NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board
14th March 2024

Subject:	**Unscheduled Care Update & North Ayrshire Improvement Plans**
Purpose:	To update the IJB on performance in relation to Unscheduled Care in Ayrshire and Arran, highlighting areas of risk and to detail an update on the progress of winter plans and actions being progressed to reduce delays and unmet need within the North Ayrshire Health and Social Care Partnership's Community Care Services.
Recommendation:	The IJB are asked to note the ongoing programme of work in relation to Unscheduled Care, recent performance information and the progress of the specific actions being taken in North Ayrshire.

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	√
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

Glossary of Terms	
IJB	Integration Joint Board
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
LOS	Length of Stay
ED	Emergency Department
CAU	Combined Assessment Unit
UHC	University Hospital Crosshouse
UHA	University Hospital Ayr
MHO	Mental Health Officer
FNC	Flow Navigation Centre
EICT	Enhanced Intermediate Care Team
SAS	Scottish Ambulance Service
OPG	Office of the Public Guardian
CFSD	Centre for Sustainable Delivery

1.	**EXECUTIVE SUMMARY**
1.1	The Integration Joint Boards have delegated responsibility for elements of Urgent and Unscheduled Care activity in large hospitals. A previous report was presented to the IJB in June 2022 setting out those arrangements, the programme of work in place to improve performance at that time and the areas where focused action was required to improve services for the people of Ayrshire and Arran. An update was provided to IJB in October 2023 which set out the position at that time and this report provides a further update in relation to Unscheduled care to ensure that the Integration Joint Board are aware of the current situation, challenges, risks and potential impact.
2.	**BACKGROUND**
2.1	A programme of improvement work has continued relating to Unscheduled Care performance across Ayrshire and Arran. The previous reports(s) described the Scottish Government's approach to reshaping Unscheduled Care Services via the Urgent and Unscheduled Care Collaborative in Scotland and the approach taken in Ayrshire and Arran regarding this.
2.2	In November 2023 an Urgent and Unscheduled Care Programme Board, co-chaired by the NHS AA Deputy Nurse Director and the Deputy Medical Director, was established. The Board has responsibility for oversight of the revised Urgent and Unscheduled Care Improvement Plan. The Plan is based on a 30/60/90 day improvement methodology and has specific workstreams with identified leads for each workstream area. Highlight reports detailing performance and progress against planned improvement work are presented weekly to the Programme Board and submitted on a fortnightly basis to the Scottish Government. The key trajectories and improvements associated with the plan include the following: • At least 95% of patients will wait less than 4 hours from arrival at the Emergency Department to treatment, admission, or discharge (unscheduled attendances only). • At least 95% of all flow 1 (minor injury) attendances at Emergency Departments will be discharged within 4 hours of arrival. • No patient will wait for longer than 12 hours in the Emergency Department. • The median turnaround time for Scottish Ambulance Service vehicles at both acute hospitals will be in line with the national median time. A summary of the focus of workstreams from the Urgent and Unscheduled Care Plan are detailed below: **Workstream 1** – Reconfiguring Front Door Services – This workstream has a particular focus on alleviating congestion and increasing flow at the front door. This aims to maximise flow in the Combined Assessment Unit, with a number of actions to improve performance including implementing a comprehensive CAU bundle, establishing a next day bookable appointment system to mitigate overnight stays in CAU, creating specialised frailty units and adopting a Homefirst approach to support discharge. **Workstream 2** – Reducing Acute Length of Stay – This workstream has a particular focus on improving patient flow throughout the acute hospitals to provide more effective and streamlined transfers of care, with a number of actions to improve performance including the implementation of safe transfer care plans, implementation of discharge to assess processes, implementation of a CAU specialty pull model, optimisation of Homefirst and the use of the Discharge Lounge. **Workstream 3** – Providing Front Door Alternatives – This workstream has a particular focus on providing alternatives to front door attendance, with a number of actions to improve overall performance including maintaining and growing Flow Navigation Cantre pathways,

	minor injury scheduling, SAS Call Before Convey and Direct Care Home referrals to the Ayrshire Urgent Care Service.
2.3	**North Ayrshire - Winter Preparedness and Delayed Discharge Improvement Plan**
	The Partnership's Health and Community Care teams, alongside Mental Health colleagues, commenced the development of a local winter preparedness and delayed discharge improvement plan in response to service performance levels and community unmet need in late 2023. This was in anticipation of seasonal demands to ensure resilience across the health and care system in North Ayrshire. This was anticipated to be a short-term plan however has developed to become a longer-term improvement plan and is being developed alongside the service's Transformation Plan. The Plan continues to focus on enhancing Care at Home Capacity, Discharge to Assess and Adults with Incapacity. A project delivery group has been developed, which meets on a fortnightly basis to review progress of actions and performance within each of the workstream areas. Further detail of the plan and performance is detailed in Appendix 1 of this report.
2.4	**Winter Preparedness and Whole System Self-Assessment**
	Winter Preparedness Checklist In September 2023, ahead of the Scottish Government's Winter Plan, Health Boards and Health and Social Care Partnerships were asked to work in collaboration as a whole system to complete a Winter Preparedness Checklist to provide an overview of Ayrshire and Arran's state of readiness for Winter. Winter resilience priorities promote the strengthening of whole system planning to ensure there is resilience across key areas for supporting seasonal increases in demand. **Whole System Discharge Planning Self-Assessment** In addition to the Winter Checklist, Health Boards and Health and Social Care Partnerships have also been asked to submit a quarterly Whole System Discharge Planning Self-Assessment Tool. The Self-Assessment is designed to provide assurances to Scottish ministers that the Delayed Discharge and Hospital Occupancy Action Plan is being enacted as part of preparations for winter and the recent Whole System submission was for Quarter 3. The HSCP await formal feedback on the Q2 return.
3	**ASSESSMENT**
3.1	**Unscheduled Care Performance**
	The information below provides an overview of some of the performance in areas highlighted as a priority and puts into context over time the Unscheduled Care Performance in Ayrshire and Arran. This information is now also accompanied by the Discovery Debrief on the National Unscheduled Care Programme from the Centre for Sustainable Delivery (CFSD). The CFSD have produced a report setting out the baseline and benchmarking references for NHS AA against other Boards across a key set of indicators. The report also sets out the areas where there is variation and areas of focus for improvement. **<u>Emergency Department Attendances:</u>** Since November 2020 Ayrshire and Arran has been implementing The Redesign of Urgent Care Programme. This looks to build on opportunities to support the public to access the Right Care in the Right Place at the Right Time. This Programme has been delivering service

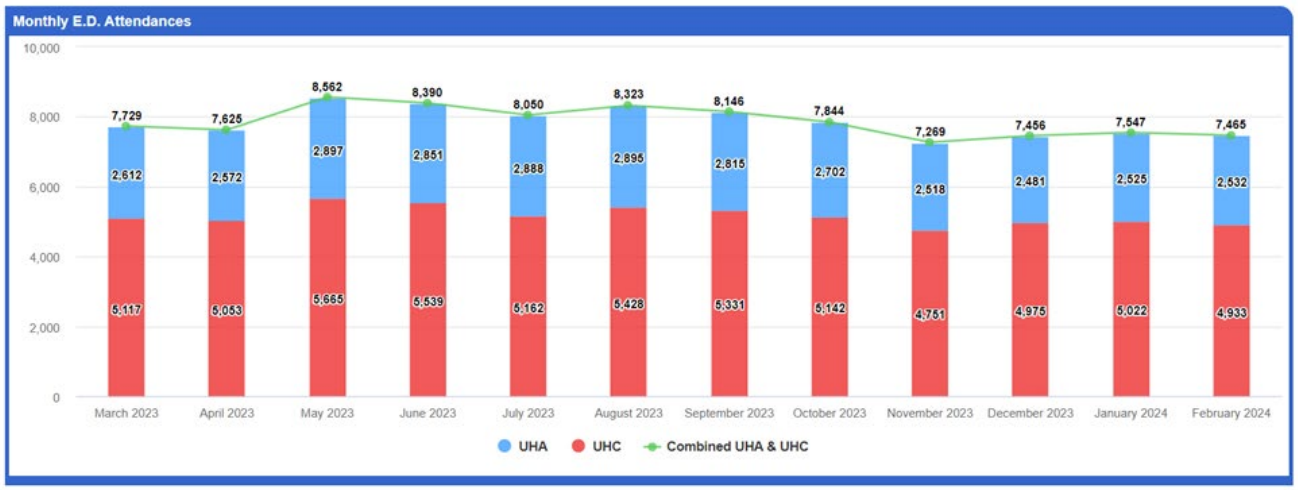
redesign within Ayrshire and Arran since that time with the implementation of a Flow Navigation Centre which acts as the hub and single point of access for calls originating through the NHS24 111 telephone line. The intent of the Flow Navigation Centre was that each ED would see a reduction in self-presentations due to the ability to triage at NHS24, a clinical assessment at the FNC, and the opportunity to schedule patients to attend either ED or MIU. Performance of services prehospital has been maintained above the baseline level with less than 15% of Ayrshire and Urgent Care Services demand requiring unscheduled care. In December 2023, there were 11,574 patients who accessed care via Ayrshire Urgent Care Service (AUCS). 90% of these patients received alternative care in the community as an alternative to front door attendance. This exceeded the local target of 85%.

