NORTH AYRSHIRE
Health and Social Care Partnership

**Integration Joint Board**
**12 October 2023**

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| **Subject:** | **Urgent and Unscheduled Care Update & North Ayrshire Improvement Plans** |
| **Purpose:** | To highlight to the IJB performance in relation to Urgent and Unscheduled Care, highlighting areas of risk and to detail the current plans for winter preparedness, including actions and plans 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 Urgent and Unscheduled Care and Winter planning across Ayrshire and Arran and the specific actions being progressed in North Ayrshire. |

| **Glossary of Terms** | |
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| 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 |

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| **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. This report will provide an update to the current position and an overview of whole system plans to ensure that the Integration Joint Board is aware of the current situation, challenges, risks and potential impact. |
| **2.** | **BACKGROUND** |
| 2.1 | The previous report referred to the impact and legacy of Covid-19 which was evident in performance measures and trends, not only for Urgent and Unscheduled Care, but across the health and care system. This report will detail the programme of work that has been in place across Ayrshire and Arran to support patient outcomes and improve performance. |

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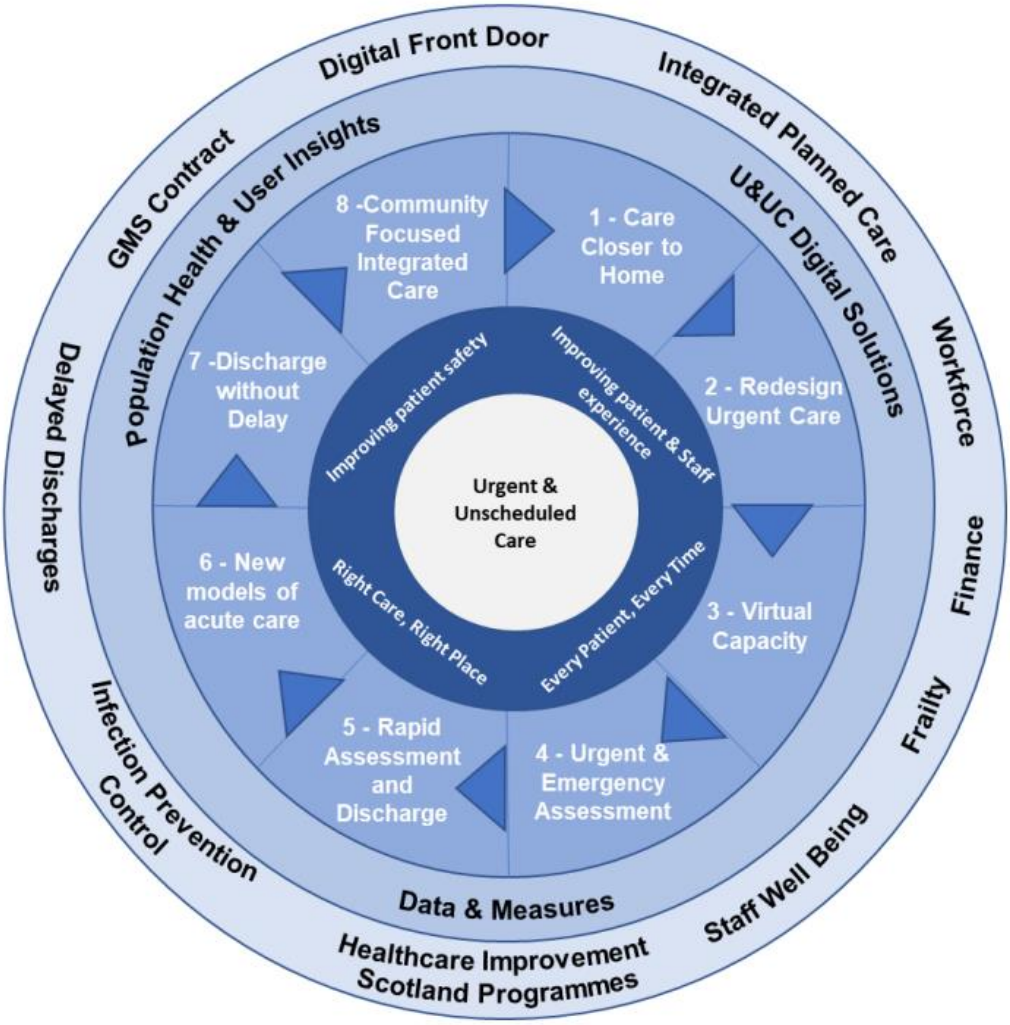
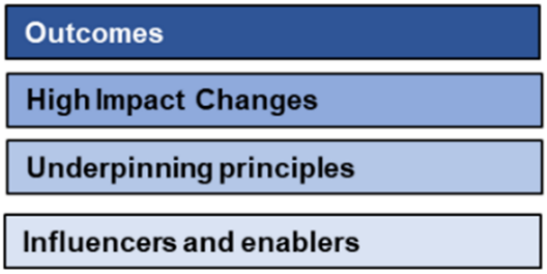
| 2.2 | The improvement work has also been supported by a series of Whole System Intervention(s) which took place across both acute and community hospital sites late in 2022 through to mid-2023. These Whole System Interventions were sponsored by the 3 HSCP Directors and commenced with a 2-week event in November 2022 supported by a range of teams from across both hospital and community settings and continued with events fortnightly and latterly monthly until April 2023. The ambition of the Whole System Intervention(s) was twofold:<br><br>1. To firstly assist with immediate decompression of the acute and community hospitals in Ayrshire and Arran which at the time were experiencing extended periods of challenge due to capacity and demand.<br>2. To identify and support medium to longer term improvements which could be implemented across the whole system.<br><br>Following the events an action plan was developed and this was monitored through the Discharge Without Delay Oversight Group. |
| 2.3 | Whilst there have been significant efforts made and some areas of improving performance and patient outcomes, there remain areas where progress has been challenging.<br><br>The previous report presented to IJB on unscheduled care provided information on additional acute hospital bed capacity which had been created across both University Hospital Crosshouse and University Hospital Ayr as a response to the COVID pandemic. This additional bed capacity was however unfunded, and it was estimated that cost of those beds for 2022-23 would be £9m, to date for 2023-24 after 5 months the unfunded beds have cost £4.7m. A focussed programme of work with a view to closing the unfunded beds, linked to the activity around improving Urgent and Unscheduled Care Performance, has been in place since 2022. Whilst a number of unfunded beds have been closed across University Hospital Crosshouse and University Hospital Ayr, there remain unfunded beds remain open going into the winter period. In addition to this both hospital sites have utilised the Full Capacity Protocol which results in placing additional patients in unfunded beds in ward areas and other areas of the hospital. This also impacts on wider community services including the use of capacity in downstream beds and support required from HSCP community teams. |
| **3.1** | **Urgent and Unscheduled Care** |
| | **Urgent and Unscheduled Care Collaborative**<br><br>In June 2022 the Scottish Government announced its plans for reshaping unscheduled care services in Scotland through the Urgent and Unscheduled Care Collaborative. This approach of both investment and reform is designed to facilitate change using a collaborative improvement methodology across the whole system moving from a recovery phase to a period of building resilience whilst developing new models of care to optimise the delivery of unscheduled care and ultimately improve health outcomes.<br><br>The collaborative aims to facilitate change by supporting organisations to focus efforts on high impact levers and developing new pathways and models of care from a perspective focussed on people, not place. The High Impact Change model is detailed in the graphic below and this model aims to focus teams on doing the right |

things to ensure the delivery of Right Care in the Right Place, for Every Person, Every Time.




**Ayrshire and Arran Urgent and Unscheduled Care Plans**

As part of the Collaborative work, a nationally developed self-assessment tool was used locally in Ayrshire and Arran by NHS AA and HSCP colleagues to identify and agree three priority areas from the eight high impact changes detailed within the High Impact Change model.

