NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 28 March 2022**
Title:	**Winter Funding Plans, North Ayrshire Health and Social Care Partnership**
Responsible Director:	**Caroline Cameron, Director of North Ayrshire Health and Social Care Partnership**
Report Author:	**Caroline Cameron, Director of North Ayrshire Health and Social Care Partnership**

1. Purpose

This is presented to the Board for:

- Awareness

This paper relates to:

- Government policy/directive;
- Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2. Report summary

2.1 Situation

On 5th October the Cabinet Secretary announced an investment of over £300m in hospital and community care to tackle what may be the toughest winter the NHS and Social Care will face. The new multi-year funding will support a range of measures to maximise hospital and primary care capacity, reduce delayed discharges, improve pay for social care staff and ensure individuals in the community who need support receive effective and responsive care.

The funding is focussed on four main areas – Maximising Capacity, Ensuring Staff Wellbeing, Ensuring System Flow and Improving Outcomes with the overarching aim being to reduce risks in community settings and supporting flow through acute hospitals. Specific funding allocations were communicated to HSCPs on 4th November with a total of £3.4million allocated to North Ayrshire in 2021-22 specifically for interim care, Multi-Disciplinary Teams and Care at Home capacity.

The North Ayrshire Health and Social Care Partnership (HSCP) plans for the funding are focussed on a whole system approach to bolstering the care workforce by increasing numbers of staff in key areas of community services, with a longer-term focus on increasing capacity across our system and to invest in services which focus on early intervention and prevention and the alternatives to hospital admission. The investment builds on the effective intervention services we have in place in North Ayrshire with high impact changes relating to multi-disciplinary team working, early intervention and planning, proactive management of long-term conditions, home-first and discharge to assess ethos, rehabilitation and reablement and investment to support effective planning for complex care requirements. The full Winter Funding Plan is attached as Appendix 1 to this report.

The Board are asked to note the plans developed by the HSCP for the deployment of the new investment in line with Scottish Government guidance and Key Performance Indicators.

2.2 Background

On 5th October the Cabinet Secretary announced an investment of over £300m in hospital and community care to tackle what may be the toughest winter the NHS and Social Care will face. The new multi-year funding will support a range of measures to maximise hospital and primary care capacity, reduce delayed discharges, improve pay for social care staff and ensure individuals in the community who need support receive effective and responsive care.

The winter package of additional support includes:

- Recruiting 1,000 additional NHS staff to support multi-disciplinary working.
- £40 million for 'step-down' care to enable hospital patients to temporarily enter care homes, or receive additional care at home support, with no financial liability to the individual or their family towards the cost of the care home.
- An additional £62 million to maximise the capacity of care at home services.
- Up to £48 million will be made available to increase the hourly rate of social care staff to match new NHS band 2 staff.
- £20 million to enhance Multi-Disciplinary Teams, enable more social work assessments to be carried out and support joint working between health and social care.
- £28 million of additional funding to support primary care.
- £4.5 million available to Health Boards to attract at least 200 registered nurses from outwith Scotland by March 2022.
- £4 million to help staff with their practical and emotional needs, including pastoral care and other measures to aid rest and recuperation.

The funding in relation to increasing the hourly rate for social care staff employed by commissioned care providers has been addressed separately with funding provided to fully meet the cost of implementation of the uplift to local commissioned providers, including an uplift to the National Care Home Contract Rate.

A separate funding allocation of £109k has been received in relation to Primary and Social Care staff wellbeing supports. The HSCP have engaged directly with staff through a consultation survey to shape proposals to utilise the support in a way which will meet staff priorities and build on the existing local approaches.

Key areas have been identified as local priorities, recognising the opportunity to build on existing local approaches:

- Support for teams to 'take a step back' together and participate in wellbeing opportunities
- Mindfulness Interventions
- Support and management of distress and anxiety; PTSD; bereavement; staff affected by 'long Covid'

This will include equity of access to support for the Primary Care and Commissioned Care workforce.

2.3 Assessment

The IJB Winter Funding Plan focusses on the key areas of funding delegated to the HSCP to deliver:

- Recruitment of Health Care Support Workers
- Step-down/interim care investment
- Care at Home capacity
- Enhancement of Multi-disciplinary teams.

The plan, included at Appendix 1, sets out the Health and Social Care Partnership's plans to invest in community services, focussing on the additional funding provided by the Scottish Government to address imminent Winter Pressures for 2021-22 with a view to supporting sustainable investment in services to deliver on our longer-term HSCP ambitions. The funding, elements of which are recurring, provides a real opportunity to address areas of investment in our community services to address issues with hospital flow (admission and discharge) and also to address elements of unmet need in communities.

The plan illustrates the alignment with the North Ayrshire Strategic Plan, provides local context in terms of our needs assessment, demographic challenges and locality priorities, outlines the KPIs attached to the funding and describes the current service delivery challenges, demands and performance.

Plans were developed over a two month period with wide engagement across HSCP teams and disciplines, with previous approval at the Partnership Senior Management Team, oversight by our Care at Home Oversight Group and were approved by the Integration Joint Board in December 2021.

Expectations require to be managed in relation to how quickly the investment will have a noticeable impact on our health and social care system, as the investment is reliant on successful recruitment. Particularly as there is ongoing recruitment underway across services including acute hospitals, community health and social care services (including commissioned providers), mental health, addictions, vaccinations and testing and primary care with all parts of the health and care system drawing on the same pool of candidates.

2.3.1 Quality/patient care

The additional investment and planned activity and capacity, made possible by the winter pressures fund, will make a significant contribution to improving outcomes for the people we provide care and support for in North Ayrshire. It is anticipated that the investment will support a reduction in delayed transfers of care, address unmet need

in community services and ensure timely assessment and review for individuals requiring support.

2.3.2 Workforce

The funding is focussed on bolstering the care workforce, recruitment into roles is underway in line with normal HR processes.

2.3.3 Financial

Report covers the allocation of additional Scottish Government Winter funding, allocation of funds in line with confirmed allocations and based on the availability of recurring and non-recurring funds. Confirmation has now been received as part of the 2022-23 budget of recurring allocations of funding to IJBs to sustain the additional capacity from the investment. In addition any funds unspent during 2021-22 due to delays in recruitment will be held in reserves by the IJB to enhance service capacity in future years.

2.3.4 Risk assessment/management

Risks are highlighted in relation to the ability to secure the additional workforce to deliver on the planned improvements.

2.3.5 Equality and diversity, including health inequalities

The investment of funding and increase in capacity will support addressing inequalities in the provision of care with equal access and support across North Ayrshire.

