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A Framework for Improving the Health, Wellbeing & Care of Older People in East Dunbartonshire 2013 - 2023

Providing more care than they consume

Our older people are an **asset,** not a burden

FOREWORD

A Framework for Improving Health, Wellbeing & Care for Older People (2013 - 2023) is a key part of the wider planning and delivery activities of the **Joint Community Care Planning Framework (JCCP) 2012-15**. The JCCP is the overarching community care planning document for East Dunbartonshire Council and East Dunbartonshire Community Health Partnership (CHP) and sets out the basis for all community care planning and service delivery across our health, social care and partner services.

A Framework for improving the Health, Wellbeing & Care of Older People in East Dunbartonshire (2013 - 2023) sets out the vision, principles, high level outcomes and strategic priorities specifically relating to Older People. These have been developed in partnership with the Council, CHP, and the Independent and Voluntary Sector.

Community planning partners' strategic Vision:-

"Older people and their carers are supported to enjoy a high quality of life, achieve their potential, and that they are safe, healthy and 'included".

Community planning partners will work together, with and for older people and their carers, to address high level Strategic Priorities:

- People living as independently as possible
- More people living at home or in a homely setting
- Carers supported and able to continue in their caring role
- Assets and resources available to the community are supported to grow and develop

The Framework is presented in three discrete sections:

Part One: Ageing Well Strategy - describes the high level shared health and social care priorities and approaches to promoting health and well-being and preventing or delaying the need for formal care. Planning assumptions have been informed by a plethora of demographic and other information, as well as a series of responses from health and social care practitioners, older people and their carers.

Part Two - Joint Strategic Commissioning Plan - describes the detail of what and how we will undertake and achieve change through specific procurement and commissioning of services, as well as identifying high level performance measures.

Part Three - Joint Strategic Commissioning Delivery Plan is currently being developed and will determine specific action; lead delivery agency; resource requirements; key performance indicators and agreed timescales.

Rhondda Geekie
Leader East Dunbartonshire Council

Ian Fraser
Chair East Dunbartonshire Community Health Partnership

Part **one** Ageing Well Strategy

CONTENT

1.	**INTRODUCTION**	**5**
2.	**KEY DRIVERS**	**6**
3.	**POLICY CONTEXT**	**7**
4.	**POPULATION PROFILE**	**9**
	4.1 DEMOGRAPHY	**9**
	4.2 PERCEPTIONS OF WELLBEING, QUALITY OF LIFE & LIFESTYLE	**12**
	4.3 MORTALITY AND LIFE EXPECTANCY	**14**
	4.4 MORBIDITY	**15**
	4.5 SERVICE USE	**16**
5.	**STAKEHOLDERS ENGAGEMENT**	**22**
	5.1 WHAT OLDER PEOPLE & THEIR CARERS TELL US	**22**
	5.2 WHAT OUR PRACTITIONERS TELL US	**23**
6.	**STRATEGIC PRIORITIES**	**25**
	6.1 PROMOTING HEALTH, INDEPENDENCE AND WELLBEING AND DEVELOPING COMMUNITY CAPACITY	**25**
	6.2 MORE PREVENTATIVE, PERSONALISED AND ANTICAPATORY CARE	**27**
	6.3 CARING FOR PEOPLE IN THE RIGHT PLACE AT THE RIGHT TIME	**31**
7.	**DELIVERING THE PRIORITIES**	**36**

1. INTRODUCTION

The Ageing Well Strategy sets out the vision, identifies shared health and social care priorities and aims to build on the success of keeping people in East Dunbartonshire healthy and living independently in communities for longer. The strategy focuses on promoting good health, preventing ill health and providing care and support when people begin to find it more difficult to continue with the life they probably enjoyed pre-retirement, or in the early years of their retirement. The age at which these difficulties emerge will vary and the preventative approach needs to be focussed on enabling people to maintain their independence and enabling them to regain it at any age.

It takes account of the need to anticipate longer term care needs and initiate, where necessary, re-ablement and rehabilitation to encourage and promote independence, either at home or in a homely setting and reduce inappropriate hospital or care home admissions .

Community planning partners' strategic Vision:-

"Older people and their carers are supported to enjoy a high quality of life, achieve their potential, and that they are safe, healthy and 'included".

This will be achieved by:

- Adopting **a joint strategic focus** across Health, Council, Independent and Voluntary sectors.
- **Reshaping services** for the ageing population within East Dunbartonshire
- Building on the **outcome focussed approach** demonstrated within the existing Single Outcome Agreement (SOA)
- Engaging with the current cohort of older people and their carers to focus delivery of **care and support services to the vulnerable older population**
- Agreeing **joint commissioning priorities** to inform future planning for transformational change
- Delivering **joined up, quality assured, services**

2. KEY DRIVERS FOR CHANGE

- Nationally, the population is ageing and the demand for health and social care services, alongside increased costs, is set against significant cuts to local government financial resources. This trend necessitates approaches that will both maximise the individual's ability to sustain their health and well-being into later life and potentially delivers longer-term financial affordability of services.
- The current fiscal climate will present a financial challenge across all sectors over the next decade. Individuals will need to take greater responsibility for their own health and wellbeing rather than looking towards the state as the provider of first resort as a result of the financial climate.
- Changes to eligibility thresholds and criteria for Council and other services means financial resources for social care services are being targeted at those people in greatest need and/or at highest risk.
- Consultation with older people and their carers indicates that they want to have access to a broad range of activities including visiting leisure centres and participating in lifelong learning opportunities. This will require approaches that promote healthier, more active and independent lives for adults, to reflect the wishes and aspirations of people living in East Dunbartonshire.
- There is an expectation that leadership for health improvement is driven by community planning partnerships and measurable outcomes of health improvement for older people are visible within local Single Outcome Agreements.
- Whilst the public sector has an important role to play in promoting health and well-being, supported self-care and preventing ill-health, it is recognised that there are many other organisations, particularly in the voluntary, community and independent sector, who may be better placed to provide these services. The East Dunbartonshire Joint Strategic Commissioning Plan will reflect an approach to service delivery which engages more actively with the Third Sector to promote a sustainable preventative approach to health and well-being.
- There is a continuing requirement to use public resources efficiently and effectively and demonstrate not only value for money but also provide quality assured and safe services. This is accompanied by performance assessment and accountability requirements that focus on how partners and stakeholders work together to deliver meaningful outcomes and how service users experience these.

3. POLICY CONTEXT

Scottish Government policy imperatives are set within the context of continuous improvement of health and social care services for older people. Services which deliver care closer to home, with a personalised approach and helps people maintain their independence.

A number of key national and local policies and legislative drivers have shaped the Framework for improving the Health, Wellbeing & Care of Older People in East Dunbartonshire (2013 - 2023)

The last 10 years and more have seen policy development centre on practical solutions to meet the needs of older people with community care needs, with major policy and legislative changes. Initial policy drivers –from the **Joint Future agenda** to the reform of health care[1]- promoted the establishment of better joined-up processes and services, for the achievement of **4 main community care outcomes:-**

- **supporting more people at home;**
- **assisting people to live independent lives;**
- **ensuring people receive a high standard of care; and**
- **better involvement and support for carers.**

Re-shaping Care for Older People Programme 2011-2021 was launched by the Scottish Government in 2010 and its principal goal is ***'to optimise the independence and wellbeing of older people at home or in a homely setting'***. This will be achieved by developing an approach which supports people to remain as independent as possible by supporting their recovery. However, it also goes beyond the current situation and emphasises the need to devise new models of delivery, including public and third sector services that are financially sustainable in the longer term. A key deliverable is developing mechanisms to enable partners to engage with communities in planning and developing these new models.

The **21st Century Review of Social Work**[2] was then a primary driver for the 'personalisation' agenda –services which are more bespoke to meet needs rather than resource-driven- as well as promoting a focus on prevention and early intervention.

The 20:20 Vision set out her strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland, in the face of the significant challenges of Scotland's public health record, the changing demography and the economic environment. It provides the strategic narrative and context for taking forward the implementation of the Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability.

The **NHS Scotland Quality Strategy** (May 2010), and associated Quality Outcomes and Indicators, provide a framework for performance management of the NHS linked to clear outcomes for safe, effective and person centred services. The Community

[1] "Building a Health Service Fit for the Future" and "Delivering for Health"- Scottish Executive 2005
[2] "Changing Lives"- Scottish Executive 2006

Care Outcomes Framework is also being revised and will provide a further set of outcomes which NHS and social care will be expected to deliver.

The Scottish Government's proposals for **Integration of Adult Health and Social Care** aim to address system challenges and ensure that services are focused on the support and care of individuals and their families – rather than on patterns of service delivery by different organisations. To achieve this, the Scottish Government will implement a legislation which will include applying commissioning standards, and the establishment of integrated budgets –starting with those for older people's services- to deliver community health and social care services and also appropriate aspects of acute health activity. Care at home instead of in care homes or hospitals is a key theme, and there are financial considerations to planning for this.

The **Christie Commission** reported for the Scottish Government on the future delivery of public services and identified four key objectives for reform which all correspond to the key drivers for personalisation, a focus on outcomes, priority for prevention and improving performance whilst reducing costs.

The personalisation of public services, commonly known as **Self Directed Support,** is a primary driver of the Scottish Government. This policy and impending legislation will have significant implications for how and what is commissioned by public services. Consequently there will be an increase in individuals' choice and control over their community care and support arrangements requiring a move away from block contracts to personalised, outcome focused services. The Self-Directed Support Bill will be enacted in 2013.

Alongside this is a drive for the **co-production** of services, sometimes called an 'assets based approach' which the Scottish Government view as instrumental to achieve a successfully shift in the balance of care, as well develop public services that are focused on prevention and independence. Co-production recognises that people have 'assets' (eg knowledge, skills, experience, friends, family and communities) which can be brought to bear to support their health and wellbeing. "The approach places people at the heart of any given service and *involves them* in it, from the creation and commissioning of that service through to its design and delivery, its assessment and sometimes, where appropriate, its end"[3].

To support progress with their Reshaping Care for Older People programme policy, the Scottish Government has made available a **Transformational Change Fund** investment of £70 million nationally and £1.218 million locally for the year 2011/12, which is being used to support bridging finance to facilitate improvement across the entirety of, spend in health and social care over a ten-year period. Year two 2012/13 will see £80 million committed nationally, with a further £80 million in 2013/14 and 70 million in 2014/15.

The East Dunbartonshire **Joint Strategic Commissioning Plan** will provide the detail of how the actions of this Strategy will be achieved, and thus, is directly linked to the Change Fund. This programme of work will provide a contribution to the resource required to facilitate transformational change using the totality of resource available to partners for older people's services.

[3] CO-PRODUCTION IN HEALTH AND SOCIAL CARE *What it is and how to do it* -2012 Governance International

4. POPULATION PROFILE

4.1 DEMOGRAPHY

Current Older People's Population

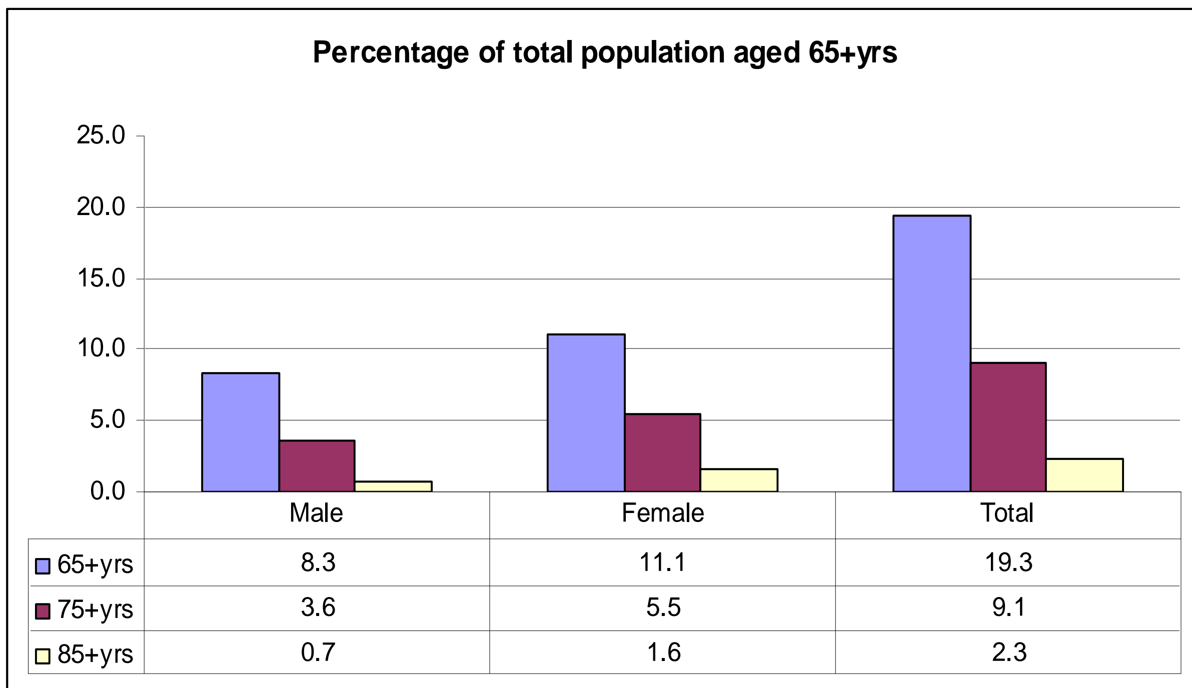
The population of East Dunbartonshire is 104,570 and accounts for 2.0 per cent of the total population of Scotland. People aged 16 to 29 years make up 16.5 per cent of the population which is smaller than Scotland (18.7%). Persons aged 60 and over make up 26.2 per cent of East Dunbartonshire which is larger than Scotland where 23.3 per cent are aged 60 and over. The numbers of residents aged 65 plus by gender are outlined in Table 1.

Table 1:

Age Group	Total Population	% of Population	Male Population	Female Population
Age 65-74	17,967	17.2%	8,356	9,611
Age 75+	9,469	9.1%	3,765	5,704

According to the National Records of Scotland (NRS), people over the age of 65yrs currently make up approximately 26.3% of the total population of 104,570.

Figure 1: Percentage of Total East Dunbartonshire Population aged 65+yrs+



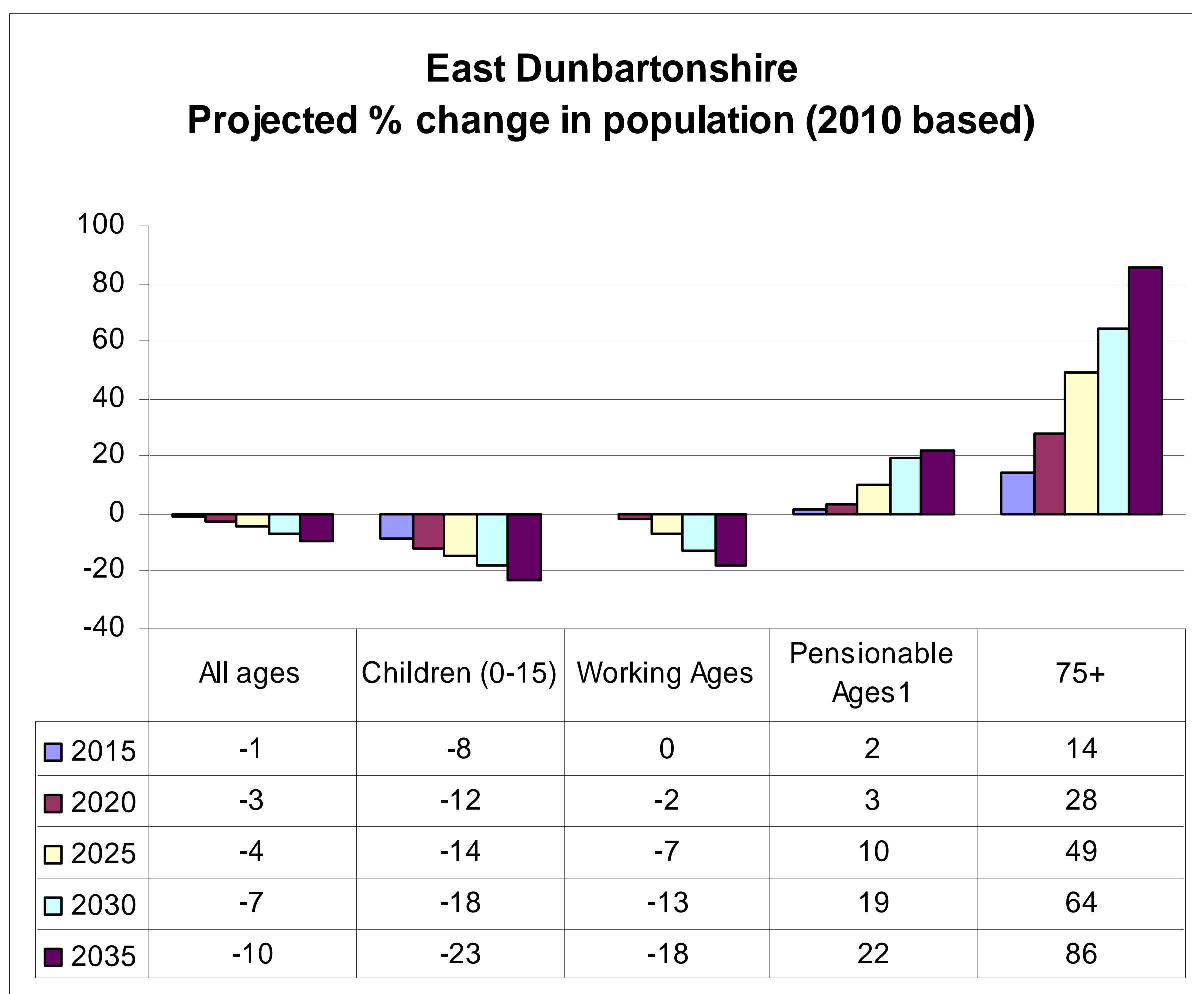
National Records of Scotland (NRS)

Population Projections

Between the 1950s (post war) and the1970s the UK experienced an increase in the number of births resulting in a current increase in those aged fifty or more. In addition, the size of completed families and the number of children being born has decreased in the last few decades so there are fewer children in the population. This national trend is very much reflected in the East Dunbartonshire population which is experiencing an increase in the older population and a reduction in the numbers of young people (Figure 2).

By 2035 the population of East Dunbartonshire is projected to be 94,343, a decrease of 9.8 per cent compared to the population in 2010.

Figure 2: Projected % change in population

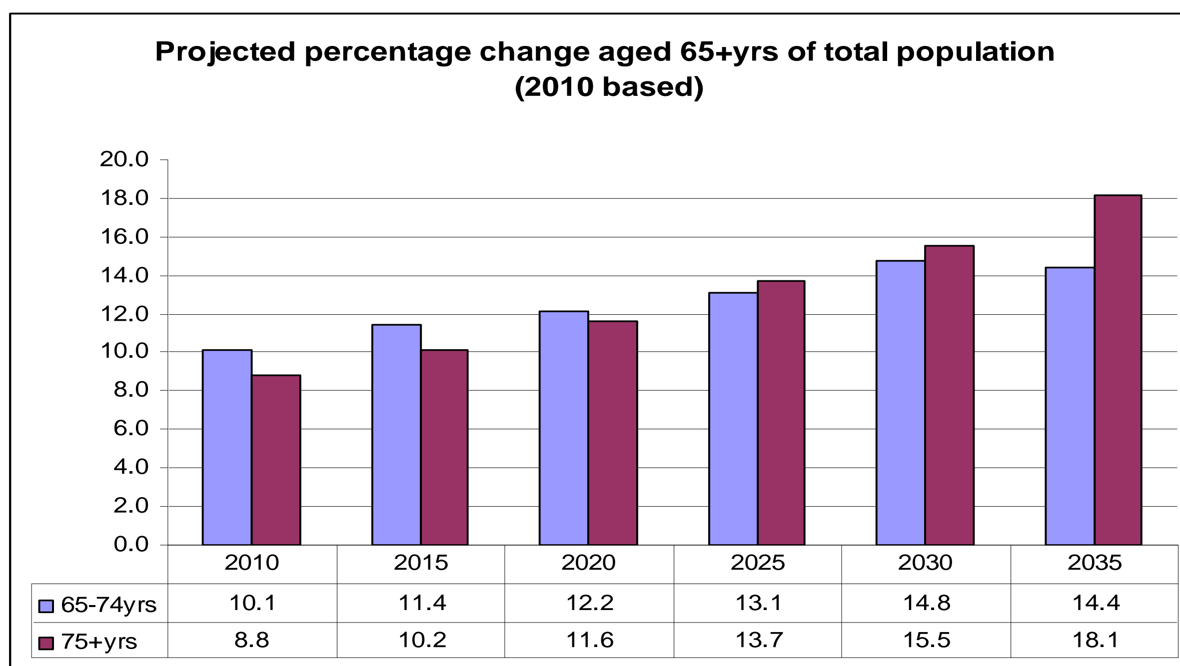


	All ages	Children (0-15)	Working Ages	Pensionable Ages1	75+
2015	-1	-8	0	2	14
2020	-3	-12	-2	3	28
2025	-4	-14	-7	10	49
2030	-7	-18	-13	19	64
2035	-10	-23	-18	22	86

Source GROS

Recent forecasts suggest that people over the age of sixty-five will account for 32.5% by 2035. By age group, there are variations. Most notably the greatest growth will be the number of people aged over seventy-five, and the over 85 age group is projected to increase by 28.8% in the 5 years to 2015, and by a further 30.6% by 2020. This is a substantially greater increase than is projected at a Scotland wide level (18.9% by 2015 and a further 22.9% by 2020). (Table 2 and Fig 3)

Figure 3: Projected percentage change aged 65+yrs of total population



	2010	2015	2020	2025	2030	2035
65-74yrs	10.1	11.4	12.2	13.1	14.8	14.4
75+yrs	8.8	10.2	11.6	13.7	15.5	18.1

(NRS)

The ageing population is also changing in profile. This means a growth in the proportion of older men as the gender gap in life expectancy narrows, as well as a growth in the older Black Minority Ethnic (BME) population. Additionally, the research highlights the increasing prevalence of some health conditions, most notably that of dementia which has been predicted to double in the next 30 years. There is also a growing group of older people with learning disabilities, particularly with rising life expectancy of those with Down's Syndrome (50-60 years) and more formal diagnoses of autistic spectrum disorder. Societal changes may result in less provision of kinship support, which reinforces the need to build capacity and responsibility within local communities (Source: Joseph Rowntree Foundation).