HIGH IMPACT CHANGE PLAN

These were initially categorised as Pre, Intra and Post Hospital delivery groups as summarised below:

| Delivery Group | Primary Workstream(s) |
|---|---|
| Pre-Hospital | • Care Home Urgent Care Pathways<br>• Medicines in Reserve (COPD)<br>• FNC/SAS Joint working<br>• Mental Health<br>• MSK Pathway |
| Intra Hospital | • Hospital at Home<br>• Discharge without Delay<br>• OPAT Cellulitis Pathway<br>• Same Day Emergency Care<br>• ED – Surgical Orthopaedic Flow |
| Post Hospital | • Discharge without Delay<br>• Rehabilitation and Reablement<br>• Multi-Disciplinary Place-based Working |

<u>REVISED NHS AA URGENT AND UNSCHEDULED CARE IMPROVEMENT PLAN 2023-24</u>

Following a review of progress mid-2023, a revised and updated Urgent and Unscheduled Care Improvement Plan (2023-24) was developed replacing the original delivery groups and initially directed into four work stream delivery groups, with a fifth group latterly added – these are detailed below:

| Workstream and aims | Workstream Priorities |
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| **1. Providing alternatives to front door attendance**<br><br>To provide alternatives to front door attendance and admission, maintaining and improving reduction in scheduled and unscheduled attendances. | • Enhance the Ayrshire Urgent Care Service to provide care that ensures that less than 15% of demand requires attendance at hospital.<br>• Eliminate inappropriate and unnecessary conveyance to hospital using the Call Before Convey Pathway.<br>• Enhance access for Care Homes to AUCS, including redirection to other appropriate pathways during the out of hours period.<br>• Provide alternative navigation to community mental health services of Urgent Mental Health Patients.<br>• Expand the evidence-based Community Rapid Respiratory Response Pathway across all three HSCPs.<br>• Further develop the Community Pharmacy pathway into AUCS to support patients to access appropriate care and avoid unnecessary attendance at the ED. |
| **2. Reconfiguration (streamlining) of front door services**<br><br>To minimise admission, stream where possible to same day care services and maximise efficiency to maintain patient flow | • Increase redirection of flow 1 attendances<br>• Eliminate 12 hour waits.<br>• Reduce and maintain NHS Ayrshire and Arran's median SAS turnaround time in line with the Scottish median.<br>• Ensure 100% of patients arriving by ambulance will be handed over within 60 minutes by August 2023 |

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| | • Stream 75 patients per week to Rapid Assessment and Care (UHC) and achieve a same day discharge of 75%<br>• Stream 60 patients per week to Rapid Assessment and Care (UHA) and achieve a same day discharge of 75%<br>• Reduce the average length of stay in Initial Assessments in both CAU's<br>• Increase same day discharge at both acute sites<br>• Use short stay pathways to maximise the % of patients managed within 72 hours<br>• Increase Hospital at Home virtual capacity |
| **3. Reducing average LOS**<br><br>To reduce the average acute length of stay (excluding delayed transfers of care) using the best practice from DwD | • Reduce average length of stay for non-delays by 20%<br>• Implement Associate Medical Director led MDT Board rounds<br>• Implement MDT board round in every acute ward<br>• Increase pre-noon discharges<br>• Increase the weekend discharge rate as a % of the weekday rate<br>• Increase the use of discharge lounges |
| **4. Reducing delayed transfers of care in all bed based care models**<br><br>To reduce the average length of stay for patients delayed in their transfers of care for South Ayrshire patients | • Increase Care at Home capacity in South Ayrshire<br>• Undertake a test of change in South Ayrshire for a virtual stroke pathway<br>• Continue to hold monthly whole system intervention events<br>• Implement discharge to assess care home model in South Ayrshire |
| **5. Paediatrics**<br><br>To reduce ED presentations, reduce time to assessment and provide care closer to home | • Redesign the GP referral pathway<br>• Reduce the average time from arrival in PAU to first medical assessment to 60 minutes<br>• Increase the % of patients that are admitted, discharged or transferred within 4 hours of arrival in Paediatric Assessment Unit<br>• Reduce admissions to, and the length of stay in, 1B by managing patients in the community via a paediatric Hospital @ Home service |

In addition to the refocused work streams a renewed governance structure of the Urgent and Unscheduled Care Improvement Plan (2023-24) has been introduced to ensure executive oversight and assurance. This Oversight Group reports directly to the Strategic Planning & Operational Group (SPOG), which includes membership from the 3 HSCP Directors, Director of Acute Services and the NHS AA Director of Transformation & Sustainability, and thereafter to the Corporate Management Team (CMT) in NHS AA. The Oversight Group is currently co-chaired by the Head of Health and Community Care in North Ayrshire and NHS AA Director of Acute Recovery and Reform.

It is the ambition of the Urgent and Unscheduled Care Improvement Plan to deliver, in full, a dedicated improvement project to eliminate SAS handovers of greater than

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| | 60 minutes, <4 hour journey times for non-admitted patients and to reduce the number of patients waiting 4, 8 and 12 hours for admission in the Emergency Department(s) and the Combined Assessment unit(s) of both University Hospital Crosshouse and University Hospital Ayr.<br><br>It is, however, recognised that whilst significant progress has been made this has not been at the pace and scale required, particularly as the system moves into respond to winter pressures. Most notably significant progress has been made in areas which relate to the Pre and Post Hospital delivery areas.<br><br>The new Urgent and Unscheduled Care Improvement Plan (2023-24) outlines ambitious trajectories with clear measures for improvement and whilst there has been success in some areas, particularly performance linked to Workstream 1, there have been challenges in achieving and sustaining improvement in Workstreams 2, 3 and 4. As such there is currently limited assurance over the scale of improvement delivery and impact on supporting the whole system, particularly over the winter period. Plans are currently being progressed to urgently develop a whole system Urgent and Unscheduled Care Recovery Plan, which will be linked specifically to improved performance and whole system winter resilience, through the identification of SMART actions. |
| 3.2 | **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.<br><br>**<u>Emergency Department Attendances:</u>**<br><br>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 August 2023, 97% of patients who contacted Ayrshire Urgent Care Services (AUCS) and required a clinician response were contacted within response time, exceeding the local target of 85%.<br><br>It is evident in the data that the Covid restrictions had an impact at different points, and data shows that ED attendances reduced considerably whilst lockdown and restriction measures were in place. 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. There was a reduction in overall ED attendances from mid 2022 to the lowest level in February 2023 however since then ED attendances have steadily risen to levels similar to early 2022. |

Despite this, the number of unscheduled ED attendances remain lower than they were over the same period in 2022:

| Number of Unscheduled ED Attendances | |
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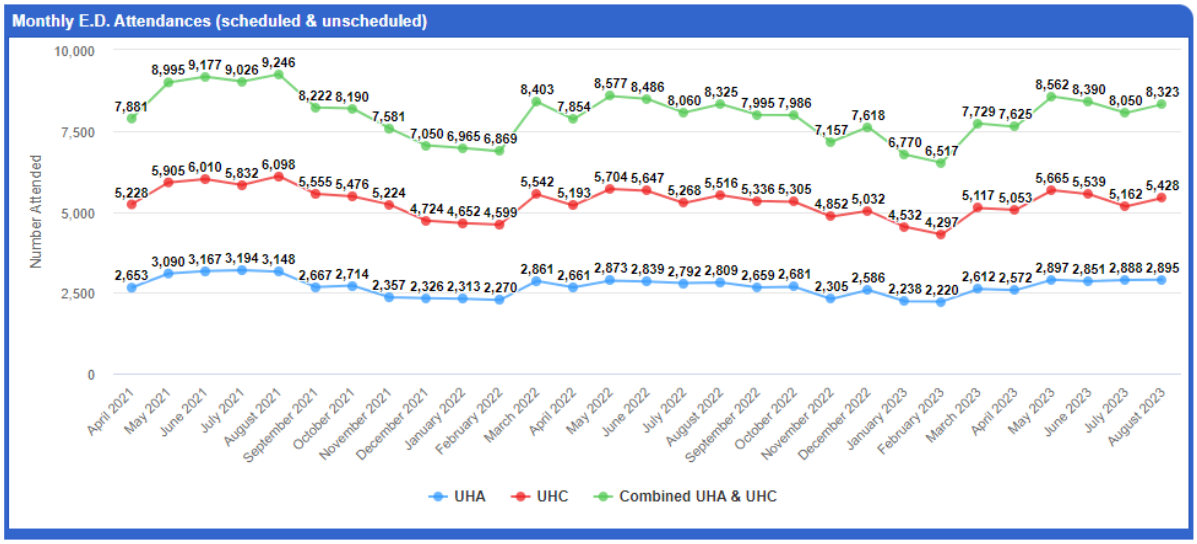
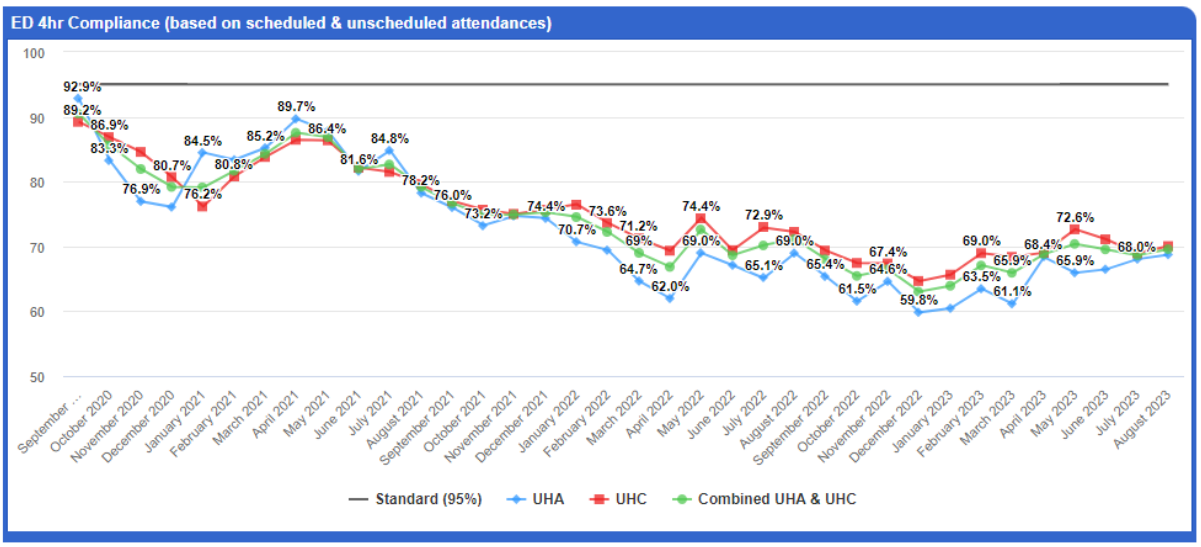
| **Jan-Aug 2023** | **59,983** |
| Jan-Aug 2022 | 60,235 |




## 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 since April 2021. However despite remaining below the 95% compliance target (of people admitted, discharged or transferred within 4 hours) there had been positive movement in terms of an overall upwards trend since March 2023. 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

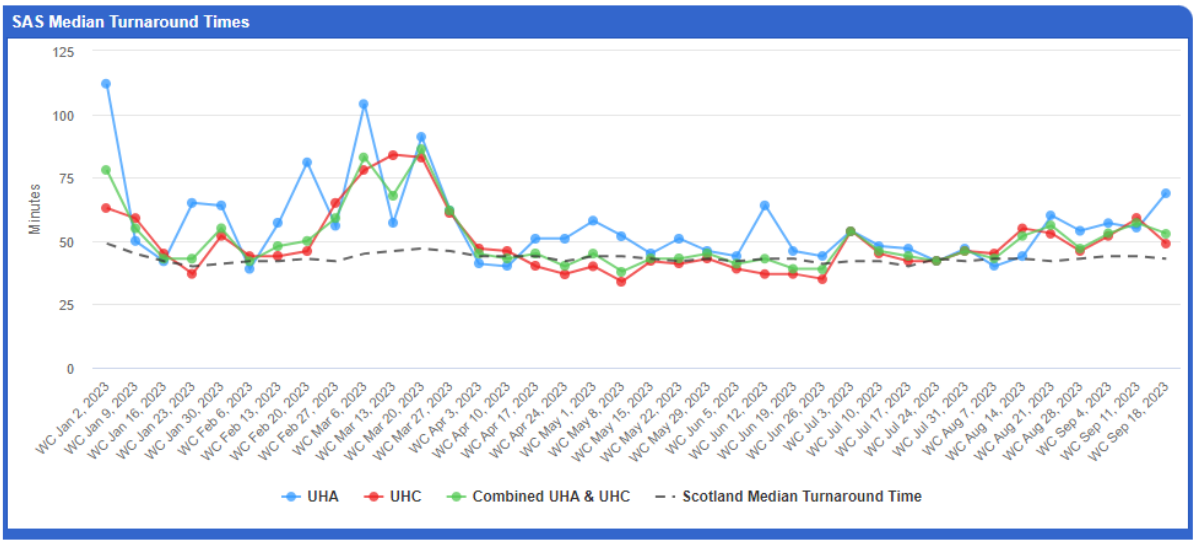
4-Hour standard continues on a sustained increase trend, reaching 68.9% in August 2023. This rise is within 'normal' variation limits, however performance remains below the 95% national target. Compliance has consistently been higher at UHC than UHA.

National Benchmarking – 4 Hour ED Target (95%)

| | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS A&A | 68.9% | 70.8% | 67.6% | 65.4% | 65.7% | 62.3% | 62.8% | 66.4% | 64.7% | 68.1% | 69.5% | 68.8% | 68.1% |
| Scotland | 66.4% | 66.0% | 65.6% | 64.0% | 64.0% | 58.3% | 65.2% | 66.3% | 64.5% | 65.7% | 67.2% | 69.0% | 69.6% |

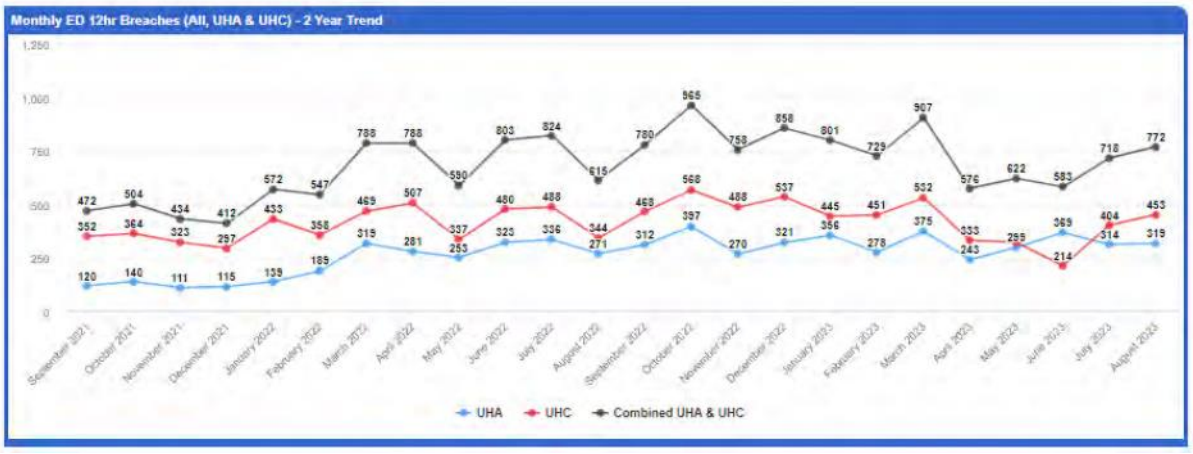
## SAS Median Turnaround Times:

The median SAS turnaround time is the amount of time it takes to reach 50% of patients and includes the time ambulance crew were waiting to handover a patient to the care of the hospital staff plus any additional time they spent at hospital. In Ayrshire and Arran this had reduced from 53 minutes in August 2022 to 47 minutes in August 2023, with peaks at other times throughout the year. Weekly data does however indicate a rise in recent weeks with the median SAS turnaround time increasing to above 50 minutes for the combined position across both acute sites.




