Meeting: **Integration Joint Board**

Date of Meeting: **30th August 2023**

Title of Report: **Spotlight on Health and Community Care**

Presented by: **Caroline Cherry, Head of Service, Health and Community Care**

The IJB is asked to:

Note the spotlight on services, key successes and challenge and areas of

It has a large integrated internal staffing across multiple disciplines and an extended staffing through commissioned providers.

6 Community Hospitals

Community Health and Social Work Teams across Argyll and Bute (including District Nursing, Allied Health Professions, Social Work). Included are Extended Community Care Teams (ECCT) who provide end of life care at home.

7 internally delivered care homes (including one nursing home).

10 externally commissioned care homes.

3 internal day services and a commissioned day service for older people.

and deliver 11,946 hrs of support (figures as of Mon 31st July) a week

We continue to build and develop key working relationships with stakeholders, and in so doing we establish clarity of roles and responsibilities (so that the patient/service users care journey is as seamless as possible).

We are focused on the transformation and maximisation of the impact of community care. This in turn fosters decreased dependency on hospital beds and the avoidance of admissions by developing robust services within community teams and localities.

Hospital at Home and its model of delivery become an embedded standard of practice (rather than a defined services area) so that we are better able to respond to and manage urgent and/or complex presentations.

We reduce pressure on the need for finite specialist resources by ensuring that needs are well managed at earlier stages of intervention (and that they continue to be well managed in partnership with patients/service users, partner organisations and families).

3.5 Discharge without Delay High Impact Change 3:

Work-streams related to this high impact change area are focused and managed via the Discharge without Delay and Unscheduled Care Work-streams. A recent heat map exercise has been undertaken across the HSCP which revealed key findings and priority focus areas. Hospital at Home and Community Integrated Models of Care are essential priorities.

This area of work has shared aims to ensure:

Admissions are avoided, wherever there is a safe alternative.

Wherever possible, discharge planning begins at the point of admission.

We move from bed management, to patient management (wherein we see the holistic needs in full and responded accordingly within resources).

Discharges are well supported, with a focus on early supported discharge/discharge to asses, safe and realistic care planning and re-ablement.

Interfaces are clear and timely, in relation to need (i.e. legal processes, specialist needs and family liaisons/dispute resolution).

Standardised models and processes are in place, which ensure that aims and expectations are clear at each stage of the care journey.

Community teams and care home provision is robust and able to receive and support discharged patients in line with their needs and wishes.

We work as a system to achieve these aims, rather than aligning with traditional models of

approach and best practice and guidance including staffing levels, criteria for admission and national guidance.

Community Services include, community nursing, adult social work, occupational therapy, and physiotherapy. The community teams work and are managed in an integrated way to support and meet the identified needs of the population of Argyll & Bute HSCP.
Currently a Community Integrated Short Life Working Group is in progress devolved for the Argyll & Bute Unscheduled Care Group (Right time, Right Place, Right care). The purpose of this group is again to standardise best practice across the HSCP for our community services. The initial focus has been on updating the Community Standards from 2019. This work will progress to standardising processes such as virtual wards, Single Point of Access.

3.7 Example-Working Together Care at Home

To manage demand the service has had to adapt and change, implementing new processes to ensure best use of all available resources. A significant change has been the implementation of Smarter Commissioning: a process which has been implemented in all localities and has very much enhanced communication and collaborative working between the HSCP staff and all external providers. Daily meetings are held with all Care at Home front line managers (Internal service and external providers). The purpose of these meetings are to ensure all available resources are being used as efficiently and effectively as possible, targeting our resources at those most in need. Since the implementation of this process we have seen a marked decrease in those awaiting social care support.

The Care at Home Service is now working with 3 external partners who now hold sponsorship licenses to employ overseas workers. Within Argyll & Bute we now have overseas workers working in the localities of Helensburgh & Lomond and Oban.
Whilst this form of recruitment has shown to be successful in attracting staff to social care, our main challenge is now access to affordable housing. The lack of affordable accommodation has impacted upon the number of staff that can be employed within social care.

3.8 Example-Virtual Wards Mid-Argyll/Mull

We have examples of good practice from the Mid Argyll and Mull team who have developed the virtual ward.

