JPIAF 10 – WHOLE SYSTEMS ANALYSIS

INTRODUCTION AND ANALYSIS OF COMPARATIVE MODEL

The Western Isles Partnership is able to evidence a good balance of care, but remains vulnerable to a number of service pressures relating particularly to delayed discharge and repeated hospital admission. A working group, the Health and Social Care Partnership Project Group, has been formed to take the lead on joint working and to support the Joint Future Committee that has the lead on developing strategic and policy initiatives.

In order to work across all client groups, the Community Planning Partnership continues to provide a wider community perspective. The Mental Health Partnership is delivering against national and local targets with a revised Joint Local Implementation Plan (JLIP) published in September 2005; and the Learning Disability Partnership is co-ordinating the strategic management of joint working in planning, developing and delivering services for people with learning disabilities living in the Western Isles, in context of The same as you? and the local Partnership in Practice agreement. (PIP). The Alcohol Drugs and Smoking Team (ADSAT) a locally based multi-agency group is leading on development of prevention, education and treatment services locally.

The Partnership has benefited from the support of the Joint Improvement Team since June 2005. They have assisted in supporting joint working at a governance and operational level, accelerating the Joint Future Agenda. After an initial scoping and assessment exercise, the JIT has engaged with stakeholders to prioritise issues such as governance arrangements, and delayed discharge, as well as providing advice on the JPIAF.

The 2004/05 evaluation as ‘average’ for the comparative model and ‘improvement required’ for the holistic approach has been helpful in enabling us to focus on improving outcomes for service users and carers, as well as challenging us to maintain high levels of care. We recognise the small negative variance of -2 in our overall performance in 2005 compared to 2004, and this has informed our priorities for the development of robust LITs to support a reduction in delayed discharge and repeat
admissions, in particular. We are able to evidence both service pressures, and good service provision by examples such as the number of respite places in care homes being fully utilised throughout the year on a rotation basis, day care referrals and attendance at day care centres increasing, and the consistently high level of home care provided in our communities. We want to ensure that we gain maximum benefit from the good investment in service provision across our diverse and many remote communities.

**Population over 65**

The Western Isles has an increasingly aging population. The over 65’s account for 20% of the population, 25% higher than the Scottish average. The overall population is projected to decrease with those under 45 predicted to fall by 36% to 41%. This impacts, not only, on the demand for health and social care services, but also has an impact on work-force availability to meet the increase in demand. To address possible future work-force shortages a number of pilots are underway, which are being evaluated to inform future investment and service redesign programmes. These include a pilot on the provision of a hot meal service to free up carer’s time to provide more personal care, and the use of aids and equipment in the home to allow service users greater independence to remain in their own homes.

**PREVENTING UNNECESSARY HOSPITAL ADMISSION**

The Partnership is committed to reducing unnecessary emergency and repeat admissions and some progress has been made during 2005/06. A number of service initiatives and refocusing of existing services are contributing to this.

- The F.A.S.T. Budget continues to be well utilised to fund short term crisis situations at home, or to expedite the hospital discharge process with 42 individuals supported in this way between April 2005 and March 2006. This funding can be accessed by all community health and social care staff throughout the Western Isles.

- The recently piloted Overnight Community Nursing Service based in the Western Isles Hospital prevented admission in 3 cases between January and
March 2006 by providing support, advice and treatment in patients own homes. (see example in JPIAF 8 return). We are currently reviewing how the service can be maintained and to raise awareness with GPs, in particular to ensure maximum take up.

- There are three Mobile Overnight Support Service (MOSS) teams covering the main population centres in the islands, a service which has been commended as good practice by an external consultant (Grampian Delayed Discharge Seminar- 5th May 2006). The teams provide overnight support to people to their own homes between the hours of 10.00pm and 7.00am. To ensure equity of service in the more rural areas, the Partnership aims to increase the take up of this service in rural Lewis and the Uists and to look at ways of developing a service to meet the overnight support needs on the Isle of Barra. We will also examine the impact of further extending unscheduled access.