Deprivation

The Scottish Index of Multiple Deprivation (SIMD) is not intended to be a definitive analysis but rather informs our understanding of the outcomes of people living in deprived areas. Although it is not generally age specific, it provides an indication of inequality across seven SIMD domains, all of which have a direct impact on the health and wellbeing of older people.

At an aggregated level, analysis of SIMD data (2012) for East Dunbartonshire masks the complexity of disadvantage in some communities and reinforces the stereotype that the area is characterised by affluence and high levels of socio-economic attainment. East Dunbartonshire is more affluent than the whole of Scotland with 54.4% living in the least deprived quintile and only 3.7% living in the most deprived quintile. In addition, only 9.3% of the population is income deprived compared to 17.1% of the population in Scotland. Furthermore, only 4.7% of the population in East Dunbartonshire is employment deprived, which is lower than the national figure of 7.6% of the Scottish population.

4.2 PERCEPTIONS OF WELLBEING, QUALITY OF LIFE AND LIFESTYLE

The Health and Wellbeing Survey (2011)[4] contains the findings of a research study on health and wellbeing carried out in 2011. The study explores the different experience of health and wellbeing in our most deprived communities[5] in the NHS Greater Glasgow & Clyde (NHSGG&C) area compared to other areas. East Dunbartonshire bought into the survey at enhanced levels to allow for local exploration between the most deprived areas and other areas. The survey provides a snapshot in time of the views and experience of the resident adult population. Whilst it cannot attribute causal relationships between the findings and the changing policy context, the study can explore the findings alongside wider changes in the NHSGG&C area.

General Health and Wellbeing

Compared to the NHSGG&C area as a whole, those in East Dunbartonshire were more likely to have a positive perception of their physical wellbeing and there was a clear relationship between age and perceptions of physical wellbeing. Older people reported lower levels of positive perceptions of health and wellbeing than the rest of the population (ranging from 96% for 16-24 year olds to 65% for those aged 75 years old and over). There was also clear evidence that less positive views correlated with factors associated with social exclusion such as feeling isolated from friends/family; all income from benefits; and individuals not in control of decisions affecting daily life.

Mental and Emotional Wellbeing and Happiness

Perceptions of mental or emotional wellbeing varied for different age groups. Those aged 16-24 were the most likely to give a positive view (96%) whilst those aged 75 or over were among the least likely to have a positive view of their mental/emotional wellbeing (82%). Negative perceptions were further compounded if people were socially excluded and living in the most deprived communities.

Views of happiness followed the same pattern for age, social exclusion and deprivation, ranging from 99% of 16-24 year olds to 83% of those aged 75 or over.

Quality of Life

Respondents with a positive view of their general health, physical health or mental/emotional wellbeing were also more likely to have a positive view of their overall quality of life. Overall, 93% of respondents gave a positive rating of their quality of life. Those aged 16-24 were the most likely to give a positive view of their overall quality of life (100%) compared with those aged 75 or over (81%). The findings illustrates the correlation with deprivation where less positive views of overall quality of life were given by those experience social exclusion and live in the most deprived areas. This is further compounded if people are living with a limiting condition or illness (44% of those aged 75 or over). A significant proportion (18%) said their long-term condition or illness substantially interfered with their day to day activities such as remaining in employment; continuing to be physically active; and sustaining social connectivity.

[4] NHS Greater Glasgow and Clyde The Health and Wellbeing Survey (2011)

[5] In 1999, our most deprived communities were given additional resources with the aim of reducing the gap between deprived and least deprived areas. The initiative was part of an umbrella programme of support which focused on Social Inclusion Partnership areas.

Community Safety

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to have a positive view of reciprocity (81% East Dunbartonshire; 77% NHSGGC). This involved perceptions about the extent to which “neighbours look out for each other”, and generally speaking “people can trust others in their local area”. Levels of positive perceptions varied slightly across all age groups but those aged 45-54 were the least likely to have a positive view of reciprocity. The survey shows that those who did not feel in control of the decisions affecting their life and particularly those who felt isolated from family/friends were less likely to have a positive perception of reciprocity or trust. Overall women were more likely than men to have positive views of reciprocity and trust.

Health Behaviours

The Health & Wellbeing Survey (2011) provides age specific data relating to a raft of lifestyle behaviours including, smoking, physical activity, alcohol consumption.

People living in East Dunbartonshire are much less likely than those in the NHS Greater Glasgow & Clyde area as a whole to be current smokers. However, East Dunbartonshire residents were less likely to meet the target for physical activity (42% East Dunbartonshire; 51% NHSGGC) and less likely to meet the target for fruit/vegetable consumption (29% East Dunbartonshire; 33% NHSGGC).

Although proportionately more respondents in East Dunbartonshire drank alcohol weekly, those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have exceeded the recommended weekly limit for alcohol consumption (17% East Dunbartonshire; 20% NHSGGC) and less likely to have been binge drinkers (27% East Dunbartonshire; 31% NHSGGC).

Table 3: % of negative health behaviours by Age and Gender

Age	**Current smoker**	**Exceeds Weekly Limit of alcohol** (new measures)	**Binge Drinker** (new measures)	**NOT meeting weekly physical activity target**	**Exceeded daily limit of Fat and Sugary Snacks**
65-74	16%	-	13%	65%	34%
75+	14%	-	7%	84%	33%
Men 65+	17%	23%	19%	70%	-
Women 65+	14%	5%	4%	77%	-
All	17%	17%	27%	58%	35%

A number of factors correlated highly with the likelihood of people being smokers; having a BMI of 25 or over; not meeting the recommended levels of physical activity; not meeting the recommended level of fruit and vegetable consumption; and binge drinking. Those exhibiting more unhealthy behaviours included those who received all household income from benefits; those who felt isolated from family and friends; those living in the most deprived areas; and those with no qualifications.

4.3 MORTALITY & LIFE EXPECTANCY

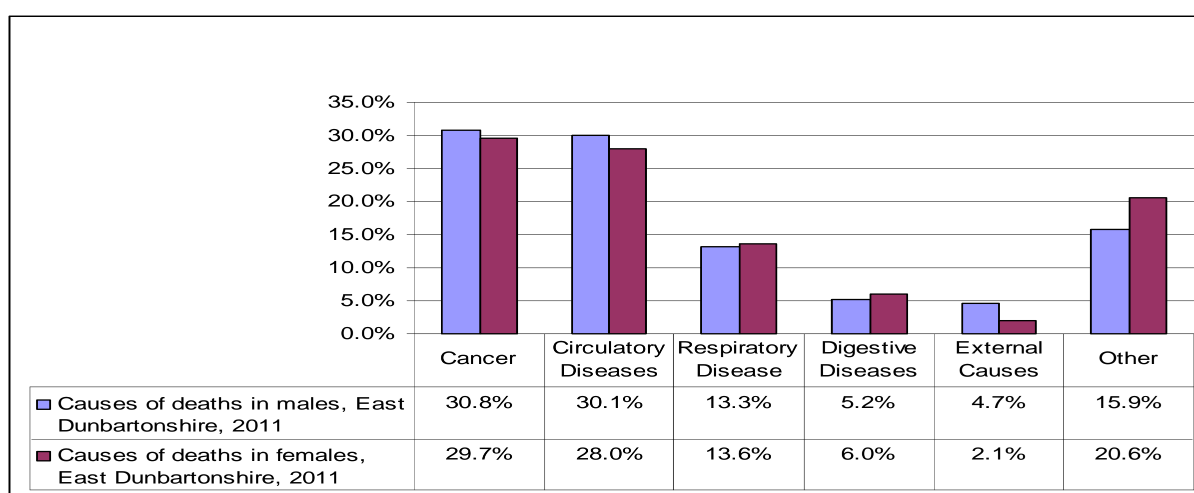
National trends indicate that in general terms people in Scotland are living longer. Residents of East Dunbartonshire can expect to live longer and healthier lives compared to other communities in Scotland. Compared to Scotland over the period 2009 to 2011, East Dunbartonshire had a lower death rate.

Table 4: Death rate (per 1,000 pop) for people ages 65+

East Dunbartonshire	Total	38.6	Male	40.9	Female	36.8
Scotland	Total	48.8	Male	51.4	Female	46.9

Mortality rates from all causes (all ages), coronary heart disease (under-75s), early deaths from cancer (under-75s) and cerebrovascular disease (under-75s) are significantly better (lower) than the Scottish average and are also among the lowest of all Scottish CHPs. The main cause of death in East Dunbartonshire was cancer, followed by circulatory disease.

Figure 4: Main causes of death



Life expectancy is continuing to grow as outlines in **Table 5** below. In East Dunbartonshire, female life expectancy at birth (82.7 years) is greater than male life expectancy (79.4 years) which are greater than the Scottish average and is the highest among all the 40 Scottish CHPs. Male life expectancy at birth in East Dunbartonshire is improving more rapidly than female life expectancy.

Table 5: Life expectancy at birth

	Life expectancy at birth			
	East Dunbartonshire		**Scotland**	
	Male	Female	Male	Female
1998-2000	75.9	80.1	72.9	78.4
2008-2010	79.4	82.7	75.8	80.4
% Change	4.6%	3.3%	4.1%	2.6%

However, there are significant inequalities in life expectancy across different communities, with a differential which is similar to variances experience between some communities in Glasgow. For example, life expectancy in Westerton West is 82.9 years whilst those living in Kirkintilloch West can expect to live for 71.2 years, which is 11.6 years less (GCPH Profiles 2010).

4.4 MORBIDITY

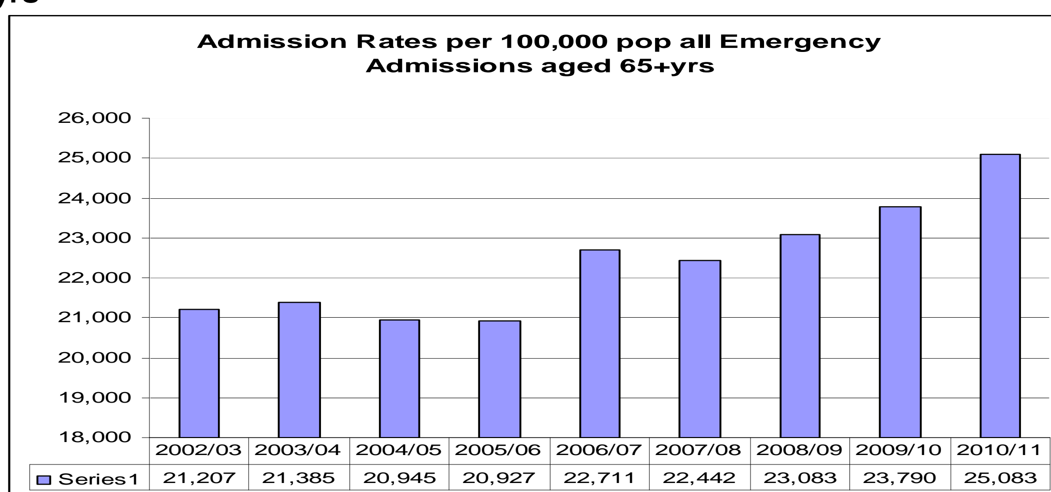
Older people are major users of health services both hospital and GP. As people get older the probability of their requiring admission to hospital increases. Not only are they admitted more frequently but their length of stay for each admission also increases. The number reporting a long standing illness increases with age as does the number needing help with one or more domestic, self-care or mobility task. Older people are also more likely to have to visit their GP or need admission to hospital.

The Health Foundation (May 2011) "Helping People Help Themselves" stated that around 80% of all consultations at GP practices are for long term conditions. Patients with a long term condition or complications of their disease account for around 60% of all hospital bed days.

A long term condition can be defined as a condition that, "requires ongoing medical care, limits what one can do, and is likely to last longer than one year". A long term condition includes any illness, health problem or disability which limits daily activities or work. According to the 2006-based household projections the percentage of people in East Dunbartonshire living with a long term condition is set to increase year on year as a consequence of the ageing population.

Between April 2011 and March 2012 in East Dunbartonshire, there were 1720.9 (crude rate per 100,000 population) hospital discharges for the main LTCs of asthma, chronic heart disease, COPD and diabetes for people of all ages.

Fig 5: Admission Rates per 100,000 pop all Emergency Admissions aged 65+yrs



	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Series1	21,207	21,385	20,945	20,927	22,711	22,442	23,083	23,790	25,083

Dementia is recognised as a long term condition which is likely to increase in line with life expectancy. According to Alzheimer Scotland, around **84,000 people have dementia in Scotland (2012)**, around 2,500 under the age of 65. The numbers of

people with dementia in Scotland is expected to double within 25 years. The number of people in East Dunbartonshire with dementia is estimated to be 1,878, of which 96.5% are over 65 years of age[6]. The diagnosis of dementia by GP practice is currently 79%, below the predicted prevalence for the CHP but is comparable with East Renfrewshire CHCP.

It has been estimated that 78% of healthcare resources are attributable to people living with long term conditions and the World Health Organisation describes their management as “the health care challenge of this century”.

4.5 SERVICE USE

4.5.1 NHS services

The Health & Wellbeing Survey (2010) revealed that 76% of respondents had seen a GP in the last year (85% of 65-74yrs and 91% of 75+). Those more likely to have seen a GP were older respondents, women, those in the most deprived areas, those with no qualifications, those with a limiting condition or illness, those who had poorer diets and those with a high GHQ12 (General Health Questionnaire, which is a measure of current mental health).
Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have seen staff at their GP surgery such as physiotherapist, chiropodist, dietician, occupational therapist or clinical psychologist (8% East Dunbartonshire; 12% NHSGGC).
Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow area as a whole to have visited hospital as an outpatient in the last year (28% East Dunbartonshire; 24% NHSGGC).
Approximately 28% had visited hospital as an outpatient to see a doctor in the last year. Those most likely to have been outpatients were those aged 75 or over, women, those with no qualifications, those who received all household income from benefits, those with a limiting condition or illness, those with a high GHQ12 score and obese people. However, people aged 65 plus reported some difficulty in reaching hospital for an appointment and this was further compounded if living in a deprived community.

People with a limiting condition or illness were more likely to contact NHS24, use the GP out of hours service, visit accident and emergency and be admitted to hospital. Older people reported that they were less likely to have visited the dentist. However, East Dunbartonshire residents were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to have contacted NHS24 in the last year (8% East Dunbartonshire; 10% NHSGGC).

More than four in five (82%) of those who had used health services in the last year felt that they had been encouraged to participate in decisions affecting their health or treatment either definitely (38%) or to some extent (44%). However, this was not the experience across all age groups and those aged 75 or over reported that they were the least likely to be involved.

[6] (http://dementiascotland.org/news/statistics-number-of-people-with-dementia-in-scotland-2012/?page=statistics.htm).

4.5.2 Social Care Services

Most older people live independently either with their partner or by themselves. Contrary to popular perception, very few live in residential care. Even among those aged 85 years and over, the majority live independently, with only 2.1% currently resident long-term in care homes in East Dunbartonshire. Moreover, the majority of the population over the age of 65 do not use formal social care services. Indeed, older people are an asset not a burden and deliver more care than they consume.

As well as focusing on targeting resources to promoting health and well-being and preventing ill-health, supporting carers to help them continue in their caring role is thus a high priority for health and social care organisations. Social care services cover a range of services to help older people maintain and/or optimise their independence, keep them socially engaged, physical healthy and have good mental wellbeing, enabling them to remain living in their own home or a homely setting for as long as possible.

This includes a variety of services across a spectrum of need from low level including information, advice, advocacy, befriending; to those which require a specialist assessment and/or are more intense and complex including care at home including personal care, occupational therapy, supported housing, respite and short breaks and residential or nursing care. Access to Council funded services is via an assessment of need and subject to eligibility criteria. The following are some of the areas of social care service which can be accessed primarily via the Council's Social Work and Housing Services.:-

i. Support for Carers

Carers who provide high levels of care for sick or disabled relatives and friends, unpaid, are more likely to suffer from poor health compared to people without caring responsibilities. 'Carers are more likely than non-carers to report high levels of psychological distress, which can include anxiety, depression, and loss of confidence and self-esteem'. (Source: Hearts and Minds: The Health Effects of Caring)

A key report on caring and health was published in 2004 (In Poor Health: the Impact of Caring on Health - Carers UK and Carers Scotland), revealing that in Scotland more than 12% of all Carers suffer from ill-health with more than 15% of those providing substantial care feeling they are in poor health. Carers UK's own research found that half of the respondents providing substantial care had suffered a physical injury since they began caring often due to having to lift or handle the disabled person. Carers also report other physical health problems associated with stress such as high blood pressure, heart problems etc.

Real Change, Not Short Change (Carers UK and Carers Scotland 2007) shows that in Scotland 71% of respondents have found that their financial situation has worsened since becoming a Carer; 62% of respondents worry about their finances either a lot or all the time; 54% report that this worry is affecting their health. However the report In the Know, the Importance of Information for Carers (Carers UK 2006) refers to 2005 research that demonstrated that an estimated £740 million a year in Carers' benefits alone could be going unclaimed every year.

Our joint approach to supporting carers is set out in our **East Dunbartonshire Joint Strategy for Carers 202012-15** and includes our shared vision of: Working together to support Carers in East Dunbartonshire by ensuring Carers are supported and

empowered to manage their caring responsibilities with confidence and in good health and to have a life of their own outside of caring.

ii. Dementia

People with dementia and their carers need support early on to come to terms with the illness, to manage its symptoms and to put in place legal, financial and care arrangements for the future. As time goes on, people with dementia need increasing help with everyday activities and personal care and eventually will require constant support and supervision. Much of this care is provided by partners and family members, who themselves need support to enable them to do so.
Recent estimates from Alzheimer Scotland[7] suggest that there are over 1,900 people with dementia in East Dunbartonshire, with a very small number (66) of those being aged under 65. Of the carers who sought support from Carers Link in East Dunbartonshire in 2012, 40% -the highest percentage- were caring for someone who had dementia.

Through Change Fund investment to date we have developed a Dementia Advisory Clinic to promote and support diagnosis at whatever the stage of a person's illness and will provide effective, appropriate post diagnostic support.. Everyone who receives a diagnosis of dementia is entitled and will receive information about their illness and the local supports available to them at every stage of their condition, to their family and people important to them.

iii. Care at home

Care at home services are what were traditionally referred to as 'home care'. In the past this has included a variety of care and support tasks including shopping and domestic tasks, as well as personal care (such as bathing). The thrust of the Reshaping Care programme is to help shift the emphasis on care at home services to re-ablement and rehabilitation models that seek to optimise the capabilities of older people. Change Fund monies have been invested locally to redesign the Councils Home Care Service to a re-ablement model.

iv. Self Directed Support

Self Directed Support, sometimes referred to as **personalisation**, is the system that gives people increased choice and control over the support they use to meet their social care needs including using personal budgets. If eligible following an assessment of need, Self Directed Support gives an individual a personal budget where they can then choose what social care and support services this money is spent on, with the opportunity to be as creative as they want, as long as the money is spent to meet their agreed, assessed needs.

Legislation has been passed, and when implemented (in 2013/14), there will be a duty to offer SDS as an option to anyone assessed as having social care needs. A snapshot of Direct Payments (to people to enable people to self direct their own care) between August 2011 and August 2012 reveals these have increased overall by 19% and, in respect of older people, by 35%. As at 31st March 2012 there were 121 people in receipt of a Direct Payments –one form of SDS- in East Dunbartonshire. The age range of those in receipt of Direct Payments is 5 years old to 103 years old. Out of 121 people in receipt of Direct Payments : 41% were Male and 59% are Female; 29% are people with a physical disability; 26% are older

7 http://dementiascotland.org/news/statistics-number-of-people-with-dementia-in-scotland-2013/

people; 21% are people with a learning disability, 20% are people with dementia and the remaining 4% are people with a Mental Illness.

The implementation of SDS will have significant implications for social care providers who will have to respond to requests for support which is more flexible, person-centred and creative, extending from a menu of traditional ‘building-based’ and ‘residential’ services such as day care and respite to tailored short breaks which have the needs of the individual at the centre.

v. Care Homes

The Scotland-wide picture regarding care homes[8] has seen a number of increasing trends over the past 10 years (since 2003) regarding increased short stay of and respite care residents (up 47%). This is consistent with more care being provided at home, primarily by ‘informal’/ unpaid carers. Carers have and will require more supports such as respite and other forms of short breaks to help them continue to in their caring role. More short breaks, however, are being provided at home or in community settings, rather than in care homes.

Long-stay (or permanent) residents equate to 584 (March 2012), having slightly decreased (down 3%) overall. The average age on admission in East Dunbartonshire currently 83 which is the highest in Scotland. Of long-stay residents in care homes, those aged 75-84 have been steadily falling (down 7%), whilst those residents aged 85 plus have been rising at a similar rate (up 8%). In addition, the average length of stay is around 2 years. This suggests that older people in East Dunbartonshire are only going into care homes later, and when it is appropriate for them to do so. For example, admission takes place when their level of need or frailty, and/or the needs of their carer have reached such a level of need or risk that they can no longer be supported at home.

1 in 2 long stay residents in care homes for older people now have a formal diagnosis of dementia (up 22%), with 47% of long stay residents in East Dunbartonshire currently medically diagnosed. This number overall has increased by 70%, demonstrating an increasing trend since 2005 and is in line with Scotland’s national dementia strategy.

vi. Housing, Adaptations and Care & Repair

Meeting the housing needs of older people is a significant and increasing issue within the context of an ageing society in East Dunbartonshire. With increasing demand for people to continue living in their own homes, there is increasing pressure to provide solutions that will enable residents to do so. Although much of the following data is not age specific it is safe to assume there are implications for older people living in East Dunbartonshire.

In terms of the local tenure profile, there are substantial variations at an area level. The most significant variation is evident in Twechar with 46% of dwellings in the social housing sector, 53% owner-occupied and just 1% in the private rented sector. Lennoxtown and Kirkintilloch also vary from the overall tenure profile in East Dunbartonshire, with an average of 22% of dwellings in social housing, 72% owner-occupied and 6% in the private rented sector.

[8] Care Home Census 2012 ; Statistics on Adult Residents in Care Homes in Scotland 30th October 2012; ISD Scotland.

The communities which have been identified as the most disadvantaged and therefore in need of intervention are also the communities that have the highest concentrations of social housing.

In East Dunbartonshire the incomes of those in public sector housing are just 46% of those earned by households living in private sector housing. It is also worth noting that income levels in private tenure in East Dunbartonshire are 12.7% higher than the national average whilst the income levels in social tenures are 6.3% lower than nationally. This income disparity demonstrates clear economic inequalities evident by tenure in the area.

