CŪRAM IS SLÀINTE NAN EILEAN SIAR

WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

DRAFT STRATEGIC PLAN: 2016-2019
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1. Introduction

The Western Isles has the greatest prevalence of obese adults, coronary heart disease and dementia in Scotland. We have the highest rate of blocked hospital beds and the third highest rate of alcohol related hospital stays. Given the profile of our ageing population, increasing levels of frailty, rising demand for services and the challenging financial climate, our failure to change will lead to the deterioration of services. Our health and social care system is therefore in need of urgent change.

But we have an opportunity to do things differently. The integration of health and social care will re-energise our approach to supporting good health. It will deliver more care based in the community; focus more on preventing illness and support those with long-term conditions to self-manage. It will seek to build on informal community supports to support independent living.

The Western Isles Integration Joint Board was formally brought into being by the Scottish Parliament on the 21st September 2015. Its job is to integrate health and social care services into a single structure to improve service user outcomes and deliver a high quality care experience.

In order to do this, we have developed a strategic plan that is capable of delivering those improvements. Over the last four months, we have engaged with communities across all of the islands, to understand where priorities lie, and to ensure that we respond to those. It is unsurprising that we’ve had a multitude of views expressed in response.

But there a few themes in common that have emerged: the need to create the conditions of effective inter-disciplinary working; the need for empowered localities which provide a stronger connection between how resources are used and the needs of the community; the need to redesign our system of care to sustain the independence of the people who use our services.

We now need to position ourselves to make radical change happen. That will be done by engaging with communities, but we all need to recognise the need to prioritise, to innovate, to reform. Above all, we need to integrate our care. These are the ambitions which are set out within this strategic plan.
2. Legislative and Policy Context

The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legislative framework for the integration of health and social care services in Scotland. It requires local authorities and health boards to integrate adult health and social care services – including some hospital services. It also provides the option locally to add in children’s services, criminal justice and additional hospital based services.

The legislation requires Health Boards and Local Authorities to establish formal partnership arrangements to oversee the integration of services. Like most partnership areas, this has been done in the Western Isles through the creation of an Integration Joint Board (IJB), which is a partnership body designed to take decisions about how to invest resources and deliver services.

The IJB is not an organisation which employs members of staff but it does have the authority to direct the two parent bodies – the Health Board and Local Authority – about how it wants integrated services to be delivered.

Each IJB will put in place a strategic plan for services and budgets under its control. The strategic plan will be widely consulted upon with non-statutory partners, patient and service-user representatives. We have until April 2016 to produce a strategic plan and it will cover a three year period. This document is the strategic plan for the Western Isles Health and Social Care Partnership.

The legislation also requires a Chief Officer to be appointed by the IJB to provide a single point of management for the integrated budget and integrated service delivery. The Chief Officer has a direct line of accountability to the Chief Executives of the Health Board and the Local Authority for the operational delivery of integrated services.

The main aim of the Act is to improve the wellbeing of people who use health and social care services – particularly those with complex needs. It does this by requiring local partners to:

- create a single system for health and social care services
- develop more informal community resources and supports
- put the emphasis on prevention and early intervention
- improve the quality and consistency of services
- provide seamless, high quality, health and social care services
- ensure that resources are used effectively and efficiently

The Scottish Government has produced a range of guidance notes to support the implementation of the Act.
3. The Western Isles Context

The agreement between the Western Isles Health Board and Comhairle Nan Eilean Siar to form an IJB is set out in the Integration Scheme.

The Integration Scheme is a legal document which covers matters such as:

- The services that will be delegated to the IJB
- Financial Management
- Clinical and care governance arrangements
- Workforce and organisational development
- Data sharing

The Integration Scheme must be submitted to the Scottish Government to ensure that it complies with the legislation, after which it is passed to the Scottish Parliament for final approval. The Western Isles Integration Scheme was approved by the Scottish Parliament on 21st September 2015.

The Western Isles Integration Scheme sets out the range of services and funding that will be delegated to the IJB. On the Local Authority side, this includes:

- Adult Social Work and Social Care
- Criminal Justice Social Work
- Housing Support, including aids and adaptations

On the NHS side, the services and funding delegated include:

- Community Nursing, including health visitors and school nursing
- Funding for General Practice, Dentistry and Pharmacy
- Mental Health
- Allied Health Professionals, including Occupational Therapy Podiatry, Dietetics, Speech Therapy and Physiotherapy
- St Brendan’s Hospital and Uist & Barra Hospital
- Part of the Western Isles Hospital, including A&E, general medicine, geriatric medicine, rehabilitation medicine, respiratory medicine

The Integration Scheme does not include specialist children’s services such as children’s social work, Child and Adolescent Mental Health Services, paediatric inpatient care, and specialist community health services for children – but it does include the universal children’s services such as health visiting and school nursing.

Responsibility for all of the funding for the integrated services is delegated to the IJB once it signs-off on its strategic plan. The Western Isles IJB will therefore take responsibility for these services on 1 April 2016. Once the resources for the integration functions are delegated to the IJB, it will then make decisions on the use of the integrated finance. The Chief Officer carries out the decisions of the IJB.
The Integration Joint Board

The Western Isles Integration Joint Board consists of four local authority elected members, four Health Board Non-Executive Directors, trades unions, third sector representatives, patient and service user representatives and professional representatives from across health and social care.

The membership of the IJB is set out in secondary legislation which the Scottish Parliament has passed. It describes the members who have a vote when decisions are being made and this includes the local councillors and the NHS Board Non-Executive Directors. However, the IJB will always seek to operate by consensus and that is why the voices of its wider membership are hugely important.