The Call Before Convey Pathway in collaboration with the Scottish Ambulance Service (SAS) is well established with 331 referrals to AUCS in December 2023. Following a clinical assessment with a senior clinician within AUCS, 90% went on to receive their treatment in a community setting. In addition there is a Care Home Pathway, Emergency Services Mental Health Pathway and Rapid Respiratory Response service all of which are successfully providing alternatives to hospital attendance.

The overall level of ED attendances at both acute hospitals is currently lower than pre-pandemic levels, as a result of the work on re- directions of patients to more appropriate settings and the Flow Navigation Centre supported by senior clinical decision makers screening patients. Total attendances to the emergency department (ED) and to either of the two combined assessment units (CAU) are average for mainland Scotland per head of population but low when adjusted for the board's demography. This suggests that effective primary care and community-based 'care closer to home' demand management processes are in place and are successfully mitigating the impact of the board having a large elderly population which would otherwise be expected to be associated with higher levels of attendance.

The number of unscheduled ED attendances remain marginally lower than they were over the same period in 2022:

Number of Unscheduled ED Attendances	
Jan – Dec 2023	90,132
Jan – Dec 2022	90,820



ED 4 Hour Wait Target:

The 4 hour Emergency Department Access target is considered nationally as a clear barometer of safe and timely care, and whole system effectiveness. Performance information shows that the 4-Hour Wait compliance for unscheduled ED attendances had been on a continuous decreasing trend. It is recognised that to achieve this target is reliant on a whole system response including reducing variation in attendances, admissions, length of stay and discharges.

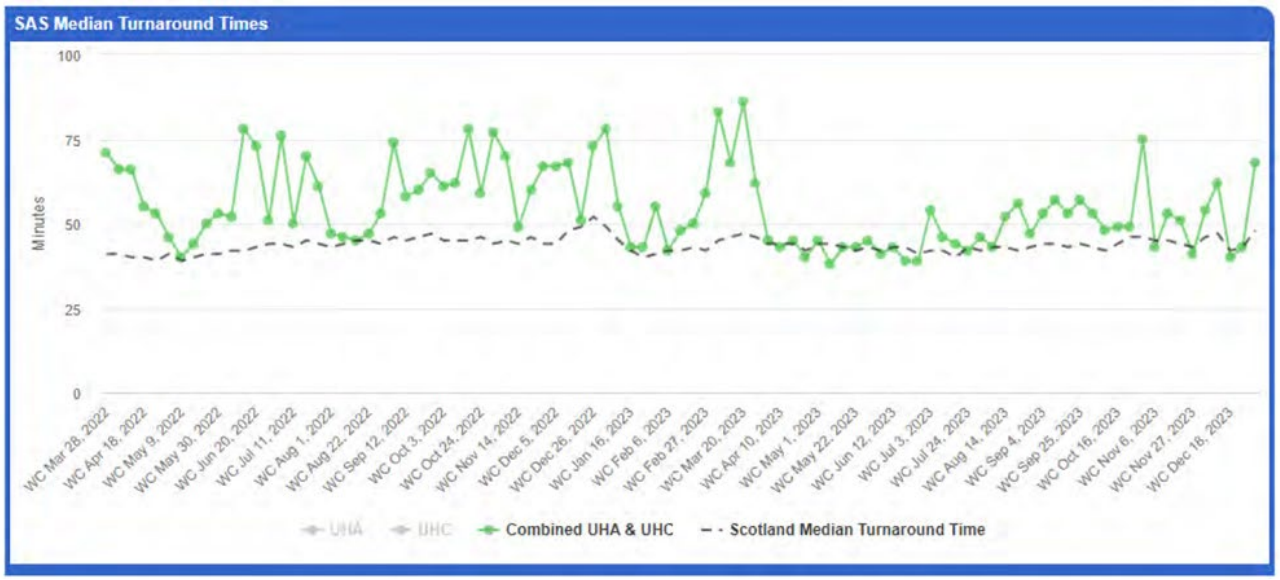
The below demonstrates AA performance against the 4 hour target against national benchmarking. Since falling to a low in December 2022, compliance against the ED 4-Hour standard continues on a sustained increase trend, however performance remains below the 95% national target. Compliance has consistently been higher at UHC than UHA.

National Benchmarking – 4 Hour ED Target (95%)

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
NHS A&A	65.7%	62.3%	62.8%	66.4%	64.7%	68.1%	69.5%	68.8%	68.1%	68.9%	67.7%	66.3%	67.5%
Scotland	64.0%	58.3%	65.2%	66.3%	64.5%	65.7%	67.2%	69.0%	69.6%	67.9%	66.5%	64.8%	63.5%

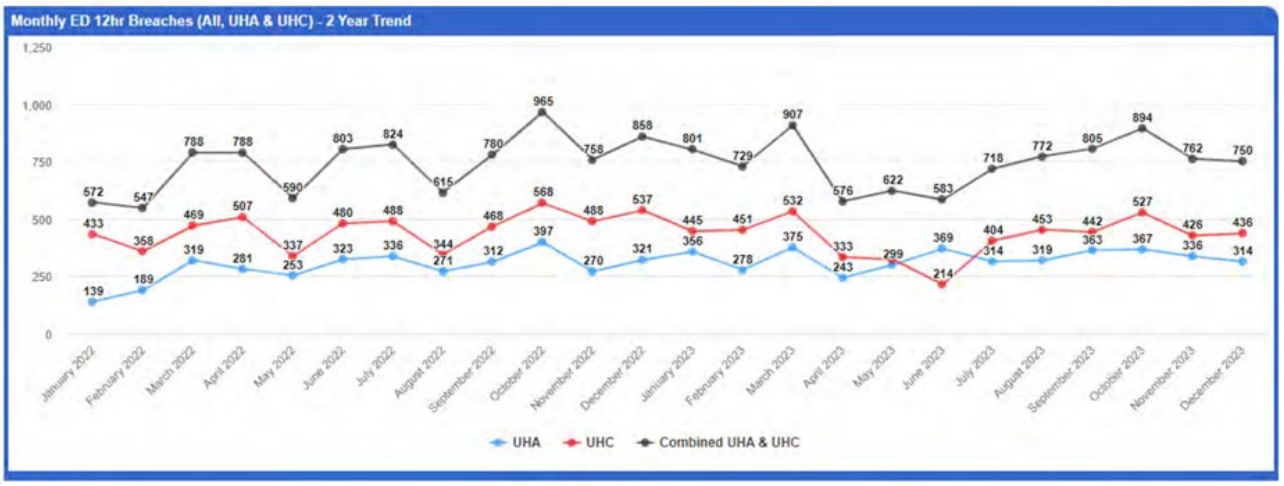
SAS Median Turnaround Times:

The turnaround time for SAS vehicles is a measure of the time between vehicle arrival and departure when conveying patients to acute hospital sites. The local target is for the overall median turnaround time to be in line with the Scottish median, and for much of the period between April and June 2023, this was achieved. Since July 2023, however, the median turnaround time has consistently exceeded the Scottish median, rising to 68 minutes for the week ending 7th January 2024, exceeding the 48 minutes nationally.



ED 12 Hour Breaches:

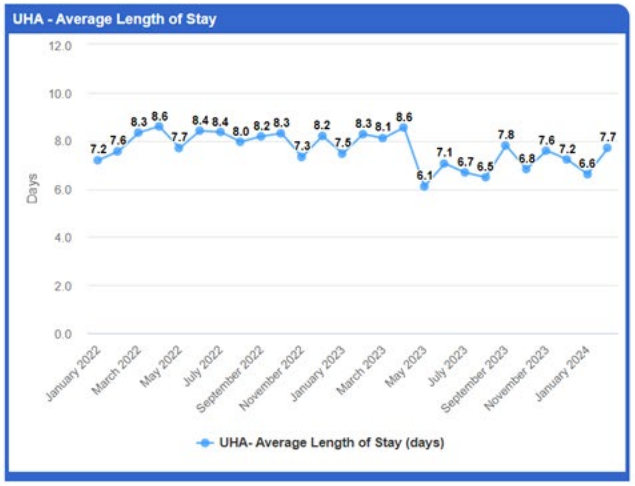
The combined number of Emergency Department 12 Hour breaches showed a positive reduction earlier last April 2023 however this was not been sustained, in December 2023 there were 436 ED 12 hour breaches at UHC and 314 at UHA.

