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**Re-Shaping Care for Older People**

**Western Isles**

**Change Plan**

**2013-2014**

**RESHAPING CARE FOR OLDER PEOPLE**

**CHANGE FUND: CHANGE PLAN 2013/14**

**Background**

The Change Fund brings statutory services such as Local Authority and Health Services together with theThird and Independent sector, to engage with carers and the public in developing strategic plans for older people that support independence and wellbeing and put in place the care and support services that local communities require

The Change Fund is intended to enable innovation through either funding the double running cost of introducing new services prior to being able to disinvest in present services, or to create short term capacity to facilitate redesign or enable new third sector services to develop which shall eventually become self financing

**Overarching Key Priorities and Outcomes of the Western Isles Change Fund**

* Reduction of hospital emergency admissions for older people
* Facilitation of accelerated discharge from hospital for older people
* To move towards a re-ablement model
* To increase support at home for older people
* To enhance Third Sector capacity and sustainability
* Effective shared planning and use of resources
* Re-align secondary care, care home and housing support provision
* Support carers capacity through a range of appropriate services delivered primarily through the Third Sector
* Development of anticipatory care models
* Maximise the development, impact and benefits realisation of eHealth (telehealthcare)

**Aim**

To redesign a needs led quality service which is sustainable, safe, integrated and efficient.

**1. Name of Partnership**

|  |
| --- |
| Western Isles |

**2. Partner Organisations**

2.1 Partners signed up to the Change Plan

**Key Partner Organisations:**

* NHS Western Isles
* Comhairle nan Eilean Siar & Community Planning Partnership (CPP)
* Third Sector via Interface Group Co-Cheangal Innse Gall (C-CIG)
* Third and Independent Sector via Western Isles Community Care Forum(WICCF)

2.2 Professional Engagement in the development of Plans

**Partnership planning groups**

* Older Peoples Partnership (includes Third sector representation)
* Community Health and Social Care Partnership (CHaSCP)
* (CHaSCP) Locality Planning Groups individual and group representation from voluntary agencies, service users and their carers
* Delayed Discharge Group
* Carers Strategy Group

The Change Fund Plan for 2013/14 will continue to support progress to date by embedding new models of care and accelerate improvement plans already in place, the Change Plan will link closely with the Western Isles Clinical Strategy re shifting services from acute to a community setting.

The Western Isles Community Health and Social Care Partnership continues to implement the review of Community Nursing in the Western Isles, this will continue with the roll out of the Digital Pen/Patient Held record across the island chain and the implementation of the Unscheduled Care Service .

Areas of development included within the Change Plan 2012-2013 which will be carried over; specifically:

* DALLAS
* Building Capacity in Community Nursing
* Reablement Project
* Emergency Respite Care Support
* Collaborative Form
* Future of Homecare
* Carers Training
* Mental Health Redesign
* Dementia

Appendix 1 sets out the key areas of development and investment for 2013/14 and beyond for the partnership. It also highlights the projects which were developed within the original change plan 2011/12 and will continue to be implemented and gather evidence of progress against intended outcomes. The ethos of the plan is to reduce dependency on hospitalisation and residential care by redesigning pathways in a more integrated way.

These will continue to build on existing HEAT targets, and will link with the Outer Hebrides Community Planning Partnerships Single Outcome Agreement (SOA) and linked strategies including:

* CHaSCP Carers Strategy
* CHaSCP 3 year plan
* Older Peoples Partnership Action Plan
* Outer Hebrides Local Housing Strategy 2011-2016
* HIFRS The Adults at Risk of Harm Guidance
* Home Fire Safety Check (HFSC) Policy and Guidance
* Alcohol and Drug Partnership Strategy
* Creating Communities of the Future
* Employability Partnership Strategy
* Development of Services for Older People in the Western Isles - Action Plan

Appendix 2 and 3 details the Outcomes Triangle and Logic Model for Older People from the SOA.

Stakeholders have been updated at key points in the process for example at Co production events held throughout 2012. A series of events have been held with invitations issued to service providers who support service users and carers. A number of communication mechanisms have been used to keep stakeholders updated on progress on specific initiatives:

* Regular update reports to key planning and advisory committees
* 3 Co production events
* Staff newsletters – Slainte
* CHaSCP website

This communication will continue throughout the Reshaping Care Programme.

Engagement with and the participation of a wide range of professional groups has been sought. For example, CPP, GP Subcommittee, Managed Clinical Networks (MCNs), Single Operating Division (SOD), Clinical Management Teams, CHaSCP Management Team, Integrated Mental Health and Learning Disabilities Planning Group, eHealth Programmes Board, on specific workstreams as required.

2.3 **Public engagement in the development of Plans**

There is a continued commitment to ensuring that 'Re-shaping Care' is taken forward following co-production principles.

The Single Outcome Agreement and the CHaSCP plan both include evidence of a commitment to partnership-working with third sector organisations. However, as the number of older people in the population continues to rise, the next five years will see an increased focus on the quality of service provision, and on the development of innovative approaches that are based on co-production and increased community capacity. A culture change is underway that will ensure that there is a recognition of the positive contribution that older people make to our communities. The development of the Joint Commissioning Strategy sees the input of older people as essential, this will be conducted through a process of Community Appraisal.

There is a stated commitment to ensure that services for older people are person-centred, safe, effective and will at all times, and in whatever setting, be delivered within an ethos that is respectful and preserves dignity, adding value to the patient/ client experience. In this context the support of unpaid carers and carers' experience are also fundamental.

Members of the Change Team attend meetings of the Western Isles Community Care Forum which has representation from health and social care, independent care home providers, home care service providers. Housing providers are included within the Change Team and have also been engaged in the preparation of the plan.

This illustrates that key stakeholders have given a great deal of consideration as to how they would re-design existing services in the coming years to meet the needs of older people.

* The engagement process including the stakeholder events has allowed fuller contributions from third and independent sector.
* The stakeholder event (including development process, outputs from conference, etc) are recorded on national VOICE web-site:

<http://www.voicescotland.org.uk/>

**3. Finance**

3.1 Resources available to Partnerships

|  |  |
| --- | --- |
| From | Amount £ |
| Monies carried forward from 2012/13 allocation | £120,000 |
| Initial central allocation | £607,000 |
| Allocation via Local Authority | £125,000 |
| Funding to Third Sector via SLAs  | £376,324 |
| TOTAL | £1,228,824 |

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3.2 Reasons for financial ‘carry forward’

Delay in recruitment to support project implementation from partner resources

3.3 Change Fund allocation by pathway

**Interim Note** – 2013/14, this is an indicative allocation the majority of the Change Fund is allocated for 2013/14, there remains a sum of £129,898 to be allocated with approval in principle to further develop projects on Dementia, Telecare and Housing Support. This has become increasingly more accurate as it is aligned to the Joint Commissioning Strategy.

The pattern of expenditure has been estimated as outlined below but there remains a degree of flexibility to ensure that only projects which are evidencing impact continue to be funded via Change Fund.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Preventative & Anticipatory Care | Proactive Care & Support at Home | Effective Care at Time of Transition | Hospital & Care Homes | Enablers |
| 2011/12 | £88,203 | £260,400 | £37,503 | £7,085 | £139,295 |
| 2012/13 | £211,411 | £78,445 | £105,097 | £45,897 | £171,150 |
| 2013/14 | £238,179 | £105,511 | £149,313 | £94,565 | £209,693 |
| 2014/15 | tbc | tbc | tbc | tbc | tbc |

3.4 Total resource allocation by pathway over the Change Fund to date.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Preventative & Anticipatory Care | Proactive Care & Support at Home | Effective Care at Time of Transition | Hospital & Care Homes | Enablers |
| 2011-14 | £537,793 | £444,356 | £291,913 | £147,547 | £520,138 |

**4. Self Assessment on Performance**

4.1 Nationally available outcome measures and indicators

A range of data indicators drawn from ISD, the SOA and the JIT Change Fund briefing indicate that services are performing better than the Scottish average in a number of areas, for example:

**Respite Provision**

**Rate of Respite Provision in the Western Isles:** **2006/06 – 2011/12**

*Source: Audit Scotland SPI Data 2006 – 2008, Scottish Government 2009 -2012*

1 – Same methodology used as in 2007/08 making 2008/09 figure comparable to 2007/08

2 – Same methodology used in 2008/09 and 2009/10 making the figures comparable

3 – New methodology used making the figure incomparable to previous years but comparable with 2010/11

4- Same methodology used in 2010/11&2011/12making the figures comparable

**Telecare Packages**

**Proportion of 75+ -rate per 1000 population aged 75+**

*Source: Scottish Government Health and Community Care - Datasets*

Exacerbations of long term conditions continue to be a significant cause of hospital admissions and extended bed days. There were more than 300 admissions due to the measured 8 most common long term conditions in the 65+ cohort in 2011/12 accounting for more than 2100 bed days. In 2011/12, Acute Myocardial Infarction (based on number of episodes) was the most common of admission.

