PE1710/E
Health and Social Care Scotland submission of 22 October 2019

The shape of Scottish society and the health and care needs of our communities is changing. People are living longer, healthier lives but there are also growing numbers of people who have complex care requirements. As the needs of our society changes, so too must the nature and form of our public services.

Public Bodies (Joint Working) (Scotland) Act 2014 changed the way in which health and social care services are planned and delivered across Scotland. Local authorities and health boards are required by law to work together (in health and social care partnerships) to plan and deliver adult community health and social care services, including services for older people – health and social care integration.

The purpose of health and social care integration is to transform people's experience of care and the outcomes they experience. This is necessary because when services are planned and delivered together, closer co-ordination will enable the fundamental changes in care models required to keep pace with people's changing needs.

Responsibility for the planning of services to meet the needs of local communities rests with integration authorities across Scotland. Each integration authority directs their health and social care partnership (HSCP) to deliver services in their local communities. Differing demographics and differing needs across Scotland leads to different responses to ensuring people receive the right care, in the right place, at the right time – in their own home or homely setting, in their local community, where possible.

We have therefore supplied individual responses to the petition from the following health and social care partnerships:

- Aberdeenshire HSCP
- Aberdeen City HSCP
- Angus HSCP
- East Ayrshire HSCP
- East Renfrewshire HSCP
- Falkirk HSCP
- North Ayrshire HSCP
- Perth & Kinross HSCP

Health and Social Care Scotland is a national collaboration through which those who lead change within health and social care partnerships can come together to learn from each other, work collectively and support one another to deliver better health and wellbeing outcomes for the people of Scotland.

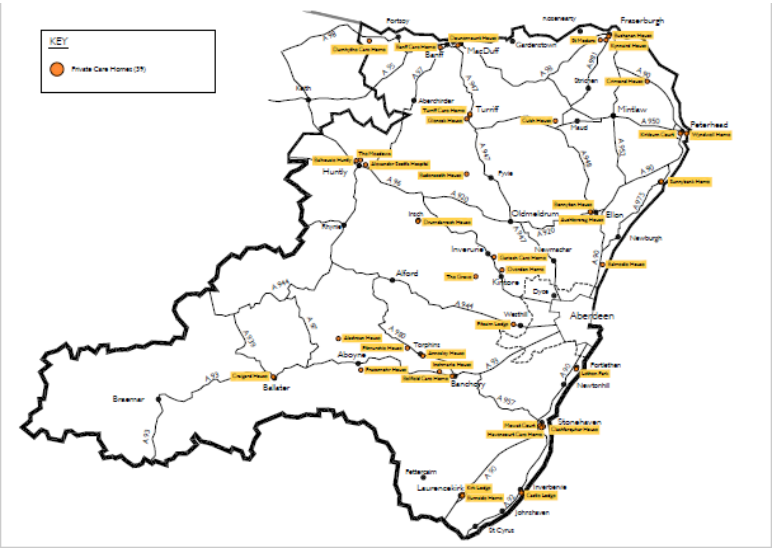
We represent 31 health and social care partnerships in Scotland.

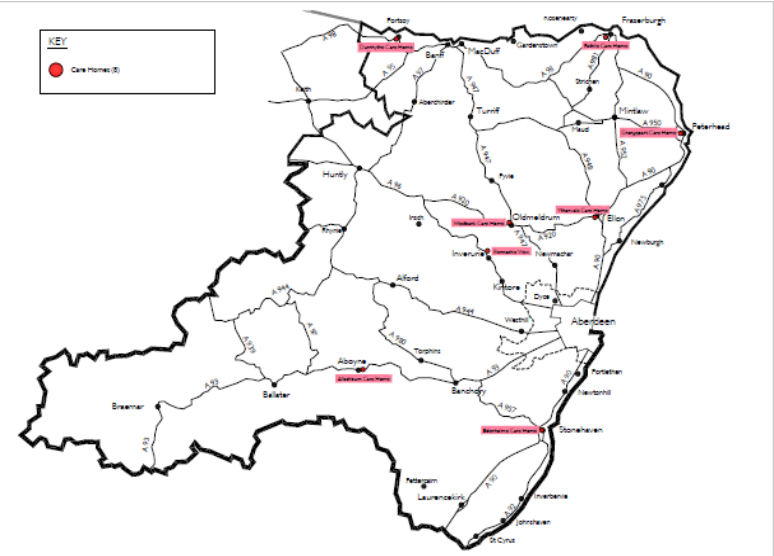
Response from Aberdeenshire HSCP:

Services in Aberdeenshire take a 'Home First' approach to assessing and providing care, in line with Scottish Government direction. However, when assessment indicates that risks to the person cannot be mitigated and their needs cannot be met safely at home, health and social care staff work in partnership with the person and their family to identify other suitable options in their community, or the community of their choice. The options available in Aberdeenshire include housing with support, care homes and community hospital services. This response focuses on the latter two options.

