PERTH & KINROSS INTEGRATION JOINT BOARD

30 March 2022

CARE AT HOME RESILIENCY

Report by Acting Head of Service ASWSC Commissioning
(Report No. G/22/55)

PURPOSE OF REPORT

In writing this report it is important to acknowledge the strengths that exist within our local Care at Home provision, this is a challenging and demanding area of social care delivery. Both our internal and external deliverers of Care at Home, work tirelessly to ensure the needs of those they care, and support are met. However, within Perth and Kinross and since we externalised our Care at Home provision, we have continued to see a level of unmet need.

The Care at Home resiliency project has sought to explore why this unmet need continues and to review both our internal and external provision in order to improve our ability to meet this need but also to ensure we look at the overall model of delivery, to ensure we are delivering outcome-based support and care, to ensure we are optimising the range of partners involved in this delivery model and to ensure that the workforce feel engaged, valued and rewarded for the work they do.

The proposals within this paper are aimed at empowering people to have greater control over their lives, have stronger connections in their community and have access to the support they need within their local community.

1. RECOMMENDATIONS

It is recommended that the IJB –

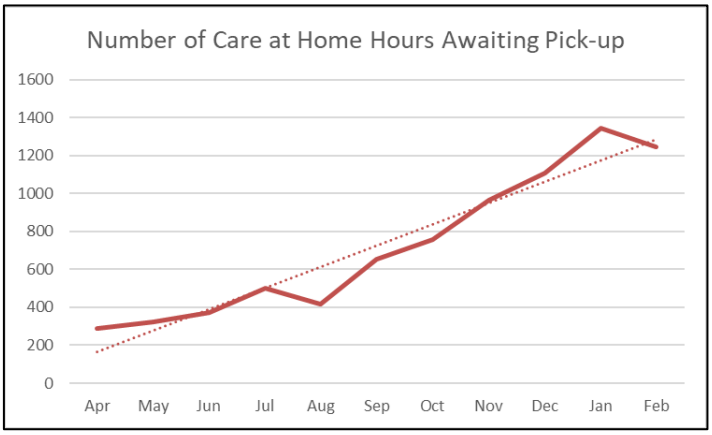
- Note the content of the report;
- Approve the developments set out in this report.

2. CURRENT POSITION

2.1 The Care at Home Resiliency project has been working to address the key challenges that have persistently presented within the current Care at Home model and are related to Rurality, Recruitment and Flexibility. These are not new to Care at Home, but Covid has further impacted on these existing challenges, and we have seen an increase in referrals within our Reablement and long-term Care at Home provision. This has been due to a variety of factors including a decrease in care home admissions and increased dependency of people due to decreased activity and reduced community supports during lockdown.

The pandemic has undeniably impacted on the project's ability to compare and contract methods of working and improvements implemented by the Resilience Project. There does continue to be a level of unmet need within Care at Home but given the increased demand, as a consequence of the Pandemic, the project feels secure in asserting that the level of need would have been far greater without the improvements to processes, referral pathways and SWiTCH investment. The ability to support people to remain at home rather than be admitted to a care home is a key achievement as demonstrated in charts 1 & 2 below:

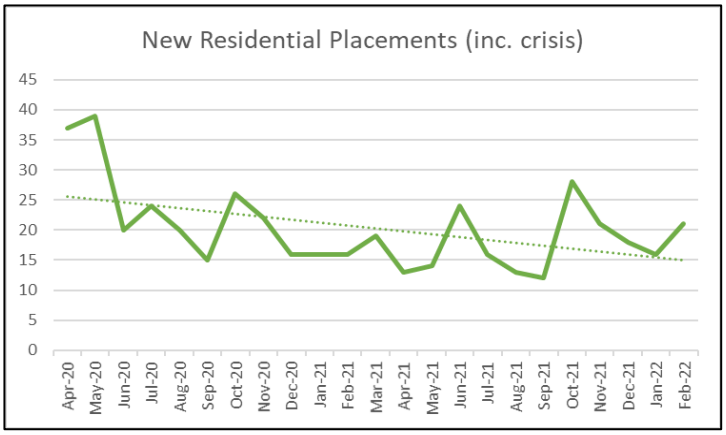
Chart 1



Source: QMO Spreadsheets

This graph shows a sharp increase in the care at home hours awaiting pick up. This includes people who are having CAH delivered by HART. In November 2021, 49% of the hours delivered by HART were for long term care at home.

