Change Plan Template

1. Name of Partnership

HIGHLAND

2. Partner Organisations

2.1 Partners signed up to the Change Plan

Highland Council
NHS Highland
Third Sector (represented by Highland Third Sector Interface)
Independent Sector (represented by Scottish Care)
Carers and Service Users (represented by Highland Senior Citizen's Network and Highland Community Care Forum)

Highland has taken a fully inclusive, cross sectoral approach to the development of this plan, using the process as an opportunity to inform the development of new planning structures within the context of integration of adult health and social care.

2.2 Professional Engagement in the development of Plans

The development of this plan spans the period of structural reorganisation related to the establishment of a Lead Agency model to integrate Health and Social Care for adults in the Highlands.

Change Plans were initially developed at a local (CHP) level, involving local management teams (which include clinical representation) and linking to Social Work management teams which have drawn on practitioner engagement. Alongside engagement with the Sectors through the interface, condition specific discussions have fed into proposals

through additional engagement with organisations from the Sectors, eg in relation to dementia specific care.

Initial practitioner and clinical engagement took place via joint meetings between the separate Health and Social Care management teams, each drawing on their staff groups to develop and test proposals. Since April 1st 2012, these management structures have been integrated. It is important to note that the integration agenda; rebalancing care and the Change Plan are inextricably linked, meaning that engagement relating to one issue has naturally covered all.

2.3 Public engagement in the development of Plans

All initiatives are in line with the Joint Community Care Plan, which was the product of extensive public engagement through a range of activities.

The Planning for Integration process is intrinsically linked to the Change Plan agenda, given the implications for service redesign and the rebalancing of care. As such, extensive public and staff engagement has taken place, through a range of methods from newsletters to large scale meetings. This engagement will continue to be built upon through an engagement plan to be developed by the Adult Services Planning and Development Group, including the development of local “Partnership Forums”

3. Finance

3.1 Resources available to Partnerships

Due to the implications of the Highland Plan for Integration, the total budget context for the Change Plan is the totality of NHS and Local Authority Adult Care resource. This means that a sum (circa £95m) was transferred from the Local Authority to the NHS to enable the NHS to discharge delegated adult care functions on behalf of the Local Authority, and to act as Lead Agency for Adult Care on behalf of the Partnership. In view of this, the concept of “additions to the pool of resource” for reshaping care of older people in the Highlands is redundant

In view of this, Table 1 has been created to describe the level of spend to date. To support the principles of Strategic Joint Commissioning, the available resources have been presented as a three year budget which allocates underspends from year one of the Change Plan across future years.

Table 1. Change Fund Expenditure

	Fully Committed	Planned	Unallocated	Total
South East CHP				
Virtual Wards	310			
Falls Prevention	45			
Enhanced Pharmacy	98			
Elderly MH Redesign	63			
Voluntary Sector	103	125		
Reablement (NHS Element)		124		
Unallocated			15	
	619	249	15	**883**
Mid Highland CHP				
Virtual Wards	238			
Falls Prevention	0			
Elderly MH redesign	0	80		
Voluntary Sector (Alzheimer's £130k)	130	70		
Reablement	73	53		
End of Life	58			
Extended Community care	150	65		
Joint Equipment store	20			
Training	86			
	755	268	0	**1,023**
North CHP				
Falls Prevention	35			
Citizens advice Bureau SLA	3			
OT Band 6		42		

Physio Band 6 costs		42		
High risk medicines (Apr - Sept)	12			
0.40 WTE B4 Hosp Disp Tech (Apr - Sept)	5			
Dementia Link Worker (Alzheimer's)	35			
Mental Health OT		65		
Training				
Unallocated			224	
	90	149	224	**463**
Reablement - ex THC	1,000			1,000
Reablement - NHSH	56			56
Totals	**2,520**	**666**	**239**	**3,425**

Summary	**12/13**	**13/14**	**14/15**	**Total**
Funding	3,910	3,910	3,425	11,245
Underspend from THC reablement 2011/12	250	250	250	750
Underspend Carried Forward (per previous sheet)	256	256	741	1,253
Total Funding	**4,416**	**4,416**	**4,416**	**13,248**
Fully Committed	2,520	2,520	2,520	
Balance not fully committed	**1,896**	**1,896**	**1,896**	**5,688**
Split of Balance				
CHP - Plans Developed - Not Committed	666	666	666	

CHP - Budget Allocated - Not Committed	239	239	239	
Unallocated (per previous sheet)	991	991	991	
Total	**1,896**	**1,896**	**1,896**	**5,688**

3.2 Reasons for financial 'carry forward'

The Partnership has following reasons for carrying resource foreword:

1. In 2011/12, the Partnership adopted an innovative approach towards the Change Plan, whereby resource allocation is predicated on the ability to demonstrate an achievable 3:1 return on that resource. This has made the deployment of the resource much more challenging, given that managers have been required to identify a return before deploying resource with the result that most initiatives will not achieve full year spend in 2011/12.
2. During 2012/13, the Partnership will be reviewing the equity and efficiency of resource allocation across health and adult social care with a view to identifying variation in outcomes that cannot be explained by population characteristics. This analysis will contribute towards a major Programme Budgeting Marginal Analysis exercise to be undertaken jointly with the Scottish Government with a view to:
   - Developing Commissioning Capability and Capacity
   - Providing a structured approach to option appraisal
   - Guiding future investment
3. In the period immediately following integration, this initiative is at an early stage of development, however the Partners are determined that a "commissioning approach", rather than a "bidding approach" will inform further Change Plan development.

3.3 Change Fund allocation by pathway

Table 1 describes the committed expenditure against the Change Fund. It mainly summarises the first phase of Change Fund proposals for the Highlands. which principally comprised direct NHS/Highland Council investment, actions and impact. The Plan describes the development of a more inclusive, cross sectoral approach, which will take time, and the development of a genuine integrated approach towards Strategic Commissioning(see Section 5 on Governance and Section 8 on the Joint Commissioning Strategy). To enable the development of these complementary facets of commissioning practice, the Change Fund has therefore been allocated over three years, to allow the impact of analysis and planning (particularly through the PBMA initiative) to inform strategic use of the resource.

Although some progress has been made on the second phase relating to the joint NHS/Highland Council/Third and Independent Sector proposals, this has not developed as quickly as first anticipated. There is a strong commitment from all parties to move forward quickly, and the establishment of the Adult Services Planning & Development Group is now seen as the vehicle to enable this.

In addition, a Change Plan working group will be set up under the ASPDG to ensure continued development of the Change Plan agenda. This group will be inclusive of all partners, and will agree a work plan to be achieved through 2012-13, including implementation of assessment criteria and proposals for further investment.

As described in Table 1, expenditure is currently grouped as "Committed or "Planned". All expenditure will be assessed against criteria (below) being developed by all the partners. This assessment will be completed in time to inform the Joint Commissioning Strategy for Older People and the investment plans for 2013-14.

Although specific allocations have been made to initiatives, an action learning and evaluation approach will be adopted and resource shifted accordingly through the assessment process.

	Criteria		**Examples**
	Non-Financial		
1	Evidence for delivering Annex C criteria		please see Annex C - evidence of carer / user satisfaction
2	evidence of user needs identified and met	e.g.	Proposer can cite evidence for need for service in respect of consultations with proposed users

		e.g.	Proposer has identified parallels with other areas who have similar services and has explained how user benefits there, would apply here
3	evidence of carer needs identified and met	e.g.	Proposer can clearly demonstrate how service will benefit carers, through consultation with carers
		e.g.	Proposer has considered impact of service on carers and how potential adverse impacts will be mitigated
4	evidence of working with others	e.g.	Proposer has explained how service will work together with other service providers for users and / or carers
5	evidence of community capacity building in proposal	e.g.	Evidence provided for the 'community - led' service
		e.g.	Evidence how proposal will build community capacity
6	evidence of organisational capacity to deliver	e.g.	track record of delivering a quality service
		e.g.	fits with what the organisation is already doing
		e.g.	capacity building needs identified as part of the proposals
	Financial		
7	Evidence for 3:1	e.g.	Evidence for delivering Annex B criteria
		e.g.	Quantitative evidence from published studies of similar services
		e.g.	Case study evidence
		e.g.	Proposer can clearly explain 'cause and effect' of savings, from inputs to outputs to outcomes
8	Evidence of good value	e.g.	Costs are based on those for similar procured or tendered services

		e.g.	Proposal includes volunteer efforts to deliver services
		e.g.	Evidence of costs from existing services
		e.g.	Proposal is fully costed i.e. includes overheads

In general terms, the key principles on which the proposals are based are:-

- Re-ablement culture and philosophy across the organisations to include education for all staff, redirection of therapy and nursing as well as investment in Care at Home Re-ablement staff and investment in Care at Home staff across all sectors.
- Improved and developed Anticipatory Care approaches including Anticipatory Care Plans and Case Management, support for self care, early intervention, augmented support in the community.
- Improved Unscheduled Care/A&E responses to prevent unnecessary admissions
- Alternatives to Admission – re-ablement approach embedded in first line services, responsive 24/7 care at home, telecare/medicine, extension and development of virtual ward, Memory clinics/early intervention in dementia, step up/step down beds in care homes and supported living accommodation, supporting choices in end of life care, out of hours sitting, home from hospital services
- Referral/Diagnostic management through primary care to improve access and to obviate the need for admission fro some diagnostics.
- Adoption of a person-centred approach, including promotion of a culture of supported self care
- Carers are equal and expert partners in the provision of care
- Effective partnership working across all sectors and creative use of resources at local level
- Co production, community resilience and community development approaches that are grown from the local level

Enabling factors in transformational change, ensuring sustainability and capacity building at a local level across the Highlands are :-

- Focus on District Community Hub/single point of access
- 24/7 Access to care
- Blurring of Social Care/Health margins as integration develops
- Involvement of Third Sector, Independent, Service Users and Carers as equal partners in the planning, assessment, design, and delivery of services. Enabling, training and empowering district multi professional teams, embedding re-ablement approach
- Devolved decision making
- Telecare/health, both response and technological development

- Tele rehab development for pulmonary, cardiac, rheumatology and falls prevention
- Long Term Conditions proactive approaches more consistent e.g Chronic Obstructive Pulmonary Disease,
- Anticipatory Care Plan Alerts roll out and improve access for all those who need to see them
- Older Adult Mental Health – upstream work and consolidation of beds/expert assessment
- Community based Consultants with in reach bed access
- Carers education and support.
- Creating capacity by stopping inefficient activity
- Review of current use of community beds
- Supporting Clinical Skills Development
- Training in health behaviour change, self management champions, nutritional care, falls prevention and dementia support
- Utilising Productive Community Services (LEAN) approach.
- Supporting long term clinical skills development/mentoring

Although specific allocations have been made to initiatives, an action learning and evaluation approach will be adopted and resource shifted accordingly.

	Preventative & Anticipatory Care	Proactive Care & Support at Home	Effective Care at Time of Transition	Hospital & Care Homes	Enablers
2012/13	£195	£1443k	£819k	£63k	£472.5k
2013/14					
2014/15					

The Plan for 2012/13 is subject to further development by the Partners as indicated above. The "Allocation by Pathway" table shows indicative apportionment across pathways. The vast bulk of these proposals represent a carry forward of initiatives from the 2011/12 Plan (attached).

Three significant factors now require to be taken into account in the further development of the Plan namely:

1. The need to develop infrastructure within the Sectors to support engagement in the Strategic Commissioning Agenda.
2. The need to develop competency, capability and capacity in Commissioning practice across all sectors

3. Discussions regarding an emerging integrated governance structure

These considerations are reflected in the "Enablers" section, where proposals for additional support to the Partnership are reflected, principally:

£50k Support to the Sectors Consultation Group
£250k Community Workers (older people): Workers delivering community based initiatives to extend services for older people. These proposals are subject to a review and evaluation of existing capacity and effectiveness, and have yet to be scaled in terms of implementation timescales
£35k Action Research Post
£75k "My Health, My Resources" Web site development
£45k Expanded support for Carers via Carers Workers
£17.5k Carers Information Initiative
Total
£472.5k

The Partnership are currently considering a range of "bids" for funding which total a sum in excess of available resources. These proposals will be considered in the light of In view of the above, and to maintain maximum flexibility for the emerging integrated arrangement (including the integrated planning and investment mechanisms which include third and independent sectors – see Section 5, Governance), the indicative apportionment for 2013 to 2015 has not been populated at this point.

It is important to note that the Partners have considered the establishment of an "Innovation Fund" to be managed by the Sectors (this option has been implemented in some other partnerships in Scotland). In the event, the Partners have come to a view that such a fund would risk providing a distraction from a comprehensive approach towards commissioning across the totality of adult care, and that the function of such a fund is discharged through the Change Fund itself, given the cross sector planning and governance arrangements in place for future use of the Fund.

3.4 Total Resource Allocation by pathway

	Preventative & Anticipatory Care	Proactive Care & Support at Home	Effective Care at Time of Transition	Hospital & Care Homes	Enablers
2011/12	£	£	£	£	£
2012/13	£	£	£	£	£
2013/14					

2014/15					

This table has not been populated due to the development of the Lead Agency model for integration of Health and Social Care Adult Care resource. As such, the totality of resource related to adult care will be described with a Partnership Agreement (running to some 600 pages) which is too large to append, and which has been scrutinised by the Scottish Government through the vehicle of the Planning for Integration Programme Board.

In addition, Highland is engaging in a Programme Budgeting, Marginal Analysis exercise with the Scottish Government. The programme under consideration is the "Older People" population. This work will furnish a level of detail beyond that requested.

4. Self Assessment Against 2011/12 Performance

4.1 Outcome measures and indicators

The key reference document for this Plan is the Highland Joint Community Care Plan 2010/13. This sets out the outcomes to be achieved across services for adults as:-

- People are healthy and have a good quality of life
- People are supported and protected to stay safe
- People are supported to maximise their independence
- People retain dignity and are free from stigma and discrimination
- People and their carers are informed and in control of their care
- People are supported to realise their potential
- People are socially and geographically connected
- Community Care services effectively, efficiently and jointly

Appendix 1 shows a range of performance information being collected and considered by the Partnership. Whilst a range of improvements have been identified, particularly in terms of increases in the availability of community based provision and activity around emergency admissions, etc, it is early in the life of Change Fund generated services to directly attribute improvements, given that many services have only been operational in the latter part

of 2011. Anecdotally, however, there is a clear indication that these services are having a positive impact, and this is explored in more detail in Section 4.2 below.

Appendix 2 Illustrates the full range performance information related to the Partnership Agreement underpinning the Lead Agency Arrangements for Adult Care. The Change Plan is expected to impact on those measures that relate to Older People.