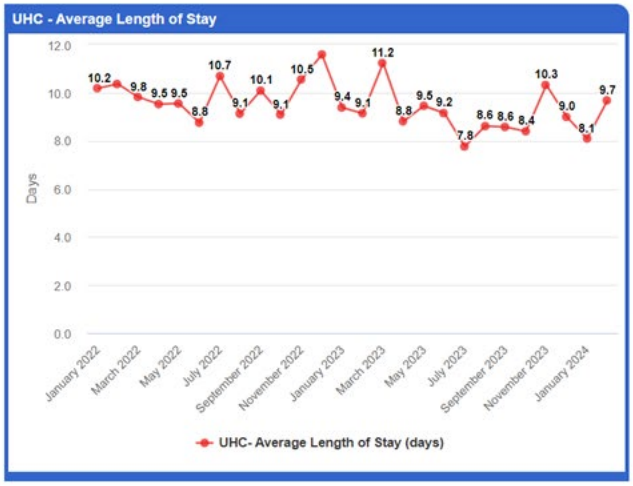


The NHS AA Annual Delivery Plan trajectory for 2023-24 was for no 12 hour breaches in ED by August 2023.

Average Length of Stay (LoS):

The average length of stay (in days) for non-delayed patients across wards at Ayr Hospital has reduced from 7.5 days in January 2023 to 6.6 days in January 2024, having reached a peak of 8.6 days in April 2023 during this period. At Crosshouse Hospital the average length of stay has reduced from 9.4 days in January 2023 to 8.1 days in January 2024, with a peak of 11.2 days experienced in March 2023. February data reports a LoS at UHA of 7.7 days and 9.7 days at XH.

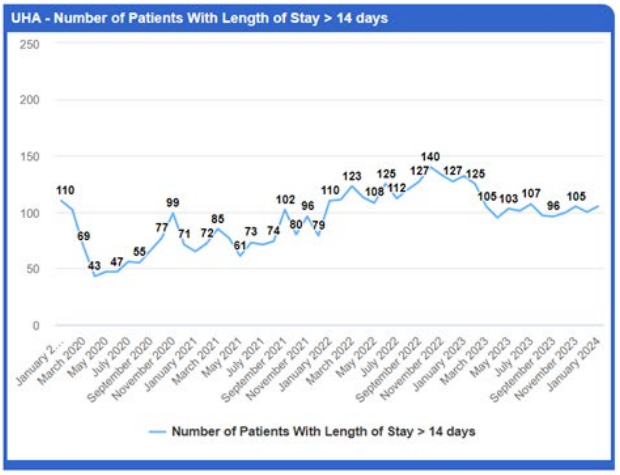


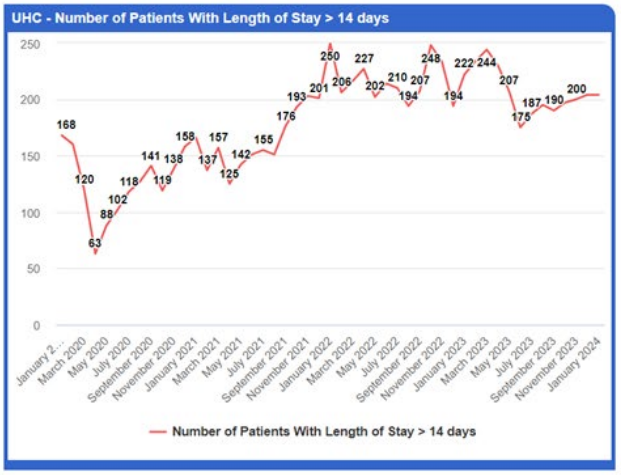


Any increase in the LoS is a significant area of concern having implications for patient care and outcomes, as there is evidence that longer lengths of stay result in higher needs of patients on discharge, with more patients requiring higher levels of care than would be anticipated on admission due to hospital acquired deconditioning.

The average LOS also masks the significant variation for patients some of which have very lengthy stays, in January 2024 there were 309 patients with a LoS over 14 days, in January 2023 there were 354 patients.

Below shows the number of patients for both sites with a LoS greater than 14 days:





The Discovery Debrief concludes that the most significant cause of NHS Ayrshire and Arran's full capacity issue is an exceptionally high number of long stay patients (i.e. those discharged after a length of stay greater than 14 days). In common with 9 out of 11 of mainland health boards, NHS Ayrshire and Arran has seen a significant increase in the number of long stay patients in hospital since 2019. The scale of this increase has been greater in NHS Ayrshire and Arran than in most other health boards and has significantly affected flow in the acute hospital sites.

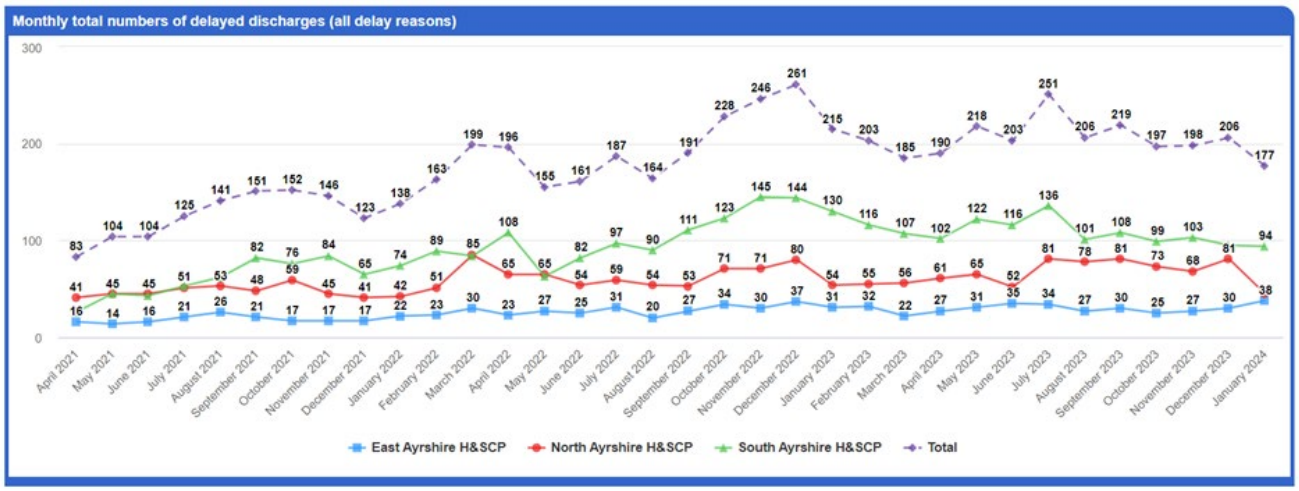
Further analysis provided from the exercise undertaken by SG colleagues into patients with LoS longer than 14 days, illustrated that in Crosshouse for all patients over 14 day stay 36% were a delay on discharge, and of those patients the greatest proportion of their duration of stay was before they became a delay with 68.9% of their bed stay LoS being before they were recorded as delays. Iindicating the maximum opportunity and gain in LoS improvement being the pre-delay/referral part of a stay or those long stay patients who do not need care to be discharged home.

NHS Ayrshire and Arran have a significant number of additional acute beds open in UHC and UHA hospitals. Length of stay is a significant driver of occupancy, previous modelling suggested that if the LoS in Ayrshire and Arran could be reduced in the two acute hospitals to the Scottish average that there would be a reduced bed requirement from the existing funded acute baseline. Delayed discharges and particularly AWI delays are high and do contribute towards this but the majority of the long-stay patient population are never recorded as a delay. Therefore, the greatest opportunity to release significant bed capacity is likely to be in reducing non-delayed long-stay patient numbers.

Delayed Transfers of Care:

Timely discharge from hospital is an important indicator of quality and is a marker for person-centred, effective, integrated and harm-free care. The term delayed discharge is used to describe a situation whereby a patient in hospital has been assessed as clinically ready for discharge from inpatient hospital care and continues to occupy a hospital bed beyond the date they are ready for discharge.

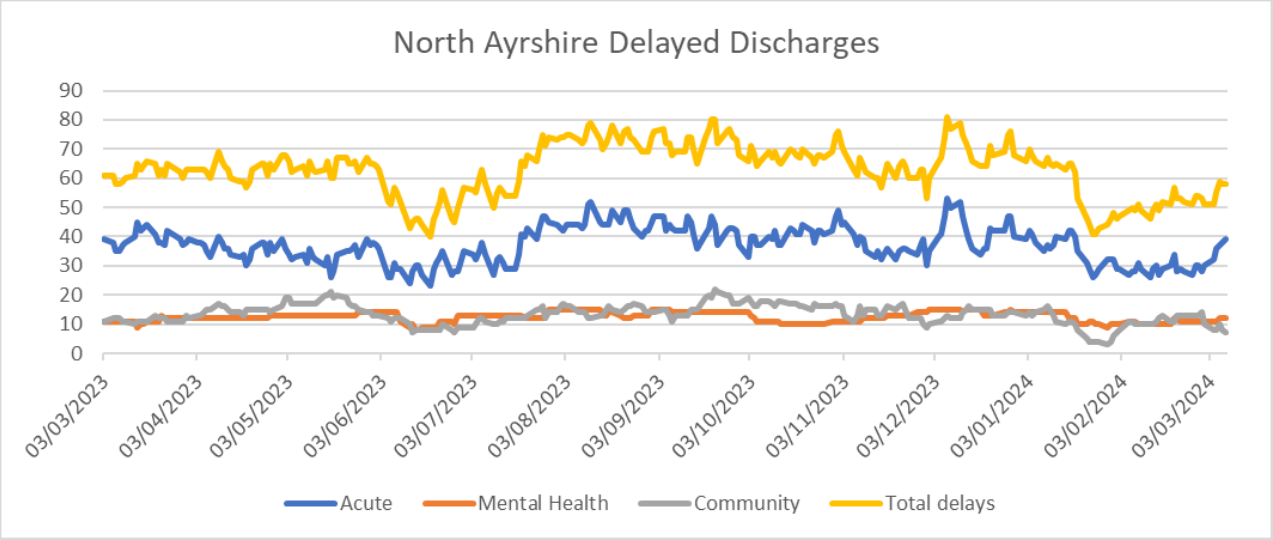
The graph below shows the number of delayed transfers of care for each HSCP, this data captures all delays across all NHS AA hospital sites including community and mental health settings. The total number of people delayed in their discharge from hospital has reduced from a peak of 251 in July 2023 to 177 at the end of January 2024.



