ADULT CARE PRESENTATION BY JULIE HEMPLEMAN

Shifting the balance of care

As you are aware NHS Scotland and Local authorities across Scotland are looking at a more efficient way of using resources (staff, buildings, information and technology) to enable a shift in the balance of care. They are also making significant investment choices which will determine the way health and social care services are shaped and delivered.

The overall aim is to achieve a more efficient use of resources across the public sector particularly within the NHS and local authorities and other partners.

Argyll and Bute council are particularly aware of the need to use the resources they have efficiently particularly in light of the dual pressures of demographic change and the more recent economic challenges. It is also mindful of the evidential research which supports the view that by shifting the balance of care, improvements can be made in service delivery and health outcomes.

In 2008 the Scottish government published a paper called "Overview of evidence relating to Shifting the balance of care: A contribution to the knowledge base"

In this they stated that there was a high level of evidence that the following interventions could contribute to shifting the balance of care;

- **Assessment of older people (especially as a prelude to care management)**
- **Multi-disciplinary working**
- **Integrated care for older people**
- **Disease management (especially in relation to long-term conditions)**
- **Early supported discharge and community-based rehabilitation for stroke**
- **and other patients**

- **Rehabilitation in the community for a range of conditions**

It also believed that there should be more of an emphasis on;

- **Home adaptations and equipment**
- **Supported discharges for older people and people after stroke**
- **Early supported discharge for older people and people after a stroke**
- **Care at home and hospital at home interventions**
- **Community hospitals**
- **Day hospitals**
- **Respite and support services to support unpaid carers**
- **Telephone support services**
- **Telephone consultation**
- **Self care support**
- **Self monitoring of long-term conditions**

The council is also mindful of papers such as "Improving care for older people" which was produced by the social work inspection agency.

This paper highlighted the need for;

- **More user involvement**
- **Accessible information for users and carers**
- **Multi-disciplinary working**
- **Improved dementia services**
- **Better delivery of services**
- **Improved service developments**
- **Use of technology at home to support older people**
- **Partnership planning**

The problems faced in Argyll and Bute are further compounded by the UK trend towards an ageing population. Although the challenges facing older people's services are UK wide they are particularly acute in Argyll and Bute. A higher proportion of Argyll and Bute's population is of pensionable age. For instance in ten years time 24% of Argyll and Bute's population are expected to be over 65 and 11% over 75. Analysis of the national population shows that the proportion of Argyll and Bute's population will be higher than the national average until at least 2024.

As the area of manager of older people's services in Cowal and Bute I am aware of the need to use the resources I have wisely. I also know that by working in close partnership with other departments such as health and other agencies, joint resources can be used more effectively and efficiently. Both Dunoon and the outlying villages have a high elderly population. Bute has similar statistics but has additional problems in that being an Island it is isolated from many specialist services. Both areas are also popular retirement locations which often means people are far away from the support of relatives and friends.

At present there is a high dependency on residential/ nursing care. One of my challenges, as an area manger, is to help people to look at other choices particularly community based choices which will provide equal support and security. I am also keen to promote the findings of the Scottish government by putting their recommendations into Practice.

Assessment of older people

I recognise that good assessment is the key to providing the right services to people according to need. It also ensures that resources aren't wasted for example that we are not duplicating services or putting in equipment that isn't needed. The new personal outcome plan (replacing the single shared assessment) is a clearer document which ensures that all professionals involved in a person's care have contributed to it . A good assessment will also inform an effective care plan. Research has shown that this is

particularly important when a person is being discharged from hospital and needs the right level of services to prevent re-admission to hospital. At the Local review and resource group all assessments are scrutinised to ensure that assessments are factual and not based on anecdotal evidence.

Multi-disciplinary working

I make sure that I work closely with other agencies and organisations. This is particularly true of health where I ensure I attend locality meetings for both Cowal and Bute. Recently both my health colleagues and I have worked together on the older people's plan looking at how the joint health and social work budget can support people more effectively in the community. Between us we have used the availability of the budget to employ a social worker who will be involved in assessment and care management of older people. We have also agreed to pilot an overnight team in Cowal for people who need support during the night. This should reduce the numbers of people requiring residential care as homecare services traditionally used in the day can continue during the night.

