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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

Building Community Capacity

Report by Chief Officer, Health and Social Care

PURPOSE OF REPORT

1. To update the Joint Board on our wider strategy to build community capacity, as a way of limiting the growth in demand for formal health and social care services.

COMPETENCE

2. The matters arising in the report have no immediate legal or HR implications. The paper proposes that we participate in a national project, working with a Scottish Government-sponsored third sector body to help us build community capacity as a means of reducing demand for formal care. This will involve a one-off cost of circa £40k, which will be funded from IJB reserves.

SUMMARY

3. The Integration Joint Board has responsibility to ensure that local health and social care services can respond to growing levels of demand. These challenges have been well-trailed within the IJB strategic plan, with growing levels of dependency in older adults who have care and support needs and a growth in other population groups, such as adults with disabilities.

4. This report focuses on the work we're doing to build community capacity, and suggests:
    - That unless we take action to constrain the growth in demand for services, we will become increasingly unable to meet public expectation and general levels of need;
    - That there is untapped potential to develop a more connected community sector in the Western Isles, which will enhance our ability to prevent or delay the escalation of need;
    - That we need to engage in a wider public debate about the expectations on the health and care system and the degree to which individual citizens bear responsibility for their health and well-being; and
    - We should enter into partnership with NDTi (the National Development Team for Inclusion), which is a not-for-profit organisation working with the Scottish Government and Healthcare Improvement Scotland to support partnerships to build community capacity and improve the interface with formal health and care services.

RECOMMENDATIONS

5. It is recommended that the IJB:

    (a) Comments on the wider ambitions we have to constrain demand for services and discuss how best community assets can be used in support of this objective;
    (b) Agrees that we enter into partnership with NDTi in support of this agenda, and that the costs associated with the work be funded from IJB reserves.

Ron Culley, Chief Officer
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CONTEXT

6. Since 2016, through careful financial management, better than anticipated income generation and ongoing recruitment challenges, the IJB has developed reserves which are capable of being invested in our long-term strategic objectives. Recognising systemic challenges around population retention and a sustainable workforce, we have developed a five year investment plan, focused on three broad areas:

    - Investment in a Sustainable Workforce
    - Investment in Digital Innovation and Infrastructure
    - Investment in Service Transformation

7. These baskets of reform will be important to progress if the IJB is to deliver on the objectives set out in the strategic plan. Given that our workforce challenges are, if anything, becoming more acute, it is all the more important that we take advantage of the reforms expressed under digital innovation and service transformation.

8. In respect of the latter, we have set aside monies to support primary care reform, mental health redesign and palliative care – but importantly, we also want to invest in community capacity and grow informal sources of support, as a way of helping people to retain their independence and live purposeful lives.

9. We have been pursuing different strands of work under this broad banner, but have been unable to devote the requisite time and energy to them in order to produce the desired outputs. For example, we have a programme of reform we're seeking to advance which seeks to support those adults living in the community who present with what might be described as 'soft vulnerability', i.e. people who don't yet need or qualify for formal care but for whom need is escalating and who are exposed to a range of everyday risks such as trips and falls, social isolation, fuel poverty, and so on. Within this context, we have developed a programme board to look at how improved multi-agency communication and referrals could better support those individuals and reduce risk/escalation of need. However, partners have found that while all are committed to it, this work is often deprioritised in the face of day-to-day operational pressures and the need to advance bigger and more time critical packages of service reform.

10. Similarly, we have developed a locality planning infrastructure across the five areas of the Western Isles to enhance the connection between the statutory providers of health and social care and communities. While we have done what we can to develop this work, there is no doubt that it too suffers from a lack of capacity.

11. It was for these reasons that the IJB agreed at its meeting in September of this year to fund a community engagement post, using reserves, to support wider community development, locality planning and communications. We are currently in the process of bringing this job into being, which we see as having an initial 18-month tenure.

