Highland Joint Community Care Plan

Plana Co-Chùram Coimhearsnachd Na Gàidhealtachd

2010/13

Highland Community Care Partnership
Com-pàirteachas Cùram Coimhearsnachd na Gàidhealtachd

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On behalf of the Highland Council, NHS Highland and our service users and carers, we are delighted to present the new Joint Community Care Plan for Highland. The Plan has been developed by the Highland Community Care Partnership and sets out the priorities for Community Care in Highland for the next few years.

There is a real need for us to do things differently. This is because our older population is growing rapidly as is the number of young disabled people who have complex needs. We know that we have to redesign our services and focus these where and when people most need them.

We also recognise how important it is to keep people physically and mentally active and socially connected as that this often prevents them from having to go into hospital or a care home. We will therefore invest in local communities and provide the support necessary for individuals and groups to better help themselves and each other.

People are actively encouraged to have greater choice and play a more active part in deciding what sort of care they would like and who should provide it. A growing number of people are now managing their own care packages.

When people are in need of health and care services, we want to support them as far as possible to stay safely in their own homes. Where it is necessary for people to go into hospital, our efforts will be targeted to get people back on their feet as soon as possible and help them to regain their confidence.

We look forward to working with the people of Highland to improve Community Care services. The Highland Council and NHS Highland are also firmly committed to working together in partnership to ensure that people can expect to receive prompt, responsive and high quality services.

WE LOOK FORWARD TO HEARING YOUR FEEDBACK ON THE PLAN
Please contact us at: info@fhcommunities.org

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1. Introduction

Ro-ràdh

1.1 This new Joint Community Care Plan has been developed by the Highland Community Care Partnership and is designed to be the blueprint for how the Highland Council, NHS Highland and our third sector partners will work together to provide Community Care services for the future.

1.2 The Plan is the result of a major consultation process across Highland during which we have listened very carefully to what people have told us is important to them.

1.3 The feedback we have received has been hugely helpful to us in developing this Plan and we are reassured that the people who responded to our *Changing Community Care*[1] consultation were positive about the outcomes we had identified as being those that are the most important[2].

2. Community Care in Highland

Cùram Coimhearsnachd sa Ghàidhealtachd

2.1 Making the difference

2.1.1 Community Care is the way we give care and support to adults of all ages who need extra help to live their day-to-day lives. It is also how we support unpaid carers.

2.1.2 Usually the people who use Community Care services have special needs arising from a physical or learning disability, or who have mental health problems and/or alcohol and substance misuse issues, or as a result of advancing age.

2.1.3 Typical examples of care and support are:

- the community nurse who takes someone's blood pressure, heart-rate or asks them about their mood so they can control their medication to enable them to live independently at home;
- the support worker who supports someone with a learning disability so they can participate safely in social events like football matches or discos and work towards greater independence; or
- the carer who helps someone with washing and dressing so that their regular, unpaid carer can take a break.

2.1.4 We try to provide care that meets people's needs. We want to help the people we work with to overcome whatever challenges they have so they can live the lives they want.

2.1.5 This plan looks at how our services can improve the lives of the people who use them. Our focus is on the **outcomes** of our efforts - the ability to live independently at home; the opportunity to go to the football, the chance to take a break from caring - for this is the difference we seek to make.

[1] The Changing Community Care consultation documents are accessible online at www.fhcommunities.org

[2] 88% of people who responded to our booklets affirmed that they are the important outcomes

2.2 The challenges we face

2.2.1 We know that the overall care needs of adults living in Highland are changing.

2.2.2 Figures show that the number of people who are 75 or over in Highland will more than double between 2008 and 2033. That people in Highland are living longer is a fact that should surely be celebrated by us all. However we know also that the demand on community care services grows markedly in those aged over 75.

2.2.3 It also looks likely that numbers of people needing help because of a learning disability, autism or mental health problem will continue to rise and their needs become more complex. The demand for help from those with a long term or lifestyle-related health condition also seems set to increase.

2.2.4 Combine these increases in demand with a financial future where real cuts in public spending seem certain and it is clear to see the challenges that Community Care services face.

2.2.5 In addition, we believe that we have an expensive over-reliance on institutional care to meet the needs of the Highland population. For example, a higher percentage of our older people live in care homes in Highland than in other parts of Scotland. People are going into care homes younger than they are in other parts of the country and they are staying longer.

2.3 Consulting people who use our services, their carers and other stakeholders

2.3.1 Given the demographic and financial factors which face Community Care, there has been a strong desire by policy-makers in Highland to develop a new and effective approach to meeting future challenges and to delivering the outcomes people seek.

2.3.2 Therefore, in developing any new approach, the views of the people who use our services and their carers are of critical importance to us. We want to be sure that our efforts are properly aligned to the delivery of the outcomes that people tell us they want. We are also keen to ensure that we engage the people who use our services, their carers and other stakeholders as active participants in meeting the challenges which lie ahead.

2.3.3 In summer 2009, the Highland Community Care Forum (HCCF) carried out an initial consultation on the Partners' behalf. HCCF staff talked to a cross-section of nearly 400 community care users and their carers. Their discussions focused on what being independent meant, what people had found helpful or difficult in maintaining their independence and what changes or improvements would help them remain at home. This work has been used to help us develop our approach to meeting the future needs of Community Care groups.

2.3.4 We used information gathered in the initial consultation to inform a further consultation undertaken between April-June 2010. To help us gather the views of the public, a set of *Changing Community Care* consultation documents were prepared and disseminated. These summarised our developing approach and aimed to give interested people the opportunity to feedback their views.

These documents set out:

- the outcomes we seek;
- the challenges we face;
- what people had already told us; and
- areas for change and improvement.

2.3.5 In parallel with the distribution of the consultation documents, Highland Community Care Forum (HCCF) carried out a second, more extensive consultation with 'harder to reach' groups. These included interviews with over 600 people from the range of service user, carer and equalities groups. HCCF's involvement provided a significant source of evidence for this Plan and underlines the importance of making sure that 'harder to reach' people are properly supported to have a voice[3].

2.3.6 In addition to the extensive consultation led by HCCF, it was pleasing that the Partners received over 300 returned consultation questionnaires, hard copy and on-line. Further community engagement included Council and NHS officers attending meetings across Highland of Ward Forums and Community Councils to discuss the Plan as it was being developed and to listen to feedback. We also engaged with a range of stakeholders in three, major planned events.

2.4 Incorporating feedback from the consultation

2.4.1 The information we received told us that we were on the right lines. It also deepened our understanding of the outcomes that people really want from our services. It has also shaped our understanding as to how we should best go about meeting those outcomes in Community Care. In describing our delivery outcomes, the level of detail provided enabled us to sharpen our focus on what we know is effective and on the activities which people tell us have the biggest, positive impact on their lives.

2.4.2 We also received a great deal of helpful information and feedback about 'areas for change and improvement'. People were positive about these[4]. However, both in responding to the documents and in face-to-face discussions, people took the opportunity to add their own personal comments and perspectives. This information has added significant detail to our understanding of the changes we need to make and has highlighted other important areas for improvement.

2.4.3 We have ensured that our amended list of strategic priorities fully reflects the wide range of feedback we have received from the people who use our services and their carers.

[3] A summary of the results of the consultation exercise undertaken by HCCF is accessible online at **www.fhcommunities.org** or at **www.highlandcommunitycareforum.org.uk**

[4] For example 78% of people who responded to our booklets affirmed that these are the improvements we need to make.

