Care at Home First

Report of a Virtual Roundtable March 22nd 2022

Background

The International Centre for Integrated Care, a strategic partnership between the International Foundation for Integrated Care (IFIC), the University of the West of Scotland and the Health and Social Care Alliance Scotland, is the home of IFIC in Scotland. The team are hosting a series of virtual Roundtables with Health and Social Care Scotland to explore hot topics in integrated care. The Flash reports and recordings can be accessed here

Over 100 professionals from across Scotland registered to discuss Care at Home First

Reflections on Current State

Prof Anne Hendry, Director of IFIC Scotland and BGS Honorary Secretary, highlighted the recent **Timely Discharge campaign** led by the British Geriatrics Society. A series of blogs describe the impact of the crisis in care at home and the harms experienced by older people, carers and professionals alike across the system. Although the blogs largely reflected experience in England, **BGS President Dr Jennifer Burns,** acknowledged the problems and solutions are broadly similar across the UK.

Service models and labels may differ but the workforce challenges are common to all UK nations.
We need to focus our energy in getting people home before they miss the window of opportunity.

Dr Adrian Hayter, NHS England National Clinical Director for Older People and Integrated Person Centred Care, outlined the Ageing Well workstreams: Anticipatory Care; Enhanced Health in Care Homes; and Urgent Community response with a new 2 hour standard for crisis response and 2 day standard for reablement. The hospital discharge service operating model can be accessed here

For the first time in 30 years as a GP I've not been able to get an increase in home care to 4 times / day to support an older person to die at home in their preferred place of care. We need to rethink how care at home is delivered and value the people who deliver it – move away from the commissioner – provider split to a more collaborative approach.

Dr Eileen Burns, NHS England Clinical Lead for Ageing Well reflected on the early pandemic response that saw many local health systems purchase additional care home and community beds under the guise of Discharge to Assess. She voiced concerns that bed based pathways too often delay or prevent succesful return home and called for a new vision of care for older people living with frailty.

We need to get upstream with a more holistic approach - anticipatory care by an integrated locality team that knows their patients and can 'pull' them home or closer to home with the rehabilitation they need and with support from the wider community

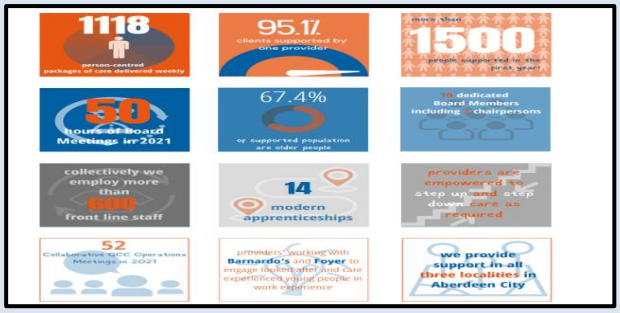
Brian Slater, Scottish Government Policy Lead applauded the community workforce for stepping up during the pandemic to free acute capacity and '***Save the NHS'***. Despite record levels of investment into the system over last winter, he considers too much funding is still caught up in acute care and systems muxt prioritise investment in care at home and in primary care and community services.

People get lost in the system - they need help to get back home quickly before they decondition in hospital and end up facing delays or not being able to return home at all

Marianne Hayward, Head of Health and Social Care, South Lanarkshire HSCP, welcomed the national Discharge without Delay programme. NHS Lanarkshire is one of 4 pathfinder sites, building on their previous work to embed Planned Date of Discharge. The work aims to use intermediate care and step down more appropriately and is underpinned by good local data, including on prevention of readmission.

In her blog she describes *"Compassion, collaborative working and communication are key to addressing the current challenges''.*

Commissioning for Outcomes



Tracey McMillan, Service Manager, Aberdeen City Council and Mike Burns, CEO at Penumbra and Co-Chair Granite Care Consortium described Aberdeen's journey towards collaborative commissioning. A series of locality workshops co-created an ambitious vision to move to a new model of outcome focused care, enablement and early intervention.

