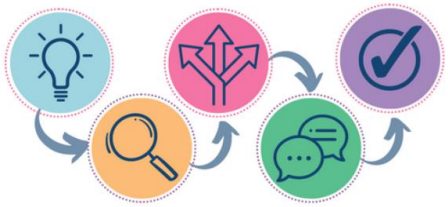
East Lothian Health & Social Care Partnership

Planning Older People's Services

Hurdle Criteria Results



19-03-2024 Version 1.0

Contents

Background

East Lothian's population is changing. People are living longer, and previous research has informed East Lothian Health and Social Care Partnership (ELHSCP) that many older people want to stay in their own homes for as long as possible.

ELHSCP is responsible for delivering effective older people's services. It wants to support individuals to make this choice become a reality. However, this cannot be achieved by ELHSCP alone. It needs to draw on the support, past-experiences and insights of county citizens and communities to continuously develop services to meet the needs of East Lothian's growing ageing population.

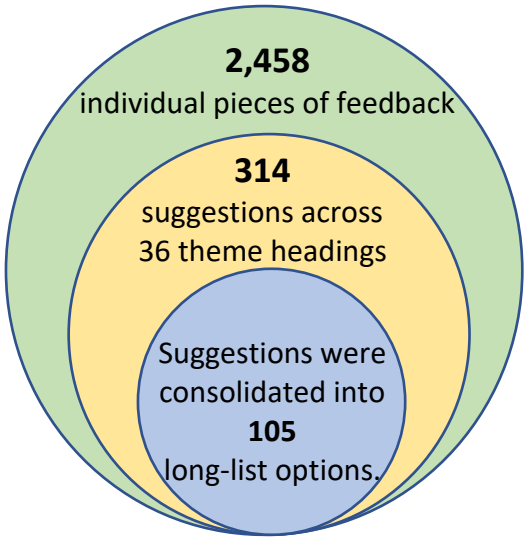
Community Engagement

ELHSCP commenced a series of community engagement events from August to December 2023, which formed the first part of a co-design process to develop the future provision of health and social care services for older people in East Lothian.

These events allowed ELHSCP to directly engage with 702 people, including community groups, area partnerships, members of the public, people with lived experience, staff groups, professional leads, carers, volunteers, medical professionals, third sector and independent advocacy organisations as well as a focused workshop with East Lothian IJB members. A further 141 submitted their responses via an online survey and 11 completed printed questionnaires.

The engagement activities have accumulated 2,458 pieces of feedback on how we can deliver or improve older people's services in East Lothian. Within this feedback, 314 suggestions were identified across 36 theme headings.

These suggestions were then consolidated into 105 long-list options which progressed to the next stage of the Planning Older Peoples Services project development – the long-list assessment against pre-set hurdle criteria.



Hurdle Criteria Assessment

This activity involved each 'long-list' option being assessed against 4 conditions that needed to be overcome or met to progress to the next stage:

Hurdle Criteria

1. Will the option lead to increased wellbeing and improved outcomes for service users in East Lothian?
2. Will the option enhance service and clinical sustainability and is it able to evolve and adapt to meet future need? (e.g. does it meet the health and wellbeing needs of the present population, without compromising those of future generations?)
3. Will the option provide fit for purpose infrastructure that supports East Lothian's current and future older population?
4. Will the option achieve long term financial viability?

Hurdle Assessment

The task of assessing the 'long-list' of options against the Hurdle Criteria fell to the overarching Project Team and the Independent Community Panel. It was pre-agreed that the decision-making process would adhere to the following rules in line with IJB standard protocols:

- If an option meets all 4 criteria, (scoring 4/4) it will automatically progress to the next stage of the process.
- If an option fails to meet the criteria, (scoring 0/4, 1/4, 2/4) it will automatically drop out of the appraisal process.
- The suggestions that score 3/4 will be allocated time for discussion on Wednesday 21st February 2024 to agree if they should progress as an exception.

Each member of the Project Team and Independent Community Panel representatives were asked to individually review the long-list suggestion against the four hurdle criteria suggestions above via an online survey in advance of the face-to-face exercise. For ease, a number of the intermediate care and palliative care suggestions were amalgamated together under the same suggestion heading, resulting in the survey outlining 82 options for consideration.

