Dumfries and Galloway
Integration Joint Board

27 September 2023

This Report relates to
Item 8 on the Agenda

Right Care, Right Place: Bed based intermediate care

Paper presented by Viv Gration

For Approval

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List of Background Papers: *(available on request from dg.hslog@nhs.scot)*	• Right Care, Right Place: Intermediate Care – Integration Joint Board, 23 March 2023 • Integration Joint Board Strategic Commissioning Plan 2022-2025 • Integration Joint Board Participation and Engagement Strategy 2022 - 2025 • Right Care Right Place Information Pack • Right Care Right Place Bed Modelling	
Appendices: *(available on request*	1	Right Care Right Place Project Charter
	2	Right Care Right Place Project Risk Assessment

from dg.hslog@nhs.scot)	3	Right Care Right Place Statement of Consultation
	4	Equality Impact Assessment – the participation, engagement and consultation
	5	Right Care Right Place Engagement Period Analysis Report
	6	Right Care Right Place Consultation Analysis Report (including reports specific to each Home Team area)
	7	Overview of Current Community Bed Estate
	8	Year 1 Commissioning Plan for flexible bed based intermediate care
	9	Medium Term Commissioning Plan for Long Term Residential Care
	10	Environmental Impact Assessment
	11	Equality Impact Assessment – Year 1 commissioning plan

Directions Required to Council, Health Board or Both		
	Title : RCRP a - i (9 in total)	**Reference Number**
	Directions to:	
	1. No Direction Required	
	2. Dumfries and Galloway Council	
	3. NHS Dumfries and Galloway	
	4. Dumfries and Galloway Council and NHS Dumfries and Galloway	*X*

1. Introduction

1.1. Further to an intensive ten month service redesign programme, this paper presents the outcome of the Right Care, Right Place: Bed Based Intermediate Care Programme, comprising

- An overview of work undertaken in relation to bed based intermediate care since January 2022
- Definition of bed based intermediate care
- Description of a flexible model for bed based intermediate care developed following period of engagement between January and March 2023. This was further refined following further discussion during period of consultation.
- An overview of consultation activities between April and July 2023
- Analysis of formal period of consultation responses (independently analysed by Sleeping Giants)
- An overview of current estate
- Commissioning proposals for flexible beds in year one (April 2024 – March 2025) by home team area to respond immediately to the priorities identified through participation, engagement and consultation with communities
- The need for further planning work with communities to develop the potential community hubs and the future role of cottage hospitals that reflect the needs of the local community needs
- Residential care commissioning plan (short, medium, long term)
- Proposal for working with communities to develop plan for medium and longer term flexible bed based intermediate care
- Outline description of a community rehabilitation model and the need for further work that will come back to the IJB on the application of the national rehabilitation framework to support the medium and longer term plans for bed

based intermediate care and the future of cottage hospitals.
- Financial framework associated with the year 1 proposals.

1.2. The paper also sets out a series of recommendations and need for directions to move forward implementation of year 1 proposals and progress medium and long term delivery.

2. Recommendations

2.1 The Integration Joint Board is asked to:

- **Confirm** that the process to date and associated outputs are consistent with the Project Mandate
- **Confirm** that the process of engagement and participation and the consultation process itself have been conducted appropriately and in a way that is proportionate to the subject matter
- **Note** consultation activities and outcomes, including relevant impact assessments
- **Approve** the definition of Flexible Bed Based Intermediate Care following revision as a result of consultation. **The revised definition is** *'Flexible bed based intermediate care is*
  - *a bed that can be used when a person can no longer live safely in their home but does not need to be in an Acute Hospital*
  - *delivered within a service that will deliver care and support in line with their Care Inspectorate registration*
  - *has wraparound health and social care and support from Home Teams and/or specialist health and social care teams that meets the need of the person'*
- **Approve** and issue the following proposed directions

Reference	Details	NHS	Council	Both
RCRP (a)	Deliver year 1 proposals for flexible bed based intermediate care as outlined in the attached commissioning plan (Appendix 8) with the aim of ensuring that care is delivered as close to home as possible and connected to communities			**X**
RCRP (b)	Given the development of an alternative model for the delivery of bed based intermediate care that reflects what people have told us, NHS Dumfries and Galloway should not re-open the currently suspended in-patient services in cottage hospitals at this time. This should be reviewed following work with communities on the future role of cottage hospital sites	**X**		
RCRP (c)	Giving appropriate consideration to the level of engagement and consultation required, work with communities to develop a way forward for the use of			**X**

		cottage hospital sites. This could include a potential role as health and social care hubs, as described by local communities that could offer a range of out-patient and day treatment services such as intravenous therapies, blood transfusions, pre-operative assessments, primary care services, AHP services and supported virtual consultations to reduce the need for unnecessary patient travel.			
	RCRP (d)	Deliver the Medium Term Commissioning Plan for Longer Term Care (Appendix 9)		**X**	
	RCRP (e)	Giving appropriate consideration to the level of engagement and consultation required, work with communities to apply the national framework for community rehabilitation ensuring the right care in the right place, by making best use of existing resources including the role and function of cottage hospital sites			**X**
	RCRP (f)	Giving appropriate consideration to the level of engagement and consultation required, work with communities to design and plan medium and long term plans for flexible bed based intermediate care.			**X**
	RCRP (g)	Giving appropriate consideration to the level of engagement and consultation required, the local authority should explore the future balance of the care home market locally to support sustainability and resilience. That may lead to a mixed model of independent and statutory sector owned and run homes.		**X**	
	RCRP (h)	Design and establish an approach to community participation in the design and delivery of services delegated to the IJB. This should be linked to the IJB Strategy and based in best practice, that promotes consistency, culture change and true collaboration while encouraging creativity and innovation			**X**
	RCRP (i)	Review a range of enablers that will			**X**

	support flexible bed based intermediate care and wider care and support including: Integrated Community Equipment Services (ICES), adaptations, digital supports and assessment practice.			

- **Recommend** that The Health and Social Care Partnership engage and work in partnership with Dumfries and Galloway Council Strategic Housing Team to shape and influence the Strategic Housing Needs Assessment, to help develop future housing models that can support the delivery of health and social care through the Strategic Housing Forum and to support their delivery through contributing to the Strategic Housing Investment Plan. This will include the need for affordable housing for new staff moving into the region.
- **Recommend** that The Health and Social Care Partnership engage and work in partnership with Dumfries and Galloway Council Planning Team to shape and influence Local Development Plan 3, ensuring the need for housing and facility development to support health and social care delivery is fully reflected and that opportunities for the re-purposing of existing Council and NHS properties, as well as the development of new facilities to deliver bed based intermediate care, are identified and delivered
- **Recommend** that the Health and Social Care Partnership engage with Dumfries and Galloway Council, NHS Dumfries and Galloway and local communities to understand transport needs to support travel for people accessing flexible bed based care, their families and Carers.
- **Recommend** that the IJB Transformation, Innovation and Futures Committee consider the concept of 20 minutes neighbourhoods and bring forward a report to a future IJB meeting on whether this should be adopted as a principle for future planning
- **Note** the financial framework for year 1 proposals as set out in section 5.

3. Background and Main Report

3.1. The health and social care system is experiencing unprecedented pressures across all areas of Dumfries and Galloway and Scotland. In response the Integration Joint Board Strategic Commissioning Plan sets out a model of care and support along with commissioning intentions to support transformation to address these pressures and other well documented issues of increased demand, financial and workforce challenges (see background papers).

3.2. The Right Care Right Place Information Pack (click here) very clearly highlights the need to adapt in order to meet increasing demand and in section 5, illustrates that many people are currently not in receipt of the right care in the right place. The Information Pack was presented to and approved for use as the basis for the engagement and consultation by the IJB in March 2023.

3.3. Work undertaken since January 2022

Date	Work Undertaken
January 2022	The IJB considered a report in January 2022 in relation to developing a new community bed model by March 2023, see background papers.