The Integration Joint Board has four over-arching responsibilities:

- To develop and implement a Strategic Plan which sets out how services will change and develop over time to meet the needs of the population;
- To put in place robust financial planning arrangements to ensure that services are delivered within budget;
- To support the development of Locality Planning Groups, which will help to plan services for local communities; and
- To oversee the delivery of all of the services delegated to it by the Local Authority and the Health Board

Western Isles Integration Joint Board

- NHS Western Isles Chair
- NHS Non-Executive Director
- NHS Non-Executive Director
- NHS Non-Executive Director
- Council Leader, CNES
- Council Convenor; CNES
- Elected Member, CNES
- Elected Member, CNES
- Chief Social Work Officer
- Lead Nurse – NHS Western Isles
- GP – NHS Western Isles
- Secondary Care – NHS Western Isles
- Chief Finance Officer IJB
- Western Isles Community Care Forum
- Western Isles Carers, Users & Supporters Network
- Trades Union Representative, CNES
- Trades Union Representative, NHS Western Isles
- C-CIG (Third sector interface)
- Service user representative
- Chief Officer, IJB
Locality Planning

The IJB is required to develop locality arrangements, to support more localised planning and delivery of services. In the Western Isles, we have identified five localities, as depicted in the map opposite: Barra & Vatersay; the Uists and Benbecula; Harris; Rural Lewis and Stornoway & Broadbay

Localities exist to help ensure that the benefits of integration improve health and wellbeing outcomes by providing a forum for professionals, communities and individuals to inform service redesign and improvement at local level. The localities agenda promotes an ethos of developing services with communities, from the bottom-up. Community empowerment is therefore at the heart of the integration agenda. We need to encourage our communities to become more involved in the services they access, and build on the natural strengths and resilience that our communities have.

We will therefore establish five Locality Planning Groups to:

- Oversee the development of integrated service planning at a locality level;
- Develop a locality plan, which will set out how services will evolve to meet the needs of the changing population;
- Deliver the IJB Strategic Plan and ensure that there is a strong connection between the planning done at locality and IJB level;
Community Planning

The IJB is responsible for planning and delivering services within a much wider context. We need to work in partnership with other public services such as our local police and fire services, Highlands and Islands Enterprise, Skills Development Scotland, Scottish Natural Heritage, Lews Castle College, Hebridean Housing Partnership, Community Land Scotland, Bord Na Gaidhlig, C-CIG (representing the third sector), and our parent bodies NHS Western Isles and the Comhairle.

The Outer Hebrides Community Planning Partnership helps coordinate initiatives and partnerships that will improve public services within the Western Isles. One of the ways that this takes place is through the implementation of the Single Outcome Agreement. The Single Outcome Agreement for 2013-23 between the Scottish Government and Outer Hebrides Community Planning Partnership sets out priorities which will focus the delivery of better outcomes for the people of the Outer Hebrides. The priorities of the Community Planning Partnership are as follows:

- The collective assets of the Western Isles have provided opportunities for sustainable economic growth
- Older people are able to positively contribute to the economy and communities, and access appropriate and quality services to enable them to retain their independence
- Children and young people have the best start in life
- Communities are safer and healthier by preventing, and reducing the harmful effects of alcohol
- Communities are physically and mentally healthier through an increase in physical and social activity
- The people of the Outer Hebrides have an improved standard of living through addressing poverty and inequalities.
- The Outer Hebrides will be better connected with high quality infrastructure supporting broadband, travel and renewables

The Integration Joint Board is a full member of the Outer Hebrides Community Planning Partnership. The over-arching priorities of the Outer Hebrides Community Planning Partnership are important to the work of the IJB. Indeed, the delivery of integrated health and social care services will be central to all of the strategic priorities listed above. To that end, it is important that the strategic plan of the IJB connects with this wider community planning agenda. For example, we have started to develop a vocational training route for our senior pupils to work as carers within the health and social care system. That is an example of the potential of community planning.

Community Planning is itself undergoing a process of change, with legislation being laid to strengthen arrangements that support the delivery of the Single Outcome Agreement. One of the developments that will link to the work of the IJB is a new focus on locality planning. This will be developed over the course of 2016/17.
4. Developing the Strategic Plan

The strategic plan has been developed through a process of engagement with local communities and the people who work in health and social care.

The Chief Officer of the IJB hosted a series of staff engagement events and public meetings across all of our localities and islands to describe the process of integration and to consider the priorities of staff, stakeholders and communities. It was important to engage in this way to ensure that we built the vision and priorities of the strategic plan on the ideas of people who deliver and use our services. The outcome of that engagement work is described visually overleaf – the more often a word was repeated the more prominent it becomes on the graph. The major priority of the people we spoke to was for more locally based community care that supported people to live independently at home.

The legislation requires that we establish a Strategic Planning Group to oversee the development and delivery of the strategic plan. It brings together a wide range of stakeholders from the NHS, Comhairle, third sector, housing, service users, carers, as well as representatives of all of the localities.

The purpose of that group is to consider how best we should use the integrated budget to deliver improvements in the experience of health and social care services and to improve the quality of people’s lives. The group has considered a series of questions in coming to a view about this, as described in the diagram below which the Scottish Government produced:
5. Our Vision and Values

Our vision is that by 2020 the people of the Western Isles will be living longer, healthier lives at home, or in a homely setting. We will have an integrated health and social care system, which focuses on preventing ill-health, anticipating care needs and supporting recovery.

We will work with people and communities to develop a framework of mutual responsibility for health and wellbeing, framing the rights and responsibilities that we all have as residents of the Western Isles.