2.3.6 Other impacts

The plans will be monitored against the key performance indicators with quarterly reports being provided by each HSCP to the Scottish Government. In North Ayrshire this information will also be provided to the IJB Performance and Audit Committee. IJB have agreed to remit responsibility for oversight to the IJB Performance and Audit Committee.

2.3.7 Communication, involvement, engagement and consultation

Plans have been developed in conjunction with North Ayrshire HSCP Management Team with wide engagement across services to develop the plan in line with Scottish Government guidance.

2.3.8 Route to the meeting

The proposals have been supported by the NA Partnership Senior Management Team and Staff Partnership Forum with recommendations made as stipulated through active consultation with the North Ayrshire Care Home Oversight Group and were agreed at the North Ayrshire IJB on 16th December 2021.

2.4 Recommendation

For awareness. Members are asked to take assurance from the plans developed by the HSCP for the deployment of the new investment in line with Scottish Government guidance and Key Performance Indicators.

3. List of appendices

The following appendices are included with this report:

- Appendix No 1 – North Ayrshire HSCP Winter Funding Plans 2021-22

Appendix 1

North Ayrshire HSCP
Winter Funding Plans 2021-22

Integration Joint Board
16th December 2021

NORTH AYRSHIRE
Health and Social Care Partnership

1. INTRODUCTION

This document sets out the Health and Social Care Partnership's plans to invest in community services, focussing on the additional funding provided by the Scottish Government to address imminent Winter Pressures for 2021-22 with a view to supporting sustainable investment in services to deliver on our longer-term HSCP ambitions.

These plans have been developed in conjunction with the Partnership Senior Management Team over a number of weeks with wide engagement across services to develop a plan in line with the Scottish Government guidance and Key Performance Indicators alongside investment in areas which support our longer term ambitions building on the already established services and developments.

On 5th October the Cabinet Secretary announced an investment of over £300m in hospital and community care to tackle what may be the toughest winter the NHS and Social Care will face. The new multi-year funding will support a range of measures to maximise hospital and primary care capacity, reduce delayed discharges, improve pay for social care staff and ensure individuals in the community who need support receive effective and responsive care. The funding, elements of which is recurring, provides a real opportunity to address areas of investment in our community services to address issues with hospital flow (admission and discharge) and also to address elements of unmet need in communities.

2. BRIDGING STRATEGIC COMMISSIONING PLAN 2021-22

In March 2021 the Integration Joint Board approved a one-year Strategic Bridging Plan to focus on both service improvement and pandemic recovery with a longer-term plan being developed during 2021-22 to allow for a period of reflection and meaningful engagement. The response to the pandemic is far from over and the longer-term effects on our communities are yet to be fully understood. The one-year strategic bridging plan reflects on our achievements, our Covid 19 experience, and the impact on our services. It outlines our approach to recovery and learning as we take stock and allow our services and communities to recover from what has been one of the most difficult years. The IJB approved a continuation of our existing vision and five supporting strategic priorities to March 2022, these are currently under review as part of the longer-term Strategic Planning process to 2030.

Any investment in services needs to take into consideration HSCP strategic priorities, our strategic needs assessment and the priorities identified in our localities. The impact will be measured through the KPIs identified but also through our performance against National Health and Wellbeing Indicators, MSG indicators and local performance monitoring.

Needs Assessment & Locality Priorities:

There are key areas in the North Ayrshire needs assessment as part of the Strategic Plan which should shape future investment and models of care for services, the key areas being:

- POPULATION CHANGES - two impacts in future – overall population continues to decrease and is expected to reduce by 2% between 2018 and 2015, within this falling population will see a growth in older population, with those 65+ accounting for more than 25% of the population by 2025, with a reduced working age population to support
- POVERTY AND DEPRIVATION – area of high deprivation resulting in social and health inequalities, the most recent SIMD figures suggest as much as 42% of North Ayrshire's population live in areas that are considered the most deprived in Scotland and around 28.3% of children in North Ayrshire live in poverty, over 1 in 4 children
- COMPLEX NEEDS – 27% of local people are living with a long-term condition (eg Arthritis, Asthma, Diabetes, COPD). Long term conditions are more common in older age groups with LTCs increasing with age with only 1.7 people in 10 under 65 with a LTC compared with those 85+ where 9.2 people in 10 are living with a LTC. Around 15% of those 65+ also live with more than one long term condition.
- HOSPITAL ACTIVITY – across most acute hospital measures (including Emergency Admissions, Unscheduled Bed Days, Delayed Discharges and preventable admissions) we see a higher proportion from older age groups, those aged over 75 account for the greatest number of hospital admissions, a growing older population places additional demands on health and care services. Those 75+ also account for the greatest volume of potentially avoidable hospital admissions.
- MENTAL HEALTH – the percentage of the local population receiving medication for some form of mental health condition is increasing, in 2018, 21.7% of local people were receiving some form of Mental Health medication, North Ayrshire is continually higher than the overall percentage for the health board area and Scotland. This suggests a greater demand for local Mental Health support. Unlike general acute admissions, the highest proportion of Mental Health admissions are among adults aged 18-44, suggesting a demand within this age group for mental health services.

The plans for investment require to support effective interventions that build on and enhance our existing models of care. Our priority is to invest in services which support an integrated care model over the life course to deliver better outcomes for our population, with prevention and early intervention as the heart of improving outcomes and managing demand for services. Our core aim for integrated care is to enable people to receive care closer to home, with services focussed on keeping people well and avoiding unnecessary hospital care. Services require to be designed around the needs of our local population and tailored to our context and priorities, meaning people can access the care and support they need locally in a more seamless way. Communities are where preventative approaches and programmes flourish, by supporting self-care and wellbeing, independence and social participation.

The priority areas for investment described include enhancing multi-disciplinary working, addressing unmet need and demand for social care services in the community, a focus on early intervention and planning for complex care needs, supporting models of care which are evidenced to avoid hospital admission and speedy discharge, enhancing rehabilitation and reablement services and ensuring resilience in our Island based services.

This investment alone is not capable of building the capacity we need in our communities or in our services and is complemented by investment already underway through for example the Primary Care Improvement Plan and the Mental Health Recovery and Renewal Fund.

3. WINTER INVESTMENT

On 5th October the Cabinet Secretary announced an investment of over £300m in hospital and community care, with further communication received on 4th November providing further detail on individual funding allocations at an HSCP level and the key performance indicators and conditions attached to funding. The Scottish Government have also supported flexibility to local areas to use the funds across the priority areas based on local need. The overarching aim of the funding is to manage a reduction in risks in community settings and support flow through acute hospitals.

