NHS Board Accounts: 2014-15 questionnaire

NHS Western Isles

Service development

1. Please give THREE examples of services that:

   (a) you plan to develop in 2014-15 (territorial boards should list local service developments, rather than national programmes)

Service	Expenditure 2013-14 £000	Planned expenditure 2014-15 £000
Mental Health Services Modernisation (implementation date yet to be determined)	Nil	Expenditure will relate to double running costs not yet determined, and will depend on the availability of brokerage from SGHD
Fracture Liaison and Osteoporosis Service (implementation date yet to be determined)	nil	39
Enhanced Healthcare at Home (also referred to as Hospital at Home) (February 2014)	67	67

   (b) you would like to develop if you had additional funding i.e. what is next on your list of priorities? (territorial boards should list local service developments, rather than national programmes)

   NHS Western Isles currently has a list of 22 desired service developments with a total estimated cost in excess of £1.5 million. The three highest cost schemes are:

   i. Nutrition and dietetic service development £173k

   ii. Well North – vascular disease £155k

   iii. Clinical Psychology £117k

   (c) you plan to withdraw, restrict or reform in 2014-15 (please provide reason(s) and anticipated savings in 2014-15) (territorial boards should list local service developments, rather than national programmes)

NHS Western Isles does not plan to withdraw or restrict any services in 2014/15. However the Board plans to reform services, summarised as follows:

i. Replacement of St Brendan's in Barra to include integrated service management

ii. Midwifery services in the Uists

iii. The North Harris area Out of Hours service

2. During 2014-15, do you plan to consult on the delivery of any specific services i.e. those resulting in significant service change?

   We continue to consult on the reprovision of health and social care services in Barra whilst we develop an outline business case for the replacement of St Brendan's.

   We are also consulting on the options for provision of out of hours services in North Harris.

Preventative spending

3. What specific preventative health programmes are included in your budget plans for 2014-15? (please give details of planned NHS board expenditure **over and above any ring-fenced allocations** in 2014-15 compared with 2013-14 within the categories shown)

Programme area	Expenditure 2013-14 £'000	Planned expenditure 2014-15 £'000
Smoking prevention/cessation		
Weight management (child/adult)		
Childsmile		
Keep Well		
Maternal and infant nutrition		
Blood borne virus prevention		
Immunisation programmes		52
Screening programmes		
Sexual health programmes		
Drug and alcohol programmes		
Other (please specify)		

4. With regard to assessment of preventative spend programmes:

   (a) What savings do you anticipate that these preventative spend programmes will deliver over the next 5-10 years (please provide specific examples)

We have not assessed likely savings, because experience tells us that there are always new and additional service pressures arising that will offset these savings.

(b) Are the results of any such assessments reflected in your financial planning? (Please give any specific examples of how financial plans have been adjusted to reflect potential savings)

See above

Change Fund / Integration Fund

5. With regard to the Change Funds:

   (a) Please give examples of THREE services that will be funded using Change Funds in 2014-15? (please include details of Change Fund spending on these services in 2013-14 and 2014-15 and related outcomes)

Programme	Expenditure 2013-14 £'000	Planned expenditure 2014-15 £'000	Outcome measures	Progress on outcome measures
Reablement	273	313	To move towards a reablement model Reduction in Hospital Emergency Admissions Accelerated Discharge from Hospital for Older People Increase focus on preventative and anticipatory care and intervention Increase awareness of service provision Effective shared planning and use of resources, reducing harmful and wasteful variation Effective shared planning and use of resources, reducing harmful and wasteful variation	Q3 Monitoring Report attached at Appendix 1
Community Nursing Modernisation	90	90	Maximise the development impact and benefits realisation of e Health People receive a quality service, and positive experience for people	Q3 Monitoring Report attached at Appendix 2

			of health and social care Increase focus on preventative and anticipatory care and intervention Increase awareness of service provision Effective shared planning and use of resources reducing harmful and wasteful variation	
Dementia Support	36	86	Development of Anticipatory Care Models Reduction of hospital emergency admission for older people Accelerated discharge from hospital People are involved in the design and delivery of their care	Q3 Monitoring Report attached at Appendix 3

(b) Have these programmes/services been evaluated? (If so, please provide details)

All projects are subject, through their conditions of funding, to submit returns in line with the Project Monitoring Framework which is Quarterly monitoring reports followed up by an annual monitoring report and visit. During 20014/15 there is agreement that Community Nursing and Reablement will be assessed by investigating the Return On Investment from the resources made available.

