

Embedded and emerging good practice in health and social care

Aligned to the <u>Framework for Community Health and Social Care Integrated Services</u>

Health and Socia	l Care Partnership: East Lothian									
Author and conta	act details: Morven McLelland (To	eam l	Manager Occupational Therapy)							
	6 Email: mmclelland @eastlothia									
Name of good pra	actice: Wellwynd Hub									
Select (x) all areas	that apply to your good practice (s	seleci	t more than one if applicable)							
CLIENT GROUP	Children and young people		Older adults	Х						
	Younger adults									
SETTING	City		Remote & rural (incl islands)	Х						
	Corporate		Urban	Х						
SERVICE AREA	Addictions		Management team							
	Admission avoidance		Mental health							
	Community care services incl care at home/care homes		Physical disabilities	Х						
	Day services		Physical health	Х						
	Housing incl Homelessness	Х	Primary care							
	Intermediate Care incl Hospital at Home	Х	Rehabilitation	X						
	Justice services		Social care services							
	Learning disabilities		Supported discharge							
	Other – please specify									
ELEMENTS of FRAMEWORK	Anticipatory care planning		Live independently at home or in a homely setting	Х						
	Assets based approach	Х	Manage own care							
	Connect with communities		Reablement	Х						
	First point of contact	Х	Seamless working with acute							
	Enhanced care in care homes / supported accom		Short term targeted interventions to meet more complex needs							
	Fully integrated community teams	Х	Teams aligned with general practice							
	Other – please specify									
ENABLERS	Agile working		Information sharing	Х						
	Aligned plans		Infrastructure							
	Clarity of vision		Management information							
	Clinical and care governance		Shared accountability							
	Collaborative leadership		Strong team ethos	Х						
	Culture and values		Technology	Х						
	Fit for purpose	Х	Well-developed lead professional	Х						
	premises		roles							
	Improvement capacity		Well-developed relationships	Х						
	Other – please specify									

East Lothian HSCP

Wellwynd Hub

Summary of situation

Wellwynd Hub has transformed services for people requiring occupational therapy, TEC (technology-enabled care) and housing interventions within East Lothian.

We provide TEC awareness sessions to support staff in finding effective solutions for assisting clients with every day activities.

Wellwynd Hub also offers occupational therapy intervention. Instead of Occupational Therapists visiting a person at home, clients attend the Hub. From operating a once weekly clinic, the Occupational Therapy Team now offers a service three days a week and it is hoped that this can be rolled out to the East and West of the county allowing more people to access this unique service at the point of need.

This development is an innovative approach supported in partnership by East Lothian Council's Housing Team, Occupational Therapy, Physiotherapy and the TEC Team.

East Lothian Council Housing service initiated the opportunity for the partners to use Wellwynd, a four apartment, ex-warden's flat in Tranent, which has been converted into a homely environment. The flat includes a variety of equipment and adaptations to use to assess individuals needs e.g. bathroom and wet floor shower area, profiling beds, Closomat, small aids, and telecare equipment for the more complex of cases, including the use of smart technology to help support people and provide demonstration and impartial advice.

By demonstrating an improvement of personal and functional outcomes, costs of service provision have reduced, including a reduction in waiting times for people requiring occupational therapy intervention. This has empowered clients to self-manage their long-term condition or disability and subsequently manage independently for longer.

Actions taken

The initial aim was to provide a fully adapted and resourced house so that staff and clients could access this with a view to assessment, training and support.

Local and government drivers also gave the impetus to transform services to provide an assessment service at the earliest point of need and to reduce waiting times.

Evidence reveals a person's health and function begins to decline when they are unable to reach their feet to cut their toenails or walk 400 yards (LifeCurve™). If people continue to decline on the LifeCurve the likelihood of requiring services increases. This continues to the point where people require not only equipment but also care at home services and potentially need residential or nursing care in the longer term.

