ITEM No …10……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 14TH DECEMBER 2022**

REPORT ON: **MANAGEMENT OF SOCIAL CARE CAPACITY AND FLOW**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB94-2022**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to sets out the actions being undertaken to manage and reduce the unmet need for social care in Dundee Health and Social Care Partnership.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the work being undertaken to address the challenges of managing social care capacity and flow and the associated action plan in place to meet those challenges.

3.0 FINANCIAL IMPLICATIONS

3.1 Financial investment in managing social care capacity comes from delegated recurring resources to Dundee Integration Joint Board and additional recurring Scottish Government allocations to the IJB. These investments have already been incorporated in the IJB's 2022/23 Revenue Budget.

3.2 £5.5m to has been budgeted to support increased capacity and new models of care alongside £6.5m to meet national policy relating to increased social care pay (to improve social care sector viability and secure longer-term sustainability), and £0.8m to support additional local social care sustainability. It should be noted that the significant funding provided to increase social care pay and sustainability has not directly increased social care capacity to meet demographic demand but has protected the availability of existing social care.

3.3 Approximately £1m of existing resources are to be re-invested in the Discharge to Assess social care model which is currently being reviewed and redeveloped.

4.0 MAIN TEXT

4.1 Nationally there are challenges about the availability of social care and a growing volume of unmet need. As at 31 October, there were 14,446 people waiting for assessment or a care package, 1% lower than in the previous week (14,664), and 10% higher than the number waiting at 15 November 2021 (13,153). As at 31 October, there were 59,278 hours of care yet to be provided for those 5,437 who have had an assessment, similar to the previous week (59,197), and 13% more than at 15 November 2021 (52,636). While 8% of those people are in hospital the majority are in the community. In Dundee in the same week there were 277 people waiting for over 3000 hours of care. We currently provide around 15,000 hours of social care a week.

4.2 As outlined in DIJB5-22 Fairer Working Conditions we are working locally to implement fair work principles with all our providers. This includes ensuring staff are paid the living wage and that providers are enabled to avoid down time for staff by using down time flexibly among other measures. This work has now been completed but remains under review.

4.3 Part of the work has been to empower providers to be flexible to the needs of their service users through the roll out use of frailty tool. This action is complete with all providers using the tool but ongoing support is required to providers to use tool.

4.4 In relation to increasing in-house service capacity we planned to recruit 40 additional social care worker posts. We have experienced a high turnover of staff during this period and this has meant it has not been possible to recruit as many additional staff as we would have hoped. Instead, we have recruited 7 additional staff and 10 sessional workers into the service. We have also temporarily increased staff's contracts using the monetary value of the 23 posts that are still outstanding. We have undertaken a number of measures in order to improve recruitment including sharing real-life case study examples of working in the social care sector to encouraging people to consider social care as a future career path. We are exploring the role of modern apprentices, attending recruitment events, working with the job centre, offering placements and a range of other measures. Working groups are in place to progress this.

4.5 In addition to recruitment we are also looking at ways to ensure social care is a rewarding career and improve retention. This includes enablement training and care coordination.

4.6 We are making improvements to process such as the development of a triage system with the Resource Matching Unit (RMU) to ensure those most in need of services are prioritised appropriately, in line with eligibility criteria and the further promotion of eligibility criteria across all teams.

4.7 Right person right place right time is key to how we support people to receive the best support and make better use of social care. To achieve this we are working to change our Front Door Model. To do this we are in the process of recruiting support workers that will work closely with RMU to ensure timely reviews are being carried out for those in receipt of care packages and those who go home to await.

4.8 Technology is a further key part of our action plan and this includes promoting the use of technology-enabled care options to further increase independence, better use of mobile and flexible working technology and improved communication between systems. Alexa devices have been ordered and received. A protocol has been devised for loaning technology out to service users and family members. Technology Assistants will install and demonstrate the functions available with the Alexa device such as video calling, "drop in" via video call, medication reminders, shopping lists, SOS contacts, music, audio books, weather forecasts, news stories etc. It can also be programmed to turn lights on and off if the person has smart bulbs. GPS trackers for those who wander are also available to trial.

