AGENDA ITEM NO.12

REPORT NO. IJB 64/18

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 29 AUGUST 2018

THE ANGUS CARE MODEL - PROGRESS REPORT

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

This report provides an update to the Integration Joint Board (IJB) on the current position in relation to the implementation of the Angus Care Model which aims to facilitate a more integrated and innovative approach to service provision for people in need of care and support.

1. RECOMMENDATIONS

It is recommended that the IJB:

(i) notes the progress made in the implementation of the Angus Care Model since the last update in April 2018 (IJB report no. 26/18);

(ii) notes that the work to develop Community Care and Treatment Services in Angus is aligned to NHS Tayside Primary Care Implementation Plan;

(iii) acknowledges the work underway to raise awareness and communication of the Angus Care Model.

2. BACKGROUND

The IJB approved the developments associated with the delivery of the Angus Care Model which were outlined in report no. IJB 9/18 and progress reported to the IJB in April 2018 (IJB 26/18).

3. CURRENT POSITION

A summary of the progress made to deliver the Angus Care Model is illustrated in **Appendix 1**. Ongoing actions are described below:

3.1 Inpatient care

A summary of the progress made to reconfigure inpatient care in Angus is detailed in **Appendix 2**.

3.1.1 Medicine for the Elderly and Stroke Rehabilitation

It has been agreed that the total number of Medicine for the Elderly (MFE) beds in Angus will reduce from 74 to 58. At the time of this report the number of MFE beds has reduced to 60.

At the request of the NHS Tayside Asset Management Group (AMG) a Strategic Assessment has been completed in relation to the intention for Medicine for Elderly (MFE) and Stroke Rehabilitation Services to relocate from 'A' Block

Stracathro Hospital into the vacated former Mulberry Unit in the Susan Carnegie Centre, Stracathro.

Work will commence to complete a Strategic Assessment in relation to Isla and Clova wards in Whitehills Health and Community Care Centre.

3.1.2 Psychiatry of Old Age

The day of care audit within Psychiatry of Old Age (POA) has been revisited to capture more meaningful information about availability and alternatives to admission, as well as considering barriers and challenges to timely discharge. This will support and improve information for future planning and the continued review of inpatient requirements.

Opportunities within the Angus Care Model to address the future shape of care home provision in Angus care homes will also include consideration of the management of 'stress & distress' for people with dementia. It is anticipated that this will improve the availability of suitable placements to support admission and discharge planning.

More recently (July 2018) there have been more occasions when there have been no patients from Angus delayed in Ninewells Hospital. This reflects the improved systems and provision of care at home.

3.2 Minor Injury and Illness Units (MIIU) / Community Care & Treatment Services

In line with the delivery of plans outlined in the Angus Care Model, limited progress has been made in the reorganisation of MIIU services and the establishment of services more focused on supporting care and treatment needs of the population.

Operating times of MIIU services in Brechin and Montrose changed on 4 June 2018. From this date the MIIUs were closed on Public Holidays and Saturday and Sunday.

Appendix 3 shows the number of Montrose and Brechin residents attending MIIU services in Arbroath before and following the changes to opening times at Montrose and Brechin MIIUs. There is no significant variance in numbers presenting at Arbroath or Whitehills Health and Community Care Centre MIIUs following the changes to Montrose and Brechin MIIU opening times.

Lloyds Pharmacy in Montrose and Davidsons Pharmacy in Brechin now provide an Injecting Equipment Provision (needle exchange) service. Several clients of this service continue to present at Brechin and Montrose MIIU for equipment, which is being provided, however they are advised to attend the local pharmacy for their future requirements.

There has been one referral from Montrose MIIU to Arbroath MIIU for planned care since the reduction in opening hours.

Recruitment and retention continues to cause concern, mainly due to the staff age group. Three very experienced MIIU registered nurses recently retired and a further four have given notice of their intention to retire in December / January. As 60% of the MIIU workforce is over 50 years old, this will be an ongoing issue.

