Integrated Services

1. **Does NHS Highland consider it is addressing adequately the quality of life for patients in delayed discharge from hospital and on care at home packages?**

Argyll and Bute Health and Social Care Partnership

Argyll and Bute Health and Social Care Partnership (HSCP) remains committed to realising the objectives set out by the First Minister, as part of the national mission to reduce delayed discharges. That said, we do acknowledge that some people continue to experience a delay whilst we are undergoing our service redesign and system transformation. We are confident that determined efforts are made to ensure good quality of life for those patients who are delayed in hospital. Patient choice and control is central to our approach, and we are clear that the needs and wellbeing of all our patients is central to our assessment and care management processes; we continue to ensure that planning has a core focus on enablement, re-ablement and maximising independence, at every stage.

Our current planning centres around assessing people in their own homes so that they can get home sooner, which aims to ensure that these goals are maximised with as little delay as possible. Recent initiatives to supplement care for those who experience delay have included focussed support from our volunteers within ward environments and a meaningful activity programme, which supports our patients to stay active and connected within out hospital spaces - this includes facilitating access to community services and supports. We are also committed to facilitating and improving carer and family involvement.

Highland Health and Social Care Partnership

There are currently 39 people in delay who are waiting on Care at Home packages or increase to a package of care (18% of total delays). All individuals are discussed by the integrated team through the Decision-Making Team (DMT) process. Patients, families/carers are also included in discussions to ensure that wishes and appropriate plans/support is put in place. Where possible we will work with other providers and family members to expedite any discharge. We will also work with families to ensure awareness of all options including Direct Payment. We share information re options such as this with the wider community as part of our work with the independent and third sector. In several districts, we run community “Pop-Up Hubs” which are used to involve the public and enhance awareness of community alternatives. Staff also undertake meaningful activities with patients to improve their quality of life, cognition and reduce stress across our delayed discharge ward, Neuro-rehabilitation unit and Elderly wards.

Ward 4A have afternoon tea every Thursday and a games afternoon every Friday. This is through the good will and kindness of their own staff, taking in home baking and using donated games. Many of the staff come in on their time off to attend these sessions to provide plenty of interaction. They have organised music sessions throughout December to prepare for the festive season - again this is done through volunteer work

and good will. Spokes for Folks is the volunteer trike rides who take patients out around the grounds of UHI and beyond - Ward 4A are setting this up.

As a more established ward, 2C make excellent use of the volunteer service for meaningful activities. They have a variety of board and card games on the ward and the volunteers visit multiple times per week to engage with meaningful interactions.

We have two therapy dogs visiting the medical wards twice per week - Red and Bonnie.

Integrated Services

2. **How many people are waiting on adult social care assessments in NHS Highland's area?**

Argyll and Bute Health and Social Care Partnership

As of 10 November 2024, seven people are awaiting an adult social care assessment from a discharge perspective. This accounts for 15% of all patients currently in delay. The average timescale for these assessments is currently 28 days, which is inside the national target.

Highland Health and Social Care Partnership

There are currently 32 people waiting on assessment (15% of total delays), of which 17 are in Raigmore. Those individuals are being supported by the social work In-reach team. All individuals are discussed at their District Decision-Making Team DMT. DMT has representation from social work, care at home, community nursing and Allied Health Practitioners and community hospitals (and Rural General Hospitals where applicable).

Integrated Services

3 **How will NHS Highland mitigate against market forces in using private care providers, and what is being done to address the shortage of placements in rural communities?**

Argyll and Bute Health and Social Care Partnership

A Provider Stakeholder Group is in place for care homes, to support independent providers. Work is ongoing in the Island of Mull to look at provision, and capital work to expand placements in Bute is being planned. Long term work with Hub North is being conducted to look at long term demand and models of care.

Highland Health and Social Care Partnership

NHS Highland continues to recognise the importance of having in place clear care commissioning strategies and market facilitation plan, to support its Joint Strategic Plan

intentions. This need is even more pressing and an increasing priority, with the further sector turbulence being experienced and reduced service capacity currently available.

We are working on a Joint Strategic Needs Assessment (JSNA), which was not ready to be included within the original Joint Strategic Plan agreed late 2023.

We are also creating the dedicated resources needed to develop this critical area of strategic work around locality modelling, forecasting and engagement. This activity needs to be progressed separately from operational activity but must be informed by it.

In terms of timescales, the appointment of resources will inform the speed of this area of activity, but it is anticipated that whilst a JSNA may be available by the end of the financial year, and a care strategy of more detailed intentions also available by this time, the detailed work by localities will be a longer-term iterative process taking place over the next 2 years.

Integrated Services

4 What is NHS Highland doing to ensure equality of access to community nursing, social and Allied Health Professional care, and how will you maintain and improve access particularly for people in rural areas?

Argyll and Bute Health and Social Care Partnership

Single Point of Contact arrangements are currently under review for Argyll and Bute HSCP, as part of our service review/redesign. This work includes a focus on our multi-disciplinary assessment and allocation arrangements, which aims to improve allocation so that cases are managed in the right place, at the right time, and by the right team(s).

We are committed to ensuring that our assessment and care management redesign process is sighted on holistic approaches to care planning; in other words, we aim to look at the totality of care need in every case to ensure that we have the right professionals involved, that we reduce duplication where it exists, and that we remain focussed on our enabling ethos. In support of this work, we also remain focussed on developing and implementing our Digital First agenda, which aims to support wider connectivity and equity of access to services by using virtual/digital modalities (where appropriate and in line with assessment protocols).

Highland Health and Social Care Partnership

All districts have core integrated teams which include community nursing, Care at Home, Allied Health Practitioners (Physio, Occupational Therapy for example), Social Work, care homes and community hospitals. These teams are based in the district/area in which they work. Based on professional judgement tools, annual reviews of activity and demand are carried out with establishment and staffing based on the outcomes.