4.9 We know that service users want to be as independent as possible for as long as possible and this needs to be at the centre of our approach which is an enablement one. We are more closely linking the Independent Living Review Team to the Social Care Response Service (SCRS), providing staff training and using provider down time more effectively to promote independence.

4.10 A piece of equipment has been identified that will allow safe moving and handling with one carer rather than two carers. This is being tested and will hopefully allow a more efficient but still safe level of provision.

4.11 We know that early intervention is key to preventing the need for higher cost, less effective interventions at a later stage. We have therefore put in place proactive outbound calling in our Social Care Response service. This means that rather than waiting for someone to press their alarm proactive calls are made which can reduce unnecessary hospital admissions.

4.12 Service user feedback is key to informing improvement work going forward, ensuring we provide a service that is person centred and responds to the needs of the Dundee population. We have a staff member dedicated to carrying out SCRS, Enablement Home Care & Community Mental Health Team surveys.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

6.1 This report has not been subject to a risk assessment as it is for noting only.

7.0 CONSULTATIONS

7.1 The Chief (Finance) Officer and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

8.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

9.1 None

Vicky Irons
Chief Officer

DATE: 23 November 2022

Care At Home and Externally Commissioned Services – Service Development's

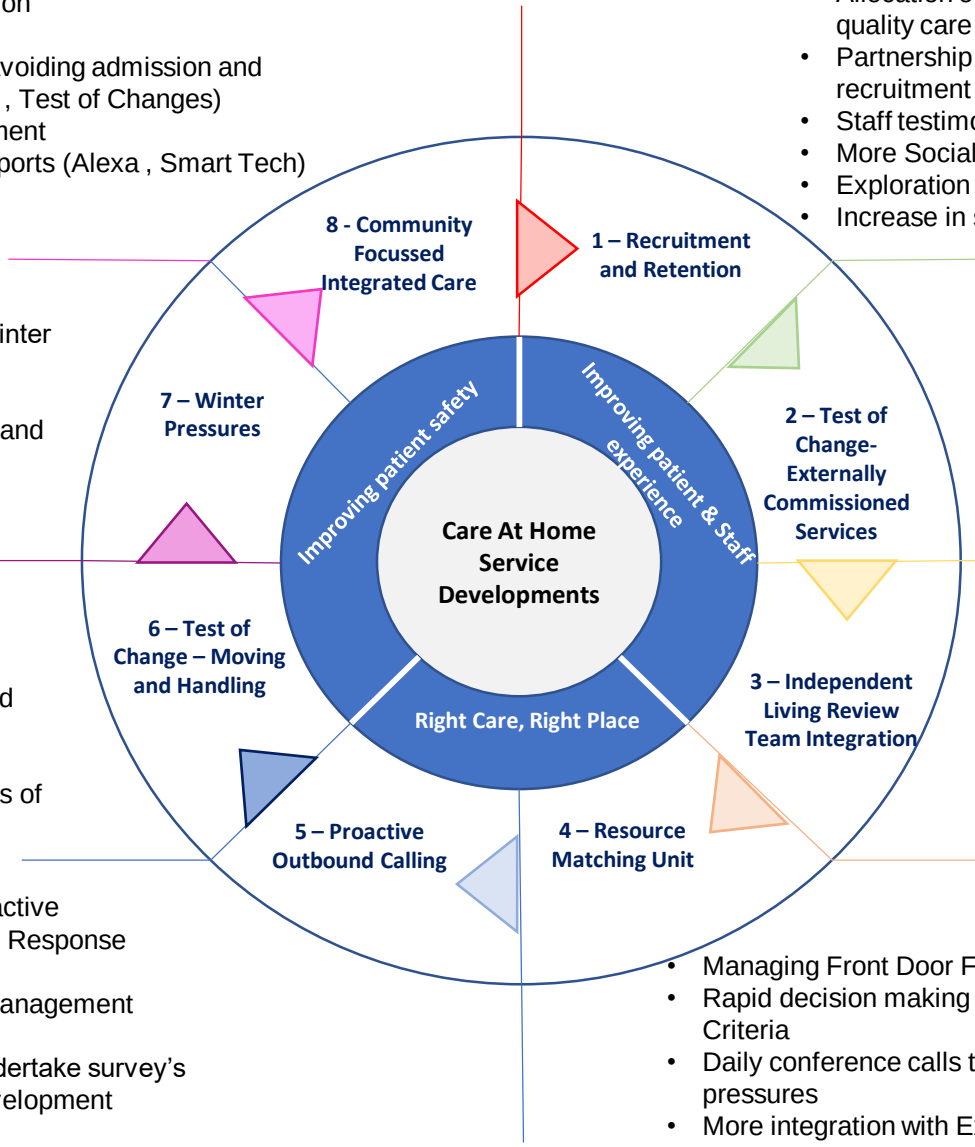
Right Care, Right Place for Every Person Every Time