3.3 Enablement and Response Services

Service continues to bed in following the positive evaluation from the Care Inspectorate. It has an improvement plan which is being progressed. The staffing situation is more settled following a period of sickness absence. A new Team Manager has been appointed.

3.4 Help to Live at Home and the Option 3 Framework

Help to Live at Home is in its concluding stages with the option 3 framework now up and running, as previously reported. The Resource Allocation Meetings held jointly with private and third party providers are improving the matching process between service user need and the allocation of care at home hours. There have been some issues with capacity to provide in certain geographical areas, and these are being addressed with providers in order to secure improvements. Overall, capacity has increased. The creation of the option 3 framework has had some impact on option 1 and option 2 provision; these are covered in a separate report to IJB on 29 August.

3.5 Enhanced Community Support

Enhanced Community Support (ECS) continues to work effectively across the South and North East localities. Posts are currently advertised for implementing ECS in the North West. Further discussions are taking place re the GP role within this in relation to the new GP contract. A Sharing and Learning event will take place on 20 September 2018 to review ECS across Angus, as each area has developed the service differently. This will be an opportunity to share good practice and help inform future development of ECS in Angus.

3.6 Monifieth Integrated Care

Monifieth Integrated Care (MIC) is a pilot project commencing in early September. It involves the colocation of a number of different Partnership services in Monifieth Health Centre: Social Work, Third Sector (Voluntary Action Angus), Allied Health Professionals, District Nursing, GPs and private care providers. Team management will be provided jointly by a social work team manager and a senior district nurse. Monifieth already has a well-established multi-disciplinary team meeting approach and Enhanced Community Support as part of the Angus Care Model, but we believe that permanent colocation will improve joint working through better shared assessment, cross-professional empathy, improved skills and reduced duplication, thereby benefiting patients/service users. We will measure improvements in service through a performance framework and benefits realisation tool, which will include qualitative and quantitative measures. Support has been provided to the staff involved through development sessions and will continue after the commencement. MIC is supported by a steering group and operational group and connects closely with the South West Locality Improvement Group. If successful, we will roll the model out across the county, allowing for some variation to meet local need.

4. COMMUNICATION, PARTICIPATION AND ENGAGEMENT

Angus Health & Social Care Partnership is committed to genuine approaches to work with all stakeholders impacted by health and social care integration. We know that local people, communities and co-contributors are central to the shaping and improving the delivery of outcomes in Angus. We are aware of our responsibilities to ensure we inform our stakeholders of significant service change and the need for clear communication.

We have planned the next series of 'Continuing the Conversation' events and these will take place in October 2018 – see flyer in **Appendix 2**. We have listened and responded to feedback and all events will take place from 4pm – 6pm. Events will be held in each locality with an additional event taking place in Birkhill, at the request of Birkhill & Muirhead Community Council. As all healthcare services in this area are provided by Dundee Health & Social Care Partnership, we have requested their support and input at this specific event.

Conversation topics will include:

- Palliative Care and End of Life
- Living Well
- Prescribing matters
- Falls prevention

- Older people's mental health
- 'What's new in your locality?'
- Developing the 2019-2022 Strategic Commissioning Plan

At the request of Perth and Kinross Health & Social Care Partnership and iHub, a meeting has been arranged to share learning about the development and achievements of the Angus Care Model.

5. NEXT STEPS

We remain ambitious with our plans to develop an Angus Care Model which will deliver the very best outcomes for the people of Angus through the delivery of health and social care services available in our localities. Our next Strategic Commissioning Plan (2019 – 2022) will document how we will further develop the Angus Care Model within our four priority areas. It will describe how we will work differently and more innovatively to ensure we meet the many challenges associated with delivering safe, effective and person-centred care in the context of increasing demand for care, continued financial restraint whilst addressing the need for workforce change.

We will also describe how the people of Angus can help us to deliver these ambitions by taking more responsibility for their own health and wellbeing, becoming more informed about knowing who to turn to at time of need and being more aware of how they can support others in their community. This will support the delivery of our greater ambition; An Angus that Actively Cares.

6. FINANCIAL IMPLICATIONS

There is no change to the financial implications since the last report.