## ED 12 Hour Breaches:

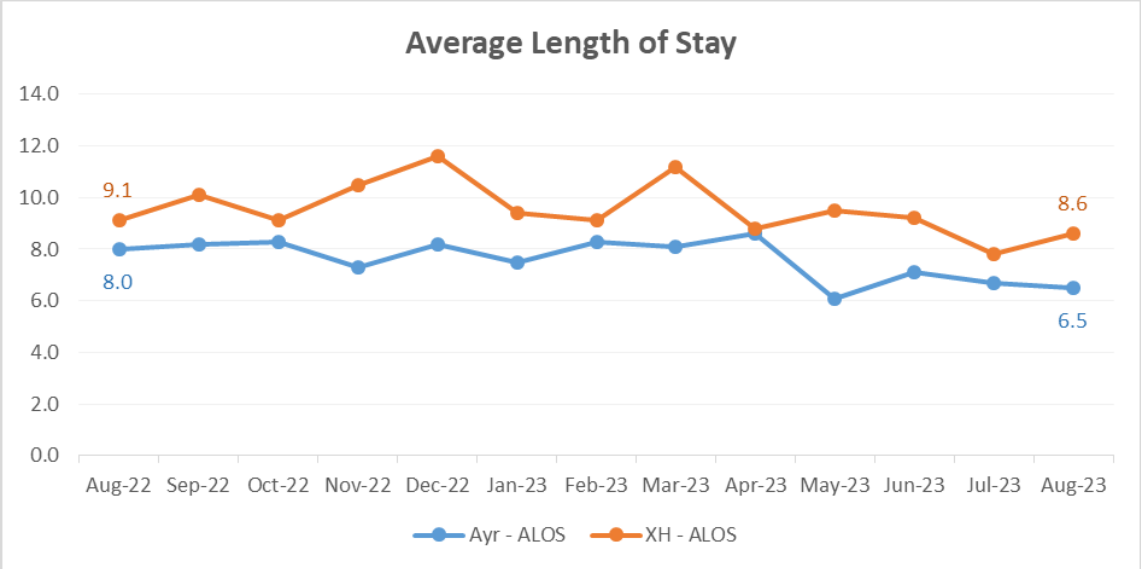
The combined number of Emergency Department 12 Hour breaches showed a positive reduction earlier in April 2023 however this was not maintained and since June 2023 these have been steadily rising.




The NHS AA Annual Delivery Plan trajectory for 2023-24 is for no 12 hour breaches in ED by August 2023. In August 2023, the number of breaches at University Hospital Crosshouse (UHC) increased to 453 from 404 breaches. The number of breaches at University Hospital Ayr (UHA) have remained similar in comparison with the previous month from 314 to 319.

**Average Length of Stay (LoS):**

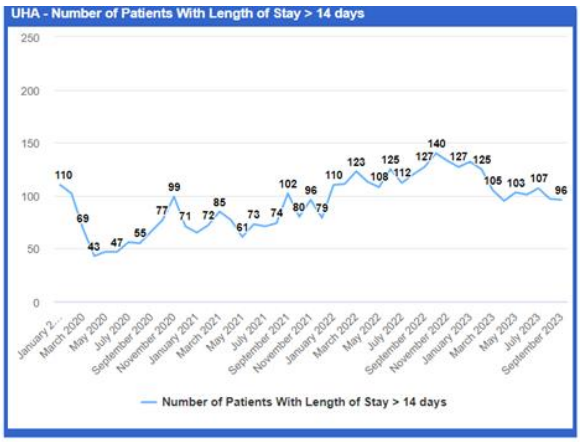
The average length of stay (in days) for non-delayed patients across wards at Ayr Hospital has reduced from 8.0 days in August 2022 to 6.5 days in August 2023, having reached a peak of 8.6 days in April 2023 during this period. At Crosshouse Hospital the average length of stay has reduced from 9.1 days in August 2022 to 8.6 days in August 2023, with a peak of 11.6 days experienced in December 2022. September data reports a LoS at UHA of 7.8 days and 8.6 days at XH.

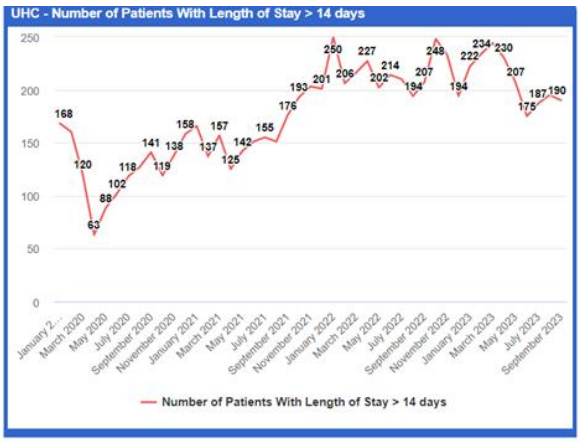



Any increase in the LoS is a significant area of concern having implications for patient care and outcomes, as there is evidence that longer lengths of stay result in higher needs of patients on discharge, with more patients requiring higher levels of care than would be anticipated on admission due to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

The average LOS also masks the significant variation for patients some of which have very lengthy stays, in September 2023 there were 286 patients with a LoS over 14 days, in September 2022 there were 334 patients.

