DRAFT

Caithness Community Partnership

Adult Health & Social Care Plan 2017

BACKGROUND

The Highland Partnership Agreement, signed in 2012, outlined the development of the Lead Agency model, the agreed Governance structures, an outcomes framework and Performance management framework for the development of integrated adult services in Highland.

Within the Highland Health and Social Care Partnership the focus is shifting from responding to crisis towards promoting well-being – embracing a model of care that focuses on empowering people. Anticipatory care, re-ablement and an emphasis on strengthening and building on capability and independence are the cornerstones of the approach of the Partnership. Community groups, the voluntary and independent sectors and people and carers are considered valued partners. There is a commitment to work together in ways that empower, enable and promote confidence and capability for supported self care and self management.

There is a growing realisation that integration alone will not deliver the improvements in outcomes that we seek and only by pulling on the assets we find in our communities and neighbourhoods, focussing on outcomes, prevention and anticipatory care and working more flexibly with our independent and third sector partners will we better serve the people of Highland.

In summary, the agreement stated that NHS Highland will develop and deliver integrated adult care services which will:-

- Achieve the outcomes as agreed by the Highland Partnership within the Partnership Agreement
- Reflect need and demographic changes across the Highland area through the period of the commission.
- Reflect the ambitions of NHS Highland and The Highland Council as outlined in the Single Outcome Agreement and the Partnership Agreement
- Reflect clinical and practice evidence of effectiveness in Health and Social Care.
- Demonstrate improvements in outcomes for individuals, families, carers and communities.
- Demonstrate improvements in safety, quality and experience for individuals, families and carers

HIGHLAND CONTEXT

As Lead Agency for Adult Services, NHS Highland must now explain how services will be developed, delivered and monitored in line with local and National expectations. These include–

- Scottish Government- Reshaping Care: a Programme for Change 2011-2021
- Highland Council- Single Outcome Agreement
- NHS Highland Strategic Framework-Better Health , Better Care, Better Value
- The Highland Quality Approach

Reshaping care is a 10 year whole system transformation programme that seeks not only to shift the location of care (from institution to community) but also to transform the culture and philosophy of care from reactive services provided *to* people towards preventative, anticipatory and coordinated care and support at home delivered *with* people.

The Single Outcome Agreement highlights how the wider community planning partnership contributes to health and wellbeing of people in a wide range of ways – from the provision of volunteering opportunities, community development support, leisure activities, community and lifelong learning and support for enjoying the outdoor environment, through to the provision of a wide range of voluntary sector services. The focus remains on improving outcomes as detailed in the Partnership Agreement.

The Highland Quality Approach captures the spirit of how NHS Highland is working to improve care and outcomes. By focusing on quality and being person centred it will achieve better health, better care and better value for more people. Through the HQA, NHS Highland will eliminate waste, reduce harm and manage variation.

The key elements of the HQA include our Vision, Mission and Values. The approach is founded on every person being at the top with our three strategies supporting this commitment:

Quality – We relentlessly pursue the highest possible outcomes of care. This means we invest in the most up to date technologies, treatments and medicines and we take all necessary steps to avoid harm. It also means we take early steps to prevent ill heath and reduce inequalities.

Care – We create a caring experience. Whether someone is being cared for at home, in a care home or in hospital, looking after people in a caring way focussed on individual wishes is really important.

People – We will strive to attract and develop the best teams. To make this successful staff have to be supported to do their jobs and come up with ways to continually improve. Key elements to support this include developing our leaders, having a culture of continuous improvement, keeping up with research, supporting innovation and being focussed on making measurable improvements

CAITHNESS CONTEXT

Caithness has an increasingly aging population and a growing number of people who live with multiple and complex conditions. The subsequent increase in demand for services in an age of austerity requires us to achieve more through better use of resources.

We need fundamental change in the way we deliver services to cope with these increasing demands and we are being challenged to increase that pace of change. The key drivers for change are the needs and expectations of the people who use our services. Services must also adapt to the way in which people with multiple, complex and frequently changing conditions require to access care and support.