Dundee Health & Social Care Partnership

High Impact Changes and Aims- Care At Home and Externally Commissioned Services

- Whole system Integration and collaboration
- Integrated health and social care MDTs
- Range of community services aimed at avoiding admission and supporting discharge (ILRT, Enablement , Test of Changes)
- Supporting prevention and self-management
- Step up of technology Enabled Care supports (Alexa , Smart Tech)

- Allocation of 40 additional care worker posts to provide safe, resilient and quality care and support
- Partnership working wit Job Centre and Discovery works in relation to recruitment into Social Care
- Staff testimonials / videos / on what its like to work in Social Care
- More Social Media opportunities to showcase roles
- Exploration of Modern Apprentices working in Social Care
- Increase in staffing hours over winter period



- Optimise discharge without any delays
- Increase in staffing hours for 6 month's over winter period – to support better outcomes
- Service stability over winter pressure months
- Optimising Flow by aligning capacity with demand across the system

- Fair working so that front line team's are paid full shifts rather than actual delivery- helps support recruitment and retention
- Upskill teams to incorporate ILRT tasks and offer supports out with normal visits to support self management/care
- Ad hoc visits to support with kitchen , bathroom or domestic rehab – supporting Independent Living tasks out with normal Social Care Supports
- Improve patient safety and confidence by adopting the Enablement approach to all externally commissioned services
- Frailty Tool to empower providers to be flexible to needs of service users

- Developing new models of rapid support to individuals in relation to M+H assessment and support
- Support staffing resources to provide a safe and robust service without reliance on increasing resources as not always needed
- Upskill staffing to support every changing needs of service users

- Improve patient experience by reducing the need for Social Care
- Supports a review of functional abilities rapidly while in the community setting
- Integration of ILRT with RMU/Enablement to support assessment at front door – reduction of 30% in social care requests (David to check figures !)

- Shift the balance of care from Reactive to Proactive
- Integration of proactive calling into Social Care Response team
- Alternative pathways and sign posting – self management promotion
- Service user feedback – dedicated team to undertake survey's with service users , which is key to service development

- Managing Front Door Flow – Every Patient, Every Time
- Rapid decision making and allocation using Triage tool /Eligibility Criteria
- Daily conference calls to highlight hospital/locality Social Care pressures
- More integration with Externally commissioned service providers
- Partnership working across the D2A pathway
- Support workers to be recruited to ensure timely review's are carried out

Care at Home and Externally Commissioned Services

Aim/outcome:	Primary Drivers:	Secondary Drivers:	Change Ideas	Measuring impact:

Overall Aim:
Right Care, Right Place, Every Patient, Every Time

Aim: Develop and redesign Social Care Pathway's

Outcome:To support better outcomes for service users , ensuring Social Care services are providing a safe, resilient and quality care service

Primary Drivers:

- Support a reduction in unmet need
- Safe, resilient and quality care
- Further develop self management and digital solutions
- Improve the image of Social Care to attract applicants into the sector