Chart 2



Source: Funding Panel Administrator

This graph shows a steady decline in admissions to residential homes, which is an identified benefit of the project - to keep people at home for longer

It was initially anticipated that the project would achieve £200k savings through redesign, however this has not been possible, as referred to earlier, the Pandemic resulted in an increase in need for Care at Home services.

2.2 The project centred around three workstreams -

Workstream 1 - Internal review:

Aim: *To streamline in-house processes and create a single management structure for the quality monitoring of care at home to provide equity and consistency across the three localities.*

Quality Monitoring Officers now regularly attend the daily huddles at PRI, improving discharge pathways by providing early information and highlighting areas of risk. The assessment process across all localities and referring teams has been reviewed to ensure consistency of approach and that choice and control for any individual accessing Care at Home is at the core of our assessment activity. Waiting lists have been reviewed with all quality monitoring officers now using the same template which ensures easier reporting into the project performance framework, with information readily available on request.

Workstream 2 - Immediate Covid Response:

Aim: *To implement an immediate solution to manage unmet need in the community and hospital*.

An internal care at home team was introduced - SWiTCH (Supporting with Transition to Care at Home). This temporary team provided a mixture of care at home and reablement, increasing capacity for our HART team to focus on early intervention and prevention support as intended. This amongst other measures, as detailed below, has increased capacity and reduced pressure on services, and allowed us time to pursue additional developments.

- Creation of robust links between Integrated Hospital Discharge Team, HART and Care at Home (Implementation phase)
- Continue to ensure TEC and Digital solutions are integral to support service users and their families
- Transform approach to provision of care through development of a matching unit and flexible care visits (Implementation phase)
- Ensure physical activity is integral to support service users and their families

Workstream 3 - **Long term redesign**:

Aim: *To design a flexible, responsive, outcome-based approach to supporting people at home*.

We have engaged with people in local communities, hosting information and development sessions to create a new approach to providing care at home services in Perth and Kinross. Five themes were highlighted, Community Links, Learning and Training, Recruitment and Retention, Personal Assistants and Self-employed Carers and Support Networks for Providers, each with its own working group, actions, and key developments.

2.3 Workstream 3 represents the key area of Care at Home development for the Health and Social Care Partnership. We have considered a variety of different models and explored how they could be implemented within Perth and Kinross. There is no one model that exclusively will meet the needs of our population and whilst we know that our existing Commissioned Care at Home is appropriate and meets the needs of many individuals, it isn't able to on its own to fulfil our current requirements.

The original three workstreams concluded in October 2021 and the ongoing work was split in to three working groups - **Strengthen the Foundations**; *To continue to develop proactive and preventative care to ensure integrated support for people at home*, **Supporting the Workforce to Thrive**; *To nurture and strengthen the social care workforce so they feel engaged, valued, and rewarded* and **Fit for the Future**; *To transform the way we plan and deliver social care support*. These working groups form the ongoing commitment to Care at Home.

The rurality of Perth and Kinross is extremely challenging with regards recruitment and retention, this is where, in the majority, we experience unmet need. We are clear that if we want to ensure we work in a proactive and person-centred manner that enables more people live in their own homes for longer, that investing in more of the same will be ineffective in achieving this. Through our community engagement activity, trialling of different models and learning gained from other areas we understand that Community based approaches work well.

The model we believe would work best within Perth and Kinross is that of the Wellbeing Team approach, small, self-managing teams, that operate in local neighbourhoods, they are values-led at every step, focussed on co-production, supporting people to make decisions about their life and support and committed to the wellbeing, both of the people they support and the members of the team.

Not only do Wellbeing Teams work well for the individuals receiving care and support but we know that where Self-Managed Teams exist in other areas they report a more flexible approach, improved quality of work life and increased job satisfaction, this is vital to our ability to recruit and retain high quality staff.

2.4 A series of co-production groups have been held, with a wide range of stakeholders interested and engaged in the project, and included organisations already providing services within rural locations, including but not limited to, community groups, private providers, care homes, Live Active, GP representation, Care and Wellbeing CiC, PKAVS, NHS Healthy Communities, social work, and Alzheimer's Scotland. These groups provide a forum to:

- Discuss care at home in its entirety, at a local level, including how early intervention and prevention/community supports are linked, so that people can remain at home for longer.
- Share what kind of informal and formal support is currently available in the community.
- Find out if local people know about support options and how to access them.
- Agree what can be adapted and how this is done for older people.
- Represent the voice of the clients with Care at Home Providers sharing case studies and helping match people into opportunities, as well as identifying any gaps.