In 2011/12 the number of episodes in the over 65s has increased since 2010/11 from just under 200 to over 300.

**LTC Episodes**

*Source: SMR01*

The number of bed days has also increased from under 1500 in 2010/11 to over 2100.

**LTC Bed Days**

*Source: SMR01*

The figures year to year show a significant drop in the total number of bed days between 2009/10 and 2011/12.

|  |  |  |  |
| --- | --- | --- | --- |
| Bed Days LTC 65+ |   |   |   |
|   | 2009/10 | 2010/11 | 2011/12 |
| Diabetes Mellitus | 47 | 360 | 14 |
| Hypertensive Diseases | 39 | 80 | 59 |
| Angina Pectoris | 100 | 16 | 166 |
| Acute Myocardial Infarction | 252 | 141 | 454 |
| Other Ischaemic Heart Disease | 173 | 121 | 192 |
| Heart Failure | 3518 | 307 | 426 |
| COPD | 454 | 376 | 758 |
| Asthma  | 63 | 75 | 46 |
| Total | 4646 | 1476 | 2115 |

*Source: SMR01*

However, there has been an increase in the total number of episodes.

|  |  |  |  |
| --- | --- | --- | --- |
| Episodes – LTC 65+ |   |   |   |
|   | 2009/10 | 2010/11 | 2011/12 |
| Diabetes Mellitus | 6 | 17 | 2 |
| Hypertensive Diseases | 12 | 3 | 9 |
| Angina Pectoris | 28 | 8 | 31 |
| Acute Myocardial Infarction | 59 | 47 | 103 |
| Other Ischaemic Heart Disease | 77 | 37 | 63 |
| Heart Failure | 44 | 33 | 38 |
| COPD | 62 | 40 | 63 |
| Asthma  | 15 | 12 | 8 |
| Total | 303 | 197 | 317 |

*Source: SMR01*

Significant improvements have been made, and there is local understanding regarding the small number of admissions with excessive lengths of stay.

Overall in 2011/12, there has been a reduction in admissions among the over 65s for diabetes mellitus, hypertensive diseases, ischaemic heart disease, heart failure, COPD and asthma.

The length of stay for admissions with diabetes mellitus, ischaemic heart disease and asthma has also decreased, with a significant decrease seen in the length of stay for patients with a diagnosis of heart failure. However, there are increases in the length of stay all other diagnoses, with the most significant being seen in length of stay for myocardial infarction.

Between 2010 and 2011, there has been a 1% increase in the 65+ population in the Western Isles.

NHS Western Isles is continuing to modernise and optimise its acute services and will continue to focus on shifting existing available resources towards anticipatory, preventative and community based care.

The Community Health and Social Care Partnership has established a firm commitment to re-shaping health and social care services for older people. The national average have consistently been exceeded on delayed discharges and intensive home care provisions

**Delayed Discharges in the Western Isles**

Community care and nursing teams give priority to hospital discharge referrals.

**OCCUPIED BED DAYS by DELAYED DISCHARGE PATIENTS**

**Jan – Dec 2011-2012**

The trend for the first 3 quarters of 2012 displayed a reduction in number and a more stable pattern when compared with the previous year. The final quarter however, shows an increase in the number of occupied bed days to levels experienced the year before.

**Older People receiving Intensive Home Care (10+ hrs per weeks): 2012**

*Source: Scottish Government Health and Community Care - Datasets*

**SPARRA**

SPARRA (Scottish Patients at Risk of Readmission or Admission) is a risk prediction tool of patients at risk of hospital admission based on linking hospitalisation, prescribing, Emergency Department, Psychiatric Inpatient and Outpatient data. The tool is used to help identify patients with complex care needs who are likely to benefit most from anticipatory health care.

 The current Western Isles SPARRA data (looking at those who have a risk score of 30 or more and are at risk of admission or readmission between October 2012 and September 2013) calculates risk for almost 1200 Western Isles residents. Almost 1000 of these are aged over 65.

In the 3 years prior to October 2012, the number of bed days attributed to this cohort was over 30,000 (emergency and elective). This gives an average of around 33 bed days per patient over the 3 years.

 The over 65s on SPARRA have also contributed over 2000 emergency admissions over the period.

SPARRA lists 16 conditions which would fall into the category of Long Term Conditions. The over 65 cohort have between 1 and 11 conditions and an average of 4.13 conditions per person.

The most prevalent long term conditions are those you would expect to see for persons of this age group, e.g. Arthritis, Atrial Fibrillation, Heart Disease, Cerebrovascular Disease, COPD, Diabetes, Heart Failure and Cancer.

The majority of the over 65s have a risk score of less than 50%. Over 100 have a score of 50-59%, more than 50 have a score of 60-69% and less than 30 have a score of 70-79% with the remainder having a risk score of 80-89%.

The most prevalent conditions in those with a risk score of over 50% are Arthritis, Atrial Fibrillation, Heart Disease and Heart Failure, all with more than 70 instances.

The results of this are being used by GP practices to improve the management of people with complex needs.

**Quality Outcomes Framework**

The Quality Outcomes Framework register consists of data from General Practitioners to monitor prevalence of certain diseases and conditions. These data are used as a source of information on the level of different types of health problems in the population. Prevalence is a measure of the frequency of a disease or condition in a population at a particular point at time. The QOF register may count patients with one specific disease or condition, or it may include multiple conditions. There may also be other criteria for inclusion on a QOF register, such as age or date of diagnosis. Therefore, the data are indicative rather than absolute. The QOF prevalence rates are crude because they are not adjusted to account for patient age distribution or other factors that will differ between practices.

The following table shows the QOF register for the Western Isles for 2011/12. Included are prevalence data with rates given for Western Isles and Scotland for comparison. Also included are the percentage increase (-decrease) since the 2010/11 register.

**QOF Registers and Prevalence – Western Isles**

|  |  |  |  |
| --- | --- | --- | --- |
| **Conditions** | **Patients on Register 2011/12** | **Prevalence per 100 patients** | **% increase (- decrease) 2010/11 Western Isles Register** |
| **Western Isles** | **Scotland** |
| Asthma | 1801 | 6.6 | 6.0 | 0.3 |
| Atrial Fibrillation | 779 | 2.9 | 1.5 | 7.3 |
| Cancer | 688 | 2.5 | 1.9 | 7.3 |
| CHD (Coronary Heart Disease) | 1651 | 6.0 | 4.4 | -1.0 |
| CKD (Chronic Kidney Disease) | 927 | 3.4 | 3.3 | 6.7 |
| COPD (Chronic Obstructive Pulmonary Disease) | 450 | 1.6 | 2.1 | 3.4 |
| CVD (Primary Prevention of Cardiovascular Disease) | 770 | 2.8 | 1.5 | 37.3 |
| Dementia | 274 | 1.0 | 0.7 | 4.6 |
| Depression 1 (of 2): conditions assessed for depression | 2554 | 9.4 | 7.8 | 0.3 |
| Depression 2 (of 2): new diagnosis of depression | 2357 | 8.6 | 9.0 | 5.1 |
| Diabetes | 1191 | 4.4 | 4.4 | 3.1 |
| Epilepsy | 211 | 0.8 | 0.7 | -2.3 |
| Heart Failure | 517 | 1.9 | 0.8 | 4.2 |
| Hypertension | 5487 | 20.1 | 13.7 | 0.6 |
| Hypothyroidism | 1709 | 6.3 | 3.7 | 2.8 |
| Learning Disabilities | 151 | 0.6 | 0.5 | 8.6 |
| LVD (Left Ventricular Dysfunction) | 330 | 1.2 | 0.6 | 2.5 |
| Mental Health | 318 | 1.2 | 0.9 | 0.3 |
| Obesity | 3413 | 12.5 | 8.6 | 5.7 |
| Palliative Care | 85 | 0.3 | 0.2 | -8.6 |
| "Smoking" (conditions assessed for smoking) | 8425 | 30.9 | 24.3 | 0.4 |
| Stroke & Transient Ischaemic Attack (TIA) | 681 | 2.5 | 2.1 | 0.7 |
| *www.isdscotland.org/qof* |  |  |  |  |
| *Quality & Outcomes Framework (QOF) for April 2011 - March 2012, Scotland* |  |  |
| *Data source: QOF Calculator Database, as at 18th July 2012.* |

**Dementia**

As maintenance of the number of Dementia registrations on the QOF register has recently been aHEAT target and remains high on the Government agenda, with a new target being developed for 2013/14 to measure post-diagnostic support systems for dementia sufferers, the following charts show the prevalence in the Western Isles compared with Scotland and also the numbers on the Western Isles dementia register. The prevalence in the Western Isles remains higher than the Scotland rate which shows that we are over-achieving with the number of registrations compared with the rest of Scotland. Studies have shown that people with a dementia diagnosis are more likely to have a hospital stay during the year than those without and that, once in hospital, people with dementia are shown to have a longer length of stay. The Western Isles has recognised that an increase in prevalence due to demographic change means that this is a key group for partnerships to focus Change Fund activity on.

