Transforming Models of Care for Older People in Tayside

1 SITUATION

The purpose of this paper is to set out a five year plan to transform care for older people in Tayside in line with The Scottish Government’s “Achieving Sustainable Quality in Scotland’s Healthcare. A 2020 Vision”. The Older Peoples Board (OPB) share the Government’s vision that everyone will live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system in Tayside which delivers the following:

- Integrated health and social care
- A focus on prevention, anticipation and supported self-management
- Day case treatment as the norm
- Care, whatever the setting which is provided to the highest standards of quality and safety, with the person at the centre of all decisions
- A focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

Over the next few years NHS Tayside in partnership with Local Authorities must ensure that in the face of an increasing elderly population and subsequent complexity of health and social care needs, a high quality service continues to be provided for older people and their carers in Tayside. This is not only what they expect but also what they deserve.

One of the Scottish Government’s key policies to support Boards in their direction of travel is ‘Reshaping Care for Older People – A Programme for Change 2011-2015’. Key Bills relating to this are Self-directed Support and Integration of Adult Health and Social Care and supporting strategies which run concurrently include Scotland’s National Dementia Strategy 2013-16.

The principal policy goal of the Reshaping Care for Older People programme is to optimise independence and wellbeing for older people at home or in a homely setting improving services for older people by shifting care towards anticipatory care with prevention as a key element. A lot of work has been done locally and nationally through the projects within the Change Fund that have already shown clear improvements in the care of older people and we should also highlight the joint up models of care in the three areas of Tayside with a clear emphasis on self directed care and self management as central to sustainability.

However, the implications of the current financial situation and demographic changes make this a challenging task, as an increasing number of people will require improved services, care and support. Over the next 20 years demography alone could increase expenditure on health and social care by over 70%. It is therefore imperative that we seek substantially more radical changes in how we designed services for older people in Tayside and this paper is describing the model we believe will achieve that.

¹ NHS Tayside OPB believes that although health and social care integration is paramount to achieve a sustainable model of care for older people, there is significant work to be done to further integrate services within health such as MfE, POA and Primary and Community Teams. The OPB also believes there is scope for further integrated work between MfE and POA services across the three areas should be commissioned.
To support the required changes the Government provided a Change Fund in each partnership area. To ensure continuing professional and public engagement, each area has embedded the process of change through the whole system and across all partnership arrangements rather than through separate processes, thus all groups which sit within the Change Fund have multidisciplinary professional involvement from primary and secondary care; voluntary and independent sectors; service user and care. Examples include:

- Older People’s Strategic Planning Groups and Dementia Implementation Groups.

  *These groups set the strategic direction in partnership areas and are responsible for the development of the longer term Older People Commissioning Strategies*

- Change Plan Monitoring and Implementation Groups and workstream specific groups.

  *The groups build collective ownership for the current and future programme of change and provide collective scrutiny of the progress towards agreed targets*

- Developed Voluntary Sector Networks including, Carers Forum and Care Home and Resource Providers Forums.

  *These focus on quality improvement, service redesign and strategic development. Many of the proposed changes arose from these fora. They test the sensitivity of current changes and will originate and contribute to ongoing work*

- Stakeholder events in each area confirm the proposed high level objectives, strengthen communication and ensure that everyone involved is able to maintain an overview and an understanding of the entire process of change.

Set within this strategic direction, the OPB wishes to support a transformational model of community care for older people in Tayside which:

- Puts communities in control

- Establishes a hospital without doors - continuity of care (in reach and out reach) model

- Breaks down professional boundaries
2 BACKGROUND & CONTEXT

A considerable amount of work has taken place in each of the CHP areas over the past three years testing new models of care which move from reactive to planned care models. NHS Tayside invested in the development of Risk Stratification Tools such as PEONY which were tested in an early model of ‘Virtual Wards’ based on work in Croydon, Wandsworth and Devon. Each of the CHP areas moved on to develop local models of ‘Early Intervention’ or ‘Prevention of Admission’ schemes. The principles of risk satisfaction have remained with less reliance on the use of algorithms such as PEONY or SPARRA and a greater acceptance of an agreed set of risk criteria which include markers of frailty such as a history of falls, polypharmacy including high risk combination of drugs, failing to cope and frequent house calls to GPs. All these developments have been based on a principle of Multidisciplinary Team (MDT) working with GP and Medicine for the Elderly involvement.