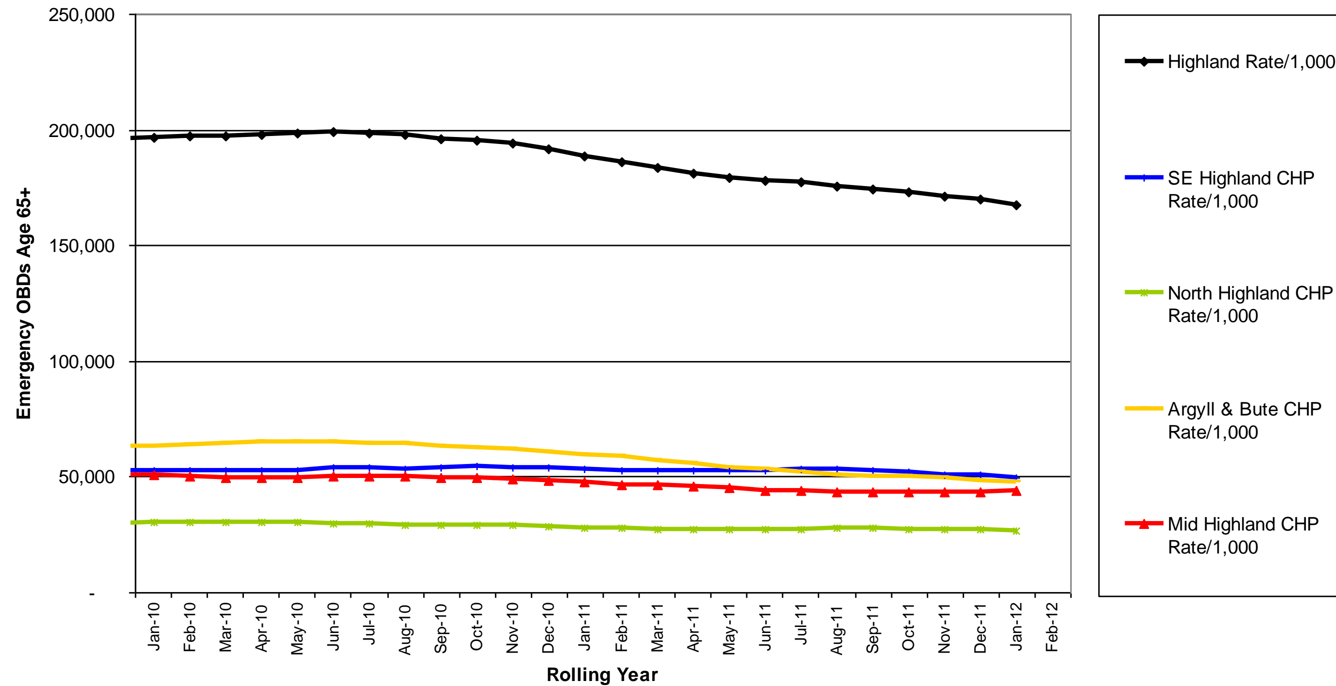
Performance will now be reported every two months.

4.2 Local improvement measures

As indicated above, a number of local and national improvement measures are linked to the Change Plan. For the Highland Partnership, however, evidence of the achievement of the 3:1 return on investment is of crucial importance. Work is being undertaken to establish the impact of Change Fund investment in terms of Care Home activity, however this is at an early stage.

In terms of hospital activity, the original Change Plan the key measure of impact was hoped to be in terms of Occupied Bed Days related to emergency admissions of the over 65year population.

As can be seen below, significant impact has been made in this respect, however it is not possible to attribute all progress to individual initiatives, but rather to the broad range of activity, including Change Fund related activity.



Graph 1 Provides a comparison across all NHS Highland between December 2010 and December 2011. This graph shows a reduction in the number of occupied bed days from of 191,662, to 169,746. This gives a 'saving' of 21,916 occupied bed days, equating, in full opportunity cost terms, to £6.57m. It is important to recognise that whilst this sum may be the a 'value' of the reduced activity it does not follow that this is the amount of money could be removed from budgets, due to fixed costs, staffing costs, other patients occupying the beds etc

Area (All) District (All) Practice Name (All) TYPE EMERG Specialty Description (All) SITE (All) Custom List 1 65+

Index   Current Index: 22, Not Indexed (Actual OBDs/Admissions)

65+ Emerg. Occupied Bed Days

Sum of OBDs in Year (Rated as per Index Above)

65+ OBDs

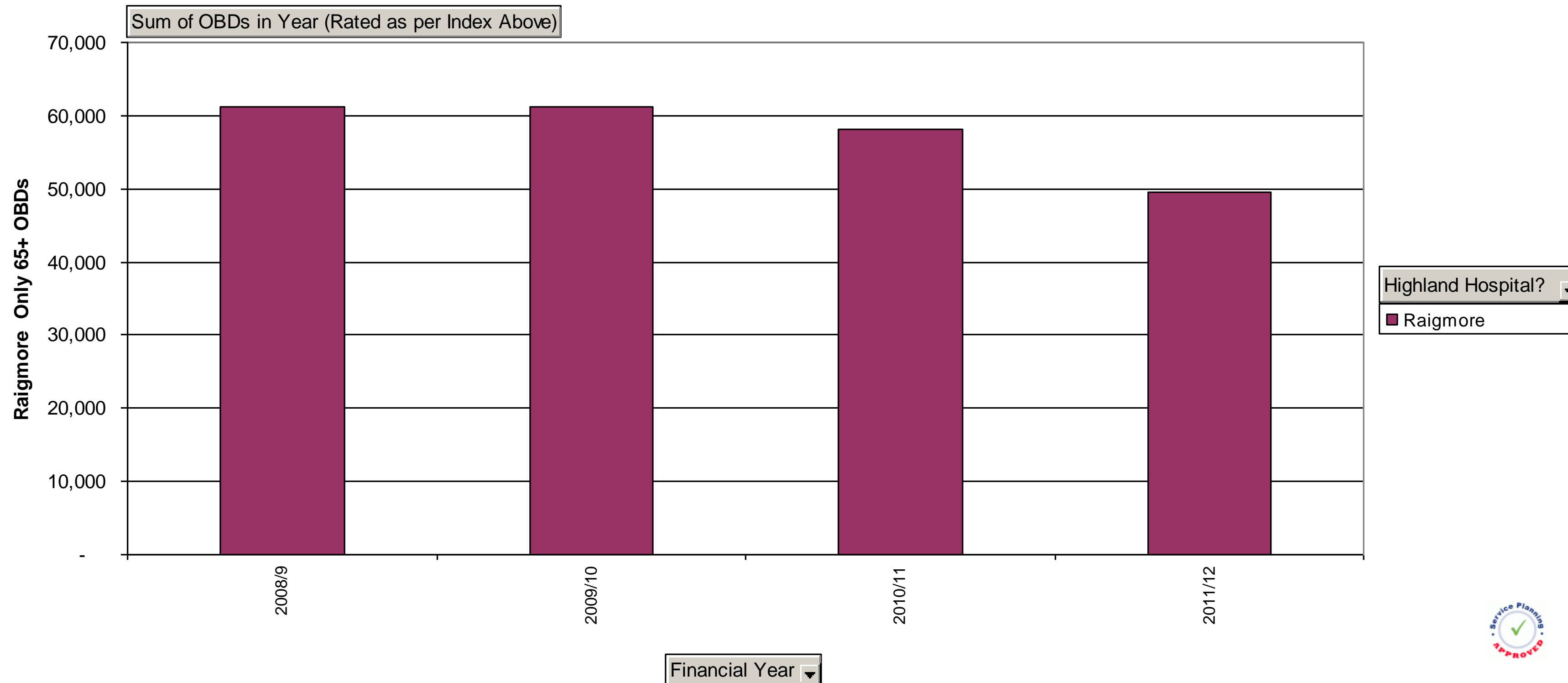
250,000
200,000
150,000
100,000
50,000
-

2008/9
2009/10
2010/11
2011/12

Financial Year

Highland Hospital?
Non-Highland Hospital
RGH
Raigmore
Community

Graph 2 Shows the split across hospital settings.



Graph 3 Focuses on Raigmore Hospital occupied bed days. Modified to correct under reporting, this comes to 51,500. For Raigmore Hospital, the 'saving' for the 65+ cohort is between 2010/11 (58,125) and 2011/12 (51,500), which is a reduction of 6,625 Occupied Bed Days. The full opportunity cost of this is approximately £ 1.99m.

In terms of the proposed return on investment of the 2010/11 Plan, and allowing for proportionate return over the period of deployment of the resource, this suggests that the desired impact is in line for achievement over a two year period, albeit that the issue of direct attribution remains ever present..

Additional analysis has been undertaken to break these figures down by specialism.

NHS Highland • Age 65+ Emergency OBDs Rate/1,000 of 65+ Popn.

Rolling Year Position by Month • Jan-10 to Jan-12

Source: ISD_SMR01.mdb

Emergency OBDs Age 65+ /1,000 of 65+ Popn

4,000
3,500
3,000
2,500
2,000

Jan-10 Feb-10 Mar-10 Apr-10 May-10 Jun-10 Jul-10 Aug-10 Sep-10 Oct-10 Nov-10 Dec-10 Jan-11 Feb-11 Mar-11 Apr-11 May-11 Jun-11 Jul-11 Aug-11 Sep-11 Oct-11 Nov-11 Dec-11 Jan-12 Feb-12

Rolling Year

Highland Rate/1,000
SE Highland CHP Rate/1,000
North Highland CHP Rate/1,000
Argyll & Bute CHP Rate/1,000
Mid Highland CHP Rate/1,000

Graph 4 Expresses the above activity in terms of the relationship to the ageing population, suggesting that current interventions are decreasing occupied bed days used per 1000 head of population over 65years.

4.4 Successes and lessons learnt

The most significant lessons for the Partnership are:

- Aspiring to a return like the 3:1 concept has a positive impact in testing proposals to invest.
- Setting such a challenge delays the design of programmes
- Commissioning within an integrated, cross sectoral environment requires the development of new skills and relationships that may not be immediately available

5. Governance

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

The Partners have now agreed that a Joint Strategic Commissioning Group will oversee the Partnership Agreement (with minutes being approved via the NHS Board and the HC Adult and Child Committee), and the Community Health and Care Partnership Committee.

This replaces the pre integration governance structure, whereby, the Leadership and Performance Group was the place where NHS and Council governance regimes joined, supported by a Chief Officer Group (Community Care).

The Partners recognised the need for an “Executive Group” to support Governance structures and therefore formed a group to take forward the work of developing highland level plans for the commissioning of adult care.

The partners envisaged a new type of Group to manage planning and investment in adult care. This group needs to:

- Engage all sectors in planning investment
- Promote and demonstrate equality of status within it’s membership
- Be fully and openly provided with relevant analysis and planning information
- Support the development of commissioning skills
- Develop a 5 year strategic commissioning plan for adult care

This group is seen as the fore runner of increased breadth of involvement in service planning in operational structures.

The group needs to be small enough to function, but may have additional inputs as needed. The current membership is:

- Chief Operating Officer
- Directors of Operations (X3)
- Director of Transitions
- Director of Public Health
- Head of Social Care
- Head of Financial Planning
- Head of Community Care
- GP Representative
- Carer Representative
- Service User Representative
- 3rd Sector Representative
- Independent Sector Representative

The group has oversight of a number of pieces of work relating to adult care reporting in through sub groups, eg. Change Fund; Care at Home review etc. and reports into the NHS Senior Management Team and NHS Board Improvement Committee

6. Carers

6.1 Describe the range of services that improve outcomes for carers

The Partners approach to commissioning services has been informed by the views of carers , as equal and expert partners in care, following a short consultation exercise undertaken by one of the Partners, Highland Community Care Forum.

In order to enable carers to continue to care for as long as they are able or wish to the Partners will seek to

commission initiatives which promote the wellbeing, capacity to care and resilience of carers. Such initiatives may include:-

- increasing access to Carer Support Plans for all older carers/carers of older people
- training for carers,
- benefits checks,
- social opportunities
- respite opportunities
- the promotion of carers own health needs.

This list is not exhaustive. In addition many of the services commissioned for older people generally will support carers e.g.:-

- falls prevention
- virtual wards
- enhanced pharmacy
- training around carer awareness and carer identification

The Partners also feel that it is vital to recognise that some of the proposals brought forward under the Change Fund may result in additional pressures being placed on carers or in an increase in a caring role. Accordingly, the partners will develop a robust set of standards to measure the effect of submissions on carers and to require the identification of measures which will mitigate any negative impact. These standards will be applied to all submissions.

6.2 Indicate the total amount of Partnership resource allocated to support carers to enable them to continue to care

The Partners have commissioned a range of services which will support carers:-

Virtual wards – provide rapid intervention, usually in the persons own home or at a facility nearby. The direct support provided to carers includes:-

- Earlier intervention prevents crisis admissions to hospital
- Intervention at home reduces the impact of an admission on the carers by reducing stress and reducing the need to travel long distances
- Increases the opportunities for carers to be fundamentally involved in decisions relating to medical based care
- Carers are better informed of the options and choices that they have

Falls prevention initiatives – when delivered in partnerships with the cared for and carer supports carers by:-

- Providing training and advice to both the cared for and carer enabling both parties to develop their confidence around falls and falls prevention
- Creates a greater understanding between the carer and the cared for of each others needs
- Creates a safer home environment

Enhanced pharmacy – developing a more joined up approach to prescribing a range of medication. Access to an enhanced pharmacy service provides support to carers by:-

- Increasing the opportunity for a carer to be included as a partner in the prescribing process by involving them at the earliest opportunity and supporting them to develop their own confidence around the medication provided to the cared for person
- Carers have a better understanding of the medication and the aspirations of the medication
- Carers can provide input into the timing and method of intervention reducing stress and sharing knowledge

Elderly mental health redesign – enhancing a service which is both specialist and available locally. Creating a service which provides specialist interventions supports carers by:-

- Enabling access to specialist services which are available locally
- Supporting the pathway to earlier diagnosis and treatment enables the carer to understand the cared for persons condition and prognosis at an earlier stage. This in turn helps them to plan for the future with more accuracy

Voluntary sector initiatives – a range of initiatives to support both the carer and the cared for person.

- Initiatives such as increased access to Carers Support Plans, training and information enables carers to manage their caring role, develop their own resilience and manage their own wellbeing
- Access to Dementia Link Workers supports carers to understand the progression of the cared for persons illness and also receive support in their caring role
- Access to information and support from organisations such as CAB enables carers to access the appropriate benefits in a timely fashion
- Initiatives which provide activities and supports for the cared for person can act as an opportunity for respite for the carer

Reablement – working with individuals to support them to recover lost skills and confidence enables the cared for person to regain independence and can impact on the level of care required.

End of life support – specialist services working with families at end of life provides support to carers by:-

- Enabling access to specialist nursing reducing the burden of care at a difficult time
- Can act as an opportunity for regular short periods of respite for the carer
- Access to income maximisation information can support a carer to access additional income and prepare for life after caring

Joint equipment store – easier access to vital pieces of equipment supports carers by:-

- Reducing the negative impacts of the caring role by enabling access to equipment which reduces the burden of physical care
- Helps carers to better understand how to use equipment effectively

Training – developing a better awareness of the role and importance of carers amongst the partners staff and developing training which supports carers is of direct benefit to carers by:-

- Developing the skills of carers both in terms of their own caring role and also safeguarding their own wellbeing
- Raising the awareness of carers, their role and their needs amongst the partners develops better relationships with carers and will also help to identify hidden carers, enabling carers to access support earlier in their caring role
- Supporting committee chairs, strategic leads and directors of operations to develop a better understanding of carers and their needs enables them to ensure that the commissioning process and any developments support carers

Additional AHP staff – access to local, trained AHP staff provides support to carers by:-

- Ensuring that carers can access timely information and practical support in their own local areas
- Supports the cared for person to regain lost skills and enhance their own mobility reducing the impact of the physical caring role for the carer.