Integrated Care

In terms of integrated care I am also aware of the need to close the traditional gap between health and social care. A good example of this is our work with the integrated care team. This team ensures that patients are discharged timiously from hospital by ensuring that their immediate needs are catered for. By liaising with this team the discharge co-ordinator can ensure that valuable social work resources aren't tied up in short-term care. In this way the patient is rehabilitated at home without expensive services being put in. It also ensures that patients do not lose their independence and mobility or become dependant on services they no longer require.

Improved dementia services

As an area manager I am also committed to the improvement of dementia services, particularly as the number of people with dementia is steadily increasing.

The re-design of dementia services in Argyll and Bute aims to

- Provide an equity of access to dementia services across Argyll and Bute

- Establish local based community dementia teams
- Retain dementia impatient services locally for those requiring specialist care

Community Dementia service developments will also include

- Specialist dementia community psychiatric nurses
- Specialist dementia occupational therapists
- Community development workers (employed by Alzheimer Scotland
- Enhanced funding for social work home care services

The benefits of this service are that there will be an enhancement of specialist

- Services throughout Argyll and Bute
- Improved care and support for patients and their families who remain at home
- Improved access to specialist support and advice for care homes, community service and community hospitals
- Integration of NHS and social work dementia services locally
- Improved inpatient facilities for patients requiring specialist dementia continuing care.

Better delivery of services

As before better delivery of services relies on ensuring that those with the most need are prioritised and that where there is less need I encourage staff to look at other options. This may involve a service user being directed elsewhere or make more use of the voluntary services. In addition to the assessment tool staff also use an IRON score to ensure they have assessed people correctly. The IRON score is an effective management tool to ensure the service matches the need of the person concerned.

Improved service developments

I am also aware of the need to keep abreast of service developments and at present this includes the older people's plan, the redesign of dementia services as well as the general Social work plan. This documents the council's targets and aims throughout the year. In addition I ensure that I regularly monitor my own team's performance by looking at the council's pyramid system which measures our success particularly in terms of

the efficient allocations of work to the team as well as ensuring assessments are completed within 28 days.

Technology to support people at home

The improved use of tele-health care services has made it easier for people to remain in their own homes. In addition to community alarms, the use of door sensors and pressure mats has meant that people can be monitored at home. This is particularly relevant to dementia patients who would have traditionally need residential care. I the future it is anticipated that service users will be able to monitored remotely with the use of internal camera's within their home allowing them to choose a menu of care which allows them to retain a level of independence.

Partnership Planning

Finally it is hoped that by using the best skills and resources of each organisation partnership planning will allow better use of scarce resources. It will also provide a more seamless services which avoids duplication of tasks and numerous different assessments. In this way service users can retain their independence for longer knowing that they are receiving both efficient heath and social care services. Clearly the shift from more institutional services to home based community care will not happen overnight. I believe however that as service delivery improves and confidence grows the public perception will alter accordingly.

In summary the key actions that emerge from this document are:

Efficiency

The delivery of services needs to be more focused and prioritised according to need. This can be done by ensuring that

- Those contributing to assessments use the same care and assessment framework.

- Care plans focus on enablement and rehabilitation rather than encourage dependency
- Services reflect the level of need using the IRON score assessment tool rather than anecdotal evidence
- Packages are reviewed frequently to ensure they still meet the service users requirements and can be decreased if necessary

Cost saving

Cost saving needs to be part of everyday practice and considered in all aspects of the our work. This can be achieved by making sure that;

- The services we provide represent value for money making the most effective use of both internal and external provision.
- That we don't duplicate services provided by other agencies or fail to include the assistance offered by family, friends or voluntary agencies in our assessments
- That we help service users reach their full potential rather than provide packages of care which take away their motivation and independence
- That the service user is made aware of the cost implications of the care they receive and are given the opportunity to explore other options if necessary.

Integration

Integration of services ensures that all professionals work towards a common aim and a shared outcome. This can be achieved by;

- Defining the most appropriate person to take the lead and ensuring that services are co-ordinated effectively
- Ensuring Valuable services are used where there is most need and not tied up in those who represent a lower priority
- Specific conditions such as dementia are signposted to those who have specific knowledge and expertise.
- Partnership working that allows new developments to take place and outcomes to be shared.

Effectiveness

The effectiveness of the service needs to be consistently monitored and evaluated by;

- Reviewing our work and the quality of the service we provide

- Assessing data such as pyramid to ensure we our keeping to our performance targets
- Keeping to the aims and objectives of the service plan and demonstrating our effectiveness through our performance and development
- Look outside our service to ensure we remain competitive and efficient and in line with similar services.

Julie Hempleman