An MDT will have representation from a range of Practitioners including OPCMHTs (Older People Community Mental Health Teams), AHPs, locality pharmacists, nurses, social work staff and/or voluntary sector staff as appropriate. The function of the MDT is to identify those at risk through regular MDT meetings and local knowledge, to appoint a named care coordinator who is known to patients and carers, promote Anticipatory Care Planning (ACP) and carry out Comprehensive Geriatric Assessment when required.

The presence of Medicine for the Elderly (MfE) Consultants in the community and as part of the MDT working with GPs is key to the success of any planned care model. We know that models from England which have evaluated successfully all followed a model of strong GP engagement; those that didn’t including Croydon have had to radically change their models.

Larger studies such as Torfaen in Wales have also evidenced that multidisciplinary assessment and co-ordination which includes MfE and GPs enable greater numbers of patients to be safely managed at home and when hospital care is required, the length of stay is reduced.

The crucial alignment of MfE Consultants to General Practice and localities requires both service redesign within managed services, and consistent effort by the partnerships to engage with GPs to test models that can demonstrate to them the worth of engagement and time in hosting regular meetings within the practice. The current workload within primary care makes it particularly challenging for practitioners to engage in tests of change and concerted effort is required to support this process. Successes have been based on the support provided by the MDT to managing complex patients and in particular in the development of care coordination by the district nurses attached to the projects and the work undertaken by locality pharmacists.

Progress in CHPs has been slowed by the inability to recruit MfE posts set alongside the growing demand for this specialist resource across the system.

Other medical specialties in the care of older people such as Psychiatry of Old Age have evolved over the years from an institutional long-stay facilities for older people with mental illnesses to the current mostly community based remit with the creation of Community Mental Health Teams for Older People including those with dementia. There is a longer tradition of joint working with primary care in community settings than has been the case with MfE physicians. Therefore, the forthcoming locality based changes in the provision of care for older people in Tayside will be an opportunity to align both specialties around GP practices.
Traditionally, District Nursing service delivery has been predominately reactive with very limited proactive work. Current evidence shows that if you can work with older people proactively through early intervention it improves their outcomes. DNs are highly skilled and best placed to take the lead and coordinate role in the care of older people. The forthcoming locality based changes creates the opportunity to maximise the added value of District Nursing.

2.1 Local Unscheduled Care Action Plan (LUCAP) in 2013-14

The Local Unscheduled Care Action Plan (LUCAP) in 2013-14 gave NHS Tayside the opportunity to manage the peaks in winter activity through developing Enhanced Community Support (ECS) to both enable early intervention and provide a resourced response to escalation of need. This enhanced support also facilitated timely discharge back into the community. The funding provided for this pilot created the capacity to facilitate multidisciplinary approaches to care coordination, delivery and early intervention in conjunction with General Practice and Medicine for the Elderly with input from Psychiatry of Old Age.

The pilot supported not only those patients who require a short term higher level of intervention to remain at home but also facilitate the discharge of medically and clinically stable patients from hospital to home (‘home’ includes where that is a Care Home). Any prolonged stay in hospital adds to the risk of functional and cognitive decline in the frail older person. The pilot was tested in the 4 highest admitting practices all with large populations of people over 65 years. These practices also had high numbers of care homes within the practice boundaries.

The ‘winter pilot’ was a unique approach to the delivery of increased winter capacity. Rather than opening surge beds, the opportunity was taken to test whether investment within the community to deliver this MDT model of enhanced support and early intervention, would reduce bed days used within Ninewells thereby releasing bed capacity.

One distinct difference to existing work within CHPs was the identification of a specific resource for GP input to the pilot. This was required as the enhanced element necessitated an increase in GP capacity to contribute to daily MDT members ‘huddles’, triage of daily house calls and weekly MDT meetings.

2.1.1 Outcomes from the Interim Report

An interim report to the Board on 5th March 2014 demonstrated a reduction in admission and length of stay (LOS) across the 4 Practices involved and an instruction to continue to pilot until October 31st 2014.

Data was provided by Tayside Centre for Clinical Effectiveness and the Business Unit. Interim results for the elderly population from the pilot practices included:

- Reduction in admissions by 12.2%
- Reduction in mean LOS by 26.2%
- Overall reduction in bed days per night of 18.9 per night.