In relation to Reablement, the Homecare step up step down element will only begin in 2014/15 and it has been agreed that the Health and Social Care Data Analyst will work closely with this service to identify at the outset appropriate measures and data gathering. This has also been agreed for the additional post of Dementia Specialist Nurse/Coordinator.

(c) Do you plan to continue to fund these services in 2015-16 through the Integration Fund?

It is our intention to continue to fund these three elements

6. Can you give examples of any specific services that you are developing with local authority and/or third sector parties as a result of the planned Integration Fund (please provide details of the service, along with planned investment by each partner)?

   The example of our development of an intermediate care development presented to the Health and Social Care Committee is included as appendix 4. This project has been agreed as a priority for continued development to 2015-16 through Integration funding and CNES partnership funding.

Reducing inequalities

7. What specific programmes are aimed at reducing inequalities? (please include details of THREE services in the format shown below)

Programme	**Expenditure 2013-14 £'000**	**Planned expenditure 2014-15 £'000**	**Outcome measures**	**Progress on outcome measures**
Keep Well	110	110	ABI's, No. of people screened for Diabetes, Cholesterol, High Blood Pressure, Weight	Currently meeting targets

			Intervention	
Maternal & Infant Nutrition	55	55	As per Government Strategies	Currently meeting targets
Healthy Working Lives (HWL)	23	15	As per HWL Strategies	Currently meeting targets

Backlog maintenance

8. Please provide details of the THREE main actions in 2014-15 that will address backlog maintenance, providing:

   (a) details of the action (investment/disposal etc.);

   (b) planned expenditure/receipts from this action in 2014-15; and

   (c) the impact this will have on your overall level of backlog maintenance (high/medium/low risk)

   (d) what proportion does your planned spending on backlog maintenance in 2014-15 represent of your total capital budget?

NHS Western Isles Backlog Maintenance Costs				
		Risk Category		Total £
Low	Moderate	Significant	High	
199,101	595,051	243,250	11,400	1,048,802
18.98%	56.73%	23.19%	1.1%	100%

The above table highlights the risk profiled physical condition backlog maintenance costs and their percentage in relation to the total physical condition backlog costs. This information has been compiled from the new condition survey carried out in 2012/13. The vast majority of the high and significant risk costs are related to the poor condition of the roof, boiler plant and associated services at the Stornoway Health centre. A smaller portion of the significant and moderate risk items are related to the St Brendan's hospital on the Isles of Barra.

The three main actions addressing backlog maintenance in 2014/15 will be:

1. Investment

In order to reduce the significant and high risk items the key areas of backlog maintenance to be addressed with investment in 2014/15 will be:

- Stornoway Health Centre- replacement boilers
- Stornoway Health Centre- replacement roof
- Stornoway Health Centre- replacement fire alarm and emergency lighting

Further backlog projects which will reduce the moderate and low risk items are:

- Western Isles Hospital – Internal refurbishment program – a 4 year project to replacement floor coverings, ceiling tiles, fire doors, lights etc
- Laxdale Court Staff Residences - replacement windows and doors
- 4 year project currently in year two to replace fire alarm systems to all buildings over ten years old.

The 2014/15 estimated investment required for backlog maintenance projects is £672k, of which £472k will be funded from the Board's capital allocation (dependant on Board approval / final allocation from Scottish Government) and £200k from revenue budgets.

2. Disposal

The majority of the Board's surplus properties would require investment in the form of backlog maintenance to bring them into use therefore it is more cost effective to dispose of them, as they are of little benefit or value to the Board. The Board has already taken steps to rationalise its estate commencing with the disposal of domestic properties. Further rationalisation options will form part of the Board's long term capital plans as detailed in the 2014 PAMS relating to the possible options for centralising services within clinical hubs.