Secondary Drivers:

- Proactive Models of Care rather than Reactive
- Extending & improving Care At Home services
- Equitable Care, support and delivery
- Access to the right professional first time
- Developing & promoting self management
- Building sustainable workforce models
- Competent and Skilled workforce (retention)
- Digital supports and Technology Enabled Care Models
- Step up care using Downtime/ adhoc availability
- Understanding of good practice models within Care At Home
- A Focus on continuity and approaches that's support positive outcomes

Change Ideas

- Integration of Independent Living Review Team and Enablement Team
- Winter Pressures- Step Up Care and Support
- Proactive Outbound Calling – Proactive not Reactive
- Resource Matching Unit / Triage Tool
- Moving and Handling – Test of Change
- Shared understanding of roles & responsibilities
- Digital Solutions to support Self Care and Management
- Partnership working with Job Centre and Discovery Works
- Test of changes - Adhoc Availability/ Fair Work / Moving and Handling

Measuring impact:

- Level's of unmet need
- Service user feedback
- Improved Outcomes/ statistics
- ILRT statistics
- Recruitment and Retention Figures
- Staff feedback from surveys
- Patient flow during winter pressure months
- Digital technology statistics
- Care Inspectorate grades/feedback

Independent Living Review- Integration

- Front door approach
- Functional ability needs led assessment
- Prescribed Independent living tasks
- Can support reductions/Increases in care (optimum level)
- Has supported a reduction in care packages by
- Integral to external provider test of change
- Will support providers when assigning tasks in down time

Recruitment and Retention

- Support from Job Centre and Discovery works
- Partnership working - Team Managers and Job center staff working together on application forms , how these are shortlisted to help candidates write robust applications
- Exploration of work experience opportunities
- Exploration of modern apprentices within Care at Home
- Upskill staff with more meaningful tasks outwith normal social care , ie kitchen rehab (ad hoc test of change) and training and development opportunities
- Staff video testimonials to accompany job adverts
- Staff written testimonials to be included in job pack
- Attend job fairs and recruitment events
- Staff surveys to hear meaningful feedback about job satisfaction / ideas staff have
- Sharing of candidates that were appointable with a care company (perhaps only a few vacancies) can sign post to other providers that have vacancies

Winter Pressures and Support

- Additional Recruitment of 40 Social Care worker posts
- Front line staff engagement, resulting in staff agreeing to additional hours to support over winter (using current 33 unfilled posts so no budget deficit)
- Sharing of service users visits during adverse weather – multi disciplinary engagement between RMU and externally commissioned teams
- Support a reduction of unmet need over winter pressures months
- Ongoing use of frailty tool by providers to empower them to be flexible in their support to service users
- Triage tool developed by RMU to identify those in most need is in place
- Palliative care pathway stepped-up and weekly conference call in place – partnership working with RMU to identify rapid support for those with a life limiting diagnosis – right care , at the right time in the right place
- Front door model to be staffed by support workers to review those in receipt of care packages or for those who go home to await services

Proactive Outbound Calling

- Social Care Response Team will undertake scheduled outbound calls via the community alarm systems to those who may require support , rather than waiting for them to press the alarm (reactive model)
- The team will include falls prevention for anyone at risk and falls assessment for those who may have fallen which can support unscheduled admissions into hospital (ie potential falls risk identified , team can refer to falls team, OT or ILRT rather than waiting for them to fall and then this support is put in place)
- The RMU unmet need list will be incorporated into the outbound calling to promote a conversation around that persons latest update on their care and support needs (ie managing ok or in crisis using the RMU triage tool)
- OPC has proven success in supporting those who may be at home without care , just knowing that someone is going to call , helps support positive outcomes
- Sign posting by outbound caller to other services if person is I need , ie community meals service