A STEP CHANGE IN MANAGING DEMAND

12. The older adult proportion of the population is projected to increase for all partnership areas but is greatest in the Western Isles, with 37.1% of the population predicted to be aged 65+ by 2037. The impact of depopulation and an ageing society is that we will have a smaller workforce to support our health and social services, and a smaller number of unpaid family carers. This presents a very challenging circumstance to support our older citizens into the future.

13. We will also see a rise in numbers of people living alone. The Western Isles already has the greatest proportion of lone pensioner households in Scotland – and this is likely to increase into the future. This is particularly significant as living alone has strong associations with social isolation and loneliness, which increase risks to health for people with dementia and depression.

14. These core demographic trends indicate that we are working with a rising tide of demand for services. In response, we have sought to develop more efficient systems, and have had some success here – the sustained reductions in delayed discharges between 2016 and 2018 testify to a more efficient system, but these successes are now being pegged back by the erosion of community care capacity (mostly because of vacancies, although partly transitional service redesign as well). In any event, what we know is that greater efficiency alone won't be enough to cope with the profile of need we can anticipate over the ten years – we will also have to transform our service offer and importantly open up conversations with communities about the role of informal social capital in helping those who need support.

15. Of course, the reality is that the health and social care system already only functions because of this social capital. For example, the role of unpaid carers (typically, members of a person's family, who provide care for a loved-one) is foundational in all that we do. But even then, we see great variability, with some unpaid carers literally providing support to the point that their own health and well-being breaks down, while other families see the role of the state as being solely responsible for the provision of care. Equally, we already have a number of imaginative and important third sector bodies who work for their communities – not just the array of care providers and social clubs we have across the islands but also and increasingly Community Trusts.

16. However, we have not managed to consistently define or describe the interface between less formal social capacity and our core service arrangements. Some pioneering work is being taken forward through our local MPower project, which uses community link workers to connect people who might present to formal healthcare services to less formal forms of support. While this contributes to our overall aspiration to provide diversionary routes to community supports, we would further benefit from national expertise and support around this wider agenda. That is one of the central reasons that we want to enter into a partnership with NDTi – to help us navigate that relationship and help us to build enduring community capacity.

PROPOSAL

17. We have been in discussion with NDTi over a period of months about whether there is a fit between our own local ambitions and their Community Led Support (CLS) programme. CLS is based on a set of principles about how care and support should be delivered. These are implemented in ways that are determined by people directly delivering services along with local partners and members of the community they are serving. CLS assists organisations to work collaboratively with their communities, delivering more efficient and effective working processes and much more community-focused, timely and person-centred responses. It will help us support that group of people who may not qualify for formal care and support but for whom we have a specific interest in preventing the escalation of need.

18. NDTi have entered into partnership with Healthcare Improvement Scotland to support a new cohort of HSCPs to join the CLS programme, building on the four existing pathfinders. The programme runs for 18 months and funding from Healthcare Improvement Scotland will cover 30 - 40% of the costs associated with the programme. The remaining costs (likely to be in the region of £40k) will be met from our own reserves.

19. The new LPG/Community Development post we are creating will be the officer who works directly with NDTi, although it also presupposes an interface with senior management and indeed the IJB itself.

20. Importantly, we see the role of NDTi as being tailored to our local context. This will mean building on the community conversations that have recently been undertaken across the Western Isles by Comhairle colleagues, and during which specific questions were asked of the local population about supporting those who do not meet eligibility thresholds for social care. It will also mean making sense of the community landscape, using established service arrangements like Mpower to anchor future activity.

CONCLUSION

21. The IJB continues to wrestle with growing demand for service year-on-year and while we already have some enterprises under way to address this problem, a wider partnership with HIS and NDTi will be of value as we seek to reform our service arrangements within health and social care. Given that the need for a step change in our ability to marshal demand is becoming ever more apparent, it is therefore recommended that we enter into this partnership.

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