It should be noted that not all delayed patients are cared for in the two acute hospitals and on average about 50% of delays are in acute sites. The delayed discharge position across Ayrshire and Arran continues to improve with a total of 158 delayed patients at 1st March 2024, of those there are 106 standard delays, as summarised below:

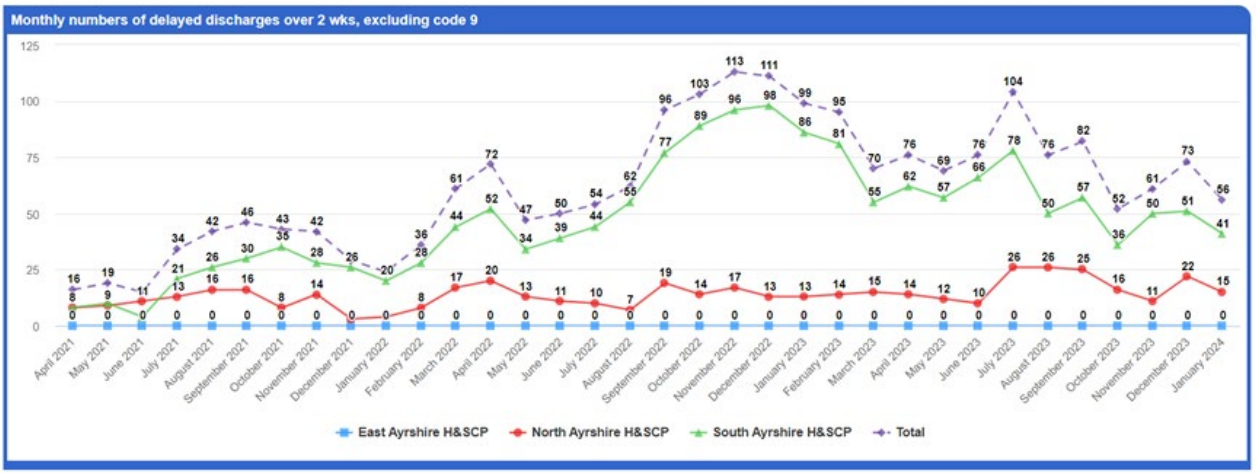
Partnership	Total delays			
	Acute	Mental Health	Community	TOTAL
SOUTH	33	3	28	**64**
EAST	28	8	10	**46**
NORTH	27	11	10	**48**
TOTAL	**88**	**22**	**48**	**158**

The table below illustrates in more detail the movement in delayed patients for North Ayrshire and their location over the last 12 months:



As at 8 March 2024 there were 58 delayed patients for North Ayrshire, 5 of which in GG&C hospitals, the NHA AA delays are split between 34 in NHS Acute hospitals, 7 in A&A Community Hospitals and 12 in Mental Health wards. Of the total 58 delays, 10 relate to patients where AWI legislation applies. For the 34 acute hospital delays, outwith AWI delays, there were only 7 patients delayed for more than 14 days. Outwith AWI delays, which do have an extended length of stay, the remaining delayed discharges are very fluid, change on a daily basis and represent a constantly changing patient co-hort.

The formal measure of performance for Delayed Discharges applies to the number of delays over two weeks, the table below shows the number of delays over two weeks at the end of month census date for each HSCP.



There are many factors which impact upon levels of delayed discharges within any Health and Social Care Partnership including capacity for onward care provision and Adults with Incapacity legislation. The process for supporting individuals to be discharged when their health and care needs have changed can be very complex. Limitations of community capacity in Care at Home, Care Homes and for complex care services remain the main challenge to further reducing delayed discharges, plans are impacted by staff absence, vacancies and ongoing fragility in the provider market.

Adults with Incapacity

Adults with Incapacity delays refer to hospital inpatients who are considered to be a delayed discharge due to the adult lacking capacity to make informed decisions regarding their future care and where a need has been identified for a proxy decision make to be formally appointed under the Adults with Incapacity (Scotland) Act 2000 (hereafter AWI Act). This allows for a nominated person to make some or all decisions on the adult's behalf and ensure that their best interests, views and the least restrictive options are considered. For many adults this results in the application of a Guardianship Order to safeguard their welfare and manage their financial or property affairs. Applying for a Guardianship Order under the AWI Act requires the involvement of several agencies ranging from social work staff, Mental Health Officer's (MHO), Independent Advocacy workers, Local Authority and private solicitors, Scottish Legal Aid Board, Scottish Courts and the Office of the Public Guardian. Unfortunately, there can be delays at any point in this process at these various stages and a number of challenges have been recognised nationally in progressing.

Delays linked to AWI across Ayrshire remain high, of the 158 delays at 1st March 2024 22% relate to AWI delays, people delayed for the longest time in terms of delays are usually associated with AWI processes therefore this has a significant impact on the individual people delayed.

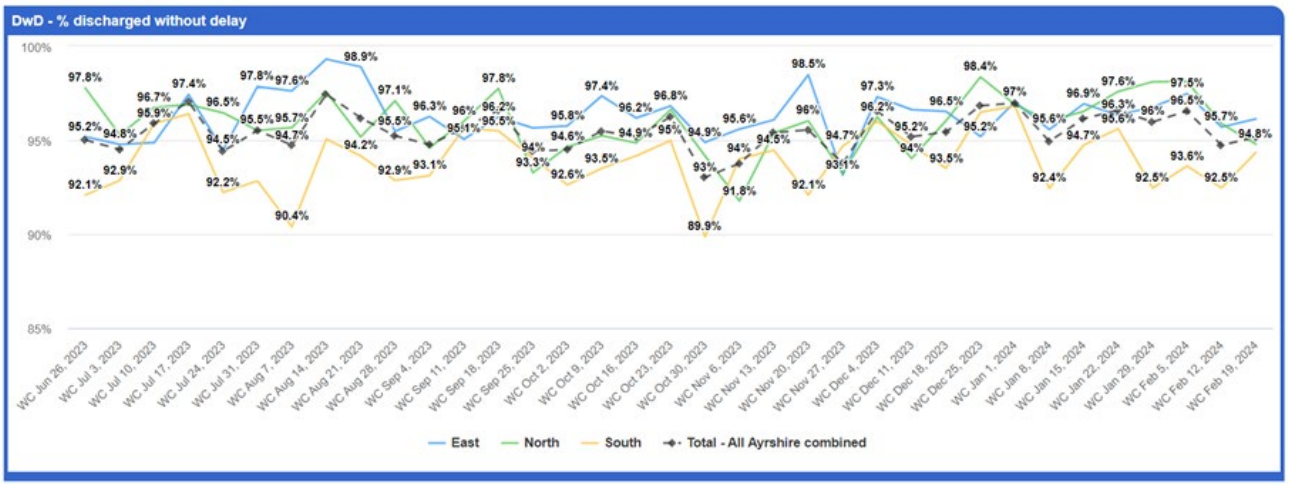
Accessing Care and Support

Limitations of community capacity for care and support services continue to be the main challenge to reducing delayed discharges. This includes access to Care at Home services, Care Home placements including interim care beds and long term placements, and support for adults with complex needs. There are limited resources for delivery of care across all of these service areas for both services that are delivered directly by the Health and Social Care Partnership and those commissioned via third sector and independent providers. This is typically impacted by the significant workforce challenges facing the Health and Social Care sector and continues to limit the success of plans to expand and enhance service delivery.

Discharge without Delay:

NHS AA and the three Ayrshire HSCPs were part of a national pathfinder programme in relation to Discharge without Delay (DwD), which has now been rolled out across Scotland. This is supported by the Scottish Government DwD steering group and improvement teams. One of the aims of the programme is to deliver Discharge without Delay within both community and acute settings, working in close partnership with hospital and community teams to agree the most effective and efficient process to ensure positive outcomes for patients.