Our care will be delivered by integrated teams, with the traditional roles of health and social care professionals changing and adapting over time to meet the needs of the population. Care will be provided to the highest standards of quality and safety, with the person who uses our services at the centre of all decisions. We will seek to personalise support arrangements, to maximise people's ability to exercise choice and control over the lives they lead. We will build on the support arrangements and assets that people have in their lives and support unpaid carers as equal partners in care.

We will prioritise support for people to stay at home or in a homely setting as long as this is appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible. When hospital treatment is required, and cannot be provided in a community setting, there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission. Lengthy hospital stays will become a thing of the past.

Health and social care services will be planned and delivered as locally as possible. This means the day-to-day services that people rely on to support their personal independence will be organised and coordinated within localities. We will increasingly operate our local services from health and social care hubs, which bring together a range of services within a single campus. Other services, which people use more periodically to sustain their independence, or which require highly specialised input, will operate across localities or will be provided in centres of expertise on the mainland.

Caring for more people in the community will result in a shift in resources from hospitals to community-based care. This shift will be recognised as a positive improvement in the quality of our services, progress towards our vision and therefore the kind of service change we expect to see.
Our Values

Health and Care Western Isles abides by the values of partnership, collaboration and cooperation across NHS Western Isles, Comhairle Nan Eilean Siar, the third and private sectors. We subscribe to a set of values based on the human rights of the people who use our services, including:

- Respect for the inherent dignity and worth of all individuals.
- Promotion of individual autonomy including the freedom and support to make one’s own choices.
- Support to ensure full and effective participation and inclusion in society.
- Respect for difference and a desire to respond to individual needs.
- Equal access to resources, services, information and opportunity.

We will strive to ensure that our services are focused on improving personal outcomes and which are focused on the capacity of service users to make autonomous decisions and lead purposeful lives. Our role is to make best use of personal capabilities, assets, family, and community.

We also hold to the principle of subsidiarity, which holds that services should planned and led locally in a way that engages with the community.
6. Our Changing Population

The population of the Western Isles is changing. Over the next 15 years, the size of our population will decrease and yet we can expect the number of older people to increase, as well as the number of people with complex long-term conditions. This puts an obligation on us to redesign our services to meet the changing needs of our communities.

The older adult proportion of the population is projected to increase for all partnership areas but is greatest in the Western Isles, with 37.1% of the population predicted to be aged 65+ by 2037.

Figure 1: NHS Board area population structures ranked by % Aged 65+, 2037

The impact of depopulation and an ageing society is that we will have a smaller workforce to support our health and social services, and a smaller number of unpaid family carers. This presents a very challenging circumstance to support our older citizens into the future.

We will also see a rise in numbers of people living alone. The latest census estimates suggest that the Western Isles already has the greatest proportion in lone pensioner households in Scotland – and this is likely to increase into the future.

This is particularly significant as living alone has strong associations with social isolation and loneliness, which increase risks to health for people with dementia and depression. Indeed, evidence is now emerging that the health impact of loneliness on mortality is equivalent to that of smoking and greater than that of obesity.
We also need to be aware of levels of fuel poverty, which exists where a household has to spend more than 10% of its income on fuel costs. Lack of energy efficiency within our housing stock is one factor contributing to the very high levels of fuel poverty that are experienced within the Western Isles. Relatively greater driving distances to work and services, damp and wet maritime weather conditions, high fuel costs and generally lower household incomes all contribute to the Western Isles having the highest level of fuel poverty across all Scottish local authorities.

We also know that we have a significant challenge with alcohol misuse, which can increase injuries, mental health issues, violence, social disorder, family stress, and employment difficulties and is a contributory factor in a range of other diseases including cancer, stroke and heart disease.

Although above the national average, the latest figures demonstrate a substantial improvement, with the rate of alcohol related hospitalisations in Scotland decreasing markedly over the last decade.

By contrast, the proportion of our adult population who are overweight (72%) or obese (33.5%) in the Western Isles, is increasing and is among the highest in Scotland. The Western Isles is an outlier in terms of adults meeting recommended regular physical activity levels. This may be a contributory factor in higher-than-average Coronary Heart Disease (CHD), and stroke prevalence in the Western Isles.

As we survive longer and medicine improves, we can see a corresponding increase in the number of people living with a range of long term conditions. These range from the most common conditions like CHD, stroke and cancer, to a variety of other chronic physical or mental health conditions including diabetes, dementia, asthma and
depression. Results from the annual Scottish Health Surveys in the Western Isles over period 2008-11 found that around 4 in 10 adults had a long-term condition or disability, with the majority describing these as limiting their quality of life. Most Long-term conditions have a strong association with age and as result there is a significant projected increase in prevalence over the next fifteen years.

**Figure 3: Long-term Conditions prevalence projections, 2008/2031**

Many long term conditions are mental health related, including depression, dementia and other mental health conditions. The Western Isles tends to have high levels of such conditions relative to the rest of Scotland, which in part reflects the older population profile. Overall projections are for a 73% increase in dementia cases over the next 20 years.

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**So What Does the Data Tell us?**

1. We will need to respond to a growth in the long-term conditions associated with older age – and dementia in particular;
2. We will need to take account of the falling numbers of adults who will be able to provide unpaid care for family members;
3. We need to address the growing number of people living alone and who might experience social isolation;
4. High levels of obesity and physical inactivity are increasing the overall burden of illness and disease;
5. Integrated health and social care teams will be critical in delivering anticipatory care and self-management approaches;
6. Our record in keeping people out of hospital is reasonable but we are not good at supporting discharge;
7. Addressing health inequalities within Western Isles communities will be a key challenge for services;
8. Alcohol misuse continues to have an impact on the physical and mental health of our population;
9. Tackling fuel poverty and poor housing will be important to keep people healthy at home;
10. Mental health and well-being will be an increasingly important service aim.
7. Our Current Service Provision

Across the Western Isles, our health and social care teams work hard every single day of the year to provide high quality and person-centred care.