	June – October 2022	'Time to Talk' a public engagement programme set the scene and provided 'pre-engagement' for the Right Care Right Place engagement work.
	October 2022	The Strategic Planning and Transformation Directorate were asked to take the lead on the Community Bed Review. The Right Care Right Place Programme established. The term bed-based intermediate care was adopted to recognise the importance of the connections with other aspects of community health and social care, namely Home Teams and care and support at home.
	October 2022 – January 2023	Programme Team established, comprising colleagues from Strategic Planning and Transformation Directorate; Community Beds and Supported Living Division of the Community Health and Social Care Directorate; Communications and Engagement Team; and Finance Preparation of communications and engagement plan as well as information pack and other resources to support engagement Engaged an independent partner, Sleeping Giants, to support the design, delivery and analysis of the public engagement.
	December 2022	Briefing provided to the IJB at their meeting on 08 December 2022. The briefing defined a 2 month period of participation and engagement with local communities during January and February 2023 to inform reporting to the IJB in March 2023, and as a precursor to a 12 week period of formal consultation through to the summer (provisionally scheduled at this time for April to July 2023).
	20 January – 3 March 2023	Period of Participation and Engagement.
	March – April 2023	Flexible bed based intermediate care model proposed and agreed at IJB meeting on 23 March 2023 as the basis for consultation. Resulting from this meeting the IJB: • Reflected on the projected changes in the local population, the associated changes in level of need over time and the outputs from the resulting modelling. • Considered that the engagement and participation to date had been sufficiently comprehensive, robust and proportionate to underpin the future planning of bed based intermediate care. • Reviewed and considered the feedback from the engagement period. • Discussed the options presented for each Home Team area and noted that they reflect and respond to the feedback from the engagement and participation period, as well meet the projected

	future need for bed based intermediate care. The IJB noted that these were not the final options but did represent the start of the process. • Approved in principle the proposed flexible bed based intermediate care model, subject to consultation. • Approved the formal consultation of proposed flexible bed based intermediate care options with communities. • Confirmed ongoing support for the process and issued a direction to Dumfries and Galloway Council and NHS Dumfries and Galloway to carry out the formal consultation
14 April – 07 July 2023	Period of Consultation.
July – September 2023	Health and Social care Leadership Team reviewed the project charter and risk assessment (appendices 1 and 2). Independent analysis of consultation responses and development of draft final report. Presentation of draft findings and recommendations to a wide range of governance groups, including professional advisory committees, Area Partnership Forum, NHS Board Management Team, Council Senior Leadership Team. Briefings on the findings and emergent recommendations provided to the Strategic Planning Group and IJB at workshops and also offered to local Political Groups.
27 September 2023	Presentation of final report to IJB for decision.

3.4. The project charter, the project risk assessment, statement of consultation and the equality impact assessment on the participation, engagement and consultation work are all attached as appendices 1 – 4 as confirmation of the work undertaken.

3.5. <u>Bed based Intermediate Care</u>

3.6. At their meeting in March 2023, the IJB agreed the definition of bed based intermediate care as ‘a bed that can be used when a person can no longer live safely in their home but does not need to be in an Acute Hospital.’ In Dumfries and Galloway this sort of care is often delivered in cottage hospitals, in care homes or in supported accommodation (such as sheltered housing or extra care housing).

3.7. Bed based intermediate care is generally expected to be short term and can include supporting people to move from hospital to return home, supporting people to change from receiving care at home to moving into a residential care home, or supporting people to recover from an illness. It can also support the management of a long term condition, palliative/end of life care or provide short breaks for Carers respite.

3.8. Right Care Right Place reflects the importance of the person centred, human rights based approaches to health and social care described within the IJB Model of Care and Support as well as connecting with Local Place Plans. Local Place Plans (LPPs) offer communities the opportunity to produce a plan for their area expressing their aspirations and ambitions for future change (for background information click here).

3.9. Flexible model

3.10. During the engagement period people told us that care that is close to home, in a homely setting and connected with their local community are the most important aspects of this type of care. The independent analysis of what people told us is attached at Appendix 5.

3.11. Establishing flexible bed based intermediate care within the existing estate (NHS, Council, Registered Landlords, Third Sector and Independent Sector) would see a small proportion of bed capacity within various settings reallocated for different purposes. These could include palliative care, end of life care, step up/step down care and short breaks for Carer respite.

3.12. People told us that they want a range of care options that support them to stay at home and/or within their local communities. The IJB Model of Care promotes choice and control, the move to a flexible model along with the changes to Care and Support at Home and development of Home Teams will enhance the range of options for people to choose from.

3.13. These places generally have some form of 24 hour support or care whether in person or using technology. Their use as a location for bed based interim care will require wraparound care from Home Teams. It is expected that these registered provider partners will deliver care and support that is within their Care Inspectorate registration. There may be some additional awareness and training needs for staff within these services and this will be developed and delivered collaboratively.

3.14. This approach was agreed in principle as a way forward by the IJB at their meeting in March 2023, subject to consultation.

3.15. The period of consultation has resulted in an important revision to the definition of flexible bed based intermediate care. It is proposed that the following definition is adopted across Dumfries and Galloway:

'Flexible bed based intermediate care is

- *a bed that can be used when a person can no longer live safely in their home but does not need to be in an Acute Hospital*
- *delivered within a service that will deliver care and support in line with their Care Inspectorate registration*
- *has wraparound health and social care and support from Home Teams and/or specialist health and social care teams that meets the need of the person'*

3.16. This approach would enable the Partnership to support delivery of this type of care in a way that reflects what people told us is important.

3.17. Consultation activities

3.18. The twelve week consultation period from 14 April to 07 July 2023 comprised of 15

public consultation events across the region. In addition consultation sessions were arranged for cottage hospital staff, palliative care staff, professional advisory committees, GPs, Care Home partners, Area Partnership Forum and third sector partners through their regular forum. A total of 510 people attended these events. (370 members of the public and 140 other members of staff/volunteers and GPs).

3.19. The consultation events were designed to enable people to source information, ask questions, seek clarity and complete surveys on the day or take surveys with them to complete later, either online or in hard copy.

3.20. It is difficult to estimate the total number of people that information was seen by as such a wide range of methods including adverts and press releases in local press, social media posts were used. This direct marketing as well as emails from partner organisations sharing the information via their distribution lists is difficult to quantify but is estimated to be between **8-10,000** people.

3.21. Methods of communication and engagement have included:

- adverts in the local papers
- articles on NHS and council staff intranet
- audio versions of documents on request
- circulation of emails across all sectors with engagement and consultation details and links to the online surveys
- documents available to download online
- electronic mail shot to known community groups inviting attendance at events
- Paid for Facebook adverts
- facilitated focus groups/workshops on MS Teams (Zoom on request)
- posters in community (approximately 80 for engagement period, approximately 160 for consultation period)
- posts on Partnership web pages (using Alt text making it more accessible for eReader software)
- presentations and discussions at existing meetings and bespoke sessions offered to stakeholders across all sectors and community groups
- regular press releases – region wide
- provision of facilitation packs to staff involved in facilitating discussions (included all engagement and consultation information and facilitation guides)
- radio adverts
- regular social media updates, including team/partner twitter accounts and LinkedIn

3.22. A survey questionnaire (online and hard copy) was developed for each of the seven home team areas (throughout this report Dumfries North and South Home Teams have been combined for planning purposes. This is because they cover the same geographical area, but are aligned to different GP practices). The surveys aimed to capture people's thoughts on:

- Whether the engagement findings from earlier in the year have been accurately reflected
- Forecasted future needs
- Proposed delivery approach (flexible model)
- Ideas for delivery over the short, medium and long term.

3.23. The Statement of Consultation at Appendix 3 provides detail of all communications,

engagement and consultation activities relating to Right Care Right Place.

3.24. Analysis of consultation survey responses

3.25. 236 responses were received and have been analysed by home team area. The number of responses across the Home Team areas varied from 12 to 61 with higher numbers typically being observed where cottage hospital in-patient services have been temporarily suspended.

3.26. Appendix 6 is the analysis report from Sleeping Giants. This includes analysis from each of the seven home team areas (Dumfries North and South combined).

3.27. The headline findings emerging from across all seven Home Team areas are summarised in this section. This includes an overview of the key themes identified in the analysis of the open ended responses and a summary of the answers given to the following two closed questions[1]:

- To what extent do you agree with what has been said in the previous engagement activity? and
- To what extent do you agree with the proposal of a flexible approach to bed based intermediate care?

3.28. Key Themes

3.29. Although the proposals set out in the consultation forms for each of the Home Team areas varied (to reflect both existing provision and forecasted need), a number of common themes emerged in the responses given:

People want change but recognised the challenges created by the capacity in health and social care:
Calls for more and better intermediate care provision were made but the feasibility of the proposals set out within the consultation forms were often questioned because of a lack of beds in care homes and cottage hospitals, a lack of social care, staff shortages, a need for more skilled staff and long waiting lists. Improving care was therefore perceived as dependent on tackling these issues.

Intermediate care should be available close to home:
People didn't want to travel to Dumfries or a cottage hospital in another area to access care. Instead, they wanted to stay close to their friends, family and local community. This was particularly important for palliative and end of life care.

Cottage hospitals are important to local communities across the region:
In addition to enabling people to stay close to home, cottage hospitals were described as providing more specialist nursing care, particularly when compared with care homes, and therefore better suited to step-up and step-down care. In areas where inpatient services had been suspended,

[1] The remainder of the questions focused on short, medium and longer term proposals specific to intermediate care need in each of the seven Home Team areas.

respondents expressed frustration at their loss.