Community hospitals in Aberdeenshire provide a step-up and step-down service with the aim of preventing unnecessary admission to, and facilitating early discharge from, secondary hospital care. There are 11 community hospitals in Aberdeenshire, and community hospital provision in each of our six localities.

Care home provision in Aberdeenshire includes both residential and nursing care, with a mix of direct provision by the Health & Social Care Partnership and commissioned independent sector provision. The majority of the total 1727 care home places for older people in Aberdeenshire are provided by the independent sector:





- There are 36 independent sector care homes, registered to provide 1429 places, representing 83% of the Aberdeenshire Care Home market. *Figure 1 (left) shows their location.*
- The remaining 298 registered care home places are provided directly by Aberdeenshire Health & Social Care Partnership from 8 care homes. This represents 17% of the care home market. *Figure 2 shows the location of our in-house care homes.*

The population of Aberdeenshire is projected to increase in future, with the highest proportional increase in those aged over 65. Prevention, early intervention, rehabilitation and enablement are priorities for the health and social care partnership with the aim of enabling people to retain and regain their health, wellbeing and independence for as long as possible. Community hospitals and intermediate care beds in local care homes play a key role in delivering these priorities. However, the impact of these approaches on demand for permanent care home places cannot be accurately quantified at this time and the IJB recognises there may still be a need for additional care home provision in the area to meet the needs of an increased population in future. Officers from the health and social care partnership are actively reviewing and planning for the future of our community hospital and care home services. Development of a 60 bed health and social care partnership care home is at planning stage.

Aberdeenshire Integration Joint Board (IJB) agree with the petitioner that community hospitals and care homes play an important role in the care landscape for older people and those living with long term conditions.

However, given that the responsibility for the planning and delivery of services to meet the needs of local communities rests with Integration Joint Board, and we are actively engaged in the review and planning of community hospital and care home services at present, Aberdeenshire Integration Joint Board are unsure that there is any benefit in requesting that the Scottish Government review Scotland-wide.

From Aberdeen City HSCP:

Aberdeen City has no community hospitals (in the sense we understand the petitioner is referring to) and has no Council run care homes. We have responded in respect of community care provision in general and in relation to care provided in care homes commissioned by Aberdeen City Health and Social Care Partnership.

In terms of care home provision in Aberdeen, we are operating at almost maximum capacity. We have had three home closures in the last 3 years and the fragility of the care home market is on our strategic risk register. Aberdeen City is not an easy place for independent providers to set up and run care homes. Property costs are high and staff recruitment and retention is challenging. With our changing demographics and increasing demand we know that the care home market is not going to be able to provide a long term solution to the care needs of our increasingly older population with more complex health needs.

In Aberdeen City we have reduced our delayed discharge bed days by 75% in the last 4 years – from 4,203 (June 2015) to 1,066 (June 2019) by using the Home First approach and by utilising a range of measures including interim care home beds and housing. Our revamped care at home framework has also helped increase service availability and therefore reduced the number of people waiting for a care at home package to be put in place. In the main, our current delays are those requiring complex care packages – particularly those with learning disabilities, and mental health and substance misuse issues, including those with incapacity where the necessary legal proxy decision-making arrangements have not been put in place. We have made limited progress in relation to increasing awareness of the value of early arrangement of Power of Attorney or Guardianship by participating in a national media campaign and undertaking refresher training for staff, however this still remains an issue. The length of time and cost, related to putting such arrangements in place, are major considerations.

In relation to care in the community, one size definitely does not fit all – a range of support needs to be offered. With the introduction of Self Directed Support legislation, people have the right to choose how they want their care to be provided and to be fully involved in those arrangements. The care required is more complex, more expensive and unsustainable in the long term. It's a challenge, and it's not easy, but at the forefront of every decision in relation to care, alongside what is the best care provision to meet someone's needs, is the safety of the individual. Aberdeen City Health and Social Care Partnership is using outcomes focused commissioning approach to re-balance care provision. Our care homes are being asked to meet the most complex and challenging care needs and our Care at Home Framework is being redesigned to encompass a range of levels of care needs with a move away from the traditional time and task towards more flexible, outcomes based funding. In addition we are fostering improved working relationships with health and social care providers to better understand the challenges they face and work together to identify solutions. Our care homes can be creative, interesting and fun places. We have examples of community and intergenerational activity whereby school children and care home residents jointly

undertake activities such as gardening, games, coffee mornings, education in technology etc.