7. Support Mechanisms

7.1 What support has helped you so far? What didn't?

7.2 What support, if any, could you offer other Partnerships?

8. Joint Commissioning Strategy for Older People

In terms of your Joint Commissioning Strategy:
- what Partners will be involved in the preparation of the Strategy;
- what are the estimated total resources for the Strategy;
- what governance arrangements are you planning on implementing;
- what is the timeline involved;
- how will your Joint Commissioning Strategy link in with your Change Fund application?

Highland Strategic Commissioning relates to the totality of resource for Adult Health and Social Care.

Highland has sought to establish a shared understanding of definitions, purpose and process of "Commissioning; and to reflect on our capability and capacity to progress a commissioning approach within the wider context of the Highland Quality Approach, and the Lead Agency model for the provision of integrated Health and Social Care. This has lead to the development of **A Highland Quality Approach to Strategic Commissioning**, which was agreed by the NHS Board on June 5th, 2012, but which was developed in collaboration with all Sectors.

NHS Highland has agreed to develop Quality Commissioning practice which displays the following:

1. Understands the population needs by engaging with communities and representatives
2. Engages provider organisations when setting priorities
3. Outcomes are the heart of the process
4. Maps and engages the fullest practical range of providers
5. Considers investing in the provider base
6. Ensures contract processes are transparent and fair
7. Ensures long-term contracts and risk-sharing
8. Seeks feedback to review effectiveness of the commissioning process

Highland commissioning practice is therefore about growing involvement, capacity and capability across all sectors.

For the NHS, this means moving from a "provider" focus (i.e. commissioning from ourselves) to strategically commissioning and leading the development of an equitable, evidence based, transparent and engaged model for planning investment (and disinvestment)

For other provider sectors, (such as voluntary and independent), this means a move from bidding and design in isolation; to a collaboration with the statutory sectors.

For communities and representative groups, this means finding new ways to engage proportionately, so that the community's voice is present throughout, but the process is not disabled by consultations.

Highland has committed to a model of Commissioning which means that all sectors have to behave differently, with the focus shifting from "consultation" to "engagement and innovation in line with agreed community priorities".

This also means making explicit links with existing, complementary initiatives. There is a good fit with:

- Co-production frameworks – Governance International suggest that "Co-production of public services means professionals and citizens making use of each other's assets, resources and contributions to achieve better outcomes and efficiencies". Good commissioning means understanding all available assets, not just public sector finance. The Highland 3rd Sector Interface describes the biggest issue in this approach as being *"that we commission for jointly agreed needs"*. To achieve this, the *"biggest change in co-production is in agreeing with partners what wants we should be meeting, and not what needs we think service users have; so that 'the help they get is right for them"*. This represents *"a change in the way care is commissioned, with the benefit that listening to users about their health issues is much more likely to ensure that they 'engage in the co-production of their health outcomes"*.
- Small tests of change – (PDSA) provide evidence of efficiency and effectiveness of resource allocation and return.
- The LEAN framework – provides whole system analysis and rapid improvement methodologies.
- Integrated Resource Frameworks – (IRF, PBMA) provide resource mapping methodologies and investment option appraisal methodologies.
- Self Directed Support which effectively makes the person in receipt of the service the commissioner, but which also places a responsibility on agencies to disinvest in services that people choose not to use.

"Commissioning for Outcomes" takes us to a different, more challenging level. Commissioning for Outcomes means we understand the differences between *inputs; outputs and outcomes*, with the defined outcomes being sought dominating the business of commissioning. That means a move from "numbers of people seen", to more difficult returns about the quality of experience and the level of personal benefit.

We have agreed that Commissioning for outcomes means a collaborative approach towards planning, which involves all sectors and the population as active, equal partners in both decisions to invest *and* assessing whether the return on investment meets the commitments given by providers.

All Partners in the Highlands recognise the need to reflect on their current capability, capacity and approach and their readiness to engage in strategically commissioning for outcomes, specifically in terms of:

<u>Management Capabilities and Capacity</u> – The skill sets required for commissioning are extensive but traditional, target-orientated planning has limited the development of such skills to date. Are the capability of commissioners and of the resources available to them be effective?

<u>Information Systems</u> – Do these systematically provide the individual and population level data on costs or outcomes required for commissioning?

<u>The External Environment and Provider Base</u> – Is there an awareness that investment by one partner may impact on another? Effective joint strategic commissioning requires a mutual understanding of interdependency across organisational boundaries, and the capacity and commitment to switch funding from one organisation to another.

<u>Leadership and Culture</u> – Is critical. Do the relationships and behaviours express equity and mutual respect, and is there a sense of trust between partners?.

An initial reflection on the above would suggest that we need to develop in all of these areas.

Points 1 to 5 below suggest the components of the Highland Commissioning agenda that we are currently to pursuing:

1. A Shared Understanding of what we mean by "Commissioning" is required. All collaborating organisations need to understand what commissioning is, and what it is not, and what we are commissioning (i.e. what outcomes).

2. Capacity and Capability needs to be developed to enable all organisations to contribute. This means establishing a programme with the aim of developing and sharing analytical skills and information, understanding what the information is telling us, understanding the implications for planning investment etc.

3. A Spectrum of Proportionate Engagement needs to be understood. Major engagement exercises, such as the development of the Community Care Plan give a mandate for action, however some initiatives, such as those impacting significantly on hospitals may require formal consultation measures. The key point is that a major redesign, such as implementing Reablement, may require less engagement at a local level than the development of a day service in a village hall.

4. Planning Investment over the next 3 to 5years is required to build stability and breadth in the provider base.

5. Provider Base; User Engagement and Community Development. All of the above need to take place with the full and equal engagement of all sectors to ensure that the provider base and community capacity is developed to full potential.

As part of the above, Highland have engaged with the JIT to develop a major, cross sector, Commissioning Capability and Capacity Development Programme, and with the Scottish Government to implement a Programme Budgeting; Marginal Analysis (PBMA) initiative. These two initiatives will underpin delivery of a Strategic Commissioning Plan by April 1st 2013.

The Partnership is clear that the Change Plan is a small part of the broader Strategic Commissioning Plan for all adult health and social care.

This Change Fund Plan has been prepared; authored and agreed by the NHS, Local Authority; Third Sector ; Service Users; Carers and Independent Sector interests.

Signed

Tina Morrow **Highland Community Care Forum (Carers Representative)**

Ian McNamara **Highland Senior Citizen's Network (Service User's Represenative)**

Stephen Pennington **Scottish Care (Independent Sector Representative)**

Hazel Allen **Third Sector Representative**

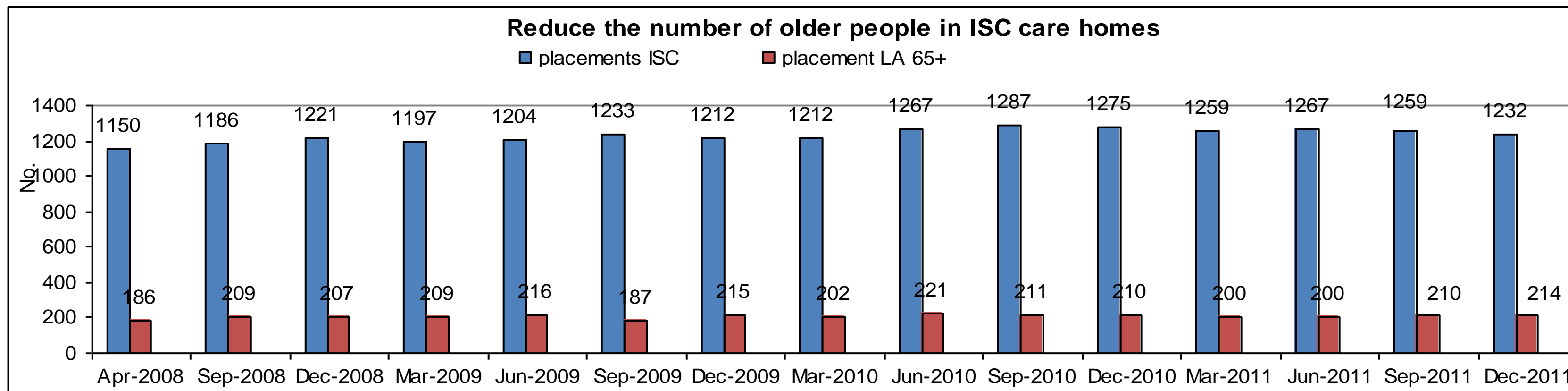
Alistair Dodds **Highland Council**

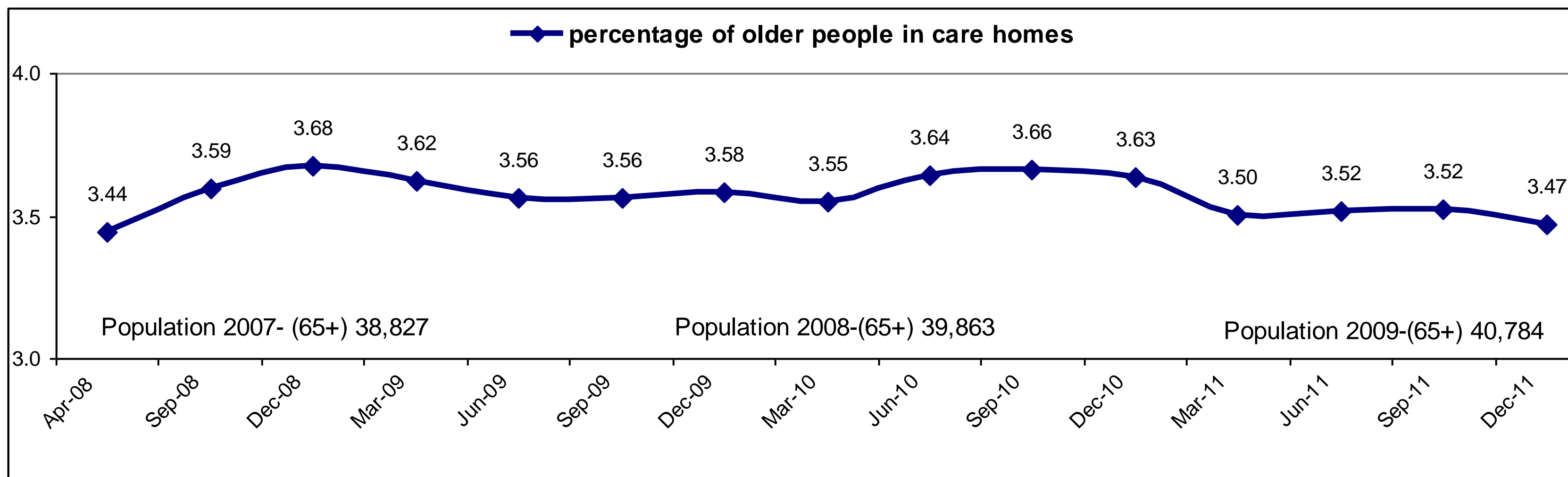
Elaine Mead **NHS Highland**

APPENDIX 1
HIGHLAND PARTNERSHIP
PRIMARY AND COMMUNITY CARE FOR OLDER PEOPLE PERFORMANCE REPORT –FEBRUARY 2012

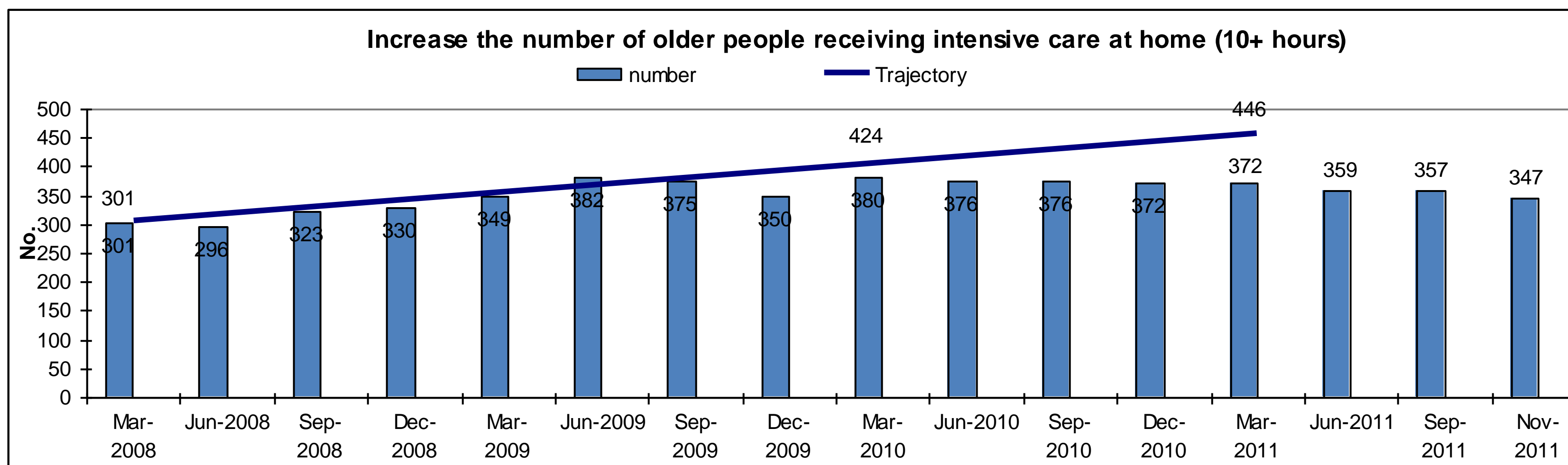
SECTION 1 - SHIFTING THE BALANCE OF CARE.