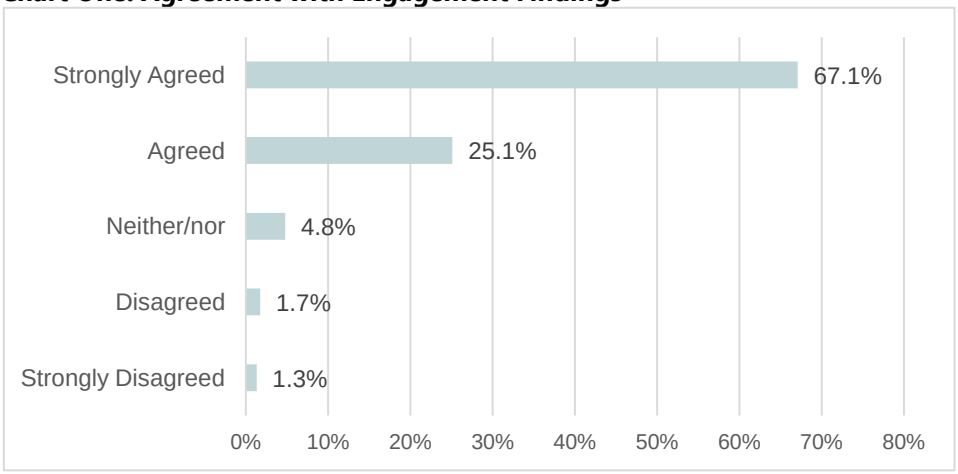
Other forms of care were also called for:
Although there was broad agreement that care should be available locally and that cottage hospitals had an important role to play in this, others called for a broader approach so that all needs could be met. For some people, being able to stay in their own home was preferable to a care home or intermediate care bed elsewhere but others felt that care homes and sheltered housing enabled more social interaction or connection with local communities.

There were mixed views on the role of Home Teams:
While some respondents identified them as playing a key role in a flexible model of bed based intermediate care, others felt that they were unable to provide the rapid response needed to prevent a hospital stay or lack the capacity needed.

3.30. Agreement with Earlier Engagement Findings

3.31. Each of the seven consultation forms (one for each home team area) presented a summary of the findings emerging from the earlier Right Care, Right Place engagement activity and asked respondents if they agreed or disagreed with what had been said. As shown in Chart One, a large majority of respondents from all areas agreed (92.2% (213) agreed or strongly agreed) and only 3.0% (7) disagreed or strongly disagreed.

Chart One: Agreement with Engagement Findings



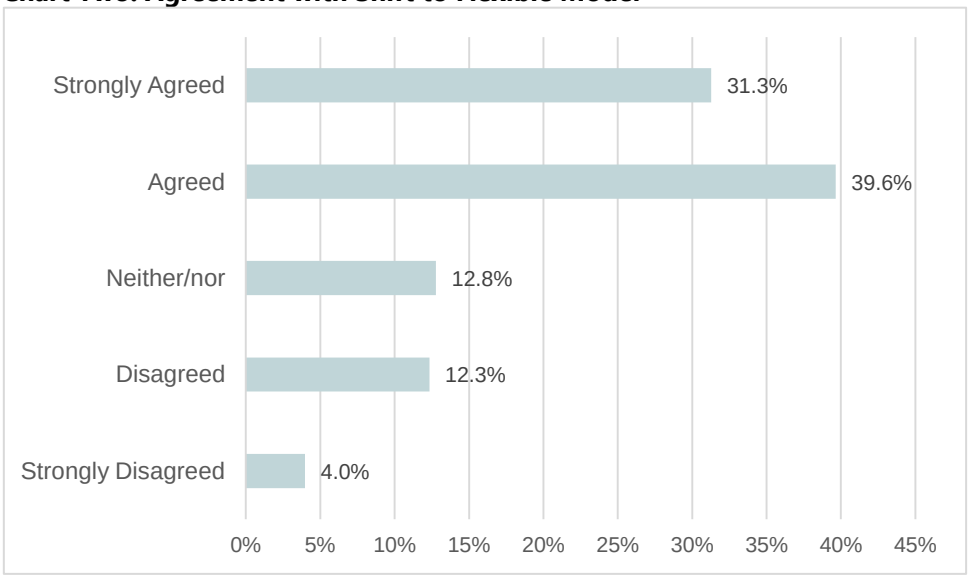
Base: All respondents who answered the question (n=231)

3.32. In explaining their answers, respondents typically emphasised the importance of cottage hospitals or the provision of care close to home. Others however highlighted the challenges created by staff shortages and bed numbers.

3.33. Agreement with Flexible Delivery model

3.34. Respondents from all areas were asked if they agreed or disagreed with the shift to a flexible delivery model and the majority agreed (70.9%), 161 either agreed or strongly agreed) and 16.3% (37) disagreed or strongly disagreed.

Chart Two: Agreement with Shift to Flexible Model



Base: All respondents who answered the question (n=227)

3.35. Despite high levels of agreement, respondents often questioned the feasibility of the approach given the challenges facing health and social care (e.g. staffing, bed numbers and social care provision). Others raised the following concerns:

- That the proposed approach might block beds elsewhere. For example, what would happen to those in need of a sheltered housing placement if units were used to provide intermediate care?
- The use of care home beds could increase demands on already stretched community nurses and Home Teams; and
- Long term care home residents could be disrupted by intermediate beds.

3.36. Therefore, further details on the proposals – and how they can be achieved – are needed to enable members of the public to make a more informed judgement about how a flexible model might work in their area.

3.37. However there is also a need to act with some urgency in the provision of palliative and end of life care close to home. Therefore a commissioning plan for year 1 has been developed setting out proposals for establishing flexible bed based intermediate care in each Home Team area.

3.38. <u>Overview of Current Community Bed Based Care Estate</u>

3.39. Appendix 7 provides a detailed overview of the current community bed estate. This includes for care homes their location, total bed numbers, registration details along with the last care inspectorate grade for environment/setting. Additionally details of the cottage hospital estate, their current use and the existing bed layout.

3.40. Care home registrations set out the maximum number of residents as well as the age categories and type of care the homes are registered to provide. There are 29 care homes within the region, 26 for mainly older people and 3 for younger adults with enduring mental health issues or learning disabilities. The largest home for older people accommodates 85 residents, the smallest accommodating12 residents.

3.41. The Care Inspectorate inspection quality themes were reviewed in April 2018 with the 'how good is our setting' changing to 'quality of environment'. The quality of environment inspection looks at where the service is delivered, for example how clean, well maintained and accessible it is, the atmosphere of the service and how welcoming it is. A six point grading scale is used with 1 being unsatisfactory and 6 being excellent. All homes have current grades of 3 (satisfactory) or above. Not all quality themes are assessed at each inspection therefore some care homes have not yet been assessed under the new environment grading. The oldest grades are 4 in 2016; the latest is 3 in 2023.

3.42. There are 9 cottage hospitals within the estate detailed in Appendix 7. This includes the current bed numbers and room configurations along with what they are currently utilised for, both inpatient and outpatient services. Cottage hospitals provide a range of intermediate inpatient services. These can be defined as: rehabilitation (that cannot be delivered at home); step up care; step down care; and end of life/palliative care that cannot be delivered at home.

3.43. 4 cottage hospitals are currently suspended for inpatient services and Mountainhall Ward 1 was opened temporarily as a community hospital to assist supporting surge capacity and flow from DGRI. Mountainhall Treatment Centre is a modern building with multiple single rooms. Along with the other cottage hospitals consideration needs to be given to what role Mountainhall Treatment Centre has in supporting both surge capacity and capacity for intermediate care in the future.

3.44. NHS Dumfries and Galloway are committed to ensuring that its facilities are maintained to a high standard ensuring compliance with statutory standards and health and safety regulations. The buildings are regularly assessed and backlog maintenance quantified. Buildings are also reviewed for their functional suitability and quality. This has led the Board to consider repurposing some of its existing estate to make best use of the facility to provide a base for the provision of modern health care.

3.45. Reviewing functional suitability and quality of buildings involves consideration of six aspects of the property (physical condition, functional suitability, space utilisation, quality, statutory requirements and environmental management). This can only be undertaken when there are proposals in place for their use and therefore will be carried out as proposals and plans are developed with communities moving forward.

3.46. The existing estate consists of over 90 buildings on 38 sites it is therefore important that each site/building is put to optimal and most efficient use. The drive toward a net carbon zero estate by 2040 will impact on the estate profile leading to improvements and a greater efficiency of a rationalised estate as building energy accounts for approx 90% of our carbon emissions.

3.47. <u>Year 1 Commissioning Plan</u>

3.48. It is clear from the bed modelling (for link to Modelling Future Demand for Health and Social Care in Dumfries and Galloway click here) and what people have told us that there is a need for some short term action in relation to flexible bed based intermediate care. Therefore a short term / year 1 Commissioning Plan has been developed, see Appendix 8. This sets out the planning assumptions and details of the requirements in each home team area.

