Chief Officer: Angie Wood	
Health and Social Care Partnership: Aberdeenshire	
HSCScotland five essential elements *(please tick relevant priority):*	
Transforming the approach to improving health, wellbeing and independence	✓
Building stronger community care systems and primary care services	✓
Establishing a new focus on mental health	
Securing a sustainable acute hospital service and specialist care service	
Strengthening future partnerships to ensure a modern sustainable workforce	✓

Title: Schivas Wing – Residential Care Home: New Opportunities

Situation:

Providing patient centered rehabilitation/enablement care and palliative care within a residential care home setting. The level of care provided would not be deliverable within the person's own home but does not require the facilities of an acute hospital. It maintains continuity of care within the community and prevents delays through efficient use of all associated health and social care resources.

What action did the integration authority take:

Contracts and commissioning team supported the local integrated team alongside the local Care Inspectorate Officer to review the model of care offered within the area. We determined that we required a more flexible model to meet the needs of people within that community.

Our new model of care which has been operational now for three months is within one of our internal HSCP residential care homes. We offer up to 8 beds within Schivas Wing for the purpose of person centered Rehab/Enablement and Palliative Care.

There is an in-reach community nursing model which supports the people within the Schivas Wing, the wider care home and community, therefore ensuring care is delivered to the right person at the right time but most important is that this service has supported people much closer to home.

The team also includes AHP staff and a co-ordinator post. This has enabled us to provide care and support within the local community delivered by our own Health and Social Care Staff. This has strengthened the multi-disciplinary team and improved communications.

Developing this partnership has been challenging at times however we are seeing outcomes that do suggest this has built a stronger primary care and community care team across the area.

The model will be reviewed regularly using our key performance indicators. There have been lessons learned while undertaking such a redesign. Significantly it requires a great awareness of the process of change and the impact this has on the professionals within the integrated team, their roles and identity. As the model as progressed there have been opportunities for staff to shadow and gain knowledge and experience of each other's roles and communication has been a key part of this process.

Impact:

Our staff within the Care Home and the in-reach support are all members of the local HSCP team. This has encouraged continuity of care by facilitating a smooth transistion from "home to Schivas" or "Schivas to home" for our service users.

Resources are being allocated more efficiently across the area especially in respect of nursing tasks. Skills and knowledge are being developed for our care staff within the setting due to new admissions to the Schivas Wing which includes care for those under 65 with complex conditions.

This model has allowed for people to be cared for in their own community with this care delivered by their local team that know them, within a service that is flexible and responsive to their needs. This is particularly important as enables people at their end of their life to have options to be cared for within their local community in a more homely setting.

Issues that are raised in the delivery of the model are being addressed more timeously by escalation to the Location manager who can meet with the team to review and support the team as a whole.

Core components of your example which should be applicable across Scotland:

We have developed a service specification for the model of care that can be shared with other areas to evidence our vision and our service outcomes. We are aware of other areas in Aberdeenshire that we may wish to develop this model, capturing the learning from this process was important to us.

The joint working with our contracts team and close links with the Care Inspectorate throughout this process has been key to the delivery of the model.