes



7

Options

Assuming 10% population growth in 5 years

	what	Impact of this
1	No intervention	An additional 90 beds will be required. This will need more than £3million additional resources at todays prices. There is capacity in the Angus care homes to support this. Care homes not fully meeting local needs as demand around dementia care in particular is growing Care homes at financial risk due to recruitment issues and agency nursing costs
2	Same model of care homes but support people with low and medium dependency to stay at home	Approximately 70 fewer beds needed but more high intensity care at home packages needed (supporting an additional 160 people in the community) Care homes at financial risk due to recruitment issues and agency nursing costs
3	Change the care home model and develop peripatetic nursing support and ensure only high dependency needs require care home placement	Approximately 70 beds less Social care led models of dementia care, frailty and intermediate care. Respite focused on enablement. Nursing support for all nursing needs dedicated to all care homes
4	Increase respite	An additional 12 beds needed More care support More people can be supported at home
5	Increase intermediate care	Initially an additional 6 beds needed Step up and step down care Reduced admissions to hospital and reduced risk of delays in discharge

Accommodation for People with Learning Disability

Reviewed separately, accommodation for people with learning is developing work in 3 priority areas

Priority 1. People requiring to move from a hospital setting.
There are very small numbers of individuals in hospital waiting for the right type of accommodation and support in the community. Angus Community Care Charitable Trust (ACCCT) is currently redeveloping a four person shared house in Forfar in order to create one, two-person tenancy for existing tenants and two, one-person tenancies for the two individuals who remain in hospital. This work is expected to be completed imminently.

Priority 2. Replacement of the Gables care Home.
The Gables Care home is the only remaining local authority care home for adults with a learning disability in Angus; despite refurbishment over the years, the building is not really fit for purpose. The current Gables site has capacity to deliver seven 1-bed flats, four 1-bed houses, one 3-bed house, a communal lounge and staff accommodation. This will provide accommodation for all of the existing residents

Priority 3. Core supported accommodation in South West Locality.
In core supported housing an individual will have a tenancy within a scheme of properties which have 24 hour on-site support as part of the tenancy agreement. This may or may not include communal facilities but it will include immediate access to staff support. There are currently no local facilities of this nature in Carnoustie or Monifieth. Three providers are interested in pursuing this opportunity further and are looking to identify potential properties.

9. You asked us.....

You asked us.....	Our answer
Please explain about the availability of x-ray in the Minor Injury and Illness Units at weekends and public holidays.	The Radiography department has commissioned a specific piece of work looking at demand and capacity for the Angus x-ray services. If an urgent x ray is required, this can be provided in Ninewells Hospital, Dundee 24/7. If a patient presents in the Out of Hours (e.g weekends and public holidays) and an x ray is required, but not urgent, this can be accessed in Whitehills Health and Community Care Centre, Forfar and Arbroath Infirmary (Mon - Fri) and in Links Health Centre, Montrose on Tuesday mornings.
If a person is moved into respite to facilitate discharge, will they be charged?	People may be charged but this is dependent upon a number of factors. Everybody over 65 is eligible to free personal care. Some people will also be eligible for free nursing care. The remainder of the charge fee is subject to a financial assessment which identifies if an individual is able to contribute to any remaining costs.
Do you have information about the average length of stay per hospital?	We know that the average length of stay for an Angus person following an admission in an emergency is 9.6 days. This is dependent on a variety of factors. For example clinical presentation, person's needs at time of discharge. We know that there is variation between the 4 localities and this is one of the factors that will be considered as part of the inpatient care review.
What is the percentage of residents of care homes who need medical supervision?	People who live in care homes use GP services like others who live in the community. GPs respond to need as appropriate.
What's happening about volunteers providing a nail cutting service?	The Podiatry Service is in the process of seeking funding to enable volunteers to provide personal foot care with training provided by the NHS Tayside podiatry service
What about Modern Apprenticeship Schemes – to attract younger people into care/health jobs?	We are making meaningful contacts with employers, Colleges of Further Education to improve the opportunities and availability of apprenticeship schemes across the NHS and Council in Angus. We have close links with the Dundee & Angus, Developing the Young Workforce Group. In November 2017 we are holding a careers fair in Forfar and our theme is attracting younger people into the workforce.

	This will include professional and non professional posts. We are also working with our partners in the independent and third sector appreciating we need to manage our workforce challenges collectively.
Please explain the process for how people are appointed to receive a ferritin infusion appointment and why do some people have to go to Ninewells rather than Whitehills Health and Community Care Centre.	Firstly it may be that there is a clinical need for a person to have their ferritin infusion in Ninewells. Medicine for the Elderly patients in the North West locality receive ferritin infusion at Whitehills Health and Community Care Centre as do all intravenous iron infusions for renal patient in the North West locality (which is the biggest group).
Why are Forfar residents admitted to Roxburghe House when there are palliative care facilities in Whitehills Health and Community Care Centre?	Unfortunately we are unable to comment on specific cases without the permission of the individuals involved. Whenever possible we try to adhere to a patient's and their family's palliative care wishes. On occasions people request to go Roxburgh rather than Whitehills Health and Community Care Centre (WHCCC) in Forfar. The decision to admit someone to Roxburghe House rather than the palliative care beds in WHCCC is dependent upon a number of factors. For example the clinical needs of the patient; many people require 24 hour medical support and/or require specific clinical input which cannot be provided at Whitehills.