Current models of healthcare services are stretched and do not always suit the patients, their carers or the aspirations of the workforce and our health services have tended to focus on urgent care – fix and treat rather than anticipation, prevention and self management.

The future model of care is one with an empowered patient in a shared decision-making partnership with the clinician. There needs to be co-creation of care packages that include prevention and rapid access to services when required. The growth of supported self-management is a key priority as this allows patients to regain control of their own health. Critical to this will be shifting the balance of where care and support is delivered, from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals and people staying in hospitals only for as long as they need specific treatment.

Healthcare now needs to extend far beyond the classical settings of hospitals, GP practices, and hospices and reach more effectively into a person's own home and community. However, the expectation in the minds of many of our population remains that care should be hospital based, when the evidence tells us that this is not always the optimal location.

OUTCOME AND PERFORMANCE FRAMEWORKS

The Partnership Agreement confirms that the Lead Agency will adopt and pursue implementation of the aims that are detailed in the strategies and plans that underpin adult community care provision.

The key document has been the Highland Joint Community Care Plan 2010/13 and the Highland Strategic Plan 2014/19. These set out the outcomes to be achieved across services for adults as:-

Outcome 1 – people are healthy and have a good quality of life

Outcome 2 – people are supported and protected to stay safe

Outcome 3 – people are supported to maximise their independence

Outcome 4 – people retain dignity and are free from stigma and discrimination

Outcome 5 – people and their carers are informed and in control of their care

Outcome 6 – people are supported to realise their potential

Outcome 7 – people are socially and geographically connected

Outcome 8 – we deliver Community Care services effectively, efficiently and jointly

People are healthy and have a good quality of life	
Outcomes	**Actions**
People's health needs are met at the earliest and most local level	Expand capacity in primary care teams, continue to develop advanced practice roles Develop GP Clusters Explore the potential for social prescribing Further development of Integrated teams Strengthen anticipatory care planning Reduce referrals to secondary care through development of local alternatives and clinical decision support Maximise use of technology for remote consultation and tele-medicine Develop a Hub and Spoke Model to support community maternity units (CMU)
People's health needs are anticipated and planned for	Improve use of data to inform planning and action at local level Roll out of Frailty assessment tool and pathway Develop the Integrated team multidisciplinary meetings to include anticipatory care with GP involvement
People are supported to recover from illness, mental illness and drug dependencies	Continue redesign of Acute services in CGH – Acute Assessment Unit, Rapid Access and Emergency Ambulatory Care, Increase the size and capacity of the Emergency Department, Develop a Nurse triage system within the Emergency Department, Improve the patient flow within CGH to reduce the length of stay, Develop an Emergency Anaesthetic Support Team Redesign Dunbar Hospital to become a Community Health & Social Care Hub supporting ambulatory care, minor

	injuries unit, primary care emergency centre, community inpatient beds, palliative care. Further roll out of supported community wards Offer specialised assessment to those presenting in acute distress to CGH Develop & deliver The Decider 32 Life skills Group to those with moderate to severe emotional instability disorders Develop & deliver The Decider 12 life skills Group to those with mild to moderate mental health conditions Continued development of recovery support for those affected by addiction across Caithness Develop ex service users to facilitate SMART recovery groups for those affected by addiction across Caithness Develop further group interventions for those referred into mental health services in Caithness
Promote more timely discharges from hospital to reduce length of stay including delayed discharge figures to be reduced to single figures	Implement daily dynamic discharge programme in CGH Embed community pull from hospitals supposted by daily huddles, production boards & community wards Embed the Admission,Transfer and Discharge Policy in CGH & Community Hospitals Roll out of Fraility assessment tool and pathway Embed Criteria Led Discharge & Discharge to Assess in CGH & Community Hospitals Develop the independent sector care at home provision and increase local providers Develop community led care at home provision in line with the Boleskine model
People are supported and protected to stay safe and to maximise their independence	
People gain and retain the skills which keep them safe at home and in the community.	Maximise use of technology for condition management Redesign of day care centres to community resource centres All community staff to provide falls multifactorial risk assessment and follow up actions from assessment Build Dementia support through link workers and the roll-out of dementia friendly communities
People remain at, or return, home with appropriate support.	Strengthen anticipatory care planning Integrate Care at Home into the District teams & co-locate with Integrated teams Develop Community Infrastructure – rapid response and 24/7 community services Develop flexible use of care homes including step-up/step down beds Review care packages and promote choice e.g. Self Directed Support Complete co-loction of Integrated Teams Complete Neighbourhood support and District Nurse Review Redesign of community equipment stores and continuing development of Caithness Handyperson and Minor Adaptation Scheme
Carers feel able to continue in their caring role.	Carers needs are part of the social care assessment Promote carer awareness amongst ward staff, GPs and community based staff in line with the NHSH Carers Strategy Further development of innovative respite solutions home based or otherwise using self directed support

