East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 11 September 2019

BY: Chief Officer

SUBJECT: New Models of Care for Dementia & Psychiatry of Older Adults Provision and Repatriation of East Lothian Patients.

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1 PURPOSE

1.1 To provide the IJB with an update position on the work to develop New Models of Care for Dementia & Psychiatry of Older Adults provision and the repatriation of East Lothian patients from Midlothian Community Hospital.

2 RECOMMENDATIONS

2.1 The IJB is asked to note the contents and ongoing actions of this joint report with Midlothian IJB on the repatriation of patients from Midlothian Community Hospital to East Lothian.

2.2 The IJB is also asked to instruct the Chief Officer to continue with the implementation of the East Lothian Direction (D03c) 2019/20 to repatriate patients belonging to East Lothian and in conjunction with the changes required for the development of the new East Lothian Community Hospital.

3 BACKGROUND

3.1 East Lothian and Midlothian IJB's both have Directions 2019/20 to repatriate patients belonging to East Lothian but who have in recent years accessed Midlothian Community Hospital, specifically wards Rossbank and Glenlee. This is part of the development for the New East Lothian Community Hospital in Haddington. The repatriation of these patients links to other service transition taking place in East Lothian.

3.2 This forms part of the East Lothian IJB Direction to repatriate East Lothian patients from Midlothian Community Hospital.

4 ENGAGEMENT

4.1 Significant engagement on all Directions was undertaken as part of the development and production of the East Lothian IJB Directions 2019/20.

4.2 In addition a mechanism for on-going engagement is built into the Change Board structure in the form of multi-stakeholder Reference Groups.

5 POLICY IMPLICATIONS

5.1 Contributes to the achievement of action on dementia as set out in the East Lothian IJB Strategic Plan 2019-2022:

Actions proposed in dementia work

Initial planning to outline possibilities for best use of Midlothian and East Lothian community hospital services for people with a diagnosis of dementia.

This work is being developed in conjunction with Midlothian Health and Social Care Partnership:

- analysis of data on use and need for East Lothian individuals using Midlothian Community Hospital
- outline options and consider model of repatriation of East Lothian individuals with a diagnosis of dementia requiring in- patient care from Midlothian Community Hospital to East Lothian (new) Community Hospital.
- to outline options for a local dementia specialist care home in East Lothian
- to review and develop the existing local dementia care pathway to ensure high quality care at each part of the pathway, as well as consider the impact of barriers and inequalities that affect access to support
- to review and develop the post diagnostic support for people given a diagnosis of dementia.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy.

7 DIRECTIONS

7.1 D03c - Deliver to East Lothian IJB in 2019/20 the financial resources released through the repatriation of East Lothian residents from Midlothian Community Hospital (new East Lothian Direction - replaces D03a and D03b).

7.2 The repatriation of East Lothian patients from Midlothian Community Hospital is in response to the Direction as set out in the D03a, D03b and subsequently updated to DO3c in 2019/20 East Lothian IJB Directions.

8 RESOURCE IMPLICATIONS

8.1 Financial – Services transitioned and delivered within current envelope of recurring costs.

8.2 Personnel – Senior Managers, Staff side representatives and staff area representatives involved in supporting staff through transition.

8.3 Other – none.

9 BACKGROUND PAPERS

9.1 Attached joint paper - **Midlothian and East Lothian development of New Models of Care for Dementia and Psychiatry of Older Adults Provision involving repatriation of East Lothian patients**

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DATE	3 September 2019

Title of Report:

Midlothian and East Lothian development of New Models of Care for Dementia and Psychiatry of Older Adults Provision involving repatriation of East Lothian patients

Purpose of Report

To provide and update to East Lothian Integrated Joint Board on progress of Direction D03c 2019/20 (updated DO3b 2018/19).

To note that the Chief Officer has received regular updates on progress from the Chief Nurse.

