Agenda Item 6vi.

Single Outcome Agreement
Between the Highland Community Planning Partnership and the Scottish Government
2013/14 – 2018/19

Performance Report
Year 3: FY 2015-16

Older People

Highland Community Planning Board
7th October 2016

Background: The direction of travel as articulated in the five year plan at the time of integration remains unchanged with the focus on improving quality and safety and outcomes for older people .

This has enabled much work to be progressed across care homes such as the National initiative – My Home Life and working with the sector to raise expectation of Care Inspectorate grades.

A further focus on improving patient flow through care processes has resulted in some considerable redesign work around health and social care such as streamlining these processes, focussing on person centred care and improving outcomes.

The Strategic Commissioning approach adopted by NHS Highland in 2012 has strengthened relationships across all care providers and sectors and enabled the testing of new and innovative forms of care delivery which allow the flex of resources and encourage community engagement and resilience.

Performance Framework: The partnership has reviewed the performance framework which had been in place for some time prior to integration. Some new indicators have been developed in relation to new contracts, tariffs and zoning across the Care at Home sector and these are currently being tested. All of these new indicators will be presented to the Joint Monitoring Committee in November in accordance with the requirements of the Public Bodies(Joint Working)(Scotland)Act 2014.

Results: the table below illustrates progress against the agreed targets with the following summary.

People are healthy and have a good quality of life: We continue to see a reduction in the length of stay in care homes and an increased number of people cared for until the end of their life in their own home and community. The development of specialist health approaches within the community such as community huddles and virtual wards where those most at risk receive detailed attention and planning, is proving successful and rolling out across many communities.

Technology continues to play a role with the testing of home health monitoring devises to aid self management and the continued development of Living it Up – a website which provides advice and guidance as well as peer support and volunteering opportunities*. Let's get on*

with it together a well established self management approach remains in place and supports many people with long term conditions to make the most of their lives.

Care at home services are under review with emerging models across Highland. The relationship with the Third and Independent sector is now as full partners, as all focus on solutions aimed at keeping people safe and well at home. The focus remains on early intervention and anticipatory care to avert crises. This has benefits to the individual but also importantly to their carer(s). Integration has enabled a more holistic approach as well as the streamlining of services delivered in various premises enabling the development of consistency of approach, good working relationships and the sharing of relevant information.

People are supported and protected to stay safe: Following on from a number of concerning care quality and safety issues in some of our care homes, a large scale investigation protocol has been developed and attracted National recognition. Developed within the sphere of Adult Support and Protection legislation, this protocol unfortunately has been utilised a number of times and the process is now under review. In the main, care homes have been accepting of this approach and have welcomed the improvement support they have received as a result. However it is important at all times not to replicate the work of the Care Inspectorate, not to overwhelm the care home with offers of support and to ensure a measured and proportionate response that will appropriately support residents.

Quality standards across care homes are now on the increase with targets for improvement agreed and this is supplemented by *My Home Life*.

The Scottish Fire and Rescue Service have initiated a number of multi-agency case conferences following a spike in fatal fires across Highland. The focus has been on sharing information and learning as well as improved awareness about prevention and risk across services. Police Scotland and NHS Highland personnel have found this approach to be very helpful and a number of changes to processes are to be taken forward as a result.

People are supported to maximise their independence: Developments in Telecare, care at home and integrated community teams with a single point of access and coordinated care are producing a safer environment for people in their own homes and close working with partners in the Handy Person Schemes, Housing and the Scottish Fire Service is developing a more holistic approach to care in the community.

Partners work closely together utilising existing funds and the Self Directed Support approach to come up with local solutions. Pop-up wards where patients are encouraged to get dressed, leave the side of their bed and socialise over meal times are proving a successful intermediate care approach that enables older people to retain their independence and confidence.

Work continues with Education and further education to explore the development of a Care Academy to ensure that young people are attracted into the care services and given opportunities to develop further skills should they wish to do so.