REPORT AUTHORS:
Gail Smith, Head of Community Health and Care Services (North)
George Bowie, Head of Community Health and Care Services (South)

EMAIL DETAILS:
gailsmith@nhs.net
bowiegs@angus.gov.uk

8 August 2018

List of Appendices:
Appendix 1 - Developing the Angus Care Model
Appendix 2 - 'Continuing the Conversation' Flyer
Appendix 3 - Number of Montrose and Brechin residents attending MIIU services in Arbroath and Forfar

Appendix 1 Developing the Angus Care Model

What is the Angus Care Model?
The Angus Care Model provides better integrated services and is delivering an innovative approach for supporting people in our four localities.

The need for change:

- **Growing demand for care:**

In 2037:

Angus population expected **115,327**

Over 65 years	Over 75 years (20,930 people)
1 in 3	1 in 5

Life expectancy will continue to improve. We need to do more with less

- **Workforce challenges:** 44% of nurses over 50 years old
- **Financial pressures**

What do we aim to do?

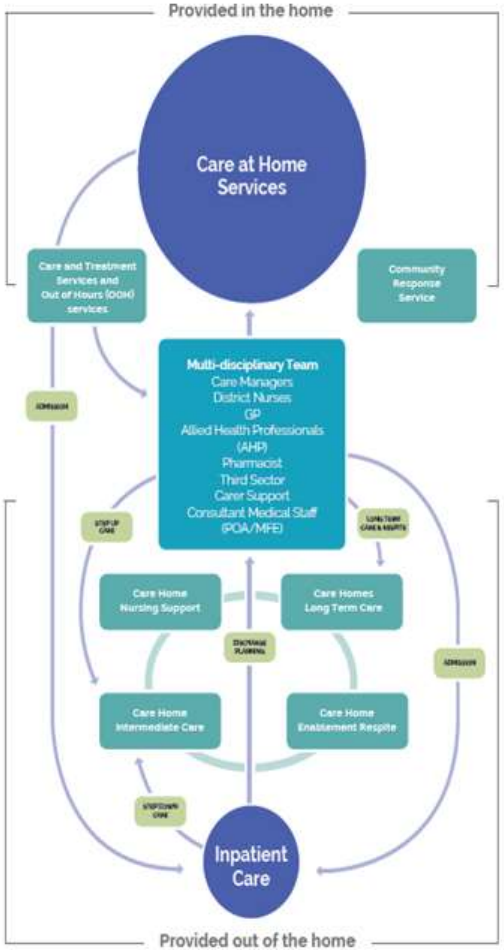
- **Rebalance** care, maximising support for people in their own homes.
- **Reconfigure** access to services delivering a workable geographic model of care outside the home.
- **Realise** a sustainable workforce delivering the right care in the right place.
- **Respond** to early warning signs and risks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

Supporting activities:

- Held a series of 'Continuing the Conversation' events across our localities.
- Undertook a number of audits and data reviews to understand demand, capacity and activity.

Developing the Angus Care Model

The Angus Care Model: built on a foundation of an Angus that actively cares



Shifting the balance of care:

What we have achieved so far?

Enhanced Community Support	Multidiciplinary team approach to support adults and older people to remain at home. Closer working between team members resulting in a more joined-up approach to supporting people at home. Reduced length of time people spend in hospital when admitted in an emergency by 10% to 10.6 days.
Help to Live at Home Programme	Improved availability of personal care by 33% Long-term personal care is now almost entirely commissioned through private and voluntary care providers (over 90%). Number of personal care hours delivered increased from 4500 in April 2015 to 6200 in November 2017.
Inpatient care	More care is delivered in the community. As a result we had an average of 37 empty beds each day in our Angus hospitals and occupancy levels in some of our hospitals were low. Brechin Infirmary and Montrose Royal Infirmary, which were not fit for purpose, are now closed. We have reduced the number of medicine for the elderly beds from 74 to 58 and number of Psychiatry of Old Age beds from 42 to 35.We still have average of 22 empty beds.
Care Homes	Average age of an older person living in a care home has increased from 83 years in 2014/15 to 84.9 years in 2016/17 Average length of stay in a care home has reduced from 21 in 2014/15 months to 17 months in 2016/17. A new process developed with GPs and pharmacy has led to zero medication waste in care homes. Piloting three step-up beds in North East locality
Prescribing	Increase in number of people having a medication review. Increase in drug switches