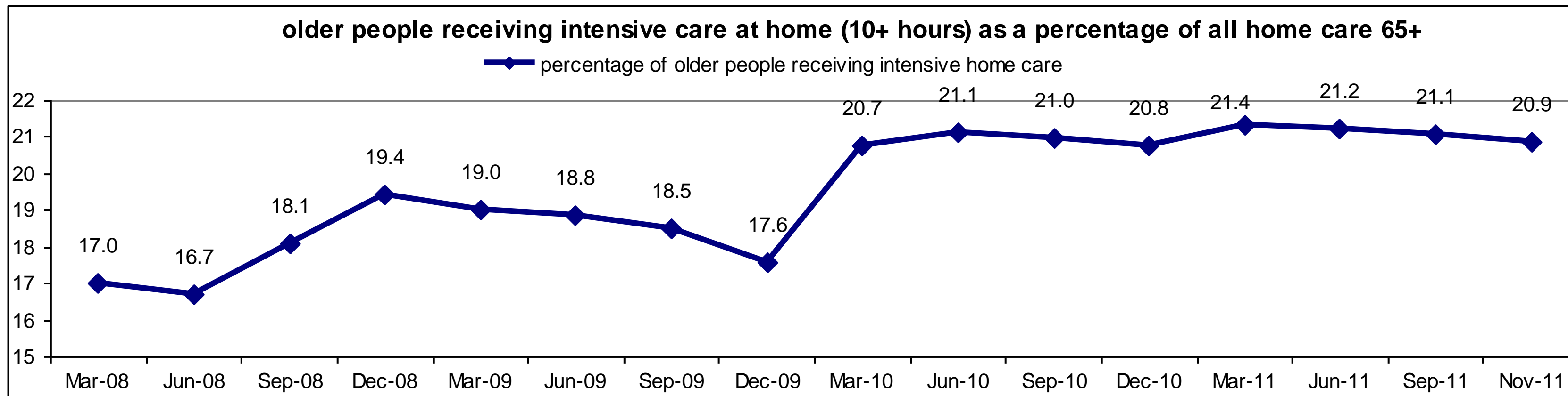
Target (i): The new Community Care Plan envisages the level of provision staying around the same, as the population increases, albeit there should be increased use of intermediate placements over the LA and independent sectors.
Six monthly reporting requirements
Percentage = the combined number above as a percentage of the total mid-year population estimates for Highland who are 65 and above as published by the General Register Office for Scotland (GROS)





Target (ii): To increase the number and percentage of older people receiving intensive care at home (10+ hours)
Target: Increase to 446 by March 2011 from baseline of 301 (March 2010 target = 424).
Number: People aged 65 and above who receive a care at home service totalling more than 10 hours in one week.
Percentage: The number above as a percentage of the total number of people aged 65 and above receiving a care at home service.



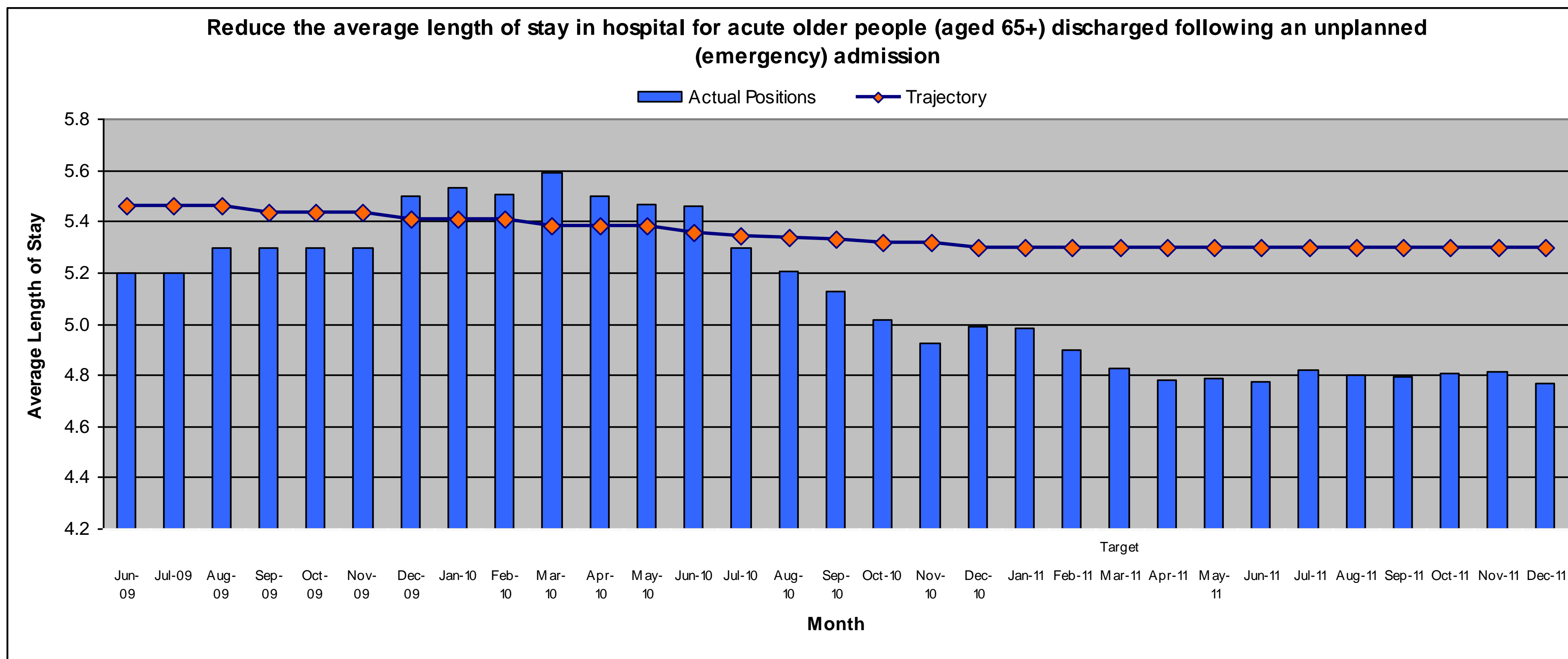


Target (iii): To increase the number and percentage of older people receiving intensive home care and community nursing services

This information is currently not collected and at present there is no method available which reports on combined services. This is an issue for the data sharing partnership.

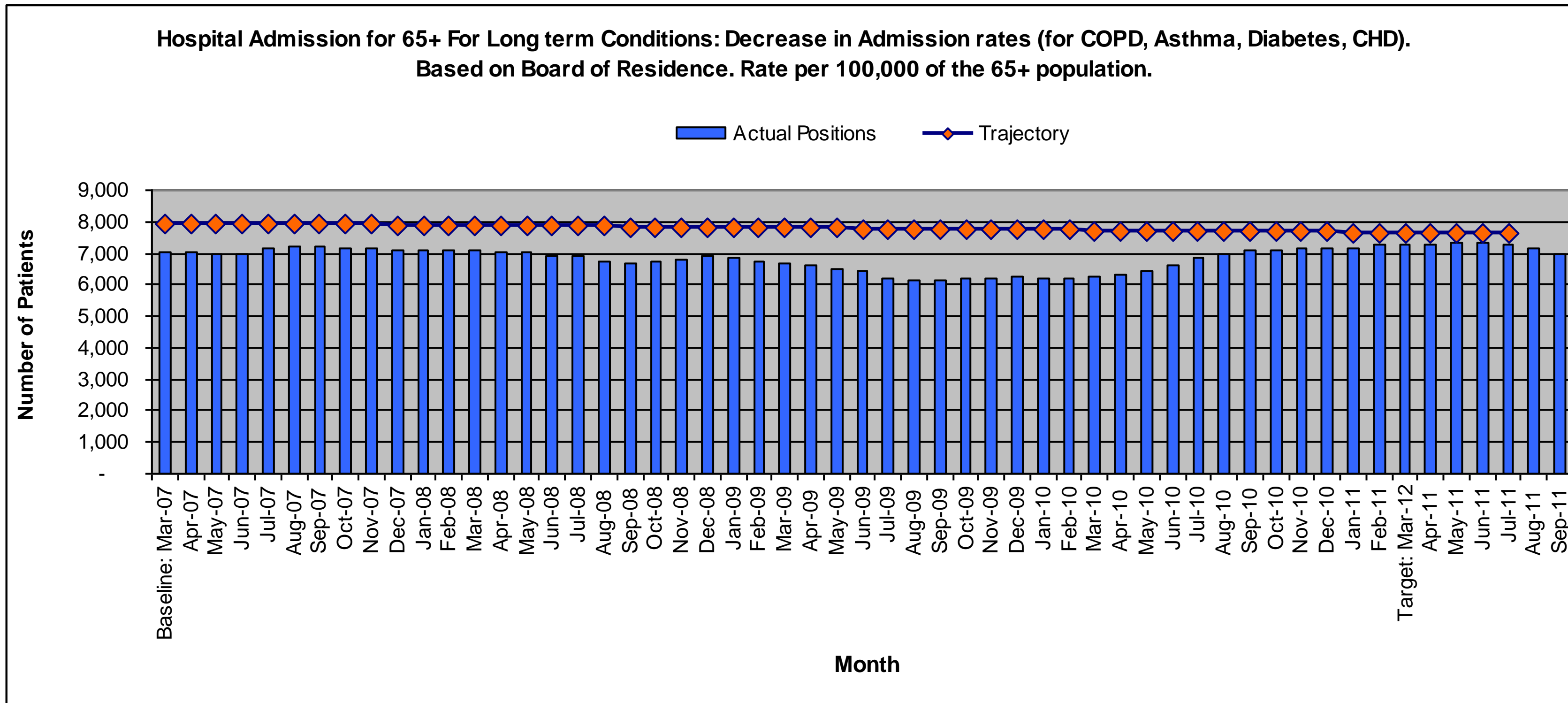
Target (iv): To reduce the average length of stay in hospital for acute inpatients aged 65 and over, following an unplanned (emergency) admission.

This target is derived from the HEAT Target E4.2, which requires a 1.7% reduction per annum from the baseline performance in 2007/08 to the end of the financial year 2010/11 i.e. achieving a 5% reduction in total over the 3 years.



Baseline: Performance during 2007/08 = 5.6 days
Target: Performance during 2010/11 = 5.3 days

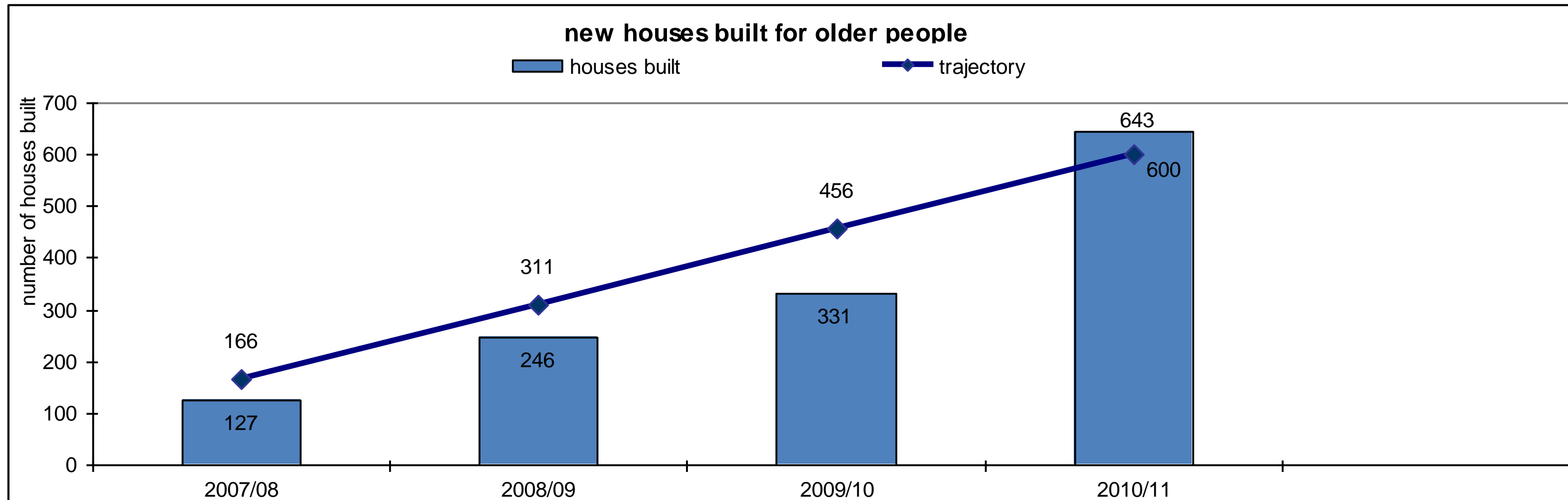
Target (v): To reduce hospital admission rates (per 100,000 population) of patients aged 65 and over who have a primary diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, Diabetes or Coronary Heart Disease (CHD).
This target is derived from the HEAT Target T6, which requires a reduction from the baseline performance in 2006/07 to the end of the financial year 2010/11. The reduction was determined locally by each Board. NHS highland set a target of 1% per annum reduction from the baseline year by the target deadline.



Baseline: Performance during 2006/07 = 7,953 admissions per 100,000
Target: Performance during 2010/11 = 7,640 admissions per 100,000

Target (vi): To increase the average age of care home residents
There is no update on the previously reported 2008/09 position therefore no graphs have been included in this report

Target (vii): To increase the number of new houses built for older people
Target: to build 600 new houses suitable for older people or people with disabilities by March 2011 (starting from a baseline of 127 in April 2008)
This target is now complete.



Target (viii): Increase the percentage of older people with complex care needs who are cared for at home.
This target is derived from the Heat Target T8, which requires Highland CPP to achieve a minimum of 28% by March 2011.

Older people with complex care needs are defined as people aged 65 and over who are:

- Receiving 10+ Hours of home care (purchased or provided by LA)
- Resident in a Care Home
- Resident Long-term in Hospital

Responsible Division	March 2011 HC	March 2011 CH	March 2011 LTH	March 2011 Total	Percentage of all older people receiving long term care at home
Highland CPP	368	1498	24	1890	19%

March 2011 Trajectory for Highland CPP = 28%

Baseline: Performance during 2003/04 = 21%
Target: Performance during 2010/11 = 28%

SECTION 2 - FINANCIAL MEASURES

Reporting Requirement - 6 Monthly Update & Year End Position

Target (i): To decrease the social work spend on care homes and care home placements

Target (ii): To increase the social work spend on care at home services
There is no update on the previously reported year end position for 2009/10 position therefore no graphs have been included in this report

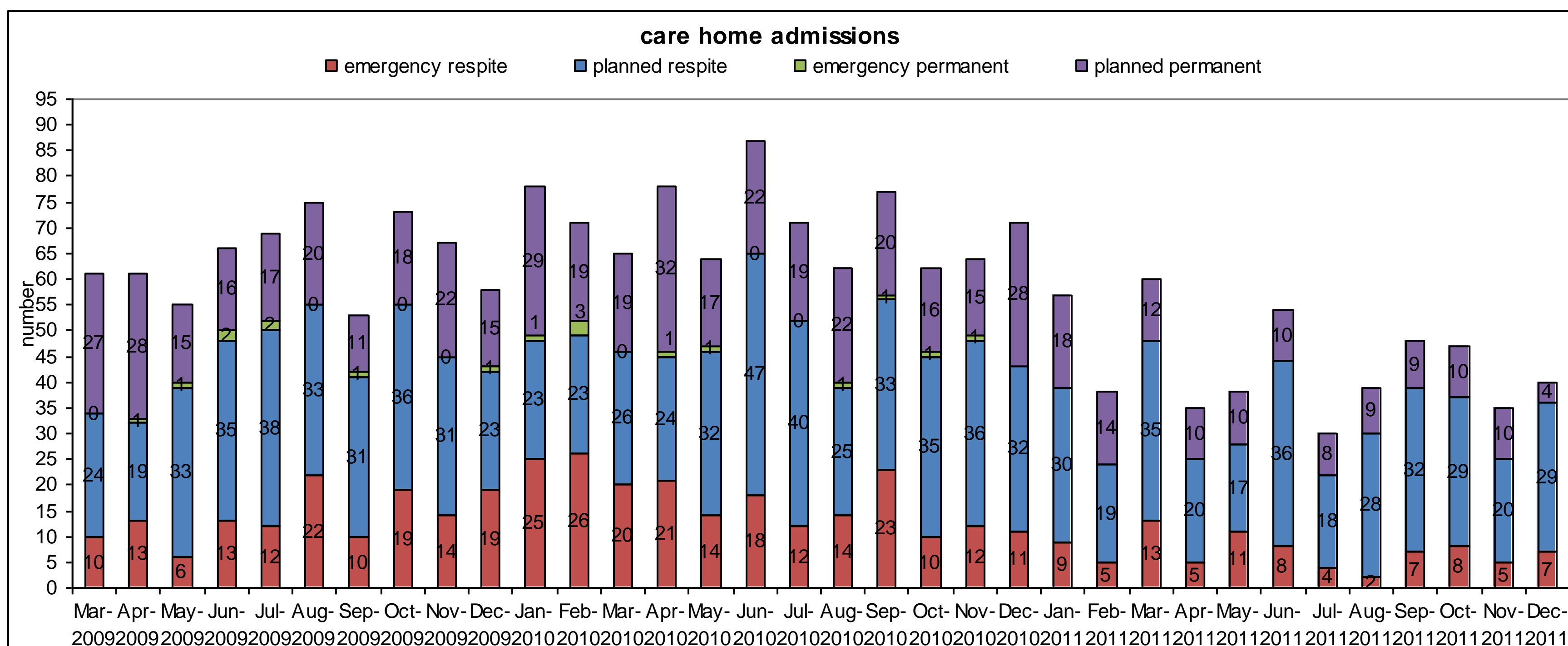
Target (iii): To reduce the NHS spend on hospital admissions for patients aged 65 and over with a Long Term Condition.
There is no update on the previously reported position therefore no graph has been supplied by the NHS for this report.