	In partnership with Connecting Carers roll out the 2018 Carers Act
People are active participants in meeting their own care needs.	Digital Health Initiatives - shared decision making through use of Smartphone apps for patients Create resource packs, condition specific, for self management and improve shared decision making Support using technology and self help information to allow more people to self manage their conditions. Continue to develop the 'Lets Get on with It Together' model of self management
People retain dignity and are free from stigma and discrimination	
People are supported to tackle stigma and discrimination. .	Review the benefits of current models of care facilities for learning disabled clients Implement and embed the Personal Outcome plan as the community assessment tool 3 yearly Health Screening Assessment available to all people with a Learning Disability All planned admissions to hospital to complete a "getting to know me document" – with Parents/ carers/ 3rd sector providers All GP practises have a named CLDN link nurse Implementation of the Sensory Strategy – See Hear Hospitals & Care Homes audited regularly to improve environmental standards for older people in line with OPAH
Our services and those we commission actively promote equality	Traditional models of day care are reviewed with regard to a more enabling approach and less dependence on day care facilities. Grow community support offering a wider choice for people and their carers and providing a more inclusive support model Collaborate with Children's Services to develop transition pathways for young people with a learning disability into adult hood
People and their carers are informed and in control of their care	
People know how to stay as healthy and fit as possible.	Work with the independent and 3rd sector to develop and run exercise classes in the community using their exercise instructors for conditions such as heart disease, respiratory disease, risk of falls, obesity and active exercise referral Maximise use of technology for condition management and consultation
People are in control of decisions that are made about their care and the care they receive.	Enter into and engage with staff and the public about timely and appropriate treatment and choices Increase end of life provision & choice of location at end of life Develop clinical pathways and reduce variation Develop and pilot 'Attend Anywhere' Publish Director of Public Health Report on Realistic Medicince Hold Public Events on principles of realistic medicine in line with national initiative
People know about the services we provide and	Continue to consult with developed groups such as the Caithness Redesign Programme Board and Reference Group, Caithness Community Planning Partnership, Dounreay Stakeholders Group, Caithness Health Information

how to access them.	Group, CGH Patient Council Consult with the public on how they want to be advised on services and access Further develop the Caithness section on the NHS Highland website
People are supported to realise their potential	
People have access to training, employment and volunteering opportunities.	Enable people with learning disabilities to develop skills that lead towards employment through facilitating volunteering, work based learning and initial supported employment opportunities Work in partnership with the independent and third sector to develop micro and social enterprise opportunities for people with learning disabilities to contribute to their community
People have access to a range of community based development opportunities.	Engage with local communities in ensuring that people with learning disabilities are active participants in community developments Enable people with learning disabilities to be active and visible participants in their communities through broadening access to our facilities to other sections of the community creating health and wellbeing hubs
People are socially and geographically connected	
Voluntary and community effort contributes to more supportive communities.	Develop more health & well being HUBs in communities following the example of Dunbeath and Brora HUBs Further development of support provided by organisations such as The Laurandy Centre, Caithness Mental Health Support group, Sight & Hearing, Dunbeath HUB
People have access to a range of transport to maintain their networks	Help to develop transport proposals and solutions that come from the locality plans to ensure lack of transport is not a barrier to access
People do not become socially isolated.	Work with Caithness Health Information Forum to support community support groups such as Befriending, Caithness Food Friends, Lunch Clubs
We deliver Community Care services effectively, efficiently and jointly	
Care is delivered using joined-up core processes	Continue to develop the 'single point of access' for community services Further develop and embed enablement as the default position in community services
Resources are accessed quickly and equitably	Simplify the pathway for accessing funding for community care services Develop the District Care Panel to get a greater understanding of NHS Highland contractual arrangements with independent & 3rd sector providers Develop all community staffs knowledge of self directed support Train all community staff in equipment assessment to reduce the need for onward referral
Decisions about the allocation of resources are made jointly	Develop eligibility criteria for all social care packages aligned to levels of need and implement eligibility threshold Establish criteria for agency and locum spend Continue with improvement work programmes to reduce waste, harm and variation