The Board currently has six surplus domestic properties and has assumed a prudent estimate in 2014/15 forecasts for the sale of two of these properties, generating profits of £104k over a net book value of £165k.

The disposal of these properties will have an impact on the backlog maintenance costs however this will be related to the lower risk items only as these buildings are either currently unused or do not have an impact on the provision of the boards clinical services. However the disposal of these properties will assist in the funding of backlog maintenance for other Board properties.

3. Review of current strategy

Approximately 85% of the Board's estate was resurveyed by Capita in December 2012 and as a result there has been an increase of £159,549 in backlog maintenance costs and associated risks due to the ageing of assets. The Board's plan to address these will be detailed in its 2014 PAMS report. However as detailed above all of this increase and the higher risk items will be addressed in the next 3 years by the refurbishment of the Stornoway Health Centre and by the replacement of St Brendan's hospital.

The Board's capital programme planned for 2014/15 is £3.374m (net of the anticipated receipts from the disposal of surplus property). The capital spend on

back log maintenance of £472k therefore accounts for 14% of the total capital allocation.

Brokerage

9. (a) Did you have any brokerage in 2013-14?

   No new brokerage; we are half way through a brokerage repayment schedule for brokerage received in 2008/09.

   (b) If YES, was this brokerage anticipated at the start of the accounting period or did the requirement emerge during the year?

   N/A

10. (a) Do you anticipate the need for any brokerage in 2014-15?

   Potentially.

   (b) If YES, how much would you anticipate requiring and for what purpose?

   The sum is not yet determined, but would relate to any double running costs for the implementation of modernised Mental Health services

NRAC formula

11. What are your views on progress towards achieving NRAC parity?

   NHS Western Isles has moved from being £10.7 million above parity to £4.4 million above parity following the recent review. This has no impact in the short term but makes more realistic the prospect of moving to parity over the longer term. Having said that it is very difficult to reduce baseline costs even to the revised extent, as this would require significant infrastructure rationalisation.

Equalities

12. Please provide up to THREE specific examples of how the use of an equality and diversity impact assessment has influenced budget decisions.

   Although there have been a number of assessments, none have so far influenced any budget decisions.

Sustainable development

13. Please provide up to THREE specific examples of how the NHSScotland sustainable development strategy has influenced budget decisions.

    This is manifested in all building works now undertaken. Two current projects, being the replacement of St Brendan's and the development of the Harris Hub in Tarbert, are focused on sustainability, as are plans relating to backlog maintenance for one of the medical centres.

Project Name and Provider: Reablement Phase 2 (incorporating Community Equipment Service development, equipment servicing and maintenance and CES vehicles)				
Years Funded and Amount: 2011/12 - £12,000 2012/13 - £96,000 2013/14 -£185,200				
Change Fund Outcome	**Outputs**	**Target**	**Quarterly**	**Year to date Actual**
HL1 – Reduction in Hospital Emergency Admissions	HL15 No of people proactively identified as at risk of hospital admission and provided with appropriate support	24	3	13
HL2 – Accelerated Discharge from Hospital for Older People	HL14 No of people supported to self manage their health conditions	19 Fast track hosp discharges	0	7
HL3 – To move towards a reablement model	HL7 No of people in receipt of Reablement	48 people supported with reablement 137 supported with equipment provision 75 people offered falls assessment and intervention	23 14 24	45 64 Explore screening of home care referrals by OT
	HL16 No of people who have had a fall that has receive a targeted falls prevention service	75	24	64
SS1 – Increase focus on preventative and anticipatory care and intervention	SS6 No of people in receipt of preventative and anticipatory health and care planning approaches	10 SPARRA patients and evaluate impact	0	0 Referrals are awaited from GP practice
EW3 – Increase awareness of service provision	EW12 No of marketing campaigns	Leaflet and Poster	3	A draft leaflet and poster for carers and referrers to the Reablement service is completed and has been sent to