- The newly appointed Mental Health Senior Practitioner based in the community and linked to the Acute Psychiatric Assessment Unit is now routinely attending case conferences and by providing a specialist assessment prevented inappropriate hospital admission in 5 cases between February 2005 and May 2005. This will continue to be monitored during 2006/07 to inform future LITs.

- Since the appointment of a locum geriatrician the use of the day hospital has increased from 30 consultations in September 2005 to 131 in February 2006. The Day Hospital is now able to administer blood transfusions, a service that previously required an inpatient admission. By extending into providing falls assessments, follow-up appointments for vulnerable adults discharged from hospital, assessment of adults in the community whose condition is deteriorating it is estimated that in January 2006, 14 patients who would otherwise have required admission were assessed and managed in the day hospital.
For example: *one elderly lady was able to receive titration of medication to balance her deteriorating heart condition by attending day hospital twice weekly and so was able to remain at home. Another lady with nephritic syndrome who had previously been admitted to a ward on a regular basis was able to treated in the day hospital and remain at home.*

- A programme to monitor the condition of adults with a previous history of repeat hospital admission by inviting them to regular appointments in the day hospital resulted in an estimated 14 admissions being prevented.

- The Highlands and Islands Fire Board has launched a campaign to alert young and old to the risk of fires and stressing the importance of fire detectors. It will focus on Island lifestyles and the problems caused by consumption of alcohol and the effect this has on people’s ability to respond.

- Lack of public transport to allow patients to return home after receiving treatment can be a challenge in remote and rural areas. To ensure that this does not result in inappropriate admission to hospital, the Scottish Ambulance Service has undertaken to endeavour to provide transport to allow patients to return home when ever possible. We will take forward further work to examine the impact of transport on admissions and discharges and undertake an audit during 2006/07 to inform transport solutions for the WI communities and LITs for 2007/08.

- We recognise that prevention of falls, especially in an elderly population is important in preventing hospital admission. To prevent falls *Safetywise*, a project set up to ensure that the elderly and physically disabled are living in a safe and comfortable environment provide advice, assistance and onward referral where appropriate. Clients can self refer or are referred following admission to hospital for injuries caused by a fall or when community based staff recognise a need for this service. We aim to develop a LIT (s) on anticipatory and preventative care for 2007/08.

- To address the need to manage long term chronic conditions the Partnership intend to assess how the outcomes of a pilot project undertaken by Highland
NHS, focusing on the sharing of information at GP practice level can be applied locally.

- An audit of recent hospital admissions from Care Homes was carried out in December 2005. We have identified the use of IV antibiotics and other IV intervention in care homes and in the community as one way of preventing hospital admission. (Audit Dec 2005), and are training a cohort of nurses to be able to provide this. This also makes better use of community resources and improves the service users’ experience. This will be extended to include blood transfusions in care homes and we have identified a number of patients where this will prevent hospital admission. The impact and the number of admissions prevented of this new initiative will be monitored. The cohort of nurses trained to provide this service will be sufficient to provide the service across the islands, but limited to enable regular use of their new skills. We will consider this area for a LIT in 2007/08 once good baseline information is available.

- The importance of provision of day care services to enhance the mental health and provide stimulation for the older people is recognised. However with many elderly people living in remote and rural locations there is not provision throughout the islands. The new Care Home Developments in Carloway and South Uist will extend the range of day care services from 2006/07.

- Telemedicine is important for the Western Isles. The Service redesign Group led by NHS WI it has been agreed that the Director of Social Work, CnES would take the lead in exploring the potential for extending the current Community Alarm Service to encompass more specialist telecare areas including medical monitoring. This will inform LITs for 2007/08 and beyond.

- The Occupational Therapy Service, working together with community nurses has taken the lead in the development of an integrated equipment service with input from infection control, Health and Safety, facilities management, technical services, social work and FAIRE (Community Alarm). Training and awareness raising sessions across different occupational groups and around the
islands, along as the establishment of two new equipment stores will increase the speed of access to identified kit.