Out of a possible 21 responses, 18 were received, providing an 86% return rate.

Survey Results

- 26 long-list options automatically progressed to the short-list stage, having meet all 4 hurdle criteria for a supermajority (67%) of recipients.
- 12 long-list options automatically dropped out of any further appraisal process as they were unable to meet the supermajority conditions (received 8 or more votes across at least 2 hurdle criteria).

The remaining 44 long-list options were then put to a vote as part of the face-to-face exercise, which was held on Wednesday 21st February 2024.

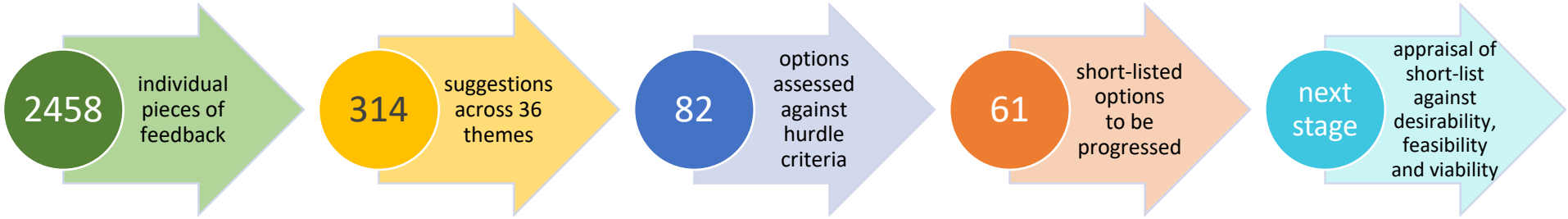
Face-to-face Exercise

The in-person, hurdle criteria assessment was attended by 21 Project Team and Independent Community Panel representatives. Each of the remaining options which were up for discussion (44), were discussed and consensus agreed as to whether or not the option would be added to the short-list.

All hurdle criteria questions required binary responses - either a yes / no. Where consensus was not reached, a vote was undertaken by a show of hands, and the result was determined by a supermajority (no less than 67%) of votes.

Following the hurdle criteria assessment, a total of 61 options have been placed on the short-list.

Process to date



Short Listed Options

Each of the 61 short-listed options are detailed below by theme.

Care at Home

Option 21: In order to improve outcomes, stability, service provision, terms and conditions and control over the market, careful consideration should be given to expanding the internal (HSCP) Care at Home service.

Option 25: We should review what constitutes the essential elements of a care package. Care-at-home services have cut back on the application of creams, administration of basic medications (e.g. eye drops), bathing and meal prep. This option has strong links to moving away from time-and-task model to a more outcome-focused approach that builds personal connections. There are also strong links with delaying discharge.

Option 18: We should develop and introduce locality-based block contracts with target outcomes for delivery of care-at-home/ intermediate care services. (There is potential pilot focused on internally provided care-at-home services in a local area where commissioning and retaining external provision has been challenging).

Option 23: There should be a wholesale review of scheduling and time management within Care at Home services (internal and external).

Care Homes

Option 31/32: ELHSCP should scope and consider building / developing new care home sites as per the findings of the Community Hospitals and Care Homes Provision Change Board final report (e.g. developing Belhaven site, redeveloping Eskgreen site, site in Preston Seton and Gosford, leasing entire building from current provider).

Option 34: If ELHSCP is unable to build or develop new Care Home sites, then consideration should be given to commissioning additional social work funded beds within existing care homes.

Option 35: ELHSCP should introduce an awareness raising and training programme for all care home staff related to supporting residents and family members with mental health issues. This could be linked with other issues (e.g. dementia, stress and distress, complex behaviours).

Communication

Option 24: There is a lack of understanding and awareness related to Care at Home services. We must improve awareness and understanding in relation to the variety/type of assistance available, which providers are operating in East Lothian and who they support, and also promote career/job opportunities.

Option 81: We should promote and raise awareness of intermediate and community-based care. This may help to manage expectations, ensure the population know what is available and possibly improve recruitment.