3. Changing Community Care

Ag Atharrachadh Cùram Coimhearsnachd

3.1 The outcomes that people seek

3.1.1 Community Care is the term we use to describe how we support adults who need extra help to live their day-to-day lives. It includes services provided by Health, Housing and Social Work. It involves support provided by the private and voluntary sectors too.

3.1.2 As stated above, our focus is on the outcomes of that support; the positive differences that, together, we can make to people's lives.

3.1.3 We have developed a set of themes to describe and guide the intended outcomes of our interventions, to ensure that we contribute to a position where:

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

3.1.4 We use these themes to structure the translation of our action planning processes into meeting the high level outcomes that people tell us they want.

3.2 What people have told us

3.2.1 In developing this Plan, we have made determined efforts to gather the views of the people who use services, carers and other community care stakeholders. We have gathered service user and carer views on what factors support adults in need to retain and regain their independence. We have also sought people's views on whether there are other issues we need to consider in shaping a Community Care Plan.

3.2.2 Many people placed a very high value on independence and being able to remain at or return home. For most, it did not mean 'going it alone' but having access to the right level of help and community support. Some described 'interdependence' as a more helpful way to think about how people support each other.

3.2.3 Some of the things people told us that helped them retain independence were:

- **clear communication** by service providers so that people know who to speak to, what services are available and how to access them;
- **caring and understanding attitudes** from service providers being treated with respect and dignity and as individuals;
- **living in a caring community** where they have strong connections with family and supportive friends;
- **being involved in a support group** where people can relate to and support each other;
- **appropriate and individual support services** so that people can remain at home;

- **preventive care and earlier help** can delay or avoid the need for crisis intervention later on (for example, suitable home adaptations fitted quickly and prompt access to physiotherapy service);
- **good respite care opportunities** for the individual and his or her carer;
- **adequate financial support** to relieve the pressure that many people experience;
- **good access to transport and personal mobility** that enables people to have the freedom to do what they want when they want to;
- the **opportunity to maintain important** relationships and to be or become socially active was key to people retaining their independence and confidence to live at home; and
- **access to meaningful and flexible training, employment or voluntary opportunities** enables people to feel more confident and widen their own expectations of living independently.

3.3 Other issues that people raised

The response to the *Changing Community Care* consultation demonstrated wide agreement that the issues identified above were important. However people identified a range of other issues which they thought should be considered in shaping a new Plan:

- **taking a proactive approach:** finding better ways of monitoring people's changing needs and reviewing their support appropriately;
- **investment in quick access to low level supports**: to support people to maintain their capabilities and avoid crises;
- **having somewhere to go** was a key issue to a range of vulnerable people in times of crisis;
- **consistency and continuity** of service was highlighted with many people saying they had experienced 'stop/start services' or that those who supported them changed too frequently to build proper relationships;
- **reintegration of isolated people**: developing more opportunities, to allow isolated people to mix with a wider range of people in everyday situations; and
- **taking a holistic approach** was seen as important when caring for the mental and physical well being particularly of older people and people with mental ill-health.

3.4 Key areas for change and improvement

3.4.1 To meet the challenges we face in providing care, and to do it in a way which both reflects what people have told us and helps us develop a model for services necessary to meet future challenges, we recognise that our services for adults in need must change and improve. A list of our key areas for improvement is given here:

3.4.2 **Helping to quickly restore people's skills and confidence**
Our Community Care services play an invaluable role in helping people to live where they want to - at home in their community.

However bouts of ill health can result in people being taken to hospital and admitted to care homes and we know that this results in people quickly losing the skills they need for independent living.

We want to help people who have had a crisis or a bout of poor health to

regain as much independence as quickly as possible. We will seek to refocus our services so they target help to people to quickly regain lost skills.

To do this we need to build the capacity across our services to act proactively and to intervene quickly. Our work must therefore focus on developing the skills and knowledge of our staff to bring a clear reablement focus. We must also aim to bring Health and Social Work professionals much closer together at District levels, streamlining our helping and personal planning processes to co-ordinate closer working between professionals and speedier responses to need.

3.4.3 **Housing and support solutions**

Greater availability of affordable housing with the right level of help on hand is the key to many people living successfully in the community. The need for flexible responses of this type was highlighted by a range of groups during the consultation. People said that not everyone wants to live by themselves, but with flexible home-based support for older people or shared accommodation for people who have a learning disability, individuals could be enabled to live as independently as possible.

We believe it is important to work together to plan any new housing so that it is suitable for changing need and with support in mind.

By enhancing Care at Home services and other home-based supports, we aim to provide more flexible help to support people to live in their own homes for longer.

Our care homes provide accommodation for older people who have the highest level of need and who are no longer able to remain in their own home.

Using a reablement approach whereby intensive levels of intervention are used to help people to regain their confidence through relearning and learning new skills, we aim to prevent unscheduled hospital admissions and to support the efforts of people to re-establish community living.

3.4.4 **Improved joint working between the key agencies**

Our aim is to join up Health, Housing and Social Work help and in doing so, be more than the sum of our parts. One of the main things we will do is have one single helping process that all professionals use. This will be simpler, with less bureaucracy and give more freedom to professionals to bring resources to bear. This should mean that help is available earlier and more people getting the right sort of help at the right time. In doing this, we aim to address the need to act in a more preventative way, something that people reiterated throughout our consultations. We will also ensure that there is sufficient investment in prevention, particularly in low level support that is available at an early stage.

The consultation feedback also pointed to the need to develop improved engagement with the widest range of partners within the universal, community, voluntary and commercial sectors. People told us that this was also necessary for better coordination of information, services and opportunities.

In developing a comprehensive Outcomes Framework for Community Care, we are seeking to ensure that the outcomes people seek are supported within a logical model for delivery that includes the full range of potential partners,

focusing on the ways to create the conditions for adults with support needs to achieve sustainable community living.

3.4.5 **Helping people and communities to better help themselves**

Across the country it is understood that sometimes services can unhelpfully create dependency. People also think that communities have become less supportive of each other and not looking after their neediest members.

Where people and communities can accept more of the responsibility for their own care and support, we believe they should. People have told us that they would welcome more preventative and proactive supports in their communities.

Through a review of day and community services for older people and people who have a learning disability, we will seek to co-ordinate the opportunities available for people to ensure there is a broad spectrum of community-based supports for independent living designed to mitigate social isolation and increase the opportunities for people to contribute and participate in stimulating, social settings.

We will seek to target the efforts of formal services at those people who have the highest and most complex needs and, by streamlining our role and recycling resources, support community-based and voluntary effort.

People also talked about the importance of transport. This was often seen as a key underpinning factor in addressing isolation and enabling access to services. People said that there is a need for equitable, accessible and flexible provision of transport across Highland. Transport is an issue that is much wider than Social Work and Health. However we are committed to working together with our partners in an effort to improve the transport opportunities that adults with support needs can access.

3.4.6 **Better information and better communication**

People who use services and their carers have told us that clear and accessible information and advice is essential to ensure that they know who to speak to, what services are available and how to access them.

We believe that, by providing good information at the right time, we can also help people to help themselves. This might be information about ways to manage a medical condition or about financial and welfare benefits may be available. We believe providing good information is fundamental to people becoming more active in their care.

We also heard from people that the tenor of professionals' communication is extremely important in building relationships and trust with service users and carers.

People have told us about the importance of the skills and knowledge that professionals bring to their role. They have stressed how the quality of listening, valuing and empathy in professionals' work affects adults who are in need.

Highlighted to be of particular importance were the communication skills of staff working with people who have dementia, autism and sensory impairment. We will therefore seek to ensure that improving these skills and competencies remain at the heart of the professional skill set.