<table>
<tr><td></td><td>undertaken incorporating publications, leaflets, posters, brochures, advertising, websites etc.</td><td>Produced produced

Promotion on WIH website
Press release</td><td></td><td>stakeholders for consultation.</td></tr>
<tr><td>ER1
Effective shared planning and use of resources, reducing harmful and wasteful variation</td><td>ER3- People are in receipt of services which ensure high-impact efficiency and productivity approaches that are implemented reliably</td><td>Vehicle: reduction in verbal complaints or reduction in any Datix Incidents Change to Risk Register
OT free time to deliver reablement in Uist and Barra instead of delivering equipment</td><td></td><td>Four WTE Community Equipment Service (CES) staff have been recruited in August 2013 and started in their posts on 1 September 2013. Subsequently, one of the post holders has left the service for permanent employment elsewhere and we are currently recruiting to this post again. Another part time CES assistant is being recruited for the Uists and Barra to make this service sustainable and to meet health and safety requirements.

CES equipment deliveries and uplifts:
<table>
<tr><td>Area / Month</td><td>Lewis and Harris</td><td>Uists</td><td>Barra</td></tr>
<tr><td>April to June 2013</td><td>615</td><td>22</td><td>0</td></tr>
<tr><td>July to September 2013</td><td>806</td><td>62</td><td>3</td></tr>
<tr><td>October to December 2013</td><td>817</td><td>63</td><td>5</td></tr>
</table>
</td></tr>
<tr><td></td><td>ER6 – service has been developed and delivered in partnership and reduces duplication</td><td>Equipment Servicing Contract Saving of 20 % Vat by combining with partner organisation direct efficiency saving</td><td></td><td>Contract is in place</td></tr>
<tr><td colspan="5">Comments:

<table>
<tr><td>Male</td><td>38%</td><td>Physical Disability</td><td>87%</td></tr>
<tr><td>Female</td><td>62 %</td><td>Alzheimers/Dementia</td><td>13%</td></tr>
</table>
</td></tr>
</table>

60-65	8%	65-75	13%	75-85	35%	85+	36%

Area	Male	Female
Lewis	30%	57%
Harris	8%	5%

The Canadian Occupational Performance Measure as a patient reported outcome measure was used with 8 of the clients during this quarter.
Clients score their performance and satisfaction with every day activities prior to intervention and at completion of intervention. On average, scores prior to intervention for Performance are 2.75 / 10 and following completion of intervention, scores are on average 8.75 / 10. Satisfaction scores prior to intervention is on average 1/10 and following intervention Satisfaction scores are on average 8.75/10

The CnES Reablement project proposed in the step-up, step-down unit has been approved by the Health and Social Care Committee and the planning phase for this has started in January 2014.

The Hospital at Home scheme commences on 3 February 2014. Referrals to the Reablement service are anticipated and will be monitored to identify what the additional demand is as part of the evaluation of the pilot. Reablement OT has been involved in the planning and supporting the set up. The CES has offered training regarding equipment, requisitioning of equipment and setting up a satellite store within the WIH which can be accessed out of hours.

Project Name and Provider: Modernising Community Nursing – NHS Western Isles Q3				
Years Funded and Amount: **2011/12 –** £18,000 **2012/13 –** £70,000 **2013/14 -** £90,000				
Change Fund Outcome	**Outputs**	**Target**	**Quarterly**	**Year to date Actual**
HL5 Maximise the development impact and benefits realisation of e Health	HL 10 – No of people in receipt of an anticipatory mode of care	Implementation of Patient held Record to all Community Nursing Teams **Key Milestone** East Team by September Lessons Learned Dec Roll Out February 13		Live 4 out of 5 team with the intention live in Barra by January 2014 ROI will be carried out on Digital Pen within 2014 Patient Facing Time in East Team were Pen has been operational for 12 months Up from 29% to 44% Caseload and team management has reduced from 25% to 16% Small reductions in administration and travel time this is attributed to more than one initiative and includes RTC
PE1 – People receive a quality service, and positive experience for people of health and social care	PE4 No of people who were involved in the design of their care packages	100% of all patients have a person centred care plan following implementation of Patient held record **Key Milestone** Rolling Programme		Rolled out in conjunction with Digital Pen any patient who has received a visit from Community Nursing Staff within this period now has a person centred care plan Audit of documentation within East Team identified there was some work to be done to ensure all records