To instruct the Chief Officer to continue with the implementation of the East Lothian Direction D03c 2019/20 to repatriate patients belonging to East Lothian and in conjunction with the changes required for the development of the new East Lothian Community Hospital.

Summary

East Lothian and Midlothian IJB's both have Directions 2019/20 to repatriate patients belonging to East Lothian but who have in recent years accessed Midlothian Community Hospital- specifically wards Rossbank and Glenlee. This is part of the development for the New East Lothian Community Hospital in Haddington. The repatriation of these patients links to other service transition taking place in East Lothian.

With the repatriation of these (East Lothian) patients from Midlothian Community Hospital Glenlee and Rossbank wards, the IJB in Midlothian have been considering the redesign of inpatient mental health beds to allow care closer to home deliver services on budget and continue to provide high quality services.

Introduction

In light of the IJB Directions from East and Midlothian and following on from the letter from the Scottish Government in June 2018, Transforming Specialist Dementia Hospital Care (See Appendix 1) it was agreed after discussion that East Lothian and Midlothian partnerships would develop separate plans but take note of the development from each other to move forward with development of new models of care for Dementia and Psychology of Older Adults provision.

Each area will provide their inpatient services locally. In East Lothian this is the new East Lothian Community Hospital which opens its older adult's mental health inpatient unit in October 2019, the development of which offers that possibility. This will allow patients to be cared for closer to their home and benefit for carers and families to be able to visit and care for their relatives closer to their home and community.

It was agreed that both areas would work to a shared timeline/milestone of October 2019 to commence the repatriation. It is not anticipated that this will be the end date for repatriation. Nor is this the only development for either partnership. Both Midlothian and East Lothian are able to use this opportunity to develop services further for older people requiring support locally. This allows both in patient and step down care, where people can be cared for closer to home and with less hospital input, in a more home like setting.

East Lothian

In East Lothian a short life working group has been established, chaired by the interim Chief Nurse to develop options on:

- The repatriation of East Lothian patients from Midlothian Community Hospital wards Rossbank and Glenlee back to the New East Lothian Community Hospital September 2019.
- The transition of patients from Herdmanflat Hospital Lammerlaw ward to the New East Lothian Community Hospital
- The use and capacity of the top floor of Crookston care home and how this may be able to be redesigned for people with behaviours that challenge. Any redesign would also take account of those patients who do not require to be in hospital as they have no clinical need and can be cared for in more appropriate facilities close to home[1].

The aims and objectives for the East Lothian developments are:

1. Services transitioned and delivered within current envelope of recurring costs.
2. Equal access for all East Lothian patients to have East Lothian service provision where ever possible (the objective of the repatriation of the current Directions D03c is to help achieve this).
3. To offer care close to home or in a homely setting whenever possible. Hospital care is only offered if required.
4. Redesign of community teams to support discharge, prevent unnecessary admission to hospital care and support GPs and our care providers to deliver high quality mental health care within community settings.

[1] 2018 Transforming Specialist Hospital Dementia Care.

5. Full use of locally based services, spaces and places in order to support people, families and have options for people to be cared for locally.

Midlothian – for information

Within Midlothian a short life working group was set up to explore the redesign opportunities arising from the reconfiguration of beds within Midlothian Community Hospital. MHSCP approach to care is person-centred, aiming to support people to stay healthy and to recover from ill health as fully as possible.

To this end a key part of this is providing care closer to home, or in a homely setting and reducing use of inpatients beds wherever it is appropriate. Midlothian Community Hospital currently provides mental health care for older people on two wards, Rossbank (24 beds) for assessment admissions and Glenlee (20 beds) for dementia care.

A version of this joint paper went to the Midlothian Transformation Project Board on the 24th April and subsequently to Midlothian IJB on the 13th June 2019. Both boards supported the paper and actions outlined for the redesign and repatriation.