Target (iv): To increase the NHS spend on community services for patients aged 65 and over with a Long Term Condition.
Currently being developed by the NHS, there is no update for this report

SECTION 3 - SERVICE PERFORMANCE MEASURES (Monthly Reporting)

Target (i): To decrease the number of new admissions to care homes

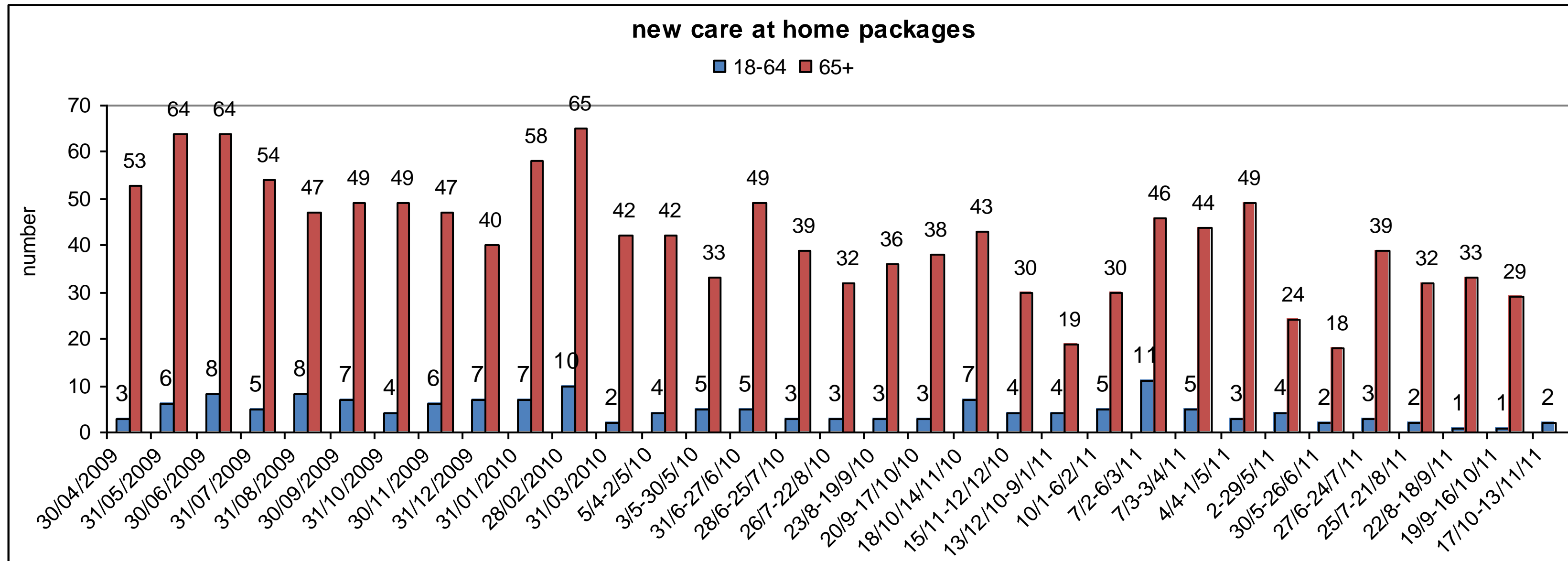
Target is to reduce the number of people admitted to care homes during each month (all client categories). This is part of the target and action plan for Section 1(i) to reduce the total number and percentage of older people in care homes. It is also closely linked to the modernisation of the Care At Home service and therefore there is no specific target purely in relation to admissions. Data collection commenced in March 2009 for this measure, no previous baseline is available. This has been broken down to show the number of emergency admissions and the planned admissions split between respite and permanent.

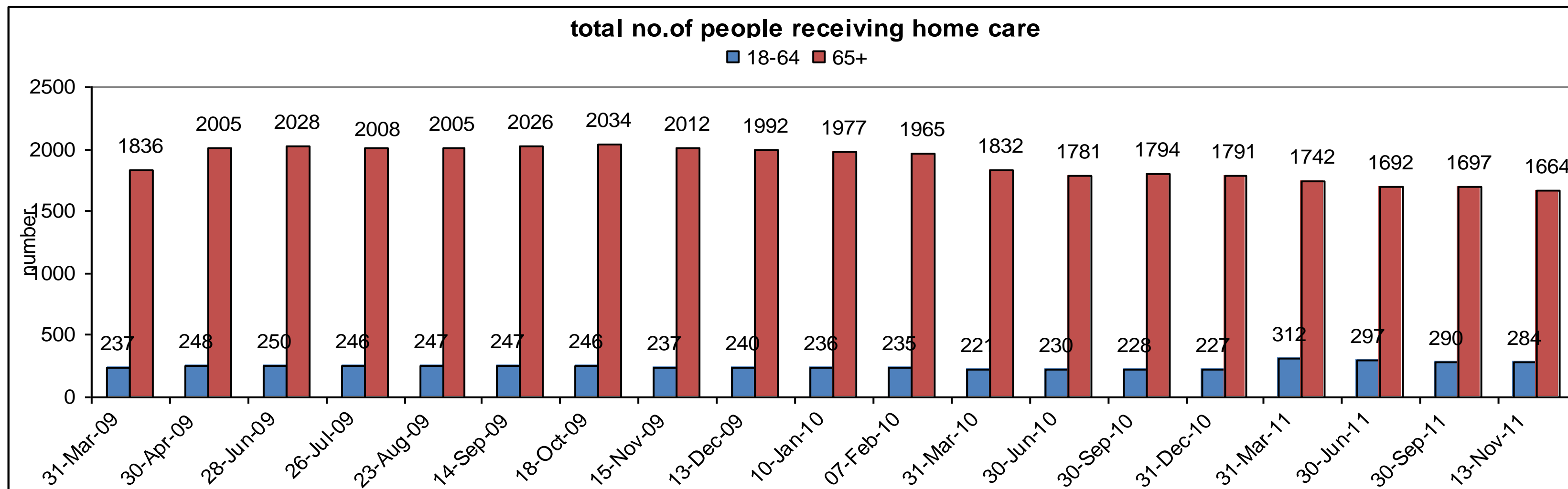


Target (ii): To increase the number of new care at home packages arranged

Data shown is the number of people for whom a new care at home service was arranged following an assessment and who were not previously in receipt of a service. Data collection commenced in April 2009 for this measure no previous baseline figure is available.

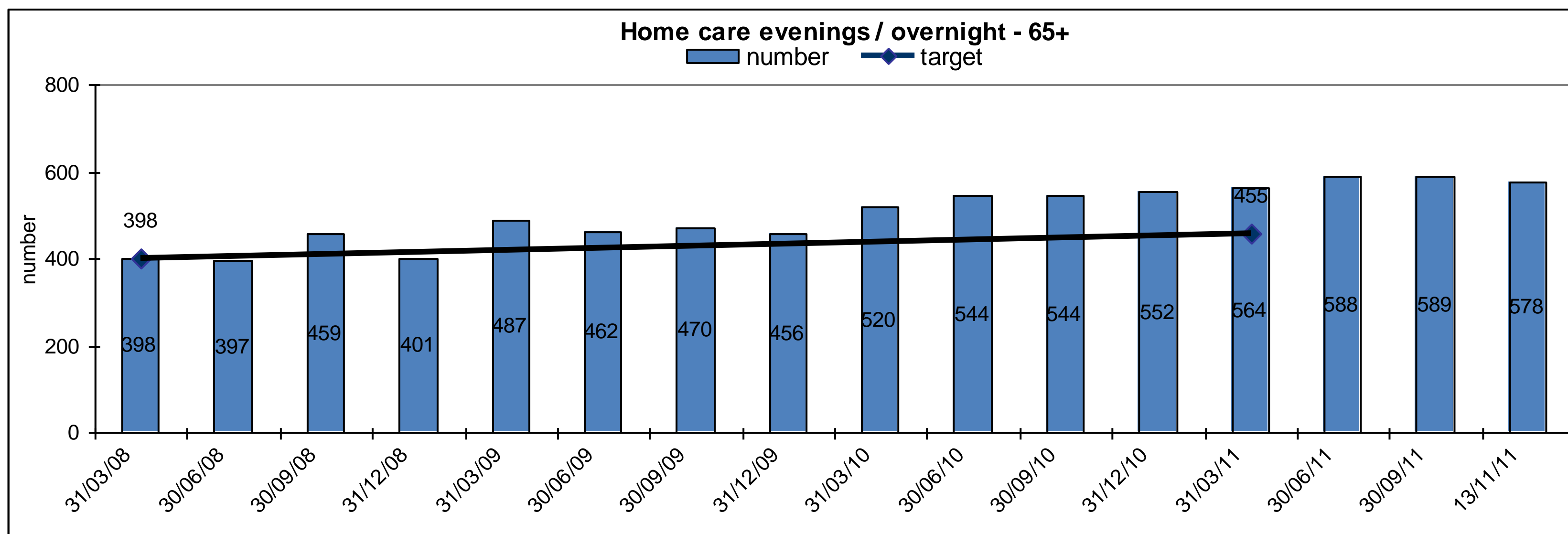
As requested a further graph has been included to show the total number of people receiving a home care service by age group

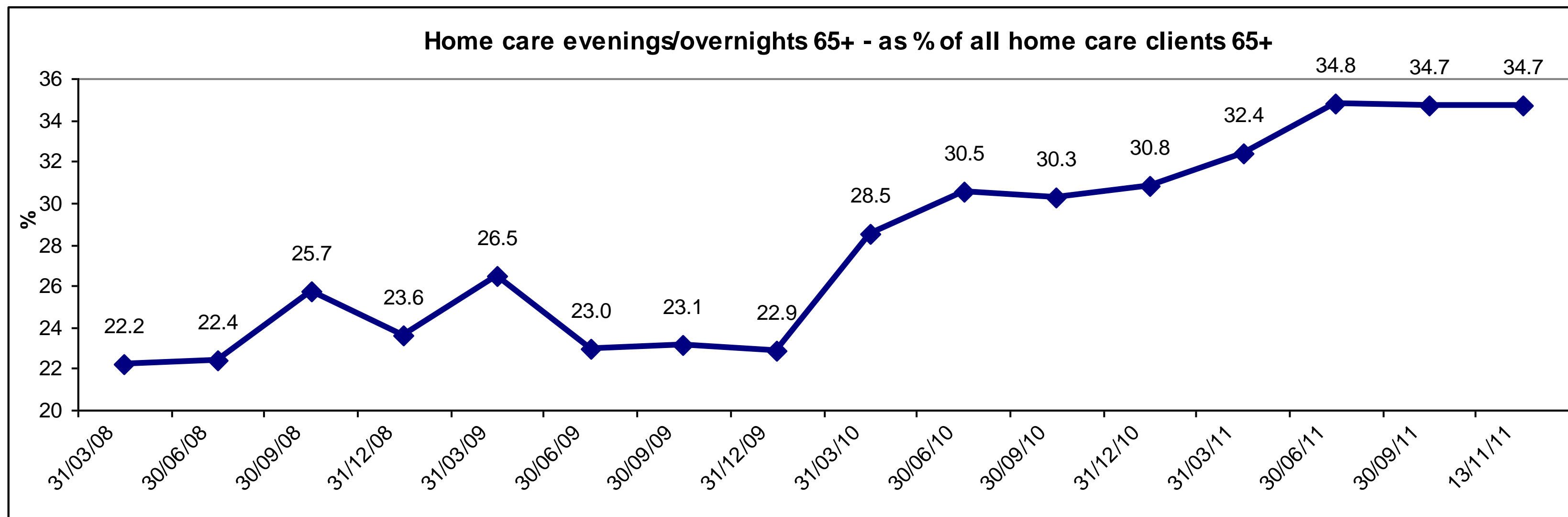




Target (iii): To increase the number and percentage of older people getting home care in the evenings or overnight

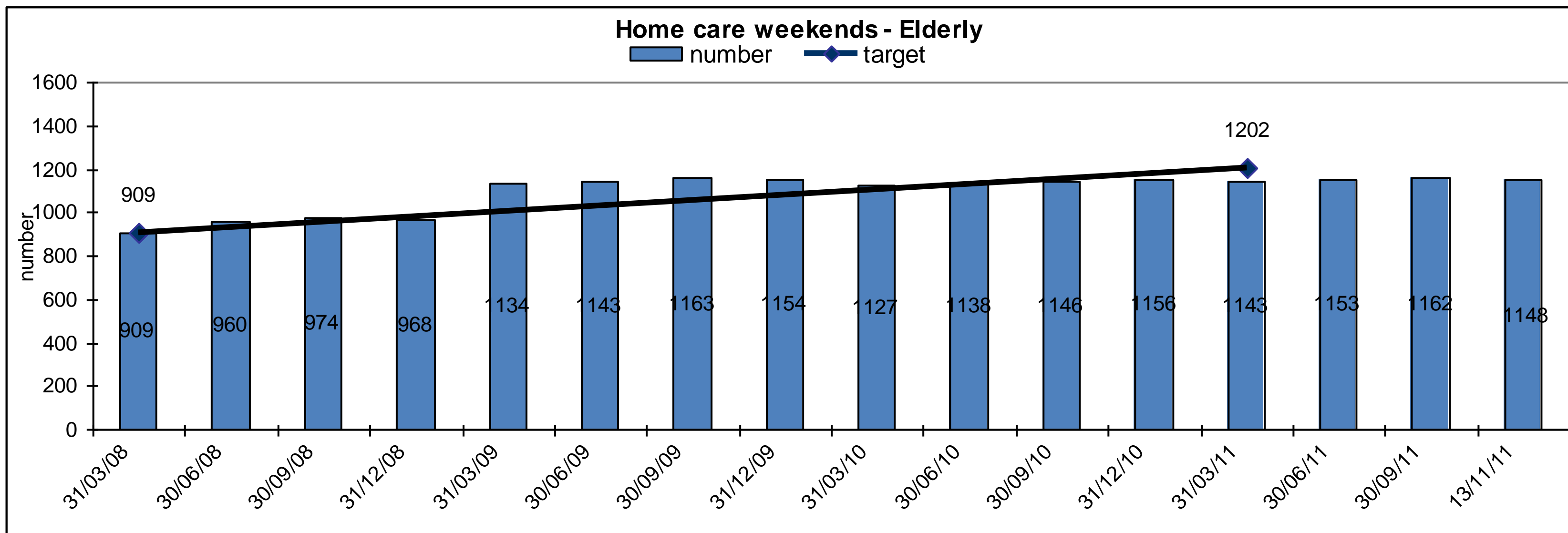
Target is to increase the number of older people receiving an evening (7pm to 10pm) or overnight (10pm to 7am) service from a baseline of 398 in April 2008 to 455 by March 2011 (see blue line on graph). New data collection system was introduced in March 2009 for this measure. Percentage is the above number expressed as a percentage of all older home care clients (65+).





