Item 5.3

Report

Capacity & Demand

Edinburgh Integration Joint Board

15 July 2016

1. Executive Summary

1.1 The purpose of this report is to update the Edinburgh Integration Joint Board, on the background context for a whole system capacity and demand review for older people to be undertaken, and to outline the approach for taking this forward.

2. Recommendations

2.1 To accept the report as assurance that the Edinburgh Health & Social Care Partnership (EHSCP), is taking a whole system approach to improve the effective use of resources to improve pathways for people.

2.2 To accept that the Phase 3 Business case proposals for change will go to the Strategic Planning Group and/or the Professional Advisory Group in the first instance, and to the IJB by exception.

3. Background

3.1 Edinburgh's Joint Commissioning Plan for Older People 2012-22, *Live Well in Later Life* 2012 -22 clearly highlights the case for change in the range of functions that require to be developed going forward, to respond to the changing needs, and growth of the population. In particular, the number of people in Edinburgh in the 85+ age group is expected to almost double by 2032, from 11,040 in 2012, to 19,294.

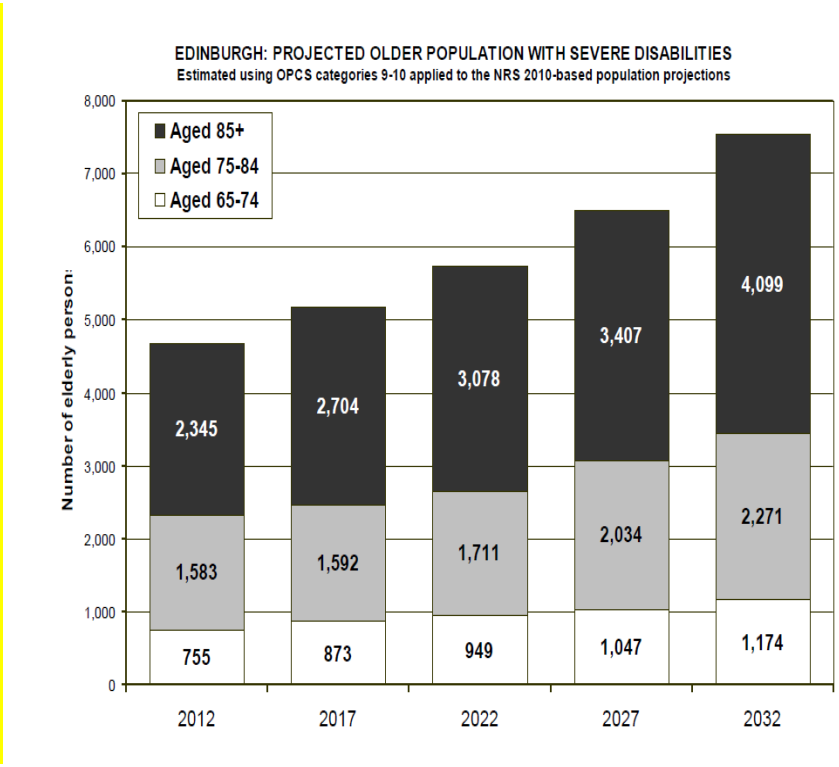
3.2 The 2012 Live Well in Later Life plan concluded that the following changes were required to meet the demands going forward**, if existing levels of service was directly matched to population growth, and no changes to the models of care were delivered**, by 2022, Edinburgh would need to provide:

- 428,000 additional hours of home care per year
- 748 additional care home beds

- 7,900 additional intermediate care hours per year
- 150 additional long stay hospital beds for older people (inpatient complex care beds).

3.3 This picture forms the key basis for change as we move forward.

3.4 Although healthy life expectancy is growing, and many advances are being made in order that older people remain healthier for longer, at home, or in a homely setting, as key assets not only in their own self management, but as providers of care and support for others, the level of older people who have severe disabilities in Edinburgh, is set to grow too between 2012 and 2032, as the chart below indicates:



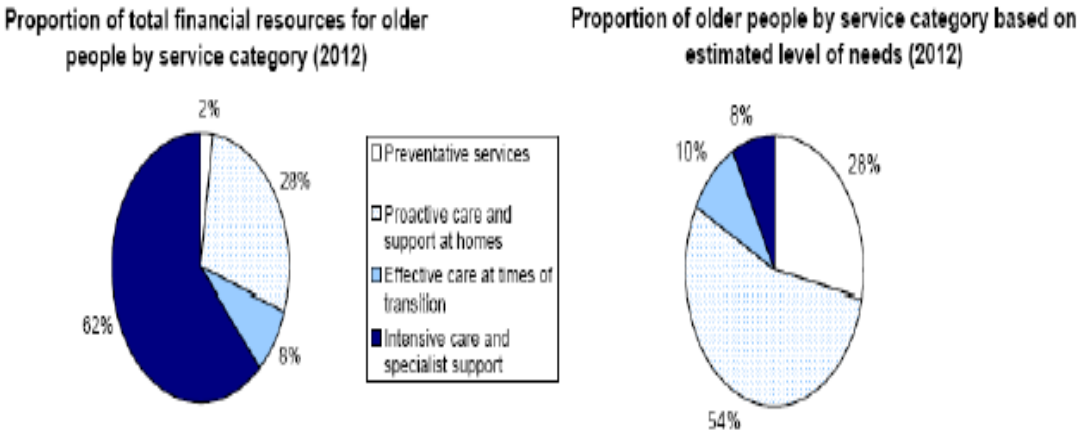
OPCS – Office of Population Censuses and Surveys - supports operational and strategic planning, resource utilisation, performance management, research and epidemiology

3.5 By 2022, it is estimated that the number of people in Edinburgh with dementia is likely to rise by 22.4% to 8,745 people and by 2032, the number could rise by 61.7% to 11,548 people. Of these, 1 in 8 (12.5%) have severe dementia; 1 in 3 (32.1%) have moderate dementia and just over half (55.4%) have mild dementia.

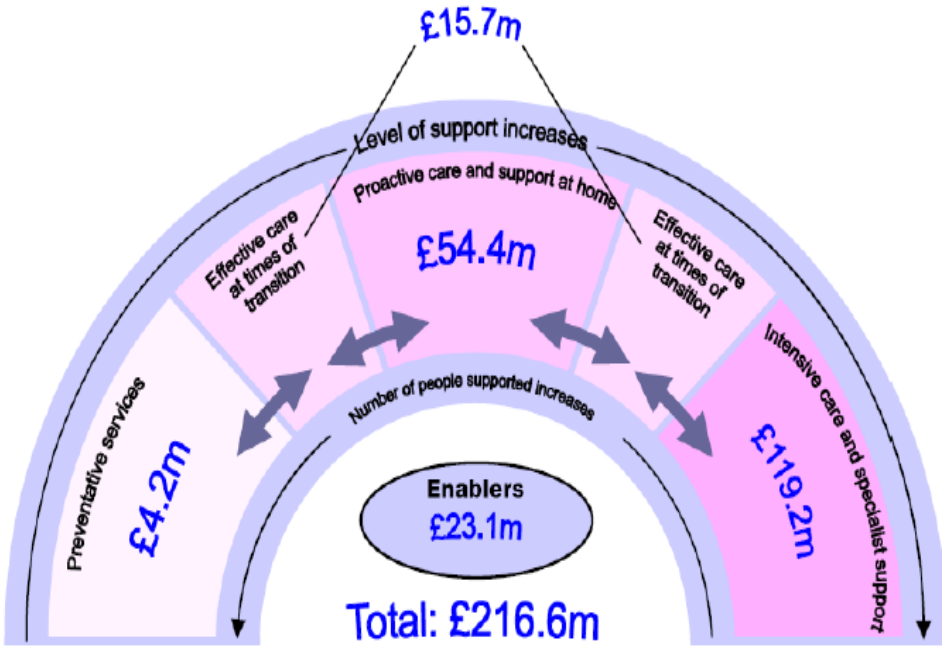
3.6 In 2012, the balance of care for older people in Edinburgh, from a health and social care perspective was considered in each category of service provision described by the Scottish Government's Reshaping care for Older People outline, and included:

Preventative Services	Proactive care and support at home	Effective care at times of transition	Intensive care and specialist support	Enablers
• lunch and day clubs • community connecting • befriending services • volunteering • community transport • support for carers • information and advice • case finding and anticipatory care planning • health promotion • housing support	•self care • care and repair • housing support • care at home • telehealthcare • community alarm telecare service • social care day services • equipment & adaptations • housing with care & support • management of long term conditions • community nursing	• re-ablement • rehabilitation • intermediate care services • residential respite care • short breaks and breaks from caring • comprehensive assessment (COMPASS) • care pathways • palliative care • medicines management • step up/ step down • post diagnostic support • day hospitals	• care homes • specialist hospital assessment • treatment & rehabilitation • NHS inpatient complex care • acute hospital care	• general practitioners (GPs) • assessment teams • training and development • research, information and evaluation • planning and commissioning • outcomes focussed assessment • integrated working • co-production • data sharing • communication & engagement

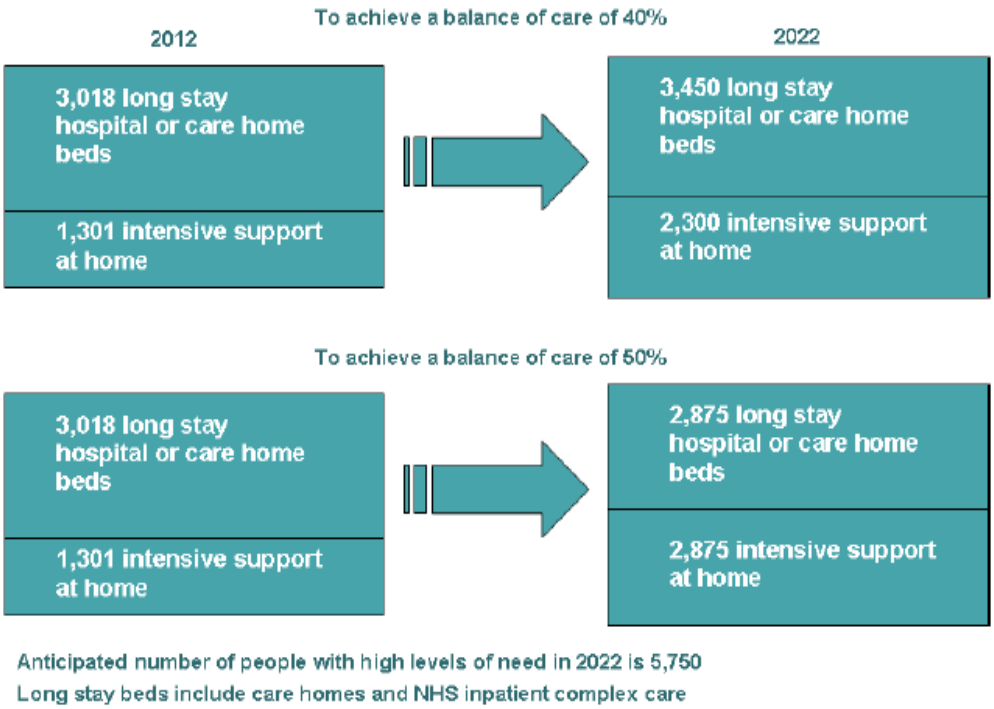
3.7 The proportion of finances against the proportion of older people using each service category is highlighted below, for 2012:



3.8 In money terms the split across the spectrum of care provision, in 2012, was as below:



3.9 In 2012, it was considered that in order to change the balance of care, for those with high level of need, that by 2022, it was anticipated that around 5,750 older people would have intensive levels of need. The diagram below shows the balance of services required to meet the 40% target or a more ambitious target of 50% of people with intensive needs being supported at home, in a care home or complex hospital environment:



3.10 All of the assumptions indicated in 2012, required to be retested, as the environment is changing constantly. For example, the health and social care partnership has set the ambition for the balance of care at 45%, and more recently, in February 2016, the future numbers of Hospital Based Clinical Complex Care (HBCCC) has been revisited, and the availability of beds depend on decisions being taken on existing NHS premises. If leases are not renewed, and no beds are re-provisioned elsewhere, the number of HBCCC beds in the system would reduce from 269 to 128 by 2018. Additionally it is recognised that in the Balfour Unit at Astley Ainslie Hospital, our accommodation is substandard and requires a longer term solution. This is discussed in more detail under another item at this Integrated Joint Board (IJB).