Specific Key Performance Indicators aligned to the funding include:

- Number of people delayed in their discharge from hospital.
- Hospital bed days associated with delays and overall length of stay in hospital.
- Number of people who have been discharged to an interim care home.
- Number of people who have moved on from the interim placement by the agreed date for the placement to end.
- Average length of interim care placements.
- Number of NHS staff recruited at bands 3 and 4, to roles across community services and acute.
- Increase in assessments carried out at home rather than hospital.
- Evidence of a reduction in the number of people waiting for an assessment.
- Significant reductions in delayed discharge and occupied bed days.
- Evidence of the types of services and activity funded, and the number of people supported by these.
- % increase in the use of community equipment and technology to enable care, or other digital resources to support care provision.
- Evidence of resource to support the use of technology and digital resources.

Reductions in:

- Those waiting for an assessment for care.
- Those waiting for a care at home service.
- Unmet hours of care.

The £300m winter package of additional support includes:

- Recruiting 1,000 additional NHS staff to support multi-disciplinary working.
- £40 million for 'step-down' care to enable hospital patients to temporarily enter care homes, or receive additional care at home support, with no financial liability to the individual or their family towards the cost of the care home.
- An additional £62 million to maximise the capacity of care at home services.
- Up to £48 million will be made available to increase the hourly rate of social care staff to match new NHS band 2 staff.
- £20 million to enhance Multi-Disciplinary Teams, enable more social work assessments to be carried out and support joint working between health and social care.
- £28 million of additional funding to support primary care.
- £4.5 million available to Health Boards to attract at least 200 registered nurses from outwith Scotland by March 2022.
- £4 million to help staff with their practical and emotional needs, including pastoral care and other measures to aid rest and recuperation.

This plan focussed on the North Ayrshire impact and delegated funding and resource in relation to the specific areas below:

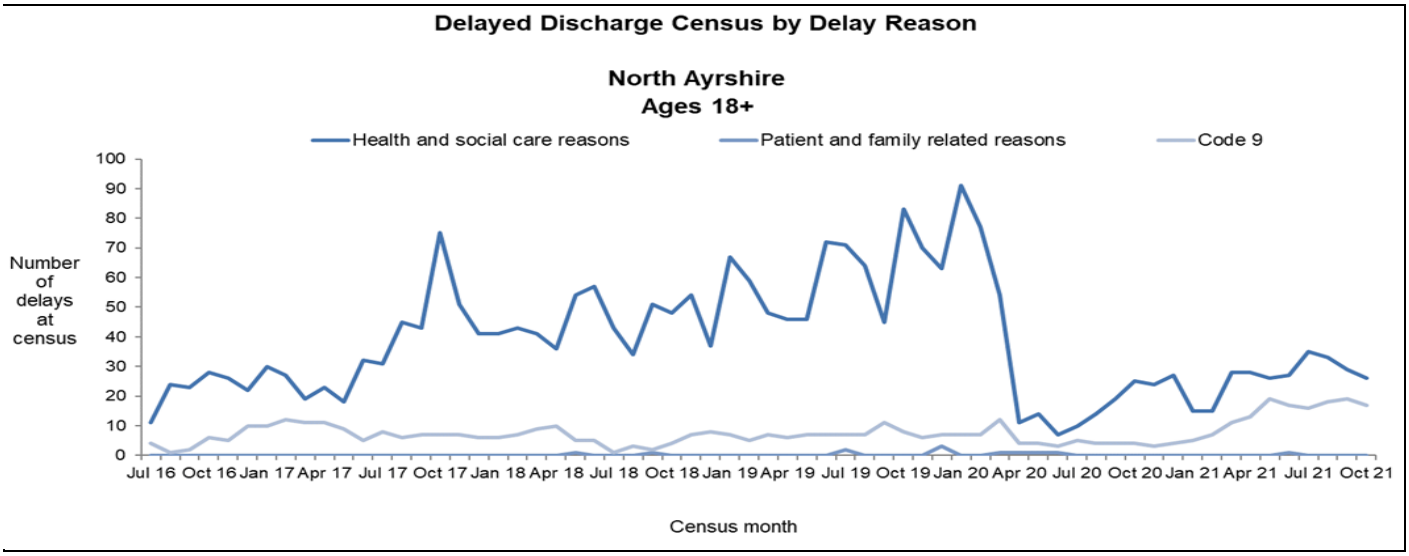
- Recruitment of Health Care Support Workers
- Step-down/interim care investment
- Care at Home capacity
- Enhancement of Multi-disciplinary teams.

Together with our North Ayrshire Strategic Priorities it is important to understand the service delivery context in terms of the North Ayrshire position for the areas of performance and activity that the funding is to support, this is set out in the following sections.

3.1 Delayed Transfers of Care

Timely discharge from hospital is an important indicator of quality and is a marker for person-centred, effective, integrated and harm-free care. A delayed discharge occurs when a hospital patient who is clinically ready for discharge from inpatient hospital care continues to occupy a hospital bed beyond the date they are ready for discharge.

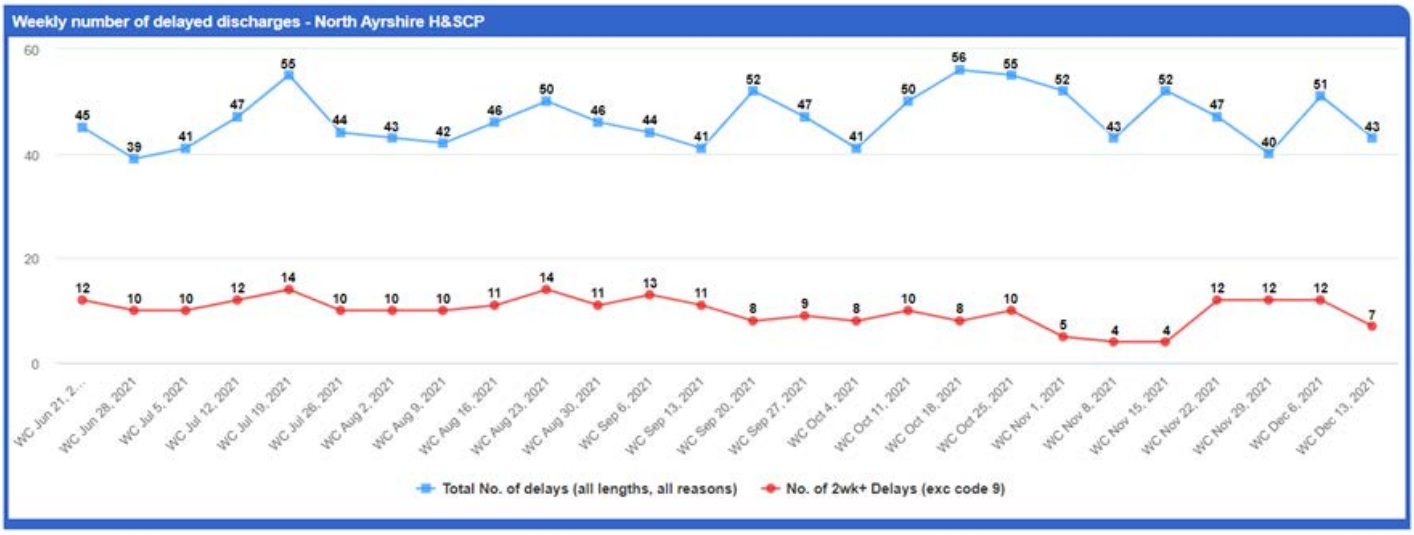
The tables below show the number of delayed discharges over a period of time, North Ayrshire Delayed Discharges Total Delays by reason since 2016:

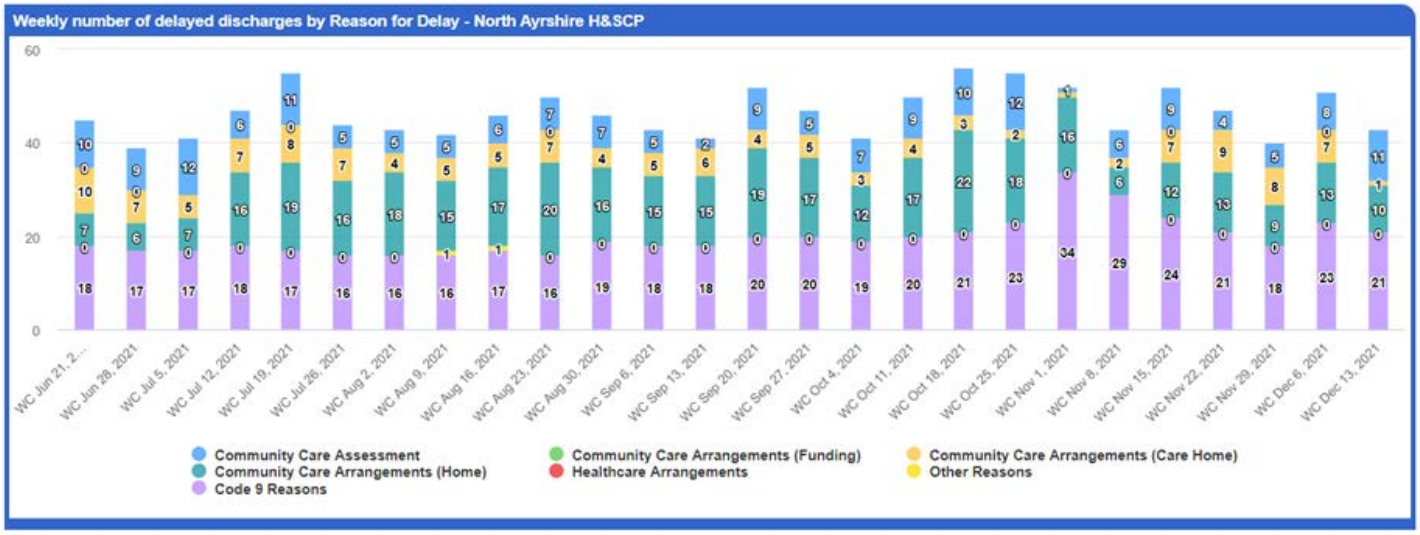


Key points to note:

- Delayed discharge figures across Scotland have been affected by measures put in place to respond to COVID-19. The marked fall in delayed discharges during 2020 is likely to be due to patients being moved out of hospital to increase capacity.
- In March 2020 at the first lock-down there was capacity freed up in community services to respond to supporting packages of care from hospital and the need in communities due to the number of individuals who decided to step back from care provision as a result of lock-down, the introduction of shielding and the workforce challenges across the HSCP were less stark than they currently are.
- In addition there were no financial constraints to supporting new packages of care and long term care placements. Prior to March 2020 the limiting factor to addressing delayed transfers of care through investment in community capacity was financial with resources constrained to support care in the community and long-term care placements.

North Ayrshire Delays over the last 6 months:





Key points to note:

- A further key measure is the number of delays which are for longer than two weeks (excluding code 9 complex delays), as the accepted timescale for a social care long term care assessment is 14 days with the ambition that assessments will take less time.
- The performance for delayed discharges in North Ayrshire has remained relatively static for the last six months, it should be noted that the patients reflected in the delays are not the same individuals impacted and therefore does not represent the true demand on community services to put packages of care in place to facilitate discharge, many patients are supported with care before becoming a delay.
- Within the overall delays there are different reasons for why patients may be delayed in care being put in place – the summary table above illustrates the reasons for delays with the purple part of the bar chart representing complex Code 9 delays, about 50% of the North Ayrshire daily delays are classed as Code 9 delays, the reasons for these include:
    - Adults with Incapacity – who are subject to guardianship processes and therefore cannot be legally transferred from hospital, normal timescales to progress a private or local authority guardianship is between 3 to 6 months
    - Complex Care arrangements – where individuals have complex needs which cannot be readily supported through traditional care and support – this includes for example individuals with complex Mental Health or Learning Disability needs where very specialist services are required to be commissioned to meet their needs
    - Individuals in closed wards due to Covid outbreaks where moves to other care facilities are paused for a period in line with Infection Prevention and Control guidance

<u>North HSCP Plans to reduce Delayed Transfers of Care:</u>

North Ayrshire HSCP continues to prioritise delayed discharges with specific focus on waiting times. Regular scrutiny and review of performance remains in place with daily assurance around the position and actions required. The HSCP have continued to prioritise social care capacity in both care at home and care homes for individuals ready for discharge from hospital, with a continued impact on community waits for Care at Home support.

