AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**27 January 2025**
Report By:	**Kate Rocks Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/52/2024/CG**
Contact Officer:	**Laura Moore, Inverclyde HSCP Chief Nurse & Alan Best Head of Health & Community Care Inverclyde Health & Social Care Partnership**	**Contact No:**	**01475 715212**
Subject:	**Inverclyde HSCP Collaborative Care Home Support Team (CCHST)**		

1.0 PURPOSE AND SUMMARY

1.1 ☐For Decision ☒For Information/Noting

1.2 The purpose of this paper is to advise and provide assurance to the Integration Joint Board of the work that is overseen by the local Collaborative Care Home Support Team (CCHST) including significant areas of improvement and good practice.

2.0 RECOMMENDATIONS

2.1 Members of the Integration Joint Board are asked to note the contents of this report and the assurance concerning the work of the HSCP Collaborative Care Home Support Team (CCHST).

Kate Rocks
Chief Officer
Inverclyde Health and Social Care Partnership

3.0 BACKGROUND AND CONTEXT

3.1 In June 2020, Executive Nurse Directors (END) were instructed by the Cabinet Secretary for Health and Social Care to be accountable for the provision of nursing leadership and support and guidance within care homes. Further to this Scottish Government allocated funding to NHS Boards to support this work.

In December 2022 a Letter setting out new arrangements for NHS Boards and local authorities in providing enhanced clinical and care support for care homes were received confirming new arrangements for providing enhanced collaborative clinical and care support for social care in Scotland. The letter focused on building on current good practice to strengthen collaborative cross sector support to care homes. A number of recommendations were developed with the overall focus on continued enhanced support for adult and older people's care homes to support the sector as it emerges from the pandemic.

3.2 The recommendations support a partnership approach, which recognises the experience of care home staff and the provision of support to care homes in the context of ensuring a homely environment in which people live and work. The letter provides guiding principles and a framework which recommends that health and social care professionals continue to work together to identify ways to improve the health and wellbeing of people living in care homes, as described in My Health, My Care, My Home - healthcare framework for adults living in care homes published by Scottish Government in June 2022 and Health and Social Care Standards in Scotland.

Across NHSGGC the Care Home Collaborative (CHC) was set up to support the Executive Nurse Directors (END) function in 2021 with money received annually from Scottish Government. The Care Home Collaborative (CHC) support training and education locally, provides specialist support and advice and work to provide additional leadership, support and guidance to all care homes across NHSGGC. All HSCPs set up local multi-disciplinary care home huddles, now called Collaborative Care Home Support Teams (CCHSTs) to support the requirements.

3.3 Inverclyde HSCP Collaborative Care Home Support (CCHST) meetings take place weekly with multi-disciplinary membership including - Community Nursing, Chief Nurse, Commissioning, Social work, mental health, care at home and Care inspectorate colleagues. The meeting is chaired by the Interim Head of Service for Health and Community Care and the agenda includes updates on any areas of concern, work related to the implementation of the Healthcare framework, national and local care home meeting / policy updates, Care Inspectorate feedback and discussion of Adult Support and Protection concerns. The meeting facilitates a Multi-Disciplinary Team (MDT) approach, whereby all relevant members of the teams can work together to support the care home teams. The team are supported by wider members of the Multi-disciplinary Team (MDT) including Allied Health Professionals (AHPs), pharmacy colleagues and psychiatry.

The Collaborative Care Home Support (CCHST) continue to use the Collaborative Care Home Support (CCHST) weekly care home report to Red/Amber/Green rate any concerns for local care homes, this is submitted to the Care Home Collaborative (CHC) weekly. Discussion takes place at the Collaborative Care Home Support (CCHST) however a full Multi-disciplinary Team (MDT) meeting is often held to support delivery of a detailed action plan when homes require further support e.g. - when grades reduce by Care Inspectorate or significant event reporting highlights trends. Action plans are agreed with home managers to support and guide care homes. This approach has been commended by the Care Inspectorate who are part of all discussions.

3.4 The overall objective for the Collaborative Care Home Support (CCHST), in line with the My Health – My Care – My Home: Healthcare framework for adults living in care homes, is to work collaboratively with care home staff to improve the health and wellbeing of people living in care homes. In May 2024 Scottish Government confirmed that they would like to see increased

consistency of best practice across Scotland and expect this to be reflected in the Board reports on the allocated spending. A decision on baselining the funding from 2025 onwards will be based on these reports. NHSGGC has reviewed governance structures in relation to all aspects of Care Home work led by the Executive Nurse Director and HSCP Chief Officers and new governance process are now in place.