- Think about care at home models, such as a Boleskine, Buurtzorg approach, where we support a local solution with local communities in more detail.

2.5 The Scottish Government allocated £62 million for 2021/22, to build capacity in care at home community-based services. This recurring funding was aimed at fulfilling unmet need, and to deal with the current surge in demand and complexity of individual needs, also helping to ease pressures on unpaid carers.

The HSCP have used part of this allocation to improve pay and conditions for our External Care at Home providers and ensured a more equitable pay rate across Care at Home provision as a whole, in addition this funding has been aligned to the new Care at Home model (Wellbeing Teams), both of these financial investments will improve capacity and meet current and future demographic pressures.

2.6 Other actions/developments were considered by the project such as autonomous decision-making regards Care Home placements by HART staff, provision of broadband/device as part of care package, 15-minute project, volunteering, enhanced carers, and Community brokerage all of which have been closed or fall under the responsibility of groups/teams out with the project governance structure.

KEY DEVELOPMENTS

3.1 **Wellbeing team approach** for unmet need in rural locations. This approach will bring, more flexibility of service provision, increased quality of work life, less absenteeism and employee turnover, increased job satisfaction and organisational commitment. This team will provide a culture of team responsibility, shift the decision making closer to the front line. A team that is committed to wellbeing of the people they support and its team members. In addition to a traditional personal-care delivery CAH model, this team would also look at technology, aids and adaptations, support from family, friends, the wider community, as well as other services and paid support.

3.2 **Improved Reputation of Social Care.** The value and reputation placed upon Social Care is low and this affects recruitment. To turn this around, the project secured funding for a 2-year Digital Marketing Graduate whose primary aim will be to circulate positive messages and real local stories around the benefits of social care on all social media platforms.

3.3 **Recruitment and Retention** is a huge barrier for successful Care at Home Delivery. The project has developed a number of pathways into care to provide more consistency of approach across all providers.

3.4 **Young Workforce -** The project is developing the young workforce through secondary schools, Perth College UHI and Youth Services to promote careers and offer more work placements, through foundation apprenticeships and work experience.

3.5 **Employability -** The Economic Wellbeing Plan highlighted a number of proposed projects including one to address the serious recruitment issues being faced in the Care Sector. A "Get into Care" academy will be launched to provide a partnership approach to be delivered by Local training organisations who have a previous track record of successfully delivering Health and Social Care training. There will be a flexible training grant to support individuals to address other training needs and barriers. Individuals will be supported with job searches and employers supported to recruit via Recruitment Incentives

3.6 **Flexible Response.** The project has and will support a move away from task and time activities by providing a more flexible approach that supports relationships and wellbeing of service users and care staff.

CONCLUSION

Social care does not stand alone and impacts across many areas of our communities, improvement plans and developments. ***(appendix 1)*** Great inroads into effective collaborative working across all stakeholders for the benefit of people using services have been made but employing people remains difficult. As a partnership we need to further challenge the way people think about social care and the value placed upon the social care workforce within our own services and outwith. If we can support the workforce to thrive and have partners and stakeholders working together then the ultimate goal of providing quality person centred care for service users will be achieved. The HSCP will continue working with partners to develop and design a flexible, responsive, human rights, outcome-based approach to supporting people at home. The work of the team is ongoing, and activity will be absorbed within business as usual with all relevant officers and teams contributing as required.

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NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	**Yes / None**
HSCP Strategic Commissioning Plan	**Yes**
Transformation Programme	**None**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Assessments	
Equality Impact Assessment	**Yes**
Risk	**Yes**
Other assessments (enter here from para 3.3)	
Consultation	
External	**Yes**
Internal	**Yes**
Legal & Governance	
Legal	**No**
Clinical/Care/Professional Governance	**Yes**
Corporate Governance	**Yes**
Directions	**No**
Communication	
Communications Plan	**Yes**

1. Strategic Implications

1.1 Strategic Commissioning Plan

This report is relevant to the HSCP key strategic objective 2: *Early Intervention and Prevention.* Phase 2 is relevant to objective 1: *Working Together with Our Communities*. The intention to use the principles of co-production is relevant to strategic objective 3: *Person-Centred Health, Care and Support* and strategic objective 5: *Making the Best Use of People, Facilities and Resources.* It is intended that strategic objective 4: *Reducing Inequalities and Unequal Health Outcomes and Promoting Healthy Living* will be advanced by ensuring service provision is equitable across all locality areas in Perth and Kinross.

