ARGYLL AND BUTE COUNCIL	**HELENSBURGH AND LOMOND AREA COMMITTEE**
COMMUNITY SERVICES	**9 DECEMBER 2014**

CARE AT HOME REPORT – HELENSBURGH AND LOMOND AREA

1.0 INTRODUCTION

1.1 The purpose of this report is to update the Area Committee on the most important issues related to the Adult Care Social Work Teams within the Helensburgh and Lomond area.

This report will aim to show the direction of travel in terms of our work in Adult Social Care. The progress and joint working that has been put into place and our aims to build on our work; evidencing an open and transparent process that strives to ensure that a high quality, personalised service is provided to our most vulnerable citizens within our local community.

2.0 RECOMMENDATION

2.1 That the Area Committee notes the content of the report.

3.0 DETAIL

3.1 In our last report we highlighted how the **Reshaping Care for Older People** (RCOP) would be amongst our greatest challenges for the foreseeable future. We also continue to raise the profile of our work in regard to the **Personalisation Agenda** (SDS), and we continue to build on the foundations for the future **integration of services**.

3.2 Whilst the Social Work and Health Team are co-located within the JDU; we will see both these teams integrate to become the Extended Community Care Team (ECCT) in the future. The staffing establishment within the ECCT will consist of; Community Nursing, Adult Care staff in Social Work, and Allied Health Professionals.

3.3 In Helensburgh & Lomond, we consider ourselves quite a way ahead already in terms of the locality of our Health and Social Care Teams.

Whilst we are set up conveniently in the Jeannie Deans Unit, we can demonstrate a clear benefit from easy access to our Health Colleagues so we can be confident that our **Hospital Discharge Processes** continue to improve.

What we would like to see more focus on is the Reablement Service that promotes our commitment to our **Balance of Care.**

3.4 Hospital Discharge Processes

Whilst we last reported how we recognise the need to be prompt at the point of admission and to identify a clear plan for discharge. We continue with our **Virtual Ward Meeting** twice a week, our District Nurse Team Leader, Carol Anne, our Occupational Health Senior Anne and our Adult Care Operations and Resource Team Leaders Liz McCrory and David Hall meet to discuss, share and update information that is gathered on site at the Vale of Leven Hospital and by other means of communication and reporting from the 6 other hospitals we work with here in Helensburgh and Lomond.

3.5 Communication

We have placed great importance on the effective streams of communication between our Hospital Wards, the Health Staff within those wards, our own community Health colleagues and our Social Care Staff because we understand how important this process is to the person who is being discharged.

We understand the importance of communication between ourselves; our workers and our Commissioning Staff (HPO's- Home Care Procurement Officers) because it is they who are responsible for ensuring there is a service set up that is individually tailored to suit the person's needs upon discharge.

The communication between Social Care Worker and the HPO and the Team Leaders has not always been great, but we are working to improve on that.

We work together in supervision and in general to ensure communication is happening outside of the Virtual Ward meetings because whilst we need to be clear about the client's needs as a discharged patient we also need to be clear about the patient who will revert back to the client who needs their discharge service Reviewed to ensure we are maximising Independence and Enablement.

3.6 Enablement

Our Health colleagues will report that whilst we can assess, co-ordinate and provide a service from our Independent Sector, we remain unable to commit to the principle of **Enablement.**

The principle of **'Enablement'** is described by Dundee City Council for example; (report is recorded in italic).

What is Home Care Enablement?

- *Enablement will help you to re-learn skills you may have lost, or to develop new skills, in order that you can be more independent and improve your quality of life.*
- *Enablement is a short term service and will last for a period of up to a maximum of six weeks*
- *As well as receiving support from enablement workers, a range of aids and equipment may also be identified to help you to be independent.*

What is a Home Care Enablement Team?

Home Care Enablement Teams are based in the community across Dundee City.

The Enablement Teams are made up of:

- *Home Care Enablement Organisers*
- *Trained Home Care Enablement Workers(the staff are made up of a mixture of both male and female workers)*

They are supported by:

- *Occupational Therapists/Occupational Therapy Assistants*
- *Physiotherapy staff*
- *Pharmacy Technicians*

What do the Enablement Teams do?

The teams provide care and support to enable you to:

- *Get home after a stay in hospital*
- *Remain at home, and live as independently as possible*

Update on Enablement:

Further November 2014 updates have informed us that we have a Physiotherapist about to commence employment so we are hopeful that this service may grow if we are able to demonstrate an increased percentage in the people we can safely support at home; so increasing our Balance of Care and decreasing our ongoing larger packages.