3.5 **Evidence of Impact Return**

In November 2024 NHSGGC were asked by Scottish Government to complete an Evidence of Impact return in order to provide evidence of the Collaborative Care Home Support (CCHST) across NHSGGC with regard to –

- Assurance that the Board is providing nursing leadership, support and guidance within care homes
- Additional support provided to care home residents, families and staff as a result of this funding
- Assurance that teams are both working collaboratively with care home staff, and meeting the needs of care home residents and staff
- Impact of the funding
- Learning from the work and ongoing evidence

Every HSCP completed their own template which was returned to the Care Home Collaborative (CHC) who collated all of their own evidence with that of the HSCPs in to one document which was returned to Scottish Government. National and local feedback is awaited in response to this return.

3.6 The Evidence of Impact document for Inverclyde provided a good overarching picture of the work that is overseen by the local Collaborative Care Home Support Team (CCHST) including significant areas of improvement and good practice. The aim of this paper is to provide a comprehensive update on the Collaborative Care Home Support (CCHST) work in relation to care homes and to showcase the good practice.

3.7 **Care Home Assurance Tool visits**

Inverclyde HSCP carry out annual Care Home Assurance Tool (CHAT) visits to all Inverclyde Care Homes - older adult, adult and Inverclyde Association for Mental Health (IAMH) care homes (17 in total). The last round of visits took place in Summer 2024. Managers were informed of the planned visits and self-assessed their current position against the criteria prior to the visit. Visiting teams utilised the previous visit report and the self-assessment to prepare them with a background on the home and their current situation. Visiting teams are made up of a group of up to four staff representing nursing, commissioning, social work and a senior nurse leading the visit from the HSCP. Themes for 2024 included the need for RESTORE 2 and RESTORE mini training to assist homes to recognise deterioration of residents, this has now been delivered to all homes. Care Home Liaison Nurses (CHLN) and other Multi-disciplinary Team (MDT) members support care homes as required with any agreed actions from Care Home Assurance Tool (CHAT) visits, to maintain continuous improvement and to share good practice. These visits are over and above the routine contractual processes and day to day multi-disciplinary support to homes.

3.8 **Stress and distress training**

As a result of numerous AP1's and discussions with care homes, NHS Education for Scotland (NES) Essentials in Psychological Care – Dementia training programme led by the Local Clinical Psychologist and the Care Home Collaborative (CHC) was delivered locally. The training supports the development of key skills, knowledge and competencies for staff to be proactive to

prevent distressed behaviour arising in a person living with dementia. The Collaborative Care Home Support (CCHST) identified a local increase in AP1's and concerns related to stress and distress, and this was discussed at a Quarterly meeting with all local care homes. It was agreed collaboratively that training would be held at different venues and times at the request of the care homes to facilitate attendance and nearly seventy staff attended the sessions.

Feedback received to date from the training events to date includes -

- "increased my understanding of stress & distress – trainers were excellent"
- "great training"
- "presentations were interesting and motivational"
- "I felt all the training was helpful"

Pre and post course participant scorings show a definite shift towards increase/improvement in knowledge of dementia and use of behaviour charts.

3.9 **Call Before You Convey (CB4YC)**

Inverclyde HSCP rolled out a Call Before You Convey (CB4YC) model which commenced December 2023.

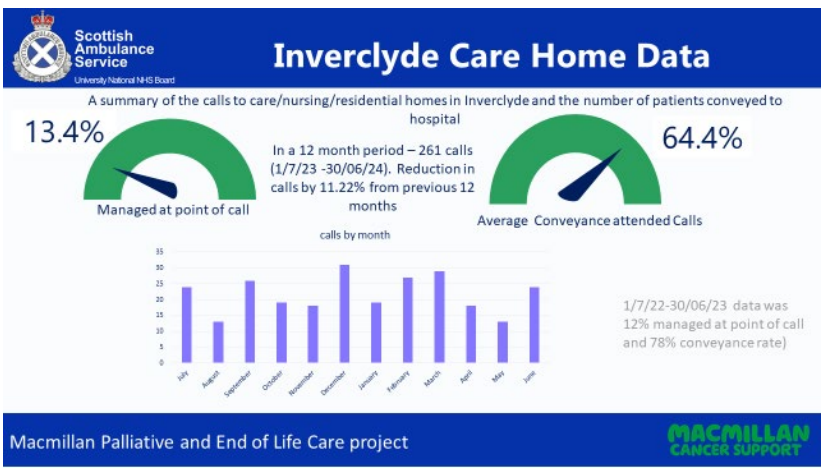
The agreed staffing model and clinical escalation was:

- an additional Band 6 District Nurse (DN) rostered each weekend to provide capacity to visit care homes as required
- weekend cover provided by Advanced Nurse Practitioner (ANP) working additional hours, to be called out as required by District Nurse (DN) team
- direct access to professional advice from Ardgowan Hospice during the weekends for both care homes and District Nurse (DN)/ Advanced Nurse Practitioner (ANP)

Due to this senior clinical support provided by Ardgowan Hospice, the Call Before You Convey (CB4YC) model in Inverclyde was limited to residents with Palliative and End of Life Care needs initially.