Community

Option 6: Lunch clubs or some form of outreach service surrounding meal prep / delivery for the most socially isolated and vulnerable should be introduced across East Lothian.

Option 51: We should develop and build upon existing volunteering schemes within communities (e.g. volunteer transport schemes, Gifford Community Volunteers, First Responder Groups, befrienders, buddy systems, food delivery / meal share, telephone support and check in, end of life support). This may help with social isolation, building community spirit, transport difficulties, mental health and poverty. Could be particularly useful in more rural locations and new housing developments.

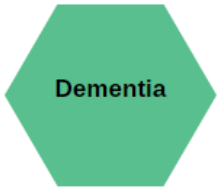
Day Centres

Option 49: ELHSCP should explore and develop an outreach service in collaboration with Day Centres. Service could potentially support carers, care at home provision and those at end of life.

Option 56: Day Centre provision should be extended to evenings and weekends.

Option 100: We should explore the potential for using day centres as a respite opportunity for unpaid carers further.

Dementia



Option 47: We should develop an awareness raising campaign and training programme in relation to dementia, including training for hospital staff, care home staff, day centre staff, carers, and other identified groups.

Option 57: We should review and develop provision of services to people living with young onset dementia. Care homes, day centres and a variety of other core services are not tailored to meet people's individual needs.

Option 59: In the spirit of people remaining within their own home / community for as long as possible, there should be sufficient dementia services within the community to achieve this.

ELHSCP Strategy, Operations and Staffing

Option 7: ELHSCP should raise awareness of Future Care Planning (previously known as Anticipatory Care Planning) and ensure that it is embedded within health and social care practice.

Option 33: Professional support and training networks should be established between the Oak Tree Ward (ELCH) and care homes. Care home staff would benefit from the support / advice and additional training / awareness raising related to dementia, stress / distress and managing complex behaviours.

Option 36: We should develop and expand the role of the East Lothian Care Home Assessment, Support and Education Team (e.g. single point of contact, training for Care Home staff, short-term intensive support service to help keep complex cases local rather than moved to specialist provisions).

Option 37: We should develop a 24 hour helpline / single point of contact for providers, professionals and service users to provide guidance, assistance, advice regarding placement breakdowns, hospital admissions / discharge, out of hours support and a full-service directory.

Option 40: A review of working relationships and lines of communication should be undertaken between health and social care services. Particular focus on GP practices to Care Homes; Oak Tree Ward (ELCH) to Care Homes; Occupational Therapy to Care Homes;

Hospital discharge planning to Care Homes; Hospital at Home to GP practices; District Nurses to GP practices; Hospital discharge to Social Work.

Option 42: There are often long-delays in recruitment processes when it comes to employing new staff within ELC/ELHSCP care homes (and other services) often resulting in candidates accepting jobs elsewhere in the meantime. ELHSCP should work in collaboration with ELC Human Resources to review the process and attempt to streamline.

Option 58: We should commission and structure health and social care services in a way that moves away from the older people / generational / geriatric model. People are living longer, long-term health conditions are not exclusive to 65+, care homes are generally not appropriate for younger people, mental health services for 65+ are limited, many people die before the 65+ mark etc. We need to develop more intergenerational services for East Lothian residents throughout people's lifespan.

Option 66: We should review existing flow centre processes and infrastructure to ensure that staff are sufficiently trained to challenge and discuss all relevant care pathways and options.

Option 76: We should adopt more collaborative commissioning approaches with community groups, taking account of elements of gender responsive budgeting and human rights.

Option 92: Staffing and workforce development should be better organised, advertised and facilitated at an ELHSCP level. This includes development of career pathways, training / development opportunities, reviewing job titles / roles to ensure they are reflective, and expectations are clear.

Option 98: We should explore cluster geriatricians / senior clinicians being made available for queries related to the increasing number of older people being cared for within their own homes and the community.

Option 101: The remit and role of the Care Broker Team should be developed and expanded. Some Social Work functions could be transferred, achieving better promotion and oversight of SDS, and a central point of contact for queries.

Finance and Investment

Option 72: NHS Lothian set-aside funding arrangements should be reviewed with a view to some funding being returned to local authority areas based on performance. Where local service improvements lead to reduced acute demand this should be reflected from a funding perspective.