A significant number of patients are discharged without delay, currently sitting at 95.2% of patients across A&A.



The overall proportion of patients discharged without delay has remained fairly constant between 94% and 95% since May 2022. This varies by HSCP with North Ayrshire HSCP currently reporting 94.8% and East Ayrshire HSCP reporting generally being the highest since May 2022. The percentage of discharges without delay in South Ayrshire HSCP has increased from 87.0% in w/c 2 May 2022 to 94.3% in w/c 19 February 2024.

3.2 **North Ayrshire HSCP Context and Plans**

3.2.1 **Care at Home**

Demand for Care at Home services has been consistently high for a period of time with an approximate increase in demand of over 30% since pre pandemic levels. Referrals to Care at Home services in North Ayrshire are made from a number of sources – community referrals such as family, self-referral, GP/nurse etc, referrals made from the Enhanced Intermediate Care Team and referrals to support people on discharge from hospital. There is an eligibility criteria with formal Care at Home supports only provided to those who have been assessed as having critical and/or substantial care needs. There can often be high turnover across the Care at Home service due to constant changes in people's assessed needs, planned short term support via Reablement services and service change due to admission to settings such as Hospitals and Care Homes.

In addition to the high volume of demand for services, it is also recognised that there has been an increasing complexity in the needs of people in our communities as people live at home for longer with a range of complex health and care needs. This is further impacted by the local demographic challenges our communities face and the result this has on the health of the population. Being the second highest area for Child Poverty, the second highest for proportion of the population with Long Term Conditions and a growing older population. The Care at Home service undertook a formal review of the Care at Home Assistant role in 2022, resulting in a regrading for this workforce in 2023, and this took into consideration the change in the complexity of needs of people that are being supported in the community. The development of the Care at Home role incorporates a range of skills including supporting people with administration of medication and a range of extended complex moving and handling and personal care supports.

Across 2023, the Care at Home service received an average of 296 referrals per month, with around 51% of all referrals to support hospital discharge. Note, some numbers may be duplicated due to re-referrals where change in discharge status occurs. The level of community referrals can be fairly static however referrals via the hospital can experience high peaks in demand. This year the Care at Home team have received a total of 323 referrals in January 2024, and 335 referrals in February 2024. This is inclusive of new and increase referrals from all referral sources. In February alone a total of 87 referrals were received to increase existing care packages for people who are already in receipt of Care at Home in North Ayrshire.

In the month of January 2024, a total of 122 care packages were confirmed to support people with discharge from hospital, with a further 66 new packages provided in the community, and 60 increases to existing care packages for people in the community. In February 2024 this was 141 care packages to support people with discharge from hospital, with a further 71 new packages of support provided in the community and 73 increases to existing care packages for people in the community.

	2023 average	Jan-24	Feb-24
Number of referrals	296	323	335
Number confirmed:			
Hospital		122	141
Community		66	71
Increase to existing		60	73

The Care at Home Service continues to support around 2,000 people in North Ayrshire on a weekly basis, with 86% receiving services via the Partnership's inhouse Care at Home teams and 14% via commissioned care providers. There are also over 4,000 people who receive supports via the Care at Home's Community Alarm and Telecare service. With over 30,000 Care at Home visits on a weekly basis, this goes some way to illustrate the size and scale of current Care at Home provision across North Ayrshire.

Following a recent review of Care at Home provision, a decision was taken in March 2023 by the Partnership's Integration Joint Board that when the current contracts in place for Care at Home provision with the three Care at Home providers comes to a natural end in June 2024, all Care at Home services via Self Directed Support Option 3 will be provided by the Partnership's in-house Care at Home Team. The decision that was made has required a significant financial investment and reflects the Partnership's commitment to delivering high quality care through this critical frontline service. It is anticipated that this may impact approximately 280 people who are in receipt of around 3,000 hours of care and support weekly. The decision also reflects a fairer approach to care provision across North Ayrshire and will allow the Partnership to provide greater long-term stability and quality of care provision for all Care at Home service users in North Ayrshire.

During 2024-25, and as part of the HSCPs Transformation Plan, the service role, function and pathways will be further reviewed alongside the review of Community Rehab Models to maximise the impact of the Care at Home Service. This will ensure once further service delivery is transferred in-house that the model and service configuration, including the management structure and pathways of support are as efficient as possible. This will complement the work underway to reduce the unmet need for Care at Home services.

3.2.2 **Care Homes**

There are 17 older people's care homes in North Ayrshire which provide a mix of both residential and nursing level care. Concerns regarding the fragility of the older people's care home market in Scotland are well documented and in North Ayrshire there has been a continued trend of reducing care home bed availability across the market. There have also been concerns regarding the quality and sustainability of care home provision in North Ayrshire with the permanent closure of 2 care homes in North Ayrshire in recent years.

Throughout 2023 capacity for care home placements has been a challenge, with a continued decline in bed availability having an impact on the choice(s) of placement available to people in North Ayrshire. The table below provides an overview of the current number of older people's care home Placements that are funded by the Health and Social Care Partnership and bed availability, including interim bed availability, across North Ayrshire.

Month	Total Funded Placements	Care Home Bed Availability
Sep 22	759	56
Dec 22	782	38
Mar 23	757	71
June 23	770	45
Sep 23	788	28
Dec 23	788	34
Feb 24	784	30

Despite this, the North Health and Social Care Partnership has continued to ensure that there are no waits in either the community or in a hospital setting for funding for a long-term care home placement for older people and this has now consistently been the position since 2020. Furthermore, the Partnership has also continued to access interim beds for people who are delayed in their discharge from hospital and can move to a more homely setting as part of the discharge to assess process. Since December 2023, 13 North Ayrshire residents have transferred from a hospital setting to an interim care placement for further assessment of their long term care needs. The admission of residents from hospital settings continues to be prioritised to minimise delays to discharge:

	Admission From:	
	Community	Hospital
Jul-23	10	9
Aug-23	17	17
Sep-23	7	16
Oct-23	4	14
Nov-23	15	14
Dec-23	11	10

For 2024-25 the budget will include provision for a total of 765 care home placements, to be managed across the financial year, the potential impact on waits in both hospital and community as a result of this reduced level will require to be closely monitored.

3.2.3 **Unmet Need**

The HSCPs provide weekly data returns to the Scottish Government to illustrate unmet need across the system. This focusses particularly on waits for Care at Home Services, Statutory Social Care Assessments and Social Care Reviews.

The below table provides a snapshot of this data return from June 2022 to Feb 2024:

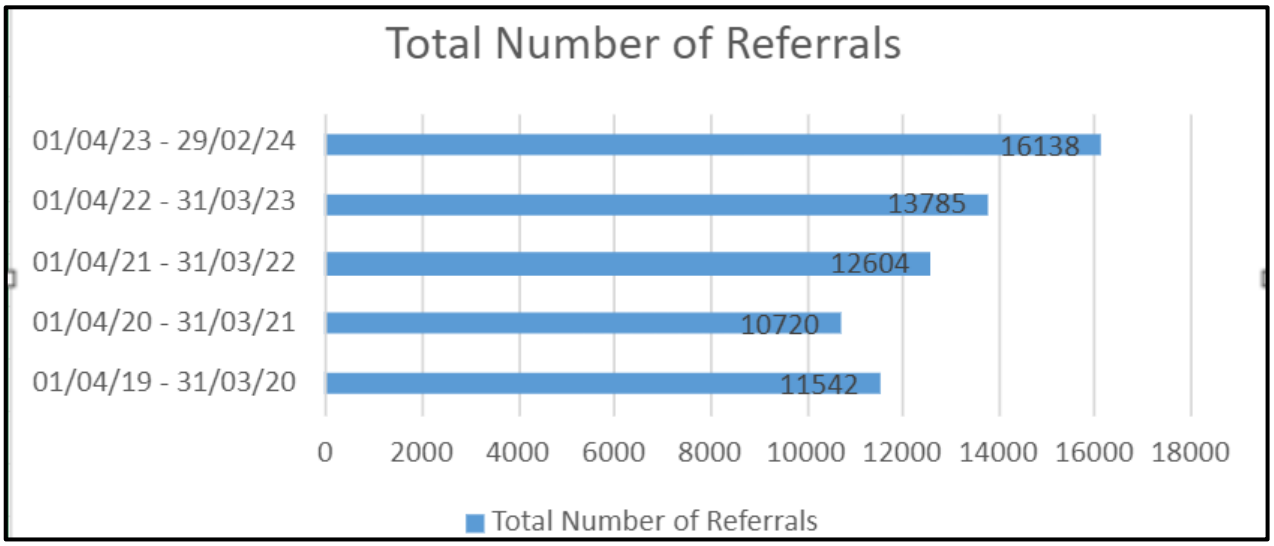
Unmet Need Data Return	Jun-22	Sep-22	Jan-23	Jul-23	Sep-23	Feb-24
Waiting for Social Care Assessment						
Hospital	1	3	3	2	3	1
Community	195	231	249	189	229	249
Assessed and Awaiting POC:						
Hospital	27	18	25	21	33	11
Community	147	165	229	205	202	175
Awaiting a Statutory Review	339	299	360	297	346	441
Weekly Hours of Unmet Need						
Hospital	325	216	341	251	359	122
Community	1,284	1,413	1,721	1,299	1,483	1,056