**Number of people accessing early dementia diagnosis and support**

**QoF Dementia Register – Raw Prevalence Rates Comparison (Western Isles and Scotland)**

*Source: Quality Outcomes Framework, ISD*

**Proportion of 85+ population placed in residential care**

Of around 225 Care Home places in the Western Isles, the 85+ cohort accounts for 45%.

**Rate of long-stay residents aged 65+ supported in care homes**

**Balance of Care: Supported in Care Homes, Intensive Home Care and NHS Continuing Care**

At a national level the Western Isles compares favourably in relation to the shift from Acute/Care Home bed spaces to community settings. This is not attributed to Change Fund but is in relation to the ongoing strategic direction which has been adopted to shift the balance of care from care homes and hospital settings through an ongoing programme of bed reduction. Since 2005 the NHS have reduced hospital bed spaces from 150 to 97 and care homes have been reducing bed spaces since 2008 through a programme of refurbishment and reconfiguration. This has reduced through time from 55 to 46. This programme will continue through the ongoing programme of modernising mental health services in the Western Isles, and the review of Community based assets.

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*Source: Scottish Government Quarterly Monitoring: Home Care Census and ISD Continuing Care Census*

This approach has led to an increase in intensive care packages to those most at need within the community.

The steady decline in the number of long stay residents in care homes accompanied by an increase in intensive home care packages has shown a gradual reduction in the number of home care packages to those aged 65-74 and an increase in home care packages to those aged 85 plus, delivering home care at the point of most need.

**Direct Payment Packages.**

Western Isles Community Care Forum has a constantly changing list of approx. 400 carers, all of whom live with, or in the same area as, the older person.  Despite repeated attempts through local organisations, mailshots and extensive advertising, there are many unidentified carers in the area.  Some carers deliberately elect to continue in an unsupported role and that is a trend which is more noticeable in the islands than elsewhere.

This view purported by Western Isles Community Care Forum is represented in a corresponding low level of Self Directed Support packages across the Western Isles. The Comhairle are currently promoting the availability of Direct Payments although an apparent barrier as reflected above appears to be the administrative element of managing this. Opportunities to promote these within Community Groups and through the vehicle of the Change Plan is a focussed outcome.

The Partnership will continue to support through mainstream services the uptake of Direct Payment Packages, this has shown an increase throughout 2012.

*Source: Scottish Government Self-Directed support publication*

**Number of people case/ care managed**

There is significant indication that improved case management could improve the quality of care provided for patients and reduce unplanned admissions.

The partnership plans to continue to improve services aimed at improving anticipatory care, supporting independence and increased capacity through::

* The enhancement of dementia services to support early diagnosis and support, through the appointment of a Dementia Nurse Consultant
* Extending the range of proactive services for example: enablement teams, virtual wards, and the falls pathway. This has been achieved through the appointment of additional staff
* Reducing avoidable unscheduled attendances and admissions to hospital including the roll-out of anticipatory care planning; Chronic Obstructive Pulmonary Disease (COPD) care pathways and additional support to care homes through dementia liaison support
* Augmenting enablement teams to increase capacity and enhance anticipatory care services
* Improving medicines management for the Elderly alongside General Practitioners, improving access
* Redesign of mental health services including dementia support

**65+ Emergency admissions**

The Western Isles bed day rates per 100,000 population for all Emergency Admissions for patients aged 65+ remains significantly higher than the rest of Scotland.

The bed day rates per 100,000 population for patients aged 65+ with multiple emergency admissions has increased significantly since 2010/11 whereas the rate for Scotland is showing a decrease. The Western Isles rate remains significantly high.

The partnership has also used the Change Fund to create capacity within the community nursing service. Investment in these areas will create further capacity in the community nursing service to support the development of an integrated care/case management service. This will also enable community nursing to review and redefine its role and create the capacity in the longer term to enable more care to be delivered as close to home as possible.

**Performance Monitoring**

A range of local data indicators drawn from the Community Health and Social Care Partnership and the Comhailre Community Care Outcome Measures are used to inform service provision for example:

**CHaSCP Performance Monitoring**

**Percentage of Community Care service users feeling safe**

|  |  |
| --- | --- |
| **Month Ending** | **Percentage** |
| 31/03/2011 | 75.93% |
| 31/03/2012 | 87% |
| February 2013 | 90% |

**Percentage of users (and carers) satisfied with their involvement in their involvement in design of care package**

|  |  |
| --- | --- |
| **Month Ending**  | **Percentage** |
| 31/02/2011 | 85.19% |
| 31/03/2012 | 85% |
| February 2013 | 83% |

**In addition the following information is collected by Comhairle nan Eilean Siar**

1.
2. No of assessments, including Mobile Overnight Support Service, SSAs , reviews and re-assessments
3. Total completed between April 2012 –January 2013 = **566**
4. In addition to the above there was a review of 15 complex cases
5. **% of (family) carers able to continue in caring role**
6.
7. No who have family carers – 308
8. No of carers able to continue in caring role – 257
9. % of carers able to continue in caring role – 83%

All figures relating to CHaSCP Performance Monitoring are based upon data correct as at March 2012 updated data not available until March 2013, anticipate that figures will be similar.

**Overarching Key Priorities and Outcomes of the Western Isles Change Fund**

* Reduction of hospital emergency admissions for older people
* Facilitation of accelerated discharge from hospital for older people
* To move towards a re-ablement model
* To increase support at home for older people
* To enhance Third Sector capacity and sustainability
* Effective shared planning and use of resources
* Re-align secondary care, care home and housing support provision
* Support carers capacity through a range of appropriate services delivered primarily through the Third Sector
* Development of anticipatory care models
* Maximise the development, impact and benefits realisation of eHealth (telehealthcare)
* To look for savings through enablement, personal well-being and carer support
* To ensure that necessary services are provided through continuous and joint review of care plans with resources redirected where appropriate
* To reduce the costs of care through anticipatory and preventative approaches
* To review prescribing costs and medicines management for older people with complex care management

**Key changes and continued integration of health planning to achieve over the lifetime of the Change Fund (4 years)**

**Rehabilitation and re-ablement**

* The partnership has enhanced its service delivery with the development of a Reablement Team with occupational therapy.Teams are now undertaking enablement focused assessment of referrals. During 2013 the Change Team will be investigating the expansion of the reablement service to include additional functions and the addition of a step up step down facility.

**Dementia**

* Services designed to ensure people with dementia are offered support from early diagnosis through to more complex care needs in partnership with Alzheimers Scotland and other care providers.

**Telecare**

* Telecare is mainstreamed and embedded to ensure prompt service provision to older people who are at risk.

**Supporting people to manage Long Term Conditions**

* Well established self management programmes
* To have in place anticipatory care plans based on at risk patient date
* A wide range of education and support for carers and people with loc=ng term conditions delivered via health, social care and the third sector organisations, and improved carer support, would assist older people to avoid unnecessary admissions and A&E attendances and improve their quality of life.

**Supported Housing and Housing with Care**

## The Outer Hebrides Local Housing Strategy 2011-2016 (LHS) contains a strategic outcome aimed at ensuring that more people can secure the housing services they require to live independently in their preferred choice of accommodation. The strategy examines the challenges faced by the Comhairle and its partners in achieving this aim and identifies priority actions to address these. In summary the main issues are:-

**Demographics** -- Our Housing Needs and Demand Assessment (December 2011) identifies 5,620 persons aged 65 years or above living in the Outer Hebrides. This is equivalent to over a fifth of the population and a third of all households. Projections show there will be a sharp rise in men aged 65 and above and women aged 80 years and above who live alone over the next two decades. These trends will apply across the Outer Hebrides. The vast majority of our older population live in private sector housing.

**Service demands --** This increase in older people, often living alone, will drive up the demand for home care, as well as for other housing services, for example aids and adaptations, that enable people to live independently within their own homes in safety and comfort. Meeting increased demand in the face of severe public expenditure constraints will involve finding new ways of working and greater use of technology, including telecare and telehealth, to support vulnerable people in their homes.

**House condition --**The strategy also considers and addresses the challenges faced in terms of the condition of our private housing stock, and the extent of fuel poverty experienced across all housing tenures ,both crucial issues which impinge on the potential success of care at home packages .

The strategy has clear linkages to Health and Social Care Agendas and clearly recognises that the Change Fund and the development of the Change Plan brings new opportunities to enhance the housing contribution to the social care and health agendas.