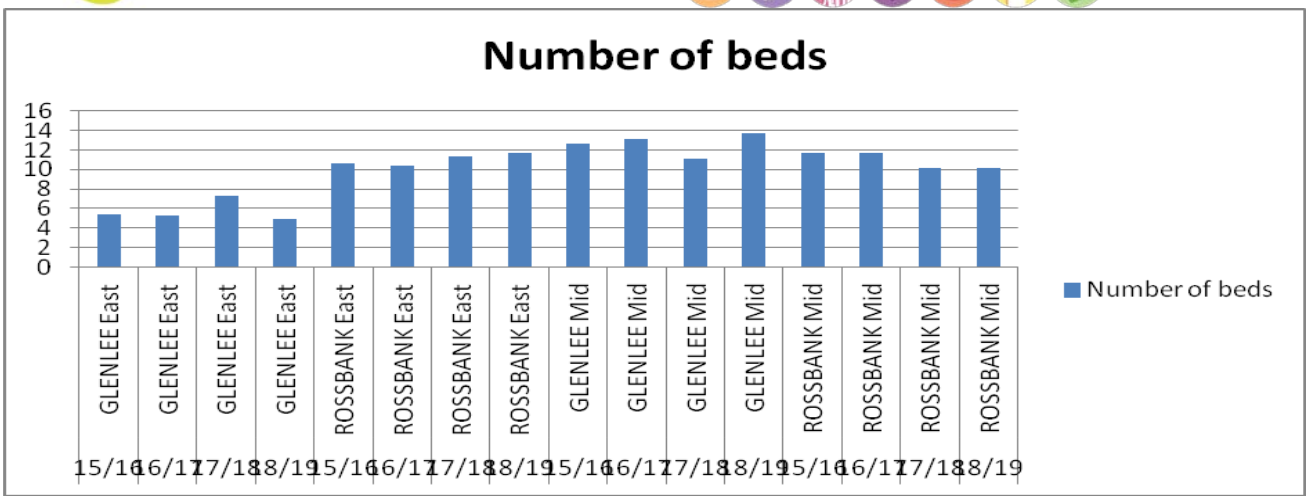
Current Situation

Bed Occupancy

Midlothian bed usage - By using the occupied bed day's information to calculate the number of beds required (Chart 1), the last 3 years information suggests that the numbers of beds required for Midlothian patients are: 24 in total, 11 in Rossbank and 13 in Glenlee. This would be equivalent to the current situation for Midlothian; if a reduction in reliance on hospital beds is required then this should be reduced to 20 in total. There is a need to provide an environment and a clinical model to support this. This model would free up a ward in the hospital for an alternative use.

East Lothian bed usage - By using the same information from chart 1 the last 3 years information for East Lothian indicates that 17 beds are utilised over the two wards. This is 6 in Glenlee and 11 in Rossbank. More analysis of the reasons behind referrals into both wards is being undertaken. This will help to further develop clinical pathways and local supports in East.

Chart 1



- 17 beds usage – East Lothian- across Rossbank and Glenlee wards
- 24 beds usage Midlothian

Future Proposal

East Lothian

The transition to the new East Lothian Community Hospital from Herdmanflat, Midlothian Community Hospital and potential transition to Crookston (top floor) to care and support patients who require step down support or care and support for challenging behaviours and for patients who do not meet the criteria for HBCCC.

In developing these transitions the following areas will require further consideration:

a. Workforce - current staff at Midlothian community hospital will need supported to decide whether to remain or move with the services. This will be lead by the HR team and Trade Union support using current policy and workforce organisational change processes.
b. Training needs – with the transition and development of other services then there is a requirement to development new skills and training for staff and staff teams.
c. Clarity of patient pathways including referral processes, clear admission criteria and appropriate fast throughput to relevant services.