According to the Scottish House Condition Survey 2004-07 (SHCS), approximately 35,000 (81%) of dwellings in East Dunbartonshire suffer from some element of disrepair; which is slightly worse than the national position at 78%. Furthermore, the SHCS identifies that approximately 16,000 dwellings are in serious or urgent levels of disrepair (37%), which is approximately the same as national levels (38%). Overwhelmingly, serious disrepair in East Dunbartonshire is located in private sector housing (81%) which is considerably higher than the Scottish position at 72%.

The Council carried out a housing need and demand assessment in partnership with other local authorities in the Glasgow Clyde Valley area. The study estimated that the housing requirement in East Dunbartonshire up to 2020 will be in the region of 7,700 units, which includes 4,800 affordable homes (which includes homes for social rent and low cost home ownership) and 2,900 private homes.

In some cases older people may be living in houses that are larger than they would like. However frequently people want to remain in the house where they have lived most of their lives even if they find it difficult to maintain. Many older people therefore require adaptations (often quite minor) to allow them to remain in their own homes

The Care and Repair service assists elderly owner to live independently in their own home by enabling them to access repairs, improvements or adaptations to their home. The qualifying criteria for these services has been widened to include those customers who are home-owners or privately renting tenants aged 70 and over or aged 60 and over with a disability or long-term illness. The Small Repairs/Home Safety Service has also been widened to include Council and Registered Social Landlord tenants.

The service assists clients to access local authority grants, savings or loans, as well as managing the repair process for the client. The Care & Repair service in East Dunbartonshire plays an essential role in the delivery of aids and adaptations and repairs and maintenance services which can help prevent future falls from taking place and eliminate the risk of injury from a number of sources in and around the home. The Care and repair scheme provides a diverse range of services across the authority, including information and advice services about local housing and additional support options,

The number of clients who have accessed the Care & Repair Scheme during 2012/13 amounts to 2,467. East Dunbartonshire Council has assisted approximately 100 customers for adaptations during the 12/13 year and has spent approximately £350,000. The council's housing service has also invested £300,000 on council properties throughout the year and this service has also received Change Fund investment.

4.5.3 Wider Community Planning Services

i. Leisure

The Health & Wellbeing Survey (2011) suggests those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to rate local leisure/sports facilities positively (66% East Dunbartonshire; 49% NHSGGC). Those aged 65 or over were the most likely to give a positive rating, with men (68%) and women (73%) rating local services as excellent. However, this varied considerably with people living in deprived communities and who felt socially excluded reporting less positive perceptions.

ii. Public Transport

Those in East Dunbartonshire were less likely than those in the NHS Greater Glasgow & Clyde area as a whole to rate local public transport positively (64% East Dunbartonshire; 75% NHSGGC) and those aged 65 and over were the least likely to rate public transport positively.

Table 7: Perceived Quality of Public Transport (Q42c) by Age

Age	Excellent/ Good	Adequate	Poor/ Very Poor	Number
65-74	57%	26%	16%	163
75+	68%	27%	5%	138
All	64%	28%	7%	944

iii. Police Services

Those in East Dunbartonshire were more likely than those in the NHS Greater Glasgow & Clyde area as a whole to rate the police positively (58% East Dunbartonshire; 51% NHSGGC) and older people were the most likely to report positive perception than those under 25 years. However, those in the most deprived areas were the most likely to rate the police positively.

Table 8: Perceived Quality of Police (Q42g) by Age and Gender

Age	Excellent/ Good	Adequate	Poor/ Very Poor	Number
65-74	54%	39%	7%	139
75+	61%	31%	8%	120
Men 65+	64%	27%	9%	104
Women 65+	52%	42%	6%	155
All	58%	37%	6%	857

5. STAKEHOLDERS ENGAGEMENT

Community Planning partners have an ongoing programme of listening to older people, their carers and health and social care staff across various settings. This contributes significantly to the body of knowledge and understanding about local needs.

5.1 WHAT OLDER PEOPLE & THEIR CARERS TELL US

A series of engagement events with older people and their carers took place during June and July 2012. The aim was to elicit their views regarding the key factors they believe would maintain their overall health, wellbeing and quality of life.

Over 250 people took part in eight events which were hosted and delivered in various settings including lunch clubs, sheltered housing complexes, user forums and carer groups. Participants ranged from individual members of the public to those involved in community and voluntary groups.

Based on these engagement events and previously held seminars in respect of developing a local Vision for Reshaping Care for Older People, the following themes emerged:

Remaining Healthy - the need to remain healthier for longer was cited as being one of the most important aspect of becoming older.

Home Care - people placed great value placed on homecare services. However, concerns were raised about the service becoming less flexible in terms of the level and type of support available, the limited amount of allocated time to deliver the care required, and the constant change of personnel meant there was inconsistency in the care for the older people.

Connecting with their community - Some older people and carers expressed feelings of isolation and their desire to socialise which many felt was vital for helping them to stay independent at home. There was no issue in relation to whether services were provided by either public or third sector organisations and many cited the value of church run activities.

Providing information - Value was placed on the provision of a range of information that was accessible and in plain language and in a variety of formats such as leaflets, posters, web-based.

Equipment & Telehealth - this was seen as an essential requirement to allow people to be cared for in their own homes, as well as preventing injury to their carer.

Day Centres - Day Centres were cited as important services for both the older person and their carers.

Assessing need and paying for care - Many individual were happy to pay for some care but believed the current system of assessing need and allocated care was complex, difficult to understand and even more difficult to navigate.

Carer respite - Older people recognised the need to provide respite for their carers in order that they can stay healthy and able to continue their caring role for longer.

Care Homes - Some concerns were raised about the robustness of the inspections of care homes. It was felt more credence was given to the building and furnishings rather than client care.

Public Transport - A number of groups raised the need to improved public transport in terms of bus routes and frequency as this is an essential service that helped in the prevention of isolation.

Health & Social Care Services - A single point of access to public sector services was highlighted by a number of groups as vital. Carers expressed the need to improve 24/7 access to health and social care services where appropriate. Some individuals experienced frustration in relation to the number of different practitioners they see, this included GPs, nurses, social work staff.

Power of Attorney and Guardianship - People highlighted the need to raise awareness and provide advice in relation to securing power of attorney and guardianship

Housing - People raised the need to provide a range of housing options to meet the diverse needs of older people. Services such as the Care and Repair service are much valued and felt to be vital for keeping people safe and secure in their own homes.

Voluntary Sector - Residents felt the voluntary sector was underfunded which impacted on their ability to provide consistent support and/or services, as well as limited capacity to increase the reach of their services. Many believed there is a need to build confidence in and competence of the third sector to deliver care to the same standard as traditionally delivered by public sector organisations.

Volunteering - opportunities for older people and for those who want to support/assist older people was greatly valued but there were concerns raised about the over reliance on volunteers to provide what people considered to be essential public sector services**.** Carers believed that volunteering played an important role in supporting older people and carers to stay connected to their own communities.

5.2 WHAT OUR PRACTITIONERS TELL US

A range of stakeholders were invited to a protected learning time event (PLT) held in May 2012, to discuss how services for older people within East Dunbartonshire could be further improved. Over 150 people attended including CHP staff, hospital sector staff, GPs and practice staff, social work staff, voluntary organisations and members of the Public Partnership Forum. The aim of this event was for stakeholders to discuss how we could improve services for older people within East Dunbartonshire. People were grouped together into geographical communities to create the opportunity for them to discuss and share information about local issues, developments and potential solutions. Participants were tasked with discussing two questions:

1. How do we support people to stay independent longer and to self-manage their condition?

2. What is working well/what are the gaps to ensure services are sufficiently flexible to meet the needs of this population over the 24/7 period

Participants identified a spectrum of services that they felt were working well. This ranged from social interaction support such as befriending to more targeted support for more vulnerable individuals, for example rehabilitation services.

Key areas were also highlighted where improvement was considered necessary. This included more effective joint working across sectors and organisations; more flexible services across the full week (including out of hours); better IT systems that communicate across organisational boundaries; and more systematic and coordinated access to the diverse voluntary sector. A number of specific themes emerged during discussions including:

Access to information, advice and resources was considered vital to empower patients to more effectively manage their own health. It was acknowledged that professionals didn't need to provide all the necessary information but they should be well informed about a menu of potential support and services available for older people that could be delivered by a range of non-statutory sector organisations.

Developing a collaborative anticipatory care approach was a common theme. Many stressed the need for proactive intervention much earlier, even before service users made regular contact with services. Emphasis was placed on the need to effectively anticipate deterioration in health rather than wait for ill health'. An important step would be to establish a single point of access for Older People's services which would result in quicker referrals.

End of life sensitive and practical discussions with service users, regarding both clinical and non-clinical issues, was felt to be vital and need be delivered at an earlier stage.

Building community capacity was considered to be an important step towards co-production where a range of community, voluntary and independent sector organisations are able to deliver a range of health and well-being preventative intervention and support services. A single point of access for practitioners and the public to the voluntary sector was suggested in order to reduce current barriers.

Adopting a public health preventative approach to supporting older people to stay healthy was advocated by many participants. This involves starting very early, including looking after your health programmes in schools and intergenerational work to promote health improvement at a population level.

Supporting older people to remain at home was considered by all to beneficial to the health and well-being of the individual and their families and carers. It was advised that this would only be achieved if appropriate home care support was in place to ensure the safety and quality of life is maintained for older people.

Self directed support was seen to be an important and emerging approach to enable older people and their carers to make choices about the type and level of support they require.

Supporting carers to maintain the caring role was a common theme and was considered a priority to enable both the individual and the carer to stay healthy and active within their community.

6. STRATEGIC PRIORITIES

The national Re-shaping Care for Older People Programme is an important driver for partners to develop strategies and commissioning plans, as well as local Transformational Change Plans, to improve the quality and outcomes of our current models of care.
The next 20 years will see an ageing population, a continuing shift in the pattern of disease towards long-term conditions, and growing numbers of older people with multiple conditions and complex needs. These changes in themselves will make the current model of health and social care delivery unsustainable.

In line with national policy, it is our goal to '**optimise the independence and wellbeing of older people at home or in a homely setting'.** The use of the Change Fund will be multi-faceted but will essentially act as a bridge to achieve transformational change and allow partners to target resource at those in greatest need. It will also support communities through capacity building and co-production, long term conditions management, carers support, re-ablement, anticipatory care and rehabilitation. Services will need to be responsive to the changing population profile of citizens to enable them to lead healthy independent lives and support their wellbeing.

Community planning partners' strategic Vision is that:-

"Older people and their carers are supported to enjoy a high quality of life, achieve their potential, and that they are safe, healthy and 'included"*.*

Community planning partners will work together, with and for older people and their carers, to address high level Strategic Priorities[9]:

- **People living as independently as possible**
- **More people living at home or in a homely setting**
- **Carers supported and able to continue in their caring role**
- **Assets and resources available to the community are supported to grow and develop**

The pace of change is likely to quicken, and it will be important to plan for some of these changes. There will be a need to use the total resource available to partners differently to achieve efficient and effective services. Integrated planning of service configuration, service design and workforce requirements will be necessary, as well as other forms of care such as the informal care provided by family members, friends and other members of the community. It is widely understood that the future of health and social care services will not be 'more of the same'.

6.1 PROMOTING HEALTH, INDEPENDENCE AND WELLBEING AND DEVELOPING COMMUNITY CAPACITY

There is no agreed definition of older or old people and people differ widely in what they consider to be old. Older people are not a homogenous group. They have

[9] Enshrined with in the East Dunbartonshire Joint Community Care Planning Framework 2012-15

different interests, life circumstances and aspirations. They want to take part in activities that improve their wellbeing and enjoy living independently in their home for as long as possible.

Though many older people lead happy, well-balanced and independent lives the transition into later life can be affected by many different variables, including physical and mental health, financial security, societal attitudes, geographical location, access to support and services and responsibility for the care of others (Age Concern and Mental Health Foundation 2004).

Healthy Lifestyles

Everyone benefits from healthy living, (not smoking, eating healthily, not drinking too much and being physically active) but older people benefit even more than others. The maintenance of physical activity in later life is central to improving physical health. Regular exercise has beneficial effects on general health, mobility and independence, and is associated with a reduced risk of depression and related benefits for mental wellbeing, such as reduced anxiety and enhanced mood and self-esteem (DH 2005c). Physical health and mental health, in turn, also have an impact on older people's economic circumstances and on their ability to participate in society (Marmot et al. 2003). Physical activity includes all forms of activity, such as 'everyday' walking, cycling, dancing, gardening and organised and competitive sport.

Good nutrition can help to combat chronic disease whilst poor nutrition predisposes to disease and adversely affects its outcome in terms of complications and delays recovery from illness. It is essential that older people like everyone else have opportunities to be physically active and choose a healthy diet to stay healthier for longer.

Smoking is the single largest preventable cause of cancer. There are benefits to stopping smoking even in later life. By stopping smoking, people can avoid smoking-related disease and live longer. For example, over a period of time, an ex-smoker's risk of suffering from heart disease can fall to the level of someone who has never smoked.

Immunisation against influenza and pneumococcal infection is of great benefit to the individual and the population. These evidence-based preventative steps also reduce the burden on overstretched health and social care services by reducing the number of people who develop disease and subsequently need to access services.

Financial Inclusion

It is widely accepted that the stresses of living in poverty are particularly harmful to a number of vulnerable groups including older people and low income, age and poor health have been identified as factors in increasing social exclusion in communities. Older people are often reluctant to claim benefits because of the complexity of the claiming process, the stigma associated with claiming benefits (particularly means tested benefits), ignorance of their rights and limited access to advice services.

Putting money back into residents' pockets is one of the most powerful actions organisations can take in relation to addressing social inclusion. Having an adequate income is essential if older people are to maintain a decent standard of living – eating properly, heating their homes adequately and being able to afford to socialise. Access to good quality advice and information including benefit maximisation is therefore essential to enable older people to make the best use of

services and maintain their independence, quality of life and promote their social inclusion.

Social Interaction

Isolation is a particular risk factor for older people from minority ethnic groups, those in rural areas and for people older than 75 who may be widowed or live alone (Office of the Deputy Prime Minister 2006). Social activities, social networks, keeping busy and 'getting out and about', good physical health and family contact are among the factors most frequently mentioned by older people as important to their mental wellbeing (Third Sector First 2005; Audit Commission 2004).

Meaningfully active

Working, either in a paid or voluntary capacity, is good for your health and many older people make an important contribution across all sectors, many of which would not function without them. As well as the positive health gains for the individual, older people add to the economic advantage of communities in the longer term. There is a need to build community capacity that involves older people supporting older people, consequently generating more care within and for the community

Priorities:

- Building strong local health alliances as a way to deliver joint health improvement priorities and reduce inequalities
- Deliver leisure, cultural and recreational activities and services that reflect the needs of older people in order to maximise both physical and mental health outcomes, as well as optimising commercial opportunities
- Increase older people and carer awareness of entitlements and develop robust referral mechanism to maximise the reach and facilitate easier access to good quality financial inclusion and income maximisation services
- Develop community capacity and strengthen social networks that connect older people and carers to their communities, helping them access additional information, advice and services, as well as encouraging them to play their full part in contributing to the life of their community

6.2 MORE PREVENTATIVE, PERSONALISED AND ANTICIPATORY CARE

Old age is not an illness and the majority of older people are active, independent and participate in their community. They can continue to use, and benefit from, services that they have been enjoying prior to retirement. However, the probability of experiencing a wide range of health problems and limitations of function increase with age.

Keeping older people healthy by preventing and managing illness is vital for keeping people more independent for longer and an important aspect is to support individuals to build resilience to sustain independence and prevent or reduce reliance on services. The challenge for services is to provide more preventative, personalised, anticipatory care, and better co-ordination and integration across the whole system of services. To do nothing would result in increasing pressures on existing resources and services, which in the current financial climate is not sustainable.

A number of approaches, interventions and services are being developed to support individuals and their carers to remain as healthy and independent as possible.

Supported self-care/self-management

There is a commitment by health and social care partners to develop a model of supported self-care/self-management. This approach provides a portfolio of techniques and tools based on a continuum of interventions which supports a patient-care giver relationship that is collaborative in nature. The key components include:

- providing information for people affected by long term conditions in a range of accessible formats to meet the needs of diverse populations
- providing patient education and self-management programmes that help people to better understand and effectively manage their condition
- assisting self-care though peer support, buddying, self-help and advocacy
- improving Access to Health & Well-Being interventions and services provided at the right time as part of the planned management of their condition
- supporting for Carers to improve outcomes for the individual and the carers themselves
- optimising advances in electronic technology such as Telecare and Telehealth, which use of a range of technologies to support those at home

Personalisation and self-directed support

Personalisation and the increasing use of self-directed support and individual budgets may provide positive outcomes for the ageing population with high care needs to choose and control services which are safe for them as well as socially and/or culturally acceptable. Self Directed Support is about having choice, flexibility and control over your life. It is about making sure that people with social care needs are helped to find support to live the way they wish to lead their lives, and is a key driver in the adoption of an assets based approach –or co-production- to the development and delivery of services to meet social care needs.

Enactment of the Social Care (Self-directed Support) (Scotland) Act 2012 will begin from 2013. This will mean that, following an assessment of need, individuals will be required by law to be offered 4 SDS Options – on a sliding scale for flexibility, power and choice – from maximum to minimum:

(i) Direct Payment – the individual is given their Individual budget and manages their own monies/support, perhaps with support from another person or through legal Power of Attorney;
(ii) Individual Budget – the individual still manages their choices for support and how their monies are spent – but the Local Authority hold the sum (budget) on their behalf.
(iii) The Local Authority, in discussion with the individual, chooses the services/support required to meet the individual's outcomes.
(iv) A mixture of options from A, B, C for different parts of the Support Plan.

Examples of how SDS could benefit a service user include: paying for a Personal Assistant (PA) to support needs whilst studying for a degree; purchasing airline tickets for family members to visit, giving carer a short break; paying a friend to

support an individual going to Church/Mosque; instead of day centre, support to go cycling; visiting a friend; paying for gym membership; having a short break on the South Coast and hiring a local PA. A carer could also benefit by, for example: a short break away with support for service user; driving lessons/test to enable a carer to transport or visit service user; purchasing a washing machine to reduce trips to the launderette; employing a PA to accompany a carer and service user on holiday; or laundry or cleaning service enabling the carer to focus on personal care.

Anticipatory care

As the needs of an individual increases and they become more vulnerable, they may benefit from a care pathways that is individually tailored to meet their requirements and to prevent unnecessary hospital admissions. A model of anticipatory care builds on the continuum of supported self-care whilst also providing a more detailed anticipatory care plan that clearly identifies the support mechanisms that work together to maintain the individual in their own home and support early discharge. Considerable work is underway to redesign health and social care services to ensure anticipatory care becomes main-streamed. The pathway will involve:

- identifying vulnerable people through predictive modelling tools e.g. SPARRA (Scottish Patients At Risk of Readmission/ Admission).
- assessing and anticipating support needs, including early diagnosis of dementia; support for adults with incapacity, predicting exacerbation of disease and hospital admission, and falls prevention.
- reviewing specific supports and services required.
- sharing the anticipatory care plan with relevant health and social care providers to prevent unnecessary hospital admission and allow effective discharge planning.

Housing and housing support

The growth in the older population necessitates an on-going requirement to identify and invest in housing and support options that enable older people to maintain independence, including housing aids, adaptations and assistive technology.

Given the high levels of outright home ownership in East Dunbartonshire, it is likely that the current and emerging older population may have property equity that could facilitate a move to a more appropriate or sustainable house types if the right product were available or developed in the private housing market. The projected and substantial growth in frail elderly households suggests the requirement and justification for the development of more intense forms of supported or progressive care housing in the area.

Local strategic priorities and specific actions in respect of older people are outlined in the East Dunbartonshire Local Housing Strategy 2011-2016.

Rapid access to adaptations and equipment

According to the Scottish Government's "Shifting the Balance of Care" agenda, adaptations represent excellent value for money and as such provide a cost effective approach to independent living. As with all preventative services, the provision of aids & adaptations requires investment. Evidence suggests the benefits outweigh the cost in terms of reductions in the use of home care and delays in requiring more intensive services in the future. It is also suggested that investment in this area and

will achieve efficiencies through a system focused on early intervention, prevention and re-enablement.

The provision of Aids & Adaptations can be effective in:-

- maintaining functional ability, social participation and quality of life for service users living within the community
- decreasing falls in elderly at high risk of falling
- reducing exposure to risk
- enhancing life quality
- potential savings in the cost of care provision
- supporting early discharge from hospital
- building the confidence of service users/carers

The East Dunbartonshire model of delivery involves a combination of an Occupational Therapist and aids & adaptations, in conjunction with the support from the re-ablement team. The service focuses on increasing or maintaining functional independence, social participation and quality of life from a preventive perspective.

Support for Carers

As indicated above, shifting the balance of care from residential and institutional settings to care at home and more people being cared for at home for longer has implications for Carers. A key source of informal or unpaid care is the people who live in the same household. However, the last half century has seen a major decline in older people living in the same household as their adult children or in other more complex types of household. The vast majority of older people now live alone or with only their partners.

Consequently, the need to provide carers with the help and support they will require to undertake their caring role will increase significantly. Supporting carers can not only lead to increased positive health outcomes for the patient, but also for the carer themselves. The Joint approach to supporting carers is set out in our **East Dunbartonshire Joint Strategy for Carers (2012-15).**

Power of Attorney and Guardianship

With increasing older age individuals may become more vulnerable to incapacity to manage their own affairs. Carers may be close to someone who:

- is finding it difficult to make decisions for themselves
- wants to put their affairs in order in case the time comes when they need help
- may already be unable to cope with managing their personal welfare and finances
- has asked you to administer their finances and property because they are planning to be abroad for a while
- is taking decisions that are not in their best interests, for example, overspending or making unnecessary purchases.

Health and social care partners will need to work in partnership with the independent and voluntary sector to raise awareness of Power of Attorney and Guardianship in

order that residents are able to access the support they require to meet their needs. This involves supporting individuals to put appropriate arrangements in place at the right time for the management of their affairs.