**EMERGENCY AND MULTIPLE ADMISSIONS**

The QIS Clinical Indicators Report 2005 indicated that our admission rate for over 65’s is in line with the national average and while length of stay is longer it is on par with that of geographically similar areas (QIS Report, page 100). However, we experience the largest number of alcohol related admissions (QIS Report p71). An Unscheduled Care Collaborative is working to reduce the number of emergency admissions and multiple admissions by seeking to better understand the reasons for admission and to develop protocols to prevent inappropriate admission in future. An Alcohol and Mental Health Liaison Nurse will shortly be appointed to support and improve the overall service offered to service users in this group. It is anticipated that this post will have a beneficial impact on the number of emergency and repeat admissions to Western Isles Hospital. We will set specific LITs for this client group in 2007, building on the specific LIT for SSA we have developed for 2006.

We will undertake a detailed audit of a cohort of repeat admissions during 2006 to further inform our approach to reducing the number of inappropriate repeat admissions. We will aim to develop specific LITs for 2006/07 by targeting repeat admissions within specific timescales e.g. within 7 days, 28 days of admission.

**DELAYED DISCHARGES**

We note the increase in the total number of delayed discharges and in the numbers of patients delayed more than 6 weeks. This number has fluctuated over the year with a reduction to 10 in April 2006. The main cause of delay is the lack of availability of care home places, although we are exploring other alternatives if possible.

The Partnership is committed to improving the process for patients and has in place a number of systems to constantly monitor the position.
A Health and Social Discharge Steering Group has been established, chaired by the Director of Nursing, to overview strategic issues, with a multi-disciplinary sub-group responsible for individual patient reviews.

A revised Delayed Discharge Policy is currently under review and has gone out for public consultation.

A senior nurse has been appointed as a Patient Journey Facilitator to monitor patients following admission to ensure arrangements are in place for their timely discharge and that their health and social care needs continue to be met once they return to the hospital. We will aim to introduce more robust discharge planning from point of admission during 2006.

A new hospital based home care assessor is responsible for assessing the home care needs of patients immediately prior to discharge to allow packages to be put in place when required.

At the weekly multidisciplinary ward meetings where patients are discussed the Single Shared Assessment process is initiated when appropriate and contact made with the community care social work team. In the current absence of a hospital based social worker and staff shortages in the community care social work team, the Patient Journey Facilitator co-ordinates the contributions of hospital staff, maintains contact with community staff and as she is also present at the monthly care home placement panel is able to provide information on the current health status of patients awaiting placement.

The Partnership aims to reduce the number of people delayed in short stay beds and those delayed over 6 weeks as a matter of priority, in line with the national targets. With reference to the census on 15 April 2006 the following delays were reported:

<table>
<thead>
<tr>
<th>Delayed Range</th>
<th>Count</th>
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<tbody>
<tr>
<td>Delayed 0 – 6 weeks</td>
<td>4</td>
</tr>
<tr>
<td>Delayed 7 – 9 weeks</td>
<td>2</td>
</tr>
<tr>
<td>Delayed over 10 weeks</td>
<td>4</td>
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NHS GERIATRIC LONG STAY BED USE

The Partnership aims to reduce the number of people in long stay beds and work will be taken forward during 2006 to identify alternative provision where possible. There are long stay patients in Clisham Ward which is a 28 bed psychiatric inpatient ward, incorporating a 4 bed acute psychiatric assessment unit and Erisort ward which is a 28 bed medical work of mixed sub-specialities including Orthopaedic Rehabilitation, Respite with 9 long stay Psychiatric beds. There are no discharge or rehabilitation planning arrangements for patients in these long stay beds. The Health Board and the Comhairle are highly conscious that the environment on Erisort Ward is far from ideal for the care of this patient group and are actively exploring alternative accommodation in the community for these patients.

Proposals are being taken forward to develop a dementia unit in Dun Berisay, a care home in Stornoway to provide an opportunity to increase capacity to cater for needs currently met in hospital. The Comhairle has committed the capital cost with joint revenue funding. The project will proceed once the Health Board has allocated the balance of revenue funding required.

There are a number of people with enduring mental illness, learning disabilities and acquired physical disabilities in long stay out of area placements off the Islands. The Partnership is committed to examining alternatives and providing local care and support if possible. We will be taking forward a review of people in out of area placements during 2006/07.