And whole system impact

- Zero boarding in Wards 5 and 6 Ninewells (in comparison to same period last year with 273)

2.1.2 Outcomes from the final Evaluation
Sustainability is important and we need robust evaluation to enable us to decide where best to invest any funding to gain maximum effect. Full evaluation is underway and is being led by Dr Ellie Hothersall, Public Health Consultant. However, the following outcomes have already been confirmed:

- A total of 316 patients were seen by the Enhanced Community Support (ECS) project over the 4 months. The most common reasons for referral to the service were infection (26%) and falls (24%). Response times were generally swift, with 43% being seen the same day as referral, and 62% overall within 48 hours. The average duration was 11 days (per patient).

- During the project 218 patients were referred for Locality Pharmacist review; 60 patients were referred to social work; 7 were referred to the third sector and 93 were referred to AHPs.

- Emergency admissions were reduced by 8% in the ECS practices, compared with a rise of 10% for other GP practices in Dundee.

- Patient story examples

**Case history: Mrs S**

Mrs S lives alone and is normally very independent. She has a complex past medical history, and had fallen at home and suffered a hairline fracture of right scapula. She also seemed confused and unsteady. The family were concerned for her welfare and felt that she needed to be admitted to hospital for further investigation. The patient’s GP asked the ECS to do an initial assessment.

The Early Intervention Nurse (Locality District Nurse) and GP subsequently agreed with the family to keep Mrs S at home, with the input of 3 daily home visits from social care, a community alarm and key safe, and daily nursing visits. After 7 days the social care was able to be withdrawn.

Meanwhile, referral to OT meant that handrails were installed in the house, and an urgent review at RVH has ensured that appropriate further investigations were arranged on an outpatient basis, rather than requiring admission, but without compromising safety.
Evaluation demonstrates that both Patient and staff satisfaction was positive, this has been captured on a DVD.

2.1.3 Mitigating Factors

In comparison with 2012-13, the winter of 2013-14 had a lower burden of infectious disease in the community (specifically, significantly lower levels of influenza). There was also considerably less pressure on beds in Ninewells hospital due to Norovirus, compared with the same time period the year before. This in itself could have reduced the rate of hospital admissions, and length of stay. However, by measuring both admission rates and length of stay for the other practices in Dundee, we are more confident that the trend seen in ECS practices reflects a genuine improvement, as in every parameter measured the practices show a marked difference from the rest of the practices in Dundee, which admit to the same wards.

Case history: Mrs D

Mrs D lives with her husband in sheltered housing. They have no formal care. She had attended A&E two weeks previously and had been referred to the Locality Pharmacist via the Falls Trial (this means that anyone over 65 who attends A & E at Ninewells is triaged by a Physiotherapist and referred to the appropriate professional for follow-up in the community). In this case due to the regular medication which the patient was prescribed it was thought that a polypharmacy review was required as a priority.

After discussion at the Multidisciplinary meeting within the GP practice it was decided that an assessment at home by the Early Intervention (Locality DN) nurse would also benefit the patient. Physio was already visiting and had provided patient with a mobilator.

Following the assessment and with patient consent the following arrangements were made:

- Referral to Social Work for carers to assist with personal care.
- Analgesia was reviewed and patients’ understanding of new regime confirmed.
- Referral to OT for assessment of bathroom area.
- Liaison with GP re patient’s circumstances and blood samples taken as requested.

Following these interventions both patient and carer stress has been reduced. The intervention is currently still in place.

“Everyone [on the nursing side] tries to go to all the meetings [MDTs], to get extra information and learning. All nurses feel their skills and knowledge have been improved. When team members discuss going back to traditional District Nursing roles, they feel they will carry this skill and knowledge with them”.

Social work: “I think that one of the reasons why the pilot has worked well is the link between the social care team and the nurses, and I think we should be doing more in order to replicate this across other areas”.

"Everyone [on the nursing side] tries to go to all the meetings [MDTs], to get extra information and learning. All nurses feel their skills and knowledge have been improved. When team members discuss going back to traditional District Nursing roles, they feel they will carry this skill and knowledge with them".
2.1.4 Outcomes from the Lochleven Care Home Project – Winter Plan

As part of the LUCAP winter plan project, a specific intervention was put in place to review all patients within Lochleven Care Home. This 100 bed Care Home sits within the locality of the 3/4 GP practices and only has one wing (25 residents) covered by a dedicated GP practice. An MfE Consultant, Locality Pharmacist and a supporting MDT team jointly reviewed all willing residents along with Care Home staff.