**Resources --** The Comhairle’s financial resources are focused in such a way to support the LHS and the agreed actions within it. For 2012/13 the **Local Housing Strategy Capital Budget** in relation to activities linked to the Independent Living Objective was:-

|  |  |
| --- | --- |
| **Budget Heading**  | ***Budget £000***  |
| Adaptations for people with Disabilities: |
|  *Major Adaptation works*  | 500 |
|  *Small Adaptations*  | 80 |
| Below Tolerable Standard properties (BTS)  | 400  |
| Fuel Poverty Measures | 92  |
| Minor Works Scheme | 100  |

Through Partnership working and the redesign local services we will maximise the no of people in supported accommodation or living independently in the community, as part of the review of tour asset infrastructure there will be a review of our demand for supported accommodation outwith peoples own homes.

**Anticipatory Care: supporting people to stay well and early interventions when help is required**

The Western Isles has significant areas of identified social deprivation and health inequalities reflected in poor health outcomes.

Well North is a community based health improvement initiative set up with Keep Well funding. There has been considerable success demonstrated in addressing these issues through the Well North Programme aimed at 40 to 69 Years.

The capacity of local communities with regard to self-help, health care and well-being is growing with greater health awareness and access to health assessments and healthy living advice.

The Change Fund is supporting the MyAction initiative which supports patients, families and carers of those at risk of cardiovascular disease, this is through a validated evidence based programme incorporating tailored physical activity, dietetic advice and specialist nursing and medical support. The ethos of the programme is based on long term self management following a period of structured rehabilitation and reablement. MyAction supports lifestyle change, and encourage community involvement with resulting improvements in well being. This is a well developed model with good data collection

This is an anticipatory care programme which links professional support with community based help to improve health and wellbeing. It also offers opportunities for early identification of conditions such as diabetes and high blood pressure.

* A co-production approach established from more detailed local research
* A focus on preventative services aimed at maintaining independence
* Cultural changes in service delivery with service users directing and designing the services they need in partnership with staff: more older people and their carers engaged in self-directed support
* A greater shift towards health improvement and positive engagement in healthier lives
* Third Sector and community organisations are providing a broad range of local social and well-being support activities; self-help groups are established to provided information and advice to local people. There is a commitment with all partners engaged in ' Re-shaping Care' to develop a broader knowledge base of the current resources that are available locally, to identify gaps and to build capacity.
* The Western Isles Health Promotion department provide a range of support via exercise programmes which promote health and wellbeing amongst the older population, support and information through the Western Isles HI project which provides health information and links to local support groups and through its resource service which provides resources on loan to residential homes and with older people community groups.

**Supporting people at home and in the community: all services adopting a re-ablement approach to service delivery**

* Rehabilitation and re-ablement approaches embedded in joint assessment and care planning processes and extended to all eligible older people
* Delayed discharges maintained at zero and reduction in 6 week periods
* Integrated approach to day care and respite
* Care at home staff are trained in enhanced personal care tasks and short programmes of re-ablement to enable people to remain at home and independently
* More flexible use of care homes incorporating a range of respite options, re-ablement, improved support for dementia care, with a view to a reduction in admissions through an alternative to admission programme
* Increase community based respite care, availability increased and additional options that are flexible and responsive, respite at home and shortbreaks
* Generic and multi-agency health and social care training in place to support changes to service delivery re independent living and support to carers
* Increasing use of tele-health and new technology to support people to remain confidently and safely within a home environment
* Supporting people with long term conditions to live independently and able to manage their condition, helped by both professional support and telecare.

**Increasing the quality and availability of end of life care available in the community**

* Developing new approaches with the third and independent sector
* Increasing support from mainstream services
* Increasing the use of advanced care planning by working more closely with GP practices
* Increasing emotional and practical support for carers

**Expanding the involvement of community groups and voluntary organisations in the planning and provision of care and support**

**Building community capacity**

The key principle will be to build on existing good practice and to identify with local communities any potential areas for innovative practice towards shifting the balance of care.

The Change Fund will continue to be used to support stakeholder consultation events and has led to the Third Sector completing a mapping exercise and shared resource base across the spectrum of health and social care. This investment will underpin future development within Joint Commissioning.

Issues that have been raised at consultation events, financial support for the community care forum, consideration of transport infrastructures, the broader picture of housing-related needs and local housing options, local accessibility of support and services and more social opportunities with informal support for service users and their carers. Many of these areas have been supported through the Change Fund Small Grant Scheme to test out areas of best practice.

**Joint workforce planning**

* Increased joint education and training opportunities for staff across the sector
* Exploration of opportunities to develop more integrated teams for service delivery
* Exploration of generic support workers to support professionals across specialities

**An established and integrated strategic approach to re-shaping care**

* Implementation of the Change Plan monitored through a comprehensive planning structure
* Integrated resource management
* Joint commissioning and performance frameworks

**Improved joint data collection, performance measurement and analysis of outcomes**

* Integrated care pathways with information-sharing and performance management systems in place
* Joint governance arrangements developed to oversee the Change Fund usage
* Development of a funding, Monitoring and Evaluation Framework to support the assessment of shifting the balance of care and on project delivery.

**Key Performance Measures**

20012/2013 has been one of implementation and development for many of the projects and service enhancements funded by the Change Fund. Projects are in the early stages of progress and have started to monitor progress to date.

Performance information requires to be robust, frequently available and routinely reported, therefore the Partnership agreed to focus initially on ***A1, A2a, b and A3***

By initially focusing on these measures will demonstrate progress on delivering the shift in the balance of care. It also enables outcomes of initiatives and service enhancements to be directly attributed to these measures.

Measures which are currently collected or are under development are outlined below

Work has been taken forward at to develop the outcome measures appropriate for the Change Fund investment.

This outlines the key measures which the partnership will use to monitor performance and report on progress. These include:

* nationally available outcome measures and indicators
* local improvement measures.
* partnership resource use

National Measures Collected

A1. Emergency inpatient bed day rates for people aged 75+ (NHS HEAT 2011/12)

A2. a. Patients whose discharge from hospital is delayed

A3. Prevalence rates for diagnosis of Dementia (NHS QOF)

A5. Percentage of time in the last 6 months of life spent at home or in a community setting

**National Measures Under Development**

**A2. b. Accumulated bed-days for people delayed**

A6. Experience measures and support for carers from the Community Care Outcomes Framework (Community Care Benchmarking Network)

**Local improvement Measures Collected**

B6. Rates of 65+ conveyed to Accident & Emergency with principal diagnosis of a fall (Data from Scottish Ambulance Service) – (local analysis of A&E data)

A4. Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting – local measures available from 2011 Housing Needs Assessment

A5. Percentage of time in the last 6 months of life spent at home or in a community setting – local Measures under development

B5. Respite care for older people per 1000 population

**Local Improvement Measures Under Development**

B1. Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared with Out-of-Hours staff (under development for SPARRA patients)

2012 will see development of discrete monitoring around Change Fund measures national/local which would sit as a discrete report alongside the existing Integrated Performance Reporting to the Board.  Local measures attached to specific Change Fund projects have been developed. As part of the new Western Isles Balanced Scorecard Reporting there is a section around CHaSCP which includes measurements against a range of strategic CHaSCP objectives.

Measures collected under the Single Outcome Agreement include:

* Decrease dependency ratio of non working age population (0-15 & 65+) to working age population (16-64) (NRS)
* Life Expectancy at 65 years (NRS)
* Percentage where the time from first contact to completion assessment is less than or equal to four weeks for new Clients aged 65+ (CnES)
* Older people (65+) rating the area within a 15 minute walk from their own home as very safe (Northern Constabulary Community Consultation)
* Percentage of users satisfied with opportunities for social interaction (CnES)
* Reduce percentage of pensioners in fuel poverty (Scottish House Condition Survey)
* Reported Alcohol Related Fires per 10,000 population (Highland & Island Fire & Rescue Service)

**Partnership resources** **under development**

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| **Change Fund Measures C** **Partnership Resource Use**  |  |  |  |  |
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| **C1. Per capita weighted cost of accumulated bed days lost to delayed discharge** |  |
|  | tbc– activity in place developing costing |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |
| **C2. Cost of emergency inpatient bed days for people over 75 per 1000 population** |  |  |
|  |  |  |  |  |
|  | Total Cost | Per capita | Per 1000 population |  |  |
|  | £8,129,948 | £2,989 | £2,988,951 |  |  |
| **C3. A measure of the balance of care e.g. split between spend on institutional and community based care for over 65s (based on IRF 2010/11)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  | Institutional  | Community Care | Total | Ratio balance of care |  |
|  | £27,181,362 | £16,471,694 | £43,653,056 | 62% | 38% |

The above breakdown on C3 is based on estimated percentage of use, using actual client based data our total resource envelope is £46,432,763 further work to identify being undertaken to confirm the split between institutional and community care.