Midlothian – for information

In Midlothian services will need to be provided differently. Doing this would aim to reduce the number of beds beyond the current requirements and in order to support care closer to home or at home there are a number of developing strands of work that is required which will in effect help bolster and develop community teams:

Communication / Consultation / Involvement

Although there will be individual Communication plans within both East and Midlothian it is considered vital for there to be some joint communication approaches. The areas for joint communications are:

- Joint Communications with patients and carers: For East Lothian patients there should be clear messages with patients and carers that there would be a transition period from September with a phased reduction and where appropriate 'new' patients would be admitted to the new East Lothian Community Hospital. Current East Lothian patients it is hoped would remain in Midlothian unless agreement was reached together with the patient, carers and the clinical teams.
- Joint Communications with the public and local media.
- Joint Communications with all current staff: all staff needs to be informed as soon as possible that there are some planned changes within both areas. Unions and HR will also need to be communicated with jointly.

Risks

If either H&SCP slip on any of the timescales in relation to the community services they need to provide, this could impact on the reduction of beds within Midlothian.

If the environmental elements required in the Midlothian wards can't be completed in a timely fashion this will impact on the ability to reduce beds within Midlothian and potentially create unutilised space.

Governance for East Lothian IJB

This paper and its proposals have now been through the following governance routes.

- Agreed and supported by the Older People and Access Management group May 2019.
- Tabled, discussed and supported at the East Lothian IJB Strategic Board on 12th June 2019 by Chief Nurse.
- Presented to the Strategic Change Board Shifting the Balance of Care on the 18th June 2019. Supported by the Board with additional emphasis highlighted on the need to for there to be clear and robust admission processes to ensure adherence to care model for patients and staffing models to support people with emotional communication issues (behaviours that challenge).

- Paper circulated and presented by the Chief Nurse to the Core Management Team of the IJB on the 19th June 2019. This was supported by the Core Management team.

- This High level vision paper being presented to the IJB Board meeting on the 11th September 2019.

Next Steps

1. **Clarity on the plan** - clarity and confirmation of service transitions and timeline (including any contingency for slippage). The Older People and Access Management group, led by the Chief Nurse will continue, at its meetings with the operational actions required to achieve this Direction.
2. **Agreed joint Governance routes across and between both Midlothian and East Lothian.** Regular update conference calls take place with the relevant programme managers and the joint paper is being taken through local governance routes in both Midlothian and East Lothian (as identified above).
3. **Staff/Partnership:** Programme Manager meeting with Partnership Representative to ensure correct procedure and communication is undertaken regarding potentially changing roles. Chief Nurse meets regularly with Staff Side representative. Staff side representative also attends Strategic Change Board and Core Management Team. Interim Chief Nurse to invite staff side representation to attend the Older People and Access Management Group as part of the operational phase of the repatriation programme.
4. **Financial split, including Beds:** Agreement reached between Midlothian and East Lothian with regards to the number of beds to be transferred; at present this is likely to be 17 beds to East Lothian and 24 beds for Midlothian. This then has implications for staff groups and support requirements identified under item 3 above. Chief Officers of East and Midlothian IJB have agreed split of resources based on 17/24 beds.
5. **Communication:** joint communication timeline and communication messages drawn up between respective Communication and Engagement teams. This will form part of the operational actions. Chief Nurse to update and invite East Lothian Communications team to attend Older People and Access Management meeting.
6. **Care Inspectorate –** East Lothian IJB Chief Officer met with the Care Inspectorate to discuss registration of new facilities at the Care Inspectorate offices in Dunfermline on the 23rd July 2019. An informal visit to Crookston was arranged with Chief Officer and Care inspectorate staff for the 6th September 2019.
7. **Chief Nurse –** to continue to provide regular updates as required. Chief Nurse has been providing updates ongoing as outlined in the Governance

actions identified above. The Chief Nurse regularly updates the Core Management Team and directly with the Chief Officer at regular 1:1 meetings.

Appendix 1

https://www.gov.scot/publications/transforming-specialist-dementia-hospital-care/