	Over time there had been no demonstrable improvement in the position in terms of unmet need throughout 2023. It was evident that the Partnership's inhouse Care at Home service has continued in its growth month on month, however the benefit of this has been negated throughout 2022 and 2023 by both ongoing demand for services and the continuous reduction in capacity via independent care providers. There has, however, been significant improvement in terms of levels of unmet need both in the community and to support hospital discharge, in an ongoing basis since December 2023. This has seen the reduction in the average number of people awaiting a package of care to support hospital discharge from an average of 28 people in December 2023, to an average of 13 people in February 2024. The number of people in the community awaiting a new package of care has also reduced from an average of 221 people in December 2023 to an average of 176 people in 2024. Furthermore, the total amount of unmet care hours combined for all community and hospital care packages has reduced by around 29% on a weekly basis, which is equivalent to over 400 hours of care. There continues to be a significant difference in the level of unmet need between individuals awaiting care in hospital compared to in the community, with almost 90% of the current hours of unmet need being for individuals on the community waiting list and a significant number of individuals in the community awaiting assessment and review. This is reflective of the continued focus on prioritising packages of care for individuals in hospital to support with wider hospital pressures. However, the impact of this is the continued risk posed to those individuals in the community who have been assessed as requiring support and this is not in place, this is not in line with the early intervention approach to keeping people safe, fit and well. The Partnership has undertaken a number of initiatives linked to the management of demand for services and unmet need as is described within the Delayed Discharge and Winter Preparedness Improvement Plan.
3.2.4	**Enhanced Intermediate Care Team**
	North Ayrshire Health and Social Care Partnership has developed a strong Enhanced Intermediate Care Team which comprises of a range of practitioners who form a multi-disciplinary team focused on rapid access and problem-solving for people in their own homes across all of mainland North Ayrshire. The service can safely support a dynamic caseload of over 150 patients at any one time, who require rehabilitation and reablement due to falls, frailty, low grade infections and general functional decline. A review of the Enhanced ICT Service has been commissioned and commenced late in 2023 with a refocus of the current EICT service to deliver rehabilitation and enablement as part of a comprehensive rehabilitation pathway utilising and building on current developments in Wards 1 and 2 of Woodland View to extend options to deliver home and community-hospital based care. It is anticipated that the outcomes of this will include further development of EICT to ensure a service that is able to work efficiently and effectively in delivering a range of services offered across North Ayrshire. This will ensure that delivery models are flexible, connected and responsive and will strengthen community rehabilitation Partnership wide to maximise available capacity.

The below tables demonstrate some of the recent performance and activity of the EICT service:

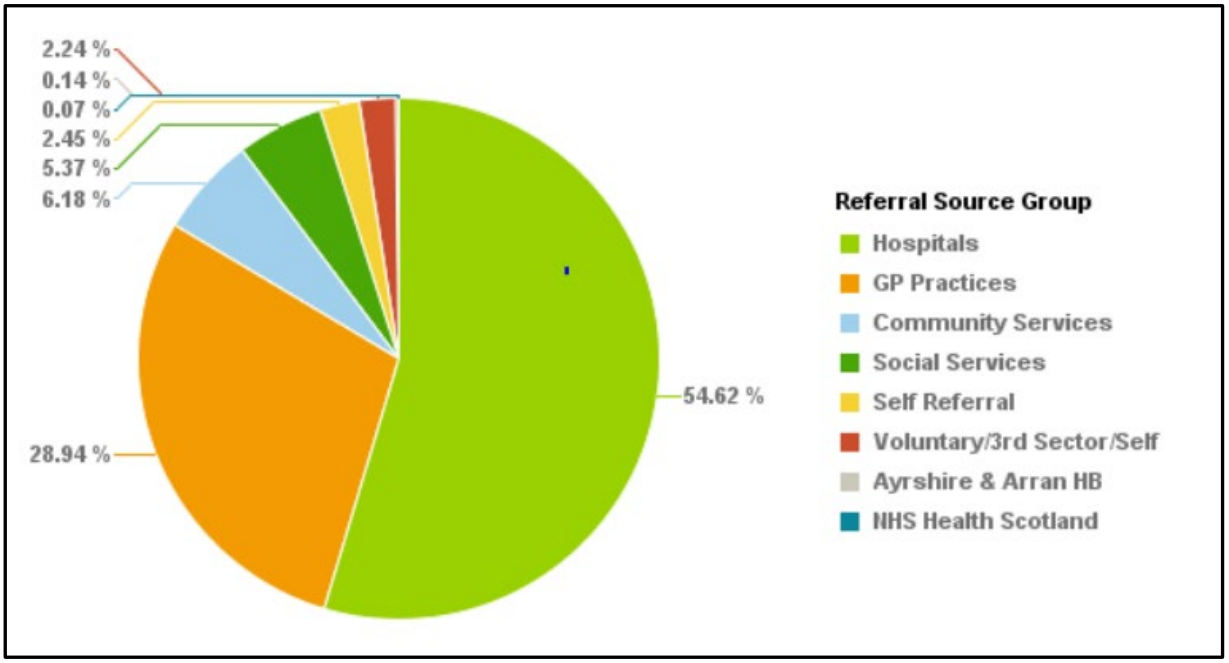
Total number of referrals to the Enhanced Intermediate Care and Community Rehab Hub:

**Note increase in recent year due to expansion of hub as single point of contact for Community OT service*

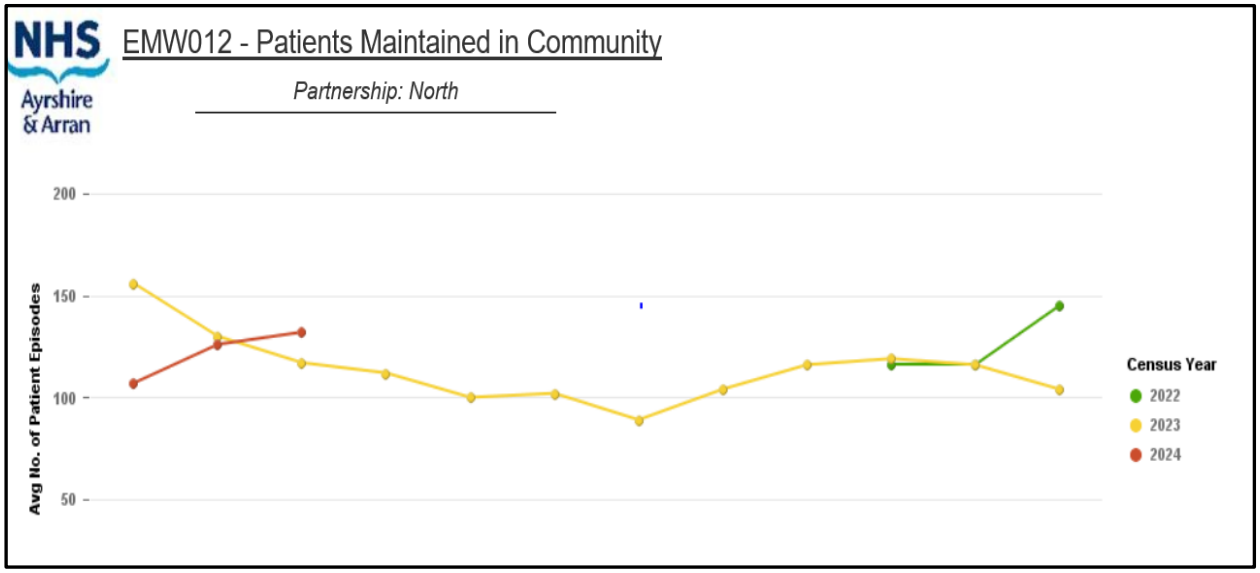


Source of referrals to the Enhanced Intermediate Care and Community Rehab Hub:

01/04/2023 - 29/02/2024



Community Patient Activity 2022 - 2024:



3.2.5 **Adults With Incapacity (Delayed Discharges)**

Adults with Incapacity delays refer to hospital inpatients who are considered to be a delayed discharge due to the adult lacking capacity to make informed decisions regarding their future care and where a need has been identified for a proxy decision maker to be formally appointed under the Adults with Incapacity (Scotland) Act 2000 (hereafter AWI Act). The AWI Act provides a legal framework to safeguard the welfare and financial affairs of individuals who lack capacity and allows for a nominated person to make some or all decisions on the adult's behalf and to ensure that their best interests, views and the least restrictive options for their care and support are considered. For many adults this results in the application of a Guardianship Order to safeguard their welfare and manage their financial or property affairs.