Target (iv): To increase the number and percentage of older people getting home care at weekends

Target is to increase the number of older people receiving a weekend home care service from a baseline of 909 in April 2008 to 1202 by March 2011 (see blue line on graph). New data collection system was introduced in March 2009 for this measure. Percentage is the above number expressed as a percentage of all older home care clients (65+).


Home care weekends - Elderly
number
target
number
1600
1400
1200
1000
800
600
400
200
0
909
1202
909
960
974
968
1134
1143
1163
1154
1127
1138
1146
1156
1143
1153
1162
1148
31/03/08
30/06/08
30/09/08
31/12/08
31/03/09
30/06/09
30/09/09
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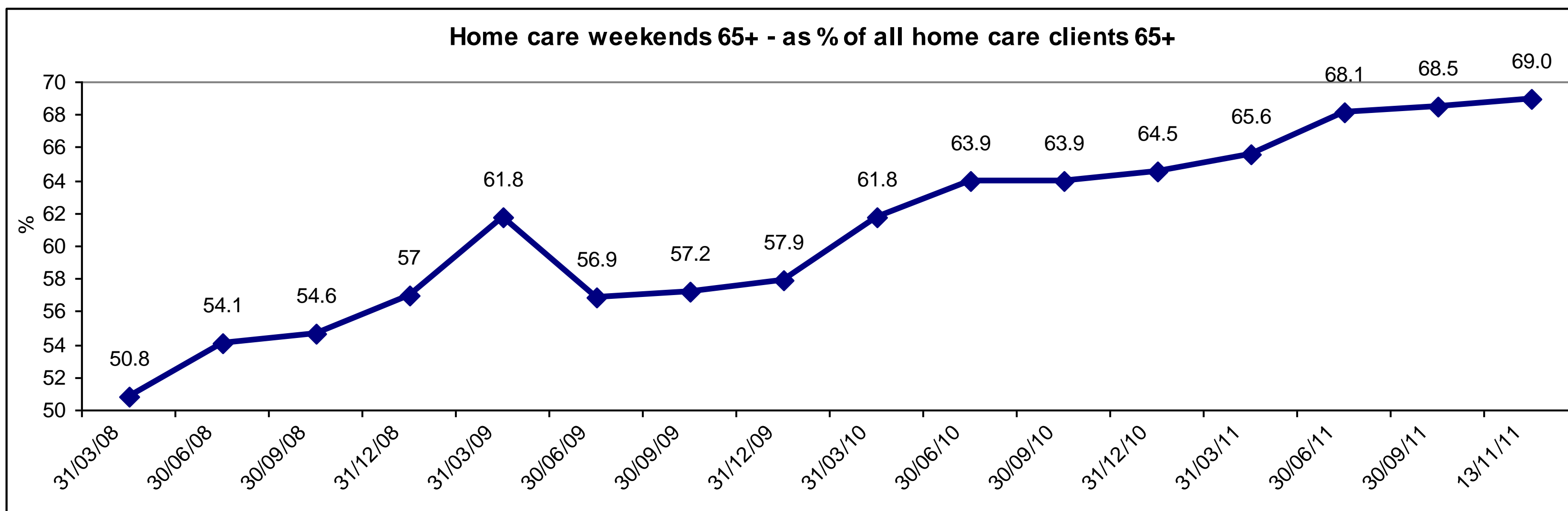
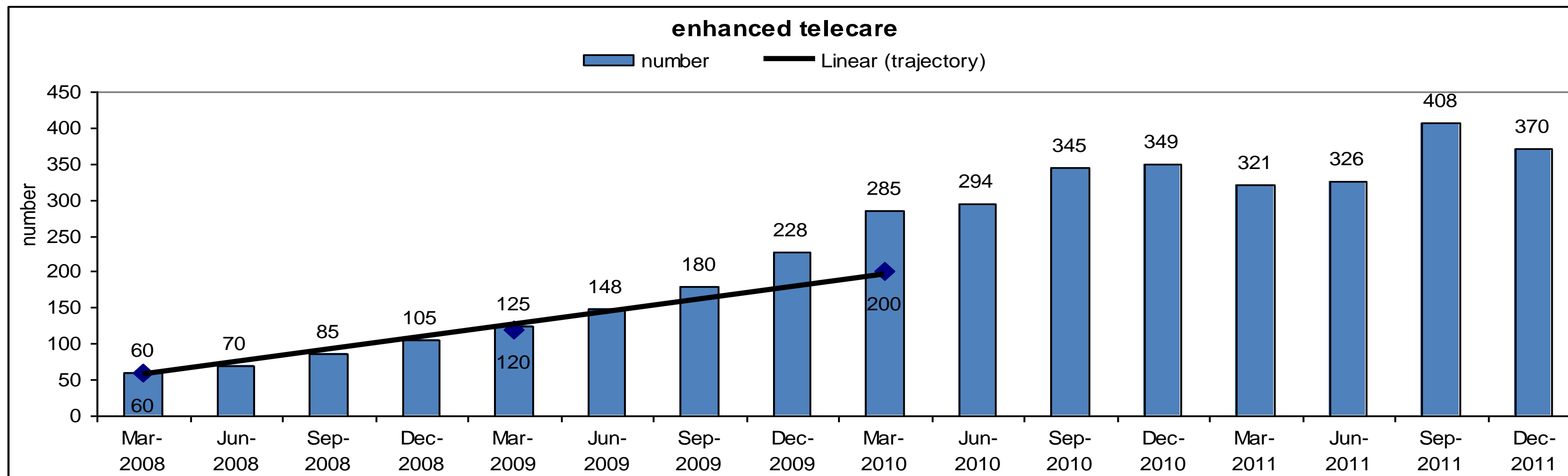
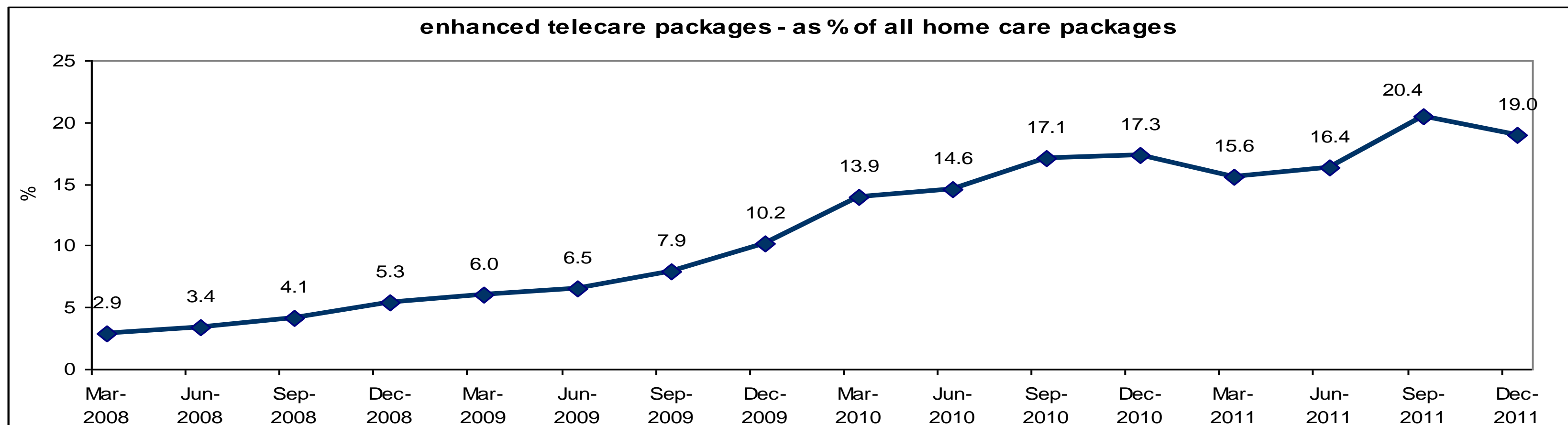
13/11/11


Home care weekends 65+ - as % of all home care clients 65+
%
70
68
66
64
62
60
58
56
54
52
50
50.8
54.1
54.6
57
61.8
56.9
57.2
57.9
61.8
63.9
63.9
64.5
65.6
68.1
68.5
69.0
31/03/08
30/06/08
30/09/08
31/12/08
31/03/09
30/06/09
30/09/09
31/12/09
31/03/10
30/06/10
30/09/10
31/12/10
31/03/11
30/06/11
30/09/11
13/11/11

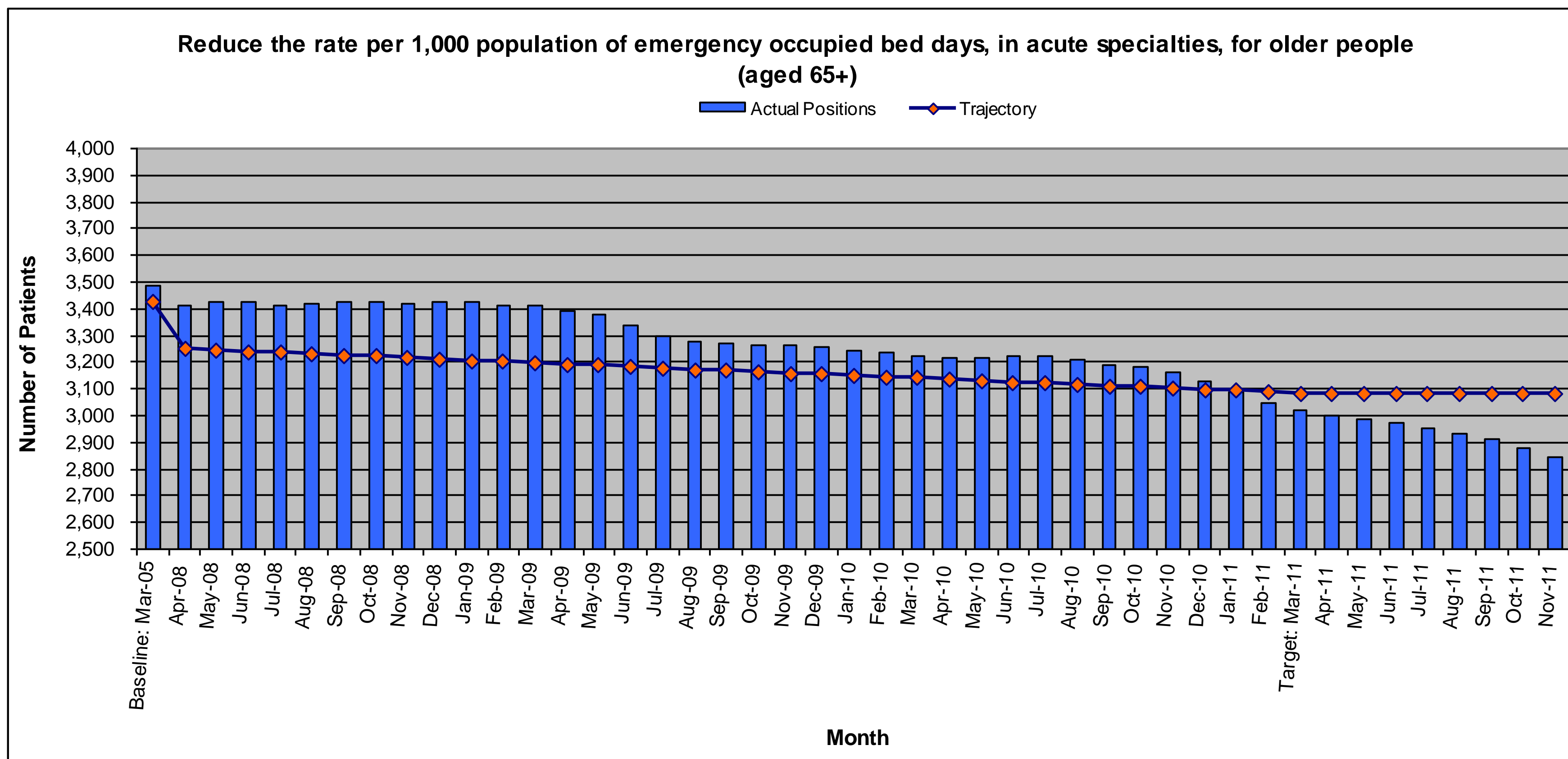
Target (v): To increase the total number and percentage of all people with an enhanced telecare service
Target is to increase the number of people who have an enhanced telecare service from a baseline of 60 in April in 2008 to 120 by March 2009 (see blue line on graph). This target has been achieved. The basic telecare service comprises a base unit, personal alarm and home fire safety telecare sensors. Enhanced telecare includes more sophisticated telecare sensors such as environmental and health sensors, along with tailored response services
Number = all people who receive an enhanced telecare service.
Percentage = number with enhanced telecare as a percentage of the total number of all people receiving a care at home service.
A revised target has been set of 200 by March 2010.
This remains as a Social Work Corporate Indicator for 11/12 with a target to continue to increase provision.
There is currently no update to the June 2011 figures.





Target (vi): To reduce the rate, per 1,000 population, of occupied beddays for emergency admissions in acute specialities for those aged 65 and over.

This target is based on HEAT Target T12, which requires a 10% reduction from the baseline performance in 2004/05 to the end of the financial year 2010/11.



