APPENDIX 2

Falkirk: A place to Live Well

Falkirk Partnership

STRATEGIC JOINT COMMISSIONING PLAN FOR OLDER PEOPLE 2014 - 2017

Contents

JOINT STATEMENT

Falkirk Partnership is committed to making sure that services and supports for older people, their carers and families are high quality and accessible to the right people at the right time.

We understand that there are a number of critical factors in being able to achieve our strategic vision which is "**to enable older people in 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."**

Our partnership approach is well developed and over the past year we have worked together as statutory services, Third and Independent sectors with older people and their carers to develop our Joint Commissioning Plan.

Through this work we understand that the critical success factors to achieving our vision include:

- Putting older people, their carers and families at the heart of service design and development;
- Taking an asset based approach to service development, which recognises the wealth of our communities;
- Recognise the importance of independence by focussing on re-ablement, rehabilitation and recovery;
- Taking innovative approaches to the way that we collaborate within the partnership, including the way that we use physical resources such as buildings;
- Communicating frequently in a way which is accessible and understandable, and allows an ongoing, two way dialogue.

We are therefore committed to delivering the outcomes set out within the Joint Strategic Commissioning Plan for Older People.

Introduction

The Joint Strategic Commissioning Plan has been prepared by the Falkirk Community Planning Partnership to describe our shared view of how care services and supports for older people, their carers and families need to change over the next 3 years (2014-2017) and beyond.

The Partnership recognises that we need to work together to provide co-ordinated care and support for older people, their carers and families living in the Falkirk area. In order to ensure that the right health, social care and housing support is available, partners within the statutory, third and independent sectors must continue to work together – and for this to happen all partners will be working to a common vision and set of aims, objectives and outcomes- using their skills and resources in joined up ways.

What will the plan do?

The Strategic Joint Commissioning Plan for Older People's Services sets out:

- Our vision for Falkirk as a place to live well
- Why change is necessary
- What people told us about the supports and services that are important
- The policy and planning context
- Our priorities and how we will action these.

How has the plan been developed?

NHS Forth Valley, Falkirk Council, CVS Falkirk and District and Scottish Care have worked closely together to develop the plan. We have considered changes that will have an impact on the services that we currently deliver. This includes an increasing population of older people who are living longer and have increased and changing expectations, health inequalities and disease, policy that will affect services (for example the Integration of Health and Social Care and Self Directed Support), and the ongoing constraints set by the economic climate.

The priorities and actions have also been informed by gathering feedback from the wider third and independent sectors and, most importantly, from older people, their carers and families. We asked communities and partners who deliver services for their thoughts on the draft plan, through a series of events, discussion groups and presentations across the Falkirk Council area.

Through consultation, we know that communities are keen to be involved in service design and evaluation. We have developed a plan for communication and engagement which sets

out ongoing discussion with older people, and their carers and families so we can all be confident that we are moving in the right direction, getting the best value from all our resources, and achieving the outcomes that deliver the best possible quality of life for older people whatever their health and social care needs.

The plan has also been approved by Elected Members, the Community Planning Partnership Leadership Group and Falkirk Council and NHS Partnership Board.

Our Vision

Our vision for Falkirk is "**to enable older people in 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 Joint Commissioning Plan, sets out priorities and actions which will enable partners to continue to make progress towards achieving the vision, within the initial 3 year period.

We recognise that to deliver this ambitious vision will require substantial changes to both attitudes and the way that services are delivered and that organisations, individuals and communities will need to embrace change. We will need to shift investment from reactive, crisis driven actions that can lead to dependency, to actions which enable people to have ownership of their own wellbeing and care, and that support their well-being and independence.

We know the biggest concerns for older people are isolation, personal safety, feeling connected and being valued. As these are major factors in determining health and care needs, our aim is to address these for all older people.

We also know that overall older people provide far more care than they receive. Across Scotland approximately 20,000 people over 65 years receive more than 20 hours home care per week while over 40,000 provide more than 20 hours unpaid care per week. Older people are an asset not a burden and we must work to ensure their important contribution can be sustained and developed alongside wider community supports.

The changes that we would like to see happening within the Falkirk Council area through the delivery of the plan over the next 3 years are:

- Older people and their carers have control over their own health, care and well being through a range of community based services;
- Older people live in a homely environment within a supportive community, in order to avoid unnecessary admissions to care homes or hospitals;
- Older people, their carers and families will have control and choice over decisions about their care, particularly at times of transition;
- Supports are in place to ensure that older people are not admitted to hospital where this is not appropriate and that discharge is not delayed.
- An enabling infrastructure of integrated working practice across all partners and communities is in place to underpin and support the pathway of care.

These changes are included within the Community Planning Partnership's Single Outcome Agreement (SOA).

Why Change is Necessary

In Falkirk, we are aware that we are faced with a number of challenges that mean that the demand for health and social care services has been and will continue to substantially increase. The possibility of delivering the same level of services to a greater number of people with increasingly complex needs is not financially feasible. Quite simply, we will not have the resources to be able to deliver health and social care in the current reactive way.

The key challenges that we face are summarised below.

Falkirk's Older Population

In 2013, there are approximately 26,278 people aged over 65 living in Falkirk, which is 17% of the total area population (currently 155,705). By 2035 it is projected that 42,708 people will be aged 65 or older, accounting for 25%, a quarter of the total population in the Falkirk area.

Life Expectancy

A major challenge is the growing number of older people, who are often living with multiple long term conditions, some of which may be caused by a combination of living longer and lifestyle choices.