Hospitals

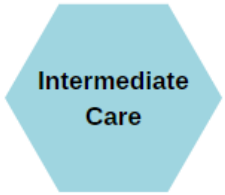
Option 39: An audit of hospital readmissions should be completed to consider whether or not the pressure applied to get individuals discharged from hospital at pace is having a negative impact on their outcomes. Currently, appropriate discharge planning is not happening, information sharing is limited and equipment is not put in place quick enough.

Option 65: Direct GP access to ELCH beds should be explored and simplified where appropriate (e.g. overnight monitoring, tests, supervision of medication, nurse led care, short term rehab / stabilisation).

Option 69: Edington and Belhaven satellite hospitals should close with all community hospital beds located within East Lothian Community Hospital (ELCH). Consideration should be given to opening ELCH Ward 6 on a more permanent basis.

Option 71: Edington and/or Belhaven sites should be redeveloped as larger ELHSCP/Local Authority-run sites. Consideration to be given to protected step-up and step-down provision, palliative care, care home beds, community respite and community hub approach.

Intermediate Care



Option 8: Volunteer befriender or sitter services should be explored to support people receiving care-at-home or end-of-life care, with specific focus on those with limited or no family and friends.

Option 53: We should look for opportunities to engage with the Leg Club Movement, which is a global initiative, designed to care for people suffering from or at risk of chronic leg disease within a social model of care.

Option 77: We should develop additional step-down services to ensure timely and safely managed discharges from hospital and ensure that older people are ready to go home.

Option 79: Alternative and innovative approaches to intermediate care should be explored further by ELHSCP (e.g. [1] Midlothian Community Respiratory Team; [2] 24 hour supported living services for older people in Glasgow; [3] Richmond Fellowship integrated day services for people with dementia; [4] Expansion of the Active and Independent Living Clinic at Well Wynd; [5] Pilot Intrapreneurship Programme by the Lens / Dumfries and Galloway HSCP [small grants / project investment]).

Option 80: As per the findings of the Provision Change Board, ELHSCP should increase investment in intermediate care services to ensure that we fulfil our strategic objectives, and our hospital / care home bed numbers are sufficient to meet our needs. The following services featured prominently in engagement phase 1: (1) Hospital at Home / Hospital to Home; (2) Care at Home; (3) Mental Health services; (4) Technology Enabled Care (TEC); (5) Day Centres; (6) Community hubs; (7) Occupational Therapy and Physio; (8) Pain Management.

Option 84: We should invest in additional outreach services with appropriate transport to facilitate - like a roaming heart failure nurse, respiratory nurse, antibiotic nurse etc.

Minor Injuries

Option 93: We should develop a specific East Lothian minor injuries service to complement existing central provision (for example, services Minor Injuries services in Edinburgh). Full options development and appraisal would be required.

Palliative and End of Life Care

Option 11: Palliative and End of Life Care should be reviewed and mapped throughout East Lothian. This exercise should include:

1) Hospice provision for East Lothian residents (e.g. Hospice beds and services, Hospice at Home).
2) The potential for a death doula service.
3) Awareness raising campaign incorporating Power of Attorney, planning in advance, available supports and services.
4) Creation of a dedicated internal / commissioned palliative care team.
5) Single point of contact including support to Care Homes, individuals and families.
6) Provision of palliative and end of life care within care homes.
7) Training, workforce development and support for carers (particular focus on upskilling care home staff).
8) Partnership working with Macmillan, St Columba's and Maria Curie.
9) Provision of services to those under 65.
10) Review of unscheduled care service and how palliative and end of life care changes could impact it.

Option 14: We should develop an end-of-life care sheet that contains simple contact information, reassurance, and guidance for those caring for a relative at the end of their life.

Partnership Development

Option 1: ELHSCP should collaborate with partner organisations (e.g. Connected Communities, Libraries, Enjoy Leisure, VCEL, Education and Children's Services, Neighbourhood Networks, Penumbra etc) to develop robust programme of activities for older people to tackle social isolation, mobility, fuel poverty, health and wellbeing. Could this be incorporated into a more focussed social prescribing approach.