3.4.7 **Carers as our partners**

Unpaid carers are our partners in providing Community Care. They are the people who provide help and support to partners, relatives, friends or neighbours without financial remuneration. The work done by carers is immense and this informal support helps many people to stay at home when they might otherwise have to move into a care home. It also helps prevent emergencies and stops people from needing other specialist services.

The importance of supporting carers was underlined in the consultation process. People told us that carers need to be supported with appropriate information, equipment and training and to be monitored so that they do not hit a crisis. The availability of appropriate, local short respite breaks as a key resource in helping people manage in their caring role was also pointed to. We want to make sure we do all we can to support adult carers and will seek to continue to ensure that they are respected and valued for the important task they perform.

3.4.8 **Young Carers**

One of three main outcomes of 'For Highland's Young Carers 2008-2011'[5] is to "reduce the number of inappropriate caring roles taken on by young carers." To help us achieve this requires Community Care professionals to identify where parents are relying on children and young people to provide their care and to include the young carer in care planning processes. To protect that child or young person requires professionals to ensure that they are not taking on an inappropriate level of caring, one which will prevent them from achieving their potential to be safe, healthy, achieving, nurtured, active, respected and responsible and included.

3.4.9 **Using new assistive technologies**

'Telehealth' is equipment that monitors a person's health and 'Telecare' is equipment that monitors a person's social care needs. Both can give early warning that things are not quite as they should be. Staff can intervene earlier to prevent someone becoming so ill that they eventually need emergency care in a hospital or admission to a care home. Technology can also help carers to continue to perform the caring role by providing a little extra assistance that gives them confidence that the person they care for is safe.

People have told us that technology can never be a substitute for hands-on care. That is, of course, correct but we believe that it does have an important role to play. We will seek to increase our use of these technologies as we believe they will allow us to offer help when it's actually needed, not just in case it is.

3.4.10 **Being in control**

It is becoming widely accepted that people should play as full a role as possible in shaping and delivering their own care, together with their paid and unpaid carers. People told us they wanted to be treated holistically as individuals, not simply seen as a collection of needs waiting to be met. By engaging people

[5] Available at **www.forhighlandsyoungcarers.co.uk**

actively and having a clear understanding about the intended outcomes of any intervention, we aim to ensure that the help people receive is closely tailored to meeting their individual needs and wants.

We are also working to ensure that people can access a range of flexible, personalised supports through the provision of Self Directed Support. This will sometimes be in the form of a financial payment. This should mean that people not only feel more in control of the decisions which affect their care and their life, but also that there is a wider range of potential supports for them to choose from to help them achieve the outcomes they seek.

Whether or not people want to play a big role in directing their own care, we believe that they should feel in control of the decisions which affect their care and their lives.

3.4.11 **Creating local, specialised services**

At the moment, we recognise that there are not enough services in Highland for people who have the 'most difficult to meet' needs. As a result, many people are placed in very specialist facilities, often in other parts of the country. This can make it hard for people to keep in contact with their families and friends. It can also be very expensive to pay for the most specialist care.

We believe we must support more people to be cared for closer to their families and communities and, in order to achieve this, we aim to develop new, cost effective local services. In a difficult financial climate where there are no new resources, we will need to ensure that the largest and most complex packages of care both deliver their intended outcomes as efficiently as possible and that resources are recycled where high levels of support are in effect acting counterproductively. To do this, we need to form close partnerships between professionals, service users and carers to look closely at how we currently do things and at how we might do things differently in the future. This will ensure that together we can provide support proactively and manage risk creatively and appropriately.

3.4.12 **Making clearer links between needs and resources**

Community Care has grown up in such a way that different groups of people who seem to have similar levels of need appear to get very different levels and types of service. Older people and adults with a learning disability are an example. This doesn't seem fair.

People have told us that within groups, people who have similar needs can also receive very different levels of service. People want us to ensure that there is equity across Highland when it comes to the distribution of services and resources.

We will aim to make the links between the needs people have and the resources they receive much clearer, both at a personal and at a planning level. This should also help us allocate our resources more fairly and more affordably in the future.

3.4.13 **Embarking on a road to recovery**

People's lives can be affected by a range of ongoing challenges to their health

and wellbeing. This may be as a result of an enduring mental health problem or it may be as a result of an addiction to alcohol or drugs.

However people can and do recover control in their lives, even where they may continue to live with ongoing symptoms and difficulties.

We propose that our mental health and substance misuse services should focus on the areas which have been shown to help people to recover hope, purpose and relationship-building and to develop self-management. If recovery is a journey, then we believe that the role of our staff can be to provide a route map and signposts on that journey. This can be done without taking control away from the service user they travel alongside.

3.4.14 **Working in a way that is more targeted**
As an aid to strengthening joint working, services in Highland for mental health and substance misuse are using clear targets to measure their performance.

We heard that people were concerned that targets might mean that certain activities and priorities are favoured ahead of others; also that our interventions need to be balanced ones, based on a holistic understanding of the individual and the individual's circumstances.

We agree with that point of view and would aim to use interventions of just such a type to produce reductions in the suicide rate, reductions in the number of readmissions to psychiatric hospital and to provide faster assistance for those people who have dementia. Talking therapies such as cognitive behavioural therapy have been shown to help people with some mental health conditions. Whilst understanding the critical role that the right medication can play, we aim to increase the access people have to these talking therapies and to reduce the number of people who are prescribed anti-depressants.

Focusing on these tangible results for people can, we believe, provide real momentum for improving the help we offer.

4. A New Model for Community Care Services
Modail Ùr airson Seirbheisean Cùram Coimhearsnachd

4.1 Given the challenges we face and the breadth of our areas for change and improvement, we believe we need a new model for service delivery in community care. This new model seeks to clarify the roles we undertake and ensures that we engage with the broadest range of partners to help us deliver the outcomes that people seek.

4.2 In common with similar work being undertaken across Scotland, and reflecting what we have heard through the process of consultation, we need to modernise our services and reshape them so they can effect a shift in the balance of care to support earlier intervention and community-based support, together with the provision of more intensive services for those people who need them.

4.3 In many areas of Scotland, local authorities and NHS Boards have been moving towards much more closely integrated health and social care services. In Highland, we are exploring how we might develop a 'Lead Agency' model whereby NHS Highland would in future become the lead agency for adult social care.

4.4 In the meantime, we are continuing to progress with an integrated model which is based on a set of sustainable activities that deliver a range of important outcomes for people and support a number of important partnership relationships with those in the universal, voluntary and community-based sectors. The proposed model is based on an integrated, tiered model of intervention.

4.5 *Chart 1 (see overleaf)* illustrates a service delivery model that is relevant across the different Community Care groups. It shows how formal, statutory activity, or activity that is funded by statutory partners, will be targeted at the people who have the highest and most complex levels of need and who are at greatest risk.

4.6 The inverted triangle is embedded in a range of other activities, which are shown to either side of the triangle. This represents the increasing importance of activity in the voluntary and community sectors and services provided by universal and partnership providers to meet lower levels of need.

4.7 Tier 3: Formal, targeted services for adults in need

4.7.1 These are a set of integrated services that support people who have the most complex needs and who are at the greatest risk of harm. Wherever possible, services aim to support people to manage at home and in the community, preventing the need for institutional care. People have told us that our inputs need to be targeted to prevent people's needs quickly escalating.

