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 strategic change and re-design within Health and Community Care.

1. EXECUTIVE SUMMARY

The purpose of this report is to shine a spotlight on services, challenges and strategic change under the service area, Health and Community Care. The report will present with descriptors of service, key successes and challenges and the areas taken forward as strategic change. Detail on legislation and policy that governs health and community care are not included.

2. INTRODUCTION

In 2022 portfolios for Heads of Adult Services was re-defined to have a better balance of services. The three Heads of Service are: Primary Care, Health and Community Care and Acute and Complex Care. Although there is defined area of service within health and community care, there is clear overlap in operational service delivery and work-streams.

Health and Community Care covers a wide range of functions focused on supporting adults to live well in the community and access timely health care in their own communities when required. Much has been achieved with regards to developing a whole Argyll and Bute approach to service delivery but this remains an area of development.

Health and Community Care is the largest operational function of the HSCP with a primary focus of delivering care in Argyll & Bute and focuses on the delivery of the following strategic objectives:

1. Reduce the number of avoidable emergency hospital admissions & minimise the time that people are delayed in hospital
2. Support people to live fulfilling lives in their own homes for as long as possible
3. Institute a continuous quality improvement management process across the functions delegated to the partnership
5. Promote health and wellbeing across our communities and age groups
6. Support unpaid carers, to reduce the impact of their caring role on their own health and wellbeing
7. Support staff to continuously improve the information, support, and care they deliver
8. Efficiently and effectively manage all resources to deliver best value

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.
- Care at Home Services across Argyll & Bute provide services to 1,049 supported person's and deliver 11,946 hrs of support (figures as of Mon 31st July) a week. The service is supported by 12 external partner provider organisations who provide the greatest majority of this support. Internally delivered services exist in Mull and the isles, Islay and Jura, Mid Argyll and Kintyre. A responder function is also commissioned.
- Contact and working with external providers makes up a large part of work within care homes and care at home. The proportion of Adult Care spend under contract for the year 22/23 was 94%, this is above the Council target of 90%. The majority of this comes from the contracts for Care at Home Service, the National Care Home Contract and out of area care home placements. Other contracts/grants include those for Responder Services, Day Services, Carers Support Services and Community Transport.
- Unscheduled Care as a system wide approach sits under Health and Community Care

3. DETAIL OF REPORT

3.1 Strategy-What are we trying to achieve

Strategically there is a need to be clear what should be available to older adults and to work with older adults to promote independence, dignity and respect. To provide support at home or in a homely setting particularly at the end of life. The older adult strategy is being developed but largely focuses on:

- Ensuring that care at home can be developed to meet need
- Ensuring that we have a clear vison of what should be available for palliative and end of life care
- Providing locally joined up actions on dementia
- Understanding what could be the future offer of care homes and housing, including sustainable models of care and suitable environments. The two pronged approach of meeting the environmental challenges short term whilst developing the strategic assessment for the future working with Hub North.
- Including an understanding of the impact of loneliness and isolation on older people
- Right care, right time

3.2 Unscheduled Care-High Impact Changes:

Unscheduled care broadly means a health and social response unplanned which could be avoided by a planned response or right care, right time.
In terms of the 8 High Impact Changes, the areas of particular focus for Unscheduled Care are as detailed below. The overarching aim is to deliver high quality adult services which robustly manage

the patient journey to promote living well in later life (and dying well) with a focus on patient /service user choice, prevention and supported self-care.
The success of these work streams, and by extension the delivery of the strategic aims they represent, depends on:

- Communication and Integration.
- Prevention and Learning Lessons to support transformation of services.
- Patient/Service User Centred care.
- Collaboration and Engagement and Co-production.
- Resource Investment, Management and Evaluation.

3.3 Care Closer To Home – High Impact Change 1:

Work-streams related to this high impact change area are focussed and managed via the Care at Home and Care Homes and Housing work streams (and Hospital at Home Pilot). This approach encompasses a ''home first'' approach, with **Right Care, Right Time, Right Place** at its core. Ensuring that patients are optimally cared for, wherever safe and possible, in their own homes or homely setting is a key priority.

This area of work has shared aims to ensure:

- Understanding and applying population based planning to the delivery of health and social care services.
- Determining appropriate staffing levels, skills and competencies, which are linked to required activity – workforce analysis, support nurturing and development are key.
- Maximising the efficient use of estate and facilities by being clinically/needs led, and utilising 'new ways of working'.
- Avoiding unplanned, unnecessary admissions and referrals to institutional health and social care, hospitals and prevent social exclusion. Ensuring the best quality of service with community wealth and re-ablement focus at the core.
- Improve access to/appetite for remote consultation and patient monitoring – enabling increased capacity and flexibility for both staff and patients (potential to relieve pressure on estates and facilitate more rapid access to services, while promoting living well in a homely setting).
- Continue to develop and improve our offerings and support for Unpaid Carers.
- Improve relationships with partner-sectors to develop our offering for patients and service users.

3.4 Redesign of Urgent Care – High Impact Change 2:

Work-streams related to this high impact change area are focused and managed via our Hospital at Home, Unscheduled Care and Community Hospital work-streams. This approach is guided by the utilisation of appropriate performance management and trend data to ensure that the correct resources are applied at the right time, right place and in the right format (and wherever possible reducing prevalence of unscheduled care, ambulatory and hospital care).
This area of work has shared aims to ensure:

- We ensure safe and appropriate staffing levels and skills, which are equipped to deal with the needs of populations.
- We modernise and maximise our estates and facilities to ensure that they are fit for purpose, well utilised and capable of delivering high quality care.

- 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 organisation specific involvement.
- Seven Day Services: Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working.