3.7 Balance of Care

Whilst **Enablement** supports people to remain at home for as long as possible, we believe that it also decreases the need for larger packages of care in the long term.

As you will be aware, we are measured on our Balance of Care and we have a target set at 80/20. In our Helensburgh and Lomond October 2014 Pyramid Report, I was able to comment;

'At 76%.....We are currently just under our target but we are working with Health in Helensburgh and Lomond and whereas we have 7 hospitals to manage, we are combining our efforts to understand how we can improve outcomes for discharged patients who want to return and remain at home.

We could be using an enablement service to build confidence and get people back home but this is not working out well due to OT and Physio funding being restricted.

We would also be able to utilise a step up and down model in a person's own home if we had further access to 24 hour care short term (and increased use of Tele care technology). We are currently (October) working with our health colleagues to seek clarification on this service development'

3.8 Access to 24 hour care short term:

Our H&L Homecare Procurement Officers report at the front line so it is important to note the value we hold in our Carrgom Overnight Response Team.

The HPO's report how CORT will carry out planned care through the night and although this is not an ongoing long term arrangement for our clients, we do benefit immensely from this service.

The main benefit is that we can now plan further discharges because we can ask them to attend to clients who are just out of hospital who may need support to use the toilet or those who need to be turned in the night 'out of hours'.

Concern

The main issue of concern for this service is that it does not extend to a wide enough area with limits for planned discharges for clients who need that service but live in Clynder or Kilcreggan, for example.

3.9 Tele Care

In our last report we included information about how a bid had been received from Allied Healthcare to support the testing of Tele Care equipment.

The bid also included the updating of key holder details and a customer quality questionnaire.

If agreed, we had hoped the service to be in place from 1st April 2014 until 31st March 2015, but to date we have not heard what came of this bid.

Whilst we can report we have a significant number of Reviews of this service still outstanding along with a significant lack of Responders in the Helensburgh and Lomond area, we are keen to address this deficit and look forward to proposals to further resource to minimise risk to those who are dependent on the equipment being in good and safe working order.

3.10 Reshaping of Care for Older People (RCOP)

Lastly, with an update on our work in **RCOP. The Reshaping of Care for Older People** we continue to meet on a 6 weekly basis at the Jeannie Deans Unit**.**

We aim to keep the focus on the meaning of this movement and how it aims to revolutionise the way we deliver services to people over the age of 65 years.

The model of care recognises the need for community care, health, private, voluntary and third sectors to be aligned to focus on the four common goals:

1. ***supporting people to live in their communities for longer***
2. ***anticipating, recognising and preventing difficulties***
3. ***regaining skills and confidence or learning new skills***
4. ***delivering care that is dignified, respectful and person centred***

In order to achieve these goals there are a number of principles and actions that need to be taken forward within an integrated whole system framework.

These Principles are:

1. ***Single point of access in the community for both health and social care services***

2. ***Joint use of an electronic assessment focussed on personal outcomes plans***
3. ***Person centred joint anticipatory care planning***
4. ***Joint monitoring and reviewing of care plans***
5. ***Shift in culture towards Enablement/ Reablement***
6. ***Prevention of unnecessary admissions to hospital***
7. ***Prompt discharge home from hospital***
8. ***Supporting structured community management of high risk individuals***
9. ***High quality end of life care delivered in place of choice***
10. ***People to have more control, choice and independence***
11. ***Supporting people to manage their own illness***
12. ***Support people to actively engage with the private, voluntary and third sector***
13. ***Developing services with third and private sector, co-production modelling***
14. ***Clearly defined roles and responsibilities***
15. ***Flexible and responsive team approach to care, delivered at home across 24/7***

In the Helensburgh & Lomond locality we continue to see great success in partnership working. Our local forums take place 6 weekly throughout the year and the membership of these meetings consists of the statutory services, general practitioners, voluntary organisations and members of the private sector. In the near future we hope to be able to identify a representative for the general public and in preparation for planning and mapping of our services; we have set up public consultation sessions.

Conversation Cafes

On Friday, the 21st November 2014, we are looking forward to meeting the public on a series of dates with the first meeting being held in Arrochar at the Three Villages Hall then moving onto meet folks at the Oasis in Garelochead. This marks the first of a series of Conversation Cafes to ensure effective public consultation around what RCOP actually aims to achieve. Importantly,

the public consultation will aim to seek the opinions and concerns of the people it will have the greatest impact on.

4.0 CONCLUSION

This report updates the Area Committee on the most important issues related to the Adult Care Social Work Teams within the Helensburgh and Lomond area.

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