Priorities:

- Embed self-support/management approaches for people with long term conditions
- Establish a model of anticipatory care across health and social care services
- Develop a range of housing options to meet the needs of older people and improve the level of housing support provided
- Develop, in partnership with Registered Social Landlords, new housing which is accessible and built to varying needs standards. This will include provision of equipment, adaptations and Smart/Telecare technology
- Further develop a multi-faceted aids & adaptations model of service
- Deliver the priorities outlined in the Joint Carers Strategy (2012-15), including respite support and technological solutions
- Raise awareness of and support residents to access Power of Attorney and Guardianship

6.3 CARING FOR PEOPLE IN THE RIGHT PLACE AT THE RIGHT TIME

A key principle in the care of vulnerable older people is that of timely help through joined up care. Health and social care systems are complex with many interfaces. Older people should experience the care and support they receive as if it were from a single source, or managed through a single source. This is fundamental to the development of the single assessment process which seeks to ensure that older people only have to tell their story once to those who are helping them, rather than repeating it to each person involved in their care and that professionals have access to all the information they need to provide support and care.

Health and social care services are required to review patterns of service delivery to plan appropriately to meet the needs of older people and to ensure measures intended to increase the efficiency of service do not disadvantage older people. They also need to ensure that staff providing care for older patients have the essential knowledge and skills to provide appropriate care. Supporting older people across community and hospital settings across the 24hr, 7 day period requires coordinated planning with all partners. Key aspects include:

Early supportive discharge

The arguments for moving more care closer to where patients live are compelling. Hospitals are expensive, impersonal and risky places in which to deliver care that does not require a high tech and specialised environment. In recent years, health policy in Scotland has very clearly aimed to shift the provision of at least some elements of care out of hospitals and into community settings. A key challenge is achieving a shift in the balance of care within the context of hugely complex

healthcare delivery systems and across different patient groups from very different social and economic circumstances.

Early discharge interventions are designed to provide coordinated rehabilitation and specialist care for patients discharged early from hospital in order to relieve the pressure on acute hospital beds. Evidence suggests that discharge planning can reduce the length of hospital stay, increase patient satisfaction, and reduce the number of patients experiencing a delay.

East Dunbartonshire health and social care partners are currently involved in a range of work to support the development of a range approaches which focus on prevention, rehabilitation, re-ablement and recovery to support early discharge. The intention is not only to help to stop unnecessary admissions to hospital but also to help ensure a timely discharge following a hospital stay.

Re-ablement

Key messages are beginning to emerge from current research evidence regarding the benefits of implementing a re-ablement model of health and social care. Re-ablement supports a service focus on independence and harnesses the joint input of health and social services. The focus is on restoring independent functioning rather than resolving health care issues, and on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves.

According to the Social Care Institute for Excellence, this approach helps people learn or re-learn the skills necessary for daily living, which have been lost through deterioration in health and/or increased support needs. It is also suggested re-ablement is cost-effective; reducing ongoing support needs through sustaining independent living.

The evidence also suggests that people [and their carers] using this type of service appear to welcome re-ablement and the need for social care services is reduced by 60 per cent compared to if they had used conventional home care. Other results show that up to 63 per cent of reablement users no longer need the service after six to 12 weeks, and that 26 per cent had a reduced requirement for home care hours[10]

East Dunbartonshire health and social care partners are committed to this approach and is currently redesigning services to ensure care workers have the appropriate training and supervision to adopt a model of support which facilitates ongoing independence for older people.

Out of Hours Services

Until April 2004, general practitioners (GPs) in the UK were responsible for either directly providing primary healthcare services or for arranging 24-hour cover for their registered patients. The new General Medical Services contract (nGMS) transferred this responsibility to health authorities, allowing GP practices to opt out of the provision of out-of-hours services.[1] As a result, by the end of 2004, 95% of GP practices in Scotland had done so as had most in the rest of the UK. As a result, rather than patients being guaranteed access to a GP (usually either their own or another through a local GP co-operative), they can choose a range of routes into care. The out-of-hours period is defined as 18:30 to 08:00 weekdays and all day at

[10] (http://www.scie.org.uk/files/EmergingMessages.pdf)

weekends and bank holidays, though in practice in many parts of the country the service starts at 18:00 through local agreements. The Primary Medical Services (Scotland) Act 2004 placed a duty on NHS boards to provide primary medical services to their resident population.[2] NHS provision for out-of-hours care is the responsibility of the 14 territorial health boards, and two special health boards – namely the Scottish Ambulance Service (SAS) and NHS 24 service which provides 24-hour telephone access to trained nurses. Patients can access services through NHS 24, out-of-hours centres, Accident and Emergency (A&E) departments and the SAS.

The CHP has identified a number of improvement actions which are detailed in the Joint Strategic Commissioning Plan. These involve developing practice protocols for multi-disciplinary teams; better integrating patient assessment and planning with out of hours services; and improving information sharing and patient pathways relating to out of hours.

Medicines management

Medicines management is described by the Department of Health, as the process of managing the way in which medicines are chosen, bought, delivered, prescribed, administered and reviewed, including appropriate safe, agreed withdrawal, in order to make the most of the contribution medicines can make to improving care and treatment.

Medicines have often been the first treatment offered to patients when they present with health problems and whilst they can be of significant value, they can also cause harm if not used appropriately. It is essential that their management is as effective as possible. The Medicines Management workstream within the Scottish Patient Safety Programme aims to provide safe and effective medicines management. A particularly growing issue is 'polypharmacy' which is when patients are prescribes multiple medicines. This can lead to increased adverse medication reactions, decreases in drug compliance and ultimately increased wastage. The CHP will further collaborate with health and social care professionals, physicians and patients to identify and deliver programmes to support effective administration of medicines, address polypharmacy problems, and reduce risk and waste.

Specialist Clinical Support

The demand for acute medical admissions has risen relentlessly over recent decades and older people constitute the fastest growing section of the admitted population. The rise in demand for acute admissions has been accompanied by a decline in the number of acute hospital beds and greater use of early supported discharge schemes. The impact of admission avoidance schemes is uncertain, although it is recognised that many acute medical conditions can be dealt with comprehensively and safely in the community, provided systems are in place to allow this to happen.

Health and social care partners in East Dunbartonshire recognise that the clinical problems and needs of older patients are often substantially different from those of younger patients. Many older residents are admitted with acute or sub-acute medical illness, which often presents in non-specific manner, and may be accompanied by cognitive or functional deterioration. Furthermore, many older patients have multiple co-morbidities, polypharmacy and complex social care needs. Health data illustrates that patients with complex issues are less likely to be

discharged from acute services, have significantly longer length of stay in hospital if admitted, and have higher re-admission rates. The CHP acknowledges the benefits of patients receiving a comprehensive Geriatric Assessment (CGA) and has prioritised reviewing geriatrician support outwith the hospital setting.

Care home setting

The ability to make choices about how people live their lives should not be restricted to those who live in their own homes. It is about better support, more tailored to individual choices and preferences in all care settings. Some older people may have very complex health and care needs where being at home may not be considered the safest place. A care setting could be the person's home, a hospital, a day service, a care home or anywhere that care and support is provided.

Older people wherever they are being cared for can expect a good standard and quality of care. Respect for dignity and human rights is central to the provision of care in all settings and central to the process of commissioning of care on an individual or contract basis.

East Dunbartonshire is committed to working with the third sector, who provide all of the care home provision in the area, to share ideas, expertise, good practice and consensus regarding our philosophy for care and support and how this will be delivered. This will include exploring re-ablement models of care within care homes where appropriate, and options for intermediate care (also known as step-up/ step-down).

Palliative care

The World Health Organization (WHO) defined palliative care in 2004 as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

In 2004 WHO recommended that planning for care at the end of life should be responsive to patient choice regarding place of care and place of death.

East Dunbartonshire health and social care partners are committed to providing palliative care which focuses on the person, not the disease, and applies a holistic approach to meeting the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement (Living and Dying Well - a national action plan for palliative and end of life care in Scotland 2008). Palliative and end of life care are integral aspects of the care delivered by local health or social care professional involves the provision of support that takes account of the quality of life for both patients and families at every stage of the disease process and is not just about care in the last months, days and hours of a person's life. A number of key areas for improvement have been identified and include improving support for all palliative care patients to enable them to die at home if they wish; providing bereavement support for carers; and working with care homes to enable them to better support families with end of life care.

Priorities:

- Review the patterns of health and social services, ensuring appropriate services are available and that measures intended to increase the efficiency of service do not disadvantage older people
- Further develop interventions to support early discharge from hospital
- Embed a re-ablement model of care across health and social care services
- Improving information sharing and patient pathways relating to out of hours.
- Develop programmes to support effective administration of medicines, address polypharmacy problems, and reduce risk and waste.
- Further enhance the knowledge, skills and competency of the workforce caring for older people
- Review geriatrician support within a continuing care environment
- Work with patients, carers and providers to better support families with end of life care

7. DELIVERING THE PRIORITIES

To achieve the cultural shift toward personalisation, co-production, early intervention and the preventative agenda envisioned by "Transformational Change for Older people" will mean working across boundaries of social care, housing, benefit services, leisure, adult education, transport and health.

It will mean working across sectors with partners from independent, voluntary and community organisations to ensure a strategic balance of investment in local services from support to people with fairly low needs right across the range to people with very complex needs. The aim must be to shift the main focus of care and support away from intervention at the point of crisis to a more pro-active and preventative model centred on improved well-being, with greater choice and control for individuals.

Strong leadership is critical and the Strategy will be agreed and signed up to by Community Planning partners, as part of the Single Outcome Agreement.

East Dunbartonshire Council and Community Health Partnership have developed a Joint Strategic Commissioning Plan –Part 2 of the Framework for Improving Health, Wellbeing and Care in East Dunbartonshire 2013-23- which will act as the delivery plan for this Ageing Well Strategy (Part 1), and will form the basis for future commissioning by both Health and Council services. Resources spent across the whole system need to be taken into account to make the transformational changes and all agencies will be held to account through review of agreed key performance indicators.

The East Dunbartonshire Older People's Transformational Change Programme Board will take the lead in ensuring implementation of this Strategy and the monitoring of progress against Strategic Commissioning Plan priorities. Engagement with local communities and their ownership of the agenda and experience of the outcomes will be critical in judging success.

Part **two** Joint Strategic Commissioning Plan

JOINT STRATEGIC COMMISSIONING PLAN

CONTENTS

1.	**Introduction**	**39**
	1.1 Context and background	39
	1.2 Purpose	40
	1.3 What is Commissioning?	41
2.	**Analysis- Preparing for future demand**	**42**
	2.1 Legislation, local and national policy context	43
	2.2 Population needs	43
	2.3 Stakeholder engagement	44
	2.4 Older People Services	45
	2.4.1 East Dunbartonshire Council	45
	2.4.2 NHS Greater Glasgow & Clyde	47
	2.4.3 Independent Sector	49
	2.4.4 Voluntary Services including Volunteering	50
	2.5 Expenditure on services	51
	2.6 Analysis of service delivery	52
3.	**The Planning**	**54**
	3.1 The Design of future services	54
	3.2 The Commissioning Model	55
4.	**Commissioning Priorities**	**56**
	4.1 Promoting Health & Wellbeing	56
	4.2 Preventative & Anticipatory Care	57
	4.3 Proactive Care & support at Home	59
	4.4 Effective Care at Times of Transition	61
	4.5 Hospital and Care Homes	63
5.	**Governance Arrangements**	**66**
6.	**Opportunities & Challenges**	**67**

1. INTRODUCTION

1.1 CONTEXT AND BACKGROUND

This Joint Strategic Commissioning Plan for Older People is being progressed by East Dunbartonshire Council and the Community Health Partnership with a range of stakeholders including our partners in the voluntary sector, older people and their carers. It sets out in detail the medium term (1-3 years) priorities and will set out the longer term (to ten years) commissioning priorities for both health and social care services for older people between 2013 and 2023. This document will replace the Older People's element of the existing Social Work Commissioning Strategy as it relates to joint older people's services.

The plan is being developed in response to national policy drivers, in particular, the Scottish Government's Reshaping Care for Older People agenda. More recently, the Scottish Government's plans for integration of health and social care services emphasise the need to:

- deliver joined-up commissioning priorities locally across social care and health
- respond to local challenges to identify and address gaps
- review resources to develop improved targeting and fairer access to services.

Re-shaping Care for Older People Programme for Change to 2021 which the Scottish Government launched in 2010 has as its principal goal**:** ***'to optimise the independence and well being of older people at home or in a homely setting'***. This can be best achieved by developing an approach which supports people to remain as independent as possible by supporting their recovery with for example, rehabilitation, and re-ablement services. We also have to look beyond the current situation and devise new models of delivery which include public services that are financially sustainable in the longer term, and partnership engagement with communities in how new models will be designed and measured.

The 'Vision' for the East Dunbartonshire Partnership is that we are committed to continuously improving health and social care delivery. This will be best achieved by using resources effectively in partnership to progress the best possible outcomes for older people in East Dunbartonshire.

Our Vision is: ***Our older people are supported to enjoy a high quality of life, achieve their potential, and that they are safe, healthy and 'included'***.

This is the outcome (Outcome 5, one of 9 Local SOA[11] Outcomes) for the older people in our community that we are tasked to achieve by the Scottish Government, and is enshrined within our local Single Outcome Agreement (see Figure 1- below).

This strategic commissioning plan has been developed alongside the development our **East Dunbartonshire Ageing Well Strategy** and constitutes **Part 2** of **A Framework for improving Health, Wellbeing & Care of Older People (2013 – 2023)**. It will provide the detail as to how we will implement the changes to achieve the reshaping of care for older people.

[11] East Dunbartonshire Single Outcome agreement 2012-13

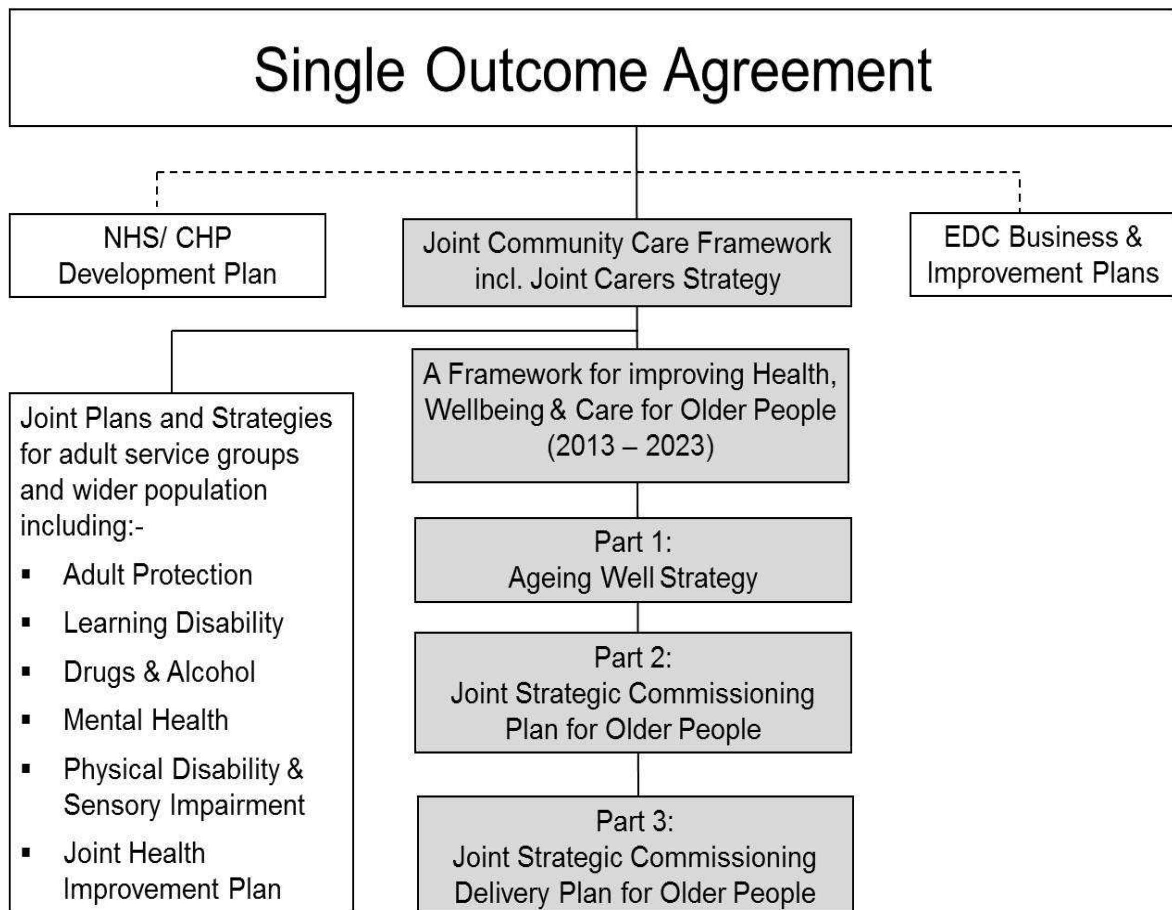
This will act as an important mechanism specific to joint planning and commissioning, and to drive the redesign of service provision, engaging with the independent and voluntary sectors.

This plan also provides an opportunity for the partnerships from health, the council, housing, independent and voluntary sectors to shape and influence future planning needs and services for older people by improving and maintaining health, well being and care, and addressing inequalities, over the next decade.

1.2 PURPOSE

Where our Ageing Well Strategy identifies our shared health and social care priorities, this joint strategic commissioning plan, then describes the detail of how we will undertake this change through the procurement and commissioning of services. The diagram (Figure 1) shows the relationship between all the relevant strategies and plans. It relates to services for all older people, aged 65 and over, who require health and social care and support. It covers a range of services to help older people maintain and/or optimise their independence, keep them socially engaged, physical healthy and have good mental wellbeing, enabling them to remain living in their own home or a homely setting for as long as possible. The plan also focuses on services for those who are frailer and may have complex health and social care support needs.

Figure 1.



The strategic commissioning plan for older people will inform service users, carers, the wider public, commissioners, service providers and other stakeholders of the joint commissioning intentions of East Dunbartonshire Council and Community Health Partnership. It has been developed in partnership with the third sectors and informed by community representatives and the public. It focuses on establishing health and social care service priorities across East Dunbartonshire, for older people, identifying current provision, addressing gaps and inequalities in service delivery and access across localities.

Older People are not a uniform group and they have a wide range of needs over different phases of their lives. This includes:

- those aged 65+ who in many cases will not consider themselves 'old', who may still be active and may remain so into late older age;
- those in a transitional phase between healthy active lifestyle and who may not yet need or be accessing additional support.

The **East Dunbartonshire Ageing Well Strategy** focuses on setting out the shared health and social care priorities for the whole ageing population including those who do not yet require 'formal' care.

This **Joint Strategic Commissioning Plan** will primarily focus on the commissioning priorities for:

- older people, particularly those aged over 75 years old, who are vulnerable as a result of social circumstances and/or health problems and have complex health and social care needs.

Developing assets and resources within the community and third sector to help keep people healthier for longer is part of what we need to nurture and grow in order for us to focus our commissioning of services on those with the greatest need. Thus, there is some crossover between tiers of needs, and the planning and commissioning we do to meet those needs and demands.

Geographically the strategy covers the area within East Dunbartonshire Council's boundaries; however, there are some areas of service delivered by agreement with neighbouring council areas.

1.3 WHAT IS COMMISSIONING?

This strategy defines commissioning as:

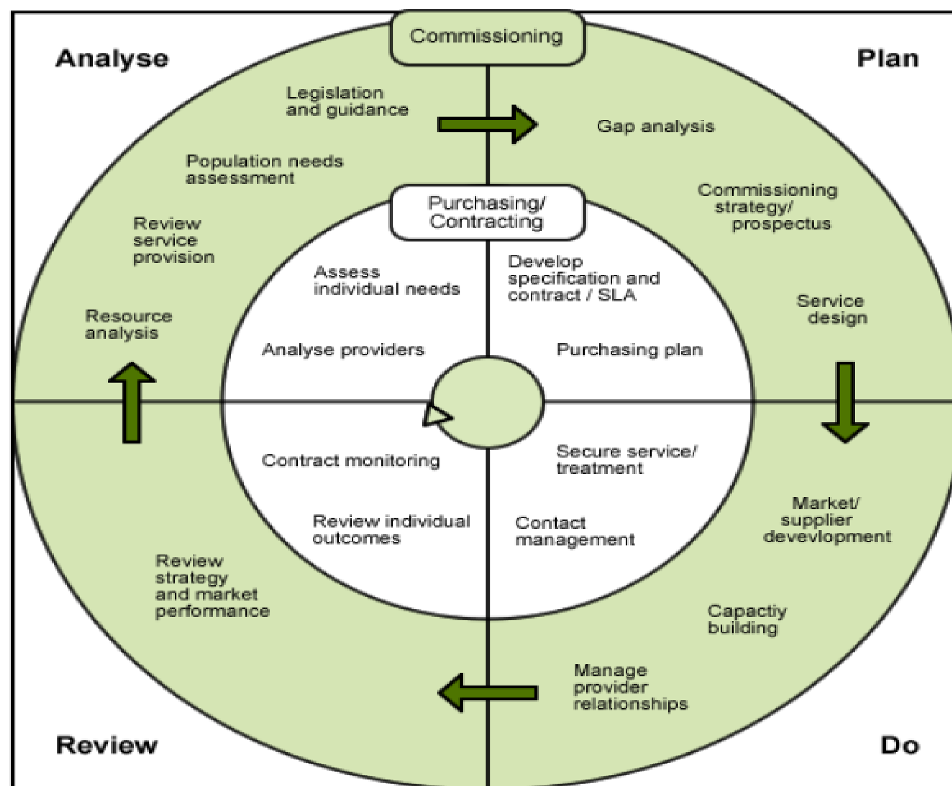
"*the term used for all the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place*" (SWIA12).

Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government and, in some cases, from a pooled or aligned budget.

Commissioning care and support services to improve outcomes for people is a complex multi-faceted process involving a wide range of tasks and indeed skill-sets; moreover, this is made more complex where the outcomes for the population of interest are "dependent on care services accessed from a plurality of interdependent providers commissioned by separate commissioners".[13]

One of the key benefits of integrating commissioning processes is it promotes efficiency by bringing costs within a single commissioning process and enables greater scope for allocation of scarce resources.

Figure 1: Commissioning Cycle, Institute of Public Care 2007



Source: Institute for Public Care.

This joint strategic commissioning strategy will focus on the **'analysis' and 'planning' stages of the commissioning** cycle (Sections 2 and 3- below), whilst the 'do' (Section 4) and 'review' will be set out as the actions which will constitute the **Joint Delivery Plan for Older People** . Appendix 1 gives an outline of this commissioning process.

2. ANALYSIS - Preparing For Future Demands

This section provides a summary of information outlined in detail in Part One of this document. Public sector organisations are faced with a difficult economic and financial climate. The challenge will be to plan and deliver services that can continue

[13] JIT guidance: Joint Commissioning Strategies. A guide to getting started. August 2011.

to meet the health and social care needs of increasing numbers of older people balanced against maintaining older people's independence in their own home for as long as possible.