Over the last few years, we have sought to develop our services and respond to the challenges of growing demand and tighter resources.

Older People’s Care

The delivery of care and support to older people relies on a network of linked professionals across the NHS, Comhairle, third and independent sectors, who provide medical care, nursing care, therapeutic care, day care, home care and residential care.

There are seven care homes in the Western Isles: three in Stornoway, two in Harris, two in the Uists and one in Barra. The care homes themselves range from the old - Dun Berisay in Stornoway was built in the 1960s - to the very new - Harris House has 16 beds and was opened in 2014. Further capital investment has been earmarked to support new extra-care housing in Barra to replace the St Brendan’s Care Home. This will provide older people with individual tenancies, while retaining the high-level care input of traditional residential care. We continue to face significant pressures on care home bed availability in Lewis and Harris.

Our balance of care remains positive, with the majority of older people with assessed care needs being supported at home by our home care service. This involves care and support for people in their own home to help them with personal and other essential tasks. It is a key service in supporting older people to remain at home.

The Comhairle is the largest provider of care at home services in the Western Isles. The level of care at home provision had been declining steadily in Scotland over the last 10 years. However, the level of care at home provided by the Comhairle had remained consistently higher than the national average. In 2013-2014, the level of care at home provided by Western Isles Comhairle was 70 per 1,000 older people compared with 53 per 1,000 older people for Scotland.

We face significant challenges in meeting the assessed need and demand for care at home services. A number of older people are waiting for a care at home package. This is a problem across the islands, but is most acute in some of the most remote and rural areas and is exacerbated by care at home staff having to travel very large distances to visit older people. In light of these challenges, we are carrying out a significant redesign exercise in respect of our care at home services.

The proportion of older people in the Western Isles who spend the last 6 months of their life at home or in a community setting is increasing. By 2012-2013, this was higher than the proportion for Scotland as a whole. We have procedures to support palliative care, with community unscheduled care nurses making a strong
contribution. This approach helps to avoid calls to NHS 24 or presentation at hospital, and helps to minimise stress for the older people and families concerned.

We are also improving our use of technology to support personal independence. Over 800 people in the Western Isles have a community alarm or other telecare service, which is higher per capita usage than the national average. We are committed to expanding the number of community alarms by 15% each year until we reach the point where everyone over the age of 75 years, assessed as benefitting from having an alarm, has one.

In respect of the care and support we offer to people with a dementia diagnosis, we recognise that we have more to do. We are keen to revive our post diagnostic support and will liaise with Alzheimer Scotland, service users and carers on how to improve our overall service offer. We want to build a comprehensive strategy to support people with dementia.

The Partnership has inter-agency procedures for adult support and protection, which are designed to ensure consistent intervention and practice. However, we know that we can also strengthen our protection work in respect of our use of case conferences, data collection and use, and service planning.

**Support for People with Long-term Conditions**

Across the Partnership, we have a well-developed network of condition-specific services which help people with chronic illnesses to achieve good personal outcomes and self-manage their conditions. This includes:

- The nurse-led heart failure service which provides education to enable patients and carers to self-monitor and self-manage their condition. The service had also begun work with GPs to provide intravenous diuretics in the community to reduce the number of patients admitted to hospital with heart failure.
- The cardiovascular disease prevention and rehabilitation service, *Hebrides Healthy Hearts*, offers a menu-based rehabilitation programme. This is provided to patients with acute coronary syndrome or angina, or following cardiac surgery, heart transplant or device implantation, as well as supporting individuals who were at high risk of developing cardiovascular disease. The core team consists of a cardiac rehabilitation nurse, dietician, physiotherapist and Comhairle exercise specialists, with referral to other specialists for specific input.
- We have recently appointed a Multiple Sclerosis and a Parkinson’s disease specialist nurse. This is a positive development which will allow for the provision of consistent and coordinated care, and for people to be given information and support to manage their own conditions.
We also recognise that there is opportunity to improve how we support people with long-term conditions. For example, we have not widely used Anticipatory Care Plans. These seek to anticipate significant changes in a patient’s condition and describe actions which can be applied to support those living with a long-term condition to plan for an expected change in health or social circumstance. They also incorporate health improvement and staying well.

**Support for Carers**

We continue to face challenges in identifying carers and in trying to ensure that they received the right help and support to enable them to continue in their caring role. We have picked up on the reluctance of some carers to accept help and support, which is something we will keep working at.

Most carers tell us they feel supported with their own healthcare needs and this has enabled them to continue in their caring role. The third sector has an active and hugely important role in providing support to carers. The Western Isles Community Care Forum, for example, maintains a register of carers and keeps this up to date by liaising with GPs and the local community to encourage carers to register.

Nonetheless, the support we provide to unpaid carers will be even more important into the future.

**Support for Adults with Disabilities**

We provide and support a range of formal and informal support services for adults throughout the Western Isles. These services are targeted towards a broad spectrum of the population in both directly supporting people who receive care but also in some cases to support those who are carers themselves.

The type of support arrangements that we offer are generally for adults with complex needs who need support structures or financial assistance to be arranged to achieve specific personalised goals.

We continue to develop self-directed support arrangements, which give people choice and control over how they use support to meet personal outcomes. Since April 2014, councils have a statutory duty to offer the four self-directed options to people who need social work services. Although we have increased the number of people who are supported via a direct payment (where people are given money to employ a carer or meet their own needs), we have yet to develop a comprehensive framework for the delivery of self-directed support.

**Children’s Services**

Although our partnership is not responsible for specialist children’s services like children’s social work, specialist children’s mental health teams, or paediatric care, we are responsible for very important universal services for children: health visiting and school nursing and
traditional family health services such as GPs, pharmacists and dentists.