A group of 10 providers felt they could work together and with Aberdeen City HSCP and their arms length provider Bon Accord Care. Investing time to buld trusting relationships and creating space for open and transparent dialogue were critical for success. The integrated model offers improved pathways for people and collective resilience for providers and commissioners. It allows Bon Accord Care to focus on hospital discharge and end of life care. Tracey and Mike highlight courageous leadership of the Chief Officer and senior leaders. *None of this has been without risk … but standing still was riskier.*

You can access a presentation on the Aberdeen City innovation under this report.

Christine Ferguson, Director Corporate Service, Shetland Islands Council shared the place based model developed for their 15 inhabited islands. Small local care centres offer a mix of residential care, short term or respite care, intensive community support at home and day services – all working closely with 'wrap around' support from healthcare staff based at the adjacent village health centres. She acknowledged local pressures from lack of appropriate housing for a care workforce but the Council reported a positive impact on recruitment and retention from introducing a pool car initiative for care workers.

Boundaries don't matter if you build strong relationships

If we get this right maybe we will need a smaller hospital !

Karen Hedge, National Director Scottish Care, affirmed the importance of both pay and career opportunities for the care at home workforce, calling for faster progress on Fair Work and a shift towards valuing the care at home workforce as salaried professionals. She highlighted the Future of Care at Home report with GSA's European School of innovation and design.

Read more from Karen's team in these Scottish Care resources:
Time for Change
Future Landscape
Seeing The Diamond in Social Care Data

Can't talk workforce without mentioning how external forces affect them- recent example of staff calling in sick, but when we got to the bottom of it, they couldn't afford to fill their car with fuel. We need to recognise that social care contributes money to the economy.
£3.4 billion, more than agriculture, forestry and fishing

In social care in East Ayrshire there is a total of 5,740 jobs. Alongside this direct employment, there is an estimated further 1,140 'indirect' and 830 'induced' jobs. The 'gross value added' by these 7,710 jobs in the social care sector to the local economy is in the region of £133.4M. As 95% of the care at home workforce is local, investment has a powerful community wealthbuilding and anti-poverty impact and helps in closing the gender pay gap. Following East Ayrhsire's best value service review of care at home 2019/2020, the HSCP commited to regrading of posts to align with other professions, introduced a social care learning hub and improved the career structure and business and management support.
Erik Sutherland, Head of Locality Health & Care Services, East Ayrshire HSCP

Valuing care work with, and beyond, better pay, is essential, which means culture change. I see that culture change is frequently mentioned but there is no funding on research into what that means and how it can be done. It's time to get into what culture change means, and how to do that urgently. The practical focus must be on reviewing and changing recruitment messaging in the whole social care sector. **Dr Stephen Gibb, Reader, UWS**

SVQ programmes have a key role in social care education but we also need to support the workforce to develop critical thinking skills and leadership for integrated care. Reflective education is important, however for a transformative workforce there needs to be more invested in formal education. UWS offers articulated undergraduate and postgradulate education that builds these skills. This short video and report reflect very positive feedback from our students. **Helen Rainey, Programme lead, UWS**

***Mike Burns**: We need to move to a single tier of investment and professional development*

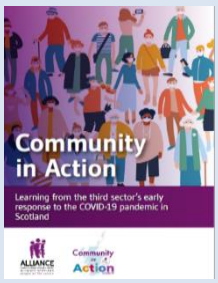
Mobilising Community Capacity

Alison Bunce, Compassionate Inverclyde / Inverclyde Cares Programme Lead explained how Inverclyde citizens have become a vital community first response and a central component of the caring circles supporting older people and those who are lonely or isolated at home. Building on the experience and valued contribution of *No One Dies Alone* companions, *Back Home Boxes* volunteers and *Back Home visitors*, Compassionate Inverclyde is developing a new support initiative *No One Goes Home Alone*. This will be piloted for over 75s who live alone and are returning home from hospital after a stay of 2 weeks. Local volunteers will add value to the role of the care workers who often have limited time to spend in the home.

You can find out more about Compassionate Inverclyde here and view mterials from IFIC Scotland's Compassionate Communities Active Learning Programme here

Sara Redmond, Chief Officer, Health and Social Care Alliance Scotland highlighted our need for human connections, relationships, hopes and goals. She reminded us that people value family members being involved in their care and support.

Unpaid carers are a key part of the patchwork of care and need investment and support to enable them to continue caring.