SUPPORT IN THE COMMUNITY

The number of people supported in care homes remains constant, taking account of our increasing population of older people and our commitment to support people to remain in their own home as long as possible. The challenge to meet the demand for suitable places for people in hospital and in the community necessitates the holding of monthly meetings of the Care Placement Panel to review and prioritise those awaiting placement.
It is recognised that the current range of Care Units (4 bedroomed units, situated in several villages around the islands, with a warden in attendance during the daytime and early evening) is not providing a real alternative to residential care. Newhaven consultants have been instructed to work with the local housing association to develop plans to enable the care units to be redeveloped as a form of ‘very sheltered housing’. This, together with the Mobile Overnight Support Service will allow clients to remain in their own community.

The South Uist Care Development is due to come into service at the end of 2006. As well as providing additional day care services it will provide local physiotherapy, and podiatry services. It is recognised that ready access to these services is important in supporting and maintaining independent living abilities. The Health Board’s ‘Best Foot Forward’ foot health strategy provided training to carers and residential and nursing staff throughout the islands. Formal treatment plans and reducing waiting times for assessment resulted in 83% of patients surveyed reporting improvements in foot health.

A 5.4% increase in the number of people receiving more than 10 hours a week of home care reflects the commitment of the Partnership to support people in their own homes. The increased expenditure in the home care budget presents challenges and will have to be carefully monitored.

**Service Redesign**

NHS Western Isles established a number of service redesign groups in February 2004 to examine how services such as primary care out-of-hours, radiology, community health services, surgical services, paediatrics, psychiatry, general medicine and maternity services could be targeted to better meet the needs of the population. This has also provided an opportunity to engage a wide range of front line staff and representatives from patient groups and the wider population. We will be examining the broader role of intermediate care services appropriate for the Western Isles communities this year.
**SINGLE SHARED ASSESSMENT**

A total of 71 single shared assessments have been completed from April 2005 to March 2006. To address the increased demand for services caused by the increasing number of older people being maintained in their own home with support from health, social work and voluntary sector organisations we have trained more community nurses to take the lead assessors role. All existing lead assessors have had the opportunity to attend refresh/retrain sessions, and we continue to make progress with general awareness raising sessions for other members of staff expected to contribute to the SSA process.

The Partnership is committed to the continued development of the SSA process and ensuring it becomes imbedded into practice across all client groups. We have prioritised clients with learning disabilities for the current year as a significant number of these clients are being cared for by increasingly elderly carer’s. In 2007/08 we intend to set more challenging targets for adult clients aged below 65 with mental health problems and those with substance misuse.

Although we currently use a paper tool, funding from the national eCare programme has been allocated to the development of electronic SSA’s locally, and a short term post of project manager established by the Health Board. Shortening the cross referral process by starting a programme of co-location of staff in included in our Local Improvement Targets and work to commence with this will start shortly.

**Carer’s Assessments**

The Partnership recognises that Carers should be given the opportunity to express their needs that need to be met to assist them in continuing to function in their supporting role. The use of Carers assessments is currently being actively promoted as an important way of highlighting good practice. We aim to assess the needs of the carers to allow identified needs to be met in a planned way.

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For Example: *In the case of an elderly gentlemen who was the main carer for his wife after she suffered a stroke and became totally dependent on him a Carer’s Assessment highlighted the strain and exhaustion suffered by the gentleman and facilitated discussion on his need for a sitter service during the week to allow him time to himself, which in typically Western Isles fashion he wished to invest in his croft.*
AIDS AND ADAPTATIONS

The Partnership is aware of the significant impact the use of appropriate equipment can have on improving the quality of life for an individual. The use of equipment and adaptations made to the living environment of service users can also reduce their dependence of Home Care workers.

The Community Alarm system is a good example of a joint initiative that has developed over the years and is now used by over 800 clients. The Care and Repair Service provides a home improvement service to vulnerable adults. Problems of capacity in the local construction industry, caused to some extent by the severe storm in January 2005 have caused delays in our ability to provide meet demand. The Partnership has tried to alleviate some of these delays by using the Comhairle’s Direct Service Organisation to undertake some of the more urgent work.