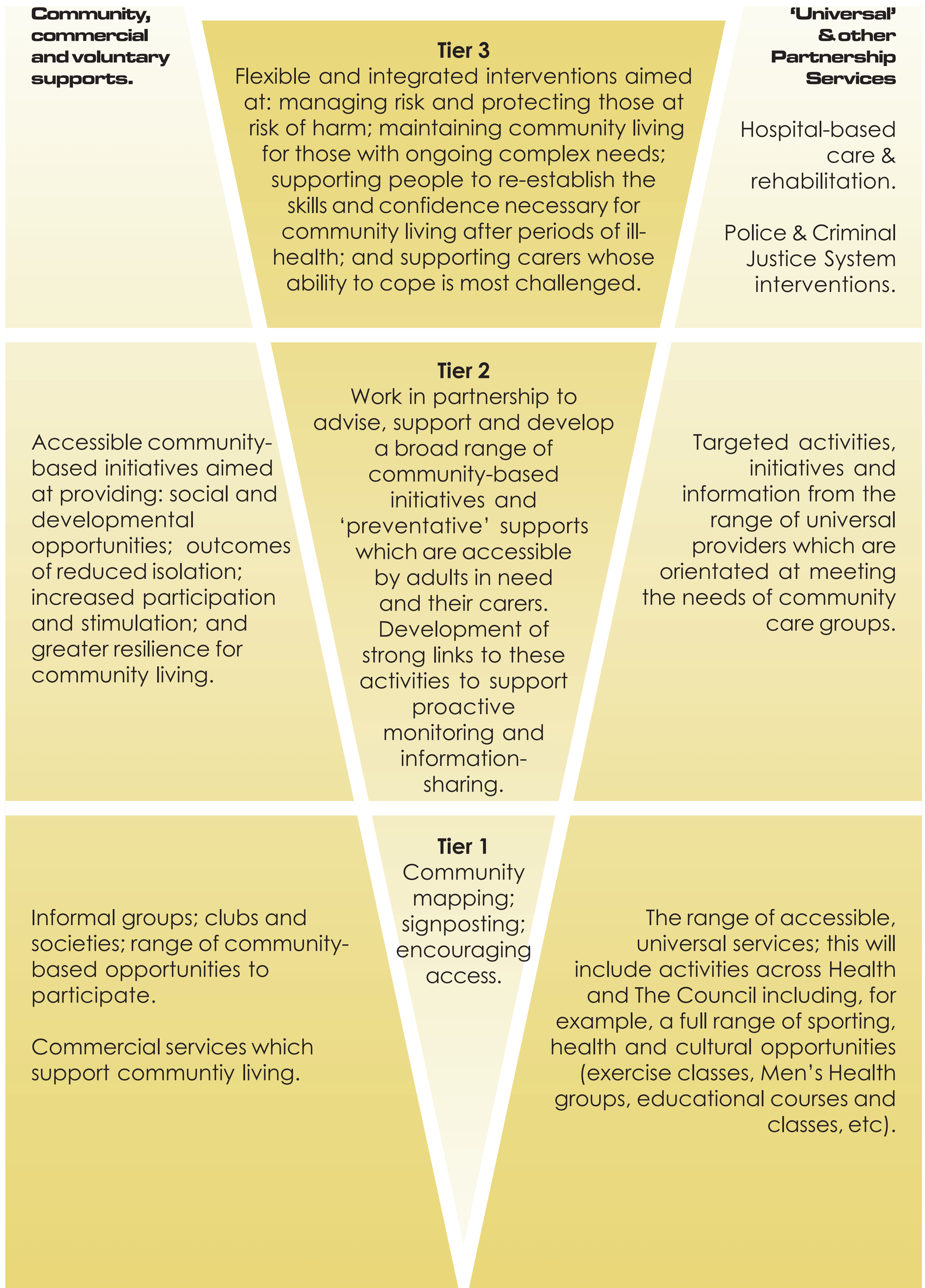
4.7.2 Services at this level will be provided whenever they are necessary to ensure that support is in place to:

- manage risk and protect those at risk of harm;
- maintain those with high level, continuing needs in the community;
- carry out a reablement plan aimed at re-establishing as much independence as possible with people after a period of ill-health; and
- support carers whose ability to cope is most challenged.

4.7.3 Services will provide focussed and targeted supports aimed at preventing unscheduled admissions to hospital and promoting early hospital discharge. It will be important to ensure that joint working between social care and allied health professionals is maximised, particularly in the areas of reablement, rehabilitation and recovery.

4.7.4 Service users will be involved in personal planning processes which will set out an agreed set of intended outcomes for the person, with timescales clearly specified and the success of those outcomes monitored and measured.

CHART 1: Role for Statutory Community Care Services (directly provided and commissioned)



4.8 Tier 2: Community-based supports for Community Care Groups

4.8.1 These supports are provided in partnership with a broad range of voluntary, community-based, commercial and universal efforts which are aimed at providing opportunities and activities that support the sustainability of community living for adults who have support needs. This represents a great deal of preventative activity which often maintains people's social connectedness and functioning and bolsters their capacity for more robust community living.

4.8.2 Encompassing the broadest range of supports to people who have support needs and their carers, and including activities such as peer support, supported social gatherings, exercise and fitness classes, health awareness sessions, courses, classes, community transport schemes, volunteering opportunities, social enterprises, handyperson schemes and befriending, the role for the statutory sector will be to work to stimulate, support and partner this broad range of activity. This will include a co-ordinating role for health and social care staff to ensure that partnership provision links into these activities, for example, ensuring information about self-care and falls prevention is properly shared, and that those who may benefit from formal provision at an early stage are identified.

4.9 Tier 1: Information to facilitate access to appropriate supports

4.9.1 This focuses on information-giving and signposting, making people aware of the full range of support activities and facilities that are available to adults with support needs and their carers in our communities.

4.9.2 Wherever possible, people prefer to meet others in informal settings. Being interested and involved in groups or societies is positively associated with personal well-being. However, simply not knowing that these opportunities exist can often be the stumbling block which prevents people getting involved. The existence of appropriate activities and supports, whether universal, voluntary, commercial or community-run, need to be signposted wherever possible. Statutory partners need to work together to develop better, simpler routes for sharing information of this sort to encourage active community living for all adults.

5. Community Care Outcomes Framework
Frèam Bhuilean Cùram Coimhearsnachd

5.1 Introducing the Outcomes Framework

5.1.1 In common with much practice in this field, work has been undertaken to develop an Outcomes Framework for Community Care which is clearly linked to the Single Outcome Agreement objectives. We have constructed a tiered model that aims to logically integrate the outcomes which we are aiming to achieve at each level. That is to say, by demonstrating that we are achieving outcomes at a lower level, we can be clear that we are contributing to the achievement of the higher level outcomes *(see Chart 2 overleaf)*.

5.1.2 As stated above, the information we received from the *Changing Community Care* consultation deepened our understanding of the outcomes that people told us they want from our services. It has also shaped our understanding as to

how we should go about meeting those outcomes in Community Care and, in describing our delivery outcomes, the level of detail provided has sharpened our focus on what we know is effective and on the activities which people tell us have the biggest positive impact on their lives

5.1.3 The **Single Outcome Agreement Outcomes** which we seek to contribute to in Community Care sit at the top level of the triangle:

A People across the Highlands have access to the services they need.
B People are, and feel, safe from crime, disorder and danger.
C Our communities take a greater role in shaping their future.
D Public services are delivered effectively, efficiently and jointly.
E More people are supported into employment.
F Healthy life expectancy is improved especially for the most disadvantaged.
G The health and independence of older people is maximised.
H Attitudes and behaviours towards alcohol and other drugs are changed and those in need are supported by better prevention and treatment services.
I The impact of poverty and disadvantage is reduced.