By the end of March 2014

- The pharmacy team reviewed 90 residents at MDT meetings - patients and relatives also invited.
- The team identified and recommended medication changes in most patients, ranging from 1-6 recommended changes per patient, with a median of 3.

Summary of outcomes

- Significant changes in prescribing
- Process and paperwork developed and ready for rollout
- Only 38/86 (44%) of residents had a summary on eKIS; information sometimes incorrect – at the end of the project all residents had their ACPs reviewed
- Quality of ACP’s done outwith the MDT team is suboptimal

3 AREAS FOR FOCUS (Appendix 1: Action Plan)

3.1 Understanding the Scope of Change

The principles of delivering a new model of care for older people in Tayside are based upon continuity of care enabled across the community and in and out of any required (planned) hospital stay.

It is recognised that General Practice is a universal service accessed by all; as such it can act as a gatekeeper to care. Contact with General Practice is a constant in most people’s lives. GPs hold the most complete and comprehensive medical record.

General Practice and other health and care services for older people have evolved in a reactive and disjointed fashion to cope with the needs of older people. However, none of these services were designed to manage the increasingly ageing population and their complex co-morbidities. Therefore, it is essential that older people have access to the expertise of Medicine for the Elderly both on an inpatient and outpatient basis. It is recognised that a Comprehensive Geriatric Assessment does not require to take place in a hospital setting Conroy et al Age and Ageing (2014).

By establishing a locality or community focus we aim to transform the traditional medical model into a comprehensive MDT bio-psycho-social model of care. This model will deliver a holistic approach that will meet the needs of the population as they go through the ageing process. Wherever possible, this same team will assess and deliver care, following the patient into hospital and home where this is required, and thus provide continuity of care which is person-centred.
3.2 Reducing Variation in Service Delivery

3.2.1 Clinical Standards Setting

NHS Tayside OPB’s Term of Reference highlights that one of its remits is to “establish, embed and measure a core set of minimum clinical standards and competencies required across the whole system pathway. To create a person – centred care system where older people and their carers are enabled to make decisions about service improvement.”

To reduce variation and assure equity of the quality of care being delivered across Tayside, whilst acknowledging the local needs, a minimum set of clinical standards in older people’s care pathways needs to be implemented. An example of a set of process standards that have been agreed pan-Tayside by the MfE medical teams are listed below:

Locality working

- MfE services across Tayside will provide input into the care of older people in the community
- MfE Consultant will be aligned to defined groups of GP practices to provide geographically-based community services. This may also include aligning with community hospitals and care homes.
- The priority areas will be the establishment of liaison services to care homes, polypharmacy clinics, admission prevention and development of alternative models of community-based care, MDT working with GP practices and input into GP run community hospitals.

Clinics and Day Hospitals

- All services will provide an out-patient service including as a minimum: General MFE clinics, Parkinson's disease and Falls clinics.
- All services need to provide an urgent "emergency access" service to support admission prevention.
- No waiting time for a non-urgent review should exceed 6 weeks
- Emergency access referrals will be seen on the same day or next working day

Rehabilitation and Step-down services

- All older patients whose predicted hospital stay, following MDT assessment, exceeds 7 days will have access to a rehabilitation / step-down service.
- The focus of these services will be on rehabilitation, but may also include transitional and palliative care.
- All services will aim for a mean length of stay of 21 days to ensure services are used optimally and to facilitate patient flow from acute beds.
- To optimise the use of consultant time, and care continuity, patients will ideally remain under the admitting consultant after transfer.
- All patients going to 24 hour care should have Anticipatory Care plan and DNA CPR (if appropriate) in place.
The OP Joint Clinical Forum members are currently working on the clinical standards of three priority clinical pathways:

- Delirium
- Dementia Diagnosis
- Frailty

### 3.2.2 Workforce Requirements

The ECS winter pilot demonstrated that at an operational level each partnership area requires to deliver services to their distinct localities within the parameters of Local Authority boundaries, systems of working and within available resources. However, the OPB would wish to promote standards of care that provide continuity of access and service to older people wherever they live for all elements of Early Intervention and Enhanced Community Support. This should be delivered in a locality model and will include:

- **Standardised General Practitioner model of support governed by Service Level Agreements**
  
  This will include a salaried model of GP aligned to each locality based upon population need who will work closely with MfE and POA teams.