Nonetheless, we have an important role in working within a wider partnership environment with education, and other key children’s services. We are contributing to a picture where more children and young people are being helped to meet their developmental milestones, achieve their potential and move into sustained and positive destinations.

**Universal Services**

There are three hospitals within the Western Isles. The Western Isles Hospital in Stornoway is a rural General Hospital. The IJB will have responsibility for the resource which funds general medicine, geriatric medicine, psychiatry, rehabilitation medicine. That amounts to a significant proportion of the 93 staffed beds.

The Uist and Barra Hospital is a community hospital in Benbecula, serving the communities of North and South Uist, Benbecula and Eriskay. It provides emergency, general medicine and nursing care.

St Brendan’s Hospital on Barra is a 5 bed hospital in Castlebay and it too provides emergency, general medicine and nursing care. Plans are underway to redevelop St Brendan’s into a health and social care hub. The resources for the day-to-day running of the hospitals in the southern isles will be delegated to the Integration Joint Board.

For the majority of people their main contact with the NHS is via their GP, and the ability to access this service is an important aspect of ensuring the health and wellbeing of the population.

The Western Isles in common with other rural areas has comparatively low GP Practice list sizes. This means that patients in Western Isles are relatively well served in terms of the number of GPs per patient population. This is supported by our annual patient GP survey which indicates, based on the 2014 survey, that 96% of respondents were satisfied with ability to access GP within 48 hours.

The level of GP provision in the Western Isles has remained fairly constant over recent years although the organisation of General Practices has changed, with the amalgamation of some practices in rural Lewis becoming part of the Langabhat Practice. We now have nine practices in total.

Within primary care, we have implemented a range of tools and resources from the Scottish Patient Safety Programme. For example, our dietetic service was working with district nurses to support self-management nutrition tools for patients within the community. Screening for the risk of malnutrition enables early and effective interventions.

We are also undertaking work to reduce polypharmacy by reviewing medication with patients over the phone or by video-conferencing. While there have been some challenges from patients in accepting
this approach, our evaluation of the project found that it reduces the amount of medications prescribed.

Dentistry is provided by our community dental service, which has coverage across the islands. It is anticipated that an independent dental service will be developed in Stornoway.

Pharmacy services are often delivered by GP practices, although there are three independent pharmacies in the Stornoway and Broadbay locality.

We have two independent opticians operating from the Stornoway area, with two opticians visiting the islands on a variable basis.

**Unscheduled Care**

Over the last few years, we have sought to develop systems that prevent unnecessary hospital admission. There are number of settings in which unscheduled care can be delivered from NHS24 and the Scottish Ambulance Services to emergency respite beds and hospital. Our unscheduled care rates are lower than average for Scotland across A&E, hospital admissions and NHS24 services, with only ambulance service activity being broadly comparable.

However, the level of multiple attendances at hospital by patients is significant: almost a half of all hospital attendances in the Western Isles are repeat visits.

Furthermore, the level of emergency hospital activity for older people is the highest in Scotland when measured in terms of the hospital bed days older people utilise.

**Figure 4: Hospital Emergency Admission Bed Day Rates Age 75+**

![Rate of Emergency Admissions Bed Days in 75+, 2002/03 - 2014/15](chart)

Indeed, arguably our greatest failing as a partnership has been in the length of time that older people wait in hospital despite being ready for discharge. We consistently have more than 30 of the 96 beds in the Western Isles Hospital occupied by people who do not need to be there. We are the worst performing partnership in Scotland on this measure and we need to improve our record. Hospitals are not the most appropriate setting for long-term patient care. We have been working hard to turn this around – but now need to become more radical in shifting resources from supporting people to stay in hospital to supporting people to live in the community. That will involve reducing the number of hospital beds.
8. Our Resources

The financial outlook for the next three years is very challenging. We anticipate that the IJB will have an outline budget of around £57million for 2016/17, which will require us to make significant efficiency savings. We are looking to find savings of £5million over three years.

Budget Setting Process

Before the IJB agrees a budget, a number of steps have to be taken, beginning with the Scottish Parliament’s overall budget setting process, which determines how much money is given to the NHS and how much is given to local government.

Once that information is known, NHS Western Isles and Comhairle Nan Eilean Siar will each set their own budget for the year. That will take account of public consultation feedback and the priorities of the two parent bodies.

The IJB budget is made up of resources passed to it by the two parent bodies. These resources are intended to reflect the functions or services that will pass to the IJB. As part of that process, the Chief Officer and Chief Finance Officer of the IJB will work on a draft budget, which will set out how resources will be spent over the following year. This budget then has to be agreed by the IJB on the basis that it is able to meet its statutory requirements.

Our Current Spend

The outline budget of the IJB is £57million per annum. Although this is a significant resource, we have had to respond to increasing demand for services. As a result, we’ve struggled to stay on top of the day-to-day spending that keeps our health and social care system operating. The large graph on page 26 outlines how we currently spend that resource.

How we will manage costs

In recognition of our budget reduction, the IJB must find substantial savings over the next three years whilst continuing to meet statutory duties. As the graph below demonstrates, the next few years will see a gap of at least £5m opening between the available resources and the resources required to meet demand:

Forecast Demand v Budget

[Graph showing forecast demand and budget over years 2015/16 to 2018/19 with a gap between the two lines.]
In outline terms, the financial health of the IJB will depend on the delivery of savings from four related activities:

- The identification of efficiencies through a workforce planning exercise carried out by service managers;
- The identification of efficiencies that can be delivered by integrating services that have historically been run separately by NHS Western Isles and the Comhairle;
- The identification of efficiencies that can be delivered through service redesign and strategic commissioning; and
- The identification of savings as a result of service choices being made.