Life expectancy is an estimate of how many years a person might be expected to live, and healthy life expectancy is an estimate of how many years a person might live in 'full health'. The difference between these figures can provide an indication of the level of demand that may be put on services. Over recent years, life expectancy has increased in Falkirk and it is predicted to continue to rise.

Falkirk males have a difference of 10 years between healthy life expectancy and life expectancy. Falkirk males are expected to live until 76.4 years, however, from 66.4 years of age they are expected to require some form of health or social support. Females in Falkirk have a difference of 10.9 years between Healthy Life Expectancy and Life Expectancy.

Lifestyle Choices and Disease

There is an expectation that the 'burden of disease' will continue to increase proportionally as the number of people living longer over the age of 65 continues to rise. This could be significantly exacerbated by the lifestyle choices that people make, such as unhealthy eating, excessive alcohol consumption and smoking, which may result in an increase in the number of people diagnosed with diabetes, heart disease, cancer and arthritis. This will have a significant impact on service provision.

It is estimated that during the 3 years of this plan, heart disease will increase by 7%, stroke by 8% and dementia by 9%. This will have a significant impact on service delivery and how older people are supported fully for as long as possible in their communities.

Hospital Care

The commissioning of Forth Valley Royal Hospital during 2011 was the final stage in a significant disinvestment in acute bed numbers, with Forth Valley now having the lowest number of acute beds per 1,000 of population in Scotland. It is therefore critical that we work to minimise emergency admissions and ensure patients are able to be discharged from hospital as quickly as possible, meeting the national Delayed Discharge target. It is recognised that there are some patients with high level needs whose discharge will take longer to arrange and therefore the standard maximum delay is not always applicable.

Financial Framework

In order to best inform planning and decision making, the partnership will consider the most effective ways to make better use of resources across health and social care. Difficult decisions on service priorities will be required due to the combination of increased demand for services from an ageing population and a prolonged period of severely constrained public spend, including the requirement to generate significant cash releasing savings year on year. In real-terms, reductions in public expenditure are now estimated to be required until at least 2017/18, which makes our challenge greater.

What people told us about the supports and services that are important

To develop the plan, we have been working with communities, community groups, third sector organisations, independent sector providers, Housing Associations, NHS Forth Valley and Falkirk Council to gather information about what our priorities should be and how we can improve services over the next 3 years.

The consistent themes that were raised as being important are:

Planning services around individual need

People are very clear that one service does not fit all. Services have to be planned and adapted to suit the needs of individuals. Individuals, their carers and families should have choices about which services that they would like to access and have a say in their own care plan.

When more formal health or social care is required, people would like care plans to be developed which recognise them as people instead of an illness or disability, plan ahead and anticipate future needs, and incorporate the choices of the older person, their carer and families.

Within the community, people want to be informed about the range of activities and support services that are available, for example sport, leisure and activity groups, lunch clubs and other day services. This will enable people to choose which supports are most appropriate at any given time and allow people to manage their own health and wellbeing. Older people should recognised as an asset to communities and not treated as a burden.

Within residential and hospital settings, people would like service providers to work together effectively so that individual care plans are transferable across all services.

Working together to deliver services

A great deal of the feedback that we received focussed on the need for agencies across all sectors to work more closely together. People were clear that supports and services should be available when they were needed and that the continuity of care and service should not break down when being delivered by different agencies – service users should not notice when they are moving from services that are being provided by one agency or department to another.

The partnership will ensure this happens by improving assessment procedures and developing better ways to refer and communicate.

Developing our Workforce

There is a broad recognition that we cannot expect services to become more focussed on recovery and keeping people independent for as long as possible, without providing training,

education and support for staff across all agencies, and importantly also to unpaid carers and communities.

The Partnership will action this by promoting the Partnership's vision, making sure that staff across all agencies and communities themselves are aware of, and have access to the plan, and by providing information and training with a focus on recovery and re-ablement.

Keeping you involved

Communities want to be involved in reshaping care for older people. This includes being able to contribute to how services are developed and also to monitor and evaluate how the plan is being taken forward across the Partnership. Communities also want to be more informed about the services and supports that are available to them to enable greater choice and ownership of wellbeing and care. A lot of people told us that there is a need for better communication amongst partners, between staff, with patients and carers and to the wider community.

The Partnership will make this possible by providing regular opportunities for ongoing participation. This will be through regular communication to keep communities informed of progress and developments and also by working with existing groups, organisations and forums with an interest in services for older people to enable input to service design and evaluation. The Partnership has developed a plan for engagement which describes the actions that we will take to keep people involved and informed.

Policy and Planning Context

During the development of the plan, the Falkirk Partnership has taken into account the evolving policy landscape – both at national and local level. This includes the Scottish Government's 2011 vision for Reshaping Care for Older People and the move towards the integration of health and social care services. For example, we recognise that when commissioning services for older people, we must be clear about the outcomes we are working towards and consider how best these can be achieved, supported by an integrated approach – whether this be working collaboratively with partners, or full integration in providing services together. Integration can happen across sectors, organisations and geographies.

