APPENDIX 1

WESTERN ISLES - LOCAL CHANGE PLAN

Name of partnership:

Western Isles Community Health and Social Care Partnership

Partner organisations:

Outer Hebrides Community Planning Partnership, NHS Western Isles, Comhairle nan Eilean Siar, Co-Cheangal Innse Gall, Western Isles Community Care Forum, Western Isles Carers, Users and Supporters Network and Scottish Care.

Finance – use of Change Fund and additional resources

Income:

<table>
<thead>
<tr>
<th>From</th>
<th>Amount £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial central allocation</td>
<td>531,000.00</td>
</tr>
<tr>
<td>Added by NHS Board</td>
<td>0.00</td>
</tr>
<tr>
<td>Added by local authority</td>
<td>0.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>531,000.00</td>
</tr>
</tbody>
</table>

(Please see section - ‘Summary of Partnership Budget’, page 5)
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)

It is recognised by all partners that this is not an exhaustive list of outcomes required to meet the needs of our changing demographic and the resultant challenges thereof, for example dementia. We require step change to achieve these and other outcomes in a comprehensive and sustainable manner.

Crucial to this process is the recognition of making the various initiatives self-funding during the four-year funding period of the Change Fund. We will use relevant local and national data to measure financial performance related to shifting the balance of care.
## Outline expenditure (Year 1):

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Recourses</th>
<th>Cost/Budget*</th>
<th>Accumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Joint Change Team</strong></td>
<td>This team will consist of joint planning, finance, health and social care intelligence and information, project and admin support. This will be provided through a combination of existing resources and new short term investment. External specialist support will also be essential at times. This team is to provide vital short-term additional capacity to plan, design and deliver whole system change. Funding will be used for years 1, 2 and potentially part of year 3.</td>
<td>£96,000</td>
<td>£96,000</td>
</tr>
<tr>
<td><strong>2. Building capacity and enabling effective third sector engagement</strong></td>
<td>We plan to provide resources over the life of the programme to enable the Third Sector to fully participate, as true partners in developing, planning and delivering transformational change. As full members of the Change Team and to lead in a number of key workstreams. Strong links between the Change Team, Voluntary and the Independent Sectors will be developed to ensure integrated planning to meet the needs of our population. (SLA/contract development, service mapping and capacity building)</td>
<td>£30,000</td>
<td>£126,000</td>
</tr>
<tr>
<td><strong>3. Shifting the Balance of Care Workstreams</strong></td>
<td>Recognising the demographic, geographic and economic challenges facing the Western Isles and Scotland as a whole. Shifting the balance of care will require planned and well co-ordinated multiple workstreams to design and deliver services in an integrated way, which ensures patients/service users are able to maximise their independence, prevent admissions to hospital and secure effective care in their home/community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workstream</td>
<td>Recourses</td>
<td>Cost/Budget*</td>
<td>Accumulative</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>a) Reablement Team</strong></td>
<td>There is strong evidence to support the development of reablement. Home care reablement uses the interpersonal skills of home carers, along with other professionals such as Occupational Therapists, Physiotherapists etc. to provide better outcomes for service users. Goal planning is used to re-able the service user to learn or relearn daily living skills and maximise their independence and preventing admission to hospital</td>
<td>£150,000</td>
<td></td>
</tr>
<tr>
<td><strong>b) Joint Review Team</strong></td>
<td>To review all local home and community care arrangements and mainland placements. There will be strong links between this work and that of the reablement team and the Mainland Placement Panel. A review of community care packages is essential to ensure that those in greatest need receive the services they require and that these are provided within available resources. A clear objective will be to design and deliver local capacity to reduce our joint dependence on Mainland providers and the significant expenditure that this represents. Work to link our commissioning needs with the potential local provision by Third Sector and Independent providers is essential.</td>
<td>£45,000</td>
<td></td>
</tr>
<tr>
<td><strong>c) Delayed Discharges</strong></td>
<td>To free up capacity currently dedicated to the care of patients inappropriately placed in hospital by designing and providing appropriate alternatives to admission. Strong links between this work and the work of the care review and reablement work. The aim in years 2-3 is to integrate the work of sections a, b and c.</td>
<td>£50,000</td>
<td></td>
</tr>
<tr>
<td><em>Sub total</em></td>
<td></td>
<td>£245,000</td>
<td>£371,000</td>
</tr>
<tr>
<td><strong>4. eHealth and Telehealthcare Initiatives,</strong></td>
<td>Development of a shared, editable live eSSA through design and implementation of a system adaptor to facilitate the introduction of an electronic collaborative form</td>
<td>£100,000</td>
<td></td>
</tr>
</tbody>
</table>
The introduction of time saving applications for community based Health and Social Care workers in the field.