With the delegation of specific housing functions under the Public Bodies(Joint Working)(Scotland)Act 2014 , innovative solutions are being explored with partners in housing associations and local enterprise. This is an exciting area where bespoke housing , fitted out with the relevant technology for independent living, is being developed alongside work with housing partners to provide appropriate housing for those wishing to down size and stay in their community. This is a very sensitive area but one that requires thought now in order to provide for the future, given the lead in times for these kind of developments.

The Highland Partnership has received further Scottish Government funding aimed at building up Telecare usage, testing new home health monitoring equipment and extending progress made through the Living it Up initiative. This work being progressed over the next year will need to evidence the added benefits of technology in assisting care provision for the future and enabling independence. The Telecare service has been further reviewed to embed it more robustly within the integrated teams and raise the profile of assistive technology in the widest sense.

People and their carers are informed and in control of their care – A carers Improvement group has focussed improvements on supporting carers in line with expectations developed in the Carers(Scotland)Act 2016. Though implementation of this Act has been delayed until 2018, the Improvement group have been progressing a considerable amount of activity namely –

- Review and redesign of carers support plans.
- revision of the current strategy – Equal Partners in Care
- review of respite provision and explorations of new models of delivery that will improve equity and effectiveness
- development of carers support in hospitals
- establishing baseline evaluation data- qualitative and quantitative
- promoting care positive employers

A number of Third sector organisations locally and Nationally provide a wealth of information for carers and cared-for people and this is greatly appreciated. All sectors work closely to keep information and contact details up to date and relevant.

The SDS approach continues to develop with more staff across organisations aware and confident to support people and their carers through the choices. Working with the support of other sectors has enabled innovative and sustainable solutions to be tried out.

People are supported to realise their potential: Investing in Volunteers continues to be a key plank of our support to those in hospital with a wide range of activities now being undertaken. These include socialisation and friendship as well as support at meal times and tea breaks.
Many young people have also been encouraged to get involved realising the added benefit they bring. The Volunteer Services Manager has been able to develop this approach outwith Raigmore Hospital due to the commitment of staff within wards to provide ongoing support to their volunteers and the mutual respect and benefit is now widely accepted.
A volunteering strategy and steering group oversees this work, assessing progress against National standards and most recently the implementation of the National data base – Volunteer Information System, will mean an improvement in data recording and management.

Through the Technology Enabled Care workstream, Living it up continues to be promoted and developed. This also offers volunteering opportunities and signposts those interested to further information. Those who have a long term condition are particularly valuable in volunteering to support those with a new but similar diagnosis and feedback from the public is that this role is very beneficial to those who volunteer **and** those who they support.

Other trials have focussed on home health monitoring which is proving to support those with a long term condition to manage that condition themselves more effectively and with confidence. These trials will be evaluated by Edinburgh University to demonstrate the impact on individual health and well being as well as on hospital and community services.

The third sector continue to develop a range of activities aimed at older adults to promote bone strength, encourage activity at a level that suits each individual and encourage healthy choices. These are well received across Highland and provide a very valuable link across and within communities. The Highland Partnership is committed to supporting the development of this expertise in the sector and encouraging communities in new initiatives.

People are socially and geographically connected: This outcome is probably the most difficult to attribute to specific activities and yet is vital in maintaining health and wellbeing. Reviews of day care in some areas have enabled more localised and community focussed activities to flourish and work continues to focus on the lack of transport in some areas. Community transport Schemes are often a very vital lifeline and information about the services they deliver is so important to individuals, their carers and communities.
NHS Highland launched a loneliness campaign in 2016 – *Reach Out*, aimed at empowering everyone to do something to prevent loneliness in their area or community. Social isolation can be very debilitating and risky for older people and it is hoped that this campaign supported by local newspapers will raise awareness and encourage people to get involved.