CHART 2: Community Care Outcomes Framework

5.1.4 The **High Level Outcomes for Community Care** across all adult groups sit across the middle part of the triangle. The achievement of these outcomes will describe and promote the broad strategic direction of travel for Community Care. It is intended that these outcomes will be themed in order to communicate the focus of our work, with these themes reflecting the feedback we received from the *Changing Community Care* consultation:

1. People are healthy and have a good quality of life;
2. People are supported and protected to stay safe;
3. People are supported to maximise their independence;
4. People retain dignity and are free from stigma and discrimination;
5. People and their carers are informed and in control of their care;
6. People are supported to realise their potential;
7. People are socially and geographically connected; and
8. We deliver Community Care services effectively, efficiently and jointly.

5.1.5 At the bottom level of the triangle is a set of **Delivery Outcomes** that services are currently working to directly deliver. The achievement of these outcomes will demonstrate that we are meeting the higher level outcomes. They will also often impact directly on the quality of service users' and carers' lives. These outcomes identify what the Strategic Planning Groups are seeking to achieve for the relevant service user groups, or area of operation, and will often be linked to specific performance indicators or targets. The clear expectation is that there will be action plans associated with the achievement of each of these delivery outcomes.

5.2 Implementing the Joint Community Care Plan

5.2.1 In order to deliver the range of outcomes that are set out within our Framework, we need a number of properly aligned multi-agency Strategic Planning Groups, each with a supporting Delivery Group to ensure that work is planned and effectively taken forward. These Strategic Planning Groups are fully integrated within a joint governance structure (*see Chart 3 overleaf*) to ensure the required actions are implemented at an operational level.

5.2.2 A number of Strategic Planning Groups are currently proposed:

STRATEGIC PLANNING GROUPS	
Adult Support and Protection	Older People
Carers	Physical Disability
Housing and Homelessness	Sensory Impairment
Learning Disability	Substance Misuse
Mental Health	Transitions
Brain-affected conditions	

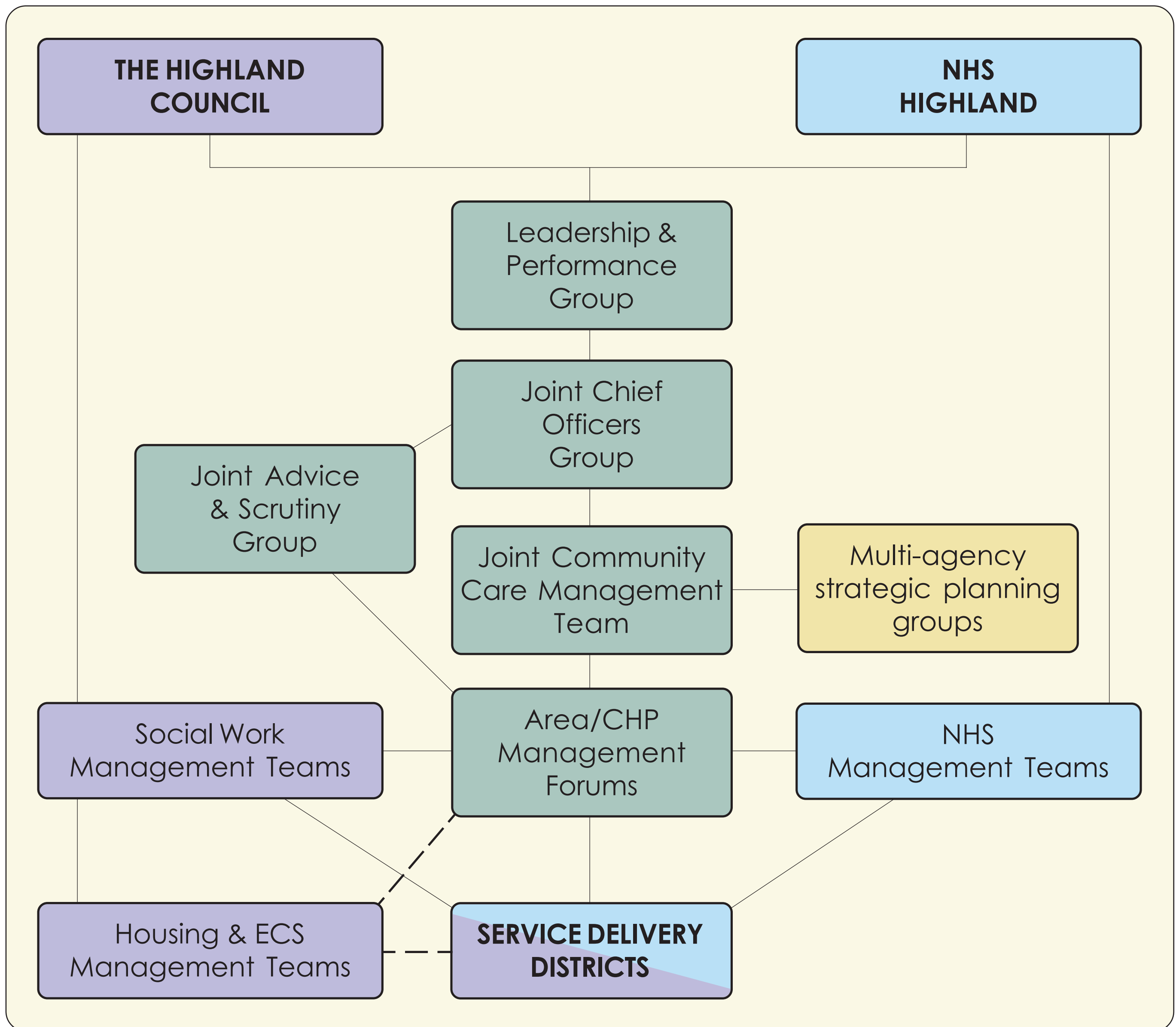
5.2.3 Some of these strategic groupings are already established with outcomes clearly worked up and outcome measures identified. However, others are in the process of being established with outcomes still to be finalised.

5.2.4 It should be noted that this is not an exhaustive list of Strategic Planning Groups and over time, there may be changes and additions. The recent announcement by the Scottish Government to invest in the 'Reshaping Care for Older People' agenda[6] now means that Highland's strategy for older people's service will be more ambitious and this will be taken account of in setting up the new strategic planning group for this important area of work.

5.2.5 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes that are owned by one or more of the Community Care Strategic Planning Groups. These have yet to be fully fleshed out and will be supported by clear action planning processes.

[6] Further information can be accessed online at **www.scotland.gov.uk/Topics/Health/care/reshaping**

CHART 3: Joint Governance Structure



6. Delivering the Outcomes that People Seek

A' Lìbhrigeadh nam Builean a bhios Daoine a' Sireadh

6.1 People are healthy and have a good quality of life

6.1.1 Community Care services in Highland will promote the quality of life of the people we work with and for people to live as long, healthy and active lives as they can.

6.1.2 To achieve this will mean making sure people know how they can stay fit and healthy and ensuring that the services which prevent difficulties and promote independence are in place.

6.1.3 We need to ensure that we provide people with the right help quickly when they need it, so that their health does not deteriorate. When people do have longer-term problems, we must plan in advance what might go wrong, how services can work jointly to help them, and what steps people themselves can take in managing their own conditions.

6.1.4 We also want to help people to recover where they have had ongoing challenges to their health and well-being. This may be from an enduring mental health problem or as a result of an addiction to alcohol or drugs. We know that medication can help, but services should also focus on the other areas which have been shown to make a difference, for example, helping people to develop hope, purpose, relationship-building and their ability to manage their own lives.