Given the predicted financial context faced by the IJB, we are seeking to save a total of £5 million over the next three years. This will involve making difficult decisions; and this is especially challenging for the service areas delegated to the Integration Joint Board given the growth in demand for services.

Some of the savings will come from workforce efficiencies like cutting sickness absence, deleting vacant posts or combining management roles. Other savings will come from service redesign, including reducing high-cost care packages, long-stay mainland placements, and the centralisation of some ancillary services. Some services may be removed if they aren’t well used or delivered equitably across all localities.

Understanding how we use resources

Although we might not be able to influence the size of our overall budget, we can determine how best to use it. In order to do that, we need to develop a better understanding of how our population consumes resources. Common sense tells us that we all use different amounts of health and social care resources: for example, children and older people will visit their GP much more often than young adults. So, the amount of health and social care used by each person will vary.

When this variation is a result of higher levels of need then that is perfectly explainable. However, sometimes we see a variation in resource use which is more difficult to explain. Rather than this being driven by the needs of people using services, it can be driven by inconsistent clinical or organisational decisions about how to give people access to the right type of care.

The reason that this is important to the work of the IJB is that if we understand this variation we can do something about it, making the system more efficient. Sometimes, we know that our system of health and social care leads to people consuming large amounts of resources that they don’t need. For example, we have a particularly pronounced challenge with delayed discharges, where people are stuck in hospital because they are waiting for care packages. Not only is this very expensive and inefficient, it has a significant human cost. After just 72 hours in hospital, older people can begin to experience functional decline. This has led us to a situation where just 600
The biggest opportunities for cost reductions are often with people managing long-term conditions. Chronic diseases like diabetes can be expensive if it isn’t properly managed and can result in expensive interventions in hospital. However, there is good evidence to suggest that if we invest in more technology and education to help the patient self-manage their condition, it can substantially decrease their demand for healthcare services, reducing expenditure, and allowing us to capture some of those savings.

All of this provides another good reason for moving to a decentralised locality model: it will allow for comparison about how we use resources differently and lead us to consider remedial actions. In time, we will work towards a ‘consumption budget’ for each area which provides information about the total cost of providing health and social care services for each local population. In time, we can then work towards a position of equity, where each community is given their fair share of resources.

The Case for Change
Demand for services continues to increase, as a result of our ageing population and a rise in comorbidities, which is resulting in more complex care packages. In addition, our current model of health and social care too often relies on expensive and at times unnecessary hospital treatment when we could be using that resource differently to support people to live in the community. We now need to reduce our hospital bed capacity and transfer more of our hospital staff into community settings. This will mean our services will look radically different into the future.
How we currently invest the budget

- Adult Mental Health Services: 13%
- Hospital Services: 6%
- Care Homes: 11%
- Adult Care and Support: 5%
- Home Care: 10%
- Criminal Justice: 0.1%
- Social Work: 2%
- Third Sector: 4%
- Change Funds/Resource Transfer: 5%
- Allied Health Professionals: 3%
- Medicine and Drugs: 13%
- GPs: 13%
- Dentistry: 6%
- Opticians: 1%
- Management: 3%
- Community Nursing: 1%
- Addiction Services: 1%
- Community Nursing: 6%
10. Our Strategic Priorities

Our strategic priorities are expressed as 12 priority areas for action in pursuit of our vision of high quality, sustainable and integrated care. These areas connect to three broad themes:

1. Quality of care
2. Health of the population
3. Value and financial sustainability

These themes are often referred to as the ‘Triple Aim’. The Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimising the performance of health and social care services. Organisations and communities that attain the Triple Aim will have healthier populations, in part because of new designs that better identify problems and solutions further upstream and outside of hospital based care. People can expect less complex and much more coordinated care and the burden of illness will decrease.

For each of these domains there will be 12 priority areas for action, often building on existing work and all requiring focused attention and acceleration. These areas include integrated care, safe care, personalised care, supporting recovery, primary care, housing and community capacity, self-management, unpaid carers, the early years, reducing variation, technology and use of assets, and finally workforce planning.

These strategic priorities are the output of the work we’ve done to assess and forecast the needs of the population, consider how best our services can respond to those needs, and identify how best to deliver the required change.

The importance of delivering on the strategic objectives for the success of our partnership cannot be over-stated. It is the mechanism by which we will deliver better care and support for people, and make better use of the significant resources we invest in health and social care provision.

The simple truth is that our services cannot continue to be planned and delivered in the way they have been; the current situation is neither desirable in terms of optimising wellbeing, nor financially viable. With the full involvement of all stakeholders, and the creation of a single system for the planning and delivery of services, we can now think innovatively about how support services might be provided in the future.