Option 4: We should develop links with East Lothian schools and Queen Margaret University to encourage volunteering opportunities (two way), intergenerational links / older friends' scheme, awareness raising, and career development related to the older people agenda. Particular opportunity to establish links between local schools and care homes.

Option 5: ELHSCP, in collaboration with partner organisations, should develop and hold a health and social care career day to increase awareness of providers, training / job opportunities, career pathways and community benefits. Ideal opportunity to work in collaboration with Queen Margaret University and existing health and social care providers.

Option 28: ELHSCP should collaborate with East Lothian Council planning department and Care Home providers to inform and influence future developments. ELHSCP should share information and data on demographics, inequity of access, geographic spread of existing homes and local needs. Future developments should take into consideration community connections, co-location with other services, local provision of health and social care services (e.g. GP) and their capacity.

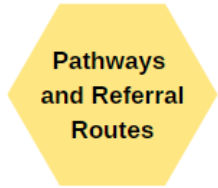
Option 44: ELHSCP should work in closer collaboration with Education partners to establish stronger links between care homes, hospitals, older people, and young people. Examples could include work placements for older children, career development and information, play sessions for younger children, reading clubs and outreach opportunities for care home residents to visit schools to mentor / buddy or vice versa.

Option 90: ELHSCP should review and update their engagement and communications and workforce development plans taking in to consideration the following: 1) building stronger and sustainable relationships with ongoing ELC engagements and developments (e.g. Place, Poverty, Local Development Plan, Local Housing Strategy, Planning Department); 2) Working with Education Department and local institutions (e.g. Queen Margaret University, Edinburgh College) to promote health and social care career opportunities, pathways and work placements / experience; 3) Collaboration with ELC Human Resources.

Option 91: ELHSCP should collaborate with NHS Lothian Public Health Partnership and Place Team to review DNA (did not attend) data for East Lothian residents and consider potential service improvements.

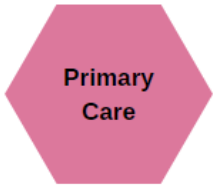
Option 103: We should explore opportunities to link in with the Fire Service and their fire safety checks in terms of assessing frailty, adaptations and equipment.

Pathways and Referral Routes



Option 38 ELHSCP should review all referral pathways and patient / family journeys through the health and social care system in order to identify gaps, improve and streamline processes and ensure that they remain outcomes-focused, and person-centred at all times.

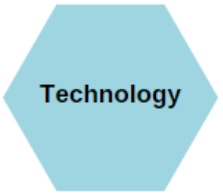
Primary Care



Option 74: ELHCSP should undertake a whole-system review for GP appointments. Accessing appointments and services can be particularly problematic for older people and those with mental-health conditions.

Option 98: We should introduce polypharmacy reviews and ensure that they are not exclusive to care home settings. (Polypharmacy reviews are important for people who are regularly prescribed five or more medications. Their aim is to ensure that the medications are effective, the patient isn't experiencing side effects and that all the medicines the patient is taking are still necessary.)

Technology



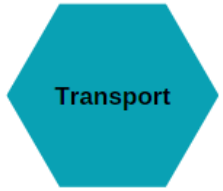
Option 85: We should explore better use of technology and associated services to allow people to remain within their own homes for longer. Examples include 24 hour supported living services for Older People, non-invasive home motion sensors, Near Me, Community Alarm Systems and smarter working / information sharing between staff groups.

Option 86: We should review the existing community alarm system and processes in order to ensure they are fit for purpose, flexible to needs and making use of technological developments.

Option 88: The different IT systems we use across health and social care should be harmonised. We should have one cloud-based system that we can all feed into (care at home providers, NHS staff, day centre, HSCP staff etc), within the limits of GDPR and information-sharing agreements. If a whole-system approach is impossible or unmanageable, then consideration should be given to shared care planning systems.

Option 89: We should give Care Home staff access to TRAK in order to assist with continuity of care, care planning and discharge planning.