The length of time from identification of a need for installation of equipment is an important measure of effectiveness in this area. Referrals for the OT service can come from any source and so the service has identified the need to develop the provision of advice, information and education. Improvements required in the distribution of equipment and better integration with the provision of nursing equipment will be commenced in the coming year. As the South Uist and Carloway Care Developments are completed the opportunities for immediate access to equipment will be enhanced. A new post of Technician to deal with the assessment and delivery of equipment to parts of rural Lewis and Harris has been established.

Adaptations fall into various categories ranging from minor adaptations that will clearly enhance quality of life to major work that is essential to allow someone to continue living at, or return home. The Comhairle has committed substantial resources to meet the cost of adaptations to Council Housing in previous years, and in recognition of this, the Health Board has undertaken to consider making funding available in appropriate cases.
Better Outcomes for Older People

It is intended, under the auspices of the Older People’s Partnership, to develop a joint strategy on services for Older People in the Western Isles, building on the home care review, review of housing etc. Independent researchers have been commissioned to produce the strategy taking into account associated needs assessment and capacity planning. To this end, the research company RP&M Associates have been asked to undertake an initial scoping exercise.

The document ‘Better Outcomes for Older People’ is an integral part of this research work in that it underpins the service development aspirations in the Western Isles.

The Partnership is committed to improving services in line with Better Outcomes for Older People six key themes that have informed the development of the LITs and service redesign priorities.

Assessment of need
The work being progressed on the older people’s strategy and capacity planning will provide robust information on needs and unmet needs. Through the SSA process we will ensure that new and existing clients are provided with a comprehensive assessment, including a focus on health and well being. The provision of independent advocacy for older people in particular is important and we will ensure a specific focus on this over the next few years. The role of the voluntary sector and locality groups are important in representing the views of people in local communities and we are building on some good work in this area.

Standards and quality of Care
We will continue to assess our quality of care in context of existing standards and indicators (NHS QIS Older People Standards in Acute Care; NHS QIS Learning Disability Quality Indicators, SWAI Performance Improvement Framework etc). The recommendations of external assessors are being addressed and will inform further development of LITs and service redesign.
Application and delivery of best practice
We will endeavour to develop and monitor our LITs with due account to evidence and best practice. We are investing in ongoing evaluation and will need to take account of the implications for staff training and development.

Communication. Multi-professional and multi-agency working

The focus on carer assessments is evident in our LITs and we will need to ensure ongoing attention to issues and needs identified. The role of SSA in supporting the client pathway and the work being undertaken as part of the unscheduled care programme will assist in better understanding the pathways and areas for improvement. The revised Discharge Planning Policy is also relevant in this regard and aims to improve communication with the patient, carers and professionals.

Developing Integrated care and partnership and Monitoring and evaluation of care

We are undertaking significant work, with support from the JIT to better engage with the range of stakeholders to better understanding journeys of care. The LITs will contribute to this work and a detailed development programme is being developed with workshops and events in June and August to ensure effective implementation and evaluation.

CONCLUSION

The Partnership is focused now on improving and developing services for older people and other client groups and we believe we are developing good capacity to deliver improved outcomes to the people of the Western Isles.

The support from the JIT has been particularly helpful in providing practical assistance since June 2005. The JIT support will continue to the end of 2006 and we expect to be in a position to continue the good progress, with better developed arrangements to localities.
References

1. Care of Older People – Podiatry Empowerment and Health Improvement Service Business Plan
2. Foot Health Strategy – Best Foot Forward 2002-2003
3. Health Improvement Plan 2004/07
4. Home Care Service Review – University of Glasgow 2005
5. Independent Review of Home Care Service: Western Isles – Elaine Campbell
6. Mental Health (Care and Treatment) (Scotland) Act 2003 Joint Local Improvement Plan – Western Isles. September 2005
7. Western Isles Community Well Being Action Plan 2004/05
8. Housing Community Care Needs Assessment – DTZ Pieda Consulting 2005
9. Audit of Care Home Admissions – Ella Macbain January 2006
10. Partnership In Practice Agreement September 2004
11. NHS QIS Clinical Indicators 2005
12. JIT Action Plan
13. JIT Initial Report
14. JIT Joint Strategic Planning Framework and Approach to Older Peoples Service Planning.