Baseline: Performance during 2004/05 = 3,424 beddays
Target: Performance during 2010/11 = 3,082 beddays

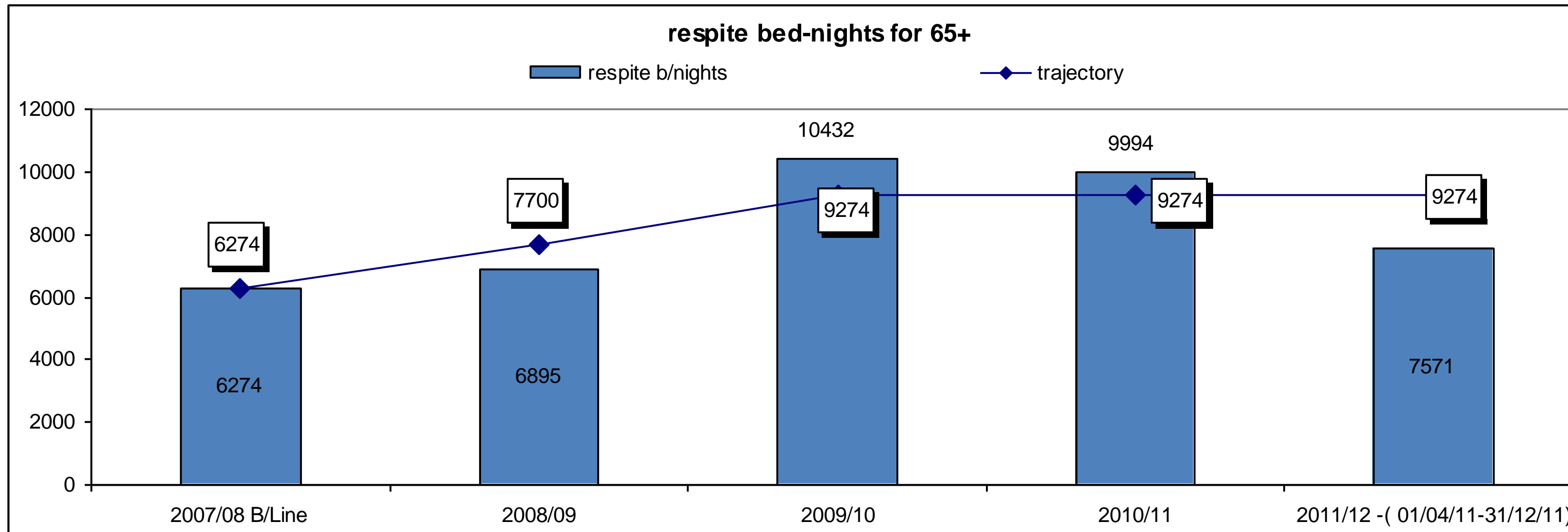
Target (vii): Prevention indicator (e.g. falls prevention)
Definitions, targets and data sources require to be confirmed for this measure.

Target (viii): Rehabilitator indicator
Definitions, targets and data sources require to be confirmed for this measure.

Target (x): Respite indicator

The target was to provide an additional 3,000 respite bed nights to clients aged 65+ during 2008/10. This has been achieved. The baseline for April 2008 was the 6,274 bed nights provided during 2007/08. The graph shows the respite provision per annum over the 2 year period in comparison to the target.

The new target agreed as part of the Corporate Indicator review for 11/12 is to maintain respite bed nights usage at the 9274 per annum level.



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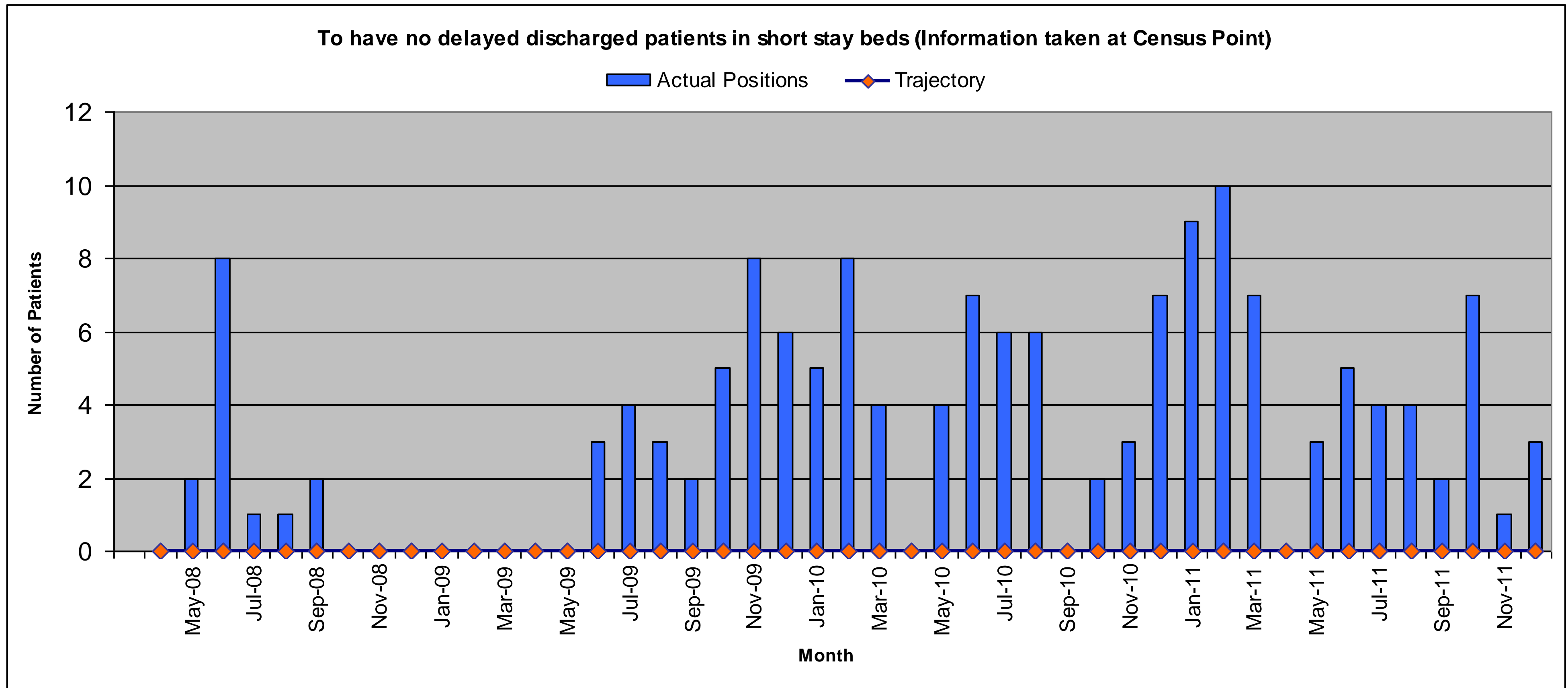
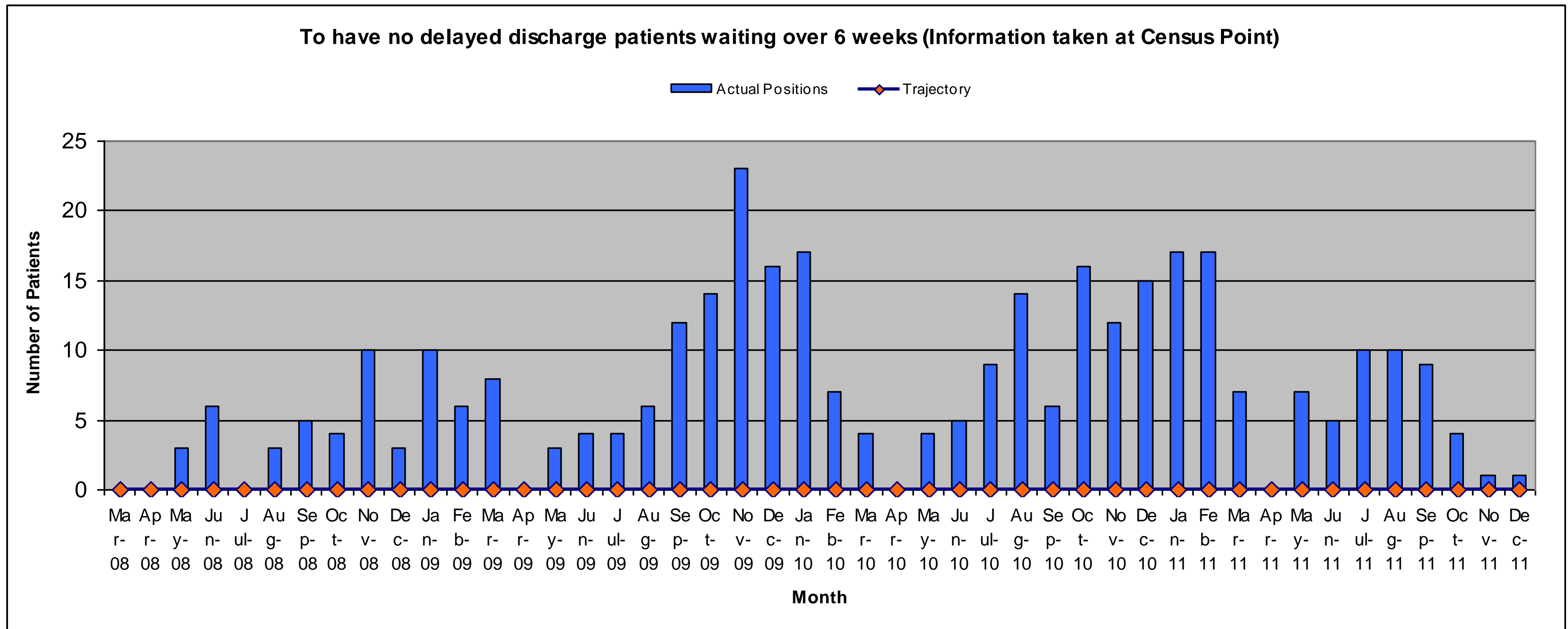
Target (ii): To have no patients with a delayed discharge in a short stay bed.



Target (iii): To have no patients with a delayed discharge over 6 weeks.



SECTION 4 - SERVICE EFFICIENCY MEASURES

Target (i): To increase the number and percentage of Single Shared Assessments undertaken within 15 days. This is a local target set in 2008. A national initiative was introduced in April 2010 with Local Authorities to monitor information for assessment waiting times and while there is no national taget, COSLA and the Scottish Government will keep under review the timescales submitted by councils and consider what appropriate standards might be applied in the future.

1. Eligibility Criteria and Waiting Times									
Number of clients aged 65+ with a completed community care		Quarter Jan-Mar 10	Quarter Apr-Jun10	Quarter Jul-Sep 10	Quarter Oct-Dec 10	Quarter Jan-Mar11	Quarter Apr-Jun11	Quarter Jul-Sep11	Quarter Oct-Dec11
Critical	65-74	9	21	20	26	19	17	16	10
	75-84	40	50	60	57	58	53	31	29
	85+	26	45	57	38	46	57	29	22
Substantial	65-74	20	27	20	14	29	25	19	12
	75-84	33	74	53	48	46	57	42	24
	85+	26	51	39	33	54	48	39	36
Moderate	65-74	16	28	21	17	19	22	11	10
	75-84	40	70	62	33	49	48	25	31
	85+	36	72	43	19	41	55	26	27
Low risk	65-74	3	9	0	1	1	2	3	0
	75-84	7	10	5	7	9	5	2	0
	85+	13	11	12	6	6	6	4	2
No risk	65-74	0	0	0	0	0	0	0	0
	75-84	0	0	0	0	0	0	0	0
	85+	0	0	0	0	0	0	0	0
Not available	65-74	20	20	20	12	18	13	21	12
	75-84	33	45	33	23	30	34	19	19
	85+	29	38	22	9	21	30	19	23
Totals		**351**	**571**	**467**	**343**	**446**	**472**	**306**	**257**

Time intervals from first contact to completion of a community care assessment – number of people aged 65+ in each eligibility category		Jan-Mar 10	Apr-Jun10	Jul-Sep 10	Oct-Dec 10	Jan-Mar11	Apr-Jun11	Jul-Sep11	Oct-Dec11
	Less than or equal to 2 days	8	11	12	10	7	14	17	9
	More than 2 days and <= 1 week	9	8	3	13	10	14	13	12
	More than 1 week and <= 2 weeks	7	21	12	21	24	24	11	7
	More than 2 weeks and <= 3 weeks	5	9	13	16	21	23	10	4
Critical	More than 3 weeks and <= 4 weeks	6	8	8	8	15	8	9	6
	More than 4 weeks and <= 6 weeks	13	13	11	12	16	12	7	7
	More than 6 weeks and <= 8 weeks	7	7	6	11	5	7	2	4
	More than 8 weeks and <= 10 wks	4	7	6	6	5	9	2	3
	More than 10 weeks	16	32	66	24	20	16	5	9
	Less than or equal to 2 days	11	16	9	10	11	15	10	7
	More than 2 days and <= 1 week	9	16	11	10	13	10	12	4
	More than 1 week and <= 2 weeks	6	15	12	7	14	10	20	8
	More than 2 weeks and <= 3 weeks	13	10	10	17	13	21	9	9
Substantial	More than 3 weeks and <= 4 weeks	3	17	7	11	6	18	10	8
	More than 4 weeks and <= 6 weeks	7	16	11	7	14	13	14	11
	More than 6 weeks and <= 8 weeks	10	11	3	11	7	10	5	4
	More than 8 weeks and <= 10 wks	3	9	9	6	8	7	4	2
	More than 10 weeks	17	42	40	16	43	26	16	19
	Less than or equal to 2 days	6	10	10	6	10	5	6	2
	More than 2 days and <= 1 week	4	8	9	7	5	5	3	12
	More than 1 week and <= 2 weeks	6	19	11	4	14	14	8	8
	More than 2 weeks and <= 3 weeks	3	12	15	9	9	21	6	5
Moderate	More than 3 weeks and <= 4 weeks	3	10	11	3	12	10	3	8
	More than 4 weeks and <= 6 weeks	5	11	10	6	11	22	10	10
	More than 6 weeks and <= 8 weeks	10	10	7	8	12	9	6	3
	More than 8 weeks and <= 10 wks	6	13	7	5	3	7	5	4
	More than 10 weeks	49	77	46	21	33	32	15	16

Time intervals from first contact to completion of a community care assessment – number of people aged 65+ in each eligibility category		**Jan-Mar 10**	**Apr-Jun10**	**Jul-Sep 10**	**Oct-Dec 10**	**Jan-Mar**
Low risk	Less than or equal to 2 days	0	0	2	2	
	More than 2 days and <= 1 week	1	2	1	1	
	More than 1 week and <= 2 weeks	1	1	1	1	
	More than 2 weeks and <= 3 weeks	1	5	2	5	
	More than 3 weeks and <= 4 weeks	0	5	1	1	
	More than 4 weeks and <= 6 weeks	4	3	6	2	
	More than 6 weeks and <= 8 weeks	2	1	0	1	
	More than 8 weeks and <= 10 wks	2	1	1	0	
	More than 10 weeks	12	12	3	1	
Not available	Less than or equal to 2 days	3	6	8	3	
	More than 2 days and <= 1 week	1	6	4	2	
	More than 1 week and <= 2 weeks	5	10	6	4	
	More than 2 weeks and <= 3 weeks	4	8	6	3	
	More than 3 weeks and <= 4 weeks	8	10	3	2	
	More than 4 weeks and <= 6 weeks	6	11	12	4	
	More than 6 weeks and <= 8 weeks	6	12	8	3	
	More than 8 weeks and <= 10 wks	5	1	3	5	
	More than 10 weeks	44	39	25	18	

APPENDIX 2

1. SCHEDULE PART 20A – AIMS & OutcomeS FOR INTEGRATED Adult Services (clause **Error! Reference source not found.**)

1 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.