Our Strategic Plan has five aims: prevention, resilience, personalisation, connections and communities. We are undertaking a major and radical re think of the way care is provided with a view to improving outcomes for people through a greater use of personal and community assets in addition to traditional care, and an increased use of technology to connect people both socially and for care provision. In Aberdeen we are very aware of the issue of isolation. We would highlight that isolation is probably a more real danger for those not in receipt of care and this is where our prevention, resilience, connections and communities agendas would come into play.

As a community, health and social care partnerships work together to learn from each other. In Aberdeen City we are certainly willing to share any of our successes to benefit others and have many examples of learning from others.

From Angus HSCP:

The Angus Strategic Plan makes a commitment to shift the balance of care. It calls for healthcare to extend beyond the traditional setting of hospitals and reach more effectively into a person's own home and community. Enhanced Community Support (ECS) is a term used to describe the locality model of care for frail elderly adults within Angus. This is centred around a multi-disciplinary team within General Practice. This is now implemented in all areas of Angus. All areas have functioning teams and the outcomes in terms of reduction in bed days throughout Angus provides evidence that this model is effective in managing patients within the community rather than hospital.

ECS includes a locality geriatrician model where each of the four Angus localities had an aligned geriatrician, with geriatricians attending primary care multi-disciplinary meetings for every Angus practice. This model is well embedded with strong primary/secondary care relationships with Medicine for the Elderly (MFE). The same MFE staff also work within the Acute Frailty Team in-reaching into hospital so there is continuity of care across the primary/secondary care interface.

With strong community and staff engagement, we undertook a review of our community based inpatient care in 2017. We reduced the number of psychiatry of old age beds from 42 to 35 and the number of medicine for the elderly beds has reduced from 74 to 60. The number of stroke rehabilitation beds remains unchanged at 10.

We are currently reviewing the discharge pathway for people with dementia who experience stress and distress.

People within Angus have access to a wide range of community-based services including three hospitals with inpatient beds at:

- Arbroath Infirmary (Medicine for the Elderly)
- Stracathro Hospital, by Brechin (Medicine for the Elderly, Stroke Rehabilitation and Psychiatry of Old Age)
- Whitehills Health and Community Care Centre in Forfar (Medicine for the Elderly, Stroke Rehabilitation and Psychiatry of Old Age)

Community hospitals in Angus provide a step-down service with the aim of facilitating early discharge from secondary hospital care.

Care home provision in Angus includes both residential and nursing care, with a mix of direct provision by Angus Health and Social Care Partnership and commissioned independent sector provision. 80 residential care home beds are provided directly by Angus Health and Social Care Partnership with the majority of the total of 1000 care home places for older people in Angus being provided by the independent sector. We are currently undertaking a review of care home provision across Angus.

As Angus HSCP is already actively involved in the review and planning of community hospital and care home services we are unsure that there is any benefit in requesting that the Scottish Government review Scotland-wide.

From East Ayrshire HSCP:

It is vitally important in East Ayrshire that our communities are afforded opportunities to participate in engagement and consultation events to help define our strategic direction. These events have provided real clarity that our residents have a strong preference for their care to be provided in their own homes where appropriate, to have opportunities to maximise their independence and only provide care in other facilities when people's needs cannot be supported at home.

Our local communities and our national strategies have also informed us that people wish only to be in hospital when it is clinically indicated and they wish to return home as promptly as possible. This has allowed us to develop a mixed model of care where care at home is supported without delay and meets the assessed needs of the person in receipt of services and their carers.

We took a strategic decision to move out of direct delivery of care home provision following a Best Value Review of Residential Services for Older People 2004–05.

Following this the strategic direction for support for older people was set including the development of community-based supports and supported accommodation (2006–11). This approach was shaped by elected members and community engagement. Plans continued to evolve through Reshaping Care for Older People (2011–14) and the Integrated Care Fund (2015–18). East Ayrshire has not delivered care home services in Council run facilities since 2007 and the prioritisation of community direct delivery was based on investment in local resource centres, housing options and intermediate care and reablement development in care at home.

Given the reduction in number of people receiving care in residential settings we continue to promote our strategic commissioning framework as the most effective model of purchasing this type of care as and when required. We commission this care in all of our localities to ensure, wherever possible that people can remain in their own communities and have sound contract monitoring arrangements in place to support quality provision.