The key policies and strategies that we have taken into consideration during the development of the plan are shown in table 1 below and include:

Table 1

National Drivers	Local Drivers
▪ Reshaping Care for Older People ▪ Caring Together ▪ Healthcare Quality Strategy for Scotland ▪ National Dementia Strategy ▪ Self-Directed Support Bill ▪ National Strategy for Housing for Older People ▪ Community Empowerment & Renewal Bill ▪ Equally Well	▪ Strategic Community Plan ▪ Falkirk Council Corporate Plan ▪ NHS Forth Valley Corporate Plan ▪ Forth Valley Carers Strategy ▪ Poverty Strategy: Towards a Fairer Falkirk ▪ Culture & Sport Strategy: Falkirk Community Trust ▪ Local Housing Strategy ▪ Equally Well In Falkirk ▪ Single Outcome Agreement ▪ Falkirk Partnership Change Plan

Reshaping Care for Older People Change Fund

The Scottish Government launched their vision for Reshaping Care for Older People in 2011. Along with the vision, resources have been made available to each Partnership area in the form of a four year Change Fund. The Falkirk Partnership received an allocation averaging £2million per annum between 2011 and 2015. The purpose of the Change Fund is to allow Partnerships to invest in transformational change; to shift the balance of care from reactive, high cost services to supporting early intervention and preventative supports, delivered within the community. It is intended that over the four year period, Partnerships have a commissioning framework which allows disinvestment in some services, to enable ongoing investment in the new model of care.

Falkirk Partnership have allocated funds to a range of projects across all sectors, supporting projects which focus on changing the way that services are delivered within community, acute and residential care settings. The overall impact of the investment and the transformational change is closely monitored locally and nationally by the Joint Improvement Team on behalf of the Scottish Government.

What do we mean by Commissioning?

Commissioning is the process of planning and delivering services. This involves understanding needs, planning how these should be met and putting services in place, either by delivering services directly or purchasing them. Moving forward, Falkirk Partnership will ensure that every opportunity is explored to allow older people, their carers and families to be involved in the commissioning process, for example through gathering information to help develop service specifications and re-shape services to reflect need and individual requirements.

The plan sets out how the Falkirk Partnership will work towards the Scottish Government's Reshaping Care for Older People Strategy, which describes a new model for delivering care that focuses on keeping people independent with a good quality of life. The table 2 below gives examples of the shift from 'old' to 'new' models of care:

Table 2

Old care model	**New care model**
Reactive care	Preventative care
Hospital centred	Embedded in communities
Disjointed care	Integrated, continuous care
Patient as passive recipient	Patient as partner
Carers undervalued	Carers supported as partners
Self care infrequent	Self care encouraged and facilitated
Low tech	High tech
Episodic care	Team based
Geared towards acute conditions	Geared towards long-term conditions

Our Priorities

We understand that reshaping care is complex and complicated. It is important that the right services are in place, at the right time, and in order to achieve this, the Joint Commissioning Plan sets out our intentions, based on headings of the Re-shaping Care Pathway. The areas covered are:

- Preventative and Anticipatory Care: Promoting Health and Wellbeing
- Proactive Care and Support at Home: Supporting Living at Home
- Effective Care at Times of Transition: Effective Care at the Right Time
- Hospital and Care Homes
- Enablers: A framework of systems and supports to facilitate change
- Cross-cutting themes

It is acknowledged that many services can relate to more than one heading of the Re-shaping Care Pathway, and that in addition, there are specific cross-cutting themes that should flow through each aspect of service design and delivery. These are, for example, re-ablement, recovery, technology and support for carers.

The diagram shown on page 12 illustrates the Care Pathway. It is intended that there is movement in both directions i.e. that people do not progress through the pathway, but can move according to their care and support needs, at any given time.

Population Need	Pathway	Services	Priority Outputs
General Population Needs	**Preventative and Anticipatory Care**	Services include: - Health Improvement - Co-production - Volunteering - Leisure and Culture - Social Groups - Community Groups - Information Services - Falls Prevention - Carers Support	Action focuses on supporting the development of networks and supports within communities, which will allow older people to remain active citizens and maintain control of their health. Priority areas will be: - Early Intervention - Self Directed Support - Universal Services - Co-production – increased community capacity - Support to Carers
Some Care and Support Needs	**Proactive Care and Support at Home**	Services include: - Assessment and Case Management (SW & NHS) - ReACH Team - Care at Home Services - Rehab at Home Service - Housing with Care Reablement Service - Day Opportunities, including Day Care - Equipment and Adaptations	Action focuses on providing high quality care in older people's homes which can assist with Reablement and Rehabilitation in order to maximise independence. Priority areas will be: - Enhanced interagency person-centred planning with ACP in place for 75+ years. - Integrated Care Pathways - Support for Carers - Continue to modernise Care at Home Services - Telecare and Teleheathcare Equipment - Third and Independent Sector Community Supports - Handyperson Service
Higher Levels of Need	**Effective Care at Time of Transition**	Services include: - Dementia Link Workers - CMHT (E) - Complex Care	Action focuses on meeting changing needs, effectively, timely and safely with interventions delivered by skilled practitioners to support individuals to maintain a fulfilled life. Priority areas will be: - Integrated Intermediated Care Hub Model - High quality palliative care and end-of-life services - Support older people with dementia and their carers.
Complex Needs	**Hospital and Residential Care**	Services include: - 96 Community Hospital Beds (FCH) - 24 Community Hospital Beds (Bo'ness) - 16 Old Age Psychiatry Beds - Strathcarron Hospice - Tryst Park - Residential Care Homes - Nursing Care Homes	Hospitals and Care Homes will continue to play an important role in the care of older people with urgent care and very high longer term needs. However, supporting older people to remain at home for as long as possible will be a priority. Priority areas will be: - Hub Co - Reduce average length of stay in LTC - Reduce acute admissions and bed days >75years - Alternatives to admissions - Older People's Housing Strategy

Preventative and Anticipatory Care: Promoting Health & Wellbeing

SOA Outcome: Older people and their carers have control of their own health, care and well-being through a range of community based services.