As the work on developing outcomes progresses the partnership will review the potential financial impact of and the inter-relationship between core outcomes.

The change fund plan for 2013/14 draws on the work of the Integrated Resource Framework (IRF)

The central premise of this work is that by integrating resources consumed by a population within a geographical locality there are opportunities to reconfigure and redesign models of service delivery in a more effective way.

The IRF mapping work is a key enabler in the delivery of the partnership’s shift towards Joint Commissioning and Integrated budgets

The IRF work supports the implementation of the Change fund and the Health and Social Care integration

We also plan to combine planning/data and analysis expertise to allow a more integrated approach to data analysis and information which is currently being gathered across the change fund workstreams. This approach will allow the partnership to gather more robust data to support key activity which will evidence the contribution of the to the ten national community care outcomes

**Successes and lessons learned**

The partnership has progressed a range of projects and initiatives during the course of 2011/12 that have resulted in more effective and efficient service delivery. In addition there are a number of tests in progress:

* The further integration of case/care management across partnership areas. This will be accelerated in 2012
* Chronic pain. group work courses have been commissioned
* Partnership pathway work aimed at reducing admissions to hospital and care home settings and improving patient flow following hospitalisation
* Implementation of a new falls pathway.
* Successful COPD pathway implemented and monitoring any associated reduction in admissions and bed days.
* Early detection and education, self management promotion, anticipatory care planning and preparation for end of life care
* Joint planning and training workshops with Change Team Partners including the Independent and Third Sector representatives
* Ongoing development of telehealth including Patient Held Record and DALLAS.
* The expansion of the governance arrangements to fully embed the Third and Independent Sectors.

**5. Governance**

5.1 Describe your Partnership governance framework and financial framework to enable Partnership decisions if they have changed since 2011/12.

Progress in achieving local outcomes and meeting local targets will be scrutinised by Change Team (a sub-group of the Joint Liaison and Planning Group) is responsible for developing, managing and monitoring the Change Plan. Governance arrangements follow existing framework, NHSWIs Corporate Management Team, Joint Services Committee and Community Planning Partnership. There will be ongoing management scrutiny by senior officers of the relevant agencies.

**OHCPP**

**Health Board**

**CnES**

**Policy & Resource Committee**

**Joint Services Committee**

**Joint Liaison and Planning Group**

**(Incorporating Joint Change Team)**

The Change Team views the Plan as a living, evolving document which will change over time as targets and outcomes are achieved and local priorities change

The Change Plan priorities are also reflected in the local development plans of partner agencies and a range of joint strategies and plans.

A performance framework which includes a suite of measures to ensure timely review of data and variation management has been developed this ensures that appropriate indicators and targets are in place to support the delivery of the Change Fund outcomes.

**6. Carers**

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| National projections indicate that over 9% growth in total number of carers aged over 50 between 2009 and 2030 (Joint Improvement Team core datasets).

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| However, the number of carers aged over 65 over the same period increases by over 40%with a reduction in the number of carers aged between 50 and 64. |

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|  | **Age 50 - 64** | **65+** | **total carers over 50** |
| **2009** | 1003 | 423 | 1426 |
| **2010** | 1017 | 427 | 1444 |
| **2011** | 1022 | 435 | 1457 |
| **2012** | 1029 | 432 | 1461 |
| **2013** | 1023 | 462 | 1485 |
| **2014** | 1029 | 473 | 1502 |
| **2020** | 1072 | 519 | 1591 |
| **2025** | 1039 | 546 | 1585 |
| **2030** | 972 | 589 | 1561 |

Source: Joint Improvement Team core datasets.

The Partnership will continue to support carers through the following initiatives during 2013/14

This Change Plan will target carers and cared for people over the age of 60 years by taking a preventative approach. It aims to increase the capacity of carers enabling them to undertake their caring role by identifying them at an early stage, recognising them as key partners in the delivery of care, assessing their needs and providing a range of appropriate supports. These supports will include relevant and timely information and training with the aim of maintaining the carers’ own health and mental well-being and supporting them to continue in their caring role.

**Respite care**

The Change fund would enable respite provision to be increased. We will continue to work with partners to develop proposals for respite and training for carers to build on what has been achieved locally through the Carers Information Strategy.

**Carers Training**

A key element, promoting a cultural shift to ensure that services users and carers are central partners in service provision and care planning.

Through Change Fund allocation to the Western Isles Community Care Forum in partnership with Tagsa Uibhist has developed a training post which will deliver training in people’s homes, this approach ensures that this is tailored to individuals needs and has an island wide remit. The planned outcomes of this investment will be to develop a self-sustaining skill and knowledge base, promoting service user engagement, self-management, advance directives, self-directed support and self-help options

**Carers strategy 2012-2015**

The key priorities include carer involvement, provision of information, short breaks and health and well-being.

This investment is made in addition to Carer Information Strategy funding, existing funding and support to local carer’s services and short breaks funding.

The areas of investment are summarised as follows;

The partners consider that support and improvement of outcomes for carers is core to all aspects of project delivery within the Western Isles specifically:

* Work around Building capacity, co production, and Joint Commissioning
* Mental Health Service Redesign
* Improving access to emergency respite and care support
* Workstreams to improve travel
* Building social support network opportunities through involvement in workshops and training
* Implementation of the General Practitioner LES to provide better support to multi disciplinary case conferences together with strengthening the focus on carer needs
* Improving anticipatory care plans and early diagnosis
* Development of improved training and support for carers linked to Carer Assessments and building on the Carers Information Strategy and associated funding (The Third Sector is leading on the delivery of Carers Information Strategy via an SLA with NHS Western Isles and undertaking Carer assessments)
* Improved Discharge Planning
* Carers being equal partners as part of Change Team through Third sector representation via WICCF

**7. Support Mechanisms**

Areas considered crucial as support include:

* Identified JIT lead
* JIT website
* Localised support if required
* Facilitation from JIT at consultation events
* Analyst support from Analytical Services Division

Western Isles Change Team consider that areas where the Western Isles can provide support includes:

* Engaging in information sharing particularly around the Partnerships approach to telehealth and telecare to overcome remote and rural issues in supporting patients and carers in the community.

**8. Joint Commissioning Strategy for Older People**

The Change Team has supported the development of a commissioning framework which determines strategic priorities within the Joint Commissioning Plan.

We will be carrying out a Community Consultation on the Joint Commissioning strategy, and would anticipate initial joint services being commissioned from 2013. This will link directly with Change Plan and local strategic plans.

**This Change Fund Plan has been prepared and agreed by the NHS, Local Authority, Third Sector and Independent Sector interests.**

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| **Preventative and Anticipatory Care** |

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| **Proactive Care and Support at Home** |

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| **Effective Care at Times of Transition** |

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| **Hospital and Care Home(s)** |

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| Build social networks and opportunities for participation. |
| Early diagnosis of dementia. |
| Prevention of Falls and Fractures. |
| Information & Support for Self Management & self directed support. |
| Prediction of risk of recurrent admissions. |
| Anticipatory Care Planning. |
| Suitable, and varied, housing and housing support. |
| Outcomes focussed assessmentSupport for carers. |

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| Responsive flexible, self-directed home care. |
| Integrated Case/Care Management. |
| Carer Support. |
| Rapid access to equipment. |
| Timely adaptations, including housing adaptations. |
| Telehealthcare. |

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| Reablement & Rehabilitation. |
| Specialist clinical advice for community teams. |
| NHS24, SAS and Out of Hours access ACPs. |
| Range of Intermediate Care alternatives to emergency admission. |
| Responsive and flexible palliative care. |
| Medicines Management. |
| Access to range of housing options. |
| Support for carers. |

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| Urgent triage to identify frail older people. |
| Early assessment and rehab in the appropriate specialist unit. |
| Prevention and treatment of delirium. |
| Effective and timely discharge home or transfer to intermediate care. |
| Medicine reconciliation and reviews. |
| Specialist clinical support for care homes. |
| Carers as equal Partners. |