Applying for a Guardianship Order under the AWI Act requires the involvement of multiple agencies ranging from Social Work staff, MHO's, Independent Advocacy workers, Local Authority and private solicitors, Scottish Legal Aid Board, Scottish Courts and the Office of the Public Guardian. Unfortunately, the process can be lengthy and there can be delays at any point in this at various stages many of these often outwith the Partnership's control such as capacity assessments and family disputes. A number of these challenges have been recognised nationally. North Ayrshire Health and Social Care Partnership has experienced high levels of delays linked to AWI processes. To date a number of measures have already been implemented including additional MHO capacity and dedicated MHO support within the Partnership's Hospital Social Work Assessment team. Despite this, delays linked to AWI in North Ayrshire remain high, and whilst this can account for around one third of all delays across the Partnership at any one time, people delayed for the longest time in terms of delays are usually associated with AWI processes therefore this has a significant impact on the individual people delayed.

The longest AWI delays are also associated with individuals where no powers exist before their hospital admission and no one has legal authority to make decisions on their behalf. There can be delays even where a POA arrangement is in place as there is follow up required regarding the nature of the POA powers and legal agreement, complexities of capacity assessment and family views and wishes. Therefore it is key that priority is given to prevention and early intervention. In the 10 years between 2000-2010 around 175,000 people registered a POA with the Office of the Public Guardian in Scotland – an average of 17,500 per year. In 2013, the annual OPG registrations across Scotland had increased to 45,004. In 2018 there were 58,848 and in 2023 these had increased to 70,409 representing

a 56% increase over the decade and 20% increase since 2018. In North Ayrshire the percentage increase in the previous decade has been 73%, therefore above the national position, however whilst this is positive and a clear indication of the success of recent National Power of Attorney campaigns, to ensure continued impact in North Ayrshire this requires further attention.

Evidence indicates the negative impact of an extended delayed discharge and prolonged hospital stay on individuals physical and emotional wellbeing therefore it is a priority for the North Partnership to continue to develop practice and procedures to improve performance associated with AWI delays. This is a key component of the local Winter Preparedness and Delayed Discharge Improvement Plan and to ensure clear understanding of the current North Ayrshire position a recent self-assessment has been undertaken using the Scottish Government's AWI Good Practice Guidance. The self-assessment has identified a number of positive areas of practice and recent developments within North Ayrshire including:

- Power of Attorney campaigns (national and local)
- Guardianship activity oversight
- 13ZA application including recent Practice Enhancement Notice
- Development of Practitioners Guidance for Requesting Capacity Assessments
- Hospital Based Locality Social Work Team
- Dedicated Hospital MHO including specialist support for discharge planning
- Interim bed capacity and discharge to assess models of care
- Good MDT working
- Hospital Co-ordinator and link to community wards
- Arran Unscheduled care response plan including intermediate care and step down
- Local and robust Senior Management oversight of Delayed Discharge performance

The following further areas for improvement have been identified as an outcome of the self-assessment and are being progressed as part of the Delayed Discharge Improvement Plan:

- Development of a Pan Ayrshire discharge planning protocol
- Local Power of Attorney campaign
- Early referral and promotion of anticipatory care planning – development of close links with acute discharge planning teams
- Implementation of Guardianship activity tracker with exemplar timescales
- Review of demand, current MHO capacity and development of linked performance dashboard
- Implementation of Supported Decision Making to complement current AWI training

There have been some early indicators in late 2023 and into early 2024 of a positive movement in terms of a reduction for people delayed in their discharge from hospital (linked to social work assessment/requirement for long term care needs) and in particular for adults with incapacity however this has been over a short period of time and will be influenced by fluctuations in referral activity and demand. It is also important to emphasise that there are limits to the control that the Partnership can exert in influencing the desired reduction in AWI delays as has been previously described this can often be due to a variety of factors that are out with the Partnership's control, including the demographic composition of our communities and the restrictions of the AWI legislation which is designed to uphold an individual's Human Rights.

Date	Number of AWI Delays
21/09/23	24
20/10/23	25
20/11/23	26
20/12/23	15
22/01/24	20
20/02/24	17
08/03/24	10

The HSCP continue to engage with SG colleagues to understand and learn from best practice in other areas and to share the work being progressed in North Ayrshire.

3.2.6 **Mental Health Unscheduled Care**

Mental Health wards in Ayrshire and Arran, predominantly within Woodland View, have been operating at full capacity with significant bed pressures for a sustained period of time, with the implications of a high admission threshold and the impact this has on community teams including our CMHTs. There are significant challenges with delayed discharges in Mental Health Wards but also with providing robust alternatives to admission.

Mental Health Assessment Hub:

The new Mental Health Unscheduled Care Assessment Hub is a specialist in-patient care provision in Woodland View is nurse-led and provides intensive assessment by highly qualified clinicians for a period of up to 72 hours.

The referral criteria includes patients presenting to Mental Health Unscheduled Care teams with acute mental illness and/or associated risk profile who would be eligible to access an adult acute mental health bed, to facilitate a period of ongoing assessment to determine the most appropriate plan of treatment. It is not envisioned that children/young people admitted to acute adult beds in extreme circumstances would be considered appropriate for the Hub.

The hub will not be an appropriate referral option where the primary problem is not related to mental illness e.g. where:

- Physical health needs are the primary or immediate need e.g. overdose or self-injury, where person not assessed as medically fit for transfer.
- The patient has an organic illness e.g. ARBD, dementia.
- There is acute intoxication with alcohol or drugs.
- Where the persons needs would be best met by a specialist Learning Disability Service.

The Hub was due to formally launch in 2023 however due to delays in estates works this has been delayed. The Mental Health Unscheduled Care Service instead commenced a 4 week soft launch of the Hub early in 2024. This allowed the Hub to open with reduced capacity to test out pathways, policies and procedures. Having opened on the 05 February and closed on the 29 February 2024, the service supported 15 people pass through the doors. Referrals were received from a variety of different teams from within the Mental Health Unscheduled Care Service, with one out of area person also supported.

Of the 15 people supported, 11 were discharged back to the community and 4 transferred into Woodland View acute admission wards. On the morning of 29 February 2024 there were five empty beds in the acute ward in Woodland View and four pass beds. Whilst delivery was only for a short period, it can be reasonably concluded that the impact of the

	pilot resulted in the diversion of 11 potential acute admissions with better outcomes for people who were able to be supported to return home to their communities. The Hub is currently closed for a period of reflective practice, however the service will re-open on 11 March 2024. Due to the current environment capacity is limited to no more than 2 patients. The planned model will be for a maximum capacity of 5 when estate works are complete and it is evident from the success of the pilot the significant benefit this service will provide as the front door for acute Mental Health admissions.
3.3	**North Ayrshire - Winter Preparedness and Delayed Discharge Improvement Plan**
	The Partnership's Health and Community Care teams, alongside Mental Health colleagues developed a local winter preparedness and delayed discharge improvement plan in response to service performance levels and community unmet need to ensure resilience across the health and care system in North Ayrshire. This plan was shared with the IJB in October 2023. This was anticipated to be a short-term plan however has developed to become a vital component of the Community Care Teams Transformation Plan. The previous report provided a summary of the workstreams associated with the plan and there is an update on the plan, key activities and performance indicators summarised in Appendix 1.
4.	**CONCLUSION**
4.1	In summary, whilst it is evident that there have been significant efforts made in the planning and implementation of the programme of work to address ongoing performance linked to both unscheduled care across NHS AA and in North Ayrshire, unfortunately the desired improvements have not yet been achieved across the whole system. • Average length of Stay in both acute sites has reduced slightly but remains high and higher than the Scottish average. The Discovery data points to the majority of the long stay patient population never being recorded as a delay, therefore, the greatest opportunity to release significant bed capacity is likely to be in reducing non-delayed long-stay patient numbers. • Priority performance areas, ie 4 hour compliance and 12 hour breaches, have been set ambitious targets these areas both remain off target and an area for concern, being symptomatic of the bed pressures within the hospitals. • Delayed discharges in North Ayrshire fluctuated throughout 2023, reducing to lower levels in mid-2023 and then peaking in early December 2023 to the highest levels seen all year. In late December 2023 delayed discharge levels began to reduce and have stabilised throughout January and February 2024 at a lower level than had been seen through most of 2023. There are risks to this position however and performance in this area is dependent on volume and demand for supports. • Levels of community unmet need also fluctuated throughout 2023. This position had worsened over the 2022-23 winter period then experienced a period of stability and improvement however levels of unmet need, similarly to levels of delayed discharge, increased to the highest levels throughout the year in December 2023. Similarly, to the performance relating to delayed discharge, there has been a consistently improving picture since the beginning of 2024. • Despite this improvement in performance and access to Care at Home supports for people both in the community and to support discharge, there remains a significant level of risk being held in the system and in our communities. • The impending Care at Home transfer and move to a model of care in North Ayrshire whereby Care at Home supports via Self Directed Support Option 3 are delivered via the Partnership's in-house Care at Home teams represents a positive move for the quality and sustainability of safe care services in North Ayrshire. However, there are inherent risks with this transfer and this may have some initial impacts on overall capacity whilst care provision is transferred and the workforce stabilised. • North Ayrshire HSCP continues to proactively respond to these demands and adapt