2. Resource Implications

2.1 Financial

The Chief Finance Officer has been consulted and has indicated agreement with the proposals. The total yearly costs of the Wellbeing Team amounts to £848,005.

2.2 Workforce

A values-based recruitment plan has been drafted and agreed by Perth and Kinross Council Human Resources Manager.

3. Assessments

3.1 Equality Impact Assessment

Proposals have been considered under the Corporate Equalities Impact Assessment process (EqIA) with the following outcome:

Assessed as **relevant** and the following positive outcomes expected following implementation:

- The proposal to work with Live Active leisure and the Falls Service manager will promote physical activity, recreational and leisure activities.
- Working with community stakeholders we will support people interested in becoming self-employed carers and/or personal assistants, including expansion of training opportunities in rural Perthshire.
- The proposals will promote human rights, wellbeing, independent living and equity.
- The proposals include measures to increase and improve access for people from minority ethnic groups.
- We will use our combined health and social care resources efficiently, economically and effectively to improve health and wellbeing outcomes for the people of Perth and Kinross. Our model will be creatively designed using the principles of co-production. Service provision will be equitable across all locality areas in Perth and Kinross ensuring people's wellbeing.
- Employment opportunities and careers in care will be promoted along with career pathways in Reablement and care at home.
- Social inclusion will be promoted through the process of co-production.
- Perth and Kinross residents will be enabled to stay safely in their own homes for longer.
- Working alongside the Developing the Young workforce team to create a presence in schools, giving young people information on how they can get into careers in care and the positive aspects of care roles.
- Technology enabled care (TEC) options will be promoted enabling more people to have the choice to remain independent within their own homes for longer.
- Staff travel will be reduced through community employment opportunities; people working in the areas they live in.

3.2 Risk

A full risk register has been prepared for these proposals.

3.3 Other assessments

Performance

A whole-system cause-and-effect analysis has illustrated the complex interdependency of variables affecting our ability to sustainably provide for people's needs at home. While some aspects of this system can be directly or indirectly influenced, many causal variables are beyond our scope of control.

As such our evaluation measurements will predominantly focus on process measures that can be directly attributed to the project redesign objectives and user experience.

Benefits

4. Consultation – Patient/Service User first priority

4.1 External

- Clients/Unpaid Carers/Families
- Members of the public
- Private Care Providers
- Education Establishments e.g., schools, colleges, universities
- Community Groups
- Care and Wellbeing Community Interest Company
- Support Choices
- Ward based professionals

4.2 Internal

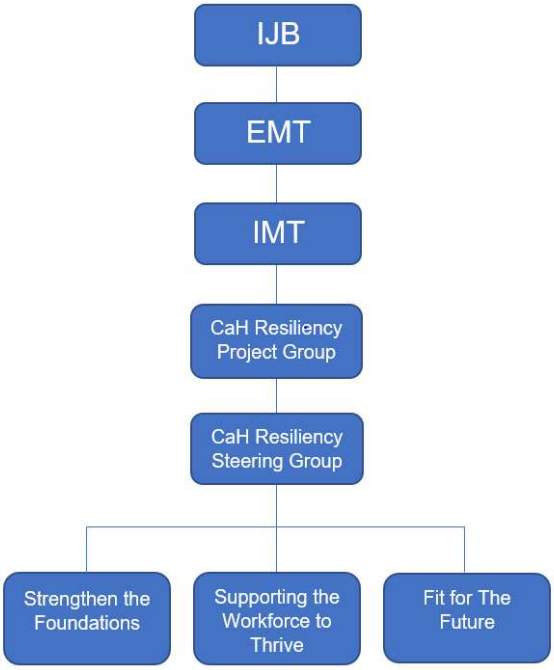
- HSCP social care staff
- Executive management team (EMT)
- Integrated management team (IMT)
- PKC HR
- HSCP Finance
- PKC Skills and Employment Initiatives
- PKC Learning and Development

4.3 Impact of Recommendation

The impact of this recommendation on service users, carers and the third sector will be to support people to live well, to have more purpose, have control over the support they get, and feel like they are part of their community. Keeping people active at home and in their communities is key to living independently for as long as possible.

5. Legal and Governance

Governance Structure



6. Directions

Not applicable.

7. Communication

7.1 A Communication and Engagement plan has been completed and is available upon request.

8. Background Papers/References

Not applicable

9. Appendices

Appendix 1 – Objectives/Process/Outcomes