3.11 These circumstance allows an ideal opportunity to reconsider the model of care for older people, and how needs might be met differently going forward. At previous Executive Groups, in February 2016, it was considered that there requires to be a whole system approach to capacity and demand review of HBCCC and Care Homes, taking into consideration the impacts on wider community supports. The capacity and demand work will encompass these elements.

3.12 Through Edinburgh's *Live Well in Later Life* programme of work, some of the changes required to achieve better outcomes and a balance of care, have been tested over the last few years including:

- Care home liaison service
- Step up and step down care in a care home environment
- Behavioural support service
- Shifting day service provision to a re-ablement approach through the *Be Able Service*
- A locality approach to the care at home contracts
- Enhancing re-ablement and intermediate care
- Preventative innovations through the third sector
- Housing with support including Madelvic Square, Brandfield Street and Elizabeth Maginnis Court providing flexible alternatives to hospital or care home stays
- COMPASS, **Comp**rehensive **Ass**essment for frail older people
- Hospital at Home and Hospital to Home
- New care homes becoming operational

3.13 Over this time, many of these developments have been taken forward and become sustained in their delivery as planned, however owing to key financial

constraints, some have not developed into sustainable provision, for example, care home liaison, step up and step down services, which has led to the best pathway for people not being delivered for individuals, or for the system, and a degree of frustration for those who have been involved.

3.14 It has also become clear that a renewed focus on a whole system approach to developing capacity to meet demand is required, with partners across the Edinburgh Partnership, Acute Services, third, independent and housing all working together to consider the best pathways for older people, to meet the more recent priorities set within Edinburgh's Integration Joint Board's Strategic Plan and taking into consideration:

- the changing criteria associated with Hospital Based Complex Clinical Care
- changes associated with Care Home capacity in Edinburgh
- the development of the Locality Hub and Cluster models
- the desire to have new models of care and the right mix of services and supports
- work associated with improving whole system pathways, being led by the IJB Chair, to enhance community services and reduce those delayed in hospital
- ongoing financial pressures

4. Main report

4. <u>The Approach</u>

4.1 This whole system approach to reviewing demand and capacity is now clearly required, so that the Partnership can determine ***how will we most effectively meet Health & Social Care needs in Edinburgh, taking account of budget reductions and service demand projections?"***

4.2 The IJB has challenged itself with delivering 45% of care in a community based setting by 2020. A whole systems view of service delivery will help the IJB to understand where savings can be realised but also where investment needs to be made across the system to support this shift.

4.3 It has been agreed within the Health & Social Care Partnership, through the Transformation Programme, led by the IJB Chair, that a programme approach will be taken to determine the future capacity and demand for older people, with Project Support from Ernst and Young colleagues, who will be able to

provide skills associated with project management, analytical support and financial gap analysis.

4.4 This work will support the IJB to meet Strategic Plan priorities, drive improvements and value from the reducing funds available, and will look at;

- What level and type of care and support services will be needed to support demand?
- How we can best ensure sustainability of service?
- What is the right mix of service provision?
- How can we deliver services most cost effectively?

4.5 It is anticipated that opportunities for further integration and outcomes based commissioning, will be optimised, as will the development of the market to respond to changes in demand, with the overall aim to shift the balance of care to improve experience, and reduce unit costs wherever possible. The work will assess delivery models for health and social care services across the whole system, including;

- The front door
- Short term intervention services
- Complex care in both community and residential settings

4.6 Key questions will be asked to progress the work, to allow us to identify the baseline of the current scope of services, define the future service landscape, and ultimately develop outline business cases, including:

<u>Phase 1</u>

- What are the current cost and demand drivers across the whole system that may impact on how we deliver services?

<u>Phase 2</u>

- What are the services that we need to provide to best support the population?
- What are the current models of delivery for those services?
- What opportunities are available to develop market capacity across the whole system?

<u>Phase 3</u>

- What are the strategic delivery options and opportunities available across the 'quick win' and longer term 'sustained transformational change' spectrum?