	and expand services as necessary, with workforce, provider sustainably and financial resource challenges being the limiting factor to the pace of improvement. There remains an urgency for Partners across NHS Ayrshire and Arran and the three Health and Social Care Partnership's to continue to prioritise efforts and subsequently improve performance linked to unscheduled care, community unmet need and levels of delayed discharges to ensure resilience and continued delivery of critical services. This report has set out the plans in place to improve, via the Pan Ayrshire Urgent and Unscheduled Care Improvement Plan and the North Partnership's specific plans for winter preparedness and delayed discharge performance improvement. The Budget report for 2024-25 outlines a request from NHS AA to develop a joint strategic commissioning plan for Unscheduled Care aligned with set-aside resources. There is an ambition that the commissioning plan will indicate an expectation of service delivery that will see sustained and affordable improvement in relation to performance outcomes for the citizens of Ayrshire and assure best value to support the financial balance of urgent and unscheduled care provision through a review and system wide redesign of the preferred models of care. The Plan will be developed and brought to the IJB for approval during 2024-25.
4.2	**Anticipated Outcomes**
	Improved awareness for the IJB of current performance and challenges and the work underway to improve services for the citizens of Ayrshire and Arran and our local communities. This will ensure that the IJB will be in an informed position to monitor performance and direct further interventions if future performance does not improve in line with plans.
4.3	**Measuring Impact**
	Urgent and Unscheduled care measures are tracked through the NHS Pentana Performance Framework and through the established governance arrangements. Performance linked to community unmet need, demand and the Enhanced Intermediate Care Team review will be tracked through existing Partnership oversight arrangements. The IJB will receive updates on progress.
5.	**IMPLICATIONS**

Financial:	The IJB previously received funding for winter during 2021 which included investment in Care at Home, MDTs and interim care. The IJB approved a plan in December 2021 to invest this resource and this plan remains current. There has been no further funding specifically following this allocation to support winter or unscheduled care pressures for HSCPs. North Ayrshire IJB are reporting a projected overspend for 2023-24 with recovery actions in progress, therefore there is no further resource available. Acute services in Ayrshire and Arran are projecting additional costs due to unfunded beds which remain open across both sites, the closure of these unfunded beds will be an ambition for NHS AA during 2024-25.

Human Resources:	Workforce across the system remains a challenge, plans are in place to proactively grow and retain our health and care workforce and to support staff to respond to the growing demands placed on services.
Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 sets out the IJBs responsibilities for Unscheduled Care services delivered from large hospitals, this is further detailed in the Integration Scheme.
Equality:	Addressing whole system pressures on acute services, unscheduled care and levels of unmet need will improve timely and appropriate access to services for the whole population of Ayrshire and Arran.
Children and Young People	Addressing whole system pressures on acute services, unscheduled care and levels of unmet need will improve timely and appropriate access to services for the whole population of Ayrshire and Arran.
Environmental & Sustainability:	N/A
Key Priorities:	The reshaping of Unscheduled Care activity, access to services and whole system planning to support seasonal service demands and improve health outcomes aligns with the vision and values of the IJB.
Risk Implications:	Risks are noted in the report, the most important risk being the risk of harm being posed to patients in hospital and people in the community as a result of the current lack of whole system performance improvements.
Community Benefits:	N/A

Kerry Logan, Head of Service Health and Community Care, klogan@north-ayrshire.gov.uk Click here to enter text. Click here to enter text.

Links to previous reports:

- IJB December 2021 – Winter Funding Plans - Document.ashx (cmis.uk.com)
- IJB June 2022 – Unscheduled Care Performance:

IJB Report June 2022 - Unscheduled Care Fl

- IJB November 2022 – Unscheduled Care Performance Update**:**

IJB Report Nov 2022 - Unscheduled Care Fe

- IJB Report October 2023 Unscheduled Care and Winter planning:

IJB Report October 2023 Unscheduled Ca

APPENDIX 1

North Ayrshire - Winter Preparedness and Delayed Discharge Improvement Plan

Workstream	Service Lead
Care at Home Capacity It is understood that timely access to Care at Home supports is crucial in supporting people to live independently in their communities. This workstream aims to ensure continued delivery of these crucial supports, whilst building on capacity to reduce delays in accessing Care at Home services. This will be achieved by enhancing the inhouse Care at Home workforce through effective management of absence, recruitment strategies and development and retention of the workforce.	Service Delivery Teams
Key Actions: • Care at Home recruitment strategy across both the mainland and islands incorporating workforce retention plans • Service specific training plans building on the new Learning and Development Strategy, including SVQ opportunities • Staff engagement and wellbeing support • Wellbeing at work action plan(s) **Key Performance Updates:** • Significant levels of recruitment activity around a range of difficult to fill posts, including vacancies on Arran • 16% reduction in frontline Care at Home Assistant vacancies since October 2023 • 2.61% reduction in frontline Care at Home Assistant absence since October 2023 • 62% reduction in non-frontline Care at Home absence since October 2023 • 238 people have attended Care at Home recruitment events between Nov 23 to Feb 24, from this 40 people have been appointed and are at varying stages of recruitment process • 7 new CAH staff will join via the Council's Skills for Life employability initiative from April 2024	
Waiting List and Unmet Need It is recognised that timely access to care and supports, and a reduction in delays in accessing services, is crucial in supporting people to provide alternative approaches to managing capacity and demand and to ensure that there are safe systems in place for oversight of this.	Locality Social Work /Reablement/Service Delivery Team
Key Actions: • Moving and Handling service developments • Care management system software developments • Promotion of tech solutions including Community Alarm and Telecare services • Reablement focused review of the Care at Home waiting list • Reablement focused pilot for accessing Care at Home supports • Introduction of Unmet Need Assurance and Oversight Group • Programme of reviews for all Care at Home provision commenced **Key Performance Updates:** • 53% reduction in the number of people awaiting a care package to support	

discharge from hospital since December 2023
- 29% reduction in the weekly hours of unmet need for people in the community awaiting Care at Home supports

AWI/Guardianship The negative impact of an extended delayed discharge and prolonged hospital stay on individuals physical and emotional wellbeing is recognized therefore it is a priority for this workstream to review current systems, practice and processes to ensure safe and timely supports for adults with incapacity.	Locality Social Work Teams

Key Actions:

- Pan Ayrshire benchmarking
- Pan Ayrshire discharge planning protocol
- Good practice guidance self-assessment
- Guardianship activity oversight, including the use of 13za and Implementation of Guardianship activity tracker with exemplar timescales
- MHO lead to support discharge planning
- Early referral and promotion of anticipatory care planning – development of close links with acute discharge planning teams
- Review of demand, current MHO capacity and development of linked performance dashboard
- Implementation of Supported Decision Making to complement current AWI training

Key Performance Updates:

- 32% reduction in AWI delays since October 2023
- National position – on 23 October 2023 NAHSCP were the highest ranked Local Authority in terms of AWI delays – as at 4 March 2024 NAHSCP were the 9th ranked in Scotland in terms of AWI delays

Discharge to Assess This workstream aims to further enhance the hospital-based assessment team systems and processes to support the Discharge without Delay ethos of good discharge planning	Locality Social Work/Service Delivery/Long Term Conditions Teams

Key Actions:

- Interim bed capacity
- Early referral and assessment timescales
- MDT and Planned Date of Discharge
- Daily locality meetings and Senior Management escalation/oversight
- Hospital Co-ordinator and link to community wards
- Develop demand and capacity dashboard
- Arran Unscheduled care response plan including intermediate care and step down

Key Performance Updates:

- 13 North Ayrshire adults discharged to an interim bed since December 2023 preventing an extended hospital based stay
- Since July 2023 the Hospital Co-ordinator has screened 510 community ward referrals – of these new more appropriate care and treatment pathways have been identified for 119 people (23%)
- The Hospital based HSCP team have supported acute colleagues with on-site ward

decompression, including supporting reviews of patients with the longest lengths of stay	
Mental Health and Learning Disabilities – to support Discharge without Delay and provide alternatives to hospital admission	Mental Health and Learning Disability Teams

Key Actions:

- Interim/Step Down bed capacity for complex needs
- Open Adult MH assessment unit in Woodland View as 72 hour assessment unit
- Grow Adult provider capacity and sustainability
- Engage with other LA/HSCP/Board areas re OOA patients

Key Performance Updates:

- Unscheduled care hub opened for trial period with 2 patient capacity, 15 patients supported through pathway with admission avoided for 11 of those, re-opens on 11th March and plans to scale up to 5 beds on a permanent basis
- Commissioning team have supported alongside IRISS across two workstreams, Foundations for Change focusing on contracts and commissioning and Space to Practice (focusing on the role of Community Social Work), engagement with adult social care providers to harness market capability and capacity
- Regular engagement and communication with other HSCP areas areas re OOA patients
- Intensive Support Team for Learning Disabilities now established with only Social Worker post to be readvertised, team now operational and starting to review individual out of area plans for individuals