south ayrshire
health & social care
partnership

Meeting of South Ayrshire Health and Social Care Partnership	Integration Joint Board
Held on:	3rd April 2024
Agenda Item:	10
Title:	Racecourse Road Intermediate Care Unit - Progress Report

Summary:

The purpose of this report is to provide an update on the impact the intermediate care unit has had on flow, delayed discharges and care at home capacity since opening in December 2022 and to provide some high-level data.

Author:	Helen Brown, Service Manager (Maintenance Care) Registered Services

Recommendations:

It is recommended that the Integration Joint Board note the positive contribution the intermediate care unit has made.

Route to meeting:

Directions:		Implications:	
1. No Directions Required	☐	Financial	☐
2. Directions to NHS Ayrshire & Arran	☐	HR	☐
3. Directions to South Ayrshire Council	☐	Legal	☐
4. Directions to both SAC & NHS	☐	Equalities	☐
		Sustainability	☐
		Policy	☐
		ICT	☐

RACECOURSE ROAD INTERMENTDIATE CARE UNIT – PROGRESS REORT

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide an update on the impact the intermediate care unit has had on flow, delayed discharges and care at home capacity since opening in December 2022 and to provide some high-level data.

2. RECOMMENDATION

2.1 It is recommended that the Integration Joint Board note the positive contribution the intermediate care unit has made.

3. BACKGROUND INFORMATION

3.1 2022, post pandemic recovery, saw a significant increase in demand for social care services, and a reduction in capacity to supply them. Delayed discharges in South Ayrshire reached its peak of 176 delays in December 22, due in part to the collapse of 2 private home care companies, and challenges with recruitment.

3.2 In 2022, South Ayrshire Council care at home service only successfully recruited 60 staff, giving a net gain of 28 posts. (in contrast 2023 saw a net increase of 110).

3.3 The negative impact of remaining in hospital after being assessed as medically fit is well documented and affects all areas of a person's life. It was clear therefore that the partnership needed to do things differently to support people out of hospital in a timely manner. A significant contributor to hospital delays was lack of capacity in home care, with reablement services being unable to pass patients on after their targeted 6-week period.

3.4 South Lodge residential unit had long been seen as "not fit for purpose" and had previously reduced its complement of occupied beds, leaving the top floor empty. The model of residential care is becoming less of a requirement as people generally stay at home for longer accessing support within their homes. This provided an opportunity to utilise the space in South Lodge for the introduction of "Intermediate Care".

3.5 "Intermediate care" provides *rehabilitation, support and care for individuals who have been in hospital and require additional support before they can return home.* The model offers short term, intensive support to individuals to regain their independence, confidence and decision making through a philosophy of reablement.

RRICU was set up to provide care for 10 people from hospital with a further 2 community beds. Occupational Therapy assistants carry out full assessments and goal setting - with care staff supporting the patients with their activities of daily living. The goal setting focusses on care at home tasks and regaining confidence to return home. Discharge is planned on admission with weekly assessments of progress taking place with a maximum stay of 6 weeks as a planned objective.

3.6 The unit offers individual bedrooms, with TVs, shared bathroom facilities, a fully equipped kitchen and laundry room. Service users can practice the skills they will need in their own homes for example, loading the dishwasher or washing dishes at the sink. Equipment such as perch stools are used for support. Microwave meals are provided as well as the opportunity to prepare other dishes. Staff will support the individual to

order shopping online for their return home, as well as exploring the use of other technology enabled care solutions to provide support once back home.

3.7 Referrals are received from Ayr hospital, home first practitioners, for people who are currently coded as 25d - a delay attributable to care at home. Working closely with the reablement team, staff in RRICU visit the hospital a minimum of twice weekly to carry out assessments. Patients must have reablement potential for consideration for a place within the unit and have been assessed as requiring a care package for support at home.

3.8 The unit is supported medically by Barns Medical Centre, who tendered for an enhanced GP service to support the additional 12 beds, with the ICT team providing physio support as part of any required rehab. Barns GP practice offer pharmacy and ANP support - their experiences have been captured in this report.

4. REPORT

4.1 At the time of the initial evaluation, (August 23) the following data was available:

- In total 140 referrals had been received with 77 patients being admitted. * by March 24 129 patients had been admitted

- 66 patients had been discharged home, with 57 returning home with no POC (86.4%)
- A further 3 patients were discharged with a reduction in their care package (3.9%)
- 6 patients (7.9%) were discharged with the same level of care as assessed on discharge from hospital.
- The average length of stay between December 22 and August 23 was 25 days.

4.2 The initial project aim was to reduce the demand on care at home services by reducing POC required on discharge from the unit by 50%. In actual fact, 90.1% of people coming through the unit went home with a reduction in care.
This therefore had an impact on care at home demand saving 117hours per day.

4.3 It is also important to understand the longer-term implications for people leaving the intermediate care unit to ensure that the reductions in care packages were sustainable. An initial search identified that as of 31st December 67 patients had remained out of hospital and 10 had been readmitted at some point after returning home and had again become a delayed discharge.

4.4 The initial evaluation highlighted learning and drew the following conclusions:

- During the first 8 months Racecourse Road intermediate care unit had fully re-abled 86% of its service users. In addition, service users reported an increase in their confidence levels.
- This equated to a saving of 25,500 hours of care at home service across a year and a saving of 1952 acute hospital bed days.
- There were 3 service users for whom there was a delay in receiving a care package, but a pathway has been developed for their prioritisation.
- The 2 step up beds were not utilised as intended and so it has been agreed to increase the number of step-down beds to 12 on the top floor.
- Success has been due to having the right people in the right place - namely management and staff who had a good understanding of the reablement ethos,

the aims of the service and were able to adhere to clear criteria. This was critical to the success of the unit.

4.5 Permanent funding has now been secured to ensure that the impact on the system remains positive.

5. STRATEGIC CONTEXT

5.1 Summarise in this section how the report contents will further the IJB's current Strategic Plan Objectives.

6. IMPLICATIONS

6.1 Financial Implications
6.1.1 There are no financial implications

6.2 Human Resource Implications
6.2.1 There are no human resource implications

6.3 Legal Implications
6.3.1 There are no legal implications

6.4 Equalities implications
6.4.1 There are no equality implications

6.5 Sustainability implications
6.5.1 There are no sustainability implications

6.6 Clinical/professional assessment
6.6.1 There are no issues requiring professional advice in this report.

7. CONSULTATION AND PARTNERSHIP WORKING

Consultation and partnership working is not required in generating this report.

8. RISK ASSESSMENT

8.1 Use this section to provide the IJB or the Committee/Group with your assessment of the risk to the IJB/Committee/Group arising from the content and recommendations of the report. These should include reputational, political and community considerations.

8.2 If you believe there are no risks state this here. If you believe there may well be risks summarise them here. They could, for example be financial, reputational, patient or service user risks, partner organisation risks, professional risks, legal risks, health and safety risks, personnel related risk, etc.

8.3 In terms of the IJB Risk Management Strategy would you categorise the level or risk as high, medium or low?

REPORT AUTHOR AND PERSON TO CONTACT

Name: Helen Brown
Phone number: 07467 330954

Email address: helen.brown@south-ayrshire.gov.uk

BACKGROUND PAPERS

N/A

20th March 2024.