In order to drive change across the 12 priority areas, we have identified 25 key deliverables, which are the actions we will take to make the changes happen.
<table>
<thead>
<tr>
<th>Triple Aim</th>
<th>National Outcome Measure</th>
<th>Focus of Change</th>
<th>Key Deliverables</th>
</tr>
</thead>
</table>
| Quality of Care | People who use health and social care services have positive experiences of those services, and have their dignity respected | Integrated Care                        | 1. We will put in place locality planning and service arrangements to support more responsive local services  
2. Multi-disciplinary teams will deliver holistic, well-coordinated care, which builds on the natural capacities in people’s lives |
|                 | People using health and social care services are safe from harm                           | Safe Care                              | 3. We will implement the Scottish Patient Safety Programme within primary care and as part of that we will review the use of higher risk medications and address polypharmacy  
4. We will continue to strengthen our adult protection protocols through case conferences, data collection and use, and service planning. |
|                 | Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services | Personalisation of care                | 5. People with assessed social care will be supported to use personal budgets to access care and support from a diverse range of providers to maximise the choice and control they have over their lives.  
6. We will develop a strategy and service model that supports people who have dementia to live at home for as long as possible. This will include the delivery of post diagnostic support that will support people who have received a diagnosis of dementia. |
|                 | People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community | Supporting Recovery                    | 7. We will encourage rehabilitation and recovery of personal independence by developing an intensive reablement service  
8. We will develop an intermediate care service to prevent hospital admission and support discharge within our care hubs  
9. We will transform our mental health provision to deliver an integrated community model which is empowering to users and supports people to remain in control of their own lives |
|                 |                                                                                          | Primary Care                           | 10. We will support our general practices to collaborate, develop multi-professional teams and influence local service arrangements  
11. To reduce unnecessary clinical interventions and personalise the care experience, we will work with health and social care professionals to increase our use of Anticipatory Care Plans |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Action</th>
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<tbody>
<tr>
<td>Housing and Community Capacity</td>
<td>We will diversify our existing residential estate to create additional capacity in Extra Care Housing and specialist nursing care and will work with partners to ensure our existing housing stock is maintained and adapted to a standard which supports people to live at home for as long as possible.</td>
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<td></td>
<td>We will work with communities and the third sector to support community ventures which tackle social isolation, including, where appropriate, supporting community transport.</td>
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<tr>
<td>Health of the Population</td>
<td>We will support our Alcohol and Drug Partnership to deliver on its strategic commissioning role to support the recovery of people dependent on alcohol, by focusing on prevention and educational services.</td>
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<tr>
<td></td>
<td>We will support people with long-term conditions to self-manage through the provision of advice and clinical support. Specifically, we will develop personal technology/systems that allow patients to monitor their vital statistics.</td>
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<td></td>
<td>We will work with the third sector to increase the numbers of identified carers, offer every identified carer a carer support plan and assess their eligibility for formal support. This will tie into the equitable provision of respite care, to ensure that carers are supported to maintain their caring role.</td>
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<td></td>
<td>We will continue to contribute to the Western Isles Early Years Collaborative, to ensure that our children get the best start in life. This will include the further development of early intervention and prevention strategies that will be delivered by our universal services, including health visitors and GPs.</td>
</tr>
<tr>
<td>Value and Sustainability</td>
<td>Where appropriate, we will reduce the variation between localities in resource use at end-of-life by supporting palliative care at home or in a homely setting.</td>
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<td></td>
<td>Where appropriate, we will seek to reduce expenditure on the top 2% of the population who use the highest levels of resource, to ensure greater levels of healthcare equity.</td>
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<td></td>
<td>We will continue to invest in technology and improve processes to ensure that we maximise the potential of telecare, telehealth and networking with clinical and professional networks.</td>
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<td></td>
<td>We will reduce the number of long-term placements within off-island health and social care facilities in favour of a more efficient use of local resources.</td>
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<td></td>
<td>We will establish a health and social care hub in every locality area, which will deliver co-located integrated services.</td>
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<td></td>
<td>We will develop a three year workforce plan, based on labour market intelligence, which will consider how best our partnership can compete within the local, national and international labour market and grow a workforce from within our communities through the provision of educational opportunities.</td>
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<td></td>
<td>We will work with our parent bodies - NHS Western Isles and Comhairle Nan Eilean Siar - to keep people healthy at work and support them through periods of transition from one model or care to another.</td>
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<tr>
<td></td>
<td>We will work with our parent bodies - NHS Western Isles and Comhairle Nan Eilean Siar - to increase the proportion of our staff whose contract of employment provides guaranteed hours and predictable patterns of work.</td>
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11. Developing a Model of Change

The change process will need to be driven through leadership across our health and social care system.

We have been trying to shift away from the traditional acute-focused care, which was the norm during the second half of the 20th Century, to a system which is much more responsive to supporting people with long-term conditions live independently in the community.

<table>
<thead>
<tr>
<th>20th Century</th>
<th>21st Century</th>
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<tbody>
<tr>
<td>Centrally planned</td>
<td>Locally planned</td>
</tr>
<tr>
<td>Input driven</td>
<td>Outcomes driven</td>
</tr>
<tr>
<td>Organisational focus</td>
<td>Partnership focus</td>
</tr>
<tr>
<td>Geared towards acute conditions</td>
<td>Geared towards long-term conditions</td>
</tr>
<tr>
<td>Hospital-centred</td>
<td>Embedded in communities</td>
</tr>
<tr>
<td>Lead professional dependent</td>
<td>Integrated teams</td>
</tr>
<tr>
<td>Episodic care</td>
<td>Continuous care</td>
</tr>
<tr>
<td>Disjointed care</td>
<td>Holistic care</td>
</tr>
<tr>
<td>Reactive care</td>
<td>Preventative care</td>
</tr>
<tr>
<td>User as passive recipient</td>
<td>User as active participant</td>
</tr>
<tr>
<td>Self-care infrequent</td>
<td>Self-care encouraged and facilitated</td>
</tr>
<tr>
<td>Carers undervalued</td>
<td>Carers supported as partners</td>
</tr>
<tr>
<td>Low tech</td>
<td>High tech</td>
</tr>
<tr>
<td>Disaggregated patient information</td>
<td>Aggregated patient information</td>
</tr>
</tbody>
</table>

Leadership within the Partnership

The ongoing development of a strong partnership focus by the leadership of NHS Western Isles, the Comhairle, and the third and independent sectors is clearly a crucial component in the delivery of our proposed reforms. To that extent, we are committed to ensuring that:

- The work of the IJB dovetails with the strategic priorities of the two parent bodies and the Community Plan;
- The management of the integrated service reports to a joint Corporate Management Team, co-chaired by the Chief Executives of the Comhairle and NHS Western Isles;
- The Chief Officer is supported by a strong team of senior managers and lead professionals who will be responsible for the delivery of the strategic plan;
- We develop a strategic relationship with the third and independent sectors which recognises their contribution as equal partners;
- We work with all of the communities of the Western Isles to transform our service offer and our approach to delivering care and support;
- Our leadership involves decentralising power, responsibility, resources and accountability to localities;
Change Funds
In order to make the transition to the new model of care, the Scottish Government has provided partnerships with additional funding over a number of years. We used the Older Peoples Change Fund to support a range of new projects, some of which delivered a lasting impact and hence have been continued with mainstream NHS/Comhairle funding.