6.1.5 In our consultation, people told us:

- the best way of finding out what individuals need to remain independent and to identify potential problems and solutions is at a local level;
- anticipatory care, together with health promotion, can prevent individuals losing their confidence and independence; it is also essential in helping prevent a crisis that might be very difficult for someone to recover from; and
- preventive services are important so that people can be helped to maintain their independence and any problems identified and responded to at an early stage.

6.1.6 In our consultation, people told us:

- *the best way of finding out what individuals need to remain independent and to identify potential problems and solutions is at a local level;*
- *anticipatory care, together with health promotion, can prevent individuals losing their confidence and independence; it is also essential in helping prevent a crisis that might be very difficult for someone to recover from; and*
- *preventive services are important so that people can be helped to maintain their independence and any problems identified and responded to at an early stage.*

THE OUTCOMES THAT PEOPLE SEEK:

- People's health needs are met at the earliest stage and at the most local level possible.
- People's health needs are anticipated and planned.
- People are supported to recover from ongoing and enduring illness, mental illness and drug dependency.

6.1.7 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes:

PEOPLE'S HEALTH NEEDS ARE MET AT THE EARLIEST STAGE AND AT THE MOST LOCAL LEVEL POSSIBLE
People with alcohol and substance misuse problems benefit from an appropriate 'brief intervention' approach.

continued...

People are able to access local Community Care services through District Teams.
People with a mental illness receive early and aggressive intervention using psychological as well as pharmacological treatments.
People with a mental illness are able to access safe and supportive environments outwith a hospital setting to promote recovery and reablement.
Carers receive good medical information for themselves and the person they provide care for.
People benefit from accessing high quality public health, safety and welfare advice.
PEOPLE'S HEALTH NEEDS ARE ANTICIPATED AND PLANNED FOR
People with a long-term condition are supported proactively by co-ordinated services.
People who have potentially high needs are supported with anticipatory care plans.
People who have a learning disability receive regular, proactive health screening.
Carers are offered training in the management of disability and potential conflict with the self-determination of the person they care for.
PEOPLE ARE SUPPORTED TO RECOVER FROM ONGOING AND ENDURING ILLNESS, MENTAL ILLNESS AND DRUG DEPENDENCY
People with a mental illness receive help from services that have a clear recovery ethos.
People who have substance misuse issues receive help from services that have a clear recovery ethos.
People with a degenerative condition and their families are able to access appropriate psychological support.

6.2 People are supported and protected to stay safe

6.2.1 Individuals who provide support to people in need must often help them to assess and manage the risks that they take, thus allowing them to live the lives they want to live without being unnecessarily restricted. To do this successfully often requires working with people to gain and retain the skills and confidence they need to keep themselves safe. This can be particularly important after a period of ill-health, crisis or hospitalisation.

6.2.2 Our supports must also try to ensure that people in need and their carers have the opportunity to create or access the safe and secure environments they would wish to live in. The quality of the Community Care services we provide in Highland plays an important role in contributing to availability of those environments. Furthermore, we aim to support more people with the most challenging needs locally.

6.2.3 A number of people in our communities, including those who have a learning disability, mental health problems or who are frail, can be less able to protect themselves from risk of harm than others. Harm may be inflicted by others who deliberately seek to harm them or occasionally by those who can no longer cope with the burden of their care.

6.2.4 It is important therefore that professionals who work with adults at risk of harm are alert to the potential dangers of harm in all its guises and are available to respond speedily, effectively and jointly to protect adults from suspected harm. In Highland, a multi-agency Adult Support and Protection Committee oversees policy and practice in this area.

6.2.5 In our consultation, people told us:

- *services, such as physiotherapy, that enable people to regain and retain mobility, need to be in place much faster for people who can quickly lose their confidence;*
- *service providers need to communicate between each other to prevent people getting into difficulties; and*
- *being bored and having nothing to do is very destructive to people's wellbeing.*

THE OUTCOMES THAT PEOPLE SEEK:

- People gain and retain the skills which keep them safe at home and in the community.
- People are supported to stay safe through the operation of our policies and procedures.
- People with complex and challenging needs are supported to stay safe.

6.2.6 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes:

PEOPLE GAIN AND RETAIN THE SKILLS WHICH KEEP THEM SAFE AT HOME AND IN THE COMMUNITY
Risk enablement is the basis of transition planning.

continued...

Rehabilitative and reablement intensive supports are available to respond to urgent need.
People are supported by services that have a clear reablement ethos.
Adults at risk of harm are empowered to protect themselves.
Use of Telecare and Telehealth solutions is increased.
Telecare response options are enhanced.
PEOPLE ARE SUPPORTED TO STAY SAFE THROUGH THE OPERATION OF OUR POLICIES AND PROCEDURES
Systems and processes are in place to protect adults at risk of harm.
All relevant staff are appropriately trained in Adult Support and Protection processes.
People who are in urgent need are able access 24x7 monitoring and response co-ordination through the NHS Highland's Out of Hours Hub.
People who have a hearing impairment or who are visually impaired are supported to ensure appropriate safety and warning equipment is fitted in their homes.
Effective integrated care pathways offer a flexible range of services from assessment to recovery for those with alcohol and drug dependencies.
People who have an acute mental illness receive appropriate support from trained workers.
PEOPLE WITH COMPLEX AND CHALLENGING NEEDS ARE SUPPORTED TO STAY SAFE
Adults with challenging behaviour are supported in environments which are as safe and unrestrictive as possible.
New models of sustainable community living are established.

6.3 People are supported to maximise their independence

6.3.1 Nobody wants to become ill or dependent on others and those who require our support tell us loudly that they would like to be able to use the skills they have as much as possible. We must therefore target our efforts to make sure that:

- people benefit as much as possible from the existing range of community-based services and activities which provide the foundation for community living. In particular, we recognise the critical importance of having access to appropriate housing which complements people's abilities and promotes their potential for independent living;

- we provide the right help at the right time to prevent difficulties worsening and people's capacity for community living becoming compromised. We recognise that the speed of delivery of preventative help is often a key factor in whether people can continue to live at home or need to be looked after in hospitals or care homes; and
- we retain a strong focus on the outcomes of our support. We need to know that our work is appropriately targeted; that we are having a real, positive impact on the lives of service users and carers; and that service users are active participants in that endeavour.

6.3.2 In all of the above, we recognise the huge role that carers play in supporting community living for adults in need in Highland. We see adult carers as our partners in Community Care and understand the imperative of valuing and listening to their opinions and supporting them to cope with their caring role.

6.3.3 In our consultation, people told us:

- *early advice and support can prevent people losing their homes or having to go into care or into hospital;*
- *there should be more information about what to expect to happen after a diagnosis of a long term condition such as dementia;*
- *carers' ability to care needs to be monitored to ensure that they are coping and do not encounter a crisis; and*
- *lack of affordable housing is a major issue and it is important to plan any new housing so that it is suitable for changing need and with support in mind.*

THE OUTCOMES THAT PEOPLE SEEK:

- People remain at, or return, home with appropriate support.
- Carers feel able to continue in their caring role.
- People have access to appropriate housing which maximises their independence and wellbeing.
- People are active participants in meeting their own care needs.

6.3.4 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes:

PEOPLE REMAIN AT, OR RETURN, HOME WITH APPROPRIATE SUPPORT
People who have a physical disability receive focused environmental assessment and appropriate and timely adaptation, equipment or Telecare services.

continued...

