Aberdeenshire Health & Social Care Partnership

REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD – 23 MAY 2018

UPDATE FROM THE RESHAPING CARE AT HOME PROGRAMME GROUP

1 Recommendations

It is recommended that the IJB:

1.1 Consider progress to date of the Reshaping Care at Home Programme Group;
1.2 Acknowledge progress towards meeting the associated strategic priorities;
1.3 Acknowledge implementation of some projects has been slower than originally anticipated and be assured actions are in place to address these issues;
1.4 Agree to receive future reports, including further analysis of performance information; and
1.5 Agree to receive a future report detailing Aberdeenshire's approach to Digital Health & Care.

2 Risk

2.1 IJB Risk 1: Sufficiency of Resources – There is a risk the resources available to the Integration Joint Board (IJB) are not sufficient to reshape services to deliver against the strategic priorities

2.2 IJB Risk 2: Health and Social Care Policy – There is a risk that without progressing the reshaping care at home programme of work the IJB will not be aligned to national policy and will not deliver against its local strategic priorities.

2.3 IJB Risk 4: Service Capacity/Business Transformation – The reshaping care at home programme of work aims to develop services which are fit for the future, both in terms of financial resources and available workforce. Without this programme of work there is a risk resources will not be sufficient to meet the increasing demand for services.

3 Background

3.1 In 2011 the Scottish Government issued, "Reshaping Care for Older People; A Programme for Change". This strategy laid out the direction in which the Scottish Government wished councils, and subsequently Health and Social Care Partnerships, to move towards in developing support for older people.

3.2 The vision of this national strategy is that;

"Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting."

3.3 This vision is reflected within the Strategic priorities of the Aberdeenshire Health & Social Care Partnership, specifically Priority 9, "The most appropriate use of acute and community resources".

3.4 The Aberdeenshire Reshaping Care at Home Programme Group was established in November 2017 and includes a wide range of officers leading the individual projects of work. Initially the programme consisted of 6 key areas of work however it has expanded to include an additional 8 areas, ensuring a consistent and cohesive approach to change. There are some areas which are well established and stable, including the Joint Equipment Service and others where major change and redesign is either occurring or being developed. These areas will be the focus of this report.

3.5 Although care at home is broadly thought of as care in a person's home or "homecare", the reshaping care at home programme of work looks beyond homecare and considers how all resources are coordinated to support the person at home or as close to home as possible. Diagram 1 describes the potential interaction between different resources in relation to prevention, enablement and ongoing support.

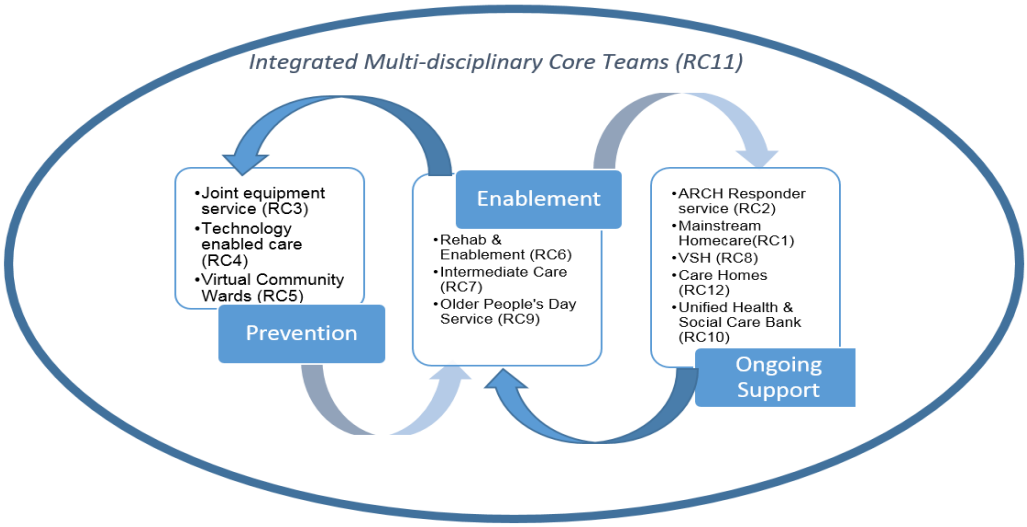

Diagram 1

4 Mainstream Homecare

4.1 Members discussed care at home provision at the Integration Joint Board (IJB) meeting on 23 November 2016 and agreed the Aberdeenshire

Health & Social Care Partnership (AHSCP) internal home care service prioritise its delivery across four key pillars, namely:

a) Enablement – 6 week intensive intervention;
b) Rapid Response - providing a 24 hour responder service for planned and unplanned need;
c) Complex cases, end of life and palliative care; and
d) Hard to reach, remote and rural areas.