Preventative and anticipatory care is not just about the services that are provided by statutory services, for example falls prevention services and anticipatory care planning. The third sector has a critical role to play in supporting the development of networks and supports within communities, which will allow older people to remain active citizens and maintain control of their health and well-being. Statutory sector partners will continue to work with Third sector organisations and groups and independent sectors to ensure that networks are developed and supported.

The Change Fund is supporting a range of preventative services and the partnership will continue to focus on the provision of a range of services including:

- Community groups
- Information services
- Carer support
- Volunteering
- Health Improvement
- Information services.

We recognise that in order for older people, their carers and families to be able to maintain control of their health, care and well-being advice and information about services and support within the community must be accessible for people to make informed choices. In addition to the range of service provided, the partnership will continue to:

- Build capacity in our communities by working with organisations to design and deliver innovative services which improve outcomes for our older people with an aim to longer term sustainable improvements.
- Promote positive lifestyles, through for example work with Falkirk Community Trust, such as one Step Forth programme which promotes walking and active lifestyles, the 'cuppa' screenings programmed in the Hippodrome and a community choir which brings together adults of all ages.
- Promote volunteering through the CVS and Volunteer Centre to create meaningful opportunities for older people that improve their health and wellbeing, reduce social isolation and builds confidence and capacity that can lead to improved independence and community resilience. Volunteering opportunities will also be created to provide younger people with skills and experience in working with and supporting older people, introducing intergenerational activity which benefits all ages.

We are keen to recognise individuals as assets within their community, but understand that in some areas, there is a need for a wider cultural change in terms of perception and expectations on statutory services by older people and their carers. In order to affect this cultural change, we must ensure that we communicate key messages particularly regarding the significance of early intervention, prevention and re-ablement to all stakeholders – from older people and their carers to social and health care staff at all levels.

Priorities

- Establish and implement an integrated model for locality based planning and development.
- Develop sustainable community networks and capacity, recognising older people as assets.

Proactive Care and Support at Home: Supporting Living at Home

SOA Outcome: Older people will be able to live in a homely environment within a supportive community, where possible, in order to avoid unnecessary admissions to care homes or hospitals.

The partnership will focus action on providing high quality care in older people's homes which can assist with reablement and rehabilitation to maximise their independence. The core services include:

- Integrated case/ care management
- Carer support, including short breaks and respite
- Care at Home services, including, Rehab at Home, MECS
- Day opportunities, including day hospital
- Equipment and adaptations
- Telehealthcare technology
- Housing options
- Review agency and interagency assessment and care plan arrangements

The partnership recognises that there is also a need to modernise services to ensure these meet the needs of older people and their carers and are responsive, flexible and cost effective. We would like to provide services which allow increased supported integration into community services. In modernising services we will continue to identify and act on opportunities for joint working between third and independent sector organisations. In addition to the range of service provided, the partnership will augment arrangements in the following areas:

- **Person-centred planning**, as an integrated, interagency assessment framework is critical in being able to anticipate and plan the care needs of older people in a way which enables preventative and reabling support. Carer Assessment and access to anticipatory support for carers will be an integrated process within this care planning model.
- **Anticipatory Care Plans**, which are expected to reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of these plans is to support individuals to have greater control of their own health and care and better choice of care preferences through proactive communication across primary care team, agencies and care settings.
- **Carers support and respite** - building on the considerable activity already taking place with a range of organisations providing excellent support and services to carers. This means we can build on this foundation already in place through the Forth Valley Integrated Carers Strategy and Falkirk Delivery Plan and will focus on the agreed action areas.

- **Care and Support at Home** – there is a significant service re-design programme underway with examples including the introduction of a Real Time Monitoring electronic system to monitor and manage the delivery of home care services; a pilot overnight carers service which will enable service users to be more effectively maintained at home; the introduction of Falls Bundles which aim to reduce the number of fallers within the community.
- **Telecare and telehealth technology** will continue to be promoted to enable older people to be supported more safely and independently at home, through the current services and involvement in the Living It Up national project.
- **Specialist Day Services** - we recognise that there is a need to modernise current specialist day services for older people. We would like to provide services which allow increased supported integration into community services. In modernising services we will act on opportunities for joint working between specialist day services and third sector organisations and other stakeholders.
- **Day Hospital Services** - There is potential development in relation to day hospital models. For example work is underway to review the Day Hospital approach within Forth Valley Royal Hospital where a 'Hub' approach is being introduced. This will ensure quicker access to assessment, earlier intervention and prevention of unnecessary admissions to the acute hospital. Day Hospital models for people with old age psychiatry needs have undergone changes, for example, there is now a staff team providing outreach to individuals in their home environment and older people are now accessing day hospitals for specific group and individuals support and interventions.
- **Redesign of community equipment services** – In partnership with NHS Forth Valley and the 3 Local Authorities a whole system review of Community Equipment provision across Forth Valley has been completed. This review identified a number of key areas that partners required to address to develop an integrated approach across the various client groups to streamline assessment and provision pathways. The multi agency group will activate to progress work to ensure consistent, standardised, joint approaches in areas of policy and assessment practice.
- **Range of housing options and timely adaptations** - We recognise that in order for older people to be able to live independently in their own homes for as long as possible, we must ensure that housing options are available and communicated effectively and that adaptations are provided to all tenures on a needs basis, as required. Key areas of development are to agree the model of specialist housing for older people to avoid unnecessary admissions to care homes or hospital; ensure advice and information is available to older people; ensure older people are not routinely delayed in hospital waiting for adaptations or admitted to hospital because they have accidents waiting for adaptations and operate a small repairs scheme for older people across all tenures.