This will also provide important performance and planning data.

Development of EMIS Web as the NHS vehicle for eSSA, Community Nursing and AHP systems.

Supported by continued development of the CareFirst database system.

Sub total

5. Education and Training. An imperative is to design and provide high quality education and training across all sectors to support joint working and an integrated model of service.

Joint training within an integrated model will further enhance standards of practice and provide ongoing revenue savings.

Estimated total

* Costings are only indicative at this stage

Summary of current partnership budget:

**Total partnership expenditure for care of older people - Integrated Resource Framework (IRF)**

<table>
<thead>
<tr>
<th></th>
<th>NHS WI</th>
<th>Other boards</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Patients / Day Cases</td>
<td>12,296</td>
<td>2,720</td>
<td>15,016</td>
</tr>
<tr>
<td>Out Patients</td>
<td>1,906</td>
<td>213</td>
<td>2,119</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>1,324</td>
<td></td>
<td>1,324</td>
</tr>
<tr>
<td>Community Nursing</td>
<td>2,244</td>
<td></td>
<td>2,244</td>
</tr>
<tr>
<td>GMS / GPS, etc.</td>
<td>4,505</td>
<td></td>
<td>4,505</td>
</tr>
<tr>
<td>Patient Travel</td>
<td></td>
<td>398</td>
<td>398</td>
</tr>
<tr>
<td>Total</td>
<td>22,275</td>
<td>3,331</td>
<td>25,606</td>
</tr>
</tbody>
</table>

Comhairle nan Eilean Siar

LFR 3 – Net Expenditure - Older Persons 2009/10 (£’000)

12,611

The above table represents the draft IRF ‘Outturns’ data for NHS Western Isles and Comhairle nan Eilean Siar. Further work is ongoing to refine the figures, for completion by end of May 2011 in line with SGHD guidance.

NHS Western Isles and Comhairle nan Eilean Siar will continue to work jointly, to fully identify and bring into play the total resources available to facilitate and deliver significant shifts in the balance of care delivered throughout the Western Isles.
Summary of key outcomes/outputs achieved through current resources:

We will continue to work collaboratively to further improve performance against a series of national targets (outlined below) and we will develop more refined performance improvement trajectories, monitoring and wider reporting mechanisms. Further work will be done to develop local performance targets. Key performance areas:

- Reduction in Emergency admissions for 65+
- Reduction in bed days for 65+
- Reduction in the number of avoidable admissions
- Zero Delayed Discharges
- Increased % of people 65+ with intensive needs receiving care at home
- Increased % of people 65+ receiving personal care
- Decrease % of people admitted twice or more without a SSA
- Increased Self Directed Support/Personalisation
- Increased short-break provision to support carers and service users

Key changes to achieve over the next 5 years

- **Joint Change Team** - Establishment of a tripartite change team with NHS Western Isles, Comhairle nan Eilean Siar and the Third Sector. The Change Team will operate through years 1-3 with no ongoing costs beyond year three. The Joint Change Team will provide much needed planning and analysis capacity, supporting and strengthening existing planning structures for example, OHCPP, JSC, LDPs, eHealth Programmes Board, Integrated Mental Health and Learning Disabilities Planning Group, Older Peoples Planning Partnership, Older Adults Mental Health Forum etc. Year 1 – (i) Team established, planning priorities and strategic action plan agreed.

- **Integrated Resource Framework and service change** - Undertake further detailed analysis of referral patterns, prescribing and patient pathways to understand variation in practice and identify ways to improve outcomes for patients and better use of existing resources. This would also incorporate a review of current LES (Local Enhanced Services) with GP Practice using them as a ‘vehicle of change’ to support better utilisation of resources and secure more effective anticipatory care and reduced variation/cost. Develop greater alignment of budgets and an understanding of the total resources available. Year 1 – (i) Further refine financial and referral data. (ii) Undertake review of LESs and patient pathways to improve patient centredness and reduce variation in line with the quality ambitions of NHS Scotland Quality Strategy.