4.2 Internal homecare teams continue to provide care on a long-term basis to a large number of service users across Aberdeenshire. The intention of using the 4 pillars approach is to purposefully reduce the level of long-term homecare the internal service provides, hence allowing a greater focus on rehabilitation & enablement alongside the other areas of priority. The task of rebalancing has proven operationally challenging and it is recognised that teams require continuing support to take this forward.

4.3 In response to these challenges early implementer work has started in Peterhead and Central Buchan. The teams covering these areas are developing plans to redress the balance of care in line with the 4 pillars and move towards external providers having the main role in providing longer term Self-directed Support care packages under Options 2 and 3. The plan includes both the benefits of carrying out this work and also the potential associated risks, including the financial impact over the short-term of moving provision from inhouse to external providers.

4.4 In addition, Inverurie, Kemnay, and Westhill location teams have also commenced work on how they wish to redress the balance of care, with a specific emphasis on increasing enablement opportunities. Whilst both approaches move the focus of internal homecare towards prioritising work against the 4 pillars their implementation processes are diverse. This reflects the historical differences between locations across Aberdeenshire and emphasises that whilst it is important to have consistency regarding the quality and accessibility of services there will inevitably be some operational variances. The Reshaping Care at Home Programme Group has an important role in monitoring each areas approach.

5 Responders Service (ARCH)

5.1 The Responder service is fully established across Aberdeenshire providing a response from 8 bases. In February 2018 responders were called-out over 400 times, with the majority of calls relating to personal care needs and resulting in service users remaining at home with no additional care needs.

5.2 To ensure consistency of access to the responder service guidance (Table 1) has been created giving practitioners advice on the role and remit of the service. Work is ongoing to evaluate the efficiency of the current model and to ensure it supports those at greatest need across Aberdeenshire.

Key Area 1 Unplanned care	**Priority 1**	▪ Emergencies at sheltered housing facilities (e.g. a fire) ▪ Immediate critical/substantial risk to health & wellbeing which indicates harm could occur without support being provided. ▪ Where the nature of the call request cannot be identified, for example, no voice contact or difficult to understand caller.
	Priority 2	▪ Uninjured fallers unable to get up unaided ▪ Palliative / End of life care
	Priority 3	▪ Unplanned urgent care needs
Key Area 2 Planned care	**Priority 4**	▪ Virtual community ward patients
	Priority 5	▪ Priority Discharge patients
	Priority 6	▪ Rehab & Enablement support

Table 1

6 Digital Health and Care in Aberdeenshire

6.1 On 25 October 2017, the IJB instructed officers to explore the development of an Aberdeenshire Digital Health & Care approach, including assessing our current provision against potential future developments; ensuring we maximize Aberdeenshire outcomes; taking any learnings from national approaches, with an awareness of budgetary challenges. Work is underway against each of these actions.

6.2 Assessing our Current Provision

Consideration of the extent to which our services are currently supported, enabled and optimised by digital technology includes review of our position in relation to key nationally recognised programme areas of work. These include, Home and Mobile Health Monitoring (HMHM), Digital telecare, Video Consultation, and other key areas of digital transformation such as increasing online access in primary care.

Aberdeenshire's, and indeed Grampian's, position regarding some of these emergent themes, particularly around HMHM and video consultation, is still very much in the formative/ test of change phase. Gaps are being identified and opportunities are currently being promoted, pursued and tested through early adopter mechanisms as part of nationally funded programmes.

6.3 Home and Mobile Health Monitoring (HMHM)

National funding has been secured (March 2018) to support and encourage GP practices in Grampian to free up practice appointments and practice staff time through the use of HMHM for blood pressure monitoring. This initiative is being led by Aberdeenshire H&SCP.

6.4 Video Consultation

National and NHS Grampian funding has been committed to support and encourage primary care and community-based services in Grampian to spread the use of video consultations direct from people's homes and mobile devices to allow greater and more convenient access to both routine care and more specialist support. Primary care and Allied Health Professionals (AHPs), along with support for models of care including the Virtual Community Wards, are amongst those services that the opportunity for greater use of video consulting has been identified. Access to and use of Attend Anywhere (the nationally procured video consulting platform) is currently available to services, alongside provision of basic equipment (webcams, speakers, microphones, and screens/monitors) which has been procured in Grampian using the national Digital Primary Care Development Fund.

6.5 Telecare

Within the community alarm and telecare service, work is underway to address possible gaps in uptake, in particular through the development of ways by which we can better embed the consideration of telecare as a standardised part of rehabilitation pathways and social care assessment processes.

6.6 Development of an Aberdeenshire approach:

Similar to many other H&SCPs, officers in Aberdeenshire are developing a local approach for Digital Health & Care. This approach will draw on emerging best practice from elsewhere and be consistent with national policy, in particular Scotland's Digital Health & Care Strategy. An outline Digital Health and Care approach for Aberdeenshire can now be fleshed out, set within this overall national policy context, national and local programmes of work, including current Aberdeenshire test of change initiatives. It is recommended a further report detailing Aberdeenshire's approach to Digital Health & Care be considered at a future meeting of the IJB.