3.49. At any time there are homes in the region that have 'unavailable beds' in September this accounted for approximately 6% of the estate. This can be for a range of different reasons such as on hold for planned admissions, outbreaks (for example flu, norovirus or covid 19), suspension of placements, staffing challenges or repairs underway. Early commissioning conversations with some care home partners have indicated that there is potential within existing homes to commission flexible beds in this short term.

3.50. Planning assumptions include:

- Home Team areas are the basis of local communities
- Flexible beds in each home team area will be used for palliative care, end of life care, step up/step down to/from hospital,
- Short breaks for respite for Carers will make use of the flexible beds and will be limited to use of one in the east and another in the west at any time. These can be any of the flexible beds in the home team areas and will be bookable through the Community Waiting Times Team. If these are not needed for respite for Carers at any time, they can be used flexibly for other purposes in line with the flexible model.
- All current care homes are in operation
- Discharge to assess and rapid response pathways are operational
- Current Home Team workforce will be sufficient to support year 1 proposals
- Intensive, in patient, rehabilitation will be provided in four cottage hospitals (Lochmaben, Annan, Castle Douglas and Dalrymple Ward)
- Care and Support at Home Collaborative continues
- The use of technology, aids and adaptations is maximised
- Current assessment processes should be reviewed to reflect new ways of working

3.51. As with all aspects of health and social care and support delivery there is a level of complexity and interconnected services that require consideration. The financial framework for this programme of work is based on year 1 starting on 1 April 2024 and is set out in section 5 below. This will enable all sectors of the partnership to make the necessary adaptations to facilitate progress to establish flexible bed based intermediate care in each of the home team areas.

3.52. Given the ongoing system pressures, it will be important that commissioning and procurement processes are not the cause of any delay in moving forward with the year 1 commissioning plan. If IJB approve this plan, the Commissioning and Procurement Teams will undertake as much of their processes as early as possible within current financial year to enable swift delivery.

3.53. The following table describes the proposed locations to commission flexible bed based intermediate care for each home team area (commissioning plans) along with potential ways forward for development with communities.

Home Team Area	**Commissioning plans and potential ways forward for development with communities**	**Total Flexible Beds for Intermediate Care**
The Rhins	<u>Commissioning Plan</u> Repurpose existing short break for Carers respite bed within care home to **1 flexible bed** **2 flexible beds within care homes**	3

	<u>For development with communities</u> Retain Galloway Community Hospital Dalrymple Ward (26 beds) Maximise opportunities within **Galloway Community Hospital**	
The Machars	<u>Commissioning Plan</u> **6 flexible beds within care homes** <u>For development with communities</u> Maximise opportunities within **Newton Stewart Hospital** to become a Community Health and Social Care Hub including: • outpatient gym for rehabilitation • Outpatient Parenteral Antimicrobial Therapy (OPAT) – this allows patients requiring antibiotics through a drip to be treated outside of hospital • Continue current outpatients appointments • Vaccination centre • Home Team Base • Relocate some activities from GP practice to release capacity within GP Surgery	6
Stewartry	<u>Commissioning Plan</u> **5x flexible beds within care homes** <u>For development with communities</u> Retain beds in **Castle Douglas Hospital** and increase use of rehabilitation gym for inpatient and outpatient, also continue use as vaccination centre Maximise opportunities within **Kirkcudbright Hospital** to become a Community Health and Social Care Hub including: • Renal treatments • Outpatient Parenteral Antimicrobial Therapy (OPAT) – this allows patients requiring antibiotics through a drip to be treated outside of hospital • Primary Care Team • Continue current outpatients appointments • Vaccination centre • Home Team Base	5
Mid & Upper Nithsdale	<u>Commissioning Plan</u> **5x flexible beds within care homes** <u>For development with communities</u> Maximise opportunities within **Thornhill Hospital** to become a Community Health and Social Care Hub including: • outpatient gym for rehabilitation	7

	• Outpatient Parenteral Antimicrobial Therapy (OPAT) – this allows patients requiring antibiotics through a drip to be treated outside of hospital • Continue current outpatients appointments • Vaccination centre • Home Team Base • Relocate some activities from GP practice to release capacity within GP Surgery Interim placements are care home beds that are used when people are ready for discharge from hospital but their care home of choice do not have availability. There are currently 14 interim placement beds in this area. It is proposed that 2 of these be reallocated **for flexible intermediate bed based care**	
Dumfries North & South (these two home team areas have been combined for planning purposes)	<u>Commissioning Plan</u> **5x flexible beds within care homes** Maintain **1 flexible bed in Sheltered Housing** Complex (test of change) <u>For development with communities</u> **Maintain Mountainhall Ward 1** (12 beds) as cottage hospital beds due to the current system pressures and lack of care home beds in this home team area as a result of recent care home closures. Any additional beds within this facility will be available for use as surge beds in the event of significant pressures in acute hospitals. Maximise opportunities within **Mountainhall Treatment Centre** to become a Community Health and Social Care Hub including: • Outpatient gym for rehabilitation • Outpatient Parenteral Antimicrobial Therapy (OPAT) – this allows patients requiring antibiotics through a drip to be treated outside of hospital • Continue current outpatients appointments • Continue current day care • Home Team Base • In-house care an support team Note that Mountainhall Treatment Centre is also the location of several other clinical services, including ophthalmology and renal services.	6
Mid and Upper Annandale	<u>Commissioning Plan</u> **2 x flexible beds in care homes** <u>For development with communities</u> Retain beds in **Lochmaben Hospital** Maximise opportunities within **Moffat Hospital** to become a Community Health and Social Care Hub including:	2

	• Relocate GP practice • Primary Care Services • Outpatient Parenteral Antimicrobial Therapy (OPAT) – this allows patients requiring antibiotics through a drip to be treated outside of hospital • Continue current outpatients services • Vaccination Centre • Outpatient rehabilitation gym • Home Team Base	
Lower Annandale & Eskdale	<u>Commissioning Plan</u> **2 flexible beds in care homes** <u>For development with communities</u> Retain beds in **Thomas Hope Hospital** Retain beds in **Annan Hospital** Maximise opportunities within **Thomas Hope and Annan Hospitals**	2
Total number of flexible beds for intermediate care		**31**
Total number of cottage hospitals (number of beds) (includes MHTC and GCH Dalrymple Ward)		**6 (103)**
Total number of potential community health and social care hubs (way forward to be developed with communities)		**4**

3.54. The number of people that are likely to need support in a flexible bed is interdependent with the number of people who will be resident in a care home in the future. For this reason, the forecast modelling considered all types of care home placements, both interim placements and permanent residence placements, in the calculations.

3.55. Overall, the forecast modelling suggests that there will be demand for approximately 1,500 beds (flexible beds, cottage hospital beds, care home beds and palliative care beds) by 2046, an increase of around 480 beds from the current number. The year 1 plan addresses 6.5% of this difference.

3.56. The medium term commissioning plan for long term care and the planning work with communities in relation to flexible bed based intermediate care will be the next steps in bridging this gap.

3.57. <u>Interconnected Services and Practice Considerations</u>

3.58. Central to the success of a flexible model for bed based intermediate cares are the flexible bed provider partners, the in-reach or wraparound service provided by Home Teams and out of hours community services. Enablers such as assessment processes, the Integrated Community Equipment Service (ICES), community transport and digital technology also have a key role. These will need to be refined, developed and evolved to support the new model of flexible bed based intermediate care.

3.59. There are already some examples of where the enablers have already been expanded to support capacity building, these are described within the assurances in

section 4.

3.60. *Flexible bed provider partners*

3.61. Care Home provider partners and sheltered housing landlords will provide the actual flexible bed within this model. It is anticipated that these partners will provide 24/7 care and/or support that is in line with their current registration. The people who access services from the care homes will have similar care need to those who are permanent residents.

3.62. Care Homes will have staff on site 24/7 whereas sheltered housing complexes may have alternative ways of delivering 24/7 support, such as digital solutions or with support from Care and Support at Home provider partners.

3.63. Specific contractual arrangements such as a block contract within the current contracts will be required. This is also likely to require an increased rate of pay to account for the additional administration and housekeeping burden on partners. Currently Interim Care Placements in Care homes are paid at standard National Care Home Rate, with an additional one off payment of £190 per person to support the increased rate of changeover. This payment information is provided purely as an indication of the potential additional cost, details for the rates for flexible bed based intermediate care will be confirmed through the commissioning process described in point 3.67 below.

3.64. It will be necessary to work with provider partners to understand the level of additionality flexible beds would offer compared to permanent and interim residents and establishing a funding model based on that. We have spoken with several provider partners who are receptive to the model and keen to work with the Partnership to deliver this type of care and support.