Older people receiving a Care at Home service benefit from a greater focus on rehabilitation and enablement.
Older people receiving a Care at Home service benefit from a greater range of flexible supports.
The purpose and functions of Care Homes are reviewed and a programme of modernisation implemented.
New models of sustainable community living are established that enable people to return to Highland.
CARERS FEEL ABLE TO CONTINUE IN THEIR CARING ROLE
Carers' ability to provide care is assessed and supported.
Carers and the people they care for are able to access planned and regular short respite breaks.
Carers have the opportunity to learn skills to enable them to fulfil their caring role.
Carers have the opportunity to learn self-help skills.
An assessment of the health and capacity of carers is included as part of the wider service user assessment.
PEOPLE HAVE ACCESS TO APPROPRIATE HOUSING WHICH MAXIMISES THEIR INDEPENDENCE AND WELLBEING
People benefit from a range of appropriate housing and support solutions, including having greater access to 'mainstream' housing.
Housing is available that is suitable for changing mobility and provides flexible use of space for the changing needs of older people and those with physical disabilities.
People are able to access a range of care and repair and handyperson services that support them to live at home.
House moves are well-informed and planned and support access to services where necessary.
Land allocation and planning processes help to ensure that housing suitable for those with support needs are located close to services and families.

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PEOPLE ARE ACTIVE PARTICIPANTS IN MEETING THEIR OWN CARE NEEDS
Self management of people who have long term conditions is supported by staff with appropriate knowledge and skills.
Partnership working is developed between health, social care and voluntary organisations to support the self management of those with long term conditions.
People who have dementia will receive an early diagnosis and are engaged in the management of their condition.
Young people and their families benefit from effective transitions processes.

6.4 People retain dignity and are free from stigma and discrimination

6.4.1 We know that discrimination and inequality can damage people's health, wellbeing and confidence and must be tackled if we are to make a difference to the health and wellbeing of people in Highland.

6.4.2 Equality is not about treating everyone the same but it is about treating everyone with the due dignity and respect that they deserve. It is also about making sure that, as far as possible, everyone has the same opportunities in day-to-day life.

6.4.3 High levels of inequality are also reflected in the impact that poverty has for a number of disadvantaged groups. Increasing the resources people have at their disposal is associated with better well-being and increases the opportunities they have to participate in the life of their communities.

6.4.4 In our consultation, people told us:

- *there is a need to make sure that everyone knows they can have a voice and be equal. People should be encouraged to speak up and feel positive about themselves;*
- *in order for communities to be free from discrimination and stigma, staff need to be trained appropriately to deliver services in a caring way and feel confident to challenge discrimination and report any discomfort to those in charge to appropriately deal with it;*
- *lack of money is a barrier to living independently; and*
- *for everyone to be treated with dignity, respect and to be valued, this needs to one of the main outcomes the plan.*

THE OUTCOMES THAT PEOPLE SEEK:

- People are supported to tackle stigma and discrimination.
- Our services and those we commission actively promote equality.
- People's incomes are maximised.
- People receive the supports which allow them to retain their dignity.

6.4.5 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes:

PEOPLE ARE SUPPORTED TO TACKLE STIGMA AND DISCRIMINATION
Anti-discriminatory practice is actively promoted through quality staff training and development.
Individuals and groups have the opportunity to identify their own issues and take action, accessing independent and collective advocacy as appropriate.
OUR SERVICES AND THOSE WE COMMISSION ACTIVELY PROMOTE EQUALITY
The effects of our services are routinely assessed for differential impact with respect to equalities groups.
Commissioned services are monitored for their ability to provide an equitable service to all equalities groups.
Reasonable adjustments are made in providing care to meet the needs of people with a learning disability.
Staff receive training around rights and needs of people who have a learning disability.
PEOPLE'S INCOMES ARE MAXIMISED
People are signposted to and supported to access income maximisation information and advice.
Carers get good information about financial and welfare benefits.
Benefits checks are routinely undertaken as part of the assessment process.

continued...

PEOPLE RECEIVE THE SUPPORTS WHICH ALLOW THEM TO RETAIN THEIR DIGNITY
Best practice in Adult Support and Protection is supported by policies and procedures.
Staff are appropriately trained to ensure best practice in relation to Adult Support and Protection services.
Best practice is supported by quality staff training and development.
Carers are listened to by professionals and their knowledge about the person they care for is respected.

6.5 People and their carers are informed and in control of their care

6.5.1 Information is key to many aspects of life these days and this is also true of Community Care. Our consultation with service users and carers pointed to the high importance they placed on clear communication so that people know who to speak to, what services are available and how to access them.

6.5.2 We believe there is a link between service users and carers having good quality information and them making the choices that are right for them about lifestyle, self-care and any support they are entitled to.

6.5.3 We have a long history of providing the services that we think people want and need. We haven't always got that right. In future we want the people who use Community Care services and their carers to know what their options are and to be able to choose what services they use and how they are delivered. This will mean:

- giving people support to use a direct payment (money the Council can give them to pay for their own care if that's what they want to do);
- using Personal Planning to help people to draw up their own plans for support; and
- making sure that the people who use Community Care services and their carers are involved in all the decisions that need to be made, whether at a personal level or how we provide services more generally.

6.5.4 In our consultation, people told us:

- *more information about what to expect to happen to their health and support available after a diagnosis of a long-term condition such as dementia would help them cope and plan much better;*
- *in terms of risk management, there needs to be a more flexible and common sense approach to people living their own lives and making their own decisions; and*
- *people do not know what services are available and how to access them.*

Service providers themselves need to have a better awareness in order they are able to signpost people to the help and support they need.

THE OUTCOMES THAT PEOPLE SEEK:

- People know how to stay as healthy and fit as possible.
- People are in control of decisions that are made about their care and the care that they receive.
- People know about the services we provide and how to access them.

6.5.5 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes:

PEOPLE KNOW HOW TO STAY AS HEALTHY AND FIT AS POSSIBLE
People with a long-term condition are able to access information about their condition.
Communities feel engaged and empowered to make healthier choices, including choices that relate to alcohol and drugs.
A programme of public awareness work is delivered around Adults Support and Protection principles.
Older people are well-informed about opportunities in retirement.
Older people are informed on how to minimise the risk of a fall.
PEOPLE ARE IN CONTROL OF DECISIONS THAT ARE MADE ABOUT THEIR CARE AND THE CARE THEY RECEIVE
Carers receive clear information from professionals about the matters that affect them.
Individuals and carers have access to advocacy services.
People who have a learning disability are actively involved in personal planning processes.
Citizen advocacy services are developed.
Assessment and intervention processes facilitate and reflect the management of risk by the service user and their carer.
People who are assessed as needing services have the opportunity to access a range of self-directed support options.

continued...

Carers are involved in shaping polices and the services we collectively deliver.
PEOPLE KNOW ABOUT THE SERVICES WE PROVIDE AND HOW TO ACCESS THEM
Young adults, their carers and families are confident that there is a robust plan for future needs.
Information about Community Care services is broadly disseminated through a broad range of media.
Information about transport schemes and opportunities are made accessible to 'harder to reach groups'.
Information about the opportunities which exist for community members to participate in a range of community initiatives is actively promoted.
People are signposted and supported to access information technology and/or the internet to obtain relevant information about the services that are available to them.

6.6 People are supported to realise their potential

6.6.1 People have told us that there is a danger that they can be simply seen by service providers as a 'bundle' of personal care and medical needs waiting to be met; people want to be seen and listened to as the individuals they are, holistically.

6.6.2 As people make plans for their lives ahead with the assistance of a Community Care professional, they often want to address all the components of a successful and fulfilling life. Invariably this will mean thinking about having something interesting to do, and seeking to achieve their potential in areas that are important to them.

