south ayrshire
health & social care
partnership

Meeting of South Ayrshire Health and Social Care Partnership **Held on:**	**Integration Joint Board** **15th June 2022**
Agenda Item:	**13**
Title:	**Reablement Unmet Need Assessment Team (RUN-AT)**

Summary:

The purpose of this report is to request funding and agreement to recruit four Occupational Therapy Assistants (OTA) to focus initially on current unmet need (community waiting list) with a view to progressing to early intervention and prevention for those assessed as requiring care.

Author:	**Eddie Gilmartin**

Recommendations:

It is recommended that the Integration Joint Board

i. **Agree to the funding and recruitment of four Occupational Therapy Assistants (OTA) to focus initially on current unmet need (community waiting list) with a view to progressing to early intervention and prevention for those assessed as requiring care.**

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	☐

Reablement Unmet Need Assessment Team

1. PURPOSE OF REPORT

1.1 The purpose of this report is to request funding and agreement to recruit four permanent Occupational Therapy Assistants (OTA) to focus initially on current unmet need (community waiting list) with a view to progressing to early intervention and prevention for those assessed as requiring care or prior to formal care being required.

2. RECOMMENDATION

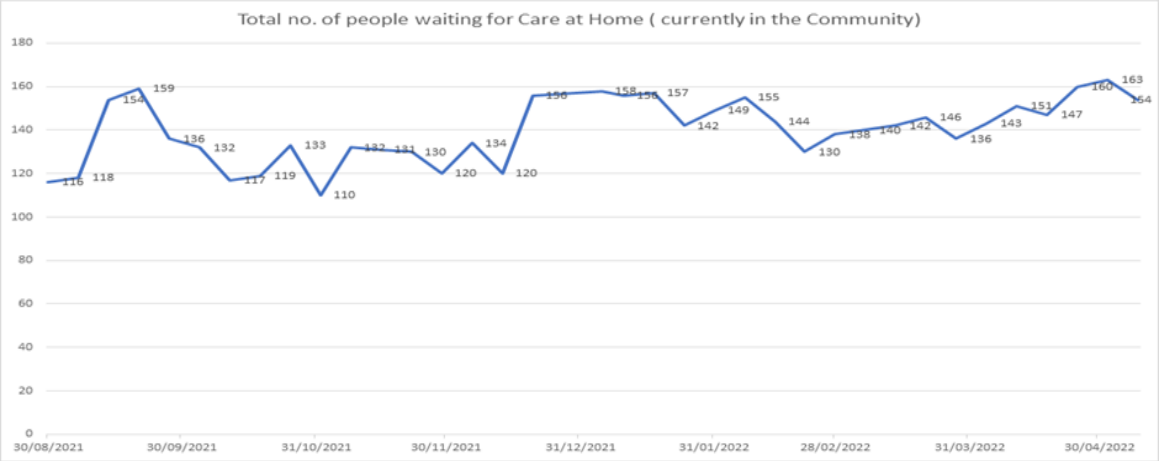
2.1 It is recommended that the Integration Joint Board

(i) Agree to the funding and recruitment of four Occupational Therapy Assistants (OTA) to focus initially on current unmet need (community waiting list) with a view to progressing to early intervention and prevention for those assessed as requiring care.

3. BACKGROUND INFORMATION

3.1 The recent 2022 Audit Scotland Social Care report described the significant challenges facing the sustainability and integration of social care due to the slow pace of change as well as demographic changes and increasing demand for services (1). An element of this relates to the limited move towards the delivery of early intervention and prevention approaches which has led to increasing numbers of people falling into crisis and subsequently requiring; admission to hospital with subsequent long waits for discharge, increasing care needs or waiting in the community for already scarce resource to become available to provide care.

3.2 Currently (20/05/22) in South Ayrshire there are 159 residents who have been assessed as requiring care in the community (CAH) for a total of 1356 hours of care (these are only those who meet ‘critical’ criteria for needs assessment). There are also 127 residents awaiting Social Work assessment for care and another 62 people waiting in hospital for a package of Care (POC) who have been assessed for a total of 862 hours of care.