3.65. Within sheltered housing the Partnership would need to take on the tenancy for units used for flexible bed based intermediate care, i.e. paying the standard rental charge whether they are used or not. This is similar to a block contract for care home provider partners. The Partnership would also have to meet the additional support costs depending on the person's needs or the facilities within individual complex.

3.66. Therefore there will be no cost to people who access flexible bed based intermediate care services.

3.67. In line with the IJB's recent commitment to 3 year contracts for provider partners, it is intended that arrangements for flexible bed based intermediate care can be on a 3 year basis. Further work is required, including engagement with provider partners to establish acceptable rates.

3.68. *Home Teams*

3.69. These are a new way of delivering community services in Dumfries and Galloway. They bring together community based health and social care practitioners in to 8 individual multi disciplinary teams across the region. See page 4 of the Right Care Right Place Information Pack (click here) for a map. As well as carrying out multi-disciplinary assessments of people's needs for care and support in a community setting, They are focused on delivering five different aspects of care and support in people's own homes and with this new model within flexible bed based intermediate

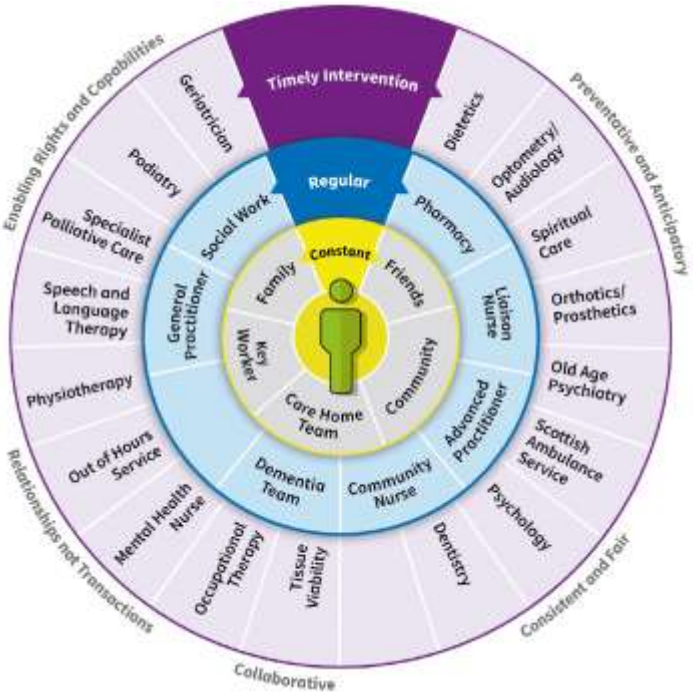
care. The five areas are:

- Rapid response - Providing rapid assessment and intervention in the community when someone is in a crisis situation, hopefully preventing the need for someone to be admitted to hospital.
- Discharge to assess - Supporting people to be discharged from hospital on time and to have a comprehensive assessment of their needs in their own home and in communities.
- Reablement and rehabilitation - Supporting people to recover from period of ill health, or from a planned operation, and regain their independence.
- Health improvement and wellbeing - Supporting and enabling people and communities to be active in maintaining or improving their health and wellbeing; building relationships to help reduce the effects of persistent inequalities
- Palliative and end of life care - Supporting people to have a good death in their own home and in communities.

3.70. Given the relatively small number of flexible bed based intermediate care suggested for year 1, Home Teams anticipate being able to deliver the care and support needed within existing resources.

3.71. Home Teams will also support delivery of the Scottish Government recently published 'My Health, My Care, My Home – healthcare framework for adults living in care homes' (Care Home Healthcare Framework) which sets out the need for multi-disciplinary support for people living in care homes. See outline of model on next page.

3.72. Work is already underway in Dumfries and Galloway to ensure that each care home has a named Advanced Practitioner. Home Teams will operate as an integral element of the 'regular' (blue) circle of the diagram below, ensuring timely interventions by core home team staff.



3.73. It may also be possible in some instances that a person accessing a flexible bed has a care and support at home package in place that can follow them into a flexible bed.

It is recognised that this will be dependent on location of the bed and availability of the staff member.

3.74. Home Teams are likely to be central to the multi disciplinary assessment processes for flexible intermediate care beds and should be supported by the wider community health and social care directorate and flexible bed based intermediate care provider partners to develop pathways into and out of these. This could include the development of joint care planning between statutory and independent partners and two way trusted assessor agreements. This is where care homes trust statutory partners to assess a person for admittance to their home and statutory sector trust the judgement of care home partners. There are examples of this across the UK and it has been found to smooth the process and reduce delays for people accessing the care they need.

3.75. *Out of hours*

3.76. Currently community out of hours support for people in the community is provided by community nursing across the whole region with additional support in the east of the region from the commissioned Marie Curie service. Care homes also use the GP Out of Hours service and this should continue.

3.77. In and out of hours Home Teams will be supporting care planning, with clear escalation actions in line with a person's individual stated needs therefore minimising the call on out of hours services. In addition the introduction of regular (weekly) Advanced Nurse Practitioner (ANP) support aims to improve anticipatory care planning as well as oversight of residents' needs. It is anticipated that this will reduce unnecessary out of hours calls.

3.78. As the flexible bed based intermediate care approach develops further work will be needed to establish whether there is need to review the current out of hours services to ensure it fully meets the needs of the people in the flexible beds.

3.79. <u>Residential care commissioning plan</u>

3.80. The number of residential care homes in Dumfries and Galloway has reduced by 31% between 2012 and 2022. This resulted in the loss of 18% of registered care home placements (226 beds). The Day of Care audit confirms that cottage hospitals have historically been filling the gap, In November 2022, 30% of 81 people in cottage hospitals were awaiting a care home placement. (<u>Right Care Right Place Information Pack</u>). Being in a hospital rather than a homely setting can have a detrimental effect on people's health and wellbeing, therefore it is essential that there are more appropriate settings available across the region.

3.81. On 12 September 2023, there were 70 people awaiting a care home placement, 41 in hospital, 17 in the community (their own home) and 12 in interim care home placements.

3.82. A snapshot taken at the end of July 2023 showed that 92% of registered care home beds for older adults were occupied. This means that there were 945 people living in a care home for older adults. National Records Scotland has predicted that the population in Dumfries and Galloway aged 75 and over will increase by 32% between 2018 and 2033. This means it is likely there will be 1,290 people living in care homes within our region by 2033.

3.83. Overall, the local forecast modelling suggests that there will be demand for approximately 1,500 beds (flexible beds, cottage hospital beds, care home beds and palliative care beds) by 2046, an increase of around 480 beds from the current number (as mentioned in section 3.55 above). An additional 31 beds every year for the next 15 years would be required to bridge the gap by 2038.

3.84. The Medium Term Commissioning Plan for Long Term Residential Care in Appendix 9 sets out opportunities to expand the number of care home beds for long term residential care over the next 3 years. In summary initial conversations with current provider partners has identified the following:

Home team area	**Number of additional beds needed within 3 years (from modelling flexible bed model)**	**Older people**	**Learning Disability/ Mental Health**
Rhins	2 placements	1 home, 8 placements	
Machars	2 placements		
Stewartry	1 placements	1 home, 10 placements	
Mid and Upper Nithsdale	1 placements		
Dumfries North and Dumfries South	2 placements		1 home, 8 placements
Mid and Upper Annandale and Eskdale	2 placements	1 homes, 2 placements	
Lower Annandale and Eskdale	1 placements		
Total	**11 placements**	**3 homes, 20 placements**	**1 home, 8 placements**

3.85. The table shows that the plan is to commission more than the projected need in the next three years and that there are no current opportunities for expansion within three home team areas (Machars, Mid and Upper Nithsdale and Lower Annandale and Eskdale).

3.86. Work continues to identify opportunities in these three areas to ensure, as far as possible, that the Partnership can deliver care and support that reflects what people have told us in important. An updated medium term commissioning plan will come forward to IJB in due course.

3.87. Commissioning 28 placements across the region, when the projected need is 11 will support the Partnership to address the existing demand for care home placements. As indicated in section 3.81 above on 12 September there were 41 people in hospital and 17 people in the community awaiting a care home placement, a further 12 are in an interim placement in a care home that is not their chosen home.

3.88. It is recognised that the care home market in Dumfries and Galloway, and beyond, is fragile. Increased running costs and workforce challenges mean that long term sustainability of homes is not guaranteed. While there may be opportunities for new developments with independent partners there are several small homes that may

struggle to remain viable in the longer term. It is important that IJB recognise this risk and ensure that future commissioning plans are designed to specifically mitigate this, including the recommendation in 3.88.

3.89. In addition to the potential of these independent sector developments the IJB may wish to consider a mixed model of residential care with development of local authority run homes. This approach would offer greater resilience in a fragile care home market. If the IJB wish to pursue this then it is advised that a direction is issued to the Council requiring the development of options for a mixed model for consideration by the IJB at a future date.