Caithness Community Partnership Adult Health & Social Care Plan 2017

Priorities & Action Plan

No	Outcome	Objective	Actions	Completed	lead
1	People's health needs are met at the earliest and most local level	Expand capacity in primary care teams and continue to develop advanced practice roles, maximise use of technology for remote consultation and tele-medicine.	Undertake workforce audit and develop workforce plan for Caithness Primary Care Recruit ANP for Dunbar/Riverbank surgery and identify funding for further ANP role Pilot remote GP consultations in Riverbank Surgery	Nov 2017 Oct 2017 March 2018	N&W Clinical Lead District Manager North Unit Lead Pharmacist, Practice Manager
2	People's health needs are anticipated and planned for	Improve use of data to inform planning and action at local level and develop the Integrated team multidisciplinary meetings to include anticipatory care with GP involvement	Training of community staff in use of frailty tool Roll out of frailty tool and pathway in Caithness community Consult with GP practices on involving integrated teams in anticipatory care	Nov 2017 Dec 2017 Nov 2017	ITLs ITLs, Professional leads District Manager, Practice Managers
3	People are supported to recover from illness, mental illness and drug dependencies	Develop & deliver 'The Decider' life skills groups to those with emotional instability disorders. Develop ex service users to facilitate SMART recovery	Develop a new pathway for direct referrals from GPs to 'The Decider' life skills groups. Consult & disseminate to GP practices Identify service users who would facilitate SMART	Nov 2017 Dec 2017 Sept 2017	CMHT CMHT CADRS Prof Lead

		groups for those affected by addiction across Caithness	recovery groups Train service users identified Start further SMART recovery groups	 Oct 2017 Dec 2017	 CADRS Prof Lead CADRS Prof Lead
4	People remain at, or return, home with appropriate support.	Develop Community Infrastructure – rapid response and 24/7 community services Develop flexible use of care homes including step-up/step down beds	Explore and agree District Nursing & Support Worker staff requirement for augmented access to community services. Identify funding stream for staff resource Develop referral criteria for step up/down care home beds Consult with GP practices to identify medical cover for step up/down beds Implement step up/down beds in care homes if viable	Oct 2017 Dec 2017 Dec 2017 Jan 2018 Mar 2018	ITLs, DM, Professional Leads, C@H Manager DM, Accountant DNs, Care Home managers, ITLs DM, Clinical lead DNs, Care Home managers, ITLs
5	Voluntary and community effort contributes to more supportive communities.	Develop more health & wellbeing HUBs in communities following the example of Dunbeath and Brora HUBs	Develop a criterion for a Caithness H&W HUB Identify localities who would like to develop a H&W HUB Work with localities to develop HUBs	Dec 2017 Jan 2018 Mar 2018	Community health practitioners, Contracts DM, Contracts DM, Community health practitioners,
6	People are in control of decisions that are made about their care and the care they receive.	Increase end of life provision & choice of location at end of life	Meet with the palliative care working group to review current end of life proposals Develop end of life options which tie in with the Caithness Re-design going forward	Dec 2017 Mar 2018	DM Palliative Care Working Group

KEY: DM - District Manager
ITL - Integrated team lead
CMHT - Community Mental Health Team
CADRS - Caithness Alcohol and Drug Recovery Service
C@H - Care at Home