7 Virtual Community Wards

7.1 The Virtual Community Ward (VCW) model has been actively and widely implemented across Aberdeenshire for the last two years, with 27 VCWs now in operation, representing participation by 84% of Aberdeenshire's GP practices.

7.2 Over the period 1 April 2016 – 31 March 2018, some 3,293 people have been admitted and discharged from a VCW and, as a result, some 1,219 hospital admissions (411 acute, 808 community hospital) are estimated to have been avoided during this time as a direct result of the operation of the VCWs. This latter point is illustrated in diagrams 2 & 3, detailing the actual outcome on discharge from a VCW, and the presumed alternate outcome for that person had the VCW not been in operation.

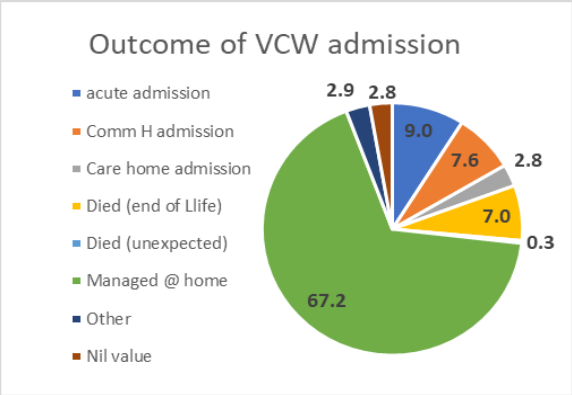

Diagram 2

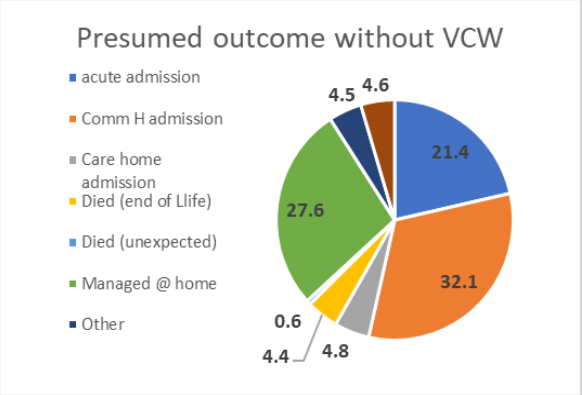

Diagram 3

7.3 The VCW model was originally designed to be tested against the potential to contribute towards the following anticipated outcomes:

1. Improved organisation of care (better use of resources, seamless pathways);
2. Patient outcomes – good quality anticipatory care;
3. Reduction in emergency hospital admissions;
4. Reduction in emergency hospital re-admissions;
5. Reduction in emergency occupied bed days;
6. Reduction in unplanned Out of Hours primary care contacts; and
7. Patient (and carer) satisfaction – good experience for people ill at home.

7.4 In relation to outcomes 1 and 2 above, a reflective exercise carried out in summer 2017, invited the core teams of staff responsible for the delivery of VCWs to provide feedback on their VCW journey so far, against a number of guiding questions. VCW team responses were overwhelmingly positive in relation to the role and benefits that the introduction of the VCW model had made to their local services and patient/service user outcomes. The primary benefit was **better and more effective communication** between the core team of health and social care staff, as a direct result of regular face to face huddles, which in turn led to:

- Better use of resources, better targeting and prioritisation of resources and patients;
- Quicker access to interventions;
- Improved care pathways (better organisation of care, more integrated/seamless patient pathways, with less disruption);
- More holistic / person centred care;

- Reduction in hospital admissions; and
- Better overall staff experience.

7.5 Alongside this, while the analysis of the quarterly reporting submitted by GP practices indicates that the VCW model is contributing to the avoidance of hospital admissions on a case by case basis, what is more difficult to do is to directly measure and attribute, in isolation, the impact of the VCW model on overall trends in emergency hospital admissions, re-admissions and occupied bed days. Over coming months officers will look to evidence the contribution that the VCW model can, and has, made to these outcomes. We will also look at how best to gain the perspective and experience of patients (and their carers) of the VCW, many of whom will not necessarily have been aware that their clinical or social care has been co-ordinated within the VCW.

7.6 Looking at the immediate future, the intention will be to share and promote information covering the last two years of the VCW, including a summary of the quarterly data collected from GP practices over the last two years, and a summary report of the feedback from the reflective exercise. That report will outline some areas for action identified as a result of the feedback received, particularly as we look to refine and further embed the VCW model and share examples of best practice across teams.

