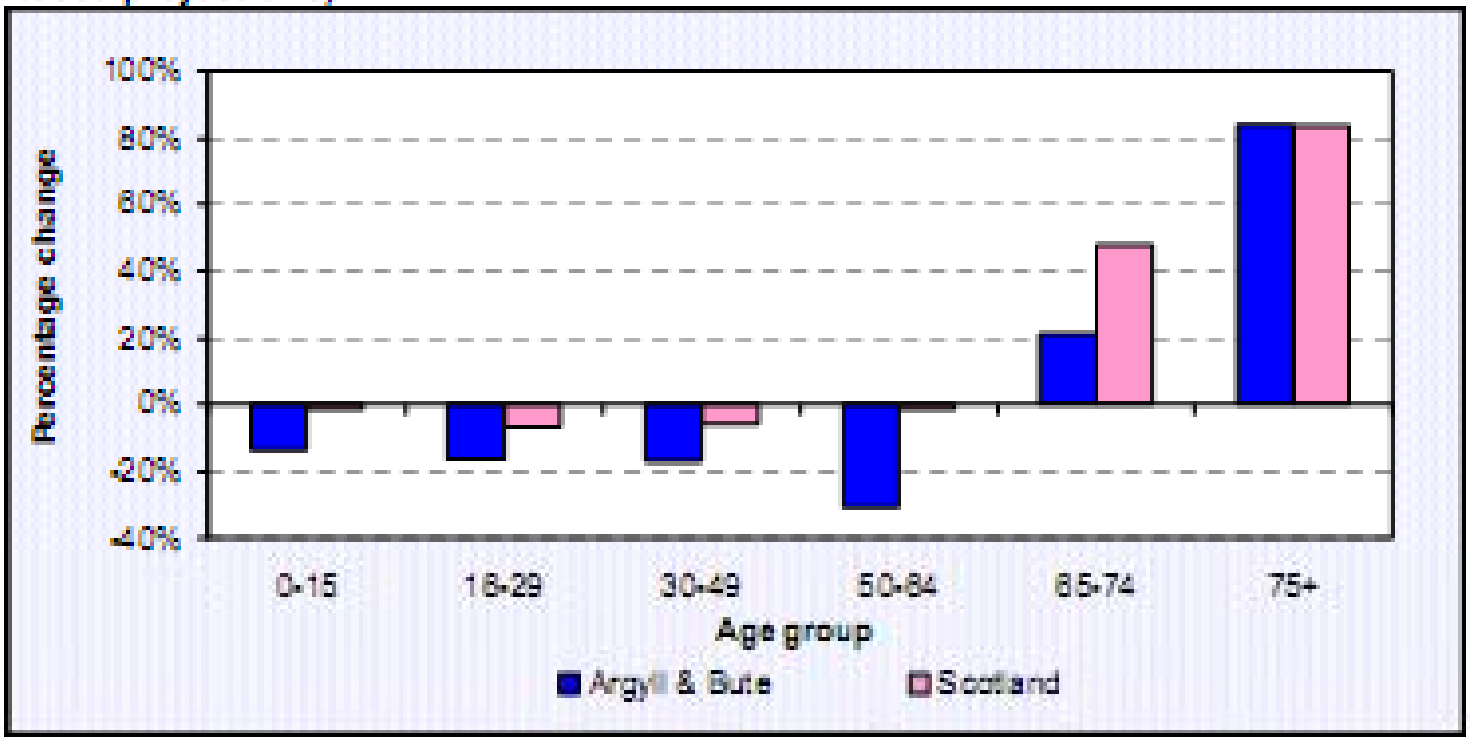
Reshaping Care for Older People in Argyll and Bute

Reshaping Care for Older People – why?

- We are a rapidly ageing country
- We face significant financial pressures
- Current services are not sustainable
- Some current services/approaches are not good enough for older people

Ageing Population

Percentage change in population in Argyll & Bute and Scotland, 2008-2033 (2008-based projections)



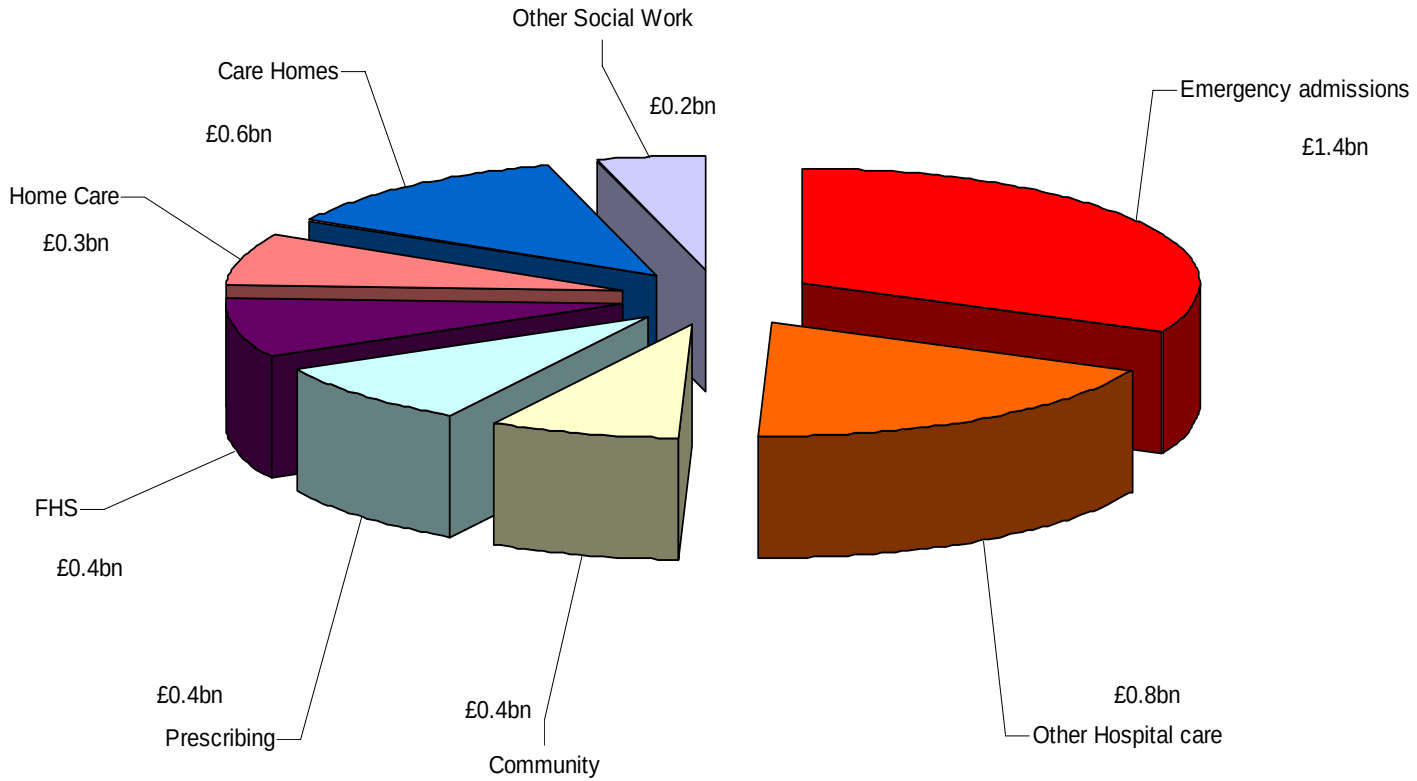
Pause for thought:

- Nearly 1/3 of the money spent on health/social care for over 65s is on emergency hospital admission

  (£1.4 billion out of £4.5billion each year)
- 89.5% of people over 65 years are not in the care system

  (97% of people between 65-74 years)
- More of the same will cost an extra £1.1 billion by 2016 – and from where?

How do we spend the £4.5 billion …



If We Don't Change:

To meet demands in Scotland we would need:

- A new 600 bed hospital every 3 years for 20 years
- A new 50 bed care home every 2 weeks for 20 years
- £2.8 billion investment in sheltered housing
- Most school leavers going into the care sector to sustain current staffing levels

Reshaping Care for Older People Aims to:

To optimise the independence and wellbeing of older people at home or in a homely setting by:

- Promoting healthy ageing
- Supporting Self Care
- Supporting communities and unpaid carers
- More preventative and anticipatory care
- More telecare/equipment/adaptations

What Do We Need To Do to Deliver This

- Better working together -
  Councils/Health/Independent Providers/Third Sector/ Communities
- Better/ more complex care at home
- New models of Care Homes and very sheltered housing
- Better crisis care
- Alternatives to emergency hospital admission
- Focus on recovery, rehabilitation and re-ablement

Our biggest challenges ….

- To build a consensus across citizens/public, clinicians, care providers around the philosophy and shape of care over the next 20 years
- To translate “agreement in principle” into decisions, actions and real changes
- To de-commission current services in order to invest in new developments
- To work together through a mutual care approach to achieve positive and sustainable change

Actions in Bute and Cowal

- Implementation of the Extended Community Care Team Approach
- Implementation of Single Point of Access
- Implementation of Lead Professional Role
- Implementation of Virtual Ward Meeting
- Implementation of daily ECCT ward meetings
- Development of co-production

Change Fund

- Pump priming fund from Scottish Government to support partnerships to make the necessary changes to address the priorities identified
- Available to partnerships over four years
- Shift in resource from NHS and Council institutional care to Independent and Third Sector organisations

Integration of Health and Social Care

- Community Health Partnerships will be replaced by Health and Social Care Partnerships
- NHS Boards and local authorities will be required to produce integrated budgets for older people's services
- A smaller proportion of resources - money and staff - will be directed towards institutional care and more resources will be invested in community provision.

Getting Community Care Right in Argyll and Bute

The Vision:

- Our vision is that the people in Argyll and Bute will live lives that are as long, healthy, active and happy as possible.
- The overall aim for Argyll and Bute Community Care Services will be to enhance the quality of the lives of the people with whom we work in order to achieve this vision
- Our Services will be aligned to focus on four common goals:
  - **Maintaining Independence**
  - **Recognising and preventing difficulties**
  - **Regaining skills and confidence**
  - **Delivering care that is dignified, respectful and person centred**

What are Our Priorities for Year One of Change Fund investment?

- Reduce the number of people who fall
- Make sure people get the right medicines at the right time
- Help people to be independent and to look after themselves – ***enablement/reablement***
- Provide palliative/end of life care in the right place
- Support communities to support older people
- Improve housing adaptations,equipment provision and use of technology to support people in their own homes
- Improve support for Carers
- Improve care for people with dementia
- Provide high quality individualised services for older people ***– self directed care***

Key Principles of the Model of Care

- Single point of access in the community for both health and social care services
- Joint use of an electronic assessment focussed on personal outcomes plans
- Person centred joint anticipatory care planning
- Joint monitoring and reviewing of care plans – lead professional
- Shift in culture towards enablement/ reablement
- Prevention of unnecessary admissions to hospital
- Prompt discharge home from hospital

Key Principles

- Supporting structured community management of high risk individuals
- High quality end of life care delivered in place of choice
- People to have more control, choice and independence
- Supporting people to manage their own illness
- Support people to actively engage with the private, voluntary and third sector
- Developing services with third and private sector, coproduction modelling
- Clearly defined roles and responsibilities
- Flexible and responsive team approach to care, delivered at home across 24/7