APPENDIX 1

Reshaping care for Older people Consultation Feedback
We Asked, You Said, We Did…

As part of a wide scale review of care and support for older people across the Falkirk district, the Falkirk Partnership, which has been formed between NHS Forth Valley, Falkirk Council, CVS Falkirk & District and Scottish Care ,have been working with communities, community groups, third sector organisations, private sector providers, to gather information about what you feel our priorities should be and how we can improve services over the next 3 years.

In order to do this, the Partnership ran 2 large events and 5 smaller discussion groups across the Falkirk area. A total of 140 people took part in these events. We also gathered views through online and paper-based questionnaires and presented information to various forums across the Falkirk area for example, the Community Care and Health Forum.

A number of key themes emerged during the process which we have summarised below and have developed in more detailed in the following sections of this report. It should be noted that here was some overlap between the responses received for each discussion point. The key themes are:

- Older people should recognised as an asset to communities and not treated as a burden
- Agencies should work together more effectively to deliver care in a more integrated way.
- Organisations and their staff need to develop the appropriate skills to engage with and provide care for older people their carers and families.
- We need to develop a more person- centred approach that meets the needs of individuals.
- Services should share information where appropriate and ensure people are aware of what is available.

NHS Forth Valley

CVS Falkirk and District Partners for the Future

ScottishCare The voice of the Independent Care Sector in Scotland

Falkirk Council

The Vision & Draft Joint Commissioning Plan	
We Asked Questions about…	**You Said…**
Your general views on the vision and draft plan. **Vision:** *To enable older people in the Falkirk Council area to live full and positive lives in their own homes or when this is not possible, within homely settings within supportive communities.*	The general feeling was that the vision and draft plan are heading in the right direction, but there are some significant challenges to be overcome. And a good starting point would be to make sure that the plan is written in clear, accessible language, so that everyone can understand it. The key points were: • Vision is a good start, but it's ambitious. • Maintaining independence is important, but support needs to be in place, based on individual need. • The plan is too complicated – it needs to be written in plain English. • Engagement has been very weak and needs to be ongoing. • Focus on services for adults with complex needs – age is just a number! • Shift 'hearts and minds' – recognise people as assets – help people to not fear becoming older.
We will… • Re-draft a plan that includes your views and comments. • Make sure that the plan is written in plain English, so that it is understandable. • Keep you involved in the process by providing information regularly, and in different formats. • Develop a glossary which explains the meaning of any technical or clinical terms which are used in the plan. • Make sure that the actions within the plan recognise people as assets and ensure that services are planned to suit individual need.	

Preventative and Anticipatory Care	
We Asked Questions about…	**You Said…**
Your views on what Preventative and Anticipatory care means to you and what the plan should include.	There was a lot of discussion about the need to help people to remain as independent as possible, and the important role that communities can play to support this. You made it clear that services should increase independence, not create dependence. The key points were: • Change the title of the section to say what it actually means! (this point applies across a number of sections) • Increase communication, joined-up working and access to services across all agencies. Provide single point of contact – information 'hub'. • Agencies need to work better together to improve services and referral processes. • Provide more activity within communities to help people feel safe, reduce isolation and support healthy living e.g. befriending, inter-generational work. • Support volunteering, community development and community based supports. • Take a person-centred approach which allows choice and ownership of support and care. Services should focus on the needs of individuals – one size does not fit all! • Early intervention, planning and assessment of risk is important – falls prevention, use of technology to link professionals. • Good access to transport is critical.
We will… • Review the title of the section to ensure that it's purpose is clear, for example 'Supporting you to be as healthy & well as possible'. • Highlight and build on the good practice and services that are currently in place in communities, such as volunteering, and community-based networks. • Recognise the importance of supportive communities and provide better information about community-based supports to all partners and within communities. • Work with the local Community Safety Partnership to develop actions which will work towards people feeling safe at home and within their community. • Ensure advice and information about community based supports is easily available and accessible to allow choice. • Make sure that the Partnership adopts a focus on individuals being able to maintain their own health and wellbeing via the range of community based supports.	