The Mid Argyll Virtual Ward is a completely multi -disciplinary, we have Scottish Ambulance Service, Tec and all other disciplines. The Virtual Ward meet twice a week on MS Teams. This has been proven to reduce admissions and support early discharge. It is supported by the Lochgilphead medical centre who provide the medical cover for it. It has been operational now for 2 years and has gone from success to success. A patient can be admitted onto the Virtual Ward by any discipline who will then be supported by the MDT.

The Mull Virtual Ward is l av

4.2 Hospitals

Bed occupancy has reduced from 83% in March 2023 to 67.7% in June 2023.
Unplanned admissions to hospital across all community hospitals average around 28 per week with the highest numbers from May to August 2023 being in Mid Argyll, followed by Rothesay.
The number of inpatients with a planned date of discharge who were not discharged on that date reduced from 76.9% in March 2023 to 65.3% in June 2023.
The number of people whose discharge was delayed increased from 27 in March 2023 to 35 in June 2023.
An average of 83 people per week are successfully discharged from Argyll and Bute hospitals.
The number of bed days lost to delays to Argyll and Bute residents placed in Greater Glasgow and Clyde Hospitals has increased steadily from 927 per week in June 23 to 1262 in mid July 2023.
The highest reason for people being delayed are people awaiting completion of arrangements in order to live in their own home non availability of services.
The second highest reason for delay is attributed to those awaiting completion of post hospital social care assessments.
In July 2023 there were 5 people being considered for the use of S13ZA of the Social Work (Scotland) Act 1968. This is where a person who lacks capacity and does not have Guardianship in place, but has been assessed as needing ongoing care in a care home setting and all parties are in agreement that this will best meet their outcomes, can be placed at the earliest possible stage.

4.3 Care Homes

Care home placements have increased over the past year for people aged over 65 years from 516 in June 2022 to 550 in June 2023.
The number of people living in care homes out with the Argyll and Bute area has reduced from 180 in June 2022 to 161 in June 2023.
The percentage occupancy of all care homes across Argyll and Bute (internally owned and externally commissioned) has increased from 78.56% in July 2022 to 81.26% in July 2023.
There are a number of vacancies across the homes however it should be noted that not all vacancies are available due to limited staffing, refurbishments etc and as above, factoring in available beds brings occupancy to 95%.

4.4 Care at Home

As at August 2023 there are 1067 people in receipt of care at home support. 113 of these people have chosen option 1 Direct Payment where they commission their won care package with funding from the HSCP. This amounts to 1863 hours per week. A further 782 people receive 8052 hours per week from externally commissioned services and 172 people receive 1953 hours of service from internal care at home services.
There are 16 registered providers with 12 providing care at home currently.
There is unmet need within the service due to recruitment and retention issues within the service both internal and external and the current picture shows 34 people who have their needs assessed but a total of 311 hours cannot be provided. There are a further 18 people who currently are in receipt of care at home support and have been assessed as requiring additional 103 hours and this cannot be delivered.
It should be noted that there is still throughput in the service with a number of hospital discharges and community referrals receiving service. The unmet need list is regularly monitored and prioritised by the service and wherever possible new service is delivered.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

This area of service contributes to supporting adults (primarily older adults) to remain at home or in a homely setting by delivering health and community care services.

6.5 Clinical and Care Governance

There is a clear clinical and care governance structure and process in place.

7 PROFESSIONAL ADVISORY

There are numerous interfaces with Professional leads with these service areas.

8 EQUALITY & DIVERSITY IMPLICATIONS

There is no proposal for specific change in service detailed in this paper.

9 GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Not relevant.

10 RISK ASSESSMENT

Risks are managed through Clinical and Care governance processes.

11 PUBLIC & USER INVOLVEMENT & ENGAGEMENT

There is an older adult reference group who we are working with to oversee standards of engagement across services. Where change and re-design is in train, engagement is in place.

12 CONCLUSIONS

The opportunity to provide a service spotlight seeks to provide the IJB with assurance of strategic direction, service areas, successes and areas of change. This paper has demonstrated the breadth of service areas under health and community care and the importance of integrated working to deliver high quality services.

13 DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

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