- **Agreed standardised Locality MfE medical model**
  
  This will include dedicated PAs to each locality with hours attached to provide input to both MDT meetings and to care homes work. Consultant will be linked by name to each care home.

- **Agreed standardised Locality Psychiatry of Old Age medical model**
  
  This will include dedicated PAs to each locality with hours attached to provide input to both MDT meetings and to Care Homes work. Consultant will be linked by name to each care home in the first instance with dedicated liaison or CMHT members aligned to specific care homes.

- **Standardised models of District Nursing**
  
  Each locality will have a named Locality or Early Intervention District Nurse(s) who works across an area or cluster of GP practices and coordinates care.

- **AHP**
  
  Each locality will have a named AHP lead(s) who works across an area or cluster of GP practices and coordinates care.

- **Locality Pharmacy**
  
  Each locality will have Pharmacists, including specialist MfE Pharmacists, who work across an area or cluster of GP practices. Each MfE consultant will oversee the care of the frail older person in clinics and through any admission and discharge process, following the patient's journey through in-patient and community settings. Each locality will have access to Advance Practitioners, Specialist Nurses, Specialist AHPs and Specialist Pharmacy support.
3.4 Measuring Impact and Enhancing the Patient Experience

Work is currently underway to create a performance assurance framework that will measure patient and carer outcomes as evidence of reliable high quality care provision. This work is closely linked to the creation of an integrated clinical and care governance framework that will future proof these outcome measures for health and social care integrated services.

Listed below are some of the LUCAP measures that may be considered:

- Impact

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data sources</th>
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<tbody>
<tr>
<td><strong>Improvement Measures: Process measure (PM)</strong></td>
<td>Outcome measure (OM)</td>
</tr>
<tr>
<td>(PM) Reduce the number of unscheduled admissions, from the practice population, to Ninewells Hospital</td>
<td>TOPAS – Business Unit</td>
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<tr>
<td>(PM) Reduction in the number of delayed discharges</td>
<td>EDISON – Business Unit</td>
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<td>(PM) Reduction emergency average length of stay</td>
<td>TOPAS – Business Unit</td>
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<tr>
<td>(OM) Improve patient and carer experience</td>
<td>Patient stories, questionnaire</td>
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<td>(OM) Improve staff experience</td>
<td>Questionnaire, interviews</td>
</tr>
<tr>
<td>(OM) Number of people diagnosed with dementia (HEAT standard)</td>
<td>Monthly data available</td>
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<tr>
<td>(OM) Number of people with dementia receiving Postdiagnostic support (HEAT Target)</td>
<td>Monthly data available</td>
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<td><strong>Proposed Balancing Measures:</strong></td>
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<tr>
<td>(BM) Reduction in the number or readmissions within 30 days of admission</td>
<td>TOPAS – Business Unit</td>
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<tr>
<td>(BM) Duration of GP domiciliary visit</td>
<td>Not captured in data</td>
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<tr>
<td>(BM) Impact on other services e.g. AHP’s, community nursing, local authority care packages</td>
<td>Data collected by services through project. Additional information provided through TOPAS</td>
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<tr>
<td>(PM) Decrease moves within care settings</td>
<td>Requires to be confirmed</td>
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<tr>
<td>(PM) decrease use and increase review of Antipsychotics in people with dementia in care homes</td>
<td>Data captured by services and pharmacy</td>
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<tr>
<td><strong>Operational measures</strong></td>
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<tr>
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<td>Response times</td>
<td>Collected in real time by project team</td>
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<td>Patient-facing time</td>
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<td>Duration of ECS intervention</td>
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<td>Admissions to care homes: both emergency and overall</td>
<td>Social work data/Business Support Unit</td>
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<td>Polypharmacy reviews</td>
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<td>Pharmacy data</td>
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<td>Voluntary service referrals/utilisation</td>
<td>Collected in real time by project team</td>
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<tr>
<td>Comparison activity: both with other areas of Tayside, and with previous year’s data</td>
<td>TOPAS – Business Unit</td>
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• Patient experience