Proactive Care at Home	
We Asked Questions about…	**You Said…**
What you feel should be included in Proactive Care and Support at Home.	There was a lot of discussion about the need to help people to remain as independent as possible, and the important role that communities can play to support this. You made it clear that services should increase independence, not create dependence. And you said that technology could be really useful, but we need to make sure that it does not replace face-to-face care and support. The key points were: • Recognise what we do well already. • Plan services around the needs of the individual to recognise the complexity of individual conditions and without artificial age limits. • Person centred approach – acknowledge that home based care is not always best – it can depend on condition. • Assessment processes should be connected, clear and faster – agencies need to act before the situation becomes a crisis. • Assessment and planning should consider carers and ensure that they are supported as quickly as possible. • Make sure that carers will feel supported and able to manage their own health and wellbeing. • Make sure that people are aware of the support & service options available to them and are able to make their own choices. • Increase activity to keep people healthy, well, safe and independent – ensure people do not become 'prisoners in their own home'. • Recognise the role of all partners in providing services e.g. voluntary and community sector. • Respite care – essential for service users and carers. • Make better use of technology to provide services (e.g. Mobile Emergency Care Service) and to link agencies through shared systems. • Increase amount of suitable housing which has been planned/designed for older people. • Adaptations and equipment should be timely and fit for purpose. • Sufficient transport links within communities and to Forth Valley Hospital are crucial to access and mobility. • Ensure that people are safe from financial and physical abuse.
We will… • Review the title of the section to ensure the purpose if clear, for example 'Supporting you to be as independent as possible' • Involve all the relevant partners, to look at what we can do to improve accessibility of pavements, shops, buildings and transport. Some of these issues are beyond the powers of the Partnership, but we can try to work with private businesses, such as shops and bus companies, to tackle them. • Prioritise the development of assessment and care plan arrangements, which put the person at the centre of the planning process, responds before points of crisis and enables agencies across all sectors to work together effectively. • Through Self Directed Support, we will ensure the co-creation of personal care plans and help people understand the options available to them through personal budgets. • Review and develop day services to provide a range of options.	

- Provide information that explains types of technology and how it may be introduced and used to improve services rather than replace them.
- Set out the local model of specialist housing.
- Provide information and support to enable people to make choices on suitable housing ,equipment and adaptations to meet assessed need.
- Implement the Forth Valley Carer's Strategy and Falkirk's local Carer's Action Plan.

Effective Care at Times of Transitions	
We Asked Questions about…	**You Said…**
Effective Care at Times of Transition; What does this mean to you and what should we include?	There was a lot of discussion about the importance of joined-up services which are available when people need them. You emphasised the challenges of the points where things change – often these happen when there is a crisis, which makes everything more difficult. There was a clear concern that people whose lives are changing should not have to worry about which service is helping them, or providing the same information over and over. The key points were: • Faster responding, consistent service - 24 hours 7 days per week – this may reduce the number of emergency admissions. • Out of hours service – consider role of e.g. paramedics, district nurses – could roles be enhanced/changed to prevent admission? • Improved information sharing between agencies and services – people should not be asked same question multiple times! • More integrated, seamless service – ONE service - service users shouldn't notice when they are moving between service providers. • Assessment process should be faster to respond to changing needs – before it becomes a crisis. • Take a key worker approach. • Providers of care across all agencies should be trained to provide appropriate care and be sensitive and respectful of individual requirements – e.g mental health, learning disability, dementia, Parkinson's. • Consider individual needs and recognise strengths – keep people independent - don't make them dependent. • Recognition that transition is stressful for service user and carer – consider the needs and views of carers and families. • Services must focus on rehabilitation and recovery. • Provide more regular, scheduled medication reviews as part of care plans. • Faster access to the same GP – consider how triage services can be used to support. • Self Directed Support – real opportunity for people to maintain ownership of care/support.