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

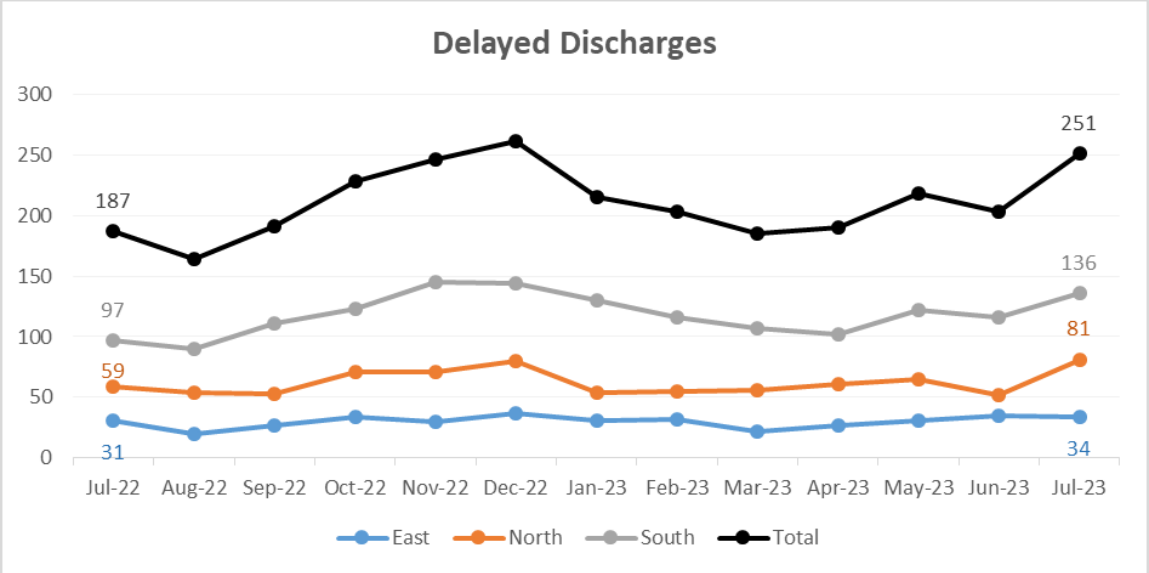



## Delayed Transfers of Care:

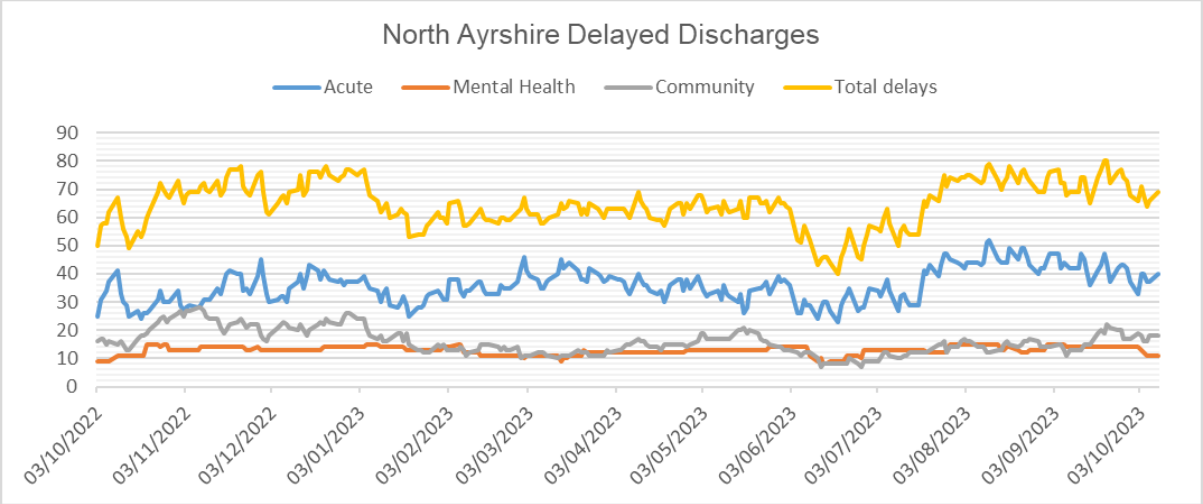
Timely discharge from hospital is an important indicator of quality and is a marker for person-centred, effective, integrated and harm-free care. The term delayed discharge is used to describe a situation whereby a patient in hospital has been assessed as clinically ready for discharge from inpatient 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 risen from 187 at the end of July 2022 to 251 at the end of July 2023 with a peak of 261 reached at the end of December 2022.




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.

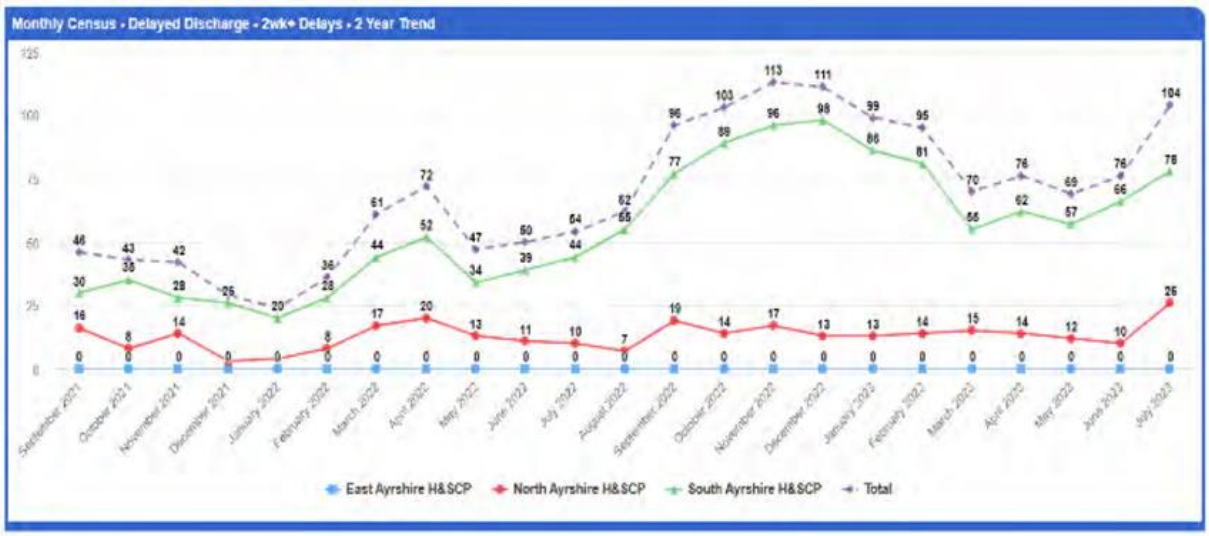
The table below illustrates in more detail the delayed patients for North Ayrshire and their location:




As at 9 October 2023 there were 69 delayed patients for North Ayrshire, these are split between 40 in NHS Acute hospitals, 18 in A&A Community Hospitals and 11 in Mental Health wards. Of the total 69 delays, 25 relate to patients where AWI legislation applies. For the 40 acute hospital delays, outwith AWI delays, there were only 5 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.

Work has progressed with the three HSCPs to reduce the length of stay for delayed patients from a median length of 30 days to 21 days by the end September 2023. Whilst data shows this did fall from 29 at April 2023 to 23 at June 2023, this has since increased to 27 in July 2023 in line with an overall increase in delays.

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 the North 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, with plans in

place in the HSCP to increase capacity, these plans have been 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.

North Ayrshire Health and Social Care Partnership has experienced high levels of delays linked to AWI processes. To date a number of measures have been implemented including additional MHO capacity and dedicated MHO support within the 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.

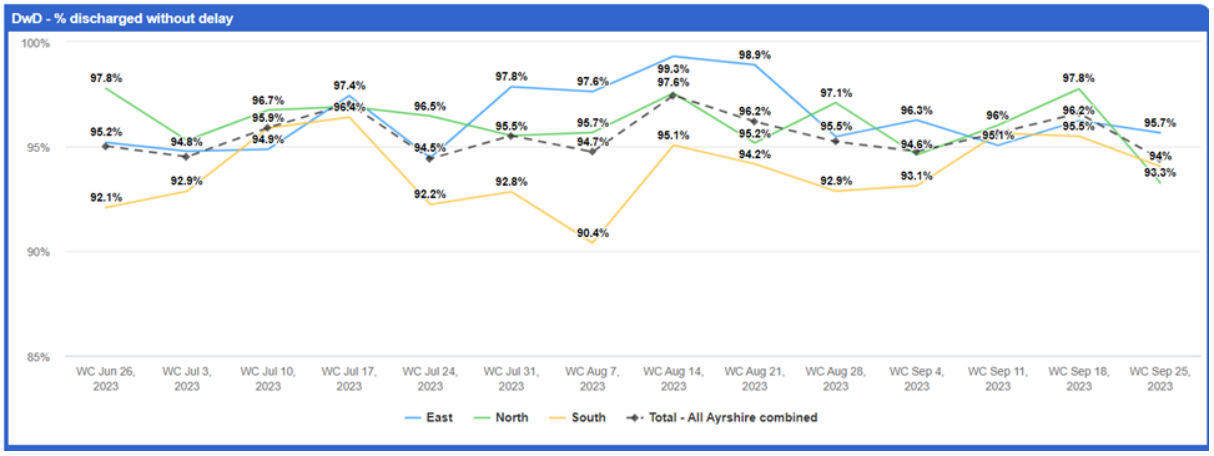
Accessing Care and Support

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 94.4% of patients across A&A, this has reduced from the 95% reported in June.




The 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 93.3% 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% in w/c 25 September 2023.