Priorities

- Review agency and interagency assessment and care plan arrangements
- Implement the Forth Valley Integrated Carers Strategy
- Continue redesign programme within Care at Home services
- Review and redesign day services
- Ensure timely access to equipment and adaptations
- Maximise use of telecare and telehealth technology
- Implement the Local Housing Strategy and Older People's Housing Plan

Effective Care at Times of Transition: Effective Care at the Right Time

SOA Outcome: *Older people and their carers will have control and choice over decisions about their care particularly at times of transition.*

As people progress through the life journey to old age, some individuals will experience challenges to their health, independence and social circumstances that requires support, care and a range of interventions to meet and manage their assessed, monitored and reviewed needs.

We will work together to meet older people's changing needs in an effective, timely, safe way with interventions delivered by skilled and competent practitioners in an effort to support individuals and their families and carers to maintain a fulfilled life.

We will ensure that in the overall delivery of services, we will support and include older people, their families and carers in planning for future care, with early planning being encouraged, particularly with people who have a dementia diagnosis.

The partnership recognises that for older people and their carers, at certain points in their life journey there can often be a number of agencies and professionals involved in delivering services. The partners are aware that the transition between and across partners services can be problematic and efforts will continue to ensure this is more effectively co-ordinated. We will do this by listening to the experiences of those older people and their carers through the various engagement arrangements in place. This needs to be sensitively and effectively managed in a way than empowers them as this can often be one of the most stressful times for older people and their families.

The Partnership will strive to deliver on a wholly person centred approach, utilising tools such as Anticipatory Care Planning to assist older people to consider future options in a more planned and informed way, rather than at points of crisis. In addition to appropriate support and care, the provision of reliable and accessible information will also be key, and partners will work with older people to better understand how this can be achieved.

Projects focussing on re-ablement are currently in place across the area. For example, support within housing with care which helps facilitate early discharge from hospital and prevents unplanned admission to the acute hospital. The projects helps service users to regain independent living skills lost due to a period of hospitalisation, deteriorating physical condition or medical cause.

Within the community, we have extended a re-ablement approach for people who are 65+ years with long term conditions and/or are frequent fallers who sustain an injury that does not require hospital admission. By offering a re-ablement service we aim to reduce needs

for long term support by helping people to (re)learn daily living skills. It is envisaged that this will assist in preventing inappropriate long term use of both health and social care services.

Providing good quality palliative care and end of life care is the responsibility of NHS Forth Valley and is delivered in partnership with all partners including Falkirk Council, Strathcarron Hospice, Marie Curie and Macmillan.

The Partnership recognises that there are specific areas of work which require ongoing focus. An example of this is Alcohol Related Brain Disorder (ARBD). Through the developing Integrated Care Pathway work, Forth Valley ADPs will consider this in more detail, and will be incorporated within the workforce development work being undertaken in partnership with the Health Scotland and STRADA.

Priorities

- Promote and Develop older adults and carers ability to self-manage long term conditions
- Develop a range of co-ordinated and responsive rehabilitation services
- Develop older adults psychiatry services including dementia, delirium and depression
- Provide high quality palliative care services and end of life support at home

Hospital and Care Homes

SOA Outcome: Supports are in place to ensure that older people are not admitted to hospital unnecessarily or on an emergency basis.

There are clear challenges to be addressed over the coming years in the delivery of acute, Community Hospital and residential and nursing care.

The Scottish Government has already established a focussed programme around ensuring patients can access appropriate health care. Some of these initiatives involve the whole population for example 12 Weeks Referral to Treatment and more targeted outcomes and policies such as:

- Reshaping Care for Older People
- Delayed Discharge
- Healthcare Environment Inspectorate – Older People in Acute Hospitals
- Scotland's National Dementia Strategy
- Reducing the Emergency Bed day rate of persons 75+
- Reducing direct admissions to long stay care homes from hospital.

Hospitals and Care Homes will continue to play an important role in the care of older people with urgent complex and complicated longer term and needs, however supporting older people to remain in their own homes for as long as possible needs to be our priority.

It is important to remain focussed on our vision for older people and on the policy objectives of shifting the balance of care away from institutional settings to home and community settings. This would suggest that there should be a presumption in favour of reducing the proportion of older people in care homes rather than maintain current ratios.

There are a number of successful initiatives in place to develop services and improve the way we support older people appropriately through acute and specialist supported care. However, Forth Valley Royal Hospital has continued to face significant pressures due to increased activity resulting in high levels of bed occupancy. Given the challenges outlined earlier, this is likely to be an increasing feature of the new health and social care model that is evolving. There is therefore a significant need, to re-model the way primary care and acute care interface, particularly around individuals with complex needs.

The role of the acute hospital will continue to focus on assessment and very short stay, avoiding admission where possible, and returning care to community services as soon as feasible. The development and delivery of NHS Forth Valley's priorities, in terms of Efficiency, Productivity and Quality, demonstrates commitment to ensuring capacity and flow through acute services is optimal. This whole system piece of work aims to support all

patients through their pathway of care as effectively and efficiently as possible, avoiding delays and ensuring safety.