The Team Manager for the HSCP hospital team is based within Crosshouse Hospital and is developing positive and effective working relationships with the acute team. The Social Work team will remain on site with a clear role around 'discharge to assess', prompting a 'home first' model and effecting timely activity around discharge arrangements with a view to reducing delayed discharges. In March 2021 the HSCP agreed a plan for further investment in the hospital social work team including a further Team Manager role to assist with the dual aspect of the role of hospital team, i.e. facilitating assessment and discharge. the additional Team Manager role is now in place and the new arrangements are embedded. Additional Occupational Therapy (OT) assistants have also been recently incorporated into the team with a direct link into the care at home reablement service.

The partnership has continued in its stabilised position around community waiting lists for admission to Care Homes and there are now no delays in terms of assessment or funding to access a Care Home placement within Community Care services in North Ayrshire for individuals. Whilst this supports more efficient discharge for those in hospital, it is also anticipated that this will reduce the need for emergency/crisis care home placements and unscheduled hospital admissions.

We continue to successfully utilise our Anam Cara dementia respite service, by converting nine beds for interim placements for individuals in hospital awaiting care at home services to reduce delayed discharges, whilst maintaining five respite beds to ensure emergency respite support is available. The interim placements have been promoted with patients and their families, and these have been utilised well over the last year. The interim funding as part of the Winter package of support provides an opportunity to pro-actively support people awaiting long term care placements to be placed on an interim basis in a residential care home and the partnership are proactively working with local care home colleagues to support these interim placements.

The partnership has also utilised the rehabilitation wards at the Ayrshire Central site to support with transferring some delayed patients to support with pressures in the acute hospitals. Whilst this doesn't impact on the overall delays, it does support with moving delayed patients away from an acute hospital setting where they no longer have a medical need for care. This also poses our acute hospital based social work team with a challenge to manage the demand coming from the different hospital sites.

The remaining resource gaps to support a reduction in delayed transfers of care are in Mental Health Officer capacity to support progress with AWI delays, the further enhancement of the community supports available to ensure community packages of care including reablement services are readily available to support safe discharge and resource to support sustainable plans for complex packages of care in the community.

Improvement Trajectories:

Health and Social Care Partnerships were asked to submit improvement trajectories to the Scottish Government in line with local plans to deploy the Winter Pressures resource, the trajectories provided by North Ayrshire are noted below:

Current DD Position	Proposed Reductions		
	Immediate Planned Reductions[1]	Planned Reductions – Nov / Dec[2]	Optimal DD position[3] – 31 March 2022
50	6	12	25

- The immediate and planned reductions reflect the impact of interim placements and care at home capacity, the latter is reliant on successful recruitment
- Optimal DD position is a realistic projection by March 2022 considering there will continue to be a number of AWI/guardianship cases, the potential for ongoing outbreaks in closed settings restricting movement and a number of complex Mental Health and LD delays

The ambition to reduce delays is reliant on securing the increase in the workforce and community capacity and also depends on the level of demand both in our communities and from hospitals.

Areas across Scotland faces challenges with delayed transfers of care, to provide some context to the number of delays in North Ayrshire, as per national position at 1st December:

- Total Delays rate per 100,000 over 75's – placed 13th
- Total Standard Delays rate per 100,000 over 75's – placed 15th
- Total Delays by partnership – placed 13th
- Total Standard Delays by partnership – placed 13th

3.2 Care at Home Service

Unmet need:

The HSCP provide weekly data returns to illustrate the unmet need across the system, with a particular focus on Care at Home Services and also the individuals in the community awaiting review and assessment. The most recent return for North Ayrshire is summarised below:

LG Care at Home Data Return - 06-12-21	North	
Number of People:	Hospital	Community
Waiting for social care assessment	4	600
Assessed and waiting on POC	11	145
In receipt of package and awaiting statutory review		465

Number of weekly hours:	Hospital	Community
Care yet to be provided for assessed individuals	142	773
Care assessed as needed and not provided (for those in reciept of a package)		399

There have been some changes around capacity for providing services which have reduced the number of people waiting through the ongoing review of the community waiting list and needs of service users. However, over a period of months there has been no significant improvement in the position in terms of unmet need and it is not expected that there will be a demonstrable improvement without additional workforce resources and capacity. There is a stark difference in the level of unmet need between individuals awaiting care in hospital compared to community, with 89% of the current unmet need being for individuals on the community waiting list. This is reflective of the continued focus on prioritising packages of care for individuals in hospital to support with wider hospital pressures.

It is useful to note that the definition of awaiting a social care assessment is those awaiting a full SSAQ assessment, the current 600 people in the community awaiting that full assessment does not represent the number of individuals awaiting assessment with no service as many will have had a quicker assessment to have services put in place.

Service Demand & Service Delivery:

The care at home service has seen a significant increase in demand and referrals for services, with an increase of 30% currently on pre-pandemic levels. Average monthly referrals are noted in the table below:

	Average CAH Monthly New Referrals for Period:				
Source	**Jan to Oct 2019**	**Jan to Oct 2020**	**Jan to July 2021**	**Sept to Nov 2021**	**Increase from 2019**
Community	118	167	160	158	34%
Hospital	150	199	170	210	40%
ICT	38	42	42	29	-24%
TOTAL	**306**	**408**	**372**	**397**	**30%**

We have a mixed model of Care at Home service delivery between the Partnership's in-house Care at Home Service and commissioned care providers. We have seen a significant shift in the balance of service delivered from the in-house service over the last year, it should be noted that this has not been in any way planned and has been reactive to respond to the capacity reduction of commissioned care providers as incrementally over a period of time packages of care and support have been passed back to the Partnership's in-house service.

The table below outlining the total service provision over the period of time illustrates the shift in the balance of provision:

	02/11/2020	**09/08/2021**	**29/11/2021**	Change since August	Change since Nov 2020
Contracted Hours	16,046	17,794	19,863	2,069	3,817
Private Planned	7,527	5,956	5,188	(768)	(2,339)
% hours private	32%	25%	21%		
% service users private	33%	30%	27%		

Community Alarm activations have increased from 61,069 alarm activations in 2019 to a total of 78,930 during 2020, full year figures are not available yet for 2021 but projections are these will be at a similar level to 2020, a sustained increase of 29% in activations. This has had a significant impact on the HSCP Community Alarm responder teams to call volume with many calls requiring a physical response to support. The night shift workforce was increased as a temporary measure to respond to this demand, it is clear at this time that the demand for the service is now at a sustained higher level which requires recurring capacity support.

There is a comprehensive ongoing programme of recruitment within the Care at Home service to ensure sufficient contingency and capacity to further reduce delayed discharges and also to ensure community waiting lists can be addressed. Over the period, it has proven difficult to successfully recruit to all vacancies and to identify additional capacity planned for the service, this has been further compounded by challenges in retaining social care staff.