6.6.3 In many of the current support services we provide, there is work done on a day-today basis to support people with emotional and social development. We want to make sure that that this help is targeted to ensure that it has as positive an impact as possible on people's lives, ensuring that people are as active participants as possible in the world around them. We want to ensure that the identified outcomes relate to increased self-sufficiency and the achievement of personal goals

6.6.4 In the area of skills development, we recognise the need to bring together a flexible framework which will allow people of different abilities to translate their efforts to develop personal and social skills into the achievement of a set of competencies associated with self-reliance, participation and, ultimately, employment.

6.6.5 In our consultation, people told us:

- *being supported to realise their potential is essential to being able to progress and develop and living fulfilled and healthy lives. However, people felt that there were very few appropriate opportunities available to those needing support to get them started;*
- *there is a need to develop mentoring and befriending schemes to give people the support they need to get started and succeed;*
- *there is a lack of promotional information about community activities available and service providers are not aware themselves what is available; and*
- *service providers could play a key role in signposting people to activities.*

THE OUTCOMES THAT PEOPLE SEEK:

- People have access to training, employing and volunteering opportunities.
- People have access to a range of community-based development opportunities.

6.6.6 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes:

PEOPLE HAVE ACCESS TO TRAINING, EMPLOYMENT AND VOLUNTEERING OPPORTUNITIES
Young people and their families benefit from the implementation of Self Directed Support and 'More Chances, More Choices'.
Young adults 'in transition' have access to supported planning processes.
People who have a Learning Disability have access to tailored education opportunities to develop skills, confidence and self esteem.
People who have a physical disability have support to engage in training, employment or voluntary work.
Users of Community Care services have access to structured, modular training programmes to achieve competencies associated with occupational activities and participation.

continued...

PEOPLE HAVE ACCESS TO A RANGE OF COMMUNITY-BASED DEVELOPMENT OPPORTUNITIES
Effective integrated care pathways offer a flexible range of services from assessment to recovery.
People have access to a wider range of transport that meet their needs.
Opportunities for health promotion, self management, ongoing rehabilitation and development are maximised through community centres and other leisure facilities.
Older people have access to life-long learning opportunities, including courses and classes.

6.7 People are socially and geographically connected

6.7.1 Highland is a huge geographical area with a very low population density. People who live here have just the same need to meet others and get out and about as people living anywhere else. Indeed many people have told us that the opportunity to be socially active is important to them retaining their independence and confidence to live at home.

6.7.2 Transport has always been a challenge in Highland. Anyone who lives outside of Inverness and who cannot afford a car, or whose condition means they are unable to drive, may find it difficult to access community services such as the local doctor or pharmacist. Day-to-day tasks like shopping for food can also be very difficult.

6.7.3 However, we do not believe it is a sustainable role for Community Care services to provide social opportunities or to provide transport for the countless potentially beneficial journeys people make. Rather we see it as our role to support and stimulate a range of voluntary and community-based efforts aimed at providing accessible social opportunities and interesting activities for people living in the community; also to work more closely with our community transport partners to make best use of our combined resources to strengthen the network of routes and resources available to them.

6.7.4 There is also a co-ordinating role for our professional staff to ensure that other provision is linked into these activities; for example, to ensure the dissemination of information about self-care or health promotion or information about opportunities for social interaction and stimulation through courses and classes run by the Council's Education, Culture and Sport Service.

6.7.5 In our consultation, people told us:

“

- *communities could do more to help but only if they get the help and support they need when they request it;*
- *the need for equitable access to transport is a key issue across Highland; and*

- *lunch clubs and other places that offer opportunities for social interaction can make a great difference to the lives of older people.*

THE OUTCOMES THAT PEOPLE SEEK:

- Voluntary and community effort contributes to more supportive communities.
- People have access to a range of transport to maintain their networks.
- People do not become socially isolated.

6.7.6 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes:

VOLUNTARY AND COMMUNITY EFFORT CONTRIBUTES TO MORE SUPPORTIVE COMMUNITIES
Community capacity building and community development is actively supported.
People are able to participate in a range of activities that they find enjoyable and personally fulfilling.
PEOPLE HAVE ACCESS TO A RANGE OF TRANSPORT TO MAINTAIN THEIR NETWORKS
Community Transport schemes and groups are appropriately developed and supported.
The possibilities of Council-run demand-led transport and Community Transport Schemes entering into reciprocal relationships to increase efficiency and flexibility are explored.
The opportunities to transform Council-run, demand-led transport into accessible scheduled services are fully explored.
Information about availability and how to use existing public and community transport networks is fully disseminated to people with support needs.
PEOPLE DO NOT BECOME SOCIALLY ISOLATED
The appropriateness of all out of area placements is reviewed and locally-based services developed.
Carers have the opportunity to talk to other carers.

People and their carers have opportunities to use the internet, teleconferencing and other information technology systems to facilitate local and national networking.

Older people have opportunities to maintain and create new relationships through a range of community-based and voluntary sector-led social networking activities.

6.8 Community Care services are delivered effectively, efficiently and jointly

6.8.1 To deliver the outcomes that people seek requires staff from the Highland Council and NHS Highland to work closely together. Professionals have different skills and abilities, and indeed work in different ways. To be truly effective, they need to be part of a single and co-ordinated helping effort which brings with it less bureaucracy and more freedom to get on with helping people who need Community Care services. Local, joint decision-making should mean that resources can be brought to bear more quickly and ensure that more people get the right help at the right time.

6.8.2 Local supports, including family, neighbours, Health, Social Work and Housing services, and the way these work together, play a key role in helping people stay in their own homes for longer.

6.8.3 Highland as a whole needs to understand that by spending money in the way it currently does means that it misses the opportunities to do other things that might work out better in the longer term. Work is underway to give partners a much clearer idea of what their choices are, and how they could jointly realign their budgets to improve the care of individuals and of the whole population. The aim will be to increase outcomes, efficiency and equity across areas.

6.8.4 In our consultation, people told us:

- *better ways of identifying who needs help in communities need to be developed in partnership with all service providers, the voluntary sector and communities;*
- *communication between Highland Council and NHS Highland is essential in ensuring continuity of care and anticipating the changing needs of people who use Community Care services; and*
- *closer, more meaningful working, including representation from communities in decision-making bodies, is needed.*

THE OUTCOMES THAT PEOPLE SEEK:

- Care is delivered using joined-up, core processes.
- Resources are accessed quickly and equitably.
- Decisions about the allocation of resources are made jointly.

6.8.5 To deliver on each of these key outcomes, we have identified a set of Delivery Outcomes:

CARE IS DELIVERED USING JOINED-UP, CORE PROCESSES
The transitions bridge and interactive guide are further developed.
Staff are competent and confident in supporting people with alcohol and drug dependencies.
The Care Programme Approach[7] for people with complex needs is developed and implemented.
Health and social care plans are available electronically.
Evidence-based staff training is promoted to support rehabilitation services.
Up to date patient pathways are in place for each Long-Term Condition.
A single pathway and single point of access is created for rehabilitation services.
Care is delivered from within a single pathway across Community Care.
Reviewing processes are streamlined.
Information systems are developed and maintained around interventions under adult support and protection legislation.
RESOURCES ARE ACCESSED QUICKLY AND EQUITABLY
Equitable weighted per capita resources are identified for each care group.
Clinical guidelines are implemented and take account of the needs of people with learning disabilities.
Resource allocation processes are streamlined.
DECISIONS ABOUT THE ALLOCATION OF RESOURCES ARE MADE JOINTLY
Financial resources for health and social care are devolved where possible to District level.
Extended Community Care teams are developed and working.

[7] The Care Programme Approach or CPA is a way of co-ordinating community health services for people with mental health problems

NOTES

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To request this information in an alternatve format
e.g., large print, Braille, computer disk, audio tape,
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