We deliver Community care Services effectively, efficiently and jointly: Although the key focus of integration was to improve outcomes for the people of Highland, it was always anticipated that there would be some economies of scale and efficiencies further down the line.
NHS Highland continues to deliver the Highland Quality Approach aimed at reducing waste, harm and variation and through a sharp focus on systems and processes has made some significant improvements. Such change is vital if we are to continue to meet the needs of the people of Highland and only through working with partners in this way will we be able to ensure a sustainable approach.
But this brings a number of challenges to traditional service delivery and the preponderance of buildings and services – not always in the right place, makes change sometimes difficult for communities. Transformational change must be driven forward together and some of the initiatives mentioned above involving partners across sectors are evidencing the benefits.

The Strategic Commissioning Approach puts all partners and stakeholders from all sectors at the heart of the redesign, building ownership and capturing solutions. This enables small tests of change which can then be spread further or which can grow within a community. This recognises that one size does not fit all and has proven to be a more sustainable approach.

The data summarised in the following table is incomplete due to the change process being taken forward within performance management.

The Joint Monitoring Committee will receive proposals for a revised format in November where some indicators will no longer be collected but new more reliable and illustrative metrics will be developed.

Older People's Delivery Plan Update as linked to Adult Balanced Scorecard				
Long Term Outcomes	Intermediate Outcomes	Indicators Adult Balanced Scorecard (OPIG)	Targets	2015/16 Outcomes
19bPeople are healthy and have a good quality of life	People's health needs are met at the earliest stage and at the most local level possible	Adult Balanced Scorecard Ind. No. 1 Providing targeted Reablement services through Integrated District Teams	40% of people receiving Reablement interventions do not require ongoing care interventions after initial 6 weeks	Following redesign in the Inner Moray Firth Operational Unit, 47% was achieved. The model is still being developed in the North and West
	People's health needs are anticipated and planned	"Adult Balanced Scorecard Ind. No. 5 Increase the age of admission of older people to long-term residential and nursing care"	Increase % in older age groups	A total of 696 admissions in 2015/16 65-74 – 11.9% 75-84 – 37.5% 85+ - 50.6%
		SW4 SPI SOLACE Percentage of adults satisfied with social care or social work services	Comparison against national trend These are based on annual published data and represent previous years data	54% 2013/14. Scottish average 55% No available data for 2015/16
		SW5 SPI SOLACE Net Residential costs per Capita per week for Older Persons (over 65)	Comparison against national trend These are based on annual published data and represent previous years data	No available data
People are supported and protected to stay safe	People are supported to stay safe through the operation of our policies and procedures	Adult Balanced Scorecard Ind. No. 14 Improve people's perceptions of their levels of safety	Increase from baseline of 92.9%	96.7% in 2013/14 Collected through public survey – not yet reported for 2015/16
People are supported to maximise their independence	People remain at, or return, home with appropriate support	SW1 SPI SOLACE Home Care costs per hour for people aged 65 or over	Comparison against national trend These are based on annual published data and represent previous years data	£30.07 2013/14. Scottish average: £20.25
		SW3 SPI SOLACE Percentage of people aged 65 or over with intensive needs receiving care at home	Comparison against national trend These are based on annual published data and represent previous years data	21% for 2013/14. Scottish average 35%
	Carers feel able to continue in their caring role	Adult Balanced Scorecard Ind. No. 27 Increase the number of Carer Support Plans through the Highland Carers Centre	Increase 1st year of operation 2012/13 63 care plans 2013/14 208 care plans Target for 2014/15 250 care plans	368 care plans during 2015/16 Delivered by Connecting carers with targeted approach being developed based on risk factors