3.3 Capacity to provide care in the community has been compromised for an extended period in South Ayrshire and the onset of Covid-19 has exacerbated the situation further. Increasing frailty and consequences of sarcopenia (muscle wasting), self-isolation, lockdown and lack of access to health providers has further impacted on people, leading to high numbers of people becoming deconditioned, socially isolated or an existing condition being exacerbated. A service review of the Care at Home service which included Care at Home, Reablement and Telecare, highlighted the need for a more efficient and effective Reablement pathway with a structure to support and address these issues but objectives have again been hampered by the impact of Covid.

3.4 People receiving Homecare from the community at this time remains limited to those requiring palliative/End of Life care or emergency input.

4. REPORT

4.1 Over the last few years, ensuring timely discharges from Hospitals across Ayrshire has been challenging, particularly during the winter period. This is in part due to a lack of capacity in community services, both Care Homes and Care at Home, the increasing demand on these services and limited joint working to streamline discharge referral pathways. Currently, these processes are cumbersome and can be the cause of increased delays in assessment and delayed discharges to the next stage of a person's journey. Issues related to these processes are currently being addressed by the National Discharge without Delay (DWD) programme through a pan-Ayrshire approach.

4.2 The Reablement Service, CAH Maintenance care and the Private care providers are already working to near maximum capacity trying to cope with the increasing demands from both the community and the acute hospitals. There is also a requirement for 'internal CAH' services to step in and support private providers struggling to cover POC due to their own retention and recruitment issues.

4.3 Demand continues to rise particularly quickly for health and care services due to an ageing population, an increase in the number of people with multiple co-morbidities and rising life expectancy for people with physical and learning

disabilities. On the back of this we have people living with the consequences of long Covid and self-isolation over the last two years leading to increasing frailty and deconditioning or they may have been awaiting elective surgery (4).

4.4 'In adult social care, the service facing the most pressure, any government would have to spend nearly £1 billion more just to keep pace with demand' (CIPFA Performance Tracker 2019)

4.5 2015-2020 the older people population of the UK increased:
- >65 years by 12% (1.1 million)
- >85 years by 18% (300,000)
- >100 years by 40% (7,000) (2)

Context: UK National trends
- 2018-19, non-elective admissions for all ages increased by 18.6%
- 2018-19 average of 13,058 people were admitted via ED each day
- Up 24.2% over 5 years = extra 2,548 emergency admissions daily

4.6 <u>Proposed Team Remit</u>

The following proposal would facilitate early identification, provision of proactive support and access to prevention and reablement services to remove, minimise or delay individuals' and carers' need for care and support. Early intervention can delay or prevent needs from increasing, prevent hospital admission and reduce the current unmet need waiting list in the community

- The team would focus initially on those people who are currently assessed as requiring care. Assessment of alternatives to formal care would be explored with the person and family/carer with a view to supporting them while waiting for care if this is required

- The team would be encouraged to think beyond adult social care services, and consider the wider range of community options including telecare, to promote people's control over their lives

- The team would provide high quality information, advice, and signposting to third sector and community support, empower individuals and carers to make the right choices

- The team will work with and across Primary Care and community services to reduce overlap of service provision and promote access to the right service at the right time

- Assessment of long-term care needs could be provided as per the National aim of people being assessed in their own home or a homely environment

- People who are and have been awaiting surgical interventions could be provided with pre-habilitation to try and ensure a shorter stay in hospital post-surgery

- People who have palliative care needs could be assessed for reablement input or equipment to enhance their quality of life

- Develop opportunities for joint assessment with NHS, Social Work and housing partners. Most people receiving a full assessment of eligibility will have complex health as well as care needs, and many experience multiple physical and mental health conditions

- The team could conduct assessment or reviews of those people with care in place but are deemed to require an increase in their POC

- Potential for team to support recovery of people living with Long-Covid. One report from the Office for National Statistics states: " an estimated 151,000 Scots reporting symptoms of Long Covid"

4.7 Recommendation

4.7.1. Using funding in General Fund Reserves, employ four Occupational Therapy Assistants (OTA) to focus initially on current unmet need (community waiting list) with a view to progressing to early intervention and prevention for those assessed as requiring care. The plan would be for these posts to be permanent with a view to establishing the benefits and build them into our workforce planning model moving forward. Due to the difficulty recruiting Homecarers in the current climate (21 vacancies in Reablement), it is expected that future funding would be available on an ongoing basis.