4.7 The timeline for delivering this work will be updated now that project support has been agreed, with it being anticipated that Phases 1 and 2 will take up to

16 weeks to complete. Phase 3 timeline will be dependent upon the outcome of Phases 1 and 2, however, options for immediate consideration will be developed within three months. Longer term considerations will include the development of the market capacity, both internally and externally, to respond to a changing demand, better management of demand by prevention, early intervention and tackling inequalities.

4.8 Governance associated with this work will be through the Older People Executive Group to the Executive Transformation Group, which has recently been refocused. The Professional Advisory Group, and the Strategic Planning Group will provide an oversight for this work, as there is a direct link to five of the Strategic Plan Actions with this work, and will in the first instance receive business case propositions.

4.9 A Project Board in July 2016, will be established to oversee the progress of this work, with the Strategic Planning & Quality Manager for Older People, playing a key role in driving this forward. An operational group taking forward work streams associated with activity, finance and workforce will also be established to drive this work forward. The Professional Advisory Group will also be involved in the workforce element specifically. An outline of the key work areas is illustrated below:

	2016							**2017**		
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Proposition of Approach to the Transformation Group										
Approval on approach by the IJB										
Establish the Project Board & Operational Group										
Phase 1 Current State										
Professional Advisory Group Engagement										
Phase 2 Future model development										
Phase 1 & 2 Report Prepared and to										

Strategic Planning Group										
Key Recommendations for Immediate business Case options										
Key recommendations for longer term business case options										

5. Key risks

5.1 Key risks for the approach are associated with;

- the project not being supported to the extent that it is required to be, to have the work done to the timescales identified
- constraints in availability of activity and financial data

5.2 It is anticipated that these risks will be mitigated by robust project leadership and management. A project risk register will be developed and reported to the Executive Transformation group by exception.

5.3 Key risks with not undertaking the capacity and demand work as set out in this paper, will result in:

- Edinburgh Health & Social Care Partnership not having the right mix of services and supports in place to meet the demand of the changing population needs for older people, which is likely to result in
- poorer outcomes for people and,
- inefficient use of resources, as well as
- an adverse impact on flow through hospitals

6. Financial implications

6.1 There are no financial implications associated with this report at this stage. Financial implications associated with the work will be built into the programme of work as highlighted above.

7. Involving people

7.1 Edinburgh Health & Social Care Partnership has engaged with, involved, and consulted with the local population, staff and other stakeholders and had in place a formal consultation process as part of developing the Strategic Plan, with the development of Locality working being a key action to deliver against the agreed priorities within the Strategic Plan.

7.2 Key stakeholders will be involved through the Older People Executive Group, the Project Board for this work, and the Transformation Executive Group.

7.3 Health and Social Care Interim Locality Managers, and professional leads will continue to engage and involve stakeholders across their localities and communities.

8. Impact on plans of other parties

8.1 The key impact of this work will be on the whole system pathway for adults, and in particular older people, which will impact partners across community social care and health care, and acute care.

8.2 It is intended that this approach will be applied to all adult client groups across Edinburgh to ensure a consistent approach is taken.

Background reading/references

Edinburgh's Joint commissioning Plan for Older People 2012 -22 – Live Well in Later Life:
http://www.edinburgh.gov.uk/transformedinburgh/downloads/file/22/live_well_in_later_life_edinburghs_joint_commissioning_plan_for_older_people_2012-2022

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Links to actions in the strategic plan

Action 19	New models to better meet the needs of frail elderly people at home and in care homes
Action 21	Shifting the balance of care
Action 22	Developing whole system capacity plans to provide the right mix of services
Action 43	Plans to achieve financial balance
Action 44	Decisions regarding investment and disinvestment

Links to priorities in strategic plan

Priority 2 – Prevention and Early Intervention	People will be supported through appropriate response, to remain at home or in a homely setting
Priority 3 – Person Centred Care	Care and interventions will be wrapped around the individuals, with the most appropriate response from the statutory, third or independent sectors being arranged.
Priority 4- Right	

Care, Right Time, Right Place	People will be supported at home for as long as possible, and will only remain in hospital for as long as is required, with timely discharge being arranged, with the most appropriate services and supports available across the whole system
Priority 5 – Making best use of the capacity across the system	As Priority 4, and will ensure informed consideration around using capacity and financial resources in a more cohesive way
Priority 6 – Managing our resources effectively	As priority 5