				were completed to standard, a SOP has been devised so that all documentation is included in uniform fashion and the other teams are now preparing to audit their records over the course of the month. The east team have 98% of their case load on individual patient held care plans.
	PE6 – No of people with increased coping mechanisms	Increase in Nursing assessment tools will be effective in measuring patient progress. Potential to introduce phone apps **Key Milestone** Learning through PHR improvements in eHealth technology		Exploring potential patient assessment tools as phone apps and workload tool as phone apps Consideration of Waterlow Tool Must Tool Falls Assessment This is currently affected by staff capacity issues within IT
SS3 - Increase focus on preventative and anticipatory care and intervention	SS6 – No off people in receipt of preventative and anticipatory health and care planning approaches	As above, increase in patient centred care allowed for by care closer to home. Measure no of people with Anticipatory Care Plans Measurements under RTC **Key Milestone** Establish Baseline no of ACPs by April 2014 and increase by 20% by March 2015		Anticipatory Care Plans are inconsistent across Western Isles and this is being addressed through patient at risk through SPARRA This work has been progressed in the last quarter with discussions ongoing with Langabhat practice re future developments
EW3 – Increase awareness of service provision	EW11 – No of organisational training sessions supported by the Change Fund Undertaken	Stakeholder engagement exercise with all relevant staff groups. RTC meetings, Webex Completion of modules		National RTC event October Local RTC meetings Integration RTC Facilitators for Community

		Key Milestone Various dates as per national agenda		Modules for Foundation completed in most teams Planning working on Up skilling of work force to meet unscheduled care
	EW13 – No of promotional initiatives undertaken including conferences; seminars; open days / evenings; special events	Raise profile of WI developments **Key Milestone** Community Nursing Futures Conference British Computer Conference 2013 NHS 2013		Digital Pen award from National Conference Completed Attending Health and Social Care Committee November 13
ER1 – Effective shared planning and use of resources reducing harmful and wasteful variation	ER4 – No of people in receipt of an integrated service	Develop Integrated Pilot **Key Milestone** To be started Summer 2013		Development of Rapid response Team/Hospital at Home in conjunction with AHP colleagues planned 4 month pilot project to assist with winter pressures pre project planning being undetrtaken identifying project measures job descriptions project steering group established. Project due to go live February 2014

Comments:
ROI will be carried out on Digital Pen within 2014

Highlights:
Patient Facing Time in East Team were Pen has been operational for 12 months Up from 28% to 40% this is attributed to more than one initiative and includes RTC

Issues:
Exploring potential patient assessment tools as phone apps and workload tool as phone apps
This is currently affected by staff capacity issues within IT

Project Name and Provider: Dementia Link Worker - Alzheimer ScotlandQ3				
Years Funded and Amount: **2012/13 -** £17,597 **2013/14 –** £35,194 **2014-15 –** agreed salary costs April to July only for Lewis post at present				
Change Fund Outcome	**Outputs**	**Target**	**Quarterly**	**Year to date Actual**
HL4 Development of anticipatory care models	**HL10** No of people in receipt of an anticipatory mode of care	All people who take up a referral to the service have an Anticipatory Care Plan	11	28 out of 32 people have anticipatory care plans started. 4 people have not yet accepted this support. This process takes time to complete as DLW has to work in line with individual's needs and preferences as well as build a relationship of trust. Please see attached PDS statistics appendix 1. 10 people with dementia have anticipatory care plan by March 14: **On target.** 20 people with dementia supported to self-manage their dementia: **This has been exceeded.** 10 people with dementia and their families supported to produce person-centred plan to guide future support by March 14**: On target.** 15 people with dementia and families linked in to peer support by March 14: **Ongoing.**