Annual Costs:

		ToS			Combined		Total	Weekly	Weekly	Annual
Post Title	Grade	SCP	Hrly Rate	Allow	Hrly rate	On Costs	Hrly Cost	Hours	Cost	Cost
Occupational Therapy Assistant	Level 7	53	£15,88	0%	£15.88	£4.76	£20.64	35	£722.40	£37,655.94
Occupational Therapy Assistant	Level 7	53	£15,88	0%	£15.88	£4.76	£20.64	35	£722.40	£37,655.94
Occupational Therapy Assistant	Level 7	53	£15,88	0%	£15.88	£4.76	£20.64	35	£722.40	£37,655.94
Occupational Therapy Assistant	Level 7	53	£15,88	0%	£15.88	£4.76	£20.64	35	£722.40	£37,655.94
Total										£ 150,623.76

5 STRATEGIC CONTEXT

5.1 SA Integration Joint Board Strategic Plan - The planning period ahead will see a continuing drive for transformational change in services and in the way that support is provided, with greater emphasis on care at home and support in the community, rather than within a hospital setting based on the Scottish Government's 2020 Vision for Healthcare in Scotland

5.2 Public Bodies (Joint Working) (Scotland) Act 2014 - The Public Bodies (Joint Working) Act 2014 sets out the legislative framework for integrating health and social care. It creates a number of new public organisations, known as

integration authorities and aims to break down the barriers to joint working between NHS boards and local authorities.

5.3 Caring for Ayrshire – The Caring for Ayrshire Transformational Change Programme is led by Ayrshire and Arran NHS Board and the three Ayrshire Integration Joint Boards. This programme of work will see dramatic change and improvements over the next few years in the way health and care services are delivered across Ayrshire.

6 IMPLICATIONS

6.1 Financial Implications

6.1.1 The financial cost of the proposal will be met from the General Reserves fund.

6.2 Human Resource Implications

6.2.1 There are no Human Resources issues arising from this report.

6.3 Legal Implications

6.3.1 There are no legal issues arising from this report.

6.4 Equalities implications

6.4.1 There are no equality implications arising from this report.

6.5 Sustainability implications

6.5.1 There are no environmental sustainability implications arising from the contents and recommendations of the report.

6.6 Clinical/professional assessment

6.6.1 It is clear that there are an increasing number of people in South Ayrshire who are currently unable to access Homecare after being assessed and identified as meeting the Critical criteria for social care provision. The needs assessments are carried out by Social Work colleagues, and it has been recognised during the Assessment and Review Team work in 2021/22 that there is a requirement for a 'Functional' element of the assessment to deliver a more holistic, people-centred approach to determine the physical and support needs of individuals.

7 CONSULTATION AND PARTNERSHIP WORKING

7.1 Discussions have taken place with HSCP, Primary Care and Community colleagues in relation to the proposed team and the avoidance of duplication of work. The recent recruitment of OT and OTAs into Primary Care related to Frailty will focus on identifying those people who score in the mild to moderate range of the Frailty index whereas the proposed team will be assessing those who currently have been assessed for care and may have more complex needs which can potentially be addressed without the need for a formal care service.

8 RISK ASSESSMENT

8.1 The risks associated with Unmet Need in the community relate to:

- Increased risk of people's health deteriorating

- Increased risk of requiring admission to hospital
- Increased risk of requiring medical input from Primary Care and HSCP providers
- Risk of care needs increasing, requiring more formal care over time and leading to irreversible changes in Quality of Life
- Increased pressure on carers and families
- Increased risk to reputation of HSCP and Council as people's needs remain unmet
- Increasing pressure on Homecare services and staff leading to difficulty retaining and recruiting staff

REPORT AUTHOR AND PERSON TO CONTACT

Name: Eddie Gilmartin
Phone number: 07833095237
Email address: Eddie.Gilmartin@aapct.scot.nhs.uk

BACKGROUND PAPERS
Assessment and Review Team Final Report


ART Completion report Final.docx


Completion Report Appendix 1 (1).docx

References

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4. Silver J.K. Prehabilitation May Help Mitigate an Increase in COVID-19 Peripandemic Surgical Morbidity and Mortality. Am. J. Phys. Med. Rehabil. 2020;99:459–463. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7253050/

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