We will…

In addition to points highlighted within the previous section:

- Review the assessment process to ensure that it is proactive avoids duplication, reduces in need for repetition, is provided in a more integrated way, includes the key worker approach, involves patients, carers and reflects a more person centred approach.
- Include actions that focus reviewing current work patterns across the Partnership to consider how we can adapt services to provide consistency across the week and ensure that any change is based on evidence.
- Support and build connections between services across the Partnership to ensure that referrals and transitions are more effective

- Improve the medication review process as part of care plans, including the role of partners.
- Produce guidance and information for communities about using medication.

Hospital & Residential Care	
We Asked Questions about…	**You Said…**
What we should be focussing on in relation to Residential & Hospital Care?	There was a lot of discussion about the importance of avoiding hospital admissions where possible, and of helping people to move back home as quickly as possible, with the right support to help them recover. You emphasised the importance of health and social care agencies dealing with these issues constructively, given the difficult financial climate. There was also a concern about some specific aspects of Forth Valley Hospital itself, particularly in relation to physical access and signposting. The key points were: • More individual care planning is required at a stage well before crisis and to ensure that hospital and residential admissions are planned. • Anticipatory care should reduce admissions – however some emergency admissions are inevitable. • New carers should be identified and supported from the point of admission, not discharge. • Respite care is important and may help prevent emergency admissions. • Provide training and education for staff in how to help people to regain their independence, and extend this to carers and families. • Increased use of technology is positive if adding to services rather than replacing. • Consider the role of GPs and District nurse, Geriatricians, Occupational Therapists, and Physiotherapists in the community. • Whole systems redesign required – improve processes rather than increase provision. • Focus on outcomes rather than number based outputs. • 24/7 service provision – why not? • Improve access within Forth Valley Hospital for example signposting to departments, colour coding in corridors.

We will…

In addition to points highlighted within the previous sections:

- Give priority to improving joint working between hospitals and community based services to increase continuity of care, reduce admissions and delays in discharge.
- Ensure that the admission, patients journey through hospital and discharge to appropriate care is improved and person centred.
- Further develop appropriate respite care that is proactive, linked to anticipatory care planning and prevents crisis situations arising.
- Develop community based dementia services to support older people with dementia and their carers through diagnosis and beyond.
- Action a medium term plan which will re-design residential care and housing with care.

Moving Forward…..	
We Asked Questions about…	**You Said…**
How we can make sure that the plan becomes a reality.	There was a lot of discussion about how important it is to change the culture within agencies, but also that this is a challenging, long-term process. You particularly emphasised the importance of much better communication between agencies, and with service users and carers. And you also stressed the potential benefits of involving service users and carers in monitoring and evaluation as well as future service planning. The key points were: • Have a common purpose - all Partners need to agree and work towards vision. • Ensure high level buy-in (Chief Exec, Board and Elected Member) of consultation outcomes to ensure it is incorporated into JCP. • Establish manageable action plans with relevant and meaningful performance indicators. • Communication needs to improve between partners and also with service users, carers, families and wider community. • Shared information systems – overcome data protection barrier. • Clarify roles across partners and make accountability clear. • Involve communities in the evaluation of actions. • Ongoing engagement of local people – service users, carers and families - move from representation to participation. • Learn from previous change processes e.g. children's services and GIRFEC. • Give services the capacity to respond to change - educate and raise awareness across all partners. • Develop and support our workforce to adapt practice towards proactive services e.g. reablement, fall prevention. Change perceptions and attitudes of staff through workforce development.

We will…

- Communicate the Partnership vision, plans and actions across the Partnership to ensure that we are working to common purpose.
- Produce a revised plan and a clear set of actions which incorporates feedback from consultation.
- Ensure that partners are aware of and understand the plan in order for wide scale support and ownership across all stakeholders.
- Implement a workforce development plan which will ensure that staff across all partners have access to information and training.
- Develop an action plan for ongoing engagement across partners and communities that includes input to future service design, monitoring and evaluation.
- Make better use of the information that we collect through shared systems.