**Enablers**

Outcomes focussed assessment

Co-production

Technology/eHealth/Data Sharing

Workforce Development/Skill Mix/Integrated Working

Organisation Development and Improvement Support

Information and Evaluation

Commissioning and Integration Resource Framework

**Appendix 1**

**Change Team Plan 2011-2014**

**Workstream – Developing Third Sector Capacity**

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| --- | --- | --- | --- | --- | --- | --- |
| **Project** | **Outcome/Output** | **Identified Care Pathways**  | **Actions** | **Lead Officer** | **Development / Implementation Timescale** | **Costings** |
| Building Capacity  | Maintain more people athomeAvoid inappropriatesocial/health interventionsIncreased independence and controlInformed publicImproved quality of life for service users and carersImproved service users and carers health | Organisation Development and Improvement SupportTechnology eHealth and Data Sharing | Mapping and gaps analysis of Third sectorDedicated support to Third Sector Building Capacity Develop integrated andcomprehensive models of information: develop and support web baseresources;Agree non web based means of sharing information;Improve support to access information: support individuals in the use ofinformation technology | Peggy Mackay WICCF | September 2012Ongoing throughout Change Fund | £45,000 |
| Leading from the Edge and Co Production events | Develop interagency working Increased organisational efficiencyImproved communicationPreparatory work for Joint Commissioning | Organisation Development and Improvement SupportCo production | Series of training, workshops and co production events | Denise SymingtonNHS | May 2012 | £23,624 |
| Dual Sensory Strategy | Joined up services reducing duplication of serviceService development to meet National Strategy and meet patient identified needProvide a well trained workforce | Enabler Organisation Development and Improvement Support | To develop a dual sensory training strategy to inform future service planning | John Gill Sight Action | November 2012 | £5,000 |
| Patient Transport Pilot | Prevent delayed dischargePrevent avoidable admissionImproved patient experienceBed days saved – financial efficiencySupport protocols, pathways of care Improved patient experience | Effective and Timely Discharge Home or transfer to intermediate care | Pilot project to assess impact on key areas of avoidable admissions, delayed discharge and improved access to respite which has been impacted on by ability to access ambulance transport | Community Transport Forum | December 11 – March 13 | £8,856 |
| Respite Support | Prevent delayed dischargePrevent avoidable admissionImproved patient experienceBed days saved – financial efficiencySupport protocols, pathways of care  | Range of Intermediate Care Alternatives to emergency admissionsOrganisation Development and Improvement SupportEffective and Timely Discharge Home or transfer to intermediate care | Fitting of hoist and tracking system to new facility | Tagsa Uibhist | September 12- February 13 | £5,000 |
| Lunch Club  And IT support | Provide Social SupportReduce isolationProvide support and respite for carersTraining for staffSustainable workforce with right skills mix | Build Social Networks and Opportunities for ParticipationOrganisation Development and Improvement SupportTechnology eHealth and Data Sharing | Purchase of IT equipment Staff training re SVQsLunch club for carers and cared forTraining for participants to keep family contacts in remote areas | Leverburgh Care Home | September 2012-September 2013 | £3,000 |
| Dementia Café Alzheimer Scotland | Support protocols, pathways of care  | Build Social Networks and Opportunities for ParticipationTechnology eHealth and Data Sharing | Refurbishment of office to a dementia caféTraining and information materialsActivities for participants | Alzheimer Scotland | September 2012- February 201 | £5,000 |
| Ice Grips Older Peoples Partnership | Support and prevention of falls Reduce hospital admissions | Build Social Networks and Opportunities for ParticipationPrevention of falls and fracturesInformation and Support for self Management and Self Directed Support | Purchase of ice grips and circulate throughout older peoples groups, and AHP clinics for active older people | Older Peoples Partnership | September 2012-February 2013 | £9,750 +AHPs£ |
| IT Equipment – Capacity Building | Sustainable workforce with right skills mixReduction in costsMore front facing time with clients | Organisation Development and Improvement SupportTechnology eHealth and Data SharingOutcomes focussed assessment and support for carers | Purchase of IT equipment Staff training re SVQs | Crossroads Lewis | September 2012-September 2013 | £3,900 |
| Mens Club Cobhair Bharraigh | Good Nutrition Reduce isolation and impact of social isolationReduce admissions to hospitalProvide community safety information | Build Social Networks and Opportunities for ParticipationInformation and Support for self Management and Self Directed Support | Provision of a men’s lunch clubProvision of targeted information and support to reduce isolation | Cobhair Bharraigh | September 2012-September 2013 | £5,000 |
| Care in the Home | Reduce delayed discharge]Reduce inappropriate social admissions | Suitable and Varied housing and housing supportRange of Intermediate Care Alternatives to emergency admissionsEffective and Timely Discharge Home or transfer to intermediate care | the home post hospital dischargeIncorporating transport, medicines pick up, shopping, shopping and preparing food emotional and social supporta lower levelenablement service -meals/practical support; and- support discharge from hospital to facilitate long term | Nicholas Hunt(British Red Cross) | December 2012-March 2014 | £5,823(2013/14 –£11,647) |
| Maintaining Independence in Later Life | Reduce isolation and impact of social isolationReduce admissions to hospitalProvide community safety information | Build Social Networks and Opportunities for ParticipationInformation and Support for self Management and Self Directed Support | Assist in maintaining better physical, mental and emotional wellbeingProvide a range of support and information , providing a more fulfilled life through social contact and befriendingCreating a safer environment for older people | Sheena StewartCaraidhean Uibhist | September 2012-September 2013 | £6,600 |

**Workstream – Workforce Development**

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| --- | --- | --- | --- | --- | --- | --- |
| **Project** | **Outcomes** | **Identified Care Pathways**  | **Actions** | **Lead Officer** | **Development / Implementation Timescale** | **Costings** |
| Change Team Support | Evidencing Shift in balance of CareData quality will be improvedInformation, monitoring, planning and administration to support operational management | Organisation Development and Improvement SupportCo productionInformation and EvaluationCommissioning and Integration ResourceBuild Social Networks and Opportunities for ParticipationTechnology eHealth and Data Sharing | Data quality will be improvedInformation, monitoring, planning and administration to support operational managementDelivery of change plan programmeDetermine the supportrequirements to develop,support and sustain coproduction and capacitybuilding models:- identify the administrative and development requirements;- confirm the priorities for early development;- agree allocation of funding for development; and- agree processes and criteria for funding allocation. | Colin Gilmour(NHS) | January 2012-March 2014 | £165,000 |
| Future of Caring at Home Career Pathway | Improved efficiencySustainable workforce with right skills mixReduction in costsIntegrated assessment | Organisation Development and Improvement SupportIntegrated Case/Care Management | To take forward key service/workforce development workstreamsReview Current Roles/PostsDevelop enablement model of careAs service integrationdevelop, we will reviewsystems, management and support arrangements.  | Norma Skinner(CNES) | December 2012-December 2014 | £100,000 |
| Modernising Community Nursing | Improvement in the Single shared assessmentPatients experience care pathways that are integrated across social, primary and community careCare closer to home Patient Held recordImproved information and statistics on the Community Nursing serviceDevelopment of Hospital at Homeavoid social admission/readmission/delayed discharge- improved quality of life for service users- improved service health- reduction in emergencyrespite placements- reduction in hospitaladmission- reduced bed days- reduction in acute beds | Organisation Development and Improvement SupportAnticipatory Care PlanningRange of Intermediate care alternatives to emergency admissionIntegrated Case Care ManagementResponsive flexible, self-directed home careSuitable, and varied, housing and housing supportSpecialist clinical support for care homes | Improve patient facing time up from 28%Improved working practicesPatient held recordDementia training Implementation of releasing time to careWorkforce planningRemove traditional boundaries of where health and social care are delivered.Increase health input to care homesDevelopment of Out of Hours services and unscheduled careDevelopment of OPIAT serviceWorkforce development including Releasing Time to CareRevised current initialassessment teams:- better integrated hospitalassessment service withreviewed skill mix; link to Virtual Ward initialassessments.develop Virtual Wards :identify people at risk of admission in the coming year Virtual Ward from a range of agencies/personnel developing core competencies; | Kathleen McCulloch(NHS) | February 2012-March 2014 | £157,298 |
| Mental Health Modernisation | To support the modernisation of the future of Mental Health Services and project manage the service change | Early diagnosis of DementiaIntegrated case care management Anticipatory Care PlanningWorkforce development skill mix and integrated workingOrganisation development and improvement support | Whole system redesign modernising Mental Health ServicesEfficiencies within working practicesBring clinicians closer to patients thus reducing patient journeysInvest in redesign | Mike Hutchison(NHS) | December 2012- March 2014 | £73,522 |
| GP LES | Management of complex care and delivery of anticipatory care.Support changes in practice and provide improved support for carersImproved support for carers,  | Support for CarersAnticipatory Care PlanningMedicines ManagementPrediction of Risk of Recurrent admissionsMedicines reconciliation and reviews | Support protocols, pathways of care application of best practiceDeliver a proactive integrated care management approach to facilitate care for those with complex care needsEarly assessment for frail older peopleGPS asked through LES to identify practical solutions to shift balance of carePoint of Care testing for Warfarin&Polypharmacy training and reviews | Brian Michie/Christine McKee(NHS) | February 2012-January 2014 | £80,006 |
| Reablement |  maintain more people athomereduction in acute bedsreduction in care homeplacementsreduced bed daysReduction in FallsPreventing admissions, Assisting early discharge for PatientsDelivering Reablement in the CommunityServices Closer to homeImproved Patient Journey | Reablement and RehabilitationEffective and Timely Discharge Home and or Transfer to Intermediate CarePrevention of falls and fracturesTimely adaptations including housing adaptationsEarly assessment and rehab in the appropriate specialist unit.Urgent triage to identify frail older people Responsive flexible, self-directed home careTelehealthcare.Medicines ManagementPrevention of falls and fractures | Reduction in falls & subsequent admissions to hospitalImproved falls risk assessmentPrevent avoidable admissionsProactive intervention to maintain independenceSupport protocols, appropriate pathways of care Involvement in maintaining and improving patients own health whilst facilitating care for those with complex care needsChange current culture ofassessment/decision making at an early stage:policy statement to changePracticeIdentify alternative resources to facilitate assessment:- rehab; and- enhanced enablement at home.Scope resources for return to home- additional community resources;- additional health resources; telecare/telehealth; and- carer support.agree model of service;remodel existingprovision; | Sonja Smit | January 2012-March 2014 | £358,000 |
| Networking | To take forward key service/workforce developmentCommunication and training from National Team | Workforce development , Skill Mix , Integrated WorkingBuild on social networks and opportunities for participation | Improved Knowledge re Change FundJoined up workingAnd Planning for future service delivery to meet identified needsDevelop interagency working Increased efficiencyImproved communicationPreparatory work for Joint CommissioningApplication of best practice | Colin Gilmour/Denise symington | April 2011 | £8,000 |
| Invest to engage workshop | Co production Improved Partnership workingImproved communication and understanding of change fund principles |  Co productionOrganisation development and improvement supportBuild on social networks and opportunities for participation | CA range of co Production EventsDevelopment support to building on Change Plan Engaging all partners including Third Sector partners, carers and cared for | Denise Symington(NHS) | May 2012 October 2012January 2013March 2013 | £16,166 |