3.90. Medium Term Planning approach for flexible bed based intermediate care

3.91. Throughout the engagement and consultation communities told us how important it is for them to be involved in future planning for their areas. Each of the home team areas is likely to have different views and wishes on how to meet the health and social care needs of their communities. It is therefore essential that community participation (as described in section 3.98 below) enables co-design and co-delivery of proposals that are specific to their areas.

3.92. This reflects the Scottish Government initiatives for Place Planning and 20 minute neighbourhoods. As well as the Net Zero ambition described in section 3.39 above.

3.93. *Place Principle:*

3.94. Place is where people, location and resources combine to create a sense of identity and purpose, and is at the heart of addressing the needs and realising the full potential of communities. Places are shaped by the way resources, services and assets are directed and used by the people who live in and invest in them.

3.95. A more joined-up, collaborative, and participative approach to services, land and buildings, across all sectors within a place, enables better outcomes for everyone and increased opportunities for people and communities to shape their own lives.

3.96. *20 minute neighbourhoods*

3.97. This concept aims to provide access to the majority of daily needs within a 20 minute walk, wheel or cycle.

3.98. While recognising that it is not practical or possible to have all health and social care and support accessible within the formal concept of 20 minute neighbourhoods, The IJB is encouraged to commit to endorse the principle of 20 minute neighbourhoods in the medium term planning of future facilities for bed based care and support.

3.99. *IJB Model of Care*

3.100. The IJB Model of Care has been developed in consultation with people across Dumfries and Galloway, and will also influence the planning approach to community health and social care; including flexible bed based intermediate care. The model of care promotes

- human rights based approach
- a holistic approach that considers all five dimensions of wellbeing (Social,

Spiritual, Physical, Emotional and Mental)

- a greater focus of resources on prevention and early/low level intervention
- the importance of individual and community resilience by taking an asset based approach
- flexible health and social care and support that is responsive to people's changing needs
- more equitable and easier access to health and social care and support across the whole system
- working as partners to address other social, economic, cultural and environmental factors that influence health and wellbeing

3.101. Delivery of the model is underpinned and supported by good conversations, relationships, technologies, innovation and integrated ways of working.

3.102. *Strategic Housing*

3.103. Dumfries and Galloway Council are in the process of developing a new Strategic Housing Needs Assessment (SHNA). An SHNA is a key piece of evidence that provides information about a region's future housing requirements including number, mix and tenure of houses that are likely to be required. It will be important that the Partnership engage with the Strategic Housing Forum to support the development of the SHNA to help develop future housing models that can support the delivery of health and social care through the Strategic Housing Investment Plan (SHIP).

3.104. The core purpose of the SHIP is to set out strategic investment priorities for affordable housing over a 5-year period to achieve the outcomes set out in the Local Housing Strategy (LHS). The SHIP reinforces the local authority as the strategic housing authority and details how investment priorities will be delivered. The SHIP should:

- Set out the investment priorities for affordable housing
- Demonstrate how these will be delivered
- Identify the resources required to deliver these priorities
- Enable the involvement of key partners.

3.105. The SHIP is a realistic and practical operational plan that rolls forward projects identified in previous SHIPs and introduces new projects. It demonstrates how, when and where the Council and its partners intend to deliver new affordable homes across the region. It also illustrates how a variety of funding mechanisms are maximised to ensure the delivery of the projects.

3.106. To ensure delivery of the medium to long term plan for flexible bed based intermediate care it will be important that the SHIP includes the development of the right type of housing to meet the needs of people accessing this type of care. As well as considering the need for affordable housing for a growing workforce.

3.107. Local Development Plan

3.108. Local Development Plans (LDP) set out how and where land and property will be used in Dumfries and Galloway. It sets out a vision for how areas will change and describe where development will take place and where it will not. Planning

applications are assessed against the development plan.

3.109. Making sure that the next iteration of this plan (LDP3) reflects the need for housing and facility developments to support health and social care delivery needs to be a priority for the Partnership. In addition the process of developing the LDP3 is sure to provide opportunities to consider the re-purposing of existing council and NHS properties.

3.110. Community Transport

3.111. Transport and travel (or lack of) regularly features in conversations with communities about health and social care and we know the rural nature of Dumfries and Galloway can make this difficult. Sustaining the model of community care and support, such as flexible bed based care and support, in the long term will therefore require good affordable transport links.

3.112. *Community Participation*

3.113. There is a statutory duty for public bodies, such as the IJB, to involve people and communities in the planning and development of health and care services. In addition participation is a key element of the human rights based approach which requires that people are supported to be active citizens and they are involved in decisions that affect their lives.

3.114. The recently published 'Planning with People: Community and Participation Guidance' (click here) includes a new approach. This promotes consistency, culture change and true collaboration while also encouraging creativity and innovation based on best practice.

3.115. Building on the engagement and consultation in relation to Right Care, Right Place there is an opportunity, and a necessity, to fulfil the IJB commitment to enable participation as set out in the IJB Participation and Engagement Strategy, see background papers.

3.116. In order to achieve this level of participation it is suggested that the IJB considers developing a Community Participation Plan that is in line with Key Action 3.2 of their Participation and Engagement Strategy. That is that the participation is overseen by the Consultation and Engagement Working Group, 'to use existing networks and groups and establish new groups where necessary to help plan and ultimately assess engagement work'.

3.117. This area of work could consist of:

- regular panel meetings with the purpose of developing an independent and autonomous 'community view' around specific significant change programmes
- knowledge building, consultation and capacity building
- collaborative spaces for key groups to come together as equals to consider findings, share thinking and co-produce alternatives, solutions and recommendations
- development of best practice tools
- support communities to actively participate

3.118. Further work to scope, define and commission the approach, in line with the IJB approved Participation and Engagement Strategy, is required.

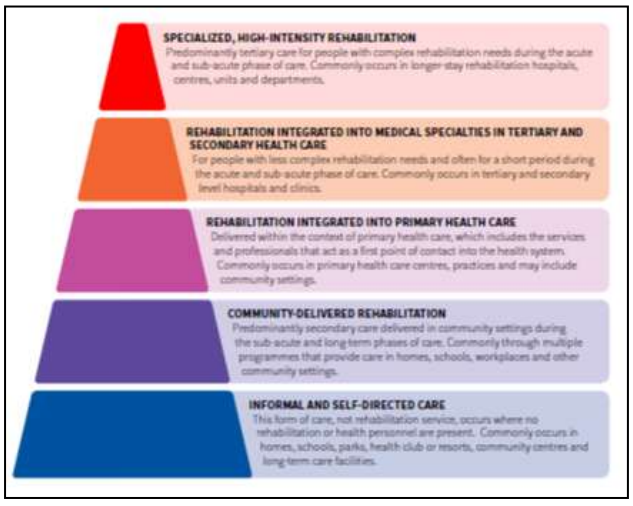
3.119. Community Rehabilitation Model

3.120. A key aspect of community health and social care is rehabilitation.

3.121. The Scottish Government has outlined in the Once for Scotland Rehabilitation Framework 2022 (click here) requirements to deliver quality rehabilitation. Gaining access to the right rehabilitation at the right time, in the right place not only provides efficient and effective use of resources it is at individual level the 'right thing to do'. This focus on outcomes aligns to the principles of Realistic Medicine and the Early Intervention and Preventative programmes.

3.122. Quality rehabilitation delivery requires application of the rehabilitation pyramid shown in Figure 1. It is essential all elements: Universal, Targeted, and Specialist can be provided locally within all settings including bed based services. Providing access to specialist rehabilitation within our community beds provides and could provide further enhanced essential transfer of care from acute services, delivering maximisation of resources and appropriate service provision closer to a person's home.

3.123. The delivery of rehabilitation services require a whole system approach, with bed based services not being considered in isolation. The creation of Home Teams and complex rehabilitation outpatient services alongside the review of bed based intermediate care provides an ideal opportunity to undertake exploratory and developmental work to ensure delivery of quality multi-disciplinary multi-agency rehabilitation across Dumfries and Galloway.



Extracted from WHO 2019, Rehabilitation in health systems: guide for action

3.124. Details of how this rehabilitation framework will be applied locally and the resulting impact on what capacity will be required where should be developed and presented to the IJB at a future date. This will extend beyond just flexible bed based intermediate care and so should give consideration to all community services.

4. Conclusions

4.1. The initial phase (engagement and consultation) of The Right Care Right Place Programme relating to Bed Based Intermediate Care has concluded. The relevant governance requirements, namely Project Charter, Risk Assessment, Statement of Consultation, Equality Impact Assessments and Environment and Climate Impact Assessment have been completed and approved.

4.2. Five themes arose from the period of public engagement. This table sets out assurance/response statements for presentation as part of the report to Integration Joint Board.