2.1 LEGISLATION, LOCAL AND NATIONAL POLICY CONTEXT

Over the next 20 years, the number of people aged 65 and over will constitute a third of our population locally. Scottish Government policy imperatives are set within the context of continual improvement of health and social care services available for older people that delivers care closer to home, with a personalised approach and helps people maintain their independence. A number of key national and local policies and legislative drivers have shaped the strategy for reshaping care for older people and in turn, this Joint Strategic Commissioning Plan. These are outlined in detail in **Section 3 of the Ageing Well Strategy**.

This **Joint Strategic Commissioning Plan** will provide the detail of how the actions of the **Ageing Well Strategy** will be achieved, and thus, is directly linked to the **Transformational Change Fund** programme of work which will provide a substantial contribution to the resource required to achieve such transformational change.

2.2 POPULATION NEEDS

Ageing does not necessarily mean care and support are required, however as the population gets older the potential for additional demands for community health and care resources has to be allowed for over a longer period.

"Older people are an asset not a burden and provide more care than they consume."

The health & well-being profile in East Dunbartonshire compares favourably with other parts of Scotland:

- People experience relatively good health;
- Male and female life expectancy is better than the Scottish average;
- Deaths from cancer, heart disease and stroke among the lowest in Scotland;
- Extreme fuel poverty is significantly less common, and;
- Crime rate is significantly lower.

It is important that we recognise that the ageing population is a potential economic asset to the area, for example, by their contribution to the volunteering landscape within East Dunbartonshire. There are however significant challenges predicted over the next two decades in the population of 104,680 in East Dunbartonshire, including:-

- fewer young people,
- fewer people of working age, and this alongside
- a significant increase in the ageing population

The Ageing Well Strategy provides in graph form what the expected population projections are over the duration of the strategy and beyond. Recent forecasts suggest that people are living longer and those over the age of sixty five will account for approximately a third of the population by 2031, with the greatest growth in the number of people aged over seventy-five. Coupled with a growing ageing ethnic community, this is the greatest ageing population in Scotland.[1] In addition, there are marked variances in deprivation and health outcomes and an 11.6 year's difference in life expectancy within the locality.

This demographic profile will require us to engage in a dialogue on how resources are deployed to maximise their impact and ensure they are more equitably distributed, against predicted population growth and potential demand for service provision. Partners need to work together to address these inequalities and target services and support where the greatest need is.

More details provided in **Section 4 of the Ageing Well Strategy.**

2.3 STAKEHOLDER ENGAGEMENT

As indicated in Ageing Well strategy (Section 6), we engaged with service users, carers, staff and the wider community regarding the needs of our older people. Some key issues identified were:

- access to information, advice and resources
- a single point of access to Health & Social Care Services
- developing a collaborative anticipatory care approach
- end of life sensitive and practical discussions
- building community and voluntary sector capacity, including volunteering
- adopting a public health preventative approach
- supporting older people to remain at home
- self directed support
- home Care
- social inclusion and people being connected with their community
- equipment & Telehealth
- day centres and opportunities
- assessing need and paying for care
- carer respite
- care homes
- public Transport
- raising awareness of Power of Attorney and Guardianship
- housing

More detail around these priorities is set out in **Section 5 of the Ageing Well Strategy.**

2.4 OLDER PEOPLE'S SERVICES & EXPENDITURE

2.4.1 East Dunbartonshire Council

The Council's Social Work Service is required to ensure that statutory duties relating to care and protection of persons in need are met and legislation relevant to public protection and services to offenders is fully complied with. Social work is required to deliver in respect of functions and services that are compulsory under legislation. Within the Council, Social Work has a lead role in contributing to specific local outcomes in the Single Outcome Agreement 2011-14: 4; 5; and 6; and a contribution to the other 6, significantly to 3 and 7. The ultimate priority of the service is to ensure safety, effective care and support, and positive outcomes for our most vulnerable children, young people and adults.

In terms of external governance social work services are inspected on a regular basis by a new single agency called Social Care & Social Work Improvement Scotland (SCSWIS)., commonly known as the Care Inspectorate..

The aim of community care is to enable people to live for as long as and as independently as possible in their own homes or in the community. The scale and importance of social work services delivered to allow vulnerable and/or at risk individuals to remain in their own homes has increased over recent years, reflecting demographic and social changes and national policy priorities as indicated above. Alongside this growth there has been a heightened expectation of service performance and a requirement for a more integrated approach amongst those organisations involved in the delivery of services, which will be strengthened by legislation following the current consultation on Integration of Adult Health & Social Care. The organisational structure of Social Work Adults & Community Care services closely mirrors the developing shape of NHS services, with a clearly defined rehabilitation focus bringing together older people and physical disabilities, and a unified identity for adult services. Many of the core processes are governed by statutory guidance, including:

- community Care Assessment
- development of Care Plans
- care Management and Review
- risk Assessment and Management
- adult Protection
- hospital Assessment and Discharge
- Person-Centred Planning
- mental Health Officer (MHO) services, including detentions, community treatment orders, reports to courts and tribunals
- occupational Therapy Assessments
- day Care (subject to Care Commission Registration)
- residential Care (subject to Care Commission Registration)
- identification and assessment of Carers

- provision of Advocacy
- Care at Home services (subject to Care Commission Registration)
- Direct Payments

Local authorities have a duty, undertaken by social work service, to undertake assessments of need and then to develop packages of care, plan and commission services either from its own service or from the private and voluntary sector. As part of the Social Work Service, the Planning & Development Team supports front-line service delivery by planning, developing, commissioning and monitoring services based on assessments of needs both on an individual, care group and/or community basis.

The resources currently (2012/13) provided and commissioned by Social Work to meet the needs of older people include:-

- management and staffing- including service management, Social Work Older People's Team, Rehabilitation Team (including OT's), and Hospital Assessment and Intake Service.
- joint equipment store- delivery and fitting charges for OT equipment- 1612 orders made which provided 2582 items of equipment in 2011/12 at a cost of around £330k.
- adaptations (ramps, handrails, minor adapts, ceiling track hoists, shower/loo cabinets) - 363 provided at a cost of over £105k in 2011/12, and 91 stairlifts installed at cost of around £181k.
- day care services which supports 323 service users, and 6 commissioned daycare centres
- home care- over 7,300 hours of homecare per week delivered to 939 customers over age 65 all (Jul -Sep 2012 census).
- Direct Payments- self directed support delivered to 81 older people (Dec 2012)
- Telecare (assistive technology)- 1855 Community Alarm Users, and 406 Sheltered House Alarms (168 of which have at least 1 additional Telecare sensor in use)
- Meals on wheels and lunch clubs- 9 lunch clubs and 389 people receiving meals-on-wheels
- Supported living
- transport
- funding to commission and/or support befriending, advocacy services, older people forums, Citizens Advice, and exercise classes for older people.
- care homes- currently there 584 EDC customers in care homes (March 2012), and there are 11 care homes locally (all of which are private/ independent).
- community services delivered by wider Council departments such as Housing and Connect Services also provide: Housing Support, tenant participation and sheltered housing forums.

- sheltered housing- 6 Local Authority complexes housing with approximately 200 tenants, and 5 private complexes
- Hourcare 24 provides a 'round-the-clock' lifeline to the outside world at the touch of a button. The 24-hour Contact Centre staff will, upon be alerted, either contacting a friend or relative , sending one of our Mobile Officers to assist , or if necessary, alert one of the emergency services.
- Care & Repair service which provides maintenance, repairs and home safety checks , advice and information- 2476 people have utilised the Care & Repair Service since April 2012

Existing housing stock within East Dunbartonshire is approximately 43,000 households of which 85% is currently privately owned. The council own 3,500 properties (including 151 sheltered properties for older people) and 1,600 are owned by Registered Social Landlords (including 500 specifically for older people).

2.4.2 NHS Greater Glasgow and Clyde

East Dunbartonshire Community Health Partnership (CHP) was established in April 2006. It is currently responsible for managing and delivering community-based health care services and leading programmes to improve the overall health of all communities within East Dunbartonshire. Following the introduction of legislation expected in 2013, CHP's will be abolished and replaced by Adult Health & Social Care Partnerships as part of the Scottish Governments plans to integrate local authority and health services, initially for older people.

The CHP directly manages a number of services which specifically focus on treatment, care and support for older people. These include:-

- Older People's Mental Health Services - The Woodlands Centre provides assessment of and treatment for a range of mental health complaints including depression, anxiety and memory loss. The main aims of the service are to promote positive mental health, to treat any psychiatric disorder by using a variety of medical and non medical approaches and to provide an alternative to hospital admission or support an early discharge.
- Community Rehabilitation Service - a new rehabilitation service which includes GP Rapid Response, early supported discharge, domiciliary physiotherapy, community older people's team and community physical disability team.
- Community Nursing Service - will provide nursing care to patients who require care delivery within their own home. The team consists of District Nursing Sisters, Community Staff Nurses and Health Care Assistants. The Team provides care to all adults within East Dunbartonshire who are housebound and require nursing intervention. They also deliver care to patients who are not housebound but are undergoing oncology treatment or have a Long Term Health Condition.

As well as directly managing the services described above, the CHP is also responsible for contracting and/or monitoring a range of universal primary care health services including GP's, dentistry, optometry, physiotherapy, occupational therapy and podiatry,

East Dunbartonshire has no hospitals within its boundaries and is served by 4 main Acute sites: Stobhill, Glasgow Royal Infirmary, Western Infirmary and Gartnavel.

NHS Greater Glasgow & Clyde (NHSGG&C) is currently reviewing the shape of clinical services beyond 2015 to make sure we can adapt to future changes, challenges and opportunities. The Clinical Services Fit for the Future programme is designing a new strategy for Greater Glasgow and Clyde which aims to ensure that:

- care is patient centred with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- sustainable and affordable clinical services can be delivered across NHSGGC;
- the pressures on hospital, primary care and community services are addressed.

The work is being led by eight clinical groups looking at: Population Health, Emergency Care and Trauma, Planned Care, Child and Maternal Health, Older People's Services, Chronic Disease Management, Cancer, Mental Health

The programme is being taken forward in three phases:

- Developing the 'Case for Change'[14]
- Developing service models (available for wider engagement by April 2013).
- Developing options to deliver the new service models. The timeline for developing detailed options for delivery will depend on the implications of the service model work and the need to have an inclusive, open process of options development, but is likely to be in the second half of 2013.

Each group has engaged with patient reference groups involving patients, carers and voluntary groups as well as more widely with staff across NHSGGC. Updates and information on key stages of the programme have been shared with partner agencies, including through CH(C)P committees and the work has been involved by current joint planning activity including the Change Fund processes.

The Case for Change sets out the key issues which will have to be addressed to ensure high quality care in the future, and provides the basis for the development of service models. It describes nine key themes:

1. The health needs of our population are significant and changing;
2. We need to do more to support people to manage their own health and prevent crisis;
3. Our services are not always organised in the best way for patients;
4. We need to do more to make sure that care is always provided in the most appropriate setting;
5. There is growing pressure on primary care and community services;
6. We need to provide the highest quality specialist care;
7. Increasing specialisation needs to be balanced with the need for co-ordinated care which takes an overview of the patient;

- [14] http://library.nhsggc.org.uk/mediaAssets/Board%20Papers/12-55.pdf

8. Healthcare is changing and we need to keep pace with best practice and standards;
9. We need to support our workforce to meet future changes.

Together these issues paint a picture of health services which need to change to make sure that we can continue to deliver high quality services and improve outcomes. The years ahead will see significant changes to the population and health needs of NHS Greater Glasgow and Clyde, starting from a point where there are already major challenges in terms of poor health outcomes and inequalities. It is clear that not enough focus on prevention and support for people at an early stage in

their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages of illness. The growing complexity of need, including multi morbidity and a wide range of care and support needs, mean that users and carers can feel inadequately supported and services can feel complex and fragmented. This poses significant challenges to the way we deliver health services and work with partner agencies, to ensure that our services adapt to these changing needs.

The health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. A more consistent and joined up approach is required across all parts of the system, targeting interventions and support where they are most needed. The case for change tells us that we need to

improve outcomes by organising and delivering services differently to prevent ill health in the first place, to support patients with multiple conditions more effectively and to enable older people to live more independently. We also need to change our hospitals to ensure that high quality care is consistently available, that there is timely access for all to specialist care and that we have 24 /7 access to specialised emergency care.

2.4.3 Independent Sector Services

There is a thriving private and independent sector in East Dunbartonshire, which constitutes the entirety of the care home sector provision and an increasing ratio of care at home services.

In relation to care homes East Dunbartonshire has no Local Authority run care homes, but there are currently 12 private/ independently-run care homes within the Council boundary, and around half of our EDC resident long-term care home population (584 at March 2012) live in care homes outwith the area. Nationally the number of residents in care homes for older people run by the private sector has increased by 8 per cent[15].

There are currently around 30 providers of care at home services delivering to EDC customers. In 2010, the ratio of care at home provided by EDC Home care to that purchased for EDC customers was 70:30 in-house (EDC).

Since then, a number of factors have contributed to this ratio reducing in terms of in-house provision to a current level of 55:45.

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[15] Care Home Census 2012 ; Statistics on Adult Residents in Care Homes in Scotland 30th October 2012; ISD Scotland

The independent sector also provides accommodation for older people in the form of 5 sheltered housing complexes.

In late 2012, the Council hosted a provider Forum specifically to engage with this sector to share ideas, expertise, good practice and consensus regarding our philosophy for care and support and how this will be delivered, including promoting and improving future engagement with the sector and Community Planning Partners.

Aside from committing to work on the latter, areas for future discussion and development include:

- reviewing person centred assessment processes;
- NHS to revise protocols to prevent hospital admissions from care homes , for example, exploring opportunities for clinical/ nursing tasks such as rehydration to be carried out by nursing staff in care homes;
- developing innovative ways on how services are provided to sheltered and very sheltered housing;
- using sheltered housing and other complexes in EDC as community settings for access to socialising and self-directed support opportunities;
- development of a one stop shop for care at home support, housing support and sheltered housing.

We will work with the independent sector to understand their contribution, and what their vision is for delivering care and support services for the future.

2.4.4 Voluntary Services and Volunteering

The Voluntary Sector in East Dunbartonshire involves over 500 local community and social enterprise groups. These voluntary sector services are provided by groups who operate across all of East Dunbartonshire, and rely on volunteers. Most of these groups are very specific to local communities within the area. All of these services are run by and for local people, and cover a vast range of support and services in the spectrum of adult community care needs including:-

- advice and information;
- advocacy,
- therapeutic art therapy; befriending (social and sometimes practical support)
- carers Support-
- Church Groups;
- black & minority ethnic day and social support activities;
- housing and tenants and residents groups;
- healthy living and recreation

Local Community Planning partners have reviewed the strategic development requirements of the local Social Economy to ensure that issues such as local procurement policies do not hinder the potential of the Social Economy as a possible

service provider. This will lead to the development of a ten year Social Economy Development Plan as part of our Vision for the Voluntary Sector.

An analysis of charitable sector income for East Dunbartonshire shows over £46m, however, this includes large charities such as the Beatson Hospital (Cancer Research) which generates £20m only a proportion of which will be of direct benefit to East Dunbartonshire residents.. When the incomes of large charitable organisations are excluded, approximately £16M can be apportioned directly to East Dunbartonshire.

EDVA is a local infrastructure support agency (Third Sector Interface) supported by both Community Planning and The Scottish Government to provide capacity building and promotional support to Volunteering, Voluntary Sector, Community engagement through Community Planning and development of the Social Economy.

There has been a recent strategic focus on older people by EDVA in partnership with public and voluntary sector leads This has been reflected in strong involvement in the Reshaping Care for Older People programme delivered through the Transformational Change Programme Board. As a direct consequence of involvement at this strategic level, a new approach has been developed that comprises of a single point of access into the voluntary sector for service users, carers and practitioners across all sectors.

2.5 EXPENDITURE ON SERVICES

A breakdown of the resource use across East Dunbartonshire is provided in the table below. This is extracted from the work carried out for the Integrated Resource Framework and represents an estimate of the totality of resource consumed by residents within East Dunbartonshire categorised by reshaping care pathways for 2010/11. This data represents a combination of operational budgets directly managed by East Dunbartonshire CHP and by East Dunbartonshire Council Social Work services but also includes an estimate of consumption of Acute Hospital resources based on an overall allocation of NHS Greater Glasgow & Clyde costs to individual partnerships.

From the table it can be seen that the largest proportion of East Dunbartonshire resources is allocated to expenditure on hospital and care homes, with an estimated 75% of NHS resource spent on hospital care. The ultimate goal is to shift resources from hospital and institutional care upstream toward more of a preventative and anticipatory approach with more investment in community based services and care at home. We currently allocate a mere 2.1% of the total resource on preventative and anticipatory care and 23% on care at home and housing support.

Table – Total spend and percentage spend by care pathway 2010/11

Total Resources 2010/11	Preventative & Anticipatory Care	Proactive Care & Support at Home	Effective Care at Time of Transition	Hospital & Care Homes	Total
NHS	£1,010,458	£14,296,809	£1,658,181	£50,401,696	£67,367,144

Social Work	£948,000	£8,180,267	£5,053,733	£10,200,999	£24,383,000
TOTAL	**£1,958,458**	**£22,477,076**	**£6,711,914**	**£60,602,695**	**£91,750,143**
Total Resources 2010/11	**Preventative & Anticipatory Care**	**Proactive Care & Support at Home**	**Effective Care at Time of Transition**	**Hospital & Care Homes**	**Total**
% NHS	1.5%	21.22%	2.46%	74.82%	100%
% Social Work	3.89%	33.55%	20.73%	41.84%	100%
% Total	**2.13%**	**24.5%**	**7.32%**	**66.05%**	**100%**

In comparison to other partnerships across Greater Glasgow and Clyde, East Dunbartonshire appears to have the lowest proportion of resource allocation per older person aged 65+ on community based services and one of the highest allocations to hospital based care in 2010/11. The balance of hospital to community based services is broadly consistent across the NHS board area at 50/50 with East Dunbartonshire sitting at 58/42.

East Dunbartonshire partnership has a history of good performance in respect of delayed discharges from hospital. Recent pressures have challenged this performance but the partnership is committed to analysing and understanding the current situation to improve future performance.

However there is clearly significant work required to shift the balance of care away from hospital / institutional care towards support to allow more older people to be cared for at home within the community. This coupled with the significant increases in the older population for East Dunbartonshire requires a shift in resource, and better use of resources, to cope with this additional demand.

2.6 ANALYSIS OF SERVICE DELIVERY

A plethora of evidence tells us that we cannot sustain how we currently deliver care across Scotland, with currently about a third of all money spent on older people's care being spent on unplanned, emergency admissions to hospital. Many admissions to hospital could and should be avoided if there was better support in the community such as rapid response home care, telecare, overnight and weekend care. This would give better outcomes for older people and cost less.

Much of the policy and legislative drivers referred to above has a focus on avoidance of hospital admissions. This is something that is supported by health and social care partners, as well as people in the community, because a stay in hospital should be simply about addressing a 'critical incident': providing appropriate care, treatment and support to enable a person to return home.

There is a raft of evidence and reports from engagement with people who agree that they want to avoid being in a hospital setting, as this increases a persons

dependence on care and exposes them to a risk of infection. In addition, recovering from a critical incident is demonstrated to be better within a homely setting.

A final factor is the cost of hospital admissions: that people go into hospital, sometimes inappropriately, and then are delayed from being discharged home or to an appropriate care setting.

A significant proportion of demand for services comes from increasing numbers of frail older people, as well as those who may have long-term and complex conditions. However, it is important to note that the majority (97%) of the ageing population (between the ages of 65 and 74) do not receive any form of 'formal care'. It is worthwhile noting that a relatively small increase in the proportion of older people who do not depend upon more intensive health and social care, would have a substantial impact upon the ability of more specialised services to be sustainable.

In relation to care homes East Dunbartonshire has no Local Authority run care homes, but there are currently 12 (including 3 recently developed) private/ independently-run care homes within the Council boundary, and around half of our EDC resident population (584 at March 2012) live in care homes outwith the area. Nationally the number of residents in care homes for older people run by the private sector has increased by 8 per cent[16].

In the latest census period the largest proportion of residents were admitted to care homes from hospitals (50 per cent). A further 32 per cent were admitted from their own home. Most (78%) discharges from care homes are due to death, and a further 18 per cent were discharged to either another care home or hospital. Very few long stay residents (4 per cent) returned to their own home or supported accommodation / sheltered housing.

As we seek to reshape and redesign how we deliver care and support for older people, the engagement of care homes is a crucial part of this process with regard to developing different models of care. National evidence shows that it is not until after the age of 85 that dependence on statutory provision substantially increases. Indeed, of long-stay residents in care homes in East Dunbartonshire, those aged 75-84 have been steadily falling (down 7%), whilst those residents aged 85 plus have been rising at a similar rate (up 8%). 45% of all EDC home care customers are in the over 85 age bracket, with 20% of them receiving 20 or more hours per week

Recent presentations to the Council's Resource Screening Group have been increasingly in relation to an over 80 years population who have had good health and who have not been known to social care services until an incident or event which then impacts on people having very high care needs.

Key issues include:-

In East Dunbartonshire, in line with national trends, we are experiencing:

- substantial increases in the numbers of older people needing to access social care services
- inequity of provision for some service as a consequence of socio-economic factors such as deprivation, eligibility and costs ceilings,

[16] Care Home Census 2012 ; Statistics on Adult Residents in Care Homes in Scotland 30th October 2012; ISD Scotland

- a preponderance of people who self-arrange their admission to care homes without an assessment of need or cognisance to alternative community provisions
- a high level of admissions to care homes directly from hospitals
- home care that has not focused specifically on re-ablement potentially exacerbating dependency
- limited housing stock options, and advice regarding alternatives.
- almost a third of our annual total spend on older people's services is on unplanned admissions to hospital

Analysis of the data, our resources and from conversations with the community tell us that:

- increasing numbers of older people are taking up Self Directed Support whilst ensuring older people are given the support and confidence to be creative in how their needs are met through Individual Budgets and the choice and control to shape their own service delivery
- we need to focus on primary prevention including advice and information, positive physical, emotional and socio-economic activities to help maintain good health, wellbeing and quality of life into later life
- we need to develop services within the context of the personalisation agenda, enabling older people to have choice and control over their health and social care needs
- we need to develop alternatives to hospital admissions, both in terms of step-up (prevention) and step-down (facilitate early discharge) e.g. through intermediate care provision, preferably in people's own homes
- we need to develop our services and grow confidence in people and professionals that services can be responsive out-of-hours and provide a level of care at home or in a homely setting where systems ensure this response is akin to or better than they which may be provided in hospital/ care home.