The partnership has already made progress to put in place services or reviews including:

- **Consultant Nurse for Older People**, to enhance best practice, deliver on national agendas and offer support and guidance across the wider NHS Forth Valley Structures. In conjunction with the Consultant Nurse for Palliative Care they have developed robust links with the Care Home Sector which includes education and interventions in implementing policies on DNACPR, Anticipatory Care planning.

- **Care Home Liaison Specialist Nurse** who provides education, support and guidance across the care Home sector linked to individuals with challenges to their mental health. This post has been successful in assisting homes and individuals to reduce the use of anti-psychotic medication and has had major success in reducing admissions to the acute hospital environments.

- **Alzheimer's Consultant Nurse within the Acute Hospital**, who has established a clear pathway for people with dementia admitted into acute care to help improve the care they receive in general hospital settings. Work is ongoing to develop a pathway for people who are admitted with delirium, as is work to consider the alternatives to admission, particularly with people admitted with a delirium. Two NHS Forth Valley nurses are among one hundred dementia champions who have started work across Scotland to help drive up standards of care for people with dementia.

- An initial **review of local authority residential care homes**, with the support of JIT. We recognise that there are opportunities to redesign care for older people in a way that will meet our strategic vision. This will involve a redesign of existing provision and an expansion of more community based models of care such as very sheltered housing. Further work will be taken forward through secured funding via East Central Hub, to enable detailed scoping work to be undertaken on potential capital developments which could enable us to be better placed to meet future need.

Priorities

- Deliver the Efficiency Productivity and Quality programme for Capacity and Flow
- Implement Delayed Discharge Action Plan
- Develop and implement a local Dementia strategy
- Implement Acute Care Standards for mental health and older people's services
- Conclude the review of high end care provision with Hubco

Enablers: A framework of systems and supports to facilitate change

SOA Outcome: An enabling infrastructure of integrated working practice across all partners and communities is in place to underpin and support the pathway of care.

The partnership has identified key enablers within the local infrastructure to support the implementation of the Joint Commissioning Plan and reshape services for older people. These include:

- A single Performance Management system, which will allow us to monitor progress and identify gaps in service, and anticipate future requirements.
- A Single Resource Framework**,** which will allow the Partnership to consider service development and options based on an overview of total financial resource.
- Decisions are based on assessment of impact in relation to health, equality and poverty, when considering service development or change.
- A model of co-production is in place that allows communities to contribute to the design of supports and services for older people.
- Locality based planning models are established, which will allow planning of services to take place at a local level and take account of the integration of health and social care
- The partnership is aware of buildings and facilities across the area so that we can make best use of assets in the delivery of services
- A Workforce Development Framework which sets out how the Partnership will equip staff with the skills and knowledge required to reflect changes in services.
- A Partnership Communications and Engagement Plan which will ensure that all partners communicate and work towards and a common vision.

Further details about how the Partnership intend to continue to develop and implement a framework of systems and supports to facilitate change are provided in Appendix 1.

Priorities

- Develop an integrated performance management system
- Develop and apply Impact Assessment protocols
- Finalise the Integrated Resource Framework
- Establish and implement an integrated model for locality based planning and development
- Implement 'Better Assets, Better Services'
- Develop and implement an intergraded workforce development Framework
- Implement Communications and Engagement Strategy

Cross-Cutting Themes

Re-ablement

Re-ablement describes the process of supporting people to recover from, or manage a period of poor health or deteriorated health due to a long term condition. All care and support for older people, their carers and families should promote recovery and rehabilitation, by helping people to gain the confidence and skills that allows them to better manage and cope with their situation. This may be by helping people regain skills in basic daily tasks such as dressing or preparing a hot drink, through to the older person opting to reduce the amount of support at home they receive.

Personal Outcomes

In developing our plan, the Partnership have established a set of mid-term outcomes which describe the overall changes for older people, their carers and families, that we are working towards during the period 2013-2016. Central to the development of the plan's outcomes, has been the Partnership's focus on improving outcomes for individuals.

Self Directed Support

In November 2010, the Scottish Government published a 10 year Strategy for the implementation of Self Directed Support (SDS). This was followed by the Social Care Self Directed Support (Scotland) Act 2013, which will place a duty on local authorities to offer a range of options to people when planning to meet their support needs and will become law in spring 2014.

What this means in practice is that individuals who are assessed as needing support from the local authority will have more choice and control over how their support is provided. The assessment will focus on outcomes and be carried out in partnership with individuals and their families. It will concentrate on what people want to achieve with the support they receive. This means that support can be more flexible and more creative as long as it safely and legally achieves the outcomes.

Falkirk has set up a dedicated Self Directed Support team to ensure we make the changes necessary to implement Self Directed Support. The Team will manage the changes we need to make to the way that we work, to ensure Self Directed Support becomes a reality for the people we support. To ensure that this happens, we have worked with service providers, staff, service users and carers to develop processes and procedures.

Understanding Patient Pathways

In order to plan services effectively and therefore improve personal outcomes, we need to understand patient pathways; what causes people to be admitted to hospital and what

should be put in place to help people stay out of hospital or make sure that hospital stays are as short as possible, and where possible, are planned.
Information Services Directorate Scotland is supporting the Partnership to link patient/client data between health and social care, so that we can understand patient pathways between home, social care, intermediate care and admission to acute services. This knowledge allows the Partnership to have an overview of what causes and affects differences in personal outcomes, and therefore to shift resource appropriately.