Transport



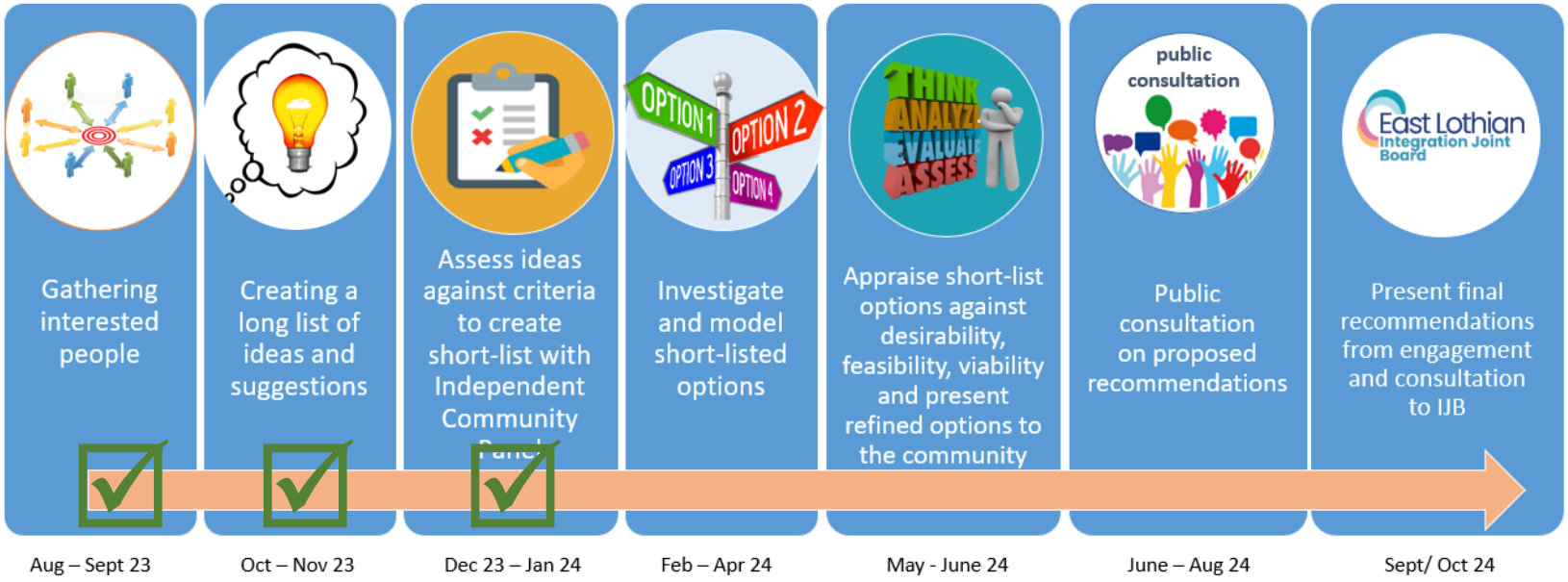
Option 94: When referrals are being made for secondary care services and appointments being planned, travel distance and accessibility should be considered for the older person. This system should be reviewed, streamlined and improved.

Option 104: Transport links to key health and social care sites (e.g. ELCH, GP practices, day centres, care homes) should be reviewed and developed in collaboration with ELC colleagues (e.g. transport, planning, infrastructure, Connected Communities) and existing service providers (e.g. Handicabs, Royal Voluntary Service, local taxi companies). Consideration should be given to commissioning services or developing volunteer initiatives. Wider transport considerations related to the provision of intermediate care should also be reviewed and developed. Good practice should be explored nationally (e.g. Pingo services, taxi card schemes, patient transport).

Next Stages

We have now completed the first three stages of the Planning Older People's Services Project Development.

Timeline



Timeline may be subject to change.

The next phase of development is to investigate and model each of the 61 short listed options. It is worth noting that some of the options may not require further development and may be referred to Health and Social Care Partnership staff for immediate action. The scoping and modelling will involve assessing the demand for each option, identifying the resource and cost implications, looking at projected timescales for delivering the suggestion, benefits and risks.

Once this activity has been completed each option will be assessed again in terms of desirability, feasibility, and viability as part of an options appraisal exercise. It is anticipated that this assessment will be completed by June 2024, following which there will be a public consultation on the proposed recommendations.