3. PLANNING

3.1 DESIGN OF FUTURE SERVICES

Scottish Government policy imperatives are set within the context of continual improvement of health and social care services available for older people that delivers care closer to home, with a personalised approach and helps people maintain their independence. A predicted 50% increase in the local population aged 75 yrs plus, a 103% increase in 85 yrs plus group, an increased number of 'older' carers, alongside a difficult economic climate, particularly in the public sector, all of which means **DOING MORE WITH LESS AND DOING THINGS DIFFERENTLY.** A long-standing goal of the Scottish Government is to have better joined-up services

which provide care and support to people when its needed and is as seamless as possible. It is intended that this will be achieved in the context of emerging health and social care integration.

3.2 COMMISSIONING MODEL

The Commissioning model [Figure 2] is based on the priorities outlined in the 'Ageing Well Strategy' and are founded on achieving four important outcomes;

- People living as independently as possible
- More people living at home or in a homely setting
- Carers are able to continue in their caring role
- Assets and resources available to the community are supported to grow and develop

The Scottish Government has determined four key areas for action to deliver these outcomes:

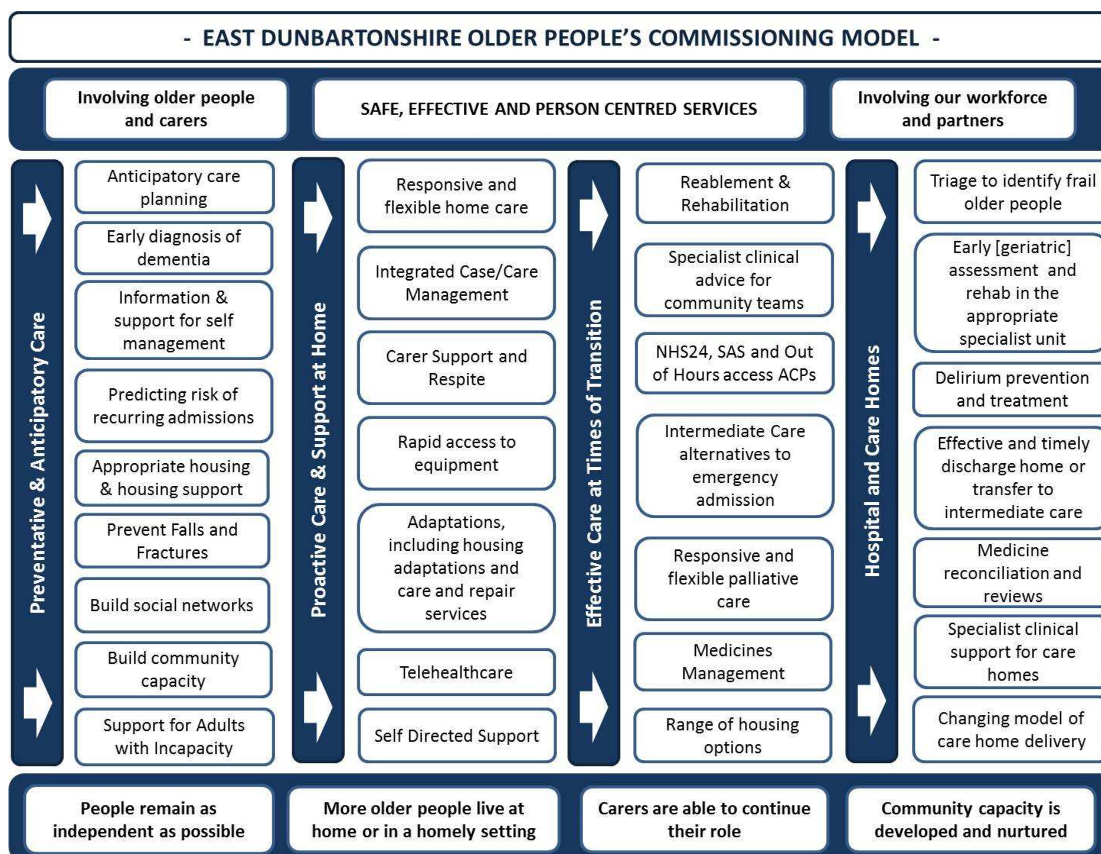
Preventative and Anticipatory Care - this can take many forms. It helps reduce avoidable unscheduled hospital admissions for people with pre-existing conditions, particularly older people, and those with mental health conditions.

Proactive Care and Support at Home - this includes responsive and more flexible home care, respite and other supports to help carers continue their caring role, faster access to equipment and adaptations, and telecare/ telehealth.

Effective Care at Times of Transition - this includes rehabilitation and re-ablement approaches eg to delivering home care.

Hospital and Care Home(s) - which includes effective and timely discharges home or to an appropriate care setting.

Fig - East Dunbartonshire Commissioning Model



4. COMMISSIONING PRIORITIES

This section presents a refined presentation of the short (Year 1) to medium term priorities (next 3 years) which will achieve our 10 year vision. It reflects learning from the analysis and planning stages outlined above. It also includes a synopsis of the key priorities in terms of investments/new activity –with particular regard to Change Fund investment made and planned over the next year- and how these intend to deliver improved outcomes and the performance indicators on which success will be measured.

4.1 PROMOTING HEALTH & WELLBEING (included within the Prevention & Anticipatory Care pillar)

Our aim is to counteract social isolation and promote health and maximise their independence by supporting the development of community and user-led activities, building connections between community groups and making it as easy as possible for older people in East Dunbartonshire to maintain a social life and access a range of services and activities within their communities.

Older people in East Dunbartonshire will be more in control of their own health and well being. To achieve this, we will develop supported self care and will collaborate across all sectors to improve linkages and identify good practice and gaps in current services; and provide, and signpost to, core information and resources.

We will put the community at the heart of service design and delivery and focus long-term strategy on building assets and resources within communities to support older

people across East Dunbartonshire and investing in the voluntary sector, using a Social Enterprise model, to identify unmet need and gaps in delivery.

The development and sustainability of an engagement approach comprising community, social and economic development elements designed to build community involvement, increase best practice, quality design and delivery..

We currently commission a range of low intensity, preventative support services from the Third Sector. For example, we have invested Change Fund resources in: the establishment of an Older People's Advice Line, which provides a single point of access to locally based services such as financial advice and leisure services; the introduction of an enhanced Befriending Service which supports older people who are isolated by assisting them to get to the shops, attend appointments, and remain active in their community; and expanded access to Care & Repair services. We will continue to invest in and work with the third sector to maximise capacity to not only sustain but grow these lower level services as part of the community infrastructure.

Measuring Progress

Community Planning Partners will use the following indicators to monitor progress in relation to **Promoting Health & Wellbeing**:

- Percentage of people aged 65+ indicating satisfaction with life in general
- Percentage of people aged 65+ indicating satisfaction with their social interaction opportunities

These indicators form part of East Dunbartonshire's Performance Framework for Older People's Services and are reported regularly to the East Dunbartonshire Health Care & Protection Group

4.2 PREVENTATIVE & ANTICIPATORY CARE

Anticipatory care planning involves identifying people who may be at risk of hospital admissions and working with them to plan for expected changes in health status through the completion of an Anticipatory Care Plan which also incorporates health improvement and staying well.

We will use existing prediction tools and work with GPs and district nurses to identify people who are at risk of being admitted to hospital. We will work specifically with care home and care at home providers to develop interventions which will prevent avoidable admissions.

Through the Change Fund, we have developed a model of Anticipatory Care Planning. We will build on this to embed anticipatory care into practice, processes, and systems across health, social care, housing and voluntary organisations with the aim of improving the confidence of people and their carers to enable them to manage their long term conditions, reducing hospital admissions, and promoting earlier discharge.

Specific areas of priority for commissioning are:-

4.2.1 Power of Attorney/ Guardianship

Change Fund monies are being used to significantly expand and accelerate the provision of services relevant to the application and granting of guardianship and power of attorney.

We will continue to work to increase the level of awareness in all communities and amongst health and social care staff across all sectors of these to ensure that this not a cause of significant delay for people in respect of securing stability of care and support arrangements; and will support people who may be vulnerable to incapacity to make appropriate arrangements. We will deliver this through engagement and development of a strategy with relevant stakeholders including the third and independent sector.

4.2.2 Dementia

We will work with GPs and a range of health and social care practitioners to promote and support diagnosis at whatever the stage of their illness and will provide effective, appropriate post diagnostic support.

Through Change Fund investment to date we have developed a Dementia Advisory Clinic to deliver on this. Everyone who receives a diagnosis of dementia is entitled and will receive information about their illness and the local supports available to them at every stage of their condition, to their family and people important to them.

4.2.3 Information and Support for Self-management

Access to a range of self-management resources and approaches are essential if there is an expectation that patients will cope and live well with their condition. Health, social work, community partners, service users, carers and the third sector must collaborate to ensure timely access to current services and to influence future development of others. To assist in this, we have used the Change Fund to establish a project, in partnership with the voluntary sector, to develop a local model of collaborative working.

4.2.4 Appropriate housing support

We view housing support as a key preventative care function. We will develop a range of housing options to meet the needs of older people and improve the level of housing support we provide in enabling older people to remain at home and be independent. To deliver on this we will develop, in partnership with Registered Social Landlords, new housing which is accessible and built to varying needs standards. This will include provision of equipment, adaptations and Smart/ Telecare technology. We have and will continue to invest in Care & Repair services which include advice, assistance and preventative support which enable people to continue to live independently in their own home. In the longer term we will develop a supported accommodation strategy which will include consideration of the development of housing with support on the former Lenzie Hospital site.

More detail of the **Housing Contribution** to Reshaping Care for Older People is attached at **Appendix 2.**

4.2.5 Preventing falls

We know that falls are a primary source of emergency hospital admissions. The new element of the Care & Repair service, funded by the Change Fund, undertakes falls prevention assessments within people's homes, and this will be expanded subject to demand. In addition, access to equipment will be delivered within agreed timescales.

We will engage with the Leisure Trust and other community resources locally to promote programmes of physical activity to support the older population to remain healthy and active.

We will continue to provide support to avoid fuel poverty through engagement with the Energy Saving Trust to offer energy advice and free cavity wall and loft insulation.

4.2.6 Income maximisation

We will continue to deliver advice and support to promote the uptake of benefits and entitlements for older people, and ensure that our Citizens Advice Service is in a position to properly plan for the future impact of welfare reforms.

Measuring Progress

Community Planning Partners will use the following indicators to monitor progress in relation to **Preventative and Anticipatory Care:**

- Prevalence rates for the diagnosis of dementia
- Number of people accessing Care & Repair services

These indicators form part of East Dunbartonshire's Performance Framework for Older People's Services and are reported regularly to the East Dunbartonshire Health Care & Protection Group

4.3 PROACTIVE CARE AND SUPPORT AT HOME

Specific areas of priority for commissioning are:-

4.3.1 Responsive and flexible homecare

We will re-shape home care services to provide flexible effectively-targeted home care which can respond 24 hours per day, 7 days per week. This will be delivered by a mix of in-house and private provision- the latter who will be supported to develop re-ablement.

We will increase provision of personal care within people's own homes in order to maintain a positive balance of care. We will establish a 're-ablement' model of home care, which entails working with people to help them to do things for themselves, to reach their optimum level of independence, instead of having things done 'to' or 'for' them, which can create dependence and increase vulnerability.

4.3.2 Carer support and respite

Our Ageing Well Strategy emphasises the importance we place on supporting carers to continue in their caring role. We have produced an **East Dunbartonshire Joint Carers Strategy 2012-15** and will work with community groups, the Third and Independent sectors to deliver its objectives. This includes the provision of short breaks, respite; further developing mechanisms to involve carers in service design and development; and building a community of care support through direct service provision and voluntary community capacity building.

4.3.3 Rapid access to equipment

Our long-term aims are to integrate equipment budgets across primary care and social work; refocus EquipU and support the expansion of this service to include Smart technology.

4.3.4 Housing adaptations and care & repair services

Our approach will be to ensure access to housing adaptations for targeted groups to enable older people to live safely and independently at home, reducing the risk of hospital admission and enabling them to return home when they have been admitted to hospital.

We will achieve this through:

- utilising the Change Fund to purchase and store adaptation equipment to be readily available for people when needed;
- expanding and promoting the existing Care & Repair services, using Change Fund monies, to ensure access to all targeted groups, regardless of tenure.

4.3.5 Assistive/ Smart technology

Within the context of a comprehensive telecare strategy, we have utilised the Change Fund to purchase a range of assistive technology equipment to assist us in the development of a goal to establish universal access to Telecare as an effective option for older people aged 75 and over. In support of this aim, we will;

- assess anyone in this age group who enters the health & social care system for a package of basic Telecare;
- ensure that all relevant frontline staff across all sectors have received appropriate training for their role on equipment and use of telecare to achieve appropriate demand and delivery;
- engage with carers to ensure that they understand and are reassured by telecare as an effective means of managing risk;
- review service models to consider if and how technological solutions can be utilised as an alternative part of a package of care.
- We have secured and equipped a demonstration ‘Smart flat’ which will be used to showcase and promote assistive/ Smart technology solutions and equipment

4.3.6 Self Directed Support

We are committed to increasing uptake self directed support (SDS) to give people who require support greater independence and more choice, control and flexibility in how their care and support is delivered. This can lead to positive outcomes which can improve, enhance or sustain health and wellbeing.

To achieve this we:

- have utilised Change Fund monies to develop a range of service options including care at home, respite and day support services that can be accessed directly and assembled into bespoke care packages by individuals and families;

- have established and promoted a policy and procedure for SDS to increase uptake amongst people aged 65+;
- will analyse the impact of SDS on the third and independent sector provider to support market development and develop local markets which are responsive, flexible and innovative.

Measuring Progress

Community Planning Partners will use the following indicators to monitor progress in relation to **Proactive Care and Support at Home:**

- Number of people with high levels of care needs who are cared for at home
- Waiting time between request for a housing adaptation, assessment of need and delivery of any required adaptation
- Number of people aged 75+ with a telecare package
- Percentage of service-users satisfied with their involvement in the design of their care package
- Percentage of carers who feel supported and capable of continuing in their caring role
- Number of people aged 65+ receiving a Self Directed Support (SDS) package or a Direct Payment

These indicators form part of East Dunbartonshire's Performance Framework for Older People's Services and are reported regularly to the East Dunbartonshire Health Care & Protection Group

4.4 EFFECTIVE CARE AT TIMES OF TRANSITION

The main focus of community assessment, re-ablement and rehabilitation is to support people to stay at home, facilitate early supported discharge and prevent avoidable hospital and formal care setting admissions, enabling them to live as independently as possible, whilst managing their own lives.

We are utilising the Change Fund to implement a re-ablement model of home care and will increase the anticipatory and preventative aspect through increasing the number of community referrals and re-invest any resource dividend generated by re-ablement to meet future demand.

We will establish a joint rehabilitation and re-ablement service which has a Single Point of Access (SPOA); and further scope service redesign options within the context of integrated services;

With our partners we will develop models of intermediate care (also known as step-up/ step-down) services by exploring options across a variety of settings and ensuring that these are readily available to services including out-of-hours.

We will provide comprehensive and effective support to people who have palliative care needs.

In support of this, we will:

- establish advance care plans for people with palliative care needs and full implementation of Making Plans Together including training for GPs;
- promote the Living & Dying Well actions across all relevant sectors;
- establish a protocol for access to care at home services for all palliative care patients to ensure that those who wish to die at home can do so;
- enable care homes to support families to make decisions and provide end of life care.

4.4.1 Medicines Management

The aims of effective medicines management are to improve health and well being, enable people to care for themselves, improve the skills of health professionals, reduce waste and save money. In support of this, our approach will be to:

- reduce poly-pharmacy;
- ensure that prescribing is considered strategically within an integrated resource framework for older people;
- support vulnerable older people to manage their medication at home through the provision of training for patients, carers and relevant staff.

4.4.2 Range of housing options

It is critical that the Local Housing Strategy considers how well the East Dunbartonshire housing system meets the needs of specific household groups and how these needs are likely to emerge or change over time.

The growth in the older population means we will need to continue to identify housing and support options that enable older people to maintain their independence, including continued investment in housing aids and adaptations and assistive technology.

Given the high levels of outright home ownership in East Dunbartonshire, it is also likely that older and ageing populations may have property equity that could facilitate a move to more appropriate or sustainable house types if the right products were available or developed in the private housing market.

Our approach will be to develop a range of housing options and types of tenure to ensure that all older people maximise their ability to remain at home in their own communities. In support of this, we will:

- ensure that the LHS and SHIP are accurately informed as to current and developing need for older people;
- quantify the need for specialist, amenity or adapted housing;
- target information to older people in unsuitable housing on alternative housing, care and support options;
- ensure access to support and advice for people who wish to downsize;
- develop a database of specially adapted properties and ensure that there is a good match of households to homes through the allocations system.

4.4.3 Specialist clinical advice for community teams

Our approach will be to ensure that clinicians have access to information, specialist advice and a range of community options to enable them to make the most appropriate clinical decisions. To achieve this we will establish a robust community process that ensures clinical integrity and expertise that is comparable to that within acute context; including a community role for consultant geriatricians. We will also review the use of day hospital provision in partnership with geriatricians to improve access to specialist assessment and clinical services.

Measuring Progress

Community Planning Partners will use the following indicators to monitor progress in relation to **Effective Care At Times Of Transition**:

- Percentage of Re-ablement service-users who are successful in reducing their home care dependency after their period of re-ablement
- Number of emergency in-patient admissions for people aged 75+
- Number of unplanned Acute bed-days for people aged 75+

These indicators form part of East Dunbartonshire's Performance Framework for Older People's Services and are reported regularly to the East Dunbartonshire Health Care & Protection Group

4.5 HOSPITAL AND CARE HOMES

With an increasing elderly population and growing demands on services the NHSGGC Acute Services Review will consider current pathways of care and service models to consider how fit for purpose they are to meet the future requirements beyond 2015. This scope of this work includes acute assessment, rehabilitation, continuing care services and elderly mental illness.

Early comprehensive geriatric assessment is recognised as a major factor in reducing inappropriate admissions and in reducing length of stay in acute hospitals. We have used the Change Fund to increase our capacity for geriatrician assessment in hospital and will continue to explore the current geriatrician model with the aim of further increasing capacity, both within hospital and in the community and for out-of-hours Allied Health Professionals (AHPs) eg OT's, Physiotherapists.

To build on this we will further promote the use of fast-track GP referral to Day Hospital for geriatrician review; ensure appropriate signposting of available services; and work with GEMS service and NHS 24 to ensure appropriate referrals out of hours.

4.5.1 Delirium prevention and treatment

Delirium or 'acute confusional state' is a common clinical syndrome characterised by disturbed consciousness and a change in cognitive function or perception that develops over a short period of time (1-2 days). Delirium arises where people have mental health problems, underlying physical conditions including UTI's, problematic alcohol use, dehydration or poor nutrition, and can be exacerbated by moves within care settings such as hospital wards.

Our approach in this area will be to:

- implement and monitor National Standards for Dementia and Delirium Guidelines;
- work with care homes to implement and monitor the ‘Food, Fluid and Nutrition’ policy work with the independent sector to identify training requirements and support delivery of care to older people with physical illness such as UTI’s;
- implement the Oral Health Strategy in relation to support to care homes.

4.5.2 Promote excellence in dementia care

NHS Education Scotland (NES) and the Scottish Social Services Council (SSSC) are undertaking a partnership project on behalf of the Scottish Government to support the delivery of the educational actions in the change programme outlined in Scotland’s National Dementia Strategy.

We will:

- raise awareness of “Promoting Excellence; A framework for all health and social services staff working with people with dementia, their families and carers”;
- promote the role of “dementia champions” as change agents across sectors;
- promote use of Alzheimer’s Society “This is me” tool to support people with dementia who are going into hospital.

4.5.3 Effective and timely discharge home or transfer to intermediate care

Planning for a person’s discharge from hospital should occur from the point of their admission, so that when they are declared ‘fit for discharge’, they have been appropriately assessed and care and support services are in place to facilitate their return home or to a homely setting.

In support of this we will:

- work with Acute Sector partners to meet new delayed discharge targets through improving discharge planning processes and hospital-community liaison;
- work towards a position that no patient is discharged from hospital directly into long-term residential care, unless this is necessary;
- increase investment into care at home services.

4.5.4 Medicine reconciliation and review

We will ensure that patients are receiving the most appropriate, cost-effective medicines with the aim of optimising the clinical impact of the medicines and reducing the number of medication related problems and reducing waste.

To achieve this we will:

- establish new governance arrangements;
- identify prescribing issues which impact on older people’s health with a view to developing a local pharmacy strategy for older people with associated standards and targets;

- consider the prescribing implications of all service redesign initiatives;
- deliver on medicines waste programme and chronic medication service and minor ailments scheme;
- develop engagement mechanisms with local pharmacies to deliver good prescribing practice.

4.5.5 Specialist clinical support for care homes

- Implement the recommendations of the Oral Health Strategy in care homes;
- Quantify any local contribution required to support care homes;
- Ensure that care homes deliver the nursing competencies required by their registration.