Effective use of technology
Agencies across the partnership are working with a range of technologies to support and enhance current care packages. Technology helps support older people to remain as independent as possible and also helps agencies work together more effectively. In the long-term, effective use of technology as part of an overall care package, will support self-management and re-ablement, allow early detection of individual need and help to reduce emergency admission.

The Mobile Emergency Care Service (MECS) is an example of a service which has been established for some time and provides emergency care through a central control centre. This service has now been enhanced by the use of telecare, which includes the use of a range of detectors for example falls, movement and temperature. Innovations in telehealthcare are also being used, for example medication reminders, blood pressure and blood glucose monitoring. Real time monitoring is also now being used to monitor and manage home care services, resulting in improved personal outcomes and providers being able to operate more effectively.

Carers
The Partnership recognises the critical role that carers have – particularly unpaid carers and therefore carers are central to the delivery of the JCP. We have developed an Integrated Carers Strategy for the Forth Valley which is being delivered at a local level. The strategy reflects national policy in a move towards a more integrated approach in delivering health and social care services, where carers:

- Are recognised and valued as equal partners in care;
- Are supported and empowered to manage their caring responsibilities with confidence, in good health and enabled to have a life of their own outside of caring;
- Are fully engaged as participants in the planning and shaping of services required for the service user and the support for themselves;
- Are not disadvantaged, or discriminated against, by virtue of being a carer; and
- Young carers are supported to be children and young people first and foremost.

We recognise that there is considerable activity already taking place in Forth Valley with a range of organisations providing excellent support and services to carers. This means we can build on this foundation, already in place. During 2014 to 2017 we will focus on the following action areas:

- Support for carers
- Training, education and information
- Development of short breaks and respite for carers
- Raising awareness
- Improving performance and quality.

The voice of carers is central to how we improve support so we are advocating the use of 'Talking Points' which provides a more outcomes based approach.

Co-production

As partners, we recognise the skills, knowledge and experience of older people, their carers and families, and the wider community. We want to ensure that we make the most of this expertise in the delivery of the plan. We aim to achieve this by involving people in the following ways:

- Planning the services we deliver: Listen and act and feedback on what people tell us about how policies, strategies should be developed, which plan ahead.
- Evaluating and improving services: Involve people in the design and development of new services by providing a forum for commissioners to work with communities.
- Helping to deliver services: Understand the skills and will within communities, where appropriate support communities develop supports.
- Assessing progress: Involving people in the review of services, considering what works well and areas that could be improved and also our progress in delivering the plan.

We also understand that in some areas, this is a change to the way of working. We are therefore focussing time on supporting staff across the partnership, to understand the benefits of working with communities and how to do this effectively.

Falkirk Partnership Joint Commissioning Plan: Services for Older People

Priorities and Actions

Themed Area	Outcome	Priorities	Actions
Preventative and Anticipatory Care **Promoting Health and Wellbeing**	Older People, their carers and families have control over their health, care and well-being through a range of community based services	Review agency and interagency assessment and care plan arrangements	• Redesign Emergency Care Pathway (Forth Valley Wide Initiative). • Ensure that agency referral processes are consistent any allow delivery of person centred planning. • Explore and establish mobile ICT solutions to maximise patient facing time. • Promote 'Release Time to Care' to enable staff to improve efficiency in practice. • Ensure Anticipatory Care Plans are in place for those over 75 years. • Ensure the timely implementation of the re-ablement pathway. • Develop the role of the Third and Independent sectors in supporting re-ablement.
		Develop sustainable community networks and capacity, recognising older people as assets	• Develop work based on Bo'ness Community Engagement Pilot, across the wider Council area. • Provide training and awareness raising for staff about using asset based approaches and co-production. • Work within communities to establish and support activities to promote healthy, active lifestyles. • Facilitate and enable opportunities in volunteering. • Ensure information is clear and community based supports are accessible. • Engage with partners within the Community Planning Partnership regarding wider issues such as community safety and transport. • Promote opportunities for independent sector to work with voluntary and community groups.
Proactive Care and	Older people live in a	Implement Self-Directed	• Ensure the co-creation of personal care plans through the

Themed Area	Outcome	Priorities	Actions
Support at Home **Supporting Living at Home**	homely environment within a supportive community, in order to avoid unnecessary admissions to care homes or hospitals	Support	implementation of self-directed support. • Ensure the option of personal budgets is made available. • Provide information, skills and capacity to stakeholders to allow full participation in SDS.
		Continue to prioritise day care services	• Continue to modernise in-house care at home services which consider the needs of individuals. • Review and redesign day services • Develop and support the role of the third and independent sectors roles to provide home care and day care services • Identify frequent fallers and those at risk of falling within FV falls register. • Increase awareness of falls risk and prevention amongst partners, implement consistent assessment and promote understanding of trigger factors. • Increase provision of support such as OTAGO training. • Reduce future risk of admission to hospital for unharmed fallers through co-ordinated response to individuals risk management.
		Implement the Forth Valley Integrated Carers Strategy	• Include the needs of carers within assessment and planning processes. • Identify carers quickly and make information and support available at all points of the care pathway. • Improve uptake of carers assessments. • Continue work between REACH team and third sector partners via co-location of a Carer Support Liaison Officer.
		Ensure timely access to equipment and adaptations following assessment of need	• Implement Forth Valley Community Equipment Improvement Plan • Develop and implement a joint strategic and operational approach to the delivery of adaptation services • Continue to make use of technology to enhance care including provision of satellite pulmonary tele-rehab service. • Provide information that explains types of technology and how it may be