- **Strengthening community capacity** - Through a more integrated review, redesign and planning of community services (Home Care, Community Nursing, AHPs and GP services), delivering an integrated ‘Single system’ approach to assessing need, access and delivery of care at home. Year 1 – (i) Undertaking a joint review of current community care ‘packages’ and aligning ongoing reviews of Community Nursing and Home Care Services and budgets. (ii) Explore the potential to provide improved local flexibility in enhanced short-term care provision (short-term additional hours/care, overnight support, local budgets)

- **Joint care-planning** - Continue to develop and implement improved (Single Shared Assessment, Anticipatory Care Plans). Year 1 – (i) Working with systems designers develop systems ‘adaptor’ and ‘collaborative form’ to
support the development of a joint, shared, editable ‘live’ eSSA.

- **Maximising independence** - Through significant whole system working focused on clear anticipatory care, targeted reablement, rehabilitation, improvements in Long-term condition management, equipment, adaption’s and housing. **Year 1** – (i) Undertake a ‘Reablement’ Pilot (Lewis area). (ii) Review of both local and mainland packages of care. (iii) Improve the management of delayed discharges and begin to free up capacity to provide alternatives to admission.

- **Supporting greater systems integration** – Utilise EMIS Web as the vehicle to deliver great integration, electronic records, appointment systems, service information and eSSA. **Year 1** – (i) To develop EMIS Web to support integrated systems between Community Nursing, GP’s and eSSA. **Years 2-3** – (i) Develop EMIS Web for AHP services.

- **Third Sector capacity building** - improved support, investment and better utilisation of Third Sector Organisations. Working with the Third Sector to develop improved efficiency, capacity and resources across the Western Isles. **Year 1** – (i) Undertake detailed service and capacity mapping of Third Sector, identifying new or improved service opportunities, reducing duplication, improved efficiency, developing capacity and implementing revised Service Level Agreements (SLAs) with Third Sector organisations as part of the process of ‘Shifting the balance of care’ by greater utilisation of the Third Sector.

- **Supporting informal carers** - Building upon the work on the Carers Strategy and Carers Information Strategy to deliver tangible additional support for carers. The Third Sector is already being commissioned to take forward the Carer’s Information Strategy on behalf of the key partner organisations. **Year 1** - (i) This will be further strengthened by greater focus on refining and progressing joint Carers and Older People’s Strategies, linked with improving capacity within the Third Sector and increasing support for carer’s. (ii) A project will also be undertaken to identify potential opportunities to support the ‘co-location’ of some Third sector organisations and develop ‘Carer Centres’ (both physically and virtually) to provide greater support and raise the profile of carer’s (including Young Carers) and Third Sector organisations.

- **Housing** – Working in partnership with all key agencies, OHCPP, Housing associations etc. to secure significant improvements in housing provision, supported accommodation and housing modification/adaptations. Supporting the development of ‘caring communities’ ‘Better neighbours’ and similar initiatives. **Year 1** – (i) Further strengthen and improve the existing integrated Community Equipment Service. (ii) Strengthen integrated working with housing and associated agencies to develop robust longer-term strategies.

- **Benefits realisation from eHealth and Telehealth initiatives** – There are a number of ongoing initiatives (Telecare, Telehealth) and plans in development that offer real potential to modernise working processes and the communication structures that support these. **Year 1** – (i) CnES representation on NHS WI’s eHealth Programmes Board supporting a joint approach to planning from the outset. In addition we will reconstitute the concordat between NHS WI’s, CnES, UHI and HIE.
Utilisation of Change Fund and outcomes anticipated

The Change Fund will be utilised to:

1. Significantly improve the partnerships strategic alignment through the development of a Joint Commissioning Strategy for older people’s services. Including for example, development of a joint Dementia Strategy, Housing Strategy, Respite Strategy etc.

2. Greater integration of community services with a ‘single system’ approach to assessing need, accessing and delivery of care at home

3. Maximise the development, impact and benefits realisation of eHealth (Telecare, Telemedicine) through the continued development of our integrated eHealth Programmes Board, targeted application of technological solutions to enhance care and support in the home, reduce admission and the need for patients to travel for secondary and tertiary care.