Table 1. Inpatient care review - Timescale

Red	Action at risk of not being completed
Amber	Action maybe at risk if issues not addressed
Green	Action on schedule or completed

	Jan 2018	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan 19	Feb	Mar
Action	IJB approval to reduce inpatient capacity from 126 to 103 beds (no change to stroke beds)	Prosen bed reduction from 15 10 Rowan bed reduction from 15 to 13	Withdrawal of inpatient care from Montrose Infirmary (MRI)	3 x IIC Beds open in Fordmill Care Home Montrose	Brechin site closure complete	Montrose site closure complete	Isla/Clova 1st phase reduction from 29 to 24 beds (-5 beds)	Submit Strategic Assessment for change of use of Mulberry to NHS Tayside Asset Management Group							
Total beds MFE	**74 to reduce to 58 (-16 beds)**	MFE 74 No change	MFE 65 (-9 beds)	MFE 65 (-9 beds)	MFE 65 (- 9 beds)	MFE 65 (-9 beds)	MFE 60 (-14 beds)	MFE 60 (-14 beds)							
Total beds POA	**POA 42 to reduce to 35 (-7)**	POA 35 beds	POA 35 beds	POA 35 beds	POA 35 beds	POA 35 beds	POA 35 beds	35	35	35	35	35	35	35	35

Appendix 2 – ‘Continuing the Conversation’ Flyer

ANGUS
Health & Social Care Partnership

Angus Care Model

Building sustainable, safe and effective care for the future

Continuing the conversation

Monday 15 October 2018
4pm to 6pm
Birkhill Millennium Hall

Wednesday 17 October 2018
4pm to 6pm
Links Health Centre, Montrose

Thursday 18 October 2018
4pm to 6pm
Kirriemuir Town Hall

Monday 22 October 2018
4pm to 6pm
Monifieth Burgh Chamber (within Monifieth Library)

Tuesday 23 October 2018
4pm to 6pm
Angus Carers Centre, Arbroath

Come along and talk to staff at our drop in sessions.
Get involved in shaping the future model of care in Angus.
Conversation topics include:

- Palliative Care and End of Life
- Living well
- Prescribing matters
- Falls prevention
- Older people's mental health
- What's new in your locality?

Appendix 3

Table 1 - Number of residents from Brechin/Montrose who attended Arbroath MIIU during a weekend prior to the reduction in opening hours, one week after and one weekend in July.

Date	Number of patients from Brechin	Number of patients from Montrose	Total number of patients	Self presentation	NHS 24 referral	Other	Attendance prior to 16.30	Attendance after 16.30
Sat 12th May	3	8	**11**	6	5	0	2	9
Sun 13th May	2	4	**6**	0	6	0	6	0
Sat 9th June	2	9	**11**	4	6	1 (ambulance)	5	6
Sun 10thJune	1	4	**5**	1	3	1 (ambulance)	1	4
Sat 23rd July	1	11	**12**	4	6	2 (ambulance)	5	6
Sun 24th July	2	9	**11**	5	6	0	7	4

Table 2. Number of residents from Brechin/Montrose who attended Forfar MIIU during a weekend prior to the reduction in opening hours, one week after and one weekend in July.

Date	Number of patients from Brechin	Number of patients from Montrose	Total number of patients	Self presentation	NHS 24 referral	Other	Attendance prior to 16.30	Attendance after 16.30
Sat 12th May	0	0	**0**	0	0	0	0	0
Sun 13th May	1	0	**1**	1	0	0	1	0
Sat 9th June	1	1	**2**	1	1	0	2	0
Sun 10thJune	0	2	**2**	1	1	0	1	1
Sat 23rd July	0	1	**1**	0	0	0	0	1
Sun 24th July	1	0	**1**	1	0	0	1	0