				15 people with dementia supported to maintain community connections by March 14: **Ongoing.** 15 people with dementia have legal and financial arrangements in place for the future including powers of attorney by March 2014: **Ongoing**. Establish peer support initiative for people with dementia and their carers/family members by March 14: **Ongoing.** **UB DLW undergoing induction so is not running an active caseload it is anticipated she will have a caseload of 8-10 people by March 2014.** This is a service for people diagnosed with dementia from 1st April 2014
HL1 Reduction of hospital emergency admissions for older people	HL14 No of people supported to self manage their health conditions.	Educate and support all people to manage dementia		Progress: DLW has regular contact with people with dementia and their carers/families and part of this role includes promoting: Good for the Brain – see Appendix 2 and Looking after yourself – Appendix 2a promoting the benefits of a healthy lifestyle particularly with Vascular Dementia. LH DLW promotes existing Alzheimer Scotland training materials for carers to promote coping strategies around

				stress and distressed behaviour and advice on how to prepare for changes.
	HL12 No of Older People who are kept active through activity	Educate and Support all people to manage dementia		DLW is supporting people with dementia and their carers to identify strengths, maintain skills, identify support networks and signposting to other agencies when appropriate to support people with dementia to maintain independence for longer. LH DLW has began introducing person with dementia and their carers and families to dementia café, singing group and carers groups etc for peer support and community connection opportunities. Carer support group and Peer support groups have been challenging to establish.
HL2 Accelerated Discharge from Hospital	HL9 No of people provided with appropriate care package to support accelerated discharge from hospital	Promote early discharge from hospital for people with dementia		As the link worker is for people newly diagnosed with dementia , no impact can be demonstrated regarding early discharge from hospital.
PE2 People are involved in the design and delivery of their care	PE4 No of people who were involved in the design of their care package	All people accepting a referral to the service are involved in developing a person centred plan		10people with dementia and their families supported to produce person centred plan to guide future support by March 2014:**On target**

	PE6 No of people with increased coping mechanisms	All people accepting a referral to the service receive support following the five pillars model of community support		20 people with dementia (and their families) in their first year of being supported with 5 Pillars model of post-diagnostic support: **This has been exceeded**
	PE7 No reporting reduced stress/ability to manage	No of people reporting an increased ability to cope and reduced stress		• This will be reported as people are exiting the service too soon to report

Comments:

- **Initial issues (last report) with RMS system and referrals has now been addressed.**
- **Initial issues with inappropriate referrals i.e. pre 1/4/13 from health and social care professionals –issue has now addressed.**
- **Information on stage on dementia and date of diagnosis information is now clearly identified by referral source**.
- **Regular and joint supervision meetings take place to discuss caseload in line with Change fund application to ensure outcomes are clear and time scaled. Caseload takes into account geographical spread, requirement for recording information as well as time to allow DLW to attend necessary meetings and training opportunities.**

Uist and Barra Dementia Link Worker (UB DLW):

Postholder began 6.1.14 so is currently undergoing induction process. Anticipate same outcomes as above although there is not an established Alzheimer Scotland Dementia Resource Centre in Southern Isles Service manager and CMHT will be supporting UB DLW to develop local network to provide support to people with dementia diagnosed from 1st April2013, their carers/families and others.

UB DLW will be involved in setting up of local support group and dementia cafe.

Male	25%	Physical Disability	%
Female	75%	Alzheimers/Dementia	100%

60-65	5%	65-75	20%	75-85	50%	85+	25%

Area	Male	Female

Lewis	25%	75%	
Harris	25%	75%	

Appendix 4 Hospital at Home Priority Service Improvement Assurance Completed Local Delivery Plan 2014/2015

NHS Scotland has moved to an outcomes based approach and the LDP will reflect the introduction of the Quality Strategy and the Route Map. This year the LDP has 3 elements which are underpinned by finance and workforce planning:

1. Improvement & Co-production Plan (Route Map)
2. NHS Board Contribution to Community Planning Partnership Plans
3. HEAT risk management plans and delivery trajectories

It is recognised that this is a transitional year and work will continue, to ensure that the LDP continues to complement and align with other local and national planning requirements. The LDP now integrates and is integral to the Route Map.