3.3 North Ayrshire Intermediate Care and Rehab Service

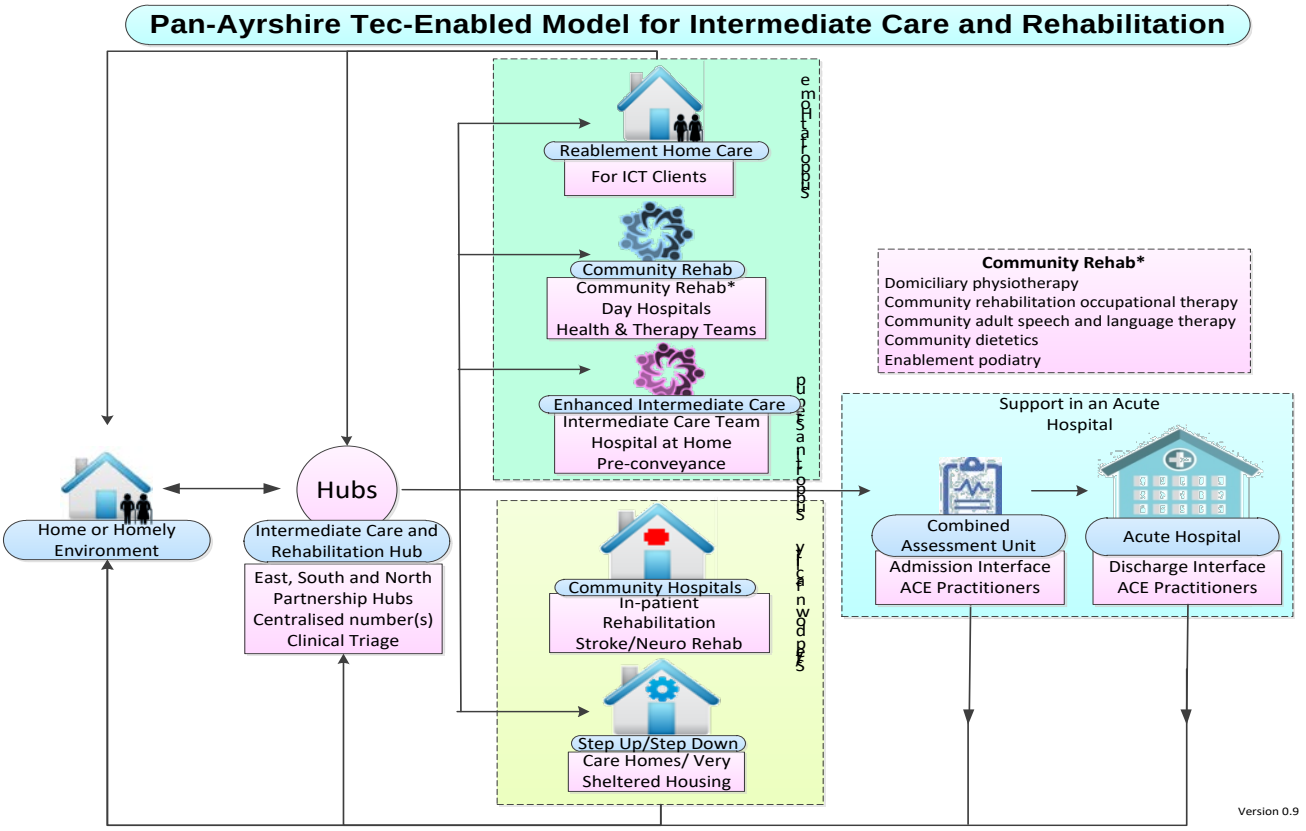
Launched in November 2018 the model of Enhanced Intermediate Care and Rehabilitation focusses on providing high quality care and support through early intervention and preventative action to help stop older people and people with complex needs becoming unwell in the first place or supporting them to manage their conditions more effectively at home or a homely environment. The enablers for the model include Technology Enabled Care (TEC) and locality based Multi-disciplinary teams.

The model is developed around Intermediate Care and Rehabilitation Hubs which provide a single point of access, with screening and clinical triage, ensuring the person is seen by the right service, first time. The hubs operate 9am-5pm, 7 days per week. The model supports people at different stages of their recovery journey and will link up and build on existing intermediate care and rehabilitation services.

The model has been developed by the Intermediate Care and Rehabilitation Network and is built around four tiers:

1. Individual requires support as part of primary and community services but can remain at home - this includes intensive medical support, rapid response and the use of remote clinical monitoring in the home with technology.
2. Individual requires Community Rehabilitation in order to stay at home, to live independently through early intervention approaches, self-management programmes with personal health and wellbeing goals
3. Individual requires quick responding short term Enhanced Intermediate Care or step up/step down into community hospital or care home setting
4. Individual is complex / unstable and requires acute hospital care

The illustration below describes the model in action:



The North Ayrshire service provides a co-ordinated response to deterioration and crisis by preventing unnecessary acute hospital admission and where possible supporting people's recovery at home or a homely environment. The team have two key roles in providing intermediate care to facilitate early discharge and in the prevention of admissions. Since the Intermediate Care and Rehab model was launched across the 3 HSCPs in 2018 the services have evolved over time in terms of capacity and scope of services provided to adapt to local need and demand. In North Ayrshire we invested in the service and have retained the Enhanced ICT model which is a clinically led GP model supported by ANPs, which allows the team to support a far higher level of support in the community providing a model of hospital at home provision through specialist, co-ordinated and comprehensive care and treatment of people in their own home.

Key features include:

- 7 day service with no service waiting list – referrals responded to same day
- Referral pathway including GPs, Community Nursing, Self, Services, Family etc
- Clinical triage model – diverting to Health and Therapy Team, ICT and Enhanced ICT

Current ICT Activity:

	w/c 29/11	w/c 06/12
Total Referrals Received in Community Hub	228	228
Appropriate Referrals Accepted to ICT	66	61
Supported at home through ICT	91	95
Receiving Enhanced ICT medical team support	24	36
Referrals to ICT, of those:	35	32
- Number preventing admission	20	19
- Number supporting discharge	4	6
- Rejected (not medically fit)	4	2
- Other	7	7

There has been short term investment in ICT through the mobilisation plan to increase team capacity in the short term to address increased demands on the service. The contribution of the service is invaluable and completely aligns with the ambitions of the winter funding and our longer-term ambitions to have robust pathways and intermediate support with a rehabilitation approach to services for older people. This increased capacity requires to be supported on a longer-term basis with additional resource to further enhance the role and function of the team.