Unpaid carers were largely overlooked during the pandemic and many assumptions were made about their ability to care as community services were reduced. A spirit of collaboration with the Third sector excelled during this time. The ALLIANCE report Community in Action describes the learning from 51 examples of the sector's early response to COVID 19.

Let's only intervene with formal care when we need to – strengthen the natural assets first

Stephen McCullough, Head of Care Hanover Scotland pointed out that housing and social landlords are important community assets. He described Hanover's Housing with Care developments on 3 sites in Moray. They offer a homely environment and on site care teams through a partnership with Moray HSCP. Varis Court in Forres offers unscheduled short stay flats with inreach support from the local district nursing team - watch a video here

Hanover has also worked with some HSCPs to align the local care at home workforce with their sheltered housing units to improve efficency and continuity of care for the tenants.

RSLs are willing to be at the table with HSCPs - and can access HAG funding to develop homes for life so people move in when they are ready and they don't need to move on

Home First and Intermediate Care

Paul Williams, AHP Associate Director, spoke of work underway in **Scottish Borders** to develop a Home First pathway - initially D2A then adding crisis response for admission avoidance. Reablement is provided by health care support workers supervised by a district nurse or AHP. Local evaluation found 57% reduction in hours of care required after Home First.

But the service gets clogged and outcomes aren't optimal. Need to commit to reablement to see the longer term benefits or people just come back through the system again.

Inability to transfer to mainstream CAH has a substantial impact on flow and the number of people achieving independence. We need to take more of an early intervention approach. ***Eddie Gilmartin, South Ayrshire HSCP***

Dr Douglas Lowdon, NHS Tayside Associate Medical Director explained every Consultant Geriatrician in Tayside is aligned to a locality. They contribute to the Enhanced community support team, attend weekly GP practice based MDTs and link daily with local community coordinators. However, despite this excellent anticipatory care, older people still experience acute crises, particularly out of hours. So comprehensive assessment at the hospital front door are critical elements of their whole system pathways. You can learn more about frailty at the front door from Dr Lowdon's slides under report.

Hospital induced dependency is the biggest virus older people face
Our 24/7 acute frailty service at Ninewells enabled rapid turn around and 'pull' to our sensational community models ! – so we could close beds and move staff to community

Dr Jo Bowden Consultant in Palliative Medicine, NHS Fife confirmed that home is the place where most people choose to be. Historically 80% of Fife's palliative care budget was spent on hospice inpatient care for only 4% of the population. Following a service review it was agreed that specialist Palliative Care should better support the palliative care needs of the *whole* of the population. So the team created a Single Point of Access, enhanced the Palliative Care Support Line and introduced a mobile multidisciplinary workforce operating 7 days to 8pm to allow urgent response at times of crisis / escalating need. Immediate telephone clinical advice and peer support is available for generalist clinicians caring for patients in all settings. You can learn more about the Fife model from presentation under this report.

Supporting more people to be cared for at home requires significant resource, but is high value care. Working alongside in people's homes and responding in real time is so rewarding.

Before you fund any more specialists you need more generalists like DNs and home care.

Peter Knight, Information Specialist and Head of Service, Public Health Scotland suggested the community workforce has been 'starved' of information until recently. He considers national data on social and community care has improved recently and is confident that the proposed National Care Service will drive further progress in this area.

Care Home Census information and Insights in Social Care – statistics for Scotland are available here

He recognises there is often good local data on Home First pathways, reablement and intermediate care but it is challenging to standardise this information for national reporting.

There has been a lack of national sponsorship with no real progress since a pilot of a minimum dataset for Intermediate Care in 2015/16.
Without the data nobody believes the good work that is being done in this area.

The data packs for HSCPs don't seem to have changed over last 5 years and don't reflect the information we need to be seeing in light of these discussions ***Dr Douglas Loudon, Tayside***

You can listen to the full webinar recording here

Future Roundtables

Date	Time	Topic
June 7	**12-2pm**	**Developing a Workforce Fit for the Future**
September 13	**12-2pm**	**Governance and Accountability**
December 6	**12-2pm**	**Outcomes for Wellbeing and Health Equity**

Check out our webpages to find out more about our work and resources:
https://integratedcarefoundation.org/ific-scotland

To receive regular updates and newsletters contact
Marie Curran: IFICScotland@integratedcarefoundation.org

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