4.5.6 Changing model of care home delivery

Our aims are to:

- reduce the number of people who go into long-term residential and nursing care;
- engage the independent sector to assist them to develop their contribution to the delivery of the East Dunbartonshire Ageing Well Strategy;
- develop a model of reablement within care homes, assisting residents to reach their optimum level of independence;
- improve understanding and impact of the delivery of end of life care within care homes;
- influence the development and commissioning of care homes locally to ensure alignment with the priorities set out in the Ageing Well Strategy;
- develop Intermediate Care provision

Measuring Progress

Community Planning Partners will use the following indicators to monitor progress in relation to **Hospital and Care Homes**:

- Number of bed-days consumed by patients in Acute care who are fit for discharge
- Number of people waiting more than 28 days to be discharged into a more appropriate setting once treatment is complete
- Number of bed days lost to delayed discharge for Adults with Incapacity
- Number of delayed discharges for Adults with Incapacity
- Number of new permanent admissions to care homes for people aged 65+
- Number of people aged 65+ in permanent care home placements

The These indicators form part of East Dunbartonshire’s Performance Framework for Older People’s Services and are reported regularly to the East Dunbartonshire Health Care & Protection Group

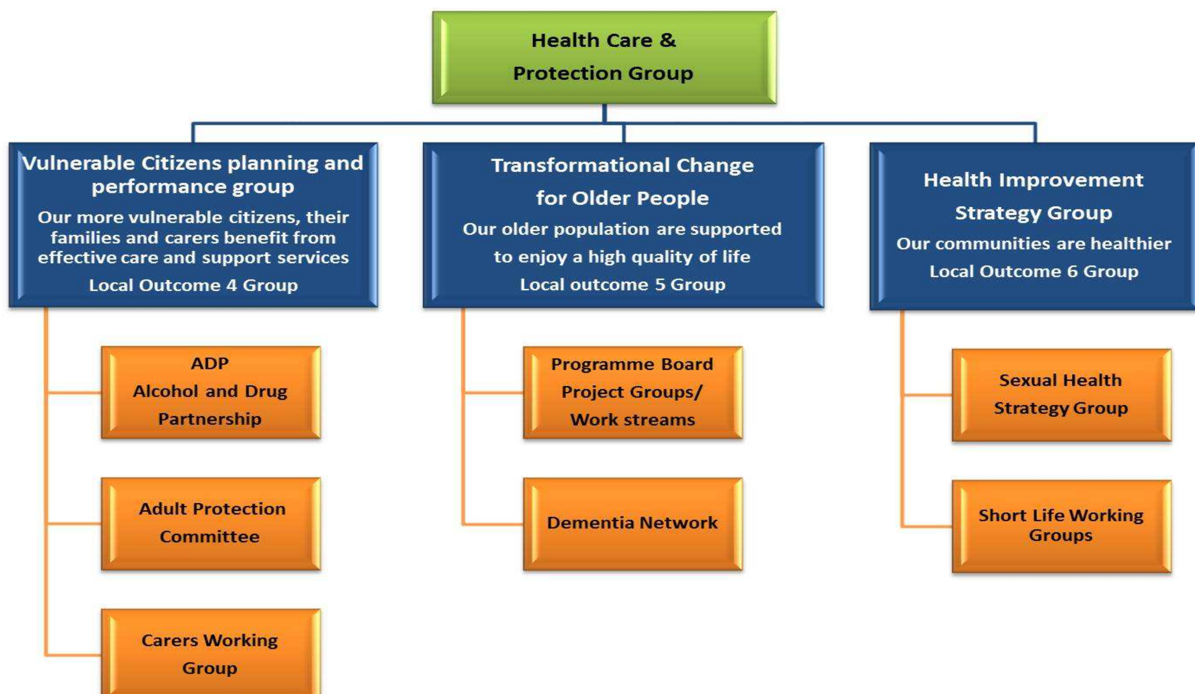
5. GOVERNANCE ARRANGEMENTS

Within East Dunbartonshire's Community Planning structure, the Health, Care and Protection Partnership Group (HC&P) is the principal planning forum for all partnership planning, policy, performance management and services for older people, adults with community care needs, and vulnerable adults with both the Adult Protection Committee, Alcohol & Drugs Partnership and Health Improvement Strategy Group operating as a component part of it. The three planning groups in the HC&P have specific remits and responsibilities in respect of Local Outcomes 4, 5 and 6. Local Outcome 5 Group is also the **Programme Board for the Transformational Change for Older People.**

This group, one of 3 Local Outcome Groups, has a span of responsibility for the highest number of people with care needs, particularly as our ageing population is growing, and living longer. The remit includes the development and delivery of our local programme of Transformational Change for older people and wider Reshaping of the balance of care for Older People, associated national agenda (eg Self Directed Support, Re-ablement), joint commissioning strategy, Older People's Mental Health plus wider issues/ themes as they impact on older people unless being taken forward elsewhere e.g. Health Improvement by LO6 Group.

The Local Outcome and issue based groups described above have a key role in achieving the national and local outcomes, and it is the Health, Care & Protection Group which has lead responsibility for the reviewing and monitoring progress and providing direction, ensuring that this is consistent with achieving the aims, objectives and desired outcomes for community care. This Joint Strategic Commissioning Plan and the whole Framework for Improving the Health, Wellbeing & care in East Dunbartonshire will be monitored through the quarterly review of progress by the Health, Care & Protection Group.

Lines of accountability for delivery of the Plan



Commissioning and procurement of services:- locally, the Council Social Work Department procures and commissions the bulk of services for older people locally, whilst the majority of NHS commissioning is undertaken at NHS Board level. Strategic commissioning is a process undertaken to ensure that public services get the best possible services to meet individual needs.

The process involves a wide range of strategic activities including: identification/agreement of strategic outcomes and priorities; understanding and forecasting needs and reviewing these regularly; analysing the factors which impact on market supply and demand; taking strategic decisions about how needs will be best met in terms of preferred models of intervention, care and support and developing sound financial frameworks and financial management systems – all of which form the basis of a Commissioning Cycle EU Procurement Directives stipulate that Social Care Services are “Part B Services.” Simply, this means that such services are not subject to the full competition rules, however, the Directives also specify that any service(s) with an estimated value (over 48 months) of more than £173,934 are subject to competition and as such should be advertised accordingly.

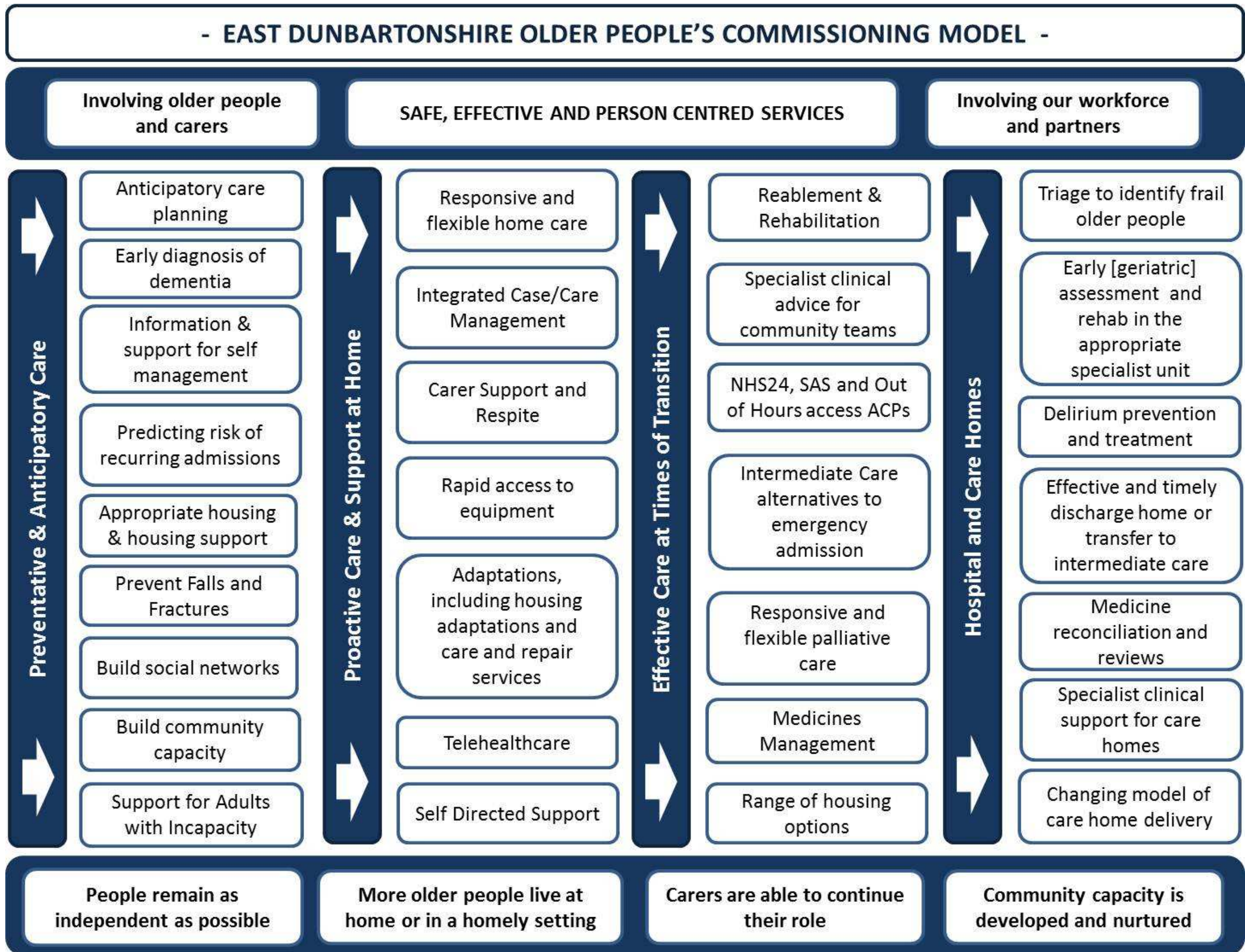
Other measures adopted by the Council include policies regarding eligibility criteria for services, currently only persons who are assessed as having ‘critical or substantial needs’ will be eligible for services. In addition, there is in place a cost ceiling for packages of care to support people at home, which is set at the CoSLA rate for care home fees (currently around £565 p/w 2012/13). Other areas include charging for residential and, more recently, non-residential services (such as home support and day care), as well as transport.

Standards and targets including e.g. waiting times for treatment and achieving standards for discharges from hospital.

6. OPPORTUNITIES & CHALLENGES

- Integration of NHS and Council services - a long-standing goal of the Scottish Government to have better joined-up services which provide care and support to people when its needed and is as seamless as possible.
- Balancing the conflicting demands of the growing ageing population against a backdrop of public services facing their most difficult financial downturn for a generation, could impact on the delivery of the strategy.
- Challenges between new (integrated) models of practice being implemented and the more traditional single system models of care.
- Equality of voice between partners to progress change.
- Ensuring the users of services are meaningfully engaged and influence the new models of service delivery.

Part **three** Joint Strategic Commissioning Delivery Plan



17

18

[17] # Hospital and Care Homes- also includes commissioning action for 'promoting Excellence in Dementia Care'
[18] See p.55 of the Framework for improving Health, Wellbeing & Care of Older people in East Dunbartonshire 2013-23 for explanation of the Commissioning Model

COMMISSIONING PRIORITY	ACTION AREA	Page
PREVENTATIVE & ANTICIPATORY CARE	Anticipatory Care Planning (ACP)	72
	Early diagnosis and effective support for people with dementia-	73
	Information and support for self management	74
	Predicting recurring hospital admission	75
	Appropriate housing support	75
	Preventing falls	77
	Building social networks	78
	Building community capacity	78
	Support for adults with incapacity	79
PROACTIVE CARE AND SUPPORT AT HOME	Responsive and flexible homecare	80
	Integrated case/care management	82
	Carer support and respite	82
	Rapid access to equipment	83
	Housing adaptations and care & repair services	84
	Telecare/Telehealthcare	85
	Self Directed Support	85
EFFECTIVE CARE AT TIMES OF TRANSITION	Re-ablement and rehabilitation	86
	Specialist clinical advice for community teams	87
	NHS24, SAS and Out of Hours access ACP's	88
	Intermediate Care alternatives to emergency admission	88
	Responsive and flexible palliative care	89
	Medicines Management	90
	Range of housing options	91
HOSPITAL AND CARE HOME(S)	Triage to identify frail older people	92
	Early [geriatric] assessment and rehab in the appropriate specialist unit	92
	Delirium prevention and treatment	93

COMMISSIONING PRIORITY	ACTION AREA	Page
	Promote excellence in Dementia Care	94
	Effective and timely discharge home or transfer to intermediate care	94
	Medicine reconciliation and review	95
	Specialist clinical support for care homes	96
	Changing model of care home delivery	96

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
PREVENTATIVE & ANTICIPATORY CARE	**Anticipatory Care (ATC) Planning:-** • Scope and develop a proactive approach to case management which will build capacity and embed approach within District Nursing practice. • Agree and embed an Anticipatory Care Plan and Self-Management across relevant professional groups • Reshape existing health and social care teams at point of entry (incl DN's,OT, Physio, Intake) to establish and embed ATC focus • Strengthen the ATC focus at pre-discharge planning	SW-15-SOA-5 Reduction in the need for emergency in-patient admissions for people aged 75+	Year1-3	CHP
	• Establish comprehensive framework for ATC practice, with relevant tools for practitioners and service users • Agreed strong, robust and embedded tools within systems including IT infrastructure to effect good sharing of information		Year 3-10	CHP

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	Early diagnosis and effective support for people with dementia- • Work with GP's to improve the rates of early diagnosis • Improve waiting times for memory clinics • Establish and agree minimum suite of support services for people with dementia eg booklet, information, access to self-assessment, advocacy services, treatment and care, carer-specific information advice and support • Ensure that all services meet quality of life eg cognitive stimulation groups • Implement the 1 year post-diagnostic guarantee (named worker for up to 1 year post diagnosis)	HCP-06-NHSPI-5 Prevalence rates for diagnosis of dementia - JIT core measure A3 HCP-16-LPI-5 / SW-08-SOA-4 % of carers who feel supported And Capable of continuing their role as a carer HCP-14-LPI-5 / SW-07-SOA4 The % of service users satisfied with their involvement in the design of their care packages (recommended outcome indicator-SCCBN & JIT)	Year 1-3	EDC
	• All relevant services are evidenced based and meet National Standards for dementia care and support • Create 'dementia-friendly' environments across a range of health and social settings to promote anti-stigma, orientation, social inclusion • An ongoing anti-stigma awareness raising campaign • Develop palliative care and planning for end of life for people with dementia		Year 3-10	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	Information and support for self management- • Integrate care across Primary, Acute and community to embed self-management incl diagnostics, care pathways, and interventions (recommendations from the LTC workstream) • Interagency workshops to identify good practice, improve linkages and gaps in current services. • Engage with patients, carers and public to build on Mental Health assets-based mapping for long term conditions. • To provide, and signpost to, core information and resources to support people to self manage. • Joint working with library services and other Transforming Care for Older People projects to improve accessibility to supported self care. • To develop role of befrienders, buddying and volunteering relevant to long term conditions.		Year 1-3	CHP
	• Exploring on-line/ web-based approaches to support practical self-management (eg e-health, tele-health) to achieve a 'normalisation' of health care management (eg through mainstream activities and services		Year 3-10	CHP

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	such as leisure) • Consistent approach to supported self care across agencies and NHS board area.			
	Predicting recurring hospital admission:- • Review and refine use of SPARRA data to predict risk/ admission, • Explore use of IRF (breakdown of spend on individuals) • Develop tools and systems which can identify and analyse other populations present inside other SW and Health care teams (eg home care, SWOPT community referrals, and OT) • Specifically analyse population who enter system via OT services • Link predicative models to ATC services • Promote and influence the Vulnerable Persons Register in GP practices		Year 1-3	CHP
	• Establish infrastructure that links clinical portals, Emergency Care Summaries • Harmonise eligibility criteria across social care and health services in order to prioritise preventative work		Year 3-10	CHP
	Appropriate housing support- • Develop a range of housing options to meet the needs of older people		Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	• Refocus the Council and RSL allocations policy to target sheltered housing at an older, frailer population • Ensure that all older people regardless of tenure have access to information on property maintenance and safety of environment • Develop and implement a comprehensive telecare strategy which ensures that all older people aged over 75 have access to assessment and equipment which will enable them to stay at home. • To develop a database of specially adapted properties and ensure that there is a good match of households to homes through the allocations system • To support rolling out the implementation of telecare/telehealth to enable older people to remain in their own homes, including quantifying cost efficiency savings to support increased investment • To further develop the annual lettings plan process to set targets for community care groups and continuously review that needs are met effectively	HCP-11-LPI-5 Waiting times between request for a housing adaptation, assessment of need and delivery of any required adaptation (JIT B2) HCP-12-LPI-5 Number of people aged 75+ with a telecare package (JIT B3-amended) HCP-13-LPI-5 Number of clients accessing care and repair services 65+ (ED-specific)		
	• Develop a housing with support project on the site of the former Lenzie Hospital • Develop a Supported Accommodation Strategy for Older People- link to BoC		Year 3-10	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	commitment to reduce number of OP in care homes			
	Preventing falls:- • Ensure all relevant H&SC staff can undertake Falls Assessment and arrange appropriate referral in various settings incl at home, care homes and acute settings • Embed risk assessment and management planning framework intervention to meet care needs identified incl referral for clinical and OT assessment, and risk-management plan • Raise awareness of conditions and issues which contribute to number and consequence of falls incl TIA's, muscle-usage (continence), warm, mobile and well-nourished and robustly medicated • Ensure access to appropriate equipment • Establish Falls-Monitoring resources and systems, and clear protocols to respond	HCP-12-LPI-5 Number of people aged 75+ with a telecare package (JIT B3-amended)	Year 1-3	CHP
	• Support the population to remain healthy and active to extend onset of osteoporosis • Develop a community approach to hazardous environments • Provide support to avoid fuel poverty		Year 3-10	CHP
	Building social networks:-		Year 1-3	Voluntary & Independent

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	• Support the development of community/user-led services which provide opportunities for social interaction and support incl faith-based, common-interest, leisure oriented; health promotion etc. • Promote inter-generational initiatives including specific projects within schools and other community locations • Signpost people to interventions and activities within their own communities • Re-examining the benefits of small-funding support to community groups e.g. transport, lettings, outings.	SW-13-SOA-5 Percentage of people 65+ indicating satisfaction with their social interaction opportunities		Sector
	• Promoting a normal active visible old age to prevent social isolation • Ensure public environments are 'old age' friendly • Implement a framework for user led monitoring and evaluations	SW-13-SOA-5 Percentage of people 65+ indicating satisfaction with their social interaction opportunities	Year 3-10	Voluntary & Independent Sector
	Building community capacity- • Sustain a case management enquiry service via a telephone & web-based access point for practitioners, older people and their carers • Identify and build the capacity of voluntary sector groups that have the potential to be	Percentage of people 65+ indicating satisfaction with their social interaction opportunities	Year 1-3	Voluntary & Independent Sector

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	future service providers • Provide groups with capacity building techniques to support their own development through resource Packs and self improvement training (Moving in2 Excellence, European Framework for Quality Management). • Develop asset-maps for older people in every community in East Dunbartonshire			
	• Build the assets and resources available within communities to support people in any geographical location in East Dunbartonshire, be that lunch clubs, faith-based groups, etc. • Develop a 10 year strategy to focus sustained investment in the voluntary sector using a Social Enterprise model identifying unmet need and gaps in delivery.		Year 3-10	Voluntary & Independent Sector
	Support for adults with incapacity- • Increase social work capacity to enable the issues of Guardianship to be progressed • Proactively promote the uptake of POA amongst families and carers, and professional staff with emphasis on BME and hard-to-reach populations • Develop a strategy with relevant stakeholders (eg CAB, Office of Public Guardian, local solicitors) to promote above • Ensure relevant staff are aware and act upon	HCP-10-NHSPI-5 Number of delayed discharges for Adults with Incapacity (Acute Beds)	Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	issues of capacity and to make appropriate referral • Challenge stigma as it relates to the loss of capacity			
	• Ensure that people who may be vulnerable to incapacity, will be supported to make appropriate arrangements eg for a Power of attorney and/or Guardianship to be in place. • Ensure that any person admitted to hospital has a incapacity recognised	HCP-09-NHSPI-5 No of acute bed days lost to delayed discharges for Adults with Incapacity. HCP-10-NHSPI-5 Number of delayed discharges for Adults with Incapacity (Acute Beds)	Year 3-10	EDC
PROACTIVE CARE AND SUPPORT AT HOME	**Responsive and flexible homecare-** • Establish an effective re-ablement focussed home care service which can respond 24 hours per day, 7 days per week • Ensure that the home care workforce is fully aware and can identify, prevent and respond to tissue viability issues • Ensure that home care is effectively targeted and time-limited where appropriate • Implement use of Standardised Shareable Assessment within Home Care	SW-14-SOA-5 Increase the number of people (65+ per 1000 population) with high levels of care needs who are cared for at home SW-15-SOA-5 Reduction in the need for emergency in-patient admissions for people aged 75+ SW-09-SOA-4 % of service users/clients satisfied with the quality of care provided HCP-14-LPI-5 / SW-07-SOA4 The % of service users satisfied with their involvement in the design of their care packages (recommended outcome indicator-SCCBN & JIT)	Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
		HCP-15-LPI-5 The % of re-ablement service users who are successful in reducing their home care dependency after their period of re-ablement (Proxy of JIT B4 in absence if comprehensive IoRN usage in ED) SW-21-SOL-4 Adult Home Care Costs per hour SW-01-AS-5 The number of people age 65+ receiving homecare SW-02-AS-5 The number of homecare hours per 1000 population age 65+ SW-03-AS-5 As a proportion of home care clients age 65+, the number receiving personal care SW-04-AS-5 As a proportion of home care clients age 65+, the number receiving a service during evenings / overnight SW-05-AS-5 As a proportion of home care clients age 65+, the number receiving a service at weekends		