5. OVERALL SUMMARY OF WINTER PRESSURES AND PLANS

Current pressures – reminder:

Delayed Transfers of Care - @ 14 December - 44 (10 Complex MH/LD)

Waiting List as at 06/12/21 for social care and care at home:

- 604 people awaiting a full SSAQ social care assessment (4 in hospital/600 in the community)
- 465 people in receipt of a social care package awaiting a statutory social care review
- 156 people (915 weekly hours) assessed and awaiting a Care at Home package – (11 in hospital/145 in the community)
- 60 people (399 weekly hours) assessed in the community and awaiting an increase to their Care at Home package
- 79 people (444 weekly hours) assessed in the community currently receiving a Care at Home package via the Reablement service awaiting transfer to mainstream services
- 13 people waiting for Care at Home on the Isle of Arran.
- Community Alarm activations have risen by 29% compared to pre pandemic levels
- 400 people waiting up to 400 days for occupational therapy assessment for equipment and or adaptations
- The recent AHP workforce exercise highlighted gap between existing AHP workforce, and the workforce required to deliver safe high-quality care in several priority areas, including inpatient rehabilitation areas at ACH

Funding:

This funding is predicated on four key principles:

- Maximising Capacity.
- Ensuring Staff Wellbeing.
- Ensuring System Flow and
- Improving Outcomes.

North Ayrshire HSCPs direct allocation of funding to address the priorities is summarised below:

Priority area	Recurring/ Non Recurring	National Funding 21/22 £'m	NAHSCP Share 21/22 £'m	Anticipated 22/23 £'m
Interim care arrangements	NR	40	1.109	0.554
Care at home capacity	R	62	1.719	3.438
Multi-Disciplinary Teams (MDTs)	R	20	0.555	1.110
TOTAL		**122**	**3.383**	**5.102**

The Scottish Government have advised that local areas have the flexibility to use the total resource, i.e. funding can be moved between the priority areas based on local need. For North Ayrshire any un-committed balance of resource for 2021-22 will be earmarked in IJB reserves at the financial year-end with consideration to supporting capacity in future years in line with the principles aligned to the funding. Spend will be monitored against the Key Performance Measures on a quarterly basis with a template expected to be provided to ensure a consistent approach across partnerships.

Plans have been developed in conjunction with the Partnership Senior Management Team over a period of two months with wide engagement across services to develop a plan in line with the Scottish Government guidance and Key Performance Indicators alongside the demands and unmet need as articulated in the proposals. There has been representation from a Multi-disciplinary team perspective from across all services including all Health and Community Care Senior Managers, our Lead AHP, Chief Social Worker, Lead Nurse and Mental Health services. The proposals have been supported by our Partnership Senior Management Team and Staff Partnership Forum with decisions made as stipulated through active consultation with our North Ayrshire Care at Home Oversight Group, which has been stood up to manage community demand and the deployment of resources. Unfortunately, there were a greater number of proposals for investment brought forward by services than those which could be supported through the funding at this time, therefore the requests were prioritised in terms of impact against the KPIs. Other proposals will be kept under review with further consideration if funding becomes available.

There is limited flexibility to shift resources between the priority areas in North Ayrshire, by far the greatest level of investment is in Care at Home services, the level of demand and unmet need for the service will require the full deployment of resource into that area. Therefore, the plans outlined below are based on the individual funding allocations for each priority area.

Proposals:

Interim Care - £1.109m:

- Funding completes model of support for Intermediate Care – as funding is non-recurring HSCP plan to use flexibility to extend period that interim beds can be used for, which would facilitate a longer term utilisation of beds beyond the winter period.
- Commission care home interim beds for appropriate assessment delays, this work has commenced and agreement reached with a number of care homes to move individuals to care homes for a maximum of six weeks and moves have already taken place. Estimate that 10 interim placements would be required at any one time, commitment of £200k would be required.
- Additional discharge facilitator to support management and co-ordination of interim placements, to act at liaison between hospital team and care homes, also to ensure timely follow up of assessment and review of interim placements. Fixed term post has been recruited for one year.
- Anam Cara, currently funded service of 9 beds from existing HSCP resource being used as interim care for care at home delays, additional costs associated with operating the service as a blended model to be met from interim care funding.
- Funding also to be used to support alternative interim care supports in line with patient/service user choice, for example flexible use of SDS.

Multi-Disciplinary Team working - £1.110m full year allocation:

- Social Worker and Social Work Assistant capacity across locality teams to support complex assessment, review AWI, support ICT and undertake statutory reviews.
- Occupational Therapy and OT Assistants, there has been a long-standing challenge with access times for OT assessment, previous attempts to bolster team capacity on a temporary basis have been unsuccessful. Will support timely access to equipment and adaptations, promote independence, reduce carer burden, minimise care at home requirements and prevent escalations of care.
- Recognising capacity challenges on the island, a number of roles on Arran (social worker, ANP, Community Equipment Technician, Admin) – supporting complex assessment, frailty and complex care and 7 day cover.
- Enhance ICT team, 3 posts funded temporarily through RMP3/4, team provide alternative to acute presentation via rapid MDT support, required to also support ICT link into rehab at Anam Cara.
- Registered Nurse post to join Hospital Based Social Work Team to support complex hospital discharge.
- Enhance Mental Health and Learning Disability teams to support complex care in the community, avoiding acute admission and supporting timely assessment and review.
- Support for transition planning particularly for children with complex needs into Adult Services.

The detailed plan for MDT capacity mapped against the KPIs is included as Annex 1.

Care at Home Capacity - £3.438m full year allocation:

Analysis of the Care at Home waiting list has identified a gap in service provision across all areas of North Ayrshire, partly due to the increase in demand in reduction in available external provision over the last 20 months. It has been identified that a complement of in-house Care at Home staff would be required to meet the current assessed unmet need levels and this workforce would be distributed across North Ayrshire to the geographical areas where this is concentrated. There will also be a requirement to invest in additional management, business support and other costs that would be required to support the increase in the Care at Home workforce.

To promote change and maximise efficiencies across the Care at Home service there is a proposal for additional posts within the Care at Home service to assess and review ongoing capacity, better utilise technology/digital supports and help manage the current levels of demand which if they remain at current levels will continue to outstrip available service provision – this includes the recruitment of business support staff to monitor and utilise Information systems and telecare advisors. The plans include investment on Arran to enable overnight supports and response. The commitment of recurring funding has enabled recent recruitment events to focus on increasing the permanent workforce which has positively impacted on recruitment.