2 The key document is the Highland Joint Community Care Plan 2010/13. This sets out the outcomes to be achieved across services for adults as:-

- People are healthy and have a good quality of life
- People are supported and protected to stay safe
- People are supported to maximise their independence
- People retain dignity and are free from stigma and discrimination
- People and their carers are informed and in control of their care
- People are supported to realise their potential
- People are socially and geographically connected
- Community Care services effectively, efficiently and jointly

3 These outcomes take account of HEAT targets, and the outcomes that the Scottish Government seek to achieve from the integration of services for older people:-

- Healthier living
- Independent living
- Positive experiences and outcomes
- Carers are supported
- Services are safe
- Engaged workforce
- Effective use of resources

4 Other plans provide more detailed articulation of the aims, outcomes and joint strategic approach in particular service areas:-

Strategy/Plan	**Timescale for review**
Joint Community Care Plan 2010/13	December 2013
Carers Strategy 2008/11	December 2012
Homelessness Strategy 2008/12	December 2012
Housing Strategy 2010/15	December 2013
Mental Health Plan 2011/12	December 2012
Transitions Policy and Procedure 2008	December 2012
Sensory Strategy 2005	December 2012

Drug and Alcohol Strategy 2014

5 There are two other strategies presently under development:-

Strategy/Policy/Plan	**Completion Due**
Ageing Well Strategy	June 2012
Physical Disability Strategy	June2012

6 These aims, strategies and plans will continue to be reviewed and developed as part of the overall approach to strategic planning and strategic commissioning. This will involve appropriate officers from each agency, 3rd and independent sector partners, and service users and carer representatives, reporting to the Joint Commissioning Group.

Performance measurement against these outcomes will be as per Schedule 30A of the Partnership Agreement

2. SCHEDULE PART 30A – ADULT SERVICES PERFORMANCE FRAMEWORK (CLAUSE **Error! Reference source not found.**)

Adult Services performance management framework

This Performance Management Framework will:

i. enable monitoring and evaluation of performance across the outcomes identified in the Highland Joint Community Care Plan.

ii. provide assurance to The Highland Council regarding the services that are commissioned as part of the lead agency arrangement.

NHS Highland will report to Highland Council on performance on a quarterly basis.

NHS Highland will also continue to collate the full range of performance information, required for local and national reporting purposes, for both lead agencies.

Impact	**JCCP Theme**	**Key Local Outcomes**	**Timescale**	**Quality Indicator**	**Baseline/ Target**	**Data Source**
Healthier living	people are healthy and have a good quality of life	People's health needs are met at the earliest and most local level possible	Quarterly	providing targeted Reablement services through Integrated District Teams	40% of people receiving Reablement interventions do not require ongoing care interventions after initial 6 weeks	TBC

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
Healthier living	people are healthy and have a good quality of life	People's health needs are met at the earliest and most local level possible	TBC	the development in the delivery of alcohol brief interventions in wider settings	target to be set by end March 2012	NHSH
Healthier living	people are healthy and have a good quality of life	People are supported to recover from ongoing and enduring illness, mental illness and drug dependencies	March 2013	the time taken to access drug or alcohol treatment services	by March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	NHSH
Healthier living	people are healthy and have a good quality of life	People's health needs are anticipated and planned for	April 2014	the number of health screening provided for people with learning disabilities	all people with learning disabilities on GP registers will be offered a proactive health screen by April 2014 and all people with learning disabilities and epilepsy are offered an annual nurse led review of their condition	NHSH
Healthier living	people are healthy and have a good quality of life	People's health needs are anticipated and planned for	TBC	Increase the age of admission of older people to long-term residential and nursing care	TBC	NHSH
Healthier living	people are healthy and have a good	People's health needs are	TBC	Improve people's perceptions of	to be evidenced through	TBC

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
	quality of life	anticipated and planned for		their levels of health	surveys	
Healthier living	people are healthy and have a good quality of life	People are supported to recover from ongoing and enduring illness, mental illness and drug dependencies	TBC	Alcohol-related crime statistics	TBC	TBC
Healthier living	people are healthy and have a good quality of life	People are supported to recover from ongoing and enduring illness, mental illness and drug dependencies	TBC	people who have dementia will receive an early diagnosis	maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources	NHSH
Healthier living	people are healthy and have a good quality of life	People's health needs are anticipated and planned for	TBC	public health indicator	TBC	TBC
Services are safe	people are supported and protected to stay safe	People are supported to stay safe through the operation of our policies and procedures	TBC	Number of people who are in urgent need who are able access 24x7 response co-ordination through the NHS Highland's Out of Hours Hub	TBC	NHSH
Services are safe	people are supported and protected to stay safe	People are supported to stay safe through the	March 2015	implementation of the Highland Adult Support & Protection	target is to complete by the end of March 2015	HASP Committee

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
		operation of our policies and procedures		Committee Action Plan 2012-15		
Services are safe	people are supported and protected to stay safe	People are supported to stay safe through the operation of our policies and procedures	TBC	Reduce the number of A&E admissions due to falls	TBC	NHSH
Services are safe	people are supported and protected to stay safe	People are supported to stay safe through the operation of our policies and procedures	TBC	Improve people's perceptions of their levels of safety	to be evidenced through surveys	TBC
Services are safe	people are supported and protected to stay safe	People with complex and challenging needs are supported to stay safe	TBC	Indicator for reviewing and monitoring of Guardianships	TBC	TBC
Independent living	people are supported to maximise their independence	People have access to appropriate housing which maximises their independence and well-being	Quarterly	number of enhanced telecare packages	baseline of 321 in 2010/11	NHSH
Independent living	people are supported to maximise their independence	People remain at, or return, home with appropriate support	Quarterly	the number of people, by age group, receiving a care at home service	Baseline is number of people over last 12 months. Data reported will be 12 month year to date totals	NHSH
Independent living	people are supported to	People remain at, or return,	Quarterly	number of people, by age	baseline is number of	NHSH

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
	maximise their independence	home with appropriate support		group, receiving a care at home service in the evenings or overnight	people over last 12 months Data reported will be 12 month year to date totals	
Independent living	people are supported to maximise their independence	People remain at, or return, home with appropriate support	Quarterly	number of people, by age group, receiving a care at home service at weekends	baseline is number of people over last 12 months Data reported will be 12 month year to date totals	NHSH
Independent living	people are supported to maximise their independence	People remain at, or return, home with appropriate support	Quarterly	the number of hours of home care provided to older people (as a rate per 1,000 population aged 65+) (Statutory Performance Indicator)	Baseline 263.3 hours per 1,000 population average over 2011/12	NHSH
Independent living	people are supported to maximise their independence	Carers feel able to continue in their caring role	Quarterly	the number of respite bed nights provided in 2011/12	baseline 9975 bed nights 2010/11 (age 65+), 3808 bed nights (age 18-64), target to maintain these levels of provision for 2012/13	NHSH
Independent living	people are supported to maximise their independence	Carers feel able to continue in their caring role	Quarterly	the number of respite day hours provided in 2011/12	baseline 78857 day hours 2010/11 (age 65+), 34201 day hours (age 18-64), target to maintain these levels of provision	NHSH

Impact	**JCCP Theme**	**Key Local Outcomes**	**Timescale**	**Quality Indicator**	**Baseline/ Target**	**Data Source**
					for 2012/13	
Independent living	people are supported to maximise their independence	People remain at, or return, home with appropriate support	TBC	number of people in receipt of Long Term Housing Support Services	Data reported will be 12 month year-to-date totals	TBC
Independent living	people are supported to maximise their independence	People remain at, or return, home with appropriate support	TBC	Self-care indicator (how many people following reablement have reduced dependency)	TBC	TBC
Independent living	people are supported to maximise their independence	Carers feel able to continue in their caring role	TBC	Increase the number of Carer Support Plans through the Highland Carers Centre	baseline TBC	Highland Carers Centre
Independent living	people are supported to maximise their independence	People are active participants in meeting their own care needs	TBC	Increase the number of people accessing the Highland Carers Centre service	baseline TBC	Highland Carers Centre
Independent living	people are supported to maximise their independence	People remain at, or return, home with appropriate support	TBC	Reduce the number of younger adults, aged 18-64, in institutional care settings	baseline TBC	NHSH
Independent living	people are supported to maximise their independence	Carers feel able to continue in their caring role	TBC	Increase the proportion of intermediate placements within residential and nursing care homes	baseline TBC	NHSH
Independent living	people are supported to	People remain at, or return,	TBC	Improve the levels of	TBC	TBC

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
	maximise their independence	home with appropriate support		awareness of sensory issues and an understanding of the needs of those with sensory impairments through training and development (measure no.of staff attending Sensory Awareness training) Increase the number of people with sensory needs accessing training and employment opportunities (data to be gathered by supported employment providers)		
Positive experiences and outcomes	people retain dignity and are free from stigma and discrimination	Our services and those we commission actively promote equality	TBC	people with learning disabilities who require reasonable adjustments have them implemented to allow them to access general health services	target is 100% of those requiring adjustments have them implemented, baseline TBC	TBC
Positive experiences and outcomes	people retain dignity and are free from stigma and discrimination	People are supported to tackle stigma and discrimination	TBC	Stigma and Discrimination indicator to be developed – self reporting of experiences of discrimination by Care Groups	TBC	TBC

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
Carers are supported	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 they receive	Quarterly	the number of people receiving a Self Directed Support package, by age group	baseline is number of people over the last 12 months, target is to increase	NHSH
Carers are supported	people and their carers are informed and in control of their care	People know how to stay as healthy and fit as possible	TBC	the number of Anticipatory Care Plans	increase number from baseline 4756, target to be agreed	NHSH
Carers are supported	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 they receive	TBC	100% of Personal Plans show evidence of engagement with the individual	target is 100%, baseline TBC	NHSH
Carers are supported	people and their carers are informed and in control of their care	People know about the services we provide and how to access them	Annual	Number of people accessing HCCF Carers Centre Service – Independent Individual Professional Advocacy Service for Carers.	The Provider will work on a casework basis providing advocacy (target a minimum of 300 cases per year)	Highland Carers Centre
Carers are supported	people and their carers are informed and in control of their care	People know about the services we provide and how to access them	Annual	Number of people accessing Advocacy Highland – Independent Individual Advocacy Service	target is for the Organisation to provide a Service to a minimum of 550 cases per each year of the Contract in place with the Council	Advocacy Highland
Carers are	people and	People know	Annual	Number of	target is that	Advocacy

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
supported	their carers are informed and in control of their care	about the services we provide and how to access them		people accessing Advocacy Highland – Independent Citizens Advocacy Service	the Organisation will ensure Advocates are matched with only one Service User at any time	Highland
Carers are supported	people and their carers are informed and in control of their care	People know about the services we provide and how to access them	Annual	Spirit Advocacy – Collective Advocacy – Learning Disability	target is to meet Service Level Agreement client numbers	Spirit Advocacy
Carers are supported	people and their carers are informed and in control of their care	People know about the services we provide and how to access them	Annual	Spirit Advocacy – Collective Advocacy – Mental Health	target is to meet Service Level Agreement client numbers	Spirit Advocacy
Carers are supported	people and their carers are informed and in control of their care	People know about the services we provide and how to access them	TBC	People Say They are Informed	TBC	TBC
Carers are supported	people and their carers are informed and in control of their care	People know how to stay as healthy and fit as possible	TBC	Public Health indicator to be developed	TBC	TBC
Engaged workforce	people are supported to realise their potential	People have access to training, employment and volunteering opportunities	Annual	increase the number of people with learning disabilities who are in further education or paid employment - number of people in education and number in open employment	Baseline and target TBC	annual Same As You return
Engaged	people are	People have	TBC	Increase, by	TBC	TBC

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
workforce	supported to realise their potential	access to training, employment and volunteering opportunities		age band, the number of people stating that they volunteer on a regular basis, as reported by the Highland 3rd sector LLD		
Engaged workforce	people are supported to realise their potential	People have access to a range of community based development opportunities	TBC	Increase the number of community-based activities in each area	TBC	TBC
Positive experiences and outcomes	people are socially and geographically connected	People do not become socially isolated	Annual	Reduce the number of people with learning disabilities, physical disabilities and complex needs or challenging behaviours placed outwith the Highland region	target: continue to review cases in out of area placements and return to Highland those already placed outwith the region where appropriate (baseline of 6 people returned to Highland from out of area placements in 2011/12, target a further 6 people in 2012/13	NHSH
Positive experiences and outcomes	people are socially and geographically connected	People do not become socially isolated	TBC	people perceive themselves to be socially and geographical connectivity (develop survey)	TBC	TBC
Effective	we deliver	care is	April 2013	The NHS	target:	NHSH

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
use of resources	Community Care services effectively, efficiently and jointly	delivered using joined-up core processes		Highland Complaints Team will work closely with the Administration and Personnel Team to ensure that joint procedures for managing health and social care complaints are integrated	complete by April 2013 and meet the needs of changes introduced at a national level	
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	care is delivered using joined-up core processes	TBC	An evaluation of the integration of NHSH and THC services to be scoped	Target: possibility of the use of a survey of people at the time their care package starts, and when there are changes	TBC
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	resources are accessed quickly and equitably	Quarterly	Increase the percentage of older adults who had a community care assessment completed within timescale	local target from initial contact to completed assessment is 15 days, baseline = 29% of all assessments during 2010/11	NHSH
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	resources are accessed quickly and equitably	TBC	AHP waiting times	TBC	TBC
Effective use of resources	we deliver Community Care services	care is delivered using joined-	TBC	Single point of access to services to be	TBC	TBC

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
	effectively, efficiently and jointly	up core processes		available in every District		
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	decisions about the allocation of resources are made jointly	Quarterly	the number of people who have their hospital discharge delayed	new target of no hospital discharges delayed by 4 or more weeks (previously 6 weeks)	NHSH
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	decisions about the allocation of resources are made jointly	TBC	Reduce the number of bed days lost due to delayed discharges	baseline TBC	NHSH
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	resources are accessed quickly and equitably	TBC	The time taken to access mental health services	Deliver faster access to mental health services and 18 weeks referral to treatment for Psychological Therapies from December 2014	TBC
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	care is delivered using joined-up core processes	TBC	unscheduled admissions – (Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population)	TBC	NHSH
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	care is delivered using joined-up core processes	TBC	Develop strategic & operational commissioning within the Lead Agency Model	TBC	TBC
Effective	we deliver	care is	TBC	Development	TBC	TBC

Impact	JCCP Theme	Key Local Outcomes	Timescale	Quality Indicator	Baseline/ Target	Data Source
use of resources	Community Care services effectively, efficiently and jointly	delivered using joined-up core processes		of a robust quality assurance process which focuses on service outcomes and core deliverables using a systematic approach to self evaluation		
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	care is delivered using joined-up core processes	TBC	Ensure that there is a skilled workforce available to deliver quality services	TBC	TBC
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	care is delivered using joined-up core processes	TBC	Improve service delivery through service review and redesign	TBC	TBC
Effective use of resources	we deliver Community Care services effectively, efficiently and jointly	care is delivered using joined-up core processes	Quarterly	Monitor complaints	TBC	NHSH