Themed Area	Outcome	Priorities	Actions
			introduced and used to improve services rather than replace them.
			•
		Implement the Local Housing Strategy and Older People's Housing Plan	• Set out the local model of specialist housing • Identify the location and services provided in Council housing with care • Identify the location of telecare and MECs in relation to all housing with care developments • Identify models of good practice in relation to older peoples' housing • Explore options available in relation to housing advice and information options for older people, identify gaps and good practice • When a model of specialist housing is identified for older people, partners work together in relation to assessments for housing with care.
Effective Care at Times of Transition **Effective Care at the Right Time**	Older people, their carers and families will have control and choice over decisions about their care, particularly at times of transition	Promote and develop older adults and carers ability to self-manage long term conditions	• Work with General Practitioners and pharmacists in the delivery of pro-active medicine management and prescribing. • Explore options to Increase use of technology in medicine management. • Identify the needs of older people with a learning disability. • Further develop therapeutic day services to offer skills and knowledge including fire safety, healthy living and eating.
		Develop older adults psychiatry services including dementia, delirium and depression	• Develop a local dementia strategy. • Promote access to dementia awareness training to all staff across the partnership. • Provide assessment and ongoing care plan within older adult psychiatry services. • Raise awareness of the symptoms of alcohol related brain injury to ensure appropriate diagnosis.
		Develop a range of co-ordinated and responsive	• Review the current intermediate care provision and implement findings.

Themed Area	Outcome	Priorities	Actions
		rehabilitation services	• Streamline effective and co-ordinated OT support to enhance patient pathway.
		Provide high quality palliative care services and end of life support at home.	• Enhance the provision of good quality palliative care in partnership with Marie Curie during weekends and evenings. • Develop an action plan to optimise patient management during the out of hours. • Maximise the uptake of palliative care Direct Enhanced Services. • Continue to approve the update and quality of the Gold Standards Framework. • Ensure that equipment is provided in line with assessed need is provided timeously.
Hospital and Residential Care	Supports are in place to ensure that older people are not admitted to hospital unnecessarily or on an emergency basis – where this is not appropriate and that discharge is not delayed.	Ensure timeous discharge from acute services	• Implement Home to home care pathway (OT) • Continue to implement rapid access diagnosis service in FV Hospital to prevent emergency admissions. • Review of admission transfer discharge protocol. • Build on pilot to mainstream a 7 day Allied Health Professional (AHP) service. • Scope and develop the administration of IV antibiotics within community settings. • Roll out enhanced self medication education programme. • Identify and support solutions across all the Partnership to ensure provision for when admission to a care home is the assessed need. • Develop a discharge hub in Falkirk Community Hospital. • Review role of Independent sector in provision of step up/step down assessment placements.
		Implement Care Standards for older people	• Older People's Acute Care Group • Implement LUCAP plan (unscheduled admissions)

Themed Area	Outcome	Priorities	Actions
		Effective use of Community Hospital	• Review high end care provision, including housing with care, residential care and community hospital provision. • Implement recommendations regarding use of existing facilities and proposal and options appraisal of new development. • Take forward strategic Community Hospital Re-fresh
		Residential care services.	• Hubco Strategic Reviews: Service Planning and Residential Care • Facilitate additional access to training opportunities for staff, across the partnership and sectors.
Enablers **A Framework of Systems and Supports to Facilitate Change**	An enabling infrastructure of integrated working practice across all partners and communities is in place to underpin and support the pathway of care.	Develop an integrated performance management system.	• Develop a performance management system which includes relevant national and local indicators. • Link national and local level performance information to establish a strategic and operational level understanding of performance and impact. • Develop information systems to support Integrated Assessment and data driven improvement in conjunction with FV Partners. • Conclude the Linked Pathways ISD Project. • Incorporate regulations established via inspection and contract commissioning within performance framework
		Develop and apply Impact Assessment protocols	• Undertake relevant Impact Assessments for each area of service and/or change. • Establish process of reviewing individual Impact. Assessments collectively to understand strategic impact. • Undertake full options appraisal and Impact Assessment for any area of investment and disinvestment.
		Finalise the Integrated Resource Framework	• Agree the scope and content of the resource envelope. • Identify areas of investment and disinvestment.
		Establish and implement an integrated model for locality	• Continue to identify areas where a Partnership or integrated approach to commissioning services will be taken.

Themed Area	Outcome	Priorities	Actions
		based planning and development	• Undertake Bo'ness Locality Planning Pilot Project. • Facilitate ongoing General Practitioners engagement regarding locality planning. • Integrate co-production and Public Social Partnership (PSP) values, most importantly community engagement, within mainstream service delivery. • Review and develop asset based approaches within locality planning framework. • Establish links with leads in social enterprise. • Further develop links with Independent sector.
		Implement 'Better Assets, Better Services'	• Review of community based facilities used by partners and implement recommendations on effective routes for integrated use of local assets. • Review Institutional Provision across Health & Social Care • Review and rationalise the existing property portfolio across Health & Social Care • Provide opportunities for shared use of space and buildings • Consider "in kind" use of buildings for community groups to ensure wider access
		Develop and implement an intergraded workforce development Framework	• Work with partners to identify cross-sector development needs • Develop and deliver joint education and training programmes • Make use of existing training resources and packages e.g. via JIT and provide access across the partnership, including to volunteers.
		Implement Communications and Engagement Strategy	• Develop a planned approach to communicating the Partnership's vision and key messages • Establish a programme for ongoing participation within communities and across partners • Ensure information on services is in Plain English