Moving and Handling Test of Change

- Step up to a rapid model of Moving and Handling Assessment
- Care at Home have released a social care worker (who is also our moving and handling Co-Ordinator) for a period of 3 months
- Enablement service users to be seen within within 24 hours (due to dual role previously – inherent delay's were noticeable)
- Reliance on stepping up the care resource was becoming a custom and practice for front line teams while waiting on moving and handling assessment – not best use of resources it is only a technique or refresher for staff that would work
- Co-Ordinator will oversee supports to service user and staff and work with OT moving and handling assessors on prescribing of equipment if needed

Digital Supports in Self Care and Management

- Technology Assessment and Installation team set up (4 tech assistants)
- Equipment loan scheme set up
- GPS trackers available for family to try for family members who wander
- Amazon Alexa devices with video calling are available to support self care and management , medication reminders, shopping lists , exercise reminders , inactivity reminders , fluid prompt reminders
- Falls pendants with sensitivity levels are available
- Door sensors , bed sensors , chair sensors that can be programmed to family member’s mobile phone – to help promote self management

Ad hoc Availability – Test of change

- Teams to use downtime or cancellations for ad hoc support to service users
- Supports positive outcomes for service users
- Promotes a safe, resilient and quality care approach
- Makes best use of resources
- Supports a prevention of admission model (I.e. step up care using ad hoc availability for someone with a UTI / short illness
- Helps with Recruitment and retention as staff are paid for full shifts under fair work policy
- Helps upskill staff to use different models in supporting service users other that the normal social care supports
- Table on next slide has examples of tasks care workers can undertake during downtime/ ad hoc availability and the support area this can positively impact

Task	Any Training Needs / approaches	Support Areas/ Outcomes
Extra visits for those unwell	None	Prevention of admission to hospital Health and Wellbeing
Extra visits for those unwell (Specific ECS Pathway) **ECS – Enhanced Community Support**	None	Support ECS pathway Prevention of admission to hospital Health and Wellbeing
Hospital discharge – extra support for person in relation reorientation to being back home / Check food provisions / Home Safety	None	Health and Wellbeing Confidence Nutrition Safety

Task	Any Training Needs / approaches	Support Areas/ Outcomes
Encouraging Mobility	None – general prompts within Enablement ethos to mobilise (confidence levels improve if someone is present)	Falls prevention Mobility Health and Wellbeing Confidence Safety
Follow up visits for those who have fallen	None	Health and Wellbeing Confidence Escalation of need (extra care) Moving and Handling
Kitchen Rehab	None – enablement ethos / Values - tasks such as encouragement to prepare drinks , meals independently	Nutrition Health and Wellbeing Confidence

Task	Any Training Needs / approaches	Support Areas/ Outcomes
Bathroom Rehab	None - enablement ethos/values, tasks such as encouragement to Brush teeth , shave , shower independently	Hygiene Health and Wellbeing Independent living Confidence
Domestic Rehab	None – supporting under enablement ethos/values of prompts to put on washing , load dishwasher , make bed , clean	Hygiene Health and Wellbeing Independent living Falls prevention (cleaning rubbish and clutter etc) Confidence
One off supports to those waiting on a package of care with RMU(provider can support a one off visit to help with personal care and hygiene	None – enablement ethos/ standard visits for Personal care	Hygiene Health and Wellbeing Confidence Assessment (provider can gauge level of service needed based on their observations – following enablement ethos)

Task	Any Training Needs / approaches	Support Areas/ Outcomes
Encouragement of movements(move it or loose it / CAPPA TBC)	Lower level prompts – possibly some training needed (Rachel / mascha from falls team / ILRT	Health and Wellbeing Confidence Mobility
Technology	Shopping lists , reminders , Alexa systems	Social isolation Loneliness Health and Wellbeing
Personal care	None – support using the enablement ethos , ie ask person to stand	Hygiene Health and Wellbeing Confidence
Independent Living Review Team Tasks	None – supporting under enablement ethos/values of prompts to put on washing , load dishwasher , make cup of tea . mobilise , stair practice ILRT will prescribe tasks	Health and Wellbeing Confidence Independent living