We have bespoke arrangements for palliative care, end of life care and for adults with incapacity within our care home sector, which is committed to providing more than an alternative roof with examples such as promoting exercise through CAPA, structured activities, regular outings for residents and encouraging strong links with family and the surrounding communities.

A recent thematic inspection noted the significant progress in East Ayrshire in identifying and supporting personal outcomes across our communities through Self-Directed Support (SDS). East Ayrshire Health and Social Care Partnership's recognition of the key contribution technology enabled care helps to provide good outcomes and improve independence for a significant number of people.

Across all partners in East Ayrshire there has been a strong commitment to SDS and positive practice and relationships focused on person centred planning. These all have a central theme of supporting people in their own homes and where hospital care is required that we endeavour to enable people to return home as quickly as possible.

For people with complex needs who are unable to return home and who require a care home setting we adopt a person-centred approach and endeavour to facilitate a move to the care home of their choice. Within our hospital settings we promote a system of early referral in order that Partnership staff can start the assessment process prior to the individual being deemed medically fit for discharge. A further downstream transfer to a community hospital is only considered if there are rehabilitative considerations that cannot be provided in the person's own home. As a result unnecessary delays in hospital discharge arrangements are avoided and people are supported to leave hospital in a safe and timely manner.

We have no one waiting for a care home or delayed in hospital or at home waiting for services.

East Ayrshire Community Hospital is a valuable asset in our community providing a broad range of services and patient pathways where step down from acute hospital care or step up from the community is deemed necessary. We have a range of day attendance and outpatients with nurse and allied health professional (AHP) led pathways continuing to expand and have recently implemented pathways for palliative care, rehabilitation and end of life care.

The hospital is a vital community hub for many other services delivered locally and provides shared flexible space for many third and independent sector services. This whole system approach optimises our potential to deliver a responsive service to support people to live longer, healthier lives closer to home.

In October 2019, our communities will come together to look ahead to consider how we should design and deliver services for the next 5 and 10 years and beyond and ensure we continue to hear and meet the needs of our communities.

On this basis the concerns raised in the petition do not directly affect the provision of care in East Ayrshire.

From East Renfrewshire HSCP:

We agree with the core principles set out in the Scottish Government 'Hospital Based Complex Clinical Care' guidance:

- As far as possible hospitals should not be places where people live, even for people with ongoing clinical need
- When someone is living in the community it is not the role of the NHS to pay for accommodation and living costs (except specific short term, time limited episodes of care, e.g. NHS respite, intermediate care)
- This reform of NHS Continuing Care contributes to the realisation of the 20:20 vision with the NHS building healthcare support around the individual, in the community, through the work of Health and Social Care Partnerships
- More people with ongoing clinical needs should be cared for in the community, with services commissioned to provide this

Across NHS Greater Glasgow & Clyde (NHSGGC), our shared 'Moving Forward Together' Programme is designed to:

- Support and empower people to improve their own health
- Support people to live independently at home for longer
- Empower and support people to manage their own long term conditions
- Enable people to stay in their communities accessing the care they need
- Enable people to access high quality primary and community care services close to home
- Provide access to world class hospital based care when the required level of care or treatment cannot be provided in the community
- Deliver hospital care on an ambulatory or day case basis whenever possible
- Provide highly specialist hospital services for the people of Greater Glasgow and Clyde and for some services, in the West of Scotland

As stated in our Strategic Plan for East Renfrewshire, our aim will always be to return people home as quickly as possible and to support people at home wherever possible.

We recognise that sometimes people require additional support and we are developing our residential care home, Bonnyton House, using six beds as an intensive rehabilitation resource to prevent hospital admission and to ensure a safe return home for people discharged from hospital. Following refurbishment, we will create a further six beds so people who need end of life care, who can't be supported to die at home, could also be supported at Bonnyton House.

To fund this and in line with the NHS Complex Care Guidance, our Integration Joint Board (IJB) directed NHSGGC to decommission Mearnskirk House (an NHS continuing care facility in East Renfrewshire). We worked with colleagues from acute services and south Glasgow Health and Social Care Partnerships to find alternative arrangements for the few patients who remained in the facility, which closed earlier this year.

From Falkirk HSCP:

The difference between hospital care and residential care must be made clear and defined to ensure clarity of response.

Hospitals are clinical care facilities, where people are under the direct care of a named medical practitioner, supported by nursing and allied health professional (AHP) staff. The environment is subject to HEI standards and tends not to be “homely”. There is little scope for promoting independence and prolonged stays are now recognised as being harmful to long term outcomes for people. There is little privacy. A stay in hospital is not subject to a financial assessment and is free at the point of delivery.