Options not being taken forward.

East Lothian Health and Social Care Partnership is committed to be open and transparent in its decision-making processes. As such, outline below are the remaining options / suggestions that were included within the 105 suggestions which came out of the initial community engagement activities, which unfortunately did not meet the necessary hurdle criteria to join the short-list.

The following options are not being taken forward within the scope of this project

Option 26: Care at Home
We should consider paying retainers for care-at-home providers/workers to ensure continuity of care for those before and after hospital admission.

Option 29: Care Homes
ELHSCP /ELIJB should create financial incentives to encourage developers to build care homes and services in certain locations.

Option 43
We should develop an intergenerational care-home model whereby students or young adults are offered a reduced rent / place to stay on the condition that they work a set number of hours within the home.

Option 48: Communication
We should develop a podcast to allow unpaid carers to share their stories, experiences, and advice, building a positive, supportive community in the process.

Option 102: Communication
ELHSCP should learn from colleagues in Children's Services about promoting and making best use of Self-Directed Support (SDS).

Option 50: Community
We should explore and develop community food / meal share opportunities to assist with social isolation, community wealth building and health and wellbeing outcomes.

Option 55: Day Centres
Day Centre provision/services should be expanded by co-locating within Care Homes. This may help to connect communities, combat social isolation, and promote intergenerational work.

Option 60: Dementia
ELHSCP / NHS Lothian should make use of virtual reality technology to help people living with dementia to recapture their memories. A pilot project is taking place in Dumfries and Galloway as part of Lens Perspectives work.

Option 61/62: ELHSCP Strategy, Operations and Staffing
A Day Hospital model / approach (on-site or via outreach) should be explored to co-locate a variety of services (e.g. wellness, nutrition, SALT, Occupational Therapy) for older people in a single location. This would assist with care planning (anticipatory care planning), co-ordination, care pathways, communication and social isolation.

Option 3: ELHSCP Strategy, Operations and Staffing
ELHSCP should develop a community hub model across geographical areas that ensures equitable access to preventative services related to mental health, pain management, Well Woman clinics, Older People clinics, OT / PT, wound and skin care. Hubs could also act as a single / first point of contact for information on available health and social care services. It would have strong links with existing CTAC service.

Option 67: ELHSCP Strategy, Operations and Staffing
We should further explore the Same Day Emergency Care (SDEC) model available at Western General as an alternative to acute hospital admission, for example by making an SDEC offshoot available at ELCH.

Option 17: Finance and Investment
We should explore alternative uses of Eskgreen building (e.g. office space, community hub, provision of primary or secondary health care services).

Option 54: Finance and Investment
ELHSCP should liaise with East Lothian Council colleagues to revisit venue charges for vital community and health and social care services (e.g. Day Centres, Lunch Clubs, Community Groups). These are vital services that help to keep people within their own communities and homes for longer contributing to key strategic priorities.

Option 73: Finance and Investment
We should commission external efficiency review of HSCP finances and services to encourage innovation.

Option 82: Finance and Investment
ELC / ELHSCP Should offer reduced rent or office space to health and social care providers to encourage them to operate or expand within East Lothian.

Option 68: Hospitals
The Edington and Belhaven satellite hospitals should re-open with return to original service provision.

Option 78: Intermediate Care
ELHSCP should invest further in adaptations to maximise the chance of East Lothian's older people remaining within their own homes for longer and increasing the prospect of them returning home quicker from hospital.

Option 2: Partnership Development
ELHSCP should work with East Lothian Council / Enjoy Leisure to provide older people with free access to sport and community facilities.

Option 87: Partnership Development
ELHSCP should partner with East Lothian Works to develop a health and social care career training course.

Option 75: Primary Care
GP practice for Pencaitland should be considered.

Option 64: Technology
ELHSCP should consider adopting and raising awareness of the LifeCurve approach as a golden thread throughout their work. [The ADL LifeCurve™ is based on the concept of the Compression of Functional Decline (CFD), developed by Prof. Peter Gore and colleagues at Newcastle University, and additional research, carried out by ADL Smartcare's dedicated research department in Newcastle.]