A virtual ward meeting is held weekly at which community nursing staff, care home staff, hospice nurse/ doctor highlight and discuss any deteriorating residents. There is an open invite for care homes to attend the virtual ward.

Scottish Ambulance Service (SAS) data shows that in the 12 months (July 2023 to June 2024) there has been a reduction in calls to SAS of over 11%. 13.4% of those where an ambulance was called were managed at the point of call, up from 12% in 2022/23 and only 64.4% were conveyed.



Pilot results to date show that from December 2023 to end August 2024, 37 care home residents were discussed as part of the pilot, and they ALL died in their care home and were not conveyed. Professionals involved in this pilot have spent significant time with families, care home staff, Scottish Ambulance Service (SAS) and individuals themselves to assess and manage deteriorations appropriately and in their professional opinions the majority if not all of these residents would have been conveyed without this service. The main learning points have been the need for increased palliative and end of life care education, the need to communicate effectively with care home residents and their families and the need for anticipatory discussions and planning as people start to deteriorate – recognising dying.

The Collaborative Care Home Support (CCHST) commissioned Ardgowan hospice to run a 6-week education programme with the aim of establishing Palliative Care champions within our 13 older people's care homes across Inverclyde as part of the Call Before You Convey (CB4YC) pilot.

The program ran for 6 weeks and included locally delivered face to face sessions which helped staff build up a network with each other and gave them the opportunity to share experiences. A Google Classroom was also set up as a learning platform to share resources and each nurse was asked to identify a Quality Improvement project which would be supported by Hospice and Care Home Liaison Nurses.

Feedback from the Call Before You Convey (CB4YC) pilot was overwhelmingly positive. Ten feedback forms were received, and everyone, when asked, 'How confident do you feel getting in touch with the hospice team for palliative care advice?' scored 5/5 – very confident.
Feedback included:

- I have found all the sessions to be very informative and helpful
- I am now no longer afraid to challenge doctors and colleagues regarding palliative medications and seeking advice
- It has been very intense…but has been a very good course
- Sessions have been pitched at a very easily absorbed level
- Every professional who has given talks throughout the course has been excellent, very informative… and has shown that there is an amazing team [at the hospice] to support people at the end of life

Since completion there has been a significant increase in calls to the Hospice advice line from care homes which participated in the training (Dec 22-March 23 = 6 calls, Dec 23-Sept 24 = 27 calls), evidencing that care home colleagues are seeking advice and support as required.
Callers have been comfortable using the Palliative Performance status taught in the course to aid a commonality of language.

Due to the success of the initial course a second one is in progress and a further course is planned for Spring 2025.

3.10 **Urinary Tract Infection (UTI)**

As a result of a local care home having a significant rise in the numbers of UTI's (11 in month) the Collaborative Care Home Support (CCHST) liaised with the care home and agreed to request support from the Care Home Collaborative (CHC) team.

The aim of the project was to achieve a 10% increase in fluid intake for the 5 residents with the most frequent instance of UTI. Actions included -

- Hydration posters were displayed around the home to raise awareness on the importance of
  adequate hydration
- The introduction of the visual drinks menu promoting the variety of different drinks on the trolley
- Introduction of hydration stations to support resident access to fluids
- Introduction of meaningful activity prior to a hydration round, promoting the 'feel-good' social aspects of eating and drinking with others.

The results included -

- A reduction in instance of Urinary Tract Infection (UTI)
- 26% increase in fluid intake over the course of the project and maintained this in the absence of the Care Home Collaborative (CHC) team.
- The team all reported noticing benefits to their residents.

- Improved quality of fluid intake recording over the course of the project (accurate completions, refusals documented and sources of fluids).

3.11 **Falls Pathway**

Inverclyde care homes participate in the NHSGGC Falls pathway and have been provided with iPads as required to support this. Inverclyde HSCP has implemented targeted support initiatives for care homes to address the critical issue of falls among residents. By providing specialised training for staff, the HSCP equips caregivers with the skills needed to assess fall risks and implement preventive measures.

This includes conducting regular safety audits and promoting physical activity. Additionally, the HSCP closely monitors reported falls and identifies care homes with patterns of increased incidents, ensuring they receive focused support and resources. When a pattern of risk is identified, our Rehabilitation and Enablement Services (RES) employ a multidisciplinary approach to support individual fallers, collaborating with various health professionals to create personalized intervention plans. The local team provide care homes with falls resources and training videos and can arrange a falls follow up Q&A and/or training session, taking an interactive approach for example with - sensory impairment glasses that show how it feels to have a visual impairment and the team talk through any case studies about residents who are falling and encourage staff to come up with solutions themselves, so that they engage with the process.