Theme from Consultation (Section 3.23 above)	**Assurance/Response**
 Capacity Challenges	Current models are not sustainable Good to see that people are supportive of change Proposed flexible model, alongside commissioning plans for additional capacity, use of digital supports alongside face to face care, new models of care and support across whole system will help to make best use of existing resources to meet the needs of people in Dumfries and Galloway. Technology has been proven to be successful in creating staff capacity in supported accommodation in Dumfries, Castle Douglas and Newtown Stewart.. For example the use of movement sensors and health monitoring equipment for conditions such as epilepsy has freed up staff from having to provide waking night and sleepover cover during the night but also enabling people with conditions more freedom during the day so that staff capacity can be used elsewhere.
 Close to Home	Central to the flexible model is people being able to stay close to home and connected with their communities. Year 1 commissioning plan sets out proposals for flexible beds within each Home Team area for delivery with some urgency. In addition The Health and Social Care Partnership is keen to explore transport options to support travel to these community services. Development of integrated community transport solutions will be key to ensuring community facilities are accessible and are crucial to the net zero ambition.
 Availability of Specialist Care	Each Home Team area has a range of specialist professionals who will provide wraparound and in-reach care for people in their own homes, within flexible bed based interimediate care and residential care. Digital solutions may also support access to specialist care and support as required.
 Wider forms of care locally	The IJB Model of Care describes how people who access care and support should have choice and control in their own care. A flexible model for bed based intermediate care is only one aspect of community health and social care. Care and Support at Home is well established and work is ongoing to make best use of those resources, other developments such as Hospital at Home are underway to support delivery of the IJB model of care.

In addition the year 1 commissioning plan includes development of community health and social care hubs within existing estate. This will also support delivery of care and support closer to people's home.

Home Teams' ability to deliver

It is early days for Home Teams as they were only formally established in winter of 2022. This new way of working will take time to fully embed and for all aspects of their work to be fully effective.

The flexible bed based intermediate care proposals are a new resource for home teams to use in their areas. This will help them to make best use of their resources and meet the needs of people in their areas while enabling people to retain connections with their communites and to establish relationships with the home team practitioners.

4.3. As a result of data analysis, extensive engagement and consultation there is a need to move swiftly to deliver flexible bed based intermediate care close to home. Therefore a year 1 commissioning plan with proposals for flexible beds within each home team area has been developed. The year 1 commissioning plan also describes areas for further work with communities in relation to the future role of cottage hospitals.

4.4. Given the development of an alternative model for the delivery of bed based intermediate care that reflects what people have told us, NHS Dumfries and Galloway should not re-open the currently suspended in-patient services in cottage hospitals at this time. This should be reviewed following work with communities on the future role of cottage hospital sites.

4.5. A flexible model for bed based intermediate care beyond year 1 will need also require full involvement of the communities within home team areas to ensure these are designed to meet the health and social care needs of the communities. Therefore it is proposed that a Community Participation approach is established to ensure the Partnership meets all the statutory duties and people's human right to be heard.

4.6. This participation will support the development of a home team area based plan for medium and long term delivery of a flexible bed based intermediate care model.

4.7. The change to a flexible bed based intermediate care model will inevitably have an impact on long term residential care. Therefore a medium term commissioning plan for long term residential care has also been developed. It is also suggested that the IJB may wish to consider a mixed model of care home delivery to mitigate against the risks associated with the fragile nature of the care home market in terms of viability and long term sustainability of homes in the region.

4.8. Rehabilitation within the community is a further consideration within a flexible bed intermediate care as well as within people's homes, cottage hospitals and the wider community. The National 'Once for Scotland Rehabilitation Framework' provides the context for implementation locally and a plan for how this can be implemented across a range of setting should be developed for presentation to a future IJB.

4.9. The change of model for the delivery of bed based intermediate care will also impact on a range of interconnected services and practice. Therefore it will be important to review enablers such as use of technology, aids and adaptations as well as assessment processes.

4.10. In addition, working in partnership with key stakeholders in relation to strategic housing, use of existing buildings, community transport needs and concepts such as 20 minute neighbourhoods are also recommended.

4.11. Workforce challenges are well reported across all areas of health and social care and support, including independent and statutory sectors. While the Communities Directorate expect to be able to support the year 1 commissioning plan within existing resources there will inevitably be workforce implications to this new model going forward.

5. Resource Implications

5.1. A financial framework has been developed, setting the resource context underpinning this work and clarifying the anticipated costs of delivering the year 1 proposals. This framework is set out below.

5.2. Overall Position

5.3. The transformation of bed based community Health and Care services is a critical strand of the overall IJB strategy, but it must be underpinned by a robust financial and workforce model to support the delivery of any changes proposed. Whilst there are existing budgets identified as part of the delegated Health and Social Care budget position, it is recognised that the financial position is incredibly challenging with a significant underlying financial deficit within the budget and the need to deliver substantial savings to balance the budget. The opening plan for 2023/24 set out a projected deficit of £25.128m for the year and an ambitious savings plan to go alongside it. Any review or transformation of services must recognise this financial context and seek to support the achievement of a balanced financial position for the IJB.

5.4. Adult Social Care budgets

5.5. The budgets which are within the scope of this programme primarily sit within the Community Health and Social Care Directorate and managed through the Home Teams. Based on the 2023/24 budgets, the total budgets aligned to the Right Care Right Place programme is estimated at £78.307m with £23.265m from Health budgets and £55.042m from Social Care budgets. In addition to the bed based care resource, it includes the cost of the Home Teams and Care at Home resource across the new geographical areas which the newly established Home Teams are aligned to.

5.6. Within the Social Care funding delegated to the IJB, care home budgets (including residential, EMI, Nursing, and respite care placements) equates to £33.729m, with an existing budget for approximately 1,000 placements of which we currently have about 950 (of which 40 are out of region), resulting in a net underspend of circa £2.3m within this budget. As part of the opening budget for the IJB for 2023/24, this underspend was offset against pressures and overspends within the wider Social Care budget. At the latest financial forecast, the underspend is now forecast to be

£1.8m (£0.5m less than planned) due to costs associated with interim care placements. It is estimated that 29% of care home costs are received in income with any loss in income from vacant beds netted off in the underspend.

5.7. Care at home budgets for the over 65's budget equates to £15.714m (including £3.2m of Option 1 care – direct payments) this equates to approximately 11,200 care at home hours.

5.8. We receive approx. 2% of the cost of care at home as service user income. The ratio of service user income to costs is important if we are to see a shift from care homes to care at home models of care. An over 65's residential care placement costs £763 and equates to approximately 35 hours of care at home.

5.9. We are also currently funding 14 'block' care home beds (interim) from IJB reserves for 2023/24 at a cost of £570k for a 12 month period. These beds provide a level of surge capacity for the system but have no funding source beyond 31 March 2024.

5.10. NHS Budgets

5.11. The NHS budgets include the cost of the Home Teams and the existing Community Hospitals (excluding property costs), reflecting the budgets allocated based on existing service delivery models and staffing ratios. The Home Teams are now fully established with a number of the deployed staff from the Cottage Hospitals supporting increasing numbers of clients at home. Workforce challenges remain the most significant issue and active recruitment to more difficult to fill posts is ongoing.

5.12. Financial Implications of Changes Proposed

5.13. The 31 flexible Social Care beds identified in year one would cost around £1.233m (residential rate of £763 at 2023/24 price base) and funding would need to be released through savings to allow this to progress.

5.14. In year one, the continued suspension of cottage hospital inpatient beds has the potential to reduce the required budgets £2.217m. This assumes that the beds created as surge capacity within Mountainhall Treatment Centre would continue for a further 12 month period until other service changes are embedded and bed usage has been monitored.

5.15. The existing costs of all NHS property related costs (rates, energy, maintenance etc) have been assumed to continue at current levels until we are clearer on the future use of the NHS estate. Whilst the backlog maintenance challenge is significant and there is limited capital budget availability, it is acknowledged that any improvements and reconfiguration of buildings would require to be prioritised as part of the NHS Boards capital programme and a funding source identified.

5.16. Overall Summary

5.17. At this stage of the Right Care Right Place Programme it is difficult to fully understand and assess the financial implications of the changes proposed especially when much of the engagement work about the future use of existing Community Hospitals will be undertaken in the next phase of the work. The changes identified in year one reflect what can be quantified and assessed at this stage but it is recognised that the ambitions in future years require some further investment.

5.18. Recommendations

- Acknowledge the potential to release savings from the NHS delegated budget of £2.217m to reduce the underlying deficit for the IJB.
- Note the increased costs associated with the 31 additional flexible beds, with funding options for this to be considered as part of 2024/25 budget setting process given the significant additional cost of £1.233m associated with this proposal.
- Recognise that further work will need to be undertaken over the next six months to fully understand and assess proposed changed and the financial modelling to support this.