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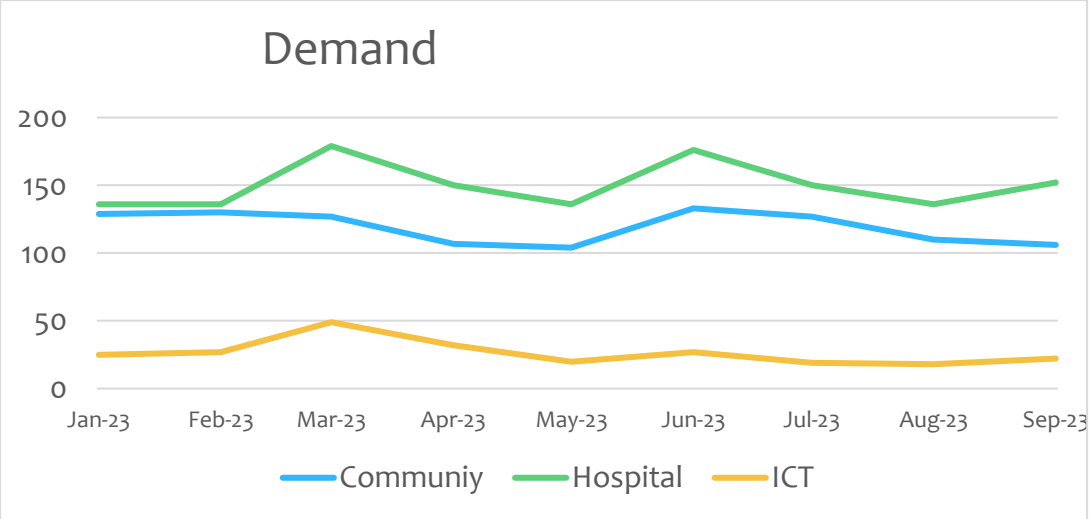
| 3.3 | **Winter Preparations** |
| | **Winter Preparedness Checklist**<br><br>In September 2023, ahead of the Scottish Government's Winter Plan, Health Boards and Health and Social Care Partnerships were asked to work in collaboration as a whole system to complete a Winter Preparedness Checklist to 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.<br><br>The Winter Preparedness Checklist was focused on the key areas as follows:<br><br>• Overview of preparedness and business continuity planning<br>• Urgent and Unscheduled Health and Social Care,<br>• Planned Care;<br>• Primary, Mental Health and Social Care;<br>• Health and Social Care Workforce and Staff Wellbeing.<br><br>**Whole System Discharge Planning Self-Assessment**<br><br>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 ministers that the Delayed Discharge and Hospital Occupancy Action Plan is being enacted as part of preparations for winter and the recent submission was for Quarter 2. We anticipate feedback from Scottish Government later in October 2023. |
| 3.4 | **Service Demands** |
| 3.4.1 | **Care at Home Service** |

Demand for Care at Home services remains high, and at approx. 30% of an increase from 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.

Across 2023, the service has 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 is fairly static however referrals via the hospital can experience high peaks in demand. What is challenging to articulate is the level of need and complexity for those requiring Care at Home supports however it is recognised that the landscape of traditional Care at Home supports has changed with people who have more complex health and social care needs choosing to be supported in their own homes. This is reflected in the recent Care at Home Assistant role review which supports the workforce in the undertaking of more advanced types of care and support.




In the month of September 174 Care at Home Packages were confirmed to support discharge from hospital, with a further 54 in the community.

The trend is further illustrated by the average number of people who received a Care at Home service on a weekly basis. Pre pandemic in 2019 to 2020 an average of 1,239 people on weekly basis across North Ayrshire were receiving care via inhouse delivery, compared to 863 people via external providers. Currently an average of 1,767 people on average on a weekly basis receive their care at home via inhouse Care at Home provision compared to 280 people via external providers.

This has significantly shifted from the position previously reported below:

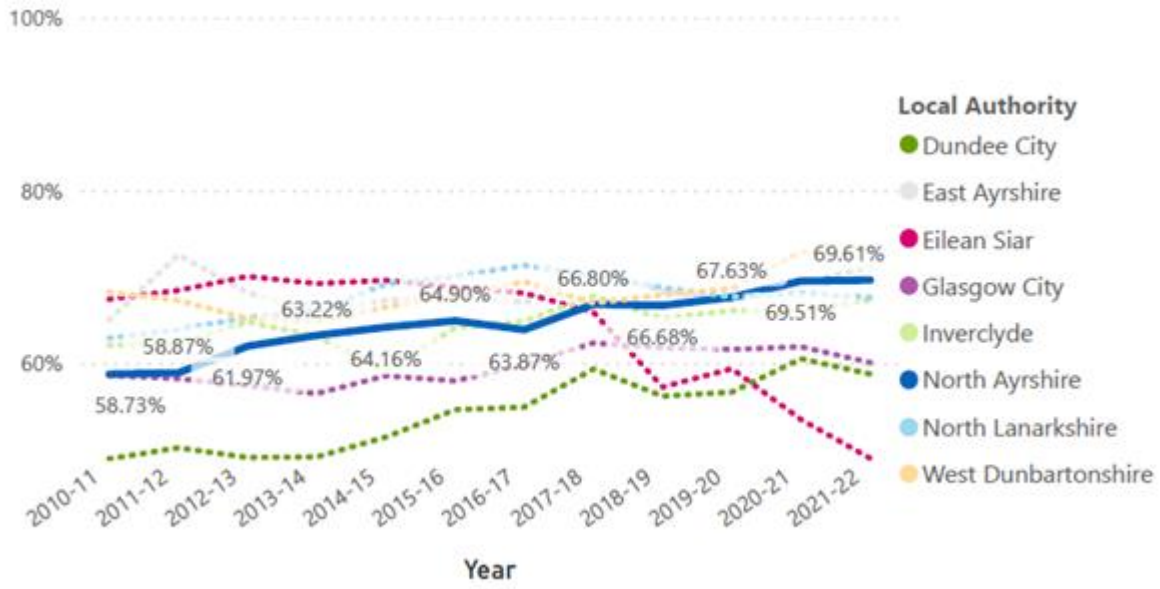
| | In House Service | | | Commissioned Providers | | |
|---|---|---|---|---|---|---|
| Calendar Year | Total No Supported Over Year | Average Weekly No | Total Planned Hours | Total No Supported Over Year | Average Weekly No | Total Planned Hours |
| 2019 | 2,524 | 1,239 | 400,000 | 878 | 863 | 300,000 |
| 2022 | 2,662 | 1,452 | 530,000 | 691 | 476 | 250,000 |

The level of Care at Home provision in place across North Ayrshire is further demonstrated by recent figures which detail over 12,300 hours of support (circa 640k annually) and 31,000 Care at Home visits provided on a weekly basis by the Partnership's In-house care at service, with a further 3,000 hours of support (circa 156k annually) provided on a weekly basis by commissioned care providers.

The most recent Local Government Benchmarking Framework (LGBF) information published for 2021-22 also demonstrates the impact this investment has on supporting people to remain supported at home.

The graph below illustrates North Ayrshire performance compared to our family group:

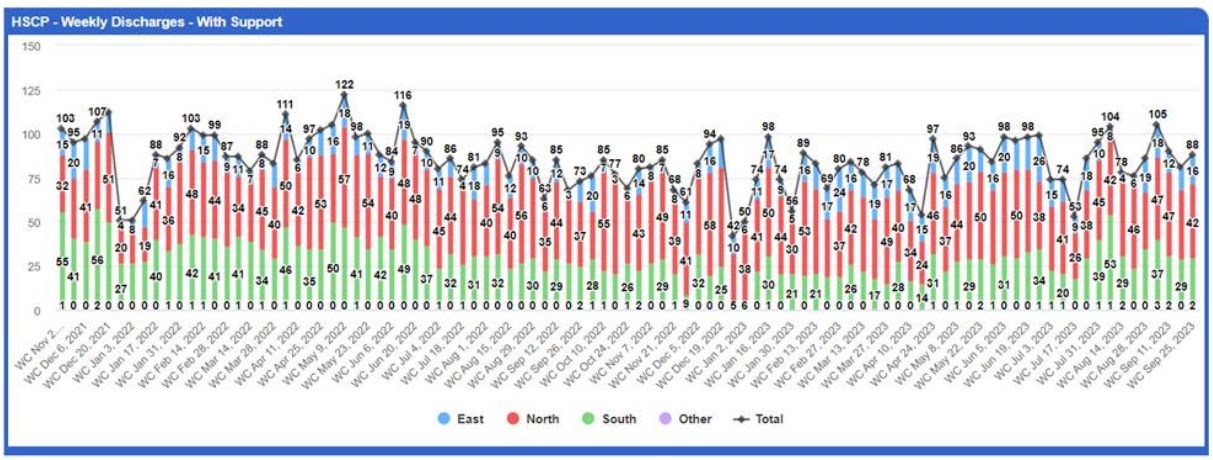
*Percentage of people aged 65 years and over with long-term health needs who are receiving personal care at home:*




North Ayrshire is continuing to improve performance in this area, providing the third best performance in our family group after West Dunbartonshire and East Ayrshire Councils (72.9% and 71.13% respectively). It should be noted, that due to data completeness issues, some data for this indicator has been modelled by the Improvement Service.