4. To redesign the partnerships Out Of Hours Services, looking to develop single system working, greater efficiency and improved access to service both in and out of hours. Developing clear pathways of care linked with robust anticipatory care planning and integrated services across all sectors.

5. Improved management, review and potential repatriation of patients currently receiving care through mainland specialist units as part of redesigning increasingly integrated adult mental health services

6. Working with the Independent Sector and all key partners, begin to explore, map and design future Care Home provision. Ensuring it is able to meet the needs of our local communities, challenging geography and population demographics. Looking to move away from traditional solely ‘long stay’ facilities to more flexible facilities providing a range of services. For example, potentially ‘Step Up, Step Down’, Respite, Palliative Care, ‘Outreach’, Specialist Care service, possible ‘Care Hub’ type arrangements

This will be achieved through:

1. Improved organisational readiness and capacity for change through careful planning, system redesign and improvement (LEAN will be the underlying methodology supporting all change), specific OD programmes, team building, personal development and skills utilisation. We do not underestimate the cultural changes that will be required in many parts of our systems and ways of working.

2. Improved Workforce planning, together with improved recruitment, retention and careers development opportunities of staff across all agencies. Supporting the development of a more integrated, flexible workforce across agencies, providing new and rewarding employment opportunities and enable the delivery of sustainable services. Develop greater opportunities for and utilisation of ‘volunteers’ linked with work experience, alternative routes to paid employment and career pathways

3. Improved capacity of the Third Sector to support anticipatory care, reablement, respite and transport. Supporting increasing levels of care provided in the home/community
Key performance measures to assess progress

Key performance measures will remain as SOA, HEAT and CCO targets/measures.

However, specific performance measures to monitor progress and indicate the delivery of targets will be developed and agreed.

Summary of how Change Fund will enable shifts in care budgets and impact on the totality of spend by the partnership over the next 5 years

It is recognised that more work needs to be undertaken in terms of the IRF and accurately identifying the ‘real’ spend and available transferable resources. Greater clarity around aligned budgets/spend and extracting efficiencies as well as resource transfer.

We clearly expect to see and demonstrate more appropriate use of acute and care home resources, with evident improved efficiencies and ‘value for money’. Visible, person-centred, effective and efficient community based care/services, which deliver better outcomes for patients/service users, which are fully integrated, robust, sustainable, flexible and cost effective.

This process does need to be a progressive, iterative and effectively project managed in conjunction with all partners. It is expected that through the development of a Joint Change Team the capacity for planning, service change and delivery will be secured. This group would have a life span of 2-3 years (there after mainstreamed) and will take probably 12 months or so to develop the robust long-term integrated commissioning arrangements/strategies, working collaboratively with all key local planning structures, e.g. OHCPP, LPG’s, Integrated strategy and planning groups etc. so as to ensure we succeed in ‘Shifting the balance of care’ and radically change future care deliver and outcomes for the people of the Western Isles.
Indicate the financial mechanism and governance framework

Governance Framework:

- OHCPP
- CnES
- Policy & Resource Committee
- Joint Services Committee
- Health Board
- Joint Liaison and Planning Group (Incorporating Joint Change Team)
Outer Hebrides Community Planning Partnership:

Providing effective strategic connections and community engagement, through:

- High level guidance and oversight
- Consultation and wider community engagement
- Supporting the monitoring and progress of ‘Change Plan’
- Ensuring connection with SOA
- Providing a further interface with Housing, Third Sector and independent sectors
- Supporting linkages with overarching strategies and cross agency workstreams in terms of housing, further education, training and wider workforce and economic development.

Financial Governance:

Financial Governance would be through the existing NHS WI and Comhairle structures.

Support requirements to assist delivery:

The partnership would wish to work closely with SGHD, SBC Team and JIT to take this forward; we anticipate that additional support (advice and capacity) is likely to be required over the life-time of the ‘Change Plan’. Initially probably in respect of IRF, OD programme design and delivery e.g. ‘developing the capacity and culture to change’ and securing wider networks and support systems for staff across all agencies, including the Third Sector and Independent Sectors.

Signed

Gordon Jamieson
NHS Western Isles

Malcolm Burr
Comhairle nan Eilean Siar

Terri Davies
Co-Cheangal Innse Gall
(Third Sector Interface)

John Maclean
Western Isles Community Care Forum

Jinty Morrison
Western Isles Carers, Users and supporters Network

Ranald Mair
Scottish Care