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	Integrated case/care management- • Establishing a robust and effective SSA process including electronic sharing, better integrated care planning • Review and redesign joint care management processes and procedures • Establish an OD process to engage all relevant teams • Develop performance management systems to record sharing and outcomes • Develop multi-disciplinary and inter-disciplinary working • Establish joint teams		Year 1-3	EDC
	• Ensure that all service users/ patients have an integrated care plan which includes ATC and self-management plan		Year 3-10	CHP
	Carer support and respite- • Finalise an agreed joint carers strategy • Link carers organisations into wider community capacity building • Provide a range of information for carers • Effective systems in place to proactively identify carers • Establish effective Carers assessment and	HCP-16-LPI-5 / SW-08-SOA-4 % of carers who feel supported And Capable of continuing their role as a carer	Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	health checks for carers • Prioritise short breaks and flexible breaks at home • Further develop mechanisms to involve carers in service design and development • Build community of care support through direct service provision and voluntary community capacity building • Embed the process of identifying and supporting carers across all settings			
	• Develop and increase the range of options for respite/ short breaks • Develop and prioritise self-directed support options	HCP-17-LPI-5 Number of people 65+ receiving Self-Directed Support package or a Direct Payment.	Year 3-10	EDC
	Rapid access to equipment;- • Maximise self-assessment opportunities • Promote self-funded commercially available equipment and repair as a positive option • Better integrate sensory impairment services and assessment processes • Link to Telecare strategy	HCP-12-LPI-5 Number of people aged 75+ with a telecare package (JIT B3-amended)	Year 1-3	EDC
	• Integrate equipment budgets across primary care and social work	Loosely HCP-12-LPI-5 Number of people aged 75+ with a telecare package	Year 3-10	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	• Refocus the JOTS approach • Support the expansion of the Equip-U service to include Telecare	(JIT B3-amended)		
	Housing adaptations and care & repair services- • Expand and consolidate Care & Repair services to ensure access to all targeted groups, regardless of tenure • Ensure effective access to housing adaptations for targeted groups in order to prevent admission and support discharge • Involve key community planning partners in broader approach to home safety (Fire & Rescue) • To widely promote and increase the uptake of Care & Repair services to enable vulnerable or older people to tackle property disrepair and improve the amenity and condition of their homes • Advertise new preventative support officer's role, remit & services offered	HCP-13-LPI-5 Number of clients accessing care and repair services 65+ (ED-specific) HCP-11-LPI-5 Waiting times between request for a housing adaptation, assessment of need and delivery of any required adaptation (JIT B2)	Year 1-3	EDC
	• Prioritise housing support as a key preventative function		Year 3-10	EDC
	Telecare/Telehealthcare- • Assess anyone who enters the system of	HCP-12-LPI-5 Number of people	Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	health & social care provision for a package of basic Telecare, with a view to driving a policy of universal access to Telecare for those aged over 75. In addition, review service models, and consider if and how technological solutions can be utilised as an alternative part of a package of care. • Ensure all relevant frontline staff have received appropriate training for their role on equipment and use of telecare to achieve appropriate demand and deliver	aged 75+ with a telecare package (JIT B3-amended)		
	• Within the context of a comprehensive telecare strategy , telecare is an effective and available option for older people aged 75 and over • Carers understand and are reassured by telecare as an effective means of managing risk	HCP-12-LPI-5 Number of people aged 75+ with a telecare package (JIT B3-amended)	Year 3-10	EDC
	Self Directed Support- • Utilise bridging funding to develop a range of service options including care at home, respite and day support services that can be accessed directly and assembled into bespoke care packages by individuals and families • Establish and promote a policy and procedure for SDS to increase uptake amongst people aged 65+	HCP-17-LPI-5 Number of people 65+ receiving Self-Directed Support package or a Direct Payment.	Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	• Analyse the impact of SDS on the third sector provider to support market development • Develop local markets which are responsive, flexible and innovative. • Develop a communication strategy and action plan which ensures information and knowledge about SDS is widespread particularly amongst people aged 65+ • Analyse the impact of SDS on the third sector provider to support market development			
	• Analyse the impact of SDS on older people including in relation to quality, equality of access and risk		Year 3-10	EDC
EFFECTIVE CARE AT TIMES OF TRANSITION.	**Re-ablement and rehabilitation-** • Influence and implement re-ablement approaches across the workforce in community, primary care and acute services incl home care, district nursing , OP MH, day care, rehab services, and care homes • Establish a joint rehabilitation and re-ablement service which has a Single Point of Access (SPOA) • Scope service redesign options within the context of integrated services • Any resource dividend generated by re-ablement is re-invested back to meet future	HCP-15-LPI-5 The % of re-ablement service users who are successful in reducing their home care dependency after their period of re-ablement (Proxy of JIT B4 in absence if comprehensive IoRN usage in ED)	Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	demand			
	• Ensure that re-ablement has an anticipatory and preventative focus incl by increase proportion of referrals from community as opposed to acute • Increase provision of personal care within people's own homes in order to maintain a positive balance of care	HCP-15-LPI-5 The % of re-ablement service users who are successful in reducing their home care dependency after their period of re-ablement (Proxy of JIT B4 in absence if comprehensive IoRN usage in ED)	Year 3-10	EDC
	<u>Specialist clinical advice for community teams-</u> • Consolidate and develop professional support to all staff to incorporate and influence integrated working/ structures • Establish a community role for consultant geriatricians • Review the use of day hospital provision in partnership with geriatricians to improve access to specialist assessment and clinical services	HCP-08-NHSPI-5 Unplanned acute beds (75+) rate per 1,000 population - (also JIT A1) SW-15-SOA-5 Reduction in the need for emergency in-patient admissions for people aged 75+	Year 1-3	CHP
	• Establish a robust community process that ensures clinical integrity and expertise that is comparable to that within acute context		Year 3-10	CHP

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	NHS24, SAS and Out of Hours access ACPs- • Develop an OOH protocol covering SW, DN, EMI, OPMH, OOH Nursing, community alarms, NHS24, GEMS, SAS, GP's and care homes to enable effective community options for clinical decision-makers • Establish a mechanism to integrate Anticipatory Care Plans plans and other assessment information into Emergency Care Summaries for use by OOH services • Scope technological solutions to achieve effective information sharing • Contribute to NHS GG&C Clinical Services Review to develop an effective OOH service provision on a potential sector basis		Year 1-3	CHP
	• Implement and monitor OOH protocol • Participate with other partnerships in regional discussions with SAS to improve pathways and develop effective alternatives to hospital admissions		Year 3-10	CHP
	Intermediate Care alternatives to emergency admission- • Establish effective connection to intermediate care options particularly from OOH services • Scope options for intermediate care services benchmarked against SG Framework to inform the development of a local service		Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	model			
	• Establish a range of intermediate care options available across a variety of settings • Implement actions from the NHS GG&C Clinical Services Review • Raise awareness and confidence in the quality and standards of intermediate care options		Year 3-10	CHP
	Responsive and flexible palliative care- • Establish advance care plans for people with palliative care needs and full implementation of Making Plans Together including training for GP's • Monitor and review status of Living & Dying Well across all GP practices • Establish a protocol for access to care at home services for all palliative care patients to ensure that all persons who wish to die at home can do so • Provide bereavement support for carers including adapting to a post-carer role • Establish a dialogue with faith groups • Deliver spiritual care training to all relevant staff • Support care homes to support families to		Year 1-3	CHP

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	make decisions and provide end of life care			
	• Decrease the numbers of people who die in hospital • Provide comprehensive and effective support for palliative care patients in all settings		Year 3-10	CHP
	Medicines Management- • Improve support to vulnerable older people to manage their medication at home by maintaining early identification of those requiring additional support, provide training for patients, carers and relevant staff • Support GP's to be more efficient in prescribing, review the risks for people on multiple medications, through QOF arrangements, and other prescribing initiatives • Participate in 'Script Switch' pilot and develop recommendations from the findings • Review the data to support an increase 'formulary compliance' amongst GP practices and non-GP prescribers • Deliver wound dressing pilot to improve efficiency in costs and patient safety • Contribute to NHSGG&C wide initiatives to ensure compliance with formulary • Deliver awareness campaigns to reduce medicines wastage		Year 1-3	CHP

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	• Consider the prescribing implications to all service redesign initiatives			
	• Reduce the impact of poly-pharmacy across all settings • Scope the potential for non-pharmacological solutions as an alternative to traditional prescribing • Ensure that prescribing is considered strategically within an integrated resource framework for older people		Year 3-10	CHP
	Range of housing options- • Ensure that the LHS and SHIP are accurately informed as to current and developing need for older people • Provide easier access to support and advice which enables people who wish to downsize • To develop an evidence base which quantifies need for specialist, amenity or adapted housing using HNDA outcomes, existing community care data and service user information across the housing, health and social work service delivery framework • To target information to older people under occupying or in unsuitable housing on alternative housing, care and support options • To develop a database of specially adapted properties and ensure that there is a good	HCP-11-LPI-5 Waiting times between request for a housing adaptation, assessment of need and delivery of any required adaptation (JIT B2) HCP-12-LPI-5 Number of people aged 75+ with a telecare package (JIT B3-amended) HCP-13-LPI-5 Number of clients accessing care and repair services 65+ (ED-specific)	Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	match of households to homes through the allocations system			
	• Develop a range of housing options and types of tenure to ensure that all older people maximise their ability to remain at home in their own communities		Year 3-10	EDC
HOSPITAL AND CARE HOME(S)	**Triage to identify frail older people-** • Explore current model of geriatricians		Year 1-3	CHP
	• Greater links with community • Shared care model • Delivering on outcomes from AfC Review • Funding to provide community capacity		Year 3-10	CHP
	Early [geriatric] assessment and rehab in the appropriate specialist unit- • Further promote the use of fast-track referral to Day Hospital for geriatrician review direct from GPs • Ensure appropriate signposting of available services • Use of Elderly Care Assessment Nurses and AHP staff at hospital "front door" to ensure patients are identified and signposted / referred to the most appropriate clinical and care setting	SW-15-SOA-5 Reduction in the need for emergency in-patient admissions for people aged 75+ HCP-08-NHSPI-5 Unplanned acute beds (75+) rate per 1,000 population - (also JIT A1) HCP-08-NHSPI-5 Unplanned acute beds (75+) rate per 1,000 population - (also JIT A1)	Year 1-3	CHP

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	• Work with GEMS service and NHS 24 to ensure appropriate referrals out of hours			
	• Continued use of Day Hospital and links between GPs and geriatricians		Year 3-10	CHP
	Delirium prevention and treatment- • Implement and monitor National Standards for Dementia • Raise awareness of delirium across all staff groups and promote Delirium Guidelines • Drive a reduction in the the number of patients who experience multiple moves in hospital settings • Implement the 'Food, Fluid and Nutrition' policy including training care home staff • Work with the independent sector to identify training requirements and support delivery of care to older people with physical illness such as UTI's- link to/ support geriatrician support • Implement the Oral Health Strategy in relation to support to care homes	HCP-06-NHSPI-5 Prevalence rates for diagnosis of dementia - JIT core measure A3	Year 1-3	CHP
	• Review geriatrician support within a continuing care environment • Continued awareness raising and promotion of appropriate interventions		Year 3-10	CHP
	Promote excellence in Dementia Care-		Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	• Raise awareness of "*Promoting Excellence; A framework for all health and social services staff working with people with dementia, their families and carers"* • Promote the role of "dementia champions" as change agents • Promote use of Alzheimer's Society "This is me" tool to support people with dementia who are going into hospital • Review Cognitive Impairment Assessment, Documentation and Care Planning	HCP-06-NHSPI-5 Prevalence rates for diagnosis of dementia - JIT core measure A3		
	Effective and timely discharge home or transfer to intermediate care- • Consolidate existing compliance with the national standards for delayed discharges and move to comply with new targets • Increase early referral to social work following acute admission • Promote nurse or AHP-led discharge systems where clinically appropriate • Encourage supported discharge planning at point of admission • Improve hospital-community liaison function and review current team configurations • Deliver LTC workplan including self-management input delivered within acute	HCP-05-NHSPI-5 Number of people waiting more than 28 days to be discharged from hospital into a more appropriate care setting once treatment is complete (exception codes) (formerly SW-11-SOA-5 Maintain zero delayed discharge over 6 weeks for patients) SW-10-SOA-5 Reduction in the number of bed days consumed by patients in acute care for those who are fit for discharge HCP-09-NHSPI-5 No of acute bed days lost to delayed discharges for Adults with Incapacity.	Year 1-3	EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	settings	HCP-10-NHSPI-5 Number of delayed discharges for Adults with Incapacity (Acute Beds)		
	• Partnership agrees policy that no patient will be discharged from hospital directly into long-term residential care • Increase investment into care at home services		Year 3-10	EDC
	Medicine reconciliation and review- • Establish new governance arrangements incl: local prescribing budgets, prescribing indicators, patient safety, compliance with formulary, interface between acute and primary care • Scope prescribing issues which impact on older people's health with a view to developing a local pharmacy strategy for older people with associated standards and targets • Service redesigns to consider prescribing impact re- effectiveness, efficiency and costs • Deliver on medicines waste programme and chronic medication service and minor ailments scheme • Develop engagement mechanisms with local pharmacies to deliver good prescribing practice		Year 1-3	CHP

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	• An effective and efficient strategy which influences good prescribing practice		Year 3-10	CHP
	Specialist clinical support for care homes- • Contribute to review of Care Homes Practice • Implement the recommendations of the Oral Health Strategy in care homes • Scope and develop an integrated oversight of care home standards • Scope any local contribution required to support care homes • Ensure that care homes deliver the nursing competencies required by their registration		Year 1-3	Voluntary & Independent Sector
	• Deliver an integrated approach to care home standards		Year 3-10	EDC
	Changing model of care home delivery- • Develop model of re-ablement within care homes • Influence the development and commissioning of care homes locally to ensure that it matches need • Engage the independent sector to assist them to develop their contribution to the delivery of the local Ageing Well Strategy • Equitably apply Council eligibility criteria to waiting times for Free Personal Care		Year 1-3	Voluntary & Independent Sector EDC

Commissioning Priority	Specific Action	Performance Indicator	Timescale	Lead
	assessment to include those who self-arrange their care home placement			
	• Reduce the number of people who go into long-term residential and nursing care • Improve understanding and impact of the delivery of end of ife care within care homes	HCP-20-LPI-5 Number of new permanent admissions to care homes for 65+(JIT B8iii) HCP-21-LPI-5 Number of people in permanent care home placement (JIT B8iv amended) SW-22-SOL-4 Gross residential costs per week	Year 3-10	CHP

Appendix 1

COMMISSIONING: DEFINING THE STAGES OF THE PROCESS

Analyse

- Identify the impact that you wish to have in relation to your strategic objective. This will take account of the mission and key policy drivers within your organisation and will mean focussing resources on the achievement of results for people who use our services. This "**Outcome based**' commissioning" is a strategic process of specifying, securing and monitoring outcomes to meet peoples' needs at a strategic level.

- Develop an understanding of the needs of service users and link this back to the outcomes desired for service delivery. This will involve consultation with service users and organisations that advocate on their behalf. You will be seeking to understand 'how' you will know that the outcomes and impact you are looking for have been achieved.

Plan

- Resources or a budget for the service should be agreed based on the outcomes sought and the assessed need. Initial targets will become clearer once the budget is agreed. The process is reiterative and may require that you take a step back if it is clear that your budget will not allow you to achieve the desired outcomes.

- The best service available within resources should be designed based on the outcomes sought and the assessed need. Effective outcome based commissioning minimises the attention on inputs and the micromanagement of services and focuses on the achievements made by service users at the end of any programme.

Do

- Options appraisal helps decide how the service should be delivered. Purchasing the service through a competitive process – procurement – is often the best option in terms of securing Best Value. At this point you will engage more fully with procurement professionals to follow established processes that will take account of Best Value, EU legislation and the strategic aims of the procurement strategy.

Review

- Once your service delivery organisation is in place you will have to monitor and evaluate the service delivery, involving key stakeholders (particularly service users) as appropriate. Monitoring and evaluation should be proportionate to the contract value and contract length to ensure value for money. Information gathered from the monitoring/evaluation process should help you redesign the service and make decisions regarding any future contracting processes.

Appendix 2

HOUSING CONTRIBUTION TEMPLATE

This template should be completed jointly by appropriate lead officers from local authority housing and the health and social care partnership. Once completed the template should be incorporated as a discrete element within the Joint Strategic Commissioning Plan for Older People.

It should be signed off as part of the overall Joint Strategic Commissioning Plan for Older People by the signatories to that overall plan **and the Chief Housing Officer**.

Theme	Detail
Outcomes relevant to the housing contribution (*Note1)*	The Single Outcome Agreements relevant to the housing contribution are: Number 2 - East Dunbartonshire has an increasingly attractive and accessible built and natural environment for our residents and visitors Number 7 - East Dunbartonshire is a safe environment in which to live, work and visit Number 5 - Our older population are supported to enjoy a high quality of life Number 8 - Our communities are equipped to make the most of training and employment opportunities, activities and facilities that contribute to their quality of life and wellbeing The joint strategic commissioning plan describes the detail of how the partnership will undertake the change through the procurement and commissioning of services. The diagram Figure 1 on page 40 shows the relationship between all the relevant strategies and plans. It relates to services for all older people, aged 65 and over, who require health and social care and support. It covers a range of services to help older people maintain and/or optimise their independence, keep them socially engaged, physical healthy and have good mental wellbeing, enabling them to remain living in their own home or a homely setting for as long as possible. The plan also focuses on services for those who are more frail and may have complex health and social care support needs. Outcome 4 of the Council's Local Housing Strategy relates to housing outcomes for Older People. When developing this outcome, stakeholders ie health, social work, cross departmental staff and older people, were fully consulted on the development process.

	This included participating in the options appraisal process, scoring and weighting of priorities and developing final outcome tables. The outcomes will be monitored by the LHS affordable housing Working Group and reported to Scottish Government on an annual basis.
Strategic direction of travel and proposed investment changes within the draft Joint Strategic Commissioning Plan for Older People *(Note 2)*	The council has a duty to meet housing need and as part of the LHS development, East Dunbartonshire Council engaged in a joint process with authorities in the Glasgow Clyde Valley Strategic Development Plan area to produce a regional housing need and demand assessment. Within this process the council had to focus on the need for elderly people. The Council's Local Housing Strategy aims to ensure that careful consideration is given to the types of properties that will be developed to meet this projected older people demand. Given the high level of outright ownership in the area the current and emerging older population may have property equity that could facilitate a move to more appropriate housing if the right products were available on the market. This would allow people to maintain independence throughout their lifetime The LHS and Strategic Housing Investment Plan (SHIP) therefore details how we aim to develop the right products in both the social and the private housing market eg build lifetime homes and ensure all new properties for social rent are built to varying needs standards. The amount of grant funding to Registered Social Landlords (RSL's) has reduced and has therefore meant a reduced investment in new affordable housing. The LHS also states how the council will continue to invest in Care & Repair services for both private and public sector residents. The Council's Scheme of Assistance states that mandatory grants are available up to 80% of the overall cost for disabled adaptations in the private sector. The Council's Private Sector Housing Grant subsidises these adaptations will also have the current resources reduced in future years – this will impact on the level of adaptations being carried out.

The housing contribution – investment already planned on the basis of the LHS (and if appropriate the LA Housing Business Plan for its own stock) (*Note 3)*	The LHS Strategic Aim 4 – More people with particular housing needs access suitable housing options which promote independent living Key outcomes are: • The Council aim to ensure all council owned properties will meet the Scottish Housing Quality Standard by 2015 • Housing Revenue Account (HRA) business plan will be updated and revised annually • Strategic Housing Investment Plan (SHIP) – will be updated annually in line with LHS strategic priorities and Scottish Government funding • Continue to work in partnership with RSL's and developers to develop properties for older people • Continue to work with RSL's and developers to building Shared equity properties for older people • Implement matrix system developed by Housing and Social Work or to prioritise access to housing for community care groups based on level of risk and nature of need. • Support rolling out the implementation of telecare/telehealth to enable older people to remain in their own homes • Widely promote Care & Repair Scheme • Develop an evidence base which quantifies need for specialist amenity or adapted housing to meet the strategic aims • Target information to older people under-occupying or in unsuitable housing on alternative housing, care and support options • Develop a database of specially adapted properties and ensure there is a good match of households to homes in the allocations system • Facilitate Incentive to Move Scheme
Likely future impact of plan upon housing resources (*Note 4)*	Developing properties for older people can incur additional costs for adaptations such as wet rooms, kitchens, wheelchair accessible and single storey properties. Should there be a requirement in future to build more properties especially for older people with particular needs then this would impact on the overall number of new affordable homes that can be constructed. Currently the SHIP has guaranteed funding for the next 3 years but thereafter it is unclear as to the level of Scottish Government grant funding and the level of prudential borrowing that the council can obtain to support the new housing development programme.

	Continued funding would also be required to continue and also enhance the Care & Repair Service to provide additional housing advice, information and support for older people. The current level of resources per year, is as follows: • Adaptations to private sector properties - £500,000 • Adaptations to council owned properties - £300,000 • Adaptations to Registered Social Landlord properties – £300,000 • Care & Repair - £148,000
Process for integrating the housing contribution to the Joint Strategic Commissioning Plan for Older People in future *(Note 5)*	The Change Fund Programme Board has a Housing representative as a Lead officer. The Housing representative has full voting rights The Housing service has been involved in developing the Joint Strategic Commissioning Plan by attending planning and development meetings with Health and Social Work staff. The Housing service is also represented at the Provider Forum. Any integration of housing revenue account monies or private sector housing grant funding in future would need to involve services discussion about how to achieve better outcomes
Outline and understanding of shared data sources , and gaps to be addressed *(Note 6)*	As part of the LHS development, East Dunbartonshire Council engaged in a joint process with authorities in the Glasgow Clyde Valley Strategic Development Plan area to produce a regional housing need and demand assessment. Estimates of need and demand for affordable and private housing have been established up to 2025. It proved very challenging gathering information on future provision for older people. It has been recognised that a community care housing needs assessment requires to be carried out in partnership with health, social work and housing (also referred to in note 7)
Key challenges going forward *(Note 7)*	• There is a gap in needs evidence for community care needs for older people. If we can't evidence then it is difficult to make decisions • Reduced Scottish Government grant funding for new build • Reduction in Private Sector Housing Grant • Shortage of land for new build developments in East Dunbartonshire • More recognition of Housing contribution for future

	Change Fund proposals • Shared understanding between all representatives on the Programme Board about difference between public and private sector housing, legislation, funding sources, reporting mechanisms • Training for cross departmental council staff to gain understanding on housing needs of older people and budgets to be able to plan more effectively

Note 1: This should reflect those health and social care measures, including outcomes that are considered most likely to be impacted by the housing contribution. They should include national and local measures, as detailed in the JSC Plan for Older People

Note 2: This should describe the proposed overall shift in the balance of care and outline the key service re-design proposals in the JSC Plan for Older People that are intended to deliver this shift

Note 3: This should detail those aspects of the current LHS that contribute to delivery of the JSC Plan for Older People focusing on change in service delivery to support health and social care outcomes, and should also reference the local authority's investment plans for its own stock where appropriate

Note 4: This should outline the potential impact that the plan is likely to have on housing resources, both services and bricks and mortar, going forward

Note 5: This should explain local proposals for ensuring that the housing contribution is clearly articulated and how a stronger housing perspective will be incorporated into future JSC processes and plans

Note 6: This should describe the data sources that have been used by both health and social care and housing in compiling the JSC Plan for Older People and the Local Housing Strategy and identify any currently apparent gaps in the data that, were they to be addressed, would better support joint working between the sectors

Note 7: This should highlight any particular issues regarding housings' contribution that have emerged from discussions relating to the completion of this HCS and/or any other related processes

Other Formats:

This document can be provided in large print, Braille, or an audio cassette and can be translated into other community languages. Please contact the Council's Corporate Communications Team at:

East Dunbartonshire Council
Southbank Marina
Kirkintilloch
G66 1TJ
Tel: 0141 578 8000

本文件可按要求翻譯成中文，如有此需要，請電 0300 123 4510。

Gabhaidh an sgrìobhainn seo cur gu Gàidhlig ma tha sin a dhìth oirbh. Cuiribh fòin gu 0300 123 4510

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