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<tr>
<th>Data</th>
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<tr>
<td>Patient and carer perspective</td>
<td>Qualitative interviews, patient narratives collected</td>
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<td>Perspective of staff</td>
<td>Qualitative interviews, focus group meetings, collection of ad hoc messages</td>
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<tr>
<td>Financial impact</td>
<td>Actual spend from Finance department. Other costs obtained direct from relevant departments</td>
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3.5 Population targets and roll out plans

The ECS project focused on practice populations with large numbers of older people, heavy usage of services, both health and local authorities, and high admission rates. As work progresses through the Integration agenda the OPB will ensure that roll out is:

- Based in defined localities which each partnership is signed up to
- Focuses within these on localities on greatest need and where admission rates are high
- Takes account of deprivation when factoring the age of a population (die younger)
- Takes account of available staffing resource
- Focused on GP practices who are willing to engage, and learn from each experience

When rolling out ECS the OPB would wish to ensure that the focus remains on patient-centred care and the team composition will reflect this. Improvement Methodology tells us that where a project so clearly depends on the personalities within a team, there is a concern that extending the remit will result in a dilution of effect, or “mission creep”, where teams created later do not operate in the same way or within quite the same parameters as the original. This consequently means that the original effect seen is also likely to be diminished.

To mitigate this risk, the OPB will provide leadership and a reporting structure through the establishment of:

- Tayside Joint Operational Group chaired by a Lead Officer
- Locality Operational Groups with project leads reporting to Tayside Group

3.6 Areas of Work Which are Important to This Programme of Work

- The Health and Social Care integration agenda
- ehealth development
- ACP sharing across I-T systems
- Mobile health applications – test for MiDis users underway in Tayside
- GP remote access to VISION/EMIS in Care Homes
- GMS Contract
- Steps to Better Care Projects: Chronic Pain Services; Mental Health Review
- NHS Tayside Shaping Surgical Services
- Transforming Out Patients Services
- Post Diagnostic support for Dementia and Dementia Standards
- NHS Tayside Palliative Care
- NHS Tayside Psychiatry of Old Age Subgroup (within OP Joint Clinical Forum), including Review of Psychological Therapies for Older People
- Transforming District Nursing
4 ASSESSMENT OF WHAT IS NEEDED

This work needs to be aligned to health and social care Integration agenda and transition plans.

We require to reframe the culture and organisational structure so that specialist services for frail older people in the community are the norm.

We require to acknowledge that NHS Tayside Older Peoples Board is central to the clinical strategy aligning with commissioning processes.

We will focus on the creation of locality clusters focussing on 25-30,000 population (see attached diagram “Proposed Locality Plus”).

We will recognise that clusters must suit local need, and recognise acuity of those populations served ie increased numbers of Care Homes clustered around a particular locality or high referring practices.

We will continue to test the models to ascertain the optimal model, create clinical and patient buy in and demonstrate effectiveness.

5 RECOMMENDATIONS

5.1. From the LUCAP evaluation

Ensure realistic primary care funding follows. The considerable savings realised through the winter plan need to be reflected in a realistic reallocation to primary care, acknowledging that the success of the project hinges on the relationships between the health and social care teams and the requirement to appoint to posts on a permanent basis.

Ensure that the focus remains on patient-centred care and the team composition reflects this. Promoting self care and self management are important as is the need to identify and support carers and develop community resilience.

Expand the contribution of the Third sector. One of the aims of the winter project was to explore the extent of third sector involvement in this area, and to identify ways to increase this in the future. It is apparent that there is currently very low use of the third sector (two referrals in four months), and thus there is considerable opportunity to widen the scope. This may involve ‘Home from Hospital’ support.

Continue evaluation of this work. Usage, referrals and discharge rates, admissions and occupied bed days (both total numbers and unscheduled ones) should be reported quarterly to the Older People’s Board, who will innovate and govern the future of this work.

5.2 Further recommendations

- EMT to endorse and support the programme of work outlined in this paper to transform the model of care for older people in Tayside.

- EMT are asked to provide any additional organisational knowledge that can impact on this programme of work.

- EMT are asked to continue to support the pan-Tayside role of the OPB by highlighting local programmes of work that could impact/interface with this transformation.
6 REPORT SIGN OFF

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19 May 2014