For the period 2015/16-2017/18, the Scottish Government has given each partnership access to an Integrated Care Fund. Our share of that pot locally is £640,000 across three years. The first year of that resource has already been committed to expanding the number of long-term care beds we have on the islands in order to reduce the number of older people living in hospital. So we will see the expansion of the Bethesda care home so that we can provide nine respite beds, which will allow the other care homes to dedicate their capacity to long-term care.

The remainder of the resource has yet to be allocated to a specific programme of work, but it is important in the current financial climate that we use that money to best effect and that this is aligned with the strategic plan. The IJB will consider this matter during 2016/17 and all proposals will be based on six broad principles: co-production; sustainability; locality involvement; leverage; partnership; and outcomes focused care.

Clinical and Care Governance
The Integration Joint Board is accountable for ensuring that appropriate clinical and care governance arrangements are in place. To enable it to do so, we will put in place structures and processes to support clinical and care governance and to provide assurance on the quality of health and social care we deliver. This includes:

- An Integrated Clinical and Care Governance Group will be established to provide assurance that the care we deliver is safe and appropriate
- The Chief Social Work Officer will continue to report directly to the Council on professional social work matters
- The medical, dental, nursing and AHP leads within the integrated service structure will report directly to the Medical Director and Nurse Director on professional matters

In addition, we will develop clear links to our Area Clinical Forum; Managed Clinical Networks; Adult and Child Protection Committees and other appropriate professional groups.
Delivering the Change

Our success will also be dependent on creating the conditions for professionals to use their experience and judgement to maximum effect in improving outcomes for service users. This will be focused on improving the coordination of care across different professional roles; the effectiveness of communication within and across disciplines; and the empowerment of professionals to make effective evidence-based decisions.

The reforms which we are proposing are intended to move us towards that operational environment, where multi-disciplinary teams are the norm and where interventions are built around the needs of the individual.

Physical Environment
Housing, adaptations, aids, design changes, and assistive technology to maintain the independence of the person and support family carers

Multi-disciplinary teams
Locality teams that bring together GPs, social care, community nursing, social work, AHPs, and mental health practitioners to ensure that care is responsive and well-coordinated

Community Support
The informal capacity that exists within a locality area to support socialisation, transport, physical activity, educational opportunities, which will improve mental and physical health and well-being

Specialist Care
The highly specialised health and social care input which is required periodically to improve health outcomes, often delivered within specialist secondary care facilities
Community Engagement

One of the major innovations of the health and social care integration agenda is to put a renewed focus on the importance of community leadership and community development. This is about more than just the empowerment of Locality Planning Groups, important as that may be: it is also about building on community assets and infrastructure to ensure that local people are able to live purposeful lives.

This will mean that people are socially connected, to friends and family; are able to pursue the every-day activities that support people’s interests and ambitions.

This is often provided by community initiatives which are supported by multiple funding partners and it is important that we continue to support community ventures even when resources are tight.

There is emerging evidence of the value of a ‘place-based system of care’, which involves organisations collaborating to improve health and care services for a geographically-defined population, managing the common resources available to them. This is often based on strong community engagement relationships, which drives the reform process within localities.

This is a model that we would like to explore in the Western Isles.
12. Measuring Improvements and Communicating Change

**It is extremely important that we understand the impact of our reform process and our services on the outcomes that people experience.** We will therefore put arrangements in place to measure this impact over time.

**Reporting and Performance Management Arrangements**

One of the features of the integration agenda is that for the first time, the NHS and local government will be required to work towards a single set of high-level outcomes. These were developed by the Scottish Government at a national level and have to be used by each partnership to monitor progress. They are underpinned by a suite of national indicators, which can be used locally to benchmark improvement. These outcomes and indicators are described in Annex 2. We will devise a performance management system which builds the national indictors into our local reporting system and we will publish an annual performance report.

**National Care Standards**

The National Care Standards describe what people using a range of care services in Scotland can expect. They are based on key principles underpinning quality care services and are a blend of expectations about quality and service requirements such as space and staff training. They are used by service providers to maintain and improve the quality of services provided.

Work is underway to anchor the national standards on a set of overarching principles which deliver a greater focus on human rights, wellbeing, and individuals’ experiences of care. This will provide a stronger foundation for scrutiny and inspection, and a means by which service providers can be held to account. Importantly, it fits with our strategic planning approach and we will continue to uphold these standards in the services we offer.

**Communicating Change**

It is hugely important that as we change our service and support arrangements over the next few years that we communicate effectively with members of staff, stakeholders and communities. To that extent, we are committed to:

- Providing regular updates, newsletters, media articles and blogs that can be disseminated to inform people about our work;
- Hosting regular staff meetings to allow for feedback about the changes we’re introducing, including engagement with trades unions and other staff representatives;
- Update reports to Comhairle committees and the NHS Board to ensure that both parent organisations are kept up-to-date with our work
- Contributing to Locality Planning Groups and to public engagement sessions about programmes of change