The Rehabilitation and Enablement Services (RES) team are also working with Scottish Ambulance Service (SAS) around prevention of conveyance giving priority around rehab for these residents as well as aligning Allied Health Professional (AHP) support workers to each care home to support walking aid reviews.

4.0 PROPOSALS

4.1 The Integration Joint Board is asked to note the evidence that has been collated which contributed to the Scottish Government Evidence of Impact return in November 2024. The evidence demonstrates improvements and good practice in Inverclyde Care Homes which has been supported by the local Collaborative Care Home Support (CCHST) Multi-disciplinary team and the Care Home Collaborative (CHC).

5.0 IMPLICATIONS

5.1 The table below shows whether risks and implications apply if the recommendation(s) is(are) agreed:

SUBJECT	YES	NO
Financial		x
Legal/Risk		x
Human Resources		x
Strategic Plan Priorities		x
Equalities, Fairer Scotland Duty & Children and Young People		x
Clinical or Care Governance		x
National Wellbeing Outcomes		x
Environmental & Sustainability		x
Data Protection		x

5.2 **Finance**

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A					

5.3 **Legal/Risk**

None.

5.4 **Human Resources**

None

5.5 **Strategic Plan Priorities**

None

5.6 **Equalities**

(a) Equalities

This report has been considered under the Corporate Equalities Impact Assessment (EqIA) process with the following outcome:

	YES – Assessed as relevant and an EqIA is required, a copy of which will be placed on the HSCP section of the Council website: **HSCP Equality Impact Assessments (EIA) - Inverclyde Council**
NO	NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, assessed as not relevant and no EqIA is required. Provide any other relevant reasons why an EqIA is not necessary/screening statement.

(b) Equality Outcomes

How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
We have improved our knowledge of the local population who identify as belonging to protected groups and have a better understanding of the challenges they face.	Positive Impact
Children and Young People who are at risk due to local inequalities, are identified early and supported to achieve positive health outcomes.	N/A
Inverclyde's most vulnerable and often excluded people are supported to be active and respected members of their community.	Positive Impact
People that are New to Scotland, through resettlement or asylum, who make Inverclyde their home, feel welcomed, are safe, and able to access the HSCP services they may need.	N/A

(c) Fairer Scotland Duty

If this report affects or proposes any major strategic decision:-

Has there been active consideration of how this report's recommendations reduce inequalities of outcome?

	YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
NO	NO – Assessed as not relevant under the Fairer Scotland Duty for the following reasons: Provide reasons why the report has been assessed as not relevant. See above.

(d) **Children and Young People**

Has a Children's Rights and Wellbeing Impact Assessment been carried out?

	YES – Assessed as relevant and a CRWIA is required.
NO	NO – Assessed as not relevant as this report does not involve a new policy, function or strategy or recommends a substantive change to an existing policy, function or strategy which will have an impact on children's rights.

5.7 **Clinical or Care Governance**

The CCHST continue to use the CCHST weekly care home report to RAG rate any concerns for local care homes, this is submitted to the CHC weekly. Discussion takes place at the CCHST however a full MDT meeting is often held to support delivery of a detailed action plan when homes require further support e.g. - when grades reduce by Care Inspectorate or significant event reporting highlights trends. Action plans are agreed with home managers to support and guide care homes. This approach has been commended by the Care Inspectorate who are part of all discussions.

5.8 **National Wellbeing Outcomes**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Positive Impact
People, including those with disabilities or long-term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Positive Impact
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Positive Impact
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Positive Impact
Health and social care services contribute to reducing health inequalities.	Positive Impact
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	N/A
People using health and social care services are safe from harm.	Positive Impact
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Positive Impact
Resources are used effectively in the provision of health and social care services.	Positive Impact

5.9 **Environmental/Sustainability**

Summarise any environmental / climate change impacts which relate to this report.

Has a Strategic Environmental Assessment been carried out?

	YES – assessed as relevant and a Strategic Environmental Assessment is required.
NO	NO – This report does not propose or seek approval for a plan, policy, programme, strategy or document which is like to have significant environmental effects, if implemented.

5.10 **Data Protection**

Has a Data Protection Impact Assessment been carried out?

	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.
NO	NO – Assessed as not relevant as this report does not involve data processing which may result in a high risk to the rights and freedoms of individuals.

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	x
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 None

8.0 BACKGROUND PAPERS

8.1 None.