Residential care is considered a person’s residence or home, is encouraged to be a homely environment and promotes a more individual and person centred ethos. Independence is promoted and individual bedrooms allow greater privacy and dignity. Placement in a residential care home is subject to a financial assessment and will incur a cost above a threshold. Care homes are subject to Care Inspection standards.

People should not be in community hospitals when they no longer require medical care and are reported as ‘delayed discharges’. The focus should be on the provision of intermediate care and community care rather than hospital care.

The principle of caring for people in their own homes, when it is possible to do so is correct. Institutional care should be the last choice when home has proved not viable or unsustainable. It should be in agreement with the person, when possible.

With the advancement of the provision of care in the community through the development of advanced practice community nursing roles, occupational therapy, physiotherapy, reablement approach in homecare, and community teams working in an integrated way, the requirement for community/cottage hospitals and care home placements has reduced. Advances in medicines and technology have also helped support people to stay at home, impacting on the need for ‘institutional beds’.

Many of the community/cottage hospitals and council care homes in Scotland are housed in old buildings which are no longer conducive to 21st century care. It is prudent for Health Boards and HSCPS’s to work with communities to develop plans to close these facilities and invest in community care.

From North Ayrshire HSCP:

North Ayrshire Health and Social Care Partnership would welcome the proposed review, which will assist us in ensuring the care and support we are offering is appropriate to the changing needs of our elderly population and those with long term conditions.

Our view is cohesively in line with the Scottish Government, as our strategic plan states we should aim for people to live in their own homes/communities for as long as possible.

Provision available in North Ayrshire for people in the community, includes:

- Care at home
- District nursing and primary care services
- Locality teams
- Dementia support service
- Memory cafes
- Community mental health teams
- Day services
- Community hubs offering a range of activities based within sheltered housing units
- Sensory impairment teams
- Telecare
- Health and therapy teams
- Enhanced intermediate care team
- Falls service
- Head injury unit

We have 19 independent sector care homes across North Ayrshire (including Arran). Additionally, on Arran, we have a 30 bed residential care home operated by the HSCP. North Ayrshire also has a dementia respite unit in Kilbirnie.

Provision available for people in North Ayrshire who live in a care home setting:

- A range of allied health professional services, including physiotherapy, occupational therapy, speech and language and dietetics
- Mental health care home liaison service

Training is provided for care home staff across North Ayrshire, to ensure staff can meet people's changing needs.

From Perth & Kinross HSCP:

Since the Integration Joint Board (IJB) was established (2016), it has been focused on integrating health and social care for the people residing within Perth & Kinross to ensure that people have equal access to quality care at the right time, by the right person and in the right place. We work collaboratively with our partner organisations NHS Tayside and Perth & Kinross Council, as well as independent and third sector care providers, and more importantly with those we support and their carers.

We are committed to ensuring that the services we provide and / or commission have a positive impact on outcomes for people living in our communities. We want to enable people living in Perth & Kinross to lead healthy and active lives so as to live independently as long as possible with choice and control over the decisions they make about their care and support.

However, like other integration authorities across Scotland, we are operating within an increasingly challenging financial environment with an ever growing older population who will be living in the future with more complex care needs. We have made a commitment within our Strategic Commissioning and 3 year Financial Plan to transform services, moving more towards early intervention, preventative approaches to care so as to meet this increasing demand for our services and to ensure sustainable health and care services.

In Perth & Kinross we offer a range of services dependent on the assessed need of an individual. Sometimes these services may not be based as close to an individual's home or where there is most demand, as we would like. We are therefore undertaking a review of our health and care services which includes 68 inpatient rehabilitation beds provided from four community hospitals and a Medicine from the Elderly Unit in Perth Royal Infirmary. This will ensure we have the right number of beds in the areas with most demand to ensure equity of access.

Alongside this review, the Partnership is investing significantly into enhancing health and care community services to deliver earlier intervention and prevention approaches of care so as to be able to respond to people who are frail and deteriorating in the community and offer support at home, if this is the best care for them.

The Partnership has access to 46 Council residential care home beds, which are managed by the Partnership. In addition, there are around 1,300 private sector care home beds, from which the Partnership can commission. These care home beds offer a range of care such as long term, stepdown, step-up and respite care. Two new care homes are being built (financed by the private sector) adding an additional 150 beds into Perth & Kinross. The Partnership has commenced discussions with the owners of the care homes to identify further alternative options to provision of care.

We continue to work with our independent and third sector colleagues, as well as local people and community groups, to further develop a range of lower level supports to improve health and wellbeing and reduce social isolation.

The services provided in Perth & Kinross will continue to be safe, effective and efficient, based on an individual's assessed needs.