An analysis has been undertaken of the current demand and unmet need for the service and the overall funding allocation will be sufficient to fund capacity to meet the current community and hospital waiting lists and the associated management capacity, the additional recurring capacity required to address unmet need is outlined below:

- 82 x Care at Home Assistants (includes enhancing community alarm responder service and also support additional care at home capacity on Arran)
- 3 x Senior Care at Home Assistants
- 4 x Care at Home Managers – split between in hours and OOH service to provide appropriate management support to increased workforce
- Enhance Business Support – including enhancing recruitment capacity, CM2000 support, performance and monitoring with extended hours of support to the business unit
- 2 x Telecare Advisors to support the enhancement of telecare services to increase use of equipment and other digital resources to support care provision, this capacity would be aligned to the programme of work for Analogue to Digital
- Other additional workforce enabling costs including transport, uniforms, mobile phones, CM2000 licences, email addresses

The full estimated cost of the Care at Home investment outlined above is £2.944m. The HSCP have given Trade Union and care at home staff a commitment to undertake a robust review of the service commencing in Spring 2022, it is recommended that the remaining funding of £0.5m is uncommitted to provide resource to implement any changes required following that review.

Other areas - 1,000 Health Care Support Workers:

Whilst the funding for the recruitment of Health Care Support Workers was not directly allocated to HSCPs, an agreement was reached across Ayrshire and Arran to share the Health Board NRAC allocation of 74 WTE between Acute services and the 3 HSCPs.

The North Ayrshire agreed allocation is 11.6WTE, by engaging with leads in the HSCP the optimum areas to deploy the roles into the Partnership were identified and communicated to the team co-ordinating recruitment to ensure they could be aligned appropriately to our teams. It was agreed to align the posts to two areas with a focus on maintaining and improving people's functional abilities to aid system flow, provide alternatives to admission and minimise the need for escalations of care.

Specifically, proposals have been agreed to deploy the North Ayrshire HCSWs as set out below:

- 8.6 WTE Band 3 - to support inpatient rehabilitation in Ward 1 (general rehab for older people) and Redburn (stroke rehab) wards at Ayrshire Central, to support flow through rehab wards and facilitate discharge and support acute referrals for rehab beds
- 3 WTE Band 3 - to enhance rehabilitation and reablement supports at Anam Cara for both the 9 step down beds and the 5 respite beds, linking the rehabilitation support with the community ICT team, opportunity to strengthen step down model and also incorporate step-up options in the future, incorporating therapy programmes for users of the service to maintain and improve function and mobility.

Previous workforce exercises have identified gaps in the AHP workforce in the inpatient rehab areas, with consequent reduced capacity to provide the levels of rehabilitation required to support improved outcomes for people and minimise length of stay. The greatest impact of the roles in both settings will be a 7 day working approach. In both settings Band 3s will work under the professional direction and supervision or a registered nurse or AHP with the HCSWs placed in Anam Cara being supported via the Community ICT team.

6. ANTICIPATED IMPACT

The additional investment and planned activity outlined above, made possible by the winter pressures fund, will make a significant contribution to improving outcomes for the people we provide care and support for in North Ayrshire. The investment and desired impact is predicated on growing our workforce, recognising there are both local and national challenges in recruiting and retaining the workforce across Health and Social Care services. Any challenges with recruitment will impact on plans to deliver on improvements and it is important that this is monitored to ensure plans can be adapted if required and to ensure appropriate action is taken to accelerate and promote recruitment programmes.

Glossary of Terms:	
HSCP	Health and Social Care Partnership
AHP	Allied Health Professional
ICT	Intermediate Care & Treatment
HCSW	Health Care Support Worker
MDT	Multi Disciplinary Team
ANP	Advanced Nurse Practitioner
WTE	Whole Time Equivalent
AWI	Adults with Incapacity
NRAC	National Resource Allocation
OOH	Out of Hours
OT	Occupational Therapist
KPI	Key Performance Indicator
TEC	Technology Enabled Care
SSAQ	Single Shared Assessment Questionnaire
ACH	Ayrshire Central Hospital

Annex 1 – Enhancing Multi-disciplinary Working

			Key Performance Indicators					
Service Area	**Investment Requested**	**Improvement Area**	**Significant reductions in delayed discharge and occupied bed days**	**Increase in assessments carried out at home rather than hospital.**	**Evidence of a reduction in the number of people waiting for an assessment**	**Evidence of a reduction in the length of time people are waiting for an assessment.**	**Priority**	**Total Cost**
H&CC – Social Work Teams	5 x additional social work posts (SW & SWAs) aligned to locality Social Work teams to support complex assessment to support discharge, review, AWI and support ICT social care requirements.	Community waits for assessment and review	√		√	√	**HIGH**	£ 237,222
H&CC – Hospital Based Social Work Team	MHO within Hospital Assessment Team - G10 Social Worker	Hospital discharge	√		√	√	**HIGH**	£ -
H&CC - NAC Community OT service	Previous limited success to fixed term recruitment through mobilisation 2 x grade 10 Occupational Therapists and 3 x grade 7 Occupational Therapy Assistants	Community waits for assessment and review	√		√	√	**HIGH**	£ 224,114
H&CC - Hospital Based Social Work Team	1 x B7 RN to support complex hospital discharge and assessment	Hospital discharge	√	√	√	√	**MEDIUM**	£ 57,103
H&CC – ICT	3 x B6 practitioners Mon – sun day shifts Fixed term recruitment in process linked to RMP3/	Hospital discharge/admission avoidance	√				**MEDIUM**	£ 161,910
H&CC – Community Equipment Store	1 x Store Technician	Hospital discharge/admission avoidance			√	√	**MEDIUM**	£ 35,080
H&CC - Arran	1 x social worker for locality social work team (support complex assessment and support MDT) 0.6 x ANP B7 (frailty, complex Care, MDT)	Hospital discharge/admission avoidance/assessment and review	√	√	√	√	**HIGH**	£ 158,522
H&CC – ICT	Enhance role of enhanced ICT - following review of service. Plan to be developed - to incorporate tasks not undertaken and ensure capacity to support 'Hospital at Home' Model	Hospital discharge/admission avoidance	√	√			**HIGH**	£ 100,000
Mental Health	Enhance Mental Health and Learning Disability teams to support complex care in the community, avoiding acute admission and supporting timely assessment and review. Support for transition planning particularly for children with complex needs into Adult Services	Hospital discharge/admission avoidance/assessment and review	√		√	√	**HIGH**	£ 136,049
							TOTAL	**£ 1,110,000**