6. Impact on Health and Social Care Partnership Outcomes, Priorities and Policy

6.1. Through the Partnership Delivery Plan the Right Care, Right Place review has been mapped to the Strategic Commissioning Plan 2022-25 as follows, this denotes the primary SCI and Tactical Priority:

- Strategic Commissioning Intention (SCI) 5 – People's care and support is safe, effective and sustainable
- Tactical Priority 5.4 – The strategic commissioning cycle supports the sustainability of the model of care

In addition, this work will contribute to:

- SCI 4 - People have access to the care and support they need
- SCI 7 - People's chosen outcome are improved through available financial resources being allocated in line with the model of care and delivering best value

6.2. Further, in mapping to the 9 National Health and Wellbeing Outcomes, the following primary and secondary outcomes have been identified:

- Outcome 2 – People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- Outcome 4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

7. Legal and Risk Implications

7.1. This programme relates to major service change that may have a significant impact on people who use services, people who deliver care and support, including Carers. There are legal requirements for carrying out such reviews, with a focus on effective and robust stakeholder engagement.

7.2. There is reputational risk to the organisation as elements of the programme could be controversial. To mitigate this, the programme has been undertaken guided by national standards for communication and consultation and supported by Healthcare Improvement Scotland team to ensure good practice.

7.3. The Statement of Consultation at Appendix 3 includes a statement from Healthcare

Improvement Scotland that confirms their support for the processes followed.

7.4. The after effects of the Covid-19 pandemic, rising energy costs and general cost of living increases mean that the residential care home market in Dumfries and Galloway and beyond is fragile. There are risks to the viability and sustainability of the model if care homes close. The Commissioning Team and Care Home Tactical Team have a risk assessment and management process in place, this is overseen by the Collaborative Care Home Support Team.

7.5. In the event that the IJB approve the flexible model and approach a full risk profile of provider partners will be undertaken by operational teams to further define, assess and mitigate this risk.

8. Consultation

8.1. Statement of Consultation included at Appendix 3.

8.2. Throughout the engagement and consultation periods we have sought to ensure under-represented groups and communities of interest have their voices heard**.**

8.3. Targeted and repeated invitations to engage in different formats were sent out through local support groups such as LGBT+ (Lesbian, Gay, Bisexual or Transgender Plus), the Powerful Voices Together Group, Dumfries and Galloway Multicultural Association, Dumfries and Galloway Carers Centre and the Youth Council. Staff groups and protected characteristic group networks (including Women's Network, Black and Minority Ethnic Staff Network, Staff Disability Network and LGBT + Staff Network) were also specifically asked to engage in addition to the generic engagement activities highlighted in the Statement of Consultation.

8.4. The majority of groups preferred to complete surveys online or by post so it is impossible to determine how many people from under-represented groups participated in the engagement and consultation periods. Only a very small number of people completed the Equality and Diversity questions in the survey.

9. Equality and Human Rights Impact Assessment

9.1. An Equality Impact Assessment for Phase 1 of Right Care Right Place is attached as Appendix 4.

9.2. An Environmental, Sustainability and Climate Change Impact Assessment was also carried out in relation to Right Care Right Place. This is attached as Appendix 10.

9.3. An Equality Impact Assessment for Phase 2 of Right Care Right Place (Flexible model) has been started. A copy of the working document is attached as Appendix 11.

10. Glossary

10.1. All acronyms must be set out in full the first time they appear in a paper with the acronym following in brackets.

EQIA	**Equality Impact Assessment**
GP	**General Practitioner**

	IJB	**Integration Joint Board**
	PID	**Project Initiation Document**
	RCRP	**Right Care, Right Place**
	SCI	**Strategic Commissioning Intention**
	SHIP	**Strategic Housing Investment Plan**
	LHS	**Local Housing Strategy**
	ICES	**Integrated Community Equipment Service**

Dumfries and Galloway Integration Joint Board

DIRECTION

(ISSUED UNDER SECTIONS 26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014)

<table>
<tr><td>1.</td><td>Title of Direction and Reference Number</td><td>Set of 9 Directions relating to Right Care Right Place: Bed Based Intermediate Care
Reference Number will be added once the direction is formally logged</td></tr>
<tr><td>2.</td><td>Date Direction Issued by Integration Joint Board</td><td>27 September 2023</td></tr>
<tr><td>3.</td><td>Date from which Direction takes effect</td><td>To be confirmed by IJB</td></tr>
<tr><td>4.</td><td>Direction to</td><td>Provided in section 7.

Set of 9 directions relating to Right Care Right Place</td></tr>
<tr><td>5.</td><td>Does this direction supersede, amend or cancel a previous Direction? If yes, include the reference number(s)</td><td>Supersedes the direction to carry out review of community beds</td></tr>
<tr><td>6.</td><td>Functions covered by Direction</td><td>Cottage hospitals; residential care homes; home teams; short breaks for Carers respite</td></tr>
<tr><td>7.</td><td>Full text of Direction</td><td>
<table>
<tr><th>Reference</th><th>Details</th><th>NHS</th><th>Council</th><th>Both</th></tr>
<tr><td>RCRP (a)</td><td>Deliver year 1 proposals for flexible bed based intermediate care as outlined in the attached commissioning plan (Appendix 8) with the aim of ensuring that care is delivered as close to home as possible and connected to communities</td><td></td><td></td><td>X</td></tr>
</table>
</td></tr>
</table>

		RCRP (b)	Given the development of an alternative model for the delivery of bed based intermediate care that reflects what people have told us, NHS Dumfries and Galloway should not re-open the currently suspended in-patient services in cottage hospitals at this time. This should be reviewed following work with communities on the future role of cottage hospital sites	**X**		
		RCRP (c)	Giving appropriate consideration to the level of engagement and consultation required, work with communities to develop a way forward for the use of cottage hospitals. This could include a potential role as health and social care hubs. That could include a range of out-patient and day treatment services such as intravenous therapies, blood transfusions, pre-operative assessments, primary care services, AHP services and supported virtual consultations to reduce the need for unnecessary patient travel.			**X**
		RCRP (d)	Deliver the Medium Term Commissioning Plan for Longer		**X**	

			Term Care (Appendix 9)			
		RCRP (e)	Giving appropriate consideration to the level of engagement and consultation required, work with communities to apply the national framework for community rehabilitation ensuring the right care in the right place, by making best use of existing resources including the role and function of cottage hospital sites			**X**
		RCRP (f)	Giving appropriate consideration to the level of engagement and consultation required, work with communities to design and plan medium and long term plans for flexible bed based intermediate care.			**X**
		RCRP (g)	Giving appropriate consideration to the level of engagement and consultation required, the local authority should explore the future balance of the care home market locally to support sustainability and resilience. That may lead to a mixed model of independent and statutory sector owned and run homes.		**X**	
		RCRP (h)	Design and establish an			**X**

			approach to community participation in the design and delivery of services delegated to the IJB. This should be linked to the IJB Strategy and based in best practice, that promotes consistency, culture change and true collaboration while encouraging creativity and innovation			
		RCRP (i)	Review a range of enablers that will support flexible bed based intermediate care and wider care and support including: Integrated Community Equipment Services (ICES), adaptations, digital supports and assessment practice.			**X**
8.	Budget allocated by Integration Joint Board to carry out Direction	To be confirmed through the 2024/25 budget setting process.				
9.	Desired Outcomes	Through the Partnership Delivery Plan the Right Care, Right Place review has been mapped to the Strategic Commissioning Plan 2022-25 as follows, this denotes the primary SCI and Tactical Priority: • Strategic Commissioning Intention (SCI) 5 – People's care and support is safe, effective and sustainable • Tactical Priority 5.4 – The strategic commissioning cycle supports the sustainability of the model of care In addition, this work will contribute to: • SCI 4 - People have access to the care and support they need				

<table>
<tr><td></td><td></td><td colspan="2">SCI 7 - People's chosen outcome are improved through available financial resources being allocated in line with the model of care and delivering best value Further, in mapping to the 9 National Health and Wellbeing Outcomes, the following primary and secondary outcomes have been identified: Outcome 2 – People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.</td></tr>
<tr><td rowspan="3">10.</td><td rowspan="3">Is there a need for engagement with the third sector in delivery of this direction?</td><td>YES</td><td>NO</td></tr>
<tr><td>Tick or Cross X</td><td>Tick or Cross</td></tr>
<tr><td colspan="2">.</td></tr>
<tr><td>11.</td><td>Performance Monitoring Arrangements</td><td colspan="2">Directions will be reported to the relevant IJB Committee on a 6 monthly basis.
An annual report of all current Directions will be presented to the IJB</td></tr>
<tr><td>12.</td><td>Date Direction will be Reviewed</td><td colspan="2">March 2024 – just before the start of year 1</td></tr>
</table>