The ultimate aim of the service is to avoid functional decline, reduce the need on services, engage people with increased activity levels and supported self-management. This aim links directly with government drivers, including:

• Active and Independent Living Programme (2016–2020)

- Carers (Scotland) Act 2016
- Co-ordinated, integrated and fit for purpose; A Delivery Framework for Adult Rehabilitation in Scotland (2007)
- Digital health and care strategy (2018)
- East Lothian Integration Joint Board Strategic Plan 2019–2022
- East Lothian Partnership: Single Outcome Agreement 2013–2023
- East Lothian Partnership: The East Lothian Plan 2017–2027
- Health and Social Care Delivery Plan (2016)
- National Dementia Strategy: 2017–2020
- Realising Realistic Medicine: CMO for Scotland annual report 2015– 2016

These drivers all promote early intervention, prevention, self-management and empowerment of individuals.

The team is delivering a service at the earliest point of need and is now delighted to be able to offer this.

Demographics indicate demand on our services continues to grow due to house building (10,000 new properties by 2020), people living for longer, and the increase of children and adults with more complex needs.

Management of resources will require a different approach to support a change in how we deliver assessment services. This required a different mind-set from both staff and clients. We also use an asset-based approach ensuring we use the person's skills to help them find their own solutions as well as receiving support from clinicians.

Upskilling staff to consider different types of technology at an earlier stage will make care more sustainable by freeing care to target those most in need and allow people more control of their environment and care needs.

Outcomes / impact

It is thought that this partnership model may the first in Scotland. A fully integrated approach to service delivery.

There is a well-equipped property where clinicians are able to assess people's needs and work with the person to find solutions to their difficulties. The property also has an array of telecare equipment and smart TEC devices e.g. smart speakers and smart plugs etc. This offers an added dimension to the clinic provision and can provide information and support to help people to think differently about utilising technology solutions creatively to enable them to self-manage.

Health and social care partnership staff measure a person's performance and personal outcomes and review their activity after approximately six weeks.

We also hold clinics with our housing partners where assessments are required to identify whether clients qualify for medical awards points towards their rehousing applications. These are carried out by an Occupational Therapist and a community housing officer.

Social prescribing is promoted to include a wide range of community resources and services e.g. aqua aerobics, exercise groups, leisure centres, and our digital platform Home - Access to a Better Life in East Lothian etc, and enables a self-management approach, helping to support good health and wellbeing.

Occupational therapists and physiotherapists also undertake joint work with TEC Officers and Smart TEC Occupational Therapist to help identify TEC solutions to meet client's needs.

The service frequently highlights their innovative service to others in East Lothian, and will present the service to others out with East Lothian, e.g. Royal Infirmary of Edinburgh, local GP practices, and other integrated health teams across Scotland.

There are regular open days for staff from East, Mid and Edinburgh Councils to visit, including Deaf Action and RNIB. They have been keen to learn how we develop and collate our stats and outcomes towards evidencing improvements in personal outcomes and reduction in waiting lists.

Measures / indicators of success

A 'test of change' process was used from the outset, allowing us to evaluate weekly. We were given permission to develop to improve the experience of clients.

This has led to evidenced reduction in occupational therapy waiting times, increased awareness of staff in technology and its application to a person's everyday life. This is now embedded into the assessment and interventions across the East Lothian Rehabilitation Service (ELRS) work streams. Objectively measuring this impact is a priority for the coming year.

Service expectations have been surpassed and continue to respond to changes in demand.

It was considered imperative to embed statistical data collections from the outset, to ensure goals and outcomes were achieved.

A snapshot of data taken over a 3 month period between November 2019 – January 2020 evidences that:

- 1. Occupational therapy waiting list has reduced from 421 to 322, a reduction of 23%
- 2. On average, an additional 39 people were assessed each month
- 3. The estimated year on year saving based on assessment of 39 clients each month = £57.096.00
- 4. Evidence demonstrates that 87% of people attending clinic have improved personal and/or functional outcomes
- 5. In one month alone, a combined total of 58 assessments and reviews were completed on top of existing work
- 6. A rolling programme of TEC awareness sessions for all frontline staff, in particular care staff, social workers, allied health professionals (AHPs), housing officers and district nurses. Evaluations indicate 100% would recommend this training to others and as a result has increased confidence in this area.
- 7. The Hub has been successful in demonstrating telecare and smart technology in a working environment. It has assisted in reducing anxiety, from individuals and their carers, during transition into their own properties. The use of technology has allowed greater independence and a reduction in care hours.