8 Rehab & Enablement & Intermediate Care

8.1 Rehab & Enablement refers to a period of intensive support for an individual from a multi-disciplinary team of involved professionals, for example, Care Management, Occupational Therapy & Physiotherapy with the support of internal home carers. The aim of this approach is to ensure people are given the opportunity to reach their full potential and live well at home or as close to home for as long as possible.

8.2 Intermediate Care refers to intensive support being provided in a more supportive environment (usually a Care Home) to enable a person to reach their potential and ultimately return to their own home independently or with minimal support.

8.3 There are areas of good practice for Rehabilitation & Enablement however uptake has broadly been slow across Aberdeenshire. This is notionally attributed to it being a separate pathway and steps are being taken to simplify paperwork and introducing refresher training. In addition, the work being carried out in the mainstream homecare workstream will support and promote the ongoing implementation of Rehab & Enablement in line with the 4 pillars.

8.4 There are currently 2 Intermediate Care Beds in Burnside Care Home, Laurencekirk and 2 beds in Bennachie Care Home, Inverurie. Occupancy at both resources has been variable with demand for the places not meeting expectations. There is much learning being gathered from the perspective of setting up the resources and the ongoing support required to both the care

homes and community teams. With demand now increasing the expectation remains to expand this service more widely across Aberdeenshire.

9 Very Sheltered Housing, Sheltered Housing, and Care Homes

9.1 As detailed in the Aberdeenshire H&SCP Market Position Statement, "Accommodation, Care and Support for Older People", it is our aim to "shift the balance of public expenditure towards a wide range of support which facilitates greater independence, choice and control for frail older people and people with dementia at home and in their community."

9.2 The Programme Group have therefore recently included working groups on Very Sheltered Housing (VSH) and Care Homes within its remit. Work is underway to evaluate both the existing VSH and Care Home models of care provided by the H&SCP to ensure they are responding appropriately to the evolving needs of individuals and communities. This includes the development of the 'North Care & Support Village'.

9.3 Sheltered Housing continues to be an essential part of the housing provision of Aberdeenshire Council. Ongoing review of this option is underway and health & social care partnership officers are working alongside housing department colleagues to deliver a 'joined up' approach to all aspects of housing provision.

10 Integrated Multi-Disciplinary Teams

10.1 In February 2018 a group of multi-disciplinary practitioners considered the options for developing greater integrated working, this included third sector colleagues. The group identified a number of areas where operational processes could be simplified to both release practitioner time and increase coordination leading to an improved experience for patients/service users. Whilst there is little doubt multi-disciplinary working in Aberdeenshire is advanced, there is further work before achieving a "one team" approach.

10.2 The actions from this event have been incorporated into the reshaping care at home programme of work and will therefore be monitored and reviewed monthly.

11 Performance

11.1 In relation to the various projects under the Reshaping Care at Home Programme, performance indicators have been identified as a way to track and report progress with each of these areas of work. These initial indicators have been included for information (Appendix 1). The intention of this approach is enable the programme group to monitor progress across all individual projects with the intention of measuring the progress of the overall

programme of work and identifying and responding to any unintended consequences.

12 Equalities, Staffing and Financial Implications

12.1 The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officer within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

12.2 An equalities impact assessment is not required as there are no policy changes being recommended as part of this report, which is for information only on progress made to date with the Reshaping Care at Home programme of work.

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3 May 2018

APPENDIX 1 – Draft performance measures

ID	Project	Performance Measure
RC1	Mainstream Homecare	RC1.1 Internal / External spend & Internal / External hours RC1.2 Care at home survey analysis
RC2	Responder Service (ARCH)	RC2.1 ARCH Call outs data RC2.2 Outcomes of ARCH referral
RC3	Joint Equipment Service	RC3.1 JEC Average days for delivery RC3.2 Overall trend for JEC deliveries each month
RC4	Technology Enabled Care: 1) Telecare; 2) Telehealth; 3) Telemedicine (video consulting)	RC4.1 Number of people receiving telecare / CAS RC4.2 Number of people using telehealth RC4.3 Face to face appointments saved RC4.4 Virtual consultations - number undertaken and number of practices using regularly
RC5	Virtual Community Ward	RC5.1 VCW up and running RC5.2 Total number of VCW admissions RC 5.3 Total number of hospital admissions avoided
RC6	Rehab & Enablement	RC6.1 % of referrals on R&E Pathway RC6.2 IORN (Indicator Of Relative Need) scores before and after RC 6.3 Outcome of intervention
RC7	Intermediate Care Resources	RC 7.1 Number of nights IC Beds used RC 7.2 Average length of stay
RC8	Very Sheltered Housing	Early stages of project - measures not yet identified
RC9	Older People Day Service	
RC10	Unified Health & Social Care Bank	
RC11	Integrated Working for multi-disciplinary core locality teams	
RC12	Care Homes	