As noted we have seen an unprecedented increase in demand for Care at Home Services, which has increased by 30% since pre-pandemic levels.

The graph below further illustrates this and demonstrates the weekly discharges in A&A with support required to be in place:



We are acutely aware of the local demographic challenges our communities face and the impact 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. There is evidence emerging in relation to the impact of poverty-related health inequalities with more likelihood of ED attendance and a longer length of stay on admission. The North Ayrshire HSCP are engaging with Public Health colleagues and our LIST analyst in Ayrshire and Arran to understand the impact on our local population and the evident impact this is having on demand for our services, including Unscheduled and Long-Term Care needs.

3.4.2 **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 Reviews.

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

| Unmet Need Data Return | Jun-22 | Sep-22 | Jan-23 | Apr-23 | Jul-23 | Sep-23 |
|---|---|---|---|---|---|---|
| **Waiting for Social Care Assessment:** | | | | | | |
| Hospital | 1 | 3 | 3 | 2 | 2 | 3 |
| Community | 195 | 231 | 249 | 225 | 189 | 229 |
| **Assessed and Awaiting POC:** | | | | | | |
| Hospital | 27 | 18 | 25 | 25 | 21 | 33 |
| Community | 147 | 165 | 229 | 188 | 205 | 202 |
| **Awaiting a Statutory Review** | 339 | 299 | 360 | 318 | 297 | 346 |
| **Weekly Hours of Unmet Need** | | | | | | |
| Hospital | 325 | 216 | 341 | 304 | 251 | 359 |
| Community | 1,284 | 1,413 | 1,721 | 1,170 | 1,299 | 1,483 |

Over time there has been no significant improvement in the position in terms of unmet need and whilst the Partnership's inhouse Care at Home service has continued in its growth month on month, the benefit of this has been negated by both ongoing demand for services and the continuous reduction in capacity via independent care providers. It is not expected that there will be a demonstrable improvement without additional workforce resources and capacity being in place.

There remains a significant difference in the level of unmet need between individuals awaiting care in hospital compared to community, with almost 80% 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. A focussed piece of work is underway to review all individuals on the Care at Home waiting list to ensure any risks are identified and opportunities are maximised for promoting independence, in the last two weeks 165 people have been reviewed, with a changes identified for 13.

The North HSCP has undertaken a significant and ongoing programme of recruitment across the Care at Home service to ensure sufficient contingency and capacity to maintain the safe delivery of critical Care at Home supports in North Ayrshire. Whilst

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| | the impact of this recruitment is yet to be fully realised in terms of reducing the levels of unmet need in the community, it is evident that this has enabled the ongoing delivery of care to some of the most vulnerable people across our communities in recent times of crisis and challenge across the health and care sector. It is anticipated that reduction in delayed discharges and community waits will be realised upon successful recruitment of additional capacity planned for the service. Further information on recruitment activity can be made available to members on request. |
| 3.4.3 | **Care Homes - Pressures and Demand** |
| | 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 are particular concerns regarding the pattern of reducing bed availability, quality of care being provided resulting in moratoriums on new admissions and the future stability of the market. There have been a number of changes in the care home market in North Ayrshire in recent years including Providers taking the business decision to move from supporting both residential and nursing residents to only considering residents who have been assessed as requiring nursing care. There has also been the permanent closure of 2 care homes in North Ayrshire in the previous 24 months.<br><br>Whilst to date in North Ayrshire demand has not yet outstripped capacity the table below provides a summary of the current number of Care Home Placements funded by the Health and Social Care Partnership and bed availability, including interim bed availability, across older people's care homes in North Ayrshire. This evidences a continued and recent stark decline in bed availability. In practical terms this significantly limits the choice available to people and their families and is a further barrier to supporting people to be discharged from hospital without delay. |

| Month | Total Funded Placements | Care Home Bed Availability |
|---|---|---|
| Sep-22 | 759 | 56 |
| Oct-22 | 767 | 64 |
| Nov-22 | 777 | 55 |
| Dec-22 | 782 | 38 |
| Jan-23 | 751 | 71 |
| Feb-23 | 763 | 68 |
| Mar-23 | 757 | 71 |
| Apr-23 | 772 | 46 |
| May-23 | 765 | 50 |
| Jun-23 | 770 | 45 |
| Jul-23 | 774 | 36 |
| Aug-23 | 772 | 19 |
| Sep-23 | 788 | 28 |
| Oct-23 | 794 | 14 |

As part of plans to support discharge without delay, the North Partnership has successfully utilised interim beds throughout 2022 and 2023 to facilitate earlier discharge from hospital for those people who have been considered medically fit for discharge and require an assessment of their future care needs, however are unable to be discharged home. As detailed in the above table the availability of beds has been steadily reducing throughout 2023 and there are currently no interim beds available which presents a challenge to the Partnership's plans and supporting a

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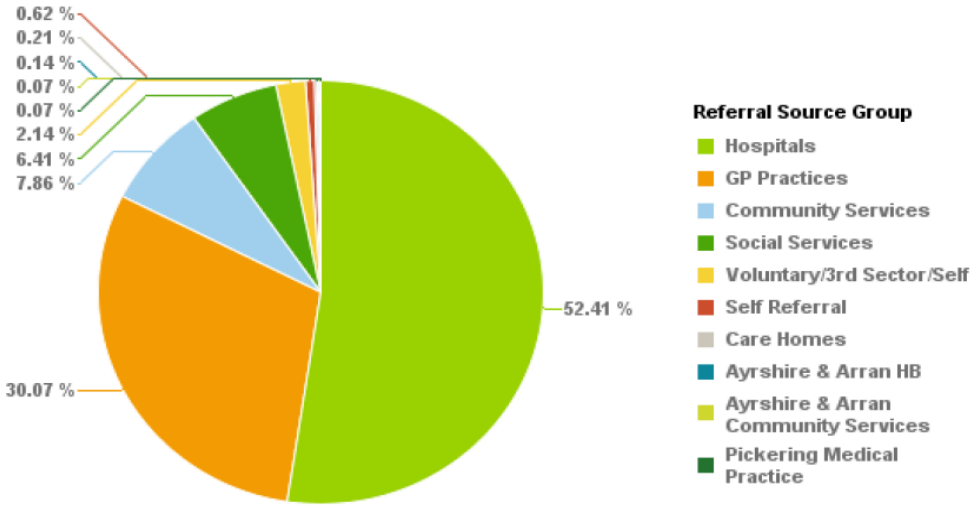
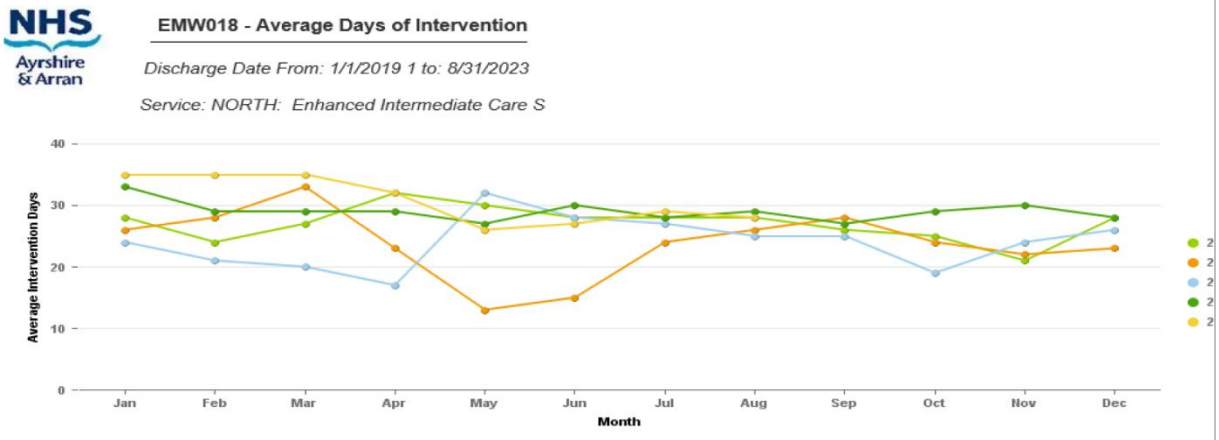
| | discharge to assess model. The Partnership has been engaging with the market in recent months and benchmarking across other HSCP's regarding the approach to commissioning interim beds. As a result, the Partnership is in the process of liaising with care homes who consider nursing referrals to commission 6 beds, ideally in one care home for a period of 6 months.<br><br>There have been positive developments in relation to support for Care Homes in North Ayrshire and this will continue over the winter period. Care Homes in Ayrshire have direct access to Urgent Care during the out of hours period for their residents. This includes redirection to other appropriate pathways. This results in a reduction in the need for Care Home residents to be conveyed to hospital for care, with much of this being provided in the preferred community setting. Between January 2023 and September 2023 there were 1,219 contacts to the Urgent Care Service regarding residents in North Ayrshire Care Homes. Of these, only 11% required onward referral to an acute hospital. |
| 3.4.4 | **Enhanced Intermediate Care Team (eICT)** |
| | 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 which is focussed on rapid access and problem-solving for people in their own homes across all of mainland North Ayrshire. The service safely supports a dynamic caseload of around 150 patients at any one time, who require rehabilitation and reablement due to falls, frailty, low grade infections and general functional decline. The team brings together a skilled and experienced group of Physiotherapists, Occupational Therapists, Technical Instructors, Dieticians, Community Psychiatric Nurses, Pharmacists, Admin workers, Rehabilitation Nurses, Advanced Nurse Practitioners (ANP) and Intermediate Care General Practitioners with Special Interest (GPwSI) into one single team. They provide a rapid response to referrals (same day or next day) and focus on providing alternatives to hospital admission. The Enhanced element of ICT is solely in place in North Ayrshire, and whilst cannot undertake all of the functions of a Hospital at Home consultant/acute led service (which is being developed/implemented in East and South Ayrshire), it does provide a robust alternative and addition in North Ayrshire to our ICT service.<br><br>The ICT model and investment across Ayrshire and Arran was implemented during 2018, with no formal review undertaken of the service since its launch. A review has commenced 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.<br><br>The below tables demonstrate some of the recent performance and activity of the eICT service: |