Even better if ...

(enablers to further the principles of integration and result in 'even better outcomes if ...')

We should be able to evidence even better outcomes of we could open an additional flats:

- A second flat is currently underway and we hope this will be operational by autumn 2023.
- We are currently seeking a third flat for the west of East Lothian to improve equitable access to the service.

NATIONAL HEALTH AND WELLBEING OUTCOMES

 People are able to look after and improve their own health and wellbeing and live in good health for longer. 							
2. 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.							
People who use health and social care services have positive experiences of those services, and have their dignity respected.							
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.							
5. Health and social care services contribute to reducing health inequaliti	es.	Х					
 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being. 							
7. People who use health and social care services are safe from harm.							
8. 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.							
Resources are used effectively and efficiently in the provision of health and social care services.							
Health and Social Care Scotland's 5 Essential Elements (click link to listen to statement of intent)							
Transforming the approach to improving health, wellbeing and independence							
2. Building stronger community care systems and primary care services							
3. Establishing a new focus on mental health							
4. Securing a sustainable acute hospital service and specialist care servi	ce						
5. Strengthening future partnerships to ensure a modern sustainable wor	kforce						
Links to any published reviews/evaluations							
Before submitting this example of good practice please ensure approval and sign-off by your head of service / chief officer.							
Author and contact details: Morven McLelland Team Manager Occupational Therapy East Lothian Rehabilitation Service mmclelland@eastlothian.gov.uk							
Approved for online publication (signature and position) Lesley Berry 15/6/2023 (verified in email trail) (signature and position)							
Date of online publication							

Operat	ion	Engrategic, Fina al, Workford Improveme	ncial, ce and		Fit for Po Premises a Work	urp	oose li I Agile	ing ar nforma Sharir rangen	ition ng Ma	ce Deliv Robust nagement ormation	Well Dev	eloped sional F	
		Resources are used effectively			& Focus on early et intervention & s prevention		accessible veloping:	ntact	lanning	II services	terventions lex needs		age individuals to
		People are safe from harm		<	Targeted care & ss support to meet ort changing needs	A	Making services more accessible and responsive by developing:	First Point of Contact	Anticipatory Care Planning	Reablement within all services	Short-term, targeted interventions to meet more complex needs		Empower and encourage individuals to express choice and take control
		People benefit from improved quality of life	e outcomes	a	care People can ort easily access e help & support		Making se and respo	First	Anticip	Reablem	Short-term to meet		
ation	ing Outcomes	Staff supported & engaged in their work	e and improve	ristics of Effective Integrated Care	port Focus on care i most and support needs at home	y working	y working deliver:	unity teams	ral Practice	acute care	Homes and odation	ation of CARE	Respond positively and proactively to an individual's needs as they repeate
Principles of Integration	Health and Wellbeing Outcomes	Reduced health inequalities	Sharing good practice to integrate care and improve outcomes	s of Effective I	Integrated GPs support MDTs aligned those with most to GP Practices complex needs		Improving outcomes by working more effectively to deliver:	Fully integrated community teams	aligned to General Practice	ess working with acute care	Enhanced Care in Care Homes and Supported Accommodation	services on a foundation of CARE	offer
Princ	National Healt	Positiv experienc care	ood practice to	Characteristic	Professionals Inte know roles and MDTs responsibilities to GP	The state of the s	Improving more e	Fully integ	Teams alig	Seamless	Enhanced Support	Building servi	Adopt a Care Co-ordination approach to
		People live independently at home	Sharing go				lependent ople to:	approach	onditions	nmunities	home or g		Ado
		Carers supported to look after own health		4	People set People are safe their own goals & have equality and priorities of opportunity	<	Promoting healthy, independent living, supporting people to:	Adopt an assets based approach	Manage their own conditions	Connect with their communities	Live independently at home or homely setting		Come together with individuals and those who care for them to assess their paeds
		People look after & improve own health			People are supported to the self-manage		Promoting living, su	Adopt an	Manage	Connect w	Live inder		Come together w
aborativ dership		red C		∀	Clarity of Vision	1	Developed tionships		Sulture d Values			O bns li onsnie	
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