3.6 Example of Integrated Working-Community Hospitals and Community Services

These services are managed locally by the Area Manager role. The Area Manager is an integrated post-holder who manages a range of health and social work staff. Integrated management of the areas is key to providing flow for patients/clients within the localities. Area Managers are supported and managed by the Senior Manager, Health & Community and responsible Head of Service.
There are 6 community hospitals within Argyll & Bute HSCP, all provide non bypass (i.e. the emergency response must be delivered) Accident & Emergency care, inpatient and outpatient care and in some locations special service including dialysis. The hospitals provide a variety of care including acute admissions, rehabilitation, and palliative/end of life care and day case treatments.
A Community Hospital group has been established to review all services. The purpose is to provide strong clinical governance processes across our hospitals sites and ensure a standardised

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 held weekly. It is a fully integrated meeting where all members of the health, social care and 3rd sector meet to escalate patient and clients who have changing and complex health and social care needs and are requiring support on the islands of Mull and Iona. Following identification of those people plans of care, including ceiling of care are discussed to allow the delivery to them of the safest care that they need, preferably in their own home. Challenges to delivering this care are also identified and solutions to discussed to ensure the delivery of seamless care in the community.

3.9 Example-Spotlight on Care Homes

Argyll & Bute Council's own internal care home services across are registered to support to 125 people across 7 locations, 6 residential care homes and 1 nursing care home.
A further 388 places are available across the area within 10 privately owned and operated care homes.
Latest data returned from the care homes (w/b 31/7/23) indicates around 95% occupancy of available beds.
All of the homes have been inspected by the Care Inspectorate at least once since the outset of the COVID-19 Pandemic in March 2020. The exception to this is Kintyre Care Centre which was recently re-registered under the ownership of the HSCP and as such is yet to receive its first inspection. Traditionally this will take place 12 months on from its registration in March 2023.
Only 1 home has been graded as less than adequate (3) by the national regulator. Work continues in partnership with this home and the Care Inspectorate to drive improvements within the agreed timeframe. All other homes both internal and external have achieved grades of 3, 4 & 5.
These results are encouraging and a testament to the hard work of the staff within the homes throughout an ever changing landscape in the last 4 years. In April 2020, the Care Home Task Force was developed to bring all care homes together to meet the challenges of the pandemic. This was a multi-agency response and this collaborative approach remains.

Care Homes are no different to other registered services at this time in that they are facing the same staffing crisis to affect the sector across the country. The rural and often remote locations of some of the care homes exacerbates these issues with travel and accommodation frequently being a major obstacle to achieving desirable staffing levels.
Low numbers of staff available can often result in delayed discharges from the hospitals across the area when the staffing provision means that safe staffing levels cannot be reached. The sector across the country is working with the regulator to develop and implement new staffing level tools which will assist in the delivery of safe levels of care.

Staff working across these homes continue to demonstrate great values towards providing the best possible outcomes for those using the service, often in the face of adversity.

We are now moving to a Collaborative Care Home approach with an increased focus on well- being, activity and access to consistent heath care services. We particularly want to focus on hearing the voice of residents.

3.10 Example-Tigh-a-Rhuda-Island development

A successful bid to the Islands fund alongside other capital monies has allowed a redesign of the standards and space of our smallest care home on Tiree. Given that the island has no hospital facility, the best possible use of the space will allow for en-suite rooms, improved staff accommodation and a more integrated partnership with local stakeholders. Positive meetings have taken place with the development trust and local Gps. We are now considering a different way to deliver care at home on the island.

4. RELEVANT DATA AND INDICATORS

4.1 Performance

A number of targets have been set against which performance is measured and the following information provides a picture of the activity across a number of health and care services.

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. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

A brief description of resource to Health and Community Care is detailed below.

6.2 Overall Budget and Forecast

For the quarter ending 30 June, the total forecast variance on health and community care services is a relatively modest overspend of £114k, Table 1.

Table 1 – Annual Budget and Forecast Expenditure as at 30 June 2023

Service	Annual Budget	Forecast Expenditure	Forecast Variance	% Variance
	£'000	£'000	£'000	
Social Care Services	45,303	45,202	100	0.22%
Health Services	123,160	123,374	(215)	-0.17%
Total Health & Community Care	**168,462**	**168,577**	**(114)**	**-0.07%**

Within Social Care services, higher demand for residential placements is forecast to result in overspend on this budget and this is offset by underspends in homecare services which are arising due to capacity issues. The forecast underspend is due to a forecast over-recovery of income from charges to clients for residential care.
Health services are forecasting a small overspend as a result of agency staffing. With continued recruitment and retention issues across a number of areas, agency cover is necessary to maintain service provision. At present, agency staffing is highest in GP out of hour's services in Oban and Dunoon, registered nursing and AHP services. There is an expectation that increased compliance with the national frameworks for the procurement of agency staffing from 1 June will lead to improvements in the forecast position.

6.3 Savings

Good progress has been made in the first quarter in achieving savings, Table 2. With a total target of £2.19m identified across a number of schemes, 49% of the target, £1.08m, has been declared. A total of £1.89m has been forecast to be achieved and work is ongoing to identify and declare the outstanding balance.

Table 2 – Savings Progress as at 30 June 2023

Service	Savings Target	Savings Declared	Forecast Achievement	% Variance
	£'000	£'000	£'000	
Social Care Services	1,286	686	1,286	100%
Health Services	908	392	600	66%
Total Health & Community Care	**2,194**	**1,078**	**1,886**	**86%**

6.4 Staff Governance

Governance exists within management and professional advisory functions.

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	

REPORT AUTHOR AND CONTACT

Author Name: Caroline Cherry, Head of Service, Health and Community Care
Email: caroline.cherry@argyll-bute.gov.uk