		Adult Balanced Scorecard Ind. No. 29a Increase the number of new requests for information through the Highland Carers Centre service	Increase from baseline of 393 2012/13	1687 requests for information during 2015/16
		Adult Balanced Scorecard Ind. No. 28 Increase the proportion of available placements within residential care homes to support intermediate care.	Increase from baseline	This is linked to redesign at local level with alternative models of intermediate care being tested
		Adult Balanced Scorecard Ind. No. 25b number of respite bednights provided 65+	Maintain 2010/11 levels of provision - 9975	Respite review conducted by Connecting Carers and working groups taking forward actions to redesign the service – focussed on new models of care and equity of access
		Adult Balanced Scorecard Ind. No. 26b number of respite dayhours provided 65+	Maintain 2010/11 levels of provision 78,857 day hours	Respite review conducted by Connecting Carers and working groups taking forward actions to redesign the service – focussed on new models of care and equity of access
		Adult Balanced Scorecard Ind. No. 29c Increase the number of carers in receipt of training by the Highland Carers Centre service	Increase from baseline – 70 carers	Continue to deliver on target. Connecting Carers have recently completed a training needs survey amongst carers with a view to introducing a new programme of training shortly.
		Adult Balanced Scorecard Ind. No. 29b Increase the number of peer support sessions facilitated by the Highland Carers Centre service	Increase from baseline - 61	132 sessions delivered 2015-2016
	People have access to appropriate housing which maximises their independence and wellbeing	Adult Balanced Scorecard Ind. No. 16b Number of enhanced telecare packages 65+	Increase from baseline – 248 in 2013	293 2015-2016 Ongoing cleansing of data with electronic data collection system now secured.

		Adult Balanced Scorecard Ind. No. 17b Number of people receiving care at home service 65+	Increase from baseline-2355 in April 2014	2453 2015-2016
		Adult Balanced Scorecard Ind. No. 18b Number of people receiving care at home service evenings/overnight 65+	Increase from baseline – 925 in April 2014	1048 2015-2016
		Adult Balanced Scorecard Ind. No. 19b Number of people receiving care at home service weekends 65+	Increase from baseline-1859 April 2014	1957 2015-2016
		Adult Balanced Scorecard Ind. No. 20 Number of hours of home care provided to older people 65+ per 1,000 population	Increase from baseline (254.8 March 2012)	256.3@ March 2016
People and their carers are informed and in control of their care	People are in control of decisions that are made about their care and the care that they receive	Adult Balanced Scorecard Ind. No. 34b number of people receiving SDS option 1 65+	Increase from baseline levels – 83 in April 2014	168 people as at March 2016
		Adult Balanced Scorecard Ind. No. 62b number of people receiving SDS option 2 (65+)	First year of operation, baseline being established	88 people receiving Option 2 as at March 2016
	People know about the services we provide and how to access them	Adult Balanced Scorecard Ind. No. 39 Advocacy Highland – Independent Individual Advocacy Service	The Organisation to provide a Service to a minimum of 550 cases per each year of the Contract in place with NHS Highland and The Highland Council	712 cases in 2015/16
People are supported to realise their potential	People have access to training, employing and volunteering opportunities	Adult Balanced Scorecard Ind. No. 46 Increase, by age band, the number of people stating that they volunteer on a regular basis	Increase 2013 cumulative figure was 38%	Feedback from Citizens' Panel for 2014/15 shows that volunteering levels remain high with 39% saying they volunteer in some capacity, 51% say they do so at least on a weekly basis. No further data currently available
	People have access to a range of community-based development opportunities	Adult Balanced Scorecard Ind. No. 47 Increase the number of community-based activities in each area	Increase	No data collected

People are socially and geographically connected	People do not become socially isolated	Adult Balanced Scorecard Ind. No. 33 People perceive themselves to be socially and geographically connected	Increase from baseline	No data collected
We deliver Community care Services effectively, efficiently and jointly	Care is delivered using joined-up, core processes	"Adult Balanced Scorecard Ind. No. 55 Improve service delivery through service review and redesign"	Number of RPIW's & Kaizen events completed No. of certified lean Leaders	52 @ March 2016 27 @ March 2016
	Decisions about the allocation of resources are made jointly	Adult Balanced Scorecard Ind. No. 60 The number of people who have their hospital discharge delayed	no hospital discharges delayed by 4 or more weeks	42 @ March 2016