**01/04/2022 - 31/03/2023**

| Referral Source Type Sub Group | No. of Referrals | No. of Saved Bed Days |
|---|---|---|
| Early Supported Discharge | 636 | 1,908 |
| Prevented Hospital Admission | 814 | 8,140 |
| Total | 1450 | 10048 |

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| 3.5 | **North Ayrshire - Winter Preparedness and Delayed Discharge Improvement Plan** |
| | The Health and Community Care teams, alongside Mental Health colleagues, have developed a local winter preparedness and delayed discharge improvement plan in response to current service performance levels and community unmet need in anticipation of seasonal demands to ensure resilience across the health and care system. |

This is summarised below:

| Workstream | Service Lead |
|---|---|
| **Care at Home Capacity –** strengthen and enhance capacity within the inhouse Care at Home workforce through effective management of absence, recruitment and retention | Service Delivery Teams |
| Key Actions:<br>• Arran recruitment strategy<br>• Mainland Care at Home recruitment strategy<br>• Care at Home recruitment trajectory<br>• Service specific training plans, for example SVQ opportunities<br>• Staff engagement and wellbeing support<br>• Wellbeing at work action plan | |
| **Waiting List and Unmet Need** – to provide alternative approaches to managing capacity and demand and ensure safe systems for oversight | Locality Social Work /Reablement/Service Delivery Team |
| Key Actions:<br>• Reablement outcomes and skills-based approach to waiting list review<br>• Reablement outcomes and skills-based approach to review of all care delivery<br>• Moving and Handling service developments<br>• Unmet need oversight and assurance group<br>• Care management system software developments<br>• Promotion of tech solutions including Community Alarm services | |
| **AWI/Guardianship** – to review current systems, practice and processes to ensure safe and timely discharge of adults with incapacity | Locality Social Work Teams |
| Key Actions:<br>• Pan Ayrshire benchmarking<br>• Pan Ayrshire discharge planning protocol<br>• Guardianship activity oversight, including the use of 13za<br>• MHO lead to support discharge planning<br>• Early Referral pathways<br>• Timescale for hospital-based capacity assessments | |
| **Discharge to Assess** –to further enhance the hospital-based assessment team systems to support the Discharge without Delay ethos of good discharge planning | Locality Social Work/Service Delivery/Long Term Conditions Teams |
| Key Actions:<br>• Interim bed capacity<br>• Early referral and assessment timescales<br>• MDT and Planned Date of Discharge<br>• Daily locality meetings and Senior Management escalation/oversight<br>• Hospital Co-ordinator and link to community wards<br>• Develop demand and capacity dashboard<br>• Arran Unscheduled care response plan including intermediate care and step down | |

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| | **Mental Health and Learning Disabilities** – to support Discharge without Delay and provide alternatives to hospital admission | Mental Health and Learning Disability Teams |
| | Key Actions:<br>• Interim/Step Down bed capacity for complex needs<br>• Open Adult MH assessment unit in Woodland View as 72 hour assessment unit<br>• Grow Adult provider capacity and sustainability<br>• Engage with other LA/HSCP/Board areas re OOA patients | |
| **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 in North Ayrshire, unfortunately the desired improvements have not yet been achieved.<br><br>• The Flow Navigation Centre continues to be effective in diverting a high number of patients to avoid presentations at acute hospital settings.<br>• Average length of Stay in both acute sites has reduced slightly for non-delayed patients but still remains high.<br>• Priority performance areas, ie 4 hour compliance and 12 hour breaches, have been set ambitious targets as part of the Urgent and Unscheduled Care Improvement Plan (2023-24) and whilst there have been some short periods of improvement these areas both remain off target and an area for concern.<br>• Delayed discharges in North Ayrshire have fluctuated throughout 2023, reducing to lower levels in mid 2023 however since July 2023 these have fluctuated and seen the highest level of delays recorded all year.<br>• Community unmet need has 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 have increased in recent months which is a concern going into the 2023-24 winter period.<br>• There is a significant level of risk being held in the system and in our communities.<br>• 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.<br><br>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 over the winter period. 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. This will be further supported by whole system planning linked to the recent Discharge Planning Self-Assessment and Winter Preparedness Checklist. | |
| 3.2 | **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 | |

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| | performance and direct further interventions if future performance does not improve in line with plans. |
| 3.3 | **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. |
| **4.** | **IMPLICATIONS** |

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| **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.<br><br>North Ayrshire IJB are reporting a projected overspend for 2023-24 with recovery actions in progress, therefore there is no further resource available.<br><br>The report highlights that acute services in Ayrshire and Arran are projecting additional costs due to unfunded beds which remain open across both sites, a total overspend of £4.7m to period 5. As a consequence, the Health Board Director of Finance has approached the 3 HSCP Chief Officers to request that HSCPs/IJBs make a payment to the Health Board for delayed discharges. |
| **Human Resources:** | Workforce across the system remains the greatest 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. |

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| **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 |

| | | |
|---|---|---|
| **Direction Required to Council, Health Board or Both** *(where Directions are required please complete Directions Template)* | Direction to :- | |
| | 1. No Direction Required | √ |
| | 2. North Ayrshire Council | |
| | 3. NHS Ayrshire & Arran | |
| | 4. North Ayrshire Council and NHS Ayrshire & Arran | |

**Kerry Logan, Head of Service Health and Community Care, klogan@north-ayrshire.gov.uk o**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 2023 – Unscheduled Care Performance Update**:**

IJB Report Nov 2022 - Unscheduled Care F