The information submitted must provide the Scottish Government Health and Social Care Department with the assurance that the Board is addressing the 12 priority areas for improvement contained within NHSScotland document "A Route Map to the 2020 Vision for Health and Social Care".

The Board is required to submit our LDP by the 14th February after the approval obtained from the Board at their meeting on the 29th January 2014. Information should be submitted to Michelle McPhail by the 20th January 2014.

You can use the template below in connection with the Route Map Assurance document Improvement & Co-production Plan

Triple Aim (delete as appropriate)	Quality of Care
Quality Ambitions (delete as appropriate)	Effective
Priority Area for Improvement (one of the 12 Priorities)	Unscheduled and Emergency Care
Service Development Title (one of the 25 key deliverables or local development plan title)	Out of Hospital Care Action Plan
Supporting Evidence	LUCAP
Produced by	Colin Gilmour

Please provide a short paragraph on what the plans are for 2014-15

Hospital at Home Pilot - a development to test a community based rapid response team. A service that provides active treatment by health care professionals, in the patient's home, of a condition that would otherwise require acute hospital in-patient care, always for a limited period.

Look for ways to release increased time for community nurses to work on admission, prevention, early discharge, including better planning of resource utilisation and IT. Recent focus has been on how we can enhance our existing workforce and utilize the full range of skills that they have developed in order to provide additional care pathway options as alternatives to admission for appropriately identified patients. This is a pressing issue as we seek to manage our winter pressures.

Additionally as we face significant problems at the discharge part of the patient flow process it makes it increasingly important to ensure that where appropriate, admission is avoided.

What will be different by 2020 ~ taking note of the objectives in the document " A Route Map to the 2020 Vision for Health and Social Care"

Identifies a particular area for accelerated improvement and enhanced roles in unscheduled and emergency care, in primary care, and in services for people living with LTC's to improve the patient pathway in order to reduce pressure on A& E departments and hospital admissions. Contribute to shifting the balance of care, support self management, link to anticipatory care planning and provide care in a home or homely setting . Provide safe, high quality, timely and tailored patient care at home that would traditionally be provided in hospital.

Outline key activities underway and / or planned.

Through more detailed analysis of existing data, people will be identified as 'at risk' and anticipatory care plans will be agreed.
Contribute to early identification of people likely to require an admission and for whom, with dedicated health and care, admission could be avoided; provide for high quality and timely discharge, admission/readmission avoidance of suitable patients identified in hospital; contribute to the development of new patient pathways; effectively utilize clinicians to ensure that the necessary information is available to treating clinicians whether they are in primary or secondary care; contribute to transforming unscheduled care.

How will progress be demonstrated? Please give key measurables and milestones.

Collection of key data through TOPAS, CORTIX and Workload Tool, for example;
improved patient flows to free up resources and support targets; a reduction in bed days utilised (through reducing avoidable; admissions and readmissions and reducing length of hospital stay); reducing patient process delays and improving information exchange; financial benefits through efficiencies as demonstrated through the use of the Digital Pen/ Patient Held Record; reduced know on effect of avoidable delays in discharge.

GPs' benefits from Hospital at Home are expected to include:
access to an effective community response as easily as an acute referral; a rapid and responsive referral and discharge process as an alternative to referral to A/E or regular hospital discharge; information on progress during time with Hospital at Home and discharge supplied quickly; a continuation of the close ongoing relationship between GPs and community nursing as an extension of the Unscheduled care Nursing Team ;
a reduction in GP input in acute interventions; a reduction in demand on the community nursing service's planned workload during intensive acute home care; reducing patient process delays & improving information exchange.

Evaluate outcomes of service considering patient safety and quality. Report by June 2014
How will key stakeholders and partners be engaged and involved?
Report on progress through joint Planning Group and Health and Social Care Committee. Consider integrated model with developing reablement team based on results of pilot.
Key plans are ~ embed document or give hyperlink