**Workstream – Utilising Technology**

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| --- | --- | --- | --- | --- | --- | --- |
| **Project** | **Outcomes** | **Identified Care Pathways**  | **Actions** | **Lead Officer** | **Development / Implementation Timescale** | **Costings** |
| Dallas/Living It Up | Support protocols, pathways of care People maintained in own home who would otherwise be admitted to hospital or care home environmentApplication of best practiceEncourage greater involvement in maintaining and improving patients own health whilst facilitating care for those with complex care needs- avoid social admission/readmission/delayed discharge- improved quality of life for service users and carers- improved service user and carers health- reduction in care homeadmissions- reduction in emergencyrespite placements- reduction in hospitaladmission- reduced bed days- reduction in acute beds | Organisation Development and Improvement SupportTechnology eHealth and Data SharingTele healthcare | Efficiencies within working practicesTransforming bookings for patientBring clinicians closer to patients thus reducing patient journeysReview of technology Obligate network developments ensure contracted use of appropriate technologyIntegrate into assessment:- build into every initialassessment; and- build in staff competency/training.Scope telehealth/telecareimplementation:- identify telehealth opportunities(e.g. e-triage (virtual wards) – trial CA/Community Nursing/NHS 24);- progress medication(polypharmacy) support; and- reduction in slips, trips, fallsproject. | Mary Sinclair(NHS) | September 2012-March 2015 | £88,867 |
| Call Confirm Live- Scheduling and Monitoring | Increased Client facing timeEnsures Client receives planned services as identified within care packageSafer working practices for lone workersSupport protocols, pathways of care Data quality will be improved | Organisation Development and Improvement SupportResponsive Flexible and Self Directed Support | IT system to efficiently allocate home care workers to service users and being able to monitor their attendance we will be able to ensure service users receive the care they are assessed as requiring whilst also meeting Health and Safety requirements for lone workers. | Kirsty Street (CNES) | February 2012-March 2013 | £45,000 |
| Patient Held Record/ Digital Pen | Introduction and development of technology to improve service efficiency and capacity Support protocols, pathways of care Data quality will be improvedApplication of best practiceReduction in duplication of effort, through repeated data collection and recording will reduce administration burden and improve information flowReal time information to support operational managementInformation on patient journey will be patient centric to facilitate care for those with complex care needs | Technology eHealth and Data SharingWorkforce Development and Skill Mix, Integrated WorkingAnticipatory Care Planning | Update technology to adapt and improve working practices, to meet advances in technologyAnticipated Benefit is that patient Facing Time will be increased upwards from 28% | Jon HarrisNHS | February 2012 | £100,000 |
| Collaborative Form | Improve case notes, and communication between agenciesIncrease in patient safety, consistency and improved patientImprove case notes, and communication between agenciesIncrease in patient safety, consistency and improved patient journey. | Enabler -Organisation Development and Improvement SupportTechnology eHealth and Data SharingTele healthcare | Development of single shared assessment linked to the Digital Pen and electronic sharing of informationevaluate current Single Shared Assessment tools and means of electronic sharing | Jon HarrisNHS | February 2012-April 2013 | £20,000 |
| aScribe/ePharmacy | Reduce complications re drug interactions, Support protocols, pathways of care Data quality will be improvedApplication of best practicePrevents avoidable readmissionsSupports dischargeWill assist prescribing nurses to prescribe in community. Reducing medication errors and improve medicines management.Provides opportunity to consider common pharmacy records and will improve auditWill improve patient safety and efficiency in prescribing.Assist with delayed discharge and improve the patient journey. | Organisation Development and Improvement SupportTechnology eHealth and Data SharingTele healthcareMedicines ManagementEffective and Timely Discharge Home and or Transfer to Intermediate Care | Updated software to improve medicines management and communication interface with primary and secondary care. Prevent admissions and speed up discharge | Jon Harris NHS | February 2012-September 2012 | £48,000 |

**Workstream -Supporting Carers**

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| --- | --- | --- | --- | --- | --- | --- |
| **Project** | **Outcomes** | **Identified Care Pathways**  | **Actions** | **Lead Officer** | **Development / Implementation Timescale** | **Costings** |
| Carers Training | Facilitate care for those with complex care needsImproved Patient ExperienceSupport Care PathwaysSafer care which is patient centric- maintain more people athome- avoid social admission/readmission/delayed discharge- improved quality of life for carers- improved carers health- reduction in care homeadmissions- reduction in emergencyrespite placements- reduction in hospitaladmission- reduced bed days- reduction in acute beds | Outcomes focussedassessment support for carersCarer SupportSupport for CarersCarers as equal Partners. | Supported CarersAssessing level of needTraining for carers at the point of transitionWill identify carer training package requirementsSupport carer's to keep well: develop carer's training in areas such as equipment,moving and handling and telecare | Peggy MacKay WICCF | March 2012-March 2014 | £57,416 |
| Outreach Ceilidh – StorytellingAn Lanntair | Support for people with dementiaImproved patient journey | Build on social networks and opportunities for participation | To develop resources and deliver outreach storytelling for people with Dementia in dementia café, care homes and in the community | An Lanntair | September 2012-March 2013 | £5,000 |
| Telephone Befriending  | Support for carers Reduce social isolationIncreased ability to copeReduction in social admissions | Carer Support | Outreach telephone befriending service to assist carers in remote and rural settings | British Red Cross | September 2012-September 2013 | £4,705 |
| FAST – emergency Respite Care and Support | avoid social admission/readmission/delayed discharge- improved quality of life for service users and carers- improved service user and carers health- reduction in care homeadmissions- reduction in emergencyrespite placements- reduction in hospitaladmission- reduced bed days- reduction in acute beds | Responsive flexible home careSuitable and varied housing supportCarer SupportRange of intermediate care alternatives to emergency admission | Setting up structures, systems and funding to support emergency/rapid support in the communityCombined with Increase respite options and resources:- reshape model of respite;- develop respite for people with dementia;- further invest in care at home;- consider implementing thehome from home respitemodel; and- procure respite based on carer's needs.Scope social/health support required:- cost SCO/Health input;- cost overnight care/support; and- identify providers.Increase respite options and resources:- reshape model of respite;- develop respite for people with dementia;- further invest in care at home;extend to provide an interventionservice at times of changing need | Kirsty Street(CNES) | November 2012-Novem ber 2013 | £30,000 |
| **Dementia Link Worker** | - improved information and supportimproved quality of life for service users and carers- improved service user and carers health | Specialist Clinical advice to community teamsSupport for carersEarly diagnosis of dementiaInformation and support for self management and self directed support | Deliver 5 Pillars of Post diagnostic support to people with dementia and their carers | Alzheimer Scotland | November 2012- March 2014 | £59,000 |
| **Caring to Communicate –** | improved information and support for formal and informal carersimproved quality of life for carers- improved carers health through appropriate training | Support for carersWorkforce development skill mix and integrated workingSpecialist clinical advice for community teams | Diagnosis to end of life dementia training | Mary Mackenzie/Christine Lapsley(NHS) | May 2012-June 2013 | £8,250 |
| **Long Term Night Respite** | avoid social admission/readmission- improved quality of life for service users and carers- improved service user and carers health- reduction in care homeadmissions- reduction in emergencyrespite placements- reduction in hospitaladmission- reduced bed days- reduction in acute beds | Carer SupportResponsive flexible and self directed home care | To alleviate sleep deprivation in carers who have prolonged periods of lack of sleep due to complex care needs of cared for | Morag MunroCrossroads Harris | September 2012- September 2013 | £18,998 |
| **A Good Night’s Sleep** | avoid social admission/readmission- improved quality of life for service users and carers- improved service user and carers health- reduction in care homeadmissions- reduction in emergencyrespite placements- reduction in hospitaladmission- reduced bed days- reduction in acute beds | Carer SupportResponsive flexible and self directed home care | Providing overnight carer 1-2 nights per week for 6 weeks to provide respite for family carer | Nicky Cowsill(Crossroads Lewis) | October 2013-March 2014 | £56,100 |

**Workstream - Organisational Capacity**

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| **Project** | **Outcomes** | **Identified Care Pathways**  | **Actions** | **Lead Officer** | **Development / Implementation Timescale** | **Costings** |
| Community Equipment Non recurring investment | Value for moneyBuilding capacity in community and care home environment to better support people in the community  | Rapid Access to equipmentCarer supportRange of intermediate care alternatives to emergency admissions | Replace equipment and build capacity in Community Equipment Service and CnES Care HomesReplacement of out of date or condemned equipmentImproved patient experienceEquipment available at the point of need | Sonja SmitAman Toor | February 2012- June 2012 | £102,378 |
| Review Team  | Multi agency review of existing home care packages to ensure care package meets patients current identified level of needSupport protocols, appropriate pathways of care Involvement in maintaining and improving patients own health whilst facilitating care for those with complex care needsEnsuring service is targeted appropriatelyGain greater insight into service demand and gaps- maintain more people at home | Outcomes focussed assessment support for carersSpecialist clinical advice for community teamsIntegrated Case/Care Management.Anticipatory Care PlanningReablement & Rehabilitation | Carers assessment:- provide responsive carersassessment; and- offer/review carers assessment at key stages (service users review/change in need).Review of Home CareCare packages tailored to need - increase/ Reduction in Care PackageReassessment of times of need - leading to more appropriate care packageReview of complex casesReview models of assessment: | Kirsty Street/ Sonja Smit | February 2012- ongoing | £26,953 |
| Asset Summit | Partnership event to identify assets which could be utilised for alternative usage including community assets | Organisational development and improvement suport | Host Partnership Event | Gayle Findlay | November 2012-February 2013 | £2,000 |
| **Community Equipment Service Vehicle** | Increase access for patientsReduction in reported incidents and complaints | Proactive Care and Support at Home | Lease of vehicle in Uist to improve access for Community Equipment Service | Sonja Smit | December 2012 | £25,284 |
| Equipment Servicing contract  | - maintain more people athome- avoid social admission/readmission/delayed discharge- improved quality of life for service users and carers- improved service users and carers health- reduction in care homeadmissions- reduction in emergencyrespite placements reduction in hospital admission- reduced bed days- reduction in acute beds | Rapid access to equipment.Timely adaptations, including housing adaptations. | To extend existing equipment servicing contract to cover community bedsDevelop an integratedequipment service:shared assessmentprocess; review and update housing adaptations procedures;- shared service  | Sonja Smit | April 2012-March 2014 | £21,000 |
| **Nutritional Care in the Community** | maintain more people at home improved quality of life for service usersimproved service user healthreduction in hospitaladmission- reduced bed days- reduction in acute beds | Specialist Clinical Advice for community TeamsIntegrated case care management Anticipatory Care Planning | Develop nutritional screening tool and review malnutrition in community and inappropriate prescribing of oral nutritional supplementsDevelop dietetic care pathwayFood First Approach | Karen France(NHS) | January 2013-March 2014 | £22,642 |
| **MyAction** | maintain more people at home improved quality of life for service users and carersimproved service user and carers healthreduction in hospitaladmission- reduced bed days- reduction in acute beds | Specialist Clinical Advice for community TeamsIntegrated case care management Anticipatory Care Planning | Integrated COPD service including Rehabilitation ongoing dietetic and lifestyle advice to include family and carers | Sara Bartram (NHS) | December 2012- March 2014 | £37,650 |
| **Integration of Health and Social Care Support** |  | Workforce development skill mix and integrated workingOrganisation development and improvement supportSuitable, and varied, housing and housing support. | Resource mappingIntegrated Management and Budget identification | Iain MacAulay(CNES) | March 2013- March 2015 | £110,000 |
| **Asset Infrastructure** | - maintain more people at home - avoid social admission/readmission/delayed discharge- improved quality of life for service users and carers- improved service user and carers health- reduction in care homeadmissions- reduction in emergencyrespite placements- reduction in hospitaladmission- reduced bed days- reduction in acute beds | Access to range of housing options Telehealthcare.Suitable, and varied, housing and housing support. | To consider needs of Care population and infrastructure developments including Dun Eisdean and Dun Berisa**y**Review the Use of BuildingAssetsIdentify potential accommodation:review current provision fordesirability/model of service;- incorporate of telecare/telehealth;.Scope social/health support required:- cost SCO/Health input;- cost overnight care/support; Re- evaluate demand for supported accommodationFinancially bridge change | Iain MacAulay(CNES) | January 2013-June 2013 | £15,000 |

**Workstreams 2013-2015 (to be agreed but to include elements of the following**

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| **Project** | **Outcomes** | **Identified Care Pathways**  | **Actions** | **Lead Officer** | **Development / Implementation Timescale** | **Costings** |
| Dementia | Maintain more people atHomeAvoid social admission/readmission/delayed dischargeImproved quality of life for service users and carersImproved service users and carers healthReduction in care homeadmissionsReduction in emergencyrespite placementsReduction in hospitaladmissionReduced bed daysReduction in acute/psychiatricBeds | Prevention and treatment of deliriumEarly diagnosis of dementia.Timely adaptations, including housing adaptationsInformation & Support for Self Management & self directed supportOutcomes focussed assessmentSupport for carersTelehealthcare | Detection and support servicesReview current modelsInvest in redesignand commission support services.Revised model care for people with dementia:- review current provision against future requirements;- agree model of service;remodel existingprovision; and- strategic procurementplacements against an agreed spectrum of care through joint commissioningAgreed model of end of life carefor people with dementia:- build on current work undertaken by working groups.Review community care models to support people with dementia at home:- enhance and develop community OT services to address dementia specific- environment adaptations;develop a health/social care crisis response including out of hours that is delivered within the home environment;- review overnight support;- develop telecare responses; andreview support worker(health/social work)/social care worker role in community mental health teams.Review support of people with dementia who require hospital admissions:- enhance current hospital liaison services.Promote self directed support for people with dementia. | Ann Hutchison/Mike Hutchison | March 2013-September 2013to bring proposal forward | £ tbc |
| Integrated Teams | Maintain more people athomeBuild community resilienceManage resources to meet growing demandDevelop social enterpriseIncreased choiceImproved service users and carers health and wellbeingFurther integration- across sectors | Workforce Development and Skill Mix, Integrated Working | areas for consideration where either similar tasks are carried out by others and/or services are restricted in volume. This willtake into account the terms and conditions of the workforce affected.  | Colin Gilmour | March 2013-September 2013 to bring proposal forward | £ tbc |
| Housing | Maintain more people athomeBuild community resilienceManage resources to meet growing demandDevelop social enterpriseIncreased choiceImproved service users and carers health and wellbeingFurther integration- across sectors | Access to a range of housing options Suitable, and varied, housing and housing support.Timely adaptations including housing adaptations | Review current provision against future requirements;Agree model of service;remodel existingprovision; andStrategic procurementplacements against an agreed spectrum of care.Identify opportunities for the development of social enterprise approaches whichaddress the following:- enable older home owners to improve their housingconditions, safety, security and comfort;- provide cost effective low level supports (handy person, practical support); and explore options for promoting Care and Repair | Isobel MacKenzie/Paul Dundas | March 2013-September 2013 to bring proposal forward | £ tbc |
| Telecare | Maintain more people athomeBuild community resilienceManage resources to meet growing demandFurther integration- across sectors | Access to a range of housing options Suitable, and varied, housing and housing support.Telehealthcare | Review current provision against future requirements;Agree model of service | Sonja Smit/Aman Toor | March 2013-September 2013 to bring proposal forward | £tbc |